pts were given EMP and VBL. Twenty-eight (37%) pts were given EMP only. Gleason pattern scores ranged from 4 (n=3), 4-7 (n=49), and 8-10 (n=23). Pre-treatment prostate specific antigen (PSA) was as follows: < 20 in 25 pts (33%), 21 to 50 in 28 pts (37%), and > 50 in 22 pts (29%). 47 pts (62%) were T2, 21 pts (28%) T3, and 7 pts (10%) T4. The median age was 77 years. All pts were treated with mega-voltage external beam radiation with a dose of 65 to 70 Gy in 7-71/2 weeks. Oral EMP 450 mg/m2 daily and VBL 3 mg/m2 weekly were given concomitantly in 47 pts. The remaining 28 pts received EMP only.

Results: Pronounced tumor regression was achieved in all pts at 6 weeks following the completion of the combined treatment. The serum PSA fell to an undetectable level in 81% of pts (61 out of 75) in 6 weeks. The long-term results with the median follow-up time of 63 months show that 80% of T2, 50% of T3 and 40% of T4 pts are free from the biochemical relapse (PSA > 4 ng/ml). In particular, the tumor control rate was impressive for those with the serum PSA 21-50, achieving a 74% freedom from the biochemical relapse. Importantly, there was no increased acute and late normal tissue morbidity from the combined regimen.

Conclusion: The long-term follow-up study of the combined EMP and EBRT confirms our earlier findings that the combined regimen is highly effective in achieving a durable tumor control in pts with locally advanced prostate cancer. Unlike other cytotoxic chemotherapeutic drugs, the combined treatment did not produce any disproportionately enhanced normal tissue toxicity.

534 POSTER DISCUSSION

External beam radiotherapy with high dose rate (HDR) brachytherapy boost in localised prostate cancer

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Purpose: To retrospectively analyse the outcome for patients (pts) with localised prostate cancer treated with conformal external beam radiotherapy (EBRT) in combination with HDR brachytherapy (BT).

Patients and Methods: Since 1988, 290 pts with localised prostate cancer (T1a-3b) have been treated with a combination of EBRT and BT in our hospital. EBRT was given with 2 Gy fractions to a total dose of 50 Gy. BT was given in two 10 Gy fractions. A remote afterloading technique was used with a HDR Ir-192 source. From 6 to 21 needles were inserted transperineally guided by transrectal ultrasound.

Data from 128 pts treated from 1988 to 1997, were analysed: The mean as well as median age was 64 years (range 50-77). Median follow-up time was 57 months (range 12-155). Preirradiatory androgen ablation therapy was given to 68 pts (50%). The tumour was classified as T1 in 16 pts (12%), T2 in 90 (70%), and T3 in 22 pts (17%). Pre-treatment PSA was available in 125 pts (98%) (range 1.2-93). PSA was <10 in 67 pts (52%), 10-20 in 29 (23%), and >20 in 29 pts (23%). Tumour pathological grade was low (Gleason score 2-4) in 37 pts (29%), intermediate (5-7) in 76 pts (59%), and high (8-10) in 15 pts (12%).

Results: At three years, the biochemical no evidence of disease rate (bNED) was 90%. Overall bNED was 83%. The bNED for pts with T1, T2, and T3 tumours was 81%, 86%, and 72% respectively. The overall bNED for pts with pre-treatment PSA <10, 10-20, and >20 was 90%, 79%, and 69% respectively. According to the histological grading the bNED was 86%, 83%, and 73% for low, intermediate and high grades. Disease progression was seen in 22 patients (17%). Local recurrence developed in 3 pts and metastatic disease in 9 pts. Eleven pts had biochemical failure only. Late severe complications were few. Urethral strictures requiring surgical intervention were seen in 9 pts.

Conclusion: Treatment results after conformal EBRT combined with HDR BT in patients with localised prostate cancer are promising.

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Oncologists' perceptions and treatment practice variations in the treatment of hormone-refractory prostate cancer (HRPC): a pilot multinational study

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Purpose: To examine differences in the treatment practices, and perceptions of hormone-refractory prostate cancer therapy in different countries worldwide.

Methods: A written questionnaire was sent to medical oncologists and urologists in 21 countries (Canada, USA, Austria, Finland, France, Germany, Hungary, Ireland, Italy, Netherlands, Norway, Poland, Slovak Republic, Spain, UK, Australia, Argentina, Brazil, Japan, Russia, South Africa) to assess aspects of HRPC including: current national guidelines and screening programs, clinical management of HRPC, historical trends, and reimbursement issues. All data were stratified by country and major geographical location and analyzed using the Fisher's Exact Test.

Results: Fifty-three oncologists from the 21 surveyed countries completed the questionnaire. The oncologists were categorized by major geographic location: North America (n=12), Europe (n=26), Australia (n=4), South America (n=5), Japan (n=3), and Other (n=3). In most cases, guidelines and screening programs are not nationally regulated or mandated. In Japan primary screening for prostate cancer is commonly performed through the health check-up system. Secondary hormone therapy is the current standard therapy for HRPC in all groups. Pain control was rated the most important parameter in first-line treatment option decisions in most groups. Most notably exceptions to this were Japan where patient satisfaction was rated the highest, and North America where median survival benefits was considered the most important. However, in both cases, pain control was the next most important parameter identified. For second-line treatment option decisions, all groups, except for Japan where patient satisfaction was again rated highest, ranked pain control most important. Moreover, 92% of the clinicians surveyed reported that quality of life evaluations were not routinely conducted. Doctors/prescribers were identified as having the most influence on the introduction and use of a new treatment in all groups, except for Japan in which health care organizations were identified as most influential.

Conclusions: For the majority of parameters assessed in this survey, the data collected from each groups was homogenous. However, Japan consistently differed from all other groups, especially in terms of importance of patient satisfaction and pain control in their treatment decision process.

Breast cancer: New drugs/regimes

536 POSTER DISCUSSION

An eight weeks dose-dense versus a 24 weeks sequential adriamycin/docetaxel combination as preoperative chemotherapy (CHT) in operable breast cancer (T2-3, N0-2,M0)

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In a previous phase II b - trial including 248 patients (P) we demonstrated that dose-dense CHT in the preoperative setting (ADOC: adriamycin 50mg/m2 + docetaxel 75 mg/m2 q 14d x 4 + G-CSF + Tamoxifen) results in a pathological complete response (pCR) - rate of 9.7%. In this current randomized study in P with cT2-3, cN0-2,M0 untreated breast cancer we want to demonstrate that this dose-dense schedule obtains a similar pCR - rate as a sequential schedule (AC-DOC: adriamycin 60 mg/m2 + cyclophosphamide 600 mg/m2 q 21d x 4 followed by docetaxel 100 mg/m2 q21d x 4) prior to surgery. Tamoxifen (20 mg/d for 5 years.) was given simultaneously in all P.

Within 22 months 728 of 1000 planned P have entered this trial. Median age was 52 years; median initial tumour diameter by palpation and by best appropriate imaging method was 4 cm and 2.8 cm, respectively; 60.7% had no palpable axillary lymphnodes. So far data on toxicity are available for 197 pts (ADOC 101, AC-DOC 96), i.e. the 4 or 8 cycles have been given completely.

Grade III/IV Toxicity	ADoc (% of P)	AC (% of P)	AC-Doc (% of P)
Anaemia	2	2	2
Neutropenia	32	61	55
Thrombopenia	0	2	1
Nausea	4	10	2
Skin	4	2	9
Nail	1	0	7
Alopecia	91	92	99
Infections	5	2	0
Neurotoxicity	1	0	4