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. 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 race 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 Cisplatine 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 cisplatine 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.