Managing Hodgkin Lymphoma

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What are the requirements for the diagnosis, staging, and risk stratification for patients with Hodgkin lymphoma?

Hello! My name is Andrew Zelenetz. I am vice chair of medicine at Memorial Sloan-Kettering Cancer Center, and I am frequently asked, "What are the requirements for the diagnosis, staging, and risk stratification for patients with Hodgkin lymphoma?" So, one of the problems that faces us today is really understanding and obtaining an accurate diagnosis, and the reason this is becoming increasingly a challenge is many clinicians have turned to smaller and smaller biopsies for the initial diagnosis. I strongly discourage this practice, obtaining an adequate tissue biopsy with either incisional or excisional lymph node biopsy is far superior to the information that can be obtained from a core needle biopsy because the cornerstone of good treatment is an accurate diagnosis. Once we have established a proper diagnosis of Hodgkin lymphoma, there are some questions about the pathology that can influence outcome such as expression of CD20 by the Reed-Sternberg cell. This is a controversial point with data saying it could be adverse and other data saying it could be favorable. Also, the infiltration of tumor-associated macrophages has been associated with a poor outcome, but this again has been validated in some studies and failed to be validated in others. It turns out that the International Prognostic Score is one of the most valuable tools that we have. This is a 7-point scale, and patients with three or fewer factors actually have very good favorable outcomes. Patients with four more factors will have an inferior outcome and generally can be considered potentially for more aggressive upfront treatment such as escalated BEACOPP. The other role and risk stratification is the role of interim PET scanning. There is important data from a Italian and Danish study suggesting that in advanced-stage Hodgkin lymphoma, the result of the PET scan after two cycles of ABVD is highly predictive of long-term outcome and actually trumps the International Prognostic Score. Similar data has been published by Dr. Zanazzi for early stage disease suggesting again that the PET-2 result is predictive of long-term outcome. Randy Gascoyne and the group in Vancouver recently published a genetic prognostic index based on gene expression profiling from paraffin using a technology called NanoString identifying about 25% of patients with a poor outcome, and this, if validated, could actually provide a very valuable tool to help identify the poor-risk patients very early in treatment, and maybe a selection of those patients for more aggressive approaches such as escalated BEACOPP rather than standard ABVD chemotherapy. And with that, I would like to thank you for your attention.