Outcome of Related and Unrelated Cord-Blood Transplantation in children at Hematopoietic Stem Cell Transplantation Research Center of Shariati Hospital

A. Ghavamzadeh1, K. Alimoghaddam1, A. Naderi2, A.A. Hamidieh1, B. Bahar1, S.A. Mousavi1, M. Iravani1
1Hematology-Oncology and Stem Cell Transplantation Research Center, Shariati Hospital, Tehran University of Medical Sciences, Tehran, Iran
2Department of Pediatrics, Kerman Medical University, Kerman, Iran

Corresponding author: Dr. Ali Naderi
Pediatric Hematologist Oncologist, Department of Pediatrics, Kerman Medical University, Kerman, Iran
Tel: +98 9163134489
Fax:
Email: dnaderihn@yahoo.com

Abstract
Introduction: In 1989, the first successful umbilical cord blood transplantations (UCBTs) was reported in a boy with fanconi's anemia, using umbilical cord (UCB) of his HLA matched sister. Cord blood transplantation is a good substitute for bone marrow or peripheral blood transplantation especially for children and small body size adults.

Methods: Between 1998 and 2007, 14 children (10 boys and 4 girls) with non-malignant (9 Beta-Thalassemia Major, 3 SCID, 1 Hurler) and malignant (1 AML) diseases were given an allogeneic CB transplant from sibling (10 cases) or unrelated (4 cases). In the majority of cases, busulfan and cyclophosphamide were given in various dosage in conditioning regimen GVHD prophylaxis consisted mainly of (CsA) alone (in 9 cases), the combination of CsA and methotrexate (in 4 cases) and methotrexate alone (in 1 case).

Results: In thalassemic patients 89% are alive but 55% with disease. Graft failure occurred in 4 thalassemic and 1 AML patients. Only 2 cases experienced GVHD (1 acute GVHD grade 2 and 1 limited chronic GVHD). All three cases of SCID that transplanted very late after many infectious complications are dead.

Conclusion: This study demonstrated that CBT is curative in some thalassemic patients but in future, we can improve results of CBT with use of ATG, Alemtuzumab, Thiotepa, G-CSF, double cord, TNC dose of 4×10⁷/kg and elimination of methotrexate for GVHD prophylaxis in HLA-match sibling.

Keywords: Cord blood transplantation, Children, Thalassemia

Received: Jun 10, 2008
Accepted: Jul 25, 2008

Introduction

In 1989, the first successful umbilical cord blood transplantations (UCBTs) was reported in a boy with fanconi's anemia, using umbilical cord (UCB) of his HLA matched sister.(1)

Two differences between UCBT and Bone marrow transplantation (BMT)/ PBSCT Specify the former from the latter in relation to the practical approach. First, the number of nucleated cells contained within each UCB unit approaches only a tenth that represented within a typical bone marrow allograft and 1/100 compared to peripheral blood allografts. Second, UCBT is associated with higher immune tolerance than does BMT, thereby permitting a more liberal HLA matching.(2)

Many patients with severe non-malignant and malignant diseases are not eligible for conventional HSCT mainly because they have no HLA identical sibling donor able to donate bone marrow.

For such patients, an alternative option is cord blood transplantation from an unrelated or related donor.(3)

Patients and methods

Between 1998 and 2007, 14 children (10 boys and 4 girls) with non-malignant (9 Beta-thalassemia major, 3 SCID, 1 Hurler), and malignant disease (1 AML) were given an allogeneic CB transplant from a sibling (10 Cases) or unrelated (4 cases).

Information on these patients was collected through computerized data recordings and inpatient and outpatient records.

Prior to transplantation, all thalassemia patients were assigned to 1 of 3 classes of risk according to the criteria proposed by Lucarelli et al.(4)

In the majority of patients, CB was collected from Shariati Hospital cord blood bank and only in three patients from foreign cord blood bank (1 from Italy, 2 from Iran).
One patient (number 3 in table 1) transplanted at day of collection without cryopreservation of cord blood progenitors.

**HLA typing and donor/recipient matching**

Low-resolution serologic typing was used for HLA-A and HLA-B and Low-resolution PCR (polymerase chain reaction) typing was used for the DRB1 antigens in all donor/recipient pairs.

**Transplantation regimen and GVHD prophylaxis**

Data regarding conditioning regimen are given in table 1.

GVHD prophylaxis consisted mainly of cyclosporine (CsA) alone (9 cases), the combination of CsA and methotrexate (MTX) (4 cases) and MTX alone (one case). Antithymocyte globulin (ATG) was associated with BU and CY in two cases (number 4 and 9 in table 1).

**Supportive therapy**

Empirical broad spectrum antibiotic therapy was started when children became febrile, and antifungal was used in the presence of clinical evidence of fungal infection or fever persisting after 3 to 5 days of antibiotics.

Cytomegalovirus (CMV) serologic status was studied before and after transplantation in all children. Prophylaxis of herpes virus and CMV infection consisted mainly of acyclovir. As prophylaxis for pneumocystis jirovecci (carinii) pneumonia, patients usually received oral cotrimoxazole, starting at 35 days after transplantation. Recipients with SCID were in full coverage of antibiotic, antifungal, antiviral and IvIg before and after transplantation.

Acute and chronic GVHD were graded according to previously published criteria. (5) Established GVHD was usually treated with steroids.

**End points**

Hematopoietic and lymphoid engraftment was documented by FISH (one case) and PCR [VNTRs (variable number tandem repeats) in one case and STRs (short tandem repeats in 11 cases)].

Full donor engraftment was defined as the presence of more than 95% of donor cells.

Myeloid engraftment was defined as the first of 3 consecutive days when the absolute neutrophil count was 0.5×10^9/L or higher with evidence of donor hematopoiesis, and platelet engraftment as the time to reach sustained platelet count of 20×10^9/L or higher in the absence of platelet transfusions for 7 consecutive days.

**Results**

**Neutrophil and platelet engraftment**

Graft failure occurred in 4 thalassemic and one AML patients. Two patients underwent a second allorganic BMT from the same donor of CB cells (table 1), that one patient sustained donor engraftment.

One patient underwent a second allogeneic PBSCT from mother because parents not allowed BMT 8 months later from same donor.

Information on chimerism was available in all patients but one. Mixed chimerism, defined as the presence of more than 5% of recipient cells, was documented in the early (i.e., the first 3-4 months) posttransplantation period in 4 thalassemic patients and 2 SCID patients.

Two thalassemic patients have a stable mixed chimerism after discontinuation of any immunosuppressive treatment with independence to regular transfusion.

**Acute and chronic GVHD**

Only 1 of the 14 patients experienced grade 2 acute GVHD, that had been transplanted from an HLA-disparate donor (table 1).

Limited chronic GVHD was diagnosed in one of the 14 patients. Other details about results are shown in table 1.

**Discussion**

Cord blood transplantation (CBT) is a good substitute for bone marrow or peripheral blood transplantation, especially for children and small body size adults. Rate of cord blood transplantation increasing in the world (6) and its indications extended to many malignant and nonmalignant disorders.

It seems that is as effective as other sources for thalassemia (7).

The most important factor for successful cord blood transplantation is timing of transplantation and risk factors of patients.

Many patients in other studies transplanted in more advanced stage of disease and after many failures of previous treatments.

For example in our study all of severe combined deficiencies transplanted very late after many infectious complications which reduce chance of successful transplantation dramatically.
<table>
<thead>
<tr>
<th></th>
<th>Age at CBT</th>
<th>Diagnosis</th>
<th>Clinical status at CBT</th>
<th>HLA</th>
<th>Conditioning</th>
<th>GVHD Prophylaxis</th>
<th>MNC infused ×10⁷/kg</th>
<th>Chimerism % of donor cells</th>
<th>Method of detection</th>
<th>Outcome and survival</th>
<th>Other</th>
<th>Source of cord</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3y</td>
<td>Thal</td>
<td>Pesaro class I</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA</td>
<td>2.08 Washed</td>
<td>+55 (2nd transplant) 100%</td>
<td>STR</td>
<td>Alive without disease</td>
<td>Retransplanted from same donor 5y later</td>
<td>Iran</td>
</tr>
<tr>
<td>2</td>
<td>9y</td>
<td>Thal</td>
<td>Pesaro class I</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA</td>
<td>1.26 Washed</td>
<td>0% 1st transplant 10% 2nd transplant</td>
<td>STR</td>
<td>Dead</td>
<td>Retransplanted from same donor 3y later</td>
<td>Iran</td>
</tr>
<tr>
<td>3</td>
<td>10y</td>
<td>Thal</td>
<td>Pesaro class I</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA</td>
<td>1.3</td>
<td>3y 99%</td>
<td>FISH</td>
<td>Alive with disease</td>
<td></td>
<td>Iran</td>
</tr>
<tr>
<td>4</td>
<td>5y</td>
<td>Thal</td>
<td>Pesaro class II</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA +MTX</td>
<td>2.43</td>
<td>1 mo 10%</td>
<td>STR</td>
<td>Alive with disease</td>
<td>ATG</td>
<td>Iran</td>
</tr>
<tr>
<td>5</td>
<td>3y</td>
<td>Thal</td>
<td>Pesaro class II</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA +MTX</td>
<td>2.34</td>
<td>4 mo 5%</td>
<td>STR</td>
<td>Alive with disease</td>
<td></td>
<td>Iran</td>
</tr>
<tr>
<td>6</td>
<td>6y</td>
<td>Thal</td>
<td>Pesaro class II</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA</td>
<td>1.01</td>
<td>3 mo Zero%</td>
<td>VNTR</td>
<td>Alive with disease</td>
<td></td>
<td>Iran</td>
</tr>
<tr>
<td>7</td>
<td>1y</td>
<td>SCID</td>
<td>Infection Prophylaxis</td>
<td>Unrelated mismatched 5/6</td>
<td>Bu(2mg/kg)</td>
<td>CsA</td>
<td>2.73</td>
<td>1y 20%</td>
<td>STR</td>
<td>Dead</td>
<td>Chronic GVHD Limited</td>
<td>Iran</td>
</tr>
<tr>
<td>8</td>
<td>4y6mo</td>
<td>Thal</td>
<td>Pesaro class II</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA +MTX</td>
<td>2.08</td>
<td>1.5y 10%</td>
<td>STR</td>
<td>Alive without disease</td>
<td></td>
<td>Germany</td>
</tr>
<tr>
<td>9</td>
<td>8mo</td>
<td>Hurler</td>
<td>Syn Cardiomyopathy</td>
<td>Unrelated mismatched 4/6</td>
<td>Bu(16mg/kg)</td>
<td>CsA +MTX</td>
<td>5.84</td>
<td>1 mo 100%</td>
<td>STR</td>
<td>+46 dead</td>
<td>ATG AcuteGVHD</td>
<td>Iran</td>
</tr>
<tr>
<td>10</td>
<td>13y</td>
<td>AML</td>
<td>In partial remission</td>
<td>Sib Matched</td>
<td>Bu(16mg/kg)</td>
<td>CsA</td>
<td>1.3</td>
<td>70% 2nd transplant 100%</td>
<td>STR</td>
<td>+51 dead</td>
<td>Retransplanted in +48 from mother</td>
<td>Iran</td>
</tr>
<tr>
<td>11</td>
<td>1y</td>
<td>SCID</td>
<td>Infection prophylaxis</td>
<td>Unrelated matched</td>
<td>Flu(100mg/m²)</td>
<td>CsA</td>
<td>3.82</td>
<td>+14d 65%</td>
<td>STR</td>
<td>Dead</td>
<td></td>
<td>Czech</td>
</tr>
<tr>
<td>12</td>
<td>21mo</td>
<td>SCID</td>
<td>Infection prophylaxis</td>
<td>Unrelated mismatched 4/6</td>
<td>Bu(2mg/kg)</td>
<td>MTX</td>
<td>1.49</td>
<td>-</td>
<td>-</td>
<td>Dead +19</td>
<td></td>
<td>Italy</td>
</tr>
<tr>
<td>13</td>
<td>6y</td>
<td>Thal</td>
<td>Pesaro class I</td>
<td>Sib Matched</td>
<td>Bu(14mg/kg)</td>
<td>CsA +MTX</td>
<td>2.9</td>
<td>5mo Zero%</td>
<td>STR</td>
<td>Alive With disease</td>
<td></td>
<td>Iran</td>
</tr>
<tr>
<td>14</td>
<td>14y</td>
<td>Thal</td>
<td>Pesaro class II</td>
<td>Sib mismatched 5/6</td>
<td>Bu(16mg/kg)</td>
<td>CsA</td>
<td>1.12</td>
<td>3mo 20%</td>
<td>STR</td>
<td>Alive without disease</td>
<td></td>
<td>Iran</td>
</tr>
</tbody>
</table>

Also one patient with acute leukemia transplanted after several relapse and in persistent leukemia state.

For improvement of results we should consider patients for cord blood transplantation earlier and also it seems wise to adhere to current recommendations of a minimum recommended TNC dose of $4.0 \times 10^7$/kg for CBT for haemoglobinopathies.\(^{(3)}\)

We can use double cord blood units in larger recipients or when cell dose is inadequate.\(^{(8)}\)

Another approach for improving the outcome of CBT is via addition of ATG, alemtuzumab (campath-1H) or thiotepa, all of which are associated with low rates of graft rejection \((9-11)\). We used ATG in 2 patients only.

In other studies the use of granulocyte colony – stimulating factor \((5-10 \, \mu g/kg/d)\) on day 1 after transplantation and on each day thereafter until the neutrophil count remained $>1.0 \times 10^9/l$ for 3 consecutive days may also have contributed to speedy engraftment especially in HLA mis-matched CBT.\(^{(12, 13)}\)

We used methotrexate (MTX) for GVHD prophylaxis in five patients (one SCID and four thalassemia) that mostly resulted in unfavorable outcome and confirm previously reported data on the unfavorable impact of MTX in CB transplant recipients \((11, 14)\).

References