EUROPEAN HEMATOLOGY ASSOCIATION

EHA-ISHBT Hematology Tutorial

Self-assessment case – Session 11
[Hodgkin Lymphoma]

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Hyderabad, India
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Disclosures

- Takeda (speaker’s bureau), Novartis (speaker’s bureau), Zydus life-sciences (advisory board), Intas Pharma (advisory board), Cipla pharma (advisory board), NATCO (advisory board), BSV (speaker’s bureau), Mankind pharma (advisory board)

Introduction

- A 27 year gentleman, no comorbidities
- Symptomatic since 2 months
- Symptoms:
  - Periodic low-grade fever
  - Weight loss, approximately 12%
  - Cough
  - Pruritus

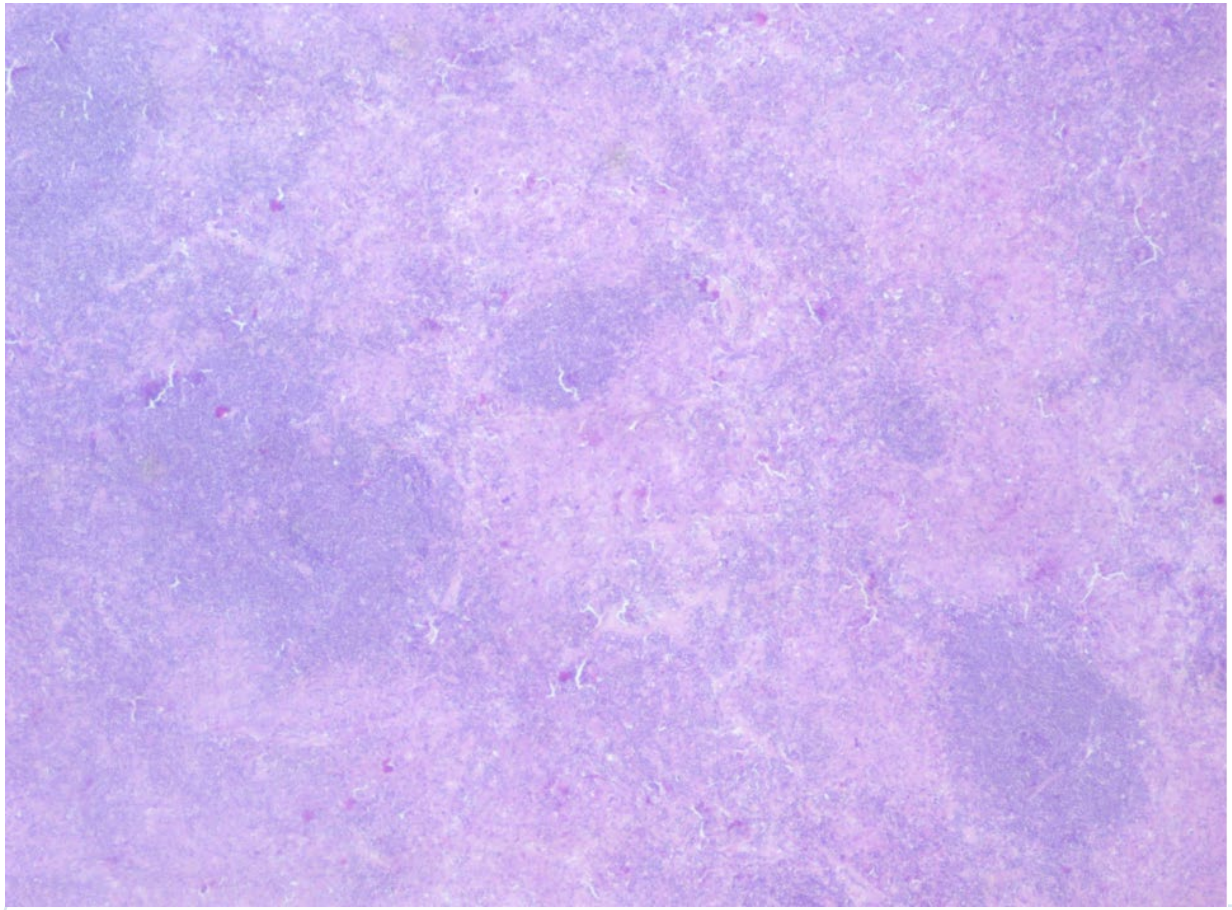
Clinical Examination

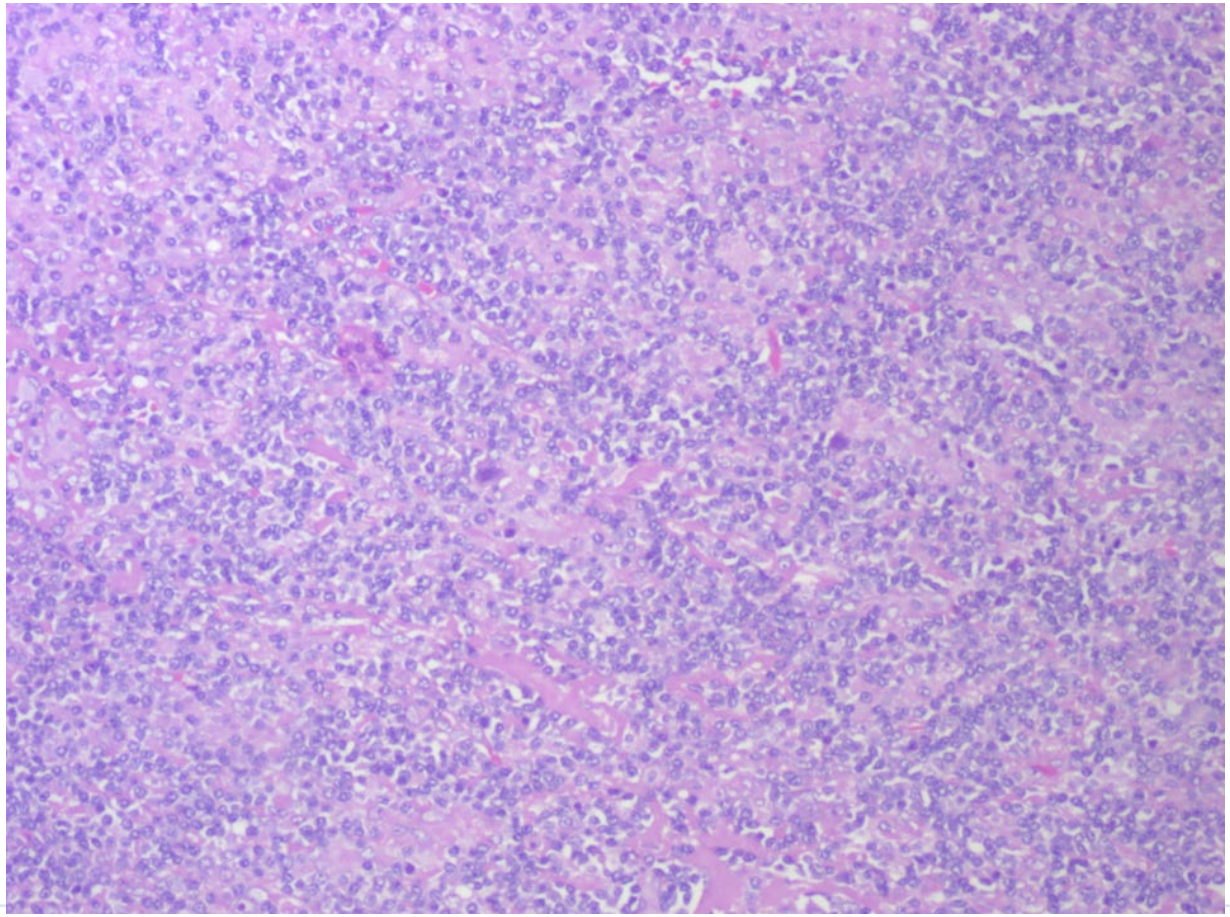
- Bilateral cervical, axillary and inguinal LNs
- No hepatosplenomegaly
- Remainder unremarkable

PET/CT scan

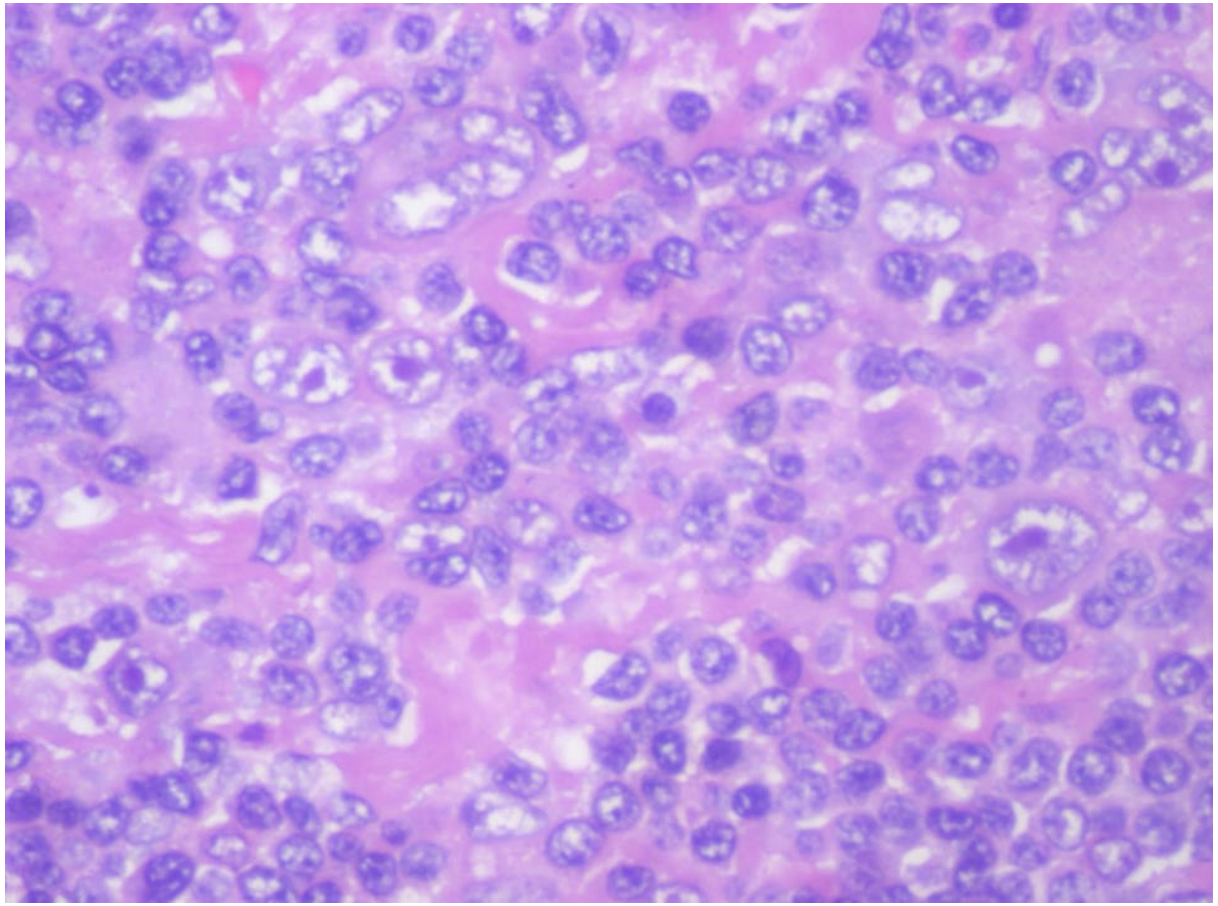
- Metabolically active LNs on either side of diaphragm including a mediastinal mass
- Size 1.5 to 3 cm, FDG-Maximum Standardized uptake: 7 to 12
- No extra-nodal involvement
- No bone marrow involvement

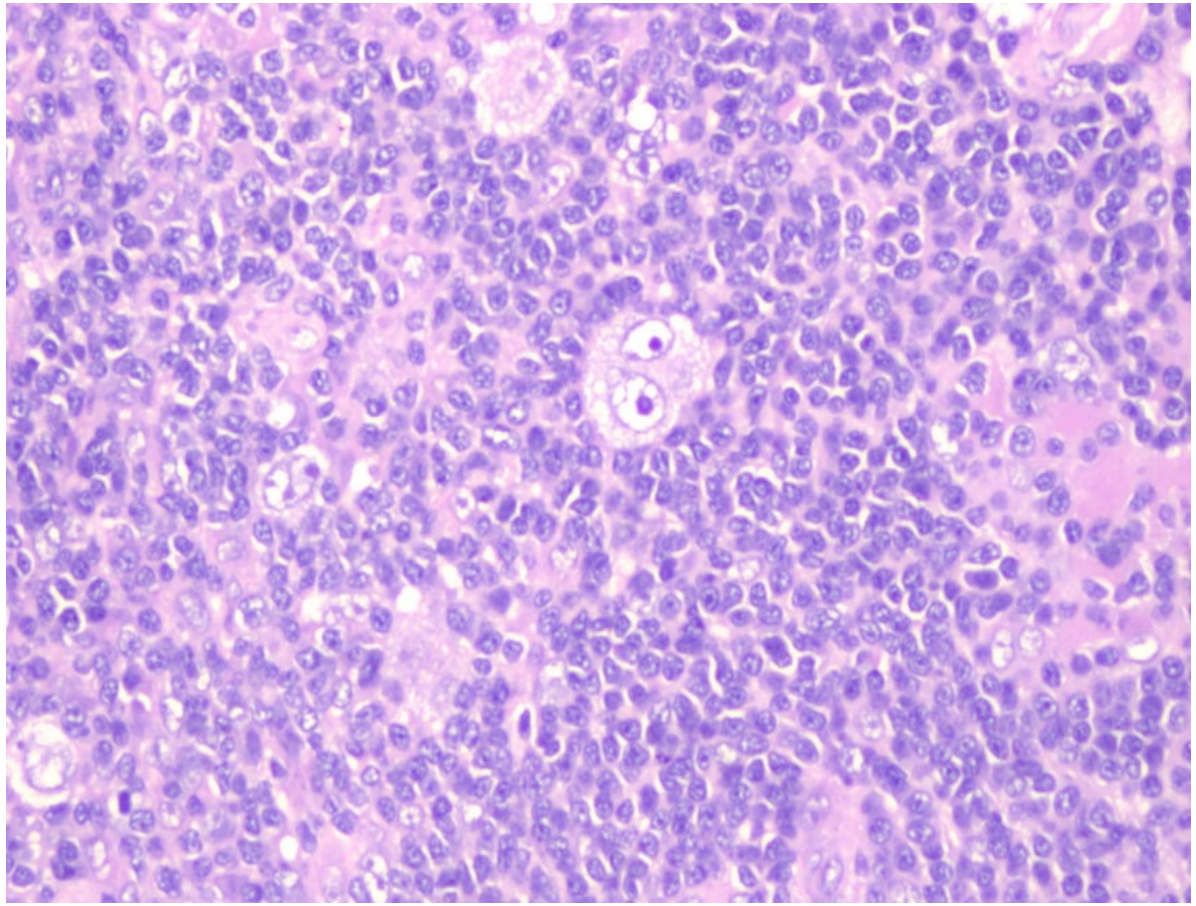
Cervical LN excisional biopsy



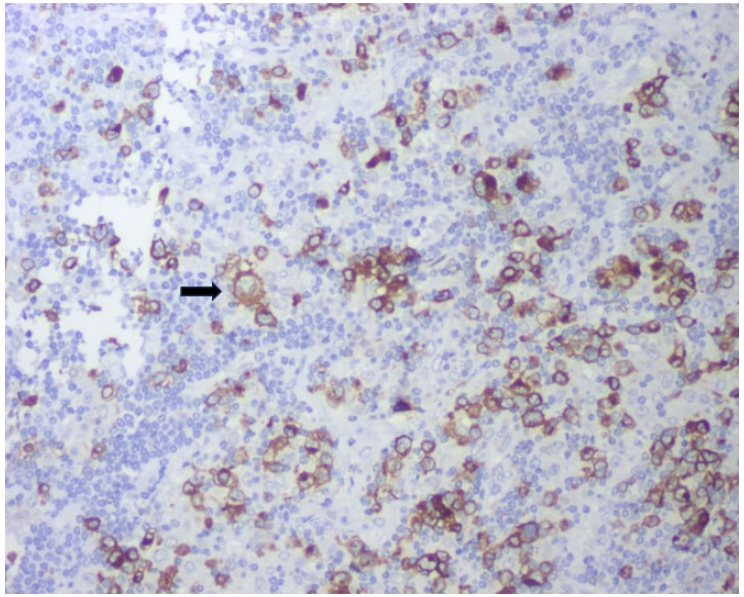


Cervical LN excisional biopsy

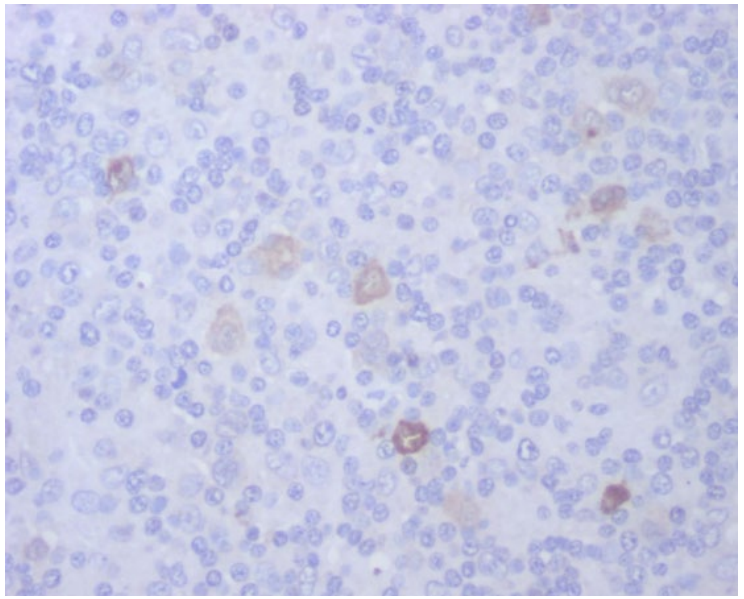




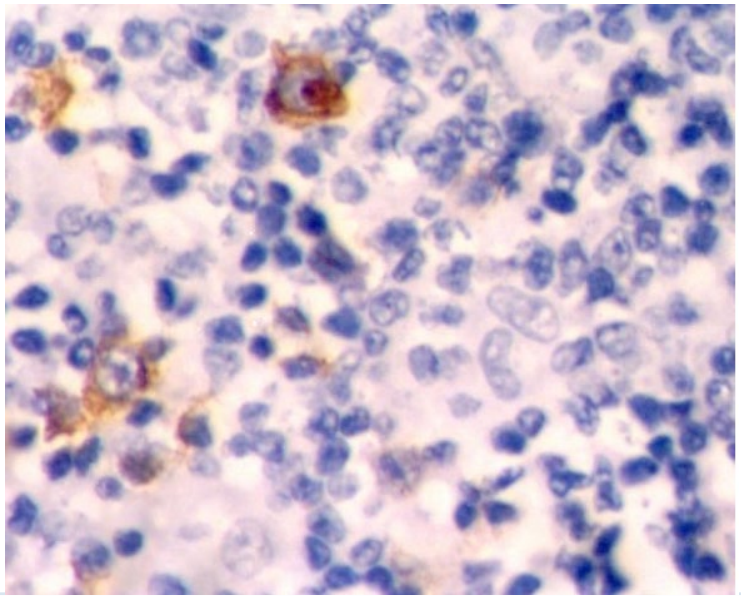
IHC



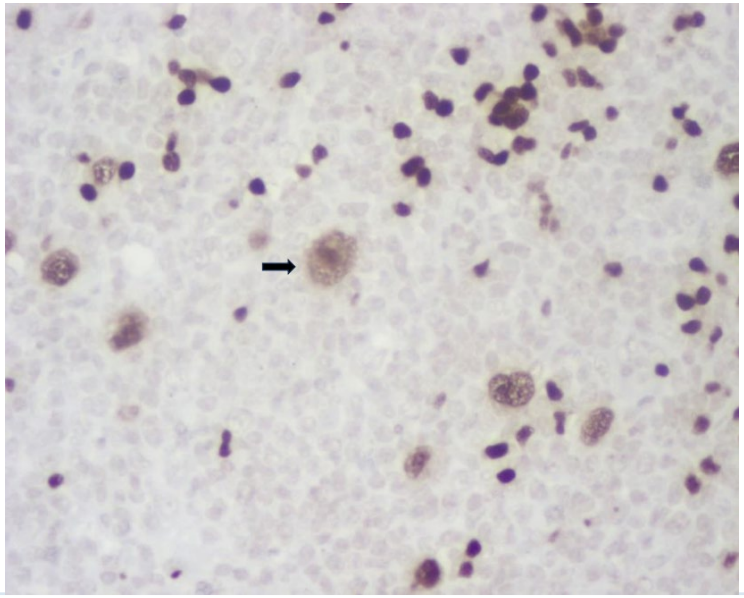
CD30



EBV-LMP



CD15



PAX5

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Questions can be answered by scanning the QR on your phone to access Slido.

For each question you have 15 seconds.

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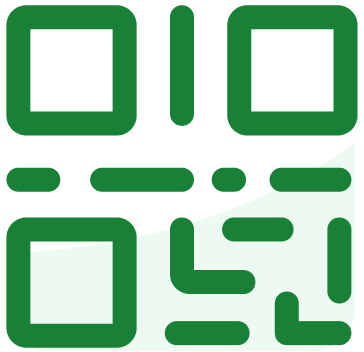

Join at slido.com
#1567301

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Q1) What is most likely diagnosis?

1. Nodular sclerosis cHL
2. Lymphocyte rich cHL
3. Mixed cellularity cHL
4. Lymphocyte depleted cHL
5. Nodular lymphocyte predominant B cell lymphoma

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11.41 What is most likely diagnosis?

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Feedback

- The HPE was suggestive of Mixed Cellularity Classical Hodgkin Lymphoma. IHC confirmed the presence of RS cells

- CD15 Positive
- CD30 Positive
- PAX5 Positive
- EBV-LMP Positive

Laboratory evaluation

- Hemoglobin: 100 g/L (13 - 18)
- WBC: 5.6 x 10^9/L (4 – 11)
  - ANC: 2.6 x 10^9/L (1.8 – 7.5)
  - ALC: 2.5 x 10^9/L (1 – 4)
- Platelet: 380 x 10^9/L (150 – 400)
- ESR: 60 mm/hr (1 – 7)
- Albumin: 42 g/L (35 – 50)
- Creatinine: 53 µmol/L (45 – 84)
- Total Bilirubin: 13.6 µmol/L (0 – 21)
- ALT: 24 units/L (10 – 50)
- AST: 22 units/L (0 – 40)

Q2) How do you risk stratify the patient?

1. Early favorable
2. Early unfavorable
3. Advanced, IPS 0-1
4. Advanced, IPS 2-3
5. Advanced, IPS 4-7

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11.42 How do you risk stratify the patient?

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The International Prognostic Score: Advanced stage cHL

PET/CT scan suggested an advanced stage disease, so the IPS applies. The score for this patient is 2 as discussed

Factors predicting poor prognosis:	Age ≥45 years	0
	Male gender	1
	Stage IV disease	0
	Serum albumin <40 g/L	0
	Hemoglobin level <105 g/L	1
	White blood cell count ≥15 x 10^9/L	0
	Lymphocyte count <0.6 x 10^9/L and / or <8% of white blood cell count	0

Hasenclever D, Diehl V. N Engl J Med 1998;339:1506–14

Q3) What are the options for frontline treatment for this patient?

1. ABVD x 2 followed by PET
2. escBEACOPP x 2 followed by PET
3. BV-AVD x 6 followed by PET
4. ABVD x 6 followed by response assessment
5. All of the above

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11.43 What are the options for frontline treatment for this patient?

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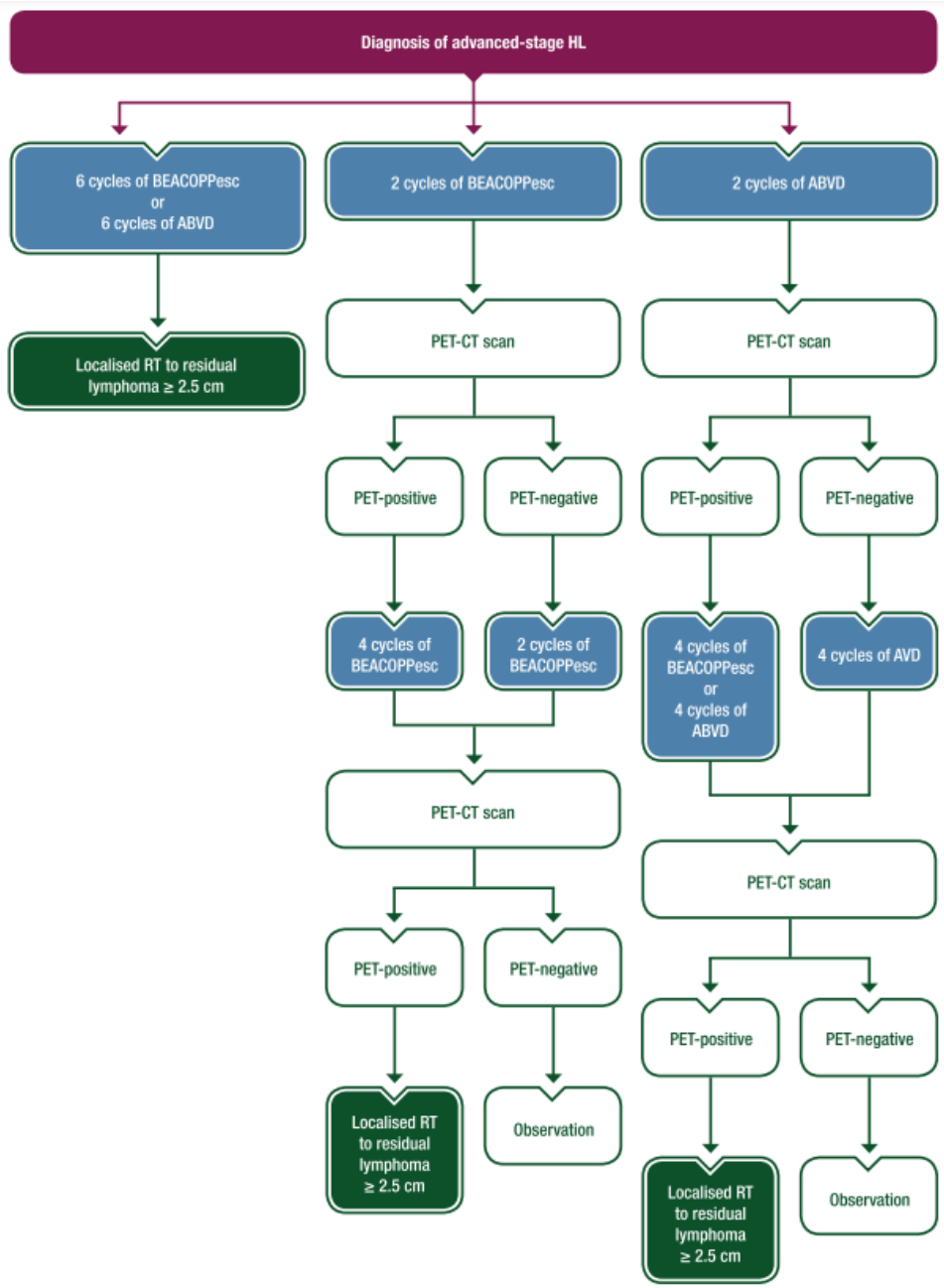
Feedback

ESMO: Advanced stage HL Rsik & Response adapted therapy

All the treatment options mentioned as standard upfront therapy, although a response adapted therapy is preferred in the PET/CT era



Eichenauer et al. Ann Oncol 2018;29 (Suppl 4): iv19–iv29

Q4) The patient received 2 cycles of ABVD followed by PET/CT which showed Deauville 3. Further treatment?

1. ABVD x 4
2. AVD x 4
3. escBEACOPP x 2
4. escBEACOPP x 4
5. BV-AVD x 4

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11.44 The patient received 2 cycles of ABVD followed by PET/CT which showed Deauville 3. Further treatment?

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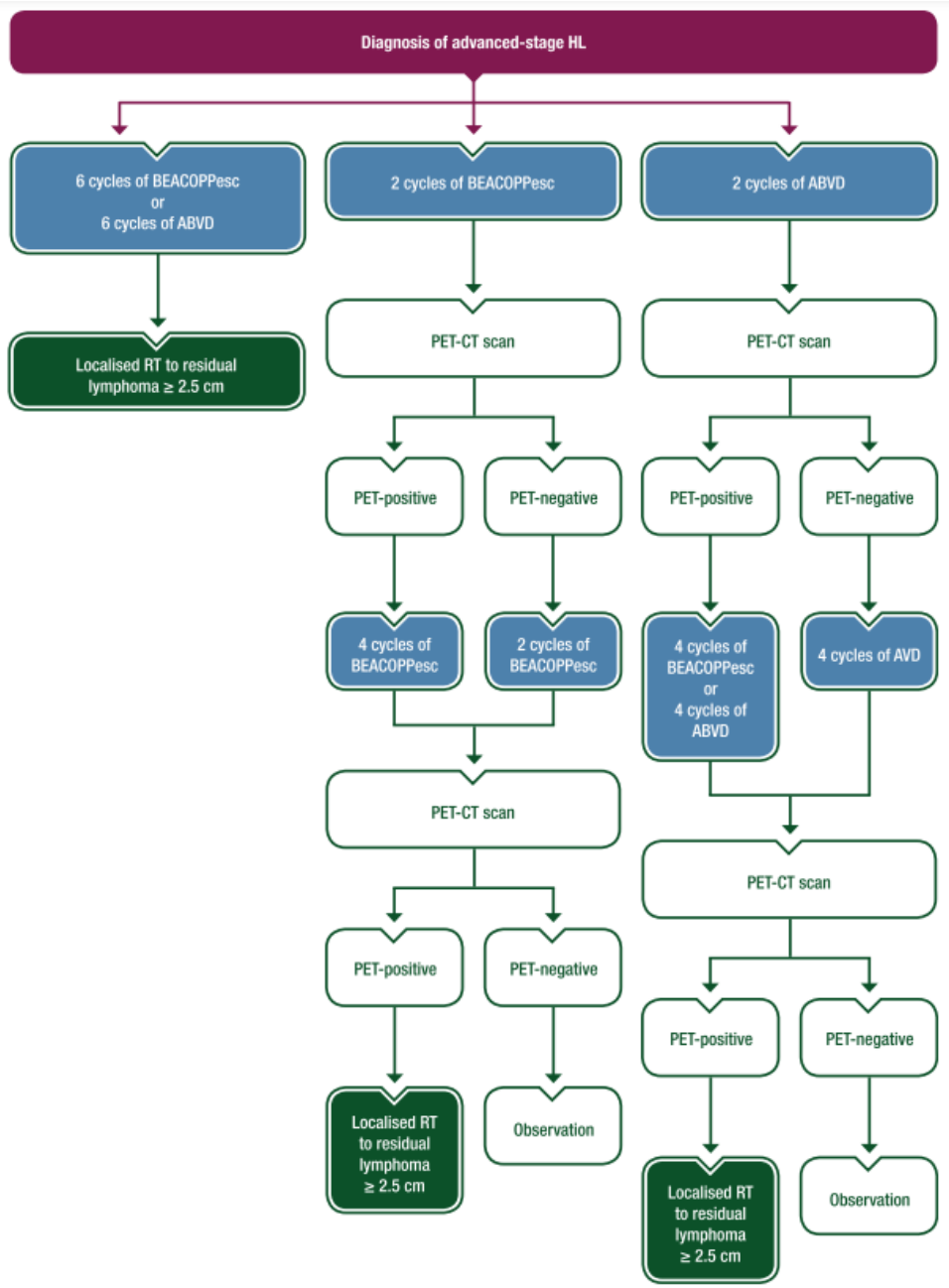
Feedback

ESMO: Advanced stage HL Rsik & Response adapted therapy

Patient showed early metabolic response and based on RATHL trial, de-escalation to AVD is non-inferior and less toxic



Eichenauer et al. Ann Oncol 2018;29 (Suppl 4): iv19–iv29

Q5) If the Deauville score was 4, what would be the further line of management?

1. AVD x 4
2. escBEACOPP x 4
3. BV-AVD x 4
4. Nivolumab-AVD x 4
5. None of the above

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11.45 If the Deauville score was 4, what would be the further line of management?

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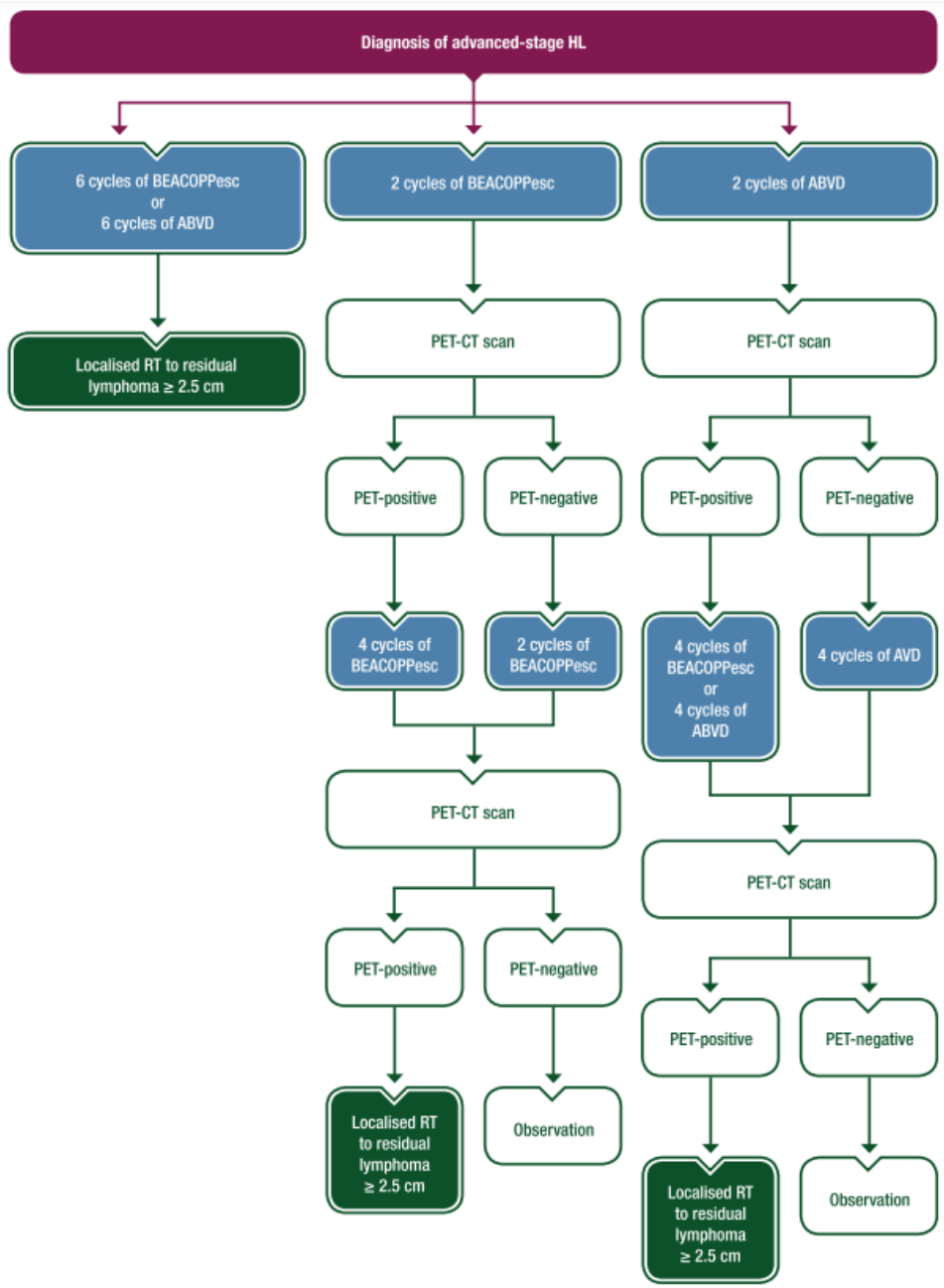
| Feedback

ESMO: Advanced stage HL Rsik & Response adapted therapy

Deauville 4 after 2 cycles of ABVD shows inadequate response. RATHL trail suggests escBEACOPP. Addition 4 cycles of ABVD is also an option. There is no data to suggest addition on BV or CPI at this stage



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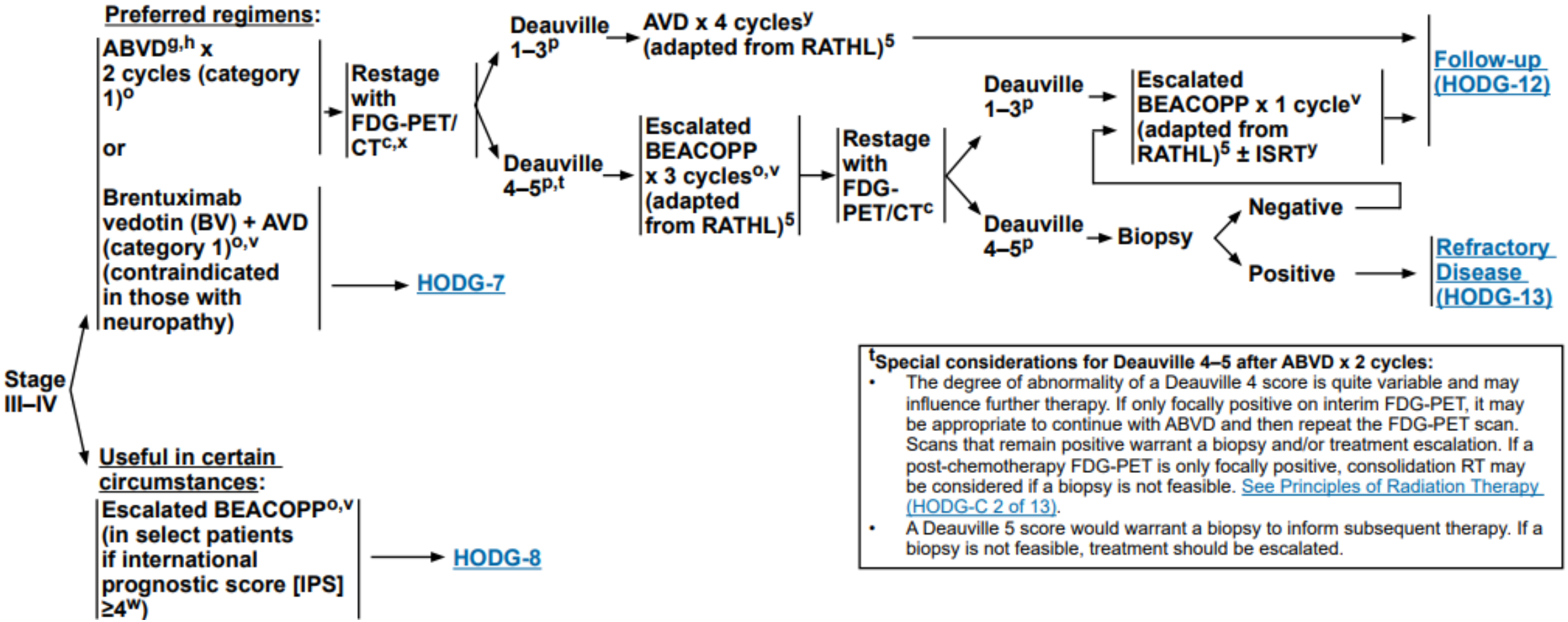
NCCN: advanced HL



[t]**Special considerations for Deauville 4–5 after ABVD x 2 cycles:**

- The degree of abnormality of a Deauville 4 score is quite variable and may influence further therapy. If only focally positive on interim FDG-PET, it may be appropriate to continue with ABVD and then repeat the FDG-PET scan. Scans that remain positive warrant a biopsy and/or treatment escalation. If a post-chemotherapy FDG-PET is only focally positive, consolidation RT may be considered if a biopsy is not feasible. See Principles of Radiation Therapy (HODG-C 2 of 13).
- A Deauville 5 score would warrant a biopsy to inform subsequent therapy. If a biopsy is not feasible, treatment should be escalated.

Q6) Patient relapsed after 6 months, repeat biopsy confirmed cHL. There was presence of extra nodal disease on PET/CT. Best treatment option is:

1. Salvage Chemotherapy → ASCT → Follow up
2. BV + Chemotherapy → ASCT → Follow up
3. BV + Chemotherapy → ASCT → BV maintenance
4. CPI + Chemotherapy → ASCT → Follow up
5. BV + CPI→ ASCT → Follow up

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11.46 Patient relapsed after 6 months, repeat biopsy confirmed cHL. There was presence of extra nodal disease on PET/CT. Best treatment option is:

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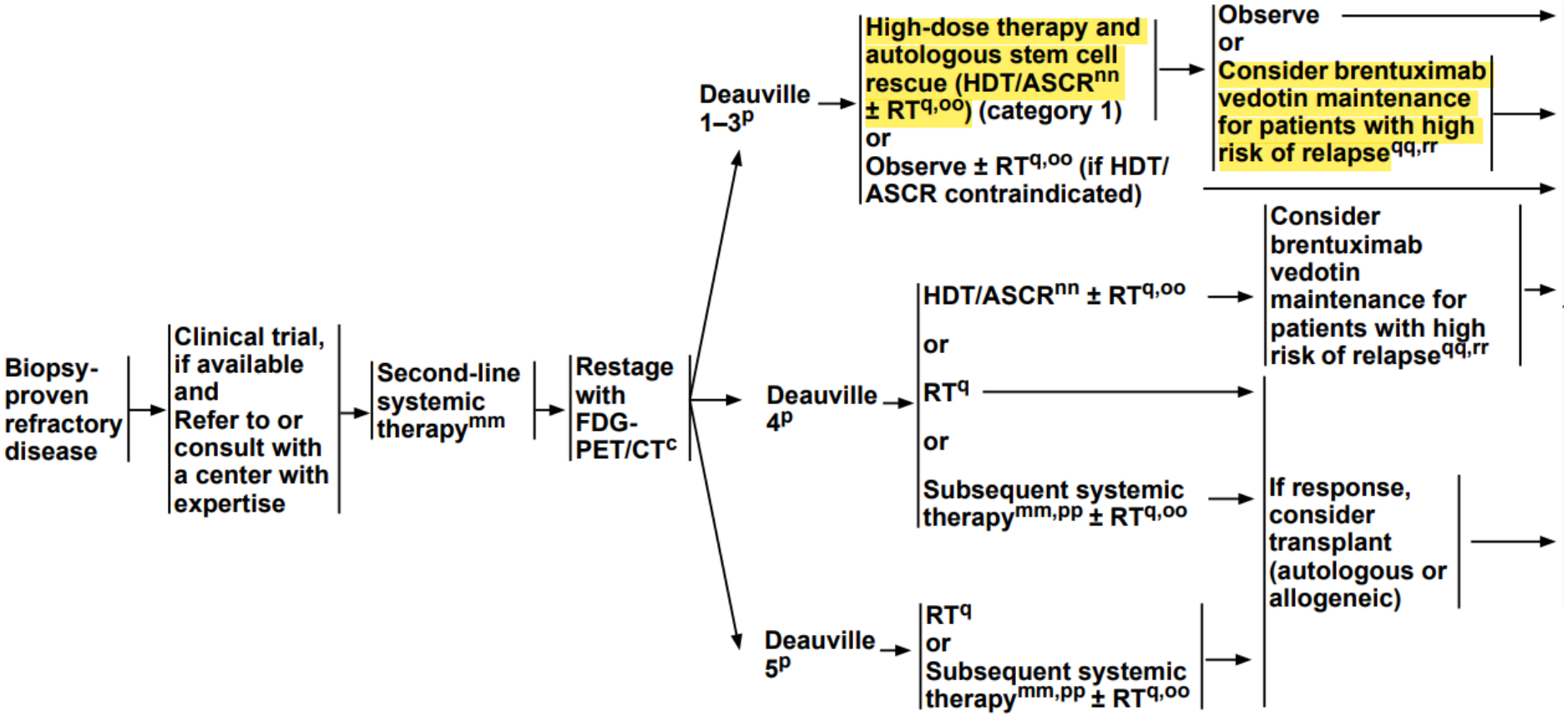
R/R cHL: NCCN document salvage options

Adults Age 18–60 Years	
Second-Line and Subsequent Therapy[i,j] (in alphabetical order)	**Therapy for Disease Refractory to at Least 3 Prior Lines of Therapy (in alphabetical order)**
• BV[1] • BV + bendamustine[2] • BV + nivolumab[3] • DHAP (dexamethasone, cisplatin, high-dose cytarabine)[4,5] • Gemcitabine/bendamustine/vinorelbine[6] • GVD (gemcitabine, vinorelbine, liposomal doxorubicin)[7] • GVD + pembrolizumab[8] • ICE (ifosfamide, carboplatin, etoposide)[5,9,10] • ICE + brentuximab vedotin[11] • ICE + nivolumab[12] • IGEV (ifosfamide, gemcitabine, vinorelbine)[13] • Pembrolizumab[14,15] • Pembrolizumab + ICE[16]	• Bendamustine[17] • Bendamustine + carboplatin + etoposide[18] • Everolimus[19] • GCD (gemcitabine, cisplatin, dexamethasone)[20] • GEMOX (gemcitabine, oxaliplatin)[21] • Lenalidomide[22] • Nivolumab[23,24] • Vinblastine[25]

NCCN Clinical Practice guideline. Version 1.2024

R/R cHL: NCCN document



Patients with 2 or more of the following risk factors are considered to be at high risk: Remission duration <1 year, END, PET positive at transplant, B symptoms, >1 second-line/subsequent therapy

NCCN Clinical Practice guideline. Version 1.2024

Feedback

- Although the first 3 are reasonable options, but considering the early extranodal relapse, BV + Chemotherapy followed by ASCT and BV maintenance is the best possible option. CPI is currently approved in post ASCT relapse setting

Follow up

- The patient received BV + chemotherapy based salvage
- Achieved CMR after 3 cycles
- Underwent HDT + ASCT
- Counselled for BV maintenance

Thank you