TO THE EDITOR: I read the recent article “Screening Children at Risk for Retinoblastoma: Consensus Report from the American Association of Ophthalmic Oncologists and Pathologists” \(^1\) with concern. This publication may have been a “consensus” of the authors, but many of us in this association were unaware of the project, had no input into the results, and do not agree with some of the statements and, most important, the screening strategy recommended. Because this is a Letter to the Editor I will forgo correcting some of the factual errors in the paper and focus on the underlying recommendations, which are seriously flawed (and potentially dangerous).

The underlying recommendation in this article is based on a misinterpretation of data. It is certainly true that, based on laterality, focality, family history, and genetic testing, some children are at high risk (approaching 50%) for the development of retinoblastoma and others are at lower risk. For example, a child born to a parent with bilateral retinoblastoma has almost a 50% risk of developing retinoblastoma (which can be unilateral or bilateral). For those children, the consensus statement correctly recognizes that frequent screening during the first year is advised because 90% of all such children will begin developing tumors by the age of 1 year.\(^2\) The article suggests screening these children until the age of 5 to 7 years, but rarely, if ever (never in our New York retinoblastoma center's experience) will tumors first begin to develop after 28 months of age. I (supported by the existing published literature) do not think screening is needed until the age of 5 to 7 years for these patients. Of course, if a child develops tumors before the age of 28 months they are at risk after treatment for many years and need long-term follow-up, but that is not “screening.”

In contrast, a child born to a parent who had unilateral retinoblastoma (who has not had genetic testing) is at a much lower risk for developing retinoblastoma. That is not the issue. The question is this: Should screening be done less often for the groups of children who overall have a lower risk of developing retinoblastoma? Screening is not needed for most of these children because they will never develop retinoblastoma, but without genetic information you do not know who will and who will not develop tumors. If you believe your screening strategy for children with 50% risk is the best for detecting retinoblastoma (and no study has ever proven any strategy is better than another), then you need to examine children at the same frequency as those who have a 50% risk. The yield will be lower and, yes, their overall risk is lower, but the appearance of tumors is the same so the timing of screening must be the same.

Let me make an analogy. Pretend you are an airline pilot and you fly many different airplanes. In each airplane there is a gauge you must check every 5 minutes because if it shows a warning and if that warning appears you must take immediate action to prevent a crash. Some planes are known to have that warning go on in 50% of the flights, but because you check the gauges every 5 minutes you never have a crash. Some planes have the gauge go off in 10% of the flights . . . and some in 1% of the flights. The chance of the gauge going off is lower in these planes . . . but if you do not check the gauges with the same frequency—every 5 minutes—you will crash.

If you follow this article’s recommendations, most of the children will be fine (because they were never going to develop retinoblastoma anyway)—the only ones you will detect later than you want are the ones who will develop retinoblastoma. My center (the oldest and largest in the United States) will not follow this article’s recommendation—we do not want any crashes and I have submitted this letter because I do not want any other center to crash.

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