

Bölüm 27

MEME KANSERİ TEDAVİSİNDE ELEKTROKEMOTERAPİ UYGULAMALARI



Çağrı BÜYÜKKASAP¹
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GİRİŞ

Meme kanseri, dünyada akciğer kanserinden sonra 2. en sık görülen ayrıca kadınlarda kanser ölümlerine bakıldığında ise ilk sırada yer alan kanserdir. 5 yıllık hayatta kalma oranı yaklaşık olarak %90'lardadır (1). Meme kanserinde multidisipliner yaklaşım, tedaviyi olumlu olarak etkilemekte, mortalitenin azalmasına yardımcı olmaktadır. Multidisipliner yaklaşım, cerrahi onkolog, radyasyon onkoloğu ve medikal onkoloğun birlikte olduğu bir ekiptir (2).

MEME KANSERİ RİSK FAKTÖRLERİ

Yaş: Yaş ile birlikte meme kanseri görülme riski artar. 49 yaşında bir kadının meme kanseri olma riski %2.1 iken, 8 kadından biri hayatı boyunca meme kanserine yakalanma riski taşır (1).

Cinsiyet: Meme kanseri kadınlarda erkeklere oranla 100 kat fazla meme kanseri görülür (1).

Obezite: Obezite (Beden Kitle İndeksi ≥ 30), mortalite ve morbiditenin artışıyla ilişkilidir genel bir artış ile ilişkilidir. Bununla birlikte, beden kitle indeksi (BKİ) ile ilişkili meme kanseri riski menopoza durumuna göre farklılık gösterir.

Daha yüksek BKİ veya perimenapozal kilo alımı artmış meme kanseri riski ile ilişkili bulunmuştur (3). Buna ek olarak 1000'den fazla epidemiyolojik çalışmanın meta analizinde BKİ'si yüksek olan hastalarda özellikle östrojen reseptör pozitif meme kanseri olmak üzere, artmış meme kanseri riski ile ilişkili bulunmuştur (4). Bu ilişki adipoz dokudan salgılanan östrojen prekürsörlerinin periferik dönüşümle östrojene dönüşmesi ve bu sayede östrojen seviyesindeki artıştan kaynaklandığı düşünülmektedir (5,6).

Premenopozal dönemde ise durum daha farklıdır. Premenopozal dönemde BKİ yüksekliği özellikle erişkinliğin ilk dönemlerinde meme kanseri riskini azalttığı bulunmuştur (7, 8). Buna karşın 19 prospektif kohorttan yaklaşık 760.000 premenopozal kadının kişisel verilerini kullanan geniş bir çalışmada ise 18-24 yaş aralığındaki en düşük ve en yüksek BKİ aralığı karşılaştırıldığında BKİ yüksekliğinin riski 4.2 kat artırdığı bulunmuştur. Bu değerlendirmenin açıklaması hala netleştirilememiştir (8).

Boy: Uzun boy hem premenapozal hem de postmenapozal dönemde artmış meme kanseri riski ile ilişkilidir (9). Mekanizma tam olarak ay-

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ileri bir çalışma hedefi olarak cerrahların ve onkologların önünde durmaktadır. Özellikle T3 ve T4 meme kanserlerinde ya da meme koruyucu cerrahi planlanan hastalarda neoadjuvan tedavi yöntemleri günümüzde kılavuzlarca önerilmekte ve kullanılmaktadır (122). Özellikle lokal ileri veya inflamatuvar meme kanseri gibi inoperable hastalarda; N2 veya N3 olan hastalarda; T4 tümörlerde önerilmektedir. Ayrıca meme koruyucu cerrahi planlanan hastalarda kitle boyutu küçültmek ve cerrahi sonrası negatif sınır sağlayabilme amacıyla da uygulanmaktadır. Elektrokemoterapi bu hasta grupların neoadjuvan tedavilerinde fayda sağlayabilir. 2013'te Cabula primer meme kanseri için EKT ile tedavi edilen bir hastada elde edilen pozitif sonuçları yayınlamıştır (123).

SONUÇ

Bu yöntem meme kanserinin cilde metastazlarının kanamalı, ekzotik tümör oluşumuyla birlikte görüldüğü ama cerrahi rezeksiyon için uygun olmayan veya sistemik tedaviye yanıt alınamayan hastaların yaşam kalitesinin önemli ölçüde iyileşmesine olanak tanır. Neoadjuvan tedavide kullanımı ise cerrahları ve onkologlar için bir çalışma hedefi olabilir.

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