## PERSISTENT STABLE MEDIASTINAL WIDENING AFTER CHEMOTHERAPY IN HODGKIN'S DISEASE

Sir—Persistent mediastinal adenopathy in Hodgkin's disease after irradiation or combined modality therapy constitutes a diagnostic and therapeutic dilemma since it may represent persistent active disease (2, 3, 6). This phenomenon was less well documented after chemotherapy alone till a recent presentation by RADFORD et coll. at the 'Third International Conference on Malignant Lymphoma, June 10–13, 1987, Lugano' (5). In this paper, the authors reported 110 cases of mediastinal Hodgkin's disease and concluded that patients with residual mediastinal abnormality after chemotherapy have a high risk of relapse and should receive radiotherapy.

We have recently seen two cases with mediastinal widening persistent after initial chemotherapy and these cases are reported because of their peculiar evolution.

*Case No. 1.* H. N., a 20-year-old female, presented in May 1984 with multiple adenopathy involving several supradiaphragmatic sites and fever, weight loss and excessive sweating, which had appeared several months before admission. A cervical lymph node biopsy revealed Hodgkin's disease, mixed cellularity. Chest tomography showed mediastinal and left hilar widening with special prominence of the aorto-pulmonary window region and a mediastinal diameter less than 1/3 of the transthoracic diameter. Further studies, including liver and bone marrow biopsy, were normal and she was considered to be in clinical stage II B.

She received 6 cycles of hybrid chemotherapy (MOPP-ABV) ending in November 1984. There was a rapid regression of the mediastinal widening within the first two months of therapy down to a small residual prominence in the aorto-pulmonary window. This prominence then showed minimal, very slow regression. CT of the chest in January 1986 showed a residual discrete mass in the left side of the mediastinum; mediastinoscopy, however, failed to reveal any abnormalities. Because of these negative findings we elected a watchful waiting and postponed all further therapy. She was last seen in July 1987 with an unchanged chest radiogram and no clinical evidence of disease.

*Case No. 2.* E. F., a 46-year-old male, presented in November 1984 with fever, weight loss, increased sweating and pruritus. Examination disclosed multiple cervical and supraclavicular enlarged lymph nodes and, on chest radiogram, widening of the mediastinum with a dominant right paratracheal mass. The mediastinum was bulky exceeding 1/3 of the transthoracic diameter. A cervical lymph node biopsy revealed Hodgkin's disease, mixed cellularity. Abdominal CT revealed a large spleen but no other abnormalities. Bone marrow was normal. He was given a final clinical stage of III B.

He received 9 courses of the same hybrid chemotherapy as described above, ending in August 1985. A response similar to that of the first case was noted, namely a rapid regression of the mediastinum during the first two months of chemotherapy down to a residual prominence in the upper paratracheal area which thereafter showed minimal but steady shrinkage. He remained free of other signs of disease at his last follow-up in June 1987.

The course of these two patients was similar insofar as an initial response to chemotherapy was followed by minimal but steady further shrinkage of mediastinal lymphadenopathy while off therapy. The residual mediastinal widening in both cases was also noted to correspond to the initial area of tumor bulk.

RADFORD et coll. (5) reported a 23% recurrence rate in cases of marked mediastinal abnormality after chemotherapy alone and suggested the addition of radiotherapy in this patient category. YOUNG et coll. (7) also stressed the importance of combined modality therapy in patients with bulky mediastinal adenopathy.

However, our two cases demonstrate the possibility of a favorable course even in such high risk patients. Although the follow-up is still short (31 and 22 months respectively after the completion of chemotherapy) the lack of disease progression and the reluctance of one patient to accept radiotherapy encouraged us to follow them up without additional therapy.

As previously described in non-Hodgkin lymphoma (4) and testicular cancer (1), residual masses may represent scar tissue or fibrotic changes, without active malignancy. Additional therapy in such situations may be useless and possibly harmful. Close clinical observation may also obviate the need of more invasive and costly restaging procedures.

*Key words:* Hodgkin's disease; chemotherapy, persistent mediastinal mass.

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August, 1987.

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## DOXORUBICIN AND 4'-EPIDOXORUBICIN IN COMBINATION CHEMOTHERAPY OF EXTENSIVE SMALL CELL LUNG CANCER

Sir—Doxorubicin and its new analogue 4'-epidoxorubicin appear to have the same wide spectrum of anticancer activity, but the analogue is stated to have less hematologic and cardiac toxicity (1). However, the effect of 4'-epidoxorubicin in small cell lung cancer (SCLC) is poorly documented and there are no controlled studies where it has been compared with doxorubicin as single drug or in combination chemotherapy. The aim of our preliminary study was to investigate the effect of the same doses of 4'-epidoxorubicin and doxorubicin in combination chemotherapy of extensive SCLC.