Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Peritonsillar Abscess & Cellulitis

Symptoms of Peritonsillar Abscess/Cellulitis

- Progressively increasing throat pain and swelling
- Muffled speech / change in voice
- Neck pain, typically unilateral
- Fevers, chills, myalgias
- Dysphagia, odynophagia

Labs

- CBC, BMP, CRP
- If needle aspiration, culture aspirate
- If SIRS or qSOFA >/= 2, add lactate, procalcitonin, blood cultures

Impending airway compromise?

Yes →
- Prepare for intubation. Anticipate difficult airway. Consider calling CRNA.
- Place IV; get labs. (See box.)
- Give antibiotics. (See box.)
- Transfer to higher level care.

No ↓

Signs/Symptoms of Impending Airway Compromise

- Drooling
- Patient in "sniffing position" (leaning forward)
- Anxious appearance with suprasternal retractions with or without stridor

Indications for CT Soft Tissue Neck with IV Contrast as Part of Initial Workup

- Toxic appearance
- Submental tenderness to palpation
- Neck stiffness, swelling, or pain with extension

Village Management

- Amoxicillin/clavulanic acid (preferred)
- If unable to swallow, IM penicillin OR ceftriaxone + clindamycin
- Ketorolac/acetaminophen
- Consider dexamethasone 10 mg.

Commercial flight to Bethel ER; discuss with ED MD if concern for airway compromise.

Consider CT. (See box.) ↓

Examination with ANY?

- Trismus
- Uvular deviation
- Peritonsillar swelling

No → Examination with peritonsillar erythema? No → Acute pharyngitis

Yes ↓

Attempt needle aspiration

No pus → Peritonsillar cellulitis

Pus ↓

Peritonsillar abscess

Peritonsillar cellulitis / Peritonsillar abscess →
- Place IV; get labs. (See box.)
- Give antibiotics. (See box.)
- IV fluids.
- Consider dexamethasone 10 mg.
- Analgesia (non-opioid first).
- Monitor in ED minimum 3 hours.

Improving → Discharge on PO antibiotics with recheck in 24 hours.

Not improving ↓

Obtain CT neck with contrast. → Deep tissue abscess → Consult ENT.

No deep tissue abscess ↓

Admit to inpatient on IV antibiotics.

Microbiology & Antibiotics

Continuum from pharyngitis > cellulitis/phlegmon > abscess. Often polymicrobial, typically GAS, *Strep viridans*, *Staph aureus*, fusobacterium, bacteriodes. MRSA coverage not indicated unless patient does not respond to initial antibiotic selection.

IV
Ampicillin/sulbactam 3 grams Q6h (preferred)
OR
Piperacillin/tazobactam 3.375 grams Q6h
OR
Ceftriaxone 1 gram Q12h + metronidazole 500 mg Q6h
OR
Clindamycin 600 mg Q6-8h (if penicillin allergy)

PO
Amoxicillin/clavulanate 875 mg BID (preferred)
OR
Cefpodoxime 300 mg Q12h + metronidazole 500 mg Q6h
OR
Clindamycin 300 mg Q6h (if penicillin allergy)

Treatment duration 14 days.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved 6/6/22. Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact Travis_Nelson@ykhc.org.