

# به نام خدا

اپروچ به بیمار آقای ۲۶ ساله با درد گلو و تب در درمانگاه پزشکی خانواده

استاد راهنما : سرکار خانم دکتر نسیم عبادتی  
ارائه دهنده : شایگان یوسفی فر

شرح حال :

بیمار آقای ۲۶ ساله با شکایت درد گلو و تب و لرز و خستگی از سه روز قبل به درمانگاه پزشکی خانواده مراجعه کرده است.

وی سابقه تماس با فرد با علایم مشابه را نمی‌دهد.

سابقه بیماری زمینه ای و بیماری قلبی و عروقی ندارد.  
سابقه مصرف قلیان ، سیگار، الکل نمیدهد.  
دانشجوی ارشد فیزیوتراپی است.

یک پارتنر جنسی دارد که ان پارتنر هم شریک جنسی دیگری ندارد.  
فرد ورزشکار بوده و دو روز در هفته باشگاه و یک روز در ماه فوتبال بازی میکند .

معاینه فیزیکی:

BP=110/70      T=37.9 C      RR=14/min      PR=83/min

پوست: پتشی -/پورپورا- /اگزانتم - /مخاط دهان سالم

گوش : التهاب -/اتور- /اوریکول غیر تندر

چشم : کنژکتیویت -/

بینی : رینوره - /احتقان - /تندرنس روی سینوس ها -/

دهان: اولسر -/ خونریزی - /

گلو : اگزودا+ /پتشی کام+ /اوولا در خط وسط / دیس فاژی -/صدای مافل -/ تغییر صدا- /استریدور- /ابریزش از

دهان- /خلط -/ بزرگ شدن لوزه‌ها

گردن: لنفادنوپاتی دو طرفه گردنی POST oricular که سیمتریک بوده است

قلب : سوفل -/ murmer -/

ریه : رال -/ ویز - /

شکم : درد- /تندرنس- /هیپاتومگالی -/ اسپلنومگالی -/





## Warning signs for complications of pharyngitis

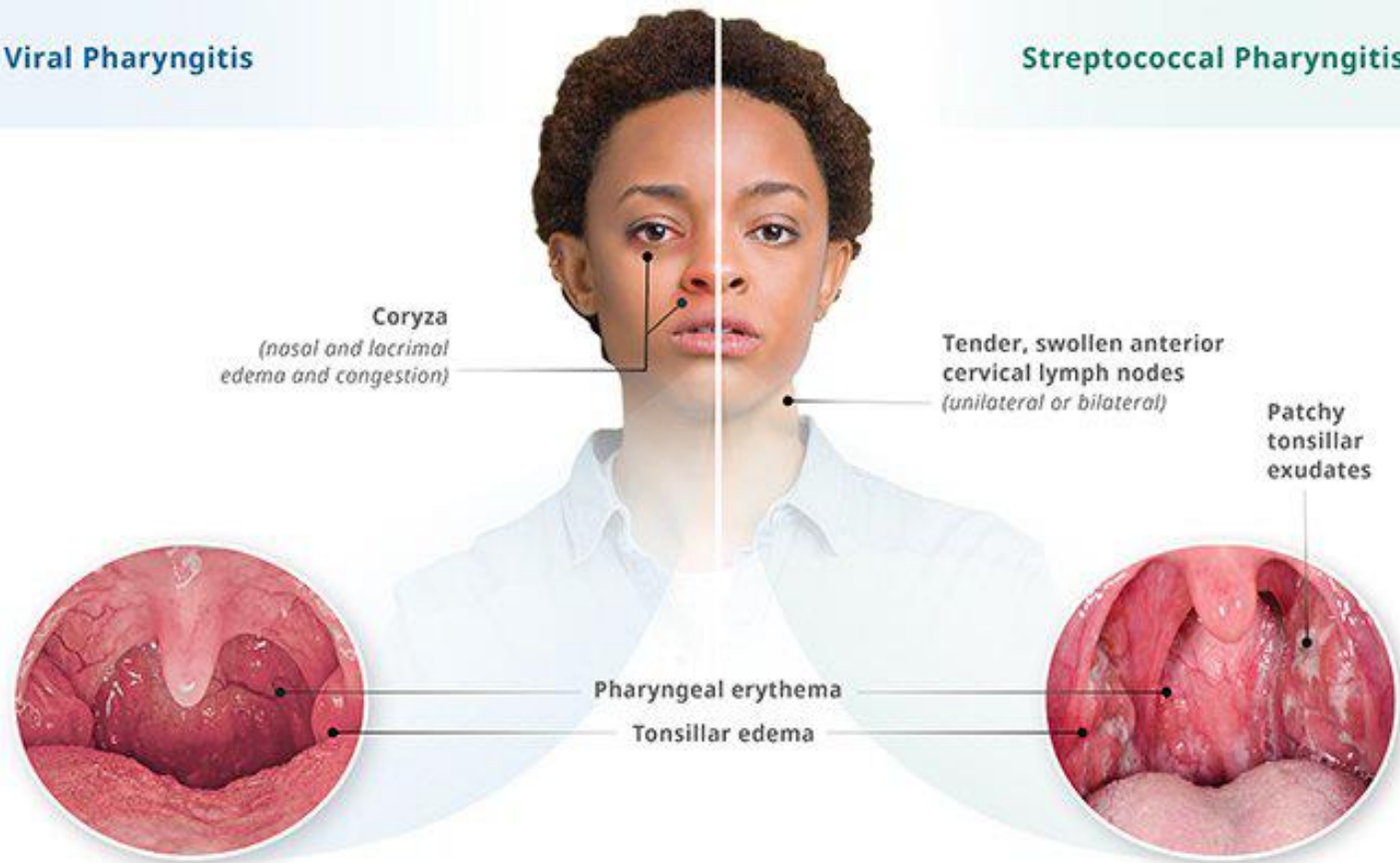
Airway obstruction
Muffled or "hot potato" voice
Drooling or pooling of saliva
Stridor
Respiratory distress (tachypnea, dyspnea, retractions)
"Sniffing" or "tripod" positions (positions that help maintain airway patency)
Deep neck space infection
Severe unilateral sore throat
Bulging of the pharyngeal wall, soft palate, or floor of oropharynx
Neck pain or swelling, torticollis (wry neck) due to muscle spasm
Crepitus
Trismus (irritation and reflex spasm of internal pterygoid muscle)
Stiff neck
Fever and rigors
History of penetrating trauma to oropharynx

افتراق فارنژیت استرپتوکوکی و فارنژیت ویرال



## Viral Pharyngitis

## Streptococcal Pharyngitis



### Features Suggestive of Viral Pharyngitis

- Subacute onset of sore throat
- Associated upper respiratory infection symptoms (cough, congestion, conjunctivitis, hoarse voice)
- Pharyngeal erythema and tonsillar edema
- Low-grade or absent fever

### Other Findings (variably present)

- Pharyngeal/tonsillar exudates
- Oral ulcers
- Viral exanthem

### Features Suggestive of Streptococcal Pharyngitis

- Acute onset of sore throat
- Absence of other upper respiratory infection symptoms
- Pharyngeal erythema and tonsillar edema
- Fever
- Tonsillar exudates

### Other Findings (variably present)

- Known group A *Streptococcus* exposure
- Palatal petechiae
- Scarlatiniform rash
- "Strawberry" tongue

بیمار یک روز بعد از شروع علائم به یک پزشک مراجعه کرده است و با تشخیص عفونت استرپتوکوک تحت درمان با پنی‌سیلین تزریقی قرار گرفته ولی در این دو روز تغییری در حال عمومی بیمار و گلو درد وی رخ نداده است.

## Clinical features of acute pharyngitis by pathogen

	Pathogen	Relative frequency*	Associated clinical syndrome and/or symptoms
Bacteria	Group A <i>Streptococcus</i>	Common	Fever, tonsillar exudates, tender cervical lymphadenopathy, scarlatiniform rash, particularly in an adolescent or young adult
	Group C or G <i>Streptococcus</i>	Less common	Similar to GAS pharyngitis but more frequently acquired in a waterborne or foodborne outbreak
	<i>Arcanobacterium haemolyticum</i>	Less common	Similar to GAS pharyngitis, scarlatiniform rash common, particularly in adolescents and young adults
	<i>Fusobacterium necrophorum</i>	Uncertain	Lemierre syndrome (septic jugular vein thrombophlebitis), possible association with recurrent or persistent pharyngitis
	<i>Neisseria gonorrhoeae</i>	Likely rare	Nonspecific symptoms such as acute sore throat, pharyngeal exudates, and cervical lymphadenopathy in a patient with risk factors for sexually transmitted infections, particularly receptive oral intercourse
	<i>Corynebacterium diphtheriae</i>	Rare	Diphtheria: Low-grade fever, anorexia, malaise, sore throat with gray-white membrane on palate, tonsil or posterior oropharynx, cervical lymphadenopathy, particularly in a patient who has not been vaccinated
	<i>Mycoplasma pneumoniae</i>	Rare	Cough, pneumonia
	<i>Chlamydia pneumoniae</i>	Rare	Fever, cough, laryngitis, pneumonia
	<i>Treponema pallidum</i>	Rare	Secondary syphilis: Sore throat may precede development of mucosal ulcers, generalized lymphadenopathy and palmar-plantar rash
	<i>Francisella tularemia</i>	Rare	Ulceroglandular fever: Severe sore throat, pharyngeal exudes, cervical lymphadenopathy (often posterior and bilateral), oral

Viruses	Respiratory viruses	Very common	Common cold: Fever, rhinorrhea, cough, hoarseness, coryza, conjunctivitis, oral ulcers
	Epstein-Barr virus	Less common	Infectious mononucleosis: Fever, fatigue, tender cervical lymphadenopathy, splenomegaly, lymphocytosis, particularly in an adolescent or young adult
	Herpes simplex virus	Less common	Severe sore throat, with or without oral ulcers
	Cytomegalovirus	Rare	Mononucleosis-like syndrome, similar to EBV but typically milder
	HIV	Rare	Acute retroviral syndrome: Fever, fatigue, lymphadenopathy, rash, myalgias, arthralgias, diarrhea, weight loss, painful mucocutaneous ulcers

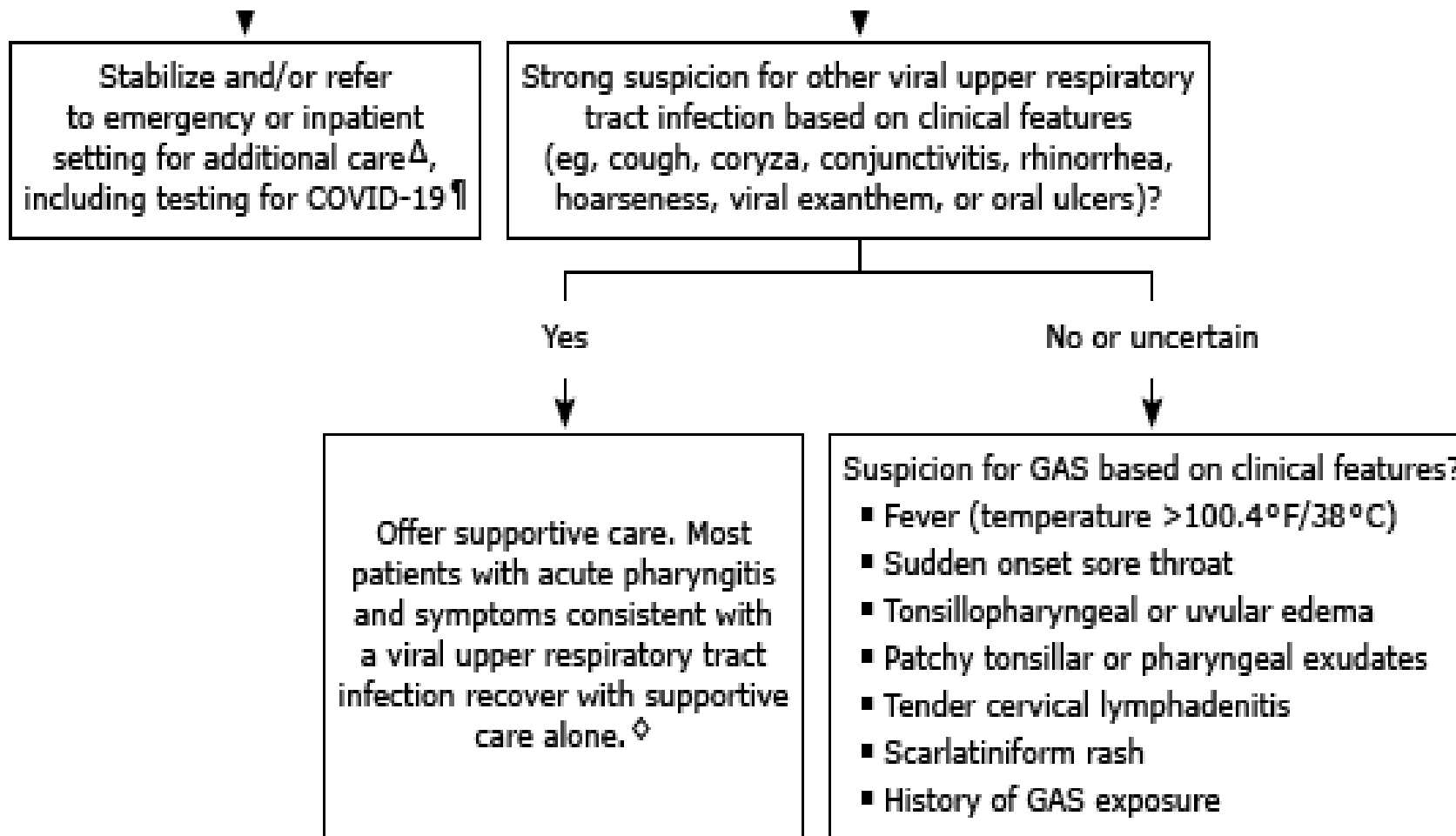
**Any of the following signs or symptoms of severe infection present:**

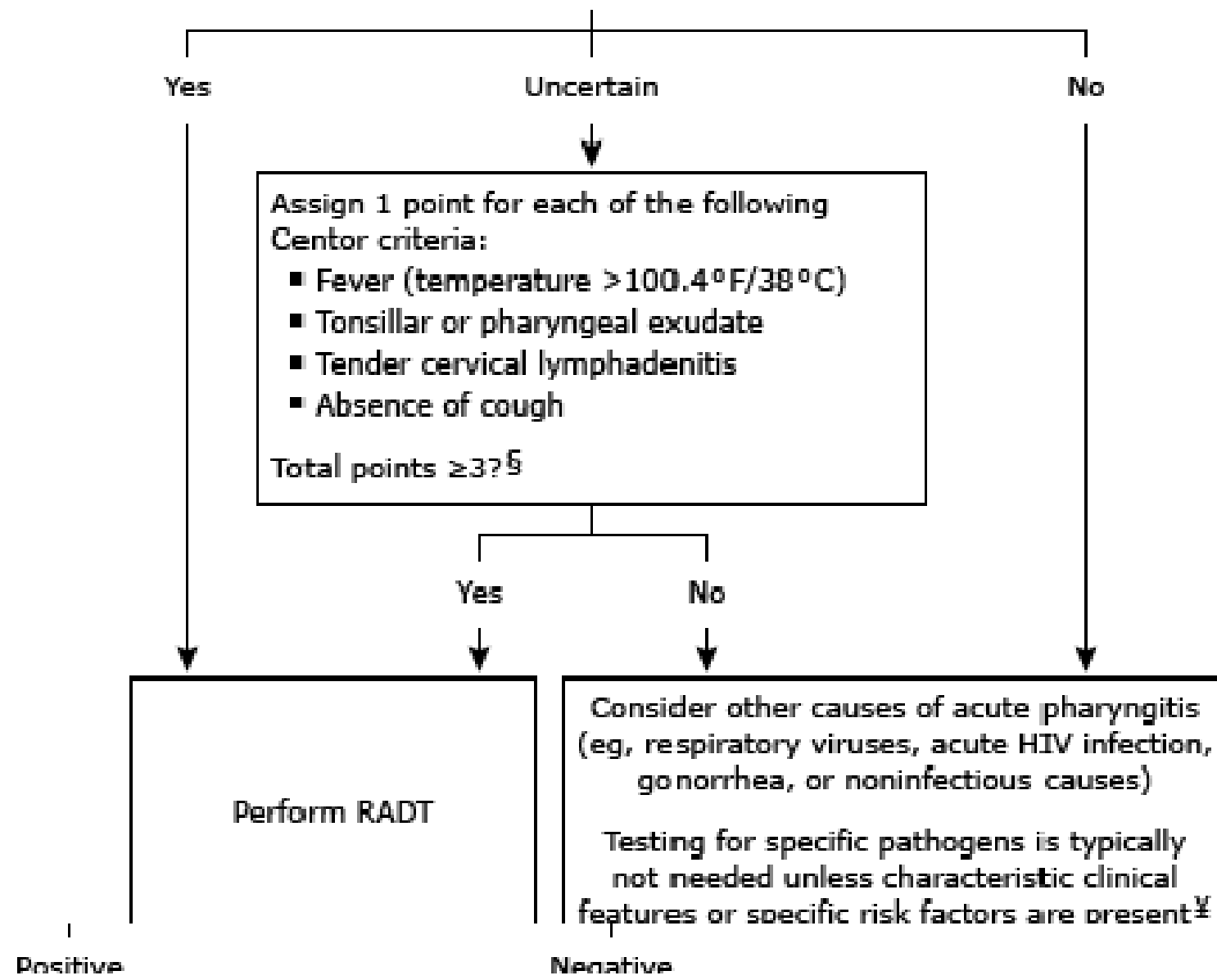
- Muffled voice
- Drooling
- Stridor
- Respiratory distress
- "Sniffing" or "tripod" positions \*
- Fever and rigors
- Severe unilateral sore throat
- Bulging of the pharyngeal wall/floor or soft palate
- Trismus
- Crepitus
- Stiff neck
- History of penetrating trauma to oropharynx

Yes

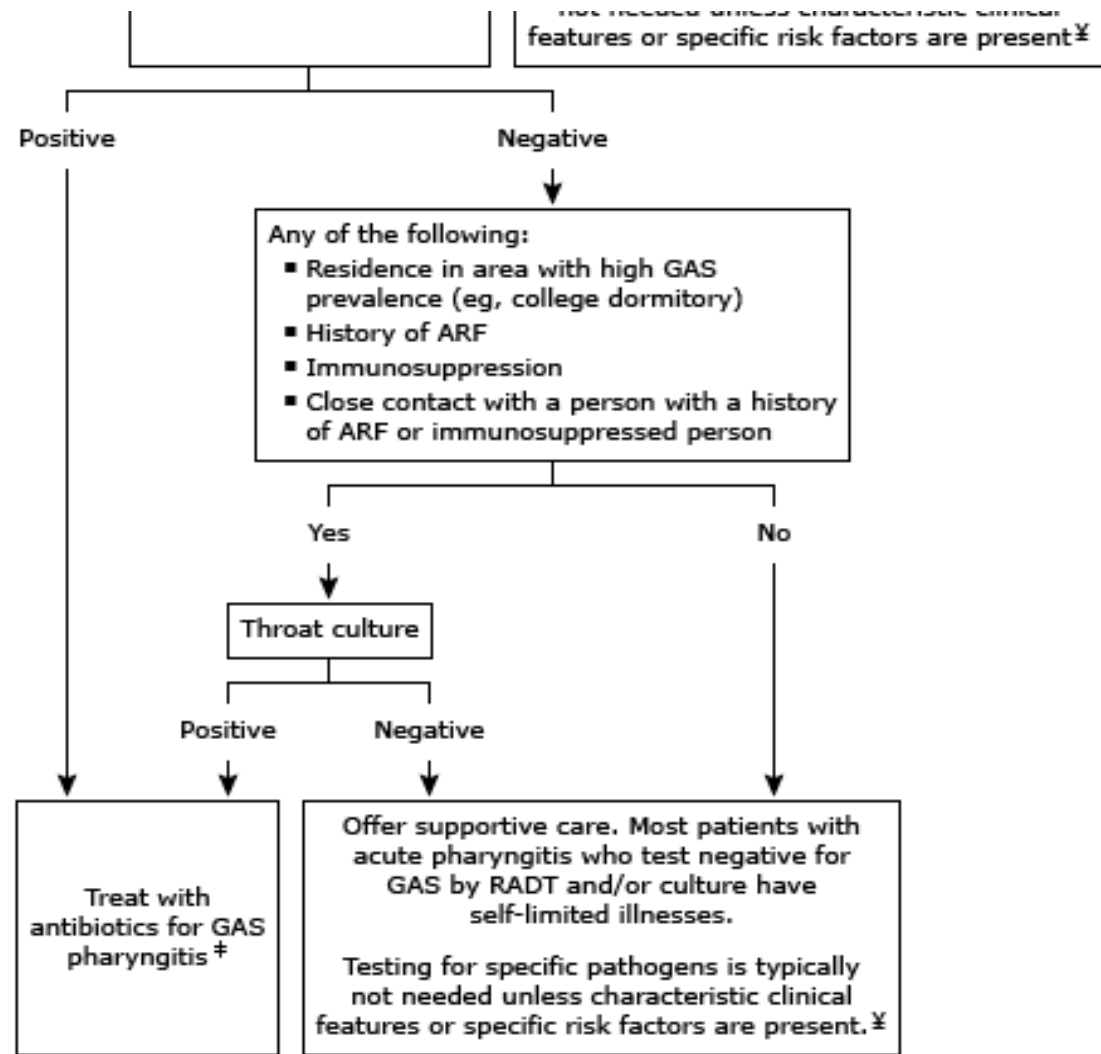
No

Test for COVID-19, continue evaluation for other possible causes of pharyngitis, and advise isolation while awaiting results †









## Clinical manifestations of infectious mononucleosis

Symptoms and signs	Frequency, percent
Symptoms	
Malaise and fatigue	90 to 100
Sweats	80 to 95
Sore throat, dysphagia	80 to 85
Anorexia	50 to 80
Nausea	50 to 70
Headache	40 to 70
Chills	40 to 60
Cough	30 to 50
Myalgia	12 to 30
Ocular muscle pain	10 to 20
Chest pain	5 to 20
Arthralgia	5 to 10
Photophobia	5 to 10

Signs	
Adenopathy	100
Fever	80 to 95
Pharyngitis	65 to 85
Splenomegaly	50 to 60
Bradycardia	35 to 50
Periorbital edema	25 to 40
Palatal enanthem	25 to 35
Liver and spleen tenderness	15 to 30
Hepatomegaly	15 to 25
Rhinitis	10 to 25

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Jaundice	5 to 10
Skin rash	3 to 6
Pneumonitis	< 3

# **Symptomatic treatment of acute pharyngitis in adults**

- Over-the-counter oral analgesics, including nonsteroidal antiinflammatory drugs (NSAIDs), acetaminophen, and aspirin, typically have a duration of effectiveness of several hours. They generally act within one to two hours to relieve sore throat symptoms due to acute pharyngitis. Oral analgesics act systemically; thus, they will address concomitant symptoms that may accompany sore throat, such as fever or headache. The choice among oral analgesics, and permissible maximum dosages, may be limited by such factors as renal or hepatic dysfunction or by current or prior gastric irritation or reflux symptoms. We typically start at a low dose and titrate up.

- Topical treatments applied locally to the throat via lozenge or spray, or via beverages or foods (eg, ice, tea, soup, and honey), are generally quicker-acting than oral analgesics, and they typically have a shorter duration of pain relief which may necessitate frequent re-dosing. There is no evidence that a particular topical lozenge or spray is superior in efficacy. The choice among them is dependent on availability and clinician or patient preference. For patients with significant sore throat pain, hydration with frozen (eg, ice or popsicles) or warmed liquids (eg, teas, soups), rather than room temperature or refrigerated fluids, may provide relief. Foods that coat the throat, including honey and hard candies, can facilitate intake of calories while temporarily relieving throat pain.

Nonpharmacologic environmental approaches may also be of benefit. These approaches include adjusting humidity to avoid a dry environment and avoiding exposure to irritants such as tobacco smoke.

## Fluids, herbs, and foods for sore throat relief

— Adjusting the temperature and texture of foods and beverages may provide local relief of sore throat pain. While data showing benefit are quite limited, these approaches are intuitive. We typically advise these measures since they are likely to be safe with minimal adverse effect, and patients often describe relief of symptoms.

For patients with significant sore throat pain, hydration with frozen (eg, ice or popsicles) or warmed liquids (eg, teas, soups), rather than room temperature or refrigerated fluids, may provide relief. Very cold foods can have a numbing-like effect that temporarily reduces or alleviates the pain of swallowing. Ice cubes or frozen popsicles facilitate hydration; ice cream and frozen yogurt provide caloric intake.

Warm fluids and foods, including teas, soups, and soft non-irritating foods, may be better tolerated by patients with throat pain than irritating foods (eg, rough-textured or spicy foods) or fluids at room temperatures. Foods that coat the throat, including honey and hard candies, can facilitate intake of calories while temporarily relieving throat pain.

Many teas and herbal drops are marketed in the United States for relief of sore throat pain; this is supported by a weak evidence base. These products may contain agents identified as demulcents, which have mucilaginous effects purported to relieve oral and pharyngeal mucosal irritation by forming a soothing film over mucous membranes. Commonly used demulcents in such products include honey, pectin, and [glycerin](#).

A small multicenter industry-sponsored randomized controlled trial of an herbal tea containing licorice root, elm inner bark, marshmallow root, and licorice root aqueous dry extract was performed in 60 adult patients presenting to clinics in the United States with acute pharyngitis. The tea was found to significantly diminish sore throat pain compared with placebo during the 30 minutes after drinking, with no serious adverse events [\[49\]](#).



## DIAGNOSIS

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### General approach

— Epstein-Barr virus (EBV)-induced IM should be suspected when an adolescent or young adult complains of sore throat, fever, and malaise and also has lymphadenopathy and

pharyngitis on physical examination [10,99]. The presence of palatal petechiae, splenomegaly, and posterior cervical adenopathy are highly suggestive of IM, while the absence of cervical lymphadenopathy and fatigue make the diagnosis less likely [100,101].

The presence of lymphocytosis and increased circulating atypical lymphocytes supports the diagnosis of EBV infection. However, the diagnosis should be confirmed with a heterophile antibody test or through EBV-specific antibodies. Although there is no specific antiviral therapy to treat IM, confirmatory testing is helpful to inform patients with IM of certain risks, such as splenic rupture and airway obstruction, as well as why fatigue may take some time to remit. A detailed discussion of serologic testing is found below.

Patients with fever, lymphadenopathy, and pharyngitis should also have a diagnostic evaluation for streptococcal infection by culture or antigen testing.

## Return to school or work

— Since EBV may be shed intermittently for months to years in people who have acquired infection, and the source of infection is rarely known in the patient who develops infectious mononucleosis, there are no restrictions regarding recently ill IM patients for returning to school or the workplace. The decision to return to full activities should be guided by the level of fatigue and other constitutional symptoms.

## Avoiding splenic rupture

— All athletes should refrain from sport activities during early illness. As recuperation occurs, clinicians should keep in mind that spontaneous or traumatic splenic rupture in the setting of IM appears to be most likely within 2 to 21 days after the onset of clinical symptoms [140]. Descriptions of splenic rupture after the fourth week are rare [64,141].

Recommendations to resume sports are somewhat arbitrary given the lack of prospective data. Several authors recommend potential resumption of all sport activities, except for strenuous contact sports, no earlier than 21 days after illness onset [142,143]. Others advocate a universal four-week time frame regardless of activity level [144].

A conservative synthesis of retrospective studies yields the following suggestions [145]:

- For athletes planning to resume noncontact sports, training can gradually start three weeks from symptom onset. This recommendation assumes that participants avoid any activities capable of causing chest or abdominal trauma.
- For strenuous contact sports (including football, gymnastics, rugby, hockey, lacrosse, wrestling, diving, and basketball) or activities associated with increased intraabdominal pressure (such as weightlifting) that may carry a higher risk of splenic injury, we recommend waiting for a minimum of four weeks after illness onset.

# RETURN TO SPORTS

# سطوح پیشگیری

**Primordial Prevention**

**Primary Prevention**

**Secondary Prevention**

**Tertiary Prevention**

**Quaternary Prevention**

# Primordial Prevention

۱- استفاده از رسانه‌ها و بیلبوردها جهت اهمیت مراقبت‌های لازم در زمان ابتلا به عفونت‌های تنفسی

۲- دسترسی همگانی به تشکیل پرونده الکترونیک سلامت جهت ثبت سوابق بیماری‌ها

۴- آموزش پزشکان و مراقبین سلامت در سطح اول ارایه خدمات در مورد نحوه برخورد بیماران مبتلا به فارنژیت و تشخیص‌های افتراقی آنها

# Primary Prevention

۱- آموزش چهره به چهره به بیمار و همراهان وی برای جلوگیری از ابتلا و گسترش ویروس

۲- آموزش چهره به چهره به بیمار و همراهان وی برای جلوگیری از ایجاد عوارض ابتلا به مونوکلئوز عفونی

۳- آموزش چهره به چهره به بیمار و همراهان وی برای بازگشت به کار و ورزش

# Secondary Prevention



# Tertiary Prevention

- ۱- تجویز داروی برای کنترل فانژیت و علایم در زمان مناسب
- ۲- تجویز درمان‌های غیرفارماکولوژیک برای کنترل علایم

# Quaternary Prevention

- ۱- عدم درخواست آزمایشات کشت و PCR در بیماران با علایم بالینی تبپیک
- ۲- عدم تجویز داروی هایی مثل کورتیکواستروئید در موارد خفیف
- ۳- عدم توصیه به ورزش و کار زودهنگام که سبب ایجاد عوارض شود

با تشکر از صبر و توجه شما