Clinical Management Guidelines for Hodgkins Lymphoma
West of Scotland Blood Cancer Network

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Appendix 1
Scottish Executive recommendations for PET scanning in Hodgkins Lymphoma (Updated Sept 2008) 8

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Approved by: Haemato-oncology MCN July 2009
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Review Date: July 2011
Reference/Version number
WoSCAN CMG HL version 3
(Updated Scottish Executive PET guidance issued Sept 2008)
Replaces
WoSCAN CMG HL version 2
Haemato-oncology MCN: 31st May 2007
RCAG Prescribing Advisory Subgroup: 31st August 2007
Essential Initial Investigations:

**History:**
*Specific to Hodgkins Lymphoma-*
- Presence of B symptoms
  - i.e. Weight loss > 10% of body weight, drenching sweats, fever,
 solated features e.g. itch, alcohol induced pain, symptoms of SVC obstruction

**Physical Examination:**
- General Health including assessment of performance status, cachexia
- Evidence and extent of lymphadenopathy/hepatosplenomegaly
- Any evidence of SVC obstruction

**Blood Tests:**
- FBC with differential white cell count.
- ESR
- U+Es
- LFTs / Albumin
- LDH
- Hepatitis B/ C /HIV testing

**Bone marrow aspirate and trephine biopsy.**
(This may be omitted in Stage 1A disease with normal FBC and ESR)

**Lymph Node Biopsy**
This is essential for accurate diagnosis and excision biopsy should always be performed when possible. Regional pathology review should be carried out by a specialist lymphoma pathology team.

**Pulmonary Function Tests:** Recommended at baseline

**Imaging**
- CXR and/or Ultrasound of neck may help in initial diagnosis.
- Echocardiogram: age >60yo/known history of cardiovascular disease/Hypertension/Diabetes
- CT Scan ; Neck, Chest, Abdomen, Pelvis

**N.B. Accurate measurements of all lymph node masses are essential for future comparisons and should be obtained at diagnosis. This is an absolute requirement of any radiology report in lymphoma patients.**
- PET scanning is now funded for all patients at diagnosis. This investigation is useful in most patients but should not unduly delay treatment. The CT component, in machines capable of dual scanning (PET-CT), should ideally, at present, not replace a baseline diagnostic CT scan.

**EACH CASE SHOULD BE DISCUSSED AT AN MDT MEETING.**
(This could be a local MDT if clear adherence to CMG guidance but all problem/difficult cases should continue to be discussed on a regional basis)
Prognostic Scoring systems in Hodgkins lymphoma

Early stage:

I. EORTC risk factors in localised disease

   A. Favourable (patients must have all features)
      1. Clinical stage 1 or 2
      2. Maximum of three nodal areas involved
      3. Age less than 50yo
      4. ESR< 50 mm/h
      5. Mediastinal/thoracic mass ratio < 0.33 at D5/6

   B. Unfavourable
      1. Clinical stage 2 with 4 or more nodal areas involved
      2. Age > 50yo
      3. ESR >50 mm/h without B symptoms or > 30 mm/h with B symptoms
      4. Mediastinal/thoracic ratio > 0.33 at D5/6

Advanced stage:

Hasenclever Score

   1. Age > 45 yo
   2. Male sex
   3. Serum Albumin < 40g/l
   4. Hb < 10.5g/dl
   5. Stage 4 disease
   6. Leucocytosis, i.e WCC >15 x 10^9/l
   7. Lymphopenia i.e. (< 0.6 x 10^9/l or < 8% of total WCC)
**MANAGEMENT OF EARLY STAGE HODGKINS LYMPHOMA**

**ALL PATIENTS:** Baseline PET-CT scan /Consider trial availability

**DEFINITION:** Clinical stage IA / IIA (CSIA/IIA)
- No bulk disease
  - (Nodal masses <10cm, mediastinal masses <0.33 intrathoracic diameter D5/6)

**Low bulk LP HD**
- Stage IA
  - or/
- Clinical stage IA HL
  - (Mass <5cm)
  - PET scan confirms localised disease
  - AND unfit for chemotherapy

**RADIOTHERAPY ALONE**
- Involved field

**Clinical stage IA /IIA**
- Classical Hodgkins

**Unsuitable for NCRI RAPID STUDY**

**RISK FACTORS (RF)**
1. ESR > 50
2. >3 Nodal areas
3. Bulk >5cm<10cm
4. Age > 50yo

**PRESENT**

**ABVD X 4-6**
**IFRT**
(30-35Gy)

**ABVD**
**X 2-4**
**IFRT**
(30-35Gy)

**ABVD**
**X 2-4**
**IFRT**
(30-35Gy)

**CONSIDER RATHL STUDY IF STAGE IIA WITH ADVERSE FEATURES**
(see advanced disease flow chart)

**CONSIDER OMITTING IFRT**

**NOT SUITABLE OR NO LOCAL ETHICAL APPROVAL**

**CONSIDER RATHL STUDY IF STAGE IIA WITH ADVERSE FEATURES**
(see advanced disease flow chart)

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**TREATMENT STRATIFIED BY:**

1. **PROGNOSTIC INDEX (Hasenclever Score)**
2. **PERFORMANCE STATUS (PS) / AGE**

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**DEFINITION:**

- CS IIB, III and IV
- BULKY DISEASE i.e.
  - a) Nodal mass >10cm
  - b) Mediastinal mass > 0.33 of intrathoracic diameter at D5/6

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**All patients – Baseline PET-CT scan where feasible**

Consider trial availability

- Elderly/frail patients or Patients with poor PS
- Young patients
  - Fit older patients

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**RATHL study not possible:**

- ABVD X 2

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**PET-CT SCAN After 2 cycles**

- PET negative
  - Complete ABVD X 6
- PET positive
  - Dose Escalation e.g. BEACOPP14

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**PET-CT SCAN After completion of treatment if no interim PET scan was performed /or that scan was positive**

- NEGATIVE
  - Stop Therapy
- POSITIVE
  - RADIOTHERAPY (Involved field, 30-35Gy)
  - OR
  - CONSIDER SALVAGE THERAPY (Discuss individual cases at MCN)

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**SHIELD STUDY Registration**

- Either
- Or

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**SHIELD STUDY Chemotherapy**

- ABVD or Reduced intensity chemotherapy e.g. ChlVPP

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MANAGEMENT OF RELAPSED OR PRIMARY REFRACTORY HODGKIN’S LYMPHOMA

**CONSIDER STRATIFICATION OF FURTHER DOSE INTENSIFICATION DEPENDENT ON RISK FACTORS** 
(Requires discussion of individual cases at regional MDT)
- Primary refractory disease on CT / PET scanning
- Evidence of PET positive disease post salvage even if chemosensitive
- Bulky or advanced stage disease at relapse +/- need for consolidative radiotherapy
- Significant extranodal/bone disease at relapse

**RELAPSE POST RADIOTHERAPY ALONE**

**PRIMARY REFRACTORY DISEASE**

**RELAPSED DISEASE PREVIOUSLY TREATED BY CHEMOTHERAPY OR/COMBINED MODALITIES**

Is patient fit for high dose chemotherapy?

- NO
  - Extensive Disease
  - Local Disease
- YES
  - TISSUE TYPE PATIENTS AND SIBLINGS**
    - SALVAGE CHEMOTHERAPY 
      DHAP, IVE, ESHAP 
      X 2-3
      - PBSC COLLECTION (AFTER 2nd CYCLE)

**STANDARD CHEMOTHERAPY/RADIOTHERAPY (by stage and site) e.g. ABVD**

**CONSIDER STRATIFICATION OF FURTHER DOSE INTENSIFICATION DEPENDENT ON RISK FACTORS**

- Consider reduced intensity allograft

**STANDARD OF CARE**

- HIGH DOSE THERAPY BEAM CHEMOTHERAPY PBSC RESCUE

* Unlicensed. Approval through local non-formulary process required.
MANAGEMENT OF HODGKINS LYMPHOMA RELAPSED POST AUTOGRRAFT

REINDUCTION SALVAGE CHEMOTHERAPY

FURTHER TREATMENT DEPENDENT ON:
1. Response
2. Age
3. Fitness
4. Time to relapse

Conventional Allograft (Very high TRM)
Reduced Intensity Allograft (Requires CR/VGPR)
Experimental Therapy e.g. Gemcitabine*

* Unlicensed. Approval through local non-formulary process required.
Protocol for the use of PET scanning in Hodgkins Lymphoma

In November 2002 the then Health Technology Board for Scotland (HTBS) published its Health Technology Assessment (HTA) that stated that:-

_all patients who require restaging of Hodgkin’s disease should be sent for a FDG-PET scan. Extension to the restaging of all patient with lymphoma should be investigated by further research._

Significant additional new research into the use of PET scan in malignant lymphomas has since been published. Furthermore, the International Working Group for Non-Hodgkin’s lymphoma have recently proposed new response criteria and associated guidelines on the use of PET imaging in lymphomas (Juweid et al, 2007; Cheson et al, 2007). The undernoted protocol has been developed in light of the emerging evidence.

Indications for the use of PET scanning in Hodgkins Lymphoma

**Hodgkin’s disease (HD)** (~ 230 new scans in Scotland each year).

1. All newly diagnosed patients with Hodgkin’s disease (HD) being considered for curative therapy should have a baseline scan.

2. Early stage HD after 3 courses of treatment within the context of the NCRI trial.

3. Patients with advanced HD (stage IIB, III and IV) who need to be considered for a change to more intensive chemotherapy early in their treatment plan (after 2 cycles of chemotherapy).

4. All HD patients with residual masses post treatment who have not been shown to be PET negative at an interim scan.

5. Patients with relapsed HD undergoing further treatment with curative intent should be considered for baseline and post treatment scanning where this will influence management.

References:-


Phase 3 trial – Using PET scans to help decide treatment options for early stage Hodgkin’s lymphoma – Chief Investigator Professor John Radford – supported by Leukaemia Research Fund.


Available at: [http://www.ukccsg.org/members/workinggroups/hodgkins/treatmentguidelines/index.html](http://www.ukccsg.org/members/workinggroups/hodgkins/treatmentguidelines/index.html)

**Cancer and Genetics**

Proposed March 2008 : Approved Sept 2008