histologically documented evidence of progressive inoperable NSCLC. Treatment consisted of IL2 (Eurocetus B.V.) as a continuous daily infusion 18×10^6 U/m^2 days 1–5 and 8–12 followed by cisplatinum 100 mg/m^2 on day 15. Tumour evaluation was performed on day 22 and two additional monthly cycles of 5 days IL2 + cisplatinum were planned in patients without progressive disease.

Patient 1 with recurrent epidermoid carcinoma was considered stable for the three cycles and died from relapse at 13 months. In patient 2 with bronchioloalveolar carcinoma progressing on platinum-containing chemotherapy, there was a 25% decrease in the measurable lesions on computed tomography scan. She suffered a myocardial infarction and died 8 months after initiation of treatment. Patient 3 was referred with bilateral nodular lesions (Fig. 1a) from a bronchioloalveolar carcinoma previously treated with platinum-containing chemotherapy and radiotherapy. Treatment was interrupted on day 15 when he developed tracheo-oesophageal fistula and an oesophageal prosthesis had to be inserted. Partial response was observed (Fig. 1b) and maintained for 5 months when the patient died from acute respiratory distress. The study was prematurely closed after 3 patients because of toxicity.

The data suggest that IL2 and cisplatin may have activity in advanced bronchiolo-alveolar carcinoma, a tumour in which no effective therapy has been described to date. This observation needs to be confirmed in a larger study using less toxic treatment such as lower doses of IL2 which have previously shown activity in NSCLC [6].

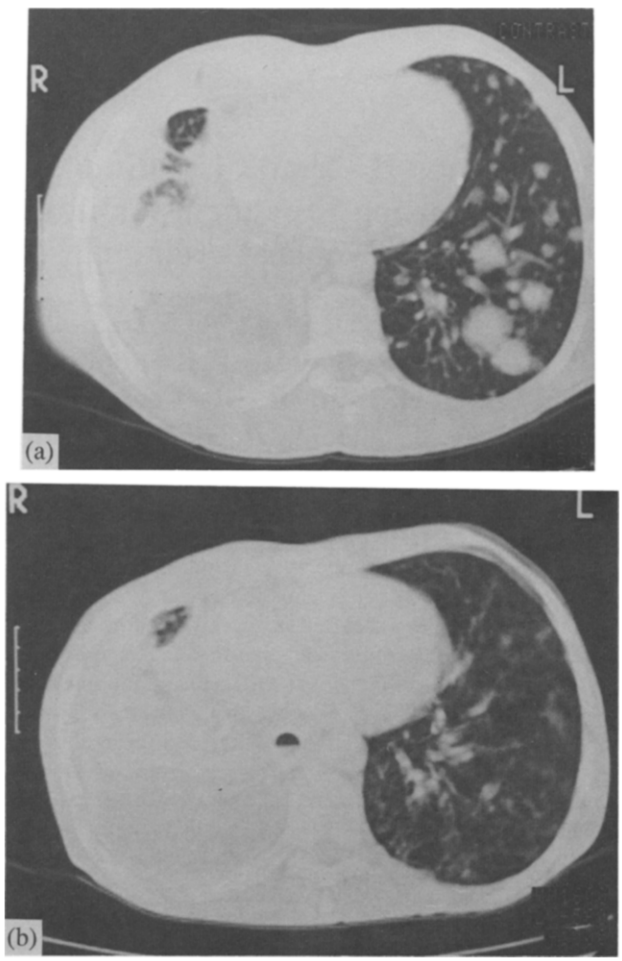

Fig. 1. Patient 3 presented evidence of partial tumour regression. Bilateral tumour nodules detectable on contiguous slices (a) have decreased by more than 50% after treatment (b). Please note oesophageal dilatation due to oesophageal prosthesis on the latter.

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Kaposi's Sarcoma in the Swiss Canton of Vaud, 1974–1990

Fabio Levi, Silvia Franceschi and Carlo La Vecchia

CASABONA *et al.* [1] described trends in AIDS-associated malignancies in Catalonia, Spain, and made a plea for sources of information other than AIDS surveillance data. Kaposi's sarcoma (KS) is of special interest since its incidence rates vary greatly worldwide. The proportions of AIDS patients presenting with KS differ by several-fold, chiefly on account of the different local predominance of homosexual and bisexual men. There is, however, limited but growing evidence that even before the spread of AIDS, incidence rates of KS also varied widely within industrialised countries. PreAIDS rates were 0.40/100 000 men in Sweden [2], 0.29/100 000 in U.S.A. [3], and only 0.14/1 000 000 men in England and Wales [4].

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Table 1. Number of registrations of KS by sex and age and annual registration rates per 100 000. Vaud Cancer Registry, Switzerland, 1974–1990

	Males						Females					
	Age (years)				All-age standardised registration rates		Age (years)				All-age standardised registration rates	
Calendar years	0–14	15–39	40–59	≥ 60	Vaud*	World†	0–14	15–39	40–59	≥ 60	Vaud*	World†
1974–1982	0	0	0	0	0	0	0	0	0	0	0	0
1983–1984	0	5	1	0	1.2	1.0	0	0	0	0	0	0
1985–1986	0	3	3	0	1.2	1.0	0	0	0	0	0	0
1987–1988	0	8	4	2	2.6	2.1	0	1	0	1	0.33	0.30
1989–1990	0	7	11	0	3.1	2.6	0	3	1	0	0.66	0.65
Total (1983–1990)	0	23	19	2	2.1	1.7	0	4	1	1	0.26	0.25

*Age-standardised to the Vaud Canton population of 1983. †Age standardised to the world standard population.

To provide further information on the descriptive epidemiology of KS in Europe, we reviewed data collected from 1974 to 1990 by the Cancer Registry of the Swiss Canton of Vaud (whose population, according to the 1980 Census, was 530 000 inhabitants) [5]. The morphology code of the International Classification of Disease—Oncology (ICD-O) for KS (M9140/3) was used to identify cases.

Numbers of KS cases by age group and sex-specific incidence rates, standardised on both the Vaud population and the world standard population, are shown in Table 1. No cases of KS were registered in the resident population of the Canton of Vaud before 1983 (i.e. the year when the first cases of AIDS were reported in Switzerland) [6]. Afterwards, a steady increase in KS registration rates emerged to a total of 44 men and 6 women between 1983 and 1990. Among males, overall standardised (world standard) incidence rates were 1.0/100 000 men from 1983 to 1986, 2.1 in 1987–1988 and 2.6 in 1989–1990. Among females, the first two cases were registered in 1987–1988, corresponding to an overall rate of 0.3/100 000 women. Incidence rates in females raised to 0.7/100 000 in 1989–1990. The largest number of cases, in both sexes, was observed in young adults (15–39 years).

Since no cases of KS were registered in the Canton of Vaud before the spread of AIDS, incidence rates were compatible with the absence of the disease or with the extremely low rates in England and Wales, especially among natives [4]. A certain degree of underascertainment can be suspected but the traditionally very high proportion of histological verification of all suspected skin lesions [7] and the 100% verification rate for KS in the Vaud Cancer Registry is reassuring.

In conclusion, this study shows that before 1983 KS was not present in the resident population of the Swiss Canton of Vaud and thus suggests that the still uncertain causative agent for KS was virtually absent in this area prior to the AIDS epidemic. Conversely, over most recent years it has become the fourth leading site of cancer incidence in males aged 15–39 (after testis, Hodgkin's disease and melanoma).

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Histological Classification of Ductal Carcinoma *in situ*

Cecily M. Quinn

IN THEIR follow-up study of 227 cases of ductal carcinoma *in situ* (DCIS) Silverstein *et al.* [1] found no significant difference in disease recurrence rate according to histological subtype. Cases were broadly divided into two major categories based on architectural patterns including the presence or absence of necrosis. Cases showing comedo necrosis (n = 108) constituted one category and all other variants (solid, cribriform, papillary,

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