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Which patients do you consider for delayed transplantation?

Hello. My name is Sergio Giralt and I am the service chief of the Adult Bone Marrow Transplant Service at Memorial Sloan-Kettering Cancer Center in New York City. I am often asked which patients do I consider for delayed transplantation. That is a very important but extremely difficult question to answer. I remind my patients that transplant is a choice, it is not a necessity. It is a choice they make based on the recommendations we give them based on our perception of what the disease will do with or without the transplant. I also remind my colleagues when this discussion comes up that each patient is an individual. Let us contrast 2 patients. Do we treat the same way a 55-year-old male who was diagnosed with myeloma serendipitously because on a routine physical examination he was found with mild anemia, elevated total protein, and the bone marrow showed 20% plasma cells with standard-risk cytogenetics? Compare that to the patient who comes into the emergency room with multiple lytic lesions, renal failure, bone marrow shows 80% plasma cells with deletion 17 and other complex cytogenetic abnormalities. Although we may give the same induction therapy to both patients and both patients may achieve, let us say, a very good partial response and after transplant they both may be in complete remission, one has to think about, should that consolidation therapy be the same for both? We currently have two randomized trials, one being performed in Europe and one being performed in North America, that is looking at the question of early versus late transplantation. The results of those trials unfortunately will not be available for many years. So what do I counsel my patients today? I would advise them that most of the data would suggest that high-dose melphalan autologous transplant is associated with the deepening of the responses and that the deeper the response, the more likely patients are not to have to deal with their disease in a long period of time. Thus, patients with a complete remission do better than patients with a near-complete remission, and those with the near-complete remission do better than those with a VGPR.

So let us think about the low-risk patient who achieves a complete remission. If that patient really does not want to proceed to transplant, I would consider him for delayed transplantation and then recommend that he have his stem cells harvested and cryopreserved. But I would watch that patient carefully, in the event of early progression, I would then encourage him to proceed to a late transplantation. Outside of that low-risk patient with a very good response, I encourage every patient to (1) participate in a clinical trial and (2) to proceed to high-dose therapy consolidation.