Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/integrating-targeted-therapy-into-the-frontline-management-of-high-risk-pediatric-chl/15429/

Time needed to complete: 36m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Integrating Targeted Therapy Into the Frontline Management of High-Risk Pediatric cHL

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Kelly:
Hello, I'm Dr. Kara Kelly, Pediatric Oncologist at Roswell Park, and a member of the Study Committee of the AHOD1331 trial with brentuximab vedotin for high-risk pediatric Hodgkin lymphoma.

I'm really pleased to be joined today by Dr. Brad Hoppe, Radiation Oncologist at the Mayo Clinic, who's also a member of the Study Committee. So Dr. Hoppe, if you could speak a little bit about your perspective, especially around the radiation that's used in the trial, as that's a question that has come up quite frequently.

Dr. Hoppe:
Yes. Thanks so much for having me. And with respect to the radiation on AHOD1331, I think a lot of people have had a lot of comments about it. There's been a lot of concerns because radiotherapy isn't used as much in advanced stage Hodgkin lymphoma in adults.

But what we did in this trial was actually really reduce the exposure to normal tissue. And we did this through a few different ways we use smaller fields. So we weren't irradiating all sites of disease like we had done in older COG studies. We were just treating sites of bulky disease in the mediastinum, as well as selective sites that we thought were at high risk of recurrence. So those slow early responding sites after two cycles of chemotherapy that were still PET positive. So by using those as the only sites that we treated with radiation, we were really able to reduce the overall exposure of radiation, so reducing the breast dose in young women, the heart dose for both men and women, and lung dose.

Additionally, we did utilize the most conformal radiation technologies available. And so, a lot of patients got IMRT. And about a quarter of the patients got proton therapy as well. And those modalities really helped reduce the high doses of radiation to the heart and lungs that were seen with 3D conformal radiation, especially with the larger fields. So again, while radiation was used on this trial in 53% of the patients, these fields were much smaller. And we expect with the more conformal techniques that were used, that the long-term toxicity from this will be quite minimal.

Dr. Kelly:
Yes, and it's also compared to other pediatric Hodgkin lymphoma trials. It was a lot - it was less radiation. You know, you look at what the Europeans used and what the St. Jude trials have also. So we're moving in the right direction there.

Dr. Hoppe:
Yeah, definitely.

Dr. Kelly:
A question that I often get from physicians is about, you know, the comparison of the BV-AVD with the BV-AVE-PC. I think some people don't like the BV-AVE-PC because it is more dose intensive and concerned about side effects. However, I would, you know, really point

people's attention to the fact that our side effect profile was pretty comparable to what was observed in adults getting the Bv-AVD regimen, and we didn't have any toxic deaths with the regimen, the peripheral neuropathy improved. So I do think that it's a much more tolerable regimen, you know, then people consider.

Additionally, the 3-year EFS of 92.1%, you know, that stands out as the best reported outcome for high-risk patients of any trial, pediatric and adult combined. If you look at the event-free survival or progression-free survival on the ECHELON trial, it was really only in about the mid 80s percent. So, especially for a younger patient where you want to avoid the risk of recurrence and need for subsequent salvage therapy, the BV-AVE-PC really should be considered.

Another point that I do think is worth emphasizing is to be aware of the dose modification in the protocol. Unlike many trials where the investigational agent is first reduced, in this study, we made a conscious decision to reduce the vincristine before reducing the brentuximab vedotin. And that allowed maintenance of the dose density of the brentuximab vedotin. And we really believe that that contributed to the excellent outcomes that were observed. So if you're using the regimen, make sure you pay attention to the dose modification scheme, especially related to peripheral neuropathy, so as to, you know, continue to maintain that great dose density of the brentuximab.

So I'd like to thank Dr. Hoppe for participating in this program, and thank all of you for listening in. We hope that the information that we shared is helpful in management of your own patients with high-risk Hodgkin lymphoma.

Dr. Hoppe:
Thanks so much.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, Inc. and is part of our MinuteCME curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.