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Clinical Image: Sore Throat that cannot be ignored

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Clinical Summary

A 23-year man presented to the emergency department three times for one-week history of sore throat with a low-grade fever. On the first attendance, he was discharged with a presumptive diagnosis of acute pharyngitis. Despite several days of antibiotics, the pain did not show any improvement. X-ray of the neck was taken on his third attendance (Figure 1). Subsequent Computerized Tomography (CT) neck showed retropharyngeal abscess (Figure 2). After one week of intravenous ceftriaxone and metronidazole, a repeated CT scan showed a recession of the abscess (Figure 3). He was discharged with one week of oral antibiotic amoxicillin/clavulanate without surgical intervention.

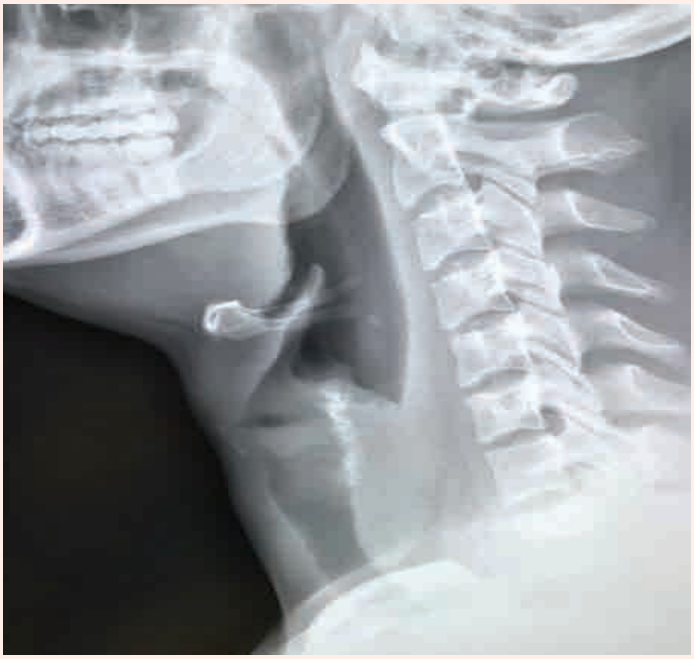

Figure 1: X ray neck (lateral view) shows soft tissue thickening up to 35 mm at C7 level.

Retropharyngeal space is bounded by the skull base superiorly; constrictor muscles of the neck and its investing fascia anteriorly; the alar layer of the prevertebral fascia posteriorly; carotid sheath laterally and fascia at the level of C7 inferiorly. The space will regress after the age of six, and it's rare for an adult to have a non-traumatic retropharyngeal abscess. Clinical symptoms are non-specific, including fever, sore throat, dysphagia, odynophagia similar to acute pharyngitis. Possible radiological features for RPA include the width of soft tissue greater than 50% of the width of the cervical vertebra at that level, straightening of cervical lordosis, non-traumatic subluxation of cervical vertebrae, gas or gas or gas fluid level in lateral neck X-ray. The sensitivity and specificity of lateral film X-ray were 80% and 100%, respectively, whereas the sensitivity and specificity of computerized tomography of the neck were 100% and 45%, respectively. Another study in Toronto revealed the sensitivity and specificity of CT were 81% and 57%, respectively. Early recognition is the key. Complications, such as airway obstruction, mediastinitis, necrotizing fasciitis, carotid artery erosion, and sepsis can be fatal. Management is a broad-spectrum intravenous antibiotic with or without surgical intervention.

A 23-year man presented to the emergency department three times for one-week history of sore throat with a low-grade fever. On the first attendance, he was discharged with a presumptive diagnosis of acute pharyngitis. Despite several days of antibiotics, the pain did not show any improvement. X-ray of the neck was taken on his third attendance (Figure 1). Subsequent Computerized Tomography (CT) neck showed retropharyngeal abscess (Figure 2). After one week of intravenous ceftriaxone and metronidazole, a repeated CT scan showed a recession of the abscess (Figure 3). He was discharged with one week of oral antibiotic amoxicillin/clavulanate without surgical intervention. Retropharyngeal space is bounded by the skull base superiorly; constrictor muscles of the neck and its investing fascia anteriorly; the alar layer of the prevertebral fascia posteriorly; carotid sheath laterally and fascia at the level of C7 inferiorly. The space will regress after the age of six, and it is rare for an adult to have a non-traumatic retropharyngeal abscess. Early recognition is the key. Complications, such as airway obstruction, mediastinitis, necrotizing fasciitis, carotid artery erosion, and sepsis can be fatal. Management is a broad-spectrum intravenous antibiotic with or without surgical intervention.

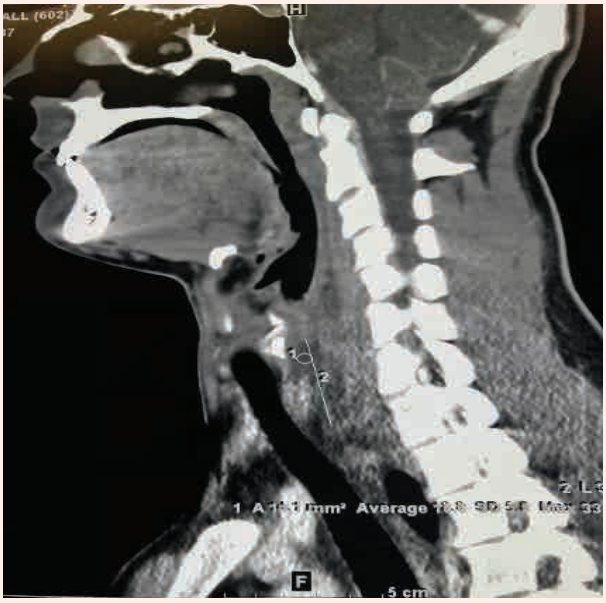

Figure 2: Computerized Tomography (CT) neck was performed showing 3.2 x 1.9 cm x 7 cm Retro Pharyngeal Abscess (RPA) in craniocaudal length from C5 to T2, together with mediastinitis throughout the superior mediastinal fat. The glottis and trachea are displaced without compression.

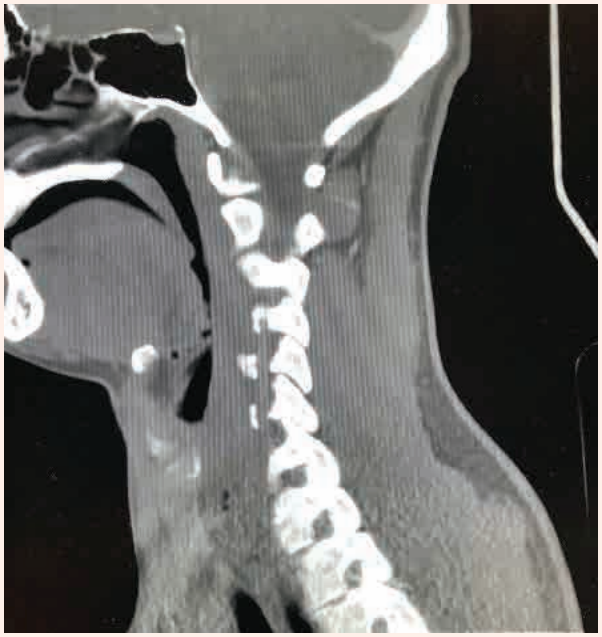

Figure 3: Recession of retropharyngeal abscess after intravenous antibiotics.