

Preface



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Guest Editors

Hodgkin's Lymphoma (HL) is one of the best curable cancers in adulthood. Today, patients in different stages can be cured with modern risk-, and response-adapted treatment strategies in 85%–95 % of cases.

Over the past 60 years, however, the risk of failure changed for the patient to survive the diagnosis of HL. Before 1960, the high risk of dying from the tumor threatened the patient. Later on, invasive diagnostic procedures such as exploratory laparotomy and splenectomy put patients at risk because they caused high rates of morbidity and sometimes mortality. With the advent of large field radiotherapy in the 1970s, higher survival rates were achieved at the cost of short-term and long-term, potentially fatal, sequelae. This risk of late effects secondary to aggressive treatment is increased further with combined modality approaches applied from the 1980s to present. Currently, one of the highest risks for HL patients is not getting the best risk-adapted therapy from the very beginning of diagnosis.

This issue of *Hematology/Oncology Clinics of North America* gives an overview on current therapeutic and diagnostic strategies supporting the doctor in private practices and in the academic institution to diagnose and treat HL patients according to their personal needs and individual risk profiles using the most effective and least toxic strategy. Further, the overviews presented in this issue address the pathology, biology, molecular-pathogenesis, and epidemiology of HL. Novel diagnostic tools and new therapeutic strategies developed to maintain high cure rates and reduce long-term toxicities in cancer survivors also are discussed.

The advent of fluorodeoxyglucose-positron emission tomography as a response- and a prognosis-predicting tool at an early point in the carrier of an HL patient, enables clinicians to tailor therapy according to the individual risk of failure to induction therapy and prevent overtreatment and/or undertreatment.

The unresolved question whether or not we need an intermediate (early unfavorable) stage allocation in HL is addressed in detail. The role of adjuvant or consolidative radiation in conjunction with chemotherapy is discussed, and it is questioned whether the doctor will become the most prominent risk factor for HL patients in the future if he/she is not familiar with the most efficacious therapeutic tools, and even more if he/she is not willing to put a patient in the best available clinical trial.

As of 2007, each HL patient has the right to be cured in the most suitable time with the best strategy available if he/she has access to modern cancer care. We hope you find that this issue provides the information and tools to accomplish this goal.

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