erythema nodosum and rheumatoid arthritis, and a patient with polyidermatomyositis, panarteritis nodosa and chronic inflammatory demyelinating polyneuropathy. Of 44 patients with inflammatory and immune manifestations, 35 (80%) received treatment with corticoids. Of these, 80% (28 patients) developed corticodependence. Of the subgroup of 13 patients with inflammatory arthritis, 12 required steroid treatment and 10 of them were corticodependent. The median overall survival (OS) for the complete cohort was 34 months, being 33 months for patients without immune manifestations and 34.2 months with these manifestations. No statistically significant differences were found between both groups (p=0.8689). **Conclusions:** Argentinian CMML patients have similar characteristics to those reported in international literature. Concurrent cases of autoimmune diseases and/or systemic inflammatory syndromes occurred in 62.85% of CMML patients. The most often observed were inflammatory arthritis and autoimmune hematologic disorder. Corticosteroids were used in 80% of inflammatory and immune manifestations, 80% of these, developed corticodependence. There were no statistically differences in overall survival between patients with and without SAID. **Keywords:** CML, chronic myelogenous leukemia, chronic myelomonocytic leukemia, systemic inflammatory syndromes, corticosteroids

CML-373

Stop Imatinib: Real World Data from a Tertiary Care Center in India

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Context: CML in India has AAR per 100,000 of 0.71 in males and 0.53 in females, with the highest incidence in the age group of 55 to74 years. Imatinib is usually the first choice, due to cost issues and availability. 5 year OS data from Indian studies range from 86-94%. While there are international data suggesting that imatinib can safely be discontinued in patients with a sustained deep molecular response (MR), there are no reported studies from India on cessation of TKI. **Objective:** To determine the duration of treatment free remission (TFR) after stopping Imatinib in CML-CP patients with stable major or deep MR. **Design:** This is a retrospective analysis evaluating "stop imatinib", in patients with CML-CP, treated at a tertiary care center in India from January 2008 till December 2014. **Setting:** Department of Medical oncology, AIIMS, New Delhi, India. All available case records of CML patients registered between Jan 2008 and December 2014 were screened to identify records with documented trial of stop imatinib fulfilling the following - age ≥18 years, CML-CP on imatinib, minimum duration of imatinib-3 years, at least MMR, never had CML-AP/BC. Of a total of 665 registered cases, 414 case records were available for screening, 33 patients who were given a trial of stop Imatinib were identified for analysis. **Main Outcomes Measures:** TFR after stopping Imatinib. **Results:** A total of 33 case records (21 males,12 females) were identified. The median age at diagnosis was 35 years. Using Sokal and Hasford scores 17,12, 2 and 8, 3, 20 were low, intermediate and high risk respectively. 27/33 experienced toxicity of any grade and 8/-33 had grade III/IV toxicities. 22/33 had taken imatinib for 5 years or more before stopping. After stopping Imatinib,19 patients had more than 1 log increase in BCR-ABL1/ABL1 IS % ratio but only 13/33 had loss of MMR. At a median follow up of 15.6 months after stopping Imatinib, 17/33 were treatment free. The median TFR in our cohort was 8.1 months. **Conclusions:** Cessation of Imatinib is safe and effective in Indian patients with CML-CP with a stable major/deep MR. **Keywords:** CML-CP, stop imatinib, TFR, CML, chronic myelogenous leukemia

CML-386

Kinetics of QPCR Decrease in Newly Diagnosed Chronic Phase Egyptian CML Patients: Do we have a Better Prognostic Tool?

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Context: Treating CML changed from being content with hematological remission to aiming for cytogenic, molecular and even treatment free remission through the introduction of TKIs associated with newer guidelines & milestones of response depending on FISH the QPCR. But is it logical to treat all CML patients alike regardless of their initial QPCR value or rate of decline depending on fixed values at certain milestones instead of a more dynamic approach. **Objectives:** Compare the ability of halving time and reduction ratio with EMR in predicting response and events in newly diagnosed CP-CML patients in Egypt. **Methods:** This prospective study was conducted on sixty newly diagnosed adult patients with Ph positive CP CML within 3 months of recruitment and started TKI as treatment for their CML. Patients recruitment took place in the period between September 2014 and June 2017, data entry was closed on June 2018 (range 12-45 months) and median 35 months. QPCR measurement of BCR-ABL using IS at baseline, end of 1st, 2nd, 3rd, 6th & 12th months. Halving time and reduction ratio were calculated at 3 months using the equations formulated by (*Branford et al., 2014* & *Hanfstein et al., 2014*). Cutoff values for both halving time and reduction ratio using ROC curves and their relation to MMR at 12 months or TKI failure. Events were defined for OS, PFS, and FFS according to ELN recommendations and were calculated to the last follow-up appointment or first event. **Results:** All our patients didn't have progression or death so FFS was the only survival parameter evaluated with a cumulative incidence of 30%. HT ≤19 days with MMR at 12 months (P=0.044), FFS (P=0.12) and EMR (P= 0.013) while RR >0.11% had MMR (P=0.01), FFS (P=0.026) and EMR (P=0.002). MMR at 12 months with EMR (P=0.137), HT ≤19 days (P=0.035) and RR ≥0.11 (P=0.001). EFS with EMR (P=0.208), HT ≤19 days (P=0.088) and RR ≥0.11 (P=0.002). **Conclusions:** RR was statistically superior to HT and EMR in predicting both MMR at 12 months and FFS. **Keywords:** CML, chronic myelogenous leukemia, halving time, reduction ratio, EMR