Unrelated Donor Marrow Transplantation Therapy for Chronic Myelogenous Leukemia: Initial Experience of the National Marrow Donor Program

By Philip McGlave, Glenn Bartsch, Claudio Anasetti, Robert Ash, Patrick Beatty, James Gajewski, and Nancy A. Kernan

In the interval from December 1987 to November 1990, 198 consecutive patients with chronic myelogenous leukemia (CML) received unrelated donor marrow transplantation using marrow procured by the National Marrow Donor Program (NMDP) at 21 NMDP-affiliated marrow transplant centers. Baseline donor and recipient data as well as follow-up data were obtained systematically in all cases by the NMDP. The median interval from the initiation of a search for an unrelated donor to bone marrow transplantation was 8.4 months (range, 1.7 to 34.6 months). Seventy-five recipients were female and 121 were male. At time of transplant, 115 patients were in chronic phase, 51 in accelerated phase, 14 in blast crisis, and 16 in a second or subsequent chronic phase. In 133 cases, donors and recipients were identical at the HLA A, B, and DR loci using standard serologic typing, and in 63 cases, there was nonidentity at one HLA locus. Patients were prepared for transplantation with a combination of high-dose chemotherapy and total body irradiation (N = 169) or with high-dose chemotherapy only (N = 27). Thirty-five patients received marrow depleted ex vivo of T lymphocytes, whereas 161 patients received non-T-depleted marrow. One hundred seventy-four of 196 patients engrafted (absolute neutrophil count ≥500/mm3 for 3 consecutive days). The median time to engraftment was 22 days (6 to 69 days). Twenty-two patients failed to engraft, and an additional 10 patients experienced late graft failure. The incidence of grades III or IV acute graft-versus-host disease (GVHD) was 0.54 ± 0.10, and that of extensive chronic GVHD was 0.52 ± 0.12. A lower incidence of both grades III and IV acute GVHD (P = .0003) and of extensive chronic GVHD (P < .01) were independently associated with use of T-depleted marrow. The actuarial incidence of hematologic relapse at 2 years is 0.11 ± 0.06. The 2-year actuarial incidence of disease-free survival for patients transplanted in first chronic phase within 1 year of diagnosis is 0.45 ± 0.21, in chronic phase more than 1 year from diagnosis is 0.36 ± 0.11, in accelerated phase is 0.27 ± 0.12, in second or subsequent chronic phase is 0.22 ± 0.21, and in blast crisis is 0. Fifteen of 55 patients transplanted at 40 to 50 years of age survive. Proportional hazards analysis revealed that transplantation with HLA-matched donor marrow (P = .01), transplantation at younger age (P < .02), and transplantation in first chronic phase (P < .04) had independent, beneficial effects on disease-free survival. Thirty-eight (50%) of patients surviving at 1 year had normal activity levels (Karnofsky = 100%), whereas 31 recipients (41%) had mild impairment of activity (Karnofsky = 90% to 80%) and 7 recipients (9%) had severe impairment of activity (Karnofsky ≤ 70% to 30%). Development of the NMDP has facilitated the use of HLA-matched unrelated donors for marrow transplantation. This treatment modality can result in prolonged disease-free survival in some patients with CML, especially younger patients transplanted early in their disease course using donors matched at the HLA A, B, and DR loci. A high incidence of graft failure, acute and chronic GVHD, and prolonged convalescence can complicate treatment.

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identical at the HLA A locus, HLA B locus, and HLA DR locus using serologic testing. In 63 cases, nonidentity between donor and recipient was detected at one HLA A, B, or DR locus.

Unrelated bone marrow donors. Ninety-eight females and 98 males served as unrelated donors. Median donor age was 37.8 years (range, 19.1 to 55.6 years). All donors signed informed consent approved by their local institutional review boards.

Unrelated donor bone marrow recipients and transplant conditions. Seventy-five consecutive female and 121 male patients received unrelated donor marrow transplant therapy for CML. All patients had Philadelphia chromosome (Ph')-positive CML and met eligibility criteria that varied from institution to institution but conformed to general NMDP guidelines. The median age of the recipients was 33.3 years (range, 19.1 to 55.6 years). At time of transplant, 115 patients were in first chronic phase (CP), 51 in accelerated phase (AP), 16 in second or subsequent chronic phase (>1CP), and 14 in blast crisis (BC). For purposes of this analysis, accelerated phase was defined as the presence of one or more of the following patient characteristics at time of transplantation: leukocytosis (WBC \( \geq 10^5/\mu L \)), thrombocytosis (platelets \( \geq 10^5/\mu L \)), thrombocytopenia (platelets \( \leq 10^5/\mu L \)), anemia (hemoglobin \( < 10 \, \text{g/dL} \)), or palpable splenomegaly uncontrolled by therapy with hydroxyurea, busulfan, or interferon alpha; basophilia or eosinophilia (\( >10\%\) basophils or eosinophils in the peripheral blood or bone marrow); chromosome abnormalities other than or in addition to the single Ph' (deletion of the short arm of chromosome 22 associated with translocation of chromosome 9 or with other translocations); and moderate or severe myelofibrosis. Blast crisis was defined as \( \geq 30\%\) blasts in the bone marrow or peripheral blood. Patients were considered to be in a second or subsequent chronic phase if the morphology of their peripheral blood and bone marrow was compatible with chronic phase but they had experienced one or more blast crises. Patients with none of the above findings were considered to be in chronic phase. All recipients or their guardians signed informed consent approved by their local institutional review boards.

In 169 cases, patients were prepared for transplant with a combination of fractionated (N = 167) or single-dose (N = 2) total body irradiation (TBI) and cyclophosphamide alone or in combination with cytosine arabinoside or VP-16. In 27 cases, patients were prepared with regimens not containing TBI. Such regimens consisted of busulfan and cyclophosphamide (N = 24) or busulfan, cyclophosphamide, and VP-16 (N = 3).

In 161 cases, patients received in vivo acute graft-versus-host disease (GVHD) prophylaxis with combinations of methotrexate, cyclosporine, ATG, and prednisone or with the anti-CD-5 ricin A chain immunotoxin. In 22 cases, patients received bone marrow depleted of T lymphocytes ex vivo with anti-CD3 monoclonal antibody plus complement. In 10 cases, patients received bone marrow depleted of T lymphocytes ex vivo with soybean agglutinin and E rosettes. In three cases, patients received marrow depleted ex vivo of T lymphocytes with anti-CD3 monoclonal antibody conjugated to the ricin A chain.

Data gathering and statistical analysis. All data pertaining to donors and recipients were obtained using forms designed by the NMDP for this purpose. Baseline data on all donors and information concerning the harvest procedure were obtained by NMDP donor and collection centers and forwarded to the NMDP data center for transcription, storage, and subsequent retrieval. Recipient baseline information as well as information obtained at 100 days, 6 months, 1 year, and then annually posttransplant were obtained by the NMDP transplant center and forwarded to the NMDP data center. Patient outcome was analyzed to date of last follow-up. A death form was completed in the case of each death in this series.

Disease-free survival (DFS) curves were calculated by the method of Kaplan and Meier. The time to event was defined as time from first transplant to time of (1) relapse for patients who were reported free of disease after transplant, (2) day 28 posttransplant for patients who survived at least 28 days but were never free of the disease after transplant, or (3) death for patients not covered by (1) or (2). In univariate analyses, the log rank statistic was determined, and its significance probability is cited. The 2-year disease-free survival rates and their 95% confidence intervals are cited.

In multivariate analyses involving the event of DFS and relapse, the proportional hazards model was used with the following covariates: recipient age, recipient cytomegalovirus (CMV) status, HLA match (0 or 1 antigen disparity), ex vivo manipulation of bone marrow to deplete T lymphocytes, interval between diagnosis and transplant, disease stage (CP versus other all stages).

For nonfatal events such as engraftment, grade III/IV acute GVHD, and extensive chronic GVHD death was defined as a censored variable in the life table analyses. The censoring data point for the analyses involving nonfatal events was either the date of censoring variable, the date of contact, or the last regular follow-up visit. Both the Kaplan-Meier model and proportional hazards model were used. The independent variables considered were: recipient age, recipient CMV status, HLA-matched (0 or 1 antigen disparity) ex vivo T lymphocyte depletion, and disease stage (CP versus other for late graft failure analysis only).

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**Table 1. Study Characteristics**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
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<tr>
<td>Transplant interval</td>
<td>12/87–11/90</td>
</tr>
<tr>
<td>Transplant centers</td>
<td>N = 21</td>
</tr>
<tr>
<td>Collection centers</td>
<td>N = 36</td>
</tr>
<tr>
<td>Donor centers</td>
<td>N = 46</td>
</tr>
<tr>
<td>Patients</td>
<td>N = 196</td>
</tr>
<tr>
<td>Recipient age</td>
<td>Median = 33.3 yr, Range = 4.5–54.5 yr</td>
</tr>
<tr>
<td>Donor age</td>
<td>Median = 37.8 yr, Range = 19.1–55.6 yr</td>
</tr>
<tr>
<td>Recipient disease stage</td>
<td>CP: N = 115, AP: N = 51, BC: N = 14, &gt;1 CP: N = 16</td>
</tr>
<tr>
<td>Donor-recipient HLA match</td>
<td>Match: N = 133, Mismatch: N = 63</td>
</tr>
<tr>
<td>BMT preparation</td>
<td>Chemotherapy + TBI: N = 169, Chemotherapy only: N = 27</td>
</tr>
<tr>
<td>GVHD prophylaxis</td>
<td>N = 35</td>
</tr>
<tr>
<td>T-lymphocyte depletion</td>
<td>N = 161</td>
</tr>
</tbody>
</table>
UNRELATED DONOR MARROW TRANSPLANT FOR CML

RESULTS

Engraftment. Engraftment was defined as the achievement of a peripheral blood absolute neutrophil count greater than 500/µL for 3 consecutive days. Formal studies of donor/recipient chimerism were not reported in all cases. Engraftment occurred in 174 of 196 patients. The actuarial incidence of initial engraftment before day +100 was 0.94 ± 0.04, and the median time to engraftment was 22 days (range, 6 to 69 days). Two of 35 patients receiving T-lymphocyte-depleted marrow and 20 of 161 patients receiving non-T-depleted marrow failed to engraft. Late graft failure was defined as the development of pancytopenia in patients who had previously engrafted. Late graft failure occurred in 10 patients at a range of 14 to 147 days after engraftment. In proportional hazards analysis, no independent association of late graft failure with T-lymphocyte depletion, donor/recipient matching, recipient age, disease stage, or recipient CMV status was identified.

Acute GVHD. The incidence of grades II to IV acute GVHD was 0.82 ± 0.07. The 0.20 ± 0.20 incidence of grade III or IV seen in recipients of T-lymphocyte-depleted bone marrow was significantly lower than the incidence of 0.60 ± 0.11 observed in recipients of bone marrow that was not T-depleted (P = 0.003) (Fig 1). Analysis by proportional hazards model showed a significant, independent association of T depletion (P = 0.002; RR = 0.15 [0.05 to 0.49]) but not of donor/recipient matching, recipient age, disease stage, or recipient CMV status with a reduced incidence of grades III to IV acute GVHD.

Chronic GVHD. The 1-year actuarial incidence of extensive chronic GVHD was 0.22 ± 0.20 in recipients of T-
lymphocyte-depleted bone marrow, significantly lower than that of 0.59 ± 0.13 observed in recipients of marrow not depleted of T lymphocytes (P = 0.01) (Fig 2). Proportional hazards analysis demonstrated that use of T-lymphocyte-depleted bone marrow (P = 0.03; RR = 0.33 [0.12 to 0.91]), but not donor/recipient matching, recipient age, or recipient CMV status was independently associated with a diminished incidence of extensive chronic GVHD.

Relapse. Relapse was defined as the recurrence of morphologic evidence of leukemia in the peripheral blood or bone marrow. Relapse has been identified in 15 patients at a range of 28 to 752 days following transplant. The 2-year actuarial incidence of relapse is 0.16 ± 0.14 in recipients of T lymphocyte-depleted bone marrow, not significantly different from the 0.10 ± 0.07 incidence seen in recipients of marrow that had not been T depleted (P = 0.28). Transplant at prolonged interval from diagnosis was independently associated with increased risk of relapse in proportional hazards analysis (P = 0.03; RR = 1.22 [1.02 to 1.46]). Other characteristics studied, including T lymphocyte depletion, disease stage (chronic versus other), donor/recipient matching, recipient age, or recipient CMV status, were not independently associated with relapse.

DFS. DFS was defined as survival without evidence of hematologic relapse in peripheral blood or marrow. The incidence of DFS for patients in various disease stages is represented in Fig 3. The 0.45 ± 0.21 2-year actuarial incidence of DFS observed in patients in chronic phase transplanted within 1 year of diagnosis is significantly higher than the 0.36 ± 0.11 incidence seen in patients in chronic phase transplanted more than 1 year from diagnosis (P = 0.03) (Fig 4). When patients were grouped by age and donor/recipient matching status, older recipients of mismatched marrow fared poorly (DFS, 0.14 ± 0.13) compared with other patient subsets (Fig 5). Analysis by proportional hazards model indicated that transplant with an HLA-matched donor, transplant at a younger age, and transplant in first chronic phase compared with transplant in any other disease stage were independently associated with better DFS (Table 2). Use of marrow depleted of T lymphocytes was associated with a trend for better DFS; however, this association did not reach statistical significance (P = 0.10).

Causes of death. In the majority of cases, a single cause of death was difficult to identify. Investigators were asked to list in order of importance clinical conditions contributing to death. The number and percentage of cases in which com-
common clinical problems were considered a primary or a secondary cause of death are listed in Table 3. As expected, GVHD, infection, pneumonitis, and graft failure are important clinical problems associated with the death of CML patients after unrelated donor bone marrow transplantation.

Assessment of survivors. The level of activity observed in patients surviving at 1 year (N = 76) was measured using the Karnofsky activity score. Results are presented in Table 4. Fifty percent of patients had impairment of activity when assessed at 1 year, and in 10% of cases overall, this impairment resulted in significant debility. No association between impaired activity levels at 1 year and either use of mismatched donor marrow or transplant at an older age could be demonstrated (data not presented).

DISCUSSION

The development of the NMDP has facilitated the identification of unrelated donors and the procurement of unrelated donor marrow. Because the NMDP also gathers and stores data concerning both the donor and the recipient, it has become possible to assess the efficacy of unrelated donor transplantation therapy for CML in a large number of cases.

In this study, unrelated donor marrow transplant therapy for CML is associated with a high incidence of engraftment problems. Twenty-two patients failed to engraft, and an additional 10 patients experienced late graft failure. Failure to engraft was observed in recipients of both phenotypically matched and phenotypically mismatched unrelated donor marrow. This incidence of failure to engraft is strikingly higher than expected in the case of matched sibling donor transplantation therapy for leukemia and raises the possibility that nonidentity between donor and recipient for transplantation antigens, either HLA or non-HLA, contributes to graft failure as has been observed in the related donor setting.\(^\text{2,24}\) Indeed, recent reports demonstrate that in some cases, failure of unrelated donor marrow to engraft may be associated with important structural polymorphisms not recognized by current serologic HLA typing methods.\(^\text{25}\) T-lymphocyte depletion has also been associated with failure to engraft in the related donor setting.\(^\text{26}\) In this series, however, only 2 of 35 patients receiving T-lymphocyte-depleted marrow failed to engraft. An additional 10 patients experienced late graft failure after initial engraftment. No independent association of late graft failure with donor/recipient match, T-lymphocyte depletion, or other marrow transplant characteristics, however, could be identified. Engraftment problems were considered a primary or secondary cause of death in 15% of cases. Graft failure must be considered a serious potential complication of unrelated donor marrow transplant therapy for CML. Investigators undertaking this therapeutic modality may wish to develop contingency plans for the potential of graft failure, including storage of “backup” autologous peripheral blood or marrow stem cells.

The incidence of grades III and IV acute GVHD was 54% in this series. This is strikingly higher than expected in the case of related donor transplantation therapy for CML and again suggests that nonidentity between donor and recipient for either HLA or non-HLA transplantation antigens may have an important effect. The use of T-depleted marrow reduces the incidence of grades III and IV acute GVHD sig-
nificantly compared with the use of non-T-depleted bone marrow; a finding also observed in related donor transplant therapy for CML. No other patient characteristic tested, including donorrecipient matching status, recipient age, disease stage, or recipient CMV status, was independently associated with the development of acute GVHD. Similarly, the 52% incidence of extensive chronic GVHD is extremely high in this series and is probably attributable to nonidentity at either HLA or non-HLA transplantation antigens. Use of T-lymphocyte-depleted bone marrow was the only transplant variable that could be independently associated with a reduced incidence of extensive chronic GVHD. Acute and chronic GVHD were implicated in 35% of the deaths in the series.

These data suggest that the development of GVHD following unrelated donor therapy for CML is a problem of grave clinical importance. Currently available HLA A, B, and DR serologic testing may not be sensitive enough to detect clinically relevant donorrecipient nonidentity. This raises the possibility that application of newer methods to determine HLA class I and class II identity may be useful to predict donorrecipient pairs in which graft failure and GVHD will not occur. These methods include analysis of restriction fragment length polymorphisms, allelic typing techniques, isolectric focusing, and actual nucleotide sequencing as well as analysis of T-cell precursors (CTLP) to assess the T-cell repertoire of the recipient. These data also suggest that studies testing innovative approaches to GVHD prophylaxis including use of marrow depleted of T lymphocytes ex vivo by a variety of techniques are indicated in this setting.

Hematologic relapse has occurred in 15 patients to date. Of interest, transplant at a prolonged interval from diagnosis was independently associated with increased risk of relapse in proportional hazards analysis. At present, relapse cannot be independently associated with advanced disease stage at time of transplantation or with the use of T lymphocyte-depleted marrow, although these transplant characteristics have previously been associated with relapse in related donor transplant therapy for CML. Both the low relapse rate and the failure to associate relapse with advanced disease stage or T depletion may simply reflect a relatively short median follow-up in this series.

At last contact, 64 patients survive without hematologic evidence of relapse following unrelated donor transplant therapy for CML. Better disease-free survival is independently associated with transplant in chronic phase rather than with advanced disease. The actuarial incidence of disease-free survival at 2 years for patients transplanted early in chronic phase is significantly higher than that of patients transplanted later in chronic phase. These observations are similar to those observed in the related donor transplant setting. The use of donorrecipient pairs matched at the HLA A, B, and DR loci is also independently associated with better disease-free survival. These findings confirm a previously reported insignificant trend suggesting better outcome in CML recipients of matched unrelated donor marrow.

Better DFS was also associated with younger recipient age. This conforms with results seen in the related donor transplant setting. Of interest, however, 15 of 55 patients transplanted between the ages of 40 and 55 years are surviving disease free. The compounded effect of older age and the use of mismatched marrow is evidenced by the relatively poor DFS at 2 years seen in patients over 30 years of age receiving marrow from mismatched donors compared with younger recipients and with older recipients of matched marrow (Fig 5). Poor results under these circumstances suggest that efforts should be redoubled in the case of these older mismatched patients to find a matched donor. On the other hand, this group may lend itself to clinical studies in which innovative approaches to transplantation such as T-lymphocyte depletion are tested.

Although the use of marrow depleted of T lymphocytes was independently associated with a decreased incidence of acute and chronic GVHD, no significant independent association between the use of such marrow and better DFS could be seen in this series. This observation may simply reflect the small number of patients receiving T-depleted marrow in the series because an insignificant trend toward better DFS in recipients of T-depleted marrow was identified in the proportional hazards model. The impact of T depletion must be interpreted with caution. This GVHD prophylaxis method was used in only 3 of 21 transplant centers. Other centerspecific factors could contribute to the effects attributed to T depletion. Furthermore, a direct association between T depletion and relapse has been demonstrated in related donor transplant therapy for CML. Although no independent effect of T depletion on the incidence of relapse is seen here, prolonged follow-up may be necessary to detect such an association. Two other potential complications of T-lymphocyte depletion in the mismatched donor setting include graft failure and development of B-cell lymphoma. Although no such associations could be made in this study, they remain as ominous potential complications that must be considered as new acute GVHD prophylaxis approaches involving varying degrees of ex vivo or in vivo T-lymphocyte depletion are tested in the unrelated donor setting.

The majority of patients (50%) assessed at 1 year had normal levels of activity; however, 41% of patients had at least insufficient follow-up to make meaningful comparisons.

Table 3. Primary or Secondary Causes of Death

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<tr>
<th>Problem</th>
<th>No. of Cases</th>
<th>% Deaths</th>
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</thead>
<tbody>
<tr>
<td>Infections*</td>
<td>40*</td>
<td>40*</td>
</tr>
<tr>
<td>Acute or chronic GVHD</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Interstitial pneumonitis</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Graft failure</td>
<td>15</td>
<td>15</td>
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<tr>
<td>Recurrent leukemia</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Second malignancies</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

* For example, infections were listed as a primary or secondary cause of death in 40% of cases.

Table 4. Karnofsky Activity Assessment at 1 Year

<table>
<thead>
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<th>Score</th>
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<td>100</td>
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<td>50</td>
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<tr>
<td>90–80</td>
<td>31</td>
<td>41</td>
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<td>70–30</td>
<td>7</td>
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</table>
mild or moderate impairment of activity and an additional 9% of patients had profound impairment of activity. No association between impaired activity levels at 1 year and the use of mismatched marrow or transplant at older age could be identified. These observations do suggest that prolonged convalescence after unrelated donor transplantation is a real possibility that should be raised when patients undergo counseling before transplantation.

This study suggests that therapy for CML with marrow transplantation using unrelated donors can provide stable engraftment in a majority of recipients and prolonged DFS in some cases. The beneficial effects of marrow transplantation are particularly apparent when transplant is performed in younger patients in chronic phase and when HLA-matched donor marrow is used. Although T-lymphocyte depletion markedly diminishes the incidence of acute and chronic GVHD, the overall effect of T depletion on the outcome of unrelated donor bone marrow transplantation therapy for CML is not known and can be determined only after prolonged follow-up. Problems associated with failure to achieve engraftment and with a high incidence of GVHD as well as delayed convalescence in some cases can be anticipated in patients with CML undergoing unrelated donor transplantation. The efficient identification of matched unrelated donors through the NMDP and a rapidly expanding network of donor registries with international links will make unrelated donor BMT available to more patients with CML. Further clinical studies are needed to determine the efficacy of newly developed methods for identification of matched donor/recipient pairs, the risks and benefits associated with aggressive acute GVHD prophylaxis, and the importance of other variables that may affect the outcome of unrelated donor marrow transplantation for CML and other lethal diseases.

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REFERENCES


20. Kernan NA (for The Research and Publication Committee of the NMDP): Outcome of 459 marrow transplants derived from unrelated donors for treatment of acquired and congenital lymphohematopoietic disorders or metabolic disorders: Initial report from the National Marrow Donor Program (NMDP). Blood 78:77a, 1991 (abstr, suppl 1)
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