台灣婦癌醫學會會訊

2011 年 4,5 月

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壹、 會務報告

一、本會主辦之癌症聯合年會圓滿閉幕

第 16 屆全國癌症聯合年會由本會主辦，已於 5 月 1 日圓滿閉幕。除了豐富的內容與精采的演講，本次年會的 welcome party 更是令人印象深刻；臺北賓館原本是總統府與外交部專門用來接待外賓的場所，而我們竟然能到臺北賓館舉辦 welcome party，並請蕭副總統頒獎，實在相當特別。

二、2011 年會員大會

於 4 月 30 日在國防醫學大學 32 教室舉行。本年度婦癌醫學會婦癌專科證書更新方面，共計有 71 人通過審核，3 人不通過。其他相關報告與討論事項，請見附件一。

三、6/26 臺灣婦科達文西手術論壇

中華民國婦癌醫學會與三總婦產部、台灣婦產科醫學會及台北榮總婦產部擬於民國 100 年 6 月 26 日假三總 B1 第二會議協辦研討會(Robotic GYN Surgery Symposiumin Taiwan, 2011/ 2011 台灣婦科達文西手術論壇)，敬請撥冗出席。因場地座位有限，故採報名方式參加。報名聯絡方式如下:

E-mail: gyntsgh2@gmail.com　　傳　真: 02-87927199

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會議議程請見附件二。

四、6/30 為 ASGO abstract 期限

- ASGO 2011 (Asian Society of Gynecologic Oncology 2nd Biennial Meeting)
  - Date: November 4-5, 2011
  - Venue: The Ritz-carlton Seoul, Seoul, Korea
  - Important Days:
    - Abstract Submission Due: 30, June, 2011
    - Abstract Acceptance Notice: 31, August, 2011
    - Pre-registration Due: 31, August, 2011

五、7/9 東區婦癌學術研討會

敬邀參加民國 100 年 7 月 9 日(星期六)假花蓮慈濟醫院協力樓二樓合心講堂舉辦的「東區婦癌學術研討會」，講題精采，敬請撥冗參加，躍踴出席。會議議程

請見附件三。

六、8/20-8/21 中區婦癌學術研討會暨腹腔鏡工作坊

本會擬於 100 年 8 月 20 日至 21 日(星期六、日)舉辦**中區婦癌學術研討會暨腹腔鏡工作坊**，為致力提昇會員們對於使用腹腔鏡治療早期子宮內膜癌的學術與技術，此次活動採專題演講、討論及腹腔鏡工作坊。8/20-21 之中區婦癌學術研討會**採報名方式參加，請於 6/30(星期四前)惠予回覆報名回條。**會議內容與報名回條請見附件四之 a、四之 b。

七、近期國內外婦癌相關活動一覽表

日期	活動名稱	活動地點
2011/6/26	2011 台灣婦科達文西手術論壇	三總 B1 第二會議廳
2011/7/9	東區婦癌學術研討會	花蓮慈濟醫院協力樓二樓合心講堂
2011/8/20-8/21 W 六~W 日	中區婦癌學術研討會暨腹腔鏡工作坊及第六次理監事會議	童綜合醫院梧棲院區、台中彰濱
2011/11/4-11/5	2nd ASGO biennial meeting	Seoul, Korea
2011/11/19-11/20 W 六~W 日	中區婦癌學術研討會及第七次理監事會議	台中榮總
2012/10/13-10/16	14th IGCS (http://www2.kenes.com/igcs2012/Pages/home.aspx)	Vancouver, Canada

八、學會網站誠徵文稿

歡迎各位會員踴躍賜稿，以充實學會的網站內容。來稿請e-mail至
tago.gyn@gmail.com

貳、近期文獻摘選

<<<子宮頸類>>>

Ref A cisplatin + gemcitabine:當今最強的 CCRT regimen.

Phase III, open-label, randomized study comparing concurrent gemcitabine plus cisplatin and radiation followed by adjuvant gemcitabine and cisplatin versus concurrent cisplatin and radiation in patients with stage IIB to IVA carcinoma of the cervix. (J Clin Oncol. 2011 May 1;29(13):1678-85)

Ref B 大勢所趨，cervical screening 將邁向 HPV-based, longer screening interval. Human papillomavirus testing in the prevention of cervical cancer. (J Natl Cancer Inst. 2011 Mar 2;103(5):368-83)

Ref C 前哨淋巴結極準確（當雙側皆有測到的時候） Bilateral negative sentinel nodes accurately predict absence of lymph node metastasis in early cervical cancer: results of the SENTICOL study. (J Clin Oncol. 2011 May 1;29(13):1686-91)

<<<卵巢類>>>

Ref D 與傳統打法相比, Weekly topotecan 的效果比較差. A phase II study of two topotecan regimens evaluated in recurrent platinum-sensitive ovarian, fallopian tube or primary peritoneal cancer: a Gynecologic Oncology Group Study (GOG 146Q). (Gynecol Oncol. 2011 Mar;120(3):454-8)

Ref E 使用 bevacizumab 其實並不划算. At what cost does a potential survival advantage of bevacizumab make sense for the primary treatment of ovarian cancer? A cost-effectiveness analysis. J Clin Oncol. 2011 Apr 1;29(10):1247-51.

<<<子宮類>>>

Ref F 低風險與中風險之內膜癌患者宜避免使用 Pelvic RT. Long-term outcome and quality of life of patients with endometrial carcinoma treated with or without pelvic radiotherapy in the post operative radiation therapy in endometrial carcinoma 1 (PORTEC-1) trial. (J Clin Oncol. 2011 May 1;29(13):1692-700)

Ref G 子宮內投藥系統 + GnRH analogue 的效果. Progestin intrauterine

device and GnRH analogue for uterus-sparing treatment of endometrial precancers and well-differentiated early endometrial carcinoma in young women. (Ann Oncol. 2011 Mar;22(3):643-9)

Ref H Gynecologic oncologist 所治療的內膜癌患者,有較佳之存活.

Influence of gynecologic oncologists on the survival of patients with endometrial cancer. J Clin Oncol. 2011 Mar 1;29(7):832-8.

<<<其他類>>>

Ref I Low-risk GTN: 每兩週 iv Dactinomycin 優於每週 im MTX.

Phase III trial of weekly methotrexate or pulsed dactinomycin for low-risk gestational trophoblastic neoplasia: a gynecologic oncology group study. (J Clin Oncol. 2011 Mar 1;29(7):825-31)

Ref J **Paclitaxel-acute pain syndrome.** Natural history of paclitaxel-associated acute pain syndrome: prospective cohort study NCCTG N08C1. (J Clin Oncol. 2011 Apr 10;29(11):1472-8)

Ref K 肺癌似乎與 HPV 無關. Assessment of human papillomavirus in lung tumor tissue. (J Natl Cancer Inst. 2011 Mar 16;103(6):501-7)

ABSTRACTS

Ref A

Phase III, open-label, randomized study comparing concurrent gemcitabine plus cisplatin and radiation followed by adjuvant gemcitabine and cisplatin versus concurrent cisplatin and radiation in patients with stage IIB to IVA carcinoma of the cervix.

J Clin Oncol. 2011 May 1;29(13):1678-85.Dueñas-González A, Zarbá JJ, Patel F, Alcedo JC, Beslija S, Casanova L, Pattaranutaporn P, Hameed S, Blair JM, Barraclough H, Orlando M.

Source

National Cancer Institute/Institute of Biomedical Research, Universidad Nacional Autónoma de México, México City, México.

Abstract

PURPOSE:

To determine whether addition of gemcitabine to concurrent cisplatin chemoradiotherapy

and as adjuvant chemotherapy with cisplatin improves progression-free survival (PFS) at 3 years compared with current standard of care in locally advanced cervical cancer.
PATIENTS AND METHODS:
Eligible chemotherapy- and radiotherapy-naive patients with stage IIB to IVA disease and Karnofsky performance score ≥ 70 were randomly assigned to arm A (**cisplatin 40 mg/m(2) and gemcitabine 125 mg/m(2) weekly for 6 weeks** with concurrent external-beam radiotherapy [XRT] 50.4 Gy in 28 fractions, followed by brachytherapy [BCT] 30 to 35 Gy in 96 hours, and **then two adjuvant 21-day cycles of cisplatin, 50 mg/m(2) on day 1, plus gemcitabine, 1,000 mg/m(2) on days 1 and 8**) or to arm B (cisplatin and concurrent XRT followed by BCT only; dosing same as for arm A).
RESULTS:
Between May 2002 and March 2004, 515 patients were enrolled (arm A, n = 259; arm B, n = 256). **PFS at 3 years** was significantly improved in arm A versus arm B (74.4% v 65.0%, respectively; P = .029), as were **overall PFS** (log-rank P = .0227; hazard ratio [HR], 0.68; 95% CI, 0.49 to 0.95), **overall survival** (log-rank P = .0224; HR, 0.68; 95% CI, 0.49 to 0.95), and **time to progressive** disease (log-rank P = .0012; HR, 0.54; 95% CI, 0.37 to 0.79). **Grade 3 and 4 toxicities** were more frequent in arm A than in arm B (**86.5%** v 46.3%, respectively; P < .001), including two deaths possibly related to treatment toxicity in arm A.
CONCLUSION:
Gemcitabine plus cisplatin chemoradiotherapy followed by BCT and adjuvant gemcitabine/cisplatin chemotherapy improved survival outcomes with increased but clinically manageable toxicity when compared with standard treatment

Ref B

Human papillomavirus testing in the prevention of cervical cancer.

J Natl Cancer Inst. 2011 Mar 2;103(5):368-83. Schiffman M, et al. Division of Cancer Epidemiology and Genetics, National Cancer Institute, Bethesda, MD, USA.
Abstract
Strong evidence now supports the adoption of cervical cancer prevention strategies that explicitly focus on persistent infection with the causal agent, human papillomavirus (HPV). To inform an evidence-based transition to a new public health approach for cervical cancer screening, we summarize the natural history and cervical carcinogenicity of HPV and discuss the promise and uncertainties of currently available screening methods. New HPV infections acquired at any age are virtually always benign, but persistent infections with one of approximately 12 carcinogenic HPV types explain virtually all cases of cervical cancer. In the absence of an overtly persistent HPV infection, the risk of cervical cancer is extremely low. Thus, HPV test results predict the

risk of cervical cancer and its precursors (cervical intraepithelial neoplasia grade 3) better and longer than cytological or colposcopic abnormalities, which are signs of HPV infection. The **logical and inevitable move to HPV-based cervical cancer prevention strategies will require longer screening intervals** that will disrupt current gynecologic and cytology laboratory practices built on frequent screening. A major challenge will be implementing programs that do not overtreat HPV-positive women who do not have obvious long-term persistence of HPV or treatable lesions at the time of initial evaluation. **The greatest potential** for reduction in cervical cancer rates from HPV screening is in **low-resource regions** that can implement infrequent rounds of low-cost HPV testing and treatment

Ref C

Bilateral negative sentinel nodes accurately predict absence of lymph node metastasis in early cervical cancer: results of the SENTICOL study.

J Clin Oncol. 2011 May 1;29(13):1686-91. Lécuru F, Mathevet P, Querleu D, Leblanc E, Morice P, Daraï E, Marret H, Magaud L, Gillaizeau F, Chatellier G, Dargent D.

Source

Service de Chirurgie Gynécologique et Cancérologique, Hôpital Européen Georges Pompidou, 20 rue Leblanc, 75015 Paris, France. fabrice.lecuru@egp.aphp.fr

Abstract

PURPOSE:

Sentinel lymph node (SLN) biopsy may be used to target lymph node metastases in patients with early cervical cancer. Whether SLN biopsy only is acceptable in the staging and surgical management of early cervical cancer remains unknown. This prospective multicenter study (SENTICOL [Ganglion Sentinelle dans le Cancer du Col]) assessed the sensitivity and negative predictive value (NPV) of SLN biopsy.

PATIENTS AND METHODS:

Adults with cervical carcinoma who met the International Federation of Gynecology and Obstetrics criteria for stage IA1 with lymphovascular space invasion to stage IB1 underwent **technetium 99 lymphoscintigraphy** and **Patent Blue injection** followed by **laparoscopic** lymph node mapping, SLN removal, and lymph node dissection. **Only surgeons trained in SLN biopsy** in cervical carcinoma participated in the study. SLNs and nonsentinel lymph nodes underwent routine staining. Negative SLNs were subjected to ultrastaging. The reference method was pelvic and/or para-aortic lymphadenectomy with histologic examination of all nodes.

RESULTS:

One hundred forty-five patients were enrolled, and 139 were included in a modified

intention-to-diagnose analysis. Intraoperative radioisotope-blue dye mapping detected at least one SLN in 136 patients (97.8%; 95% CI, 93.8% to 99.6%), 23 of whom had true-positive results and two who had false-negative results, yielding **92.0% sensitivity** (23 of 25; 95% CI, 74.0% to 99.0%) and **98.2% NPV** (111 of 113; 95% CI, 74.0% to 99.0%) for node metastasis detection. **No false-negative** results were observed in the 104 patients (76.5%) in whom SLN were **identified bilaterally**.

CONCLUSION:

Combined labeling for node mapping was associated with high rates of SLN detection and with high sensitivity and NPV for metastasis detection. However, **SLN biopsy was fully reliable only when SLNs were detected bilaterally**.

Ref D

A phase II study of two topotecan regimens evaluated in recurrent platinum-sensitive ovarian, fallopian tube or primary peritoneal cancer: a Gynecologic Oncology Group Study (GOG 146Q).

Gynecol Oncol. 2011 Mar;120(3):454-8. Herzog TJ, Sill MW, Walker JL, O'Malley D, Shahin M, DeGeest K, Weiner SA, Mutch D, DeBernardo RL, Lentz SS.

Source

Columbia University, New York Presbyterian Hospital, Department of OB/GYN, New York, NY 10032, USA. th2135@columbia.edu

Abstract

OBJECTIVE:

To evaluate the efficacy and safety of **topotecan** in patients with recurrent ovarian, primary peritoneal, and fallopian tube carcinomas.

METHODS:

A randomized phase II analysis of platinum-sensitive patients with measurable disease was performed independently assessing intravenous topotecan **1.25 mg/m2 daily×5 every 21 days** (regimen I) and **topotecan 4.0 mg/m2/day on days 1, 8, and 15 of a 28-day cycle** (regimen II). All patients were treated until disease progression, unmanageable toxicity, or patient refusal. Insufficient accrual related to regimen I resulted in a redesign of the study as a single arm phase II trial assessing only regimen II. More complete efficacy data is presented for regimen II as enrollment on regimen I was insufficient for some analyses.

RESULTS:

A total of 81 patients were enrolled. One patient was ineligible. Fifteen patients received regimen I, while 65 patients were treated with regimen II. The **response rate** on regimen I (daily×5) was 27% (90% CI: 10-51%) and 12% (90% CI: 6-21%) on regimen II (weekly). The median PFS and OS were 4.8 and 27.8 months, respectively, for regimen II.

Grade 3/4 neutropenia rate was 93% with daily×5 dosing and 28% for weekly treatment. Febrile neutropenia was very low in both groups.
CONCLUSION:
The weekly regimen of topotecan appeared **less activ**e but resulted in **less toxicity** than the daily regimen in platinum-sensitive recurrent ovarian cancer patients.

Ref E

At what cost does a potential survival advantage of bevacizumab make sense for the primary treatment of ovarian cancer? A cost-effectiveness analysis.

J Clin Oncol. 2011 Apr 1;29(10):1247-51.Cohn DE, Kim KH, Resnick KE, O'Malley DM, Straughn JM Jr.
Source
The Ohio State University College of Medicine, Columbus, OH, USA.
david.cohn@osumc.edu
Abstract
PURPOSE:
To determine whether the addition of bevacizumab to paclitaxel and carboplatin for the primary treatment of advanced ovarian cancer can be cost effective.
METHODS:
A cost-effectiveness analysis compared the three arms of the Gynecologic Oncology Group (GOG) 218 study (paclitaxel plus carboplatin [PC], PC plus bevacizumab [PCB], and PCB plus bevacizumab maintenance [PCB+B]). Actual and estimated costs of treatment plus the potential costs of complications were established for each strategy. Progression-free survival (PFS) and bowel perforation rates were taken from recently reported results of GOG 218. Sensitivity analysis was performed for pertinent uncertainties in the model. Incremental cost-effectiveness ratios (ICERs) per progression-free life-year saved (PF-LYS) were estimated.
RESULTS:
For the 600 patients entered onto each arm of GOG 218 at the baseline estimates of PFS and bowel perforation, the cost of PC was $2.5 million, compared with $21.4 million for PCB and $78.3 million for PCB+B. These costs led to an ICER of $479,712 per PF-LYS for PCB and $401,088 per PF-LYS for PCB+B. When the cost of bevacizumab was reduced to 25% of baseline, the ICER of PCB+B fell below $100,000 per PF-LYS. ICERs were not substantially reduced when the perforation rate was equal across all arms.
CONCLUSION:
The addition of bevacizumab to standard chemotherapy in patients with advanced ovarian

cancer **is not cost effective**. Treatment with maintenance bevacizumab leads to improved PFS but is associated with both direct and indirect costs. The cost effectiveness of bevacizumab in the adjuvant treatment of ovarian cancer is primarily dependent on drug costs.

Ref F

Long-term outcome and quality of life of patients with endometrial carcinoma treated with or without pelvic radiotherapy in the post operative radiation therapy in endometrial carcinoma 1 (PORTEC-1) trial.

J Clin Oncol. 2011 May 1;29(13):1692-700. Nout RA, van de Poll-Franse LV, Lybeert ML, Wárlám-Rodenhuis CC, Jobsen JJ, Mens JW, Lutgens LC, Pras B, van Putten WL, Creutzberg CL.

Source

Department of Clinical Oncology, Leiden University Medical Center, PO PO Box 9600, 2300 RC Leiden, The Netherlands. r.a.nout@lumc.nl

Abstract

PURPOSE:

To determine the long-term outcome and health-related quality of life (HRQL) of patients with endometrial carcinoma (EC) treated with or without pelvic radiotherapy in the Post Operative Radiation Therapy in Endometrial Carcinoma 1 (PORTEC-1) trial.

PATIENTS AND METHODS:

Between 1990 and 1997, 714 patients with **stage IC grade 1 to 2 or IB grade 2 to 3** EC were randomly allocated to pelvic external-beam radiotherapy (EBRT) or no additional treatment (NAT). HRQL was evaluated with the Short Form 36-Item (SF-36) questionnaire; subscales from the European Organisation for Research and Treatment of Cancer (EORTC) PR25 module for bowel and bladder symptoms and the OV28 and CX24 modules for sexual symptoms; and demographic questions. Analysis was by intention-to-treat.

RESULTS:

Median follow-up was 13.3 years. The **15-year actuarial locoregional recurrence** rates were 5.8% for EBRT versus 15.5% for NAT (**P < .001**), and **15-year overall survival** was 52% versus 60% (**P = .14**). Of the 351 patients confirmed to be alive with correct address, 246 (70%) returned the questionnaire. Patients treated with EBRT reported significant (P < .01) and clinically relevant higher rates of urinary incontinence, diarrhea, and fecal leakage leading to more limitations in daily activities. **Increased symptoms** were reflected by the frequent use of incontinence materials after EBRT (day and night use, 42.9% v 15.2% for NAT; **P < .001**). Patients treated with EBRT reported lower

scores on the SF-36 scales "physical functioning" (P = .004) and "role-physical" (P = .003).

CONCLUSION:

EBRT for endometrial cancer is associated with long-term urinary and bowel symptoms and lower physical and role-physical functioning, even 15 years after treatment. Despite its efficacy in reducing locoregional recurrence, **EBRT should be avoided in patients with low- and intermediate-risk EC.**

Ref G

Progestin intrauterine device and GnRH analogue for uterus-sparing treatment of endometrial precancers and well-differentiated early endometrial carcinoma in young women.

Ann Oncol. 2011 Mar;22(3):643-9. Minig L, Franchi D, Boveri S, Casadio C, Bocciolone L, Sideri M.

Source

Gynecology Department, European Institute of Oncology, Milan, Italy. lucasminig@yahoo.com

Abstract

BACKGROUND:

To test the efficacy of **levonorgestrel-release intrauterine device** (LNG-IUD) plus gonadotropin-releasing hormone (GnRH) for treating women aged <40 years with atypical endometrial hyperplasia (AEH) or presumed International Federation of Gynecology and Obstetrics stage IA limited to the endometrium, well differentiated (G1), endometrioid endometrial cancer (EC), who wish to preserve their fertility.

PATIENTS AND METHODS:

A prospective observational study was conducted. Treatment consisted on the insertion of an **LNG-IUD for 1 year plus GnRH analogue for 6 months**.

RESULTS:

From January 1996 to June 2009, 20 and 14 patients with AEH and EC, respectively, were studied. **Complete response rate** was 95% in patients with AEH and 57.1% in women with EC-G1. A **progression of the disease** was observed in one (5%) and in four patients (28%) with AEH and EC, respectively. Four of 20 patients with AEH and 2 of 14 with EC-G1 experienced **recurrences**. The **average relapse time** was 36 months (range: 16-62 months). All of them were alive without evidence of disease at the last follow-up, mean: 29 months (range: 4-102 months). Nine women achieved 11 **spontaneous pregnancies**.

CONCLUSIONS:

The combined treatment showed effectiveness in a substantial proportion of patients with

AEH and EC. Close follow-up during and after treatment is crucial.

Ref H

Influence of gynecologic oncologists on the survival of patients with endometrial cancer.

J Clin Oncol. 2011 Mar 1;29(7):832-8.Chan JK, Sherman AE, Kapp DS, Zhang R, Osann KE, Maxwell L, Chen LM, Deshmukh H.

Source

University of California, San Francisco (UCSF) School of Medicine, UCSF Helen Diller Family Comprehensive Cancer Center, San Francisco, CA 94143-1702, USA. chanjohn@obgyn.ucsf.edu

Abstract

PURPOSE:

Despite a lack of evidence for survival benefit, the American College of Obstetrics and Gynecology has recommendations for referral to gynecologic oncologists for the treatment of endometrial cancer. Therefore, we propose to determine the influence of gynecologic oncologists on the treatment and survival of patients with endometrial cancer.

PATIENTS AND METHODS:

Data were obtained from Medicare and Surveillance, Epidemiology, and End Results (**SEER) databases** from 1988 to 2005. Kaplan-Meier and Cox proportional hazard methods were used for analyses.

RESULTS:

Of 18,338 women, 21.4% received care from gynecologic oncologists (group A) while 78.6% were treated by others (group B). Women in group A were older (age > 71 years: 49.6% v 44%; P < .001), had more lymph nodes (> 16) removed (22% v 17%; P < .001), presented with more advanced (stages III to IV) cancers (21.9% v 14.6%; P < .001), had higher-grade tumors (P < .001), and were more likely to receive chemotherapy for advanced disease (22.6% v 12.4%; P < .001). In those with stages II to IV disease, the 5-year disease-specific survival (DSS) of group A was 79% versus 73% in group B (P = .001). Moreover, **in advanced-stage (III to IV) disease, group A had 5-year DSS of 72% versus 64% in group B (P < .001)**. However, **no association with DSS was identified in stage I cancers**. On multivariable analysis, younger age, early stage, lower grade, and treatment by gynecologic oncologists were independent prognostic factors for improved survival.

CONCLUSION:

Patients with endometrial cancer treated by gynecologic oncologists were more likely to undergo staging surgery and receive adjuvant chemotherapy for advanced disease. Care

provided by gynecologic oncologists improved the survival of those with high-risk cancers.

Ref I

Phase III trial of weekly methotrexate or pulsed dactinomycin for low-risk gestational trophoblastic neoplasia: a gynecologic oncology group study.

J Clin Oncol. 2011 Mar 1;29(7):825-31. Osborne RJ, Filiaci V, Schink JC, Mannel RS, Alvarez Secord A, Kelley JL, Provencher D, Scott Miller D, Covens AL, Lage JM.

Source

Odette Cancer Centre, Toronto, Ontario, Canada. ray.osborne@sunnybrook.ca

Abstract

PURPOSE:

There is no consensus on the best regimen for the primary treatment of **low-risk gestational trophoblastic neoplasia (GTN)**.

PATIENTS AND METHODS:

Two commonly used single-drug regimens were compared with respect to the proportion of patients meeting the criteria for a complete response (CR) in a randomized phase III trial conducted by the Gynecologic Oncology Group. Eligibility was purposefully broad to maximize the generalizability of the results and included patients with a WHO risk score of 0 to 6 and patients with metastatic disease (limited to lung lesions < 2 cm, adnexa, or vagina) or choriocarcinoma.

RESULTS:

Two hundred forty women were enrolled, and 216 were deemed eligible. **Biweekly intravenous dactinomycin 1.25 mg/m²** was statistically superior to **weekly intramuscular (IM) methotrexate 30 mg/m²** (**CR: 70% v 53%; P = .01**). Similarly, in patients with low-risk GTN as defined before the 2002 WHO risk score revisions (risk score of 0 to 4 and excluding choriocarcinoma), response was 58% and 73% in the methotrexate and dactinomycin arms, respectively (P = .03). Both regimens were less effective if the WHO risk score was 5 or 6 or if the diagnosis was choriocarcinoma (CR: 9% and 42%, respectively). There were two potential recurrences; one at 4 months (dactinomycin) and one at 22 months (methotrexate). Not all patients completed follow-up. Both regimens were well tolerated.

CONCLUSION:

The biweekly dactinomycin regimen has a higher CR rate than the weekly IM methotrexate regimen in low-risk GTN, a generally curable disease.

Ref J

Natural history of paclitaxel-associated acute pain syndrome:

prospective cohort study NCCTG N08C1.

J Clin Oncol. 2011 Apr 10;29(11):1472-8. Loprinzi CL, Reeves BN, Dakhil SR, Sloan JA, Wolf SL, Burger KN, Kamal A, Le-Lindqwister NA, Soori GS, Jaslowski AJ, Novotny PJ, Lachance DH.

Source

Department of Oncology, Mayo Clinic, 200 First St, SW, Rochester, MN 55905, USA. cloprinzi@mayo.edu

Abstract

PURPOSE:

The characteristics and natural history of the **paclitaxel-acute pain syndrome (P-APS)** and paclitaxel's more chronic neuropathy have not been well delineated.

METHODS:

Patients receiving weekly paclitaxel (70 to 90 mg/m(2)) completed daily questionnaires and weekly European Organisation for Research and Treatment of Cancer (EORTC) Chemotherapy-Induced Peripheral Neuropathy (CIPN) -20 instruments during the entire course of therapy.

RESULTS:

P-APS symptoms **peaked 3 days after chemotherapy**. Twenty percent of patients had pain scores of 5 to 10 of 10 with the first dose of paclitaxel. **Sensory neuropathy** symptoms were more prominent than were motor or autonomic neuropathy symptoms. Of the sensory neuropathy symptoms, numbness and tingling were more prominent than was shooting or burning pain. Patients with higher P-APS pain scores with the first dose of paclitaxel appeared to have more chronic neuropathy.

CONCLUSION:

These data support that the P-APS is **related to nerve pathology** as opposed to being arthralgias and/or myalgias. Numbness and tingling are more prominent chronic neuropathic symptoms than is shooting or burning pain.

Ref K

Assessment of human papillomavirus in lung tumor tissue.

J Natl Cancer Inst. 2011 Mar 16;103(6):501-7. Koshiol J, et al.Infections and Immunoepidemiology Branch, Division of Cancer Epidemiology and Genetics, National Cancer Institute, Bethesda, MD 20892-7248, USA.

BACKGROUND:

Lung cancer kills more than 1 million people worldwide each year. Whereas several human papillomavirus (HPV)-associated cancers have been identified, the role of HPV in lung carcinogenesis remains controversial.

METHODS:

We selected 450 lung cancer patients from an Italian population-based case-control study, the Environment and Genetics in Lung Cancer Etiology. These patients were selected from those with an adequate number of unstained tissue sections and included all those who had never smoked and a random sample of the remaining patients. We used real-time polymerase chain reaction (PCR) to test specimens from these patients for HPV DNA, specifically for E6 gene sequences from HPV16 and E7 gene sequences from HPV18. We also tested a subset of 92 specimens from all never-smokers and a random selection of smokers for additional HPV types by a PCR-based test for at least 54 mucosal HPV genotypes. DNA was extracted from ethanol- or formalin-fixed paraffin-embedded tumor tissue under strict PCR clean conditions. The prevalence of HPV in tumor tissue was investigated.

RESULTS:

Specimens from 399 of 450 patients had adequate DNA for analysis. Most patients were current (220 patients or 48.9%) smokers, and 92 patients (20.4%) were women. When HPV16 and HPV18 type-specific primers were used, two specimens were positive for HPV16 at low copy number but were negative on additional type-specific HPV16 testing. Neither these specimens nor the others examined for a broad range of HPV types were positive for any HPV type.

CONCLUSIONS:

When DNA contamination was avoided and state-of-the-art highly sensitive HPV DNA detection assays were used, we found **no evidence** that HPV was associated with lung cancer **in a representative Western population**. Our results provide the strongest evidence to date to **rule out a role for HPV** in lung carcinogenesis in Western populations.

參、附件

台灣婦癌醫學會
第七屆第二次會員大會會議記錄

一、時間：100 年 4 月 30 日（星期六）上午 11：20

二、地點：國防醫學院 32 教室

三、出席人員：應出席人數 160 人，實際出席 95 人

缺席人員：55 人

四、主席：張廷彰 理事長

六、紀錄：葉盈秀

壹、大會開始

貳、理事長致詞

參、頒獎

頒發台灣婦癌醫學會專科醫師證書：99 年度通過專科醫師考試者劉希儒、黃家彥、林肇柏三位醫師。

肆、報告事項

1.理事長報告

A. 第十六屆台灣癌症聯合學術年會今年由本會主辦，由於去年本會組團至俄羅斯拜訪該國相關學會，因此今年特地邀請俄羅斯講者來台為年會演講；除此之外，亦邀請了日本的 Dr.Sagae 講述 JGOG，內容豐富是不能錯過的講說。

B. 年會的 Welcome Party 已在昨日(4 月 29 日)假台北賓館舉辦，台北賓館是我國外交部及總統府專用來接待外賓的場所，這次榮幸的能借到該場地，並請蕭副總統為我們頒發台灣癌症醫療終身成就獎，真的是很難得的經驗。

2.秘書長報告

A. 符合 100 年度之「婦癌專科醫師」換証資料者共 75 人，其中 69 人通過審核，2 位醫師的換証審核，需待理監事會議討論後決定。

B. 99 年度會務工作報告、決算收支表、現金出納表、資產負債表、基金收支表、財產目錄及人員待遇表。

C. 100 年度工作計畫及收支預算表。

D. 專科醫師證書換證後，由於和中華民國婦癌醫學會兩會合頒證書，證書格式尚待討論，待理監事會議通過後立即頒發證書。

3.常務監事報告

A.章程委員會—謝長堯醫師

B.國際事務委員會—楊育正醫師

本會去年至俄羅斯拜會該國學會，未來本學會在國際事務的發展上也請理事長多多協助。

C.會員資格審查委員會—陳祈安醫師

今年專科醫師換證，共有 3 位醫師未通過(趙德彰、盧堂安、楊正暉醫師)；劉杭生及陳光煒醫師未符合會員資格(每年需至少參加一次地區性會議及年會的要求)，請會員們於大會上表決是否給予換證；榮譽會員高銘憲雖未申申換證，因其在婦癌上的貢獻，仍給予換發新證。

D.財務委員會—顏明賢醫師

E.醫療及倫理委員會—葉聯舜醫師

F.教育委員會—周振陽醫師

G.學術研究委員會—王功亮醫師

ASGO 今年 7/31-8/1 在韓國首爾的會議建議資淺的醫師參加，未來 11 月份所辦理的 ASGO 大型會議，希望學會能整個動員躍踴參與，以顯示台灣的婦癌專業實力。

TGOG 研究計畫共有八個 study 預計於本年度 6 月 30 日前投稿 ASGO，待 abstract 被大會接受後，則將於 11/4 於韓國首爾發表。

伍、提案討論

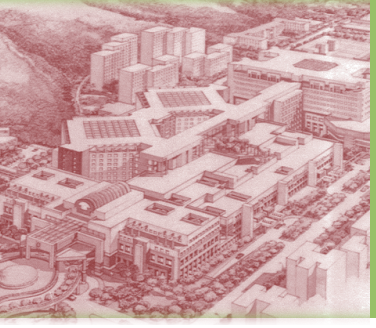
一、討論是否給予劉杭生及陳光煒醫師換發專科醫師新證。

決議：經全體一致表決通過，兩位醫師雖未達本會每年需至少參加一次

地區性會議及年會的要求，考量其致力研究婦癌領域，請會員們於大會上表決，是否仍給以換證。

陸、臨時動議

柒、散會



2011台灣婦科達文西手術論壇

Robotic GYN Surgery Symposium in Taiwan, 2011

Title	Speaker	Time
院長致詞		0930-0935
Opening remark		0935-0940
State of the art Robotic surgery-2011 2011年達文西手術之現況	Robert Holloway FSU, USA	0940-1000
Robotic surgery for management of stage I uterine and cervical cancers 達文西手術於早期子宮內膜癌暨子宮頸癌之應用	Robert Holloway FSU, USA	1000-1050
Break		1050-1110
The Master's Hand: The Promise of Surgical Robotics in Gynecologic Oncological Surgery 機械手臂在婦科癌症手術之展望	Joseph S. Ng NUS, Singapore	1110-1200
Lunch		1200-1300
Robotic surgery for complicated benign GYN diseases 達文西手術於複雜性婦科疾病之應用	Hung-Cheng Lai 賴鴻政, TSGH, Taiwan	1300-1330
Robotic surgery for reproductive medicine 達文西手術於生殖醫學之應用	Yu-Jung Chen 陳怡仁, TVGH, Taiwan	1330-1400
Robotic surgery in pelvic reconstruction 達文西手術於骨盆腔重建之應用	Cheng-Chang Chang 張正昌, TSGH, Taiwan	1400-1430
Break		1430-1450
Robotic surgery of stage IV endometriosis 達文西手術於子宮內膜異位症之應用	Robert Holloway FSU, USA	1450-1520
Avoiding complications of Robotic GYN surgery 婦科達文西手術併發症之預防	Robert Holloway FSU, USA	1520-1550
Discussion: Robotic GYN surgery in Taiwan Opportunities and Challenges 台灣發展達文西婦科手術之機會與挑戰	Hung-Cheng Lai 賴鴻政, TSGH, Taiwan	1550-1650

日期: 2011.6.26 (日)

地點: 三軍總醫院 B1第二演講廳

主辦單位: 三軍總醫院

協辦單位: 中華婦癌醫學會
台灣婦產科醫學會
台北榮總婦產部

東區婦癌學術研討會

New Trends in Gynecology Cancers: origin, epigenetics and early detection

時間　　2011/7/9（星期六）

地點：　　花蓮慈濟醫院協力樓二樓合心講堂

主辦單位　中華民國婦癌醫學會、台灣婦癌醫學會、花蓮慈濟醫院婦產部

協辦單位　台灣婦產科醫學會

交通　　10點50分的太魯閣號前往花蓮，到達時間爲12點55分,

議程

13:10-13:20 Opening remark

13:30-14:10 HPV and Origin of cervical cancer: epidemiology and clinical data in Taiwan 黃慧君

14:10-14:45 Stem cells in gynecology oncology丁大清

14:45-14:55 Coffee Break

14:55-15:35 Epigenetics and biomarkers in gynecology cancers 賴鴻政

15:35-16:15 Origin of Gynecological neoplasia: hypothesis, evidences and clinical implication 朱堂元

16:15-16:55 Update 2011 ASCO news ：Focus on ovarian cancer 劉文雄

16:55~17:00 Closing remark

台灣婦癌醫學會
Taiwan Association of Gynecologic Oncologists
TEL / FAX：886-3-318-7501
E-mail：tago.gyn@gmail.com
網站：http://www.tago.org.tw

親愛的會員：

GOG 的 LAP II 結果已於 2010 年底發表，結論為早期子宮內膜癌的手術治療，使用開腹式或腹腔鏡方式，並不影響治療的結果，因此，腹腔鏡手術是一個可以考慮的選擇。

然而，癌症的治療必須基於對癌症臨床表現深切的認知並瞭解癌症手術的重點，徹底避免人為造成不良事件的發生。有鑑於此，本學會將於往後的一年內，致力於提昇會員對於使用腹腔鏡治療早期子宮內膜癌的學術與技術。

今年 8 月 20-21 日，學會將於台中童綜合醫院及彰濱秀傳亞洲遠距微創中心進行腹腔鏡子宮內膜癌治療系列的課程，其中包括專題演講、討論及腹腔鏡工作坊。腹腔鏡工作坊的內容，包括大型動物模式的練習。估計舉辦工作坊的花費約需台幣 100 萬，本著學會的宗旨，如果可以提昇本會會員的技能，本會當盡力籌款進行，謹於此時就教於各位會員，是否願意參加於 8 月 21 日舉辦的中區婦癌學術研討會之腹腔鏡工作坊。順頌

時綏

註一：8 月 21 日的腹腔鏡工作坊：大型動物經腹腔鏡的淋巴切除、腸道修補、血管修補、輸尿管修補、子宮/輸卵管/卵巢切除等
註二：參加者需負擔部份費用 5000-6000 元。

理事長 張廷彰

100 / 8 / 20 -21 中區婦癌學術研討會暨腹腔鏡工作坊報名回條

姓名：_____

□參加 8/20-21 之研討會及腹腔鏡工作坊
□只參加 8/20 學術研討會
□只參加 8/21 腹腔鏡工作坊
□皆不克參加

100/8/20-21 中區婦癌學術研討會暨腹腔鏡工作坊活動**採報名方式參加**，報名方式如下：
1. E-mail：tago.gyn@gmail.com
2. Tel：03-318-7501
3. Fax：03-318-7501
連絡人：秘書 葉盈秀

(敬請於 6/30(週四)前回覆意見，謝謝您！)

台灣婦癌中區學術研討會

時　　間：民國 100 年 8 月 20 日（星期六）9:30-18:30
地　　點：童綜合醫院梧棲院區 20 樓視聽教室(台中市梧棲區中棲路 1 段 699 號)
主辦單位：台灣婦癌醫學會、童綜合醫療社團法人童綜合醫院
協辦單位：中華民國婦癌醫學會、台灣婦產科醫學會

時 間	活 動 內 容		
9:30	報到		
9:50	Opening Remarks 張子明　副院長 (童綜合醫院副院長) 張廷彰　理事長 (台灣婦癌醫學會理事長) 王功亮　主任 (台灣婦癌醫學會學術委員會主席)		
Symposium of minimally invasive surgery in gynecologic cancers			
10:00	The feasibility and concern in the surgery for cervical cancer 賴鴻政　醫師 (三軍總醫院婦產部主治醫師)		座長：　劉錦成　主任 顏明賢　主任
10:30	Current evidence in the management of endometrial cancer 張志隆　醫師(馬偕紀念醫院婦產部婦癌科主治醫師)		
11:00	Current management for ovarian cancer 陳怡仁　醫師 (台北榮民總醫院婦產部主治醫師)		
11:30	The technique of laparoscopic pelvic and para-aortic lymph nodes dissection 王功亮　主任 (馬偕紀念醫院婦產部主任)		
12:00	Lunch Time	12:00-12:45 台灣婦癌醫學會理監事會議 12:45-13:30 中華民國婦癌醫學會理監事會議	(19F 會議室)
13:30	Introduction of animal lab workshop 林武周主任		座長：　余慕賢　副院長
Symposium of the management of complications during minimally invasive surgery			
14:00	Urinary tract injury　林文榮醫師		座長：　林武周主任
14:30	Bowel tract injury　陳自諒醫師		
15:00	Great vessel injury　（邀請中）		
15:30	Closing Remarks　張廷彰　理事長 (台灣婦癌醫學會理事長)		
15:40	Coffee Break		
16:00	**TGOG 會議** (主持人：　王功亮主任)　**(19F 會議室)**		**(20 樓視聽教室)** 準會員訓練口頭報告 主持人：周振陽主任 教育委員及相關人員參加
	16:00-16:40	子宮頸癌（賴瓊慧教授）	
	16:40-17:20	內膜癌（顏明賢主任）	
	17:20-18:00	卵巢癌（周振陽主任）	
	18:00-18:30	DSMC　（陳祈安主任）	