

# Case Report

## Intractable Unilateral Quinsy Secondary to Impacted Foreign Body in Tonsil

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We report a case of an impacted foreign body in the tonsil presenting as an intractable unilateral quinsy. A completely embedded foreign body should be considered in cases of unilateral quinsy not responding to aggressive medical line of treatment.

**Key words:** Foreign body, tonsil, quinsy

Very few foreign bodies introduced into the oropharynx become completely embedded into the tonsil. It is rare for the tonsil to serve as a resting niche for a foreign body.

Most series on foreign bodies in food and air passages are notable for according to foreign bodies in the pharynx or tonsil (Citron, 1948). Completely embedded foreign bodies in the tonsil are rare (Osbourne, 1966; Soni et al, 1980). Gullion (1939) described the presence of a shell splinter in the tonsillar fossa for 20 years. Citron (1948) and Ross (1941) both reported the finding of teeth in the tonsil. Osborne (1966) reported a ballpoint pen cap as a foreign body embedded in the left tonsil of a female child.

An unusual presentation of a patient with refractory unilateral quinsy not responding to aggressive line of medical management due to initially undiagnosed foreign body of the tonsil but with subsequent discovery has prompted us to report this case.

### Case report

A 45 year-old gentleman was referred to the ENT department complaining of unilateral sore throat for 4 days with pain radiating to the left ear. There was no history of accidental insertion or impaction of any foreign object in the oropharynx. There was no history of recurrent sore throats. General examination revealed the patient to be mildly febrile (37.8° C) and dehydrated. Examination of the throat showed the presence of a moderately enlarged left tonsil with erythema in the region of the supra-tonsillar cleft and appearance suggestive of a collection of debris in this region. The uvula appeared pushed towards the opposite side. The patient was admitted and started on intravenous antibiotics and intravenous fluid alimentation. Haematological investigation revealed slightly raised white blood cell count ( $12.9 \times 10^9$ /lit). Screening for glandular fever was negative. A diagnosis of a left para-tonsillar abscess (Quinsy) was made and an attempt done to drain this region. However only a small amount of blood with pus returned. The returning pus was sent for culture sensitivity. This did not grow any organisms. Over the ensuing 48 hours two further unsuccessful attempts at draining the collection was made. As the patients'

symptoms did not improve a CT scan was done to rule out any pus in the para-tonsillar neck spaces (Fig. 1). The CT scan revealed marked soft tissue swelling of the left tonsillar bed and oro-pharynx, measuring up to 4cm in maximum diameter. In the centre of this region was a 2cm in diameter low attenuation area representing a necrotic centre. There was a focal hyper-dense area of bone density within this necrotic area. Bilateral tonsillectomy was then performed. On sectioning the left tonsil, inspissated material surrounding a small bony spicule was noted the origin of which could not be ascertained. The patient had an uneventful post-operative recovery. A year on he has had no further problems.



Fig. 1: CT scan showing focal hyperdense area of bone density within soft tissue swelling of the left tonsillar bed.

### Discussion

Foreign body embedded in the tonsil giving rise to intractable, unilateral para-tonsillar abscess (quinsy) is a rare condition. An extensive review of the English medical literature shows only one such case report to have been published (Soni et al, 1980).

Young children chew the ends of pens and similar objects (Laws and Walters, 1997). The possibility of an impacted foreign body should always be considered with a history of trauma (Laws and Walters, 1997). Osborne (1966) reported a ballpoint pen cap embedded in the tonsil for 5 days. Sekhar et al (1998) report a ballpoint pen plug embedded for 3 months. However, in our case there was no history of any obvious foreign body penetration in the

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left tonsil. The presence of the foreign body was responsible for the refractory nature of the para-tonsillar abscess. This report highlights the fact that with unilateral intractable para-tonsillar abscess not responding to medical line of management, the suspicion of a foreign body must be kept in mind

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