Table 1. Patients' characteristics (and response to MFL)

Total no. of evaluable patients	31
Mean age in years	55, range 38–82
Oestrogen receptor content of primary tumour	
Positive	9
Negative	5
Unknown	17
Dominant site of metastasis	
Visceral (liver or lungs)	18
Bone exclusive	6
Soft tissue	7
Previous treatment for metastatic disease (response to MFL)	
None	2 (2 PR)
Radiotherapy and/or hormonal	9 (6 PR, 3 SD)
Chemotherapy (CMF) without anthracycline	11 (2 PR, 6 SD, 3 PD)
Anthracycline-based chemotherapy:	
Within 6 months before MFL	3 (3 PD)
More than 6 months before MFL	6 (4 SD, 2 PD)

CMF, cyclophosphamide, methotrexate, 5-fluorouracil; PR, partial response; SD, stable disease; PD, progressive disease; MFL, mitoxantrone, 5-fluorouracil, leucovorin.

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Recombinant Granulocyte Colony Stimulating Factor in the Treatment of Small Cell Lung Cancer: A Long-term Follow-up

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CELL LINES derived from solid tumours can show an enhanced proliferative response when grown in the presence of haemato-

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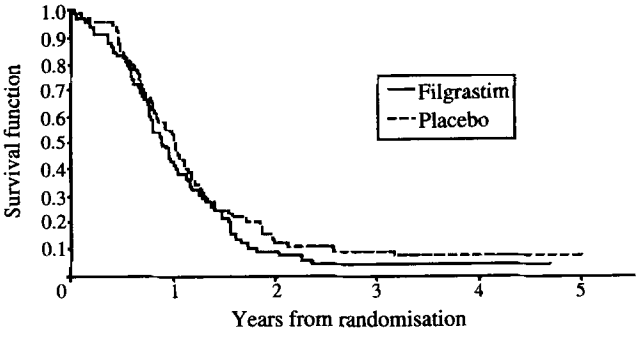

Figure 1. Overall survival.

poietic growth factors [1, 2]. This has suggested that the clinical use of such factors may result in tumour stimulation and reduced response to cytotoxic chemotherapy, and hence may adversely affect survival. A long-term follow-up has been completed on patients with small cell lung cancer (SCLC), who were randomised to receive either "r-metHuG-CSF" (Filgrastim) or placebo in a study which clearly showed that Filgrastim reduces the infectious complications of cytotoxic chemotherapy [3, 4].

Between June 1989 and April 1991, 130 patients were recruited from 13 European centres. As of 30 November 1994, disease progression and survival data were available for 129 patients (65 Filgrastim, 64 placebo). The patient that was not followed-up was randomised into the study, but received no study medication (Filgrastim or placebo) and was excluded from all study analyses. Time to disease progression was calculated by counting the number of days between the date of randomisation and first recorded date of disease progression or, in the absence of a disease progression, the date of death. The time to death was calculated as the number of days from randomisation to death. The Kaplan–Meier (KM) curves of the time to disease progression and the time to death were compared by using the log-rank test adjusting for country and disease stage (i.e. limited or extensive).

The median follow-up at this time is 1755 days (range 1306–1992). The KM median of the time to disease progression is 225 days for patients treated with Filgrastim and 198 days for patients treated with placebo ($P=0.81$). The proportion of patients surviving more than 2 years is 6/65 (9%) and 8/64 (13%) in the Filgrastim and placebo groups, respectively, and the KM median of the time to death is 323 days for patients treated with Filgrastim and 368 days for patients treated with placebo ($P=0.27$). The KM curves for the time to death are presented in Figure 1. These are the first long-term, controlled, follow-up data for SCLC patients treated with Filgrastim. In our previous publication [4], a significant but modest increase in chemotherapy dose intensity (less than 10% for all days) was noted in the Filgrastim group, and it was suggested that this increase would be insufficient to produce any enhanced antitumour effect. The data presented here support that conclusion. They also confirm preliminary conclusions derived from the original study, providing no support for the hypothesis that the use of Filgrastim in this patient population may result in tumour stimulation.

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Increasing Incidence of Cancer of the Sigmoid and Ascending Colon for Men in South-east Netherlands

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COLORECTAL CANCER is the third most prevalent cancer in Europe and its large geographical variation in incidence [1] is generally attributed to exogenous factors [2]. The uneven anatomical distribution of colorectal tumours [3] and the subsite-specific trends in incidence [4, 5] indicate that aetiological factors may not be similar throughout the large bowel. Since time trends may reflect changes in exposure to risk factors, we studied incidence patterns related to subsite, gender and age in the southeastern area of The Netherlands from 1975 to 1989, a period in which flexible endoscopy and sphincter-saving surgery for rectal cancer became more common.

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