23rd INTERNATIONAL ULTMANN CHICAGO LYMPHOMA SYMPOSIUM

APRIL 10-11, 2026

JW MARRIOTT CHICAGO

#IUCLS2026

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23rd INTERNATIONAL ULTMANN CHICAGO LYMPHOMA

Immune Chaos: Navigating Checkpoint Inhibitor Toxicities in Hodgkin Lymphoma

Kaitlin Kelly, PharmD, BCOP
Clinical Pharmacist Specialist, Lymphoma and Multiple Myeloma
University of Chicago Medicine

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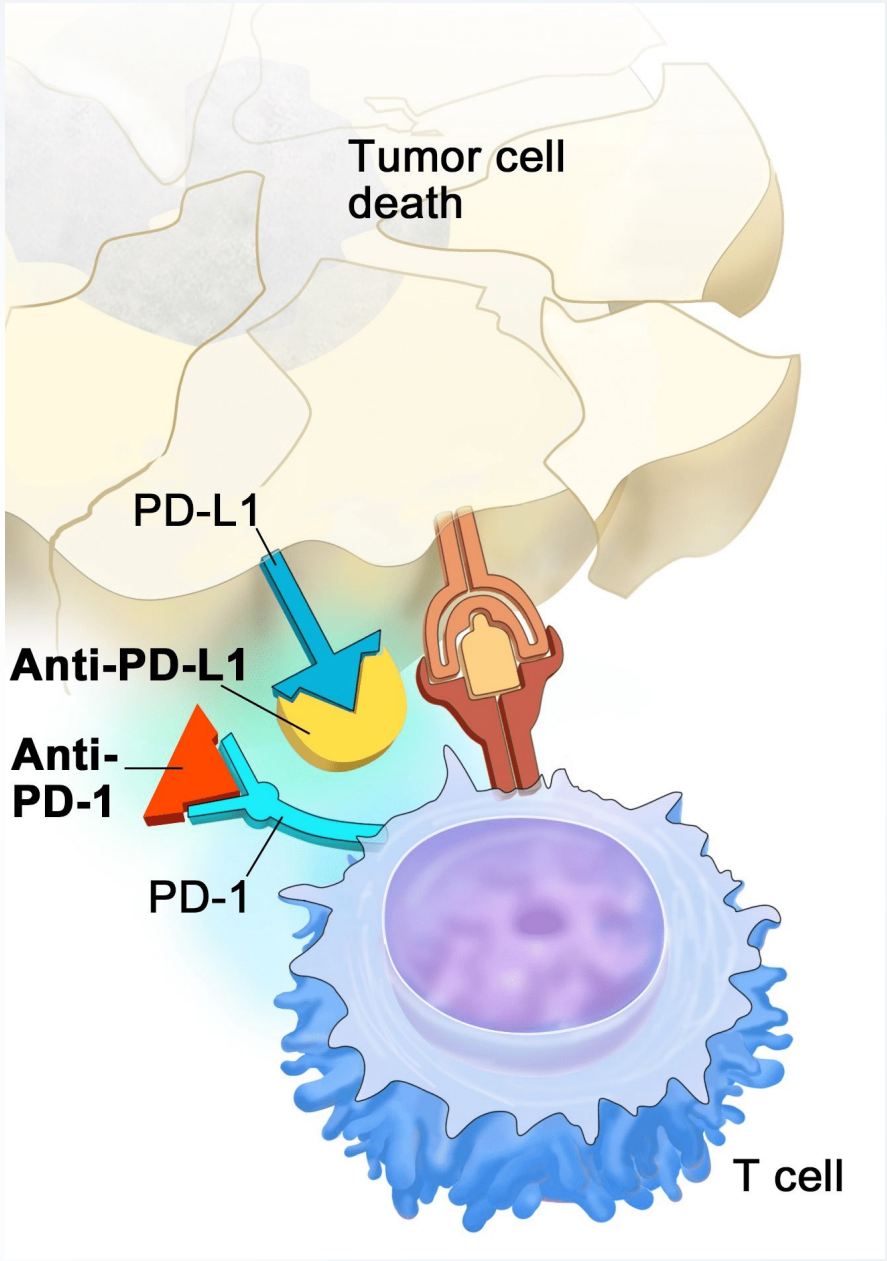
Disclosure

Nothing to disclose

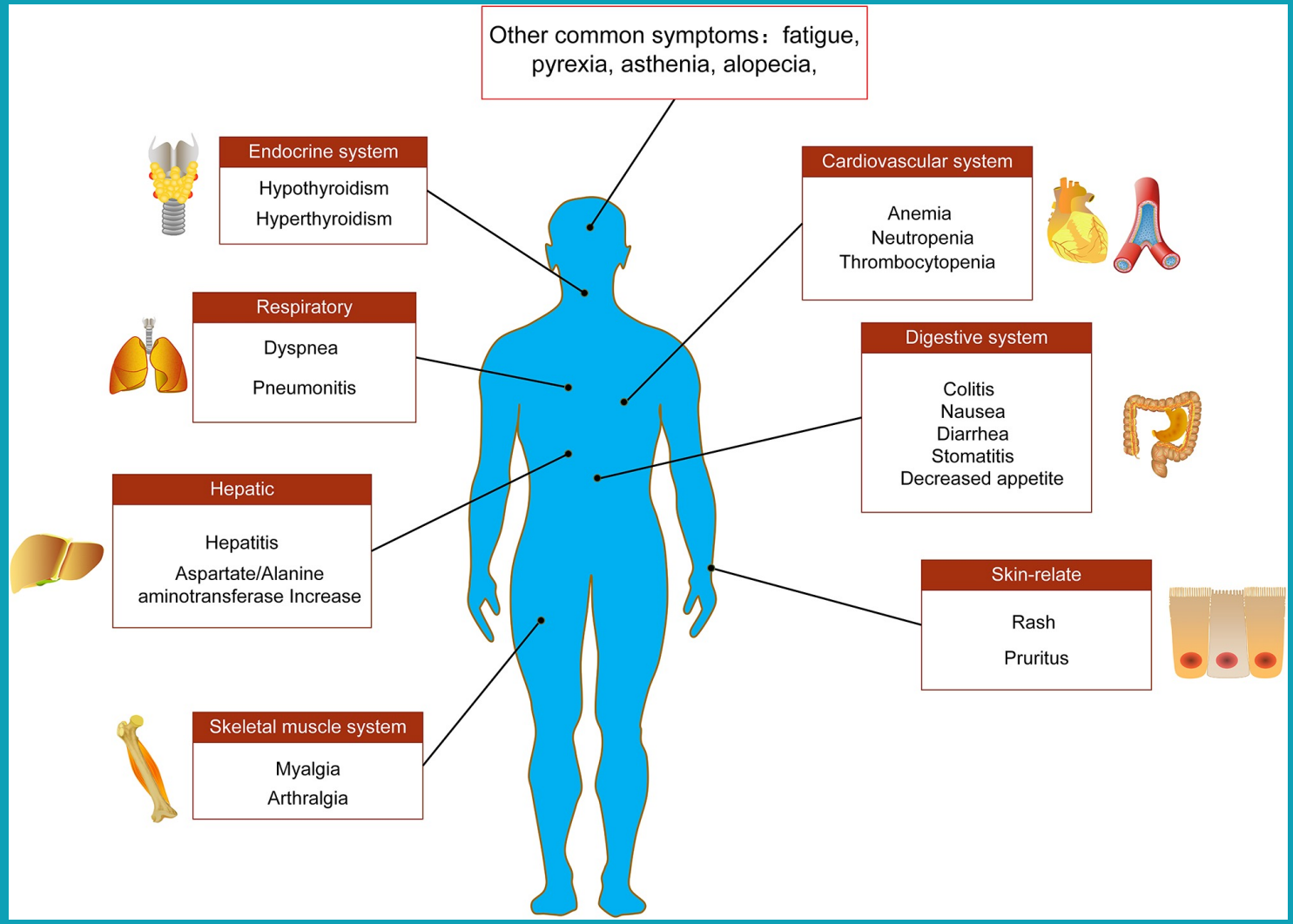
Checkpoint Inhibitors and Hodgkin Lymphoma

Malignant Reed-Sternberg cells overexpress PD-L1 / PD-L2 due to 9p24.1 genetic amplification



Moy RH, Younes A. Immune Checkpoint Inhibition in Hodgkin Lymphoma. *Hemasphere*. 2018;2(1):e20. Published 2018 Feb 16.

Immune Related Adverse Events (IrAEs)



Martins F, Sofiya L, Sykiotis GP, et al. Adverse effects of immune-checkpoint inhibitors: epidemiology, management and surveillance. *Nat Rev Clin Oncol*. 2019;16(9):563-580.

Hodgkin Lymphoma and Checkpoint Inhibitors

Trial	Regimen	# of Cycles	# of Patients	Elevated AST/ALT	Rash/ Skin	Thyroid Dysfunction	Adrenal Insufficiency	Pneumonitis	Colitis
SWOG S1826 *Advanced cHL*	Nivo-AVD arm	6 cycles	483	30-35%	25%	7%	-	2%	1%
NIVAHL Trial *Early Stage Unfavorable cHL*	Nivo-AVD	4 cycles + IS-RT	109	25%	10-25%	21%	-	<2%	2-5%
MSKCC Pembro-GVD	Pembro-GVD	2-4 cycles	39	41%	15%	10-15%	-	<5%	3-5%
NICE	Nivolumab x 2 to Nivo-ICE	2-3 cycles	35	1-2%	1-3%	1%	-	-	-
CHECKMATE 205	Nivolumab	Until disease progression	243	11%	10-15%	17%	1%%	7%	5%
KEYNOTE-087	Pembrolizumab	Until disease progression	210	20-30%	11-20%	10-15%	-	3%	1-2%
Advani et al (2021)	BV-Nivolumab	4 cycles	91	1%	5%	0%		4%	1%

Immune Checkpoint Inhibitor Related Toxicities

Acute = Reversible Damage

- Rapid T-cell Activation
- Inflammatory Surge from rapid proliferation of autoreactive T-cells
- Typically, reversible damage from inflammation to specific organs

Chronic = Irreversible Damage

- T-cell mediated destruction of specialized cells affecting endocrine glands
- Persistent T-cell activation that waxes and wanes, leading to autoimmune conditions
- Reactivation of memory T-cells causing persistent dysfunction

Complications of Checkpoint Inhibitors

Acute Complications

- Dermatologic
- Hepatotoxicity
- Gastrointestinal
- Pulmonary
- Hematologic

Chronic Complications

- Endocrine Dysfunction
- Acute to Chronic Complications

Management of Immunotherapy-Related Toxicities. Version 1.2026 © 2026 National Comprehensive Cancer Network© (NCCN©)

Acute: Dermatologic Toxicity

Dermatologic

Onset:
2-4 weeks

Symptoms:

- Maculopapular Rash
- Pruritus
- Bullous dermatitis
- Stevens-Johnson syndrome (SJS) or Toxic Epidermal necrolysis (TEN)
- Lichen planus and lichenoid diseases
- Psoriasis and psoriasiform diseases

Acute: Dermatologic Toxicity

Maculopapular Rash

Consider dermatological consult

Grade 1
Less than 10% BSA

- Continue immunotherapy
- Topical emollient and moderate potency steroids to areas
- Pruritus: Antihistamines

Grade 2
10-30% BSA

- Continue immunotherapy
- Topical emollient + moderate-high potency steroids
- Pruritus: Antihistamines
- If unresponsive within 1 week consider oral prednisone 0.5 mg/kg/day

Grade 3
>30% BSA

- HOLD immunotherapy
- High potency topical steroids
- Oral prednisone 0.5-1 mg/kg/day
  - Increase to 2 mg/kg/day if no improvement
- Consider inpatient care

Management of Immunotherapy-Related Toxicities. Version 1.2026 © 2026 National Comprehensive Cancer Network© (NCCN©)

Acute: Hepatotoxicity

Hepatobiliary Toxicity

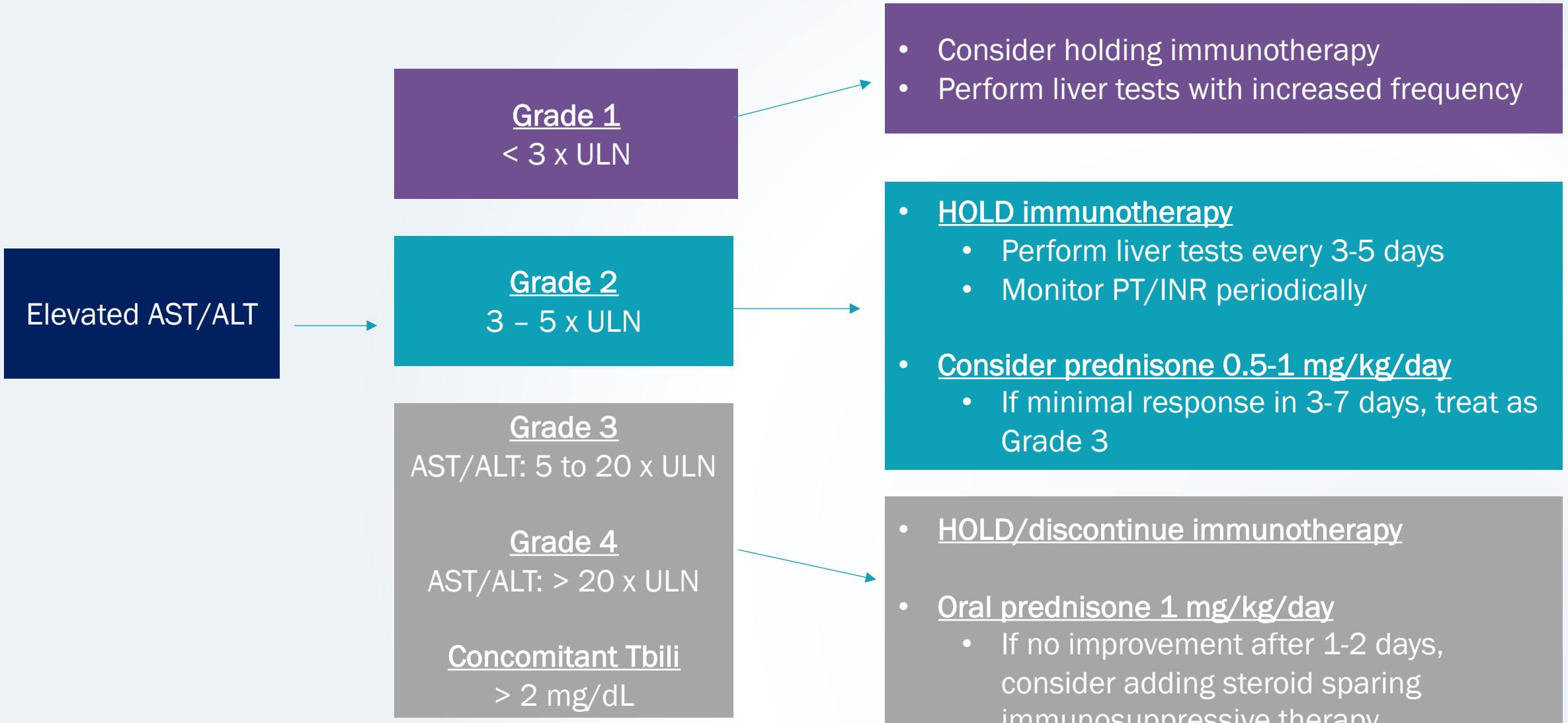
Onset:

6-14 weeks

Symptoms

- Mainly asymptomatic
- Assess hepatotoxic medications
- Consider CK, aldolase, and ferritin
- Consider abdominal US
- Consider hepatology referral

Acute: Hepatotoxicity



Steroid Refractory Autoimmune Hepatitis

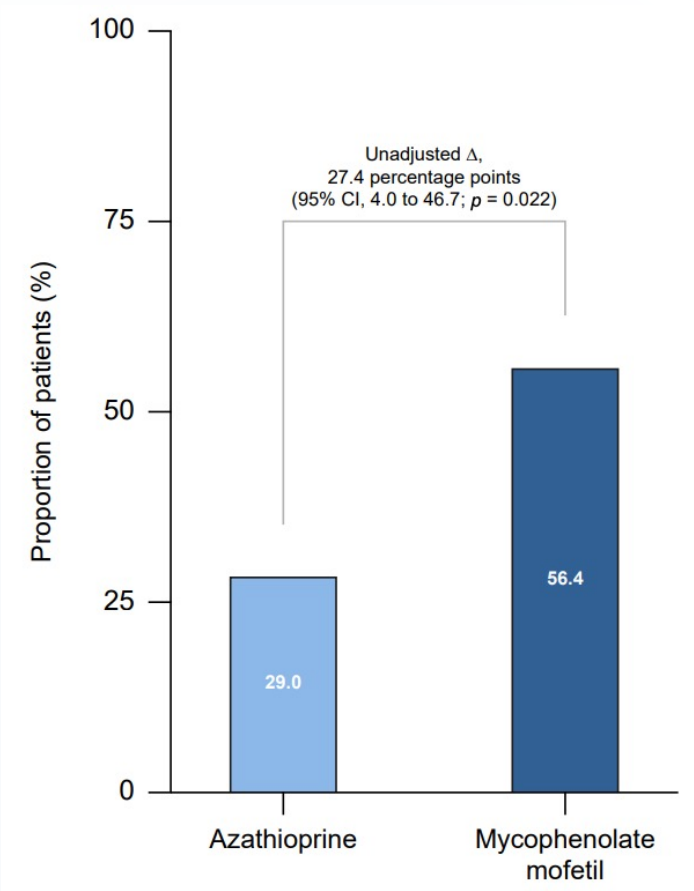
- Incidence: 0.3-1.5%
- Recommend urgent GI/hepatology referral
- Steroid refractory: No improvement after 1-2 days of prednisone

Prednisone 0.5-1 mg/kg/day

Mycophenolate mofetil (MMF)
Max dose: 1.5 g every 12 hours

Tacrolimus
Lowest dose with biochemical response (no goal trough)

Azathioprine vs. MMF in steroid refractory autoimmune hepatitis



Chronic: Endocrine Dysfunction

Thyroiditis / Hypothyroidism	→	Onset: 4-8 weeks	→ Symptoms • Fatigue • Weight gain • Cold Intolerance • Arthralgias • Hair thinning • Constipation
Hypophysitis / Adrenal Insufficiency	→	Onset: 8-12 weeks	→ Symptoms • Fatigue • Nausea • Anorexia • Weakness • Abdominal pain • Hypotension

Chronic: Endocrine Dysfunction

Hypothyroidism

- Monitor TSH
  - Baseline
  - Every 4-6 weeks

Subclinical Hypothyroidism
TSH: 4 to <10, Normal FT4, patient asymptomatic

- Continue immunotherapy and monitor

Subclinical Hypothyroidism
Elevated TSH (>10) and normal FT4

- Continue immunotherapy
- Consider levothyroxine 1.2 – 1.4 mcg/kg/day
  - Especially if symptomatic

Overt Hypothyroidism
Elevated TSH (>10) and low FT4

- Continue immunotherapy once adrenal insufficiency is ruled out
- Start levothyroxine 1.2 – 1.4 mcg/kg/day
- Monitor TSH in 4-6 weeks for dose change

Chronic: Endocrine Dysfunction

Thyrotoxicosis

- Low or suppressed TSH + high FT4/total T3
  - Continue immunotherapy if asymptomatic
  - Consider propranolol or atenolol or metoprolol as needed
  - Endocrinology referral recommended
  - Repeat TFTs in 4-6 weeks

Adrenal Insufficiency

- High ACTH with low morning cortisol, abdominal cosyntropin stimulation test
  - Overall rare diagnosis
  - Endocrinology referral recommended

Acute to Chronic Immune Checkpoint Inhibitor Related Toxicities

Pneumonitis

- Onset: 8-12 weeks
  - May become chronic if fibrotic and last months to years
  - Monitor with history of bleomycin exposure in R/R setting

Colitis

- Onset: 5-10 weeks
  - Monitor if chemotherapy is a part of treatment

Dermatologic

- Onset 2-6 months
  - Chronic autoimmune skin disease may persist
    - Monitor with rheumatologic adverse events (inflammatory arthritis, myositis)

Other Considerations

Previous Autoimmune Disease

What we know:

- Excluded from HL clinical trials
- Clinical practice: controversial

Where the dilemma lies:

- Risk of an autoimmune flare
- Risk of Immune Checkpoint Inhibitor Related Toxicities

Meta-analysis studies (including hematological cancers)

- Most included psoriasis, rheumatoid arthritis, and inflammatory bowel disease
- Median onset of flare: ~2 months from therapy initiation
- Majority of flares were mild-moderate and noted in ~30-40% of patients

Clinical Practice Considerations

- Select patients with well controlled autoimmune disease may be eligible
- Collaborate with autoimmune specialist
- Low barrier for early steroid use

Zhang K, Kong X, Li Y, Wang Z, Zhang L, Xuan L. PD-1/PD-L1 Inhibitors in Patients With Preexisting Autoimmune Diseases. *Front Pharmacol.* 2022;13:854967. Published 2022 Mar 18.
Maeda O. Immune checkpoint inhibitors for patients with pre-existing autoimmune diseases. *Nagoya J Med Sci.* 2023;85(1):33-34.

Immune Checkpoint Inhibitor Toxicity Summary

0-4 weeks	4-8 weeks	8-12 weeks	3-6 months	Over 6 months / post-treatment
• Rash, pruritus • Rare myocarditis	• Thyroiditis • Hematologic • Early hepatitis	• Colitis • Pneumonitis • Hypophysitis	• Pneumonitis • Nephritis • Rheumatologic	• Chronic endocrinopathies • Persistent arthritis • Fibrotic lung disease

Considerations

Is this a reversible or irreversible toxicity?

Which management: Topical vs. oral corticosteroids or hormone therapy?

Should a referral be placed to another specialist for co-management?

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Thank you!

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Kaitlin.kelly2@uchicagomedicine.org

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