

806

METASTATIC PATTERN (MTS), LEUKEMOID REACTION (LR) TUMOR SPECIFIC FEVER (TSF), AND BONE MARROW INVASION (BMI) IN UNDIFFERENTIATED CARCINOMA OF NASOPHARYNGEAL TYPE (UCNT) PATIENTS (Pts).

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We have studied with the same pretherapeutic work up 255 consecutive UCNT pts confirmed histo-serologically, seen between 10/85 and 01/92, all treated with chemotherapy (CT) in neoadjuvant or palliative programs with locoregional (142) or MTS (113). All compared with Head & Neck squamous epidermoid HNSCC seen in the same period. They had CT scan (head, thoraco-abdominal, bone scan, EBV serology, bone marrow aspiration + biopsy, biochemical and CBC tests baseline, q 3 months (mth) for 1 yr, q 6 mth afterwards. Initial TNM stage, 1st symptom date correlated with LR, TSF, BMI (all TSF had no infectious workup), and MTS patterns. They were 193 M/62 F, median age 35 (7-77), 134 north african, 99 european, 22 others. **Results** : BMI was seen in 28 pts (11%) of all and 25% of MTS, LR (≥ 20000 WBC/mm³) was seen in 41 pts (16%), with 24% of MTS, and 10% of non MTS having it. TSF was seen in 23 pts (9%), 17% of MTS, and 2% of non MTS. MTS appeared in 80% of cases within 18 mths from 1st symptom and were linked to high N (N2c or N3) in over 80% of cases. Nodal hypodensity in CT scans was seen in 26% pts vs 74% of HNSCC pts. Bone MTS in 72% of UCNT MTS, vs 25% HNSCC. Lung : 18% of UCNT MTS vs 84% HNSCC. Only one hypercalcemic episode was observed in 113 MTS UCNT. Liver MTS were seen in 29% of UCNT MTS. No carcinomatous meningitis seen, despite T4 in $\geq 40\%$ pts UCNT. TSF was seen in 4 pts with BMI, 17 pts with LR, (4 with both). The incidence of paraneoplastic syndromes (TSF, LR) is 18.5 overall and higher in MTS (30%) than non MTS (10%). They were reversible with successful CT. These elements support the distinction of UCNT as a separate entity among H&N cancer of epidermoid lineage, since natural history and clinical evolution under score basic biological differences between UCNT-HNSCC.

808

RESULTS OF CHEMOTHERAPY IN LOCALLY ADVANCED CARCINOMA OF THE HEAD AND NECK (HNC)

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Ninety four consecutive patients (pts) with stage III and IV HNC were treated with a chemotherapy (CT) regimen consisting of cisplatin (120 mg/m² IV d1), Fluorouracil (1000 mg/m² IV continuous infusion d 2-6), and Bleomycin (5 mg IM d 1-5). Pts received at least three cycles repeated every three weeks. In 68 pts the CT was the initial therapy (=primary CT) and surgery and/or radiotherapy was subsequently planned. In the remaining 26 the CT was given on relapse after surgery or radiotherapy (=secondary CT). 86 pts were male and 8 female. Median age was 56 years (21-77). 88 pts were evaluated for response.

Quality of response was strongly associated with initial treatment. Pts receiving primary CT obtained 42% CR, 41% PR, and 17% NR whereas in secondary CT these figures were 25%, 8%, and 67% respectively (p=0.0001). Median survival was 20 months for pts receiving primary CT and 7 months for the pts receiving secondary CT (p<0.0005).

Toxicity mainly mucositis was moderate. Six toxic deaths were observed (three sepsis, two acute myocardial infarction and one acute renal failure).

In previously untreated pts with HNC chemotherapy achieves a high rate of responses but the exact role of this therapy is not well defined yet.

810

HIGH DOSE IFOSFAMIDE AS A SINGLE AGENT AND IN COMBINATION WITH CISPLATINUM IN THE TREATMENT OF ADVANCED/RECURRENT SQ. CELL CA. OF HEAD AND NECK

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193 patients with histologically proven squamous cell carcinoma of the head and neck advanced and/or recurrent were treated with a single drug therapy of Ifosfamide 1.5 g/m² IV drip for half an hour in 125 ml of dextrose saline for 5 days and Meams 20% of the total Ifosfamide dose in 3 doses for 5 days, or in combination with cisplatin 10 mg/m² IV infusion for 5 days following Ifosfamide drip. The courses of treatment were repeated at the interval of every four weeks and total 3 cycles were given. Out of 193 patients 64 received Ifosfamide alone and 129 received Ifosfamide with cisplatin. 6 CR and 25 PR (total response 53%) were observed in 58 evaluable patients of Ifosfamide group and 18 CR and 57 PR (Total response 64.4%) were observed in 117 evaluable patients of combination group.

Nausea, vomiting, alopecia and leucopenia was experienced by all patients.

807

THYROID CANCER - DIFFERENCES IN PROGNOSTIC INDEX AND CLINICAL OUTCOME OF PAPILLARY, MIXED AND FOLLICULAR TYPES AMONG WOMEN AND MEN.

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To evaluate individual tumour mortality and relapse risk, clinical data on 218 women and 91 males with papillary, mixed or follicular thyroid cancer were separately analysed and thereafter compared. Seven parameters were ranked: histopathological type, age, T/pT-stage, N/pN-stage, metastasis, grade of differentiation and symptoms. The median follow up was 9.5 years for women and 9.3 years for men, range 1-18 years. The multivariate analysis on women revealed two significant parameters, follicular type and age >60 years, associated with relapse risk. Regarding tumour mortality risk, three significant parameters were found: lymph node engagement, age and presence of one or more metastases. Concerning men the multivariate analysis revealed no significant parameters associated with relapse risk. Regarding tumour mortality risk, four significant parameters were found: lymph node engagement, symptoms, age and presence of one or more metastases. Finally a scoring index were created to evaluate the individual risk factors. The scoring index was divided into three categories: low-, medium- and high-risk. The most important discrepancy in tumour mortality risk in women was between the low and medium versus the high risk patients. In tumour related mortality for men there were significant differences between all three groups: low-, medium- and high-risk. The calculation of separate prognostic index for both female and male patients is of importance since the risk factors seem to be partly different.

809

SURGERY AND POSTOPERATIVE IRRADIATION IN PATIENTS WITH HEAD AND NECK CARCINOMAS

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From 1982 to 1986, 141 pts (12 females and 129 males) were treated by surgery and subsequent irradiation in order to prevent locoregional recurrence. Tumor was completely removed in 105 pts, incompletely in 13, whereas resection was dubious in 8 pts. Tumors were located in oropharynx and mouth. Histology confirmed squamous carcinomas in 140 and fusocellular carcinoma in 1 patient. Recurrence occurred in 36 pts, 14 of them had local, 18 regional and 7 had both local and regional recurrence. Metastases developed in 8 pts: 5 - lungs, 3 - bones, 1 - brain, 1 - liver; some of the pts had more than one metastatic site. Distribution by stages was as follows: Stage I - 5, Stage II - 31, Stage III - 69, Stage IV - 36. Postoperative irradiation was started within 7-82 days after surgery. Survival and disease free survival was correlated to dose, stage, time interval between surgery and irradiation, and the results of resected lymph node examination.

811

METASTATIC PATTERNS IN SQUAMOUS CELL LARYNGEAL AND HYPOPHARYNGEAL CARCINOMA PATIENTS: IGR EXPERIENCE.

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We retrospectively reviewed the clinical records of 1563 laryngeal and hypopharyngeal patients (PTS) treated at the Gustave Roussy Institut from 1974 to 1980. Of them 261 PTS (16.4 %) presented metastasis (MTS) as evolutive pattern of disease some time after locoregional approaches were performed.

Patients characteristics : male : 258, female : 3, median age : 57 (37-85) ; histologies : well differentiated squamous cell carcinoma (SCC) : 232, poorly differentiated SCC : 28, Larynx : 84, Hypopharynx : 177, tumor staging : T1 = 39, T2 = 61, T3 = 135, T4 = 20, TX = 6 ; N0 = 99, N1 = 43, N2 = 14, N3 = 99, NX = 6 ; Neck dissection : 133 PTS ; extracapsular spread : 85 PTS (63.9 %) ; previous treatments : surgery (S) = 12, radiotherapy (RT) = 119, S+R = 113, chemotherapy (C) = 2, S+R+C = 3, no treatment = 12. More than 50 % of the PTS presented their MTS between 3 and 20 months after the initial treatment. **Metastatic deposits sites alone or associated** : lung : 181 (70 %), bone 88 (26 %), skin 31 (12 %), liver 25 (9.5 %), extra cervical nodes 3 (0.5 %), brain 8 (3 %), digestive tract 5 (1.9 %), bone marrow 1 (0.3 %), pericardic 1 (0.3 %), renal 1 (0.3 %), adrenal 1 (0.3 %).

These results are comparable with those of the literature, in terms of metastatic patterns of disease. However, this last issue must be carefully assessed because our retrospective study takes a period where some actual iconographic methods were not clinically available and/or validated.