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Quinsy: A bilateral presentation

by

S. KRISTENSEN, A. JUUL and F. NIELSEN (Esbjerg, Denmark)

Abstract

Bilateral peritonsillar abscesses are rare and often not diagnosed until tonsillectomy. As the condition may create diagnostic problems and serious complications, a case history is presented. The importance of rapid otorhinolaryngological examination and treatment is stressed.

In Anglo-Saxon literature 'quinsy' is the name used to describe a peritonsillar abscess. The word 'quinsy' originates in medieval English, describing any throat infection. The term is taken from the Latin 'quinancia'. In ancient Greece all inflammations of the throat or neck were described as 'cynanche' but Hippocrates reserved the word for those cases which were complicated by difficulty in swallowing and breathing, among them peritonsillar abscesses (Brandow, 1973).

Peritonsillar abscess is a relatively frequent complication of acute tonsillitis and infectious mononucleosis (Bonding, 1973; Johnsen, 1981). The disease occurs most frequently in adults but not uncommonly in children (Grahne, 1958).

It is important to diagnose and treat peritonsillar abscess rapidly and adequately, partly in order to prevent respiratory obstruction, and partly to avoid perforation of the abscess into the parapharyngeal space with spread along the neck vessels to the mediastinum or skull base. Spontaneous perforation of the abscess with risk of aspiration may also occur (Bonding, 1973).

Bilateral peritonsillar abscess is rare (Brook and Shah, 1981) and, as it may create diagnostic difficulties, we have found it relevant to publish a case.

Case History

A 25-year-old man was admitted after four days of increasing pain in the throat and neck and a feeling of a swelling in the throat. For several years he had had two to three annual episodes of tonsillitis with high fever.

On admission the patient had marked dysphagia. Besides that, a highly thickened speech, trismus, and a perceptible but not troubled respiration. He had a temperature of 39.4°C. Both tonsils were clearly swollen, reaching each other centrally, injected, and covered with greyish-white exudate.

On the suspicion of peritonsillar abscess, 'hot' tonsillectomy was performed and, surprisingly enough, big abscess cavities were found behind both tonsils. The post-operative course was uneventful.

Laboratory tests: Haemoglobin 9.3 mmol./l., sedimentation rate 46 mm./h., leucocytes 14.9 × 10^9/l. with 84 per cent neutrophils, 13 per cent lymphocytes, and 3 per cent monocytes. Monospot test negative. Tonsil and pus cultures showed growth of beta-hemolytic streptococci group A, sensitive to penicillin.

Discussion

The frequency of bilateral peritonsillar abscess varies between 0.0 per cent in the literature (Table I). Its occurrence seems to have decreased over the past 25 years and this may be attributed to the increasing use of antibiotics.

Owing to the lack of asymmetry, the differential diagnostic considerations in bilateral peritonsillar abscess are: 1) severe acute tonsillitis and 2) infectious mononucleosis, but trismus is rarely seen in such cases.

Beeden and Evans (1970) and Bonding (1973) found peritonsillar abscess to be rare in children under 10 years of age while more than 70 per cent of the cases was seen in adults over 40 without seasonal variation.

Besides antibiotics the treatment consists of surgical drainage, with either incision or 'hot' ton-

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TABLE I

FREQUENCY OF BILATERAL PERITONSILLAR ABSCESS, AS REPORTED BY VARIOUS AUTHORS

Authors	Size of Series	No.	(%)
1958: Grahne	725	49	(6.8)
1970: Beeden & Evans	111	6	(5.4)
1973: Bonding	317	10	(3.2)
1973: Brandow	156	3	(1.9)
1981: Fried & Forrest	84	0	(0.0)

sillectomy. The latter produces effective drainage and is often the best treatment. It also gives the shortest hospitalization period as some of the patients who have had a peritonsillar abscess incised are later admitted for cold tonsillectomy. Thus, Moesgaard Nielsen and Greisen (1981) recommend tonsillectomy in patients under 30 years of age as this group of patients have a great tendency to suffer from recurrent tonsillitis after one attack of peritonsillar abscess. In patients over 30 years of age, 'hot' tonsillectomy is recommended only in cases with previous indications for tonsillectomy.

Flodström and Hallander (1976) made a bacteriological investigation of pus from peritonsillar abscesses and they concluded that beta-hemolytic streptococci and various anaerobic bacteria (bacteroides, fusobacterium and peptostreptococcus) were the predominant flora. Previous statements that staphylococcus aureus, haemophilus influenzae, and pneumococci have a considerable importance in peritonsillar abscesses could not be verified.

The presence of trismus and a poor general condition in patients with symptoms of tonsillitis and symmetrical swelling of the tonsils and peritonsillar tissues should thus cause rapid oto-rhinolaryngological examination and treatment.

References

BEEDEN, A. G., and EVANS, J. N. G. (1970) Quinsy tonsillectomy—a further report. *Journal of Laryngology and Otology,* **84:** 443–448.

BONDING, P. (1973) Tonsillectomy à chaud. *Journal of Laryngology and Otology,* **87:** 1171–1182.

BRANDOW, E. C. (1973) Immediate tonsillectomy for peritonsillar abscess. *Transaction of the American Academy of Ophthalmology and Otolaryngology,* **77:** 412–416.

BROOK, I., and SHAH, K. (1981) Bilateral peritonsillar abscess: an unusual presentation. *South Medical Journal,* **74:** 514–515.

FLODSTRÖM, A., and HALLANDER, H. O. (1976) Microbiological aspect on peritonsillar abscess. *Scandinavia Journal of Infectious Diseases,* **8:** 157–160.

FRIED, M. P., and FORREST, J. L. (1981) Peritonsillitis. *Archives of Otolaryngology,* **107:** 283–286.

GRAHNE, B. (1958) Abscess tonsillectomy. *Archives of Otolaryngology,* **68:** 332–336.

JOHNSEN, T. (1981) Infectious mononucleosis and peritonsillar abscess. *Journal of Laryngology and Otology,* **95:** 873–876.

MOESGAARD NIELSEN, V., and GREISEN, O. (1981) Peritonsillar abscess. *Journal of Laryngology and Otology,* **95:** 801–807.

Address for correspondence:
Søren Kristensen, M.D.,
ENT-Department,
Sct. Joseph's Hospital,
6700 Esbjerg,
Denmark.

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