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G-NU-1

Prediction of Recovery of Swallowing Disorder in Stroke Patients after Rehabilitation

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Background: 55% of acute stroke patients may have dysphagia, in which 40% will show aspiration in videofluoroscopic swallowing examination (VFSS). However, 75% of dysphagic stroke patients will return to normal swallowing at the time discharged from inpatient rehabilitation. However, there is no literature reporting on the factors predicting the recovery from dysphagia after stroke.

Patients and Method: A prospective longitudinal cohort study was carried out on 44 dysphagic stroke patients in the stroke rehabilitation unit. Poor outcome of swallowing with persistent aspiration required modified diet 3 months demonstrated by VFSS were correlated with various clinical and VFSS factors. The clinical factors included medical history variables (history of recurrent pneumonia, aspiration pneumonia and long term intubation/tracheostomy), behavioral variables, gross motor function, oral motor test, and bedside trial swallowing. The VFSS factors, which was performed within 1 to 2 weeks poststroke, included oral phase dysphagia, delayed pharyngeal swallow reflex, cricopharyngeal dysfunction, reduced laryngeal movement, stasis in valleculae/pyriform fossa, esophageal phase dysphagia and aspiration. The factors were analyzed by univariate and then multivariate regression analysis.

Results: In univariate analysis, both the clinical oral phase dysphagia ($p=0.042$) and VFSS evidence of oral phase dysphagia ($p=0.027$) predicted poor swallowing outcome after 3 months. In multivariate regression analysis, medical history variable ($p=0.02$) and videofluoroscopic oral phase dysphagia ($p = 0.004$) were the significant factors.

Conclusion: With regression analysis, the factors predicting poor dysphagic outcome after stroke rehabilitation are the medical variables (history of recurrent pneumonia, aspiration pneumonia and long term intubation/tracheostomy) and videofluoroscopic oral phase dysphagia.

G-RM-1

The Use of Gemcitabine and Cisplatin in Chinese Patients with Advanced Non-Small Cell Lung Carcinoma (NSCLC)

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Background: Gemcitabine is a deoxycytidine analog with documented anticancer activity. The aim is to study the effects of administration of Gemcitabine and cisplatin as primary and salvage chemotherapy in patients with NSCLC with respect to tumour response and clinical toxicity.

Patients and Method: A retrospective review of 22 NSCLC patients who had received Gemcitabine and cisplatin from Jan, 1999 to Sept, 2000.

Results: 22 patients (12 males and 10 females) had received Gemcitabine and cisplatin, with a mean age of 51.6 years. 8 (36.4%) were smokers and 14 (63.6%) were non-smokers. 18 patients (81.8%) had adenocarcinoma, 2 had squamous cell carcinoma (9.1%), 1 had lymphoepithelioma-like carcinoma (4.5%) and 1 had NSCLC (4.5%). 8 patients had stage IIIB disease (36.4%) and 14 had stage IV disease (63.6%). 9 patients (40.9%) received Gemcitabine and cisplatin as primary chemotherapy and 13 (59.1%) as salvage chemotherapy. Only 5 patients (22.7%) were able to complete the intended 6 cycles of chemotherapy without significant dose reduction or omission. The mean number of chemotherapy cycles received were 2.86 and the majority of chemotherapy-related toxicity (42.1%) occurred after the second monthly cycle of Gemcitabine and cisplatin, with 19 patients able to received 2 or more cycles. 2 patients (9.1%) refused further chemotherapy despite clinical response because of severe vomiting. Myelotoxicity occurred in 15 (78.9%) out of these 19 patients, with various forms of manifestation: neutropenia (overall 73.7%) of WHO grade I (31.6%), grade II (26.3%), grade III (15.8%); thrombocytopenia (overall 42.1%). 17 patients (7 in the primary group and 10 in the secondary group) were evaluated successfully for clinical response, and among them are 2 (28.6%) with partial response and 5 (71.4%) with static disease in the primary group whereas in the salvage group: 1 (10%) with partial response, 6 (60%) with static disease and 3 (30%) with progressive disease.

Conclusions: (1) Gemcitabine and cisplatin could cause myelotoxicity with neutropenia and thrombocytopenia in >70% of patients, necessitating dose omission or cessation of chemotherapy. (2) More experience with Gemcitabine and cisplatin as primary and salvage chemotherapy for NSCLC is needed, although no significant disease progression can be found in the primary group. The efficacy of Gemcitabine plus cisplatin or other chemotherapeutic agents as primary chemotherapy in Chinese NSCLC patients deserves further evaluation.