Acta Derm Venereol (Stockh) 1995; 75: 494–499

LETTERS TO THE EDITOR

The Use of DAV (DTIC, ACNU and VCR) and Natural Interferon-β Combination Therapy in Malignant Melanoma

Sir,

Malignant melanoma is a skin cancer with a most unfavorable prognosis. Through developments in biotechnology, several kinds of biological response modifiers (BRM), such as interferons (IFNs)-α and -γ, interleukin-2 (IL-2) and tumor necrosis factors (TNF), have generally been applied for the treatment of advanced-stage malignant melanoma (1, 2), but they do not exert an effect sufficient to cure the patients. In this report, we discuss the use of DAV (DTIC, ACNU and VCR) plus nIFN-β for the treatment of malignant melanoma in a series of patients seen at our hospital.

Thirty-eight patients with nodular melanoma, 15 patients with superficial spreading melanoma, 51 patients with acral lentiginous melanoma, 13 patients with lentigo maligna melanoma and 6 patients with unknown subtypes seen between 1972 and 1994 were entered for a retrospective study. Sixty-seven patients were histologically confirmed to have stage III, 14 patients were at stage IV, 17 were at stage II, 21 were at stage I, and in 4 the stage was unknown (UICC, pTNM pathological classification).

DAV (DTIC, ACNU and VCR) plus nIFN-β combination therapy was designed by Ishihara et al. (3). Each 30-day cycle of treatment consisted of a course of DTIC (dakarbazine) 80–140 mg/m^2 intravenously (IV) on days 1 through 5, a course of ACNU (nimustine hydrochloride) 50–80 mg/m^2 IV on day 1, a course of VCR (vincristine sulfate) 1–1.5 mg/m^2 (maximum 2.0 mg/body) IV on day 1 and a course of natural interferon beta (nIFN-β) three million IU subcutaneously on days 1 through 10. Actuarial probability curves were produced using the Kaplan-Meier method. The resulting distributions were compared by means of the generalized Wilcoxon test and Cox-Mantel test using SD-BASE II.

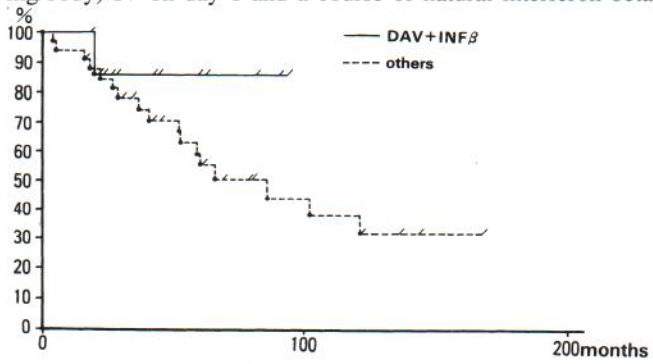

Fig. 1. Survival rates of 47 patients with stage III malignant melanoma, excluding N2 cases, according to initial treatment. *DAV + IFNβ*, 15 patients treated with nIFN-β plus DAV; *others*, 32 patients given other forms of therapy, such as BCG plus DAV or DTIC, picibanil (OK432) plus DAV or DTIC, DAV or DTIC alone.

The survival rate of patients with stage III (N0 and N1) malignant melanoma treated with this combined therapy in the present series was slightly better than that of patients treated with other forms of therapy (Fig. 1). That is, the 5-year survival of patients treated with nIFN-β plus DAV was 85.2%, whereas that of patients not given this therapy was 54.9%. The prognosis of patients with stage I and II malignant melanoma was generally good, irrespective of the type of therapy: the 5-year survival rate of patients given nIFN-β plus DAV combination therapy was 100%. On the other hand, the prognosis of patients with stage III (N2) and IV disease treated with nIFN-β plus DAV combination therapy was very poor, with a 5-year survival rate of only 13%. These results indicate the usefulness of combined therapy with nIFN-β plus DAV for stage III (N0, N1) malignant melanoma. Therefore, a large randomized study is needed, in order to prove the value of nIFN-β plus DAV combination therapy.

REFERENCES

1. von Stamm U, Brocker EB, von Depka Prondzinski M, Ruiter DJ, Rumke P, Broding C, et al. Effects of systemic interferon-alpha (IFN-alpha) on the antigenic phenotype of melanoma metastases. EORTC melanoma group cooperative study No. 18852. Melanoma Res 1993; 3: 173–180.
2. Garbe C. Chemotherapy and chemoimmunotherapy in disseminated malignant melanoma. Melanoma Res 1993; 3: 291–299.
3. Ishihara K, Yamazaki N, Asano K. Chemotherapy of malignant melanoma. Gan To Kagaku Ryoho (Japan) 1993; 20: 1287–1292. (In Japanese).
4. Enomoto T, Hamada M. Cryosurgery and OK 432 in the treatment of malignant melanoma. Arch Otolaryngol 1984; 110: 127–129.

Accepted March 30, 1995.

Tetsuo Nagatani[1], Shin-ichi Ichiyama[2], Rie Onuma[2], Megumi Miyazawa[1], Toshiko Matsuzaki[1], Kanata Miyagawa[3], Naoko Baba[1], Mitsuaki Uchiyama[4] and Hiroshi Nakajima[1].
Departments of Dermatology, [1]Yokohama City University School of Medicine, 3–9 Fukuura, Kagazawa-ku, Yokohama 236, [2]Yokosuka Mutual Aid Hospital, Yokosuka, [3]Sagamihara National Hospital, Sagamihara and [4]Kanagawa Cancer Center, Yokohama, Japan.

 ISSN 0001-5555