探討術前化學治療後腫瘤期別判定

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Current and future cancer staging after neoadjuvant treatment for solid tumors

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幾個重點：

臨床期別(clicnial stage) 資料收集來自病人的病史臨床醫師的檢查以及影像學的結果綜合。病理分期(pathologic stage)是依據手術的發現以及切除下來的病理標本的病理報告的結果。

術前治療包括術前化學治療,術前放射線治療,術前免疫治療等,沒有立刻開刀統稱為 N A T,

臨床上使用的情形: 1,腫瘤危及生命有遠端轉移的情形不適合立刻手術, 2, 術前治療往往在控制看不見的潛伏性的隱藏的遠端轉移其實這個腫瘤看起來雖然是很早期先控制，3, 做術前治療可以評估這個術前治療對這個腫瘤的敏感性, 能夠判斷腫瘤的反應以及效果 4, 遠端轉移有在進展或者逐漸擴散時候能夠被拿來評估其他的治療可以在下一次的手術要做之前的時候考慮其他的術前治療，5, 術前化學治療有反應了可以讓原來要做很大的手術很廣泛的手術或輕的手術可以做得比較局部一點可以增加甚至可以增加腫瘤完全切除乾淨的可能性, 創造一個手術邊緣是乾淨的一個情形, 可以減少局部復發或者是鄰近復發 .

The Clinical Case for Giving NAT

The life-threatening aspect of solid tumors is nearly always distant metastatic disease and is rarely local or regional disease.

Neoadjuvant systemic therapies treat occult distant metastatic disease at the earliest point in time.

Primary tumor sensitivity to these therapies can be assessed by measuring and documenting tumor response.

Development or progression of distant metastatic disease can be assessed, and an alternative systemic treatment may be indicated before surgical resection if it is still considered appropriate.

A response to NAT may reduce local tumor burden to allow less extensive surgery (or sometimes nonsurgical management) and may increase the likelihood of complete resection with negative pathological surgical margins, thereby reducing the risk of local or regional recurrence.

案例解說: 乳癌的病人,45 歲的女性, 核磁共振有一個 2.2 公分的不規則狀的硬塊在左邊乳房的外上方,觸診的時候發覺到左邊腋下也有大的淋巴結,然後 MRI 也看到有腋下淋巴結大的現象, 穿刺切片是浸潤性乳癌, 第三度的生化,分化差, ER, PR, her2 陰性, 就是三陰性乳癌

期別3B, 正子檢查的時候沒有看到遠端轉移, 接受術前的化學治療四個月後, 整個腫瘤及腋下的淋巴節都沒有看到(消失了)，cCR 就是完全反應, 腫瘤完全消失, Her y-clinical stage is now ycT0 ycN0 cM0. Currently, there are no data fields for yc designation in cancer registry software; therefore, no ycTNM categories or stage group is entered.
在術前評估結果, 目前沒有沒有數據的欄位對應, 術前治療後的不管是 yc, yp, 目前沒有可填的登記的軟體, 所以沒有yc T N M的分期, 這篇文章最後的結論: 第一個病人三陰性乳癌的病人,她對術前化學治療非常好,臨床或者是病理的反應都是完全反應, 已經越來越多這樣的現象, 腋下前哨淋巴節是陰性的時候, 腋下淋巴節廓清就已經沒有那麼需要
第八版的訊息對肺,胰臟,肝臟,大腸,攝護腺,骨頭,軟組織,婦科,泌尿系統,甲狀腺,頭頸部的癌症: 有一個單一的預後的分期,沒有分開臨床跟病理的期別分析, 但是乳癌,黑色素細胞癌,口腔癌有分臨床跟病理上的期別不同, 食道,胃有不同的臨床, 病理還有治療後的病理報告的期別
In the eighth edition of the AJCC Cancer Staging Manual, for most solid tumors (including lung, pancreas, liver, colorectal, prostate, bone, soft tissue sarcoma, gynecological and genitourinary cancers, thyroid, and most head and neck carcinomas), there is a single prognostic stage group table with no separation of clinical and pathological stage groups. The implication in each of these chapters is that pathological staging will always be more accurate and will supplant clinical staging, and surgery will be performed for the majority of these tumors. Staging of breast carcinoma, melanoma, human papillomavirus-mediated (p16-positive) oropharyngeal carcinoma, and Merkel cell carcinoma includes separate clinical (cTNM) and pathological (pTNM) stage group tables. For esophageal and stomach carcinomas, there are separate clinical, pathological, and posttherapy pathological (yp) stage group tables.
2019 韓國放射線雜誌(Korean J Radology)一篇文章: Introduction of a New Staging System of Breast Cancer for Radiologists: An Emphasis on the Prognostic Stage
其中提到術前治療後的分期(Post-Neoadjuvant Therapy Staging) Neoadjuvant therapy is widely performed in locally advanced breast cancer, IBC, and even operable breast cancer (21). After neoadjuvant therapy, the y prefix is used. The ycT is determined by measuring the largest single focus of the residual tumor by examination or imaging (Fig. 8). When there is no residual disease, it is classified as ycT0. IBC(發炎性乳癌) (cT4d) retains the same classification stage even if complete resolution of the tumor is observed.(即使整個腫瘤完全消失也維持 cT4d) The ycN is determined by clinical or radiographic findings of residual lymph nodes. Pre-treatment M1 disease is designated as M1 throughout treatment.