metastases from colon carcinoma (8 pts) and rectum carcinoma (14 pts) with the combination of continuous infusion of FUDR 0.20 mg/kg/day + LV 7.5 mg/m^2/day + 20 mg on days 1–14 and bolus MMC 10 mg/m^2 on day 1 via hepatic artery. Cycles were administered every four weeks. Patients characteristics were as follows: (M/F: 17/5), median age 61.5 years (range 43–75), median PS 0. 18 pts were pretreated with systematic chemotherapy including 5-FU + LV. Total number of cycles was 91 with a median of 6 cycles for patients (range 1–10). 16/22 pts are evaluable for response (6 pts are not evaluable: 3 too early and 3 died before the first clinical evaluation); 1 CR (in a pt pretreated with adjuvant chemotherapy), 9 PR (4 in pts pretreated with systemic chemotherapy for metastatic disease, 4 in pts pretreated with adjuvant chemotherapy and 1 in a chemotherapy-naive pt), 2 MR, 2 SD and 1 progression; the overall response rate is 62.50% (C.I. 35.4–84.8). Median time to progression is 6 months (range 2–15+). Overall median survival is 6 months (range 1–19+). 22/22 pts are evaluable for toxicity (WHO) as reported below:

	grade 1–2 N° (%)	grade 3–4 N° (%)
nausea/vomiting	9 (40.9)	1 (4)
diarrhea	13 (59)	5 (22.7)
bilirubin	1 (4)	1 (4)
AST-ALT	12 (54.5)	0
leukocytopenia	5 (22.7)	0
thrombocytopenia	1 (4)	3 (13.6)

The study continues to accrue pts to better define the response rate and the toxicity of this regimen.

712 POSTER

RESECTION OF NON COLORECTAL HEPATIC METASTASES: LONG TERM RESULTS

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The aim of this multicentric retrospective study was to evaluate survival after resection of non colorectal hepatic metastases (HM).

Patients and Methods—Between 1976 and 1990, 91 patients underwent resection of 60 synchronous and 31 metachronous non-colorectal and non-endocrine HM. The most common sites of the primary tumor (PT) were: stomach (n = 16), breast (n = 14), lung (n = 8) and exocrine pancreas (n = 7). The most common histopathologic types were adenocarcinoma (n = 42) and squamous cell carcinoma (n = 15). The surgical procedures were: 20 wedge resections and 71 radical hepatectomies.

Results—Resection was curative in 77% of the patients. Operative mortality was 1%. There were seven biliary fistulas and 11 septic complications. Half of the patients underwent adjuvant chemotherapy. Cumulative survival following curative resection was 54% at 1 year, 40% at 2 years, 32% at 3 years and 26% at 5 years. After palliative resection, survival was 33% at 1 year. Survival was not influenced by the time elapsed between resection of the PT and resection of the HM. There was no significant difference in survival between synchromous versus metachronous liver metastases, or according to the site of the PT. Wedge resection was as effective as lobectomy.

Conclusions. Surgical resection of HM in patients with PT other than colorectal cancer is advocated: postoperative morbidity and mortality are low; when resection is performed with curative intent, survival is similar to that obtained after resection of colorectal HM.

713 POSTER

REGIONAL CHEMOTHERAPY IN THE COMBINED TREATMENT OF RECTAL CANCER

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Patients with rectal cancer (RC) were administered preoperative selective intraarterial polychemotherapy (IASP) in the combined treatment for maximum devitalization of tumor tissue and better survival. 135 patients (pt) were stratified into three groups: (1) surgery alone—75 pt, (2) systemic polychemotherapy prior to surgery—eight pt, (3) surgery after IASP—52 pt. Preoperative systemic polychemotherapy did not improve 3-year survival compared to patients treated with surgery alone. Selective IASP respectively with subsequent surgery improved 3-year survival by 13.6% (from 59.4 + 3.8% to 73.0 + 5%, P 0.05). Thus, IASP resulted in a significantly better prognosis for patients with RC compared to surgery alone and in combination with preoperative systemic polychemotherapy.

714 POSTER

PROTRACTED 5-FLUOROURACIL INFUSION (5FU-PI) WITH WEEKLY LOW DOSES OF FOLINIC ACID (FA) IN METASTATIC COLON CANCER (MCC)

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A high response rate (RR = ±60%) has been reported in MCC with 5FU-PI (200 mg/m^2/day) modulated by weekly FA low doses (20 mg/m^2) (Leichman *et al.*, ASCO 1990). We used the same drug schedule in 8 consecutive patients with evolutive MCC (M/F 1:1; age: 61 ± 5 y; mainly liver metasases). A subcutaneous port system was implanted and 5FU was delivered with an ambulatory Pharmacia CADD-1 pump. Treatment was administered until progression or grade 3/4 toxicity. After the 1st 4-week cycle, 3 PD and 4SD were documented. 1 patient withdrew for intolerable GI toxicity. A mean of 3.25 courses (<1 to 6) was given. Only one patient had a documented PR after the 3rd cycle but relapsed within 2 months (RR = 12.5%). Survival was 11, 18, 18, 20, 25+, 31, 32, 60 weeks. All deaths were due to MCC. No complication occurred with the infusion system. We observed the following toxicity grades: Hematology gr0:8; Nausea grI:2; Stomatitis grI:1, grII:2; Diarrhea grII:1, grIII:1, grIV:1; Epistaxis grII:1; Hand-foot syndrome grI:1, grIII:1; Myalgia grI:1, grII:1. One patient had 1 episode of angina pectoris during treatment. The high RR as initially reported by Leichman could not be confirmed and this treatment was associated with significant non-hematological toxicities.

715 POSTER

FLUOROURACIL (5-FU) AND LEVO-FOLINIC ACID (LFA) IN ELDERLY PATIENTS WITH ADVANCED COLORECTAL CANCER: ACTIVE AND SAFE COMBINATION?

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In 36 patients (pts) (22 males, 14 females) older than 65 years (66–81, mean 72.5), P.S. 0–2, suffering from colon cancer with metastasis or inoperable relapses, systemic chemotherapy (CT) according with Machover (1986) scheme was administered. The schedule was: from day 1 to day 5: LFA 100 mg/sqm + 5-FU 370 mg/sqm. in bolus infusion, every 28 days. Metastatic sites were: 11 pts 1 site, 17 pts 2 sites, 8 pts 3 or more sites. The total number of cycles administered was 207 (mean 5.7, median 5).

Therapeutic results and toxicity (WHO, Cancer 1991: 47:207) were: 1 C.R., 5 P.R., 18 N.C., 12 P.D. (P.R. + C.R. = 15%). No life threatening toxicity were recorded: Nausea and vomiting G 3, 11 pts; Diarrhea G 3, 2 pts; G 2, 7 pts; Mucositis G 3, 4 pts; G 2, 3 pts; Leucopenia G 1, 1 pts; Hand foot syndrome, 3 pts.

Overall survival has been 11.6 months (4–23+), with a median of 9 months. The conclusion of this study must be resumed as follows:

(a) The combination of LFA and 5-FU in 5 days schedule is feasible in elderly pts;

(b) Mild toxicity has been recorded, no extreme grade toxicities were seen;

(c) The number of clinical responses seems to be lower than in younger pts (19% in our series);

(d) The real impact of this or different treatment in old patients must be investigated in larger series including different types of CT.

716 POSTER

OXALIPLATIN WITH HIGH-DOSE FOLINIC ACID AND 5-FLUOROURACIL 48 H INFUSION IN PRETREATED METASTATIC COLORECTAL CANCER (CRC)

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We report a phase II study in pretreated CRC. Regimen (FOLFOX2) was administered every two weeks. It consisted of oxaliplatin 100 mg/m^2 iv day 1; FA 500 mg/m^2 over 2 h, followed by 5FU 1.5–2 g/m^2 24 h CI days 1&2. Initial 5FU dose was 1.5 g/m^2 for two cycles and increased to