International Journal of Enhanced Research in Medicines & Dental Care (IJERMDC),
ISSN: 2349-1590, Vol. 4 Issue 10, October-2017, Impact Factor: 1.338

Quinsy: A Case Report

Dr. Jogender Kumar Jangra[1], Dr. Ravinder Solanki[2], Dr. Monika Khokhar[3], Dr. Dolly Rana[4]

[1]MDS (Oral & Maxillofacial Surgery), Consultant Oral Surgeon at Shri Ganesh Dental Clinic and Maxillofacial Centre Rohtak Haryana
[2]MDS (Oral & Maxillofacial Surgery), Associate Professor, PGIDS, Rohtak Haryana
[3]Consultant Endodontist, Shri Ganesh Dental & Maxillo-Facial Clinic, Rohtak (Haryana)
[4]PG Student, Department of Oral & Maxillofacial Surgery, PGIDS, Rohtak Haryana

ABSTRACT

Quinsy is a deep infection of the head & neck that occurs in adult & usually a complication of acute tonsillitis of the palatine tonsils. It is typically formed by a combination of aerobic & anaerobic bacteria. The presenting symptoms include throat pain, fever, hoarseness in voice &sometimes trismus. Ultrasonography and C.T. Scan are useful method in diagnosis. But needle aspiration remains the gold standard for the diagnosis. Treatment of Peritonsilar abscess includes needle aspiration or incision & drainage with appropriate antibiotic therapy. Incision & drainage is gold standard method of treatment. Early diagnosis of the abscess allows appropriate treatment to begin before the abscess spread into the surrounding anatomic plains. The purpose of this paper is to provide the knowledge of this space infection for their accurate diagnosis and management.

Key Words: Peritonsilar abscess, Quinsy, Palatine tonsil, Lateral pharyngeal space infection, Pterygomandibular space Infection

INTRODUCTION

Peritonsilar abscess is a localized space infection in the connective tissue bed of the faucial tonsil between it and the medial surface of the superior constrictor of the pharynx & the tonsil. It is usually common in peoples of 20-40years of age. (6) The infection begins as a superficial infection which progresses into tonsilar cellulitis and then abscess if left untreated. (6)

CASE REPORT

30 years old female presented in my centre with the complaint of pain over her left side of face, difficult in swallowing and hoarseness in voice for last 3 days.She had a history of throat pain.On general physical examination, patient looks ill, toxic and dehydrated with pyrexia.

On local examination, during extra oral inspection no obvious swelling was seen while on palpation, tenderness was found in submandibular region right side with ipsilateral submandibular lymphadenopthy. Intraoral inspection showed erythematous swelling in soft palate and tonsilar region right side with contra lateral deviation of uvula (Fig. 1).

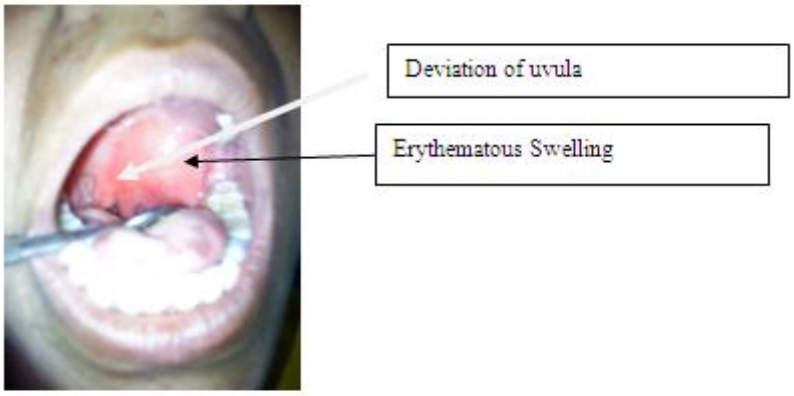

Figure 1: Peritonsillar abscess

On palpation, swelling was soft, tender and compressible without any discharge. No odontogenic cause of infection was detected. On Needle aspiration (18 G needle) of swelling, pus was obtained confirming the presence of abscess. Pus was sent for gram staining and culture and drug sensitivity testing. All routine investigations were carried out. Intravenous Antibiotics and fluid therapy was started immediately and abscess was drained intra orally under local anesthesia (Fig.2& 3). Approximately 10-15 ml pus was drained out. Swelling was negligible by the 4th postoperative day.

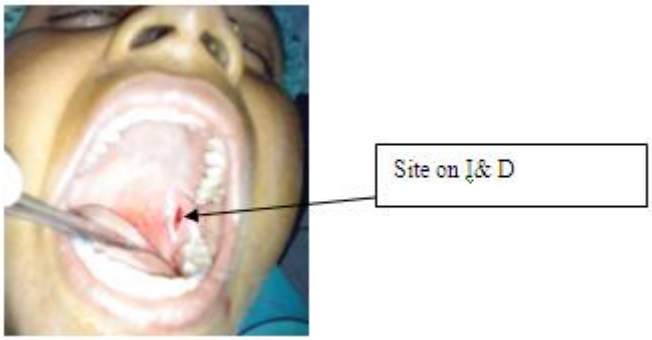

Figure 2: Incision

Figure 3: Incision and drainage.

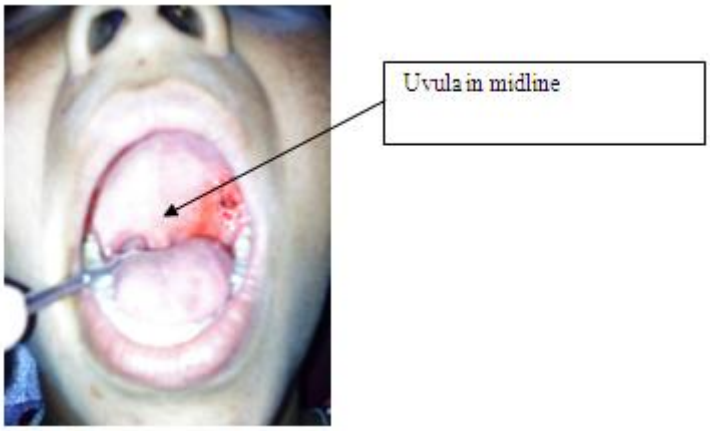

Figure 4: postoperative Day.

DISCUSSION

Peritonsilar abscess also known as Quinsy, occurs secondary to pharyngotonsillitis. (3) Young children are seldom affected, unless they are immunocompromised. Chronic tonsillitis or multiple antibiotics for acute tonsillitis may predispose the persons to the development of a peritonsillar abscess. The most common organisms associated with it are Streptococcus pyogenes (aerobic bacteria) and Fusobacterium (anaerobic bacteria). (6)

Peritonsilar space is analogous to the vestibular space intraorally. (1) This space lies between the or pharyngeal mucosa & the superior pharyngeal constrictor muscle. It contains & surrounds the palatine tonsil. Palatine tonsilar infection

may drain through or pharyngeal mucosa or may perforate the superior constrictor muscle & buccopharyngeal fascia to enter the lateral pharyngeal space. Peritonsilar abscess form in the area between the palatine tonsil and its capsule. (6)

Patients usually relate a history of sore throat with malaise which progressively resulting in odontophagia. Patient looks and feels toxic, ill, anorexic & becomes rapidly dehydrated due to poor oral intake. (3,) Abscess results in awkward speech with dysphonia or peculiar muffled "hot potato in mouth voice" (1, 2, 3 and 6). In extreme infection, patient even cannot tolerate his own secretion resulting in drooling of saliva and may experience airway comprise. Swelling demonstrates a bulging mass in superior aspect of the tonsilar fossa with contra lateral deviation of uvula. This finding helps to differentiate peritonsillar abscess from lateral pharyngeal space infection which lies on the lateral side of superior constrictor muscle. The common signs of peritonsillar abscess are Erythematous swelling of tonsils with deviation of uvula to contra lateral side, cervical lymphadenopathy; Muffled "hot potato" voice and mild trismus. The symptoms of peritonsillar abscess are Progressive worsening sore throat, fever, hoarseness in voiceand difficulty in swallowing.

Diagnosis of the abscess can be made by proper history, physical examination, needle aspiration and C.T. Scan. Peritonsillar space infection should be differentiated from peritonsillarcellulitis, mononucleosis, cervical adenitis, neoplasm and aneurysm of internal carotid artery and infection of salivary gland, mastoid bone and infection of dental origin especially of lateral pharyngeal and pteryogomandibular spaces (Table 1).

Table 1: Differential diagnosis (1)

Space	Peritonsillar	Lateral pharyngeal	Pterygomandibular
Anatomy	Between superior constrictor & mucous membrane	Between medial pterygoid & superior constrictor.	Between mandible & medial pterygoid.
Trismus	Mild	Moderate	Severe
Dental Involvement	No	Yes	Yes
Site of swelling in mouth	Esp. of soft palate & little over Faucial pillar	Esp. over Faucial pillars & little over soft palate	Over medial aspect of anterior border of ramus
Extra oral swelling	Nil	Nil	Little

The management of peritonsillar abscess requires both the incision and drainage and selection of empirical antibiotics followed by therapeutic antibiotics. Drainage of abscess can be done by aspiration with 18guage needle on 10-ml syringe in the lateral soft palatal region adjacent to the superior pole of the tonsil or by incision and drainage with 11number BP blade through intraoral approach. (3) When aspirating the lateral pole, the needle should be directed posterior and medial to avoid penetration through the wall of the carotid artery or ascending pharyngeal branch of the external carotid artery. (3)Incision and Drainage should be done in upright position and a good suction should always be there to prevent aspiration of pus. One episode of peritonsillar abscess does not mandate tonsillectomy because recurrence rate is low (7, 8, and 9). Earlier tonsillectomy may lead to excessive bleeding due to hyperemia of the tonsilar bed as a result of the infection. (10, 11)

CONCLUSION

Peritonsillar abscess is uncommon maxillofacial space infection, usually of nonodontogenic origin leading to tense swelling of anterior pillar of the fauces &a bulge of the soft palate. Aim of this article is to empower a general dental practioner to be able to differentiate between lateral pharyngeal, pteryogomandibular and peritonsillar space infections as they are usually encountered with maxillofacial space infections. Hence it becomes mandatory on their part that they acquainted with peritonsillar abscess so that they can easily differentiate and diagnose such condition and refer the patient to concerned specialist for its proper management.

BIBLIOGRAPHY

[1]. Topazian, Goldberg, Hupp, Oral and maxillofacial Infections, Saunders: 4th Edition; 2002: 207,324.
[2]. Killy and Kay's Outline of oral surgery: Part 1, 2nd Edition;
[3]. Surgical Pathology: Vol. 5; Oral& Maxillofacial Surgery, R.J. Fonseca-1st Edition 2000:111,112.
[4]. Daniel M. Laskin, Oral and Maxillofacial Surgery, Mosbey: Vol 11; 2003:230.
[5]. Hordingham M: Peritonsilar Infection. Otolarygol Clin North Am 1987; 20:273-8.
[6]. Terrence E.S,Peritonsillar abscess: Diagnosis & treatment; Am Fam Physician 2002; 65:93-6.
[7]. Perkins A: An approach to diagnosing the acute sore throat, Am Fam Phys 55:131, 1997.
[8]. Raut VV, Yung MW: Peritonsillar Abscess: the rationale for interval tonsillectomy, Ear Nose Throat J 79:206, 2000.

[9]. Scott PM, Loftus WK, Kew j, et al: diagnosis of peritonsillar infection: the prospective study of ultrasound, computerized tomography and clinical diagnosis, J laryngol Otol 113:229, 1999.
[10]. Herzon FS: Permucosal needle drainage of peritonsillar abscess. Laryngoscope 1984; 10:104.
[11]. Herzon FS, Aldridge JF: Peritonsillar abscess needle aspiration. Arch Otolaryngol Head Neck Surg 1981; 89: 910.