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OPTIMIZED RADIOTHERAPY PLANNING IN INOPERABLE UTERUS CARCINOMA

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The therapy of choice in inoperable uterus carcinoma is the combined radiotherapy, i.e. the percutaneous radiation and High-dose-rate (HDR) Afterloading. HDR is administered to ensure the devastating tumor dose, whereas percutaneous radiation therapy is necessary to include the different lymph nodes for preventing further spreading of the tumor cells. To protect healthy tissue and organs (bladder, rectum) next to the tumor and to avoid a too high radiation dose (hot spots) in the uterus itself already radiated by the HDR-Afterloading, these areas are blocked out by a standardized lead-shielding. However, patients with higher tumor classification and consequently inoperable mostly show a fixation or lateral dislocation of the uterus, which causes an inhomogeneous dose distribution and hot spots in spite of the shielding technique.

Therefore at the radiation center in the Zentralklinikum Augsburg a method is used to determine the precise anatomical uterus location to facilitate the individual percutaneous radiation therapy by blocking out the already radiated regions. The poster presents this method and the follow-up of 47 treated patients with regard to clinical outcome and complications.

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CLINICAL EXPERIENCES WITH 53 CASES OF FALLOPIAN TUBE CARCINOMAS

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Primary cancer of the fallopian tube is a rarely diagnosed tumor. Fifty-three patients (pat.) with carcinoma of the fallopian tube treated between 1969-1993 were reviewed. No patients had a preoperative diagnosis. The median age of the patients was 55 years. Treatment consisted of different surgery techniques alone, in other cases a combination of surgery and radiation or a combination of surgery and chemotherapy, but also the combination surgery-radiation-chemotherapy. Staging: 36% stage I, 43% stage II, 14% stage III and 7% stage IV. Grading: 21%-G1, 38%-G2, 36%-G3. The five-year survival was 35%, depending on stage: in stage I patients treated by surgery and radiation the 5-year survival was 64%, in stage II pat. treated by surgery and radiation it was 23%. The 5-year survival of G1-tumors (all treatments) was 37.5%, of G2-tumors - 18.8% and of G3-tumors it was 50%. The results suggest the need for aggressive postoperative adjuvant therapy (radiation, radio-AU, chemotherapy, combination of these techniques) target for metastasis in fallopian tube carcinoma.

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A MULTI-CENTER COMPARISON OF PAP-SMEAR RESULTS IN ISRAEL

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No cervical cancer screening of average risk women is recommended in Israel mainly due to a low incidence. Yet, women and gynecologists still tend to perform these tests. A multi-clinic pap-smear screening is offered to women ages 35-54, q3y, since 1992. This activity utilizes 10 cytology laboratories. As it is of interest to study the incidence of malignant and premalignant cervical lesions in Israeli women, an evaluation and quality-control components were added to the program consisting of demographic and risk factor data provided by the women and standardized cytology report. Among the first 1533 women screened, 35 were diagnosed with SIL1 lesions, none with SIL2 and none with malignancy. About half the women were recalled for repeated tests and 6.4-8.2% were recalled for colposcopy. The high recall rate has a major impact on cost-effectiveness.

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TREATMENT OF ADVANCED OR RECURRENT CARCINOMA OF THE UTERINE CERVIX WITH IFOSFAMIDE, CARBOPLATIN, CISPLATIN AND BLEOMYCIN

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A Phase II study was performed in patients meeting the eligibility criteria: biopsy verified measurable disease, age < 70 years, WHO performance < 3, and sufficient bone marrow, renal, hepatic and pulmonary function. Treatment: Prior irradiated pts received Ifosfamide (IF): 1.2g/m² d.1-3, carboplatin (C): 150mg/m² d.1, cisplatin (P): 60mg/m² d.2-3, and bleomycin (B): 250mg/m² i.v. d.1-3 q.4w. Bleomycin (B): 15 IU/m² d.2,8,15,22, thereafter d.2,15 q.4w. to a maximum of 180 IU/m². In non-irradiated pts the dosages were IF: 1.5g/m², C: 200mg/m², P: 50mg/m², B: 300mg/m², B: 15 IU/m². A total of 2-10 cycles were planned depending on response. Dose modifications were performed according to myelosuppression, renal and pulmonary function.

Patients: 27 were evaluable for response, 26 for toxicity. Median age 48.5 years (33-68). Median treatment cycles were 4 (1-8).

Results: Total response rate 15/27, 56% (95% confidence limits 35%-75%), consisting of 1 CR (duration 12+ weeks) and 5 PR in 6 non-irradiated, 1 CR (21+w) and 8 PR, RR 43% was observed in 21 irradiated pts. Four pts had stable disease, 6 PD and two refused further treatment before first evaluation.

Toxicity: 19 pts (70%) had leucocyte nadir below 1.0 (x 10⁹), median 0.6 (0.1-2.0). Nine pts (33%) received antibiotics for febrile neutropenia. Platelet nadir below 20 were seen in 11 (41%), median 27 (3-150). Dose reduction due to myelosuppression were carried out in 21 pts.

Conclusion: The combination results in an impressive response in non-irradiated patients - but additional patients have to be included before firm conclusions can be drawn.

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CARBOPLATIN AND FLUOROURACIL IN CERVIX TUMORS.

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14 patients (pts) with tumor of the cervix, relapsing after local therapy (9 pts) or with distant metastases (1 pleural 3 lung and 1 lung and bones) were treated with carboplatin (JMB) 300 mg/m² day 1 plus fluorouracil 1000 mg/m² day 1 to 4 as a continuous infusion, every 28 days.

Patients' median age was 51.5 years (range 35-63), the median performance status 1 (range 1-3). 8 pts were previously submitted to surgery, 2 received brachytherapy, 7 external radiotherapy and 4 brachy- and radiotherapy. 10 pts had squamous cell carcinoma, 3 large cell epidermoid carcinoma and 1 pt mixed müllerian tumor.

The median number of cycles of chemotherapy was 4,5 (range 2-8).

Grade 3-4 toxicity was nausea and vomiting in 5 pts and mucositis in 1 pt.

6 pts attained a partial response (42.85%), 1 pt stable disease and in 7 pts the tumor progressed.

In a previous study of chemotherapy using cisplatin instead of JMB in cervix tumors we obtained a similar response rate, with one complete response. However toxicity was more pronounced because of vomiting and impaired renal function. The latter, often present because of local tumor infiltration, makes cisplatin not advisable. JMB could be preferable.

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VALUE OF MAGNETIC RESONANCE IMAGING IN PRIMARY IRRADIATION OF UTERINE CERVICAL CARCINOMAS.

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This study shows the reliability of magnetic resonance imaging (MRI) in planning, in evaluation of response and in follow up of primary irradiated carcinomas of the uterine cervix.

Before primary radiotherapy (RTX) MRI permits as a result of the determination of tumor extension and tumor volume a definite contour of the external fields and also an adequate dosage for the intracervical brachytherapy dependent on the volume of the tumor.

After RTX the MRI examination allows an accurate assessment of the response to the treatment and therewith the further clinical course.

The MRI scans were obtained before, immediately after RTX, 3 and 6 months after RTX and at a 1-year interval thereafter.

In 50 patients (median age: 59y; range: 28-81) treated with MRI assisted therapy, 65% showed a total remission, 25% a residual tumor or a recurrence with the necessary of an additional therapy and 10% no response to the treatment. The overall 5-year survival rate is 44%.