Pediatric Malignancies Presenting as Peritonsillar Abscesses

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ABSTRACT

INTRODUCTION

The initial presentation and management of the peritonsillar abscess (PTA) is typically based on some classic signs and symptoms. The hallmark of a PTA is the presence of pain, fever, dysphagia, trismus, drooling, and no fluctuance on physical exam. Aspiration of pus as well as right lymphadenopathy were noted on physical exam. The abscess was drained with the patient under local anesthesia (Figures 1-2). The patient was discharged the next day with right peritonsillar soft tissue swelling consistent with possible phlegmon. The WBC count was normal. The abscess drained well after 24 hours. The final pathology report revealed a Burkitt’s lymphoma.

METHODS

A review of the literature demonstrated a high rate of malignancy in pediatric patients diagnosed with a peritonsillar abscess (PTA). We discuss these cases in detail and performed a literature review of similar cases in order to ensure that those caring for pediatric patients can avoid in differentiating potential malignancy from a PTA.

RESULTS

Of the five patients, three were male and two were female. The mean age of the patients was 4 years. 1/5 had a sore throat, 1/5 had odynophagia, 1/5 had decreased oral intake, 0/5 had trismus and 0/5 had fever that prompted their initial evaluation. 0/3 had an elevated WBC count, and 0/5 had CT findings suggesting abscess. All five patients had soft palate swelling or peritonsillar swelling with tonsillar erythema and right neck lymphadenopathy. A CT scan showed 3x2cm right parapharyngeal soft tissue swelling consistent with possible phlegmon (Figure 2). The WBC count was normal. The abscess drained well after 24 hours. The final pathology report revealed a Burkitt’s lymphoma. He is currently undergoing chemotherapy.

DISCUSSION

We retrospectively reviewed the medical charts and diagnostic imaging of those presenting with a PTA at Nationwide Children’s Hospital from 2007 to 2016. We initially diagnosed with a PTA and had a clinicopathologic diagnosis of malignancy. The mean age was 4 years. 100% had a sore throat, 98% had odynophagia, 87-100% had trismus, 83-100% had decreased oral intake and 66-100% had fever that prompted their initial evaluation. 1/3 had an elevated WBC count, and 1/5 had CT findings suggesting abscess. All five patients had soft palate swelling or peritonsillar swelling with tonsillar erythema and right neck lymphadenopathy. A CT scan showed 3x2cm right parapharyngeal soft tissue swelling consistent with possible phlegmon (Figure 2). The WBC count was normal. The abscess drained well after 24 hours. The final pathology report revealed a Burkitt’s lymphoma. He is currently undergoing chemotherapy.

CONCLUSIONS

The rate of malignancy in children presenting with a PTA continues to increase, and this is likely due in part to the increasing recognition of atypical clinical presentation. Overcoming the diagnostic challenge of atypical PTA presentation requires a high level of suspicion for malignancy in atypical cases. Imaging of those presenting with an atypical clinical picture for a PTA should be considered.

REFERENCES


Figure 1. Right parapharyngeal soft tissue swelling, later shown to be Burkitt’s lymphoma.

Figure 2. Right parapharyngeal soft tissue swelling, later shown to be Burkitt’s lymphoma.

Figure 3. Right parapharyngeal soft tissue swelling, later shown to be Burkitt’s lymphoma.

Figure 1. Soft tissue mass in the right peritonsillar area, later shown to be Burkitt’s lymphoma.