Among the fibers: A multimodality imaging review of intramuscular mass lesions

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Abstract
The common presentations of patient complaints regarding the musculoskeletal system, such as pain, swelling, and restriction of movement, lead to the imaging discovery of various lesions often located in, or arising from, skeletal muscle in the region of interest. Knowledge of the patients’ clinical history, laboratory parameters, and various imaging characteristics of the implicated lesions would assist the radiologist in coming to a timely, reasonably accurate conclusion about the etiology of the patient’s complaints, the severity of disease, and in directing patient therapy.

Key words: Abscess; intramuscular; hemangioma; hematoma; lipoma; liposarcoma; myocysticercosis; myositis ossificans; sarcoma; vascular malformation

Introduction
The common presentations of patient complaints regarding the musculoskeletal system lead to the imaging discovery of various lesions of skeletal muscle, of varied etiology, including traumatic, infectious, autoimmune, inflammatory, neoplastic, and iatrogenic. Imaging may help in their timely diagnosis, avoid unnecessary surgical intervention, and provide guidance for pathological diagnosis.

Intramuscular Abscesses
Infection and subsequent inflammation of muscle may be due to varied etiology, such as hematogenous septic seeding (bacterial, fungal), direct extension from a local source of infection (i.e., osteomyelitis, cellulitis), or via a parallel autoimmune response to remote infection, such as in Lyme disease and influenza. The most common microbe implicated is Staphylococcus aureus, and in a Koch’s endemic country like India, Mycobacterium tuberculosis.

On ultrasonography (USG), abscesses typically appear as variably defined heteroechoic collections, with internal debris and occasional septation. Enlargement of the affected muscle is seen. Perilesional vascularity is marked on color Doppler, and edema with inflammatory changes is noted to surround the lesion. On computed tomography (CT), enlargement of the muscle with surrounding fat-stranding is noted. The abscess per se appears as a focal hypodensity with peripheral rim enhancement with contrast, which helps differentiate it from myonecrosis, which does not show...
enhancement. On magnetic resonance (MR) [Figure 1], muscular enlargement with edema is present as T2 hyperintensity. The abscess appears T1-hypointense and T2-hyperintense, with peripheral contrast enhancement and occasional internal septation and fluid–fluid level [Figure 2A and B]. However, signal intensity may vary depending on the proportion of blood/proteinaceous material present within the cavity. This may cause confusion in the differentiation of abscesses and hematomata.

Though abscesses intuitively appear to present as acute collections, they may mimic a malignant mass lesion in the subacute or chronic clinical scenario. In such cases, cold abscesses caused by \(M. \text{tuberculosis}\) are to be considered. Occurring as a consequence to unmitigated infection of the vertebrae (i.e., Pott disease) [Figures 3 and 4], these muscular collections often coexist with destructive vertebral lesions and other stigmata of Koch’s. On imaging, they are seen to appear similar to their acute counterparts.

### Intramuscular Benign Tumors

**Lipoma**

Lipoma are the most common benign mesenchymal soft-tissue tumors. Intramuscular lipomata are uncommon

![Figure 1: Femoral osteomyelitis in a 40-year-old male with left thigh pain. Axial STIR MR image of bilateral thighs shows left proximal medullary femoral hyperintensity with spread into the adductor and hamstring muscles. Incidental STIR hyperintensity of the right gluteus maximus noted after intramuscular injection administration](image)

![Figure 2 (A and B): Abscess within the quadriceps in a 20-year-old immunocompromised female. (A) Sagittal T1W and (B) sagittal T2W images of the thigh showing fluid–fluid level in a suppurative collection within the vastus intermedius](image)

![Figure 3: Cold abscess in a 42-year-old male with active pulmonary Koch’s. Axial contrast-enhanced (CE) CT image shows a well-defined, peripherally enhancing hypodensity in the left psoas, crossing the midline. Aspirates revealed acid fast bacilli (AFB)](image)

![Figure 4: Cold abscess in a 67-year-old lady with lower back ache. Coronal MRI shows a T2/STIR hyperintense collection noted within the right psoas muscle, noted to extend from the L1-L2 intervertebral disc. Histopathology confirmed the presence of AFB. Incidentally noted is a right renal cyst](image)
and constitute just over 1.8% of all primary tumors of adipose tissue and <1% of all lipomas.\textsuperscript{[3]} On ultrasound (US), they are usually well-defined, hyperechoic masses with scanty internal vascularity.\textsuperscript{[2]}

On CT [Figure 5], lipomata are usually well-defined and homogeneous, with a low tissue attenuation (approx. –65 to –120HU), without contrast enhancement. On MR imaging (MRI) [Figure 6A–D], the signal intensity of lesion parallels that of subcutaneous fat on all sequences, being hyperintense to skeletal muscle on both T1- (T1W) and T2-weighted (T2W) images.

**Hemangioma**

Hemangiomata frequently involve soft tissue. Soft-tissue hemangiomata are benign endothelial neoplasms that histologically resemble normal blood vessels. Intramuscular hemangiomata account for approximately 0.8% of all benign soft-tissue tumors.\textsuperscript{[3]} US can identify abnormal Doppler flow patterns or features consistent with phleboliths. Angiography may demonstrate the fine vascular details of a hemangioma, useful when embolization or surgical resection of complex lesions is considered. Presence of fat within a hemangioma is characteristic, and often serves to differentiate it from an intramuscular arteriovenous malformation (the latter of which tends to exhibit phleboliths). On MRI [Figure 7A–C], T1W images show an amorphous low-to-intermediate signal intensity mass with ill-defined margins due to peripheral flow voids and variable intralesional fat suppression [Figures 8A,B and 9A,B]. T2W images show low-signal intensity in areas of vascular components. Plain CT [Figure 7D] generally shows a poorly defined lesion with attenuation similar to that of skeletal muscle.

**Neurofibroma**

Neurofibromata [Figure 10A and B] are benign peripheral nerve sheath tumors, usually solitary and sporadic.

A majority of cases are localized (90%), and not associated with neurofibromatosis Type 2.\textsuperscript{[4]} They may also be diffuse or plexiform, the latter being pathognomonic of neurofibromatosis Type 1. On CT, localized neurofibromata are well-defined, hypodense, and show little-to-no contrast enhancement. On MR, they appear T1-hypointense, T2-hyperintense, and show heterogeneous contrast enhancement.

**Desmoid Fibromatosis**

Desmoid fibromatoses [Figure 11A and B] are a rare (incidence of 0.03% of all neoplasms\textsuperscript{[5]}), broad group of fibroproliferative lesions that show myofibroblastic cells, dense collagen deposition, and variable myxoid stroma. Aggressive desmoid fibromas show local infiltrative growth and recurrence, but are unable to metastasize. They may occur in the fascial or musculo-aponeurotic planes. On USG, they have smooth, sharp margins with variable echogenicity; unenhanced CT may show a well-defined hyperattenuating intramuscular lesion with variable contrast enhancement. MR reveals hypointensity on T1 and T2 weighting, with moderate to marked contrast enhancement.

**Myxoma**

Intramuscular myxomas [Figure 12A–C] are a rare benign type of soft-tissue myxoma, which present as deep-seated masses composed of fibroblasts and abundant myxoid stroma. With an incidence of approximately 0.1 per 100,000, the average age of detection is 40–60 years predominantly in female patients.\textsuperscript{[6]} USG reveals a hypoechoic mass with a heterogeneous echotexture, often with posterior acoustic enhancement. On MR, it appears T1-hypointense,
T2-hyperintense, and shows variable peripheral and internal contrast enhancement.[3]

**Hamartoma**

Mesenchymal hamartomata [Figure 13A–D] are usually benign collection of heterotopically located mature soft tissue. They may contain muscular, lipomatous, fibrous, and neural components.

US reveals a homogeneously isoechoic, vascular lesion. On MRI, the lesion appears T1 iso-to-hypointense, and T2 and short inversion time inversion recovery (STIR) hyperintense.
they appear T1-hypointense and T2-hyperintense, with variable contrast enhancement. Foci of necrosis within the tumor herald a poor prognosis.

**Diffuse large B-cell lymphoma**

Diffuse large B-cell lymphoma (DLBCL) is the most prevalent form of non-Hodgkin’s lymphoma (NHL), and has a high incidence among the elderly, with a predilection for involving the muscles surrounding the pelvic girdle. Primary involvement of skeletal muscle by DLBCL is exceptionally rare, and accounts for 0.5% of all extranodal lymphomas. US of the same may reveal diffusely bulky muscle, and may sometimes show a heterogeneous, hypoechoic variably defined mass in the substance of the muscle. On CT, the affected muscle(s) appears bulky and shows diffuse contrast enhancement. MRI [Figure 16] is considered superior in imaging of primary muscular lymphomas. Isointensity to muscle on T1W images and hyperintensity on T2W images are seen.

**Atypical lipomatous tumors**

Atypical lipomatous tumors (ALT) is the new term that has replaced the older “liposarcoma” (according to the World
common soft-tissue sarcoma, accounting for 10–35% of all cases. Lesions are commonly intramuscular, and involve the lower extremity (i.e., thigh) more frequently than the upper. On US, a heterogeneous, multilobulated, typically well-defined mass is noted. CT and MR show a well-defined, lobulated, predominantly fat-intensity lesion with foci of nonadiposity within. Nonlipomatous components are most often seen as prominent thick septa (>2 mm) that may show nodularity, and this serves to differentiate it from a lipoma. Moderate to marked enhancement of the septa is noted with contrast.

**Secondary intramuscular malignant tumors**

Metastases to skeletal muscle are rare, and are seen in 16–17.5% of all autopsies of cancer patients with widespread metastatic disease, predominantly in the musculature of
the trunk. The common primaries involved are genital tumors (24.6%), gastrointestinal tumors (21.3%), urological tumors (16.4%), and malignant melanoma (13.1%), bronchial carcinoma (8.2%), thyroid gland carcinoma (4.9%), and breast carcinoma (3.3%).

On US, muscular metastases are noted to be variably defined, hypoechoic masses within the substance of the muscle. The CT appearance [Figure 18A and B] is usually that of hypoattenuating lesions with variable definition and contrast enhancement.

On MRI [Figure 19A and B], skeletal metastases appear isointense to muscle on T1 images, show heterogeneous signal with perilesional edema on T2 images, and show peripheral enhancement on contrast images [Figure 20A–C]. A rare tumor to metastasize muscle is synovial sarcoma. Despite its name, synovial sarcoma is not of synovial origin, and is usually extraarticular. Common occurrence is within the soft tissue around the joints of the extremities (lower limb commonly) [Figure 21A–D]. The ultimate diagnosis of a suspected muscular metastasis, however, is via histopathology.

Myositis ossificans
Myositis ossificans (MO) is the occurrence of heterotopic ossification that usually follows trauma to the associated joint. It may also occur without history of trauma, in paraplegics. MO circumscripta is heterotopic calcification that follows trauma, whereas MO progressiva (now known as fibrodysplasia ossificans progressiva) is a rare inherited disorder inherited predominantly via sporadic mutation.

Myositis ossificans circumscripta
MO circumscripta on radiographs appear as peripherally ossified, centrally lucent masses usually found around joints. Calcification usually starts by approximately 2 weeks, and assumes its classical appearance by 2 months. CT findings [Figure 22A] are similar, demonstrating calcification that proceeds from the periphery to the center.

On MRI [Figure 22B–D], features vary with the age of the lesion. Early MO is T1 isointense to muscle, T2 hyperintense peripherally, and heterogeneously hyperintense centrally. Late MO resembles bone and shows low peripheral and high central intensity on both sequences. While early MO may heterogeneously enhance, late MO usually does not.
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Myositis ossificans progressiva

MO progressiva [Figure 23] is characterized by insidious fibrosis and calcification of muscles, ligaments, and tendons that ultimately proves fatal due to involvement of the respiratory musculature.

Intramuscular hematomata

Intramuscular hematomata may be spontaneous, or secondary to hemorrhagic diathesis, anticoagulant therapy, trauma, tumor, recent surgery, or biopsy. In muscular trauma, blunt injury is commonly implicated. US imaging of acute mild muscular trauma may reveal focal isoechoic muscle swelling against the background of the undamaged muscle tissue. The appearance of more severe contusions with hematoma formation varies with the elapsed time: within 24 hours, hematoma may appear both hypo- and hyperechoic. In the following days, hematomas may appear hypo- or anechoic, until coagulation renders them inhomogeneous. Ultimately, they resolve, sometimes with residual scarring. In case of incisive injuries, US may reveal disrupted muscle fibers with local hematoma [Figure 24A].

CT images [Figure 24B and C] show increased bulk of the affected muscle, with intramuscular hyperdensity (>40 HU), representing acute bleed. As it develops, a focal hypodensity takes its place. MR appearance [Figure 25A and B] varies with the age of the hematoma: acute hematoma show iso-hypointensity to muscle on T1W; and slightly hypo- or hyperintensity on T2W. Subacute hematoma show three levels of intensity on T1 images: a low-intensity capsular sign, high-intensity in the peripheral zone, and central isosignal.

As the hematoma develops, the central and peripheral signal intensities tend to decrease, on both T1W and T2W sequences. Chronic hematomas may present with hypointense collections on T1W images and hyperintense on T2W images. In all cases of suspected hematoma, clinical/sonological follow-up must be done till resolution, in order to conclusively rule out a hemorrhagic sarcoma.

Intramuscular vascular malformations

Vascular malformations need to be differentiated from true vascular neoplasms such as hemangioma, as this holds therapeutic and prognostic significance. Vascular malformations are classified on the basis of MRI as being either high-flow malformations [arteriovenous (AV) malformations, AV fistulae], or slow-flow malformations (venous, lymphatic, capillary, or combined).

On US, venous malformations appear as multiple compressible dilated tortuous veins clumped together. Color Doppler flow [Figure 26A] and venous waveform should be sought within this lesion, which, if present, is diagnostic. Changes in flow are noted with maneuvers such as gravity dependency and Valsalva. However, due to sluggish flow, flow may be absent altogether. Phleboliths may be seen [Figure 27], which is often the distinguishing characteristic between an arteriovenous malformation and a hemangioma, the latter of which tends to contain intraleisional fat. On MRI, the slow-flow channels are seen as T2-hyperintense lobules or serpiginous channels. Contrast MR shows delayed, heterogeneous enhancement [Figures 26B and C, 28A–C].

Myocysticercosis

Cysticercosis is a parasitic infection caused by ingestion of the eggs of Taenia solium or Taenia saginata, transmitted through the feco-oral route. Humans are a definitive host

Figure 23: Myositis ossificans progressiva (fibrodysplasia ossificans progressiva) in a 26-year-old male with progressive breathing difficulty. Unenhanced axial CT of the chest reveals extensive muscular ossification involving the left anterior chest and upper limbs. Band-like ossification is noted involving the interscapular region

Figure 24 (A-C): Hematoma in a young male with history of trauma to the abdominal wall. (A) Heteroechoic psoas hematoma on ultrasound; (B) Unenhanced axial CT image shows heterodense collections within the right psoas muscle, and anterolateral abdominal musculature; (C) Axial CECT of the pelvis shows lack of enhancement
for the adult parasite. Cysticerci are the larval stage of the tapeworm, and may be found disseminated in neural and soft tissue, where it incites an inflammatory reaction and may calcify over extended periods of time. The clinical differential diagnosis for soft-tissue cysticercoses may be lipoma, epidermoid cyst, abscess/pyomyositis, tuberculous lymphadenitis, myxoma, neurofibroma, or fat necrosis.

Diagnosis may be made on the basis of radiographs, which may show multiple calcified specks (so-called “rice-grain” calcification) in the substance of muscle. US may reveal a well-defined lesion with surrounding perilesional edema, often revealing the parasite’s scolex within [Figure 29].

On MR [Figure 30A and B], it appears hypointense on T1W and hyperintense on T2W images. Peripheral rim enhancement of the cyst wall may be seen. Intramuscular cysts are oriented in the direction of the muscle fibers. The scolex may be seen as a tiny hypointense speck within the hyperintense cyst. Presence of such a lesion in a patient with known neurocysticercosis should always raise suspicion for myocysticercosis.

**Intramuscular endometriosis**

Endometriosis is the presence of endometrial tissue outside the uterine cavity. Abdominal wall endometriosis may occur following the implantation of endometrial cells into the soft
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tissues of the abdominal wall after open uterine surgeries like cesarean sections. The incidence rate is reported at 0.4–0.1%.\(^{14}\)

US [Figure 31A] reveals a heterogeneous hypoechoic, irregularly margined lesion within the affected muscle (commonly the abdominal recti). Color Doppler may reveal flow. On CT [Figure 31B], irregularity and bulkiness of the affected muscle may be seen, with occasional hyperdense/hypodense foci within, representing the endometrial islands. MR reveals a poorly contrast-enhancing heterogeneous hypo-hyperintense area within the affected muscle, with muscle bulkiness.

**Conclusion**

Imaging of patients with musculoskeletal complaints may reveal the presence of various intramuscular lesions that may not be readily apparent on clinical examination. Oftentimes, a dire diagnosis may masquerade under a clinically benign presentation, and keeping in mind the various imaging characteristics of the implicated lesions would assist in coming to a timely, reasonably accurate conclusion about the etiology of the patient’s complaints and the severity of disease, in addition to helping sample the lesion for histopathology and in directing patient therapy.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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