CLINICAL PRACTICE GUIDELINE: Emergency Department

Peri-Tonsillar Abscess (Quinsy)

Disclaimer: This Clinical Practice Guideline ('CPG') was written for use in The Royal Victorian Eye and Ear Hospital Emergency Department. It should be used under the guidance of an Ophthalmology or ENT registrar. If clinical advice is required, please contact the Eye and Ear Admitting Officer for assistance: EYE: +61 3 9929 8033; ENT: +61 3 9929 8032. Links to internal Eye and Ear documents cannot be accessed from the website CPG.

See also: Acute tonsillitis

Description:

Peri-tonsillar abscess is a complication of acute tonsillitis. It is a collection of pus between the capsule of the palatine tonsil and the pharyngeal muscles.

Red Flags:

- Severe sore throat with dysphagia and stridor and no evidence of tonsillitis or pharyngitis is acute epiglottitis until proven otherwise.
- Stridor, altered level of consciousness and oxygen desaturation may herald a complete airway obstruction – involve anaesthetist/ENT on site to secure airway and arrange for immediate ambulance transfer to a tertiary hospital with ENT and ICU/HDU capabilities.
- Dysphonia/voice change can indicate inferior extension or the oedema/inflammation onto the larynx. Need assessment by ENT with Fibreoptic Nasoendoscopy (FNE)
- Consider systemic sepsis in patients with hypotension, tachycardia and pyrexia. They may require aggressive fluid resuscitation.
- Can be complicated by a parapharyngeal abscess.
- Consider malignancy if patient over 50 years old. Specialist outpatient follow-up in 2 weeks following acute infection.

Differential diagnosis includes:

- Peritonsillar cellulitis
- Parapharyngeal abscess

How to Assess:

History:

- Fevers and malaise
- Unilateral throat pain/ear pain
- Dysphagia, odynophagia with poor oral intake.
- Muffled or 'hot potato' voice changes
- Failure to respond to first-line broad-spectrum oral antibiotics
- Systemic symptoms

Examination:

- Fetor
- Trismus can suggest cellulitis or abscess (often improved following administration of 8mg IV dexamethasone in adult)
- Asymmetrical bulging of the soft palate may cause the uvula to deviate to the contralateral side
- Take care in examination of a patient's throat – rushing the examination may cause pain or elicit gag reflex with minimal stimulation
- Pay careful attention to the soft palate – enlarged tonsils are often mistaken for quinsy
- Fibreoptic Nasoendoscopy
    - Identifies inferior extension of the oedema/ inflammation into the larynx, who may require transfer to a tertiary centre

Investigations:

- Blood tests: FBE, LFTs, U&E, CRP
- Consider CT neck with contrast if parapharyngeal abscess suspected

Acute Management:

- Start with ABCD if it is appropriate
- Intravenous (IV) fluid as required dexamethasone (0.15 mg/kg (max 10 mg) as a single dose IV
- Consent the patient for aspiration/incision and drainage using the MR160Y Consent for Procedure – Outside the Theatre Setting form
- Aspiration may be attempted by an experienced clinician to differentiate quinsy from peritonsillar cellulitis and to localize the abscess (if present) for incision and drainage
- Local anesthesia: use a dental syringe with Lignospan® (lidocaine hydrochloride 2%/ adrenaline (epinephrine) 1:80,000) to infiltrate the anterior pillar
- Aspiration: use a 21G or 18G needle to attempt aspiration. Consider the proximity of the internal carotid artery at approximately 1.5cm depth. The aspiration needle should not be pointed laterally.
- Incision and drainage: use a 15 Blade to incise the quinsy. Further widen the opening with curved artery forceps.
- IV antibiotic cover for Streptococcus and anaerobic organisms
    - Consider delaying the administration of antibiotics until pus can be sent for M/C/S
    - Adults:
        - Benzylpenicillin 1.2g IV QID and metronidazole 500mg IV 12 hourly
        - If allergic to penicillin: clindamycin 450 mg IV TDS or request Infectious Disease consultation
- Admission for overnight IV antibiotics/fluid/adequate analgesia
- Note that the incision often spontaneously closes within a few hours and may require blunt dissection the next day to ensure any re-collection can drain
- In the stable patient from whom pus cannot be drained, it is reasonable to admit for IV fluid and antibiotics and repeat attempt aspiration and/or incision and drainage next day
- CT neck with contrast may be indicated if patient is not improving and/or there is failure of aspiration and or incision and drainage

Ongoing Management:

Upon significant improvement consider IV to oral switch for antibiotics:

- Amoxicillin+clavulanate 875mg+125mg oral BD for a total treatment duration of 7 days (IV + oral)
- In penicillin allergy: clindamycin 450mg oral TDS a total treatment duration of 7 days (IV + oral)

Follow up:

- For first episode of quinsy, GP follow-up is adequate
- For recurrent quinsy, specialist outpatient clinic (Head and Neck) follow-up for consideration of elective tonsillectomy

Evidence Table

Author(s)	Title	Source	Level of Evidence (I – VII)
Nicholas J et al.	Peritonsillar Abscess	Am Fam Physician 2008 ;77(2):199-202	VII
Fairbanks DN et al.	Pocket Guide to Antimicrobial Therapy in Otolaryngology—Head and Neck Surgery. 12th ed.	Alexandria, Va.: American Academy of Otolaryngology—Head and Neck Surgery Foundation, Inc. 2005: 40, 86–90.	

The Hierarchy of Evidence

The Hierarchy of evidence is based on summaries from the National Health and Medical Research Council (2009), the Oxford Centre for Evidence-based Medicine Levels of Evidence (2011) and Melynk and Fineout-Overholt (2011).

I) Evidence obtained from a systematic review of all relevant randomised control trials.

II) Evidence obtained from at least one well designed randomised control trial.

III) Evidence obtained from well-designed controlled trials without randomisation.

IV) Evidence obtained from well-designed cohort studies, case control studies, interrupted time series with a control group, historically controlled studies, interrupted time series without a control group or with case series.

V) Evidence obtained from systematic reviews of descriptive and qualitative studies.

VI) Evidence obtained from single descriptive and qualitative studies.

VII) Expert opinion from clinician, authorities and/or reports of expert committees or based on physiology.

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