revealing significant differences. The gains of adjuvant chemotherapy in colon cancer stage III are well established in the literature, but the benefits are comparably limited and may be even less if treatment is not provided as in the trials (early start after chemotherapy, 6 or more months of treatment, adequate compliance at least 60%).

1067

Analysis of the EORTC Melanoma Group 18952 randomized trial on 2 intermediate dose schedules of IFN-alpha2b compared with observation in 1388 patients with high risk melanoma stages IIB-III

A.M.M. Eggermont, S. Suciu, W. Ruka, A. Testori, W. Kruit, C.J.A. Punt, M. Delaunay, F. Sales, K. Stoitchkov, G. Groenewegen, R. Mackie, P. Patel, D. Lienard. *EORTC Melanoma Group, Belgium*

Introduction: EORTC 18952 is the largest adjuvant IFN trial ever conducted in melanoma. The efficacy of intermediate doses of IFN-α 2b (10 MU qd, 5d/wk,sc,4 wks followed by either (arm A) 10MU, sc, tiw, for ONE YEAR, or by (arm B) 5MU, tiw, sc for TWO YEARS, was compared to observation (arm C). in 1388 patients with high risk melanomas (T4N0M0, anyTN1-2M0). The intent-to-treat analysis has been used.

Results: A total of 740 pts developed distant metastases and 648 died; the median follow up was 4.2 yrs. The differences between the 3 arms were not statistically different neither in terms of distant metastasis free interval (DMFI) (p=0.22) not in terms of survival (p=0.40).

Endpoint		Control	1-year IFN-α 2b	2-year IFN-α 2b
Distant Metastasis-	4-year rate (SE)	44.4% (3.1%)	44.6% (2.2%)	48.7% (2.2%)
Free Interval	HR (95% CI)	1	0.95 (0.79-1.16)	0.85 (0.70-1.04)
	P2-value		0.62	0.11
Survival	4-year rate (SE)	51.8% (3.1%)	53.0% (2.2%)	55.1% (2.2%)
	HR (95% CI)	1	0.99 (0.80-1.21)	0.89 (0.72-1.10)
	P2-value		0.88	0.27

HR: Hazard ratio

Treatment regimens were relatively well tolerated with an overall reporting of grade 3-4 toxicities in about 10% of the patients in the treatment arms A and B. In contrast to a very low rate of haematologic and hepatotoxic events the constitutional symptoms such as fatigue, anorexia and mood changes including severe depression were the most frequent causes for reductions, interruptions and for going of treatment early.

Conclusions: One year treatment with highintermediate dose (10 MU) IFN-α 2b showed no effect at all whereas 2-year treatment with the lower dose with 5 MU had a marginal effect that failed to reach significance. Duration may therefore well be of more importance than dose.

The question whether IFN is a cytokine that requires long term maintenance treatment for a significant improvement of outcome is presently addressed in the EORTC18991 trial which investigates the impact of 5 years of treatment with PEG-Intron in comparison to observation in stage III melanoma.

1068

Breast cancer screening - status and perspectives

E. Lynge. *University of Copenhagen Panum Institute, Institute of Public Health, Copenhagen, Denmark*

Randomised controlled trial from Sweden have demonstrated that it is possible to reduce the mortality from breast cancer when mammography screening is offered to women aged 50-69 every second year. Based on these results, service mammography screening is now offered throughout Europe. Screening is, however, testing of healthy women, and screening therefore has both potential advantages and potential disadvantages. It is, furthermore, not a straightforward task to customize the trial results to routine health care, and quality assurance is therefore needed of all activities in the service screening programmes. The presentation will review the outcome of service screening. It will include available data on the effect of service screening on breast cancer incidence and stage distribution, the effect on treatment, the occurrence of false positive tests, the occurrence of false negative tests as measured by the proportionate interval cancer rate, and the effect on breast cancer mortality.

1069

Prostate cancer screening - status and perspectives

F.H. Schröder. *Erasmus University Dr Molewaterplein 40, Dept. of Urology/ P.O. Box 2040, Rotterdam, The Netherlands*

Screening for prostate cancer remains controversial in spite of positive indirect evidence that screening may effect prostate cancer mortality. This evidence is mainly related to the decreasing prostate cancer mortality in the US and to the so-called "Innsbruck screening study" which shows a 32% prostate cancer mortality in a geographical comparison. In the meantime, major randomized studies are ongoing in the United States and in Europe which will eventually produce the answer to most of the open questions. These relate to mainly: Does prostate cancer screening decrease prostate cancer mortality? What are the appropriate age-groups to be screened? What are the appropriate time intervals? At what time should screening commence? Can risk groups be identified which warrant more aggressive diagnostic strategies? Many of these answers will remain pending until the outcome of the ongoing randomized studies is known. However, intermediate endpoint evaluation at least give some clue. The European Randomized Study of Screening for Prostate Cancer (ERSPC) allows estimates of stage migration, leadtime, overdiagnosis, screening interval evaluation and other important features. The design of more appropriate screening tests is also subject of these protocols. Facts will be presented.

1070

Cervical cancer screening - status and perspectives

J. Cuzick. *Cancer Research Uk, Epidemiology, Mathematics and Statistics, London, United Kingdom*

Cervical screening has been the most successful cancer prevention programme ever implemented. However the approach does have limitations in terms of the infrastructure and expertise required, and is now more that 50 years old.

Ongoing audit is essential if high quality screening is to be maintained. The current performance of the England screening program will be reviewed. Results of a pilot audit based on the screening histories or lack thereof in women who develop cancer will be presented. Such audits should become routine for all organized screening programmes.

The human papilloma virus is now established as the primary cause in over 95% of all cervix cancers worldwide. It is readily detectable in material collected in a smear, and is an obvious candidate for screening. There are three potential roles for the test:-

i) Improving management in women with borderline or mildly dyskaryotic smears.

ii) Post-treatment surveillance to detect incomplete excision on CIN

iii) As a part of primary screening to improve sensitivity

HPV has better sensitivity for CIN 2/3 than cytology, and thus argues for its use in the first two situations. Questions of specificity are crucial in assessing its appropriateness in primary screening and a potential algorithm will be presented.

1071

Screening for colorectal cancer

O. Kronborg. *Odense University Hospital, Department of surgery, Odense, Denmark*

Organised screening for familial colorectal cancer (CRC) is in place in the Nordic countries, based on countrywide registers. Screening for metachronous neoplasia after curative treatment of sporadic CRC, usually is done by colonoscopy with intervals of a few years, but the predictive value of microsattelite instability may cause a substantial reduction of the number of colonoscopies.

Also colonoscopic follow-up in adenoma patients may bee limited, based on predictive value of different histopathologic features. Effectiveness of colonoscopic screening with multiple biopsies in patients with IBD is very minor.

The major impact on mortality from CRC will come from screening of the average population above 50 years of age. So far, the efficiency has been demonstrated in RCT's with fecal occult blood tests (FOBT's), and within the next few years flexible 60 cm sigmoidoscopy may be demonstrated to have a place in combination with FOBT's.

The evidence for a reduced incidence of CRC because of removal of polyps still is limited, but promising. Initial colonoscopy in average risk