



Should all Hodgkin's Lymphoma patients be treated the same?

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TRANSCRIPT

I think Hodgkin's Lymphoma is one of the most interesting diseases that we treat because this is really a great example in the world of cancer medicine how we've seen the development of two issues. First, there's a group of patients that will have a very high cure rate with standard therapy and in North America that's typically a four-drug treatment called ABVD. The concerns in those patients are how we continue to maintain very good cure rates while we try to minimize the possibility of acute side effects and as well, long-term treatment effects such as the risk of second cancers and other complications such as heart disease.

In contrast, there's another group of patients, those typically with more advanced disease, where improving outcomes with the disease still remains important – increasing cure rates but at the same time this understanding that we need to be cautious in terms of maintaining a concern for late effects, things again like second cancers and other risks like heart disease, that we must continue to play out in both ways.

The approach to how we look at Hodgkin's Lymphoma is largely based on risk. The risk can be defined very simply just based on stage. Historically in North America we would think of two groups. First, patients who have what we call limited stage or localized disease. This is typically stage I or II. This is one or two sites of disease, patients without very big lymph node masses, certainly things that are smaller than ten centimeters. Usually people that don't have signs of having a lot of lymphoma on board, so people who have not had what we call B symptoms, so no unexplained weight loss, no drenching fevers, no recurring night sweats.

In that group of patients, we know that typically briefer courses of chemotherapy, potentially between two to four cycles of ABVD is very appropriate and is associated with a very good cure rate. Historically, this was the group of patients where we would often rely on radiation as part of a combined treatment package with chemotherapy followed by radiation. As we've learned more about late effects, and there have been increasing concerns about these, even though radiation techniques have evolved, both clinicians (and patients I think) have started to emphasize more of a discussion about trying to understand the tradeoffs of the use of radiation, and potentially balancing that with potentially higher rates of relapse that may be still seen, and balancing that with the risk of second cancer or accelerated heart disease that you may see with the application of radiation.

In contrast, the patients that have more disease on board (people with larger masses, people with those symptoms of fever, night sweats, weight loss and those people with stage III or IV disease) are those that are generally treated with longer applications of chemotherapy, typically six or even eight cycles of ABVD. In Europe this is where, particularly in Germany, they have pioneered the development of a regimen called escalated BEACOPP, and that's something that can be considered in patients with higher risk, though largely it has not caught on because there are some concerns with toxicities with the regimen.

Are all Hodgkin's Lymphoma patients treated the same? Certainly not, and a lot of it is based on the risk profile in terms of the amount of disease and that will often dictate the treatment approach.