QUESTION 48 Hodgkin’s disease

A 40-year-old woman treated for Hodgkin’s disease in her early twenties with mantle radiotherapy is at highest risk of which of the following cancers?
A. Breast.
B. Lung.
C. Thyroid.
D. Lymphoma.
E. Sarcoma.

Hodgkin’s disease

Comprises of 2 biologicall distinct disease
1. Classical HL – subclassified to the morohology of ^1Reed – Sternberg cells and the composition of cellular background → nodular sclerosis HL (NSHL), mixed cellularity JL (MCHL), lymphocyte rich classical HL (LRCHL) and lymphocyte depleted HL (LDHL)
2. Nodular Lymphocyte predominance HL (NLPHL)

Presentation
- Palpable non tender lymphadenopathy (neck, supraclavicular & axilla)
- 50% will have mediastinal adenopathy at diagnosis
- subdiaphragmatic presentation is unusual and more common in older males
- 1/3 pts present with fevers, night sweats and/or wt loss (B Sx in Ann Arbor staging classification)

Rare presentations
- Older pt mixed cellularity Hodgkin’s disease in an abdo site
- Fevers persists for days to weeks, followed by afebrile intervals and then recurrence of fever
- Patter known as Pel-Epstein Fever
- Severe and unexplained itching
- Cutaneous disorders such as erthema nodosum, ichthyosiform athrophy,

Diagnosis
- Most pt have nodular sclerosing hodgkin’s disease
- Minority have mixed-cellularity Hodgkin’s disease
- Rare Lymphoicyte-predominant and lymphocyte deplete Hodgkin’s

Differentials (if look like Hodgkins’ histologically)
1. Inflammatory process
2. Mononucleosis
3. Non-Hodgkin’s lymphoma
4. Phenytoin induced lymphadenopathy

Staging procedures
1. Excisional tissue biopsy (not FNA/ core biopsy)
2. Hx and physical (incl. HIV risk factors)
3. CT chest/abdo/pelvis and Gallium or PET scan
4. FBE/ESR/Bone marrow biopsy
5. UEC/urate/LFT/LDH B2 microglobulin

Treatment
General outline of treatment

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^1 Large cells that have bilobed, double or multiple nuclei, with a prominent, eosinophilic, inclusion – like nucleolus in at least 2 lobes or nuclei
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- Very good prognosis” clinical stage I:
  - isolated high neck disease, NLPHL, low ESR, female
  - IF XRT ≥ 36 Gy alone
- Clinical stage I – IIA (?IIB):
  - “abbreviated” chemotherapy & IF XRT 24 - 30 Gy
  - role for chemotherapy alone in selected cases
- “Bulky” mediastinal disease:
  - Full chemotherapy & XRT to site of bulk
- Clinical stage (?IIB) III – IV:
  - “full” chemotherapy (± 30 Gy XRT to sites of initial bulk)

**Chemotherapy regimens**
5. ABVD – doxorubicin, bleomycin, vinblastine and dacarbazine
6. MOPP – Mechlorethamine, vincristine, procarbazine and prednisolone
7. Stanford V – weekly chemotherapy regimen administered for 12 weeks becoming more popular

**Long term complications**
1. Second malignancies
   - Risk for development of acute leukemia in the first 10 yrs after treatment (3-10%) with combination chemo regimens that contain alkylating agents
   - Age of pt being treated with those >60 years higher risk
   - Non-Hodgkin lymphoma (1 – 5 % at 10 years)

**Thoracic RTx**
1. Women should have screening mammograms 5 – 10 years after treatment
2. Discouraged from smoking as RTx accelerates coronary artery disease
3. Cause hypothyroidism
4. Lhermittie’s syndrome occurs in ~ 15% of pts

**Other solid tumours**
1. Thyroid (X30)
2. Lung (X4)
3. Bone (X 5 – 20)
4. Brain (X10)

2. Cardiac injury
3. Infertility
   - Treatment with ABVD rather than MOPP increases the changes to retain fertility

Answer:

Mantle radiotherapy is confined to the chest, neck, or under the arms
Main complication is pericardial, myocardial and even coronary arteries damage
Risk is greater with higher doses of RTx

For women, the risk would be breast Ca. Answer A