disease. One patient died of pneumonia within 5 d after the last administration of bortezomib on cycle1. Dose reduction was necessary in 4 patients because of an adverse event. Overall, the most commonly reported adverse events of any grade in this study were diarrhoea in 1 patient, pyrexia in 2 patients, paralytic ileus in 2 patients, peripheral neuropathy in 3 patients, thrombocytopenia in 16 patients, rash in 1 patient and upper respiratory tract infection in 2 patients. The most common grade 3 and 4 adverse events related to the study drug were peripheral neuropathy, diarrhoea and thrombocytopenia. Upper respiratory tract infection was probably an unrelated toxicity to the study drug. Peripheral neuropathy was reported on the baseline evaluation of 2 patients, who later developed worsening of symptoms. Three patients discontinued because of adverse events, two patients due to peripheral neuropathy and one patient due to severe thrombocytopenia which lead to subdural hematoma after trauma. Conclusions.The preliminary findings in this study demonstrate that bortezomib in combination with dexamethazone has synergistic therapeutic activity in patients with relapsed or refractory multiple myeloma after front-line treatment. The efficacy and toxicity results are also favourable relative to other standard cytotoxic therapies used for salvage therapy after front-line treatment.

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MULTI-DAY INFUSION OF AUTOLOGOUS CRYOPRESERVED PERIPHERAL BLOOD PROGENITOR CELLS IN PATIENTS WITH HEMATOLOGICAL MALIGNANCIES- THE INFLUENCE ON ENGRAFTMENT AND TOXICITY

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Peripheral blood progenitor cells (PBPC) are increasingly used as source of stem cells in both autologous and allogeneic settings for patients with hematological malignancies. Based on previously non-randomized studies for enhanced engraftment during multi-day infusion of cryopreserved PBPC in the autologous transplantation, some transplant centers infuse harvests over 3 days. To evaluate the benefit of fractionated infusions of PBPC we included 37 patients with hematological malignancies (AML 11, NHL 9, HD 9, MM 6, ALL 2) treated with high-dose chemotherapy (HDT) followed by autologous stem cell transplantation (ASCT) at Department of hematology, Skopje, Macedonia. The patients were randomized to receive cryopreserved PBPC concentrates divided over 1,2 or more than 3 days. PBPC were mobilized with high-dose VP16 2g/m^2 for AML patients, intermediate-dose cyclophosphamide 1-2 g/m^2 for lymphoproliferative malignancies and/or G-CSF 5microgr/kg alone. PBPC concentrates were cryopreserved with 5% DMSO solutions using controlled rate freezing procedures (Nicole plus PC Espace 330. Patients received daily G-CSF 10microgr/kg i.v over 30 min beginning 4h after the infusion of the first aliquot of PBPCs. The median amount of infused PBPC solution was 430 ml (240-780ml). Engraftment was registered for Ne>0.5x10^9/L on day +10 (8-14) and for Plt>20x10^9/L on day +13 (8-20) with no sasystical difference between groups that received 1, 2 or more than 3 days infusions of PBPCs. Transfusion requirements were for Er 2 doses (0-4) and Plt 14 doses (0-33). The statistical data revealed that infusion related toxicity was similar for all groups of patients. At the end we can conclude that multi-day infusion of PBPC harvests does not influence the engraftment or reduce toxicity.

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THIRD ALLOGENEIC SIBLING TRANSPLANTATION FOR ACUTE MYELOID LEUKEMIA: A CASE REPORT

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The most frequent therapeutic dilemma after leukemia relapse is allowing any further attempt at leukemia erradication, or whether to offer only palliative treatment. Remission induction for AML relapsing after HSCT can be achieved in abuout 40% of patients. We present a case of 34 years female patient with AML FAB M2 with no cytogenetic abnormalities diagnosed in April 1998. After two induction chemotherapy cycles (ARA-C 100mg/m^2 days 1-7 and Doxorubicin 50mg/m^2 days 1,3,5) and consolidation with one cycle of high dose chemotherapy (ARA-C 2x500 mg/m^2 days 1-6 and Doxorubicin 50mg/m^2 days 4-6) complete remission was achieved. First allogeneic sibling transplantation was preformed from fresh bone marrow as source of stem cells and Bu-Cy conditioning, followed by conventional GVHD prophylaxis with MTX+ Cyclosporine. After 24 months disease relapse was registered. The patient was treated with induction chemotherapy with two more cycles of DAE regimen followed by second allogeneic transplant from the same donor with peripheral blood progenitors (PBPC). Two years after the second transplant third relapse was registered. Remission was achieved with L6 chemotherapy regimen with low dose cytarabine and thioguanine. After that, third allogeneic sibling transplantation was preformed with Bu-Cy conditioning, PBPC as source and no GVHD prophylaxis. The patient is still +180 days in CR after the third allogeneic transplantation with good quality of life. At the end we can conclude that leukemia relapse after stem cell transplantation still remains a significant cause of treatment failure in patients with acute leukemia. The success of multiple transplants depend very much on the time interval from the first transplantation, the intensity of prior therapy, the risk of high mortality rate due to increased regimen toxisity (RRT) as well as undelaying disease and patient performance status prior transplantation.

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GRANULOCYTE-COLONY-STIMULATING FACTOR (FILGRASTIM) IS SAFE AND USEFUL TO IMPROVE NEUTROPENIA INDUCED BY IMATINIB THERAPY IN PATIENT WITH CHRONIC-PHASE CHRONIC MYELOGENOUS LEUKAEMIA

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Background. Hematological toxicity during imatinib therapy in patients with chronic myelogenous leukaemia (CML) is common occurring in about 30-50% of cases. Grade 3 or 4 neutropenia occurs in 35-45% of patients with CML in chronic phase who receive imatinib. Often myelosuppression results in treatment interruption or dose reduction producing a negative effect on the efficacy of therapy. *Aims.* To reverse neutropenia induced by imatinib therapy in a patient with chronic-phase CML we used granulocyte-colony-stimulating factor (filgrastim) evaluating the response and the safety. *Methods.* A chronic-phase CML Philadelphia positive was diagnosed in a 42 years old woman presenting with elevated thrombocytosis (platelets 1082x10^9/L), splenomegaly and mild leucocytosis (white cells 10.8 x10^9/L). Cytogenetic analysys showed a tipical bcl-abl rearrangement in 100% of mitoses. Hematological and clinical parameters were used to obtain a mild Sokal risk score (0.9). Imatinib was started at standard dose of 400 mg/day producing a partial cytogenetic response (bcl-abl in 30% of mitoses). After 8 weeks of therapy the patient showed a rapid decrease of