989

PREDNIMUSTINE - CLINICAL ACTIVITY IN LOW GRADE NHL REFRACTORY TO CHLORAMBUCIL AND PREDNISOLONE.

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86 patients with low grade NHL were treated with chlorambucil plus prednisolone until the disease progressed and the therapy could not be continued. 39 such refractory patients were then treated with prednimustine, 200mg orally day 1-3 every 2 weeks. Of these 39 patients, 20 had CLL, 14 had follicular CB-CC, 2 CC, and 2 immunocytoma. 29 had stage IV disease, 4 stage III, 5 stage II, and one stage I. Median age was 63 years, and male/females were 21/18. Performance status was 0-1 in 35 patients and 2 in 2 patients. Of 35 patients evaluable for response, 15 (43%, C.I. 27-59) had an objective response (5 CR, 10 PR).Median time to progression was 16 weeks for all 35, and 32 + weeks for the 15 responding patients. Severe hematological toxicity was recorded for most of the patients in both parts of the study, indicating that the treatment could not have been intensified and thus supporting that patients were truly refractory to chlorambucil plus prednisolone before prednimustine was given. Non-hematologicaltoxicity included mild to moderate elevation of liver function tests, nausea/vomiting and infections.Clinical side effects were slightly more frequent in the second (prednimustine) part of the study, possibly due to a poorer general condition of the patients. The study has shown that prednimustine possesses clinical activity in patients with low grade NHL refractory to chlorambucil plus prednisolone.

990

CHOICE OF THERAPY IN NON HODGKIN'S LYMPHOMA TAKING INTO CONSIDERATION THE DATA OF LYMPHOCYTES RESISTANCE RESEARCH IN VITRO

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We studied the resistancy of lymphocytes to the different cytostatic preparations for 31 patients with non Hodgkin's lymphoma before treatment.The diffusive forms of the disease were choosen so the count of normal lymphocytes could be neglected.The resistance of lymphocytes was determined by registration of electroconductivity(10^3-10^7Hz)and the rate of acid hemolysis before and after addition to the cell suspension cyclophosphamide(1300 mg/ml)and vincristine(200 mg/ml);or cyclophosphamide and doxorubicini(100mg/ml);or adriablastinum(100 mg/ml),cyclophosphamide,vincristine and bleomycinum(30 mg/ml);or vepezidi(120 mg/ml).Then we began the treatment of the patients with cytostatic preparations to whom the resistance of lymphocytes was the least.In this case the treatment was always more effective compared with the control group - 19 patients.

991

PHORBOL-12,13-DIBUTYRATE IMPROVES QUALITY OF CYTOGENETIC PREPARATION IN LYMPHOID MALIGNANCIES

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Biopsies of enlarged lymph node in the clinical situation of suspicion of malignant lymphoma is usually done before histologic confirmation when neither cell lineage nor histologic subtype are available. In this constellation a mitogen should be able to activate B- and T-cell proliferation without any toxity for lymphatic cells or overstimulation of fibroblasts. Phorbol-12,13-dibutyrate (PDBu) was taken as a tumorpromotor to activate a variety of cellular responses, and therefore also cell proliferation. The effect of PDBu alone and PDBu together with A23187 (A), a Ca2+-Ionophore inducing $Ca2^+$ mobilization, was investigated on lymph node biopsies from 13 consecutive patients under suspicion of malignant lymphoma and acute lymphatic leucemia.

We compared quality and quantity of mitoses obtained in unstimulated and stimulated short-term cultures under standard conditions with final concentrations of 5nM for PDBu alone and 10nM PDBu in combination with 500nM A. There was no evidence of lymphotoxity of neither P or PA. Focussing of high quality of analyzable metaphases best results were regularly found in 24h culture followed by 48h cultures stimulated with PDBu alone ($p < 0,05$) and 24h culture without any agents within a patient. Stimulation with PA was inferior to P and of no further benefit.