LETTER TO THE EDITOR

A case of orbital myositis preceding the intestinal symptoms of Crohn’s disease

Dear Sir,

Muscle involvement is a rare extraintestinal manifestation of Crohn’s disease (CD). It can be related either to therapy or to disease related myositis or to a coexistent autoimmune disorder affecting the muscle. Colonic disease is more often associated with the myopathy than is small bowel involvement alone and precedes the development of myositis in most cases.

We present the case of a 35-year-old woman who was referred to our hospital due to diarrheas, low grade fever, weight loss of 9 kg and low back pain of 1 month duration. She had a medical history of unilateral orbital myositis one year ago that responded well to steroids. The findings on colonoscopy and biopsy specimens were compatible with CD, affecting mostly the right part of the colon, without involvement of the terminal ileum. Plain X-rays showed involvement of the sacroileal joints and Shobber test was positive. Treatment with a tapered dose of steroids and azathioprine combined with sulphasalazine was initiated with excellent response for the following period until present.

Orbital myositis (inflammatory orbital pseudotumor) is a non-specific inflammatory process of unknown origin, affecting one or more of the extraocular muscles. TNF-α mediated inflammation may be involved in its pathogenesis. Diagnosis is based on history, clinical manifestations, radiologic findings and therapeutic response to steroids. This situation may be recurrent and simulates to thyroid ophthalmopathy. There are a few case reports of orbital myositis as an extraintestinal manifestation of IBD.

We reviewed the MRI of the orbits that was performed in our patient one year ago, revealing minor left exophthalmos, with symmetric total enlargement of the left lateral rectus muscle, involving its tendinous insertion on the globe. The thickened muscle appeared with increased signal intensity on T2-weighted sequences and homogeneous enhancement on fat-suppressed T1-weighted sequences following Gadolinium administration (Fig. 1a,b). The symmetric total enlargement of the left lateral rectus muscle made the diagnosis of a unilateral solitary myositis and excluded thyroid myopathy, which is characterized by fusiform appearance of the enlarged muscle, without involvement of its tendon insertion.

We reasonably argue that the previous incidence of orbital myositis in our patient one year ago should be attributed to underlying subclinical CD. Of note no other obvious reason for the development of orbital myositis was discovered despite the thorough work-up that was done. Actually, the involvement of the sacroileal joints, which was shown even in plain X-rays, is a proof of CD of prolonged duration.
duration, despite the delayed development of intestinal symptoms. 

Differential diagnosis of orbital myositis should include inflammatory bowel disease taking into account that this rare extraintestinal manifestation can precede intestinal symptoms and can also coexist with other extraintestinal manifestations of Crohn’s disease.

References