Newer Therapies: Updates from ASH 2016

Steven M. Horwitz M.D.
Associate Attending
Lymphoma Service
Memorial Sloan Kettering Cancer Center

ASH 2016 Lymphoma

- B-cell Lymphoma
  - Follicular Lymphoma
  - Diffuse Large Cell Lymphoma
  - Marginal Zone
- T-cell Lymphoma
  - CTCL
- Hodgkin Lymphoma
  - Checkpoint inhibitors

Obinutuzumab-based induction and maintenance prolongs progression-free survival (PFS) in patients with previously untreated follicular lymphoma: primary results of the randomized Phase III GALLIUM study


1 Kings College Hospital, London, United Kingdom;
2 Cancer Research UK Centre, University of Southampton, Southampton, United Kingdom;
3 Tokai University School of Medicine, Isehara, Kanagawa, Japan;
4 University of Kiel, Kiel, Germany;
5 Monash Health and Monash University, Melbourne, Australia;
6 Foothills Medical Centre and Tom Baker Cancer Centre, Calgary, AB, Canada;
7 Cancer Research UK and UCL Cancer Trials Centre, London, United Kingdom;
8 Cross Cancer Institute, Edmonton, AB, Canada;
9 Gemeinschaftspraxis Dr. Rudolf Schlag/Dr. Björn Schöttker, Würzburg, Germany;
10 Peter MacCallum Cancer Centre, Melbourne, Australia;
11 Charles University, Prague, Czech Republic;
12 Genentech Inc, South San Francisco, CA, USA;
13 F. Hoffmann-La Roche Ltd, Basel, Switzerland;
14 HELIOS-Klinikum, Erfurt, Germany;
15 Ludwig-Maximilians-University, Munich, Germany
GALLIUM study: Design

Primary endpoint
- PFS (INV-assessed in FL)

Obinutuzumab (GA101; G)
- Glycoengineered type II anti-CD20 mAb
- Greater direct cell death induction and ADCC/ADCP activity than R

Marcus et al ASH 2017

GALLIUM: Response rates at end of induction (FL)*

<table>
<thead>
<tr>
<th>CT (by investigator)</th>
<th>R-chemo, n=601</th>
<th>G-chemo, n=601</th>
</tr>
</thead>
<tbody>
<tr>
<td>% (n) 95% CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORR</td>
<td>86.9% (522); 83.9, 89.5</td>
<td>88.4% (531); 85.7, 91.0</td>
</tr>
<tr>
<td>CR</td>
<td>23.8% (143); 20.4, 27.4</td>
<td>19.5% (117); 16.4, 22.9</td>
</tr>
<tr>
<td>PR</td>
<td>63.4% (376)</td>
<td>69.4% (415)</td>
</tr>
<tr>
<td>SD</td>
<td>3.3% (8)</td>
<td>0.5% (1)</td>
</tr>
<tr>
<td>PD</td>
<td>4.0% (24)</td>
<td>2.3% (14)</td>
</tr>
<tr>
<td>Not evaluable/missing</td>
<td>3.5% (12) / 4.3% (26)</td>
<td>4.0% (24) / 4.7% (28)</td>
</tr>
</tbody>
</table>

Marcus et al ASH 2017

GALLIUM: INV-assessed PFS (FL; primary endpoint)

Marcus et al ASH 2017
GALLIUM: OS (FL)

Pts with event, n (%)
R-chemo, n=602
G-chemo, n=601

3-yr OS,
19.1
(95% CI)
19.4
(95% CI)

HR (95% CI),
0.75 (0.49, 1.17),
p=0.21

GALLIUM: Safety summary (FL)

Any AE

<table>
<thead>
<tr>
<th></th>
<th>R-chemo (n=597)</th>
<th>G-chemo (n=595)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any AE</td>
<td>98.3% (587)</td>
<td>99.5% (592)</td>
</tr>
<tr>
<td>Grade 3 AEs (ontx in either arm)</td>
<td>62.8% (303)</td>
<td>74.6% (444)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>21.4% (130)</td>
<td>14.9% (95)</td>
</tr>
<tr>
<td>Leucopenia</td>
<td>8.4% (52)</td>
<td>8.0% (54)</td>
</tr>
<tr>
<td>Focalle neutropenia</td>
<td>4.9% (30)</td>
<td>6.0% (34)</td>
</tr>
<tr>
<td>IRRs*</td>
<td>3.9% (22)</td>
<td>6.7% (40)</td>
</tr>
<tr>
<td>Grade 3 AEs of special interest by category (selected)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections†</td>
<td>15.6% (93)</td>
<td>20.0% (119)</td>
</tr>
<tr>
<td>IRRs†</td>
<td>6.7% (40)</td>
<td>12.4% (74)</td>
</tr>
<tr>
<td>Second neoplasms§</td>
<td>2.7% (16)</td>
<td>4.7% (28)</td>
</tr>
<tr>
<td>SAEs</td>
<td>39.9% (238)</td>
<td>46.1% (274)</td>
</tr>
<tr>
<td>AE causing treatment discontinuation</td>
<td>14.2% (85)</td>
<td>16.3% (97)</td>
</tr>
<tr>
<td>Grade 5 (fatal) AEs</td>
<td>3.4% (20)</td>
<td>4.0% (24)</td>
</tr>
</tbody>
</table>

Median change from baseline in IgG levels at end of induction, g/l

<table>
<thead>
<tr>
<th></th>
<th>R-chemo</th>
<th>G-chemo</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-1.45 (-16.1 to -9.9)</td>
<td>-1.50 (-12.2 to -9.2)</td>
</tr>
</tbody>
</table>

GALLIUM: Grade 5 (fatal) AEs by treatment (FL)*

Marcus et al ASH 2017
**GALLIUM: Conclusions**

- G-chemo + maintenance superior to R-chemo + maintenance in untreated advanced FL patients at interim efficacy analysis
  - Clinically meaningful improvement in PFS: 34% reduction in risk; HR=0.66
  - PFS result supported by other time-to-event endpoints
- Non-fatal AEs were higher in the G arm
  - IRs, cytopenias, and infection
- Fatal AEs more common in patients on bendamustine in both arms
- G-based therapy significantly improves outcome compared with R-based therapy and should now be considered as a first-line treatment for FL

---

**Obinutuzumab plus bendamustine followed by obinutuzumab maintenance prolongs overall survival compared with bendamustine alone in patients with rituximab-refractory indolent non-Hodgkin lymphoma: updated results of the GADOLIN study**

Bruce D Cheson, Marek Trněný, Kamal Bouabdallah, Greg Dueck, John Gribben, Pieternella J Lugtenburg, Gilles Salles, Günter Fingerle-Rowson, Federico Mattiello, Elisabeth Wassner-Fritsch, Lauri H Sehn

**GADOLIN: Study design**

Open-label, multicenter, randomized, Phase III study in rituximab-refractory iNHL patients

- Rituximab-refractory definition: Failure to respond to, or progression during any prior rituximab-containing regimen (monotherapy or combined with chemotherapy), or progression within 6 months of the last rituximab dose, in the induction or maintenance setting
- Endpoints considered in current analysis: PFS (INV), OS, TTNT, safety

Bruce D Cheson et al. ASH 2017
Conclusions

- Updated analysis of GADOLIN
  - Confirms that G-B induction plus G maintenance significantly reduces risk of disease progression or death relative to B alone in rituximab-refractory FL patients (48% risk reduction)
  - Demonstrates a significant improvement in OS in the G-B arm (42% risk reduction in FL patients)
  - Confirms the comparable safety profile observed in the primary analysis
- Collectively, these data establish G-B induction plus G maintenance as a new standard of care for rituximab-refractory FL patients
Obinutuzumab or rituximab plus CHOP in patients with previously untreated diffuse large B-cell lymphoma: final results from an open-label, randomized Phase III study (GOYA)

**GOYA: Study design**

- **International, open-label, randomized Phase III study in 1L DLBCL pts.**
- **Scientific support from the Foundation Oncologic Ligure**

**Primary Endpoint:** PFS

- Number of CHOP cycles pre-planned for all pts at each site
- Randomization stratification factors: planned number of CHOP cycles, IPI, geographic region

**GOYA: Investigator-assessed PFS (primary endpoint)**

- Kaplan-Meier plot of investigator-assessed PFS by treatment arm

- **B, CHOP, n=712:** 215 pts
- **G, CHOP, n=706:** 201 pts

- **4-yr PFS, %:** 79.8 vs 81.6
- **2-yr PFS, %:** 73.1 vs 73.4
- **3-yr PFS, %:** 66.9 vs 69.6

- **HR (95% CI):** 0.92 (0.76, 1.11)
- **p-value:** 0.3868

*Vitolo et al. ASH 2017*
Conclusions

• In GOYA, G-CHOP did not improve PFS compared with R-CHOP in previously untreated pts with DLBCL.

• AEs were consistent with the known safety profile of G.
  – Grade 3–5 AEs and SAEs were more common in the G-CHOP arm.

• Further analyses of GOYA data will inform and shape the direction of future research activities in DLBCL.

• R-CHOP remains the standard of care in this setting.

Phase III Randomized Study of R-CHOP vs. DA-EPOCH-R and Molecular Analysis of Untreated Large B-Cell Lymphoma: CALGB/Alliance 50303


Abstract 469, American Society of Hematology, Dec 4, 2016

50303 Response

<table>
<thead>
<tr>
<th></th>
<th>R-CHOP</th>
<th>DA-EPOCH-R</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORR</td>
<td>89.3%</td>
<td>88.8%</td>
<td>0.983</td>
</tr>
<tr>
<td>CR/CRu</td>
<td>62.3%</td>
<td>61.1%</td>
<td></td>
</tr>
<tr>
<td>PR</td>
<td>27%</td>
<td>27.2%</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>2.6%</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>PD</td>
<td>2.7%</td>
<td>&lt;1%</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>6.4%</td>
<td>6.9%</td>
<td></td>
</tr>
</tbody>
</table>
### 50303 Grade 3-5 Toxicities

<table>
<thead>
<tr>
<th>Event</th>
<th>R-CHOP</th>
<th>DA-EPOCH-R</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment related deaths*</td>
<td>3%</td>
<td>3%</td>
<td>0.975</td>
</tr>
<tr>
<td>ALL Gr 3-4</td>
<td>76.3%</td>
<td>96.5%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hematologic</td>
<td>73.1%</td>
<td>97.7%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Non-Hematologic</td>
<td>41.3%</td>
<td>70.9%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ANC</td>
<td>58%</td>
<td>56%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Platelets</td>
<td>11%</td>
<td>65%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Febrile neutropenia</td>
<td>17%</td>
<td>35%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Infection</td>
<td>11%</td>
<td>14%</td>
<td>0.169</td>
</tr>
<tr>
<td>Mucositis</td>
<td>2%</td>
<td>6%</td>
<td>0.011</td>
</tr>
<tr>
<td>Neuropathy - sensory</td>
<td>2%</td>
<td>14%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Neuropathy - motor</td>
<td>2%</td>
<td>8%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

* Treatment related deaths (10 total, 5 in each arm)
  - R-CHOP – CHF (1), CNS bleed (1), infection (1), F/N (1), unknown (1)
  - DA-EPOCH R – infection (2), MI (1), unknown (2)

### 50303 Event Free Survival

- Median follow-up: 5.0 y
- HR=1.14 (0.82-1.51)
- p = 0.4386

### 50303 5-yr EFS by IPI and age

<table>
<thead>
<tr>
<th>% of Pts</th>
<th>ALL</th>
<th>R-CHOP</th>
<th>DA-EPOCH-R</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 60</td>
<td>59</td>
<td>71%</td>
<td>73%</td>
<td>0.70%</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>41</td>
<td>63%</td>
<td>65%</td>
<td>61%</td>
</tr>
<tr>
<td>IPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1</td>
<td>27</td>
<td>83%</td>
<td>90%</td>
<td>0.003</td>
</tr>
<tr>
<td>2</td>
<td>38</td>
<td>70%</td>
<td>72%</td>
<td>68%</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>55%</td>
<td>50%</td>
<td>61%</td>
</tr>
<tr>
<td>≥ 5</td>
<td>10</td>
<td>53%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>
Conclusions

- No difference in 3-yr EFS or 3-yr OS
  - EFS: R-CHOP 81% vs DA-EPOCH-R 81%
  - OS: R-CHOP 85% vs DA-EPOCH-R 85%
- No clinical subgroup identified based on age or IPI that appears to benefit from DA-EPOCH-R
  - Inadequate numbers to comment on PMBCL (n=28)
  - Double expressor, double hit analysis pending
- DA-EPOCH-R associated with modest increase in Gr 3-4 toxicities (cytopenias, F/N, neuropathy)
- “Pending” conclusions - Multiple potential PET, pharmacogenomic, pathology, and molecular correlates
  - May identify prognostic subsets, new therapeutic targets, and new biomarkers for response or toxicity

Single Agent Ibrutinib in Marginal Zone Lymphoma

- N=63
- Relapsed or Progressive disease
- ORR 48% by IRC
- CR 3%
- 18 month Duration of Response 62%
- On 19 January, 2017, the US Food and Drug Administration (FDA) has approved ibrutinib for the treatment of patients with marginal zone lymphoma who require systemic therapy and have received at least one prior anti-CD20-based therapy.

Noy et al. ASH 2016

ASH 2016 Lymphoma

- B-cell Lymphoma
  - Follicular Lymphoma
  - Diffuse Large Cell Lymphoma
  - Marginal Zone
- T-cell Lymphoma
  - CTCL
- Hodgkin Lymphoma
  - Checkpoint inhibitors
A Phase 2 Study of Pembrolizumab for the Treatment of Relapsed/Refractory Mycosis Fungoides and Sézary Syndrome

Coordinating Center: M Cheever
R Shine (project manager); Steven Fling (correlative core)
CITN, Fred Hutchinson Cancer Research Center

Principal Investigator: Y Kim, H Kohrt (Co-PI)
Lead Sub-I: M Khodadoust
J Ranbarger, J Kim (pathology); S Li (biostatistician)
Stanford University SOM

Investigative sites/site PI:
A Rock (U Penn); F Foss (Yale); PG Porcu (OSU); A Shustov (SCCA);
A Moskowitz (MSKCC); L Sokol (Moffitt); S Shanbhag (Johns Hopkins)

Correlative Studies: S Fling, Y Yang, J Yearley; P Balubaliahmanyam, H Maecker

NCI Collaboration: E Sharon
Funding Support: National Cancer Institute

Responses seen across all clinical characteristics

Overall response rate: 38%

Deep and Durable responses with pembrolizumab

Overall response rate: 38%
Pembrolizumab has good activity in CTCL (~38% ORR)

- Responses appear to be durable
  - 8 of 9 responses currently ongoing

- Pembrolizumab is safe and well tolerated
  - Skin flare seen in Sézary patients with high PD-1 expression

- Extensive correlative studies are ongoing

- Follow up trial: CITN-13 pembrolizumab with interferon-α

---

**Brentuximab Vedotin Demonstrates Significantly Superior Clinical Outcomes in Patients With CD30-Expressing Cutaneous T-Cell Lymphoma Versus Physician's Choice (Methotrexate or Bexarotene): the Phase 3 ALCANZA study**

Youn H. Kim, Sean Whittaker, Steven Horwitz, Madeleine Duviç, Reinhard Dummer, Julia Scarisbrick, Pietro Quaglino, Pier Luigi Zinzani, Pascal Wolter, Yinghui Wang, Maria Corinna Palanca-Wessels, Erin Zagadailov, William L. Trepicchio, Yi Liu, Meredith Little, H. Miles Prince

**ALCANZA**: A randomized, open-label, phase 3 trial of brentuximab vedotin vs physician’s choice (methotrexate or bexarotene) in patients with CD30+ CTCL

**Screening**
- Diagnosis of CD30+ MF or pcALCL
- >10% CD30+ on either neoplastic cells or lymphoid infiltrate by central review of ≥1 biopsy (≥2 required for MF)
- MF patients with ≥1 prior systemic therapy
- pcALCL patients with prior radiotherapy or ≥1 prior systemic therapy

**Exclusion**
- Progression on both prior methotrexate and bexarotene
- Methotrexate or bexarotene was managed as standard of care, targeting maximum tolerated effective dose
- Patients were recruited from 52 centers across 15 countries
Primary and key secondary endpoint analyses (ITT population)

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Brentuximab vedotin</th>
<th>Physician's Choice</th>
<th>Difference Between Arms (95% CI)</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORR4, n (%)</td>
<td>36 (56.3%)</td>
<td>8 (12.5%)</td>
<td>43.8% (29.3, 58.4)</td>
<td>p&lt;0.0001</td>
</tr>
<tr>
<td>Key secondary endpoints</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CR, n (%)</td>
<td>10 (15.6%)</td>
<td>2 (1.6%)</td>
<td>14.1% (-4.0, 31.5)</td>
<td>p=0.0046 adj</td>
</tr>
<tr>
<td>Median PFS, months</td>
<td>16.7</td>
<td>3.5</td>
<td></td>
<td>p&lt;0.0001 adj</td>
</tr>
<tr>
<td>Mean maximum reduction in Skindex-29 symptom domain, points</td>
<td>-27.96</td>
<td>-8.62</td>
<td>-18.9 (-26.6, -11.2)</td>
<td>p&lt;0.0001 adj</td>
</tr>
</tbody>
</table>

Progression-free survival (ITT population)

- Log-rank test p-value: <0.0001
- Hazard ratio (95% CI): 0.270 (0.169, 0.430)
- Median (months): 
  - BV: 16.7
  - MTX or Bex: 3.5
- Number of events:
  - BV: 36
  - MTX or Bex: 50

Summary and conclusions

- First report of a randomized phase 3 trial in CTCL with convincing demonstration of improved efficacy of a new systemic agent over standard-of-care options
- Brentuximab vedotin showed superior primary and secondary efficacy outcomes over physician's choice of either bexarotene or methotrexate in MF and pALCL (CD30 expressing CTCL). All endpoints were highly significant:
  - ORR4 (56.3% vs 12.5%, p<0.0001; primary endpoint)
  - ORR (67% vs 20%) and CR rate (16% vs 2%)
  - PFS (17 vs 4 months)
  - Reduction in patient-reported life quality symptom burden, measured by Skindex-29 (-27.96 vs -8.62)
- Safety data for brentuximab vedotin were consistent with its established tolerability profile
- These compelling results have potential practice-changing implications for the use of brentuximab vedotin in managing CD30-expressing CTCL in patients who require systemic therapy.
ASH 2016 Lymphoma

- B-cell Lymphoma
  - Follicular Lymphoma
  - Diffuse Large Cell Lymphoma
  - Marginal Zone
- T-cell Lymphoma
  - CTCL
- Hodgkin Lymphoma
  - Checkpoint inhibitors

Longer term Follow up of Phase 1 trial of Pembrolizumab (KEYNOTE-013)

Data cut off: Nov 17, 2014
Median duration of follow-up: 5 months
Moskowitz CM et al., ASH 2014

Data cut off: Oct 27, 2015
Median duration of follow-up: 19 months
Armand P et al, ASH 2015

Data cut off: Sep 27, 2016
Median follow-up: 29 months
Armand et al. ASH 2016 abstract #1108

Keynote 013 - Best Overall Response

<table>
<thead>
<tr>
<th></th>
<th>All Patients N=31</th>
<th>Prior ASCT, BV Post ASCT n=38</th>
<th>ASCT ineligible, Failed BV n=8</th>
<th>Prior ASCT, BV Pre ASCT n=7</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORR</td>
<td>18 (58%)</td>
<td>11 (59%)</td>
<td>1 (13%)</td>
<td>4 (57%)</td>
</tr>
<tr>
<td>CR</td>
<td>6 (19%)</td>
<td>4 (26%)</td>
<td>2 (25%)</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>PR</td>
<td>12 (39%)</td>
<td>8 (39%)</td>
<td>5 (63%)</td>
<td>4 (57%)</td>
</tr>
</tbody>
</table>

Data cutoff date: September 27, 2016
Armand et al. ASH 2016 abstract #1108
**Keynote 013 – Durability of Responses**

Change From Baseline in Target Lesions

<table>
<thead>
<tr>
<th>Time Since Initiation of Treatment (months)</th>
<th>Change From Baseline In Target Lesions (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>30</td>
<td>0</td>
</tr>
</tbody>
</table>

**Change From Baseline In Target Lesions**

- CR
- PR
- SD
- PD

**Best Overall Response**

- CR
- PR
- SD
- PD

**Data cutoff date:** September 27, 2016

Armand et al. ASH 2016 abstract #1108

### Longer term Follow up Phase 2 Study of Nivolumab (CheckMate 205): Cohorts A and B

- Phase II study conducted in Europe and North America

**Nivolumab 3 mg/kg IV Q2W**

Treatment until disease progression or unacceptable toxicity

Patients could elect to discontinue nivolumab and proceed to allogeneic (allo)-HSC T

- Cohort A: BV naïve post-ASCT
- Cohort B: BV treated post-ASCT

**Primary Endpoint**

- ORR by IRRC

**Additional endpoints**

- Duration of response
- Duration of CR/PR
- PFS by IRRC
- OS
- Safety

### Duration of Response by Best Response

**Cohort A: Nivolumab in BV-Naïve Post-ASCT Patients**

<table>
<thead>
<tr>
<th>Months</th>
<th>CR</th>
<th>PR</th>
<th>SD</th>
<th>PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Median duration of follow-up, mo**

- CR: 14
- PR: 13
- SD: 12
- PD: 9

**Median DDR, mo (95% CI)**

- CR: 3 (1-20)
- PR: 0 (0-10)
- SD: 1 (1-50)
- PD: 0 (0-20)
Hodgkin Lymphoma Conclusions

- PD1 blockade is effective - longer follow-up show durability of some responses.
- Combinations incorporating brentuximab vedotin and nivolumab preliminarily look highly effective.