Editorial: Treatment of eyelid tumours

At one time the treatment of cancer was vested more or less exclusively in the hands of the surgeon—if no recognition is made of the rather meaningless and sometimes bizarre treatments which were provided by certain medical practitioners and which had no significant influence on the progress of the disease—although, it must be recognized that a profound personal interest in a patient afflicted by a devastating disease may provide a remarkable boost to the morale, despite the absence of any rational basis for the particular treatment. The advent of irradiation as a treatment for malignant disease marked an important step forward, but inevitably there was a considerable conflict between the surgeon (who had an established role in the treatment of cancer) and the radiotherapist (who was striving for such recognition). It is, of course, essential in putting forward a new doctrine to emphasize its importance, and this almost certainly applied to radiotherapy in the early days. However, the passage of time is a remarkable natural healer of conflict, and this is shown by the numerous multidiscipline clinics which have gradually developed over the years with involvement by the surgeon, radiotherapist, chemotherapist, and the pathologist who is no longer in isolation but concerned in correlating the clinical and histological features of the disease and particularly in recognizing certain characteristics which provide some clue to the likely progress of the disease and even the possible response to treatment.

This recognition of an interdependence of different disciplines is of significance and in the management of many forms of malignant disease there is a clear recognition of the role of each different form of therapy. For example, in breast cancer radiotherapy usually follows surgical treatment, whereas in certain forms of malignant disease of the bladder or naso-pharynx, irradiation is carried out sometimes before surgery. In certain other conditions the various roles are slightly less defined—such as in the craniopharyngiomas—when some neurosurgeons limit their treatment to the immediate relief of pressure by dealing with the cystic part of the tumour, particularly if the tumour is adjacent to the optic chiasma or the associated parts of the afferent visual pathways, so that the final resolution of the tumour is the province of the radiotherapist, whereas other neurosurgeons may feel impelled to attempt to eradicate the tumour irrespective of its extent.

In certain situations, however, there seem to be no clear guidelines regarding the treatment of cancer, and this certainly applies to tumours involving the eyelids, as illustrated in the two papers in this issue dealing with the same condition; in one the treatment is surgical whereas in the other it is irradiation. This must inevitably lead to confusion in the person who is confronted by such a case and yet has only a limited personal experience of the problem.

It is obviously not possible in an editorial to resolve such a situation, but it is reasonable to try to define the scope of the problem. There is little doubt that irradiation is an effective procedure in most tumours of the eyelids, provided it is carried out in a sufficiently thorough manner and provided the radiotherapist is aware of the damage to the eye which may result indirectly from the treatment so that every effort is made to avoid any complications by local measures—such as, by the use sometimes of a haptic contact lens. There is also little doubt that surgical treatment is effective but there are two important provisos: the surgeon must have a deep understanding of cancer so that the operation is planned to deal with the full extent of the possible spread of the disease and this demands that the niceties of surgical technique are entirely secondary to the consideration of the eradication of the tumour; and, the surgeon must have sufficient experience to be able to restore an adequate functioning eyelid, which is sometimes difficult particularly in the upper eyelid when there has been extensive disease, otherwise there is the long-term problem of exposure of the eye quite apart from the cosmetic defect.

There is one feature which predominates over all others in the conflicting claims of the surgeon and of the radiotherapist to deal independently with tumours of the eyelid; the person who advocates a particular method must have the knowledge and experience to stand a reasonable chance of effecting a cure because the problems of a recurrence after either method of treatment are likely to be formidable.