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Causes of Uveal Melanomas and its Symptoms: An Editorial

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Editorial Note

The Iris, Ciliary body, or Choroid is affected by Uveal melanoma, which is a type of eye cancer. Tumors develop from pigment cells in the uvea, which are reason for the eye's color. These melanocytes are not to be confused with the cells of the retinal pigment epithelium, which do not develop melanomas and are found beneath the retina. Symptoms and Signs Depending on the location and size of the tumour, ocular melanoma may manifest with no symptoms. When symptoms do appear, they can include: • blurred vision • double vision • discomfort • pain • a sensation of a foreign body in the field of vision • a reduction in the overall field of vision • loss of vision • A perception of flashes of light in the eye.

Uveal melanomas, often known as ocular melanomas in the media and among the general public, can develop in any of the three regions of the uvea and are sometimes referred to as choroid melanoma, ciliary body melanoma, or iris melanoma depending on their location. Large tumours frequently spread to numerous portions of the uvea. True iris melanomas, which originate within the iris and infiltrating the iris, are unique in their genesis and prognosis, therefore the other tumours are often referred to as posterior Uveal melanomas combined.

Uveal cancers can develop from melanocytes found in the eye. Iris freckles and moles are common benign melanocytic malignancies. Unless they show signs of malignancy, in which case they are categorized as iris melanomas. Iris melanomas, despite being produced from Uveal melanocytes, have more in common with cutaneous (skin) melanomas in that they typically contain *BRAF* mutations linked to UV damage. Iris melanomas are far less likely to spread than other Uveal melanomas, and they are also less likely to cause blindness. The iris is involved in about 5% of Uveal melanomas. Benign choroid melanocytic tumours, such as choroid freckles and nevi, are quite common and no health problems unless they show symptoms of malignancy, in which case they are classified as melanomas. Uveal melanoma is unique from the majority of cutaneous melanomas caused by UV exposure.

It has various characteristics in common with non-exposed melanomas, such as acral and mucosal melanomas. *BRAF* mutations are exceedingly rare in posterior Uveal melanomas; instead, *GNAQ/GNA11* mutations are common in Uveal melanomas, a condition that is shared with blue nevi, Nevus of Ota, and ocular melanises. Mutations in *GNAQ/GNA11*, like *BRAF*, are early events in carcinogenesis and have no bearing on tumour stage or subsequent metastatic dissemination. Mutations in the *BAP1* gene, on the other hand, are closely connected to metastatic spread and patient survival.

The usage of a cell phone is not linked to an increased incidence of Uveal melanoma. Uveal melanoma has no known cause. Uveal nevi are prevalent, but only a small percentage of them proceed to melanoma. Because the Uveal tract lacks lymphatic pathways, metastasis occurs by local extension and/or blood-borne spread. The liver is the most prevalent site of metastasis for Uveal melanoma; for most of the percentage of ocular melanoma patients, the liver is the first site of metastasis. The lung, bones, and just underneath the skin are all common sites of metastasis. Within 15 years of treatment for the initial tumour, almost half of the patients will develop metastases. 90% of the time, the liver will be implicated. Patients should not be declared cured even after a ten-year interval of monitoring since metastasis might occur more than ten years following treatment of the initial tumour.

The average survival period after a liver metastasis diagnosis is determined on the extent of systemic spread. For metastatic Uveal melanoma, the disease-free interval, performance status, liver substitution by metastases, and serum lactic dehydrogenase levels are the most important prognostic markers. Metastatic Uveal melanoma is now incurable. Many clinical studies, the most prominent of which is The Collaborative Ocular Melanoma Study, have influenced the treatment approach for Uveal melanoma.

The treatment varies depending on a number of parameters, the most important of which are the tumours size and the findings of analyzing biopsied tumour material. The afflicted eye can be removed as a primary treatment; however this is now reserved for situations of high tumour load or associated secondary issues. In affluent countries, advances in radiation therapy have greatly reduced the number of patients treated with enucleating. The plaque is placed for a few days before being removed. The possibility of metastases following plaque radiotherapy is the same as enucleating, implying that micro metastatic spread occurs before the main tumour is treated. A new study of clinical subtyping in Uveal melanoma was conducted using genomic data.