News

Portuguese Association of Urology

The Congress of the Portuguese Association of Urology will be held in Funchal, Madeira Island, 12–15 June 1991. The main topics of the meeting are surgical vs. non-surgical treatment of benign prostatic hypertrophy, prosthesis and cost-benefit ratio in urology. For further details contact: Dr Manuel Mendes Silva, Rua Consiglieri Pedroso 123, 2745 Queluz, Portugal. Tel (351) 1 4354044, fax (351) 1 4355334.

Brachytherapy Meeting

The annual Brachytherapy Meeting, organised by Groupe Européen de Curiethérapie (GEC) and the European Society for Therapeutic Radiology and Oncology (ESTRO), will take place in Baden Baden, Germany, 15–17 May 1991. Full details of the main meeting and the teaching course can be obtained from the ESTRO Secretariat, Department of Radiotherapy, U H St Rafael, Capucijnenvoer 33, 3000 Leuven, Belgium. Tel (32) 16 212 213, fax (32) 16 212 228.

European Congress of Radiology

The European Congress of Radiology will take place in Vienna, Austria, 15–20 September 1991. Further details can be obtained from the administrative and scientific secretariat, ECR '91, The Vienna Academy of Postgraduate Medical Education and Research, Alserstrasse 4, A-1090 Vienna, Austria. Tel (43) 1 42 13 83-0 or 1 42 71 65, fax (43) 1 42 13 83-23.

American Association for Cancer Research

The 82nd annual meeting of the American Association for Cancer Research will take place on 15–18 May 1991 in Houston, Texas, USA. Full details can be obtained from the American Association for Cancer Research, Public Ledger Building, Suite 816, 6th and Chestnut Streets, Philadelphia, PA 19106, USA. Tel (1) 215 440 9300, fax (1) 215 440 9313.

ESMO Fellowships for Medical Oncology

The Fellowship and Award Committee of the European Society for Medical Oncology (ESMO) fosters a fellowship programme. The aim of this programme is to provide scholarships to young medical oncologists for 1 or 2 years of preclinical training in an outstanding European laboratory. These fellowships will be sponsored by a number of pharmaceutical firms. Several firms have already welcomed the idea of the ESMO fellowship programme. Boehringer Ingelheim, Hoffmann–La Roche, Amgen, Glaxo and Sterling were the first companies to sponsor the programme.

Candidates should meet the following requirements. The age limit is 35, the applicant must have trained for at least 3 years, and have clinical experience in medical oncology. The applicant should be, or commit himself or herself to becoming an ESMO member. His or her origin institute has to be an ESMO member and the host has to be or become an ESMO member.

Candidates are invited to submit applications to the chairman of the Fellowship Committee which will select the future fellowship recipients. Application files should include: (1) curriculum vitae and career goals; (2) host institute of preference; (3) letter of acceptance from the person at the host institute responsible for the project, including a detailed account of the future research programme, and approval by the Department Head; and (4) a letter from the researcher responsible for the project at the origin institute, including the approval of the Head of Department supporting the candidate's application and explaining his or her expectations careerwise.

The deadline for submission of fellowship applications will be 15 March 1991. Selected recipients will be informed before the end of May 1991, at least for projects to commence in September or October 1991. The Fellowship Committee encourages applications in all areas pertaining to human cancer, with emphasis on clinically related laboratory projects. Selection criteria will be based on the application file submitted. The amount of financial assistance provided will be roughly ECU 30 000 per annum depending to a large extent on the cost of living in the host country. During the period spent in the host institution the fellowship recipients will be allocated a tutor whom he/she will be able to contact for any form of assistance or advice regarding their on-going project and who will in general be responsible to ensure the follow-up of work in progress and liaise with the ESMO Fellowship Committee.

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Letters

Dacarbazine in Advanced Squamous Cell Carcinoma of the Head and Neck

José M. Buesa, Roberto Fernández, Francisco J. Barón, Isabel Palacio, Juan Cueva, Emilio Esteban and José M. Gracia

ONLY A few drugs have objective activity against advanced squamous cell carcinoma of the head and neck (SCCHN), and more effective agents are needed to improve the prognosis of

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these patients. The data on the efficacy of dacarbazine in head and neck cancer are limited, with no remissions observed in 33 patients treated in phase I–II studies [1–3]. Patients received 250–350 mg/m^2 by intravenous push for 5–10 consecutive days every 3–5 weeks. If calcium ions are supplied to preclude hypotensive episodes dacarbazine can be given up to a dose of 1.9 g/m^2 every 3 weeks [4]. From this experience a dose of 1.2 g/m^2 was selected for study in SCCHN.

All patients had histologically confirmed squamous cell carcinoma of the head and neck. Eligibility criteria included: locoregionally recurrent or metastatic disease not amenable to curative therapy, Karnofsky index 60% or more, measurable or evaluable disease, leucocytes over 3500/μl, platelets over 100 000/μl, serum creatinine 1.2 mg/dl or less and bilirubin 2 mg/dl or less. Patients signed an informed consent form.

Every 3 weeks patients received dacarbazine 1.2 g/m^2 as an intravenous infusion over 20 min, with 5 ml 10% calcium gluconate at the start and 10 and 20 min from the beginning of therapy. Additional calcium gluconate was given if the systolic blood pressure was lower than 80 mm Hg or heart rate higher than 140/min within 90 min from the infusion. Special care was taken to protect dacarbazine from light: the drug was quickly reconstituted, and the flask and tubing were wrapped with tinfoil. Weekly blood cell counts were done in the first 2 cycles; if the haematological nadir was grade 1 or lower after the first course, the dacarbazine dose was increased by 20%. In the absence of progression, patients received at least 2 cycles. WHO criteria for response to therapy and toxicity were used [5].

24 patients entered the study. 2 were evaluable only for toxicity (early death in 1 case, cessation of treatment due to cardiac toxicity in the second) and 1 patient was lost to follow-up. The characteristics of the evaluable patients are shown in Table 1. Response to therapy was as follows: partial remission 1, stable disease 2 and progressive disease 18 (9 after only 1 cycle). The overall response rate was 5% (95% CI, 0–9%). The partial remission occurred in a patient progressing on cisplatin-based therapy and lasted 8 weeks.

23 patients evaluable for toxicity received 45 courses of dacarbazine (median 2, range 1–5), 11 had only 1 cycle and the dose was increased in 7 without a significant increase in toxicity.

Table 1. Characteristics of 21 evaluable patients

M/F	21/0
Mean Karnofsky index (range)	70 (60–100)
Mean age (yr) (range)	57 (36–74)
Primary site	
Larynx	8
Oropharynx	6
Oral cavity	6
Hypopharynx	1
Sites of disease	
Primary tumour	1
Primary and metastatic	5
Metastatic only	15
Measurable disease	17
Evaluable disease	4
Previous therapy	
Surgery	13
Radiotherapy	16
Chemotherapy	13

3 patients had less than 3000 leucocytes/μl and 1 less than 100 000 platelets/μl. Nausea and vomiting grade 2 or higher occurred in 16 patients, diarrhoea grade 1 in 9, moderate pain during dacarbazine injection in 11, a systolic blood pressure lower than 80 mm Hg in 7 and a heart rate higher than 140/min in 2. A patient with ectopic atrial beats had prolonged hypotension that led to interruption of dacarbazine therapy.

Our results indicate that dacarbazine in high intermittent doses has no activity in patients with advanced squamous cell carcinoma of the head and neck.

1. Kokron O, Pridun N, Zischinsky W. DTIC in der therapie solider tumoren. *Wien Klin Wochrft* 1978, **90**, 864–867.
2. Kingra GS, Comis R, Olson KB, Horton J. 5-(3,3-dimethyl-1-triazeno) imidazole-4-carboxamide (NSC-45388) in the treatment of malignant tumors other than melanoma. *Cancer Chemother Rep* 1971, 55, 281–283.
3. Goldin A, Carter S, Mantel N. Evaluation of antineoplastic activity: requirements of test systems. In: Sartorelli AC, Johns DG, eds. *Antineoplastic and Immunosuppressive Agents*. Berlin, Springer, 1974, Vol. 1, 12–32.
4. Buesa JM, Gracia M, Valle M, Estrada E, Hidalgo OF, Lacave AJ. Phase I trial of intermittent high-dose dacarbazine. *Cancer Treat Rep* 1984, **68**, 499–504.
5. WHO. *Handbook for Reporting Results of Cancer Treatment*. WHO Offset Publication No. 48. Geneva, WHO, 1979.

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5-aza-2′-deoxycytidine in Advanced or Recurrent Cancer of the Uterine Cervix

Jan B. Vermorken, Salvatore Tumolo, Klaas J. Roozendaal, Jean-Paul Guastalla, Ted A.W. Splinter and Josette Renard

5-aza-2′-deoxycytidine (DAC) acts by incorporation into DNA, after conversion to the nucleotide by deoxycytidine kinase [1]. This leads to hypomethylation of DNA, which has been associated with activation of gene expression and induction of cell differentiation. A direct cytotoxic and growth inhibitory effect on leukaemic cells resistant to differentiation has been

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