The addition of rituximab to CHOP significantly improved the complete remission rate (75% versus 63%) and overall survival at two years (70.2% versus 57.3%) in patients aged between 60 and 80 years.[4] Importantly, these gains were made without apparent increase in overall toxicity.

The apparent success with combination therapy cannot yet be applied to all patients with lymphoma. Lymphoma is a heterogenous disease and the responses to treatment are clearly dependent upon a number of factors including the exact type of lymphoma and the age of the patient. For instance, there are currently no data supporting any role for the combination of rituximab and chemotherapy in people under 60 years old.

The cost of treatment needs consideration. One cycle of treatment with rituximab-CHOP costs approximately $4000 compared with $500 for CHOP alone. Another consideration is the new data which show that increasing the frequency of CHOP to fortnightly produces comparable improvements, in overall survival and complete remission rates, to those seen with rituximab-CHOP. Given these findings, and the cost of rituximab, it will be important to establish the optimal number of infusions, as well as the specific sub-group of patients for whom this drug is truly beneficial.

Conclusion

Therapeutic antibodies have not revolutionised the management of patients with cancer. However, the incremental gains associated with the use of these drugs have cemented their place in the clinical management of a select group of individuals. Over the next few years the precise role of these and other antibodies as adjuvant or first-line treatment for specific diseases will become apparent.

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REFERENCES

1. Cobleigh MA, Vogel CL, Tripathy D, Robert NJ, Scholl S, Fehrenbacher L, et al. Multinational study of the efficacy and safety of humanized anti-HER2 monoclonal antibody in women who have HER2-overexpressing metastatic breast cancer that has progressed after chemotherapy for metastatic disease. J Clin Oncol 1999;17:2639-48. (sponsored trial)
2. Slamon DJ, Leyland-Jones B, Shak S, Fuchs H, Paton V, Bajamonde A, et al. Use of chemotherapy plus a monoclonal antibody against HER2 for metastatic breast cancer that overexpresses HER2. N Engl J Med 2001;344:783-92. (sponsored trial, randomised trial)
3. McLaughlin P, Grillo-Lopez AJ, Link BK, Levy R, Czuczman MS, Williams ME, et al. Rituximab chimeric anti-CD20 monoclonal antibody therapy for relapsed indolent lymphoma: half of patients respond to a four-dose treatment program. J Clin Oncol 1998;16:2825-33. (sponsored trial)
4. Coiffier B, Lepage E, Briere J, Herbrecht R, Tilly H, Bouabdallah R, et al. CHOP chemotherapy plus rituximab compared with CHOP alone in elderly patients with diffuse large-B-cell lymphoma. N Engl J Med 2002;346:235-42. (sponsored trial, randomised trial)

Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 151)

9. Trastuzumab is only indicated for women with breast cancers which overexpress the receptor HER2.
10. A serious adverse reaction to rituximab may not develop until two days after the infusion.

Book review

Australian Medicines Handbook Drug Choice Companion: Aged Care.

Adelaide: Australian Medicines Handbook; 2003.

218 pages. Price $50, students $45, plus postage.

Shanthi Kanagarajah, Geriatrician, Melbourne

The Companion is intended for use in conjunction with the Australian Medicines Handbook (AMH), the well-known and highly valuable drug formulary. It aims to assist those working in aged care, especially in residential facilities. The nearly pocket sized volume with a ring binding is easy to handle and the cover is probably resistant to contamination by bodily fluids.

The text itself is organised into common clinical problems in the aged care setting, with dementia and other neurological conditions heading the list. Following the instructions inside the front cover, I used the index to trace my way through typical clinical questions. Each topic is subdivided into consistent subheadings that include diagnostic issues and non-drug issues. The subsections on 'evidence' are a neat way of giving credence to the book's assertions.

There are useful summaries on conditions that one meets much more often in nursing homes than in textbooks of medicine – restless legs syndrome, managing stroke risk in people with advanced morbidity, and (not) crushing or splitting tablets. Several practice points and warnings are highlighted as call-outs, an effective device to focus one's attention to key messages.

The brevity of the work does present difficulties, for example there is no evidence section under insomnia. In Parkinsonism the problem of a poor clinical response to dopaminergic therapy is clearly stated, but the difficulty of existing postural hypotension (such as in multisystem atrophy) being aggravated by the drugs, is only hinted at. I found the inclusion of the section on irritable bowel syndrome puzzling, given that it may be 'less common in older than in younger people' and 'convincing evidence for the efficacy of drug treatments… is lacking'. Disabling stroke is a difficult management problem in nursing homes and hostels and a section on the therapeutics of spasticity would have been useful.

The Companion reasonably succeeds in its aim of assisting the busy aged care worker at the bedside. Doctors, nurses and pharmacists, particularly those doing medication reviews, should find this extremely useful. It is a 'first of its kind' in Australia.