高雄榮民總醫院

惡性卵巢生殖細胞癌

診療原則

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婦癌醫療團隊擬訂

注意事項：這個診療原則主要作為醫師和其他保健專家診療癌症病人參考之用。假如你是一個癌症病人，直接引用這個診療原則並不恰當，只有你的醫師才能決定給你最恰當的治療。

會議討論日期

- 上次會議：1010207 ,1020131,1030121

- 本共識與上一版的差異
  - 治療前評估增加CEA 、CA-199(流程圖一)
  - 將主動脈旁淋巴結最好能取到left renal vein的高度修正爲renal vessel的高度(流程圖三)
  - 可以不必化學治療者，將stage IA dysgerminoma修正爲stage I dysgerminoma (流程圖六、七)
  - Bleomycin劑量誤植爲15 mg，修正爲15 mg/m2 (流程圖八)
  - 第一線化學治療失敗時，增加附註注意Bleomycin 總累積劑量，流程圖十一)

治療前的評估

疑似有卵巢惡性腫瘤的35歲以下年輕女性患者，在開始治療之前，建議檢查包括：

◆骨盆腔超音波、腹部與骨盆腔電腦斷層掃瞄等影像檢查
◆血清AFP、hCG、LDH、CA-125 、CEA 、CA-199
◆全血球計數檢查、全套生化檢查
◆肺部X光
◆若有胃腸道的症狀，則宜進行胃腸道的評估檢查

流程圖一

患者的染色體若含有46,XY

◆雙側的性線應及早切除者：
若爲45,X/46,XY鑲嵌型或是46,XY，而且腹腔內的性線呈發育不良(dysgenesis)者
◆考慮等到青春期之後再摘除性線者：
若爲46,XY，罹患雄性素反應不良症候群，而腹腔內性線(即睪丸)的組織型態正常者

流程圖二

分期手術

手術中經由冷凍切片診斷爲生殖細胞癌之後，若患者仍想要懷孕，則可保留子宮與對側卵巢。若要進行完整的分期手術，注意事項包括：

◆術前的腸道準備應同腸道手術之準備
◆宜用中央垂直開腹切口，以獲取充份的手術視野
◆進入腹腔，即抽取腹水或經由腹腔灌洗取得腹膜腔細胞學檢查的標本
◆盡可能完整的取出腫瘤，檢體需盡快送病理檢驗，並常規性送冷凍切片
◆若患者不想保留生育能力，則行全子宮及兩側卵巢輸卵管切除手術；若想要懷孕的患者，在經由冷凍切片證實爲惡性生殖細胞腫瘤者，可保留子宮與對側卵巢
◆應詳細檢查對側，必要時施行對側卵巢的切片檢查
◆考慮盡量切除主要腫瘤側的輸卵管漏斗部骨盆韌帶
◆粘黏處需切片送檢
◆評估所有的腸道表面，且所有的可疑處都要切片送檢
◆若無明顯卵巢外擴散病灶，則需隨機腹膜取樣，如子宮直腸陷窩、骨盆腔側壁、膀胱漿膜、兩側大腸側窩、橫隔膜下表面等
◆橫結腸下網膜切除手術
◆淋巴結評估應包括骨盆淋巴結及主動脈旁淋巴結，主動脈旁淋巴結希望取到inferior mesenteric artery的高度，如有可能最好能取到renal vessel的高度
◆考慮切除之前腹腔鏡手術的埠管路徑
◆完整手術記錄殘餘腫瘤的大小與位置

流程圖三

首次減積手術

◆由於化學治療對於卵巢惡性生殖細胞腫瘤非常有效，因而即使腫瘤病灶已廣泛地散佈，仍可行生育保留手術，保留其正常的子宮與正常的對側卵巢。
◆手術的範圍應該要兼顧盡量清除病變與不造成手術併發症，不可因手術併發症而延誤手術後化學治療的進行。

流程圖四

關於較保守的手術

◆由於患者大部份爲年輕女性，而生殖細胞腫瘤多爲單側性，且化學治療非常有效，因而即使腫瘤病灶已廣泛地散佈，大部份的患者仍可行生育保留手術，保留其正常的子宮與正常的對側卵巢（但若患者不考慮保留生育能力，則全部切除）。

◆對於雙側卵巢都有病灶，但仍極力想保留生育能力的患者，臨床醫師與病患及家屬溝通討論保留單側卵巢的利弊得失，或許可以考慮保留一側之卵巢與輸卵管，再於手術之後進行化學治療。

◆對側卵巢若外觀正常，則除了 dysgerminoma 或含有 dysgerminoma 成份的mixed germ cell tumor 以外，不宜做不必要的切片，以免造成卵巢提早衰竭或黏粘，損及日後的生育能力。

流程圖五

關於分期手術不完全的患者

◆可能可以不必化學治療者（即臨床上看來像是 stage IA grade 1 immature teratoma 或 stage I dysgerminoma者)：
進一步徹底的分期手術確認，或追蹤
◆已知需化學治療者：
通常不需要單獨爲了進一步分期而再次手術

流程圖六

手術之後不用化學治療的狀況

◆充分的分期（comprehensive staging）手術之後的 Stage IA grade 1 immature teratoma
◆充分的分期手術之後的 Stage I dysgerminoma

流程圖七

第一線化學治療

◆首選配方：BEP（bleomycin 、 etoposide 、 cisplatin ）每21天1次， 共3-4次 (11,17,21)

●較適合台灣人的配方： Cisplatin 50 mg/m2,IV,day 1
Etoposide 100 mg/m2,IV,on days 1-3
Bleomycin 15 mg/m2, IV, on days 1-3（每天總量不超過25mg）

◆施行BEP配方前，考慮安排肺功能檢查。

◆重要副作用

●Pulmonary fibrosis

危險因子： Bleomycin 終身累積劑量450mg以上
Bleomycin 單次劑量超過25mg/m2
年紀超過70歲
肺氣腫
肺部曾經接受放射線治療

●Acute myelogenous leukemia(AML)

危險因子： Etoposide 累積劑量2000 mg/m2以上

●卵巢傷害

可能有益之預防措施：在化學治療開始之前與進行期間，考慮使用gonadotropin-releasing hormone agonists或口服避孕藥

流程圖八

放射治療

僅限於：
◆身體狀況不適合化學治療的dysgerminoma 患者，或
◆經過多種化學治療後，仍有腫瘤相關之局部症狀者
◆各種原因無法化學治療者，可考慮放射治療

流程圖九

完成治療之後的追蹤

◆ 追蹤頻率：

- 前兩年建議每2-4個月追蹤一次
- 三到五年每3-6個月追蹤一次
- 其後每6-12個月追蹤一次

◆ 追蹤項目：

- 詢問病史、理學檢查
- 超音波、Chest X-ray(每年一次)
- 血中腫瘤標記檢查(若治療前的某項血中腫瘤標記有上升者)
- 可依臨床判斷而安排影像檢查(如CT、MRI 、 PET scan等)，尤其是對治療前血中腫瘤標記正常而無法用血中腫瘤標記來追蹤的患者

流程圖十

第一線化學治療失敗時

惡性生殖細胞腫瘤的「鉑敏感性」(platinum-sensitive)：
◆定義爲在含鉑類藥物的化學治療結束後 6 個月之上才發生復發
◆考慮使用先前之化學治療處方(注意Bleomycin 總累積劑量)

惡性生殖細胞腫瘤的「鉑抗藥性」(platinum-resistant)：
◆定義爲在含鉑類藥物的化學治療當中或化學治療結束後 6 個月之內即發生復發
●VIP (Vinoblastine 0.11 mg/kg/day x 2d 、 ifosfamid 4gm/m2、cisplatin 50mg/m2 x 6 cycles) 處方(26)，或
●TIP (paclitacel 175mg/m2、 ifosfamide4gm/m2、cisplatin 50mg/m2 x6 cycles) 處方(24)，或
●高劑量化學治療等

流程圖十一

姑息緩解性治療

- 支持性照護，或
- 姑息緩解性之放射治療，或
- 緩解性的化學治療

流程圖十二

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