Conjunctival melanoma

Conjunctival melanoma (CM) is a rare unilateral disease of the middle aged and elderly. It is those centres where these cases are collected which have developed and reported current management strategies. For example, in this issue of the journal Paridaens et al report on 95 cases from 1948 to 1991 where orbital exenteration was undertaken for CM, and conclude that this drastic operation often fails to cure. As a professional community however, we have yet to pool the resources at our disposal to understand the nature of the condition. Until we do it will be difficult to assess whether there has been any change in the behaviour of CM.

While some ophthalmologists will never see a new case in their careers, most of us are confronted from time to time by lesions which might be CM. At this early point we should seek to avoid the pitfalls of generating needless anxiety while ensuring appropriate intervention and referral when necessary. This has become easier since the concept of primary acquired melanosis (PAM) has become widely accepted and has done much to clarify diagnostic and management strategy. Accordingly we have derived diagnostic algorithms for ‘in-house’ use which are published on page 592, which some readers may find useful.

Meanwhile the sevenfold increase in the prevalence of cutaneous melanoma is properly matched by the number of publications describing this cancer in Australia, Europe, and the USA in the past 20 years. The incontrovertible epidemiological evidence for this increase has stimulated examination of possible aetiological factors ranging from a change in global irradiation, through social habits, to factors at the genetic and molecular level. It is worth asking if there are any parallels between pigmented tumours of the skin and the conjunctiva. Important questions, some prompted by recent publications, include:

(a) Is there a change in prevalence of PAM and/or CM in those countries where cutaneous melanoma is increasing?

(b) Do any of the risk factors applicable to cutaneous melanoma apply to CM— for example, pale skin, freckles, number of moles, sunburn?

(c) Does the wearing of spectacles confer any protection against the development of CM and PAM?

(d) Are there genetic susceptibilities to tumours of the skin and eye, other than those which appear to exist for xeroderma pigmentosus and dysplastic naevus syndrome?

(e) Is CM amenable to classification with regard to prognosis according to proliferative indices, chromosomal anomalies, oestrogen sensitivity, etc.

Attempts to answer these and other questions will be greatly facilitated by comprehensive reporting of PAM and CM. Cancer registries exist for other conditions—for example, leukaemia, and attract good returns of data from enthusiasts. OPCS statistics currently do have an entry for ocular tumours. However, the entry is not subdivided into the different tumours of the eye, there is no entry for tumour related deaths, and there is likely to be considerable under-reporting.

Should the reporting of all ocular tumours, including CM, be made automatic by ocular pathologists, or should we support and join the development of a clinical oncology information network? Both could be developed through the offices of the Royal College of Ophthalmologists. Any such step would be complementary and contributory to the Ocular Oncology Group of the European Organisation for Research and Treatment of Cancer. (B Damato, 1994 personal communication) It should not be beyond us to develop the infrastructure for collating comprehensive data on ocular tumours. Jakobiec wrote of CM in 1980 as ‘unfinished business’, and years later this is still an apt description of this frightening lesion, whose only concession so far is its rarity.  

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