V. Diehl

University of Cologne, Germany

Advanced Hodgkin's lymphoma: doxorubicin, bleomycin, vinblastine, dacarbazine and beyond

In 2009 patients with Hodgkin's lymphoma in all stages and all different histologies can be cured when treated with the right therapy from the moment of diagnosis. In early stages cure is possible with 2 ABVD and 20 Gy IF-RT in nearly 97% (HD10, GHSG) and in intermediate stages with 2 BEACOPP esc + 2 ABVD + 30 Gy IF-RT in 95% (HD14, GHSG). In advanced stages (in the GHSG and EORTC/GELA only stages IIB LMM, III,IV - and not like in the USA/Canada including in advanced stages all I-II B and bulk > 5 cm, that are in the GHSG and EORTC/GELA included in the intermediate, early unfavorable stages and amount to about 30% of all patients!!!)- if you start with 6-8 courses of ABVD and add in 45% of patients additive IF-RT: you reach about 75% PFS at 5 years (Aleman *et al*., NEJM, EORTC). When starting with 6-8 courses of BEACOPP esc or BEACOPP-14 you reach a PFS at 5 years of 88% (HD 9;12;15, GHSG) with the higher risk of more acute toxicity and infertility and a risk of AML/MDS which is not higher than 1% (HD12;15 in about 2500 treated patients). The question now arises which group of patients with Hodgkin's lymphoma in the true advanced stages (IIB-LMM, III-IV) can be cured when using ABVD as induction regimen and which patients need a more aggressive treatment, f.e BEACOPP esc/14. To answer this question every doctor treating Hodgkin Lymphoma patients has to balance the whole package of induction and salvage therapy to reach a long term cure with the least possible burden of acute and long term toxicity and the highest number of cures possible, optimally reached at the earliest time point, since the patient is not interested in a prolongation of hospitalization and suffering when salvage becomes necessary! The advent of the IPS and FDG-PET have now enabled doctors to tailor therapy according to their risk to develop progressive or relapsing disease and to modulate treatment according to the assessmant of an early therapy response already after 1 or 2 courses of chemotherapy. In the presentation I shall elude on the different options used nowadays in the international studies launched around the world when using only the FDG-PET as response indicator after 2 ABVD or as in the Israelian study using IPS as risk indicator and FDG-PET as response modulator. The question remains and has to be discussed intensively: will BEACOPP esc or HDCT+SCT with IGEV or DHAP after PET-2 pos after 2 ABVD not be 8 weeks too late (remember the Diehl-Kairos-Principle!!) when it would be more effective and less long term toxic to start in the high IPS- risk group with 2 BEACOPP esc and deescalate to ABVD when PET is negative already after 2 BEAesc!