Angina fever

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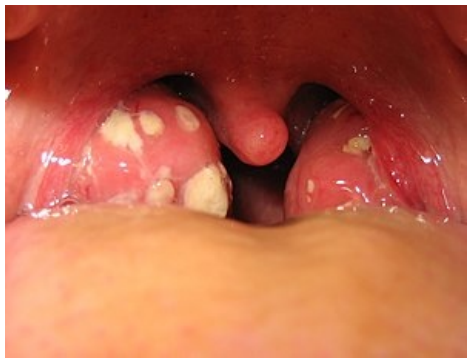

Lacunar angina

Angina is an acute tonsillitis caused by the β-hemolytic streptococcus *Streptococcus pyogenes*. It produces Dick's erytrogen toxin, the release of which into the bloodstream is responsible for the accompanying symptoms. Angina is mainly manifested by fever and sore throat. It typically occurs in smaller epidemics in children's collectives (mostly 4–12 years old).[1]

Originator

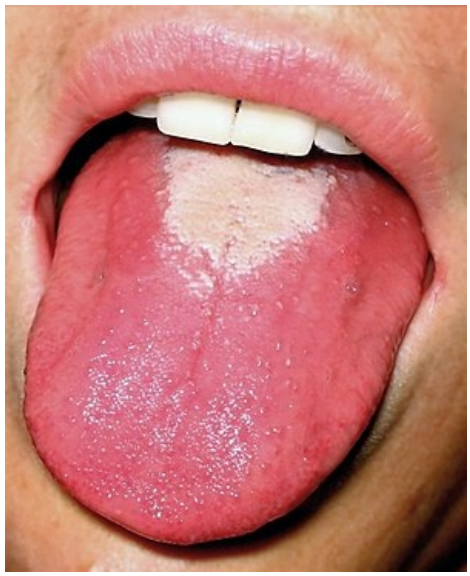
Streptococcus pyogenes belongs to group A streptococci. The bacteria are G+, oval to round, non-motile and non-sporulating. It produces an erythrogenic exotoxin that causes inflammation (acute tonsillitis accompanied by exanthema). M-protein and hyaluronic acid act as surface antigens of the capsule. They increase virulence and show immunological cross-reactivity to cardiac myosin and sarcolemma. [2]

Incubation period

2–4 days.[2]

Clinical picture

- Catarrhal to lacunar angina,
- raspberry tongue,
- facial erythema with circumoral pallor (Filatov's sign),
- swelling of regional lymph nodes.


Raspberry tongue

General symptoms: vomiting, abdominal pain, headache, fever exanthema (mainly in the lower abdomen, on the chest and inner sides of the limbs - embolization predilection), small papules in the area of the nail beds and on the balls of the feet (Schrámek's sign). [1].

Diagnostics

Swab from the pharynx - culture certificate of streptococci. And determining the level of antibodies against streptolysin O (**ASLO**), streptolysin S. Also against hyaluronidase, streptokinase and deoxyribonuclease (to assess the course of the disease, they are not of great importance in the acute phase).

Complications

Rheumatic fever - with a latency of 10-20 days (Pancarditis, arthritis, erythema annulare, chorea minor). **Acute poststreptococcal glomerulonephritis** – hematuria 6–10 days after infection [2].

Treatment

The drug of choice is Penicillin V 100,000 IU/kg/d for 10 days (difficulties should subside after 24–48 hours). In case of treatment failure or allergy to penicillin, cephalosporins (5 days), amoxicillin with clavulanic acid, macrolides.

aminopenicillins should not be administered if infectious mononucleosis is suspected[2]

Carriership of Streptococcus pyogenes

The prevalence *Streptococcus pyogenes* carriage in the pediatric population is (depending on the area) 15 to 20%, in the adult population it is lower. Asymptomatic carriers are not at risk of developing suppurative or non-suppurative complications. At the same time, they are not considered a significant reservoir for the spread of streptococcal infection. Therefore, these asymptomatic carriers do not need to be identified or treated. Performing control cultures after therapy is not recommended (cost-benefit).[3][4]

Links

Related Articles

- **Streptococcus**: Streptococcus pyogenes • Streptococcus agalactiae • Streptococcus pneumoniae • Streptococcus mutans • Oral streptococci
- **Streptococcal infections**: Group A streptococcal infections • Fever • Angina fever • Erysipelas • Impetigo • Infections caused by viridating streptococci • Complications and treatment of streptococcal infections • Rheumatic fever
- Angina ■ Differential diagnosis of angina pectoris

References

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