

# Peritonsillar Abscess: Adult

## Ears, Eyes, Nose, Throat and Mouth

Clinical Decision Tools for RNs with Additional Authorized Practice [RN(AAP)s]

Effective Date: May 4, 2022

---

### 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 saltwater gargles.

### Pharmacological Interventions

The pharmacological interventions recommended for the treatment of mild peritonsillar abscess (abscess less than 1 centimeter 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* (RxFiles Academic Detailing Program, 2021), *Peritonsillar Abscess*, (Galioto, 2017) *Peritonsillar Abscess: Antibiotics* (Dynamed, 2018) and *CPS Drug Information* (Canadian Pharmacists Association, 2021).

### Analgesics and Antipyretics

	Drug	Dose	Route	Frequency	Duration
<b>Adult</b>					
	Acetaminophen	500-1000 mg (maximum daily dose of 4 g/day)	p.o.	q4-6h prn	5-7 days
AND/ OR	Ibuprofen	400 mg (maximum daily dose of 1600 mg/day)	p.o.	6-8h prn	5-7 days

## Oral Antibiotics

	Drugs	Dose	Route	Frequency	Duration
<b>Adult (without penicillin allergy)</b>					
	Penicillin V	500 mg	p.o.	q6h	10-14 days
<b>PLUS</b>	MetroNIDAZOLE	500 mg	p.o.	q6h	10-14 days
<b>OR</b>	Amoxicillin/ clavulanate	875/125 mg	p.o.	b.i.d.	10-14 days
<b>Adult (with penicillin allergy)</b>					
	Clindamycin	300-450 mg	p.o.	q8h	10-14 days

## 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 saltwater 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

- Anti-infective Review Panel. (2019). *Anti-infective guidelines for community-acquired infections*. MUMS Guideline Clearinghouse.
- Brashers, V., & Huether, S. (2019). Alterations of pulmonary function in children. In K. McCance & S. Huether (Eds.), *Pathophysiology: The biologic basis for disease in adults and children* (8th ed., pp. 1202-1227). Elsevier.
- Canadian Pharmacists Association. (2021). *CPS drug information*. <https://www-myrxtx-ca.ezproxy.saskpolytech.ca/search>
- Dynamed. (2018). *Peritonsillar abscess: Antibiotics*. <https://www.dynamed.com/condition/peritonsillar-abscess#ANTIBIOTICS>
- Galioto, N. (2017). Peritonsillar abscess. *American Family Physician*, 95(8), 501-506. [www.aafp.org/journals/afp.html](http://www.aafp.org/journals/afp.html)
- RxFiles Academic Detailing Program. (2021). *RxFiles: Drug comparison charts* (13th ed.). Saskatoon Health Region.
- Wald, E. (2017). *Peritonsillar cellulitis and abscess*. [www.uptodate.com](http://www.uptodate.com)

### NOTICE OF INTENDED USE OF THIS CLINICAL DECISION TOOL

This CRNS Clinical Decision Tool (CDT) exists solely for use in Saskatchewan by an RN with additional authorized practice as granted by the CRNS. The CDT is current as of the date of its publication and updated every three years or as needed. A member must notify the CRNS if there has been a change in best practice regarding the CDT. This CDT does not relieve the RN with additional practice qualifications from exercising sound professional RN judgment and responsibility to deliver safe, competent, ethical and culturally appropriate RN services. The RN must consult a physician/NP when clients' needs necessitate deviation from the CDT. While the CRNS has made every effort to ensure the CDT provides accurate and expert information and guidance, it is impossible to predict the circumstances in which it may be used. Accordingly, to the extent permitted by law, the CRNS shall not be held liable to any person or entity with respect to any loss or damage caused by what is contained or left out of this CDT.

CRNS © This CDT is to be reproduced only with the authorization of the CRNS.