Advancing the Treatments of Retinoblastoma: Stuck in the 1950s

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With advancing age and wisdom, we are often apt to romance the simpler time of our youth. The world was less complicated. We were not hyperstimulated in an era devoid of email, cell phones, and texts. However, survival rates from pediatric cancers, notably retinoblastoma, were much lower. There was no Knudson two-hit hypothesis, RB1 gene, patient-derived orthotopic xenografts, or whole-genome sequencing. However, there was external beam radiation [1], intra-arterial therapy [2], intravitreal therapy [3], and melphanal [4]. Fast-forward to the present, where advances in science and medicine are improving health care, but with the background force of social media. Our challenge as clinicians and scientists is to assure that science and medicine are kept in parallel with bench-to-bedside research as a feedback loop. The medical treatment we bring to our patients today must be thoroughly evaluated using the research tools that have been made available.

In this issue of Ocular Oncology and Pathology, we are presented with 2 separate case reports, each documenting the novel use of intracameral melphanal for the treatment of anterior chamber seeding from advanced intraocular retinoblastoma [5, 6]. The first patient was an 11-year-old with unilateral International Classification of Retinoblastoma (ICRB) Group E eye with anterior chamber seeding and involvement of the trabecular meshwork for 270 degrees. The visual acuity was “normal OU”. Initial treatment consisted of a multitier approach using intra-arterial, intravitreal, and intracameral melphanal. This was followed by 4 monthly cycles of neoadjuvant systemic carboplatin and etoposide. An anterior chamber recurrence was noted 3.5 months later and further intracameral and intravitreal melphanal were delivered. Reported complications included heterochromia and opacification of the lens cortex, necessitating cataract surgery. Endothelial cell density remained stable during therapy; however, following cataract surgery, a 10% endothelial cell loss was noted. At 5 years of follow-up, the child was disease free with 20/20 vision in both eyes. The second patient had bilateral retinoblastoma (ICRB Group D right eye and Group E left eye) diagnosed at 1 year of age. The left eye had been enucleated, and the right eye developed ciliary body and anterior chamber relapse. Intraophthalmic artery chemotherapy was ineffective, so in hopes of avoiding external radiation, the authors elected to couple 4 alternating courses of intravitreal and intracameral melphanal with a seventh cycle of systemic chemotherapry. At 3 years of follow-up, the patient had no recurrent disease and “useful vision” despite documented atrophic choroidal scarring and retinal vascular toxicity.
Intracameral melphalan builds upon a decade of local chemotherapy delivery methods for the treatment of intraocular retinoblastoma. We have moved rapidly from periocular to intra-arterial to intravitreal and now to intracameral administration with the specific aims of delivering an increasingly higher concentration of chemotherapy in hopes of controlling ocular disease, while mitigating systemic side effects [7–9]. These advances have been heralded as successes, but each in turn has been overshadowed by a battery of subsequent case reports and small case series detailing complications of the technique [10–13]. Many reports show late toxicity to the organ for which salvage was attempted, while reports of metastatic disease remind us that losing sight of the entire child can have dire consequences. Such has been the history of retinoblastoma management from the era of external beam radiotherapy through systemic chemotherapy to the present. However, the rapidity at which we cycle through therapies has accelerated, leaving little time to assess the balance of efficacy and toxicity. In the end, as clinicians, we are left with a paucity of evidence-based medicine to improve outcomes in our retinoblastoma patients.

Central to this argument is that any treatment we render does leave a proverbial footprint upon our vulnerable patient population [14]. Late effects is a fertile research environment in pediatric oncology but one that often seems overlooked in retinoblastoma. There was a 50-year lag between the adoption of external beam radiotherapy as a standard-of-care therapeutic approach to retinoblastoma patients and the reported increased incidence of second malignancies in retinoblastoma survivors treated with this modality [15]. To prevent such treatment-related morbidity, it is imperative that we understand what we are doing prior to doing it. We have designed a decade worth of novel approaches to therapy in a void of pharmacology and pharmacokinetics, all the while citing a single in vitro cell toxicity assay to legitimize our choice of a single chemotherapeutic agent developed in the 1950s as a derivative of nitrogen mustard [16]. Our vision has been laser focused on local delivery, but horribly myopic in our choice of a drug.

The overall survival rate for pediatric cancers has improved from approximately 30% in the 1970s to over 80% currently, and retinoblastoma survival rates now exceed 90% in developed countries. For pediatric malignancies, this improvement is undeniably linked to the enrollment and monitoring of patients on prospective clinical protocols that have helped stratify patients according to clinical and genomic risk features, optimize treatments, and attenuate long-term morbidities [17]. While clinical trials have been essential in advancing the field of pediatric oncology, there is a significant time lapse from trial design to implementation to outcome data. To keep the science of tumor biology, technological advances, and treatment in parallel, we must rely upon preclinical models that incorporate the disciplines of chemical biology and pharmacology. Bench-to-bedside medicine can lead to prospective, retinoblastoma protocol-driven research studies with reportable patient outcomes, toxicities, and improved ocular event-free survival with long-term vision data [18]. These results are generalizable to the retinoblastoma community, rather than specific to a single patient on a given day in a certain clinic. Bench-to-bedside medicine has also identified novel targeted pathways for drug development and prevented us from subjecting our patients to unnecessary toxicities [19, 20]. None of the treatment modalities discussed in these 2 case reports was tested in a preclinical model with subsequent scientific peer review before being introduced into children. So for the time being, we must await the barrage of case reports and small case series that will come forth, heralding successes or horrors, while we continue to be stuck in the 1950s.

References


