淋巴癌

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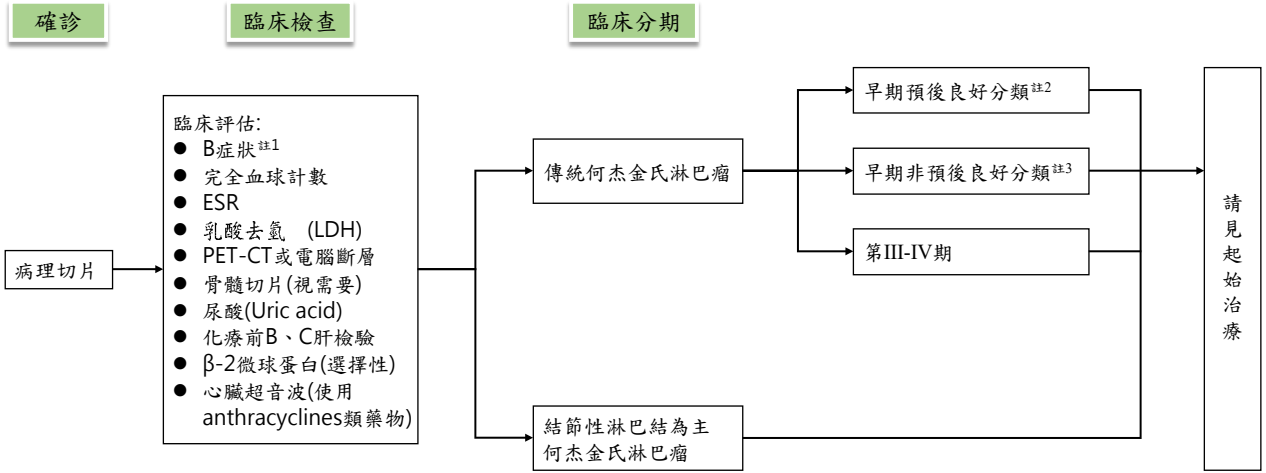
淋巴癌診療指引修訂

2025-01-06修訂第七版	2026-01-08修訂第八版
● 更新文獻	● 更新文獻 ● 新增淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL) 治療內容 ● 化療處方Hodgkin's Lymphoma:審視無修訂 ● 化療處方DLBCL:審視無修訂 ● 化療處方Follicular Lymphoma(FL):審視無修訂 ● 化療處方Peripheral T-Cell Lymphoma:審視無修訂

《淋巴癌診療指引共識—何杰金氏症 (Hodgkin lymphoma)》



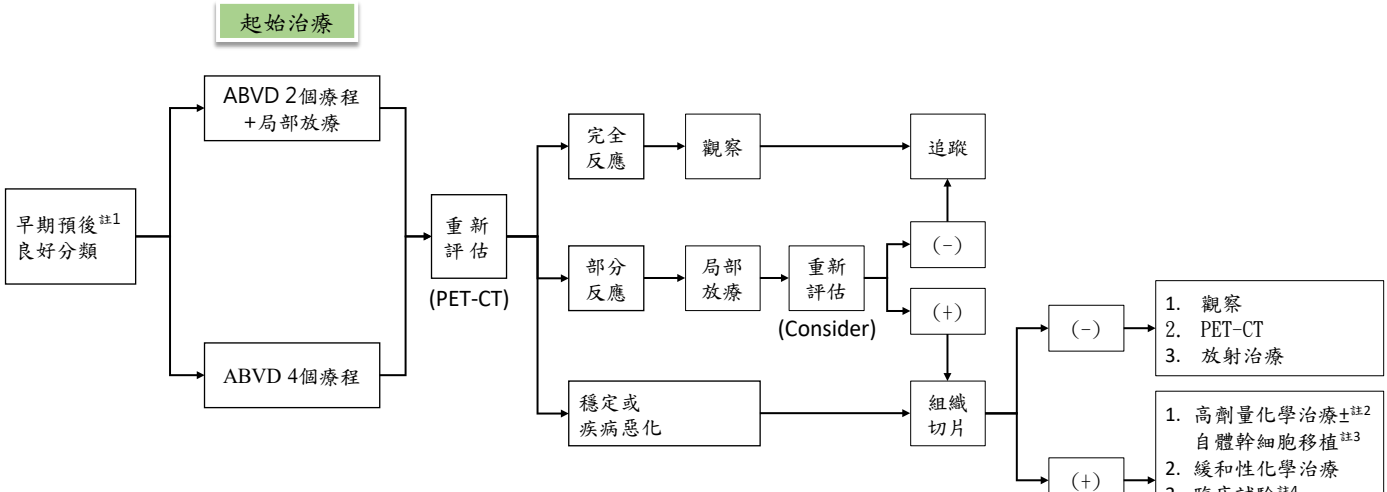
註1.B symptoms:fever, night sweating, body weight loss.
註2.早期預後良好定義:1.Age<50y/o, 2.ESR normal, 3.Stage I-II, 4.No B symptoms, 5.No bulky disease.
註3.預後不良因子:ESR>50, Bsymptoms, Nodal sites>3. Bulky tumor(≧10) or large mediastinum lesion(MMR>0.33).

《淋巴癌診療指引共識—CLASSICAL HODGKIN LYMPHOMA(CHL) 臨床分期》

Clinical stage	Bulky Mediastinal Disease or >10cm Adenopathy	ESR > 50 or # site > 3	Guidelines page
I / IIA	No	No	Favorable Disease
	No	Yes	Favorable/ Unfavorable Disease
	Yes	Yes/No	Unfavorable Disease
IB / IIB	Yes / No	Yes/No	Unfavorable Disease
III-IV	Yes / No	N/A	Advanced Disease

《淋巴癌診療指引共識—何杰金氏症 (Hodgkin lymphoma)》

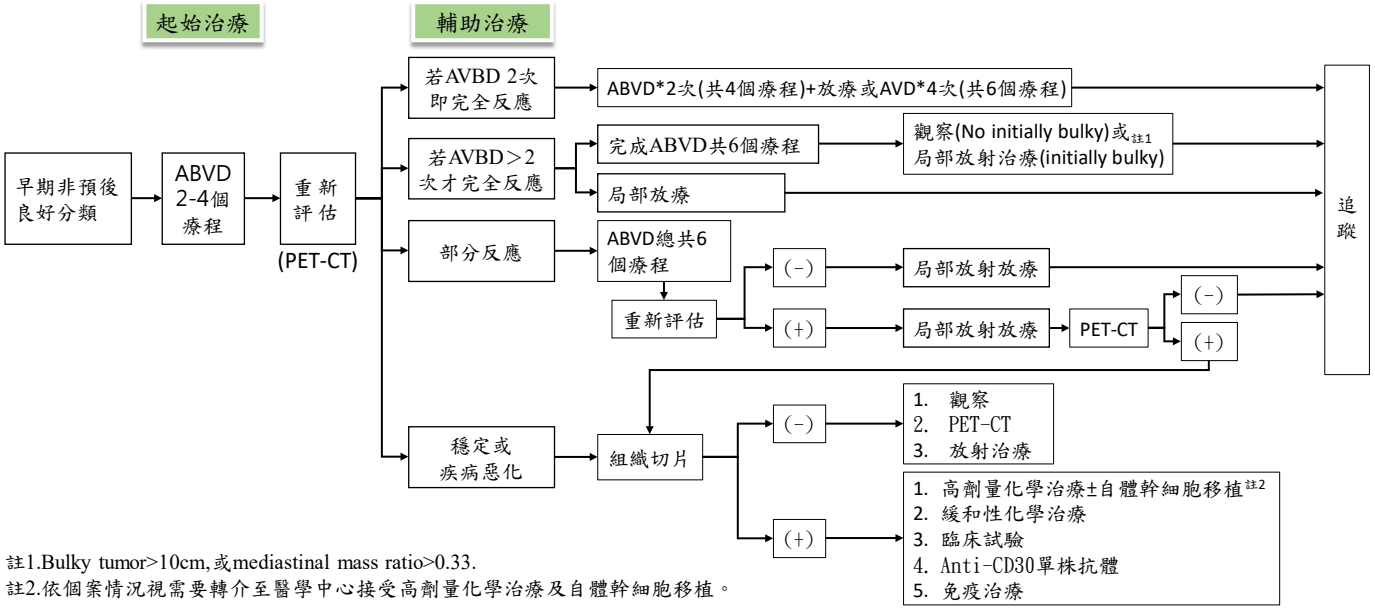
《組織型態：傳統何杰金氏淋巴瘤》



註1.早期預後良好定義:1.Age<50y/o 2.ESR normal 3.Stage I~II 4.No B symptoms 5.No bulky disease
註2.Rituximab may be added electively (self-paid) if CD 20 is positive in IHD stain.
註3.依個案情況視需要轉介至醫學中心接受高劑量化學治療及自體幹細胞移植。
註4.Clinical trial is always an option of treatment.

《淋巴癌診療指引共識—何杰金氏症 (Hodgkin lymphoma)》

《組織型態：傳統何杰金氏淋巴瘤》

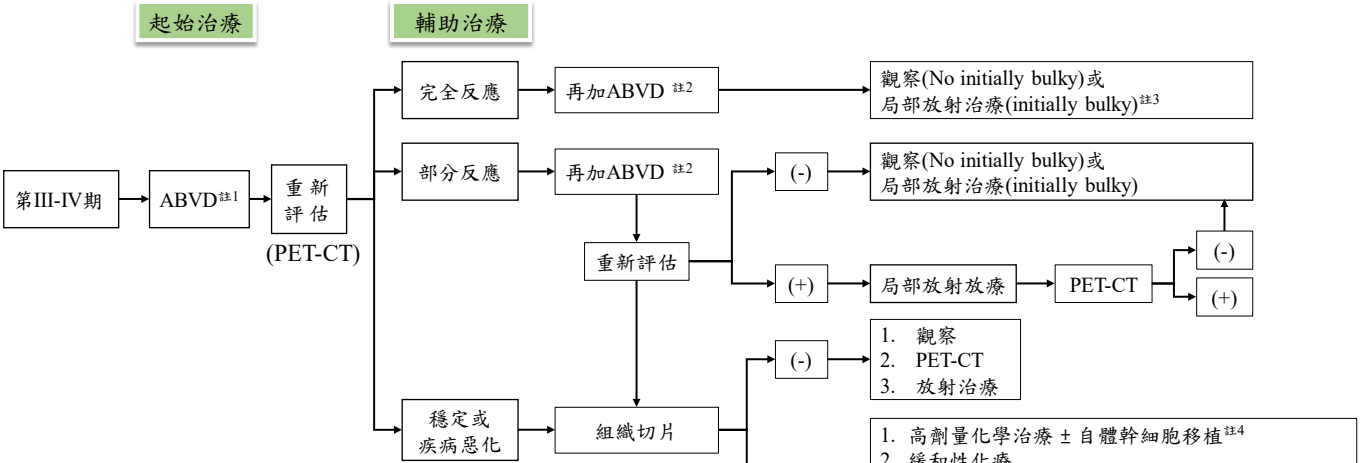


註1.Bulky tumor>10cm,或mediastinal mass ratio>0.33.

註2.依個案情況視需要轉介至醫學中心接受高劑量化學治療及自體幹細胞移植。

《淋巴癌診療指引共識—何杰金氏症 (Hodgkin lymphoma)》

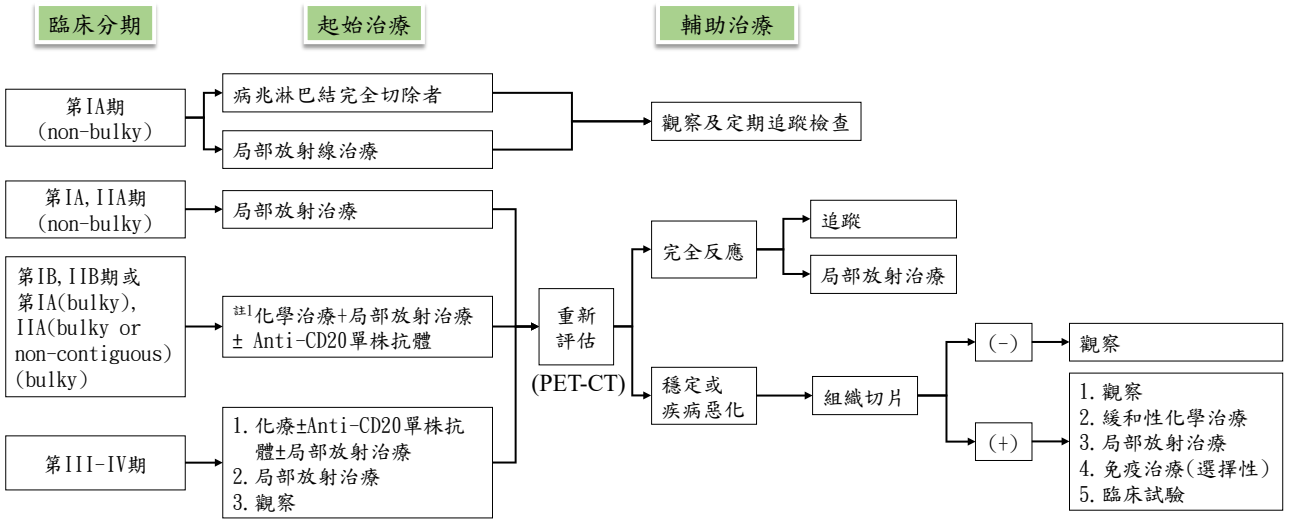
《組織型態：傳統何杰金氏淋巴瘤》



註1.化學治療至少2次療程，再進行重新評估(PET-CT)。
註2.總共6個療程。
註3.巨大腫瘤意指bukly tumor >10cm, 或mediastinal mass ratio >0.33.
註4.依個案情況視需要轉介至醫學中心接受高劑量化學治療及自體幹細胞移植。
註5.Brentuximab vedotin可採專案申請及臨時採購等方式進行。

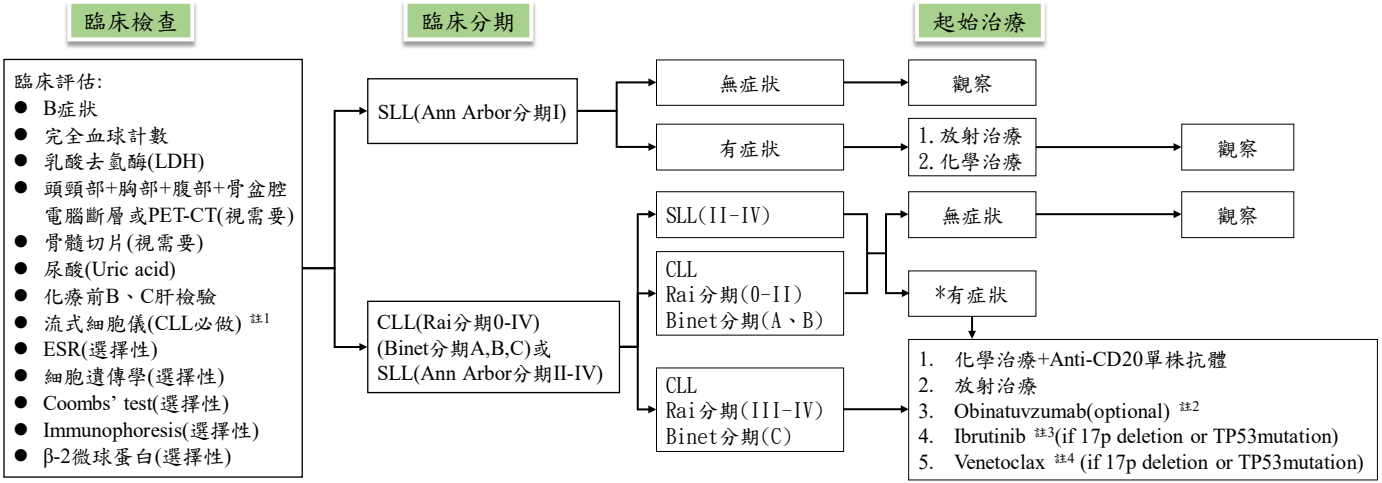
《淋巴癌診療指引共識—何杰金氏症 (Hodgkin lymphoma)》

《組織型態：結節性淋巴結為主何杰金氏淋巴瘤》



註1.化學治療至少2次療程，再進行重新評估(PET-CT)。

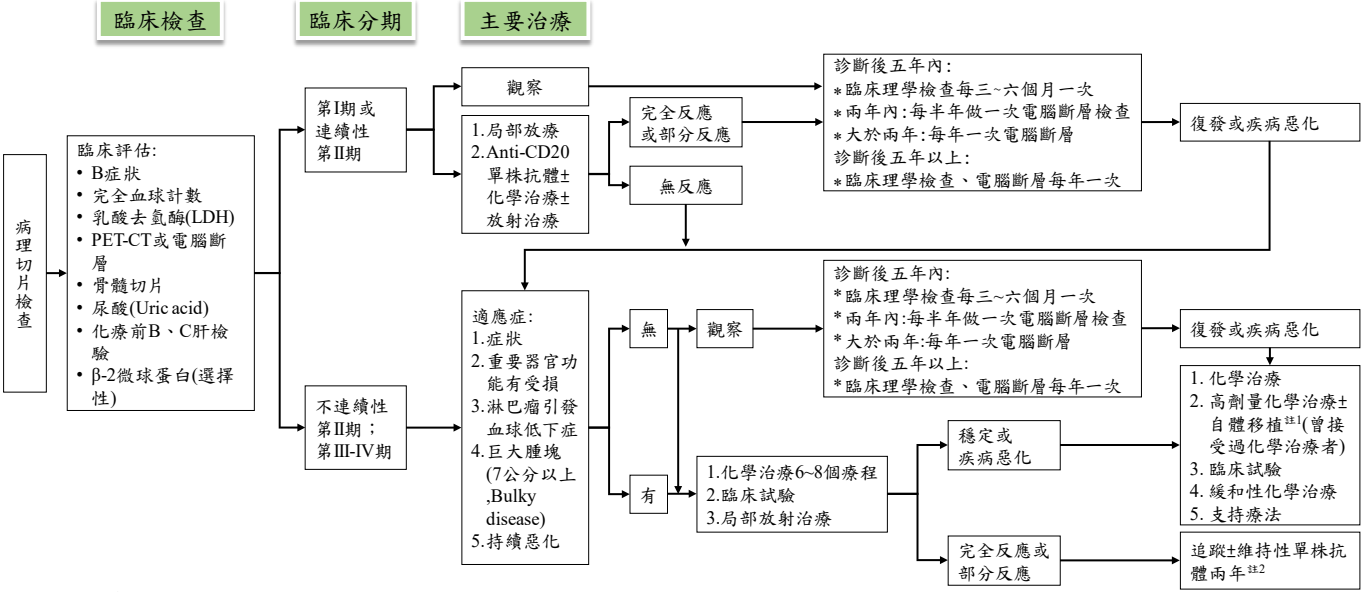
《淋巴癌診療共識—慢性淋巴細胞白血病 (CLL)/ 小淋巴細胞淋巴瘤 (SLL)》



評估有以下症狀:
1.Fatigue(severe) 2.Night sweats 3.Weight loss 4.Fever without infection
*Threatened end-organ function
*Progressive bulky disease(spleen>6cm below costal margin, lymph nodes>10cm
*Progressive anemia
*Progressive thrombocytopenia
Gazyva(Obinatuvzumab)(optional)

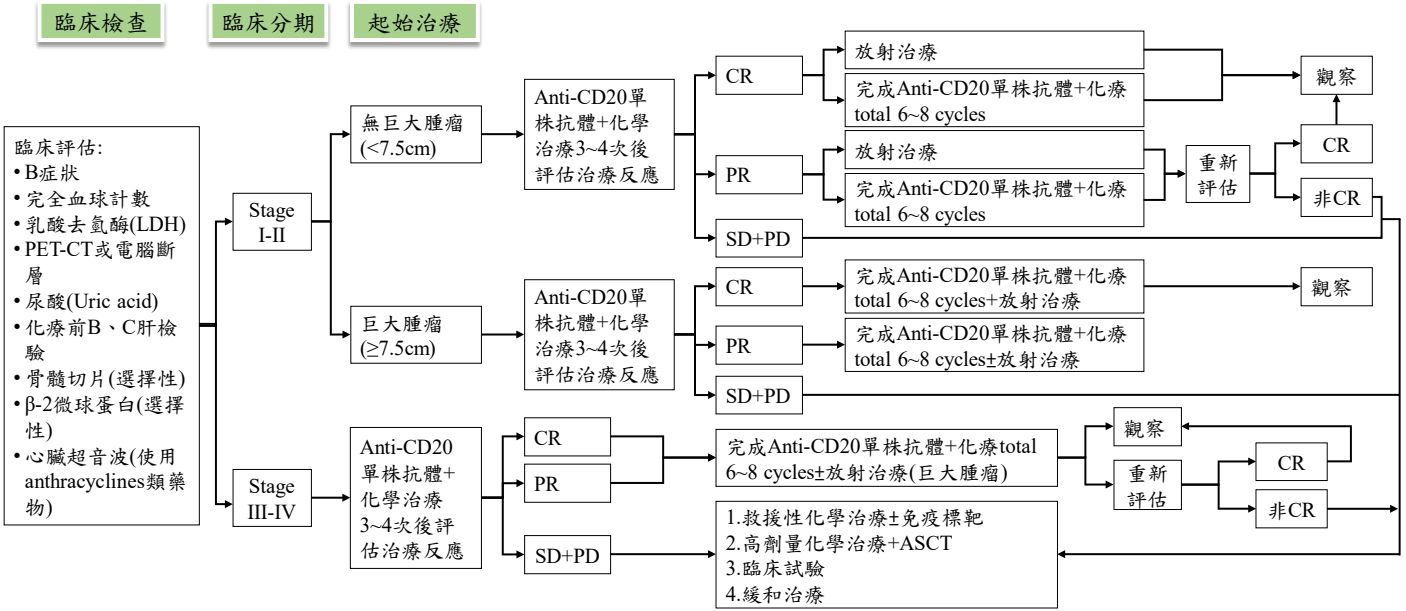
註1.依個案情況視需要轉介至雙和醫院接受流式細胞儀檢測。
註2.Obinatuvzumab可採專案申請及臨時採購等方式進行。
註3.Ibrutinib可採專案申請及臨時採購等方式進行。
註4.Venetoclax可採專案申請及臨時採購等方式進行。

《淋巴癌診療共識—濾泡淋巴瘤 (Follicular Lymphoma)》 Grade 1-2



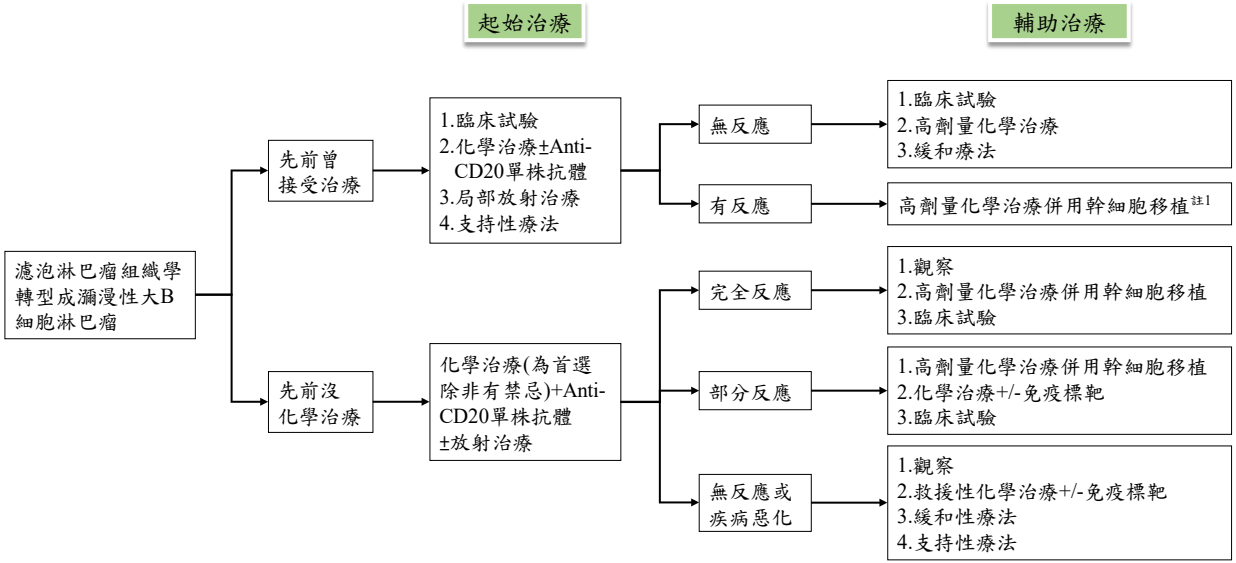
註1. 依個案情況視需要轉介至醫學中心接受高劑量化學治療及自體移植。
註2.Rituximab持續性治療每三個月施打一次，持續二年，僅適用於濾泡性淋巴瘤(Gr.I-III)。

《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 / 濾泡性淋巴瘤 Gr.III(DLBCL/FL Gr.III)》



*Rituximab持續性治療每三個月施打一次，持續二年，僅適用於濾泡性淋巴瘤(Gr.I-III)。

《淋巴癌診療共識—濾泡淋巴瘤轉型成瀰漫性大 B 細胞淋巴瘤 (FL → DLBCL)》

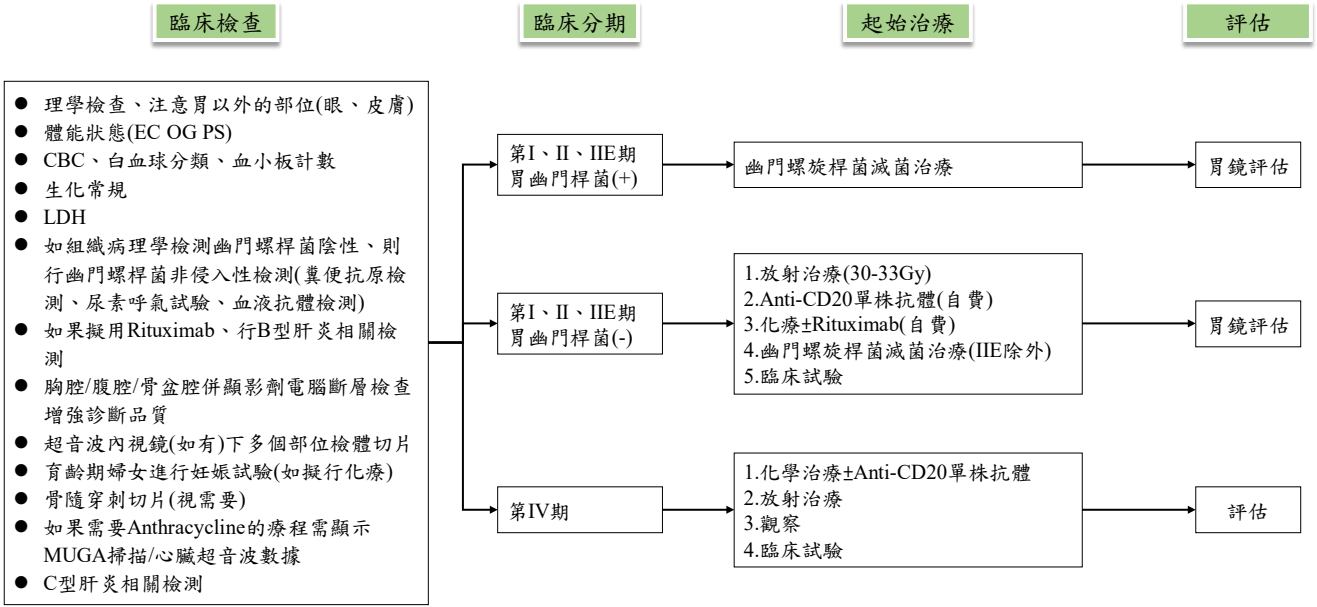


註1. 依個案情況視需要轉介至醫學中心接受高劑量化學治療及幹細胞移植。

《淋巴癌診療共識》—胃黏膜淋巴組織相關淋巴瘤 (Gastric MALT lymphoma) Lugano Staging

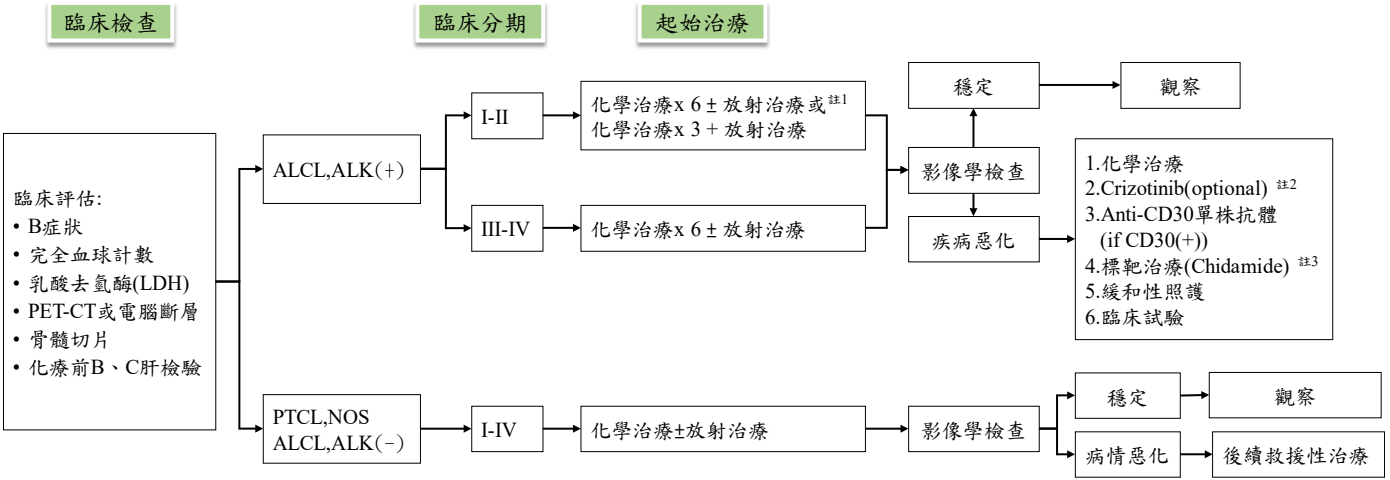
Lugano Staging System for Gastrointestinal Lymphomas		Lugano Modification of Ann Arbor Staging System	TNM Staging System Adapted for Gastric Lymphoma	Tumor Extension
Stage I	Confined to GI tract [a]			
	I_1=mucosa, submucosa	I_E	T1 N0 M0	Mucosa, submucosa
	I_2=muscularis propria, serosa	I_E	T2 N0 M0	Muscularis propria
		I_E	T3 N0 M0	Serosa
Stage II	Extending into abdomen			
	II_1=local nodal involvement	II_E	T1-3 N1 M0	Perigastric lymph nodes
	II_2=distant nodal involvement	II_E	T1-3 N2 M0	More distant regional lymph nodes
Stage IIE	Penetration of serosa to involve adjacent organs or tissues	II_E	T4 N0 M0	Invasion of adjacent structures
Stage IV [b]	Disseminated extranodal involvement or concomitant supradiaphragmatic nodal involvement		T1-4 N3 M0	Lymph nodes on both sides of the diaphragm/ distant metastases(eg, bone marrow or additional extranodal sites)
		IV	T1-4 N0-3 M1	

《淋巴癌診療共識—胃黏膜淋巴組織相關淋巴瘤 (Gastric MALT lymphoma)》



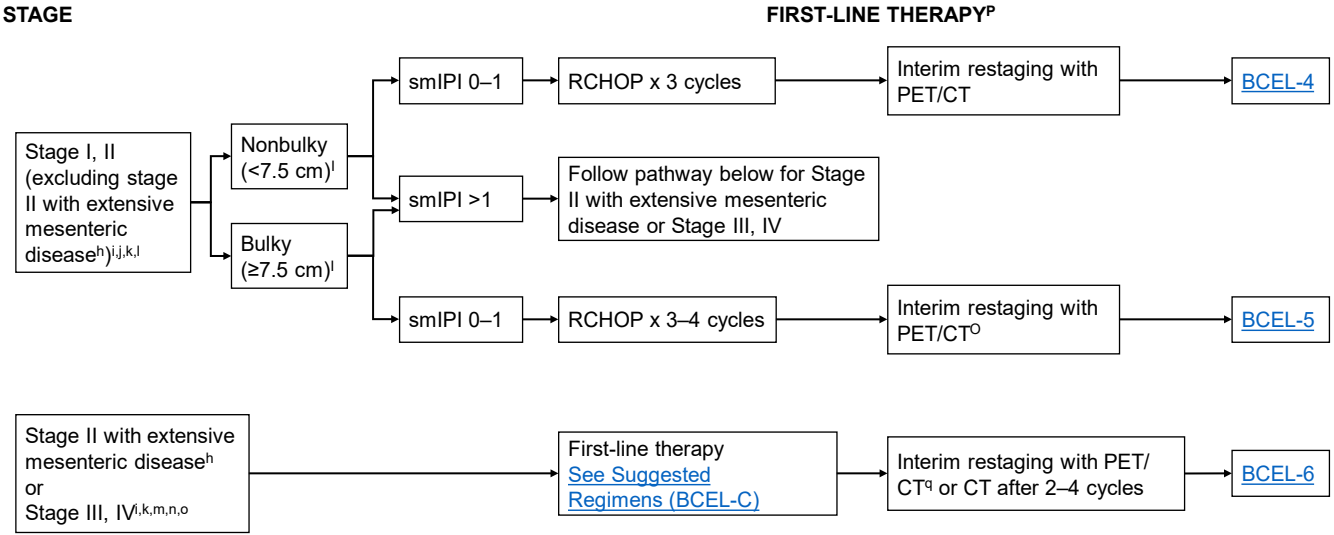
《淋巴癌診療共識—T 細胞淋巴瘤》

《 (Cutaneous T-cell lymphoma and T-immunoblastic lymphoma are not included) 》



註1.Treatment with diffuse large B cell lymphoma without rituximab.
註2.Crizotinib可採專案申請及臨時採購等方式進行。
註3.Chidamide可採專案申請及臨時採購等方式進行。

《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》



《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》

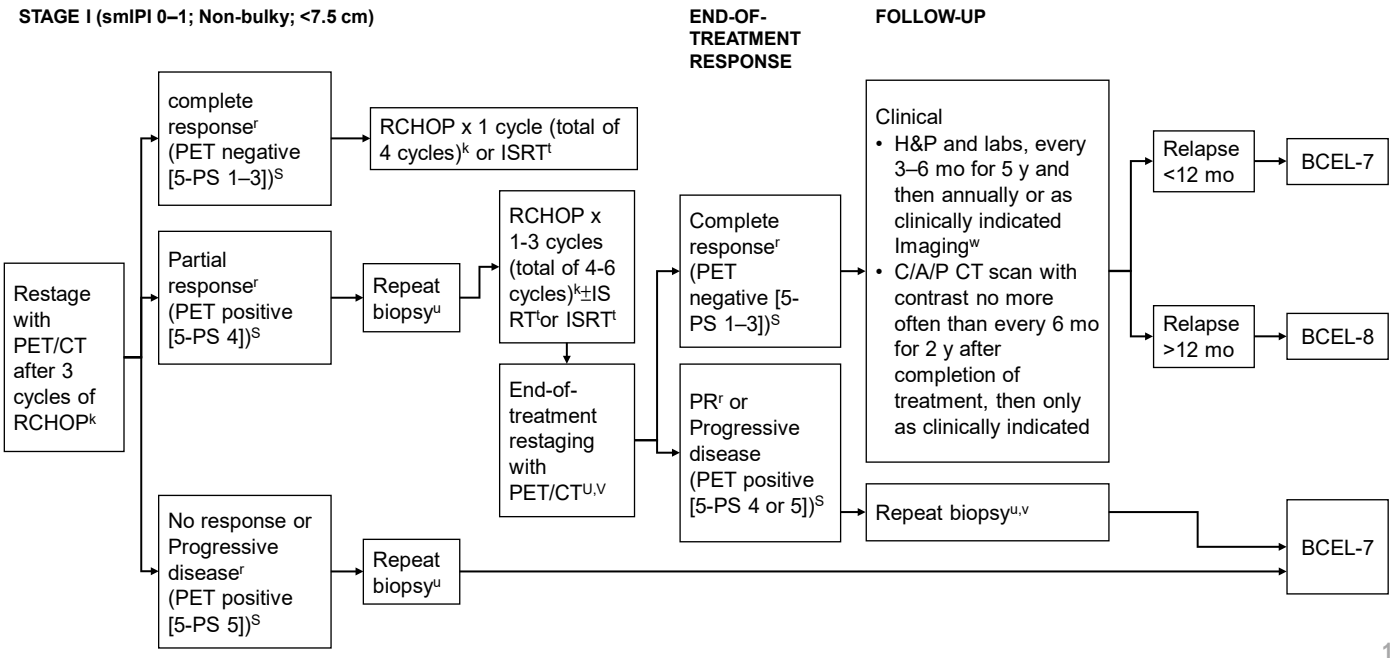
WORKUP

ESSENTIAL:
- Physical exam: attention to node-bearing areas, including Waldeyer's ring, and to size of liver and spleen
- Performance status
- B symptoms
- CBC with differential
- LDH
- Comprehensive metabolic panel
- Uric acid
- PET/CT scan (preferred) or C/A/P CT with contrast of diagnostic quality
- Calculation of International Prognostic Index (IPI) (BCEL-A 2 of 3)
- Hepatitis B testing[f]
- Echocardiogram or MUGA scan if anthracycline or anthracenedione-based regimen is indicated
- Pregnancy testing in patients of childbearing age (if chemotherapy or RT planned)

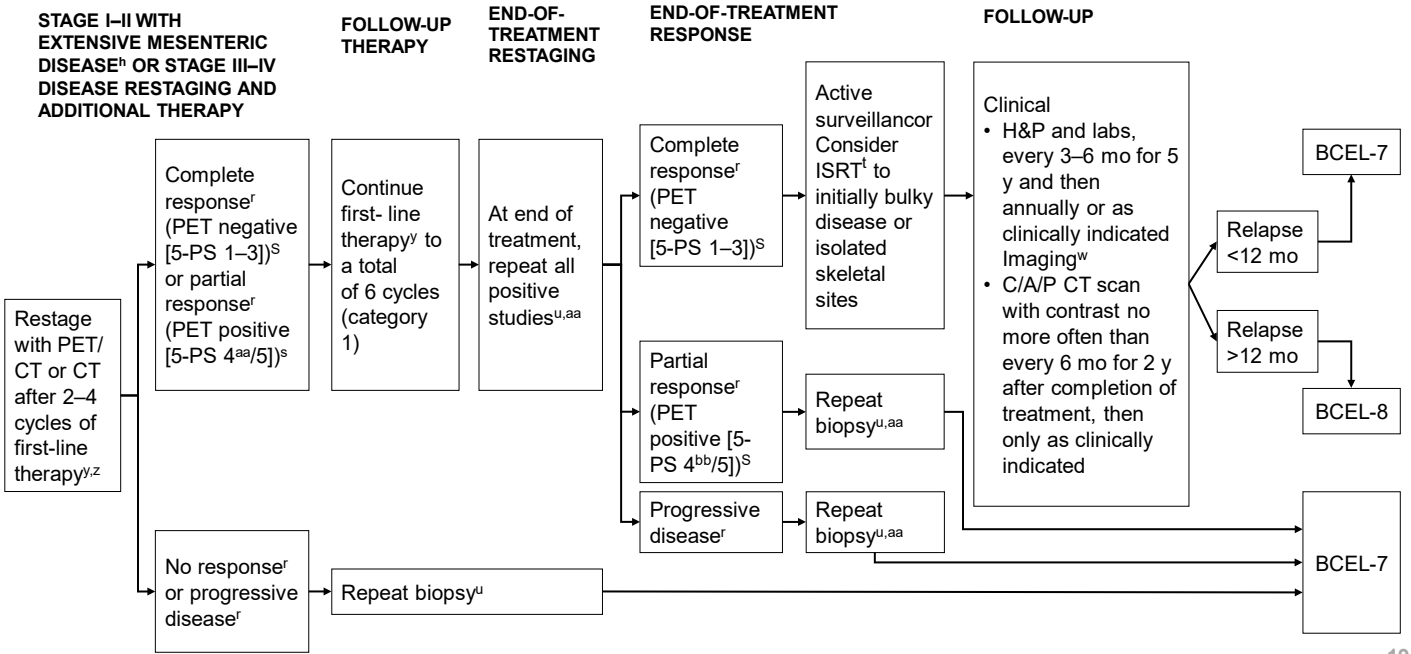
USEFUL IN SELECTED CASES:
- Head CT/MRI with contrast or neck CT/MRI with contrast
- HIV testing
- Hepatitis C testing
- Beta-2-microglobulin
- Lumbar puncture for patients at risk for CNS involvement; see BCEL-A 3 of 3
- Adequate bone marrow biopsy (>1.6 cm) ± aspirate; bone marrow biopsy is not necessary if PET/CT scan demonstrates bone disease. Bone marrow biopsy with a negative PET/CT scan may reveal discordant lymphoma
- Discuss fertility preservation[g]

→ First-Line Therapy (BCEL-3)

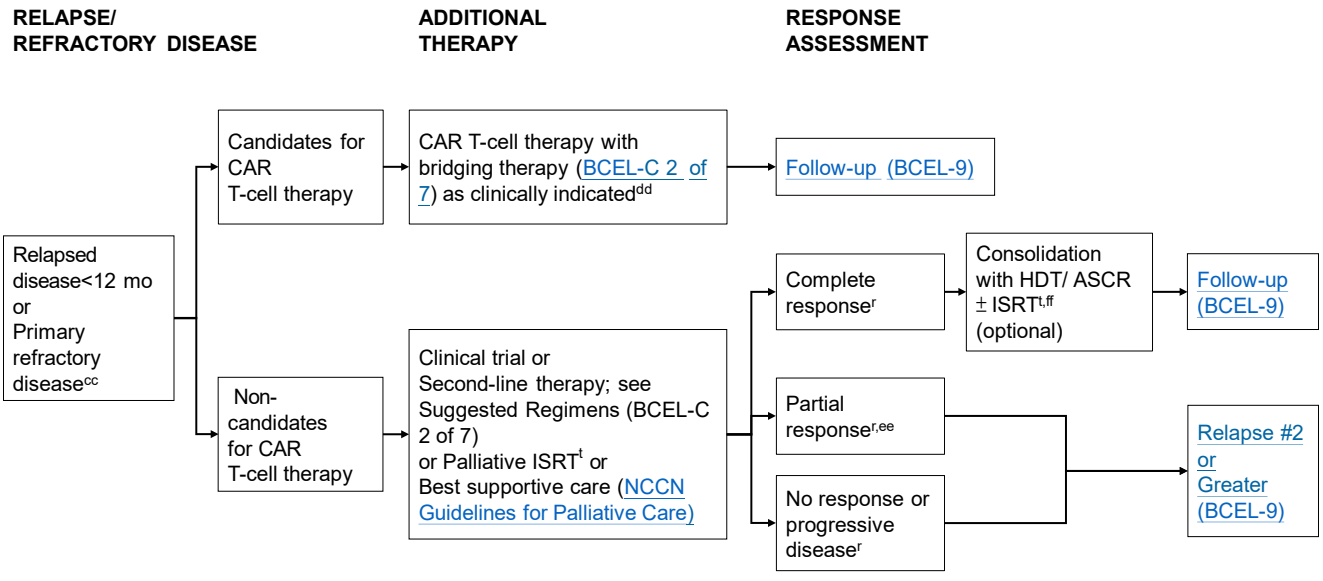
《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)



《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》



《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》



《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》

INTERNATIONAL PROGNOSTIC INDEX[a]	
ALL PATIENTS:	**INTERNATIONAL INDEX, ALL PATIENTS:**
• Age >60 years • Serum LDH > normal • Performance status 2–4 • Stage III or IV • Extranodal involvement >1 site	• Low 0 or 1 • Low-intermediate 2 • High-intermediate 3 • High 4 or 5

STAGE-MODIFIED INTERNATIONAL PROGNOSTIC INDEX (smIPI)[b]	
STAGE I OR II PATIENTS:	**INTERNATIONAL INDEX, STAGE I OR II PATIENTS:**
• Age >60 years • Serum LDH > normal • Performance status 2–4 • Stage II or IIE	• Low 0 or 1 • High 2 – 4

NCCN-IPI[c]			
		RISK GROUP	
Age, years		Low	0–1
>40 to ≤60	1	Low-intermediate	2–3
>60 to <75	2	High-intermediate	4–5
≥75	3	High	≥6
LDH, normalized			
>1 to ≤3	1		
>3	2		
Ann Arbor stage III–IV	1		
Extranodal disease*	1	*Disease in bone marrow, CNS, liver/GI tract, or lung.	
Performance status ≥2	1		

《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》

PROGNOSTIC MODEL TO ASSESS THE RISK OF CNS DISEASE[d]	
RISK FACTORS	**RISK GROUPS**
• Age >60 years • Serum LDH > normal • Performance status >1 • Stage III or IV • Extranodal involvement >1 site • Kidney or adrenal gland involvement	• Low risk 0–1 • Intermediate-risk 2–3 • High-risk 4–6 or kidney or adrenal gland involvement

- Additional indications for CNS prophylaxis independent of CNS risk score
  - Testicular lymphoma
  - Primary cutaneous DLBCL, leg type
  - Stage IE DLBCL of the breast
  - Kidney or adrenal gland involvement
- Role of CNS prophylaxis remains controversial but can be considered in patients with high-risk factors based on the aforementioned criteria. If CNS prophylaxis is used, options include:
  - Systemic high-dose methotrexate (3–3.5 g/m^2 for 2–4 cycles) during or after the course of treatment[e] and/or
  - IT methotrexate and/or cytarabine (4–8 doses) during or after the course of treatment

《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL) 》

SUGGESTED TREATMENT REGIENS [a,b]

FIRST-LINE THERAPY			
Stage I–II (excluding stage II with extensive mesenteric disease)	**Stage II (with extensive mesentericdisease) or Stage III–IV**	**Patients with Poor Left Ventricular Function[e,f,g] (all stages)**	**Very Frail Patients and Patients >80 Years of Age with Comorbidities[f,g] (all stages)**
• RCHOP (rituximab,[c] cyclophosphamide, doxorubicin, vincristine, prednisone) • Pola-R-CHP (polatuzumab vedotin-piiq, rituximab, cyclophosphamide, doxorubicin, prednisone) (smIPI >1)[d] (category 1)	**Preferred regimens** • RCHOP (rituximab,[c] cyclophosphamide, doxorubicin, vincristine, prednisone) (category 1) • Pola-R-CHP (polatuzumab vedotin-piiq, rituximab, cyclophosphamide, doxorubicin, prednisone) (IPI ≥2)[d] (category 1) **Other recommended regimens** • Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) + rituximab	**Other recommended regimens (in alphabetical order by category)** • DA-EPOCH[h] (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) + rituximab • RCDOP (rituximab, cyclophosphamide, liposomal doxorubicin, vincristine, prednisone) • RCEOP (rituximab, cyclophosphamide, etoposide, vincristine, prednisone) • RGCVP (rituximab, gemcitabine, cyclophosphamide, vincristine, prednisone) • RCEPP (rituximab, cyclophosphamide, etoposide, prednisone, procarbazine) (category 2B)	**Other recommended regimens (in alphabetical order by category)** • RCDOP • R-mini-CHOP • RGCVP • RCEPP (category 2B)

《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》

CONCURRENT PRESENTATION WITH CNS DISEASE[i]
• Parenchymal: systemic high-dose methotrexate (≥3 g/m^2 given with RCHOP cycle that has been supported by growth factors). Different schedules have been used for the integration of high-dose methotrexate with RCHOP; however, the Panel prefers day 15 of a 21-day cycle. • Leptomeningeal: IT methotrexate/cytarabine, consider Ommaya reservoir placement. Systemic high-dose methotrexate (3–3.5 g/m^2) can be given in combination with RCHOP or as consolidation after RCHOP + IT methotrexate/cytarabine

《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》

SUGGESTED TREATMENT REGIMENS [a,b]

SECOND-LINE THERAPY[e,j,k] (relapsed disease <12 mo or primary refractory disease)	
Candidates for CAR T-Cell Therapy	**Non-Candidates for CAR T-Cell Therapy**
• **CAR T-cell therapy[l]** ▶ Axicabtagene ciloleucel (CD19-directed) (category 1) ▶ Lisocabtagene maraleucel (CD19-directed) (category 1) **Bridging Therapy Options (≥1 cycles as needed until CAR T-cell product is available)** • DHA + platinum (carboplatin, cisplatin, or oxaliplatin) ± rituximab • GDP (gemcitabine, dexamethasone, carboplatin or cisplatin) ± rituximab • GemOx ± rituximab • ICE ± rituximab • Polatuzumab vedotin-piiq ± rituximab ± bendamustine[m] • ISRT (can be used as monotherapy or sequentially with systemic therapy) (NHODG-D 3 of 4)	**Preferred regimens (in alphabetical order)** • Epcoritamab-bysp + GemOx[n,o] • Glofitamab-gxbm + GemOx[n,o] • Polatuzumab vedotin-piiq ± bendamustine[m] ± rituximab • Polatuzumab vedotin-piiq + mosunetuzumab-axgb[n,o] • Tafasitamab-cxix[p] + lenalidomide (excluding primary refractory disease) **Other recommended regimens (in alphabetical order)** • CEOP (cyclophosphamide, etoposide, vincristine, prednisone) ± rituximab • DHA (dexamethasone, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin) ± rituximab • ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin) ± rituximab • GDP (gemcitabine, dexamethasone, carboplatin or cisplatin) ± rituximab • GemOx (gemcitabine, oxaliplatin) ± rituximab (if unable to receive epcoritamab-bysp or glofitamab-gxbm) • ICE (ifosfamide, carboplatin, etoposide) ± rituximab • MINE (mesna, ifosfamide, mitoxantrone, etoposide) ± rituximab **Useful in certain circumstances** • Brentuximab vedotin for CD30+ disease[q] • Ibrutinib[n] (non-GCB DLBCL) • Lenalidomide ± rituximab (non-GCB DLBCL)

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《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》

SUGGESTED TREATMENT REGIMENS [a,b]

SECOND-LINE THERAPY[e,j,k] (relapsed disease >12 mo)	
Intention to Proceed to Transplant	**No Intention to Proceed to Transplant**
Preferred regimens (in alphabetical order) • DHA (dexamethasone, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin) ± rituximab • GDP (gemcitabine, dexamethasone, carboplatin or cisplatin) ± rituximab • ICE (ifosfamide, carboplatin, etoposide) ± rituximab **Other recommended regimens (in alphabetical order)** • ESHAP (etoposide, methylprednisolone, cytarabine, cisplatin) ± rituximab • GemOx (gemcitabine, oxaliplatin) ± rituximab • MINE (mesna, ifosfamide, mitoxantrone, etoposide) ± rituximab	**Preferred regimens (in alphabetical order)** • CAR T-cell therapy (CD19-directed)l (with bridging therapy as needed; BCEL-C 2 of 7) (if eligible) ► Lisocabtagene maraleucel • Epcoritamab-bysp + GemOx[n,o] • Glofitamab-gxbm + GemOx[n,o] (category 1) • Polatuzumab vedotin-piiq ± bendamustine[m] ± rituximab • Polatuzumab vedotin-piiq + mosunetuzumab-axgb[n,o] • Tafasitamab-cxixp + lenalidomide **Other recommended regimens (in alphabetical order)** • CEOP (cyclophosphamide, etoposide, vincristine, prednisone) ± rituximab • GDP (gemcitabine, dexamethasone, carboplatin or cisplatin) ± rituximab • GemOx ± rituximab (if unable to receive epcoritamab-bysp or glofitamab-gxbm) • Rituximab **Useful in certain circumstances** • Brentuximab vedotin for CD30+ disease[q] • Ibrutinib[n] (non-GCB DLBCL) • Lenalidomide ± rituximab (non-GCB DLBCL)

《淋巴癌診療共識—瀰漫性大 B 細胞淋巴瘤 (DLBCL)》

SUGGESTED TREATMENT REGIMENS a,b

THIRD-LINE AND SUBSEQUENT THERAPY **Subsequent systemic therapy options include second-line therapy regimens (BCEL-C 2 of 7 and BCEL-C 3 of 7) that were not previously used.**	
Preferred regimens	**Other recommended regimens**
• T-cell engager therapy ▶ CAR T-cell therapy[l] (preferred if not previously given) (in alphabetical order) ◊ Axicabtagene ciloleucel (CD19-directed) ◊ Lisocabtagene maraleucel (CD19-directed) ◊ Tisagenlecleucel (CD19-directed) ▶ Bispecific antibody therapy (only after at least two lines of systemic therapy; including patients with disease progression after transplant or CAR T-cell therapy) (in alphabetical order) ◊ Epcoritamab-bysp[n,o] ◊ Glofitamab-gxbm[n,o]	• Brentuximab vedotin + lenalidomide + rituximab (for CD30+ disease)[q] • Loncastuximab tesirine-lpyl[p] • Selinexor (including patients with disease progression after transplant or CAR T-cell therapy)

《AJCC 8th》

➢ Lugano Classification for Hodgkin and Non-Hodgkin Lymphoma	
Limited Stage	**Stage Description**
I	Involvement of a single lymphatic site (i.e., nodal region,Waldeyer's ring, thymus, or spleen)
IE	Single extralymphatic site in the absence of nodal involvement (rare in Hodgkin lymphoma)
II	Involvement of two or more lymph node regions on the same side of the diaphragm
IIE	Contiguous extralymphatic extension from a nodal site with or without involvement of other lymph node regions on the same side of the diaphragm
II bulky	Stage II with disease bulk

- Stage II bulky may be considered either early or advanced stage based on lymphoma histology and prognostic factors (see discussion of Hodgkin lymphoma prognostic factors).
- The definition of disease bulk vanes according to lymphoma histology. In the Lugano classification, bulk in Hodgkin lymphoma is defined as a mass greater than one third of the thoracic diameter on CT of the chest or a mass >10 cm. For NHL, the recommended definitions of bulk vary by lymphoma histology. In follicular lymphoma, 6 cm has been sugge-sted based on the Follicular Lymphoma International Prognostic Index-2 (FLIPI-2) and its validation. In DLBCL, cutoffs ranging from 5 to 10 cm have been used, although 10 cm is recommendded."

➢ Lugano Classification for Hodgkin and Non-Hodgkin Lymphoma	
Advanced Stage	**Stage Description**
III	Involvement of lymph node regions on both sides of the diaphragm; nodes above the diaphragm with spleen involvement
IV	Diffuse or disseminated involvement of one or more extralymphatic organs, with or without associated lymph node involvement; or noncontiguous extralymphatic organ involvement in conjunction with nodal Stage II disease or any extralymphatic organ involvement in nodal Stage III disease Stage IV includes any involvement of the CSF, bone marrow, liver, or multiple lung lesions (other than by direct extension in Stage IIE disease)
Note: Hodgkin lymphoma uses A or B designation with stage group. A/B is no longer used in NHL	

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➢ Modified Ray staging system (for CLL/SLL)			
Stage	**Risk**	**Findings**	**Survival(mo)**
0	Low	Lymphocytosis only	>120
I	Intermediate	+ Adenopathy	95
II	Intermediate	+ Enlarged spleen and/or liver	72
III	High	Lymphocytosis + Hgb < 11g/dl	30
IV	High	Lymphocytosis + Plt <100,000/μL	30

➢Binet staging system (for Chronic Lymphocytic Leukemia)			
108年(含)後診斷個案			
Stage	**Hemoglobin**	**Plateles**	**Enlarged area**
A	≧10g/dL	≧100,000/mm3	<3 area
B	≧10g/dL	≧100,000/mm3	≧3 area
C	<10g/dL	<100,000/mm3	Any number
107年(含)前診斷個案			
Stage	**Findings**		**Survival(mo)**
A	Lymphocytosis only		>120
B	+ Adenopathy		95
C	+ Enlarged spleen and/or liver		72

《AJCC 8th》

➢ Durie-Salmon Staging System (for Multiple Myeloma)	
Stage	**Factors**
I	with All of the following: • Hb > 10 g/dL • Serum calcium normal < 12 mg/dL • Bone x-ray: normal bone structure or solitary bone plasmacytoma only • Low M-component production rate IgG value < 5g/dL IgA value < 3 g/dL Bence Jones protein < 4 g/24 h
II	Neither stage I nor stage III
III	with one or more of the following: • Hb < 8.5 g/dL • Serum calcium > 12 mg/dL • Advanced lytic bone lesions • High M-component production rate IgG value > 7 g/dL IgA value > 5 g/dL Bence Jones protein > 12 g/24 h
Subclassification Criteria : A：Normal renal function (Serum Cre level < 2.0 mg/dL) (< 177 umol/L) B：Abnormal renal function (Serum Cre level ≧2.0 mg/dL) (≧ 177 umol/L)	

惡性淋巴瘤(Hodgkin's Lymphoma)化療診療指引

First-line Therapy (Classical Hodgkin's Lymphoma, CHL)

化療系統 處方代碼	處方	藥名	劑量 (mg/m²)	途徑	輸注時間	天數	頻率	療程數	文獻
	ABVD	Doxorubicin	25	IVD		D1,15	Q4W	2-6	1-3
		Bleomycin	10 unit	IVD		D1,15			
		Vinblastine	6	IVD		D1,15			
		Dacarbazine	375	IVD		D1,15			
	Brentuximab vedotin+AVD	Brentuximab vedotin	1.2 mg/kg	IVD		D1,15	Q4W	up to 6 cycles	4
		Doxorubicin	25	IVD		D1,15			
		Vinblastine	6	IVD		D1,15			
		Dacarbazine	375	IVD		D1,15			

惡性淋巴瘤(Hodgkin's Lymphoma)化療診療指引

Second-Line Therapy (Classical Hodgkin's Lymphoma, CHL)

化療系統 處方代碼	處方	藥名	劑量 (mg/m²)	途徑	輸注時間	天數	頻率	療程數	文獻
	DHAP	Dexamethasone	oral /IV: 40 mg	PO/ IVD		D1-4	Q3-4W	2 cycles (transplant) 2-4 cycles (nontransplant)	5-6
		Cisplatin	100	IVD	24h	D1			
		(High-dose) Cytarabine	2000	IVD	Q12H	D2			
	ESHAP	Etoposide	40	IVD	24h	D1-4	Q4W	up to 6 cycles	7-8
		Methylprednisolone	500mg	IVD		D1-4			
		Cisplatin	25	IVD		D1-4			
		Ara-C	2000mg	IVD		D5			

參考文獻

1. Engert A, Plutschow A, Eich HT, et al. Reduced treatment intensity in patients with early-stage Hodgkin's lymphoma. N Engl J Med. 2010;363(7):640-652.
2. Eich HT, Diehl V, Gorgen H, et al. Intensified chemotherapy and dose-reduced involved-field radiotherapy in patients with early unfavorable Hodgkin's lymphoma: final analysis of the German Hodgkin Study Group HD11 trial. J Clin Oncol. 2010;28(27):4199-4206.
3. Raemaekers JM, Andre MP, Federico M, et al. Omitting radiotherapy in early positron emission tomography-negative stage I/II Hodgkin lymphoma is associated with an increased risk of early relapse: Clinical results of the preplanned interim analysis of the randomized EORTC/LYSA/FIL H10 trial. J Clin Oncol. 2014;32(12):1188-1194.
4. Connors JM, Jurczak W, Straus DJ, et al. Brentuximab Vedotin with Chemotherapy for Stage III or IV Hodgkin's Lymphoma. New England Journal of Medicine. 2018;378(4):331-344.
5. Josting A, Rudolph C, Reiser M, et al. Time-intensified dexamethasone/cisplatin/cytarabine: an effective salvage therapy with low toxicity in patients with relapsed and refractory Hodgkin's disease. Ann Oncol. 2002;13(10):1628-1635.
6. Abali H, Urun Y, Oksuzoglu B, et al. Comparison of ICE (ifosfamide-carboplatin-etoposide) versus DHAP (cytosine arabinosidecisplatin-dexamethasone) as salvage chemotherapy in patients with relapsed or refractory lymphoma. Cancer Invest. 2008;26(4):401-406.
7. Aparicio J, Segura A, Garcera S, et al. ESHAP is an active regimen for relapsing Hodgkin's disease. Ann Oncol. 1999;10(5):593-595.
8. Fernandez de Larrea C, Martinez C, Gaya A, et al. Salvage chemotherapy with alternating MINE-ESHAP regimen in relapsed or refractory Hodgkin's lymphoma followed by autologous stem-cell transplantation. Ann Oncol. 2010;21(6):1211-1216.

惡性淋巴瘤(DLBCL)化療診療指引

First-line Therapy (Diffuse Large B-Cell Lymphoma, DLBCL)

化療系統 處方代碼	處方	藥名	劑量 (mg/m²)	途徑	輸注時間	天數	頻率	療程數	文獻
X001	RCHOP	Rituximab	375	IVD		D1	Q3W	6-8	1
		Cyclophosphamide	750	IVD		D1			
		Doxorubicin	50	IVD		D1			
		Vincristine	1.4 (max:2mg)	PO		D1			
		Prednisone	100mg	PO		D1-5			
	RCDOP (For poor Left Ventricular Function)	Rituximab	375	IVD		D1	Q3W	6-8	2-3
		Cyclophosphamide	750	IVD		D1			
		Lipo-Doxorubicin	30	IVD		D1			
		Vincristine	1.4 (max:2mg)	PO		D1			
		Prednisone	60mg	PO		D1-5			

惡性淋巴瘤(DLBCL)化療診療指引

First-line Therapy (Diffuse Large B-Cell Lymphoma, DLBCL)

化療系統 處方代碼	處方	藥名	劑量 (mg/m²)	途徑	輸注時間	天數	頻率	療程數	文獻
X003	DA-EPOCH-R	Cyclophosphamide	750	IVD	1h	D5	Q3W	6	4-5
		Etoposide	50	IVD	24h	D1-4			
		Doxorubicin	10	IVD	24h	D1-4			
		Vincristine	0.4	PO	24h	D1-4			
		Rituximab	375	IVD	12h	D1			
		Prednisone	60	PO	BID	D1-5			

*Etoposide, doxorubicin and vincristine in one bag

惡性淋巴瘤(DLBCL)化療診療指引

Second-Line Therapy (Diffuse Large B-Cell Lymphoma, DLBCL)'

化療系統 處方代碼	處方	藥名	劑量 (mg/m²)	途徑	輸注時間	天數	頻率	療程數	文獻
	DHAP ± Rituximab	Dexamethasone	oral /IV: 40 mg	PO/ IVD		D1-4	Q3-4W		6
		Cisplatin	100	IVD		D1			
		(High-dose) Cytarabine	2000	IVD		D2			
		± Rituximab	375	IVD		D1			
X005	ESHAP ± Rituximab (R-ESHAP)	Etoposide	40	IVD	2h	D1-4	Q3-4W	6	7
		Methylprednisolone	500mg	IVD		D1-4			
		Cisplatin	25	IVD	22h	D1-4			
		(High-dose) Cytarabine	2000	IVD	3h	D5			
		± Rituximab	375	IVD	依醫師指示	D1			

參考文獻

1. Poeschel V, Held G, Ziepert M, et al. Four versus six cycles of CHOP chemotherapy in combination with six applications of rituximab in patients with aggressive B-cell lymphoma with favourable prognosis (FLYER): a randomised, phase 3, non-inferiority trial. Lancet 2019;394:2271-2281.
2. Martino R, Perea G, Caballero MD, et al. Cyclophosphamide, pegylated liposomal doxorubicin (Caelyx), vincristine and prednisone (CCOP) in elderly patients with diffuse large B-cell lymphoma: Results from a prospective phase II study. Haematologica 2002;87:822-827.
3. Zaja F, Tomadini V, Zaccaria A, et al. CHOP-rituximab with pegylated liposomal doxorubicin for the treatment of elderly patients with diffuse large B-cell lymphoma. Leuk Lymphoma 2006;47:2174-2180.
4. Dunleavy K, Fanale MA, Abramson JS, et al. Dose-adjusted EPOCH-R (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin, and rituximab) in untreated aggressive diffuse large B-cell lymphoma with MYC rearrangement: a prospective, multicentre, single-arm phase 2 study. Lancet Haematol 2018;5:e609-e617.
5. Johnson NA, Slack GW, Savage KJ et al. Concurrent expression of MYC and BCL2 in diffuse large B-cell lymphoma treated with rituximab plus cyclophosphamide, doxorubicin, vincristine, and prednisone. J Clin Oncol 2012;30:3452-3459.
6. Gisselbrecht C, Schmitz N, Mounier N, et al. Rituximab maintenance therapy after autologous stem-cell transplantation in patients with relapsed CD20+ diffuse large B-cell lymphoma: Final analysis of the collaborative trial in relapsed aggressive lymphoma. J Clin Oncol 2012;30:4462-4469.
7. Martín A, Conde E, Arnan M, et al. R-ESHAP as salvage therapy for patients with relapsed or refractory diffuse large B-cell lymphoma: the influence of prior exposure to rituximab on outcome. A GEL/TAMO study. Haematologica. 2008;93(12):1829-1836. doi:10.3324/haematol.13440

惡性淋巴瘤(Peripheral T-Cell Lymphoma)化療診療指引

First-line Therapy (Peripheral T-Cell Lymphoma)

化療系統 處方代碼	處方	藥名	劑量 (mg/m^2)	途徑	輸注時間	天數	頻率	療程數	文獻
X002	CHOP	Cyclophosphamide	750	IVD	30min	D1	Q3W	8	1
		Doxorubicin	50	IVD	30min	D1			
		Vincristine	1.4 (max:2mg)	PO	10min	D1			
		Prednisone	100mg	PO		D1-5			

參考文獻

1. Simon A, Peoch M, Casassus P, et al. Upfront VIP-reinforced-ABVD (VIP-rABVD) is not superior to CHOP/21 in newly diagnosed peripheral T cell lymphoma. Results of the randomized phase III trial GOELAMS-LTP95. Br J Haematol. 2010;151(2):159-166.

惡性淋巴瘤(Follicular lymphoma)化療診療指引

First-line Therapy (Follicular lymphoma, FL, grade 1-2)

化療系統處方代碼	處方	藥名	劑量 (mg/m^2)	途徑	輸注時間	天數	頻率	療程數	文獻
X006	Bendamustine ± Rituximab*	Bendamustine	90	IVD		D1-2	Q4W	6	1-2
		Rituximab	375	IVD		D1			
	Bendamustine +Obinutuzumab*	Bendamustine	90	IVD		D1-2	Q4W (Cycle1) Q8W (Cycle 2-6)	6	3
		Obinutuzumab	1000mg	IVD		D1,8,15 D1			
X001	RCHOP*	Rituximab	375	IVD	依醫囑調整	D1	Q3W	6-8	4-5
		Cyclophosphamide	750	IVD	30min	D1			
		Doxorubicin	50	IVD	30min	D1			
		Vincristine	1.4 (max:2mg)	PO	10min	D1			
		Prednisone	100mg	PO		D1-5			

*Second-line (The first-line regimen is not repeated)

惡性淋巴瘤(Follicular lymphoma)化療診療指引

First-line Therapy (Follicular lymphoma, FL, grade 1-2)

化療系統 處方代碼	處方	藥名	劑量 (mg/m²)	途徑	輸注時間	天數	頻率	療程數	文獻
X004	RCOP*	Rituximab	375	IVD	依醫囑調整	D1	Q3W	6-8	6
		Cyclophosphamide	750	IVD	30min	D1			
		Vincristine	1.4 (max:2mg)	PO	10min	D1			
		Prednisone	100mg	PO		D1-5			
	Rituximab# (for elderly or infirm)	Rituximab	375	IVD		D1	QW	4	7
	Rituximab	Rituximab	375	IVD		D1	Q8-12W	2 years	9

*Second-line (The first-line regimen is not repeated)

惡性淋巴瘤(Follicular lymphoma)化療診療指引

Third-line Therapy (Follicular lymphoma,FL,grade 1-2)

化療系統 處方代碼	處方	藥名	劑量 (mg/m²)	途徑	輸注時間	天數	頻率	療程數	文獻
	Copanlisilb*	Copanlisilb	60mg	IVD		D1,8,15	Q4W	Until disease progression or unacceptable toxicity	8

*If R/R to > 2 prior treatments

化療參考文獻

1. Rummel MJ, Niederle N, Maschmeyer G, et al. Bendamustine plus rituximab versus CHOP plus rituximab as first-line treatment for patients with indolent and mantle-cell lymphomas: an open-label, multicentre, randomised, phase 3 non-inferiority trial. Lancet. 2013;381(9873):1203-1210.
2. Flinn IW, van der Jagt R, Kahl BS, et al. Randomized trial of bendamustine-rituximab or R-CHOP/R-CVP in first-line treatment of indolent NHL or MCL: the BRIGHT study. Blood. 2014;123(19):2944-2952.
3. Marcus R, Davies A, Ando K, et al. Obinutuzumab for the first-line treatment of follicular lymphoma. N Engl J Med 2017;377:1331-134
4. Czuczman MS, Weaver R, Alkuzweny B, Berlfein J, Grillo-Lopez AJ. Prolonged clinical and molecular remission in patients with lowgrade or follicular non-Hodgkin's lymphoma treated with rituximab plus CHOP chemotherapy: 9-year follow-up. J Clin Oncol. 2004;22(23):4711-4716.
5. Hiddemann W, Kneba M, Dreyling M, et al. Frontline therapy with rituximab added to the combination of cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) significantly improves the outcome for patients with advanced-stage follicular lymphoma compared with therapy with CHOP alone: results of a prospective randomized study of the German Low-Grade Lymphoma Study Group. Blood. 2005;106(12):3725-3732.
6. Marcus R, Imrie K, Solal-Celigny P, et al. Phase III study of R-CVP compared with cyclophosphamide, vincristine, and prednisone alone in patients with previously untreated advanced follicular lymphoma. J Clin Oncol 2008;26:4579-4586.
7. Ardeshna KM, Qian W, Smith P, et al. Rituximab versus a watch-and-wait approach in patients with advanced-stage, asymptomatic, non-bulky follicular lymphoma: an open-label randomised phase 3 trial. Lancet Oncol 2014;15:424-435.
8. Dreyling M, Santoro A, Mollica L, et al. Long-term safety and efficacy of the PI3K inhibitor copanlisib in patients with relapsed or refractory indolent lymphoma: 2-year follow-up of the CHRONOS-1 study. Am J Hematol 2020;95:362-371.
9. Bachy E, Seymour JF, Feugier P, et al. Sustained progression-free survival benefit of rituximab maintenance in p