To the editor:

Measles in bone marrow transplant recipients

Machado et al.1 should be congratulated on seizing the opportunity of the 1997 measles outbreak in São Paulo, Brazil, for learning about measles in marrow transplant recipients. Per the report, only 8 of 156 patients (5.1%) developed measles, and only 1 patient (0.6%) had a severe disease (measles pneumonia). But both the incidence and the severity of measles were likely underestimated. Measles was defined by seroconversion (appearance or 4-fold rise of specific antibodies). A significant fraction of transplant recipients cannot seroconvert (reviewed in Storek and Witherspoon2 and in Parkman and Weinberg3). In the São Paulo study, patients with symptoms or signs of measles who did not seroconvert were considered to be patients without measles. The immunity of the patients who could not seroconvert was probably more compromised than the immunity of the patients who could seroconvert. Therefore, the incidence of measles in the patients who could not seroconvert may have been high and the course of the disease in these patients may have been severe. Thus, substantially more than 5.1% transplant recipients may develop measles during an outbreak, and substantially more than 0.6% patients may have a severe course.

Jan Storek

Correspondence: Jan Storek, Fred Hutchinson Cancer Research Center, D1-100, 1100 Fairview Avenue N, Seattle, WA 98109-1024; e-mail: jstorek@fhcrc.org

References


To the editor:

Treatment options in chronic myelogenous leukemia

The perspective “Chronic myelogenous leukemia: current treatment options”1 provides a succinct, direct, and evenhanded approach to a complex topic, for which I congratulate the authors. I have a lone concern with the final aspect of the review, the dependence on age to determine the recommended treatment option.

As the authors state, scoring systems devised by Sokal and Hassford can be used to predict survival for individual patients receiving nontransplant therapy. Similarly, Gratwohl’s scoring system estimates survival after allotransplantation; the reliability of this scoring system was recently confirmed by the International Bone Marrow Transplant (IBMT) Registry.2 Advanced age is a poor prognostic factor for all patients, whether they undergo transplantation or receive nontransplant therapies. The other variables used in these scoring techniques are necessary to estimate outcome.

Recipient age may influence outcome in adults undergoing allogeneic transplantation for chronic myelogenous leukemia (CML) to a lesser degree than is commonly thought. Bolwell recently summarized relevant data and concluded that the inclusion of pediatric patients (grouped with young adults) in many studies has led to the impression that older adults fare far more poorly with transplantation than do younger adults.3 He found only a slightly higher risk of transplantation-related mortality in older compared to younger adults. Data from Seattle4 and our own center,5 among others, indicate that conventional allogeneic transplantation can be performed safely in older patients. Data from the same institutions suggest that transplantation less than 6 months4 and 3 months5 from diagnosis can further improve results, including in older patients.

Thomas et al.’s original report of allogeneic transplantation in CML found a direct relationship between mortality rate and interval from diagnosis to transplantation and an association between older age and longer interval from diagnosis to transplantation.6 Delaying transplantation in older patients contributes to a higher mortality rate. The fact that every study does not demonstrate a significant influence of this interval on outcome does not prove a lack of influence any more than studies that fail to demonstrate an adverse influence of older age prove the absence of an adverse effect. These studies are not appropriately designed to detect the absence of such differences.

Last, results at specific institutions, often with large patient numbers, are clearly better than overall IBMT Registry results. Many studies with favorable results have included large numbers of patients and have utilized similar approaches. Using targeted busulfan and cyclophosphamide, the Seattle group reports one-year transplantation-related mortality rates of approximately 10% and rare relapses. Institutions with poor results should consider referring patients to centers consistently achieving favorable results.

We can all agree that the decision can best be made by a well-informed patient; that patient depends on clinicians to provide an accurate, fair, and complete description of his or her options.

Edward A. Copelan

Correspondence: Ohio State University, 315-B Starling-Loving Hall, 320 W 10th Ave, Columbus, OH 43210
Measles in bone marrow transplant recipients

Jan Storek