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Bilateral Peritonsillar Abscess

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A forty-nine-year old woman not suffering from any medical illness presented to the emergency department with mild odynophagia, mild difficulty in breathing and muffled voice. She was vitally stable. On examination she had bilateral swollen tonsils with central uvula. Quinsy tonsillectomy was performed under general anesthesia; the patient was put on intravenous antibiotic and analgesics. Postoperative period was uneventful and she was dischargedafter 48 hours on a course of cefuroxime.

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Quinsy or peritonsillar abscess (PTA) is a common head and neck infection[1,2].It usually starts with tonsillitis followed by cellulites and eventually progress to abscess formation.Symptoms can be divided into local and general. Local symptoms include odynophagia, drooling, trismus, and voice changes. General symptoms include fever, malaise,headache and neck pain[1]. On examination, the tonsil appears enlarged with the uvula displaced to the opposite side[1].

However, these features might be absent in a patient with bilateral PTA. This might make the diagnosis of bilateralperitonsillar abscess difficult especially for inexperienced physicians[3].

The aim of this report is to present an unusual case of bilateral peritonsillar abscess which presented with generalized symptoms ofsore throat.

THE CASE

A forty-nine years old Bahraini female patient, notknown to have any medical illnesspresented to the emergency department with history ofmild odynophagia, mild difficulty in breathing and muffled voice. The symptoms started 3 weeks ago, during a vacation abroad; the patient ignored the symptoms and continued enjoying herself.As the symptoms persisted and progressed, the patient was forced to present herself to the emergency department.

On examination, the patient was afebrile and vitally stable. She had bilateral swollen tonsils grade 4. No exudates were noted. The uvula was central. No palpable lymph nodes were detected, see figure 1.

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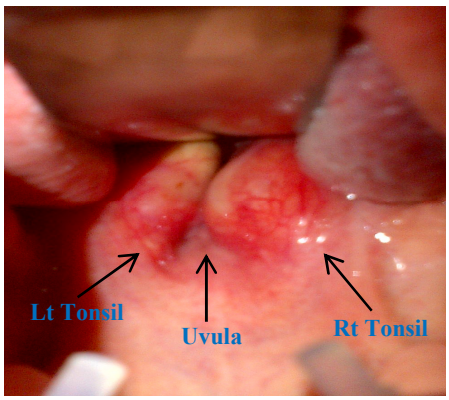

Figure 1: Bilateral Enlarged Tonsils Containing Puss

Hematological investigations were within normal range, no indication of infection.
She was urgently booked for tonsillectomy. During dissection of the tonsils, copiousamount of yellowish pus poured out from both tonsils. The pus from the right tonsil was fluid in texture while the left side was semi fluid. Swab was taken and only Coryneform species were identified, which is part of the skin flora, an indication that the specimen was contaminated; therefore of doubtful clinical significance.

She was started on IVantibiotics(cefuroxime) and analgesicsand was monitored closely. Within 48 hours, the patient improvedsignificantly and within one week all her symptoms disappeared and her pharynx was back to normal.

DISCUSSION

Peritonsillar abscess usually begins as tonsillitis followed by cellulites and eventually progress toabscess formation.Cellulitis is thought to be the result of inflammation of the Weber Glands, which are salivary glands located in the soft palate. The Weber glands function is to clear the tonsillar areafrom debris. Hence, inflammation of the Weber glands will lead to accumulation of debris in the tonsillar area and the formation of cellulites. As the infection progress, necrosis of the tissue and pus formation takes place[4].

Symptoms usually include sore throat, odynophagia, trismus, hoarseness of the voice, otolagia and drooling;general symptoms include fever, malaise, headache and neck pain.Our patient had only mild difficulty in breathing, mild odynophagia and muffled voice. She was more agitated with the duration of her symptoms than the severity of her condition, unlike other case reports which presented with severe pain and other typical features of peritonsillar abscess[1].

There are various methods to manage peritonsillar abscess. Through the 1970's,quinsy-tonsillectomy, or “hot” tonsillectomy was the preferred management[5-11].In the 1980's, the

preferred management was needle aspiration, as it could be done by non-otolaryngologist, provides quick relief of symptoms, could be diagnostic and therapeutic, cost-effective and prevents the patient from undergoing the risks of general anesthesia[12-17].Another method of management of bilateralPTA isincision and drainage.No agreement on the various modes of treatment for PTA. Because of this, different institutions adopted different modes of therapeutic regimens, which might not provide optimum quality of patient care at reasonable cost[2].

It should be noted that allthe three methods mentioned above are acceptable in the medical practice[18].However, if the patient does not improve after an attempt of needle aspiration, a second trial should be done, and with repeated failure the patient will eventually need to undergo tonsillectomy or incision and drainage[1]. Tonsillectomy is favored as the management of choice for bilateral peritonsillar abscesses. Quinsy-tonsillectomy was performed in our case, similar to the study by James et al[19]. In the case reported by James et al, the culture showed anaerobic and aerobic bacteria, in contrast to our case where no pathogen was found[19].

It is known that bilateral Quinsy is rare. This case should be called‘cold Quinsy”;a terminology never been described in the literature. This could be the first case of cold Quinsy to be documented.

Giger et al in a retrospective cohort study which was performed on 205 patients who underwent bilateral abscess tonsillectomy under general anesthesia found that there is an increased risk of hemorrhage after quinsy tonsillectomy; bleeding occurred in 13%, ipsilateral hemorrhage was observed in 4% and contralateral hemorrhage in 9%[20]. Our case was bilateral abscess and had no bleeding postoperatively.

CONCLUSION

A rare case of bilateral peritonsillar abscess was presented. She was treated surgically by dissection of the tonsils and medically by IVantibiotics and analgesics. She hasimproved within 48hours and discharged on oral antibiotics and analgesics.

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