EUROPEAN HEMATOLOGY ASSOCIATION

haematologica

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ABSTRACT BOOK

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Word of Welcome

On behalf of the EHA Board and the Scientific Program Committee we are pleased to introduce to you this year's Abstract Program. The richness of the program is a testament to EHA's spirit: unity through diversity.

The Scientific Program Committee has compiled an exciting program of Simultaneous Oral and Poster Sessions from close to 2500 submitted abstracts representing all fields of hematology. For the second year, a number of presenters will have the opportunity to pitch their abstract. These Poster pitches are an exciting opportunity to promote basic science and research, and to invite delegates to the poster walks.

The six Best Abstracts will be presented during the Presidential Symposium on Friday afternoon. This will be a session not to miss. During this plenary session EHA is also awarding, for the first time, the best abstracts by trainees in four categories in basic and clinical hematology research. These awardees and the travel grant winners can be found on the next page. YoungEHA are the future of hematology!

The late breaking abstract submission is an integral part of the scientific program. The late breaking submission is intended for abstracts with "hot" data that were not available by the time of the regular submission deadline. Only few abstracts, with the most exciting results are selected for a presentation in the Late Breaking Oral Session on Sunday morning.

A selection of abstracts will be presented during the regular Poster Walks. The Poster Session consists of two parts: the Poster Walk and dedicated Poster Browsing Time. This setup guarantees sufficient time for discussion of the important research presented, so look out for the Poster Walk Moderators in their red baseball caps! There will also be E-posters available on the E-poster screens, for which a specific time is allocated during the Poster Browsing Time at the end of each Walk. The Simultaneous Oral Sessions are spread over three days (Friday to Sunday) providing you with ample opportunity to attend a number of these important sessions.

All posters can be viewed on the E-poster screens from Friday morning to Saturday evening. All the abstracts are also available on the EHA Learning Center, for which you have complimentary access after the congress: learningcenter.ehaweb.org.

On behalf of the EHA Board, the committees and all the people involved in this year's EHA Congress, we thank you for coming to Madrid and wish you a great meeting.

Shai Izraeli

Chair Scientific Program Committee 22nd Congress

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Travel Grant Winners

For this Congress 140 travel grants have been awarded to junior members of EHA, based on the mean score of their abstracts.
EHA congratulates the following persons with their travel grants:

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YoungEHA Best Abstract Awards

One of the primary missions of the European Hematology Association is to support young hematology clinicians and researchers. This year we are proud to announce the launching of the YoungEHA Best Abstract Awards. These will be awarded to the highest ranking abstracts in the following four categories: Clinicians or medical students training for a PhD degree, PhD research students, postdoctoral fellows and clinical hematology trainees. We are honored that these outstanding YoungEHA trainees will be presenting during the EHA congress – they are the future of Hematology!

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Myeloma and other monoclonal gammopathies - Clinical 3

P669

OUTCOMES IN PATIENTS ALLOCATED TO NO-ASCT BASED ON DEPTH OF RESPONSE: INITIAL RESULTS OF A PHASE 2 TRIAL ASSESSING THE IMPACT OF MINIMAL RESIDUAL DISEASE (MRD) IN PATIENTS WITH DEFERRED ASCT (PADIMAC)

K. Yong[1,*], R. De Tute[2], D. De-Silva[1], E. Phillips[3], N. Counsell[3], J. Cavenagh[4], C. Roddie[1], R. Owen[2], M. Streetly[5], S. Schey[6], M. Koh[7], J. Crowe[8], M. Quinn[9], S. D'Sa[10], A. Virchis[11], G. Cook[12], C. Crawley[13], G. Pratt[14], M. Cook[15], J. Ashcroft[16], R. Benjamin[6], T. Adedayo[3], N. Braganca[3], J. Lyons-Lewis[17], P. Smith[3], L. Clifton-Hadley[3], N. Rabin[17], R. Popat[1]
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Background: The role of autologous stem cell transplantation (ASCT) as first line therapy for newly diagnosed (ND) patients with multiple myeloma (MM) remains under evaluation given the deep responses to novel induction regimens. Outcomes for those not proceeding to ASCT following induction remain unclear, likely to be influenced by genetic risk and response depth. This study was designed to evaluate a stratified approach to ASCT, investigating if patients in CR/VGPR to induction may safely be assigned to delayed ASCT.
Aims: This single arm phase 2 clinical trial conducted at 13 UK sites aimed to determine the progression free survival (PFS) for patients who achieved ≥VGPR to induction therapy with no further treatment. Here we report the primary endpoint, PFS at 2 years in the patients not proceeding to ASCT, and the influence of MRD status on PFS.
Methods: NDMM patients eligible for ASCT received PAD (bortezomib 1.3mg/m2 IV or SC days 1, 4, 8, 11; doxorubicin 9mg/m^2 days 1-4, dexamethasone 40mg days 1-4 (and days 8-11 and 15-18 for cycle 1 only)) for 4-6 cycles. Those achieving <PR were off protocol; all others had PBSCH followed by restaging including MRD assessment on bone marrow using multi-parameter flow cytometry. Those in PR were stratified to ASCT (no maintenance) whereas those achieving ≥VGPR stopped treatment. Responses were assessed at 100 days post PBSCH (including MRD), and at monthly intervals for up to 2 years. High risk disease was defined by the presence of one or more adverse FISH lesions (t(4;14), t(14;16), t(14;20), del(17p13), +1q21).
Results: Between April 2011 and January 2014 153 patients were enrolled (median age 55, range 28-71 years), 139 (91%) received 4-6 cycles of PAD. The majority (88.2%) received SC bortezomib, 18 (11.8%) received at least 1 cycle IV. FISH data was available for 132 patients, 89 (67.4%) patients were standard and 43 (32.6%) adverse risk. 51 (33.6%) patients were ISS I, 67 (44.1%) ISS II and 34 (22.4%) ISS III. The overall response rate to PAD was 82.4% (≥VGPR: 41.2%). Responses were similar irrespective of ISS or genetic risk (standard: ≥VGPR 37.5%, PR 40.9%, adverse: ≥VGPR 53.5%, PR 34.9%). Post-PBSCH, 63 (41.2%) patients achieved ≥VGPR, and 44 (28.8%) patients achieved PR of whom 36 proceeded to ASCT. After a median follow-up of 45.4 months from registration, median overall PFS was 22.5m (95% CI: 18.1-25.3). For those who achieved ≥VGPR, median PFS from PBSCH was 8.9m (95% CI: 4.6-13.3) and 25.7m (95% CI: 13.7-37.6) for MRD+ (N=25) and MRD- (N=16) patients at D100 post-PBSCH respectively, 2y-PFS 28.0% (95% CI: 10.4-45.6) and 56.3% (95% CI: 32.0-80.6) respectively. PR patients proceeding to ASCT had a median PFS of 17.2m (95% CI: 14.2-20.2) and 23.1m (95% CI: 16.8-29.4) for those who were MRD+ (N=20) and MRD- (N=7) at D100 respectively, 2y-PFS 15.0% (95% CI: 0-30.7) and 42.9% (95% CI: 6.2-79.6) respectively.
Summary/Conclusions: This is the first study to report outcomes of patients stratified to ASCT by depth of response. The overall PFS for the study is shorter than other published trials, most likely due to the inferior outcome for MRD+ patients not proceeding to ASCT. The median PFS for ≥VGPR patients who are MRD- and stopped therapy was similar to that in PR patients achieving MRD- status post-ASCT. The PFS for ASCT was relatively short, reflecting selection of those only achieving PR. Response rate alone is not sufficient to identify patients who would benefit from ASCT and use of MRD to stratify treatment is now being investigated.