8:45–9:30 AM

Hodgkin Lymphoma

PRESENTER

Philippe Armand, MD, PhD
Dana-Farber Cancer Institute
Harvard Medical School

PANELISTS

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Methodist Hospital

MODERATOR
Mehdi Hamadani, MD

THE 2nd ANNUAL HemOnc Pulse LIVE | AUSTIN 2025

Controversies & Unanswered Qs in R/R Hodgkin Lymphoma

Presenter

Philippe Armand, MD, PhD

Dana-Farber Cancer Institute
Harvard Medical School

Historical Paradigm

1L HL: chemotherapy or combined modality therapy

RR HL: salvage chemotherapy + ASCT

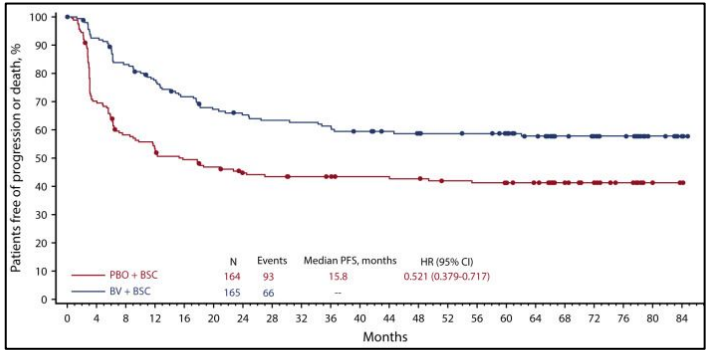
Linch. *Lancet*. 1993.
Schmitz. *Lancet*. 2002.
Schmitz, ASCO 2005.

Historical Paradigm

1L HL: chemotherapy or combined modality therapy

RR HL: salvage chemotherapy + ASCT

Brentuximab vedotin consolidation



AETHERA: BV consolidation vs placebo *in high-risk patients:*
Primary refractory/<1y relapse or extranodal disease at relapse

Moskowitz. *Lancet*. 2015.
Moskowitz. *Blood*. 2018.

Historical Paradigm

New Opportunities

Shifting role of checkpoint inhibition (CPI) in 2L

Shifting paradigms in 1L therapy

Historical Paradigm

New Opportunities…

Shifting role of checkpoint inhibition (CPI) in 2L
Shifting paradigms in 1L therapy

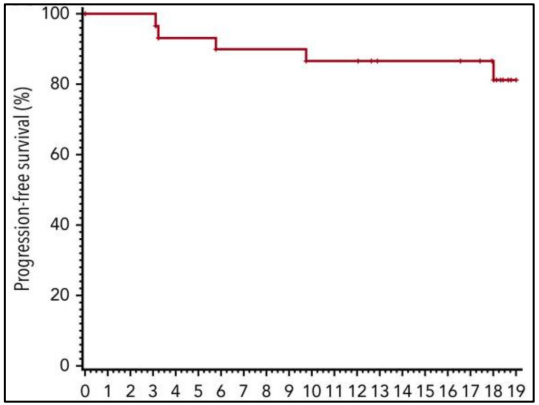
Bringing New Questions

Optimal place of CPI and BV
Role of ASCT
Modern risk stratification

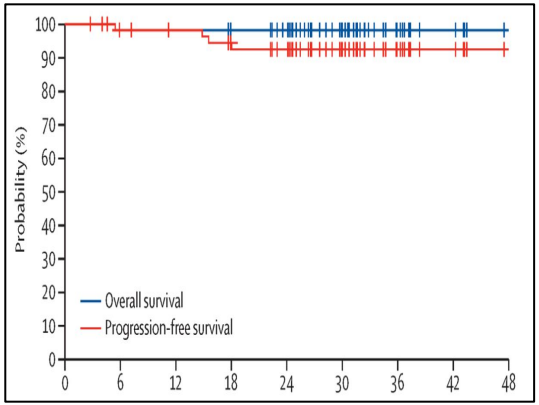
CPI in 2L Treatment of HL

CPI in 2L Treatment of HL

1. CPI as Consolidation



30 pts with HL post ASCT
Pembro x 8 cycles
19m PFS 81%
Similar in high-risk patients

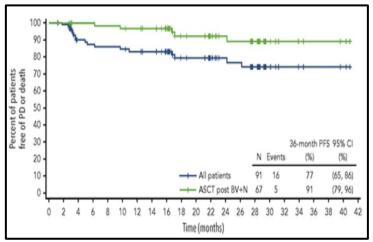


59 pts with HL post ASCT
BV/nivo x 8 cycles
19m PFS 94%
Similar in high-risk patients

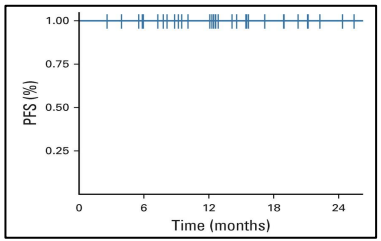
Armand. *Blood*. 2019.
Herrera. *Lancet Haematol*. 2022.

CPI in 2L Treatment of HL

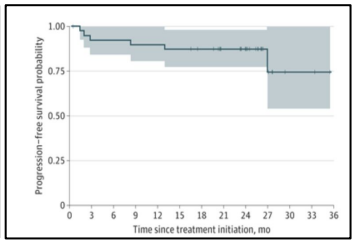
1. CPI as Consolidation
2. CPI as part of salvage therapy



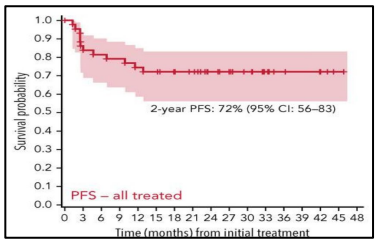
91 pts with RR HL
BV + nivolumab up to 4
ORR 85%, CRR 67%
3y PFS 77%, 91% for direct ASCT



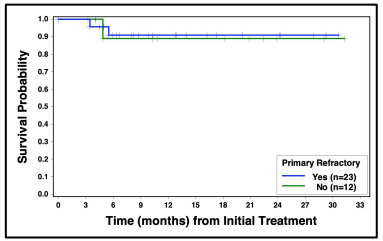
38 pts with RR HL
Pembro-GVD up to 4
ORR 100%, CRR 95%
2y PFS 96%



42 pts with RR HL
Pembro-ICE x 2 + Pem x1
ORR 97% CRR 87% 37 eval pts
2y PFS 87%



43 pts with RR HL
Nivo->N-ICE resp-adapted
ITT ORR 91%, CRR 88%
2y PFS 72%

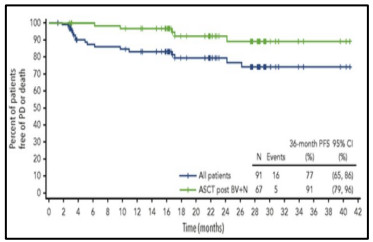


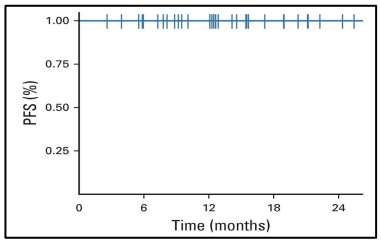
35 pts with RR HL
N->N-ICE 2 cycles
ITT ORR 100%, CRR 89%
1y PFS 90%

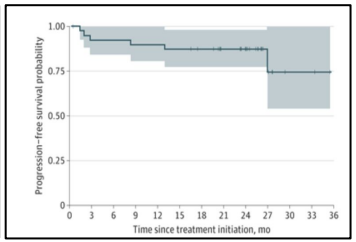
Advani. *Blood*. 2021; Moskowitz. *J Clin Oncol*. 2021; Mei. *Blood*. 2022, ASH 2022; Bryan. *JAMA Oncol*. 2023.

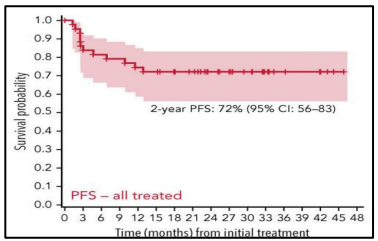
CPI in 2L Treatment of HL

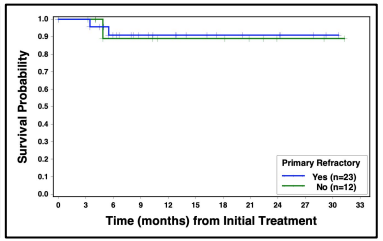
1. CPI as Consolidation
2. CPI as part of salvage therapy











Summary CPI/chemo salvage

ORR ~90%-100%, CRR ~85%-95%

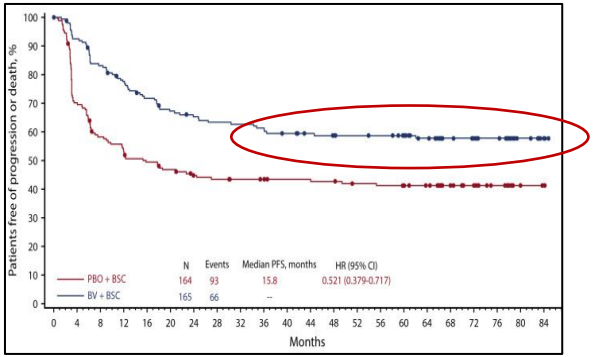
2-y PFS 70%-95%

Advani. *Blood*. 2021; Moskowitz. *J Clin Oncol*. 2021; Mei. *Blood*. 2022, ASH 2022; Bryan. *JAMA Oncol*. 2023.

CPI in 2L Treatment of HL

1. CPI as Consolidation
2. CPI as part of salvage therapy

   Better than chemo salvage + BV consolidation?



AETHERA: BV consolidation vs placebo

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Moskowitz. *Blood*. 2018.

CPI in 2L Treatment of HL

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2. CPI as part of salvage therapy
   - Better than chemo salvage + BV consolidation?

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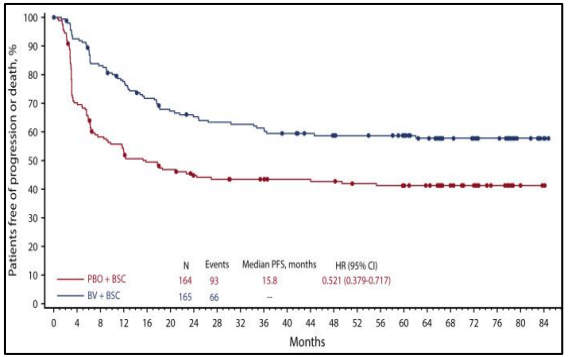

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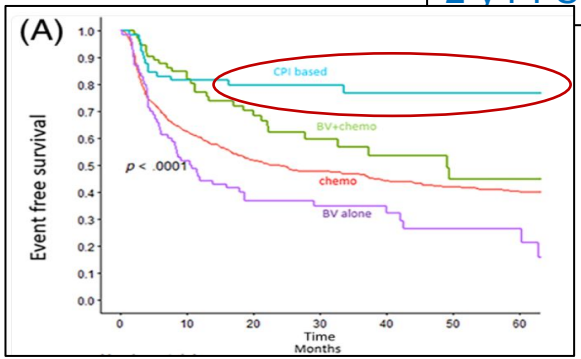


Multicenter retro comparison 936 **ASCT** pts

Moskowitz. *Blood*. 2018.
Desai. *Am J Hematol*. 2023.

CPI in 2L Treatment of HL

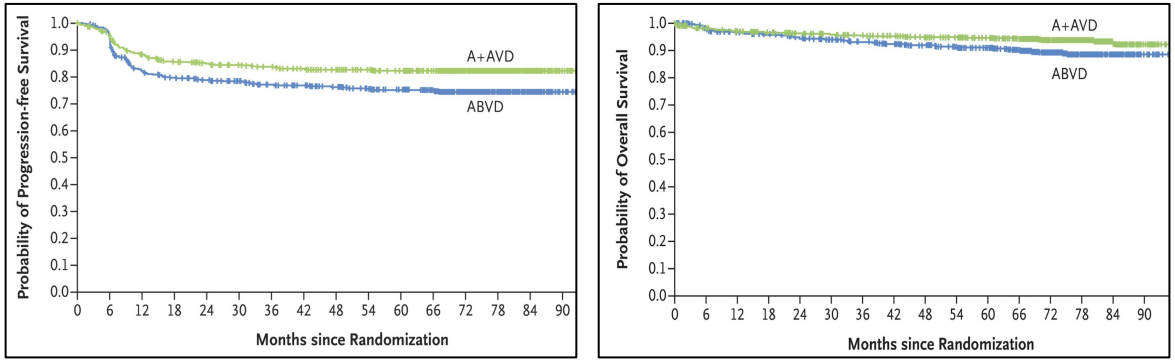
Changes in 1L treatment

CPI in 2L Treatment of HL

Changes in 1L treatment

1. BV as part of 1L therapy

BV-AVD > ABVD in advanced stage HL



ECHELON-1: BV-AVD vs ABVD in advanced stage 1L HL

Ansell. *N Engl J Med*. 2022.

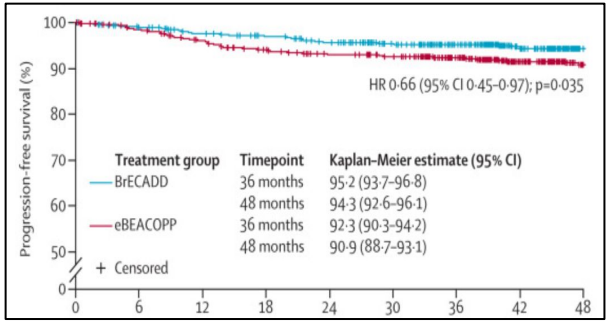
CPI in 2L Treatment of HL

Changes in 1L treatment

1. BV as part of 1L therapy

   BV-AVD > ABVD in advanced stage HL

   PET-adapted BrECADD > eBEACOPP in adv stg HL



HD21: BrECADD vs eBEACOPP in 1L adv stg

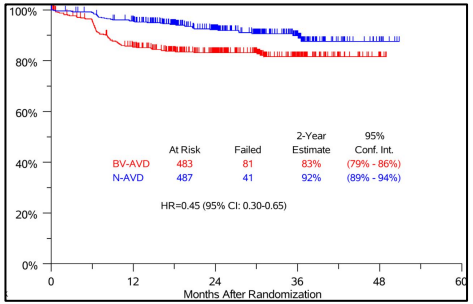
Borchmann. *Lancet.* 2024.

CPI in 2L Treatment of HL

Changes in 1L treatment

1. BV as part of 1L therapy
2. CPI as part of 1L therapy

Nivo-AVD > BV-AVD in adv stg HL



S1826: N-AVD vs BV-AVD in 1L adv stg

Herrera. *N Engl J Med*. 2024.

Optimal Place of BV and CPI

Optimal Place of BV and CPI

Many interlocking pieces with various levels of evidence

Can start with clearest and most impactful evidence

Optimal Place of BV and CPI

1. Addition of BV (BrECADD) or CPI (N-AVD) to 1L is beneficial.
   (How this applies to early stage is frustratingly unclear.)

Optimal Place of BV and CPI

1. Addition of BV (BrECADD) or CPI (N-AVD) to 1L is beneficial.
2. Addition of CPI to chemotherapy salvage is beneficial.
    - Magnitude of benefit may be higher than in 1L.
    - Stakes are also much higher.

Optimal Place of BV and CPI

1. Addition of BV (BrECADD) or CPI (N-AVD) to 1L is beneficial.
2. Addition of CPI to chemotherapy salvage is beneficial.

Implications for consolidation post ASCT

- CPI could possibly be useful post ASCT but makes less sense
  - Data not as compelling
  - Does not leverage chemosensitization

Optimal Place of BV and CPI

1. Addition of BV (BrECADD) or CPI (N-AVD) to 1L is beneficial.
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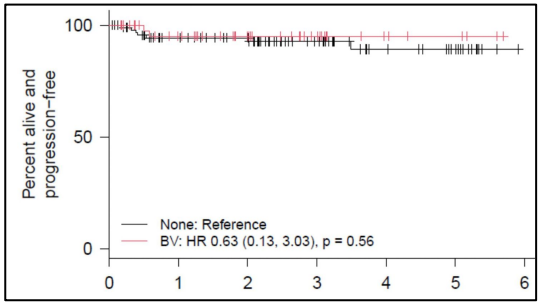
CPI could possibly be useful post ASCT but makes less sense

BV consolidation post CPI salvage

Retrospective data question benefit



Multicenter retro study of BV consolidation
146 pts CPI salvage

Falade, ASH 2023.

Optimal Place of BV and CPI

1. Addition of BV (BrECADD) or CPI (N-AVD) to 1L is beneficial
2. Addition of CPI to chemotherapy salvage is beneficial

Implications for consolidation post ASCT

- CPI could possibly be useful post ASCT but makes less sense
- BV consolidation post CPI salvage
  - Retrospective data question benefit
  - But often last chance to give BV in curative setting
  - Unclear whom to give it to…

Optimal Place of BV and CPI

1. Addition of BV (BrECADD) or CPI (N-AVD) to 1L is beneficial.
2. Addition of CPI to chemotherapy salvage is beneficial.

Implications for consolidation post ASCT

Implications for 2L salvage therapy

- How does CPI use in 1L (eg Nivo-AVD) affect CPI benefit in 2L?
- How does it affect use of BV with salvage or in consolidation?
- How do we define checkpoint-refractory patients?
- (Easier if using BrECADD in 1L)

Optimal Place of BV and CPI

Role of ASCT

Optimal Place of BV and CPI

Role of ASCT

Is CPI + chemo powerful enough to omit ASCT?

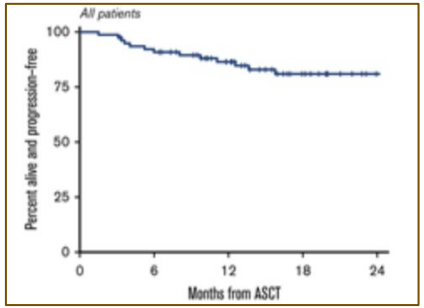
Summary CPI/chemo salvage
ORR ~90%-100%, CRR ~85%-95%
2-y PFS 70%-95%

Optimal Place of BV and CPI

Role of ASCT

Is CPI + chemo powerful enough to omit ASCT?

ASCT may instead be the driver of excellent outcomes (chemosensitization).



Retro study 78 US pts, med 3 lines prior to PD1
18-mo PFS 81%; 67% for 3x refractory

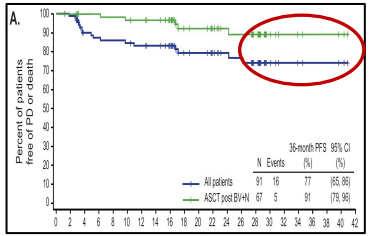
Merryman. *Blood Adv*. 2021.

Optimal Place of BV and CPI

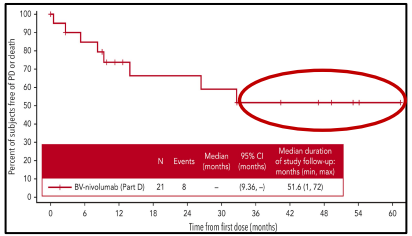
Role of ASCT

Is CPI + chemo powerful enough to omit ASCT?

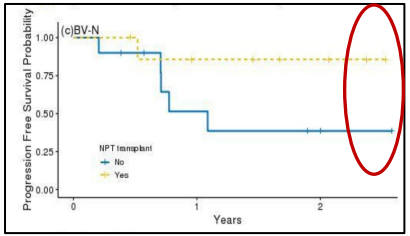
ASCT may instead be the driver of excellent outcomes (chemosensitization).



BV/nivo 2L



BV/nivo 1L



BV/nivo RR

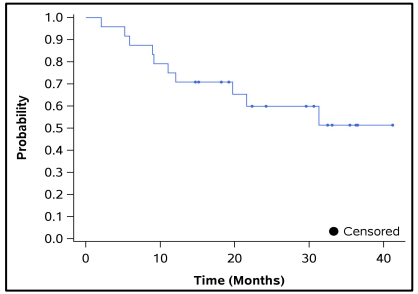
Advani. *Blood*. 2021.
Diefenbach. *Lancet Haematol*. 2020.
Friedberg. *Blood*. 2024

Optimal Place of BV and CPI

Role of ASCT

Is CPI + chemo powerful enough to omit ASCT?

- ASCT may instead be the driver of excellent outcomes (chemosensitization).
- All comers PFS very likely to be inferior w/o ASCT
- Does not rule out favorable PFS2



24 (of 40) pts in CR after Pem-GND, Pem maintenance no ASCT
2y PFS 61%

Moskowitz, ASH 2024.

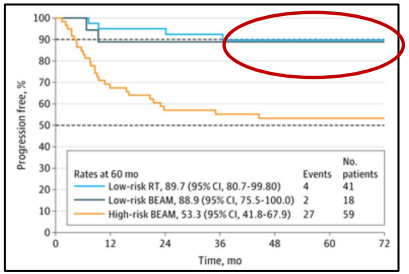
Optimal Place of BV and CPI

Role of ASCT

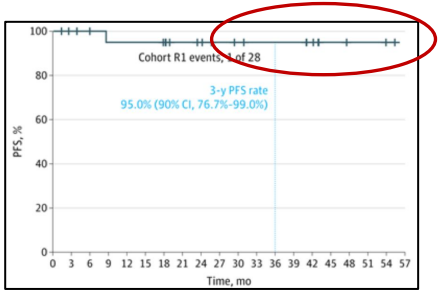
Is CPI + chemo powerful enough to omit ASCT?

If so, in whom?

Learning from pediatrics



41 pts low risk (2 cycles 1L + late relapse/early CMR to salvage)
Chemo (IEP/ABVD) + RT
4y PFS 90%



28 pts low risk (complicated criteria)
BV/nivo +/- BV-benda + ISRT if CMR
3y PFS 95%

Daw. *JAMA Oncol*. 2025.
Daw. *JAMA Oncol*. 2025.

Optimal Place of BV and CPI

Role of ASCT

Is CPI + chemo powerful enough to omit ASCT?

If so, in whom?

- Learning from pediatrics
  - There is a group of patients who can do very well w/o ASCT
  - Requires low-risk definition that encompasses 1L rx and TTR
  - Likely requires RT (and no RT in 1L)

Brockelmann. *J Clin Oncol.* 2020.

Optimal Place of BV and CPI

Role of ASCT

Is CPI + chemo powerful enough to omit ASCT?

If so, in whom?

- Learning from pediatrics
  - There is a group of patients who can do very well w/o ASCT
  - Requires low-risk definition that encompasses 1L rx and TTR
  - Likely requires RT (and no RT in 1L)
- And from the Germans
  - Some adult data from early favorable pts treated with aggressive 2L chemo (and no RT…)

Brockelmann. *J Clin Oncol*. 2020.

NEW QUESTIONS

Optimal Place of BV and CPI

Role of ASCT

How to risk stratify?

NEW QUESTIONS

Optimal Place of BV and CPI

Role of ASCT

How to risk stratify?

Standard risk stratification schemes not predictive and may not apply to modern era

AETHERA risk factors also pre-CPI

Josting. *J Clin Oncol*. 2022
Brockelmann. *Ann Oncol*. 2018
Moskowitz. *Blood*. 2018.

NEW QUESTIONS

Optimal Place of BV and CPI

Role of ASCT

How to risk stratify?

Standard risk stratification schemes not predictive and may not apply to modern era

AETHERA risk factors also pre-CPI

Novel biomarkers?

- The promise of ctDNA

Current Practice

- Evidence supports using CPI in salvage
- Too early to generally abandon ASCT
  - May be omitted in very carefully selected patients
- Can still consider BV consolidation in “high-risk” patients
- (Don’t forget allogeneic stem cell transplantation for post-ASCT failure.)

CONCLUSIONS

Current Practice

Future Practice?

- Risk-based use of ASCT
- Risk-based used of consolidation
- Novel vs tailored salvage regimens

THANK YOU

PANEL DISCUSSION

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Q & A

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