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European Journal of Cancer Vol. 32A, No. 5, pp. 900–901, 1996.

Printed in Great Britain
0959–8049/96 $15.00 + 0.00

S0959-8049(96)00007-X

Follow-up for Stage 1 Teratoma Surveillance Patients

F. Lander,[1] S. MacBride,[1] L. Samuel,[1] G. Howard[1] and M. Cornbleet[2]

[1]Department of Clinical Oncology, Western General Hospital; and [2]Marie Curie Centre, Fairmilehead, Edinburgh, U.K.

DR BRADA in his recent article, "Is There a Need to Follow-up Cancer Patients?" [1] raises important clinical and economic questions regarding future planning of oncology services. Testicular cancer was only briefly mentioned in the article. It is a disease which affects an important group of patients where follow-up is generally thought to be useful clinically. Not only is this disease curable with current therapies, but the development of tumour markers and CT scanning allows recurrent disease to be detected before it is clinically evident. Testicular cancer also affects a group of usually young and employed men, where extensive and time consuming follow-up is costly both to the patients and the Health Service. Is our current tradition of seeing a doctor on each consultation necessary?

We reviewed the management of 54 patients presenting to the Western General Hospital, between January 1986 and December 1990, with Stage 1 teratoma. Of these, 11 patients (20%) were considered to be high risk (greater than two out of four poor histological prognostic factors) and received adjuvant chemotherapy. 9 of the remaining 43 (21%) patients relapsed and received chemotherapy. The average age of these patients was 32 years, 7 months. Of those who relapsed, 82 and 18% did so within the first 6 months and 26 months, respectively (range, 1–26 months; median, 4 months; mean, 7 months 23 days). Relapse was detected by CT scan alone in 4 cases, CT scan and markers in 3 cases, and by markers alone in 2 cases. No cases were detected by clinical examination [2].

From this study, it could be concluded that, since no relapses were detected by clinical examination, follow-up consultations with doctors could be reduced. However, there is still the problem of psychological morbidity. Anxiety usually caused by the threat of recurrence, has been proven to be of clinical significance in a substantial proportion of patients [3–5] and 'reassurance' is considered to be an important function of these clinics. Follow-up visits have been recognised to generate anxiety [6] and result in a feeling of loss of control [7]. In a study of testicular cancer survivors and their relatives, Moynihan [8] found a high level of psychological morbidity, and the two high risk groups were those who were infertile or uncertain of their fertility and those who were unemployed. In a study by Tinkler and associates [9], assessing sexual function after orchidectomy and radiotherapy for testicular cancer, 24% felt disabled by their treatment and this appeared to be related to the presence of only one testicle. They recommended testicular implants.

The psychological effect of follow-up for these patients needs to be studied further, particularly as the clinical value is now questionable. With the answers to these questions, the non-clinical role of a Follow-up Clinic will be clearer and then decisions can be made as to whether or not changes can be made in the organisation of the clinic itself. We know from our initial study that doctors seldom, if ever, identify recurrence themselves. If patients were aware of this, but felt the doctor provided a role in 'reassurance' then a clinic visit is justifiable. However, if we only increase anxiety and alternative arrangements (i.e. regular contact by telephone, surveillance by a trained clinical nurse specialist), as suggested by Dr Brada [1], are considered more suitable and constructive by patients, this may then lead to an improved use of resources and service provided.

Correspondence to F. Lander at the Northern Centre for Cancer Treatment, Newcastle General Hospital, Westgate Road, Newcastle-Upon-Tyne, U.K.
Received 19 Oct. 1995; accepted 19 Dec. 1995.

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European Journal of Cancer Vol. 32A, No. 5, pp. 901–902, 1996.

Printed in Great Britain
0959–8049/96 $15.00 + 0.00

S0959-8049(96)00002-0

Single Agent Paclitaxel in Advanced Squamous Cell Head and Neck Carcinoma

V. Gebbia, A. Testa, G. Cannata and N. Gebbia

Service of Chemotherapy, Policlinico—via del Vespro No. 129, University of Palermo, 90127 Palermo, Italy

TREATMENT OF recurrent squamous cell carcinomas of the head and neck region (SCHNC) still represents a major challenge for both medical oncologists and radiotherapists. Most chemotherapeutic regimens currently employed include active drugs such as cisplatin, methotrexate, infusional 5-fluorouracil, bleomycin and vinca alkaloids [1, 2]. Recently, paclitaxel, a taxane diterpenoid, isolated and extracted from *Taxus Brevifolia*, has been successfully employed in the treatment of several human malignancies, notably ovarian carcinoma [3]. Initial trials have shown that paclitaxel's maximum tolerated dose depends on the extent of pretreatment, being as high as 250 mg/m^2 every 21 days in previously or minimally pretreated patients, and as low as 175 mg/m^2 in pretreated patients [3, 4]. Recently, Forastiere and associates [5–7] tested paclitaxel at a dose of 250 mg/m^2 as a 24-h continuous infusion, achieving a 40% overall response rate. These interesting results prompted us to test paclitaxel in advanced SCHNC.

With the aim of evaluating the clinical efficacy and toxicity profile of paclitaxel in the treatment of recurrent SCHNC, we carried out a phase II trial on a series of 21 patients. Before entry into the trial, all patients had to fulfil the following entry criteria: verbal informed consent, histologically confirmed diagnosis of recurrent and/or metastatic SCHNC, with the exception of nasopharyngeal origin; performance status according to Karnofsky Index >50; life-expectancy >2 months; absence of uncontrolled metabolic, cardiovascular, infective or renal diseases. Patients were thoroughly staged with physical and othorhinolarygology examination, chest X-ray, abdominal sonogram, CT scan of the head and neck, EKG, haemocromocytometric analysis and routine serum chemistry tests.

The treatment plan included paclitaxel 175 mg/m^2 given in 500 ml of normal saline as a 3-h infusion every 21 days. A premedication with dexamethasone 8 mg plus diphenhydramine 50 mg and ranitidine 50 mg were given intravenously 1 h before paclitaxel administration. Anti-emetic therapy was tropisetron 5 mg, i.v. bolus, 15 min before chemotherapy. Patients were re-staged after three full cycles of chemotherapy with physical examination, ORL examination, chest X-ray and CT scan as needed. Definition of response was based on the standard WHO criteria.

21 patients were treated. There were 19 males (90%) and two females (10%) with a mean age of 61.4 years (range 48–70 years) and a mean performance status according to Karnofsky index of 70 (range 60–90). Tumour sites were tongue (3 patients), oral cavity (6 patients), larynx (10 patients) and maxillary sinus (2 patients). All patients had previous surgery and/or radiotherapy and, at entry, had recurrent disease previously treated with chemotherapy. 15 patients had received neoadjuvant chemotherapy with cisplatin, continuous venous infusion 5-fluorouracil and i.v. bolus vinorelbine (2 patients). 7 patients had received chemotherapy for recurrent disease. One patient was lost to follow-up and so not evaluable. No complete response was seen. Partial tumour regression was recorded in 4 of the 20 evaluable patients (20%) with a mean duration of 4.5+ months (range 3.0+–7.5 months). 6 patients (30%) had stable disease and 10 progressed (50%). The treatment was very well tolerated by most patients with no severe allergic adverse events. Minor allergic reactions, such as skin rash, were noted in 2 cases. All patients experienced alopecia. Leucopenia was recorded in 13 cases (65%): grade 3 leucopenia was observed in 5 patients (25%). Grade 2 thrombocytopenia was seen in 4 cases (20%) and grade 3 thrombocytopenia in 1 case. Despite the pretreatment with cisplatin and 5-fluorouracil, neurotoxicity was not a major side-effect. However, grade 1–2 paresthesias were noted in 11 patients (55%) and grade 2 myalgias in 9 patients. Constipation was a complaint in several cases, but it was not possible to discern if this was due to paclitaxel or the antiemetic therapy. Nausea/vomiting was generally mild, with only 2 patients complaining of grade 3 vomiting.

In conclusion, paclitaxel, given as single agent at a dose of 175 mg/m^2, was well tolerated by most patients with recurrent SCHNC and can be safely given on an outpatient basis. The 20% overall response rate achieved here demonstrates that single agent paclitaxel is active in recurrent SCHNC. However, its degree of efficacy does not seem better than that reported for other drugs both in terms of objective response rate and duration of remission. These data are in accordance with those reported by Thornton and associates [7], where a 25% overall response rate in a series of 26 evaluable patients

Correspondence to V. Gebbia.
Received 15 Dec. 1995; accepted 2 Jan. 1996.