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NEOADJUVANT CHEMOTHERAPY WITH ADRIAMYCIN, CISPLATIN, VINCRISTINE AND CICLOPHOSPHAMIDE (ADOC) IN INVASIVE THYMOMAS, PRELIMINARY RESULTS.

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Surgery or radiation therapy are widely employed as first treatments in invasive thymoma. Systemic chemotherapy is usually reserved for patients with unresectable disease, or showing progression after surgical or radiation therapy. Cisplatin containing regimens have been repeatedly found to be highly effective in patients with advanced disease, with overall response rates ranging between 80-90%. From February 1990 to February 1993 7 patients (pts) bearing invasive thymoma stage III - IVA, according to Masaoka staging, entered the study. They were 4 males and 3 females, median age 47 years (range 23 - 70). Hystology was: lymphoepithelial 4 cases, epithelial 3 cases. According to Fornasiero et al (Cancer 1992) adriamycin (40 mg/sqm) and cisplatin (50 mg/sqm) on day 1, vincristine 1 mg/sqm on day 2, and ciclophosphamide (700 mg/sqm) on day 3, every 28 days, have been administered. Pts received a median of 4 cycles (range 3 - 5); among 6 pts evaluable for response 5 (83.3%) attained a partial response and underwent radical surgery. Malignant residual disease was found at post-chemotherapy histology. Disease free interval was: 3, 6+, 12+, 16+, 23+ respectively. 1 patient showing stable disease at the end of the fourth cycle was referred to radiotherapy. Toxicity was tolerable: grade III (WHO) nausea vomiting occurred in 2 patients, leukopenia grade III in 2 patients. These preliminary results suggest that ADOC scheme is active as neoadjuvant approach in invasive thymoma stage III and IVA.

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PRIMARY NON-HODGKIN LYMPHOMA OF THE CENTRAL NERVOUS SYSTEM (PCNSL): TREATMENT RESULTS FOR 17 CASES.

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17 patients (pts) with histologically proven PCNSL, 11 men and 6 women with a Karnofsky Performance Status (P.S.) > 60, were treated and followed longitudinally at Niguarda Hospital, in Milan, from january '79 trough march '92. The histologic types were classified according to the Kiel classification and the Working Formulation;their ages ranged from 11 to 74 years(median 51.8). Pre-treatment evaluation included HIV-1 antibody titers, total body CT, lumbar puncture, bone marrow aspirate, brain CT and contrast enhanced MRI, neurological examination. None had occult systemic lymphoma. All the pts had a surgical treatment: stereotactic biopsy in 5 pts, complete resection in 4 pts and partial resection in 8 pts. 15/17 pts received irradiation on the whole brain and a local boost on the lesion; the administered total dose was 45-55 Gy in 5-7 weeks. 3/17 pts are alive (17.6%) without evidence of systemic or local disease. The median survival of the whole group of pts was 13 months,of biopsied + RT pts 10 months, of total/partial resection + RT 13 months. Only biopsied pts had a 2 months median survival. Karnofsky P.S. > 70 was significant prognostic factor (p< 0.001); local recurrence at the site of the original disease remains the predominant cause of failure. Nobody had distant metastasis. Despite high dose irradiation, PCNSL still exhibits excessive mortality. Combination of adjuvant chemotherapy following alternative fractionated (iperfractionation) radiation therapy with a radiosensitizing and lymphocidal chemoterapeutic agent like a hydroxyurea can improve the survival rate in PCNSL.

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CHOP TREATMENT IN EIGHTY CASES OF INTERMEDIATE AND HIGH GRADE NON-HODGKIN'S LYMPHOMAS.

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We analyzed 80 patients (pts) with intermediate and high grade non-Hodgkin's lymphoma treated with CHOP regimen and evaluated the rate of complete response (CR), overall survival (OS), disease free survival (DFS) and some prognostic factors predicting outcome. 32 pts were in stage I-II and 48 in stage III e IV; 20% of pts had bulky disease and the same percentage had mediastinal or bone marrow involvement. 20/80 had sistemic symptoms. The CR rate was 64% with a CR+PR rate=89%. The 3 years DFS and OS were respectively 83% and 63%. We performed an univariate analysis on our data: ECOG, number of disease sites, mediastinal and bone marrow involvement, stage and LDH level, appeared significant prognostic factors for response and ECOG, LDH level, bone marrow involvement and extranodal disease for survival. Pts with 0 vs 1 or 1 adverse prognostic factors for survival, confirmed a decrease both in CR and OS rate as shown in the table below:

N.progn. factors	%CR	%OS (3 years)
0	92	91
1	80	77
2	50	61
3	25	25
4	*	*

No pts had 4 adverse prognostic factors

So different prognostic Groups of pts had been recognized, showing the importance to state an uniform staging system to identify the subgroups of pts that need effectively new and more aggressive therapy.

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ROLE OF RADIOTHERAPY IN THE MANAGEMENT OF ORBITAL LYMPHOMA

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Orbital lymphomas, mostly NHL, are very infrequent. Radiotherapy (RT) can achieve an effective local control on stage I, obtaining a complete response in a high percentage of cases. However, impact of RT on the lens is heavy, involving sometimes high degree cataract. From 1985 to 1992 in our Department 8 orbital lymphomas underwent RT, using a new technique, that allows to create narrow shield-tunnel encompassing the lens and to move on time by time different portion of the orbit volume. The irradiation is delivered in isocentric technique tilting the beam and contemporarily the eye so that the visual axis becomes as much perpedicular as possible to the central axis of the beam. 5 out of 8 pts achieved complete radiological response whereas 3 showed residual disease. 1 out of 3 was biopsed without evidence of tumor and free from local recurrence at 3 years, 2 pts are free from local progression at 12-16 months.

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SYNCHRONOUS AND METACHRONOUS LYMPHOMA AND RENAL CARCINOMA REPORT OF EIGHT CASES

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In the last decade we observed in our Institution 8 patients (pts) with synchronous or metachronous lymphomas (7 non-Hodgkin's lymphoma + 1 Hodgkin's lymphoma) and renal carcinoma (ca).
In six cases of synchronous tumors, renal ca was discovered during staging procedures for lymphoma; whereas in two pts in complete remission (CR) for lymphoma, a metachronous renal ca was discovered during the usual follow-up and only in one case it was symptomatic.
Except for two pts with synchronous tumors (because of their bad physical conditions), all the pts, after achieved CR for lymphoma , were treated with nefrectomy. All these six pts are actually alive and without evidence of either lymphoma or renal ca. The incidence of multiple primaries in the literatures has resulted of 2,7 to 6,8% (O'Boyle et al Am. J. Med. 87: 1989) and very few reports are about association of these two entities. The increasingly common use of CT scanning in this last decade, may account for finding of a relatively high incidence of synchronous lymphoma and renal ca., when it is still asymptomatic. This can make problems of differential diagnosis and, in the case of synchronous tumors potentially curable, the necessity to state the prior treatment.

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FOLLOW-UP OF THE SERUM FERRITIN VALUES IN THE PATIENTS WITH NON HODGKIN LYMPHOMAS

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Serum ferritin concentration as a tumor associated marker was investigated in 30 patients with Non Hodgkin lymphomas during the period of four years. The aim of this tudy was to estimate significance of determination and longitudina follow up of serum ferritin concentration in patients with Non Hodgkin lymphomas. The study included 16 patients with low grade malignant Non Hodgkin lymphomas and 14 patients with high grade malignant Non Hodgkin lymphomas of different tumor stages (2 with stage I, 14 with stage II, 3 with stage III, 11 with stage IV). Serum ferritin levels were measured using fluoroimmunoassay after staging the disease, in the course of therapy and after achievement of complete remission up to period of 3-6 months. Increased serum ferritin concentrations were fund in 66,67% of the unselected patients. A significant correlation was found between ferritin levlel and progressed clinical stages of the disease. However, there was no correlation between hystological type of disease and level of ferritin as well as presence of systemic symptomes and level of ferritin. The serum ferritin concentration followed closely the activity of the disease: increased pretreatment serum ferritin levels normalized completly when patients achieved complete remission. In contrast, in patients with tumor relapse or tumor progression, serum ferritin levels increased again. The data suggest that the serum ferritin concentrations can be used for follow-up patients with malignant lymphomas. It is a helpful additional parameter for the control of the disease.