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BRONCHIOLITIS OBLITERANS IN BONE MARROW TRANSPLANT RECIPIENTS IN HONG KONG.

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453 consecutive Chinese adult recipients of bone marrow transplant (BMT) (including 317 allogeneic BMT, 42 matched-unrelated donor (MUD) BMT) for haematological diseases were followed with lung function tests before and after BMT at Days 90, 180, 360 and then annually plus additional tests if respiratory symptoms developed or abnormal lung functions were detected. 37 patients (35 allogeneic and 2 MUD BMT) developed significant airflow obstruction compatible with bronchiolitis obliterans, including 20 male and 17 female patients. The haematological diagnoses at BMT were: acute myeloid leukaemia = 10, acute lymphoid leukaemia = 2, chronic myeloid leukaemia = 22, myelodysplastic syndrome = 2, kappa-light chain myeloma. Significant airflow obstruction was first detected on 351± 250 days after BMT. Most of these patients also had chronic graft versus host disease involving the eyes, skin, liver and the gut despite having immunosuppressive therapy. Lung function at detection of airflow obstruction were: FEV_1 = 2.10± 0.67 L (76± 21% of predicted), with a fall of 31± 19% compared to pre-BMT, FEV_1/FVC = 68± 11%, FEF_{25-75} = 1.47± 0.76 L (37± 19% of predicted) with a fall of 57± 24% compared to pre-BMT . Mean duration of follow-up was 45± 30 months. 4 patients (11%) developed bronchiectasis after the onset of bronchiolitis obliterans as evidenced by high-resolution CT scan of thorax. 6 patients (16%) died with progressive respiratory failure. Surviving patients have static or worse lung functions compared to onset. In summary, there is a high incidence of bronchiolitis obliterans (11%) in allogeneic BMT recipients. Flow rates at low lung volumes is a sensitive parameter. The airflow obstruction remains static or deteriorate despite immunosuppressive and inhaled steroid therapy.

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COMBINATION OF PACLITAXEL AND CARBOPLATIN IN ADVANCED NON-SMALL CELL LUNG CANCER (NSCLC)

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NSCLC is the major cause of cancer death in Hong Kong and almost always presents in very advanced stages rendering curative treatment not feasible. NSCLC is increasingly being treated with chemotherapy although there has not been consensus in the choice of currently available combinations of newer and more effective therapy. We have, therefore, studied the response rate and safety profile of paclitaxel and carboplatin in patients with metastatic or locally advanced NSCLC in both chemotherapy-naive and previously treated stage III and IV patients with good performance status. Patients with major organ failure, previous malignancies, active uncontrolled infection or definite contraindications for the use of corticosteroids were excluded. Paclitaxel 175gm/m^2 as 3 hr IVI and carboplatin IVI AUC=6 over 30 mins. Were given in 3-weekly intervals for 6 cycles. Pre-medications with dexamethasone, cimetidine, and fluid hydration were given. Interim results were obtained from 17 patients (4F) with age 59± 10.2 yrs. There were 12 adenocarcinomas and 2 undifferentiated NSCLC 3 squamous cell CA with 6 in TNM stage IIIB and 11 in stage IV. The objective partial response rate after III course of chemotherapy occurred in 27% of patients 46% of cases had stable disease and 27% had progressive disease after assessment for tumor size by two-dimensional measurements of chest x-rays or lymph node and bronchoscopic assessment. 5 out of 14 patient completed 6 courses of chemotherapy. The overall response rate is (33%), stable disease (33%) and progressive disease (33%). Adverse reactions including allergy (17%), hepatotoxicity (6%), thrombocytopenia (12%), and neutropenia (12%). There had been no treatment-related death. The combination of paclitaxel and carboplatin appears to be a fairly well tolerated and highly effective regime in the treatment of advanced NSCLC. Further studies are warranted to evaluate the impact of this combination on the median term response and survival of these unfortunate patients.