# Guidance for General Practitioners and others on the management of infections caused by Group A Streptococcus

There has been an increase in invasive Group A *Streptococcus* (iGAS) cases notified to HPSC in the last quarter of 2022 and in early 2023.

Group A streptococci are often found in the throat and on the skin of healthy people. If it causes infection, the majority of these cases are of a mild illness. **Very rarely it can cause severe illness and life-threatening infections.**

## WHAT IS INVASIVE GROUP A STREP (IGAS)?

iGAS is an acute and frequently life-threatening clinical presentation. Features may include bacteremia leading to sepsis (and puerperal sepsis,) cellulitis, pneumonia, meningitis, and septic arthritis. Two of the most severe manifestations of iGAS are necrotizing fasciitis and Streptococcal Toxic Shock Syndrome (STSS).

## WHAT SHOULD ALERT YOU TO POSSIBLE IGAS INFECTION?

Consider iGAS in patients with tonsillitis, pharyngitis, scarlet fever, cellulitis, impetigo or other presentations, who appear more unwell than you would normally expect.

## A. SUSPECTED INVASIVE GROUP A STREPTOCOCCUS INFECTION

- Patients with symptoms or physical findings consistent with iGAS infection should be **immediately referred to hospital.** These may include:
    - High fever, chills, rigors, sweats, myalgia and localised pain (suggesting sepsis, bacteraemia or other invasive bacterial infection)
    - Abrupt onset of fever and severe pain, which may be early findings in STSS
    - In patients with cellulitis or other skin/soft tissue infections, pain and tenderness out of proportion to the appearance of the area, oedema, erythema, skin anaesthesia or bullae formation are suggestive of necrotizing fasciitis

- Symptoms suggestive of complicated non-invasive GAS infection including presentations such as quinsy, parapharyngeal abscess

## Management of non-invasive Group A Streptococcal infection

### 1. TONSILLITIS/ PHARYNGITIS / SCARLET FEVER:

- Most tonsillitis / pharyngitis seen in the community is **viral** in origin and only bacterial infections require antibiotic treatment. Pharyngitis may indicate potential Group A Streptococcus infection.
- Details of treatment recommendations are included in the Irish national antibiotic prescribing guidelines for treatment of community infections, please see here for more information.
- For tonsillitis / pharyngitis, usual duration of antibiotics is for 5 days, and depending on clinical response duration can be extended to 10 days
- For scarlet fever, the antibiotic treatment duration is 10 days for most of the recommended antibiotics.

### 2. IMPETIGO

- Although impetigo is often caused by Group A *Streptococcus*, the most common causative organism is *Staphylococcus aureus*
- Details of treatment recommendations are included in the Irish national antibiotic prescribing guidelines for treatment of community infections, see here for further information.

### 3. CELLULITIS

- Details of treatment recommendations are included in the Irish national antibiotic prescribing guidelines for treatment of community infections (www.antibioticprescribing.ie). For cellulitis guideline, please see here
- If persistent fever, unwell, or failing to respond to oral therapy, referral to hospital is indicated for further management with intravenous antibiotics

- If rapidly spreading cellulitis, or any findings associated with necrotizing fasciitis or Streptococcal Toxic Shock Syndrome (STSS), **refer urgently to Emergency Department.**

You may be contacted by Public Health Medicine colleagues regarding notified case(s) of iGAS infection:*

- Symptomatic close contacts of an iGAS case, with symptoms that could be attributable to noninvasive GAS Infection (e.g., sore throat/impetigo), should be treated with empiric antibiotics. Treatment should not be delayed by awaiting microbiology lab confirmation. Additional information is available here and at www.antibioticprescribing.ie
- Certain events e.g., an iGAS outbreak in a congregate setting, may require wider antibiotic coverage (i.e., treatment and/or chemoprophylaxis as indicated by Public Health risk assessment). Please liaise closely with Public Health Medicine colleagues.

**Any patient with suspected iGAS infection should be referred immediately to hospital*