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CURRENT RESULTS OF NEUTRON THERAPY FOR LOCALLY ADVANCED PROSTATIC ADENOCARCINOMAS (STAGE C) AT THE UCL-CLINIQUES ST-LUC (Brussels)

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At the UCL Cyclotron of Louvain-La-Neuve, up to December 1981, neutron therapy was performed with neutrons produced by bombarding a beryllium target with 50 MeV deuterons; from 1982, neutrons have been produced using 65 MeV protons (additional filter 2cm polythene). According to the treatment policy adopted in our Center, locally advanced adenocarcinomas of the prostatic gland are treated with a combination of P (65)+BE neutrons and 18 MV X-rays. A mixed schedule modality is applied, following the RTOG protocol, designed for locally advanced tumours (C and D1), but three neutron fractions and two photon fractions are given per week. At the end of December 1986, our recruitment consisted of 18 stage A, 16 stage B, 39 stage C and 17 stage D. In order to allow us to compare our results with the RTOG study, the present analysis, performed in March 1987, includes our 39 patients with stage C, having a minimum follow-up of one year. These 39 patients were treated from October 1979 to December 1986 (20 with tumour present and 19 after TURP). The local control rate reaches 94% at one year, 78% at two years, 74% at three years and 70% at four years. The survival rate reaches 97% at one year, 71% at two years and 52% at three years (all causes of death included). Only one severe complication (after multiple TURP) was observed.

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OBJECTIVE RESPONSE CRITERIA FOR CLINICAL TRIALS OF TREATMENT OF CARCINOMA OF THE PROSTATE

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Although carcinoma of the prostate very frequently metastasizes to bone, there are often few marker lesions which are objectively measurable for use in the assessment of the results of clinical trials. Bone metastases are evaluable but not measurable. Soft tissue lesions are measurable but uncommon, and only occur in patients with a poor prognosis. Traditionally, serum acid phosphatase estimations have been used to evaluate tumour response, but this enzyme is not a good tumour marker. More experience is needed in the use of protein specific antigen as a marker in clinical trials. This paper will discuss all the currently available methods of measuring objective tumour response and their application in Phase II and Phase III trials.

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SINGLE DRUG POLYESTRADIOL PHOSPHATE (PEP) THERAPY IN PROSTATIC CANCER (CAP).

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Insufficient suppression of testosterone (T) levels has been reported for PEP as single drug at previously used dosages ($\leq$ 160 mg im every 4:th week). However, liver side effects of estrogens are drastically reduced when the drug is given parenterally, compared to oral treatment.
Three groups of CAP patients (N=9 each) were given 160, 240 or 320 mg single PEP im every fourth week. Mean observation time was 10.7 (6-18) months. Castration levels of T were reached after 1 month in the 320 and 6 months in the 240 mg group. Mean T level in the 160 mg group after 6 months was below 2 nM. Cardiovascular side effects of estrogens usually appear within 3-4 months of treatment. No such effects were observed in these patients.

I.m. PEP may be an attractive alternative for estrogen treatment of CAP, providing sufficient T suppression at appropriate dosages and without major cardiovascular side effects. Assays of serum estradiol-17β and T provide a convenient and specific way of monitoring the treatment.

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CYPROTERONE ACETATE THERAPY IN THE TREATMENT OF PROSTATIC CARCINOMA: PERSONAL EXPERIENCE WITH 193 PATIENTS SINCE JANUARY 1981

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From January 1981 to March 1987 we saw 437 new patients with prostatic carcinoma; 193 of them were treated by an association of cyproterone acetate plus orchiectomy, and the follow-up for these cases was more than 6 months. Cases included stage C, stage D and also stage B patients. The purpose of this retrospective study is to give the results of our own conception of the treatment: association of orchiectomy plus anti-androgentherapy since the introduction of this last type of treatment in our private practice six years ago. The association with transurethral resection and cobalt-therapy depending on patient age and physical findings is discussed, as well as the place of oestrogen therapy. Use of an invasive hormonal treatment, especially for stage B2 disease, is an uncommon experience, but we feel that maximum use should be made of therapeutic possibilities, especially for patients under 70 years old who cannot benefit from radical prostatectomy.