LETTERS TO THE EDITOR

Comments on Peritonsillar Infections: A Prospective Study of 100 Consecutive Cases

Comentario sobre las infecciones periamigdalinas: estudio prospectivo de 100 casos consecutivos

To the Editor,

We read with great interest a work on healthcare in peritonsillar infections published recently by your Journal, and would find it highly constructive to reopen the debate on its therapeutic alternatives. Our centre offers tertiary healthcare coverage for a population of 350,000 and we can corroborate the epidemiological aspects reported by the authors regarding the distribution by age and gender, relationship with acute pharyngotonsillitis, second episodes and time between onset of symptoms and consultation.

We conducted a prospective monitoring from January 2005 until June 2012, which allowed us to collect 812 cases and observe an increase in incidence (from 75 in 2005 to 129 in 2011), the appearance of bilaterality in 1.4%, and a similar amount of phlegmonous and abscessified forms (49.1% vs 50.9%). Adequate and direct training of colleagues in primary care has failed to reverse this trend. This implies that the symptoms are unpredictable, even in a context of immunosuppression as discussed by other authors.

Therefore, we observed that our percentage of peritonsillar abscesses was greater than that presented by Costales-Marcos et al.1 without reaching that reported by other communications.2

The diagnosis of peritonsillar abscess in our environment has been established according to puncture-aspiration of supplicative collections or to the presence thereof through incision and drainage of the suspicious region under powdered topical anaesthesia, despite obtaining a negative puncture.

Out of 398 cases diagnosed with abscesses, puncture was negative in 87 cases. Whilst also assuming a significant anaerobic component in the aetiopathogenesis of the disorder, 3,4 the opening of the suppurative collection ensures focal detoxification.3,5 Peritonsillar abscesses point to the prestyloid space and, although this muscular diaphragm tends to protect the large vessels, it lacks a defined anatomical limit which prevents caudal progression. Our series included 8 cases with parapharyngeal collection (1.3%) and 2 with mediastinal involvement (0.2%).

These small percentages, the detection of 21.8% of abscesses through incision-drainage and the clinical verification of immediate improvement following drainage, strongly recommended this manoeuvre, which is adequately tested in the training period of resident physicians, equally simple and with a low cost.

Recommending admission for 1 night, hospital stay in 772 patients with peritonsillar infection was not more than 24 h, with a mean period of 40 h, still higher than that reported by other authors.2 Patients were treated with amoxicillin-clavulanate and clindamycin, along with intravenous steroid support from the time of admission. The empiricism of antibiotic therapy is due to the frequent absence of any isolates caused by prior antimicrobial therapy, as well as easy contamination with oxygen of anaerobic suppurations. In general, coverage against Streptococcus spp. and anaerobes should not be delayed by days.3,5 Corticosteroid therapy rapidly relieves trismus by pterygoid irritation.

Upon discharge it is only necessary to extend this antibiotic treatment for 1 week orally, in a similar way as reported by the authors. The incidence of a second abscess or peritonsillar phlegmon remains at 4.5% of cases, but hospital stay and cost are optimised accordingly.

References


Reply to the Letter "Comments on Peritonsillar Infections: A Prospective Study of 100 Consecutive Cases" [1]

Réplica a la carta «Comentario sobre las infecciones periamigdalinas: estudio prospectivo de 100 casos consecutivos»

To the Director,

We appreciate the comments on the article "Peritonsillar infections: a prospective study of 100 consecutive cases" published in the journal Acta Otorrinolaringológica Española (Number 3, Volume 63, pages 212–217), signed by Costales-Marcos et al. [1] We wish to extend our thanks for the contribution given, in which abundant case material is collected from a hospital that offers health coverage to a wide population area. The elevated number of cases treated makes it possible to discern that the experience acquired in peritonsillar infection treatment is extensive. We believe that the authors could present their series in detail in the form of an original report and compare their series with others published; this would enrich the knowledge of the management of this type of infections, so prevalent and so widely discussed.

The authors of the comments thoroughly describe the characteristics of their series, which are similar, in general, to those published in our article. [1] However, it seems that they are in favour of incision-drainage as a method of eliminating the purulent material. As indicated in our article, [1] there is no consensus about the ideal management method, although both puncture-aspiration and incision-drainage seem to have the same clinical efficacy and the method of choice varies among the different series. In the 100 cases studied prospectively in our series, puncture-aspiration at the moment of diagnosis is the method of choice, as it is for other authors. [2] However, given the absence of consensus, incision-drainage, that chosen by the authors of the commentary, seems likewise appropriate, according to the literature. [1,3]

In short, our article presents and analyses the data from a prospective series of patients with the objective of achieving an optimum outcome in the management of these very prevalent infections. It seems suitable that, joining various experiences, establishing consensus protocols can be established for the management of these infections.

References


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