1988; JCO 6: 239-252, 1998) to prognostic factors that had been prospectively identified in the previous trials (Int J Radiation Onc Biol Phys 11: 23-30, 1985; Blood 73: 47-56, 1989), together with response-related indicators (JCO 6: 596-602, 1988; Am J Hematol 37: 253-257, 1991; Ann Intern Med.114: 361-365, 1991).

In favourable patients, the extension of this strategy in the H6F trial allowed to spare them not only the adjuvant chemotherapy (CT) but also laparotomy, establishing subtotal nodal irradiation (STNI) as a new standard in clinically staged patients (ASH 1992; JCO 11: 2258-2272, 1993). In the subsequent trials (H7F, H8F), brief combined non-toxic CT regimens with radiotherapy restricted only to the involved-field (IF RT) provided superior freedom from progression (FFP) and at least comparable overall survivals (OS) to(S) TNI.

In unfavourable patients, in the H5U trial, combined CT/RT modalities, preferably with an adriamycin-containing regimen, provided better results than TNI. In the subsequent H7U and H8U yrial, treatment adjustments balanced the respective intensitiesof CT and RT: treatment de escalation proved dangerous.

In advanced stage disease, an earlier trial suggested that early response could be used to adapt treatment modality and length (JCO 6: 596-602, 1988; JCO 12: 279-287, 1994). In the subsequent trial, this observation has been successfully utilized for the early salvage of relapses (Ann Oncol 2: 63-66, 1991) or poor responders(Ann Oncol, 1997) and the important question of adjuvant RT is being investigated in a randomised way.

Underlying all HD trials, two basic concerns sustain the EORTC strategy, that encompass all patients with HD. One is the need for permanent and prospective assessment of prognostic factors, with which treatment continuously interacts; in this respect a continuum may exist between "localised" and "advanced" HD. The other is aiming at the best possible treatment intensity adaptation to patient's requirements for the sake of sparing short and long- term toxicities including those measured by function and Quality of Life impairments. Combined modalities, including intensive ones, may remain the best options for these tasks. The role of RT may persist in all patients categories, and that of immunotherapy may develop, in parallel to the better understanding of HD natural history.

Working together with newly cooperating countries, like Poland, will allow a markedly better understanding of early and late treatment effects, conditions for continuing to improve the care for our patients.

16

NEW APPROACHES TO FOLLICULAR LYMPHONA

A Z S Rohatiner

ICRF Departament of Medical Oncology, ST Bartholomew's Hospital (SBH), Londyn, UK

With conventional therapy, follicular lymphona remains incurable for most patients. An experimental approach is therefore justified.

Recognition of the association between follicular lymphona and the (14;18) translocation and the possibility of detecting residual disease at the molecular level using the polymerase chain reaction (PCR), have led to the concept of 'molecular remission'.

Several new approaches, some of which have been reported to result in 'molecular remission' eg. the chimaeric antibody antti-CD20 and the combination Fludarabine, Mitoxantrone and Dexamethasone are currently being evaluated at SBH. These and other treatment options, including high dose treatment (Cyclophosphamide + total body irradiation) supported by autologous haemopoietic progenitor cells, radio-labelled anti-CD20 and the nonmyeloablative regimen comprising Fladarabine and Cyclophosphamide supported by allogeneic bone marrow transplantation will be discussed.