structure, often showing diffuse enlargement with poorly defined margins. Unfortunately, CT does not reliably differentiate lacrimal involvement from other potential causes, including bacterial inflammation.[2] When extraocular muscles are involved, the muscle and tendons enlarge, resulting in a tubular configuration[2] that contrasts with the normal tendons of thyroid ophthalmopathy. Other potential CT findings include diffuse infiltration within orbital fat, a poorly-defined orbital mass, scleral enhancement, enlargement of Tenon's space, and infiltrations along the optic nerve causing diffuse enlargement.[2,7,8] In contrast, CT performed in cases of orbital cellulitis typically shows diffuse orbital infiltrate with decreased signal of orbital fat and may show sinus involvement, bony erosions or venous thrombosis.[8]

Corticosteroids are the mainstay of treatment, usually providing rapid regression of symptoms and decreasing the incidence of permanent disability due to sclerosis. Without treatment, the inflammation may diminish, but recurrent inflammatory episodes and residual fibrosis are common. Even with treatment, 23% to 56% of patients suffer recurrences.[4] In cases of diagnostic uncertainty, steroid resistance or recurrence, biopsy is suggested.[4] If the lesion is large and sclerotic, surgical debulking is an option.[4] Other treatment options include radiation therapy and immunosuppressive agents such as cyclosporine, cyclophosphamide, azathioprine and methotrexate.[4]

Conclusion

Orbital pseudotumour is a rare ophthalmologic condition that mimics a variety of pathologic processes, creating a diagnostic dilemma for emergency physicians. A careful history, physical examination, diagnostic suspicion and appropriate imaging are essential in arriving at the correct diagnosis.

Competing interests: None declared.

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Correspondence to: Dr. Tamara Thomas, Loma Linda University, Department of Emergency Medicine, 11234 Anderson St., Rm. A108, Loma Linda CA 92354; 909 558-4344, fax 909 558-0121, TThomas@ahs.llumc.edu

Erratum

In our January issue we listed the names of all the reviewers who had so kindly offered their time and expertise during 2005. Regrettably, John W. King's name was missed. — The Editors