BJO

British Journal of Ophthalmology

Editorials

Metastases to the conjunctiva

As ophthalmologists we all encounter, from time to time, a variety of rare or unusual diseases. Unfortunately these conditions are not always fully described in the literature, as rare conditions by their very nature tend not to be reported as part of a large series but are more likely to appear as a succession of single case reports. Of course, on occasions case reports may emphasise the more obscure aspects of what is already a rare condition, and may actually ask more questions rather than provide answers. In this context the paper in this issue of the *BJO* by Kiratli and colleagues concerning metastases to the conjunctiva (p 5) represents a major contribution to our knowledge about a condition previously only reported in two small series stressing particular aspects of the disease – eyelid involvement and metastatic malignant melanoma,[1 2] and a handful of case reports, often involving unusual primaries.[3 4]

The rarity of the condition is immediately evident from the number of cases reported in the series, with only 10 cases presenting over a 20 year period. This should be contrasted with an earlier 20 year review of posterior uveal tumours[5] by the same ocular oncology clinic, in which 3000 cases were reported. Despite the small number, the degree of concordance between the individual cases provides us with a good profile of the typical tumour, the presentation being due either to the mass effect of the tumour or to inflammation in a patient with known malignant disease. The underlying primary tumour, as in uveal metastases, arose in the breast or respiratory tract in the majority of cases, although in two cases the primary was a dermal malignant melanoma. This similarity with metastases to the uveal tract is not too surprising given the fact that in the majority of patients' coexistent conjunctival and uveal metastases were present. Additionally, in most cases the patient not only had other ocular metastases but also had widespread metastatic disease, a reflection of the late stage at which conjunctival metastases present. Presumably in view of the tiny fraction of cardiac output passing through it, the question of whether the conjunctiva represents a hostile or inviting environment to tumour cells may be somewhat academic since the likelihood of a patient developing a metastatic tumour at this site is very small indeed, and therefore only likely to occur in patients with advanced metastatic disease.[6]

So what can we learn from this paper? In a patient with malignant disease the possibility of a conjunctival lesion being a secondary deposit should be borne in mind, and it may provide a simpler option with regard to a biopsy diagnosis when there is coexistent uveal and conjunctival disease. Again it emphasises the importance of excluding metastatic malignant melanoma before making the diagnosis of a primary conjunctival melanoma, particularly in view of the much poorer prognosis in the metastatic disease.

Lastly, conjunctival metastases represent a very bad prognostic sign for the patient; in addition to the high incidence of metastatic disease in other organs, the mean survival time from diagnosis was only 9 months.

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