Background

Mainstay therapies for patients with stage III or IV classical Hodgkin lymphoma (cHL) include several multagent chemotherapy regimens:

- A combination of doxorubicin, bleomycin, vinblastine, and dacarbazine (ABVD) is commonly administered in the frontline (1L) setting.

- Approximately 30% of patients with stage III or IV cHL will be refractory to or relapse following 1L ABVD treatment.

- Brentuximab vedotin in combination with doxorubicin, vinblastine, and dacarbazine (A+AVD) is an option for 1L treatment of stage III or IV cHL and combines a novel targeted therapy with standard chemotherapy regimens.

- In the 5-year update of the ECHELON-1 trial, patients with stage III or IV cHL randomized to 1L A+AVD compared with ABVD continued to demonstrate a robust and durable improvement in progression-free survival (PFS; 82.9% vs 79.3%, CI 79.4-85 vs 76.9-80.5, p < 0.001), with a 22% reduction in the risk of disease progression or death (hazard ratio: 0.58 [0.53-0.67]), noninferiority P < 0.002.

Methods

Study Design

The CONNECT physician survey was an anonymous double-blind, online survey administered from October 19, 2020, to November 16, 2020.

Participating Physicians

Physicians were recruited using a large online panel of hematologists with ≥2 years medical practice experience, which includes physicians, patients, and caregivers.

Results

In total, 301 physicians participated in the survey (Figure 1).

Overall 1L cHL Treatment Considerations

Physicians reported clinical trial, efficacy, and safety data and official guideline recommendations as the most important considerations (ranked 1 or 2) when selecting 1L cHL treatments: patient personal goals, treatment costs, and patient financial support programs were ranked 1 or 2 by <10% of physicians (Figure 2A). Relecom A, et al.

- Within clinical data considerations, efficacy attributes were the dominant drivers of 1L stage III or IV cHL treatment decisions, including mutational status (97%), long-term PFS (81%), cutaneous toxicity attributes (71%), and complete response rate (81%), while physicians noted that having had the greatest or most essential impact on their decision-making when selecting 1L cHL treatments.

- When asked about acceptable long-term toxicity trade-offs for increased efficacy, in patients with stage III or IV cHL, physicians stated an additional median of 8 months of OS and 6 months of PFS would be worth the potential for durability for the following reasons: 50% of physicians believed that disease stage was the most important patient characteristic to consider when deciding on a 1L treatment for stage III or IV cHL, followed by fitness/frailty (Eastern Cooperative Oncology Group performance score), and comorbidities (28%).

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Stage III or IV cHL 1L Treatment Preferences

- When physicians were asked to choose their first-choice treatment among A+AVD, ABVD, or PET-Adapted ABVD for various patient types with stage III or IV cHL, (Figure 3), A+AVD was generally selected by more physicians than ABVD or PET-Adapted ABVD with 37%-50% of physicians selecting A+AVD as their first-choice regimen.

- Significantly more physicians selected A+AVD than ABVD as their first-choice treatment for all patient types.

- Numerous more physicians selected A+AVD than PET-Adapted ABVD for all patient types except for younger, more fit patients, these differences were significant for those with stage III or IV disease, those with stage IV disease, and those with a perceived high-risk of relapse.

Patient-Specific Treatment Considerations

- No significant differences in treatment preferences were noted between physicians practicing in community compared with academic settings.

Stage III or IV cHL 1L Treatment Preferences by Patient Profile

- When presented with several patient profiles and various treatment options that may be given with or without radiation:

- 51% of participating physicians preferred a pembrolizumab-based strategy for patients with stage III or IV cHL as demonstrated by Patient 1 (Figure 4A).

- OS and PFS were selected by physicians as the top reasons for choosing the treatment regimen selected by Patient 1 (Figure 4A).

- Treatment options, tolerability, and quality of life were selected as top reasons for choosing a less intensive treatment regimen (e.g., brentuximab vedotin monotherapy, AHD).

- Physicians were provided a list of possible patient types and asked to select in each patient type the most dominant treatment for all patient types: 42% of physicians selected A+AVD for all patient types except for younger, more fit patients, these differences were significant for those with stage III or IV disease, those with stage IV disease, and those with a perceived high-risk of relapse.

- No significant differences in treatment preferences were noted between physicians practicing in community compared with academic settings.

Patient Considerations When Selecting a 1L cHL Treatment

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- Treatment cost

- Patient treatment goals

- Comorbidities

- Patient lifestyle

- Access to clinical trials

- Financial support available

- Consultation with colleagues

- Medical literature

- Patient age

- Patient gender

- Patient performance score.

- Deauville score

- International Prognostic Index

- Comorbidities

- Symptom burden

- Stage

Limitations

- As this was an opt-in group of survey participants already part of established research panels, results may not be applicable to all physicians who treat patients with cHL.

Conclusions

- Treatment preferences for patients with stage III or IV cHL varied based on patient characteristics, including presence of bulky mediastinal disease, disease stage, perceived risk of relapse, age, and comorbidities.

- Efficacy attributes, including OS and PFS, quality of life, and patient age were top reasons cited by surveyed physicians for selecting a specific 1L treatment regimen in stage III or IV cHL.

References

[References list]

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