Role of Single-Breath Carbon Monoxide-diffusing Capacity in Monitoring the Pulmonary Effects of Bleomycin in Germ Cell Tumor Patients

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ABSTRACT

Serial pulmonary function tests including single-breath carbon monoxide-diffusing capacity (DLco), forced vital capacity (FVC), and forced expiratory volume in 1 sec were performed in a relatively homogeneous group of male patients with germ cell tumors treated with vinblastine, bleomycin, and cis-diaminedichloroplatinum. Of the pulmonary function tests used, the DLco was shown to be the most sensitive indicator of subclinical bleomycin pulmonary effects. Decreases in DLco were both total dose and schedule dependent. Patients receiving their total dose of bleomycin at a rate of 25 ± 2 (S.D.) units/week developed a linear decrease in DLco with increasing total doses of bleomycin. Changes in FVC did not correlate with bleomycin total dose. Although both the mean DLco and FVC decreased after completion of bleomycin therapy, the mean FVC returned to base-line levels rapidly, whereas the decrease in mean DLco was persistent for several months. When routine volumetric tests (FVC and forced expiratory volume in 1 sec) and DLco are used in a systematic manner, DLco is the most sensitive indicator of the subclinical pulmonary effects of bleomycin in germ cell tumor patients treated with vinblastine, bleomycin, and cis-diaminedichloroplatinum.

INTRODUCTION

Bleomycin is a nonmyelosuppressive antitumor antibiotic with documented activity in testicular carcinoma (2). It has become an important component of recent combination chemotherapy programs for testis cancer. Current therapeutic regimens using bleomycin combined with either vinblastine or vinblastine plus DDP3 are capable of inducing long-term complete responses in 40 to 60% of patients with metastatic disease (7, 14).

Pulmonary fibrosis is the primary dose-limiting toxicity of bleomycin. Fatal pulmonary fibrosis occurs in 1 to 2% of patients, and an additional 2 to 3% of patients develop well-documented interstitial fibrosis related to bleomycin (2, 3). Clinical manifestations of bleomycin pulmonary toxicity occur sporadically at total doses of 100 to 500 units. There is a significant increase in the incidence of bleomycin pulmonary toxicity when total doses in excess of 500 units are administered (3). The incidence of subclinical pulmonary toxicity manifested by unexpected findings of pulmonary fibrosis at autopsy parallels the incidence of clinically appreciated pulmonary toxicity, raising the possibility that the incidence of subclinical disease is at least as great as that of the clinically apparent disease (3).

Several studies have used pulmonary function tests in an attempt to monitor pulmonary toxicity. Most studies have been performed in heterogeneous groups of patients receiving bleomycin in various doses and by various schedules and routes of administration (10, 13, 17).

Male patients with metastatic germ cell tumors represent a relatively homogeneous group of previously healthy young patients. With current treatment regimens which include bleomycin, these patients can be expected to survive for prolonged periods of time. The present study was designed to evaluate the efficacy of standard, serial pulmonary function tests in a series of such patients receiving a standard treatment program including bleomycin administered by a single route of administration and with the same dosage and schedule in an attempt to assess whether any pulmonary function test would be a useful predictor of clinically apparent bleomycin pulmonary toxicity or indicator of subclinical bleomycin pulmonary toxicity.

MATERIALS AND METHODS

Patient Characteristics. Eleven male patients, 9 with testicular carcinoma and 2 with primary mediastinal germ cell tumors, were evaluated. The mean and median age was 25 years (range, 19 to 47 years). Three patients had pulmonary metastases. Three patients were cigarette smokers. All smokers were instructed to refrain from smoking prior to pulmonary function tests. Both patients with primary mediastinal germ cell tumors had received prior radiotherapy to the mediastinum. One patient received 6000 rads in 5 weeks to the mediastinum 6 months prior to initiating chemotherapy. The second patient presented with superior vena cava syndrome and received 1000 rads in 2 days to the mediastinum followed by an additional 3000 rads in 3 weeks. The 2 patients who received prior radiotherapy are analyzed separately, since it has been reported that prior radiotherapy increases the risk of developing bleomycin pulmonary toxicity (8, 15).

Chemotherapy. All patients were treated i.v. with a 3-drug regimen including vinblastine (0.2 mg/kg/day for 2 days), DDP (20 mg/sq m/day for 5 days), and bleomycin (30 units weekly for 12 doses). No “synchronization” of vinblastine and bleomycin doses was used. Chemotherapy was withheld in any patient having a leukocyte count of less than 1000 cells/cu mm or if a documented infection was present. Bleomycin therapy was reinitiated upon resolution of leukopenia and/or the infectious process.
Changes in pulmonary function tests were, in general, not used in the decision to terminate bleomycin therapy. Bleomycin therapy was discontinued if: (a) radiological findings consistent with bleomycin pulmonary toxicity developed; (b) the patient developed dyspnea on exertion during routine activity, in the absence of a significant anemia; or (c) fine crackling rales were apparent on routine weekly physical examination. If no pulmonary toxicity as defined above was observed, bleomycin was discontinued after 360 units had been administered. After discontinuing bleomycin, therapy consisted of vinblastine (0.3 mg/kg every 4 weeks) in patients in complete remission. Patients who experienced a partial response continued vinblastine and DDP until a complete remission occurred.

Pulmonary Function Tests. FVC and FEV₁ were measured by standard spirometric techniques using a Med-Science wedge spirometer recording on a Tektronics storage oscilloscope. DLco was determined by the method of Ogilvie et al. (12) as modified by Mitchell and Renzetti (11). DLco measurements were performed in duplicate. Determinations were required to agree within 2 ml/min/mm Hg. If the first 2 determinations did not meet these criteria, further measurements were made until 2 such values were obtained; these were then averaged. All DLco values were corrected for hemoglobin concentration by the method of Dinakara et al. (6).

Baseline pulmonary function tests were performed prior to initiating therapy and serially thereafter at 1- to 3-week intervals. Changes in pulmonary function tests were analyzed both as a percentage of the initial pretreatment value and as a change in the percentage of the predicted values. Predicted values for DLco were obtained from the formulae given by Bates et al. (1), while predicted values for FVC and FEV₁ were based upon age and height (9). The initial DLco was 98 ± 9% (S.D.) of the predicted value in the 9 patients who had no prior radiotherapy, and the initial FVC was 100 ± 16% of the predicted value. The data, except when otherwise noted in the text, are expressed as the percentage of the initial pretreatment value.

Statistical Analysis. Statistical analyses were performed using the Student t test for paired samples, the analysis of variance for groups with unequal replication (16), and linear regression analysis, where appropriate.

RESULTS

Chart 1 shows the effects of increasing total doses of bleomycin on the mean DLco and FVC in the 9 patients who had not received prior radiotherapy. A significant decrease in the mean DLco was noted after a total dose of 60 units of bleomycin had been reached. The mean DLco decreased progressively with increasing bleomycin doses. No statistically significant changes occurred in the mean FVC values with increasing total doses of bleomycin, and no patient developed changes in FEV₁, independent of changes in FVC.

In most patients, a linear decrease in DLco was observed with increasing doses of bleomycin, and this preceded any significant decrease in FVC. An illustrative case is presented in Chart 2.

A significant alteration in the rate at which the total bleomycin dose was administered (dose rate) accounted for some of the variability in the mean values of DLco presented in Chart 1. Of the 9 patients who had not received prior radiotherapy, 6 received their total bleomycin dose on a schedule approximating the projected 30 units/week dose rate (25 ± 2 (S.D.) units/week). Three other patients received their total bleomycin dose at a significantly reduced dose rate (16 ± 1.6 units/week) because of severe and persistent leukopenia during therapy.

A linear regression analysis of the DLco determinations of the 6 patients who received an average weekly dose of bleomycin of 25 ± 2 units is presented in Chart 3. The relationship between decreasing DLco and increasing total doses of bleomycin was linear (p < 0.001). No correlation existed between FVC and bleomycin dose (data not shown). Those patients who received the total bleomycin dose at a rate of 16 ± 1.6 units/week experienced either a delayed or decreased rate of decline and/or recovery to control values during delays in therapy, followed by a fall in DLco upon reinstitution of bleomycin at a rate of 30 units/week. An example of the effects of an alteration in the scheduling of bleomycin is presented in Chart 4. Because of severe myelosuppression, this patient received only 120 units of bleomycin in the first 9.4 weeks of therapy, an average of 13 units/week. During this period, the DLco initially declined and returned to baseline levels. Upon reinstitution of bleomycin at a dose of 30 units/week, the DLco decreased rapidly.

The relationship between the total dose of bleomycin administered and changes in DLco and FVC is presented in Chart 5. There was a statistically significant relationship between the total bleomycin dose administered and the change in DLco (p
Pulmonary toxicity, confirmed by light and electron microscopy studies, developed in 2 patients. Serial DLco and FVC determinations for these 2 patients are shown in Chart 7. Both patients developed precipitous decreases both in DLco and FVC after the last dose of bleomycin therapy. The patient shown in Chart 7A had a persistent large abdominal mass after 3 full courses of therapy including 360 units of bleomycin. An additional 30 units of bleomycin was administered when the DLco and FVC were 41 and 84% of the initial values, respectively. At that time, the patient had no pulmonary symptoms and no physical or radiographic findings consistent with pulmonary toxicity. Within 1 month, the patient developed respiratory failure and died. The second patient (Chart 7B) had received the first 120 units of bleomycin at a decreased dose rate as shown in Chart 4. After reinstitution of bleomycin at a dose of 30 units/week, a rapid decrease (10% of the initial value per week) in both DLco and FVC developed. One month following therapy, both D.
detectable abnormalities in pulmonary function tests occur during bleomycin therapy when no detectable radiographic findings are apparent. Yagoda et al. (17) and Krakoff et al. (10) have reported that decreases in total lung capacity and DLco occur in most patients treated with bleomycin, although no correlation was found between changes in these parameters and the total dose administered. The majority of patients studied by Pasqual et al. (13) developed a decrease in FVC before and during therapy with bleomycin, but the relationship between these changes and bleomycin dose was obscured by the presence or absence of pulmonary metastases. Samuels et al. (15) have stated that the FVC is the most reliable indicator of bleomycin pulmonary toxicity, but the relationships among the dose of bleomycin, timing of FVC measurements, and the type of other pulmonary function tests performed were not presented.

The design of the present study differs from most previous investigations, primarily in that the patient population was a relatively homogeneous group of previously healthy young men with germ cell tumors. In addition, the dose and route of bleomycin administration was standardized; pulmonary function tests were performed serially, and the relationship between the timing of pulmonary function testing and bleomycin therapy is presented.

Under these conditions, DLco was found to be a more sensitive indicator of subclinical bleomycin pulmonary effects than were standard volumetric measurements. Decreases in DLco during bleomycin therapy were found to be both total dose and schedule dependent. The latter relationship may account for some of the variability reported previously in correlating changes in DLco with bleomycin therapy.

The persistence of the decrease in DLco after discontinuing bleomycin may explain our recently reported observation that patients with germ cell tumors who have received bleomycin 1 to 6 months prior to instituting a new therapeutic regimen including bleomycin are more likely to develop bleomycin pulmonary toxicity than patients who have never received bleomycin (5).

Several reports have indicated that the risk of developing pulmonary toxicity is increased in patients who have received prior radiotherapy (8, 15). Both patients who had received radiotherapy in the present study developed precipitous and prolonged decreases in DLco after low total doses of bleomycin were administered.

DISCUSSION

Previous studies examining the relationship between changes in pulmonary function tests and bleomycin administration have been performed in groups of patients heterogeneous with respect to age, sex, type of cancer, and the presence or absence of pulmonary metastases or other nonmalignant pulmonary disease (10, 13, 17). Within these studies, there has also been substantial variability in bleomycin dose, rate of drug delivery, route of administration, and the total dose of drug administered. In addition, the timing of the pulmonary function testing relative to the total dose of bleomycin or time from discontinuation of therapy has, in general, not been well defined.

With these constraints, most previous studies have demonstrated that detectable abnormalities in pulmonary function tests occur during bleomycin therapy when no detectable radiographic findings are apparent. Yagoda et al. (17) and Krakoff et al. (10) have reported that decreases in total lung capacity and DLco occur in most patients treated with bleomycin, although no correlation was found between changes in these parameters and the total dose administered. The majority of patients studied by Pasqual et al. (13) developed a decrease in FVC before and during therapy with bleomycin, but the relationship between these changes and bleomycin dose was obscured by the presence or absence of pulmonary metastases. Samuels et al. (15) have stated that the FVC is the most reliable indicator of bleomycin pulmonary toxicity, but the relationships among the dose of bleomycin, timing of FVC measurements, and the type of other pulmonary function tests performed were not presented.

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Chart 8 shows the changes in DLco of all patients, including the 2 patients who developed severe bleomycin pulmonary toxicity. It is apparent that more data are necessary to define whether the DLco will be of value in predicting which individual patient will develop severe bleomycin pulmonary toxicity. It would appear, however, that caution should be exerted in continuing bleomycin therapy in patients whose DLco has fallen to ≤40% of the initial or predicted value, regardless of FVC changes, or in patients who develop rapid, parallel decreases in both DLco and FVC while on therapy (Chart 7).

As used in this study, bleomycin was part of a 3-drug program including vinblastine and DDP. Therefore, the possibility exists that significant drug interactions may account for some of the results noted. Neither vinblastine nor DDP has been reported to be a clinically significant pulmonary toxin. It is unlikely, therefore, that a direct effect of either drug on the lungs was involved in the observed pulmonary function abnormalities. On the other hand, the major excretory pathway for bleomycin is renal, and we have shown that the elimination half-life of bleomycin varies inversely with changes in creatinine clearance (4). It is conceivable that alterations in bleomycin elimination secondary to DDP-induced nephrotoxicity might have contributed to the results observed in this study. We examined bleomycin pharmacokinetics in 5 patients. There was no correlation between the elimination half-lives in these patients and abnormalities in pulmonary function tests. Since only one or two pharmacokinetic studies were performed in an individual patient throughout the treatment program, the lack of a significant correlation may have resulted from inadequate sampling.

In contrast to previous conclusions by others, it appears that the DLco is a sensitive indicator of subclinical bleomycin pulmonary effects when the test is performed systematically in a relatively homogeneous group of young male germ cell tumor patients treated with vinblastine, bleomycin, and DDP.

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