NHS Greater Glasgow and Clyde

CLINICAL GUIDELINE

Preseptal and Orbital Cellulitis Treatment Guidelines (Adult)

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Antimicrobial Utilisation Committee

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Adult Preseptal and Orbital Cellulitis Treatment Guidelines

The differentiation between preseptal and deep orbital cellulitis is difficult, based on clinical observation and clinical presentation may not always reflect the underlying disease severity. Subtle pathology may evolve into severe pathology very quickly. Joint ENT and Ophthalmology decision to proceed to CT scan, if impaired on eye examine or different or difficult to assess.

	Examination and Recommendations	Antibiotic Treatment
Preseptal Cellulitis Likely organisms *Staphycococcus aureus* *Streptococcus pneumoniae*, *H. influenzae*, *Moraxella catarrhalis*, anaerobes	Proptosis is absent, The following are not impaired • Visual Activity or Visual Acuity • Pupillary Reactions • Ocular Motility	Oral Co-amoxiclav 625 mg 8 hourly **for 7 days** *If true penicillin allergy* Oral Clindamycin 600 mg 8 hourly **Plus** Oral Ciprofloxacin 500mg 12 hourly **for 7 days** **If sepsis or rapid progression:** IV Co-amoxiclav 1.2g 8 hourly *if true penicillin allergy* IV Clindamycin 600mg 6 hourly **Plus** Oral Ciprofloxacin 500mg 12 hourly **Switch to oral therapy following clinical improvement**
Orbital cellulitis Likely organisms *Staphycococcus aureus* *Streptococcus pneumoniae*, *Streptococcus*. pyogenes, *Streptococcus* milleri, *H. influenzae*, *Moraxella*	**Orbital Cellulitis Presentation** • Severe pain • Tense, red orbit with lid closure • Pyrexia **Examination** • Visual Activity or Visual Acuity • Colour vision • Pupillary reactions • Ocular motility • Optic disc • Chemosis • Diplopia	IV Clindamycin 600 mg 6 hourly **Plus** IV Ceftriaxone 2 g every 24 hours **Duration 21 days IV / Oral** *If true penicillin allergy* IV Vancomycin (see GG&C dosing guidelines, NB loading dose) **Plus** Oral Ciprofloxacin 750mg 12 hourly **Plus**

catarrhalis, anaerobes	• Proptosis • Skin sensation • Bloods (FBC with differential, CRP, blood cultures) • Send Swabs, Pus to microbiology • Contact ENT on call • consider CT scan (brain/orbits/sinuses) • if intracranial infection refer to neurosur • If orbital abscess present external drain IV antibiotics • if orbital abscess absent IV antibiotics • 4-hourly neuro observations • daily ophthalmic review If MRSA discuss with microbiology	IV Clindamycin 600 mg 6 hourly **Duration 21 days IV / Oral** Patients without abscess, clearly improving and afebrile for at least 48 hours, consider **change from IV to oral antibiotics** Change IV ceftriaxone to oral co-amoxiclav 625 mg IV Clindamycin to Oral Clindamycin 600 mg 8 hourly IV Vancomycin to oral clindamycin 600mg 8 hourly.