In April 2012, the 16th annual ESH-EBMT Training Course on Blood and Marrow Transplantation was held in Sofia, Bulgaria, organised by Dr. Dobrin Konstantinov of the city’s Children’s Onco-haematology Hospital (SCOH). The programme addressed a broad range of topics relevant to the modern practice of bone marrow transplantation, particularly the principles underlying transplantation and the range of potential complications. It was a great course for a trainee and was well attended with over 100 delegates, providing lots of opportunities to discuss practice across Europe.

Details of future courses will be available on the EBMT and ESH websites.

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Strong evidence for significantly improved transplant outcome in unrelated donor haemopoietic progenitor cell transplants by matching for Human Leukocyte Antigens (HLA) using high resolution typing between patient and donor has been published over recent years (1-8). From these retrospective studies the National Marrow Donor Program (NMDP, USA) issued HLA matching guidelines of best practice for matched unrelated donor (MUD) progenitor cell transplants in adults (9;10). The core component of the NMDP guidelines for optimal transplant outcome requires a high resolution HLA-A, B, C and DRB1 loci matched unrelated donor to be used where a HLA matched sibling is not available. The NMDP did not offer donor selection guidelines for paediatrics.

In a recent publication,(11) we presented the first detailed prospective study analysing overall survival (OS) in bone marrow transplantation for paediatric ALL after the introduction of high resolution HLA matching. The transplants were analysed over five HLA typing epochs delineated by changes in HLA typing methodology. 356 consecutive paediatric ALL stem cell transplants performed between 1988 and 2007 were reviewed; 79 of these transplants were performed after the introduction of high resolution (HR) HLA class I and class II matching to the transplant programme in January 2002.

Comparisons of matched unrelated donor (MUD) transplant outcomes before and after this period were made. The study shows (Figure 1) matching at the HR level for HLA-A,-B,-C,-DRB1 and -DQB1 correlates with a greater than 25% improvement in two and five year OS in paediatric ALL patients transplanted with matched unrelated donors.

Comparisons with contemporaneous HLA matched sibling, HLA mismatched unrelated donor found the HR-MUD transplants had comparable five year OS (Figure 2) (88.2%) to the HLA matched sibling transplants (86.7%).

Univariate and multivariate analysis was performed to look for other factors that might explain these changes.
High risk leukaemias have a much higher relapse rate post transplant. No change in the percentage of high risk cases was observed for the differing epochs. However, some reduction in relapse rates was observed across the whole cohort, with a relapse rate of 16% since 2002 compared to 32% prior to that (Table 1). This explains the improved survival observed in the matched sibling donor transplants and contributes to the improvement seen in the unrelated donor transplants.

Table 1. The reduction in relapse rate is due to better pre-transplant chemotherapy. The relapse rate of 15% that we see is very similar to that found in those patients who reach transplant from the recently published UK relapse study R3 and is not unique to our institution.

However, competing risk analysis also showed a statistically significant reduction in non-relapse mortality in the HR-MUD transplants from an historical level of near 20% to 6% (Figure 3) (11). There was no corresponding reduction in NRM in the sibling or mismatched unrelated donor transplants.

In conclusion, we believe that our clinical experience of using high resolution class I and II typing since 2002 concurs with the NMDP retrospective data and does result in significantly improved survival for high resolution fully matched unrelated donor transplants. No improvement were seen in less than fully matched transplants. The outcome and clinical course of high resolution HLA matched unrelated donor transplants is identical to matched sibling transplants.

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References:
11. Harvey J, Green A, Comish J, Steward CG, Cummins M, Keen L et al. Improved survival in matched unrelated donor transplant for childhood ALL since the introduction of high-resolution matching at HLA class I and II. Bone Marrow Transplant. 2012 (Transplantation advance online publication, 20 February 2012; doi:10.1038/bmt.2012.8.).
As a Centre, we are interested in normal versus leukaemic stem cells, specifically the mechanisms that regulate the stem cell fate decisions as well as how stem cells evade cytotoxic chemotherapies thus precluding disease cure. Our research is truly translational informing several clinical trial designs over the years. We do not exist in isolation but have strong collaborative links locally and worldwide with specialist laboratories including University of Manchester, City of Hope University of California Los Angeles, and Terry Fox Laboratories in Vancouver. Our studies have been made possible by research council funding, industry support, national leukaemia charity funding, local patient trust funds as well as on-going input from the Friends of Paul O’Gorman Leukaemia Research Centre in Glasgow.

With her medical training, Tessa has always been interested in translational research leading to improved patient care. She pursued her interest in the science behind medicine by completing her PhD at the Beatson Institute for Cancer Research in Glasgow. This was the springboard to developing her research group in haematopoiesis at University of Glasgow.

More or less simultaneously at the time Tessa was returning to Glasgow from two years post-doctoral research at the British Columbia Cancer Centre in Vancouver under the tutelage of Prof Connie Eaves, the molecularly targeted tyrosine kinase inhibitor, imatinib was coming through clinical trial. Tessa was lead clinician for STI571 (as it was known then) clinical trials in chronic myeloid leukaemia (CML) in Scotland alongside growing her reputation for solid scientific research into leukaemic stem cells (LSC).

It seems incredible looking back, but it wasn’t a globally accepted view that such ‘wonder drugs’ wouldn’t be so wonderful in terms of cure unless they were targeted to the right cell population, that is LSC which formulate new and inventive ways to subvert therapies designed to kill them. So, for the last decade or so, Tessa has headed her interdisciplinary group using a Systems Biology approach to uncover novel targets for therapy based on genes and pathways critical for stem cell survival and quiescence.
Heather has worked with Tessa since 1999 on iterations of that precise research focus characterising quiescent LSC and testing pipeline and clinical trial investigational medicinal products for efficacy against this key disease sustaining cell population. With her background in pharmaceutical science, Heather has brought a new dimension to the basic stem cell research of the group, instigating the subtheme of nanobiology developing drug delivery methods targeted at stem cells.

In 2001, following a citywide laboratory review, it was decided that oncology services should be centralised at a new Beatson West of Scotland Cancer Centre sited at Gartnavel General Hospital in Glasgow. Tessa had the vision to begin planning for a purpose built leukaemia research centre at Gartnavel; it took many years of fundraising until eventually the Paul O’Gorman Leukaemia Research Centre was opened by Dr Richard Rockefeller in May 2008. The Centre will soon have six research groups investigating normal versus leukaemic stem cells to understand mechanisms that subvert normal haemopoiesis and promote leukaemia development as well as ways in which to target LSC to achieve disease eradication. Programs currently underway include research into:

- the control of cell division, self-renewal and maintenance of quiescence (Dr Mhairi Copland)
- using a Systems Biology approach to uncover novel targets for therapy based on genes and pathways critical for stem cell survival and quiescence (Prof Tessa Holyoake)
- the transcriptional mechanisms orchestrating normal and leukaemic stem cell fate decisions in vivo (Dr Kamil Kranc)
- the cellular and molecular mechanisms that control normal lymphoid and leukaemic cell development (Dr Alison Michie)
- transcriptional and proteomic changes involved in blood cell commitment and how they are altered by leukaemic oncogenes (Dr Helen Wheadon)

The current active research projects in Holyoake / Jørgensen lab are asking multiple questions including are there significant differences in the regulation of survival for CML versus normal haemopoietic stem cells (HSC) and can these differences be exploited for therapy? Our approach here is to perform mRNA, microRNA and proteomics profiling and a genome wide epigenetic screen. We next will ask what is the mechanism underlying CML stem cell resistance to tyrosine kinase inhibitors (TKI)? We aim to use our profiling data to identify early and late factors or pathways that mediate survival of LSC when exposed to TKIs. When proliferating versus quiescent stem cells were compared, we found chemokine ligands to be upregulated in association with quiescence; so we are now asking if chemokines have a role in HSC quiescence?

Here, we are using knock-down and chemical inhibitor as well as over-expression approaches to modulate chemokine expression to examine the effect on cell-cycle in vitro on human quiescent HSC. We are investigating autophagy induction by TKI as a survival pathway and more importantly its potential for inhibition in CML to potentiate TKI-induced cell death.

We are proud to be a truly international Centre with students and staff hailing from as far flung places as India and Iceland with France, Spain, Germany, Italy, Poland, Argentina and Canada represented in between!
It’s not all work and no play; we’re more than a laboratory, more like a community sharing leisure time as well as work time together. Annually we enter a team into the Cycle Glasgow challenge raising money for our Centre (just some of the Paul O’Gorman Pedallers are in the picture, right); we have enjoyed a fundraising Ladies’ Lunch (with one or two men) hosted by Elaine C Smith and her co-stars of the stage production as well as the real life characters who inspired the phenomenon that is the Calendar Girls (our ladies line-up in the photo), to name but a few of our group activities.

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Some recent publications:

1. EK Allan, TL Holyoake, AR Craig and HG Jørgensen (2011): Omacetaxine may have a role in Chronic Myeloid Leukaemia eradication through down-regulation of Mcl-1 and induction of apoptosis in stem/progenitor cells. Leukemia 25(6):985-94


PERMISSION TO MISMATCH

Effect of T-cell-epitope matching at HLA-DPB1 in recipients of unrelated-donor haemopoietic-cell transplantation: a retrospective study.

The current gold standard unrelated donor is one matched at high resolution for HLA-A,-B,-C,-DRB1 (+/- -DQB1) (10/10). HLA-DPB1 is at least as polymorphic as HLA-DQB1 and has been shown in numerous studies to result in allogenicity in much the same way as other HLA molecules. Despite this, DPB1 has not been routinely included in donor selection algorithms due, in part, to the difficulty in matching for this locus. In addition, most clinical results are based on the impact of allele level matching, showing no increase in overall survival except in specific subgroups of patients.

In this recent study, published in the Lancet Oncology, Shaw and Fleischhauer et al, have considered the impact of HLA-DPB1 matching between patient and donor in a novel way – taking both allele-level and epitope-level matching into account in the same analysis. Their results show a survival detriment for patients with donors with a non-permissive mismatch, compared to those with a permissive mismatch or an allele level match. Since approximately only 30% of donors will have non-permissive mismatches, it is possible to avoid these, while in 70% of patients adding a survival advantage over and above the use of a 10/10 matched donor.

This study used a novel model for grouping HLA-DPB1 alleles based on functional studies previously published by Fleischhauer et al. In brief, in a laboratory system, T cells alloreactive to the donor's HLA-DPB1 *09:01 were isolated from a patient who rejected their 9/10 matched transplant and tested for crossreactivity against the most common HLA-DPB1 alleles. On the basis of these functional experiments, DPB1 alleles could be classified into three groups predicted to have a high, intermediate, or low immunogenic potential at a T cell epitope (TCE) level. Those with low immunogenicity are predicted to be ‘permissive’ mismatches i.e. resulting in no adverse clinical outcome, while those with intermediate or high immunogenicity are predicted to be ‘non - permissive’ mismatches i.e. resulting in an adverse clinical outcome.

The study set consisted of 8539 UD transplants submitted to the International Histocompatibility Working Group in HCT (a large collaborative project). Recipients and UDs were classified as HLA-DPB1-matched (20.1%), HLA-DPB1-mismatched and TCE-mismatched (non-permissive; 31.3%), or HLA-DPB1-mismatched but TCE-matched (permissive; 48.6%).

In HLA 10/10-matched transplants (n=5428), non-permissive HLA-DPB1 mismatches were associated with statistically significantly increased hazards of overall mortality (HR 1.15; 95% CI 1.05-1.25; p=0.002), non-relapse mortality (HR 1.28; 95% CI 1.21-1.36; p=0.007 and severe aGvHD: OR 1.34; 95% CI 1.17-1.54; p<0.001). Interestingly, there was no significant difference between the permissive and non-permissive TCE mismatched pairs in relapse risk (HR=0.89; 95% 0.77-1.02; p=0.10).

In conclusion, the authors suggest that pre-transplant HLA-DPB1 typing may be useful for patients and donors where there is a choice between more than one equally HLA matched donor. In 70% of cases either an allele match or DPB1 permissive mismatch can be selected, thus improving the outcome for patients.

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Fleischhauer K et al. Effect of T-cell-epitope matching at HLA-DPB1 in recipients of unrelated-donor haemopoietic-cell transplantation: a retrospective study. Lancet Oncology 2012
In March 2012, Anthony Nolan announced that it had issued its first two units from its cord blood bank, with three more reserved for patients in the UK and the USA – proof that the blood cancer charity’s investment in cord blood is starting to pay off.

Guy Parkes, head of the cord blood project at Anthony Nolan, says, “Although the scheme has been running since 2008, we always knew that we would have to reach a critical mass of units banked before we started seeing the benefits. We’ve now banked nearly 1,000 cords for clinical use, and we’ve finally reached the stage where transplant centres are choosing our cord blood units for transplant. The fact that five of our cords have been issued or reserved in the last few weeks is also validation of our policy to only bank the highest quality cord blood units.”

On 23rd February, Anthony Nolan co-hosted the ‘Symposium on Alternative Donor Transplantation: The State of the Art’ which covered significant areas of interest in unrelated, cord and haploidentical transplant (more details with speaker slides on the BSBMT website). The data that were presented both by UK and international speakers reinforced Anthony Nolan’s policy of pursuing quality as a central theme in their cord blood banking. The symposium also confirmed the importance of cord blood transplants in the treatment of blood cancer and other blood disorders, particularly in children.

Anthony Nolan’s cord blood strategy focuses on building a supply of cord blood units to match the unmet need from the UK and overseas. The charity aims to reduce the UK’s reliance on cord blood units imported from overseas and, in the process, reduce costs to the NHS.
Their approach to cord blood banking is based on four criteria:

**Security**
- Extensive range IDM virology assays including NAT testing on HBV, HCV, HIV and HTLV
- Bacteriology assays for aerobic and anaerobic bacteria and fungi presence to ensure sterility
- Haemoglobinopathy screening
- Strict donor eligibility criteria and screening

**Identity**
- High resolution HLA Typing on HLA-A,-B,-C, -DRB3, -DRB4, -DRB5 and -DQB1 loci and allelic level typing on DRB1
- Confirmatory typing from an attached segment from CBU and maternal haplotype matching with CBU. Cord tissue sample also available for DNA testing.

**Purity**
- The pre-processing threshold for clinically suitable units is increasing to 1400 x 10^6 Total Nucleated Cells (TNC)*
- The threshold for CD34+ pre-processing for clinically suitable units is increasing to 3.2 x 10^6 *

**Potency**
- Colony Forming Unit assay to confirm CD34+ potency, Clone > 10% prior to cryopreservation
- Viability protocols 7AAD and Annexin V

*current thresholds TNC 1200 x 10^6 & 1.9 x 10^6 CD34+ will increase with effect from June 2012

Anthony Nolan is continuing to expand its cord blood scheme by opening a new collection centre at Birmingham Women’s Hospital in May. This will be the fifth collection centre run by Anthony Nolan, with others at King’s College Hospital, Leicester Infirmary, Leicester General and the Royal Free in Hampstead, which was opened by Health Minister Anne Milton on 23rd January 2012.
Who would have thought that presenting a poster at the EBMT (UK) Nursing & Allied Professionals group 40th meeting in June last year would have meant that I got to visit Zurich in November? Well that is exactly what happened and here’s how ……..

I am a research nurse working for Leeds University and we are running a research study called ALLINEX (ALLograft INformation EXchange), funded by Macmillan Cancer Support and working in collaboration with the Blood and Marrow Transplant Service at St. James’s University Hospital, Leeds.

Our aim is to evaluate an intervention for follow up of survivors of allogeneic Haemopoietic Stem Cell Transplant (HSCT): using the internet as an information exchange between patients, carers and their clinical team.

In early 2011 we had analysed the results from the first phase of the study which looked at the patient’s psychological issues and which services they had accessed such as social work, psychology, occupational therapy etc. A poster abstract was submitted and accepted and I duly registered for the conference.

The conference itself was attended by 25 nurses and allied professionals within the transplant speciality from across the UK. It was not my first EBMT conference and I have always found them very friendly, well organised and interesting and this was no exception. Presentations covered such topics as the future of unrelated HSCT, GvHD, survivorship and using patient feedback to improve practice. The content was absorbing and discussion afterwards was thought provoking. My poster was well received and was awarded the Poster Prize of £100.

A month after the conference, I was even more amazed to receive an e-mail from one of the EBMT (UK) NAP committee to say that because of my work on the poster they had thought of me when approached by the EBMT National Nurses Groups to nominate a nurse to attend their study day in Zurich in November 2011.

So feeling like I had won the lottery I headed off to Zurich to attend the EBMT Nurses Group & EBMT Swiss Nurses Working Group Study day. There were about 180 international delegates including nurses and doctors. Presentations included:

- Update on treatment and outcomes for CML by Professor Olavarria, Spain, explaining that CML is now mostly treated by oral medication (Tyrosine Kinase Inhibitors) and that BMT numbers are falling but as a therapy it is still used in certain circumstances.
- Adherence to oral tumour therapies by S. Degen, nurse specialist from Switzerland, who quoted from a study performed in 2009 that only 1 in 7 patients are perfectly compliant to their therapy.
- The role of stem cell transplantation in the lymphomas by Professor Schmitz, Germany who informed us that the role of radiotherapy in the treatment of lymphomas is decreasing and that survival is improving and close to 90%. Antibody treatments have caused improvements in survival and, similar to CML, are causing the numbers of transplants needed for this group of patients to fall. HSCT is still needed, however, for relapsed patients where they will get approximately 40% survival.

Continued on page 11

Beverly Horne
• HSCT for severe autoimmune diseases by Professor Saccardi, Italy and Professor Martin, Switzerland. HSCT may result in high risk of late effects which can be exacerbated by problems from original disease.

• Study on ambulatory care reported by Arnold Mank from the Netherlands which looked at early discharge in the aplastic phase until bone marrow recovery. Patients were very positive about the ambulatory care but as can be expected the psychological burden on the carers was high. No life threatening situation occurred but 60% needed re-admission for a period of time, usually due to fever. They are going to continue to look at this, concentrating on fevers and infections and also whether home visits should be included in the package of care.

• New trends in HSCT by Professor Passweg, Switzerland who informed the conference that Germany, Holland and Belgium perform the most HSCTs. Looking at the EBMT activity survey in 2010 there were 238,026 allografts performed between 1990 and 2010, with survival at 45% which was influenced by co-morbidities. Cord blood transplant is increasing in Europe with France and Spain doing the most cord blood transplants. Professor Passweg stated that cellular therapy, using natural killer (NK) cells was the future for HSCTs with less GvHD.

• Objective and practice of (not) getting to know each other – a panel debate about whether the patient and donor should be allowed to be in touch and the pros and cons of allowing this.

• Late effects by K. Davis and J. Brennan from London on the set up of the Late Effects clinic and how each of the body systems are assessed with the patients being followed up for life.

• A patient’s story by a patient from the Netherlands. He told his story about his 2 HSCTs and 2 relapses, plus the fact that he has also had skin cancer. He felt it was important to accept being unwell; to have goals and to participate in sport which he found was a therapy for his body and mind. Exercise helped him to deal with his treatment and psychological therapy was also important and put the balance back in his life. He did feel that the psychological care of the patients warranted more attention than it presently got.

After the study day had finished we were given a tour of the transplant ward at the University Hospital, Zurich.

They have 8 beds and perform 89 transplants per year with strict isolation; the rooms were split by a plastic screen with the anteroom being for the clinical staff to perform their routines, the visitors to sit etc. The patient occupied the rest of the room where they spent the isolation period. As few people as possible entered the patient’s side of the room and there was no en-suite; the commode was at the end of the bed with the nurses emptying it from the anteroom and the patient performed personal cares from a wash bowl. Anecdotal reports from the nurse showing us round were that there was less GvHD with this method of care. It was an amazing day where I learnt a lot and saw a different way to care for transplant patients.

As far as our research study goes we have now developed our intervention – a website for the HSCT patients and their carers, called ALLINEX. The website includes information about blood and marrow transplants and what the potential problems might be in the short and long term. ALLINEX also contains information and advice on social and psychological issues and local support within their own region, both at the hospital and in the community. There is an end of life section, with practical advice on considerations before and after death and where to obtain support at this very difficult time in their lives. The website has the facility to e-mail the clinical team directly and the patients have a forum where they are able to post messages to each other. Feedback from the patients and clinical team has been excellent and our first GP to comment has said that she thinks the site will be useful to GPs as well. We are about to enter phase 3 of the research study where we are to formally evaluate the website as an intervention and we are going to do a randomised study with half the patients receiving standard care and the other half standard care plus access to the website. Our aspirations are for the website to be rolled out nationwide with each region having their own section, so keep your eyes and ears open!
At school, I had no idea whatsoever that I would become a doctor but I did want to be a rock star!

My family was and still is very religious and has been plagued by priests or, to be more specific, Anglican clergy – father, both grandfathers, brother, sister-in-law, even my aunt! So I dutifully went off to Lancaster University in 1983 to read Religious Studies and Archaeology. This was actually more subversive than it sounds given that it comprised roughly equal coverage of all world religions, most of which my father used to refer to as ‘rank idolatory’. He wanted me to become an Anglican priest like him and would have preferred me to read straight Theology. However, I don’t think he realised quite what Religious Studies was, and, hey, it was close enough. It was during that time, I was in two fantastic bands - a rootsy blues rock outfit and a quirky indie band heavily influenced by bands of the era such as The Smiths, Echo and the Bunnymen and The Cure.

I left University hoping that the indie band would make it big and I’d be off round the world on tour releasing platinum selling albums. We did produce an album and I loved it and still listen to it. Some bits are still fantastic and only a few bits make me cringe! So imagine my excitement when a letter from EMI arrived shortly after release. Unfortunately, it wasn’t a contract. The review described the songs as ‘awash with reverb’ and our promo shot featured us ‘modelling overcoats’!

The band fizzled out and I wasn’t that disappointed. By that time I was working at a Day Centre for unemployed people and with those dealing with addiction to drugs and alcohol. This became increasingly medicalised as I moved from a rehab unit to a Health Authority Psychology Department to a Mental Health Unit.

I realised that I needed to re-train and the two options I entertained were psychotherapy and medicine. I was advised in no uncertain terms, by a Consultant Psychiatrist, not to do psychotherapy and, actually, what I really fancied was medicine.
So, at the age of 28, I was accepted by Sheffield University Medical School via the Pre-Med course to read medicine. I loved it, being a student again, actually feeling vocational about what I was studying and being in two new fantastic bands. This was now the 90’s and both outfits were distinctly acid-jazz flavoured. I no longer hankered after being a rock star but was frequently gigging and we were having a lot of fun.

I married aged 23 and was supported through Med School by my wife. My son was born during my Obs and Gynae attachment and after a long procession of my fellow med students visiting the newborn, his arrival was cited by over half the year as one of their requisite witnessed births! I qualified and was on a post take ward round as a House Officer when I got the call from my wife saying she was in labour again. I cycled home and delivered my daughter myself shortly afterwards on the back seat of our car.

I settled on Haematology as the most interesting and exciting specialty and became a Haematology SpR continuing to really enjoy my work.

Getting on in age, a bit, I thought I’d better get on and qualify. But, instead I sidestepped and launched into a research career commencing a PhD in Myeloma Bone Disease. I quickly learnt that the practice of scientific research is very different from the practice of clinical medicine. I duly experienced the manic highs and lows as a researcher ranging from the frustration of failed experiments and rejected papers to the elation of experiments that yield really interesting results, papers accepted in good journals and the thrill of fun of international conferences.

Meanwhile, the music was getting jazzy and I found myself playing on the same bill as Courtney Pine, Snake Davis and the Pasadena Roof Orchestra, as well as other less well known but truly excellent musicians on over a hundred professional engagements. This was a thrill, but I must say I was feeling out of my depth and stretched as I tried to balance the demands of home life, research work, clinical and on-call duties with gigging all over the country, travelling home late at night. I gig far less often these days but am quite content and actually enjoy it more!

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Recent BMT related publications include:


Hammaad Khalil

Marrow is a nationwide student led organisation that works in collaboration with Anthony Nolan. Marrow aims to raise awareness of blood cancers, the need for more donors as well as the importance of fundraising for Anthony Nolan to help them keep saving lives.

It costs Anthony Nolan £125 to sign one person onto the bone marrow register. Every 23 minutes somebody is diagnosed with a blood cancer and for every one that Anthony Nolan can save, one isn’t. This is largely because of the lack of donors on the bone marrow register.

At Marrow Lancaster we aim to recruit as many people to the Anthony Nolan register as possible, and fundraise lots of money while we’re doing it. We train up volunteers so we can run recruitment events in and around Lancaster to get people on to the register. We deliver recruitment training sessions after which you’re ready to become a Marrow recruiter and help us out at our next recruitment event.

Since December 2010 Lancaster Marrow have signed up over 350 people onto the bone marrow register and our aim is to double this by the end of 2012. To help us do this we need many volunteers to help us on our mission.

If you would like to get involved in any way, or are just interested in putting yourself on to the bone marrow register then please contact the Anthony Nolan team (http://www.anthonynolan.org/Home/Contact-Us.aspx).

Please show your support to this great cause and get involved with your local Marrow group to help us save more lives of those taken with blood cancer.

Thank you

Hammaad Khalil
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Firstly I must advertise that EBMT 2013 will be held in London on 7-10th April at the Excel Conference centre, London. It is clearly a very important date for your diary but it is also a chance for the UK to produce a top class meeting. Jane Apperley is President and together with Francesco Dazzi, David Marks and Tuula Rintala is responsible for organising the meeting. I know that we at the BSBMT are keen to help and that Jane and her team are keen to hear from anyone who has ideas and who wants to help. Let’s help to make it the best EBMT yet.

We do know how to produce good meetings here in the UK. The symposium on ‘Alternative Donor Transplantation: The State of the Art’ held on the 23rd February was excellent thanks to the co-organisers Alejandro Madrigal, Charles Craddock and Derwood Pamphilon who put together an outstanding meeting and there was a great audience to enjoy some really good talks. It was nice that the Department of Health also supported this important meeting. I am hoping we will continue to repeat this meeting on a bi-annual basis. It also represented an exciting collaboration between the Anthony Nolan, BSBMT and the BBMR. Please remember our Education day on the 3rd October.

It has been a difficult time for the BSBMT over the last 6 months. Our finances are a constant cause for concern and we were told this year that we had to produce a business case to justify our registry funding which is key to producing the excellent data, publications and studies we produce. We were successful this year and thanks go to Keiren, Jenny Charles and Gordon who helped to produce a really well written and well argued case.

It is clear that we remain under intense scrutiny and that we have to have a dialogue with Purchasers together with other transplant stakeholders. We therefore held a round table meeting on 24th February and we had some full and frank discussions around transplantation in the future.

The future is of course uncertain particularly as government reforms filter slowly through. It is great that Tony Pagluica has the opportunity to chair the committee overseeing the future of commissioning for stem cell transplantation. It was nice to see both Tony and Gordon gain their Chairs in the last 12 months as both have been such hard working supporters of the BSBMT.

Another change that has been controversial is the SABTO recommendations suggesting that the universal leukodepletion has obviated the need to select CMV negative blood products for CMV negative recipients. Clearly this is a major change and I am sure all of us feel nervous about this. We will be developing an audit with the CTC to monitor the impact of this change. We are of course very keen to hear about any CMV negative patients who develop CMV viraemia or illness during their transplant and will be prospectively collecting data and auditing the impact of these changes.

We have a great organisation and there are so many people who work tirelessly to promote our organisation particularly our dedicated hard working committee, staff and members of the CTC. I would like to thank everyone who gives their expertise and time so freely to the BSBMT.

Graham Jackson
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