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Secondary malignant neoplasms, progression-free survival and overall survival in patients treated for Hodgkin lymphoma: A systematic review and meta-analysis of randomized clinical trials

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Abstract

Treatment intensification to maximize disease control and reduced-intensity approaches to minimize the risk of late sequelae have been evaluated in newly diagnosed Hodgkin lymphoma. The influence of these interventions on the risk of secondary malignant neoplasms, progression-free survival and overall survival is reported in the present meta-analysis based on individual patient data from 9498 patients treated within 16 randomized controlled trials for newly diagnosed Hodgkin lymphoma between 1984 and 2007. Secondary malignant neoplasms were meta-analyzed using Peto's method as time-to-event outcomes. For progression-free and overall survival, hazard ratios derived from each trial using Cox regression were combined by inverse-variance weighting. Five study questions (combined-modality treatment vs chemotherapy alone; more extended vs involved-field radiotherapy; radiation at higher doses vs radiation at 20 Gy; more vs fewer cycles of the same chemotherapy protocol; standard-dose chemotherapy vs intensified chemotherapy) were investigated. After a median follow-up of 7.4 years, dose-intensified chemotherapy resulted in better progression-free survival ($p=0.007$) rates as compared with standard-dose chemotherapy, but was associated with an increased risk of therapy-related acute myeloid leukemia/myelodysplastic syndromes ($p=0.0028$). No progression-free or overall survival differences were observed between combined-modality and chemotherapy alone, but more secondary malignancies were seen after combined-modality ($p=0.010$). For the remaining three study questions, outcomes and secondary malignancy rates did not differ significantly between treatment strategies. The results of this meta-analysis help to weigh up efficacy and secondary malignancy risk for the choice of first-line treatment of Hodgkin lymphoma patients. However, final conclusions regarding secondary solid tumors require longer follow-up.

Introduction

Hodgkin lymphoma (HL) is a lymphoid malignancy with an incidence of 3-4/100.000/year. Young adults are most often affected.¹ At present, about 80% of patients achieve long-term remission after treatment with multi-agent chemotherapy optionally followed by radiotherapy (RT).² Given the mostly young age at diagnosis and the excellent long-term prognosis, therapy-related late effects including secondary malignant neoplasms (SMN), cardiovascular disease and infertility have become increasingly important.³⁻⁶ Several recent clinical trials evaluated the possibility of reducing toxicity by limiting chemotherapy and RT without compromising efficacy.² Conversely, some studies for patients with newly diagnosed advanced HL investigated intensified chemotherapy protocols to improve the clinical outcome of high-risk patients.²

SMN are divided into secondary hematological malignancies including therapy-related acute myeloid leukemia/myelodysplastic syndromes (t-AML/MDS) and secondary non-Hodgkin lymphomas (NHL) and the heterogeneous group of secondary solid tumors. An association between the use of alkylating agents and topoisomerase-II-inhibitors and the development of t-AML/MDS has been demonstrated.⁷⁻⁹ Both drug classes are included in first-line chemotherapy protocols such as ABVD, escalated BEACOPP and Stanford V.¹⁰⁻¹² For secondary NHL, such associations have not been identified.¹³ The time interval between HL treatment and the occurrence of secondary hematological malignancies is usually short, ranging between four and ten years in most cases.^{9, 13} In contrast, the risk of secondary solid tumors remains significantly increased for up to 25 years and more.^{3, 4}

In the present meta-analysis using individual patient data (IPD), SMN, progression-free survival (PFS) and overall survival (OS) of patients treated in randomized clinical trials comparing different treatment approaches (combined-modality treatment (CMT) vs chemotherapy alone; more extended radiotherapy (RT) vs involved-field RT (IF-RT); RT at higher doses vs RT at 20 Gy; more vs fewer cycles of the same chemotherapy protocol; standard-dose chemotherapy vs intensified chemotherapy) were investigated. Acceptable chemotherapy regimens were ABVD or similar (e.g.,

MOPP/ABV) or (for the last study question above) any dose-intensified chemotherapy randomly compared with a standard dose ABVD-like regimen.

Methods

Searches for randomized clinical trials including patients with newly diagnosed HL that compared treatment approaches according to the mentioned study questions and published from 1984 onwards were performed in March 2010 using the electronic literature databases Medline and Cochrane Central. Reference lists of all relevant retrieved publications and previous meta-analyses were searched. All identified articles were screened independently by two authors. Trials had to have enrolled at least 50 patients per treatment group and to have finished recruitment before or during 2007, to avoid trials with inadequate follow-up. Searches were repeated in April 2015.

IPD were requested from the investigators of the eligible trials, including birth date, sex, HL diagnosis date, stage at diagnosis, presence of B symptoms, randomization date, allocated treatment, remission status after first-line treatment, relapse date, date and type of SMN, death date and last follow-up date concerning clinical outcome and vital status.

Statistical methods

For quality control, each trial included in the meta-analysis was initially analyzed separately, comparing the treatment arms with respect to recruitment times, patient characteristics, complete remission rates, follow-up duration, PFS, OS and time to SMN. Results were compared with previous trial publications and inconsistencies queried. Risk of bias was assessed for each trial according to the Cochrane recommendations.¹⁴ To assess completeness of follow-up, the median observation time was calculated using the Kaplan-Meier method with reverse censoring at death. The distribution of last information dates was quantified using the interquartile range of the dates of last information (IQR-DLI). This range includes the central 50% of last information dates and thus represents the extent to which patients in a given study are lost to follow-up over a broad time

interval. Large IQR-DLI values (absolute or relative to median follow-up) suggest poorer follow-up quality.

Randomized comparisons for each study question were combined across the appropriate trials to obtain a pooled Peto's odds ratio (OR) for SMN rates, with 95% confidence intervals (CI).^{15, 16} Three types of SMN, i.e. t-AML/MDS, secondary NHL and secondary solid tumors were also analyzed separately.

Subgroup analyses were performed to investigate whether the SMN rates depended upon the stage according to Ann Arbor classification (early stages I and II vs advanced stages III and IV), age (≤ 50 years vs > 50 years) and gender. Treatment subgroups were defined for the intensified chemotherapy question only (escalated BEACOPP vs Stanford V vs EBV/CAD-based vs ChIVPP-based). Results were displayed chronologically by recruitment period in order to reveal time period effects.

Sensitivity analyses were conducted excluding SMN that had occurred after HL recurrence: follow-up times were censored at HL recurrence. Further sensitivity analyses were performed as follows: firstly, SMN data were analyzed using a one-step Cox proportional hazards regression, stratified by trial. Secondly, analyses were repeated with the exclusion of the less complete follow-up periods in each trial, censoring at the date at which 75% of surviving patients in the particular trial were still being followed. Thirdly, overall SMN and separate secondary solid tumor analyses were repeated excluding non-melanoma skin cancers (NMSC). Finally, the cumulative incidence method, which considers non-SMN death as a competing risk, was employed.^{17, 18}

All analyses were performed in SAS (version 9.3) and RevMan (version 5.2).

Results

Results of the search

A total of 3515 references (excluding duplicates) published after 1984 were identified in 2010 and reviewed for eligibility. The majority did not meet the predefined criteria and were excluded for the

following reasons: 1419 references did not concern HL patients, 1162 did not report a clinical trial, 161 reported on patients in the second-line setting, 98 reported non-randomized trials, 97 were review articles and 53 were duplicates. Hence, 578 references fulfilled the predefined general eligibility criteria and were reassessed concerning the exact treatment comparison. A total of 21 randomized clinical trials for the first-line treatment of HL including at least 50 patients per study arm and comparing treatment modalities matching with at least one of the five study questions were identified. Data were received for 16 trials conducted between 1984 and 2007 (Figure 1).¹⁹⁻³³ No data were received for four studies.³⁴⁻³⁷ One additional trial first published in 2013 was only found in the 2015 search, so IPD were not sought.³⁸ One trial was split for analysis since the participating centers could choose between two alternative intensified chemotherapy regimens.³²

Characteristics of the included studies

All included studies, grouped according to the study questions are described in table 1.

Three aspects of the risk of bias (randomization, allocation concealment, attrition bias) according to the Cochrane scheme were judged to be low in 13 of 16 trials, while randomization and allocation concealment were uncertain in two trials and considered high risk in one trial. High risk of bias due to lack of blinding applied to all trials with respect to SMN and PFS, OS was presumed to be entirely objective. Sixteen patients from two studies with no evaluable data after randomization were excluded from the meta-analysis.^{20, 26} Those patients had also been excluded from the analyses of the respective study groups.

The median follow-up within the trials ranged between 3.5 and 17.6 years (overall median follow-up: 7.4 years). A histogram of follow-up times to SMN or last information is displayed in Fig. 6 (online only); although 75% of patients had more than 5 years of follow-up, only 16% were followed beyond 10 years. A comparison of the distribution of follow-up times between the treatment arms of the included studies yielded a significant difference according to the log-rank test ($p=0.036$) in only one of 16 cases.

The IQR-DLI varied among trials from 0.4 to 6.6 years (median: 3.1 years). Studies with longer follow-up tended to have a wider scatter. The ratio between the IQR-DLI and the median follow-up varied between 0.05 and 0.59 (median: 0.34). Thus, in half of the included studies the central 50% of last information dates stretch over a time interval of at least three years or one third of the median follow-up duration.

Patient characteristics

IPD from 9498 patients treated within 16 randomized clinical trials for newly diagnosed HL were included. At the time of HL treatment, patients were aged between 14 and 75 according to inclusion criteria of the included studies (eight exceptions between ten and 87 years), median age was 33 years. During the course of follow-up, an SMN was reported for 438/9498 patients (4.6%), including 63 t-AML/MDS (0.7%), 86 secondary NHL (0.9%) and 276 (2.9%) secondary solid tumors. Breast (39/276), lung (35/276), skin (29/276) and bowel (colon, rectum) (23/276) were the sites most often affected. In 13 patients (0.1%) diagnosed with an SMN, information on the tumor entity was lacking. Cumulative incidences of SMN at five, ten, 15 and 20 years (regarding death as a competing risk) were 2.4%, 5.8%, 13% and 23% respectively.

Results of the treatment comparisons

(1) CMT vs chemotherapy alone

A total of 1011 patients treated within the EORTC 20884 (advanced stages), EORTC-GELA H9-F (early stages) and GHSG HD3 (advanced stages) trials were analyzed. After a median follow-up of 7.8 years, 30/671 patients (4.5%) treated with CMT and 10/340 patients (2.9%) treated with chemotherapy alone had been diagnosed with an SMN. This difference was significant, favoring patients who had received chemotherapy only ($p=0.010$; Peto's OR: 0.43, 95%-CI: 0.23-0.82) (figures 2, 3; table 2). Especially patients aged 50 and younger ($p=0.04$), female patients ($p=0.01$) and those with advanced stages ($p=0.01$) had a significantly reduced risk to develop an SMN when treated with chemotherapy alone. No reduced SMN rate with chemotherapy alone was

observed among patients diagnosed with early stages ($p=0.68$). An analysis separately evaluating the incidence rates for t-AML/MDS, secondary NHL and secondary solid tumors revealed a risk reduction after chemotherapy alone only for the development of t-AML/MDS ($p=0.037$) but not for secondary NHL and solid tumors. The PFS and OS rates did not significantly differ between treatment groups (table 2). However, there was some evidence of inferior tumor control with chemotherapy alone (HR: 1.31, 95%-CI: 0.99-1.73, $p=0.06$). Subgroup analyses indicated that stage and age were significant effect modifiers (interaction p -values were <0.0001 (stage) and 0.02 (age)). PFS was significantly impaired after chemotherapy alone in comparison with CMT for early-stage patients and patients aged ≤ 50 (online tables 6, 8).

(2) More extended RT vs involved field RT

A total of 2397 early-stage patients treated within the EORTC-GELA H8-U, the GHSG HD8, the Italian HD94 and the Milan trials were analyzed. After a median follow-up of 10.8 years, 91/1026 patients (8.9%) who had received RT to more extended fields and 96/1371 patients (7.0%) who had received IF-RT had been diagnosed with an SMN. This difference was not statistically significant ($p=0.32$; Peto's OR: 0.86, 95%-CI: 0.64-1.16) (online figures 6, 7). When separately analyzing the incidence rates of t-AML/MDS, secondary NHL and secondary solid tumors, there were also no significant differences between the treatment groups. The same is true for the PFS and OS rates (table 2). Subgroup analyses according to gender and age did not identify any heterogeneity of the treatment effect across any subgroups.

(3) RT at higher doses vs RT at 20 Gy

A total of 2962 early-stage patients treated within the EORTC-GELA H9-F, GHSG HD10 and GHSG HD11 trials were analyzed. After a median follow-up of 7.4 years, 54/1489 patients (3.6%) who had RT at a dose of 30 Gy or 36 Gy and 56/1473 patients (3.8%) who had RT at a dose of 20 Gy had developed an SMN. Thus, the rate of SMN did not differ between the treatment groups ($p=0.87$; Peto's OR: 1.03, 95%-CI: 0.71-1.50) (online figures 8, 9). There were also no differences when the rates for t-AML/MDS, secondary NHL and secondary solid tumors were separately

considered. The clinical outcome was similar in both treatment groups, with no differences in PFS and OS. Additional subgroup analyses according to gender and age did not identify differences between any subgroups.

(4) More vs fewer cycles of the same chemotherapy protocol

A total of 2403 early-stage patients treated within the EORTC-GELA H8-U, EORTC-GELA H9-U and GHSG HD10 trials were analyzed. After a median follow-up of 7.8 years, 48/1201 patients (4.0%) who had been treated with more cycles and 53/1202 patients (4.4%) who had received fewer cycles of the same chemotherapy protocol had developed an SMN. This difference was not statistically significant ($p=0.65$; Peto's OR: 1.10, 95%-CI: 0.74-1.62) (online figures 10, 11). The SMN incidences did also not differ between the patient groups when t-AML/MDS, secondary NHL and secondary solid tumors were separately considered. The clinical outcome after treatment with more or fewer cycles of the same chemotherapy was comparable, without any significant PFS and OS differences. Additional subgroup analyses according to gender and age did not identify differences between any subgroups.

(5) Standard-dose chemotherapy (ABVD or COPP/ABVD) vs intensified chemotherapy

A total of 2996 advanced-stage patients treated within a GITIL-IIL trial, the GISL HD2000 trial, the GHSG HD9 trial, the HD9601 trial from Italy and the British LY09 and ISRCTN64141244 trials were analyzed. The rates of RT were comparable in both treatment groups of the included studies with the exception of the ISRCTN64141244 and HD9601 trials, administering Stanford V as intensified regimen. After a median follow-up of 6.7 years, 31/1305 patients (2.8%) who had received standard-dose chemotherapy (ABVD, COPP/ABVD) and 60/1691 patients (3.5%) treated with intensified chemotherapy protocols (escalated BEACOPP, Stanford V, ChIVPP/PABIOE, ChIVPP/EVA, MOPP/EBV/CAD, COPP/EBV/CAD) had developed an SMN. This difference was not statistically significant ($p=0.15$; Peto's OR: 1.37, 95%-CI: 0.89-2.10) (figures 4, 5). When separately considering t-AML/MDS, secondary NHL and secondary solid tumors, an increased risk to develop t-AML/MDS was seen for patients treated with intensified chemotherapy protocols

($p=0.0028$) whereas the incidence rates for secondary NHL and secondary solid tumors did not differ between the treatment groups (table 3). Overall, tumor control was significantly better with intensified chemotherapy regimens as compared with standard-dose protocols ($p=0.007$; HR: 0.82, 95%-CI: (0.70 – 0.95)) while there were no significant differences in OS ($p=0.12$; HR: 0.85, 95%-CI: (0.70 – 1.04)). However, subgroup analyses revealed that especially patients aged ≤ 50 appear to benefit from more aggressive chemotherapy approaches as the improved PFS also translated into a better OS in these patients ($p=0.02$). In contrast with patients older than 50 years, patients aged ≤ 50 also had a significantly greater SMN risk with intensified chemotherapy protocols than with standard-dose chemotherapy (interaction $p=0.02$; treatment effect in younger subgroup: $p=0.01$). Additional subgroup analyses revealed differences between the different intensified protocols for PFS (interaction $p<0.00001$) and OS (interaction $p=0.006$). Patients treated with escalated BEACOPP had superior PFS and OS rates in comparison with those receiving standard-dose chemotherapy. For Stanford V, PFS was worse than with standard-dose chemotherapy. No PFS and OS differences in comparison with standard-dose chemotherapy were observed for ChIVPP/PABIOE, ChIVPP/EVA, MOPP/EBV/CAD and COPP/EBV/CAD. For SMN no interaction in chemotherapy subgroups were found (interaction $p=0.06$) (online table 8).

All main meta-analytic results are summarized in table 2.

Sensitivity analyses agreed with the described main analyses. The results of sensitivity analyses concerning censoring of incomplete follow-up periods and exclusion of NMSC are summarized in tables 4 and 5 (online only).

Discussion

The present meta-analysis including 9498 patients treated within 16 randomized clinical trials for newly diagnosed HL between 1984 and 2007 represents one of the largest analyses of SMN, PFS and OS of HL patients based on randomized comparisons. The major findings were as follows: 1) after a median follow-up of 7.4 years, the overall SMN rate was 4.6%; 2) compared with patients receiving chemotherapy alone, an increased SMN rate was observed in patients receiving CMT; 3)

patients with early-stage HL treated with CMT had a better PFS than patients treated with chemotherapy alone; 4) compared with patients receiving standard-dose chemotherapy, those receiving intensified chemotherapy protocols more often developed t-AML/MDS; 5) compared with ABVD-like protocols, PFS and OS in advanced-stage patients were improved with escalated BEACOPP but higher rates of SMN were observed.

The overall SMN rate of 4.6% in the present meta-analysis was lower than in previous reports. A meta-analysis from our group included a total of 9312 patients treated between 1962 and 2000. After median follow-up times ranging between four and 32 years for the considered trials, the overall SMN rate was 7.6%.^{39, 40} A British analysis including 5798 patients treated between 1963 and 2001 reported an SMN rate of 7.9%.⁴ According to a Dutch study with a median follow-up of 19.1 years, the overall SMN rate was 23% and the risk for the development of an SMN was still increased 30 years after HL treatment.³ Two reasons likely contribute to the higher SMN rates in these previous analyses: (1) a relevant proportion of the expected secondary solid tumors that are often diagnosed ten or more years after HL treatment has not yet occurred in the patients included in the present meta-analysis due to the limited median follow-up of 7.4 years; (2) the SMN rate observed within the present meta-analysis is probably truly lower than the rates seen in the older analyses, since in recent years RT fields and doses were reduced and chemotherapy protocols were modified with the aim of decreasing the SMN risk.

In the present meta-analysis, patients receiving CMT for HL had a significantly increased risk to develop an SMN when compared with chemotherapy alone. Figure 3 shows that at 10 years after first-line treatment, the absolute cumulative SMN risks are approximately 3% and 10%, a risk difference of 7%. This result is in line with previous analyses such as the above mentioned British study, in which patients treated with chemotherapy alone had a significantly lower relative risk for the development of an SMN than patients receiving CMT.⁴ Subgroup analyses of the present analysis separately considering t-AML/MDS, secondary NHL and secondary solid tumors detected a significantly increased risk after CMT only for t-AML/MDS but not for secondary NHL and

secondary solid tumors. This finding is consistent with older reports including a study from Italy comprising 1659 patients treated with RT alone, CMT or chemotherapy alone. At 15 years, the t-AML/MDS rate after CMT was significantly higher than after chemotherapy alone ($p=0.05$).⁴¹

According to the present meta-analysis, patients diagnosed with early-stage HL had a better PFS after CMT than after chemotherapy alone. However, this finding has to be interpreted with caution as it derives from only one of the included trials. Nonetheless, similar data also came from the randomized EORTC/LYSA/FIL H10 study and the RAPID trial conducted in the UK. These studies evaluated the PET-guided omission of consolidating RT after chemotherapy in patients with early-stage HL. Both studies revealed a significantly increased event rate after chemotherapy alone also in patients with a good response to chemotherapy resulting in a negative interim PET.⁴²⁻⁴⁴ Additional data supporting the use of CMT in early-stage HL come from a previous Cochrane systematic review including 1245 patients from five randomized studies and an analysis comprising 20,600 patients registered in the U.S. National Cancer Data Base that both have not only demonstrated a better PFS but also an improved OS among patients treated with CMT compared with chemotherapy alone.^{45, 46}

In the present meta-analysis, an increased t-AML/MDS rate was seen in patients receiving intensified chemotherapy compared with patients treated with standard-dose chemotherapy. This finding is consistent with other reports on t-AML/MDS after HL treatment. An analysis by the GHSG including 11,952 patients treated within prospective studies for newly diagnosed HL demonstrated that patients receiving no BEACOPP or up to four cycles of escalated BEACOPP had significantly lower cumulative t-AML/MDS rates than patients treated with four or more cycles of escalated BEACOPP (0.3% vs 0.7% vs 1.7%; $p<0.0001$).⁷

For escalated BEACOPP, the increased t-AML/MDS risk contrasts with an improved clinical outcome. PFS ($p<0.00001$) and OS ($p=0.0005$) rates were better than those seen with standard-dose protocols, i.e. ABVD or COPP/ABVD. This is in line with the results of a network meta-analysis on the effect of the initial treatment strategy on the survival of patients with advanced HL.

That analysis including a total of 9,993 patients revealed a survival advantage of 10% at five years for escalated BEACOPP in comparison with ABVD.⁴⁷

Generally, this meta-analysis provides high-quality evidence on SMN, PFS and OS among patients treated for HL, as the used data are from participants of large randomized trials for the first-line treatment of HL. However, the analysis has some limitations. With a median overall follow-up of 7.4 years, valid estimates are only possible for secondary hematological malignancies while final conclusions regarding secondary solid tumors that often occur more than ten years after HL cannot be drawn. Long-term data of HL patients treated within clinical trials are therefore necessary but often difficult to obtain due to different factors including a limited duration of insurance for study participants and a lack of funding sources. There is also some uncertainty about the completeness of SMN reporting which is of particular importance due to the small number of SMN events. Finally, for certain outcomes and study questions there was a considerable heterogeneity of up to 89% between the included trials which means that the overall meta-analytic results may not apply in all situations.

Nonetheless, given the relevant proportion of HL patients that have developed an SMN already after a median observation of 7.4 years, the present report underscores the need for treatment approaches allowing a more accurate allocation to defined risk groups, in order to prevent overtreatment and reduce the risk for the development of potentially fatal SMN. At present, interim PET is considered the most promising tool to stratify treatment. Some mature results addressing this issue are already available and additional studies will be analyzed in the near future.^{48, 49} The replacement of conventional chemotherapy by novel agents such as the CD30-directed antibody-drug conjugate brentuximab vedotin and antibodies targeting the programmed death cell protein 1 (PD-1) may also reduce the risk for the development of SMN.^{50, 51}

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Contributions of authors

JF was responsible for protocol development, trial selection and assessment, data collection, statistical analyses, and writing of the manuscript.

DAE was responsible for trial selection and assessment, data collection, interpretation of results, and writing of the manuscript.

IB was responsible for data collection, preparation of the final data base, statistical analyses, writing of the manuscript.

IM was responsible for the trials search strategy.

AE contributed to the protocol development, and interpretation of results.

NC, VdS, MF, CF, AMG, MH-A, PH, PJ, SL, MB, AP, MRS, PV, SV were responsible for data acquisition.

All authors revised the manuscript.

Declaration of Interests

JF was as a statistician involved in planning two included studies (GHSG HD10; GHSG HD11) and in data analysis and publication of one study (GHSG HD9).

AE is chairman of the German Hodgkin Study Group, involved in planning and publication of two included studies (GHSG HD10; GHSG HD11) and in publication of two others (GHSG HD8; GHSG HD9).

DAE, IB, IM declare no conflict of interest.

MB, AMG, AP, CF ,MF, MH-A, MRS, NC, PJ, PH, PV, SL, SV, and VdS were involved in one or more of the studies contributing to the meta-analysis.

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Table 1: Description of included studies

Comparison (standard vs. experimental)	Study	Stage	Recruitment		Follow up	Treatment arm		N		
			Start	Length (y)	Median (y)	Standard	Experimental	Total	Standard	Experimental
CMT vs chemotherapy alone	EORTC 20884 (19)	IIIA-IVB	1989	10.7	9.0	6-8MOPP/ABV + IF	6-8MOPP/ABV	333	172	161
	GHSG HD3 (24)	IIIB-IVB	1984	4.2	12.9	3(COPP+ABVD) + IF	4(COPP+ABVD)	100	51	49
	EORTC-GELA H9-F (21)	IA-IIIB	1998	5.75	6.6	6EBVP+ 20/36Gy IF	6EBVP	578	448	130
Extended vs involved-field RT (after CT)	GHSG HD8 (25)	IA-IIIA	1993	5	10.3	4COPP/ABVD + EF	4COPP/ABVD + IF	1064	532	532
	Milan (30)	IA-IIA	1990	6.5	17.5	4ABVD + STNI	4ABVD + IF	140	68	72
	EORTC-GELA H8-U (20)	IA-IIIB	1993	6	8.8	4MOPP/ABV + STNI	4/6MOPP/ABV + IF	984	324	660
	HD94 Rome (31)	IA-IIIA	1994	4	10.5	4ABVD + EF	4ABVD + IF	209	102	107
Higher dose vs 20 Gy RT (after CT)	GHSG HD10 (22)	IA-IIIB	1998	4.75	7.5	2/4ABVD + 30Gy IF	2/4ABVD + 20Gy IF	1163	575	588
	GHSG HD11 (23)	IA-IIIB	1998	4.75	7.4	4ABVD/4BEACOPP +30Gy IF	4ABVD/4BEACOPP +20Gy IF	1351	675	676
	EORTC H9-F (21)	IA-IIIB	1998	5.75	6.6	6EBVP+36Gy IF	6EBVP+20Gy IF	448	239	209
More vs fewer CT cycles	EORTC H8U (20)	IA-IIIB	1993	6	8.8	6MOPP/ABV + IF	4MOPP/ABV + IF	669	336	333
	EORTC H9-U (21)	IA-IIIB	1998	4	7.0	6ABVD +RT	4ABVD +RT	553	276	277
	GHSG HD10 (22)	IA-IIIB	1998	4.75	7.5	4ABVD + 20/30Gy IF	2ABVD + 20/30Gy IF	1190	596	594
Standard-dose vs intensified CT (regimen +/- RT)	GHSG HD9 (26)	IIB-IVB	1993	5.2	8.6	8COPP/ABVD	8BEACOPPesc	727	261	466
	IIL HD9601 (28)	IIB - IVB	1996	4.3	6.9	6ABVD	Stanford V or 6MEC	335	122	213
	GISL HD2000 (27)	IIB-IVB	2000	7.25	3.5	6ABVD	6BEACOPP or 6CEC	295	99	196
	GITIL-IIL NCT 01251107 (29)	IB*, IIB-IVB	2000	7.0	4.6	6-8ABVD	4BEACOPPesc + 4BEACOPPbas	331	168	163
	UKLG LY09 Alt (32)	IA-IVB	1998	3.7	7.9	6-8ABVD	6-8CHLVPP/EVA Hybrid 6/8ChIVPP/PABLOE alternating	569	287	282
	UKLG LY09 Hyb (32)	IA-IVB	1998	3.7	8.1			219	107	112
UKLG ISRCTN64141244 (33)	I-IV**	1998	3.7	5.5	ABVD	Stanford V	520	261	259	

*only 1 patient, ** symptoms not specified, CMT = combined-modality treatment, RT = radiotherapy, CT = chemotherapy, y=year, IF = involved field, EF = extended field, STNI = subtotal nodal irradiation, EORTC = European Organization for Research and Treatment of Cancer, GELA = Groupe d'Etude des Lymphomes de l'Adulte, GHSG = German Hodgkins' Study Group, GISL =

Gruppo Italiano per lo Studio dei Linfomi, GITIL = Gruppo Italiano di Terapie Innovative nei Linfomi, IIL = Intergruppo Italiano Linfomi, UKLG = United Kingdom National Cancer Research Institute Lymphoma Group.

MOPP/ABV = mechlorethamine, vincristine, procarbazine, prednisone/doxorubicin, bleomycin, vinblastine

EBVP = epirubicin, bleomycin, vinblastine, prednisone

ABVD = doxorubicin, bleomycin, vinblastine, dacarbazine

BEACOPP = bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone

COPP/ABVD = cyclophosphamide, vincristine, procarbazine, prednisone/doxorubicin, bleomycin, vinblastine, dacarbazine

CEC = COPPEBVCAD = cyclophosphamide, lomustine, vindesine, melphalan, prednisone, epidoxorubicin, vincristine, procarbazine, vinblastine, bleomycin

MEC = MOPP/EBV/CAD = mechlorethamine, vincristine, procarbazine, prednisone, epidoxorubicin, bleomycin, vinblastine, lomustine, doxorubicin, vindesine

Stanford V = adriamycin, vinblastine, mechlorethamine, vincristine, bleomycin, etoposide, prednisone

ChIVPP/PABIOE = chlorambucil, vinblastine, procarbazine, prednisolone/prednisolone, doxorubicin, bleomycin, vincristine, etoposide

ChIVPP/EVA = chlorambucil, vinblastine, procarbazine, prednisolone/etoposide, vincristine, doxorubicin

Table 2: Treatment effect and heterogeneity for secondary malignant neoplasms (SMN), overall survival (OS) and progression free survival (PFS)

Summary of main results									
Comparison (standard vs. experimental)	SMN			OS			PFS		
	OR (95%-CI)	I ²	N	HR (95%-CI)	I ²	N	HR (95%-CI)	I ²	N
CMT vs chemotherapy alone	0.433 (0.28 – 0.82)	0%	30 (4.5%) vs 10 (2.9%)	0.71 (0.46 - 1.11)	39%	53 (7.9%) vs 31 (9.1%)	1.31 (0.99 – 1.73)	89%	123 (18.3%) vs 83 (24.4%)
Extended vs involved-field RT (after CT)	0.862 (0.64 – 1.16)	67%	92 (9.0%) vs 96 (7.0%)	0.89 (0.70 – 1.12)	0%	132 (12.9%) vs 155 (11.3%)	0.99 (0.81 – 1.21)	0%	175 (17.1%) vs 224 (16.3%)
Higher dose vs 20 Gy RT (after CT)	1.032 (0.71 – 1.50)	72%	54 (3.6%) vs 56 (3.8%)	0.91 (0.65 – 1.28)	0%	72 (4.8%) vs 66 (4.5%)	1.20 (0.97 – 1.48)	1%	165 (11.1%) vs 190 (12.9%)
More vs fewer CT cycles	1.096 (0.74 – 1.62)	0%	48 (4.0%) vs 53 (4.4%)	0.99 (0.73 – 1.34)	0%	82 (6.8%) vs 82 (6.8%)	1.15 (0.91 - 1.45)	31%	133 (11.0%) vs 152 (12.6%)
Standard-dose vs intensified CT (regimen +/- RT)	1.37 (0.89 – 2.10)	11%	31 (2.4%) vs 60 (3.6%)	0.85 (0.70 – 1.04)	63%	191 (14.6%) vs 213 (12.6%)	0.82 (0.70 – 0.95)	85%	350 (26.8%) vs 372 (22.0%)

CMT = combined-modality treatment, RT = radiotherapy, CT = chemotherapy, OR = odds ratio by Peto method, HR = hazard ratio by Cox regression, CI = confidence interval, I² = heterogeneity, N = number of events

Table 3: Summary of SMN results for each SMN type

Comparison (standard vs. experimental)	Solid tumor		t-AML/MDS		NHL	
	OR	p	OR	p	OR	p
CMT vs chemotherapy alone	0.627	0.29	0.293	0.037	0.325	0.21
Extended vs involved- field RT (after CT)	0.851	0.37	0.517	0.14	1.18	0.66
Higher dose vs 20 Gy RT (after CT)	1.20	0.43	0.662	0.65	0.845	0.67
More vs fewer CT cycles	1.15	0.56	0.261	0.10	1.94	0.13
Standard-dose vs intensified CT (regimen +/- RT)	1.00	1.0	4.51	0.0028	0.61	0.26

t-AML/MDS = therapy-related acute myeloid leukemia/myelodysplastic syndromes, NHL = non-Hodgkin lymphomas, CMT = combined-modality treatment, RT = radiotherapy, CT = chemotherapy, OR = Peto odds ratio, p = p-value

Figures – Legend

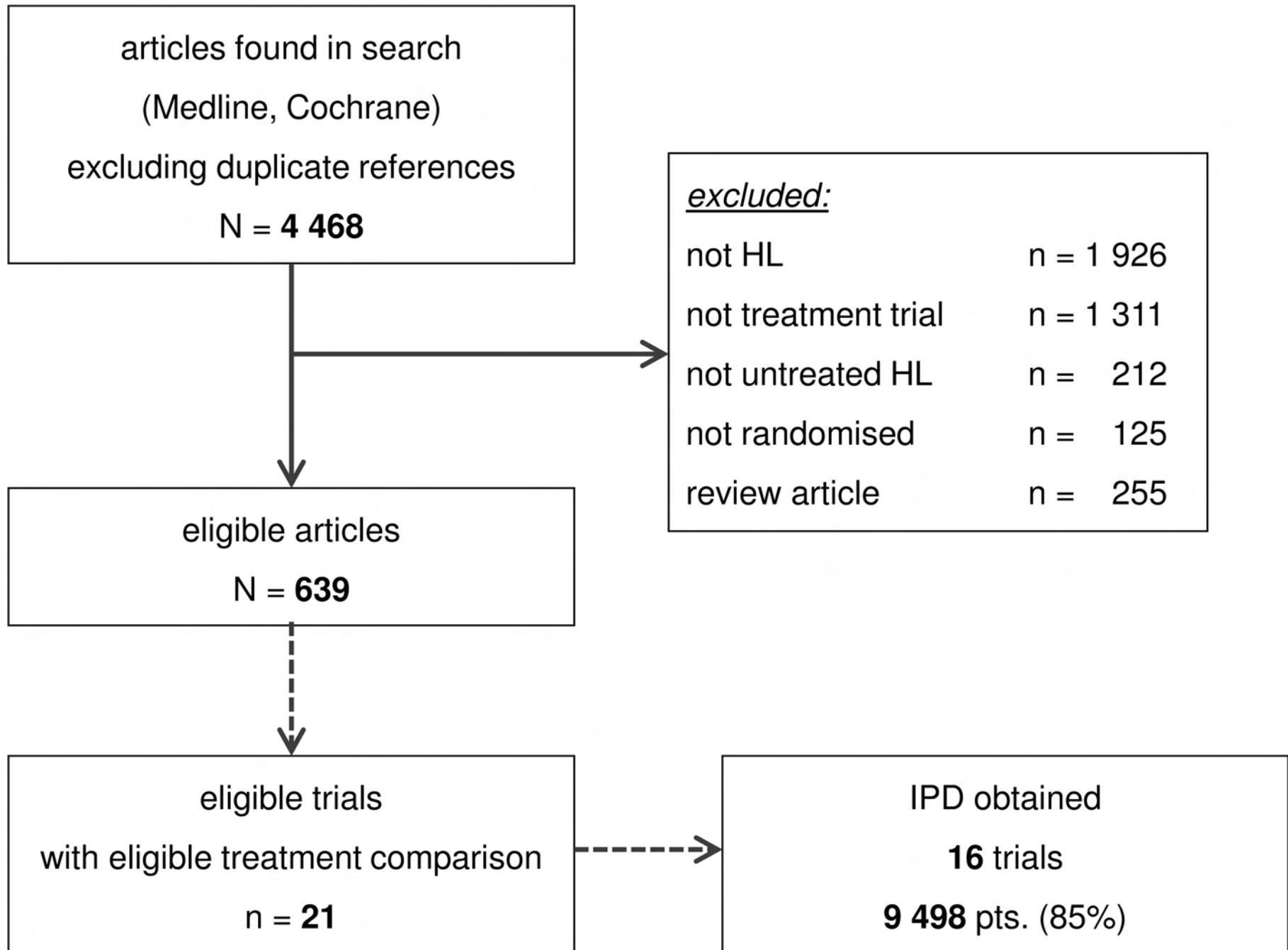
Figure 1: Search results (combined for both searches in 2010 and 2015). HL = Hodgkin lymphoma, IPD = individual patient data

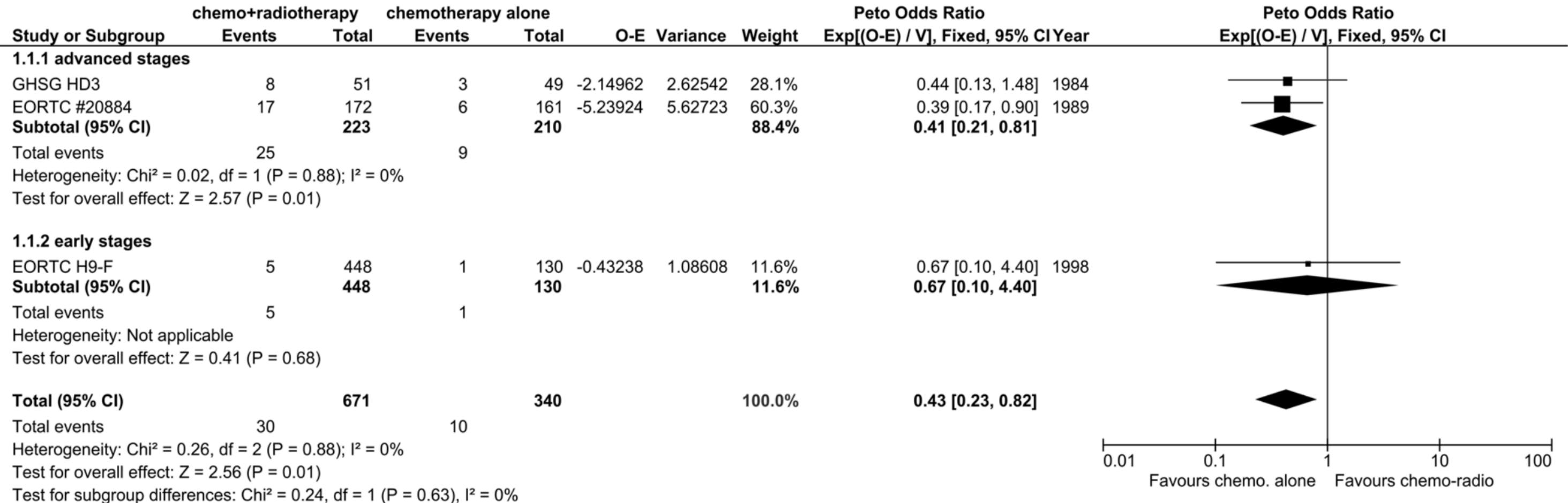
Figure 2: Additional Radiotherapy, secondary malignant neoplasms, forest plot for Peto Odds Ratios. CI = confidence interval, O-E = observed minus expected, V = variance, I^2 = measure of heterogeneity

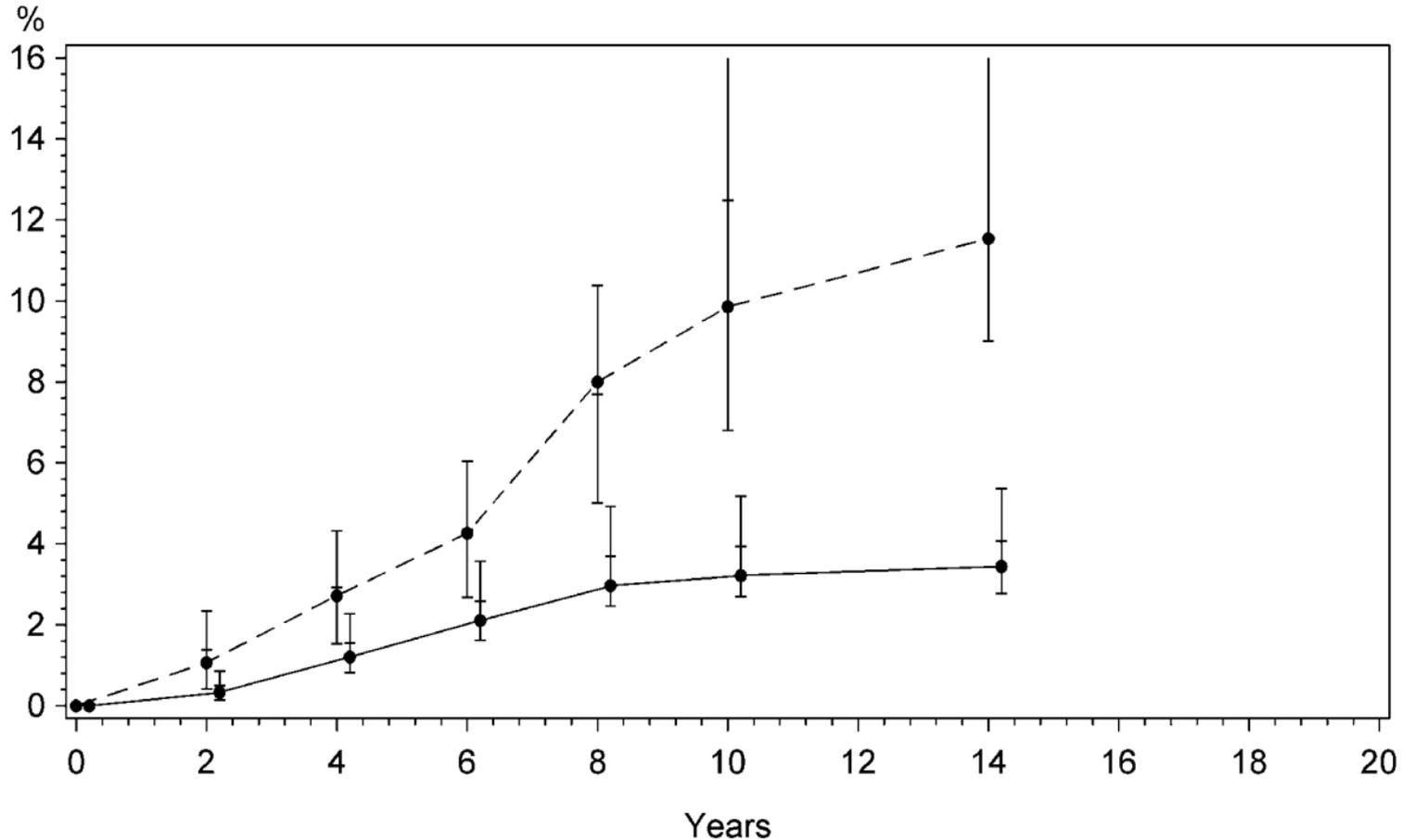
Figure 3: Additional radiotherapy, cumulative incidence of SMN (Peto meta-analysis). Vertical bars depict approximate 95% confidence intervals (CI) for cumulative incidence rates. CT = chemotherapy, RT = radiotherapy.

Figure 4: Intensified chemotherapy, secondary malignant neoplasms, forest plot for Peto Odds Ratios. CI = confidence interval, O-E = observed minus expected, V = variance, I^2 = measure of heterogeneity

Figure 5: Intensified chemotherapy, cumulative incidence of SMN (Peto meta-analysis). Vertical bars depict approximate 95% confidence intervals (CI) for cumulative incidence rates







'CT + RT'



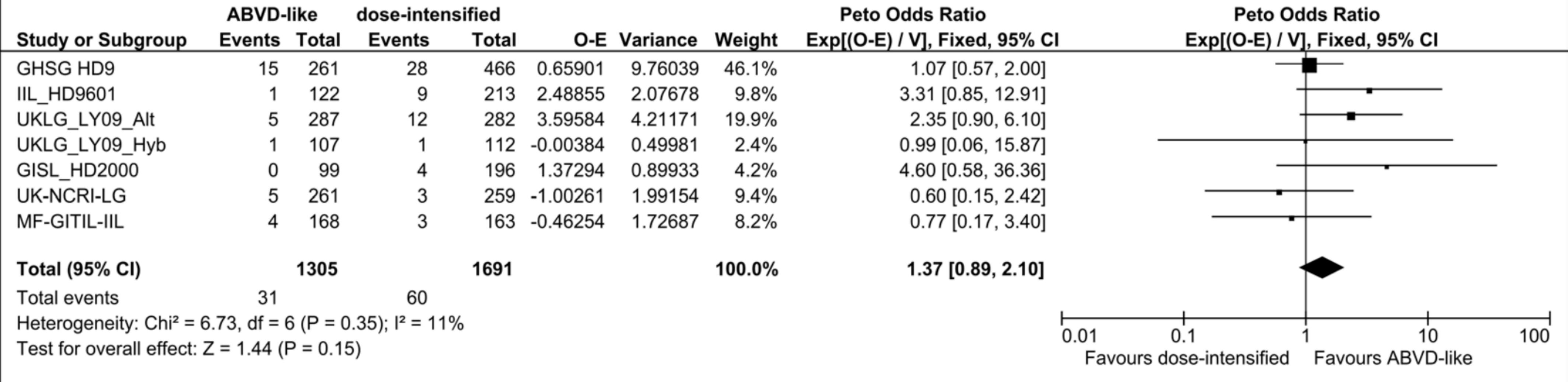
'CT alone'

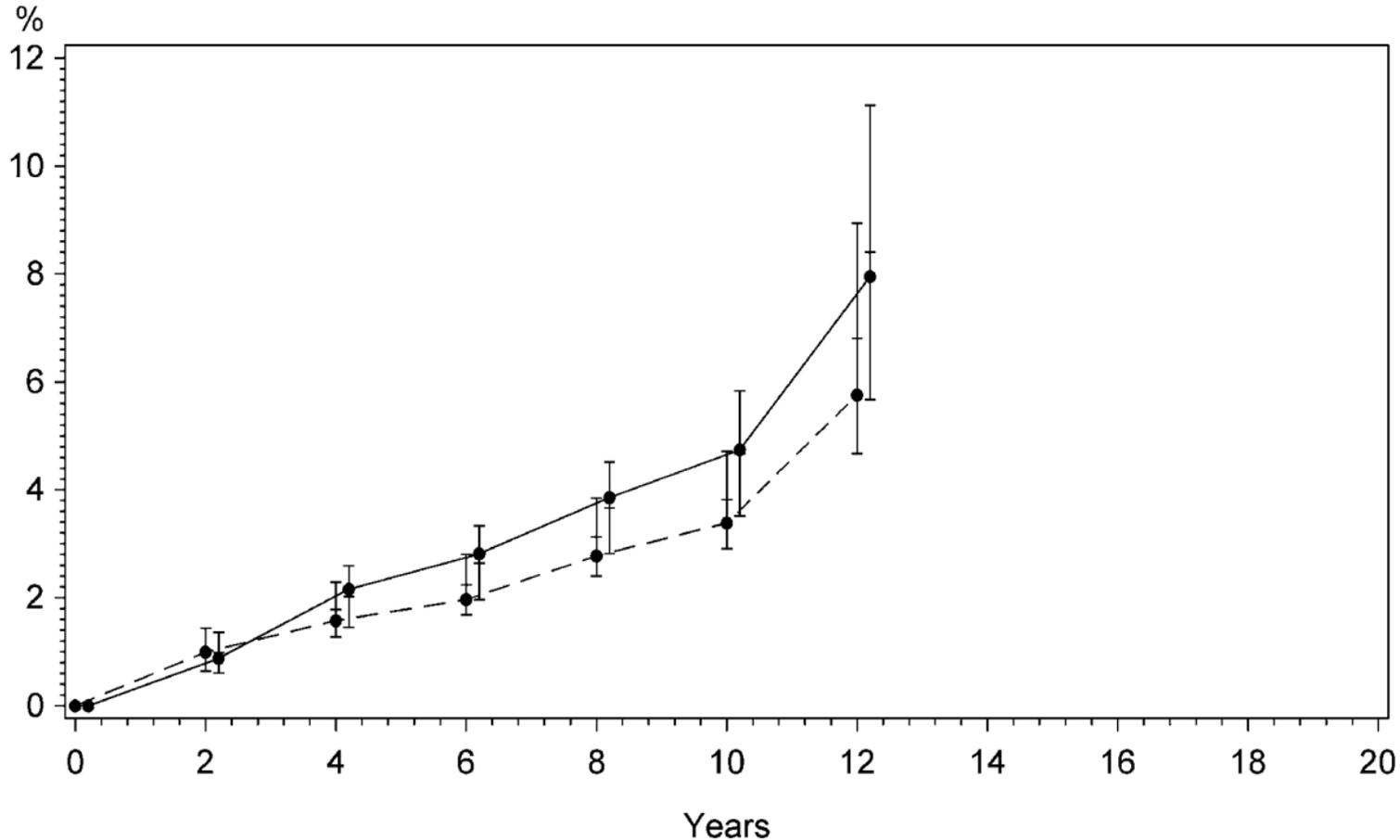


'CT + RT' 95%CI



'CT alone' 95%CI





●—● 'ABVD-like' ●—● 'intensified'
—— 'ABVD-like' 95%CI —— 'intensified' 95%CI

Supplementary Materials

to

Secondary malignant neoplasms, progression-free survival and overall survival in patients treated for Hodgkin lymphoma: A systematic review and meta-analysis of randomized clinical trials

Dennis A. Eichenauer et al.

List of Figures with titles and legends

Supplemental Figure 1: Histogram of the distribution of follow-up times to secondary malignant neoplasm

Supplemental Figure 2: Radiotherapy field, secondary malignant neoplasms, forest plot for Peto Odds Ratios. IF = involved field, EF = extended field, CI = confidence interval, O-E = observed minus expected, V = variance, I^2 = measure of heterogeneity

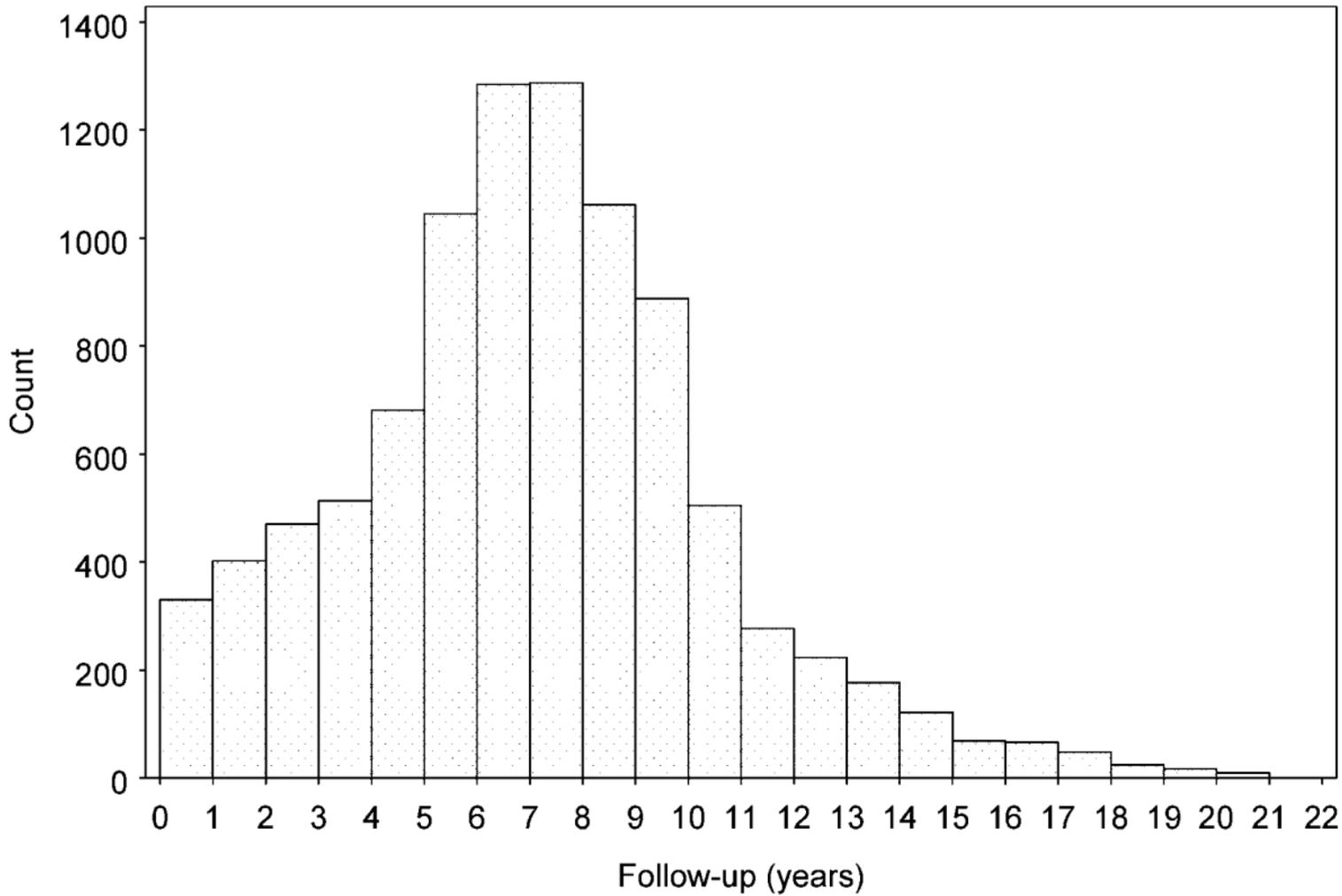
Supplemental Figure 3: Radiotherapy field, cumulative incidence of SMN (Peto meta-analysis). Vertical bars depict approximate 95% confidence intervals (CI) for cumulative incidence rates. IF = involved field, EF/STNI = extended field / subtotal nodal irradiation

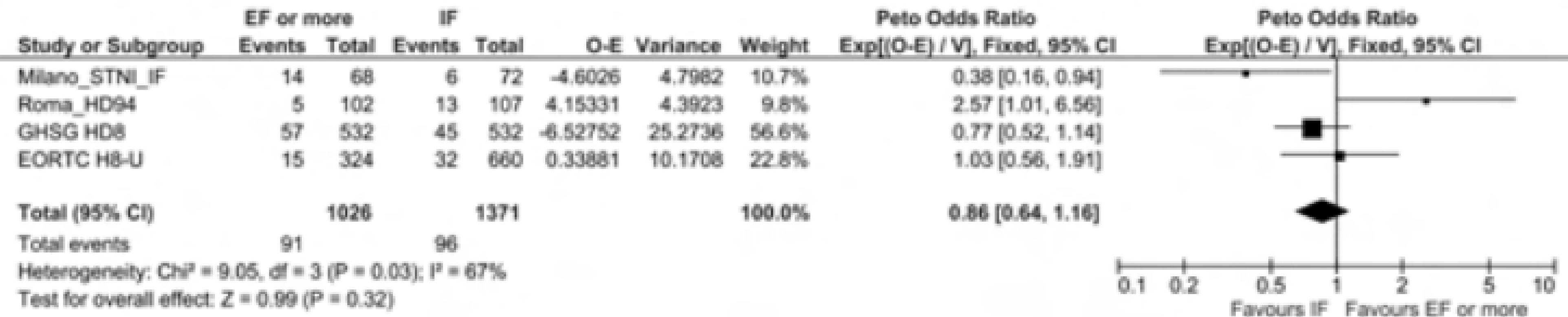
Supplemental Figure 4: Radiotherapy dose, secondary malignant neoplasms, forest plot for Peto Odds Ratios. CI = confidence interval, O-E = observed minus expected, V = variance, I^2 = measure of heterogeneity

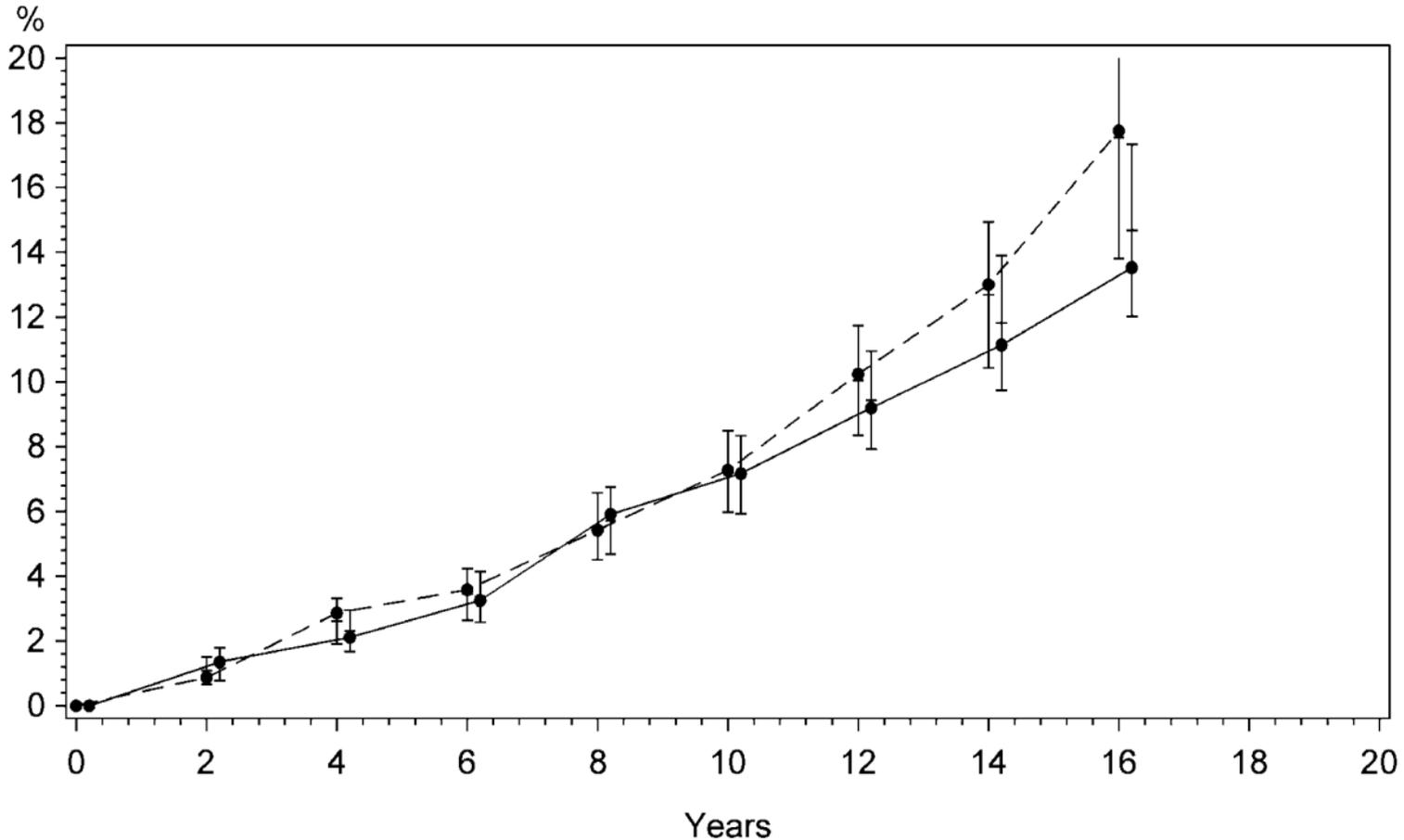
Supplemental Figure 5: Radiotherapy dose, cumulative incidence of SMN (Peto meta-analysis). Vertical bars depict approximate 95% confidence intervals (CI) for cumulative incidence rates.

Supplemental Figure 6: Chemotherapy cycles, secondary malignant neoplasms, forest plot for Peto Odds Ratios. CI = confidence interval, O-E = observed minus expected, V = variance, I^2 = measure of heterogeneity

Supplemental Figure 7: Chemotherapy cycles, cumulative incidence of SMN (Peto meta-analysis). Vertical bars depict approximate 95% confidence intervals (CI) for cumulative incidence rates.







●—●

'EF/STNI'

●—●

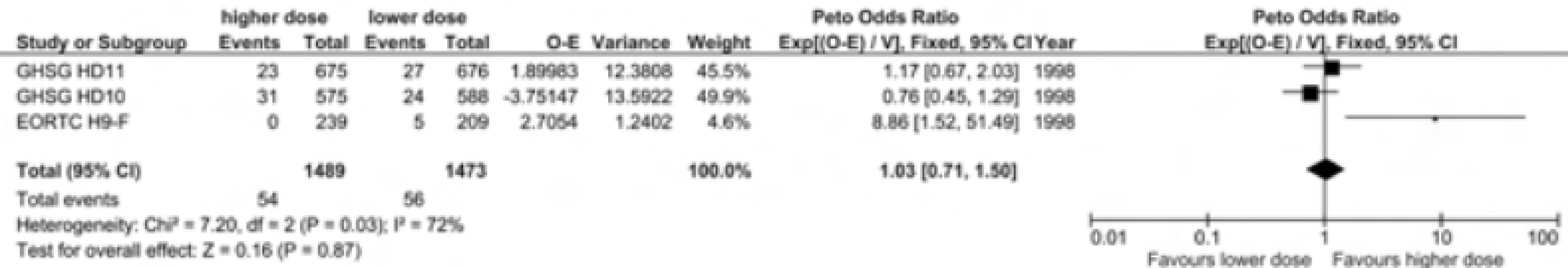
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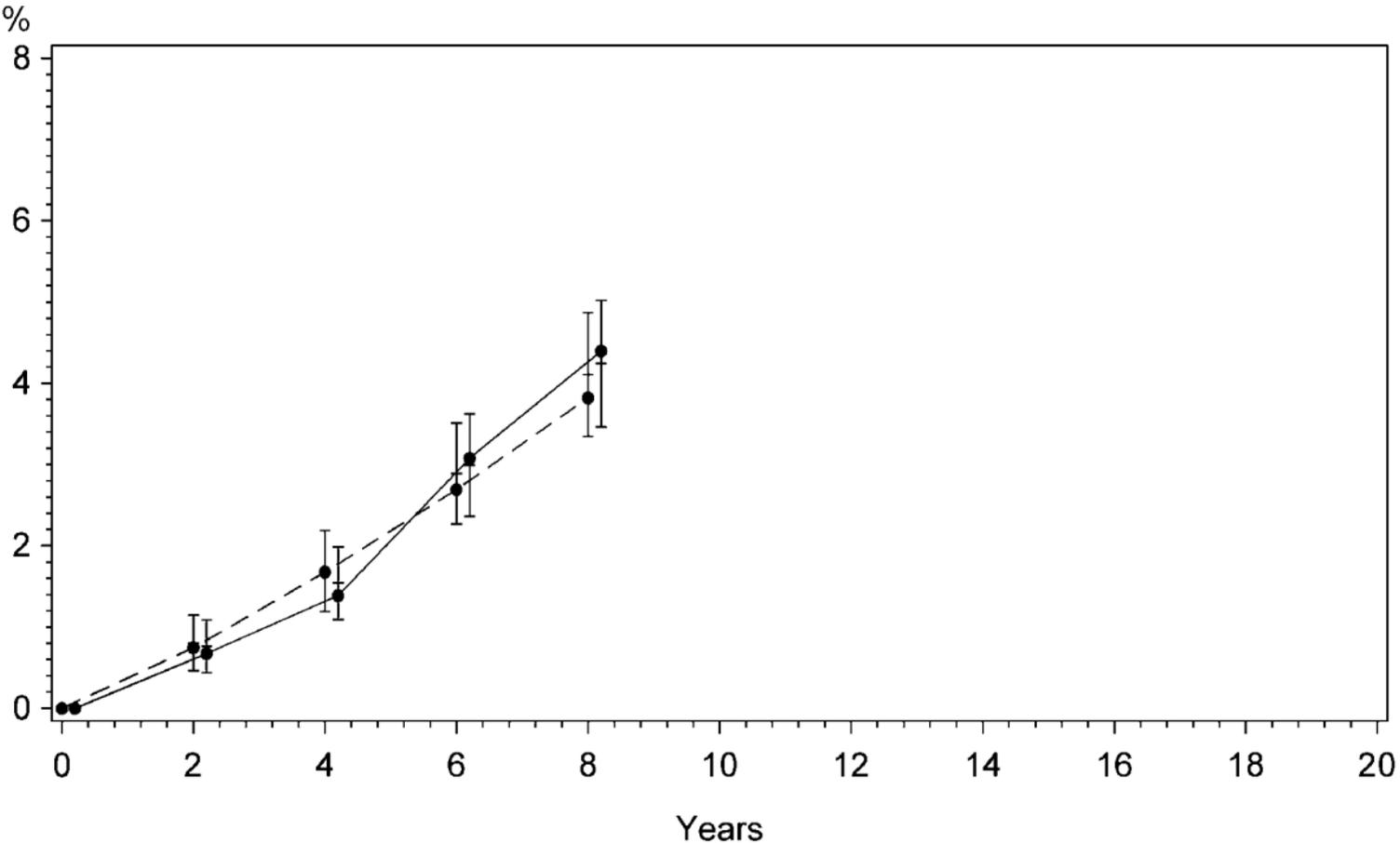
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'EF/STNI' 95%CI

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'IF' 95%CI





'higher'



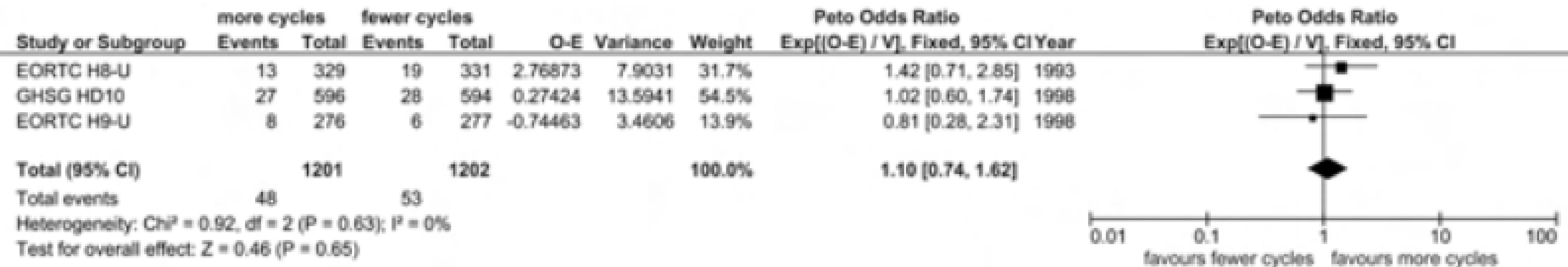
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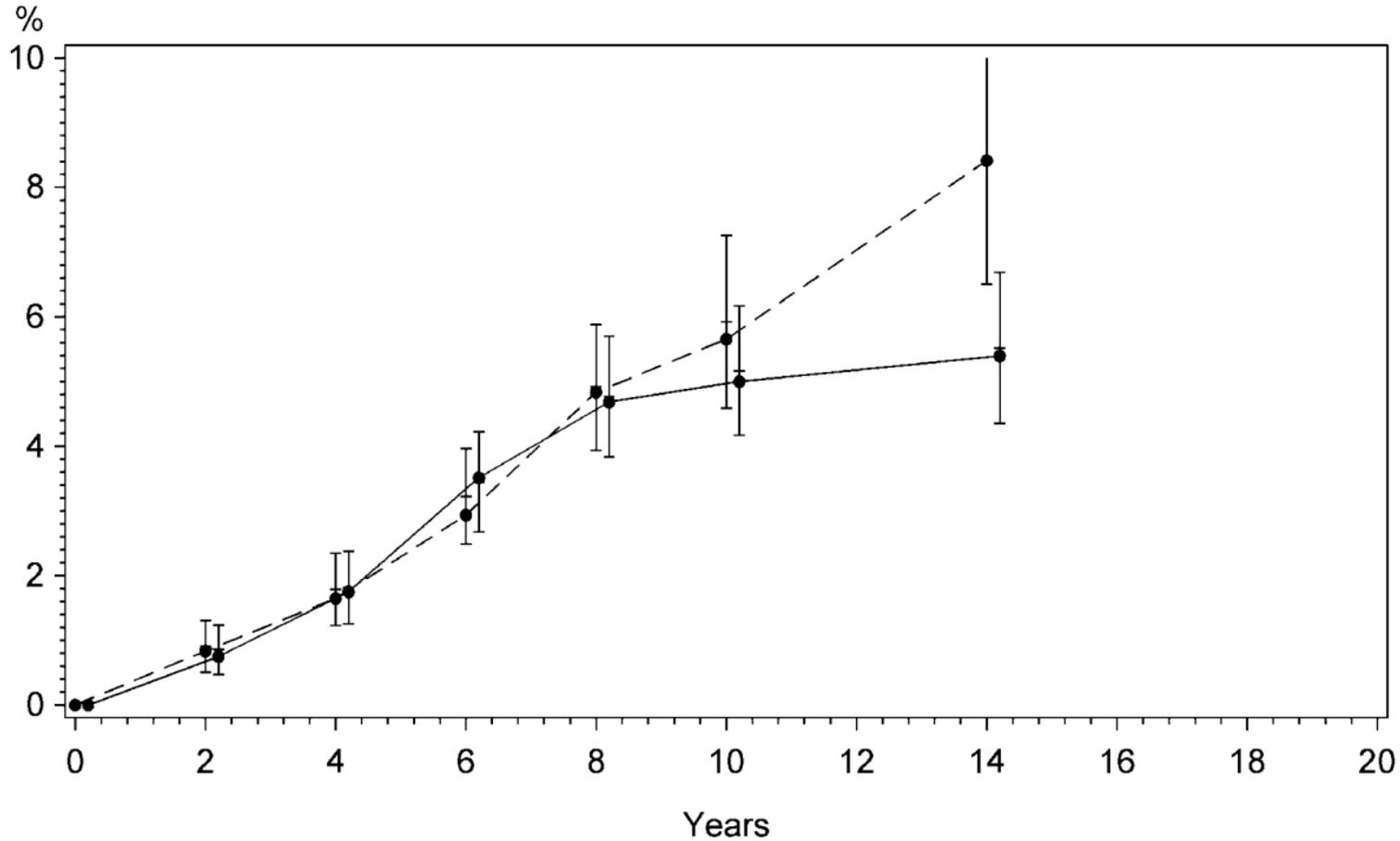


'higher' 95%CI



'lower' 95%CI





'fewer'



'more'



'fewer' 95%CI



'more' 95%CI