etoposide (or vinblastine) and ifosfamide salvage therapy for male germ cell tumors. Ann Oncol 1992; 3:211-16

To the Editor:

The experience of Drs. Musi, Di Vito, and Rosti with salvage chemotherapy for recurrent thymoma using a platinum-based regimen reiterates the observations we reported previously1 and raises new issues on the choice of therapy for recurrences after a second remission. A prolonged disease-free interval, usually greater than 12 months, has been shown to be a predictor of response to salvage chemotherapy in breast, lung, and ovarian cancers, as well as in Hodgkin’s lymphomas.1 Our report supported these observations. However, the reported case of Musi et al seems to suggest that shorter disease-free intervals do not preclude response.

We are ambivalent about deleting doxorubicin from the regimen. In a recent trial by Loehrer and others,2 30 patients treated with doxorubicin in combination with cisplatin and cyclophosphamide yielded three complete and 12 partial responders, for an overall response rate of 50%. Formasiero et al reported an overall response rate of 91% in 32 patients treated with doxorubicin, cisplatin, vincristine, and cyclophosphamide. Etoposide, in combination with cisplatin, is emerging as an alternative regimen for unresectable thymomas.

High-dose chemotherapy with stem cell support is a novel treatment option for recurrent disease, but currently is not recommended due to the paucity of evidence that it improves clinical outcome.

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The Changing Presentation of Lung Adenocarcinoma

To the Editor:

We read with great interest the article by Quinn and colleagues (December 1996),1 and we agree with him on this rarely reported topic. We recently studied the changing radiographic presentation of 121 bronchogenic adenocarcinomas in France over a period of 11 years in a consecutive series.2 We described three radiographic forms: peripheral, hilar, and mediastino-hilar.

Over the period (1985-1993), peripheral tumors represented 51.6%, hilar tumors 27%, and mediastino-hilar 18.9% of those described. The proportion of peripheral forms is similar in the group in the study by Quinn et al (49%). The sum of hilar and mediastino-hilar forms in our series is equal to the central tumors in their series. 45.9% and 46%, respectively. Since 1990, the peripheral and mediastino-hilar forms have become significantly more frequent, although the hilar form is rarer. These mediastino-hilar adenocarcinomas are associated with a higher mortality.

Using the results of the study by Quinn et al, we have pooled hilar and mediastino-hilar radiographic forms to compare the evolution of peripheral vs central tumors. We have not found any significant radiographic modification (p=0.121). But over a longer period, this change could perhaps appear. It is one of the interests of the paper by Quinn et al to compare current data to historical data.

We think that this mediastino-hilar is a new aggressive form of lung adenocarcinomas.

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To the Editor:

Drs. Jeanfautre and Tuchais report an experience in France similar to that which we have recently noted in the United States.1 Adenocarcinoma now presents with central origin (46%) as often as peripheral origin (49%). This is a change from earlier studies reporting adenocarcinoma arising as peripheral tumors in 72% of the patients.2 We were prompted to perform our study because of the increased relative incidence of adenocarcinoma, now making it the most common type of bronchogenic carcinoma in the United States.3

We would be interested in any information from Drs. Jeanfautre and Tuchais regarding the relative frequency of different cell types of bronchogenic carcinoma in France.

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