胰臟癌治療研討會

活動時間： 109 年 12 月 19 日（星期六）晚上 16:00-18:40
活動地點：迷路小章魚餐廳
活動住址: 高雄市鼓山區富農路 86 號

時間	主題	講師	主持人
16:00~16:10	Opening	饒坤銘　理事長	
16:10~16:50	From the fundamental mPC treatment to the Novel one for mCRPC	高雄榮總 郭威廷 醫師	高雄榮總 林仁泰 醫師
16:50~17:30	Urothelial carcinoma treatment in IO era	台大醫院 蔡育傑 醫師	成大醫院 歐建慧 醫師
17:30~17:40	Discussion	ALL	
17:40~18:30	What's on the Horizon Optimize HCC Treatment Strategy	台大醫院 紹幼雲 醫師	義大癌治療醫院 饒坤銘 醫師
18:30~18:40	Closing Q&A	饒坤銘　理事長	

From the fundamental mPC treatment to the Novel one for mCRPC

Prostate cancer (PC) is a major global health concern, as the most common malignancy among men in economically developed countries and second to lung cancer worldwide . In 2012, an estimated 1.1 million (15% of all cancers diagnosed in men) new PC cases were diagnosed worldwide, and 307 000 (6.6%) men died of the disease, making it the fifth leading cause of death from cancer in men .

The androgen receptor (AR) is a nuclear hormone receptor predominately dependent on activation by dihydrotestosterone, a ligand produced through intracellular conversion of testosterone, to induce nuclear localization and target gene transcription . The AR is commonly involved in driving PC development and progression, and many agents used to treat PC target the AR signaling axis. Androgen deprivation therapy (ADT) by medical or surgical means has been used as the main component of first-line PC therapy in the metastatic state. Although disease regression and stability may occur for varying lengths of time, disease progression is inevitable and reactivation of AR-axis signaling has been identified as an important driver of this process . The loss of response to ADT, leading to castration-resistant prostate cancer (CRPC), is associated with compensatory mechanisms allowing post-castration activation of the AR, including AR gene amplification, mutation, incomplete blockade of ligand-dependent AR activation, and aberrant AR co-regulator activity, among other mechanism**s.**

Urothelial carcinoma treatment in IO era

Bladder cancer is the most common malignancy involving the urinary system. Urothelial (transitional cell) carcinoma is the predominant histologic type in the United States and Europe, where it accounts for 90 percent of all bladder cancers. In other areas of the world, non-urothelial carcinomas are more frequent. Much less commonly, urothelial cancers can arise in the renal pelvis, ureter, or urethra.

Approximately 25 percent of patients will have muscle-invasive disease and either present with or later develop metastases. Systemic chemotherapy is the standard approach for the initial treatment of patients with inoperable locally advanced or metastatic urothelial malignancies. Although initial response rates are high, the median survival with multiagent chemotherapy is approximately 15 months . While this is superior to the estimated six-month survival with metastatic disease prior to the development of modern chemotherapy regimens, the five-year survival rate is approximately 15 percent with contemporary regimens . Second-line chemotherapy has had only a limited role, but checkpoint inhibitor immunotherapy offers an additional option for patients progressing after their initial systemic therapy.

The approach to systemic treatment for metastatic urothelial carcinoma arising in the renal pelvis or ureter is based on results from trials composed primarily of patients with urothelial carcinoma of the bladder.

Systemic therapy for metastatic urothelial cancer is reviewed here. The use of neoadjuvant or adjuvant chemotherapy in conjunction with cystectomy and as part of a multimodality approach to preserve the bladder is discussed separately.

What's on the Horizon Optimize HCC Treatment Strategy

Hepatocellular carcinoma (HCC), is the sixth most frequent form of cancer and leads to the fourth highest number of deaths each year. HCC results from a combination of environmental factors and aging as there are driver mutations at oncogenes which occur during aging. Most of HCCs are diagnosed at advanced stage preventing curative therapies. Treatment in advanced stage is a challenging and pressing problem, and novel and well-tolerated therapies are urgently needed. We will discuss further advances beyond sorafenib that target additional signaling pathways and immune checkpoint proteins. The scenario of possible systemic therapies for patients with advanced HCC has changed dramatically in recent years. Personalized genomics and various other omics approaches may identify actionable biochemical targets, which are activated in individual patients, which may enhance therapeutic outcomes. Further studies are needed to identify predictive biomarkers and aberrantly activated signaling pathways capable of guiding the clinician in choosing the most appropriate therapy for the individual patient.

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