

## 國軍左營總醫院放射腫瘤科

## 2026 年口咽下咽癌放射線治療指引

初版放射腫瘤科共識會議日期：2022 年 4 月 7 日(與國軍高雄總醫院放射腫瘤科崔樂平主任)，

初版定案日期：2022 年 4 月 7 日，本版修訂日期：2026 年 6 月 5 日(與國軍高雄總醫院放射腫瘤科崔樂平主任)

期別依據：AJCC 8<sup>th</sup> edition (hypopharynx) or 9<sup>th</sup> edition (oropharynx)

口咽下咽癌放射線治療指引與監測修正對照表

2025	2026	說明
期別依據：AJCC 8 <sup>th</sup> edition (2017)	期別依據：AJCC 9 <sup>th</sup> edition (2026, oropharynx)	更新期別依據
	根治性放射治療技術之 二、無手術之放射治療新增 Reduce field boost 可考慮再做 CT scan simulation 評估療 效，並做為 treatment plan 參考。	Adaptive radiotherapy for H&N cancer
	更新 references	補充

## 口咽癌放射治療適應症

### 一、根治性目的(Curative intent)

#### 1. Early stage

T1-2 , N0 Definitive RT

T0-2 , N1 with single node  $\leq 3\text{cm}$  : Definitive RT or CCRT

#### 2. Locoregional advanced resectable disease : Definitive CCRT or induction chemotherapy followed by RT +/- systemic therapy.

T3-4 , Nany, Tany , N1 (single node  $> 3\text{cm}$  or 2 more ipsilateral node  $\leq 6\text{ cm}$ ) - N3

#### 3. 手術後之輔助性放射治療(Adjuvant radiotherapy)

A. Positive or close margin

B. ENE (Extracapsular nodal extension)

C. LN(+)

D. PNI (Perineural invasion)

E. LVP(Lymphovascular permeation)

F. pT3 or pT4

#### 4. 未產生遠端轉移之局部復發

### 二、緩解性目的(Palliative intent)

#### 1. 無法手術切除 : T4b or unresectable nodal disease 或 T4a 因內科問題或患者意願未接受手術切除

2. 有遠端轉移病灶
3. 併有遠端轉移且產生症狀之局部復發

## 下咽癌放射治療適應症

### 一、根治性目的(Curative intent)

1. Early stage (T1 N0) : Definitive RT
2. Locoregional advanced resectable disease (T1, N+ or T2-4a, any N): Definitive CCRT or induction chemotherapy followed by RT +/- systemic therapy
3. 手術後之輔助性放射治療(Adjuvant radiotherapy)
  - A. Positive or close margin
  - B. ENE (Extracapsular nodal extension)
  - C. LN(+)
  - D. PNI (Perineural invasion)
  - E. LVP(Lymphovascular permeation)
  - F. pT3 or pT4
4. 未產生遠端轉移之局部復發

## 二、緩解性目的(Palliative intent)

1. 無法手術切除 T4b or Unresectable nodal disease 或 T4a 因內科問題或患者意願未接受手術切除
2. 有遠端轉移病灶
3. 併有遠端轉移且產生症狀之局部復發

## 根治性放射治療必要流程

### 一、治療計劃前完整的臨床評估

1. 確認期別、手術紀錄及病理報告，包括組織型態、腫瘤大小、邊緣、有無神經旁侵犯、有無淋巴血管浸潤、有無淋巴結轉移(包括數目/區域)、有無淋巴結膜外侵犯(ENE)。
2. 必要檢驗以排除有全身轉移之可能。
3. 經團隊會議討論及相關科別照會。
4. 必要時會做放射治療前的牙科會診及牙齒處置。

### 二、治療體位設定

1. 病人採仰臥，以頭頸模具固定，治療標記設定於模具及身體上。

### 三、模擬攝影

1. 病人依設定體位躺上電腦斷層攝影床，以金屬線進行必要標記(如手術疤痕、腫大之頸部淋巴、可疑腫塊)，口咽癌視腫瘤位置需要時口中可含 cork 固定，並配合模具固定身體位置。
2. 通常電腦斷層掃描每切面間距為 2.5mm，掃描範圍應包含整個口腔腫瘤及頸部淋巴區域，通常至少包括從眼眶到上縱膈腔。
3. 掃描後應以油性水洗不掉簽字筆作好標記供治療辨認。

#### 四、治療計劃(treatment planning)

1. 臨床腫瘤體積(CTV：clinical target volume)
  - A. 手術後之輔助性放射治療：CTV 包括原發腫瘤區(primary tumor bed)、侵犯淋巴部位/淋巴區以及潛在風險淋巴區。
  - B. 無手術之放射治療：CTV 包括原發腫瘤部位、侵犯淋巴部位/淋巴區以及潛在風險淋巴區。
  - C. 局部復發病人：CTV 包括復發部位。
2. 採用 IMRT 為治療方式，以減少危急器官放射劑量。
3. 治療計劃標靶體積(PTV：planning target volume)：PTV 依 CTV 增加 0.3 至 0.5 公分。鄰近腦幹處，考慮器官忍受劑量可為 0.1 公分。
4. 劑量評估參數：至少包括腦幹、脊髓、腮腺、顛下頷關節，當腫瘤位置較高時，尚要包括眼睛、視神經，視交叉等劑量。

五、放射治療前評估紀錄：包括病理報告、期別、核磁共振或電腦斷層攝影影像報告、病人簡史、理學檢查、重要檢查結果、診斷評估、體能狀態及治療計劃。

六、首次治療前應使用定位照相驗證片以確保照射範圍正確性，並由主治醫師確認簽章後才能進行。

#### 根治性放射治療技術

### 一、手術後之輔助性放射治療

1. 原發腫瘤區(primary tumor bed)給予 60Gy-66Gy，侵犯淋巴部位(involved nodes area)給予 54-63 Gy，未侵犯但有潛在風險淋巴區(uninvolved nodes area)給予 44-50Gy。每天一次，每週五至六次。
2. 若以 conventional sequential two phase radiotherapy 治療，daily fraction: 1.8-2 Gy. Phase I: cover primary tumor with adequate margin and regional lymphatic region at risk with 44-50Gy. Phase II: boost additional dose to primary tumor bed and nodal bed for total 58-66Gy。總治療次數 29-33 次。
3. 若以 Simultaneous Integrated boost(SIB) technique 治療，daily fraction: 2-2.2 Gy for CTV-H (primary tumor bed or involved nodes area); 1.8-2 Gy for CTV-M (high-risk primary tumor bed or involved nodes region); 1.6-1.8 Gy for CTV-L (low-risk uninvolved nodes area)。總治療次數 30-35 次。
4. 輔助性放射治療建議於手術後三至四週後開始實施。

### 二、無手術之放射治療

1. 原發腫瘤部位(primary tumor area) 及侵犯淋巴部位(involved nodes area)給予 66-72Gy，未侵犯但有潛在風險淋巴區(uninvolved nodes area)給予 44-63Gy。總治療次數 33-40 次。每天一次，每週五至六次。
2. 若以 conventional sequential three phase radiotherapy 治療，daily fraction: 1.8-2 Gy. Phase I: cover primary tumor with adequate margin and regional lymphatic region at risk with 44-50Gy. Phase II: boost additional dose to primary tumor and nodal areas with limited margin to totally 55-63Gy。Phase III: boost additional dose to primary tumor and nodal areas to totally 66-72Gy。總治療次數 33-40 次。Reduce field boost 可考慮再做 CT scan simulation 評估療效，並做為 treatment plan 參考。

3. 若以 Simultaneous Integrated boost(SIB) technique 治療，daily fraction：2-2.2 Gy for CTV-H(primary tumor bed or involved nodes area)；1.8-2 Gy for CTV-M(high-risk primary tumor bed or involved nodes region)；1.6-1.8 Gy for CTV-L (low-risk uninvolved nodes area)。總治療次數 35 次。

三、 Example：

1. Postoperative RT：

Simultaneous Integrated boost (SIB) technique：differential “dose painting” for each fraction throughout the entire course

A. For margin positive：

CTV-H<sub>(70Gy)</sub>：2.0Gy x 35Fx

CTV-M<sub>(63Gy)</sub>：1.8Gy x 35Fx

CTV-L<sub>(56Gy)</sub>：1.6Gy x 35Fx

CTV- H<sub>(70Gy)</sub>：primary tumor bed with 0.5-1.0 cm margin

CTV- M<sub>(63Gy)</sub>：primary tumor bed with 1.0-1.5 cm margin/involved nodal area

CTV- L<sub>(56Gy)</sub>：uninvolved nodal area

B. For margin close or ECS of neck node：

CTV-H<sub>(66Gy)</sub>：2.0Gy x 33Fx

CTV-M<sub>(59.4Gy)</sub>：1.8Gy x 33Fx

CTV-L<sub>(52.8Gy)</sub> : 1.6Gy x 33Fx

CTV- H<sub>(66Gy)</sub> : primary tumor bed with 0.5-1.0 cm margin / involved nodal bed

CTV- M<sub>(59.4Gy)</sub> : primary tumor bed with 1.0-1.5 cm margin / involved nodal

area CTV- L<sub>(52.8Gy)</sub> : uninvolved nodal area

C. For other adverse risk features :

CTV-H<sub>(60Gy)</sub> : 2.0Gy x 30Fx

CTV-L<sub>(54Gy)</sub> : 1.8Gy x 30Fx

CTV- H<sub>(60Gy)</sub> : primary tumor bed with 1.0-1.5 cm margin / involved nodal area

CTV- L<sub>(54Gy)</sub> : uninvolved nodal area

**\*\*可根據病人情況調整計畫\*\***

Sequential (Two phases) : deliver the initial phase (week 4-5) followed by high-dose boost volume phase (week 6-7) using 2  
separate dose plans

CTV-H : 60Gy/30fx-70Gy/35fx

CTV-L : 44Gy/22fx-50Gy/25fx

CTV-H : primary tumor bed with 0.5-1.5 cm margin / involved nodal bed with 0.5 cm margin or involved nodal area

CTV-L : uninvolved nodal area

2.Definitive RT :

Simultaneous Integrated boost (SIB) technique : differential “dose painting” for each fraction throughout the entire course

CTV-H<sub>(70Gy)</sub>/CTV-M<sub>(63Gy)</sub>/CTV-L<sub>(56Gy)</sub> : 2.0Gy/1.8Gy/1.6Gy x 35Fx

CTV- H<sub>(70Gy)</sub> : primary tumor with 0.5-1.0 cm margin / involved node with 0.5 cm margin

CTV- M<sub>(63Gy)</sub> : CTV-H+ 0.5-1.0cm margin / involved nodal area

CTV- L<sub>(56Gy)</sub> : uninvolved nodal area

\*\*可根據病人情況調整計畫\*\*

Sequential (Three phases) : deliver the initial phase (week 4-5) followed by moderate-dose boost volume phase (week 5-6.5), then gross tumor boost to high dose (week 6.5 to 8), usually using 3 separate dose plans.

CTV-H:primary tumor with involved nodal area :

66.6Gy/37fx – 75.6Gy/42fx

CTV-M:primary tumor with 1.5-2.0 cm margin / involved node with 1.0-1.5 cm margin or involved nodal level :

57.6 Gy/ 32 fx– 61.2 Gy/ 34 fx

CTV-L:uninvolved nodal area :

41.4Gy/23fx-50.4Gy/28fx

### 重要器官劑量評估參數

NOTE : All dose constraints below should be met whether the patient undergoes 3D-CRT or IMRT techniques.

#### *Critical Normal Structures*

Dose constraints are given below :

Structure	true structure constraint	PRV constraint
Brainstem	54 Gy max dose	no more than 1% to exceed 60 Gy
Spinal Cord	45 Gy max dose	no more than 1% to exceed 50 Gy
Optic Nerves , Chiasm	54Gy max dose	54 Gy max dose
Mandible , TM joint	70 Gy , if not possible then no more than 1cc to exceed 75 Gy	

Parotid glands: Mean dose <26 Gy (optimal) or 30 Gy(acceptable), should be achieved in at least one gland; or at least 50% of one gland will receive < 33 Gy (optimal) or 35Gy(acceptable) (should be achieved in at least one gland).

Submandibular/sublingual glands and oral cavity : Reduce the dose as much as possible.

Other normal structures can be considered:

Each cochlea	No more than 5% receives 55 Gy or more (Mean dose less than 45 Gy)
Eyes	Max dose less than 50 Gy

Lens	Max dose less than 10Gy
Glottic Larynx	Mean dose less than 40 Gy
Esophagus , Postericoid pharynx	Mean dose less than 45 Gy

根治性咽喉癌放射治療常見之副作用及程度分級：

CTCAE v5.0

Adverse event	Grade				
	1	2	3	4	5
Oral pain Definition: A disorder characterized by a sensation of marked discomfort in the mouth, tongue or lips	Mild pain	Moderate pain; limiting Instrumental ADL	Severe pain; limiting self care ADL	-	-
Mucositis oral Definition: A disorder characterized by inflammation of the oral mucosal	Asymptomatic or mild symptoms; intervention nor indicated	Moderate pain; not interfering with oral intake; modified diet indicated	Severe pain; interfering with oral intake	Life-threatening consequences; urgent intervention indicated	death
Dry mouth Definition: A disorder characterized by reduced salivary flow in the oral cavity	Symptomatic(e.g., dry or thick saliva) without significant dietary alteration; unstimulated saliva flow>0.2ml/min	Moderate symptoms; oral intake alteration(e.g., copious water, other lubricants, diet limited to purees and/or soft, moist foods); unstimulated saliva 0.1-0.2 ml/min	Inability to adequately aliment orally; tube feeding or TPN indicated; unstimulated saliva <0.1 ml/min	-	-
Dysphagia Definition: A disorder characterized by difficulty in swallowing	Symptomatic, able to eat regular diet	Symptomatic and altered eating/swallowing	Severely altered eating/swallowing; tube feeding or TPN or hospitalization indicated	Life-Threatening consequences; urgent intervention indicated	Death

Dermatitis radiation	Faint erythema or dry desquamation	Moderate to brisk erythema; patchy moist desquamation, mostly confined to skin folds and creases; moderate edema	Moist desquamation in areas other than skin folds and creases; bleeding induced by minor trauma or abrasion	Life-threatening consequences; skin necrosis or ulceration of full thickness dermis; spontaneous bleeding from involved site; skin graft indicated	Death
Definition: A finding of inflammatory reaction occurring as a result of exposure to biologically effective levels of ionizing radiation					

根治性咽喉癌放射治療可能副作用與處置：

一、急性副作用：

1. 口腔黏膜炎：常以溫開水漱口，嚴重時可請醫師處方漱口劑及藥膏。
2. 嗅覺味覺遲鈍：需配合調節食物口味，在治療後將漸漸恢復。
3. 皮膚炎：減少磨擦，嚴重時可請醫師處方藥膏。
4. 口乾：隨身攜帶水壺漱口或飲用。
5. 下巴、頸部淋巴水腫：嚴重時可請醫師處理或開處方藥物。
6. 短暫性脊髓病變：在治療後將漸漸恢復。
7. 在經濟條件許可下，治療期間可建議病患服用 Glutamine 降低黏膜副作用。

二、慢性副作用：

1. 口乾：隨身攜帶水壺漱口或飲用，嚴重時可請醫師處方藥物。
2. 蛀牙：保持口腔清潔，定期牙科門診防治。
3. 牙關緊閉：練習張口運動。
4. 頸部僵硬：經常做頸部柔軟運動及手部按摩。
5. 中耳炎及聽力減退：定期耳鼻喉科門診追蹤。
6. 少數零星個案且較嚴重的副作用，如腦組織壞死、視神經及視網膜病變、腦幹病變、腦下垂體功能低下、永久性脊髓病變、骨頭壞死、白內障、吞嚥困難、大量出血及中風等等：定期門診追蹤，嚴重時可考慮介入處置。

**參考文獻：**

1. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology: Head and Neck cancers Version 2.2026. Available at [chrome-extension://efaidnbmnnnibpcajpcgclefindmkaj/https://www.nccn.org/professionals/physician\\_gls/pdf/head-and-neck.pdf](https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf). Accessed May 31, 2026.
2. CTCAE v5.0. Common Terminology Criteria for Adverse Events (CTCAE). Published : Nov. 27, 2017.
3. Smith A, Danielle E, Adel E, et al. Determining optimal clinical target volume margins in head and neck cancer based on microscopic extracapsular extension of metastatic neck nodes. *Int J Radiat Oncol Biol Phys.* 2006;64(3):678-683.
4. Chao KS, Wippold FJ, Ozyigit G, et al. Determination and delineation of nodal target volumes for head and neck cancer based on patterns of failure in patients receiving definitive and postoperative IMRT. *Int J Radiat Oncol Biol Phys* 2002 ; 53(5) : 1174-84.
5. Lee NY, deArruda FF, Puri DR, et al. A comparison of intensity-modulated radiation therapy and concomitant boost radiotherapy in the setting of concurrent chemotherapy for locally advanced oropharyngeal carcinoma. *Int J Radiat Oncol Biol Phys.* 2006 ; 66(4) : 966-74.
6. Anderson JD, DeWees TA, Ma DJ, et al. A Prospective Study of Mucosal Sparing Radiation Therapy in Resected Oropharyngeal Cancer Patients. *Int J Radiat Oncol Biol Phys.* 2023;115, 192-201.
7. Ward MC, Koyfman SA, Bakst RL, et al. Retreatment of Recurrent or Second Primary Head and Neck Cancer After Prior Radiation: Executive Summary of the American Radium Society Appropriate Use Criteria. *Int J Radiat Oncol Biol Phys.* 2022;113,759-786.
8. Lu DJ, Luu M, Gay C, et al. Nodal Metastasis Count and Oncologic Outcomes in Head and Neck Cancer: A Secondary Analysis of NRG/RTOG 9501, NRG/RTOG 0234, and EORTC 22931. *Int J Radiat Oncol Biol Phys.* 2022;113,787-795.
9. deArruda FF, Puri DR, Zhung J, et al. Intensity-modulated radiation therapy for the treatment of oropharyngeal carcinoma: the Memorial Sloan-Kettering Cancer Center experience. *Int J Radiat Oncol Biol Phys.* 2006 Feb 1 ; 64(2) : 363-73.

10. Garden AS<sup>1</sup>,DongL,Morrison WH, et al. Patterns of disease recurrence following treatment of oropharyngeal cancer with intensity modulated radiation therapy. *Int J RadiatOncolBiol Phys*. 2013 Mar 15 ; 85(4) : 941-7.
11. Daly ME<sup>1</sup>,Le QT, Maxim PG, et al. Intensity-modulated radiotherapy in the treatment of oropharyngeal cancer : clinical outcomes and patterns of failure. *Int J RadiatOncolBiol Phys*. 2010 Apr ; 76(5) : 1339-46.
12. Lee NY,O'MearaW,Chan K, et al. Concurrent chemotherapy and intensity modulated radiotherapy for locoregionally advanced laryngeal and hypopharyngeal cancers. *Int J RadiatOncolBiolPhys*. 2007 ; 69(2) : 459-68.
13. Overgaard J,HansenHS,SpechtL,et al. Five compared with six fractions per week of conventional radiotherapy of squamous-cell carcinoma of head and neck : DAHANCA 6 and 7 randomized controlled trial. *Lancet*. 2003 ; 362(9388) : 933-40.
14. Bernier J,CooperJS,Pajuk TF, et al. Defining risk levels in locally advanced head and neck cancers : A comparative analysis of concurrent postoperative radiation plus chemotherapy trials of the EORTC (#22931) and RTOG (#9501). *Head Neck*. 2005 ; 27 : 843-50.
15. AdelsteinDJ,et al. An Intergroup Phase III Comparison of Standard Radiation Therapy and Two Schedules of Concurrent Chemoradiotherapy in Patients WithUnresectable Squamous Cell Head and Neck Cancer. *J ClinOncol*. 2003 21 : 92-8.
16. GrégoireV,CocheE,Cosnard G et al. Selection and delineation of lymph node target volumes in head and neck conformal radiotherapy. Proposal for standardizing terminology and procedure based on the surgical experience. *RadiotherOncol*. 2000 Aug ; 56(2) : 135-50.
17. PignonJP,le Maître A,MaillardE,et al. Meta-analysis of chemotherapy in head and neck cancer (MACH-NC): an update on 93 randomised trials and 17,346 patients. *RadiotherOncol*. 2009 ; 92 : 4.
18. Maxwell JH,FerrisRL,GoodingW,et al. Extracapsular spread in head and neck carcinoma: impact of site and human papillomavirus status. *Cancer*. 2013 ; 119 : 3302.
19. Cooper JS,ZhangQ,PajakTF,et al. Long-term follow-up of the RTOG 9501/intergroup phase III trial: postoperative concurrent radiation therapy and chemotherapy in high-risk squamous cell carcinoma of the head and neck. *Int J RadiatOncolBiolPhys*. 2012 ; 84 : 1198.
20. HarariPM,HarrisJ,KiesMS,et al. Postoperative chemoradiotherapy and cetuximab for high-risk squamous cell carcinoma of the head and neck: Radiation Therapy Oncology Group RTOG-0234. *J ClinOncol*. 2014 ; 32 : 2486.

21. AngKK,HarrisJ,Wheeler R, et al. Human papillomavirus and survival of patients with oropharyngeal cancer. *N Engl J Med.* 2010 Jul 1;363(1) : 24-35.
22. MehraR,AngKK,Burtness B, et al. Management of human papillomavirus-positive and human papillomavirus-negative head and neck cancer. *SeminRadiatOncol.* 2012 Jul ; 22(3) : 194-7.
23. VermorkenJB,Remenar E, van Herpen C, et al. Cisplatin,Fluorouracil,andDocetaxel in Unresectable Head and Neck Cancer. *N Engl J Med.* 2007;357 ; 17. (TAX 323)
24. LorchJH,GoloubevaO,Haddad RI, el at. Induction chemotherapy with cisplatin and fluorouracil alone or in combination with docetaxel in locally advanced squamous-cell cancer of the head and neck : long-term results of the TAX 324 randomised phase 3 trial. *Lancet Oncol.* 2011;12:153-9.
25. HittR,GrauJJ,López-Pousa A, et al. A randomized phase III trial comparing induction chemotherapy followed by chemoradiotherapy versus chemoradiotherapy alone as treatment of unresectable head and neck cancer. *Ann Oncol.* 2014 ; 25(1) : 216-25.
26. ForastiereAA,ZhangQ,Weber RS et al. Long-term results of RTOG 91-11: a comparison of three nonsurgical treatment strategies to preserve the larynx in patients with locally advanced larynx cancer. *J ClinOncol.* 2013 Mar 1 ; 31(7) : 845-52.
27. Denis F,GaraudP,Bardet E, et al. Final results of the 94-01 French Head and Neck Oncology and Radiotherapy Group randomized trial comparing radiotherapy alone with concomitant radiochemotherapy in advanced-stage oropharynx carcinoma. *J ClinOncol.* 2004 ; 22(1) : 69-76.
28. Haddad R,O'Neill A, Rabinowits G, et al. Induction chemotherapy followed by concurrent chemoradiotherapy (sequential chemoradiotherapy) versus concurrent chemoradiotherapy alone in locally advanced head and neck cancer (PARADIGM): a randomised phase 3 trial. *Lancet Oncol.* 2013;14(3) : 257-64.
29. GeoffroisL,MartinL,DeRaucourt D, et al. Induction Chemotherapy Followed by Cetuximab Radiotherapy Is Not Superior to Concurrent Chemoradiotherapy for Head and Neck Carcinomas: Results of the GORTEC 2007-02 Phase III Randomized Trial. *J Clin Oncol.*2018;36(31):3077-83..

30. Cohen EE, Karrison TG, Kocherinsky M, et al. Phase III randomized trial of induction chemotherapy in patients with N2 or N3 locally advanced head and neck cancer. *J Clin Oncol*. 2014;32(25):2735-43.
31. RTOG 0920 A phase III study of postoperative radiation therapy (IMRT) +/- cetuximab for locally-advanced resected head and neck cancer.
32. RTOG 1016, Phase III trial of Radiotherapy plus Cetuximab versus chemoradiotherapy in HPV-associated oropharynx cancer.
33. RTOG 1216 Randomized phase II/III trial of surgery and postoperative radiation delivered with concurrent cisplatin versus docetaxel versus docetaxel and cetuximab for high-risk squamous cell cancer of the head and neck.
34. Grégoire V, Evans M, Le QT, et al. Delineation of the primary tumour Clinical Target Volumes (CTV-P) in laryngeal, hypopharyngeal, oropharyngeal and oral cavity squamous cell carcinoma: AIRO, CACA, DAHANCA, EORTC, GEORCC, GORTEC, HKNPCSG, HNCIG, IAG-KHT, LPRHHT, NCIC CTG, NCRI, NRG Oncology, PHNS, SBRT, SOMERA, SRO, SSHNO, TROG consensus guidelines. *Radiother Oncol*. 2018;126:3-24.

### 2026 年口咽下咽癌放射治療品質監測指標

1. 根治性口咽下咽癌病人接受放射治療前，主治醫師對該療程進行確認及簽章比率:閾值:95%  
分子定義：監測期間內，因口咽下咽癌進行根治性放射治療，於接受放射治療前，主治醫師對病患療程進行確認及簽章之人數  
分母定義：監測期間內，因口咽下咽癌進行根治性放射治療總人數
2. 根治性口咽下咽癌病人接受放射治療前，使用定位照相以確保照射範圍正確性之比率:閾值:95%  
分子定義：監測期間內，因口咽下咽癌進行根治性放射治療，於接受放射治療前，使用定位照相或影像導引以確保照射範圍正確性之人數  
分母定義：監測期間內，因口咽下咽癌進行根治性放射治療總人數
3. 根治性口咽下咽癌病人接受放射治療時，劑量符合標準政策之比率:閾值:90%  
分子定義：監測期間內，因口咽下咽癌進行根治性放射治療，於療程完成時，總劑量與標準劑量誤差為正負(含)10%以內之人數  
分母定義：監測期間內，因口咽下咽癌進行根治性放射治療總人數
4. 根治性口咽下咽癌病人接受放射治療時，治療時間符合標準政策之比率:閾值:90%  
分子定義：監測期間內，因口咽下咽癌進行根治性放射治療，於療程完成時，總治療時間與標準治療時間誤差為正負(含)兩週之人數  
分母定義：監測期間內，因口咽下咽癌進行根治性放射治療總人數
5. 根治性口咽下咽癌病人接受放射治療時，治療次數符合標準政策之比率:閾值:90%以上  
分子定義：監測期間內，因口咽下咽癌進行根治性放射治療，於療程完成時，實際次數與標準次數誤差為正負(含)10%以內之人數  
分母定義：監測期間內，因口咽下咽癌進行根治性放射治療總人數

6. 根治性口咽下咽癌病人接受放射治療時，急性期非血液副作用出現第三級或以上之反應的比率:閾值:30%

分子定義：監測期間內，因口咽下咽癌進行根治性放射治療，於療程完成時，急性期副作用出現第三級或以上之反應之人數

分母定義：監測期間內，因口咽下咽癌進行根治性放射治療總人數