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**Bedside Transoral Ultrasonographically Guided Drainage of a Retropharyngeal Abscess in the Emergency Department**

*To the Editor:*

Retropharyngeal abscess may present with nonspecific findings and complaints.¹ Radiography provides clues, but computed tomography (CT) is frequently required for diagnosis.² Once the abscess is discovered, rapid surgical treatment is critical to avoid complications such as loss of airway, fatal infection, and neurologic disasters.³ In contrast to retropharyngeal abscess, peritonsillar abscess drainage is easily accomplished in the emergency department (ED) when ultrasonographic guidance is used.⁴ Intraoral ultrasonographic evaluation is highly sensitive and specific for the presence of a peritonsillar abscess and avoids “blind sticks” that were once both diagnostic and therapeutic. Review of the literature reveals no published reports of retropharyngeal abscess drainage by emergency physicians. We describe, to our knowledge, the first case of a retropharyngeal abscess drained in the ED by an emergency physician.

A 46-year-old man was transferred to the ED from an outside facility at midnight with a perivertebral abscess on CT. The patient’s symptoms began with a sore throat and progressed to neck stiffness and trismus during several days. The plastic surgery service, on call for facial trauma, accepted the transfer but deferred patient care. Physical examination revealed a febrile man unable to turn his head. The ED regularly performed ultrasonographically guided peritonsillar abscess drainage and periodically received referrals from ear, nose, and throat. CT (Figure 1) images suggested that intraoral access to the abscess was feasible.

An endocavity probe was inserted into the patient’s mouth, revealing an unusually deep and large abscess...
An 18-gauge 1.8-inch needle, typically used for peritonsillar abscess drainage, was not long enough and a 14-gauge 3.5-inch needle was then used for drainage. Twenty-two milliliters of green pus was successfully drained. The patient had immediate relief and asked to be discharged home. He was admitted to an observation unit and received 3 doses of ampicillin/sulbactam intravenously. The patient was discharged the next day and recovered uneventfully.

Retropharyngeal abscesses are potentially life threatening and can cause catastrophic complications if not discovered and treated, including mediastinal infection, sepsis, airway obstruction, and neurologic disasters. If the index of suspicion is high enough, definitive diagnosis is typically made on CT of the neck. In the ED setting, soft tissue lateral neck radiograph is a common imaging starting point. The retropharyngeal tissue stripe is typically greater than 6 mm at C-2 and 22 mm at C-6 in the presence of an abscess.

Antibiotic administration is not adequate to resolve a developed abscess alone, and incision and drainage in an operating room is necessary. Needle drainage of peritonsillar abscess is a common technique, and blind drainage by ear, nose, and throat specialists has an accuracy of 85%, but ultrasonographically guided needle drainage approaches 100%. However, unlike peritonsillar abscess, there are no descriptions of retropharyngeal abscess drainage under intraoral ultrasonography by emergency physicians or other specialties.

In this case, emergency physicians were able to successfully provide treatment for the retropharyngeal abscess. Because of call schedule peculiarity, the patient would have to have been transferred yet again, away from a tertiary care center. Although this is rare, in community settings the ability to drain retropharyngeal abscess may avoid challenging transfers.

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Considerations That Follow From the Demonstration of Outcome Bias

To the Editor:

Drs. Gupta, Schriger, and Tabas have produced an elegant demonstration of outcome bias in our assessment of the care we provide. They warn us in a delightful and nonthreatening way that our retrospective judgments are suspect when we know the outcomes. They also stop short of making extensive recommendations based on their results. Several considerations follow naturally from their conclusions and could form the bases of departmental processes, institutional approaches, public policy, and future research.

At a departmental level, case conferences and morbidity and mortality conferences should be presented in a manner that allows discussion of the quality of care before revelation of the outcomes. In both conferences, the inclusion of cases both with and without poor outcomes keeps the crowd guessing and may help reduce bias based on the presumption of injury. Explicit training in the nature of outcome bias also enhances the value of these conferences.

At an institutional level, peer review can be developed beyond the notion of sentinel events or discovered cases. The