



# 中山醫學大學附設醫院

## 淋巴瘤診療指引 (Hodgkin Lymphoma)

2025/12/18 Version 14.0  
 2024/12/26 Version 13.0  
 2023/12/02 Version12.0  
 2022/12/22 Version12.0  
 2021/11/18 Version12.0  
 2021/01/27 Version 11.0  
 2019/11/21 Version 10.0  
 2018/11/15 Version 9.0  
 2017/12/21 Version 8.0  
 2016/11/17 Version 7.0  
 2015/11/19 Version 6.0  
 2014/11/20 Version 5.0  
 2013/11/21 Version 4.0  
 2012/11/22 Version 3.0  
 2011/11/23 Version 2.0  
 2010/07/14 Version 1.0

本臨床指引參考美國NCCN版本與淋巴瘤多專科醫療團隊編修

癌症委員會主任委員	癌症委員會執行長	癌症中心主任	抗癌藥物安全小組	團隊負責人



修訂內容：

頁數	第13版	第14版																
P12	<p>ChemoTherapy regimen</p> <p><b><u>Hodgkin lymphoma :</u></b></p> <p>★Most common variants</p> <p>ABVD : (doxorubicin 、 bleomycin 、 vinblastine 、 dacarbazine)</p> <p>Doxorubicin (Adriamycin) 25 mg/m2 iv D1 and 15</p> <p>Bleomycin 10 U/m2 iv D1 and 15</p> <p>Vinblastine 6 mg/m2 iv D1 and 15</p> <p>Dacarbazine (DTIC) 375 mg/m2 iv D1 and 15 Q4w</p>	<p>五、化學治療原則(Principles of chemotherapy)</p> <p><b><u>Hodgkin lymphoma :</u></b></p> <p>ABVD : (doxorubicin 、 bleomycin 、 vinblastine 、 dacarbazine)</p> <table border="1" data-bbox="1218 560 2011 671"> <tr> <td>Doxorubicin (Adriamycin) 25 mg/m2</td> <td>iv D1 and 15</td> </tr> <tr> <td>Bleomycin 10 U/m2</td> <td>iv D1 and 15</td> </tr> <tr> <td>Vinblastine 6 mg/m2</td> <td>iv D1 and 15</td> </tr> <tr> <td>Dacarbazine (DTIC) 375 mg/m2</td> <td>iv D1 and 15 Q4w</td> </tr> </table> <p>McKelvey EM. cancer 1976;38:1484-1493.Lenz G. J clin Oncol 2005;23:1984-1992. Hiddemann W.Blood 2005;106:3725-3732</p> <p>AAVD (Adcetris 、 Adriamycin 、 Velban 、 Dacarbazine )</p> <table border="1" data-bbox="1218 778 2107 916"> <tr> <td>Brentuximab vedotin (Adcetris) 1.2 mg/kg</td> <td>IV D1 and 15</td> </tr> <tr> <td>Doxorubicin (Adriamycin) 25 mg/m2</td> <td>IV D1 and 15</td> </tr> <tr> <td>Vinblastine (Velban) 6 mg/m2</td> <td>IV D1 and 15</td> </tr> <tr> <td>Dacarbazine (DTIC) 375 mg/m2</td> <td>IV D1 and 15 Q4w</td> </tr> </table> <p><small>1.MSK 13-034: Kumar A, Casulo C, Yahalom J, Schöder H, Barr PM, Caron P, Chiu A, Cozzitino LS, Drullinsky P, Friedberg JW, Geracitano JF, Hamilton A, Hamlin PA, Horwitz SM, Jacob AG, Maszar MJ, McArthur GN, McCall SJ, Moskowitz AJ, Noy A, Palomba ML, Portlock CS, Struss DJ, VankarEli N, Verwey SL, Yang J, Younes A, Zelenetz AD, Zhang Z, Moskowitz CH. Brentuximab vedotin and AVD followed by involved-site radiotherapy in early stage, unfavorable risk Hodgkin lymphoma. Blood. 2016 Sep 15;128(11):1458-64. Epub 2016 Jul 25. <a href="#">link to original article</a> dosing details in manuscript have been reviewed by our editors free full text available at EuroPMC <a href="#">EuroPMC NCT01868451</a></small></p>	Doxorubicin (Adriamycin) 25 mg/m2	iv D1 and 15	Bleomycin 10 U/m2	iv D1 and 15	Vinblastine 6 mg/m2	iv D1 and 15	Dacarbazine (DTIC) 375 mg/m2	iv D1 and 15 Q4w	Brentuximab vedotin (Adcetris) 1.2 mg/kg	IV D1 and 15	Doxorubicin (Adriamycin) 25 mg/m2	IV D1 and 15	Vinblastine (Velban) 6 mg/m2	IV D1 and 15	Dacarbazine (DTIC) 375 mg/m2	IV D1 and 15 Q4w
Doxorubicin (Adriamycin) 25 mg/m2	iv D1 and 15																	
Bleomycin 10 U/m2	iv D1 and 15																	
Vinblastine 6 mg/m2	iv D1 and 15																	
Dacarbazine (DTIC) 375 mg/m2	iv D1 and 15 Q4w																	
Brentuximab vedotin (Adcetris) 1.2 mg/kg	IV D1 and 15																	
Doxorubicin (Adriamycin) 25 mg/m2	IV D1 and 15																	
Vinblastine (Velban) 6 mg/m2	IV D1 and 15																	
Dacarbazine (DTIC) 375 mg/m2	IV D1 and 15 Q4w																	



## 目錄

一、前言.....	3
二、組織病理分類與分化.....	4
三、分期.....	9
四、淋巴癌(Hodgkin Lymphoma)臨床指引.....	10
五、化學治療原則 (Principles of chemotherapy).....	11
六、實證醫學 .....	12
七、International Prognostic Score (IPS) 1 point per factor ( advanced disease).....	14
八、Unfavorable Risk Factors for Stage I-II Classical Hodgkin Lymphoma.....	15
九、實證醫學.....	15
十、安寧緩和照護原則.....	16
十一、參考文獻(Reference) .....	16



## 一、前言

淋巴癌，是指由淋巴組織所衍生出的惡性腫瘤。淋巴癌的臨床表現，常常是不正常的淋巴結腫大，有時還會合併發燒，體重減輕，夜間盜汗等症狀，也就是所謂的B症狀 (B Symptom)。這樣的腫瘤，因其具有不正常增生與分化的特性，所以淋巴癌基本上都是惡性的。為了在名稱上不會混淆，惡性淋巴癌反而能更精準的讓病人了解其罹患疾病的特性。

淋巴癌大致上可分為兩大類，一是何杰金氏淋巴癌 (Hodgkin lymphoma)，一是非何杰金氏淋巴癌 (Non-Hodgkin' s lymphoma)。約莫80%的淋巴癌屬於非何杰氏金淋巴瘤，而何杰金氏淋巴瘤佔約20%。何杰金氏淋巴瘤與非何杰金氏淋巴瘤的區別在於組織型態的差異。何杰金氏淋巴瘤的癌細胞常常會出現如貓頭鷹眼狀的細胞型態，這類的細胞，我們稱之為Reed-Sternberg Cell (RS cell)。其癌細胞的免疫組織染色，會呈現陽性的 CD15以及CD30。何杰金氏淋巴瘤的組織分類，根據世界衛生組織 (WHO) 的分類，可區分為兩大類，典型 (classic) 何杰金氏淋巴瘤及nodular lymphocyte predominant。而典型何杰金氏淋巴瘤又細分為五大類，分別是 Lymphocyte-rich classic HL, Nodular sclerosis, Mixed Cellularity, Lymphocyte depleted, 以及無法分類的典型何杰金氏淋巴瘤



## 二、組織病理分類與分化

2017年WHO淋巴瘤分類 (Classification of lymphoma)

### Mature B-cell neoplasms

Chronic lymphocytic leukemia/small lymphocytic lymphoma

Monoclonal B-cell lymphocytosis\*

B-cell prolymphocytic leukemia

Splenic marginal zone lymphoma

Hairy cell leukemia

Splenic B-cell lymphoma/leukemia, unclassifiable

Splenic diffuse red pulp small B-cell lymphoma

Hairy cell leukemia-variant

Lymphoplasmacytic lymphoma

Waldenström macroglobulinemia

Monoclonal gammopathy of undetermined significance (MGUS), IgM\*

m heavy-chain disease

g heavy-chain disease

a heavy-chain disease

Monoclonal gammopathy of undetermined significance (MGUS), IgG/A\*

Plasma cell myeloma

Solitary plasmacytoma of bone

Extrasosseous plasmacytoma

Monoclonal immunoglobulin deposition diseases\*

Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue

(MALT lymphoma)

Nodal marginal zone lymphoma

Pediatric nodal marginal zone lymphoma

Follicular lymphoma



In situ follicular neoplasia\*  
Duodenal-type follicular lymphoma\*  
Pediatric-type follicular lymphoma\*  
Large B-cell lymphoma with IRF4 rearrangement\*  
Primary cutaneous follicle center lymphoma  
Mantle cell lymphoma  
In situ mantle cell neoplasia\*  
Diffuse large B-cell lymphoma (DLBCL), NOS  
Germinal center B-cell type\*  
Activated B-cell type\*  
T-cell/histiocyte-rich large B-cell lymphoma  
Primary DLBCL of the central nervous system (CNS)  
Primary cutaneous DLBCL, leg type  
EBV1 DLBCL, NOS\*  
EBV1 mucocutaneous ulcer\*  
DLBCL associated with chronic inflammation  
Lymphomatoid granulomatosis  
Primary mediastinal (thymic) large B-cell lymphoma  
Intravascular large B-cell lymphoma  
ALK1 large B-cell lymphoma  
Plasmablastic lymphoma  
Primary effusion lymphoma  
HHV81 DLBCL, NOS\*  
Burkitt lymphoma  
Burkitt-like lymphoma with 11q aberration\*  
High-grade B-cell lymphoma, with MYC and BCL2 and/or BCL6 rearrangements\*  
High-grade B-cell lymphoma, NOS\*



B-cell lymphoma, unclassifiable, with features intermediate between DLBCL and classical Hodgkin lymphoma  
Mature T and NK neoplasms  
T-cell prolymphocytic leukemia  
T-cell large granular lymphocytic leukemia  
Chronic lymphoproliferative disorder of NK cells  
Aggressive NK-cell leukemia  
Systemic EBV1 T-cell lymphoma of childhood\*  
Hydroa vacciniforme-like lymphoproliferative disorder\*  
Adult T-cell leukemia/lymphoma  
Extranodal NK-/T-cell lymphoma, nasal type  
Enteropathy-associated T-cell lymphoma  
Monomorphic epitheliotropic intestinal T-cell lymphoma\*  
Indolent T-cell lymphoproliferative disorder of the GI tract\*  
Hepatosplenic T-cell lymphoma  
Subcutaneous panniculitis-like T-cell lymphoma  
Mycosis fungoides  
Sézary syndrome  
Primary cutaneous CD301 T-cell lymphoproliferative disorders  
Lymphomatoid papulosis  
Primary cutaneous anaplastic large cell lymphoma  
Primary cutaneous gd T-cell lymphoma  
Primary cutaneous CD81 aggressive epidermotropic cytotoxic T-cell lymphoma  
Primary cutaneous acral CD81 T-cell lymphoma\*  
Primary cutaneous CD41 small/medium T-cell lymphoproliferative disorder\*  
Peripheral T-cell lymphoma, NOS  
Angioimmunoblastic T-cell lymphoma  
Follicular T-cell lymphoma\*



Nodal peripheral T-cell lymphoma with TFH phenotype\*  
Anaplastic large-cell lymphoma, ALK1、ALK2\*  
Breast implant-associated anaplastic large-cell lymphoma\*  
Hodgkin lymphoma  
Nodular lymphocyte predominant Hodgkin lymphoma  
Classical Hodgkin lymphoma  
Nodular sclerosis classical Hodgkin lymphoma  
Lymphocyte-rich classical Hodgkin lymphoma  
Mixed cellularity classical Hodgkin lymphoma  
Lymphocyte-depleted classical Hodgkin lymphoma  
Posttransplant lymphoproliferative disorders (PTLD)  
Plasmacytic hyperplasia PTL D  
Infectious mononucleosis PTL D  
Florid follicular hyperplasia PTL D\*  
Polymorphic PTL D  
Monomorphic PTL D (B- and T-/NK-cell types)  
Classical Hodgkin lymphoma PTL D  
Histiocytic and dendritic cell neoplasms  
Histiocytic sarcoma  
Langerhans cell histiocytosis  
Langerhans cell sarcoma  
Indeterminate dendritic cell tumor  
Interdigitating dendritic cell sarcoma  
Follicular dendritic cell sarcoma  
Fibroblastic reticular cell tumor  
Disseminated juvenile xanthogranuloma  
Erdheim-Chester disease\*



### 三、分期

淋巴癌的分期，是依照 Ann Arbor Staging System 來分期。淋巴癌一般分為四期，簡單的說，當淋巴癌只侵犯單一區域淋巴結時，稱為第一期。當淋巴癌侵犯兩個區域以上淋巴結，且在橫膈膜同側時，稱為第二期。當淋巴癌侵犯兩個區域以上淋巴結，且在橫膈膜異側時，稱為第三期。當淋巴癌侵犯淋巴組織以外的地方，或是侵犯肝臟或骨髓時，則稱為第四期。這樣分期的目的，是為了決定治療方式與評估預後。簡單的說，三、四期病患的預後一般來說比一、二期的病患差。

### 四、淋巴瘤(Hodgkin Lymphoma)臨床指引

WORK-UP-主要檢查	STAGE	PRIMARY TREATMENT	Restage and Following Treatment
Physical Exam Performance status B symptoms CBC/DC LDH、ESR、Liver function Uric acid<optional> Comprehensive metabolic panel CT scan with contrast<optional> Bone marrow biopsy± aspiration Calculation of International Prognostic Score (IPS) Hepatitis B、C testing<optional> echocardiogram<optional> PET-CT <optional> Discussion of fertility issues and sperm banking(optional)	Stage IA – IIA (No bulky disease)	Chemotherapy (ABVD) * 2 cycles→restage with PET/CT	CR→Observe or CR→ABVD*1cycle (total 3) or AVD*4cycle (total 6) PR→ABVD*2cycle (total 4) or AVD*4cycle (total 6) ABVD x 1cycle + ISRT 30 Gy(per RAPID, H10F) Biopsy- proven refractory disease→Second-line systemic therapy
	Stage I – II Unfavorable <sup>1</sup> (No bulky disease) Or Bulky mediastinal Disease >10cm	Chemotherapy (ABVD)* 2 cycles→restage with PET/CT	CR→ABVD*2 cycles (total 4) + ISRT or PR→ABVD*2cycles (total 4) + ISRT Escalated BEACOPP*2 cycle + ISRT NR→Biopsy Negative→AVD x 4 cycles(total 6) + ISRT→F/U Positive→restage with PET/CT
	Stage III - IV	Chemotherapy (ABVD)* 2 cycles →restage with PET/CT	CR→AVD*4 cycle→ ISRT CR→ABVD*2 cycle→Observe or ISRT to initially bulky (total 4)→restage with PET/CT PR→Escalated BEACOPP x 2 cycles→restage with PET/CT→CR or PR→biopsy



## 五、化學治療原則(Principles of chemotherapy)

### Hodgkin lymphoma :

**ABVD** : (doxorubicin 、bleomycin 、vinblastine 、dacarbazine)

Doxorubicin (Adriamycin) 25 mg/m <sup>2</sup>	iv D1 and 15
Bleomycin 10 U/m <sup>2</sup>	iv D1 and 15
Vinblastine 6 mg/m <sup>2</sup>	iv D1 and 15
Dacarbazine (DTIC) 375 mg/m <sup>2</sup>	iv D1 and 15 Q4w

McKelvey EM. cancer 1976;38:1484-1493.Lenz G. J clin Oncol 2005;23:1984-1992.

Hiddemann W.Blood 2005;106:3725-3732

**AAVD** (Adcetris 、Adriamycin 、Velban 、Dacarbazine )

Brentuximab vedotin (Adcetris) 1.2 mg/kg	IV D1 and 15
Doxorubicin (Adriamycin) 25 mg/m <sup>2</sup>	IV D1 and 15
Vinblastine (Velban) 6 mg/m <sup>2</sup>	IV D1 and 15
Dacarbazine (DTIC) 375 mg/m <sup>2</sup>	IV D1 and 15 Q4w

1.MSK 13-034: Kumar A, Casulo C, Yahalom J, Schöder H, Barr PM, Caron P, Chiu A, Constine LS, Drullinsky P, Friedberg JW, Gerecitano JF, Hamilton A, Hamlin PA, Horwitz SM, Jacob AG, Matasar MJ, McArthur GN, McCall SJ, Moskowitz AJ, Noy A, Palomba ML, Portlock CS, Straus DJ, VanderEls N, Verwys SL, Yang J, Younes A, Zelenetz AD, Zhang Z, Moskowitz CH. Brentuximab vedotin and AVD followed by involved-site radiotherapy in early stage, unfavorable risk Hodgkin lymphoma. Blood. 2016 Sep 15;128(11):1458-64. Epub 2016 Jul 25. [link to original article](#) dosing details in manuscript have been reviewed by our editors free full text available at EuroPMC [EuroPMC NCT01868451](#)

## 六、放射線治療原則 (Second-Line or Subsequent Therapy Options)

1. Brentuximab vedotin (only for CHL)
2. Involved-site Radiation Therapy (ISRT)

Dose:

### (1) Combined Modality Therapy

- \*Non-bulky disease (stage I-II): 20\*–30 Gy (if treated with ABVD), 30 Gy (if treated with Stanford V); 1.5-2.0 Gy per fraction
- \*Non-bulky disease (stage IB-IIB): 30 Gy; 1.5-2.0 Gy per fraction
- \*Bulky disease sites (all stages): 30–36 Gy; 1.5-2.0 Gy per fraction

### (2) ISRT Alone (uncommon, except for NLPHL):

- \*Involved regions: 30–36 Gy (the dose of 30 Gy is mainly used for NLPHL); 1.5-2.0 Gy per fraction
- \*Uninvolved regions: 25–30 Gy; 1.5-2.0 Gy per fraction

★Brentuximab vedotin 1.8mg/kg 以 30 分鐘以上靜脈輸注方式給藥，每 3 週一次，若患者體重超過 100kg，應以 100kg 算所需劑量。持續治療直到疾病惡化(disease progression)或出現無法接受的毒性為止。  
達到病況穩定(stable disease)或改善的患者，應接受最少 8 個療程，最多至 16 個療程(約 1 年)的治療。

### ★健保給付原則:

Brentuximab vedotin (如 Adcetris)，限用於成人患者：

1. 治療復發或頑固型 CD30+何杰金氏淋巴瘤(HL)：(1)已接受自體幹細胞移植(ASCT)，或(2)無法使用 ASCT 或多重藥物化療，且先前至少已接受兩種治療。
2. 治療復發或頑固型全身性退行分化型大細胞淋巴瘤(systemic anaplastic large cell lymphoma；sALCL)。
3. 每次申請療程以 4 個療程為限，再申請應檢附前次治療結果評估資料。若病人病情已達完全緩解，得再給付 4 個療程。健保給付以 16 個療程為上限。



**★Additional Therapy Options(only for CHL)**

1. Bendamustine
2. Nivolumab (for patients previously treated with brentuximab vedotin)
3. Pembrolizumab(for patients previously treated with brentuximab vedotin)

備註:Canellos GP et al. Chemotherapy of advanced Hodgkin's disease with MOPP, ABVD, or MOPP alternating with ABVD. N Eng J Med 1992; 327:1478.

**七、 International Prognostic Score (IPS) 1 point per factor ( advanced disease)**

- Albumin <4 g/dL
- Hemoglobin <10.5 g/dL
- Male
- Age ≥45 years
- Stage IV disease
- Leukocytosis (white blood cell count at least 15,000/mm<sup>3</sup>)
- Lymphocytopenia (lymphocyte count less than 8% of white blood cell count, and/or lymphocyte count less than 600/mm<sup>3</sup>)

## 八、Unfavorable Risk Factors for Stage I-II Classical Hodgkin Lymphoma

Risk Factor	GHSB	EORTC	NCCN
Age		≥50	
Histology			
ESR and B symptoms	>50 if A; >30 if B	>50 if A; >30 if B	≥50 or any B symptoms
Mediastinal mass	MMR > .33	MTR > .35	MMR > .33
# Nodal sites	>2*	>3*	>3
E lesion	any		
Bulky			>10 cm

## 九、實證醫學

Categories of Evidence and Consensus :

Category 1: There is uniform NCCN consensus, based on high-level evidence, that the recommendation is appropriate.

Category 2A: There is uniform NCCN consensus, based on lower-level evidence including clinical experience, that the recommendation is appropriate.

Category 2B: There is nonuniform NCCN consensus (but no major disagreement), based on lower-level evidence including clinical experience, that the recommendation is appropriate.

Category 3: There is major NCCN disagreement that the recommendation is appropriate.

All recommendations are category 2A unless otherwise noted.

## 十、安寧緩和照護原則

若預期疾病難以治癒時，病人存活期小於 6 個月便適合安寧療護(Pomeranz & Brustman, 2005；Waldrop & Rinfrette, 2009)。若藉由症狀、檢驗數據、及確切的腫瘤診斷，證實臨床上該惡性腫瘤已經廣泛侵犯、或進展快速；功能分數(Palliative Performance Scale)低於 70%；拒絕進一步腫瘤治癒性治療，或者在治療之下仍持續惡化者，即可轉介緩和醫療團隊（彭等，2006）。

## 十一、參考文獻(Reference)

1. NCCN Clinical Practice Guidelines in Oncology. Hodgkin's Lymphomas V3.2025
2. McKelvey EM. cancer 1976;38:1484-1493. Lenz G. J clin Oncol 2005;23:1984-1992. Hiddemann W. Blood 2005;106:3725-3732
3. Velasquez WS. Blood 1988;71:117-122.
4. Velasquez WS. J clin Oncol 1994;12:1169-1176.
5. Moskowitz CH. J clin oncol 1999;17:3776-3785.
6. Kewalramans T. blood 2004;103:3684-3688
7. Canellos GP et al. Chemotherapy of advanced Hodgkin's disease with MOPP, ABVD, or MOPP alternating with ABVD. N Eng J Med 1992; 327:1478.
8. BLOOD, 19 MAY 2016 x VOLUME 127, NUMBER 20:2376
9. MSK 13-034: Kumar A, Casulo C, Yahalom J, Schöder H, Barr PM, Caron P, Chiu A, Constine LS, Drullinsky P, Friedberg JW, Gerecitano JF, Hamilton A, Hamlin PA, Horwitz SM, Jacob AG, Matasar MJ, McArthur GN, McCall SJ, Moskowitz AJ, Noy A, Palomba ML, Portlock CS, Straus DJ, VanderEls N, Verwys SL, Yang J, Younes A, Zelenetz AD, Zhang Z, Moskowitz CH. Brentuximab vedotin and AVD followed by involved-site radiotherapy in early stage, unfavorable risk Hodgkin lymphoma. Blood. 2016 Sep 15;128(11):1458-64.