台灣婦癌醫學會會訊

2012 年 12 月-2013 年 2 月

理事長: 陳祈安醫師
秘書長: 鄭文芳醫師
各委員會召集人:
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國際事務委員會：楊育正醫師
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學術研究委員會：王功亮醫師
副秘書長：
陳子和醫師、陳子健醫師、陳啟豪醫師
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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
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學會秘書: 蘇芳萱小姐

壹、 會務報告

(一)、第八屆第五次理監事聯席會議記錄

時　　間：102 年 02 月 23 日（星期六）中午 12 時

地　　點：台灣大學醫學院附設醫院新竹分院（五樓第一會議室）

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

理　　事- 張志隆、周宏學、何志明、洪耀欽、葉聯舜、王鵬惠、劉文雄、劉復興、

謝長堯、鄭雅敏、林浩、賴鴻政

常務監事- 屠乃方

監　　事- 李耀泰、許博欽、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- 楊育正、余堅忍、趙灌中、余慕賢、何師竹、陳啟豪

一、會議開始

二、確認上次會議紀錄

三、主席致詞

四、報告事項

一、　主席報告

二、　秘書長會務報告-各委員會、委員名單

A. 章程委員會

B. 國際事務委員會

C. 會員資格審查委員會

決議：2012 年專科醫師甄審，通過醫師共 5 位（黃于芳醫師、蕭聖謀醫師、江盈澄醫師、陳宇立醫師，與許世典醫師），將於 2013/07/13(六)會員大會時頒發證書。

D. 財務委員會

E. 醫療及倫理委員會

F. 教育委員會

決議：學會排定之準會員口頭訓練報告時間，如準會員因故無法參加，需於 2 個月前請假，且須檢附請假相關證明，如教育委員會核定請假通過，學會將另外安排準會員報告時間。

G. 學術研究委員會

五、討論事項

一、　第 18 屆 TJCC 學會時段、會議室及講師

決議：2013/07/13(六) 台大國際會議中心 202 會議室

1. 12:30~13:20 會員大會。
2. 13:30~14:20 國外講師演講：Shun-Ping Wang- Preimplantation Genetic Diagnosis: The Past, Present, and Future.
3. 14:30~15:20 國內講師演講：賴鴻政教授-癌症幹細胞。

二、 2012 年資產負債表、收支決算表，及收支餘絀表；2013 年收支預算表

六、臨時動議

七、散會

(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
2013/02/23	**北區婦癌學術研討會**	台灣大學附設醫院新竹分院
2013/05/18	**中區婦癌研討會**	彰濱秀傳醫院
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）

(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 (page 5)

(Duke University)

對於 optimally resected stage IIIC endometrial cancer, 單作 adjuvant chemotherapy 而沒作 radiotherapy 的患者, 其 survival 較差

Ref 2 (page 6)

(Washington University)

有 positive peritoneal cytology 的 stage I-II endometrial cancer患者, 不論 histologic type, 其 survival 就是較差, 因而在 adjuvant treatment 方面要有所考量

Ref 3 (page 7)

(Memorial Sloan-Kettering)

若有spleen 的 parenchymal metastasis 發生於 ovarian, tubal or peritoneal cancer, 則似乎應將之歸類於 stage IV

Ref 4 (page 8)

(EORTC study)

Low-risk neutropenic fever 患者之 oral antibiotic treatment

Ref 5 (page 9)

(ASCO guideline)

Antimicrobial prophylaxis and outpatient management of fever and neutropenia in adults treated for malignancy

Ref 6 (page 10)

(JCO)

CA125 longitudinal algorithm 比 single-threshold 能更早篩檢出 ovarian cancer

Ref 7 (page 11)

(JCO)

在 EMA-CO 之前先用 low-dose EP 來 induction, 可使 EMA-CO 造成的 early death rate 從 7.2% 降到 0.7%

Ref 1

Gynecol Oncol. 2013 Jan;128(1):65-70.

A multicenter evaluation of adjuvant therapy in women with optimally resected stage IIIC endometrial cancer.

Secord AA, Geller MA, Broadwater G, Holloway R, Shuler K, Dao NY, Gehrig PA, O'Malley DM, Finkler N, Havrilesky LJ.

Source

Gynecologic Oncology, Duke University Medical Center, Durham, NC 27710, USA. secor002@mc.duke.edu

Abstract

OBJECTIVE:

To determine if there is an advantage to combination chemotherapy and radiation for **optimally resected stage IIIC endometrial cancer (EC)**.

METHODS:

A multicenter retrospective analysis of patients with EC from 1991 to 2008 was conducted. Inclusion criteria were lymph node assessment and optimally resected disease. Recurrence-free (RFS) and overall survival (OS) were analyzed using Kaplan-Meier method and Cox proportional hazards model.

RESULTS:

265 patients with optimally resected stage IIIC EC were identified. Postoperative therapies included radiotherapy in 17% (n=45), chemotherapy in 17% (n=46), and both chemotherapy and radiation in 61% (n=161). Three-year RFS was 56% for chemotherapy alone, compared to 73% for radiation alone, and 73% for combination therapy (p=0.12). **Those receiving chemotherapy alone had the worst 3-year OS (78%) compared to either radiotherapy alone (95%) or combination therapy (90%) (p=0.005).** After adjustment for stage and grade those treated with **chemotherapy alone were at a 2.2 fold increased risk of recurrence** (95% CI, 1.2 to 4.2; p=0.02) and **4.0 fold increased risk of death** (95% CI, 1.6 to 10.0; p=0.004) compared to those treated with chemotherapy and radiation. In contrast there was no significant difference in RFS [HR=1.0 (95% CI, 0.5 to 2.0; p=0.92)] or OS [HR=1.1 (95% CI, 0.3 to 3.6; p=0.91)] for those treated with radiation alone compared to those treated with chemotherapy and radiation.

CONCLUSION:

Adjuvant therapy with either radiation alone or chemotherapy and radiation was associated with improved outcomes for patients with optimally resected stage IIIC EC compared to those treated with chemotherapy only.

Ref 2

Gynecol Oncol. 2013 Jan;128(1):77-82.

Positive peritoneal cytology is an independent risk-factor in early stage endometrial cancer.

Garg G, Gao F, Wright JD, Hagemann AR, Mutch DG, Powell MA.

Source

Division of Gynecologic Oncology, Washington University School of Medicine and Siteman Cancer Center, St. Louis, MO, USA. gunjalgarg@yahoo.com

Abstract

OBJECTIVE:

In light of the recent changes in the International Federation of Gynecology and Obstetrics (FIGO) staging system, the objective of this study was to determine the prognostic significance of positive peritoneal cytology (PPC) among patients with early stage endometrial cancer.

METHODS:

Data were extracted from the **Surveillance, Epidemiology, and End Results database** between 1988 and 2005. Only those patients with **stage I/II** endometrial cancer who had undergone a **complete staging procedure (lymph-node removal)** were included. Statistical analyses used Chi-square test, Kaplan-Meier log rank, and Cox proportional hazards models.

RESULTS:

A total of 14,704 patients were identified: 14,219 with negative peritoneal cytology (NPC) and 485 with positive peritoneal cytology. More patients with PPC compared to those with NPC were diagnosed with high-risk factors such grade III disease (40.2% vs. 23.8%, p<0.0001), and unfavorable histologic types such as clear cell/serous carcinoma (17.5% vs. 7.5%, p=<0.0001) and carcinosarcoma (9.3% vs. 5.6%, p<0.0001). When compared to patients with negative peritoneal cytology, **survival was significantly worse among patients with positive peritoneal cytology (p<0.0001): 5-year disease specific survival 95.1% vs. 80.8% in endometrioid adenocarcinoma; 78.0% vs. 50.4% in clear cell/serous cancer; and 64.7% vs. 32.3% in carcinosarcoma.** After adjusting for other contributing factors in the **multivariable model**, PPC remained an independent predictor of poor survival **(p<0.0001) in all histologic types** examined.

CONCLUSION:

PPC is an independent risk factor in patients with early stage endometrial cancer. **Although, no longer a part of the current FIGO staging criteria**, peritoneal cytology status should **still be considered for accurate risk-stratification** of these patients.

Ref 3

Gynecol Oncol. 2013 Jan;128(1):28-33.

Parenchymal splenic metastasis is an independent negative predictor of overall survival in advanced ovarian, fallopian tube, and primary peritoneal cancer.

Tanner EJ, Long KC, Feffer JB, Leitao MM Jr, Abu-Rustum NR, Barakat RR, Chi DS, Gardner GJ.

Source

Gynecology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, NY 10065, USA.

Abstract

OBJECTIVE:

The purpose of this study was to evaluate the significance of parenchymal splenic metastasis (PSM) in ovarian (OC), fallopian tube (FTC), and primary peritoneal cancer (PPC).

METHODS:

All patients with stage IIIB-IV OC, FTC, and PPC undergoing primary cytoreduction from 2001 to 2010 at our institution were identified. In patients undergoing splenectomy, pathology was reviewed for the presence of PSM. Multivariate Cox regression and Kaplan-Meier survival analysis were used to evaluate factors associated with overall survival (OS).

RESULTS:

Of 576 patients identified, stage was: IIIB - 23 (4%), IIIC - 468 (81.2%), and IV - 85 (14.8%). Optimal cytoreduction was achieved in 430 patients (74.7%), including 85 of 97 patients (87.6%) undergoing splenectomy. PSM was identified in 20 patients (20.6%) undergoing splenectomy, including 3 of 5 patients (60%) with radiographically identified parenchymal liver metastases and 17 of 92 patients (18.5%) without such radiographic findings (P=0.059). Age, preoperative albumin, residual disease, stage, bulky upper abdominal disease, IP chemotherapy, and PSM were associated with OS on univariate analysis. **Splenectomy was not associated with survival.** Age, preoperative albumin, residual disease, stage, and **PSM** (HR=0.46; 95% CI, 0.27-0.77) were associated with OS on **multivariate analysis**. **In the subset of patients undergoing splenectomy, OS was lower for patients with PSM versus those without PSM (28.5 v 51.2months, P=0.004).**

CONCLUSIONS:

PSM is independently associated with decreased OS in patients with advanced OC, FTC, and PPC. PSM occurs in the setting of other evidence of hematogenously disseminated disease, but also occurs outside this setting. **PSM should be considered a criterion for stage IV disease**.

Ref 4

J Clin Oncol. doi: 10.1200/JCO.2012.45.8109. Epub 2013 Jan 28.

Oral antibiotics for fever in low-risk neutropenic patients with cancer: a double-blind, randomized, multicenter trial comparing single daily moxifloxacin with twice daily ciprofloxacin plus amoxicillin/clavulanic acid combination therapy--EORTC infectious diseases group trial XV.

Kern WV, Marchetti O, Drgona L, Akan H, Aoun M, Akova M, de Bock R, Paesmans M, Viscoli C, Calandra T.

Source

Universitätsklinikum Freiburg, Freiburg, Germany. kern@if-freiburg.de

Abstract

PURPOSE:

This double-blind, multicenter trial compared the efficacy and safety of a single daily oral dose of moxifloxacin with oral combination therapy in low-risk febrile neutropenic patients with cancer.

PATIENTS AND METHODS:

Inclusion criteria were cancer, **febrile neutropenia, low risk of complications as predicted by a Multinational Association for Supportive Care in Cancer (MASCC) score > 20**, ability to swallow, and ≤ one single intravenous dose of empiric antibiotic therapy before study drug treatment initiation. Early discharge was encouraged when a set of predefined criteria was met. Patients received either **moxifloxacin (400 mg once daily) monotherapy or oral ciprofloxacin (750 mg twice daily) plus amoxicillin/clavulanic acid (1,000 mg twice daily)**. The trial was designed to show equivalence of the two drug regimens in terms of therapy success, defined as defervescence and improvement in clinical status during study drug treatment (< 10% difference).

RESULTS:

Among the 333 patients evaluated in an intention-to-treat analysis, therapy success was observed in 80% of the patients administered moxifloxacin and in 82% of the patients administered combination therapy (95% CI for the difference, -10% to 8%, consistent with equivalence). Minor differences in tolerability, safety, and reasons for failure were observed. More than 50% of the patients in the two arms were discharged on protocol therapy, with 5% readmissions among those in either arm. Survival was similar (99%) in both arms.

CONCLUSION:

Monotherapy with once daily oral moxifloxacin is efficacious and safe in low-risk febrile neutropenic patients identified with the help of the MASCC scoring system, discharged early, and observed as outpatients.

Ref 5

J Clin Oncol. 2013 Feb 20;31(6):794-810.

Antimicrobial prophylaxis and outpatient management of fever and neutropenia in adults treated for malignancy: American Society of Clinical Oncology clinical practice guideline.

Flowers CR, Seidenfeld J, Bow EJ, Karten C, Gleason C, Hawley DK, Kuderer NM, Langston AA, Marr KA, Rolston KV, Ramsey SD.

Source

Emory University School of Medicine, Atlanta, GA, USA.

Abstract

PURPOSE:

To provide guidelines on antimicrobial prophylaxis for adult neutropenic oncology outpatients and on selection and treatment as outpatients of those with fever and neutropenia.

METHODS:

A literature search identified relevant studies published in English. Primary outcomes included: development of fever and/or infections in afebrile neutropenic outpatients and recovery without complications and overall mortality in febrile neutropenic outpatients. Secondary outcomes included: in afebrile neutropenic outpatients, infection-related mortality; in outpatients with fever and neutropenia, defervescence without regimen change, time to defervescence, infectious complications, and recurrent fever; and in both groups, hospital admissions, duration, and adverse effects of antimicrobials. An Expert Panel developed guidelines based on extracted data and informal consensus.

RESULTS:

Forty-seven articles from 43 studies met selection criteria.

RECOMMENDATIONS:

Antibacterial and antifungal prophylaxis are only recommended for patients expected to have < 100 neutrophils/μL for > 7 days, unless other factors increase risks for complications or mortality to similar levels. **Inpatient treatment is standard to manage febrile neutropenic episodes**, although **carefully selected** patients may be managed as **outpatients** after systematic assessment beginning with a validated risk index (eg, Multinational Association for Supportive Care in Cancer **[MASCC] score or Talcott's rules**). Patients with MASCC scores ≥ 21 or in Talcott group 4, and without other risk factors, can be managed safely as outpatients. **Febrile neutropenic patients** should receive initial doses of empirical antibacterial therapy within an hour of triage and should either be monitored for at least 4 hours to determine suitability for outpatient management or be admitted to the hospital. An oral fluoroquinolone plus amoxicillin/clavulanate (or plus clindamycin if penicillin allergic) is recommended as empiric therapy, unless fluoroquinolone prophylaxis was used before fever developed.

Ref 6

J Clin Oncol. 2013 Jan 20;31(3):387-92.

Longitudinal screening algorithm that incorporates change over time in CA125 levels identifies ovarian cancer earlier than a single-threshold rule.

Drescher CW, Shah C, Thorpe J, O'Briant K, Anderson GL, Berg CD, Urban N, McIntosh MW.

Source

Fred Hutchinson Cancer Research Center, 1100 Fairview Ave N, M2-B230, Seattle, WA 98104, USA. cdresche@fhcrc.org

Abstract

PURPOSE:

Longitudinal algorithms incorporate change over time in biomarker levels to individualize screening decision rules. Compared with a **single-threshold (ST)** rule, smaller deviations from baseline biomarker levels are required to signal disease. We demonstrated improvement in ovarian cancer early detection by using a **longitudinal algorithm to monitor annual CA125 levels**.

PATIENTS AND METHODS:

We retrospectively evaluated serial preclinical serum CA125 values measured annually in **44 incident ovarian cancer cases** identified from participants in the PLCO (Prostate Lung Colorectal and Ovarian) Cancer Screening Trial to determine how frequently and to what extent the **parametric empirical Bayes (PEB)** longitudinal screening algorithm identifies ovarian cancer earlier than an ST rule.

RESULTS:

The PEB algorithm detected ovarian cancer earlier than an ST rule in a substantial proportion of cases. At 99% specificity, which corresponded to **the ST-rule CA125 cutoff ≥ 35 U/mL** that was used in the PLCO trial, 20% of cases were identified earlier by using the PEB algorithm. Among these cases, **the PEB signaled abnormal CA125 values, on average, 10 months earlier and at a CA125 concentration 42% lower (20 U/mL) than the ST-rule cutoff.** The proportion of cases detected earlier by the PEB algorithm and the earliness of detection increased as the specificity of the screening rule was reduced.

CONCLUSION:

The PEB longitudinal algorithm identifies ovarian cancer earlier and at lower biomarker concentrations than an ST screening algorithm adjusted to the same specificity. Longitudinal biomarker assessment by using the PEB algorithm may have application for screening other solid tumors in which biomarkers are available.

Ref 7

J Clin Oncol. 2013 Jan 10;31(2):280-6.

EMA/CO for high-risk gestational trophoblastic neoplasia: good outcomes with induction low-dose etoposide-cisplatin and genetic analysis.

Alifrangis C, Agarwal R, Short D, Fisher RA, Sebire NJ, Harvey R, Savage PM, Seckl MJ.

Source

Charing Cross Gestational Trophoblastic Disease Centre, Charing Cross Hospital, Imperial College Academic Science National Health Service Trust, London, United Kingdom.

Abstract

PURPOSE:

Patients with high-risk (International Federation of Gynecology and Obstetrics score ≥ 7) gestational trophoblastic neoplasia (GTN) frequently receive etoposide, methotrexate, and dactinomycin alternating weekly with cyclophosphamide and vincristine **(EMA/CO)**. Between 1979 and 1995, overall survival (OS) with this regimen at our institute was 85.4% **with a significant proportion of early deaths (< 4 weeks)**. Here, we determine whether survival rates have improved in a more recent patient cohort (1995 to 2010).

PATIENTS AND METHODS:

Patients receiving EMA/CO were identified using the Charing Cross GTN database. Genetic analysis identified nongestational trophoblastic tumors (nGTTs). The use of **induction low-dose etoposide 100 mg/m(2) and cisplatin 20 mg/m(2) (EP; days 1 and 2 every 7 days)** since 1995 to reduce early deaths before commencing EMA/CO was noted.

RESULTS:

Four hundred thirty-eight patients received EMA/CO between 1995 and 2010. Six patients had nGTTs, 140 had high-risk disease, and 250 had relapsed/resistant low-risk GTN. OS was 94.3% in high-risk patients (90.4% including nGTTs) and 99.6% in the low-risk group, with a median follow-up time of 4.2 years. All patients with nGTT and seven patients with high-risk GTNs died as a result of drug-resistant disease. **EP induction chemotherapy was given to 23.1% of high-risk patients (33 of 140 patients)** with a large disease burden, and **the early death rate was only 0.7%** (n = 1; 95% CI, 0.1% to 3.7%) **compared with 7.2%** (n = 11 of 151 patients; 95% CI, 4.1% to 12.6%) in the pre-1995 cohort.

CONCLUSION:

OS after EMA/CO for high-risk GTN has increased by nearly 9%. This reflects a more accurate estimate of OS by excluding nGTTs (3.9%) in patients with atypical presentations using genetic diagnosis. Low-dose induction EP in selected individuals also

allows near complete elimination of early deaths. The latter **should be considered routinely in high-risk GTN**.