PURPOSE
To evaluate local transarterial chemoperfusion (TACP) of therapy-resistant, locally recurrent malignant tumors and lymph node metastases in the pelvis with respect to clinical response, tumor response and survival.

MATERIALS AND METHODS
Between 2003 and 2005, 24 outpatients (median age 56.5 years, range 33-82) were treated with 128 TACPs (min. 3; mean 5 sess/patient) in 4-week intervals. Depending on the tumor location and vascularization, a fluoroscopy catheter was placed either in the abdominal aorta or internal pelvic artery. A combination of mitomycin C (6 mg/m (2)) and gemcitabine (1500 mg/m (2)) was administered over 60 minutes. The tumor size was measured using CT or MRI. The radiological response was classified according to RECIST (Response Evaluation Criteria In Solid Tumors) as "complete response" (CR), "partial response" (PR), "stable disease" (SD) and "progressive disease" (PD). The clinical response was classified as "response (clinical)" if the symptoms improved distinctly, "stable disease (clinical)" if complaints were stabilized, and "progression (clinical)" if symptoms deteriorated or new symptoms appeared. After the third TACP, patients were evaluated for clinical and radiological response. In the case of clinical and radiological progression, therapy was stopped and the patient was referred to the hospital's tumor board. In the case of radiological response and clinical progression or clinical response and radiological progression, therapy was continued. Therapy could be stopped by the patient at any time.

RESULTS
Treatment was tolerated well by all patients. No clinically relevant problems and no grade III or IV toxicity according to CTC (Common Toxicity Criteria) appeared. Tumor-related pain, bleeding, restricted mobility of the lower extremities, incontinence, urinary tract obstruction, and constipation were reduced in 9/17, 5/6, 3/3, 1/3, 2/5, and 1/3 of cases (clinical response rate: 54%). Radiologically, 4/24 (17%) patients showed PR, 12/24 (50%) SD, and 8/24 (34%) PD (tumor control (PR+SD): 67% of cases). Tumor response (median survival since first TACP) was as follows: colorectal: 2 PR, 7 SD, 2 PD
(11.5 months), ovarian: 1 SD, 2 PD (8.5 mon), cervical: 1 PR, 1 SD (6 mon), breast: 2 SD (6 mon), gastric: 1 PD (11 mon), adrenal gland: 1 PD (12 mon), anal: 1 PD (10 mon), prostate: 1 PD (20 mon), Gartner's duct: 1 PR (20 mon), renal cell carcinoma: 1 SD (10 mon).

CONCLUSION
Since tumor-related complaints were improved in 54% of the cases and control of tumor growth (PR+SD) was achieved in 67% of the cases, TACP for recurrent pelvic malignancies should be considered as a palliative oncological treatment option.