518 PUBLICATION

WHOLE ABDOMINOPELVIC RADIOTHERAPY IN EPITHELIAL OVARIAN CANCER: A RETROSPECTIVE STUDY OF 48 PATIENTS

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Aim: To assess results and morbidity of whole abdominopelvic irradiation (WAI) in ovarian cancer.

Patients and methods: From January 1983 to December 1992 48 patients (pts.) with median age of 54.2 years, who presented epithelial ovarian cancer, were treated with WAI in our department. Patients were staged according to FIGO classification: stage I 9 pts., stage II 10 pts and stage III 29 pts. All pts. have had primary surgery; 41 out of 48 pts. have received chemotherapy (CT) and only 38 pts. have had second look laparotomy with debulking surgery in 18 pts. WAI consisted of whole abdominal dose of 22 Gy (at 1.6 Gy per fraction) and a total pelvic dose of 40 Gy; whereas the paraortic lymph nodes were boosted to a dose of 30 Gy. The series was divided in 3 groups: the first 22 pts. underwent macroscopically complete surgical resection at first laparotomy; in the second group 12 pts. had no residual disease after CT and or second surgical removal. Finally 14 pts. had histologically proven residual disease before radiation therapy.

Results: The median follow up was 48 months. For all pts, overall survival was 60.64% and overall survival in groups 1, 2 and 3 was respectively 81.14%, 62.86% and 28.57%. Six pts experienced small bowel complications requiring surgery.

Conclusions: High dose WAI is an effective treatment for patients with minimal residual disease with an acceptable complication rate.

519 PUBLICATION

TREATMENT OF PERITONEAL CARCINOSIS USING HYPERTHERMIC INTRAPERITONEAL PERFUSION

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The peritoneal surface is the second most common anatomical site for recurrence by gastrointestinal and ovarian cancer; 50% of all patients treated for gastric, ovarian or colo-rectal cancer present a "Peritoneal Carcinosis". 50% of patients with PC die without other metastases. Treatment of PC is controversial. Surgery is usually impractical because of its multiplicity and often microscopic size; systemic chemotherapy (CT) is inefficacious because cytotoxic agents do not penetrate into the peritoneal surface in good concentration; intra-peritoneal CT is inefficacious for the low penetration of drugs into the nodule of carcinosis (not more than 1–3 m) in normothermia. Since 1985 Fujimoto *et al.* showed that intraperitoneal hyperthermic perfusion (IPHP) combined with CT is effective in treatment of Peritoneal Carcinosis. We treat peritoneal carcinosis with Intraperitoneal Hyperthermic Perfusion with high doses of CDDP + MMC. Preliminary results in tern of toxicity and responses are impressive according to the data of the literature. The authors report their experience on this new treatment in a disease considered incurable up today.

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520 PUBLICATION

FIRST-LINE CHEMOTHERAPY WITH CARBOPLATIN, CISPLATIN AND CYCLOPHOSPHAMIDE (C.C.C) IN ADVANCED OVARIAN CANCER (AOC)

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The combination of C.C.C was delivered to 30 patients with AOC. Of these patients 24 had suboptimally debulked and 6 had optimally debulked tumors. C.C.C regimen was given as follows: Carboplatin 200 mg/m^2 d1, Cisplatin 60 mg/m^2 d2 and Cyclophosphamide 550 mg/m^2 d1, 2 q 4 weeks, for 6 cycles. Of 24 patients with sub-optimally debulked, measurable disease 23 (96%) had a clinical response, including 18 (75%) with clinical complete response (CR), of whom 15 underwent a second look laparotomy. Macroscopic CR was found in 10 (42%) patients of whom 6 (25%) had a pathologic CR. After a median follow-up duration of 16 months median survival is pending. For all 30 patients, grade IV leucopenia was noted in 50% and leucopenic fever in 23% of the patients. Grade IV thrombocytopenia was noted in 20%. No other grade III–IV toxicity was noted. There was no toxic death. 90–100% of planned dose was administered to 87% of pts, while 13% received 80–89% of the planned dose. C.C.C is active and safe in ovarian cancer.

521 PUBLICATION

OVARIAN CARCINOMA AFTER LONG-TERM OVULATION INDUCTION-REALITY OR COINCIDENCE?

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In September 1994 thirty-nine years old woman was admitted for lower right abdominal pain. During 1993/1994 there were 7 ovulation inductions with hMG/hCG followed by either artificial insemination of IVF-ET procedure, the last one in April. Complaints dated from that time. Lower right abdominal pain persisted and even worsened after treatment with antibiotics and hemotherapeutics. After preoperative evaluation adnexectomy was performed. Multilocular highly differentiated serous papillary cystadenocarcinoma was found, displaying moderate nuclear atypia and small areas of clear-cell differentiation, with foci of necrosis and stromal microinvasion. Elevated serum CA-125 levels at the time of operation slightly decreased four weeks after (from 145 IU/ml to 124 IU/ml). Serum concentrations of CA-125 were within normal range between 6^{th} to 8^{th} postoperative week. Nine weeks after operation, at the end of December, severe metrorrhagia occurred and curettage was performed. Histological evaluation of the obtained material showed papillary cystadenocarcinoma endometrioides endometrii G_1NG_1. Serum CA-125 were extremely elevated to the values of 1360 IU/ml. In January 1995 hysterectomy, adnexectomy and omentectomy were performed. There were no apparent metastatic features during the operative procedure. In order to assess current knowledge of the potential excess risk of ovarian carcinomas associated with ovulation induction, a Medline search of the literature was performed. It was confirmed that up to December 1994 there are eleven cases of ovarian malignancies after ovulation induction. Our patient is the twelfth one.

522 PUBLICATION

TREATMENT OF ADVANCED OVARIAN CANCER (AOC). FROM PLATINUM COMPOUND TO TAXOL: AN INDIAN EXPERIENCE

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From Jan. '91 patients with AOC have been treated with P (400 mg/m^2 Q 4 W × 6) and cyclophosphamide (C) (600 mg/m^2 Q 4 W × 6). Between Jan. '91–Oct. '94 19 patients with AOC (St. III c = 15, St IV = 4) median age 53 yrs (36–73) were treated with PC Protocol. 15/19 had primary debulking, of which 5 were suboptimal. 4/19 received PC primum only 1/4 subsequently had suboptimal interval debulking, 3 progressed on therapy. Median Progression free interval for the group is 8 mths (1–47 range). There was no neurotoxicity, nephrotoxicity, Myelosuppression was minimal (gr I–II). PC although standard and well tolerated treatment survival remains suboptimal. Taxol (T) has been identified as an active agent in salvage therapy in AOC. T is being indigenously manufactured in India (Inlaxel, Dabur India ltd.) and available for use since Nov. '94. We have treated so far 2 patients of AOC primarily with P (300 mg/m^2 Q 4 W × 6) and T (135 mg/m^2 escalated to 175 mg/m^2 Q 4 W × 6). T is given as 3 hrs infusion followed by 1 hr infusion of P with premedication. The toxicity of TP is acceptable in the above doses. No cardiotoxicity, nausea gr I–II, myelosuppression gr I–II, arthralgia and myalgia managable with mild analgesic and mild autonomic disturbances were observed. We intend to escalate further the dose of T till such point where myelosuppression is manageable without support of growth factors, the target being higher dose intensity for better survival advantage. The data will be updated till Sep. '95 & discussed.

523 PUBLICATION

TOLERABILITY OF PAGLITAXEL (TAXOL®) IN PLATINUM PRETREATED ADVANCED OVARIAN CANCER PATIENTS

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Forty-four pts entered this non-randomized phase II study. The pts were treated with TXL (3-hour iv infusion) 175 mg/m^2 as second- (n = 23) or third-line (n = 13) chemotherapy or with TXL 135 mg/m^2 as fourth-line chemotherapy (n = 8). Standard premedication was required. All the pts are evaluable for toxicity and 35 are evaluable for objective response. An objective remission was observed in 17 (16 PR + 1 CR)/34 evaluable pts (50%). The median TTP was 28 weeks. The hematological toxicity was mild: grade 3 leukopenia in 8/44 pts (18%); gr. 3 alopecia was universal. Gr. 2–3 paresthesias were observed in 20 pts (45%), while treatment-related pain (abdominal pain, arthralgia, myalgia) was