Background

Peritonsillar abscess is cellulitis of the space behind the tonsillar capsule extending onto the soft palate, leading to an abscess. The abscess may be within or around the tonsil. This is a very serious condition (Brashers & Huether, 2019). It is caused by bacterial infection, usually related to group A *Streptococcus* (GAS) (50%), *Streptococcus pyogenes*, *Staphylococcus aureus*, *Haemophilus influenzae*, and methicillin resistant *Staphylococcus aureus* (Brashers & Huether, 2019; Galioto, 2017).

Immediate Consultation Requirements

The RN(AAP) should seek immediate consultation from a physician/NP when any of the following circumstances exist:
- abscess is greater than 1 centimetre in diameter,
- client appears acutely ill,
- client is drooling,
- client is having difficulty swallowing,
- client is having difficulty breathing, and/or
- is having difficulty or is unable to open the mouth (trismus) (Brashers & Huether, 2019; Galioto, 2017; Interprofessional Advisory Group [IPAG], personal communication August 28, 2019).

Predisposing and Risk Factors

Predisposing and risk factors for peritonsillar abscess include a recent episode of pharyngitis.

Health History and Physical Exam

Subjective Findings

The circumstances of the presenting complaint should be determined. These include:
- gradually increasing pain in ear, throat and neck;
- high fever;
- malaise;
- dysphagia (difficulty swallowing);
- dysphonia (“hot potato” voice);
- drooling;
• trismus (difficulty opening mouth); and/or
• leans forward when sitting or standing to ease breathing and manage oral secretions (Brashers & Huether, 2019; Galioto, 2017).

**Objective Findings**

The signs and symptoms of peritonsillar abscess may include:

• high fever;
• tachycardia;
• foul odour to the client’s breath;
• appears acutely ill or distressed;
• affected tonsil, is red, and grossly swollen towards the uvula (medial aspect);
• tonsil may displace the uvula and soft palate to the opposite side of the pharynx;
• swelling and redness of the soft palate;
• trismus;
• increased salivation;
• dysphonia;
• referred ear pain on the affected side;
• tonsillar/cervical lymph nodes enlarged and very tender; and/or
• fluctuance may be felt on the affected side of palate (Brashers & Huether, 2019; Galioto, 2017).

**Differential Diagnosis**

The following should be considered as part of the differential diagnosis:

• peritonsillar cellulitis (the area between the tonsil and its capsule is edematous and erythematous, but pus has not yet formed),
• infectious mononucleosis,
• epiglottitis,
• lymphoma or carcinoma,
• retromolar or retropharyngeal abscess, or
• gonococcal pharyngitis (Brashers & Huether, 2019; Galioto, 2017; Wald, 2017).

**Making the Diagnosis**

The diagnosis is usually made clinically based on the health history and physical exam.

**Investigations and Diagnostic Tests**

A swab for culture and sensitivity should be collected if spontaneous drainage is present. Referral required in moderate to severe disease as needle aspiration and/or computerized tomography (CT) may be needed (Galioto, 2017).
Management and Interventions

Goals of Treatment
The primary goals of immediate treatment are to eradicate infection, relieve symptoms, and prevent complications (Brashers & Huether, 2019; Galioto, 2017).

Non-Pharmacological Interventions
The RN(AAP) should recommend, as appropriate, the use of salt water gargles.

Pharmacological Interventions
The pharmacological interventions recommended for the treatment of mild peritonsillar abscess (abscess less than 1 centimetre and absence of muffled voice, drooling, and trismus) are in accordance with the *Anti-infective Guidelines for Community-acquired Infections* (Anti-infective Review Panel, 2019), *RxFiles: Drug Comparison Charts* (Rx Files Academic Detailing Program, 2017), *Peritonsillar Abscess*, (Galioto, 2017).

### Analgesics and Antipyretics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Acetaminophen</td>
<td>500-1000 mg (maximum dose of 4 g/day)</td>
<td>p.o.</td>
<td>q.i.d. prn</td>
<td>5-7 days</td>
</tr>
<tr>
<td>AND/OR Ibuprofen</td>
<td>400 mg (maximum dose of 1600 mg/day)</td>
<td>p.o.</td>
<td>q8h prn</td>
<td>5-7 days</td>
</tr>
</tbody>
</table>

### Oral Antibiotics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Penicillin V</td>
<td>500 mg</td>
<td>p.o.</td>
<td>q6h</td>
<td>10-14 days</td>
</tr>
<tr>
<td>PLUS MetroNIDAZOLE</td>
<td>500 mg</td>
<td>p.o.</td>
<td>b.i.d.</td>
<td>10-14 days</td>
</tr>
<tr>
<td>OR Amoxicillin/ clavulanate</td>
<td>875/125 mg</td>
<td>p.o.</td>
<td>b.i.d.</td>
<td>10-14 days</td>
</tr>
</tbody>
</table>
### Adult (with penicillin allergy)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Route</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clindamycin</td>
<td>300-450 mg</td>
<td>p.o.</td>
<td>q8h</td>
<td>10-14 days</td>
</tr>
</tbody>
</table>

### Client and Caregiver Education

The RN(AAP) provides client and caregiver education as follows:

- Counsel about the appropriate use of medications (dose, frequency, compliance, etc.).
- Advise to return immediately if pain becomes worse, or if drooling develops; they have difficulty swallowing, difficulty breathing, or are unable to open their mouth.
- Encourage increased fluid intake.
- Advise rest until the fever resolves.
- Encourage frequent salt water gargles for the first 48 hours (Brashers & Huether, 2019; Galioto, 2017).

### Monitoring and Follow-Up

Follow-up in 24 hours. If no improvement, consult with a physician/NP.

### Complications

The following complications may be associated with peritonsillar abscess:

- airway obstruction;
- aspiration pneumonia following abscess rupture;
- sepsis;
- infection into deep tissues of jaw, neck, or chest;
- endocarditis;
- pleural effusion;
- pericarditis;
- necrotizing fasciitis; or
- poststreptococcal sequelae (e.g., glomerulonephritis, rheumatic fever) (Galioto, 2017; Wald, 2017).

### Referral

Refer to a physician/NP if client presentation is consistent with those identified in the Immediate Consultation Requirements section; if the client's pain is not managed with simple analgesics (e.g., acetaminophen, ibuprofen); and/or there is no improvement after 24 hours of antibiotic therapy (IPAG, personal communication August 28, 2019).
References


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