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**Letters to the Editor:
 Comments on *Palliative
 Endoscopic Therapy of Rectal
 Carcinoma, Dohmoto et al.,
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R. Glynne-Jones and P.J. Hoskin

Mount Vernon Hospital, Rickmansworth Road,
 Northwood, Middlesex HA6 2RN, U.K.

THE REVIEW "Palliative Endoscopic Therapy of Rectal Carcinoma" [1] suggests that radiotherapy is of little value in advanced recurrent or inoperable rectal carcinoma. The references quoted are some 10 years old and do not reflect current practice. At Mount Vernon Hospital, we have treated patients with synchronous chemoradiotherapy using high-dose irradiation incorporated with external beam and intraluminal high-dose rate afterloading treatment. This is based on the Bosset [2] regimen combining 5-FU 350 mg/m² and folinic acid 20 mg/m² daily for 5 days on the first and fifth week of a radiation schedule delivering 4500 cGy in 25 daily fractions over 5 weeks. This is followed by two intraluminal brachytherapy insertions delivering 600 cGy at 1 cm on the surface of a 2 cm diameter applicator placed within the anal canal and rectum.

7 consecutive patients who have received this schedule are evaluable with a minimum follow-up time of 6 months. These patients were all elderly (median age 83 years, range 54–87) with only one patient being under 75 years of age. 3 patients had adenocarcinoma of the rectum and 4 adenocarcinoma of the upper anal canal. Complete remission was achieved in all but 1 patient following treatment. The other patient remains in partial remission, but has progressive liver metastases. The median time to achieve complete remission was 12 weeks (range 10–24 weeks). Toxicity from this treatment is predominantly severe diarrhoea occurring in 5 patients with a median duration of 3 weeks (range 3–6 weeks), and moist desquamation seen in 2 patients, all of which have resolved spontaneously.

We conclude that this approach in advanced inoperable rectal carcinoma offers good long-term local control and may in some patients have achieved cure on longer follow-up. Whilst we concede that this involves some investment of

time and acute toxicity, the morbidity in this elderly age group has been acceptable.

1. Dohmoto M, Hünnerbein M, Schlag PM. Palliative endoscopic therapy of rectal carcinoma. *Eur J Cancer* 1996, **32A**, 25–29.
2. Bosset JF, Pavy JJ, Hamers HP, *et al.* Determination of the optimal dose of 5-fluorouracil when combined with low dose D, L-leucovorin and irradiation in rectal cancer: results of three consecutive phase II studies. *Eur J Cancer* 1993, **29A**, 1406–1419.

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J.-F. Bosset,¹ J.-J. Pavy,¹ V. Magnin,¹
 H.P. Hamers² and J.-C. Horiot³

¹Radiotherapy Department, CHU Jean Minjoz, Besançon, France; ²B. Verbeeten Institut, Tilburg, The Netherlands; and ³Centre G.F. Leclerc, Dijon, France

IN THEIR review "Palliative Endoscopic Therapy of Rectal Carcinoma", Dohmoto and associates [1] suggest that patients with rectal cancer should be divided into those who are fit for curative treatment with primary surgery and those who are not because of various reasons, including extensive local tumour infiltration, for which palliative procedures are only discussed. In this latter situation, there are indisputably some non-metastatic operable patients whose tumour which seems unresectable might be amenable to secondary curative resection after irradiation with or without chemotherapy.

The EORTC Radiotherapy Group conducted three consecutive phase II studies in order to determine the optimal dose of 5-fluorouracil (5-FU) in a radiochemotherapy-based treatment in locally rectal cancer [2]. Among the patients entered into the studies, 18 had a locally recurrent disease (LR) and 39 primarily locally advanced disease (PLA) without distant metastasis; all these patients were judged by surgeons to have extensive local infiltration that precluded curative resection. They received pelvic irradiation (45 Gy) combined with 5 FU/LV (leucovorin) chemotherapy delivered during week 1 and 5 of irradiation. In the LR group, 10 patients received an additional boost dose ranging from 9 to 30 Gy (mean 18 Gy) and 5 patients, in the PLA