designated to evaluate the effectiveness of myofascial release for these patients.

Patients were evaluated in follow-up after lumpectomy and radiation and were specifically asked questions concerning side effects from the treatment. Twelve patients reported significant chest wall tenderness, which was unresponsive to anti-inflammatory medication. These patients were referred to Physical Therapy and Occupational Therapy Departments for myofascial release.

The myofascial release protocol consisted of stretching exercises including the crossed hand, scar release, and arm pull techniques.

The initial session included pain description, range of motion measurements, functional strength testing, edema measurement, and palpation of the tissues. An explanation of techniques and the program were discussed with the patient.

The program generally started with the patient's description of how they were tolerating the program and home exercises. Palpation of the area was then done. The scar release techniques were then initiated along all of the incisions in the area. During the scar release, pressure was applied into the areas of tightness for the patient and held until a release is felt, generally in 3 to 5 mm, following the motion as the tissues relax and never forcing or leading the motion.

Following the scar release, a crossed hand technique was used along the areas of tightness in the pectoral or chest wall region and the axilla region. In the crossed hand technique, the hands were crossed against the area of restriction. The skin and elasticity of the muscles were slowly and gently stretched until the hands were stopped at a barrier. A gentle hold to stretch at the barrier for 3 to 5 min was maintained. Relaxation through the therapist's hands was allowed to penetrate the patient with the therapist aware of any subtle movements under their hands as the tissues relax and never forcing or leading the motion.

The third step was an arm pull technique. The patient's arm was elevated to draw out the elasticity of the shoulder joint. The arm was then held in the position with the therapist feeling for any subtle changes throughout the limb.

Following these techniques, a temperature modality such as moist heat or a cold pack were applied to the area for 15 min. The patient was also instructed in a progressive home exercise program starting with free range of motion activity and building up to a resistive exercise program with weights or therabite.

The patients were generally on a therapy program three times per week for 3 to 4 weeks. Self scar tissue releases can be taught prior to discharge.

The patients were located with radiation therapy between the years 1987 and 1994. A dose of 45 to 50 Gy was delivered 1.8 to 2.0 Gy fractionation per week, with tangent fields used with 6 MV photons. All patients were simulated. Wedges were used when necessary to improve dose homogeneity. Computerized treatment plans were generated. Boosts were given between 10 and 16 Gy, 2 Gy per fractionation, when indicated, referral to Occupational Therapy or Physical Therapy service to these patients. But follow-up is not significant if the proper questions and concerns of the patient are not addressed. Unfortunately, side effects of treatment are frequently neglected. For conservative breast management patients, a pain history should be obtained and, when indicated, referral to Occupational Therapy or Physical Therapy Departments trained in the myofascial release techniques should be arranged.

Multidisciplinary practice is critical for quality cancer care. Of interest, the treatment recommendation for myofascial release for this problem resulted from discussions with my wife, an occupational therapist. The important point is that radiation oncologists should strive to include and listen to the various related specialties and paraprofessionals for the benefit of our patients.

Finally, myofascial release may be of help for other patient groups such as extremity sarcoma or head and neck cases.

In conclusion, we believe that myofascial release is an effective treatment modality for distressing chest wall symptoms following conservative breast management.

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LONG-TERM FOLLOW-UP OF PATIENTS UNDERGOING DEFINITIVE RADIATION THERAPY FOR SEBACEOUS CARCINOMA OF THE OCULAR ADNEXAE

To the Editor: An earlier article from our group addressed the radiotherapeutic treatment of sebaceous carcinoma of the ocular adnexae (1). As we emphasize in that report, local control at the primary site after radiation and/or surgery is 90% at 5 years. Of note, many of these patients were irradiated postoperatively following orbital exenteration. The purpose of the brief communication was to illustrate that good local control figures, with superior functional results, could be achieved using definitive radiation therapy following more conservative surgical approaches and reconstruction. This approach not only allows patients to retain vision but also, with proper radiotherapeutic technique, renders excellent cosmetic results. Since various physicians have consulted us regarding the use of definitive radiation therapy in this setting, we feel this communication is in the best interest of patient care.

We initially reported on four patients using definitive radiation therapy following biopsies with local NED times ranging from 30–117
months. One of these four patients developed a recurrence and required orbital exenteration approximately 5 years following the publication. Thus, despite the use of definitive radiation therapy, careful follow-up is still needed, particularly with patients showing Padgetoid intraepithelial pathologic components. While we still advocate the use of definitive irradiation following conservative surgery, the natural history of Meibomian gland carcinoma is an aggressive one, and patients should be informed of this at the time of consideration of therapeutic options. Thus, while definitive irradiation continues to be a good option with respect to local control, cosmetic, and functional results, thorough routine clinical evaluations are necessary due to potential late relapses and distant failure patterns. We propose to establish an international referral center for this disease at Massachusetts Eye and Ear Infirmary in order to accrue enough patients to address the issue of radiation therapy in the setting of conservative surgery as opposed to more extensive surgical options (including orbital exenteration). Thus, the help of all international Journal of Radiation Oncology, Biology and Physics readers would be greatly appreciated in facilitating patient accrual for this rare and biologically aggressive disease.

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