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Commentary Open Access

# Older Patients with Lymphoma

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## Commentary

Lymphoma is a collection of malignant lymphocyte neoplasms with over 90 subtypes. Non-Hodgkin lymphoma and Hodgkin lymphoma are the two most common classifications. Lymphoma affects about 82,000 people in the United States every year. Smoking and obesity are two key modifiable risk factors, with genetic, viral, and inflammatory etiologies also playing a role. Lymphoma usually begins as a painless adenopathy, with systemic symptoms such as fever, unexplained weight loss, and night sweats developing as the disease progresses. When it comes to diagnosis, an open lymph node biopsy is suggested. To stage lymphoma, the Lugarno classification system takes into account symptoms and the extent of the disease as seen on positron emission tomography/computed tomography. The primary subtypes of lymphoma require different chemotherapy treatment approaches. CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) with or without rituximab (R-CHOP), bendamustine, and lenalidomide are all used to treat non-Hodgkin lymphoma. Hodgkin lymphoma is treated with a combination of ABVD (doxorubicin, bleomycin, vinblastine, vincristine, bleomycin, topside, and prednisone) and radiotherapy. Neuropathy, cardio toxicity, and secondary malignancies like lung and breast cancer are all side effects of chemotherapy that should be considered throughout the joint decision-making process when choosing a treatment schedule. Patients should be monitored for problems and relapse after achieving remission, in addition to age-appropriate tests recommended by the US Preventive Services Task Force. Because lymphoma is an immunosuppressive disease, patients should receive a 13-valent pneumococcal conjugate vaccine followed by a 23-valent pneumococcal polysaccharide vaccine at least eight weeks later, along with other age-appropriate vaccines. Immunizations for household contacts should also be up to date [1].

One-half of newly diagnosed lymphoma patients are over the age of 60, with a large number over the age of 80. Because of the presence of concomitant illnesses, older lymphoma patients may not tolerate the high-dose therapy employed in younger patients. Diffuse large B-cell lymphoma accounts for more than 60% of all lymphomas seen in the elderly [2]. The clinical appearance and prognosis indicators are the same as in young patients. Even when patients are treated with the cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) regimen, the response rate in senior individuals is usually lower than in young people. As a result, even while disease-free survival rates are not much lower in the elderly, event-free and overall survival rates are lower. The addition of rituximab to the CHOP regimen has recently been proven to improve the survival of these older patients while lowering the treatment's toxicity. Except for those with significant organ failure related to other conditions, patients over the age of 80 can be treated with rituximab plus CHOP. After relapse, only a small percentage of these elderly patients may benefit from salvage treatment. In 2019, more than 82,000 new lymphoma patients are expected to be diagnosed, accounting for 4.7 percent of all new cancer cases in the United States [3]. Non-Hodgkin lymphoma has a five-year survival rate of 72.0 percent, while Hodgkin lymphoma has an 86.6 percent survival rate. Lymphoma is expected to kill over 21,000 people in 2019, accounting for 3.5 percent of all cancer fatalities. Non-Hodgkin lymphoma is more common in men and whites, and it gets worse with age. Patients with non-Hodgkin lymphoma are on average 67 years old when they are diagnosed, and 76 years old when they die. Because of the better survival rate among younger patients, Hodgkin lymphoma is most usually diagnosed between the ages of 20 and 34. However, the median age at death is 68.

Lymphoma is caused by a combination of genetic, infectious, and inflammatory factors. Patients with non-Hodgkin lymphoma and Hodgkin lymphoma had a 1.7-fold and 3.1-fold greater chance of getting lymphoma, respectively. A family history of a certain lymphoma subtype is linked to the development of that subtype. Infection raises lymphoma risk through three main mechanisms: direct lymphocyte transformation, immunosuppression, and chronic antigenic stimulation. Rheumatoid arthritis, systemic lupus erythematous, Jorgen syndrome, dermatomyositis, and celiac disease are inflammatory diseases that raise the risk of lymphoma due to illness-specific reasons and the use of immunosuppressive medicines on a long-term basis. Current or previous cigarette use, as well as obesity, are modifiable risk factors (body mass index of 30 kg per m2 or higher). Non-Hodgkin lymphoma has also been linked to breast implants and long-term pesticide exposure [4].

Adenopathy is a common symptom of lymphoma. Indolent adenopathy can wax and wane over years, whereas more severe varieties can have fast progressing adenopathy. Hodgkin lymphoma is most commonly found in the lymph nodes above the diaphragm. Non-Hodgkin lymphoma can develop everywhere in the body, including subtypes starting in the gastrointestinal tract, skin, and central nervous system. Fever, unexplained weight loss, and night sweats are common systemic symptoms in patients with severe illness. Direct invasion or haematogenous dissemination to the spleen, liver, lungs, or bone marrow allows lymphoma to spread to extra nodal locations [5]. Because of the structural compression caused by the expanding tumour, high-grade lymphomas can present as oncologic emergencies, such as superior vena cava syndrome, malignant epidural spinal cord compression, or malignant pericardial effusion. Lymphoma causes Para neoplastic cerebellar degeneration in Hodgkin lymphoma and dermatomyositis and polymyositis in Hodgkin and non-Hodgkin lymphomas, respectively.

An open lymph node biopsy is used to diagnose lymphoma, which is based on morphology, immunohistochemistry, and flow cytometer. Although fine-needle aspiration and core needle biopsy are frequently used to evaluate adenopathy, neither will offer enough tissue to diagnose lymphoma since Hodgkin lymphoma must be confirmed by the presence of Reed-Sternberg cells.

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## Conflict of Interest

None

### References

1. Mareschal S, Lanic H, Ruminy P (2011) The proportion of activated B-cell like subtype among de novo diffuse large B-cell lymphoma increases with age. Haematologica 96:1888-1890.
2. Trebouet A, Marchand T, Lemal R (2013) Lymphoma occurring in patients over 90 years of age: characteristics, outcomes, and prognostic factors. Ann Oncol 24:2612-2618.
3. Clark TG, Altman DG, De Stavola BL (2002) Quantification of the completeness of follow-up. Lancet 359:1309–1310.
4. Huang B, Law MW, Khong PL (2009) Whole-body PET/CT scanning: estimation of radiation dose and cancer risk. Radiology 251:166–174.
5. Ng AK, Travis LB (2008) Second primary cancers: an overview. Hematol Oncol Clin North Am 22:271–289, vii.