apy and cisplatin (believed to be a radiosensitizing agent) is controversial. Improved local control and survival from adding this compound to radiation has been demonstrated in one study, but at least two others studies were negative. The interpretation of many studies is difficult due to small patient samples and methodological flaws. It may be concluded therefore that chemotherapy may have a role as an adjunct to radiation in locally advanced NSCLC, but the gain from this approach should be weighted against increased early and late toxicity. Moreover, improvement of similar magnitude has been achieved with the use of modified radiotherapy techniques (hyperfractionation, CHART). A possible benefit from combined modality treatment should therefore be confirmed in further research.

1292

Non-small cell lung cancer: How extensive should surgery be?

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Objective: Surgery is the treatment of choice in stage I and II bronchial carcinoma (BC). In stage III with extrapulmonal structures/organs involved, however, operative treatment is discussed controversially. Involvement of peripheral and mediastinal structures requires extensive interventions, e.g. mediastinal lymph node dissection and/or broncho- and angioplastic procedures.

Material and Methods: 6907 patients with BC, admitted to our institution between 1984 and 1994, were analysed. 2464 patients (36%) were resected.

Results: R_0-resection was achieved in 1996 patients, including 454 cases of BC stage IIIA, and 323 cases of BC stage IIIB. R_0-resection rates were 81% and 58%, respectively. 5-yr-survival was 26% in stage IIIA and 19% in IIIB. 5-yr-survival rates vary in correlation to spread of lymph node metastases, in case of stage IIIA between 39% and 14%. Stage IIIB collectives showed 5-yr-survival rates between 24% and 14%, respectively. Mediastinal lymph node involvement, therefore, appears to be a relevant prognostic factor. 30-day-mortality for all R_0-resected stage III tumours was 9%.

Conclusions: Surgery in BC stage III offers potential cure after complete resection. Adequate surgical management necessarily encompasses technically complicated procedures. A close interdisciplinary cooperation is required.

1293

New drugs and their possible impact on patient outcome

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CPT-11 is a semi-synthetic water soluble derivative of camptothecin. It is administered at the dose of 350 mg/sqm every 3 weeks (wks). Overall 455 patients (pts) have been treated in phase II studies. The response rate (RR) was 12.9%, stable disease (SD) 42%. Overall median survival (ms) was 9 months (mts), 14.5 for partial (P) R and 12.5 for SD. 61% of pts with PR or SD had pain relief attributable to CPT-11. Toxicity include short lasting neutropenia, early and delayed diarrhea (dd), nausea (n), vomiting (v), hair loss, fatigue. dd was significantly reduced with prompt administration of loperamide and antibiotics starting after 24 hrs if dd was not resolved.

Tomudex is a specific TS inhibitor administered at the dose of 3 mg/sqm every 3 wks. Compared to 5FU/folinic acid (FA) regimen in 3 large randomised studies, RR and toxicities were comparable. Improved PS and weight gain was demonstrated in both arms. Overall ms was comparable in 2 trials and superior for 5FU/FA in one.

Oxaliplatin is a non-nephrotoxic third generation platinum complex. It is given at the dose of 130 mg/sqm over 2 hrs in 5% glucose every 3 wks. Dose-limiting toxicity is a peripheral dysesthesia aggravated by cold. It has been investigated, mainly, in combination with continuous infusion of 5FU. RR of 50% to 28% have been reported for 1st and 2nd line treatment respectively. ms was 16 and 12 mts. 20 to 30% of pts with liver and lung metastases could be reoperated with a curative aim. New agents with various mechanism of action provide reason for optimism regarding the management of pts with advanced disease.

1294

Intense local therapy in resectable rectal cancer

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Purpose: To describe methodology and results in rectal cancer combining preoperative chemoradiation, radical surgical resection and intraoperative electron irradiation (IORT).

Methods & Materials: From 8/95 to 6/96 76 patients with localized rectal cancer were treated with preoperative irradiation (40–50 Gy), simultaneous 5FU iv ci (500–1000 mg/m2) +/– CBDCA 55 mg iv, d 1–4/21–24 of radiotherapy. Radical surgery was performed 4–6 weeks after the completion of the neoadjuvant segment. IORT electron boost was added to the presacral space (10–15 Gy) after tumor resection. Adjuvant chemotherapy using 5FU-LV was recommended to patients with B2-C tumor downstage. Pretreatment clinical findings showed: mobile disease (9%), tethered (49%) and fixation (42%).

Results: Tolerance to the treatment program was acceptable. Pathologic tumor downstaging identifed 25% of pT_0/pTmic surgical specimens. With a median follow-up of 24 months (range +3 to +99 months) patterns of tumor progresion has shown 1 mixed recurrence (anastomotic site + lung) and 9 systemic failures. Actuarial cause specific survival is projected 72% at 8 years.

Conclusion: Intense local therapy is feasible in resectable rectal cancer patients in the context of an expert group in IORT and chemoradiation. Pelvic failure has been eradicated (presacral IORT boosted region). Tolerance to the integral treatment intensity was acceptable. Up dated results to May 97 will be presented.

1295

Frontiers in the management of colorectal cancer – Combined modality treatment

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Even after apparently curative surgery for colorectal cancer, microscopic deposits are frequently left. These deposits, each containing between 10^6–10^8 cells may be eradicated by radiotherapy, chemotherapy or immunotherapy resulting in improved disease-free and overall survival. Radiotherapy is the most effective modality, potentially killing 10^6–10^8 cells if the doses are sufficiently high but is limited to a region such as the pelvic cavity in rectal cancer. Preoperative radiotherapy, being more dose-efficient than postoperative, has also reduced local failure rates and improved survival. Chemotherapy has limited cell kill effects, but has yet improved survival to a limited but clinically relevant extent in colon Dukes' C. The relative benefits may be as large also in Dukes' stage, but the absolute gains are then much less due to fewer recurrences and the routine use of the additional treatment is then questionable. Both radiotherapy and chemotherapy may have acute and late adverse effects. Inappropriate techniques, such as used in certain radiotherapy trials, have also caused both acute and late effects, at least partly counterbalancing the positive effects. Each modality must be used in an optimized way. This also relates to the surgery. If the surgical techniques are optimized, such as they could be in rectal cancer, the relative gains by for example preoperative radiotherapy may not change, or they may even increase, but the absolute gains, and thus cost-effectiveness, may decrease. A review of recent results from controlled clinical trials will be made and directions for future improvements in outcome presented.

1296

To 5-FU or not to 5-FU? When, how and why to use the new active agents in advanced colorectal cancer

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Patient characteristics, disease history and pretreatment characteristics should be determinant in the choice of systemic treatment in ACRC. The availability of modern imaging and reliable markers should be fully exploited now that a surge in surgical enthusiasm and molecular pharmacology tumor markers: p53, thymidilate synthase, mismatch repair defects, ADCC presence are put forward as putative natural history and treatment dependant pronostic factors. New thymidilate synthase active drugs, CPT-11 and Oxaliplatin have proven viable alternatives to 5-FU. The current prevalence of previous adjuvant treatment in metastatic disease populations and the simultaneous availability of new active agents are opportunities not to

miss. Recent data from our experience with the active CPT-11/oxaliplatin combination will be presented, as well as published or ongoing results of CPT-11/5-FU combinations and oxaliplatin/5-FU combinations. We are now in colorectal cancer treatment exactly where we were twenty years ago with breast cancer. We should not repeat time wasting errors, and try to take the opportunities without waiting for metanalysis or consensus decisions making.

1297

Adjuvant therapy: how effective, and for which patients? A meta- analysis

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Chemotherapy can improve survival in colorectal cancer. To help define the size of benefit achievable for different types of patient, and the optimal chemotherapy regimen, a meta-analysis of all randomised trials comparing chemotherapy with surgery alone was undertaken. Individual patient data from a systematic overview of studies starting before 1987, was supplemented by published data from more recent studies. Almost all chemotherapy regimens tested involved 5-fluorouracil (5-FU), with or without other drugs. The 50 studies, involving 18,000 patients, were divided into broad groups based on pharmacokinetic considerations. As anticipated, short bolus chemotherapy regimens appeared the least effective. But, when 5-FU was given as a one-week continuous infusion through the portal vein the annual death rate was reduced by 14%SD5 ($p = 0.006$). Considering all prolonged systemic chemotherapy regimens together, the death rate was reduced by 11%SD3 ($p = 0.001$). However, the benefits seen in studies of 5-FU biomodulated by folinic acid (29%SD9: $p = 0.0007$) or by levamisole (22%SD9; $p = 0.01$) were significantly larger than in studies testing unmodulated 5-FU regimens (6%SD4; $p = 0.11$). There remain unanswered questions about who should be treated as most trials of 5-FU/folinic acid included only colon cancer patients and most of the benefit seen in them was among Dukes stage C (N+) patients. It seems reasonable to extrapolate from colon to rectal cancer as in the earlier trials of unmodulated 5-FU the benefits appeared similar for rectal and colon cancer. But, for stage B (N−) patients worthwhile benefit is not yet firmly established and more randomised evidence is needed.

1298

Laparoscopic surgery for colorectal cancer – Is it safe?

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Laparoscopic surgery for colorectal cancer is one of the most controversial applications of the new wave of endoscopic procedures for digestive diseases. The principal concerns revolve around the adequacy of margins of excision and the development of unusual patterns of recurrence such as port site recurrences. Despite the publication of large individual series of laparoscopic resections for colorectal cancer the issues surrounding the health care economics and patterns of recurrence have not yet been resolved. Port site recurrences have been reported to occur more frequently than do wound recurrences with conventional open surgery, but in the author's experience of over eighty laparoscopic colorectal resections there has not yet been one port site recurrence.

However, in both the authors' experience and that of others data are emerging to suggest that hospital stay is not significantly diminished by the use of laparoscopic surgery alone and other factors such as early restoration of nutrition, anaesthetic management and forced mobilisation may be more important, but if so are equally applicable to those undergoing conventional open surgery. None of these debates will be resolved by the publication of further series by individual surgeons of groups and the results of randomised clinical trials must be awaited. In the UK, the Medical Research Council's CLASICC (Conventional versus Laparoscopic-Assisted Surgery in Colorectal Cancer) trial is now under way and is recruiting rapidly. The trial incorporates both pathological surrogate end points as well as clinical ones and has major quality of life and health care economic studies embedded in it. It is anticipated that this, and similar trials, will finally allow a decision to be made as to whether laparoscopic surgery for colorectal cancer is safe and cost effective.

1299

Tumour specific antigens: Perspectives for vaccination

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Cytolytic T lymphocytes (CTL) that specifically lyse autologous tumour cells are often found in the blood of cancer patients. Many of the tumor antigens recognized by such CTL have been identified over the last six years. Several of them are truely tumour specific antigens and they are now be used to try to induce or to enhance tumour rejection responses in cancer patients.

There are three main classes of tumour antigens recognized by CTL: antigens encoded by genes, such as the MAGE genes, that are expressed in many tumors but that are silent in most normal tissues; differentiation antigens, such as tyrosinase, that are only expressed in normal melanocytes and in melanomas; and antigens encoded by genes that are mutated in the tumour cells. Although it seems very likely that many other tumor antigens are still to be identified, the priority is now to demonstrate that immunization against some of these antigens is clinically valuable.

A small number of patients with advanced disease received several injections of an antigenic peptide encoded by gene MAGE-3, in the absence of adjuvant. Tumour regressions were observed in 5 out of 17 melanoma tumour-bearing patients. These preliminary results might be improved by testing other modalities of immunization such as peptides or proteins combined with adjuvants, recombinant adenoviruses or poxviruses containing the genes encoding the antigens, or antigen presenting cells such as dendritic cells, incubated *in vitro* with the antigens and injected back into the patient.

1300

Vaccination against lung cancer: Animal models

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Cytolytic T lymphocytes (CTL) directed against peptides presented by MHC class I molecules, constitute powerful effectors of the immune system against tumors. CTL recognizable peptide antigens have been isolated from human and murine tumors. We have isolated two Tumor Associated Antigen (TAA) peptides from a murine metastatic lung carcinoma (3LL-D122). One of the peptides, derived from a mutated connexin 37 gene (MUT1) constitutes a shared TAA between two independent lung carcinomas. Peptide vaccines based on MUT1 can cause rejection of established D122 micrometastases when the peptides are loaded on effective Antigen Presenting Cells (APCs) like the TAP deficient RMA-S cells. Syngeneic fibroblasts (BLK cells) and IL-6 transduced BLK cells loaded with MUT1 can also serve for vaccination while IL-2 transduced BLK vaccines were found to have reduced efficacy.

A second TAA peptide, He-9, was shown to be derived from an aberrant β-globin gene expressed in 3LL lines. The ability of the peptides and other K^b binding β-globin peptides to induce anti-tumor CTL versus autoimmune effects will be described.

1301

Preclinical and clinical experience with peptide-based vaccines against HPV16-induced tumors

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T-cell immunity occurs naturally against tumors induced by viruses and other causes. In the latter case self antigens are increasingly found to be targets of tumor associated CTL. In all categories of tumors the T cell response usually falls short of the maximally possible response. This situation calls for vaccination, primarily in situations of low tumor burden and adoptive transfer with tumor specific T cells in case of higher tumor burden. Indeed we recently observed that patients with HPV16 positive cervical carcinomas or CIN lesions only rarely show CTL responses against predicted HPV16 epitopes presented by HLA class I molecules.

In a mouse HPV16 positive tumor model we found that effective protection against $HPV16^+$ tumor inocula could be achieved by vaccination with an HPV 16 E7 derived peptide in incomplete Freund adjuvant (IFA) or pulsed onto dendritic cells (DC) or with E7 protein in IFA or pulsed onto DC. In a clinical HPV16 vaccination trial 15 patients have been vaccinated with either of three escalating doses of two HLA-A*0201 binding CTL-inducing peptides and a helper peptide binding to all known HLA-DR molecules, mixed with Montanide ISA 51 adjuvant. No toxicity was associated with