

at the end of treatment. We have noted also 38 patients (15%) of 254 patients, with decreasing hemoglobin level during treatment higher than 1 g/dl.

Results: No impact on outcome of treatment was observed in the group of patients with low level of Hgb before irradiation. Increase of locoregional failure of postoperative radiotherapy was noted in group of patients with Hgb level at the end of irradiation below 13 g/dl ($p = 0,004$) and also in group of patients with decreasing of Hgb level during treatment ($p = 0,038$).

Conclusions: Low Hgb levels at the end of postoperative irradiation and decreasing during irradiation were associated with a statistically significant increase in locoregional failure of patients with advanced carcinoma of larynx.

46.

STEREOTACTIC MAMMOTOME BREAST BIOPSY – ANALYSIS OF RESULTS

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The purpose of work is to assess stereotactic mammotome biopsy technology in diagnostics of nonpalpable breast lesions. In the period from April to December 2000 mammotome biopsy procedure was performed on 395 female patients at the I Oncological Surgery department the Great Poland Cancer Center in Poznań. In all patients, diagnosed lesions were non-palpable and categorised as BI-RADS III, IV, V. Patients were aged between 16 and 78 (average 52.6 years). They divided into three groups depending on radiological characteristics of the examined lesions - separate analyses were carried out for patients with microcalcifications suspicious tumours and radial scar. Diagnostic examination was performed on an ambulatory basis. Procedure was carried out on a Fischer mammotome table using the Mammothome Biopsy System. The Cancers were detected in 17 % cases. All patients with diagnosed cancer underwent further surgical procedure. In 83 % patients in whom benign lesions were found mammography screening was recommended at 6 month intervals. The Stereotactic Mammothome Breast Biopsy System is a sensitive, minimally invasive diagnostic technology characterised by: very high diagnostic precision, minimal traumatization of

surrounding tissues, excellent cosmetic effect, economical procedure.

47.

ALLOGENEIC BONE MARROW TRANSPLANTATION IN CHILDREN WITH ACUTE LYMPHOBLASTIC LEUKEMIA IN FIRST AND SECOND COMPLETE REMISSION CONDITIONED WITH FRACTIONATED TOTAL BODY IRRADIATION AND ETOPOSIDE OR CYCLOPHOSPHAMIDE

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Patients and methods: From 1993 to 2001 thirty two children underwent bone marrow transplantation (BMT) for ALL (12 in I CR and 20 in II CR after early BM or BM/organ relapse). Except 2 syngeneic all other were HLA-identical siblings transplants. All patients (pts) were conditioned with FTBI 2 x 1,5 Gy for 4 days (total dose 12 Gy) with lung shielding (9 Gy) and CY 60 mg/kg *i.v* for 2 days (total dose 120 mg/kg) ($n=1$ in I CR and $n = 11$ in II CR) or VP 60 mg/kg *i.v* ($n = 11$ in I CR and $n = 9$ in II CR). Pts in I CR have been given $1,1-4,9 \times 10^8$ MNC/kg (med. $2,7 \times 10^8$ /kg), while pts in II CR $1,9-4,0 \times 10^8$ MNC/kg (med. $2,7 \times 10^8$ /kg). For GvHD prevention CsA 3 mg/kg/d *i.v* was administered alone in 22 pts ($n = 9$ in I CR and $n = 13$ in II CR) or in combination with "short" MTX +/- PRED in 8 pts ($n = 3$ in I CR and $n = 5$ in II CR). Two pts transplanted with syngeneic BM received no GvHD prevention. Regimen related toxicity (RRT) was graded according to the system developed by Bearman *et al.* (1988).

Results: Only mild or moderate expression of RRT was observed (GI toxicity I⁰ - 80%, II⁰ - 4%; stomatitis I⁰ - 40%, II⁰ - 20%; hepatic toxicity I⁰ - 28%; renal, bladder and cardiac toxicity I⁰ - 4%) and no transplant related deaths occurred (TRM = 0%). Among 12 pts transplanted in I CR only one child relapsed 4 months from BMT, while remaining 11 pts are alive in CCR with a median follow-up of 33 months (range 6 to 66 months) and 92% probability of 5-year EFS. Of 20 children transplanted in II CR 6 relapsed 1-14 months from BMT (median 6,5 months). Fourteen of

them remain in CCR with a median follow-up 19,5 months (range 1 to 96 months) and 66% probability of 8-year EFS.

Conclusions:

1. In children with ALL the FTBI-12Gy-containing regimen is well tolerated without the life-threatening toxic complications.
2. FTBI-12Gy-containing regimen demonstrates very good antileukemic efficacy for HR-ALL in I CR, but only limited for ALL in II CR.
3. In context of good tolerance of FTBI in a total dose of 12 Gy and its limited antileukemic efficacy in children with ALL in II CR the escalation of FTBI total dose from 12 Gy to 13,2 Gy appears to be justified in those children. *Supported by grant KBN 4 PO5E 108 18.*

48. COMBINED CHEMOTHERAPY AND RADIATION IN LOCALLY ADVANCED NSCLC

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In locally advanced inoperable NSCLC radiotherapy has traditionally been considered the mainstay of treatment. Unfortunately, in most instances this method does not allow for eradication of bulky tumor in the thorax and does not prevent uncontrolled systemic disease. In consequence the prognosis of these patients is dismal and has remained essentially unchanged within the last decades. The five-year survival rates after irradiation varies between 3 and 10%. During the last decades several approaches have been tested to improve this outcome. Of those, particular attention has focused on combining chemotherapy and radiation. Two most frequently used strategies have included induction chemotherapy followed by radiation, or concurrent chemoradiation. The results of a few phase III trials comparing radiation alone with radiation supplemented by chemotherapy have demonstrated modest yet significant survival benefit from the combined approach. Two recent studies suggested that concomitant chemoradiation might be more effective than

chemotherapy preceding radiation. The gain from the concurrent use of both modalities should however be weighted against increased toxicity. Further studies built upon recent positive results should focus on identifying means of optimal interactions between the two modalities. This research should define the most effective types and doses of anticancer agents as well as the optimal features of radiotherapy.

49. ADJUVANT TREATMENT TO SURGERY: IS IT STILL A PLACE FOR RADIO-OR CHEMOTHERAPY?

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The two metaanalysis conducted by the Cambridge group has cent the scene for adjuvant treatment as well as the pattern of failure analysis after surgery. In the pattern of failure analysis performed after a complete resection, local failure is a rare event for pathological stage I and II disease (less than 10 %). In opposite, for stage III, local failure remains an issue due to the wide range of tumor extent, from resectable disease to unresectable tumor. In contrast, distant metastasis is a common problem with figures ranging from 20 to 50%. A last issue is certainly the problem of second cancer induced by a long history of tobacco smoking rising the question of chemoprevention.

To prevent distant metastasis, a systemic treatment is the logical answer. The metaanalysis suggested a slight nonsignificant benefit for a sequential Cisplatin based chemotherapy. The recent American trial of Keller et al comparing postoperative radiotherapy to a combined chemo-radiotherapy approach did not showed any difference for stage III disease: the only important prognostic factor was the type of mediastinal exploration: sampling vs. radical dissection. Several trials are on going worldwide: Anita, ALPI, and IALT... The main characteristics of those trials are to include a cisplatin based chemotherapy program and a large number of patients. This implies necessary a low efficacy; a small difference is expected. Furthermore, the already published trials showed a low compliance to chemotherapy.