高雄榮民總醫院
上尿路泌尿上皮癌
診療原則

2020年02月18日第一版

泌尿道癌症醫療團隊擬訂

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

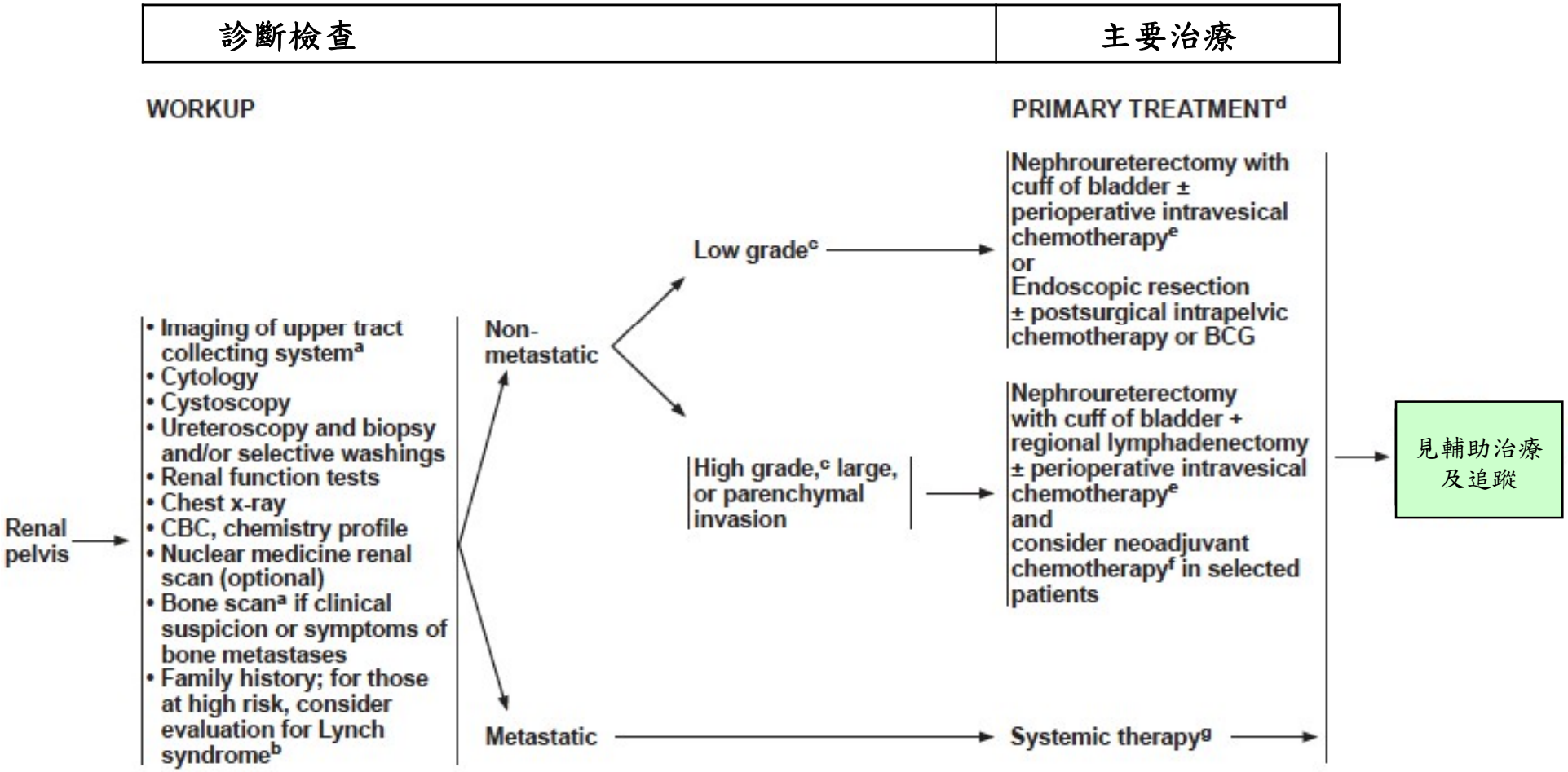
上次會議：2019/02/19

本共識與上一版的差異

上一版	新版
1. 無	1.新增與期別相關之主要檢查必要項目

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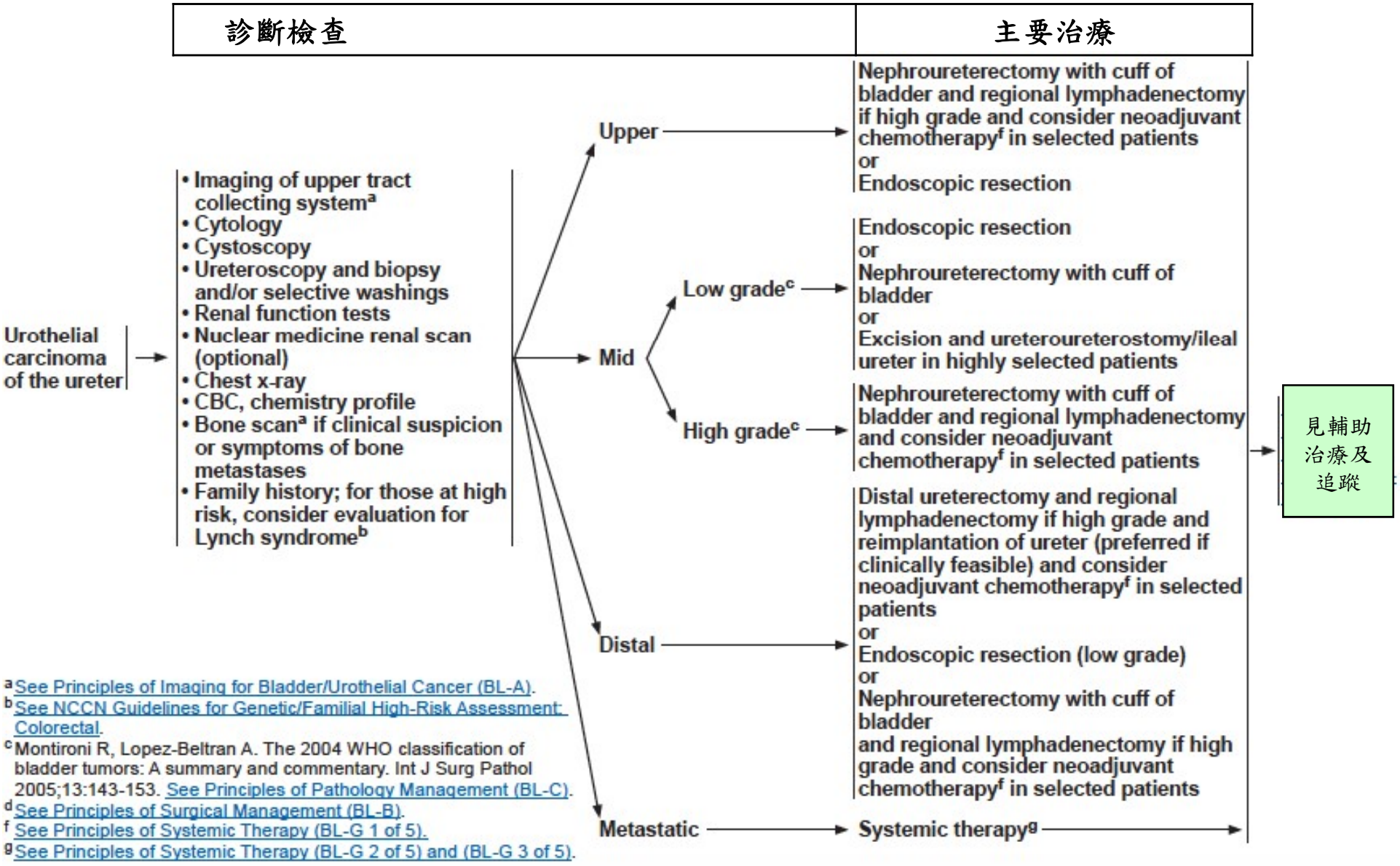
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必要項目：Urine cytology 、cystoscopy/uteteroscopy 、CXR 、image

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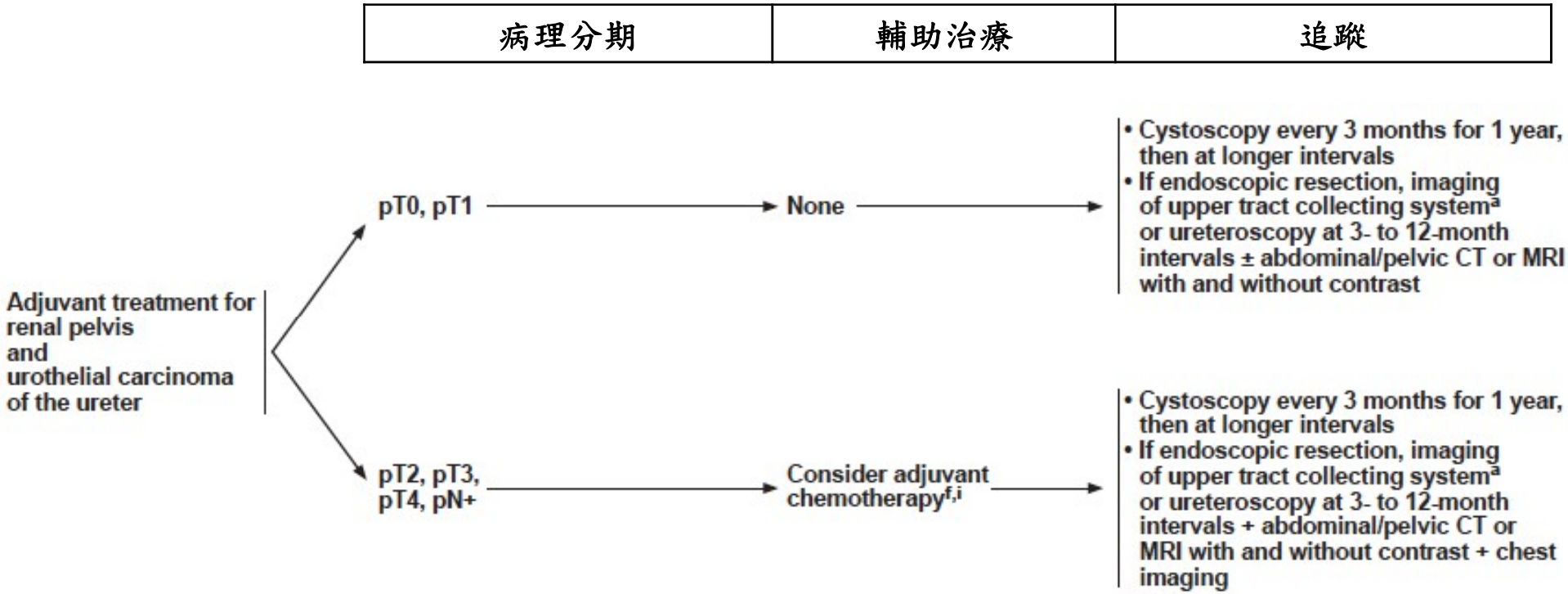
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[a] See Principles of Imaging for Bladder/Urothelial Cancer (BL-A).
[b] See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal.
[c] Montironi R, Lopez-Beltran A. The 2004 WHO classification of bladder tumors: A summary and commentary. Int J Surg Pathol 2005;13:143-153. See Principles of Pathology Management (BL-C).
[d] See Principles of Surgical Management (BL-B).
[f] See Principles of Systemic Therapy (BL-G 1 of 5).
[g] See Principles of Systemic Therapy (BL-G 2 of 5) and (BL-G 3 of 5).

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Principles of Surgical Management

Endoscopic Management of Upper Tract Urothelial Cancer (UTUC)

• **Favorable** clinical and pathologic criteria for nephron preservation:
- **Low-grade tumor based on cytology and biopsy**
- **Papillary architecture**
- **Tumor size <1.5 cm**
- **Unifocal tumor**
- **Cross-sectional imaging showing no concern for invasive disease**

• For favorable tumors - ureteroscopic and percutaneous management provide similar survival outcomes compared to nephroureterectomy

• Less favorable clinical and pathologic criteria for nephron preservation:
- Multifocal tumors
- Flat or sessile tumor architecture
- Tumor size >1.5 cm
- High-grade tumors
- cT2-T4 tumors
- Mid and proximal ureteral tumor due to technical challenges
- Tumor crossing infundibulum or ureteropelvic junction

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Principles of Surgical Management

• Imperative indications for conservative therapy of UTUC
➢Bilateral renal pelvis and/or urothelial carcinoma of the ureter
➢Solitary or solitary functioning kidney
➢Chronic kidney disease/renal insufficiency
➢Hereditary predisposition (eg, hereditary nonpolyposis colon cancer [HNPCC])

• Percutaneous or ureteroscopic surgical procedures
➢Tumor fulguration/cautery
➢Tumor resection incorporating electrical energy, baskets, or cold cup devices with fulguration of the tumor bed
➢Laser therapies (Nd:YAG – penetration 4–6 mm; Ho:YAG – shallow penetration <0.5 mm)

• Extirpative surgical procedures
➢Segmental ureterectomy ± ureteral reimplantation for distal ureteral tumors
➢Complete ureterectomy with ileal ureter replacement (proximal/mid ureteral tumors)

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Principles of Surgical Management

Regional Lymphadenectomy

• Recommended for patients with high-grade upper GU tract tumors.
• Left-sided renal pelvic, upper ureteral, and midureteral tumors:
➢Regional lymphadenectomy should include at a minimum the paraaortic lymph nodes from the renal hilum to the aortic bifurcation.
➢Most midureteral tumors will also include the common iliac, external iliac, obturator, and hypogastric lymph nodes.
• Right-sided renal pelvic, upper ureteral, and midureteral tumors:
➢Regional lymphadenectomy should include at a minimum the paracaval lymph nodes from the renal hilum to the aortic bifurcation.
➢Most midureteral tumors will also include the common iliac, external iliac, obturator, and hypogastric lymph nodes.
• Distal ureteral tumors:
➢Regional lymphadenectomy should be performed and include at a minimum the common iliac, external iliac, obturator, and hypogastric lymph nodes.

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Principles of Surgical Management

• Topical immunotherapy and chemotherapy management
➢BCG, mitomycin
➢Route of administration might include percutaneous antegrade (preferred) or retrograde ureteral catheters
➢Induction and maintenance therapy regimens, similar to intravesical therapy, can be used

• Patients with renal pelvis and urothelial carcinoma of the ureter managed with nephron-preserving procedures and adjunctive therapies require long-term surveillance, including cross-sectional urography or endoscopic visualization. Treatment can be associated with patient anxiety, tumor seeding, and the need for multiple procedures and ultimate nephroureterectomy with bladder cuff. Clinical/pathologic understaging is problematic. Recurrence or tumor persistence might be life-threatening due to disease progression.

Principles of Intravesical Treatment

Postsurgical Intrapelvic Therapy for Upper Tract Tumors

- Consider for patients with non-metastatic, low-grade tumors of the renal pelvis.
- Induction (adjuvant) therapy should be initiated 3–4 weeks after endoscopic resection.
- The most commonly used agents are BCG, mitomycin C, and gemcitabine.
- Role of maintenance in this context is uncertain.
- Efficacy of this treatment in upper urinary tract cancer has not been established.

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Principles of Systemic Therapy

• Neoadjuvant chemotherapy may be considered for select patients with UTUC, particularly for higher stage and/or grade tumors, as renal function will decline after nephroureterectomy and may preclude adjuvant therapy.
• Carboplatin should not be substituted for cisplatin in the perioperative setting. For patients with borderline renal function or minimal dysfunction, a split-dose administration of cisplatin may be considered (such as 35 mg/m2 on days 1 and 2 or days 1 and 8) (category 2B). While safer, the relative efficacy of the cisplatin-containing combination administered with such modifications remains undefined.
• For patients with borderline renal function, estimate GFR to assess eligibility for cisplatin.

處方請參考膀胱癌

修訂指引

- 化療處方參考膀胱癌指引。
- 本共識依下列參考資料修改版本
  - NCCN Clinical Practical Guidelines in Oncology ™ Upper GU Tract Tumors (V3.2019)
  - EAU Guidelines on Upper Urinary Tract Urothelial Carcinoma, 2016