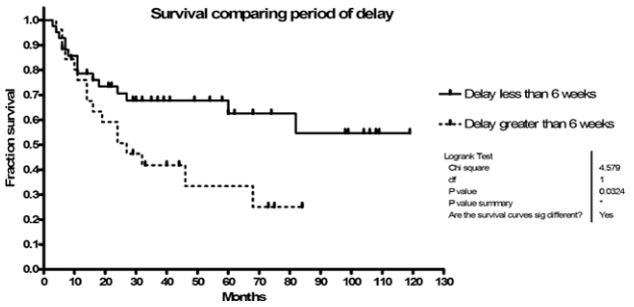

Fig 1. Kaplan-Meier survival graph of delay of less or greater than six weeks

1086 PUBLICATION

Role of radiotherapy in the treatment of cervical lymph node metastases from unknown primary site: results of a retrospective analysis of 113 patients

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Background: The management of patients with cervical lymph node metastases (CLNM) from unknown primary tumours is a major challenge. This study presents data collected in Radiotherapy Departments at the Hospital "Maggiore della Carità" Novara and the European Institute of Oncology, Milan, Italy.
Materials and methods: From 1980 to 2004, 116 patients (96 males and 20 females) with CLNM from an unknown primary site were treated with radiotherapy (RT). The histological subtypes included 91 squamous cell carcinoma, 12 undifferentiated carcinoma, 7 adenocarcinoma, and 5 other histologies. Nodal stage included 24 N1, 6 N2 and 23 N3. The treatment policy was to treat all suitable candidates with surgery followed by RT and possibly chemotherapy. Seventy-three patients were irradiated to both sides of the neck including of the mucosa of nasopharynx, larynx, hypopharynx and larynx; 29/116 were treated only on the ipsilateral or bilateral neck without extensive mucosal irradiation. Conventional fractionation was used in 107/116 patients (median dose 54 Gy, range: 30–70 Gy) and hyperfractionation in 8 (1.2 Gy bid to a total dose of 64–74 Gy).
Results: The 5-year actuarial overall survival was 40.7% and the actuarial disease free survival was 27%. The emergence of the occult primary was observed in 23 patients (20%); 19/23 of the emerging primaries were within the head and neck region: larynx (7 cases), oropharynx (5 case), oral cavity (3 cases) and others (4 cases). At univariate analysis, with log rank test, favourable prognostic factors were: the initial nodal stage (N1-N2a) vs the advanced nodal stage (N2b,c-N3); the use of 3D-conformal RT technique vs 2D technique; the absence of lower neck lymph node metastasis at diagnosis; the neck dissection vs no dissection and the radiotherapy on bilateral neck and mucosa vs irradiation limited to ipsilateral neck. On multivariate regression analysis, the initial nodal stage (N1-N2a vs N2b,c-N3) resulted as a favourable prognostic factor and, but only for the disease free survival data, also the use of 3D-conformal RT technique vs 2D technique.
Conclusions: This study confirmed that patients with CLNM from occult head and neck cancer had similar prognosis to other head and neck malignancies. Extensive irradiation to both sides of the neck and to the pharyngeal mucosa resulted in significantly less loco-regional failures and better survival.

1087 PUBLICATION

A phase I-II trial of gefitinib (IRESSA) and radiotherapy in patients with locally advanced inoperable squamous cell carcinoma of the head and neck (SCCHN)

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Background: Gefitinib, an orally active epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor, induces growth arrest in SCCHN cell lines mainly by blocking cells in G1 and preventing them from entering the cell cycle. Clinical studies have demonstrated the activity of gefitinib monotherapy in SCCHN. Preclinical studies have shown that the combination of RT and drugs interfering with the EGF pathway may result in radiosensitization in squamous cell carcinomas that over express EGFR.
Methods: Pts with histologically confirmed, newly diagnosed, locally advanced inoperable SCCHN, never pretreated with surgery, chemotherapy or RT were enrolled into a phase I-II trial of gefitinib and RT. Two doses of gefitinib were tested (250 and 500 mg/day) in the dose-escalation phase and continued for up to 12 months; RT was administered concomitantly according to standard procedures (minimum of 52.0 grays; boost to the primary tumor site up to at least 64.0 grays). The recommended dose of gefitinib for phase II was determined by the dose-limiting toxicities (DLTs) observed during its combined administration with RT and for 2 weeks thereafter (phase I). Activity was evaluated 4 weeks after the end of the combined treatment and every 8 weeks thereafter, according to RECIST criteria.
Results: 12 pts (9 M, 3 F, median age 58) have been evaluated thus far. The most common primary tumor site was the hypopharynx (5 cases); TNM stage was IV A (10 pts) and IV B (2 pts); tumor grades were 1 (2 pts), 2 (6 pts) and 3 (4 pts). All pts completed the combined treatment according to the protocol. Total radiation dose was 60–74 grays. Overall best response was complete response in 3 pts, partial response in 5 pts, and unconfirmed partial response in 1 pt; 3 pts were not evaluable. Gefitinib-related grade 3 toxicities were mucositis (n = 1), liver toxicity (n = 1). RT-related grade 3 toxicities were stomatitis/mucositis (n = 5), general health deterioration (n = 1). Three pts died during treatment with gefitinib alone (not considered treatment related). DLT occurred in 3 pts treated with gefitinib 500 mg (grade 3 stomatitis, 3 pts [RT-related]; grade 3 ALT increased, 1 pt [gefitinib-related]), and therefore 250 mg was selected as the recommended gefitinib dose for phase II.
Conclusion: Accrual is continuing in the phase II trial. More mature data will be presented.
IRESSA is a trademark of the AstraZeneca group of companies

1088 PUBLICATION

A community hospital multidisciplinary thyroid committee: establishment and early results

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Introduction: Thyroid patients need multiple types of investigation, treatment and follow up, including medical therapy, surgery and radioiodine. Physicians who treat these patients at St. Mary's Hospital, a 300 bed community hospital, felt that a regular multispecialty case review would allow coherent decision-making. Developments in the literature and conferences are also discussed, so as to offer evidence-based integrated care in a resource-efficient manner.
Methods: Original team members were from Endocrinology, Surgical Oncology, Pathology and Medical Oncology within St. Mary's, later joined by a Nuclear Medicine physician from l'Université de Montréal and an Endocrine Surgeon from the McGill University Health Center. Each patient was presented including history, risk factors, imaging and bloodwork. The pathologist reviewed available cytology and histology. There was discussion about how to proceed. A single recording secretary (the author) dictated a summary of each case, documenting recommendations of the committee, including points of controversy. The presenting physician met with the patient to review the recommendations. Patients could be presented more than once.
Results: From January 03 to April 05, 143 patients were discussed, 16 males, 127 females; the average age was 47 range 18–94. There were 71 malignancies; 61 pure papillary carcinomas, 5 follicular carcinomas, 3 malignancy not clearly classifiable. 2 patients had simultaneous follicular and papillary cancers. 42 patients had nuclear medicine involvement