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HORMONAL THERAPY OF ADVANCED ADENOCARCINOMA OF THE PANCREAS WITH SOMATOSTATIN AND GNRH ANALOGS.

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Hormone dependence of adenocarcinoma of the exocrine pancreas is suggested by the presence of sex steroids and peptide hormone receptors. Pancreatic carcinoma in Syrian golden hamsters is inhibited by treatment with GNRH and/or Somatostatin analogs. In order to test the clinical significance of these observations, 14 patients (pts) with histological proven advanced inoperable (11 pts) or recurrent (3 pts) pancreatic carcinoma were treated with Leuprolide Depot 3,75 mg i.m. monthly and Octreotide 200 mg s.c. tid (8 pts) or 500 mg s.c. bid (6 pts). Median age was 60 years (45-80) with 5 males and 9 females. Tumor extension was: localized disease only: 1 pt, metastases: 13 pts (liver: 8 pts lymphnodes: 6 pts, peritoneum: 2 pts, lung: 1 pt). Toxicity was mild and reversible: nausea: 1 pt, diarrhoea (WHO gr.1), flushing and disuria: 1 pt, mild agitation and malaise: 1 pt. 2 pts are too early for evaluation. Among the other 12 pts no objective response was observed, although 2 pts have exhibited a durable SD (8 and 9 months). Median survival was 3 months (1+ - 10). Conclusion: Leuprolide + Octreotide treatment, in the doses and schedule employed, does not appear to be active in pancreatic cancer.

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NEOADJUVANT CHEMOTHERAPY (NCT) IN LOCALLY ADVANCED GASTRIC CARCINOMA (LAGC)

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The interest of NCT in LAGC has yet to be evaluated. Since 1988, 30 patients (pts) with LAGC were included in this phase II study.
Population: median age: 60 years, performance status (PS) 0 or 1: 26 pts, prior laparotomy: 4 pts, tumor of the cardia: 15 pts, median tumor size was 80 mm, enlarged lymphnodes on CT scan: 15 pts, linits: 7 pts.
Protocol: Pts were to receive 2 or 3 cycles of combination 5FU (1g/m²/d x5d every 4 weeks) and CDDP (100 mg/m² on day 2) according to efficacy and were then submitted to surgery.
Results: 3 pts were not evaluable for response (1 toxicity related death, 1 lost to follow-up after 1 cycle, 1 coronary spasm after 1 day of therapy). Of 27 evaluable pts, 1 achieved a CR (4%) and 14 a PR (52%) (OR= 56±18%). Pts who had tumor located in the cardia had a better response (79% vs 31%, p=0.01). 28 pts underwent surgery and macroscopically complete resection was possible in 23 pts (77%) no operative mortality. The histology of the gastrectomy showed for those Pts a T1 tumor: 2 pts-T2: 3 pts-T3: 13 pts-T4: 5 pts.
Survival: 20 deaths occurred during a median follow-up of 48 months (m). The median survival was 16 m, the 1-, 2- and 3-year survival was 67, 42 and 38% respectively. 10 pts are alive, 8 for a duration ranging from 47 to 63 m. Only one of them failed to respond to NCT (p=0.01). Survival was significantly better in pts with a good PS (p=0.0001) and without linitis (p=0.002).
In conclusion, NCT seems to allow better surgery in pts with LAGC and seems to prolong long-term survival.

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CARCINOMA OF THE GALLBLADDER

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During the period between 1977 and 1989, a total of 46 patients with primary carcinoma of the gallbladder were treated surgically with or without chemotherapy and radiation in three main hospitals in Israel. Of this number: 34(74%) were females and 12(26%)- males, with a mean age of 72 years (range 35 to 97 years). THE FOLLOWING ACTUARIAL SURVIVAL CURVES WERE OBTAINED:OVERALL SURVIVAL : After 6 months - 63%,24 months-23%, 48 months-10%, 66 months- 0.06% THE MEDIAN SURVIVAL TIME-9.79 months. OUTCOME: 8 pts (17%) are alive, 35 pts died due to gallbladder carcinoma, 3 pts (7%) died due to other causes.
CONCLUSIONS:1.Cholecystectomy can be the curative procedure in stages I-II,but a wedge excision of the gallbladder bed of the liver and portal lymphadenectomy is advised.
2.There is little evidence that more extensive surgical procedures significantly increase survival rates.
3.The role of radiation therapy and chemotherapy is not yet defined, but the results, until now, have been disappointing.
4.By immunohistochemistry: 92% of the specimens were stained by CA 19-9, 43% - by CEA Monoclonal, 78% - by B-72, and surprisingly, CA 15-3 also stained 78% of the samples.

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GASTRIC CANCER PATIENTS PREOPERATIVE IMMUNE STATE CORRECTION

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45 gastric cancer patients before operation received immunotherapy. 38 received p.o. Metindoli, Sol.Retinoli acetatis and Sol.Tocopheroli acetatis (1), 7 of them supplementary Sol.Mildronati iv (2). $CD4^+$, $CD8^+$, $CD38^+$, HLA DR^+, L, Ly, Mo % and absolute level of peripheral blood was determined by laser flow cytofluorimeter Ortho Spectrum III. Treatment (1) statistically significant influenced Mo level of patients with II, III stage and influenced to the L, Ly and HLA DR^+ cells level of p-ts, whom were performed gastrectomy. Treatment (2) increased HLA DR^+ cells % level and absolute level, when gastrectomy was performed. It corelated with theoretical view that Sol.Mildronati induced biosynthesis of interferon and antibodies.

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THE USE OF ROUTINE MAGNESIUM SUPPLEMENTS WITH A CISPLATIN-CONTAINING CHEMOTHERAPY REGIMEN.

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Cisplatin is an effective antineoplastic agent, but can cause hypomagnesaemia. Continuous infusion 5-fluorouracil (5FU) has synergistic anti-tumour effects when given with cisplatin, and when combined with epirubicin (ECF) leads to promising results in the treatment of upper gastrointestinal (GI) tumours. It is not known if this regime exacerbates cisplatin induced hypomagnesaemia.

Thirty-two patients with upper GI tumours were randomised to receive magnesium (Mg) intravenously in pre- and post-hydration fluids with cisplatin, or to receive intravenous Mg only when the serum Mg was low. Serum Mg was measured on admission for chemotherapy, and between each cycle of cisplatin. Twenty-eight patients were evaluable. All patients randomised to receive Mg on as "as required" basis had at least one episode of hypomagnesaemia. The mean serum Mg level on admission for chemotherapy was significantly lower than in those patients who received Mg routinely (p = 0.002), as was the interim Mg level (p = 0.002). After omission of magnesium from the first cycle of cisplatin, Mg supplements were necessary in 50% of subsequent cycles, usually by the 2nd or 3rd cycle. There were several instances of symptomatic hypomagnesaemia requiring further intravenous Mg in mid-cycle.

Patients treated with cisplatin in combination with continuous infusion 5FU should routinely receive intravenous Mg supplements.

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COMBINED CHEMORADIOTHERAPY WITH OR WITHOUT SURGERY OF NON-METASTATIC SQUAMOUS OESOPHAGOUS CARCINOMA. MD. Isla, A. Sáenz, A. Tres, P. Escudero, E. Pujol, C. Santander, V. Alonso, J. Florián, M. Gonzalez, C. Jara. Medical Oncology Service. Hospital Clínico Universitario. Zaragoza. SPAIN.

Between June 1986 and October 1992 two prospective non-randomized and consecutive treatment schemes with curative intent of squamous cell carcinoma of the oesophagous non-metatic were developed. These schemes consisted of concomitant administration chemotherapy (cisplatin and 5-fluorouracil, 2 cycles) and radiotherapy (30 Gys) and after surgery (esophaguectomy) on the first scheme (S1), and without surgery with high dose chemotherapy (4 cycles) and radiotherapy (55 Gys) on the second scheme (S2). Entry criteria in both schemes were: 1)Histologic diagnosis of squamous cell carcinoma of the oesophagous non metastatic,2)Age<70 years,3)Perfomance status<3 (ECOG),4)No previously treated.
RESULTS: Fourteen patients were included in S1 and 12 patients in S2. Median age: 56 (S1) and 60,5 years(S2). Stage distribution: I 7,1%(S1) and 8,4%(S2), II 50% (S1) and 33,3%(S2), III 43%(S1) and 58,3%(S2). Toxicity was moderate in both schemes standing out nausea/vomiting grade III 28,4%(S1), leukopenia and mucositis grade III 16,7%(S2). Complete histological response was achieved in 42,6%(S1)(95% CI,68,7%-16,9%) and 50%(S2)(95% CI,78,2%-21,7%). Operative mortality (S1) was 27%. Median time follow up: 7,5 (S1)(range 4-44) and 11 months (S2)(range 5-24). Median survival: 6 (S1) and 23 months(S2). One year actuarial survival: 28%(S1) and 71%(S2). Difference survival between two schemes was statistically significant (P<0.05). Grade palliation was important.
CONCLUSION: High dose combined chemoradiotherapy without surgery may be an alternative to surgery treatment wich determines high risk of operative mortality and doesn,t warrant definitive locorregional control.