Management of small choroidal melanocytic tumour

Papadopoulou *et al*[1] are to be congratulated for submitting an informative article regarding the management of small choroidal melanoma with pertinent discussion and various educational points to remember. We were, however, surprised, not to find the use of OCT (optical coherence tomography) as part of the management to help the diagnosis or in the discussion section. The authors[1] correctly highlight the use of B-scan ultrasound to document the echographic features of melanocytic tumours; however, the use of OCT is complementary to human observation, echography and fluorescein angiography in cases of shallow subretinal fluid for multiple retinal pathology including small choroidal melanomas. Latest-generation OCT machines are quick, non-invasive and reliable with good reproducibility. With availability of enhanced depth-imaging mode, scanning of the choroid is now feasible. This has been well described by Shields *et al*,[2–5] and we find their mnemonic TFSOM (presence of three or more features suggests high risk of small choroidal melanoma vs benign choroidal naevus) very useful for risk stratification in choroidal melanocytic tumours. (TFSOM=T, thickness>2.0 mm; F, subretinal fluid; S, symptomatic; O, orange pigmentation; M, margin touching the optic nerve.) Also the referral guidelines developed by the ocular oncology group, for the Royal College of Ophthalmologists UK,[6] recommend referral for specialist oncology opinion of any suspicious choroidal naevi >2.0 mm thickness or thickness >1.5 mm if associated with serous retinal detachment and orange pigment. OCT to detect serous retinal detachment (subretinal fluid) should be used to improve management of melanocytic choroidal lesions.

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