Introduction: Orbital cellulitis generally results from extension of an infection of the paranasal sinuses (PNS), ethmoidal sinusi- tis being the leading cause. (1) The oedema of the sinus mucosa can narrow the ostia, producing obstruction in normal sinus drainage. The microbial flora can prolifer- ate, invading the oedematous mucosa and determining suppuration. The infection can gain access to the orbit through the orbital wall, which is thin and perforated. The subperios- tal or intraorbital abscesses can appear with clinical signs of proptosis, ophthalmoplegia, oedema and erythema of the eyelids, fever, malaise, oedema as well as erythema of the left eyelid, orbital pain and conjunctivitis. Complex laboratory tests and interdiscipli- nary examination including ENT and ophthalmology check-ups were performed. MRI of the head confirmed the diagnosis as it was suspected: Left extrachoanal orbital abscess and orbital cellulitis, as a complication of ethmoido-maxillary sinusitis. Vigorous medical treatment with multi-disciplinary approach solved the case leaving no need for surgical intervention. Hence, teamwork in such diseases is mandatory to obtain favourable evolution.

Case report: A 2-year old male child presented in our hospital suffering from fever 38.8°C, malaise, intermitt- tent purulent rhinorrhea, oedema and erythema of the left eyelid, proptosis, ophthalmoplegia, left eye conjunc- tivitis and altered general status. History revealed that his family-doctor treated him two weeks ago, diagnosing rhino-pharyngitis, prescribing Clarithromycin, Ibuprofen and nasal decongestants for seven days. Except from the presence of intermittent purulent rhinorrhea from the left nostril, the evolution was apparently good, in the initial days and hence was not followed by the family doctor. The parents were convinced it to be an upper respiratory tract infection, simplest of its kind. Sudden reappearance of fever a day before, which had worsened to 39°C the next day despite of Ibuprofen administration by the mother, accompanied by conjunctivitis and orbital celluli-
Neurosurgeons were in the opinion of getting a surgical drainage of the abscess done in the ENT or Ophthalmology Department. Further, Antibiotic therapy was changed to Meropenem, Metronidazol and Vancomycin, in association with Aspirin, endonasal decongestants. A surgical intervention was discussed and planned under ophthalmology and ENT doctors valued teamwork. However, under combined antibiotic therapy, together with endonasal decongestants, the evolution was magnificent, with clear reduction of the abscess, persisting only minimal inflammatory changes in the extraorbital periethmoid intraorbital fatty tissue, after just one week of initiation of this intensive treatment.

Conclusions: Hence, it can be concluded, that teamwork plays an extremely important role in such complicated cases where the decision hangs between surgical and medical specialties making interdisciplinary approach mandatory. Intensive vigorous medical therapy can overcome the need of surgery in many cases, as was seen in our case of complicated ethmoido-maxillary sinusitis.