poechoic areas and had variable internal reflectivity, mostly medium to high (Figure 2).

A systemic workup was obtained, including magnetic resonance imaging of the brain and orbit, computed tomography of the chest, abdomen, and pelvis, and a bone scan. Computed tomography demonstrated multiple pulmonary nodules and prominent lymph nodes. The bone scan showed left iliac and right clavicle hot spots. Biopsy of the lung lesion confirmed metastatic prostate adenocarcinoma. His ocular lesion was presumed to be metastatic from the same primary cancer. He was treated with oral ketoconazole, 200 mg 3 times a day for 7 weeks, and 1 dose of intramuscular leuprolide acetate, 22.5 mg. At 7 weeks, visual acuity remained hand motions but the patient had a subjective improvement in vision. Ocular echography demonstrated a slight decrease in the apical dimension of the tumor. Ketoconazole was then discontinued while leuprolide acetate was maintained at a 30-mg intramuscular injection every 4 months. Five months after the initial visit, his visual acuity improved to 20/60 and retinal pigment epithelial changes appeared on the surface of the tumor. The tumor size decreased to 14.5 × 10 mm in basal dimension and a maximum apical height of 4 mm. Ten months later, the patient’s visual acuity declined to counting fingers due to macular hemorrhages and choroidal atrophy. The tumor continued to decrease in size over several years. At the 5-year follow-up, the tumor has indistinct basal dimensions and a maximum apical height of 1.6 mm on echography.

Comment. In recent years, 2 cases of choroidal metastasis from prostate cancer have been successfully treated with hormonal therapy without radiation.5,6 One patient was treated with oral ketoconazole, 200 mg 3 times a day for 7 weeks, and 1 dose of intramuscular leuprolide acetate, 22.5 mg. At 7 weeks, visual acuity remained hand motions but the patient had a subjective improvement in vision. Ocular echography demonstrated a slight decrease in the apical dimension of the tumor. Ketoconazole was then discontinued while leuprolide acetate was maintained at a 30-mg intramuscular injection every 4 months. Five months after the initial visit, his visual acuity improved to 20/60 and retinal pigment epithelial changes appeared on the surface of the tumor. The tumor size decreased to 14.5 × 10 mm in basal dimension and a maximum apical height of 4 mm. Ten months later, the patient’s visual acuity declined to counting fingers due to macular hemorrhages and choroidal atrophy. The tumor continued to decrease in size over several years. At the 5-year follow-up, the tumor has indistinct basal dimensions and a maximum apical height of 1.6 mm on echography.

Reduction of Vascular Endothelial Growth Factor A in Human Breast Milk After Intravitreal Injection of Bevacizumab but Not Ranibizumab

Anti–vascular endothelial growth factor (VEGF) drugs such as bevacizumab (Avastin) and ranibizumab (Lucentis) are increasingly used in patients with choroidal neovascularization owing to causes other than wet age-related macular degeneration, such as myopia and chorioretinitis, and in patients with macular edema due to retinal vein occlusion or diabetes mellitus.1 These conditions often affect younger patients and include women of child-bearing potential. There are only very limited data about the use of anti-VEGF agents in pregnant or nursing women.

In this case study, serum and breast milk of a 32-year-old patient were analyzed for the concentrations of VEGFA before and after intravitreal injection of bevacizumab and ranibizumab.

Methods. A 32-year-old woman, who was breastfeeding her 12-week-old son, was diagnosed as having scar-associated choroidal neovascularization in her left eye. Treatment with intravitreal bevacizumab was recommended. With preliminary data of VEGFA concentrations after the first injection of bevacizumab available, the treatment was changed to ranibizumab. After 3 injections, no signs of active choroidal neovascularization were detected. Informed consent was obtained before any study-related procedure was performed. The institutional review board waived approval. The study was con-
ferred across the blood-retina barrier and the placenta has been shown that Fc-containing antibodies can be trans-ferred only the fragment antigen-binding (Fab) region. It has been described that ranibizumab consists of the molecular structure of the proteins: whereas bevacizumab, but not ranibizumab, on VEGFA levels in serum and breast milk.

To our knowledge, this is the first descrip-tion of a significant effect of treatment with intravitreal bevacizumab in the serum.

After intravitreal treatment with bevacizumab, the VEGFA level in breast milk slowly decreased, from 13.3 ng/mL to 8.6 ng/mL after 2 weeks, marking a decrease of 35%. In the following weeks, the VEGFA level recovered slowly. Following the intravitreal injection of ranibizumab, the level of VEGFA in breast milk remained stable without significant alterations except for 1 outlier. No free bevacizumab was detected in breast milk at any time.

Comment. To our knowledge, this is the first description of a significant effect of treatment with intravitreal bevacizumab, but not ranibizumab, on VEGFA levels in serum and breast milk.

This distinction could be explained by a difference in the molecular structure of the proteins: whereas bevacizumab consists of a humanized IgG antibody with a fragment crystallizable (Fc) region, ranibizumab consists of only the fragment antigen-binding (Fab) region. It has been shown that Fc-containing antibodies can be transferred across the blood-retina barrier and the placenta via the Fc receptor of the neonate (FcRn). Both VEGFA and its receptors are important in the rodent mammary gland during pregnancy and lactation, and VEGFA receptors are expressed in the human newborn intestine, although their function has not yet been explained.

Based on our data, the possibility of adverse events in the mother or the infant by reduction of the VEGFA levels in the serum or breast milk after intravitreal bevacizumab cannot be excluded. Consequently, in our opinion, if anti-VEGF treatment is required in nursing women, ranibizumab should be preferred to bevacizumab because of a lower effect on VEGFA levels in the serum and breast milk.

Figure 1. Concentrations of vascular endothelial growth factor A (VEGFA) and bevacizumab in the serum.

Figure 2. Concentrations of vascular endothelial growth factor A (VEGFA) and bevacizumab in breast milk.

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