Transplantation (T) in Waldenström Macroglobulinemia (Wm). The French experience. O Tournilhac[1], V Leblond[2], R Tabrizi[3], R Gressin[4], P Colombat[5], N Milpied[6], B Cazin[7], M Divine[8], B Dreyfus[9], JY Cahn[10], B Pignon[11], B Desablens[12], JF Perrier[1], JO Bay[1], P Travade[1]. From CHU [1]Clermont-FD, [2]Pitié-Salpétrière, [3]Bordeaux, [4]Grenoble, [5]Tours, [6]Nantes, [7]Lille, [8]Créteil, [9]Poitiers, [10]Besançon, [11]Reims, [12]Amiens. France.

Wm is a rare and incurable lymphoproliferative disorder. Several cytotoxic therapies can be used such as chlorambucil (C), or anthracycline containing regimens (A). More recently, fludarabine (F), rituximab (R) have been shown to effect good response rate with still uncertain impact on survival. Because stem cells T improves survival in myeloma, this procedure has been developed in few cases of Wm. Herein we report data of 28 T (10 alloT including 1 non myeloablative T, 18 autoT) in 27 Wm from 12 centers.

	Code, age at T	D-T (m)	Previous treatments	Stat. at T	Cond. regimens	Resp (3m)	EFS (m)	OS (m)	
1	44	60	4(C,A,A,O)	SD	TAM	CR	52	52+	ALLOGRAFT
2	50	15	2(A,F)	PR	CyTBI	CR	19	19+	
3	42	60	3(C,F,A)	PR	CyTBI	CR	74	74+	
4	39	18	5(C,F,A,S,O)	SD	CyTBI	PR	3	18(D)	
5	56	51	2(C,F)	PD	CyThioTBI	SD	10	11(#)	
6	44	61	2(C,A)	PR	CyTBI	NE	3	3(#)	
7	48	77	3(C,A,I)	PR	CyTBI	PR	43	43+	
8	48	22	3(A,F,C,Auto)	PD	CyTBI	PD	0	17(#D)	
9	35	9	2(A,F)	PD	CyTBI	CR	59	59+	
10	56	70	4(C,O,F+C,R)	CR	CyTBI (mini)	CR	3	3+	
1	62	84	5(C,A,F,A,O)	PR	MelTBI	CR	22	78+	AUTOGRAFT
3	47	132	3(C,F,P)	PR	CyTBI	PR	25	25+	
4	63	186	5(I,C,O,A,O)	PR	Mel	PR	7	16(D)	
5	61	36	3(C,O,O)	PR	BEAM	CR	22	22+	
6	55	115	3(C,A,R,P)	PR	BEAM	CR	9	10(D)	
7	51	7	2 (A,P)	PR	CyVP16TBI	PR	3	3+	
8	61	40	1(A)	PR	BuMelThio	CR	25	25+	
9	35	10	3(F,A,O)	PR	MelTBI	CR	24	49+	
10	42	34	5(O,C,O,A,O)	PR	MelTBI	PR	8	9(#D)	
11	52	64	5(C,A,F,P,F+A)	PR	CyTBI	PR	24	27+	
12	47	15	4(F,A,A,O)	SD	CyTBI	PR	34	34+	
13	48	19	3(A,F,C)	PR	BEAM	PD	NE°	NE°	
14	53	24	2(C,F+C)	CR	CyTBI	CR	16	16+	
15	58	8	1(A)	PR	MelTBI	PR	4	4+	
16	63	13	4(O,A,O,O)	PR	MelTBI	PR	10	13(D)	
17	65	252	4(O,C,A,F+A)	PR	MelTBI	PR	3	3(#)	
18	56	9	1(A)	PR	MelTBI	PR	12	12+	
19	38	14	2(A,F)	PR	CyTBI	CR	10	10+	

m: months, **D-T :** time from diagnosis to T, **+:** alive, **F+A:** F + anthracycline, **F+C:** F + cyclophosphamide, **P:** cisplatin cont. therapy, **R:** rituximab, **S:** splenectomy, **I :** localized irradiation, **O:** other drugs, **CR :** complete remission, **PR :** partial R, **SD :** stable disease, **NE :** non evaluable for response, **° :** transplanted twice.

(See Table). Median age was 50 (35-65) years. Median time from diagnosis to T was 34(7-252) m. All patients but 9 had been previously heavily pretreated by ≥ 3 lines.

Nine patients died, 3 from transplantation related toxicity (#) (one from visceral toxicity, one from thrombotic microangiopathy, one from secondary leukemia), 4 from disease progression (D), and 2 from both causes (#D).

CR was achieved in 5 alloT and 7 autoT. With a median follow-up of 17 (3-78) months after T, 17 patients remain alive, 9 still in CR and 9 in relapse, PR or SD.

T is feasible in Wm, induces high response rate and can be followed by long survival even in heavily pretreated patients, with acceptable toxicity. Nevertheless its real impact on survival should be demonstrated in prospective trials.