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Case Report
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Uvular Edema as a Red Herring: An Atypical Presentation of Peritonsillar Abscess without Classic Tonsillar Bulge or Trismus

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Abstract

Peritonsillar Abscess (PTA) classically presents with severe unilateral odynophagia, trismus, muffled voice, and medial tonsillar displacement with contralateral uvular deviation. We report a 56-year-old male smoker with hypertension who presented with four days of progressive throat pain and dysphagia dominated by marked cystic enlargement of the uvula and bilateral tonsillar enlargement, without significant anterior-pillar bulge, trismus, fever, or airway compromise. Initial conservative therapy with corticosteroids and antibiotics produced partial resolution of uvular edema but persistent dysphagia. Contrast-enhanced CT of the neck revealed a 15 mm right peritonsillar collection with mild peripheral rim enhancement and moderate upper-airway narrowing. Needle aspiration yielded 2 mL of pus; culture grew Streptococcus species sensitive to ceftriaxone and clindamycin. Addition of clindamycin led to rapid clinical and laboratory improvement. This case highlights that PTA can masquerade as isolated uvular edema (Quincke's disease) and underscores the value of early cross-sectional imaging when classic local signs are incomplete or absent.

Keywords: Peritonsillar abscess; Uvular edema; Quincke's disease; Atypical presentation; Needle aspiration; Case report

Introduction

Peritonsillar abscess is the most common deep-neck-space infection in adults and usually follows acute tonsillitis. Classic clinical features include progressive unilateral odynophagia, trismus, "hot-potato" voice, fever, and an asymmetrically bulging soft palate with contralateral uvular deviation. Marked uvular edema (hydrops) may accompany PTA but is rarely the dominant finding; when prominent, it more commonly suggests allergic angioedema or Quincke's disease.

Concurrent PTA and marked uvular hydrops have been described in only a handful of adult and pediatric case reports. In most of those cases, obvious peritonsillar swelling or trismus was clinically evident. We present an unusual adult case in which severe cystic uvular enlargement dominated the clinical picture, the anterior tonsillar pillar showed minimal bulge, and trismus and fever were absent leading to an initial working diagnosis of isolated uvular edema. Failure of conservative therapy prompted CT imaging that unmasked a small but clinically significant PTA.

Case Presentation

A 56-year-old Saudi male with a history of hypertension and long-term smoking presented to the emergency department with a four-day history of progressive throat pain and dysphagia. He was unable to tolerate oral intake. There was no history of trauma, recent surgery (apart from remote left tympanoplasty complicated by transient facial weakness), fever, hoarseness, stridor, or dyspnea. Oxygen saturation remained normal on room air.

On examination the patient was afebrile and hemodynamically stable. Oropharyngeal inspection revealed marked enlargement of a cystic-appearing uvula, bilateral tonsillar enlargement without overt erythema or exudate, and only minimal right anterior-pillar fullness. There was no trismus, no palpable cervical lymphadenopathy, and no respiratory distress. White-cell count was 17000/μL. Chest and neck radiographs were unremarkable.

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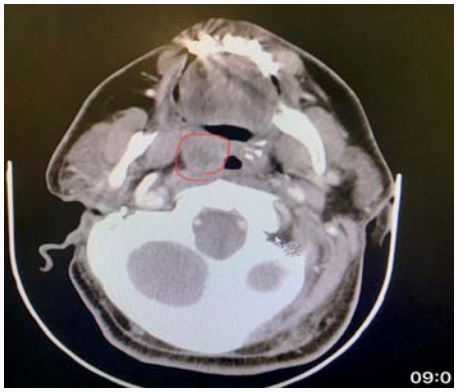

Figure 1: Axial contrast-enhanced CT image of the neck showing an irregular, lobulated, low-attenuation collection (≈15 mm) in the right peritonsillar region (red circle) with mild peripheral rim enhancement and moderate upper-airway narrowing.

Figure 2: Adjacent axial contrast-enhanced CT slice confirming the right peritonsillar low-attenuation collection (red circle) with surrounding soft-tissue edema. Bilateral tonsilloliths are also noted.

The patient was admitted for observation and treated with intravenous hydrocortisone, empiric antibiotics, paracetamol, and a proton-pump inhibitor. Within 24 hours the uvular edema largely subsided; however, dysphagia persisted, and minimal right tonsillar bulging remained.

Contrast-enhanced CT of the neck demonstrated an irregular, lobulated, low-attenuation collection in the right peritonsillar region measuring approximately 15 mm in maximum axial dimension, with mild peripheral rim enhancement and inferior extension toward the supraglottic region (Figure 1 and 2). Moderate narrowing of the upper airway was present. An enlarged right deep cervical lymph node (10 mm short axis) and bilateral sub-centimeter reactive nodes were noted, along with bilateral tonsilloliths.

Under local anesthesia, needle aspiration of the right peritonsillar region yielded 2 mL of purulent material. Intravenous ceftriaxone was continued, and clindamycin was added. Culture grew Streptococcus species sensitive to both agents. The patient improved rapidly: oral intake resumed, white-cell count fell to 8000/μL, and he was discharged on oral antibiotics with complete resolution of symptoms.

Discussion

This case is notable for the relative absence of classic localizing signs of PTA. The dominant feature was cystic uvular enlargement that initially suggested Quincke's disease or infectious uvulitis. Only after partial resolution of the uvular edema did subtle right-sided tonsillar asymmetry become apparent, prompting imaging.

Previous reports of concurrent PTA and uvular hydrops are rare [1-3]. In most of these, peritonsillar swelling or trismus was clinically evident. Our patient lacked trismus, fever, and frank anterior-pillar bulge, illustrating that even a relatively small (15 mm) collection can produce significant symptoms and moderate airway narrowing.

The pathophysiology of the prominent uvular edema is best understood as a secondary inflammatory (reactive) hydrops. The uvula consists of highly vascularized loose areolar tissue that readily accumulates fluid. Local release of inflammatory mediators from the adjacent PTA increases vascular permeability, while lymphatic congestion in the soft palate impairs fluid clearance. Mechanical mass effect further contributes. Imaging showed no direct invasion of the abscess into the uvula, supporting a reactive mechanism.

The microbiological finding is consistent with the polymicrobial nature of PTA [4]. Needle aspiration under local anesthesia remains a safe and effective first-line drainage method.

This case reinforces that persistent dysphagia after resolution of isolated uvular edema should prompt imaging, and that absence of trismus or dramatic tonsillar displacement does not exclude PTA.

Conclusion

Peritonsillar abscess may present predominantly as severe uvular edema with only subtle ipsilateral tonsillar findings, mimicking Quincke's disease. Early recognition, judicious use of contrast-enhanced CT, and prompt needle aspiration with culture-directed antibiotics can achieve rapid resolution and prevent airway complications.

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