Table 1. Laboratory parameters and clinical manifestations at onset in six patients with TTP.

<table>
<thead>
<tr>
<th>Hb</th>
<th>PR</th>
<th>LDH</th>
<th>Neurological findings</th>
<th>Kidney findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>g/dL</td>
<td>x10/L</td>
<td>U/L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RR</td>
<td>6.5</td>
<td>9.0</td>
<td>2750</td>
<td>no</td>
</tr>
<tr>
<td>MD</td>
<td>6.8</td>
<td>5.0</td>
<td>1498</td>
<td>no</td>
</tr>
<tr>
<td>DA</td>
<td>11.0</td>
<td>2.0</td>
<td>5786</td>
<td>yes</td>
</tr>
<tr>
<td>CM</td>
<td>7.5</td>
<td>13.0</td>
<td>2450</td>
<td>no</td>
</tr>
<tr>
<td>PLM</td>
<td>6.7</td>
<td>14.0</td>
<td>1743</td>
<td>yes</td>
</tr>
<tr>
<td>BS</td>
<td>7.2</td>
<td>11</td>
<td>1570</td>
<td>no</td>
</tr>
</tbody>
</table>

All patients received the first plasma exchange employing fresh frozen plasma, and CPP was used in the following procedures. PE was performed daily until normalization of the platelet count and serum LDH levels.

Two patients (B.S. and P.M.L.) died 8 and 5 days, respectively, after beginning plasma exchange, and the addition of high-dose iv immunoglobulins in one case did not produce any effect. Clinical remission was reached in four patients. In one case, neurological disorders at onset such as amnesia and paresis improved after three PE procedures.

Normalization of platelet count was obtained after 7, 11, 13 and 17 plasma exchange procedures, respectively. Our experience confirms the data reported by Perotti et al. regarding hematological recovery, while the neurological disorders that appeared during the treatment in two patients did not seem to be influenced by the addition of CPP.

These observations seem to limit the efficacy of CPP as compared to fresh frozen plasma in the treatment of TTP.

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References

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Prolonged low doses of oral etoposide may be effective in individual patients with advanced lymphoproliferative disorders refractory to aggressive chemotherapy

Sir,

etoposide, a semisynthetic podophyllin derivate, is currently employed in the treatment of several malignancies. The antitumor efficacy of etoposide is highly schedule dependent and it has been demonstrated that five-day administration is superior to single day administration. Oral etoposide has greatly facilitated the use of multiple-day schedules and the drug displays good activity in many extrahematological malignancies as well as in lymphoma. From December 93 to May 94, we treated with prolonged low doses of oral etoposide 24 patients with advanced hematological malignancies not eligible for further intensive approaches due to age >60 years and/or severe previous infective complications. Of these, ten patients had ALL, 8 AML, 4 NHL and 2 had CML.

Etoposide (50 mg/m² per day) was administrated orally for 21 consecutive days; patients who showed a response or stable disease on day 28 received a second and a third cycle of the same treatment. Responder patients received maintenance etoposide at the same dosage 10 days/month until relapse. Three patients (12.5%) died during the first cycle of intracerebral hemorrhage (1 patient) or infective complications (2 patients); no other toxic deaths were observed. All other patients received at least 2 cycles. Two ALL and 1 NHL patient (12.5%) obtained a complete remission of short duration (2, 3, 7 months); 1 ALL and 2 NHL patients (12.5%) achieved a partial response. No patient with myeloproliferative disease attained a response. Data from responder patients are shown in Table 1.

As for toxicity, 15/24 patients (62.5%) suffered febrile episodes during treatment (4 sepsis, 6 bronchopneumonia, 1 fungal sinusitis and 4 fever of unknown origin). One patient developed an intracerebral hemorrhage, while 8/24 patients (33.3%) displayed cutaneous hemorrhagic manifestations. Ten patients (41.6%) had mild nausea (WHO < 2) and vomiting, and 6/24 (25%) mucositis (WHO 2).

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