Quinsy Following Tonsillectomy

Pages with reference to book, From 19 To 19

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Pentonsillar abscess or Quinsy has a similar presentation as pentonsillar ceflulitis One can progress to the other[1]. The term quinsy comes from cynanche, (Greek: Cyn, dog, ancien throttle)[2]. Being a clinically descriptive tenn, it should be retained. In all cases tonsillectomy is traditionally recommended, either immediately or six weeks later. We have been unable to find previous reports in the English literature of quinsy occurring alter tonsillectomy except in Spanish literature[3] and are therefore, presenting four cases of the condition.

Case Reports

Case 1

A 16 year old male presented with a three days history of sore throat, progressing to dysphagia, despite oral antibiotics. As a child he had undergone tonsillectomy. Examination revealed a large swelling of the left soft palate and upper fauces. He had a temperature of 102°F with a white cell count of 7,400/cu nun. There was no evidence of sinus or ear sepsis.

Incision of the mass revealed no pus. High dosage intravenous penicillin was started followed by rapid resolution leading to discharge from hospital alter two days. At operation, six weeks later, small remanants were removed from both tonsillar beds by sharp dissection. Histopathology showed lymphoid tissue. Post-surgical recovery was uneventful.

Case 2

A 20 year old male presented with five days history of a cold followed by a sore throat. On the day before admission he was unable to swallow or open his mouth. At the age of six, he had been subjected to tonsillectomy. On examination there was considerable trismus and a large swelling of the soft palate and lateral pharyngeal wall which was pushing his swollen uvula to the left. The temperature was 103°F and white cell count 12,100/ cu mm. Incision of the mass revealed no pus. High dosage pencillin and plenty of fluids were administered with resolution over next five days. A throat swab showed no growth. He never came for follow-up alter discharge.

Case 3

A female aged 2 1 years, presented with one week history of pain in the right side of the throat which progressed to dysphagia and trismus soon before admission despite treatment with antibiotics. Tonsillectomy had been performed at the age of 12 ears. Examination revealed a right sided swelling of the soft palate and fauces, pushing the uvula to the left. An oedematous tonsillar remnant was seen between the right faucial pillars. Her temperature was 102°F and blood analysis showed a WBC Count of 15,600 per cu mm with a negative Paul Bunnell test. No pus was obtained on incision. High dosage Ampicillin was given intravenously with rapid resolution. Six weeks later, she was readmitted for removal of the tonsillar remnant and has remained well since then.

Case 4

A 25 years old female, school teacher had her tonsils removed at the age of 15. She gave history of post-tonsillectomy bleeding followed by blood transfusion. before coming to hospital, she developed a sore throat which despite Erythromycin, progressed until she was unable to swallow or talk properly. Examination revealed swelling of the left soft palate and tonsillar pillars which displaced the uvula to the right. Tonsillar remnant w’as seen. Incision of the soft palate drained pus and rapid resolution followed. The pus was sterile on culture. Patient failed to attend her follow-up appointments.

Discussion

The advisability of immediate or delayed tonsillectomy alter peritonsillar abscess[3-5]. is a disputed issue. Recently the need for tonsillectomy has been questioned. A high incidence of tonsillitis or abscess alter drainage has also been reported. But it is unanimously accepted that tonsillectomy, if performed, prevents further peritonsillitis. In three out of the four cases reported above, there was a confirmed tonsillar remnant present and possibly also in the one who failed to return. Careful complete tonsillar dissection is therefore, needed to prevent further complications.

Fried and Forrest[1] pointed out that there is little difference in presentation between Pentonsilkar abscess and cellulitis. The observations of the presented cases support the theory as three out of four cases had no pus on aspiration, as they had received oral antibiotics prior to admission.

The fact that quinsy following tonsillectomy has not previously been reported suggests that it is relatively uncommon. One must conclude that, in majority of cases, tonsillectomy will prevent quinsy formation, if the removal is complete.

References

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