AHOD0031

Gepubliceerd: 28-04-2008 Laatst bijgewerkt: 18-08-2022

To determine whether involved field radiation therapy (IFRT) can be eliminated based upon early and complete response to multiagent chemotherapy To determine whether the addition of an additional two cycles of chemotherapy (DECA) can improve...

Ethische beoordeling	Positief advies
Status	Werving gestart
Type aandoening	-
Onderzoekstype	Interventie onderzoek

Samenvatting

ID

NL-OMON25408

Bron
NTR

Verkorte titel
N/A

Aandoening

paediatric patients, intermediate risk hodgkin disease, Hodgkin.

Ondersteuning

Primaire sponsor: The Children's Oncology Group, USA
Overige ondersteuning: Dutch Childhood Oncology Group, The Hague

Onderzoeksproduct en/of interventie

Uitkomstmaten

Primaire uitkomstmaten

Efficacy endpoints.
The primary endpoint for efficacy analysis is event-free survival (EFS), which is the minimum time from study entry, time of response assessment, or randomization (as appropriate) until treatment failure (disease progression, disease recurrence, biopsy positive residual after

completion of all protocol therapy), occurrence of a second malignant neoplasm, or death from any cause.
The patients to be included in the analyses for Aim 1.12 (=To determine whether involved field radiation therapy (IFRT) can be eliminated based upon early and complete response to multiagent chemotherapy.)
are the cohort of all RER patients who are randomized. The patients to be included in the analyses for Aim 1.13 (=To determine whether the addition of an additional two cycles of chemotherapy (DECA) can improve outcome in those with a slow early response to standard chemotherapy.)
are the cohort of all SER patients who are randomized. These analyses will include randomized patients with protocol violations and randomized patients removed for protocol therapy. However, patients who are determined to be ineligible based on the study eligibility/entry criteria will be excluded.

Toxicity endpoints.
 The primary endpoint for toxicity analysis will be occurrence of any key toxicity, which in this study is the occurrence of any Grade 4 non-haematologic toxicity, or Grade 3 non-haematologic toxicity that doesn’t respond to treatment within 7 days despite recommended therapy modification, or toxic death, which is any death primarily attributable to treatment. Exceptions are Grade 3 nausea, vomiting or liver function abnormalities that return to Grade  2 within 7 days.

All treated patients will be included in the toxicity analyses.

Toelichting onderzoek

Achtergrond van het onderzoek

Cure rates for pediatric Hodgkin disease remain among the highest in pediatric oncology. However, cure often comes with a significant cost in the form of delayed effects of therapy. This protocol will evaluate a dose intensive regimen ABVE-PC in the treatment of intermediate risk Hodgkin disease. This protocol will combine dose intensity with response-based augmentation or reduction in therapy to

1) improve outcome for all intermediate risk pediatric patients with Hodgkin disease and

2) decrease the risk for delayed effects of treatment.

The standard arm for this protocol will be 4 cycles of ABVE-PC plus consolidative involved field radiation therapy. Slow early responders will be randomized to either the standard arm, or the augmented therapy arm, which will add 2 additional cycles of different chemotherapy (DECA) to the standard arm. Rapid early responders who then go on to a complete response following 4 cycles of chemotherapy will be randomized to the standard arm, or the reduced therapy arm, where consolidative radiation therapy will be omitted.

Doel van het onderzoek

To determine whether involved field radiation therapy (IFRT) can be eliminated based upon early and complete response to multiagent chemotherapy
To determine whether the addition of an additional two cycles of chemotherapy (DECA) can improve outcome in those with a slow early response to standard chemotherapy.

Onderzoeksopzet

Every year : interim report for the overall-study,

Per patient:

Response will be assessed at the following time points:

In all patients after 2 cycles of ABVE-PC.

In all patients, after completion of 4 cycles of ABVE-PC.

In SER group, after completion of 2 cycles of DECA and if still not in CR, after all chemotherapy, prior to RT.

In all patients who receive IFRT, 6 weeks after completion of IFRT only if not in CR at start of radiotherapy.

In ALL patients, 12 weeks after completion of therapy (chemotherapy or radiation therapy whichever ended last).

Onderzoeksproduct en/of interventie

The standard arm for this protocol will be 4 cycles of ABVE-PC plus consolidative involved field radiation therapy. Slow early responders will be randomized to either the standard arm, or the augmented therapy arm, which will add 2 additional cycles of different chemotherapy (DECA) to the standard arm. Rapid early responders who then go on to a complete response following 4 cycles of chemotherapy will be randomized to the standard arm, or the reduced therapy arm, where consolidative radiation therapy will be omitted.

Contactpersonen

Publiek

TNO Quality of Life,
P.O. Box 2215
K.M. Pal, van der-de Bruin

Leiden 2301 CE
The Netherlands
+31 (0)71 5181836

Wetenschappelijk

TNO Quality of Life,
P.O. Box 2215
K.M. Pal, van der-de Bruin
Leiden 2301 CE
The Netherlands
+31 (0)71 5181836

Deelname eisen

Belangrijkste voorwaarden om deel te mogen nemen (Inclusiecriteria)

- Patients with newly diagnosed, pathologically confirmed Hodgkin disease (all histologies) are eligible for this protocol if they meet the following clinical stage guidelines:

1. All Stage IB regardless of bulk disease

2. All Stage IIB regardless of bulk disease

3. Stage IA only with bulk disease

4. Stage IIA only with bulk disease

5. All Stage IAE, IIAE regardless of bulk disease

6. All Stage IIIA, IIIAE, IIIAS, IIIAE+S regardless of bulk disease

7. All Stage IVA, IVAE regardless of bulk disease

See Appendix I of the protocol for definitions of clinical staging, E criteria, B symptoms and bulk disease.

Clinical Staging

Staging on this study will be determined by the clinical stage. Patients who have surgical staging (by laparotomy) alone are ineligible for entry on this protocol.
Surgically staged patients may be entered on this study if they also have pre-surgical staging that meets the above criteria. Surgical staging is strongly discouraged.

8. Ages 0 - 21 years inclusive.

9. Organ Function Requirements

- Adequate renal function defined as:

* Creatinine clearance or radioisotope GFR ³ 70mL/min/1.73m2
or

* A serum/plasma creatinine calculation using the Schwartz formula

(Schwartz et al. J. Peds, 106:522, 1985)

Estimated Creatinine Clearance (in mL/min/1.73 m2)** =
(k)(L)/Pcr

Where L = child’s length in cm

Pcr = plasma (or serum) creatinine (in mg/dL)

k Values =

0.33 low birth weight infant

0.45 term infant

0.55 child

0.55 adolescent female

0.70 adolescent male

**The conversion formula for serum/plasma creatinine when reported in □Mol/L units:

(k • ht)/(sCr in □Mol/L • 88.4)

* Adequate liver function defined as:

-Total bilirubin ≤ 1.5 x normal, and

- SGOT (AST) or SGPT (ALT) < 2.5 x normal.

*Adequate cardiac function defined as:

- Shortening fraction of 27% by echocardiogram, or if echocardiogram not feasible, ejection fraction of 50% by radionuclide angiogram (MUGA), unless due to large mediastinal mass from HD. Study chair approval required for entry onto protocol with shortening fraction < 27% or ejection fraction < 50%.

- No pathologic prolongation of QTc interval on 12-lead ECG

* Adequate pulmonary function defined as:

- FEV1/FVC > 60% by pulmonary function test, unless due to large mediastinal mass from HD. Study chair approval required for entry onto protocol with FEV1/FVC≤ 60%

- For children who cannot adequately perform PFTs, no evidence of dyspnea at rest, no exercise intolerance, and a pulse oximetry > 94%. PFTs should not be attempted for children under the age of 7 years.

Patients with other pre-existing cardiac or pulmonary abnormalities require Study Chair approval prior to being placed on therapy.

10. Women who are pregnant or breast-feeding will not be eligible.

11. Previous therapies. Patients may not have received any previous chemotherapy, biological modifiers such as monoclonal antibody therapy or radiation therapy.
Patients may not have received corticosteroids within 28 days of enrollment on this protocol, except as specified in Section 5.1 for emergent treatment for respiratory distress or spinal cord compression, or for treatment of contrast agent allergy required for CT scan.

12. Venous access.
Adequate venous access is required. An infusaport (portacath) is recommended, but not required.

13. Informed Consent.
The patient and/or the patient's legally authorized guardian must acknowledge in writing that consent to become a study subject has been obtained, in accordance with institutional policies approved by the U.S. Department of Health and Human Services.

14. Protocol Approval.
Approval for the use of this treatment protocol by the individual institution's Human Rights Committee must be obtained, in accordance with the institutional assurance policies of the U.S. Department of Health and Human Services.

Belangrijkste redenen om niet deel te kunnen nemen (Exclusiecriteria)

Criteria for case exclusion include:

1. Equivocal immunophenotyping results

2. Morphologically unclassifiable lymphoma

3. Pathology review diagnosis not included in this study

Onderzoeksopzet

Opzet

Type:	Interventie onderzoek
Onderzoeksmodel:	Parallel
Toewijzing:	Gerandomiseerd
Blindering:	Open / niet geblindeerd
Controle:	N.v.t. / onbekend

Deelname

Nederland

Status:	Werving gestart
(Verwachte) startdatum:	15-05-2006
Aantal proefpersonen:	1700
Type:	Verwachte startdatum

Ethische beoordeling

Positief advies

Datum:	28-04-2008
Soort:	Eerste indiening

Registraties

Opgevolgd door onderstaande (mogelijk meer actuele) registratie

Geen registraties gevonden.

Andere (mogelijk minder actuele) registraties in dit register

Geen registraties gevonden.

In overige registers

Register	ID
NTR-new	NL1256
NTR-old	NTR1302
Ander register	METC : 2004/019
ISRCTN	ISRCTN wordt niet meer aangevraagd.

Resultaten