was done in each pt (lung dose ≤ 800 rads). Dose rate was during each irradiation ≤ 4 rads/mn. Immediate tolerance to TBI was better in pts receiving fractionnated TBI rather than one set TBI. 3 pts out of 5 receiving one set TBI died from interstitial pneumonia. One pt out of 28 died from pneumonia in pts receiving fractionnated regimen. No relapse was observed in pts grafted in complete remission. Aplasia was slightly longer in pts receiving fractionnated TBI (grç ≤ 500/µl: 22± 4 days) than in pts receiving single dose TBI (16 ± 4). Despite that difference, morbidity by infection was the same in both groups. Fractionnated regimen of TBI seem to limit complications of marrow transplantation. Our current protocols investigate 220 rads x 5 in standard risk pts and 240 x 5 in high risk pts. 15/20 pts (75%) are alive in the standard risk, 4/13 pts (31%) are alive in the high risk group.

17.

RANDOMIZED TRIAL OF CISPLATIN (C), METHOTREXATE (A),BLEOMYCIN (B) AND VINCRISTINE (O) vs ABO IN SQUAMOUS CELL HEAD AND NECK CANCER. M.Clavel, J.Wildiers, F.Cognetti, M.Van Rijmenant, R. Rosso, A.Rossi, A.Kirkpatrick, O.Dalesio, M.Rozencweig. EORTC Head and Neck Cooperative Group.

This ongoing trial was initiated to assess the role of C in CABO. Of 216 patients (pts) randomized, 211 were eligible, 127 were evalubale and 66 were too early. All pts had measurable a/o evaluable lesions, a performance status (WHO) ≤ 2, no prior chemotherapy and normal hematologic and renal functions. The distribution of pts in the 2 arms was well balanced in terms of performance status, presentation, and prior therapy. The CABO regimen consisted of C : 50 mg/sq m on d4, A = 40 mg/sq m on d1 & 15, B : 10 mg on d1, 8, 15 and O : 2 mg on d1, 8, 15. O was withdrawn after 6 injections. In the other arm, A, B and O were given on d1, 8, 15 at the same dosage as in the CABO regimen. Both treatments were administered on an ambulatory basis. Patients received three 3-wk courses of CABO or ABO as induction therapy. Among 71 pts in the CABO arm, there were 14 complete and 29 partial responses for an overall response rate of 61%. Among 56 pts in the ABO arm, there were 4 complete and 15 partial remissions for an overall response rate of 34%. The corresponding overall response rates were 68 vs 35% in pts with measurable lesions, 65 vs 45 % in those with previously untreated stage III/IV disease and 60 vs 31% in those with recurrent a/o metastatic disease. At this point,there are no differences between the two treatment arms in terms of time to progression and survival. Toxic effects were essentially mild to moderate and consisted mainly of leukopenia, nausea and vomiting, constipation or diarrhea, cutaneous alterations, drug fever, neurologic manifestations and minor renal function impairment.As expected, ABO was better tolerated than CABO with particular respect to gastrointestinal distress. The apparently superior efficacy of CABO remains to be documented .

18.

COMPUTED TOMOGRAPHY (CT) GUIDED PERCUTANEOUS BIOPSY OF MALIGNANCIES : USE IN DIAGNOSIS AND TREATMENT. B.Ody, D.Mirescu and H.Hauser, Division of Radiodiagnosis, Hôpital cantonal universitaire, CH 1211 Geneva 4, Switzerland.

During the last 5 years (November 1978-November 1983), 255 patients have been biopsied under CT control to obtain specimen for histological and cytological examination. 190 of them had before the puncture a suspicion of malignant masses (103 males and 87 females, all between 20 to 84 years of age, mean 59,5 (± 13,5 SD). Fine or large bored needles were used to perform percutaneous punctures in various organs under local anaesthesia. 2/3 of the biopsies were abdominal, particularly in the liver and in the retroperitoneum, the remainder concerned mainly the bone (vertebral column and pelvis), soft tissues and the chest. In 92 % of the cases, sufficient probe material was obtained. Minor complications were observed in 8 patients and only one serious, non lethal, abdominal hemorrhage. The main indications to the CT controled percutaneous biopsies were : confirmation of malignant nature of a mass, confirmation of metastatic spread, proof of the histological type of malignancy before chemotherapy and/or radiotherapy, search of tumoral tissues after unsuccessful biopsies by other methods (endoscopy, cytology of excretions, blind puncture). 40 % of our biopsies were adenocarcinoma, hepatocarcinoma 14 %, squamous cell carcinoma 10 %, undifferentiated carcinoma and lymphoma (9 % of each). 12 patients have had iterative punctures in the following period either to determine the efficiency of the treatment or to proove the malignant nature of new lesions. Thus, the CT guided biopsy is a safe, useful, precise and quick method to allow histological diagnosis of cancer, especially for small and/or deep thoracic and abdominal tumours. Its cost and morbidity are inferior to those of exploratory surgery.

19.

RADIOISOTOPIC EVALUATION BEFORE INTRAPERITONEAL CHEMOTHERAPY. D.K.SLOSMAN, M.FORNI, M.AAPRO, PA.BRIOSCHI, A.DONATH, F.KRAUER Nuclear Medicin Division, Oncohaematology division, Gynecology Division, University Hospital of Geneva.

Evidence from the peritoneal dialysis literature suggests that the peritoneal permeability of many hydrophilic antineoplastic drugs may be considerably less than plasma clearance. The concentration difference between the peritoneal cavity and plasma offers a potentially exploitable advantage.

The aim of this study was to evaluate the drug distribution in the peritoneal cavity with scintigraphic photoimaging technique. 3 evaluable patients who were refractory to systemic chemotherapy were included : 2 ovarian tumors (stage III) and 1 peritoneal mesothelioma. Semipermanent Tenckhoff silastic dialysis catheters were implanted surgically in the peritoneal cavity under local anesthesia. The patients received a single 1 hour instillation of 2.000 ml isotonic steril dialysed solution (HAUSMAN lab. St-Gall) in which 2 mCi of MAA (macroagregate albumin) labeled with Tc99m were diluated. An antero-posterior static scintigraphic image was performed in all patients. Furthermore in one case, tomoscintigraphy was performed too.

In all cases the intraperitoneal space was completely demonstrated. The distribution appeared to be very uncompleted.

To achieve wide distribution a large volume of fluid was administred. Nevertheless static images and tomoscintigraphy pointed out very heterogenous distribution of activity suggesting that all tumor-bearing areas were not adequately exposed.

Among the important factors of failure in the "belly bath" technique for intraperitoneal infusion and delivery of drugs : the lack of a wide and homogenous distribution may reduce the accessibility of drug to all surfaces and represent probably an important variable for inadequate penetration of the tumor by the drug.