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Orbital and Pre-Septal (Peri-Orbital) Cellulitis Adult Protocol

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11/04/2017	R Weir	Updated antibiotic guidelines	1.0
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1. Patients are safe to follow up as outpatients if they have only pre-septal cellulitis:

- Minimal upper lid oedema
- Systemically well
- Normal eye examination (i.e.: none of the signs of orbital cellulitis below)

1.1 Treatment plan for Pre-septal Cellulitis

- **PO Co-amoxiclav 625mg tds** for 7 days (if penicillin allergy - **PO Doxycycline 100mg bd + PO Metronidazole 400mg tds**)
- Ophthalmology outpatients review (frequency dependent on clinical concern)
- Advise patient if no improvement within 24 hours or systemically unwell to return for admission.

2. Indications for admission (Orbital cellulitis)

- Proptosis
- Diplopia or ophthalmoplegia
- Reduced visual acuity.
- Reduced light reflexes or abnormal swinging light test.
- For those in whom a full eye examination is not possible
- Systemically unwell or concern of septic shock
- Central nervous signs or symptoms (eg drowsiness, vomiting, headache, seizure or cranial nerve lesion)

2.1 Treatment plan for Orbital Cellulitis

- Intravenous access, blood for FBC, U&E, culture
- Commence **IV Co-amoxiclav 1.2g tds**
- If non-severe (i.e. rash) penicillin allergy - **IV Ceftriaxone 2g od + PO metronidazole**
- If severe penicillin allergy (i.e. anaphylaxis) / MRSA positive - **IV Vancomycin + IV Gentamicin + PO Metronidazole**
- If clinical features of necrotising fasciitis, septic shock, penetrating foreign body injury or deterioration despite initial antibiotic therapy – discuss with microbiology consultant.
- Most cases will require at least 7 days of antibiotic with 48hrs IV therapy as a minimum.
- Commence Otrivine nasal drops QID.
- Adequate analgaesia.
- Arrange Ophthalmic and ENT opinions. Admitted under ENT.
- Daily Ophthalmological assessment: visual acuity, colour vision, eye movements and pupil reflexes.
- If gross proptosis, ophthalmoplegia, or concern – CT + hourly assessment

3. Indications for CT scanning

- Central signs
- Unable to accurately assess vision.
- Proptosis, ophthalmoplegia, deteriorating visual acuity or colour vision.
- Bilateral oedema
- No improvement at 24 hours
- Swinging pyrexia not resolving within 36 hours

4. Indications for surgery

- To be decided by ENT, if abscess present on CT
- Rapidly decreasing vision – Orbital decompression (don't wait for scan)

References

Howe L, Jones NS: Guidelines for the management of periorbital cellulitis/abscess. Clin. Otolaryngol. 2004, 29, 725–728

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