Fibrous dysplasia is a rare, non-malignant disease that involves the development and thickening of craniofacial bones, causing facial asymmetry, visual, neurological and dental complications. Decreased visual acuity in orbitofrontal and sphenoidal fibrous dysplasia appears as a result of compressive lesions on the optic nerve. The aim of this article is to present the ophthalmologic complications due to the association of two entities that both involved the optic nerve: orbitofrontal fibrous dysplasia associated with a large sphenoid sinus mucocele. We report the case of a 20-years old male patient, who was admitted to the Neurosurgery Unit II of “Prof. Dr. Nicolae Oblu” Emergency Clinical Hospital, Iassy, Romania for headache, sudden decrease in visual acuity of both eyes in the last month, though more markedly in his right eye and facial deformity with right frontal bony bulging. The patient hadn’t in his previous medical history any dermatological or endocrinological diseases. The first histopathological examination confirmed that the orbitofrontal and sphenoidal lesion had a typical appearance of fibrous dysplasia and the second biopsy revealed a sphenoid sinus mucocele. Six months after the evacuation of the sphenoid sinus mucocele, patient recovered completely his vision only in the left eye (20/20) and the right eye had no light perception, he also developed a peripheral right facial nerve palsy.

The ophthalmological examination revealed a visual acuity of the right eye (VA RE) = hand movements and best corrected visual acuity of the left eye (VA LE) = 20/60; there was an afferent pupillary defect in the right eye; the ophthalmoscopic examination revealed optic disc atrophy in the right eye and normally looking optic disc in the left eye.

Skull X-ray showed a “ground-glass” appearance of the frontal bone (Figure 1A).

Cranio-cerebral computed-tomography (CT) scan showed expansive, hyperdense and inhomogenous lesions, involving the frontal, ethmoid and sphenoid bones on both sides, yet predominantly on the right (Figure 1B), and a cystic and osteocondensed lesion located in the anterior and middle cranial fossa.
The MRI scan of the head identified a well-defined neoformation, having 57/56/41 mm (ap / transverse / cranio-caudal), relatively homogeneous, with polycyclic contour, located in the sella turcica and parasellar, that extended predominantly anteriorly to the right ethmoid bone, but also posteriorly to the retroesellar region with compressive effect on the optic chiasm and neighboring structures (Figure 1C). Another extensive lesion affecting the right frontal bone, showed in homogeneous structure. The thickness of the right frontal bone had a diameter of 28/16 mm (Figure 1D).

There was also an incomplete development of the cerebral frontal lobes, especially of the right lobe, but no other significant pathological changes of the brain parenchyma. Bilateral hyperostosis of the great sphenoid wings could be seen. Right polypoid chronic maxillary sinusitis associated with moderate inflammatory features of its inner wall and a mild chronic ethmoiditis, predominantly on the right side (Figure 1B).

Based on these radiological findings a diagnosis of monostotic craniofacial dysplasia associated with a sphenoid sinus mucocele, causing bilateral partial obliteration of both optic canals with compression of both optic nerves was made.

The patient underwent two successive surgeries. The first was an attempt to perform bilateral decompression of the optic nerves and the second one aimed to evacuate the large sphenoid sinus mucocele, using a transfacial and transmaxillary approach with sampling of a sphenoid bone fragment for the histopathological exam (Figure 2). The first microscopical exam established the diagnosis of fibrous dysplasia, as the normal bone and marrow were replaced by fibrous tissue and haphazardly distributed thin bone trabeculae, seen as “Chinese letters” on the fibrous background (Figure 3, 4). The second lesion was a sphenoid sinus mucocele. Two weeks postoperatively, the patient had best corrected visual acuity of the left eye 20/20, but there was no light perception in the right eye. Later, the patient developed right-sided peripheral facial nerve palsy. Six months after the surgery, the ophthalmological examination revealed: VA LE = 20/20 and VA RE = no light perception (NLP). The ophthalmoscopical examination...
revealed normally looking left optic disc and total secondary right optic disc atrophy.

**Discussions**

Fibrous dysplasia is a developmental disorder of growing bones [5], and its frequency varies between 5 - 7% of all benign bone tumors [7]. The presentation forms of fibrous dysplasia are: the monostotic form (usually asymptomatic and incidental findings), polyostotic form as well McCune-Albright syndrome (polyostotic fibrous dysplasia, multiple endocrine abnormalities, skin pigmentation, precocious puberty) [8], and Mazabraud syndrome (intramuscular myxoma).

Craniofacial involvement in monostotic fibrous dysplasia could be found in only 10%-30%, but the percentage is higher (50-100%) in the polyostotic form [5,9,10].

Among the craniofacial localizations of fibrous dysplasia, the maxillozygomatic complex is most frequent affected [11]. Ethmoid, sphenoid, temporal and frontal bones are rarely involved [12].

In cases of orbitofrontal sphenoidal fibrous dysplasia, the decrease of visual acuity is progressive, produced by bone proliferation and compression of the optic nerve (50-90% of the cases) [13].

Sphenoid mucocele is also a rare condition comprising 1–2% of all mucoceles [14] with less than 150 cases reported until now. Mucocele is defined as the accumulation and retention of mucoid secretion within a paranasal sinus, leading to thinning and distension and erosion of one or several of its bony walls. Several hypotheses are postulated for the formation of mucocele, like blockage of duct, cystic dilation of mucous gland and cystic degeneration of polyp [15]. Sphenoidal mucocele have various clinical presentations because of adjacent non-bony structures, namely first six cranial nerves, the carotid arteries, the cavernous sinuses and the pituitary gland. Headache is the most common symptom [16]. Visual impairment is the second-most common symptom, and is mostly because of optic nerve involvement. It can lead to decreased visual acuity and even blindness, which is usually irreversible [17]. Visual disturbance can occur because of the third nerve involvement [18].

Investigations for diagnosing sphenoid mucocele include plain X-ray of skull A.P. and Lat. views, which can show enlargement and ballooning of the sella with erosion of its walls. CT scan of the brain in case of sphenoid mucocele would show a hypodense cystic lesion in the sphenoid sinus with or without extension to the adjacent sellar, suprasellar, paraseellar and retroseellar regions. It has to be differentiated with other cystic lesions usually seen in this location, such as craniopharyangioma, Rathke cleft cyst, cystic pituitary adenoma, epidermoid cyst, cystic optic nerve glioma and arachnoid cyst. MRI scans of the brain can diagnose mucocele without doubt as a cystic homogenous lesion in relation to the parasanal sinuses [14,19]. These lesions tend to extend and expand along the path of least resistance. The slow and silent expansion of a mucocele may be unsuspected until bone is eroded and it impinges on adjacent structures. Sphenoidal mucoceles generally tend to spread more frequently in an anterior–inferior fashion with invasion of the ethmoid, the nasal fossae and the nasopharynx. It may show upward invasion with destruction of the sellar floor. There may be an invasion in the orbital cavity when spreading occurs sideways. More rarely, the intermediate cranial fossa is invaded through the lateral wall and the posterior cranial fossa through the posterior wall [20].

In our case, visual impairment in both eyes was initially determined by the progressive compression of the optic canals, predominantly of the right side, due to the orbitofrontal fibrous dysplasia. Sudden visual impairment, more markedly in the patient’s right eye appeared due to supplementary compression of the optic chiasm and right optic nerve by the large sphenoid sinus mucocele; after the evacuation of the mucocele, visual acuity fully recovered in the patient’s left eye (20/20). The patient’s visual acuity of the right eye remained without light perception due to right secondary optic disc atrophy.

Patients diagnosed with craniofacial fibrous dysplasia often involves facial asymmetry, exophthalmia, limitation of eye movements and decreased visual acuity [21], due to compression of the optic nerve [22]. Impaired vision is the most feared complication [21], and is the most common complication of fibrous dysplasia that affects the craniofacial bones [23], especially the sphenos-ethmoid complex [5]. In craniofacial fibrous dysplasia there are some other ocular manifestations that could be associated with decreased visual acuity, such as impaired sense of color, visual field defects and pupillary defect. All of them would appear in a progressive or acute manner [13,21].

The compressive effect of craniofacial fibrous dysplasia on the optic nerve and optic chiasm can be identified using CT and MRI scans.

From radiographic point of view, there are three forms of fibrous dysplasia [24]: the compact form (50% of the cases), the lytic form and the mixed form. Our patient had the compact form of fibrous dysplasia which affected the sphenoid bone, and bilateral orbital roofs and frontal bones.

The MRI aspect depends on the degree of fibrous tissue cellularity and the number of bone trabeculae [25]. The differential diagnosis may be carried out by: chordoma, chondroma, hyperstotic meningioma, osteoma, osteosarcoma, hyperostosis and ossifed fibroma. Surgery is indicated in symptomatic cases. In asymptomatic cases, in which fibrous dysplasia impairs important structures, clinical monitoring and repeated imaging are recommended [26].

Conservative treatment may be indicated in patients with unaffected visual acuity accompanied by radiological control, interpreted in the context of clinical correlations [21]. Treatment with corticosteroids has been used successfully in patients with fibrous dysplasia as a temporary measure in patients who have loss of visual acuity [27], but it has not been used in patients complaining of recurrent of visual acuity [21]. Surgical treatment is controversial and consists of preventive or therapeutic decompression of optical channel [1,28-30], which leads many times to loss of visual acuity in the affected eye or to an increased incidence of visual acuity changes [23,28].

In our patient, the first surgery was an attempt to decompress the bilateral optic nerve and the second one to evacuate the large sphenoid sinus mucocele, in order to decompress the optic chiasm.
Postoperatively, the patient had fully recovered sight in his left eye, but his right eye sight was permanently impaired, the right optic nerve being already atrophied.

In orbitofrontal fibrous dysplasia, the surgical approach is set out depending on the location of the lesion. Most lesions may be reached by anterior approach: transfacially, through the coronary approach or endoscopically [31]. The lesions which are limited on the frontal, ethmoidal or sphenoidal region may be respected by an endonasal approach. In our case, the surgical approach was performed through the right maxilla.

**Conclusion**

In the case reported here, the patient was diagnosed late, when he was admitted to the Neurosurgery Unit, for bilateral visual acuity impairment, headache and facial deformity. Optic nerve and optic chiasm compression was due to the association of two entities that both involved the optic nerve: orbitofrontal fibrous dysplasia associated with a large sphenoid sinus mucocele, which caused right optic nerve atrophy and permanent visual impairment in the right eye.

The patient should see the physician at first clinical signs, as to make the treatment possible at an appropriate time, so as he should not be left with serious sequelae, particularly the permanent impairment of the visual acuity.

**Conflict of Interests**

The authors declare that they have no conflict of interests.

**References**