Adjuvant bi-weekly schedule of gemcitabine plus carboplatin in resected stage IA (>2cm) to IIA non-small cell lung cancer: a phase II study from Kanazawa Postoperative Adjuvant Chemotherapy Study Group

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Background: Gemcitabine plus carboplatin (GCa) chemotherapy has shown to have activity against non-small cell lung cancer (NSCLC) and to be a well-tolerated treatment. Our aim was to evaluate the feasibility and clinical efficacy of adjuvant bi-weekly GCa in completely resected stage IA (>2cm) to IIA NSCLC.

Methods: Eligibility required completely resected stage IA (>2cm) to IIA NSCLC, no prior chemotherapy or radiotherapy, ECOG PS 0-1, age under 76 years. Patients were to receive four cycles, each at 4-week intervals, of G (1000mg/m², d 1, 15) and Ca (AUC 2.5; d 1, 15). Cycles were repeated until 4 treatments.

Results: Between 03/2005 and 10/2006, 56 pts were enrolled and 54 pts were eligible, data on 45 pts (30 male and 15 female, median age 64 years) were currently evaluated. ECOG PS 0:1 =42:3, Stage I:II:IIIA =31: 9: 5, Histology adeno:squamous:others =37: 7: 3. Median number of GCa treatments was 4(1-4) and median dose intensity was 94% for both G and Ca. Grade 3/4 hematological events included leukopenia(7%), neutropenia (7%), and anemia (4%). Grade 3/4 non-hematological events included nausea (2%), infection (4%). Preliminary 1 year disease-free survival was 83%.

Conclusions: Adjuvant bi-weekly schedule of gemcitabine plus carboplatin was feasible with acceptable level of toxicity in completely resected stage IA (>2cm) to IIA non-small cell lung cancer. Disease-free and overall survival are still under evaluation.

Limited surgery for elderly patients with non-small cell lung cancer who have high risk for lobectomy: Comparison of the short- and the long-term outcomes with standard surgery

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Background: The incidence of lung cancer in the elderly is increasing in many countries. Although lobectomy is the standard of care for early-stage lung cancer even in the elderly, segmentectomy and wedge resection are commonly provided in the elderly to reduce operative risk. However, the short- and the long-term effects of such procedures remain unclear. The aim of this study was to determine the significance of compromised limited surgery in the elderly.

Methods: The medical records of 116 patients (75 or older) who underwent pulmonary resection for clinical stage I from 1991 to 2003 were analyzed retrospectively. The patients were divided into two groups; the compromised limited surgery group (CLS) (the patients who underwent sublobar resection due to their impaired physical condition) and the standard surgery group (SS). The clinical variables, operative complications, and survival were compared between two groups.

Results: CLS was performed for 43 patients and SS for 73. Median age was 77 years old (range 75-87) consisting of 76 males. There were 80 adenocarcinomas, 25 squamous carcinomas, and 11 others. Median follow-up period was 1136 days. The reasons for CLS were poor pulmonary function for 17, cerebro- or cardio-vascular diseases for 17, and others for 9 patients. Pathological stage was I in 93 patients. There was no significant association between surgical procedures and these clinical variables. Operative mortality was 0% after CLS and 0.9% (n=1) after SS. Operative complications and cause of death was summarized in table. There was no significant difference of operative complications (mild or severe) between the two groups. Overall survival at 1, 3, and 5 years after CLS (SS) was 98% (90), 70% (80), and 66% (68) (Figure).

Conclusion: In the elderly patients, limited resections can be an equivalent alternative for patients who are estimated to have high operative risk for lobectomy.