Choroidal Melanoma

The Collaborative Ocular Melanoma Study

What you need to know! -- By Paul T. Finger, MD

The COMS offers the best evidence based medicine available about the diagnosis and treatment of choroidal melanoma.

Choroidal Melanoma

Choroidal melanoma is the most common primary intraocular tumor in adults. Initially appearing as a small nevus "freckle" beneath the retina, choroidal melanoma can grow in height and diameter, and may eventually spread to other organs of the body, causing death. Because choroidal melanoma is intraocular (occurring inside the eye) and not visible, patients with this disease usually do not recognize its presence until the tumor grows to a size that impairs vision by obstruction, retinal detachment, hemorrhage, or other complication. Periodic dilated retinal examination is the best means of early detection.

The Collaborative Ocular Melanoma Study (COMS) was a multicenter, international, investigation designed to answer critical questions about treatment of choroidal melanoma. There were 3 questions to be answered:

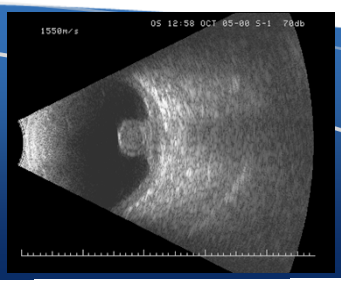
1) What happens to small, untreated choroidal melanomas?
2) Is iodine-plaque radiotherapy equal to or better than removal (enucleation) of the eye to prevent metastasis.
3) Does external radiation of the eye before enucleation improve survival?

Continued on Pages 3 and 4

Treatment Arms

Small Choroidal Melanoma	These tumors were initially treated with observation.
Medium Choroidal Melanoma	These tumors were randomized to plaque irradiation or enucleation (removal of the eye). The purpose of this study was to determine if there was a difference in survival.
Large Choroidal Melanoma	Treated by enucleation, half were pretreated with 20 Gy of external beam radiation therapy to see if it would prevent metastasis.

The COMS was funded by the National Institute of Health and The National Eye Institute. It started in 1985 and lasted 18 years.



Small Choroidal Melanoma Study

Entry Criteria:

- 1.0 - 3.0 mm in height, 5.0 – 16.0 largest basal diameter

Management:

- Chosen by ophthalmologist and patient (Selection Bias?)
- Followed with annual COMS visits annually for 2 years

  With additional phone interviews

Results:

- **Kaplan Meier: Growth 21% at 2 years and 31% at 5 years**
- Most grew within the first 36 months of observation
- **Risk Factors for growth**: Tumor size, orange pigment, absence of overlying drusen/RPE changes
- 3% died of metastatic choroidal melanoma

There exists a controversy surrounding treatment. Unlike dermatologists, eye cancer specialists are likely to offer "Observation As Treatment" for suspected small choroidal melanomas. Observation offers the patient time (without the risk of treatment-related vision loss) at the risk (small increase in the probability) of death from metastatic choroidal melanoma. This is despite the results of COMS evidence that **patient age** and **largest tumor diameter** are the best predictors for metastasis.

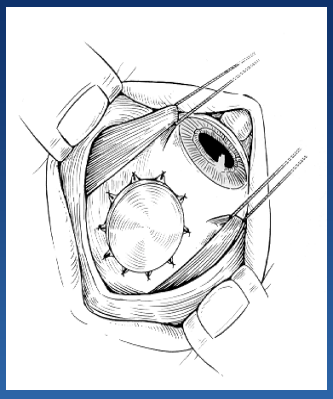
Current practice dictates that eye cancer specialists perform clinical assessments, classify such small choroidal tumors and discuss the potential risks and benefits of observation, biopsy and treatment with each patient.

Small Choroidal Melanoma Growth

Further, we determine the patient's ability to understand what has been presented and recommend the approach that is likely to do the "least" harm.

Until better methods of diagnosis are available, "Observation as treatment" will continue to be an option of care for benign and suspicious choroidal nevi, as well as most small indeterminate choroidal tumors.

On the other hand, based on an international internet-based survey, the majority of eye cancer specialists will not recommend observation for small malignant choroidal melanomas that are documented to grow.



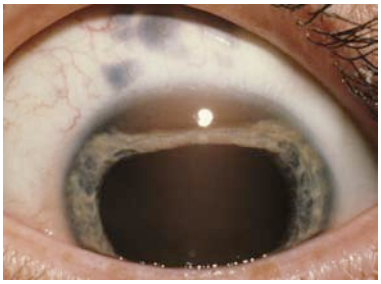
This is an image of a gold eye plaque surgically attached to the eye wall as to cover the malignant melanoma of choroid plus a 2-3 mm margin.

Eye Plaque Irradiation

This illustration demonstrates how an eye plaque can be placed onto the sclera as to treat a portion of the choroid. Based on pre-operative ultrasound imaging, we calculate how deep the radiation needs to penetrate in order to destroy the underlying malignancy.

The COMS radiation oncologists chose to use iodine-125 seeds in gold plaques for the medium-sized tumor trial as best available plaque in 1985.

Medium-Sized Choroidal Melanoma Trial



This trial was conceived to determine if eye and vision-sparing radiation therapy was more, less or equally effective (compared to enucleation) for patient

Patient enrollment in the COMS' Randomized Trial of ***I-125 Brachytherapy for Medium Choroidal Melanoma*** began in February 1987 and was completed in July 1998.

Melanoma selection criteria for this trial included:

1) Tumor size of 2.5 to 10.0 mm in apical height and no more than 16.0 in longest basal diameter.

2) Patients had to be at least 21 years old.

3) Have no other primary cancers, and no other disease likely to threaten their lives within five years.

3) No prior treatment or biopsy.

Eligible patients enrolled and received treatment at 43 clinical centers located in major population areas of the United States and Canada.

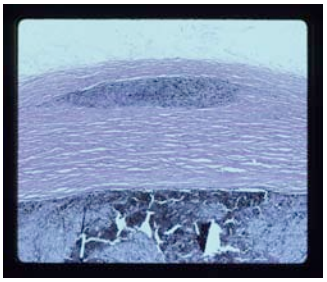
The study enrolled **1317 patients** with medium-sized choroidal melanoma. The group was evenly divided by gender, and the **mean age was approximately 60 years**.

Patients were assigned to one of two treatment groups by randomization. One group--660 patients--was assigned to have the affected eye removed. The other group--657 patients--was assigned to radiation treatment.The radiation treatment was iodine-125 episcleral plaque.

Results:

Scientists Found Similar Survival Rates for Eye Cancer Therapies

COMS Increased Nationwide Availability of Eye Sparing Plaque Treatment



"COMS certified eye cancer specialists were noted to achieve a diagnostic accuracy of 99.5% among enucleated cases."

"50% of tumors exhibited scleral invasion"

"Researchers have found that the survival rates for two alternative treatments for primary eye cancer--radiation therapy and removal of the eye--are about the same." Prior to this finding, there was a question in the medical community didn't know if eye-sparing treatment might result in higher mortality.

Also, as a consequence of this research, the capability of doctors nationwide to provide more accurate diagnoses and state-of-the-art treatments for eye cancer has been greatly expanded. Mortality data were compared in the July 2001 issue of *Archives of Ophthalmology*.

SUGGESTED READING:

The COMS randomized trial of iodine 125 brachytherapy for choroidal melanoma. III. Initial mortality findings. COMS Report No. 18. Arch Ophthalmol 119: 969-982, 2001.

The COMS randomized trial of iodine 125 brachytherapy for choroidal melanoma: V. Twelve-year mortality rates and prognostic factors: COMS report No. 28. Arch Ophthalmol. 2006 Dec;124(12):1684-93.

Accuracy of diagnosis of choroidal melanomas in the Collaborative Ocular Melanoma Study: COMS report No. 1. Arch Ophthalmol 1990;108(9):1268-73.

Factors predictive of growth and treatment of small choroidal melanoma: COMS report No. 5. Arch Ophthalmol 1997:115(12) :1537-44.

Large Choroidal Melanoma Study

Patient enrollment in the COMS' Randomized Trial of ***Pre-Enucleation Radiation for Large Choroidal Melanoma*** began in November 1986 and was completed in December 1994. A total of **1003 patients** enrolled on the trial and were assigned to one of two treatment groups, and of this number, 994 were treated as assigned. Eligible patients were at least 21 years old, had no other primary tumor, and had no other disease that threatened their lives within five years. Previous treatment for choroidal cancer or secondary treatment related to the eye cancer rendered a patient ineligible. Nearly two-thirds of all patients enrolled had at least one blood relative with cancer.

Patients were divided into two groups by randomization. The mean age of patients in both groups was approximately **60 years**. One group -- 506 patients -- were assigned to have the affected eye removed without the radiation treatment. The other group -- 497 patients -- were assigned radiation treatment to the eye before it was removed. **The dosage of external beam radiation given to patients was 2000 rads (cGy) in five fractions** (A total dose of 2000 rads is as large a dose as radiation oncologists believe reasonable to treat preoperatively for this tumor). The eye was removed as soon as possible after the last radiation treatment, on the same day whenever possible.

The five-year survival status of 80 percent (801) of all 1003 patients revealed that **38% (181) of the patients assigned to the radiation treatment died, compared with 43 percent (202) of those patients who did not have pre-operative radiation** Therefore, radiation treatment was not an effective was to improve patient survival rates. There was no evidence of radiation damage to the other eye.

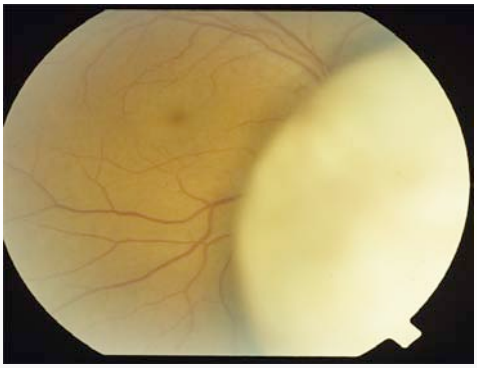
NEI Press Release

NATIONAL INSTITUTES OF HEALTH
National Eye Institute

Radiation Treatment for Eye Cancer Does Not Change Patients' Five-Year Survival

Researchers found that patients with large eye melanomas had similar five-year survival rates regardless of whether they were treated with radiation prior to removal of the eye or had their eye removed without prior radiation therapy. These findings appear in a scientific paper published in the June 1998 issue of the *American Journal of Ophthalmology*.

"**This clinical trial found neither benefit nor harm from treating ocular melanoma patients with radiation before removal of the eye**," said Dr. Carl Kupfer, director of the NEI. "Radiation therapy is costly and has the potential for side effects. Unless a survival benefit is shown with further follow-up, **it is unlikely doctors will advise it** for their patients with large melanoma eye tumors."



Treatment of Large Choroidal Melanoma

In 1985, when the COMS started, it was widely accepted that tumors greater than 16 mm in largest basal diameter or more than 10 mm in height should be treated by enucleation.

Encouraged by the results of the medium-sized COMS trial (showing no survival advantage to enucleation) larger and larger plaques were manufactured to treat larger and larger tumors.

At The New York Eye Cancer Center, we have up to 24 mm wide plaques and will treat tumors as large as 16 mm in height.

Dr. Finger has been pleased to find that most of these patients retain their eye and some useful vision. Those who don't are typically grateful for having had a chance to keep their eye.

SUGGESTED READING:

Collaborative Ocular Melanoma Study Group: **The Collaborative Ocular Melanoma Study (COMS) randomized trial of pre-enucleation radiation of large choroidal melanoma. IV. Ten-year Mortality findings and prognostic factors.** COMS Report No. 24. Am J Ophthalmol 138:936-951, 2004.

2005 Study Centers for the COMS Clinical Trial

Arizona
Leonard Joffe, M.D., F.R.C.S.
Retina Associates Southwest

California
Bradley R. Straatsma, M.D.
Jules Stein Eye Institute
University of California at Los Angeles
A. Linn Murphree, M.D.
Doheny Eye Institute
University of Southern California
Man M. Singh Hayreh, M.D.
Southern California Permanente Group
Schatz, McDonald, Johnson, and Ai

Colorado
Kenneth R. Hovland, M.D.
Adventist Hospital
Denver, CO

Florida
Timothy G. Murray, M.D.
Bascom Palmer Eye Institute
University of Miami School of Medicine
Miami, FL
W. Sanderson Grizzard, M.D.
Retina Associates of Florida, P.A.
South Tampa Medical Center

Georgia
Paul Steinberg, Jr., M.D.
Emory Eye Center
Emory University
Eye Consultants of Atlanta, P.C.

Illinois
Lee M. Jampol, M.D.
Northwestern University Medical School
Norman P. Blair, M.D.
University of Illinois

Indiana
John T. Minturn, M.D.
Midwest Eye Institute

Iowa
Thomas A. Weingeist, M.D., Ph.D.
H. Culver Boldt, M.D.
University of Iowa Hospitals and Clinics

Louisiana
Gerald Cohen, M.D
Touro Infirmary

Maryland
Andrew P. Schachat, M.D.
Wilmer Ophthalmological Institute
The Johns Hopkins Medical Institutions

Massachusetts
Clement L. Trempe, M.D.
Schepens Retina Associates

Michigan
Andrew K. Vine, M.D.
W. K. Kellogg Eye Center
University of Michigan

Raymond R. Margherio, M.D.
Associated Retinal Consultants, P.C.
Royal Oak, MI

Minnesota
Dennis M. Robertson, M.D.
Mayo Foundation
Rochester, MN

Missouri
Washington University School of Medicine
St. Louis, MO

New York
Paul T. Finger, M.D.
New York Eye and Ear Infirmary
North Shore University Hospital

David H. Abramson, M.D.
Cornell University Medical Center

North Carolina
Jonathan J. Dutton, M.D., Ph.D.
Duke University Eye Center

Ohio
Z. Nicholas Zakov, M.D.
Retina Associates of Cleveland/
Case Western Reserve University

Francie A. Gutman, M.D.
Cleveland Clinic Foundation

Frederick H. Davidorf, M.D.
Ohio State University College of Medicine

Oklahoma
Reagan H. Bradford, Jr. M.D.
Dean A. McGee Eye Institute

Oregon
David J. Wilson, M.D.
Casey Eye Institute
Oregon Health Sciences University

Pennsylvania
Karl R. Olsen, M.D.
Retina-Vitreous Consultants

Texas
Dwain G. Fuller, M.D.
Texas Retina Associates
Richard S. Ruiz, M.D.
Hermann Eye Center
Wichard A. Van Heuven, M.D.
University of Texas
Health Science Center

J. Paul Dieckert, M.D.
Scott and White Memorial Hospital

Virginia
Brian P. Conway, M.D.
University of Virginia
Health Sciences Center

Washington
Edward B. McLean, M.D.
Ophthalmic Consultants Northwest, Inc.

Craig G. Wells, M.D.
University of Washington
School of Medicine

Wisconsin
Suresh R. Chandra, M.D.
University of Wisconsin

William F. Mieler, M.D.
Medical College of Wisconsin

Canada

E. Rand Simpson, M.D.
Hugh McGowan, M.D.
Ontario Cancer Institute/Princess
Margaret Hospital
Toronto, Ontario, Canada

Christina Corriveau, M.D.
Notre Dame Hospital
Montreal, Quebec, Canada

Resource Centers:

Chairman's Office

Stuart L. Fine, M.D.
Scheie Eye Institute
University of Pennsylvania

Coordinating Center

Barbara S. Hawkins, Ph.D.
Clinical Trials and Biometry Division
Wilmer Ophthalmological Institute
The Johns Hopkins Medical Institutions

NEI Representative

Natalie Kurinij, Ph.D.
National Eye Institute
National Institutes of Health

For more information contact:
Paul T. Finger, MD, FACS
The New York Eye Cancer Center
115 East 61st Street – Suite 5B
New York, NY 10065
Tel: 1212-832-8170

About Paul T. Finger, MD

Dr. Finger was a principal investigator for the Collaborative Ocular Melanoma Study and has created world-renowned web sites (e.g. http://eyecancer.com and http://eyecancerbig.com).

Dr. Finger was certified by "COMS" as a visual acuity examiner, ultrasonographer, ophthalmic oncologist and surgeon. He is a Fellow of both the American College of Surgeons and the American Academy of Ophthalmology and cares for patients from all over the world.

Dr. Finger has developed new methods for the diagnosis and treatment of many ocular tumors, holds several patents and has written hundreds of scientific publications. Dr. Finger lectures frequently at local, national and international meetings.

Dr. Finger has a particular interest in choroidal melanoma, ciliary body melanoma and iris melanomas.

Dr. Finger is the Director of Ocular Tumor Services at The New York Eye Cancer Center.

The New York Eye Cancer Center

115 East 61st Street – Suite 5B
New York, NY 10065

1212-832-8170 and http://paultfingermd.com

The Eye Cancer Foundation

115 East 61st Street – Suite 5B
New York, New York, USA 10065

Please consider donating to the Foundation!

Telephone 1212-832-8170 and
www.eyecancercure.com/donate-now.html

To Donate by credit card, scan QR code or

SCAN ME

Visit our website
https://www.eyecancercure.com/donate-now.html