CM D or CID. Grade 3 or 4 neutropenia developed in 35% and 37% of patients, respectively. Infections occurred in 40% of patients treated with 2-CdA (2 patients died of sepsis) and 38% of patients treated with CMD or CID (1 patient died of sepsis).

There was one fatal neurologic complication in a patient with pre-existing paraneoplastic neurological syndrome, who died of an apparent rapidly progressive sensimotor peripheral neuropathy after completing the treatment with 2-CdA alone.

The results of our study revealed that 2-CdA as monotherapy has significant antitumor activity in previously treated LGNHL patients. The overall response rate was 36.2%. Similar effects have been observed by others. 4,5 It should be stressed that the activity of 2-CdA in previously treated LGNHL seems to be similar to that of another purine analog - fludarabine. 6,7

There is still little experience on using new purine analogs in combination with other drugs in LGNHL treatment. Impressive results were observed by McLaughlin, using a combination of fludarabine, mitoxantrone and dexamethasone in patients with recurrent or relapsed LGNHL. 8 He recorded a 94% overall response rate with 47% CRs. The combination of 2-CdA with mitoxantrone also resulted in a high (76%) rate of responses. 9 The relatively low rate of responses observed in our patients is probably a consequence of the advanced stage of the disease and the multiple previous therapies.

In conclusion, these preliminary results suggest that addition of mitoxantrone or idarubicin and dexamethasone to 2-CdA in previously treated patients with LGNHL may not be of any advantage over 2-CdA alone. 10 However, randomized studies are necessary to confirm this.

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Key words
Low grade non-Hodgkin’s lymphoma, 2-chlorodeoxyadenosine, mitoxantrone, idarubicin, combination chemotherapy

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Table 2. Response according to the treatment of LGNHL with 2-CdA, CMD or CID.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>No. of patients</th>
<th>CR</th>
<th>PR</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-CdA</td>
<td>36</td>
<td>4</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>CMD</td>
<td>17</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>CID</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

The differences among the groups treated with the different regimens are not significant (χ² test) (p>0.05). CR: complete response; PR: partial response; NR: no response.

References
MULTIPLE BLOOD SAMPLES REVEALED CHRONIC LYMPHOADENITIS AND LYMPHOEPITHELIAL THYMOMA. AFTER MEDICAL RADIO-

THERAPY THE PATIENT WAS WELL UNTIL JANUARY 1996, WHEN FEVER REAPPEARED TOGETHER WITH HEPATOSPLEMOGENALY AND A GENERALIZED EDEMATOUS STATE. SPLENECTOMY REVEALED A FIBROCONGESTED SPLEEN, ABDOMINAL LYMPH NODES HAD ABUNDANT PLASMA CELLS, A LIVER BIOPSY WAS NORMAL. SHE WENT THROUGH 3 YEARS OF TREATMENT WITH ANTI-MYCOBACTERIAL, ANTI-HIV, AND ANTIMICROBIAL AGENTS. THE PROGNOSIS OF PATIENTS WITH AGGRESSIVE NON-

HODGKIN'S LYMPHOMA WHO FAIL TO ACHIEVE A COMPLETE REMISSION WITH FIRST-LINE ANTHRACYCLINE-CONTAINING CHEMOTHERAPY OR WHO RELAPSE REMAINS POOR.5,6,7,8 MANY SALVAGE REGIMENS HAVE BEEN REPORTED FOR THESE PATIENTS WITH VARYING EFFECTIVENESS AND VERY POOR CHANCE OF LONG-TERM SURVIVAL.9,10 IFOSFAMIDE HAS BEEN INCLUDED IN SOME OF THESE REGIMENS, OFTEN IN ASSOCIATION WITH ETOPOSIDE.11,12,13 IMPROVED SURVIVAL MAY BE OBTAINED WITH HIGH DOSE CHEMOTHERAPY AND AUTOLOGOUS HEMATOPOIETIC STEM CELL TRANSPLANTATION, ESPECIALLY IN CHEMOSENSITIVE RELAPSES.14

Sir,

We designed a novel salvage program including high-dose ifosfamide infusion plus high-dose fractionated etoposide and methylprednisolone (IFOVM), followed by DHAP chemotherapy5 and subsequent intensive chemotherapy with autologous peripheral blood stem cell transplantation (APBSCT) for patients with refractory or relapsed aggressive NHL.

Between November 1996 and December 1998, 20 consecutive patients were included in this protocol. Patient characteristics at diagnosis are summarized in Table 1. Informed consent was obtained from all patients. IFOVM induction salvage chemotherapy consisted of ifosfamide (10 g/m² as a 72-hour continuous intravenous infusion on days 1-3), etoposide (150 mg/m² every 12 hours as a 2-hour i.v. infusion on days 1 to 3), mesna (20% of the total dose of ifos-

References

Key words
Castleman’s disease, Kaposi’s sarcoma, treatment.

Funding
This work was supported by the AIRC and by PF Biotechnology, CNR, Italy.

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Haematologica vol. 85(2):February 2000

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