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TNM AND CLINICAL RELEVANCE - TESTICULAR TUMORS

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Until now, for pts. with testicular germ cell tumors the T-category was of low clinical importance. In a prospective TNM-study for testicular tumors we found out, that it is unfavourable to comprise the infiltration into the rete testis and into the epididymis in one category (T3). As to our own results almost half of the pts. with an infiltration of the epididymis had an advanced disease (bulky tumor/distant metastases), whereas only 10 % of the pts. with an invasion into the rete testis had advanced disease. In future, the T-category could become more important, if a surveillance strategy is considered.
For prognosis and the choice of therapy the N- and M-categories are of crucial importance. Especially at this point the classification of N-category shows severe shortcomings. Neither the number nor the size of metastases are defined exactly. In the N1-category the solitary metastase should be limited in size up to 2 cm. The N2-category should be subdivided into multiple metastases below 2 cm and 2-5 cm in size, whereas the N3-category should reflect bulky disease of more than 5 cm as this tumor masses require inductive chemotherapy. Until now the N4-category comprised iliac lymph node metastases as well as mediastinal and supraclavicular nodes. Several examinations revealed a similar prognostic value for pts. with iliac lymph node metastases and only retroperitoneal ones. Therefore they should be included into the N2-category. On the other hand supradiaphragmal metastases show a survival rate comparable to pts. with distant metastases, and a primary chemotherapy is indicative.
According to these findings we presented in the course of the TNM-study a new classification to the UICC, that will be considered in the next edition. First results in the course of the disease of the study patients will be presented.

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RESULTS OF TNM POLLS

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7.500 oncologists from German-speaking countries in either leading or independent position were asked
1. whether they know of the TNM system
2. whether they used the system
3. whether they used another classification's system
4. or whether they used a modified TNM system

from those asked 3.266 (43%) answers were received, 75% of the replies came to about 1/3 each from general surgeons, gynaecologists and internists. In the whole 5,1% of the collective do not have any knowledge neither of the TNM appelation nor of the UICC. 65% of all oncologists use the TNM classification without any limitation. 16% of the general surgeons applie the DUKES's classification for colo-rectal carcinomas. 26% of the gynaecologists use FIGO's classifications (which is identical to the UICC's classification since 1978). Most frequently were Urologists who either use other classifications' systems or a modified TNM system.

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Asb 01

ASBESTOS AT THE WORKPLACE AND DISEASES

H.-J. Woitowitz

The fate of ten thousands of workers with ascertained or suspected asbestos-related diseases in the USA has led to a thorough discussion about the responsibility for such "industrial latency damages." In the FRG the number of persons, which have been exposed during production or in "user" industries after WW II cannot be estimated. Asbestos exposure can result in both inflammatory and neoplastic diseases: asbestosis, lung cancer and mesothelioma. The incidence of asbestos-related diseases which have for the first time been announced and compensated as occupational diseases is increasing. Today, asbestos fibers take the first place among the cancerogenic working materials.

Mesothelioma of pleura and peritoneum is considered as a signal tumor for an occupational asbestos exposure. However, there is broad epidemiological evidence on a 2- to 3-fold higher death rate for asbestos-related lung cancer. Both kinds of occupational cancer show latency periods of several decades. Association of the diagnosis lung cancer or mesothelioma and an occupational asbestos exposure decades ago is rather complicated for the general practitioner, clinician or pathologist. Central diagnostic aims are the early, histologically confirmed diagnosis in connection with a qualified occupational history. So, the physician can contribute decisively to the task of enabling the social protection, which is intented by law, for the patients and their relatives in cases of occupational cancer.

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Asb 02

THE FIBRE AS A CARCINOGENIC AGENT

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According to the findings that long, thin, and durable fibres have a high carcinogenic potency after intrapleural and intraperitoneal administration, the elongated shape of a particle represents a carcinogenic agent; this physical phenomenon is a special cause of cancer. It induces a biological process which can lead to cancer by several as yet unknown steps. Some granular dusts which are chemically similar to asbestos did not produce tumours. However, the properties of the material the fibres are made of determine the carcinogenic potency of a fibre in a secondary way although they do not seem to be responsible for the true carcinogenic agent. For example, these properties determine the degree of solubility and flexibility. The durability of fibres in the tissue is a very important property with regard to their carcinogenic effect because the induction of a tumour takes many years or some decades. We assume that a fibre has to remain by the bronchial or serosa cells until the induction of tumour cells occurs; without this permanent contact the generation of a tumour might not happen. In contrast to fibres, such a presence is obviously not necessary in the case of cigarette smoke components. If our hypothesis is correct, there could be a "durability-threshold value" for fibres whose length and diameter would otherwise indicate a high carcinogenic potency. In this case, if this threshold is not met, the cancer risk, even on exposure to a high number of such fibres, would be zero. The proof of this theory would be of interest for the production of very thin but "safe" man-made fibres.

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