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What are the challenges with autologous transplant in treating Hodgkin lymphoma refractory disease?

Hello. My name is Bastian von Tresckow. I am a trial physician of the German Hodgkin Study Group, and I am specializing in relapsed and refractory disease. In daily practice, I am commonly asked the following question, “Despite the advances in the treatment of Hodgkin lymphoma, patients with refractory disease still have poor prognosis. What are the challenges with autologous transplant where there is brentuximab vedotin in treating the refractory disease; what other therapies may be considered?” Well, I think the best thing as always in medicine is to prevent relapsed or refractory disease, so that is why I think the upfront therapy should be the best available and the most effective therapy. The German Hodgkin Study Group has recently shown that with 6 cycles of BEACOPP escalated for advanced-stage Hodgkin lymphoma, you get a progression-free survival of about 90% and overall survival of about 95%, so these are by far the best results that could ever be demonstrated. So I think you really should choose this regimen to avoid relapsed or refractory disease because once the patient has become refractory, the prognosis dramatically worsens and there are less and less possibilities to break refractory disease. If you have a refractory patient after first-line, one option is the tandem transplant, double autologous transplant. This has been reported in the H96 trial by Morschhauser and colleagues in the JCO 2008, and we recently got the 10-year followup of this trial. If you cannot salvage a patient with an autologous transplant, of course brentuximab vedotin is the preferred therapy, and even for autologous transplant, you have to get the patient at least in a stable disease, so if conventional salvage like DHAP or ICE fails, we might consider brentuximab vedotin as salvage therapy to allow for autologous transplant.