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CLINICAL COURSE OF CHRONIC TONSILLITIS IN DIFFERENT AGE GROUPS

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ABSTRACT

Background: Chronic and recurrent tonsillar disease can present differently across childhood, adolescence and adulthood. Clinical decisions are complicated by variation in definitions and by overlap between tonsillitis and other causes of sore throat. Objective: To summarize age-related clinical patterns and outline a practical approach to assessment using published literature. Methods: A narrative review was developed from selected peer-reviewed reviews, clinical recommendations and reference works concerning chronic or recurrent tonsillitis, age-related presentation, diagnostic assessment and tonsillectomy. No original patient data were collected, and no meta-analysis was performed. Results: Childhood is associated with a substantial burden of acute and recurrent tonsillar infections and tonsillar hypertrophy. Adolescents may experience persistent or recurrent symptoms that affect school attendance and daily functioning. In adults, persistent throat discomfort, halitosis and disabling recurrences warrant careful evaluation, including consideration of alternative diagnoses when symptoms are unilateral or otherwise atypical. Episode documentation, examination, functional impact and selective microbiological testing are more informative than age alone. Conclusion: Age can help frame the clinical assessment but should not be used as an isolated diagnostic or treatment criterion. The figures in this review are qualitative summaries of published clinical descriptions, not original patient-level data.

Keywords: chronic tonsillitis; recurrent tonsillitis; age groups; children; adolescents; adults; clinical assessment; tonsillectomy.

INTRODUCTION

Chronic tonsillitis is used in clinical practice to describe persistent tonsillar inflammation and symptoms, whereas recurrent acute tonsillitis refers to distinct episodes separated by intervals with few or no symptoms. These terms are not always applied consistently in studies, which makes direct comparisons difficult. Patients may report sore throat, painful swallowing, halitosis, tonsillar crypt debris, fever during exacerbations or cervical lymph-node tenderness. The frequency and impact of these complaints vary, and symptoms may overlap with viral pharyngitis, allergic or irritant conditions, reflux-related symptoms and other disorders [1–3].

Age is clinically relevant because the probability of common pathogens, the ability to describe symptoms, the effect on school or work, and the likelihood of coexisting tonsillar hypertrophy differ across life stages. Nevertheless, a child's enlarged tonsils do not by themselves establish chronic infection, and persistent symptoms in an adult should not

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automatically be attributed to tonsillitis. A careful history and examination remain central to clinical decision-making [1,2].

This review summarizes the age-related clinical features described in the literature and discusses how they can inform assessment. It is intended as a narrative synthesis rather than a report of a new clinical cohort.

LITERATURE REVIEW

Acute tonsillitis is common in childhood, while group A streptococcus (GAS) is a relevant bacterial cause particularly among school-aged children. Viral causes account for many sore-throat presentations across age groups, and clinical findings alone may not reliably distinguish viral from bacterial infection. Accordingly, scoring systems and targeted testing can support decisions in selected cases, but neither a positive symptom pattern nor age alone should be treated as definitive microbiological evidence [1,2].

A key distinction is between repeated acute episodes and persistent symptoms. Recurrent acute tonsillitis involves discrete attacks with symptom-free or symptom-poor intervals; chronic tonsillar complaints may include continuing discomfort, halitosis or crypt debris. Studies may use different case definitions, so apparent age differences should be interpreted cautiously. Microbiological studies also report differences in organisms recovered from tonsillar tissue, but these findings do not establish that a particular organism explains every patient's symptoms or justify antibiotic selection based on age alone [2,3].

Current recommendations emphasize recording episodes, evaluating their severity and functional impact, and balancing the expected benefits of tonsillectomy against postoperative pain and bleeding risk. The 2023 systematic review by Guntinas-Lichius and colleagues recommends structured episode assessment and individualized treatment decisions for recurrent acute tonsillitis [2]. These recommendations concern recurrent acute disease and should not be transferred uncritically to every patient described as having chronic tonsillitis.

MATERIALS AND METHODS

A focused narrative review was prepared using selected peer-reviewed publications and clinical guidance identified through PubMed/PMC, PubMed records and professional otolaryngology sources. Search concepts included chronic tonsillitis, recurrent acute tonsillitis, children, adolescents, adults, clinical features, assessment and tonsillectomy. Sources were included when they addressed definitions, age-related clinical presentation, diagnostic evaluation or management. The material was organized thematically by age group and clinical decision point.

This was not a systematic review: no protocol was registered, no formal risk-of-bias assessment was performed and no pooled effect estimates were calculated. No patient recruitment, clinical examinations, laboratory tests or original statistical analyses were undertaken. Table 1 and Figures 1–2 are qualitative educational syntheses derived from the cited literature; they must not be interpreted as prevalence estimates or as data collected from patients.

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RESULTS

The literature supports three practical observations. First, recurrent infections and tonsillar enlargement are particularly relevant in childhood, but enlargement alone does not establish the cause of symptoms. Second, adolescents may continue to experience childhood-onset recurrences while becoming more able to report persistent discomfort, halitosis and effects on school or daily activities. Third, adults with recurrent or persistent symptoms need assessment of symptom pattern and functional burden, as well as consideration of alternative causes when findings are atypical [1–3].

Table 1 summarizes the main qualitative patterns. These are clinical tendencies described in the literature, not rigid age-specific rules.

Table 1. Qualitative comparison of chronic and recurrent tonsillar disease by age group

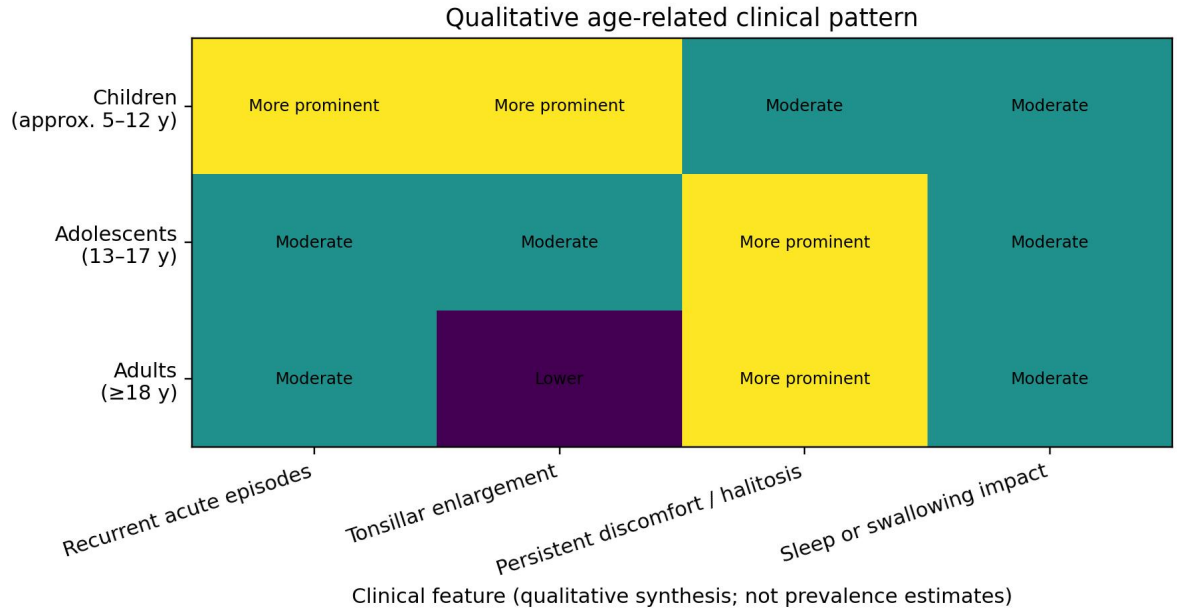
Age group	Clinical pattern often considered	Assessment priorities	Cautions
Children (approx. 5–12 years)	Recurrent sore throat or febrile episodes; tonsillar hypertrophy may be prominent.	Document episode frequency and severity; assess swallowing, sleep, breathing and school absence; test for GAS when indicated.	Hypertrophy is not synonymous with chronic infection; consider sleep-disordered breathing.
Adolescents (13–17 years)	Recurrences may persist; halitosis, crypt debris and functional effects may be reported more clearly.	Clarify symptom-free intervals, fever, swallowing pain and effect on attendance; consider differential diagnoses when symptoms are atypical.	Do not assume every sore throat episode is bacterial.
Adults (≥18 years)	Persistent throat discomfort, halitosis or disabling recurrent episodes may occur.	Assess episode history, comorbidities, smoking/irritant exposure and red flags; investigate atypical findings.	Unilateral persistent symptoms, marked asymmetry or neck mass require timely evaluation.

Interpretation of Table 1. The table shows that clinical findings should be interpreted in the context of age and individual symptom history rather than by age alone. In children, recurrent episodes and enlarged tonsils may be prominent, so assessment should also cover sleep, breathing, swallowing and school absence. In adolescents, it is useful to distinguish separate acute attacks from persistent throat discomfort and document effects on daily activities. In adults, ongoing or recurrent symptoms require consideration of contributing conditions and warning signs, particularly persistent unilateral symptoms, marked

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asymmetry or a neck mass. These descriptions are qualitative patterns summarized from published guidance; they are not measured frequencies or findings from a patient cohort.

Figure 1. Age-related clinical patterns described in the literature (qualitative synthesis; not prevalence data).



The comparison highlights areas that may guide questioning and examination. The relative labels are explanatory only and do not represent measured rates or a validated severity scale.

CLINICAL AND DIAGNOSTIC ASSESSMENT

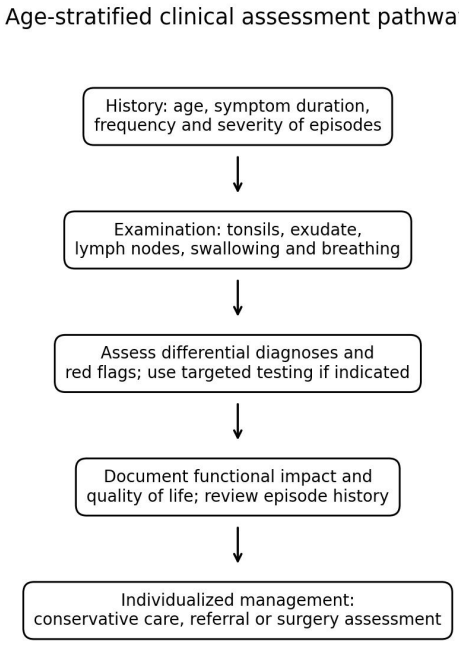
Assessment should begin with the chronology of symptoms: the number of episodes, duration, severity, fever, swallowing pain and whether the patient returns to baseline between attacks. Examination should document tonsillar size and surface changes, exudate when present, cervical lymph nodes and any signs of airway compromise or complications. A sore throat should not automatically be classified as tonsillitis, because viral pharyngitis and other causes may produce similar complaints [1,2].

When bacterial infection is plausible and the result would affect management, a rapid antigen test or throat culture may be appropriate according to local guidance. Centor, McIsaac or FeverPAIN scores can support risk assessment in relevant settings, but they are not substitutes for clinical judgment. Persistent unilateral symptoms, marked asymmetry, a neck mass, unexplained weight loss, or breathing difficulty require further evaluation rather than repeated empirical treatment [2,4].

Functional impact is also important. Sleep disruption, missed school or work, reduced oral intake and repeated need for medical visits help describe the burden of disease. A structured record of episodes improves later decisions about referral or surgery.

Figure 2. Suggested pathway for age-stratified clinical assessment.

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IMPLICATIONS FOR MANAGEMENT

Management should be individualized. Uncomplicated episodes with a low likelihood of bacterial infection are generally managed with supportive care and symptom control, following local clinical guidance. Antibiotics should be reserved for situations in which bacterial infection is sufficiently likely or confirmed and treatment is indicated; age alone is not a reason to prescribe them. Repeated antibiotic courses without a clear indication may expose patients to adverse effects and contribute to antimicrobial resistance [1,2].

Tonsillectomy may be considered when recurrent episodes are adequately documented, sufficiently severe and disruptive, and meet applicable guideline criteria. The 2023 review describes thresholds commonly used in guidance—at least seven qualifying episodes in one year, five per year for two years, or three per year for three years—while emphasizing clinical documentation and shared decision-making [2]. These thresholds apply to recurrent acute tonsillitis guidance, not automatically to every case of persistent throat discomfort. Surgical risks, including postoperative pain and bleeding, must be discussed.

DISCUSSION

The main message from the reviewed literature is that age modifies the context of presentation but does not independently determine diagnosis or treatment. In children, clinicians may encounter frequent infections and prominent tonsillar hypertrophy; however, the presence of large tonsils should be interpreted alongside symptoms, sleep and swallowing function. In adolescents, a detailed history can distinguish discrete acute attacks from continuing symptoms and clarify the effect on school participation. Adults may report a longer history of throat discomfort or halitosis, but alternative causes deserve particular attention when symptoms are persistent, unilateral or accompanied by other warning signs [1–3].

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A second issue is the inconsistent boundary between chronic tonsillitis and recurrent acute tonsillitis. This matters because treatment evidence and surgical thresholds are largely framed around documented recurrent episodes. Studies that combine persistent symptoms with discrete attacks may describe clinically different groups under one label, weakening age-group comparisons. Future studies should define the phenotype explicitly, record episode frequency and severity prospectively, and use consistent measures of quality of life and treatment outcomes.

Microbiological findings require similar caution. Differences in organisms recovered from tonsillar tissue across age groups may be biologically relevant, but culture results must be interpreted with symptoms and examination. A finding in tonsillar tissue does not by itself prove the cause of ongoing complaints, and it should not be used as the sole basis for antimicrobial selection. In clinical practice, the strongest approach combines history, examination, selective testing and follow-up of documented episodes [2,3].

This review has limitations. It is narrative and purposive rather than systematic, and the qualitative diagram is not a validated scoring instrument. The included sources do not provide a single standardized dataset that allows reliable numerical comparison of chronic tonsillitis prevalence across all three age groups. Therefore, no pooled percentages or original patient outcomes are presented. The conclusions should be understood as a structured synthesis of published clinical guidance and reviews, not as evidence from a new cohort.

CONCLUSION

Chronic and recurrent tonsillar disease can present differently in children, adolescents and adults, but age should be interpreted together with symptom chronology, examination findings, episode documentation and functional impact. Childhood assessment often needs particular attention to tonsillar hypertrophy, sleep and swallowing; adolescent assessment should clarify recurrence and school impact; adult assessment should consider persistent symptoms and alternative diagnoses. Targeted microbiological testing and guideline-based decisions can reduce unnecessary antibiotics and support appropriate referral for tonsillectomy. Prospective studies using consistent definitions and age-stratified outcomes are needed to improve comparisons.

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