
Editorial

Lacrimal lesions and orbital surgeons

Perhaps one of the factors that influences the decision to pursue a career in ophthalmology is the rarity with which one has to make decisions that could influence life expectancy. That is not the lot of the orbital surgeon, particularly when managing lacrimal fossa lesions. There are few other instances in ophthalmic practice where a wrong decision can be so costly. In this issue the results of the Moorfields orbital clinic's experience in the management of lacrimal gland tumours are reported in two papers by Wright *et al.* It is an extraordinary piece of work: extraordinary because of the size of the series, the length of the follow-up, and, in particular, because the cases have all been managed by one surgeon. It is this type of work that advances knowledge. Yet, as the papers acknowledge, much work remains to be done and many questions remain unanswered.

Make no mistake, the management of lacrimal gland lesions is not easy. There are problems associated with clinical decision-making, the surgery is demanding, and the pathology is difficult. The lacrimal gland has a limited range of pathological responses. However these lesions are rare and indeed the average ophthalmologist could expect to see a new case every 10 years or so. There are many diagnostic pitfalls. Imaging techniques contribute to the management but are not diagnostic. Most of the lesions be they developmental, infective, inflammatory, or neoplastic will shrink with systemic steroids. There is no place for a trial of steroids. For persisting lesions the only decision to be made is whether to

carry out an incisional or an excisional biopsy. The main concern is with the mis-diagnosis of a benign mixed cell tumour, carrying out an incisional biopsy, and breaching the false capsule with the associated significant risk of malignant recurrence. Even in the best hands mistakes can occur. The art is in retrieving that situation. Malignant tumours of the gland are aggressive lesions requiring aggressive management. An incisional biopsy is a relatively straightforward procedure while an excisional biopsy, with or without retention of the palpebral lobe of the gland, is technically difficult requiring intimate knowledge of orbital anatomy. The anaesthetist has an important role to play. Hypotensive anaesthesia contributes to a blood free operative field and enhancement of tissue planes. Ultimately the diagnosis is in the hands of the pathologist. On the face of it the reclassification in Wright's paper of two of the malignant tumours as benign seems at best careless. This simply highlights the difficulty the pathologist has to face and this further supports the antagonist's side in the debate over the technique of fine needle aspirational biopsy.

These papers contain clear guidelines on the management of these tumours, based on experience and supported by clearly presented clinical evidence. If ever there was a case for the establishment of recognised referral centres for the management of orbital cases it is contained within these papers. They are to be commended.

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