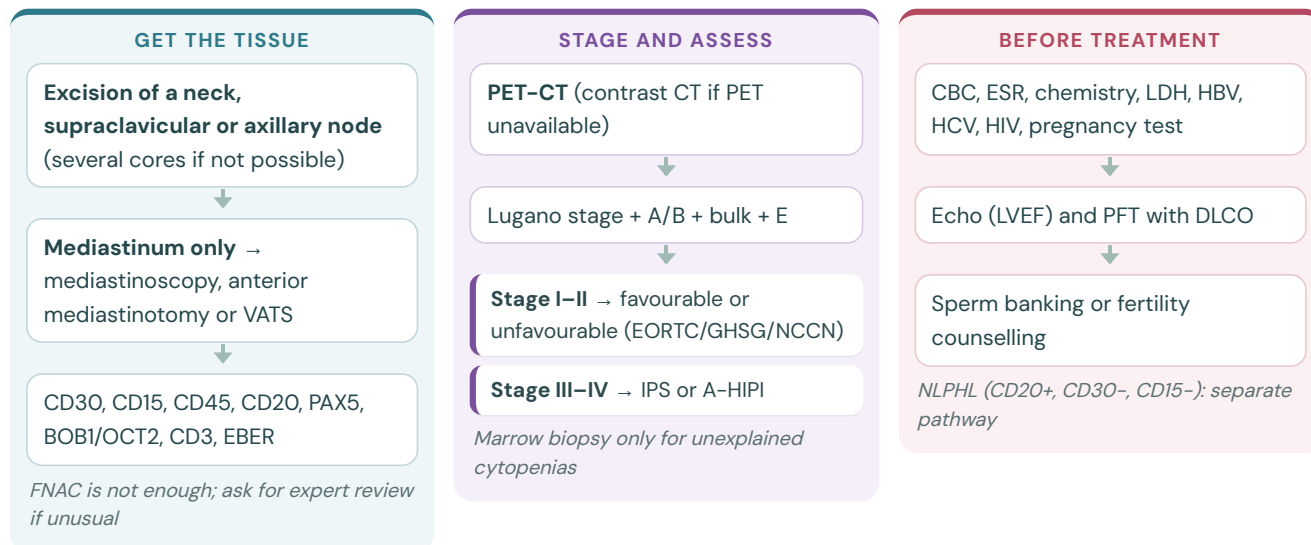


Hodgkin Lymphoma: Suspected Hodgkin lymphoma: to a treatment group

Dr. Haritha Chiramana

MD, DM · Senior Medical
Oncologist & Hemato-Oncologist

Persistent node, mediastinal mass, or unexplained B symptoms or itch → no empirical anti-TB treatment → biopsy plan



All patients: stop smoking · vaccines before treatment · photograph and measure palpable nodes · discuss in a lymphoma multidisciplinary team.

Hodgkin Lymphoma: Early-stage classic

HL: PET-adapted ABVD

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Stage I–II cHL → ABVD × 2 → PET2 (Deauville score)

FAVOURABLE, PET2 1–3

All GHSG favourable → 20 Gy ISRT, stop

Others → choose with the patient

Chemotherapy only: ABVD × 2 (≤60) or AVD × 2 (>60, lung disease); up to 4 for Deauville 3 or bulk

CMT: ABVD × 1 + 30 Gy

No PET available: ABVD × 3 + 30 Gy

UNFAVOURABLE, PET2 1–3

CMT: ABVD × 2 + 30 Gy ISRT

or chemotherapy only: AVD × 4 (no bleomycin)

Breast, heart or lung in the field, smoker
→ chemotherapy only; neck-only disease
→ CMT easier

PET2 4–5 (ANY EARLY STAGE)

Single Deauville 4 → ABVD × 2 (unfavourable; or BrECADD × 2)

PET4: 1–4 → 30 Gy; 5 → biopsy

Multiple 4 or any 5 at PET2 → biopsy first

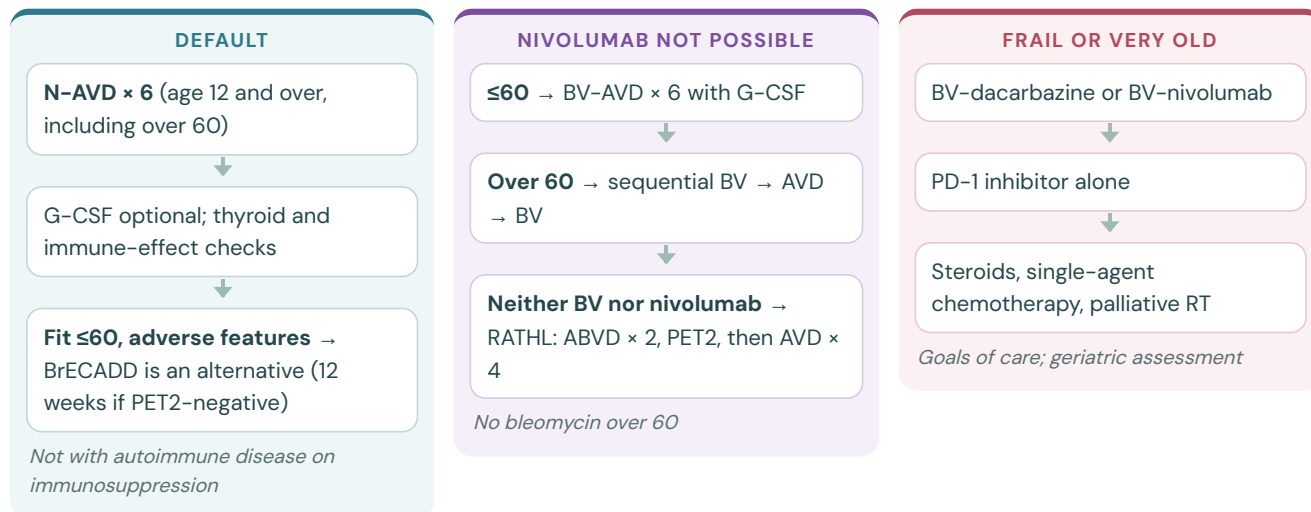
Viable cHL on biopsy → Algorithm 4

All patients: PET at the end of treatment · visits every 3–6 months for 2 years · no routine surveillance scans · late-effect plan.

Hodgkin Lymphoma: Advanced classic HL: first-line choice

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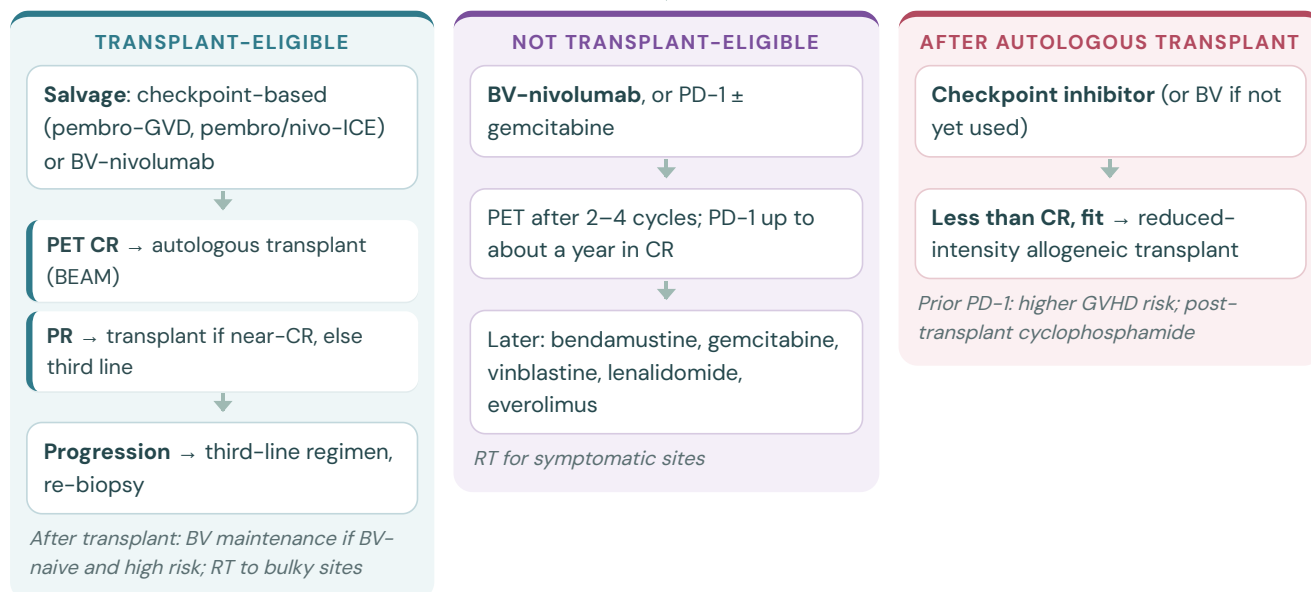
Stage III–IV → age, fitness, autoimmune disease, neuropathy, heart and lungs → access to nivolumab and BV


All patients: end-of-treatment PET (Deauville 4–5 → biopsy) · no RT for bulky disease in complete response · CBC yearly in follow-up · dexrazoxane if cardiac risk.

Hodgkin Lymphoma: Relapsed or refractory classic HL

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Suspected relapse or PET-positive residue → biopsy (exclude grey zone, other cancer, infection, flare) → PET



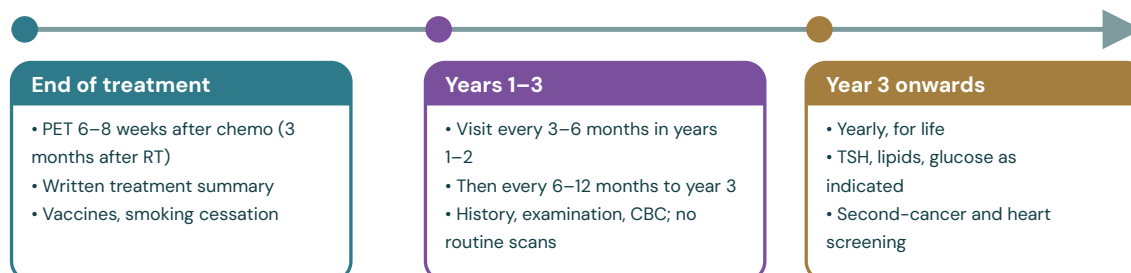
All patients: clinical trial where available · fertility counselling before transplant · infection prophylaxis · early palliative care when cure is no longer the aim.

Hodgkin Lymphoma: Follow-up and survivorship plan

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A simple follow-up rhythm after treatment of Hodgkin lymphoma



No routine PET or CT in a patient in complete remission: scans rarely find relapse before symptoms do, and add radiation. Scan only for new symptoms, signs or laboratory changes; if CT is needed, keep the number low in the first two years. NPLHL: every 3–6 months for 2 years, 6-monthly in year 3, then yearly for at least 5–10 years (late relapses).

A simple follow-up rhythm, adapted from the UpToDate early-stage, advanced-stage, survivorship and NPLHL reviews (consistent with NCCN). Individualise by age, stage and treatment received.

Help the treatment work

- Keep every cycle on schedule
- Stop smoking; protect the lungs
- Bank sperm or discuss fertility first
- Report fever the same day
- Keep the written treatment summary

Red flags to report

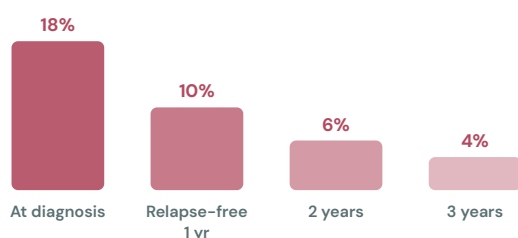
- Fever with chills during chemotherapy
- New cough or breathlessness (bleomycin)
- Numb or weak hands and feet
- Diarrhoea, rash or tiredness on nivolumab
- Face or arm swelling, noisy breathing

Do not forget

- PET 6–8 weeks after chemotherapy
- No routine scans in remission
- TSH yearly after neck RT
- Breast screening from 25 or 8 years after chest RT
- Heart and lipid checks for life

When relapses happen: mostly early, but never "never"

Risk of relapse within the next years (British Columbia, 1402 patients)



Late relapses

- No plateau: 2.5% at 10, 4.3% at 15, 6.9% at 20 years (GHSG)
- Biopsy every suspected relapse: it may be another cancer, NHL or infection

Competing risks

- In an early-stage cohort, deaths from other causes overtook Hodgkin deaths 8 years after diagnosis
- Second cancers and heart disease lead

A relapse is treatable: second-line immunotherapy-based salvage and an autologous transplant cure more than half.

When relapses happen (Haggood 2016; Bröckelmann 2017; UpToDate survivorship review). Most relapses come in the first 2–3 years; follow-up then shifts towards late effects.