Commentary: Vitrectomy as a treatment modality in vitreous seeding secondary to ciliary body melanocytoma

The variation in the presentation of anterior uveal tumors throws up several possibilities related to their management. Diagnostic work-up with slit-lamp examination, gonioscopy, transillumination test, ultrasound biomicroscopy (UBM), fluorescein angiography, and magnetic resonance imaging (MRI) help to reach a provisional diagnosis. One needs to establish the cystic/solid and melanocytic/nonmelanocytic nature of the tumor, and a decision about FNAC[1]/incision/excision biopsy[2-5] is arrived at depending on the tumor size, location, and surgeon's familiarity of the biopsy technique. Often, the benign/malignant nature of the tumor can be established with this approach using histopathological and immunohistochemistry testing and a treatment plan is put in place. While benign, nonprogressive tumors can be observed, intervention is required for malignant or progressively enlarging tumors. In literature with adult subjects, surgical excision is successful for globe salvage in 71--81% with final visual acuity of ≥20/40 achieved in 50--53%, but has its own share of complications.[2-4] Complete surgical excision of intraocular tumor with established pathological evaluation leads to favorable long-term outcomes.

Management options for tumors with an established diagnosis of CB melanocytoma include observation, plaque radiation,[6] surgical excision, or enucleation. In the current study,[7] the authors have done well to surgically remove the dense pigmented vitreous floaters and achieved gratifying visual outcome. However, this report throws up other pertinent questions that the literature is deficient about. How does one predict the risk of recurrences of necrosis and pigment release, besides the rare possibility of malignant transformation?[8]

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Access this article online

Quick Response Code:

Website: www.ijo.in

DOI: 10.4103/ijo.IJO_1119_19

Cite this article as: Rishi P. Commentary: Vitrectomy as a treatment modality in vitreous seeding secondary to ciliary body melanocytoma. Indian J Ophthalmol 2019;67:2085.