

for local control ($p < 0.0003$) followed by radiation technique (conformal >conventional) ($p < 0.02$). Tumor distribution and acute treatment toxicities data from the two techniques are shown in Table 1.

Conclusion: Conformal therapy contributes significantly in the local control and improves the therapeutic index of patients with anal canal cancer. It is now the standard technique at our institution.

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POSTER

Histopathological response to preoperative chemoradiation for resectable pancreatic adenocarcinoma: the French phase II FFCD 9704-SFRO trial

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Purpose: To define and evaluate histopathological response rates with preoperative chemoradiation (RT-CT) for resectable pancreatic adenocarcinoma.

Patients: Between January 1998 and March 2003, 41 patients (pts) (25 males; mean age: 59 years; range: 33–75) with localized, potentially resectable pancreatic adenocarcinoma were treated with 50 Gy combined with 5-Fluorouracil (300 mg/m²/d; d1-d5; week 1–5) and Cisplatin (20 mg/m²/d; d1-d5 and d29-d33). Radiographic restaging was performed 4 to 6 weeks later and pts presenting with resectable disease underwent surgical resection.

Results: Twenty six (63%) of 41 pts underwent curative surgery. Standardized histologic response was measured and graded by a single pathologist. According to the difficulty to characterize viable cells by conventional anatomopathological evaluation, the effectiveness of the preoperative chemoradiation was defined by the proportion of severely degenerative cancer cells (SDCC), their density and histological distribution and the proportion of necrotic tumoral tissue. SDCC cancer cells were defined by a nuclei absent, piknotic or irregular-shaped, and an acidophilic or vacuolated cytoplasm. Eleven of 24 (46%) specimens presented more than 80% of SDCC, and 8/11 (72%) specimens were associated with large necrosis areas. The histologic distribution was characterized by the low density of nonaffected cancer cells, principally located in the center of the tumor, and an important fibrous and amorphous connective tissue associated with cancer-cells' defects (type A of the Ishikawa's classification). Histologic complete response was observed in one specimen, and 9/24 (37%) specimens were characterized by 50 to 80% of SDCC, with fairly the same histologic distribution. Finally, 4/24 specimens presented with a low rate of SDCC, few necrosis area and several non affected cancer cells (type C of the Ishikawa's classification).

Conclusion: Preoperative 5-Fluorouracil-Cisplatin-based concurrent RT-CT for resectable pancreatic adenocarcinoma provides antitumoral effect, with 20/24 (83%) specimens presenting an histological response rate superior to 50% and one complete histopathologic response. With regard to the feasibility of this therapeutic schedule and the rate of major histologic response, this approach could offer a clinical benefit. Further gemcitabine-based chemoradiation regimens, will determine the predictive factors of the treatment response, and the improvement in survival.

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POSTER

Randomized comparison of capecitabine plus oxaliplatin (CapOx) versus capecitabine plus gemcitabine (CapGem) versus gemcitabine plus oxaliplatin (GemOx) in advanced pancreatic cancer

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Background: Gemcitabine, oxaliplatin, and capecitabine are active agents in pancreas cancer. This study was performed to define an optimal regimen for combination therapy.

Methods: Between July 2002 and May 2004, 190 patients were recruited from 44 centres. Patients received 3-week regimens of either capecitabine 2 × 1000 mg/m² po d1–14 plus oxaliplatin 130 mg/m² iv d1 (CapOx) or capecitabine 2 × 825 mg/m² po d1–14 plus gemcitabine 1000 mg/m²

applied as a 30-min infusion d1+8 (CapGem) or gemcitabine 1000 mg/m² applied as a 30-min infusion d1+8 plus oxaliplatin 130 mg/m² d8 (GemOx). The primary endpoint of the trial was progression-free survival at 3 months. **Results:** Patients in the CapOx, CapGem, and GemOx-arms were well balanced according to the strata Karnofsky Performance status (KPS >70% in 92% vs 89% vs 90%) and stage of disease (metastatic disease in 76% vs 74% vs 75%). Median age was 63 years (range 37–75). Patients received a median of 4 cycles of treatment. In a per patient analysis of CapOx vs CapGem vs GemOx, hematological grade 3–4 toxicity occurred in 8%, 18%, and 21%, while non-hematological grade 3–4 toxicity was documented in 55%, 39%, and 51%, respectively. 167 patients were evaluable for response. The analysis of CapOx vs CapGem vs GemOx did not show any complete remission, while partial responses were obtained in 19%, 21%, and 12% of patients, and stable disease was documented in 33%, 41%, and 40% for a disease control rate of 52%, 62%, and 52%, respectively. Median PFS was comparable between CapOx, CapGem and GemOx treatment arms and amounted to 129 days, 143 days, and 102 days respectively with a median progression-free survival at 3 months of 54%, 59%, and 56%. Median overall survival for CapOx was 245 days, for CapGem 238 days, and for GemOx 206 days, respectively (two-sided logrank test, $p = 0.57$).

Conclusions: The current evaluation of this trial indicates a comparable efficacy with regard to the primary endpoint and tolerability for the investigated regimens CapOx, CapGem, and GemOx.

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POSTER

Outcome of node negative gastric cancer personal experience on 278 patients

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In recent decades, the incidence of gastric cancer has declined, but the prognosis in the Western countries has not improved, the 5-year survival being 20–30%. Lymph node involvement is an important prognostic variable in gastric cancer. A surgical approach of potentially curable gastric cancer, including extended lymphadenectomy, seems to give better results when compared with less radical procedures. The therapeutic value of an extended lymphadenectomy is unproven in randomized trials; however, the high long-term survival rates reported by experienced centers after systematic, standardized extensive D2 and D3 gastrectomies are encouraging. In order to evaluate the outcome of node-negative gastric cancer who underwent curative gastric resection at San Raffaele Hospital of Milan, between 1987 and 2004.

Materials and methods: Patients: Between 1987 and 2004, 278 patients (157 males, 121 females) underwent a R0 gastric resection for gastric cancer, performed at the Department of Surgery, Vita-Salute San Raffaele University, Milan. The surgical procedure consisted of 39 (14%) total and 239 (86%) subtotal gastrectomies. A standard dissection encompassing N1 lymph nodes was defined as a D1 dissection, whereas complete removal of N2 lymph nodes was considered a D2 dissection. The extent of lymph node dissection was limited D1 ($n = 120$, 43%) or extended D2 ($n = 152$, 55%) and D3 ($n = 6$, 2%). The mean number of examines lymph nodes was 16.

Statistical analysis was carried out using the Statistical Package for the Social Sciences (SPSS 11.0). The results were expressed as mean ± SD. Overall survival was calculated according to the Kaplan-Meier method. Frequencies were compared by the Pearson's chi square method, and the multivariate analysis was performed using the Cox proportional hazards model, all with two sides at a significance level of $p < 0.05$.

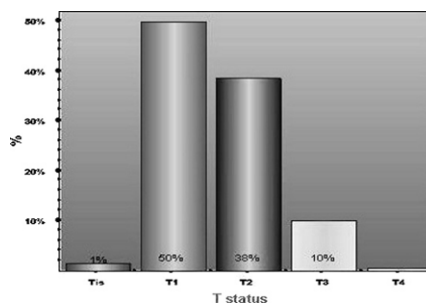


Fig. 1.

Results: The tumor stage was: T1 ($n = 143$), T2 ($n = 105$), T3 ($n = 10$), T4 ($n = 2$) (Fig 1). The median age of patients with node-negative gastric cancer was 65+/-11 years. The median tumour size was 3.8 cm (range