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BONE INVOLVEMENT IN CHILDHOOD HODGKIN'S DISEASE

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Bone involvement is rare in childhood Hodgkin's disease. Our experience is very limited on this clinical picture. Between January 1972 and December 1991 thirteen patients (pts) with osseous involvement were identified from a series of 611 children with Hodgkin's disease as a single institution. Mean age was 11.4±4.3 years, ranging from 4 to 16 years. Seven were boys. Initial stage distribution was as follows: stage I,1 patient; II,5 pts; III,3 pts; and IV,4 pts. Ten pts had B symptoms. Histopathology: NS,5 pts; MC,6 pts; LD,1; and unclassied one patient. Time of bone involvement: at presentation, 5 pts; at 1st relapse, 4 pts; 2nd relapse, 2 pts; and 3rd relapse, 2 pts The incidence of bone involvement was found to be 0.8% at presentation. Bone lesions were localized on axial skeleton in ten and multiple in six pts. All the pts had concurrent organ involvement at the time of bone invasions. Lytic, sclerotic lesions and periostal reaction were the most common radiologic findings. Therapeutic approaches were on the time of bone involvement. Nine pts received chemotherapy (CT) plus radiotherapy, whereas four pts received only CT. One of the initial involved patient died of infection at 3 months. 2 and 3-year overall survivals were 52% and 43% respectively.

Key words: Hodgkin's disease, bone metastasis; chemotherapy.

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SECONDARY MALIGNANCIES FOLLOWING THERAPY OF HODGKIN'S DISEASE (HD)

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Second malignancies (SECMAL) are a serious late complication of therapy in patients with curable malignant tumors. The frequency and outcome of SECMAL was investigated in 364 patients (pts) with HD treated at Hannover Medical School between 1970 and 1990. The minimum follow up for eligible patients was 12 months (mo).

Study patients: 364 pts; median age at diagnoses 34 years (16-78); median follow up 79 mo (12-248). Stage (Ann Arbor): stage I 61 (17 %), II 154 (43 %), III 94 (26 %), IV 51 (14 %). Treatment: Radiotherapy (Rtx) 76 pts (21 %), chemotherapy (Ctx) 67 (18 %), combined Ctx + Rtx 219 (61 %). Ctx (282 pts) consisted of COPP/ABVD (27 %), COPP (22 %), COP/ABV/IMEP (12 %), COPP/ABVD + VP16 (11 %), ABVD (1 %) or other regimens (6 %).

Results: 23/364 pts (6.31 %) developed SECMAL (4 pts developed more than 1 SECMAL) after a median time interval of 77 months from completion of therapy for HD of 77 months. Histology of SECMAL: AML 4, MDS 2, NHL 4, other solid tumors 17. Prior treatment: Ctx 2 pts (2.9 %), Rtx 4 pts (5.3 %) and combined Ctx/Rtx 15 pts (7.8 %). 13/23 pts (57 %) died from their SECMAL.

Conclusion: The frequency of SECMAL in this population was 6.31 % after a median follow up of 6 1/2 years. A trend towards an increased incidence of SECMAL was observed in patients receiving combined modality treatment. Since 11 of 23 pts with SECMAL were initially diagnosed with 'early stage' HD (stages I/II A/B), the use of the different treatment modalities in these patients must be assessed according to their risk-benefit in controlled clinical trials.

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HODGKIN'S DISEASE (HD) PATIENTS, CLINICAL STAGE (CS) I AND II, WITH PARTICULAR CLINICAL FEATURES: STAGING AND THERAPEUTIC IMPLICATIONS

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The presence of particular features at presentation in early stages HD patients probably has different staging and therapeutic implications. We have identified 5 subsets out of 829 pts treated in our institution from 1970 to 1992 for HD CS I and II: 1) disease presenting in cervical nodes only (15%); 2) B symtoms (14%); 3) mediastinal bulky and/or hilar disease (24%); 4) infradiaphragmatic onset of disease (6%); 5) PS III A1 (15% of PS cases). We have analysed the clinical features and the O.S. and R.F.S., according to treatment modalities and radiotherapy volume. In group 1 and 4, male gender, advanced age, histologic subtypes LP and MC, absence of subclinical disease at staging laparotomy were more frequent, while pts of groups 2 and 3 had contrary features. We observed an advantage in O.S. and R.F.S. at 5 and 10 yrs with radio-chemotherapy combination only in group 2, while in the other groups combined modality treatment gave better results in terms of R.F.S., but not of O.S. Finally we made some considerations about staging and therapeutic procedures in the various subsets of patients.

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HODGKIN'S DISEASE IN CHILDREN - REDUCED TAILORED CHEMOTHERAPY FOR STAGE I-II DISEASE.

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Hodgkin's disease in children is one of the malignancies with very good prognosis due to improvement of therapy. In an attempt to reduce late effects we treated 41 stage I and II patients with alternating COPP ABVD 2-3 courses tailored according to clinical response. Staging was based on various imaging modalities and gallium scan, without staging laparatomy. Radiotherapy was given only to bulky mediastinum. 4 patients relapsed, 14-57 months from diagnosis, 1 of them died of radiation pneumonitis. A second remission was attained in the other 3 patients, resulting in an overall survival of 98%, with a median follow up of 5 years. We conclude that stage I and II Hodgkin's disease in children can be effectively treated by 2-3 courses of COPP-ABVD with excelent results and presumably less late effects of therapy.

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RESULTS OF TREATING CHILDREN SUFFERING FROM HODGKIN LYMPHOMA

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69 children were treated for Hodgkin lymphoma from January 1974 till December 1992. Exclusively with irradiation were treated 8 children who were in the first or second stage of the disease; seven of them are still alive, while one died during relapse of the disease. 46 children were treated with Protocols MOPP and ABVD combined with irradiation; 36 (87%) of these children are still alive and show no sign of the disease. In 10 (22%) cases were relapses during which 6 (13%) of the children died. 15 children who were treated with Protocol HD-85 are still in the first remission. Of the total of 69 children 62 were still alive on the 1st January 1993 (89.9%); 58 (84%) of the children are still in the first remission. The achieved results are satisfactory and do not differ significantly from those achieved at similar Centres in Europe.

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111-IN-PENTETREOTIDE TUMOR-IMAGING IN MALIGNANT LYMPHOMA.

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Therapy in Hodgkin's Disease (HD) and Non Hodgkin Lymphoma(NHL) depends on clinical staging.Conventional techniques (Chest X-Ray, Ultrasound, CTscan, MRI) have limitations. Lymphoid cells can express Somatostatin(S)-Receptors(R). SR can be visualised in-vivo by 111-Indium labeled pentreotide (S-analogue) using a gamma camera. A study of SR-imaging vs conventional imaging techniques in HD and NHL was performed. Forty-nine SR-scans were obtained in 35 patients (pts)(23x 1,10x2,2x3 scans). 240 MBq 111-Indium labeled pentetreotide (20mcg) was administrered as a iv bolus infusion to 8 pts with HD (6x NS,2x MC) and 27 pts with NHL(6x CLL,5x LG,11x IG,5x HG). No adverse reactions were observed. Total body images and SPECT abdomen and pelvis were made after 24 and 48 hrs. In HD 9 additional tumor localisations were found (total 31 tumor(T) positive (P) sites). 3 T negative (N) localisations were detected (2x bulky residue, 1x calcified lymphnode). Sensitivity 91%. In NHL 4 additional sites on a total of 51 TP sides were found. SR-scanning in CLL (7/47) and LG NHL (3/29) has low sensitivty. Sensitivity of SR-scanning in NHL: total 39%, without CLL and LG 72%.

Conclusion: SR-imaging can be used in staging procedure of HD & NHL HG as an addition to conventional techniques rather than a substitution.
2. Low sensitivity for CLL & LG NHL; IG NHL takes up a middle position.

KEY NOTES: Somatostatin-Receptor imaging; Malignant Lymphoma; Tumor staging.