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**SURVIVAL AFTER CHILDHOOD ACUTE LEUKEMIA AND NON-HODGKIN'S  
LYMPHOMA IN FRANCE, 1990-2000.**

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## **Abstract**

This article describes the survival after childhood acute leukemia (AL) and non-Hodgkin's lymphoma (NHL) of the French population aged less than 15 years. The French National Registry of Childhood Leukemia and Lymphoma recorded 3995 cases of acute lymphoblastic leukemia (ALL), 812 of acute myeloid leukemia (AML) and 1137 of NHL over the period, 1990-2000. Overall survival rates at 5 years were 82% (95% CI 80-83), 58% (95% CI 54-61) and 87% (95% CI 85-89) for ALL, AML and NHL, respectively. Survival after AL increased from 77% (95% CI 75-80) in 1990-1992 to 85% (95% CI 83-87) in 1997-2000 for ALL and from 47% (95% CI 41-54) to 61% (95% CI 55-67) for AML. Among the AL cases, children aged 1-4 years had the most favorable prognosis. Down's syndrome was associated with poor survival after ALL. No gender-related variations in survival were evidenced. The results reported herein are similar to those reported by other European registries and clinical trials.

## **Keywords**

Children, survival, acute leukemia, lymphoma, population-based cancer registry, France

## **Introduction**

In France, as is the case in other industrialized countries, acute leukemia (AL) is the most frequent cancer in children aged less than 15 years (1). Acute lymphoblastic leukemia (ALL) accounts for approximately 80% of childhood leukemia cases. The incidence rate for ALL, standardized on the world population, is 34.3 cases per million children per year with a sex ratio of 1.4 in mainland France (2). Acute myeloid leukemia (AML) and non-Hodgkin's lymphoma (NHL) are rarer childhood diseases, with a standardized rate of 7.1 and 8.9 cases per million children per year, respectively.

Over the past 30 years, a remarkable increase in the childhood survival after malignant hematopoietic diseases has been observed in industrialized countries. Non-Hodgkin's lymphoma, which was a fatal cancer before 1970, has become a curable disease in the great majority of cases. In spite of an improvement in the survival of children with acute non-lymphocytic leukemia, survival at 5 years still remained very low in Europe with a rate of 37% (3) at the beginning of nineties. Survival after ALL increased from 50% in the seventies to more than 80% in the nineties (4). This improvement is particularly due to progress in the treatment networks and application of the advances in centres specializing in the treatment of childhood cancers (5).

The aim of this study was to describe the survival of children aged less than 15 years presenting with acute leukemia or non-Hodgkin's lymphoma and residing in mainland France at the time of diagnosis for the period from 1990 to 2000. This is the first French report on the survival of children with acute leukemia or NHL based on a nationwide basis. The data were provided by the French National Registry of Childhood Leukemia and Lymphoma (NRCL).

## **Patients and method**

### *\* Case registration*

The methods used by the NRCL to record cases and code diagnoses have been described in detail elsewhere (2). The NRCL includes all malignant hematopoietic diseases occurring in children aged less than 15 years residing in mainland France at the time of diagnosis. However, Hodgkin's disease has only been recorded since 1999. Cases are actively retrieved from pediatric hematology and oncology departments (about 40 centres). Many children with acute leukemia and non-Hodgkin's lymphoma are also identified from inclusion lists of clinical trials. Since 1998, many hospital admission departments have also provided the NRCL with lists of children hospitalized for cancer. A non-nominal list of childhood cancer deaths in France is forwarded by the French National Institute of Health and Medical Research (INSERM) department responsible for information on medical causes of death (Cépi-cd). The diagnoses are coded according to the international classification of diseases for oncology (ICD-O-3).

From 1990 to 2000, the NRCL registered 6414 childhood cases of hematopoietic malignancies, including 4914 cases of acute leukemia (AL) and 1139 of non-Hodgkin's lymphoma (NHL). Lymphomas and myeloproliferative and myelodysplastic syndromes with more than 20% blasts at diagnosis were coded as acute leukemia. Microscopic diagnosis was available for 98% of the cases. The cytological findings were reported for 99% of the ALL and 98% of the AML. The cyto-histologic results were obtained for 98% of the NHL. Three cases identified by death certificate only or discovered during autopsy were excluded from the study. Thirty-seven cases of

malignant hematopoietic disease were secondary to a tumour or treatment. Those cases were not included in the survival analyses.

\* *Vital status*

When birthplace was known, the NRCL verified the vital status of each the cases through the administrative unit ("*commune*") of the place of birth, using a national electronic procedure, completed manually when necessary. Vital status was thus determined for 5652 (94%) of the 6013 cases of AL and NHL. For the remainder of the cases, the last follow-up date was the date of the last consultation reported in the hospital files. From 1990 to 1998, the follow-up duration was greater than 5 years for 99% of the AL and 98% of the NHL cases. For cases diagnosed from 1990 to 2000, the cut-off date was December 31, 2003. At that date, vital status was known for 97% and 89% of the AL and NHL cases, respectively. The mean duration of follow-up was 5.9 years (0-14 years).

\* *Statistical analysis*

The observed survival rates were estimated using the Kaplan-Meier method. The roles of age at diagnosis (< 1 year, 1-4 years, 5-9 years and 10-14 years), gender, immunology for ALL, histology for NHL, FAB (French American British) type for AML, inclusion in clinical trials and period of diagnosis were analyzed. The log rank test was used to compare the survival curves of the subgroups. Survival rates have been reported with their 95% confidence intervals in brackets. Multivariate analyses were carried out using a Cox proportional hazard model and the effects of the different variables on survival were estimated by hazard ratios (HR) for those covariates. In

order to check the proportionality assumption of the Cox model, cumulative hazard functions  $[\log(-\log S(T))]$  were plotted.



## Results

### *\* Population description*

From 1990 to 2000, the NRCL registered 4876 cases of acute leukemia (3995 ALL, 812 AML and 69 unspecified AL) and 1137 cases of NHL as primary cancers.

Table 1 shows the distribution of cases by disease type. For ALL, 57% of the cases were boys and 48% aged 1-4 years, with the expected incidence peak at 2 years. Down's syndrome was present in 65 ALL cases (56 cases with immature B-cells, 7 unspecified ALL, 1 case with Burkitt cells and 1 case with T-cells) and 52 AML cases. AML was as frequent in girls as in boys. For NHL, the male/female ratio was 2. Out of the 1137 NHL cases, 64% had B-cell NHL, of which Burkitt's lymphoma was the most frequent histological sub-type (72%). Lymphoblastic T-cell NHL accounted for 77% of the T-cell NHL cases.

The survival rates for ALL were 94% (93-95) at 1 year and 82% (80-83) at 5 years (Fig. 1). Deaths occurred regularly over the period. During the 5 years of follow-up, the survival of AML cases was consistently lower than that of ALL cases. The AML survival rate decreased markedly over the 3 years post-diagnosis, from 93% (91-95) at 3 months to 60% (57-64) at 3 years. Death due to NHL mainly occurred in the two years post-diagnosis (125 deaths at 2 years).

### *\* Diagnostic subtypes*

Table 2 shows the distribution of leukemia and lymphoma cases and their survival rates. Acute leukemia of the M4/5 and M1/2 types was the most frequent, accounting for 36 and 30% of AML cases, respectively. The acute promyelocytic (M3) and myeloblastic (M1-M2) types had the best prognoses at 5 years, with survival rates of 83% (73-93) and 62% (56-68), respectively. Acute megakaryoblastic leukemia (M7)

(38% (28-49)) and erythroleukemia M6 (41% (19-64)) had the poorest outcomes. Immature B-cell ALL accounted for 95% of B-cell ALL. The survival rate at 5 years (85% (84-86)) was higher than that for T-cell ALL (67% (63-71)). There were also survival differences between the histological types of NHL. Five-year survival was markedly greater for Burkitt NHL (92% (90-94)) than for T-cell lymphoblastic NHL (79% (73-84)).

*\* Cases individual characteristics*

Table 3 shows the survival rates at 3 months, 1 year and 5 years for AL and NHL by age at diagnosis, gender and presence/absence of Down's syndrome. Irrespective of follow-up duration, the survival of infants aged less than 1 year was consistently inferior to that of children aged 1-9 years. The 5-year survival of infants aged less than 1 year was 48% for ALL and 45% for AML, while that for children aged 1-4 years was 87% for ALL and 62% for AML. In contrast, the survival of children aged 1-4 years with T-cell ALL was the same survival as those of the other age groups (67%, 63%, 72%, 62% for less than 1 year, 1-4, 5-9 and more than 10 years). For NHL, no major variation with age was observed. There was no significant between-gender difference in survival irrespective of follow-up duration or disease subtype. The prognosis was poorest in ALL cases with Down's syndrome, but Down's syndrome did not significantly decrease the survival of the AML cases.

Multivariate analyses gave similar results (table 4). The variables included in the model were gender, age, presence of Down's syndrome, period of diagnosis, and FAB type for AML. For ALL, infants aged less than 1 year had a six-fold higher risk of death than children aged 1-4 years (HR = 5.7 (5.4-6.0)). The AML hazard ratio was also significantly higher for infants (HR = 1.7 (1.4-2.0)) and for cases aged more than

10 years (HR = 1.3 (1.0-1.6)) than for those aged 1-4 years. No significant variation in hazard ratio with age was observed for T-cell or mature B-cell ALL.

*\* Inclusion in clinical trial protocols*

Almost all the ALL (94%) and most of the NHL cases (81%) were enrolled in clinical trials between 1990 and 2000 (Table 1). Children with AML were less often (66%) included in trials. The children were enrolled in a clinical trial or reported as trial exclusions, or not included in a trial but nonetheless treated per-protocol. In the latter situation, non-inclusion was considered related to reasons other than clinical or laboratory criteria (e.g. parent's refusal). The survival of the cases included in a trial was not different to that of cases not included but treated per-protocol.

*\* Temporal trend*

From the first (1990-1992) to the last (1997-2000) diagnostic period, 5-year survival increased from 77% (75 - 80) to 85% (83 - 87) for ALL and from 47% (41 - 54) to 61% (55 - 67) for AML. In contrast to the survival rate for Burkitt ALL cases, which was already high in the early nineties, the survival of children with immature B-cell and T-cell ALL improved over the period, increasing from 80% to 88% and from 60% to 71%, respectively. The temporal increase in AL survival was remained in the multivariate analysis (Table 4). The temporal variations in AL survival rates are shown by gender, age at diagnosis, presence/absence of Down's syndrome and disease subtype in figures 2 (ALL) and 3 (AML). Improvement in survival was observed, to a variable degree, in most categories. The NHL survival rates for the periods 90-95 and 95-00 were similar.

*\* Cases per centre*

From 1990 to 2000, 44 hospital departments were responsible for the initial treatment of childhood blood malignancies in mainland France. On average, the departments treated 8 cases of ALL (range: 0.1 to 34.1), 1.9 cases of AML (range: 0.1 to 6.5) and 3 cases of NHL (range: 0.1 to 9.7) per year. When centres treating less than 5 cases per year were compared with those treating 5 or more cases per year, there was no significant difference in survival: 79% (75-83) vs. 82% (81-83) for ALL, 56% (52-60) vs. 62% (55-68) for AML and 86% (84-89) vs. 88% (85-91) for NHL.

## Discussion

This study was the first to analyze childhood AL and NHL survival in France on a nation-wide basis. The strength of the study resides in the high proportion of cases with microscopic diagnosis and complete follow-up, and in the exhaustiveness of the NRCL (99% for leukemia and 97% for NHL). The authors previously reported (2) that the characteristics of the French cases (sex-ratio, age distribution, presence/absence of Down's syndrome) were similar to those of other European cases. The present study did not address white blood cell count, a known prognostic factor for ALL (6, 7, 8) that is used in risk assessment, since that variable is not recorded in the NRCL.

### *Survival estimations and temporal variations*

Overall, survival improved over the whole period, 1990-2000. These positive trends reflect therapeutic progress: combination chemotherapies, large scale use of bone-marrow transplants for AML and adaptation of treatment intensity to the severity of the disease (9, 10). Several European cancer registries have reported this temporal survival trend for periods before (3, 11-13) or during (6) that considered herein. In the United States, SEER noted a similar increase in survival for AL (14). Between 1970 and 1990, the prognosis of NHL improved in Europe (15) and the United States (14), as treatments took into account disease staging and histological subtype (16, 17). Following that marked increase, the 5-year survival after NHL seems to have reached a plateau at close to 90%. However, a significant positive trend in survival throughout the period 1990-2000 was observed for the lymphoblastic T-cell NHL subtype (from 72% (64-81) in 1990-1995 to 85% (78-92) in 1995-2000). The French 5-year survivals estimated by the NRCL were similar to those estimated by the Italian and U.K. registries (6, 18) and by recent large-scale European clinical trials (7, 19, 20, 21).

For AML, contrasting survivals were observed, with the highest rate for subtype M3 and the lowest for subtype M7, as has been reported in previous studies (3, 22).

#### *Gender*

In the present data, gender did not affect AL survival. For ALL, this finding is not consistent with previous studies (12, 18, 23) that reported a more positive outcome for girls. Some authors have suggested that the difference was partially explained by the differences in the distributions of immunophenotype and DNA index or by different biological mechanisms of reaction to treatment, depending on gender. With regard to AML, the result reported herein is consistent with several studies (11, 24, 25). Two other studies have reported superior survival for girls, but no biological mechanism has been suggested as an explanation (3, 26).

#### *Infants*

The poor survival of infant AL cases aged less than 1 year is consistent with most cancer registry studies (3, 12, 6, 18) and clinical trials (7). In line with Pullen *et al.* (27), this study did not evidence any between-age-group difference in T-cell ALL survival. For AML, a marked increase in the survival of infants aged less than one year was observed throughout the period (90-95: 33% (21-44) vs. 95-00: 57% (46-69)). In the last period, infants had a prognosis that was as good as that of other children ( $p = 0.09$ ). This improvement in survival has also been observed in clinical trial protocols: age less than one year was not an adverse prognostic factor in the LAME 89/91 (28) or AML10 and AML12 (20) trials.

#### *Down's syndrome*

As has been previously reported, survival was lower for children with ALL and Down's syndrome than for those without the syndrome, although survival tended to improve between 1990 and 2000. As Craze and Stiller (11, 29) have pointed out, in

AML with Down's syndrome, the survival is similar to that observed in AML without the syndrome thanks to adaptation of chemotherapy to the patient's sensitivity (30).

#### *Cases per centre*

The number of cases treated by hospital department did not influence survival. Stiller *et al.* reported similar results for children with ALL in the United Kingdom in the eighties (18). In France, the homogeneity of survival is doubtless due to the fact that all cases are treated in specialized departments in which standardized patient care patterns are implemented irrespective of the number of cases treated.

The incidence and survival rates determined by the NRCL are similar to those reported by other European registry studies and clinical trials. For most AL, survival clearly increased over the period, 1990-2000.

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**Conflict of interest statement**

The authors disclose any financial and personal relationships with other people or organizations that could inappropriately influence their work.



## References

1. Desandes E, Clavel J, Berger C, Bernard JL, Blouin P, de Lumley L, et al. Cancer incidence among children in France, 1990-1999. *Pediatr Blood Cancer* 2004;43(7):749-57.
2. Clavel J, Goubin A, Auclerc MF, Auvrignon A, Waterkeyn C, Patte C, et al. Incidence of childhood leukaemia and non-Hodgkin's lymphoma in France: National Registry of Childhood Leukaemia and Lymphoma, 1990-1999. *Eur J Cancer Prev* 2004;13(2):97-103.
3. Gatta G, Luksch R, Coleman MP, Corazziari I. Survival from acute non-lymphocytic leukaemia (ANLL) and chronic myeloid leukaemia (CML) in European children since 1978: a population-based study. *Eur J Cancer* 2001;37(6):695-702.
4. Pui CH, Evans WE. Acute lymphoblastic leukemia. *New England J Medecine* 1998;339(9):605-614.
5. Stiller CA, Draper GJ. Treatment centre size, entry to trials, and survival in acute lymphoblastic leukaemia. *Arch Dis Child* 1989;64(5):657-61 (abstract).
6. Pastore G, Viscomi S, Gerov GL, Terracini B, Madon E, Magnani C. Population-based survival after childhood lymphoblastic leukaemia in time periods corresponding to specific clinical trials from 1979 to 1998--a report from the Childhood Cancer Registry of Piedmont (Italy). *Eur J Cancer* 2003;39(7):952-60.
7. Schaison G, Auclerc MF, Baruchel A, Leblanc T, Leverger G. [Prognosis of acute lymphoblastic leukemia in children. Results of the French protocol FRALLE 93]. *Bull Acad Natl Med* 2001;185(1):149-60; discussion 160-2.
8. Donadieu J, Auclerc MF, Baruchel A, Leblanc T, Landman-Parker J, Perel Y, et al. Critical study of prognostic factors in childhood acute lymphoblastic leukaemia: differences in outcome are poorly explained by the most significant prognostic variables. Fralle group. French Acute Lymphoblastic Leukaemia study group. *Br J Haematol* 1998;102(3):729-39.
9. Pui CH. Childhood leukemias. *N Engl J Med* 1995;332(24):1618-30.
10. Pui CH, Campana D, Evans WE. Childhood acute lymphoblastic leukaemia--current status and future perspectives. *Lancet Oncol* 2001;2(10):597-607.

11. Stiller CA, Eatock EM. Survival from acute non-lymphocytic leukaemia, 1971-88: a population based study. *Arch Dis Child* 1994;70(3):219-23.
12. Coebergh JW, Pastore G, Gatta G, Corazziari I, Kamps W. Variation in survival of European children with acute lymphoblastic leukaemia, diagnosed in 1978--1992: the EURO CARE study. *Eur J Cancer* 2001;37(6):687-94.
13. Schillinger JA, Grosclaude PC, Honjo S, Quinn MJ, Sloggett A, Coleman MP. Survival after acute lymphocytic leukaemia: effects of socioeconomic status and geographic region. *Arch Dis Child* 1999;80(4):311-7.
14. Gloeckler Ries LA, Smith MA, Gurney JG, Linet M, Young JL, Tamra T, et al. Cancer incidence and survival among children and adolescents: United States SEER Program 1975-1995: National cancer institute.
15. Pastore G, Magnani C, Verdecchia A, Pession A, Viscomi S, Coebergh JW. Survival of childhood lymphomas in Europe, 1978--1992: a report from the EURO CARE study. *Eur J Cancer* 2001;37(6):703-10.
16. Sandlund JT, Downing JR, Crist WM. Non-Hodgkin's lymphoma in childhood. *N Engl J Med* 1996;334(19):1238-48.
17. Patte C. Non-Hodgkin's lymphoma. *Eur J Cancer* 1998;34(3):359-62; discussion 362-3.
18. Stiller CA, Eatock EM. Patterns of care and survival for children with acute lymphoblastic leukaemia diagnosed between 1980 and 1994. *Arch Dis Child* 1999;81(3):202-8.
19. Patte C, Auperin A, Michon J, Behrendt H, Leverger G, Frappaz D, et al. The Societe Francaise d'Oncologie Pediatrique LMB89 protocol: highly effective multiagent chemotherapy tailored to the tumor burden and initial response in 561 unselected children with B-cell lymphomas and L3 leukemia. *Blood* 2001;97(11):3370-9.
20. Webb DK, Harrison G, Stevens RF, Gibson BG, Hann IM, Wheatley K. Relationships between age at diagnosis, clinical features, and outcome of therapy in children treated in the

Medical Research Council AML 10 and 12 trials for acute myeloid leukemia. *Blood* 2001;98(6):1714-20.

21. Brugieres L, Deley MC, Pacquement H, Meguerian-Bedoyan Z, Terrier-Lacombe MJ, Robert A, et al. CD30(+) anaplastic large-cell lymphoma in children: analysis of 82 patients enrolled in two consecutive studies of the French Society of Pediatric Oncology. *Blood* 1998;92(10):3591-8.

22. Creutzig U, Zimmermann M, Ritter J, Henze G, Graf N, Loffler H, et al. Definition of a standard-risk group in children with AML. *Br J Haematol* 1999;104(3):630-9.

23. Pui CH, Boyett JM, Relling MV, Harrison PL, Rivera GK, Behm FG, et al. Sex differences in prognosis for children with acute lymphoblastic leukemia. *J Clin Oncol* 1999;17(3):818-24.

24. Grier HE, Gelber RD, Camitta BM, Delorey MJ, Link MP, Price KN, et al. Prognostic factors in childhood acute myelogenous leukemia. *J Clin Oncol* 1987;5(7):1026-32.

25. Wells RJ, Arthur DC, Srivastava A, Heerema NA, Le Beau M, Alonzo TA, et al. Prognostic variables in newly diagnosed children and adolescents with acute myeloid leukemia: Children's Cancer Group Study 213. *Leukemia* 2002;16(4):601-7.

26. Lie SO, Jonmundsson G, Mellander L, Siimes MA, Yssing M, Gustafsson G. A population-based study of 272 children with acute myeloid leukaemia treated on two consecutive protocols with different intensity: best outcome in girls, infants, and children with Down's syndrome. *Nordic Society of Paediatric Haematology and Oncology (NOPHO). Br J Haematol* 1996;94(1):82-8.

27. Pullen J, Shuster JJ, Link M, Borowitz M, Amylon M, Carroll AJ, et al. Significance of commonly used prognostic factors differs for children with T cell acute lymphocytic leukemia (ALL), as compared to those with B-precursor ALL. A Pediatric Oncology Group (POG) study. *Leukemia* 1999;13(11):1696-707.

28. Auvrignon A, Baruchel A, Behar C, Benoit Y, Bernard F, Dalle JH, et al. Protocole multicentrique de traitement des leucémies aiguës myéloblastique de l'enfant et de

l'adolescent. Etude randomisée d'un traitement d'entretien par un interleukine 2. In. France; 2003.

29. Craze JL, Harrison G, Wheatley K, Hann IM, Chessells JM. Improved outcome of acute myeloid leukaemia in Down's syndrome. Arch Dis Child 1999;81(1):32-7.

30. Gams AS. Acute myeloid leukemia and Down syndrome evolution of modern therapy--state of the art review. Pediatr Blood Cancer 2005;44(1):13-20 (abstract).