Table 1. Patient characteristics (n = 10)

Sex	
Male	6
Female	4
Median age (years)	59 (35–73 years)
WHO performance status	1 (range 0–2)
Weight loss (%)	
Unknown	2
1–5	2
6–10	3
11–20	3
Extent of disease	
Metastatic	3
Locoregional and metastatic	7
Localisation of tumour sites	
Lymph nodes	11
Lungs	2
Liver	5
Other	1
Pretreatment	
Oesophageal resection	3

Treatment was discontinued because of progression ($n = 8$) or poor general performance status ($n = 2$).

No objective responses were seen. Two patients had stable disease for a duration of 2 and 10 months. All patients have died. The median survival was 8.8 months (range 3.6–14.9 months) after start of treatment.

In this study, no objective responses to the combination of cRA and IFN-α were seen (95% confidence interval: 0–31%). One patient experienced stabilisation of the disease for a period of 10 months. The toxicity of this regimen was mild. Recent clinical studies in squamous cell cancer of the skin and cervix have demonstrated greater antitumour activity of the combination of cRA and IFN-α, compared with either agent alone [4, 5], although two phase II studies in advanced non-small-cell lung cancer could not confirm these results: 2 PRs in 58 patients [6, 7]. Toma and colleagues reported on 2 patients with oesophageal cancer; both achieved complete remission after treatment with IFN-α 6×10^6 IU every day and cRA 1 mg/kg/day with a response duration of 8 and 36 months, respectively [8]. In our study, the IFN-α dose was 3×10^6 IU per day, and a second difference may be the stage of disease; 7 of our patients had bulky disease at the start of treatment with the primary tumour still *in situ*.

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Oral Tegafur and Folinic Acid for the Treatment of Advanced Colorectal Cancer

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TEGAFUR (TG) is a fluoropyrimidine precursor of 5-fluorouracil (5-FU). It is given orally for prolonged periods in divided doses to simulate a protracted continuous infusion of 5-FU. The activity of orally administered TG is similar to that of intravenous 5-FU in advanced colorectal cancer, with superimposable response and survival results as shown in several comparative trials [1, 2], but with the added advantage of oral administration, an important consideration to improve the quality of life of the patients receiving this palliative therapy. As for toxicity, it is also similar to that of continuous infusion 5-FU, with predominant digestive toxicity and minimal myelosuppression. Several phase II studies in advanced colorectal cancer have been reported [3, 4]. The most widely used schedule was TG 1 gr/m^2/day orally for 21 days every 4 weeks, although alternative schedules with different doses and duration have also been tested. 5-FU can be modulated by folinic acid (FA) with a higher response rate in colorectal carcinoma demonstrated in previous studies [5, 6]. Few studies of oral therapy with

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TG plus FA either high or low dose [7–10] have been reported.

In September 1991, a phase II trial of outpatient oral chemotherapy for patients with metastatic colorectal carcinoma was initiated. Chemotherapy consisted of: TG 1200 mg/day and FA 45 mg/day, in 3 oral daily fractions on days 1–21, every 28 days. Treatment was continued until progression or unacceptable toxicity.

36 patients were included in this study. Patient characteristics were as follows: Mean age at diagnosis was 62.4 years (range 34–75 years); 20 patients were male and 16 female; median Zubrod performance status was 1; location of disease: unresectable primary tumour 13%, locoregional relapse 47% and metastatic disease 50%; previous adjuvant chemotherapy had been given to 11% of patients. A total of 257 cycles of chemotherapy were administered (mean 7.1 cycles/patient).

Overall toxicity was moderate (grades III–IV WHO): nausea/vomiting 2.7% patients, mucositis 5.5%, diarrhoea 5.5%. Epigastric discomfort was experienced by 27.7%. There were no neutropenic fever episodes, red cell transfusion or toxic deaths. A 33% reduction of TG and FA dose was scheduled for patients with epigastric discomfort (12% of patients) and for diarrhoea in 15% of patients. Therapy was stopped in a patient for unacceptable epigastric discomfort.

The overall response rate was 15/36 (41.6%; 95% confidence interval, 25–57%): no complete responses, 15 partial responses, 11 had no changes and 10 had progressive disease. The median response duration was 8 months. The median survival time was 10 months, 1-year survival 45%, 2-year survival 17% and 4-year survival 5.7%. The median follow-up was 10.5 months (range 2–50) and the median time to progression 6 months.

It is remarkable that toxicity with this schedule of treatment was moderate, consisting mostly of gastrointestinal symptoms, mostly epigastric discomfort (27% of patients). This toxicity is comparable to that reported in other studies [7, 9, 10], even though a high incidence of epigastric discomfort has not been previously reported. This schedule shows a satisfactory response rate (41.5% RR). Survival is comparable to that of other palliative chemotherapy schedules in advanced colorectal cancer. Survival was significantly longer in responders than in non-responders (Mantel–Haenszel test: $Z = 3.01$, $P < 0.01$).

For the afore-mentioned reasons, it is concluded that this schedule of outpatient oral therapy with TG and FA is moderately effective in palliation for advanced colorectal cancer patients with mild toxicity. Response and survival are comparable to those reported with standard intravenous chemotherapy.

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Sjögren's Syndrome and Multiple Myeloma

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SJÖGREN SYNDROME (SS) is an autoimmune disease characterised by the presence of at least two of the following: keratoconjunctivitis sicca, xerostomia and any one of the autoimmune diseases such as rheumatoid arthritis, systemic lupus erythematosus, scleroderma and primary biliar cirrhosis. B-cell lymphoma is an occasional complication of SS, macroglobulinaemia develops in some patients [4]. Most of the reported monoclonal gammopathies in Caucasian patients with SS involve the IgM class [5]. Non-IgM monoclonal gammopathies in patients with SS is infrequent. Here we describe a Spanish patient with SS associated with multiple myeloma.

A 65-year-old woman was admitted to our hospital for xerostomia and xeropthalmia. Examination revealed keratoconjunctivitis sicca by the Schirmer-I-test (bilateral eyes: 1

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