- 前言:
- 惡性淋巴瘤(或簡稱淋巴癌)乃由體內淋巴系統包括淋巴細胞、淋巴管、淋巴腺及一些淋巴器官或組織如脾臟、胸腺及扁桃腺等所長出的惡性腫瘤。依腫瘤病理組織型態的不同可分為何杰金氏淋巴瘤(Hodgkin‘s disease)與非何杰金氏淋巴瘤(Non-Hodgkin’s lymphoma)兩大類，兩者的臨床症狀很相似但其預後卻有所不同。
- 台灣地區及本院的非何杰金氏淋巴瘤發生率皆遠高於何杰金氏病，另依據衛生署民國九十五年癌症統計提料顯示，非何杰金氏淋巴瘤在癌症死因中名列第十一名。
- 因此，血液、肉瘤、腦瘤暨其他癌團隊，特別先針對濾泡型淋巴瘤擬定臨床指引，而 B Cell 淋巴癌中的第一位是DLBCL ，第二位則是Follicular Lymphoma。為此我們除了參考美國NCCN (National Comprehensive Cancer Network)治療準則外，另依據本院多科團隊之討論修訂，來完成本院第一版濾泡型淋巴瘤之治療共識。

- **本共識依下列參考資料修改版本：**
- NCCN Clinical Practice Guidelines in Oncology- NHL V.1.2013

- **制訂人員：**
- 腫瘤內科： 林世強醫師、謝佩穎醫師、鄧仲仁醫師
- 放射腫瘤： 熊佩韋醫師
- 組織病理： 黃文志醫師
- 影像醫學： 陳郁惟醫師

DIAGNOSIS

ESSENTIAL:·

- Hematopathology review of all slides with at least one paraffin block representative of the tumor. Rebiopsy if consult material is nondiagnostic.
- An FNA or core needle biopsy alone is not generally suitable for the initial diagnosis of lymphoma. In certain circumstances, when a lymph node is not easily accessible for excisional or incisional biopsy, a combination of core biopsy and FNA biopsies in conjunction with appropriate ancillary techniques for the differential diagnosis (immunohistochemistry, flow cytometry, PCR for IgH and TCR gene rearrangements, and FISH for major translocations) may be sufficient for diagnosis. Histologic grading cannot be performed on an FNA.
- Adequate immunophenotyping to establish diagnosis
  - Recommended panel for paraffin section immunohistochemistry: CD20, CD3, CD5, CD10, BCL2, BCL6, cyclin D1, CD21 or CD23, or
  - Cell surface marker analysis by flow cytometry: kappa/lambda, CD19, CD20, CD5, CD23, CD10(Lymphoma、leukemia change**才做)**
- USEFUL UNDER CERTAIN CIRCUMSTANCES:
  - · Paraffin section immunohistochemistry: Ki67

WORKUP

ESSENTIAL:

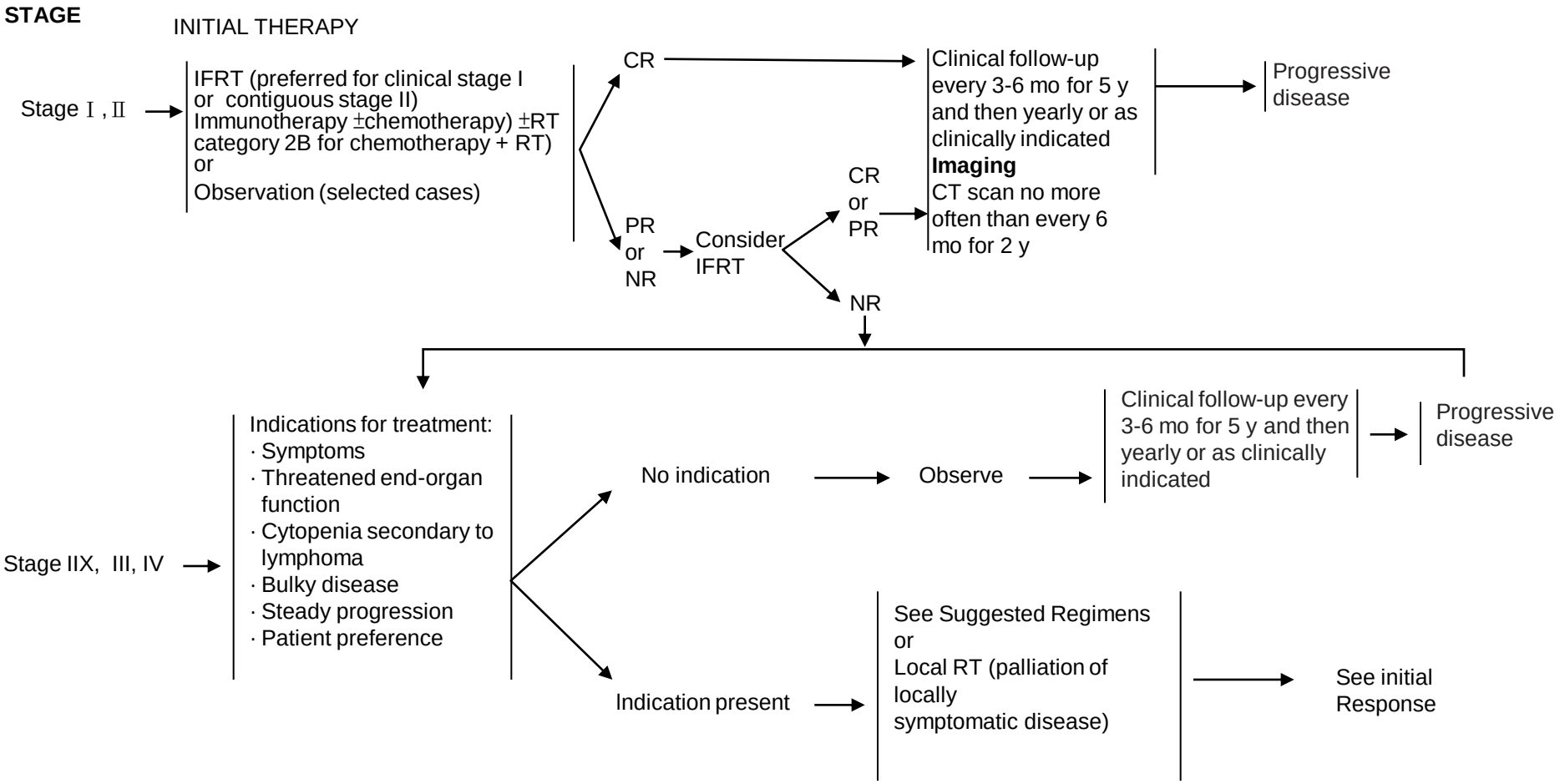
· Physical exam: attention to node-bearing areas, including Waldeyer's ring, and to size of liver and spleen
· Performance status
· B symptoms
· CBC, differential, platelets
· LDH
· Beta-2-microglobulin
· Comprehensive metabolic panel
· Chest/abdominal/pelvic CT with contrast of diagnostic quality
· Hepatitis B testing
· Bone marrow biopsy + aspirate to document clinical stage I-II disease
· Pregnancy testing in women of child-bearing age (if chemotherapy planned)

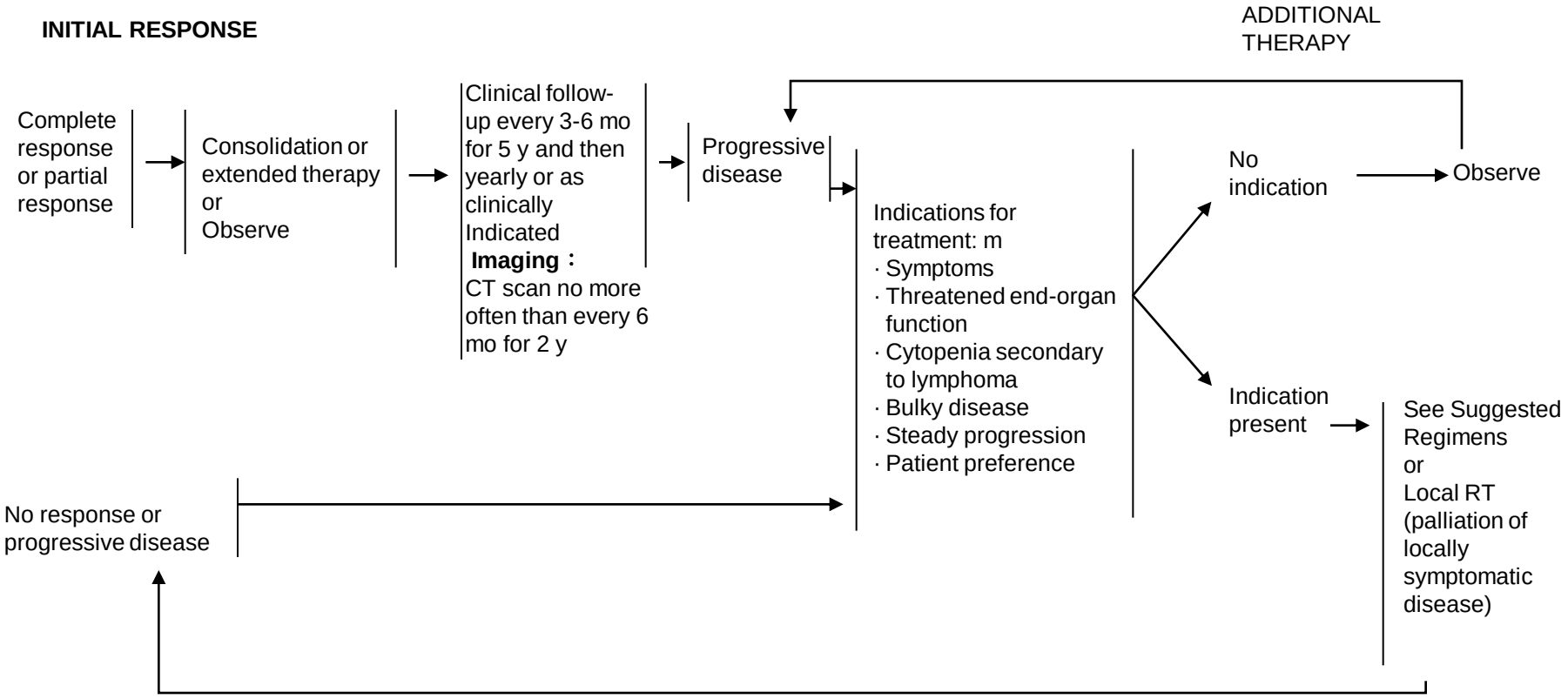
USEFUL IN SELECTED CASES:

· Cardiac Fuction Test (RNA,EF) /echocardiogram if anthracycline or anthracenediones- based regimen is indicated
· Neck CT
· PET-CT scan
· Uric acid
· Discussion of fertility issues and sperm banking
· SPEP and/or quantitative immunoglobulin levels
· Hepatitis C testing

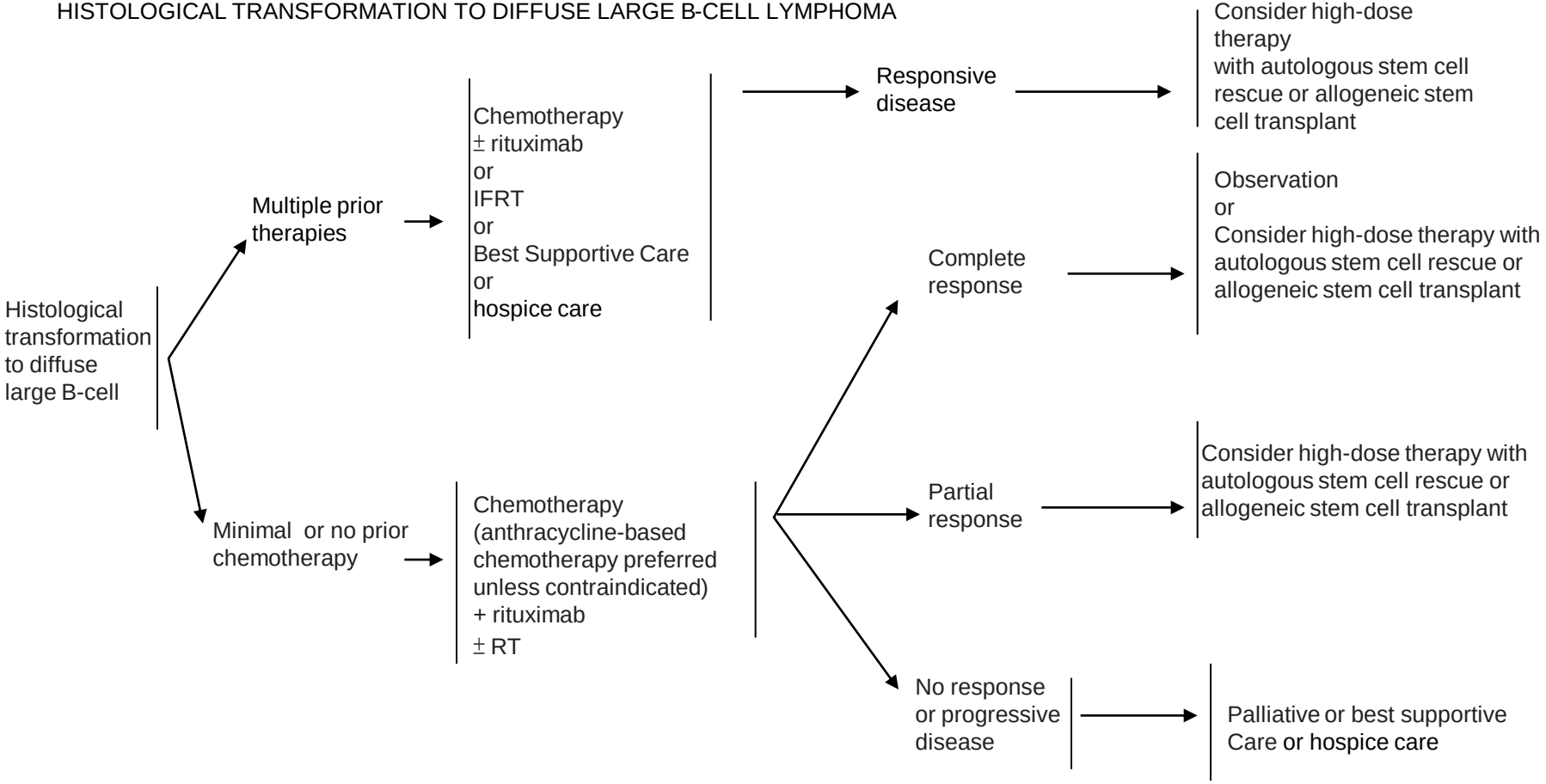
Stage I, II

Stage IIX, III, IV


STAGE
INITIAL THERAPY
Stage Ⅰ, Ⅱ
IFRT (preferred for clinical stage I or contiguous stage II)
Immunotherapy ±chemotherapy) ±RT category 2B for chemotherapy + RT)
or
Observation (selected cases)
CR
PR or NR
Consider IFRT
CR or PR
NR
Clinical follow-up every 3-6 mo for 5 y and then yearly or as clinically indicated
Imaging
CT scan no more often than every 6 mo for 2 y
Progressive disease
Stage IIX, III, IV
Indications for treatment:
· Symptoms
· Threatened end-organ function
· Cytopenia secondary to lymphoma
· Bulky disease
· Steady progression
· Patient preference
No indication
Observe
Clinical follow-up every 3-6 mo for 5 y and then yearly or as clinically indicated
Progressive disease
Indication present
See Suggested Regimens
or
Local RT (palliation of locally symptomatic disease)
See initial Response


INITIAL RESPONSE
ADDITIONAL THERAPY
Complete response or partial response
Consolidation or extended therapy or Observe
Clinical follow-up every 3-6 mo for 5 y and then yearly or as clinically Indicated
Imaging：
CT scan no more often than every 6 mo for 2 y
Progressive disease
Indications for treatment: m
· Symptoms
· Threatened end-organ function
· Cytopenia secondary to lymphoma
· Bulky disease
· Steady progression
· Patient preference
No indication
Observe
Indication present
See Suggested Regimens or Local RT (palliation of locally symptomatic disease)
No response or progressive disease

HISTOLOGICAL TRANSFORMATION TO DIFFUSE LARGE B-CELL LYMPHOMA



INTERNATIONAL PROGNOSTIC INDEX

ALLPATIENTS:

- Age > 60 years
- Serum LDH ＞ 1x normal
- Performance status 2-4
- Stage III orⅣ
- Extranodal involvement > 1site

INTERNATIONAL INDEX ALL PATIENTS:

LOW	0 or 1
Low intermediate	2
High intermediate	3
High	4 or 5

AGE-ADJUSTED INTERNATIONAL PROGNOSTIC INDEX

PTIENTS ≦ 60 YEARS:

- Stage III orⅣ
- Serum LDH > 1x normal
- Performance status 2- 4

INTERNATIONAL INDEX, PATIENTS ≦ 60 YEARS:

Low	0
Low / intermediate	1
High / intermediate	2
High	3

亞東紀念醫院 Follicular Lymphoma臨床指引

Follicular lymphoma
Clinical Guidelines
in Oncology, FEMH –v1. 2013

GELF CRITERIA

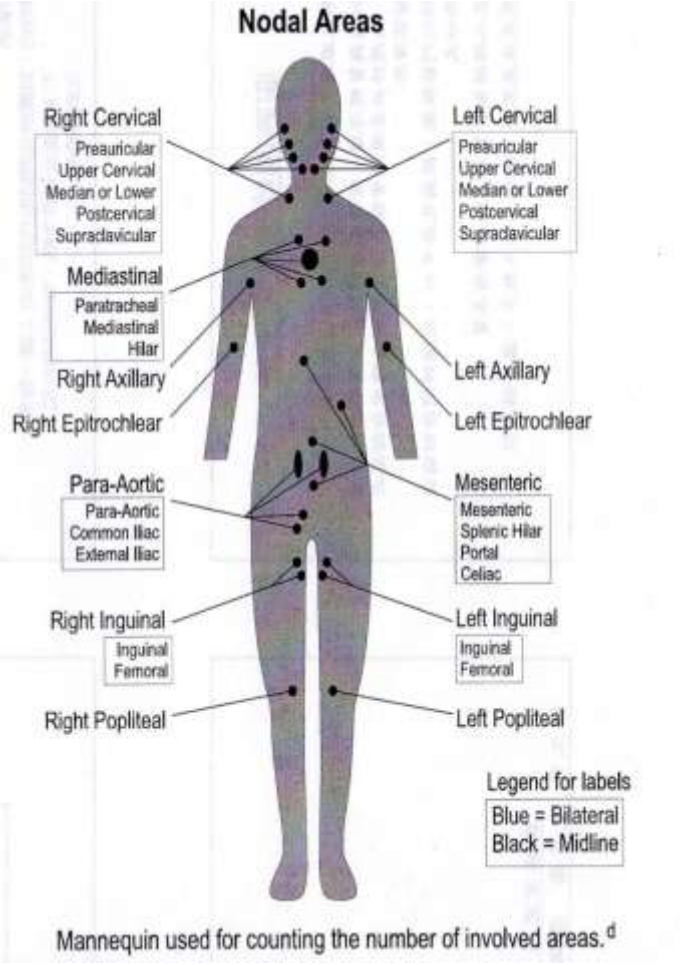
Involvement of ≥3 nodal sites, each with a diameter of ≥3 cm
· Any nodal or extranodal tumor mass with a diameter of ≥7 cm
· B symptoms
· Splenomegaly
· Pleural effusions or peritoneal ascites
· Cytopenias (leukocytes < 1.0 x 10 9/L and/or platelets < 100 x 10 9/L)
· Leukemia (> 5.0 x 10 9/L malignant cells)

FLIPI - 1 CRITERIA

Age	≥60 y
Ann Arbor stage	III-IV
Hemoglobin level	< 12 g/dL
Serum LDH level	> ULN (upper limit of normal)
Number of nodal sites	≥5

Risk group according to FLIPI chart

	Number of factors
Low	0-1
Intermediate	2
High	≥3



Mannequin used for counting the number of involved areas.[d]

SUGGESTED TREATMENT REGIMENS
(in alphabetical order)

First-line Therapy
- R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) (category 1)
- R-COP (rituximab, cyclophosphamide, vincristine, prednisone) (category 1)
- Fludarabine + rituximab
- First-line Therapy for Elderly or Infirm (if none of the above are tolerable)
- Rituximab, preferred
- Single agent alkylators ± rituximab (eg, chlorambucil or cyclophosphamide)

First-line Consolidation or Extended Dosing
- Rituximab maintenance up to 2 y (category 1)

Second-line and Subsequent Therapy
- Chemoimmunotherapy (as in first-line therapy)
- **Fludarabine base(EX:RFND)**
- **Lenalidomide ± rituximab**
- **Rituximab**
- FCMR (fludarabine, cyclophosphamide, mitoxantrone, rituximab) (category 1)
- See Second-line Therapy for DLBCL

Second-line Consolidation or Extended Dosing
- High dose therapy with autologous stem cell rescue
- Allogeneic stem cell transplant for highly selected patients
- Rituximab maintenance (category 1)

For patients with locally bulky or symptomatic disease, consider IFRT 4-30 Gy ± additional systemic therapy.

Reference from NCCN V.1.2013 , difference as following:

- **Workup:> "Beta-2-microglobulin" was moved to Essential from Useful in Selected Cases.**
- **Stage I-II:> After initial treatment with immunotherapy ± chemotherapy, the option to "Consider IFRT" was added for a PR or NR.**
- **First-line therapy:> "RFND (rituximab, fludarabine, mitoxantrone, dexamethasone)" was removed as a treatment option.**
- **Second-line and subsequent therapy:> The following treatment options were added, Lenalidomide ± rituximab、 Rituximab 、Fludarabine base(EX:RFND)**