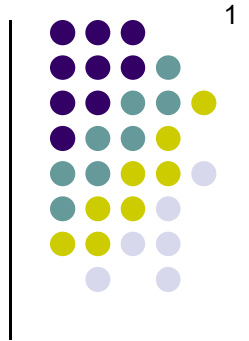


Proptosis

Proptosis



Key question...



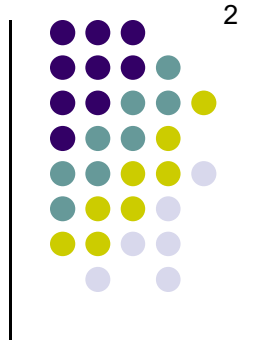
Proptosis

Proptosis

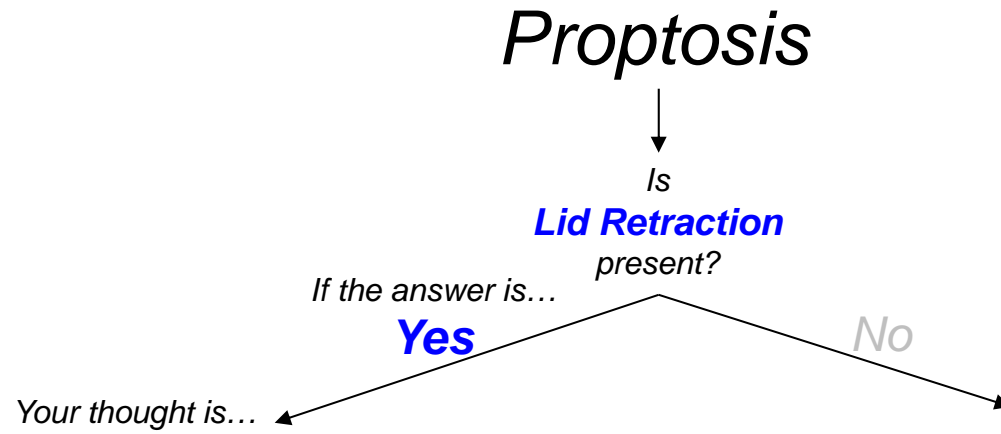


Is

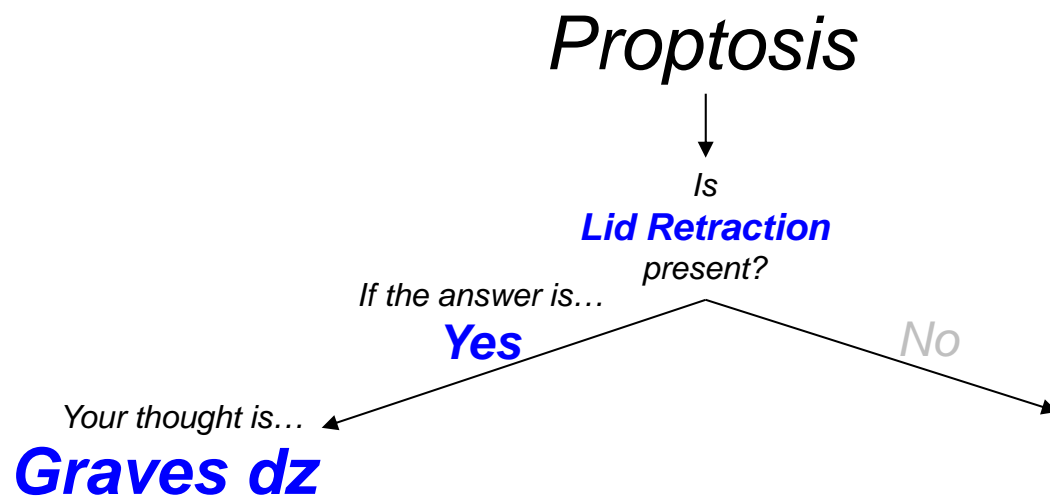
Lid Retraction
present?



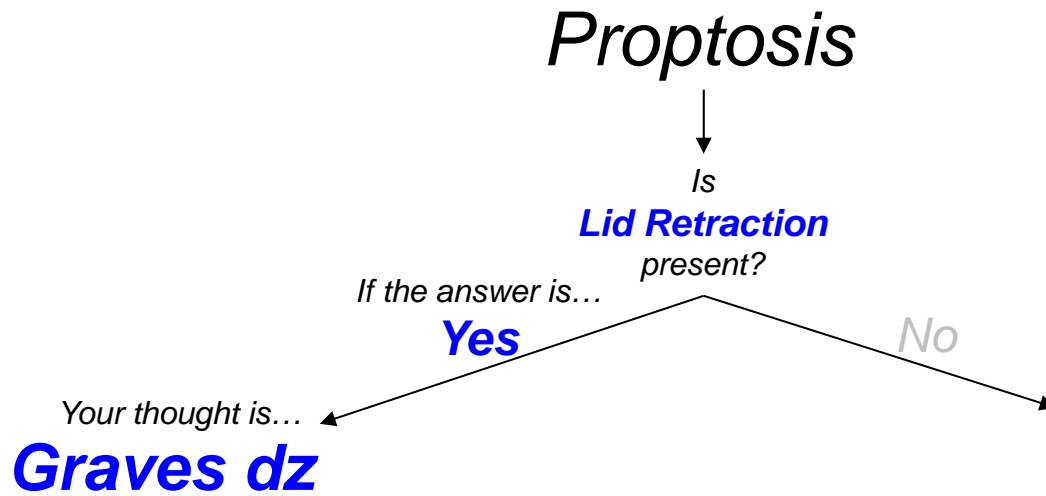
Proptosis



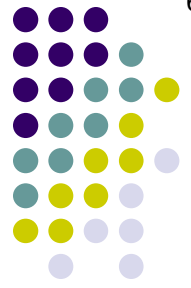
Proptosis



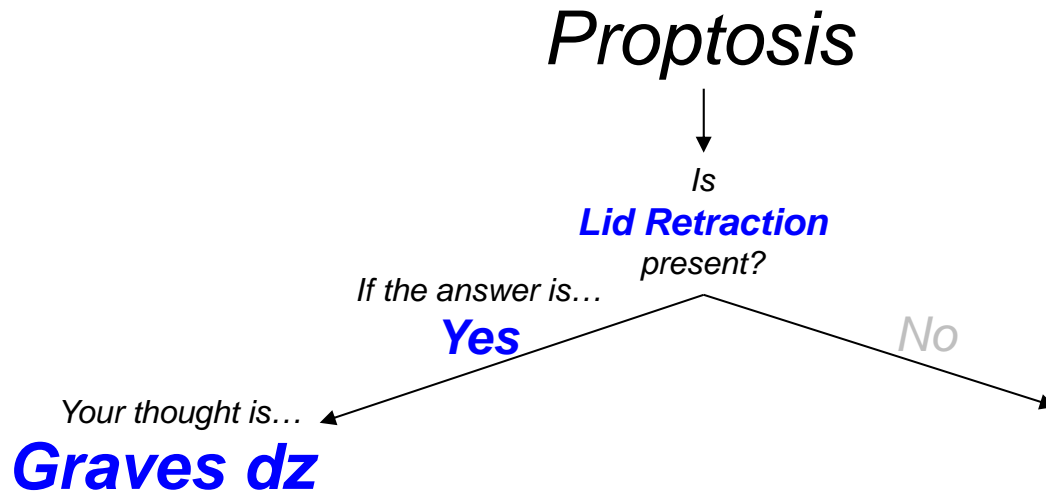
Proptosis



How common is lid retraction in Graves disease?



Proptosis

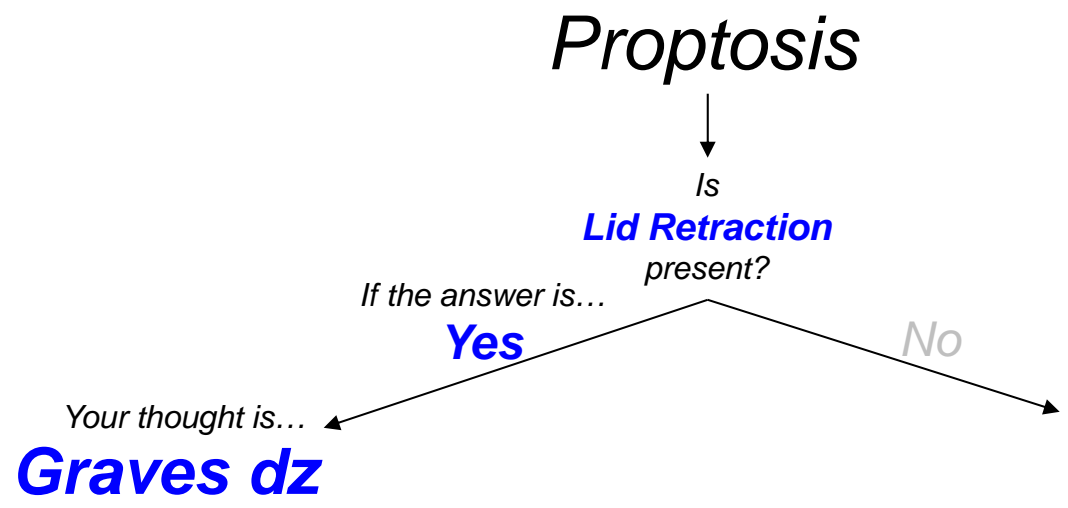


How common is lid retraction in Graves disease?

It is ubiquitous, with greater than 90% of Graves pts manifesting it at some point. Because of this ubiquity, lid retraction is a key diagnostic finding in Graves dz—if a pt has lid retraction plus laboratory evidence of thyroid dysfunction, the diagnosis of Graves dz is made.



Proptosis

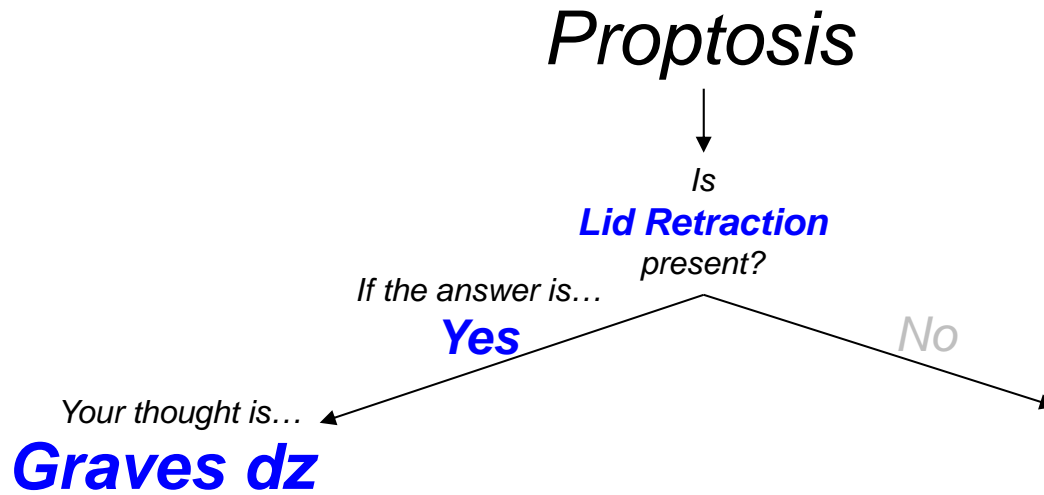


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Does the absence of lid retraction rule out Graves?



Proptosis



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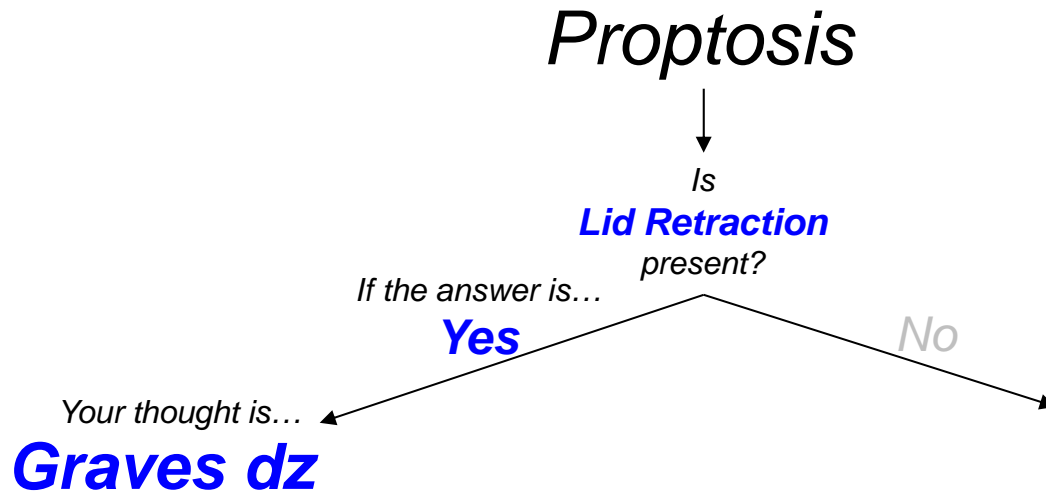
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Does the absence of lid retraction rule out Graves?

No, but it make it **much** less likely



Proptosis



How common is lid retraction in Graves disease?

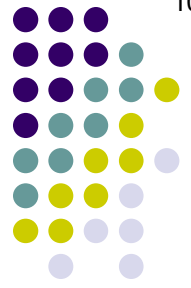
There is an important exception to the 'absence of lid retraction indicates it isn't Graves dz' contention--in fact, such pts can present with ptosis. Under what circumstance might a Graves pt present with no lid retraction, or even frank ptosis?

*...the point.
...s dz—if a pt
...nosis of*

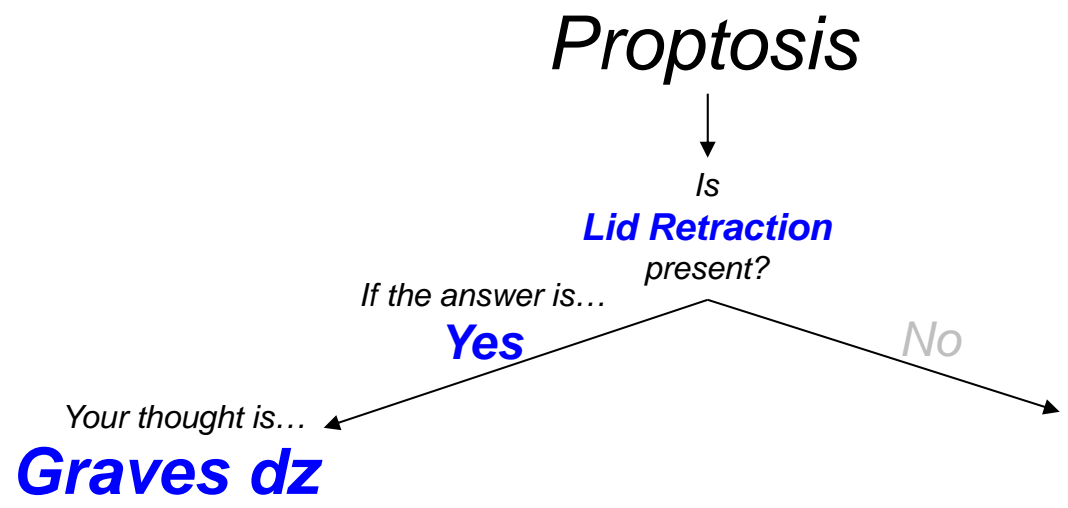
Graves dz is made.

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There is an important exception to the 'absence of lid retraction indicates it isn't Graves dz' contention--in fact, such pts can present with ptosis. Under what circumstance might a Graves pt present with no lid retraction, or even frank ptosis?

If the pt has concurrent two words

Graves dz is made.

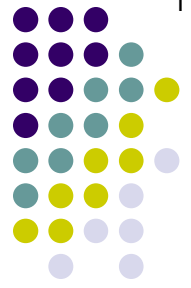
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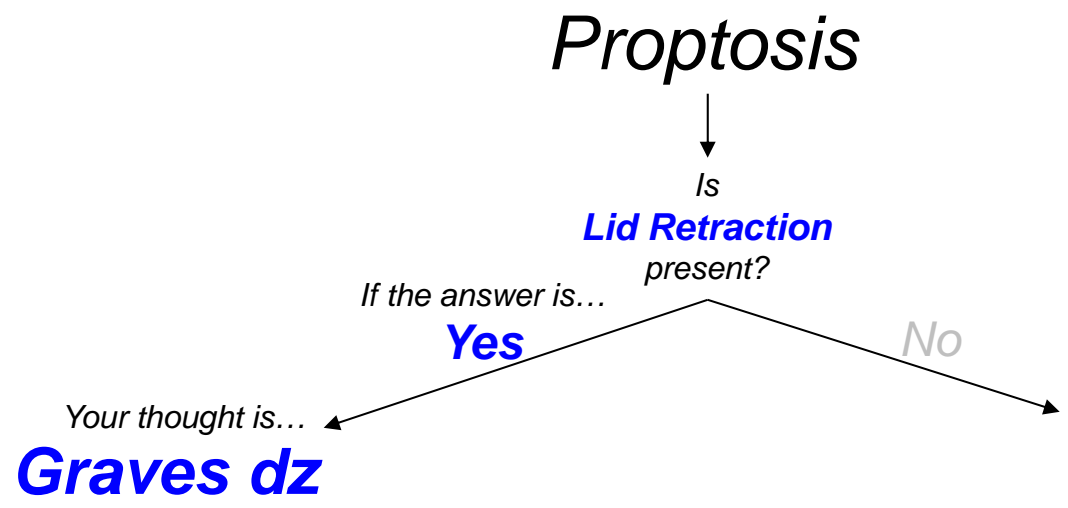
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There is an important exception to the 'absence of lid retraction indicates it isn't Graves dz' contention--in fact, such pts can present with ptosis. Under what circumstance might a Graves pt present with no lid retraction, or even frank ptosis?

If the pt has concurrent myasthenia gravis

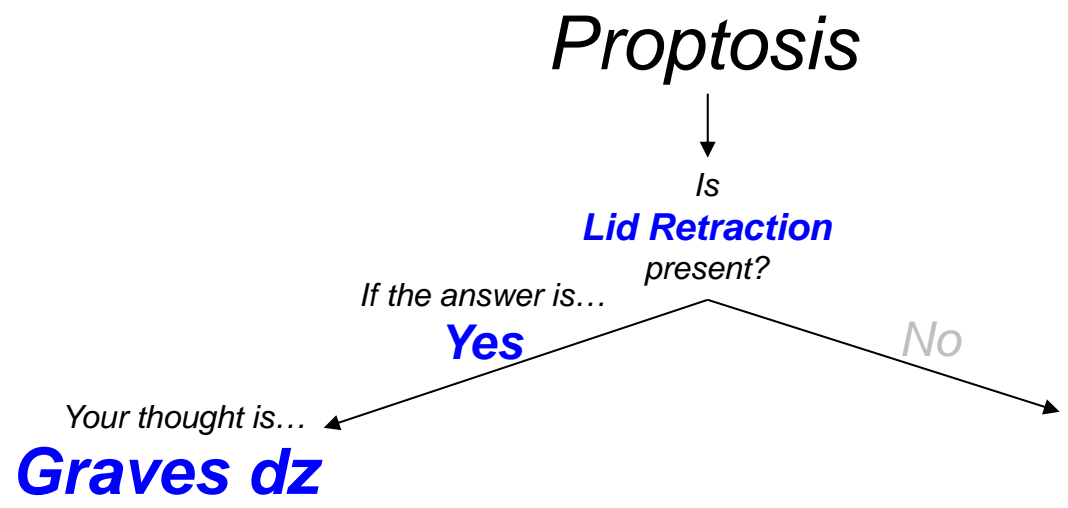
Graves dz is made.

Does the absence of lid retraction rule out Graves?
No, but it make it **much** less likely

...e point.
...s dz—if a pt
...nosis of



Proptosis



How common is lid retraction in MG? What one word best characterizes the clinical course of ptosis in MG?

There is an... **myasthenia gravis** ... point.

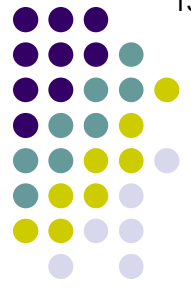
Graves dz' ... s dz—if a pt ...

circumstance might a Graves pt present with no lid retraction, or even frank ptosis? ...

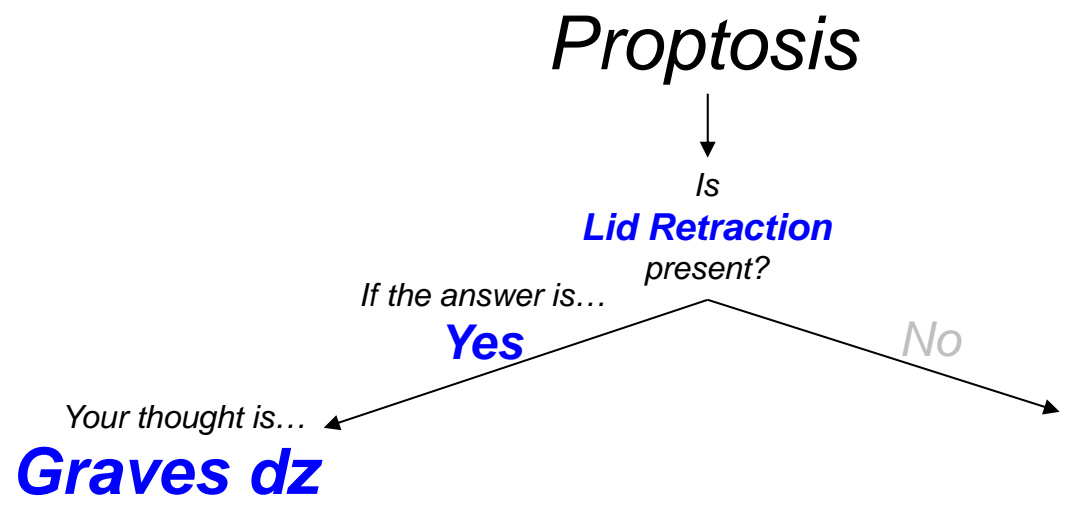
If the pt has concurrent ... nosis of ...

Graves dz is made.

Does the absence of lid retraction rule out Graves?
No, but it make it **much** less likely



Proptosis



How common is lid retraction in Graves dz? What one word best characterizes the clinical course of ptosis in MG?

There is an exam to exam. Variable. That is, one would expect the degree of ptosis to vary from exam to exam.

circumstance might a Graves pt present with no lid retraction, or even frank ptosis?

If the pt has concurrent myasthenia gravis

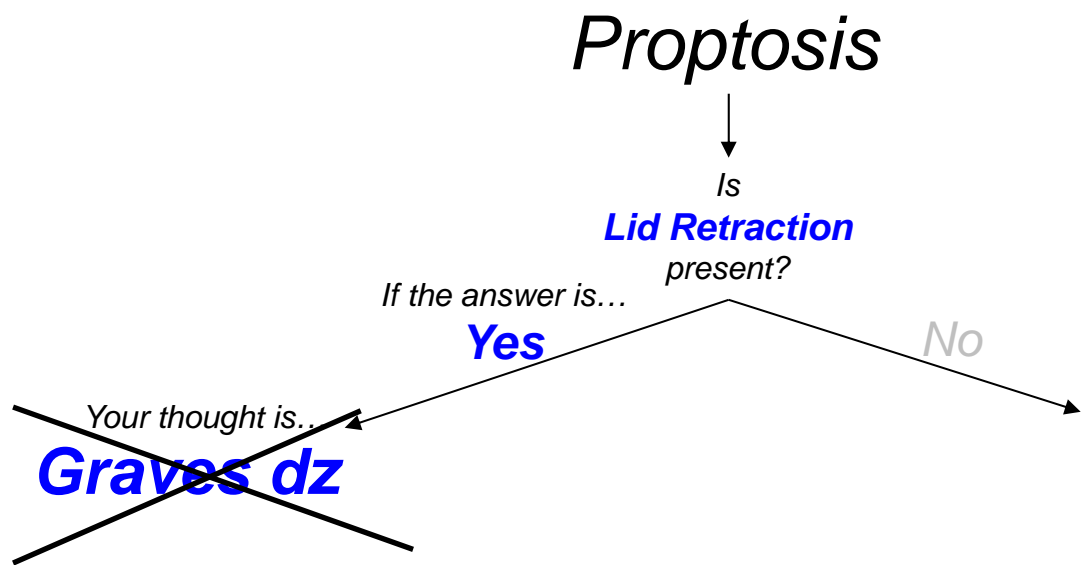
Graves dz is made.

Does the absence of lid retraction rule out Graves?

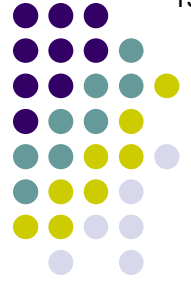
No, but it make it much less likely



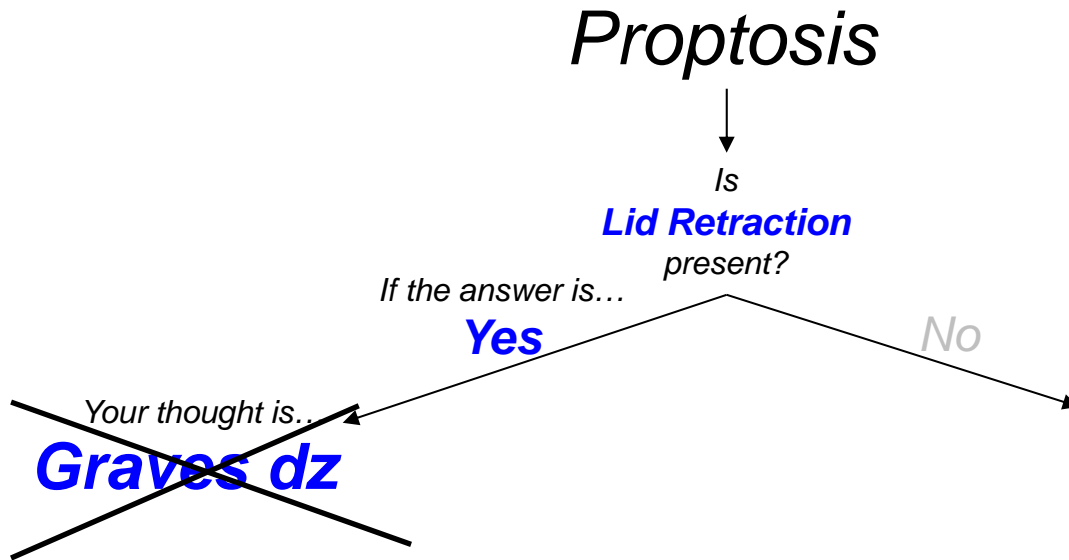
Proptosis



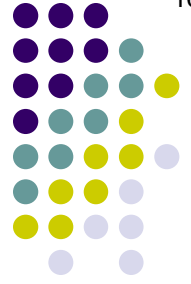
What if it's not Graves dz? What else can cause proptosis + lid retraction?



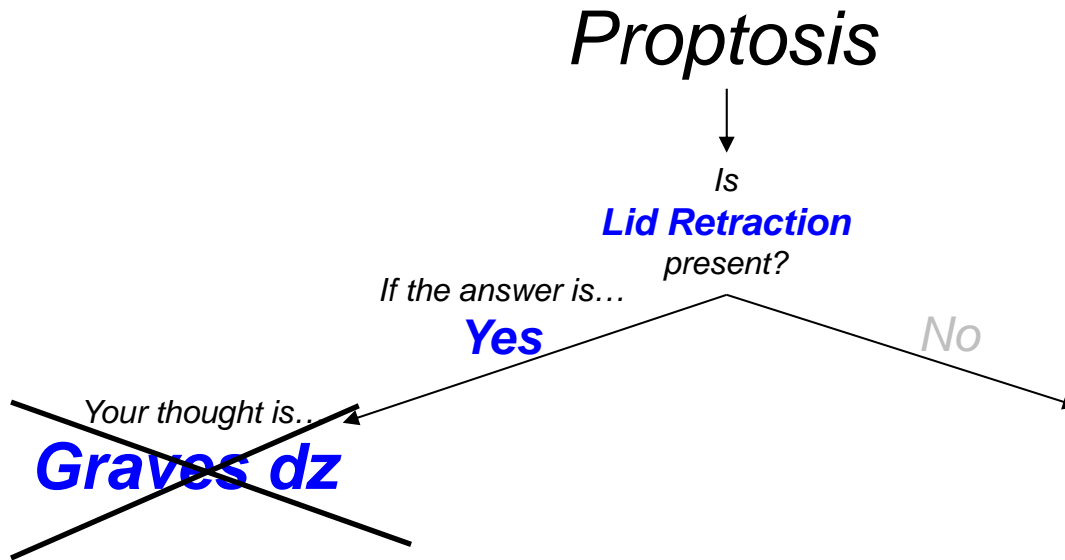
Proptosis



What if it's not Graves dz? What else can cause proptosis + lid retraction?
 An abnormally large globe as in high axial myopia, or buphthalmos. (Of course, such cases would not consist of lid retraction + proptosis; rather, they would consist of lid retraction +)



Proptosis

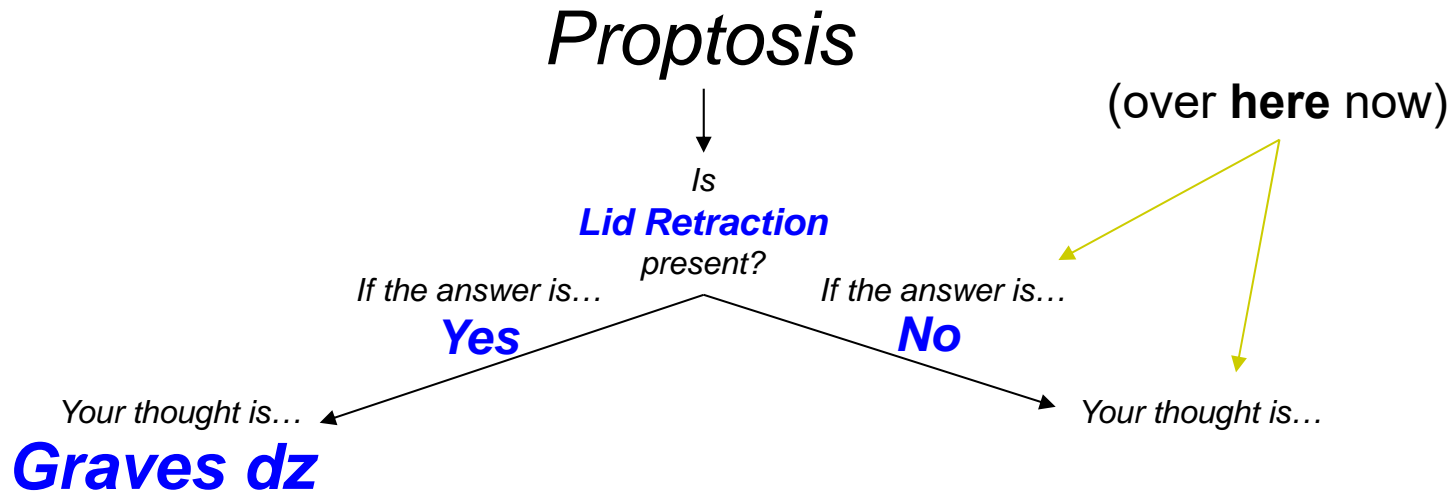


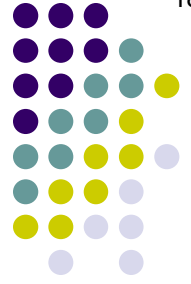
What if it's not Graves dz? What else can cause proptosis + lid retraction?

An abnormally large globe as in high axial myopia, or buphthalmos. (Of course, such cases would not consist of lid retraction + proptosis; rather, they would consist of lid retraction + **pseudoproptosis**.)

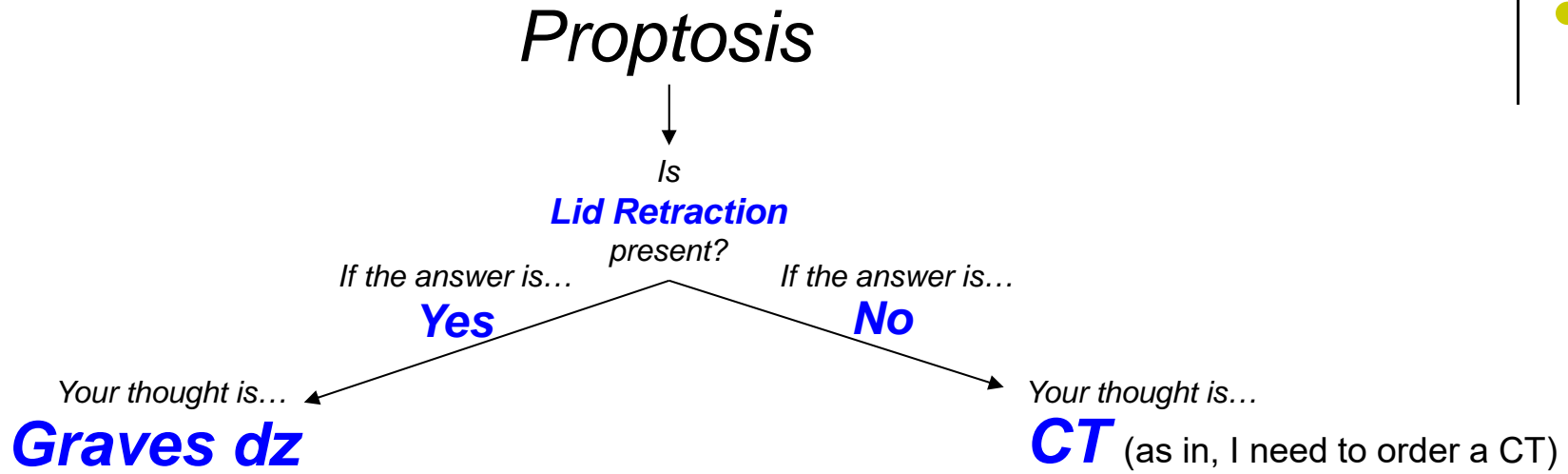


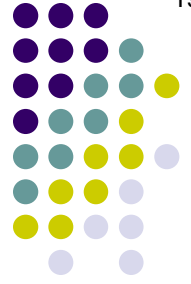
Proptosis



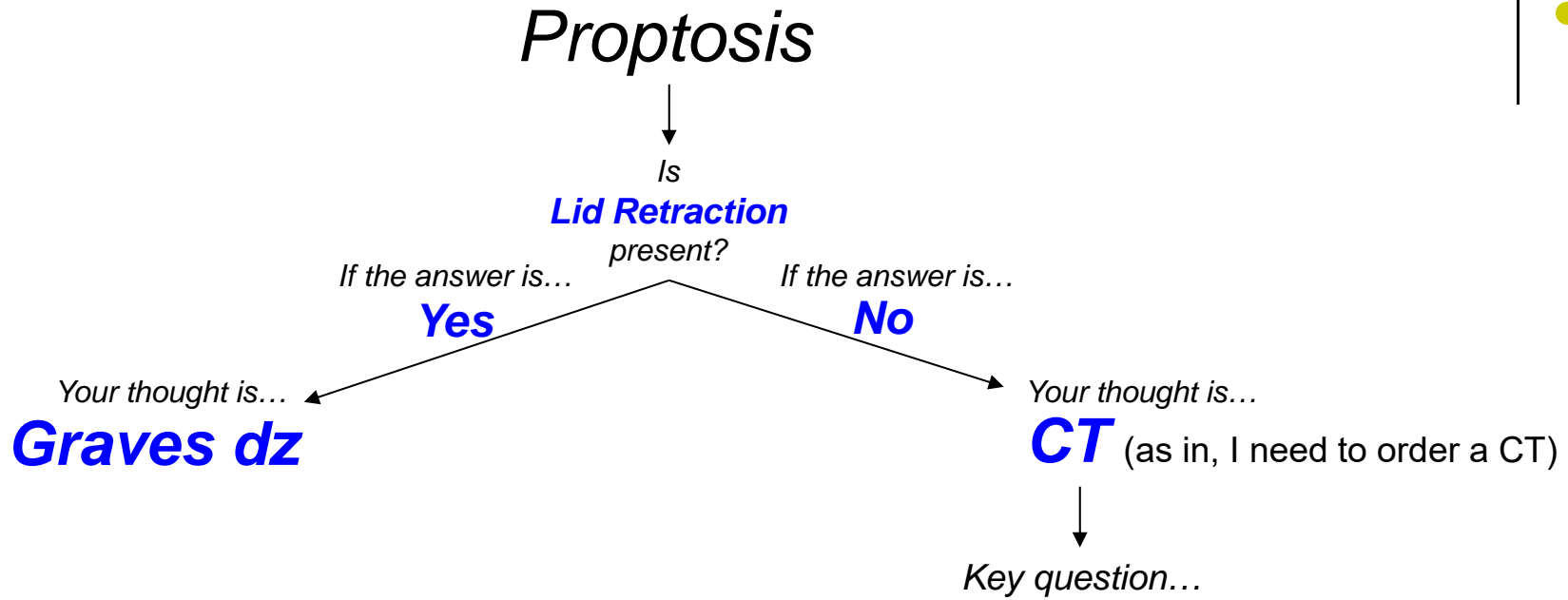


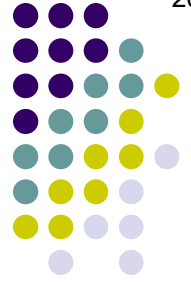
Proptosis



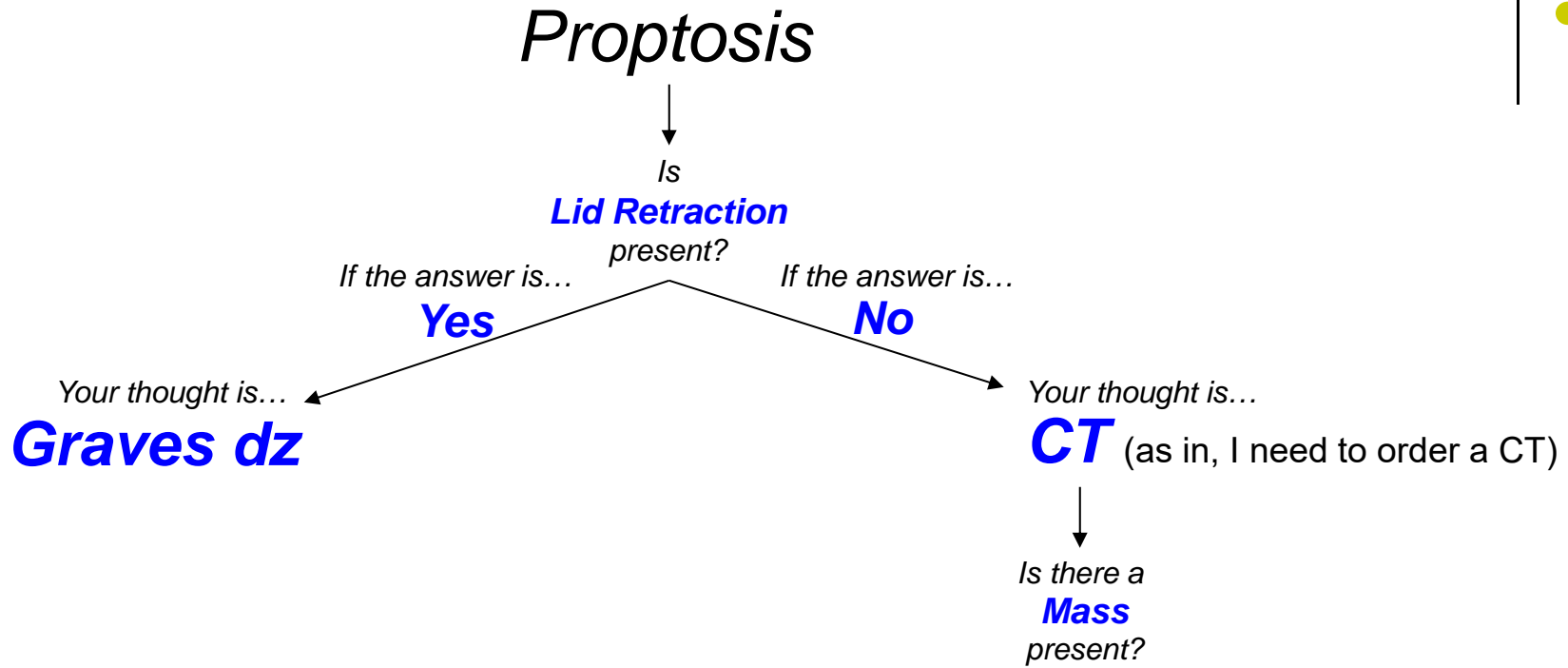


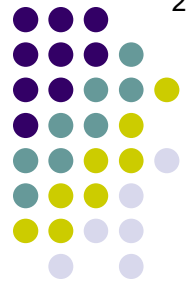
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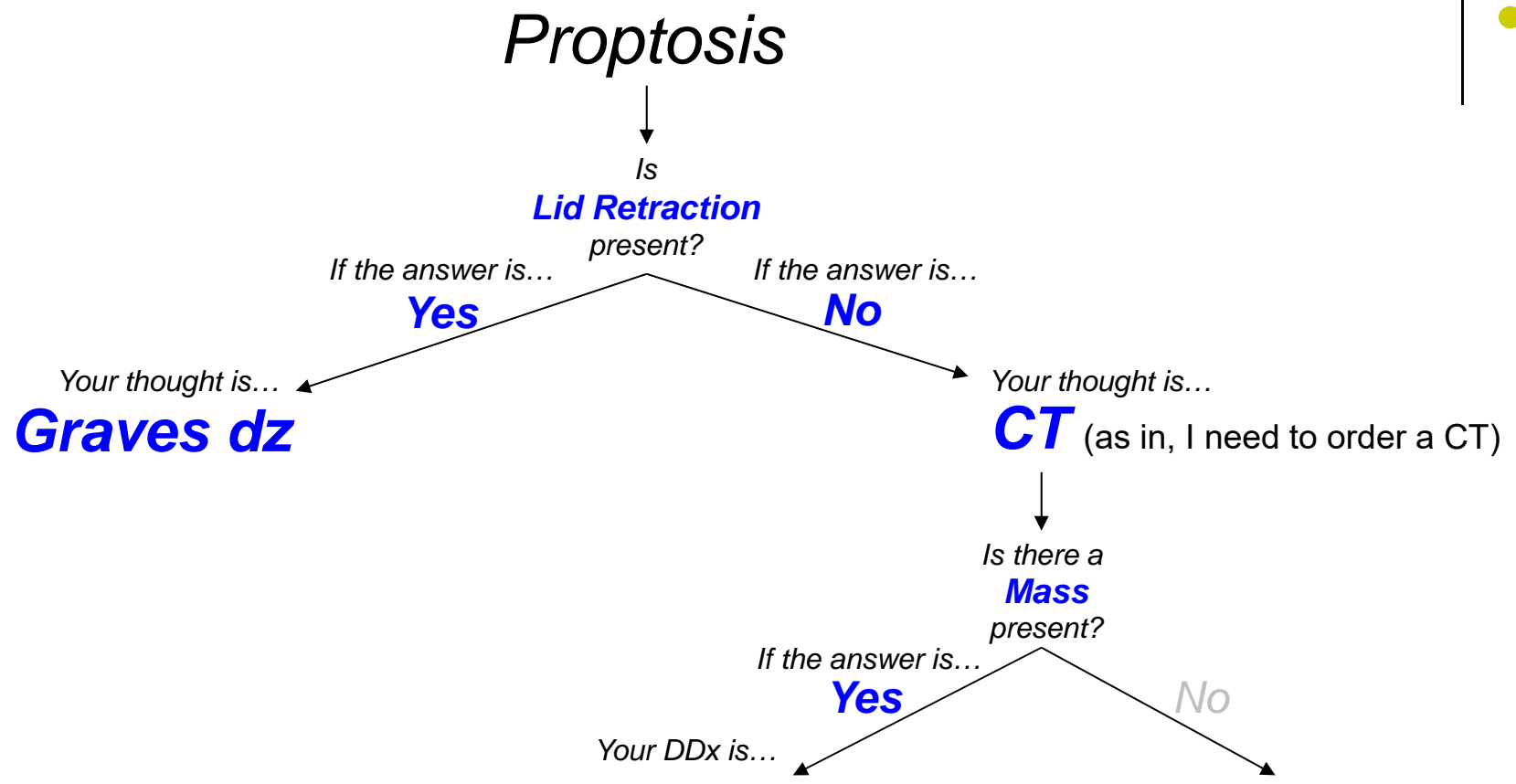


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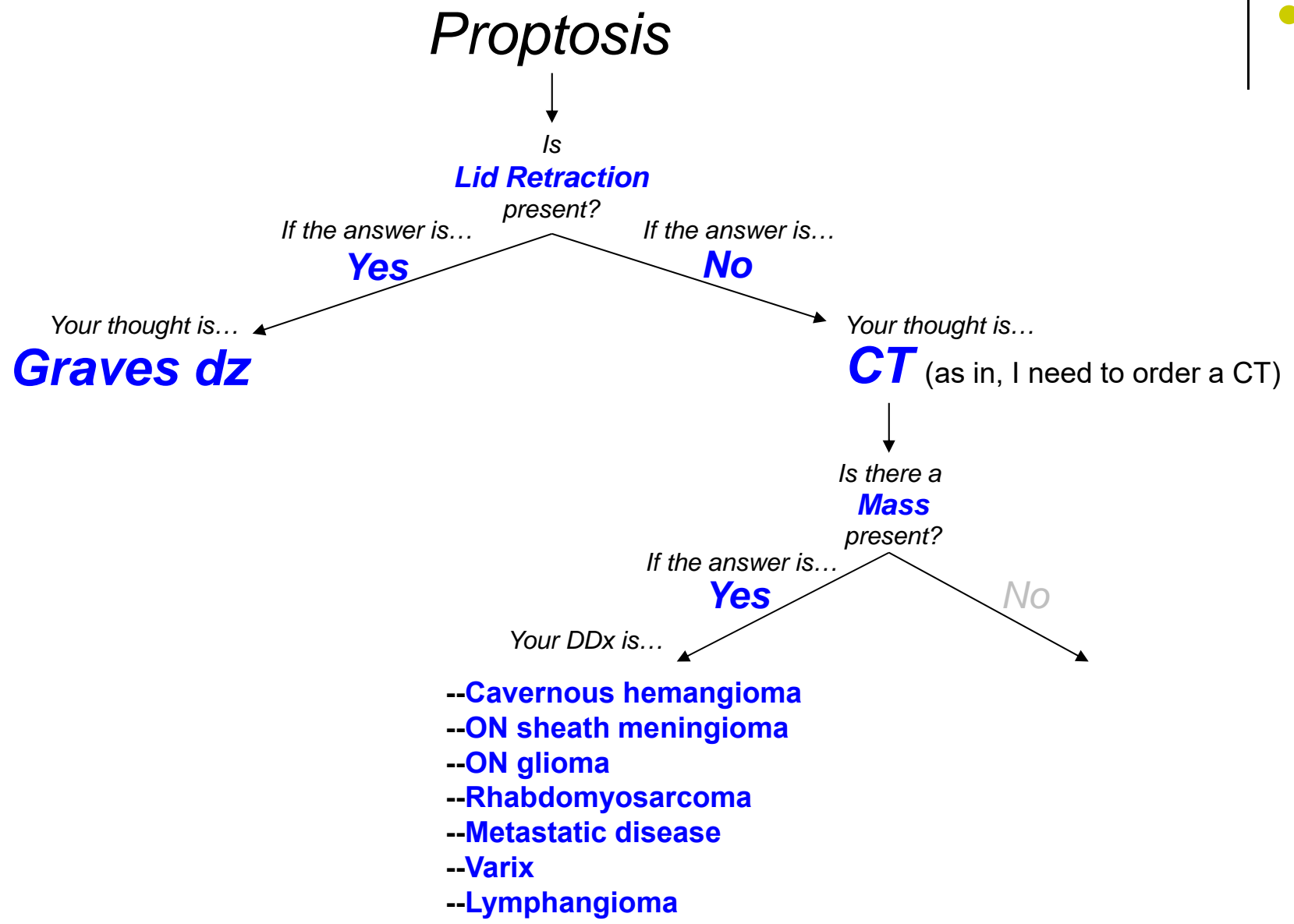


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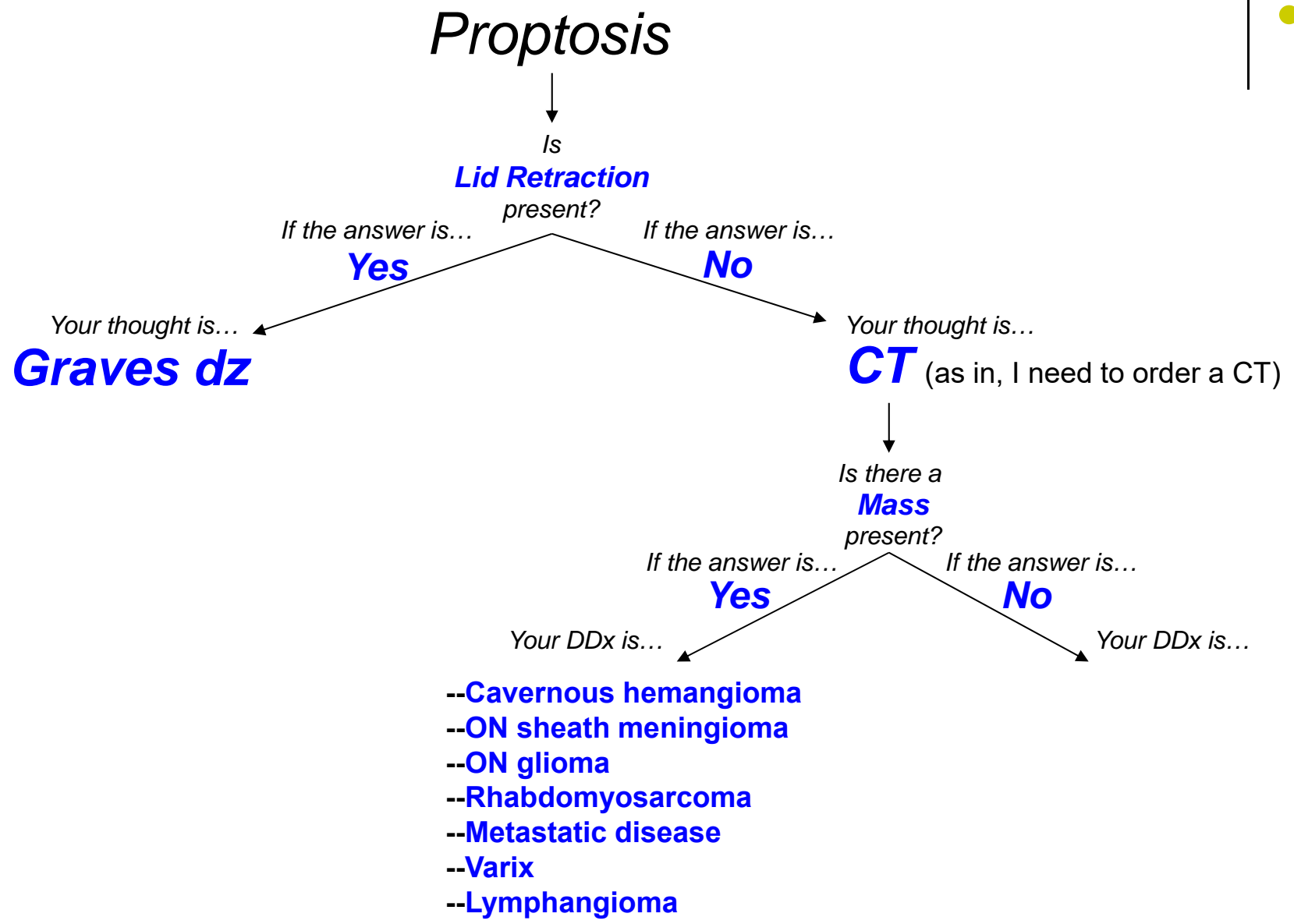


Proptosis



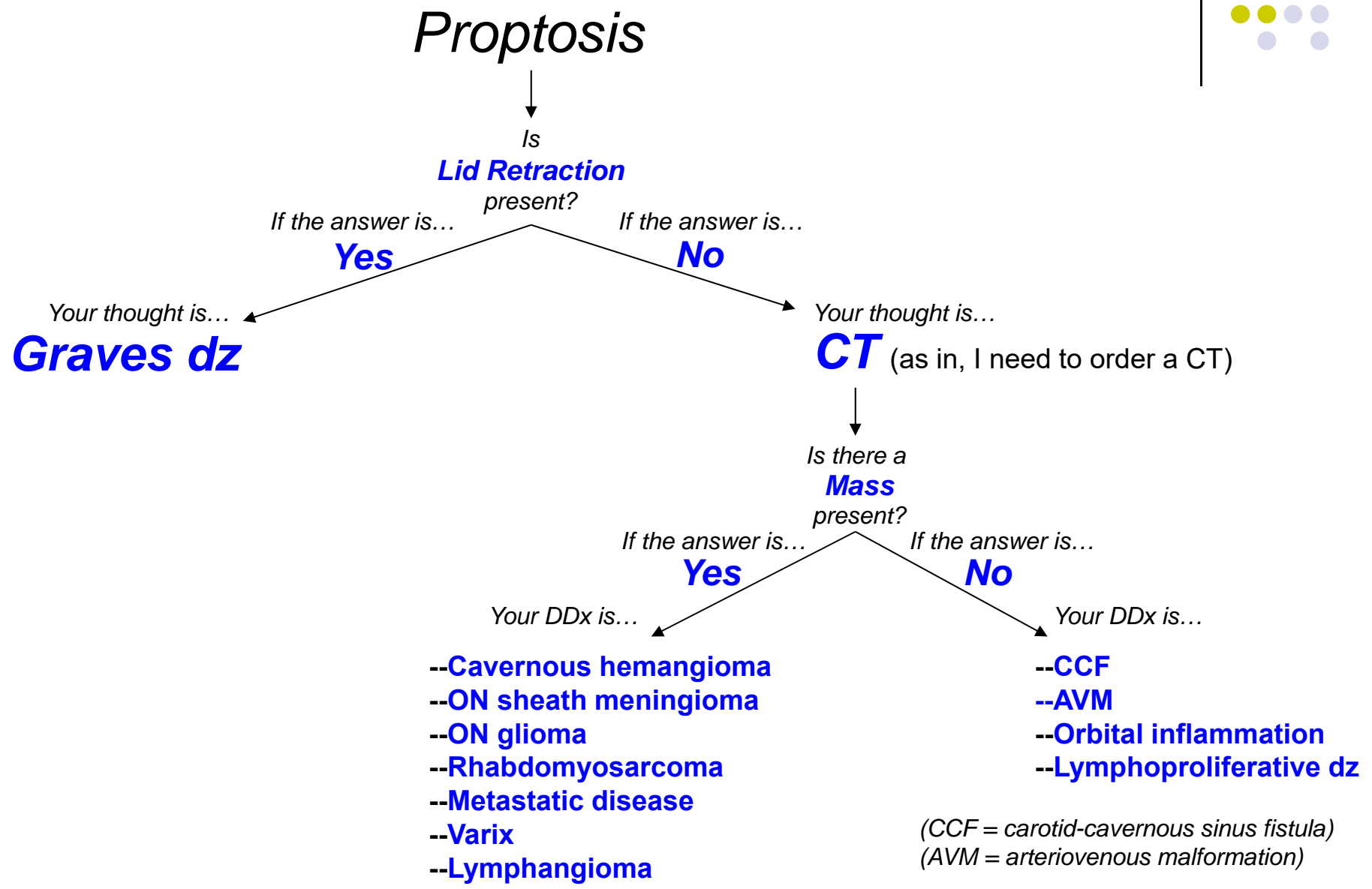


Proptosis





Proptosis

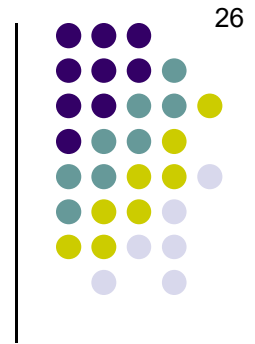


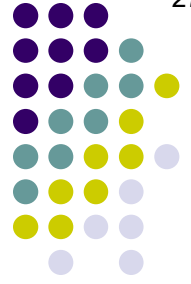
A

Proptosis: Fill in the blanks

- Proptosis + lid retraction = Graves disease
- Proptosis *w/o* lid retraction = Imaging

Bears repeating
for emphasis!

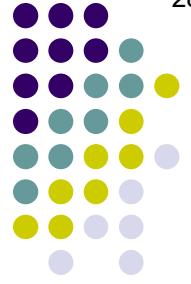




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Note: Some authorities argue that, in adults, **all** proptosis (ie, whether or not lid retraction is present) is Graves dz until proven otherwise!



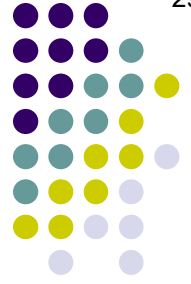
Q

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Are we talking about unilateral proptosis, or bilateral proptosis?



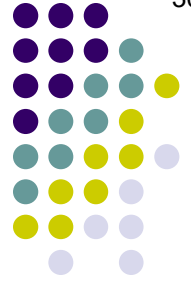
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*Are we talking about unilateral proptosis, or bilateral proptosis?
It can be either*



Q

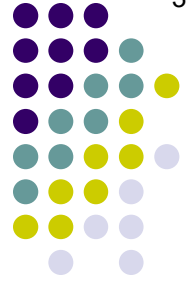
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Where does TED rank as a cause of unilateral proptosis in adults?



A

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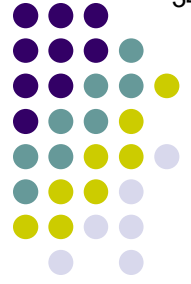
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 #1

Where does TED rank as a cause of bilateral proptosis in adults?
 #1



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*What about in the **pediatric** population--is the relationship between proptosis and Graves dz as strong?*



Q/A

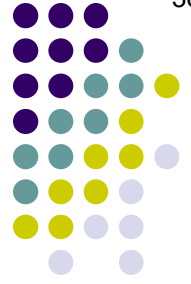
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*What about in the **pediatric** population--is the relationship between proptosis and Graves dz as strong?*

No. Graves is rare in children, and when it does occur, only about 10% of pts present with proptosis. (Rule of thumb: In children, proptosis is more likely to be or than to be inflammatory.)



A

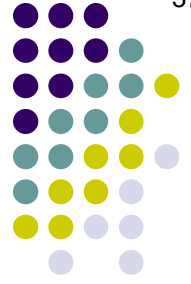
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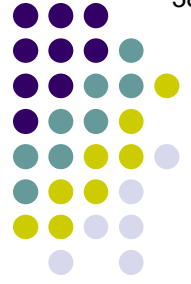
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Q

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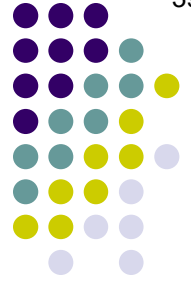
- Proptosis + lid retraction = Graves disease
 - Proptosis *w/o* lid retraction = Imaging
- If one suspects orbital disease, a 2 mm disparity on exophthalmometry--the so-called 'limit of normal'—is reassuring? or cause for concern?



A

Proptosis: Fill in the blanks

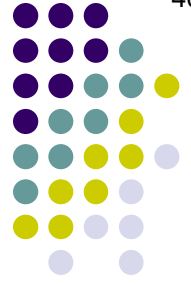
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- If one suspects orbital disease, a 2 mm disparity on exophthalmometry--the so-called 'limit of normal'—is highly suspicious for an orbital process



Q

Proptosis: Fill in the blanks

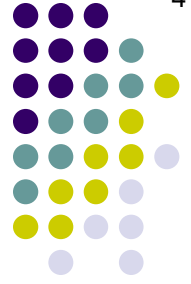
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- Ask the patient to simple maneuver --if proptosis worsens, it's probably an cause of proptosis



A

Proptosis: Fill in the blanks

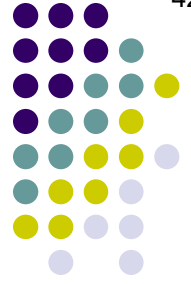
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- Ask the patient to Valsalva --if proptosis worsens, it's probably an orbital venous anomaly



Q

Proptosis: Fill in the blanks

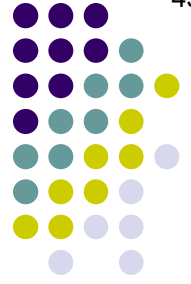
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- If one suspects orbital disease, a 2 mm disparity on exophthalmometry--the so-called 'limit of normal'—is highly suspicious for an orbital process
- Ask the patient to Valsalva --if proptosis worsens, it's probably an orbital venous anomaly
- In evaluating proptosis, always consider contralateral pathologic condition



A

Proptosis: Fill in the blanks

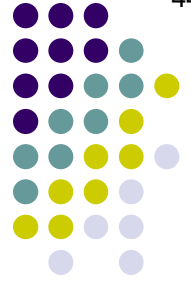
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Q

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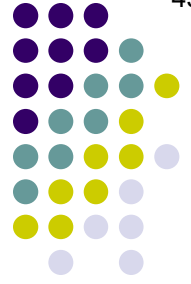
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- In evaluating proptosis, always consider contralateral enophthalmos
- Auscultate for a pathologic sound (indicates dx or dx)



A

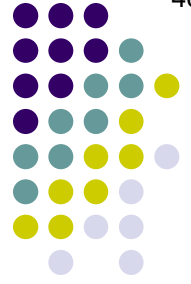
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- Auscultate for a bruit (indicates CCF or AVM)



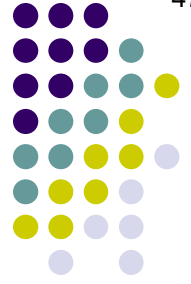
Q

- All of the following are likely to produce rapid proptosis in a child *except*:
 - Lymphangioma
 - Orbital cellulitis
 - Rhabdomyosarcoma
 - Optic nerve glioma



A

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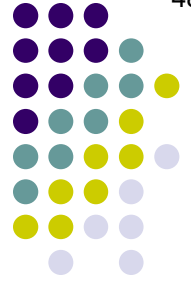
Q

- All of the following are likely to produce rapid proptosis in a child *except*:
 - **Lymphangioma**
 - Orbital cellulitis
 - Rhabdomyosarcoma
 - Optic nerve glioma

Under what clinical circumstances might a lymphangioma be expected to expand rapidly?

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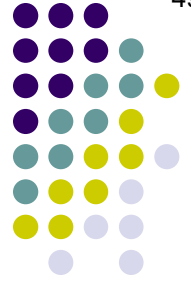
Q/A

- All of the following are likely to produce rapid proptosis in a child *except*:
 - **Lymphangioma**
 - Orbital cellulitis
 - Rhabdomyosarcoma
 - Optic nerve glioma

Under what clinical circumstances might a lymphangioma be expected to expand rapidly?

--If the pt as an infection

--If the lesion undergoes



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--If the lesion undergoes spontaneous intralesional hemorrhage



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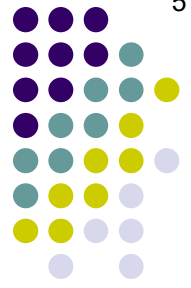
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S/he will usually be toxic—ill-appearing, febrile, and in pain, in addition to the ocular stigmata of proptosis, chemosis, etc



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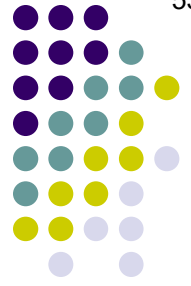
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