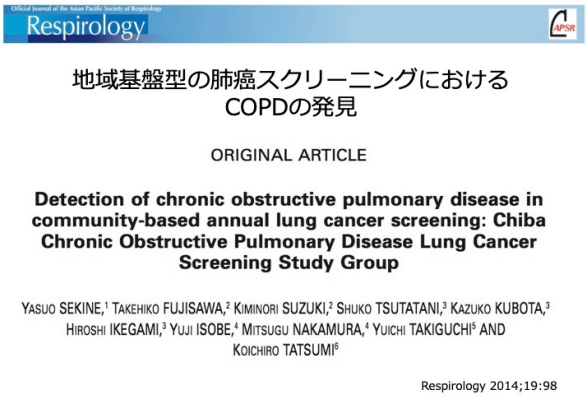
肺がんおよび悪性胸膜中皮腫の治療

肺がんの治療は医師人生 40 年の間で劇的な進化をみた。1979 年大学卒業時、抗癌剤は毒薬に近かった。益と不利益のバランスという考え方はこの当時はなかった。肺がん化学療法の主役である白金製剤シスプラチンは 1983 年に日本で承認されている。シスプラチン単独治療の限界は知られており、1990 年以降に承認された第三世代の抗がん薬の何を加えるのかが一時議論されていた。

2002 年 7 月、EGFR-TKI ゲフィチニブ（イレッサ®）が薬事承認を受けた。この当時は遺伝子変異、ドライバー遺伝子という考え方はなかった。EGFR 遺伝子変異は肺がんのドライバー遺伝子と同定され、それに対する分子標的治療薬として EGFR-TKI ゲフィチニブの有効性が証明された。同時に、有害事象としての薬剤性肺障害である肺線維症の発症が日本を揺るがす問題となった。肺がんドライバー遺伝子の同定が進み、次々と分子標的治療薬の開発が進んで 2020 年の時点に至っている。

がん細胞の免疫機構の異常（非自己と認識しない免疫機構）を制御する、がん免疫治療（免疫チェックポイント阻害薬）ニボルマブ（オプジーボ®）が 2014 年に薬事承認を受けた。テールプラトーというがん患者さんの長期生存が得られる可能性が示唆されている。2018 年ノーベル医学生理学賞を本庶佑 京都大学特別教授が受賞した。



呼吸器内科では、呼吸器外科・千葉県との協力の下、全国の自治体で初めて肺がん（COPD）検診を導入した。肺がんの基礎疾患として COPD を発見して、その経過観察中に早期肺がんを発見して外科手術に持っていこうという試みである。地域基盤型の肺癌スクリーニングにおける COPD 発見の可能性を検討した。60 歳以上の喫煙歴・呼吸器症状があった住民の約 30%は COPD の診断であった。COPD と診断された住民の半数は中等症・重症 COPD であったが、医療機関で診断・加療されている COPD 患者さんは極めて少数であった（Respirology 2014;19:98-104）。

アスベストの健康被害の一つである悪性胸膜中皮腫は数十年後に発現する。千葉県がんセンターの田川雅敏博士が主導で世界で初めて「NK4 遺伝子発現ベクターを用いた悪性中皮腫の臨床研究」を施行した。NK4 は正常な細胞を傷つけず、がん細胞の増殖を抑制して栄養供給血管を断つという効果が期待される。呼吸器内科のがん免疫研究のかなりの部分は田川雅敏博士の指導によるものである。下記の【免疫】業績に挙げるように、多田裕司が千葉県がんセンターの田川雅敏博士の指導を受けた時点から開始している。

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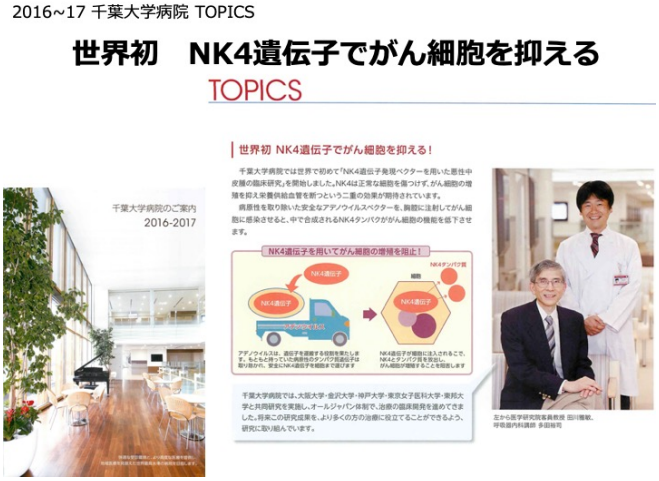

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