

ALLOGENEIC BONE MARROW (BM) PERIPHERAL BLOOD PROGENITOR CELLS (PBPC) TRANSPLANTATIONS IN TWO CASES PREPARED WITH THE USE OF TOTAL BODY IRRADIATION (TBI)

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The main aims for preparative regimens in BMT/PBPCT are malignant cell eradication and/or immunosuppression to facilitate engraftment. TBI is used in concert with cyclophosphamide (Cy) to increase activity.

In our Unit two TBI + Cy conditioned allo-transplantations - (1) BMT and (2) PBPCT - have been performed. Patients - (1) 7 years and (2) 10 years old, males, suffering from: (1) ALL - second and (2) ALL - fourth remission, received transplant material from HLA identical siblings. Transplant preparative regimens consisted of TBI (Co-60 + electrons 6 and 9 MeV: 12-16 Gy. performed in Great Poland Cancer Centre, Poznań) and Cy (200mg/kg bw). Patients received routine decontamination for infection prevention. Heparine for VOD and Cyclosporine + MTX for GvHD prophylaxis. Treatment related toxicity was judged according to WHO scale, standard criteria were used for GvHD grading.

Both patients were Hepatitis B virus positive, patient (2) was also HCV + before treatment. Hematological recovery was observed in both patient (1) 13 and (2) 10 days after transplantation. Toxicity in patient (1) was WHO-1 for the liver and WHO-1 for kidneys. There was no skin or mucosal toxicity. Patient (2) had WHO-2 GIT mucosa and WHO-3 liver toxicities on day +15. No skin toxicity was observed. On day +16 patient (2) rapidly developed signs of pulmonary complications further followed by CNS involvement. He required artificial ventilation. No aGvHD observed. Patient died on day +31. Patient (1) is alive and well +36 days after transplantation. aGvHD grade I (skin) was observed on day +25 after transplantation and responded well to glukokortikosteroid therapy (2mg/kg for 5 days).

The post-transplant history of these two cases reflects on possible complications of BMT/PBPCT with TBI.

THE ROLE OF SURGERY IN COMBINED TREATMENT OF CANCERS

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Surgery is the oldest and the most important treatment for cancer (75 - 80% patients presenting with cancer). Surgery is the simple, safe and the only treatment that could cure most patients (20% from 50% of 5 year survival).

Unfortunately, when patients with solid tumors present to the physician for the first time, about 50% already have micrometastases beyond the primary site.

The magnitude of surgical resection is modified by the use of adjuvant treatment modalities (radiotherapy, chemotherapy, biologic therapy - 50% of 5 year survival).

The role of surgery in the combined treatment of cancer patients can be divided into a few separate areas:

* Definitive surgical treatment of primary cancer (operatio m. Halsted, m. Miles)

* Cytoreductive surgery (to reduce the bulk of residual disease)

* Surgical resection of metastatic disease (40% of 5 year survival in pulmonary and hepatic metastases)

* Surgery for palliation and oncologic emergencies (the treatment of exsanguinating hemorrhage, perforation, the relief of pain)

* Diagnostic surgery for exact histologic diagnosis and precise staging when planning

* Surgery in cancer prevention (carcinoma "in situ", treatment to prevent subsequent cancers)

Slides show the role of surgery in combined treatment of cancers.