

18

CLINICAL EXPECTATIONS FROM BASIC CLINICAL RE-SEARCH IN LUNG CANCER.

H. Skovgaard Poulsen

University of Copenhagen and Department of Oncology, Rigshospitalet, Copenhagen, Denmark. Lung Cancer is a frequent tumor in humans. Patients with Non-Small Cell Lung Cancer are often candidates for radical operation. Many patients will recur locally and/or with metastatic disease, indicating that classic staging procedures does not predict biological tumor behaviour sufficiently. Patients with Small Cell Lung Cancer (SCLC) are primarily treated with chemotherapy. Despite the apparent initial sensitivity of SCLC to chemotherapy, most patients recur indicating that clinical drug sensitivity is a relative phenomenon. Increasing understanding of molecular biology features in tumor cell as well as their interaction with "normal" cells have occurred. These features includes expression of oncogenes and growth factors, signal transduction, mechanisms of radiation and drug resistance. Several of these features will be presented and their possibly influence on clinical decision making will be discussed.

19

ADJUVANT TREATMENT OF RENAL CELL TUMORS

De Mulder PHM. Department of Medical Oncology, University Hospital Nijmegen, Nijmegen, The Netherlands

Renal cell carcinoma (RCC) accounts for 2-3 % of all adult cancers, its peak incidence is in the fifth and sixth decade of life and is only curable with surgery when the tumor is limited to the kidney or in a small proportion when microscopic nodal invasion is found. Approximately 25 % of the patients present with metastatic disease and another 50% will develop metastasis within one year after adequate local treatment, indicating residual microscopic tumor after surgery. The tumor is chemotherapy resistant in most cases and responses on hormonal treatment are rare. Relative best responses are seen with the treatment of biological response modifiers like interferons and more recently with interleukin-2. Well recognized characteristics of responding patients are the following: (1) good performance status; (2) limited tumor burden; (3) removal of the primary tumor; (4) pulmonary and nodal involvement only; (5) long duration (> 12-24 months) between primary surgery and the onset of metastases. A considerable group of patients meet at least three of the above mentioned good prognostic features and might therefore considered candidates for adjuvant treatment.

20

NON-HODGKIN'S LYMPHOMA - BEST TREATMENT IN 1993

F. Cavalli

One of the critical issues for any adjuvant treatment is adequate selection of patients after a standardized surgical procedure. For example the extent of nodal dissection is an unknown, however, considered relevant factor. Patients with pT1-2N0M0 disease do have a 5 year survival rate of 90-100% and should not be treated with adjuvant therapy. Patients with a pT3-4 tumor have a survival rate of 25-50% and in case of nodal involvement 10%. The preliminary results of the adjuvant study with interferon alpha (Delta P Gruppe, Germany) revealed the poor prognosis of patients with N+ disease, who showed a relapse in 80% of the patients within 30 months. No difference was found in the interferon treated group, however the number of patients with a significant high risk were under represented. Therefore a role for adjuvant treatment for the high risk (N+) group could not be detected in view of the low numbers and therefore the lack of discriminatory power. Adjuvant studies should be focussed on recognized high risk groups after standard surgical treatment enabling the estimation of the nodal status furthermore adequate numbers should be treated to reach sufficient statistical power. Recently such a study has been initiated applying subcutaneous Interleukin-2 as adjuvant immunotherapy.