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Brentuximab vedotin is certainly in Hodgkin lymphoma, the flavor of the month as far as new treatments go. It is really exciting. It is an immunotoxin that is really active. If you have seen the data from the first studies presented as a waterfall plot where you look at what the tumor volume did after treatment, essentially everybody has a shrinkage, and a high proportion have an objective response, that is have a 50% shrinkage, and some have a complete response even with advanced refractory disease. It is an incredibly active drug, and so its place right now is, I think, in patients who recur, and it is a way to get people to transplant with minimal toxicity, that is, it is relatively easy to give, neuropathies are the biggest nuisance in administrating it, and it is so active you can often induce remissions in patients and allow them to have a transplant when they either would not be even able to have it or they would have gotten there in a more difficult way. The drug is actually approved for people who failed transplant, and in that setting, it is a wonderful drug to make people well again, but it does not cure very many people. We actually do not know how many, maybe some but not very many, time will tell what proportion. The real thing you would like to do with the drug is if it is so active is to give it upfront, and right now, people are trying to figure out how to do that. There was discussion at this meeting of, in very favorable patients, perhaps skipping ABVD completely and just giving brentuximab vedotin to a PET-negative remission and then give radiotherapy. Interesting idea. There has been an effort to try to incorporate it into ABVD, and to do that you have to get rid of the bleomycin because it turns out, there is overlapping pulmonary toxicity, and there is an effort to try to find a way to incorporate it into BEACOPP. But if the patient can get it, it helps everybody from people with end-stage disease to hopefully, eventually either making it easier to cure them or maybe even increasing the cure rate in certain subgroups of patients. It is an exciting drug.

When patients with brentuximab vedotin get peripheral neuropathy, which is not rare at all, and if you give enough of it most patients do, you can either sometimes skip or delay a dose or you can reduce the dose, both of which might help. Sometimes, you have to stop the drug according to how severe the neuropathy is, but occasionally it limits your ability to treat the patients. Most of the time, you can find way around it.