relapse or progression (time to 25% treatment failures using standard PFS=2.8 y; using mPFS=1.1 y) (Figure 1). These overestimates occur because the addition of radiotherapy to the primary chemotherapy "rescues" patients whose primary chemotherapy has failed (PET positive residual disease still present after completion of the primary chemotherapy) and creates the appearance of successful treatment. *Conclusions.* Use of the mPFS endpoint provides a superior assessment compared to standard PFS if the goal of a clinical trial testing treatment for advanced stage Hodgkin lymphoma is to identify the most effective chemotherapy regimen. This is particularly important in an era when post-chemotherapy evaluation with PET has become standard and major efforts are being made to determine the potential benefit of adding novel agents such as antibody-drug conjugates and checkpoint inhibitors to standard chemotherapy.

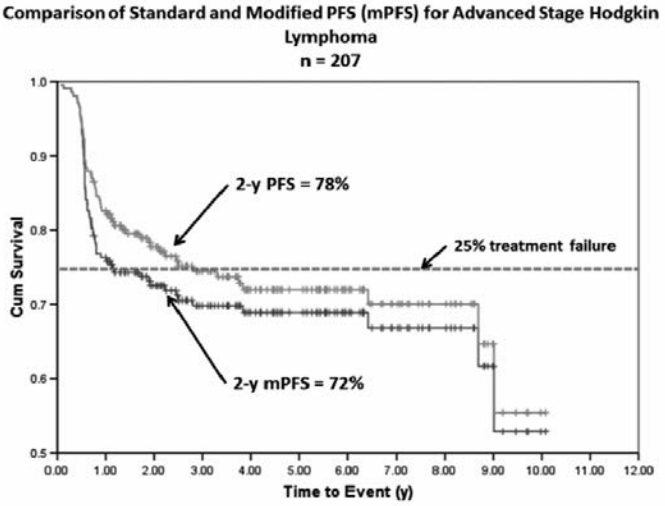

Figure 1.

P008

TREATMENT RESULTS FOR HODGKIN LYMPHOMA IN BRAZIL: FIRST REPORT FROM THE BRAZILIAN PROSPECTIVE HODGKIN'S LYMPHOMA REGISTRY

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Introduction. Data about Hodgkin Lymphoma (HL) in developing countries are scarce. In 2009, a prospective registry of HL was implemented in Brazil. *Methods.* Twenty institutions take part in the registry. Clinical, treatment and outcome data were prospectively collected in a web-based platform, and are reported here for the first time. *Results.* 756 HL patients (pts) with diagnosis until December 31, 2014 were identified. Twenty-one pts with nodular-predominant HL, 11 pts younger than 13 years-old and 38 pts with HIV were excluded, with 686 pts available for this analysis. Median age was 30 years-old (13-90); 67 (10%) pts were older than 60. Females comprised 346 pts (50%). Median time from onset of symptoms to diagnosis was 6 (0-60) months. Forty-four (7%) pts had limited disease, 180 (26%) had intermediate disease and 445 (65%) had advanced disease by GHSG criteria. Stage IVB was present in 26%, B symptoms in 69%, low albumin in 63% and a high-risk IPS score in 38%. Median time from diagnosis to beginning of treatment was 0.72 months (0-10.87 months). Median follow-up was 37 months (0.53-94) for all patients, and 40 months (4-94) for patients alive. ABVD was the first-line treatment in 93% of pts. Twenty-one patients died during treatment. After completed treatment, the complete remission (CR) rate was 73%, unconfirmed CR was 12%, partial remission was 4%, stable disease was 2% and progressive disease was 9%. Among those who received ABVD, the median number of cycles was 4 for limited and intermediate and 6 for advanced disease. Radiotherapy (RT) was used in 33% of advanced disease pts, 65% of intermediate disease pts, and 77% of limited disease pts. The median dose of RT was 36 Gy for localized disease, and 32 Gy for advanced disease. The median time from the end of chemotherapy to the beginning of RT was 1.7 months. The 3-year OS and 3-year PFS were 90% and 74%, respectively. The 3-y PFS in limited disease, intermediate disease and advanced disease were 95%, 88% and 66% ($p<0.0001$), respectively. The 3-year OS for limited disease, intermediate disease and advanced disease were 100%, 96% and 86% ($p=0.0001$), respectively. *Conclusions.* Advanced stage and poor risk patients predominated. Radiation doses used for localized disease appear higher than current recommendations. Outcomes for advanced disease appear to be 5-10% lower than in developed countries, in part due to very advanced disease at diagnosis, and to an excess of deaths during treatment.

P009

DOSE-DENSE/DOSE-INTENSE ABVD IN ADVANCED-STAGE HODGKIN'S LYMPHOMA: A LONG-TERM FOLLOW UP STUDY

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One-hundred forty-three patients with advanced-stage HL were treated with a dose-dense three-weekly version of the ABVD regimen, which was also dose intensified, in the first 4 cycles, by escalating doxorubicin. Specifications are contained in the published article (Russo F BHJ 166,1,118, 2014). Twelve patients (8.4%) received radiotherapy (RT) on residual mediastinal or extramediastinal bulk disease. Results were compared with a historical series of 111 patients treated with standard ABVD+/-RT. The demographics and clinical characteristics are in Figure 1. Ninety-six percent of patients completed the planned 6 cycles (median time=16.8 weeks). Median actual dose intensities were 20.87 (23.11 cycles 1-4), 6.72, 3.89 and 248 mg/m^2/week for doxorubicin, bleomycin, vinblastine and dacarbazine, respectively. This corresponded to a 66.9% (85.0%, cycles 1-4) increase in dose intensity for doxorubicin, (total dose 380 mg/m^2) and of 32% for the other agents, over standard ABVD. Intensified ABVD confirmed to be highly tolerated with low rates of hospitalization during treatment, a low incidence of G3/ G4 events, low post-treatment cardiac and pulmonary toxicities and a very low rate of gonadic toxicity. Only two cases of second cancer were recorded. One-hundred-eleven out of 143 (79%) showed a PET normalization at the end of 2nd cycle. Comparison between intensified and standard ABVD showed complete remission (CR) rates 93.7% in intensified ABVD and 80.2% in standard ABVD, respectively ($p=0.002$). EFS and OS rates at 7 years were 85.7% *vs* 68.1% and 93.9% *vs* 76.3%. At univariate analysis the predictive factors of low CR rate were IPS≥3 ($p=0.032$), and PET2pos ($p<0.001$). At multivariate analysis PET2pos ($p<0.001$) was the only independent risk factor predictive of low CR rate. Seven-yr EFS was significantly better in patients with PET2neg (log rank 13.2, $p<0.001$) and in patients with IPS 0-2 (log rank 4.3, $p=0.032$). At Cox regression analysis PET2 was the only independent factor predictive of EFS. As on