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What are the important conclusions that practicing clinicians should be aware of in regards to the recent NCCN guidelines in HL?

Welcome to *Managing Hodgkin Lymphoma*. My name is Richard Hoppe. I am a professor of radiation oncology at the Stanford Cancer Center, and I specialize in the management of patients with lymphoma. I also chair the NCCN Hodgkin Lymphoma Guidelines committee. As we know, updates to the NCCN Guidelines on Hodgkin lymphoma were recently published, and as a result, I am frequently asked, "What are the important conclusions that practicing clinicians should be aware of?" Firstly, it is important to realize that the NCCN Guidelines go through a thorough annual re-evaluation, and that changes are made based upon published clinical trials and changes in practice patterns at NCCN institutions. One of the most important things for practicing oncologists is to realize that there are important choices for the patient being treated for favorable stage I or II Hodgkin lymphoma, that is management with combined modality therapy or management with chemotherapy alone. As background, it is important to know that clinical trials in general experience indicate that there will be about 5% to 7% difference in freedom from progression at 7 years favoring the combined modality approach, but differences in overall survival are not evident. Despite the differences in freedom from progression, and given the absence of differences in overall survival, the NCCN Guidelines incorporate options for treatment with chemotherapy alone for patients with stage 1 or 2 disease. So, how to choose? It is clearly not a situation of one size fits all. Given we live in a world of personalized medicine, it is appropriate to consider the patient's gender, age, and preferences. For example, a young woman with disease involving the mediastinum, supraclavicular, and ipsilateral axillary areas might be given the option of treatment with chemotherapy alone in order to avoid radiation exposure of the breast and the risk for secondary breast cancer despite the slightly higher risk for relapse. On the other hand, a 45-year-old man with the same disease distribution, the choice might be combined modality therapy in order to minimize the relapse risk and disruption to his life that would occur in the management of relapse which often includes a stem cell transplant. In any case, it is important to follow the eligibility criteria for these different treatment programs as detailed in the guidelines. Most importantly, treatment with chemotherapy alone is not appropriate for patients with large mediastinal adenopathy or B symptoms. Patients with large mediastinal adenopathy should all be treated with combined modality therapy until current clinical trials have completed testing programs of chemotherapy alone. Thank you for viewing this activity. For additional resources, please view the other educational activities on *ManagingHodgkinLymphoma.com.*