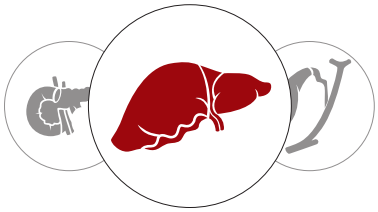

BÖLÜM 14

Hepatoselluler Karsinom

Ayşe KEFELİ [1]

ÖZET

Hepatoselluler Karsinom (HSK), karaciğer en sık primer tümörüdür ve tüm kanserler arasında 6. sıklıkta, kansere bağlı ölümler arasında 4. sırada yer alır. Hepatoselluler Karsinom, sıklıkla sirotik karaciğerden kaynaklansa da siroz olmadan da HSK gelişebilir. Erken dönemde semptoma neden olmaması nedeniyle sıklıkla geç tanı konulur. Küratif tek tedavi seçeneği cerrahi rezeksiyon ve karaciğer nakli olması ve ileri hastalıkta kür şansı olmaması nedeniyle yüksek riskli hastalara tarama önerilir. Sirotik hastalar ve diğer yüksek riskli hastalar ultrasonografi (USG) ile nodül varlığı açısından taranırlar. Bazı kılavuzlar USG ile AFP bakılmasını da önerir. Tanı sıklıkla USG'de tespit edilen nodülün kontrastlı görünütülemede tipik boyanma özelliği göstermesi ile konulur. Nadiren biyopsi gereklidir. Hepatoselluler Karsinom tanısı alan hastalarda tedavi kararı, hastanın performans durumu, kitlenin morfolojik özellkileri, karaciğer fonksiyonlarına göre verilir. Uygun hastada cerrahi rezeksiyon küratif tedavidir. Cerrahi rezeksiyon yapılmadığından nakil kriterlerini karşılayan hastalara karaciğer nakli yapılabilir böylelikle altta yatan karaciğer hastalığı da tedavi edilebilir. Cerrahi ya da karaciğer nakli için uygun olmayan hastalara lokal ablasyon ya da embolizasyon tedavileri uygulanabilir. Radyofrekans ablasyon ve transarteryal embolizasyon gibi tedavilerin başarıları oldukça iyidir. Tüm bu seçenekler uygun olmadığında sistemik tedavi verilebilir ancak sisitemik tedavi ile kür elde edilemez ancak sağ kalım süresi uzatılabilir.

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Sorafenib: PDGF, VEGF reseptör kinaz inhibitörüdür Sorafenib, radyolojik tedavilere dahi uygun olmayan ve Child-A karaciğer fonksiyonuna sahip ileri evre vakaların (makrovasküler invazyon veya ekstrahepatik metastaz) ilk basamak tedavisi için önerilmektedir. Child-B'de hepatik dekompansasyon gelişebileceği için dikkatle kullanılmalıdır. Bu nedenle genellikle Child-Pugh skoru 7'nin üzerinde veya dekompanse sirozu olan vakalar için önerilmez. Tedavinin kesilmesinin veya doz azaltımının en yaygın nedenleri el-ayak deri reaksiyonu, döküntü ve ishaldir (124).

Regorafenib: Yeni bir multikinaz inhibitörü olup çoklu anjiyogenik yolaklara (VEGFR, PDGFR, TIE2 ve FGFR) ve onkojenik yolaklara (RET, KIT, c-RAF / RAF-1 ve BRAF) karşı sorafenibden daha güçlü inhibitör aktivitelere sahiptir. En sık görülen yan etkileri hipertansiyon, el-ayak cilt reaksiyonu, yorgunluk ve ishaldir (1).

Lenvatinib: Özellikle sorafenib tolere edemeyen veya edemeyeceklerde ilk seçenek tedavidir. Viral etyolojiler dışındaki sebeplerle kronik karaciğer hastalığında sorafenib yerine tercih edilmesi konusunda görüşler net değildir.

Atezolizumab ve bevacizumab: Child Pugh A sirozluda ve performans durumu iyi olanlarda ilk seçenek tedavi olarak tercih edilebilir.

İkinci Basamak Tedavi

Tedavi altında iken büyüyen tümörlerde veya birinci basamak tedaviyi tolere edemeyenlerde ikinci basamak tedavi uygulanır. En iyi rejim oluşturulmamıştır ve bir ajanın diğerine tercih edilmesine rehberlik edecek hiçbir biyo-belirteç yoktur. Tirozin kinaz inhibitörleri (yani, sorafenib [birinci basamak tedavi için uygulanmadıysa] veya regorafenib) veya immün kontrol noktası inhibitörleri nivolumab veya pembrolizumab kullanılabilir. İlerlemiş karaciğer hastalığı ve/veya yaşam beklentisi kısa olan hastalarda her bir rejimin yan etki profili dikkatle değerlendirilmelidir. Lenvatinib, sorafenib başarısızlığından sonra başka bir tedavi seçeneğidir (126,127,128). Ancak sorafenib başarısız olduktan sonra lenvatinibin işe yarayıp yaramayacağı bilinmemektedir. Birinci basamak olarak kullanılan atezolizumab artı bevacizumabın başarısızlığından sonra ikinci basamak tedaviyi inceleyen hiçbir çalışma yoktur.

Mevcut veriler, çeşitli geleneksel sitotoksik ajanlar ve/veya kombinasyon ilaç rejimleri için orta düzeyde bir antitümör etkinliği olduğunu göstermektedir. Bununla birlikte, özellikle moleküler hedefli tedaviler ve immünoterapideki gelişmeler ışığında sitotoksik kemoterapi için uygun hasta seçimi net değildir.

Hepatit B virüs reaktivasyonu — Sistemik kemoterapi gören HSK hastalarında viral hepatit reaktivasyonu meydana gelebilir, bu nedenle antiviral ilaçları sürdürmek önemlidir.

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