detectable tumors \(10^9\) cells). The ability to deliver multiple fractions of TRT now exists with the advent of fully human mAb’s. It is time to apply the principles of dose-dense chemotherapy delivery to TRT and investigate the feasibility and efficacy of multiple fractions (cycles) of these very promising agents.

Tod W. Speer

Conflict-of-interest disclosure: The author declares no competing financial interests.

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References


Response

Multiple administrations of the fully human monoclonal antibody Ofatumumab

We thank Tod W. Speer, MD, for his valuable comments, which basically underline what we have stated in our paper.1 Multiple administrations of a fully human monoclonal antibody such as Ofatumumab in immunocompetent patients would not likely induce antibody formation—and thereby make the treatment ineffective—because of the lack of immunogenicity. That this might offer significant advantages above murine or chimeric antibodies, for instance, after labeling the antibody with an isotope and performing repeated radioimmunotherapy, remains to be established by the appropriate clinical studies. In that regard, Dr Speer comes forward with interesting theoretical calculations in terms of schedules inducing the most effective cell kill. Again, these hypotheses need to be proven by clinical trials.

Anton Hagenbeek

Conflict of interest disclosure: The author declares no competing financial interests.

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Reference


To the editor:

Nonmyeloablative conditioning for relapsed follicular lymphoma

Khouri et al from the M. D. Anderson Cancer Center (Houston, TX) report the long-term outcome of 47 patients with chemotherapy-sensitive follicular lymphoma who received a nonmyeloablative allogeneic stem cell transplantation from predominantly (96%) sibling donors. With a median follow-up of 60 months, only 7 patients had died from complications. The 5-year overall survival was 85%.1 Median age at transplantation was 53 years, and all patients had chemotherapy-sensitive disease.

The authors state that “these results compare favorably to earlier studies using nonmyeloablative conditioning which were associated with treatment-related mortality up to 40%.” Here they refer to a registry study by the Center for International Blood and Marrow Transplant Research (CIBMTR).2 This is not an an appropriate comparison. The patients treated by Khouri et al all had chemotherapy-sensitive disease, and an excellent performance status (as shown by the average very low International Prognostic Index [IPI]). By contrast, 33 of 113 patients in the original CIBMTR study had a decreased performance status that was associated with a 2.4 increased risk of treatment-related mortality. Sixty-six of 113 had chemotherapy-resistant disease, which was also associated with a doubling of treatment-related mortality. Survival curves illustrating the effect of performance status and disease sensitivity from this early study are shown in Figure 1 (not included in the original publication). The importance of performance status and disease sensitivity for the outcome of allogeneic transplantation has been confirmed numerous times and by multiple groups.3-6

For patients with an excellent performance status and chemotherapy-sensitive disease, the outcome with allogeneic transplantation is excellent, whether reduced intensity or myeloablative conditioning is used,3,7 and the study by Khouri et al provides further evidence for this. It does not provide evidence that nonmyeloablative conditioning is superior. In the most recent update from the CIBMTR on follicular lymphoma, the overall treatment-related mortality at 1 and 3 years was 23% to 28%, with
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