Clinical experiences with UFT/LV: a series of case studies

Experiences with UFT/LV as maintenance therapy in a first-line setting

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Both patients in the following case studies have metastatic colorectal cancer sensitive to fluorouracil-based treatment and opt to take oral tegafur-uracil/leucovorin (UFT/LV) as maintenance chemotherapy until disease progression.

The first case study is a 73-year old male who was diagnosed with rectal adenocarcinoma in December 2001. The patient had stage pT3 N2 (13/19) M1 G3 R0 disease, with synchronous metastatic spread to almost all segments of the liver and multiple para-aortal lymph nodes. Following anterior surgical resection of the rectum, high-dose chemotherapy was initiated comprising intravenous (IV) fluorouracil (2600 mg/m^2 over 24 h) and folinic acid (500 mg/m^2 over 2 h) weekly × 6 with repeat cycles every 8 weeks. During cycle 2, grade 2 diarrhoea and anticipatory vomiting resulted in a dose reduction in IV fluorouracil to 75% of the initial dose. After 3 cycles, a single residual hepatic lesion of 6 mm diameter persisted for which the patient refused surgery. After consultation, the patient decided in favour of oral maintenance chemotherapy and to remain on therapy until disease progression. After 4 months of treatment with UFT 300 mg/m^2/day plus LV 90 mg/day, the CT scan of the liver revealed a complete remission which was confirmed 2 months later after cycle 6. During therapy with UFT/LV, there are no clinical signs of disease progression with the patient having an excellent quality of life.

The second case study is a 67-year old male who was diagnosed with rectal adenocarcinoma in November 2000. Neoadjuvant radio-chemotherapy (54 Gy, IV - fluorouracil 225 mg/m^2) was followed by an abdomino-perineal rectal resection (R1). Two months later, multiple bilateral pulmonary metastases were diagnosed and biomodulated IV chemotherapy (folinic acid, 500 mg/m^2 over 2 h, followed by 5-FU 2600 mg/m^2 over 24 h) weekly × 6, q50d, was initiated. Due to grade 2 diarrhoea, the dose of fluorouracil was reduced to 2000 mg/m^2 over 24 h and oxaliplatin (85 mg/m^2 every 2 weeks) was added due to the high-risk situation of the patient (R1 resection and bilateral pulmonary lesions). Six cycles of this combination regimen were administered and the bilateral pulmonary lesions regressed to minimal residues of about 5 mm in diameter. Following consultation, the patient expressed a preference for oral as opposed to IV chemotherapy with view to remaining on therapy until disease progression. After 4 months of treatment with UFT 300 mg/m^2/day plus LV 90 mg/day, there are no clinical signs of disease progression.

These case reports bring attention to the concept of continuing oral chemotherapy until disease progression as a means of consolidating remission, Skipper *et al.* [1]. However, it remains unclear as to any advantage that continuation of treatment may have in prolongation of time to progression. Where the intention of chemotherapy is limited to palliation, as in these case studies, extent of toxicity and quality of life during treatment are of paramount importance, and in our experience this is reflected in patients preference for oral therapy over IV therapy and the requirement of fewer treatment-related hospital visits.

Reference

1 Skipper HE *et al.* Laboratory models: the historical perspective. *Cancer Treat Rep* 1986; **70**:3–7.