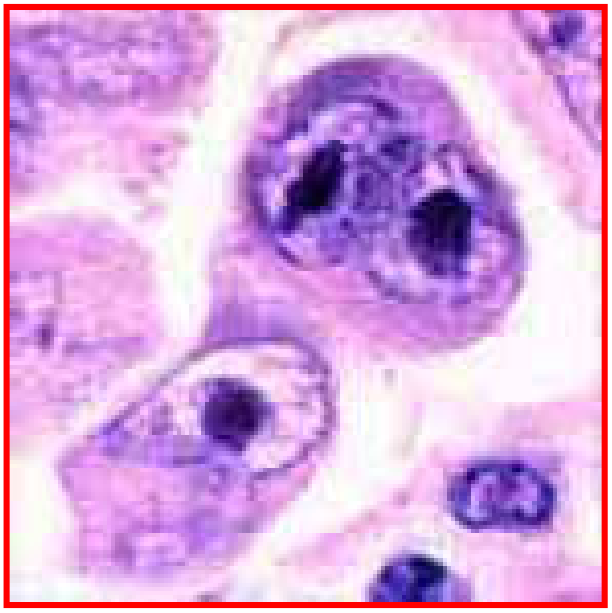
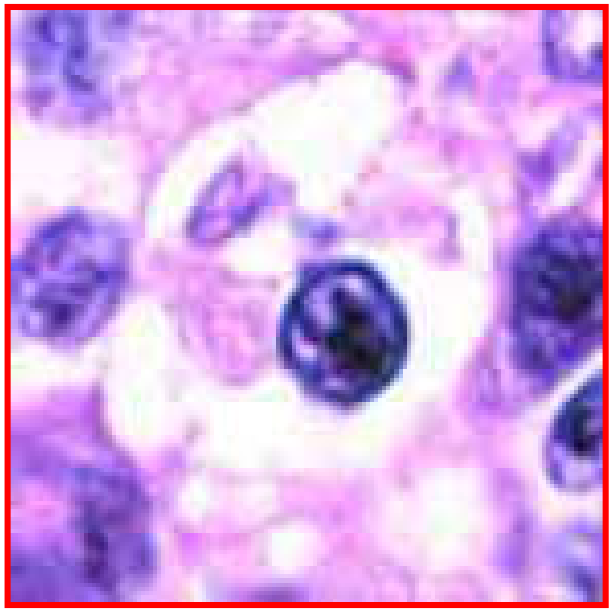
RS cell and variants



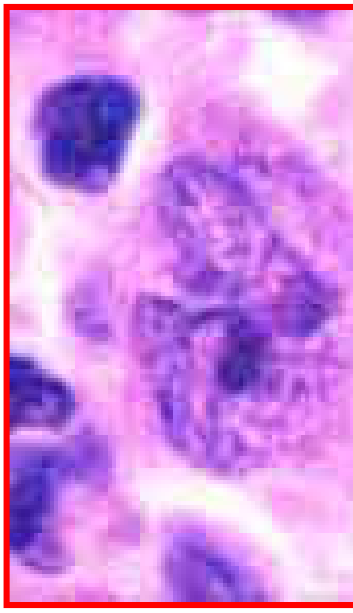
classic RS cell

(mixed cellularity)



lacunar cell

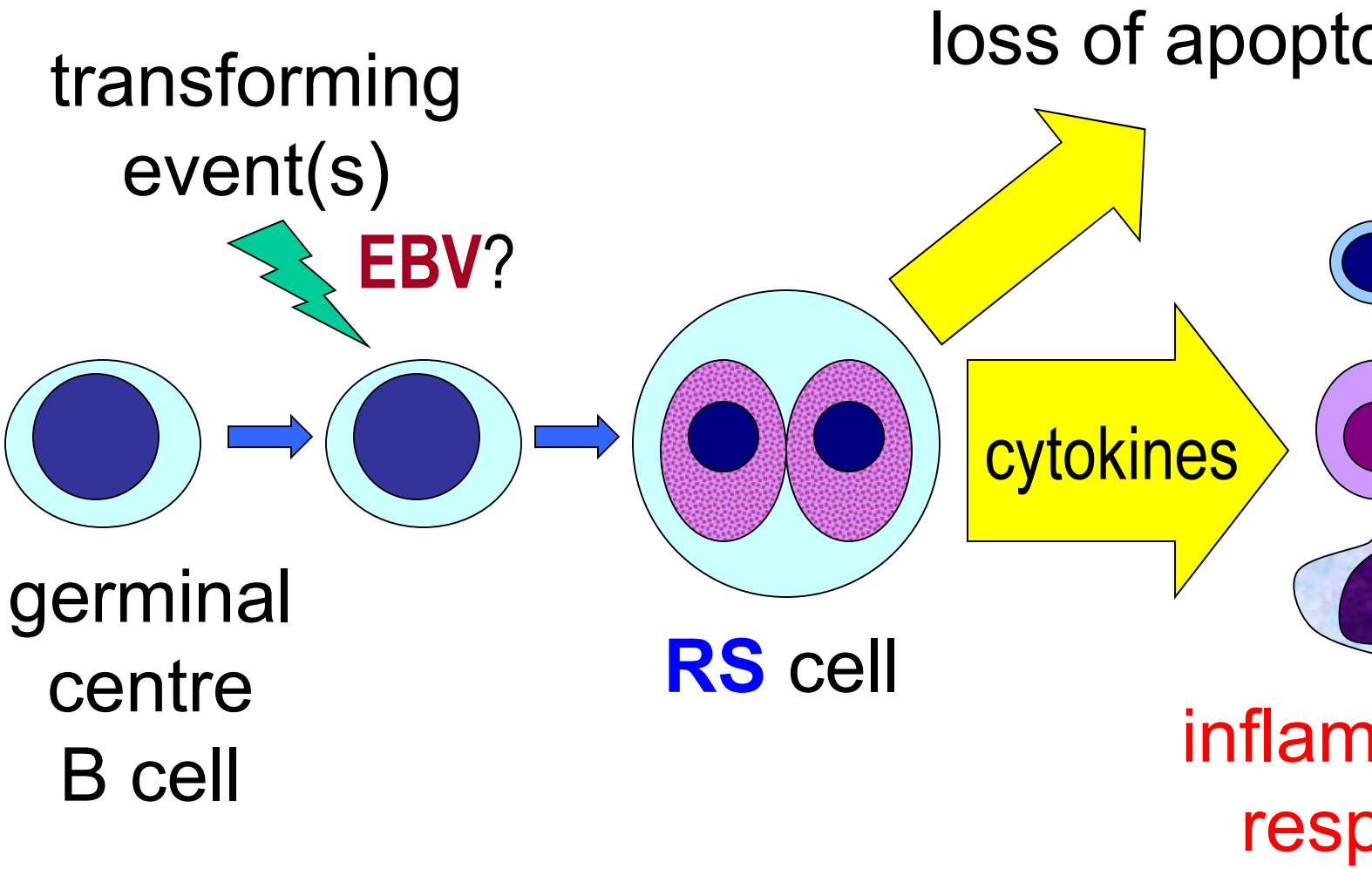
(nodular sclerosis)



popcor

(lymphoc
predomir

A possible model of pathogenesis



Hodgkin lymphoma
Histologic subtypes

- Classical Hodgkin lymphoma
  - nodular sclerosis (most common subtyp
  - mixed cellularity
  - lymphocyte-rich
  - lymphocyte depleted

Epidemiology

- less frequent than non-Hodgkin lymphoma
- overall M>F
- peak incidence in 3rd decade

Age distribution of new Hodgk lymphoma cases

Associated (etiological?) factors

- EBV infection
- smaller family size
- higher socio-economic status
- caucasian > non-caucasian
- possible genetic predisposition
- other: HIV? occupation? herbicides?

Clinical manifestations

- lymphadenopathy
- contiguous spread
- extranodal sites relatively uncommon except in advanced disease
- “B” symptoms

Treatment and Prognosi

Stage	Treatment	Failure-free survival	Overal year surviv
I,II	ABVD x 4 & radiation	70-80%	80-90
III,IV	ABVD x 6	60-70%	70-80

Hodgkin's Disease/Lymphom
Treatment

With appropriate treatment about 85% of patients with Hodgkin's disease are curab

⑩I A,B	Radiation Therapy
⑩II A	Combination Chemo Radiotherapy
⑩IIB; IIIA,B; IVA,B	Combination Chemo (+/- radiotherapy)

Hodgkin's Disease/Lymphom
Treatment

- Radiation therapy (35-40 Gy) 80-90% RC
  - Mantle field
  - Paraaortic field
  - Pelvic field

- Combination chemotherapy
  - ABVD 80% RC
  - BEACOPP 90% RC

Hodgkin's Disease
Stanford V

Doxorubicin	25 mg/m2	IV	Days 1& 1
Vinblastine	6 mg/m2	IV	Days 1 &
Mechorethamine	6 mg/m2	IV	Day 1
Vincristine	1.4 mg/m2	IV	Days 8 &
Bleomycin	5 u/m2	IV	Days 8 &
Etoposide	60 mg/m2	IV	Days 15 &
Prednisone	40 mg/m2	PO	QOD

Treatment Repeated q 28 days

Vincristine max dose = 2.0 mg

Velban dose reduced to 4 mg/m2, VCR to 1 mg/m2, cycle 3, pts>50

Prednisone tapered beginning week 10

Bartlett, JCO 1995;