Guideline 6-20

A Quality Initiative of the Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

Management of Early-Stage Hodgkin Lymphoma


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Section 1: Recommendations

The complete guideline is available on the CCO website: https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=350545, and includes a summary of the key evidence associated with each recommendation, the guideline development methods, the evidence review and a summary of the review process.

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Management of Early-Stage Hodgkin Lymphoma

Section 1: Recommendations

GUIDELINE OBJECTIVES
To make recommendations on management strategies for patients with early-stage Hodgkin lymphoma (HL).

TARGET POPULATION
Patients with early-stage Hodgkin Lymphoma.

INTENDED USERS
Clinicians involved in the management of patients with early-stage Hodgkin lymphoma, including radiation oncologists and clinical hematologists/oncologists.

RECOMMENDATIONS

Recommendation 1A
Patients with early-stage classical Hodgkin lymphoma should not be treated with radiotherapy alone.

Recommendation 1B
In patients with early-stage nodular lymphocyte predominant HL (NLPHL), it is reasonable to use involved-field radiation therapy alone. However, no phase III clinical trials have focused exclusively on NLPHL, therefore, no strong evidence base for such treatment, or for relative dosage, is currently available, and this recommendation is based on the expert opinion of the guideline authors.

Recommendation 2
Chemotherapy plus radiotherapy or chemotherapy alone are recommended treatment options for patients with early-stage nonbulky Hodgkin lymphoma.

Qualifying Statements for Recommendation 2
The decision on which treatment option to use should involve a patient-centred discussion with a hematologist/medical oncologist and a radiation oncologist. Patients should be aware of inferior progression-free survival (PFS) with chemotherapy alone, and of the possibility of late radiotherapy toxicity.

Recommendation 3
When delivered as part of a planned combined modality treatment approach, involved field radiation therapy (IFRT) should be used for patients with early stage HL.

Qualifying Statements for Recommendation 3
The evidence at the present time is insufficient to support or refute the comparative superiority of involved nodal radiation therapy (INRT) or involved site radiation therapy (ISRT) over IFRT. It is recognized that the EORTC H10 study [1] demonstrated the statistically superior event-free survival associated with INRT compared with chemotherapy alone in
Recommendation 4
The dose of involved field radiation should be 20 Gy for patients with favourable characteristics and between 30 to 36 Gy for patients with unfavourable characteristics (see Appendix 1 for definitions of favourable and unfavourable characteristics).

Recommendation 5
The Working Group does not recommend the use of a negative interim positron emission tomography scan alone to identify patients with early-stage HL for whom radiotherapy can be omitted without a reduction in PFS.

Recommendation 6A
Patients with early-stage, favourable risk Hodgkin lymphoma who are being treated with combined modality therapy should receive two cycles of chemotherapy before radiotherapy.

Recommendation 6B
Patients with early-stage, unfavourable risk Hodgkin lymphoma, who are being treated with combined modality therapy, should receive four cycles of chemotherapy before radiotherapy.

Recommendation 7
Doxorubicin, bleomycin, vinblastine, and dacarbazine (ABVD) should be the regimen of choice when administered before radiotherapy, except under the circumstances that follow in Recommendation 8.

Recommendation 8
Patients with early-stage, unfavourable risk Hodgkin lymphoma may be considered for treatment with either four cycles of ABVD, or two cycles of escalated bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine and prednisone (BEACOPP) followed by two cycles of ABVD before radiotherapy.

Qualifying Statements for Recommendation 8
The BEACOPP approach improves freedom from treatment failure and PFS but is associated with more adverse events. Overall survival rates at 91 months follow-up did not differ, but available data are not sufficiently mature to assess late adverse effects and long-term outcomes.