Managing Hodgkin Lymphoma

How is the management of Hodgkin lymphoma evolving?

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Welcome to *Managing Hodgkin Lymphoma*. My name is Anas Younes, and I am the chief of the Lymphoma Service at Memorial Sloan-Kettering Cancer Center. I am frequently asked, How is the management of Hodgkin lymphoma evolving? It is interesting to know that, although ABVD—which is the most widely used regimen for the treatment of Hodgkin lymphoma—was introduced almost 4 decades ago, it is still the most widely used regimen for the treatment of patients' Hodgkin lymphoma. However, this is evolving as implicated by the question. Brentuximab vedotin is the only FDA approved drug for the treatment of relapsed Hodgkin lymphoma. It showed approximately 75% response rate, and about 34% complete response rate in patients who are heavily pretreated and had a prior autologous transplant. So, it makes a lot of sense to move a very effective drug that works in the relapse setting and start combining it in the frontline regimens and pretransplant setting—and that is what we are having right now. So, there is a randomized, international trial called ECHELON 1 comparing standard ABVD with AVD plus brentuximab vedotin in patients with advanced-stage Hodgkin lymphoma. This accrued more than half the patients and, hopefully, will finish accrual before the end of the year. It will take about 2 years of follow-up before we find out, but if the new regimen—which is AVD plus brentuximab vedotin—turns out to be superior than standard AVD, then this certainly will change the standard of care. There is a hint that this may be true, but we have to wait for the results, of course, of the randomized trial. The hint came from the long-term follow-up of the phase 1 trial that combined AVD with brentuximab vedotin and showed, with a 3-year follow-up, approximately 92% remained disease-free, which is remarkable. There is also attempts to combine brentuximab vedotin in a pretransplant setting, either in sequential mode; you give brentuximab vedotin as single agent, followed by, for example, chemotherapy, or concurrently, for example, with bendamustine. Either way, there is an improvement in the overall response rate and complete response rate with these treatment strategies, and this may evolve with time to include brentuximab vedotin as part of the induction pretransplant regimens. And, of course, PD1 made lot of the news as single agent even in patients who relapsed after autologous transplant, many of them received prior brentuximab vedotin, the risk response rate exceeded 60%. So, it is natural to think now combining PD1 antibody with brentuximab vedotin in the relapsed patient and start moving these combinations in frontline and then also in the pretransplant setting. Thank you for viewing this activity. For additional resources, please view the other educational activities on *ManagingHodgkinLymphoma.com.*