Periorbital cellulitis treatment guidelines pediatrics

Periorbital cellulitis, also known as preseptal cellulitis, is a common infection of the eyelids and periorbital soft tissues characterized by acute eyelid erythema and edema. Initial antibiotic therapy is empirical. In most cases, a causade is not identified. The antibiotic selection should be directed towards the most common causative agents (namely organisms that typically cause upper respiratory tract infections and sinusitis). Such common organisms include Streptococcus pneumoniae, Haemophilus influenzae, Staphylococcus aureus, other streptocooks, and anaerobics. [1, 2] Clinical improvement should occur within 24-48 hours. If the patient worsens, consider an underlying orbital process or resistant organism(s). In some cases, the duration of treatment depends on the severity of the disease. In adult patients who are non-toxic and who will follow appropriate follow-up, oral antibiotics may be treated on an outpatient basis. But most pediatric patients require admission; intravenous (IV) antibiotics should be started. The condition should be treated initially as orbital cellulitis in children younger than one year, patients who are difficult to investigate, and immunocompromised patients. Patients undergoing outpatient treatment should be seen daily to ensure clinical improvement. When clinical improvement is noted, the patient can be switched to oral antibiotics. [3] Empirical therapeutic regimens for periorbital cellulitis are described below, including those for outpatient and inpatient treatment. [4, 5, 6] For organism-specific treatment, see Periorbital Cellulitis Organism-specific therapy. Monotherapy Clindamycin covers S aureus (including methicillin-resistant S aureus [MRSA]), S pneumoniae, most other streptococci, and anaerobes [7] but has poor H influenzae coverage. [8] Age-based clindamycin regimens are as follows: Pediatric: 30-40 mg/kg/day PO divided q8h for 10-14 days (not more than 1.8 g/day) Adult: 600 mg PO q8h for 10-14 days{ref11) Combination therapy Consider combination therapy in patients who are not immunized to H influenzae or in patients unable to take clindamycin. The options are as follows: Trimethoprim-sulfamethoxazole (covers S aureus [including MRSA], S pneumoniae, and H influenzae) Pediatric: Trimethoprim 8-10 mg/kg/day PO/IV divided q12h for 10 days Adult: Trimethoprim 160 mg PO q12h for 10 days or Doxycycline (covers S aureus [including MRSA], S, pneumoniae, pneumoniae, pneumoniae and H influenzae) Children older than 8 years: 2-4 mg/kg/day PO divided q12h for 7-10 days Adult: 100 mg PO q12h in 1 day, then 100 mg PO q24h for 10-14 days Trimethoprim-sulfamethoxazole (TMP-SMX) and doxycycline fail to adequately cover group A Streptococcus. In addition, doxycycline is contraindicated in children younger than 8 years of age. Therefore, combination therapy with TMP-SMX or doxycycline is recommended, along with one of the following: (covers most streptocooks; poor coverage for MRSA and anaerobics) Pediatric: 45-90 mg/kg/day divided q12h for 10-14 days Adult: 875 mg PO q12h for 10-14 days or Cefpodoxime (covers most streptocooks; poor coverage for MRSA and anaerobics) Pediatric: 10 mg/kg/day divided q12h for 10 days Adult: 200-400 mg PO q12h for 10-14 days or Cefdinir (covers most streptococcal species; poor coverage for MRSA and anaerobics) Pediatric: 14 mg/kg/day PO divided q12h for 10 days (not more than 600 mg/day) Adult: 600 mg PO daily for 10-14 days Initial inpatient therapy should include the most causative organisms until clinical improvement occurs. Inpatients are as follows: Piperacillin/tazobactam (covers S aureus, streptokocci, H influenzae, and anaerobics) Age 2-9 months: 240 mg/kg/day IV divided q8h for 7-10 days Older than 9 months: 3,375 g IV q6h for 7-10 days or Amoxicillin-clavulanic acid (covers Surerepus, stococcus, H influenzae, and anaerobics) Pediatric: 45 mg/kg/day divided q12h for 10-14 days Adult: 875 mg PO q12h for 10-14 days [4, 5, 9] or Cefuroxime (covers S aureus, streptococci, H influenzae, and anaerobes) Age 3 months and older: 50-100 mg/kg/day IM/IV divided q8h for 10-114 days (not more than 9 g /day) Adult: 1.5 g IV q8h for 10-14 days or Ceftriaxone (covers S aureus, streptococcus, H influenzae, and anaerobes) Pediatric : 50-100 mg/kg/day IM/IV Adult : 1-2 g IM/IV q24h [10] If MRSA is suspected, add vancomycin. Age-based vancomycin regimens are as follows: Age 1 month to 11 years: 10-15 mg/kg IV q6-8h (maximum 1 g/dose) Older than 12 years: 1 g (15 mg/kg) q12h for 7-10 days – Periorbital cellulitis is a common, usually benign, bacterial infection of the eyelids. It occurs mainly after trauma to the eyelids (insect bites or abrasion).– Orbital cellulitis is a serious infection involving the contents of the orbit (fat and ocular muscles) that can lead to loss of vision or a brain abscess. It usually occurs secondary to spread from sinusitis (e.g. as a complication of ethmoid sinusitis).– Periorbital and orbital cellulitis are more common in children than in adults.– The most common organisms that cause periorbital and orbital cellulitis are Staphylococcus aureus, Streptococcus pneumoniae and other streptococcus, as well as Haemophilus influenzae type b (Hib) in children living in countries where immunisation rates with Hibtiber are still low. Clinical features – Signs common to both periorbital and orbital cellulitis: acute eyelid erythema and edema; edema has a violaceous shade if secondary to H. influenzae.– In the case of orbital cellulitis alone:• Pain with eye movements;• Ophthalmopleggia (paralysis of eye movements) often with double vision (double vision);• Protrusions in the eye (eye bulges out of the socket);• High fever, systemic signs. Treatment – Ioc for the following: orbital Children less than 3 months, critically ill, the patient appears , local complications, weakened patient (chronic condition, elderly), if there is a risk of non-compliance with or failure of outpatient treatment. Treat the other patients as outpatient patients.– Outpatient antibiotic therapy :cefalexin PO for 7 to 10 daysDjuter 0 to 7 days: 25 mg/kg 2 times daily Newborn 8 days to 1 month: 25 mg/kg 3 times daily Child over 1 month: 25 mg/kg 2 times daily (max. 2 g daily)Children ≥ 40 kg and adults: 1 g 2 times daily oramoxicillin/clavulanic acid (co-amoxikliav) PO for 7 to 10 daysUse formulations in a ratio of 8:1 or 7:1 exclusively. Dose expressed in amoxicillin:Children < 40 kg: 50 mg/kg 2 times dailyChildren ≥ 40 kg and adults:Ratio 8:1: 3000 mg daily (2 tab 500/62.5 mg 3 times daily)Ratio 7:1: 3 2625 mg daily (1 tab of 875/125 mg 3 times daily)– Inpatient antibiotic therapy :ceftriaxon slow IV (3 minutes) or infusion IV (30 minutes; 60 minutes in newborns) for at least 5 daysChildren: a dose of 100 mg/kg on the first day; then 50 mg/kg 2 times dailyCnations: 1 to 2 g once daily+cloxacillin IV infusion (60 minutes) Newborns 0 to 7 days (< 2 kg): 50 mg/kg every 12 hoursExpensive 0 to 7 days (≥ 2 kg): 50 mg/kg every 8 hoursExpensive 8 days to < 1 month (< 2 kg) : 50 mg/kg every 8 hoursExpensive 8 days to < 1 month (≥ 2 kg): 50 mg/kg every 6 hoursChildren 1 month and over: 25 to 50 mg/kg every 6 hours (max. 8 g daily)Children ≥ 40 kg and adults: 2 g every 6 hoursIf there is clinical improvement (patient afebrile and erythema and edema have improved) after 5 days, switch to amoxicillin/lucivulan acid PO at the specified doses above to complete 7 to 10 days of treatment. If there is no improvement in the first 48 hours (suspicion of methicillin resistant S. aureus), replace cloxacillin with:clindamycin IV infusion (30 minutes) Newborn 0 to 7 days (< 2 kg): 5 mg/kg every 12 hours Neonater 0 to 7 days (≥ 2 kg): 5 mg/kg every 8 hoursExpensive 8 days to < 1 month (< 2 kg): 5 mg/kg every 8 hoursExpensive 8 days to < 1 month (≥ 2 kg): 10 mg/kg every 8 hoursChildren 1 month and over: 10 mg/kg every 8 hours (max. 1. 1 800 mg daily)Adults: 600 mg every 8 hoursAfter 5 days, switch to clindamycin PO at the same doses to complete 7 to 10 days of treatment.– If orbital cellulitis does not respond to IV antibiotics , consider an abscess. Transfer the patient to a surgical center of drainage. by Sean M. Fox · 29 March 2013 The red eye complaint is frequently found in Peds ED. We have maintained some considerations with respect to conjunctivitis (especially in newborns), but sometimes, instead of seeing the red eyes we were expecting, we see a child who looks like Rocky Balboa. The basics occur mainly in children < 5 years Periorbital cellulitis is 3 times as usual as orbital cellulitis. Causes Causes (specifically related to the ethmoid sinus) is the most common cause direct extension from local structure Bug Bite Stye Dacryocystitis Dental Abscess Impetigo Direct Trauma Hematogenous Spread Bugs Staphylococcus aureus and S. epidermidis and S. pyogenesis are the primary culprits (~ 75% of cases) currently. MRSA should be considered based on your local resistance patterns. H. influenzae type b was, historically, the most common cause, but vaccination has greatly reduced it as a cause. Clinical findings Periorbital Cellulitis is a clinical diagnosis! No lab value or radiology is needed to make the diagnosis of unilateral eyelid swelling, redness, and/or heat. This can be very mild... or rather severe to the point that the eyelids are swollen closed. Soreness may also occur. Features concerning for extension into orbit (orbital cellulitis) Blurred vision (get one Visual Sharpness!) Proptosis Restricted Range of Movement of the Eye Chemosis Increased intraorbital pressure In cases where swelling prevents adequate eye examination, imaging with CT may be required to distinguish periorbital cellulitis from orbital cellulitis. Elevations in the WBC count, CRP and or ESR may involve orbital involvement, but they are not good enough to base your management on alone. Management The source of the infection can help determine the best empirical antibiotic choice: Rhinosinusitis – Augmentin, 2nd or 3rd generation cephalosporin Dental abscess – Clindamycin or Augmentin Stye – 1st generation cephalosporin, or Clindamycin if MRSA is a concern Impetigo – Clindamycin or 1st generation cephorsporin Hematogenous Spread – 3rd generation cephalosporin PLUS clindamycin or Vancomycin Simple (mild) periorbital cellulitis Mostly only redness without eyelid swelling Can be started on oral antibiotics Therapy is typically 7-10 days These children should see clinically very good and have no signs of toxicity. All other intravenous antibiotics and hospitalization are appropriate. If there is no improvement in 24 to 48 hours of therapy: Reconsidering antibiotic coverage Reconsidering the diagnosis – is this really orbital cellulitis? Trying to gain cultures Blood cultures are not often helpful... but ocular discharge cultures are! When to obtain CT? Eyelid swelling prevents adequate examination of the eye. CNS involvement (ophthalmoplegia, lethargy, seizures, focal deficits, etc.) Change in visual acuity Proptosis No improvement in 24 – 48 hours of appropriate therapy. Clinical deterioration Hauser A, Fogarasi S. Periorbital and Orbital Cellulitis. Pediatrics in review. 2010; 21; 242. Al-Nammari S, Robertson B, Ferguson C. Should a child with preseptal periorbital cellulitis be treated with intravenous or oral antibiotics? BestBETs 2007. Tags: Periorbital CellulitisPerseptal Cellulitis Cellulitis Cellulitis Cellulitis

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