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course of MTX for people receiving MUD transplantation. For RIC, GVHD prophylaxis was achieved by starting on Day 2 with 3 mg/kg PO of pluS CYA and 2 g mycophenolate mofetil per day [7-9]. The brief course of MTX was not used when umbilical cord HSC was the source. Peripheral granulocyte counts over 500/-L for three straight days were engraftment. When engraftment was not achieved in the parent tissue, the failure or rejection of the patients who remained alive following a transplant for more than 28 days. Day 100 following the operation saw a calculation of the engraftment failure rate [10].

Laminar high efficiency particulate air (HEPA) filters were used to keep all patients in a secure setting. All patients received standard prophylactic doses of acyclovir, fluconazole, and sulfamethoxazole along with trimethoprim. Weekly CMV monitoring was done via antigenemia assaying after 2005 and qualitative DNA-polymerase chain reaction (PCR) up until that point. After two consecutive positive PCR results or one positive cell in the antigenemia assay, preventive 10 mg/kg ganciclovir was started [11]. All blood components underwent irradiation and filtration. According to the guidelines issued by the hospital transfusion committee, minimum values were established to initiate platelet and red blood cell transfusions to maintain

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Both the cumulative incidence of acute GVHD for MRD vs. MUD (147-57.5 percent and 39-65 percent, respectively; p-value = 0.358) and the cumulative incidence of chronic GVHD (110-52.6 percent and 20-46.7 percent, respectively; p-value = 0.573) did not di er. Donors older than 40 years had a considerably higher incidence of both acute and chronic GVHD. 77 people experienced acute GVHD (65.8 percent). receivers from donors who were older (>40 years) and 92 (52 percent) from donors who were younger (p-value = 0.03) Chronic GVHD occurred in 64 (43%) recipients from younger donors and 54 (60%) recipients from older (>40 years) donors (p-value = 0.015). e occurrence of acute or chronic GVHD was una ected by ABO incompatibility, donor gender, MRD or MUD, or CMV serological status. With the advent of non-myeloablative conditioning regimens, DNA-based high resolution HLA typing, and improved clinical support, much has been done in the last ten years to increase the e cacy of HSCT [15]. As a result, there are more MUD transplants performed globally, and while acute and