



2026 07 / 18 Sat

台大醫學院101教室
National Taiwan University
College of Medicine

台灣肺癌研究學會 第2屆第2次會員大會暨學術研討會

2nd General Assembly and Academic Symposium of TASLC



IMDELLTRA[®]

(tarlatamab) for injection
1 mg & 10 mg single-use vials

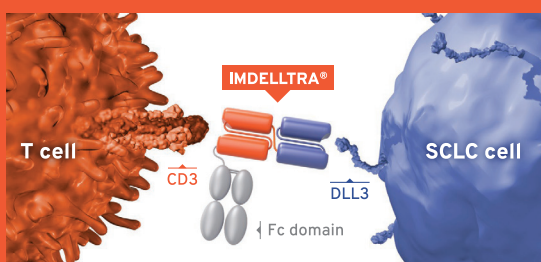
連結創新，攜手同行

IMDELLTRA[®] 安泰適[®]

雙特異性 DLL3 導向的 CD3 T 細胞銜接系統¹

適用於使用含鉑化學治療期間或之後疾病惡化之擴散期小細胞肺癌(ES-SCLC) 成人病人²

創新作用機轉¹



透過活化自身 T 細胞對抗 DLL3 表現腫瘤細胞
治療前無須檢測腫瘤細胞 DLL3 表現程度

突破性療效反應^{3,4}

整體反應率
ORR

反應持續時間
mDoR

40%

(95% CI: 31-51)
Primary endpoint

9.7月

(95% CI: 2.7-20.7+ months)

治療整體耐受性良好
絕大部分 CRS 屬於 Grade 1-2

Abbreviation : DLL3 = delta-like ligand 3; SCLC = small cell lung cancer; ES = extensive-stage; CRS = cytokine release syndrome

Reference : 1. Paz-Ares L, et al. J Clin Oncol. 2023 Jun 1;41(16):2893-2903; 2. IMDELLTRA[®] 仿單 _ 版本日期 : 2025-03-19; 3. Sands JM, et al. Cancer. 2025 Feb 1;131(3):e35738; 4. Sands J, et al. Presented at World Conference on Lung Cancer (WCLC) 2024 Annual Meeting, Sep 7 – 10, 2024; San Diego, CA. Oral..

簡易仿單

安泰適[®] 注射劑 1 毫克 IMDELLTRA[®] for Injection 1 mg (tarlatamab) 衛部醫藥字第 001281 號
安泰適[®] 注射劑 10 毫克 IMDELLTRA[®] for Injection 10 mg (tarlatamab) 衛部醫藥字第 001282 號

適應症：適用於治療使用含鉑化學治療期間或之後疾病惡化之擴散期小細胞肺癌(ES-SCLC) 的成人病人。此適應症係依據腫瘤整體反應率及反應持續時間加速核准。此適應症仍須執行確認性試驗以證明其臨床效益。
建議劑量：以一小時的時間採靜脈輸注方式給予 IMDELLTRA。IMDELLTRA 的建議劑量漸增給藥時間表請見表 1。劑量漸增方式給藥，以降低細胞激素釋放症候群(CRS) 的發生率及嚴重程度。在劑量漸增給藥時間表之後，每 2 週給予 IMDELLTRA 一次，直至疾病惡化或出現不可接受的毒性。

表 1. IMDELLTRA 建議的用法和劑量 (每個週期以 28 天為一個週期)				
給藥時間表	天	IMDELLTRA 劑量	給藥說明	建議的監測
劑量漸增給藥時間表 第 1 週期	第 1 天	漸增劑量 1 mg	請在適當的醫療機構中，以靜脈輸注 1 小時給予 IMDELLTRA。	在第 1 週期第 1 天及第 1 週期第 8 天，在適當的醫療機構中從開始輸注 IMDELLTRA 起監測病人 22 至 24 小時。建議病人從開始輸注 IMDELLTRA 起算，在照護者陪同下，距離適當的醫療機構保持 1 小時範圍內共 48 小時。
	第 8 天	10 mg		
	第 15 天	10 mg		
第 2 週期	第 1 及 15 天	10 mg	在 IMDELLTRA 輸液後觀察病人 6-8 小時。	在 IMDELLTRA 輸液後觀察病人 6-8 小時。
第 3 及 4 週期	第 1 及 15 天	10 mg		
第 5 週期及後續輸注	第 1 及 15 天	10 mg		

在第 1 週期期間，依表 2 所述給予 IMDELLTRA 給藥的建議併用藥物，以降低細胞激素釋放症候群的風險。

表 2 第 1 週期 IMDELLTRA 給藥的建議併用藥物		
治療日	藥物	給藥方式
第 1 天及第 8 天	靜脈注射給予 8 mg dexamethasone (或等效藥物)	在 IMDELLTRA 輸液前 1 小時內
第 1 天 第 8 天及第 15 天	用 4-5 小時靜脈輸注 1 公升生理食鹽水	完成 IMDELLTRA 輸注後立刻給予

警語和注意事項：1. 細胞激素釋放症候群：IMDELLTRA 可能造成細胞激素釋放症候群(CRS)，包括嚴重或危及生命的反應。CRS 的臨床徵象和症狀包括發燒、低血壓、疲勞、心悸過速、頭痛、低血氧、噁心和嘔吐。

可能危及生命的 CRS 併發症包括心臟功能障礙、急性呼吸窘迫症候群、神經毒性、腎臟和 / 或肝臟衰竭，以及瀰漫性血管內凝血(DIC)。在以 IMDELLTRA 治療期間，請密切監測病人的 CRS 徵象和症狀。一旦出現 CRS 的徵象時，立即停用 IMDELLTRA 輸液、評估病人是否需要住院，並根據嚴重程度實施支持性照護。根據嚴重程度暫停或永久停用 IMDELLTRA。建議病人在發生 CRS 的徵象或症狀時就醫。2. 神經毒性：根據嚴重程度細胞相關神經毒性症候群(ICANS)：IMDELLTRA 可能造成嚴重或危及生命的神經毒性，包括 ICANS。ICANS 可能與 CRS 同時發生，在 CRS 緩解後發生，或在未發生 CRS 時發生。ICANS 的臨床徵象和症狀可能包括但不限於意識狀態混亂、意識程度下降、失去定向感、嗜睡、倦怠和思維遲緩。在治療期間，請密切監測病人的神經毒性和 ICANS 徵象和症狀。一旦出現 ICANS 徵兆，立即評估病人並根據嚴重程度提供支持性治療。根據嚴重程度，暫停 IMDELLTRA 或永久停用。3. 血球減少症：IMDELLTRA 可能造成血球減少症，包括嗜中性白血球低下、血小板減少症和貧血。應監測病人的血球減少症徵象和症狀。在每一劑 IMDELLTRA 治療前，以及當臨床需要時，執行全血球計數。根據血球減少症的嚴重程度，暫停或永久停用 IMDELLTRA。4. 感染：IMDELLTRA 可能造成嚴重感染，包括危及生命和致命的感染。以 IMDELLTRA 治療前及過程中監測病人的感染徵象和症狀，並依臨床需要治療。根據嚴重程度暫停或永久停用 IMDELLTRA。5. 肝毒性：IMDELLTRA 可造成肝毒性。肝臟酵素升高可能伴隨或不伴隨併發 CRS。以每一劑 IMDELLTRA 治療前，以及當臨床需要時，監測肝臟酵素及膽紅素。根據嚴重程度，暫停 IMDELLTRA 或永久停用。6. 過敏：IMDELLTRA 可造成嚴重過敏反應。過敏的臨床徵象與症狀可能包括但不限於皮疹及支氣管痙攣。在 IMDELLTRA 治療期間監測病人的過敏徵象和症狀，並依臨床需要處理。根據嚴重程度，暫停或考慮永久停用 IMDELLTRA。7. 胚胎 - 胎兒毒性：根據其作用機制，給予孕婦 IMDELLTRA 可能會對胎兒造成傷害。告知病人胎兒承受的潛在風險。建議育齡女性於 IMDELLTRA 治療期間以及最後一劑後 2 個月內，採取有效避孕措施。不良反應：臨床試驗中，最常見的(>20%) 不良反應為細胞激素釋放症候群、疲勞、發燒、味覺障礙、食慾下降、肌肉骨骼疼痛、便秘、貧血及噁心。



安泰適[®] 注射劑
1 毫克
完整電子仿單
請掃此二維條碼



安泰適[®] 注射劑
10 毫克
完整電子仿單
請掃此二維條碼

AMGEN

TWN-757-0325-80001

AMGEN 台灣安進藥品有限公司

地址：110 台北市信義區松仁路 100 號 13 樓之 1

TEL : (02)2544-2888 ; FAX : (02)2713-5781

藥品資訊諮詢專線：0080 1611 483 ; Medinfo.JAPAC@amgen.com

藥品不良反應通報：0080 1611 483 ; Safety-Taiwan@amgen.com

僅供醫療人員參考使用

北市衛藥廣字第

號



2026 07 / 18 Sat

台大醫學院101教室
National Taiwan University
College of Medicine

台灣肺癌研究學會

第2屆第2次會員大會暨學術研討會

2nd General Assembly and Academic Symposium of TASLC

Time	Topic	Speaker	Moderator
13:30–13:35	Opening	楊志新 理事長 Prof. Chih-Hsin Yang 台灣肺癌研究學會	
13:35–14:05	ctDNA minimal residual disease (MRD) testing in early-stage NSCLC	Dr. Aaron Chia-Ken Tan National Cancer Centre Singapore	楊志新 理事長 Prof. Chih-Hsin Yang 台灣肺癌研究學會
14:05–14:35	Molecular diagnostics in non-small cell lung cancer.	Prof. Hidenori Kage The University of Tokyo Hospital	楊志新 理事長 Prof. Chih-Hsin Yang 台灣肺癌研究學會
14:35–14:50	Break		
14:50–15:50	會員大會 General Assembly		
15:50–16:20	重新檢視非吸菸族群之肺癌篩檢 Re-evaluating Lung Cancer Screening in Never-Smokers	何肇基 醫師 Prof. Chao-Chi ho 臺大醫院	楊泮池 榮譽理事長 Prof. Pan-Chyr Yang 台灣肺癌研究學會
16:20–16:50	早期肺癌治療新進展 Recent Advances in Early-Stage Lung Cancer Treatment	林孟暉 醫師 Prof. Mong-Wei Lin 臺大醫院	李岡遠 副校長 Prof. Kang-Yun Lee 臺北醫學大學
16:50–17:00	Closing	李岡遠 副校長 Prof. Kang-Yun Lee 臺北醫學大學	





Moderator



● 楊志新 副校長
James Chih-Hsin Yang, M.D., Ph.D.

Vice President, National Taiwan University



● 楊泮池 院士
Pan-Chyr Yang, M.D., Ph.D.

Academician, Academia Sinica (Elected 2006–Present)

Professor, Department of Internal Medicine,
College of Medicine, NTU (1993–Present)

Attending Physician, Department of Internal Medicine,
National Taiwan University Hospital (NTUH) (1986–Present)



● 李岡遠 副校長
Kang-Yun Lee, M.D., Ph.D.

Vice President, Taipei Medical University

Professor, Department of Internal Medicine,
School of Medicine, College of Medicine, TMU

Director, Graduate Institute of Translational Medicine, TMU

Attending Physician, Division of Pulmonary Medicine,
Shuang Ho Hospital, Ministry of Health and Welfare



Speaker



Aaron Chia-Ken Tan, M.D., Ph.D.

Medical Oncologist
Division of Medical Oncology
National Cancer Centre Singapore

Dr. Aaron Tan Chia-Ken is a Consultant Medical Oncologist at the National Cancer Centre Singapore (NCCS) and Sengkang General Hospital, where he also serves as an Assistant Professor.

Dr. Tan completed his undergraduate medical training (MBBS) and Bachelor of Science (Medicine) with Honours at the University of New South Wales, Australia. Driven by a passion for oncology research, he went on to obtain a PhD in cancer drug discovery from The University of Sydney in 2011. He completed his advanced specialty training in Medical Oncology in Sydney, earning his Fellowship of the Royal Australasian College of Physicians (FRACP). Following his time in Australia, he underwent further fellowship training at NCCS, focusing on drug development, early-phase clinical trials, and lung cancer translational research.

His clinical and research interests lie in lung/thoracic oncology and cancer genomic medicine. As an active clinical investigator, Dr. Tan has been recognized with several prestigious accolades, including the National Medical Research Council (NMRC) Transition Award (2025) and multiple Investigator Grants. He has published extensively in international journals on targeted therapies, immunotherapy, and molecular profiling, contributing significantly to advancing precision medicine for cancer patients.



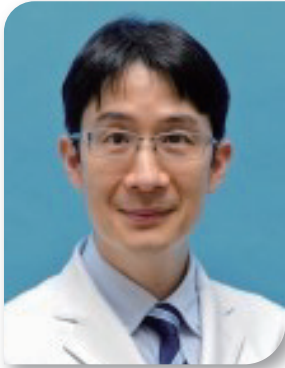
Abstract

ctDNA minimal residual disease (MRD) testing in early-stage NSCLC

The Asian Thoracic Oncology Research Group (ATORG) convened a 27-member expert panel to develop consensus guidance on using circulating tumour DNA (ctDNA)-based minimal residual disease (MRD) testing in early-stage resected non-small cell lung cancer (NSCLC). Using a Delphi methodology, the panel produced 23 position statements — nearly all achieving strong consensus — covering areas such as assay standardisation, clinical application, and trial design. Key findings include the need for defined analytical performance thresholds, standardised reporting and pre-analytical handling, and harmonised blood sampling timepoints across trials. While MRD assays show high specificity and positive predictive value, inconsistent sensitivity means they are not yet ready for routine use in guiding adjuvant therapy de-escalation outside of clinical trials. The recommendations also emphasise the importance of broader access, sustainable funding, and real-world data generation to support wider adoption, with future trials needing to account for the distinct biology of different driver gene subtypes.



Speaker



Hidenori Kage, M.D., Ph.D.

Professor

Department of Respiratory Medicine

The University of Tokyo

Hidenori Kage is the Professor and Chair of Department of Respiratory Medicine at The University of Tokyo. After graduating from The University of Tokyo in 2000 with an M.D. degree, he completed his four years of residency and fellowship in pulmonary medicine. He then entered the PhD program at The University of Tokyo and earned his degree in 2008. He was a postdoc at the University of Southern California from 2011 to 2014. He became Professor and Chair of Department of Respiratory Medicine at The University of Tokyo in 2023. His main research interests are cancer genomic medicine and basic lung cancer research with over 130 peer-reviewed publications. He was involved in the development and approval of GenMineTOP, a comprehensive genomic profiling test with dual DNA and RNA panels. He continues to emphasize the importance of recognizing lung cancer with driver oncogene alterations and the pitfalls leading to false negative findings to appropriately treat these patients with targeted therapy.



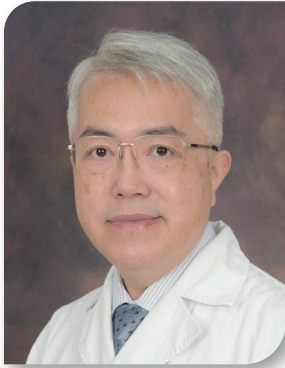
Abstract

Molecular diagnostics in non-small cell lung cancer

Molecular targeted therapy is a cornerstone of the treatment of advanced non-small cell lung cancer. Clinicians specializing in lung cancer around the world send biopsy and resected samples to laboratories to determine whether they harbor driver oncogene alterations such as EGFR mutations and ALK fusions, hoping to provide patients with guideline-recommended molecular targeted therapy. As the number of approved inhibitors has increased, so has the need to test multiple genes simultaneously. Use of multigene testing can preserve samples and shorten turnaround time compared with multiple single gene testing and is considered standard of care. Recently, many countries have approved comprehensive genomic profiling tests, which provide clinicians with information on hundreds of genes and give patients opportunities for novel treatments. However, we have demonstrated that genomic testing often yields falsely negative results, which can lead to patients being deprived of molecular targeted therapy and longer survival. To avoid this, clinicians must be aware of the characteristics of each test method and try to send biopsy samples that are suitable for the test method. In addition, if clinicians should consider retesting if all the genes that were tested come back negative for alterations. Finally, molecular diagnostics is not only about identifying gene alterations and matching them to molecular targeted therapy. I will conclude by explaining how they may soon transform cancer diagnosis and treatment.



Speaker



何肇基 醫師

Chao-Chi Ho, M.D., Ph.D.

Professor

Internal Medicine

National Taiwan University Hospital

Chao-Chi Ho, MD, PhD, is a Professor of Internal Medicine at the National Taiwan University (NTU) College of Medicine. Dr. Ho earned both his MD and his PhD from the Graduate Institute of Pathology at the NTU College of Medicine.

As a dedicated pulmonologist, Dr. Ho served as an ICU attending physician for nine years before focusing his career on the diagnosis and treatment of lung cancer. His primary research interests include the application of endobronchial ultrasound (EBUS) in lung cancer diagnosis, resistance mechanisms to Epidermal Growth Factor Receptor Tyrosine Kinase Inhibitors (EGFR-TKIs), and the management of EGFR-mutant lung cancer patients, including EGFR-TKI off-target effects.

Dr. Ho leads the bronchoscopy and endobronchial ultrasound teams for lung cancer diagnosis. Additionally, he serves as a co-investigator for lung cancer clinical trials led by Professor James Chih-Hsin Yang.



Abstract

重新檢視非吸菸族群之肺癌篩檢 Re-evaluating Lung Cancer Screening in Never-Smokers

The current global paradigm for lung cancer screening, heavily influenced by Western trials like the National Lung Screening Trial (NLST) and the NELSON trial, relies almost exclusively on heavy smoking history as the primary risk factor for eligibility. However, this established Western framework is fundamentally inapplicable to Taiwan, where the epidemiological landscape of lung cancer is starkly different. In Taiwan, lung cancer is the leading cause of oncological mortality, yet the majority of cases occur in individuals who have never smoked. Specifically, never-smokers account for over 50% of all lung cancer cases nationwide and a staggering 90% of female patients. Historically, nearly 60% of these never-smoking patients presented with advanced stage IV disease at clinical diagnosis, highlighting a critical failure in traditional screening criteria that ignore non-smoking risks. Together, the two seminal studies on Taiwan's experience—the retrospective national registry analysis and the prospective TALENT trial—provide definitive evidence on how to address this public health challenge. They demonstrate that introducing low-dose computed tomography (LDCT) to a never-smoking population triggers a massive, favorable stage-shift. The national registry data revealed an exponential increase in the detection of early-stage lung adenocarcinoma (LUAD) alongside a significant decline in advanced-stage incidence-based mortality (ASIBM), proving that early intervention saves lives. Crucially, TALENT identified a family history of lung cancer (LCFH) as the most powerful risk factor, demonstrating that the prevalence of invasive cancer escalates significantly with the number of affected first-degree relatives. These findings solidify the rationale for why Taiwan must shift its clinical focus entirely toward risk-stratified screening for never-smokers. Relying on smoking history leaves the vast majority of Taiwan's at-risk population invisible to early detection, condemning them to late-stage diagnoses with poor prognoses. However, the studies also warn of "detection inflation" and potential overdiagnosis if screening is completely unrestricted, as national advanced-stage incidence remained stable in certain demographics despite surging LDCT volumes. Therefore, Taiwan's explicit focus on never-smokers is not just justified, but medically urgent; it allows the healthcare system to abandon inefficient Western criteria and instead deploy an organized, risk-targeted national program that uses age, sex, and familial history to maximize early therapeutic intervention while mitigating the harms of overdiagnosis.



Speaker



林孟暉 醫師

Mong-Wei Lin, M.D., Ph.D.

Professor and Chief

Division of Thoracic Surgery, Department of Surgery

National Taiwan University Hospital, Taiwan

Dr. Mong-Wei Lin is Professor of Surgery at National Taiwan University and Vice Chair of the School of Medicine. He is Chief of the Division of Thoracic Surgery at National Taiwan University Hospital (NTUH) and serves as a board member of both the Taiwan Association of Thoracic and Cardiovascular Surgery (TATCS) and the Taiwan Society of Thoracic Surgery (TSTS).

Dr. Lin earned his medical degree from the School of Medicine, National Taiwan University, and completed residency training in general surgery and thoracic surgery at NTUH. He pursued advanced fellowship training at Massachusetts General Hospital, Harvard Medical School, in 2010, and at Keio University Hospital in Japan in 2012. He received his PhD from the Graduate Institute of Pathology at National Taiwan University in 2014. From July 2024 to July 2025, he served as Visiting Professor of Surgery at Harvard Medical School.

Dr. Lin has authored more than 140 SCI-indexed publications in leading peer-reviewed journals, including Annals of Surgery, The Journal of Thoracic and Cardiovascular Surgery, and The Annals of Thoracic Surgery. His clinical and research interests focus on minimally invasive thoracic surgery and early-stage lung cancer, particularly through the integration of pathology, radiomics, and multidisciplinary translational research. He has received numerous awards for medical research and education and is committed to advancing thoracic surgery through innovation and improved patient care.



Abstract

早期肺癌治療新進展 Recent Advances in Early-Stage Lung Cancer Treatment

The management of early-stage lung cancer has evolved rapidly with advances in surgical techniques, imaging, and perioperative technology. Minimally invasive approaches, particularly robotic-assisted thoracic surgery, have improved surgical precision, lymph node dissection, and postoperative recovery. At the same time, sublobar resection has gained increasing importance for selected patients with small peripheral lung cancers, supported by emerging evidence on oncologic safety and lung function preservation. New technologies, including advanced imaging, three-dimensional reconstruction, artificial intelligence, and image-guided surgery, are further refining patient selection, surgical planning, and intraoperative decision-making. This talk will highlight recent developments in the surgical treatment of early-stage lung cancer and discuss how innovation is reshaping personalized, function-preserving thoracic cancer care.



Note

10 REASONS TO CHOOSE GIOTRIF® (afatinib) tablets



安復克®
GIOTRIF®
(afatinib) tablets

衛署藥廣字第108120377號

健保給付規定

1. 限單獨使用於具有 EGFR TK 基因突變之局部晚期或轉移性 (即第 III B、III C 期或第 IV 期) 之肺腺癌病患之第一線治療。
2. 先前已使用過第一線含鉑化學治療，但仍惡化的局部晚期或轉移性之鱗狀組織非小細胞肺癌之第二線治療。

適應症

1. Giotrif 適用於具有 EGFR-TK 突變之局部晚期或轉移性之非小細胞肺癌 (NSCLC) 患者之第一線治療。
2. Giotrif 適用於在含鉑類化學治療期間或之後惡化的局部晚期或轉移性之鱗狀組織非小細胞肺癌 (NSCLC) 患者。

處方資訊摘要

安復克膜衣錠30毫克 衛署藥輸字第 026032 號
安復克膜衣錠40毫克 衛署藥輸字第 026033 號

【適應症】 1. Giotrif 適用於具有 EGFR-TK 突變之局部晚期或轉移性之非小細胞肺癌 (NSCLC) 患者之第一線治療。 2. Giotrif 適用於在含鉑類化學治療期間或之後惡化的局部晚期或轉移性之鱗狀組織非小細胞肺癌 (NSCLC) 患者。【用法用量】 建議劑量：作為第一線治療，即用於先前未曾接受 EGFR-酪氨酸激酶抑制劑 (EGFR-TKI) 治療的病人時，Giotrif 的建議劑量為 40 mg 口服，一天一次。用於先前曾接受過第一線含鉑類療法之鱗狀組織非小細胞肺癌病人時，Giotrif 的建議劑量為 40 mg 口服，一天一次。Giotrif 不可與食物同時服用。不可在服用 Giotrif 之前至少 3 小時內與之後至少 1 小時內進食。錠劑應配以開水整粒吞服。Giotrif 治療應持續至疾病惡化，或直到病人無法再耐受。【禁忌】 Giotrif 禁用於已知對 afatinib 或本產品之任何其他成分過敏的病人。【警語及注意事項】 腹瀉：Giotrif 治療期間曾有腹瀉 (包括嚴重腹瀉) 的報告。腹瀉的積極處理極為重要，包括適當補充水分，並使用止瀉劑，或直到病人無法再耐受。【禁藥】 Giotrif 禁用於已知對 afatinib 或本產品之任何其他成分過敏的病人。曾有接受 Giotrif 治療的病人發生皮疹/瘙癢的報告。有嚴重或長時間皮膚反應的病人也可能需要暫時停止治療、調降劑量、使用其他醫療介入措施、以及轉診給擅長治療這類皮膚反應的專科醫師。間質性肺炎 (ILD)：在所有臨床試驗中，接受 Giotrif 治療的病人有 0.7% 曾有藥物相關類ILD事件的報告 (包括有 0.5% 病人發生 CTCAE 第 3 級 (含) 以上的類ILD不良反應)。嚴重肝損傷：在 Giotrif 治療期間，曾有不到 1% 的病人發生肝臟衰竭 (包括致死事件)。建議應定期檢測肝功能。對於出現肝功能惡化的病人，可能必須暫停 Giotrif 治療。【不良反應】 在 LUX-Lung 3 試驗 (1200, 32) 中，接受一天一次 Giotrif 40 mg 治療的藥物不良反應 (adverse drug reactions) 整體發生率與 pemetrexed/cisplatin 相近 (100% vs 96%)。接受 Giotrif 治療的病人有 57% 因藥物不良反應而調降劑量。整體而言，調降劑量可降低常見不良事件的發生率。接受一天一次 Giotrif 40 mg 治療的病人因藥物不良反應而中斷治療者較 pemetrexed/cisplatin 組少 (8% vs 12%)。在接受 Giotrif 40 mg 治療的病人中，分別有 1.3% 與 0.0% 病人因腹瀉與皮疹/瘙癢之藥物不良反應而中斷治療。



安立適[®]

ALECENSA[®]

alectinib 150 mg capsules

BEYOND BARRIERS.
BEYOND EXPECTATIONS.

有效 · 安全性佳

PFS 顯著改善¹

CNS 惡化時間顯著改善¹

OS 顯著改善¹

唯一核准於 ALK+ NSCLC
病人術後輔助治療之標靶治療

ALECENSA[®] 處方說明

適應症：

- (1) ALECENSA[®] 適用於 ALK 陽性的晚期非小細胞肺癌 (NSCLC) 病人。
(2) ALECENSA[®] 適用於 ALK 陽性非小細胞肺癌 (NSCLC) 病人切除腫瘤後 (腫瘤 ≥4 公分或淋巴結陽性) 的輔助治療。

用法及用量：

- (1) 治療 ALK 陽性的晚期非小細胞肺癌：ALECENSA[®] 的建議劑量為 600 毫克與食物併服每日兩次。應持續服用 ALECENSA[®]，直到出現疾病惡化的現象或無法耐受的毒性反應為止。切勿打開膠囊或將膠囊內容物溶化使用。如果漏服一劑 ALECENSA[®]，或是在服用一劑 ALECENSA[®] 後發生嘔吐反應，應於排定的時間服用下一劑。
(2) ALK 陽性非小細胞肺癌切除腫瘤後的輔助治療：ALECENSA[®] 的建議劑量為 600 毫克與食物併服每日兩次。應持續服用 ALECENSA[®] 直到疾病復發、出現無法接受的毒性反應或治療達 2 年為止。切勿打開膠囊或將膠囊內容物溶化使用。如果漏服一劑 ALECENSA[®]，或是在服用一劑 ALECENSA[®] 後發生嘔吐反應，應於排定的時間服用下一劑。
(3) 肝功能不全之建議劑量：重度肝功能不全病人 (Child-Pugh C) 的 ALECENSA[®] 建議劑量為 450 毫克每日口服兩次。參見仿單特殊族群注意事項及藥物動力學特性。

警語及副作用：可能不良反應包括肝毒性、間質性肺病 (ILD)、非感染性肺炎、腎功能不全、心悸徐緩、嚴重肌肉痛與肌酸磷酸激酶 (CPK) 升高、溶血性貧血、胚胎 - 胎兒毒性等。

使用前請詳閱說明書警語及注意事項 詳細資料備索 衛部藥輸字第 027028 號 北市衛藥廣字第 號

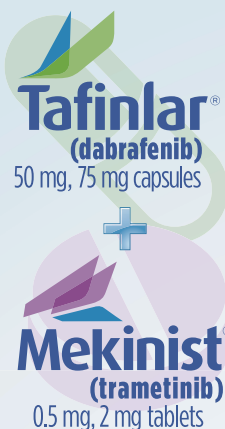
Innovation all for the patients



台灣中外製藥股份有限公司

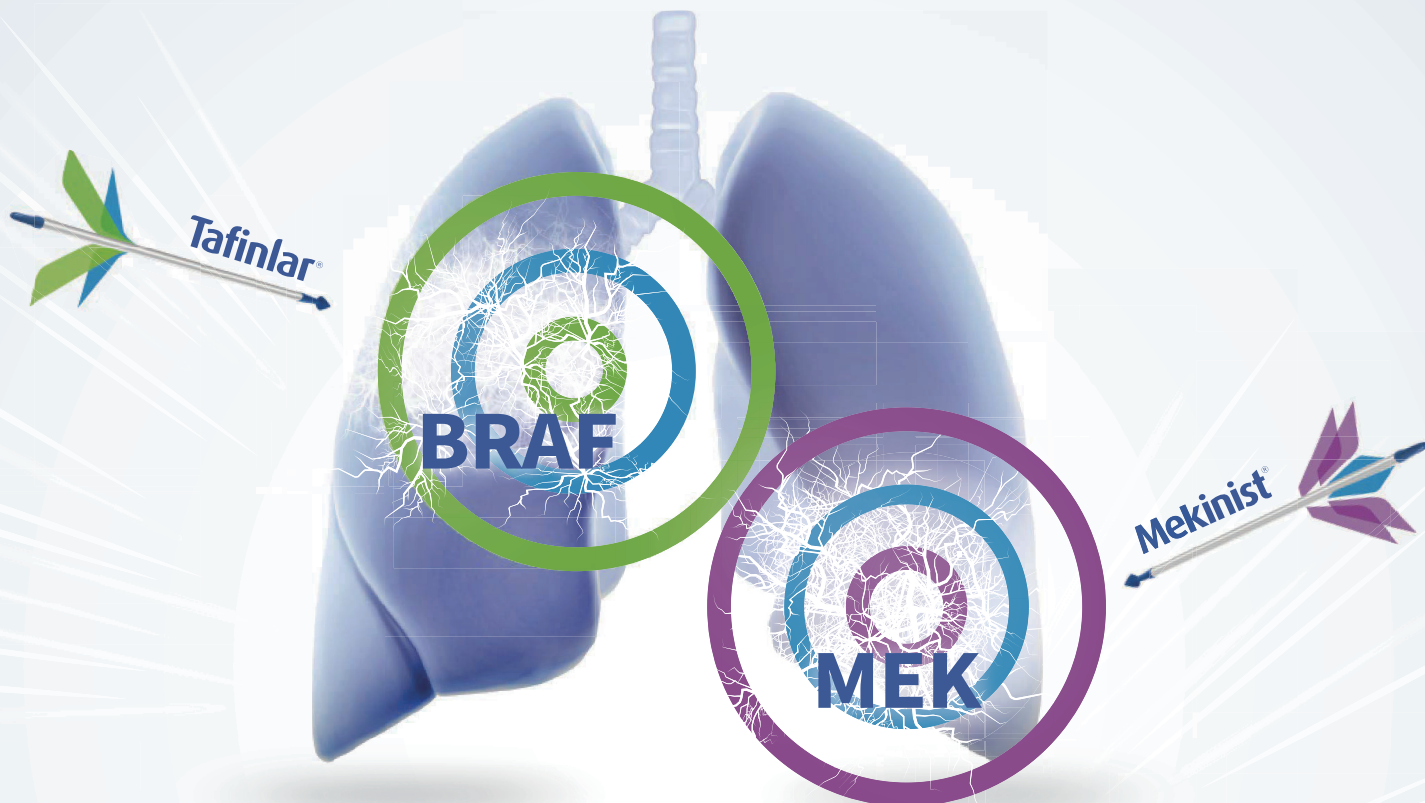
台灣中外製藥股份有限公司
10548 台北市松山區敦化北路 260 號 3 樓

電話：(02)2715-2000
傳真：(02)2715-2100



針對 BRAF V600 突變之 晚期非小細胞肺癌的

雙標靶治療



Identify the Target . Take Action.

泰伏樂 膠囊50/75毫克 (衛部藥輸字第026578/026579 號)

禁忌：對活性成分或任何賦形劑過敏。**警語：**新發生惡性腫瘤。新發生表皮鱗狀細胞癌。新發生原發性黑色素瘤。新發生非皮膚性惡性腫瘤。出血。視力損傷。發燒。左心室功能異常，腎衰竭。肝臟反應。高血壓。間質性肺炎。肺炎。紅疹。嚴重皮膚不良反應。高血糖。G6PD缺乏症。橫紋肌溶解症。胰臟炎。房室傳導阻滯。束支傳導阻滯，靜脈栓塞。肺栓塞。胃腸道異常。嗜血性淋巴組織球增生症。升高胃中pH 值的藥物可能會降低生體可用率。腫瘤溶解症後群。急性發熱性嗜中性球皮膚病。**副作用：**Dabrafenib單一使用：乳突痛，食慾降低，頭痛，咳嗽，噁心，嘔吐，腹瀉，皮膚角化過度，禿髮，皮疹，掌趾紅斑觸痛症候群，關節痛，肌痛，四肢疼痛，發燒，疲倦，發冷，無力。Dabrafenib與Trametinib合併使用：泌尿道感染，鼻咽炎，嗜中性球減少，食慾降低，頭痛，暈眩，高血壓，出血，咳嗽，腹痛，便秘，腹瀉，噁心，嘔吐，皮膚乾燥，瘙癢，紅疹，紅斑，關節痛，肌痛，四肢疼痛，肌肉痙攣，疲倦，發冷，無力，周邊水腫，發燒，類流感疾病，丙胺酸轉胺酶升高，天冬胺酸轉胺酶升高。在兒童安全性彙整資料中發現，體重增加為極常見不良反應。

詳細資訊請掃QR code參閱完整仿單



泰伏樂 膠囊50毫克



泰伏樂 膠囊75毫克

麥欣靈 膜衣錠0.5/2毫克 (衛部藥輸字第026817/026818號)

禁忌：對活性物質或任一賦形劑過敏者。**警語：**黑色素瘤為BRAF V600突變檢測陰性的病人使用trametinib 的安全性及療效未曾被評估。曾經使用BRAF抑制劑時惡化的病人，併用trametinib 與dabrafenib療效較低。過去未曾在BRAF V600突變陽性黑色素瘤已轉移至腦部的病人評估trametinib 與dabrafenib 併用療法的安全性及療效。當trametinib與dabrafenib併用時，有可能發生新的皮膚或非皮膚惡性腫瘤。在RAS突變存在的情況下，使用dabrafenib治療可能會導致發生非皮膚性惡性腫瘤的風險升高。出血。左心室功能障礙。發燒。高血壓。間質性肺炎。肺炎。視覺障礙。皮疹。嚴重皮膚不良反應，高血糖，橫紋肌溶解症。腎衰竭。胰臟炎。QT間期延長。肝臟相關事件。肝功能不全。房室傳導阻滯。束支傳導阻滯。靜脈栓塞。肺栓塞。胃腸異常。嗜血性淋巴組織球增生症。腫瘤溶解症後群。急性發熱性嗜中性球皮膚病。**副作用：**Trametinib 單一治療：高血壓，出血，咳嗽，呼吸困難，腹瀉，噁心，嘔吐，便秘，腹痛，口乾，皮疹，痤瘡樣皮膚炎，皮膚乾燥，皮膚瘙癢，掉髮，疲倦，周邊水腫，發熱，天門冬胺酸轉胺酶增加。Dabrafenib與Trametinib並用：泌尿道感染，咽喉炎，鼻咽炎，嗜中性球減少，食慾降低，頭痛，暈眩，高血壓，出血，咳嗽，腹痛，便秘，腹瀉，噁心，嘔吐，丙胺酸轉胺酶上升，天門冬胺酸轉胺酶上升，皮膚乾燥，瘙癢，紅疹，紅斑，痤瘡性皮膚炎，關節痛，肌痛，四肢疼痛，肌肉痙攣，疲倦，發冷，無力，周邊水腫，發燒，類流感疾病。在兒童安全性彙整資料中發現，體重增加為極常見不良反應。

詳細資訊請掃QR code參閱完整仿單



麥欣靈 膜衣錠0.5毫克



麥欣靈 膜衣錠2毫克

Refined 3rd Generation EGFR TKI



Smart CNS protect
Intracranial PFS 29.0 months²

Sustained PFS
mPFS 19.3 months¹

Reliable safety
Lower incidence rate of skin & gastrointestinal toxicities¹

Reference:
1. Shun Lu et al. J Clin Oncol 2022;40:3162-3171.
2. Shun Lu et al. Cancer Communications. 2024;44:1005-1017.





LIBTAYO[®]

(cemiplimab)

力汰瘤濃縮輸注液



Right Tests for Right Treatments Turn Genomics into ACTions

ACT Onco[®]+

ACT Drug[®]+

ACT Lung[™]



最大化肺癌病患的檢體使用效率



DNA / RNA-based panels 雙管齊下
全方面精準找藥不漏接



75.3%¹

OF

Chance of Identifying Actionable Biomarkers, including:

- FDA In-label Biomarkers
- Biomarkers Recommended by NCCN Guidelines
- Known and Unknown Fusion Partners

1. 2024 Jan 29;60(2):236. doi: 10.3390/medicina60020236.

Make
personalized
medicine
accessible to all
使精準醫療普及



行動基因生技
股份有限公司
www.actgenomics.com



台灣肺癌研究學會

Taiwan Association for the Study of Lung Cancer