Dr Jemma Longley
Medical Oncology Registrar
Cancer Research UK Clinical Fellow
University of Southampton Hospital
NHS Foundation Trust, UK

Professor Stefano Luminari
Professor of Medical Oncology
University of Modena and Reggio Emilia
Italy
Nothing to disclose
• A case presentation of advanced Hodgkin Lymphoma

• Audience opinion poll regarding treatment options

• Discussion in the context of ESMO Clinical Practice Guidelines
• 23 year old gentleman previously fit and well presented with an 8 month history of night sweats, recurrent chest infections and bilateral neck swelling

• Cervical lymph node biopsy showed classical Hodgkin Lymphoma

• Stage IV disease characterised by PET-CT

• IPS score 2/7 (male, stage IV disease)

• Non-smoker, no other comorbidity

IPS, International Prognostic Score; PET-CT, positron emission tomography-computed tomography
PET-CT Pre-treatment

Primarily supradiaphragmatic disease
Involvement of extranodal site C7 vertebra
Stage IVB disease

PET-CT, positron emission tomography-computed tomography
Audience Opinion Poll

How would you manage this patient?
Q1. How would you manage this patient?

1. #6-8 cycles of ABVD

2. #6 BEACOPPesc

3. PET-CT following #2 ABVD to assess response

4. PET-CT following #2 BEACOPPesc to assess response

(one answer)
• #2 ABVD followed by interim PET-CT to assess response (RATHL trial)

• Response to treatment with resolution of constitutional symptoms but residual FDG activity in the mediastinum – Deauville 4 (image on next slide)

• Switched to #6 BEACOPPesc

ABVD, doxorubicin, bleomycin, vinblastine, dacarbazine; BEACOPP, bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone; FDG, fludeoxyglucose; PET-CT, positron emission tomography-computed tomography
ABVD, doxorubicin, bleomycin, vinblastine, dacarbazine; PET-CT, positron emission tomography-computed tomography
• PET-CT after #4 BEACOPPesc showed complete metabolic response – Deauville 1

• Completed a total of #6 BEACOPPesc complicated by two admissions with febrile neutropenia and back pain secondary to growth factor support

• End of treatment CT showed a residual small lymph node in the left cervical region (< 1.5cm) – no bulky disease therefore no radiotherapy offered

• Surveillance CT scan scheduled for 4 months

BEACOPP, bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone; CT, computed tomography; PET-CT, positron emission tomography-computed tomography
• CT at 4 months showed small increase in size of left paratracheal node

• Further characterised by PET-CT which showed disease activity in the mediastinum – Deauville 5 consistent with relapsed disease

• Patient well with no clinical signs or symptoms- re-biopsy confirmed nodular sclerosing Hodgkin Lymphoma
PET-CT, positron emission tomography-computed tomography
• ICE chemotherapy induction with a view to autologous stem cell transplant (ASCT) if remission achieved

• Tolerated well but unfortunately PET-CT after #3 ICE showed progression of lymphoma with persistent FDG avid disease in the mediastinum Deauville 5

• Patient still experiencing no B symptoms, ASCT abandoned following stem cell harvest

ASCT, autologous stem cell transplant; FDG, fludeoxyglucose; ICE, ifosfamide, carboplatin, etoposide; PET-CT, positron emission tomography-computed tomography
Audience Opinion Poll

How would you manage this patient?
Q2. How would you manage this patient?

1. Brentuximab vedotin induction and ASCT
2. Nivolumab induction and ASCT
3. Brentuximab vedotin with a view to allograft
4. Nivolumab with a view to allograft

(one answer)
• Given chemo refractory disease, funding for nivolumab applied for and approved

• If remission achieved for consideration of allogenic stem cell transplant

• PET-CT after #4 of 2 weekly nivolumab showed a complete metabolic response

• Completed a total of #7 with minimal toxicity

• Currently undergoing an allograft with an HLA matched unrelated donor 4 weeks after completion of nivolumab

HLA, human leucocyte antigen; PET-CT, positron emission tomography-computed tomography
Discussion Points

- Role of brentuximab vedotin
- Use of checkpoint inhibitors to induce remission
- Management of early relapse
- Interim PET-CT and response adapted therapy
- The safety of allograft following immunotherapy
- ABVD versus BEACOPP in response adapted therapy

ABVD, doxorubicin, bleomycin, vinblastine, dacarbazine; BEACOPP, bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone; PET-CT, positron emission tomography-computed tomography
Many thanks for your attention

Special thanks to Dr Rob Lown and Dr Ken Tung for their help in preparing this presentation

Any Questions?

Contact jemma.longley@uhs.nhs.uk