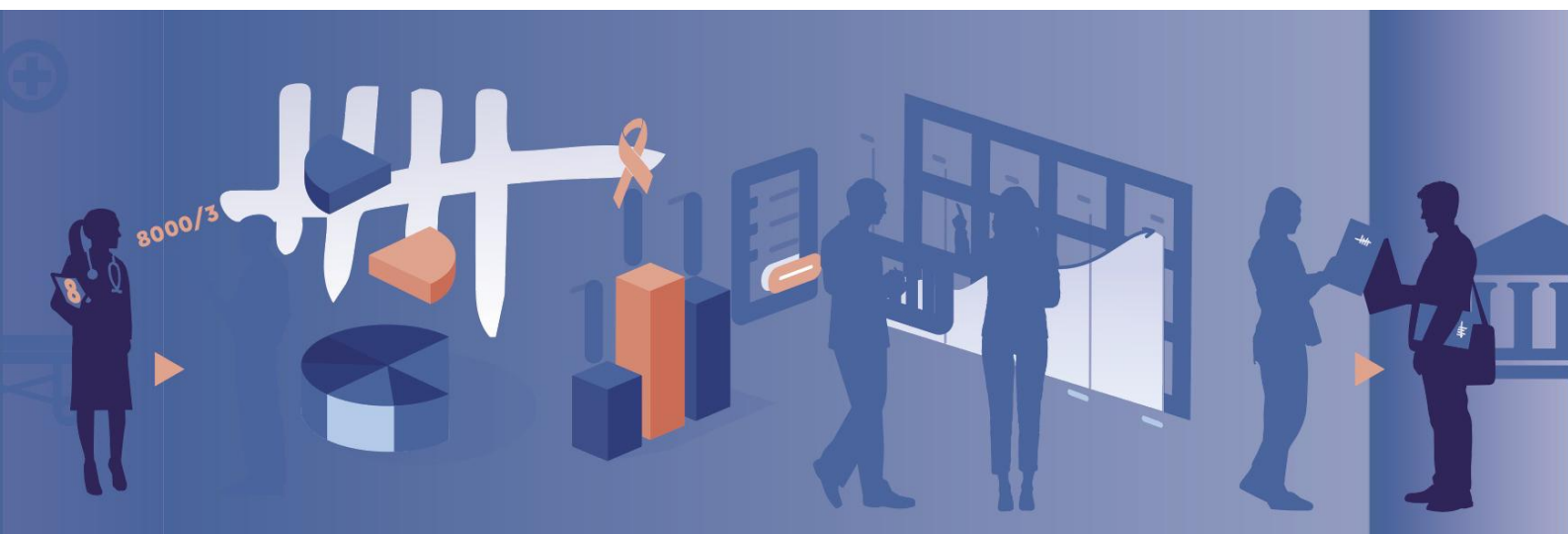


# Volume-outcome relationship in cancer care:

## ACUTE MYELOID LEUKEMIA – LITERATURE OVERVIEW





## Colophon

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# ACUTE MYELOID LEUKEMIA

## 1. Epidemiology

Acute myeloid leukemia (AML) is an aggressive haematologic malignancy characterized by the clonal proliferation of immature myeloid cells in the bone marrow, peripheral blood, and occasionally extramedullary sites. In 2023, the Belgian Cancer Registry (BCR) recorded 601 new cases of AML, with a slight male predominance and increasing incidence above 60 years.<sup>1</sup> Overall, AML is mostly diagnosed in the older population and is rare under 40. Information about adolescents and young adults (AYA), aged between 15 and 39 years, with AML is limited and heterogeneous. BCR analysed epidemiological trends in haematological malignancies between 2004 and 2018, identifying AML as the subtype with the lowest 5- and 10-year relative survival rates, 25% and 22%, respectively.<sup>2</sup> Notably, among patients who survived the first year following diagnosis, 90% were still alive 5 years later. No consistent improvement in 5-year relative survival was observed over the study period. Further epidemiological details for Belgium are available in the BCR report 'Haematological malignancies in Belgium 2004–2018', pages 144–151.<sup>3</sup>

AML involves a heterogeneous group of diseases defined by distinct genetic, cytogenetic, and molecular abnormalities. Subtypes include core-binding factor leukemias such as t(8;21) and inv(16), which are generally associated with favorable prognosis, as well as high-risk entities like AML with TP53 mutations or complex karyotypes. Over the past decade, there have been significant advances in cytogenetic and molecular profiling, leading to more refined disease classification and risk stratification. The 2022 WHO classification and ELN risk stratification systems guide diagnostic and therapeutic decisions based on these molecular features.<sup>4</sup>

Clinical presentation is often nonspecific, including fatigue, infections, bleeding, and cytopenias. Diagnosis is confirmed by bone marrow aspiration showing  $\geq 20\%$  blasts, supported by immunophenotyping and molecular testing. Prompt recognition followed by immediate decision making is essential, as untreated AML can progress rapidly and lead to life-threatening complications such as disseminated intravascular coagulation or leukostasis. Initial treatment consists of intensive induction chemotherapy (IC), typically with cytarabine and an anthracycline ("7+3" regimen), aiming to achieve complete remission. Consolidation strategies depend on risk category and measurable residual disease (MRD) status. Patients with favourable-risk AML and MRD negativity may proceed with chemotherapy alone, while those with intermediate or adverse risk features are considered for allogeneic haematopoietic stem cell transplantation (alloHCT). The role of autologous HCT (autoHCT) is limited and generally reserved for specific intermediate risk cases.

Novel agents such as FLT3 inhibitors, IDH1/2 inhibitors, and BCL-2 antagonists have expanded therapeutic options, particularly for older or unfit patients. Despite advances, AML remains a challenging disease requiring multidisciplinary expertise, including haematopathology, molecular diagnostics, transplant coordination, and supportive care. Long-term follow-up focuses on relapse surveillance, management of late effects, and psychosocial support.<sup>4</sup>

## 2. Aims and scope of the current literature study

The aim of this literature study was to evaluate the evidence for a volume-outcome association in the oncologic care of AML. A targeted literature search was conducted in October 2025 using the PubMed and Cochrane Library databases and broad MeSH terms searches (e.g. AML, volume, outcome, centralisation). The aim was to compile a general overview of the available evidence, with firstly a particular focus on studies that summarize existing data, including (systematic) reviews and meta-analyses. This was further supplemented with more recent individual studies. A full systematic literature review was beyond the scope of the current study.

To guide the selection process, several criteria were established. First, regarding outcomes, the primary focus was on post-treatment mortality and overall survival. Second, evidence related to care concentration across the entire oncologic trajectory was searched, rather than focusing on specific treatment modalities. However, given that chemotherapy is the key part of AML treatment, most research has focused on it. More specifically, intensive induction chemotherapy has been studied most, because of its complexity and early mortality risk. Third, for insights into the organisation of AML care in other countries, priority was given to studies involving populations most relevant to the Belgian context.

### 3. Evidence in literature

Since evidence regarding a volume-outcome association in AML care may have been previously summarised, an initial search was conducted to identify existing systematic reviews and meta-analyses on this topic. However, the available literature consists primarily of retrospective observational cohort studies. The main studies are presented in an overview table below.

First author	Year	Country	Data source (years)	Patients (n)	High-volume definition	Main findings for high volume	Specific limitations*
Kaplan et al. <sup>5</sup>	2025	The Netherlands	The Netherlands Cancer Registry (2014-2018)	1761	> 20 patients/year treated with intensive induction chemo (IC)	Increase of 10 IC-treated patients annually associated with 8% lower mortality risk [HR 0.92, 95% CI 0.87-0.98, p=0.01]. Improved OS after 100 days (p=0.05) (HR 0.91, 95% CI 0.83-0.99)	Lack of data about treatment-related outcomes
Betghe et al. <sup>6</sup>	2025	Germany	German Registry for Haematopoietic Stem Cell Transplantation and Cell Therapy (2015-2021)	5328	≥40 patients/year treated with allogeneic haematopoietic stem cell transplantation (alloHCT)	Improved OS after 12 months (p=0.0004); OS 65.8% (95%CI [62.7%; 69.1%]) for patients transplanted in a centre with < 40 HCT/year and 71.1% [69.7% ; 72.5%] in a centre with ≥ 40 HCT/year	
Battiwalla et al. <sup>7</sup>	2024	USA	HCA Healthcare's cancer registry (2011-2018)	1391	Sarah Cannon Blood Cancer Network (HCA-SCBCN) hospitals certified as specialized blood cancer centres	Improved median OS for HCA-SCBCN vs. HCA-non-SCBCN (p<0.0001) (median 31 months vs 18 months)	
Taylor et al. <sup>8</sup>	2023	USA	National Cancer Database (2004-2016)	127 988	≥662 patients/study period treated for AML	OS was higher at academic centers compared to all other facility types (HR 0.90, 95% CI: 0.87–0.93, P<0.001) and worse at low compared to high volume facilities (HR 1.14, 95% CI: 1.12–1.16, P<0.001)	Large data span: early years may not reflect current molecular and treatment advances
Semerad et al. <sup>9</sup>	2021	Czech Republic	Database of Acute Leukemia Tool (2007-2019)	1028	≥10 patients/year treated with IC and/or alloHCT	Trend to reduced early mortality (NS) (HR 1.23, 95% CI 0.78-1.93)	AlloHCT only in high-volume hospitals



First author	Year	Country	Data source (years)	Patients (n)	High-volume definition	Main findings for high volume	Specific limitations*
Law et al. <sup>10</sup>	2021	USA	Kaiser Permanente Northern California Cancer Registry (2013-2017)	661	Regionalisation of IC from 21 local centres to 3 regional centres in 2015	Reduced mortality after 180 days (HR = 0.64; 95% CI = 0.44-0.92) after regionalisation vs. before	Temporal bias
Majhail et al. <sup>11</sup>	2020	USA	Survey + data from Center for International Blood and Marrow Transplant Research (2008-2010) (2012-2014)	11 537	>40 patients treated with alloHCT in 2010  >40 patients treated with alloHCT in 2014	Improved OS after 100 days (difference 3%; p<0.001) and 12 months (difference 6%; p<0.001)  Improved OS after 12 months (difference 3%; p<0.017)	
Zeidan et al. <sup>12</sup>	2020	USA	Premier Healthcare database (2010-2017)	6442	≥9 patients/year treated with IC	Reduced in-hospital death and discharge to hospice (OR, 0.80; 95% CI, 0.67-0.95; p=0.01)	Lack of data about social and financial status
Medeiros et al. <sup>13</sup>	2019	USA	Two randomized controlled trials: ECOG-ACRIN 1900 and SWOG S0106 (2002-2009)	1252	≥10 patients recruited/study period	Improved complete remission rates (OR, 1.08; p=0.0051), trend to improved OS (HR 0.97, 95%CI 0.94-1.0, p=0.069).	Institutional clinical trial accrual volume was used as a surrogate for institutional experience
Lemaistre et al. <sup>14</sup>	2019	USA	HCA electronic medical records and SEER database (2011-2018)	4882 (HCA) and 19 349 (SEER)	HCA Healthcare community hospitals, including HCA-SCBCN hospitals HCA Healthcare (HCA) network of 131 community hospitals	Reduced mortality at 30 (19% vs 16%), 90 (33% vs 27%) and 120 days (37% vs 30%) (p<0.001) and improved OS (HR 0.68; p<0.001)	
Wolfson et al. <sup>15</sup>	2017	USA	National Cancer Institute database (1998-2008)	490 Age group: 1-39 years	Comprehensive Cancer Centre and Children's Oncology Group centre	Improved OS for 15–21-year-olds (HR 1.7; 95% CI, 1.1-2.7; p=0.02)	Only younger population included
Ho et al. <sup>16</sup>	2017	USA	California Cancer Registry (1992-2012)	6359	National Cancer Institute centres	Reduced mortality after 60 days (OR = 0.45, 95% CI = 0.36-0.56)	



First author	Year	Country	Data source (years)	Patients (n)	High-volume definition	Main findings for high volume	Specific limitations*
Bhatt et al. <sup>17</sup>	2017	USA	National Cancer Database (2003-2011)	60 738	Academic centres	Improved 1- year (47.0% vs 31.9%) and 5-year OS (24.6% vs 15.0%) (p<0.0001) and reduced mortality after 1 month (OR 1.52; 95%CI 1.46-1.59; p<0.0001)	Selected database with possible underreporting of AML patients
Thompson et al. <sup>18</sup>	2016	USA	Medicare inpatient fee-for-service (2013)	7568 Age group: ≥65 years	Median of 10 (high) and 25 (very high) patients/year treated with chemotherapy	Reduced mortality at 30 days (OR 0.57; 95%CI 0.48-0.67) and 1 year (OR 0.67; 95%CI 0.58-0.78) for very high vs low volume (p < 0.001), and at 1 year for high vs low (OR 0.86; 95%CI 0.74-0.99; p < 0.05).	Only older patient population included
Go et al. <sup>19</sup>	2016	USA	National Cancer Database (2003-2011)	8128 Age group: 18-39 years	Academic centres	Higher survival probability (adjusted HR 1.41; 95%CI 1.11-1.79; p=0.02) for good risk AML	Only younger population included
Giri et al. <sup>20</sup>	2015	USA	Nationwide Inpatient Sample database (2009-2011)	3640	>75 <sup>th</sup> percentile based on the number of patients/year treated with chemo	Reduced mortality rate (OR 3.26; 95%CI 1.98-5.38; p<0.001)	No differentiation between induction and consolidation chemo
Loberiza et al. <sup>21</sup>	2005	USA	Survey in transplant centres (1998-2000)	1426	>20 patients/year/physician undergoing alloHCT	Reduced mortality after 1 year (OR 0.78; 95%CI 0.63-0.98; p=0.03)	Inclusion of patients with AML, ALL, and CML, also for high-volume definition

ALL: Acute Lymphoblastic Leukemia, alloHCT: Allogeneic Haematopoietic Stem Cell Transplantation, CI: Confidence Interval, CML: Chronic Myeloid Leukemia, HR: Hazard Ratio, IC: Intensive Induction Chemotherapy, NS: Not Significant, OR: Odds Ratio, OS: Overall Survival, SCBCN: Sarah Cannon Blood Cancer Network, SEER: Surveillance Epidemiology and End Results

\* General limitations are discussed in section 7 (Discussion and conclusion)

## 4. Organisation of AML care in other countries

### 4.1 Worldwide

The **European LeukemiaNet (ELN)** was created to stimulate leukemia research and standardisation of clinical practices across Europe. It has developed into a worldwide collaborative network comprising approximately 220 centres in 45 countries. The network includes around 120 leukemia trial groups and engages interdisciplinary partners in diagnostics, treatment development, registry coordination, and guideline set up.<sup>22</sup>

The ELN recommendations are widely used for the diagnosis, risk stratification, and treatment planning of AML. Initially published in 2010 and subsequently updated in 2017 and 2022, these consensus-based guidelines reflect ongoing developments in molecular profiling, targeted therapies, and clinical evidence. Their integration into clinical trials, registries, and routine care highlights their relevance and applicability in haematology practice worldwide.<sup>23</sup>

The **European Society for Blood and Marrow Transplantation (EBMT)** is a professional organisation that supports collaboration, data collection, and research in HCT. It maintains a large international registry and coordinates multicentre studies and working groups. One of these working groups is JACIE, a certification program providing accreditation for transplant centres based on strict criteria. These criteria cover clinical care, stem cell collection, and laboratory processing. Centres must meet minimum activity thresholds, including at least 10 allogeneic transplants per year for adult programmes and five per year for paediatric programmes. By this, JACIE certification assures that transplant centres have a required level of practice in accordance with agreed standards of excellence. Accreditation is voluntary but widely adopted in Europe and beyond, and often required for participation in clinical trials or for reimbursement.<sup>24</sup> Studies show that the introduction of the JACIE quality management system improves relapse-free survival after allogeneic HCT (HR=0.86, 95%CI 0.78-0.95, p=0.01).<sup>25</sup> Even merely working towards implementation of the quality management system triggers a dynamic process associated with a steeper reduction in mortality over the years and a significantly improved survival after alloHCT.<sup>26</sup>

### 4.2 The Netherlands

The care of patients with AML is organised through nine regional cancer networks across the Netherlands. These networks consist of multiple hospitals designed to collectively manage AML, providing integrated care over multiple stages of patient treatment. The diagnostic procedures are typically performed at the referring hospital. The administration of IC and the performance of HCT, however, is limited to hospitals that meet specific structural and clinical criteria. These criteria are defined by a classification system developed by the Haemato-Oncology Foundation for Adults in the Netherlands (HOVON). It was originally designed to determine hospital eligibility for participation in clinical intervention studies.

The system classifies hospitals into five levels (A to D), based on their capacity to deliver haematological care:

- Level A: Academic centres authorised to perform all intensive procedures, including IC, autologous stem cell transplantation (autoHCT), and allogeneic stem cell transplantation (alloHCT).
- Level B: Hospitals qualified for IC and autoHCT.
- Level C: Subdivided into C-HIC and C-HCT.
  - C-HIC centres can administer IC and provide post-transplantation care.
  - C-HCT centres are limited to non-intensive haematological care and post-HCT follow-up.
- Level D: Facilities restricted to non-intensive haematological care only.

Thus, a patient needing alloHCT after receiving IC in a non-academic centre, must be referred to an academic centre for this. Afterwards, the post-transplantation care can again take place in the hospital that administered IC.<sup>5,27</sup>

### 4.3 Denmark

In Denmark, treatment for AML takes place in ten specialised haematological departments, with six of these administering IC and only two performing alloHCT. Since 2000, all patients diagnosed with AML are recorded in the Danish National Acute Leukemia Registry. For each patient, more than 150 patient-, leukemia-, treatment- and outcome-related variables can be reported. A validation study of the quality of these registrations showed that the coverage of this registry was 99.6%.<sup>28,29</sup>

#### 4.4 Czech Republic

Treatment of AML patients is centralised within seven academic hospitals in the Czech Republic. All newly diagnosed AML cases are referred from local hospitals to these academic centres for diagnostic confirmation and treatment. These institutions collaborate through the CzeCh Leukemia Study Group for Life (CELL), a national consortium dedicated to optimising leukemia care and research. As part of this coordinated approach, the CELL group maintains a comprehensive real-world registry known as DATOOL-AML (Database of Acute Leukemia Tool). This database collects clinical data on both intensively and non-intensively treated patients, including data on the type of AML, treatment modalities and effects, and follow-up. The detailed registry enables longitudinal monitoring, outcome analysis, and quality assurance across the national network. The centralised structure ensures uniform standards of care and facilitates participation in multicentre clinical trials.<sup>9,30</sup>

#### 4.5 United Kingdom

In the UK, care for AML is increasingly structured through a hub-and-spoke model, designed to improve outcomes by concentrating expertise and standardising treatment. Major hospitals, such as University College London Hospital, act as hubs. These centres provide advanced diagnostics, coordinate multidisciplinary team discussions, deliver complex interventions like IC and HCT, and ensure access to clinical trials. The hubs are supported by spokes, which are regional hospitals or satellite units which manage initial consultations, diagnostics, early referral to hubs and follow-up. This hub-and-spoke model enables that patients can access high-level expertise without being displaced from their local care networks, improving continuity and reducing travel burdens.<sup>31</sup>

#### 4.6 Germany

To qualify for reimbursement in Germany, centres must now perform at least 40 allogeneic stem cell transplants annually. Aside from this healthcare decision in 2022, AML care in Germany is not centralised or organised through a formal hub-and-spoke structure.<sup>5</sup>

### 5. International guidelines

**1. European LeukemiaNET (ELN):** Diagnosis and management of AML in adults: 2022 recommendations from an international expert panel on behalf of the ELN<sup>23</sup>

The 2022 ELN guidelines, which are an updated version of the 2010 and 2017 guidelines, for adult AML do not address a possible volume-outcome effect. They focus on diagnostic criteria, genetic risk stratification, treatment recommendations, and MRD monitoring, without reference to centre experience, case thresholds, or institutional volumes. In 2024, new ELN classification of AML patients receiving less intense therapies was published<sup>32</sup>.

**2. European Society for Medical Oncology (ESMO):** Acute myeloid leukemia in adult patients: 2020 ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up<sup>4</sup>

The ESMO Clinical Practice Guidelines for AML do not mention volume-outcome effects. The document focuses on diagnostic criteria, treatment strategies, and follow-up recommendations, without addressing institutional case volumes or their impact on outcomes. However, the guidelines highlight the importance of centre and clinician experience in AML care, particularly when deciding on IC or for performing HCT.

**3. National Comprehensive Cancer Network (NCCN):** Acute Myeloid Leukemia NCCN Guidelines Version 2.2026<sup>33</sup>

The NCCN guidelines for AML do not explicitly mention volume-outcome effects. However, they do emphasise the importance of treatment at experienced centres, especially for complex therapies like HCT.

### 6. Extra reading material

**1. Organisation of care for adults with a rare or complex cancer – KCE Report 219Cs (2014)**<sup>34</sup>

The KCE (Belgian Health Care Knowledge Centre) report on rare cancers includes AML under rare haematologic malignancies and supports centralisation of care. Although AML is not discussed in detail, the report confirms that HCT and other complex haematologic treatments benefit from volume-outcome effects. It recommends minimum caseloads, multidisciplinary teams, and referral pathways to high-volume centres to improve outcomes and ensure equitable access to expertise.

## 2. Referentiecentra voor zeldzame en complexe kankers - KOTK (2020 and 2023)<sup>35,36</sup>

In 2020, KOTK (Kom op Tegen Kanker) published a dossier explaining the rationale and criteria for establishing reference centres. These proposals were inspired by many interviews and meetings with healthcare providers, patient representatives and policy makers. Based on this dossier, KOTK formulated ten specific policy recommendations in 2023 aimed at improving care for patients with rare and complex cancers, including AML, through the development of dedicated reference centres.

## 7. Discussion and conclusion

Due to its clinical heterogeneity and treatment complexity, the management of AML requires substantial expertise and institutional capacity. While the evidence is not entirely uniform (2 studies did not show significant results), the majority of studies suggest that higher centre volume is associated with improved outcomes in AML care. This supports the rationale for centralising AML treatment in high-volume centres to optimise patient outcomes, particularly for IC and HCR.

The 2 studies that did not show a significant better outcome in high-volume hospitals are:

- The Czech study by Semerad et al (2007-2019): mortality rates only tended to be higher in low volume hospitals. However, the authors do state that only a minority of patients were treated in the low volume hospitals and that these patients were treated more frequently in the more recent time period 2013-2019 (where in general a lower early mortality rate and better overall survival are observed)<sup>9</sup>.
- Medeiros et al found an improvement of OS in patients treated within 2 clinical trials at high volume centres (median 2.4 years vs 2.0 years in low volume centres,  $p=0.043$ ) but only a trend towards improved OS in multivariable Cox models (HR 0.97, 95%CI 0.94-1.0,  $p=0.069$ )<sup>13</sup>. The authors discuss that clinical trial patient volume may not be an indicator of true centre AML volume, since only a subset of patients was eligible for these trials.

The available studies regarding volume-outcome effects in AML are primarily retrospective observational cohort studies, for which several important considerations must be addressed:

1. Most studies only include a part of the patient population (only treated with (intensive) chemotherapy or stem cell transplantation).
2. Most available research is retrospective and based on registry data, hospital discharge records, or administrative databases. These sources often lack granular clinical detail, such as cytogenetic risk, comorbidities, or treatment intent. Furthermore, coding inconsistencies and referral bias may confound results.
3. The definition of 'high-volume' varies across studies. Some use the number of patients receiving IC per year, while others include transplant activity. Centre volume reflects not only clinical throughput but also the presence of multidisciplinary teams, access to clinical trials, and adherence to guideline-based care. However, no consensus exists regarding the minimum threshold required to classify a centre as 'high-volume', and definitions remain arbitrary across publications. Moreover, numerous studies have been conducted in the USA, often comparing academic with community centres, a comparison that is less applicable to the Belgian hospital system.
4. Most volume-outcome studies do not stratify AML by biological subtype, age group, or treatment intent. This broad approach may mask the distinct challenges associated with high-risk, elderly or young patients, who often require tailored supportive care and nuanced decision making. Stratifying outcomes by disease profile and treatment pathway would allow for more specific recommendations and better reflect the needs of vulnerable populations.<sup>37</sup>

Differences in the treatment of AYA patients with AML highlight important distinctions between paediatric and adult protocols and medical centres. Although survival outcomes for AYA AML patients do not differ substantially between paediatric and adult treatment settings, the causes of treatment failure diverge: higher-intensity paediatric protocols are associated with increased treatment-related mortality (TRM) but lower relapse or progression rates. Paediatric protocols typically deliver higher cumulative doses of chemotherapy over two induction cycles, perform lumbar punctures more frequently to assess for CNS disease, rely heavily on MRD response to guide therapy intensity and decisions regarding stem cell transplantation, and tend to adhere strictly to standardised treatment pathways. In contrast, adult regimens are designed with a focus on tolerability and are often extrapolated from protocols intended for older patients, resulting in less intensive therapeutic approaches. Paediatric providers are also more likely to enrol patients in clinical trials and to treat aggressively compared with their adult counterparts. Despite these differences, the factors determining whether an AYA patient is treated on a paediatric or adult protocol remain unclear, raising questions about whether referral network patterns, institutional practices, or patient preferences influence these decisions. Collectively, these observations underscore the need for careful risk

stratification and enhanced supportive care to ensure that maximal treatment intensity is directed to those AYA patients most likely to benefit, while minimizing TRM among those for whom such intensity may pose undue risk <sup>38-40</sup>.

Early mortality in AML is most pronounced during the initial phase of treatment, particularly within the first 30 days following IC. This underscores the critical and complex nature of IC, which carries substantial risk due to disease burden, treatment toxicity, and complications such as infections or bleeding.<sup>5</sup> While AML has always been considered a haematologic emergency, recent studies suggest that the exact time from diagnosis to treatment initiation may be less prognostically relevant than previously assumed. In stable patients, awaiting the results of molecular and cytogenetic testing before starting treatment might be justifiable.<sup>8</sup> In addition to IC, HCT remains the most critical treatment modality for AML. Accordingly, most European countries maintain designated transplant centres, ensuring that eligible patients have access to specialised infrastructure and multidisciplinary expertise. This already aligns with a broader trend toward centralisation of AML care, integrating both induction and transplant strategies within specialised, high-volume centres. However, the increasing use of novel oral targeted drugs, often administered in lower intensity regimens, may reduce the importance of centralisation. Nonetheless, these therapies can still induce severe toxicities such as cytopenias, for which specialised care remains essential.<sup>37</sup> In addition, improved outcomes in high-volume centres likely reflect more than just numerical experience. These institutions typically offer structured care pathways, multidisciplinary discussions, and access to clinical trials. Moreover, they are more likely to implement timely molecular diagnostics and risk-adapted treatment strategies, which are critical in AML management.<sup>5</sup>

In summary, AML care benefits from centralisation in reference centres, where more expertise is associated with improved outcomes. While definitions of 'high-volume' remain inconsistent, the underlying principle of expertise-driven care is well supported. Further research is needed to establish validated criteria and/or thresholds for these reference centres, and to explore volume-outcome relationships across diverse AML subgroups, based on both patient and leukemia characteristics, and treatment modalities.



## 8. Abbreviations

ALL	Acute Lymphoblastic Leukemia
AML	Acute Myeloid Leukemia
AYA	Adolescents and young adults
BCR	Belgian Cancer Registry
CELL	CzEch Leukemia Study Group for Life
CI	Confidence Interval
CML	Chronic Myeloid Leukemia
CNS	Central Nervous System
DATool-AML	Database of Acute Leukemia Tool
EBMT	European Society for Blood and Marrow Transplantation
ELN	European Leukemia Net
ESMO	European Society for Medical Oncology
HCT	Haematopoietic cell transplantation
HOVON	Stichting Haemato-Oncologie voor Volwassenen Nederland
HR	Hazard Ratio
IC	Intensive Induction Chemotherapy
KCE	Federaal Kenniscentrum voor de Gezondheidszorg
KOTK	Kom Op Tegen Kanker
MRD	Measurable Residual Disease
NCCN	National Comprehensive Cancer Network
NS	Not Significant
OR	Odds Ratio
OS	Overall Survival
SCBCN	Sarah Cannon Blood Cancer Network
SEER	Surveillance Epidemiology and End Results
TRM	Treatment-related Mortality
WHO	World Health Organisation

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