

Answers to the Medical Quiz

1. The fundus picture shows the presence of choroidal folds at the macular area, which are more apparent above the macula.
2. The B mode echography shows a well-encapsulated round lesion in the orbit behind the eyeball, which has produced pressure indentation of the sclera resulting in induced hypermetropia. The A mode echography shows reduced axial length and high reflective echoes within the lesion.
3. Vision is reduced because of the induced hypermetropia due to indenting of the eyeball.
4. An MRI with contrast.

The clinical picture and echography suggest a vascular space occupying lesion within the orbit most likely a cavernous haemangioma.

Vascular lesions cause about 11% of clinical orbital disease¹. Intermittent exophthalmos, vascular engorgement with Valsalva maneuver, orbital pulsation or bruit and haemorrhage are suspicious features of orbital vascular disease. Most common orbital vascular pathology could be hamartomas, neoplasms and arteriovenous malformations. Cavernous haemangiomas are benign, low flow non-infiltrative vascular hamartomas. Orbital cavernous haemangiomas are normally isolated lesions but can rarely be associated with multiple haemangiomas elsewhere in the body as a part of the blue rubber bleb naevus syndrome. Posterior pole choroidal striae without proptosis are a rare occurrence and induced hypermetropia as a cause of initial presentation is also a rare event. MRI offers better definition of details and localization. MRI demonstrates the lesion as isointense to muscles and gray matter on T1 and hyperintense on T2 weighted images which show progressive enhancement with contrast². Ultrasonography shows a well-demarcated mass with high reflective echoes within due to multiple blood filled vascular channels³. Surgical excision of the encapsulated mass is the ideal mode of management of the symptomatic patient.

REFERENCES

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3. Byrne SF. Standardized echography in the differentiation of orbital lesions. *Survey of Ophthalmology* 1984; 29: 226-8.

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