National audit of the management of peritonsillar abscess

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An anonymous postal survey of 200 consultants was used to audit the current prevalent practices in the management of quinsy in the UK; 101 responded. The findings reveal that on average an otolaryngology department treats 29 cases per year, the vast majority (94%) on an inpatient basis. The main initial treatment was needle aspiration combined with intravenous antibiotics. Interestingly, those departments treating more than 20 cases a year are more likely to use needle aspiration, while departments in England and Wales use significantly more incision and drainage than those in Scotland. Incision and drainage (52%) was the most common form of treatment of non-resolving patients. The median hospital stay was two days.

METHODS

A survey was carried out, by postal questionnaire, of 200 (36%) consultants selected randomly from the full membership list (560 members) of the British Association of Otolaryngologists–Head and Neck Surgeons (BAO–HNS). Responses were anonymous. A total of 101 surgeons replied, representing a 51% response rate. Questions were asked on the mode of treatment, the setting, the antibiotic route used, and the numbers treated each year. Details of the questions asked are shown in box 1.

RESULTS

All the percentages given are those of the total number of respondents (101). Altogether 68% managed all their patients as inpatients, and only four (4%) managed less than 60% as inpatients. No respondents managed all their patients as outpatients (fig 1).

The main initial method of treatment was needle aspiration, being performed by 61 (60%) of surgeons (fig 2). Twenty five (25%) performed incision and drainage on initial presentation. Only one (1%) performed abscess tonsillectomy at first presentation. Interestingly, five (5%) treated their patients with intravenous antibiotics alone in the first instance.

In addition, at first presentation, all respondents gave their patients antibiotics. Ninety seven (96%) respondents gave their patients intravenous antibiotics, three (3%) gave intramuscular antibiotics, and one surgeon gave oral antibiotics.

If the abscess did not resolve with the initial treatment, the most common subsequent management was incision and drainage (52%) (fig 2). Other forms of subsequent treatment included repeat aspiration (22%), abscess tonsillectomy (12%), and review of antibiotics (1%).

The median length of inpatient stay was two days (52% respondents). The length of stay (fig 3) was one day in 5% of responses, three days in 25%, four days in 5%, and no responses were given in 11%.

The average annual number of cases seen by an otolaryngology department was 29. Two per cent of respondents worked in departments which treated five or fewer cases per year, 7% 6–10 cases, 23% saw 11–20 cases, 16% 21–30 cases, 11% 31–40 cases, 11% 41–50 cases, and 17% worked in departments that treated more than 50 cases per year. No information was available for 14% of replies (fig 4).

Analysis by number of patients treated per year (table 1) shows that needle aspiration is used significantly more by consultants who treat more than 20 patients a year than by consultants who treat fewer than 20 patients a year (χ², p=0.003). On the other hand incision and drainage is used significantly more by consultants who treat fewer than 20 patients a year than by consultants who treat more than 20 patients a year (χ², p=0.001). No significant differences were observed for any of the other forms of treatment.

Abbreviations: BAO–HNS, British Association of Otolaryngologists–Head and Neck Surgeons; HTBS, Health Technology Board for Scotland; HTB, Health Technology Board; χ², chi-squared test.
Analysis by geography shows that consultants in England and Wales performed significantly more incision and drainage procedures than Scottish based consultants ($\chi^2$, p=0.014), while the reverse was true for aspiration ($\chi^2$, p=0.012). No significant differences were found when comparing other forms of treatment.

**DISCUSSION**

Health technology assessment is now considered both an ethical and economic imperative. In their duty of care towards patients, clinicians are obliged to ensure that their interventions are clinically effective. Moreover, “since resources are scarce relative to needs, and the use of resources in one way prevents their use in other ways” there is a need for the assessment and awareness of the cost effectiveness of an intervention. This would allow the elimination of clinically ineffective treatments, and the replacement of less cost effective treatments with more cost effective ones with equal clinical effectiveness. Moreover, the fact that an intervention has been used for many years is not a guarantee of its effectiveness, clinical or otherwise.\(^2\)

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**Table 1** Analysis of mode of treatment by numbers of patients treated per year

<table>
<thead>
<tr>
<th>Mode of treatment</th>
<th>&lt;20 Patients/year (n=31)</th>
<th>&gt;20 Patients/year (n=64)</th>
<th>p Value (by $\chi^2$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Needle aspiration</td>
<td>12</td>
<td>45</td>
<td>0.003*</td>
</tr>
<tr>
<td>B. Incision and drainage</td>
<td>14</td>
<td>9</td>
<td>0.001*</td>
</tr>
<tr>
<td>C. Abscess tonsillectomy</td>
<td>0</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td>D. Other</td>
<td>2</td>
<td>3</td>
<td>0.66</td>
</tr>
<tr>
<td>A + B</td>
<td>3</td>
<td>4</td>
<td>0.679</td>
</tr>
<tr>
<td>A + D</td>
<td>0</td>
<td>1</td>
<td>1.00</td>
</tr>
<tr>
<td>B + D</td>
<td>0</td>
<td>1</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Significant at 95%.
The National Institute for Clinical Excellence and the Health Technology Board for Scotland (HTBS) were established “to provide guidance to the NHS on the use of selected new and established technologies” and whether “an intervention can be recommended as a cost effective use of NHS resources”. However, they can only assess a limited number of treatments each year; for example the HTBS will assess 10 interventions in 2001–02. It will therefore fall to the different specialties to perform evaluations of many of the treatments in their field. One such example is the Statements of Clinical effectiveness in Otorhinolaryngology 1998, produced by the BAO–HNS.

To be able to assess the effectiveness of different interventions for the same condition, comparison with existing or prevalent practice is essential. This necessitates that we define and elucidate the prevalent practices, especially for conditions that have several different modes of treatment. It would also seem logical that we concentrate first on the most common conditions or the most expensive treatments, and hence the choice of peritonsillar abscesses which is one of the commonest reasons for acute admissions in otorhinolaryngology.

On a more local level, the introduction of clinical governance necessitates the audit of clinical practices. Among other things, this necessitates comparison of individual practice with the existing prevalent practice. Thus, the need for the determination of current prevalent practice is further increased, especially in conditions where there are several alternative modes of treatment. The findings indicate that the majority of surgeons manage patients by needle aspiration, or less commonly by incision and drainage on first presentation. Both these methods have been demonstrated to be equally clinically effective.

There are, however, significant differences in the mode of treatment used according to the caseload managed, with departments treating more than 20 patients a year more likely to use aspiration. Moreover there appears to be geographical variations in the choice of mode of treatment, with significantly more surgeons in England and Wales using incision and drainage. The reasons for both these findings are unclear as both treatment procedures require almost exactly the same equipment and facilities to be performed adequately, and require very similar degrees of skill and expertise. In fact, surgeons performing aspiration are usually also trained in incision and drainage in case the abscess recurs. This would therefore suggest that there should not be any significant effects of large caseloads or the type of facilities available on the choice of treatment method. Moreover, as both techniques are equally effective for the treatment of the disease, the severity of the condition when the patient first presents should not be a factor in the choice of treatment method. Hence, in our opinion, variations due to location or number of patients treated cannot be explained on the basis of a more severe caseload, requiring a certain treatment to the exclusion of others. The differences may be due to differences in emphasis during training, or preference of one “school” of technique.

Interestingly, this study demonstrates the fact that almost all new consultants treat the condition on an inpatient basis. This highlights a fundamental difference to the management in the US, where the majority are treated as outpatients. Moreover, there are several studies that have demonstrated the effectiveness of outpatient treatment. This difference may be due to the differences in set-ups and outpatient support mechanisms of the health services in the two countries, or may be driven by economic factors. It, however, highlights an area that requires further study, and we are currently in the process of evaluating outpatient patient treatment in the UK setting.

Another interesting finding was that all respondents gave intravenous antibiotics after the drainage procedure. There is some evidence however that suggests that oral antibiotics are as effective as parenteral antibiotics, and are more cost effective. Further study of mode of antibiotic treatment in peritonsillar abscesses may clarify this issue.

Treatment of the abscess recurrence after initial drainage was found in the survey to be mainly by incision and drainage, although a smaller (22%) percentage repeated the needle aspiration, and a few treated it with abscess tonsillectomy. No evidence was found in the literature comparing those methods for treatment of recurrence, highlighting the fact that this has not been studied—probably due to the very low incidence.

CONCLUSION
Peritonsillar abscess is a relatively common cause of acute admission to an otolaryngology ward in the UK. On average a department treats approximately 30 cases per year. The majority of UK consultants manage patients on an inpatient basis, initially by needle aspiration (61%) or less commonly by incision and drainage (25%). All also give them antibiotics, the majority (96%) intravenously. Interestingly, those departments treating more than 20 cases a year are more likely to use needle aspiration, while departments in England and Wales use significantly more incision and drainage than those in Scotland. For unresolved cases, most (52%) perform incision and drainage, or less commonly repeat aspiration (21%). A small proportion (12%) resort to abscess tonsillectomy. The median duration of stay was two days. The need was highlighted for further study of treatment of peritonsillar abscesses on an outpatient basis, the optimal mode of antibiotic treatment, and the management of abscess recurrence.

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REFERENCES

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Sources of inspiration

My most inspirational textbook was the 6th edition of *Harrison’s Principles of Internal Medicine*, strangely enough, not because I read it in preparation for the membership, but because, years afterwards, I came to appreciate more fully the significance of its dedication “to all those who have taught us, and especially to our younger colleagues who continue to teach and inspire us”. Starting with our younger colleagues, I can only say “Thank you for all those searching challenges which have helped to keep me on my toes”. Some of those challenges raised such fundamental issues that they were recycled as hypotheses worthy to be tested through the medium of a different kind of textbook, namely, the literature search, or through the medium of a fully fledged research project.

With regard to my more formal instruction in medicine, my most inspirational role model was my Professor of Medicine, Barry Adams, who taught me everything I shall ever need to know about that magical synthesis of experiential learning and published knowledge. He had up to date facts and figures of all the common medical conditions diagnosed in patients who had passed through his department, and was capable of raising any clinical discussion to a higher intellectual level by placing experiential knowledge of this kind in the context of published evidence. He also had the honesty to be “up front” with the limits of his knowledge, and to caution against slavish acceptance of conventional wisdom including his own. With his mischievous sense of humour, he relished the idea of “standing the logic on its head”, which was one way of searching for new insights and testing new hypotheses. Although he did not quite put it that way, his perspective was that “there were a lot of answers out there, all waiting for the right questions”. Above all however, I admired his compassion and his unfailing courtesy towards his patients. — O M P Jolobe, Geriatrician, Department of Adult Medicine, Tameside General Hospital, Ashton under Lyne, UK