ISSN 0973-1482

Journal of Cancer Research and Therapeutics

October-December 2011 ■ Volume **7** ■ Issue **4**

Official Journal of
Association of Radiation Oncologist of India

Full Text Online at: www.cancerjournal.net

Impact Factor® for 2010
0.825

PubMed Indexed

Wolters Kluwer Health | Medknow Publications

High dose rate interstitial brachytherapy in carcinoma eyelid: Can it be a primary treatment modality?

Access this article online	
Website: www.cancerjournal.net	Quick Response Code:
DOI: 10.4103/0973-1482.92018	

Sir,

We read with great interest the article by Azad *et al*.[1] We congratulate the authors for carrying out a commendable work. We would like to articulate a few of our observations.

Surgical excision is the gold standard of treatment for an eyelid malignancy. Mohs micrographic surgery is the most reliable method for tumor extirpation as agreed by the authors themselves. Surgical excision offers the best cure rate and lowest recurrence rates.[2]

The Australian Mohs database II[3] has clearly shown that surgical modality is the best possible option for periocular basal cell carcinomas. Avril[4] in a randomized controlled trial has proven superiority of controlled surgical excision over radiotherapy as a primary modality of management and at the same time higher recurrences following radiotherapy. The five-year disease-free survival rates in the authors' series for basal cell carcinoma is not an encouraging enough indication for the use of interstitial brachytherapy.[1]

Malhotra *et al*.[5] have shown that the best option for a periocular squamous cell carcinoma is Mohs micrographic surgery. These tumors are known to be relatively radioresistant. Postoperative radiotherapy is recommended in cases with microscopic perineural invasion.

Sebaceous gland carcinomas of the eyelid are notorious for recurrences if not completely excised. Frozen section control or Mohs microsurgery is the way to go as evaluation of margins till histopathologic clearance is of prime importance. Protocol-based conjunctival map biopsies greatly aid in the management of pagetoid variants.

We do not agree with the authors' views that surgical corrections are associated with severe dysfunction and poor cosmesis. This is an exception rather than a rule. Two examples are provided where extensive excision of almost the entire eyelids was done with good function as well as cosmesis [Figure 1].

We would again like to congratulate the authors for exploring the pros and cons of a new possibility as a primary modality in the management of eyelid carcinomas.

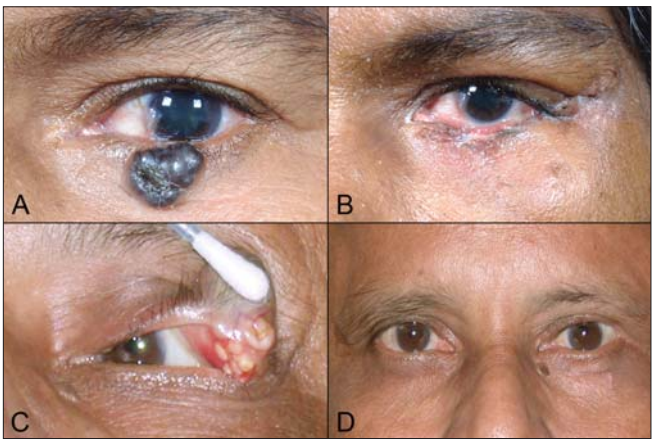

Figure 1: (A) A large malignant melanoma of the eyelid involving upto half of the eyelid, (B) The lesion is excised along with almost two thirds of the eyelid followed by a flap reconstruction, (C) An extensive left upper eyelid sebaceous gland carcinoma, (D) Postoperative picture showing a well reconstructed upper eyelid using a cutler-Beard method with good functional retention and cosmesis

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