CLINICAL STAGING OF HODGKIN'S DISEASE*

DR. HENRY S. KAPLAN

Every patient with Hodgkin's disease, once the histopathologic diagnosis is established, must have a thorough diagnostic evaluation to identify all sites of involvement. This should include a careful clinical history, with emphasis on the presence of unexplained continuous or intermittent fever, night sweats, and/or generalized pruritus. Fatigue and weight loss are important to document, but are less specific. A meticulous physical examination is essencial, and the presence of palpable lymph nodes in any of the accessible peripheral chains should be recorded and described. Equivocal lymph nodes in sites that would lead to a change in staging should be biopsied to establish clearly whether they are involved or not. Chest roentgenograms will usually reveal mediastinal or hilar adenopathy when present, but tomograms of the lung and mediastinum may be helpful in some cases. Lymphangiography is an indispensable part of the most important single reason for major errors in staging, due to failure to detect intraabdominal disease. The status of the liver should de checked by liver function tests, particularly the serum alklaine phosphatase and bromsulfthalein excretion tests. Where these are abnormal without some other satisfactory explanation, biopsy of the liver, either by the needle technique or my open surgical biopsy, is indicated. Finally, bone marrow biopsy, using the drill, Vim-Silverman, or open surgical techniques, is mandatory. When the diagnostic evaluation omits any of the above procedures, errors in staging and in the selection of proper treatment will inevitably increase significantly.

In a series of patients studied in this manner, we have been able to document the fact that, when multiple lymphatic sites are involved, the involvement is not randomly distributed but is seen to involve **contiguous** chains of lymph nodes in nearly 80 per cent of cases. Moreover, most of the instances in which involvement is noncontiguous can be explained satisfactorily by communication between involved lymphatic sites via the thoracic duct, bypassing the mediastinal and hilar lymph nodes. When such instances are omitted, less than 5 per cent of cases remain to be explained as truly noncontiguous lymphatic involvement. Thus, the sites of involvement or of probable future involvement can be predicted with great accuracy in Hodgkin's disease. This is further documented by our previously published data

* Resumo escrito pelo autor.

(1) on the sites of extension of disease in treated patients; it was observed that in over 90 per cent of instances, the next site of involvement was in a contiguous chain of lymph nodes.

The clinical classification we formerly employed was a modification of Dr. Vera Peters' original three-stage classification. It differed from her classification by subdividing her former Stage III two stages: a new Stage III, pertaining to widespread disease in lymphatic structures, both above and below the diaphragm, but without extralymphatic involvement, and a new Stage IV, reserved for cases with secondary extension to one or more extralymphatic sites such as the bone marrow, liver, lung, gastro-intestinal tract, etc. More recently, as the result of discussions held at the international conferences in Paris and Rye, New Kork, in 1965, a slight modification of our four-stage classification has been proposed for international adoption (2). We have adopted and used this new classification for about one year and have found it to be quite satisfactory. Moreover, our data on the survival of patients with Stage III and Stage IV disease, using this new classification, reveal a distinct difference in prognosis which strongly supports the validity of dividing the former Stage III category into these two new categories.

REFENRENCES

1 — ROSENBERG, S. A., and KAPLAN, H. S. — Evidence for an Orderly Progression in the Spread of Hodgkin's Disease. *Cancer Res.* 26: 1225-1231, 1966.

2 — ROSENBERG, S.A. — Report of the Committee on the Stating of Hodgkin's Disease. *Cancer Res.* 26: 1310, 1966.

ESTADIAMENTO DA DOENÇA DE HODGKIN

Nota do Editor

As seguintes definições de estadiamento foram estabelecidas pela Comissão e aprovadas pelos membros da Conferência. Esta classificação representa uma modificação da de Peters e é muito parecida com a recomendada no Simpósio sôbre Doença de Hodgkin realizado em Paris, França, em fevereiro de 1965. Espera-se seja estudada e aceita para emprego internacional.

Estádio I — Doença limitada a uma única região anatômica ou a duas regiões anatômicas contíguas, do mesmo lado do diafragma.

Estádio II — Doença em mais de duas regiões anatômicas ou em duas regiões não contíguas porém do mesmo lado do diafragma.

Estádio III — Doença em ambos os lados do diagragma, porém não se entendendo além do comprometimento de glânglios linfáticos, baço e / ou do anel de Waldeyer.

Estádio IV — Comprometimento da medula óssea, parênquima pulmonar, pleura, fígado, osso, pele, rins, tubo gastro-intestinal ou qualquer tecido ou órgão além dos gânglios linfáticos, do baço e do anel de Waldeyer.

Todos os estádios serão sub-classificados em **A** ou **B** para indicar a ausência ou a presença, respectivamente, de sintomas sistêmicos. Os seguintes sintomas abaixo relacionados são significativos:

a) — Febre;
b) — Suores noturnos;
c) — Prurido

Alguns centros preferirão continuar considerando pacientes com doença limitada a uma região anatômica. Para os que desejarem fazer tal distinção, é a seguinte a sub divisão do Estádio I:

Estádio I^1 — Doença limitada a uma região anatômica.

Estádio I^2 — Doença limitada a duas regiões anatômicas contíguas, no mesmo lado do diafragma.

Outros sintomas que aparecem no curso da Doença de Hodgkin devem ser anotados, porém não devem ser considerados suficientes, por si mesmos, para incluir determinado paciente em sub grupo B. Neste caso estão: perda de peso, mal estar, fraquesa, fadiga, anemia, leucocitose, leucopenia, linfocitopenia, hemo-sedimentação elevada, anergia cutânea, ou dor provocada pelo uso do álcool.

Membros do Comité:
Dr. Maurice Tubiana, Villejuif, Seine, France
Dr.Eric Eeasson, Manchester, England
Dr. Lilian Fuller, Houston, Texas
Dr. David A. Karnofsky, New York
Dr. Robert Lukes, Los Angeles, California
Dr. M. Vera Peters, Toronto, Canada
Dr. Saul A. Rosenberg, Palo Alto, California

REGIÕES ANATÔMICAS A CONSIDERAR NO ESTADIAMENTO DA DOENÇA DE HODGKIN