mouth. In these case there will be sudden cough with choking spells. But sometimes this may not be noticed by parents and give rise to obscure symptoms of pneumonia. Negative history of foreign body ingestion/inhalation and delayed recognition of the possibility of foreign body as the cause of the presenting symptoms in children may cause complication and even deaths. Inadequate roentgenograms, particularly not including the neck in chest x-ray and inappropriate use of endoscope may all lead to complication.⁵

Although it is not uncommon to find foreign bodies in aerodigestive tracts in children but these are very rare in young infants as in this case, however, we have removed a foreign body oesophagus in two week old infants in whom the foreign body an iron scrap was put in the mouth of the neonate by 3 year elder sibling giving an evidence of sibling rivalry even in very young children.⁶

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UNCOMMON COMPLICATION OF QUINSY

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ABSTRACT : *A rare case of "quinsy with uncommon complication" and its management with review of literature is reported. Quinsy as a complication of acute or chronic Tonsillitis and Dental Infection is still seen at regular frequency inspite of modern antibiotics. This case inspite of having an early and proper incision and drainage ended up having retro and para-pharyngeal abscess which tracked down leading to Mediastinitis and Empyema Chest. Early Inter-Costal drainage prevented fatality and helped in rapid recovery.*

Quinsy is a Latin word and Quinancia in medieval English described any throat infection. In Anglo-Saxon literature Quinsy is the term for peritonsillitis/abscess. Cynanche is a Greek word used to describe any inflammation of throat and neck. (cyn: dog. anchien : throttle). But Hippocrates reserved the word for those cases which were complicated by difficulty in swallowing (Brandon 1977). According to Bonding (1973) and Johnsen (1981) it is a relatively frequent complication of tonsillitis & infectious mononucleosis. Quinsy is more common in adults but not very rare in children (Grahne 1958). Bilateral Quinsy is rare but reported by Brook and Shah in 1981. Flodstrom

& Hallender 1976 concluded that beta. Hemolytic streptococci & various anerobic bacteria like Bacteroides Pseudobactirium peptostreptococcus were the prominent flora. Previously Staphylococcus Aureus, Haemophilus Influenzae and Pneumococcus were the organisms thought of. The first Incision and drainage was done by a French surgeon in 1362. Controversy exists regarding management of such cases, with usual treatment being Incision and drainage followed by Tonsillectomy after 6-8 weeks in the young & regular follow-up of patients above 40 years of age. Chasaignac in 1859 first proposed Tonsillectomy a Chaud immediate/hot, but it was deferred

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Fig. I

Fig. II

Fig. I & II : CT scan showing extensive abscess involving the retropharyngeal space and left parapharyngeal space.

Fig. III : CT scan showing extension to posterior mediastinum upto the level of tracheal bifurcation.

till 1970 for fear of complications of surgery. Later Beeden & Evans (1970) & Bonding (1973) & Mc Curdey (1977) pointed out that Tonsillectomy a Chaud (Hot Tonsillectomy) is safe. Bateman & Kodiek 1959 reported that 41% had proper drainage by Incision and drainage whereas Brandlow (1973) reported 70%. According to

Fig. IV :X-ray chest showing right sided empyema

Fig. V : X-ray chest showing normal lung fields with no empyema

O. Greisen the percentage of complications of routine and hot tonsillectomy are same. C.D. Randall & A.F. Jaffaris (London) reported 5 cases of post tonsillectomy Quinsy in remnants. According to V. Moesgaard, Neilsen & O. Greisen (Aalborg – Denmark.) concluded that in patients under 30 years, 63% had another attack of tonsillitis/ abscess within 3 years after incision and drainage. Whereas among those over 30 years, only 12% suffered a second attack. T. R. Neilsen, F. Clement and U. K. Andreassen (1996) report a similar case like the present one in a 25 year old person.

CASE REPORT

B.R. – A 70 year old male was admitted on 15-1-98 in our

hospital with inability to open the mouth fully for past 5 days and had difficulty in swallowing. He gave a history of Incision and drainage for (L) Quinsy in a private nursing home 5 days earlier. At the time of admission the patient was conscious, coherent, afebrile with a B.P. of 120/70. and pulse rate of 116/mt. He was mildly dehydrated with coating of tongue & presence of trismus. Thick purulent discharge was coming out from the incision site on the palate. Rest of the examination was normal. There was persistent trismus in spite of good drainage. The following investigation were done :-

- 1) C.B.P. Hg. 11.2 mg – Total W.B.C. Count 10,000; ESR – 90/118
- 2) R.B.S. 100 mg %⁹⁻⁶
- 3) Urine Exam. – Normal (No Sugar)
- 4) Blood Urea. 60 mg%
- 5) Serum Creatinine. 1.8 mg%
- 6) Pus for C/S. Staphylococcus Aureus
- 7) X-Ray. mandible; no dental infection seen

The patient was put on I.V. Ciprofloxacin; B.D. I.V. Metronidazole – 8 hourly; NSAIDS. & Serratiopeptidase. Dental opinion was also sought. On 16-1-98. About 20 ml. of pus was drained and sent for C/S. By evening on the same day he started complaining of a swelling in the neck on the left side and parotid region on left and a swelling behind the right ear with Crepitus and mild cellulitis of the left. Temporal region with swinging temperature. In view of the above findings a diagnosis of parapharyngeal abscess with venous thrombosis of deep veins was made. Later a C.T. scan of Neck and Chest was advised. As we had a strong suspicion of mediastinal spread. C.T. done on 18-1-98 revealed an extensive abscess involving retropharyngeal space & left parapharyngeal space (Figs. I & II) & extending in to the posterior mediastinum upto tracheal bifurcation (Fig. III). Hence a wide drainage from the neck was planned on 19-1-98. But on palpation just before surgery the swelling disappeared. The patient started complaining of inter scapular pain with slight breathlessness and looked toxic. There was a decreased air entry on right chest. Empyema chest was suspected and a diagnosis of Empyema (right) was confirmed by chest X-ray (Fig. IV). Later IC drain was introduced under

LA on the right side and about 1500 ml of pus was drained. It was again sent for C/S (Result / sterile) and on second day 750 ml of pus was collected. By fifth day it was 400 ml. Repeat chest X-ray on 28-1-98 (thirteenth day) revealed complete expansion of lungs (fig. 5). On 6-2-98 patient was discharged with the tube on request. On subsequent follow-up the drain was removed and all the swelling had cleared by then. Last reviewed on 23-3-98, the patient is comfortable with slight persistence of trismus. The opening on the palate which was patent all these days closed spontaneously.

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