

Teaching lectures

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NO ABSTRACT

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FOLLOW-UP IN BREAST CANCER

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It is undeniable that an accurate follow-up supplies precise and detailed information about the modes and rapidity of development of metastasis, but it has not been clinically proven that follow-up examination effect the survival time. We can assume that early detection of cancer in the other breast or of a local recurrence can influence the prognosis, allowing a better rate of recovery in these two cases. However, there is no clinical evidence that early diagnosis of metastasis can influence the survival time. Thus clinical and mammographic examinations are a sufficient and necessary combination for the early diagnosis of local recurrences of the disease and for rehabilitation end full return of function, which periodic reassessment of performance status. The results of our randomised study (Jama, May 25, 1994) have confirmed that 6 monthly chest roentgenography and bone scan allow for early diagnosis of intrathoracic and bone metastasis, without influencing the 5 years-survival. It appears that recourse to diagnostic test only in the presence of symptoms is the most appropriate procedure for the follow-up of patients with breast cancer.

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OVARIAN CANCER—NEW INSIGHTS INTO SYSTEMIC THERAPY

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The introduction of paclitaxel (Taxol) to the treatment of ovarian cancer has encouraged discussion about its role in initial treatment programs. The Gynecologic Oncology Group showed in FIGO stage III and IV, sub-optimally debulked disease that paclitaxel (in 24 hours) with cisplatin is probably the most effective treatment. An EORTC confirmatory study with a different dose and schedule is underway. Combination of paclitaxel with carboplatin is feasible and appears an attractive alternative. The results of ongoing studies are necessary before a new "standard" is recommended.

Prognostic factors to predict response of recurrent disease are helpful in standard practice. Paclitaxel and etoposide orally can be considered for salvage in progressive disease while on platinum.

Efforts to identify other new drugs have been successful: docetaxel, gemcitabine, and topoisomerase-I inhibitors appear active.

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CLINICAL USE OF RADIOLABELED MONOCLONAL ANTIBODIES IN ONCOLOGY

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Since the beginning of radioimmunodetection (RAID), different monoclonal antibodies, isotopes and imaging procedures have yield different results in term of efficacy, generating controversy regarding its usefulness. However these past five years radiolabeled monoclonal antibodies (MoAb) have become a new and contributive class of imaging agents for the detection of site of the disease. RAID is now used in combination with computed tomography, magnetic resonance imaging in colorectal and ovarian cancers. Many other malignant tumor types have been targeted and imaged with radiolabeled MoAb in a large number of pilot

and multicenter trials. Studies in these tumors including melanoma, lung carcinoma, lymphomas and recently prostatic and breast carcinomas have not been contributive enough to be included in the primary modalities for imaging. Nevertheless, the technology of RAID which has proven to be safe and accurate is close to becoming a routine modality in the following situations: in the pretherapeutic staging of primary cancer, in the evaluation of the extent of the disease, in the detection of occult disease, in the monitoring of patient management. New targeting molecules and improved imaging procedure are already under investigation leading in more specific images. These innovative approaches are developed to increase tumor to nontumor ratio and may serve as a basis for more specific therapy as vectors for toxic agents.

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RADIO THERAPY IN THE TREATMENT OF EARLY BREAST CANCER

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Radiation Therapy (RT) plays an important role in early breast cancer, in conjunction with both conservative and radical surgery. This teaching lecture will address the following points:

1. RT's quantitative contribution to local control when used as an adjuvant to conservative or radical surgery.
2. The influence of systemic therapies on local control when used in conjunction with surgery and RT.
3. The impact of RT on cosmesis after conservative surgery.
4. The long-term morbidity of RT and the importance of technique.
5. The possible influence of RT on survival.
6. Future clinical research questions involving RT.

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THE TREATMENT OF LOCALIZED SOFT TISSUE SARCOMAS (STS)

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Successful treatment of a localized STS is based on the initial work-up: MRI excellently establishes localization of tumor, size, extension into surrounding structures and organs, pulmonary metastases can be ruled out with chest CT, bone metastases with bone scintigraphy, and tumor metabolism may be studied with PET. Enormous progress has been made in the histopathological classification of sarcomas through immunohistochemistry, electronmicroscopy, and cytogenetics. Based on the clinical staging the timing and type of surgical resection, eventually combined with multimodality therapies, is decided. Today's local recurrence rate after adequate resection +/- adjuvant 50-70 Gy radiotherapy is 15%. Primarily irresectable extremity soft tissue sarcoma may become resectable in almost 90% with isolated regional perfusion with TNF. Still 40% of the patients with grade III lesions develop pulmonary metastases and surgical excision of pulmonary metastases can cure 25% of the patients. Doxorubicin and ifosfamide are the most effective chemotherapeutic agents for metastasized STS. The local control rate of STS improved, but this was not reflected in an improved disease free survival. Therefore new phase III adjuvant chemotherapy studies with growth factors in operable STS are now conducted to improve disease-free and overall survival.