the current doses had been reduced to 17.5–18 Gy to the periphery of the tumour. Nevertheless there is a significant risk of permanent hearing impairment and other neuropathies and the complication rate is related to the tumour size. Longer follow-up will be necessary to assess the long-term control and late complication rate of this technique. Dr Loeffler (Boston) treated 34 recurrent and 24 primary malignant gliomas with single-fraction SRT. The survival results and pathological and radiographic findings were considered similar to those reported for brachytherapy with a 20–25% risk of radionecrosis. It was considered that fractionated treatment may produce fewer long-term complications and should be further explored in the treatment of glial and other intracranial neoplasms. Dr Becker (Tubingen) and Dr Laing (London) reported the use of fractionated SRT in the treatment of glial and other neoplasms. However, early results of phase I/II studies are insufficient as proof of effectiveness and larger scale, hopefully randomised studies in primary and recurrent tumours will be required.

Attempts at delivering systemic therapy more locally to a glial tumour include intratumoral and intra-arterial administration. Intra-arterial chemotherapy is not superior to intravenous administration and, as was stressed, such techniques are toxic and costly with limited patient benefit. An encouraging new technique, which has been successfully used in metastatic neoplastic meningitis, is intrathecal radioimmunotherapy with monoclonal antibodies labelled with ^{131}I (Mr Coakham, Bristol). The only tumours of primary central nervous system origin treated with some success were pineal tumours and medulloblastomas. Monoclonal antibodies against neural cell adhesion molecules labelled with ^{131}I were also injected directly into cystic gliomas in 3 patients (Dr Papanastassiou, Bristol). Dr Brady (Philadelphia, USA) reported early experience of ^{125}I-labelled monoclonal antibody EGF-424 directed against epidermal growth factor receptor. Intravenous infusion has been used as adjuvant treatment in patients with high-grade astrocytoma and a randomised adjuvant study has been proposed.

It seems that high-precision stereotactically guided localised forms of therapy, either as surgical or radiotherapeutic techniques, are here to stay and the technology is becoming widely available. It is possible to advance arguments against the usefulness of these techniques based on the evidence of tumour extent and the potential toxicity of such treatment. The present evidence for effectiveness is only based on phase I/II studies. Nevertheless such techniques may achieve the same results as conventional therapy, possibly with lesser toxicity, and localised high-precision therapy will continue to find a place in the currently available range of techniques. The advocates of such treatments will have to prove in randomised studies that the investment in complex modern technology leads to superior results, both in terms of survival and quality of life.

Michael Brada
Academic Unit of Radiotherapy and Oncology
The Royal Marsden Hospital
Downs Road
Sutton, Surrey SM2 5PT, U.K.

European Council for Coordinating Cancer Research

The European Council for Coordinating Cancer Research (ECCCR) was established in Paris in 1990 specifically to take advantage of the rapidly approaching unification of Europe in 1992 and to work with the European Community (EC). Its structure complements the New York based International Council for Coordinating Cancer Research (ICCCR).

The ICCCR/ECCCR concept is the brainchild of Jacques Crozemarie, president of the French Association for Cancer Research (ARC) and Vincent T. DeVita, physician in chief of New York's Memorial Sloan-Kettering Cancer Center. Both were convinced that while there was a distinct lack of funding for the international aspects of cancer research, collaborative efforts held the key to progress in the war against cancer. International collaboration in cancer research has many strong adherents, among them Umberto Veronesi, who was one of the first to understand fully the potential importance of one European council to stimulate and promote joint research.

As president of the ECCCR, Professor Veronesi has attracted a strong board of directors from many of the major European cancer organisations and research centres including Dominique Bellet, Institut Gustave Roussy, France; Anthony Epstein, John Radcliffe Hospital, UK; Gordon McVie, Cancer Research Campaign, UK; Maria Fernanda Mendez-Nunez, Spanish Association Against Cancer, Spain; Jan Ponten, Swedish Cancer Society, Sweden; Adolfo Turano, Institute of Microbiology, Italy; Sabine von Kleist, German Cancer Care; and P.A. Voute, Emma Children's Hospital, Holland.

ECCCR's long-range goals are designed to support and complement the agenda of the EC through scientific action in cancer research, reducing duplication of national cancer research programmes and coordinating financial support for the best cancer research projects.

The EC has set a health agenda for Europe including early detection, treatment and the prevention of cancer. The increasing spirit of cooperation makes this an ideal time for Europeans to join together and make a concerted effort against cancer. Additionally, the board of ECCCR unanimously agreed to adopt and support a policy that focuses on Cancer Prevention. This should make a difference to the general perception of prevention and draw attention to specifics in research or public health policy.

To this end, ECCCR will hold a major conference in September 1992 on prevention which will mirror the cancer prevention conference, "Facts, Maybes and Rumors", held in February 1991 at the NIH campus. This conference was deemed a success by the more than 160 scientists who came from more than 10 countries. These participants recognised the need to organise a prevention conference in Europe in 1992, and felt it would be important to bring to the European and international research communities a concise picture of the current foundation of prevention research. This will also give prevention experts the opportunity to define collaboratively a research agenda.

The steering committee will set specific goals for the conference, but the overall aim is to establish and discuss those "facts" that have been scientifically proven, the "maybes" that are intriguing and under active examination and the powerful "rumours" that are unproven and often cause distorted media and public opinion about cancer. In addition, it is hoped that this 1992 prevention conference will allow for discussions of how the research community can mobilise its knowledge base and expertise in shaping healthcare policy.

Most of ECCCR's ongoing progammes, such as international scientific meetings, international joint research projects, public health policy activities and worldwide communications, are designed with the ultimate goal of generating increased interest

in the importance of cancer research and in the benefits that can accrue to everybody.

1992 will also see a second international conference on breast cancer in Paris sponsored by ECCCR, the European Society of Mastology (EUSOMA) and ARC. Under the leadership of Umberto Veronesi and Jacques Crozemarie, the conference will be the start of an overall education campaign throughout Europe to raise women's consciousness about breast cancer and to keep the medical establishment informed about the latest research.

The first international conference on breast cancer which was held in Venice this year had standing room only for 2 days. It was open to breast cancer specialists and oncologists free of charge in the hope of attracting younger doctors who need to have more rapid access to clinical information for their day to day practice.

The importance of international collaboration cannot be overemphasised. In Europe we have the capability to pool our knowledge and to arrive at some innovative solutions. We all recognise that research in isolation is neither productive nor cost-effective. ECCCR continues to take steps to sponsor conferences and symposia designed to provide a forum to discuss specific research findings, expand international communication and create research networks between scientists.

Jacques Crozemarie
ICCCR-ECCCR BP 60
94802
Villejuif Cedex
France.

Eur J Cancer, Vol. 27, No. 7, p. 943, 1991.
Printed in Great Britain
0277-5379/91 $3.00 + 0.00
Pergamon Press plc

Letters

Phase II Study of Pirarubicin in Untreated Metastatic Small Cell Lung Carcinoma

J.P. Kleisbauer, J. Vergeret, P. Balmes, M. Reynaud-Gaubert, A. Taytard, R. Targhetta, P. Thomas, F. Bonnaud and R. Poirier for the Groupe Français de Pneumo-Cancérologie (GFPC)

PIRARUBICIN a doxorubicin analogue, has a broad antitumour activity similar to that of doxorubicin. Its expected lower cardiotoxicity [1] led us to test this drug in untreated metastatic small cell lung carcinoma (SCLC).

*Table 1. Response to pirarubicin and to cisplatin/etoposide**

	Cisplatin/etoposide				
	n	CR	PR	No change	Prog.
Pirarubicin					
CR	1	1			
PR	2	1	1		
No change	5		2	3	
Prog.	12	1	7		4

* 6 patients were not crossed over.
CR = complete response, PR = partial response and Prog. = progression.

From June 1988 to February 1990, 32 patients with untreated metastatic SCLC were entered into our study of pirarubicin as first-line chemotherapy; 6 were ineligible (4 NSCLC, 2 M0). All patients fulfilled the following eligibility criteria: measurable disease, performance status less than 3, white blood cell count over 2.5 10^9/l and platelets above 100 10^9/l, and informed consent was obtained. There were 25 men and 1 woman (mean age 58, range 38–71). Pirarubicin was administered as a 60 mg/m^2 intravenous bolus on day 1. 3 weeks later, if there had been no objective progression, another course was given. In cases of progression, there was a change to chemotherapy with cisplatin 100 mg/m^2 on day 1 and etoposide 120 mg/m^2 on days 1–3, every 3 weeks for three courses. There was a third check-up for final assessment.

12 patients received one course and 14 two courses. The mean dose was 93 mg/m^2 (range 60–130). All 26 patients were evaluable for response to pirarubicin. There was 1 complete response and 2 partial responses, to give an overall response rate of 12% (95% confidence interval 3–30%). The toxicity of pirarubicin was low, with 1 case of granulocytopenia and 1 of vomiting (grade 3). 6 patients who did not receive cisplatin/etoposide deteriorated rapidly. The overall response rate to cisplatin/etoposide was 65% (41–85) (Table 1). The response rate to cisplatin/etoposide after progression or no change with pirarubicin was 59% (33–81). At the end of chemotherapy, 13 responses were obtained out of 26 patients, to give an overall response rate of 50% (30–70%). The median duration of survival for the group as a whole was 30 weeks.

Pirarubicin was marginally effective in metastatic SCLC. However, the drugs was severely assessed with bronchoscopy and early crossover and the 95% CI for the response rate did not differ significantly from that observed by Henss *et al.* [2]. The good tolerance of pirarubicin, even at a high dose, in this population warrants further studies in the dry combination.

The use of an investigational new drug in front-line therapy appears feasible and ethically acceptable in metastatic SCLC, provided an early crossover is scheduled. The overall response rate and the median survival were not modified by this strategy.

Correspondence to J.P. Kleisbauer.
J. Kleisbauer and P. Thomas are at the Department des Maladies Respiratoires, Hôpital Ste-Marguerite, 13009 Marseille; J. Vergeret and A. Taytard are at the Hôpital du Haut Lévêque, Pessac; P. Balmes and R. Targhetta at the Centre Hospitalier, Nîmes; M. Reynaud-Gaubert is at the Hôpital Nord, Marseille; F. Bonnaud is at the Hôpital du Cluzeau, Limoges; and R. Poirier is at the Centre Hospitalier, Aix en Provence, France.
Revised 2 Apr. 1991; accepted 9 Apr. 1991.

1. Dantchev D, Paintrand M, Bourut C, *et al.* Comparative experimental study and evaluation of the degree of cardiotoxicity and alopecia of twelve different anthracyclines using the golden hamster model. In: Mathé G, Maral R, De Sager R, eds. *Anthracyclines: Current Status and Future Developments*. New York, Masson, 1983, 25–36.
2. Henss H, Arnold H, Fiebig HH, Löhr GN. Phase II study of pirarubicin in small cell carcinoma. *Contributions to Oncology*, 1989, **37**, 114–118.

Acknowledgement——This study was supported by a grant from Roger Bellon Oncology.