distinctive entities. Further prognostic discrimination could be obtained by application of the International Prognostic Index to most of the clinico-pathologic entities defined by the REAL classification

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Biology and treatment of primary gastric lymphoma

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Most primary low-grade gastric lymphoma (NHL) recapitulate the histopathologic features of mucosa-associated lymphoid tissue (MALT). Therefore they often are called MALT-lymphoma, although this type of NHL does also occur in several other extranodal organs. NHL of MALT type do transform to high-grade NHL, the latter showing both components in about 33%..

Primary gastric lymphoma is a localised disease compared to nodal NHL with 75% being in stage I and II_1 though high grades have a higher tendency for a wider spread and per continuitatem growth into neighbouring organs.

There is a small predominance for the male gender. Clinical symptoms are uncharacteristic. History in low grades is longer than in low grades.

Discussion on the right treatment is still going on, though in the last years authors seem to favour a conservative organ conserving approach, which is backed by preliminary data from a prospective study, which demonstrates no advantage for stomach resection.

A completely new approach in the treatment of gastric NHL was triggered by data showing that Helicobacter pylori (H.p.) is a stimulus for the growth of low grade NHL. In prospective studies complete remissions of lymphomas after eradication of H.p. have been published, though it is to early to evaluate duration of these CRs.

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The management of non-Hodgkin's lymphomas ANNO 1997

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An overview will be given on the possibilities and limitations in the current treatment of non-Hodgkin's Lymphomas (NHL) of both low and intermediate/high grade malignancy. Although 50–60% of patients presenting with limited stages of low grade malignant NHL can be cured with involved field radiotherapy, no significant advances have been made in the treatment of patients presenting with advanced disease. In other words, for this special category of patients it has appeared to be impossible to change the natural biology during the past 30 years. However, new perspectives in the treatment of these indolent NHL's will be discussed (interferon, purine analogs, stem cell transplantation).

For the intermediate/high grade malignant NHL's CHOP chemotherapy still remains the standard treatment. At present, prognostic factor tailored treatments are being evaluated in prospective randomized phase III clinical trials. An overview will be given on the current state of affairs, ranging from intensified conventional chemotherapy to marrow-ablative treatment in selected poor risk groups.

Finally, realistic options for the treatment of relapsing patients will be indicated for the various disease categories.

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Role of high-dose chemotherapy and autologous bone marrow transplantation in the treatment of lymphoma

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• The selection of bad prognosis groups is mandatory if BMT is considered in first CR. It is now widely accepted that candidates for prospective studies can be defined as patients less than 55 years old at diagnosis, with at least 2 extranodal localisations or a tumour of at least 10 cm at diagnosis, with a bad Karnofsky score (<70%) or with bone marrow or CNS disease at initial presentation. This group is reported to have an expected survival with conventional regimen of 55% at 3 years. Only prospective and ramdomised studies are acceptable in this field.

• There is no indication for ABMT in primary refractory patients except in prospective experimental studies.

• Partial responders to first-line induction therapy are chemo-sensitive high-risk patients. This is probably the best indication for BMT in NHL.

Pilot studies with ABMT were able to report 71% disease free survival at 90 months, all with proven active lymphomas at time of BMT. These preliminary results should be confirmed, but BMT can be strongly recommended in 1991 for these patients if a biopsy shows active lymphomas after 4 courses of a conventional induction regimen.

• Patients who previously reached CR1 on conventional therapy and then relapsed, and who are not responding to conventional rescue protocols are calls *resistant relapses*. BMT is probably the only chance of cure and can be highly recommended.

Patients who previously reached CR1 on conventional therapy and then relapsed and who are still responding to conventional rescue protocols are called *sensitive relapses*.

A randomised study had shown that BMT is mandatory in theses cases.

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The role of the palliative care specialist. Controversies and definitions

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More than 60% of cancer patients are incurable. Problems of communications, physical and emotional symptoms control, environment and ethical issues are important in the process of dying. Palliative care specialists, with a team of caregivers should offer to those patients a compassionate and a professional help in which the medical role is only 50% of the entire care.

The oncologist professional is mainly bound to the clinical approach and require in several instances an integration with a PC specialist. Such experts may work in a symptom control team or in a special in-out patient unit. A number of university chairs on PC in UK, in USA and in other countries are growing, facing the need of a new approach on the care of cancer and other incurable disease.

WHO recommendations, reports of prestigious medical journals are stressing such needs in view of the fact that hospital death, assisted suicide and euthanasia are presently highly debated.

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Helplessness reduction in a palliative care unit (PCU)

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Introduction: Due to the nature and uncontrollability of the illness and treatment side-effects, cancer elicits different levels of helplessness in medical staff working in PCUs.

Purpose: 1. Identify situations that give rise to staff helplessness in PCUs. 2. Describe behavioral manifestations of staff helplessness. 3. Provide behavioral interventions to reduce staff helplessness. 4. Provide guidelines to prevent the development of staff helplessness in PCUs.

Method: Effective consultation to staff members of PCUs in the context of learned helplessness theory will be reviewed, emphasizing the integration of behavioral medicine principles in the training of medical staff. Participation of symposium attendees may be requested.

Conclusion: The PCU constitutes a setting in which death and lack of control over patient care and survival are experienced on a daily basis. Therefore, identifying and controlling helplessness reactions of medical staff members have important clinical implications and will improve patient care and staff wellbeing significantly.

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No abstract

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How should we assess alternative medicine?

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The term alternative medicine (AM) embraces a variety of therapies that can be sub-divided into two board groups – physical and psychological. Physical therapies include diet, vitamins, herbal remedies and homeopathy, immune stimulants and acupuncture. Psychological methods include meditation, hypnotherapy, relaxation therapy and visualisation. Assessment of the value of AT alone or as a complement to conventional treatment (CT) is complicated. Furthermore the majority of patients using AM use several methods at the same time. Conventional methods of assessing medical