Método: Coleta de dados prospectiva dos pacientes pediátricos hospitalizados no CEMO de 1° de janeiro de 2013 a 31/12/23. Foi definido cuidado intensivo como necessidade de uso de vasopressores e/ou inotrópicos e de suporte ventilatório. Foi feita a análise regressiva das seguintes variáveis: transplante haplo, transplante não aparentado, uso de ATG, uso de TBI, doença maligna/benigna, DECH, infecção de corrente sanguínea por bactéria multirresistente, uso de NPT, infecção por vírus, infecção por fungos. Quando p foi igual ou menor que 0,20, foi feita análise logística regressiva multivariada. **Resultados:** Neste período houve 389 admissões, sendo de 62 (15,9%) necessitaram de cuidados intensivos. Sexo masculino 256 (65,8%); idade mediana de 11 anos; doença maligna 302 (77,6%). As doenças de base mais comum foram: LLA 144 (37%), anemia aplástica 61 (15,7%), LMA 46 (12%) e linfoma de Hodgkin 43 (11%). Quanto ao tipo de transplante alogênico 216 (55,5%) sendo não aparentados 124 (31,8%), haplo 82 (22,1%), autólogo 65 (16,7%), 1° transplante alogênico e 2° haplo 4 (1%) e 22 (5,6%) que eram internações pré transplante. Uso de ATG 135 (34,7%). Uso de TBI 190 (48,8%). DECH 114 (29,3%). Hemocultura positiva 115 (29,6%), sendo 22 (5,6%) por bactéria multirresistente. 71 (18,2%) infecção fúngica, sendo os mais comuns 32 (45%) *Aspergilus sp*. e 13 (18,3%) *Fusarium sp*. Infecção por vírus 78 (20%), sendo o mais comum citomegalovírus 40 (10,2%). Uso de vasopressores 52 (13,4%), ventilação não invasiva 28 (7,2%), ventilação mecânica invasiva 32 (8,2%), hemodiálise 18 (4,6%), nutrição parenteral 187 (48,7%). Foram a óbito 27 (6,9%). Os fatores associados a UTI foram infecção por fungo (p = 0,001; OR = 2,7; 95% IC 1,45–5,02) e e hemocultura com bactéria multirresistente (p = 0,01; OR = 3,17; 95% IC 1,24–8,08). **Conclusão:** Infecção por fungos e hemocultura com bactéria multirresistente que foram associados a cuidado intensivo devido a imunossupressão a que esses paciente são sujeitos com o transplante e uso frequente de antibióticos que induzem a multirresistência.

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HIGH SURVIVAL RATES IN ELDERLY PATIENTS UNDERGOING ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION IN SÃO PAULO, BRAZIL

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Objectives: Many hematological diseases, such as Acute Myeloid Leukemia (AML) and Myelodysplastic Syndromes (MDS) commonly affect individuals diagnosed in their seventh decade of life or later. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) can cure these conditions. However, elderly patients are often considered ineligible due to high morbimortality rates. Recent advances in supportive care and new conditioning regimens have made HSCT more feasible and safer for elderly patients. However, there are few reports regarding HSCT in patients aged 70-years or older in Brazil. **Material and methods:** This retrospective observational study analyzed 44 patients aged 65-years or older who underwent their first allogeneic HSCT for myeloproliferative neoplasms: acute myelogenous leukemia (AML, n = 27), myelodysplastic syndrome (MDS, n = 12), or myelofibrosis (MF, n = 5), at two Brazilian centers in São Paulo between December 2013 and March 2024. Clinical data were collected using standardized forms based on information from electronic medical records. **Results:** The median age was 70-years (range: 65–81), with most patients being male (64%). The majority of donors were haploidentical (59%), followed by matched unrelated donors (30%) and matched sibling donors (11%). All patients received Reduced-Intensity Conditioning (RIC) regimens, with the vast majority receiving mobilized peripheral blood as the stem cell source (n = 40, 91%), and only four (9%) bone marrow. Among the 27 patients with AML, seven (26%) were not in complete remission before transplant. The main Graft-Versus-Host Disease (GVHD) prophylaxis was the combination of mycophenolate mofetil and cyclosporine or sirolimus. T-cell depletion was used in most cases with either post-transplant cyclophosphamide in 26 patients (59%) or Antithymocyte Globulin (ATG) in 15 patients (34%). Median follow-up was 18-months (range: 4–138). The Cumulative Incidence (CI) of acute GVHD grade II–IV was 28% but only 9% for grade III–IV. The CI of chronic GVHD at 2-years was 39%, but only 4 patients (9%) required prolonged immunosuppression. Median Progression-Free Survival (PFS) and Overall Survival (OS) were not reached within two years of follow-up. PFS and OS at two years were 54% and 64%, respectively. The CI of Non-Relapse Mortality (NRM) was 11% at 100 days and 19% at two years. The main causes of death were infections (33%), followed by relapse or progression (29%). **Discussion:** This retrospective study demonstrates that allogeneic HSCT is an effective and safe curative option for myeloproliferative neoplasms in patients aged 65-years or older. Despite the use of RIC regimens and the inclusion of patients not in remission before transplantation, we observed a low relapse rate. Additionally, the rates of NRM and chronic extensive GVHD were relatively low. **Conclusions:** Although the study has limitations, including its retrospective nature and lack of comparison with other specific therapies, the findings suggest HSCT is a viable treatment option for elderly patients.

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MOBILIZAÇÃO DE CÉLULAS PROGENITORAS HEMATOPOÉTICAS COM CITARABINA EM DOSES INTERMEDIÁRIAS

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