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INFUSION OF DONOR LYMPHOCYTES IN LEUKEMIA PATIENTS RELAPSED AFTER BONE MARROW TRANSPLANTATION IS SUCCESSFUL IF T CELLS OF RECIPIENTS ARE OF DONOR ORIGIN

In view of donor lymphocytes is increasingly used to treat patients with leukemic relapse after allogeneic bone marrow transplantation. Significant numbers of patients with chronic myeloid leukemia respond to this therapy, usually accompanied by graft-versus-host disease. Only a minority of patients with acute myeloid and no patients with acute lymphoblastic leukemia respond to donor lymphocyte infusion. Direct correlation of responsiveness with the absence of graft-versus-host disease suggests that infused lymphocytes are neither reactive to the leukemic cells nor to normal tissue of these patients. In an attempt to answer the question why some patients respond while others do not, we determined the genetic origin of T cells present in 19 relapsed patients at the time of donor lymphocyte infusion. All patients who had T cells of donor origin, tolerated complete remission. In contrast, all but two patients with T cells predominantly of recipient origin failed to respond. T cells responding patients showed cytoxicity in vitro against target cells of recipient origin including leukemia. T cells of nonresponding patients did not show cytoxicity in vitro against target cells of recipient origin. These findings demonstrate that the origin of T cells at the time of relapse is an important prognostic parameter. If T cells are of donor origin, complete remission occurs upon infusion of donor lymphocytes. This led us to hypothesize that autologous T cells of noreponding patients may destroy infused donor lymphocytes, thus explaining treatment failure.

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THE RECOMBINANT GAMMA-INTERFERON AND RETROPLACENTAR POLYBOLIN IN SYSTEMIC VASCULITIS IMMUNOTHERAPY. V.Chopyak*. Lviv Medical Institute, Regional Diagnostic Center, Lviv, Ukraine.

Clinico-immunologically 27 systemic vasculitis patients (SV) - were observed. In cultural immunologic investigation - their immunocompetent cells sensitivity to Gamma-interferon (GI) and retroplacentar polibolin (RP) - was estimated. Complex immunotherapy GI and RP - was applied to this patient group according to special scheme during one year. The control group made 43 patients with SV, who got traditional glucocorticoid therapy. The immunocompetent cells sensitivity to Gamma-interferon (Gl) and retroplacentar polibolin in (RP)- was served. In cultural immunologic investigation - their immunocompetent cells sensitivity to Gamma-interferon (Gl) and retroplacentar polibolin (RP) - was estimated. In an attempt to answer the question why some patients respond while others do not, we determined the genetic origin of T cells present in 19 relapsed patients at the time of donor lymphocyte infusion. All patients who had T cells of donor origin, tolerated complete remission. In contrast, all but two patients with T cells predominantly of recipient origin failed to respond. T cells responding patients showed cytoxicity in vitro against target cells of recipient origin including leukemia. T cells of nonresponding patients did not show cytoxicity in vitro against target cells of recipient origin. These findings demonstrate that the origin of T cells at the time of relapse is an important prognostic parameter. If T cells are of donor origin, complete remission occurs upon infusion of donor lymphocytes. This led us to hypothesize that autologous T cells of noreponding patients may destroy infused donor lymphocytes, thus explaining treatment failure.

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THE COMBINED IMMUNOTHERAPY OF HERPETIC INJURIES IN PATIENTS WITH HEMORRHAGIC VASCULITIS. E. Yvonnog, E. Yvonograd, V. Chopyak, V. Vopa, B. Parshchynskiy.

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The investigation of combined therapy effectiveness of 26 patients with hemorrhagic vasculitis with herpetic injuries was carried out. Combined deep interferon (Resilitor "Samitas"), acoylovir (Zovirax, Wellcome), placental immunoglobulin (Chopharm) were applied. The virologic diagnosis was carried out by method of direct immunofluorescence of smears - in from of place of injury and detection of anti-herpes virus by MNHA, in 25 patients Herpes simplex virus (HSV1) - of A group, in 14 Varicella zoster(VZ) - of B group. Everyday and twice a day (200, 0, 5 x 6 and 10 days), resildor (1 mmol MO3 times - 8 days), placental immunoglobulin (25 mg/Kg x once in 2 days - 20 days) contributed to more easy clinical flow. The abortive form was estimated in 64,0% of A group and 47,4% of B group. The main symptoms decrease was estimated in 62,36 and 46,66 in A and B groups correspondingly. The treatment, begun in prodromal period of herpetic-positive patients with hemorrhagic vasculitis was most effective and contributed to main disease stabilisation.

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ADAPTIVE IMMUNOTHERAPY WITH RECOMBINANT HUMAN IL-2 (rHuIL-2) AFTER AUTOLOGOUS STEM CELL TRANSPLANTATION (ASCT) FOR HIGH-RISK NEUROBLASTOMA (HR-NB).


Objective. A phase II/III trial, with low doses of hHuIL-2 over a prolonged period of time, was carried out. The aim of the study was to evaluate immunomodulatory effects induced by IL-2 and its potential role in facilitation or control minimal residual disease (MRD) in NB after high dose chemotherapy (HDCT) followed by ASCT.

Patient and method. From 1992 to 2996, 25 pts with HR-NB (1 in III CR, 2 in II VGP, 2 in II CR, 13 in I VGP, 7 in I RC) received rHuIL-2 (Proleukin, Aldesleukin), after a median (min-max) time of 91 (43-155) days from ASCT. Treatment schedule consisted of 2 cycles of 24-h iv for 5 days (2-4-6-8-8 MU/kg/d respectively) followed by 11 monthly and 6 bimonthly cycles of rHuIL-2 administered as 5 (2-4-4-4-4-4 MU/kg/d) for a total of 18 cycles.

Results. Were administered. 25/25 pts showed stable disease, 40/40 pts showed CR or VGPR. The rate of MRD determination during therapy. Immunological analysis globally evidenced a increment of NK and activated T cells number, Iperpesein (25/25) and trombocitopenia (4/25), were the only rHuIL-2 dependent toxicity observed during iv or sc administration. A pr stopped the iv phase for gram-negative. A pr inducedlev disease because a feverish convulsion. 20/25 pts are alive and well with a median (min-max) follow up of 10 (2-50) months, 5/25 pts relapsed with a median (min-max) time of 18 (6-41) months, one of these pts died for PD, 35 months after ASCT. Overall EFS at 5 years was 33%.

Conclusion. Adapative immunotherapy with low doses of rHuIL-2 is feasible and seems to be effective in inducing activated immunocompetent cells proliferation and in controlling MRD after HDCT and ABMT in HR-NB.

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