

高雄榮民總醫院

喉癌診療原則

2025年02月19日 2025第一版

喉癌醫療團隊擬訂

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

上次會議日期:2024/5/29

本共識與上一版的差異

上一版	新版
<ol style="list-style-type: none">1. 診斷後應screening HBV(業已列為本院guidline)2. Oral UFUR(2#BID or 1#TID)可作為取代iv-formed 5-FU之替代藥物3. Nutrition support應優先考慮腸道營養(NG, PEG)	<ol style="list-style-type: none">1. T4a,N0-3，治療方案已修改：手術，包括同側或雙側頸部清掃；甲狀腺切除術以清除中央區淋巴結，特別是當甲狀軟骨有明顯侵犯、以及顯著的聲門下延伸時，改為甲狀腺外展延伸到咽部。(thyroid cartilage with gross invasion <i>external pharyngeal extension of the thyroid gland and significant subglottic extension)</i>2. 單獨放射治療中，在T1,N0劑量新增60 Gy (2.4 Gy/fraction)，在T2,N0劑量更改65.25 64.8(2.25 2.4 Gy/fraction) to 70 Gy (2.0 Gy/fraction)

Carcinoma of the Glottis Larynx

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WORK-UP

- History(pack yr smoked) & PE; fiberoptic exam
- Biopsy of primary site or FNA of the neck
- Contrast and thin angled cuts **CT of larynx * and/or MRI with contrast of primary and neck ***
- **Bone scan*** (若有PET，可不做此項檢查)
- **Abd. Sono*** (* 與期別相關之主要檢查)

- 臨床需求時安排以下檢查
- ✓Chest CT (with or without contrast)
- ✓Consider FDG PET/CT
- ✓Preanesthesia studies
- ✓Pulmonary function evaluation for conservation surgery candidates
- ✓Consider videostroboscopy for select patients
- ✓EUA with endoscopy
- ✓Neck Sono
- ✓Panendoscopy
- ✓Dental evaluation Panorex ± teeth extraction
- ✓Nutrition, Speech and Swallowing evaluation/therapy
- ✓Audiogram
- ✓Smoking cessation counseling
- ✓Fertility/reproductive counseling
- Screening for HBV/HCV

STAGING & TREATMENT

- [Tis, N0]
詳見 Page 2
- [T1-2, N0; select T3, N0]
詳見 Page 3
- [T3 requiring total laryngectomy, N0-1]
詳見 Page 4
- [T3 requiring total laryngectomy, N2-3]
詳見 Page 6
- [T4a]
詳見 Page 7
- [T4b, N0-3; Unresectable N; Unfit for surgery]
詳見 Page 8
- [M1]
詳見Page 9

FOLLOW-UP

(base on risk of relapse, second primaries. Treatment sequelae, and toxicities)

- [Post-Tx within 1 year]
 - Every 1-3 months: complete head and neck exam + fiberoptic examination
 - Baseline CT or MRI
 - ± Neck Sono
- [1-2 years after Tx]
 - Every 2-6 months: complete head and neck exam + fiberoptic examination
 - Clinical indicated every 1 year: Larynx CT or MRI, CxR, Bone scan & Abd. Sono ± Neck Sono ±TSH, free T4*
- [3-5 years after Tx]
 - Every 4-8 months: complete head and neck exam + fiberoptic examination
- [5 years later after Tx]
 - Every 12 months: complete head and neck exam + fiberoptic examination (*if RT, every 6-12 months)

Carcinoma of the Glottis Larynx

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Carcinoma in situ

Primary treatment

Pathological features

Adjuvant Treatment

**Endoscopic resection
(Preferred)**

Follow-up

RT^{\$}, 註1

Follow-up

Carcinoma of the Glottis Larynx

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**Amenable to larynx preserving
(conservation) surgery
(T1-2, N0 or select T3, N0) @**

Primary treatment

RT\$, 註1

**Endoscopic or open
partial laryngectomy
on+/- Neck dissection**

Pathological features

Adjuvant Treatment

Adverse features* (-)

Adverse features* (+)

Positive margin

ENE(Extranodal extension)

Other adverse features(+)

pN1 without other risk features

Follow-up

Follow-up

Re-resection, if feasible or RT註1

CRT註1-2

RT註1

Consider RT註1

@Nodal disease in such glottis tumors is rare

*Adverse features: extranodal extension, positive or close margins, pT4 primary, pN2 or pN3 nodal disease, perineural invasion, vascular invasion, lymphatic invasion, subglottic extension

\$RT: Either IMRT or 3D conformal RT is recommended

Carcinoma of the Glottis Larynx

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T3 requiring(amenable to) total laryngectomy, N0-1, M0

Primary treatment

Pathological features

Adjuvant treatment

Concurrent CRT or RT if patient not candidate for CRT^{註1-2}

Follow-up, clinical assessment after 4-8 week as appropriate

pN0 without other risk features

Follow-up

pN1 without other risk features

Consider RT^{註1}

Surgery, including ipsilateral or bilateral neck dissection; consider thyroidectomy to clear central compartment nodes

Adverse features* (+)

Extranodal extension and/or positive margin

CRT^{註1-2}

Other adverse features(+)

RT or consider CRT^{註1-2}

Induction Chemotherapy^{註3}

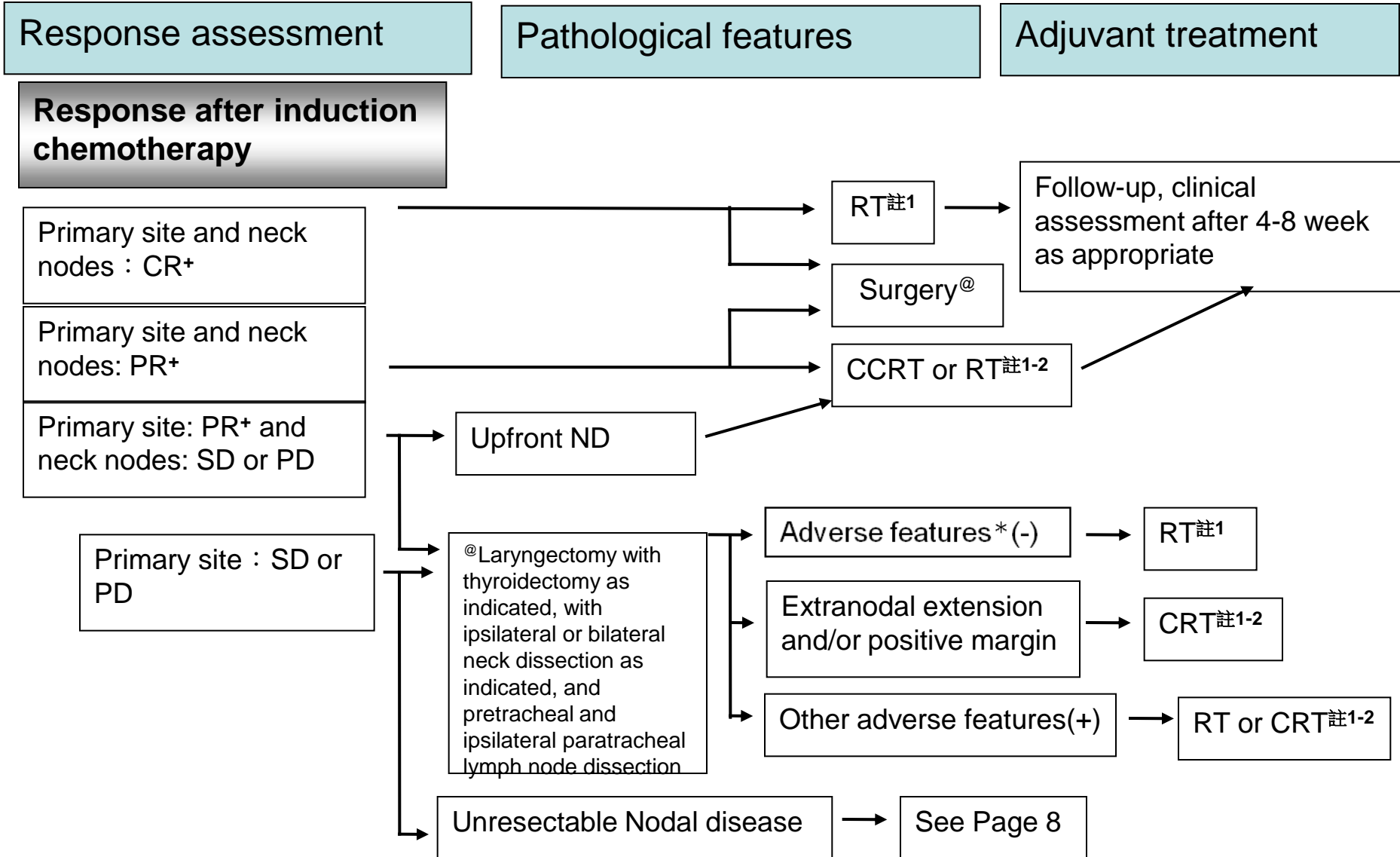
CT or MRI (with contrast) of primary and neck

See Response Assessment (Page 5)

* Adverse features : extranodal extension, positive margins, close margins, pT4 primary, pN2 or pN3 nodal disease, perineural invasion, vascular invasion, lymphatic invasion, **subglottic extension**

Carcinoma of the Glottis Larynx

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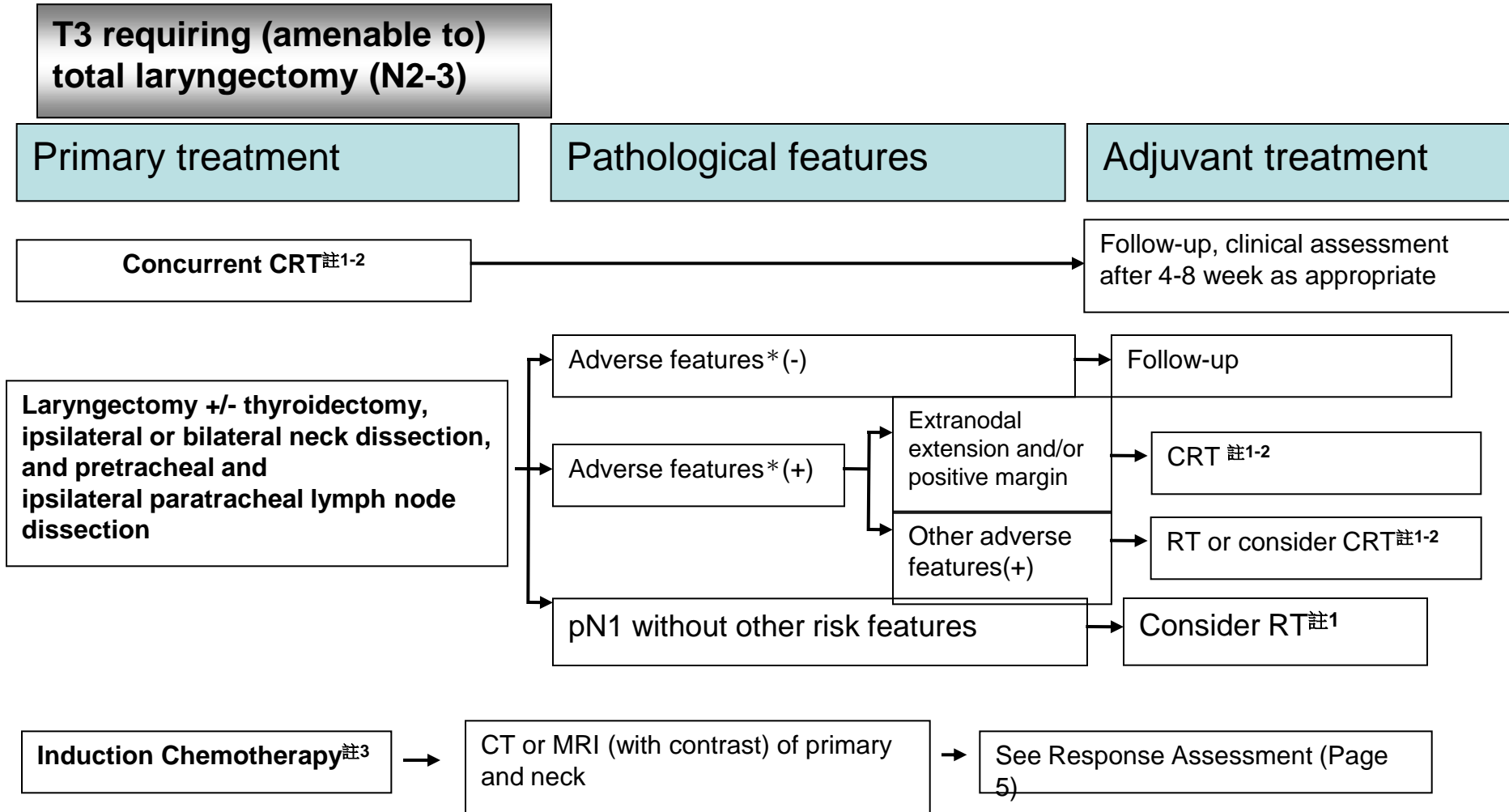


+ Primary site evaluated by CT or MRI(with contrast) of primary head and neck

* Adverse features : extranodal extension, positive margins, close margins, pT4 primary, pN2 or pN3 nodal disease, perineural invasion, vascular invasion, lymphatic invasion, subglottic extension

Carcinoma of the Glottis Larynx

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* Adverse features : extranodal extension, positive margins, close margins, pT4 primary, pN2 or pN3 nodal disease, perineural invasion, vascular invasion, lymphatic invasion, subglottic extension

Carcinoma of the Glottis Larynx

高雄榮民總醫院 臨床診療指引 Ver.1.2025 Page 7 (Ref. 12-15)

Primary treatment

Pathological features

Adjuvant treatment

T4a, N0-3

Surgery, including ipsilateral or bilateral neck dissection; thyroidectomy to clear central Compartment nodes, especially when there is thyroid cartilage with gross invasion external pharyngeal extension of the thyroid gland and significant subglottic extension

Adverse features* (-)

Follow-up

Adverse features* (+)

Extranodal extension and/or positive margin

CRT 註1-2

Other adverse features(+)

RT or consider CRT註1-2

pN1 without other risk features

Consider RT註1

Select T4a patients (high PS, multiple comorbidity or decline surgery)

Consider CRT註1-2

Follow-up, clinical assessment after 4-8 week as appropriate

Clinical trial for function-preserving surgical or RT management

Induction Chemotherapy註3

CT or MRI (with contrast) of primary and neck

See Response Assessment (Page 5)

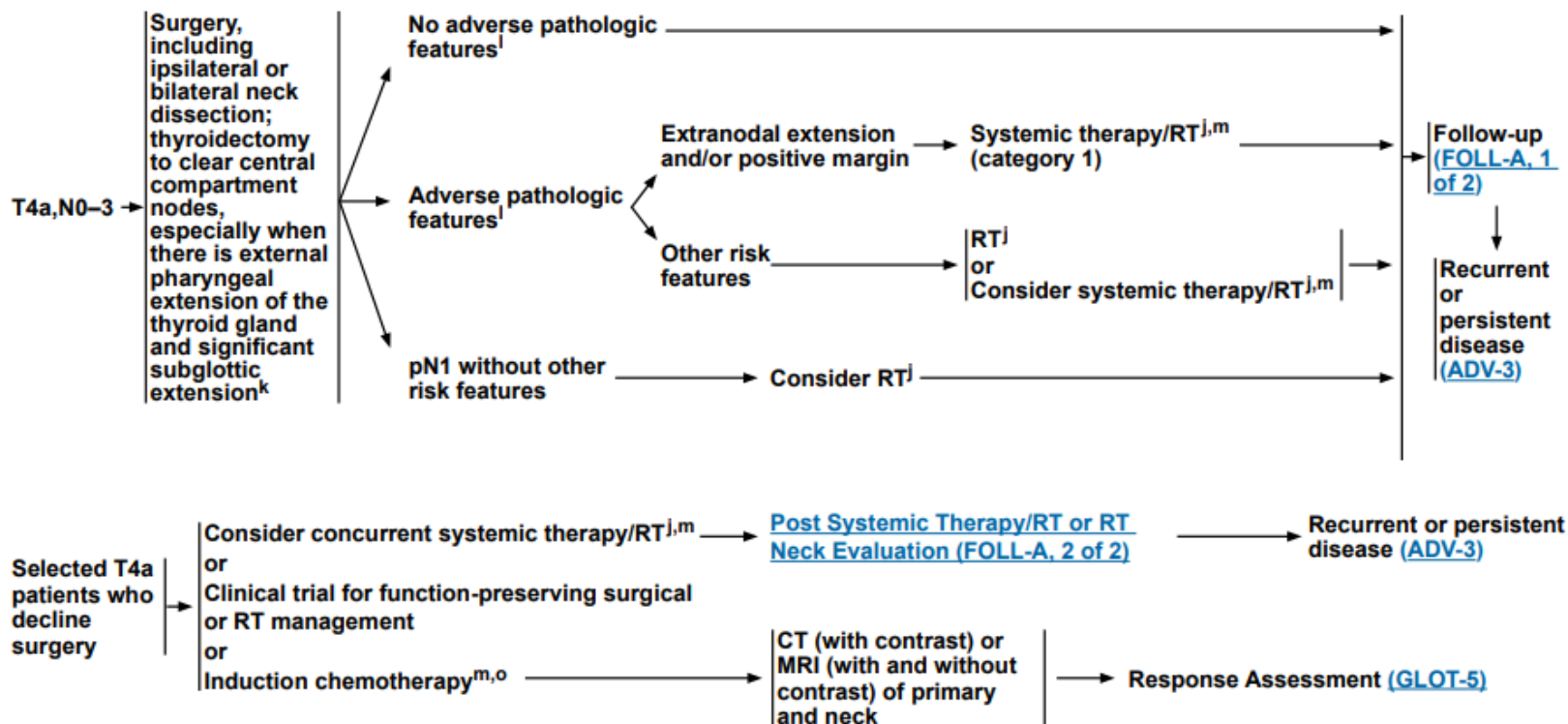
* Adverse features : extranodal extension, positive margins, close margins, pT4 primary, pN2 or pN3 nodal disease, perineural invasion, vascular invasion, lymphatic invasion, subglottic extension



CLINICAL STAGING

TREATMENT OF PRIMARY AND NECK

ADJUVANT TREATMENT



^j [Principles of Radiation Therapy \(GLOT-A\)](#).

^k [Principles of Surgery \(SURG-A\)](#).

^l Adverse pathologic features: extranodal extension, positive margins, close margins, pT4 primary, pN2 or pN3 nodal disease, perineural invasion, vascular invasion, lymphatic invasion, and subglottic extension ([Discussion](#)).

^m [Principles of Systemic Therapy for Non-Nasopharyngeal Cancers \(SYST-A\)](#).

^o See [Discussion](#) on induction chemotherapy.

Note: All recommendations are category 2A unless otherwise indicated.

Carcinoma of the Glottis Larynx

高雄榮民總醫院 臨床診療指引 Ver.1.2025 Page 8 (Ref. 16-17)

Newly diagnosed (M0)T4b, N0-3;
Unresectable nodal disease;
Unfit for surgery

Treatment

Clinical trial preferred

PS 0-1 #

Concurrent CRT^{註1-2}

Induction C/T^{註3} as indicated followed by RT or CRT^{註1,3}

PS 2*

RT^{註1}

Concurrent CRT^{註1-2}

PS 3\$

Palliative RT^{註1}

Single-agent systemic therapy^{註4}

Best supportive care

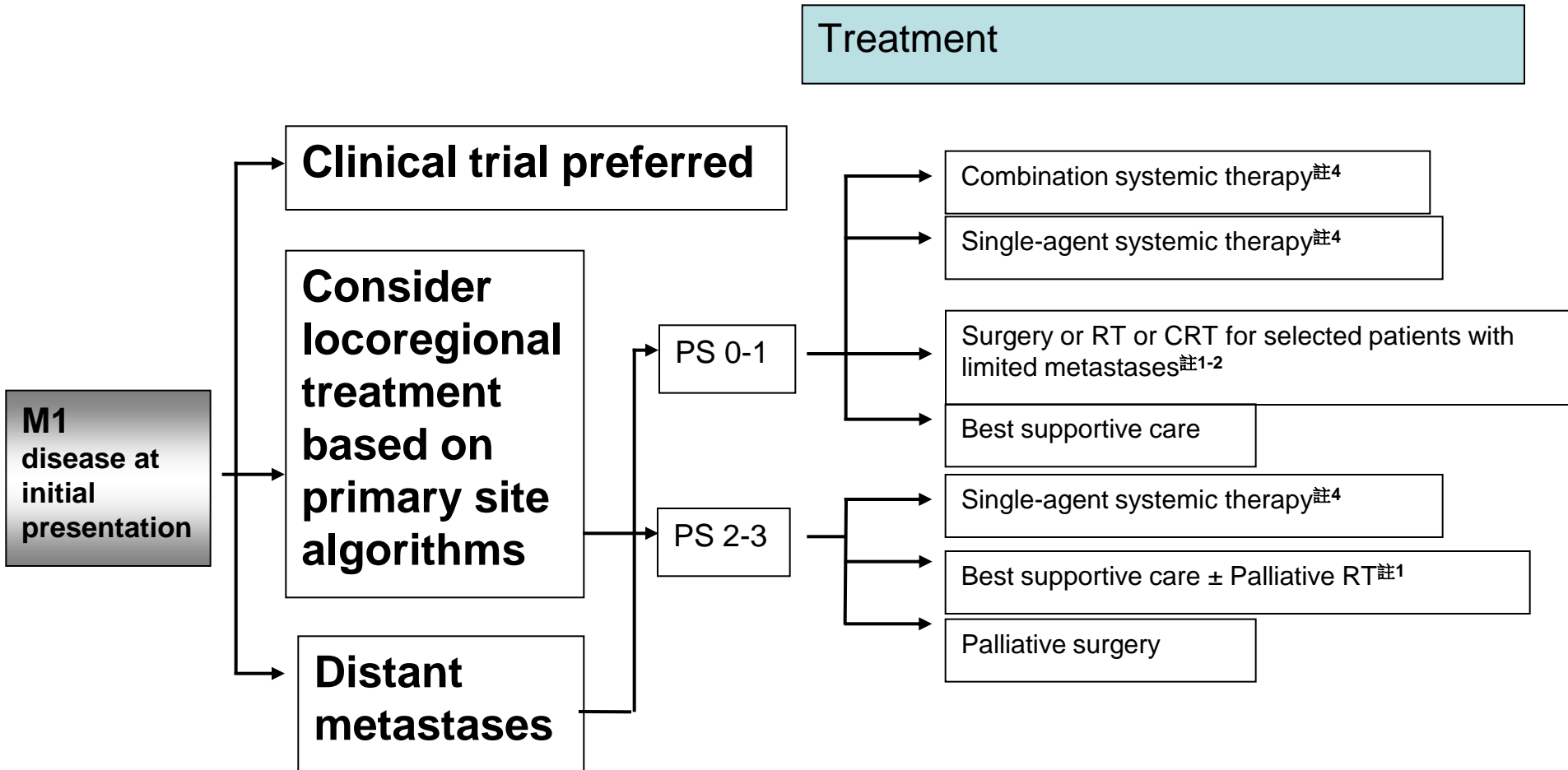
ECOG Performance Status 0-1^{註6}

* ECOG Performance Status 2

\$ ECOG Performance Status 3

Carcinoma of the Glottis Larynx

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1. PS 0-1若治療無效，除 best supportive care 外可再考慮systemic therapy, clinical trial or palliative RT
2. PS 2-3 single agent systemic therapy 若治療無效，除 best supportive care 外可再考慮 alternate single agent systemic therapy or palliative RT

Carcinoma of the Glottis Larynx

註1 高雄榮民總醫院 臨床診療指引 Ver.1.2025 Page 10 (Ref. 21)

Principles of Radiotherapy

Definitive (RT alone)

- Tis, N0 : 60.75 - 66 Gy (2.0-2.25 Gy/fraction)
- T1, N0 : 63 - 66 Gy (2.0-2.25 Gy/fraction) or 50 - 52 Gy (3.28-3.12 Gy/fraction) or 60 Gy (2.4 Gy/fraction)
- T2, N0 : ~~65.25~~ 64.8 - 70 Gy (2.0-2.25 2.4 Gy/fraction)
- \geq T2, N1 :
 - ✓ High risk : Primary tumor and involved lymph nodes
 - 66 - 70 Gy (2.0-2.2 Gy/fraction) : daily Monday-Friday in 6-7 weeks
 - Concomitant boost accelerated RT
 - ◆ 72 Gy /6 weeks (1.8 Gy/fraction, large field ; 1.5Gy boost as second daily fraction during last 12 treatment days)
 - ◆ 66-70 Gy (2.0 Gy/fraction; 6 fractions/wk accelerated)
 - Hyperfractionation : 79.2 – 81.6 Gy /7 weeks (1.2 Gy/fraction, twice daily)
 - ✓ Low to intermittent risk : Sites of suspected subclinical spread

Postoperative (RT or Concurrent CRT)

- Preferred interval between resection and postoperative RT is \leq 6 weeks
- High risk: Adverse features such as positive margins
 - ✓ 60-66 Gy (1.8-2.0 Gy/fraction); daily Monday-Friday in 6-6.5 weeks
- Low to intermediate risk: sites of suspected subclinical spread
 - ✓ 44-50 Gy (2.0 Gy/fraction) to 54-63 Gy (1.6-1.8 Gy/fraction)

Concurrent CRT

- High-risk: typically 70-70.2 Gy (1.8-2.0 Gy/fraction); daily Monday-Friday in 7 weeks
- Low to intermediate risk: 44-50 Gy (2.0 Gy/fraction) to 54-63 Gy (1.6-1.8 Gy/fraction)



PRINCIPLES OF RADIATION THERAPY^a

DEFINITIVE:

RT Alone

- Tis,N0: 60.75 Gy (2.25 Gy/fraction) to 66 Gy (2.0 Gy/fraction)
- T1,N0:
 - ▶ 63 Gy (2.25 Gy/fraction, preferred) to 66 Gy (2.0 Gy/fraction)
 - or
 - ▶ 60 Gy (2.4 Gy/fraction)¹
 - or
 - ▶ 50 Gy (3.12 Gy/fraction) to 52 Gy (3.28 Gy/fraction)²
- T2,N0: 64.8(2.4 Gy/fraction) to 70 Gy (2.0 Gy/fraction)¹
- ≥T2,N1:
 - ▶ PTV
 - ◊ High risk: Primary tumor and involved lymph nodes [this includes possible local subclinical infiltration at the primary site and at the high-risk level lymph node(s)]
 - Fractionation: 66 Gy (2.2 Gy/fraction) to 70 Gy (2.0 Gy/fraction); daily Monday–Friday in 6–7 weeks^b
 - Concomitant boost accelerated RT:
 - 72 Gy/6 weeks (1.8 Gy/fraction, large field; 1.5 Gy boost as second daily fraction during last 12 treatment days)
 - 66–70 Gy (2.0 Gy/fraction; 6 fractions/wk accelerated)
 - Hyperfractionation: 79.2–81.6 Gy/7 weeks (1.2 Gy/fraction, twice daily)
 - ◊ Low to intermediate risk: Sites of suspected subclinical spread
 - 44–50 Gy (2.0 Gy/fraction) to 54–63 Gy (1.6–1.8 Gy/fraction)^c

IMRT (preferred) is recommended.

¹ Kodaira T, Kagami Y, Machida R, et al. Long-term follow-up of a randomized controlled trial on accelerated radiation therapy versus standard fractionated radiation therapy for early glottic cancer (JCOG0701A3). *Int J Radiat Oncol Biol Phys* 2023;117:1118-1124.

² Gowda RV, Henk JM, Mais KL, et al. Three weeks radiotherapy for T1 glottic cancer: the Christie and Royal Marsden Hospital Experience. *Radiother Oncol* 2003;68:105-111.

^a See [Principles of Radiation Techniques \(RAD-A\)](#) and [Discussion](#).

^b For doses >70 Gy, some clinicians feel that the fractionation should be slightly modified (eg, <2.0 Gy/fraction for at least some of the treatment) to minimize toxicity. An additional 2–3 doses can be added depending on clinical circumstances.

^c Suggest 44–50 Gy in sequentially planned IMRT or 54–63 Gy with IMRT dose painting technique (dependent on dose per fraction).

CONCURRENT SYSTEMIC THERAPY/RT:^{d,e}

• PTV

- ▶ High risk: Typically 70 Gy (2.0 Gy/fraction)
- ▶ Low to intermediate risk: 44–50 Gy (2.0 Gy/fraction) to 54–63 Gy (1.6–1.8 Gy/fraction)^c

^d [Principles of Systemic Therapy for Non-Nasopharyngeal Cancers \(SYST-A\)](#).

^e Based on published data, concurrent systemic therapy/RT most commonly uses conventional fractionation at 2.0 Gy per fraction to a typical dose of 70 Gy in 7 weeks with single-agent cisplatin given every 3 weeks at 100 mg/m²; 2–3 cycles of chemotherapy are used depending on the radiation fractionation scheme (RTOG 0129) (Ang KK, Harris J, Wheeler R, et al. Human papillomavirus and survival of patients with oropharyngeal cancer. *N Engl J Med* 2010;363:24-35). When carboplatin and 5-FU are used, then the recommended regimen is standard fractionation plus 3 cycles of chemotherapy [Bourhis J, Sire C, Graff P, et al. Concomitant chemoradiotherapy versus acceleration of radiotherapy with or without concomitant chemotherapy in locally advanced head and neck carcinoma (GORTEC 99-02): an open-label phase 3 randomised trial. *Lancet Oncol* 2012;13:145-153]. Other fraction sizes (eg, 1.8 Gy, conventional), multiagent chemotherapy, other dosing schedules of cisplatin, or altered fractionation with chemotherapy are efficacious, and there is no consensus on the optimal approach. In general, the use of concurrent systemic therapy/RT carries a high toxicity burden; multiagent chemotherapy will likely further increase the toxicity burden. For any systemic therapy/RT approach, close attention should be paid to published reports for the specific chemotherapy agent, dose, and schedule of administration. Systemic therapy/RT should be performed by an experienced team and should include substantial supportive care.

Note: All recommendations are category 2A unless otherwise indicated.

Carcinoma of the Glottis Larynx

註2 高雄榮民總醫院 臨床診療指引 Ver.1.2025 Page 11 (Ref. 22-27)

Principles of Chemotherapy

Concurrent with RT

Regimen 1: q3w CDDP ± Cetuximab^{註5} + RT

- Cisplatin (80-100mg/ m²) q3w during R/T
- Cetuximab(400mg/ m²) loading dose first week, then Cetuximab(250mg/ m²) maintain dose D1 + Cisplatin (80-100mg/ m²) q3w D2 during R/T

Regimen 2: Weekly CDDP ± Cetuximab^{註5} + RT

- Cisplatin (30-40mg/ m²) weekly during R/T
- Cetuximab(400mg/ m²) loading dose first week, and then Cisplatin (30-40mg/ m²) weekly D1 + Cetuximab(250mg/ m²) maintain dose D2 during R/T

Regimen 3: q3w Carboplatin^{註5} ± Cetuximab^{註5} + RT

- Carboplatin (AUC x 5mg) q3w during R/T
- Cetuximab(400mg/ m²) loading dose first week, then Cetuximab(250mg/ m²) maintain dose D1 + Carboplatin (AUC x 5mg) q3w D2 during R/T

Regimen 4: Weekly Cetuximab^{註5} + RT

- Cetuximab(400mg/ m²) loading dose first week, then Cetuximab(250mg/ m²) maintain dose during RT

Regimen5: Carboplatin + 5-FU + Hydroxyurea (CCr < 60) + RT

- Carboplatin (AUC x 1.25mg) D1-D4
- Fluorouracil (5-FU) (850mg/m²) D1-D4
- Hydroxyurea 1CAP BID D1-D5

Regimen6: Cisplatin + 5-FU + Hydroxyurea + RT

- Cisplatin(20mg/ m²) D1-D4
- Fluorouracil (5-FU) (850mg/m²) D1-D4
- Hydroxyurea 1CAP BID D1-D5

Regimen 7: Doxetaxel + RT

- Doxetaxel (60g/m²) D1, if cisplatin not eligible

Carcinoma of the Glottis Larynx

註3

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Regimens of Chemotherapy

Induction, adjuvant, 建議1-4cycles

Regimen 1 : q3-4 weeks T^{註5} + P ± F (5-FU or UFUR) ± weekly Cetuximab^{註5}

- Taxotere(60 mg/ m²) D1
- Cisplatin(60-75 mg/ m²) D1
- Fluorouracil (5-FU) (600-750mg/m²) D2-D5 or **UFUR**
- Cetuximab (400mg/ m²) loading dose first week, then Cetuximab (250mg/ m²) maintain dose

Regimen 2: q3-4 weeks Platinum ± F ± weekly Cetuximab^{註5}

- Cisplatin(80-100mg/ m²) D1 or Cisplatin (20mg/ m²) D1-D5 or Carboplatin (AUC x 5mg) D1
- Fluorouracil (5-FU) (600-1000mg/m²) D2-D5 or **UFUR**
- Cetuximab(400mg/m²) loading dose first week, then weekly Cetuximab (250mg/ m²)

Carcinoma of the Glottis Larynx

註3

高雄榮民總醫院 臨床診療指引 Ver.1.2025 Page 13 (Ref. 22-27)

Regimens of Chemotherapy

Induction, adjuvant, 建議1-4cycles

Regimen 3: weekly Cetuximab^{註5}

- Cetuximab (400mg/ m²) loading dose first week, then Cetuximab (250mg/ m²) maintain dose

Regimen 4: oral Fluorouracil

- Ufur cap (tegafur 100mg+uracil 224mg) 2# BID-TID
(可作為取代iv-formed 5-FU之替代藥物)

Regimen 5: weekly Methotrexate

- Methotrexate (40-60mg/ m²)

Carcinoma of the Glottis Larynx

註4

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Regimens of Chemotherapy

Recurrent, unresectable, metastatic *

Regimen 1 (First line): q3 weeks Pembrolizumab^{註5} ± Platinum ± F

- Pembrolizumab(200mg) D1
- Cisplatin(80-100mg/m²) D1 or Cisplatin (20mg/ m²) D1-D5 or Carboplatin (AUC x 5mg) D1
- Fluorouracil (5-FU) (600-1000 mg/m²) D2-D5

Regimen 2 (First line): q3 weeks Pembrolizumab^{註5}

- Pembrolizumab(200mg) D1 (if CPS ≥ 1)

Regimen 3 (Subsequent line): q2 weeks Nivolumab^{註5}

Nivolumab(3mg/kg) D1

Regimen 4 (Subsequent line): q3 weeks Pembrolizumab^{註5}

- Pembrolizumab(200mg) D1 (if disease progression on or after platinum therapy)

Regimen 5: q3-4 weeks Platinum ± F ± weekly Cetuximab^{註5}

- Cisplatin(80-100mg/ m²) D1 or Cisplatin (20mg/ m²) D1-D5 or Carboplatin (AUC x 5mg) D1
- Fluorouracil (5-FU) (600-1000 mg/m²) D2-D5
- Cetuximab(400mg/ m²) loading dose first week, then weekly Cetuximab (250mg/ m²)

Regimen 6: q3 weeks Pembrolizumab^{註5} + Platinum + Doxetacel

- Pembrolizumab(200mg) D1
- Cisplatin(80-100mg/ m²) D1 or Cisplatin (20mg/ m²) D1-D5 or Carboplatin (AUC x 5mg) D1
- Taxotere(60 mg/ m²)

*針對Recurrent or persistent disease with M1，建議NGS

Carcinoma of the Glottis Larynx

註4 高雄榮民總醫院 臨床診療指引 Ver.1.2025 Page 15 (Ref. 22-27)

Regimens of Chemotherapy

Recurrent, unresectable, metastatic *

Regimen 7: q3-4 weeks T ± Platinum ± weekly Cetuximab^{註5}

- Taxotere(60 mg/ m²) D1
 - Cisplatin(60-75 mg/ m²) D1 or Carboplatin (AUC x 5mg) D1
- Cetuximab(400mg/ m²) loading dose first week, then weekly Cetuximab (250mg/ m²)

Regimen 8: cisplatin+ epirubicin+ 5-FU+ Leucovorin

- Cisplatin (60 mg/ m²) D1
- Epirubicin (50 mg/ m²) D1
- Fluorouracil (5-FU) (2000 mg/m²) D1

Regimen 9: q2 weeks Bevacizumab

- Bevacizumab (200 mg/ m²) D1

Regimen 10: weekly Gemcitabine

- Gemcitabine (1000 mg/m²) D1

*針對Recurrent or persistent disease with M1，建議NGS

Carcinoma of the Glottis Larynx

註5

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特殊用藥健保給付規定

Taxotere

- 頭頸部癌，限局部晚期且無遠端轉移之頭頸部鱗狀細胞癌且無法手術切除者。
- 與Cisplatin 及5-FU 併用，作為放射治療前的引導治療，限使用四個療程。

Cetuximab

- 限與放射線療法合併使用於局部晚期之口咽癌、下咽癌及喉癌患者，使用總療程以接受8次輸注為上限。需經事前審查核准後使用。

符合下列條件之一：

- 1.年齡 ≥ 70 歲
 - 2.Ccr < 50 ml/min
 - 3.聽力障礙者 (聽力障礙定義為500Hz、1000Hz、2000Hz 平均聽力損失大於25 分貝)
 - 4.無法耐受platinum-based 化學治療。
- 限無法接受局部治療之復發及/或轉移性頭頸部鱗狀細胞癌，且未曾申報 cetuximab 之病患使用。需經事前審查核准後使用，使用總療程以18週為限，每9週申請一次，需無疾病惡化情形方得繼續使用。(106/4/1)

Carboplatin

- 限腎功能不佳 (CCr < 60) 或曾作單側或以上腎切除之惡性腫瘤患者使用。

Carcinoma of the Glottis Larynx

註5

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特殊用藥健保給付規定

Pembrolizumab、Nivolumab

• 先前已使用過 platinum 類化學治療失敗後，又有疾病惡化的復發或轉移性頭頸部鱗狀細胞癌成人患者。本類藥品與 cetuximab 僅能擇一使用，且治療失敗時不可互換。

• 符合下列條件：

1. 病人身體狀況良好(ECOG \leq 1)
2. NYHA (the New York Heart Association) Functional Class I 或 II
3. GOT < 60U/L 及 GPT < 60U/L，且 T-bilirubin < 1.5mg/dL；Creatinine < 1.5mg/dL，且 eGFR > 60mL/min/1.73m²
4. PD-L1 表現量 TPS \geq 50%

• 初次申請以 12 週為限，申請時需檢附以下資料：病理或細胞檢查報告、生物標記(PD-L1)表現量檢測報告、病人身體狀況良好(ECOG \leq 1) 及心肺與肝腎功能之評估資料、符合 i-RECIST 定義之影像檢查及報告(上述影像檢查之給付範圍不包括 PET)、先前已接受過之治療與完整用藥資料、使用免疫檢查點抑制劑之治療計畫(treatment protocol)。

• 用藥後每 12 週評估一次，以 i-RECIST 或 mRECIST 標準評定反應，依下列原則給付：

- I. 有療效反應者(PR 及 CR)得繼續使用；
- II. 出現疾病惡化(PD)或出現中、重度或危及生命之藥物不良反應時，應停止使用；
- III. 疾病呈穩定狀態者(SD)，可持續再用藥 4 週，並於 4 週後再次評估，經再次評估若為 PR、CR 者，得再繼續使用 12 週。若仍為 SD 或已 PD 者，應停止使用。

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Eastern Cooperative Oncology Group (ECOG) Performance Status

Grade	Description	Suggestion
0	Normal activity fully ambulatory (無症狀)	按照標準化療評估及療程。
1	Symptoms, but nearly fully ambulatory (有症狀，完全步行，但對生活無影響)	按照標準化療評估及療程。
2	Some bed time, but needs to be in bed less than 50% of normal daytime (躺在床上的時間<50%)	按照標準化療評估及療程。
3	Needs to be in bed more than 50% of normal daytime (躺在床上的時間>50%)	可視情況考慮停止化學治療。
4	Unable to get out of bed (長期完全臥床)	建議停止化學治療。
5	Dead	

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