現職：郭綜合醫院 院長
成功大學醫學院醫學系婦產學科教授
經歷：成功大學醫學院醫學系副系主任
成大醫院教學中心主任
成大醫院一般婦產科主任
台灣婦產科醫學會理事
台灣婦癌醫學會理事
台灣婦產科內視鏡暨微創醫學會理事

鄭雅敏
SY21

乳癌患者之婦科疾病照護

Breast cancer is the leading cause of cancer death in women in the United States. It is also the top one female cancer in Taiwan. Although breast cancer risk increases with age, approximately 35% of breast cancers occur during the reproductive and perimenopausal years. Common women's health issues such as contraception, pregnancy, menopause, and sexual functioning are uniquely affected by breast cancer diagnosis and treatment.

Two-thirds of breast cancers are hormone-sensitive and adjuvant hormonal therapies like tamoxifen or aromatase inhibitors have substantially decreased the disease recurrence of contralateral breast cancer. These hormonal therapies in premenopausal women can affect menstruation, reproduction and gynecologic health such as menorrhagia, symptomatic fibroids(25%) and nearly 67% have an underlying uterine disorder with potential to cause abnormal uterine bleeding (AUB). It also induce menopausal vasomotor symptoms and sexual side effects. Breast cancer treatment can have a marked affect on fertility in women who have delayed childbearing and have fewer remaining reproductive years.

Women's healthcare providers need to understand safe and effective treatment options to manage them. Providing counseling and evidence-based education is important for primary care providers and gynecologists who care for those women who have or previously had breast cancer.

The clinical dilemma of balancing the risk of breast cancer recurrence with symptoms and quality of life can be challenging for health care professionals and patients. Health care professionals can benefit from understanding available new technologies and their potential to markedly affect and improve the quality of life of premenopausal women who survive breast cancer.

■專題演講——一般婦科

現職：台北市聯醫忠孝分院婦產部主治醫師
台北市聯醫婦幼分院 部定助理教授
經歷：高雄醫學院婦產部 主治醫師
美哈佛大學醫院 Hebrew senile life
Framihgan 骨鬆研究 研修醫師
長庚大學臨床醫學研究所博士畢
長庚紀念醫院婦產部主治醫師

鄭碧華

SY22

類升醣素胜肽對控制婦女肥胖的功效

Bi Hua Cheng, MD, PhD
Department of OBS&GYN, Taipei City Hospital,
Zhongxiao branch and women’s and children’s branch, Taipei

肥胖與過重在ＷＨＯ的定義：異常的或過多的脂肪堆積在身體,增高健康危害之風險,降低生活品質，減少生命的長度的慢性病，診斷用 BMI >25 為過重 , BMI>30 為肥胖，會產生很多種併發症，包括了第二型糖尿病，代謝症候群，心血管疾病，退化性關節炎，睡眠呼吸中止症候群，憂鬱，非酒精性脂肪肝，不孕症，癌症，胃食道逆流... 等等，研究顯示：肥胖會增加罹患冠狀動脈心臟病的相對風險,在過重者增加 1.17 倍而肥胖者增加 1.49 倍，冠心症猝死發生率每增加 BMI 五單位，心因性猝死風險增加 16 %; 5 分之一的心房顫動症有肥胖症，14% 女性心臟衰竭有慢性肥胖。台灣肥胖醫學會在 2023 年成人肥胖防治實證指引指出 臨床醫師面對身體質量比 BMI 24 以上的過重 [BMI 24～27]； 肥胖[BMI 27-30] 重度肥胖 [BMI >30], 應該詳做病史評估，執行身體檢查，實驗室檢查，飲食評估，並展開積極治療步驟：建議飲食介入，運動介入，相關心理成面介入（尤其防自殺)，藥物治療適時介入，重度肥胖手術治療的時機，提供肥胖治療的藥物與非適應症之減重藥物等使用的基本原則，及早讓過重與肥胖婦女有足夠時間，且經由決策分享（SDM ）的方式選取自己減重方式，並達成減重至少 5-10%，便可體會減重的好處; 生活型態改變開始加入規律的中強度有氧運動，每週能夠至少 150～300 分鐘，即一週 4-5 次運動，一次至少 45-60 分鐘；力行低脂低熱高纖飲食，每天以減少 500 至 1000 大卡開始。若是持續生活型態控制不佳，需加入藥物，再不理想，持續 BMI 大於 27.5 則應考慮減重手術。

建議用藥於 BMI 大於 30 和 BMI 大於 27 加上有一種合併症(高血壓，二型糖尿病，血脂異常，生殖生育障礙)... 等婦女。實證呈現減重 0～5% 可以改善高血壓和血糖, 減重 5%～10%可以預防第二型糖尿病，非洒精性脂肪肝，多囊性卵巢症侯群並改善血脂; 減重 10～15% 可以減少心血管疾病，小便應力性失禁，並改善非酒精性脂肪肝炎,阻塞性睡眠呼吸中止症侯群，胃食道逆流，退化性関節炎; 減重大於 15 %有助於第二型糖尿病緩解改善及減少心血管死亡率和心藏衰竭。減重對肥胖與過重婦女健康有非常正向義意也為其更年期和老者肥胖防治把関與中老年健康促進加油。目前台灣衛福部公告核准減重用藥 1.Olistat,口服藥物，減重 3～5%，1999 為美 FDA 核准，然現在因有慢性吸收不良症候群，除非對特殊族群，九成以上醫師不喜建議此藥。2. 類醣體胜肽短效型 liraglutide （屬 GLP-1 agonist)注射藥物，每天一次皮下注射，減重 ~5 % 目前食藥署 2023/2 於核准用於減重; 3.Naltrexone/Bupropion ER 。食藥署 2022 核准，口服方式，經中樞抑制食慾. 注意衛福部對於非適應症的減重藥物是採不建議使用（如衛生福利部 2020 公告禁用 Lorcaserin) 以共同保障病人用藥�

Glucagon like peptide-1 [GLP-1] (liraglutide 利拉魯肽是)類升醣胜肽-1 類似，可以抑制人體食慾中樞，使食慾下降，並且藉由降低胃排空而增加飽足感，進而達到減重效果；對於肥胖及糖尿病前期個案有降低糖尿病... 等等益處，為本次報告重點內容 期將 GPL-1RAs 的重要臨床試驗實證相關 efficacy and safety 對過重和肥胖婦女尚未罹患糖尿病的 RCT 等資訊將在會議中呈現以為本會會員在忙碌臨床工作，面對減重之實證憑據。

陳子健

SY23

現職：馬偕紀念醫院主治醫師
馬偕醫學院助理教授
經歷：台灣婦產科醫學會副秘書長
台灣婦癌醫學會理事
台灣婦科醫學會理事

外陰與陰道表皮內癌前病變之診斷與處置

HPV DNA can be identified in over 80% of vulvar intraepithelial neoplasia (VIN), and type 16 is the most common. The "usual typeVIN (uVIN)" is caused by HPV and encompasses high-grade lesions (VIN 2 and 3). The differentiated type of VIN (dVIN) is not caused by HPV, and is shown to be associated with other vulvar dermatoses such as lichen sclerosis and lichen plants. The risk of vulvar cancer in the 10 years following high-grade uVIN and dVIN was 10% and 50% respectively. Most VIN is asymptomatic. The predominant symptom in symptomatic patients is pruritus. Careful inspection of the vulva in bright light followed by biopsies of suspicious lesions is the most productive diagnostic technique. Colposcopy especially after application of 5% acetic acid can be very helpful. Management of VIN include excision, laser, alternative ablative techniques, and non-surgical treatment such as imiquimod, cidofovir, photodynamic therapy, etc.

The incidence of vaginal intraepithelial neoplasia (VAIN) is estimated to be 0.2 to 0.3 cases per 100,000. Approximately 50% to 90% of patients with VAIN have concurrent or prior history of CIN or VIN. HPV is implicated in the development of VAIN, and HPV 16 and 18 are the most prevalent subtypes. Progression to vaginal cancer occurred in 2% to 20% of patients with VAIN. The overall spontaneous regression rate was 78% in VAIN 1 or 2. The rate of occult invasive vaginal cancer in VAIN3 is reported as high as 28%. VAIN is usually asymptomatic and most commonly detected by cytologic examination. Vaginal colposcopy with Lugol solution stain is important when the vaginal cytology is abnormal but no gross abnormality is seen. Colposcopically abnormal areas warrant biopsy. Treatment options include local excision, partial or total vaginectomy, laser vaporization, electrocoagulation, topical fluorouracil (5-FU), topical imiquimod, and radiation.