

The following abstracts were taken from Blood, Volume 110, issue 11, November 16, 2007

rank p) between AZA and BSC, LDAC, and Std CT, respectively, were 12.9 mo (0.55; p=0.0003), 9.1 mo (0.60; p=0.016), and 8.7 mo (0.69; p=0.19). Median OS per IPSS cytogenetic subgroup showed similar results (Table). The 1, 2, and 3-mo survival rates did not differ between AZA and BSC only (p>0.20). AZA was well tolerated with safety data consistent with previous reports.

Conclusion

These data confirm and extend previous CALGB findings. This AZA trial is the first MDS clinical study to demonstrate a

OS Analyses per IPSS Cytogenetic Group

Group	% (n/N) Pts	AZA Median (Months)	CCR Median (Months)	HR (95%CI)	Log-rank p
Good	46 (166/358)	Not reached	17.1	0.61 (0.39, 0.96)	0.030
Intermediate	21 (76/358)	26.3	17.0	0.43 (0.21, 0.88)	0.017
Poor	28 (100/358)	17.2	6.0	0.52 (0.32, 0.87)	0.011

significant OS advantage, thus altering the natural disease course. AZA should now be

considered first-line therapy for higher-risk MDS pts. ★

[819] RESULTS OF THE INITIAL TREATMENT PHASE OF A STUDY OF THREE ALTERNATIVE DOSING SCHEDULES OF AZACITIDINE (VIDAZA®) IN PATIENTS WITH MYELODYSPLASTIC SYNDROMES (MDS). SESSION TYPE: ORAL SESSION

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Background

Azacitidine (Vidaza®) is an effective and safe treatment (Tx) for patients (pts) with MDS (JCO 2002;20:2429) at a dosing schedule of 75 mg/m²/day SC for 7 days every 4 weeks. A dosing schedule eliminating the need for weekend administration would be more convenient to pts and clinicians. Reported here are results of the recently completed initial Tx phase (6 cycles of randomized Tx) of an ongoing study evaluating 3 alternative azacitidine dosing schedules.

Methods

In this phase II multicenter, open-label trial, MDS pts were randomized to 1 of 3 regimens administered every 4 weeks for 6 cycles: AZA 5-2-2 (75 mg/m²/day x 5 days, followed by 2 days no Tx, followed by 75 mg/m²/day x 2 days); AZA 5-2-5 (50 mg/m²/day x 5 days, followed by 2 days no Tx, followed by 50 mg/m²/day x 5 days); or AZA 5 (75 mg/m²/day x 5 days). Major and

minor hematologic improvements (HI) were assessed by International Working Group (IWG) criteria (Blood 2000;96:3671) and pts with ≥56 Tx days were IWG evaluable. To determine whether therapeutic response is maintained after 6 cycles, a 12-month maintenance phase using the AZA-5 regimen administered every 4 or 6 weeks was added, and pts with at least stable disease were eligible to participate in that phase of the study. Results: A total of 151 pts were randomized to Tx with AZA 5-2-2 (n=50), AZA 5-2-5 (n=51), or AZA 5 (n=50). Most pts are FAB classification RA/RARS (57%) or RAEB (30%). Of the 139 pts (92%) who received ≥56 days of Tx and are IWG evaluable, 74 pts (49%) completed ≥6 Tx cycles. The median number of Tx cycles across all Tx arms was 6. Of IWG-evaluable pts, 71 (51%) experienced HI (Table). The proportions of red blood cell (RBC) transfusion-dependent pts who achieved transfusion independence were AZA 5-2-2: 55% (12/22), AZA 5-2-5:

60% (12/20), and AZA-5: 67% (16/24). In FAB low-risk (RA/RARS) transfusion-dependent pts at baseline, RBC transfusion independence was reached by 60% (9/15), 56% (5/9), and 61% (11/18), respectively. No Tx-related mortality has been reported. Most grades 3 and 4 Tx-related AEs were hematological (AZA 5-2-2: 44%, AZA 5-2-5: 33%, AZA 5: 18%).

Conclusions

Independent of the alternative dosing regimen, the results of the initial 6-cycle Tx phase demonstrate a consistent response for HI, RBC transfusion independence, and safety profile across a broad range of MDS pts, including FAB low-risk pts. These results appear similar to those with the approved FDA regimen and further support the benefit of azacitidine in pts who are transfusion-dependent. Eligible pts continue to receive Tx during the ongoing 12-month maintenance phase of the study. ★