

Europe has invested heavily over the last few years however, and has gained positions in relative terms. The market is growing at an overall rate of 20% per year thanks to the success of the three main media for information distribution: online access, portable databases (CD-ROM) and videotext systems.

To meet the new demands of the information market, the EC has launched the IMPACT program (Information Market Policy Actions) aiming for the creation of a common market of information services and outlines the major obstacles to the European expansion.

The European Commission Host Organisation (ECHO) was created in 1980 in order to demonstrate the possibilities and cost-effectiveness of distant-independent tariff and easy access to electronic databases. The majority of ECHO's services are multilingual and therefore largely eliminate language barriers.

ECHO's main functions are:

- To provide database services (Research and Development, Language Industry, Industry and Economy, User Support).
- Database awareness activities.
- Demonstrating advanced access to information services.

The EC is therefore implementing a vast program for the development of a European service market for automated information handling. The clinical and research sectors may still be largely unaware of these developments.

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1. IMO Working Papers 90/4-5 rev. 1. Commission of the European Communities, 1990.

### **Report on the Third WHO Workshop on National Cancer Control Policy Development, Vienna, Austria, 10-12 June 1992**

The 29 countries and the major European cancer organisations reinforced the need for National Cancer Control Policy as a framework for national planning and implementation of cancer control. This included control of exposure to increasing cancer risks, in particular to tobacco; public information and education; education and training of health professionals in every aspect of cancer control; screening programmes; cancer patient management, including palliative care and pain relief; statistical information systems; clinical, epidemiological and basic research and evaluation—all based on good quality control. All of these are becoming recognised as essential components of national, as well as Common European Cancer Policy. It was agreed that national policy on prevention—because of its multisectoral and political implications—is particularly fruitful as a starting point for further collaboration and cooperation. The background

papers prepared by WHO suggested the meeting undertake a wide-ranging review of present problems in cancer prevention and discussion of a framework around which these could be implemented. Indeed, the papers presented by the participants did achieve this aim. The representatives of all countries felt the need for practical recommendations they could support which would confer maximum benefit on their countries. There was, for the first time at such a meeting, an overwhelming expression of the urgent need to further support the fight against tobacco. This was seen as the one single action which would produce, more than any others, the greatest reduction in morbidity and mortality from cancer. The representatives supported removal of the barriers to successful implementation of anti-tobacco policy in government, parliament, the tobacco industry, the health services and education. Indeed, education of school children, young adults and the public in general. However, the medical and other health professionals across the whole field of cancer control in particular, were seen as the major route to progress. Such education needed to be soundly based, its importance recognised and its implementation rewarded. The arguments for this strategy were those in favour of health gains as well as health care. Each has a cost which should be determined by economic appraisal, resource management and quality control. These strategies are particularly important in the countries of central and eastern Europe, where mortality from the cancers caused by cigarette smoking are rising under the age of 65; the prevalence of cigarette smoking is increasing and the tobacco industry regards these countries as new and profitable markets. The representatives considered and approved the statement of the major European cancer organisations who had decided on a major commitment to the campaign against tobacco independent of political considerations. The meeting concluded that an explicitly stated policy and action plan on cancer prevention should be demanded from the governments of all member states. The meeting endorsed the following consensus statement:

Representatives of member countries agree to obtain the support of their medical communities to ensure their governments' participation in a comprehensive anti-tobacco programme based on sound information and good education. The key elements of such a programme include a number of actions more appropriate in some countries than others.

Specifically the programme is to include legislation on:

- (i) Banning direct and indirect tobacco advertising (including sponsorship and advertising at the point of sale).
- (ii) Introduction or addition of a pricing policy.
- (iii) Restriction of the use of tobacco in public places.
- (iv) Reduction of the tar content to or below EC level.

The representatives further endorsed the WHO's Active Plan for a Tobacco-free Europe, the immediate Legislation Proposals (UICC Tobacco-free Europe Conference Kazimierz, Poland 1990) and Cancer Prevention in Europe recommendations (OEI, Moscow, 1991). The representatives also endorsed Declaration of the European Forum of Medical Associations and WHO on Tobacco, Basle, 1992.

Additional points raised by participants included:

- (a) Recognition of the role of all members of the primary health care team in (cancer) prevention programmes; advice by family doctors on behavioural changes, on smoking

- cessation in particular shown to be the most cost-effective procedure.
- (b) Successful cancer control largely depends upon the quality of family health care in general, because it includes all aspects of medical care.
  - (c) Special emphasis should now be placed on improving the quality of continuing education of physicians and nurses in primary health care.
  - (d) Primary prevention in cancer through risk-oriented intervention measures is inseparable from prevention of cardiovascular diseases and some other chronic diseases. Therefore, cooperation between cardiology and oncology in prevention is to be promoted.
  - (e) Prohibition of the sale of tobacco to minors (those under the age of 16) is an important element in the prevention of smoking in adolescents.

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## Letters

### Feasibility Trial of a Combination of Vinorelbine, Ifosfamide, Fluorouracil and Folinic Acid (VIF Regimen) in Advanced Urothelial Cancer

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SUBSTANTIAL IMPROVEMENTS have been made in the treatment of advanced urothelial cancer. The most encouraging results are obtained with the M-VAC regimen which offers a high response rate with a substantial complete response rate and about 15% of long-term survivors [1, 2]. Unfortunately, there is no standard salvage regimen for patients who relapse or who are refractory to M-VAC. In addition, in case of impaired renal or cardiac functions there is no standard alternative regimen to M-VAC. In order to develop such an alternative regimen, we have studied the combination of three potentially active drugs: 5-fluorouracil (FU), ifosfamide (I) and vinorelbine (V). The choice of FU was based on the results of several trials [3-5] which suggested some activity against urothelial cancer. Whereas ifosfamide has been

extensively investigated in several solid tumours, few clinical trials have been conducted in urothelial cancer. Authors who have performed such studies, especially in the treatment of squamous cell carcinoma of the bladder, report impressive response rates for ifosfamide when used either as single agent or in combination with anthracyclines [6]. V (or nor 5'-anhydrovinblastine) is a new vinca-alkaloid selected for its improved therapeutic index compared with its parent compound vinblastine. Although this drug has not yet been tested in bladder cancer, it is of particular interest since it showed some activity in patients pretreated with other vinca-alkaloid containing regimens [7].

We report here the results of a feasibility trial of a combination of V-I-FU and folinic acid (VIF regimen) in advanced stage urothelial cancer.

From January 1990 to March 1991, 14 patients with advanced urothelial cancer were treated in this phase II trial. Patient characteristics are summarised in the Table 1. 4 patients were not pretreated since they could not receive M-VAC because of impaired renal function. All but 1 of the remaining 10 patients had received at least one line of prior cisplatin-containing chemotherapy. The median interval between the last therapy and VIF regimen was 6 months (range, 1-13).

The chemotherapy consisted of: V 25 mg/m<sup>2</sup>/day, days 1 and 8; I 2 g/m<sup>2</sup>/day, days 1-3; FU 400 mg/m<sup>2</sup>/day, days 1-3 and folinic acid 300 mg/m<sup>2</sup>/day, days 1-3; repeated every 3 weeks. V was administered in rapid intravenous infusion, I in 1-h infusion in 1 l DW5 with uromitexan 2.4 g/m<sup>2</sup>/day, days 1-3 in continuous infusion; FU in a 1-h infusion in 500 ml DW5 and folinic acid in intravenous push 15 min prior to FU infusion.

45 cycles were administered, the median number of cycles being four (range, one to six). In only 27/45 (60%) could the

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