Hospital Anxiety and Depression Scale (HADS) and Lawton and Brody's instrumental activities of daily living.

Apart from age, both cohorts were well matched for baseline characteristics. The median age of patients undergoing RIC was significantly higher to those undergoing MY conditioning (59 vs. 42 yrs, $p < 0.0001$). The compliance for completion of QOL assessments was: baseline, 98%; Day30, 91%; day100, 85%; day180, 84%; and day365, 85%. The main reason for non-compliance was illness due to toxicity or disease relapse.

QOL data were analyzed for both cohorts without imputation. QOL scores did not differ for the two study groups at baseline. There was a decline in QOL scores in post transplant period with lowest scores at day30 followed by subsequent slow improvement to baseline by day365. The RIC cohort had better QLQ-C30 scores in the domains of physical functioning ($p = 0.005$) and role functioning ($p = 0.02$) at day30. No other significant differences were noted between the two groups at other time points. Recovery post transplant was similar in the two cohorts. In a multivariate analysis, clinically meaningful differences in favor of RIC cohort were observed in the role functioning domain of QLQ-C30. In addition, patients with HCT-comorbidity scores ≥ 3 had significantly worse scores for emotional functioning and global health domain of QLQC-30, FACT-BMT, FACT-An and HADS.

Imputing QOL data using worst scores for patients who did not complete QOL questionnaire due to illness did not significantly influence the above results.

We conclude that both MY and RIC regimens resulted in similar QOL at 1-year post transplant.

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IMPLEMENTATION OF A HEMATOLOGICAL MALIGNANCY-BASED SURVIVORSHIP CLINIC

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Background: There are approximately 12 million cancer survivors in the U.S. Cancer survivors are at increased risk for health complications such as heart disease, secondary malignancies, and psychological distress. Reflecting the needs of cancer survivors as part of our health care system, the Institute of Medicine issued a seminal report, From Cancer Patient to Cancer Survivor: Lost in Transition, recognizing cancer survivorship as a "distinct phase of cancer care." A dedicated survivorship clinic with creation of personal care plans and treatment summaries can serve the needs of this growing cohort of patients.

Objective: To determine the viability of a transplant/hematological malignancy-based survivorship clinic with treatment summary and care plan for survivors.

Methods: A literature search was initiated examining recommendations and guidelines regarding follow-up of cancer patients. We incorporated and consolidated guidelines from ASCO, NMDP, NCCN, and COG, pertinent articles from the PubMed database, and the growing literature for cancer survivorship. Awareness of the program was to be initiated with letters to affiliated physicians, lecture series, patient-oriented educational handouts, and articles in the hospital literature.

Data Synthesis: A treatment care plan was devised for all survivorship clinic patients. This care plan summarized patients' prior care with recommendations for follow-up such as cardiac and cancer screening, osteoporosis, thyroid disease, and vaccination schedules–all based on our consolidative review of available evidence-based or expert guidelines. A referral base was developed with specialists focused on lymphedema, psychiatric issues (needs determined by screening tools), social work, art therapy, exercise, and nutrition.

Results: Patients from affiliated hematologists/oncologists were seen in the survivorship clinic. Unique care plans were devised for them based on their history of having had a hematologic malignancy or a stem cell transplant. A satisfaction survey was to be implemented. Preliminary satisfaction from both physicians and the patients themselves was positive.

Conclusion: A transplant/hematologic malignancy-based survivorship clinic is feasible and fills an important need in a large, urban, hospital-based cancer center. Further investigation will focus on developing a computer-based treatment summary and care plan, increasing patient referrals, and developing a lecture series devoted to survivorship.

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OUTCOME OF SOLID ORGAN TRANSPLANT FOLLOWING BLOOD AND MARROW TRANSPLANT (BMT) IN PEDIATRIC PATIENTS

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Blood and marrow transplant (BMT) may be curative for children with malignancies as well as life-threatening non-malignant diseases. However, permanent organ failure may result from conditioning regimens or other BMT-related toxicities. Solid organ transplant (SOT) may be indicated for a select group of pediatric patients, but this poses difficult decisions for families and caregivers. There is limited information available about the outcome of children who received SOT following BMT. At the Children's Hospital of Philadelphia, we have identified eight children (4 males) who have received a solid organ transplant following a BMT. Patients (pts) were 6 months to 18 years at the time of BMT. Diseases for which BMT was indicated included: thalassemia, Wiskott-Adrich syndrome, Shwachman-Diamond/bone marrow failure, sickle cell disease (SCD), erythopoetic porphyria (EP), acute lymphoblastic leukemia, chronic granulamotous disease, and neuroblastoma. BM donors were matched sibling in 4, unrelated in 3, and autologous for one. Time from BMT to SOT was 13 days-7 years (median, 27 months), with two pts <2 months who received liver transplants. Indications for liver transplant included VOD (2), chronic GVHD (1).Lung SOT was performed for 2 pts with bronchiolitis obliterans (2), and kidney transplants for 3 pts with renal failure. Three of the organs were from a living related donor (2- liver, 1-kidney), and 5 were cadaveric organs. Four pts were on immunosuppressant agents at the time of the SOT: 2 pts <2 months from BMT on a cyclosporine infusion, one pt on tacrolimus for treatment of BOOP, and one pt with EP on both azathioprine and prednisone due to a previous liver transplant. Seven pts (2-lungs, 2-liver, 3-kidney) are alive with functioning allografts two to 157 months from SOT. One pt with thalassemia developed multiple mesenteric artery thromboses following two attempts at liver transplant and died. Advances in organ procurement, operative technique, immunosuppressant therapy and infection control may allow SOT for a select group of pts post BMT. However, scarcity of donor organs available in a timely fashion continues to be a limiting factor. Children who have undergo BMT and develop single organ failure should be considered for a solid organ transplant if there is a high likelihood of cure of the primary disease.

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FIRST DESCRIPTION OF A SUCCESSFUL PREGNANCY AFTER MYELOABLATIVE STEM CELL TRANSPLANTATION IN A SICKLE CELL PATIENT BY MEANS OF AN OVARIAN TISSUE AUTOGRAFT

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The preservation of fertility is an emerging concern in patients treated by myeloablative hematopoietic stem cell transplantation (HSCT). One major drawback of autologous gonadic tissue transplant being the risk of leukemia recurrence, this procedure is first to be proposed to patients allografted for non malignant diseases. Cryopreservation of ovarian tissue with subsequent autotransplantation is an emerging procedure that has led to 6 reported births until today, none of them being obtained after HSCT. Moreover, 3 of these 6 pregnancies were obtained through *in vitro* fertilization procedures. We report the restoration of ovarian activity followed by pregnancy and live birth after an orthotopic transplantation of ovarian tissue in a 19 year old female patient transplanted for sickle cell anemia. The patient having experienced a CNS stroke received an