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**WEEKLY**

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 dose less than 1301 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. Correlative laboratory studies of TAM and DDP pharmacokinetics as well as serial arterial washouts of the effect of TAM/DDP on the expression of GADD 153 and p53 are in progress. Supported by NIH grant CA 52151.


To provide patients with more meaningful prognostic information and to facilitate decision-making about adjuvant therapy, we have analyzed the categorical variable "long-term survival" (defined as survival for at least three years after the date of the first distant metastasis). A cohort of 25 long-term survivors (LTS) has been identified among the patients with stage IV melanoma seen at Memorial Sloan-Kettering Cancer Center (MSKCC). The control group consisted of 180 patients seen at MSKCC during the same period who were known to have survived less than 3 years after diagnosis of stage IV disease. The median age of the LTS was 49.5 years, compared to 57.5 years for the controls. Of the LTS, 50% were females, compared to 30% of the controls. These differences were not statistically significant. Other characteristics of the LTS were as follows: The primary site was an extremity in 28%, the trunk in 28%, and head and neck in 12%. Interestingly, 32% had an unknown primary site. 49% had presented initially with stage I or II, 24% with stage III, and 26% with stage IV disease. The initial metastatic site was lung only in 28% and brain only in 6%. Median disease-free interval prior to diagnosis of stage IV disease was 38 months for patients with stage I or II disease and 34.4 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, 14/25 (56%) 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 a partial response (PR) to chemotherapy, another PR 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 (by surgery and/or chemotherapy); 4 of the controls had achieved a CR (3 to chemotherapy and 1 to immunotherapy). Thus, the LTS were more likely to have undergone a complete resection of their metastases than were 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-09207-16.)

**ROLE OF CT SCANS IN THE STAGING OF MELANOMA PATIENTS WITH LOCAL/REGIONAL DISEASE.** A.C. Buzaid, L. Tinoco, M. Ross, S. Legbas, 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). Objective: To study the value of CT scans in the staging of melanoma patients with stage IV disease. Methods: Retrospective review of the records of 99 pts who presented with or developed as first site of recurrence nodular or intransit mets or local recurrence. Pts were staged with completion of workup of all metastatic foci. When the scan identified either regional or distant disease which was not appreciated on physical examination, CT was functional in detecting occult mets, but all imaging studies were reviewed and those with no prior symptoms evaluated by surgery and/or immunotherapy. Thus, the LTS were more likely to have undergone a complete resection of their metastases than were 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-09207-16.)