Peritonsillar Abscess (PTA)

Children's Mercy KANSAS CITY | Evidence Based Practice

Alternate diagnoses:
- Tonsillitis
- Mononucleosis
- Intratonsillar abscess
- Retro/parapharyngeal abscess

Pt presents with concern for peritonsillar abscess (PTA)

Complete history and physical examination

Do clinical findings suggest PTA?

No → Off pathway; Consider alternate diagnosis

Yes

- Consult ENT
- Consider transfer to AH ED if at CMK ED
- Make NPO
- Perform Rapid Strep testing if not done
- Consider mononucleosis testing
- CT not indicated

QR code for mobile view

Features of PTA (any of the following):
- Trismus
  - Difficulty opening mouth, actively and passively
- Difficulty swallowing
- Spitting out saliva
- Fever
- Muffled or "hot potato" voice
- Unilateral throat pain
- Soft palate erythema with fullness/bulging (link to images)
- Uvula deviation

Bedside drainage considerations:
- Age of pt
- Caregiver acceptance

Based on initial discussion, is ENT concerned for PTA and planning bedside evaluation?

No → Off pathway; Consider alternate diagnosis

Yes

Is pt a candidate for bedside drainage?

No → Inpatient admission

Yes

- Engage Child Life
- Place IV
- Start IV antibiotics at discretion of ED
- Prepare supplies for ENT
- Administer pain management as indicated
- IV steroids if indicated- do not administer until after ENT evaluation
  - Dexamethasone 0.5 mg/kg (max 12 mg)

ENT to perform bedside drainage
- Send drainage for cultures (aerobic and anaerobic)

Initiate PO challenge

Does pt meet discharge criteria?

No → **Admit**
- Admit to Gen Peds service for medical management
- Oral antibiotic recommendations

Yes → **Discharge**
- PCP follow-up after 1 - 2 weeks
- ENT clinic visit for ≥ 2 PTA within 1 month
- Oral antibiotic recommendations

IV Antibiotic Recommendations

First line:
- Ampicillin/sulbactam 50 mg of ampicillin component/kg/dose (max 2000 mg of ampicillin component/dose)

If penicillin allergy/risk for MRSA:
- Clindamycin 10 mg/kg/dose (max 600 mg/dose)

Supplies for ENT:
- Cetacaine spray
- 18 gauge spinal needle
- 5 cc syringe (2)
- Suction set up in room
- Culture swab in room
- Lidocaine 1%/ epinephrine 1:100,000 injectable solution
- 18 gauge needle to draw up lidocaine
- 11 blade
- Curved hemostat
- Blank consent form

Discharge Criteria
- Drainage successful
- Tolerating PO
- Pain controlled

Oral Antibiotic Recommendations

First Line:
- Amoxicillin/clavulanate
  - 20 mg/kg/dose every 12 hours (max single dose 875 mg)

If penicillin allergy/risk for MRSA:
- Clindamycin (for pts who have responded to IV clindamycin)
  - 13 mg/kg/dose every 8 hours (max single dose 600 mg)

Note: When culture and susceptibility data is available, antibiotics can be tailored to ensure coverage of identified pathogens.

If empiric therapy was employed for presumed MRSA infection:

First Line:
- Clindamycin (as above)

If clindamycin contraindicated:
- Linezolid*
  - < 12 years old: 10 mg/kg/dose every 8 hours (max 600 mg/dose)
  - ≥ 12 years old: 10 mg/kg/dose every 12 hours (max 600 mg/dose)

*Consider Infectious Diseases consult due to ordering limitations

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Link to synopsis and references

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