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CORRESPONDENCE

Sir,

Diagnostic information provided by referrers to patients with suspected uveal melanoma

Hospital-based clinicians may face special difficulties when disclosing a diagnosis of malignancy, lacking pre-existing longitudinal relationships with patients.[1] Ophthalmologists in a Canadian survey perceived a need for training in breaking bad news pertaining to ocular malignancies.[2]

We conducted a prospective service evaluation to determine what diagnostic information is provided by referring clinicians to patients referred to the Liverpool Ocular Oncology Centre (LOOC) with suspected ocular malignancy. We further investigated patients' perspectives on information disclosure. Questionnaires were provided to patients who were diagnosed with choroidal/ciliary body melanoma at LOOC over a 5-month period. A total of 50 of 61 patients (82%) (24 male, 26 female; mean age 61 years) completed questionnaires.

Uveal melanoma was the suspected diagnosis in 80% of referral letters. In all, 64% of the patients stated that they had been informed by their referring clinician that they may have a malignancy, 30% stated they had not been told, and 6% were unsure. In all, 52% said they had been given a diagnosis.

In all, 64% of the patients felt that the referrer should be the person to inform a patient about possible malignancy, whereas 34% felt that this should be disclosed by LOOC, unless the patient specifically asks (2% abstained).

Of patients who had been informed about possible malignancy by their referrers, 58% ($n = 18$) felt that this had not caused them additional anxiety before their LOOC appointment. Overall, 81% ($n = 25$) felt that this had allowed them to be better prepared for the appointment.

The context for disclosing a diagnosis of malignancy should be determined by patient preferences, which vary.[1] Ophthalmologists should take note that most patients in our survey felt that this responsibility lay with the referrer. Despite the fact that uveal melanoma was suspected in most referral letters, a substantial proportion of patients stated that they were not informed about possible malignancy. Clinicians can be reassured that most patients feel that disclosure of this information by the referrer does not unnecessarily increase their anxiety. This is supported by comments from cancer patients in another study who report, not uncommonly, that 'receiving bad news is not as difficult as anticipating it'.[3]

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Reply to Loh and Wong

We read with interest the excellent work of Loh and Wong[1] in describing an earlier stage of myopic foveoschisis documented by optical coherence tomography. We noted that it was reported the central retinal thickness (CRT) was initially documented to be 159 μm, and more than 3 years later, to be 303 μm. Following the diagrams provided, the CRT/central foveal thickness appears to be similar, with splitting of the layers around it. We would like to enquire if these documented measurements were taken from automatic derived measurements or manually from the images obtained. Although it may not have any bearing on the excellent case reported by Loh and Wong, we wish to point out that automatic measurements tend to differ from manually measured thickness, especially if the software is unable to distinguish the contour of the layers in the retina. It has been reported that the difference between automated measurements and manual measurements is 7.9 ± 90.8 μm, with a maximum difference of 455 μm.[2] This is an important aspect to acknowledge, especially when documenting OCT findings for patients.

Conflict of interest

The authors declare no conflict of interest.

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