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Case Report

Bilateral Peritonsillar Cellulitis in a 38-Year-Old Female: A Case Report

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Bilateral Peritonsillar Cellulitis
Case Report
Deep Neck Space Infection
Interval Tonsillectomy
Peritonsillar Abscess

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A B S T R A K

Peritonsillar cellulitis represents an inflammatory reaction of the tissue between the palatine tonsil capsule and pharyngeal muscles without pus collection, representing a stage in the progression from acute tonsillitis to peritonsillar abscess. Bilateral involvement is uncommon and presents diagnostic challenges as classic unilateral signs are absent. **Case report:** A 38-year-old female presented with five days of progressive sore throat, fever, dysphagia, and hot potato voice. Physical examination revealed bilateral peritonsillar swelling, hyperemia, and edema with T3-T3 tonsillar hypertrophy and exudate. Aspiration of both peritonsillar areas produced no pus. Laboratory studies demonstrated leukocytosis with neutrophilia. The patient was admitted and treated with intravenous third generation cephalosporin (ceftriaxone), metronidazole, glucocorticoid (methylprednisolone), and supportive care. After three days, swelling subsided, leading to discharge with plans for interval tonsillectomy. **Conclusion:** This case demonstrates that bilateral peritonsillar cellulitis can mimic abscess clinically but requires different management. Negative aspiration distinguishes cellulitis from abscess, guiding conservative treatment and timing of definitive surgical intervention.

INTRODUCTION

Peritonsillar cellulitis is defined as an inflammatory reaction of the loose connective tissue between the fibrous capsule of the palatine tonsil and the superior pharyngeal constrictor muscle, caused by infection but not associated with pus collection. It represents a transitional phase in the progression from acute exudative tonsillitis through cellulitis to peritonsillar abscess (quinsy) formation. Boundaries of the peritonsillar space are fibrous capsule of palatine tonsil medially, Superior pharyngeal constrictor muscle and buccopharyngeal fascia laterally, anterior tonsillar pillar (palatoglossus muscle) anteriorly, posterior tonsillar pillar (palatopharyngeus muscle) posteriorly, soft palate and torus tubarius superiorly, and pyriform sinus and base of tongue inferiorly. The peritonsillar space consists of loose connective tissue that is highly susceptible to abscess formation following infection. (Galioto, 2017; Guidera et al., 2014; Gupta & McDowell, 2023).

The distinction between cellulitis and abscess is clinically significant. Peritonsillar abscess is defined as a collection of purulent material between the tonsillar capsule and pharyngeal muscles, typically at the upper pole. While cellulitis involves erythema and edema without fluctuance, abscess formation is characterized by tissue necrosis and pus accumulation. The most common causative organisms include Group A beta-hemolytic Streptococcus, Staphylococcus species, and respiratory anaerobes such as Bacteroides and Fusobacterium(Galioto, 2017; Gupta & McDowell, 2023).

Clinical presentation typically includes fever, progressively worsening sore throat, dysphagia, odynophagia, and otalgia. The classic "hot potato" voice (muffled speech) results from pharyngeal edema, while trismus develops due to

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inflammation of the pterygoid muscles. Physical examination findings include erythematous, swollen tonsils, edema of the soft palate, and cervical lymphadenopathy. Bilateral involvement is uncommon, as peritonsillar infection is virtually always unilateral. The absence of classic asymmetry and uvular deviation in bilateral cases can complicate diagnosis(Boon et al., 2018; Galioto, 2017; Gupta & McDowell, 2023; Papacharalampous et al., 2011).

Diagnosis is primarily clinical, supported by needle aspiration, which remains the gold standard for differentiating cellulitis from abscess. Imaging studies, including intraoral ultrasonography and contrast-enhanced CT scanning, may be employed when the diagnosis is uncertain, or complications are suspected. Point-of-care ultrasonography demonstrates high sensitivity for identifying abscess collections and guiding aspirations (Esposito et al., 2022; Kim et al., 2023; Mohamad & Yaroko, 2013; Walls et al., 2023).

Treatment of peritonsillar cellulitis involves antimicrobial therapy covering both aerobic and anaerobic pathogens, while abscess requires additional surgical drainage. Empiric antibiotic regimens should include coverage for Group A streptococcus, S. aureus, and respiratory anaerobes. Common regimens include penicillin with metronidazole, amoxicillin-clavulanic acid, or broad-spectrum cephalosporins. Corticosteroids may reduce symptoms and accelerate recovery. The total antibiotic course typically spans 14 days. (Carbone et al., 2012; Galioto, 2017; McClay et al., 2003; Wu et al., 2021)

Interval tonsillectomy is recommended for patients with recurrent peritonsillar infections or those who have experienced peritonsillar abscess. The optimal timing remains debated, with options including quinsy tonsillectomy (performed during the acute phase) and interval tonsillectomy (delayed 6-8 weeks after infection resolution). Delayed interval tonsillectomy allows inflammation to resolve, reducing intraoperative bleeding risk, though fibrosis may increase dissection difficulty. (Agerhäll et al., 2023; Ahmad et al., 2017; Javed et al., 2014; Mujtaba Ghauri et al., n.d.; Naik et al., 2013)

CASE REPORT

Patient Information

A 38-year-old female patient presented to the ENT clinic with a five-day history of progressive throat symptoms. The patient reported severe sore throat, low-grade fever, difficulty swallowing (dysphagia), and changes in voice quality described as muffled and mimicking "hot potato voice." Symptoms began with a mild sore throat that progressively worsened despite over-the-counter medications. The patient has had a history of several previous infections of the palatine tonsils that require antibiotic treatment. No significant comorbidities, immunocompromised states, or recent antibiotic use were reported. Family history was non-contributory. The patient was a housewife with no history of smoking or chronic alcohol consumption. Recent exposure to individuals with a sore throat was identified as one of her children suffers from it.

Clinical Findings

Physical examination revealed a mildly ill-appearing female with stable vital signs except for low-grade fever. Oropharyngeal examination demonstrated bilateral peritonsillar swelling with marked hyperemia and edema of both peritonsillar areas, tonsillar hypertrophy graded at T3-T3 and hyperemia exudates on both tonsils, soft palate edema without classic unilateral bulge or uvular deviation. Trismus was absent, allowing adequate oral examination, no cervical lymphadenopathy was found and oral hygiene was maintained despite dysphagia.

Figure 1. Oropharyngeal Examination at Day of Hospital Visit, Green Crosses Showed the Site For Peritonsillar Aspiration

Aspiration using needle and syringe was done on both sides of peritonsillar area at the most fluctuating area marked with a green cross, however no pus was obtained from either side, confirming the absence of abscess. Bloodwork was done with the results of complete blood count showing leucocytosis with neutrophilia and other metabolic panels such as blood glucose, SGOT, SGPT, blood urea and creatinine at normal level. The diagnosis of peritonsillar cellulitis was established through a combination of clinical evaluation, physical examination, laboratory studies, and diagnostic needle aspiration.

The patient was treated with intravenous therapy of ceftriaxone 1g IV every 12 hours, Metronidazole 500mg IV every 8 hours, Lameson (methylprednisolone) 62.5mg IV every 12 hours, omeprazole 40mg IV every 24 hours, paracetamol 1g every 8 hours, ketorolac 30mg as needed and ondansetron 4mg as needed. Supportive care for the patient includes maintenance of hydration with IV fluids, soft diet progression as tolerated and close monitoring for airway compromise

After 24 hours of intravenous therapy, the patient showed persistent peritonsillar swelling and hot potato voice. Dysphagia remained significant, requiring mainly a liquid diet. No adverse events were noted. This initial slow response is consistent with severe cellulitis requiring more than 24 hours for clinical improvement(Hur et al., 2018; Walls et al., 2023). Marked improvement was observed on the second day. Swelling began to decrease, voice became raspy but clearer, and the patient could tolerate foods with harder textures. This demonstrated an appropriate response to antimicrobial therapy. A significant resolution of peritonsillar swelling occurred on the third day. The patient was afebrile, could swallow comfortably, and showed no signs of complications. Blood work was not repeated as the patient's condition was improving and did not worsen, consistent with clinical judgment in stable patients (Galioto, 2017).

Figure 2. Oropharyngeal Examination at the Second Day of Hospitalisation, Decrease in Peritonsillar Area Was Observed.

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Figure 3. Oropharyngeal Examination at Third Day of Hospitalisation, Bilateral Peritonsillar Area Showed Minimal Oedema and Hyperaemia

The patient was discharged after the third day and given oral antibiotics of cefixime 200mg every 12 hours, metronidazole 500mg every 8 hours, paracetamol 600mg 3 times a day, methylprednisolone 16mg twice a day with tapered down dosage. Interval tonsillectomy was scheduled 6 weeks after discharge from the hospital.

TIMELINE

Table 1. Timeline

Day	Date	Event	Clinical Findings	Interventions
0	Baseline	Symptom onset	Mild sore throat	Over-the-counter analgesics
3	-	Progression	Worsening throat pain, fever	Continued home treatment
5	Admission	Emergency presentation	Severe dysphagia, hot potato voice, bilateral peritonsillar swelling	Admission, laboratory tests, attempted aspiration
5	Admission	Diagnosis confirmed	Leukocytosis with neutrophilia, no pus on aspiration	IV antibiotics initiated
6	Day 1	Treatment day 1	Persistent swelling, hot potato voice, liquid diet only	Continued IV therapy, monitoring
7	Day 2	Treatment day 2	Decreasing swelling, raspy but clearer voice, able to tolerate soft foods	Continued IV therapy
8	Day 3	Treatment day 3	Significant improvement, tonsils T3-T3, peritonsillar swelling subsided	Discharge planning, interval tonsillectomy scheduled
8	Discharge	Discharge	Stable condition	Oral antibiotics prescribed, follow-up arranged

DISCUSSION

In this case report, a 38-year-old female patient came to ENT clinic with history of fever, sore throat, dysphagia, dysphonia and "hot-potato voice". According to the patient, she has experienced several episodes of sore throat in the previous years and during the previous visits her tonsils were constantly hyperthrophied and inflamed. History of chronic diseases, autoimmune, metabolic conditions and immunocomprosied state were denied. Physical examination finding showed low-grade fever, bilateral peritonsillar swelling with hyperemia and edema of both peritonsillar areas, tonsillar hypertrophy at T3-T3 hyperemia and exudates on both tonsils, and soft palate edema. Aspiration from both peritonsillar areas produces no pus or profuse bleeding. Bloodwork showed leukocytosis and neutrophilia. The patient was diagnosed with bilateral peritonsillar cellulitis. Differential diagnosis considered for this case were bilateral peritonsillar abscess, acute exudative tonsillitis, parapharyngeal abscess and supraglottitis. The absence of uvular deviation and symmetrical presentation were notable, as these features typically suggest unilateral peritonsillar abscess (Castagnini et al., 2016; Galioto, 2017; Gupta & McDowell, 2023; Mohamad & Yaroko, 2013).

Bilateral peritonsillar infections are rare, with bilateral abscesses reported in only 1.9% to 4.9% of cases. The symmetrical presentation lacks classic signs of unilateral abscess, potentially delaying diagnosis. In bilateral disease, the risk of airway obstruction is theoretically higher due to larger occupied spaces. Diagnostic needle aspiration is considered the gold standard for differentiation and should be performed when bilateral involvement is suspected(Boon et al., 2018; Mohamad & Yaroko, 2013; Papacharalampous et al., 2011).

The pathophysiology of peritonsillar cellulitis involves infection spreading from tonsillar crypts beyond the capsule, causing inflammatory edema without pus formation. Weber's glands, minor salivary glands in the peritonsillar space, may become obstructed by inflammation, contributing to abscess formation if progression occurs(Galioto, 2017; Gupta & McDowell, 2023).

No imaging studies were performed as the clinical presentation was clear, and aspiration provided definitive diagnostic information. The absence of purulent material distinguished this case from bilateral peritonsillar abscess, which would require incision and drainage (Kim et al., 2023; Mohamad & Yaroko, 2013; Putra et al., 2025) . The bilateral and symmetrical nature of the presentation created diagnostic uncertainty, as classic signs of unilateral peritonsillar abscess (uvular deviation, asymmetric bulge) were absent. The differentiation between cellulitis and early abscess formation was critical, as management differs significantly. The decision to perform bilateral diagnostic aspirations was essential for accurate diagnosis and appropriate treatment selection. (Forner et al., 2020; Kim et al., 2023; Mohamad & Yaroko, 2013; Putra et al., 2025).

The patient was initiated on empiric intravenous antibiotic therapy covering both aerobic and anaerobic pathogens, consistent with guidelines for deep neck space infections: (Esposito et al., 2022) ceftriaxone (broad-spectrum cephalosporin) for Gram-positive and some Gram-negative coverage, metronidazole for anaerobic coverage, particularly for *Bacteroides* species)(AlAwadh et al., 2017), methylprednisolone as anti-inflammatory to reduce edema and symptoms)(Hur et al., 2018), omeprazole for gastroprotection during steroid therapy, paracetamol as antipyretic and analgesic, additional therapy of ketorolac for breakthrough pain and ondansetron as antiemetic. This regimen provides coverage for Group A streptococcus, *S. aureus*, and respiratory anaerobes, which are the most common pathogens in peritonsillar infections. The combination of ceftriaxone and metronidazole is particularly effective for polymicrobial infections, and previous studies reveal that peritonsillar cellulitis and abscess are rarely caused by single organism and more ofthen caused by several species of bacteria consisting of Gram positive and Gram negative bacterias such as beta-hemolytic *Streptococcus*, *Staphylococcus* species, and respiratory anaerobes such as *Bacteroides* and *Fusobacterium*. Hence, (Carbone et al., 2012; Galioto, 2017; Herzon et al., 2018; McClay et al., 2003; Wu et al., 2021).

While penicillin remains effective for peritonsillar infections, broad-spectrum regimens are often employed initially. The combination of ceftriaxone and metronidazole provides appropriate coverage for polymicrobial infections, including anaerobes. Corticosteroids reduce inflammation and may speed recovery, though evidence is mixed. (Carbone et al., 2012; Chau et al., 2014; Herzon et al., 2018; Hur et al., 2018; Kent et al., 2019; Wu et al., 2021).

Common choices for intravenous systemin corticosteroids include dexamethasone and methylpresinolone. Previous study has shown that usage of dexamethasone can help with reducing pain in patients with peritonsillar abscess. This patient has been given NSAID in the form of paracetamol and ketorolac, which should have helped with the pain. However, the

patient also complained dysphagia and dysphonia, which may suggest difficulty in coordinating the muscles of swallowing and voice production. Studies had shown that usage of steroid in the form of methylprednisolone in patients with peritonsillar abscess helped in reducing trismus. The muscle tension relieving effect of methylprednisolone became the basis of why it was chosen for this patient. (Chau et al., 2014; Lee et al., 2016).

The patient was discharged on oral antibiotics to complete a 14-day total course. Arrangements were made for interval tonsillectomy after 6 weeks to prevent recurrence (Ahmad et al., 2017; Naik et al., 2013; Wu et al., 2021). The decision to perform interval tonsillectomy rather than immediate (quinsy) tonsillectomy was based on several factors. First, the diagnosis was cellulitis without abscess formation, making immediate surgery unnecessary. Second, performing tonsillectomy in the setting of acute inflammation carries higher risks of intraoperative and postoperative hemorrhage due to hyperemic tissues and altered tissue planes. Third, interval tonsillectomy allows resolution of inflammation, reducing bleeding risk, though fibrosis may increase dissection difficulty(Ahmad et al., 2017; Javed et al., 2014; Naik et al., 2013; Simon et al., 2013).

The 6-week interval is supported by literature indicating that this timeframe allows adequate resolution of acute inflammation while minimizing dense fibrosis that complicates delayed procedures. Studies comparing quinsy versus interval tonsillectomy show no significant difference in operative time or complications, but interval procedures may have lower postoperative hemorrhage rates (Ahmad et al., 2017; Albertz & Nazar, 2012; Javed et al., 2014; Mujtaba Ghauri et al., n.d.; Naik et al., 2013; Simon et al., 2013).

Strengths and Limitations of Management

The primary strength of this case management was the definitive diagnostic approach through bilateral needle aspiration, which immediately distinguished cellulitis from abscess and guided appropriate conservative therapy. The empiric antibiotic regimen provided adequate coverage for polymicrobial infection based on current guidelines. Close monitoring allowed for timely detection of treatment response or potential deterioration (Mohamad & Yaroko, 2013).

Limitations include the absence of imaging studies (CT or ultrasound) to confirm the extent of infection and rule out deep neck space involvement. However, this was mitigated by the clear diagnostic aspiration and stable clinical course. Additionally, bacterial cultures could not be obtained due to the absence of pus, preventing pathogen identification and antibiotic susceptibility testing (Collins et al., 2014; Galioto, 2017; Kim et al., 2023; Mallorie et al., 2012).

CONCLUSION

This case demonstrates that bilateral peritonsillar cellulitis can mimic abscess clinically but requires different management. Negative aspiration distinguishes cellulitis from abscess, guiding conservative treatment and timing of definitive surgical intervention.

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