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1 **Expression levels of CD33 is a predictive factor for**
2 **effect of Gemtuzumab Ozogamicin at different doses**
3 **in adult acute myeloid leukemia**

4

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15

16 **Declaration of interests**

17 AKB has served on advisory boards for Wyeth/Pfizer during the study. The remaining
18 authors declare no conflict of interest

19 **Running title:** CD33 levels and GO response in adult AML

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39 **Abstract**

40 It remains unclear in adult acute myeloid leukemia (AML) whether leukemic expression
41 levels of CD33, the target antigen for Gemtuzumab Ozogamicin (GO), add prognostic
42 information on GO effectiveness at different doses. CD33 expression quantified in 1583
43 patients recruited to UK-NCRI-AML17 (younger adults) and UK-NCRI-AML16 (older
44 adults) trials was correlated with clinical outcomes and benefit from GO including a dose
45 randomisation. CD33 expression associated with genetic subgroups, including lower levels in
46 both adverse karyotype and core-binding factor (CBF)-AML, but was not independently
47 prognostic. When comparing GO versus no GO (n=393, CBF-AMLs excluded) by stratified
48 subgroup-adjusted analysis, patients with lowest quartile (Q1) %CD33-positivity had no
49 benefit from GO (relapse risk, HR 2.41[1.27–4.56], p=0.009 for trend; overall survival, HR
50 1.52[0.92–2.52]). However from the dose randomisation (NCRI-AML17, n=464, CBF-
51 AMLs included), 6mg/m² GO only had a relapse benefit without increased early mortality in
52 CD33-low (Q1) patients (relapse risk HR 0.64[0.36–1.12] versus 1.70[0.99-2.92] for CD33-
53 high, p=0.007 for trend). Thus CD33 expression is a predictive factor for GO effect in adult
54 AML; although GO does not appear to benefit the non-CBF AML patients with lowest CD33
55 expression a higher GO dose may be more effective for CD33-low but not CD33-high
56 younger adults.

57

58 **Introduction**

59 The modest improvement with conventional cytotoxic therapies in the majority of acute
60 myeloid leukemia (AML) patients provides an opportunity for immunotherapeutic strategies
61 for treating this disease. Expression of CD33 is a feature of most AMLs and has been
62 exploited for immuno-targeting using gemtuzumab ozogamicin (GO), a CD33-directed
63 antibody-drug conjugate (ADC) that has served as a paradigm for antigen-specific
64 immunotherapy of cancer.¹ When combined with intensive chemotherapy GO significantly
65 improves outcomes in newly diagnosed adult AML,²⁻⁶ and studies demonstrate the
66 importance of appropriately defining patient subgroups that may most benefit from this
67 therapy. A meta-analysis of 3325 adult patients, who did not require to be CD33 positive, in 5
68 randomised controlled trials of GO combined with intensive chemotherapy, showed that GO
69 significantly reduced relapse risk and improved overall survival.⁷ The greatest benefit was
70 observed in patients with favourable-risk cytogenetics although significant benefit was also
71 observed for intermediate-risk patients. No benefit was observed from the addition of GO in
72 patients with adverse-risk disease. The meta-analysis appeared to show equivalent outcomes
73 in all genetic subgroups from the lower dosage of GO compared to the higher dose with
74 single dose schedules. This GO-derived reduced relapse risk is also observed when added to
75 intensive chemotherapy in pediatric AML⁸ though associations with risk group are less clear
76 in these patients.

77 A key parameter for the potential efficacy of an ADC may be expression levels of the
78 targeted antigen on leukemic cells as this will determine how much of the conjugate will
79 bind. In AML, CD33 blast expression is heterogeneous between patients but there has been
80 uncertainty of the clinical importance of this for GO effectiveness since CD33 expression
81 levels are associated with established prognostic factors including genetic subgroups. Higher
82 CD33 expression is a feature of patients with *FLT3-ITD* mutation or *NPM1* mutation,⁹⁻¹²

83 while low CD33 expression is characteristic of core-binding factor (CBF) -AML in pediatric
84 patients ^{9,11} although, perhaps paradoxically, the CBF-AML subgroup derived the most
85 benefit from GO in adult trials. Furthermore CD33 expression level may potentially be a
86 prognostic factor independently of these genetic associations as observed in pediatric AML.¹¹
87 Results from the Children's Oncology Group (COG) AML trials showed that benefit from
88 GO at a single dose of 3mg/m² at first induction and then intensification ⁹ was restricted to
89 pediatric patients with high CD33 blast expression; this was also true for CBF-AMLs. High
90 CD33 also correlated with response to GO in the French ALFA-0701 older adult cohort in
91 which a higher cumulative dose of GO at induction (sequential schedule of 3mg/m²) was
92 administered with standard chemotherapy.¹⁰ Notwithstanding these data it remains unclear
93 whether CD33 expression levels are independently predictive of GO benefit in adults and
94 how this might compare at different doses of GO.

95 The most recent UK- National Cancer Research Institute (NCRI) -AML trials of younger
96 (NCRI-AML17) and older (NCRI-AML16) adult patients included standard induction
97 chemotherapy randomised with or without a single dose of GO, a GO dose randomisation
98 (NCR-AML17 only) and an assessment of CD33 expression by AML blasts in the pre-
99 treatment sample. We thus performed a retrospective analysis of CD33 expression on the GO
100 treatment effect in a large cohort of these patients

101

102 **Methods**

103 **Study Cohort**

104 The NCRI-AML16 (ISRCTN11036523) and NCRI-AML17 (ISRCTN55675535) trials
105 enrolled patients with AML (de novo or secondary) or high-risk myelodysplastic syndrome
106 (MDS); patients were mostly aged ≥ 60 years in NCRI-AML16 and mostly aged < 60 years

107 old in NCRI-AML17 (protocols in supplementary information; Figures S1-S2). In both trials
108 CD33-positivity was not an entry requirement and patients were randomised into intensive
109 chemotherapy arms with or without a single dose of GO in course 1 of induction. In NCRI-
110 AML16 GO was given at 3mg/m², while in NCRI-AML17 patients were randomised to
111 receive either 3mg/m² or 6mg/m² of GO. Trials were conducted in accordance with the
112 Declaration of Helsinki and both institutional and research ethics committee approvals were
113 obtained. Data regarding chemotherapy interventions¹³ and dose comparisons¹⁴ are published
114 separately. Acute promyelocytic leukemia (APML) patients and patients <16 years were
115 excluded from this analysis.

116 **Flow cytometric assessment of CD33 expression**

117 CD33 expression of AML blasts from 1583 pre-treatment BM/PB samples of non-APML
118 patients (NCRI-AML16, n=334; NCRI-AML17, n=1249, patient deployment shown in
119 Figure 1) was prospectively determined by multiparameter flow cytometry (MFC). Staining
120 and data acquisition were performed by three national reference flow cytometric laboratories
121 sharing standard operating procedures,¹⁴ and then centrally analysed for CD33 blast
122 expression levels without knowledge of other clinical data for retrospective correlation with
123 clinical characteristics and outcome.

124 AML blast CD33 levels were measured both by median fluorescence intensity of CD33
125 (CD33-MFI) and also as percentage (%) CD33-positivity (gating described in supplemental
126 methods). CD33-MFI was also measured for the immunophenotypically immature
127 CD34⁺CD38^{low} stem/progenitor cell (SPC) population when present. The CD33-MFI values
128 in each patient were standardized using the CD33-MFI values of lymphocytes (uniformly
129 CD33 negative) present within the same sample. %CD33-positivity was also determined
130 using lymphocytes in each sample; blast cells with CD33 expression equivalent to

131 lymphocytes were classed as CD33⁻ and blasts with higher expression were classed as CD33⁺
132 (Figure S3). A broad range of CD33-MFI and %CD33-positivity values were observed and so
133 patients were grouped into quartiles (Q1, Q2, Q3, Q4) for both type of measurements.

134

135 **Statistical methods**

136 Clinical outcome data up to March 2015 for patients enrolled on NCRI-AML16 and NCRI-
137 AML17 were analysed with median follow up of 40.7 months (range 1.2–71.4 months)
138 (AML16 41.8 months (1.3–67.4), AML17 39.7 months (1.2–71.4)). Endpoint definitions are
139 as described by Cheson with the exception that we report here overall response rate (ORR;
140 CR+CRi, i.e. recovery is not required).¹⁵ Demographic data were compared using the
141 Wilcoxon rank-sum/Kruskal Wallis test or Spearman's correlation, or chi-squared/Mantel-
142 Haenszel test for the dichotomous outcome of CD33⁻ or CD33⁺. Agreement between local
143 and central measurement of CD33 was performed using Bland-Altman plots. Univariate
144 analyses of time to event outcomes were performed using the logrank test; multivariable
145 adjusted analyses were performed using Cox regression. Analysis of the effect of GO
146 treatment was performed stratified by trial as the randomisation was 1:1 in AML16 and 2:1 in
147 AML17, and data displayed using Forest plots. In all cases, estimates of odds/hazard ratios
148 (OR/HR) are given with 95% confidence intervals. Analyses were performed using SAS
149 version 9.3.

150

151 **Results**

152 **CD33 expression levels and correlations with disease characteristics**

153 Patients from the two trials were divided into quartiles based on CD33-MFI (inter-quartile
154 cut-points; 3·52, 8·71, 19·66) or quartiles based on %CD33-positivity of the total blast
155 population (inter-quartile cut-points; 37·1%, 75·8%, 94·9%). A non-linear correlation
156 between these two parameters was observed and overlap of quartiles (Figure S4). There was
157 poor agreement between our %CD33-positivity data (acquired by the reference laboratories
158 and centrally analysed) and that entered into trial database by local laboratories (Figure S5).
159 Disease characteristics were then assessed across the CD33 quartiles. Cytogenetic data was
160 available for 1454 of 1583 patients (92%). Corroborating the published data, CBF-AML was
161 found to be inversely correlated with CD33 expression across the quartiles ($p < 0·0001$, Figure
162 2a-b; Table 1). However, in this adult cohort adverse-risk disease was also associated with
163 lower CD33 expression ($p < 0·0001$, Figure 2a-b). Intermediate-risk cytogenetics significantly
164 increased in prevalence with increasing CD33 quartile ($p < 0·0001$, Figure 2a-b). While *FLT3-*
165 *ITD* and *NPM1* mutations increased in prevalence with increasing CD33 expression
166 ($p < 0·0001$, Figure 2c-d; Table 1), as already reported,⁹⁻¹¹ intermediate-risk patients lacking
167 these mutations were inversely associated with CD33 levels. All the above correlations were
168 observed using either CD33-MFI or %CD33-positivity as the assessment variable.

169 In addition to total AML blasts, we also assessed CD33 expression in immunophenotypically
170 immature CD34⁺CD38^{low} blasts, which are enriched for chemo-resistant leukemic stem-cell
171 (LSC) –like populations in some patients. This analysis was performed on all patients with
172 detectable CD34⁺CD38^{low} blasts (n=1301), and then focussed on patients with significantly
173 expanded CD34⁺CD38^{low} blasts (n=779) using a threshold of greater than 0·35% of total
174 WBC (>2SD above mean normal frequency) to exclude patients with immature blasts that
175 may be predominantly non-leukemic. As with total blasts there was considerable variation in
176 CD33 levels on immature blasts across the cohort (Table S1). We classified patients with
177 expanded CD34⁺CD38^{low} cells into CD33⁻ (Q1) and CD33⁺ (Q2-Q4), under the supposition

178 that CD33⁻ cells represent a GO-unresponsive subpopulation, and thus may have prognostic
179 value. Comparison between patient sub-groups showed that expanded CD34⁺CD38^{low} blasts
180 in CBF-AMLs were almost always CD33⁺ (in Q2-Q4), while in both intermediate-risk and
181 adverse-risk patients the CD34⁺CD38^{low} blasts were more heterogeneous, containing
182 significant numbers of CD33⁻ cells (Q1) (Figure 2c). Patients with CD33⁺ CD34⁺CD38^{low}
183 blasts showed greater prevalence of *FLT3-ITD* mutation (16% vs 7%, p=0.03) and *NPM1*
184 mutation (12% vs 6%, p=0.1) (Table S1).

185

186 **CD33 expression levels and clinical outcomes**

187 In an analysis adjusted for trial, there was no significant difference in outcomes between
188 patients with and without CD33 data (p=0.4). Higher CD33 expression levels, by either
189 measurement, showed significant positive prognostic value in univariate analyses for both
190 overall survival (OS) and cumulative incidence of relapse (CIR) (Table 2). This did not
191 remain significant, however, after adjustment in multivariable analysis for cytogenetics, age,
192 log-WBC, performance status, *FLT3-ITD* mutation, *NPM1* mutation, secondary disease and
193 trial protocol, (OS; HR 1.01 [0.93–1.09], p=0.8 using CD33-MFI and HR 1.01 [0.94–1.09],
194 p=0.8 using % CD33-positivity, CIR; HR 0.99 [0.91–1.08], p=0.8 using CD33-MFI and HR
195 1.00 [0.91–1.09], p=0.9 using %CD33-positivity, Table 2). Therefore, in contrast to pediatric
196 AML, CD33 expression on blasts is not independently prognostic for outcomes in our adult
197 cohort. In NCRI-AML17 all CBF-AML patients received GO during induction. There was no
198 evidence of a significant association between CD33 expression quartiles and outcomes in this
199 subgroup (Figure S6), suggesting that other biological factors are important. Perhaps
200 surprisingly patients with expanded CD34⁺CD38^{low} blasts that were CD33⁻ had a
201 significantly improved OS (HR 0.61 [0.45–0.84] p=0.002; Table S2).

202

203 **CD33 expression and impact on GO-sensitivity**

204 We then asked whether CD33 expression levels were relevant to benefit in outcomes
205 observed in patients receiving GO with their induction chemotherapy compared with patients
206 receiving chemotherapy alone (GO vs no GO). 393 patients across the two trials were
207 assessable for this GO vs no GO comparison with CBF-AMLs excluded as these were all
208 given GO in AML17 and there were only two CBF-AMLs in AML16. A total of 244 patients
209 received GO (AML16 n=42, all allocated 3mg/m², AML17 n=202 at either 3mg/m² (n=100)
210 or 6mg/m² (n=102); Figure 1) (In AML17, patients receiving DA were not randomised
211 between GO and no GO – all received GO at either 3mg/m² or 6mg/m²). The results showed
212 no evidence of significant interaction between GO and CD33 quartiles on survival, using
213 either CD33 parameter (Figure 3a). When evaluating relapse, however, there was a
214 significant interaction between GO and %CD33-positive blasts (p=0.009 for trend). Patients
215 with the lowest %CD33-positive blasts (Q1) had a significantly greater relapse risk when
216 given GO (HR 2.41 [1.27–4.56]) while patients with the highest %CD33-positive blasts (Q4)
217 showed reduced relapse risk (HR 0.63 [0.35–1.12]) (Figure 3b). This differential benefit was
218 not observed using blast CD33-MFI (Figure 3b).

219 Having established CD33 expression was relevant to effect of GO on relapse, we then
220 assessed for difference in outcomes by CD33 expression in 464 patients entering the AML17
221 GO dose randomisation (3mg/m², n=239; 6mg/m², n=225; Figure 1). Stratification of patients
222 by CD33 expression quartiles showed a differential benefit by GO dose for relapse (Figure
223 4a) but not for OS (Figure 4b). Using %CD33-positivity, patients with lowest CD33
224 expression (Q1) had most benefit from the higher 6mg/m² dose of GO (p=0.007 for trend)
225 (Figure 4a). Importantly, there was no excess early (60-day) mortality from the 6mg/m² dose

226 in these patients (Figure 4c). Patients with the highest %CD33-positive blast levels (Q4) did
227 not benefit from the higher dose (relapse, HR 1.70 [0.99–2.92]) (Figure 4a).

228 As expanded CD34⁺CD38^{low} blasts in CBF-AMLs were almost always CD33⁺, we
229 hypothesized this might contribute to greater GO efficacy in CBF-AMLs as clearance of
230 potential LSCs in the CD34⁺CD38^{low} subset by GO would not be limited by their low CD33
231 expression. An exploratory subgroup analysis of non-CBF AML patients in the GO versus no
232 GO and GO dose randomisations did not show a significant interaction between GO
233 treatments and CD33⁺ versus CD33⁻ expanded CD34⁺CD38^{low} blasts (Figure S7).

234

235 **Discussion**

236 In this report, we assessed the importance of CD33 expression levels in a large cohort of
237 adult AML patients that included randomisations to receive standard chemotherapy alone or
238 in combination with a single dose of GO at 3mg/m² or 6mg/m².

239 Greater efficacy of GO in patients with higher levels of the target antigen is logical and
240 supported by in vitro data showing a direct relationship between CD33 expression and GO-
241 sensitivity,¹⁶ and clinical data from GO monotherapy in relapsed AML patients¹⁷ and older
242 patients deemed unfit for intensive chemotherapy.¹⁸ Very recent data has emerged from the
243 COG and French ALFA trials that pediatric and older (50-70 years) AML patients with lower
244 CD33 expression do not benefit from the addition of GO to standard chemotherapy (3mg/m²
245 single dose at induction I and intensification II in COG trial, 3mg/m² fractionated doses at
246 induction I plus single dose at consolidation for ALFA-0701).⁹⁻¹⁰ In these studies CD33 levels
247 were measured using % positivity and MFI respectively. We assessed CD33 using both types
248 of measurement sub-divided by quartiles rather than a single threshold value in order to
249 evaluate prognostic and response correlations for the range of blast CD33 expression.

250 Interestingly our non-linear concordance profile of these measurements (Figure S2) is similar
251 to that of the ALFA group¹⁰ despite the inevitable differences of instrumentation as well as
252 reagents and blast gating between studies. This further validates these CD33 biomarker
253 assays as reproducible and practical in different centers but also shows that CD33MFI and
254 %CD33-positivity are not equivalent for some patients since higher %CD33 values are
255 included in CD33-MFI lower quartiles. Notwithstanding we observed similar associations for
256 both expression parameters with patient disease characteristics such as cytogenetics and
257 molecular aberrations (*FLT3-ITD* and *NPM1* mutations). From our adult cohort adverse
258 karyotype, wild type *FLT3 / NPM1* as well as CBF-AML are all associated with lower CD33
259 expression. We also demonstrate an independent correlation between %CD33-positivity and
260 GO benefit for younger and older adults with non-CBF AML.

261 The recent COG data similarly describes an association between CD33 expression (by a
262 different CD33-MFI assay) and GO response in their pediatric AAMLL0531 cohort ⁹ that
263 included ~25% CBF AMLs. It appears that there was a relatively higher frequency of CBF-
264 AMLs with low CD33 expression (~45% of CBFs in Q1) enrolled in their trial than in our
265 adult cohort (~29% of CBFs in Q1, Table 1). Since CD33-low patients derive the least
266 benefit from GO, this may plausibly contribute to why the significant association of GO
267 benefit with CBF-AML reported from adult studies has not been demonstrated for this COG
268 cohort.⁸

269 In this study all CBF-AML patients included in the analysis received GO (3mg/m² or
270 6mg/m²) at induction, thus excluding an analysis of GO versus no GO stratified by CD33
271 expression quartiles. There was however no significant correlation between CBF CD33
272 expression and outcome suggesting that other factors are also important for the relative GO
273 sensitivity of this subgroup in adults.

274 Our analysis also defined CD33 levels in the immunophenotypically immature
275 CD34⁺CD38^{low} blast population, which is often expanded in AML and reported as clinically
276 and experimentally relevant for treatment responses.¹⁹⁻²¹ Previous data have shown that high
277 CD33 expression by such cells enhances their GO sensitivity.²² Interestingly, expanded
278 immature blasts in CBF-AMLs were almost exclusively CD33⁺ despite lower CD33
279 expression of the global blast population. Conversely, there was variable CD33 expression on
280 expanded CD34⁺CD38^{low} blasts in intermediate-risk and adverse-risk patients. CD33-
281 positivity of this candidate LSC- enriched population may allow effective antigen-specific
282 targeting and clearance of potentially more chemo-resistant subpopulations in CBF-AMLs.
283 Our results however did not show a significant interaction between CD33 status of expanded
284 CD34⁺CD38^{low} blasts in non-CBF AML patients and GO response. This is not unexpected
285 due to the confounding variables of heterogeneous CD33 expression in the main blast
286 population between patients and other biological factors for GO resistance.

287 The clinical trials of combined chemotherapy with GO, mentioned earlier, used different
288 doses and schedules of GO, however the meta-analysis of the individual patient data from
289 these trials suggested a single dose of 3mg/m² was as effective at preventing relapse as a
290 6mg/m² dose, while having less toxicity. The NCRI-AML17 trial included a 6mg/m² vs
291 3mg/m² randomisation to ascertain whether efficacy was enhanced by the higher dose.
292 Results overall showed no significant benefit and a higher rate of veno-occlusive disease with
293 the higher dose although there was trend for improved outcomes in the adverse karyotype
294 patients.²³ Our analysis using CD33 as a stratification variable showed a significant
295 interaction between dose and %CD33-positivity levels in NCRI-AML17 patients (younger
296 adults); the higher 6mg/m² dose of GO most improved relapse risk and was well tolerated by
297 patients with the lowest CD33 expression levels. Conversely, patients with higher CD33
298 levels independently of risk group do not appear to derive any additional benefit from

299 increasing the dose from 3mg/m² to 6mg/m² as single induction dose. This is the first
300 demonstration of a pre-treatment biomarker that could inform appropriate use of a higher GO
301 dose (and potentially other CD33-targeted antibody conjugates) at induction and suggests that
302 the 6mg/m² dose benefit for adverse-risk AML outcomes may be specific to patients with Q1-
303 CD33 expression.

304 Further optimisation of treatment schedules in ongoing trials includes a single GO dose
305 versus fractionated GO dose comparison (NCRI-AML18/19). Interestingly from the ALFA-
306 0701 data the fractionated GO schedule (3mg/m² on day 1, maximum dose: 5mg) did not
307 improve outcome in older adults with lower CD33 expression. This may imply that a single
308 higher 6mg/m² dose is more effective than a cumulative higher dose at reducing relapse in the
309 CD33-lower subgroup potentially since CD33 re-expression by blasts after initial exposure to
310 GO may be even lower than pre-treatment levels. Assessment of CD33 expression will also
311 be required in trials using next-generation CD33-directed ADC such as SGN-CD33A,
312 reported to be more potent than GO and without liver toxicity.²⁴ Ultimately, this could lead to
313 a more personalized mode of GO treatment based on patient AML blast CD33 expression
314 levels.

315

316 Supplementary information accompanies this paper on the Leukemia website

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412

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419

420

421 **Figure Legends**

422 Figure 1

423 Outline of AML patient sample flow for CD33 assessment using pre-treatment samples from
424 NCRI-AML16 and NCRI-AML17. CBF, core-binding factor. GO, gemtuzumab ozogamicin.

425

426 Figure 2

427 AML blast CD33 expression in patient subgroups

428 CD33 expression of pre-treatment AML blasts by normalised CD33-MFI (arbitrary units) and
429 % positivity in cytogenetic risk groups (A) and intermediate-risk patients subdivided based
430 on mutational (*FLT3-ITD* and *NPM1*) background (B). Expanded CD34⁺CD38^{low} blasts
431 (when at least 0.35% of total WBC) classified as CD33⁻ (Q1 CD33-MFI) or CD33⁺ (Q2-Q4
432 CD33-MFI) assessed in cytogenetic risk groups and mutational groups (C).

433

434 Figure 3

435 Effect of CD33 expression levels on (A) overall survival and (B) relapse in GO versus no GO
436 randomised AML patients

437 Forest plot analysis of 393 non-CBF patients assessable for GO vs no GO comparison.
438 Patients were stratified into CD33 expression quartile using CD33-MFI and %CD33-
439 positivity.

440

441 Figure 4

442 Effect of CD33 expression levels on (A) relapse, (B) overall survival and (C) early mortality
443 (60 days) in patients randomised to receive 6mg/m² or 3mg/m² GO dose

444 Forest plot analysis of 464 younger patients (NCRI-AML17 trial) assessable for GO vs no
445 GO comparison. Patients were stratified into CD33 expression quartile using CD33-MFI and
446 %CD33-positivity.

Table 1: Patient demographics and CD33 expression levels by CD33 MFI and %CD33 positivity

Characteristic	CD33 MFI normalised blasts					%CD33 positivity				
	Q1	Q2	Q3	Q4	p-value	Q1	Q2	Q3	Q4	p-value
No of patients	386	386	387	386		395	396	397	395	
Trial AML16 AML17	100 (26%) 286 (74%)	60 (16%) 326 (84%)	64 (17%) 323 (83%)	75 (19%) 311 (81%)	0.005*	105 (27%) 290 (73%)	71 (18%) 325 (82%)	78 (20%) 319 (80%)	80 (20%) 315 (80%)	0.08*
Randomisation† (AML16/AML17)										
GO	39 (42%)	26 (33%)	33 (32%)	51 (43%)		39 (42%)	34 (34%)	36 (40%)	40 (36%)	
No GO	53 (58%)	54 (68%)	69 (68%)	67 (57%)		54 (58%)	65 (66%)	55 (60%)	70 (64%)	
GO dose (AML17)										
GO 3mg/m ²	41 (47%)	54 (50%)	63 (50%)	79 (56%)		54 (54%)	55 (45%)	60 (55%)	70 (53%)	
GO 6mg/m ²	46 (53%)	54 (50%)	62 (50%)	62 (44%)		46 (46%)	68 (55%)	50 (45%)	61 (47%)	
Age at diagnosis, y										
16-29	25 (6%)	44 (11%)	39 (10%)	41 (11%)	<.0001**	25 (6%)	34 (9%)	50 (13%)	41 (10%)	<.0001**
30-39	25 (6%)	39 (10%)	35 (9%)	30 (8%)		28 (7%)	36 (9%)	36 (9%)	30 (8%)	
40-49	48 (12%)	75 (19%)	67 (17%)	98 (25%)		53 (13%)	73 (18%)	84 (21%)	78 (20%)	
50-59	106 (27%)	107 (28%)	127 (33%)	109 (28%)		106 (27%)	125 (32%)	105 (26%)	115 (29%)	
60-69	139 (36%)	97 (25%)	100 (26%)	82 (21%)		136 (34%)	103 (26%)	95 (24%)	106 (27%)	
70+	43 (11%)	24 (6%)	19 (5%)	26 (7%)		47 (12%)	25 (6%)	27 (7%)	25 (7%)	
median (range)	59 (16-79)	54 (16-78)	54 (16-79)	52 (16-77)		59 (16-79)	54 (16-79)	52 (16-77)	54 (17-79)	
Sex										
Female	154 (40%)	160 (41%)	172 (44%)	201 (52%)	0.0004*	149 (39%)	178 (45%)	181 (46%)	192 (49%)	0.001*
Male	232 (60%)	226 (59%)	215 (56%)	185 (48%)		246 (62%)	218 (55%)	216 (54%)	203 (51%)	
Diagnosis										
De Novo	300 (78%)	331 (86%)	320 (83%)	344 (89%)	0.0001*	311 (79%)	322 (81%)	339 (85%)	352 (89%)	<.0001*
Secondary	49 (13%)	32 (8%)	46 (12%)	31 (8%)		50 (13%)	44 (11%)	39 (10%)	31 (8%)	
MDS	37 (10%)	23 (6%)	21 (5%)	11 (3%)		34 (9%)	30 (8%)	19 (5%)	12 (3%)	
WHO PS										
0	250 (65%)	265 (69%)	259 (67%)	257 (67%)	0.7**	264 (67%)	273 (69%)	256 (64%)	267 (68%)	0.6**
1	114 (30%)	104 (27%)	111 (29%)	116 (30%)		112 (28%)	104 (27%)	121 (30%)	115 (29%)	
2	17 (4%)	12 (3%)	10 (3%)	7 (2%)		14 (4%)	11 (3%)	13 (3%)	10 (3%)	
3	5 (1%)	4 (1%)	7 (2%)	6 (2%)		5 (1%)	7 (2%)	7 (2%)	3 (1%)	
4	0	1 (<.5%)	0	0		0	1 (<.5%)	0	0	

WBC count											
	0-9.9	257 (67%)	198 (51%)	171 (44%)	155 (40%)		255 (65%)	218 (55%)	183 (46%)	152 (38%)	
	10-49.9	93 (24%)	121 (31%)	148 (38%)	136 (35%)		94 (24%)	124 (31%)	132 (33%)	155 (39%)	
	50-99.9	13 (3%)	36 (9%)	40 (11%)	53 (14%)	<.0001**	22 (6%)	26 (7%)	50 (13%)	48 (12%)	<.0001**
	100+	23 (6%)	31 (8%)	28 (7%)	42 (11%)		24 (6%)	28 (7%)	32 (8%)	40 (10%)	
	Median (range)	4.9 (0.4-430.0)	9.2 (0.4-334.9)	12.8 (0.6-249.0)	16.4 (0.7-345.0)		5.1 (0.4-430.0)	7.2 (0.6-334.9)	12.7 (0.7-266)	16.6 (0.7-345.0)	
Cytogenetics											
	Favourable	54 (16%)	74 (21%)	40 (11%)	18 (5%)		48 (14%)	88 (24%)	41 (11%)	10 (3%)	
	Intermediate	203 (59%)	219 (61%)	254 (70%)	308 (87%)	0.4**	214 (61%)	211 (57%)	270 (72%)	312 (87%)	0.7**
	Adverse	87 (25%)	66 (18%)	71 (19%)	28 (8%)		90 (26%)	71 (19%)	62 (17%)	36 (10%)	
	Unknown	42	27	21	32		43	25	24	37	
FLT3-ITD											
	WT	303 (93%)	295 (86%)	289 (81%)	235 (67%)	<.0001*	315 (92%)	315 (88%)	294 (82%)	230 (65%)	<.0001*
	Mutant	22 (7%)	48 (14%)	66 (19%)	116 (33%)		27 (8%)	43 (12%)	64 (18%)	122 (35%)	
	Unknown	61	43	32	35		53	38	39	43	
NPM1c											
	WT	299 (95%)	272 (80%)	231 (67%)	148 (44%)	<.0001*	316 (95%)	291 (83%)	220 (64%)	155 (46%)	<.0001*
	Mutant	16 (5%)	66 (20%)	112 (33%)	188 (56%)		17 (5%)	61 (17%)	125 (36%)	185 (54%)	
	Unknown	71	48	44	50		62	44	52	55	
ITD/NPM1c											
	ITD WT, NPM1c WT	281 (89%)	248 (74%)	205 (60%)	116 (35%)		295 (89%)	271 (78%)	197 (57%)	115 (34%)	
	ITD WT, NPM1c Mut	11 (4%)	41 (12%)	73 (21%)	110 (33%)	<.0001*	9 (3%)	36 (10%)	85 (25%)	109 (32%)	<.0001*
	ITD Mut, NPM1c WT	17 (5%)	22 (7%)	26 (8%)	32 (10%)		19 (6%)	17 (5%)	23 (7%)	40 (12%)	
	ITD Mut, NPM1c Mut	5 (2%)	25 (7%)	39 (11%)	77 (23%)		8 (2%)	25 (7%)	40 (12%)	75 (22%)	
	Unknown	72	50	44	51		64	47	52	56	
Post-course 1 risk score (AML17)											
	Good	50 (20%)	80 (27%)	44 (15%)	39 (13%)	0.04**	47 (18%)	86 (28%)	55 (18%)	26 (9%)	0.2**
	Standard	88 (34%)	118 (39%)	147 (49%)	186 (62%)		91 (35%)	111 (36%)	163 (54%)	176 (59%)	
	Poor	118 (46%)	103 (34%)	112 (37%)	73 (25%)		118 (46%)	108 (35%)	85 (28%)	95 (32%)	

*: Wilcoxon-Rank Sum/Kruskal-Wallis test; **: Spearman correlation; †: excluding CBF leukaemia (AML16 n=2, AML17 n=46);

Abbreviations: GO=gemtuzumab ozogamicin, WHO PS=World Health Organisation performance score, WBC=white blood cell, FLT3-ITD=FLT3 internal tandem duplication, WT=wild type; Mut=mutated, MFI=median fluorescence intensity.

Table 2: Clinical outcomes and CD33 expression

	CD33 MFI normalised blasts					%CD33 positivity				
Outcome	Q1	Q2	Q3	Q4	OR/HR, 95% CI, p-value unadjusted/adjusted	Q1	Q2	Q3	Q4	OR/HR, 95% CI, p-value unadjusted/adjusted
CR/CRI	79%	80%	87%	89%	0.75 (0.66–0.85) p<.0001; 0.81 (0.68–0.96) p=0.02	76%	85%	85%	87%	0.78 (0.69–0.88) p<.0001; 0.86 (0.73–1.02) p=0.08
OS	27%	36%	37%	48%	0.90 (0.85–0.95) p=0.0005; 1.01 (0.93–1.09) p=0.8	27%	35%	40%	45%	0.90 (0.85–0.96) p=0.0007; 1.01 (0.94–1.09) p=0.8
CIR	56%	54%	49%	50%	0.93 (0.86–0.99) p=0.03; 0.99 (0.91–1.08) p=0.8	57%	55%	50%	50%	0.91 (0.85–0.98) p=0.01; 1.00 (0.91–1.09) p=0.9

Note: Adjusted OR/HR for age, cytogenetics, trial, log (WBC), secondary disease, ITD, NPM1. OR/HR presented per quartile.

Abbreviations: CR=complete remission, CRI=complete remission with incomplete blood count recovery, OS=overall survival, CIR=cumulative incidence of relapse, MFI=median fluorescence intensity, OR=odds ratio, HR=hazard ratio, CI=confidence interval.

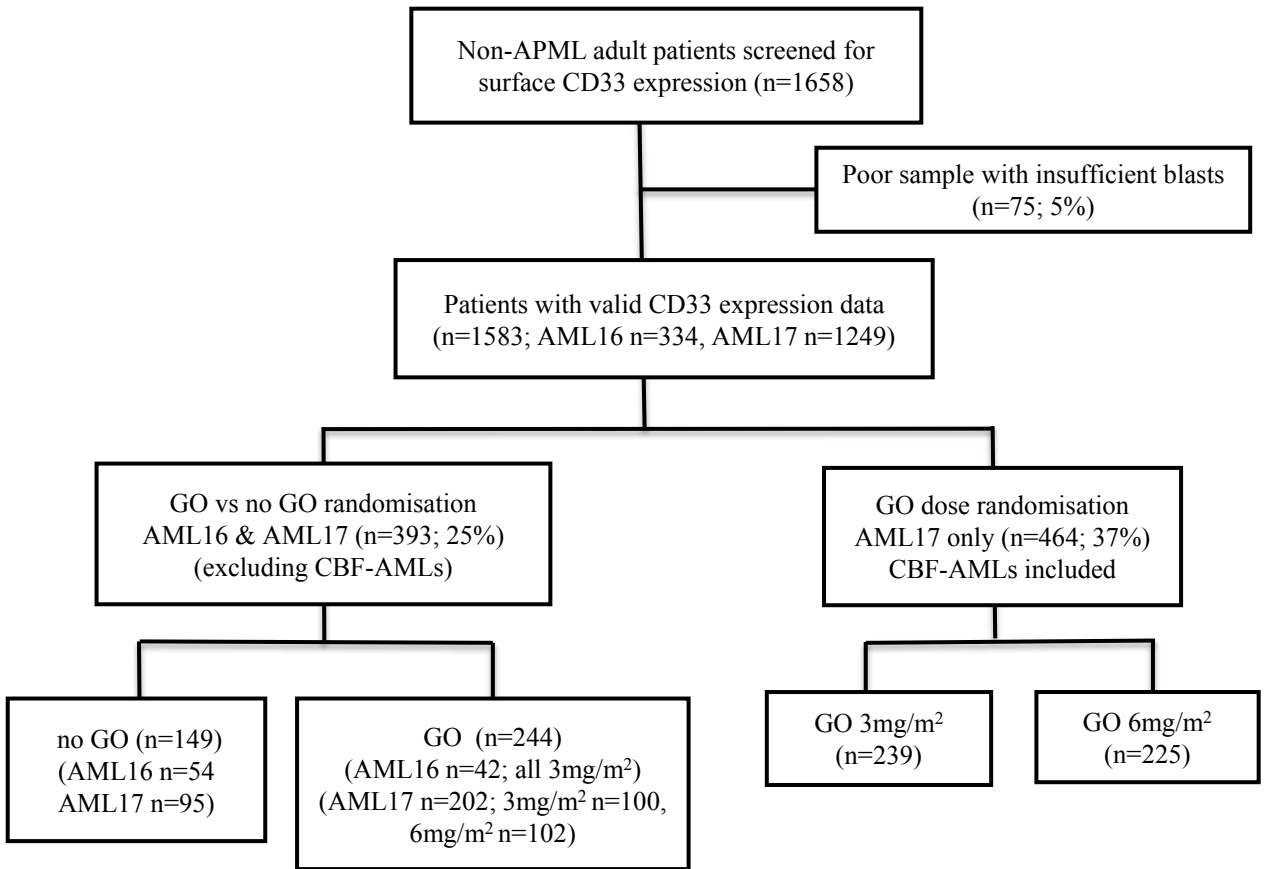


Figure 1

Outline of AML patient sample flow for CD33 assessment

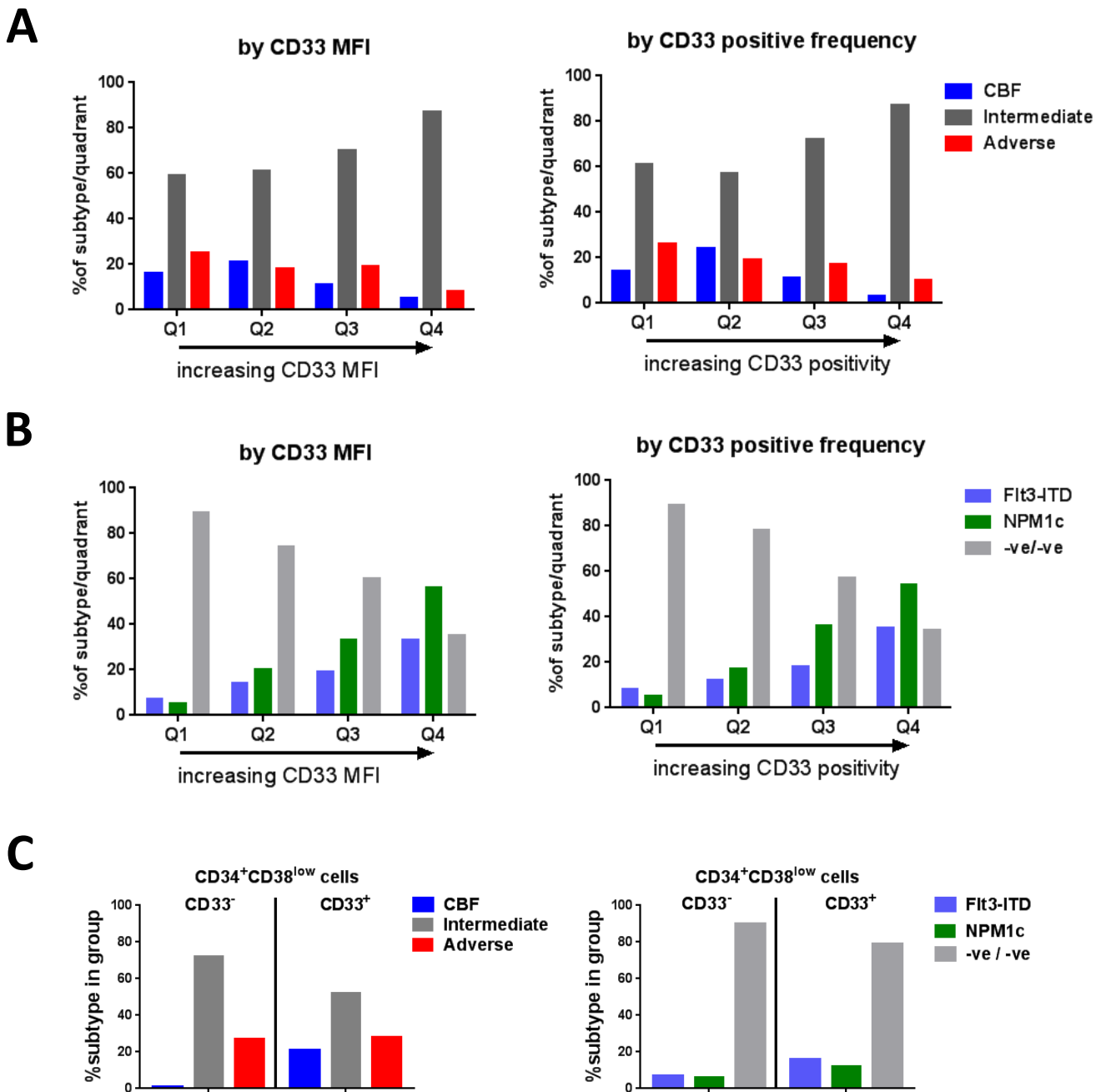


Figure 2

Distribution of CD33 expression with cytogenetic and mutational characteristics of AML patients

Figure 3: Effect of CD33 expression levels on outcomes in GO versus no GO randomised AML patients

Figure 3a: Effect of GO on overall survival stratified by CD33 expression

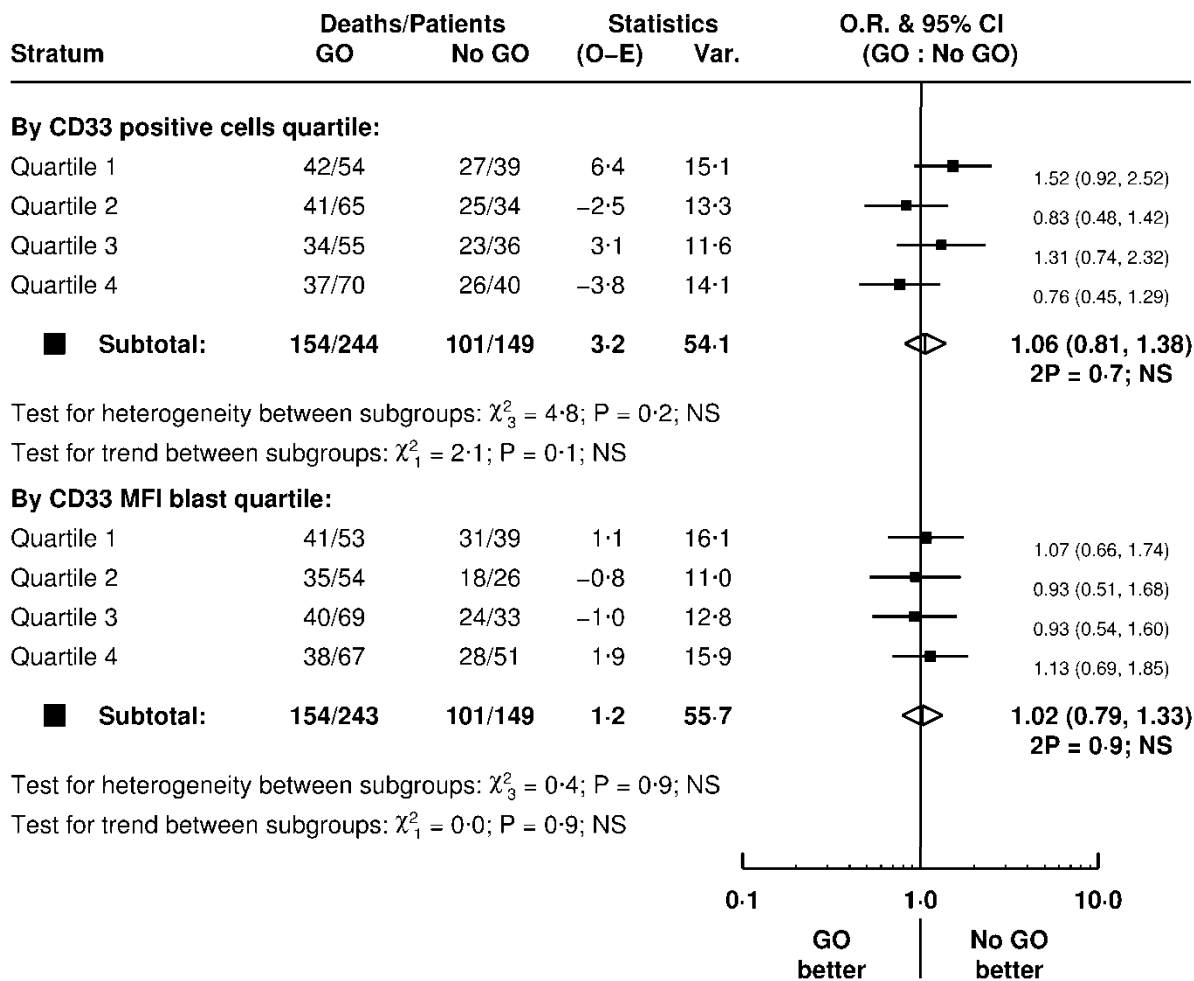


Figure 3: Effect of CD33 expression levels on outcomes in GO versus no GO randomised AML patients

Figure 3b: Effect of GO on relapse stratified by CD33 expression

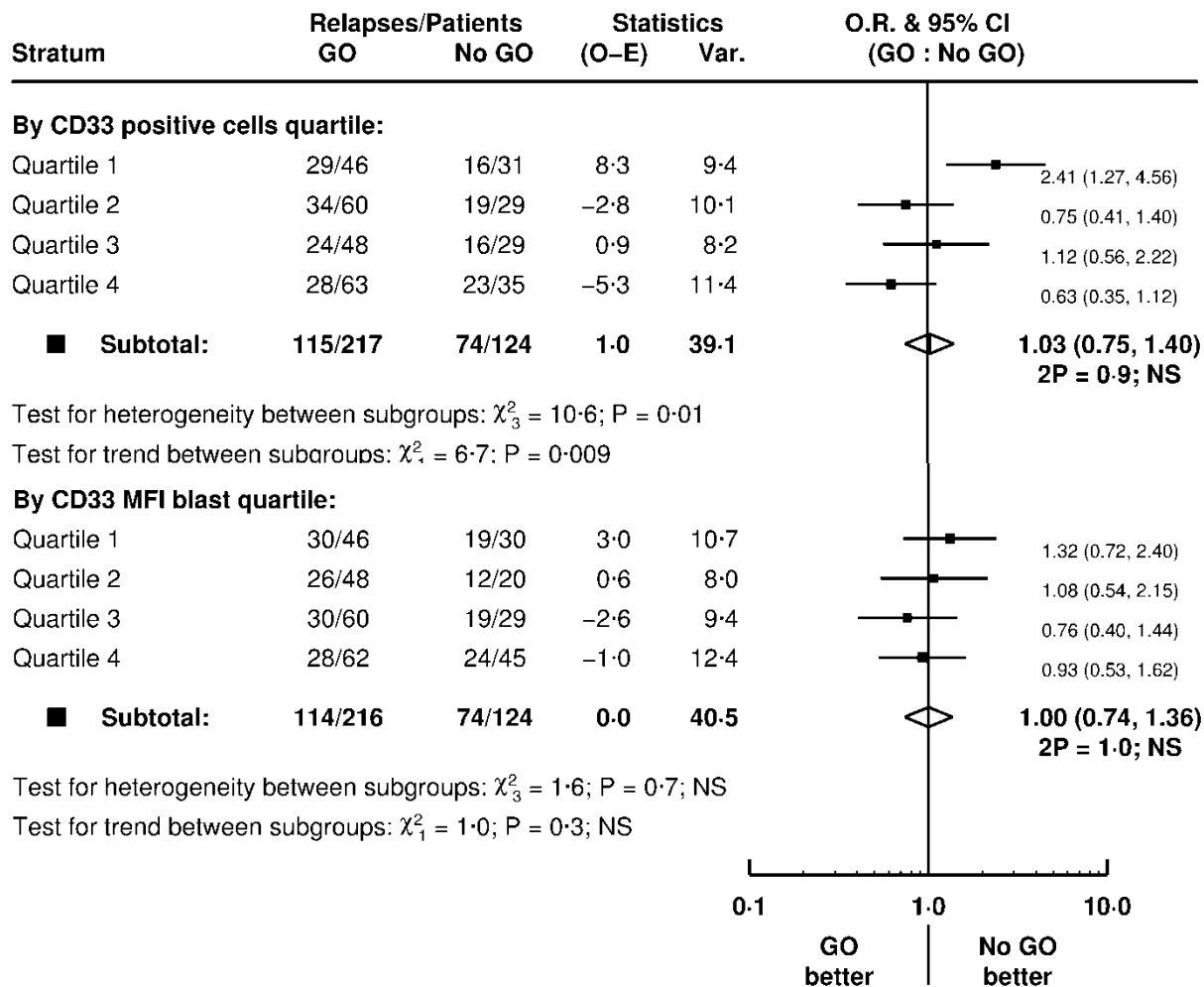


Figure 4: Effect of CD33 expression levels on **A.** relapse , **B.** survival , **C.** early mortality rates , in patients randomised to receive 6mg/m² or 3mg/m² GO dose

Figure 4a: Effect of GO dose on relapse stratified by CD33 expression

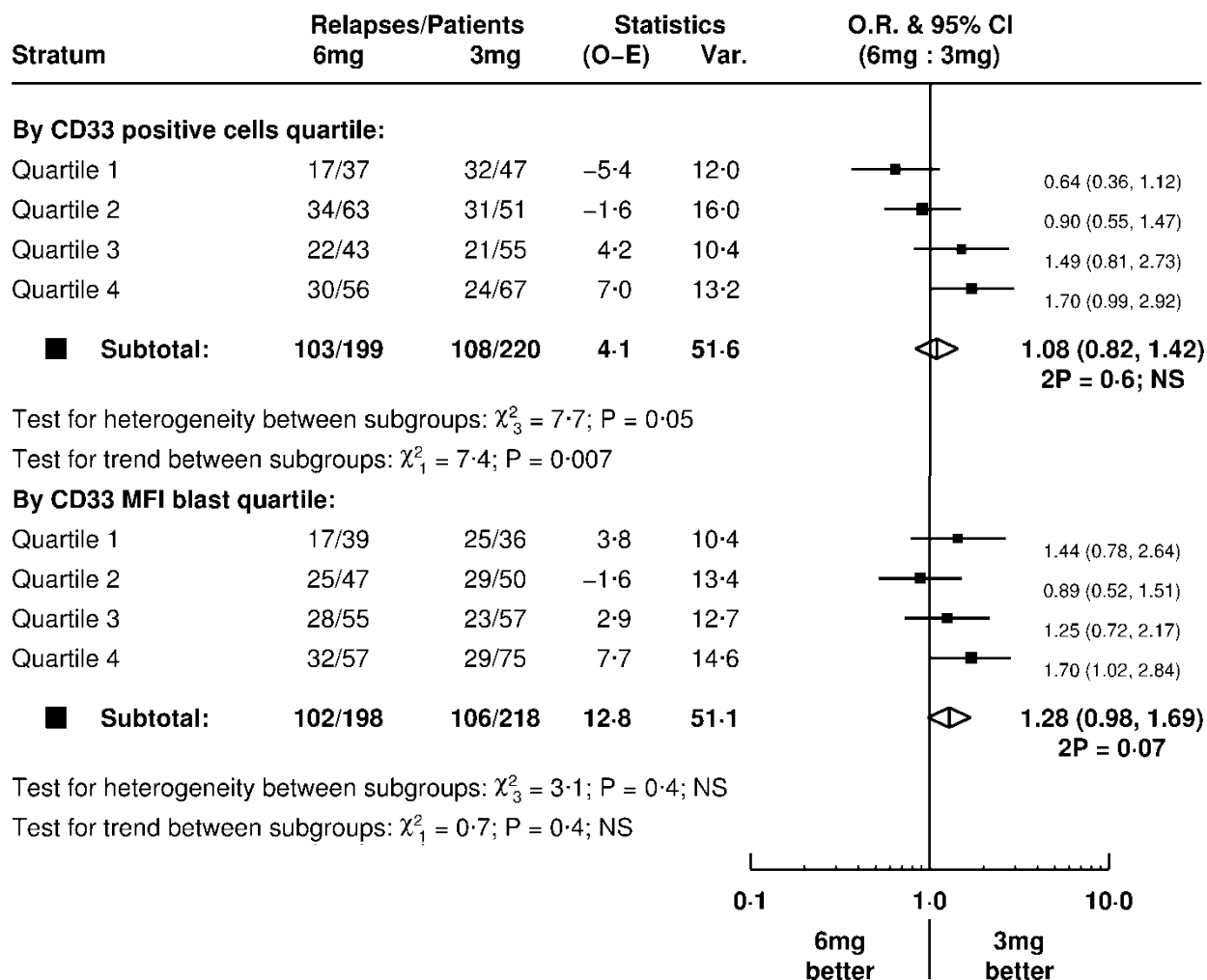


Figure 4: Effect of CD33 expression levels on **A.** relapse , **B.** survival , **C.** early mortality rates , in patients randomised to receive 6mg/m² or 3mg/m² GO dose

Figure 4b: Effect of GO dose on survival stratified by CD33 expression

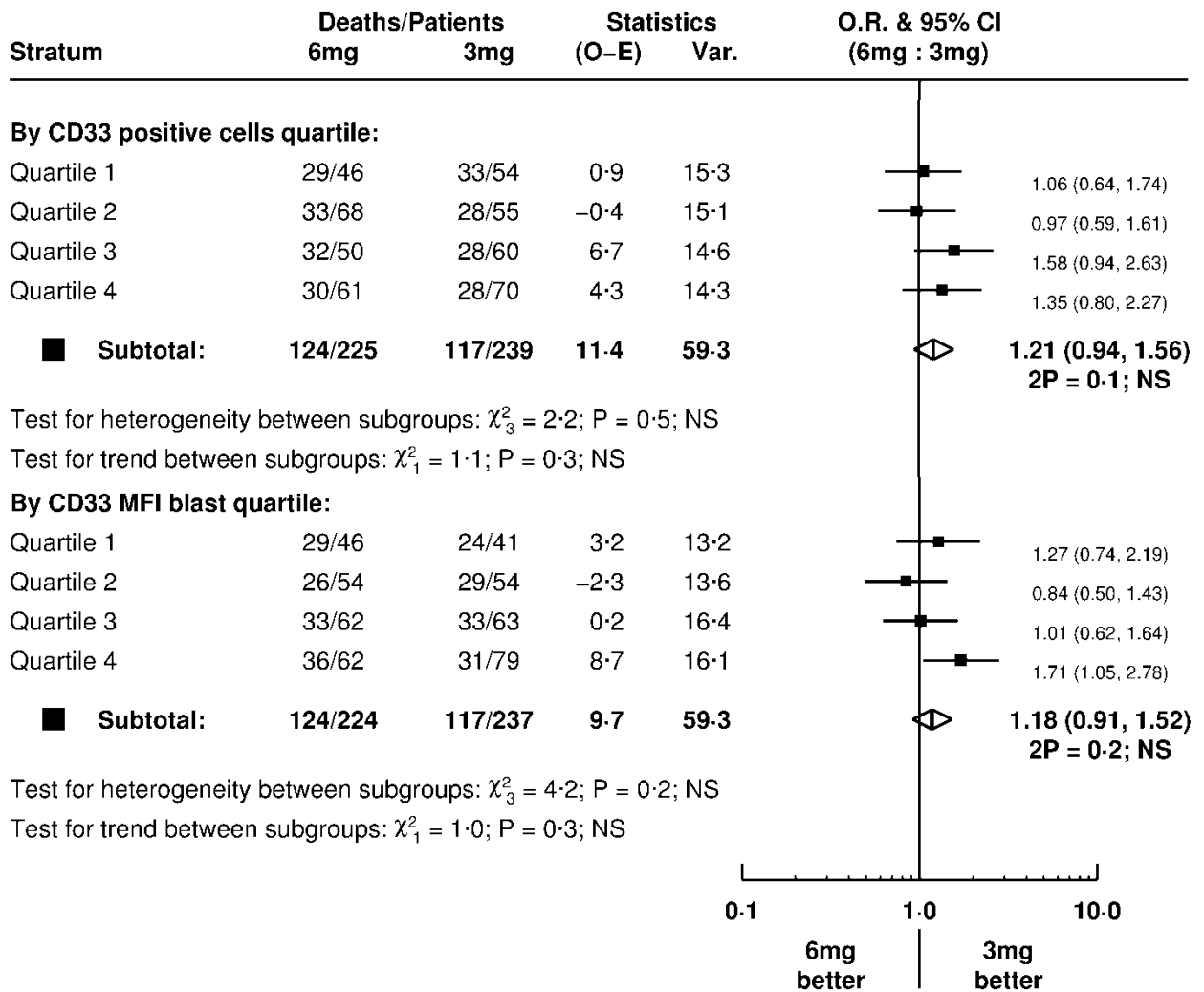


Figure 4: Effect of CD33 expression levels on **A.** relapse , **B.** survival , **C.** early mortality rates , in patients randomised to receive 6mg/m² or 3mg/m² GO dose

Figure 4c: Effect of GO dose on early mortality stratified by CD33 expression

