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Node negative T1−2 anal cancer: radiotherapy alone or concomitant radio-chemotherapy?

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Background: To evaluate the influence of concomitant chemotherapy (CHT) on locoregional control (LRC) in patients with T1−2 N0 anal cancer treated conservatively by primary radiotherapy (RT).
Materials and Methods: Between 1976 and 2008, 146 patients (pts) with T1 (n = 29) or T2 (n = 117) N0 M0 squamous cell carcinoma of the anal cancer were treated curatively by RT alone (71 pts) or by combined RT-CHT (75 pts). Median age at diagnosis was 66 years (range, 35−94) and the female/male ratio was 105/41. Tumor size ranged from 0.2−5 cm (median 3 cm). RT was delivered in two sequences with a median overall treatment time (OTT) of 62 days. The first and the second RT sequences were delivered at a median dose of 36 and 24 Gy, respectively, separated by a median gap of 30 days. 76 pts were treated with brachytherapy mainly as a boost (median dose 20 Gy). Concurrent CT consisted of mitomycin C ± infusional 5-fluorouracil. Univariate and multivariate analysis were performed in order to asses patient-, tumor- and treatment-related factors influencing LRC.
Results: After a median follow-up of 61 months (range, 4–245), 124 (85%) of patients were locally controlled. The 5-year actuarial LRC and overall survival for the whole population were 81.5% and 74.5% respectively. The 5-year LRC was 75.5% and 87% for patients treated with RT alone and patients treated with RT-CHT (p = 0.15). The 5-year cancer specific survival was 85% and 95% for patients treated with RT alone and RT-CHT (p = 0.17). In the multivariate analysis, no clinical (age, sex, tumor stage) or therapeutic factors (addition of chemotherapy, OTT) were found to influence significantly the LRC, while the addition of chemotherapy was of borderline significance (p = 0.064).
Conclusions: In the management of node negative T1−2 anal cancer, LRC tends to be superior in patients treated by combined RT-CHT even though the difference was not significant. Randomized studies are warranted in order to assess definitively the role of the combined treatment in these early stage tumors.

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Experience on surgical treatment of gastrointestinal stromal tumor (GIST) of the stomach

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Background: We have retrospectively analyzed the hospital records of 75 patients who underwent a gastric surgical procedure for gastrointestinal stromal tumor between August 1994 and October 2008.
Methods: The patients were 37 males and 38 females with a mean age of 63 (SD 12). The class of risk (Miettinen/NIH), at the pathological evaluation of surgical specimen, was very-low in 12 patients (16.4%), low in 23 (31.5%), medium in 12 (16.4%), and high in 26 (35.6%). The mitotic count (/50 HPF) was <5 in 51 pts (70.8%), 6−10 in 9 pts (12.5%) and >10 in 12 pts (16.7%), with a mean of **7.4/50 HPF** (sd 13.2). All the patients underwent gastric surgery. A conventional open approach was employed in 47 cases (62.7%); 28 patients (37.3%) were treated with laparoscopic minimally invasive approach. The mean time of follow-up was 65 months (SD 50) (min 3 – max 173 months).
Results: Relapse occurred in 10 patients (13.3%) and metastatic spread in 10 pts (13.3%). The relapse rate sorted by pathological risk was 6 in the medium/high risk group and 4 in the very low/low risk group. There was neither statistic difference in relapse rate sorted by classes of risk nor in relapse rate sorted by surgical approach (relapse rate: 9% in laparoscopy, 17.3% in laparotomy). 14 patients (18.7%) have died (9 males, 5 females; 6 of them after GIST relapse).
Conclusions: In our experience, the laparoscopic approach to gastric GIST was feasible and safe.

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Response evaluation in third- and fourth-line treatment of GIST: the role of PET

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Background: Response evaluation in gastrointestinal stromal tumors is difficult. Computed tomography and size-based assessments have been found inadequate to draw prognostic conclusions in patients treated with tyrosine kinase inhibitors (TKI). Density criteria (CHOI) have recently been shown to better define prognostic subsets of patients evaluated with CT. Still, positron emission tomography (PET) might be better at identifying responders with good outcome early, as shown for first and recently second-line treatment in GIST (Prior et al.; J Clin Oncol 2009). We wanted to evaluate the role of PET in third- and fourth-line TKI treatment of GIST.
Methods: We retrospectively reviewed patients with GIST who had received third- or fourth-line treatment with TKI and had undergone PET for response evaluation. Patient needed to have a baseline and at least one subsequent PET. Results of the first “early” PET after treatment start have been used throughout this analysis and EORTC PET Study Group criteria applied.
Results: Twelve treatment courses were evaluable, seven with Nilotinib in third- and five with Sorafenib in fourth-line treatment, in 8 patients, median age 60 y (range 36−78 y), who had all failed prior Imatinib and Sunitinib treatment due to disease progession. Baseline and follow-up PET were performed within a median of 34 days (range 9−84 days). Median progression-free survival (PFS) was 262 days in patients responding to PET versus 76 days in patients with stable or progressing disease (p = 0.15).
Conclusions: This small series suggests that PET retains its value for outcome prediction in third- and fourth-line TKI treatment of GIST. This could be of particular clinical value in these vulnerable patients with large tumour masses. Early PET may help in stopping ineffective, but toxic therapy and help switching to a more effective therapy. PET should be evaluated further in this patient population.

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Gemcitabine and Oxaliplatine combination chemotherapy for metastatic well differentiated neuroendocrine carcinomas: a single-centre experience

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Background: Streptozocin-based regimens are considered the standard of care for patients with advanced, unresectable well-differentiated endocrine carcinomas (WDEC) and little data exists regarding the efficacy of chemotherapy after failure of first line therapy. Several targeted therapies are currently being evaluated in this setting but none is yet approved.
Patients and Method: We conducted a retrospective analysis of patients with advanced WDEC treated with gemcitabine-oxaliplatin combination (GEMOX) at our institution. Treatment comprised gemcitabine 1000 mg/m^2 and oxaliplatin 100 mg/m^2 on day one every 2 weeks. Patients were followed for evidence of toxicity, response, and survival.
Results: Thirty four patients were included, median age was 55 (range 32−73) years, 17 patients were male. The primary tumors site was: pancreas (n = 10), ileum (n = 11), lung/bronchus (n = 4), thymus (n = 2), ovary (n = 1), rectal (n = 1) gallbladder (n = 1) renal pelvis (n = 1) paraganglioma (n = 1) and unknown in 2 patients. Eleven patients had functioning tumors: 8 ileal carcinoids, 1 bronchial carcinoid, 2 pancreatic gastrinomas. The median number of metastatic site was 1 (range 0−5) and the median number of previous chemotherapy regimen was 2 (range 0−4, 6 patients were chemotherapy naive). Twenty six patients had RECIST-defined progression prior to initiation of GEMOX and 8 had some kind of radiological progression (5−15%) with clinical deterioration. Twenty three patients started GEMOX at full dose, while 4 patients started at 75% dose and 5 patients started GEMOX at half dose, in those cases doses were reduced “a priori” because these patients were heavily pre-treated. Overall 194 cyles of GEMOX were administered: 129 at full dose, 19 at 75% and 47 at 50% dose. Toxicity was overall manageable; however 8 (28.6%) patients had to discontinue treatment due to oxaliplatin induced neurotoxicity (grade II). Thirty patients were assessable for response, no complete response was seen, there were 4 (12%) partial responses, 4 patients had disease progression at first assessment. The median progression-free survival (n = 34) was 8.2 months and median overall survival (n = 34) was 23.4 months.
Conclusion: GEMOX shows promising activity in pre-treated patients with WDEC with manageable toxicity.