台灣婦癌醫學會會訊

2012 年 3,4 月

理事長: 張廷彰醫師
秘書長: 周宏學醫師
各委員會召集人:
章程委員會：謝長堯理事
國際事務委員會：楊育正理事
會員資格審查委員會：陳祈安常務理事
財務委員會：顏明賢常務理事
醫療及倫理委員會：葉聯舜常務理事
教育委員會：周振陽常務理事
學術研究委員會：王功亮常務理事
副秘書長：
劉文雄醫師、黃慧君醫師、陳子健醫師
學會網址: www.tago.org.tw
學會 E-mail address: tago.gyn@gmail.com
學會地址：333 桃園縣龜山鄉復興街 5 號林口長庚醫院兒童大樓 B2 婦產部轉
學會電話：(03) 328-1200 ext 8290; 傳真/電話：(03) 318-7501
學會秘書: 葉君苓小姐

壹、 會務報告

一、今年 TJCC 婦癌相關之活動與特別演講

第十七屆台灣癌症聯合學術年會暨第八屆第一次會員大會
時間：民國 101 年 5 月 6 日 (星期日)
地點 ：國醫中心 31 教室(北市內湖區民權東路六段 161 號)

座長:張廷彰理事長
09:30-10:20
Relevance of the sentinel node biopsy in early stages of endometrial cancer

Emile Darai (Professor and chief of Obstetrics and Gynecology, Department of Tenon Hospital, University Pierre et Marie Curie, Paris, France)

座長:(待安排)
10:50-11:40
Molecular signaling regulating cancer metastasis
王陸海院士

12:00-12:50
Advances and International Collaborations in Gynecologic Oncology Group Clinical Trials
莊志芳副教授

13:00-13:30 **中華民國婦癌醫學會第十屆第一次會員大會暨第十屆理監事改選**
13:30-14:30 **台灣婦癌醫學會第八屆第一次會員大會暨第八屆理監事改選**

座長:陳祈安主任、王功亮主任
14:30-14:50
Hypoxia as a future target for cancer treatment in gynecological malignancies
童寶玲醫師 台大醫院婦產部

14:50-15:10
A New Approach to Intra-peritoneal Hyperthermia for Ovarian Cancer Treatment
張志隆主任　馬偕紀念醫院婦產部

15:20-16:20
台灣婦癌醫學會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(三軍總醫院婦產部 503 會議室)

二、 第八屆第一次會員大會暨第八屆理監事改選

本會僅訂 101 年 5 月 6 日(日)下午 13:30~14:30 假國防醫學 31 教室舉行第八屆第一次會員大會暨第八屆理監事改選，依據本學會章程第二章第七條，本會正式會員有同等之表決權、選舉權、被選舉權與罷免權，但準會員、合作會員及榮譽會員無前項權利，**敬請正式會員撥冗出席投票**。如您無法出席，請委託本會其他會員代為執行權利。

三、(補)第七屆第七次理監事聯席會會議紀錄

時間：100 年 11 月 26 日（星期六）中午 12 時 10 分

地點：台南奇美醫院第二醫療大樓 9 樓空橋內科討論室

主席：張廷彰理事長

出席：

常務理事 陳祈安、顏明賢、簡婉儀、周振陽、葉聯舜

理事 楊育正、何師竹、劉復興、余慕賢、謝長堯、黃國.、洪耀欽、曾志仁、黃順賢

常務監事 屠乃方

監事 張志隆、李耀泰、鄭雅敏、張簡展照、王鵬惠

列席 秘書長周宏學 ;副秘書長劉文雄、陳子健 ;秘書：葉君苓、趙懿德

請假 王功亮、鄭文芳、朱堂元、何志明、余堅忍、趙灌中、鄭丞傑、黃慧君

一、主席(理事長)致詞

每一屆有 8 次的理監事會議，第 9 次為改選。本次為本屆第七次之理監事會議，也是倒數第二次。我們在這快 2 年的時間，一直都是兢兢業業，一方面充實學會財務資源，但另一方面最重要的是利用所有的資源去充足學會的各項功能，藉由每一位理監事及會員的參與，提升我國婦癌診療的品質，經由歷屆理監事的努力，目前我們學會對社會的貢獻，大家有目共睹，已成為其他學會效仿的對象。離下屆學會的改選，尚有半年，個人一方面感謝各位對我的支持，另方面也請各位不吝提出學會可以進一步努力之處及個人不足的地方，讓我們持續的努力。

二、秘書長會務報告

1. 財務狀況報告：

截至 100 年 11 月 23 日;以下報告的數字為尚未核銷 2011 年 ASGO 韓國會議支出之費用，目前為止仍有部份會員尚未繳交核銷費用之資料至秘書處;核銷完成的總經費約莫與目前這個數字差距約 30 萬元左右。

(可支配金 2,468,140；基金 1,473,196；共 4,013,316)

活儲（大眾)：842,487 元

基金（華南)：1,473,196 元

活儲(合作金庫)：700,100 元

郵儲：997,533 元

2. 學會所有的支出都會先與會計師確認，一切收入支出均符合中華民國國稅局會計法的法規，如造成諸位核銷的不便，敬請見諒。

三、各委員會工作報告

1. 會員資格審查委員會—陳祈安醫師

A.100/12/3(六)假 台大醫院舉辦 100 年度專科醫師甄審，合計 5 位去年口試未通過的醫師，這 5 位直接參加口試甄審;2 位去年筆試未通過;2 位今年新報名。

B.目前筆試題目已收到 10 多位委員的出題，希望大家多踴躍出題，題目越多越好。

C.口試委員預備 3 組，約莫 9 人（與去年一樣）;筆試時間訂於下週六早上 9 點半至 10 點開始;口試下午 1 點開始，請參加口試的口試委員中午 12 點前抵達台大兒醫大樓 15 樓會議室用餐並交換意見。

2. 財務委員會—顏明賢醫師

理事長已經報告，學會的財務非常健全，本來是要提醒因為剛辦完癌症年會，約有 1 千 6 百多萬元的收入，這些收入都是會納入學會的帳戶，所以國稅局一定會來查稅。

四、討論事項

<u>提案 1：2012 年地區年會時間。（秘書處）</u>

說明：

月份	時間	地區	備註
2 月	2/4(六)	台中榮總	中區研討會暨何師竹主任榮退演講
5 月	5/6(日) 早上	國防醫學院	17 屆台灣癌症聯合學術年會(31 會議室，容納 112 人)
8 月	8/25（六）	高雄長庚	張簡展照主任
11 月	11/24（六）	台中中國醫藥大學附設醫院	洪耀欽主任;擬與產科不孕症主任討論是否與院慶活動結合。

周宏學秘書長：

2012 年地區年會時間，以往慣例 5 月為台灣癌症聯合年會，2012 年由放射醫學腫瘤學會主辦,地點在國防醫學院;因為去年開會的前三天國防部臨時通知對岸的學者不可以到國防醫學院，後來是由副總統層級來打通此狀況，所以今年主辦單位一再保障兩岸的貴賓不會再受到影響;明年再教育地區會議時間,目前 2 月地區年會已敲定 2 月 4 日訂於台中榮總，結合何師竹主任榮退演講。

張廷彰理事長：

何師竹理事對婦癌的貢獻非常大，但是榮退並非意味以後就不再做事情，而是將做更具有啟發性的事情與會議;台灣婦癌醫學會與中華民國婦癌醫學將聯合舉辦該會議,希望在座的各位理監事都能撥冗來參加這具有啟發性的會議;進一步的活動細節目前仍在規劃中。

周宏學秘書長：

以往年會本學會都爭取在星期六的時間，但因今年在籌辦會議中很多學會都提

出希望可以也可以安排在星期六，於是籌備會議最後決定用輪流的方式。

張廷彰理事長：

近年來有不少醫院在準備 JCI 評鑑,本次年會將邀請已經通過 JCI 評鑑的韓國梨花大學主任來演講婦產科或是婦癌科醫師在 JCI presentation 的準備工作及注意事項。

洪耀欽主任：

每年中國醫藥大學附設醫院都會舉辦院慶，今年謹訂於 12 月 17 日（六）歡迎大家參加。

決議：

8 月 25 日（六）高雄長庚 （張簡展照醫師）;11 月 24 日（六）台中中國醫藥大學附設醫院（洪耀欽主任），擬與產科不孕症主任討論是否與院慶活動結合。

提案 2：第 17 屆台灣癌症聯合學術年會（秘書處）

說明：

一、本學會學術委員：陳祈安主任、周振陽主任

二、國內外演講者邀請（各一），於 2012 年 1 月 15 日前提供大會『中英文之演講者姓名、職稱、演講題目及主持人姓名、職稱』;2012 年 2 月 17 日繳交演講摘要。

三、壁報論文投稿相關事宜：投稿方式：僅接受網路上傳投稿。截止日期：2012 年 2 月 6 日(一)

張廷彰理事長：

國內外演講者的邀請,除了之前理事長建議的人選之外;,如果還有其他適合的人選學會可以想辦法找其他單位 support 經費。

決議：

如各位理監事有想法與提議請與學會秘書處聯絡，最後將統籌後與諸位理監事報告;壁報論文投稿相關訊息將會 mail 給各位會員。

提案 3：申請太平洋紫杉醇用於子宮內膜癌治療的健保給付（張廷彰理事長）

張廷彰理事長：

以前曾經努力過，但健保局都說備查，也沒有給予任何回應;為了病人著想，我們現在應該提供更健全的證據來向健保局申請;我們是否考慮舉辦大型的 symposium 或是連署，讓健保局知道這是一件很重要的事情，列入審查。

楊育正院長：

健保局是不會通過的，early ovarian cancer 也是要自費，也更要積極爭取。站在照顧女性的病人，當然是希望，甚至範圍更大;但也要替健保局思考，看在怎樣的策略之下，才可以成功。

陳祈安主任：

我們到底能不能申請，或是由廠商申請。因為廠商不會 support 這種，因為廠商太多家，不一定有市場。

張廷彰理事長：

因為病人需要，我們還是試試看。

楊育正院長：

如果真的想通過這個案子，大概只能透過立法委員的協助，為了照顧我們的老百姓，就要看立法委員願不願意去質詢;過了專利期，藥價大幅下降之後，具有足夠的 medicine study support 是可以列入健保給付的，這樣對財務與實際我們的需求是可以 balance。

決議：

張廷彰理事長擬進一步討論請教那位立法委員

提案 4：與口述歷史學者合作，進行台灣抹片史的撰述（張廷彰理事長）

說明：

張廷彰理事長：

包括何師竹主任及一些前輩在台灣子宮頸癌抹片有相當大的貢獻;但是已經有一些婦產科醫師慢慢凋零，目前還有一些當時參加台灣最早期的抹片，希望有個機會可以把台灣的抹片史呈現出最完整。像外科都有找醫學口述學者;台灣比較老的抹片資料是放在台灣省衛生處，也就是現在的國民健康局。因為臨床醫師沒有時間，如果可以與口述歷史學者及其學生合作，且若國民健康局也願意出一點經費，我們也在籌措別的經費，或許可以將台灣抹片的歷史片段慢慢統整起來。當然我們在座的理監事對子宮頸癌的篩檢都相當有貢獻。不知道各位理監事的意下如何？

決議：

將朝以上說明的方向進行。

提案 5：發展 total parietal peritonectomy 並申請成為健保新給付項目（張廷彰理事長）

說明&決議:

張廷彰理事長：

這次去參加韓國 ASGO，ASGO 裡面就有個韓國癌症中心的 Team，就是在講這個部份。在台灣我們希望爭取此手術項目及代碼列入卵巢癌手術的健保給付之中。

四、 近期國內外婦癌相關活動一覽表

日期	活動名稱	活動地點
2012/4/14 14:00	TGOG 月例會	馬偕醫院 12043 室

2012/5/5-5/6	臺灣癌症聯合年會	國防醫學院
2012/5/20 下午	TGOG 月例會	待決
2012/8/25	南區婦癌學術研討會	高雄長庚醫院
2012/10/13-10/16	14th IGCS (http://www2.kenes.com/igcs2012/Pages/home.aspx)	Vancouver, Canada
2012/11/24	中區婦癌學術研討會	台中中國醫藥大學附設醫院

五、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、近期文獻摘錄

本期特選 1

最新的美國 cervical screening guideline 大幅延長 screening interval

CA Cancer J Clin. 2012 Mar 14. doi: 10.3322/caac.21139. [Epub ahead of print]
American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer.

Abstract
An update to the American Cancer Society (ACS) guideline regarding screening for the early detection of cervical precancerous lesions and cancer is presented. The guidelines are based on a systematic evidence review, **contributions from 6 working groups**, and a recent symposium cosponsored by the ACS, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology, which was attended by 25 organizations. The new screening recommendations address **age-appropriate** screening strategies, including the use of cytology and high-risk human papillomavirus (HPV) testing, follow-up (eg, the management of screen positives and screening intervals for screen negatives) of women after screening, the age at which to exit screening, future

considerations regarding HPV testing alone as a primary screening approach, and screening strategies for women vaccinated against HPV16 and HPV18 infections.

1) Cervical cancer screening should begin at age 21 years. Women **younger than age 21 years should not be tested** with either the Pap test or the HPV test.
2) Women between the ages of 21 and 29 years should have a **Pap test every 3 years**. HPV testing should not be used in this age group unless it is needed after an abnormal Pap test.
3) Women between the ages of 30 and 65 years should have a **Pap test plus an HPV test (called "co-testing") every 5 years**. This is preferred, but it is **also okay to continue to have Pap tests alone every 3 years**.
4) Women older than 65 years who have had regular Pap tests that were normal **should not be screened** for cervical cancer. Once screening is stopped, it should not be started again. Women who have had serious cervical precancer should **be tested for at least 20 years after that diagnosis**, even if screening continues past age 65 years.
5) A woman who has had a hysterectomy (with removal of the cervix) for reasons not related to cervical cancer and who has not had cervical cancer or serious precancer should not be screened.
6) A woman who has been vaccinated against HPV should still follow the screening recommendations for her age group.

TABLE 1. Summary of Recommendations

POPULATION	PAGE NUMBER	RECOMMENDED SCREENING METHOD[a]	MANAGEMENT OF SCREEN RESULTS	COMMENTS
Aged < 21 y	7	No screening		HPV testing should not be used for screening or management of ASC-US in this age group
Aged 21-29 y	8-9	Cytology alone every 3 y	HPV-positive ASC-US[b] or cytology of LSIL or more severe: Refer to ASCCP guidelines[2]	HPV testing should not be used for screening in this age group
			Cytology negative or HPV-negative ASC-US[b]: Rescreen with cytology in 3 y	
Aged 30-65 y	9-16	HPV and cytology "cotesting" every 5 y (preferred)	HPV-positive ASC-US or cytology of LSIL or more severe: Refer to ASCCP guidelines[2]	Screening by HPV testing alone is not recommended for most clinical settings
			HPV positive, cytology negative: Option 1: 12-mo follow-up with cotesting Option 2: Test for HPV16 or HPV16/18 genotypes • If HPV16 or HPV16/18 positive: refer to colposcopy • If HPV16 or HPV16/18 negative: 12-mo follow-up with cotesting	
			Cotest negative or HPV-negative ASC-US: Rescreen with cotesting in 5 y	
		Cytology alone every 3 y (acceptable)	HPV-positive ASC-US[b] or cytology of LSIL or more severe: Refer to ASCCP guidelines [2]	
			Cytology negative or HPV-negative ASC-US[b]: Rescreen with cytology in 3 y	
Aged > 65 y	16-17	No screening following adequate negative prior screening		Women with a history of CIN2 or a more severe diagnosis should continue routine screening for at least 20 y
After hysterectomy	17-18	No screening		Applies to women without a cervix and without a history of CIN2 or a more severe diagnosis in the past 20 y or cervical cancer ever
HPV vaccinated	18-19	Follow age-specific recommendations (same as unvaccinated women)		

ASCCP indicates American Society for Colposcopy and Cervical Pathology; ASC-US, atypical squamous cells of undetermined significance; CIN2, cervical intraepithelial neoplasia grade 2; HPV, human papillomavirus; LSIL, low-grade squamous intraepithelial lesion.

[a]Women should not be screened annually at any age by any method.

[b]ASC-US cytology with secondary HPV testing for management decisions.

本期特選 2

ASCO: 肥胖者之化療劑量宜基於實際體重

J Clin Oncol. 2012 May 1;30(13):1553-61. Epub 2012 Apr 2.

Appropriate chemotherapy dosing for obese adult patients with cancer: american society of clinical oncology clinical practice guideline.

Griggs JJ, Mangu PB, Anderson H, Balaban EP, Dignam JJ, Hryniuk WM, Morrison VA, Pini TM, Runowicz CD, Rosner GL, Shayne M, Sparreboom A, Sucheston LE, Lyman GH.

Source

2318 Mill Rd, Suite 800, Alexandria, VA 22314; guidelines@asco.org.

Abstract

PURPOSE To provide recommendations for appropriate cytotoxic chemotherapy dosing for obese adult patients with cancer. METHODS The American Society of Clinical Oncology convened a Panel of experts in medical and gynecologic oncology, clinical pharmacology, pharmacokinetics and pharmacogenetics, and biostatistics and a patient representative. MEDLINE searches identified studies published in English between 1996 and 2010, and a systematic review of the literature was conducted. A majority of studies involved breast, ovarian, colon, and lung cancers. This guideline does not address dosing for novel targeted agents. Results Practice pattern studies demonstrate that **up to 40% of obese patients receive limited chemotherapy doses that are not based on actual body weight.** Concerns about toxicity or overdosing in obese patients with cancer, based on the use of actual body weight, are unfounded. Recommendations **The Panel recommends that full weight-based cytotoxic chemotherapy doses be used to treat obese patients with cancer, particularly when the goal of treatment is cure.** There is no evidence that short- or long-term toxicity is increased among obese patients receiving full weight-based doses. Most data indicate that myelosuppression is the same or less pronounced among the obese than the non-obese who are administered full weight-based doses. Clinicians should respond to all treatment-related toxicities in obese patients in the same ways they do for non-obese patients. The use of fixed-dose chemotherapy is rarely justified, but the Panel does recommend fixed dosing for a few select agents. The Panel recommends further research into the role of pharmacokinetics and pharmacogenetics to guide appropriate dosing of obese patients with cancer

其他文獻摘錄

Ref 1 (p11) **我們 TGOG 之傑作 (Impact Factor 4.9)**: small cell neuroendocrine cervical cancer 最好用 radiotherapy + 至少 5 cycles of

cisplatin-etoposide-containing chemotherapy 來治療

Eur J Cancer. 2012 Jan 13. [Epub ahead of print]

Primary treatment and prognostic factors of small cell neuroendocrine carcinoma of the uterine cervix: A Taiwanese Gynecologic Oncology Group study.

Ref 2 (p12) 我們 TGOG 之傑作 (Impact Factor 3.76): ovarian granulose cell tumor

Gynecol Oncol. 2012 Feb;124(2):244-9. Epub 2011 Oct 20.

A long-term follow-up study of 176 cases with adult-type ovarian granulosa cell tumors.

Ref 3 (p13) 韓國 KGOG 已經有 JCO 的 paper 了 (Impact Factor: 18.970)

J Clin Oncol. 2012 Apr 20;30(12):1329-34. Epub 2012 Mar 12.

Preoperative identification of a low-risk group for lymph node metastasis in endometrial cancer: a korean gynecologic oncology group study.

Ref 4 (p14) WHI study: 單用 Premarin,反而較少 breast cancer risk

Lancet Oncol. 2012 May;13(5):476-86. Epub 2012 Mar 7.

Conjugated equine oestrogen and breast cancer incidence and mortality in postmenopausal women with hysterectomy: extended follow-up of the Women's Health Initiative randomised placebo-controlled trial.

Ref 5 (p15) MSKCC 的改良式 intraperitoneal chemotherapy

Gynecol Oncol. 2012 Mar 21. [Epub ahead of print]

Progression-free and overall survival of a modified outpatient regimen of primary intravenous/intraperitoneal paclitaxel and intraperitoneal cisplatin in ovarian, fallopian tube, and primary peritoneal cancer.

Ref 6 (p16) Irradiation 或為 ovarian clear cell carcinoma 的一條活路

J Clin Oncol. 2012 Apr 9. [Epub ahead of print]

Low-Stage Ovarian Clear Cell Carcinoma: Population-Based Outcomes in British Columbia, Canada, With Evidence for a Survival Benefit As a Result of Irradiation.

Ref 7 (p17) Platinum-sensitive recurrence: Olaparib

N Engl J Med. 2012 Apr 12;366(15):1382-92. Epub 2012 Mar 27.

Olaparib maintenance therapy in platinum-sensitive relapsed ovarian

cancer.

Ref 8 (p18) 子宮頸癌 CCRT with weekly cisplatin-topotecan

Gynecol Oncol. 2012 Apr;125(1):158-62. Epub 2011 Dec 22.

A phase I study of concurrent weekly topotecan and cisplatin chemotherapy with whole pelvic radiation therapy in locally advanced cervical cancer: a gynecologic oncology group study.

Ref 9 (p19) CCRT for advanced vulva SCC

Gynecol Oncol. 2012 Mar;124(3):529-33. Epub 2011 Nov 9.

A phase II trial of radiation therapy and weekly cisplatin chemotherapy for the treatment of locally-advanced squamous cell carcinoma of the vulva: a gynecologic oncology group study.

Ref 10 (p20) Radiosurgery 於處理單顆 brain metastasis 的角色

Cancer. 2012 Feb 15;118(4):1138-44. doi: 10.1002/cncr.26379. Epub 2011 Jul 14.

Single brain metastasis: whole-brain irradiation plus either radiosurgery or neurosurgical resection.

Ref 11 (p21) 下肢 lymphedema 之新手術療法

Gynecol Oncol. 2012 Apr 17. [Epub ahead of print]

A novel approach to the treatment of lower extremity lymphedema by transferring a vascularized submental lymph node flap to the ankle.

Ref 1 我們 TGOG 之傑作 (Impact Factor 4.9): small cell neuroendocrine cervical cancer 最好用 radiotherapy + 至少 5 cycles of cisplatin-etoposide-containing chemotherapy 來治療

Eur J Cancer. 2012 Jan 13. [Epub ahead of print]

Primary treatment and prognostic factors of small cell neuroendocrine carcinoma of the uterine cervix: A Taiwanese Gynecologic Oncology Group study.

Wang KL, Chang TC, Jung SM, Chen CH, Cheng YM, Wu HH, Liou WS, Hsu ST, Ou YC, Yeh LS, Lai HC, Huang CY, Chen TC, Chang CJ, Lai CH.

Source

Department of Obstetrics and Gynecology, Mackay Memorial Hospital and Mackay Medical College, Taipei, Taiwan; Department of Nursing, Mackay Medicine, Nursing and Management College, Taipei, Taiwan; Department of Obstetrics and Gynecology, Taipei Medical University, Taipei, Taiwan.

Abstract

BACKGROUND:

Our aims were to investigate the treatment and clinicopathological variables in relation to prognosis in small cell neuroendocrine cervical carcinoma (SCNECC).

PATIENTS AND METHODS:

Clinical data of SCNECC patients with International Federation of Gynaecology and Obstetrics (FIGO) stages I-IV treated between 1987 and 2009 at member hospitals of the Taiwanese Gynecologic Oncology Group (TGOG) were retrospectively reviewed.

RESULTS:

Of the 179 eligible patients, 104 were of FIGO stage I, 19 stage IIA, 23 stage IIB, 9 stage III, and 24 stage IV. The median failure-free survival (FFS) was 16.0months, and the median cancer-specific survival (CSS) was 24.8months. In multivariate analysis, FIGO stage and lymph node metastasis were selected as independent variables in stages I-IV. **In stages IIB-IVB, primary treatment containing etoposide and platinum for at least 5 cycles (EP5+) (n=16) was associated with significantly better 5-year FFS (42.9% versus 11.8%, p=0.041) and CSS (45.6% versus 17.1%, p=0.035) compared to other treatments (n=40)**. Furthermore, **concurrent chemoradiation with EP5+ (CCRT-EP5+) was associated with even better 5-year FFS (62.5% versus 13.1%, p=0.025) and CSS (75.0% versus 16.9%, p=0.016)**.

CONCLUSIONS:

FIGO stage and lymph node metastasis are significant prognostic factors in SCNECC. **In stages IIB-IVB, CCRT-EP5+ might be the treatment of choice, which could be also true for earlier stages.** Despite limitations of a retrospective study spanning a long time period and heterogeneous managements, the results provide an important basis for designing future prospective studies

Ref 2 **我們 TGOG 之傑作 (Impact Factor 3.76):**

Gynecol Oncol. 2012 Feb;124(2):244-9. Epub 2011 Oct 20.

A long-term follow-up study of 176 cases with adult-type ovarian granulosa cell tumors.

Sun HD, Lin H, Jao MS, Wang KL, Liou WS, Hung YC, Chiang YC, Lu CH, Lai HC, Yu MH.

Source

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Abstract

OBJECTIVE:

Because of rarity, indolent clinical course, and of most importance, small sample size studies of previous ovarian granulosa cell tumors (GCTs), this study was conducted to

report the clinical characteristics and long-term outcomes of 176 pathologically confirmed GCTs.
METHODS:
Between 1984 and 2010, we retrospectively evaluated 176 patients from multiple medical centers in Taiwan.
RESULTS:
The mean age at the diagnosis was 46 years and nearly half of the patients (45.7%) were in their fourth or fifth decades of life. The most common symptoms included abdominal pain (28.5%), followed by irregular menstruation (16.7%). The mean tumor size was 10.4 cm. The stage distribution at diagnosis was stage I in 77.8% of patients, stage II in 5.1%, stages III-V in 6.1%, and unknown in 11% of patients. The median follow-up period was 60.7 months. The recurrence rate was 21%. The overall 5- and 10-year survival rates were 96.5% and 94.1%, respectively. In univariate analysis, initial stage, presence of residual tumor after initial surgery, need for adjuvant chemotherapy, and tumor size were associated with disease recurrence. **In the multivariate analysis, only the presence of residual tumor after initial surgery and tumor size were significantly associated with recurrence**.
CONCLUSIONS:
The outcomes of patients with GCTs were good, with nearly to 95% of patients surviving 5 and 10 years. The prognosis was related to initial stage, presence of residual tumor after initial surgery, and tumor size (>13.5 cm). **Different surgical methods and/or adjuvant therapy appear not to affect the outcome**.

Ref 3 韓國 KGOG 已經有 JCO 的 paper 了 (Impact Factor: 18.970)

J Clin Oncol. 2012 Apr 20;30(12):1329-34. Epub 2012 Mar 12.

Preoperative identification of a low-risk group for lymph node metastasis in endometrial cancer: a korean gynecologic oncology group study.

Kang S, Kang WD, Chung HH, Jeong DH, Seo SS, Lee JM, Lee JK, Kim JW, Kim SM, Park SY, Kim KT.

Source
Department of Obstetrics and Gynecology and Cancer Research Institute, College of Medicine, Seoul National University, 101 Daehak-ro Jongno-gu, 110-744, Seoul, Republic of Korea; kjwksh@snu.ac.kr.

Abstract
PURPOSE The aim of this study was to develop a preoperative risk prediction model for lymph node metastasis in patients with endometrial cancer and to identify a low-risk group before surgery. PATIENTS AND METHODS The medical records of 360 patients with endometrial cancer who underwent surgical staging were collected from four

institutions and were retrospectively reviewed. By using serum CA-125 levels, preoperative biopsy data, and magnetic resonance imaging (MRI) data, a multivariate logistic model was created. Patients whose predicted probability was less than 4% were defined as low risk. The developed model was externally validated in 180 patients from two independent institutions. Results **Serum CA-125** levels and **three MRI parameters** (deep myometrial invasion, lymph node enlargement, and extension beyond uterine corpus) were found to be **independent risk factors for nodal metastasis**. The model classified 53% of patients as part of a low-risk group, and the false negative rate was 1.7%. In the validation cohort, the model classified 43% of patients as low-risk, and the **false negative rate was 1.4%**. The model showed good discrimination (area under the receiver operator characteristic curve = 0.85) and was calibrated well. The negative likelihood ratio of our low-risk criteria was 0.11 (95% CI, 0.04 to 0.29), which was equivalent to the false-negative rate of 1.3% (95% CI, 0.5% to 3.3%) at the assumed prevalence of nodal metastasis of 10%. CONCLUSION Using serum CA-125 and MRI as criteria resulted in the accurate identification of a low-risk group for lymph node metastasis among patients with endometrial cancer.

Ref 4 WHI study: 單用 Premarin,反而較少 breast cancer risk

Lancet Oncol. 2012 May;13(5):476-86. Epub 2012 Mar 7.

Conjugated equine oestrogen and breast cancer incidence and mortality in postmenopausal women with hysterectomy: extended follow-up of the Women's Health Initiative randomised placebo-controlled trial.

Anderson GL, Chlebowski RT, Aragaki AK, Kuller LH, Manson JE, Gass M, Bluhm E, Connelly S, Hubbell FA, Lane D, Martin L, Ockene J, Rohan T, Schenken R, Wactawski-Wende J.

Source

Fred Hutchinson Cancer Research Center, Public Health Sciences, Seattle, WA, USA.

Abstract

BACKGROUND:

By contrast with many observational studies, women in **the Women's Health Initiative (WHI) trial** who were randomly allocated to receive oestrogen alone had a lower incidence of invasive breast cancer than did those who received placebo. We aimed to assess the influence of oestrogen use on longer term breast cancer incidence and mortality in extended follow-up of this cohort.

METHODS:

Between 1993 and 1998, the WHI enrolled 10 739 postmenopausal women from 40 US clinical centres into a randomised, double-masked, placebo-controlled trial. Women aged 50-79 years who had undergone hysterectomy and had expected 3-year survival and mammography clearance were randomly allocated by a computerised, permuted block

algorithm, stratified by age group and centre, to receive oral conjugated equine oestrogen (0·625 mg per day; n=5310) or matched placebo (n=5429). The trial intervention was terminated early on Feb 29, 2004, because of an adverse effect on stroke. Follow-up continued until planned termination (March 31, 2005). Consent was sought for extended surveillance from the 9786 living participants in active follow-up, of whom 7645 agreed. Using data from this extended follow-up (to Aug 14, 2009), we assessed long-term effects of oestrogen use on invasive breast cancer incidence, tumour characteristics, and mortality. We used Cox regression models to estimate hazard ratios (HRs) in the intention-to-treat population. This study is registered with ClinicalTrials.gov, number NCT00000611.

FINDINGS:

After a median follow-up of 11·8 years (IQR 9·1-12·9), **the use of oestrogen for a median of 5·9 years (2·5-7·3) was associated with bwer incidence of invasive breast cancer** (151 cases, 0·27% per year) compared with placebo (199 cases, 0·35% per year; HR 0·77, 95% CI 0·62-0·95; p=0·02) with no difference (p=0·76) between intervention phase (0·79, 0·61-1·02) and post-intervention phaseeffects (0·75, 0·51-1·09). In subgroup analyses, we noted breast cancer risk reduction with oestrogen use was concentrated in women without benign breast disease (p=0·01) or a family history of breast cancer (p=0·02). **In the oestrogen group, fewer women died from breast cancer** (six deaths, 0·009% per year) compared with controls (16 deaths, 0·024% per year; HR 0·37, 95% CI 0·13-0·91; p=0·03). Fewer women in theoestrogen group died from any cause after a breast cancer diagnosis (30 deaths, 0·046% per year) than did controls (50 deaths, 0·076%; HR 0·62, 95% CI 0·39-0·97; p=0·04).

INTERPRETATION:

Our findings **provide reassurance for women with hysterectomy seeking relief of climacteric symptoms in terms of the effects of oestrogen use for about 5 years on breast cancer incidence and mortality**. However, our data do not support use of oestrogen for breast cancer risk reduction because any noted benefit probably does not apply to populations at increased risk of such cancer.

Ref 5 MSKCC 的改良式 intraperitoneal chemotherapy

Gynecol Oncol. 2012 Mar 21. [Epub ahead of print]

Progression-free and overall survival of a modified outpatient regimen of primary intravenous/intraperitoneal paclitaxel and intraperitoneal cisplatin in ovarian, fallopian tube, and primary peritoneal cancer.

Barlin JN, Dao F, Zgheib NB, Ferguson SE, Sabbatini PJ, Hensley ML, Bell-McGuinn KM, Konner J, Tew WP, Aghajanian C, Chi DS.

Source

Gynecology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center,

New York, NY, USA.

Abstract

OBJECTIVE:

GOG study 172 demonstrated improved progression-free (PFS) and overall (OS) survival for patients with stage III optimally debulked ovarian and peritoneal carcinoma treated with IV/IP paclitaxel and IP cisplatin compared to standard IV therapy. The inpatient administration, toxicity profile, and limited completion rate have been blamed for the lack of acceptance and widespread use of this regimen. We sought to evaluate the PFS, OS, toxicity, and completion rate of a modified outpatient IP regimen.

METHODS:

Using a prospectively maintained database, we evaluated the outcomes of patients who underwent primary optimal cytoreduction for stage III ovarian, tubal, or peritoneal carcinoma followed by IV/IP chemotherapy from 1/05-3/09. Our modified regimen was as follows: **IV paclitaxel (135mg/m(2)) over 3h** on day 1, **IP cisplatin (75mg/m(2))** on day 2, and IP paclitaxel (60mg/m(2)) on day 8, given every 21days for 6cycles.

RESULTS:

We identified 102 patients who initiated the modified IV/IP regimen and completed chemotherapy. The median follow-up was 43months. The median age at diagnosis was 57years (range, 23-76). Primary disease site was: ovary, 77 (75%); fallopian tube, 13 (13%); peritoneum, 12 (12%). FIGO stage was: IIIA, 8 (8%); IIIB, 4 (4%); IIIC, 90 (88%). Residual disease after cytoreduction was: none, 58 (57%); ≤1cm, 44 (43%). The most frequent grade 3/4 toxicities were: neutropenia, 12 (12%); gastrointestinal, 8 (8%); neurologic, 6 (6%). Eighty-two (80%) of 102 patients completed 4 or more cycles of IV/IP therapy; 56 (55%) completed all 6cycles. The median PFS and OS were 29 and 67months, respectively.

CONCLUSIONS:

By modifying the GOG 172 treatment regimen, **convenience, toxicity, and tolerability appear improved, with survival outcomes similar** to those of GOG 172. This modified IV/IP regimen warrants further study.

Ref 6 Irradiation 或為 ovarian clear cell carcinoma 的一條活路

J Clin Oncol. 2012 Apr 9. [Epub ahead of print]

Low-Stage Ovarian Clear Cell Carcinoma: Population-Based Outcomes in British Columbia, Canada, With Evidence for a Survival Benefit As a Result of Irradiation.

Hoskins PJ, Le N, Gilks B, Tinker A, Santos J, Wong F, Swenerton KD.

Source

All authors: British Columbia Cancer Agency, Vancouver, British Columbia, Canada.

Abstract

PURPOSETo evaluate the population-based outcomes of stage I and II ovarian clear cell carcinoma (OCCC) in a North American population treated with carboplatin/paclitaxel and abdominopelvic irradiation. PATIENTS AND METHODSRetrospective analysis was performed of 241 patients referred in the carboplatin/paclitaxel era. Irradiation was to be used with a few defined exceptions. However, because of differing beliefs as to its effectiveness, its use was consistently avoided by specific oncologists, allowing the opportunity to study its possible effect on disease-free survival (DFS) in these concurrent cohorts.ResultsFive- and 10-year DFS rates were 84% and 70% for stage IA/B; 67% and 57% for stage IC; and 49% and 44% for stage II, respectively. Five- and 10-year DFS rates for those with stage IC disease based purely on rupture were similar to rates for patients with stage IA/B, at 92% and 71%, respectively. The remaining patients with stage IC had 48% 5- and 10-year DFS. Multivariate analysis using a decision tree identified positive cytology as the most important factor (72% relapse rate if positive and 27% if negative or unknown). If, in addition, the capsule surface was involved, then the relapse rate was 93%. **Irradiation** had no discernible survival benefit for patients with stage IA and IC (rupture alone), whereas **for the remainder of patients with stage IC and stage II, it improved DFS by 20% at 5 years (relative risk, 0.5)**; the benefit was most evident in the cytologically negative/unknown group. CONCLUSIONDFS is similar in this North American population with early OCCC to the DFS reported in Asia. **A potential benefit from irradiation was evident in a subset**

Ref 7 Platinum-sensitive recurrence: Olaparib

N Engl J Med. 2012 Apr 12;366(15):1382-92. Epub 2012 Mar 27.

Olaparib maintenance therapy in platinum-sensitive relapsed ovarian cancer.

Ledermann J, Harter P, Gourley C, Friedlander M, Vergote I, Rustin G, Scott C, Meier W, Shapira-Frommer R, Safra T, Matei D, Macpherson E, Watkins C, Carmichael J, Matulonis U.

Source

University College London (UCL) Cancer Institute, UCL & UCL Hospitals Comprehensive Biomedical Research Centre, 90 Tottenham Court Rd., London W1T 4TJ, United Kingdom. j.ledermann@ctc.ucl.ac.uk

Abstract

BACKGROUND:

Olaparib (AZD2281) is an **oral poly(adenosine diphosphate [ADP]-ribose) polymerase inhibitor** that has shown antitumor activity in patients with high-grade serous ovarian cancer **with or without BRCA1 or BRCA2 germline mutations**.

METHODS:

We conducted a randomized, double-blind, placebo-controlled, phase 2 study to evaluate

maintenance treatment with olaparib in patients with platinum-sensitive, relapsed, high-grade serous ovarian cancer who had received two or more platinum-based regimens and had had a partial or complete response to their most recent platinum-based regimen. Patients were randomly assigned to receive olaparib, at a dose of **400 mg twice daily**, or placebo. The primary end point was progression-free survival according to the Response Evaluation Criteria in Solid Tumors guidelines.

RESULTS:

Of 265 patients who underwent randomization, 136 were assigned to the olaparib group and 129 to the placebo group. **Progression-free survival** was significantly longer with olaparib than with placebo (median, **8.4 months vs. 4.8 months** from randomization on completion of chemotherapy; hazard ratio for progression or death, 0.35; 95% confidence interval [CI], 0.25 to 0.49; P<0.001). Subgroup analyses of progression-free survival showed that, regardless of subgroup, patients in the olaparib group had a lower risk of progression. **Adverse events** more commonly reported in the olaparib group than in the placebo group (by more than 10% of patients) were nausea (68% vs. 35%), fatigue (49% vs. 38%), vomiting (32% vs. 14%), and anemia (17% vs. 5%); the majority of adverse events were grade 1 or 2. An interim analysis of **overall survival** (38% maturity, meaning that 38% of the patients had died) showed no significant difference between groups (hazard ratio with olaparib, 0.94; 95% CI, 0.63 to 1.39; P=0.75).

CONCLUSIONS:

Olaparib as maintenance treatment **significantly improved progression-free survival** among patients with platinum-sensitive, relapsed, high-grade serous ovarian cancer. Interim analysis showed **no overall survival benefit**. The toxicity profile of olaparib in this population was consistent with that in previous studies.

Ref 8 子宮頸癌 CCRT with weekly cisplatin-topotecan

Gynecol Oncol. 2012 Apr;125(1):158-62. Epub 2011 Dec 22.

A phase I study of concurrent weekly topotecan and cisplatin chemotherapy with whole pelvic radiation therapy in locally advanced cervical cancer: a gynecologic oncology group study.

Rose PG, Sill MW, McMeekin DS, Ahmed A, Salani R, Yamada SD, Wolfson AH, Fusco N, Fracasso PM. Case Western Reserve University, Cleveland, OH 44195, USA. rosep@ccf.org

Abstract

PURPOSE:

To determine the maximum tolerated dose (MTD) and acute dose-limiting toxicities (DLT) of intravenous topotecan administered with weekly cisplatin during pelvic radiation therapy in patients with locally advanced cervical cancer.

METHODS:

Patients were treated at one of two dose levels receiving intravenous topotecan at 0.5mg/m(2) and cisplatin at either 30 or 40 mg/m(2) given weekly for 6 weeks concurrently with pelvic radiation and intracavitary brachytherapy. The primary endpoint for the escalation study was acute dose-limiting toxicities occurring within 30 days of completing radiation therapy.
RESULTS:
Eleven patients were enrolled. Dose-limiting toxicity consisting of Grade 3 nausea and vomiting lasting >24h in one patient and grade 3 febrile neutropenia in another patient occurred at the first dose level of weekly topotecan 0.5mg/m(2) and cisplatin 40 mg/m(2). This necessitated de-escalation to weekly cisplatin 30 mg/m(2) in combination with topotecan 0.5mg/m(2) and pelvic radiation. This dose level was tolerable in 6 evaluable patients with only one DLT consisting of grade 4 thrombocytopenia, grade 3 abdominal pain and grade 3 elevated gamma glutamyl transpeptidase (GGT).
CONCLUSIONS:
In women with locally advanced cervical cancer, **intravenous topotecan 0.5mg/m(2) and cisplatin 30 mg/m(2) given weekly for 6 weeks** with concurrent pelvic radiation and intracavitary brachytherapy were tolerable. Further expansion of the feasibility cohort of this study was suspended based on the results of a phase 3 trial comparing the efficacy of platinum combinations in advanced and recurrent cervical cancer.

Ref 9 **CCRT for advanced vulva SCC**

Gynecol Oncol. 2012 Mar;124(3):529-33. Epub 2011 Nov 9.

A phase II trial of radiation therapy and weekly cisplatin chemotherapy for the treatment of locally-advanced squamous cell carcinoma of the vulva: a gynecologic oncology group study.

Moore DH, Ali S, Koh WJ, Michael H, Barnes MN, McCourt CK, Homesley HD, Walker JL.
Source
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Abstract
OBJECTIVES:
To determine the efficacy and toxicity of radiation therapy and concurrent weekly cisplatin chemotherapy in achieving a complete clinical and pathologic response when used for the primary treatment of locally-advanced vulvar carcinoma.
METHODS:
Patients with locally-advanced (T3 or T4 tumors not amenable to surgical resection via radical vulvectomy), previously untreated squamous cell carcinoma of the vulva were treated with radiation (1.8 Gy daily × 32 fractions=57.6 Gy) **plus weekly cisplatin (40**

mg/m(2)) followed by surgical resection of residual tumor (or biopsy to confirm complete clinical response). Management of the groin lymph nodes was standardized and was not a statistical endpoint. Primary endpoints were complete clinical and pathologic response rates of the primary vulvar tumor.

RESULTS:

A planned interim analysis indicated sufficient activity to reopen the study to a second stage of accrual. Among 58 evaluable patients, there were 40 (69%) who completed study treatment. Reasons for prematurely discontinuing treatment included: patient refusal (N=4), toxicity (N=9), death (N=2), other (N=3). There were 37 patients with a **complete clinical response (37/58; 64%**). Among these women there were 34 who underwent surgical biopsy and 29 (78%) who also had a complete pathological response. Common adverse effects included leukopenia, pain, radiation dermatitis, pain, or metabolic changes.

CONCLUSIONS:

This combination of radiation therapy plus weekly cisplatin successfully **yielded high complete clinical and pathologic response rates** with acceptable toxicity.

Ref 10 Radiosurgery 於處理單顆 brain metastasis 的角色

Cancer. 2012 Feb 15;118(4):1138-44. doi: 10.1002/cncr.26379. Epub 2011 Jul 14.

Single brain metastasis: whole-brain irradiation plus either radiosurgery or neurosurgical resection.

Rades D, Veninga T, Hornung D, Wittkugel O, Schild SE, Gliemroth J.

Source

Department of Radiation Oncology, University of Lubeck, Lubeck, Germany.

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Abstract

BACKGROUND:

The current study was conducted to compare **neurosurgical resection (NR)** followed by **whole-brain irradiation (WBI)** (NR + WBI) with WBI followed by **radiosurgery** (WBI + **RS**) in patients with a single brain metastasis.

METHODS:

The outcome of 41 patients treated with WBI + RS was retrospectively compared with 111 patients who received NR ;+ WBI with respect to local control of the treated metastasis and survival. Eleven additional potential prognostic factors were investigated, including WBI schedule, patient age, patient gender, Karnofsky performance score (KPS), primary tumor type, extracerebral metastases, recursive partitioning analysis (RPA) class, interval between the first diagnosis of cancer to the treatment of brain metastasis, metastatic site, maximum diameter of the metastasis, and graded prognostic assessment (GPA) score.

RESULTS:
The 1-year local control rates were 87% after WBI + RS and 56% after NR + WBI (P = .001). Using the Cox proportional hazards model, the treatment regimen remained significant (risk ratio [RR], 2.46; 95% confidence interval [95% CI], 1.29-5.17 [P = .005]). On the multivariate analysis, local control was also found to be associated with the maximum diameter of the metastasis. The 1-year survival rates were 61% after WBI + RS and 53% after NR + WBI (P = .16). Acute and late toxicities were similar in both groups. On the multivariate analysis, KPS, extracerebral metastases, RPA class, and the GPA score were found to be independent predictors of survival.
CONCLUSIONS:
The use of WBI + RS resulted in significantly better local control of the treated metastasis than NR + WBI. Survival was not found to be significantly different in either group. Because WBI + RS is **less invasive** than NR + WBI, it appears to be preferable for many patients with a single brain metastasis. These results should be confirmed in a randomized trial

Ref 11 **下肢 lymphedema 之新手術療法**

Gynecol Oncol. 2012 Apr 17. [Epub ahead of print]

A novel approach to the treatment of lower extremity lymphedema by transferring a vascularized submental lymph node flap to the ankle.

Cheng MH, Huang JJ, Nguyen DH, Saint-Cyr M, Zenn MR, Tan BK, Lee CL.
Source
Division of Reconstructive Microsurgery, Department of Plastic and Reconstructive Surgery, Chang Gung Memorial Hospital, College of Medicine, Chang Gung University, Taoyuan, Taiwan.
Abstract
OBJECTIVE:
Vascularized groin lymph node flaps have been successfully transferred to the wrist to treat postmastecomy upper limb lymphedema. This study investigated the anatomy, mechanism and outcome of a novel **vascularized submental lymph node (VSLN) flap** transfer for the treatment of lower limb lymphedema.
METHODS:
Bilateral regional submental flaps were **dissected from three fresh adult cadavers** for histological study. A unilateral submental flap was dissected in another six fresh cadavers after latex injection. The VSLN flap was transferred to the ankles of seven lower extremities in six patients with chronic lower extremity lymphedema. The mean patient age was 61±1.4years. The average duration of lymphedema symptoms was 71±42.2months.
RESULTS:

There was a mean of 3.3±1.5 lymph nodes around the submental artery typically at the junction with the facial artery, on the six cadaveric histological sections. Mean of 2.3±0.8 sizable lymph nodes were dissected and supplied by the submental artery in six cadaveric latex-injected submental flaps. All seven VSLN flaps survived. One flap required re-exploration for venous congestion but was successfully salvaged. There was no donor site morbidity. At a mean follow-up of 8.7±4.2months, the mean reduction of the leg circumference was 64±11.5% above the knee, 63.7±34.3% below the knee and 67.3±19.2% above the ankle.

CONCLUSION:

The transfer of a vascularized submental lymph node flap to the ankle is a novel approach for the effective treatment of lower limb lymphedema.