# Thirty-Seventh
# Annual Meeting of the
# American Society of Clinical Oncology
# May 12–15, 2001

San Francisco, California

# *Program/Proceedings*

ASCO™

The abstracts contained in the *Program/Proceedings* of the American Society of Clinical Oncology (ASCO) are embargoed. No public announcements of the information or data contained in these abstracts may be made by any individual, organization, institution, or media outlet before the date and time of the scheduled scientific presentation. Those studies selected for inclusion in the official ASCO Annual Meeting Press Program (less than 1% of all abstracts) will have their embargoes lifted at the time of the news briefing, or the time of the scientific presentation, whichever comes first. Abstracts that are not scheduled for presentation—"publish-only" abstracts—are embargoed until the official start of the Annual Meeting, scheduled for 8:00 a.m. (PDT) on Saturday, May 12, 2001.

In the unlikely event that ASCO makes an exception to this Embargo Policy, information regarding the exception will be publicly announced on *ASCO OnLine (*www.asco.org), the official website of the Society.

**Editor:** Steven M. Grunberg, MD

**ASCO Education, Science, and Publications Department:**
**Senior Director:** Deborah Whippen
**Managing Editor and Deputy Director, Publications:** Lisa Greaves
**Program Assistant:** Pamela Jones

The *American Society of Clinical Oncology Program/Proceedings* (ISBN 0-9664495-3-3) is published by the American Society of Clinical Oncology, Alexandria, VA 22314. The 2001 issue is produced and printed by Lippincott Williams & Wilkins, 351 West Camden Street, Baltimore, MD 21201-2436.

Editorial correspondence and production questions should be addressed to *American Society of Clinical Oncology Program/Proceedings*, American Society of Clinical Oncology Publications Department, 1900 Duke Street, Suite 200, Alexandria, VA 22314. Telephone: (703) 797-1910. Fax: (703) 299-1044. E-mail: ascopubs@asco.org.

Single issue rate, $50.00. For all areas outside the United States and possessions, there is an additional charge for surface delivery of $10.00. For airmail delivery, add $15.00.

Prices are subject to change. Back volumes exist and are available at previous published prices. For further information, call (703) 797-1910.



The American Society of Clinical Oncology assumes no responsibility for errors or omissions in this document. The reader is advised to check the appropriate medical literature and the product information currently provided by the manufacturer of each drug to be administered to verify the dosage, the method and duration of administration, or contraindications. It is the responsibility of the treating physician or other health-care professional, relying on independent experience and knowledge of the patient, to determine drug, disease, and the best treatment for the patient.

Abstract management and indexing provided by Medical Support Systems, Cambridge, MA. Composition services and print production provided by Lippincott Williams & Wilkins, Baltimore, MD, and Cadmus Professional Services, Linthicum, MD.

2405

**Active Chemotherapy for Collecting Duct Carcinoma of the Kidney.** *M. I. Milowsky, A. S. Rosmarin, S. K. Tickoo, D. M. Nanus; New York Presbyterian Hospital-Weill Medical College of Cornell University, New York, NY*

Collecting duct carcinoma (Bellini duct carcinoma), a rare variant of kidney cancer, is associated with an aggressive course and extremely poor prognosis. There are no standard treatment regimens and both immunotherapy and chemotherapy have not been effective. We describe the case of a 44-year-old man who initially presented with left flank pain and left arm paresthesias and was found to have a palpable left flank mass and a 4.5x3cm left supraclavicular lymph node. An MRI revealed a left renal mass measuring 7x6cm with extensive regional and retroperitoneal lymphadenopathy. A left radical nephrectomy was peformed and the pathology revealed a high-grade carcinoma of the kidney with involvement of regional lymph nodes and the left adrenal gland. The morphologic features including multinodularity, extensive inflammatory infiltrate (predominantly neutrophilic) admixed with tumor, solid and tubulopapillary growth pattern, focal intracellular mucin and tubal dysplasia in the surrounding kidney were consistent with collecting duct carcinoma. Anecdotal reports suggest that these tumors may respond to regimens effective in transitional cell carcinomas. Therefore, we treated the patient with a dose-intense regimen of Adriamycin (50mg/m2) and Gemcitabine (2000mg/m2) every two weeks with GCSF support, as this combination is reported to be effective and well tolerated in the treatment of transitional cell carcinoma (J Clin Onc 2000;18:840). After the first cycle of chemotherapy, the left supraclavicular lymph node significantly decreased in size and the patient's left arm paresthesias resolved. A CT done after six cycles of chemotherapy showed a ~90% decrease in the supraclavicular lymph node, and a 42% decrease in a left renal fossa soft tissue mass compared to pretreatment (Total 70% reduction in tumor volume). Toxicity consisted only of grade 1 nausea and fatigue. This report demonstrates that dose-intense Adriamycin and Gemcitabine is an active regimen for patients with collecting duct carcinoma of the kidney.

2406

**A Phase II Trial of CT2584 in Metastatic Androgen-Independent Prostate Cancer.** *D. Reese, M. Carducci, D. Petrylak, P. Nelson, D. Prager, Y. Novik, L. Shemanski, C. Paradise; University of California San Francisco, San Francisco, CA; Johns Hopkins Oncology Center, Baltimore, MD; Columbia Presbyterian Medical Center, New York, NY; Fred Hutchinson Cancer Research Center, Seattle, WA; UCLA Medical Center, Los Angeles, CA; Our Lady of Mercy Medical Center, Bronx, NY; CTI, Seattle, WA*

CT2584 is a novel lipid metabolism modulator that demonstrates antitumor activity against a wide variety of cell lines in vitro and in vivo. To evaluate the efficacy and safety of CT2584 in metastatic androgen-independent prostate cancer (AIPC), we treated 39 patients (pts.) with IV CT2584 on one of two schedules. Twenty one pts. received CT2584 455 mg/m2 days 1–3 of a 21-day cycle, while 18 pts. received CT2584 455 mg/m2 on days 1, 8, and 15 of a 21-day cycle. The maximum dose was capped at 800 mg when several patients developed hemolysis. At baseline, the median age was 68 years, median PSA 184 ng/mL (range, 11 – 2208), and median KPS 80 (60 – 100). Thirty five pts. (90%) had bone metastases and 21 (54%) had soft tissue disease. Patients were very heavily pre-treated: 17 (44%) had received one prior chemotherapy regimen, while 16 (41%) had received two or more prior chemotherapy regimens. Twenty four pts. (61%) had received prior ketoconazole, 22 (56%) prior skeletal radiation, and 15 (38%) prior investigational therapy. The median number of cycles received was 3. There were no objective responses in soft tissue. Median time to clinical progression was 2.4 months overall, 2.0 months in the pts. on a daily schedule and 2.6 months pts. on a weekly schedule. Three pts. had PSA declines of 44%, 60%, and 77% from baseline; these declines did not correlate with durable clinical benefit. There were no significant changes in the Present Pain Intensity Index or KPS. Significant adverse events included grade 3 anemia (8%) and grade 3 fatigue (10%). One pt. (3%) had grade 3 hemolysis, while 4 pts. (10%) experienced grade 1–2 hemolysis; this was felt to be due to high drug concentrations at the catheter tip and did not occur once the maximum dose was capped. Four pts. (10%) developed a pain flare during or shortly after CT2584 infusion. One pt. died of cardiac arrest that was not attributed to CT2584 administration. We conclude that in this heavily treated population of pts. with metastatic AIPC, although reasonably well tolerated, CT2584 monotherapy had no major anti-tumor activity. Further trials of this agent should focus on pts. with less advanced disease and consider combining CT2584 with cytotoxic drugs.

2407

**Parenteral Estrogen Therapy in Advanced Prostate Cancer: Retrospective Analysis of Intra-Muscular Estradiol Valerate in "Hormone Refractory" Prostate Disease.** *M. Kohli; John L McClellan VA Medical Center & University of Arkansas for Medical Sciences, Little Rock, AR*

11 prostate cancer patients post androgen ablation, were treated with intra-muscular depots of estradiol valerate. Two groups of patients were analyzed retrospectively. The first group (n=5) of patients had rising PSA values post androgen ablation and post secondary hormonal manipulation. Mean PSA was 29.3 ng/ml (range: 13–48). Metastatic work-up was unrevealing. The second group (n=6) of patients constituted patients with diffuse metastatic disease after androgen suppression. They were treated with combination of estrogen depots and a chemo-therapeutic agent. Mean PSA for this group of patients was 1272 ng/ml (range: 540-2197). All eleven patients received intra-muscular depots weekly to monthly. 9/11 patients received once daily prophylactic doses of low molecular weight heparin. 2 patients in the second group were already receiving coumadin for chronic thrombotic events. Treatment was stopped in the first group if there was progression of disease or if there was resolution of rising PSA values. Criteria for continuing treatment in the second group included either objective reduction of metastasis on imaging or decreasing PSA or stabilization of performance status. Results: All five patients in the first group showed decrease in PSA after starting treatment. After a mean period of treatment of three months mean PSA measured was 16.6 ng/ml (range: 7–35). Patients in the second group were treated for a mean period of 4.5 months. PSA decrease was noted in all patients in this period of time. Two of the six patients showed decrease in soft tissue metastatic deposits. Performance status was maintained in all patients. No evidence of any acute thrombotic event was noted in any patient. Conclusion: Depot estradiol valerate treatment in post androgen ablated progressive prostate cancer may have some value as a secondary hormonal manoeuvre and may offer palliation in combination treatment with a chemo-therapeutic agent for widely metastatic disease.

2408

**Evaluation of HER-2 in Prostate Cancer by Immunohistochemistry (IHC) with 2 Different Antigen Retrieval Techniques and Fluorescent in Situ Hybridization (FISH).** *C. J. Sweeney, M. G. Bolton, M. O. Koch, K. M. Sanchez, L. Cheng; Indiana University, Indianapolis, IN; Genentech, San Francisco, CA*

Preclinical evidence suggests a role for HER-2 overexpression in prostate cancer. The clinical significance of HER-2 expression in prostate cancer is unclear. Reported rates of overexpression vary greatly. 38 radical prostatectomy specimens from hormone naïve patients who have had a biochemical failure were analyzed by a pathologist.IHC for protein analysis using the DAKO kit was employed. Two different antigen retrieval techniques were used for the IHC: (1) "standard" (FDA approved technique) and (2) "modified"- employed a more alkaline buffer. All 38 specimens were analyzed by both techniques. FISH for gene amplification was performed by LabCorp. Both the IHC and FISH are commercially available and clinically applicable assays. The pathologist reported the T-stage and Gleason Score and the amount of HER-2 expression was reported on a 0 (no staining) to 3+ scale. With the standard technique, one specimen had 2+ staining (2.6%) compared with 10 (26.3%) had 2+ staining and 9 (23.7%) had 3+ staining with the modified technique. By the Mantel-Haenszel test there was a significant association between staining intensity with the modified technique and T-stage ($p=0.033$) and Gleason Score ($p=0.012$). None of the specimens had gene amplification of the HER-2 gene. Conclusion: Subtle changes in the antigen retrieval technique can result in the discordant frequency of overexpression. The correlation of the overexpression rate in this study with T-stage and Gleason score may be spurious and/or not clinically relevant. This data supports the need for a standardized, clinically correlated methodology to determine HER-2 status.

**Comparison of 2 Different Antigen Retrieval Techniques**

| Technique | Standard | Standard | Modified | Modified |
|---|---|---|---|---|
| Staining Intensity | 0+, 1+ | 2+, 3+ | 0+, 1+ | 2+, 3+ |
| T1 | 1 (2.6%) | 0 (0%) | 1 (2.6%) | 1 (2.6%) |
| T2 | 22 (57.9%) | 0 (0%) | 14 (36.9%) | 10 (26.3%) |
| T3 | 14 (36.9%) | 1 (2.6%) | 4 (10.5%) | 9 (23.7%) |
| N = 38 (100%) | 37 (97.4%) | 1 (2.6%) | 18 (47.4%) | 20 (52.6%) |
| Gleason 5, 6 | 11 (28.9%) | 1 (2.6%) | 19 (50%) | 4 (10.5%) |
| Gleason 7, 8, 9 | 26 (68.5%) | 0 (0%) | 0 (0%) | 15 (39.5%) |
| N= 38 (100%) | 37 (97.4%) | 1 (2.6%) | 19 (50%) | 19 (50%) |