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肺部腫瘤

胸腔感染症

胸腔超音波

介入性支氣管鏡檢查及治療

結核病診治

氣喘與慢性阻塞性肺病

末期肺病安寧照護

First talk Abstract:

The widespread implementation of low-dose computed tomography (LDCT) screening has led to a surge in the incidental discovery of small, peripheral, and often multi-focal early-stage lung cancers. While surgical resection remains the gold standard, a substantial subset of patients face barriers due to poor pulmonary reserve, advanced age, or synchronous multi-lobar tumors. Advanced endobronchial technologies—specifically electromagnetic navigation bronchoscopy (ENB) and robotic-assisted bronchoscopy (RAB)—have transformed the management of peripheral pulmonary lesions by providing sub-millimeter stability and direct visual access to the outer third of the lung parenchyma. Navigational and robotic bronchoscopy are shifting from niche diagnostic adjuncts to foundational pillars of a multi-disciplinary therapeutic strategy. By bridging the gap between screening, immediate multi-focal tissue diagnosis, and parenchymal-preserving local treatment, these platforms are highly positioned to reshape future clinical algorithms and become the standard of care for early-stage lung cancer management.

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2. 胸悶、肺炎、肺結核、肺癌
3. 一般內科疾病、胸腔超音波、支氣管鏡檢查

Second talk Abstract:
Neoadjuvant chemoimmunotherapy (chemo-IO) represents a transformative paradigm shift in resectable non-small cell lung cancer (NSCLC) by shifting the management focus from local control to early systemic eradication. Administering immune checkpoint inhibitors combined with platinum-based chemotherapy prior to surgical intervention exploits the intact primary tumor and draining lymph nodes as a rich reservoir of clonal antigens. This maximizes tumor-specific T-cell priming, targeting systemic micrometastases before surgery.
Phase III clinical trials, including CheckMate-816 and the perioperative KEYNOTE-671, AEGEAN, and CheckMate-77T studies, have validated this approach. Chemo-IO significantly improves Event-Free Survival (EFS) and Overall Survival (OS) compared to chemotherapy alone. It yields striking Pathological Complete Response (pCR, 0% viable tumor) rates of 17% to 25%, a powerful surrogate for long-term survival.

Patient selection relies heavily on rapid biomarker screening. While survival benefits span across all PD-L1 expression levels, neoadjuvant chemo-IO is strictly contraindicated in patients harboring oncogenic drivers like EGFR mutations or ALK fusions. These populations derive minimal benefit from immunotherapy and face an elevated risk of severe pneumonitis if given subsequent targeted therapies.

Real-world evidence confirms that pre-operative immunotherapy is safe, maintaining high R0 resection rates without increasing conversion to open thoracotomy. Ongoing clinical focus centers on whether patients achieving ctDNA clearance and pCR can safely de-escalate or completely skip the postoperative adjuvant phase of perioperative protocols, paving the way for personalized, minimal residual disease (MRD)-driven thoracic oncology.