CORRESPONDENCE

Difference in Rates of Response to Chemotherapeutic Agents Between Men and Women With Malignant Melanoma

In their brief communication, Luger et al (1) correctly point out the striking difference in response rates between men and women. They also point out that this difference has been reported previously for single-agent dacarbazine (DTIC) chemotherapy as well as some studies in which DTIC was used in combination (2).

In 1986 our group reported a striking difference in the male/female response with the combination of lomustine, bleomycin, and cisplatin. Whereas the overall response rate in 15 women was 67%, the response rate in 10 men was 20%. Most striking, however, was that 8 of 11 women with skin and nodal areas of involvement responded to this regimen, and none of 6 men responded (3).

We urge investigators to include response by gender in reporting data on the treatment of melanoma.

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References


Multiple Colorectal Carcinomas, Polyposis Coli, and Neurofibromatosis, Followed by Multiple Glioblastoma Multiforme

In an earlier issue of this Journal, there was a report (1) of two patients with multiple colorectal carcinomas, polyposis coli, and neurofibromatosis (2).

Patient 1 was 14 years of age in May 1986 at the time of diagnosis of multiple colon carcinomas (stages II and III) (3). He completed fluorouracil/leucovorin adjuvant chemotherapy in 1 year and was asymptomatic except for numerous unformed bowel movements. In January 1990, he developed frontal headaches, nausea and vomiting, decreased appetite, and difficulty in expression of thought. Physical examination revealed left facial weakness and weakness of grip in the left hand. Computerized axial tomography of the brain showed a 3-cm left temporal lobe lesion with vasogenic edema (Fig 1, A and B) and a 2-cm peripherally enhancing mass centered in the left thalamus (Fig 1, C and D) with compression of the left ventricle and shift of the midline structures to the right; there were no bony abnormalities (Fig 1). Results from studies of the chest and abdomen were normal. A left frontal craniectomy was performed at the University of Virginia Medical Center on January 31, 1990, with resection of the peripheral tumor. The patient then received treatment with selective intracarotid fluorouracil, 600 mg weekly, for 4 weeks coincident with whole-brain radiotherapy, 1000 cGy (cobalt), with the treatment field subsequently reduced to 9 x 8 cm for the remaining 4000 cGy. As of March 1991, he continues to receive phenytoin (Dilantin) for the prevention of seizure activity.

This patient is also of interest because of his family history. His parents are first cousins, and a younger brother, also with neurofibromatosis and polyposis coli, died of mediastinal T-cell lymphoma. Two cousins in the same generation died of leukemia (1). Whether this family is one with other members with familial lymphoblastic lymphoma/leukemia (4) is unknown because immunophenotyping was not performed on the cells of the cousins with leukemia.

This patient previously had resection of a cavernous hemangioma of the cheek, dense collagenous tissue from the scalp, and a cavernous hemolymphangioma of the temporal bone. He had no mucosal lesions, sebaceous cysts, or osteomas consistent with Gardner's syndrome (5), but he had numerous renal cysts. The intestinal polyposis syndrome the patient's condition most resembles is Turcot's syndrome (6, 7). In Turcot's syndrome, adenomas of the colon are associated with a high frequency of malignant transformation and the development of central nervous system tumors including medulloblastoma, ependymoma, and glioblastoma multiforme. To our knowledge, no previous patients with Turcot's syndrome have had neurofibromatosis.

Transforming growth factor (TGF)-beta, a polypeptide, is closely related to another polypeptide described as glioblastoma cell-derived T-cell suppressor factor (8). TGF-beta is thought to have a fundamental role in the growth of both normal and neoplastic cells and was found in fresh, surgically removed glioblastoma. Whether this patient had significant tumor levels of TGF-beta is unknown, yet levels should be studied in individual tumors of patients with multiple carcinomas of the colon, for these individuals may be at greater risk to develop glioblastoma multiforme.

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Fig 1. Computerized tomography showing a left temporal lobe lesion with vasogenic edema, with (A) and without (B) contrast, and a peripherally enhancing lesion located in the left thalamus with compression of the left ventricle, with (C) and without (D) contrast.

References


Supported in part by Public Health Service grants CA-23099 and CA-21765 from the National Cancer Institute, National Institutes of Health, Department of Health and Human Services, and by the American Lebanese Syrian Associated Charities (ALSAC).

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Erratum: “Helicobacter pylori Infection in Intestinal- and Diffuse-Type Gastric Adenocarcinomas” by Julie Parsonnet, et al. [J Natl Cancer Inst 83:640–643, 1991 (Issue 9)]. The figures in this report were reversed. The figure over the legend entitled “Figure 1” should be above the legend entitled “Figure 2” and vice versa. The Journal regrets this error.

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