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≠ Pathology
ß Internal medicine
¥ Patient Advocacy
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NCCN Guidelines Panel Disclosures

Continue
# Table of Contents

NCCN Hodgkin Disease/Lymphoma Panel Members  
Summary of Guidelines Updates  
Diagnosis and Workup (HODG-1)  
Primary Treatment  
- Classical Hodgkin Lymphoma:  
  - CS IA-IIA Favorable (HODG-2)  
  - CS I-II Unfavorable (HODG-3)  
  - CS III-IV (HODG-4)  
- Lymphocyte-predominant Hodgkin Lymphoma:  
  - CS IA-IIA (HODG-6)  
  - CS IB-IIB (HODG-6)  
  - CS IIIA-IVA (HODG-6)  
  - CS IIIB-IVB (HODG-6)  
Follow-up After Completion of Treatment and Monitoring For Late Effects (HODG-7)  
Relapse (HODG-8)  
Unfavorable Factors (localized and advanced disease) (HODG-A)  
Principles of Chemotherapy (HODG-B)  
Principles of Radiation Therapy (HODG-C)  
Revised Response Criteria (HODG-D)  
Principles of Second-line Chemotherapy (HODG-E)  

Guideline Index  
Print the Hodgkin Disease/Lymphoma Guidelines  

These guidelines are a statement of evidence and consensus of the authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult these guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment. The National Comprehensive Cancer Network makes no representations nor warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way. These guidelines are copyrighted by National Comprehensive Cancer Network. All rights reserved. These guidelines and the illustrations herein may not be reproduced in any form without the express written permission of NCCN. ©2009.
Summary of the Guidelines updates

The 2.2009 version of the Hodgkin Disease/Lymphoma represents the addition of the Discussion section correspondent to the changes in the algorithm. There was also a correction on page HODG-6 for stage IB-IIB, chemotherapy was added to the recommendation of IFRT.

Summary of changes in the 1.2009 version of the Hodgkin Disease/Lymphoma guidelines from the 2.2008 version include:

**HODG-1**
- Diagnostic was added to chest/abdominal/pelvic CT.
- PET scan replaced with PET-CT.
- IVF or ovarian tissue or oocyte cryopreservation added to “Useful in selected cases”.
- “Favorable” and “Unfavorable” replaced “nonbulky” and “bulky” in the clinical staging definitions. Due to this change stage IB-IIB nonbulky are now included with the category of stage I-II unfavorable.
- Footnote “b” is new to the page to clarify that a diagnostic CT is not needed, if an integrated PET-CT was performed.
- The factors of ESR >50, >3 sites of disease, and >1 extranodal site were added to footnote “g”.

**HODG-2**
- Footnote “k” is new to the page “Interim PET scan after 2-4 cycles has increasingly shown to have a role in management and prognosis. Further management may include IFRT, biopsy, or change in chemotherapy.”
- The option of “Observe” was added for patients with non-bulky disease in CR following 2 additional cycles.

**HODG-3**
- Footnote “p” is new to the page “The Stanford V regimen is used in this fashion for patients with bulky mediastinal disease or B symptoms. Patients with other “unfavorable” factors are not treated on this protocol.”

**HODG-6**
- For CS I-IIB LP HL, the recommendation for chemotherapy in the combination of chemotherapy + IFRT was deleted.
- PET-CT was removed from restaging, unlike CHL, most LP HL are overstaged due to PET positivity.

**HODG-7**
- Monitoring for Late Effects after 5 Years
  - Aggressive management of cardiovascular risk factors was added to the annual physical history and physical.
  - Annual mammographic/breast MRI screening was changed to annual breast screening.
  - To increase the awareness of the need to be alert for cardiovascular complications, “Cardiovascular symptoms may emerge at an earlier age” was added.
  - The recommendation for a “treatment summary and consideration of transfer to PCP” was also added.
  - The sentence “There are few data to support specific recommendations, these represent the range of practice at NCCN institutions” was added to footnote “z”.

**HODG-8**
- “At relapse, patient should be considered for re-biopsy because of risk for transformation” was added to footnote “dd”.
- “In a radiation naive patient, TLI may be an appropriate component of HDT” was added to footnote “gg”.

**HODG-A**
- A new table was added with examples of unfavorable risk factors for stage I-II Hodgkin disease according to major clinical trials groups.

**HODG-B 1 of 3**
- The following was added, “Routine use of growth factors is not recommended. Leukopenia is not a factor for delay of treatment or reduction of dose intensity.”

**HODG-E**
- C-MOPP (cyclophosphamide, vincristine, procarbazine, prednisone), CHIVPP (Chlorambucil, vinblastine, procarbazine, prednisone) were added to the examples of second-line chemotherapy regimens.
**DIAGNOSIS**

- Excisional biopsy (recommended)
- Core needle biopsy may be adequate if diagnostic
- FNA alone is insufficient
- Immunohistochemistry highly recommended for Hodgkin lymphoma
- For typical classical Hodgkin lymphoma, recommend CD3, CD15, CD20, CD30, CD45a
- For lymphocyte-predominant Hodgkin lymphoma, recommend CD3, CD15, CD20, CD21, CD30, CD57a

**WORKUP**

- H&P including:
  - B symptoms
  - Alcohol intolerance
  - Pruritus
  - Fatigue
  - Performance status
  - Exam lymphoid regions, spleen, liver
- CBC, differential, platelets
- Erythrocyte sedimentation rate (ESR)
- LDH, LFT, albumin
- BUN, creatinine
- Pregnancy test: women of childbearing age
- Chest x-ray
- Diagnostic chest/abdominal/pelvic CT
- PET-CT scan
- Adequate bone marrow biopsy in stage IB-IIIB and stage III-IV
- Counseling: Fertility, smoking cessation, psychosocial (see NCCN Distress Management Guidelines)

**Useful in selected cases:**

- Semen cryopreservation, if chemotherapy or pelvic RT contemplated
- IVF or ovarian tissue or oocyte cryopreservation
- Neck CT, if neck RT planned
- Pneumococcal, H-flu, meningococcal vaccines, if splenic RT contemplated
- HIV, if risk factors, unusual disease presentations
- Evaluation of ejection fraction
- Pulmonary functions tests (PFTs), Diffusion capacity of the lungs for carbon monoxide (DLCO)
- Semen cryopreservation, if chemotherapy or pelvic RT contemplated
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- HIV, if risk factors, unusual disease presentations
- Evaluation of ejection fraction
- Pulmonary functions tests (PFTs), Diffusion capacity of the lungs for carbon monoxide (DLCO)

**CLINICAL STAGING**

- Stage IA-IIA Favorable
- Stage I-II Unfavorable
- Stage III-IV

- Classical Hodgkin lymphoma
- Lymphocyte-predominant Hodgkin lymphoma (LPHL)

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**Note:** All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
CLINICAL PRESENTATION:
Classical Hodgkin lymphoma\textsuperscript{d}

PRIMARY TREATMENT\textsuperscript{i}

- **Chemotherapy\textsuperscript{j,k} + involved-field RT\textsuperscript{l} (IFRT) (category 1)\textsuperscript{m} → Restage after chemotherapy with PET-CT\textsuperscript{n}
- **Complete response (CR)\textsuperscript{o} → **Complete IFRT (if part of initial plan) → Observe → See Follow-up HODG-7
- **Partial response (PR)\textsuperscript{o} → **IFRT
  - **Positive → **See Progressive Disease or Relapse HODG-8
  - **Negative → **IFRT
    - **Positive → **See Progressive Disease or Relapse HODG-8
    - **Negative → **See Follow-up HODG-7
- **Biopsy → **See Progressive Disease or Relapse HODG-8

**Stage IA-IIB Favorable**

- **or**
  - **ABVD\textsuperscript{j} x 4 cycles\textsuperscript{k} (category 2B) → Restage after chemotherapy with PET-CT\textsuperscript{n}
  - **Stable (PET positive) or progressive disease\textsuperscript{o} → **Biopsy

\textsuperscript{d}Classical Hodgkin lymphoma (HL) includes nodular sclerosis (NSHL), mixed cellularity (MCHL), lymphocyte-depleted (LDHL) and lymphocyte-rich (LRHL).

\textsuperscript{i}Individualized treatment may be necessary for older patients and patients with concomitant disease.

\textsuperscript{j}See Principles of Chemotherapy (HODG-B).

\textsuperscript{k}Interim PET scan after 2-4 cycles has increasingly shown to have a role in management and prognosis. Further management may include IFRT, biopsy, or change in chemotherapy.

\textsuperscript{l}See Principles of Radiation Therapy (HODG-C).

\textsuperscript{m}Depending upon co-morbidities, subtotal lymphoid irradiation (category 1) or mantle alone may be considered for patients not able to tolerate chemotherapy.

\textsuperscript{n}An integrated PET-CT or a PET with a diagnostic CT is recommended.

\textsuperscript{o}See Revised Response Criteria for Lymphoma (HODG-D).

**Note:** All recommendations are category 2A unless otherwise indicated.

**Clinical Trials:** NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
**CLINICAL PRESENTATION:**  
Classical Hodgkin lymphoma

**PRIMARY TREATMENT:**

- **CR**: 2 additional cycles or IFRT (category 2B)  
  - PET Negative: Consolidative RT  
  - PET Positive: Biopsy  
  - See Follow-up HODG-7

- **PR**: Restage with PET-CT
  - Observation
  - IFRT (if bulky)  
  - See Follow-up HODG-7

- **Stable (PET positive) or progressive disease**: Biopsy  
  - See Progressive Disease or Relapse HODG-8

- **Non-progressive disease**: Restage after chemotherapy with PET-CT
  - RT to initial sites > 5 cm and residual PET positive sites (36 Gy begins optimally within 3 weeks)  
  - Follow-up, if progressive disease, see below

- **Progressive disease**: Biopsy  
  - See Progressive Disease or Relapse HODG-8

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### Notes:
- All recommendations are category 2A unless otherwise indicated.
- Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

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**Definitions:**
- Classical Hodgkin lymphoma (HL) includes nodular sclerosis (NSH), mixed cellularity (MCHL), lymphocyte-depleted (LDH) and lymphocyte-rich (LRH).
- Bulky mediastinal disease: B symptoms, ESR >50, >3 sites of disease, >1 extranodal site (see Unfavorable Factors, HODG-A).
- Individualized treatment may be necessary for older patients and patients with concomitant disease.
- See Principles of Chemotherapy (HODG-B).
- Interim PET scan after 2-4 cycles has increasingly shown to have a role in management and prognosis. Further management may include IFRT, biopsy, or change in chemotherapy.

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**References:**
- See Principles of Radiation Therapy (HODG-C).
- An integrated PET-CT or a PET with a diagnostic CT is recommended.  
  - See Revised Response Criteria for Lymphoma (HODG-D).
- The Stanford V regimen is used in this fashion for patients with bulky mediastinal disease or B symptoms. Patients with other “unfavorable” factors are not treated on this protocol.
- May include patients with residual PET positive sites.
- See Unfavorable Factors HODG-A.
- Do not add two additional cycles of ABVD.
CLINICAL PRESENTATION: Classical Hodgkin lymphoma\textsuperscript{d}

Primary Treatment

Stage III-IV

- ABVD\textsuperscript{j} x 4 cycles
- Stanford V\textsuperscript{j} x 3 cycles or 12 weeks
- Escalated BEACOPP (especially if IPS \textgeq 4)\textsuperscript{t}

\textsuperscript{d}Classical Hodgkin lymphoma (HL) includes nodular sclerosis (NSHL), mixed cellularity (MCHL), lymphocyte-depleted (LDHL) and lymphocyte-rich (LRHL).

\textsuperscript{t}Individualized treatment may be necessary for older patients and patients with concomitant disease.

- Restage after chemotherapy with PET-CT\textsuperscript{n}
- Progressive disease\textsuperscript{o}
- Biopsy

\textsuperscript{n}An integrated PET-CT or a PET with a diagnostic CT is recommended.

\textsuperscript{o}See Revised Response Criteria for Lymphoma (HODG-D).

See HODG-3

Diagnosis

CR\textsuperscript{o} \rightarrow 2 additional cycles

- Observe or IFRT\textsuperscript{l} (especially for initial bulky disease)\textsuperscript{r}
- PET positive\textsuperscript{u}
- PET negative\textsuperscript{u}

- Biopsy → Biopsy
- HDT/ASCR\textsuperscript{v,w}

\textsuperscript{r}See Unfavorable Factors HODG-A.

\textsuperscript{u}If there is bulky mediastinal disease on CT after 6 cycles of ABVD, consolidative RT to mediastinum recommended. It is not known in the context of PET negative whether the outcomes will be altered.

\textsuperscript{v}RT to residual disease pre or posttransplant.

\textsuperscript{w}Allotransplant is an option in select patients as a category 3.

See Follow-up HODG-7

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
CLINICAL PRESENTATION:
Classical Hodgkin lymphoma
Stage III-IV

PRIMARY TREATMENT (continued from HODG-4)

Escalated BEACOPP x 4 cycles (IPS ≥ 4)

Restage with PET-CT

CR

Restage with PET-CT

4 cycles of baseline BEACOPP

RT to initial sites > 5 cm

Observe

See Follow-up HODG-7

PR

4 cycles escalated BEACOPP

Restage with PET-CT

PET Negative

RT to initial sites > 5 cm

PET Positive

Biopsy → HDT/ASCR

or

RT to initial sites > 5 cm and residual PET positive sites

HDT/ASCR

See Follow-up HODG-7

Progressive disease

Biopsy → HDT/ASCR

Note: All recommendations are category 2A unless otherwise indicated.

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[d]Classical Hodgkin lymphoma (HL) includes nodular sclerosis (NSHL), mixed cellularity (MCHL), lymphocyte-depleted (LDHL) and lymphocyte-rich (LRHL).

[i]Individualized treatment may be necessary for older patients and patients with concomitant disease.


[k]See Principles of Radiation Therapy (HODG-C).

[n]An integrated PET-CT or a PET with a diagnostic CT is recommended.


[m]RT to residual disease pre or posttransplant.

[w]Allotransplant is an option in select patients as a category 3.
CLINICAL PRESENTATION:
Lymphocyte-predominant Hodgkin lymphoma

PRIMARY TREATMENT

CS I-IIA  →  IFRT or regional RT

CS I-IIBx  →  Chemotherapy followed by IFRT

CS III-IVA  →  Chemotherapy ± RT

CS III-IVB  →  Chemotherapy ± RT

CR → Observe

< CR → Restage

Observe, if asymptomatic or Chemotherapy (See HODG-8)

Observe, if asymptomatic or Chemotherapy or RT (See HODG-8)

Observe, if asymptomatic or Chemotherapy or RT

Restage

See Follow-up HODG-7

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

See Revised Response Criteria for Lymphoma (HODG-D).

xFor the rare patient with stage I-II who has B symptoms, combined modality therapy with chemotherapy and IFRT is recommended.

ySee Principles of Chemotherapy (HODG-B 3 of 3).
**FOLLOW-UP AFTER COMPLETION OF TREATMENT AND MONITORING FOR LATE EFFECTS**

It is recommended that the patient be provided with a treatment summary at the completion of his/her therapy. Follow-up with an oncologist is recommended especially during the first 5 y interval to detect recurrence, then annually due to the risk of late complications including second cancers and cardiovascular disease.\(^{aa,bb}\)

### Follow-up after completion of treatment

#### Interim H&P:
- Every 2-4 mo for 1-2 y, then every 3-6 mo for next 3-5 y
  - Consider annual influenza vaccine especially in high risk patients (eg, treated with chest RT, bleomycin)
- Laboratory studies:
  - CBC, platelets, ESR (if elevated at time of initial diagnosis), chemistry profile every 2-4 mo for 1-2 y, then every 3-6 mo for next 3-5 y
  - TSH at least annually if RT to neck
- Chest imaging:
  - Chest x-ray or CT every 6-12 mo during first 2-5 y

#### Abdominal/pelvic CT (category 2B):
- Every 6-12 mo for first 2-3 y
- Counseling:
  - Reproduction, health habits, psychosocial, cardiovascular, breast self-exam, skin cancer risk, end-of-treatment discussion.
  - Surveillance PET should not be done routinely due to risk for false positives. Management decisions should not be based on PET scan alone, clinical or pathological correlation is needed.

### Monitoring for Late Effects after 5 Years\(^{aa,bb}\)

#### Interim H&P: Annually
- Annual blood pressure, aggressive management of cardiovascular risk factors
- Consider baseline stress test/echocardiogram at 10 y
- Pneumococcal revaccination every 5-7 y, if patient treated with splenic RT or previous splenectomy
- Meningococcal + H-flu in selected cases
- Consider annual influenza vaccine especially in high risk patients (eg, treated with chest RT, bleomycin)
- Laboratory studies:
  - CBC, platelets, chemistry profile annually
  - TSH at least annually if RT to neck
  - Lipids
- Abdominal/pelvic CT (category 2B):
  - Every 6-12 mo for first 2-3 y
- Counseling:
  - Reproduction, health habits, psychosocial, cardiovascular, breast self-exam, skin cancer risk.
- Cardiovascular symptoms may emerge at an earlier age.
- Treatment summary and consideration of transfer to PCP.

#### Annual chest imaging (chest x-ray or chest CT) for patients at increased risk for lung cancer\(^{cc}\)

#### Annual breast screening:
- Initiate 8-10 y post-therapy, or at age 40, whichever comes first, if chest or axillary radiation. The American Cancer Society recommends breast MRI in addition to mammography for women who received irradiation to the chest between ages 10 and 30 y.
- Counseling:
  - Reproduction, health habits, psychosocial, cardiovascular, breast self-exam, skin cancer risk.
- Cardiovascular symptoms may emerge at an earlier age.
- Treatment summary and consideration of transfer to PCP.

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\(^{z}\)The frequency and types of tests may vary depending on clinical circumstances; age and stage at diagnosis, social habits, treatment modality, etc. There are few data to support specific recommendations, these represent the range of practice at NCCN institutions.


\(^{bb}\)Appropriate medical management should be instituted for any abnormalities.

\(^{cc}\)Chest imaging optional after 5 y if patient treated with a non-alkylating agent, no RT to the chest and no other risk factors are present.
CLASSICAL HODGKIN LYMPHOMA

PROGRESSIVE DISEASE OR RELAPSE

SECOND-LINE THERAPY

If primary therapy was chemotherapy alone or combination chemotherapy/RT
- Rebiopsy
- Restaging (same as initial work-up, including bone marrow biopsy)
- Consider marrow cytogenetics for MDS markers prior to transplant

If initial stage was IA-IIA:
- No prior RT and failure in initial sites only

Individualized treatment is recommended, options include:
- RT
- Non-cross resistant chemotherapy
- HDT/ASCR

HDT/ASCR (category 1) ± locoregional RT
- Non-cross resistant chemotherapy

All others

Treat as primary advanced stage Hodgkin lymphoma (See HODG-4)

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Only bulky disease is incorporated into the guideline algorithm for localized presentations, however the other factors are considered for assignment into some clinical trials.

PRINCIPLES OF CHEMOTHERAPY (1 of 3)

Classical Hodgkin Lymphoma

- The most common variants of chemotherapy used at NCCN member institutions include ABVD and Stanford V. Some institutions will use dose-escalated BEACOPP as an alternative regimen in selected cases for highly unfavorable, high-risk patients, usually with an International Prognostic Score (IPS) ≥ 4.
- Routine use of growth factors is not recommended. Leukopenia is not a factor for delay of treatment or reduction of dose intensity.
- Stage IA-IIB favorable
  - ABVD is generally administered for 4 cycles. Complete restaging takes place at completion of chemotherapy. Consolidative irradiation follows. In favorable patients, 2 cycles of ABVD followed by 30 Gy RT may be sufficient.
  - Stanford V chemotherapy for Stage I-II non-bulky disease is administered for 8 weeks (2 cycles). Complete restaging takes place at the completion of chemotherapy. Consolidative irradiation is optimally instituted within 3 wks (30 Gy to all involved fields).
- Stage I-II unfavorable (See HODG-A)
  - ABVD is generally administered for 4 cycles. Complete restaging takes place at the completion of chemotherapy. If the patient has achieved a CR or PR, two additional cycles of chemotherapy may be administered (maximum 6). Consolidative irradiation follows the completion of chemotherapy.
  - Stanford V chemotherapy is administered for 12 wks (3 cycles). Complete restaging takes place at the completion of chemotherapy. Consolidative irradiation is optimally instituted within 3 wks (36 Gy to initial sites > 5 cm and residual PET positive sites after chemotherapy).
- Stage III-IV
  - ABVD is generally administered for 6-8 cycles. Complete restaging takes place after 4 cycles of chemotherapy following which two additional cycles of chemotherapy are administered to patients who have achieved a CR or PR. Patients with bulky disease may have consolidative RT.
  - Stanford V chemotherapy is administered for 12 wks (3 cycles). Complete restaging takes place at the completion of chemotherapy. Consolidative irradiation is optimally instituted within 3 wks (For stage I-IIB, 30 Gy to initial sites; for Stage II-IV, 36 Gy to initial sites > 5 cm and spleen if focal nodules are present initially or residual PET positive sites).
  - BEACOPP (escalated dose) is administered every 3 wks. Complete restaging takes place at the end of 4 cycles and at the end of 8 cycles (completion of chemotherapy). This is followed by 30 Gy irradiation to initial sites > 5 cm and 40 Gy to residual PET positive sites.

See Principles of Chemotherapy for LPHL page HODG-B 3 of 3

See Principles of Second-line Chemotherapy page HODG-E


2 Favorable patients are defined as without the following clinical risk factors: Large mediastinal mass ≥ one-third of the maximum thorax diameter, extranodal disease, massive splenic involvement, high erythrocyte sedimentation rate (≥ 50 mm/h in asymptomatic patients or ≥ 30 mm/h in symptomatic patients, > 2 sites of disease)

**PRINCIPLES OF CHEMOTHERAPY (2 of 3)**

**Regimens and References**

**ABVD (Doxorubicin, Bleomycin, Vinblastine and Dacarbazine) plus radiation therapy**


**ABVD**


**Stanford V (Doxorubicin, vinblastine, mechlorethamine, etoposide, vincristine, bleomycin and prednisone)**


**BEACOPP (Bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine and prednisone)**


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**Note:** All recommendations are category 2A unless otherwise indicated. Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Lymphocyte-predominant Hodgkin Lymphoma

- The most common chemotherapies used at NCCN member institutions for LPHL include:
  - ABVD (doxorubicin, bleomycin, vinblastine, dacarbazine) ± rituximab
  - CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) ± rituximab
  - EPOCH (cyclophosphamide, doxorubicin, etoposide, vincristine, prednisone) ± rituximab
  - CVP (cyclophosphamide, vincristine, prednisone) ± rituximab
  - Single agent rituximab

Ongoing clinical trials will help to clarify the role of a watch-and-wait strategy or systemic therapy, including anthracycline (epirubicin or doxorubicin), bleomycin, and vinblastine-based chemotherapy or antibody-based approaches, in the treatment of these patients.


PRINCIPLES OF RADIATION THERAPY

COMBINED MODALITY-RT DOSES:

- Bulky disease sites (all stages)
  - If treated with ABVD: 30-36 Gy
  - If treated with Stanford V: 36 Gy
- Nonbulky disease (stage I-II)
  - If treated with ABVD: 30 Gy
  - If treated with Stanford V: 30 Gy
- Nonbulky disease (stage IB-IIB) and Bulky and nonbulky disease (stage III-IV)
  - If treated with BEACOPP: 30-40 Gy

RT-ALONE DOSES (uncommon, except for LPHL):

- Involved regions: 30-36 Gy
- Uninvolved regions: 25-30 Gy

RADIATION FIELDS

- When possible, the high cervical regions (all patients) and axillae (women) should be excluded from the radiation fields.
  - Involved-field: involved lymphoid region(s) only
  - Regional-field: involved and immediately adjacent lymphoid regions

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### REVISED RESPONSE CRITERIA FOR HODGKIN LYMPHOMA
(including PET)

<table>
<thead>
<tr>
<th>Response</th>
<th>Definition</th>
<th>Nodal Masses</th>
<th>Spleen, Liver</th>
<th>Bone Marrow</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CR</strong></td>
<td>Disappearance of all evidence of disease</td>
<td>FDG-avid or PET positive prior to therapy; mass of any size permitted if PET negative.</td>
<td>Not palpable, nodules disappeared</td>
<td>Infiltrate cleared on repeat biopsy; if indeterminate by morphology, immunohistochemistry should be negative</td>
</tr>
<tr>
<td><strong>PR</strong></td>
<td>Regression of measurable disease and no new sites</td>
<td>≥ 50% decrease in SPD of up to 6 largest dominant masses; no increase in size of other nodes. FDG-avid or PET positive prior to therapy; one or more PET positive sites remain positive.</td>
<td>≥ 50% decrease in SPD of nodules (for single nodule in greatest transverse diameter); no increase in size of liver or spleen</td>
<td>Irrelevant if positive prior to therapy; cell type should be specified</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>Failure to attain CR/PR or PD</td>
<td>FDG-avid or PET positive prior to therapy; PET positive at prior sites of disease and no new sites on CT or PET.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Relapsed disease or PD</strong></td>
<td>Any new lesion or increase by ≥ 50% of previously involved sites from nadir</td>
<td>Appearance of a new lesion(s) &gt; 1.5 cm in any axis, ≥ 50% increase in SPD of more than one node, or ≥ 50% increase in longest diameter of a previously identified node &gt; 1 cm in short axis Lesions PET positive if FDG-avid lymphoma or PET positive prior to therapy.</td>
<td>&gt; 50% increase from nadir in the SPD of any previous lesions</td>
<td>New or recurrent involvement</td>
</tr>
</tbody>
</table>


Note: All recommendations are category 2A unless otherwise indicated. Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
PRINCIPLES OF SECOND-LINE CHEMOTHERAPY

- The selection of second-line chemotherapy regimens depends on the pattern of relapse and the agents previously used.
  - Examples of second-line chemotherapy prior to transplant include ICE (ifosfamide, carboplatin, etoposide), C-MOPP, Mini-BEAM (carmustine, cytarabine, etoposide, melphalan), MINE (etoposide, ifosfamide, mesna, mitoxantrone), and VIM-D (etoposide, ifosfamide, mitoxantrone and dexamethasone).

- Some studies have suggested that patients with minimal disease burden at relapse (not refractory) may not need additional treatment prior to high-dose chemotherapy with stem-cell rescue. However, patients tend to have an improved outcome when ... In addition, second-line chemotherapy serves as a test for drug sensitivity and to facilitate the harvest of stem cells.

- Nitrogen mustard, procarbazine, carmustine, and melphalan may adversely affect both quality and quantity of stem-cell collection.

Staging

Table 1
Definitions of Stages in Hodgkin's Disease

Stage I Involvement of a single lymph node region (I) or localized involvement of a single extralymphatic organ or site (I-e).

Stage II Involvement of two or more lymph node regions on the same side of the diaphragm (II) or localized involvement of a single associated extralymphatic organ or site and its regional lymph node(s), with or without involvement of other lymph node regions on the same side of the diaphragm (II-e).

Note: The number of lymph node regions involved may be indicated by a subscript (e.g. II-e).

Stage III Involvement of lymph node regions on both sides of the diaphragm (III), which may also be accompanied by localized involvement of an associated extralymphatic organ or site (IIIE), by involvement of the spleen (III-e), or by both (IIIE-e).

Stage IV Disseminated (multifocal) involvement of one or more extralymphatic organs, with or without associated lymph node involvement, or isolated extralymphatic organ involvement with distant (nonregional) nodal involvement.

A No systemic symptoms present
B Unexplained fevers >38 C; drenching night sweats; or weight loss >10% of body weight


1PET scans are useful for upstaging in Stage I-II disease. If there is PET positivity outside of disease already identified, further clinical investigation is recommended to confirm or refute the observation. PET scans are usually positive in patients with HIV infection, even in the absence of Hodgkin lymphoma.
Discussion

NCCN Categories of Evidence and Consensus

Category 1: The recommendation is based on high-level evidence (e.g. randomized controlled trials) and there is uniform NCCN consensus.

Category 2A: The recommendation is based on lower-level evidence and there is uniform NCCN consensus.

Category 2B: The recommendation is based on lower-level evidence and there is nonuniform NCCN consensus (but no major disagreement).

Category 3: The recommendation is based on any level of evidence but reflects major disagreement.

All recommendations are category 2A unless otherwise noted.

Overview

Hodgkin disease/lymphoma (HD/HL) is an uncommon malignancy involving lymph nodes and the lymphatic system. In 2008, an estimated 8,220 new diagnoses and 1,350 deaths will occur in the United States. Most patients are diagnosed between 15 and 30 years of age, followed by another peak in adults aged 55 years or older.

The past few decades have seen significant progress in the management of HL; it is now curable in at least 80% of patients. With the advent of more effective treatment options, national statistics have shown an improvement in the 5-year survival rates of these patients that is unmatched in any other cancer over the past 4 decades. When appropriate treatment is selected, every patient with newly diagnosed HL has an overwhelming likelihood of being cured. In fact, cure rates for HL have increased so markedly that the overriding treatment considerations often relate to long-term toxicity, especially for patients with early- or intermediate-stage disease. For advanced disease, clinical trials still emphasize improvement in cure rates, but the potential long-term effects of treatment remain an important consideration.

The World Health Organization (WHO) classification divides HL into 2 main types: classical and lymphocyte-predominant Hodgkin lymphoma (CHL and LPHL, respectively). In Western countries, LPHL accounts for 5% and CHL for 95% of all HL cases. CHL is divided into 4 subtypes: nodular sclerosis, mixed cellularity, lymphocyte-depleted, and lymphocyte-rich.

CHL is characterized by the presence of Reed-Sternberg cells in an inflammatory background, whereas LPHL lacks Reed-Sternberg cells but is characterized by the presence of lymphocyte predominant cells, sometimes termed popcorn cells. LPHL can have nodular or diffuse pattern. The nodular subtype has lymphocyte predominant cells embedded in a background predominantly composed of B lymphocytes, whereas the diffuse subtype has a background consisting mainly of T cells.

These guidelines discuss the clinical management of CHL and LPHL, focusing exclusively on patients from postadolescence through the seventh decade of life who do not have serious intercurrent disease. The guidelines do not address HL in pediatric or elderly patients or those with unusual situations, such as HIV positivity or pregnancy. Individualized treatment may be necessary for older patients and those with concomitant disease. Consistent with NCCN philosophy, participation in clinical trials is always encouraged.

Staging and Prognosis

Staging for HL is based on Ann Arbor staging system (Table 1). Each stage (I-IV) is subdivided into A and B categories. “A” indicates that no systemic symptoms are present and “B” is assigned to patients with unexplained weight loss of more than 10% of body weight, unexplained...
fevers, or drenching night sweats. Patients with HL are usually classified into 3 groups: early-stage favorable (stage I-II with no B symptoms or large mediastinal adenopathy), early-stage unfavorable (stage I-II with large mediastinal mass, with or without B symptoms; stage I-II with B symptoms; numerous sites of disease; or significantly elevated ESR), and advanced-stage disease (stage III-IV).

Various unfavorable prognostic factors have been identified. Mediastinal bulk is an unfavorable prognostic factor in patients with early-stage HL. Mediastinal bulk on chest radiograph is measured most commonly using mediastinal mass ratio or mediastinal tumor ratio. Mediastinal mass ratio is the ratio of the maximum width of the mass and the maximum intrathoracic diameter. Mediastinal tumor ratio is the ratio of the maximum width of the mass and the intrathoracic diameter at the T5-T6 interspace. Any mass with mediastinal mass ratio greater than 0.33 or mediastinal tumor ratio greater than 0.35 is defined as bulky disease. Another definition of bulk is any single node or nodal mass that is 10 cm or greater in diameter. According to the Cotsworld modification of the Ann Arbor staging system, bulky disease is defined as a mediastinal mass exceeding one third of the internal transverse diameter of the thorax at the T5-T6 interspace on a posteroanterior chest radiograph.

Other unfavorable prognostic factors for patients with stage I to II disease include the presence of B symptoms, more than 3 sites of disease, or an erythrocyte sedimentation rate (ESR) of 50 or more. These factors are based largely on data from the European Organization for Research and Treatment of Cancer (EORTC) and the definition of unfavorable prognostic groups for their trials. Examples of unfavorable risk factors for stage I-II disease used by major clinical trial groups are listed in HODG-A.

Mauch and colleagues first reported the impact of mediastinal bulk on the prognosis of patients treated with radiation therapy (RT) alone. They found that patients with mediastinal bulk greater than one third of the chest diameter had a significantly higher risk for developing relapse (40%-50%) than those with lesser or no mediastinal disease (5%).

In addition to the unfavorable factors listed earlier, an international collaborative effort evaluating more than 5000 cases of advanced HL identified 7 adverse prognostic factors that reduce survival rates by 7% to 8% per year:

- Age 45 years or older
- Male gender
- Stage IV disease
- Albumin level below 4 g/dL
- Hemoglobin level below 10.5 g/dL
- Leucocytosis (white blood cell count more than 15,000/mm³)
- Lymphocytopenia (lymphocyte count less than 8% of the white blood count and/or lymphocyte count less than 600/mm³)

The number of unfavorable factors (International Prognostic Score [IPS]) helps to determine clinical management and predict prognosis. For instance, if the patient has more than 4 unfavorable factors (IPS ≥ 4) and advanced disease, treatment with a dose-escalated BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, and prednisone) regimen may be a more appropriate option than ABVD (doxorubicin bleomycin, vinblastine, and dacarbazine) chemotherapy or Stanford V (mechloretamine, doxorubicin, vinblastine, vincristine, bleomycin and prednisone).

Response Criteria

Clinical management of patients with HL involves initial treatment with chemotherapy or combined modality therapy, followed by restaging at the completion of chemotherapy to assess treatment response.
Assessment of response to initial treatment is essential because the need for additional treatment is based on the treatment response.

The International Working Group (IWG) published the guidelines for lymphoma response criteria in 1999.9 These criteria are based on the size reduction of enlarged lymph nodes as measured on computed tomography (CT) scan, and the extent of bone marrow involvement determined using bone marrow aspirate and biopsy. The original response criteria included CRu (complete response uncertain), indicating that it was not possible to determine whether residual masses identified on CT scan represented residual HL, scarring or some other nonmalignant process.

In 2007, the IWG guidelines were revised by the International Harmonization Project to incorporate immunohistochemistry, flow cytometry and positron emission tomography (PET) scans, in the definition of response for lymphoma.10 The revised guidelines eliminated CRu based partly on the ability of PET scan to further characterize residual masses detected with CT. Using the revised system, response is categorized as complete response, partial response, stable disease, relapsed disease, or progressive disease.

Diagnosis

Fine needle aspiration alone is insufficient for diagnosis. Although it is widely used to diagnose malignant neoplasms, its role in diagnosing lymphoma is still controversial.11,12,13 Core needle biopsy may be adequate for diagnosis, but the panel recommends excisional lymph node biopsy.

Immunohistochemistry is recommended but not necessary for CHL. The Reed-Sternberg cells of CHL usually express CD15 and CD30 but lack CD20 and CD45. Immunostaining for CD3, CD15, CD20, CD30, and CD45 is recommended.2 LPHL cells are usually CD45+ and CD20+, do not express CD15, and rarely express CD30. In addition, LPHL cells also express epithelial membrane antigen, which is usually not present in CHL. For LPHL, the guidelines recommend staining for CD3, CD15, CD20, CD21, CD30, and CD57. An expanded panel of markers may be required, especially for equivocal diagnosis.

Workup

Workup should include a thorough history and physical examination, including determination of B symptoms, alcohol intolerance, pruritus, fatigue, and performance status, and examination of the lymphoid regions, spleen, and liver (HODG-1). Standard laboratory testing should include a CBC, differential, platelets, ESR, serum lactate dehydrogenase level, albumin, and liver and renal function tests. Adequate bone marrow biopsy should be performed for patients with stage IB to IIB disease or higher. Chest radiograph and diagnostic CT scans of chest, abdomen or pelvic are appropriate imaging studies.

Patients with risk factors for HIV or unusual disease presentations should be given an HIV test. Pregnancy test should be performed before women of childbearing age undergo treatment. Semen cryopreservation in male patients, ovarian tissue or oocyte cryopreservation in female patients is recommended prior to the initiation of chemotherapy or pelvic RT.

A neck CT scan is also recommended in selected patients if RT is planned. Evaluation of ejection fraction is recommended for patients undergoing doxorubicin-based chemotherapy. Other optional procedures include pulmonary functions tests and a test of the diffusion capacity of the lungs for carbon monoxide. H-flu, pneumococcal, and meningococcal vaccines are recommended if splenic RT is contemplated.

PET scan has been used for initial staging, restaging, and follow-up of patients with lymphoma.14 In a recent meta-analysis, PET showed high positivity and specificity when used to stage and restage patients with...
lymphoma. PET is widely used after completion of therapy to assess response and, to a lesser extent, during therapy for pretreatment staging and assessment of response, as reviewed by Juweid.

Recent studies have shown that interim PET scan after 2-4 cycles of standard dose chemotherapy is a sensitive prognostic indicator. Recent prospective studies have shown that early interim PET is a strong and independent prognostic factor in patients with advanced stage and extranodal disease treated with standard ABVD chemotherapy. Advani and colleagues recently showed that in patients treated with the Stanford V regimen, freedom from progression was 96% in those with negative PET scans compared with 33% in those whose scans were positive at the completion of 12 weeks of chemotherapy. The role of PET in post therapy surveillance remains controversial, and further studies are needed to determine their role.

Dann and colleagues from an Israel Study group reported the usefulness of interim PET-CT scan after 2 cycles of BEACOPP therapy in standard and high-risk patients. Relapse or progression occurred in 27% of patients with positive PET-CT compared to 2.3% of patients with negative PET-CT.

Integrated PET-CT is a new imaging technology that has higher diagnostic accuracy than CT alone in staging HL. Hutchings and colleagues investigated the value of PET and combined PET-CT scans for staging HL, and their impact on treatment selection. PET scans would have upstaged 19% and downstaged 5% of patients, leading to a different treatment in 9%. The corresponding figures for combined PET-CT scans were 17%, 5%, and 7%. PET and PET-CT scans had higher sensitivity than CT in evaluating nodal regions (92% for PET and PET-CT vs. 83% for CT) and organ involvement (86% for PET and 73% for PET-CT vs. 37% for CT). PET was associated with more false-positive nodal sites than CT and PET-CT. However, the authors emphasize that PET and PET-CT should be used very cautiously in patients with excellent prognosis to avoid over treatment.

In another retrospective study, PET-CT performed with low-dose nonenhanced CT was found to be more sensitive and specific than routine contrast-enhanced CT in evaluating lymph node and organ involvement in patients with HL or high-grade non-Hodgkin’s lymphoma.

The NCCN PET-CT Task Force recommends using PET scans for initial staging of patients with lymphomas, including HL, and evaluating residual masses at the end of treatment. The panel recommends using PET scans to define the extent of disease, especially if the CT scan is equivocal. PET scans may upstage patients with stage I to II disease.

An integrated PET-CT or PET scan with a diagnostic CT is recommended, although PET-CT is always preferred. A separate diagnostic CT is not needed if it was part of the integrated PET-CT scan. However, management decisions should not be based on PET scan alone. PET scans are always positive in patients with HIV infection, even in the absence of HL. In cases of PET positivity outside of the disease already identified, or if the PET positive sites are inconsistent with the usual presentation of HL, additional clinical or pathologic evaluation is recommended. PET scans should not be used for routine surveillance because of the risk for false-positives.

**Principles of Radiation Therapy**

Extended-field radiation therapy (EFRT) refers to involved and immediately adjacent lymphoid regions. Involved-field radiation therapy (IFRT) refers to the involved lymphoid regions only. RT alone is rarely used for CHL but is more commonly used in LPHL. For RT alone, the recommended range of dosages is 30 to 36 Gy to involved regions and 25 to 30 Gy to uninvolved sites. The panel recommends that high
cervical regions in all patients and axillae in women be excluded from radiation fields, if those regions are uninvolved (HODG-C).

In combined modality therapy, the panel recommends 30 to 36 Gy when used with ABVD or 36 Gy when used with Stanford V (mechlorethamine, doxorubicin, vinblastine, vincristine, bleomycin and prednisone) for patients with bulky disease. In the absence of bulky disease, the radiation dose could be reduced to 30 Gy (with both ABVD and Stanford V) for patients with stage I to II disease. This recommendation is based on experience and practice across NCCN institutions. When used with BEACOPP for stage IB to IIB (nonbulky) and stage III to IV disease, 30 to 40 Gy is recommended.

**Classical Hodgkin Lymphoma**

Patients are divided into the following groups after initial diagnosis and workup (HODG-1):

- Stage I-II
- Stage III-IV

Patients with stage I-II are further classified into the following subgroups depending on the presence or absence of unfavorable factors:
- stage IA-IIA (favorable)
- stage I-II (unfavorable)

**Stage I to II**

RT alone was a standard treatment option for patients with favorable early-stage HL for many decades. However, long-term toxicity of large radiation fields includes an increased risk for heart disease, pulmonary dysfunction, and secondary malignancies. Chemotherapy regimens (ABVD and Stanford V) routinely used in advanced disease have more recently been incorporated into the management of early-stage CHL.

The ABVD regimen was first introduced by Santoro and colleagues as an alternative to MOPP (mechlorethamine, vincristine, prednisone, and procarbazine) and is associated with lower rates of sterility and leukemia. The Stanford V regimen is one of the new regimens initially developed by the Stanford group for patients with early-stage bulky and advanced-stage HL. RT is an integral part of the Stanford V regimen. Although the regimen is dose-intensive, the cumulative doses of these drugs are significantly less than those in MOPP, ABVD, alternating, or other hybrid regimens, thereby reducing the risks for chemotherapy-related infertility, secondary neoplasms, and cardiac and pulmonary toxicity.

Clinical trials have evaluated a short course of chemotherapy combined with RT for patients with early-stage disease. In a phase III randomized Intergroup trial, Press and colleagues showed that 3 cycles of doxorubicin and vinblastine followed by subtotal lymphoid irradiation (STLI) had a superior failure-free survival rate (94%) compared with STLI alone (81%).

In a recent report from the German Hodgkin Study Group (GHSG HD 7 trial), two cycles of ABVD followed by EFRT (30 Gy plus 10 Gy to the involved field) was more effective than the same dose of EFRT alone in patients with newly diagnosed early-stage favorable HL (stage IA to IIB without risk factors such as large mediastinal mass, extranodal disease, massive splenic involvement, or high ESR). At median follow-up of 7 years, no differences were seen in overall survival between the treatment groups. However, patients in the combined modality treatment group had significantly better (88%) freedom from treatment failure (FFTF) compared with those who underwent EFRT alone (67%), mainly because relapses were more frequent. Relapses occurred mostly within a year in patients who underwent EFRT alone, whereas
no relapses occurred in the combined modality arm within the first 2 years.

Several studies have investigated the reduction of chemotherapy and radiation field size to overcome the potential overlapping toxicity of doxorubicin and bleomycin with radiation. IFRT was as effective as EFRT in patients with early-stage disease.\textsuperscript{35-39}

The HD8 trial from the GHSG is the largest that investigated the efficacy of IFRT versus EFRT in early-stage unfavorable HL.\textsuperscript{36} This trial randomized 1204 patients to undergo 4 cycles of chemotherapy (COPP [cyclophosphamide, vincristine, procarbazine, and prednisone] plus ABVD) followed by EFRT or IFRT. At 5-years of follow-up, freedom from treatment failure (85.8\% for EFRT and 84.2\% for IFRT) and overall survival (90.8\% vs. 92.4\%) were similar for the groups. In contrast, acute side effects, including leukopenia, thrombocytopenias, and gastrointestinal toxicity, were more frequent in the EFRT group.

The EORTC-GELA H8 trials (H8-F and H8-U) investigated the reduction of chemotherapy and RT fields in the treatment of patients with early-stage HL.\textsuperscript{37} The H8-F trial compared 3 cycles of MOPP-ABV plus IFRT with subtotal nodal irradiation (STNI) alone in patients with favorable stage I to II disease. The H8-U trial used three different regimens (6 cycles of MOPP-ABV plus IFRT, 4 cycles of MOPP-ABV plus IFRT, and 4 cycles of MOPP-ABV plus STNI) in patients with unfavorable stage I to II disease. Median follow-up was 92 months.

In patients with early-stage favorable HL (H8-F trial), the estimated 5-year event-free survival rate was significantly higher after 3 cycles of MOPP-ABV and IFRT compared with STNI alone (98\% vs. 74\%). In patients with unfavorable early-stage HL (H8-U trial), estimated 5-year event-free survival rates were similar for the 3 groups (84\% after 6 cycles of MOPP-ABV plus IFRT, 88\% after 4 cycles plus IFRT, and 87\% after 4 cycles plus STNI). The H8 trial investigators concluded that chemotherapy plus IFRT should be standard treatment for early-stage HL.\textsuperscript{37}

The HD10 trial from the GHSG investigated the reduction of the number of cycles ABVD as well as the IFRT dose in patients with stage I-II disease with no risk factors. In this trial, patients were randomized between four vs. two cycles of ABVD and 30 Gy vs. 20 Gy of IFRT. At a median follow-up of 2 years, no statistical differences were seen in freedom from treatment failure (96.6\% and overall survival (98.5\%) between the 4 groups.\textsuperscript{40} Updated results from the 4-year follow up also showed no differences in survival rates among the treatment arms.\textsuperscript{41} The preliminary results of this trial suggest that patients with early stage HL with no risk factors may be treated effectively with 2 cycles of ABVD with a reduced dose (20 Gy) of IFRT, thereby minimizing the risk of late effects. However, the GHSG still uses a dose of 30 Gy in its current generation of clinical trials for early stage favorable disease.

In studies conducted by the Stanford Group, the Stanford V regimen and IFRT was equally effective and less toxic compared with EFRT alone in early-stage unfavorable HL. Patients with nonbulky stage I to IIA disease underwent 8 weeks of Stanford V plus 30 Gy IFRT, and those with bulky stage II disease were treated with 12 weeks of Stanford V plus 36 Gy of IFRT to bulky sites. In the most recent update, the actuarial 8-year freedom from progression (FFP) was 96\% in patients with favorable stage I to II disease and 92\% for those with stage I to II bulky disease.\textsuperscript{38} Posttreatment conceptions occurred in 25\% of patients.

A phase II study from Memorial Sloan-Kettering Cancer Center (MSKCC) and a multicenter study by the Italian group also showed similar outcomes in patients with locally extensive or advanced disease treated with the Stanford V regimen.\textsuperscript{42,43} Recently, another Italian study group compared a modified Stanford V regimen with MOPPEBVCAD (mechlorethamine, vincristine, procarbazine, prednisone,
epidoxorubicin, bleomycin, vinblastine, lomustine, doxorubicin, and vindesine) and ABVD in intermediate- and advanced-stage HL.\textsuperscript{44} ABVD and MOPPEBVCAD were superior to the Stanford V regimen in response rate, failure-free survival, and progression-free survival. However, interpretation of these results was difficult because the timing of response evaluation was different among the arms, (8 and 12 weeks for Stanford V, 16 weeks for ABVD, and 24 weeks for MOPPEBVCAD). In addition, modifications of the RT protocol for the Stanford V arm were substantial, including limitation of the number of sites irradiated (no more than 2) and a different definition of bulky disease.

However, the results MSKCC study confirms that when RT is administered according to Stanford guidelines, the Stanford V regimen is highly effective for locally extensive and advanced HL with a low toxicity profile.\textsuperscript{42} In this study, 58% of the patients for whom the Stanford V regimen failed underwent successful second-line therapy with high-dose therapy with autologous stem cell rescue (HDT/ASCR).

The recently completed E2496 Intergroup trial compared the Stanford V regimen with ABVD plus radiation for the management of bulky stage II and stage III to IV disease. Results of this trial are awaited.

Chemotherapy alone has also been investigated as a treatment option for patients with early-stage HL.\textsuperscript{45,46} In the MSKCC study, there were no significant differences in complete response duration (91% vs. 87%, respectively), FFP (86% vs. 81%, respectively), and overall survival (97% vs. 90%, respectively, \(p=0.08\)), among patients treated with ABVD plus radiation and those treated with ABVD alone.\textsuperscript{45}

In the multicenter study conducted by the National Cancer Institute of Canada-Clinical Trials Group (NCIC-CTG) and Eastern Cooperative Oncology Group, patients with stage I to IIA HL were randomized to receive ABVD (4-6 cycles) or subtotal lymphoid radiation therapy (STLI).\textsuperscript{46} In patients assigned to RT, those with any of the adverse prognostic factors (high ESR or \(\geq 4\) nodal sites) were treated with 2 cycles of ABVD before RT. At a median follow-up of 4.2 years, patients assigned to ABVD plus RT or RT alone had better FFP (93% vs. 87%, respectively) and event-free survival (88% vs. 86%, respectively) compared with those treated with ABVD alone, with no significant difference in overall survival (94% vs. 96%, respectively). In a subset analysis of patients with unfavorable prognostic factors, FFP was superior for those treated with ABVD plus RT (95% vs. 88%), but no differences were seen in 5-year overall or event-free survival rates.

Results of these trials suggest that ABVD alone could be a treatment option for patients with localized nonbulky disease, especially if they experience prompt and complete response to the first 2 cycles of ABVD, as documented by CT scan. ABVD alone may be a reasonable choice of treatment in younger patients with favorable presentations of stage I to II disease who achieve a prompt complete response on CT, in order to avoid the long-term risks of RT.\textsuperscript{47}

**NCCN Recommendations**

**Stage I A to IIA (Favorable Disease)**

In these guidelines, combined modality therapy (ABVD or Stanford V chemotherapy plus IFRT) is the preferred treatment (category 1) for patients with favorable disease (HODG-2). The panel has also included ABVD alone as an alternative treatment option with a category 2B recommendation. Highly selected patients who are unable to tolerate chemotherapy because of the presence of comorbidities may be treated with RT alone (category 1 recommendation for STLI and category 2A for mantle field irradiation).

In combined modality treatment, ABVD is generally administered for 4 cycles. Restaging occurs at the completion of chemotherapy. In patients with favorable outcomes and no risk factors according to the GHSG criteria (large mediastinal mass, massive splenic involvement,
high ESR, and > 2 sites of disease), 2 cycles followed by IFRT may be sufficient.40

Among patients treated with chemotherapy alone, ABVD is administered for 6 cycles followed by restaging. The Stanford V regimen is administered for 8 weeks (2 cycles). Restaging occurs at the completion of chemotherapy. Consolidative irradiation is optimally instituted within 3 weeks. The panel recommends using 30 Gy of IFRT (involved lymphoid regions only) with ABVD and Stanford V regimens (HODG-C).

Completion of IFRT (if it is part of initial treatment) is recommended for all patients who have achieved a complete response. Patients experiencing a partial response can be either be treated with IFRT or they can undergo biopsy prior to receiving IFRT. Further restaging is required after the completion of RT. Follow-up is recommended for patients with negative PET scan at the completion of therapy, and those with positive PET scans are treated as described for relapsed or progressive disease in HODG-8.

All patients with stable (PET positive) or progressive disease are managed as described for relapsed or progressive disease. Biopsy is recommended before initiating treatment for progressive disease.

**Stage I to II (Unfavorable Disease)**
For patients with unfavorable disease the panel recommends chemotherapy (ABVD or Stanford V) followed by IFRT or similar radiation (HODG-3).48,49

ABVD is administered for 4 cycles. Restaging occurs after completion of chemotherapy. Two additional cycles (maximum of 6) are administered for patients who have achieved complete response, followed by IFRT (30-36 Gy) especially if they had initially bulky disease (HODG-3). Patients with partial response are also treated with 2 additional cycles (maximum of 6) followed by restaging. Consolidative irradiation is recommended for patients with negative PET scans, and those with positive PET scans are treated with IFRT (30-36 Gy) followed by end-of-treatment restaging.

Stanford V is administered for 12 weeks (3 cycles) to patients with bulky mediastinal masses. Consolidative irradiation (36 Gy) is instituted within 3 weeks to all initial sites of disease greater than 5 cm. Generally, this includes the mediastinum and bilateral supraclavicular areas. Patients are restaged when they complete chemotherapy. In patients with non-progressive disease (including those with residual PET positive sites), RT (36 Gy) is recommended not only for initial sites larger than 5 cm but also residual PET-positive sites. Stanford V regimen is used as described above for patients with bulky mediastinal disease or B symptoms. Patients with other unfavorable factors are treated with 8 weeks of chemotherapy and 30 Gy involved field irradiation (analogous to the treatment of patients with stage I-IIA favorable).

For partial response with positive PET scan at end of treatment restaging, stable (PET positive) or progressive disease, biopsy is recommended before initiating treatment for progressive disease as described in HODG-8.

**Stage III to IV (Advanced Disease)**
Chemotherapy is always used for patients with advanced-stage HL. MOPP was the first successful regimen for HL, with a response rate of 84% and a 66% disease-free survival of more than 10 years from end of treatment.50 However, in addition to other long-term toxicities, MOPP is associated with loss of fertility (mostly in men) and myelodysplasia.

The landmark randomized trial by the Cancer and Leukemia Group B (CALGB) showed that ABVD alone or alternating with MOPP was superior to MOPP alone in progression-free and 5-year overall
survival.\textsuperscript{51} ABVD also was less myelotoxic than MOPP, or ABVD alternating with MOPP. These results were confirmed in a large Intergroup study, which compared ABVD with a MOPP/ABV hybrid regimen in 856 patients with advanced HL.\textsuperscript{52} The rates of complete remission (76\% vs. 80\%), 5-year failure-free survival (63\% vs. 66\%), and overall survival (82\% vs. 81\%) were similar for ABVD and MOPP/ABV, respectively. However, MOPP/ABV was associated with acute pulmonary and hematologic toxicity, myelodysplastic syndrome, and leukemia.

Another randomized controlled trial from the United Kingdom Lymphoma Group (LY09 trial) also confirmed that there was no significant difference in event free and overall survival between ABVD and other multidrug regimens in patients with advanced HL. Multidrug regimens were more toxic than ABVD and were associated with poorer outcomes in older patients.\textsuperscript{53}

ABVD has since been the standard treatment for patients with advanced-stage HL. Stanford V and BEACOPP are the other two regimens developed to improve the outcome of patients with advanced disease.

In prospective studies conducted by the Stanford group, 108 patients with stage III to IV disease were treated with 12 weeks of Stanford V regimen plus 36 Gy of RT to initially bulky sites larger than 5 cm. In the most recent update of the mature results from these studies, 8- and 12-year FFP rates were 86\% and 83\%, respectively, and 8- and 12-year overall survival rates were 95\%.\textsuperscript{38} No instances of secondary myelodysplasia or leukemia occurred. Fertility was maintained, with 72 posttreatment conceptions. Similar outcomes were reported in other studies for patients with advanced-stage HL treated with the Stanford V regimen.\textsuperscript{42,43}

The BEACOPP regimen was developed by the GHSG to improve treatment results through dose escalation and time intensification. In a phase III randomized trial (HD9), patients with stage IIB and IIIA disease with risk factors or stage IIIB and IV disease were randomized to undergo 8 cycles of COPP-ABVD (cyclophosphamide, vincristine, procarbazine, and prednisone alternating with doxorubicin, bleomycin, vinblastine, and dacarbazine), 8 cycles of standard-dose BEACOPP, or 8 cycles of dose-escalated BEACOPP.\textsuperscript{54} Each regimen was followed by RT to initial sites of disease greater than 5 cm.

At 5-year analysis, escalated-dose BEACOPP showed better tumor control and overall survival than COPP-ABVD. It also showed significantly lower rates of early progression than COPP-ABVD or standard-dose BEACOPP, and 10-year analysis showed that it conferred superior FFTF (70\% for standard-dose BEACOPP, 82\% for escalated-dose BEACOPP, and 64\% for COPP-ABVD) and overall survival rates (86\% for escalated-dose BEACOPP, 80\% for standard-dose BEACOPP, and 75\% for COPP-ABVD).\textsuperscript{55} These results confirm the efficiency of dose-escalated BEACOPP for patients with advanced-stage HL who have risk factors. The ongoing EORTC 20012 trial is comparing BEACOPP and ABVD in patients with stage III or IV HL.

Recently, a study group from Israel reported the results of a risk-adapted approach using BEACOPP to treat patients with standard- and high-risk HL.\textsuperscript{22} Patients with advanced disease (stage I-II bulky with B symptoms and stage III-IV) and IPS of 3 or higher were treated with 2 cycles of escalated BEACOPP, and all others underwent 2 cycles of standard-dose BEACOPP followed by restaging. Those with a positive PET scan received 4 additional cycles of escalated-dose BEACOPP, whereas 4 cycles of standard-dose BEACOPP were given to patients with a negative PET scan. The complete remission, 5-year event-free survival, and overall survival rates were 97\%, 85\%, and 90\%,
respectively. Event-free and overall survival rates were similar in both risk groups.

Two recent European trials evaluated the role of HDT/ASCR as a consolidative therapy for patients with advanced-stage and unfavorable HL that responded to initial chemotherapy.\(^{56,57}\) Neither trial showed an advantage for HDT/ASCR over conventional chemotherapy for patients with unfavorable and advanced HL experiencing complete or partial remission after initial course of doxorubicin-based chemotherapy. Instead, additional courses of the same conventional chemotherapy used as initial treatment produced equivalent or better outcomes than HDT/ASCR.

Several trials have addressed the role of consolidative irradiation in patients with stage III to IV HL who completed chemotherapy.\(^ {58,59,60,}\) The Southwest Oncology Group multi-institutional study also showed no improvement in overall survival rates for patients who underwent low-dose IFRT after MOP-BAP (mechlorethamine, vincristine, prednisone plus bleomycin, doxorubicin, and procarbazine), but the remission duration was prolonged in several subgroups, especially patients with bulky nodular sclerosis.\(^ {58}\)

The EORTC 20884 trial assessed the role of RT following MOPP-ABV chemotherapy in patients with advanced disease.\(^ {59,60}\) In this trial, patients with untreated stage III to IV disease underwent 6 to 8 cycles of MOPP-ABV. Those experiencing complete response after chemotherapy were randomized to no further treatment or IFRT, and those who showed partial response received IFRT to involved nodal areas and extranodal sites. The 8-year overall and event-free survival rates in the partial response group were 76% and 84%, respectively. These outcomes were not significantly different in the complete response group (with or without IFRT), suggesting that consolidative IFRT is beneficial for patients experiencing partial response after chemotherapy.

In contrast, Laskar and colleagues reported a survival advantage for consolidative RT in patients experiencing complete response after initial chemotherapy particularly in patients younger than 15 years.\(^ {61}\) However, this study included patients with a different distribution of histologic subtypes of HL than those included in Western studies, and most had early-stage HL.

The role of consolidative irradiation for bulky or residual sites after chemotherapy for stage III to IV disease is being addressed in an ongoing GHSG randomized trial (HD15) in patients with advanced stage HL treated with 6-8 cycles of BEACOPP-14.\(^ {62}\) Only patients who had positive PET scans at the end of chemotherapy received consolidative irradiation. Preliminary results of this trial showed that progression-free survival was 96% in the PET negative patients and 86% for the PET positive patients, suggesting that consolidative RT can be omitted in PET negative patients who have been treated with BEACOPP without increasing the risk of relapse or progression. Longer follow-up is necessary to confirm these preliminary results.

**NCCN Recommendations**

ABVD (4 cycles) or Stanford V (3 cycles) is recommended for primary treatment for patients with advanced disease (HODG-4).

Escalated-dose BEACOPP (4 cycles) should be considered for high-risk patients with an IPS score of four or more (HODG-5).

ABVD is generally administered for 6 to 8 cycles, with restaging after four cycles. Two additional cycles are administered for patients who have experienced complete or partial response, followed by restaging for patients with initial partial response. No further treatment is necessary for patients who have experienced complete response or those with partial response and a negative PET scan. If bulky mediastinal disease was present initially, consolidative RT to the mediastinum is recommended after 6 cycles of ABVD. Patients with
partial response and a negative PET scan can be treated with 2 more cycles of ABVD, to a total of 8. IFRT may be administered for initial sites of bulky disease (30-36 Gy) or for stage I to II disease (30 Gy).

Stanford V is administered for 12 weeks (3 cycles). Consolidative irradiation is instituted within 3 weeks (30 Gy to initial sites for stage IB-IIIB; 36 Gy to initial bulky sites of 5 cm or larger and spleen if focal nodules are present initially). Restaging and additional treatment for patients treated with Stanford V regimen are similar to stage I to II bulky disease as outlined in HODG-3.

Escalated-dose BEACOPP is administered every 3 weeks, and restaging occurs at the end of 4 cycles. Four additional cycles of baseline BEACOPP are administered for patients who have experienced complete response, whereas 4 cycles of escalated-dose BEACOPP are recommended for those with partial response, followed by end-of-treatment restaging. Consolidative irradiation (30-40 Gy to initial bulky sites > 5 cm, and 40 Gy of RT to residual PET-positive sites) is recommended for all patients. For patients experiencing partial response with positive PET scans or progressive disease, biopsy is recommended before initiating treatment.

**Lymphocyte-Predominant Hodgkin lymphoma**

LPHL is characterized by an indolent course and occasional late relapse. It has a different natural history and response to therapy compared with CHL. The GHSG has reported a comprehensive description of natural history, clinical presentation, and outcomes for LPHL. In a retrospective analysis that included 394 patients with LPHL, 63% had early-stage favorable, 16% had early-stage unfavorable, and 21% had advanced-stage disease. At a median follow-up of 50 months, FFTF (88% vs. 82%) and overall survival (96% vs. 92%) were better for LPHL compared with CHL. Among patients with LPHL, FFTF was better for early favorable disease (93%) compared with early unfavorable (87%) and advanced-stage disease (77%).

The European Task Force on Lymphoma (ETFL) also reported favorable FFTF for early-stage disease (85% for stage I; 71% for stage II) compared with those with stage III (62%) or IV (24%) disease. In the GHSG study, adverse prognostic factors for FFTF included advanced stage, low hemoglobin, and lymphopenia; age (≥ 45 years), advanced stage, and low hemoglobin were the negative prognostic factors for overall survival.

Early-stage favorable LPHL has a better prognosis than CHL and its management is different. IFRT (or slightly modified IFRT) or combined modality treatment are the treatment options for early stage LPHL. RT alone was found to be an efficient treatment for patients with stage I to II LPHL. In a retrospective analysis, Schlembach and colleagues reported favorable 5-year relapse-free (95%) and overall survival (100%) for patients with stage IA LPHL treated with IFRT and regional RT alone. There was no evidence of secondary solid tumors even after long-term follow-up (11.6 years for IFRT and 5.5 years for regional RT). Longer follow-up is needed to define the risks for cardiac toxicity. Another retrospective study from the Australasian Radiation Oncology Lymphoma Group reported longer follow-up in patients with stage I to II LPHL treated with RT alone, including mantle and total lymphoid irradiation. At 15 years, FFP was 84% for patients with stage I disease and 73% for those with stage II disease.

The GHSG compared 3 treatment options, including EFRT, IFRT, and combined modality treatment in patients with stage IA LPHL. Median follow-up was 78 months for EFRT, 40 months for combined modality, and 17 months for IFRT. Complete remissions were observed in 98% after EFRT, 95% after combined modality, and 100% after IFRT, and no significant differences were seen in FFTF, suggesting that IFRT is equally effective as EFRT and combined modality treatment. However,
in a subgroup analysis of 64 patients with LPHL included in the GHSG HD 7 trial, a trend was seen toward better 7-year FFTF for the combined modality group (96%) compared with the EFRT group (83%).

An EORTC-GELA study also showed that patients with early-stage (I-II) disease treated with RT alone, or chemotherapy followed by RT, had similar relapse-free (77% and 68%, respectively) and overall survival (90% and 100%, respectively) at 9.3 years. Additional data and longer-term follow-up are required to define the best treatment for early-stage favorable LPHL.

Patients with advanced-stage LPHL have a worse prognosis than those with early-stage favorable disease, and can be treated with chemotherapy. In the ETFL study, the 8-year disease-specific survival and FFTF were 94% and 62%, respectively, for stage III disease and 41% and 24%, respectively, for stage IV disease. Most of these patients (80%-95%) were treated with chemotherapy (MOPP- or ABVD-like regimens) with or without RT.

Because LPHL cells consistently express CD20 antigen, clinical studies have explored the efficacy of rituximab, an anti-CD20 antibody. GHSG evaluated rituximab for relapsed or refractory LPHL in a phase II trial. Of 14 patients with CD20+ LPHL, 8 experienced complete and 6 partial remission. At a median follow-up of 63 months, median time to progression was 33 months.

In a Stanford study, previously treated (10) and untreated (12) patients with stage I to IV LPHL received 4 weekly doses of rituximab at 375 mg/m². The overall response rate was 100% (41% complete, 54% partial, and 5% unconfirmed complete responses). The estimated probability of progressive disease at 10.2 months was 52%. The protocol was later modified to repeat 4 weekly 375 mg/m² doses at 6-month intervals for 2 years. Median follow-up was 72 months for limited and 30 months for extended treatment. The overall response rate was 97% (69% complete or unconfirmed complete response, 28% partial response). Among patients undergoing limited treatment with rituximab, 56% experienced complete or unconfirmed complete response, compared with 88% of those treated with extended rituximab. The estimated FFP at 30 months was 52% for limited rituximab and 88% for extended rituximab. Rituximab was well tolerated, with few adverse side effects. Additional follow-up is needed to assess benefit duration.

Without randomized trials comparing different chemotherapy regimens, no preferred chemotherapy regimen exists for LPHL, although ABVD is often used based on data for CHL. Ongoing clinical trials may clarify the role of observation, rituximab, or combination chemotherapy options for these patients. The most common regimens used at NCCN member institutions for LPHL include single-agent rituximab or any one of the following chemotherapy regimens (with or without rituximab):

- ABVD
- CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), CVP (cyclophosphamide, vincristine, and prednisone)
- EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, and doxorubicin)

**NCCN Recommendations**

**Stage I to II**

IFRT (30-36 Gy) or regional RT is recommended for all patients with stage IA to IIA disease. Chemotherapy followed by IFRT is recommended for patients with stage IB to IIB disease. For the rare patient with stage I to II who has B symptoms, combined modality therapy with chemotherapy and IFRT is recommended. (HODG-6)
**Stage III to IV**
Chemotherapy with or without RT is an appropriate treatment option for stage III to IV disease (HODG-6). Alternatively, asymptomatic patients with stage IIIA-IVA disease can undergo either observation (category 2B) or treatment with local RT for palliation.

**End of Treatment Restaging**
Restaging occurs after completion of initial therapy, and then observation is recommended for asymptomatic patients with unconfirmed complete response and all patients experiencing complete response.

**Follow-up after Completion of Treatment**
Recommendations included in the guidelines are based largely on the clinical practices at NCCN member institutions and are not supported by high-level evidence, since there are very little data available on the follow-up and monitoring late effects in patients with HL, after completion of treatment. Follow-up schedule should be individualized, depending on clinical circumstances such as patient's age, stage of the disease and initial treatment modality. Patients should be encouraged to undergo counseling on issues regarding survivorship, long-term treatment effects (secondary malignancies, cardiac disease and reproduction), health habits and psychosocial issues (HODG-7).

The panel overwhelmingly agrees that, given the long-term risks of the therapies for HL, patients should be followed up by oncologists who are aware of these risks and complications, especially during the first 5 years and then annually because of the risk for late complications, including secondary cancers and cardiovascular disease.

Interim physical examinations and blood tests (CBC, platelets, ESR if elevated at initial diagnosis and chemistry profile) are performed every 2 to 4 months up to 2 years and then every 3 to 6 months for the next 3 to 5 years. Annual influenza vaccinations should be considered for high-risk patients (those who were treated with bleomycin-based chemotherapy or chest RT).

Repeat imaging studies of initially involved sites are important, as are surveillance studies of the chest and abdomen. Chest radiograph or CT should be performed every 6 to 12 months during the first 2 to 5 years, then annually depending on clinical circumstances. Abdominal/pelvic CT (category 2B) is monitored every 6 to 12 months for the first 2 to 3 years, then annually up to 5 years. PET scans are not recommended for routine surveillance due to the risk of false positives.

**Monitoring for Late Effects**
Several modifications such as limiting the number of cycles of chemotherapy, reduction in radiation dose and irradiation field have been investigated in clinical trials in an effort to improve treatment outcome with reduced toxicity and late effects. IFRT was equally effective and less toxic compared to EFRT in patients with early stage HL treated with combined modality therapy. A brief course of chemotherapy in combination with IFRT is associated with a reduced relapse risk compared to chemotherapy alone in patients with early stage HL. RT is also associated with survival benefits in a subset of patients with relapsed or refractory disease. RT has also been used as part of conditioning regimen in radiation naïve patients prior to ASCR. However, RT remains a significant risk factor for many of the long-term effects.

Secondary malignancies, cardiovascular disease, hypothyroidism and fertility issues are the most serious late effects in long-term survivors of HL. The incidence of these late effects increases with longer follow-up time.
Secondary Malignancies

Solid tumors are the most common secondary malignancies and most develop more than 10 years after the completion of treatment. The risk of developing secondary malignancies is highest when RT is used as first-line treatment. Recent meta-analysis by Franklin and colleagues showed that the risk of developing secondary malignancies was lower with chemoradiation therapy than with RT alone as the initial treatment. The risk was marginally higher with chemoradiation therapy when compared with chemotherapy alone as initial treatment. No significant differences in the risk of developing secondary malignancies were seen with IFRT vs. EFRT, although the risk of developing breast cancer was substantially higher for EFRT. The risk for developing lung cancer or colorectal cancer is increased after treatment with chemotherapy.

Lung cancer and breast cancer are the most common secondary malignancies in patients with HL. Annual chest imaging (chest X-ray or chest CT) is recommended for patients at increased risk for lung cancer. Chest imaging is optional after 5 years for patients who were treated with nonalkylating agent chemotherapy, did not undergo RT, and have no other risk factors (HODG-7).

Annual mammogram or magnetic resonance imaging (MRI) of breast beginning no later than 8 to 10 years after completion of therapy or at the age of 40 (whichever occurs earlier) is recommended for women who have received chest or axillary irradiation (HODG-7). They should also be encouraged to perform monthly self-breast examination and undergo yearly breast examination by a health care professional. Women who received chest irradiation prior to age 30 should have screening with MRI, in addition to conventional mammography.

Cardiac Disease

Mediastinal irradiation and anthracycline-based chemotherapy are the highest risk factors for developing cardiac disease. RT-induced cardiotoxicity is observed usually more than 5-10 years after completion of treatment. However, cardiovascular symptoms may emerge at any age. Asymptomatic cardiac disease is also prevalent in patients who were treated with mantle field irradiation.

Based on data regarding increased long-term risk of cardiac disease, the panel recommends a baseline stress test or echocardiogram at 10 years after treatment and annual blood pressure monitoring, even in asymptomatic individuals. Aggressive medical management of cardiovascular risk factors is recommended.

Hypothyroidism

Abnormal thyroid function, mostly hypothyroidism is reported in about 50% of long-term survivors, especially those patients who received neck or upper mediastinal irradiation. A careful thyroid examination should be a part of physical exam. Thyroid function tests should be done at least annually to rule out hypothyroidism.

Myelosuppression

Myelosuppression is the most common side effect of chemotherapy and is associated with increased risk of infections. There are no data on the types of infections in long-term survivors of HL in different parts of the world.

Pneumococcal revaccination is recommended every 5 to 7 years, especially for patients treated with splenic RT or splenectomy. Meningococcal and H-flu revaccination can be considered in selected cases (HODG-7).
Pulmonary Toxicity

Bleomycin induced pulmonary toxicity (BPT) is well documented in patients with HL treated with bleomycin-containing chemotherapy regimens. Risk factors include older age, cumulative bleomycin dose, pulmonary irradiation and prior history of lung disease. Some reports have suggested that the use of growth factors increases the incidence of pulmonary toxicity. Martin and colleagues reported that BPT significantly decreases the 5-year overall survival rate, especially in patients 40 years or older. They also showed that the use of growth factor with chemotherapy significantly increases the incidence of BPT (26% vs. 9%). Recently, two separate studies confirmed that ABVD chemotherapy can be safely administered at the full dose intensity without any growth factor support. Five-year event free survival (87.4% vs. 80% respectively) and overall survival (94.1% vs. 91.3% respectively) rates in patients who received ABVD with no growth factors were comparable to those in patients who received prophylactic growth factor support with ABVD regimen.

Leukopenia is not a factor for reduction of dose intensity. NCCN guidelines do not recommend the routine use of growth factors.

Progressive Disease or Relapse

HDT/ASCR

Early studies exploring the use of HDT/ASCR in patients with relapsed or refractory HL produced complete response rates of 48% to 69%, as reviewed by Bryne and Gockerman. Based on these promising results, two randomized phase III studies compared HDT/ASCR with conventional chemotherapy. Both studies showed significant improvement in event-free and progression-free survival and FFTF (with no difference in overall survival) for patients with relapsed or refractory HL who underwent HDT/ASCR compared with conventional chemotherapy alone. HDT/ASCR is the best option for patients with HL that is incurable with primary treatment, even though it does not improve overall survival. Moskowitz and colleagues identified the following as prognostic factors associated with event-free survival after HDT/ASCR: extranodal sites, complete response of less than 1 year, primary refractory disease, and B symptoms. In patients with none or one factor, 5-year event-free and overall survival were 83% and 90%, respectively, which decreased to 10% and 25% if all factors were present.

Second-Line Chemotherapy

Several studies have shown the importance of cytoreduction with second-line chemotherapy before HDT/ASCR. However, none of these regimens has been studied in randomized trials. Newer regimens, such as GVD (gemcitabine, vinorelbine, and pegylated liposomal doxorubicin) and IGEV (ifosfamide, gemcitabine, and vinorelbine), have also been effective for relapsed or refractory HL.

Some studies have also suggested that patients with minimal residual disease at relapse may not need conventional-dose chemotherapy before HDT.

Radiation Therapy

Josting and colleagues from the GHSG reported that second-line RT may be effective in a select subset of patients with relapsed or refractory disease. The 5-year freedom from treatment failure and overall survival rates were 28% and 51% respectively. B symptoms and stage at the time of disease progression or relapse were identified as significant prognostic factors for overall survival.

Second-line RT may be effective in patients in good performance status with limited-stage late relapses and without B symptoms. It may be a very effective salvage regimen for patients with initial favorable stage I-II disease who are treated with chemotherapy alone and relapse in initially involved sites.
NCCN Recommendations

Patients with progressive CHL or disease relapse should undergo biopsy and restaging, including bone marrow biopsy. Bone marrow cytogenetics for markers of myelodysplastic syndromes may be considered if ASCR is planned. Management of progressive disease or relapse depends on whether primary treatment was radiation alone, chemotherapy, or combined modality therapy (HODG-8).

Patients with progressive LPHL may be managed according to the same algorithm. However, some have a chronic indolent course that may not require aggressive retreatment. These asymptomatic patients may be observed or treated with local irradiation.

For patients treated initially with chemotherapy or combined modality therapy, the algorithm is a bit more complicated and therapy more likely to be individualized. Appropriate treatment has not been identified for disease relapse in patients with initial stage IA to IIA disease who underwent chemotherapy alone and experienced failure at the initial sites and therefore individualized treatment is recommended. Options include RT, non-cross resistant chemotherapy or HDT/ASCR. RT is recommended when the sites of relapse have not been previously irradiated. In radiation naïve patients, total lymphoid irradiation (TLI) may be an appropriate component of HDT/ASCR.

For all other patients, the panel recommends HDT/ASCR (category 1) with or without locoregional RT, but disease relapse should be confirmed with biopsy. Conventional-dose second-line chemotherapy may precede high-dose therapy. Suggested regimens are listed in HODG-E. In select patients with long disease-free intervals and other favorable features, chemotherapy should be individualized.

The panel recommends that patients experiencing disease relapse after undergoing primary treatment with RT alone be treated as described for initial treatment of advanced disease as outlined in HODG-4. The extent of stage at relapse (relapse stage) after RT was the most important prognostic factor for freedom from second relapse.98

Summary

HL is an uncommon malignancy involving lymph nodes and the lymphatic system. The WHO classification divides HL into 2 main types (CHL and LPHL). CHL is characterized by the presence of Reed-Sternberg cells in an inflammatory background, whereas LPHL is characterized by the presence of lymphocytic and histiocytic cells.

The management of HL continues to evolve. Major changes have been incorporated into these guidelines since inception. Current management of HL involves initial treatment with chemotherapy or combined modality therapy, followed by restaging to assess treatment response. PET scans are recommended to evaluate initial staging and assess treatment response at restaging. Recent studies have shown the prognostic value of early interim PET scans in patients with advanced or extranodal disease. However, PET scans are not recommended for routine surveillance.

Combined modality therapy (brief course of chemotherapy and IFRT) is the preferred treatment for early-stage favorable (stage IA-IIA) CHL. Chemotherapy followed by consolidative irradiation with IFRT is recommended for early stage unfavorable (stage I-II) and advanced-stage (stage III-IV) CHL.

IFRT alone is the treatment option for early-stage favorable (stage IA-IIA) LPHL. Chemotherapy followed by IFRT is recommended for patients with stage IB-IIB disease. In rare patients who have stage I-II disease with B symptoms, combined modality therapy is recommended. Patients with advanced-stage (stage III-IV) LPHL may be treated with chemotherapy with or without RT. The role of chemotherapy or antibody-based therapy is being explored in ongoing clinical trials for early-stage and advanced-stage LPHL.
HDT/ASCR is the best treatment option for patients with relapsed or refractory HL, although it does not improve overall survival. Consistent with NCCN philosophy, participation in clinical trials is always encouraged.

HL is now curable in most patients because of the introduction of more effective and less toxic regimens. However, survivors may experience late treatment-related side effects. For this reason, long-term follow-up by an oncologist is essential after completion of treatment. Counseling about issues of survivorship and careful monitoring for late treatment-related side effects should be an integral part of follow-up for these patients.
References


Recommended Reading


