VHe 08**SELECTIVE DECONTAMINATION IN NEUTROPENIC CANCER PATIENTS WITH CIPROFLOXACIN**

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Infection has so far been a major cause of morbidity and mortality in neutropenic cancer patients. The risk of infection correlates with the degree and the duration of neutropenia. Prevention of infection is an aim which can be achieved in some instances by selective decontamination. For selective decontamination, 27 patients received 500 mg ciprofloxacin twice daily orally alone or in combination with nystatin, ketoconazole or amphotericin B. The patients suffered from acute nonlymphoblastic leukemia (n=16), acute lymphoblastic leukemia (n=7), blastic crisis of chronic myelogenous leukemia (n=1) and other tumors (n=3). The median duration of application of ciprofloxacin was 19 days with a range of 4 to 60 days. Under ciprofloxacin, fever did not appear in 14 patients, temperature over 38°C was observed in 13 cases. 5 of these patients had fungal infections, in 8 patients the origin of fever was unknown. 4 patients were treated additionally with systemic broad spectrum antibiotics; in 8 patients, broad spectrum antibiotics were given instead of ciprofloxacin. Elevated enzyme values at the start decreased during selective decontamination. In conclusion, ciprofloxacin is suited for selective decontamination in neutropenic patients. The occurrence of bacterial infections in neutropenic patients can be reduced. Ciprofloxacin seems to be a safe drug: severe side effects were not observed, especially it does not seem to prolong the neutropenic phase. II. Innere Abteilung des Krankenhauses Moabit, Turmstr. 21, D-1000 Berlin 21

VHe 09**5 OLD PATIENTS WITH ACUTE ALEUCAEMIC LEUCOSIS**

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Introduction: Typical acute leucoses are rarely to observe in elder people, even less the aleucaemic variations. After we had studied some pancytopenias, anemias and thrombocytopenias of unknown reason without success we decided to inspect regularly the bone marrow when some of these peripheral blood alterations could be seen. Within 5 months 5 patients with acute aleucaemic leucaemias could be discovered. All patients were elder than 66 years. In the peripheral blood blast cells could not be found.

Patients data:	Pat. 1	2	3	4	5
leucosis	ALL	AML	ALL	AML	AML
leading symptom	hemorrhoids	influenza	bronchitis	leucocytosis	leucocytosis
leucocytes (x10 ³)	1,3	2,6	9,8	4,2	43,6
erythrocytes (x10 ⁶)	1,9	2,7	3,8	2,9	3,0
MCV (fl)	133	109	86	94	95,3
thrombocytes (x10 ³)	230	33	48	62	62
LDH (U/l)	166	238	671	353	1.163

Abdominal ultrasound, X-ray of the chest and other technical and blood examinations were normal. 2 patients are still alive, they get busulfan drugs. Pat. 2 - 4 died after 10 days on the average. All diagnoses have been controlled by external hematologists via bone marrow cytology/histology and peripheral blood smears.

Discussion: Perhaps in elder patients the sequestration of blast cells is disturbed at the bone marrow barrier, perhaps the blast cell populations have a very short termed life in the peripheral blood. An acute aleucaemic leucosis seems to be more often in these patients. The immune system may be less effective to prevent entering viral infections which induce blast cell formation. This immune system is less effective to attack these blast cells as well. Thus aleucaemic leucosis could mean that blast cells are not "forced" to leave the bone marrow. Anemias, thrombocytopenias or pancytopenias in elder patients should be examined to exclude aleucaemic leucosis.

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VHe 10**LOW-DOSE ARA-C IN PATIENTS WITH AML AND MDS**

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During the last 18 months 20 patients with AML (M1 n=7, M2 n=10, M4 n=2, M5 n=1) and 4 patients with myelodysplasia (CMML n=1, RAEB n=2, RAEB-T n=1) were treated with LD Ara-C. AML patients could be divided into 3 categories (1) de novo AML n=10 (2) AML in relapse n=3 and (3) AML secondary to MDS n=7. The median age of the AML group was 67 years (range: 41 - 80). To make possible out-patient care s.c. application of Ara-C at doses of 10 mg/m²/12h was chosen. Therapy was continued for 8 - 21 days.

All patients responding to LD Ara-C developed bone marrow hypoplasia and pancytopenia. Therapy had to be interrupted in 14 cases because of progressive thrombocytopenia leading to intracerebral bleeding in 1 patient with RAEB. CR was obtained in 4 patients with de novo AML. Duration of CR was 6+, 4, 4, 9 months. PR was achieved in 1 patient with postmyelodysplastic AML. Presently (median time of observation 9 mo., range 6 - 20 mo.) 10 patients are still alive. Except from the case mentioned above the other patients died of progression of leukemia.

In summary our results show that CR rate and duration of AML patients treated with LD Ara-C is inferior to results of conventional aggressive chemotherapy. Therefore this regimen should be used only for patients in whom aggressive chemotherapy is contradicted. According to recent pharmacokinetic studies low efficiency and high rate of bone marrow hypoplasia might be due to s.c. administration.

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VHe 11**RADIOTHERAPY OF OSTEOLYTIC LESIONS IN MULTIPLE MYELOMA.**

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Localized painful lesions of the bones and pathologic fractures are frequent in multiple myeloma. For these patients chemotherapy alone is insufficient. Additional local treatment modalities such as radiotherapy or surgery are necessary. In 94% of our patients radiotherapy was indicated due to localized severe pain, which was accompanied in 35% by osteolytic lesions, pathologic fractures or neurologic disturbances. 85 patients (55% males, 45% females, mean age: 59 years) have been irradiated with a 60-Co- or 137-Cs-source. All received simultaneous chemotherapy. The most common treated region was the spine (54%) followed by the thoracic wall (21%) and pelvis (14%). 54% of the patients needed irradiation of more than one site during illness. After doses of at least 24 Gy 81% of all patients were free or relieved of pain. Doses of more than 30 Gy were more effective and led to a higher percentage of asymptomatic patients. Following incomplete surgery of epidural tumours radiotherapy could permanently improve neurologic symptoms mildly to completely in 10 of 11 cases. Recalcification of osteolytic lesions occurred in 12 of 16 patients when doses higher than 24 Gy were given. The mean survival period of all patients after diagnosis was 36 months, the 5- and 10-year survival rates were 31% and 10% respectively. For long-term relief of pain and neurologic deficits as well as a potential recalcification of osteolytic lesions we recommend the administration of target volume doses of 25-30 Gy in 3-4 weeks.

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