HODGKIN LYMPHOMA AND COVID-19

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In the setting of COVID infections Cancer patients due to their weakened immune system are at an increased of severe complications (ICU admission, ventilator support and deaths) as reported by the Chinese (38% vs 8%) and the Italian group (20% deaths were in patients with active cancer).

In the present scenario we are faced with several challenges:

1. Logistic issues: General beds, ICU beds and healthcare personnel being diverted for COVID-19 illness management.
2. Transfusion support: Low reserves of blood products due to limited voluntary donors.

The ASCO, ESMO guidelines suggest that treatment goals need to be revised, with priority given to patients with high cure rates.

Hodgkin lymphoma is a highly curable disease, we suggest the following changes to standard management for adult patients-

Work-up:

1. PET-CT scan may not be easily available at present and we may have to revert to using a CECT chest abdomen and pelvis with Bone marrow studies for the purpose of staging.
2. PFT/DLCo- To be avoided, in those with history of smoking, COPD, age >50 years or renal disease.

Treatment:

Limited stage-
Early favorable: 2 cycles of ABVD followed by RT. If interim PET CT is possible, then can consider for 4cycles of ABVD to avoid multiple visits for RT in those with a negative interim PET.
Early unfavorable: 4 cycles of ABVD followed by RT. If interim PET can be performed then consider 6 cycles of ABVD in those with PET negative disease (RAPID trial). Bleomycin can be omitted after 2 cycles.

Advanced stage: 6 cycles of ABVD, if interim PET can be performed and PET negative to de-escalate to AVD (RATHL study)

Low threshold to stop Bleomycin based on clinical symptoms and test for Corona infection if indicated.

Relapsed disease: For late relapses, avoid ASCT at this moment.

For relapses in less than 2-years- Prefer using GDP regimen with lower doses of Dexamethasone and G-CSF support.

Auto-SCT to be considered in early relapses.

Brentuximab to be preferred in 3rd line and beyond, can be considered in 2nd line (Stanford, sequential protocol).

If patient is on Nivolumab in a relapsed setting, if patient is in CR and has completed at least 2 months beyond CR, then consider stopping Nivolumab.

If Brentuximab is not available in the 3rd line then prefer using Pembrolizumab over Nivolumab, in view of the longer interval of dosing.

For Palliative setting, prefer using oral chemotherapy as opposed to injectable to reduce the need for hospital visits.

For elderly patients- Avoid Bleomycin in people aged>50 years, use reduced dosing and primary G-CSF support.