

## TREATMENT TACTICS OF PATIENT WITH PERITONSILLAR ABSCESS

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### ABSTRACT

In this article presents a clinical case of bilateral peritonsillar abscess on patient 43 years old. Modern diagnosis and surgical treatment led to recovery in the usual terms for this pathology.

**Key words:** bilateral peritonsillar abscess, medication therapy, abscess tonsillectomy.

### Relevance

Paratonsillar abscess (PTA) is a serious complication after exacerbation of chronic tonsillitis. It is an accumulation of purulent contents in the peritonsillar space and even the fiber of the neck. The spread of infection with PTA also occurs by lymphogenic and hematogenic pathways, can cause the development of deep neck phlegmon, mediastinitis, tonsillogenic sepsis, which pose a direct threat to the patient's life. The prognosis and effectiveness of treatment of such patients depends on timely hospitalization in an ENT hospital, surgical treatment - opening of a paratonsillar abscess and its drainage, as well as targeted complex drug therapy.

The cause of a paratonsillar abscess may be repeated sore throats, as well as foreign bodies of the tonsils, trauma to the tonsillar tissue and paratonsillar tissue. In young children, this disease occurs mainly after traumatic damage to the tonsils. It is rare in children, which is due to the low incidence of chronic tonsillitis and morphological features of the structure of the tonsils. Lacunae at this age are slit-like, superficial, little branching, which prevents infection from penetrating to the connective tissue capsule and spreading to the paratonsillar tissue. The disease may be odontogenic as a result of the spread of infection to the paratonsillar tissue from carious teeth. The development of the disease is facilitated by a decrease in the body's resistance, the retention of pus in the lacunae of the tonsils.

According to clinical and morphological changes, there are three forms of paratonsillar tissue inflammation: edematous, infiltrative and abscessing. The edematous form of inflammation is very rare, infiltrative — in 15-20% and in most cases there is an abscessing form — in 75-90% of patients.

There are several localizations of paratonsillar abscess:

1. Supratonsillary localization (anteroposterior), occurs in 73% of cases (abscess is localized between the capsule of the amygdala and the upper part of the anterior palatine arch);
2. Lower localization, occurs in 7% of cases (abscess is localized between the lower pole of the amygdala and the side wall of the pharynx);
3. Lateral localization (lateral), occurs in 4% of cases (the abscess is localized between the middle part of the amygdala and the side wall of the pharynx).
4. Posterior localization, occurs in 16% of cases (abscess is localized between the capsule of the palatine tonsil and the posterior arch);

With anteroposterior or anterior paratonsillitis, the patient is subjectively concerned about the difficulty and painfulness of opening the mouth – trismus. There is a sharp bulging of the upper pole of the amygdala together with the palatine arches and soft palate to the midline, the surface of which is tense and hyperemic, the tongue is shifted in the opposite direction, the amygdala is also pushed down and posteriorly.

Posterior paratonsillitis, localized in the fiber between the posterior arch and the amygdala, can spread to the side wall of the pharynx, swelling is noted in the same area. The palatine amygdala and anterior arch may be little changed, the uvula and soft palate are usually swollen and infiltrated, there may be nasal speech.

Lower paratonsillitis has less pronounced pharyngoscopic signs. Only edema and infiltration of the lower part of the anterior arch are noted, but the subjective manifestations of the disease in this localization are significant. The adjacent part of the tongue root is usually involved in the process, sometimes there is swelling of the lingual surface of the epiglottis, which is accompanied by painful protruding of the tongue.

External or lateral paratonsillitis is less common than other forms, but it is the most severe, with this localization, swelling and infiltration of the soft tissues of the neck on the side of the lesion, torticollis, trismus are pronounced. On the part of the pharynx, inflammatory changes are less pronounced. There is a moderate swelling of the entire tonsil and swelling of the surrounding tissues.

In all types of PA, the general status of the patient sharply worsens, and is accompanied by a high temperature.

PA according to literary sources is more common at a younger age, it is almost one-sided. Bilateral PA is extremely rare. According to the ENT department of GKB No. 1, there have been three cases of bilateral PA over the past 5 years.

Based on the above, we present a case from practice.

### Clinical case

Nazarbayev Dilshod, 43 years old, was admitted on 10.11.2019 to the ENT department of the city Hospital No. 1 with complaints of swelling in the submandibular area on both sides, lethargy, pain when swallowing, difficulty opening the mouth, body temperature rise to 39 ° C. According to the patient, he fell ill on 07.11.2019, when the temperature rose to 38.5 ° C, angina was diagnosed: he was treated at home, despite which the above symptoms continued to bother the patient. There was swelling in the submandibular area on both sides, it was difficult to swallow, there was salivation, which forced the patient to turn to the ENT department for emergency help.

Objectively: The condition at admission of moderate severity. Fever – 39 ° C. The patient is conscious, sluggish. Shows pronounced anxiety during examination. The skin is pale, clean. Respiration in the lungs, vesicular, is carried out evenly on both sides. AD 120/80 mm.sim. Pulse is 100 u/min. The heart tones are muted, rhythmic. Stool, diuresis is normal.

ENT status: Rhinoscopy: nasal breathing is satisfactory, a small amount of mucus in the common nasal passages. The septum of the nose along the middle line.

Enlarged, painful lymph nodes are detected in the right submandibular and lateral surfaces of the neck. The trism of the chewing muscles is determined.

Pharyngoscopy: on both sides, the right and left palatine tonsils are sharply enlarged, hyperemic, protrude to the midline. The anterior arches are edematous, infiltrated in the antero-upper part. There are no raids.

The swelling extends to the small tongue, the back wall of the pharynx is moderately hyperemic.

Laboratory data: In clinical blood analysis: erythrocytes –  $4.78 \times 10^{12}$ , leukocytes –  $15.2 \times 10^9$ , Hb – 115 g/l, ESR -15 mm/h.

General urinalysis: without pathology.

Biochemical blood analysis: ALT – 96.5 mmol/l, AST – 47.6 mmol/l, Bilirubin 13.9 mmol/l, urea - 5.4 mmol/l, creatinine – 111.3 mmol/L.

C-reactive protein: RF – 4 iu/ml, ASLO – 400 iu/ml, CRP -24 iu/ml. ECG – sinus rhythm with a heart rate of 96 beats/min, normal EOS position.

Based on clinical and laboratory examination methods, the patient was diagnosed with exacerbation of chronic tonsillitis complicated by bilateral PA.

Treatment: After a diagnostic puncture of the paratonsillary space, purulent contents were obtained from both sides.

Under local anesthesia of 10% lidocaine (applicationaly), an incision was made with a scalpel of the right and left front arches at the place of the greatest protrusion, the wound was expanded with a clamp and an abscess of the anterior upper location was opened. About 5.0 liquid pus was released. A smear was taken on the sowing tank.

After opening the paratonsillar abscess, we performed a hot tonsillectomy with the patient's consent. The patient performed the surgical procedure satisfactorily.

Conservative treatment: antibacterial therapy (ceftriaxone 1.0 units, 2 times a day intramuscularly, 5 days), decongestant and anti-inflammatory therapy (dexamethasone 4ml 1 time a day intramuscularly, 3 days), analgesic therapy (Analgin 25%-2.0 + Diphenhydramine 1% 1.0 intramuscularly), detoxification therapy (Sodium chlorine 0.9% -200.0 + Ascorbic acid 6.0 intravenously drip) Local treatment: Furasol is prescribed for rinsing 3 times a day for 7 days, a semi-alcoholic compress is prescribed in the submandibular area.

The condition improved significantly in the following days: he became more active, his appetite improved, swallowing became less painful. The temperature dropped to low subfebrile figures. The swelling in the submandibular area has disappeared. During pharyngoscopy, a noticeable decrease in the infiltration of the paratonsillary region was noted on both sides. Within three days, the abscess cavities expanded and were cleaned of pathological contents. On the 6th day, the decrease in inflammatory phenomena was noted. Repeated blood and urine tests indicated their normalization. The patient was discharged on the 7th day of treatment in a satisfactory condition under the supervision of an ENT doctor at the place of residence.

Conclusion: Surgical autopsy and drainage is the therapy of choice in the treatment of paratonsillar abscesses. However, antibiotic therapy is an integral part in the complex treatment of this pathology and prevents the development of local and systemic complications of this infection. The choice of antibacterial therapy depends on the pathogen, but at the initial stage of treatment, preference should be given to broad-spectrum drugs, including antibacterial drugs - mainly of the III generation.

The peculiarity of the presented observation is that this pathology is bilateral, is rare, with a more clinically severe course of the disease. With bilateral PA, there is a high risk of developing metotonsillary complications as well. The complex application of surgical and drug treatment of the disease in a hospital led to recovery in the usual terms for this pathology.

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