

Strontium Beta-Irradiation: Can it Prove Strong Enough in Curbing the Ophthalmic Hydra Called Pterygium

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Received: April 27, 2017; Published: May 03, 2017

Abstract

No other ophthalmic disorder, or may be any medical disorder, has elicited so much interest as pterygium. Even though eons have passed since it was first discovered, its propensity for regrowth like tentacles of hydra, continue to perplex the ophthalmic community. Its propensity for recurrences has attracted all and the sundry and newer modalities are being propounded to prevent recurrences. This article reviews the role of radiation therapy for recurrence prevention in pterygium management.

Keywords: Pterygium; Ophthalmic; Metalloproteinases

Etymologically derived from the Greek word 'pterygion' meaning small wing, pterygium has been in vogue since the times of Sushruta (6th century B.C.). It is a triangular, wing-like fibro-vascular encroachment of degenerative sub-epithelial conjunctiva, straddling the limbus, onto the cornea.

While primary pterygium excision with conjunctival graft remains the standard procedure for prevention of recurrences with recurrence rate of 2 - 35%, many other methodologies have been used with varying degree of success. Intra-operative and post-operative mitomycin-C (0.01 - 0.04%) with recurrence rate of 3 - 38% is another very commonly used modality [4,5].

Intra-operative Dauxorubicin (0.02%), daunorubicin (0.02%), cyclosporine A (0.1%) eye-drops, thiotepa (0.05%) eye-drops and 5-fluoro-uracil (5%) are the other medical options shown to have promising results in recurrence prevention in various studies. Off-late, sub-conjunctival anti-VEGF Bevacizumab (1.25 - 2 mg) therapy has also been proposed for the aforesaid. All these agents are associated with risk of serious complications like scleral perforations, scleritis, scleral necrosis, and endophthalmitis.

Figure 1: Pterygium in a 17-Year-Old Male.

Pterygium, with a prevalence of 0.3 to 29%, is common in the 'pterygium belt' lying 37° on either side of equator [1,2]. Chronic exposure to ultra-violet B radiations, limbal stem cell deficiency, human papilloma virus infection, p53 gene mutations and imbalance of matrix metalloproteinases (MMP) and tissue inhibitors of metalloproteinases (TIMP) have been strongly implicated in pterygium causation [3].

Whereas diagnosis and management of primary pterygium is an iotic task, managing recurrences is a titanic one.

Figure 2: Scleral Perforation Secondary to Mitomycin-C Application Intra-Operatively.

Role of beta Beta-irradiation

The standard technique is a strontium (Sr90) brachytherapy with an epibulbar plaque which has central radioactive disc and non-active rim of 2 mm.

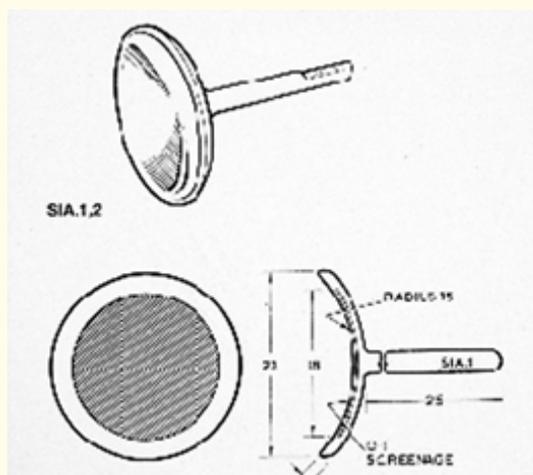


Figure 3: SR-90 Epibulbar Applicator.

A total dose of 25 - 60 Gy is to be delivered in 1 - 6 fractions at a rate of 5 - 20 Gy/min. Most commonly, a dose of 30 Gy is delivered in 3 weekly fractions of 10 Gy with the first application being administered intra-operatively, or at least within 48 hours after surgery.

Regimes of beta-irradiation advocated for recurrence prevention are:

- single application of beta-irradiation
- multiple applications over consecutive days immediately in post-op period.
- multiple applications over a 2-week period.

A literature review by Ali, *et al.* (2011) of 6000 lesions treated post-operatively with beta irradiation reported an over-all recurrence rate of 15% with very few side-effects. Another 10-year review of 104 eyes done by Qin, *et al.* (2012), treated similarly, reported nil recurrence but cataract development in 5 eyes [6,7].

Cumbersome instrumentation and inconvenience of arranging its treatment account for the limited utility of this modality although the recurrence rates are comparable to post-operative mitomycin-C application [8].

Conjunctival auto-grafting and mitomycin-C are being used by all and the sundry, undermining the role of beta radiation. Though conjunctival autografting is considered the safest and most effective, it is time consuming. Time factor becomes very pertinent in developing countries where patient to ophthalmologist ratio is negatively skewed, incidence of pterygium is high and potentially blinding diseases account for the bulk of surgical time. Comparative data for beta radiation and mitomycin C are conflicting with

one study (Amano, *et al.*) suggesting superiority of mitomycin- C while others (Snibson, *et al.* and Simsek, *et al.*) giving verdict in favour of beta irradiation [9-12].

Pterygium surgery has infallibly evolved over the years. Still the quest for an ideal recurrence free modality of pterygium management remains evasive and futile. This highlights the need to have a better understanding of the aetio-pathogenesis of pterygium as well as its recurrence. Also, treatment plan should be customized for each case rather than blindly following a single technique. Ironically, though 'pterygium' means a 'small wing', over the centuries its wings have expanded beyond our understanding and imagination. This triangular enigma can truly be called the 'Bermuda triangle' of ophthalmology as it continues to baffle us all. The exhaustive review studies by Ali, *et al.* and Qin, *et al.* definitely prove the validity and utility of beta irradiation. A concerted effort on our part is required to solve this mystery and based on the encouraging reports of the studies by Snibson, *et al.* and Simsek, *et al.* Beta irradiation could well prove to be the guiding light.

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Volume 1 Issue 1 June 2018

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