some of them have already been included in the standard treatment protocols, but further studies on other new agents are needed to determine their efficacy in children.

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Sp03

MEDICAL TREATMENT IN HODGKIN LYMPHOMA

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The treatment of HL has been designed according to risk stratification. Risk stratification is based on presenting features at diagnosis. Stage of disease, presence of bulky disease, presence of B symptoms, and number of involved nodes are the parameters of risk determination. Low risk group includes stage IA and IIA disease with no tumor bulk and no extranodal involvement. Stage IA and IIA with bulky disease or extranodal involvement, and stage IB and stage IIIA are defined as intermediate risk. Stage IIB with with bulky disease or extranodal involvement, IIIB and IV diseases are in high risk group. Treatment of HL in children consists of combined modality treatment including multiagent chemotherapy and low dose involved field radiotherapy. Modern therapy of HL can be based on both risk group and response (Table I, II, III). Standard chemotherapy in Hodgkin disease is ABVD or MOPP derivatives. Adriamycine, Dacarbazine, Bleomisin and Vinblastin are the major drugs of ABVD derivative protocols. MOPP derivatives include generally cylophospamide, vincristine, procarbazine, prednisolone. Hodgkin lymphoma is a radiosensitive disease. In general, doses of 15 to 25 Gy are used with modification based on patient and disease characteristics. In combined modality era, the extended treatment volumes are no longer needed. The Involved fields reduce the exposure of normal tissue and the late side effects by not reducing local control rate. The implementation of more tailored fields is a progress toward this goal, treating only the individual lymph nodes with a margin for microscopic disease. This, in conjunction with modern imaging, will continue to reduce exposure of normal tissue to radiation while maintaining equivalent local disease control rates. In some recent trials, radiotherapy was omitted in localized low risk disease and early responder patients.

Combined modality treatment will result in very high cure rates (Table I, II, III). The treatment results in children with early stage disease are perfect. Disease-free survival and overall survival reach up to 95% and 100%, respectively. About ten to twenty percent of advance stage patients may relapse. Since the prognostic outlook and life expectancy of HL have shown significant progress over the last decades, the quality of life and prevention of late side effects have gained considerable importance. Balance ensuring the best opportunity for long-term disease-free survival and the lowest risk of severe treatment toxicity should be achieved.

Table I. Treatment of Low Risk Group

Low Risk Studies	Treatment		EFS
POG 8625	6 MOPP/ABVD	+None	83%
(1986-92, 247 pts)	4 MOPP/ABVD	+LD-IFRT	91%
CCG 5942	4COPP/ABV	+ None	89%
(1995-98, 826 pts)	4COPP/ABV	+ LD-IFRT	100%
COG 9426	2 DBVE	CR ⇨ +LDIFRT	87%
(1996-2000, 294 pts)		<CR ⇨ +2DBVE+ LDIFRT	85%
COG AHOD0431	AVPC	CR ⇨ +None	78%
(2006-2009, 278 pts)		<CR ⇨ +LDIFRT	83%
MDH90	4 VBVP	CR ⇨ +IFRT	90%
(1990-2008,202 pts)	4 VBVP	<CR ⇨ +2-4 OPPA +IFRT	78%
GPOH-HD 2002	2 OEPA(M)/OPPA(F)	CR ⇨ +None	93%
(2002-2005,573 pts)		<CR ⇨ +LD-IFRT	92%

Table II. Treatment of Intermediate Risk Group

İntermediate Risk Studies	Treatment		EFS
CCG 5942	6 COPP/ABV	⇨ + None	78%
(1995-98,834 pts)		⇨ + LD-IFRT	84%
POG 9425	3 ABVE-PC	RER ⇨ +LDIFRT	86%
(1997-2001, 219 pts)		SER ⇨ +2ABVE-PC+ LDIFRT	88%
AHOD0031	2 ABVE–PC	RER ⇨ CR +2ABVE-PC + None	84%
(2002-2009, 1734)		RER ⇨ CR + 2ABVE-PC+ LDIFRT	88%
		RER ⇨ <CR +2ABVE-PC+LDIFRT	87%
		SER ⇨ +2DECA+2ABVE-	79%
		PC+LDIFRT	75%
		SER ⇨ +2ABVE-PC+LDIFRT	
GPOH-HD2002	2 OEPA/OPPA+4COPP/COPADC +SDIFRT		88%
(1997-2001, 219 pts)			