



433 Teams
ENT

Pharynx I, II

Color index:

432 Team – **Important** – 433 Notes – Not important

ent433team@gmail.com



جامعة
الملك سعود
King Saud University



❖ Anatomy of the pharynx:

- ✓ It extends from the base of the skull to the level 6 cervical vertebra at the lower border of cricoid cartilage.
- ✓ Funnel shaped, 10 cm length.
- ✓ Widest portion (5cm) at hyoid.
- ✓ Narrowest portion(1.5cm) at caudal end.

➤ Parts of the pharynx:

1. Nasopharynx

Opens **anteriorly** to the nose

Above: the base of skull

Below: soft palate

Laterally:

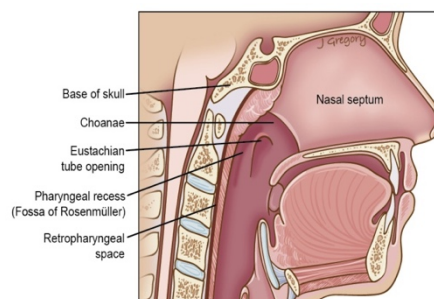
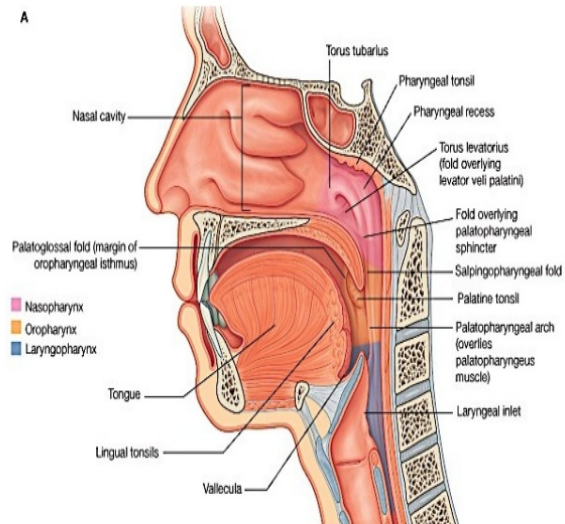
1-Opening of the Eustachian tube

2-Torus tubarius (the elevated edge of the Eustachian tube opening).

3-Pharyngeal recess (fossa of rosenmuller) (Is a depression in the pharyngeal wall behind the torus tubarius) (very important to examine nasopharynx in smoker adult complaining of nasal obstruction because nasopharyngeal cancer commonly occurs in this fossa).

4-Adenoid

5-Nasopharyngeal isthmus (opening in the floor between the soft palate and the posterior pharyngeal wall).



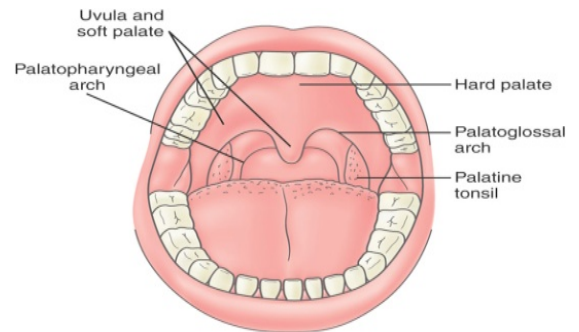
2. Oropharynx

Opens **anteriorly** to the mouth and **devided** from the oral cavity by **Tonsillar pillar**.

Above: soft palate.

Below: the upper border of epiglottis.

Palatine tonsils: between the anterior and posterior pillars.



Valleculae: Is a depression on each side of the median glossoepiglottic. It is the area between the epiglottis and base of the tongue

3. Laryngopharynx (Hypopharynx)

Opens **anteriorly** to the larynx

Above: the upper border of the epiglottis

Below: lower border of cricoid

Pyramidal fossa: (Is a depression in the mucous membrane on each side of the laryngeal inlet).

When the patient presents with halitosis, check the oral hygiene and make sure that the patient is cleaning the tongue, and exclude other causes like reflux and diverticula.

❖ Structures of pharynx

- ❖ **Pharyngeal Wall:**
 - ✓ Mucous membrane
 - ✓ Submucosa
 - ✓ Muscular layer
 - ✓ Fibrous layer (Buccopharyngeal fascia)

○ **Mucous membrane:**

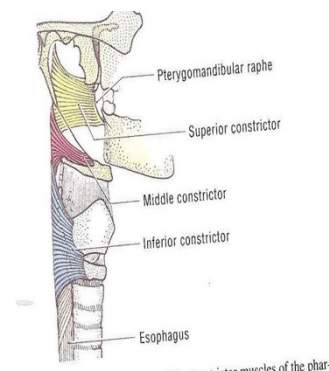
- ✓ Nasopharynx – Ciliated columnar epithelium
- ✓ Oro and hypopharynx –Stratified squamous epithelium
- ✓ Subepithelial lymphoid tissue of the pharynx(waldeyer's ring)

○ Submucosa:

- ✓ Nerves, blood vessels, and lymphatics.
- ✓ Mucous and salivary glands.
- ✓ Subepithelial lymphoid tissue (Waldeyer's Ring).

○ Characteristics of Waldeyer's Ring:

- ✓ No afferents
- ✓ Efferent to deep cervical nodes
- ✓ No capsule except the palatine tonsils



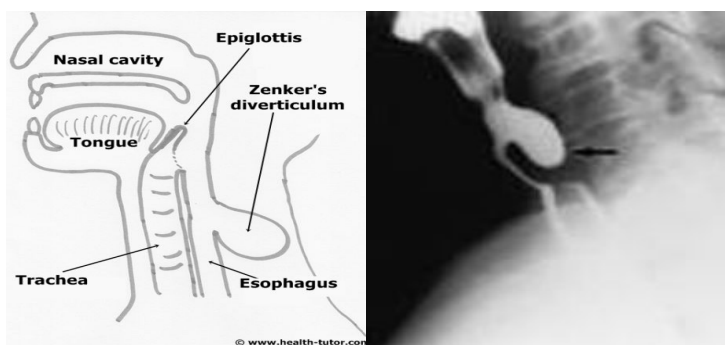
○ Muscular coat:

- **External:** Three constrictor muscles:

1. **Superior constrictor:** Arises from pterygoid, pterygomandibular ligament post end of mylohyoid fibers
2. **Middle constrictor:** Arises from the hyoid bone and stylohyoid ligament.
3. **Inferior constrictor:** Thyropharyngeus, Cricopharyngeus.

➤ Killian's dehiscence:

Potential gap between the thyropharyngeus and cricopharyngeus (Zenker's diverticulum occurs in this weak area and diagnosed by barium swallow)



- **Internal:** Three muscles:

1. Stylopharyngus
2. Salpingopharyngus
3. palatopharyngus

❖ Pharyngeal aponeurosis:

Incomplete connective tissue coat in the lateral and posterior walls of the pharynx between the muscular layers.

❖ Buccopharyngeal fascia (Pharyngobasilar fascia)

Thin layer covers the muscular layer of pharyngeal wall.

❖ Nerve Supply

○ **Sensory:** Each of the three sections of the pharynx have a different innervation:

- The **nasopharynx** is innervated by the maxillary branch of the trigeminal nerve (CN V).
- The **oropharynx** by the glossopharyngeal nerve (CN IX).
- The **laryngopharynx** by the vagus nerve (CN X).

○ **Motor:** All the muscles of the pharynx are innervated by the vagus nerve (CN X), except for the stylopharyngeus, which is innervated by the glossopharyngeal nerve (CN IX).

- Also the Sympathetic fibers of the superior cervical ganglia play a role in the innervation.

❖ Blood supply

Arterial from the external carotid artery:

- Ascending pharyngeal
- The lingual artery
- The facial artery
- The maxillary artery

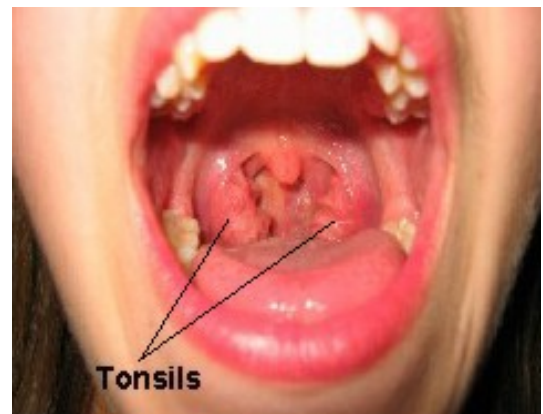
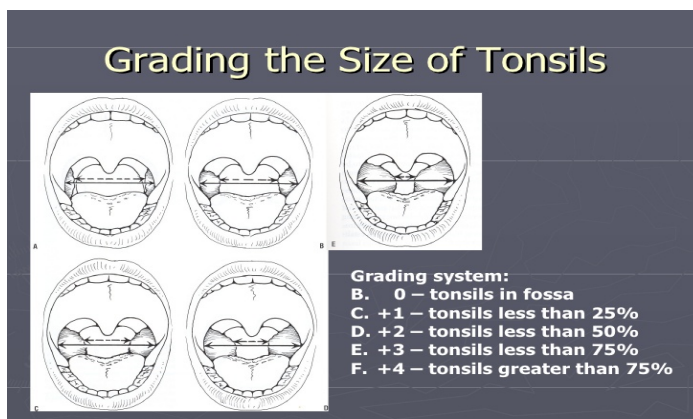
Venous drainage to the internal jugular

Lymphatics

- Retropharyngeal nodes.
- Deep cervical (jugular) nodes.

❖ Palatine tonsils:

- 12---15 crypts.
- The deep surface is separated from the constrictor muscles of the pharynx by connective tissue (capsule).
- When tonsillectomy is performed you have to make the incision in the connective tissue, if the surgeon goes more medially he will enter the tonsils, if more lateral he will enter the muscles.

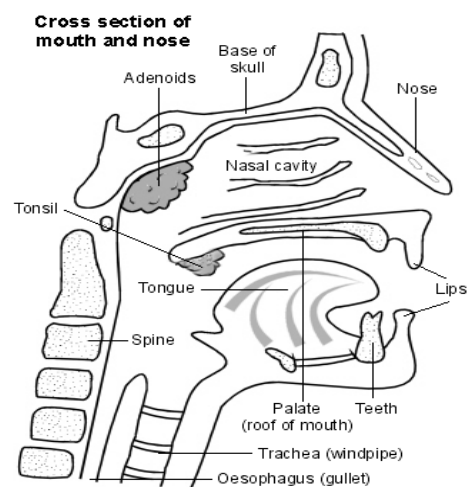


❖ Adenoid:

- Is common in children and it is diminished in size with growing, only big adenoid is removed, the mother is noticing her baby choking while he is sleeping and moving and nocturnal enuresis)
- ✓ No capsule.
- ✓ Lingual tonsils.
- ✓ Tubal tonsils.
- ✓ Lateral pharyngeal bands.
- ✓ discrete nodules.

➤ Relations of pharynx:

- **Posteriorly:** prevertebral fascia
- **Anteriorly:** Parapharyngeal space



○ **Parapharyngeal Space:**

- ✓ Potential space lies outside the pharynx.
- ✓ Triangular in cross section, it extends from the base of the skull above to the superior mediastinum and apex of hyoid bone.

- **Anteromedial wall:** Buccopharyngeal fascia
- **Posteromedial wall:** **Cervical vertebrae**, prevertebral muscle and fascia
- **Lateral wall:**
 - **(Up)** the mandible, pterygoid muscle, parotid gland
 - **(Lower)** Sternomastoid muscle

➤ **Compartment:**

- **Prestyloid:** (internal maxillary artery, fat, inferior alveolar, lingual, and auriculotemporal nerves.)

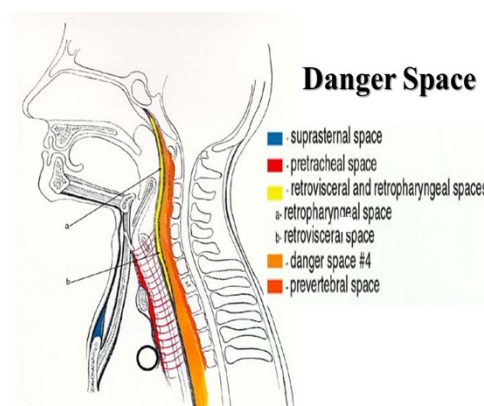
- **Poststyloid:** Neurovascular bundle (carotid artery, IJV, sympathetic chain, CN IX, X and XI)

(if the patient has tonsillitis and on examination there is bulge in lateral pharyngeal wall, on CT there is postsyloid abscess so I have to do incision and drainage since this is a dangerous area, they could have carotid rupture)

○ **Retropharyngeal Space:**

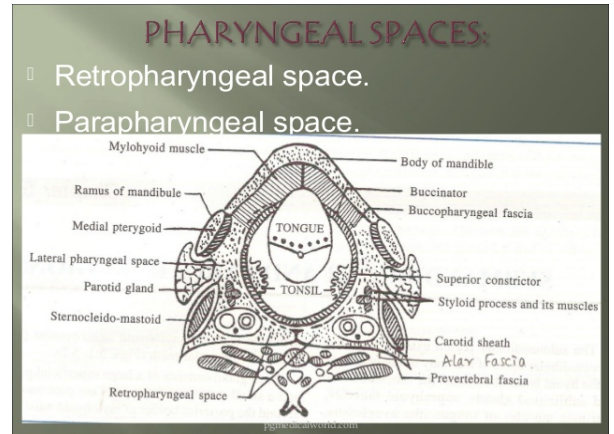
- It extend from the base of skull to superior mediastinum.
- **Lies behind the pharynx**
 - ✓ **Anterior:** posterior pharyngeal wall and its covering buccopharyngeal fascia.
 - ✓ **Posterior:** cervical vertebrae and muscles and fascia
 - ✓ **Contents:** Retropharyngeal lymph nodes

(If a child has tonsillitis and on examination you found a bulge in the posterior wall (in front of you) you do CT scan it is abscess, but if he is adult but without any acute infection, you think about TB).



Posterior to the retropharyngeal space, there is Danger Area, any infection in this area lead to mediastinitis.

Also there is Prevertebral Space and any infection in this space will be transmitted all the way down to the coccyx.



❖ Physiology of the pharynx:

1- Functions of the sub epithelial lymphoid tissue: (protective functions)

- Formation of lymphocytes
- Formation of antibodies
- Acquisition of immunity
- Localization of infection

2-Salivation

3- Deglutition: (Three stages)

- **Oral stage:**
Voluntary, closure of mouth, cessation of respiration, raising of larynx, sudden elevation of the tongue, press the tongue against the palate, and pushes it backwards towards the oropharynx
- **pharyngeal stage**
Reflux, contraction of nasopharynx sphincter, larynx rises more, laryngeal inlet closure, epiglottis diverts the food into cricopharyngeal sphincter, contraction of constrictor muscles, relaxed cricopharyngeal sphincter
- **Esophageal stage**
- **Respiration**
- **Speech**
- **Resonating cavity**
- **Articulation**
- **Taste: taste buds**

Summary

- The pharynx is situated behind the nasal cavities, the mouth and the larynx.
- It is divided into nasal, oral and laryngeal parts
- It extends from base of the skull into the 6 cervical vertebra

- It is fibromuscular structure which is covered by mucus membrane and 4 layers and lymphatic tissue called (Waldeyer's ring)
- It has 3 external muscles and 3 internal muscles

- Killian's dehiscence is the weakest area where Zenker's diverticulum occur
- Para and retropharyngeal spaces are important for their relations to the pharynx and infection and abscess formation

- Function of the lymphatic tissue in the pharynx for protection by formation lymphocytes and antibodies

- Function of pharynx is salivation, Deglutition, respiration, speech, resonating cavity, articulation and taste.

MCQs

Q1. Structures passing between upper border of superior constrictor muscle and base of skull include all except?

- A. Levator palatini
- B. Tensor tympani
- C. Eustachian tube
- D. Ascending palatine artery

Q2. All of the following statements about Zenker's diverticulum are correct except?

- A. Arises from posterior part of hypopharynx
- B. Is a traction diverticulum
- C. Causes regurgitation of undigested food
- D. Treated by diverticulectomy and cricopharyngeal myotomy

Q3. Characteristic features of submucous cleft palate include all except?

- A. Bifid uvula
- B. Notch of posterior border of hard palate
- C. Deficient palatal muscles
- D. Common association with cleft lip

Q4. All of the following cause a grey-white membrane on the tonsils except?

- A. Infectious mononucleosis
- B. Ludwig's angina
- C. Streptococcal tonsillitis
- D. Diphtheria

An-
swers:

- 1- B
- 2- C
- 3- D

❖ ADENOID

- ✓ Hypertrophy of the nasopharyngeal tonsils due to infections and other causes which can cause symptoms of airway obstruction.
- ✓ Most commonly between the age of 3-7 years.

○ Pathological types:

- 1) Inflammatory
- 2) Tuberculosis

○ Clinical features:



Mouth breathing, snoring, hyponasality (loss of normal resonance associated with a clear nasopharynx), adenoid face (long, open-mouthed, dumb-looking face of children with adenoid hypertrophy), nasal discharge and Eustachian tube obstruction.

○ Main Adverse effects:

Nasal obstruction, pharyngitis (due to dry mouth), otitis media, rhinosinusitis, recurrent upper respiratory tract infections, and obstructive sleep apnea.

○ Diagnosis:

- 1) X-ray. (should be done with the neck extended in order to fully visualize the adenoid)
 - 2) Flexible fiberoptic. (now used instead of x-ray)
- Using fiberoptic, adenoid hypertrophy is graded based on the degree of obstruction:
 - ✓ **Grade 1: <25% obstruction**
 - ✓ **Grade 2: 25-50% obstruction**
 - ✓ **Grade 3: 50-75% obstruction**
 - ✓ **Grade 4 : 75-100% (complete obstruction)**



fibreptic inserted through the nose



lateral x ray shows enlarges adenoid showing grade 3 adenoid

🚦 430 teamwork

○ Treatment of adenoid:

- ✓ **If small adenoid**: conservative steroidal nasal spray.
- ✓ **surgical**: adenoidectomy. Indications: recurrent/ persistent otitis media, recurrent/chronic sinusitis, and obstructive sleep apnea.

Adenoids are removed by inserting a catheter through the throat to retract the soft palate and visualize the adenoid. Then, the enlarged adenoid is removed using a curette or suction diathermy (heat).

❖ SLEEP APNEA

- ✓ **Snoring is a sign of partial obstruction of the upper airway during sleep.**
- ✓ **Snoring is always present during obstructive sleep apnea.**
- ✓ **Sleep apnea**: Cessation of airflow at the mouth and nostrils lasting 10 seconds for at least 30 apneic episodes.

○ Types:

- 1) Central sleep apnea: Failure of respiratory drive from the brain.
- 2) Obstructive sleep apnea (OSA): Due to anatomical narrowing of the upper airway. “For example: deviated nasal septum, large inferior turbinate, polyp, adenoid, large tongue, large tonsils and retrognathia (posterior positioning of the maxilla or mandible)”.
- 3) Mixed.

• Stages of sleep (skipped by the doctor):

○ Slow wave sleep:

- Brain waves are slow in deep restful sleep.
- There's a decrease in vascular tone and respiratory rate and basal metabolic rate.

○ Rapid eye movement:

- Brain quite active.
- Active dreaming.

- **Pathophysiology of OSA:**

- During REM or deep sleep, obstruction occurs resulting in decrease arterial oxygen and increased arterial carbon dioxide pressure.
- Nocturnal desaturation arouses patient and causes increase pulmonary and systemic arterial pressure.
- Leads to hypersomnolence (excessive sleeping or sleepiness).
- Predisposes to hypertension and stroke.

- **Predisposing Factors:**

- ✓ Obesity, nasal or pharyngeal obstruction by tonsils or adenoids in children,
- ✓ increasing age, alcohol, and smoking.

- **Investigations:**

- **Sleep study:**

EEG, EKG, EOG, pulse oximeter, respiration rate, muscle movement, nasal and oral air flow and frequency of apneic episodes and according to that the treatment method is chosen.

- Electrooculogram (EOG):

A recording of the movements of the eyes. If rapid eye movements are detected during sleep, the subject is in REM sleep.

- **Treatment:**

- ✓ ***Nonsurgical:***

- **Behavior modification:** weight reduction and avoid alcohol at night.
- **Medical treatment.**
- For uncomplicated snoring, various devices improve the caliber of the nasal airway or splint the jaw forward to improve the pharyngeal airway.

- ✓ **CPAP** (continuous positive airway pressure).

- ✓ ***Surgical:***

- **UPPP (Uvulopalatopharyngoplasty)** : a procedure that is done when the soft palate is redundant or if big tonsils or adenoids are present.

430 teamwork

○ Types of sleep apnea:

- ✓ **Central sleep apnea** : absent chest movement and should be treated by a neurologist.
- ✓ **Obstructive sleep apnea** : the chest is moving.

❖ ACUTE INFECTIONS OF THE OROPHARYNX

1) Acute tonsillitis:

○ **Causes:** viral (most common cause), bacterial (group A β -hemolytic streptococcus, moraxella, H. influenza, bacteroides).

○ **Signs & symptoms:** fever, sore throat, pain on swallowing (odynophagia), jaw stiffness (trismus), halitosis (bad breath).

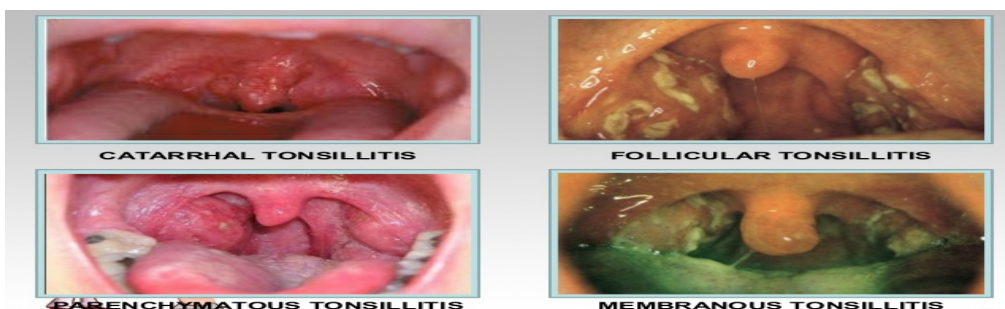
○ **Phases:** erythema, exudative, follicular tonsillitis.

○ **Complications:**

Peritonsillar abscess (Quinsy), parapharyngeal or retropharyngeal abscess, otitis media, rheumatic fever, glomerulonephritis, scarlet fever. The last three are associated with group A streptococcus (GAS).

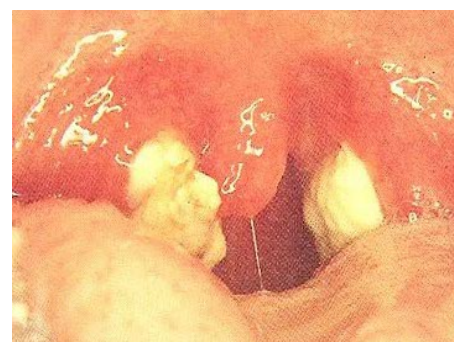
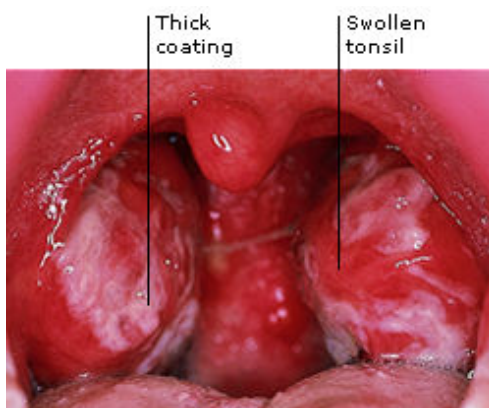
○ **Rx:**

- ✓ Oral antibiotics (pencillin), bed rest, hydration, analgesia.
- ✓ If the symptoms are severe : admit the patient and give IV fluids, IV antibiotics and analgesia.
- ✓ The Centor criteria (not accurate) to diagnose and treat GAS pharyngitis. These include the following (A score of 0-1 makes GAS infection unlikely; a score of 4 makes it likely):
- ✓ Fever, Anterior cervical lymphadenopathy, Tonsillar exudate, Absence of cough.



2) INFECTIOUS MONONUCLEOSIS:

- **Pathogen:** Epstein barr virus. **Adolescents are especially susceptible (kissing disease).**
 - **Signs & symptoms:** **membrane on tonsils (membranous tonsillitis), fever, bilateral lymphadenopathy**, malaise, exudative tonsillitis, hepatosplenomegaly. Patients who are treated with ampicillin or amoxicillin may develop a characteristic, rash.
 - **DX:**
 - ✓ Monosopt test, paul bunnell test (heterophil antibodies in serum).
 - ✓ 80% mononuclear and 10% **atypical** lymphocytes on smear.
 - ✓ CBC shows a higher count of lymphocytes than neutrophils.
 - **Complications:** involvement of cranial nerves, meningitis, autoimmune hemolytic anemia, splenic rupture (**activity restriction may be necessary to prevent splenic rupture in patients with splenic enlargement**).
 - **RX:** hydration, analgesia and oral hygiene.
- [Steroid \(in severe cases\) avoid ampicillin](#)
- **Differential diagnosis:** Diphtheria (grey membranes on tonsils).



3) Scarlet fever:

- ✓ Endotoxin produced by type A β -hemolytic streptococcus (wrong).
- ✓ The rash of scarlet fever is caused by the **streptococcal pyrogenic exotoxins** (ie, SPE A, B, C, and F).
- **Signs & symptoms:**
- ✓ Scarlet fever (known as scarlatina in older literature references) is a syndrome characterized by exudative pharyngitis, fever, and bright-red exanthema (rash).
- ✓ Red pharynx, **strawberry tongue**, perioral skin erythema and desquamation, dysphagia, malaise, severe cervical lymphadenopathy.
- **DX:** Dick test.
- **RX:** Antibiotic. Penicillin or amoxicillin.



4) Diphtheria:

- **Corynebacterium diphtheriae.** **The incidence has fallen markedly because of immunization.**
- **Signs and symptoms:**
- ✓ **local manifestations** :sore throat, fever, green plaques friable membrane.
- ✓ Characterized by a grey membrane (difficult to remove) on tonsils, fauces, and uvula, which bleeds on scraping.
- ✓ **Systemic symptoms due to the exotoxins:** Toxemia , Mild fever , Tachycardia and Paralysis
- **DX:** culture.
- **Complications:** myocarditis, nephritis, airway obstruction, death.
- **RX:** Antibiotics (penicillin or erythromycin), antitoxin.



Diphtheria antitoxin is a horse-derived hyperimmune antiserum that neutralizes circulating toxin prior to its entry into the cells.

5) Vincent's angina:

- **Acute ulcerative lesion.**
- **Gram negative fusiform bacillus and a spirillum with anaerobes.**
- **Signs and symptoms:** Sudden in onset, pain, fever, cervical adenitis, the base of the deep ulcers bleed when the membranous slough is removed, the symptoms subside in 4-7 days.
- **RX:** metronidazole (flagyl), antiseptic, mouthwash.



6) Bifid uvula: 430 teamwork

- **Signs & symptoms:** snoring and mouth breathing.

- Sometimes, the adenoid helps close the soft palate. So, before deciding on removing the whole adenoid (adenoidectomy), the doctor should examine the uvula to make sure it's not short or bifid and palpate the soft palate to check for submucosal cleft. If any of the three conditions mentioned are there, it is contraindicated to do an adenoidectomy.
- This picture shows a bifid uvula and soft palate.
- In this case, only the upper part of the adenoid is removed (partial adenoidectomy), while the lower part is kept; to bridge the gap between the soft palate and pharynx in order to prevent velopharyngeal insufficiency and hypernasality.
- Velopharyngeal insufficiency (VPI) is a disorder resulting in the improper closing of the velopharyngeal sphincter (soft palate muscle in the mouth) during speech, allowing air to escape through the nose instead of the mouth.
- If the velopharynx is not closed, snort sounds may be produced through the nose or you may hear air coming out of the nose during speech.
- Improper function of this structure also produces a nasal tone in the voice (hypernasality).

7) Moniliasis:

- White patches caused by candida albicans fungus.
- In bronchial asthma patients (using inhaled steroids) or immunocompromised patients like patients on renal dialysis.
- **RX:** nystatin- [Fluconazole](#)

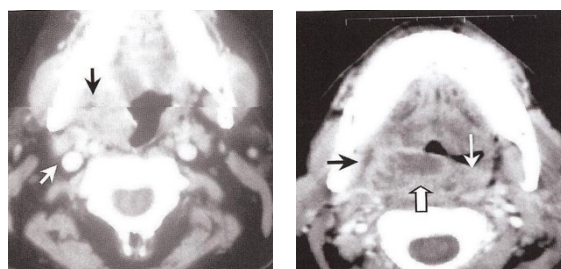
8) Peritonsillar abscess (quinsy):

- An abscess between the tonsil capsule and the adjacent lateral pharyngeal wall.
- **Signs & symptoms:** fever, otalgia odynophagia, uvular deviation, **trismus** (stiffjaw), **drooling of saliva**, **hot potato voice**. The patient, already suffering from tonsillitis, becomes more ill, has a peak of temperature and develops severe dysphagia with referred otalgia. On examination, a most striking and constant
- **feature is trismus.**
- **Complications:** para and retropharyngeal abscess, aspiration pneumonia.
- **Rx:**
 - ✓ Incision and drainage
 - ✓ Aspiration.
 - ✓ IV antibiotics.



9) Parapharyngeal abscess:

- **Source of the infection:** odontogenic, **tonsils or pharynx**, parotid.
- **Signs & symptoms:** trismus, fever, muffled voice, intraoral bulge.
- **Complications:** aspiration, cranial nerve palsy, airway compromise, septic thrombophlebitis of internal jugular, carotid blowout, endocarditis.
- **RX:** external drainage, IV antibiotics, airway management.
- **Investigations:** [Laboratory and bacteriology](#) / [CT \(best modality\)](#) / [MRI](#)



10) Retropharyngeal abscess:

- **-More common in children.**
- **Signs & symptoms:** odynophagia, hot potato voice, **drooling**, **stiff neck**, **fever**, **stridor** and **Swelling of posterior pharyngeal wall (usually unilateral)**.
- **Complications:** **mediastinitis**, airway obstruction, respiratory distress, abscess rupture.
- **RX:** **secure airway** ,internal drainage and IV antibiotics.

11) Ludwig's angina:

Bilateral cellulitis of submandibular and sublingual spaces. "usually a complication of untreated **dental** abscess" .

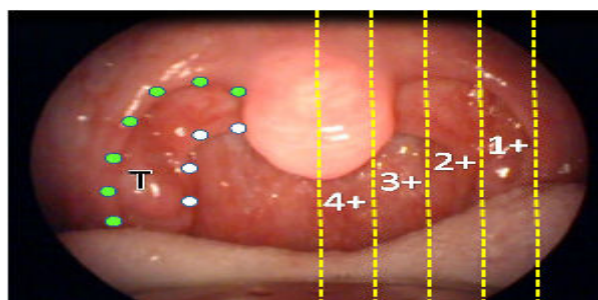
- **Signs & symptoms:** wooden floor of the mouth, neck swelling and indurations,
- drooling, the **abscess pushes the tongue upwards -> blocks airway ->**
- respiratory distress, swollen tongue, dysphagia, and trismus.
- **Complications:** airway distress, sepsis.
- **RX:** tracheostomy, external drainage and IV antibiotics.



○ Tonsillectomy

Tonsillar hypertrophy grading:

- **Grade 0** : Tonsils are found confined to the space between the anterior and posterior pillars
- **Grade 1** : Tonsils are enlarged and is just seen coming out of the anterior pillar. (cover 25% of the space between the pillars)
- **Grade 2** : The enlarged tonsil reaches to about half the distance of uvula. (cover 50% of the space between the pillars)
- **Grade 3** : The enlarged tonsil comes into contact with the uvula. (cover 75% of the space between the pillars)
- **Grade 4** : The enlargement of tonsil is so much that both tonsils lie virtually in contact with each other i.e. kissing tonsils.



Indications:

- 1) **Recurrent tonsillitis:** 6 attacks or more during 1 year or 4 attacks per year for 2 years, or 3 attacks per year for 3 years.
- 2) **Hypertrophied tonsils causing airway obstruction.**
- 3) **Unilateral tonsillar enlargement:** tonsillar enlargement suspicious of malignancy (firm unilateral enlargement in an adult smoker).
- 4) **Peritonsillar abscess (Quinsy)** -treated by incision and drainage - wait for 6 weeks then book the patient for tonsillectomy.

❖ Complications of adenoidectomy and tonsillectomy:

1) Hemorrhage (most common complication)

o Primary hemorrhage:

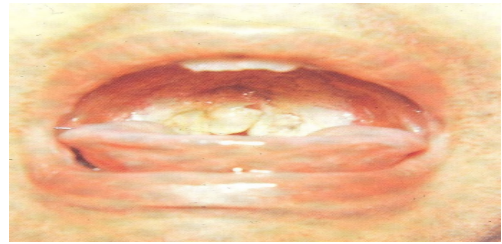
- Bleeding occurring during the surgery.
- **Causes:** bleeding tendency, acute infections, and bad technique.
- **Management:** general supportive measures, diathermy, ligature or stitches, packing.

o Reactionary hemorrhage:

- Bleeding occurring within the first 24 hours postoperative period.
- **Causes:** bleeding tendency, slipped ligature.
- **Diagnosis:** rising pulse & dropping blood pressure, rattle breathing, blood trickling from the mouth, frequent swallowing, examination.
- **Treatment:** general supportive measures, take patient back to OR, control like reactionary hemorrhage.

o Secondary hemorrhage:

- Occur 5-10 days postoperatively.
- **Due to infection:** post-op sloughy material forms in the tonsillar fossa, which may be infected resulting in secondary haemorrhage.
- **Treated by antibiotics.**
- **May need diathermy or packing.**



2) Respiratory obstruction (because of uvular edema, hematoma, aspirated material).

3) Injury to near-by structures.

4) Pulmonary and distant infections.

❖ Chronic pharyngitis

- o **Pathogenesis:** postnasal drip, irritants (dust, dry heat, smoking, alcohol), reflux esophagitis, chronic mouth breathing, allergy, granulomatous disease, connective tissue disease, malignancy.
- o **Signs & symptoms:** constant mouth clearing, dry throat, pharyngeal crusting, thick granular wall.
- o **RX:** Treat underlying cause.

❖ Aphthous Ulcer

Usually due to stress, stays for a few days and spontaneously resolves.



❖ Zenker's diverticulum

- o **Herniation of the mucosa at Killian's triangle due to increased intraluminal pressure.**
- o **Signs & symptoms:** dysphagia, regurgitation of undigested food and aspiration.
- o **DX:** barium swallow.
- o **RX:** Cricopharyngeal myotomy, diverticulectomy.



Summary

- Adenoid presents with mouth breathing, snoring, hyponasality, and nasal discharge.

Complications Nasal obstruction, pharyngitis (due to dry mouth), otitis media, rhinosinusitis, recurrent upper respiratory tract infections, and obstructive sleep apnea.

Diagnosis: Flexible fiberoptic

- Snoring is a sign of partial obstruction of the upper airway during sleep and it is always present in obstructive sleep apnea. OSA may be treated by non surgical behavior modification (CPAP,..) or surgical methods.

- Acute tonsillitis may be viral (most common cause) or bacterial (group A β -hemolytic streptococcus).

- Infectious mononucleosis (EBV) is characterized by fever, pharyngitis, and lymphadenopathy. Adolescents are especially susceptible (kissing disease).

- Diphtheria: the 'bull neck' and 'wash-leather' grey-green membrane covering the tonsils are characteristic of the acute presentation

- Scarlet fever is due to SPE and is characterized by fever, pharyngitis, and bright red exanthema.

- Peritonsillar abscess (quinsy): The patient suffers from fever, referred otalgia, odynophagia, trismus (stiff jaw), drooling of saliva, and hot potato voice.

- Retropharyngeal abscess is more common in children. They suffer from fever, sore throat, drooling, stridor, and neck stiffness.

- Ludwig's angina is usually the complication of untreated dental abscess. The abscess pushes the tongue upwards and blocks airway.

- Tonsillectomy Indications:

A. Recurrent tonsillitis: 6 attacks or more during 1 year (in lecture notes, it's 5), or 4 attacks per year for 2 years, or 3 attacks per year for 3 years.

B. Hypertrophied tonsils causing airway obstruction.

C. Suspicious of malignancy (firm unilateral enlargement in an adult smoker).

D. Peritonsillar abscess (Quinsy)

MCQ's

1) Which of the following conditions is least likely to occur as a consequence of streptococcal infection?

- A. Scarlet fever.
- B. Endocarditis.
- C. Rheumatic fever.
- D. Haemolytic uraemic syndrome.

2) A sales executive, recently returned to the UK from Ukraine, is referred to the local infectious diseases unit by his general practitioner with a sore throat of unusual appearance. On arrival, he is tachycardic with a heart rate of 110 bpm, and has a mild pyrexia of 37.7°C. There is a slight blood-stained discharge at the nasal orifices. His neck is visibly swollen. Examination of the mouth reveals a greyish-green membrane overlying the tonsils, which does not come off with gentle scraping with the tongue depressor.

What is the likely diagnosis?

- A. Streptococcal throat infection.
- B. Diphtheria.
- C. Oral candidiasis.
- D. Tonsillar carcinoma.

3) A 14-year-old boy, living in London, is brought to the hospital accident and emergency department by his mother with a 6-day history of malaise, fever and sore throat. He gives no history of recent foreign travel. His temperature is 38°C. On examination, you note that he has an inflamed pharynx, cervical lymphadenopathy, a tender enlarged liver and a palpable spleen.

What is the most likely diagnosis?

- A. Infectious mononucleosis.
- B. Malaria.
- C. Influenza.
- D. Mumps.

Answers:

- 5- D
- 6- B
- 7- A

Done By:

Ibrahim Alshalan

Othman Abid

Reviewed By:

Falwah Alharthi

Sara Habis

