Orbital myositis presenting with only unilateral orbital pain

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DESCRIPTION
A 24-year-old woman developed sudden severe periorbital pain characterised by severe, unilateral, pounding, short-lived, repetitive pain. Consequently, she was diagnosed with paroxysmal haemichania at the first visit. There was no history of diplopia or other ophthalmic symptoms. Her physical and other neurological findings were normal. Anti-thyroid and antinuclear antibodies were negative. IgG4, soluble interleukin-2 receptor, C-reactive protein and creatine kinase levels; cerebrospinal fluid analysis; and CT scan were normal. MRI revealed enlargement and increased signal in the left medial rectus muscle on gadolinium-enhanced T1-weighted imaging suggesting orbital myositis (OM) (figure 1A,B). The patient was treated with three cycles of intravenous methylprednisolone (IVMP) followed by oral prednisolone 30 mg/day, resulting in rapid resolution of the symptoms. There was no relapse after reducing the prednisolone dosage, and MRI findings were almost resolved after 2 months of steroid therapy (figure 1C,D). The most frequently used medication of OM is oral corticosteroid, and IVMP has been effectively used in some patients.1 OM is an idiopathic non-infectious inflammatory disease primarily involving extraocular muscles, characterised by acute-onset orbital pain often accompanied with diplopia, ptosis, chemosis and conjunctival injection;1 2 however, orbital myositis could develop only severe orbital pain.

Learning points
► Orbital myositis is classically characterised by acute-onset orbital pain often accompanied with ophthalmic symptoms (eg, diplopia, ptosis, chemosis and conjunctival injection); however, orbital myositis could develop only severe orbital pain.
► Orbital myositis could mimic symptoms of paroxysmal haemichania or cluster headache.
► An MRI of the orbit is helpful for diagnosing orbital myositis with atypical symptoms.
other ophthalmic symptoms; however, we should consider the possibility of OM in such a setting, and MRI would be helpful in the diagnosis process.

Contributors SU was a major contributor in writing the manuscript. TU and DY also treated the patient and interpreted the patient data. All authors read and approved the final manuscript.

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