Conclusion: proptosis is a relatively frequent symptom that can reveal several diseases, some of them can be life threatening.

was associated with a bilateral proptosis (81.3%), of grade II (68.8%), axial (93.8%) not painful (93.7%) and reducible (93.8%).

Cases (19.6%), orbital tumors in 8 cases (17.4%) and carotido-cavernous fistula in one case (2.1%). Women were more involved by hyperthyroidism (81.3%), and it (2.2%). Etiologies of the proptosis were dysthyroidism in 16 cases (34.8%), orbital cellulitis in 12 cases (26.1%), idiopathic orbital inflammatory disease in 9 cases (19.6%), orbital tumors in 8 cases (17.4%) and a case of carotido-cavernous fistula (2.1%).

grade III in 4 cases (8.7%). The proptosis was axial in 38 cases (82.6%). It was painful in 21 cases (45.6%). It was reducible in 23 cases (50%) and pulsatile in one case (2.2%). The etiologies of the proptosis were hyperthyroidism in 16 cases (34.8%), orbital cellulitis in 12 cases (26.1%), idiopathic orbital inflammatory disease in 9 cases (19.6%), orbital tumors in 8 cases (17.4%) and a case of carotido-cavernous fistula (2.1%).

0.48. The proptosis was unilateral in 32 cases (69.6%) and bilateral in 14 cases (30.4%). The proptosis was scaled as grade I in 22 cases (47.8%), grade II in 20 cases (43.5%) and grade III in 4 cases (8.7%).

Introduction

Proptosis is an abnormal protrusion of the globe. It is the consequence of the development of a process inside the orbit or a shallow orbit. It is a relatively common condition and the etiologies are various. The purpose of this study is to describe the clinical and etiological features of proptosis.

Materials and methods

We have conducted a retrospective and descriptive study based on patient’s records during 15 years, from January 2001 to December 2015. All patients went through a comprehensive ophthalmologic examination, and orbito-cerebral CT scan. T3, T4, TSH thyroid’s hormone dosage was realized upon on the clinical request. The clinical features and the etiologies of proptosis were analyzed.

Results

During the period, 46 cases of proptosis were identified. The mean age was 41.2 ± 18.8 [1;79] years. There were 15 men against 31 women with a sex ratio of 0.48. The proptosis was unilateral in 32 cases and bilateral in 14 cases. The proptosis was scaled as grade I in 22 cases (47.8%), grade II in 20 cases (43.5%) and grade III in 4 cases (8.7%). The proptosis was axial in 38 cases (82.6%). It was painful in 21 cases (45.6%). It was reducible in 23 cases (50%) and pulsatile in one case (2.2%).

The suspicion of proptosis requires confirmation by an exophthalmometer of Hertel or a Ludde rule or by CT scan or MRI. We decided to confirm cases of proptosis in this study by CT scan because it offers in the same time an etiologic investigation. The characteristics of proptosis contribute to determine their etiology. Bilateral proptosis can lead to inflammatory processes like hyperthyroidism or sometimes to lymphoma or metastasis. In our study, the proptosis was axial in 82.6%. The axial character of the proptosis indicates the space area occupied by lesions within the muscle cone. The reducibility of the proptosis has poor clinical value, but can induce an oculo-cardiac reflex [1]. Pain is a cardinal sign of inflammation and it is found mainly in the cellulitis, hyperthyroidism, and neoplasia. A case of proptosis in our study was pulsatile. Pulsation is associated with a bruit and it’s synchronous to

Discussion

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Abstract

Aims: To describe clinical and etiological features of proptosis.

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The pulse in the case of carotido-cavernous fistula. Proptosis in scaled by orbito-cerebral CT scan trough the oculo-orbital index. An index between 70 and 100, correspond to Grade I, grade II correspond to an index equal to 100, and for grade III the index is above 100.

The etiologies of the proptosis in our study are dysthyroidism in 16 cases (34.8%), orbital cellulitis in 12 cases (26.1%), idiopathic orbital inflammatory disease in 9 cases (19.6%) and a case of carotido-cavernous Fistula (2.1%). Dysthyroidism is the most frequent cause of the proptosis [2]. In our study, characteristics of thyroid orbitopathy are the same in the literature [3-5]. In about a quarter of the cases, proptosis can be unilateral and sometimes precedes the dysthyroidism [1], a situation which could lead to misdiagnosis. In our study we have found 18.7% of cases of unilateral exophthalmos linked to dysthyroidism.

Orbital cellulitis was the second cause of proptosis in our study with 26.1% of cases. In our practice, orbital cellulitis reveals a problem of early consultation and diagnosis with the risk of complications such as cavernous sinus thrombophlebitis, brain abscess and sometimes deaths [6,7]. The idiopathic orbital inflammatory disease represented 19.6% of cases of proptosis in our study. The CT scan imaging does not highlight a localized tumor and the diagnosis is confirmed by it regression with systemic steroid treatment.

Orbital tumors accounted for 17.4 percent of cases of proptosis. In childhood, rhabdomyosarcoma, and benign tumors like angioma or cyst are common. In adults less than 60 years, benign and inflammatory tumors are common. Malignancies like lymphomas and metastases are most commonly seen in subjects of more than 60 years [8]. A case of post-traumatic carotido-cavernous fistula is seen in our study. It is an abnormal communication between the carotid artery and cavernous veins. A part from the carotido-cavernous fistula, trauma can also cause dural fistula, orbital hematoma, or orbital emphysema [1,9].

The other etiologies of proptosis not found in our study are bone malformations or craniosynostoses like in Crouzon syndrome, Apert syndrome, Pfeiffer syndrome.

**Conclusion**

Proptosis is relatively common symptom and clinical and etiological investigation leads to various diseases. Dysthyroidism is the most frequent etiology of proptosis.

**References**


**Table 1. Characteristics of proptosis according to etiologies.**

<table>
<thead>
<tr>
<th>Grade n(%)</th>
<th>Sex n(%)</th>
<th>Unilateral n(%)</th>
<th>Axial n(%)</th>
<th>Painful n(%)</th>
<th>Reducible n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>II</td>
<td>III</td>
<td>F</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Dysthyroidism (N=16)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 (68,8%)</td>
<td>5 (31,3%)</td>
<td>0 (0%)</td>
<td>13 (81,3%)</td>
<td>3 (18,7%)</td>
<td>3 (18,5%)</td>
</tr>
<tr>
<td>Orbital cellulitis(N=12)</td>
<td>4 (33,3%)</td>
<td>5 (41,7%)</td>
<td>3 (25%)</td>
<td>9 (75%)</td>
<td>3 (25%)</td>
</tr>
<tr>
<td>Idiopathic Orbital Inflammatory disease (N=9)</td>
<td>6 (66,7%)</td>
<td>3 (33,3%)</td>
<td>0 (0%)</td>
<td>5 (55,6%)</td>
<td>4 (44,6%)</td>
</tr>
<tr>
<td>Orbital tumors (N=8)</td>
<td>1 (12,5%)</td>
<td>6 (75%)</td>
<td>1 (12,5%)</td>
<td>4 (50%)</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>Carotido-cavernous Fistula</td>
<td>0 (0%)</td>
<td>1 (100%)</td>
<td>0 (0%)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total (N=46)</td>
<td>22 (47,8%)</td>
<td>20 (43,5%)</td>
<td>4 (8,7%)</td>
<td>31 (68,9%)</td>
<td>15 (32,6%)</td>
</tr>
</tbody>
</table>

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