PROGRAM and ABSTRACTS

Third International Conference on Malignant Lymphoma
June, 10-13, 1987
Lugano, Switzerland
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Third International Conference on Malignant Lymphoma
June, 10-13, 1987
Lugano, Switzerland

Organizing Committee:
F. Cavalli (Bellinzona),
G. Bonadonna (Milan),
M. Rozencweig (Wallingford)

Advisory Board:
C.W. Berard (Memphis)
S.B. Murphy (Memphis)
H. Rappaport (Duarte)
S.A. Rosenberg (Stanford)
J.E. Ultmann (Chicago)
R.C. Young (Bethesda)

Sponsored by Swiss Group for Clinical Cancer Research (SAKK) and Lega Ticinese Contro il Cancro
CONFERENCE SCHEDULE

WEDNESDAY, June 10, 1987

1:00 - 4:00 p.m.  SATELLITE SYMPOSIUM (Room A)  STRATEGIES FOR THE INTEGRATION OF INTRON (INTERFERON ALFA 2B) INTO THE TREATMENT OF HEMATOLOGICAL MALIGNANCIES

4:00 - 5:00 p.m.  MEET THE PROFESSOR (Rooms B,C,E,F)

4:30 - 6:00 p.m.  POSTER SESSION I (Villa Ciani)

5:15 - 6:15 p.m.  WELCOME PARTY (Room B)

6:15 - 7:30 p.m.  Session 1 - OPENING CEREMONY (Room A)  HENRY KAPLAN MEMORIAL LECTURE (Room A)  MONOCLONAL ANTIBODIES: CURRENT STATUS AND RESEARCH AVENUES

THURSDAY, June 11, 1987

8:00 - 11:45 a.m. Session 2 - NEW ASPECTS IN THE BIOLOGY OF LYMPHOMA (Room A)

1:00 - 1:45 p.m.  KEY NOTE LECTURE (Room A)  SPECIFIC CHROMOSOME ABERRATIONS IN NON-HODGKIN'S LYMPHOMA + LYMPHOID LEUKEMIA

1:50 - 2:50 p.m.  Session 3 - HODGKIN'S DISEASE: OVERVIEW (Room A)

3:00 - 5:30 p.m.  Session 4 - HODGKIN'S DISEASE IN ADULTS (Room A)

3:00 - 5:45 p.m.  Session 5 - WORKSHOP ON NEW DIAGNOSTIC POSSIBILITIES IN LYMPHOMA (Room B)

3:00 - 6:10 p.m.  Session 6 - LYMPHOMA IN CHILDHOOD (Room C)

5:30 - 6:30 p.m.  POSTER SESSION II (Villa Ciani)

9:00 p.m.  PERFORMANCE "ROMEO AND JULIET" THEATRE COMPANY: DEL CARRETTO (Room A)

FRIDAY, June 12, 1987

8:30 - 11:45 a.m. Session 7 - LYMPHOMA IN IMMUNODEFICIENCY (Room A)

1:00 - 2:00 p.m.  POSTER SESSION III (Villa Ciani)

2:00 - 3:00 p.m.  Session 8 - NON HODGKIN'S LYMPHOMA: OVERVIEW (Room A)

3:10 - 6:00 p.m.  Session 9 - TREATMENT OF NON HODGKIN'S LYMPHOMA IN ADULTS (Room A)

3:15 - 6:00 p.m.  Session 10 - WORKSHOP ON THE CURRENT SITUATION OF BONE MARROW TRANSPLANTATION IN MALIGNANT LYMPHOMA (Room B)

3:05 - 6:00 p.m.  Session 11 - PATHOLOGY AND CLINICAL-PATHOLOGICAL CORRELATIONS (Room C)

5:30  SATELLITE WORKSHOP (Room F)  INTERFERON ALFA 2A AND LYMPHOMAS

SATURDAY, June 13, 1987

9:00 - 12:00 a.m. Session 12 - NEW TREATMENTS-REPORTS ON CURRENT STATUS (Room A)

11:00  CONCLUDING LECTURE

12:00  ADJOURN
POSTER SESSIONS

I - Wednesday, June 10, 4:30-6:00 p.m.
II - Thursday, June 11, 5:30-6:30 p.m.
III - Friday, June 12, 1:00-2:00 p.m.

LOCALISATION OF POSTERS

26 - 35
22 - 25
9 - 21
4 - 8
1 - 3

PALAZZO DEI CONGRESSI
Farmorubicin®
(epirubicin)
Expanding the boundaries of anthracycline therapy
Farmorubicin® gives you unsurpassed anthracycline efficacy

Farmorubicin matches Adriamycin®—milligram for milligram—in both single-agent¹ and combined chemotherapy regimens.² ³

| Response of Farmorubicin and Adriamycin given at equimolar doses in single-agent or combination chemotherapy |
|--------------------------------------------------|-----------|-----------|-----------|-----------|-----------|
| Response rate (%)                                | 0         | 10        | 20        | 30        | 40        | 50        |
| Single-agent therapy¹                           |           |           |           |           |           |
| Farmorubicin (75 mg/m²)                         |           |           |           |           |           |
| Adriamycin (75 mg/m²)                           |           |           |           |           |           |
| Combination therapy²                            |           |           |           |           |           |
| FEC*                                             |           |           |           |           |           |
| FAC*                                             |           |           |           |           |           |

*Farmorubicin (FEC) or Adriamycin (FAC) 50 mg/m² combined with 5-fluorouracil (500 mg/m²) and cyclophosphamide (500 mg/m²)

Farmorubicin breaks the cardiotoxicity barrier and gives you more tolerable treatment

Farmorubicin cuts Adriamycin cardiotoxicity in half and allows cumulative doses up to 1,000 mg/m² with minimal risk of CHF. ³ ⁴ ⁵ ⁶ In addition, Farmorubicin has shown less treatment-limiting myelosuppression² and fewer, less severe acute side effects.³ ⁵ ⁶

Percent of patients showing evidence of toxicity* (more than 1300 patients) (Farmorubicin dose: 75-90 mg/m² IV)⁶

<table>
<thead>
<tr>
<th>Congestive Heart Failure**</th>
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<tbody>
<tr>
<td>Previously untreated with anthracyclines</td>
</tr>
<tr>
<td>Pretreated with anthracyclines</td>
</tr>
</tbody>
</table>

Leukopenia†
untreated
pretreated

Nausea/
vomiting

Alopecia

*WHO criteria
⁷ Based on lowest WBC value recorded
**Total cumulative dose of anthracyclines ≤ 1000 mg/m²

Farmorubicin helps you sustain the remissions you achieve

Farmorubicin permits multiple additional courses of therapy at full therapeutic doses, undelayed by excessive or unpredictable hematologic toxicity.

Duration of remission in patients treated with Farmorubicin as a single agent* and in combined chemotherapy (FEC vs FAC)**

<table>
<thead>
<tr>
<th>Median duration of remission (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>Farmorubicin</td>
</tr>
<tr>
<td>Adriamycin</td>
</tr>
<tr>
<td>FEC</td>
</tr>
<tr>
<td>FAC</td>
</tr>
</tbody>
</table>

*Jain KK, et al
**Armand JP, et al, ECCO

Farmorubicin®
(epirubicin)

Expanding the boundaries of anthracycline therapy
Farmorubicin® gives you the power to help your patients

- Unsurpassed anthracycline activity
- Significantly reduced cardiotoxicity
- A new level of tolerability
- A consistent therapeutic index

Expanding the boundaries of anthracycline therapy

PHARMACOLOGY AND TOXICOLOGY

Experimental antitumor activity. Farmorubicin proved effective in a wide variety of experimental tumors, particularly leukemias L 1210, P 388, sarcomas solid and ascitic SA 108, melanoma B 16, mammary carcinoma, Lewis' lung carcinoma 38, as well as in human tumor transplanted into athymic nude mice (melanoma, breast, lung, prostatic and ovarian carcinomas).

Pharmacokinetic. In patients with normal liver and kidney functions, plasma levels of Farmorubicin exhibit a biphasic declining pattern, including a very fast first phase and a definitively slow second phase characterized by a half-life of about 30 hrs. Plasma levels of the main metabolite, namely the 13-OH derivative, are consistently lower and follow a similar curve pattern of the unchanged drug. Excretion predominantly occurs by biliary route. High plasma clearance values (1.4 l/min) indicate that the slow elimination is due to extensive tissue distribution. Farmorubicin does not surpass the blood-brain barrier (in rats).

Toxicology. Repeated administration (in rabbits and dogs) and cardio toxicity studies (in rats and rabbits) showed that epicubicin is less toxic than the parent compound. Dose is reduced (in rabbits).

Farmorubicin proved mutagenic in vitro and carcinogenic in vivo (in rodents).

CLINICAL INFORMATION

Farmorubicin proved to be active in breast, ovarian, gastric and hepatic carcinomas, malignant lymphomas, and soft tissue sarcomas. Preliminary evidence suggests that Farmorubicin may induce responses in small cell lung carcinomas, head and neck, pancreatic and rectal cancers, and acute lymphoblastic leukemia.

Central nervous system: Severe heart disease, previous treatments with maximal cumulative doses of Adriamycin or daunorubicin.

Side effects: Cardiac toxicity, alopecia, myelosuppression, gastrointestinal disorders, and hematologic toxicity.

Precautions. Patients should be carefully monitored during the first course of Farmorubicin treatment. White and red blood cell and platelet counts should be strictly monitored. At conventional dosage schedules, leukopenia is commonly transient. WBC nadir is reached between 10 and 14 days from start of treatment, and normal values are recovered within 21 days. Before and possibly during treatment, liver function should be monitored by usual laboratory tests (SGOT, SGPT, AP, bilirubin). In laboratory animals as well as in clinical settings Farmorubicin appeared associated to lower acute and chronic cardiotoxicity than Adriamycin. Although uncommon, left ventricular failure can occur, particularly in patients who have received a cumulative dose that exceed 1000 mg/m². However, cardiac decompensation can be exacerbated even several weeks after completion of treatment, proving sometimes unresponsive to specific medication. In case of simultaneous or previous irradiation to the mediastinal-pericardial area, cumulative doses should be reduced accordingly. In any case, total Farmorubicin dose should be individualized on account of possible concomitant administration of potentially cardiotoxic agents. In addition, ECG should be performed before and after every course. Appearance of ECG changes, such as T wave flattening or inversion, S-T depression, or nonspecific ST-T wave changes, may be observed. If these changes persist or occur, the patient should be hospitalized and clinically monitored. Cardiac monitoring of Farmorubicin-treated patients is of utmost importance. Heart function should be assessed by using multiple noninvasive techniques, such as ECG, echocardiography, and possibly ejection fraction as measured by myocardial scintigraphy.

Like other anthracyclines, Farmorubicin can induce hypersensitivity from rapid infusion of necrotic cells, therefore selena should be monitored accordingly to allow pharmacological control. Adequate information is still lacking on cardiac drug influence on male and female fertility, or on its teratogenic activity or fetal toxicity. Experimental data, however, suggest that Farmorubicin may harm the fetus. The drug may be given a red color to the urine, up to 1-2 days after administration.

Drug interactions and incompatibility. Farmorubicin should not be mixed with Hemin (chemical incompatibility). In combination regimens avoid mixing Farmorubicin together with other drugs into the same syringe.

Dosage and administration route. The recommended dose for single-agent Farmorubicin in adults is 75-100 mg/m² body surface, as 4-5 h.i.v. injections 3-5 weeks, with constant use of a bone marrow function. A lower dose is recommended for patients with reduced bone marrow reserve due to previous chemotherapy and/or radiotherapy, old age, or malignant bone marrow infiltration.

In this case, the total dose per course may be divided in 2 or 3 consecutive days.

In combination schedules, doses should be adequately reduced. Since the main elimination pathway is the hepatobiliary system, doses should also be reduced in patients with impaired liver function in order to prevent increased overall toxicity. In patients with serum bilirubin peaking at 1.4-3 mg/dl, a 50% reduction is recommended as well as a 75% reduction for higher values of serum bilirubin.

Moderate impaired renal function seems not to require dose reduction, due to low Farmorubicin excretion by renal route.

Modes of administration. Farmorubicin is to be administered i.v. It is inactive by oral route, and must not be given by i.m. or intrathoracic route.

Intact venous administration should occur via the tubing of a saline infusion (pico proper needle placement has been verified). This minimizes the risk of extravasation while allowing washing of the vein or completion of injection. Drug extravasation is associated with serious tissue injury, up to necrosis. Venous sclerosis may be observed, particularly when small vessels are used or injections repeated in the same vein.

<table>
<thead>
<tr>
<th>Freeze-dried preparation</th>
<th>Diluent added</th>
<th>Final concentration</th>
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<tbody>
<tr>
<td>10 mg</td>
<td>5 ml</td>
<td>2 mg/ml</td>
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<tr>
<td>20 mg</td>
<td>10 ml</td>
<td>2 mg/ml</td>
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<tr>
<td>50 mg</td>
<td>25 ml</td>
<td>2 mg/ml</td>
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</table>

The recommended solution is stable for 24 hrs at room temperature, and for 48 hrs in a refrigerator (4° - 10°C). It should be protected from direct light.

It is advisable that personnel handling this drug should wear protective gloves. Accidental contact of Farmorubicin powder or solution with skin or mucosa should be treated immediately by copious wash with soap and water.

Package quantities. Each vial contains 10 mg or 50 mg of epirubicin hydrochloride as a freeze-dried powder.

Composition.

Epirubicin hydrochloride | 10 mg | 20 mg | 50 mg |
<table>
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<tr>
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<tbody>
<tr>
<td>Excipient: Lactose</td>
<td>30 mg</td>
<td>100 mg</td>
<td>250 mg</td>
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WEDNESDAY, June 10, 1987
4:00 - 7:30 p.m.

4:00 - 5:00 p.m.

MEET THE PROFESSOR (Rooms B,C,E,F)
(Entrance free)

SPECIAL SITUATIONS IN THE TREATMENT OF HD (Room B)
J.E. Ultmann, Chicago, USA

TREATMENT OF AGGRESSIVE NHL (Room C)
G. Bonadonna, Milan, Italy

LYMPHOMA IN CHILDREN (Room E)
S.B. Murphy, Memphis, USA

AUTOLOGOUS BONE MARROW TRANSPLANTATION IN THE
TREATMENT OF LYMPHOMA (Room F)
J.O. Armitage, Omaha, USA

4:30 - 6:00 p.m.

POSTER SESSION I (Villa Ciani)
BASIC RESEARCH AND MISCELLANEOUS

Session 1 - OPENING CEREMONY (Room A)
Chairman: F. Cavalli

6:15 p.m.

WELCOME AND INTRODUCTORY REMARKS.
F. Cavalli, Bellinzona, Switzerland

6:30

HENRY KAPLAN MEMORIAL LECTURE
MONOCLONAL ANTIBODIES: CURRENT STATUS AND RESEARCH.
G. Köhler, Freiburg, West-Germany
### Session 2 - NEW ASPECTS IN THE BIOLOGY OF LYMPHOMA (Room A)
Chairmen: G. Losa and C.W. Berard

<table>
<thead>
<tr>
<th>Time</th>
<th>Abstract</th>
<th>Title, Authors</th>
</tr>
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<tbody>
<tr>
<td>8:00 a.m.</td>
<td>2</td>
<td>Ki-1 LYMPHOMA: EXPERIMENTAL AND CLINICAL FINDINGS. H. Stein, et al, Berlin, West-Germany</td>
</tr>
<tr>
<td>8:20</td>
<td>3</td>
<td>RECEPTORS OF B CELL ACTIVATION AND DIFFERENTIATION ARE VARIABLY EXPRESSED ON EBV NEGATIVE AND POSITIVE CELL LINES. M.C. Favrot, et al, Lyon, France</td>
</tr>
<tr>
<td>8:35</td>
<td>4</td>
<td>B-CELL NEOPLASIA RECAPITULATES THE NORMAL HUMORAL IMMUNE RESPONSE. D.D. Weisenburger, et al, Omaha, USA</td>
</tr>
<tr>
<td>8:50</td>
<td>5</td>
<td>MULTICLONAL LYMPHOMAS. J. Sklar, Stanford, USA</td>
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<tr>
<td>9:15</td>
<td>6</td>
<td>PERIPHERAL BLOOD GENE REARRANGEMENT ANALYSES IN MALIGNANT LYMPHOMA. S.J. Horning, et al, Stanford, USA</td>
</tr>
<tr>
<td>9:30</td>
<td>7</td>
<td>REFRACTORINESS TO CHEMOTHERAPY AND POOR SURVIVAL RELATED TO ABNORMALITIES OF CHROMOSOMES 17 AND 7 IN LYMPHOMA. P. Cabanillas, et al, Houston, USA</td>
</tr>
<tr>
<td>9:45</td>
<td>8</td>
<td>CHROMOSOMAL ABERRATIONS IN CHRONIC B-LYMPHOCYTIC LEUKAEMIA - CONSISTENCY DURING PROGRESSION OF DISEASE. J. Gunnar, et al, Huddinge, Sweden</td>
</tr>
<tr>
<td>10:00</td>
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<td>INTERMISSION</td>
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<tr>
<td>10:20</td>
<td>9</td>
<td>MIXED-LINEAGE LEUKEMIAS AND PHENOTYPIC SHIFTS OCCURRING IN RELAPSED CASES OF ACUTE T LYMPHOBLASTIC LYMPHOMAS. D. Delia, et al, Milan, Italy</td>
</tr>
<tr>
<td>10:35</td>
<td>10</td>
<td>COMBINATION THERAPY WITH CYTOKINES AND MONOCLONAL ANTIBODIES. B.F. Issell, Emeryville, USA</td>
</tr>
<tr>
<td>10:50</td>
<td>11</td>
<td>THE CLINICAL PHARMACOLOGY OF A RECOMBINANT HUMAN IL-2 ANALOG IN PATIENTS WITH CANCER. E.C. Bradley, et al, Emeryville, USA</td>
</tr>
<tr>
<td>11:05</td>
<td>12</td>
<td>DEVELOPMENT OF MONOCLONAL ANTIBODIES AGAINST HODGKIN-DERIVED CELL LINES. M. Pfleuderschuh, et al, Cologne, West-Germany</td>
</tr>
<tr>
<td>11:35</td>
<td>14</td>
<td>MALIGNANT LYMPHOMAS ASSOCIATED WITH ASBESTOS EXPOSURE. R. Jacobson, et al, Washington, USA</td>
</tr>
<tr>
<td>11:45</td>
<td></td>
<td>INTERMISSION</td>
</tr>
<tr>
<td>12:00 noon</td>
<td></td>
<td>LUNCH (Room B)</td>
</tr>
</tbody>
</table>
Thursday, June 11, 1987
8:00 a.m. - 1:45 p.m. (continued)

1:00 p.m. 15 KEY NOTE LECTURE (Room A)
SPECIFIC CHROMOSOME ABERRATIONS IN NON-HODGKIN'S LYMPHOMA
+ LYMPHOID LEUKEMIA. J.D. Rowley, Chicago, USA

1:45 p.m.
INTERMISSION

Session 3 - HODGKIN'S DISEASE: OVERVIEW (Room A)
Chairman: A. Lister

1:50 - 2:50 p.m.
1:50 p.m. 16 HODGKIN'S DISEASE: THE MILAN CANCER INSTITUTE EXPERIENCE
WITH MOPP AND ABVD. G. Bonadonna, Milan, Italy

2:10 17 HODGKIN'S DISEASE: NCI TRIALS ADDRESSING THE REMAINING
CHALLENGES. R.C. Young, Bethesda, USA

2:30 18 THE CONTINUING CHALLENGE OF HODGKIN'S DISEASE.
S.A. Rosenberg, Stanford, USA

2:50
INTERMISSION

Session 4 - HODGKIN'S DISEASE IN ADULTS (Room A)
Chairmen: R.C. Young and K.W. Brunner

3:00 - 5:30 p.m.
3:00 p.m. 19 HODGKIN'S DISEASE: IS PARA-AORTIC IRRADIATION NECESSARY IN
ALL CASES OF SURGICALLY STAGED SUPRADIAPHRAGMATIC DISEASE?
N.J.S. Voss, et al, Vancouver, Canada

3:15 20 RADIOThERAPY VS CHEMOTHERAPY IN PATIENTS WITH EARLY STAGE
HODGKIN'S DISEASE (PATH. ST. II AND IIA)) - REPORT AFTER 4.5
YEARS OF FOLLOW-UP. G.P. Biti, et al, Florence, Italy

3:30 21 THE CLINICAL STAGES I AND II HODGKIN'S DISEASE: THE EORTC
LYMPHOMA GROUP EXPERIENCE OVER TWO DECades. TOWARDS
COMPREHENSIVE MANAGEMENT TAILORED TO PROGNOSTIC FACTORS.
M. Tubiana, et al, Villejuif, France

3:45 22 RESULTS OF THE HD1 AND HD3 TRIALS OF THE GERMAN HODGKIN'S
DISEASE STUDY GROUP. V. Diehl, et al, Cologne, West-Germany

4:00 23 MOPP VS ALTERNATING MOPP/ABVD IN ADVANCED HODGKIN'S DISEASE.
R. Somers, et al, Amsterdam, The Netherlands

4:15 24 IMPROVED SURVIVAL WITH SEQUENTIAL BELO-MOPP FOLLOWED BY ABVD
FOR ADVANCED HODGKIN'S DISEASE: 7-YEARS RESULTS.
J.H. Glick, et al, Philadelphia, USA

4:30 25 RANDOMISED STUDY OF LOPP (LEUKERAN, ONCOVIN, PROCARBAZINE,
PREDNISONE) AND LOPP ALTERNATING WITH EVAP (ETOPOSIDE, VELBE,
ADRIAMYCIN, PREDNISONE) IN ADVANCED HODGKIN'S DISEASE -
PRELIMINARY RESULTS. B.W. Hancock, Sheffield, Great Britain
Thursday, June 11, 1987
3:00 - 5:30 p.m. (continued)

4:45 26 PREDICTIVE VALUE OF EARLY RESPONSE TO MOPP IN "HIGH-RISK" STAGE II AND III HODGKIN'S DISEASE. A. Levis, et al, Torino, Italy

5:00 27 THE SIGNIFICANCE OF RESIDUAL MEDIASTINAL WIDENING FOLLOWING TREATMENT FOR HODGKIN'S DISEASE. J.A. Radford, et al, Manchester, Great Britain

5:15 28 SECONDARY MALIGNANCIES AFTER HODGKIN'S DISEASE IN THE NETHERLANDS CANCER INSTITUTE. R. Somers, et al, Amsterdam, The Netherlands

Session 5 - WORKSHOP ON NEW DIAGNOSTIC POSSIBILITIES IN LYMPHOMA (Room B)
Chairman: C.W. Berard - Co-chairman: F. Rilke

3:00 - 5:45 p.m.

3:00 p.m. 29 MAC (MORPHOLOGY-ANTIBODY-CHROMOSOME) METHOD IN THE CHARACTERIZATION OF THE CELLS IN LYMPHOMAS. S. Knuutila, Helsinki, Finland

3:20 30 MONOCLONAL ANTIBODIES IN THE DIAGNOSIS OF MALIGNANT LYMPHOMAS. H. Stein, et al, Berlin, West-Germany

3:40 31 REARRANGEMENTS OF ANTIGEN RECEPTOR GENE DNA IN MALIGNANT LYMPHOMA. J. Sklar, Stanford, USA

4:00 32 Ig GENE REARRANGEMENT IN NON-HODGKIN'S LYMPHOMA. R.A. Rudder, et al, Boston, USA

4:15 33 DETECTION OF LYMPHOMA CELLS IN PERIPHERAL BLOOD AND BONE MARROW BY DNA HYBRIDISATION. M. Brada, et al, Sutton, Great Britain

4:30 34 CORRELATION BETWEEN CELL SURFACE ANTIGEN EXPRESSION, AND IMMUNOGLOBULIN AND T-CELL RECEPTOR B CHAIN GENE REARRANGEMENT IN LYMPHOPROLIFERATIVE DISORDERS. Ph. Gaulard, et al, Creteil, France


5:00 36 PROGNOSTIC VALUE OF NUCLEIC ACID FLOW CYTOMETRY IN DIFFUSE LARGE CELL LYMPHOMA. P. M. McLaughlin, et al, Houston, USA

5:15 - EVALUATION FROM THE CLINICIAN'S PERSPECTIVE. S.A. Rosenberg, Stanford, USA

5:30 DISCUSSION AND SUMMARY OF THE CHAIRMAN.
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00</td>
<td>Risk-adapted chemotherapy, involved field irradiation with reduced doses and selective splenectomy in childhood Hodgkin's disease: update of the German multicenter study Dal-HD-82. G. Schellong, et al, Münster, West-Germany</td>
</tr>
<tr>
<td>3:40</td>
<td>Hodgkin's disease in childhood: the experience of the Italian Association of Pediatric Hematology and Oncology with protocol AIBOP-MH'83. V. Vecchi, et al, Bologna, Italy</td>
</tr>
<tr>
<td>4:00</td>
<td>Limited-field and low-dose radiotherapy + ABVD chemotherapy for childhood Hodgkin's disease. F. Possati, et al, Milan, Italy</td>
</tr>
<tr>
<td>4:10</td>
<td>Update results of the protocols LMB of the French Pediatric Oncology Society (SOP) for B-cell advanced stage non-Hodgkin's lymphoma. J.M. Zucker, et al, Villejuif, France</td>
</tr>
<tr>
<td>5:00</td>
<td>High cure rate with reduction in toxicity for children with localized non-Hodgkin's lymphoma: results of a randomized study of the pediatric oncology group. M.P. Link, et al, Palo Alto, USA</td>
</tr>
<tr>
<td>5:10</td>
<td>High dose methotrexate in childhood non Hodgkin's lymphoma: its efficacy for CNS prophylaxis. C. Patte, et al, Villejuif, France</td>
</tr>
<tr>
<td>5:30</td>
<td>Advanced B cell lymphoma in children. Who remains the high risk patients? T. Philip, et al, Lyon, France</td>
</tr>
<tr>
<td>5:40</td>
<td>Malignant lymphomas under 20 years of age in a Japanese district (Kagoshima) with prevalent adult T-cell leukemia/lymphomas. K. Hasui, et al, Kagoshima-shi, Japan</td>
</tr>
</tbody>
</table>
Thursday, June 11, 1987
3:00 - 6:00 p.m. (continued)

5:50  50  BURKITT'S LYMPHOMA IN KUWAIT. M. Samir Motawy, et al, Shuwaikh, Kuwait

6:00  51  ABDOMINAL NON-HODGKIN'S LYMPHOMA IN CHILDHOOD: MIDDLE EAST TYPE. Y. Sweed, et al, Haifa, Israel

5:30 - 6:30
POSTER SESSION II (Villa Ciani)
HODGKIN'S DISEASE IN ADULTS AND LYMPHOMA IN CHILDREN

FRIDAY, June 12, 1987
8:30 - 11:45 a.m.

Session 7 - LYMPHOMA IN IMMUNODEFICIENCY (Room A)
Chairmen: C. Jasmin and H.J. Senn

8:30 a.m.  52  LYMPHOPROLIFERATIVE DISORDERS ASSOCIATED WITH IMMUNODEFICIENCY: TUMOR CHARACTERISTICS AND CYTOGENETIC ASSOCIATIONS. A.H. Filipovich, Minneapolis, USA

8:50  53  ADULT T-CELL LEUKEMIA/LYMPHOMA. K. Takatsuki, Kumamoto, Japan

9:10  54  PROGNOSTIC VALUE OF BLOOD AND BONE MARROW T-COLONY-FORMING CELLS IN PATIENTS WITH LYMPHADENOPATHY SYNDROME. C. Jasmin, et al, Villejuif, France

9:25  55  CLINICAL, MORPHOLOGIC, PHENOTYPIC, AND MOLECULAR GENETIC ANALYSIS OF AIDS/ARC-ASSOCIATED MALIGNANT LYMPHOID NEOPLASIA. D.M. Knowles, et al, New York, USA

9:40  56  EXPRESSION OF THE DEOXYNUCLEOTIDYL TERMINAL TRANSFERASE IN PERIPHERAL BLOOD CELLS OF INDIVIDUALS WITH ANTI HTLV-III/LAV ANTIBODIES. G.A. Losa, Locarno, Switzerland

9:55
INTERMISSION

10:15  57  MALIGNANT NON-HODGKIN'S LYMPHOMA IN PATIENTS WITH HIV INFECTION. P.S. Gill, et al, Los Angeles, USA

10:30  58  MALIGNANT LYMPHOMAS IN PERSONS AT HIGH RISK FOR AIDS IN ITALY: A REPORT OF 46 CASES. S. Monfardini, et al, Aviano, Italy

10:45  59  DIRECTIONS IN EXPERIMENTAL THERAPY OF AIDS AND INFECTION WITH HIV. P.A. Volberding, San Francisco, USA

11:15  60  HUMAN LYMPHOTROPIC VIRUSES (T&8 CELL) AND THEIR ROLE IN MALIGNANCY, AIDS AND CENTRAL NERVOUS SYSTEM DISEASE. R.C. Gallo, Bethesda, USA

11:45
INTERMISSION

12 noon LUNCH (Room B)
POSTER SESSION III (Villa Ciani)
NON HODGKIN'S LYMPHOMA

Session 8 - NON HODGKIN'S LYMPHOMA: OVERVIEW (Room A)
Chairman: J.E. Ultmann

2:00 - 3:00 p.m.

2:00 p.m.  61  CURRENT STATUS OF NCI-TRIALS. R.C. Young, Bethesda, USA

2:20       62  CURRENT TRIALS IN THE UNITED STATES.
               J.H. Glick, Philadelphia, USA

2:40       63  CURRENT STATUS OF TRIAL IN EUROPE, ESPECIALLY UK.
               A. Lister, London, Great Britain

3:00  INTERMISSION

Session 9 - TREATMENT OF NON HODGKIN'S LYMPHOMA IN ADULTS (Room A)
Chairmen: P. Jacobs and G. Bonadonna

3:10 - 6:00 p.m.

3:10 p.m.  64  SURVIVAL OF GOOD PROGNOSIS DIFFUSE LARGE CELL LYMPHOMA
               PATIENTS TREATED WITH CHOP OR CHOP-VARIANTS.
               J.R. Anderson, et al, Boston, USA

3:25       65  CHOP IS CURATIVE IN THIRTY PERCENT OF PATIENTS WITH DIFFUSE
               LARGE CELL LYMPHOMA: A TWELVE YEAR SOUTHWEST ONCOLOGY GROUP
               FOLLOW UP. C.A. Coltman, et al, San Antonio, USA

3:40       66  CHOP-B ALTERNATED WITH CMED IN THE TREATMENT OF AGGRESSIVE
               LYMPHOMAS. W.S. Velasquez, et al, Houston, USA

3:55       67  MACOP-B, 12 WEEKLY TREATMENTS FOR AGGRESSIVE LYMPHOMAS: 6
               YEARS OF EXPERIENCE. P. Klimo, et al, Vancouver, Canada

4:10       68  AGGRESSIVE LYMPHOMAS TREATED BY INTENSIVE CHEMOTHERAPY:
               UPDATED RESULTS OF LNH-80 PROTOCOL WITH A MEDIAN FOLLOW-UP
               OF 52 MONTHS. B. Coiffier, et al, Lyon, France

4:25       69  TREATMENT OF LYMPHOBLASTIC LYMPHOMA IN ADULTS.
               J.P. Colgan, et al, Rochester, USA

4:40       70  SOUTHWEST ONCOLOGY GROUP CLINICAL TRIALS FOR INTERMEDIATE AND
               HIGH GRADE NON-HODGKIN'S LYMPHOMAS. T.P. Miller, et al, Tucson,
               USA

4:55       71  PATTERNS OF RELAPSE IN LARGE CELL LYMPHOMA PATIENTS WITH
               MASSIVE BULKY DISEASE. M. Shipp, et al, Boston, USA
Friday, June 12, 1987
3:10 - 6:00 p.m. (continued)

5:05  72  FACTORS ASSOCIATED WITH RESPONSE, SURVIVAL AND TRANSFORMATION IN RECURRENT LOW GRADE POLYCLULAR LYMPHOMAS. J. Spinolo, et al, Houston, USA


5:35  74  LONG-TERM OUTCOME WITH OR WITHOUT TUMOR PROGRESSION IN POLYCLULAR LOW GRADE NON-HODGKIN'S LYMPHOMA. J. Erskold, et al, Copenhagen, Denmark

5:50  75  DOSE INTENSITY ANALYSIS FOR CHOP CHEMOTHERAPY IN UNFAVORABLE LYMPHOMA. R. Epelbaum, et al, Haifa, Israel

6:00  INTERMISSION

Session 10 - WORKSHOP ON THE CURRENT SITUATION OF BONE MARROW TRANSPLANTATION IN MALIGNANT LYMPHOMA (Room B)
Chairman: G.P. Canellos

3:15 - 6:00 p.m.

3:15  76  AUTOLOGOUS BONE MARROW TRANSPLANTATION IN HODGKIN'S DISEASE. J.O. Armitage, Omaha, USA


3:55  78  MARROW TRANSPLANTATION AS TREATMENT FOR MALIGNANT LYMPHOMA. F.R. Appelbaum, Seattle, USA

4:15  DISCUSSION

4:25  79  EBMT RESULTS OF AUTOLOGOUS BONE MARROW TRANSPLANTATION IN HODGKIN'S DISEASE. A.H. Goldstone, London, Great Britain

4:40  80  SEQUENTIAL HIGH-DOSE CHEMO-RADIOTHERAPY FOLLOWED BY AUTOLOGOUS BONE MARROW TRANSPLANTATION IN REFRACTORY OR RELAPSED HODGKIN'S DISEASE. A.M. Gianni, et al, Milan, Italy

4:55  81  ALLOGENEIC BONE MARROW TRANSPLANTATION FOR MALIGNANT NON HODGKIN'S LYMPHOMAS. P. Ernst, Copenhagen, Denmark

5:10  82  SELECTION CRITERIA IMPROVE DISEASE-FREE SURVIVAL IN PATIENTS WITH POOR PROGNOSIS NON-HODGKIN'S LYMPHOMA FOLLOWING AUTOLOGOUS BONE MARROW TRANSPLANTATION. T. Takvorian, et al, Boston, USA

5:25  83  ABMT IN BURKITT'S LYMPHOMA (50 CASES IN THE LYON PROTOCOL). T. Philip, et al, Lyon, France
5:40     84  CYTOXAN + TOTAL BODY IRRADIATION WITH AUTOLOGOUS BONE MARROW TRANSPLANTATION IN ADULT LYMPHOBLASTIC LYMPHOMA IN FIRST COMPLETE REMISSION. A REPORT OF THE ITALIAN LYMPHOMA STUDY GROUP. G. Santini, et al, Genua, Italy

5:50     DISCUSSION AND SUMMARY OF THE CHAIRMAN

**Session 11 - PATHOLOGY AND CLINICAL-PATHOLOGICAL CORRELATIONS (Room C)**
Chairmen: H. Rappaport and K. Lennert

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**Session 12 - NEW TREATMENTS - REPORTS ON CURRENT STATUS** (Room A)
Chairmen: S.A. Rosenberg and M. Rozencweig

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<tbody>
<tr>
<td>9:00 a.m.</td>
<td>97</td>
<td>TREATMENT OF LYMPHOMA IN JAPAN. N. Horikoshi, Tokyo, Japan</td>
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<tr>
<td>9:20</td>
<td>98</td>
<td>A PHASE I STUDY OF THE FEASIBILITY OF USING AUTOLOGOUS LYMPHOCYTES AS VECTORS TO TARGET RADIO-ACTIVE MATERIAL TO SITES OF DISEASE IN NON-HODGKIN'S LYMPHOMA. R.A. Cowan, et al, Manchester, Great Britain</td>
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<tr>
<td>9:35</td>
<td>99</td>
<td>DEOXYCOFORMICIN: AN ACTIVE NEW DRUG IN LYMPHOID MALIGNANCIES.</td>
<td>P.J. O'Dwyer, et al, Philadelphia, USA</td>
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<tr>
<td>9:50</td>
<td>100</td>
<td>COMBINATION OF CISPLATIN, HIGH DOSE ARA-C AND DECADRON IN RELAPSING LYMPHOMA. W. Velasquez, et al, Houston, USA</td>
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<tr>
<td>10:05</td>
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<td>REPORT FROM THE WORKSHOP ON NEW DIAGNOSTIC POSSIBILITY IN LYMPHOMA (Session 5). C.W. Berard, Memphis, USA</td>
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<td>10:25</td>
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<td>REPORT FROM THE WORKSHOP ON BONE MARROW TRANSPLANTATION (Session 10). G.P. Canellos, Boston, USA</td>
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<tr>
<td>10:45</td>
<td>101</td>
<td>REPORT FROM THE CONFERENCE IN LYCON ARMS (November 1986).</td>
<td>A. Lister, London, Great Britain</td>
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<tr>
<td>11:00</td>
<td>102</td>
<td>CONCLUDING LECTURE</td>
<td>SUMMARY OF THE CONFERENCE AND FUTURE DIRECTIONS OF RESEARCH IN LYMPHOMA. J.E. Ultmann, et al, Chicago, USA</td>
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<td>11:45</td>
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<td>CLOSING REMARKS. F. Cavalli, Bellinzona, Switzerland</td>
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Die richtige Formulierung bringt die besten Resultate.

25 Tabletten* à 200 mg:
Bei Herpes genitalis (oral).

Hautcrème* 10 g/5%:
Bei Herpes genitalis (lokal).

Hautcrème 2 g/5%:
Nur bei Herpes labialis (Menge ist für andere Hautinfekte zu gering).

Augensalbe* 4,5 g/3%:
Nur bei herpetischen Augeninfekten.

5 Ampullen i.v. à 250 mg:
Bei schweren Infekten im Spital.

*kassenzulässig

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