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临床妇科肿瘤学

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Clinical Gynecologic Oncology

Sixth Edition



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Clinical Gynecologic Oncology

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Genes and Cancer

PREFACE

The first five editions of *Clinical Gynecologic Oncology* were stimulated by a recognized need for a readable text on gynecologic cancer and related subjects, addressed primarily to the community physician, resident, and other students involved with these patients. The practical aspects of the clinical presentation and management of these problems were heavily emphasized in the first five editions, and we have continued that style in this text. As in every other textbook, the authors interjected their own biases on many topics, especially in those areas where more than one approach to management has been utilized. On the other hand, most major topics are treated in depth and supplemented with ample references to current literature so that the text can provide a comprehensive resource for study by the resident, fellow, or student of gynecologic oncology and serve as a source of review material.

We continued the practice of placing an outline on the first page of each chapter as a guide to the content of that section. The reader will notice that we included topics not discussed in the former editions and expanded areas previously introduced. Some of these areas include new guidelines for managing the dying patient, current management and reporting guidelines for cervical and vulvar cancer, current management and reporting guidelines for breast cancer, expanded discussion on the basic principles of genetic alterations in cancer, and new information on breast and colon cancer screening and detection. The sixth edition contains, for the first time, a color atlas of key gross and microscopic specimens for the reader's review. In addition, Drs DiSaia and Creasman have included, for the first time, other authors for three of the chapters. Much more information is included to make the text as practical as possible for the practicing gynecologist. In addition, key points are highlighted for easy review.

Fortunately, many of the gynecologic malignancies have a high "cure" rate. This relatively impressive success rate with gynecologic cancers can be attributed in great part to the development of diagnostic techniques that can identify precancerous conditions, the ability to apply highly effective therapeutic modalities that are

more restrictive elsewhere in the body, a better understanding of the disease spread patterns, and the development of more sophisticated and effective treatment in cancers that previously had very poor prognoses. As a result, today a patient with a gynecologic cancer may look toward more successful treatment and longer survival than at any other time. This optimism should be realistically transferred to the patient and her family. Patient denial must be tolerated until the patient decides that a frank conversation is desired. When the prognosis is discussed, some element of hope should always be introduced within the limits of reality and possibility.

The physician must be prepared to treat the malignancy in light of today's knowledge and to deal with the patient and her family in a compassionate and honest manner. The patient with gynecologic cancer needs to feel that her physician is confident and goal oriented. Although, unfortunately, gynecologic cancers will cause the demise of some individuals, it is hoped that the information collected in this book will help to increase the survival rate of these patients by bringing current practical knowledge to the attention of the primary care and specialized physician.

Our ideas are only intellectual instruments, which we use to break into phenomena; we must change them when they have served their purpose, as we change a blunt lancet that we have used long enough.

Claude Bernard (1813–1878)

Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of their physician.

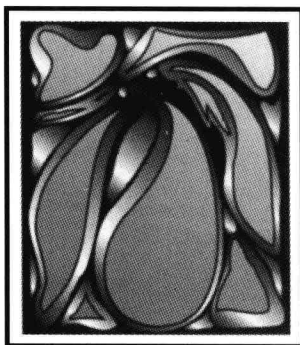
Hippocrates (440–370 BC)

Philip J. DiSaia, MD
William T. Creasman, MD

NOTICE

Pharmacology is an ever-changing field. Standard safety precautions must be followed, but as new research and clinical experience broaden our knowledge, changes in treatment and drug therapy may become necessary or appropriate. Readers are advised to check the most current product information provided by the manufacturer of each drug to be administered to verify the recommended dose, the method and duration of administration, and contraindications. It is the responsibility of the treating physician, relying on experience and knowledge of the patient, to determine dosages and the best treatment for each individual patient. Neither the publisher nor the editor assumes any liability for any injury and/or damage to persons or property arising from this publication.

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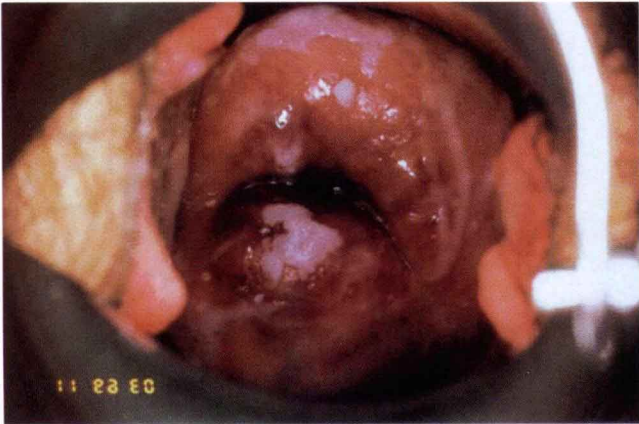


PLATE 1-1. Keratosis is seen in the transformation zone. By definition, this is white epithelium in the transformation zone before acetic acid is placed on the cervix. The importance of this finding is that there may be an underlying lesion. In this case, it was cervical intraepithelial neoplasia II.

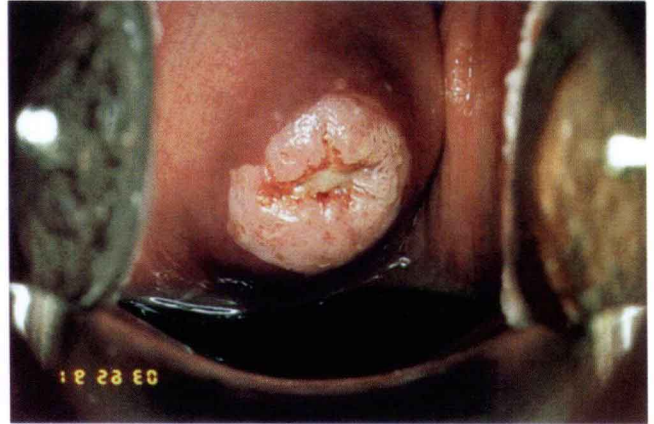


PLATE 1-2. White epithelium surrounds the entire os. Histologically, this was cervical intraepithelial neoplasia II.



PLATE 1-3. A large area of abnormality is seen in the transformation zone. Punctuation with white epithelium and mosaicism is present.



PLATE 1-4. White epithelium is present on the posterior lip of the cervix. The upper limits of the lesion cannot be visualized.

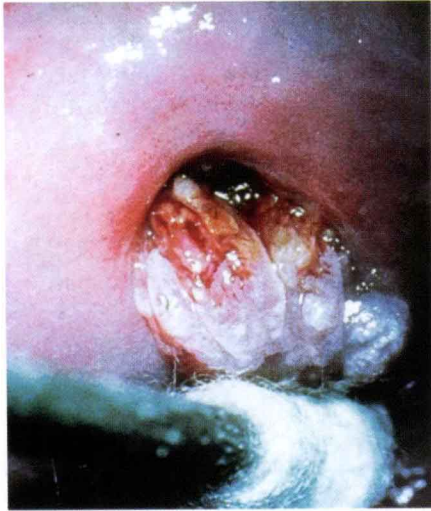


PLATE 1-5. This lesion is also noted in Plate 1-4. The cotton-tipped applicator is pushing down the posterior lip so that the upper limits of the lesion can be seen.



PLATE 1-6. White epithelium, punctuation, and mosaicism are present on a large abnormal area on the anterior lip of a pregnant cervix.



PLATE 1-7. The anterior lip of the cervix is seen with white epithelium; a hint of mosaicism is present. Note the sharp demarcation between the normal and abnormal epithelium.



PLATE 1-8. This microscopic evaluation of the biopsy from Plate 1-7 shows the sharp demarcation between the normal and abnormal epithelium.

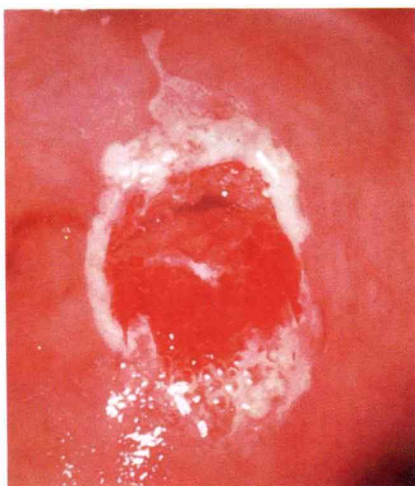


PLATE 1-9. White epithelium with a suggestion of mosaicism surrounding the entire cervical os. This patient is pregnant. One can note the aversion of the os allowing for a complete evaluation.



PLATE 1-10. Condyloma is present on the cervix.

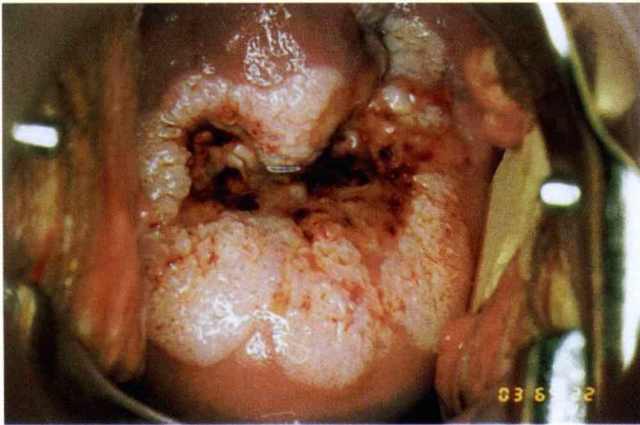


PLATE 1-11. Verrucous carcinoma of the cervix is seen. Note the similarity to a condyloma; however, necrosis is evident in the os and should be the clue.

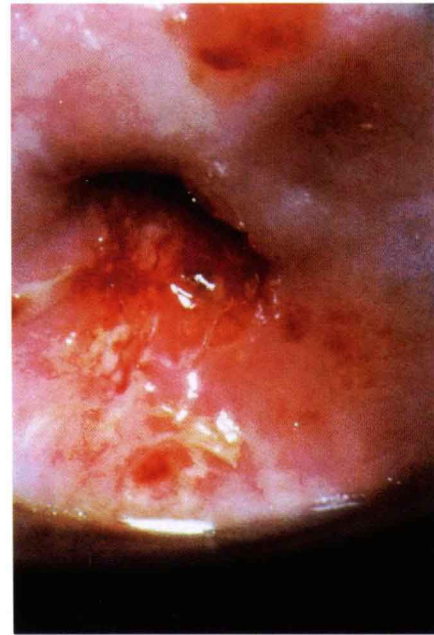


PLATE 1-12. Atypical vessels present in the 6 o'clock position. Note that the rest of the cervix appears normal colposcopically.



PLATE 2-1. Multifocal vaginal intraepithelial neoplasia (VAIN).

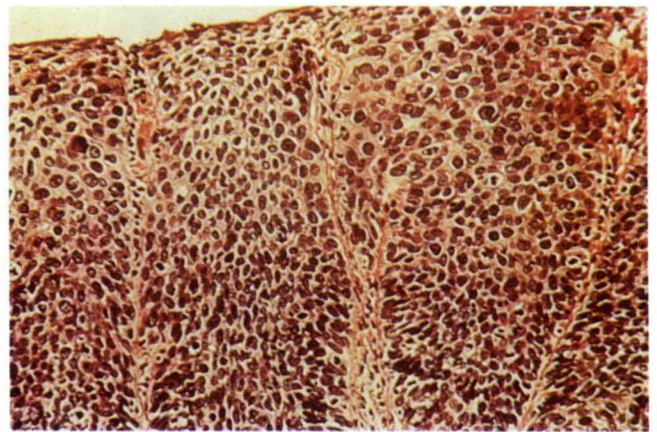


PLATE 2-2. Photomicrograph of one of the lesions (i.e., vaginal intraepithelial neoplasia) seen in gross photograph in Plate 2-1.



PLATE 2-3. A mild form of hypertrophic vulvar dystrophy is shown.

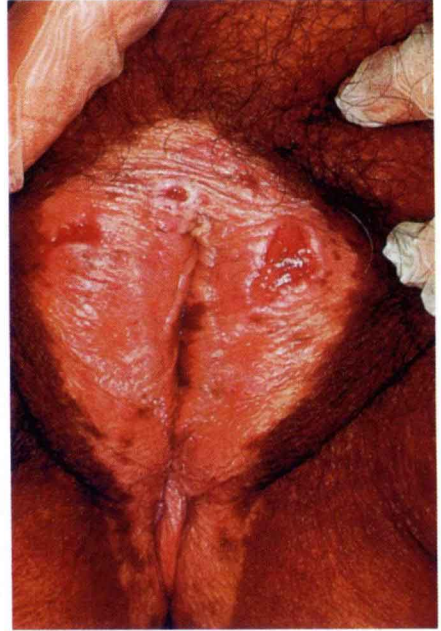


PLATE 2-4. A severe form of hypertrophic vulvar dystrophy is shown.



PLATE 2-5. Lichen sclerosis of the vulva is seen in an adult patient.



PLATE 2-6. Lichen sclerosis of the vulva is seen in a 5-year-old child.

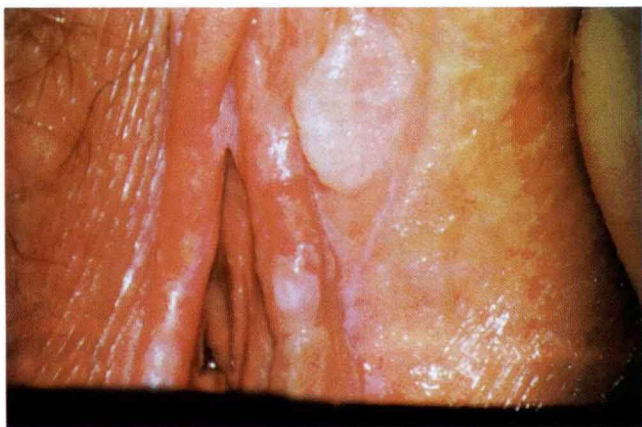


PLATE 2-7. Vulvar intraepithelial neoplasia (VIN), multifocal white lesion.



PLATE 2-8. Vulvar intraepithelial neoplasia (VIN), pseudopigmented lesion.

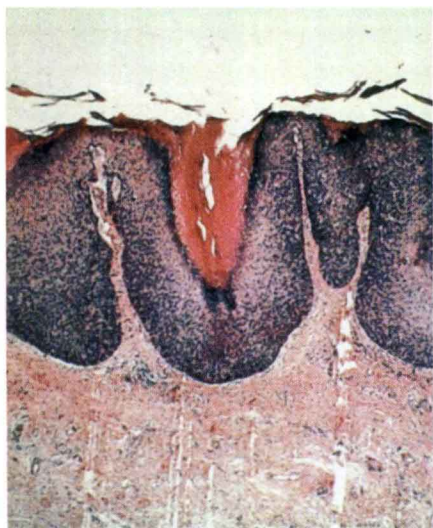


PLATE 2-9. This is a photomicrograph of the pseudopigmented lesion seen in the gross photograph in Plate 2-8.



PLATE 2-10. Vulvar skin 6 months after a skinning vulvectomy and skin graft. Note that the grafted skin remains less pigmented, which is characteristic of its site of origin.

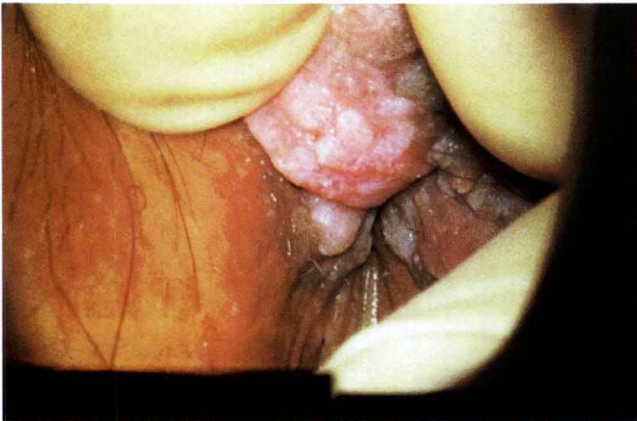


PLATE 2-11. A multifocal perianal intraepithelial neoplasm (AIN) is shown on a hemorrhoidal tag.



PLATE 2-12. Gross photograph of diffuse vulvar intraepithelial neoplasia (VIN) shows an area of occult microinvasion on the right labium majus.

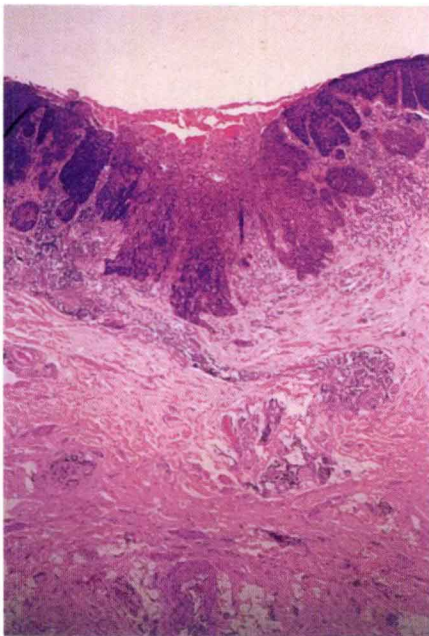


PLATE 2-13. This photomicrograph shows an area of microinvasion in the tissue seen in Plate 2-12.

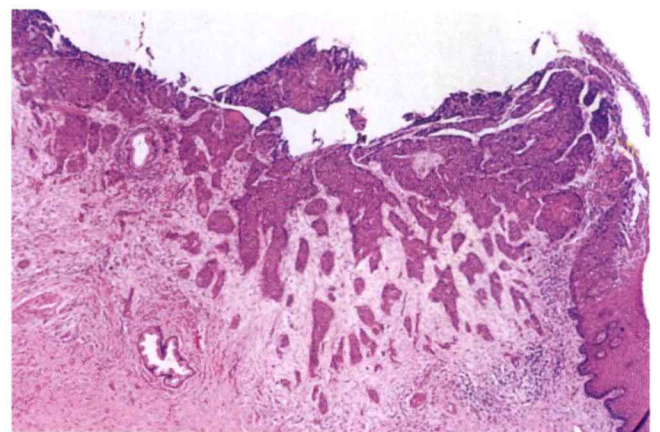


PLATE 3-1. This photomicrograph shows invasive cancer of the cervix with <1 mm invasion.

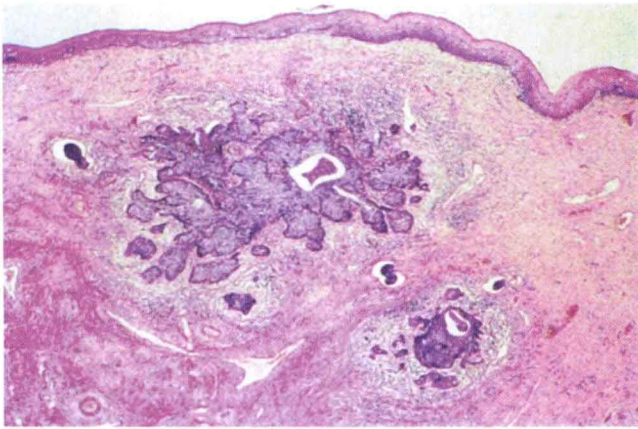


PLATE 3-2. This photomicrograph shows an example of early invasive carcinoma of the cervix with invasion <2 mm. Note the two separate invasive nodules as well as multiple vascular space involvement.

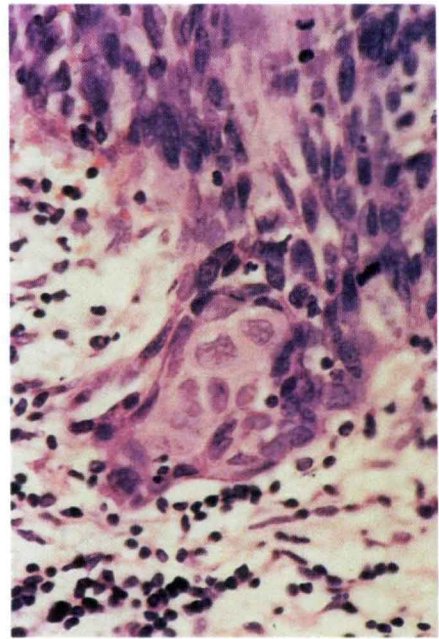


PLATE 3-3. This photomicrograph shows one of the earliest forms of microinvasion. Note that the invading bud has cells that are undergoing de-differentiation.

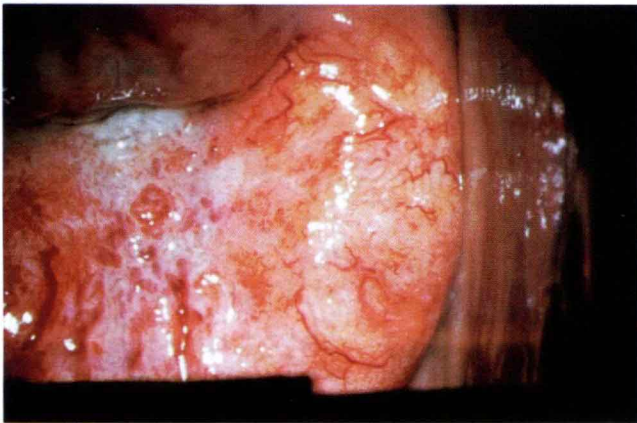


PLATE 3-4. The increased number of atypical vessels is suggestive of invasive cancer.

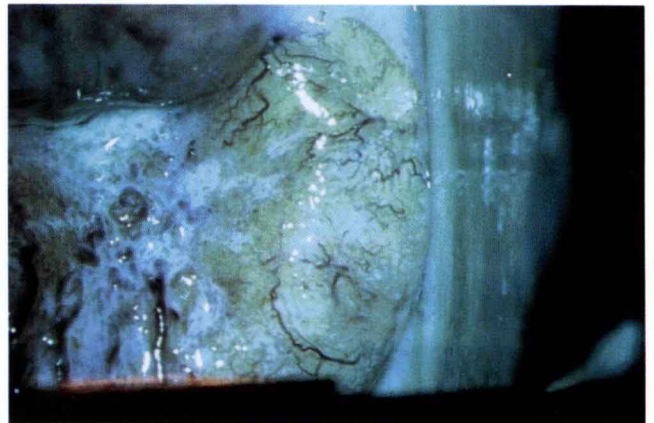


PLATE 3-5. The same cervix is shown as in Plate 3-4 but with the red free filter accentuating the vascular pattern.



PLATE 3-6. Cervical cancer is present on a prolapse of the cervix and the uterus as well as the vagina.

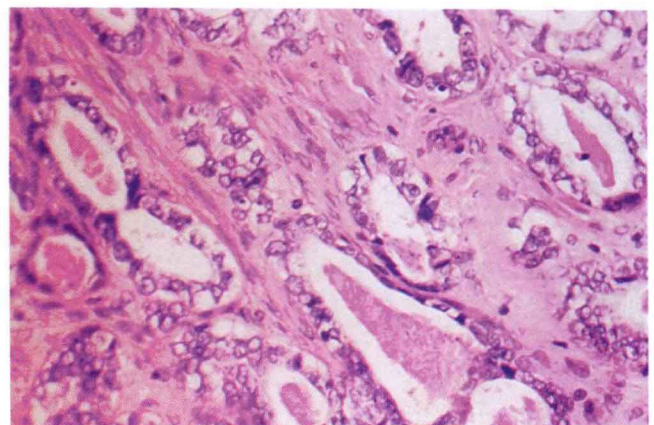


PLATE 3-7. On microscopic evaluation of an adenocarcinoma of the cervix, glandular configuration is evident.

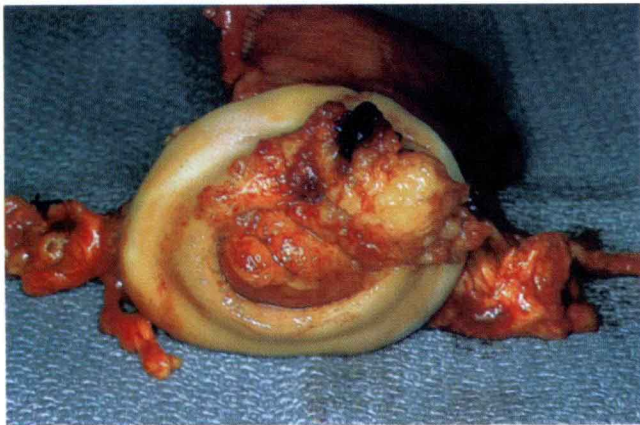


PLATE 3-8. This radical hysterectomy specimen is an example of an exophytic growth pattern of carcinoma of the cervix.

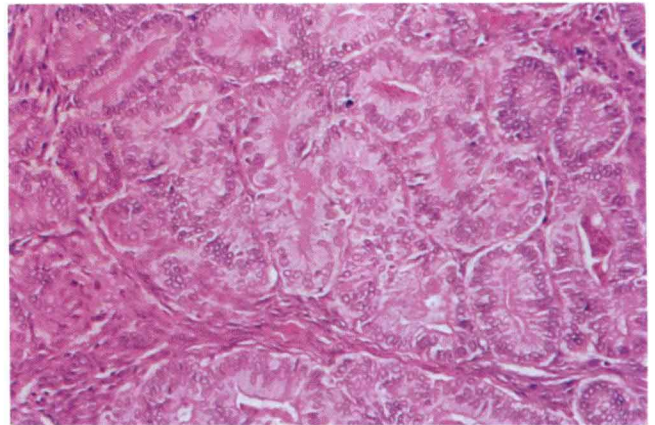


PLATE 5-1. Photomicrograph of an endometrial carcinoma, grade I.

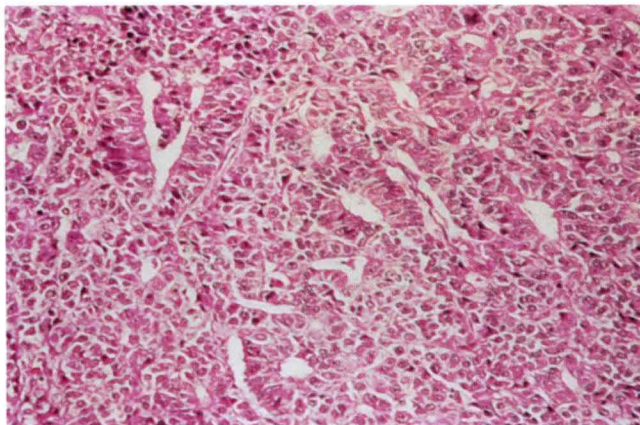


PLATE 5-2. Photomicrograph of an endometrial carcinoma, grade III.

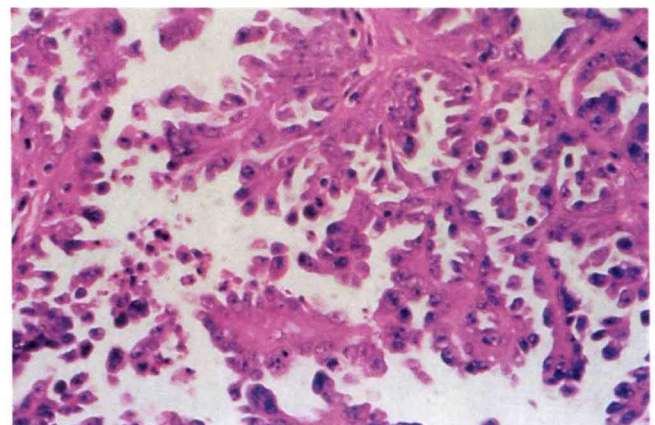


PLATE 5-3. Photomicrograph of papillary serous carcinoma of the endometrium.

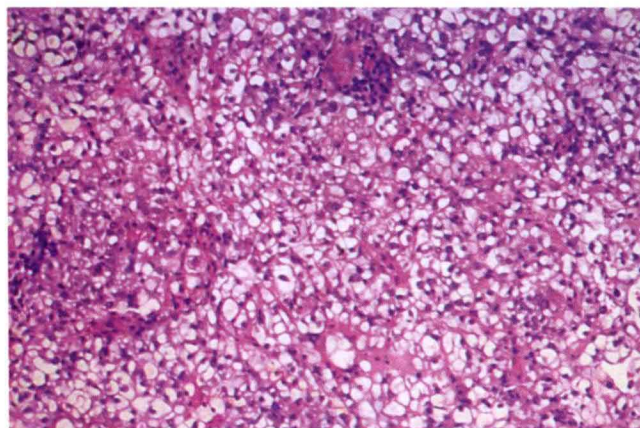


PLATE 5-4. Photomicrograph of a clear cell carcinoma of the endometrium.

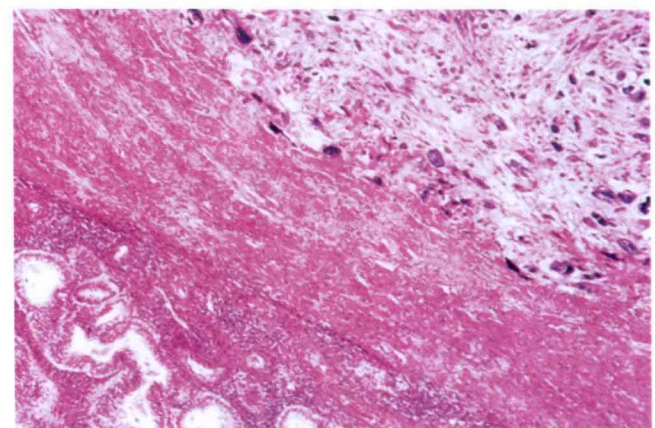


PLATE 6-1. Photomicrograph of a uterine leiomyosarcoma demonstrating the malignant lesion at the top right, normal endometrium at the bottom left, and normal myometrium between them.

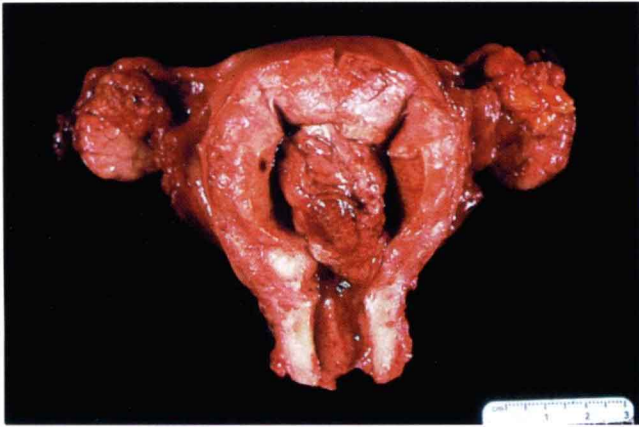


PLATE 6-2. Gross photograph of a uterus that contains a large polypoid mixed mesodermal sarcoma of the uterus.

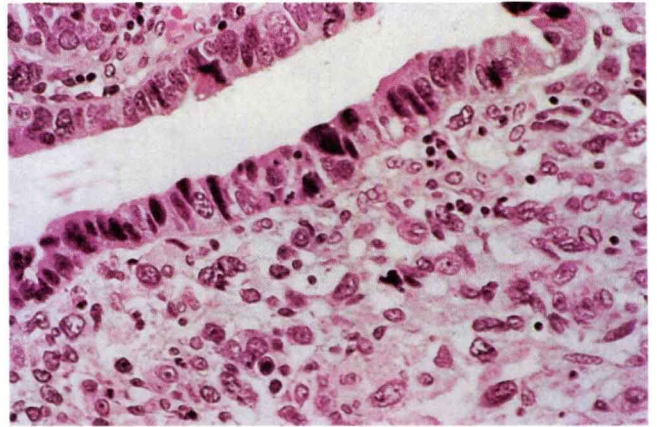


PLATE 6-3. Photomicrograph of a carcinosarcoma of the endometrium with malignant stroma and a malignant gland.

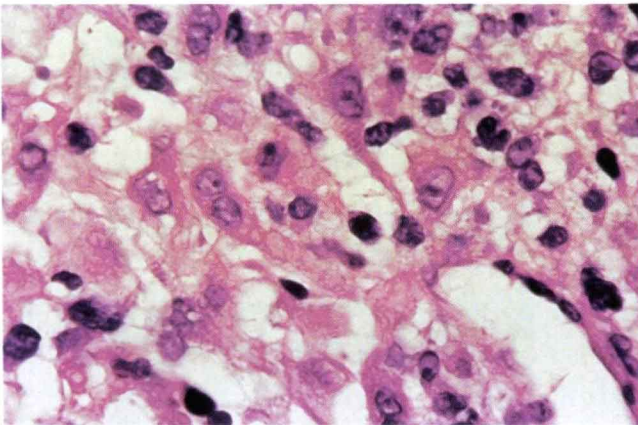


PLATE 6-4. Photomicrograph of a mixed mesodermal endometrial sarcoma with some cells demonstrating striations that are consistent with a rhabdomyosarcoma component.

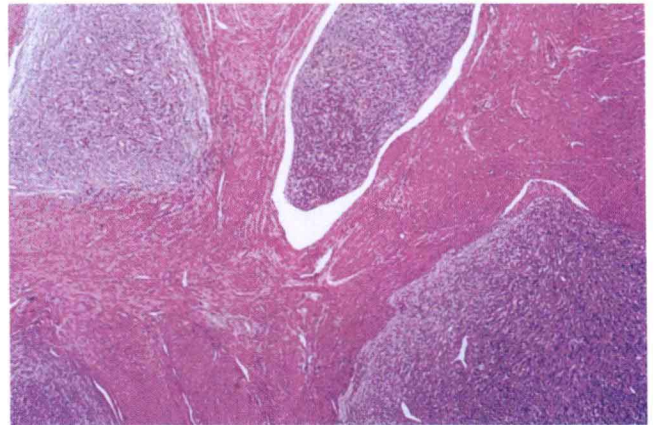


PLATE 6-5. Low-power photomicrograph of a low-grade endometrial sarcoma with invasion of the normal myometrium.

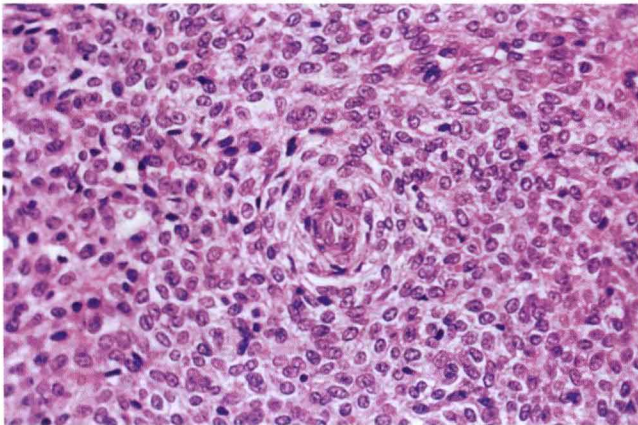


PLATE 6-6. High-power view of the low-grade endometrial sarcoma shown in Plate 6-5.



PLATE 7-1. Photomicrograph of hydatidiform mole. Note the trophoblastic proliferations and the absence of vasculature.

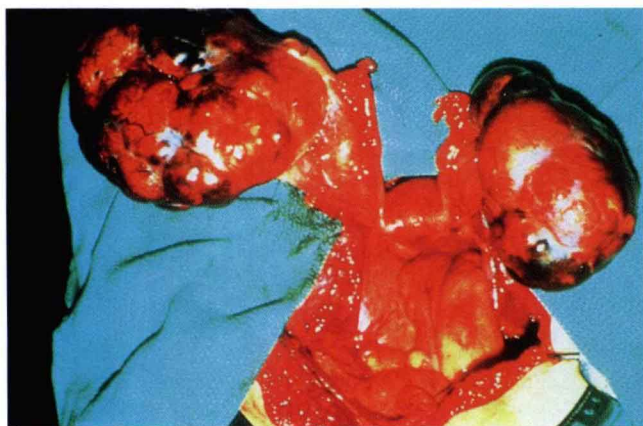


PLATE 7-2. Theca-lutein cysts in a patient with a molar pregnancy at laparotomy.



PLATE 7-3. Choriocarcinoma invading the myometrium of the uterus.

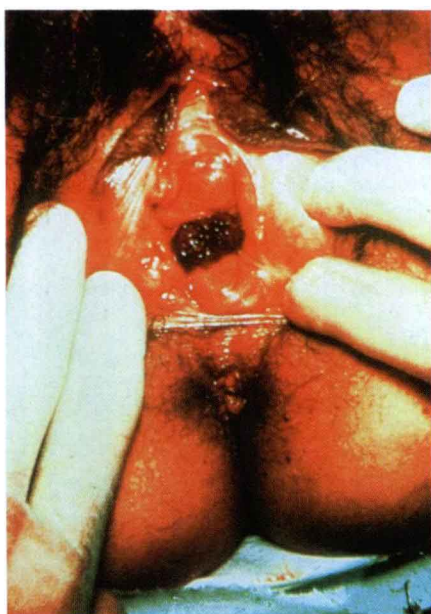


PLATE 7-4. Metastatic choriocarcinoma to the lower vagina.

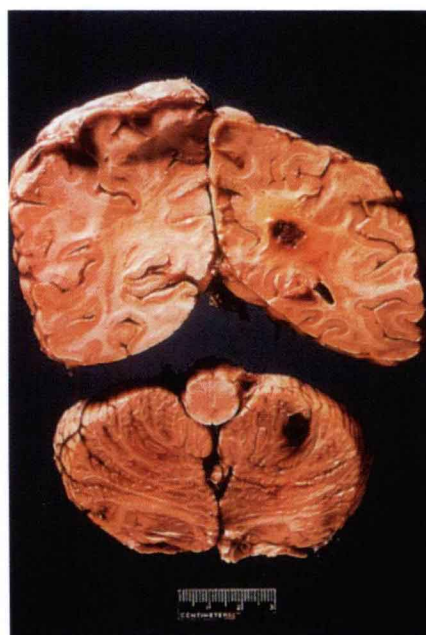


PLATE 7-5. Metastatic choriocarcinoma to the brain.