



Clinical Assessment and Therapeutic Decision-Making in an Older Adult with Acute Pharyngitis at a Primary Healthcare Facility

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Article History

Received : 09 April 2026

Revised : 11 June 2026

Accepted : 22 October 2026

Available Online : 31 October 2026

Keywords:

acute pharyngitis;
older adults;
primary healthcare;
antibiotic stewardship;
case report.

To cite this article: Sani, N., Agustin, T., Lusiana, L., Fitriani, L., Liska, Putri, L. R., & Anggraini, L. (2026). Clinical assessment and therapeutic decision-making in an older adult with acute pharyngitis at a primary healthcare facility. *Biomedical Research and Theory Letters*, 2(2), 33–39.

<https://doi.org/10.58524/btrl.v2i2.187>

Abstract

Acute pharyngitis is a common upper respiratory tract condition encountered in primary healthcare settings. Although most cases are self-limiting, distinguishing between viral and bacterial etiologies remains important for appropriate clinical management and rational antibiotic prescribing. This case report describes the clinical assessment and therapeutic management of acute pharyngitis in an older adult attending a primary healthcare facility in Bandar Lampung, Indonesia. A 69-year-old male presented to Gedong Air Public Health Center with a cough lasting several days. Physical examination revealed pharyngeal erythema, nasal mucosal redness, and tender anterior cervical lymph nodes. Initial clinical measurements showed a blood pressure of 110/80 mmHg, pulse rate of 88 beats/min, respiratory rate of 32 breaths/min, body temperature of 36°C, oxygen saturation of 97%, and body mass index of 17.3 kg/m². Based on the clinical evaluation, the patient was diagnosed with acute pharyngitis. No laboratory or microbiological investigations were performed. Pharmacological management included ciprofloxacin 500 mg, guaifenesin, and cetirizine 10 mg, accompanied by advice on hydration, adequate rest, personal hygiene, and avoidance of respiratory irritants. Clinical improvement was reported following treatment, although the timing and objective findings of follow-up assessment were not specified. This case highlights the importance of systematic clinical assessment in older adults presenting with upper respiratory tract symptoms. The absence of microbiological confirmation limits determination of the infectious etiology, while the documented tachypnea warrants further clinical consideration. The antibiotic selection also raises questions regarding adherence to evidence-based prescribing recommendations for uncomplicated acute pharyngitis. This case illustrates the importance of integrating clinical findings, diagnostic uncertainty, and evidence-based therapeutic decision-making in the management of acute pharyngitis in primary healthcare. Accurate clinical documentation, appropriate antibiotic selection, and structured follow-up are essential for evaluating treatment decisions and patient outcomes.



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1. Introduction

Acute pharyngitis is a common inflammatory condition affecting the pharyngeal mucosa and represents an important reason for medical consultation in primary healthcare settings. It is frequently associated with upper respiratory tract infections and may present with sore throat, painful swallowing, cough, fever, and cervical lymphadenopathy. Although the majority of cases are self-limiting, acute pharyngitis contributes to healthcare utilization, symptomatic discomfort, and antibiotic prescribing in outpatient settings. A systematic review by [Finley et al. \(2018\)](#) identified respiratory conditions among the frequently encountered problems in primary care, emphasizing the importance of effective management strategies for common infections. Furthermore, [Miller et al. \(2022\)](#), through a systematic review and meta-analysis, demonstrated the substantial global burden of sore throat and Group A Streptococcus (GAS) pharyngitis while highlighting limitations in the availability and comparability of epidemiological data across different populations. These findings underscore the need for appropriate clinical assessment and evidence-based treatment decisions to reduce unnecessary healthcare interventions and optimize patient outcomes.

The etiology of acute pharyngitis is heterogeneous and includes infectious and non-infectious causes. Viral pathogens are responsible for a substantial proportion of cases, whereas bacterial infections, particularly those caused by *Streptococcus pyogenes*, remain clinically important because of their association with suppurative and non-suppurative complications. In addition to infectious agents, environmental exposures and physical or chemical irritants may contribute to pharyngeal inflammation. [Renner et al. \(2012\)](#) identified tobacco smoke, air pollution, temperature changes, low humidity, and occupational irritants as potential non-infectious contributors to throat irritation and inflammatory symptoms. Consequently, the presence of pharyngeal erythema does not necessarily establish a bacterial etiology, and clinical

interpretation should consider the patient's symptoms, medical history, and possible environmental exposures. Differentiating infectious pharyngitis from non-infectious irritation is particularly relevant in primary healthcare facilities, where diagnostic resources and opportunities for microbiological confirmation may be limited.

Accurate diagnosis remains a central challenge in the clinical management of acute pharyngitis because individual symptoms and physical examination findings often overlap between viral and bacterial infections. Clinical manifestations such as fever, tonsillar exudate, tender anterior cervical lymphadenopathy, and the absence of cough have traditionally been used to estimate the probability of streptococcal infection. The Centor clinical prediction rule was developed to support diagnostic assessment in adults presenting with sore throat (Centor et al., 1981). Subsequently, McIsaac et al. (1998) proposed an age-adjusted clinical scoring approach to improve decision-making and reduce unnecessary antibiotic use. However, clinical prediction systems should not be regarded as definitive diagnostic tools. In a systematic review and validation study, Aalbers et al. (2011) demonstrated that individual clinical findings have limited discriminatory power for identifying GAS pharyngitis, although the Centor score may assist in estimating infection probability. Similarly, Ebell et al. (2000) emphasized that clinical evaluation should incorporate combinations of findings rather than relying on isolated symptoms. Therefore, diagnostic decisions should integrate systematic clinical assessment, appropriate use of prediction rules, and microbiological testing when clinically indicated and available.

The diagnostic evaluation of acute pharyngitis becomes particularly important when patients present with atypical symptoms, abnormal vital signs, or additional clinical vulnerabilities. In older adults, age-related physiological changes, nutritional status, underlying diseases, and concurrent respiratory conditions may complicate the interpretation of otherwise common symptoms. Clinical assessment should therefore extend beyond visual examination of the pharynx and include an evaluation of respiratory function, hydration status, systemic manifestations, and warning signs suggesting more serious disease. Although most acute sore throat episodes resolve without major complications, clinicians must remain attentive to possible suppurative conditions and alternative diagnoses. Little et al. (2013), in a prospective primary care cohort study, investigated clinical predictors of suppurative complications among patients presenting with acute sore throat, demonstrating the importance of evaluating disease progression and clinically relevant risk factors. These considerations support a patient-centered diagnostic approach, particularly when the clinical presentation does not clearly indicate a specific infectious etiology.

Therapeutic management of acute pharyngitis should balance symptom relief, prevention of relevant complications, and avoidance of unnecessary antimicrobial exposure. Supportive interventions, including adequate hydration, rest, and appropriate symptomatic medication, remain important components of management. Antibiotics may provide benefits in selected cases, particularly when bacterial infection is confirmed or strongly suspected according to accepted clinical guidance. Nevertheless, the magnitude of symptom improvement associated with antibiotic therapy is generally modest. A Cochrane systematic review by Spinks et al. (2021) found that antibiotics reduce the persistence of sore throat symptoms and certain complications, but emphasized the need to balance these benefits against potential harms and antimicrobial resistance. Furthermore, Hedin et al. (2023) evaluated different antibiotic treatments for GAS pharyngitis, highlighting the importance of evidence-based antibiotic selection rather than indiscriminate prescribing. Accordingly, antibiotic decisions should be supported by clinical indications, diagnostic findings, patient characteristics, and established recommendations for the suspected pathogen.

Inappropriate antibiotic prescribing for acute respiratory tract infections remains a significant challenge in primary healthcare. McCullough et al. (2017) reported discrepancies between antibiotic prescribing practices and guideline recommendations for acute respiratory infections in general practice, illustrating the potential for unnecessary antimicrobial treatment. Conversely, Tyrstrup et al. (2016) documented reductions in antibiotic prescribing for respiratory tract infections in Swedish primary care, demonstrating the feasibility of improving prescribing practices. The consequences of unnecessary antibiotic exposure extend beyond immediate treatment-related adverse effects. Bakhit et al. (2018), through a systematic review and meta-analysis, investigated the persistence and decline of antibiotic resistance following antimicrobial exposure in primary care populations. These findings highlight the importance of antimicrobial stewardship, particularly when bacterial infection has not been microbiologically established. Within this context, careful documentation of the clinical indication, antibiotic selection, dosage, and treatment duration is essential for evaluating the appropriateness of therapeutic decisions and improving the quality of primary healthcare.

Despite extensive research on the diagnosis and treatment of acute pharyngitis, individual clinical reports can provide educational value when they critically examine diagnostic uncertainty, therapeutic decision-making, and the limitations of routine clinical practice. The present case describes a 69-year-old male who attended Gedong Air Public Health Center, Bandar Lampung, Indonesia, with a history of cough and clinical findings of pharyngeal erythema and tender anterior cervical lymphadenopathy. The patient was diagnosed with acute pharyngitis based on clinical assessment without additional microbiological investigation and received pharmacological treatment, including ciprofloxacin, guaifenesin, and cetirizine, alongside non-pharmacological management. The combination of advanced age, low body mass index, documented tachypnea, and antibiotic administration without confirmation of bacterial etiology provides an opportunity to critically evaluate clinical assessment and therapeutic decision-making in a primary healthcare setting. Therefore, this case report aims to describe the patient's clinical presentation, diagnostic evaluation, management, and reported outcome, while highlighting the importance of systematic assessment, rational antibiotic prescribing, and transparent clinical documentation in the management of acute pharyngitis.

2. Materials and Methods

2.1. Study Design and Clinical Setting

This study presents a descriptive, single-patient clinical case report concerning the assessment and management of acute pharyngitis in a primary healthcare setting. The case involved a 69-year-old male patient who attended Gedong Air Public Health Center, Bandar Lampung, Indonesia. The report focuses on the patient's clinical characteristics, diagnostic evaluation, pharmacological and non-pharmacological management, and reported clinical outcome. The manuscript was structured in accordance with the CARE (CAse REport) reporting guidelines to promote transparency and completeness in reporting patient information, clinical findings, diagnostic procedures, therapeutic interventions, and outcomes (Gagnier et al., 2013).

2.2. Patient History and Clinical Assessment

The patient was a 69-year-old male who presented with a cough persisting for several days. The available clinical history indicated no reported allergies, comorbid illnesses, or previous pharmacological treatment for the presenting condition. No history of smoking or alcohol consumption was documented. The patient's general condition and level of consciousness were evaluated during the initial consultation. Clinical assessment included blood pressure, heart rate, respiratory rate, body temperature, peripheral oxygen saturation (SpO₂), and body mass index (BMI). Physical examination involved evaluation of the head, eyes, ears, nose, oral cavity, pharynx, cervical lymph nodes, respiratory system, and cardiovascular system. Particular attention was given to pharyngeal mucosal inflammation, cervical lymph node tenderness, and respiratory findings. The assessment was described using the available clinical observations without assuming additional examinations that were not documented in the original case.

2.3. Diagnostic Assessment

The diagnosis of acute pharyngitis was established clinically based on the presenting symptoms and physical examination findings. The principal findings supporting the diagnosis included pharyngeal mucosal erythema, tenderness of the anterior cervical lymph nodes, and associated upper respiratory tract symptoms. No rapid antigen detection test, throat culture, laboratory examination, or diagnostic imaging was performed during the initial consultation. Consequently, the causative organism could not be microbiologically identified. Clinical prediction approaches, including the Centor criteria, have been developed to estimate the probability of Group A Streptococcal pharyngitis based on clinical manifestations (Centor et al., 1981). However, individual clinical findings have limited discriminatory accuracy, and clinical prediction rules cannot independently establish the presence of bacterial infection (Aalbers et al., 2011; Ebell et al., 2000). No formal Centor or McIsaac score was documented in the present case. Therefore, the diagnosis was classified as clinically established acute pharyngitis without confirmed bacterial or viral etiology.

2.4. Therapeutic Intervention

The patient received pharmacological treatment consisting of ciprofloxacin 500 mg once daily, guaifenesin in a formulation reported as 6.3%, and cetirizine 10 mg once daily. The original report did not specify the treatment duration, complete guaifenesin dosage, or documented clinical rationale for selecting ciprofloxacin. Non-pharmacological management included advice regarding adequate fluid intake, sufficient rest, nutritious food consumption, personal hygiene, and avoidance of respiratory irritants such as cigarette smoke and dust. The patient was also instructed to seek further medical evaluation if symptoms worsened or warning signs developed. The administered medications are described as documented rather than presented as evidence of guideline-concordant treatment. Evidence-based management of bacterial pharyngitis requires careful consideration of antibiotic indication and selection, as discussed in the comparative review by Hedin et al. (2023).

2.5. Clinical Outcome and Follow-up Assessment

Clinical outcomes were described using the information available in the original case report, particularly changes in the patient's general condition and respiratory symptoms following treatment. The report indicated symptomatic improvement and discharge in an improved condition, accompanied by advice to continue the prescribed treatment and recommended self-care measures. However, the exact duration between treatment initiation and clinical reassessment was not specified. No repeat vital signs, standardized symptom scores, microbiological results, or detailed follow-up examination findings were documented. Accordingly, clinical improvement was reported descriptively, without attributing the observed outcome to any individual pharmacological or non-pharmacological intervention.

2.6. Ethical Considerations and Reporting Standards

The case report was prepared with attention to patient confidentiality and transparent clinical reporting, consistent with the principles of the CARE guidelines (Gagnier et al., 2013). Directly identifying patient information should be excluded from the published manuscript. Informed consent for publication and any applicable institutional ethical review or exemption requirements must be verified and documented before submission.

3. Results and Discussion

3.1. Patient Characteristics and Clinical Presentation

A 69-year-old male patient presented to Gedong Air Public Health Center, Bandar Lampung, Indonesia, with a chief complaint of cough persisting for several days. According to the available clinical history, the patient had no reported allergies, chronic medical conditions, or previous treatment for the current illness. No history of smoking or alcohol consumption was documented. The patient sought medical attention because the cough interfered with daily activities and caused discomfort. At the initial examination, the patient was conscious, oriented, and described as being in generally good condition. Blood pressure was 110/80 mmHg, heart rate was 88 beats/min, respiratory rate was 32 breaths/min, body temperature was 36°C, and peripheral oxygen saturation was 97%. The recorded body mass index (BMI) was 17.3 kg/m², indicating underweight nutritional status. The elevated respiratory rate represented a clinically important abnormality despite the absence of documented respiratory distress. Physical examination revealed erythematous pharyngeal mucosa, redness of the nasal mucosa without visible secretions, and tenderness of the anterior cervical lymph nodes on palpation. Examination of the remaining head and neck structures was reported as unremarkable. Pulmonary auscultation revealed no additional breath sounds, and cardiovascular examination showed no reported abnormalities. These findings were consistent with inflammation involving the upper respiratory tract, although they did not establish a specific infectious etiology. The patient's principal clinical characteristics and initial examination findings are summarized in **Table 1**.

Table 1. Demographic Characteristics, Vital Signs, and Clinical Findings of the Patient

Parameter	Clinical finding	Interpretation
Age	69 years	Older adult
Sex	Male	—
Chief complaint	Cough for several days	Upper respiratory symptom
Blood pressure	110/80 mmHg	No obvious abnormality
Heart rate	88 beats/min	Within usual resting range
Respiratory rate	32 breaths/min	Tachypnea
Body temperature	36°C	Afebrile at examination
SpO ₂	97%	Within usual range
BMI	17.3 kg/m ²	Underweight
Pharyngeal mucosa	Erythematous	Pharyngeal inflammation
Nasal mucosa	Red, without secretions	Mucosal inflammation
Anterior cervical lymph nodes	Tender	Cervical lymph node tenderness
Pulmonary auscultation	No additional sounds	No abnormal auscultatory findings reported
Cardiovascular examination	No abnormality reported	Unremarkable examination

Note: The table presents findings documented in the original case report. Clinical interpretations do not establish the underlying etiology.

BMI = body mass index; SpO₂ = peripheral oxygen saturation.

3.2. Diagnostic Findings and Clinical Assessment

The diagnosis of acute pharyngitis was established on the basis of the patient's clinical presentation and physical examination findings, particularly pharyngeal erythema and tender anterior cervical lymph nodes. The presence of cough and nasal mucosal inflammation suggested an associated upper respiratory tract process. However, the available findings were insufficient to distinguish definitively between viral and bacterial causes. No complete blood count, inflammatory marker assessment, rapid antigen detection test, throat culture, or diagnostic imaging was performed during the initial consultation. Consequently, microbiological confirmation of Group A Streptococcus infection was unavailable. The original report did not document a formal clinical prediction score or a systematic assessment of the probability of streptococcal pharyngitis.

The patient was classified clinically as having acute pharyngitis without documented local complications. Nevertheless, the respiratory rate of 32 breaths/min required additional clinical consideration because tachypnea may occur in conditions extending beyond uncomplicated upper respiratory inflammation. The available records did not describe repeat respiratory rate measurements or further investigations to explain this finding. Therefore, the available diagnostic information supports the reported clinical diagnosis of pharyngitis but does not definitively establish its etiology or exclude every alternative respiratory condition.

3.3. Therapeutic Interventions

The patient received a combination of pharmacological and non-pharmacological interventions. The documented pharmacological regimen consisted of ciprofloxacin 500 mg once daily, guaifenesin at a reported formulation strength of 6.3%, and cetirizine 10 mg once daily. Ciprofloxacin was administered as an antibacterial agent, guaifenesin as an expectorant, and cetirizine as an antihistamine. However, the original clinical documentation did not specify the treatment duration, complete guaifenesin dosage, or detailed clinical rationale for prescribing these medications.

Non-pharmacological management focused on supportive care and patient education. The patient was advised to maintain adequate hydration, obtain sufficient rest, consume nutritious food, practice personal hygiene, and avoid exposure to respiratory irritants, including cigarette smoke and dust. Additional instructions emphasized adherence to the prescribed treatment and the importance of seeking medical attention if symptoms worsened or warning signs developed. The documented interventions are summarized in **Table 2**. Because the bacterial etiology was not confirmed and the indication for ciprofloxacin was not explicitly recorded, the appropriateness of antibiotic selection cannot be established solely from the reported clinical information.

Table 2. Pharmacological and Non-Pharmacological Interventions Documented in the Case

Intervention	Documented regimen or recommendation	Reporting limitation
Ciprofloxacin	500 mg, once daily	Duration and indication unspecified
Guaifenesin	Reported as 6.3%	Dose, frequency, and formulation unclear
Cetirizine	10 mg, once daily	Duration unspecified
Hydration	Adequate fluid intake	No quantified intake
Rest	Sufficient rest	No specific duration
Nutritional advice	Warm and nutritious foods	No nutritional intervention assessment
Environmental precautions	Avoid dust and cigarette smoke	Exposure history not established
Personal hygiene	Maintain hand and personal hygiene	Education provided
Safety advice	Seek care for worsening symptoms	Subsequent attendance not documented

Note: Medication details reproduce the available information from the original manuscript and should not be interpreted as recommended treatment regimens.

3.4. Clinical Outcomes

The original case report described improvement in the patient's general condition and respiratory symptoms following pharmacological and supportive management. The patient was reported to have been discharged in an improved condition, with recommendations to continue

the prescribed treatment and maintain appropriate self-care practices. No complications were documented in the available account. However, the precise timing of clinical reassessment was not reported, and the available documentation did not include repeat vital signs, standardized symptom measurements, or objective findings confirming resolution of pharyngeal inflammation. Similarly, medication adherence, adverse drug reactions, and longer-term outcomes were not described. Accordingly, the reported improvement should be interpreted as a descriptive clinical observation. The available information does not establish the relative contribution of antibiotic therapy, symptomatic medication, or the natural course of illness to the reported outcome.

3.5. Clinical Interpretation and Diagnostic Uncertainty

The present case illustrates the diagnostic challenges associated with acute pharyngitis in primary healthcare, particularly when clinical evaluation is performed without microbiological confirmation. The patient presented with cough, pharyngeal erythema, and tender anterior cervical lymph nodes, findings that support inflammation of the upper respiratory tract but are not sufficient to identify a specific causative pathogen. Acute pharyngitis may arise from viral, bacterial, or non-infectious processes, and these etiologies may share overlapping clinical manifestations (Renner et al., 2012). Therefore, identifying pharyngeal inflammation should be regarded as an initial diagnostic finding rather than definitive evidence of bacterial infection.

Clinical prediction rules have been developed to improve diagnostic assessment and guide decisions regarding streptococcal testing. The Centor criteria incorporate fever, tonsillar exudates, tender anterior cervical lymphadenopathy, and the absence of cough to estimate the probability of Group A Streptococcus (GAS) pharyngitis (Centor et al., 1981). Subsequent research demonstrated that clinical scoring approaches may improve decision-making but have limitations in diagnostic accuracy, particularly when individual symptoms are considered independently (Aalbers et al., 2011; Ebell et al., 2000). In the present case, cough was the primary complaint, cervical lymph node tenderness was documented, and the measured body temperature was 36°C. However, the absence of recorded tonsillar exudates and incomplete documentation of other relevant symptoms prevented a reliable retrospective reconstruction of the complete clinical assessment. Accordingly, a formal diagnostic score should not be assigned without confirming the necessary clinical information.

Another important consideration is the patient's respiratory rate of 32 breaths/min, which indicates tachypnea. Although peripheral oxygen saturation was 97% and pulmonary auscultation was reported as normal, these findings do not independently explain the elevated respiratory rate. In an older adult presenting with cough, persistent tachypnea would warrant careful reassessment and consideration of alternative respiratory or systemic conditions. The absence of repeat measurements or additional diagnostic investigations limits the ability to determine whether this finding reflected a transient physiological response, measurement error, or an unrecognized clinical problem. This uncertainty emphasizes the importance of documenting abnormal vital signs and the clinical reasoning used to determine whether further evaluation is necessary.

3.6. Antibiotic Selection and Antimicrobial Stewardship

Antibiotic selection represents one of the most important therapeutic considerations in this case. The patient received ciprofloxacin despite the absence of microbiological confirmation of bacterial pharyngitis. Although antibiotic therapy can reduce symptom persistence and selected complications in patients with sore throat, the magnitude of benefit varies, and its use should be balanced against potential adverse effects and antimicrobial resistance (Spinks et al., 2021). The clinical decision to prescribe antibiotics should therefore consider the probability of bacterial infection, the patient's clinical condition, and the expected benefits and risks of treatment.

Evidence-based recommendations generally favor narrow-spectrum antibiotics, particularly penicillin or amoxicillin, for confirmed GAS pharyngitis. Hedin et al. (2023) examined different antibiotic treatments for streptococcal pharyngitis, providing evidence relevant to antibiotic selection. Ciprofloxacin is not a standard first-line treatment for uncomplicated streptococcal pharyngitis, and its use in the present case requires particular scrutiny. Because the original report did not identify a confirmed bacterial pathogen, a specific alternative indication, or an established reason for selecting ciprofloxacin, the available information cannot demonstrate that this prescription was consistent with recommended practice.

Inappropriate antibiotic prescribing remains a widespread concern in primary healthcare. McCullough et al. (2017) identified discrepancies between antibiotic prescribing rates and guideline recommendations for acute respiratory infections, suggesting opportunities to reduce unnecessary antimicrobial exposure. Similarly, Tyrstrup et al. (2016) reported reductions in antibiotic prescribing for respiratory tract infections in Swedish primary care, demonstrating that prescribing behavior can be improved through systematic healthcare interventions. The importance of antimicrobial stewardship extends beyond individual treatment episodes because antibiotic exposure can contribute to subsequent antimicrobial resistance. Bakhit et al. (2018) demonstrated that resistance patterns following antibiotic exposure may persist at the individual level, reinforcing the importance of limiting antibiotic use to clinically justified situations.

The present case should not be interpreted as evidence that ciprofloxacin was clinically effective or necessary. Although symptomatic improvement was reported, the absence of microbiological testing, incomplete follow-up documentation, and simultaneous administration of multiple interventions prevent attribution of recovery to the antibiotic. Instead, the case provides an opportunity to emphasize the need for transparent documentation of antibiotic indications, appropriate medication selection, and evidence-based prescribing decisions in primary healthcare.

3.7. Patient-Related Factors and Supportive Management

The patient's advanced age and low body mass index represent additional considerations in the assessment and management of acute pharyngitis. At 69 years of age, the patient may have age-related physiological vulnerabilities that warrant careful clinical evaluation, particularly when respiratory symptoms are accompanied by abnormal vital signs. The recorded BMI of 17.3 kg/m² indicates underweight status and suggests that further nutritional assessment could be clinically relevant. However, the available information does not establish malnutrition-related immune impairment or demonstrate that low BMI contributed directly to the development or progression of the present illness.

Environmental and non-infectious factors may also influence the occurrence and severity of pharyngeal symptoms. Renner et al. (2012) described several environmental contributors to throat irritation, including tobacco smoke, air pollution, and exposure to unfavorable atmospheric conditions. Nevertheless, the present case did not document specific environmental exposures, and these factors cannot be considered confirmed contributors to the patient's illness. Their relevance is primarily educational, emphasizing the importance of obtaining a comprehensive exposure history when evaluating respiratory symptoms.

Supportive management formed an important component of the treatment provided. Recommendations included adequate hydration, sufficient rest, proper personal hygiene, nutritious food intake, and avoidance of respiratory irritants. These measures were intended to improve patient comfort and support recovery. However, the available clinical records did not include standardized assessments of symptom relief or patient adherence to these recommendations. Therefore, the contribution of supportive management to the reported improvement cannot be quantified. Nevertheless, the provision of clear self-care instructions and advice regarding warning signs remains an important aspect of patient-centered care, particularly in primary healthcare settings.

3.8. Clinical Outcomes and Limitations

The patient's condition was reported to have improved following treatment, and no complications were documented in the available case description. However, this observation should be interpreted cautiously because the report did not specify the timing of follow-up or provide objective reassessment findings. Acute pharyngitis frequently follows a self-limiting course, making it difficult to distinguish the effects of treatment from spontaneous symptom resolution in an uncontrolled, single-patient report. Evidence from randomized trials and systematic reviews indicates that antibiotics may shorten symptom duration in selected patients, but improvement after receiving antibiotics does not independently establish a bacterial etiology or demonstrate treatment necessity (Spinks et al., 2021).

Several limitations should be acknowledged. First, the absence of microbiological testing prevented confirmation of the infectious etiology. Second, the elevated respiratory rate was not accompanied by documented repeat measurements or further investigation, limiting assessment of its clinical significance. Third, incomplete medication details and the absence of a documented rationale for ciprofloxacin restricted evaluation of treatment appropriateness. Fourth, the lack of structured follow-up data prevented a comprehensive assessment of clinical recovery, medication adherence, and possible adverse effects. Finally, the findings reflect one individual patient and cannot be generalized to broader populations or used to establish comparative treatment effectiveness. Despite these limitations, the case illustrates the importance of critically examining routine clinical decisions, particularly when diagnostic uncertainty and antimicrobial prescribing intersect. Transparent reporting of both available findings and missing information is essential for ensuring that clinical case reports provide reliable educational value.

3.9. Implications for Primary Healthcare Practice

The clinical implications of this case relate primarily to diagnostic reasoning, antimicrobial stewardship, and the quality of documentation in primary healthcare. Although acute pharyngitis is commonly encountered and frequently self-limiting, treatment decisions should not rely exclusively on isolated clinical findings such as pharyngeal erythema. Instead, clinicians should integrate the patient's presenting symptoms, relevant physical examination findings, vital signs, and indications for additional diagnostic testing. The present case also demonstrates why antimicrobial prescribing decisions should be critically assessed rather than evaluated solely according to the reported clinical outcome. The administration of ciprofloxacin without documented microbiological confirmation or a clear clinical justification raises questions about antibiotic selection. A favorable reported outcome does not eliminate the need to evaluate whether the chosen therapy was necessary and appropriate.

From a clinical reporting perspective, the case reinforces the importance of documenting complete medication regimens, abnormal examination findings, patient counseling, and follow-up assessments. A structured approach to these components can improve continuity of care and strengthen the educational value of case reports. Ultimately, the principal lesson is that effective management of acute pharyngitis requires not only symptom assessment and supportive treatment but also careful diagnostic evaluation, rational antimicrobial decisions, and transparent documentation of clinical outcomes.

4. Conclusions

This case report highlights the clinical challenges associated with the diagnosis and management of acute pharyngitis in older adults within primary healthcare settings. A 69-year-old male presented with persistent cough, pharyngeal erythema, and tender anterior cervical lymph nodes and was clinically diagnosed with acute pharyngitis without microbiological confirmation. The presence of tachypnea and underweight nutritional status emphasized the importance of comprehensive clinical assessment and careful interpretation of potentially significant findings. Pharmacological treatment, including ciprofloxacin, guaifenesin, and cetirizine, was accompanied by supportive care and patient education. Although clinical improvement was reported, the absence of structured follow-up data and microbiological investigations limited the assessment of treatment effectiveness and the determination of infectious etiology. Furthermore, the administration of ciprofloxacin without a clearly documented bacterial indication underscores the importance of rational antibiotic prescribing and adherence to evidence-based clinical recommendations. Overall, this case emphasizes that effective management of acute pharyngitis requires systematic diagnostic evaluation, appropriate therapeutic decision-making, antimicrobial stewardship, and accurate documentation of clinical outcomes to improve the quality and safety of primary healthcare.

Author Contributions: Conceptualization, NS and TA; methodology, LL and LF; validation, NS, TA, and LL; formal analysis, LF and L; investigation, NS, TA, LL, LF, L, LRP, and LA; resources, NS and TA; data curation, LF, L, and LRP; writing—original draft preparation, NS, LL, and LF; writing—review and editing, TA, LRP, and LA; visualization, L and LRP; supervision, NS; project administration, TA and LA. All authors have read and agreed to the published version of the manuscript.

Funding: This study did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Ethical Clearance: Not applicable. Ethical clearance was not required for this case report as it involved routine clinical management without experimental intervention.

Informed Consent Statement: Written informed consent has been obtained from the patient's guardian to publish this case report, including clinical details and images.

Data Availability Statement: All data supporting the findings of this study are contained within the article. No additional datasets were generated or analyzed.

Acknowledgments: The authors would like to express their sincere gratitude to Gedong Air Public Health Center, Bandar Lampung, Indonesia, for its support and assistance in facilitating the clinical case documentation. The authors also acknowledge the Faculty of Medicine and Medical Study Program, Malahayati University, for their academic support and contributions to the preparation of this case report.

Conflicts of Interest: The authors declare that there are no conflicts of interest regarding the publication of this article.

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