Orbital cellulitis management guideline – For Adults & Paeds

**Is it limited to Preseptal Cellulitis?**
- i.e. Eyelid only & eye not involved
- Oral Co-amoxiclav (clindamycin if penicillin allergic)
- Consider treating as an outpatient with review in eye casualty in 24-48 hours

**Indication for admission – any of:**
- Clinical suspicion of post-septal cellulitis
- Pyrexia
- Immunocompromised
- Had 36-48 hours of oral antibiotics
- <12 months old
- unable to assess eye due to swelling

**Medical management**
- **ADULTS** – iv Tazocin (allergy; iv clindamycin & iv ciprofloxacin)
- **PAEDS** – iv co-amoxiclav (allergy; iv cefuroxime & metronidazole if mild allergy - other allergy discuss with micro)
- **IMMUNOCOMPROMISED** – discuss all with microbiology/ID
- Consider nasal Otrivine & nasal steroids
- 4 hourly eye & neuro-observations
- Urgent Ophthalmology assessment & daily review
- Urgent Otolaryngology assessment & daily review

**Indication for imaging**
- CNS involvement
- Unable to examine eye/open eyelids
- Eye signs – any of: proptosis, restriction/pain on eye movement, chemosis, RAPD, reduced visual acuity/colour vision/visual field, optic nerve swelling
- Failure to improve or continued pyrexia after 36-48 hours IV antibiotics

**Discharge**
- Discharge once swelling has resolved and pyrexia settled with oral antibiotics; -co-amoxiclav -clindamycin if penicillin allergic

**Baseline Investigations**
- FBC, CRP, lactate (& blood culture if pyrexia)
- Endonasal swab

**Improvement in 36-48 hours**

**Contrast enhanced CT Orbit, Sinuses and Brain**

**Orbital Collection**

**Surgical management**
- Approach depends on local skill set
  - Evacuation of orbital pus
  - Drainage of paranasal sinus pus
- Discuss any intracranial complication with both neurosurgery & Microbiology

**Outpatient Treatment**

**Admission**

**Medical Management**

**Imaging**

**Surgical Management**