1472 PUBLICATION

Amifostine in combined radio- and chemomodalities for head and neck cancer

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Combined regimen of radio- and chemotherapy are characterized by a new quality of toxicity, which is the result of addition, sometimes synergism of the different treatment modalities. That's why the integration of cytoprotective agents in such regimen may be a new way to improve the acceptance and the therapeutic index of the combined treatments. In the first part of our presentation we describe our clinical experiences with the selective cytoprotectant amifostine in about 160 patients with advanced head and neck cancer who were treated by a simultaneous radiochemotherapy (RCT). The standard of irradiation was 2 Gy single dose, 60 Gy total dose, carboplatin administered on the days of week 1 and 5 prior to the radiation (cumulative dose 700 mg/sqm BSA). In a controlled phase II study we have injected amifostine in a total dose of 500 mg 15 minutes prior to each carboplatin infusion and have seen a significant reduction of mucositis, xerostomia, thrombocytopenia, and leucocytopenia, compared to the control group without amifostine. A placebo-controlled phase-III-trial with a similar design was closed at the end of last year. Its preliminary results will be presentes at this meeting. In further 2 trials we studied the possibilities to intensify the standard RCT due to the usage of amifostine. We had to observe a significant higher grade of mucositis and loss of taste, if the carboplatin was combined with a prolonged infusion of 5-fluorouracil, despite different types of amifostine dosage and regimen. On the other site it was possible to intensify the dose of carboplatin up to 1400 mg/sqm BSA without further increasing toxicities, if amifostine was given prior each carboplatin infusion (week 1, 3, 5, 7). In the second part of the presentation we compare the own experiences with the reports of other study groups. Positive results will be reported if the investigators have integrated the cytoprotectant according its short half life at the essential points of toxicity of each treatment. Two German groups reported about their succesful integration of amifostine in a radiochemotherapy with 5-FU as radiosensitizer for head neck tumours (Wendt, Busch). They have given the agent prior to each irradiation and have observed all effects of amifostine as a radioprotector. On the other site a Argentinian group (Giglio) stopped a pilot study amifostine because of their negative results in an alternating radiochemotherapy. Because total insufficient doses (100 mg amifostine) were used and the time schedule of amifostine administration was not defined, no cytoprotective effects could be seen.

Conclusion: The succesful integration of amifostine in the combined modalities of radio- and chemotherapy is possible but it underlies two conditions: 1. The short half life of amifostine demands a small time-window (<1 hour) between amifostine administration and radio- and/or chemotherapy. 2. The radiosensitizer in a combined therapy defines the possibility of cytoprotection. Amifostine offers the best protection against the toxicities of platinum derivates and taxanes.

1473 PUBLICATION

Rapid response radiotherapy program (RRRP): Survey of referring physicians' satisfaction

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Purpose: The RRRP was established in 1996, at the Toronto-Sunnybrook Regional Cancer Centre, to provide effective timely palliative radiotherapy to terminal cancer patients. This program has been well received by the community. In 1998, a quality assurance survey was completed to evaluate referring physicians' satisfaction.

Methods and Materials: 126 actively practicing referring physicians were sent questionnaires. 64 were completed and returned (51%).

Results: Since establishment of the RRRP, 33% of surveyed physicians reported that they have referred more patients for palliative radiotherapy. The primary reasons for referral was: quick access to services (70%) and satisfaction with services provided (59%). 80% of those surveyed rated the program ≥ 7/10 for promptness of patient consultation, radiotherapy delivery and overall impression. Weaknesses were identified as poor accessibility to services for all palliative patients in general and suboptimal communication with community physicians.

Conclusions: Measures have been implemented to improve communication links with referring physicians (faxing consultations and a quarterly newsletter). Significant health care restructuring will be required to address the issues of program accessibility and patient transportation concerns.

1474 PUBLICATION

Rapid response radiotherapy program – New approach of palliative radiotherapy delivery. It's efficiency in retrospective analysis

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Background: In January 1996, TSRCC initiated a new form of palliative radiotherapy delivery for patients with advanced cancer. The objectives were to provide palliative radiotherapy consultation, simulation and treatment in a single half day clinic within 3 working days from referral.

Objectives of this Review: A quantitative description of the patterns of utilization and quality of care being delivered.

Methods: Retrospective analysis OPIS – an administrative patient care database.

Results: Since January 1996 to June 1998 we identified 374 records corresponding to 362. 194 patients referred into the clinic were seen within 3 working days. In 255 patients radiotherapy was delivered within 3 days of consultation.

Conclusion: RRRP is a feasible model to improve access to radiotherapy for palliative patients.

1475 PUBLICATION

Frequency of complications of venous implantable ports for administration of chemotherapy in cancer patients

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Aim: to retrospectively determine the frequency of complications of venous implantable ports.

During 27 months 122 venous implantable ports for administration of chemotherapy were placed in patients with solid tumours. In adult patients (118 (97%)) Bardport^{R} implantable ports (Bard Access Systems) were mainly placed by denudation of the cephalic vein or by punction of the subclavian vein, mostly under local anesthesia.

Complications of placement were local hematoma (2/122) (2%) and pneumothorax (5/122) (4%), treated by conservative measures or by placement of a pleural drain.

After placement deep venous thrombosis in the ipsilateral arm or subclavian vein occurred in 6/122 (5%) of patients. No pulmonary embolism was noted and no port had to be removed in these patients.

5/122 (4%) catheters were removed: 3 due to suspected catheter infection (confirmed in 2), 1 due to occlusion and 1 due to local irritation.

There were 3 episodes of catheter occlusion in 3 different patients. There were no catheter dislocations, signs of catheter compression, catheter ruptures and embolisations and no patients developed skin necrosis.

Conclusion: venous implantable ports can be used in cancer patients with a low frequency of complications. No port complications specifically related to the use of chemotherapy were observed.

1476 PUBLICATION

Observer error in grading performance status in cancer patients

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Purpose: To assess the Karnofsky Performance status (KPS) scale and Eastern Cooperative Oncology Group (ECOG) scale with respect to inter-observer reliability and interobserver difference between the 2 scales.

Methods: One hundred consecutive patients in a medical oncology unit were assessed using both scales given to 3 independent raters and also given to the patients.

Results: There was a high level of agreement between most paired assessors. There were 3 exceptions which were the RMO/patient, nurse/patient pairs on the KPS scale and the RMO/patient pair on the ECOG scale. The level of agreement was better on the ECOG scale.

Conclusion: For individual raters there is no statistical difference between the ECOG or Karnofsky scale. There was good agreement between all raters