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Case Report

Clinical Profile and Management of Extraocular Muscle (EOM) Pyomyositis: A Largest Case Series

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Abstract

Pyomyositis of extraocular muscle is an infrequent entity. *Staphylococcus aureus* is the most common organism in tropical climates. We herein report clinical profiles and outcomes of cases of EOM pyomyositis. All cases presented with acute inflammatory signs, except one. The presence of Orbital Apex Syndrome (OAS) in one, leading to dreaded complication of endophthalmitis; stretch optic neuropathy in one; and central serous retinopathy in one were atypical findings. Urgent aspiration or incision and drainage are the keys to rapid resolution of signs and symptoms. We hereby conclude that the diagnosis of pyomyositis is based on careful history-taking, meticulous clinical examination and characteristic imaging findings. Early intervention leads to good prognosis.

Keyword: Orbital Abscess; Orbital Apex Syndrome; Endophthalmitis; Pyomyositis

Abbreviations

USG: Ultrasound; CE MRI: Contrast-Enhanced Magnetic Resonance Imaging; SS-OCT: Swept-Source Optical Coherence Tomography; EOM: Extraocular Muscles; OAS: Orbital Apex Syndrome; CSR: Central Serous Retinopathy

Introduction and Methodology:

Pyomyositis is an acute bacterial infection involving striated muscles [1]. Pyomyositis of Extraocular Muscles (EOM) is a rare orbital entity and typically presents with periocular pain, swelling, redness and restriction of extraocular movements, with or without associated systemic symptoms. *Staphylococcus aureus* remains the most implicated causative organism [2]. EOM pyomyositis has been sparsely reported in the literature, predominantly as isolated case reports and a limited number of small case series. To date, the largest published case series has included four patients, with an estimated total of approximately 14 cases reported worldwide [2,3]. In this context, we report a case series of six patients with EOM pyomyositis, representing the largest single-center case series reported to date. In addition to expanding the existing clinical spectrum, our series highlights atypical and vision-threatening complications, including endophthalmitis, stretch optic neuropathy and Central Serous Retinopathy (CSR), which have been rarely reported or not systematically emphasized in previous publications. Recognizing these uncommon manifestations is clinically important, as they may influence diagnostic vigilance, monitoring and management strategies. This study is a retrospective observational case series conducted at a tertiary eye care center Sadguru Netra Chikitsalaya, Chitrakoot. Medical records of patients diagnosed with Extraocular Muscle (EOM) pyomyositis between January 2020 and October 2022 were reviewed.

Patients were included based on compatible clinical features (acute periocular pain, swelling, proptosis and restriction of extraocular movements, with or without systemic symptoms) and radiological confirmation on Contrast-Enhanced Computed Tomography (CECT) and/or Magnetic Resonance Imaging (MRI) demonstrating EOM enlargement with intramuscular collection or abscess formation. Patients with orbital cellulitis without predominant muscle involvement, idiopathic orbital inflammatory disease, thyroid eye disease, traumatic myositis or neoplastic lesions were excluded.

All patients underwent complete ophthalmic evaluation and relevant laboratory investigations. Orbital ultrasonography was used to detect and monitor intramuscular collections. Empirical intravenous antibiotics were initiated as per the institutional protocol for orbital infections and subsequently modified based on microbiological culture sensitivity results. Blood cultures were not routinely obtained, as all cases represented localized orbital infections without clinical features of systemic sepsis. Pus aspirated or drained during intervention was sent for microbiological culture and sensitivity wherever feasible.

Needle aspiration was performed for localized, accessible intramuscular abscesses, while incision and drainage were reserved for large, superficial, posteriorly located or vision-threatening collections or in cases showing inadequate response to medical therapy. Systemic steroids were administered in selected cases after adequate antibiotic coverage.

Case Report

Clinical outcomes were assessed longitudinally based on the initial clinical presentation and included best-corrected visual acuity, ocular motility, degree of proptosis and resolution of pain, ptosis, inflammatory signs and associated complications. Written informed consent for publication of identifiable clinical photographs was obtained and the study adhered to the tenets of the Declaration of Helsinki.

Case 1

19-year-old male presented with the chief complaint of diminution of vision in the Left Eye [LE] for the past month, associated with dull, aching pain. It was also associated with double vision, headache and drooping of the left upper lid for the last 10 days. There was a history of intermittent fever that had not been documented and was not associated with chills or rigors.

The best corrected visual acuity was 6/6 in the right eye [RE] and 6/36 in Left Eye [LE]. In the LE, there was complete ophthalmoplegia (Fig. 1), 2 mm of axial proptosis on Hertel's exophthalmometer, eyelid swelling with moderate ptosis and mild conjunctival hyperemia with chemosis. The pupillary examination did not show a relative afferent pupillary defect. The fundus in the left eye showed a hyperemic disc with blurred margin, suggestive of optic disc edema. The right eye examination was unremarkable. A systemic examination did not reveal any abnormalities.

The blood investigations were within normal limits, except for a raised erythrocyte sedimentation rate of 36 mm at the end of one hour [Westergren Method]. Orbital Ultrasonography (USG) of the left eye showed a cystic lesion in the inferior rectus [10.77 mm in size] muscle (Fig. 1). Gadolinium-enhanced MRI orbit was done and a revealed proptosis on the left side and well-defined retro orbital T1 hypointense and T2 hyperintense peripherally enhancing lesion measuring 19 mm/15 mm/13 mm [anterior-posterior/transverse/cross-sectional] showed diffusion restriction seen in the left intraconal and extraconal spaces, likely representing an abscess with surrounding significant fat stranding and enhancement of left retro-orbital and periorbital soft tissues and left optic nerve sheath. However, the optic nerve demonstrates normal signal intensity. The posterior extension of inflammatory changes up to the orbital apex was also seen. The patient was started empirically on intravenous piperacillin 4 g and tazobactam 8 hourly. Using a 23-gauge needle attached to a 10 ml syringe, the globe is retracted superiorly and guarded using a periosteum elevator, then the needle is passed through the inferior fornix into the inferior orbit to reach the inferior rectus and pus is aspirated (Fig. 1) and a sample was sent for culture and sensitivity. The culture showed *Staphylococcus pseudintermedius* growth, sensitive to clindamycin (minimum inhibitory concentration 0.25).

There was improvement in the extraocular movement, with vision 6/9 in the LE on the next day. Fundus examination revealed optic disc edema with peripapillary hemorrhages, dilated and tortuous blood vessels and two small, discrete, whitish lesions on the superior and inferior optic disc, mimicking cotton wool spots (Fig. 1). SS-OCT passing through the retinitis lesion showed hyperreflectivity of the inner retinal layers and surrounding focal area of vitritis, which was suggestive of endophthalmitis. A vitreous biopsy was done and intravitreal clindamycin and dexamethasone were injected. However, the vitreous biopsy was

negative. On USG, the size of the abscess decreased (Fig. 1). The patient was discharged on oral steroids and oral clindamycin. After two weeks of follow-up, vision improved to 6/6 in the left eye with only mild restriction of movements in the upgaze. Fundus examination showed resolving disc edema with the resolution of exudates. There was minimal fluid in the sub-tenon's space. At the end of 3 months, the patient had 6/6 BCVA in the left eye with a full range of extraocular movements and no signs of recurrence (Fig. 1).

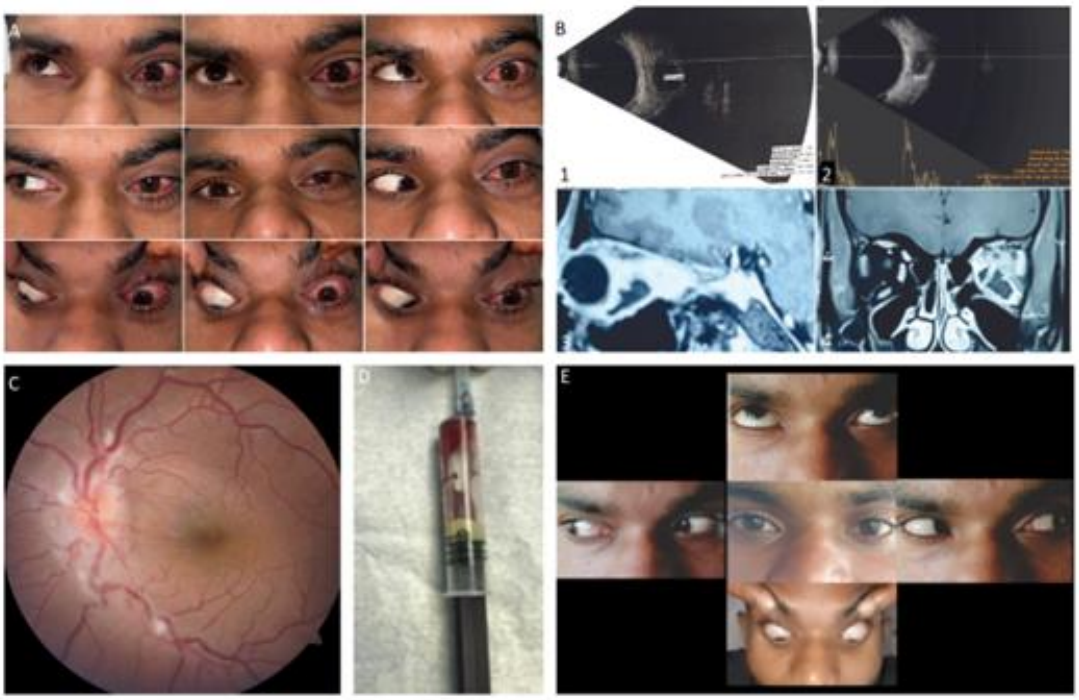

Figure 1: Case 1. A) Nine-gaze photographs showing complete ophthalmoplegia of the left eye at presentation; (B) Imaging findings of inferior rectus abscess: (1) orbital USG showing intramuscular cystic lesion, (2) reduction in abscess size on follow-up USG, (3) sagittal T2-weighted MRI showing inferior rectus abscess with posterior extension, (4) coronal T1-weighted contrast MRI showing peripheral enhancement; (C) Fundus photograph showing optic disc edema with inferotemporal exudates; (D) Aspirated pus; (E) Clinical photograph showing complete recovery of ocular motility.

Case 2

A 32-year-old male presented with pain, sudden forward bulging, redness, diminution of vision and discharge in the left eye for 5 days. The best corrected visual acuity was 6/6 in the Right Eye [RE] and 6/12 in the Left Eye [LE]. In the LE, there was complete ophthalmoplegia and 3 mm of axial proptosis on Hertel's exophthalmometer (Fig. 2). In the inferior fornix, there was a pus point (Fig. 2). There was lid edema, conjunctival hyperemia and chemosis. The pupillary examination and fundus in both eyes were unremarkable. A systemic examination did not reveal any abnormalities. The CECT orbit showed a heterogeneously dense, ill-defined lesion seen in the inferior orbit, involving the inferior rectus muscle of the left eye (S/O IR myositis) (Fig. 2). Based on clinical examination and imaging findings, a diagnosis of inferior rectus pyomyositis was made. Due to his vision threatening condition, the patient was started empirically on intravenous piperacillin 4 g and tazobactam 500 mg 8 hourly. But vision dropped the next day, so LE abscess drainage and mild debridement was done from the subconjunctival pus point. And sent for culture sensitivity. However, microbiological examination did not show any growth of the organism. There was improvement in the extraocular movement with vision 6/9 in the LE on the next day and the patient was discharged. The patient was lost in follow-up. After one year, he sent images that showed complete recovery in clinical condition (Fig. 2).

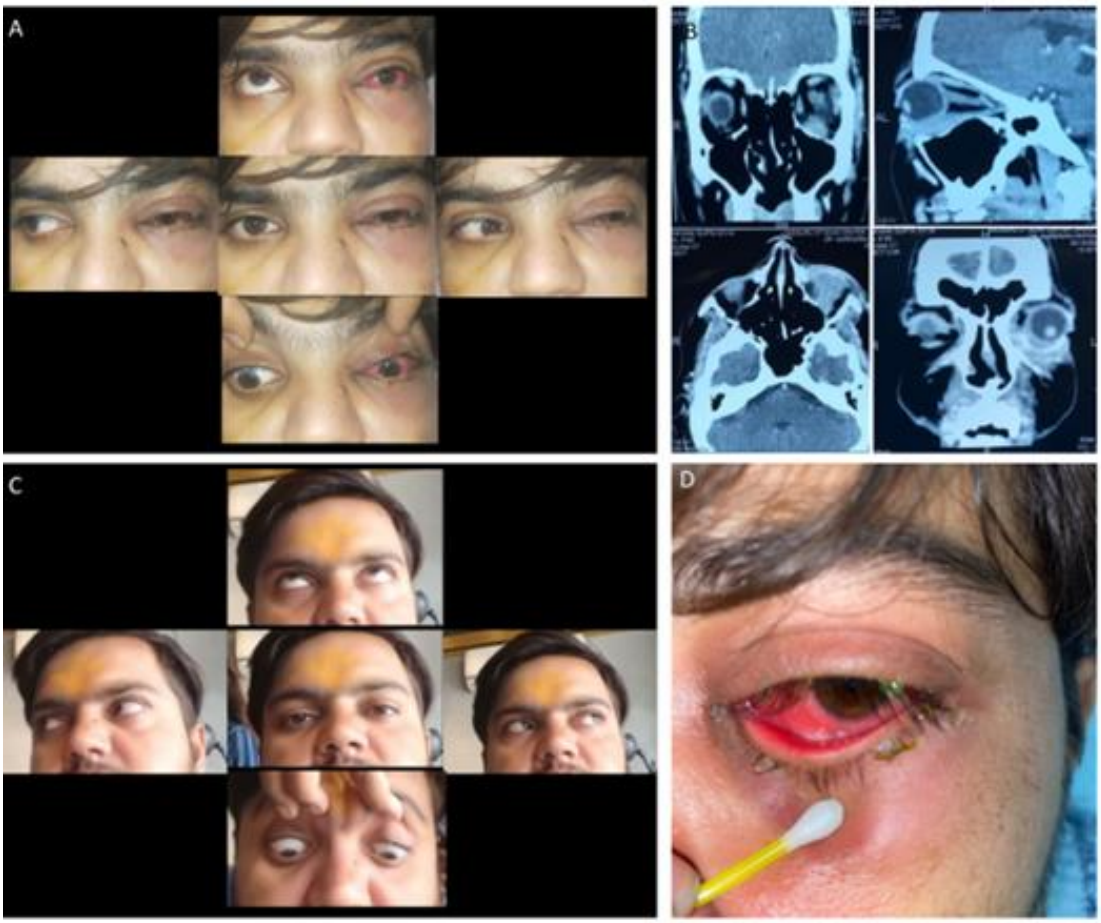

Figure 2: Case 2. A) Clinical photographs showing complete ophthalmoplegia of the left eye at presentation; (B) Contrast-enhanced imaging showing involvement of the inferior rectus muscle; (C) Clinical photograph showing complete recovery of ocular movements at 1-year follow-up; (D) Clinical photograph showing pus point at the inferior fornix.

Case 3

A 50-year-old diabetic male presented with pain, redness, discharge and swelling in RE for 3 days. There was a history of stye three days ago for which the patient took treatment, but it was not resolved. The best corrected visual acuity was hand movement in the Right Eye [RE] and 6/6 in the Left Eye [LE]. In the RE, there was complete ophthalmoplegia, severe axial proptosis, eyelid swelling with moderate ptosis, conjunctival hyperemia with chemosis and an IOP of 54 mmHg. There was an external hordeolum present laterally (Fig. 3). The pupillary examination showed a relative afferent pupillary defect. The fundus in both eyes were unremarkable. A systemic examination did not reveal any abnormalities. On the CECT orbit, there was an ill-defined heterogeneous density lesion in the superficial and pre-septal planes of the right orbit extending into extraconal planes with a swollen lateral rectus and involvement of the lacrimal gland, along with severe proptosis and stretch optic neuropathy (Fig. 2). A provisional diagnosis of lateral rectus pyomyositis with optic neuropathy was made. The patient was started empirically on intravenous piperacillin 4 gm, tazobactam 500 mg 8 hourly and ocular hypotensive agents. But vision dropped to no perception of light in a few hours, so an urgent lateral canthotomy with drainage of the abscess was done and sent for culture sensitivity. The microbiological examination showed *Staphylococcus aureus*. The patient was shifted to intravenous vancomycin 1 gm 12 hourly as per the sensitivity report. The patient started to improve and was discharged after 10 days on oral antibiotics with vision, finger counting close to the face, resolution of proptosis and minimal restriction on abduction. On the 3-month follow-up, BCVA RE was 3/60 without any proptosis or limitation of movement. However, RAPD was present and the fundus showed optic disc pallor (Fig. 3).

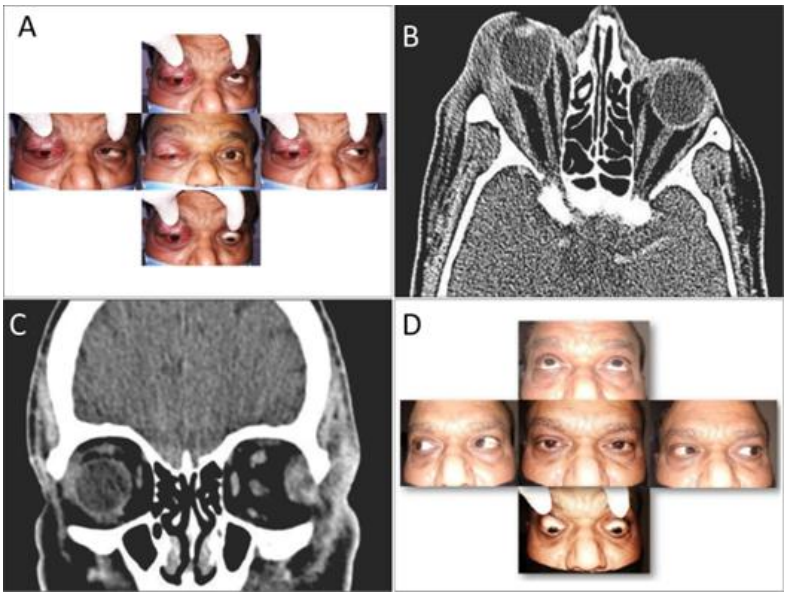

Figure 3: Case 3. (A) Clinical photograph showing acute orbital inflammation of the right eye; (B) Axial CECT orbit showing ill-defined lesion involving the lateral rectus with severe proptosis; (C) Coronal CECT orbit showing swollen lateral rectus muscle; (D) Clinical photograph showing resolution of inflammation at 3-month follow-up.

Case 4

A 4-year-old female child presented with forward bulging of LE associated with eyelid swelling, pain and redness for 20 days. There was a history of exposure to sand particles. On examination, the patient was not cooperating for vision. There was severe proptosis, ptosis with ophthalmoplegia, eyelid swelling and conjunctival hyperemia with chemosis (Fig. 4). The pupillary examination did not show a relative afferent pupillary defect. The fundus in both eyes was unremarkable. ESR was 53 mm/hour. CECT orbit showed CT scan that showed large soft tissue lesion with hypodensity in the center and minimal enhancement Involving the medial rectus of the left orbit, extending from the preseptal planes to the orbital apex region and displacing the contents of the orbit and eye globe laterally, is suggestive of MR pyomyositis (Fig. 4). The patient was started on IV antibiotics (cefotaxime, amikacin and metronidazole) while we waited for GA fitness. On day 3, an incision and drainage of pus was done from the conjunctiva and sent for culture sensitivity. And the very next day started to show improvement in ocular movement, lid edema, chemosis and congestion of the conjunctiva. Microbiological examination showed *Staphylococcus aureus*. The patient improved and was discharged on syrup amoxicillin and clavulanic acid based on culture and sensitivity (Fig. 4). After 2 years of follow-up, the patient had full extraocular movements with vision 6/6 in both eyes (Fig. 4).

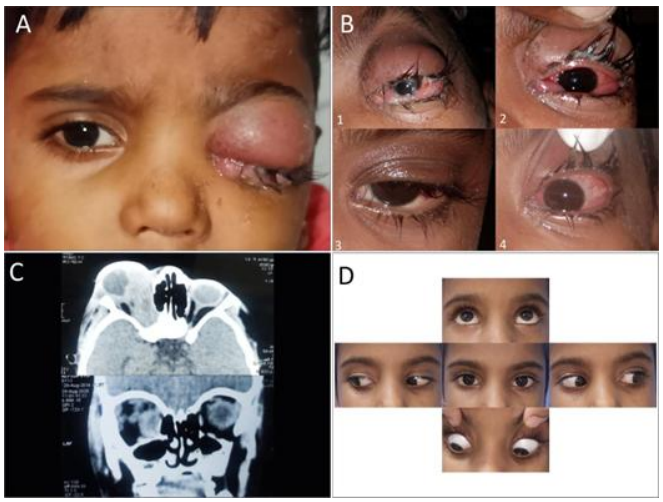

Figure 4: Case 4. (A) Clinical photograph showing severe proptosis, ptosis and ophthalmoplegia at presentation; (B) Serial clinical photographs (1-4) showing progressive improvement following treatment; (C) CECT orbit showing medial rectus abscess extending posteriorly; (D) Clinical photograph showing complete resolution at 2-year follow-up.

Case 5

A 19-year-old male presented with a deviation of the right eye, double vision and blurring of vision for 7 days. There was a history of high-grade fever. The best corrected visual acuity was 6/9 in the Right Eye [RE] and 6/6 in the Left Eye [LE]. On the cover test, there was esotropia of 10 degrees in RE. On examination, extraocular movements were restricted in all gazes except adduction. There was no lid edema or conjunctival congestion (Fig. 5). However, pupillary examination revealed a relative afferent pupillary defect. On fundus examination of the right eye, there was a cuff of subretinal fluid at the fovea, which after OCT and FA revealed central serous retinopathy (Fig. 5). Orbital USG showed a cystic cavity in the nasal quadrant. A CE-MRI T1W scan of the orbit revealed a typical hypointense peripheral enhancing lesion (16*14*12) involving the right medial rectus, extension into the fat and up to the apex, causing indentation to the adjacent optic nerve S/O abscess in the right medial rectus (Fig. 5). The patient was empirically started on IV antibiotics (cefotaxime, amikacin and metronidazole) and IV steroids. On the third day, vision dropped to 6/18. An emergency medial orbitotomy was done. As the abscess was located posteriorly, through a precaruncular incision, the medial rectus was exposed and a needle was inserted along the medial rectus to reach the abscess. Aspiration was done and it was successful. Pus was sent for cultural sensitivity (Fig. 5). Microbiological examination showed Methicillin-Resistant *Staphylococcus aureus* (MRSA). The patient was shifted to an injection of linezolid based on cultural sensitivity. The patient showed improvement in movements and his vision came back to 6/6. The patient was discharged on oral linezolid and steroids. On the 7-day follow-up, there was lower lid edema with a mild worsening of movements again. The oral steroid was stopped and the patient was kept on close follow-up. After 2 months of follow-up, vision improved to 6/6 with full EOM in all gazes (Fig. 5). There was resolution of SRF on the fundus and OCT (Fig. 5), with resolution of the cystic lesion on the B scan.

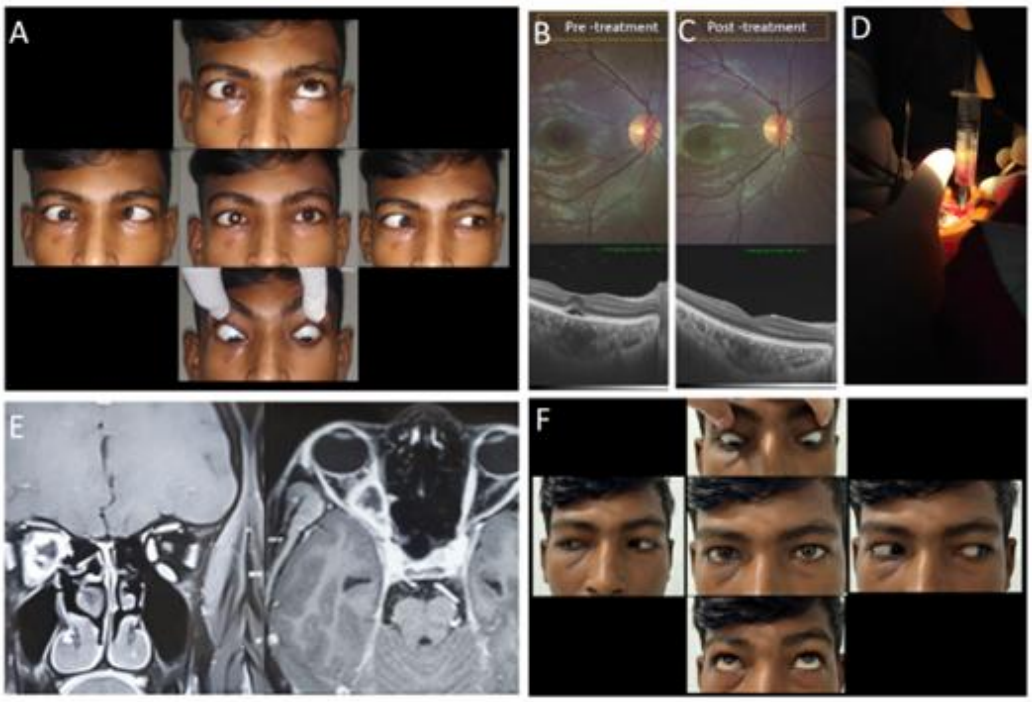

Figure 5: Case 5. (A) Clinical photograph showing esotropia with restricted ocular movements of the right eye; (B) Fundus photograph and OCT showing subretinal fluid at the fovea; (C) Fundus photograph and OCT showing resolution of subretinal fluid; (D) Clinical photograph showing aspiration of pus; (E) Contrast-enhanced MRI showing medial rectus abscess with posterior extension; (F) Clinical photograph showing resolution of motility restriction at 2-month follow-up.

Case 6

An 11-year-old female presented with pain, drooping, swelling and fullness of the left upper lid for days. The best corrected visual acuity was 6/6 in the Right Eye [RE] and 6/9 in the Left Eye [LE]. Examination showed periorbital edema with erythema, mechanical ptosis, mild tenderness, movement restriction in all gazes, 3 mm inferior dystopia and no RAPD (Fig. 6) The right eye was within the normal limit. On orbital USG, a cystic lesion was present in the superior orbit (Fig. 6). The CECT orbit revealed a small, well-defined hypodense cystic lesion with an eccentric enhancing nodule seen in the SR-LPS Complex of LE, causing

proptosis s/o cysticercosis granuloma (Fig. 6). The patient was started on treatment with tab albendazole and oral steroids and was reviewed after 7 days. However, on follow-up, patients showed worsening of signs and symptoms, with vision dropping to 6/12 LE and a new finding of RAPD. On USG, there was an increase in the size of the cystic cavity (Fig. 6). Urgent anterior orbitotomy and drainage was done under antibiotic coverage of piperacillin and tazobactam (2.25 g TDS). The patient started to show improvement and was discharged. After 3 months of follow-up, there was a complete clinical recovery (Fig. 6).

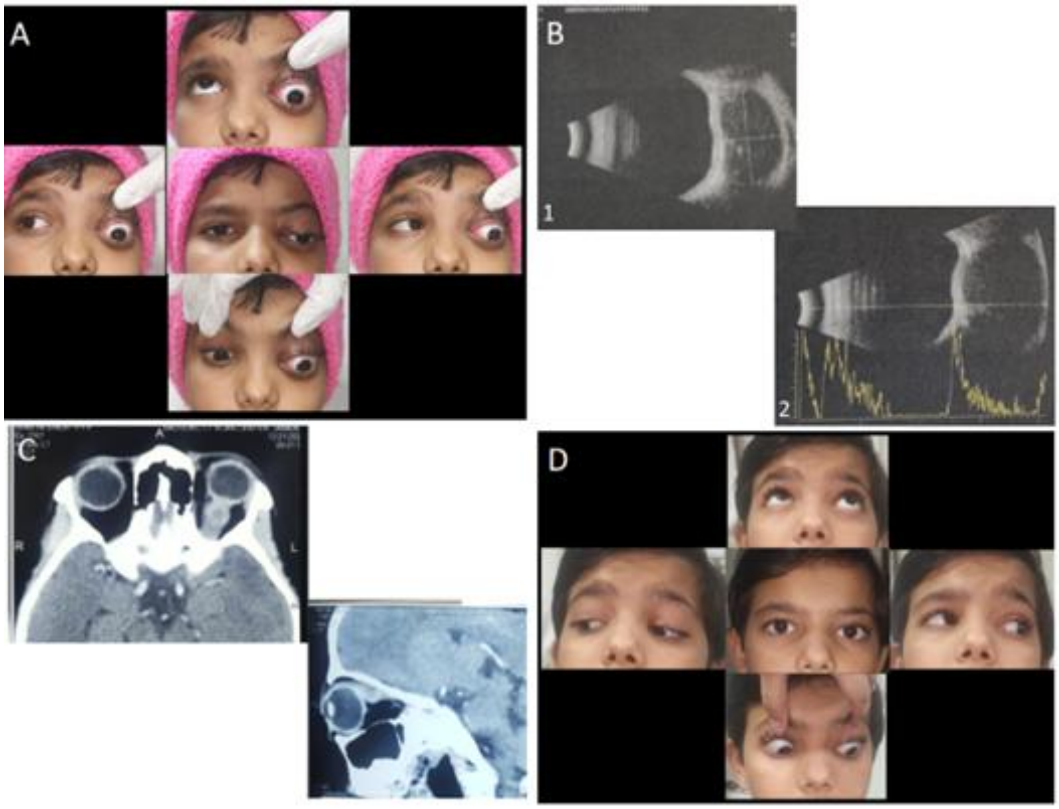

Figure 6: Case 6. (A) Clinical photograph showing proptosis, lid edema and ptosis of the left eye; (B) Orbital USG showing (1) cystic lesion at presentation and (2) increase in size on follow-up; (C) CECT orbit showing cystic lesion in the superior rectus-levator palpebrae superioris complex; (D) Clinical photograph showing complete recovery at 3-month follow-up; (A) Clinical pictures showing proptosis, lid edema, ptosis; (B) USG images; 1. Size of cystic cavity at presentation; 2. Increase in size of cystic cavity at follow up; (C) CECT orbit revealed a small, well-defined hypodense cystic lesion with an eccentric enhancing nodule seen in the SR-LPS Complex of LE; (D) Complete ocular movements at 3 months follow up with resolution of proptosis and ptosis.

Discussion

Pyomyositis is a suppurative intramuscular bacterial infection. It usually affects the large skeletal muscle; extraocular muscle involvement is a rare entity. It may occur due to contiguous spread of infection from the adjacent sinuses or may be bloodborne. 95% of causative agents in tropical areas and 75% in nontropical areas are *Staphylococcus aureus* [1]. There are 14 cases reported of almost similar presentation of EOM pyomyositis [2]. This is the largest case series till now with atypical findings not reported in the literature yet to the best of our knowledge.

Out of the 14 cases reported, there were 10 males and 4 females. Similarly, demography in our case series showed 4 males and 2 females. The clinical features of bacterial pyomyositis of EOM are comparable to those of generalized bacterial orbital cellulitis. Ophthalmoplegia and local inflammatory signs are the most common clinical features. However, one of our cases presented atypically with white eye and esotropia with limitations of movement. Systemic corticosteroids were used selectively in this series and only after initiation of adequate antimicrobial therapy and, where indicated, surgical drainage. The rationale for steroid use was to reduce severe inflammatory edema, optic nerve compression and restrictive myopathy, particularly in cases with vision-threatening features. In patients with suspected or confirmed infection-related intraocular involvement, like this case, steroids were administered cautiously and under close monitoring, always in conjunction with appropriate antimicrobial

coverage. One case demonstrated imaging features classically described as orbital cysticercosis, highlighting the potential radiological overlap with early EOM pyomyositis. Rapid clinical worsening, new-onset relative afferent pupillary defect and progressive enlargement of the lesion on serial ultrasonography served as important red flags prompting reassessment and surgical intervention, ultimately confirming an infective etiology. Two patients in the systematic review had leukemia or diabetes [1,3]. Similarly, in our case series, one patient had diabetes and had the most severe presentation. The duration of symptoms is mostly within one week in almost all cases. The most common organism reported is *Staphylococcus aureus* in the literature. However, one of our cases showed the growth of *Staphylococcus pseudointermedius*, which is atypical of EOM pyomyositis. The identification of uncommon organisms underscores the importance of obtaining culture samples whenever feasible. In the systematic review, mostly all patients have undergone incision and drainage of pus under broad-spectrum antibiotics and nearly all patients showed complete resolution with the above treatment, except three who had scarring [1,4,5]. We also went for incision and drainage in all patients except 2, in which aspiration was done directly and in one after exposing the medial rectus and it was successful. Although it should have been done under USG guidance. In our case series, all patients had complete clinical recovery except one who had optic disc pallor due to stretch optic neuropathy. The pathophysiological basis of the rare complications observed in our series appears to be multifactorial. Endogenous endophthalmitis associated with extraocular muscle pyomyositis may result from hematogenous spread of infection from inflamed orbital tissues through the rich orbital and choroidal vascular network, particularly when severe inflammation disrupts the blood-ocular barrier. In one of our cases, *Staphylococcus pseudintermedius* was isolated, a zoonotic pathogen known for biofilm formation and virulence factors such as leukotoxins and enterotoxins, which may facilitate aggressive tissue invasion and systemic dissemination, potentially explaining the severity of intraocular involvement. In the case complicated by central serous chorioretinopathy, subretinal fluid was already present at the time of diagnosis, prior to initiation of systemic corticosteroids, suggesting that inflammatory stress related to severe orbital infection may have played a primary role. Systemic steroids were nevertheless administered to control sight-threatening orbital inflammation, with close monitoring, recognizing that corticosteroids may influence the course of CSR. This case highlights the complex therapeutic decision-making required in such scenarios and underscores the need for individualized risk-benefit assessment. This study has several limitations. Visual and motility outcomes were reported descriptively, as standardized grading scales could not be uniformly applied due to the retrospective design and variability in documentation. Additionally, the duration and consistency of follow-up varied among patients, reflecting real-world challenges in managing rare orbital infections. These factors limit direct comparison of outcomes and preclude statistical analysis. However, the series still provides valuable clinical insights into a rarely reported condition.

Conclusion

Pyomyositis of EOM should be considered in any patient presenting with acute onset of orbital inflammation and characteristic CT or MRI features. And there should be high clinical suspicion for atypical cases. Once the diagnosis is confirmed, early intervention in the form of incision and drainage or aspiration with or without USG guided, coupled with antibiotics, are useful to eradicate the infection in most patients.

Conflict of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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This research did not receive any specific grant from funding agencies in the public, commercial or non-profit sectors.

Data Availability Statement

All data generated or analysed during this study are included in this article and its online supplementary material. Further inquiries can be directed at the corresponding author.

Ethical Statement

The project did not meet the definition of human subject research under the purview of the IRB according to federal regulations and therefore, was exempt.

Informed Consent Statement

Informed consent was taken for this study.

Authors' Contributions

Farheena Kulsum, Narendra Patidar, Harshdeep Singh Gaba, Ayush Mehta contributed to data collection, data analysis, manuscript writing, manuscript editing and manuscript review.

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