1237 PUBLICATION

Surgical treatment of lymph node metastases of papillary thyroid carcinoma – Possible prognostic value

R. Džodić, S. Maksimović, I. Marković, M. Inić, M. Prekajski, M. Kocić, M. Juskić, M. Durbaba, D. Gavrilović, M. Oprić. *Institute for Oncology and Radiology of Serbia, Belgrade, Yugoslavia*

Purpose: Lymph node metastases of PTC are frequent (>70%). Their prognostic importance, as well as value of the extent of surgery are controversial. The aim of this study was to analyse survival rate according to prognostic factors, prognostic value of lymph-node metastases of PTC and possible impact of surgery.

Methods: From January 1981, to January 1997, there was 148 patients surgically treated due to PTC. Total Thyroidectomy (TT) was undertaken in 140 patients – [111 TT + dissection of the central and lower jugular lymph nodes for frozen-section hystopathology; of these 80 (72.1%) patients with metastases in lower jugular lymph nodes, were treated with Modified Radical Neck Dissection (MRND) in the same act]. Palliative and diagnostic surgery of advanced forms PTC in 8 cases. Age: 43.71 ± 15.03 with Median 43 and Rang (7–80). Sex ratio: F/M – 3.1/1. Survival analysis: Kaplan-Meier, Log Rank, Wilcoxon test.

Results: Overall survival rate in this group during the 183 months follow-up reaches 84.15%. We found age over 45 (p-1.21 × 10^{-6}), tumor size over 40 mm (p-0.014), as well as extracapsular involvement (p-0.01) and distant metastases (p-4.72 × 10^{-11}), as bad prognostic factors. According to this data we found no significant difference in 15 years survival rate comparing presence or absence of lymph node metastases, either in central or jugulocarotid regions.

Conclusion: Preoperative diagnostic of lymph node metastases of PTC (frozen section) is important for adequate surgery and could have same impact on prognosis.

Pancreatic and gastric cancer

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Positron emission tomography (PET): Diagnostic benefit in pancreatic tumors?

L. Staib[1], C.G. Diederichs[2], S.N. Reske[2], H.G. Beger[1]. [1]*Dpt. of Surgery;* [2]*Dpt. of Nuclear Medicine, Univ. Ulm, 89075 Ulm, Germany*

Purpose: In patients with tumors of the pancreatic head, distinction between inflammation and malignancy can be tricky since even modern imaging techniques often are contradictive in preoperative evaluation, and since clinical symptoms can be misleading.

Methods: We compared the diagnostic value of preoperative FDG-PET in 159 patients with pancreatic tumors, such as pancreatic malignancies (n = 89), pancreatitis (n = 48) and benign pancreatic tumors (n = 22) with ERCP and CT. After translation of the original reports into a five point malignancy scale (no, probably not, indeterminate/technic. unsuccessful, probable, definite tumor), results were compared using ROC analysis.

Results: The diagnostic values (area under ROC curve) were 0.93 (ERCP), 0.86 (PET), and 0.82 (CT). Most false PET results were associated with elevated fasting glucose levels (false negative) or acute bouts of chronic pancreatitis (false positive). If patients with fasting glucose levels ≥130 mg/dl (n = 16) or ≥3-fold elevated inflammation blood chemistry index (n = 17) were excluded from evaluation, the ROC areas for the remainders (n = 126) were 0.94 (PET), 0.94* (ERCP), and 0.84 (CT). The diagnostic combination revealed 0.98* (ERCP+PET), and 0.94 (ERCP+CT) and 0.94 (PET+CT), respectively (*p < 0.02). Time to surgery was not prolonged by PET procedure. False positive metastases were seen in 9%. Surgically relevant questions, such as local resectability of the tumor or mesenteric/portal vascular infiltration were not answered by PET but by cellacography. PET was in 65% of cases of diagnostic value (additional or diagnosis confirming information), and in 5% misleading, seen retrospectively.

Conclusion: There is a diagnostic benefit of PET in preselected patients and in combination with ERCP, but PET is unlikely to influence the rate of negative laparotomies in unresectable pancreatic tumors.

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Radiotherapy and 5-FU after curative resection for the cancer of the pancreas and peri-ampullary region: A phase III trial of the EORTC GITCCG

J.H.G. Klinkenbijl, T. Sahmoud, R. van Pel, M.L. Couvreur, C.H.N. Veenhof, J.P. Arnaud, A. Hennipman, J. Wils, J. Jeekel. *Rijnstate Hospital, Arnhem, The Netherlands*

Purpose: To investigate the survival benefit of radiotherapy (2 × 20 Gy, split course) and 5-FU (Trt) as compared to surgery alone (Obs).

Methods: Eligible patients with T_{1-2} N_{0-1a} M_0 pancreatic head or T_{1-3} N_{0-1a} M_0 peri-ampullary cancer, histologically proven adenocarcinoma and WHO performance status ≤2 were randomized after a curative resection. Patients were stratified by institution and tumor localization.

Results: Between 9/87 and 4/95, 218 patients were randomized, 108 pts on Obs and 110 on Trt and 18 pts were ineligible (10 Obs and 8 Trt). Baseline characteristics were comparable between the two groups. One hundered and nineteen pts (55%) had pancreatic head cancer (61 on Obs and 58 on Trt). In the Trt arm 22 pts (22%) did not receive any treatment because of post-operative complications and patient refusal. Based on the 80 eligible pts for whom the treatment started, 74 received 40 Gy and the median dose of 5-FU was 90% of the maximum theoretical dose. Only minor toxicity was observed. The median duration of survival was 19.1 months on Obs and 23.5 months on Trt (logrank P = 0.216). The two year survival estimates were 42% (95% CI: 32–52%) and 50% (95% CI: 40–60%) on Obs and Trt, respectively. The results were not changed when stratifying for tumor location.

Conclusion: Adjuvant radiotherapy in combination with 5-FU is well tolerated. Nevertheless, this was not accompanied by a clear survival benefit.

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Activity and tolerability of gemcitabine plus cisplatin in advanced metastatic pancreatic carcinoma

V. Heinemann[1], H. Wilke, K. Possinger, K. Mergenthaler, M. Clemens, H.J. König, H.J. Illiger, A. Lackhoff, J. Blatter, A. Schallhorn, U. Fink[2]. [1]*Klinikum Grosshadern, München;* [2]*Technische Universität, München, Germany*

Purpose: Single-agent GEMZAR® (Gemcitabine HCl) has been shown to produce statistically significant Clinical Benefit, survival and time to disease progression, when compared with 5-FU in a randomized trial in patients (pts) with locally advanced and metastatic pancreatic cancer (Proc Am Soc Clin Oncol 1996, 15, 506, abstr 1624).

Methods: We report the preliminary results of an ongoing study, using the combination of gemcitabine 1000 mg/m^2 given as a 30 min infusion on days 1, 8, 15 of a 28 day schedule, and cisplatin 50 mg/m^2 on days 1 and 15 in chemonaive pts with bidimensionally measurable advanced adenocarcinoma of the exocrine pancreas.

Results: 41 pts (16 F, 25 M; median age 53.9 years) were enrolled. Median Karnofsky performance status was 80% (range 60–100%). 6 pts had locally advanced unresectable tumours with regional nodal metastases: 35 pts had metastatic disease. The median number of cycles administered was 4.2 (range 1–11). Therapy was mostly well tolerated on an outpatient basis. Grade 3 and 4 toxicity was as follows: neutropenia in 19/0% (of cycles), thrombocytopenia in 21/9.7%, haemoglobin 14.6/0%, nausea/vomiting in 12.1/2.4%, alopecia in 2.4/0%. Of 37 evaluable pts (4 pts not evaluable having received <1 cycle) there was 1 CR and 2 PRs (8.1%, 95% CI 15–35%), and 18 pts with stable disease (48.6%). Also, 1 patient had a CR but was lost to follow-up and this CR could not be confirmed. 7 additional pts had tumour reductions but did not have bidimensionally measurable disease and were not evaluable. Responses occurred after 4–6 cycles. Median survival is currently 8.6 months.

Conclusions: The combination of gemcitabine and cisplatin is active and well tolerated in pts with advanced and metastatic pancreas cancer.

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Microsatellite instability in gastric cancer

H.-Ch. Wirtz[1], W. Müller[1], T. Noguchi[1], M. Scheven[1], J. Rüschoff[2], H.E. Gabbert[1]. [1]*Dept. of Pathology Univ. of Düsseldorf;* [2]*Dept. of Pathology Univ. of Regensburg, Germany*

Purpose: The frequency of microsatellite instability (MI) and its association