Meeting report

20th Annual meeting of the American Society of Clinical Oncology

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The twentieth annual meeting of the American Society of Clinical Oncology was held 21–23 May, 1989 in San Francisco, California. This conference included educational sessions and presentations of new clinical and laboratory research in the area of clinical oncology.

The educational sessions included discussions of a number of topics of current interest: (a) cutaneous melanoma; (b) multi-modality therapy for stage III non-small-cell lung cancer; (c) childhood acute lymphoblastic leukemia; (d) contribution of cytogenetics and molecular biology to leukemia; (e) organ function preservation in head and neck cancer; (f) systemic treatment for axillary-node-negative breast cancer; (g) adjuvant therapy for colorectal cancer; (h) acquired immune deficiency syndrome (AIDS); (i) management of locally advanced bladder cancer; (j) Hodgkin’s disease; (k) age-specific cancer rehabilitation; (l) novel aspects of drug delivery: how to get more drug to the tumor.

In addition, there were special-interest topics discussing preventative therapy and screening, and biology of human cancer metastases, and a discussion of molecular biology for the oncologist.

The twentieth annual David A. Karnofsky Memorial Lecture

This lecture was presented by Dr. Gianni Bonadonna discussing the “Conceptual and practical advances in the management of primary breast cancer”. This lecture presented the history of the early adjuvant therapy clinical trials and the transition from single-drug to combination drug therapy in breast cancer. Dr. Bonadonna presented the results of the Milan Cancer Institute clinical trials in adjuvant therapy and discussed the most recent presentation in the New England Journal of Medicine of the potential benefit of treating node-negative breast cancer. This concept and discussion permeated the meeting in their controversial nature and perhaps, as Dr. Bonadonna pointed out, more questions were raised than answers.

While demonstrating the benefit of adjuvant in women with node-positive disease, and the benefits of hormonal manipulation in post-menopausal women with estrogen-receptor-positive disease, Dr. Bonadonna also pointed out the questions raised by a recent consensus report on the management of early-stage breast cancer. He raised the following questions:

1. Is estrogen receptor positivity the only criterion for using hormonal therapy?
2. Should all node-negative women be treated?
3. Should chemotherapy not be given to women with estrogen-receptor-positive disease?

He presented these as issues that still require investigation and careful considerations as the use of adjuvant therapy proceeds into the next decade.

The Plenary Session discussed five rather different topics of clinical management

The first paper was “Laryngeal preservation with induction chemotherapy and radiotherapy in the treatment for advanced laryngeal cancer: interim survival data of a VACSP study by the VA Laryngeal Cancer Study Group”. This presented the largest study of a single site of head and neck cancer in the history of clinical medicine. The study was based on the fact that the induction chemotherapy is well tolerated and may be effective in possibly downstaging head and neck cancer.
cancer. It was also based on the rationale that several studies have shown that response to chemotherapy in laryngeal cancer is predictive of response to radiotherapy and that radiotherapy is effective in controlling small-sized tumors.

The goal of this therapy was to attempt to preserve the larynx and thus to improve the quality of life for patients with this disease. The patients that were entered were in stages III and IV and had had no prior therapy. Patients were randomized to chemotherapy (cisplatin and 5-fluorouracil) plus radiotherapy, or to surgery followed by radiotherapy.

A total of 332 patients were entered between January 1985 and March 1989. Among the 147 patients evaluable after two cycles of chemotherapy, 24% achieved complete response and 60% achieved partial response. Of the 108 patients evaluable after the third cycle of chemotherapy, 40% were complete responders and 56% were partial responders. Of the patients who completed therapy, 42% are alive with the larynx in place at a median follow-up time of 34 months.

This paper was commented upon by Dr. Elliott Strong, who made the following statements:

This report validates the concept of organ preservation with acceptable patient survival. It also validates the premise that a major response to chemotherapy may herald the ability of subsequent radiotherapy to yield a complete response. This has been previously observed in smaller studies. There is similar survival, although not better, with a more conservative approach, suggesting that patients can be carefully selected for those who may not require surgery. The importance of this paper appears to lie in the size of the patient groups and the balance between these groups.

The second paper was entitled “Improved efficacy of carboplatin/cyclophosphamide versus cisplatin/cyclophosphamide in stage III-IV suboptimal ovarian cancer”. This was a Southwestern Oncology Group study, and compared the cisplatin analogue, carboplatinum to cisplatin as therapy for ovarian cancer. In this study, cisplatin at 100 mg/m² or carboplatinum at 300 mg/m² was given with 600 mg/m² cyclophosphamide, and this was repeated every 4 weeks.

There were similar numbers of combined clinical and pathological complete responses, with 33% in the carboplatinum group and 27% in the cisplatin group. The overall response rate was somewhat higher with carboplatinum (66%) than with cisplatin (56%). Pathologically documented complete responses were seen in 18% of carboplatinum-treated patients, but in only 5% of cisplatin-treated patients. The progression-free survival was identical in each group of patients with measurable disease. The overall survival for these patients was 20 months for carboplatinum and 16.8 months for cisplatin.

The major difference between the two arms was in toxicity. Carboplatinum does not have the nephrotoxicity of cisplatin but does have additional myelosuppression. There was less nausea and vomiting with carboplatinum. The conclusion of this study was that carboplatinum is a significantly better drug to administer and, therefore, on the basis of its lessened toxicity and its comparable efficacy, carboplatinum should be considered the platinum drug of choice for ovarian cancer. Dr. Alberts made the point that this drug is long overdue to be licensed in this country although it did become available in 1989.

This paper was discussed by Dr. Robert Ozols, who commented as follows:

1. The carboplatinum dose is lower than has been used in other trials with carboplatinum in ovarian cancer.

2. It is time to move on to the development of new drug regimens that may be able to succeed in curing this disease rather than to continue to compare analogue drugs in this particular type of large clinical trial. Others in the audience made similar comments, saying that perhaps the dose was low and the schedule was low, but that, nevertheless, the efficacy was similar to what has been seen in other trials and that it is time to move on to therapeutically directed trials in this particular disease.

The third paper in the plenary session was entitled “BCG versus Adriamycin intravesical therapy for in situ and papillary transitional cell carcinoma of the urinary bladder: a Southwest Oncology Group Study”. The objective of this study was to compare the efficacy and toxicity of these two agents in the prevention of recurrence of papillary carcinoma and in the treatment of in situ carcinoma of the bladder.

Patients entered included those with high-risk papillary carcinoma, with at least two recurrences within the last year, and patients with in situ carcinoma that had been proven by biopsy. The study entered 285 patients during 3 years. BCG was given at a 120-mg dose into the bladder and subcutaneously, which is equivalent to $2.4 \times 10^8$ units. This dose was given weekly for 6 weeks and at 3 and 6 months, and then every 6 months for 2 years for 11 treatments. Adriamycin was given as a 50-mg dose intravesically, weekly for 4 weeks and then monthly to 1 year. Tumor was evaluated every 3 months with cystoscopy and urinary cytology. A biopsy was performed if a lesion was seen. Recurrence of papillary carcinoma was documented with biopsy and the response of in situ carcinoma required biopsy-proven absence of tumor. The toxicities observed included cystitis in 20%-25% of patients, with hematuria in a minimum 1%-3% of patients.