The Journal of Laryngology and Otology
April 1993, Vol. **107**, pp. 354–355

A case of Quinsy in a fifteen-month old child

P. SHENOY, F.R.C.S.ED., D.L.O., V. C. DAVID, F.R.C.S.ED., F.R.C.S. (Stafford)

Abstract
A case of peritonsillar abscess in an infant is described, which is a rare lesion in infants and young children. To our knowledge this is the youngest child described in the English literature. The clinical presentation and treatment of peritonsillar abscess in infants and young children are discussed. Serious complications can occur early in the course of the disease because of physiological and anatomical factors and thus early aggressive treatment is required.

Key words: Peritonsillar abscess

Case report

A 15-month-old male infant was admitted to the paediatric ward of Stafford District General Hospital with pyrexia, dehydration, lymphadenopathy and trismus. The child has been unwell and was refusing feeds for six days prior to the admission.

Throat examination showed a large inflammatory peritonsillar mass on the left side with the uvula displaced to the right. The nose and ears examination also showed evidence of an acute upper respiratory tract infection. The chest X-ray was normal. Leucocytosis was present (13,800 per cu.mm).

The child was treated with intravenous benzyl penicillin and flucloxacillin for 24 hours. There was little improvement and the child developed stridor. At this stage the child was seen by an ENT surgeon who diagnosed a left peritonsillar abscess.

The abscess was aspirated under general anaesthesia (to confirm the diagnosis) and about 10 ml of pus was obtained. A unilateral tonsillectomy was performed and haemostasis did not present a problem. The right tonsil was not removed. Mixed anaerobes and *E. coli* sensitive to trimethoprim and ceferoxime were later cultured from the pus. Within six hours the child was afebrile and the stridor had disappeared. He started to feed normally and was ready to go home within 24 hours of surgery.

Discussion

Although tonsillitis is one of the commonest of childhood infections, peritonsillar abscess is rarely encountered in children (Richardson and Birck, 1981; HIbbert 1987), and extremely rare in infants (Wolf *et al.*, 1988). The youngest child with peritonsillar abscess reported was four months of age (Lapetus, 1988).

Diagnosis of peritonsillar abscess is often delayed in the young child because it is rare and the general practitioner or paediatrician who sees the child at first fails to recognize it. Adequate, early treatment is essential to prevent life threatening complications such as parapharyngeal abscess, laryngeal oedema and septicaemia (Wolf *et al.*, 1988). Acute sleep apnoea has been reported in a patient with bilateral peritonsillar abscesses (Lau, 1987) and infants and young children could be at greater risk of developing this complication.

The literature is filled with articles and studies arguing the merits and demerits of immediate bilateral tonsillectomy in case of peritonsillar abscess (Beeden and Evans, 1970; Summer, 1973; Muller, 1978; Richardson and Birck, 1983; Wolf *et al.*, 1988). Christensen and Madsen (1983) have advocated unilateral immediate tonsillectomy as the treatment of choice for peritonsillar abscess. The widely accepted treatment in the United Kingdom is incision and drainage under local anaesthesia (Hibbert, 1987) followed some weeks or months later by bilateral tonsillectomy if appropriate.

Several authors note that up to 30 per cent of abscesses need re-opening at least once (Beeden and Evans, 1970; Brandow, 1973; Bonding, 1976). In children and particularly in infants, it is much kinder and easier to drain the abscess under general anaesthesia administered by an anaesthetist experienced in paediatric anaesthesia. The best way to drain a peritonsillar abscess is to remove the affected tonsil which in effect 'deroofs' the abscess and prevents re-collection of pus. Any parapharyngeal extension can be drained at the same time. Muller (1978) found that tonsillectomy on the abscess side bleeds very little compared to the non-abscess side which usually bleeds to a very significant degree. It is for this reason that in such a small child only the tonsil of the affected side was removed.

Conclusion

We believe that the safest way to manage peritonsillar abscess in infants and young children is early diagnosis, parenteral antibiotics and removal of the tonsil on the abscess side only under a general anaesthetic administered by an anaesthetist experienced in paediatric anaesthesia.

Acknowledgement

We gratefully acknowledge Mrs Wendy Brakes for her help in typing this manuscript.

References

Beeden, A. G., Evans, J. N. G. (1970) Quinsy tonsillectomy. A further report. *Journal of Laryngology and Otology* **84:** 443–438.
Bonding, P. (1976) Routine abscess tonsillectomy. *The Laryngoscope* **86:** 286–290.
Brandow, E. C. Jr. (1973) Immediate tonsillectomy for peritonsillar abscess. *Transactions of the American Academy of Ophthalmology and Otolaryngology* **77:** 412.
Christensen, P. H., Madsen, U. S. (1983) Unilateral immediate tonsillectomy on the treatment of peritonsillar abscess—results with

Accepted for publication: 30 May 1992.

special attention to pharyngitis. *Journal of Laryngology and Otology* **97:** 1105–1109.
Hibbert, J. (1987) Acute infection of the pharynx and tonsils. In *Scott Brown's Otolaryngology*. 5th Edition. vol. 5, *Laryngology*. (P. M. Stell, ed.), Butterworth & Co., London, p 78–79.
Lapetus, V. F. (1988) Peritonsillar abscess in a four-month-old child. *Vestn Otorhinolaryngology* **4:** 77.
Lau, S. K. (1987) Sleep apnoea due to bilateral peritonsillar abscess. *Journal of Laryngology and Otology* **101:** 617–618.
Muller, S. P. (1978) Peritonsillar abscess—A prospective study of pathogens, treatment and morbidity. *Ear, Nose and Throat Journal* **57:** 439–444.
Richardson, K. A., Birck, H. (1981) Peritonsillar abscess in the paediatric population. *Otolaryngology—Head and Neck Surgery* **89:** 907–909.
Summer, E. (1973) Quinsy tonsillectomy; a safe procedure. *Anaesthesia* **28:** 558–568.
Wolf, M., Kronenberg, J., Kessler, A., Modan, M., Leventon, G. (1988) Peritonsillar abscess in children and its indication for tonsillectomy. *International Journal of Pediatric Otorhinolaryngology* **16:** 113–117.

Address for correspondence:
Mr P. K. Shenoy, F.R.C.S., D.L.O.,
12 Grebe Avenue,
Inverness IV2 3TD, Scotland.