

A population-based study of treatment of Hodgkin Lymphoma in older patients based on data of the Cancer Registry of Baden-Württemberg (BW), Germany

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Introduction

Hodgkin Lymphoma (HL) is a treatable condition with a 5-year survival rate for 80-90% of patients. However, older age is an adverse prognostic factor [1], which might be related to comorbidities, tumour biology and to therapy choice. Physicians have to treat a potentially curative lymphoma but protect their patients from unacceptable toxicities. The purpose of the present study was to analyze the primary treatment of incident classical HL (cHL) in older patients aged > 60 years compared to younger ones by using data of the Cancer Registry of BW.

Methods

Adult patients with cHL diagnosed between 2016-2020 were included in the study. Primary systemic therapy started within 3 months and radiotherapy within 6 months from the diagnosis date are considered. Differences in histology, Ann Arbor stage, out-of hospital therapy, systemic and radiotherapy are analysed. Information on GHSG-risk groups is rarely reported to the registry and thus not considered.

Results

The cohort includes 929 young (aged 18-60 years) patients and 323 patients aged >60 years (males: 55%). Information on primary systemic and/or radiotherapy is available for 744 young and 226 older patients.

The data show clear differences in histology, stage and therapy choice for the two age groups. Specifically, tumours in elderlies are more frequently of mixed cellularity (34% vs 22%) or non-specified histology (23% vs. 13%) and are more often diagnosed at the later stages (Fig. 1). Primary therapy in both age groups is started about 1 month after diagnosis. For older patients, radiotherapy is less often applied (35% vs 45% for younger ones), while systemic is performed predominantly with ABVD or non-standard protocols (AVD, A-AVD and PVAG) (Figure 2A, 2B). BEACOPP containing therapy, the primary choice for younger patients with advanced disease [2], is very rarely applied for elderlies. Finally, for older patients the first therapy is reported more frequently to be done in an Out-Hospital setting (31% vs 22%).

Overall, the estimated 12 months- progression free survival indicates worth prognosis for elderly compared to younger patients (79% vs. 95%, figure 3).

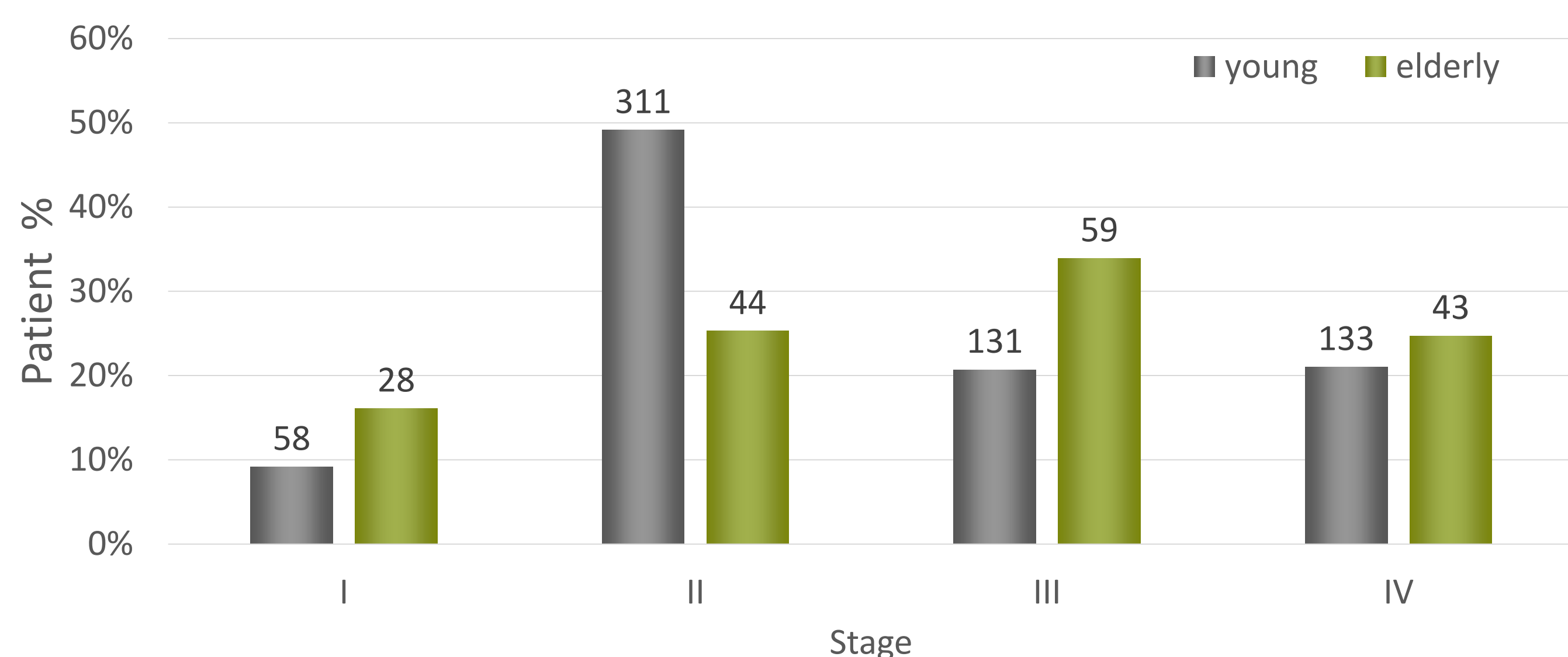


Fig. 1 Ann Arbor stages in patients treated for cHL according to registry data in young (18-60 years, N=633) vs elderly patients (>60 years, N=174).

References

- 1) Evens AM et. al. (2019) Management of older Hodgkin lymphoma patients. Hematology Am Soc Hematol Educ Program 2019 (1): 233–242.
- 2) Leitlinienprogramm Onkologie (Deutsche Krebsgesellschaft, Deutsche Krebshilfe, AWMF (2022). S3 Leitlinie Diagnostik, Therapie und Nachsorge des Hodgkin Lymphoms bei erwachsenen Patienten. Version 3.2 Oktober 2022.

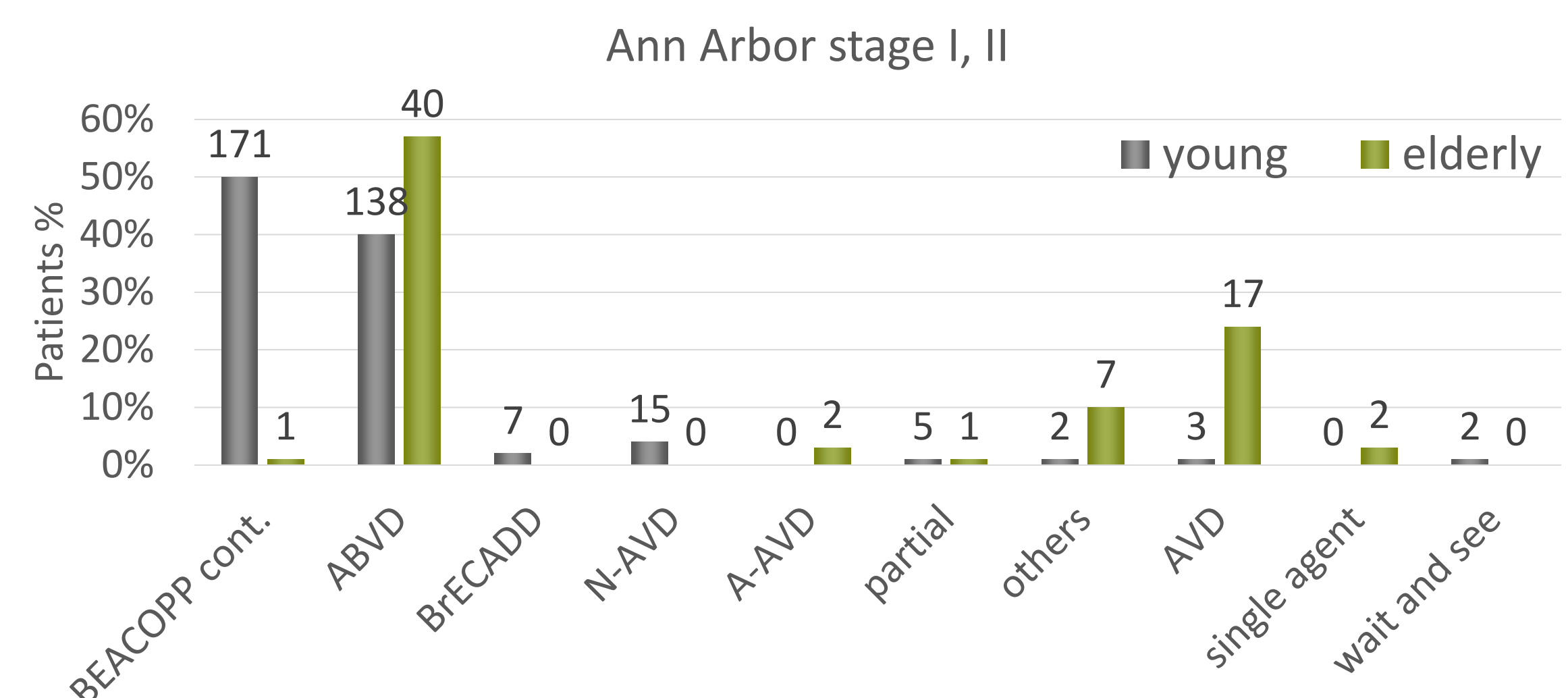


Fig. 2A. Systemic therapy regimes for early stage cHL (I, II)

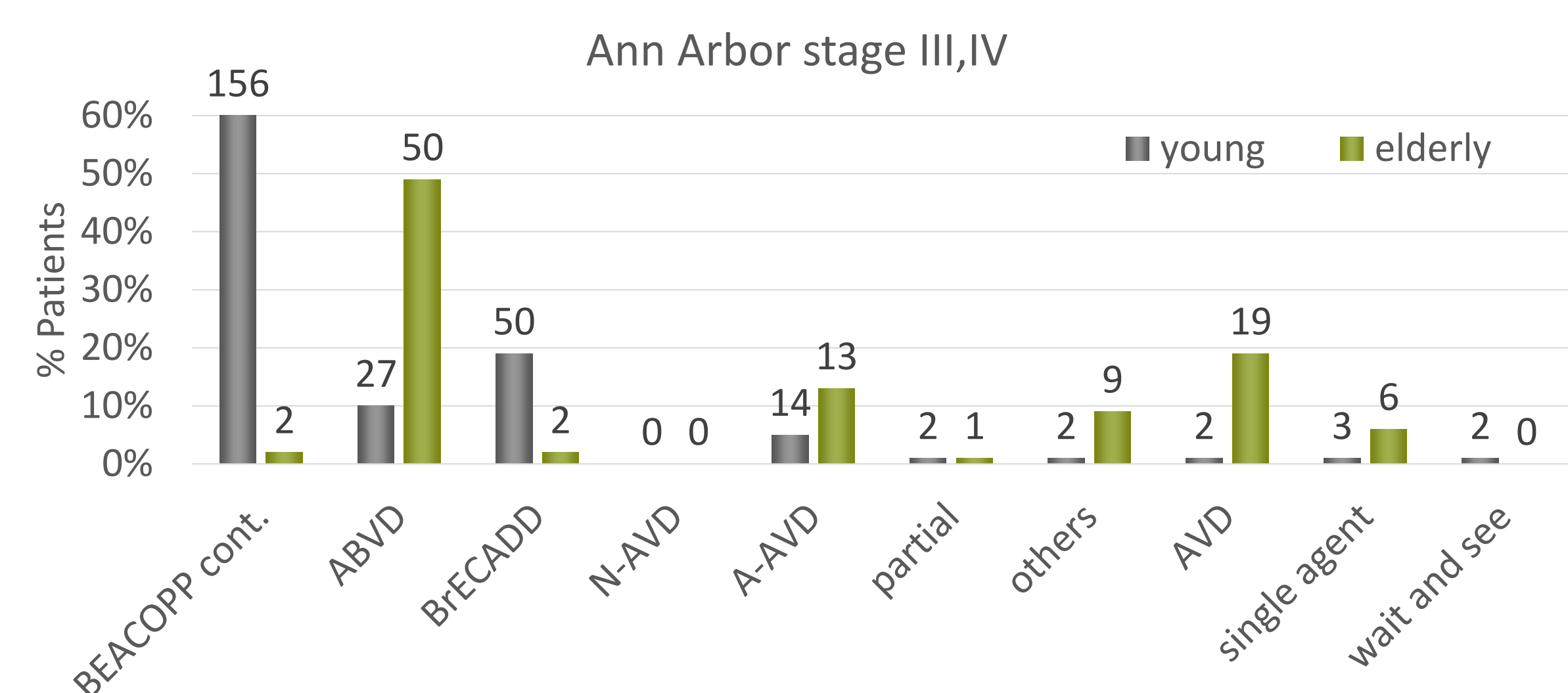


Fig. 2B Systemic therapy regimes for advanced stage cHL (III, IV). BEACOPP cont.: containing BEACOPP or BEACOPP escalated; partial: protocols with omission of at least one agent; others: PVAG, CHOP, CHOEP, COPP, B-CAP; R-AVD, Obinutuzumab-Bendamustin, Nivolumab-Cyclophosphamid.

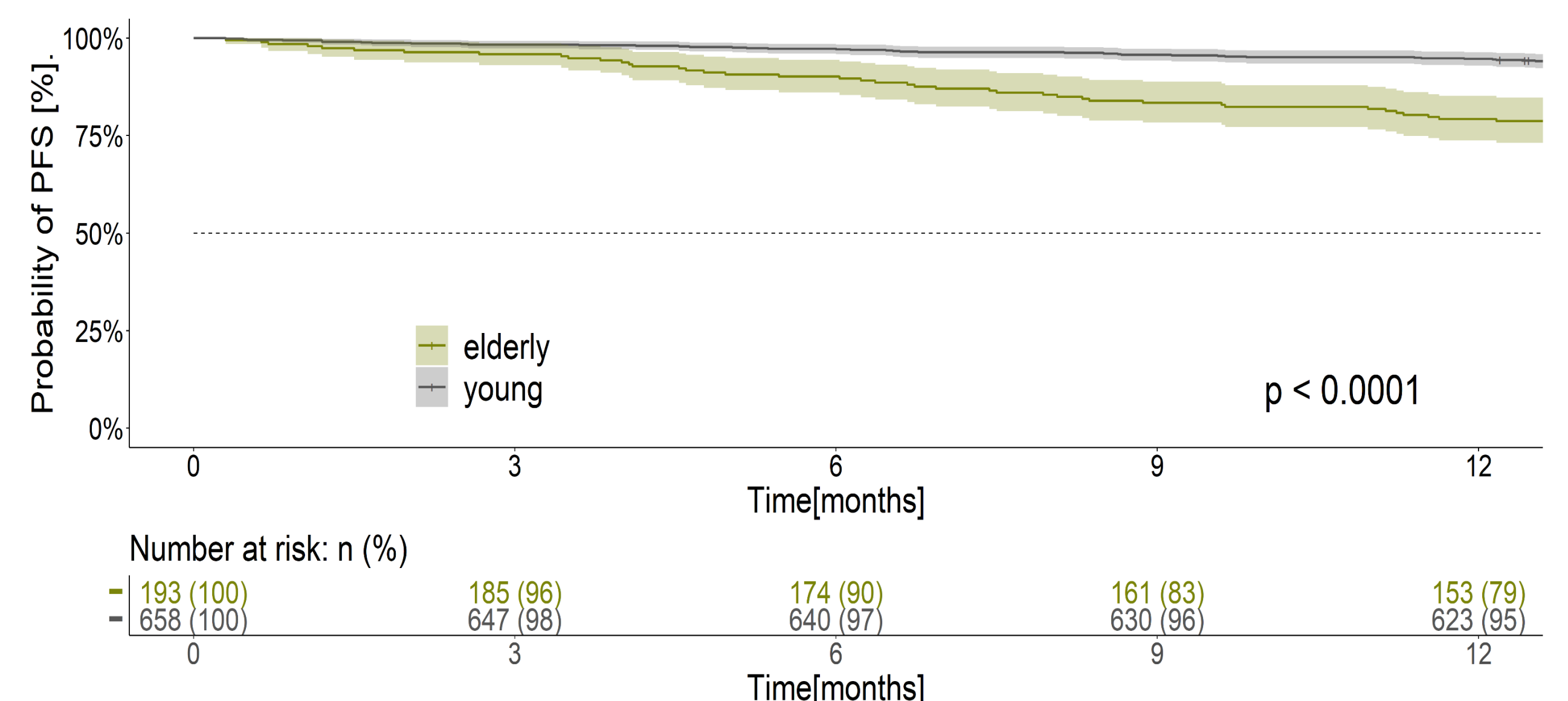


Fig.3 Progression free survival for age groups. PFS defined as the time between diagnosis and progression or relapse of cHL (follow up with progress) or death from any cause and was censored at the date of last information on the disease status.

Discussion and Conclusion

The present study upon age-dependent treatment of classical Hodgkin Lymphoma uses a population-based dataset of the Cancer Registry of BW. Although the data collected in the cancer Database are not exhaustive and may contain incomplete information, they offer extraordinarily large sample sizes and improved generalizability compared with single institutional study data.

The present analysis demonstrates clear differences in histology, stage, treatment choice and prognosis for the two age groups considered and notably less favourable outcome for the older patients. Importantly, the different outcome may reflect not only the less intensive treatment but also differences in the stage and disease biology.

Although this work does not allow any firm conclusions regarding the reason of the difference in outcome, it clearly illustrates that further studies are required to optimize the treatment of older patients with cHL, especially in the view of the population aging tendency.