Managing Hodgkin Lymphoma Expert Interview Series

An Update on the Current State of Hodgkin Lymphoma Care in Argentina

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Editor's Note:
The treatment of patients with Hodgkin lymphoma (HL) is one of the major success stories in oncology. Currently between 70–90% of treatment-naïve patients are cured of their malignancy depending on clinical stage and risk factors.[1] In patients with refractory or relapsed disease, high-dose chemotherapy (HDCT) followed by autologous hematopoietic stem cell transplant (HSCT) is the standard of care, and can lead to a cure in ~50% of patients.[2] However, current combined modality treatment regimens for first diagnosed HL patients can induce severe, life-threatening treatment-related side effects, which include secondary cancers and cardiovascular disease. Despite success in both treatment-naïve patients and patients with refractory or relapsed disease, new treatment options are needed. On behalf of *ManagingHodgkinLymphoma.com* (MHLC), George Davatelis, PhD, spoke with Astrid Pavlovsky, MD, from the Clinical Research Center – FUNDALEU and medical director of the Pavlovsky Center for Hematology in Buenos Aires, Argentina, to discuss the current challenges and opportunities in HL care in South America.

MHLC: *Let's start off by talking about the standard of care in Argentina specifically, and in South America in general. Can you tell us a little bit about the standard of care?*

Dr. Astrid Pavlovsky: I think the standard of care in Argentina and in the rest of South America is not very different from the rest of the world. We are treating patients with ABVD (Adriamycin, bleomycin, vinblastine and dacarbazine).[3] It is our first choice both for localized stage and advanced stage, and we follow the same protocols as most of the world does. We are now introducing PET-CT (positron emission tomography–computed tomography)[4] scans in most of our patients. For salvage therapy, we are using ICE (ifosfamide, carboplatin, etoposide) or ESHAP (etoposide, methylprednisolone, cytarabine (Ara-C), cisplatin (platinum))[5] or gemcitabine-based regimens and going on to stem cell transplant after that in case there is response.

MHLC: *What do you see as the biggest treatment challenges in Hodgkin's in Argentina, and are the challenges that you face different from the US or the EU?*

Dr. Astrid Pavlovsky: First of all, Argentina is a very large country, and health care system is not the same all over. I live in Buenos Aires which is the capital city, and we have a lot more resources than the rest of the country, and unfortunately, the medicine is not the same all throughout the country. The first challenge we face is to have a quick and correct diagnosis, the time from the first visit until we have the diagnosis might be longer than in developed countries. Also, we do not have as many specialized pathologists in hematology as in other places. So, one big challenge is to have a correct diagnosis with all the necessary imunohistochemistry. There is no big problem in getting the drugs, but again, there might be some problems in obtaining a PET scan. So getting PET scan at the time that is necessary and getting the radiotherapy at the time is necessary, and respecting times to make treatment more effective can be a difference between Buenos Aires and the rest of the country.

MHLC: *What do you see as some possible opportunities that are happening now in Argentina specifically or South America in the treatment of Hodgkin's?*

Dr. Astrid Pavlovsky: I think knowledge is a good opportunity. To be able to know what is going on around the world and to know what the new clinical trials are showing us, and to know what other cooperative groups are doing, and to be able to go to international meetings, that is an opportunity. We have to know that we are doing what is right, and we are learning from other cooperative groups, from other big international groups that are showing us their results. I think that with the internet and with all of the big journals being available online, we have the opportunity to do medicine as well as in any other country.

MHLC: *You are part of a group called the GATLA, which is a cooperative group throughout Argentina. Could you tell us a little bit about this group?*

Dr. Astrid Pavlovsky: Yes. The letters GATLA stand for the Argentinean Group for the Treatment of Acute Leukemia and is a big national group that started almost 50 years ago studying a group of patients with acute leukemia. Throughout the years, more people have become part of it, and today, it is a cooperative group which is now very active in Hodgkin lymphoma, non-Hodgkin lymphoma, and also in acute leukemia. It is the only national group we have, and it has quite a lot of publications in many recognized journals, and we are working hard on a new clinical trial for Hodgkin lymphoma that was started in 2005, and it is a group that really believes in working together as a country.

MHLC: *We know that approximately 80% of Hodgkin patients are actually cured using the standard of care, but the treatment side effects are becoming a very major issue. Can you tell us little bit about what your thinking is as far as addressing the concerns of the treatment-related side effects?*

Dr. Astrid Pavlovsky: I think this is something very important. As you said, we know that most patients with Hodgkin lymphoma are cured, and the median age of presentation of this disease is about 32 to 33 years old. So, if we are looking at these patients 10 years after their diagnosis, we are still having very young patients, so we cannot neglect the effect of the treatment on late toxicities on long-term survivals. The mortality for Hodgkin disease is very low, but after 6 or 7 years, we start seeing young patients dying of secondary malignancies or of complications both from radiotherapy or chemotherapy. So, I think that we are all trying to keep up this very good rate of overall survival but trying to see if we can do this while lowering the toxicity and trying to adapt therapy to each patient.

MHLC: *You are currently involved a clinical trial of assessing PET and CT adapted treatment after 3 cycles of ABVD. Can you give us a little information about this trial, and if there is any interim data that has come out so far?*

Dr. Astrid Pavlovsky: Yes. This trial was started in 2005. All patients, both localized and advanced stage receive ABVD for 3 cycles and are re-evaluated after the third cycle with a PET scan. If PET scan is negative, we stop therapy, considering the patient in complete remission. Patients who still have hypermetabolic lesions but had a good response after ABVD will continue with ABVD and have radiotherapy on these hypermetabolic lesions, and if we find patients—about 7% of patients—who do not respond to 3 cycles of ABVD, those patients will go on to salvage therapy. We have more than 350 patients in this trial—40% are advanced stage—and what we see after more than 5 years' follow up is that the event-free survival for PET negative patients is over 80%, both for localized stage and advanced stage, with overall survival for all of these patients between 96% and 99%. So, we are having the same efficacy with less treatment.

MHLC: *What are your thoughts on some of the new agents that are currently in development or have recently been approved?*

Dr. Astrid Pavlovsky: Well, the antibody-drug conjugate brentuximab vedotin has been the main advance in Hodgkin lymphoma after so many years of having only ABVD or other traditional protocols. So this is something, but brentuximab has not yet arrived to Argentina. We do have some experience in our group, but most of the experience is in Europe and the US, and this drug has really shown an advance in Hodgkin disease. I

think the future will be to try to incorporate this promising drug into first-line therapy and probably reduce chemotherapy to obtain the same efficacy and with less toxicity.

MHLC: *We are suddenly seeing older patients being diagnosed with Hodgkin's; what is your opinion about how physicians should treat these elderly patients?*

Dr. Astrid Pavlovsky: We are seeing elderly people with lymphoma, and age is a bad prognosis for Hodgkin lymphoma and the ability to tolerate treatment. ABVD is a very well-tolerated treatment, but in elderly, it can become a problem. Each elderly patient has to be looked at personally, you know not only age is important, also all the comorbidities, we should use one of the different scales we have regarding comorbidities and their risks regarding treatment. In the future we might start this group of patients with brentuximab vedotin to see if we can reduce the cycles of chemotherapy.

MHCL: *My final question is around the educational need that you see for clinicians in your country. What would be the first couple of things that you think they would need to learn about?*

Dr. Astrid Pavlovsky: Well, as I said before, I think there is a need for pathologists to become more specialized in hematopathology. I think the correct diagnosis is still a problem. I also think we need education on a correct interpretation of the results of a PET scan. It is not so easy, especially when we are doing interim PET or final PET to decide whether the PET is negative or positive, and what decisions we are going to take. Finally, most patients will do very well with first-line therapy, but there are groups of patients who will relapse. Relapsed/refractory HL is a big challenge, so we also need education on salvage therapies. And we now have this new drug brentuximab which will come into the country, so we need to see when the best time to use it is.

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