sex as prognostic factors. An additional analysis omitted all pts surviving 2 years or more.
Results: The distribution of patients characteristics was Stage IV 66%, Stage II-III 34%; prior therapy: 30%; age: 106 over 65, 44 over 75, 14 over 80; sex: 94 male. Overall median survival was 16.4 mos (14.7−18.1 mos). Overall one year survival was 62% two year survival was 29% and three year survival was 21%. Age greater that 65, 75 and 80 were not adverse prognostic factors for treatment p: 0.69−0.82. Prior treatment was not an adverse prognostic factor. Analyses found no significant differences in the distribution of patient chararcteristic within the subsets of patient of all ages and treatment histories. Analyses excluded pts survivng 2 years or more found a median survival of 12.5 (9.6−15.5) mos. There were no treatment related deaths nor unanticipated toxicities. Hospitlizations for treatment related adverse events including crossover regimen occur in less than 1% of cycles. The limiting toxicity of GFLIP is late mild-moderate neurotoxicity and on adding docetaxel brief moderate/severe cytopenia and fatigue.
Conclusion: Low dose GFLIP followed by GFLIP/docetaxel is safe and offers survival benifit for the majority of pts including bioth the elderly, the previously treated, and the poor risk as suggested by analyses omitting 2 year survivors.

3526 POSTER

Prognostic value of carbohydrate antigen (CA)19−9 decrease in response to chemotherapy for advanced pancreatic adenocarcinoma (PA)

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The assessment of chemotherapy (CHT) activity in PA is hampered by fibrotic and desmoplastic reactions. A decrease of basal CA19−9 level >49% during CHT predicts better survival (OS). This study was aimed to determine whether a different cut-off level of basal CA 19−9 decrease may allow to better assess response to CHT. Between April '97 and January '07, 251 chemo-naive patients with stage III (N = 88; 35%) or metastatic (N = 163; 65%) citologically proven PA were enrolled in 5 trials at our institution to receive either gemcitabine alone (gem; N = 32) or 4-drug gem-based combination (4D; N = 219). Response to CHT was assessed by bimonthly CT scan while CA19−9 was detected on a monthly basis. Median (m) and 1y OS was 10 months and 39%. OS per response group is reported in table 1. The differences among OS curves were significant (progressive disease [PD] vs stable disease [SD] $p < 0.00001$; PD vs partial response [PR] $p < 0.00001$; SD vs PR $p = 0.0007$). Baseline CA19−9 was detected in 248 patients (99%) and was elevated in 210 (84%). In 190 of 210 patients (90%) CA19−9 variation during CHT was available. OS per CA19−9 response group is reported in table 1. OS for group D was significantly better than for other groups (D vs B $p = 0.0004$; D vs C $p = 0.0004$; D vs A $p < 0.00001$). No difference was observed between groups B and C ($p = 0.14$) and A and B ($p = 0.18$), while group C had better OS than group A ($p = 0.006$). Based on these results we recommend to use the rate of patients with basal CA19−9 decrease >89% as a complementary measure of outcome when assessing CHT activity against PA.

Table 1.

Response	Number	mOS	1y OS
PD	66 (26%; gem 69%; 4D 20%)	4.5	8%
SD	74 (29%; gem 22%; 4D 31%)	10.2	34%
PR	111 (44%; gem 9%; 4D 49%)	15.0	60%
↓ CA19.9 <50% group A	61 (32%; gem 50%; 4D 29%)	7.4	18%
↓ CA19.9 50−69% group B	23 (12%; gem 19%; 4D 11%)	9.5	26%
↓ CA19.9 70−89% group C	50 (26%; gem 23%; 4D 27%)	10.0	36%
↓ CA19.9 >89% group D	56 (30%; gem 8%; 4D 33%)	16.6	74%

3527 POSTER

Outcome of the non randomized patients in the FFCD 9102 trial: chemo-radiation followed by surgery compared with chemo-radiation alone in squamous cancer of the esophagus

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Background: for locally advanced thoracic oesophageal cancers, the FFCD 9102 trial have demonstrated that for responders chemo-radiation only was equivalent to chemo-radiation followed by surgery in terms of overall survival [1]. What about non randomized patients?
Materials and Methods: out of 451 patients, 192 were not randomized because of no objective response or improved dysphagia, contraindication to either surgery or continuation of chemo-radiation, patient's refusal, death or no further treatment.
Results: at the end of the induction chemo-radiation, there was no difference between randomized and non-randomized patients in term of age, tumor height and diameter, doses of chemotherapy or radiotherapy. However, weight loss, body surface and Spitzer QoL Index were significantly different. Duration of follow-up was identical: 47.3 months vs 48.1 months (NS). Overall survival was significantly lower in non-randomized patients: median survival 11.5 months (SE = 1.09 months) vs 18.9 months (SE = 1.03 months) in randomized patients (HR = 1.40 [95% CI, 1.13 to 1.74], $p = 0.0024$). In the non-randomized group 112 patients were operated on, among them 80 had R0 resection (42%). For all patients operated on median survival was 17.3 months (SE = 0.65 months) versus 6.1 months (SE = 0.46 months) in non-operated patients ($p < .0001$), and was not different from survival of the randomized ones ($p = 0.58$).
Conclusion: surgery is a valuable option for patients non responding to a planned exclusive chemo-radiation therapy.

References

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3528 POSTER

Fatigue in pancreatic cancer: the potential link between exertional dyspnea, exercise limitation, skeletal musculature and neurohormonal activation

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Background: In cancer, dyspnea and reduced exercise capacity are frequently seen, but their origin is unclear. We suggest, the symptoms are due to metabolic changes within the skeletal musculature as has previously been shown for patients with heart failure.
Methods: We examined 50 patients with pancreatic cancer (PaCA, age 60±10 years [mean±SD], 20 female). Symptom limited exercise capacity (treadmill), body composition (DEXA), left ventricular (LV) systolic and diastolic function (echocardiography) and limb post-ischemic peak blood flow (i.e. muscle perfusion) were assessed. 40 healthy subjects served as controls (age 57±10 years, 19 female).
Results: 49% of PaCA patients were classified as NYHA class II or III. In PaCA patients, exercise capacity (peak VO2) was reduced by 30%, anaerobic threshold by 13% and peak VO2/kg lean tissue by 33%, while VE/VCO2-slope as a measure of ventilatory inefficiency was increased by 14% (table 1). Compared to controls, patients with PaCA had reduced limb lean mass (9%), lower fat tissue mass (32%). Total peak VO2 closely related to limb lean mass in controls ($r = 0.81$, $p < 0.0001$), but much less in PaCA ($r = 0.42$, $p = 0.004$). LV ejection fraction and diastolic function (E/A, E/e′) were normal and not different between groups. Markers of cardiovascular neurohormonal activation like mid-regional (MR) pro-adrenomedullin (60%) and MR pro-ANP (73%) as well as markers of inflammation (sTNFRs, procalcitonin) were increased in PaCA patients (all