Clinical Trial
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Palliative first-line treatment with weekly high-dose 5-fluorouracil as 24h-infusion and gemcitabine in metastatic pancreatic cancer (UICC IV)

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Abstract

Background: The aim of this study was to evaluate the efficacy and toxic side effects of combined gemcitabine plus weekly high-dose 5-Fluorouracil (5-FU) as 24h-infusion in patients with metastatic pancreatic cancer (UICC IV) as validation group of an earlier phase II study. Primary endpoints were to assess the response and tumour control rate.

Material/methods: This study comprised 60 prospectively registered patients with metastatic pancreatic cancer (UICC IV). A locally advanced disease was defined as exclusion criteria. The treatment schedule was weekly gemcitabine (1.000 mg/m(2)) as a 0.5h-infusion combined with 5-FU (2.000 mg/m(2)) as a 24h-infusion on day 1, 8 and 15 every 28 days.

Results: Response rate (CR+PR) was achieved in 7% of the patients, tumour control rate (CR+PR+SD) was achieved in 59%. Median time-to-progression was 4 months, median overall survival was 7.3 months (95% CI 5.4-9.1). The median survival of patients with normal CEA value was 10.6 months (95% CI 7.8-13.4); with a normal CA 19-9 median survival was 10.1 months (95% CI 4.6-15.7) and with ECOG performance status 0 median survival was 10.1 months (95% CI 8.6-15.3). As higher grade toxicity (grade 3/4) leukopenia (15%), anaemia (10%) and thrombopenia (5%) were observed. Nausea and diarrhea (grade 3/4) occurred in 5% of the patients and vomiting in 2%.

Conclusions: The administration of gemcitabine and 5-FU as a 24h-infusion is feasible and offers good tumour control rate accompanied by tolerable toxicity. The subgroup of patients with a good performance status (ECOG 0) and tumour markers within the normal range benefit from the gemcitabine combination therapy.

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Weekly paclitaxel as metronomic palliative chemotherapy in small cell lung cancer

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Abstract

Background: Topotecan is the standard second line agent used in relapsed small cell lung cancer (SCLC). However, the erratic availability and the cost of the drug has been a prohibitive factor for its use in second-line setting in India. Paclitaxel has shown antitumor activity in heavily pretreated patients with SCLC. Hence, this audit was performed to study the efficacy of weekly paclitaxel as a form of metronomic therapy in the second-line setting in SCLC.

Materials and methods: Fifty-seven patients of relapsed SCLC who presented to the thoracic medical oncology unit of Tata Memorial Centre, Mumbai between January 2011 and December 2015 were selected for this analysis. Weekly paclitaxel at a dose of 80 mg/m(2) was administered until progression or development of intolerable side effects or patient refusal. Data regarding baseline demographics, previous treatment history, response rate, progression-free survival, overall survival (OS), and toxicity to weekly paclitaxel was extracted from a prospectively maintained database in the thoracic medical oncology unit and was analyzed using SPSS version 16 (IBM, New York, USA). Kaplan-Meier survival analysis was performed.

Results: Median age of the cohort was 58 years (40-77 years). Etoposide with carboplatin was the regimen used in 40 patients (70.2%) whereas the remaining 17 patients received etoposide with cisplatin (29.8%). Eastern Cooperative Oncology Group performance status at relapse was 1 in 3 (5.3%), 2 in 49 (86.0%), and 3 in 5 (8.7%) patients. The response rate and clinical benefit rate were 9.1% (5 patients) and 52.7% (29 patients), respectively. Grade 3-4 toxicities were seen in 10.5% (6 patients). The median PFS was 145 days (95% confidence interval [CI]: 116.6-173.5 days) whereas the median OS was 168 days (95% CI: 112.5-223.5 days).

Conclusion: Weekly paclitaxel as a second line agent in relapsed small cell cancer of the lung is a feasible and well-tolerated agent.

Keywords: Metronomic; palliative; second line; small cell lung cancer; weekly paclitaxel.

Review
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Palliative therapy

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Abstract

There are a wide variety of palliative treatments for esophageal cancer. The aim of most treatments is to maintain oral food intake, which should stabilize or even improve quality of life. Stent placement is currently the most widely used treatment modality for palliation of dysphagia from esophageal cancer. Stent placement offers a rapid relief of dysphagia, however, the rate of complications (late hemorrhage) and recurrent dysphagia (stent migration, tumor overgrowth) is relatively high. The scientific evidence to advocate the use of anti-reflux stents for the prevention of gastro-esophageal reflux is currently too low. Photodynamic therapy is mostly used in North America; however, due to the high costs of the treatment, the long-lasting side effects and the necessity of repeated treatments, it is not an ideal treatment for palliation of malignant dysphagia. Nd:YAG laser is a relatively effective and safe treatment modality, although laser treatment is also expensive, technically difficult and requiring repeated treatment sessions at 4-6 weeks intervals. Single dose brachytherapy compares favorably to stent placement in long-term effectiveness and safety. Effective treatment strategies are probably 12 Gy given in one fraction or 16 Gy given in two fractions. Palliative chemotherapy offers response rates in recent trials (including partial and complete responses) ranging from 35% to 50%. Whether palliative chemotherapy also results in a survival benefit is not established yet. For clinical trials on palliation of esophageal cancer, the measurement of quality of life is an important outcome measure. The cancer-specific EORTC QLQ-C30 and the esophageal cancer-specific EORTC-OES-18 are validated measures for establishing quality of life status. For the future, a multimodality approach with stent placement or brachytherapy in combination with chemotherapy may be indicated.

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Cyclophosphamide, Methotrexate, and 5-Fluorouracil as Palliative Treatment for Heavily Pretreated Patients with Metastatic Breast Cancer: A Multicenter Retrospective Analysis

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Abstract

Purpose: This study aimed to evaluate the efficacy and safety of cyclophosphamide, methotrexate, and 5-fluorouracil (CMF) chemotherapy beyond standard treatment for anthracycline- and taxane-pretreated metastatic breast cancer (MBC).

Methods: We consecutively enrolled 158 MBC patients who underwent CMF chemotherapy in a palliative setting at two academic hospitals in Korea between 2002 and 2016.

Results: The median age of the 158 enrolled patients was 51 years (range, 30-77 years). The enrolled patients were treated with a median of 5 lines of systemic treatment (range, 2-11) before CMF therapy, and the median time from diagnosis of MBC to CMF administration was 36.0 months (range, 7.1-146.7 months). The median number of cycles of CMF treatment was 3 (range, 1-19), and the relative dose intensity was 90.4%. The toxicity profile was mild, with an observed 3.1% of grade 2 and 5.0% of grade 3/4 neutropenia. Among 147 patients (93.0%) whose response to CMF was evaluated, the response rate was 10.9% (16/147), with complete response (CR) in one and partial response (PR) in 15. In addition, the disease control rate (calculated as CR+PR+stable disease) was 44.2% (65/147). The median progression-free survival and overall survival were 3.1 months (95% confidence interval [CI], 2.7-3.6) and 9.4 months (95% CI, 7.1-11.6), respectively.

Conclusion: CMF therapy is effective and tolerable as salvage treatment for heavily pretreated MBC.

Keywords: Breast neoplasms; Cyclophosphamide; Fluorouracil; Methotrexate; Palliative care.

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Docetaxel, cisplatin and fluorouracil (DCF) regimen compared with non-taxane-containing palliative chemotherapy for gastric carcinoma: a systematic review and meta-analysis

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Abstract

Background: Gastric carcinoma (GC) is one of the highest cancer-mortality diseases with a high incidence rate in Asia. For surgically unfit but medically fit patients, palliative chemotherapy is the main treatment. The chemotherapy regimen of docetaxel, cisplatin and 5-fluorouracil (DCF) has been used to treat the advanced stage or metastatic GC. It is necessary to compare effectiveness and toxicities of DCF regimen with non-taxane-containing palliative chemotherapy for GC.

Methods: PubMed, EmBase, Cochrane Central Register of Controlled Trials and China National Knowledge Infrastructure databases were searched to select relative randomized controlled trials (RCTs) comparing DCF to non-taxane-containing chemotherapy for patients with palliatively resected, unresectable, recurrent or metastatic GC. Primary outcome measures were 1-year and 2-year overall survival (OS) rates. Secondary outcome measures were median survival time (MST), median time to progression (TTP), response rate and toxicities.

Results: Twelve RCTs were eligible and 1089 patients were analyzed totally (549 in DCF and 540 in control). DCF regimen increased partial response rate (38.8% vs 27.9%, p = 0.0003) and reduced progressive disease rate (18.9% vs 33.3%, p = 0.0005) compared to control regimen. Significant improvement of 2-year OS rate was found in DCF regimen (RR = 2.03, p = 0.006), but not of 1-year OS rate (RR = 1.22, p = 0.08). MST was significantly prolonged by DCF regimen (p = 0.039), but not median TTP (p = 0.054). Both 1-year OS rate and median TTP had a trend of prolongation by DCF regimen. Chemotherapy-related mortality was comparable (RR = 1.23, p = 0.49) in both regimens. In grade I-IV toxicities, DCF regimen showed a major raise of febrile neutropenia (RR = 2.33, p<0.0001) and minor raises of leucopenia (RR = 1.25, p<0.00001), neutropenia (RR = 1.19, p<0.00001), and diarrhea (RR = 1.59, p<0.00001), while in other toxicities there were no significant differences.