Tumors of the Eye in Saudi Arabia and the State of Bahrain


To the Editor: I read with interest the paper on tumors of the eye in Saudi Arabia by Huaman and Cavender [1] and would like to comment on the design and data analysis of this study and offer, for comparative purposes, the figures of these tumors in the State of Bahrain.

The critique of the study conducted in Saudi Arabia comes mainly from the method used, in which the data sample was collected and analyzed and includes the following: (a) although the cases were classified according to the World Health Organization (WHO)-Histological Typing of Tumors of the Eye and its Adnexa, those from lacrimal glands were excluded from the study [2]. The interested reader is therefore left to speculate on origin of 13 adenocarcinomas (and 14 adenomas) cases, whether dermal, lacrimal or metastatic; (b) the WHO International Classification of Diseases for Oncology [3] classification of tumors of the skin of the eyelids and canthi to the skin and not to the eye. BCC of the eyelid is a skin lesion and is not different from that arising on the face or elsewhere in the body. On the other hand, if the aim of the study was to report the frequency of BCC of the skin of eyelids among the Saudi population because of associated environmental factors, then the number of patients with squamous cell carcinoma (SCC) of same site must also be recorded for comparative reasons. The trend in tumor registries is to record BCC separately from skin malignancies because their numbers tend to overinflate the incidence of skin cancer and underestimate the rates of malignancies of other sites; (c) it would have been more informative if the nationalities of the patients were analyzed because we are well aware of the number of Bahraini patients with various eye malignancies, particularly retinoblastoma, who are referred to King Khaled Eye Specialist Hospital (KKESH) for surgery and radiotherapy; (d) in accordance with the WHO recommendations [3], the figures on conjunctival (squamous) intraepithelial neoplasia (CIN) should have been dealt with separately from primary carcinoma since the lower grades may be the result of inflammatory response rather than truly neoplastic; (e) it is pointless to list the frequencies of benign tumors apart from the association of junctional conjunctival nevi and melanoma. World tumor registries do not record these neoplasms unless warranted. On the other hand, nevi and hemangiomata are long regarded as hamartomas rather than as neoplasms and the epithelial inclusion and noninclusion cysts mentioned in the paper as well as dermoid cysts, keratosis, verrucae, histiocytosis, and xanthelasma are definitely non-neoplastic and their frequency should not appear in the paper even when referring to benign tumors.

During the period between 1952-1991, there were 3,536 Bahraini patients with histologically diagnosed malignant neoplasms in Bahrain, of whom only 27 (0.8%) had primary eye tumors. The regional topographical distribution of these tumors in accordance with the WHO International Classification of Diseases for Oncology was as follows: one melanoma of the ciliary body, six orbital tumors (four rhabdomyosarcomas and two non-Hodgkin lymphomas), three lacrimal gland malignancies (two adenocystic carcinomas and one SCC), ten conjunctival tumors (nine SCC and one melanoma), six retinoblastomas (two of whom were sisters), and one malignant melanoma of the choroid. During the same period there were also 44 Bahraini patients with noninvasive malignancies of whom seven (16%) had CIN (five squamous and one junctional nevus with features of noninvasive melanoma) and no metastatic tumors or malignancies of unknown sites in the eye. These figures on eye tumors are too small to draw a significant conclusion despite the length of the study and its inclusion of Bahraini patients only. It would be of interest to know the pattern of eye tumors in other parts of the Arab world and this further points out the need for establishing an Arab cancer registry.

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References