sion was made at 14 days after pts completed velafermin administration with no dose limiting toxicity reported. All abnormal hematology or chemistry laboratory reports were expected and consistent with pt disease conditions. The second cohort of 0.1 mg/kg dose is ongoing with 2 pts completed study drug infusion. The safety profile and clinical data of all pts will be reported.

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CAREGIVER SUPPORT GROUP ON PEDIATRIC BONE MARROW TRANSPLANT UNIT: WHAT FAMILIES ARE TALKING ABOUT AND WHY THE MEDICAL TEAM SHOULD LISTEN

Schmid, C.L.[1], Calderon, K.S.[1], Partin-Welch, P.H.[1], Huber, H.[1], Robinson, N.S.[1], Van Loon, R.A.[2] 1. Cincinnati Children's Hospital Medical Center, Cincinnati, OH; 2. University of Cincinnati, Cincinnati, OH.

Prompted by families' unrest in the Pediatric Blood and Marrow Transplant Unit at Cincinnati Children's Hospital Medical Center, in the Spring of 2005, social workers began an hour-long, weekly support group for caregivers of inpatients. Group attendance has depended upon unit census and other factors such as caregivers' ability to leave the child in the room with an attendant. Notable discussion points have emerged and the group has become not only a support for caregivers but a guide for the medical team on how to best assist families and patients through treatment and recovery. The team's understanding of the main, or previously unrecognized, family issues is resulting in a better outcome for the patients and caregivers. Overt and covert topics have emerged from the group. Overt topics, or those "on the surface" or "expected" to appear, remain consistent within almost each discussion. These explicit topics include difficulty with distance from primary residence and managing the household, benefit in connecting with other caregivers on the unit, balancing siblings' needs while caring for sick child, and financial strain. While it is necessary for the medical team to be mindful of those struggles, it is potentially even more important to consider covert issues that also make a powerful impact and often go unnoticed. Covert topics, or those not as readily voiced but shared among caregivers, may include self-care and the need to be away from the child to express emotions, responding to emotionally "needy" families on the unit, physical impact of illness on the patient, fear of returning to hospital following discharge, neediness of the ill child, comprehending medical information and advocating for the child with the medical team, how to successfully convey concerns to the team, and a repeated expression in confidence of the medical facility (potentially stated for their own reassurance). In creating a safe environment for caregivers to share their concerns, struggles, and joys, the medical team gains a better understanding of how to interpret caregivers' behavior and respond within a family-centered care model. Subsequently, the patient's treatment and recovery may go more smoothly with families feeling better supported. Acknowledging the multitude of strains and adjustments that accompany a prolonged hospitalization will benefit all involved with the patient's care and, ultimately, the patient.

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GLUTAMINE SUPPLEMENTATION TO REDUCE ORAL MUCOSITIS IN MULTIPLE MYELOMA PATIENTS RECEIVING HIGH-DOSE MELPHALAN AND AUTOLOGOUS STEM CELL TRANSPLANTATION: A FEASIBILITY STUDY

Hansen, L.K.[1], Smythe, P.A.[1], Hansen, K.S.[1], Gruenberg, D.R.[1], Callaway, D.[1] [1]Legacy Good Samaritan Hospital, NW Marrow Transplant Program, Portland, OR.

Oral mucositis is a common and distressing toxicity associated with high dose Melphalan (HDM) and autologous stem cell transplantation (ASCT). The amino acid, glutamine (GLN), has been employed in an attempt to ameliorate oral mucositis in various high dose chemotherapy regimens with mixed results. This pilot study sought to evaluate the feasibility of administering an oral GLN food supplement in patients with multiple myeloma undergoing HDM and ASCT. Twelve patients (3 females and 9 males), median age 51, consented and enrolled in the trial. GlutaSolve™ (Novartis) 15 gm bid was administered 4 days before the start of HDM and continued for at least 14 days or 28 doses. Oral assessment and mucositis ratings were scored by trained oncology nurses and physicians using the NCI Common Toxicity Criteria, version 3.0. Compliance with bid dosing, tolerance of GLN, pain medication usage, total parenteral nutrition (TPN), and hospital length of stay (LOS) were measured. The 12 study patients were compared to case controls matched by gender, age, and presence or absence of renal dysfunction. **Results:** The compliance rate for planned GLN doses was 91.3 %. Toxicities were minimal and were limited to occasional nausea, vomiting, and mild abdominal pain after taking GLN. Several patients developed aversion to ingesting GLN toward the end of the treatment period. There were no cases of clinical grades 3 or 4 oral mucositis observed in the 12 study subjects. Median clinical mucositis score was grade 1 (mean = 1.2) and median functional mucositis score was grade 1 (mean = 1.1). Control patients had median clinical and functional mucositis scores of 2 (mean = 1.5) and 1 (mean = 1.25), respectively. Only 1 study patient developed functional grade 3 mucositis (unable to adequately aliment or hydrate orally), whereas 3 control patients experienced grade 3 mucositis. None of the study patients received TPN and only 1 patient received parenteral analgesia for oral discomfort. In comparison, 2 controls received TPN due to oral mucositis and 4 received parenteral analgesia. Average LOS was 16.8 days for study patients and 17.4 days for controls. **Conclusions:** Oral GlutaSolve™ supplement is safe and well tolerated in patients receiving HDM and ASCT for treatment of multiple myeloma. Results of this pilot study suggest this inexpensive form of GLN may reduce the severity of oral mucositis and further study is warranted in patients receiving HDM and ASCT.

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ANTIBACTERIAL PROPHYLAXIS DURING NEUTROPENIC PHASE IN AUTOLOGOUS PERIPHERAL BLOOD STEM CELL TRANSPLANT (APBSCT). COMPARISON BETWEEN CIPROFLOXACIN + AMOXICILIN VS. LEVOFLOXACIN

Karduss, A.J.[1], Gomez, L.R.[1], Reyes, P.A.[1], Jimenez, J.A.[1], Jaimes, F.[2], Deossa, H.[1] 1. Instituto de Cancerologia - Clinica las Americas, Medellin, Colombia; 2. Departamento de Medicina Interna - Universidad de Antioquia, Medellin, Colombia.

From November 2002 to May 2004, the patients who received an APBST had a prophylactic antibacterial regimen with ciprofloxacin 500 mg PO BID + amoxicilin 500 mg PO TID (group A). After June 2004 our protocol changed to levaquin 500 mg PO daily (group B). We compared the incidence of fever, infections, and mortality related to the infections in these 2 groups. All the patients were in an individual room and they received filgrastin from day +7 until neutrophils recovery. In case of fever a complete physical exam, blood and urine cultures, and chest X-Ray were done, and a Carbapenem was started. There were 20 patients in group A, 13 men and 7 women, median age 38.90 years (15–67); 6 HD, 7 MM, 7 NHL. The average time with neutrophils <500 was 9.4 days and for engraftment was 11.4 days. Sixteen of twenty had fever (80%), in 7 (43.7%) the cause was unknown, in 5 (31.2%) a bacteria was found (*E. coli* [3], *S. epidermidis*[2]); 1 patient had pneumonia caused by *A. fumigatus*, and 3 had engraftment syndrome and there were no deaths. Group B were 19 patients, 12 men and 7 women, median age 50.5 (24–60), 10 MM, 5 NHL, 4 HD. Average time with neutrophils <500 was 9.47 days (7–12) and for engraftment was 11.42 days (11–14). Seventeen patients had fever (89.4%): 12 (70%) of unknown cause, in 3 (17.6%) a bacteria was found (*Burkhordelia cepacea* [1], *E. coli* [2]), 1 had engraftment syndrome and 1 pneumonia without germ. We had no deaths due to infection, and 1 patient died secondary to VOD. For comparing the groups a Fisher's test was done, and there were no significant differences in frequency of fever cases ($P = .365$) nor bacteremia cases ($P = .378$). These results remained non significant after adjustment with a logistic model for neutropenia days and the average of days for engraftment between the groups; Wald test for fever $P = .578$ and for bacteremia, $P = .370$. The prophylaxis daily