509 POSTER

PREGNANCY AFTER SUCCESSFUL TREATMENT OF GESTATIONAL TROPHOBLASTIC DISEASE (GTD)

M. Malek, H. Raïs, A. Houidi, M. El May, H. Chelli, F. Ben Ayed
Institut Salah Azaiz (ISA), Tunis, Tunisie

Although GTD is uncommon, it is extremely important because of the high degree of curability with adapted treatment. It is becoming important to preserve young patients (pts) fertility. We reviewed the productive history of all pts who received chemotherapy (CT) for a GTD at ISA, between January 1982 and December 1993. Only 34 pts had subsequent pregnancies: 19 had molar pregnancies (MP) and 15 choriocarcinomas (CC). The mean age was 27 years (range 17–38). Pts with CC received a combined regimen of CT with Vincristin and Methotrexate 9 pts and Etoposide and Actinomycin 6 pts. All those with MP were treated by a CT associating (Methotrexate and Vincristin). All of them entered a complete remission, 7 after a salvage CT.

	MP n = 15	CC n = 19
Number of pregnancies	28	29
Normal term pregnancies	18	23
Spontaneous abortion	3	1
Ectopic pregnancy	0	1
Placenta Acreta	0	0
Premature birth	1	1
Congenital malformations	3	3

Conclusion: It is actually important to achieve 2 objectives in treating pts with GTD: first to cure them, second to preserve their fertility.

510 POSTER

A PHASE I STUDY OF PACLITAXEL (TAXOL®)(TXL) AND CARBOPLATIN (CBDCA) IN THE TREATMENT OF ADVANCED OVARIAN CANCER

C. Zamagni, A. Martoni, N. Cacciari, F. Pannuti
Medical Oncology Div. S. Orsola-Malpighi Hosp. Bologna, Italy

An open non-randomized dose finding pilot study was started to evaluate the MTD and the efficacy of the combination TXL-CBDCA. Previously chemotherapy untreated patients with stage III and IV ovarian cancer are eligible for the study. Three patients are required at each dose level and standard criteria are employed to define MTD. TXL is administered as 3-hour iv infusion, followed by CBDCA 30 minutes iv infusion. Premedication with corticosteroids and antihistamines is required. The first dose level was TXL 125 mg/m^2 and CBDCA 250 mg/m^2: the dose level progression is done by firstly increasing TXL (25 mg/m^2) and then CDBCA (50 mg/m^2). Up to now 9 pts entered the study and the 3rd dose level (TXL 150 mg/m^2; CBDCA 300 mg/m^2) has been completed, without reaching the MTD. Twenty-six courses have been administered (15 level I; 7 level II and 4 level III). Gr. 4 toxicities were not observed; gr. 3 alopecia occurred in all pts; gr. 3 neutropenia occurred in 36%, 20% and 50% of courses at dose level I, II and III respectively. No thrombocytopenia occurred. Gr. 2 vomiting was observed in 30% of courses. Advanced results of this study are planned to be available for ECCO 8 meeting.

511 POSTER

PACLITAXEL ± IFOSFAMIDE IN ADVANCED OVARIAN CANCER (A.O.C.). PRELIMINARY RESULTS OF A MULTICENTRIC PILOT STUDY

L. Miglietta, D. Amoroso, M. Bruzzone, C. Granetto, E. Catsafados, S. Mammoliti[1], D. Guarneri, F. Pedullà[2], G. Foglia[2], N. Ragni[2], F. Boccardo
Ist. Naz. Ricerca sul Cancro
[1]Galliera Hospital
[2]Department of Obstetrics and Gynecology, Univ. of Genova, Italy

Paclitaxel activity with or without ifosfamide was investigated as salvage therapy in patients (pts) with a.o.c. Group I (n = 20 evaluable) pts received taxol alone 175 mg/m^2, over 3 hours, every 3 weeks. Group II (n = 13 evaluable pts) received taxol 135 mg/m^2 as in Group I; escalating doses of ifosfamide (1; 1.5; 2 gr/m^2) was administered on days 2–3 with mesna rescue. In absence of severe toxicity, ifosfamide was administered at 2 gr/m^2 for the last three cycles. The average number of courses was respectively 4 in Group I (range 1–8) and 3 in Group II (range 1–6). Overall, 3 PR were observed in 15 pts with primary platinum resistant disease, 2 PR were observed in 8 pts with platinum sensitive disease while no response was observed in 10 pts with secondary platinum resistant ovarian cancer. Our results, although preliminary, suggest that taxol ± ifosfamide show a moderate but definite activity in so heavily pretreated category of pts. As expected the activity in platinum sensitive pts was twofold the activity achieved in platinum resistant pts, showing respectively 25% of PR vs 12% of PR. However, was to note that a 20% of activity was observed in primary platinum resistant pts. Moreover taxol plus ifosfamide association seems not to achieve better results than taxol alone, while it showed a higher haematologic toxicity. It is concluded that the number of previous therapeutic lines rather than the intrinsic sensitivity to cisplatin front line treatment is probably the major determinant of taxol activity when employed as salvage treatment.

512 POSTER

TAXOL (TAX) AND ESCALATING DOSES OF IFOSFAMIDE (IFO) IN ADVANCED BREAST AND OVARIAN CANCER PATIENTS (PTS)

A. Romanini, P.G. Giannessi, M. Conti, M. Da Prato, A. Tognoni, A. Gadducci, A. Fanucchi, P.F. Conte
Medical Oncology, Santa Chiara Hospital, Pisa, Italy

TAX and IFO are active drugs in antracycline and cisplatin (Pt) resistant breast and ovarian cancer. The objective of this study was to assess the MTD of IFO given in a 3-day c.i. preceded by a fixed dose of TAX (175 mg/m^2) in a day hospital setting. Thirteen women with ovarian (9) and breast (4) cancer with advanced disease, pretreated with two or more chemotherapy regimens entered this study. Median age was 57 (range 33–69). All pts had previously received epidoxorubicin at a median dose of 360 mg/m^2 (range 360–1260) alone or in combination with Pt or 5-fluorouracil and cyclophosphamide. All pts received a 3-hour infusion of a fixed dose of TAX through a central venous infuse port, followed by a 3-day c.i. of escalating doses of IFO (4-5-6-7 g/m^2) and equal doses of Mesna, every 21 days in subsequent groups of pts. G-CSF was given only for G4 neutropenia (N) lasting longer than 72 h or febrile G4 N. MTD was defined as follows: any G4 N lasting longer than 7 days or neutrophyls <100/mL for more than 72 h despite G-CSF, any G4 febrile N for more than 72 h, any G4 thrombocytopenia, any G3 non-hematologic toxicity, except for alopecia. Hematologic toxicity and related events were:

	IFO dose level (g/m^2)		
	4	5	6
no. of pts/no. of courses	6/32	6/17	2/2
median courses/pts (range)	5.5 (1–8)	2 (1–5)	1
leukopenia WHO G3/4 (% of courses)	16 (50)	7 (41)	ne
neutropenia WHO G3/4 (% of courses)	16 (50)	11 (65)	ne
anemia WHO G3 (% of courses)	1 (3)	4 (24)	ne
fever >38°C (% of courses)	1 (3)	3 (18)	ne
G-CSF vials/pts (% of courses)	14 (10)	35 (35)	ne
red cells transfusion (% of courses)	0 (0)	4 (24)	ne

No other non-hematologic toxicity except alopecia was seen.

Responses are as follows: 2 CR, 1 PR, 1 SD, 1 PD, 1 NE, among the pts treated at the first dose level; 1SD and 5 too early, at the second dose level. The MTD has not yet been reached, but the combination TAX + IFO has acceptable toxicity and activity.

513 POSTER

TRIAL OF ORAL HEXALEN FOR RELAPSED OVARIAN CARCINOMA [OV/CA]: COMPARISON OF CA125 AND EORTC RESPONSE DEFINITIONS

G.J.S. Rustin[1,2], S.M. Crawford[3], R.E. Coleman[4], J. Lambert[5], J.A. Ledermann[6], M. Soukop[7], S. Karp[8], R.H. Phillips[1], N. Habboubi[9], K. Meely[9]
[1]Middlesex & Charing Cross [2]Mount Vernon, [3]Airedale, [4]Western Park, [5]Hammersmith, [6]UCH & Middlesex, [7]Glasgow RI, and [8]Nth Middlesex Hospitals,
[9]USB Pharma, U.K.

Between 11/91 and 11/94 71 patients (pt) with recurrent ov ca were entered into a trial of oral Hexalen 260 mg/m^2 in divided doses daily for 14 days per month [mo]. Eligibility criteria included a treatment free interval of >6 mo, complete clinical remission and serum CA125 <35 u/ml with initial & up to one 2nd line chemotherapy. Response was evaluated according to EORTC criteria in 38 of the 57 eligible pts. PR was assessed according to CA125 in 45 pts & was predicted if after 2 samples there was a ≥50% fall confirmed by a 4th sample, or a serial fall over 3 samples >75% (Rustin G, Ann Oncol suppl 4, 71–77:1993). Toxicity was assessed according to NCI criteria & is available on 65 pts. 13 pts were withdrawn because of toxicity which was mainly nausea [G 2 or 3 in 25), vomiting [G 2 or 3 in 18] and tiredness [G 2 or 3 in 17].