of pts had a good compliance. The intention-to-treat analysis showed no difference for clinical global efficacy, cure or improvement, (54% AB, 52% FCA). For the pts who had Candida at the inclusion there was a difference in the percentage of negative cultures at the end of the treatment (34% AB vs 46% FCA, $p < 0.05$). No pts had disseminated candidiasis but we did not detect any neutropenia before or during treatment. FCA was preferred by the pts according to easiness of use (37% AB vs 58% FCA, $p = 0.0007$) and the taste (46% AB vs 73% FCA, $p = 0.0001$). There was no difference in term of safety between the 2 groups. Adverse events related to study treatment were mostly moderate gastrointestinal disorders.

Conclusion: Half the mucositis induced by radiotherapy and/or chemotherapy in HNCP can be cured or improved with antifungal therapy. FCA oral suspension 50 mg is as efficacious and safe as AB oral suspension 0.5 g q.i.d.

604 POSTER DISCUSSION 1

Clinical results of docetaxel (D) and 5 fluorouracile (5FU) in metastatic/recurrent squamous cell carcinoma of the head and neck (SCCHN)

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D is an active drug in recurrent/metastatic SCCHN (response rates: 22 to 45%). D and 5FU were associated in a phase II study in patients (pts) with SCCHN. Pts received D 75 mg/m^2 1 h infusion followed by continuous 5FU 1000 mg/m^2 during 5 days, every 3 weeks (6 cycles, more in case of OR). After the inclusion of 20 pts, dose of 5FU was reduced to 750 mg/m^2 due to febrile neutropenia and mucositis. 63 pts have been treated. 54 were evaluable for toxicity and 44 for response. Of the 54 pts: 51 males/3 females; median age 53 years [40–70]; PS 0 (31 pts); 1 (23 pts); 75% of pts had locoregional disease, 21% had metastatic disease and 4 had both; 30% had previously received neoadjuvant chemotherapy (100% platin-based) and 95% prior radiotherapy. 212 cycles have been administered (median 3 [1.10]). Main toxicities (grade 3/4) were (per pt): neutropenia 65%; mucositis 30%; alopecia 11%; asthenia 11%; diarrhea 9%; anemia 7%; vomiting 2% and edema 2%. Febrile neutropenia occurred in 10% of Cy and 26% of pts. We had 4 toxic deaths among 63 patients: 2 of them were pts treated at 1000 mg/m^2 5FU dose-level. Overall response rate was 34% including: 4CR, 11PR, 15 NC, and 8 PD. Combination of D and 5FU is active in recurrent or metastatic head and neck cancer. Further evaluation of this association should be conducted in phase III trials.

605 POSTER DISCUSSION 1

Prognostic value of paranasopharyngeal extension of nasopharyngeal carcinoma (NPC)

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Purpose: To assess the correlation between paranasopharyngeal extension and T category and to evaluate the prognostic value of paranasopharyngeal space (PPS) extension in local control and distant metastasis in pts with NPC.

Methods: Between 1995–98, 142 NPC pts entered the study. TN categories were defined according to Ho's staging system. Tumor extension into the PPS was defined as: grade (G) 0 – no extension, 1 – extension to the retrostyloid space, 2 – extension to the prestyloid space and 3 – extension to the anterior part of the masticator space. Relapse free, local relapse free, and distant metastasis free survival (S) were estimated using Kaplan-Meier method.

Results: 107 (75%) were men, age 48 [15–77], histology (WHO): I vs II vs III: 11 vs 40 vs 91 pts. The G 0, 1, 2 and 3 extension were 35%, 28%, 23% and 18% respectively. Extensive involvement of PPS (G2/3) appears in 45% of T2 tumors vs 63% for T3 tumors ($p < 0.05$). The 2-year relapse free S rate for G0/1 vs G2/3 extension was 67% vs 35%.($p < 0.01$.). The 2-year overall S for G0/1 vs G2/3 extension was 80% vs 54% ($p < 0.05$). The 2-year local control rate was 70% in G0/1 vs 46% in G2/3 ($p < 0.01$). When stratified for T classification (T2 vs T3), the difference was observed only in T3 disease. There was no difference in distant metastasis free S depending on the PPS extension (G0/1 vs G2/3: 91% vs 79%).

Conclusions: 1) Extensive paranasopharyngeal involvement (G2/3) was associated with poorer treatment outcome regarding relapse free survival rate, overall survival and local control rate. 2) Extensive involvement of the PPS correlates with advanced tumor (G2/3 more frequent in T3 vs T2 category).

606 POSTER DISCUSSION 1

Therapy of cervical lymph node metastases of unknown primary tumor

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Purpose: Management of patients with cervical lymph node metastases of unknown primary site is discussed controversially. We address the outcome of radiation therapy (RT) as potentially curative treatment.

Methods: From 1981 through 1998, 78 patients with cervical lymph node metastases of unknown primary tumor received RT alone (n = 50) or simultaneous RT and chemotherapy (n = 28; 5-fluorouracil, cis-DDP) in curative intention. Fifty-five patients (71%) primarily underwent neck dissection. The treatment volume included the whole pharynx, both sides of the neck and the supraclavicular region. The mean radiation dose was 60 Gy (range 50–72 Gy), fifty-one (65%) patients received an additional boost radiation to the epipharynx with a mean dose of 10 Gy. Mean follow-up time was 7 years (median: 8 years).

Results: The cause-specific-survival rate (CSS) and locoregional control rate (LRC) for all patients were 51% and 76% at 5 years. The distant metastasis-free survival (DMF) was 68%. The addition of chemotherapy had no influence on CSS and LRC rate. Best results were achieved in patients treated after curative neck dissection (n = 47): CSS rate was 67% vs. 33% ($p = 0.006$), LRC rate was 94% vs. 52% ($p = 0.0001$). DMF survival was 83% vs. 50% ($p = 0.019$). CSS rate and LRC rate were also significantly better for patients who received more than 60 Gy ($n \approx 51$) to the epipharynx ($p = 0.03$).

Conclusion: The combination of surgery and RT in cervical lymph node metastases with unknown primary tumor is a safe and effective treatment. Prognostic factors of CSS and LRC were the extent of surgery (R_0 vs. $R_{1/2}$) and total dose (>60 Gy vs. ≤60 Gy).

607 POSTER DISCUSSION 1

Laterally pedicled V-Y advancement flaps for facial reconstruction

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Introduction: Reconstruction of major defects in the face is generally achieved with pedicled or free musculocutaneous flaps, but, in less extensive defects, local flaps or gratis are ideal solutions.

Among the local flaps, we have a good experience with laterally pedicled V-Y advancement flap.

Methods: Between 1988 and 1998, 350 laterally pedicled V-Y advancement flaps were used for soft-tissue reconstruction in the face after oncologic resections. The advancement principle is based on the vascular flow to the flap via subcutaneous lateral bridges. In contrast to the regular V-Y flap, the central subdermal base is cut from top to bottom, so that the flap can be advanced more freely, only based on its lateral pedicles. This V-Y model was used in reconstructions all over the face. The lateral limbs of the "V" must lay on rest tension lines and plies of the face. This way, more extended reconstructions can be easily achieved, as wall as reconstructions in supra- and sub-orbital, pre-auricular, bucco-mandibular and periorbital zones

Results: In the 350 flaps that were performed using this principle, 3 complete necrosis occurred. All these 3 patients had previous local irradiation. In 10 flaps, there was local infection, resolved by conservative means. The flaps healed without further problems. Good cosmetic results were obtained.

Conclusion: In our experience, laterally pedicled V-Y advancement flap is the local flap more used and with better results in reconstruction of face defects.