vision
reality
At Cell Therapeutics, Inc. (CTI),
our vision is to make cancer more treatable.
Every day we work to make this vision a reality.
As CTI’s cancer drugs progress through clinical trials to commercialization, our commitment to patients and the real issues of their cancer treatment grows stronger. The challenge to overcome the therapeutic limitations of current cancer treatment gives us focus and a sense of urgency. We believe next-generation versions of the cornerstone chemotherapy classes that are easier to administer and offer lower toxicity and/or increased effectiveness address a significant unmet need for the majority of cancer patients worldwide. Our product portfolio, which includes a next-generation drug candidate for each of the four leading classes of chemotherapy agents, is how we are turning our vision of making cancer more treatable into a reality.
product portfolio

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TAXANES, including paclitaxel, are one of the best-selling classes of chemotherapies. However, one of the most commonly used paclitaxel formulations is extremely irritating to blood vessels and requires surgical placement of a large catheter for administration. It also can cause severe life-threatening allergic reactions that typically require pre-medication with steroids and antihistamines in addition to a minimum of three hours of intravenous infusion. Paclitaxel also can lead to dose-limiting peripheral nerve damage.

ANTHRACYCLINES are used to treat lymphoma, leukemia, breast, uterine, ovarian, and lung cancers. This class of chemotherapy agents is associated with significant and irreversible damage to heart muscle. As a result, treatment with anthracyclines above cumulative doses typically used to induce remissions is not recommended.

CAMPTOTHECINS and derivatives such as topotecan and irinotecan are used to treat several cancers, including lung, ovarian, and colorectal. Significant side effects of this class include life-threatening cystitis (inflammation or infection of the bladder) as well as diarrhea and myelosuppression, which may be severe.

PLATINUM COMPOUNDS are used to treat a variety of cancers. Significant side effects associated with these compounds include a decrease in the number of blood cells in the bone marrow, kidney damage, and hearing loss. Other common side effects include hair loss, weight loss, nausea, vomiting, and peripheral nerve damage.

Early development includes preclinical, phase I, and some phase II clinical trials; late development includes phase IIb and later clinical trials.
XYOTAX has shown a survival benefit in women, potentially converting a negative risk factor for lung cancer—estrogen—into one that benefits patients.
XYOTAX™ (paclitaxel poliglumex, CT-2103)

XYOTAX is a novel polymer conjugate of paclitaxel, the most commonly used chemotherapy in the treatment of cancer. While paclitaxel has improved the outcome and survival of many patients with solid tumors, it is associated with a number of serious and often treatment-limiting side effects. XYOTAX is being developed to provide patients on paclitaxel-containing regimens with better quality of life during treatment without reducing the efficacy of this mainstay cancer drug.

Data from multiple clinical trials of XYOTAX demonstrate its ability to improve the treatment experience for non-small cell lung cancer (NSCLC) patients without compromising paclitaxel’s efficacy. In these studies, patients receiving XYOTAX had similar overall survival compared with patients in the control arm, but had a lower rate of severe side effects and decreased need for supportive care. XYOTAX was administered over a shorter infusion period and did not require routine pre-medication to avoid potential allergic reactions that occur with administration of standard paclitaxel. Fewer complications and side effects may also lower the cost of care by reducing the need for additional medications, hospitalizations, and blood transfusions.

We intend to seek approval for XYOTAX in Europe based on efficacy that is non-inferior to paclitaxel in patients with advanced NSCLC and poor performance status (PS2). This application will be supported by available phase III STELLAR clinical data, and we expect to submit this application in the first half of 2008.

Additional clinical data have demonstrated a survival advantage for XYOTAX compared with paclitaxel in women with NSCLC and pre-menopausal estrogen levels. The U.S. Food and Drug Administration (FDA) currently is reviewing two phase III study protocols designed to confirm this observation. The Gynecologic Oncology Group (GOG), a leading U.S. physician cooperative group, is conducting an ongoing phase III study of XYOTAX as maintenance therapy in first-line ovarian cancer. Positive data from the planned NSCLC trial and the ongoing ovarian trial could potentially provide the foundation for a New Drug Application (NDA) with the FDA.

We are working closely with our partner, Novartis, to complete clinical, regulatory, and manufacturing activities that are critical to bringing XYOTAX to patients. We are pleased to have found a partner with the global resources and shared commitment to cancer care.
Pixantrone (BBR 2778) is being developed as a potential replacement for anthracyclines, a class of chemotherapy drugs that are a cornerstone of treatment for a variety of blood-related (hematologic) cancers and breast cancer. Despite their efficacy, anthracyclines are associated with significant and irreversible heart damage, and treatment beyond an established maximum dose is not recommended. Pixantrone was designed to have an improved cardiac safety profile and has the potential to provide an important treatment alternative to patients with maximum anthracycline exposure who require additional treatment for their cancer.

Currently we are evaluating pixantrone in non-Hodgkin’s lymphoma (NHL), a disease typically treated with regimens that include the anthracycline doxorubicin. Ongoing clinical trials are evaluating pixantrone as first- or third-line therapy in patients with aggressive NHL. We expect interim results from these trials in aggressive NHL in the second half of 2007. We also expect to initiate a phase III trial of pixantrone as second-line therapy for indolent NHL in 2007. The patient population and market potential are substantially larger for indolent compared with aggressive NHL. Positive results from the ongoing clinical trials in aggressive NHL and the planned phase III trial in indolent NHL could enable us to submit an NDA in 2008.

In addition to the decrease in cardiac toxicity, our growing clinical experience with pixantrone suggests that it also may be associated with a lower incidence of other common anthracycline-related toxicities. These include severe nausea, mucositis (mouth sores), gastrointestinal effects, and hair loss. Importantly, data suggest that these improvements in safety and tolerability do not compromise efficacy. Pixantrone thus has the potential to make NHL more treatable, both by allowing longer or repeat treatment as well as by improving a patient’s quality of life during therapy. Moreover, the reduction in incidence and severity of mucositis may lead to a decrease in infections, which can be a serious complication due to the immunosuppressive effects of NHL treatment regimens. Given that infections in patients undergoing chemotherapy may require additional medications, blood transfusions, and hospitalizations, pixantrone has the potential to spare patients from these interventions and to reduce the cost of care.
In clinical trials, pixantrone has produced impressive and durable responses in both aggressive and indolent NHL, which account for more than 60,000 new cases of cancer in the United States each year.
We are repositioning the Company to reach potential product milestones and evaluate new product acquisitions that could allow us to re-enter the blood-related cancer market.
growth strategy

Clinical oncology is an evolving field, continually adapting to new products, treatment strategies, and clinical data. In this dynamic environment, CTI has pursued a strategy of growth through acquisition and in-licensing of novel technologies and/or drug candidates. This approach has allowed us to build a portfolio of product candidates that address diverse cancer indications while focusing the majority of our resources on late-stage development and commercial prospects rather than early-stage drug discovery.

In 1998, we in-licensed a promising polyglutamate technology from The University of Texas M. D. Anderson Cancer Center. This technology is the foundation of XYOTAX, polyglutamate linked to paclitaxel, which may have significant clinical and commercial potential. Clinical data suggest that XYOTAX retains the efficacy of paclitaxel while improving its safety and tolerability. Importantly, XYOTAX’s metabolism differs in women, which may enhance its effectiveness over standard paclitaxel formulations. Similar improvements in tolerability have been observed in clinical trials of CT-2106, which links polyglutamate to camptothecin, another common class of cancer chemotherapy agents.

Our 2003 acquisition of Novuspharma brought in pixantrone and our bis-platinate program. Pixantrone, a novel anthracycline derivative, is now a near-term commercial opportunity, while the preclinical bis-platinate program holds great promise as a driver for future growth. In keeping with our strategy of developing replacement products for each of the most commonly used chemotherapy agents, we are evaluating the bis-platinates as a substitute for platinum-based cancer therapies. As with other approved chemotherapeutic classes, platinum-based therapies are associated with significant toxicities and development of resistance.

We also see acquisition as a strategy for establishing a presence in markets where we expect to commercialize products on our own. Our 2000 acquisition of PolaRx brought us TRISENOX, which is approved for the treatment of relapsed or refractory acute promyelocytic leukemia. We divested TRISENOX to Cephalon for $70 million in 2005 and may earn up to an additional $100 million in sales and registration-directed milestones. We are now evaluating other acquisition opportunities that would bring us back into the hematology market and help us build the commercial infrastructure needed to market pixantrone.
With a commitment to making cancer more treatable, we continually evaluate new areas in which we can apply our technologies and expertise to create therapies with fewer side effects and/or improved efficacy.

Protein-based therapies—including hormones, growth factors, antibodies, cytokines, and soluble receptors—have transformed both the treatment of many diseases as well as the pharmaceutical marketplace. However, the full potential of this approach remains unrealized, primarily as a result of their relatively short plasma half-life. This necessitates frequent dosing, which drives up the cost of these therapies. Also, short half-life and frequent dosing cause wide variations in the amount of the protein present in the blood—high levels immediately following administration may lead to side effects, while subsequent degradation of the protein may lead to sub-therapeutic levels.

Despite these limitations, biologics are mainstays of cancer care and treatment of other serious illnesses, making this class of drugs the fastest growing segment of biopharmaceutical sales. Annual sales were $51 billion worldwide in 2005 and are expected to reach $87 billion by 2010. Several approaches to extend the plasma half-life of therapeutic proteins are now in commercial use, including chemical conjugation with polyethylene glycol (PEG), amino acid engineering to introduce new glycosylation sites, and the addition of non-biologically active “carrier” domains. While these methods extend plasma half-life, they require additional manufacturing steps, increasing the cost of the resulting products. Nevertheless, the market for follow-on therapies that include these modifications is substantial, with seven follow-on protein drugs currently on the market.

We have developed a proprietary Genetic Polymer™ technology that modifies the half-life of protein-based therapies without requiring costly post-protein modifications. This simple yet elegant approach uses recombinant DNA technology to add certain polymers, consisting of repeated amino acid sequences, to a protein that is then produced using standard cloning and expression technology. In addition to enhancing the stability of the resulting protein, this approach generates novel protein structures that result in new intellectual property. This opens the door to pursuing a portfolio of high value follow-on protein therapies as well as novel biopharmaceuticals. We are currently exploring the potential of this Genetic Polymer technology through our spin-off, Aequus BioPharma.
A key pitfall of therapeutic proteins is their relatively short plasma half-life, which leads to the need for frequent injections and higher associated treatment costs. Our Genetic Polymer™ technology may offer a solution.
By advancing development of the Genetic Polymer™ technology, Aequus BioPharma is positioned to provide a rapid, safe, and cost-effective way to bring cutting-edge protein therapies to patients in need of new treatment options.
In February 2007, we formed Aequus BioPharma, Inc. as an independent subsidiary by contributing certain intellectual property to Aequus, retaining an initial 70% majority ownership stake. The purpose of Aequus is to focus on aggressively advancing the development of our Genetic Polymer™ technology. We believe that spinning this technology out into a separate company with expertise in the therapeutic protein space will allow us and our shareholders to realize the value of our investment in this technology while we focus on our near-term commercial opportunities.

The Genetic Polymer technology is a platform that may address the critical challenges of the biologics market. It has the potential to yield products with improved plasma half-life, generate novel proteins that should allow development of follow-on biologics with new intellectual property, and provide a way to extend the life cycle of first-generation biologics at risk for near-term patent expiration. Together, these attributes create multiple high value development, collaboration, and out-licensing opportunities.

In addition to our initial contribution of intellectual property rights, we have committed to fund Aequus with a loan of up to $2 million and will co-develop with Aequus its first product candidate, AQB-101. This candidate is a Genetic Polymer modification of G-CSF, a protein used to help fight infection in some patients taking chemotherapy. We believe that the Genetic Polymer technology may enable a novel G-CSF product with excellent plasma half-life, activity, and safety, but with a greater ease of manufacture and potentially lower cost of goods.

Initially, Aequus will focus on developing follow-on versions of approved protein therapies. This should minimize development times, costs, and risks by providing clear paths to known markets. Future opportunities include products based on novel proteins, peptides, antibody fragments, or small inhibitory RNA (siRNA) technologies, and collaboration/out-licensing agreements that provide other biopharmaceutical companies with access to the Genetic Polymer platform.

Aequus has the management team to realize its potential, comprised of former senior members of Immunex Corp., a company that successfully commercialized multiple protein-based therapies. At Immunex, this management team participated in the research and development of Enbrel® (etanercept), a soluble cytokine receptor with 2006 sales of $4.5 billion.
As an oncologist who has treated many cancer patients and as a son who watched his mother struggle through treatment for lung cancer, I have witnessed first-hand the impact of cancer treatment today. Not only is cancer still more often than not a deadly illness, it is a disease that also threatens patients’ sense of self, self-esteem, and dignity. So much of who we are is defined by what we do, yet the side effects of most cancer regimens can create seemingly insurmountable obstacles to even the simplest daily activities.

We founded Cell Therapeutics with the vision of making cancer more treatable—of helping people undergoing cancer therapy retain their dignity, identity, and sense of hope. We have faced our own challenges while pursuing this vision, but I believe that our achievements over the past 18 months have brought us closer than ever to a new reality of cancer care.

The XYOTAX clinical trial data demonstrate that the improved side effect profile and dosing regimen of this innovative, biologically engineered version of paclitaxel may transform patients' treatment experience without compromising paclitaxel's survival benefit. Moreover, the lower rate of severe side effects and decreased need for supportive care associated with XYOTAX may significantly reduce the cost of care, which is a burden to patients and to our healthcare system.

The data also suggest that XYOTAX may improve survival in women with non-small cell lung cancer who have pre-menopausal estrogen levels. Confirmation of this observation in additional phase III clinical trials could open the door to a personalized-medicine approach to cancer, one that recognizes the roles that gender and hormonal status play in the biology of cancer and response to therapy.

We are focused on completing the clinical and regulatory activities needed for approval of XYOTAX in Europe and the United States. We are targeting submission for approval in Europe with our existing STELLAR data in the first half of 2008 and are working to complete a gender-specific clinical trial demonstrating improved survival that will support U.S. approval.

We believe pixantrone may make cancer more treatable by decreasing the known cardiac toxicity of approved anthracyclines while also reducing the incidence of nausea, mucositis, and infection. Through our ongoing pixantrone clinical programs we have identified a path to market for this promising anthracycline derivative that could support filing for approval in 2008.
With XYOTAX and pixantrone, we are positioned to commercialize products in the classes of chemotherapy most commonly used to treat solid tumors and hematologic cancers, respectively. Given the differences in market size and delivery of treatment for these cancers, we are pursuing different commercialization strategies for each product candidate. For the large solid tumor market, we have partnered with Novartis, a leading oncology company that has the resources to make XYOTAX broadly available to patients who may benefit from it. We intend to address the smaller and more focused market for hematologic cancers ourselves. This strategy is designed to meet the needs of as many patients as possible while building a sustainable business and increasing shareholder value.

Consistent with our goal to build a commercial presence in the blood-related cancer market, we are using our proprietary Genetic Polymer™ technology to create a next-generation form of G-CSF, a protein therapy commonly used to treat the low white blood cell counts that frequently result from chemotherapy. The broad potential of the Genetic Polymer technology was the catalyst for establishing Aequus BioPharma, Inc. This majority-owned subsidiary has the expertise in biologics development and commercialization to capitalize on the substantial opportunities that exist for protein-based therapeutics. Pending federal legislation on follow-on biologics may further expand the opportunities for Aequus, CTI, and our shareholders.

In our preclinical pipeline, we plan to advance our first bis-platinate compound into the clinic in 2008. We anticipate these compounds will show improved biopharmaceutical and tolerability profiles compared to approved platinum-based chemotherapies and, as first-in-class novel platinites, we believe they hold promise in treating platinum-resistant tumors. In addition, we are advancing the preclinical development of a first-in-class inhibitor of HIF-1, a promising target for cancer therapy that plays a critical role in tumor angiogenesis.

We also have worked diligently to strengthen our capital structure. The success of these efforts is reflected in the reduction of our convertible debt, the improvement in our balance sheet, and our ability to attract adequate operating capital to advance our programs.

Giving back to the community is one of CTI’s corporate values and we are proud to be long-time supporters of many local organizations. We recognize it takes a community-wide effort to fight cancer. We appreciate the involvement of our employees in these efforts as well as their dedication to our vision of making cancer more treatable.

I want to thank you, our shareholders, for standing by us and believing in our ability to attain this ambitious yet important goal. Our achievements over the past 18 months position us for success in the 18 months to come, and I look forward to sharing our progress with you as our vision transforms the reality of cancer care.

James A. Bianco, M.D.
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stock information
The Company's common stock trades on the NASDAQ and MTAX stock exchanges under the symbol CTIC.

No dividends have been paid on the common stock to date, and the Company does not anticipate paying dividends on the common stock in the foreseeable future.

On April 15, 2007, we implemented a one-for-four reverse split of our common stock.

On May 31, 2007, there were approximately 221 holders of record of the Company's common stock.

The following table lists the high and low reported sales prices for the Company's common stock as reported on NASDAQ (adjusted for our one-for-four reverse stock split):

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<th>Quarter</th>
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annual meeting
Additional information regarding the Annual Meeting will be available on CTI's Web site and in the Proxy Statement.
directors
John H. Bauer (2)
Director
Former Executive Vice President, Nintendo of America, Inc.

James A. Bianco, M.D.
Director
President and Chief Executive Officer, Cell Therapeutics, Inc.

Vartan Gregorian, Ph.D. (2, 3)
Director
President, Carnegie Corporation

Mary O. Mundinger, D.P.H. (3)
Director
Dean of School of Nursing, Columbia University

Phillip M. Nudelman, Ph.D. (1, 2, 3)
Chair of the Board of Directors
President and CEO, Hope Heart Institute

Jack W. Singer, M.D.
Director
Executive Vice President, Chief Medical Officer, and Director

Frederick W. Telling, Ph.D. (1, 2)
Director
Vice Chair, American Foundation for Pharmaceutical Education

senior management team

James A. Bianco, M.D.
President, Chief Executive Officer, and Director

Louis A. Bianco
Executive Vice President, Finance and Administration

Dan Eramian
Executive Vice President, Corporate Communications

Gabriella Pezzi, Ph.D.*
Scientific Director, Cell Therapeutics Europe S.r.l.

Mauro G. Premi*
Acting Managing Director, Cell Therapeutics Europe S.r.l.

Giovanni Ravaioli*
Human Resources Director, Cell Therapeutics Europe S.r.l.

Jack W. Singer, M.D.
Executive Vice President, Chief Medical Officer, and Director

Scott C. Stromatt, M.D.
Executive Vice President, Clinical Development and Regulatory Affairs

Except for the historical information contained herein, the matters set forth in this Annual Report include information concerning our drug development pipeline, including anticipated regulatory timelines and the status of clinical trials, which are forward-looking statements within the meaning of the “safe harbor” provisions of the Private Securities Litigation Reform Act of 1995. These forward-looking statements are subject to risks and uncertainties that may cause actual results to differ materially, including the likelihood of continued efficacy in treatment of cancers with our products, the commercialization of our products, and our ability to successfully develop and support new indications; the impact of technological advances and competition; the timing and ability to enroll and complete clinical trials; the role that other factors and other competitive products may play in accelerating the discovery and development of new therapeutic products; and other risks detailed elsewhere in this report and from time to time in CTI’s SEC reports, including its Annual Report on Form 10-K for the year ended December 31, 2006. These forward-looking statements speak only as of the date thereof. CTI disclaims any intent or obligation to update these forward-looking statements.

CTI and XYOTAX (also referred to as paclitaxel poliglumex or CT-2103) are our proprietary marks. All other product names, trademarks, and trade names referred to in this Annual Report are the property of their respective owners.

(1) member of the compensation committee
(2) member of the audit committee
(3) member of the nominating and governance committee

* Not deemed to be officers for the purposes of Section 16 of the Securities Exchange Act of 1934.