anastrozole for 10 weeks; after 4 weeks they received quinapril for 28 days; blood samples were taken at the same time as group A. Blood pressure was measured at the time of entry, before starting quinapril and twice a day during the 4 weeks of treatment with ACE inhibitor.

Primary assessment was the steady-state plasma anastrozole concentrations following once-daily anastrozole alone or anastrozole plus quinapril. The evaluation of plasma anastrozole concentrations started after 21 days of drug administration, to ensure the steady-state had been obtained. Blood samples were taken from each patient 12 h after each dose of anastrozole: at days 21 and 28 for baseline measurements; days 42 and 56 for on-treatment measurements; and day 70 for post-treatment evaluation.

Anastrozole analysis in plasma was carried out according to the Bock et al. validated method of solvent extraction, capillary gas chromatography separation and electron capture detection [4]. The plasma levels of quinapril and of its active metabolite, quinaprilat, were determined according to the method of Hengy and Most [5]. Plasma levels of anastrozole and quinapril were analysed using validated methods. The sensitivity limit was ∼3 ng/ml.

Comparisons of the plasma anastrozole levels between the two groups were obtained through the non-parametric Mann–Whitney test. The mean plasma anastrozole concentration in group A was 59.2 ng/ml on day 21 and 62.6 ng/ml on day 56. For group B, the mean concentration was 49.43 ng/ml on day 21 and 49.80 ng/ml on day 56. None of the mean values were significant at a 5% confidence level (Table 1).

In both groups of patients, the steady-state anastrozole concentrations remained similar during treatment with anastrozole 1 mg once daily, alone or in combination with quinapril; there were no statistically significant differences in plasma levels between patients who received anastrozole alone or in association with quinapril. Hypertension, monitored during the study period, was well controlled in all patients (Table 2).

In conclusion, these data show that the combination of quinapril and anastrozole can be safely and effectively administered to older patients with breast cancer and moderate hypertension. Also, the administration of quinapril to patients treated with anastrozole does not modify the plasma concentration of anastrozole and a dose modification is not required.

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Table 2. Blood pressure (mm Hg) differences before and after treatment with anastrozole plus quinapril in group B

<table>
<thead>
<tr>
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<th>Systolic</th>
<th>Diastolic</th>
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<tr>
<td>Before treatment</td>
<td>160–179</td>
<td>100–105</td>
</tr>
<tr>
<td>After treatment</td>
<td>125–140</td>
<td>75–85</td>
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Results from five patients with hypertension.

Onycholysis secondary to multiple paclitaxel 1-hour infusions: possible role for its vehicle (Cremophor EL)

We read with interest the clinical cases describe by Minisini et al. and their review of the literature related to nail toxicity associated with taxane therapy [1]. Nail changes are reported with docetaxel given as 3-weekly or weekly schedules, and with weekly paclitaxel. The authors suggested that nail changes were based on taxane-induce vascular abnormalities (hematoma, hemorrhagic lesions) and neurotoxic damage (onycholysis). Previous reports focusing on onycholysis after prolonged weekly paclitaxel hypothesized direct toxicity to the nail bed, inhibition of angiogenesis, a possible role of ultra-violet light in nail damage, higher paclitaxel dose density and cumulative doses reached with weekly schedules [2–5]. Overall, onycholysis was reported in 15–25% patients after prolonged weekly paclitaxel treatment, but it was not observed under the standard 3-weekly regimen [1–5].

We are currently conducting a study of high dose density chemotherapy in high-risk breast cancer patients. The protocol requires a mobilizing course consisting of epirubicin 150 mg/m², preceded by dexrazoxane (day 1), and paclitaxel 175 mg/m² plus filgrastim (day 2); followed by three courses of epirubicin 150 mg/m², preceded by dexrazoxane (day 1), and paclitaxel 400 mg/m² (day 2), with peripheral blood progenitor cell support and filgrastim every 16–19 days. Paclitaxel was given as a 6-h infusion in the first 24 evaluable patients (P6h patients), then as a 24-h infusion in the next 15 evaluable patients (P24h patients). The infusion time of paclitaxel 400 mg/m² was modified in order to reduce the neurotoxicity of this regimen. Toxicity was assessed according to the National Cancer Institute Common Toxicity Criteria version 2.0 (NCI-CTC 2.0), which describe two grades of nail changes: discoloration, ridging (koilonychia) or pitting (grade

References


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Durable complete remission after weekly docetaxel administration in a patient with mediastinal non-seminomatous germ-cell tumor refractory to cisplatin-based chemotherapy

The prognosis for patients with relapsed mediastinal germ-cell tumor (MNGCT) is uniformly poor. The condition of platinum refractoriness is an additional negative prognostic factor [1].

We describe the case of a 33-year-old man with MNGCT refractory to salvage chemotherapy, who entered complete remission after single agent docetaxel administration.

The patient had the following cancer history. In October 1999, a mediastinal mass of 8 cm diameter was diagnosed by chest X-ray and computed tomography (CT) scan. Histology after mediastinal mass resection revealed a yolk sac tumor. Baseline α-fetoprotein (AFP) was >100,000 ng/ml, while human chorionic gonadotropin was within the normal range. The patient underwent four cycles of PEB (cisplatin, etoposide and bleomycin) attaining a partial response at CT staging. However, the AFP values at the end of treatment failed to attain normality (98 ng/ml). He therefore received two chemotherapy cycles with a PVI scheme (cisplatin, vinblastine and ifosfamide), but during the second cycle of salvage chemotherapy AFP increased to 154 ng/ml after an initial decrease. The CT scan showed disease stabilization. The patient was therefore immediately admitted to surgery, which was performed in March 2000. The residual mass was radically resected, and no residual mass was documented either at surgery or by imaging studies. Histology of the resected tumor (MNGCT) was therefore immediately admitted to surgery, which was performed in March 2000. The residual mass was radically resected, and no residual mass was documented either at surgery or by imaging studies. Histology of the resected tumor revealed viable neoplastic germ cells scattered within necrotic tissue. The

References


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