## ThT 11

POST INDUCTION TREATMENT ALTERNATIVES IN ADULT ACUTE MYELOID LEUKEMIA (AML): A MULTICENTER STUDY

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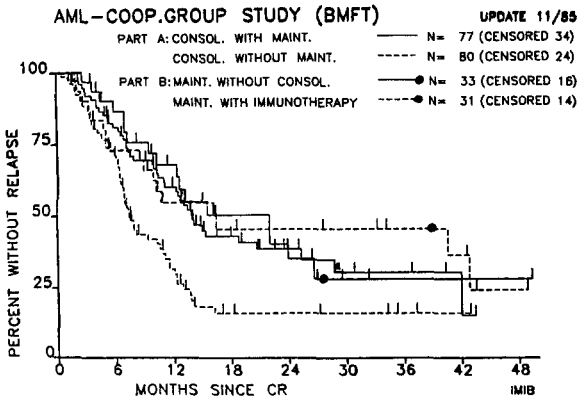
As the role of major post induction treatment alternatives for AML remained controversial we started a trial at 30 institutions in 1981. 331 of 568 (58%) adult pts with AML achieved complete remission (CR) by a 9 day combination of thioguanine, ARA-C and daunorubicin (TAD9). 221 responders were eligable by protocol criteria. Randomization was different for the two study parts; A: consolidation by TAD9 with vs without maintenance by CALGB type monthly chemotherapy. B: maintenance with vs without immunotherapy using neuraminidase treated allogeneic blasts. In part A prolongation of CR by consequent post induction chemotherapy is clearly shown (p=0.001). (Supported by BMFT 01ZP0123).

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## ThT 12

MP VERSUS VCMP: A PROSPECTIVE RANDOMIZED TRIAL IN STAGE II AND III MULTIPLE MYELOMA.

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In a multicenter trial 275 untreated myeloma patients of stages II and III were collected. The patients were randomized into 2 treatment groups. Group A: melphalan 8 mg/sqm p.o. plus prednisone 60 mg/sqm p.o.d 1-4 q 4 weeks: group B: vincristine 1 mg i.v. d 1, cyclophosphamide 100 mg/sqm p.o., melphalan 5 mg/sqm p.o., and prednisone 60 mg/sqm p.o. d 1-4 q 4 weeks. Data from 196 patients were available after 6 cycles induction therapy. The course of the disease was judged clinically as well as by tumour mass change, calculated by the method of SALMON & WAMPLER (Blood, 49, 379, 1977). Both assessments correlated well. 64% of all patients had complete (>75% tumour mass reduction) or partial remissions (>25% tumour mass reduction), 19% showed no change, and 17% progressed during induction therapy. The results were equal in both treatment groups, showing no advantage for the multi-drug regimen. Patients in remission were randomized in groups without or with maintenance therapy consisting of prior chemotherapy cycles q 8 weeks. Patients without maintenance therapy relapsed significantly earlier than patients receiving maintenance therapy (after 10 months 10% of the maintenance group versus 50% of the no maintenance group). 7/11 relapse patients of the no maintenance group went into remission again after re-induction treatment (6 cycles of their previous induction therapy scheme). Therefore in this group the influence of early relapse on survival remains open to date.
Overall survival was 75% after 2 years. No difference was found between MP and VCMP treated patients.

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## ThT 13

THREE MULTICENTER RANDOMIZED TRIALS FOR TREATMENT OF SCLC

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Alternating chemotherapy was evaluated in pts with SCLC. In study I 306 pts were randomized to receive regime A consisting of 8 cycles of CAV (= cyclophosphamide 1g/m²; adriamycin 50mg/m²; vincristine 2mg; d 1) or regime B consisting of 3 cycles (1,3,5) of VPIV (= VP16 80mg/m² d 1-3; ifosfamide 1500mg/m² d 1-5; vindesine 3mg/m² d 1) alternating with 3 cycles (2,4,6) of PAV (= cis-platinum 90mg/m²; adriamycin 60 mg/m²; vincristine 2mg day; d 1) in 3 week intervals followed by one cycle of CMCC (= cyclophosphamide 1g/m² d 1,22; methotrexate 15mg/m² d 1,4,8, 11; CCNU 100mg/m² d 1). Responders received a prophylactic cranial irradiation after 3 cycles and chest irradiation after 8 cycles. Overall best response was 59% vs. 70%, complete remission rate was 21% vs. 36%, median survival was 9.8 vs. 11.3 months, and 2-year survival was 6% vs. 9%, all in favor of arm B. Predominately response was seen after cycle 1. 10/42 (24%) non-responders in A and 17/31 (55%) non-responders in B profit from the continuous application of the same regime. Switching to the other treatment regime was successful in 29/44 (66%) pts in A and in 8/20 (40%) pts in B. Thus, immediate switch to a "non-cross-resistant"second line therapy may improve the outcome of non-responders. Therefore we designed study II comparing fixed alternating treatment with a response-orientated individualized treatment. In a pilot study on 144 pts the efficacy and cross-resistance to CAV of IVP (arm A, = ifosfamide 1500mg/m² d 1-5; VP16 120mg/m² d 3-5), and PVP (arm B, = cis-platinum 80mg/m² d 1; VP16 150mg/m² d 3-5) was tested. Non-responders switched to the standard CAV regime. Overall response and complete remission rate were similar in both treatment arms. Median survival was 9.4 vs. 11.6 months in favor of B. PVP treatment showed a higher degree of side effects (WHO criteria). 58 pts switched to the second line therapy of CAV. 13/30 (43%) pts of A and 7/28 (25%) pts of B experienced a secondary response to CAV. Thus, we used IVP as front line regime in study II. Regime A consists of alternating treatment with CAV and IVP, regime B consists of sequential IVP treatment followed by CAV at the time IVP fails to work. 130 pts entered the study until now. Overall response rate was similar in both arms (89%).

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## ThT 14

RANDOMIZED PHASE III STUDY OF CHEMO-/RADIOTHERAPY FOR SMALL CELL LUNG CANCER "LIMITED DISEASE": ROLE OF CHEST IRRADIATION

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Most therapeutic strategies in small cell lung cancer stage "limited disease", combine chemotherapy and radiation to the primary. While improvement of median survival by chemotherapy is unquestioned, the addition of chest irradiation is still controversal and optimal timing and dosage have not been determined.
Therefore, we initiated a randomized phase III study in stage "limited disease" with 3 arms combining 6 cycles of ACO with either no radiation to the primary (A), or 30 Gy (B) and 50 Gy (C) after the third cycle, respectively. All patients obtain a prophylactic cranial irradiation of 30 Gy after the third cycle. If this therapeutic regimen fails, chemotherapy is changed to cis-platinum plus etoposid.
Until October 1985 64 patients with small cell cancer stage "limited disease" have been entered into the study, 62 are evaluable. 11 of the 62 patients were females. 6 patients were non-smokers. 20 patients had weight loss, 44 cough and 10 fever at diagnosis. 21 patients were of age 33 to 49, 22 of age 50 to 59 and 19 of age 60 to 70 years, respectively. The distribution of sex, age and symptoms was well balanced between the 3 arms. In arm A 8/17 patients died, in arm B 5/24 and in arm C 12/21. Median survival in arm A is 12.2 months, in arm B 11.5 months and in arm C 15.9 months, respectively. The difference is statistically not significant and no conclusions can be drawn from the preliminary data at present. Further follow-up is necessary. The study is still open.

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