

Peritonsillar swelling is not always quinsy

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Abstract

Quinsy is a common encounter in family physician practice. It is defined as a collection of purulent material in the peritonsillar space, giving appearance of unilateral palatal bulge. Presenting symptoms include trismus, muffled voice, odynophagia, and ipsilateral otalgia. When the diagnostic needle aspiration reveals no pus, the diagnosis is changed into peritonsillar cellulitis or also known as peritonsillitis. Peritonsillitis is sufficiently treated with antibiotics unlike a quinsy which warrants surgical incision and drainage.

Introduction

Acute tonsillitis is a disease in children, whereas peritonsillar cellulitis and abscess are known to affect young adults. Peritonsillar cellulitis is considered as a transition phase of the peritonsillar inflammatory process becoming an abscess or quinsy. It may or may not be related with previous or concurrent tonsillitis. Current review confirms that peritonsillar infection begins with Weber's gland, a group of 20-25 mucous salivary glands located in the space just superior to the tonsil in the soft palate.¹ Peritonsillar cellulitis is the manifestation of inflamed Weber's gland in the soft palate.

Case Summary

A 29-year-old Malay man with no known medical illness presented with 6 days' history of fever, sore throat, and odynophagia to solid food. His mouth opening was limited, which was associated with 'hot potato voice' and neck pain on the left side. This was the first episode. There was no history of nasal and ear symptoms.

His vital signs were normal, with blood pressure of 130/84 mm Hg, pulse of 96 beats/min, and temperature of 37.9°C. Oral examination

revealed enlargement of the left tonsil with inflamed supratonsillar tissues pushing the edematous uvula towards the right side (Figure 1). However, the right tonsil was normal. The left level II cervical lymph nodes were palpable and tender. Nose and ear examination was normal. Blood examination revealed a raised white cell count of 16.86 g/dL, whereas other blood parameters were normal.

When quinsy was diagnosed, the patient was admitted for further evaluation and treatment. Soft peritonsillar swelling was aspirated according to the conventional management for quinsy. Aspiration was attempted in few sites at the most prominent bulge (Figure 2). However, no purulent material was syringed out. The diagnosis was changed to peritonsillar cellulitis. Intravenous penicillin (2.4 mU loading dose, followed by 1.2 mU six-hourly) and analgesics (oral paracetamol 1 g eight-hourly) were initiated. The patient was able to take the dose orally on the later part of the day. There was no more trismus. On the 3rd day of admission, the patient was comfortable and his oral intake returned to normal. He was discharged from the hospital, with the advice to complete the antibiotic treatment, which included oral penicillin 250 mg six-hourly for 1 week.



Figure 1.
Inflamed left supratonsillar tissue and oedematous uvula



Figure 2.
Inflamed left supratonsillar area with puncture sites seen (arrows)

*Verbal consent has been obtained for the figures.

Discussion

As the clinical features of quinsy and peritonsillar cellulitis are similar, needle aspiration of the peritonsillar swelling confirms the diagnosis of quinsy or cellulitis. Guarded needle aspiration was used to avoid over-penetration into the soft palate. The presence of pus confirms the diagnosis of quinsy. A proper incision is needed at the most prominent bulge, which should be opened with forceps to drain out the pus. However, if no pus is aspirated, the diagnosis of peritonsillar cellulitis or peritonsillitis is established. Family physicians with appropriate training and experience can diagnose and treat majority of patients with this

condition. When complications or questions arise during treatment, an otolaryngologist should be consulted.²

In this patient, the aspiration of purulent material was negative. As expected, the clinical symptoms improved after the procedure. This is attributed to release of built-in tension and pressure (due to soft tissue oedema) in the closed peritonsillar space using the method of needle aspiration. However, in either case of quinsy or cellulitis, antibiotics are started to target gram-positive bacteria, most commonly *Streptococcus*.³ Penicillin is the antibiotic of choice except in penicillin-allergic or penicillin-resistant patients. Besides intravenous benzylpenicillin, co-amoxiclav can be used as the first-line therapy.⁴ 'Hot tonsillectomy' (tonsillectomy during the attack of quinsy) is previously considered as the treatment during the quinsy episode. However, current review shows that it was not the treatment of choice in more than 80% of peritonsillar infection cases.⁵ The popularity decreased because it was associated with increased risk of bleeding and it was not cost-effective compared to elective tonsillectomy.

In recurrent cases of peritonsillar infection, tonsillectomy is indicated. If the patient was diagnosed and treated at an early stage (cellulitis instead of abscess), there would have been slightly less probability of using a surgical procedure for treatment.⁴ The recurrence of peritonsillar infection is possible even after tonsillectomy, considering the pathophysiology of the disease; however, it is rare.⁶

Conclusion

The clinical presentations of quinsy and peritonsillar space cellulitis are the same. The only confirmatory step is guarded needle aspiration of the swelling. Pus aspirate warrants incision and drainage, whereby cellulitis can be effectively treated with antibiotics alone.

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