Complete Remission in Severe Aplastic Anemia After High-Dose Cyclophosphamide Without Bone Marrow Transplantation

By Robert A. Brodsky, Lyle L. Sensenbrenner, and Richard J. Jones

Severe aplastic anemia (SAA) can be successfully treated with allogeneic bone marrow transplantation (BMT) or immunosuppressive therapy. However, the majority of patients with SAA are not eligible for BMT because they lack an HLA-identical sibling. Conventional immunosuppressive therapy also has major limitations; many of its remissions are incomplete and relapse or secondary clonal disease is common. Cyclophosphamide is a potent immunosuppressive agent that is used in all BMT conditioning regimens for patients with SAA. Preliminary evidence suggested that high-dose cyclophosphamide, even without BMT, may be beneficial to patients with SAA. Therefore, 10 patients with SAA and lacking an HLA-identical sibling were treated with high-dose cyclophosphamide (45 mg/kg/d) for 4 consecutive days with or without cyclosporine. A complete response (hemoglobin level, >13 g/dL; absolute neutrophil count, >1.5 x 10^9/L, and platelet count >125 x 10^9/L) was achieved in 7 of the 10 patients. One of the complete responders died from the acquired immunodeficiency syndrome 44 months after treatment with high-dose cyclophosphamide. The remaining patients are alive and in continuous complete remission, with a median follow-up of 10.8 years (range, 7.3 to 17.8 years). The median time to last platelet transfusion and time to 0.5 x 10^9 neutrophils/L were 85 and 95 days, respectively. None of the complete responders has relapsed or developed a clonal disease. These results suggest that high-dose cyclophosphamide, even without BMT, may be more effective than conventional immunosuppressive therapy in restoring normal hematopoiesis and preventing relapse or secondary clonal disorders. Hence, further studies confirming the efficacy of this approach in SAA are indicated. 

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Submitted May 22, 1995; accepted September 1, 1995.

Supported in part by National Institutes of Health Grant No. CA15396. R.J.J. is a Leukemia Society of America Scholar.

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0006-4971/96/8702-0027$3.00/0


Materials and Methods

Patients. Patients referred to the Johns Hopkins Oncology Center for the treatment of SAA between 1977 and 1986 were eligible...
RESULTS

Patient characteristics are shown in Table 1; no patients were excluded from analysis. The median age (19 years; range, 7 to 38 years) was similar to that of other studies of SAA.7,10,25 Of the 10 patients, 5 had SSAA and 5 had SAA. Most of the patients were newly diagnosed; the median duration of disease before treatment with high-dose cyclophosphamide was 1 month (range, 2 weeks to 1 year), and only 3 patients had received any prior therapy for their SAA.

A complete response was achieved in 7 of the 10 patients; the majority of patients with both SAA (4/5) and SSAA (3/5) were complete responders (Table 1). An ANC of 0.5 × 10⁹/L was reached at a median of 95 days (range, 34 to 201 days), and the last platelet transfusion was at a median of 85 days (range, 35 to 151 days; Table 2). The use of cyclosporine did not appear to influence whether the patients were able to achieve a complete response, with 5 of 7 patients treated with cyclophosphamide alone and 2 of 3 patients treated with cyclophosphamide plus cyclosporine attaining a complete response. None of the 7 complete responders has relapsed or developed a clonal disease, with a median follow-up of 10.8 years (range, 7.3 to 17.8 years); 6 of the 7 are alive and remain in complete remission with completely normal blood counts, and 1 patient became infected with the human immunodeficiency virus from a blood transfusion and died of acquired immunodeficiency syndrome (AIDS) 44 months after treatment (Table 2). Only 1 patient (in remission for >10 years) has an elevated mean corpuscular volume (MCV; 105 μm³; normal range, 80 to 100 μm³), which has been reported to be predictive for the development of late clonal disorders in SAA patients treated with immunosuppression.17 Dysplastic changes in the remission bone marrows (especially in the monocytic and megakaryocytic lineages) may also be associated with the development of late clonal disorders,17 but were not present in any of the patients.

High-dose cyclophosphamide was generally well-tolerated, with toxicities similar to those seen with autologous BMT. All acute side-effects resolved completely, with no evidence of late sequelae (although gonadal function has not been extensively evaluated). All patients developed febrile neutropenia requiring combinations of antibiotics. Transient nonresponders. Persistence of a transfusion requirement was evidence of no response.

Table 1. Patient Characteristics

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Age/Sex</th>
<th>ANC (×10⁹/L)</th>
<th>Retics (×10⁹/L)</th>
<th>Plts (×10⁹/L)</th>
<th>Etiology</th>
<th>Previous Therapy</th>
<th>Duration of SAA Before CY (wk)</th>
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<tr>
<td>1</td>
<td>22/F</td>
<td>670</td>
<td>18</td>
<td>8</td>
<td>Benzene exposure</td>
<td>Androgens/steroids</td>
<td>52</td>
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<tr>
<td>2</td>
<td>16/M</td>
<td>150</td>
<td>6</td>
<td>6</td>
<td>Idiopathic</td>
<td>None</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>19/M</td>
<td>40</td>
<td>2</td>
<td>1</td>
<td>Idiopathic</td>
<td>None</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>19/M</td>
<td>380</td>
<td>15</td>
<td>3</td>
<td>Benzene exposure</td>
<td>None</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>16/M</td>
<td>310</td>
<td>14</td>
<td>10</td>
<td>Idiopathic</td>
<td>None</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>30/F</td>
<td>780</td>
<td>36</td>
<td>18</td>
<td>Idiopathic</td>
<td>None</td>
<td>16</td>
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<tr>
<td>7</td>
<td>7/F</td>
<td>75</td>
<td>26</td>
<td>8</td>
<td>Idiopathic</td>
<td>None</td>
<td>4</td>
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<tr>
<td>8</td>
<td>38/M</td>
<td>600</td>
<td>35</td>
<td>10</td>
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<td>Steroids</td>
<td>40</td>
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<tr>
<td>9</td>
<td>13/F</td>
<td>20</td>
<td>16</td>
<td>26</td>
<td>Idiopathic</td>
<td>None</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>24/M</td>
<td>40</td>
<td>3</td>
<td>10</td>
<td>Idiopathic</td>
<td>Androgens/steroids</td>
<td>8</td>
</tr>
</tbody>
</table>

Abbreviations: CY, cyclophosphamide; Retics, absolute reticulocyte count; Plts, platelet count.

Table 2. Hematologic Response to High-Dose Cyclophosphamide

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Treatment (date)</th>
<th>Status</th>
<th>ANC of 500μL</th>
<th>Last Plt Transfusion</th>
<th>WBC (×10⁹/L)</th>
<th>ANC (×10⁹/L)</th>
<th>Hgb (g/dL)</th>
<th>Plts (×10⁹/L)</th>
<th>MCV (μm³)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CY (6/77)</td>
<td>CCR</td>
<td>95</td>
<td>35</td>
<td>5.7</td>
<td>2.0</td>
<td>13.8</td>
<td>322</td>
<td>99</td>
<td>03/21/95</td>
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<tr>
<td>2</td>
<td>CY (1/78)</td>
<td>CCR</td>
<td>201</td>
<td>95</td>
<td>5.9</td>
<td>1.9</td>
<td>14.6</td>
<td>295</td>
<td>98</td>
<td>03/10/95</td>
</tr>
<tr>
<td>3</td>
<td>CY (6/78)</td>
<td>NR</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>4</td>
<td>CY (4/84)</td>
<td>CCR</td>
<td>74</td>
<td>78</td>
<td>7.2</td>
<td>3.7</td>
<td>13.8</td>
<td>310</td>
<td>92</td>
<td>11/11/94</td>
</tr>
<tr>
<td>5</td>
<td>CY/CSCA (7/84)</td>
<td>CR*</td>
<td>117</td>
<td>151</td>
<td>4.2</td>
<td>2.3</td>
<td>15.1</td>
<td>140</td>
<td>94</td>
<td>05/11/87</td>
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<td>6</td>
<td>CY/CSCA (11/84)</td>
<td>CCR</td>
<td>47</td>
<td>85</td>
<td>5.8</td>
<td>2.8</td>
<td>14.6</td>
<td>166</td>
<td>105</td>
<td>03/08/95</td>
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<tr>
<td>7</td>
<td>CY (2/85)</td>
<td>CCR</td>
<td>96</td>
<td>125</td>
<td>5.4</td>
<td>2.6</td>
<td>13.8</td>
<td>182</td>
<td>96</td>
<td>07/13/94</td>
</tr>
<tr>
<td>8</td>
<td>CY/CSCA (2/86)</td>
<td>NR</td>
<td>167</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>9</td>
<td>CY (5/86)</td>
<td>NR</td>
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<td>--</td>
<td>--</td>
</tr>
<tr>
<td>10</td>
<td>CY (9/87)</td>
<td>CCR</td>
<td>34</td>
<td>35</td>
<td>8.4</td>
<td>6.1</td>
<td>13.3</td>
<td>202</td>
<td>99</td>
<td>12/22/94</td>
</tr>
</tbody>
</table>

Abbreviations: CY, cyclophosphamide; CSA, cyclosporine; CCR, continuous complete remission; NR, no response; Plt, platelet; WBC, white blood cell count; Hgb, hemoglobin.

* Died of acquired immunodeficiency syndrome 44 months after treatment.
hepatitis, presumed to be viral in origin, developed in 4 patients; 2 patients experienced self-limited renal dysfunction, although 1 required short-term dialysis for a creatinine that reached a peak of 8.3 mg/dL. Hypertension requiring treatment developed in 2 patients who received cyclosporine, and transient congestive heart failure requiring diuretics occurred in 1 patient. No patient developed hemorrhagic cystitis.

There were 3 patients who did not respond to therapy and subsequently died of their disease. One nonresponder recovered his ANC to greater than 0.5 \( \times 10^9/L \), but died 31 months after treatment from an intracerebral hemorrhage. The 2 other deaths occurred within 6 months of therapy and were secondary to intracerebral hemorrhage and sepsis, respectively.

**DISCUSSION**

We found that high-dose cyclophosphamide without BMT produced long-term survival and normal hematopoiesis in patients with SAA. The response rate in our series is comparable with response rates seen after allogeneic BMT\(^2\) or conventional immunosuppressive therapy with antithymocyte globulin and cyclosporine.\(^8,^11\) A previous report suggested a lower response rate for SAA to cyclophosphamide.\(^2\) However, most patients in the previous report received relatively low doses of cyclophosphamide and the highest dose was only two-thirds of the dose used in our study.\(^22\)

Like BMT, high-dose cyclophosphamide in our series produced complete hematopoietic recovery in all responders and was not associated with relapse or late clonal diseases despite at least 7 years of follow-up in all patients. In contrast, conventional immunosuppressive therapy frequently fails to restore normal hematopoiesis and relapse is common.\(^6,^10,^11\) Furthermore, conventional immunosuppressive therapy is also associated with a significant risk of late clonal diseases. Tichelli et al\(^7\) reported a 42% cumulative risk of developing PNH or MDS at 10 years after therapy with antilymphocyte globulin. The European Group for Bone Marrow Transplantation (EBMT) reported an 18.8% cumulative incidence of cancer at 10 years after immunosuppressive therapy;\(^16\) however, they did not include PNH in their definition of malignancy. The EBMT previously reported that the incidence of PNH after immunosuppressive therapy for SAA is at least 10%.\(^14\) The mean interval to the development of PNH and MDS after immunosuppressive therapy is 3.0 and 4.6 years, respectively.\(^14\) Recent studies using both antithymocyte globulin and cyclosporine for the treatment of SAA report a lower incidence of late clonal diseases, but these studies still have a relatively short follow-up.\(^6,^10,^11\)

As with other forms of immunosuppression, some patients with SAA failed to respond to high-dose cyclophosphamide. This may result from a failure to abrogate immunologic-mediated hematopoietic suppression (analogous to graft rejection after allogeneic BMT\(^2,^6,^26\)) or a deficiency of normal host stem cells capable of reestablishing hematopoiesis. Although high-dose cyclophosphamide may be somewhat more toxic than conventional immunosuppression, there were no deaths related to the procedure and all acute side-effects were self-limited in this series. Moreover, the median time to an ANC of 0.5 \( \times 10^9/L \) and transfusion-independence in this series (day 95 and 85, respectively) is comparable to that seen with conventional immunosuppression,\(^10\) even though no patient in our series received growth factor support.

HLA-identical sibling BMT is currently the treatment of choice for young patients with SAA, primarily because of the lower risk of relapse and late clonal disorders when compared with patients treated with immunosuppression. Our data suggest that high-dose cyclophosphamide without BMT may also effectively restore normal hematopoiesis and prevent relapse or secondary clonal disorders. Although the beneficial effects of high-dose cyclophosphamide may just be a consequence of its intensive immunosuppressive activity, it is likely that the potent cytotoxic properties of cyclophosphamide are also important; this could have important implications regarding the pathophysiology of SAA. It is not clear why aplastic anemia is a premalignant disorder.\(^25,^27,^28\) Damage to hematopoietic stem cells may lead to an autoimmune response directed against the bone marrow.\(^24\) In addition, sublethal damage to a stem cell may produce genetic mutations that give it a growth advantage. Over time, an abnormal clone arising from a slowly proliferating, transformed stem cell could become dominant. Cyclophosphamide not only causes profound immunosuppression, but also has the potential to destroy a minor population of damaged stem cells with the capacity to develop into MDS, PNH, or acute leukemia.

Although encouraging, these results remain preliminary. The study was small and the patients were all relatively young. Hence, further studies with high-dose cyclophosphamide need to be performed. Nevertheless, our data suggest that this approach should be considered as an alternative to immunosuppressive therapy in patients who lack an HLA-identical sibling.

**ACKNOWLEDGMENT**

We thank Marie C. Moineau for assistance in manuscript preparation, the Aplastic Anemia Foundation of America for help with patient follow-up, and Drs Robert Stuart and Mark Edelstein for providing excellent patient care.

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