and also has in vitro blocking activity to ATP-binding cassette (ABC) transporters. We evaluated the activity and toxicity of GP in NSCLC pts who failed prior G or both G and T (G/T).

**Methods:** Eligibilities were NSCLC failed G, measurable lesion, ECOG PS 0-3 and life expectancy > 6 wks. They were chemonaive or had failed prior chemotherapeutic regimen(s)(CTR). Treatment consisted of oral G (250 mg) daily and intravenous P (60 mg/m^2) d1, 8, 15 q4w. Primary endpoint was response rate (RR) and secondary endpoints were disease control rate (DCR), time to progression (TTP), overall survival (OS) and toxicity. GP was also tested in vitro in an adenoc. cell line with wild type EGFR and its p-glycoprotein (pgp) expressing subclones.

**Results:** From Sep 2004 to Mar 2007, 53 pts were enrolled and eligible for activity and toxicities: M/F 21/32; median age 64; PS 1/2/3 25/25/3; 8, 15 q4w. Primary prior chemotherapy was platinum based in 41/53. Activity was observed in 19/53 pts (G/P combined 14/53, P alone 5/53), including 12/19 partial responses and 7/19 stable disease. Overall DCR was 45.7%. Median (95% CI) OS was 13 months (95% CI 0.0 - 26.9). Median survival time in subgroup of 8 pts., where EC was used in the first-line setting, was not reached. EC and CHT can be easily and safely combined, there were found no 30 days mortality and minimal morbidity.

**Discussion:** There is only limited amount of information regarding positive effect of combined EC (or other method of interventional bronchology) and CHT/RAT (1.2). A synergic effect is possible, which could be the action of heat shock proteins, that are regarded as possibly the most potent stimulants of immune response in oncology and are used for development of anti-cancer vaccines (3,4). The other explanation is the thermal pre-impairment of deeper structures of a tumor which facilitates the better action of cytostatics.

**Conclusions:** Fiberbronchoscopic electrocautery under local anesthesia is an effective and safe method in treatment of patients with inoperable NSCLC, which can be used in combined modality with chemotherapy and radiotherapy. A synergic effect of electrocautery and chemotherapy is possible.

**References:**

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**P-219**

**NSCLC: Combined Modality Therapy Posters, Tue, Sept 4**

**Electrocautery in combined modality with chemotherapy and radiotherapy in treatment of non-small cell lung cancer affecting central airways**

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**Background and Methods:** Electrocautery (EC) is a method that uses alternating current for thermal destruction of tissue. Depending on the voltage and current, electrocautery causes coagulation or vaporization and carbonization of tissue. During the period 08/2002 - 02/2007 electrocautery in local anesthysan was used in treatment of 37 pts. with various indications. The author presents results of treatment in 14 patients with inoperable locally advanced non-small cell lung cancer predominantly expanding to central airways with only insubstantial affecting lung parenchyma and with no metastases (S IIIB). In these patients, electrocautery (EC) was combined with chemotherapy (CHT) and radiotherapy ( RAT ) or brachytherapy. The first dose of CHT was given just within the 1st day after EC, preferably platinum regimens (CDDP- Vinorelbine 5x, CDDP- Vinblastine 2x, CarboPt - Gemcitabine 2x, Vinorelbine monotherapy 2x, Docetaxel 2x, Gemzar monotherapy 1x). EC and CHT was used in the first-line treatment in 8 pts. and in the second-line in 6 pts. with relapsed NSCLC. EC was used on average twice in one patient ( min. 1, max. 3 ) during the treatment time.

**Results:** Recanalization of central airways was achieved in all patients (100%), complete recanalization was achieved in 6 pts. out of 8 (75%) where EC and CHT was used in the first-line setting. Treatment can be effective even in case of massive endotraehal or endobronchial lesions. The overall median survival time was 13 months ( 95% CI 0.0 - 26.9), median survival time in subgroup of 8 pts., where EC was used in the first-line setting, was not reached. EC and CHT can be easily and safely combined, there were found no 30 days mortality and minimal morbidity.

**Conclusions:** Fiborbronchoscopic electrocautery under local anesthesia is an effective and safe method in treatment of patients with inoperable NSCLC, which can be used in combined modality with chemotherapy and radiotherapy. A synergic effect of electrocautery and chemotherapy is possible.

**References:**

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**P-220**

**NSCLC: Combined Modality Therapy Posters, Tue, Sept 4**

**Radiation pneumonitis (RP) in lung cancer patients treated with chemotherapy (CT) and thoracic radiation (TR): Retrospective analyses of patients treated at a comprehensive cancer center**

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**Background:** Combined CT and TR is the current standard for locally advanced non-small cell lung cancer (NSCLC) and SCLC. Severe RP, an important adverse effect of TR, is reported in clinical trials to occur in 10% of patients receiving CT and TR. The rate in routine care may be higher as patients are not selected based on lung function. We conducted a retrospective study to assess the incidence of RP in lung cancer patients treated with CT and TR.

**Methods:** Retrospectively we identified patients who underwent combined modality therapy (concurrent or sequential CT and TR) for lung cancer (NSCLC & SCLC) at our cancer center between January 2001 and December 2004. Demographic features, RP incidence and grade (RTOG criteria), hospitalization rate, and overall survival (OS) were assessed.

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Results: 85 patients who met the selection criteria were analyzed. The demographic features were - males 61%; Caucasians - 54%; African Americans - 38%; history of pulmonary disorder - 41%; NSCLC - 78%; PS - 0-1 - 92%; Stage III - 89%. The median dose of TR was 5940 cGy. Radiation fields have been retrospectively assessed in 41 patients to date. 9 of the 41 patients (22%) received involved field radiation. 53 patients (63%) received Cisplatin/Etoposide and 20 patients (24%) received Carboplatin/Paclitaxel. 75 patients (88%) received concurrent therapy. 31 patients (36%) developed RP; 15 (18%) had RTOG grade ≥ 3 RP. Median time to development of RP was 4.6 months. Rate of RP in females and males was 42% vs. 33% (p=0.49). Rate of RP in patients with history of pulmonary disorder at baseline was 49% as compared to 28% in others (p=0.068). 1 year hospitalization rate was 74% and 37% in RP and non-RP patients (p=0.0015). For all 85 patients, the median overall survival (OS) was 19.5 months (95% CI 16.4 - 23.3). Length of OS did not differ significantly (p = 0.59) between the 31 patients who had RP vs. the 54 patients who had no RP (median OS: 19.3 vs. 18.8 months, respectively). The median survival of the 15 patients who had severe RP was 16.6 months.

Conclusions: The rate of severe RP in these 85 lung cancer patients, treated off-protocol with CT and TR, is higher than that reported in clinical trials. Despite higher morbidity (i.e., increased hospitalization) in patients with RP, survival duration did not differ significantly by RP status.

P2-221 NSCLC: Combined Modality Therapy Posters, Tue, Sept 4

Adjuvant docetaxel plus carboplatin versus observation in patients with completely resected stage IB-IIIA non-small-cell lung cancer: preliminary results of the Chinese Society of Lung Cancer randomised controlled trial (CSLC201)

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Background: Four larger clinical trials, IALT, NCIC-SCR10, ANITA and Japanese UFT trial, have shown significant OS advantages with adjuvant chemotherapy. Unless vinorelbine plus cisplatin, whether other third generation doublet chemotherapy regimen improves survival of patients with non-small-cell lung cancer (NSCLC) is not known. We aimed to compare the effect of adjuvant docetaxel plus carboplatin versus observation on survival in patients with completely resected NSCLC.

Methods: 82 patients with stage IB-IIIA NSCLC from 3 centres in China were randomly assigned to 75mg/m2 docetaxel plus AUC=5 carboplatin (n=43) or to observation (n=39). The primary endpoint was disease free survival (DFS). The second endpoint was overall survival, response rate in the chemo group and safety. Analysis was by intention to treat. This trial was closed early by the EC as adjuvant chemotherapy became a standard therapy for resected NSCLC in 2005.

Results: 82 patients with stage IB-IIIA NSCLC from 3 centres in China were randomly assigned to 75mg/m2 docetaxel plus AUC=5 carboplatin (n=43) or to observation (n=39). The primary endpoint was disease free survival (DFS). The second endpoint was overall survival, response rate in the chemo group and safety. Analysis was by intention to treat. This trial was closed early by the EC as adjuvant chemotherapy became a standard therapy for resected NSCLC in 2005.

Results: 43 patients in the chemotherapy group and 39 in the observation group received their assigned treatment. 45 (54.9%) patients had stage IB disease, 20 (24.4%) had stage II disease, and 17 (20.7%) had stage IIIA disease. Adenocarcinoma accounted for 62.2% (51 cases, Tab.1). The median chemotherapy cycles were 3. After a median follow-up of 29.5 months (range 3-51), median disease free survival time is not reached in the chemotherapy group and 34 months in the observation group (p=0.0173). Median overall survival in both groups is not reached (Fig.1).

Conclusion: Adjuvant docetaxel plus carboplatin extends disease free survival in patients with completely resected NSCLC.

P2-222 NSCLC: Combined Modality Therapy Posters, Tue, Sept 4

Can the patients with locally advanced non-small cell lung cancer (LANSCLC) tolerate 60mg/m2 docetaxel on day 1 and 30mg/m2 Cisplatin on day 1 and 2 for 2 cycles during concurrent radiotherapy (CCRT) after 2-3 cycles of induction chemotherapy?

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Background: CCRT plus consolidation chemotherapy is a standard treatment of LANSCLC. But there is still a great controversy about the chemotherapy regimen for CCRT. A group of physician in Korean found 20mg/m2 docetaxel plus 20mg/m2 cisplatin, weekly is maximum tolerated dose for patients with LANSCLC during 6 weeks of 63Gy radiotherapy. The purpose of our trial was to determine whether the NSCLC patients after 2-3 cycles of induction chemotherapy can tolerate the chemotherapy regimen of 60 mg/m2 T and 60mg/m2 cisplatin in 6 weeks radiotherapy, based on toxicity.

Methods: Previously untreated 9 patients with histological/cytologically proven Stage III non-small-cell lung cancer were eligible after induction chemotherapy for 2-3 cycles. Followed a month later by concomitant radiotherapy (62-70Gy in 31-35 fractions, 6-7weeks) delivered concurrently with cisplatin and docetaxel. The dosage of level 1 was 56 mg/m2 docetaxel, on day 1 and 28mg/m2 cisplatin, on day 1 and day 2, 2 cycles during CCRT. The radiotherapy model was conformal radiotherapy or intensity modulated radiotherapy. The dosage of level 2 was 60 mg/m2 docetaxel, on day 1 and 30 mg/m2 on day 1 and day 2. Response rate was evaluated as complete remission (CR), partial remission (PR), stable disease (SD) and progressive disease (PD).

Results: Nine patients were enrolled, with median age of 58, (43-70). Seven patients were male, 2 female. The ECOG scores of 4 patients were 0, and ECOG scores of 5 patients were 1. The loss of weight of 8 patients was 0%, that of one patient was ≤5% in three months before diagnosis. Seven patients were with squamous cell carcinoma, 2 with adenocarcinoma. The objective response was as follows: PR 8/9, SD 1/9. The toxicities were showed in table 1.

Conclusions: The patients with LANSCLC can tolerate 60mg/m2 docetaxel and 60mg/m2 cisplatin for 2 cycles during concurrent radiotherapy after 2-3 cycles of induction chemotherapy.