Key words
Daunorubicin, liposome, acute leukemia.

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References

Usefulness of the prognostic score for advanced Hodgkin’s disease in patients with human immunodeficiency virus-associated Hodgkin’s lymphoma

Prognosis of Hodgkin’s disease (HD) in HIV-infected patients has not been extensively studied. The International Prognostic Factors Project on Advanced Hodgkin’s Disease (IPFPAHD) score has been applied in a series of 12 patients with HIV-related HD in advanced stages treated with combination chemotherapy. The IPFPAHD scores were 5 (4 cases), 4 (1), 3 (6) and 2 (1). Median overall survival for patients with score 5 was 3.5 months vs 38 months for patients with scores 2-3 (p=0.01). All patients with score 5 died. These results indicate that IPFPAHD score is also useful for predicting the outcome of advanced HD in HIV-infected patients.

Sir,
The prognosis of Hodgkin’s disease (HD) in advanced stages is still poor.1,2 In 1998 the International Prognostic Factors Project on Advanced Hodgkin’s Disease (IPFPAHD) developed a score to assess the prognosis of patients with advanced HD.3 The variables included in this score were: serum albumin <40 g/L, Hb <105 g/L, male sex, age ≥45 yr, stage IV, WBC count ≥15 x 10^9/L and lymphocyte count <0.6 x 10^9/L or <8% of differential count. Patients with human immunodeficiency virus (HIV) infection are usually excluded from prognostic scores in both HD and non-Hodgkin’s lymphoma (NHL) because of their poor prognosis. Since prognosis in HIV-associated lymphomas has improved in recent years, we have evaluated the usefulness of the IPFPAHD score in HIV-associa ted HD.

From 1990 to 1999, 15 cases of HIV-associated HD were diagnosed in a single center in a cohort of 1,700 patients with HIV infection (prevalence 0.88%). The main risk behaviors for HIV infections were intravenous drug abuse (6 cases), heterosexual promiscuity (5) and homosexuality (4). Four cases had a previous diagnosis of AIDS. Histologic subtypes were lymphocyte depletion (6 cases), mixed cellularity (6) and nodular sclerosis (3). Extramedullar disease was present in 10 cases (5 in bone marrow, 2 in liver and 3 in liver and bone marrow). Median overall survival (OS) for patients with score ≥4 was 3.5 months vs 38 months for patients with scores 2-3 (p=0.01). All patients with score 5 died. These results indicate that IPFPAHD score is also useful for predicting the outcome of advanced HD in HIV-infected patients.

Table 1. Main prognostic variables of patients with advanced HD and HIV infection.

<table>
<thead>
<tr>
<th>Pt</th>
<th>Age (yr)</th>
<th>Gender</th>
<th>Stage</th>
<th>Hb (g/L)</th>
<th>WBC (x10^9/L)</th>
<th>Lymph. (x10^9/L)</th>
<th>Serum albumin (g/L)</th>
<th>Score</th>
<th>OS (mo)</th>
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<tbody>
<tr>
<td>1</td>
<td>22</td>
<td>M</td>
<td>NB</td>
<td>66</td>
<td>1.01</td>
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<td>5</td>
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<td>2</td>
<td>28</td>
<td>M</td>
<td>NB</td>
<td>68</td>
<td>2.0</td>
<td>0.2</td>
<td>26</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>M</td>
<td>IIB</td>
<td>119</td>
<td>21.0</td>
<td>2.8</td>
<td>35</td>
<td>3</td>
<td>15</td>
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<tr>
<td>4</td>
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<td>M</td>
<td>IIB</td>
<td>91</td>
<td>5.2</td>
<td>1.3</td>
<td>25</td>
<td>3</td>
<td>37</td>
</tr>
<tr>
<td>5</td>
<td>59</td>
<td>M</td>
<td>IB</td>
<td>108</td>
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<td>2</td>
<td>8+</td>
</tr>
<tr>
<td>6</td>
<td>32</td>
<td>M</td>
<td>NB</td>
<td>93</td>
<td>0.6</td>
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<td>27</td>
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<td>3</td>
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<tr>
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<td>28</td>
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<td>NB</td>
<td>113</td>
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<td>0.2</td>
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<td>4</td>
<td>29+</td>
</tr>
<tr>
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<td>M</td>
<td>NB</td>
<td>110</td>
<td>5.8</td>
<td>1.3</td>
<td>25</td>
<td>3</td>
<td>36</td>
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<td>F</td>
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<td>3</td>
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<tr>
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<td>36</td>
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<td>NB</td>
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<td>2.7</td>
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patients with AIDS-associated HD. Although our series is small, our results indicate that parameters obtained in the IPFPAH study (from which HIV-infected patients were excluded) are also useful for predicting the outcome of advanced HD in HIV-infected individuals. However, due to the small number of cases in this series, the results of our study should be confirmed in larger series based on a multicenter databases of patients with AIDS-related HD.

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Mini-ICE regimen allows mobilization of peripheral blood progenitor cells in a patient with chronic myelogenous progenitor cells failing the ICE protocol

Sir,

Autologus hematopoietic progenitor cell transplantation is an attractive investigational approach for chronic myelogenous leukemia (CML).1-2 In patients with this disorder, stem cells may be mobilized from marrow by using chemotherapy or growth factors, but the optimal method and timing remain to be adequately defined.3-4

A 41-year old male was diagnosed with Philadelphia chromosome-positive CML in chronic phase in December 1992 and began treatment with busulfan. HLA-typing demonstrated the lack of a related or suitable unrelated donor. In July 1994 the patient began therapy with interferon-α (IFN-α) which was stopped because of the absence of cytogenetic response. He was referred to our institution in March 1996 and then received chemotherapy with the ICE regimen,3 consisting of idarubicin, cytosine arabinoside and etoposide plus glycosylated G-CSF. The patient developed grade 4 hematologic toxicity requiring 45 days to recover > 0.5 x 10⁶/L granulocytes and being dependent on platelet transfusion at discharge, after 58 days of hospitalization. Extra-hematologic toxicity consisted of cutaneous rash, severe mucositis and prolonged neutropenic fever that was managed with intravenous antibiotics for 28 days and amphotericin B for 22 days. Despite eight apheresis procedures only 0.5 x 10⁶ CD 34+ cells/kg were collected, with minimal or no cytogenetic remission. In January 1998 he was treated with IFN-α plus cytosine arabinoside and then because no cytogenetic response occurred he was switched to hydroxyurea. Nearly six years after diagnosis, in November 1998, he received chemotherapy with the mini-ICE regimen (same dosage as in the ICE regimen but for only 3 days), plus glycosylated G-CSF. This procedure was initially managed on an out-patient basis, but the patient had to be admitted for 10 days because of an auxiliary infection. The times to recover >0.5 x 10⁶/L granulocytes and >20 x 10⁹/L platelets were 22 and 26 days, respectively. Four leukaphereses, starting on day +23 yielded a total of 4.39 x 10⁶ CD 34+ cells/kg, without cytogenetic response in the apheresis products.

The patient here described had been treated for six years with several regimens including hydroxyurea, IFN-α and IFN-α plus cytosine arabinoside. A previous mobilization attempt with the ICE regimen had been unsuccessful. More than two years later, a second attempt at progenitor cell collection was decided, using the less intensive mini-ICE regimen.5 Toler-