bilateral cataracts and the other eye showed no such defect, allowing a decision to be made to operate on the other eye first and so give the patient greater benefit. In a diabetic patient with cataract a clinical view of the fundus was too hazy to reveal an area of circinate retinopathy threatening but not reaching the fovea. This was easily visible with the SLO, allowing appropriate assessment of the urgency of cataract extraction for that patient. The SLO is thus truly an ophthalmoscope and not just a fundus camera.

(*f*) We have found that in some conditions the SLO avoids the need for fluorescein angiography. Cystoid macular oedema is so obvious that we have ceased to perform angiograms for this, and in two diabetics referred for assessment of the degree of retinal ischaemia, new retinal vessels which had not been obvious to two experienced clinicians were immediately apparent, so that angiography was not necessary.

(*g*) The SLO has a large research potential, partly because of the quality of the view, and partly because of the ease with which the system may be coupled to an image analyser for computer analysis of results.[4] Projects utilising this facility are now under way and will be reported in the near future.

What are the Disadvantages?

The disadvantages are:

(*a*) Because of increased technology the SLO is a little harder to use than a normal fundus camera initially, but this is offset by the fact that the teacher and student can see the picture simultaneously allowing corrective guidance to be given easily.

(*b*) The air cooling fan is a little noisier than in many fundus cameras, although one does get used to this.

(*c*) The cooling fan tends to blow dust particles onto the internal mirrors of the SLO and these require regular cleaning by trained personnel. This problem is being addressed by Rodenstock and may be improved on future models.

In conclusion, the scanning laser ophthalmoscope has already proved a great boon to our routine clinical practice. It has also opened up exciting new avenues for research.

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Sir,

The case report by Rose *et al.*[1] raises several important points regarding the management of orbital cellulitis.

The clinical diagnosis cannot be disputed. Sinusitis is the commonest cause of orbital cellulitis and may be revealed by sinus radiographs. However, a CT scan of the orbits is the investigation of choice[2] as it will demonstrate the sinusitis, outline the extent of orbital inflammation and identify an abscess. Furthermore it can be used to monitor the progress of the condition. If an abscess is identified it should be drained; under these circumstances the CT scan helps determine the surgical approach.[3] In the unusual case described a CT scan on admission may well have influenced the timing of surgery, the approach and the choice of antibiotics.

Haemophilus influenzae is rightly cited as a cause of orbital cellulitis in children. There is significant resistance of this species to ampicillin. Cefuroxime is the antibiotic of choice,[2,4] as it has good tissue penetration and a broad spectrum that includes beta-lactamase-producing bacteria. In adults cafotaxime is recommended as a first-line treatment;[2] however, cefuroxime in high doses will serve. Metronidazole is a sensible adjunct to cover anaerobes.

It is important to modify initial empirical antibiotic treatment in the light of cultures. *Streptococcus pneumoniae* is almost invariably sensitive to benzyl penicillin, and as infection was culture-proven it would have been sensible to add it to the regime. Ceftazidime and chloramphenicol seem an odd combination of cidal and static antibiotics. As with all cephalosporins there is *in vitro* evidence of antagonism with chloramphenicol.[5] Although the significance of this is unknown it is important to consider the possibility when treating serious infection.

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