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SURGICAL TREATMENT OF PANCREATIC CANCER

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172 patients suffering from pancreatic cancer were treated in our institution from 1970 to 1992. The resectatility rate acieved 17.4% 30 whipples were procedures were performed. Indication for radical surgery were local resectability of the lesion and regional lymph nodes free from metastases proved by histology. The paliative operations were carried out in 96 patients; in 39 explorative laparotomies only were performed. The preoperative mortality rate due to radical treatment revealed to be 12,6%; 13% of paliative treatment and 5,6% as consequences of the explorative laparotomy.

Late results of surgical treatment of pancreatic cancer were as follows : laparotomy - median survival time 2,5 months; paliative procedures 6 months; but after radical treatment survival was significantly better more then 24 months.

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METASTATIC CANCER WITH UNKNOWN PRIMARY.

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92 pts. presenting with metastatic carcinoma from an unknown primary were studied in order to assess their pattern of presentation, the contribution of diagnostic tests and factors influencing survival. 66 pts.(72%) presented with one metastatic site, 26 pts.(28%) had more sites. The most common involved sites were: liver 36%, bone 26% and lung 20%. The positivity rate of the diagnostic procedure was: chest X-ray 23%, mammography 0%, upper G.I. 12%, Ba. enema 0%, bone scan 60%,liver scan 94%, abdominal U.S. 67%, chest C.T. 32%, abdominal C.T. 61% and brain C.T. 75%. 9 pts.(9.8%) had localised radical therapy (surgery, RT or both), 23 (25%) had palliative RT and 18 pts.(19%) had palliative CT. The median survival was 6 months. The 24 months survival was better for pts. with one metastatic site than those with more sites (24% vs. 0%, p<0.001). Pts. with nodal involvment had better survival than those with visceral disease (60% vs.10%, p<0.01). We conclude that survival of pts. with metastatic cancer of unknown primary is short and diagnostic procedures are of limited value. The prognostic factors are the number of metastatic sites and the organ involved at presentation.

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PHASE II TRIAL OF 5-FLUORO-URACIL (5FU), FOLINIC ACID (FA) AND CISPLATINUM (CDDP) IN THE TREATMENT OF PANCREATIC ADENOCARCINOMA.

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From 01-85 to 07-92, 28 pts with histologically proven pancreatic adenocarcinoma were treated with a combination of 5-FU (375 mg/m2/d x 5 d), FA (200 mg/m2/d x 5d), and CDDP (15 mg/m2/d x 5d), every 3 weeks. 5 pts received the treatment as adjuvant therapy following curative pancreatoduodenal resection, 4 pts had locally unresectable disease, and 19 were metastatic. No one had received prior chemotherapy or radiotherapy. Median age was 60 (range : 24-80 y). Median ECOG indice was 1 (range : 0-2). One hundred and seventy four courses of therapy (median : 4, range : 2-12) were administered. The main toxicities consisted in 1 episode of WHO grade III oropharyngeal mucositis, 8 episodes of WHO grade III diarrhea, 7 episodes of WHO grade II-III peripheral neurotoxicity which obliged to stop CDDP administration; hematologic and renal toxicities were acceptable (WHO grade < II). There was no toxic death. Among the 5 pts who received the treatment as adjuvant therapy, 3 remain disease-free (4+,27+,28+ mos), and 2 relapsed respectively at 74 and 77 mos. The 23 pts with locally advanced and/or metastatic disease were evaluable for response : 1 attained a CR lasting 30 mos, and 2 a PR lasting 8 and 22+ mos. The overall response rate was 12,5 %. 5 minor responses were observed. The overall median survival time was 5.5 mos (2.5-37 mos). 3 pts are alive at 8+, 12+, and 22+ mos. Randomized studies are required to determine the interest of this 3-drug combination in the treatment of pancreatic adenocarcinoma.

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CURE IN ADVANCED GASTRIC CANCER

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35 patients with advanced gastric cancer were included and evaluated for survival in the present study.23 patients had advanced disease at diagnosis and 12 had recurrent disease.24 were male and 11 female.Performance status 50-80 Karnofsky(median 70).Median age 57(28-79).Histology confirmed in all patients as adenoCa. Treatment: All patients were treated with modified FAM combination chemotherapy (5-FU 500mg/m², Adriamycin 40mg/² and Mitomycin-C 6mg/m²),once every 3 weeks for 3-12 cycles.In 2 patients treatment was prolonged for 18 and 24 months due to continuous response.The observed response rate partial(major and minor) plus complete was 37,1%.Complete response was 5,7%(2 patients).Median survival was 12 months with range 2-142 months.The 2 patients that showed complete response remain disease free for 100 and 142 months. Discussion:The median survival of these patients is similar to the known survival of advanced cancer in other studies.The fact that 2 patients showed complete response and no recurrence for 100 and 142 months has not been discribed before and this is what makes the authors consider that gastric adenoCa may not be always the same disease.

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THE ROLE OF SURGERY IN PRIMITIVE GASTRIC LYMPHOMA

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Primitive lymphoma of the stomach still presents a dilemma both in the diagnostic and therapeutic phases. The role of surgery is not well defined. In our Institute from 1970 to 1991, 13 primitive gastric lymphomas (PGL) were diagnosed: 12 non-Hodgkin and 1 Hodgkin. According to the Working Formulation one can identify 4 cases of low level malignancy, 5 intermediate and 3 cases of high level. The pre-operative EGDS permitted a suspected lymphoma in 1 patient, whilst it was determining in 2 cases; in another 6 the diagnosis was a general malignant neoplasm and in 1 case the endoscopic report was negative. Diagnosis on radiography revealed a suspected or certain malignant ulcer in 10 cases. Nevertheless the clear diagnosis of lymphoma in 11 cases was made on the operating table. The classification according to Ann Arbor modified by Hushoff in 1975 included 2 cases at I E stage, 3 at II E-2, 3 at IV .and in 5 cases the stage was not known.

The surgical treatment was carried out in 11 patients as follows: 8 underwent a gastric resection with enlarged lymphoadenectomy, in 1 case at the spleen and another at the colon; 2 cases were treated with a total gastrectomy + splenectomy; 1 case only underwent an explorative laparotomy. Out of the patients operated on, 4 underwent postoperative chemotherapye, 1 telecobaltotherapy for the advanced phase of the disease. The best prognosis was found in stages I E 1-2 (all living at 66 months of follow up) whilst survival did not exceed 10% at 5 years in the IV stage, which conforms to existing literature. In conclusion one can state that surgery in the treatment of primitive hgastric lymphomas seems to be first rate in the early stages whilst in the advanced stage it is essentially diagnostical and takes on a preventative role in complications particularly in haemorrhages and perforations. The cheno-radiotherapy is the basic treatment for advanced stage ones and perhaps modified byological responders might have an important therapeutic role.

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ADVANCED GASTRIC CANCER: THE PLACE OF INTROPERATIVE RADIOTHERAPY (IORT) +/- POST OPERATIVE EXTERNAL BEAM RADIOTHERAPY (EBRT).

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Aims: Despite progress in surgery and anaesthesiology during the last twenty years, the prognosis of gastric cancer has not been improved, particularly for advanced disease with local extension (T3-T4) or with nodal extention (N1-N2). These advanced tumors have a high rate of local recurrence in the coeliac region. The first japanese development of IORT suggested a benefit on the local control of this disease. We treated, in a pilot, study 53 patients with a primary non metastatic adenocarcinoma to evaluate the tolerance and the potential benefit of the association of surgery, IORT and EBRT in case of serosa or nodal involvement.

Patients and techniques: Between May 1986 and December 1992, 56 patients (pts)(33 to 86 years old) received an IORT after total or subtotal gastric resection. The IORT was performed with the Lyon Intraoperative System and delivered 15 Gy +/- 3 Gy with a 9 to 18 MeV electron beam. In case of T3-T4 tumours or nodal involvement, 44 Gy of EBRT were delivered one month after surgery with 18 MV photons using a four field technique . 17 pts were N0 (4T1, 5T2, 8T3) and 4 pts only received an EBRT. 22 pts had a nodal involvement (1T1, 2T2, 16T3, 1T4) and 14 pts of them received an EBRT.

Results: In a preliminary analysis of 39 patients with 10 to 73 months of follow up, we observed 1 post operative death (pulmonary embolism), 1 death by upper GI hemorrhage 5 months after IORT, 1 necrotising pancreatitis and 2 regressive neuritis. Surgical complications were not increased compared with a surgical series. The actuarial survival in the N0 group was 56.1% at 3 years with 2 deaths related to the cancer among the 7 deaths observed and 7 patients alive NED more than 3 years after treatment. The actuarial survival in the group with nodal involvement was 57.1% at 3 years with 7 deaths related to the cancer among the 8 deaths observed and 6 patients alive NED with more than 3 years of follow up.

Conclusion: The preliminary analysis of this pilot study of IORT shows encouraging results mainly for T3T4 or N1N2 patients with no severe rdiation toxicity. The results of this series will be updated and discussed.