NON-HODGKIN LYMPHOMA TREATMENT REGIMENS:
AIDS-Related B-Cell Lymphomas (Part 1 of 3)

Clinical Trials: The NCCN recommends cancer patient participation in clinical trials as the gold standard for treatment. Cancer therapy selection, dosing, administration, and the management of related adverse events can be a complex process that should be handled by an experienced healthcare team. Clinicians must choose and review treatment options based on the individual patient; drug dose modifications and supportive care interventions should be administered accordingly. The cancer treatment regimens below may include both U.S. Food and Drug Administration-approved and unapproved indications/regimens. These regimens are only provided to supplement the latest treatment strategies. These Guidelines are a work in progress that may be refined as often as new significant data becomes available. The NCCN Guidelines® are a consensus statement of its authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult any 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 makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

Burkitt Lymphoma1*

Note: All recommendations are Category 2A unless otherwise indicated.

<table>
<thead>
<tr>
<th>REGIMEN</th>
<th>DOISING</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDE (cyclophosphamide + doxorubicin + etoposide) + rituximab2-4</td>
<td>Days 1–4: Cyclophosphamide 187.5–200mg/m² IV + doxorubicin 12.5mg/m² IV + etoposide 60mg/m² IV Day 1: Rituximab 375mg/m² IV just before CDE regimen. Repeat cycle every 4 weeks for a maximum of 6 cycles.</td>
</tr>
</tbody>
</table>

CO DOX-M/IVAC (modified) (cyclophosphamide + vincristine + doxorubicin + high-dose methotrexate alternating with ifosfamide + etoposide + high-dose cytarabine)5-7 | Days 1: Cyclophosphamide 800mg/m² IV, followed by Days 2–5: Cyclophosphamide 200mg/m² IV Day 1: Doxorubicin 40mg/m² IV Days 1 and 8: Cycle 1: Vincristine 1.5mg/m² IV; Cycle 2: Days 1, 8, and 15. Day 1: MTX 1,200mg/m² IV over 1 hour, followed by 240mg/m²/hour over 23 hours. Days 1 and 3: Cytarabine 70mg intrathecally. Day 1: Rituximab 375mg/m² IV. Day 15: MTX 12mg intrathecally. Alternate with: Days 1–5: Ifosfamide 1,500mg/m² IV + etoposide 60mg/m² IV Days 1 and 2: Cytarabine 2,000mg/m² IV every 12 hours for 4 doses Day 1: Rituximab 375mg/m² IV Day 15: MTX 12mg intrathecally. |

Dose-adjusted EPOCH (etoposide + prednisone + vincristine + cyclophosphamide + doxorubicin) + rituximab6-10* | Days 1–4: Etoposide 50mg/m² IV + prednisone 60mg/m² orally + vincristine 0.4mg/m² IV + doxorubicin 10mg/m² IV Day 1: Rituximab 375mg/m² IV Day 5: Prednisone 60mg/m² orally Day 5: Cycle 1: Cyclophosphamide 375mg/m² IV if CD4 cells ≥100/mm³ OR 187mg/m² IV if CD4 cells <100/mm³. Cyclophosphamide dose-adjustment (after Cycle 1): If nadir ANC >500/mcL, then increase by 187mg above previous cycle. If nadir ANC <500/mcL, or platelets <25,000/mcL, then decrease by 187mg below previous cycle. Repeat cycle every 3 weeks. |

HyperCVAD (cyclophosphamide + vincristine + doxorubicin + dexamethasone alternating with high-dose methotrexate and cytarabine)11-13 Days 1, 3, and 5–7–HyperCVAD | Cycles 1, 3, 5, and 7–HyperCVAD Days 1–3: Cyclophosphamide 300mg/m² IV every 12 hours for 6 doses, plus mesna 600mg/m² continuous IV Days 4 and 11: Vincristine 2mg IV Day 4: Doxorubicin 50mg/m² IV. Days 1–4 and Days 11–14: Dexamethasone 40mg daily. Cycles 2, 4, 6, 8—High-dose MTX and Cytarabine Day 1: MTX 1g/m² IV over 24 hours Days 2 and 3: Cytarabine 3g/m² IV every 12 hours for 4 doses. Repeat every 3 weeks for 8 cycles. |

Diffuse large B-cell lymphoma, lymphoma associated with Castleman’s disease, and primary effusion lymphoma1* | Days 1–4: Etoposide 50mg/m² IV + prednisone 60mg/m² orally + vincristine 0.4mg/m² IV + doxorubicin 10mg/m² IV Day 1: Rituximab 375mg/m² IV Day 5: Prednisone 60mg/m² orally Day 5: Cycle 1: Cyclophosphamide 375mg/m² IV if CD4 cells ≥100/mm³ OR 187mg/m² IV if CD4 cells <100/mm³. Cyclophosphamide dose-adjustment (after Cycle 1): If nadir ANC >500/mcL, then increase by 187mg above previous cycle. If nadir ANC <500/mcL, or platelets <25,000/mcL, then decrease by 187mg below previous cycle. Repeat cycle every 3 weeks. |
Diffuse large B-cell lymphoma, lymphoma associated with Castleman's disease, and primary effusion lymphoma\(^1\) (continued)

<table>
<thead>
<tr>
<th>REGIMEN</th>
<th>DOISING</th>
</tr>
</thead>
</table>
| **CDE (cyclophosphamide + doxorubicin + etoposide) + rituximab**\(^2\) | **Days 1–4:** Cyclophosphamide 187.5–200mg/m\(^2\) IV + doxorubicin 12.5mg/m\(^2\) IV + etoposide 60mg/m\(^2\) IV  
Day 1: Rituximab 375mg/m\(^2\) IV just before CDE regimen. Repeat cycle every 4 weeks for a maximum of 6 cycles. |
| **CHOP + rituximab**\(^3\)\(^–\)\(^5\) | **Option 1—Modified CHOP**  
Day 1: Cyclophosphamide 375mg/m\(^2\) IV + doxorubicin 25mg/m\(^2\) IV + vincristine 1.4mg/m\(^2\) IV (2mg maximum)  
Days 1–5: Prednisone 100mg orally  
Day 1: Rituximab 375mg/m\(^2\) IV. Repeat cycle every 3 weeks for at least 4 cycles, or for 2 cycles after complete response.  
**Option 2—Standard-dose CHOP**  
Day 1: Cyclophosphamide 750mg/m\(^2\) IV + doxorubicin 50mg/m\(^2\) IV + vincristine 1.4mg/m\(^2\) IV (2mg maximum)  
Days 1–5: Prednisone 100mg orally  
Day 1: Rituximab 375mg/m\(^2\) IV. Repeat cycle every 3 weeks for at least 4 cycles, or for 2 cycles after complete response. |

**Plasmablastic Lymphoma**\(^6\)\(^–\)\(^8\)

<table>
<thead>
<tr>
<th>REGIMEN</th>
<th>DOISING</th>
</tr>
</thead>
</table>
| **CODOX-M/IVAC (modified)** (cyclophosphamide + vincristine + doxorubicin + high-dose methotrexate alternating with ifosfamide + etoposide + high-dose cytarabine)**\(^9\)\(^–\)\(^11\) | **Day 1:** Cyclophosphamide 800mg/m\(^2\) IV, followed by  
**Days 2–5:** Cyclophosphamide 200mg/m\(^2\) IV  
Day 1: Doxorubicin 40mg/m\(^2\) IV  
Days 1 and 8: **Cycle 1:** Vincristine 1.5mg/m\(^2\) IV; **Cycle 2:** Days 1, 8, and 15.  
Day 1: MTX 1,200mg/m\(^2\) IV over 1 hour, followed by 240mg/m\(^2\)/hour over 23 hours.  
Days 1 and 3: Cytarabine 70mg intrathecally.  
Day 1: Rituximab 375mg/m\(^2\) IV.  
Day 15: MTX 12mg intrathecally.  
**Alternate with:**  
Days 1–5: Ifosfamide 1,500mg/m\(^2\) IV + etoposide 60mg/m\(^2\) IV  
Days 1 and 2: Cytarabine 2,000mg/m\(^2\) IV every 12 hours for 4 doses  
Day 1: Rituximab 375mg/m\(^2\) IV  
Day 15: MTX 12mg intrathecally. |
| **Dose-adjusted EPOCH (etoposide + prednisone + vincristine + cyclophosphamide + doxorubicin) + rituximab**\(^6\)\(^–\)\(^10\)\(^*\) | **Days 1–4:** Etoposide 50mg/m\(^2\) IV + prednisone 60mg/m\(^2\) orally + vincristine 0.4mg/m\(^2\) IV + doxorubicin 10mg/m\(^2\) IV  
Day 1: Rituximab 375mg/m\(^2\) IV  
Day 5: Prednisone 60mg/m\(^2\) orally  
Day 5: **Cycle 1:** Cyclophosphamide 375mg/m\(^2\) IV if CD4 cells \(\geq 100/m^3\) OR 187mg/m\(^2\) IV if CD4 cells <100/m\(^3\).  
**Cyclophosphamide dose-adjustment (after Cycle 1):** If nadir ANC >500/mcl, then increase by 187mg above previous cycle. If nadir ANC <500/mcl, or platelets <25,000/mcl, then decrease by 187mg below previous cycle. Repeat cycle every 3 weeks. |
| **HyperCVAD (cyclophosphamide + vincristine + doxorubicin + dexamethasone alternating with high-dose methotrexate and cytarabine)**\(^11\)\(^–\)\(^13\) | **Cycles 1, 3, 5, and 7—HyperCVAD**  
Days 1–3: Cyclophosphamide 300mg/m\(^2\) IV every 12 hours for 6 doses, plus mesna 600mg/m\(^2\) continuous IV  
Days 4 and 11: Vincristine 2mg IV  
Day 4: Doxorubicin 50mg/m\(^2\) IV.  
Days 1–4 and Days 11–14: Dexamethasone 40mg daily.  
**Cycles 2, 4, 6, 8—High-dose MTX and Cytarabine**  
Day 1: MTX 1g/m\(^2\) IV over 24 hours  
Days 2 and 3: Cytarabine 3g/m\(^2\) IV every 12 hours for 4 doses. Repeat every 3 weeks for 8 cycles. |

**Primary CNS Lymphoma**\(^1\)\(^–\)\(^4\)

- Consider high-dose methotrexate.  
- Consider RT alone.  
- For select patients with good performance status on HAART, see NCCN Guidelines for CNS.  
- Best supportive care.  

\* Granulocyte colony-stimulating factor (GCSF) should be given to all patients. If patients are CD20-negative, rituximab is not indicated. If CD4 <100, consider eliminating rituximab.

\† Standard CHOP is not adequate therapy.\(^1\)
References


