Managing Hodgkin Lymphoma

What are today's key issues and challenges in the management of front-line classical Hodgkin lymphoma?

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Welcome to *Managing Hodgkin Lymphoma*. I am Dr. Stephen Ansell. I am frequently asked, "What are today's key issues and challenges in the management of front-line classical Hodgkin lymphoma?"

I think there are two main issues that I would like to mention. The first, bleomycin is an agent that is utilized in combination (particularly the ABVD combination) but it is also used in escalated BEACOPP chemotherapy. One of the challenges over many years has been the toxicity of bleomycin that is seen in a high percentage of patients. In younger patients, probably around 18% to 25% of patients may have bleomycin lung toxicity, and in older patients that can even reach approximately 40%. In many patients, this may start with just shortness of breath and a cough, but for some patients this can turn into a life-threatening situation and it is often very difficult to predict. Bleomycin has been shown to have a role in the chemotherapy combination, but in general it has proven to be quite challenging for patients to be treated with bleomycin. Data that has recently been published, specifically the RATHL trial, has been very helpful in allowing us to work out how much bleomycin patients may really need. This trial looked at giving ABVD chemotherapy to patients with advanced-stage disease for two cycles, in other words four doses, and then repeating a PET scan. In patients who had a complete response to treatment, somewhere around 75% to 80% of patients, they then compared omitting bleomycin to continuing with bleomycin in the standard a ABVD regimen. The encouraging results from this data was that omitting bleomycin did not make a significant impact on the outcome of patients who were in complete response based on their PET scan. That has really impacted our practice, where we would typically after two cycles of treatment with ABVD, provided the patient is in a PET-negative complete remission, we would omit bleomycin, and that allows for continuation of treatment and a significant decrease in the likelihood of bleomycin lung toxicity.

A second, very important impact of a clinical trial on front-line therapy for patients with classical Hodgkin lymphoma has been to understand the role of radiation therapy. For many years, utilizing combination chemotherapy and then consolidation involved-field radiation therapy was the standard approach. There have been some recent trials that have compared no radiation therapy to chemotherapy plus radiation in combination.

The RAPID trial was very informative. In this study, patients received three cycles of ABVD chemotherapy and then underwent a PET scan, and again the PET scan here was very useful in patients where there was a negative PET scan. Patients were then randomized to continuing on to receiving involved-field radiation therapy compared to just completing treatment and receiving no further therapy. Although there was a small advantage to continuing on with radiation therapy, that advantage was quite modest approximately 6%. It appeared that in a high percentage of patients, the use of radiation therapy could be omitted as initial therapy and patients could just stop treatment, provided they were in a complete remission. I think an important lesson from this is that in patients with relatively low burdens of disease, patients specifically who are PET negative after three cycles of ABVD chemotherapy, and in discussion with the patient recognizing that there is a slightly decreased outcome long-term, particularly in patients where radiation may present long-term toxicities, you may consider omitting the use of radiation therapy in this subset of patients. I think all told, we are learning from randomized trials that in some patients omitting bleomycin or omitting radiation therapy is possible and the results with treatment are still very favorable. Thank you very much for reviewing this activity.