DISCUSSION
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In the present study, ninety patients suffering from various malignancies were subjected to different chemotherapeutic regimen. Prior to chemotherapy patients were screened and categorised for different types of malignancies and their stages. On examination, it was seen that Breast and gastrointestinal carcinoma (18% and 29% respectively) were most common types found in our patients. American cancer society (1978) has similarly reported that carcinoma of Breast (in females) 26%, carcinoma of gastro-intestinal tract (18%) were dominant types of malignancies. Kemp and Toms, 1978 have also reported that incidences of malignancy in different organs is in the descending order of lung (Males), Breast (females) and G.I.T.

Distribution of cancer in various age group was shown to be more (44%) in age group 40-60. Similar reports have been given by William Duncan (1982) maximum at about 45 years and by UICC (1981) (most incidences between 40-45 years of age).

Incidence of prominence of Cancer in different sexes was studied. It was seen that males (62%) had greater tendency to suffer from Cancer, as compared to females (38%). This
observation is supported by reports from American Cancer society and British data (Kemp and Toms, 1978).

It was observed that 70% of patients responded completely to the treatment. High response rates (90-100%) have been reported by De Vita et al., 1970; Goldsmith et al., 1974, using MOPP regimen. Similar reports were given by Moxley, et al., 1967 and Bonadonna et al., 1975.

In early breast cancer adjuvant chemotherapy after surgery has shown progressive disease in 18% cases in our study while Bonadona et al., 1975; 1976, showed a relapse of 5.3% after CMF regimen. late stage Breast carcinoma response rate was 22% while other workers, Broader (1974) showed a higher (50-60%) response rate while Cooper (1969) has reported response rate upto 90% with CMFVP regimen. Latest studies with regimens AC, CAF, PM-FAC and FUVAC by Salmon & Jones (1974), Bull, J. (1977). Martimer et al (1985); and Livingstone, et al (1987) respectively have shown 70-80% response. Besides choice of drugs and dosage, response rate also varies with schedule of drugs.

Response rate for Hodgkin's disease was observed in our study to be 80% while other workers have reported response rate of 90-100% using MOPP regimen (De Vita et al., 1970, Goldsmith et al., 1974). In other clinical trials 100% and 90% response with COMP and ABVD regimens respectively have
been shown by Moxley et al., 1967 and Bonadona et al., 1975. Over all response in Non-Hodgkin's Lymphoma was observed to be 67% while Luce et al., 1971 and Bagley et al., 1972; Schein et al., 1975. Mc Kelvey et al., 1975 have shown response upto 60% with BACOP and CHOP regimen. Thus response rate varies according to the combination of drugs.

In the present study over all response in acute Lymphocytic Leukaemia was 33% while other workers Rodriguez et al., 1973; Jacquillat et al., 1973. Richard Champlin et al. 1987 have reported response rate upto 70%. Response to treatment in Leukaemia is to be judged in terms of months or years of survival, without disease. In acute lymphocytic Leukaemia, 5 year leukaemia free survival corresponds to 50% response.

In this study the over all response for acute myeloid leukaemia was observed to be 50%. Similar reports have been documented by Gee et al., 1969.

In Gastric Carcinoma the over all response was 50%, while Kazua et al., 1972; Macdonald et al., 1980; Mortel, C.G., 1976 have shown response rate upto 55%. In Colo-Rectal Carcinoma response rate was 40% while Baker, 1975 reported 30% response. In our study Pancreatic carcinoma has shown a response rate of 50% while Carter and Comis, 1975; Bitran
et al, 1979 and Wiggam, 1978 reported response rates of 30, 45, 50% respectively. Carcinoma Gall Bladder and liver showed 45% response rate while Carter and Livingstone, 1970 obtained a response rate of 40–50%.

In our study testicular cancer showed a response rate of 50% while Samuels 1975 reported a response rate of 75%. Response rate of carcinoma prostate was 66% while Prout, G.R. 1973, has reported a response rate of 80–85%. Jonsson, and Hogberg, B., (1971), observed response rate of 30% by non-hormonal chemotherapeutic agent in resistant cases of Prostate carcinoma. Response rate in bladder carcinoma in our study is 50%, while Carter, S.K. and Wasserman, 1975 observed a response rate of 67%.

Response rate of Head and Neck cancer in our study was 50% while Cortes et al, 1972 and Hanham, et al, 1971 reported response rate of 50–60%. Richard and Chambers reported response rate of 85% by using Hydroxyurea as an adjuvant with surgery and radiotherapy. In Lung cancer response rate was 50% in our study while Wasserman, 1975; Bitran, et al 1978, reported a response of 30–55%.

Among early toxicity most common symptom observed is nausea and vomiting (29%). In delayed toxicity incidences
of anaemia, haemorrhage, and leucopenia were 8, 6, 9% respectively and were due to bone marrow depression caused by cyto-toxic drugs.

As time allocated for the present study was too short, long term follow up was not possible and also malignant disease requires at least 3-5 years follow up to judge the efficacy of any regimen. On the basis of our results which are comparable to various reports and are also supported by them, it is justified to recommend chemotherapy for patients suffering from malignancies as a palliative measure in advanced cases or adjunct to surgery and/or radiotherapy for early cancer.