

## Case Report

**Bilateral Peritonsillar Abscess: a case report****Dongol K**

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**Correspondence to:** Dr. Kripa Dongol**Abstract**

Although unilateral peritonsillar abscess is a common problem in otorhinolaryngology, case of bilateral peritonsillar abscess is very rare. Not a single case of bilateral peritonsillar abscess has been reported from Nepal till date. This is a case report of a 52 years old lady who presented with bilateral peritonsillar abscess in emergency and was managed with incision and drainage and antibiotics.

**Key words :** Peritonsillar, Abscess

**Introduction**

Peritonsillar abscess is a collection of pus between the tonsillar capsule and the superior constrictor muscle, usually at the superior pole. It mostly occurs as the complication of acute tonsillitis. The common age group for peritonsillar abscess is 20-40 years. It is usually unilateral, but very rarely bilateral cases have been reported in the literature. Common organisms isolated from the abscess is mixed flora of aerobes and anaerobes.<sup>1</sup> Early diagnosis and treatment of peritonsillar abscess is essential to prevent airway compromise and its spread to parapharyngeal, retropharyngeal spaces and the mediastinum.<sup>2</sup> Aspiration of pus followed by incision and drainage and intravenous antibiotics form the mainstay of treatment of peritonsillar abscess.

**Case report**

A 52 years old female presented in emergency department of our hospital with painful swallowing and fever for four days, not relieved with oral amoxicillin prescribed from local medical centre. For past two days she developed difficulty in swallowing and change in voice and was referred to our centre. However, there was no history of difficulty in breathing and no similar history in the past. On examination, patient was febrile and had mild trismus. Intraoral examination revealed bilateral diffusely swollen and erythematous soft palate and midline placed uvula as shown in figure 1. Bilateral needle aspiration was done with wide bore needle and incision and drainage was performed in the emergency. Eight mL of pus was drained from right side and six mL pus from the left side and pus was sent for culture

sensitivity. Blood investigations revealed leucocytosis with relative neutrophilia. She was treated with intravenous Ceftriaxone and Metronidazole for next five days along with analgesics and antiseptic gargles. On subsequent days, her symptoms improved and became afebrile. The pus culture showed alpha haemolytic Streptococci and Prevotella melaninogenica. The patient was discharged on oral antibiotics for next five days.



**Figure 1: Bilateral peritonsillar abscess (Post incision and drainage)**

**Discussion**

The actual frequency of bilateral peritonsillar abscesses is not known; however, it has been seen at rates of 1.9% to 24% in reports describing quinsy tonsillectomy, in which the unsuspected contralateral abscess was discovered during surgery.<sup>3</sup> In peritonsillar abscesses, the patient may present with progressive odynophagia,

dysphagia, referred otalgia, trismus, drooling of saliva, muffled voice and fever. In unilateral peritonsillar abscess, the classic intraoral finding is bulging of one anterior tonsillar pillar and the adjacent soft palate with contralateral displacement of the uvula. Patients with bilateral peritonsillar abscesses do not exhibit the classic asymmetric signs seen in unilateral peritonsillar abscess. A midline uvula with bilateral bulging of the soft palate appears to be a key sign in bilateral peritonsillar abscess as observed in our case.<sup>3</sup>

Peritonsillar abscess is usually the complication of acute tonsillitis. Acute tonsillitis progresses to inflammation of peritonsillar tissues i.e. the stage of peritonsillitis, which if untreated leads to peritonsillar abscess. Acute tonsillitis is usually bilateral, however peritonsillar abscess is usually unilateral. This may be due to use of antibiotics at various stage of the disease, changing its natural history.

Burstin and Marshall have reported case of bilateral peritonsillar abscess resulting from infectious mononucleosis.<sup>4</sup> Bilateral peritonsillar abscess may present a diagnostic dilemma. At times, it is difficult to differentiate it from minor salivary gland tumour of the palate, infiltrating carcinoma of the palate and lymphoma. Contrast enhanced CT scan is the investigating modality of choice in such dilemma.<sup>5</sup> However, needle aspiration remains the cost effective choice if we highly suspect the case as bilateral peritonsillar abscess.

Aspiration of pus followed by incision and drainage along with intravenous antibiotics forms the mainstay of treatment of peritonsillar abscess. Intravenous steroids is recommended to reduce pain and respiratory distress in the emergency.<sup>6</sup> The practice of quinsy tonsillectomy has reduced nowadays due to fear of primary and secondary haemorrhage and due to lack of clear knowledge about recurrence of the abscess. However, the reported rate of recurrence varies from 5.9% to 22.7%.<sup>7</sup>

## Conclusion

Bilateral peritonsillar abscess is very rare and the characteristic asymmetric signs of unilateral peritonsillar abscess is absent, forming a diagnostic challenge. However, early diagnosis and treatment is necessary to prevent dreadful complications like spreading deep neck abscess, mediastinitis, erosion of carotid artery and sepsis.

**Conflict of interest:** None declared

## References

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