中文翻译版

The Bethesda Handbook of Clinical Oncology

贝塞斯达临床肿瘤学手册

原书第3版

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科学出版社

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内 容 简 介

本书是由美国国家肿瘤协会(NCI)及其他权威机构编著而成,内容涵盖了所有的恶性肿瘤。本书第 3 版着重于介绍临床实践信息,包含新的化疗药物、剂量、治疗方案以及最新临床试验结果,并在前两版的基础上新增了基因组学及放疗领域的相关内容。本书包含表格、图片、流程图及缩略语等多种形式,简明扼要、便于查阅,可作为临床肿瘤科医师的诊疗指南。

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前　言

《贝塞斯达临床肿瘤学手册》是一本内容翔实、准确、易于理解的手册，适合于日常工作繁忙的临床医师使用。本书由在美国国家肿瘤机构和国家健康机构工作或者接受培训的临床医师，及其他研究机构的学者共同编著。由于篇幅的限制，本书涉及病因学、病理生理学和流行病学的相关内容较少，而着重于实际临床信息的介绍。为了使内容更为切题，本书避免了长篇累牍式的叙述，取而代之的是更多的表格、图片、流程图及缩略语。

《贝塞斯达临床肿瘤学手册》并不是一本内容极为详尽，包含病理生理和复杂肿瘤患者诊治方案解析的肿瘤学理论专著，而是为读者提供每种疾病治疗方法的精炼介绍，包括诊断、用药剂量、疗程等，是一本肿瘤学家、肿瘤学相关工作人员、住院医师、学生、护士和健康管理者独特的、有使用价值的手册。

自从10年前本书第一次出版以来，肿瘤学领域发生了巨大变化，随着第3版的问世，我们同样更新了所有章节的内容；并且增加了两个全新的章节——肿瘤医师应了解的基因组学内容、肿瘤放疗原则。我们致力于涵盖本领域的最新进展，并虚心接受读者的反馈，使本手册第3版更加完善。我们希望每个需要得到肿瘤概况的读者都将《贝塞斯达临床肿瘤学手册》视为必不可少的资源。

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目　录

第一部分　头　颈　部

第二部分　胸　　部

第三部分　消 化 系 统

第四部分　乳　　腺

第五部分　泌尿生殖系统

第六部分　妇　　科

第七部分 运动系统

第八部分 皮肤癌

第九部分 血液系统

第十部分 其他恶性肿瘤

第十一部分 支持治疗

第十二部分　常见的诊疗流程及其他主题

第一部分 头 颈 部

1 头颈部肿瘤

Dexter T. Estrada, Carter van Waes, Janaki Moni, Barbara A. Conley

流行病学

全世界每年头颈部鳞癌的发病率超过 50 万，美国每年发病率为 4 万～5 万人次，占所有新发癌症的 3%～5%，占癌症死亡率的 2%[1]。大多数患者的发病年龄在 50 岁以上，并且发病率随着年龄的增大而呈上升趋势；男女发病率之比为 2.5∶1，经年龄校正的发病率在黑种人男性较高，而且，各分期中非裔美国人生存率低于白种人。1975 年以后，头颈部肿瘤死亡率已经呈下降趋势，尤其在过去十年中其下降更为迅速[1]，约 90%的头颈部肿瘤为鳞状细胞癌，最常见的发生部位为口腔、咽、喉和下咽。鼻腔癌和鼻咽癌、唾液腺恶性肿瘤、各种肉瘤、淋巴瘤和黑色素瘤则较为罕见。

危险因素

大量饮酒可使患头部和颈部鳞癌的风险增加 4～6 倍，根据性别、种族和吸烟数量等不同，吸烟会使患病风险增加 5～25 倍，两者的共同作用使患病风险增加 15～40 倍。无烟烟草和鼻烟都与口腔癌的发生相关，病例对照研究显示，长期与鼻烟粉末接触的组织（如脸颊和牙龈）发展为肿瘤组织的相对危险性较正常组织增加将近 50 倍[2]，在亚洲和非洲的一些地区，嚼槟榔、吸烟、使用熟石灰都是造成癌前病变以及口腔鳞癌高发的危险因素[3,4]。

多灶性黏膜异常在头颈肿瘤患者中已被描述("癌变")[5]。患有头颈部肿瘤、肺癌、食管癌的患者中,每年有2%～6%的患者有发生第二原发肿瘤的风险,那些持续吸烟者发病风险最高。原发头颈部鳞癌幸存者中,第二原发肿瘤是其主要致死因素[6~8]。

研究发现EB病毒几乎与所有非角化和未分化的鼻咽癌有关,但与鼻咽部鳞癌关系不大[9],口咽部和扁桃体的肿瘤可能与人类乳头状瘤病毒(HPV)感染有关[10~12]。与HPV感染相关的癌症发病率似乎在不吸烟者中更高,在几个不同的国家中均有上升趋势。与DNA修复有关的疾病(如Fanconi贫血),以及器官移植相关免疫抑制剂的使用都将增加头颈部鳞癌的患病风险[13]。

预防和化学预防

头颈部肿瘤预防的最重要途径是戒烟和限制酒精的摄入量。口腔、咽、喉等部位发生癌前病变可表现为白斑(白色斑片不易刮去,而没有其他明显的原因)或红斑(质脆偏红)(表1.1)。

表1.1 癌前病变

	黏膜白斑	黏膜红斑	非典型增生
临床特点	发生在黏膜表面不能除掉的白斑或斑块,需除外其他口腔病变	明亮的红色天鹅绒般的斑块,临床上和病理上不能确定原因	可表现为黏膜白斑、红斑或无明显镜下病变
恶变概率	4%	15%～30%为不典型增生病灶	15%～30%
组织病理	过度角化伴有其他组织学发现;很少见到异型增生或癌变(仅6%病例中见到侵袭性或原位癌)	轻-中度异型增生占10%,重度异型增生或原位癌、浸润性癌占90%	真正病理诊断:多形性变化,核仁数目增多或增大

来源:经允许,引自McFarland M, Abaza NA, El-Mofty S. In: Damjanov I, LinderJ, eds. Anderson's pathology. St. Louis: Mosby, 1996。

不伴非典型增生的白斑进展到癌的风险大约为4%，重度不典型增生或黏膜红斑则有40%可进展为癌症。维A酸可以逆转癌前病变，然而，一项随机双盲对照研究显示，应用异维A酸、维生素A或*N*-乙酰半胱氨酸治疗头颈部鳞状细胞癌或维生素A联合*N*-乙酰半胱氨酸在预防第二原发肿瘤或提高生存等方面无明显临床获益[14,15]。

目前，尚无可以有效预防头颈部鳞状细胞癌的化学方法，美国国立癌症研究所正在进行一项关于PPAR激动剂对口腔癌前病变的预防研究，最终的结论仍在统计中[16]。其他途径的研究也正在进行，不建议脱离临床试验的化学预防，或者可以说其有潜在的危害[17~19]。

解 剖 学

颅外头颈部解剖结构简化图见图1.1。

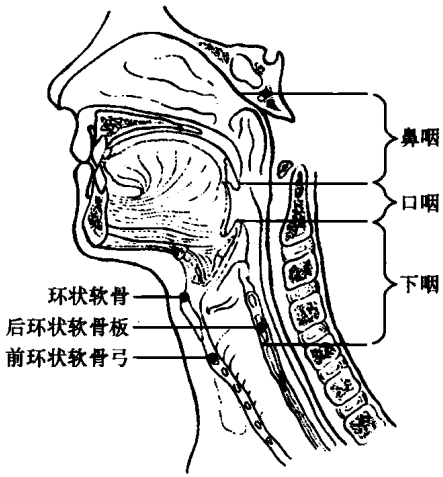

图1.1 上呼吸消化道矢状面解剖图

根据淋巴引流可把颈部分为多个区域（图1.2），Ⅰ区包括颏下或颌下淋巴结，Ⅱ区上颈部淋巴结）位于从颅底延伸至舌骨区域，Ⅲ区（中颈部淋巴结）位于舌骨和环状软骨下缘区之

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