and IP with FIGO stage, histology, grade, age, myometrial invasion, cervical and adnexal involvement, metastases to pelvic and para-aortic lymph nodes, positive peritoneal cytology, tumor size, lymph-vascular space invasion. Overall 5-year survival was 73.4±4.7%, 5-year disease-specific survival – 80.0±4.4%, 5-year relapse-free survival– 76.7±4.6%. Aneuploidy, iDNA>1.5, G0/G1 < 80%, S >6%, G2+M > 10%, IP > 25% significantly decreased 5-year disease-specific and relapse-free survival. Five-year disease-specific survival by ploidy was 96.6±3.4% (in diploid tumors) and 70.8±6.2% (in aneuploid tumors); by iDNA – 74.6±12.8% (iDNA < 1.0), 96.6±3.4% (iDNA = 1.0), 84.5±6.5% (iDNA = 1.0–1.5), and 13.5±12.1% (iDNA > 1.5). Five-year disease-specific survival by G0/G1 content was 53.3±10.6% (G0/G1 <80%), 89.8±4.3% (G0/G1 = 80–90%), and 91.7±7.8% (G0/G1 >90%); by S content – 94.4±5.4% (S6%) and 75.5±5.4% (S >6%); by G2+M content – 87.8±4.3% (G2+M10%) and 63.7±9.3% (G2+M>10%); by IP – 93.0±3.9% (IP < 18%), 79.8±8.1% (IP = 18–25%), and 48.2±12.4% (IP > 25%).
Conclusion: The most significant independent factors influencing prognosis for disease progression were iDNA, grade, IP, histologic type, myometrial invasion (in descending order).

958 PUBLICATION

Docetaxel (D) and oxaliplatine (DOCELOX) in advanced ovarian cancer (AOC): results of a phase I-II: a GERCOR study

C. Tournigand[1], A. Plantade[1], E. Carola[2], F. Maindrault-Goebel[1], M. Benamoun[3], M. Garcia[1], H. Gervais[1], F. Selle[4], C. Louvet[1], A. De Gramont[1]. *[1]Hôpital Saint Antoine, Service d'Oncologie Médicale, Paris Cedex 12, France; [2]Centre Hospitalier de Senlis, Oncologie, Senlis, France; [3]Hopital de Montfermeil, Oncologie, Montfermeil, France; [4]Hopital Tenon, Oncologie, Paris, France*

Background: docetaxel and oxaliplatin are both active drugs in AOC (Vasey et al. J Natl Cancer Inst. 2004 and Misset et al. Ann Oncol. 2001 (A phase I-II study was initiated to evaluate the tolerance and activity of the combination of oxaliplatin and D.
Material and methods: Patients (pts) with a stage III or IV epithelial OC were included. Pts were either chemonaive (1st line, L1) or relapsing >6 mts after the last platin administration (2nd line, L2 platinum sensitive). The 1st cycle was administered at the following doses: oxali 130 mg/m2 d1 and docetaxel 75 mg/m2 d1 (level 0). The D dose was increased to 85 mg/m^2 for the following cycles, if no grade 3–4 toxicity (level 1). Cycles were repeated every 21 days. 6 cycles were planned. Lenograstim was administrered as secondary prophylaxis.
Results: 32 pts were included (from 2/03 and 1/05). 26 pts were treated in 1st line and 6 in 2nd line. In 1st line, 22 pts had a stage III and 4 a stage IV. In 2nd line, the 6 pts had a stage III, and they previously received a paclitaxel/platinum based chemo as 1st line, with a median progression-free interval of 13 mts (6–32mts). 21 pts (66%) received 6 cycles. 94 cy were delivered at level 0 (32 pts) and 65 at level 1 (20 pts). Grade 3–4 tox by pt at level 0 were neutropenia (8pts, 25%) including 3 febrile neutropenia (FN), anemia (2pts, 6%), diarrhea (4 pts, 12%) and thrombocytopenia (1pt, 3%). Grade 3–4 toxicity by cycle at level 0 were neutropenia (10 cy, 11%), anemia (2 cy, 2%), diarrhea (5 cy, 5%) and thrombocytopenia (1 cy, 1%). Grade 3–4 tox by pt at level 1 were neutropenia (9pts, 45%) including 1 FN, thrombocytopenia (1 pt, 5%), N/V (1 pt, 5%), neuropathy (2 pt, 10%). Grade 3–4 toxicity by cycle at level 1 were neutropenia (9 cy, 14%), thrombocytopenia (1 cy, 1%), N/V (1 cy, 1%). Overall, 75% pts had gr 2 alopecia. Only 2 pts had a gr 3 neuropathy. Evaluation after 3 cy (n = 32): in L1, CR 6, PR10, SD 7, PD 1, ND 2. In L2, CR3, PR1, SD1, PD1. After 6 cy (n = 21): in L1 CR10, PR4, SD3, PD1. In L2, CR2, PR1.
Conclusion: The DOCELOX regimen is active and well tolerated in platinum sensitive AOC patients. The low hematological and neurological toxicity could result in a better therapeutic ratio than the classical carboplatin/paclitaxel combination.

959 PUBLICATION

Evaluation of gefinitib in combination with tamoxifen in ovarian cancer patients refractory to platinum-taxane chemotherapy – results of a phase II study (Ovar 2.6) of the AGO

J. Huober[1], U. Wagner[2], A. duBois[3], J. Pfisterer[4], S. Loibl[5], H.J. Lück[6], U. Camara[7], J. Sehouli[8], M. Gropp[9]. *[1]University of Tuebingen, Gynecology and Obstetrics, Tuebingen, Germany; [2]University of Marburg, Gynecology and Gynecologic Oncology, Marburg, Germany; [3]Dr. Horst Schmidt Kliniken, Klinik für Gynäkologie, Wiesbaden, Germany; [4]University of Schleswig-Holstein Campus Kiel, Gynecology and Obstetrics, Kiel, Germany; [5]University of Frankfurt, Gynecology and Obstetrics, Frankfurt, Germany; [6]Medizinische Hochschule Hannover, Gynecology, Hannover, Germany; [7]University of Jena, Gynecology and Obstetrics, Jena, Germany; [8]Humboldt Universität, Charite, Gynecology and Obstetrics, Berlin, Germany; [9]Evangelisches Krankenhaus, Frauenklinik, Düsseldorf, Germany*

Background: Ovarian cancer patients refractory to platinum-taxane chemotherapy have a poor prognosis. In preclinical studies the epidermal growth factor receptor tyrosine kinase inhibitor gefinitib (Iressa) has shown the potential to inhibit tamoxifen resistance. In phase I/ II studies both agents showed clinical activity in ovarian cancer patients.
Patients and methods: To evaluate safety and activity of the combination of tamoxifen/gefinitib this phase II study was started. From 6/02 to 2/03 56 pts. who relapsed during or within 6 months after platinum-taxane based therapy received tamoxifen 2×20 mg/day and gefinitib 2×250 mg/day orally until progression or until unacceptable toxicity.
Results: 15 pts. had only 1 preceeding treatment with a platinum/taxane regimen, and 41 pts. had been treated at least with 2 regimens (range 2->5). The median age was 57 years (37–80 yrs). The most frequent drug related adverse events (AE) were diarrhea in 57.2% (grade 1/2 42.9%, grade 3/4 14.3%) and acne like skin rash in 39.3% (33.9% grade 1/2, 5.4% grade 3/4) of pts. Gefinitib dose reductions to 250 mg/day were necessary in 10 pts. (14.9%). Due to AE 6 pts. (10.7%) discontinued treatment. Efficacy results showed that there were no complete or partial responses, however 16 pts. achieved stable disease. A progression was seen in 33 pts.and in 7 pts. response was not evaluable. The median time to progression was 58 days (95%CI: 55–70 days), median survival time was 253 days (95%CI 137–355 days) and the median time of treatment was 58 days (7–217 days). After 6 months 59.5% of pts. were alive.
Conclusions: The combination of gefinitib and tamoxifen could be safely administered and showed acceptable toxicicty. In this combination the addition of tamoxifen did not increase the known side effects or induced additional side effects. However response rates were low and suggest that the combination of tamoxifen and gefinitib has only modest clinical activity in ovarian cancer.

960 PUBLICATION

Pathological response of cervix carcinoma to preoperative external irradiation and high dose rate brachytherapy

P. Novaes[1], A. Jacinto[1], M. Castilho[1], A. Pellizzon[1], R. Ferrigno[1], R. Fogarolli[1], M. Maia[1], J. Salvajoli[1], P. Novik[2], F. Coelho[2]. *[1]Hospital do Cancer AC Camargo, Radiation Therapy, Sao Paulo, Brazil; [2]Hospital do Cancer AC Camargo, Gynecology, Sao Paulo, Brazil*

Purpose: To evaluate the pathologic response of invasive cervical carcinoma – stages IIa and early IIb – to external beam irradiation to the pelvis and intracavitary high dose rate brachytherapy.
Material and Method: This is a retrospective analysis of 69 patients with histopathologic proven diagnosis of cervical carcinoma treated between January 1993 to August 1999. Median age was 45 (range 22–72) years and squamous cell carcinoma was the prevalent histologic type (81%). According the FIGO staging, 1 patient was IIa and 68 patients were early IIb (less than one third of compromised parametrium). All patients received pelvic radiotherapy with 4 or 6 MeV linear accelerator – 45 Gy (25 fractions of 1.8 Gy – five days/week) – combined to intracavitary high dose rate brachytherapy (HDRB) – 12 Gy (two insertions of 6 Gy – point A). Median total irradiation time was 42 days (range 35–108). After radiation therapy, the patients were submitted to radical hysterectomy+bilateral salpingooforectomy and selective lymphadenectomy – Piver II type, after a mean time of 40 days (range 15–136). All pathological specimens were analysed according the presence of residual tumor on the cervix, paracervical tissues and pelvic lymphnodes, and we defined pathologic response as total absence of residual disease.
Results: In 26 (38%) patients there were no residual tumor on pathological specimen (complete remission). There were 68 (100%) parametrial pathologic responders, 29 (42%) complete cervical responders. Three patients were not submitted to lymphadenectomy during surgery Pelvic