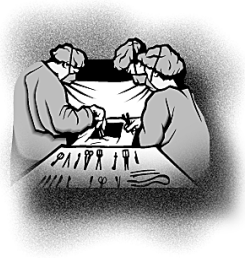

Quinsy (peritonsillar abscess)

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Sometimes tonsillitis or pharyngitis can progress to an abscess in one of the closed compartments surrounding the pharynx. The symptoms of a peritonsillar abscess are much more severe than those of tonsillitis or pharyngitis. The typical patient will be an adult who presents for care somewhat dehydrated after 3 or 4 days of worsening symptoms.

The hallmark symptoms in addition to fever and malaise are

- odynophagia — difficulty swallowing even liquids;
- trismus — difficulty opening the mouth;
- change in voice — muffled voice, "hot potato" voice.

The hallmark physical signs are

- unilateral swelling of the anterior tonsil pillar, especially the upper end of anterior tonsil pillar;
- tonsil itself is enlarged and displaced medially;
- uvula displaces to opposite side;
- tenderness and often swelling on the ipsilateral side of the neck at the angle of the jaw.

The surgical treatment is a small simple incision in the most swollen part of the upper anterior tonsil pillar to drain the pus. Needle aspiration at the same location is a newer option[1] but appears not to relieve symptoms nearly as well,[2] although steroids may mitigate that.[3] Incision and drainage (I & D) is the preferred approach at our rural hospital.

EQUIPMENT

- # 11 blade
- # 3 handle
- small curved hemostat
- Frazier suction and tubing
- tongue depressor
- 2% lidocaine with epinephrine
- 3-mL syringe with 25-gauge needle for anesthesia
- 10-mL syringe with 18-gauge needle for aspiration
- gloves and mask
- K-basin
- flashlight or headlamp

METHOD

1. Drainage of a peritonsillar abscess is generally done in the emergency department. The procedure can be done totally under local anesthesia. This makes the procedure slightly more difficult because the patient typically cannot open his or her mouth very much.
2. If the patient is very nervous it helps to use some intravenous sedation. Midazolam 4 mg administered intravenously works well to relax the patient. It is potentially dangerous to have the patient sedated to the point that they cannot cooperate in spitting out any blood or pus that accumulates in his or her mouth. Even though an anesthetized patient would be more cooperative, don't expect that you will convince a colleague to give the patient a general anesthetic. It can be difficult to intubate someone who has swelling in the back of the throat. If such is contemplated as required for the patient, then the case may warrant referral to an otolaryngologist.
3. The patient should be sitting up with a pan handy to spit any blood or pus into. A nurse can shine a flashlight into the mouth or use a

headlamp. The importance of adequate positioning and lighting cannot be overemphasized.

4. A tongue depressor is needed to retract the tongue.
5. Inject 1–2 mL lidocaine 2% with epinephrine (to minimize bleeding) just under the mucosa where the I & D incision will be made, at the point of maximal swelling (Fig. 1).
6. If you are not sure where in the swollen area to incise, you can check for pus by simple needle aspiration. You can trim the needle guard so that only a centimetre of needle shows or tape the needle so you won't insert it too deeply. Find the spot with the pus and remove as much material as possible. You can leave it just aspirated or, alternatively, proceed to incision as below.
7. Use a # 11 blade scalpel to make a tiny incision up and down no more than 1/2-cm long and inserting the scalpel blade no more than 1-cm deep. If you are worried about cutting too deeply, tape the blade at the 1-cm mark as a visual cue.
8. DO NOT extend the incision laterally as the carotid artery lies 1.5-cm lateral (and posterior) to the tonsil. As with any I & D in which there are important structures nearby, the blade is used just to access the tissue and blunt dissection is used to ensure complete drainage.
9. After making the I & D incision, use a small hemostat through the incision to probe into the abscess to release the pus. Sometimes if there is only a peritonsillitis and no abscess there may be no significant pus drainage but only a small quantity of blood.

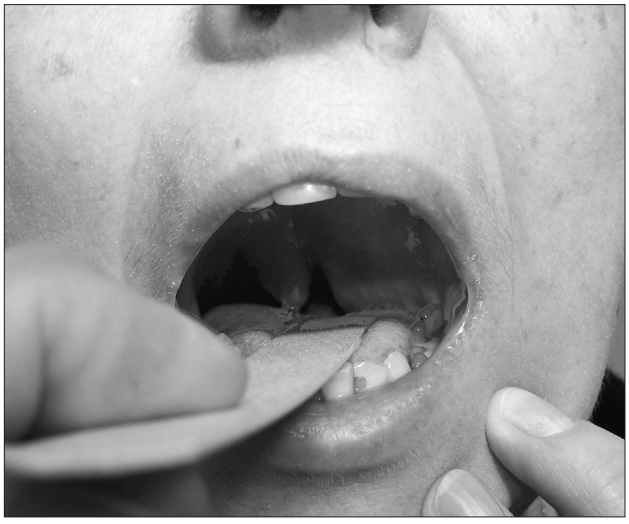

Fig. 1. Left-sided quinsy; note the displaced uvula.

FOLLOW-UP

1. If you don't get any pus or have just aspirated pus without incision, it is particularly important to recheck the patient's progress on antibiotics in 24 to 48 hours.
2. Toxic or dehydrated patients, as well as those who cannot swallow, benefit from admission to hospital for 1–2 days until they are able to swallow at least liquids.
3. Bacterial culture is usually mixed with group A β-hemolytic *Streptococcus* and *Fusobacterium* being the most commonly isolated.[4] Thus penicillin G 2 million units intravenously every 6 hours is commonly used, sometimes in combination with metronidazole. Alternately, consider clindamycin 600 mg intravenously every 8 hours.
4. If the patient can drink liquids and can go home, consider an antibiotic regime such as penicillin V 600 mg 4 times per day, clindamycin 300 mg every 6 hours or probenecid 1 gm orally followed in half an hour by penicillin G 2 million units intravenously every 12 hours for 7 days.
5. Although there is little evidence to guide us, at our hospital the patient is usually advised to have an interval tonsillectomy[5] done in 2–6 weeks following a quinsy to prevent a recurrence.

CONCLUSION

Rural doctors can effectively diagnose and treat peritonsilar abscesses. Most patients just need I & D followed by antibiotics. A few patients may need to be admitted to hospital.

Competing interests: None declared.

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