

Re: Role of Non-Group A Streptococci in Acute Pharyngitis

To the Editor: Jeffrey Tiemstra and Rosita L. F. Miranda¹ have added important data concerning the diagnosis and management of acute pharyngitis. Like previous investigators, they found that a significant percentage of adolescents and young adults presenting with acute pharyngitis grow streptococci from a group other than group A strep, which is the classic concern.

Most other articles on this subject have focused on group C and group G streptococci. I doubt that clinical presentation of group B resembles the clinical presentation of group C. In unpublished data, we did not find group B patients having such a presentation. Zwart also found that only A, C, and G caused pharyngitis.² Therefore, I would suggest that the authors look carefully at the distribution of clinical indicators in group B compared with group A and group C.

The Tiemstra article also shows that in practice (rather than in prospective studies) the sensitivity of the group A strep rapid test was only 75%. One can postulate several reasons for a difference in rapid test sensitivity from prospective studies. Just to suggest 2 possibilities: (1) sampling errors might occur more often in practice or (2) there may be publication bias for higher sensitivity studies.³

Like Zwart's classic 2000 BMJ study on treatment, the authors find a high probability of either group A or non-group A strep in patients having high pharyngitis scores.³ That article supports a clinical improvement from antibiotics for group C strep pharyngitis. In that article adults (ages 15–60) experienced a 2-day symptom improvement if they had group A pharyngitis and a 1-day symptom improvement if they had group C pharyngitis.

The addition of headache to the pharyngitis scores, although understandable, makes comparison of this study to previous studies more difficult.

A note of caution: these findings probably apply to the adolescent/young adult age group and not pre-adolescents. Previous studies have shown that non-group A infections occur commonly in college health populations but not pre-adolescents.

Congratulations for continuing the documentation that adolescent and adult pharyngitis is more complex than deciding whether the patient has group A strep.

Robert M. Centor, MD
University of Alabama Huntsville Regional Medical
Campus, Huntsville, AL
rcentor@uab.edu

References

1. Tiemstra J, Miranda RLF. Role of non-group A streptococci in acute pharyngitis. *J Am Board Fam Med* 2009;22:663–9.

2. Zwart S, Ruijs GJ, Sachs AP, van Leeuwen WJ, Gubbels JW, de Melker RA. Beta-haemolytic streptococci isolated from acute sore-throat patients: cause or coincidence? A case-control study in general practice. *Scand J Infect Dis* 2000;32:377–84.
3. Zwart S, Sachs AP, Ruijs GJ, Gubbels JW, Hoes AW, de Melker RA. Penicillin for acute sore throat: randomised double blind trial of seven days versus three days treatment or placebo in adults. *BMJ* 2000;320:150–4.

doi: 10.3122/jabfm.2010.03.090267

The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Role of Non-Group A Streptococci in Acute Pharyngitis

To the Editor: We appreciate Dr. Centor's¹ observations and comments on the literature regarding the role of non-group A strep in acute pharyngitis. In our population, group B was associated with 3 of the 4 classic criteria—fever, cervical adenopathy, and exudates—but not absence of cough (Figure 5 in our article²), suggesting that it may also represent a pathogen. Given the concerns for group B strep infection in the young adult population that includes pregnant women this certainly warrants further investigation, which we hope to pursue.

Jeffrey Tiemstra, MD
Family Medicine Center, University of Illinois at
Chicago
Chicago, IL
jtiemstr@uic.edu

References

1. Centor RM. Re: role of non-group A streptococci in acute pharyngitis. *J Am Board Fam Med* 2010;23:423.
2. Tiemstra J, Miranda RLF. Role of non-group A streptococci in acute pharyngitis. *J Am Board Fam Med* 2009;22:663–9.

doi: 10.3122/jabfm.2010.03.100045

Re: Does Having a Personal Physician Improve Quality of Care in Diabetes?

To the Editor: We have read with interest the article by Hueston,¹ “Does having a personal physician improve quality of care in diabetes?” in your January/February issue, but we have serious reservations about his conclusion for several reasons.

First, although he cites 4 articles coauthored by Arch Mainous, he omits the one by Mainous most directly relevant to this article, which was Mainous and Gill (1998),² showing that for patients the benefits of continuity of care flow more from a personal relationship than from seeing others at the same site of care.