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Results with combination chemotherapy for high-risk gestational trophoblastic tumours 1989 to 2006 : retrospective non - randomized study
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GTT were treated with the EMA/CO regimen (etoposide methotrexate, actinomycin D, cyclophosphamiode, vincristine), actinomycin D, cyclophosphamide, vincristine). 42 patients had received no prior chemotherapy and 18 had received prior chemotherapy. 8 out of 10 patients with drug resistance to EMA/CO were treated with cisplatin alone. Remaining two were treated with EMA.EP (addition of cisplatin). 42 patients who had received no prior chemotherapy, 38 (90 percent) were in remission, 18 patients had received prior chemotherapy and 15 (83 percent) were in remission; an overall survival of 88 percent for the 60 patients. One of 61 patients dies before starting chemotherapy from extensive disease. One of the 42 patients without prior chemotherapy died from febrile neutropenia. The addition of cisplatin (EMA/EP) salvaged 2 of 2 (100 percent) who developppppped drug resistance and one did require salvage surgery. Relapse after EMA/CO chemotherapy is relatively uncommon (8 percent) but survival is still very good with further chemotherapy and or surgery with 10 (100 percent) of 10 patients obtaining a further sustained remission. At present EMA/CO chemotherapy is the treatment of choice for patients with high risk GTT. Its toxicity is predictable and reversible. In patients developing resistance to EMA/CO can be successfully salvaged with high dose cisplatin or addition of cisplatin (EMA/EP). The high dose cisplatin is a very good option for relapse patients. Further studies maybe needed to assess the high dose cisplatin schedule.