高 雄 榮 民 總 醫 院

食道癌診療原則

2018年01月23日 第一版

食道癌醫療團隊共同擬定

注意事項：這個診療準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,直接引用這個研究資訊及診療準則並不恰當。只有你的醫師才能決定給你最恰當的治療。

修訂指引

- 本共識依下列參考資料修改版本

Reference: NCCN Clinical Practice Guidelines in Oncology™, Esophageal cancer,V.1.2018

會議討論

上次會議：2017/05/09

本共識與上一版的差異

上一版	新版
1. Pre-OP CCRT *with Surgical Resection 2.化學治療處方 Published C/T regimens	1.Pre-OP CCRT*/chemotherapy* with surgical resection (page 5、7) 2. Published C/T regimens (neoadjuvant/adjuvant/CCRT/metastasis) (page 9)

食道癌(總表)

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臨床診療指引 2018.01 第一版

評估	診斷	治療	追蹤

***History and physical examination**
***CBC and chemistry profile**
***Upper GI endoscopy and biopsy**
***Chest/abdominal CT**
*** UGI series**
***Upper abdominal sonography**
***Bone scan**
***PET/CT**
***Tumor markers**
Optional：
***Bronchoscopy**
***Endoscopic ultrasound(EUS)**
***LN aspiration or biopsy**

Resectable

Unresectable or Stage IV

Multi-disciplinary Evaluation
(GI, CS, CTC …..)
Nutrition assessment
(Jejunostomy feeding, NG feeding, TPN)
Evaluation of other medical comorbidity
Performance status

Palliative chemoradiotherapy or radiotherapy
Best supportive care and Nutrition support
(Jejunostomy or gastrostomy feeding)

Medical fit, resectable,
See page 4

Medical unfit for surgery but able to tolerate CCRT or Cervical esophageal tumor
Seep page5

Medical unfit for surgery and unable to tolerate CCRT
See page 5

1.If asymptomatic，History and physical every 3 month for 2 years，than every 6 month for 3~5 years.
2. Chemistry profile CBC, Tumor marker.
3.Imaging：
＊CXR every 3 month for 2 years，than every 6 month for 3~5 years.
＊Chest CT every 6 month for 2 years，than every 1year for 3~5 years.
4. Dilatation of anastomotic stenosis (OP).
* Upper GI endoscopy and biopsy as clinically indicated

Definitive CCRT 的 RT 結束後第 3 個月 FOLLOW UP chest CT

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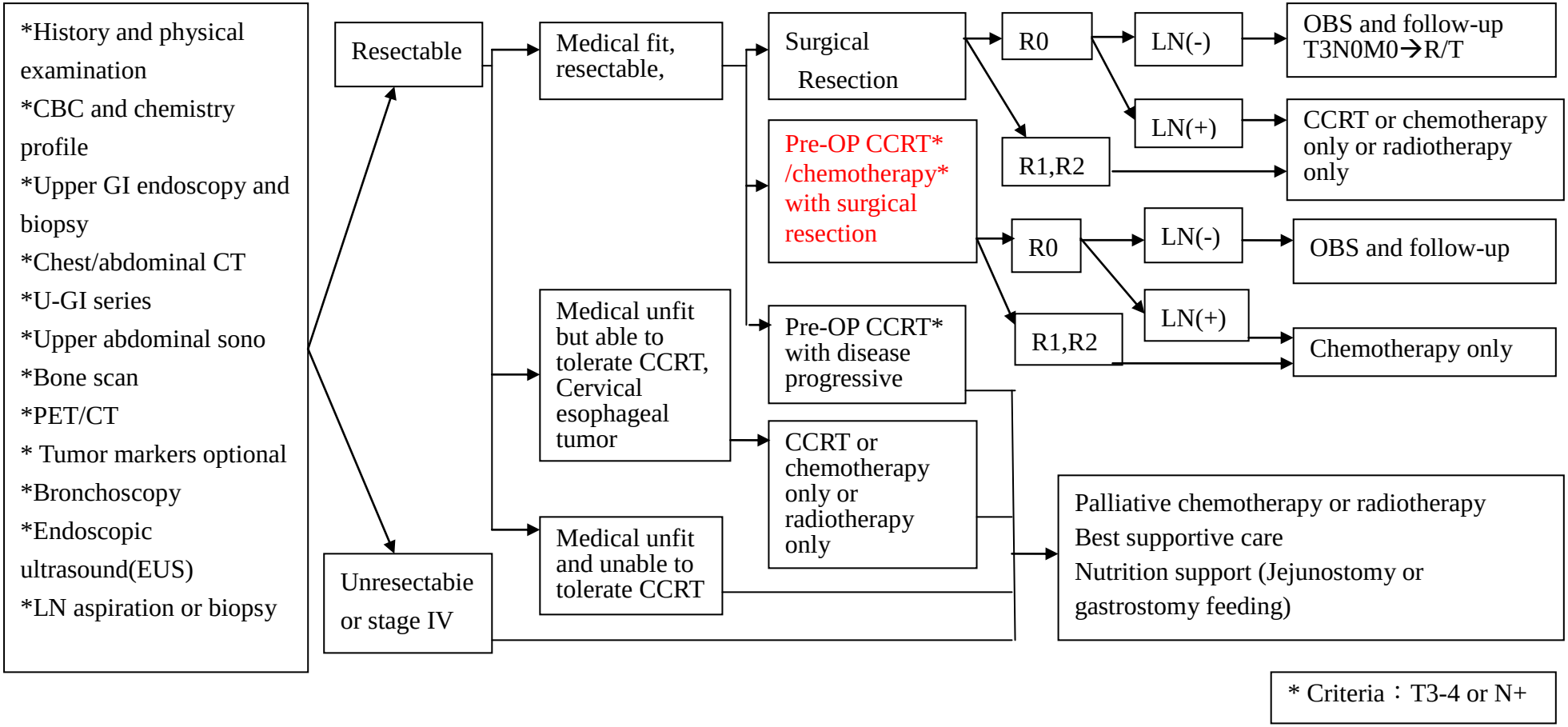
評估	診斷	治療	追蹤



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評估	診斷	治療	追蹤

***History and physical examination**
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***Endoscopic ultrasound (EUS)**
***LN aspiration or biopsy**

Medical unfit for surgery, or Cervical esophageal tumor → **CCRT or chemotherapy only or radiotherapy only**

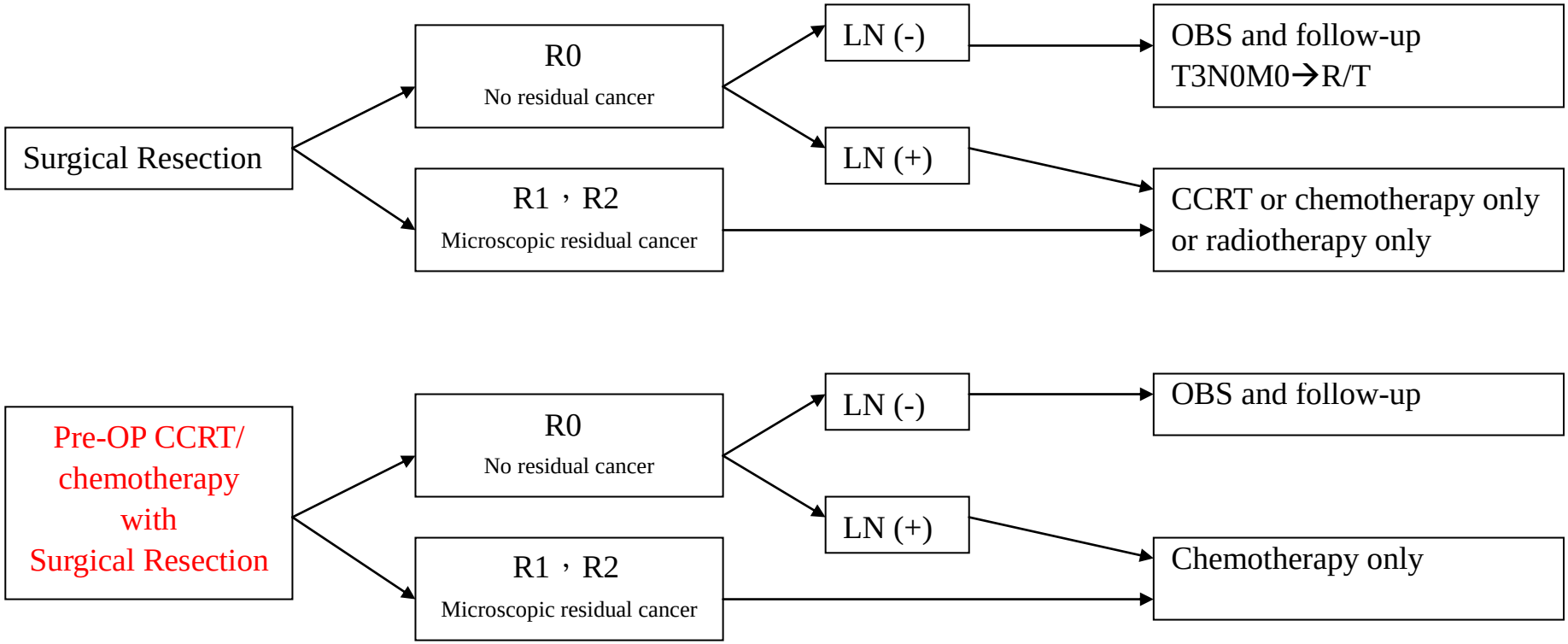
Medical unfit for surgery and unable to tolerate CCRT → **Best supportive**

Pre-OP CCRT * with Disease progressive → **Palliative chemoradiotherapy Best supportive care and Nutrition support**

1.If asymptomatic，History and physical every 3 month for 2 years，than every 6 month for 3~5 years.
2. Chemistry profile CBC, Tumor marker.
3.Imaging：
＊CXR every 3 month for 2 years，than every 6 month for 3~5 years.
＊Chest CT every 6 month for 2 years，than every 1year for 3~5 years.
* Upper GI endoscopy and biopsy as clinically indicated

Definitive CCRT 的 RT 結束後第 3 個月 FOLLOW UP chest CT

Surgical outcomes after esophagectomy/ Clinical pathologic findings	Tumor classification	Postoperative treatment



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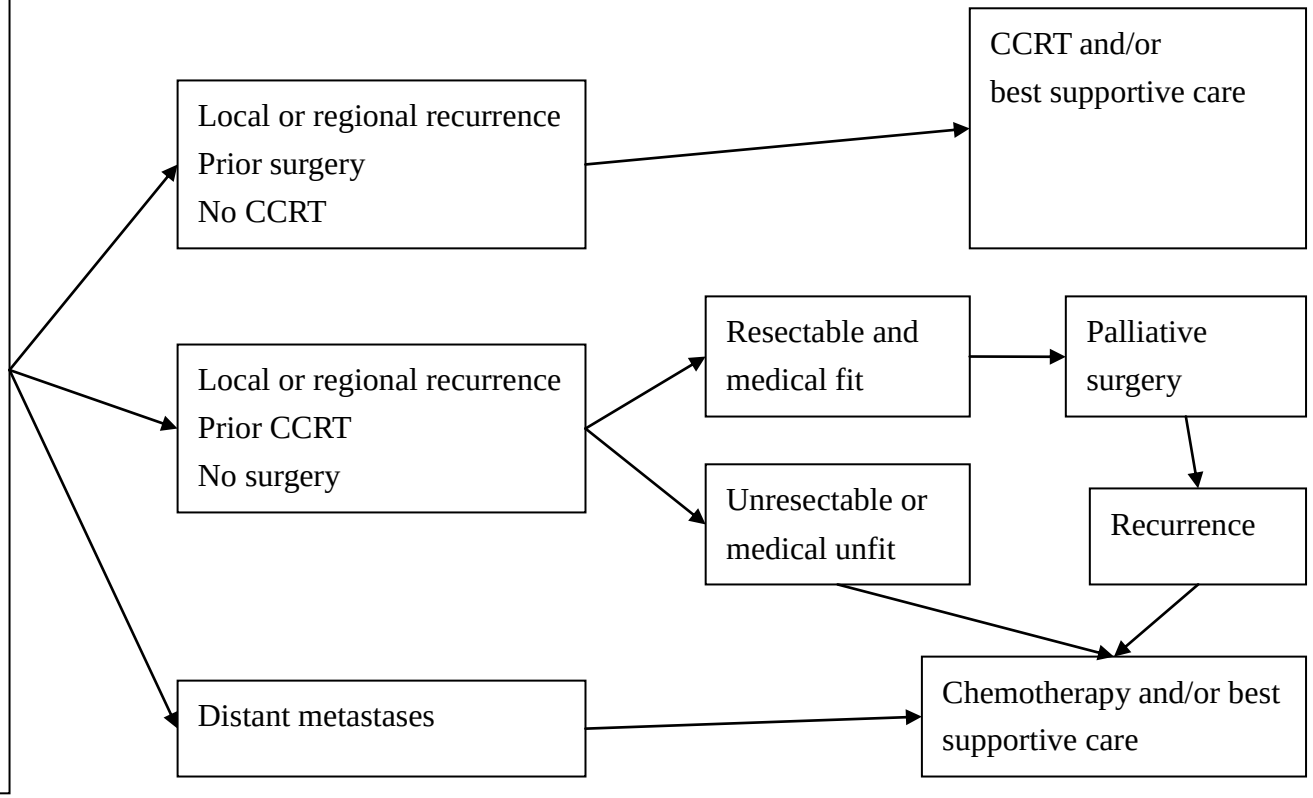
Follow-up	Recurrence	Palliative therapy

1.If asymptomatic，History and physical every 3 month for 2 years，than every 6 month for 3~5 years.
2. Chemistry profile CBC, Tumor marker.
3.Imaging：
＊CXR every 3 month for 2 years，than every 6 month for 3~5 years.
＊Chest CT every 6 month for 2 years，than every 1year for 3~5 years.
*Dilatation of anastomotic stenosis
* Upper GI endoscopy and biopsy as clinically indicated

Definitive CCRT 的 RT 結束後第 3 個月 FOLLOW UP chest CT



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化學治療處方

Published C/T regimens(neoadjuvant/adjuvant/CCRT/metastasis)	Schedule	
Cisplatin 60-75mg/m2, IV ,D1/ Carboplatin AUC 4-6 mg, IV ,D1（Ccr <60） Fluorouracil, 600-1000 mg/m2, IV ,D1-4 (Reference No.22)	Q28 D x 4-6 cycles	Performance status (ECOG)≦2 or Kamofsky Performance score≧60
Cisplatin 60-75 mg/m2, IV ,D1/ Carboplatin AUC 4-6 mg, IV ,D1（Ccr <60） Etoposide 60-100 mg/m2, IV ,D1-3 (Reference No.23)	Q21 D x 4-6 cycles	Performance status (ECOG)≦2 or Kamofsky Performance score≧60
Taxol 140-175 mg/m2, IV ,D1 Cisplatin 20 mg/m2, IV ,D1-5/ Carboplatin AUC 1mg, IV ,D1-5（Ccr <60） Fluorouracil,600-750 mg/m2, IV ,D1-5 (Reference No.24)	Q14D x 4-6 cycles	Performance status (ECOG)≦2 or Kamofsky Performance score≧60
Cisplatin 60 mg/m2, IV ,D1/ Carboplatin AUC 4-6 mg, IV ,D1（Ccr <60） Xeloda 2.5TAB/ m2, PO,D1-14 (Reference No.27)	Q21 D x 4-6 cycles	Performance status (ECOG)≦2 or Kamofsky Performance score≧60
Ufur 3CAP/m2, PO,D1-14	Q28D x6 cycles	Performance status (ECOG)≦2 or Kamofsky Performance score≧60
Mitomycin 5- 7 mg/m2, IV ,D1 Cisplatin 50-60 mg/m2, IV ,D1/ Carboplatin AUC 4-6 mg, IV ,D1（Ccr <60） Fluorouracil,480~600 mg/m2, IV ,D1 (Reference No.28)	MitomycinQ42D Cisplatin Q21D 5-FU QD MCF x 4-6 cycles	Performance status (ECOG)≦2 or Kamofsky Performance score≧60

Mitomycin 5- 7 mg/m2, IV ,D1 Cisplatin 45-60 mg/m2, IV ,D1/ Carboplatin AUC 4-6 mg, IV ,D1（Ccr <60） Ufur 3CAP/m2, PO,D1-14 (Reference No.28)	MitomycinQ42D Cisplatin Q21D Ufur QD MCU x 4-6 cycles	Performance status (ECOG)≦2 or Kamofsky Performance score≧60
Tarceva 150mg 1TAB, PO (Reference No.29)	QD (to disease progression)	Performance status (ECOG)≦2 or Kamofsky Performance score≧60

備註【1】依據影像學檢查發現疾病 progession disease 或【2】依據達到 Grade 3：Severe or advance Side effect，即先停藥，再視病患情況決定繼續治療或改變處方。

Radiotherapy (Reference No.15-21)

Dose prescription	
Combination with operation (Pre-operative or post operative RT)	1.8-2 Gy, total 45-50.4 Gy, 25-28 fraction
Concurrent CCRT without operation	1.8-2 Gy, total 50.4-59.4 Gy, 28-33 fractions
RT alone	1.8-2 Gy, total 54-64 Gy, 27-35 fractions
When the radiation dosage reach 45 Gy，the stomach area should be blocked.	

Field design

Preoperative RT or CCRT：

GTV = primary lesion and involved LN; CTV = GTV + subclinical disease (regional LN and submucosal), 4 cm proximal/distal and 1 cm radial; PTV = CTV + 1－2 cm.

Tumors above the carina: treat SCV and mediastinal LN.

Tumors at or below the carina: treat mediastinal LN, and include celiac LN for lower 1/3 and gastroesophageal junction tumors.

Postoperative RT：depended by operative findings and pathological report.

Dose limitation：

Spinal cord：Dmax ≦ 46 Gy at 1.8-2 Gy/fraction

Lung：V20 (volume receiving ≧20 Gy) < 35%。

Heart：V40 < 50%。

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