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Uganda Cancer Institute
Research is Our Resource

Adapting Treatment Protocols for Paediatric Hodgkin Lymphoma Patients in Uganda.

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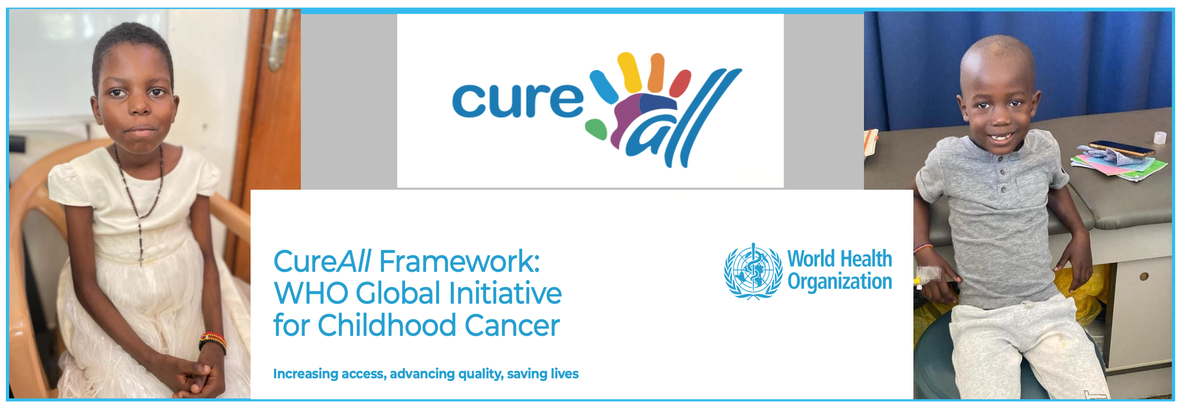
Introduction

The clinical partnership between paediatric oncology teams at CUH and the Uganda Cancer Institute (UCI) in Kampala, Uganda has been in place since spring of 2020. Initial project work focused on the safety of chemotherapy prescription and administration, but since has branched out to include patient and parent educational resources, pathology pathways and turnaround times, clinical evaluation of MDT working, and a nursing-led triage assessment tool.

The WHO Global Initiative for Childhood Cancer (GICC) was developed in 2021, with an aim to improve global childhood cancer survival outcomes to 60% for the six most common (and treatable) conditions worldwide by the year 2030. Uganda is a WHO focus country, and Hodgkin Lymphoma is one of the six index diagnoses. In high income countries, paediatric Hodgkin Lymphoma is treated according to a risk-stratified, response-adapted protocol, with overall survival of >90%.



Methods

Colleagues at UCI performed an audit of patients with Hodgkin Lymphoma treated at their centre over the past 10 years, which demonstrated that their event-free survival (EFS) at one-year, three years and five years was 48%, 40% and 35% respectively. This was hypothesized to be due to rates of treatment abandonment and patients being lost to follow-up.

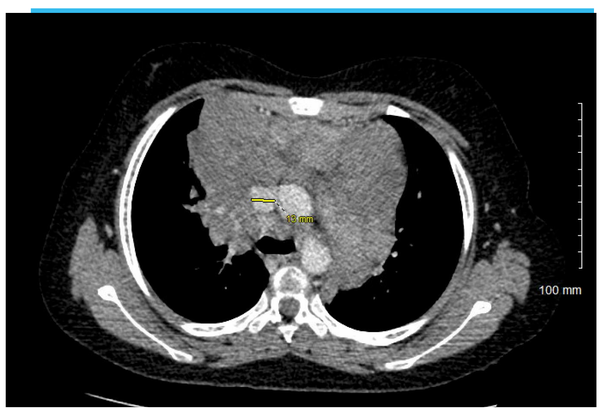
Further clarification with the team around their perceived areas for improvement in this patient cohort included the fact that all patients received the same treatment, regardless of stage of disease at presentation. All patients received chemotherapy, and some received the addition of radiotherapy. However, there was no clear guidance to aid in deciding which patients should receive this additional modality of treatment and logistical/capacity issues were the main barriers to its delivery.

Now that the UCI has a dedicated paediatric clinical oncologist and access to sophisticated modes of radiotherapy delivery, as well as greater resource available and confidence in the safe delivery of chemotherapy, the team wished to create a risk-stratified response-adapted protocol for the treatment of these patients, similar to that seen in high income countries.

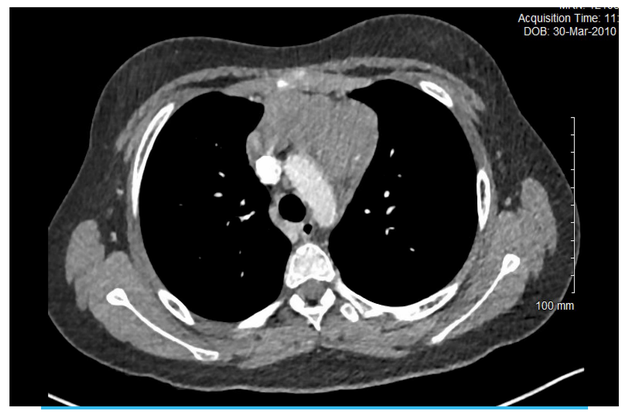
Colleagues from both UCI and CUH performed a literature review and subsequently became aware of a clinical trial protocol from South Africa aiming to standardize care across Africa (while recognizing the need for adaptation based on individual country resource).

UCI is not currently in a position to open the clinical trial as a participating site, due to limited resource in terms of unavailability of PET-CT (the main modality used for response assessment) as well as staffing capacity and IT infrastructure for rigorous data collection. Our team has had regular virtual meetings to go through the various elements of the trial protocol to determine which are/are not deliverable at the UCI.

Adaptations to the protocol have been made in line with other published data using a combination of ESR and CT scan based response assessment. This response to treatment will be utilized to determine whether patients would benefit from either intensification of chemotherapy regimes and/or the addition of radiotherapy.



CT Chest at Diagnosis – showing large mediastinal mass



CT Chest at end of treatment – shows dramatic response to chemotherapy

Discussion

Working as a team to adapt the South African clinical trial protocol has enabled us to bring the wider MDT into discussions, particularly with colleagues in pathology, radiology and clinical oncology. Our aim is to improve the participation, motivation and belief in the utility of protocol-driven cancer care in these adjacent healthcare specialties that are essential for the best possible care for children with cancer.

We will be meeting as an MDT to support the decision making around the children enrolled on this protocol, and will collect data prospectively on numbers of patients, pathology, stage of disease, response assessment and treatment outcomes. Initially this will be done using Excel, however we have applied for external grant funding to support the addition of a data manager to the UCI infrastructure.

We have developed relationships between CUH and UCI already in pathology, pharmacy and medical oncology. We hope this project will extend that partnership working to include radiology and clinical oncology, which will build expertise and support institutional team building.

Conclusions

The partnership enables us to have lively and engaging discussions around the current literature on the treatment of these conditions, and to think creatively about how best to adapt high income treatment principles in LMIC settings. This discussion also stimulates critical thinking about diagnosis, staging and treatment strategies that will improve awareness and educational opportunity to wider members of the treatment team.

As a partnership, we aspire to extend this MDT working and adaptation of proven trial protocols to the other five WHO GICC cancer diagnoses, as well as create an environment at UCI that will be able to support participation in clinical trials in the near future, increase the resilience and capacity of both the UCI and CUH and improve overall survival for children with cancer in Uganda.