

Sir,
'I took a gamble and I lost': unwarranted patient regrets about choice of treatment of uveal melanoma

We report a patient with uveal melanoma who mistakenly blamed himself for developing metastatic disease because he had chosen to undergo brachytherapy for his primary tumour instead of enucleation. Our impression is that this important cause of psychological morbidity has not received sufficient attention in the published literature.

Case report

A 63 year-old man was referred with a superior choroidal melanoma in his left eye. The visual acuities were 6/12 and 6/9 with the right and left eyes, respectively. The tumour was situated superiorly (Figure 1aFigure 1

Choroidal melanoma in left eye (a) pre-operatively, and (b) one year after brachytherapy showing early tumour regression, with vision of 6/12.) and on ultrasonography measured 19 mm × 14 mm in its basal dimensions, with a thickness of 4 mm. The diagnosis, prognosis, and choice of treatments were discussed and the patient was given an audio-cassette tape recording of the conversation, to help him remember what was said. He was treated with a 25 mm ruthenium plaque with minimum scleral and apex doses of 400 and 100 Gy, respectively. One year post-operatively, the vision was 6/12 and the tumour thickness had diminished to 2.7 mm, with no sign of any recurrence (Figure 1b). At 18 months after his ocular treatment, he developed clinical metastatic disease involving the liver and right lung. While discussing his condition with the first author, the patient casually commented that he had 'taken a gamble and lost'. On further questioning, it became evident that he believed he would not have developed metastatic disease if he had elected to have enucleation instead of radiotherapy as primary treatment of his uveal melanoma. It was possible to console the patient by explaining that his outcome would have been the same even if the eye had been removed.

Comment

A chance remark revealed that our patient believed that he would not have developed metastasis from his uveal melanoma if he had chosen to have his eye removed when he was diagnosed as having uveal melanoma. This self-blame was causing significant psychological distress to him and his relatives.

There is ample evidence that the prognosis for survival after radiotherapy is not significantly worse than that following enucleation.¹⁻⁴ It is now generally believed that

tumour dissemination from the eye occurs at an early stage, before presentation with the primary ocular tumour.^{5,6} The regrets expressed by the patient were therefore unfounded and unnecessarily causing psychological distress.

To our knowledge, there is no published information on the incidence of this type of misconception in patients with uveal melanoma and the psychological impact on any such beliefs. It is routine practice for the senior author to inform all new patients that the choice of treatment has no significant impact on survival probability; however, this important fact might be overlooked, or in time forgotten by the patient. Whenever notified of a patient with newly detected metastatic disease, the senior author routinely writes or speaks to the affected individual to express sympathy and to dispel any unwarranted regrets about choice of treatment. It is not uncommon, however, for the ocular oncologist to learn about the development of metastatic

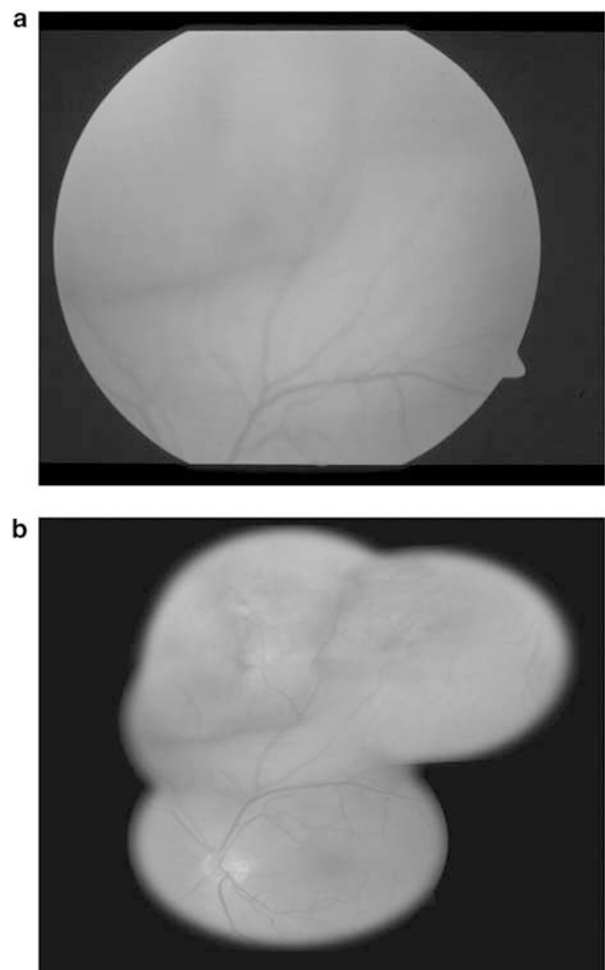


Figure 1 Choroidal melanoma in left eye (a) pre-operatively, and (b) one year after brachytherapy showing early tumour regression, with vision of 6/12.

disease only after the patient has died so that opportunities for providing consolation by specialised counselling are missed.

This case highlights the need for protocols maintaining an effective dialogue with all patients with uveal melanoma, even after they have been discharged from the ocular oncology centre, so that any concerns can be addressed without delay.

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Sir, Rose-hip keratitis

A 22-year-old male patient presented with a 1-day history of pain, redness, itching, and mild blurring of vision in his right eye, associated with a periorbital rash. He noticed the symptoms started immediately following rubbing his eyes after he ate a rose-hip fruit.

His visual acuity was normal in both eyes. The periorbital skin around the right eye was erythematous and lids were swollen. Conjunctiva was inflamed and oedematous with marked ciliary injection (Figure 1a). Tarsal conjunctiva of both upper and lower lids revealed a moderately severe papillary reaction (Figure 1c,d). The cornea showed mild haziness with small multiple peripheral infiltrates all round the circumference of the cornea (Figure 1a,b). The infiltration was mainly in the superficial layers of the cornea that is, superficial stroma although the corneal epithelium was not grossly disrupted. There was no anterior chamber activity and the intraocular pressure was within normal range.

A diagnosis of keratoconjunctivitis secondary to contact with rose-hip was made and treated with 2-hourly topical prednisolone 1% eye drops. The conjunctival inflammation and the corneal infiltrates resolved gradually and the patient was asymptomatic in 2 weeks time. The symptoms did not recur on cessation of therapy.

Discussion

Plant products, extracts, and saps are well-known causes of ocular irritation and inflammation and may lead to serious ocular surface abnormalities.^{1–3} Our patient is very unusual in that he developed a moderately severe keratoconjunctivitis following contact with rose-hip. Dog Rose (*Rosa canina*) is found in hedgerows, in scrub, and along margins of woodlands. Leaves open in April and

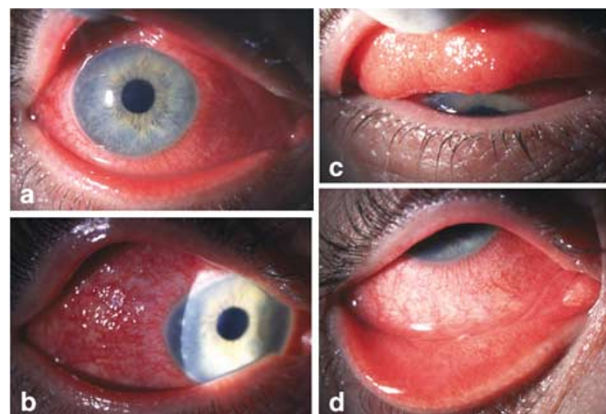


Figure 1 Slit-lamp photograph showing mild corneal haze with multiple superficial peripheral corneal infiltrates (a,b) and papillary conjunctival reaction and circumciliary injection (c,d).