optic nerve involvement. It should be followed by chemotherapy along with radiotherapy. Chemotherapy is of paramount importance in its management [7].

After enucleation, orbital bed and optic nerve examination is important. Inadequate amount of resection of optic nerve and/or spillage of tumor cells during surgery can cause recurrence. Goble et al. demonstrated the effectiveness of combination therapy enucleation, radiation and systemic chemotherapy in large tumors [8]. They conclude that aggressive therapy for orbital retinoblastoma should include local surgical biopsy, radical orbital radiotherapy and systemic chemotherapy.

If after careful enucleation, the surgical margin of the optic nerve is positive or if an orbital recurrence is present, removal of any tumor mass surgically with local irradiation and systemic chemotherapy is the management of choice. In review of our case presentation, it is hard to comment on the enucleation that took place. It is not known whether the optic nerve was extracted with as much length as possible.

Nevertheless, the patient certainly should have completed his course of initial radiation. When the patient presented with a large proptotic mass, he should have undergone the combination therapy of exenteration, radiation and chemotherapy. Unfortunately, the patient succumbed to a disease which still has a high mortality rate even with aggressive treatment.

CONCLUSION

If a child presents with ocular retinoblastoma, the utmost step is to decide whether the affected eye can be saved with the non-invasive procedures which are listed above. If however, the eye cannot be saved, then careful enucleation with extraction of a long optic nerve sample is advisable.

REFERENCES

1. Kim JW, Kathpalia V, Dunkel IJ, Wong RK, Riedel E, et al. (2009) Orbital recurrence of retinoblastoma following enucleation. Br J Ophthalmol 93: 463-467.
2. Khelfaoui F, Validire P, Auperin A, Quintana E, Michon J, et al. (1996) Histopathologic risk factors in retinoblastoma: A retrospective study of 172 patients treated in a single institution. Cancer 77: 1206-1213.
3. Messmer EP, Heinrich T, Höpping W, Sutter E, Havers W, et al. (1991) Risk factors for metastases in patients with retinoblastoma. Ophthalmology 98: 136-141.
4. Chantada GL, Gonzalez A, Fandino A, de Davila MT, Demirdjian G, et al. (2009) Some clinical findings at presentation can predict high-risk pathology features in unilateral retinoblastoma. J Pediatr Hematol Oncol 31: 325-329.
5. Klintworth GK (1994) The eye. In: Rubin, E, Farber, JL, ed. Pathology. Philadelphia: J.B. Lippincott, Chapter 29: 1480-1482.
6. Abramson DH (1985) Treatment of retinoblastoma. In: Blodi, FC, ed. Contemporary Issues in Ophthalmology, Vol. 2, retinoblastoma. New York: Churchill Livingstone; Chapter 4: 63-93.
7. Shields JA, Shields, CL, De Potter P (1992) Enucleation technique for children with retinoblastoma. J Pediatr Ophthalmol Strabismus 29: 213-215.
8. Finger PT, Czechonska G, Demirci H, Rausen A (1999) Chemotherapy for retinoblastoma: A current topic. Drugs 58: 983-996.