observed in 25 pts (57%). Hypersensitivity reactions occurred in 12 pts (27%); in 2 cases (4%) the reaction was severe (gr. 3 and 4). Partial bowel obstruction occurred within 30 days from TXL administration in 6 pts (14%): the relationship with chemotherapy was uncertain. Overall 8 pts (18%) stopped TXL treatment because of adverse events: 5 hypersensitivity reactions, gr. 3 paresthesias in one case, partial bowel obstruction in 2 cases. In our opinion pts with constipation or bowel subobstructive condition at the beginning of TXL treatment should be carefully selected and monitored.

524 PUBLICATION

CISPLATIN (C) + IFOSFAMIDE (I) FOR PATIENTS WITH OVARIAN CARCINOMA (O.C.) WITH PRIOR CARBOPLATIN (CBT) + CYCLOPHOSPHAMIDE (CTX) CHEMOTHERAPY

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Thirty patients (pts) aged 55 (45–68) 8/30 with refractory and 22/30 with recurrent O.C. received C:100 mg/m^2 day 1 and I: 5 g/m^2 over 3 days as second line therapy. Staging at first diagnosis was: stage III 24 cases, stage IV 4 cases. After primary surgery all pts were treated with CBT + CTX for six courses. Eight pts had early tumor recurrence within 6 months while 22/30 had tumor recurrence 1–2 years after first line chemotherapy. Objective response was achieved after 4 courses in 2/8 pts with resistant tumors (PRS of 4 and 6 mo duration) while 8/22 pts with tumor recurrence responded with 2 pathology CRS and 6 clinically and laboratory confirmed $\geqslant$ PRS. Time to progression was 8 mo (6–12) all pts expired within 16 months. Myelotoxicity was moderate because of GCSF or GM-CSF post chemotherapy administration. Neurotoxicity was moderate also except for one case with Grand-mal most probably due to (I). With a (33%) response rate C + I as second line is at least as effective as newer drugs. However, the major determinant of response to C + I was the progression free interval from first line chemotherapy. This interval may be an indicator for deciding Cisplatin Taxanes or both drug administration in recurrent O.C.

Paediatric oncology

525 SIOP Award lecture

THE CONSEQUENCES OF THE TREATMENT OF CHILDREN WITH CANCER. SUCCESS OR FAILURE/DO WE YET KNOW THE ANSWERS?

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Survival rates for children treated for cancer have continued to rise from the 1950's to the present day and for most diagnoses are now in excess of 50%, reaching 90% in some categories. These results have not been achieved without unwanted consequences which have long term implications for the health status of the survivors and health care costs for the community. Patients treated in the 1950's and 1960's demonstrate the long term effects of surgery and radiation therapy while more recently chemotherapeutic sequelae have increased in importance and frequency. The interaction of radiation and chemotherapy was poorly understood in the earlier decades but is now well documented.

As more intensive protocols are introduced using many different drugs it is likely that the long term survivors of the future will have as yet unrecognised complications. Even the survivors from the earlier years continue to develop new problems and need ongoing regular surveillance. The psychological problems associated with the diagnosis, long periods of intensive life threatening treatment and continuing uncertaintity of outcome add to the sequelae. A multidisciplinary approach to follow up is as necessary as it is in the initial treatment period. The optimum method of insuring that this monitoring is effective is still being evolved and requires repeated revision. Guidelines have been developed which require clinicians to check each patient on an individual basis and provide a simple method of regular review. If used systematically they should reduce the chance of missing as yet undescribed problems and allow these essentially healthy young adults to control and modify their own lifestyle.

526 ORAL

THE SIOP WILMS' TUMOR (WT) TREATMENT (TRT) STRATEGY AND RESULTS: A REPORT OF THE SIOP WILMS' TUMOR TRIAL AND STUDY COMMITTEE

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The advantage of a preoperative Trt, in non metastatic WT, in terms of surgical tumor rupture (< 5%) and chances for a favorable stage (stage I rate >50%), avoiding the need for rediotherapy (Rth) to cure, have been proven through the SIOP trials 1 and 5 and the optimal duration of a 4 weeks Actinomycin D + Vincristine (AV) preoperative chemotherapy (CT) has been established in SIOP 9. Lymphnodes invasion and unfavorable histology (UH), known to be of pronostic value and still determinable in preop-treated tumors, were considered in scheduling SIOP 6 and 9 postoperative Trt. Through randomized trials risk adapted treatment groups have been defined. Stage I: 1 post-op. and 2 maintenance AV courses are sufficient, 3-year disease free survival (DFS) = 85% and survival (S) = 95%. Stage II N0 non UH: no Rth needed, 3-drug CT using AV + Epirubicin (AVE), abdominal recurrence rate <4%, DFS = 84%, S = 92%. Stage IIN1 and III non UH: abdominal Rth and 3-drug AVE CT needed, DFS = 73%, S = 92% .Stage over I with UH: 4-drug CT using AVE + Ifosfamide DFS 49%.

527 ORAL

MOPP/ABVD AND RADIOTHERAPY IN THE TREATMENT OF PEDIATRIC HODGKIN'S DISEASE (HD)

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The aim of this paper is to assess: (1) results of combined approach (MOPP and/or ABVD and radiotherapy) in the treatment of HD in childhood and (2) factors proved to be prognostically significant. *Patients and methods:* During the period 1980–1984, 163 children aged 3 yrs–19 yrs (Me = 12 yrs) were treated for HD. There were 102 boys and 61 girls, in clinical stage I: 31 pts; II 88 pts; III 35 pts. and IV 9 pts. Histologically, the majority of children were diagnosed to have mixed cellularity (53) and nodular sclerosis (49). Mediastinal involvement was noticed in 58.5% pts and presence of systemic symptoms in 41.5%. All children received MOPP and/or ABVD and radiotherapy in "sandwich" regimen or after chemotherapy. Six cycles of chemotherapy where given in 106 pts, four in 45, and more than six cycles in 12 pts. Radiotherapy was applied on supervoltage units (TCT or Linear accelerator 10 MeV) using various techniques—the most often extended fields. *Results and conclusions:* During the follow up period from 1 yrs up to 15 yrs (Me = 8.1 yrs) overall survival rate is 96.5% and disease-free survival rate is 88.5%. In multivariate analysis, among 6 factors (age, sex, presence of systemic symptoms, bulky mediastinum, number of involved areas, hystologic subtype), advanced clinical stages and mediastinal involvement are deemed to be of the most importance for outcome. Based on these factors favourable and unfavourable subgroups are defined. Combined therapy (more or less intensive) should be designed according to subgroups. In pts with good prognosis (majority in our group) main goal is to decrease the risk of long-term treatment-related toxicity without