UCCH Pathway

UCCH Guideline
Hodgkin´s Lymphoma

2.03.01 Anlage 31

Version Apr/2020

Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Guideline Hodgkin´s Lymphoma

Version 04, Apr/2020

According to WHO classification of lymphoid neoplasms, 4th edition and Ann-Arbor staging system

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Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

= Supportive measure

= Referral

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

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Pathway: Hodgkin´s Lymphoma

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Work up

Baseline:

- History (incl. B-symptoms)
- Physical examination (incl. palpation of all lymph node areas, spleen and liver)
- Lab exam (including CBC with differential, ESR, LDH, comprehensive metabolic panel and liver function test)
- Hepatitis B/C; HIV serology
- PET-CT scan[1], (CT of neck, chest, abdominal and pelvis if no PET-CT available)
- ECG, Echocardiography and lung function test (pretreatment evaluation)
- Biopsy[2] and histopathological report[3]
- Pregnancy testing, discussion of fertility issues and sperm banking
- Only if not PET-CT performed: Bone marrow aspirate & biopsy[4]
- Supportive:
  - Offer contact to self help group
  - Offer psychooncological support

Histological subtypes[3]:

- Classical Hodgkin´s lymphoma
  - Nodular sclerosis
  - Mixed cellularity
  - Lymphocyte-depleted
  - Lymphocyte-rich
- Nodular lymphocyte-predominant Hodgkin´s lymphoma

Staging[5] and risk assessment[6]

First line therapy → TB → Pathway page 2

Relapsed disease → TB → Pathway page 3

NLPHL Nodular lymphocyte-predominant Hodgkin´s lymphoma

1 Consider additional biopsy of PET positive extranodal findings

2 Lymphnode biopsy (or a biopsy from another organ with suspected affection). Fine needle aspirations are inappropiate for a reliable diagnosis.

3 The histological report should give the diagnosis according to the World Health Organization classification. Consider validation of findings by hemato- or cytopathological reference histology

4 Due to the high sensivity of PET-CT for bone marrow involvement there is no indication for a bone marrow biopsy in patients undergoing PET-CT evaluation

5 According to the Ann Arbor classification system

6 According to GHSG, see page 5

Pathway page 2: Stage adapted first line therapy

All others (Classical Hodgkin lymphoma, nodular lymphocyte-predominant Hodgkin lymphoma)

Nodular lymphocyte-predominant Hodgkin lymphoma:

- Stage IA without risk factors[7]
- Advanced stages: Consider Rituximab-containing protocols

TB → **Radiotherapy:**

- IF-RT (30 Gy)

Limited stage:

- Stage I and Stage II A/B without risk factors[7]

TB → **Combined chemo-/radiotherapy:**

- 2x ABVD + IF-RT (20 Gy) PET CT guided treatment[8] in distinct clinical situations recommended

Consider Clinical Trial

Intermediate stage:

- Stage I and Stage II A/B with risk factors[7]
- Stage IIB with ≥3 nodal areas and or elevated ESR

TB → **Combined chemo-/radiotherapy:**

- Preferred in patients ≤60 years[9]: 2x BEACOPP esc. + 2x ABVD + IF-RT (30 Gy)
- Alternative: 4x ABVD + IF RT (30 Gy)

Consider Clinical Trial

Advanced stage:

- Stage III/IV A/B
- Stage IIB with large mediastinal mass and/or extranodal disease

TB → **Chemotherapy:**

- Preferred in patients ≤60 years[9]: PET-CT guided treatment[10] with BEACOPP esc. (4x/ 6x) + localised RT to PET positive lymphoma >2,5 cm (30 Gy)
- Alternative: 6-8x ABVD + localised RT to residual lymphoma >1.5 cm

Consider Clinical Trial:

- GHSG: HD 21 study

RT Radiotherapy, IF Involved field, GSHG German Hodgkin Study Group, ABVD Adriamycin, Bleomycin, Vinblastine, Dacarbazine; BEACOPP Bleomycin, Etoposide, Adriamycin, Cyclophosphamide, Vincristine, Procarbazine, Prednisone

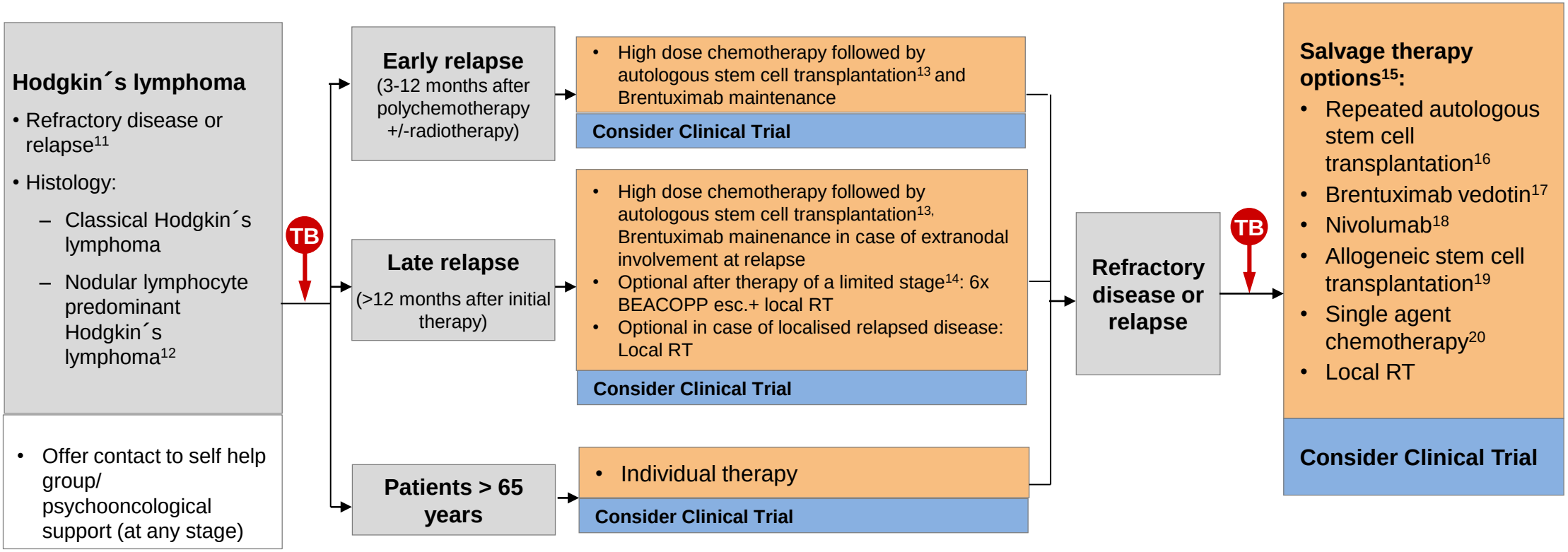
7 Risk factors: Large mediastinal mass (more than 1/3 of the maximum horizontal chest diameter), elevated ESR (>50 mm/h without B symptoms; >30 mm/h with B symptoms), ≥ 3 nodal areas, extranodal disease. See risk group stratification according to GSHG on page 5

8 PET-CT guided treatment if RT should be avoided (mediastinal mass in women ≤ 21 years or in case of suspected suboptimal response. If PET-CT remains positive after 2 x ABVD consider 2 x eBEACOPP before RT

9 In patients > 60 years or therapy limiting comorbidities the BEACOPP regimen should not be given. A stage adapted therapy with ABVD (2, 4 or 6-8 cycles) is performed. Alternatively a therapy with PVAG (6-8 cycles) can be applied in case of contraindications against parts of ABVD

10 Initial treatment with 2 x BEACOPP esc. with subsequent PET-CT. PET-CT negative patients receive another 2 cycles BEACOPP esc., PET-CT positive patients get 4 cycles BEACOPP esc. Localised RT has to be performed in PET positive lymphoma > 2,5 cm (30 Gy) after completion of chemotherapy

Pathway page 3: Relapsed disease



[11] Imaging and propagation diagnostics as necessary for staging (see work up page 1). Consider confirming biopsy especially in case of NLPHL to exclude transformation into aggressive lymphoma

[12] Consider (combination)-therapy with anti-CD20 antibody in case of CD20 positive relapsed NLPHL

[13] E.g. Salvage chemotherapy with DHAP (dexamethasone, high dose ara-C, cisplatin) or ICE (ifosfamide, carboplatin, etoposide) to reduce tumor burden and mobilization of stem cells followed by high dose chemotherapy and ASCT.

[14] E.g. after two cycles of chemotherapy followed by RT

[15] Salvage therapy options depending on previous therapy, age, performance status, comorbidities and response duration

[16] Especially in young and fit patients

[17] Approved for CD-30 positive refractory or relapsed Hodgkin lymphoma a) after autologous stem cell transplantation or b) after at least two other therapies

[18] Approved for classical Hodgkin´s lymphoma after autologous stem cell transplantation and treatment with Brentuximab vedotin

[19] Especially in case of late relapse after ASCT

[20] E.g. gemcitabine, bendamustine

Page 4: Final staging and Follow up

Final staging

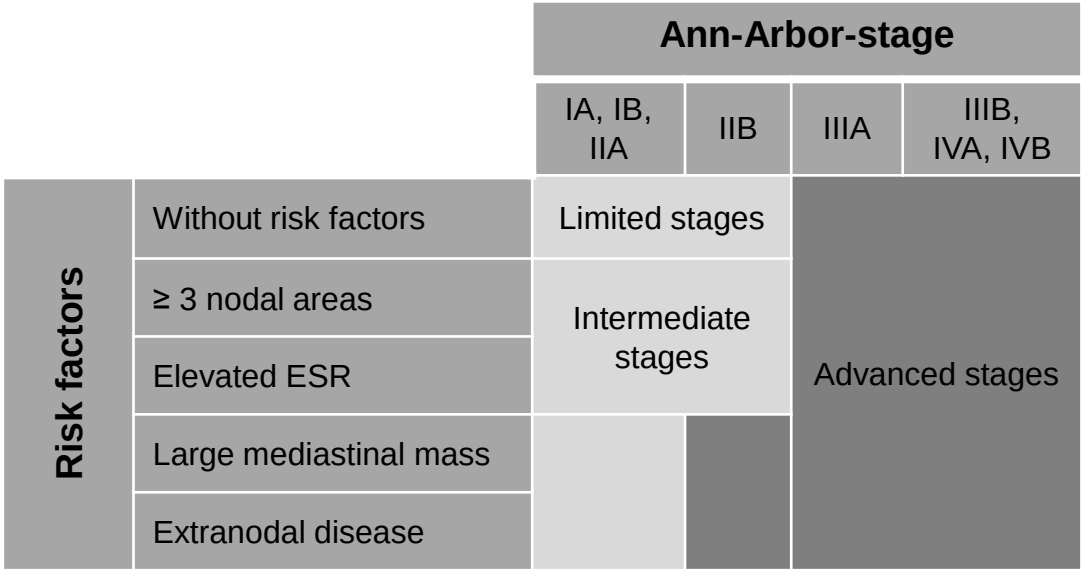
- Final staging should be carried out after completion of treatment (physical examination, laboratory analyses and contrast enhanced CT are mandatory. PET should be carried out at final staging for response assessment in lymphoma whenever this diagnostic tool is available)

Follow up

Every 3 months for 1 year, then every 6 months until year 4, afterwards yearly

- History and clinical examination, lab exam (including full blood count with differential and ESR)
- Thyroid function tests especially after irradiation of the neck (after year one, two and five)
- CT scans and previously pathologic radiographic tests must be carried out once to confirm the remission status. Thereafter, surveillance scans are not indicated unless clinical symptoms occur
- Offer contact to self help group and psychooncological support whenever necessary

Page 5: Risk group stratification according to GHSG[21]



[21] Definition of Hodgkin's lymphoma risk groups according to the German Hodgkin Study Group. Eichenauer D.A. et al: Hodgkin´s Lymphoma: ESMO Clinical Practice Guidelines. Ann Oncol. (2014)25 (suppl 3): 70 - 75