Hemangiomas are benign tumor formations of capillaries and blood vessels, common in various organs; they are extremely rare in the urinary bladder, accounting for only 0.6% of all urinary bladder tumors[1,2]. There have been fewer than 100 reported cases of histologically proven hemangioma of the urinary bladder[1].

Most urinary bladder hemangiomas are solitary and smaller than 3 cm in diameter, affecting the dome, posterior wall, or trigone of the bladder. Although hemangiomas can occur in individuals of any age, they are seen most often in individuals under 30 years of age and are slightly more common among males[2]. A hemangioma usually presents as an incidental finding during the investigation of hematuria. The most common symptom is gross hematuria, which can be accompanied by irritative urinary symptoms and abdominal pain. Urinary bladder hemangiomas occasionally coexist with cutaneous hemangioma or are associated with one of two conditions[3–5]: Sturge-Weber syndrome and Klippel-Trenaunay-Weber syndrome.

In young patients, endoscopic findings of a bluish, sessile mass and gross hematuria are highly suggestive of hemangioma[1]. The main differential diagnoses for pigmented lesions seen on endoscopy include endometriosis, melanoma, and sarcoma[6]. Imaging tests, such as ultrasound, computed tomography, and magnetic resonance imaging, are useful in defining the location and extent of a hemangioma[2].

For individuals with hemangioma, the treatment is controversial. Although there are many options available, partial cystectomy is currently the most widely used treatment for hemangioma of the urinary bladder[3,6,7]. Although hemangioma has a benign course, follow-up is mandatory in order to detect recurrence or residual disease[3,7,8]. The purpose of this case report was to underscore the importance of early diagnosis of hemangioma of the urinary bladder and of differentiating it from malignant neoplasms, which would affect the therapeutic strategy and patient survival.

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### Subconjunctival fat prolapse: a disease little known to radiologists

*Dear Editor,*

A 69-year-old male patient sought outpatient treatment with a 10-year history of fatty masses in the lateral corners of his eyes, best characterized as retropulsion of the globes. He underwent computed tomography (CT) of the orbits, which revealed intraconal fat proliferation in the lateral corners of the eyes, from the orbits to the epibulbar region (Figure 1). Given the clinical presentation and imaging findings, a diagnosis of subconjunctival fat prolapse was made.

Subconjunctival fat prolapse is an acquired, typically bilateral, condition characterized by herniation of the intraconal fat, resulting from weakness of the eyeball and intermuscular septum due to aging, trauma, or surgery[1]. It is more common in obese men between the 7th and 8th decades of life and

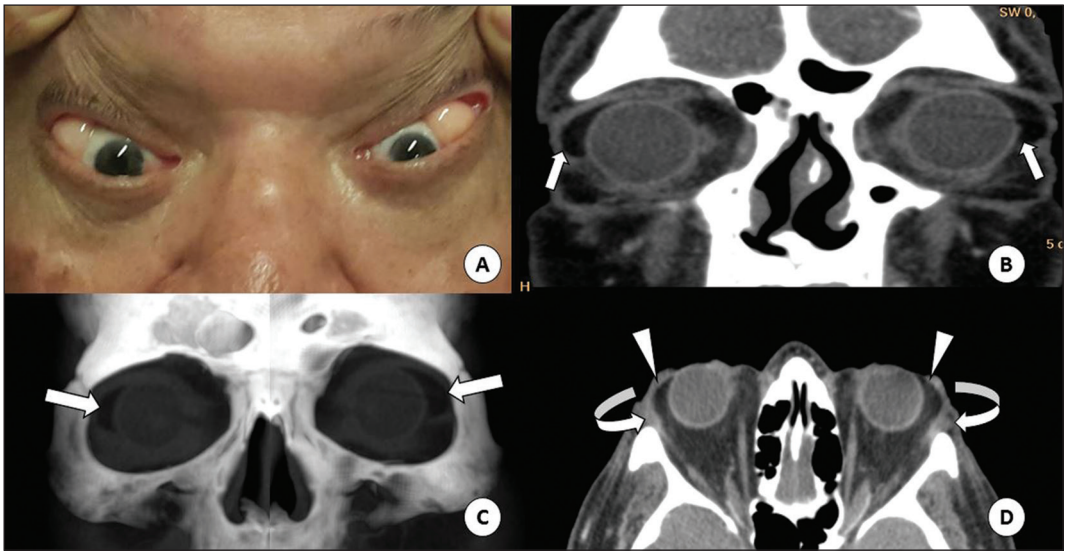


**Figure 1. A:** Fatty mass in the lateral corner of the orbits, best characterized by the retropulsion of the globes. CT of the orbits in the coronal plane (**B**), with volumetric reconstructions in the coronal plane (**C**) and axial plane (**D**), showing the masses in the lateral corners (straight arrows), contiguous with the intraconal fat (arrowheads) and pushing aside the lacrimal glands (curved arrows).

manifests clinically as a yellowish mass in the lateral corner of the eye, which becomes more evident with retropulsion of the globe[2].

The imaging tests that can facilitate the diagnosis of subconjunctival fat prolapse are CT and magnetic resonance imaging (MRI) of the orbits, the most important radiological finding being that of a mass with fat density or fat-like signal intensity, respectively, located in the temporal aspect of the orbits, contiguous with intraconal fat.

The treatment consists of transconjunctival excision, a simple, safe and effective surgical procedure. The rate of recurrence after transconjunctival excision is reported to be approximately 9%[3].

Making a clinical diagnosis of subconjunctival fat prolapse is relatively easy. However, due to its rarity, it can be misdiagnosed as conjunctival dermolipoma, lymphoma, epidermoid cyst, or lacrimal gland prolapse[4]. The main differential diagnosis is conjunctival dermolipoma, which consists of a benign lesion, usually present at birth[5], that affects young women, the mean age of such patients being 22 years[6]. Although the clinical presentation of conjunctival dermolipoma is similar to that of the subconjunctival fat prolapse, the former is typically unilateral and fairly immobile. On CT and MRI, conjunctival dermolipoma presents as a crescent-shaped fatty mass in the temporal aspect of the orbit, not in communication with the intraconal fat[1].

In conjunctival dermolipoma, surgical resection is indicated mainly for aesthetic purposes and tends to be more conservative[1]. Although resection of a conjunctival dermolipoma is a simple procedure, there can be severe complications, including blepharoptosis, diplopia, and keratoconjunctivitis sicca. Therefore, a number of different surgical techniques aimed at a lowering the rate of complications and improving the aesthetic results have been described, including resection with conjunctival flap rotation[7].

Subconjunctival fat prolapse and dermolipoma present clinically as a fatty epibulbar masses in the lateral corners of the orbits, and in some cases their differentiation by clinical aspects can be difficult. The subject is little known among radiologists, and there have been few reports of related cases. Therefore, given the difference between these two entities in terms of treatment, it is necessary that radiologists be familiar with both, in order to recognize them promptly and make the differential diagnosis through the use of imaging tests.

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### Ogilvie syndrome after use of vincristine: tomographic findings

*Dear Editor,*

A 33-year-old female patient with diffuse large B-cell non-Hodgkin lymphoma was evaluated two days after the end of the first cycle of chemotherapy. The chemotherapy regimen comprised a five-day cycle, including rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone on the first day, whereas prednisone alone was administered on the four remaining days. She reported left pleuritic pain and flatus with evacuation. She was afebrile. The abdomen was flaccid and peristaltic, without painful decompression. Because she had neutropenia, she was hospitalized, after which she evolved to having no bowel movements, with the smell of feces on her breath and painful abdominal decompression. Computed tomography (CT) of the chest and abdomen showed left pleural effusion, intestinal obstruction in the descending colon adjacent to the splenic flexure, that segment being of normal caliber, without occlusive lesions, although the transverse ascending colon and cecum were dilated, the latter being 14 cm in diameter (Figures 1 and 2). There was gas in the rectal ampulla. These findings were suggestive of acute colonic pseudo-obstruction. Colonoscopic

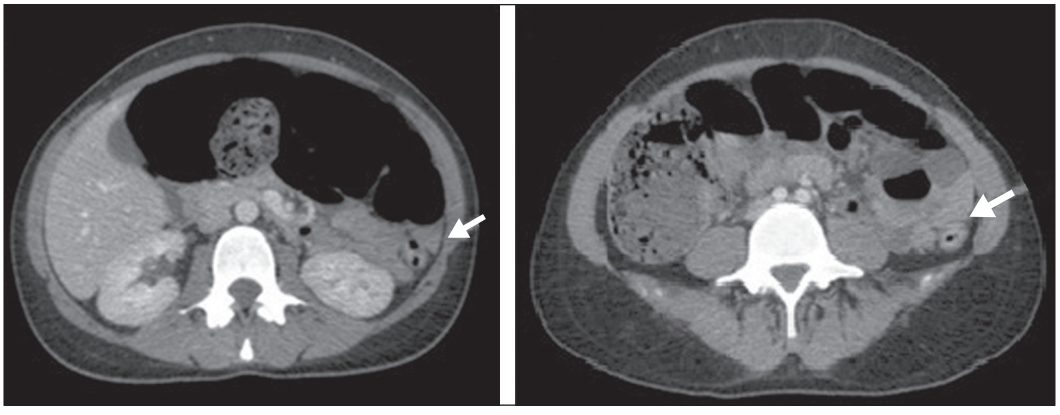

**Figure 1.** CT scan of the abdomen, in axial sections, obtained 60 s after injection of iodinated anionic contrast. Note the intestinal obstruction at the level of the proximal descending colon, adjacent to the splenic flexure. Distension of the transverse colon, ascending colon, and cecum, with the presence of fecal matter. The transitional zone can be seen at the level of the splenic flexure (arrow), with no evident obstructive material.