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Corrigendum

Long-term outcomes after enucleation or plaque brachytherapy of choroidal melanomas touching the optic disc. Brachytherapy. Vol 20 (6), November–December 2021, 1245-56. https://doi.org/10.1016/j.brachy.2021.05.162

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First, the type of ruthenium plaque designs available at St. Erik Eye Hospital are CCA, CCB, CCX, CCZ, COB, CIA and CIB. The types of plaques considered for the selection of patients included in this paper were CCA, CCB, CIB or COB. For one patient, a CIB plaque was initially selected but she was eventually treated with a notched COB plaque instead. Consequently, all patients were treated with CCA, CCB or COB plaques. “CIA”, which was mentioned in the sixth sentence in the descriptive statistics and unfortunately pictured in Figure 1, is a typo.

Next, the B and C models in Table 6 were duplicated from Table 5. The correct values for Table 6 are declared below. We included variables that were significant in univariate analysis for multivariate analysis. However, in Table 6, only transpupillary thermotherapy (TTT) at first brachytherapy was significantly associated with secondary treatment in univariate analysis. Therefore, we chose to proceed with inclusion of a size variable (tumor thickness) considering that the effect of TTT has previously been shown to be heavily influenced by tumor thickness, as well as the type of radioisotope considering the low p-value of iodine CCB vs. ruthenium COB in univariate analysis (p=0.087). It should be underlined that when including tumor thickness, iodine versus ruthenium plaque brachytherapy and TTT at first brachytherapy, the latter was significantly associated with reduced risk for secondary brachytherapy, enucleation or TTT (secondary treatment, Table 6B). We may also add that when only including tumor thickness (Exp(B) 0.9, 95 % confidence interval (CI) 0.7 to 1.1, p=0.28) and TTT at first brachytherapy (Exp(B) 0.31, 95 % CI 0.1 to 0.7, p=0.007) the latter was also significantly associated with reduced risk for secondary treatment. However, the odds ratio for secondary treatment was not significant when comparing iodine CCB vs. ruthenium COB plaques (Table 6C). One reasonable conclusion may be that the association between TTT given at the time of primary plaque brachytherapy and the risk for secondary treatment is related to plaque design, with a stronger reduction of the risk for secondary treatment if TTT is added to non-notched than notched ruthenium plaques, perhaps due to less optimal tumor coverage with non-notched plaques. An obvious limitation of the comparisons in Tables 5 to 7 is that the time to the outcome (secondary treatment) were not accounted for, and another statistical method e.g., Cox regression may have led to different results.

The authors request two corrections to their recently published article:

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Table 6
updated version. Multivariate binary logistic regressions of risk factors for secondary brachytherapy, secondary enucleation or additional TTT after plaque brachytherapy. These figures replace table 6B and 6C in the original publication. S.E., Standard error. CI, Confidence interval.

B	B	S.E.	Wald	*p*	Exp(B)	95 % CI
Tumor thickness, per mm	-0.04	0.2	0.1	0.81	1.0	0.7 to 1.3
Iodine vs. Ruthenium, all plaques	-0.5	0.8	0.3	0.56	0.6	0.1 to 3.1
TTT at first brachytherapy, yes vs. no	-1.2	0.4	7.4	0.007	0.3	0.1 to 0.7
Constant	0.7	0.7	1.0	0.32	2.0	
C	B	S.E.	Wald	*p*	Exp(B)	95 % CI
Tumor thickness, per mm	-0.04	0.2	0.03	0.85	1.0	0.6 to 1.5
Iodine CCB vs. Ruthenium COB	-1.0	1.1	0.9	0.35	0.4	0.0 to 3.0
TTT at first brachytherapy, yes vs. no	-0.6	0.7	0.7	0.40	0.6	0.2 to 2.1
Constant	0.8	1.1	0.6	0.45	2.2	