**1300**

**A PHASE I TRIAL OF HIGH DOSE TAMOXIFEN (TAM) AND WEEKLY cisPLATIN (DDP) IN THE TREATMENT OF METASTATIC MELANOMA. E.F. Mc Clay, M.E. Mc Clay, J. A. Jones, P. J. Winski. Melanoma Center, Hollings Cancer Center, Division of Hematology/Oncology, Department of Pediatrics, Medical University of South Carolina, Charleston, SC 29403**

We have previously demonstrated that TAM is synergistic with DDP in clinical trials in patients with metastatic melanoma. In the laboratory we have demonstrated that this synergy is dependent upon a TAM effect that is currently under investigation. To date we have shown that it is not the result of a TAM effect on any of the known mechanism of DDP resistance. In the laboratory TAM will make sensitive cells more sensitive, DDP resistant cell sensitive and will interfere with the ability of the tumor cells to develop resistance to DDP. In order to improve combination with a weekly dose of DDP (80 mg/m²), we initiated a phase I trial evaluating the objective response rate in patients treated with increasing doses of TAM in combination with a weekly dose of DDP (80 mg/m²). Patients were treated weekly for 3 weeks, given a 2 week rest, then treated weekly X 3 again. Response evaluation occurred at 4 and 9 weeks after the start of therapy. The starting dose of TAM was 160 mg/day and has been increased to a current dose of 320 mg/day. No responses were observed in patients treated at TAM doses less than 240 mg. In 7 patients treated above this dose there has been 1 CR, 2 PRs, 1 progressive disease and 2 too early to determine. Toxicity has been primarily hematologic in nature at the higher doses. There have been no episodes of thrombosis to date. Cumulative laboratory studies of DDP and TAM pharmacokinetics as well as serial evaluations of the effect of TAM/DDP on the expression of GADD45 and p53 are in progress. Supported by NIH grant CA 52151.

**1302**

**PREDICTORS OF LONG-TERM SURVIVAL IN STAGE IV MELANOMA. S.J. Fried, R. Reifmann, J. Applewhite, A.N. Houghton, and M. Movers. Memorial Sloan-Kettering Cancer Center, NY, NY 10021.**

Retrospective review of the records of 99 pts who presented with or developed as first site of recurrences nodules or intranat metastases primary melanoma. Pts were categorized into four groups: 1) bioUogic disease and 34.8 months for those with prior stage III disease. None of these characteristics differed significantly between the LTS and the patients surviving for less than three years.

Interestingly, the number of metastatic sites did not differ between the LTS and the controls. However, among the Lts/22% (50%) had been rendered disease-free by initial therapy for their stage IV disease; 9 had undergone complete surgical resection, and 5 had achieved a complete response (CR) to chemotherapy. In addition, 6 LTS patients had achieved initial a partial response (PR) to chemotherapy (3 to immunotherapy and 2 by surgical resection). Data on response to initial therapy were available for 100 of the controls. Only 15/100 (15%) had been rendered disease-free (14 by surgery and 1 by immunotherapy). Of the controls had achieved a PR (3 to chemotherapy and 1 to immunotherapy). Thus, the LTS were more likely to have undergone a complete resection of their metastases than the controls (56% vs. 14%; p=0.019). And, the LTS were also more likely to have achieved a CR or PR with initial chemotherapy or immunotherapy (40% vs. 5%; p=0.0001). Supported by grant CA-09207-18.)

**1303**

**ROLE OF CT SCANS IN THE STAGING OF MELANOMA. PATIENTS WITH LOCAL/REGIONAL DISEASE. A.C. Blay, L. Tinoco, M. Ross, S. Legha, R. S. Benjamin. The University of Texas M. D. Anderson Cancer Center, Houston, TX 77030.**

Introduction: We have previously shown that CT scans of the brain, chest, abdomen, and pelvis have a low yield in detecting occult metastases (mets) in patients (pts) with primary melanoma (J Clin Oncol 11:638, 1993). Objectives: To study the value of CT scans in the staging of melanoma, we reviewed retrospective records of pts with disease which was not appreciated on physical examination; false positive (FP), when the scan revealed a radiologic abnormality which did not change for at least 6 months or was proven to be histologically benign; false negative (FN), when a pt had symptoms suspicious for mets and was subsequently found to have mets, but all imaging studies were nondiagnostic; true negative (TN), when all imaging studies were negative for mets in a asymptomatic pt. Results: TP - 11 pts, FP - 21 pts, FN - 1 pt, and TN - 66 pts. Of the 11 pts with TP findings, only 2 were symptomatic. Lung mets were identified in 3 but in only 2 the chest CT identified disease which was not visible on chest-X-ray (CRX). CT of the abdomen or pelvis revealed mets in 5 pts. CT of the pelvis, however, was normal in all 32 pts with recurrent disease above the waist line. CT or MRI of the brain showed no evidence of brain mets in any patient, although it showed asymptomatic skull mets in 1. The most common CT finding were hypodense lesions and no calcified lung nodules. Conclusion: 1) TP are observed in about 10% of the pts. Because FP are more common than TP findings, histologic diagnosis of recurrence is advisable; 2) CT or MRI of the brain are not necessary in asymptomatic pts; 3) chest CT adds very little to a CxR and is not routinely indicated. In light of the cost-conscious environment of the current health-care system, our results are of practical importance.