Call for Correspondence

JNCCN is committed to providing a forum to enhance collaboration between academic medicine and the community physician. We welcome comments about the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines), articles published in the journal, or any other topic relating to cancer prevention, detection, treatment, supportive care, or survivorship. Please send correspondence to JNCCN.edmgr.com or to JNCCN@nccn.org.

Letters should be no more than 400 words, with no more than 5 references if included. Please include the full names, degrees, and affiliations of all letter authors and a phone number or e-mail address for contact.

Letters are considered for publication as space allows. NCCN reserves the right not to publish correspondence for any reason it deems appropriate. All letters are subject to editing and/or abridgment.

Letter to the Editor: Who's Watching the Kids?

Re: Margaret Tempero. Who's Watching the Kids? J Natl Compr Canc Netw 2017;15(11):1289.

Dr. Tempero's editorial, "Who's Watching the Kids," in the November 2017 issue, suggests several important steps for oncologists and their practices to better manage basic, life-altering concerns for their patients. Taking the time to get to know a patient facilitates communication about treatment, clinical research, and basic goal-setting with that person and their family.

Beginning to understand the patient's family needs and concerns is an approach that is often overlooked in the care of adults with cancer. I agree that oncologists are not educated or trained to perform the necessary counseling some individuals require or to provide services to the entire family. We could expect, however, that oncology clinicians be aware of the range of psychosocial support services available in their community.

For example, in the St. Louis, Missouri area, we have a program known as "Families Connect," which is one of the services of the Cancer Support Community of Greater St. Louis (CSC), an affiliate of

the national organization. Families Connect provides comprehensive professional support focused on stress reduction, education, coping skills, and nutrition to children and other family members of a parent with cancer, at no charge.

I am a retired hematologist-oncologist who has also worked in palliative care medicine. As the chair of the local CSC Professional Advisory Committee, I am impressed with the high-quality services our family support program provides, with the potential to offer a healthy, balanced approach to those patients with cancer whom we serve.

Our biggest hurdles are to get oncologists to understand their patients' psychosocial support needs, to be willing and able to begin discussing them effectively, and to make referrals to resources within their institutions or to community organizations such as CSC. Many communities have similar services that are dedicated to supplementing what oncologists do as part of the overall care of the patient with cancer.

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Letter to the Editor: No Evidence to Promote Interim FDG-PET Adapted Therapy in the NCCN Guidelines for Hodgkin Lymphoma

Re: Richard T. Hoppe, Ranjana H. Advani, Weiyun A. Ai, et al. Hodgkin Lymphoma Version 1.2017, NCCN Clinical Practice Guidelines in Oncology. J Natl Compr Canc Netw 2017;15(5):608–638.

The updated NCCN Clinical Practice Guidelines in Oncology for Hodgkin Lymphoma (HL)¹ promote the application of interim fluorodeoxyglucose (FDG)-PET-adapted therapy in both

early- and advanced-stage HL. Unfortunately, this approach is not supported by the studies cited.¹ In early-stage HL, treatment escalation in interim FDG-PET-positive patients may not be justified, because these patients have an excellent prognosis following standard, nonintensified therapies.² On the other hand, treatment de-escalation in patients with early-stage HL with negative interim FDG-PET results demonstrated markedly increased relapse rates in all available

Correspondence

studies.³ In patients with advanced-stage HL with positive interim FDG-PET results, treatment escalation has not proven to be beneficial, because studies showing favorable results lacked a randomization arm of patients treated with nonintensified therapies. On the contrary, the only available randomized trial on treatment escalation in advanced-stage HL showed that interim FDG-PET-adapted treatment approaches had no benefit at all.⁴ Finally, treatment de-escalation in patients with advanced-stage HL with negative interim FDG-PET results is controversial, because most patients with therapy-resistant disease have negative interim FDG-PET results.⁵ Consequently, a negative interim FDG-PET result has low value in ruling out residual disease.

The low value of interim FDG-PET in selecting the appropriate therapy regimen is most likely due to its limited sensitivity and specificity. FDG-PET images have a spatial resolution of 6 to 9 mm, and lymphomatous deposits below this threshold are missed. This theoretical underpinning is reflected by several observations: (1) a combination of lymphoma-positive bone marrow biopsies and no increased FDG uptake in the marrow⁶; (2) a high relapse rate during follow-up in patients with HL who initially experienced FDG-PET-based complete remission (CR) after treatment⁷; (3) additional radiation therapy reduces relapse rates despite achieving FDG-PET-based CR³; and (4) patients receiving palliative care and those with indolent non-Hodgkin's lymphoma (NHL) treated with noncurative therapies can experience an FDG-PET-based CR. Meanwhile, the histopathologic substrate of FDG-avid lesions at interim FDG-PET in HL is currently still unknown. Importantly, studies in NHL reported a strikingly high number of false-positive FDG-avid lesions at interim FDG-PET that were histologically verified.⁸ These results can very likely be translated to HL. Note that HL comprises only 0.1 to 10 of malignant Reed-Sternberg tumor cells⁹ and that virtually all FDG-avidity is caused by the associ-

ated inflammatory substrate, even before treatment has started.

In conclusion, the current evidence does not support the application of interim FDG-PET-adapted treatment in both early- and advanced-stage HL. Theoretical underpinnings suggest that results of future trials on interim FDG-PET will be unlikely to show benefit.

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NCCN Guidelines Staff Reply to Letter to the Editor: No Evidence to Promote Interim FDG-PET Adapted Therapy in the NCCN Guidelines for Hodgkin Lymphoma

NCCN Guidelines Staff Reply to Hugo J.A. Adams and Thomas C. Kwee's Letter to the Editor re: Re: Richard T. Hoppe, Ranjana H. Advani, Weiyun A. Ai, et al. Hodgkin Lymphoma Version 1.2017, NCCN Clinical Practice Guidelines in Oncology. *J Natl Compr Canc Netw* 2017;15(5):608–638.

In response to the 2017 version of the NCCN Clinical Practice Guidelines in Oncology for Hodgkin Lymphoma (HL),¹ Adams and Kwee point out that current evidence does not support the application of interim FDG-PET-adapted treatment in early- and late-stage HL. Several studies have demonstrated that FDG-PET performed after 2 cycles of chemotherapy has prognostic value.^{2–6} However, given the limitations of some studies, more data are needed to enhance the utility of this approach. The recommendations made in the guidelines are adapted from original clinical studies but not limited to them and are often consensus-based. In addition, participation in clinical trials are encouraged as the best management for HL.

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