Materials and Methods: Primary study aims are to (1) examine prevalence and severity of non-adherence with imatinib treatment in CML/GIST patients; and (2) identify (modifiable) variables that predict or mediate (non-)adherence. 229 patients from 46 centres in Belgium were enrolled in an observational study with assessments as listed in the table.
Results: With last-patient/last-visit scheduled in early May 2007, publication of results is anticipated for late 2007 and 2008.
Conclusions: ADAGIO should increase knowledge about (modifiable) patient-, physician-, disease-, treatment, and system-related determinants of CML and GIST patients' (non)adherence with imatinib treatment.

6020 POSTER

Prevalence of hepatitis C virus infection in B-cell non Hodgkin lymphoma patients in India

P. Malhotra[1], M.C. Menon[1], R.K. Dhiman[1], A. Sharma[2], Y.K. Chawla[2]. *[1]PGIMER, Dept. of Internal Medicine, Chandigarh, India; [2]PGIMER, Dept. of Hepatology, Chandigarh, India*

The role of hepatitis C virus (HCV) infection in the pathogenesis of non-Hodgkin's lymphoma (NHL) is controversial. A prior study from our institute (Varma S et al., Gastroenterology 2004; 126: 1498−99) had suggested lack of this association among Indian patients. However, a weakness of this study was the use of serological markers alone to diagnose HCV infection. Hence the present study was undertaken to look for the presence of this association by doing HCV RNA in patients with B-cell NHL. We determined the prevalence of HBsAg, anti-HCV antibodies and HCV RNA in 57 consecutive chemotherapy naive patients with B-cell NHL diagnosed in our institution between January 2004 and June 2005. The control group comprised of 171 patients of non malignant disorders admitted in hospital during the same period. The diagnosis of lymphoma was made by lymph node fine needle aspiration cytology (FNAC), biopsy or bone marrow examination and demonstration of CD 20 positivity. Patients and controls with prior history of jaundice, intravenous drug abuse, Interferon α therapy, corticosteroid therapy and HIV infection were excluded. Antibodies against HCV were detected by a third generation ELISA ('LG HCD 3.0 Plus'; LG Chemical Ltd., Pharmaceutical division, Seoul, Korea), detecting antibodies against three kinds of fusion proteins which are constituents of the HCV nucleocapsid; core 518, E1E2NS4 and NS5. Detection of Hepatitis B surface antigen (HBsAg) was done by direct immunoenzymatic assay of the "sandwich" type ('Bioelisa HBsAg colour', Biokit, S.A., Barcelona, Spain) HCV RNA was detected by nested RT-PCR, involving 3 steps (RNA isolation, c DNA synthesis/Reverse transcription and nested PCR: HCV RNA genotyping). Chi-square test was used to compare the prevalence of HCV infection among patients and controls. Out of the 57 newly diagnosed patients with B-cell NHL enrolled in our study, 37 (64.9%) were males and 20 (35.1%) were females. The mean age was 48.7 years (range 18−80). Using the Ann-Arbor staging, 43 patients were in stage IV, 11 were in stage III and 3 were in stage II at presentation. In the NHL group, one patient tested positive for HBsAg (1.75%) while none tested positive for anti-HCV (0%). This patient had a history of blood transfusion in the past. Among all patients, only one patient tested positive for HCV RNA (1.75%). Among controls, one tested positive for HBsAg (0.58%) and two tested positive for anti-HCV (1.17%). Thus the prevalence of HBV and HCV were not different among patients and controls. We could not demonstrate relationship of any other factors with the presence of hepatitis B or C infection either in cases or controls. In conclusion, this study reconfirmed our earlier observations of no association between HCV infection and NHL in Indian patients.

6021 POSTER

Clinical features and treatment outcome of patients with myeloid antigen coexpression in acute lymphoblastic leukemia: a study of 214 Peruvian patients

P. Montenegro[1], J. Leon Ch[1], L. Casanova[1], C. Guillen[2], M.J. Molina[2], C.L. Flores[1], L. Mas[1], C. Carracedo[1], H. Gomez[1], S. Santillana[3]. *[1]Inen, Oncologia Medica, Lima, Peru; [2]Elche, Oncologia Medica, Alicante, Spain; [3]Angloamericano, Oncologia Medica, Lima, Peru*

Aim: The purpose of the study was to evaluate the incidence of myeloid antigen coexpression and its prognostic significance in Peruvian patients with acute lymphoblastic leukemia (ALL).
Patients and Methods: A retrospective study was conducted of all ALL cases (between 14 to 57 years old) diagnosed and treated in Neoplasicas Institute (Lima-Peru) between 2002 and 2004, with available immunophenotype data. Presenting features and treatment outcome of 214 ALL patients was analyzed. The patients were similar in demographic, clinical and laboratory features and their treatment outcome. All patients were treated with a uniform treatment protocol (9904, intensive chemotherapy regimen). Myeloid antigen coexpression was defined as more than 30% isolated leukemic cells positive for CD13 and/or CD33 and/or CD15. Median age was 18.5 years. The incidence of myeloid antigen coexpression was 60 per cent.
Results: Presenting features were similar between My+ and My− with regard to age, gender, FAB morphology, white cell count, hemoglobin level, platelet count, mediastinal involvement, presence of lymphadenopathy, and proportion of blast cells detected in the marrow.
We found that only the patients with CD33(+) had difference statistically significant in terms of DFS and OS Vs My(−), DFS was 14% and OS was 18% (p: 0.032).
Conclusion: We observe smallest survival and DFS, stadistically significant among the patient with myeloid associated antigen expression CD33. This study demonstrates that myeloid antigen coexpression is common and constitutes 60% of patients ALL within the Peruvian population and that CD33 can be an adverse risk factor in Peruvian patients with ALL.

6022 POSTER

Examination of risk factors for mortality of patients with haematological malignancies admitted to intensive care

J. Cubitt, J. Smythe, G. O'Gara, P. Farquhar-Smith. *The Royal Marsden Hospital, Critical Care, London, United Kingdom*

Introduction: We examined potential risk factors for mortality of patients with haematological malignancy (including lymphomas) admitted to a cancer hospital critical care unit (CCU) over a 2 year period. Several factors that have been identified as poor prognostic factors in this group were considered for analysis, including renal replacement therapy (RRT).
Methods: Data from all patients with haematological malignancy admitted to the CCU over two years were collected retrospectively. In addition to RRT the following putative risk factors for mortality, identified from published data, were studied: mechanical ventilation, neutropenia, microbiological evidence of fungal infection, significantly deranged liver function tests (LFTs) and multiorgan failure. Outcomes were expressed in terms of CCU and hospital mortality. Univariate and multivariate analysis were used to assess whether risk factors were predictors of mortality.

Table 1: Individual risk factors and positive outcome.

Factor	N	Positive outcome	P
All patients	64	36(56.3%)	
Renal replacement therapy	19	10 (52.6%)	0.705
Ventilation	28	14 (50%)	0.375
High CRP	48	26 (54.2%)	0.562
Poor liver function	11	7 (63.6%)	0.589
Neutropenia	32	14 (43.8%)	0.046
Fungal infection	20	10 (50%)	0.498
Multi organ failure	28	14 (50%)	0.375

Results: 64 patients were identified. Overall CCU mortality was 44% after a mean stay of 9 days compared to survivor stay of 14 days. Overall hospital mortality was 64%. Individual disease mortality: Acute leukaemia (N = 24), CCU mortality 42%, Hospital Mortality 67%; Chronic leukaemia (N = 11) CCU mortality 64% Hospital Mortality 81%; Lymphomas (N = 24) CCU mortality 42% Hospital Mortality 50%; Myeloma (N = 5) CCU mortality 20% Hospital Mortality 80%
The significance of the individual risk factors was assessed by comparing the CCU mortality. A positive outcome was defined as a patient leaving CCU alive. Using primary binary regression each variable was considered separately as a prognostic factor for CCU mortality.
Conclusion: CCU mortality rates for patients with haematological malignancy were consistent with previously published. We found that only neutropenia is a significant poor prognostic factor for this population (P value 0.046, Odds ratio 0.354). None of the other risk factors assessed were shown to be significant. Further prospective study may identify other risk factors in this patient group.

6023 POSTER

Tissue microarrays method is useful for immunophenotyping analyses in patients with diffuse large B-cell lymphoma

M. Carvalho[1], C.S.C. Chiattone[1], F.S. Soares[2], K.B.R. Ribeiro[3]. *[1]Hematology and Oncology Department of the College of Medical Sciences, Oncology, São Paulo, Brazil; [2]Accamargo Hospital, Pathology, São Paulo, Brazil; [3]FCMSCSP, Statistics, São Paulo, Brazil*

Introduction: Diffuse Large B-Cell Lymphoma (DLBCL) is the most common of the non-Hodgkin lymphomas. This lymphoma may de novo