

an increase of thrombotic events and atherosclerosis progression, while the experimental use of their inhibitors results in a risk reduction for atherosclerosis, and similar findings will be observed in defective animal models. All the clinical forms of diabetes mellitus are associated with an enhanced risk of atherosclerosis and thrombosis, and in the sera of patients the levels of CD40 and CD40L are higher than in normal people. As expected on the diabetic's platelets membrane these molecules resulted overexpressed. In the hypothesis that in diabetes the CD40 and CD40L expression on the platelets, could correlate with the severity of the metabolic impairment, we have recorded the percentage of platelets bearing these molecules in a series of patients with type 2 diabetes, needing different burden of therapy to maintain a metabolic balance. We detected the positive platelets by an indirect fluorescence method, using an anti CD61 fuorescinated mouse serum and anti CD40 or anti CD40L ficoeritrinated mouse sera, and estimated the percentage of positive platelets from the ratio of positive CD40 or CD40L counts over positive CD61 counts. The overall median percentages were: CD40 16.86 (0.02–94.4); CD40L 3.1 (0.09–19.6). In the group of patients who needed only diet to be in balance the percentages were: CD40 20.39 (3.77–94.4), CD40L 1.46 (0.3–9.1); for the patients treated with oral drugs were: CD40 17,07 (5,7–69,4), CD40L 2,85 (0,3–9,1) and in the group of patients needing insulin the percentages were: CD40 6,48 (0,02–53,7), CD40L 5,52 (0,09– 19,7). Though the series is small and the variance is great with evident overlapping values, the percentage of platelets expressing CD40 or CD40L correlate with the treatment needed, with a linear trend statistically significant ( $p < 0.05$ ), possibly mirroring a parallel increase in the risk of trombotic events. The inverse correlation between the CD40 and CD40L deserves further studies.

#### L007

##### ANTIFUNGAL TREATMENT WITH CASPOFUNGIN: A SINGLE CENTRE EXPERIENCE

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Infections are the main complication of the patients with hematologic diseases during severe neutropenia and among them fungal infections are the most difficult to treat and the major cause of mortality for these patients. Because now we have a new antifungal class, Echinocandins, we have wanted to verify the tolerability and efficacy of Caspofungin.

From January 2004 until now we have treated 12 consecutive oncohemopatic and neutropenic patients. The schedule was: in case of persistent fever (at least 4 days) during broad spectrum antibiotic therapy a high-resolution CT scan of the lungs, an abdomen US scan, swabs from pharynx, nose and rectum and blood cultures were performed. In case of positivity of one or more of these findings Caspofungin was administered i.v. at the dosage of 70 mg on the first day and then 50 mg from the second day; the infusion time was 1 hour. The patients were 8 males and 4 females, the mean age was 47 yrs (range 30-60 yrs).

The diagnoses were: acute myeloid leukemia 7, acute lymphoblastic leukemia 2, lymphoma 3; the disease's phases were: onset 2, first CR 2, CR>I 2, PR 4, Relapse 1, Resistant 1. Two patients were subjected to an allogeneic BMT, 1 to an autologous BMT, the other patients to an induction or consolidation or rescue chemotherapy course. In four cases Caspofungin was administered as secondary prophylaxis of a previous probable or proven fungal infection (in 2 of these patients the infection was proven and was from *Aspergillus* spp), for the other patients Caspofungin was administered for persistent fever and at least one lesion of the lungs with no evidence of bacterial or viral infection. The mean time of treatment was 18 days (range 7-21 days); the treatment was not discontinued for anyone of them because of adverse events; the dosage of Caspofungin was not changed for anyone. For the 2 allogeneic transplants cyclosporine A administration was not changed and we did not found any renal or liver alterations. No adverse events during the infusion of Caspofungin were seen and it was not necessary to administer any drug before the infusion. We did not see breakthrough fungal infections. In only one case a proven fungal infection (*Aspergillus fumigatus*) was demonstrated so the other cases were probable or possible infections. No progression of the infection was seen. All the infections were completely cured. Four patients died: 3 of them for leukaemia and one for bacterial infection (*Pseudomonas aeruginosa*) after the fungal infection. These cases may show that now we have a new treatment option for fungal infections in neutropenic patients and this option is safe for the patients, does not preclude any other treatment (such as CsA), is well tolerated and the resolution rate of the infections is very high, probably because of the new mechanism of action of the drug. Our study should have been verified in a larger cohort of patients especially about its efficacy.

#### L008

##### EFFICACY OF SEQUENTIAL-COMBINED THERAPY WITH NEW ANTIFUNGAL DRUGS IN ADULT ACUTE NON LYMPHOID LEUKEMIA WITH INVASIVE ASPERGILLOSIS

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In adult ANLL induction fungal infection represent the main adverse event since can induce either high death rate as well as treatment delay, that may have a significant impact on disease outcome. The role of prolonged antifungal treatment for invasive aspergillosis was tested in 5 adult ANLL enrolled in intensive therapeutic protocol including stem cell transplantation. Of these 5 cases - 3 F, 2 M, median age 31 (min 21- max 48 yrs) - 4 were de novo ANLL - FAB subtype M2 2, M5 2 - and 1 Acute Promyelocytic Leukemia (APL) in molecular relapse. As induction schedule, all patients received standard or high dose cytosine-arabioside + anthracyclines +/- etoposide; infection prophylaxis included itraconazole oral solution and chinolones. During induction, median length of severe neutropenia (PMN < 500/mm<sup>3</sup>) was 23d (min 18 - max 29). Febrile episodes have been empirically treated with broad