Case Report

Orbital Lymphoma Masquerading as Orbital Cellulitis

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Background. Orbital lymphomas are primarily non-Hodgkin type and can originate from the eyelids, extracellular muscles, soft tissue orbital adnexa, conjunctiva, or lacrimal glands. Orbital malignancies often represent a diagnostic dilemma for clinicians given their varying and atypical presentations. Objective. To report a case of orbital lymphoma mimicking orbital cellulitis. Case. A 66-year-old male patient presented with sudden onset of painful proptosis with visual impairment in the left eye for 15 days. On ocular examination, best-corrected visual acuity was 6/12 in the right eye and 2/60 in the left eye, abaxial proptosis with hypertropia, swollen and erythematous eyelids, restricted extraocular movement in all cardinal position of gaze, conjunctival congestion with chemosis and tortuous vessels, sluggish pupillary reaction, and chorioretinal folds in the inferior quadrants. The case was diagnosed as left eye orbital cellulitis, and the patient was treated with broad-spectrum intravenous antibiotics and oral steroids. No clinically discernible response was noted despite 7 days of antibiotics and steroids. Contrast-enhanced computed tomography (CECT) orbit showed features suggestive of orbital lymphoma involving the ipsilateral maxillary and ethmoid sinuses. ENT consultation with diagnostic nasal endoscopy and biopsy was done. Histopathological reports showed features of non-Hodgkin lymphoma. Conclusion. Orbital malignancies masquerading as orbital cellulitis can pose a diagnostic dilemma. A multidisciplinary approach involving ENT consultation, radiological investigation, and pathological sampling can help achieve a timely diagnosis and appropriate management.

1. Introduction

Orbital lymphomas are a common type of non-Hodgkin lymphoma (NHL). It primarily originates from the eyelids, extracellular muscles, soft tissue orbital adnexa, conjunctiva, or lacrimal glands. It is most commonly located on the extraconal site, mostly anterior in the orbit or beneath the conjunctiva with a typical “salmon-patch appearance.” Lymphoma originating from one of these locations is called primary orbital lymphoma. Lymphoma originating from extraorbital sites with metastatic spread to the orbit is secondary orbital lymphoma [1]. Among all orbital malignancies, 55% are lymphoma [2]. The incidence of orbital lymphoma lies between 1 and 10% of all NHL and 5 and 15% of all extranodal NHL [3, 4]. Orbital lymphoma can be seen from 15 to 70 years, but most cases occur between 50 and 70 years. It is most commonly seen in Asian and European populations with no gender predominance [1]. Of all orbital lymphoma, 75% are unilateral, 25% are bilateral, and 40% are associated with systemic disease [4].

The major factor contributing to the pathophysiology of orbital lymphoma is immune-compromised conditions like ageing, HIV/AIDS, or immunosuppressive drugs. Recently, studies have suggested that pathogens like Chlamydia psittaci, H. pylori, and some viruses are associated with orbital lymphoma [1]. Lymphomas of B-cell lineage are more likely
to be associated with symptoms related to the eyes and have extended to the orbit than lymphomas of T-cell or NK-cell lineage [5]. Orbital lymphomas most commonly present with proptosis, a slow-growing palpable mass, or a painless swelling of the eyelids [6]. Orbital cellulitis is an infectious condition of the orbit that can lead to blindness or death. Important causes include trauma, upper respiratory tract infection, and sinus infections [7]. This case report is aimed at discussing orbital cellulitis as a rare mode of presentation of orbital lymphoma.

2. Case Description

A 66-year-old Nepalese male patient presented in the Outpatient Department (OPD) of Ophthalmology, B.P. Koirala Institute of Health Sciences, with sudden onset of painful proptosis associated with visual impairment in the left eye for 15 days (Figure 1). Other associated features were nasal stuffiness and nasal bleeding on and off but not associated with fever, recent weight loss, or night sweats. On general examination, lymph nodes were not palpable. On examination of the right eye (RE), best-corrected visual acuity (BCVA) was 6/12 with an immature senile cataract of grade I and the rest of ocular examination was within normal limits. On examination of the left eye (LE), BCVA was 2/60 with accurate projection of rays. The left eye showed abaxial proptosis with hypertropia, diffuse swelling, and erythema over the upper and lower eyelids with restricted extraocular movements in all cardinal positions of gaze. There was diffuse conjunctival congestion with chemosis and dilated tortuous vessels over the upper bulbar conjunctiva (Figure 2). Sluggish pupillary reaction in the left eye, lens, and vitreous findings was within a normal limit. A dilated fundoscopic examination of the left eye revealed optic disc edema of one diopter elevation with choroidal folds in the inferior quadrants (Figure 3). Hertel’s exophthalmometry measurement (at base of 112) was 16 mm in the right eye and 28 mm in the left eye. The intraocular pressure was 12 mmHg in the right eye and 30 mmHg in the left.

USG B-scan of the left eye showed normal intraocular structures with the presence of homogeneous mass behind the globe inferiorly (Figure 4). The patient was admitted with the provisional diagnosis of left eye orbital cellulitis in the stage of an orbital abscess with compressive optic neuropathy. Routine blood investigations were within normal limits. The patient was immediately started on a treatment of broad-spectrum intravenous Ceftriaxone 1 gm BD for 7 days, intravenous Gentamycin 80 mg TDS for 7 days, oral Metronidazole 400 mg TDS for 7 days, eye drop Ofloxacin (0.3%) QID in the left eye, and oral Prednisolone 60 mg OD the next day.

There was no improvement despite two days of intravenous antibiotics and oral steroid; contrast-enhanced computed tomography (CECT) orbit showed homogeneously enhancing soft tissue component in the retroorbital space involving the intracranial compartment including the optic nerve with an adjacent extraconal spread. It also involved the soft tissue of the anterior orbit with homogenous opacity in the ethmoidal and maxillary sinuses with few probable sites of bony erosions (Figures 5(a) and 5(b)). Otorhinolar-
Radiological imaging, including a CT scan or MRI, can help diagnose and delineate the extension of the malignant lesion such as orbital lymphoma. Diagnostic confirmation mainly depends on the pathological biopsy for grading and staging of malignancy. Further categorization of orbital lymphoma is aided by immunohistochemistry, making it easy to formulate an appropriate treatment plan. In our case, the orbit seems to be the primary locus of the lesion rather than secondary metastasis, as the normal peripheral blood smear finding makes the chance of hematogenous origin less likely. A more systematic evaluation is still needed, however, to rule out metastasis. Regarding the treatment of localized orbital lymphoma, radiotherapy is appropriate for local control [18, 19]. For metastatic or systemic spread, chemotherapy or a combination of chemotherapy and radiotherapy is highly effective [20]. The prognosis of orbital lymphoma depends upon the various subtypes of lymphoma, as MALT lymphoma has a more favorable outcome than patients with other types of lymphoma [21]. To the best of our knowledge, orbital lymphoma infrequently mimics orbital cellulitis. Hence, to improve the overall prognosis of the conditions as described above, a holistic approach with early diagnosis and management is crucial.

Figure 1: Orbital cellulitis at presentation in the left eye (front and lateral view).

Figure 2: Conjunctival congestion with tortuous vessels in the left eye.

Figure 3: Blurred disc margin with chorioretinal folds in the left eye.

Figure 4: USG B-scan: homogenous mass distorting the globe inferiorly (as shown by an arrow) in the left eye.
4. Conclusion

Orbital lymphoma masquerading as orbital cellulitis can pose a diagnostic dilemma. Orbital imaging like CT scan or MRI should always be performed in a patient with painful proptosis, especially in unilateral cases, to exclude malignancy. A tissue biopsy is needed to confirm the diagnosis of lymphoma. Therefore, a multidisciplinary approach with ENT consultation, radiological investigation, and adequate pathological sampling is necessary to obtain a correct and timely diagnosis to decrease overall morbidity and mortality.

Data Availability

No data were used to support this study.

Ethical Approval

The identity of the patient has been kept anonymous in this case report. We obtained written and informed consent from the patient for the publication of case details and images.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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References


