Differential Diagnoses of Diseases Involving the Extrinsic Ocular Musculature – A Pictorial Essay
Diagnóstico diferencial das doenças que envolvem a musculatura ocular extrínseca – Um ensaio pictórico

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Keywords
► graves ophthalmopathy
► orbital lymphoma
► orbital pseudotumor
► orbital cellulitis
► sarcoidosis

Abstract
Introduction There are some inflammatory, infectious, and neoplastic diseases affecting the extrinsic orbital musculature (EOM) that present with pain, decreased visual acuity, and proptosis. Imaging is fundamental to the differential diagnoses of these diseases with similar clinical presentations. The present case series report has as main objective to illustrate and discuss the main pathologies that affect the orbit.

Material and Methods The present series of cases discusses the main pathologies that can affect the extraocular musculature that can be characterized by computed tomography (CT) or magnetic resonance imaging (MRI) using cases from our institution.

Results and Discussion The present study compiled several cases of ophthalmopathy from our institution to illustrate and address some of these pathologies, such as orbital lymphoma, Grave disease, metastases, periorbital cellulitis, and idiopathic orbital inflammatory syndrome. The diseases are discussed according to the presentation of clinical cases with emphasis on the main imaging findings of each pathology.

Conclusion Computed tomography and MRI can help in the diagnosis and follow-up of the diseases that affect the EOM. We must be conversant with the main characteristics of the pathologies presented in the present case series report, since such findings together with clinical data can confirm the diagnosis of these diseases or at least help to narrow the differential diagnoses.

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Introduction

The extraocular muscles (EOMs) occupy the retrobulbar space and are composed of six muscles: the superior, inferior, medial, and lateral recti and the superior and inferior oblique muscles.\(^{1,2}\) They may be affected in different systemic and local diseases. Except for the superior oblique and the lateral rectus, which are innervated by the trochlear nerve and the abducens nerve respectively, the other EOMs are innervated by the oculomotor nerve; in this way, the clinical presentation of patients will depend on the muscle or nerve affected by the disease.\(^{1,2}\)

Pathologies that affect the retrobulbar space may have very similar clinical presentations; for example, for orbital inflammatory syndrome (OIS), orbital lymphoid lesions, and orbital cellulitis,\(^{3-5}\) both computed tomography (CT) and/or magnetic resonance imaging (MRI) are required to make a definite diagnosis or to assist in the indication and orientation of biopsies.

The present case series discusses the main pathologies that can affect the EOMs and that appear in the daily practice.

Objectives

The present series of cases aims to review the main orbital diseases that affect the extrinsic musculature of the orbit, illustrating with cases of our institution.

Material and Methods

The present study was approved by the ethics committee of the Hospital Universitário Cassiano Antônio Moraes (HUCAM, in the Portuguese acronym).

Patients with classic presentations of the main diseases that affect the extrinsic musculature of the orbit who underwent CT and/or MRI in the HUCAM imaging sector were selected.

A literature review was carried out using the PubMed and SciELO databases to elaborate the discussions of the cases.

Results and Discussion

Orbital Cellulitis

Seen more commonly in children and young adults, orbital cellulitis can be divided into five stages: type I, inflammatory edema; type II, diffuse orbital cellulitis; type III, subperiosteal abscess; type IV, orbital abscess; type V, cavernous sinus thrombosis.\(^{5-7}\)

The differentiation between the infection limited to the preseptal tissue and the infection that affects the postseptal tissue is fundamental because patients with infection of the preseptal tissue alone can be treated in an outpatient setting, whereas patients with postseptal tissue involvement should be admitted for intravenous antibiotic therapy and drainage when indicated.\(^{1,5,6,8,9}\)
Patients with orbital cellulitis usually present with edema
and eyelid erythema, pain, proptosis, and limitation of ocular
movements.7

In MRI, the collection of cellulite presents as isointense to
EOM and hypointense to the orbital fat in T1, and hyperin-
tense in T2, with peripheral and annular impregnation by the
contrast enhancement medium (► Fig. 1).3,5,10 In the pres-
ence of an abscess, diffusion restriction is observed, which
may aid in its identification in the absence of contrast
enhancement.11

In CT, the abscess presents as hypodense, with orbital fat
densification and peripheral contrast enhancement.9,10
When the etiologic agent is fungal or bacterial, the cellulite
presents in a similar way in both cases on radiographic
examination; in these cases, mass effect, bone erosion, and
calcifications can be observed in the CT image. However, in
MRI, the fungal lesion can be hypointense in T2 due to the
impregnation of paramagnetic substances and free radicals
released by fungi.10

In cases in which cavernous sinus thrombosis (type V)
occur, the “black turbinate sign” may be an early predictor of
mucormycosis.12

Idiopathic Orbital Inflammatory Syndrome

Also known as inflammatory pseudotumor, its etiology is not
yet defined, and its diagnosis is one of exclusion.1,13–16
Unilateral presentation is most common in adults, and
although rare, bilateral occurrence is more prevalent in the
pediatric group.17 Treatment is done with corticosteroid
therapy.15

The most typical clinical presentation is acute pain,
edema, and periorbital erythema, with or without reduction
of visual acuity and diplopia.14,16 It can be divided into five
subgroups: lacrimal, anterior, posterior, diffuse, and myo-
sitic pseudotumor.16,18

It may present as a focal intraorbital lesion or with
infiltrative features similar to lymphoma. In MRI, it is hypo-
intense in T1 and T2 with contrast enhancement, evidencing
inflammation of the muscles, tendons, and adjacent fat
(► Fig. 2).1,13,16

Orbital myositis, one of the subtypes of idiopathic orbital
inflammatory syndrome (IOIS), may involve one or two
EOMs (the inferior rectus being the most affected); it is
typically unilateral and affects tendinous insertions (unlike
orbital involvement due to thyroid disease, which usually
spares the tendinous insertions).1,16

One variant is the Tolosa-Hunt syndrome, an idiopathic
syndrome that is characterized by inflammation of the
superior orbital fissure and/or of the cavernous sinus, with
consequent recurrent painful ophthalmoplegia, which
responds to corticosteroid therapy.13,19,20 In MRI, it presents
as hypointense lesions in T1 and T2 in the cavernous sinus,
the orbital apex, or the superior orbital fissure with impreg-
nation by contrast enhancement medium.13,20 Computed
tomography findings are not specific but may aid in differ-
ential diagnoses. It may present asymmetric enlargement of
the cavernous sinus and nodular enhancement in the pre-
pontine cisterna, the cavernous sinus, and the orbital apex by
the contrast medium.17,19

Several pathologies may manifest as an orbital pseudo-
tumor, such as IgG4-related disease, idiopathic hypereosi-
nophilic syndrome (HES), sarcoidosis, granulomatosis with
polyangiitis (GPA), and Churg-Strauss syndrome. The IgG4-
related orbital pseudotumor has an estimated incidence of

![Fig. 1](image1.png)

**Fig. 1** Orbital cellulitis. A – Computed tomography without contrast:
Thickening and heterogeneity of bilateral periorbital soft tissue with
extension of the nasal and malar region (arrows). B, C and D – T2WI and T1
postcontrast show preseptal and postseptal compartments. The inflam-
matory process involves the orbital musculature (arrows). Extrudal
empyema is also noted in the right frontal convexity (arrow in b).

![Fig. 2](image2.png)

**Fig. 2** Orbital inflammatory pseudotumor. A and B – T2-WI and T1
postcontrast show an extraconal expansive lesion in the superolateral
aspect of the left orbit, involving the superior and lateral rectus
complex surrounding the lacrimal gland, with a low T2-WI sign and
with an intense homogeneous contrast enhancement (arrows). C and
D – T2-WI and T1 postcontrast after 1 year showing resolution after
corticoid treatment.
between 5 and 20% among inflammatory orbital lesions\textsuperscript{21} and has predilection for the lacrimal gland and nerves.\textsuperscript{21,22}

The HES is characterized by prolonged eosinophilia with no definite cause, leading to visceral damage.\textsuperscript{23}

Orbital involvement in patients with systemic sarcoidosis is not rare. In these cases, involvement of the lacrimal gland, of the optic nerve, and of soft tissues may occur, with anterior uveitis being the most common manifestation, followed by dacryoadenitis.\textsuperscript{24,25} Although uncommon, patients may develop strabismus due to involvement of bilateral EOMs, usually with dacryoadenitis.\textsuperscript{26,27}

Granulomatosis with polyangiitis (GPA) typically affects the kidneys and lungs, but up to 60% of the patients may present with orbital involvement including the optic nerve, and it may be the first or only manifestation of the disease.\textsuperscript{28} Clinically, it can manifest with pain, erythema, conjunctival injection, limited extraocular muscle movements, and vision loss.\textsuperscript{28,29}

The imaging findings are nonspecific, presenting more commonly in CT as an infiltrative lesion of the orbit with adjacent fat obliteration and, in some cases, sclerosis and bone erosion with or without sinus pathology. In MRI, it usually presents as a hypointense lesion in T2 with contrast enhancement.\textsuperscript{28,29}

Churg-Strauss syndrome (CSS) is a systemic vasculitis characterized by hypereosinophilia, asthma, and allergic rhinitis. Orbital manifestations are rare, but when present, may appear as an inflamed mass or inflammation of the orbital structures.\textsuperscript{30}

**Orbital Lymphoma**

Orbital lymphoma corresponds to up to \(\sim\) 12\% of all orbital tumor lesions and is typically non-Hodgkin lymphoma. It can occur anywhere in the orbit.\textsuperscript{1,31}

The EOMs lymphomas affect the muscular tendons (unlike thyroid ophthalmopathies), and the most common location of involvement is the superolateral quadrant, followed by the superomedial quadrant of the orbit.\textsuperscript{32}

Clinically, the patient may present with proptosis, palpable mass, and reduction of ocular mobility, with pain being an uncommon finding (unlike in cases of pseudotumor).\textsuperscript{16,33}

Extraocular muscles lymphomas are hyperdense expan- sive lesions in CT (\textsuperscript{\textdegree}Fig. 3) and have moderate contrast enhancement; it is difficult to differentiate them from orbital myositis. A study published in 2003 observed that lymphomas show a decrease in CT density with dual-phase contrast-enhancement protocol, whereas orbital myositis shows an increased density in the late phases.\textsuperscript{32,33}

In MRI, lymphomas are hypointense in T1 and hypo- to isointense in T2 with a homogeneous appearance on contrast enhancement.\textsuperscript{1,34}

**Orbital Metastasis**

Orbital metastasis represents 2\% of all orbital lesions, with the breast being the most common primary site. The EOM is most commonly affected by orbital metastases from cutaneous melanoma.\textsuperscript{1,31,35,36}

Generally, the symptoms are related to mass effect. A great majority is unilateral\textsuperscript{1,36,37} and can range from well-defined focal lesions to infiltrative lesions.\textsuperscript{36}

In the case of an already established metastatic cancer, biopsy of the orbital lesion is often not indicated.\textsuperscript{36}

Breast metastases often present with diffuse and irregular growth along the rectus muscles and fascial planes.\textsuperscript{38}

Computed tomography assists mainly in the diagnosis of prostatic metastases due to its predilection for bone with development of osteoblastic orbital metastases (\textsuperscript{\textdegree}Fig. 4).\textsuperscript{37}

![Fig. 3 Orbital lymphoma. A and B – Computed tomography without contrast shows left eyelid involvement with thickening of the bilateral extrinsic musculature (arrows). C and D – T1 postcontrast shows intense homogeneous contrast enhancement of the bilateral extrinsic musculature (arrows).](image1)

![Fig. 4 Orbital metastasis in computed tomography. A and B – Computed tomography without contrast shows thickening and densification of the periorbital soft tissues in the left orbit, with extension to the intraconal fat (arrows). C and D – Mass with left orbital infiltrative aspect showing intense enhancement after contrast, with intra- and extraconal components infiltrating the extrinsic musculature and involving the greasy planes and optic nerve, determining reduction of the caliber of the same and proptosis (arrows).](image2)
Signal intensity in MRI exhibits some degree of contrast enhancement and varies depending on the primary site of metastasis.\textsuperscript{39}

**Thyroid Ophthalmopathy**

Graves ophthalmopathy is the main cause of proptosis in adults. It is usually bilateral and with symmetrical involvement of EOMs. The muscle most commonly involved is the inferior rectus, followed by the medial, superior, and lateral recti, usually known by the mnemonic “I’M SLOW” (\textsuperscript{→}Fig. 5).\textsuperscript{1,32}

It is more commonly seen in patients with hyperthyroidism but can also be found in patients with hypothyroidism or normal thyroid function.\textsuperscript{1,40}

Computed tomography and MRI examinations evidenced thickening of the EOMs with relative preservation of the tendon insertions, increase of retroocular orbital fat, and may present contrast enhancement. Muscle bellies are typically hypodense in CT and hyperintense in T2 (\textsuperscript{→}Fig. 6).\textsuperscript{1,40,41}

**Miscellaneous**

Less common diseases, such as Crohn disease, Behçet disease, rheumatoid arthritis, Lyme disease, and systemic lupus erythematosus can also affect the extrinsic ocular musculature.

Patients with Crohn disease may exhibit ocular manifestations, mainly episcleritis and uveitis and, less commonly, orbital myositis.\textsuperscript{42}

The ocular involvement in Behçet disease is already well established in the literature and is usually considered when uveitis and vasculitis occur simultaneously. Patients with Behçet disease may also present with orbital myositis, although there are few reports on its occurrence.\textsuperscript{43}

Rheumatoid arthritis, systemic lupus erythematosus, and Lyme disease may also manifest with orbital myositis.\textsuperscript{44–46}

\textsuperscript{→}Table 1 summarizes the main imaging features of the pathologies mentioned in this iconographic essay.

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>Imaging Features</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cellulitis</strong></td>
<td>Edema, pain, and proptosis</td>
</tr>
<tr>
<td></td>
<td>Abscess presents as hypodense with orbital fat densification, and peripheral impregnation</td>
</tr>
<tr>
<td></td>
<td>T1-isointense T2- hyperintense peripheral and annular impregnation</td>
</tr>
<tr>
<td><strong>IOIS</strong></td>
<td>Acute pain, edema, and erythema</td>
</tr>
<tr>
<td></td>
<td>Focal or infiltrative with tendon thickening</td>
</tr>
<tr>
<td></td>
<td>T1- hypointense T2- hypointense Contrast enhancement - muscle, tendons and fat.</td>
</tr>
<tr>
<td><strong>Lymphoma</strong></td>
<td>Proptosis, palpable mass</td>
</tr>
<tr>
<td></td>
<td>Moderate contrast enhancement</td>
</tr>
<tr>
<td></td>
<td>T1-hypointense T2- hypo/isoointense homogeneous enhancement</td>
</tr>
<tr>
<td><strong>Metastasis</strong></td>
<td>Symptoms related to mass effect</td>
</tr>
<tr>
<td></td>
<td>Varies</td>
</tr>
<tr>
<td></td>
<td>T1-varies T2-varies some degree of contrast enhancement</td>
</tr>
<tr>
<td><strong>Thyroid ophthalmopathy</strong></td>
<td>Bilateral, symmetrical involvement of EOM</td>
</tr>
<tr>
<td></td>
<td>Thickening of the EOM with relative preservation of the tendon insertions. Muscle bellies are hypodense.</td>
</tr>
<tr>
<td></td>
<td>T2- Muscle bellies are hyperintense.</td>
</tr>
</tbody>
</table>

Abbreviations: EOM, extrinsic orbital musculature.
Conclusion

Computed tomography and MRI help in the diagnosis and follow-up of the diseases that affect the EOMs. We must be conversant with the main characteristics of the pathologies presented in the present case series since such findings together with clinical data can confirm the diagnosis of these diseases or at least help to narrow the differential diagnoses.

Ethics Approval and Consent to Participate

Ethical approval was provided by the HUCAM Institutional Review Board (CAAE - 08119819.8.0000.5071), Brazil.

Availability of Data and Materials

The datasets used and/or analyzed during the present study are available from the corresponding author on reasonable request. All data generated or analyzed during the present study are included in the present published article (and its supplementary information files).

Contributions of the Authors

Santana L. M. and Rosa-Junior M analyzed and interpreted the patient data regarding CT and MRI and were major contributors in the writing of the manuscript. Martins L. A. analyzed and interpreted the patient data regarding CT and MRI and made the figure slides. All authors read and approved the final manuscript.

Conflict of Interests

The authors have no conflict of interests to declare.

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