Allogeneic Bone Marrow Transplantation for High-Risk Acute Lymphoblastic Leukemia During First Complete Remission


Fifty-three patients with high-risk acute lymphoblastic leukemia (ALL) under age 50 with a histocompatible sibling donor received high-dose radiochemotherapy followed by allogeneic bone marrow transplantation (BMT). The high-risk factors used to identify the patients were: white blood cell count at initial presentation, cytogenetic abnormalities, age, extramedullary leukemic infiltration, and time from initial therapy to complete remission. Patients with one or more of the above risk factors who received BMT have a disease-free survival of 61% with a median follow-up of 66 months (range 11 months to 10.6 years), and an actuarial relapse rate of 10%. This study demonstrates that patients with high-risk ALL achieve a significant disease-free survival and cure rate with the use of allogeneic fully matched sibling BMT. However, a properly designed prospective study comparing the outcome of BMT with the best currently available chemotherapy data is required to define the ultimate role of BMT in this group of patients.

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All patients 53 34 4 0.016
Sex
Female 19 10 2
Male 34 24 2
Age (yr)
0.3, 1.8, 5t 3 3 —
16-19 34 24 4
≥ 30 16 7 — 0.003
Time from initial therapy to CR
≤ 4 wk 35 24 7 0.014
> 4 wk 18 7 3
Immunophenotype
cALLa 21 15 1
T cell 15 9 2
Null 6 3 —
B cell 3 1 —
Not done 8 6 1
WBC count at diagnosis (per µL)
1,400-24,999 24 12 1
25,000-99,000 14 10 —
≥ 100,000 15 12 3
Cytogenetics
Normal 14 9 1
Abnormal† 8 5 —
Abnormal§ 4 2 —
Not done/failed 27 18 3
Risk factors
1 36 22 3
≥ 2 17 12 1
Preparatory regimen
Ara C/Cy/TBI 17 9 1
FTBI/Cy 17 11 3
FTBI/VP-16 19 14 —
GVHD prophylaxis
Mtx/Pred 27 11 2
Csa/Pred 19 17 2
Csa/Pred/Mtx 7 6 —

Table 1. Patient Characteristics

Abbreviations: CR, complete remission; Ara C, cytosine arabinoside; Cy, cyclophosphamide; TBI, total body irradiation; FTBI, fractionated TBI; Mtx, methotrexate; Pred, prednisone; Csa, cyclosporine.

* Cox multivariate stepwise proportional hazard analysis: age and time from initial therapy to CR are continuous variables.
† Eight weeks to achieve CR.
‡ t(4;11), t(9;22), or t(8;14).
§ t(7;12), t(3;12), t(2;15), or inv-1.
||Four patients crossed over to Csa/Pred for GVHD therapy after failing Mtx/Pred prophylaxis.

On day −1, followed by marrow grafting on day 0. The next 17 patients were prepared with 1,320 cGy of fractionated TBI including partial lung shielding delivered between day −7 through day −4 and cyclophosphamide (100 mg/kg) on day −3. The subsequent 19 patients received the same TBI regimen followed by VP-16 (60 mg/kg) on day −3. The marrow inoculum for all patients was obtained from histocompatible sibling donors. Supportive care measures administered after BMT were identical to those reported previously. A combination of methotrexate and prednisone was used to prevent GVHD for the first group of patients. The next cohort participated in a prospective randomized trial and received either methotrexate/prednisone or cyclosporine/prednisone. The subsequent group participated in a study randomizing between cyclosporine/prednisone versus cyclosporine/prednisone/methotrexate (trial still ongoing).

Informed consent. All clinical protocols were reviewed and approved by the Institutional Review Board of City of Hope National Medical Center and the Administrative Panel on Human Subjects in Medical Research at Stanford University Medical Center. The risks and benefits for each patient were explained in detail at least two outpatient visits and again on the date of admission. Written consent was then obtained from the patient and, in the case of minors, from the parents or guardian. Risks and benefits were also discussed with the potential donors before initiation of therapy.

Statistical analysis. Statistical analysis to test for predictors of prolonged survival was performed using the Cox proportional hazard regression model. The method of Kaplan and Meier was used to calculate disease-free survival and the actuarial relapse.

RESULTS
Survival. At the date of evaluation (May 15, 1991), 34 patients were alive and in continued CR (Fig 1). The actuarial disease-free survival was 61%. Follow-up of the surviving patients ranged from 11 months to over 10.6 years, with a median observation time of 5.5 years. Seven patients had a follow-up period of less than 2 years after BMT. The estimated 3-year survival rate is 67% (confidence interval [c.i.] 54% to 80%). The 5-year survival rate is estimated to be 61% (c.i. 47% to 75%). One patient (unique patient number 216) who had relapsed 530 days after BMT was reinjected into another CR and received a second BMT after marrow ablation with a combination of high-dose busulfan (16 mg/kg) and high-dose VP-16 (60 mg/kg, infused on day −3). However, this patient died of another recurrence of his disease, 449 days after his second marrow transplant (979 days after the initial transplant procedure).

Causes for failure. Nineteen patients died during the observation period (Table 2). The most common cause of death was disease recurrence (79%), followed by infection (16%) and other causes (5%).
death was interstitial pneumonia, in six patients. Four patients relapsed between day +87 and +530 and the actuarial relapse rate is 10% (c.i. 1% to 19%), as illustrated in Fig 1. Six patients developed grade II through IV GVHD, which was the cause of death in two. Two patients died of complications related to chronic GVHD. Other causes for failure included sepsis, fungal disease, hepatic failure, and encephalopathy.

Prognostic factors. A multivariate stepwise Cox proportional hazard analysis of patient characteristics was performed to determine indicators of prolonged disease-free survival. Continuous independent variables in the model were age and time from initial CR. Categorical variables in the model were sex, immunophenotype, WBC count, cytogenetics, and number of risk factors (Table 1). Factors associated with prolonged disease-free survival were male sex ($P = .016$), younger age ($P = .003$), and shorter time to CR ($P = .014$).

**DISCUSSION**

This study focuses on the results obtained in 53 patients with high-risk ALL who have been treated with bone marrow ablation followed by allogeneic BMT during first CR. Our selection criteria for BMT, namely high WBC count (≥25,000/µL), certain cytogenetic abnormalities, age (≥30), extramedullary leukemia, and time to achieve a CR (>4 weeks) have remained unchanged throughout the study. Eighty-nine percent of the patients were transplanted within the first 4 months after achieving a CR. This treatment modality leads to substantially prolonged disease-free survival and cure. Only seven patients in this series have not yet been observed longer than 2 years.

During this trial period we also accepted nine adult patients with ALL in first CR who did not fulfill any of the defined high-risk criteria. At the time of this evaluation, seven of them are alive and in continued CR for 11 months to over 10 years. One patient died of interstitial pneumonia and one of recurrent ALL. These nine patients are not included in the analysis reported here.

Nineteen patients died during the course of this study. Fifteen patients died of BMT-related complications, most frequently due to supervening interstitial pneumonia (6 of 15). Four patients have relapsed, for an actuarial relapse rate of 10%. Three of these four patients had a WBC count exceeding 100,000/µL at initial presentation.

Three successive myeloablative immunosuppressive combinations have been used in this study. The latest regimen consisted of fractionated TBI and high-dose VP-16. The rationale to proceed with this new regimen was based primarily on data in patients with advanced leukemias for whom the relapse rate was found to be 32%.11 This actuarial relapse rate can be considered to be relatively low in comparison with other preparatory regimens, and has been subsequently confirmed by a separate study.12 Because the preparatory regimens used in the trial reported here have been used in a sequential fashion, it is difficult to compare their relative efficacy and merits. There were only four cases (11%) of fatal interstitial pneumonitis with the more recent use of fractionated TBI with cyclophosphamide or VP-16 (n = 36) compared with 4 (23%) of 17 patients who had been treated earlier with single-dose TBI ($P = $ not significant). Both cases of fatal sepsis and the single case of fatal leukoencephalopathy were encountered in the group of 17 patients who received cytosine-arabinoside, cyclophosphamide, and single-fraction TBI. Conversely, only a single patient relapsed who received cytosine-arabinoside, cyclophosphamide, and single-fraction TBI compared with three patients who received fractionated TBI/cyclophosphamide. No relapses have been observed in patients receiving the FTBI/VP-16 regimen, although the follow-up is relatively short for this last group of patients (median 21 months).

While no doubt exists as to the contribution of these risk factors to poor prognosis of ALL, their individual potency as high-risk predictors remains uncertain. As shown in Table 1, approximately two thirds of the patients had at least one risk factor and the remaining patients had two or more high-risk features at presentation. Of this group, there were seven adults whose only risk factor was age ≥30 years. Abnormal cytogenetics were included as high risk only if they were previously associated with a poor outcome. Eighteen patients achieved a CR after 4 weeks. Although the time to achieve a CR may be related to intensity of the induction therapy (and therefore more applicable to current intensive induction therapies), all but five patients received anthracyclines as part of the induction therapy.

The analysis of risk factors as described in Table 1 shows three patient characteristics that were associated with a higher mortality: female sex, older age, and a longer time period to achieve CR. This treatment modality leads to substantially prolonged disease-free survival and cure. Only seven patients in this series have not yet been observed longer than 2 years.

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years for patients transplanted in first CR. The vast majority of these patients are likely to be cured of their disease. An even more impressive result for BMT was reported for a group of 32 children with poor-prognosis ALL. The actuarial disease-free survival with a median follow-up of 30 months was 84% at 5 years with an actuarial relapse rate of 3.5%. 30

Our study suggests that marrow transplantation should be considered during first CR for the majority of adult patients under the age of 50 years with high-risk ALL who have a histocompatible sibling donor. These high-risk patients can expect to enjoy an actuarial disease-free survival rate of 61% with a relatively low actuarial relapse rate of 10%. Patients presenting with characteristics as shown in Table 1 have a poor outcome when treated with intensive modern-day chemotherapy, with disease-free survival of only 18% to 28%. For them, BMT offers a higher chance of disease-free survival and cure. Moreover, the results with marrow transplantation are likely to improve further as some of the causes for transplant-related morbidity and mortality (ie, GVHD and cytomegalovirus-associated interstitial pneumonia) are now more effectively prevented or treated.

Ideally, BMT may be reserved for patients with high-risk ALL after recurrence of their disease and attainment of a second remission. However, patients would need to be reinduced into a complete second remission, retain or regain a good performance status, and then require having immediate acceptance at a BMT center. Unfortunately, many patients who relapse will die of their illness or from chemotherapy-associated complications. Such complications from reinduction chemotherapy are likely to affect biologic reserves and can impact unfavorably on the final outcome. Because of serious side effects encountered during reinduction chemotherapy, a sizable fraction of these patients will never be transplanted, and those who do are likely to start off at a disadvantage.

The data presented here compare favorably with the results of chemotherapy studies in patients with high-risk ALL. The ultimate role of BMT as a treatment modality in first CR of ALL remains to be determined. This determination will require a prospective trial in which the outcome of BMT in first CR is compared with that of the “best” chemotherapy and BMT during second remission, with all patients registered at the time of initial presentation.

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REFERENCES


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