globulin therapy may also have played a protective role through its immunoregulatory effect.²²

Conclusion

This case reaffirms that *Mycoplasma pneumoniae* should be considered in the differential diagnosis of an optic neuropathy preceded by a febrile illness. Moreover, it suggests that *Mycoplasma* may play a role in the induction of a white dot syndrome.

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Orbital masquerade: hyperthyroidism and cavernous haemangioma of the orbit

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Unilateral exophthalmos is a challenging clinical problem, and hyperthyroidism, statistically, is one of the most common causes in the adult population.

The possibility of other orbital inflammations or neoplasms coexisting with hyperthyroidism requires emphasis. In this report a case is presented where the patient had a history of chemical hyperthyroidism and cavernous haemangioma of the orbit previously unrecognized.

Case report

A 32-year-old woman presented on 15 September

1982 with a several week history of intermittent blurred vision in her right eye.

Her ocular history included variable exophthalmos in the right eye that was associated previously with documented hyperthyroidism of 3 years' duration. She had received a short course of propylthiouracil and propranolol, and is presently euthyroid.

On ophthalmic examination, her best corrected visual acuity was 20/20+2 right eye and 20/15-1 left eye. The pupils were normal and the extraocular movements were full. She was orthophoric at distance and had 6 prism dioptres of exophoria at near. No diplopia could be elicited.

Orbital examination revealed mild resistance

Figure 1 Illustration of axial proptosis with lateral displacement of the right eye.

to retropulsion on the right with no lid lag or retraction. Exophthalmometry readings at a base of 106 mm, measured 23 mm right eye and 18 mm left eye. (Fig 1). Colour vision testing was within normal limits in both eyes. However, the patient exhibited hesitation in her right eye while she easily identified the figures with her left. The intraocular pressure by applanation tonometry was normal in both eyes and rose insignificantly upon upgaze. The dilated fundus examination was within normal limits.

Because of unilateral proptosis, a paucity of clinical findings compatible with Graves' orbitopathy, and hesitation in the right eye on colour vision testing a high resolution orbital computed tomogram was ordered. The study demonstrated proptosis, normal muscle diameters, and a densely enhancing right intraconal tumour (Fig 2).

On 2 November 1982, a modified Kronlein orbitotomy was performed and a 23×17×14 mm purplish mass was removed without incident. The histopathological review was compatible with cavernous haemangioma.

Postoperatively, her best corrected visual acuity improved to 20/20+1 right eye, and exophthalmometry readings returned to within 0.5 mm of each other. Colour vision testing was executed with equal facility in both eyes.

Comment

The differential diagnosis of unilateral exophthalmos is extensive, but certainly that associated with hyperthyroidism is high on the list in the general population.^{1,2} The diagnosis may, at times, be elusive in patients with euthyroid Graves' orbitopathy, a disease which has a variable and often asymmetric expression. Orbital computed tomography (CT) is superlative in identifying the typical myopathy and/or anterior migration of orbital fat, often in the contralateral, unsuspected eye as well.

Cavernous haemangioma of the orbit is probably a congenital vascular tumour, although some have proposed an acquired local haemodynamic disturbance.³ It usually presents in the

Figure 2 Computed tomogram in axial projection reveals proptosis, normal muscle diameters, and a well-circumscribed, densely enhancing intraconal tumour.

second to fourth decade, and the symptoms characteristically develop over a number of years.^{4,5} Dynamic orbital CT (CT performed in multiple positions of gaze), highlights the cardinal radiographic features of cavernous haemangioma including absence of nerve or muscle attachments, contrast enhancement, secondary changes in the bony orbit, and usual location in the upper outer muscle cone sparing a small triangular space in the orbital apex.⁶⁻⁸

The coexistence of these two diseases, namely hyperthyroidism and cavernous haemangioma of the orbit, remained unnoticed in this patient until her recent presentation. This report underscores the high level of suspicion one must evoke in the face of unilateral exophthalmos, even in the patient with known hyperthyroidism.

What is required is a meticulous scrutiny of the details in the clinical examination, so that an educated decision with strict criteria can be made when ordering orbital CT either to elucidate the mechanical forces at play in tailoring therapeutic goals, or to establish the coexistence of a suspected neoplasm when the clinical clues are apparent.

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