Managing Hodgkin Lymphoma Expert Interview Series

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

George Davatelis, PhD – Moderator/Writer
with
Claudia Shanley, MD
Hematologist
Department of Hematology and Bone Marrow Transplantation
Unit of the British Hospital of Buenos Aires
Buenos Aires, Argentina

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 Claudia Shanley, MD, a hematologist from the Department of Hematology and Bone Marrow Transplantation Unit of the British Hospital of Buenos Aires, Argentina, to discuss the current challenges and opportunities in HL care in South America.

MHLC: *Could you tell us a little bit about the standard of care for Hodgkin lymphoma in Argentina specifically, and in South America in general?*

Dr. Shanley: Yes. In mostly all urban centers in Argentina, we practically work the same. We have standards that we follow; such as the NCCN guidelines, international practices and national approaches. The approach for the treatment of Hodgkin's lymphoma patients depends on the clinical stage (defined by the Ann Arbor staging system with Costwolds modification) and the risk factors. We divide the patients into early stage favorable prognostic features Hodgkin lymphoma, early stage unfavorable prognostic features Hodgkin lymphoma, and advanced disease. As a general rule, for patients with early stage Hodgkin favorable disease (stages I or II disease without risk factors), we treat them with combined modality therapy comprised of chemotherapy: AVBD (Adriamycin, bleomycin, vinblastine and dacarbazine),[3] for 2 or 3 cycles plus involved-

field radiotherapy. For patients with early stage unfavorable Hodgkin lymphoma (stages I or IIA and some IIB with more than one risk factors), we treat them with ABVD for 6 cycles plus involved-field radiotherapy. For advanced stage—that means clinical stage III or IV—we treat them with 3 ABVD cycles, and depending on CT scan or PET/CT[4] results, continue with 3 more cycles.

MHLC: *What do you see as challenges in treating Hodgkin lymphoma in Argentina, and how do you think those challenges might differ in other regions of the world?*

Dr. Shanley: The diagnosis, staging, and treatment of Hodgkin lymphoma patients in the big cities of Argentina do not differ from other regions of the world. Unfortunately, we lack experienced pathologists in some areas of our country. The challenge in this area is to get an excisional biopsy and evaluate the architecture of the lymph node to make an accurate diagnosis. The screening for cell surface markers such as CD30 is also important for the diagnosis. When we receive patients from other centers with the diagnosis of Hodgkin lymphoma, we always try to review the biopsy before making a treatment decision. Another difficulty that we sometimes have is the time that it takes from the first symptoms until the patients have the diagnosis, resulting in an advanced disease or with typical systemic symptoms at presentation. We perform CT scan in every patient, but not everybody has the opportunity to make a PET/CT scan at diagnosis. If we have the possibility to make only one PET/CTscan, we prefer to do it to evaluate the response to treatment and not to do it at diagnosis.

MHLC: *We had done an interview with Dr. Astrid Pavlovsky, and she was talking about the differences between the urban centers like Buenos Aires and the rest of the country. What do you feel are the major differences there?*

Dr. Shanley: Yes, that is true. Unfortunately we do not have the same kind of capabilities in all of the country. We usually receive referred patients from hematologists that live away from the big cities, and the major differences are based on the accurate diagnosis and staging.

MHLC: *We talked about the challenges that you see. What about opportunities for treating Hodgkin lymphoma in Argentina?*

Dr. Shanley: I think that there are more opportunities nowadays that we have not had before, and we have access to many drugs that before we did not. We participate in international meetings and we have the opportunity for second opinions with experts in difficult patients, but there is still an unmet need for relapse/refractory patients.

MHLC: *We know of a cooperative group in your country called GATLA. Do you know the group, and if so, can you tell us a little bit about it?*

Dr. Shanley: Yes. GATLA means Argentine Group for Treatment of Acute Leukemia. It is a cooperative group for treatment of hematological diseases, not only leukemias, but also Hodgkin and non-Hodgkin lymphomas. It is a serious group with members of different areas of the country. They have their own protocols, they have considerable experience, and they publish a lot.

MHLC: *We know that approximately 80% of Hodgkin patients are cured using the standard of care, but the treatment-related side effects has become a major issue these days. Can you tell us your latest thinking on addressing these adverse treatment-related events?*

Dr. Shanley: The treatment of Hodgkin lymphoma has evolved successfully and the goal of treatment is focused on maintaining efficacy while reducing toxicity. I think that it is extremely important to closely follow-up the patients. This has to be done regularly in order to detect treatment-related toxicity. We make follow-up visits that include physical exam, labs with thyroid function, and cancer screening not only if the patient has received radiotherapy just in order to prevent breast cancer or thyroid cancer but also search for second malignancies. It is also important to control heart and lung function.

MHLC: *There are a lot of new agents that are currently in development or recently approved. Could you give us an overview of some of these drugs that you are familiar with, and give us your assessment of them?*

Dr. Shanley: Despite the high cure rate with initial therapy, some patients are refractory or relapse after initial complete remission, and the standard of care for this patients is high-dose chemotherapy and autologous stem cell transplantation. For patients who relapse post-autologous stem cell transplantation, new drugs are needed. Brentuximab vedotin, bendamustine, everolimus, histone deacetylase inhibitors, have shown promising results. I have had little experience with the antibody drug conjugate brentuximab vedotin. I have treated five relapsed/refractory patients, all of them as compassionate treatment, because we do not have the drug in our country yet. The first two patients completed 16 doses of treatment, they did very well while they received the treatment, without significant side effects, but progressed after it. We could not use it as a bridge to an allogeneic bone marrow transplantation. Two other patients that are still alive lost the response with brentuximab, and afterwards received bendamustine, with partial response. The fifth one died promptly, not related to the drug, nor to progressive disease.

MHLC: *Most of the new drugs coming out, and especially brentuximab, are relegated to either second-line or third-line salvage therapy. What do you think of using a drug like brentuximab early on, maybe even on a first-line basis?*

Dr. Shanley: Yes. I think that it will be great using it as first-line, in combination with ABVD or AVD (because of the pulmonary toxicity). We are seeing more young refractory and relapsed patients, so we need to offer something else to this population.

MHLC: *When do you think brentuximab will be approved in Argentina?*

Dr. Shanley: I do not really know because it depends on the national economic politics. Once a drug is approved by the FDA, it is easier for our local regulatory bureau to approve it, but I do not know how long it will take. I hope that perhaps by next year it will available, because we have a lot of patients that can benefit with that drug.

MHLC:*Demographic changes are resulting in a higher number of older patients being diagnosed with Hodgkin lymphoma. With this changing demographic, how do you think doctors should treat elderly patients, both in Argentina and in the rest of South America?*

Dr. Shanley: It depends on the comorbidities the patients have. The risk of toxicity of the treatment is high, and elderly patients do not tolerate full doses of chemotherapy. I think that if the patient has no comorbidities, we must try to offer a potentially curative treatment, adjusting dose to each particular patient and modifying according to evolution. I think that aggressive treatments like BEACOPP are not recommended for elderly patients, and prognostic factors are very important in making decisions in these population. A balance between treatment benefit and quality of life is mandatory.

MHLC:*What do you believe are the key educational needs of the physicians in your country and the rest of South America?*

Dr. Shanley: I think that we need a network of pathologists for training because it is important to make a good diagnosis. Most hematologists in our country belong to the Argentine Society of Hematology, and our national guidelines are determined by its members. I think that maintaining updating these guidelines is very important for all the physicians in our country because they are adapted to our local necessities. I think that perhaps making clinical research in some aggressive diseases or in relapsed/refractory patients with new agents would also help. We need a national and reliable registry of the disease, because we lack national statistics on Hodgkin lymphoma.

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