

hours after the end of the first course of chemoradiotherapy. Adduct levels were determined by immunocytochemistry using the polyclonal antibody NK1 A-59 for the buccal cells. A 32 P-postlabeling technique was used to quantify selectively the major cisplatin-DNA adducts (GG and AG adducts) in WBC and tumor.

Results: So far, in 16 patients, adduct levels have been measured; 10 after i.v. and 6 after i.a. cisplatin infusion. Tumor sites were oropharynx (n=10), oral cavity (n=3) and hypopharynx (n=3). Normal tissue samples were obtained from all 16 patients, primary tumor from 10 patients with tumors, accessible for biopsy. See table for results of the adduct-levels in tumor and WBC.

Chemotherapy- regime, concurrently with RT:		Cisplatin-DNA adducts (in fmol/ μ g DNA) in:			
		WBC		Tumor	
		GG	AG	GG	AG
100 mg/m ² i.v.	mean	0,929	0,117	3,946	0,388
	SD	0,249	0,036	1,183	0,067
150 mg/m ² i.a.	mean	0,826	0,093	4,070	0,373
	SD	0,211	0,028	0,523	0,145

The difference between adduct levels in WBC and primary tumor was statistically significant ($p < 0.02$) for both the i.a. and i.v. treated patients. There were no differences in adduct levels in either WBC or tumor between the i.a. and i.v. group. Analysis of adducts in buccal cells is ongoing.

Conclusions: Cisplatin-DNA adduct levels in primary tumor of H&N cancer are 4-fold increased compared to WBC, both after supradose i.a. and conventional i.v. cisplatin-based chemoradiation. Despite the selective supradose i.a. administration of cisplatin, adduct levels in primary tumor are comparable to levels obtained after conventional i.v. cisplatin. Whether cisplatin-DNA adduct levels correlate with treatment outcome, is subject of current research.

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POSTER

Cisplatin + vinorelbine in recurrent salivary gland malignancies: final report on 42 cases

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In a randomized trial we have shown that cisplatin (DDP) + vinorelbine (VNB) is superior to VNB alone in recurrent Salivary Gland Malignancies (SGM) (Cancer 91:541-7:2001), although results on a large number of pts are lacking. Here we report final results of this combination. Between April 1993 and February 2001 42 pts (35 m, 17 f; median age= 57 yrs; median ECOG PS= 1) affected by recurrent/metastatic SGM (major SG = 23 pts, minor SG = 19 pts / adenocarcinoma = 10 pts; adenoid cystic ca. =27, malignant mixed t. =1; undifferentiated ca.=3; mucoepidermoid ca.=1 / local recurrence = 18 pts, local + mts =7, mts only =17) have been treated with DDP 80 mg/m², on day 1 plus VNB 25 mg/m² on day 1 and 8 (every 3 weeks for a minimum of 3 cycles). All pts had received a loco-regional treatment (surgery + radiation =36 pts; surgery =3; radiotherapy =3) and 12 pts had received a first line DDP-based chemotherapy. Results of first line DDP+VNB (30 cases): 4 CR (13%), 8 PR (27%), 11 NC (37%) and 7 PD (23%); median CR duration =15 months (6-28); median PR duration =7.5 m (3-11); median overall survival =10 months (range=3-29; CR=19 m.; PR=12.5 m). Results of second line DDP+VNB (12 pts) =2 PR (17%), 4 NC (33%) and 6 PD (50%); median PR duration =4 m.; median overall survival =5 m. (1-12). Toxicity (42 pts): G3: nausea/vomiting 7%, leukopenia 12%; G2: nausea/vomiting 50%, leukopenia 19%, thrombocytopenia 7%, anemia 7%, peripheral neurotoxicity 7%. In conclusion DDP+VNB is an active first line combination for recurrent/metastatic SGM with acceptable toxicity; the clinical role of this scheme in second line therapy is poor.

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POSTER

Early stage oral cavity squamous cell carcinoma

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Introduction: To evaluate the treatment result of early stage oral cavity cancer and assess the importance of elective neck dissection

Material and Methods: There were 781 clinical stage I-II oral cavity cancer received radical surgery in Chang Gung Memorial Hospital from April 1, 1994 to July 31, 2002. The median age was 50 (ranging from 23

to 85) and 712 (91.2%) are male, 69 (8.8%) are female. Only 88 (11%) patients are without smoking, alcohol and/or beta1 quid exposure. Seven hundred and fifty seven (96.9%) patients received CT or MRT as staging modality. Three hundred and sixty (46.1%) patients were T1 lesion and 421 (53.9%) were T2 lesion. The site distribution was tongue: 397 (50.7%), gum: 30(3.8%), palate: 51(6.5%), cheek: 223(28.6%), retromolar: 28(3.6%), lip: 22(2.8%), and mouth floor: 30(3.8%). Four hundred and eighty eight (62.5%) patients received elective supra-omohyoid neck dissection. Free tissue flap was performed after excision by plastic surgeons. One hundred and twenty nine (16.5%) patients received postoperative radiotherapy.

Result: N stage change is noted in 58 (11.9%) patients after neck dissection. There are 12 (6.6%) patients in T1 lesions and 46 (15.1%) in T2 lesions ($p=0.008$). T upstage is noted in 25 patients after operation. Bone invasion is found in 11 (1.4%) patients. The 5-year overall survival for clinical stage I is 83.8% and 79.4% for stage II ($p=0.06$). The 5-year overall survival for pathological stage I is 78.6%, stage II: 73.4%, III-IV: 71.2% ($p=0.002$). Neck operation or not has no significant survival difference in overall survival (79.66% vs. 72.3%, $p=0.161$) but significant difference in loco-regional recurrence (32.4% vs. 18.9%, $p=0.000$). However, in the tongue cancer patients, neck operation has significant survival benefit. (84.6% vs. 75.6%, $p=0.047$) and no difference in other subsites.

Conclusion: There are about 12% of patients will become positive neck lymphadenopathy after elective neck dissection in clinical stage I-II patients. Elective neck dissection may be considered in early stage oral cavity cancer to improve loco-regional control especially for tongue cancer that neck dissection may improve survival.

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POSTER

Head and neck reconstruction in oncology

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Introduction: Advanced carcinomas involving head and neck present a major therapeutic challenge because of their poor prognosis, the frequently associated medical problems of the patients, and the adverse effect of treatment on oral and pharyngeal function. Therapeutic techniques combining multiple treatment modalities are commonly employed for patients with advanced disease. Modern reconstructive techniques allow immediate reconstruction and better functional outcomes, while allowing the patients to progress through to multimodality treatment in a timely manner.

Material and Methods: Between February 1990 and March 2003 we performed head and neck reconstructions in 412 patients (M-353/F-59) with myocutaneous flaps, 26 of which were full-thickness defects. To repair these defects we have used the following 426 flaps: Pectoralis major 297; Trapezius myocutaneous flap 39; Sternocleidomastoid 4; Platysma 8;

