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Orbital pseudotumour secondary to giant cell arteritis: an unreported condition

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Giant cell arteritis causes sudden blindness but may also cause ophthalmoparesis, attributable to infarction of the cranial nerve or extraocular muscle. Orbital pseudotumour associated with painful diplopia has been recognised in other types of vasculitis but not previously in giant cell arteritis.

Case report

A 66 year old woman gave a 10 day history of malaise, fever, aches in the head and eye, pain in the cheeks worsened by chewing, and tender lumps on her temples. Sinusitis had been diagnosed, and she had been treated with oral co-trimoxazole, amoxycillin and clavulanic acid, and ciprofloxacin for seven days, and with intravenous amoxycillin and clavulanic acid for one day, with no relief. For two days she experienced diplopia and noticed prominence of her right eye. When examined she had a fever (37.5°C) and dilated, pulsatile, non-tender temporal and occipital arteries. There was 4 mm right sided proptosis, measured with an exophthalmometer, and globally restricted right eye movements; there was no ptosis, abnormality of the pupils or optic discs, loss of visual acuity, or sensory loss. The erythrocyte sedimentation rate (Westergren method) was 122 mm in the first hour and her white cell count was normal, but aspartate transaminase and alkaline phosphatase activities were moderately raised. Examination of the cerebrospinal fluid showed a lymphocyte count of $7 \times 10^6/l$. Computed tomography of the orbits confirmed proptosis of the right globe with normal extraocular muscles and paranasal sinuses. A temporal artery biopsy subsequently confirmed the diagnosis of giant cell arteritis.

She was treated with oral prednisolone 80 mg daily. Within six hours her headache improved and within 36 hours she no longer had fever or diplopia and the

proptosis had resolved. After 10 days the erythrocyte sedimentation rate and liver enzyme activity were normal. She was well four months after presenting, taking gradually reduced doses of steroids.

Comment

Patients with giant cell arteritis have occasionally experienced diplopia and presented with extraocular muscle paresis.¹ This is often attributable to infarction of the cranial nerve trunk,¹ although ischaemic necrosis of the extraocular muscle has also been shown.² Perivascular oedema accompanying vasculitic conditions such as polyarteritis nodosa³ and Wegener's granulomatosis⁴ can lead to varying degrees of inflammation of the orbital soft tissue. When this affects extraocular muscle (orbital myositis) painful diplopia may occur; more extensive diffuse or discrete orbital inflammation (orbital pseudotumour) with painful proptosis and ophthalmoparesis has also been seen. Although orbital pseudotumour has not been described previously in patients with giant cell arteritis, its occurrence was predicted in a recent review.⁵ Giant cell arteritis was confirmed histologically in our case, and the prompt resolution of painful proptosis induced by steroid treatment supports the diagnosis of orbital pseudotumour associated with vasculitis causing globally restricted eye movements. It was unlikely that our patient had an infection of the orbit as no organism or source was identified, and she responded rapidly to steroids but not to broad spectrum antibiotics.

Recognising that giant cell arteritis may cause painful orbital pseudotumour may prevent a delay in diagnosis and reduce the threat to vision.

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Injuries caused by tripping over paving stones: an unappreciated problem

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Injuries sustained by people tripping over uneven or broken paving stones are not uncommon, though the incidence and severity of such injuries have not been recorded. We studied the number and type of such injuries recorded by our hospital.

Patients, methods, and results

Cases were collected retrospectively by analysis of the medicolegal reports prepared in our department during the 12 months January to December 1988. In addition, we included those patients seen prospectively in the fracture clinic during the three months January to March 1989. Only patients whose injuries had been directly caused by tripping over uneven, broken, or loose paving stones were included.

We found 27 fractures in 24 patients and one case of anterior dislocation of the shoulder. The table gives details of the injuries. Internal fixation was required in four cases. The other patients were treated conservatively, though six required manipulation of their