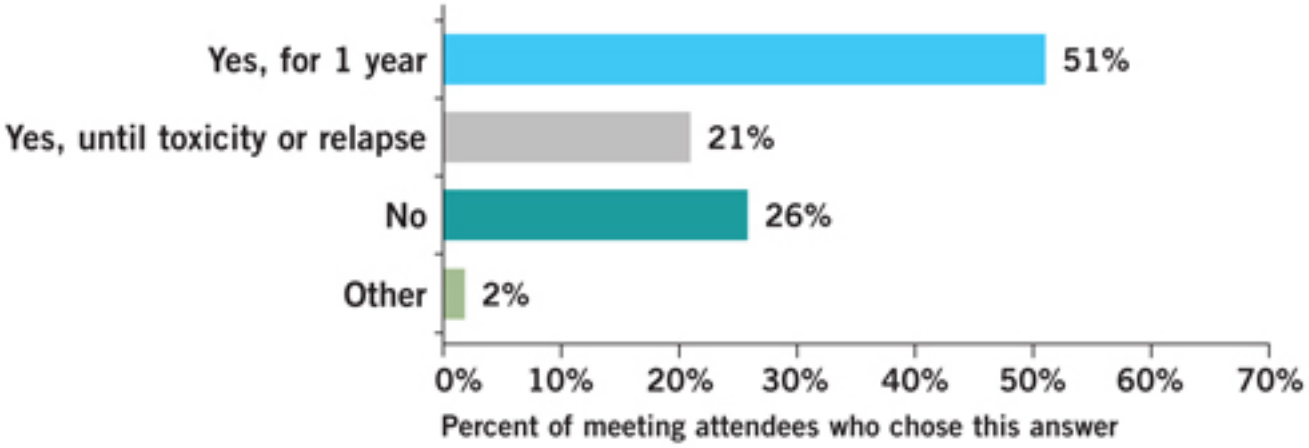
Year in Review

Proceedings from a Multitumor CME Symposium Focused on the Application of Emerging Research Information to the Care of Patients with Common Cancers

Hodgkin Lymphoma — Craig Moskowitz, MD

A 38-year-old man with Hodgkin lymphoma (HL) receives ABVD chemotherapy but experiences recurrent disease in the liver and multiple nodes 12 months later. The patient receives ICE chemotherapy followed by autologous stem cell transplant and achieves a complete response. Would you recommend consolidation brentuximab vedotin?



DR LOVE: Brad, last year, I remember when we were doing this series and Craig let us know that he was about to present a very, very interesting study at ASH looking at B-vedotin consolidation in Hodgkin lymphoma after relapse. Now it's a year later. It's been presented. I tried to put together a case that I thought could be made for a patient who might have this considered. So we said: Thirty-eight-year-old patient, gets ABVD but has recurrent disease 12 months later, but the disease includes involvement in the liver. The patient gets ICE, autologous transplant, is in a CR. Looks like the vast majority of the audience would use consolidation with B-vedotin. How would you think it through, Brad?

DR KAHL: I would not. My logic is that if you take 10 patients like this and you take them to an autotransplant, probably 4 or 5 are cured walking out the door. You don't know who's cured yet, but of 10 maybe 5 are cured. So I'm not comfortable with this strategy of administering brentuximab vedotin to all of those 10 patients when, by definition, there are 5 who don't need it and have no chance of benefiting from it.

The AETHERA study does show a big progression-free survival benefit, but unless there's something I don't know, there wasn't an overall survival benefit. Until I see an overall survival benefit, I would personally reserve the brentuximab vedotin and use it for the patients who relapse.

DR LOVE: Craig, when you first started talking about this, I was thinking everybody was going to do it. How do you respond to this issue about the fact that there's no survival benefit?

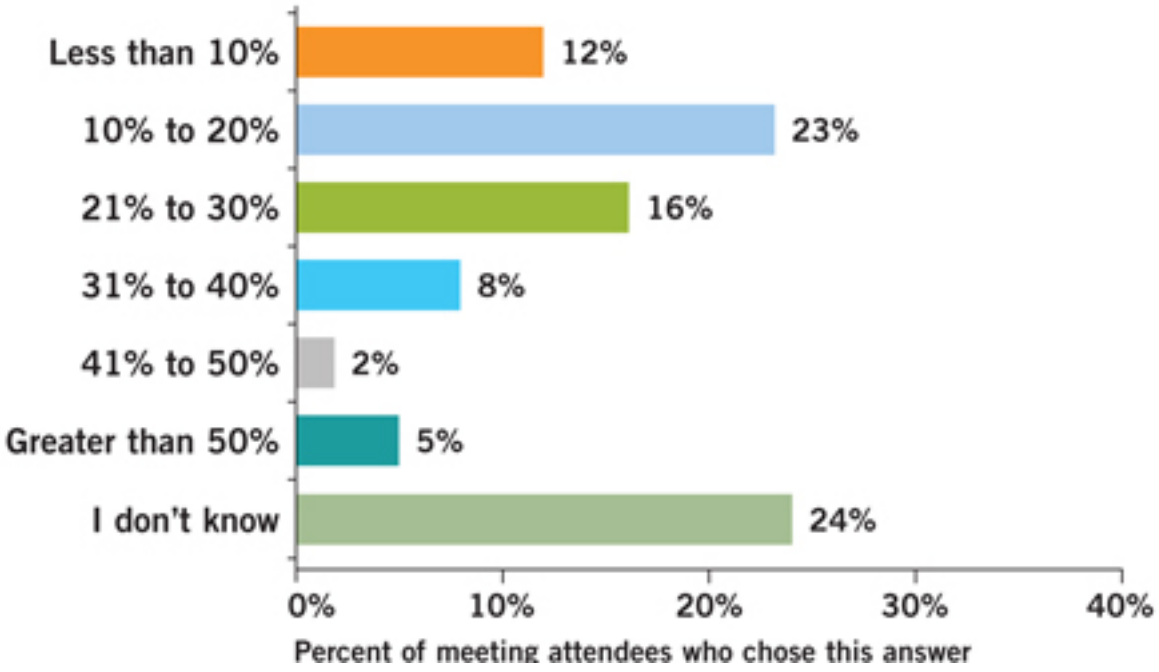
DR MOSKOWITZ: When we wrote the study back in 2009 at EHA this was in the pre-PET era. This was also in an era where there were no new agents in Hodgkin lymphoma. People would get single-agent vinblastine if there was a transplant failure.

The median survival in that setting was 30 months. The median survival in 2016 for a patient where a stem cell transplant fails is probably close to 6 years. In fact, the AETHERA study was just amended this week to study patients out to 2021 to look at overall survival. We're going to have to wait.

DR LOVE: Also, when you first presented, I didn't pick up on the fact that you were picking out adverse-prognosis patients in the trial — liver involvement, early relapse before 12 months. It wasn't everybody.

DR MOSKOWITZ: Yes. The patients have to have either primary refractory disease, remission duration of less than a year or remission duration of after a year with extranodal involvement, as this patient had. Those are the patients that were eligible. If you look at that in general for relapsed and refractory Hodgkin lymphoma, about 3 out of 4 patients would be eligible for participation in this study.

What is the likelihood that a patient with HL who is started on 16 cycles of brentuximab vedotin consolidation therapy will have treatment stopped due to adverse events?



Approximately what percent of patients with relapsed/refractory HL experience objective tumor responses to anti-PD-1/anti-PD-L1 antibodies?