1332 POSTER

Levomepromazine (nozinan) has efficacy in delayed chemotherapy induced emesis (DCIE) following platinum-based treatment

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Introduction: Up to 50% patients may experience DCIE post platinum-based regimes, despite receiving recommended dexamethasone-based combinations post chemotherapy. Levomepromazine can quickly rescue patients from DCIE and prevent it in future cycles. We retrospectively studied our implemented policy of subcutaneous nozinan for rescue (SCR), prophylactic subcutaneous nozinan (PSCN)with chemotherapy, and post-chemotherapy oral nozinan (PON). The latter 2 interventions replaced pre-chemotherapy dexamethasone/ondansetron, and post-chemotherapy dexamethasone/metoclopramide, respectively.

Methods: (May 2000-February 2001): the above groups were identified in a population treated with platinum agents. Doses: SCR/PSCN=25mg/24hrs, PON=12.5mg BD for 3 days. Assessable parameters: control of nausea and vomiting within 24 and 48 hours, and side-effects. (NCI CTC grading).

Results: 21 patients (12 female, 9 male) had DCIE following either high-dose cisplatin (18) or carboplatin (3)based regimes. 18 patients required admission-16 received SCR, 2 declined and received oral rescue (POR). 6 received PSCN for future cycles, 9 also received PON for future cycles. 3 did not present, despite DCIE, and received PSCN (1), PSCN and PON (1), or PON(1).

20 cycles of chemotherapy in 18 patients required rescue: In 18/20 cycles (90%), complete control (CC)of nausea, and in 19/20 cycles (95%)CC of vomiting, was obtained within 24 hours of rescue. 21 cycles of chemotherapy required PSCN. In 19/21 cycles (90.5%) complete prevention (CP) of nausea and vomiting was obtained in the first 24 hours post-chemotherapy.45 cycles of chemotherapy was followed by PON, with CP of nausea and vomiting in 43/45 cycles (95.5%), within 24 hours post-chemotherapy. At 48 hours post-rescue, only 2/20 cycles (10%) were not CC for nausea, and 1/20 (5%) not CC for vomiting. 48 hours post-chemotherapy,2/21 cycles (9.5%)were not CP for nausea and vomiting in the PSCN group, and in 2/45 cycles (4.4%)for the PON group. The 2 failures in the PON group were amenable to re-rescue with SCR. Nozinan was discontinued in 4 (19%) due to: sedation (1), hypotension (1), headache (1) and focal fit (1).

Conclusion: Levomepromazine appears effective in rescuing patients from platinum-DCIE not prevented with standard treatments, and in preventing emesis in vulnerable patients for whom recognised standard antiemetic regimes are ineffective.

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Administration of GM-CSF as enemas in the management of radiation proctitis

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Aim: To evaluate the effectiveness of the GM-CSF in the treatment of radiation proctitis.

Patients - Methods: Four men with a mean age of 63.5 years (average age: 62–71 years) who suffered from radiation proctitis was the material of this preliminary study. All patients had a long-term history of proctitis (average 2–4 years) previously treated with various methods of treatment. In these patients 800 μg GM - CSF was administrated daily as enemas for 15 days. Rectosigmoidoscopy and biopsies were performed before and after the treatment.

Results: Significant improvement, both clinically and endoscopically, was observed in all patients after the treatment. Only one patient had recurrence of symptoms four months after treatment, during the six months follow - up period. This patient presented regression of symptomatology after additional GM - CSF medication.

Conclusion: It seems that GM - CSF topical therapy exerts a significant therapeutic effect against radiation proctitis. These data have to be confirmed with larger number of patients.

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Protective effect of Amifostine during fractionated radiotherapy in patients with pelvic carcinomas: results of a randomized trial

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Purpose: Bowel and bladder toxicity is a significant side effect in patients (pts) irradiated for pelvic malignacies. Preclinical and clinical data have shown that amifostine has a radioprotective effect on normal tissues. The aim of this randomized trial is to evaluate whether pretreatment with amifostine can reduce treatment induced toxicity in pts with rectal, bladder, prostate and gynecological cancer treated with radiotherapy.

Methods: Two hundred and six (206) pts with pelvic malignacies (rectal: n = 32, bladder: n = 47, prostate: n = 40, gynecological: n = 87) were randomized to receive radiotherapy (group A: 95 pts) or radiotherapy plus amifostine (group B: 111 pts). Amifostine 340 mg/sqm was administered IV 15 minutes before radiotherapy. Antiemetics were given routinely before the infusion of amifostine. The pts characteristics were comparable for both treatment groups. All patients received conventional radiotherapy (1.8–2.0 Gy daily, 5 days/week), radical (65–70 Gy) of postoperative (50–60 Gy), 45 Gy given to the whole pelvis. Skin, bowel, bladder and hematological toxicities were evaluated according to the RTOG/EORTC scoring system.

Results: Acute toxicity grade 2/3 of lower GI tract and bladder was significantly reduced in the amifostine group ($p < 0.05$ in wks 3–7 of treatment). In a median follow up of 9 months few late effects grade 2/3 were observed in both groups (bladder: 1 pt of group A, small intestine: 1 pt of group B). Response of pts with evaluable disease 6 weeks after completion of radiotherapy, showed no statistically significant difference between the two groups. (CR/PR: group A: 85.8%, group B: 90.6%, $p = 0.87$). Local relapse: 10 pts (4 pts of group A, 6 pts of group B). Distant metastasis: 8 pts (4 pts of group A, 4 pts of group B). Amifostine was well tolerated; moderate hypotension occurred in 2 pts and moderate nausea in 1 pt.

Conclusions: This randomized trial confirms that amifostine reduces radiation-related toxicity of bladder and lower GI tract in pts with pelvic malignancies without evidence of tumor protection. Longer follow up will show the effect of amifostine on late toxicity.

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The patterns of symptom identification and response in a community-based oncology practice

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Purpose: The literature suggests that symptoms experienced by cancer patients receiving chemotherapy are often under-identified and under-managed. In a retrospective study the pattern of symptom identification and management was examined.

Methods: The charts of 230 breast, colon and lung cancer patients were audited to determine how symptoms were noted in the chart (mentioned or identified as a problem) and what actions were subsequently taken to manage the symptoms. A modified chart-stimulated interview process involving nurses and oncologists at the 2 sites was used to identify 'themes' regarding how symptoms are identified and why actions are taken to manage some of them.

Results: 95% of patients had a least one symptom mentioned in the chart, with 55% having 5 or more symptoms mentioned. The most common symptoms mentioned were local site injection reactions (71%), pain (53%), fatigue (51%) and nausea (51%). The pattern of symptom occurrence varied by cancer site. For most symptoms actions to manage the symptom were more likely to be taken when it was identified as a problem versus being mentioned in the chart. The actions taken to manage symptoms (education/monitoring, medications, referral) varied by cancer site as well as by type of symptom. There was significant physician variability in the identification and management of symptoms. Logistic regression analyses revealed that actions were more likely to be taken when the symptom was identified as a problem, and when the symptom was pain, stomatitis or leukopenia. Oncologists infrequently identified and intervened with psychosocial and quality-of-life symptoms. The qualitative analyses revealed that oncologists that have a treatment care orientation (versus a total care orientation) fo-