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Recurrent Ovarian Carcinoma: Salvage Treatment with Platinum in Patients Responding to First-line Platinum-based Regimens

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DESPITE RESULTS obtained with cisplatin-based combination chemotherapy in advanced ovarian carcinoma, only 20–30% of patients will be disease-free at 5 years [1–3]. With few exceptions [4] salvage treatment of pretreated patients has yielded disappointing results [5, 6]. To evaluate whether ovarian cancer patients recurring after platinum-based initial therapy respond to retreatment with the same agents, 236 patients entered into two consecutive randomised trials [2, 7] were retrospectively reviewed.

38 patients receiving a median cumulative dose of initial platinum of 300 mg/m^2 (range 100–600 mg/m^2) with a treatment-free interval, that is, period of time between the completion of first-line treatment and salvage platinum-based therapy (TFI) > 3 months, had been retreated with a median number of four courses (range 2–12) of salvage therapy. Of 38 patients, 24 (63%) were treated with cisplatin, alone (CDDP, 100 mg/m^2 d. 1 q 28) or in combination (CDDP, 60 mg/m^2 d. 1 q 28); the remaining 14 patients (27%) received single-agent carboplatin (CBDCA, 400 mg/m^2 d. 1 q 28).

The overall response rate in 35 clinically/surgically evaluable patients was 49%: complete response (CR) 23% (8 patients), partial response (PR) 26% (9 patients), stable disease (SD) 37% (13 patients), progressive disease (PD) 14% (5 patients). Median duration of response was 5 months (range 2–18). Median survival was 11 months (range 2–43). Response was analysed according to TFI (Table 1). Objective response was observed in 27% of cases with TFI ≤ 12 months and 65% with TFI > 12 months, respectively (P 0.02). WHO Grade 2 neurotoxicity was observed in only 3 patients.

Ovarian cancer patients recurring after platinum-based initial therapy respond to salvage treatment with the same agents and response rate increases significantly in patients with longer TFI. However, the real impact on survival of salvage treatment has yet to be determined.

Table 1. Response rate according to TFI

TFI	≤12 months		>12 months	
CR	2	27%	6	65%
PR	2		7	
SD	7		6	
PD	4		1	

P = 0.02.

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P53 Immunostaining in Melanocytic Lesions

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IT HAS recently been suggested by Hall *et al.* that p53 immunostaining may be used as a marker of neoplastic disease in diagnostic cytopathology [1]. However, in a study of benign breast disease [2], Heyderman *et al.* concluded that immunopositivity for p53 protein is not a reliable indicator of malignancy.

The distinction between regular nevi and premalignant or malignant melanocytic lesions has been recognised as a difficult problem in diagnostic pathology, and various histopathological criteria for dysplastic nevi have been proposed [3]. Immuno-

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