

Orbital Disorders

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(PERI)ORBITAL CELLULITIS 1
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(PERI)ORBITAL CELLULITIS

ORBITAL CELLULITIS - infection of orbital tissues (posterior to orbital septum)

PERIORBITAL (S. PRESEPTAL) CELLULITIS - infection of periorbital skin and eyelid (anterior to orbital septum).

Sources of infection:

- a) **extension** from paranasal sinuses (**ethmoid sinusitis** – 90% cases!!!), teeth
- b) introduced via **orbital trauma / surgery** (most commonly - *S. aureus* and *S. pyogenes*).
- c) **hematogenous spread** from bacteremia (most commonly - *Haemophilus influenzae* type b, *Streptococcus pneumoniae*).

SYMPTOMS & SIGNS

- primarily **children** (periorbital cellulitis < 5 yr of age, orbital cellulitis > 5 yr).
- > 90% unilateral.
- extreme orbital pain, **exophthalmos** (with painful resistance to globe retropulsion)*, **painful ophthalmoplegia***, eyelid-conjunctival redness & swelling, decreased visual acuity*, nasal discharge.

*absent in PERIORBITAL CELLULITIS

Peri-orbital cellulitis caused by *Pseudomonas aeruginosa* (in acute myelogenous leukemia):



Acute infection of orbital tissue (esp. preseptal):

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Mucormycosis of orbit (uncontrolled diabetes mellitus, especially with ketoacidosis); potentially fatal fungal infection that involves nose, sinuses and orbit → proptosis, ophthalmoplegia, visual loss:

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- fever & malaise, **progressing rapidly to prostration!**
- **complications:**
 - 1) **vision loss** (from optic neuritis, increased intraocular pressure, ischemia)
 - 2) thrombophlebitis of orbital veins → **cavernous sinus thrombosis** (dilation of episcleral vessels is first sign!)
 - 3) **panophthalmitis**
 - 4) infection **spread to meninges / brain**.

N.B. orbital veins (drain from middle third of face, including paranasal sinuses) have no valves - allow infection passage both anterograde and retrograde!

DIAGNOSIS

X-ray of sinuses, **CT** of orbit

Blood cultures (positive only in 33%)

Needle aspiration of orbit is contraindicated!

Indications for **CSF culture**:

- 1) infant < 1 yr with no external focus of infection
- 2) suspected spread to CNS

TREATMENT

- **antibiotics** i/v ASAP (e.g. CEFUROXIME, CEPHALEXIN, CEFAZOLIN, NAFCILLIN).
in preantibiotic era mortality rate was 17% (20% of survivors were blind in affected eye!)
- if secondary to sinusitis – add **nasal decongestants**.
- if infection does not respond to antibiotics in 48-72 h or if suppuration is suspected → **incision & drainage**.

EXOPHTHALMOS (PROPTOSIS)

- *eyeball protrusion*.

ETIOLOGY

1. **Orbital** inflammation, edema, infiltration (e.g. hyperthyroidism), tumors, injuries, hemorrhage, orbital pseudotumor (non-neoplastic cellular infiltration and proliferation, e.g. Wegener's granulomatosis), shallow orbits.
 2. **Cavernous sinus thrombosis, carotic-cavernous fistula** (pulsating exophthalmos with orbital bruit).
 3. **Eyeball enlargement** (e.g. congenital glaucoma, unilateral high myopia).
- causes of PSEUDOPROPTOSIS - lid retraction, unilateral high myopia, facial asymmetry, contralateral enophthalmos.

If orbital pressure is eccentric → eyeball deviation, diplopia.

Globe exposure can lead to *corneal drying, infection (exposure keratitis), ulceration!!!*

DIAGNOSIS

HERTEL exophthalmometer - formal measurement of position of anterior corneal surface in relation to lateral orbit wall.

- if proptosis is > 2 millimeters - **space-occupying orbit lesion** must be suspected.

Etiological diagnosis: CT / MRI of orbit, thyroid studies.

TREATMENT

Etiology determines therapy.

- cornea should be protected from exposure.
- surgical orbital decompression.

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