
TO THE EDITOR: I read with interest the article by Zhao et al on pars plana vitrectomy for refractory retinoblastoma. Any intraocular intervention in an eye with active intraocular malignancy has the risk of inadvertent tumor dissemination, seeding of the surgical wound along with extraocular spread. The authors treated the surgical entry points with subconjunctival melphalan and also in follow-up examinations under anaesthesia. They did not note any seeding in the surgical entry points on histopathologic examination of vitrectomized eyes that eventually required enucleation. Interestingly, a study by Shields et al of 11 eyes that underwent pars plana vitrectomy in eyes with undiagnosed retinoblastoma found that the vitrectomy ports were free of tumor. It would be interesting to know if any clinically healthy margin was also resected during endoresection of the mass. Also, was hypotensive anesthesia used? We have noted that, during endoresection of choroidal melanoma, intraocular hemorrhage may be very severe and may not be controlled with hypotensive anesthesia and raised infusion pressure alone. Perfluorocarbon liquids may be needed as a temporary tamponade which is replaced with silicone oil on around day 10. It would be interesting to know specific difficulties, if any, that the authors faced during endoresection of retinoblastoma, considering that calcifications within the mass may be difficult to cut/remove with the cutter. In how many cases did the authors remove silicone oil and what was the usual time interval between the primary vitrectomy and the silicone oil removal?

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