Managing Hodgkin Lymphoma

Updates in Hodgkin Lymphoma

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Hello, my name is James Armitage. I am a professor of Medicine at the University of Nebraska Medical Center, and I am talking to you live from the 12th International Conference on Malignant Lymphoma being held in Lugano, Switzerland. I would like to take this opportunity to provide you with some brief meeting highlights from this year's conference. Now, Hodgkin lymphoma is a topic that is harder and harder to have too many new innovations in because we treat it really, really well. On young patients with localized disease, the cure rate is about 90%. However, there still are some interesting things going on. These include new treatments, ways to modify therapy with the goal largely of reducing toxicity, and some debate about which is the best standard treatment of the ones that have been around for some time. Of the new treatments, the most exciting is brentuximab vedotin, as a single agent it is tremendously active, and it is now being incorporated into new regimens. It became apparent that it could not be given safely with bleomycin, and so the ABVD regimen is not ABVD plus brentuximab but AVD plus brentuximab. We will know in the next few years whether or not that provides an advance, although for good-risk patients, as I said a few minutes ago, it will not be easy to prove that because the cure rate with our standard therapy is so high. With high-risk patients, however, it may be that brentuximab will be able to make a real difference. Now, because we do so well in treating patients with Hodgkin lymphoma, one of the goals is how to reduce toxicity. We know with the treatments that we have used over the last few decades in patients with early stage Hodgkin lymphoma, ultimately after you follow them 20 years or 30 years, more will die from things that might be related to the treatment, most especially second cancers and cardiovascular events, than will die of lymphoma. And even in high-risk patients, those who are cured remain at high risk for late events, often 10 or 20 years after the original treatment. Well, the problem you have got is you do not want to be just continuing to reduce therapy until you reach the point that people start to die from Hodgkin lymphoma, but the PET scan provides a new way to potentially answer this question. And there are several studies being presented here all looking at the hypothesis that you can take a patient and give them some amount of treatment and then do an early PET scan. If that early PET scan has quickly turned negative, usually after two cycles of the therapy that we are talking about, then you might be able to reduce the intensity of the treatment or shorten the amount of treatment and still cure the patient. There are number of studies

that hint that might well turn out to be the case. Conversely, if you have patients, for example that you start treating with ABVD, most often those with higher risk or higher stage disease, and you gave two cycles of ABVD and the PET scan remains positive, you know that those patients are less likely to be cured, and the hypothesis that is being tested is that perhaps by switching to something like BEACOPP, a much more intensive regimen, you can still cure the patients that would have been destined to fail, had they got continued ABVD. These are important questions. There is no definite answer yet. Some early data is being presented here at Lugano. I think if you have a choice, it would be better to enter a patient in a clinical trial than it would be to apply this idea in routine practice, but it is something that is likely to really change the future. Now, the last thing I said was the ABVD-BEACOPP debate. That is really the two regimens that are dominant nowadays. If you are a German oncologist, you should give BEACOPP to almost everybody except the best rest early-stage patients. Americans usually give ABVD to everybody and try to salvage those that fail with a bone marrow transplant. Of course, there is an Italian study that suggests that the ultimate outcome is not significantly different with that approach from giving them ABVD all the way through. Data, including data presented here, that addresses the issue of identifying those patients that should get BEACOPP from the outset and take the higher risk that go with that more intensive regimen and those for whom ABVD is easier to give and less risky initial regimen and then transplant if they fail is an equally good outcome. The issue remains unsolved. There are some patients almost certainly as you give BEACOPP, I personally administered it to younger patients with very high-risk disease, but where that line belongs, I think, is not absolutely certain and both data from here and data that you will be seeing over the next few years will hopefully help resolve this question for us. I want to thank you for paying attention. I hope you enjoyed this information and that you will take the time to view other highlights from this year's ICML, International Conference on Malignant Lymphoma, that occurs every other year in Lugano, Switzerland. Thank you.