

Ovarian AMH production is transiently affected in pubertal and prepubertal girls with acute lymphoblastic leukaemia and non-Hodgkin lymphoma receiving chemotherapy: a prospective, longitudinal study.

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INTRODUCTION

Improvements in the treatment of acute lymphoblastic leukaemia (ALL) and non-Hodgkin lymphoma (NHL) have increased survival, with the consequent concern about the long-term effects that childhood chemotherapy may have on ovarian function.

AMH is an indirect, reliable biomarker of the ovarian reserve, useful for the assessment of cancer therapy-related ovarian damage.

AIM

To evaluate small ovarian follicle status in girls and adolescents with haematologic malignancies during and after treatment (Post Tx)

METHOD

A prospective longitudinal cohort study including girls < 18 years-old with ALL or NHL (2013-2016).

Hormonal evaluation: baseline, every 3 months during chemotherapy, and annually up to 3 years after end of chemotherapy.

Main outcome measure: -Serum **AMH** level (EIA Inmunotech-Beckman-Coulter)

Secondary outcome measures: -Serum **FSH** (IFMA)

Results were analysed according to age or pubertal stage and expressed as medians (range) or percentage, as appropriate

N= 23

Median age at

Median total for

Median followtreatment com Pubertal, n (%) Pre-Pubertal, r

Table 2. Immunophenotype of included patients

Immunop Acute lymphol leukaemia

Common A Pro-B ALL

Pre-B ALL

Non-Hodgkin l

ALL Risk S



- Girls who were pubertal at diagnosis received GnRHa (triptorelin) for 8.4 months (4.8-16).
- The interval between GnRHa suspension and restart of menses was 4.8 months (2.4-7.2).
- All the girls recovered regular menses.
- 8/15 prepubertal girls at diagnosis began puberty during the follow-up.

Table 1. Characteristics of included patients

diagnosis, yr	7.3 (1-15.7)
ollow-up, yr	4.7 (3-5.1)
-up after npletion, yr	2.8 (2.5-3.1)
	8 (34.8)
ר (%)	15 (65.2)

henotype	n	%
olastic	19	82.6
LL	16	84.2
	1	10
	2	15
ymphoma	4	17.4

tratification	n	%			
dard risk	3	15.8			
ium risk	10	52.6			
risk	6	31.6			

4/6 received cranial radiotherapy (1260 cGy)

Table 3. AMH levels (median and range), number of patients with AMH < 3rd centile

	basal	3m	6m	9m	12m	15m	18m	24m	1 <u>st</u> yr postTx	2 nd yr postTx	3 rd yr postTx
AMH pmol/L											
Median (range)	13 (1.2-55)	6.7 (1.2-38)	1.9 (1.2-21)	5,1 (1.2-25.6)	4.8 (1.2-49)	9.0 (1.2-71.2)	14.7 (1.2-40.5)	15.2 (3.0-29.7)	17.7 (3.0-58.4)	14.9 (1.2-46.2)	17.6 (1.2-41.7)
< 3 rd centile n (%)	4 (17.4)	8 (34.8)	14 (63.3)	12 (60.0)	10 (50.0)	5 (26 .3)	5 (27.7)	2 (10.5)	3 (13.0)	3 (13.0)	5 (21.73)

Figure 1. Progression of AMH serum levels during the follow-up



AMH was low (<3rd centile) in 20 patients (86.9%) at some point during treatment. In 4 girls AMH was low since diagnosis, all were prepuberal. In the others, a marked decrease of AMH was observed during first year of treatment (**Figure 1**).

Table 4. FSH levels (median and range) and number of patients with FSH > 97th centile in pubertal girls

	basal	3 m	6m	9m	12m	15m	18m	24m	1 <u>st</u> yr postTx	2 nd yr postTx	3 rd yr postTx
FSH UI/L											
Pubertal, n Median (range)	8 5 (1-9)	8 2.3 (0.8-9.8)	8 5.2 (0.8-16.9)	7 2.3 (0.2-30.9)	8 3.5 (0.4-14.8)	7 4.4 (0.9-11.0)	7 3.8 (1.2-5.5)	10 5.2 (1.2-12.3)	15 4.4 (0.6-15.2)	15 4.3 (2.1-7.9)	16 5.9 (1.5-22.2)
> 97 th centile n (%)	1 (12.5)	1 (12.5)	2 (25)	1 (14.3)	1 (12.5)	1 (12.5)	0	2 (20)	1 (6.7)	0	2 (12.5)

• Increased FSH was seen in 5/16 (31,2%) girls.

RESULTS

Figure 2. AMH serum levels in girls with low AMH at 3rd year Post Tx



4/5 girls who did not recover AMH had basal AMH <25th centile before treatment (Figure 2) and a diagnosis of high-risk ALL or NHL, receiving more aggressive chemotherapy.

15/20 (75%) patients recovered normal serum AMH. (Table 3)

CONCLUSIONS

These preliminary results suggest that most girls with ALL or NHL suffered a transient dysfunction of the ovarian follicles during chemotherapy, with long term recovery in most of them. Most of the girls with persistently low AMH had received more aggressive chemotherapy.



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