Letters

Corrections

Due to an editing error, August's *EyeNet* listed incorrect ICD-10 codes for vitreomacular adhesion ("Making an ICD-10 Superbill," Savvy Coder). The online version has the correct codes: H43.391, H43.392, and H43.393.

In "The Mysteries of Ebola-Associated Uveitis," (Clinical Update, September), *EyeNet* incorrectly stated that herpesvirus is an RNA virus. It is a DNA virus. The online versions of this article remove the mention of RNA.

—The editors regret these errors.

Some Clarifications

It was with great interest that we read the excellent article "Diagnosis and Management of Orbital Lymphoma" (Pearls, June) by Drs. Trisha Sharma and Manjunath Kamath. While we agree with the majority of the information presented in the article, there are a couple of points we would like to comment upon.

The CT image presented in the article is not typical of orbital lymphoma. In the vast majority of cases, orbital lymphomas conform to the globe rather than indent or deform it. In addition, bone erosion is very rarely seen in orbital lymphoma. Absence of such distinguishes it from other aggressive solid tumors of the orbit. This is referred to in the text, but the image presented is inconsistent with their description. Furthermore, while CT is an adequate diagnostic imaging modality, we preferentially obtain an MRI in order to better visualize the soft tissues of the orbit. Figures 1-3 show what in our experience are more typical MR images of orbital lymphoma.

Orbital lymphomatous tumors are typically of B-cell origin.[1] It is true that the gold standard in the management of this condition, which is frequently encountered in an oculoplastics practice, is radiation therapy.[2] We disagree with the authors' comment that the entirety of the orbit needs to be treated in order to prevent recurrence of the disease. This has not been our experience, and the literature does not support such a statement. In fact, every effort is made to avoid irradiating the adjacent uninvolved orbital structures with hopes of preventing additional morbidity. A typical radiation dose would be between 30 and 40 Gy to the tumor, with anywhere between 60% and 90% of this dose to the adjacent orbital tissues, as it is impossible to completely eliminate them from the radiation cone. With such doses, local cure is almost always achieved.[3-5] This strategy is supported by the fact that, as reviewed by Russell et al., the majority of MALT B-cell lymphomas arise from the conjunctiva and lacrimal gland, with only a small percentage involving the posterior orbit.[4] Significantly lower doses of radiation have also had good success rates.[3]

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1 Parikh RR et al. *Leuk Lymphoma.* 2015;56(5):1266-1270.
2 Munch-Petersen HD et al. *JAMA Ophthalmol.* 2015;133(2):165-173.
3 Fasola CE et al. *Int J Radiat Oncol Biol Phys.* 2013;86(5):930-935.
4 Russell W et al. *Clin Adv Hematol Oncol.* 2013;11(4):209-214.
5 Stannard C et al. *Eye.* 2013;27(2):119-127.

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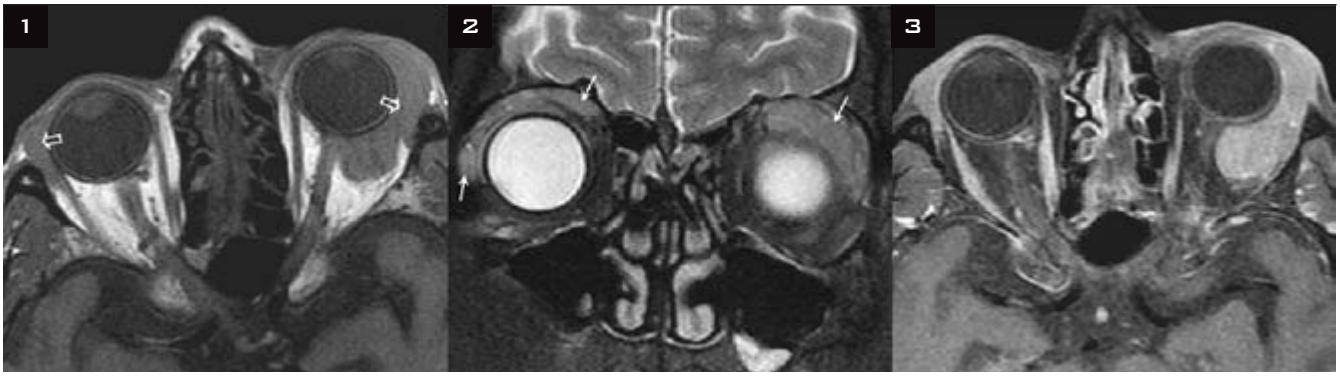

TYPICAL MR IMAGES. Images of a bilateral infiltrative orbital process. Note how the tumors (arrows) contour to the globe and grow along the bony confines of the orbit rather than invade into the bone. Following incisional biopsy, these tumors were confirmed to be MALT lymphomas of both orbits.

EVAN H. BLACK, MD, FACS

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Authors' Reply

We are pleased that our article generated interest among our peers. Please note that *EyeNet* is read by doctors in developing countries as well as those in the developed world. The purpose of this article was to bring all relevant details of orbital lymphoma to light for the sake of thoroughness. While some treatments may seem outdated or irrelevant in developed nations, unfortunately these might be the only viable options in countries where affordability and resources are important considerations.

We agree with Drs. Castillo, Black, and White that the CT image does not represent a typical presentation. However, it was the best image available to us that depicts a proven case of B-cell lymphoma based on histology and response to chemotherapy. Notably, we work in a government hospital in a developing country with limited resources—MRI is not available. We mentioned the diagnostic features of orbital lymphoma as seen in various modalities, but we did not say that CT is preferable over MRI. We do agree with Drs. Castillo, Black, and White that it is advisable for all clinicians, especially those of us who work in a less than ideal setup, to be well versed with the characteristic appearance of orbital lymphoma in all the standard diagnostic modalities to facilitate fast and accurate diagnosis with the equipment readily available.

Our statement regarding irradiation of the entire orbit to prevent recurrence created some controversy. While results of localized radiation therapy for orbital lymphoma have been encouraging, the possibility of recurrence and late significant morbidity discourages this treatment protocol in developing nations where patients do not follow up or cannot afford future salvage therapy. We disagree with the comment that there is no support in the literature for a regimen that involves radiation to the entire orbit, and present references below.[1-4] This has been an ongoing debate in recent years, and the decision should be left to the treating doctor. We do, however, agree that it would have been appropriate to discuss local irradiation therapy as an additional treatment modality in this article, in keeping with the current trends.

We appreciate this analysis—it helps maintain the standards of this publication and initiates an intelligent discourse among peers.

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1 Pfeffer MR et al. *Int J Radiat Oncol Biol Phys*. 2004;60(2):527-530.
2 Yadav BS et al. *Indian J Ophthalmol*. 2009;57(2):91-97.
3 De Cicco LD et al. *Radiat Oncol*. 2009;4:60.
4 Zhou P et al. *Int J Radiat Oncol Biol Phys*. 2005;63(3):866-871.

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