Quinsy tonsillectomy or interval tonsillectomy — a prospective randomised trial

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Fifty-one patients with peritonsillar abscesses were randomised to undergo either quinsy tonsillectomy (QT) or interval tonsillectomy (IT), and the two groups were compared. The QT group lost fewer (10,3 v. 17,9) working days and less blood during the operation (158,6 ml v. 205,7 ml); haemostasis was easier and the operation was technically simpler in this group. There was no significant difference in length of hospital stay and neither group had intra- or postoperative complications. Only 64% of the IT group returned for tonsillectomy. In this study QT had distinct advantages over drainage and IT in the management of peritonsillar abscesses.

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Guy de Chauliac, a 14th-century French surgeon, first described incision and drainage of peritonsillar abscesses (PTA) and Chassaignac first reported 'tonsillectomy *à chaud*' (quinsy tonsillectomy) in 1859.[1] Controversy persists about the best management of PTA. Opinions include antibiotics only,[2] aspiration and incision and drainage,[3-7] unilateral[8,9] or bilateral quinsy tonsillectomy (QT) and interval tonsillectomy (IT).

Two retrospective non-randomised studies have compared QT and IT. In a study of 68 cases McCurdy[1] concluded that QT is a safe, reliable and expeditious form of treatment for PTA, that it is technically easier than IT, and that it is a one-stage procedure and reduces hospitalisation by almost 50%. From a study of 45 cases Lockhart *et al.*[10] concluded that QT reduced hospitalisation and work-hours lost.

We report on a prospective, randomised trial comparing IT and QT with regard to: (*i*) period of hospitalisation; (*ii*) loss of employment; (*iii*) intra-operative blood loss; (*iv*) intra-operative and postoperative surgical and anaesthetic complications; and (*v*) technical difficulty of the procedure.

Patients and methods

All patients between 16 and 40 years of age presenting to Groote Schuur Hospital between August 1990 and September 1991 with PTAs proven by needle aspiration and a history of past tonsillitis or PTA abscess and who consented to tonsillectomy were included in the study. They were randomised into the QT or the IT group using computer-generated simple randomisation.

Those randomised to QT had the abscess aspirated to dryness and were started on intravenous penicillin. Bilateral tonsillectomy was done within 24 hours of admission unless the patient was admitted over the weekend, in which case the operation was done on the Monday. Once apyrexial and eating, patients were discharged on a course of oral penicillin.

Those randomised to IT had the abscess aspirated to dryness and were started on a course of penicillin. A booking for tonsillectomy 6 - 8 weeks later was made. Patients who were unable to swallow or very ill were admitted for supportive therapy and intravenous penicillin.

At surgery blood loss was accurately recorded by weighing the swabs and measuring the suction bottle contents. The surgeon noted the side that bled the most, the ease of haemostasis and the surgical difficulty compared with a routine tonsillectomy. Any intra- and postoperative complications were recorded.

Fifty-one patients were included in the study, 29 of whom were randomised to QT. Of the 22 randomised to IT, only 14 returned for surgery.

Results

The results are set out in Tables I, II and III. Five patients in the IT group required two admissions. There were no intra-operative anaesthetic or surgical complications and no postoperative haemorrhages.

Table I. Economic implications of QT v. IT

	QT	IT	*P*-value
Days in hospital	2,6 ± 0,9	3,0 ± 1,5	> 0,05
Work days lost	10,3 ± 0,8	17,9 ± 2,4	< 0,001

Table II. Bleeding and haemostasis in the QT and IT groups

	QT	IT	*P*-value
Mean blood loss (ml)	158,6 ± 67,7	205,7 ± 139,6	
Difficult haemostasis	31%	64%	< 0,05
Bleeding mainly PTA side	58%	57%	> 0,05

Table III. Technical difficulty of the operation

	Easy	Normal	Difficult
QT, abscess side	32%	32%	36%
IT, abscess side	0%	14%	86%
QT, non-abscess side	0%	68%	32%

Discussion

QT is the standard method of treatment of PTA in many centres,[3,8,9,11,12] but this policy can be criticised in that some patients may never develop subsequent tonsillar disease. Age has been suggested as a predictor of subsequent PTA or tonsillitis. Herbild and Bonding[3] reported that 48% of

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patients with PTAs managed by drainage and aged under 40 years and 17% of those aged over 40 years had recurrent PTA or tonsillitis.[3] In children a past history of tonsillitis has not been shown to have predictive value for post-PTA tonsillar disease.[13]

Reported advantages of QT include a reduction in the period of hospitalisation, a single procedure, technical simplicity of the operation on the affected side, complete drainage of the pus, prompt resolution of pain, trismus and pyrexia, and prevention of recurrent tonsillar disease.[3,9,11,12]

The economic advantage of QT is evident from the significant reduction in work-days lost. However, there was no difference in the duration of hospitalisation (Table I).

Operative blood loss during QT has been reported both as more and as less than with IT.[1,10,14] In this study the QT group lost less blood during the operation, haemostasis was easier and the procedure was technically simpler than IT. In both groups bleeding occurred predominantly on the side of the PTA (Tables II and III).

Kristensen and Tveteras,[15] in a retrospective study of 1 150 patients, reported postoperative haemorrhage after 3% of routine tonsillectomies; there were no haemorrhages after QT, but haemorrhage occurred after 19% of ITs. Bonding[12] found no significant difference in the rates of postoperative haemorrhage between QT and routine tonsillectomy. No patient in either of our groups had a postoperative haemorrhage.

Increased anaesthetic risk due to abscess rupture or difficult intubation is said to be a disadvantage of QT. Aspirating the PTA to dryness and administering intravenous antibiotics overnight reduced trismus and tonsillar swelling pre-operatively and negated the risk of rupturing a large abscess. There were no anaesthetic complications.

Perhaps the most striking difference between the QT and IT groups was the immediate pain relief experienced by patients after QT, compared with the IT group, who had gradual pain relief over a few days after PTA drainage.

The poor rate of return of patients for IT (64%) meant that booked theatre time was wasted and is a further reason to favour QT.

Conclusion

We suggest that QT for treatment of PTA has distinct advantages over drainage followed by IT.

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Personality traits, brief recurrent depression and attempted suicide

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This study investigated the relationship between attempted suicide, personality factors and brief recurrent depression.

Over a period of 1 year, the demographic and psychiatric factors of 307 patients who had attempted suicide and subsequently been hospitalised at H. F. Verwoerd Hospital and referred to its Department of Psychiatry were recorded. Their personality traits were evaluated clinically. After 5 years, 205 respondents were traced to complete a follow-up questionnaire and, where possible, a personality assessment was completed on clinical grounds. They were also evaluated for brief recurrent depression.

Among the men, antisocial, dependent and histrionic personality traits, in that order, were most commonly noted and among the women, histrionic, dependent and antisocial traits.

A clear relationship between suicidal behaviour and the syndrome of brief recurrent depression was established. The latter was also found to be related to histrionic personality traits in women. This underscores the relationship between suicide attempts and histrionic personality traits.

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