Complete Summary

GUIDELINE TITLE

Hodgkin´s Disease—unfavorable clinical stage I and II.

BIBLIOGRAPHIC SOURCE(S)

Mendenhall NP, Chang D, Hoppe RT, Ng A, Colman M, Constine LS, Deming RL, Morris DE, Wolkov HB, Yahalom J, Chauvenet AR, Hudson MM, Winter JN, Expert Panel on Radiation Oncology-Hodgkin's Disease. Hodgkin's disease - unfavorable clinical stage I and II. [online publication]. Reston (VA): American College of Radiology (ACR); 2006. 10 p. [43 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American College of Radiology Expert Panel on Radiation Oncology. Hodgkin's disease unfavorable clinical stage I and II. American College of Radiology. Appropriateness Criteria. Reston (VA): American College of Radiology (ACR); 2000. 10 p.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Hodgkin's disease – unfavorable clinical stage I and II

GUIDELINE CATEGORY

Risk Assessment
Treatment

CLINICAL SPECIALTY

Hematology
Internal Medicine
Oncology
Radiation Oncology
Radiology

INTENDED USERS

Health Plans
Hospitals
Managed Care Organizations
Physicians
Utilization Management

GUIDELINE OBJECTIVE(S)

To evaluate the appropriateness of treatment procedures for patients with unfavorable clinical stage I and II Hodgkin's disease

TARGET POPULATION

Patients with unfavorable clinical stage I and II Hodgkin's disease

INTERVENTIONS AND PRACTICES CONSIDERED

1. Radiation therapy
    - Involved field radiation therapy (IFRT)
    - Extended field RT (EFRT)
    - Subtotal lymphoid irradiation (STLI)
    - Total lymphoid irradiation (TLI)
    - STLI/TLI plus spleen
    - Mantle
    - Mediastinum/bilateral hila/bilateral supraclavicular
2. Chemotherapy
3. Combination therapy
    - Chemotherapy plus IFRT
    - Chemotherapy plus EFRT
    - Chemotherapy plus STLI/TLI
4. Biopsy
5. Observation

MAJOR OUTCOMES CONSIDERED

- Utility of positron emission tomography (PET)

- Impact of prognostic factors
- Relapse-free and overall survival rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer performed literature searches of peer-reviewed medical journals and the major applicable articles were identified and collected.

NUMBER OF SOURCE DOCUMENTS

The total number of source documents identified as the result of the literature search is not known.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not stated

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

One or two topic leaders within a panel assume the responsibility of developing an evidence table for each clinical condition, based on analysis of the current literature. These tables serve as a basis for developing a narrative specific to each clinical condition.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Since data available from existing scientific studies are usually insufficient for meta-analysis, broad-based consensus techniques are needed for reaching

agreement in the formulation of the appropriateness criteria. The American College of Radiology (ACR) Appropriateness Criteria panels use a modified Delphi technique to arrive at consensus. Serial surveys are conducted by distributing questionnaires to consolidate expert opinions within each panel. These questionnaires are distributed to the participants along with the evidence table and narrative as developed by the topic leader(s). Questionnaires are completed by participants in their own professional setting without influence of the other members. Voting is conducted using a scoring system from 1-9, indicating the least to the most appropriate imaging examination or therapeutic procedure. The survey results are collected, tabulated in anonymous fashion, and redistributed after each round. A maximum of three rounds is conducted and opinions are unified to the highest degree possible. Eighty percent agreement is considered a consensus. This modified Delphi technique enables individual, unbiased expression, is economical, easy to understand, and relatively simple to conduct.

If consensus cannot be reached by the Delphi technique, the panel is convened and group consensus techniques are utilized. The strengths and weaknesses of each test or procedure are discussed and consensus reached whenever possible. If "No consensus" appears in the rating column, reasons for this decision are added to the comment sections.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Criteria developed by the Expert Panels are reviewed by the American College of Radiology (ACR) Committee on Appropriateness Criteria.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

ACR Appropriateness Criteria®

Clinical Condition: Hodgkin's Disease -- Unfavorable Clinical Stage I and II

Variant 1: 26-year-old male; CS IIB NSHD; supradiaphragmatic, no bulky disease; fevers >38 degrees C and drenching night sweats.

Treatment	Appropriateness Rating	Comments
4-6 months chemotherapy plus involved field RT (IFRT)	8	
4-6 months chemotherapy only	6	Limited data. Relapse rates may be higher, but survival may be the same.
4-6 months chemotherapy plus extended field RT (EFRT)	2	
Radiation alone, subtotal lymphoid irradiation (STLI)	1	
4-6 months chemotherapy plus STLI	1	
Radiation alone, involved field	1	
Radiation Dose/Combined Modality (4 months conventional chemo and good response)		
20-30 Gy IFRT	8	Emerging data suggest that 20 Gy is insufficient.
31-36 Gy IFRT	4	
>36-40 Gy IFRT	2	
>40 Gy IFRT	1	
Radiation Dose/Combined Modality (6 months conventional chemo and good response)		
20-30 Gy IFRT	8	
31-36 Gy IFRT	2	
>36-40 Gy IFRT	2	
>40 Gy IFRT	1	
Appropriateness Criteria Scale **1 2 3 4 5 6 7 8 9** **1 = Least appropriate 9 = Most appropriate**		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 2: 26-year-old male; CS IIB NSHD; supradiaphragmatic, bulky disease 10 cm in the neck; marrow uninvolved; fevers >38 degrees C and drenching night sweats.

Treatment	Appropriateness Rating	Comments
4-6 months chemotherapy plus involved field RT (IFRT)	8	
4-6 months chemotherapy plus STLI/TLI	1	
4-6 months chemotherapy only	1	
Radiation alone, STLI/TLI plus spleen	1	
Radiation alone, mantle	1	
Radiation Dose/Combined Modality (4 months conventional chemo and good response)		
20-30 Gy IFRT	6	Limited data. Relapse rates may be higher, but survival may be the same.
31-36 Gy IFRT	8	
>36-40 Gy IFRT	4	
>40 Gy IFRT	1	
Radiation Dose/Combined Modality (6 months conventional chemo and good response)		
20-30 Gy IFRT	8	Data on<30 Gy are limited.
31-36 Gy IFRT	6	
>36-40 Gy IFRT	3	
>40 Gy IFRT	1	
Appropriateness Criteria Scale **1 2 3 4 5 6 7 8 9** **1 = Least appropriate 9 = Most appropriate**		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 3: 26-year-old male; CS IIA NSHD. MTR=0.38 (ratio at T5-6). MMR=0.31 (ratio at maximum intrathoracic diameter).

Treatment	Appropriateness Rating	Comments
4-6 months chemotherapy plus involved field RT (IFRT)	8	
Radiation alone, STLI/TLI plus spleen	1	
Radiation alone, mantle	1	
4-6 months chemotherapy plus STLI/TLI	1	
4-6 months chemotherapy only	1	
Radiation Dose/Combined Modality (4 months conventional chemo and good response)		
20-30 Gy IFRT	6	
31-36 Gy IFRT	8	
>36-40 Gy IFRT	4	
>40 Gy IFRT	1	
Boost mediastinum dose to 36 Gy	8	
Boost mediastinum dose to 40 Gy	6	If the mediastinum is boosted >36 Gy, careful consideration should be given to using a "shrinking field" technique.
Boost mediastinum dose to 44 Gy	1	If the mediastinum is boosted >36 Gy, careful consideration should be given to using a "shrinking field" technique.
Radiation Dose/Combined Modality (6 months conventional chemo and good response)		
20-30 Gy IFRT	8	
31-36 Gy IFRT	6	

Treatment	Appropriateness Rating	Comments
>36-40 Gy IFRT	3	
>40 Gy IFRT	1	
Boost mediastinum dose to 36 Gy	8	
Boost mediastinum dose to 40 Gy	5	If the mediastinum is boosted >36 Gy, careful consideration should be given to using a "shrinking field" technique.
Boost mediastinum dose to 44 Gy	1	If the mediastinum is boosted >36 Gy, careful consideration should be given to using a "shrinking field" technique.
Appropriateness Criteria Scale **1 2 3 4 5 6 7 8 9** **1 = Least appropriate 9 = Most appropriate**		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 4: 26-year-old male; CS IIA NSHD. MTR=0.45. MMR=0.38.

Treatment	Appropriateness Rating	Comments
4-6 months chemotherapy plus involved field RT (IFRT)	8	
Radiation alone, mantle	1	
Radiation alone, STLI/TLI plus spleen	1	
4-6 months chemotherapy plus STLI/TLI	1	
Radiation Dose/Combined Modality (4 months conventional chemo and good response)		
20-30 Gy IFRT	4	
31-36 Gy IFRT	8	
>36-40 Gy IFRT	4	

Treatment	Appropriateness Rating	Comments
>40 Gy IFRT	1	
Boost mediastinum dose to 36 Gy	8	
Boost mediastinum dose to 40 Gy	6	
Boost mediastinum dose to 44 Gy	1	
Radiation Dose/Combined Modality (6 months conventional chemo and good response)		
20-30 Gy IFRT	8	
31-36 Gy IFRT	6	
>36-40 Gy IFRT	3	
>40 Gy IFRT	1	
Boost mediastinum dose to 36 Gy	8	
Boost mediastinum dose to 40 Gy	4	
Boost mediastinum dose to 44 Gy	1	
Appropriateness Criteria Scale **1 2 3 4 5 6 7 8 9** **1 = Least appropriate 9 = Most appropriate**		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 5: 26-year-old female; CS IIA NSHD involving mediastinum and left supraclavicular. MMR=0.38. Good response on CT to 6 months of conventional chemotherapy, PET negative.

Treatment	Appropriateness Rating	Comments
Radiotherapy Volume		
Involved field	8	
Mediastinum/bilateral hila/bilateral	8	

Treatment	Appropriateness Rating	Comments
supraclavicular		
Full mantle	1	
STLI plus spleen	1	
Radiation Dose/Combined Modality (6 months conventional chemo and good response)		
20-30 Gy IFRT	8	
31-36 Gy IFRT	6	
>36-40 Gy IFRT	3	
>40 Gy IFRT	1	
Boost mediastinum dose to 36 Gy	8	
Boost mediastinum dose to 40 Gy	3	
Boost mediastinum dose to 44 Gy	1	
Mediastinal Volume		
Treat post-chemo volume only (laterally)	8	If there is no lung extension, the width of the postchemo RT field may correspond to the post-chemo extent of disease; however, the superior-inferior extent of the field should encompass the initial extent of disease.
Treat pre-chemo volume to 10-15 Gy, then shrink	1	If there is no lung extension, the width of the postchemo RT field may correspond to the post-chemo extent of disease; however, the superior-inferior extent of the field should encompass the initial extent of disease.
Inferior margin 2 cm below pre-chemo volume	8	
Inferior margin 2 cm below post-chemo volume	1	
Inferior margin 5 cm below post-chemo	1	

Treatment	Appropriateness Rating	Comments
volume		
Inferior margin approximately at diaphragm	1	
Inferior margin 5 cm below pre-chemo volume	1	
Appropriateness Criteria Scale **1 2 3 4 5 6 7 8 9** **1 = Least appropriate 9 = Most appropriate**		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 6: 26-year-old female; CS IIA NSHD involving mediastinum and left supraclavicular; MMR=0.38. Completion of chemo for 6 months and IFRT with complete response but residual PET scan avidity in the mediastinum 2 months later.

Treatment	Appropriateness Rating	Comments
Observe and rescan in 2-3 months	8	
Observe and rescan in 6 months	4	
Biopsy now	4	
Salvage chemo with ESHAP or other salvage regimen and expectation of auto transplant without any radiation without biopsy.	2	
Salvage chemo with ESHAP or other salvage regimen and expectation of auto transplant with mediastinal RT without biopsy.	1	

Treatment	Appropriateness Rating	Comments
Appropriateness Criteria Scale **1 2 3 4 5 6 7 8 9** **1 = Least appropriate 9 = Most appropriate**		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Variant 7: 26-year-old male; CS IIB NSHD; supradiaphragmatic, no bulky disease. PET scan shows an additional focus of activity at the splenic hilum not visible on CT.

Treatment	Appropriateness Rating	Comments
4-6 cycles chemo and IFRT to all sites of disease seen on CT and PET	No consensus	Residual PET activity after treatment with chemo is associated with a worse prognosis. It is unclear, however, what adjustments to treatment need to be made in this scenario.
4-6 cycles chemo and IFRT to all sites of disease seen on CT only	No consensus	Residual PET activity after treatment with chemo is associated with a worse prognosis. It is unclear, however, what adjustments to treatment need to be made in this scenario.
Appropriateness Criteria Scale **1 2 3 4 5 6 7 8 9** **1 = Least appropriate 9 = Most appropriate**		

Note: Abbreviations used in the tables are listed at the end of the "Major Recommendations" field.

Summary of Literature Review

Despite the excellent predictive value of the Ann Arbor staging system for Hodgkin's disease, it has been shown that certain presentations of stage I-II may be associated with a distinctly worse freedom from progression when initial treatment is with irradiation alone. More intensive management approaches are indicated for some of these patients. Numerous analyses have evaluated the impact of prognostic factors in stage I-II disease in order to identify patients who benefit from more intensive therapy. Prognostic factors identified in these analyses include the number of involved lymphoid regions, the size of individual nodes, the extent of mediastinal disease, patient gender and age, the presence of B symptoms or pruritus, histology, and erythrocyte sedimentation rate (ESR). A pooled analysis of patients with localized disease from the GELA H8 and H9 trials confirmed that age >45 years, male sex, hemoglobin <10.5 g/dL, lymphocytes <600/microL, B symptoms with elevated ESR, and extranodal sites significantly

correlated with survival rate. Overall tumor burden was shown to correlate well with prognosis.

In the United States there has been general consensus that two of these factors in stage I-II Hodgkin's disease should influence management decisions. The first is constitutional (B) symptoms -- unexplained fevers, drenching night sweats, or significant weight loss as clearly defined in the Ann Arbor staging classification system. The presence of B symptoms is correlated with a higher likelihood of systemic disease, including occult subdiaphragmatic disease, detectable only by staging laparotomy and splenectomy. Evidence suggests that fevers and weight loss have more prognostic significance than night sweats alone.

The second prognostic factor that should influence treatment selection is the presence of large mediastinal adenopathy or bulky disease in non mediastinal sites. Several retrospective series have shown very strong correlation between mediastinal mass size and prognosis for patients treated with irradiation alone or chemotherapy alone. These series suggest that patients who present with large mediastinal adenopathy can be treated more effectively with combined modality therapy when freedom from relapse or freedom from treatment failure is the endpoint.

Appropriate evaluation for patients with unfavorable early stage disease includes computed tomography (CT) scanning, blood studies, and bone marrow biopsy, but no longer requires laparotomy. Positron emission tomography (PET) has been incorporated into the workup because of its sensitivity in detecting subclinical disease, further obviating the need for pathologic staging. One study found that patients with early stage disease who were upstaged to stage III or IV by PET had worse outcomes, suggesting a need to incorporate PET into the staging procedure and management decisions.

Treatment of patients with unfavorable stage I-II Hodgkin's lymphoma with radiation or chemotherapy alone is not recommended due to the high risk of relapse. Data from a variety of studies using different criteria for risk stratification consistently demonstrate a benefit for freedom from disease progression with the addition of consolidative irradiation after chemotherapy but, as of yet, no improvement in survival. In a Spanish series of patients treated with adriamycin, bleomycin, vinblastine, and dacarbazine (ABVD), using consolidative radiation therapy only for patients with bulky disease or an incomplete response to chemotherapy, progression-free and overall survival rates at 7 years were 76% and 92%, respectively, in patients with bulky mediastinal disease and 82% and 94% in patients with B symptoms. In the NCIC/ECOG trial, which excluded patients with bulky disease and B symptoms, but included patients with other unfavorable features such as male gender, four or more sites of involvement, age 40 years or older, and elevated erythrocyte sedimentation rate (ESR), freedom from disease progression was superior in patients treated with combined modality therapy, although survival was the same. A trial in patients with non-bulky IA/B, IIA/B, and IIIA disease showed no benefit to extended field radiation therapy (EFRT) following 6 cycles of ABVD vs. ABVD alone, but was powered to detect only a benefit of at least 20%. A recent meta-analysis has shown superior overall and progression-free survival with combined modality therapy for both early-stage and advanced-stage disease. Patients treated with combined modality therapy for

stage I-II Hodgkin's disease with large mediastinal adenopathy can expect five-year survival and freedom-from-relapse rates of at least 85% to 90%.

Trials have not demonstrated a benefit of irradiating radiographically uninvolved sites when at least 4 cycles of chemotherapy are given. Thus, involved field radiation therapy (IFRT) should be the standard treatment volume, when at least four cycles of chemotherapy are given. The value of including PET positive sites that are radiographically negative in the radiation field is unknown.

Emerging data suggest that combined-modality therapy with reduced radiation treatment volumes will reduce the risk of long-term complications, specifically second malignancies.

In the setting of planned combined modality therapy for patients with large mediastinal adenopathy or bulky disease, treatment is initiated with chemotherapy in order to reduce the size of the mass to be irradiated, as well as to treat all occult sites of disease. Shrinkage of the mass with initial chemotherapy permits the use of more generous lung blocks, thereby providing additional protection for the lungs. Following chemotherapy, treatment is administered to involved or slightly extended fields that generally include the mediastinum and bilateral hilar and supraclavicular regions. The initial lateral extent of mediastinal disease should not be treated, unless there was known extranodal disease extension into the pulmonary parenchyma or chest wall. Irradiation of the pre-chemotherapy volume may result in excessive pulmonary toxicity.

A randomized study of radiation dose in combined modality therapy conducted by the German Hodgkin's Study Group has demonstrated no difference in outcome between radiation doses of 20 Gy and 40 Gy to sites without bulky disease. A recent interim analysis of the German Hodgkin's trial HD11 comparing 20 Gy vs. 30 Gy of IFRT after 4 cycles of chemotherapy for early unfavorable patients showed little difference in 3-year freedom from treatment failure (90% vs. 87%) and overall survival (97% vs. 97%), although follow-up is limited. In combined modality programs for bulky mediastinal disease, a dose of ≥36 Gy has commonly been used, although there is little evidence to define the optimal dose. One study showed in combined modality therapy that doses of >30 Gy were not needed for tumors ≤6 cm. However, the high in-field relapse rate of 26% in larger tumors (>9 cm) treated with combined modality therapy using radiation doses of ≤35 Gy suggests a possible role for higher doses. Response to chemotherapy may serve as an additional factor influencing dose.

Chemotherapy regimens differ across studies, and the optimal type or duration of systemic treatment is not known. Most studies have used anthracycline-based chemotherapy, usually adriamycin. The EORTC H6U trial found superior freedom from progression with 6 cycles of ABVD as compared with 6 cycles of mechlorethamine, vincristine, procarbazine, and prednisone (MOPP). The use of less intensive chemotherapy in patients with unfavorable-prognosis disease has been associated with significantly inferior treatment outcomes; in the EORTC H7U trial comparing 6 cycles of epirubicin, bleomycin, vinblastine, and prednisone (EBVP) to 6 cycles of MOPP/ABVD followed by IFRT, patients on the EBVP arm had an inferior 6-year event-free survival rate (68% vs. 90%). Preliminary results from the GHSG HD11 and the EORTC H9U trials, both comparing 4 cycles of bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, prednisone,

and procarbazine (BEACOPP) with 4 to 6 cycles of ABVD, showed no significant failure-free or overall survival benefit to the use of BEACOPP.

A common clinical problem following completion of therapy for patients with a large mediastinal mass is residual abnormality on chest radiograph or chest CT scan. In fact, despite the overall excellent prognosis for these patients, the majority will have residual abnormalities secondary to sclerosis or fibrosis of previously involved nodes. In general, these patients may be followed closely, provided there is no evidence of progressive radiographic abnormality.

PET is emerging as a potentially useful tool in evaluating residual radiographic abnormality. Studies have reported that it has superior sensitivity, specificity, and predictive value compared to CT in the post-treatment setting, and PET evaluation of a patient's response to therapy may serve as an important prognostic factor. Additionally, PET response during chemotherapy may serve as an early predictor of treatment success, allowing risk-adapted therapy by intensifying treatment for higher-risk patients. It is unknown whether risk-adapted therapy based on early response criteria, including PET findings will result in better outcomes.

Abbreviations

- C, Celsius
- CS, clinical stage
- CT, computed tomography
- EFRT, extended field radiation therapy
- ESHAP, etoposide, cisplatin, cytarabine, and methylprednisolone
- IFRT, involved field radiation therapy
- MMR, mediastinal mass ratio
- MTR, median time to relapse
- NSHD, nodular sclerosing Hodgkin's disease
- PET, positron emission tomography
- RT, radiation therapy
- STLI, subtotal lymphoid irradiation
- TLI, total lymphoid irradiation

CLINICAL ALGORITHM(S)

Algorithms were not developed from criteria guidelines.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on analysis of the current literature and expert panel consensus.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Selection of appropriate treatment procedures for patients with unfavorable clinical stage I and II Hodgkin's disease

POTENTIAL HARMS

Toxicity associated with chemo and radiation therapy

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

An American College of Radiology (ACR) Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists, and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those exams generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the U.S. Food and Drug Administration (FDA) have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Mendenhall NP, Chang D, Hoppe RT, Ng A, Colman M, Constine LS, Deming RL, Morris DE, Wolkov HB, Yahalom J, Chauvenet AR, Hudson MM, Winter JN, Expert Panel on Radiation Oncology-Hodgkin's Disease. Hodgkin's disease - unfavorable clinical stage I and II. [online publication]. Reston (VA): American College of Radiology (ACR); 2006. 10 p. [43 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 (revised 2006)

GUIDELINE DEVELOPER(S)

American College of Radiology - Medical Specialty Society

SOURCE(S) OF FUNDING

The American College of Radiology (ACR) provided the funding and the resources for these ACR Appropriateness Criteria®.

GUIDELINE COMMITTEE

Committee on Appropriateness Criteria, Expert Panel on Radiation Oncology–Hodgkin's Disease

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Panel Members: Nancy P. Mendenhall, MD; Daniel Chang, MD; Richard T. Hoppe, MD; Andrea Ng, MD; Martin Colman, MD; Louis S. Constine, MD; Richard L. Deming, MD; David Eric Morris, MD; Harvey B. Wolkov, MD; Joachim Yahalom, MD; Allen R. Chauvenet, MD; Melissa M. Hudson, MD; Jane N. Winter, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American College of Radiology Expert Panel on Radiation Oncology. Hodgkin's disease unfavorable clinical stage I and II. American College of Radiology. Appropriateness Criteria. Reston (VA): American College of Radiology (ACR); 2000. 10 p.

The appropriateness criteria are reviewed annually and updated by the panels as needed, depending on introduction of new and highly significant scientific evidence.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American College of Radiology (ACR) Web site.

ACR Appropriateness Criteria® *Anytime*, *Anywhere*™ (PDA application). Available from the ACR Web site.

Print copies: Available from the American College of Radiology, 1891 Preston White Drive, Reston, VA 20191. Telephone: (703) 648-8900.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- ACR Appropriateness Criteria®. Background and development. Reston (VA): American College of Radiology; 2 p. Electronic copies: Available in Portable Document Format (PDF) from the American College of Radiology (ACR) Web site.

PATIENT RESOURCES

None available

NGC STATUS

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