台灣婦癌醫學會會訊

2013 年 3.4,5 月

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學會網址: www.tago.org.tw
學會 E-mail address: tago.gyn@gmail.com
學會地址：10041 台北市中正區中山南路 8 號台灣大學附設醫院婦產部轉台灣婦癌醫學會
學會電話：(02)2311-8982; 傳真：(02)2311-4965
學會秘書: 蘇芳萱小姐

壹、 會務報告

一、第八屆第六次理監事聯席會議記錄

時 間：102 年 5 月 18 日（星期六）中午 12 時

地 點：彰濱秀傳紀念醫院（8 樓美蒂琪會議室會議室）

主 席：陳祈安 理事長

出 席：
常務理事- 王功亮、顏明賢、簡婉儀、周振陽、張廷彰、余慕賢

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謝長堯、鄭雅敏、林浩、楊育正、何師竹、賴鴻政

常務監事- 屠乃方

監 事- 李耀泰、許耿福、鄭丞傑

列 席- 秘書長 鄭文芳；
副秘書長 陳子和、陳子健；
秘書 蘇芳萱

請 假- 余堅忍、趙灌中、王鵬惠、陳啟豪、許博欽

報告事項:

 # 專科醫師頒證儀式

將於 2013/07/13 會員大會進行。

 # 準會員口頭訓練補報時間與地點

2013/07/13(週六)，於台大醫院兒童醫療大樓婦產部會議室舉行。

 # 準會員推薦表

將推薦者(本會專科醫師)修改為: 指導者（本會專科醫師）

#專科醫師甄審今年度時間

決議： 2013/12/07(六)，於台大醫院兒童醫療大樓婦產部會議室舉行。

 # 2013 年 ASGO 會議補助

TGOG 研究成果發表論文（未發表過），限為第一作者或年輕醫師，學會贊助一篇一萬元整。

 # 學會網站之研討會講師錄影檔

設定為學會會員才可點閱。

#暫定之明年度研討會時間

（北區）台北榮民總醫院，2014/01/11(六)
（中區）彰化基督教醫院，2014/05/17，或 2014/07/19(視 TJCC 大會時間而訂)
（南區）高雄醫學大學附設醫院，2014/11/22

二、 近期國內外婦癌相關活動一覽表

日期	活動名稱	活動地點
2013/07/13-14	第十八屆台灣癌症聯合學術年會暨第八屆第二次會員大會	台大醫院國際會議中心（台北市中正區徐州路2號）
2013/08/2-4	**International Symposium on Radical Hysterectomy**	Asan Medical Center, Seoul, Korea
2013/10/19-22	**18th International Meeting of the European Society of Gynaecological Cancer (ESGO 18)**	Liverpool, UK
2013/11/16	南區婦癌研討會	高雄長庚醫院
2013/12/13-15	**3rd Biennial Meeting of Asian Society of Gynecologic Oncology**	The Westin Miyako, Kyoto, Japan
2014/01/11	北區婦癌研討會	台北榮民總醫院
2014/05/17，或 2014/07/19(視TJCC大會時間而訂)	中區婦癌研討會	彰化基督教醫院
2014/11/22	南區婦癌研討會	高雄醫學大學附設醫院

三、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

Ref 1

Gynecol Oncol. 2013 Jun;129(3):528-32.

Low yield of residual vulvar carcinoma and dysplasia upon re-excision for close or positive margins.

Ioffe YJ, Erickson BK, Foster KE, Mutch DG, Powell MA, Thaker PH, Hagemann AR, Conner MG, Huh WK, Massad LS.

Source

Washington University in St Louis School of Medicine, Department of Obstetrics & Gynecology, Division of Gynecologic Oncology, 660 S. Euclid Ave, St Louis, MO 63110, USA. ioffey@wudosis.wustl.edu

Abstract

OBJECTIVES:

The objectives of this study are to determine the utility of re-excision after a primary diagnosis of vulvar carcinoma by assessing the frequency of residual carcinoma found upon re-excision and to quantitate the wound breakdown and carcinoma recurrence rates.

METHODS:

We reviewed 1122 cases of VIN or vulvar carcinoma. Women who underwent re-excisional procedures, as part of their initial surgical treatment were identified. Associations between the margin status of the original excisional sample and histology of re-excision, as well as association between the depth of invasion upon initial excision and histology of re-excision were analyzed with Chi-square tests.

RESULTS:

We identified 84 evaluable patients, 72 with stage I disease, 4 with stage II, and 7 with stage III disease. Upon the initial excisional procedure, 33 patients (39%) had carcinoma-positive margins, 27 patients had VIN-positive margins (32%) and 24 patients (28%) had negative margins (>1mm). Upon re-excision, **1/24 (4%)** patients with negative margins, **2/27 (7%)** patients with VIN-positive margins, and **11/33 (33%)** patients with carcinoma-positive margins were **found to have carcinoma in the re-excision specimens** ($p<0.0001$, $\chi(2)=31$). Deeper tumor invasion of the initial excisional specimen (1-12mm) was associated with a higher chance of finding carcinoma upon re-excision (range 18-42%, depending on depth of invasion) ($p=0.015$, $\chi(2)=19$). Nineteen patients **(23%) had vulvar wound breakdown post re-excision**. Twelve patients (15%) experienced recurrences.

CONCLUSIONS:

The yield of micro- or invasive carcinoma at re-excision is low, with a **high wound breakdown rate**. Re-excision should be considered for patients with margins positive for carcinoma, especially for women with deep invasion, **while women with VIN or close but clear margins may be followed**.

Ref 2

Gynecol Oncol. 2013 Jun;129(3):500-4.

Potential of an age-stratified CA125 cut-off value to improve the prognostic classification of patients with endometrial cancer.

Chao A, Tang YH, Lai CH, Chang CJ, Chang SC, Wu TI, Hsueh S, Wang CJ, Chou HH, Chang TC.

Source

Department of Obstetrics and Gynecology, Chang Gung Memorial Hospital, Taoyuan, Taiwan. angel945@cgmh.org.tw

Abstract

OBJECTIVE:

It is not clear whether the prognostic value of pretreatment serum CA125 levels is independent or through association with other clinicopathological features in endometrial cancer.

METHODS:

All patients with endometrial cancer treated between 2000 and 2010 were retrospectively reviewed. The correlation of clinicopathological characteristics, CA125 and treatment outcomes was analyzed. Receiver operating characteristics (ROC) curves were used to determine the CA125 cut-off values. Cox proportional hazard regression was used for multivariate analysis.

RESULTS:

Of the 923 eligible patients, **757** had serum CA125 levels measured before treatment. We identified 264 (34.9%) patients with pretreatment serum CA125>35 U/mL. **By multivariate analysis,** advanced stage (P=0.001), serous or clear cell carcinoma (P=0.008), positive peritoneal cytology (P=0.042), and lymph node metastases (P=0.004) were significant risk factors for cancer-specific survival (CSS), while serum CA125>35 U/mL (P=0.067) was of borderline statistical significance. **Using ROC curve stratified by age,** we found that a serum CA125>35 U/mL was significant for CSS (HR=2.34, 95% CI=1.04-5.29) among patients >49 years old. After adjustment for confounding factors, serum CA125>105 U/mL was significant (HR=6.03, 95% CI=1.19-30.63) in patients ≤49 years old.

CONCLUSIONS:

These results suggest that **an age-stratified cut-off level for CA125 (35 U/mL in patients >49 years old and 105 U/mL in patients ≤49 years old) can improve the prognostic stratification** of patients with endometrial cancer.

Ref 3

Gynecol Oncol. 2013 Apr 28. pii: S0090-8258(13)00311-9. doi: 10.1016/j.ygyno.2013.04.055. [Epub ahead of print]

Recurrence patterns after extended treatment with bevacizumab for ovarian, fallopian tube, and primary peritoneal cancers.

Dao MD, Alwan LM, Gray HJ, Tamimi HK, Goff BA, Liao JB.

Source

Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of Washington, Seattle, WA, USA.

Abstract

OBJECTIVE:

To evaluate patterns of recurrence for ovarian, fallopian tube, and primary peritoneal cancer patients undergoing extended treatment with bevacizumab (BEV).

METHODS:

A retrospective review of patients with primary ovarian, fallopian tube, or peritoneal cancer treated with BEV alone or in combination with other chemotherapy from 2001 to 2011 was performed. Qualified patients were identified by chemotherapy records. Electronic medical records, labs, and imaging reports were reviewed and abstracted.

RESULTS:

Of 108 patients identified, 89 patients met study criteria by having disease progression either during treatment with BEV or after discontinuing BEV without initiating any other treatment. Patients on extended BEV therapy (>12 cycles) were **more likely to recur in extra-visceral sites** (p=0.04), especially in lymph nodes (p=0.0002), and presented with **fewer symptoms at time of recurrence** (p=0.02), compared to patients who had received≤12 cycles. **CA-125 becomes less reliable** for the detection of recurrent disease with extended BEV therapy (p=0.03 for≤12 cycles vs. p=0.08 for >12 cycles). Radiology was superior to CA-125, symptom, and physical exam, in detecting recurrence with extended BEV therapy (all p<0.0001).

CONCLUSIONS:

Extended treatment with BEV in ovarian, fallopian tube, and peritoneal cancers **results in alterations in the patterns of recurrence**. Radiologic imaging is more reliable than CA-125, symptoms, or physical exam, in identifying recurrent disease in patients undergoing BEV treatment. As novel targeted therapies continue to be employed, guidelines for gynecologic cancer surveillance must continue to be reexamined.

Ref 4

Gynecol Oncol. 2013 Apr 26. pii: S0090-8258(13)00306-5. doi: 10.1016/j.ygyno.2013.04.050. [Epub ahead of print]

Is vaccination with quadrivalent HPV vaccine after loop electrosurgical excision procedure effective in preventing recurrence in patients with high-grade cervical intraepithelial neoplasia (CIN2-3)?

Kang WD, Choi HS, Kim SM.

Source

Department of Obstetrics and Gynecology, Chonnam National University Medical School, Gwangju, Republic of Korea.

Abstract

OBJECTIVES:

This study was conducted to determine whether vaccination with the quadrivalent human papillomavirus (HPV) vaccine after loop electrosurgical excision procedure (LEEP) for high-grade cervical intraepithelial neoplasia (CIN2-3) is effective in preventing recurrence of CIN2-3.

METHODS:

Between August 2007 and July 2010, **737 patients** aged 20-45years who were diagnosed with CIN2-3 were treated by LEEP and followed. Three hundred and sixty patients were vaccinated with the quadrivalent HPV vaccine after LEEP (vaccination group), and 377 patients were followed without vaccination (non-vaccination group). The vaccination group received the first dose at 1week after LEEP and the remaining two doses two and six months later. Post-LEEP follow-up was performed at 3, 6, 9, 12, 18, and 24months during the first 2years and yearly thereafter.

RESULTS:

Irrespective of causal HPV type, 36 (4.9%) patients developed recurrence. In the **vaccination group (360 patients), 9 patients (2.5%) developed recurrence, whereas 27 patients (7.2%) in the non-vaccination group (377 patients) developed recurrence.** In patients infected with HPV of 16 and/or 18 type, 5 patients (2.5%) in the vaccination group (197 patients) and 18 patients (8.5%) in the non-vaccination group (211 patients) developed recurrent disease related to vaccine HPV types (HPV 16 or 18 types) after LEEP (P<0.01). **Multivariate analysis** showed that no vaccination after LEEP was **an independent risk factor** for recurrent CIN2-3 (HR=2.840; 95% confidence interval, 1.335-6.042; P<0.01).

CONCLUSIONS:

Vaccination with the **quadrivalent HPV vaccine after treatment may be considered in preventing recurrence of CIN2-3**.

Ref 5

Gynecol Oncol. 2013 Jul;130(1):213-8.

Multiple large bowel resections: Potential risk factor for anastomotic leak.

Kalogera E, Dowdy SC, Mariani A, Weaver AL, Aletti G, Bakkum-Gamez JN, Cliby WA.

Source

Division of Gynecologic Surgery, Mayo Clinic, Rochester, MN, USA.

Abstract

OBJECTIVES:

Identify risk factors of **anastomotic leak (AL)** after **large bowel resection (LBR) for ovarian cancer (OC)** and compare outcomes between AL and no AL.

METHODS:

All cases of AL after LBR for OC between 01/01/1994 and 05/20/2011 were identified and matched 1:2 with controls for age (±5years), sub-stage (IIIA/IIIB; IIIC; IV), and date of surgery (±4years). Patient-specific and intraoperative risk factors, use of protective stomas, and outcomes were abstracted. A stratified conditional logistic regression model was fit to determine the association between each factor and AL.

RESULTS:

42 AL cases were evaluable and matched with 84 controls. Two-thirds of the AL had stage IIIC disease and >90% of both cases and controls were cytoreduced to <1cm residual disease. No patient-specific risk factors were associated with AL (pre-operative albumin was not available for most patients). Rectosigmoid resection coupled with additional LBR was associated with AL (OR=2.73, 95% CI 1.13-6.59, P=0.025), and **protective stomas** were associated with decreased risk of AL (0% vs. 10.7%, P=0.024). AL patients had longer length of stay (P<0.001), were less likely to start chemotherapy (P=0.020), and had longer time to chemotherapy (P=0.007). Cases tended to have higher 90-day mortality (P=0.061) and were more likely to have **poorer overall survival** (HR=2.05, 95% CI 1.18-3.57, P=0.011).

CONCLUSIONS:

Multiple LBRs appear to be associated with increased risk of AL and protective stomas with decreased risk. Since **AL after OC cytoreduction significantly delays chemotherapy and negatively impacts survival**, surgeons should **strongly consider temporary diversion in selected patients (poor nutritional status, multiple LBRs, previous pelvic radiation, very low anterior resection, steroid use)**.

Ref 6

Gynecol Oncol. 2013 Apr;129(1):63-8.

Platinum resistance after neoadjuvant chemotherapy compared to primary surgery in patients with advanced epithelial ovarian carcinoma.

Rauh-Hain JA, Nitschmann CC, Worley MJ Jr, Bradford LS, Berkowitz RS, Schorge JO, Campos SM, del Carmen MG, Horowitz NS.

Source

Division of Gynecologic Oncology, Vincent Obstetrics and Gynecology, Massachusetts General Hospital, **Harvard Medical School**, Boston, MA, USA.

Abstract

OBJECTIVE:

Primary debulking surgery (PDS) has historically been the standard treatment for advanced ovarian cancer. Recent data appear to support a paradigm shift toward neoadjuvant chemotherapy with interval debulking surgery (NACT-IDS) for a subset of women with advanced ovarian cancer. It remains unresolved whether NACT-IDS increases the risk of platinum resistance. We compared response to chemotherapy in patients that received NACT-IDS vs. PDS.

METHODS:

From our Cancer Registry database we identified patients with stages IIIC and IV epithelial ovarian cancer who underwent treatment from January, 2005 to December, 2010. Standard univariate analyses were performed, as were multivariable analysis with logistic regression. The Kaplan-Meier method was used to generate survival data.

RESULTS:

The study population consisted of 425 patients, 95 (22.3%) underwent NACT-IDS and 330 (77.6%) PDS. After the initial platinum-based chemotherapy, 42 (**44.2%) women in the NACT-IDS group were considered to have platinum resistant disease**, compared to 103 (31.2%) in the PDS group (P=0.01). When multivariate logistic regression was used to control for factors independently associated with platinum resistance, NACT-IDS was no longer associated with an initial increased risk. However, **in women that had a recurrence and were retreated with platinum-based chemotherapy**, 32 (**88.8%**) in the NACT-IDS group had developed a recurrence within six months and were considered **platinum resistant**, compared to 62 (55.3%) in the PDS (P<0.001).

CONCLUSION:

In women with EOC that have a recurrence and are treated again with platinum-based chemotherapy, **NACT-IDS appears to increase the risk of platinum resistance**.

Ref 7

Gynecol Oncol. 2013 May 4. pii: S0090-8258(13)00725-7. doi: 10.1016/j.ygyno.2013.04.469. [Epub ahead of print]

Involved-field radiation therapy for locoregionally recurrent ovarian cancer.

Brown AP, Jhingran A, Klopp AH, Schmeler KM, Ramirez PT, Eifel PJ.

Source

Department of Radiation Oncology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA.

Abstract

OBJECTIVE:

To evaluate the effectiveness of definitive involved-field radiation therapy (IFRT) for selected patients with locoregionally-recurrent ovarian cancer.

METHODS:

We retrospectively reviewed records of 102 epithelial ovarian cancer patients treated with definitive IFRT (≥45Gy). **IFRT was directed to localized nodal (49%) and extranodal (51%) recurrences.**

RESULTS:

The median time from diagnosis to IFRT was 36months (range, 1-311), and the median follow-up after IFRT was 37months (range, 1-123). Patients received a median of three chemotherapy courses before IFRT (range, 0-9). **Five-year overall (OS) and progression-free survival (PFS) rates after IFRT were 40% and 24% respectively; the 5-year in-field disease control rate was 71%.** Thirty-five patients (35%) had no evidence of disease at a median of 38months after IFRT (range, 7-122), including 25 continuously without disease for a median of 61months (range, 17-122) and 10 with salvage treatment following disease recurrence, disease-free for a median of 39months after salvage treatment (range, 7-92). **Eight clear cell carcinoma patients had higher 5-year OS** (88% versus 37%; p=0.05) and PFS (75% versus 20%; p=0.01) rates than other patients. Patients sensitive to initial platinum chemotherapy had a higher 5-year OS rate than platinum-resistant patients (43% versus 27%, p=0.03). Patients who required chemotherapy for recurrence after IFRT often benefitted from longer chemotherapy-free intervals after than before IFRT.

CONCLUSIONS:

Definitive IFRT can **yield excellent local control, protracted disease-free intervals, and even cures in carefully selected patients**. RT should be considered a tool in the curative management of locoregionally-recurrent ovarian cancer.

Ref 8

Gynecol Oncol. 2013 May;129(2):304-9.

A prospective phase II study of chemoradiation followed by adjuvant chemotherapy for FIGO stage I-IIIA (1988) uterine papillary serous carcinoma of the endometrium.

Jhingran A, Ramondetta LM, Bodurka DC, Slomovitz BM, Brown J, Levy LB, Garcia ME, Eifel PJ, Lu KH, Burke TW.

Source

Department of Radiation Oncology, The University of Texas MD Anderson Cancer Center, Houston, TX 77030, USA. ajhingra@mdanderson.org

Abstract

OBJECTIVE:

To prospectively evaluate tumor control, survival, and toxic effects in patients with International Federation of Gynecology and Obstetrics (1988) **stage I-IIIA papillary serous carcinoma of the endometrium** treated with concurrent chemoradiation and adjuvant chemotherapy.

METHODS:

Thirty-two patients were enrolled from October 2001 through July 2009. Patients underwent full surgical disease staging and **postoperative concurrent weekly paclitaxel (50 mg/m2) and pelvic RT to 45 Gy plus a vaginal cuff boost followed by 4 cycles of adjuvant paclitaxel (135 mg/m2).**

RESULTS:

Thirty patients (94%) were evaluable (3 with stage IA disease, 11 IB, 3 IC, 1 IIB, and 12 IIIA). Eighteen patients (60%) received all 5 planned courses of concurrent chemotherapy, 10 (33%) received 4 courses, and 2 (7%) received 3 courses. All 30 patients received RT; 27 (90%) received the full dose, 2 received 43.2 Gy, and 1 received 39.6 Gy owing to toxic effects. Twenty-three patients (77%) completed all 4 cycles of adjuvant paclitaxel, 3 (10%) completed 3 cycles, 2 (7%) completed 2 cycles, and 2 received no adjuvant therapy. **Overall survival (OS), progression-free survival (PFS), and local control rates** for all patients were 93%, 87%, and 87%, respectively, at 2 years and **85%, 83%, and 87%, respectively, at 5years**. Six patients developed **(20%) grade 3/4 toxicities from the treatment**. Four patients (13%) had grade 3 or more severe bowel complications and two patients developed symptomatic pelvic fractures.

CONCLUSIONS:

Treatment with concurrent paclitaxel and pelvic RT followed by 4 courses of systemic paclitaxel **produced favorable results** in patients with surgically staged I-III UPSC.