

Hodgkin Lymphoma, Version 1.2026

Ranjana H. Advani, MD^{1,*}; Christopher R. Kelsey, MD^{2,*}; Philippe Armand, MD, PhD³; Celeste M. Bello, MD, MSPH⁴; Cecil M. Benitez, MD, PhD⁵; David Bond, MD⁶; Weina Chen, MD, PhD⁷; Sheen Cherian, MD⁸; Magdalena Czader, MD, PhD⁹; Bouthaina Dabaja, MD¹⁰; Megan E. Daly, MD¹¹; Zachary Frosch, MD, MSHP¹²; Leo I. Gordon, MD¹³; Neil Hansen, MD¹⁴; Alex F. Herrera, MD¹⁵; Ephraim P. Hochberg, MD¹⁶; Richard T. Hoppe, MD^{1,*}; Iris Isufi, MD¹⁷; Patrick B. Johnston, MD, PhD¹⁸; Kara Kelly, MD¹⁹; Vaishalee P. Kenkre, MD²⁰; Justin Kline, MD²¹; Ryan C. Lynch, MD²²; Jonathan McConathy, MD, PhD²³; David Morgan, MD²⁴; Alex Niu, MD¹⁹; Suman Paul, PhD, MBBS²⁵; Rachel Rabinovitch, MD²⁶; Ali Salavati, MD, MPH⁵; Dahlia Sano, MBChB²⁷; Harsh Shah, DO²⁸; Michael Spinner, MD²⁹; Jakub Svoboda, MD³⁰; Jane N. Winter, MD¹³; Joachim Yahalom, MD³¹; Joanna C. Yang, MD, MPH^{32,*}; Sarah Montgomery, BA^{33,*}; and Katie Stehman, PA-C, MMS^{33,*}

Abstract

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Hodgkin lymphoma provide expert, multidisciplinary recommendations for the diagnosis and treatment of Hodgkin lymphoma. The panel convenes annually to update recommendations based on a review of recently published clinical trials. This selection from the NCCN Guidelines for Hodgkin Lymphoma focuses on the management of newly diagnosed and relapsed/refractory classic Hodgkin lymphoma in adults aged 18 to 60 years.

J Natl Compr Canc Netw 2026;24(2):41–60
doi:10.6004/jnccn.2026.0006

Overview

Hodgkin lymphoma (HL) is an uncommon malignancy of B-cell origin. Most patients are diagnosed between ages 15 and 30 years, followed by another peak in adults aged ≥ 55 years. In 2025, an estimated 8,720 people will be diagnosed with HL in the United States and 1,150 people will die of the disease.¹ The WHO classification divides HL into 2 main types: classic HL (CHL) and nodular lymphocyte-predominant HL (NLPHL), also known as nodular lymphocyte predominant B-cell lymphoma (NLPBL).^{2,3} In Western countries, CHL accounts for 95% and NLPHL accounts for 5% of all HL.⁴

CHL is divided into 4 subtypes: nodular sclerosis CHL; mixed cellularity CHL; lymphocyte-depleted CHL; and lymphocyte-rich CHL. CHL is characterized by the presence of Reed-Sternberg cells in an inflammatory background, whereas NLPHL lacks Reed-Sternberg cells but is characterized by the presence of lymphocytic-histiocytic cells, sometimes termed *popcorn cells*.

The past few decades have seen significant progress in the management of HL, in large part due to the advent of more effective treatment options, including novel therapies such as immune checkpoint inhibitors (CPIs). HL is among the most curable of malignancies with modern treatments, and newly diagnosed HL has a very high likelihood of being cured with

appropriate management. In fact, cure rates for HL have increased so markedly that overriding treatment considerations often relate to long-term toxicity. Clinical trials still emphasize improvement in cure rates for patients with advanced disease, but the potential long-term effects of treatment remain an important consideration.

Management of CHL in Adults Aged 18 to 60 Years

Patients are divided into the following groups after initial diagnosis and workup:

- Stage I–II
- Stage III–IV

Patients with stage I–II are further classified into the following subgroups depending on the presence or absence of NCCN unfavorable factors (Figure 1):

- Stage IA–IIA (favorable with non-bulky disease)
- Stage I–II (unfavorable with B symptoms, bulky mediastinal disease, or >10 cm adenopathy)

¹Stanford Cancer Institute; ²Duke Cancer Institute; ³Dana-Farber/Brigham and Women's Cancer Center; ⁴Moffitt Cancer Center; ⁵UCLA Jonsson Comprehensive Cancer Center; ⁶The Ohio State University Comprehensive Cancer Center-James Cancer Hospital and Solove Research Institute; ⁷UT Southwestern Simmons Comprehensive Cancer Center; ⁸Case Comprehensive Cancer Center/University Hospitals Seidman Cancer Center and Cleveland Clinic Taussig Cancer Institute; ⁹Indiana University Melvin and Bren Simon Comprehensive Cancer Center; ¹⁰The University of Texas MD Anderson Cancer Center; ¹¹UC Davis Comprehensive Cancer Center; ¹²Fox Chase Cancer Center; ¹³Robert H. Lurie Comprehensive Cancer Center of Northwestern University; ¹⁴Fred & Pamela Buffett Cancer Center; ¹⁵City of Hope National Medical Center; ¹⁶Mass General Cancer Center; ¹⁷Yale Cancer Center/Smilow Cancer Hospital; ¹⁸Mayo Clinic Comprehensive Cancer Center; ¹⁹Roswell Park Comprehensive Cancer Center; ²⁰University of Wisconsin Carbone Cancer Center; ²¹The UChicago Medicine Comprehensive Cancer Center; ²²Fred Hutchinson Cancer Center; ²³O'Neal Comprehensive Cancer Center at UAB; ²⁴Vanderbilt-Ingram Cancer Center; ²⁵Johns Hopkins Kimmel Cancer Center; ²⁶University of Colorado Cancer Center; ²⁷University of Michigan Rogel Cancer Center; ²⁸Huntsman Cancer Institute at the University of Utah; ²⁹UCSF Helen Diller Family Comprehensive Cancer Center; ³⁰Abramson Cancer Center at the University of Pennsylvania; ³¹Memorial Sloan Kettering Cancer Center; ³²Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine; and ³³National Comprehensive Cancer Network.

*Discussion Writing Committee Member.

To view disclosures of external relationships for the NCCN Guidelines panel, go to <https://www.nccn.org/guidelines/guidelines-panels-and-disclosure/disclosure-panels>

The full NCCN Guidelines for Hodgkin Lymphoma are not printed in this issue of JNCCN. The complete and most recent version of these guidelines is available free of charge at NCCN.org.

NCCN CATEGORIES OF EVIDENCE AND CONSENSUS

Category 1: Based upon high-level evidence (≥ 1 randomized phase 3 trials or high-quality, robust meta-analyses), there is uniform NCCN consensus ($\geq 85\%$ support of the Panel) that the intervention is appropriate.

Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus ($\geq 85\%$ support of the Panel) that the intervention is appropriate.

Category 2B: Based upon lower-level evidence, there is NCCN consensus ($\geq 50\%$, but $< 85\%$ support of the Panel) that the intervention is appropriate.

Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

NCCN recognizes the importance of clinical trials and encourages participation when applicable and available. Trials should be designed to maximize inclusiveness and broad representative enrollment.

PLEASE NOTE

The NCCN Guidelines® are a statement of evidence and consensus of the authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult the NCCN Guidelines® is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment. The National Comprehensive Cancer Network® (NCCN®) makes no representations or warranties of any kind regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

NCCN CATEGORIES OF PREFERENCE

Preferred: Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.

Other: Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.

Useful in certain: Other interventions that may be used for selected patient populations (defined with recommendation).

All recommendations are considered appropriate.

The standard treatment of early-stage CHL is with either combined modality therapy (CMT) or chemotherapy alone. Selection of CMT or chemotherapy alone should be based on patient age, sex, family history of cancer or cardiac disease, comorbid conditions, and sites of involvement. CMT provides for a better progression-free survival (PFS)/freedom from progression. There was no difference in overall survival (OS) in prospective randomized trials, but these studies were not powered to detect an OS benefit. All patients will benefit from

multidisciplinary team (including radiation oncology) input before final treatment decisions. Chemotherapy alone may be preferred for individuals assigned female at birth with intact breast tissue who are < 30 years where recommended RT dose-volume histogram constraints for breast tissue are exceeded, if cardiac constraints cannot be met, or in the presence of high-risk comorbidities. Alternatively, CMT may be preferred if the doxorubicin dose would exceed 200 mg/m^2 provided that breast and cardiac radiation constraints can be met.

UNFAVORABLE RISK FACTORS**Unfavorable Risk Factors for Stage I-II Hodgkin Lymphoma**

Risk Factor	GHSG	EORTC	NCCN
Age		$\geq 50 \text{ mm/hr}$	
ESR and B symptoms	$\geq 50 \text{ mm/hr}$ if A; $\geq 30 \text{ mm/hr}$ if B	$\geq 50 \text{ mm/hr}$ if A; $\geq 30 \text{ mm/hr}$ if B	$\geq 50 \text{ mm/hr}$ or any B symptoms
Mediastinal mass ⁿ	MMR > 0.33	MTR > 0.35	MMR > 0.33
# Nodal regions	$\geq 3^*$	$\geq 4^*$	≥ 4
E lesion	any		
Bulky ⁿ			$> 10 \text{ cm}$

GHSG = German Hodgkin Study Group
EORTC = European Organization for
Research and Treatment of Cancer

MMR = Mediastinal mass ratio, maximum width of mass/maximum intrathoracic diameter as measured on chest radiograph (CXR)
MTR = Mediastinal thoracic ratio, maximum width of mediastinal mass/intrathoracic diameter at T5-6 as measured on CXR

International Prognostic Score (IPS) 1 point per factor (advanced disease)[†]

- Albumin $< 4 \text{ g/dL}$
- Hemoglobin $< 10.5 \text{ g/dL}$
- Male
- Age ≥ 45 years
- Stage IV disease
- Leukocytosis (white blood cell count $\geq 15,000/\text{mm}^3$)
- Lymphocytopenia (lymphocyte count $< 8\%$ of white blood cell count, and/or lymphocyte count $< 600/\text{mm}^3$)

[†]From: Hasenclever D, Diehl V. A prognostic score for advanced Hodgkin's disease. International Prognostic Factors Project on Advanced Hodgkin's Disease. N Engl J Med 1998;339:1506-1514. Copyright © 1998 Massachusetts Medical Society. Adapted with permission.

* Note that the EORTC includes the infraclavicular/subpectoral area with the axilla while the GHSG includes it with the cervical. Both EORTC and GHSG combine the mediastinum and bilateral hila as a single region.

ⁿ The definition of mediastinal bulk is best assessed with a standard CXR, as practice-changing studies utilized this staging modality. If a staging CXR is not obtained, disease bulk can also be assessed with CT. In this scenario, a single mass or nodal conglomerate measuring (in any direction) $> 1/3$ the maximum transverse diameter of the chest, or any tumor mass or nodal conglomerate $> 10 \text{ cm}$ (also measured in any direction) should be considered "bulky."

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Continued

HODG-3

Figure 1. HODG-3. NCCN Clinical Practice Guidelines in Oncology for Hodgkin Lymphoma, Version 1.2026.