(85.7 % vs 69.9%, respectively, (P=0.28). The engraftment data as well as stem cell harvesting were comparable between the two groups. After ASCT, the difference between the two groups did not reach the level of statistical significance with respect to progression-free survival and overall survival because of the short period of follow up.
Conclusions The results of this retrospective comparison of bortezomib-containing regimens with the VAD as induction treatment prior to ASCT for MM suggest that the choice of induction therapy may be improtant to long-term post- transplant outcomes. Future trials of pre- transplant induction therapies should be designed to analyze differences in progression free and overall survival.

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10-year experience in the treatment of multiple myeloma with autologous stem cell transplantation

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Background: Multiple myeloma (MM) is a plasma-cell proliferative neoplasm.The second most common hematologic cancer, with 5 years prevalence about 183 000. Incidence is 5,7 /100 000 in EU. 5-years survival is 28%. Treatment with HDT and single autologous transplantation is a category I recommendation of the NCCN. In young patients, the impact of dose intensity has been demonstrated, and single HDT supported with ASCT using a conditioning regimen with Melphalan should be considered a standard of care. Double transplantation can be proposed to patients failing to achieve a VGPR after a first ASCT.
Material and methods: during a 10 years period we have performed 195 stem-cell transplantation in different hematological malignancies. 34 (17,5%) high dose chemotherapy and autologous stem-cells transplantation were performed in 30 patients (4 tandem transplantation) with multiple myeloma. In this trial we retrospectively analyzed the epidemiology characteristic of this patients. Gender: Female: 16 Male: 14. Median age: 51 years (from 43- 64 years).
Results: Diagnose was made according to Salmon and Durie criteria. 25 patients with IgG, 4 with IgA, and 1 with light chain myeloma. Bence-Jones positive myeloma was diagnosed in 8 patient, 5 of them were with chronic renal failure. Fracture of spine was presented in 12 patients and 2 patients has fracture of hip. For the induction of remission we used VAD regimen in 20 patients, Cy-Tal-Dex in 10 patients. As a second line therapy in the case of failure to achieve complet remission we introduce Thal/Dex regimen. in 10 patient Only in two patient we use Bortezomib, Alkeran, Dexamethason. Conditioning regimen consisted Melphalan 200 mg/m^2. In tandem transplantation the dose of second conditioning was 140 mg/m^2.The volume of CD34+ cells was 3,88 x 10^8/Kg.bw. Period from diagnose to transplantation is 12 months. From 30 patients 80% are alive, 6 died (3 renal failure, 2 fatal cerebral bleeding and 1 multiorgan failure). The DFS is 24 months, OS is 48 months and survival after transplantation is 35 months.
Conclusion: novel agents such as thalidomide, bortezomib, or lenalidomide have been introduced to improve high-dose therapy, and promising results have been reported. Conversely, results from myeloablative allogeneic stem cell transplantation remain disappointing due to high TRM, justifying the exploration of strategies such as RIC, which have been shown to be feasible but for which proof of efficacy requires continued study.

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Salvage therapy with bortezomib in myeloma patients with relapse or progression after stem cell transplantation

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Background: Bortezomid has been demonstrated to be efficacious end well tolerated in patients (pts) with relapse multiple myeloma (MM).
Patients and methods: We have retrospectively analysed MM patients who relapsed or progressed after stem cell transplantation (SCT) and received Bortezomib as salvage therapy.
Results: Between 1994 and 2010, 22 MM pts with median age of 50 years (range 3-65), in relapse or progression after high dose therapy (10 single autologous SCT, 9 double autologous SCT and 3 autologous and allogenic SCT), were treated with Bortezomib and dexamethasone (14 pts) associated with Thalidomide in 8 pts. Median time between SCT and Bortezomib was 31 months (range 5-123). Patients received a median 7 (2-10) cycles of Bortezomib. The overall response rate was 36% (5 CR+VGPR and 3PR). With median follow up of 10 months (range 2-56), 14 pts (63%) are alive (6 CR+VGPR and 4 PR). Eleven patients experienced at least grade 2 or higher haematological and neuropathy toxicities. The most common grade 3/4 AEs includes thrombocytopenia (22%), neutropenia (5%). The overall incidence of neuropathy was 41%, including 23% grade 3.
Conclusions: This study shows that Bortezomib is well-tolerated, feasible and active therapeutic option in patients with relapsed and progressive MM after SCT.

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At-home management of aplastic phase following high-dose chemotherapy and autologous haematopoietic stem cell transplantation for multiple myeloma patients: a pilot study

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After high-dose chemotherapy with autologous hematopoietic stem cell transplantation (HSCT) long hospital stays in the aplastic phase are expensive, lead to increased risk of hospital infections and to increasing pressure on available hospital beds. The aim of this pilot study was to analyze the feasibility of a home care program (HCP) regiment for Multiple Myeloma patients receiving high-dose melphalan, and undergoing autologous HSCT to be at home for the aplastic period, without daily hospital visits. The HCP consisted of patients who were discharged the day after stem cell reinfusion, after which specialized transplant physicians delivered all supportive care including transfusions and parenteral antibiotics at home. Sixteen patients consecutively entering the HPC program from June 2010 until to day and the results of the study will be introduced during the next EBMT congress.