ABSTRACT
Leukemia is the most common malignancy of childhood. Chloromas are rare presentations of underlying leukemic disease. It is important to diagnose these cases early in the course as they respond more favourably to focal irradiation. We present a rare case of chloroma of orbit in a young male patient who presented with severe proptosis and a large mass involving the left orbit. The orbital lesion was the initial presentation which led to further diagnosis of acute myeloid leukemia in our case. The patient was evaluated radiologically for the extension of disease and treatment planning.

CASE REPORT
A 16-year-old male presented with progressively increasing painful swelling involving left orbit since three months. The swelling started initially in the left lower lid and progressively increased involving the entire orbit causing axial proptosis which was non pulsatile and irreducible. Movements of the globe were grossly limited. There was complete loss of vision in left eye. Initially it was suspected to be the case of rhabdomyosarcoma. Routine blood investigations and peripheral smear revealed acute myeloid leukemia. Bone marrow examination also confirmed the same. Other investigations including chest X-ray and ultrasound abdomen were normal. He was referred for imaging evaluation to Radio Diagnosis Department, Victoria Hospital, Bangalore. Patient was explained about the radiological procedures and informed consent was taken from the patient and guardians for performing ultrasound and computed tomography.

High resolution ultrasonography of left orbit [Table/Fig-1] revealed a large homogenous hyperechoic mass lesion involving both intraconal and extraconal spaces of orbit. There was axial proptosis of left eye with inferolateral displacement. The globe was completely encased with intraocular extension causing distortion. The lesion demonstrated significant internal vascularity on Doppler interrogation [Table/Fig-2].

Plain and contrast enhanced computed tomography of orbits [Table/Fig-3-5] revealed large fairly defined homogenously enhancing soft tissue attenuation mass lesion involving both intra and extraconal spaces of left orbit. The lesion extended into preseptal and periorbital soft tissues, left superficial temporal fossa, abutting the left lacrimal bone medially, and...
These tumours have been observed in patients with acute myelogenous leukemia, chronic myelogenous leukemia, and other myeloproliferative diseases, such as myelofibrosis with myeloid metaplasia, hyperesosinophilic syndrome, or polycythemia vera [2]. The commonest presentation of chloromas is progression of disease in a case of acute myeloid leukemia (73%) [3].

Leukemias are the commonest paediatric malignancies with 15%–20% of cases arising from myeloid origin [4]. Patients with myelogenous leukemia are prone to develop rare solid tumours of primitive precursors of granulocytic series of leucocytes termed chloromas or granulocytic sarcomas. These uncommon neoplasms can occur in a diagnosed case of myelogenous leukemia or may herald the future development of leukemic disease by months to years. In a patient with known diagnosis, development of chloromas may represent relapse of an already treated systemic disease or may be the presenting sign of associated systemic disease [1,5]. Skin, orbit, CNS and genitourinary system are commonly involved. In the head and neck region, the orbit is the most preferred site followed by skull and epidural spaces. Chloromas of the orbit usually arise from subperiosteal region of superior orbital wall, with a tendency to encase rather than invade sclera and underlying bone [1].

They are common in children than in adults, peak prevalence is in patients aged 7-8 years with slight male predominance. The lesions are often multifocal; and most frequently arise in bones, especially the skull and orbit [3]. Clinical presentation with orbital involvement most commonly is with proptosis. Other symptoms like periorbital cellulitis or swelling or mass in the lacrimal gland or eyelid may be seen. It may be bilateral [6-8]. At radiography, granulocytic sarcoma usually appears as a soft-tissue mass. On ultrasound, a non specific, homogeneous, hypoechoic or echogenic solid mass is seen. The borders may appear infiltrative. On unenhanced CT scans, granulocytic sarcomas are generally homogeneously isoattenuating to slightly hyperattenuating relative to muscle components of the orbit. Chloromas appear isointense to slightly hyperintense or heterogeneously isointense to slightly hypointense relative to gray matter or muscle on T1-weighted images, replacing the high signal intensity of the bone marrow. On T2-weighted images they are heterogeneously isointense to slightly hyperintense. The lesion is usually hyperintense in comparison to sclera in all sequences secondary to its low fibrous component, which helps to delineate the extension of actual tumour. On administration of intravenous gadolinium, these lesions demonstrate homogeneous enhancement [1,9].

MR imaging helps in better characterisation of the soft tissue components of the orbit. Chloromas appear isointense to hypointense relative to gray matter or muscle on T1-weighted images, replacing the high signal intensity of the bone marrow. On T2-weighted images they are heterogeneously isointense to slightly hyperintense. The lesion is usually hypointense in comparison to sclera in all sequences secondary to its low fibrous component, which helps to delineate the extension of actual tumour. On administration of intravenous gadolinium, these lesions demonstrate homogeneous enhancement [1,9].

Differentials to consider in patients without history of leukemia include rhabdomyosarcoma, orbital cellulitis, metastatic neuroblastoma and Langerhans cell histiocytosis [10]. It is clinically challenging to differentiate granulocytic sarcoma...
from other malignancy. In patients with retrobulbar orbital mass causing rapidly progressive proptosis possibilities of malignant and inflammatory processes need to be considered [11].

Rhabdomyosarcoma is the commonest extraocular orbital malignancy in children and relatively more common compared to chloromas. It is more likely to cause bone erosions and commonly involves lateral orbit, in contrast to chloromas which have less propensity to erode the bone and which usually involve superior orbit. Orbital cellulitis usually presents with orbital swelling associated with inflammatory signs. Metastatic neuroblastoma usually head and neck, predominantly orbit. There may be multiple lytic lesions containing calcifications and causing aggressive periosteal reaction. Similar lesions in other bones and abdominal mass usually directs to a diagnosis of neuroblastoma. If lesions are bilateral, Langerhans’ cell histiocytosis is to be considered in differentials. LCH typically presents with multiple well defined lytic lesions with beveled edges [11]. Possible differentials in a diagnosed case of leukemia include various complications of the disease, namely abscess, hematoma or development of secondary malignancy. Orbital abscess show peripheral wall enhancement and hematomas do not enhance compared to homogenous enhancement of chloromas [11]. As chloromas are manifestations of underlying systemic disease, they are treated accordingly with systemic chemotherapy. Focal irradiation or surgery is useful in intractable cases or in cases causing mass effect on adjacent structures. However, local treatment does not affect overall survival of the patient [12].

CONCLUSION

Chloromas are relatively rare tumours. It is important to diagnose these lesions early in their course as they respond favourably to focal irradiation. CT and MR imaging are helpful in localising and characterising these lesions. They provide valuable information regarding the extension of involvement, which is helpful for treatment planning including biopsy, radiotherapy and post treatment follow up. Although the imaging findings are non-specific, it should be included in the differential diagnosis of an orbital mass in paediatric age group, especially when multicentric and recurrent.

REFERENCES


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