Response monitoring

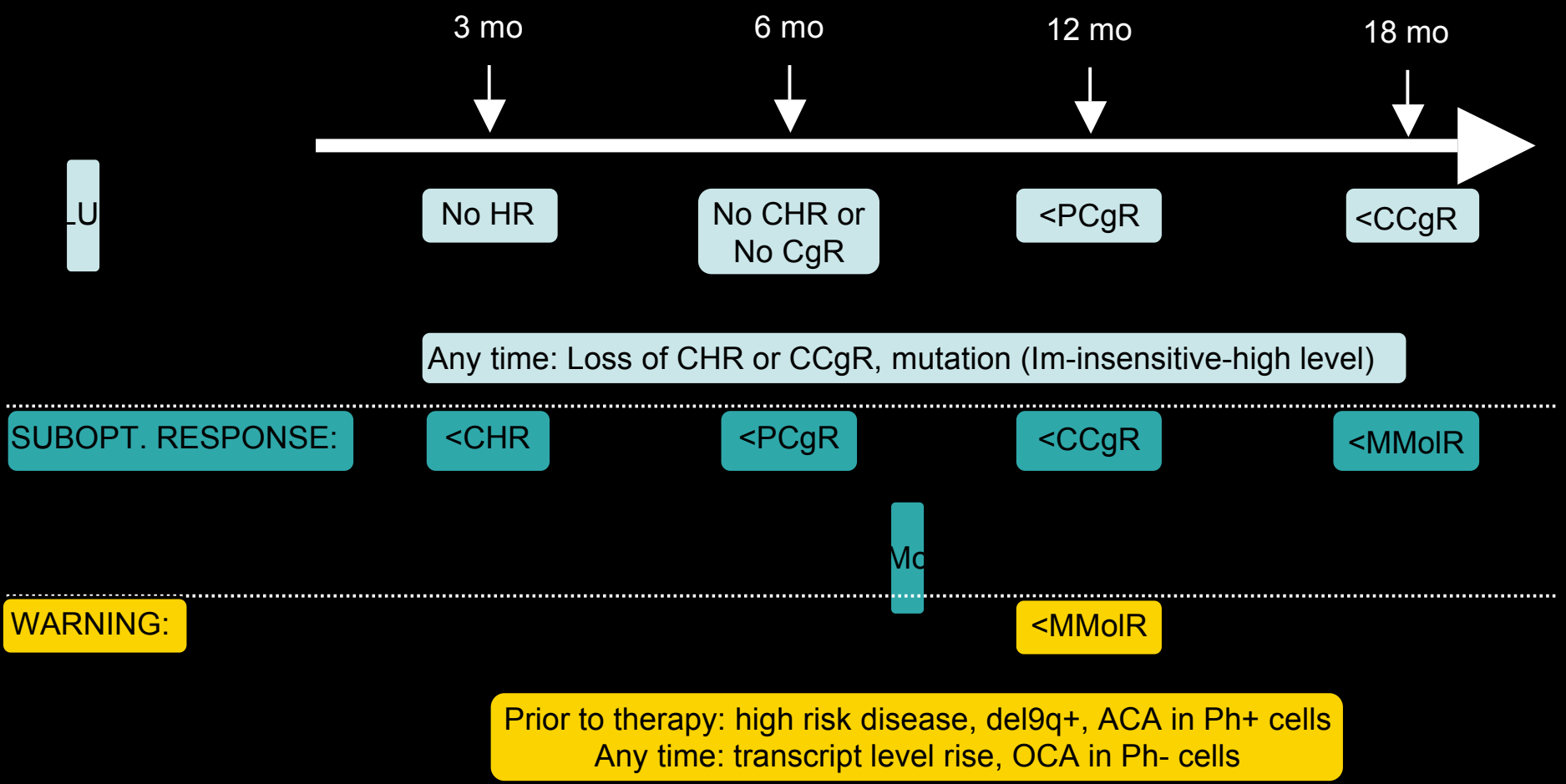
- *Hematological Response:*
  - q2wk until CHR (confirmed), then q3mo

- *Cytogenetic Reesponse:*
  - q6mo until CCyR, then q12mo (initially FISH, subsequently when BM cannot be obtained, or MP cannot be analyzed)

- *Molecular Response:*
  - q3mo

- *Mutational Analysis:*
  - prior to treatment: no, but cells should be stored
  - during treatment: failure, suboptimal response, sustained increase of transcript level

Definition of Failure, suboptimal response and warning



Consequences?

- Failure… Continuing Imatinib with the current dose is no longer appropriate and would likely benefit from other treatment modalities

- Subop. Resp… Patient may still have substantional benefit from continuing Imatinib at the current dose, but the long-term outcome of the treatment would not likely be favourable. The patient is eligible for other treatment modalities.

- Warning… SD-Imatinib may not be the best choice. The patient requires more careful monitoring. The patient may be eligible for other treatment modalities.

Treatment policy vor ECP-CML

- initial 400 mg Imatinib/d
- alternative IFN/HU or LD-AraC
- HD-Imatinib (experimental)
- Allografting (high risk, low EBMT-Score)
- Imatinib-Trial
- discuss choice between alloSCT and Imatinib with patients (little reason to deny Imatinib trial, as response to Imatinib can reinforce or weaken indication for alloSCT)

Alternative therapies and indications

INTOLERANCE TOXICITY	SCT or IFN± LD-Ara-C vs. new agents	Shared decision
FAILURE	SCT or IM 600 or 800 mg/d (alt.: invest. ther.)	Check compliance Rule out high resist. mutation
SUBOPT. RESP.	IM 600 or 800 mg/d (SCT if low SCT risk and high risk disease, invest. ther.)	Check compliance!
WARNINGS	continue IM 400 mg/d	Observe! Check compliance!