Argon laser and xenon arc coagulation of malignant choroidal melanomata: histological findings in 6 cases

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SUMMARY The histological findings in 6 choroidal melanomata which had been treated by photocoagulation are reported. Bruch’s membrane had been ruptured in 5 cases. Vitreous haemorrhage and seeding of tumour cells in the vitreous were observed in 3 cases. Little histological evidence of interference with tumour blood supply was found.

In recent years the management of small malignant melanomata of the choroid has been a controversial subject. Conservative measures are particularly desirable in cases in which there is a small tumour not interfering with visual acuity in the only good eye. The measures advocated to avoid enucleation are photocoagulation,1,2 radiotherapy,3,4 cryotherapy,5 diathermy,6 and local excision.7 Photocoagulation as a means of treatment of malignant melanoma of the choroid was introduced by Meyer-Schwickerath in 1952.1 The technique aimed at surrounding the tumour with a scar which both limited its spread and deprived it of its blood supply. Subsequently the tumour itself was ablated by direct treatment.

The present paper reports the histological findings in 6 eyes containing melanomata which had been treated by photocoagulation.

Materials and methods

Cases
The 6 eyes studied had been treated by argon laser coagulation, xenon arc coagulation, or a combination of the two. Case 2 also received radiotherapy. The clinical details are given in Table 1. For comparative purposes the histological findings in 100 consecutive globes enucleated for malignant melanoma were reviewed.

Histological findings
The histological findings in the 6 treated cases are summarised in Table 2. Three of the tumours (cases 1, 5, and 6) were low to intermediate grade malignancy (spindle B) and 3 (cases 2, 3, and 4) contained a significant epithelioid component (mixed).

Discussion
There was no obvious difference between the findings in the 3 cases treated with the argon laser alone and the 2 cases treated by a combination of argon laser and xenon arc. Case 5, which was treated by xenon arc alone, is discussed later. Case 2 was treated additionally by x-radiation, but showed no special features attributable to this.
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Table 1  Clinical details

<table>
<thead>
<tr>
<th>Case</th>
<th>Age at presentation</th>
<th>Visual acuity</th>
<th>Size at presentation (disc diameters)</th>
<th>Type of treatment</th>
<th>No. of treatments</th>
<th>Interval between last treatment and enucleation (mths)</th>
<th>Duration (mths) of treatment</th>
<th>Reason for enucleation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>47, F</td>
<td>6/9</td>
<td>6/24</td>
<td>3½</td>
<td>Argon laser</td>
<td>1</td>
<td>11</td>
<td>Refused enucleation initially</td>
</tr>
<tr>
<td>2</td>
<td>39, M</td>
<td>6/5</td>
<td>NPL</td>
<td>3</td>
<td>Argon laser</td>
<td>2</td>
<td>22</td>
<td>Vitreous haemorrhage</td>
</tr>
<tr>
<td>3</td>
<td>44, M</td>
<td>6/9</td>
<td>6/24</td>
<td>5</td>
<td>Argon laser</td>
<td>3</td>
<td>23</td>
<td>Continued growth</td>
</tr>
<tr>
<td>4</td>
<td>54, M</td>
<td>6/9</td>
<td>6/24</td>
<td>4</td>
<td>Argon laser</td>
<td>6</td>
<td>19</td>
<td>Continued growth</td>
</tr>
<tr>
<td>5</td>
<td>37, F</td>
<td>6/5</td>
<td>6/5</td>
<td>4</td>
<td>Argon laser</td>
<td>2</td>
<td>9</td>
<td>Continued growth</td>
</tr>
<tr>
<td>6</td>
<td>62, M</td>
<td>6/9</td>
<td>6/36</td>
<td>1</td>
<td>Argon laser</td>
<td>6</td>
<td>3</td>
<td>Vitreous haemorrhage</td>
</tr>
</tbody>
</table>

*Number of burns in parentheses. NPL = no perception of light.

Table 2  Histological findings

<table>
<thead>
<tr>
<th>Case</th>
<th>Cross-sectional area mm²</th>
<th>Tumour type</th>
<th>Pigmentation</th>
<th>Vascularity</th>
<th>Reticulin</th>
<th>Necrosis</th>
<th>Scleral invasion</th>
<th>Extra-scleral spread</th>
<th>Adjacent choroidal vessels</th>
<th>Bruch’s membrane disrupted</th>
<th>Iris atrophy</th>
<th>Vitreous haemorrhage</th>
<th>Tumour cells</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>28</td>
<td>Spindle B</td>
<td>–</td>
<td>++</td>
<td>+</td>
<td>–</td>
<td>Normal</td>
<td>Yes</td>
<td>Normal</td>
<td>Yes</td>
<td>Normal</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2</td>
<td>49</td>
<td>Mixed</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>Focal</td>
<td>Normal</td>
<td>Yes</td>
<td>Normal</td>
<td>Yes</td>
<td>Normal</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>3</td>
<td>28</td>
<td>Mixed</td>
<td>++++</td>
<td>++</td>
<td>+++</td>
<td>–</td>
<td>Normal</td>
<td>Yes</td>
<td>Minimal sclerosis</td>
<td>Yes</td>
<td>Normal</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>4</td>
<td>65</td>
<td>Mixed</td>
<td>++++</td>
<td>+</td>
<td>+</td>
<td>Focal</td>
<td>Normal</td>
<td>Yes</td>
<td>Minimal sclerosis</td>
<td>Yes</td>
<td>Normal</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>5</td>
<td>39</td>
<td>Spindle B</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>–</td>
<td>Normal</td>
<td>Yes</td>
<td>No</td>
<td>Post-necrotic atrophy</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>Spindle B</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>–</td>
<td>Minimal sclerosis</td>
<td>Yes</td>
<td>Post-necrotic atrophy</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

*At plane of section showing largest.
untreated tumours. In case 6, which was a comparatively small low-grade (spindle B) tumour, there was a wide gap in Bruch’s membrane but no evidence of the aggressive growth of tumour through the gap which is normally seen when rupture occurs spontaneously. Rupture of Bruch’s membrane and concomitant destruction of the overlying retina may allow eruption of the tumour into the vitreous as seen in cases 2, 3, and 4. These were the more anaplastic (mixed) tumours. Some reservation must therefore be expressed at the suggestion that the cell type of the tumour seems to be of no importance concerning the prognosis and effectiveness of light coagulation therapy. The seeding of tumour cells in the vitreous may have no prognostic significance, but vitreous haemorrhage makes enucleation necessary because further observation of the progress of the tumour becomes impossible. Vitreous haemorrhage has been one of the commonest events leading to enucleation in previous series.\textsuperscript{13,23}

Surprisingly, previous authors appear not to have commented on damage to Bruch’s membrane, though Lund\textsuperscript{7} illustrates a treated tumour with 2 apparent ruptures. Vogel\textsuperscript{19} specifically stated that he had not found any evidence of seeding of tumour cells in the vitreous. A possible explanation is that previous series had been treated mainly by xenon arc photocoagulation and François et al.\textsuperscript{24} have commented that damage to Bruch’s membrane in macular lesions treated by photocoagulation is more likely to occur.

Fig. 1  Case 3, showing multiple breaks in Bruch’s membrane with tumour sprouting into vitreous. (Gordon and Sweet’s stain for reticulin, \texttimes20).

Fig. 2  Case 6, showing broad gap in Bruch’s membrane (arrows) but little evidence of aggressive growth of tumour into vitreous. (Gordon and Sweet’s stain for reticulin, \texttimes20).
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Fig. 3 Case 5, showing tumour separated from vitreous by a fibroglial band. (Haematoxylin and eosin, ×126).

Fig. 4 Case 4, showing tumour in direct contact with vitreous, with cells exfoliating. (Haematoxylin and eosin, ×126).

with the argon laser than with the xenon arc. In this respect it is noteworthy that in the present series the only tumour treated by xenon arc alone (case 5) was the only case in which rupture of Bruch’s membrane did not occur. With the exception of the case reported by Boniuk and Girard, previous studies have reported necrosis. 13 15–18 20 21

Necrosis in superficial parts of the tumour in globes enucleated shortly after treatment may be a direct effect of the photocoagulation. 12 16–20 25 Necrosis occurring at longer intervals after treatment has been attributed to vascular deprivation resulting from choroidal scarring. 13 17 19 and narrowed choroidal vessels were observed in the scarred area by Hepler et al. 14 In the present series some focal necrosis was seen in cases 2 and 4. This was clearly unrelated to the treatment, as the interval between treatment and enucleation was too long.

Like Curtin and Norton 25 we were unable to find evidence of significant occlusion of the choroidal vessels adjacent to the tumour in these or, indeed, any of the cases. We did observe variable choroidal scarring at the margin of the tumours, but the scarring, when present, did not appear to be restricting access to the choroidal blood supply, probably because the tumour was able to grow beyond the scar (Fig. 5). Makley et al. 16 similarly reported that the choroidal vessels adjacent to the tumour were patent in one of their cases. However, combined fluorescein and histological studies by Apple et al. 26 of eyes enucleated within 24 hours of treatment by the argon laser showed leaky, necrotic choroidal vessels occluded by fused erythrocytes adjacent to the tumour. Chan et al. 27 were able to produce occlusion of the choroidal circu-

Fig. 5 Margin of tumour in case 4 showing choroidal scar (above arrow) and dilated vessels in choroid (below arrow). The choriocapillaris (tip of arrow) is intact peripheral to the scar. (Gordon and Sweet’s stain for reticulin, ×32).
lation, though they had to use very high intensity photocoagulation. The absence of much histological
evidence of choroidal vascular sclerosis may therefore
indicate inadequacy of the treatment or reversibility of
the damage.

Since in 5 of our 6 cases the tumours failed, for
reasons other than their estimated size in disc
diameters, to conform to the criteria laid down by
Meyer-Schwickerath and François as suitable for
treatment by photocoagulation, their failure to re-
spond satisfactorily cannot be held to reflect on the
efficacy of the method in suitable cases. However, on
the basis of our findings the advisability of treating
these tumours which do not conform to the criteria is
questionable, especially in patients who refuse
enucleation, because (1) there is no evidence that the
vascular supply was significantly affected; (2) the
damage to the retina and Bruch’s membrane allows
seeding of the tumour into the vitreous; and (3)
vitreous haemorrhage is likely to make enucleation
inevitable.

We thank the ophthalmic surgeons who kindly furnished details of
treatment given to their cases and Miss K. Hughes and Mrs C. M.
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