Oncology, Kent & Canterbury Hospital, Ethelbert Road, Canterbury, Kent CT1 5NG, UK. Tel. (0227) 766877 ext. 4190, Fax (0227) 470749. Telephone enquiries can also be made to Marion Anderson, BOA Meeting Secretary, Tel. (0703) 685398.

Micro 92

The Royal Microscopical Society is organising an international microscopy conference and exhibition, called Micro 92, on 7–10 July 1992, at the Ramada Inn West, London. For further details, contact the Royal Microscopical Society, 37/38 St Clements, Oxford OX4 1AJ, U.K. Telephone: (44) 0865 248768; Fax: (44) 0865 791237.

Zinc Finger Proteins

The New York Academy of Sciences is sponsoring a meeting on zinc finger proteins in oncogenesis on 7–10 September 1992 in Noordwijkerhout, The Netherlands. Further information can be obtained from the Conference Department, New York Academy of Sciences, 2 East 63rd Street, New York, New York 10021, USA. Tel. (212) 838 0230, Fax (212) 888 2894.

Psychosocial Oncology

The 6th annual meeting of the European Society of Psychosocial Oncology (ESPO) will be an international congress on 12–14 October 1992, in Beaune, France. Abstracts must be submitted by 1 May 1992. Further information can be obtained from Professor R. Zittoun, Service d'Hématologie, Hôpital Hôtel Dieu, 1 place du Parvis de Notre Dame, 75004 Paris, France. Tel. 33 1 42348413, Fax. 42348406.

European Association for Palliative Care

The second European Association for Palliative Care congress will be held on 19–22 October 1992, in Brussels. For further information, contact Professor C. Deckers, Centre des Tumeurs, Ave Hippocrate 10, B-1200 Brussels, Belgium. Tel. 32 2 7644757, Fax. 7644764.

Pisa Symposium on Breast Cancer

To celebrate the 650th anniversary of the University of Pisa, a symposium on breast cancer is planned for 19–21 October 1992, in Pisa. For further details, contact Dr PierFranco Conte or Dr Antonella Surbone, Medical Oncology, Santa Chiara Hospital, 56100 Pisa, Italy. Tel. 39 50 592070, Fax. 39 50 592069.

UICC International Cancer Congress

The XVI UICC international cancer congress will be held in New Delhi on 30 Oct–5 Nov, 1994. For further details, contact the Congress Secretariat, XVI International Congress, Tata Memorial Centre, Parel, Bombay 400 012, India. Tel. 91 22 4129750, Fax. 4129937.

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Letters

Preoperative Radiotherapy in the Treatment of Cancer of the Oesophagus

David J. Girling, Lesley A. Stewart and Mahesh K.B. Parmar, on behalf of the Medical Research Council Oesophageal Cancer Working Party

THE PROGNOSIS of patients with oesophageal cancer remains poor, even after surgical resection. Considerable interest has been shown in preoperative radiotherapy to improve the results of surgery. As a start to investigating whether this treatment improves survival, we sought information on all randomised trials that compared surgery alone (S) versus radiotherapy followed by surgery (RS), by undertaking a MEDLINE search and by seeking information on unpublished trials. Three published trials and one unpublished trial were identified (Table 1).

In the trial by Launois *et al.* [1], the radiotherapy dose was 40 Gy and the interval between radiotherapy and surgery was 8 days or less. 124 patients with squamous carcinoma were randomised, but survival analysis was confined to the 60 patients who successfully underwent surgical resection and who survived the 30-day postoperative period. Actuarial survival rates at 5 years were 11.5% in the S group and 9.5% in the RS group. The authors concluded that preoperative radiotherapy did not produce a significant short-term or long-term benefit.

In the trial by Gignoux *et al.* [2], the radiotherapy dose was 33 Gy and the interval between radiotherapy and surgery was 8 days or less. 229 patients with squamous carcinoma at least 20 cm from the dental line were randomised. Actuarial survival rates, based on the 208 patients who were fully evaluable at 5 years, were 9% in the S group and 10% in the RS group. In patients whose cancer was successfully resected, 5-year survival was 10% and 16%, respectively. The authors concluded that although combined treatment may delay local recurrence, this benefit is not translated into a survival benefit.

In the trial by Wang *et al.* [3], the radiotherapy dose was 40 Gy and the interval between radiotherapy and surgery was 2–4 weeks. 206 patients with mid-thoracic oesophageal cancer less than 8 cm in length were randomised. At 5 years, 141 of the 206 patients randomised were assessable. For the 184 patients with resectable lesions, 140 were assessable at 3 years and 128 at 5 years. The survivors at the time of analysis are shown in Table 1. The authors concluded that both in the whole study

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Table 1. Four prospective randomised trials comparing surgery (S) versus radiotherapy followed by surgery (RS) in the treatment of cancer of the oesophagus

	Study							
	Launois *et al.* 1981 [1]		Gignoux *et al.* 1987 [2]		Wang *et al.* 1989 [3]		Nygaard *et al.* (unpublished)	
	S	RS	S	RS	S	RS	S	RS
Patients randomised	57	67	114	115	102	104	106	111
Operable patients	47	62	106	97	102	104	79	70
Respectable patients	33	47	87	75	87	97	57	57
Operative mortality	11	14	19	24	5	5	11	12
Patients in survival analysis	26	34	106	102	102	104	91	95
3 years								
Actual survival	—	—	—	—	—	—	6%	19%
Number of resected patients surviving*	—	—	—	—	28/66	35/74	—	—
5 Years								
Actuarial survival	—	—	9%	10%	—	—	—	—
Number of patients surviving*	—	—	—	—	19/64	27/77	—	—
Actuarial survival for resected patients	11.5%	9.5%	10%	16%	—	—	—	—
Number of resected patients surviving*	—	—	—	—	19/57	26/71	—	—

* Denominators are numbers of patients assessable for period stated.

population and in the patients in whom resection was possible, preoperative radiotherapy improved survival. Nevertheless, they indicated that none of the differences was statistically significant at the 5% level.

In the trial by Nygaard *et al.* (Ullevaal Hospital, Oslo, Norway), the radiotherapy dose was 35 Gy and the interval between radiotherapy and surgery was 3 weeks. 217 patients with squamous cell cancer at least 21 cm from the incisors were randomised and survival analyses were based on the 186 treated according to protocol. Actuarial survival rates at 3 years were 6% in the S group and 19% in the RS group. The authors concluded that preoperative radiotherapy significantly improved survival.

The results of these four trials might appear contradictory. They could, however, be consistent with a modest but worthwhile improvement in survival when preoperative radiotherapy is given. It is not possible to use the published data in an overview (meta-analysis), combining the results of all the trials, because different methods of analysis have been used and the results have been presented in different ways. To investigate whether preoperative radiotherapy improves survival in oesophageal cancer, we have therefore initiated an overview which aims to collect individual updated survival information from all the patients randomised into all relevant trials. To do this successfully we need to include data from all relevant trials. If readers know of any other such trials, we would be grateful if they could send us details.

1. Launois B, Delarue D, Campion JP, Kerbaol M. Preoperative radiotherapy for carcinoma of the esophagus. *Surg Gynecol Obstet* 1981, **153**, 690–692.
2. Gignoux M, Roussel A, Paillot B, *et al.* The value of preoperative radiotherapy in esophageal cancer: results of a study of the EORTC. *World J Surg* 1987, **11**, 426–432.
3. Wang M, Gu X-Z, Yin W-B, Huang G-J, Wang L-J, Zhang D-W. Randomised clinical trial on the combination of preoperative irradiation and surgery in the treatment of esophageal carcinoma: report on 206 patients. *Int J Radiat Oncol Biol Phys* 1989, **16**, 325–327.

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Undifferentiated Small Cell Neuroendocrine Carcinoma of the Urinary Bladder

Maurizio Amichetti, Sebastiana Boi, Gianni Fellin, Paolo Dalla Palma and Lucio Luciani

EXTRAPULMONARY UNDIFFERENTIATED small cell carcinoma (SCC) has been described in several organs. Primary SCC of the urinary tract is rare but has been increasingly reported [1]. Undifferentiated SCC of the bladder is a rare but aggressive subset of urinary tract neoplasms, frequently showing neuroendocrine differentiation [2]. We report one such case. A 56-year-old woman was admitted for gross painless haematuria. Laboratory data and clinical examination were normal. Abdominopelvic computed tomography (CT) showed a right bladder lesion without nodal metastases. Cytoscopic examination revealed a large solid tumour involving the right lateral wall. A transurethral resection was performed. Light microscopy showed an undifferentiated SCC. Immunoperoxidase staining for keratin was positive in 80% of the cells, neuron specific enolase in 70% and neurofilament in 50%; chromogranine was diffusely positive, see Fig. 1. Two courses of a combination of methotrexate, cisplatin and vinblastine were administered, followed by radiotherapy (total dose of 64 Gy) combined with three infusions of cisplatin. A cystoscopic examination was negative and random biopsies showed no residual tumour but whole-body CT revealed metastatic diffusion. Therefore cyclophosphamide, epirubicin and vincristine were started. The disease progressed and the patient died 13 months after diagnosis.

The first case of SCC of the bladder was described in 1981 [3], 63 additional cases have been reported in English to date. Despite extensive and accurate pathological studies, the histogenesis of SCC of the bladder has yet to be defined. Some theories have been proposed. The presence of multipotential epithelial cells capable of differentiation in more than one cell

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