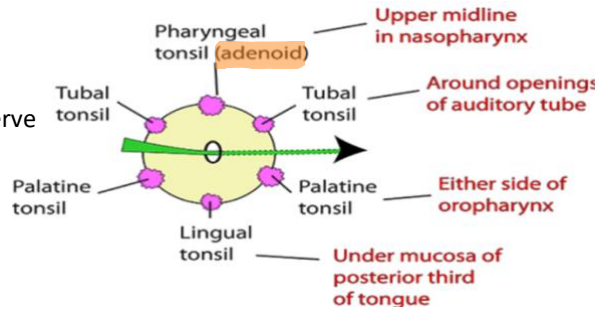
Tonsils, Pharynx and Larynx



- Tonsils containing mainly the B-cells.
- Laterally to the palatine tonsils —> Superior constrictor ms —> glosso-pharyngeal nerve
- Medially —> the fibrous capsule.
- Vascular supply: Tonsillar artery, Ascending pharyngeal artery ▸ BLEEDING

WALDEYER'S RING : circle of protective lymphoid tissue at the upper end of the respiratory and alimentary tracts.

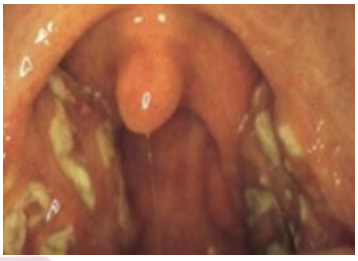
|] Tonsillitis

- 3-7 years
- Mostly Viral … then bacterial (B-hemolytic streptococcus)
- Clinically : Sore throat, Dysphagia, Otalgia, Fever, Weakness and Fatiguability, Nausea, Poor appetite, Dehydration, Inflamed and swollen tonsils, Inability to open mouth completely, **Hot potato** sign, Enlarged Jugulodigastric LNs, Drooling of saliva, and Airway obstruction.
- DIAGNOSIS >> Clinically!! …. If acute tonsillitis ? spread to deep neck structures ? —> **lateral neck CT scan.**

→ Types of tonsillitis :

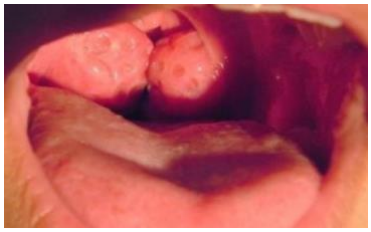
Follicular tonsillitis

- Common in children
- infx in the Surface of T.
- white-yellowish points + pus



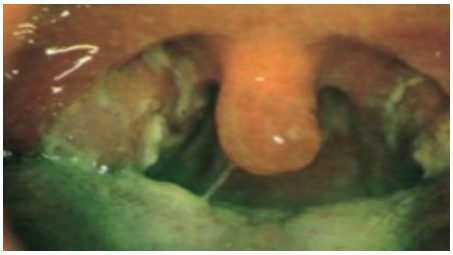
Parenchymatous tonsillitis

- Common in adult
- Infx in the whole tonsil
- **kissing tonsils** / Swollen



Membranous tonsillitis

- pyogenic / complicated follicular
- pus forms pseudo-membrane / medially
- (redness, swollen tonsils, marked hyperemia of the pillars, uvula and soft palate)



DDx :

1. **Infectious Mononucleosis**
   Glandular fever
   - EBV , Adult
   - pt obviously toxic
   - sore throat not responding to abx 1-2 wks
   - Large jugulodigastric LNs
   - Dirty .. covered by Wt membrane
   - Do serology after 48 hrs -> **heterophile Abs / Monospot**
   - Blood film -> atypical lymphocytes

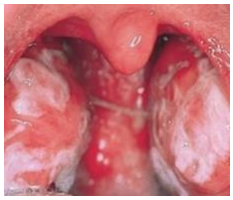
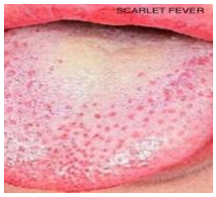
2. **Scarlet Fever**
   - Mainly in children
   - Post strep infx
   - Rash & **Strawberry tongue**

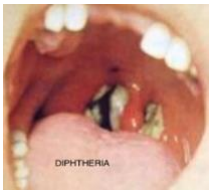
3. **Diphtheria**
   - **grey** in color
   - Membrane is fixed
   - Low fever
   - pt more toxic
   - **Antitoxins** + **Penicillin**

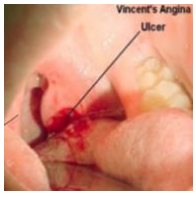
4. **Vincent Angina**
   - Membranous pharyngitis
   - painful ulceration, edema hyperemic patches.
   - Spread of Acute necrotizing ulcerative gingivitis to the pharynx
   - **emergent surgery**

Management :

- Symptomatic & Supportive treatment.
- Antibiotic may be to prevent 2ry bacterial infections.
- Obstruction >> give oral/ systemic steroids.
- Ampicillin should be avoided





→ Complications of tonsillitis : (see pictures below)

A) Peritonsillar abscess (Quinsy)
- . Between the tonsils & lateral wall… unilateral / a bulging above & on the sides of tonsils.
- . sore throat, spiking fever, **trismus** (most specific), inability to talk properly ▶ **I &D + IV abx**

(trismus → Ms spasm in TMJ) (→ complicated: Sepsis, Air way obstruction)

B) Para-pharyngeal abscess:-
- . Laterally -> deeper lobes of the parotid, mandible, sternocleidomastoid
- . Medially -> superior constrictor of the pharynx.
- . Present with Large swelling in the upper part of the neck, pharyngeal wall pushed medially.
- . Do CT —> Admission , Intensive IV abx, **NO Incision or Drainage** -> risk of trauma to IJV.

C) Retro-pharyngeal abscess:-
- . spread of infx to the retro-pharyngeal LN -> **emergency** -> may spread to the *spine & spinal cord.*
- . If Adult -> test for TB -> to role out **Potts disease.**
- . Management ▸ IV antibiotics and surgical drainage… **submandibular approach**

D) Otitis media – most common
E) Rheumatic fever
F) Post-streptococcal glomerulonephritis

→ Management of acute tonsillitis :

- Mild to Moderate ▸ Oral abx 10 dys, Analgesia, Antipyretics! Don't give (Cephalosporin, septrin and ciproxin) as first line.

- Sever , with toxic manifestation ▸ Throat swab, Admission, IV Antibiotics for 24-48 hours >> Oral Antibiotics 7-10 days…. Analgesia and Antipyretics, IV Fluids, Check swab results and do Paul Bunnel test if not improving after 48 hours.

- Tonsillectomy ▸ **Dissection** and **Guillotine**.

Absolute Indications: Malignancy, OSA

Relative Indications:

Acute tonsillitis, Recurrent attacks of tonsillitis or acute otitis media, Part of snoring or OSA surgery, 2nd attack of quinsy, Dysphagia and FTT.

Contraindications:

Bleeding disorder, Acute infx last 2-3 wks, Cleft palate, OCPs, Younger than 3 yrs

Complications:

1ry Bleeding…. *2ry Bleeding* …. Injury to the uvula, soft palate, or posterior pharyngeal wall

(1ry Bleeding: خلال يوم واحد — loose Ligature, Bp↑ → Assess pt & hydrated & B.Transfusion)

(2ry Bleeding: خلال اسبوع due to infx — Admission, IV Abx → May need Surgery)

Dental damage…. *Tonsillar remnants*…. *Infection*… *TM Joint dislocation*.

[ ] Pharyngitis

- **Acute** :

  Simple ▸ by cold air or fumes -> irritation with **odynophagia**.

  Infective ▸ by viral or streptococcal infx -> irritation with **odynophagia**.

  ⇨ Tx : Symptom relief with antibiotics

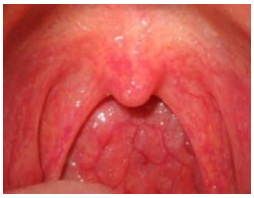
- **Chronic** :

  Endogenous ▸ by post nasal drip , GERD , smoking

  Exogenous ▸ by smoking and chronic dental sepsis.

  -> Both cause **sore throat**, red & congested pharynx.

  ⇨ Tx : Treat the cause



[ ] Adenoiditis:

- Pt present with

  Nasal obstruction ▸ mouth breathing, snoring, sleep apnea, hypo-nasal speech, nasal discharge, difficulty feeding infants.

  Eustachian tube obstruction ▸ decreased hearing, recurrent AOM.

  Adenoid face / Frog face ▸ Open mouth, Protruded frontal teeth.

  ⇨ Tx : Adenoidectomy

  - Indications —> Nasal obstruction, Otitis media with effusion, Recurrent AOM, Chronic Rhinosinusitis, Sleep Apnea.
  - Contraindications —> as Tonsillectomy
  - Complications—> Bleeding, Soft palate damage, dislocation of cervical spine (Grisel Syndrome), Eustachian tube stenosis, hypernasal speech, Recurrence (incomplete removal)