

Case Report

Atypical presentation of peritonsillar abscess

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Abstract

Peritonsillar abscess is a known complication of tonsillitis. The patient usually present with typical symptoms of odynophagia, fever and difficulty in mouth opening. The diagnosis is established by clinical examination that commonly revealed unilateral peritonsillar swelling. Aspiration of pus will confirm the diagnosis. We report an atypical presentation of peritonsillar abscess case which presented with dysphagia without fever, odynophagia and trismus.

Keywords: Peritonsillar abscess, atypical, presentation

Introduction

Quinsy or commonly known as peritonsillar abscess is the collection of pus within the peritonsillar space. The typical clinical presentations includes odynophagia, dysphagia, drooling of saliva, muffled voice and high grade fever. Trismus is a pathognomonic sign of a patient with peritonsillar infection. These symptoms depend on the severity and size of the abscess.

Case Summary

A 46-year old Malay gentleman presented to emergency unit at 2 am in the morning with 2 weeks history of dysphagia. On the day of admission he developed difficulty in breathing. He admitted having disturbed sleep with snoring and occasional sudden awakening, gasping for air. There was positive nasal symptoms especially unilateral nasal obstruction. He denied any history of fever, difficulty in mouth opening, drooling of saliva and no history of recurrent tonsillitis except one episode of peritonsillar abscess six years prior to this presentation. There was no known medical illness such as diabetes mellitus and hypertension.

Examination revealed an obese patient in moderate respiratory distress. He was breathing through the mouth. He was not in pain and mildly dehydrated. Oral and oropharyngeal examinations could be performed easily as he can widely open the mouth without trismus. There was a right sided palatal bulge with no sign of inflammation such as erythematous overlying mucosa (Figure 1). The mass was not fluctuant on palpation. The ipsilateral tonsil was obscured by the mass but contralateral tonsil was visible and normal looking. Nasoendoscopy revealed a deviated nasal septum to right and a

bulging arising from the floor of the posterior part of the nose. The fossa of Rosenmuller were normal. The mass can be seen extending to the left nasopharynx area (Figure 2). Routine blood parameters including random blood sugar were essentially normal except slight increase in total white cell count.

As there was no fever, trismus and odynophagia, a provisional diagnosis of right palatal mass was made rather than a peritonsillar abscess. Dexamethasone was given in view of relieving the impending airway obstruction. He was arranged for computed tomograph scan and to be followed by punch biopsy of the mass. Prophylactic antibiotics were started. However on the fourth of admission, the bulge became less tense and erythema over the mucosa became prominent. Aspiration was attempted and thick pus was collected. An incision and drainage was immediately done and on the next day the patient can tolerate orally well. He was discharged on antibiotics and tonsillectomy was planned.

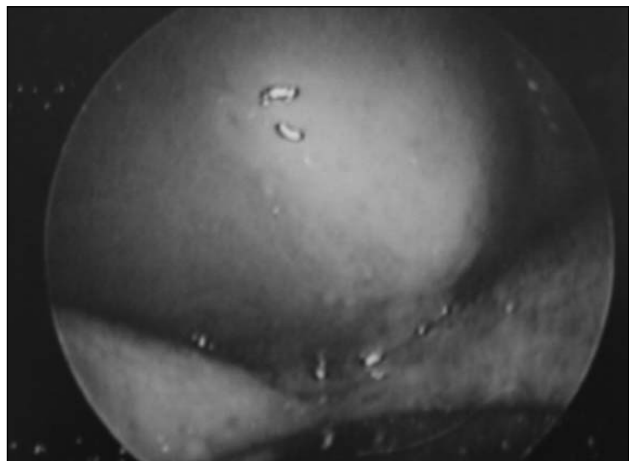


Figure 1: Right sided palatal bulge can be clearly seen as there was no trismus that limit the mouth opening

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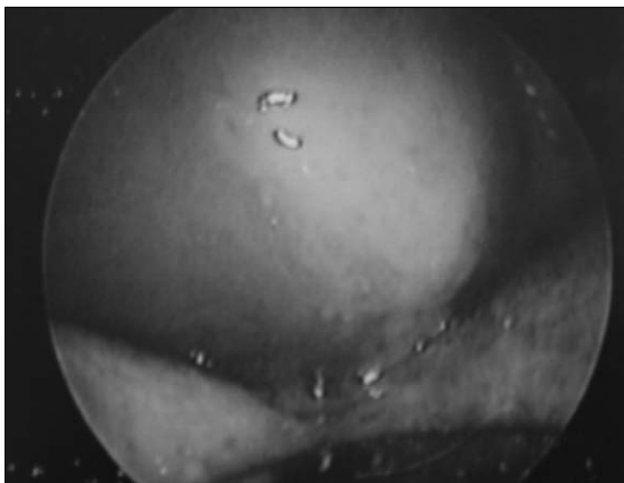


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Discussion

Peritonsillar abscess (quinsy) is characterized by collection of purulent secretion between the fibrous capsule of the palatine tonsil and the pharyngeal superior constrictor muscle.^{1,2} It is one of the most common site of deep infection of the head and neck.^{3,4} This potential space normally contain loose connective tissue. If an infection settled in this space, a period of peritonsillar cellulitis without abscess precede. Later on it will become an abscess which is usually safely drained via an opening made by using blade and sinus forceps.

In this case, the presentation with only difficulty in breathing, obstructive symptoms such as snoring and dysphagia is atypical for peritonsillar infection. The common symptoms include severe sore throat associated with high grade fever, malaise, dysphagia and odynophagia and ipsilateral otalgia due to referred pain. Drooling or pooling of saliva is often

present due to severe pain associated with swallowing.⁵ The patient often speak in a muffled voice (hot potato voice). However, all of these typical symptoms are not present in our patient thus the initial working diagnosis was directed away from an acute peritonsillar infection.

Trismus is almost always the consistent sign of peritonsillar cellulitis or abscess. It is due to pain from inflammation and spasm of masticator muscles.⁵ Classically the patient will present with tonsillar asymmetry, with the tonsil on the affected side will be pushed inferiorly and medially, as well as the edematous uvula will be pushed contralaterally. Marked tender cervical lymphadenopathies may be palpated on affected side. In this case the the ipsilateral tonsil was obscured by the mass and the uvula though mildly pushed to opposite side was normal looking. There was no distinctive palpable lymphnodes. Some reports do suggest for a computed tomograph scan of the neck to diagnose peritonsillar abscess when the diagnosis of peritonsillar abscess is in question to distinguish between peritonsillar cellulitis and peritonsillar abscess, as well as demonstrate the spread of the infection to any contiguous spaces in the deep neck,^{6,7} but needle aspiration still remains a crucial diagnostic and therapeutic tool for peritonsillar abscess.^{3,4}

Incision and drainage of the abscess is the definitive treatment once a suppurative collection is established.^{8,9} Hot (or immediate) tonsillectomy during the period of peritonsillar abscess may be considered in some centers for patients who have strong indications for tonsillectomy such as a recurrent or nonresolving peritonsillar abscess^{7,10} although in some countries, like Japan, immediate tonsillectomy is considered only for selected cases due to the risk of post-operative complications.¹¹

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