BÖLÜM 6

PROLİFERATİF VE PREKÜRSÖR LEZYONLAR

Tuba KARA[1]
Derya ERDOĞAN[2]

GİRİŞ

İntraduktal proliferatif lezyonlar (IDPL), değişen derecelerde artmış kanser riski taşıyan, bazıları kanser göstergesi iken bir kısmı invaziv meme kanseri (İMK) prekürsörü olan lezyonlardır (1,2). Bu lezyonları tanımlamak için "İntraduktal" terimi kullanılsa da en sık terminal duktal lobuler ünite (TDLU)'den kaynaklanırlar (1-3). Daha küçük bir kısmı ise daha büyük ve laktiferöz duktus orijinlidir.

Terminoloji

IDPL geleneksel olarak 3 kategoriye ayrılır: Olağan duktal hiperplazi (ODH), Atipik duktal Hiperplazi (ADH), Duktal karsinoma in situ (DKIS) (1-5). Çoğu vakada bu farklı kategorilerin ayrımı morfoloji ile standart histopatolojik kriterlere göre yapılabilir. Bununla birlikte bazı lezyonların, örneğin ADH ve bazı düşük dereceli DKIS (DD-DKIS) ayrımı problem oluşturabilir. Ayrıca mammografi taramalarının artması ile birlikte sitolojik atipi gösteren, ancak sitolojik ve yapısal olarak ADH veya DKIS kriterlerini tam olarak taşımayan lezyonların saptanması da artış göstermektedir. Belirgin proliferasyon göstermeyen ve geçmişte klinging karsinom, atipik kistik lobul ve atipik asiner değişiklik olarak isimlendirilen lezyonlar artık Flat Epitelya Atipi (FEA) olarak isimlendirilmektedir (1-4).

Dünyada yaygın olarak kullanılan IDPL sınıflama sistemi özellikle ADH ve küçük DD-DKIS lezyonlarını ayırmada gözlemciler arası uyumsuzluklar göstermektedir. Geçtiğimiz dekatta geleneksel terminoloji yerine "Duktal İntraepitelyal Neoplazi" terimi kullanılmış, karsinom ise invaziv tümörlerde kullanılmıştır (6). Ancak yeni bir tanı kriteri eklemeyip, gözlemciler arası uyuma katkısı olmadığından bu isimlendirme pek kabul görmemiştir. Moleküler gelişmeler ve genetik bilgiler ise geleneksel sınıflamayı geliştirmeye katkı sağlamaktadır. Standart tanı kriterlerinin kullanılması gözlemcilerarası tanısal uyumu arttırmaktadır.

İnvaziv Karsinoma Progresyon

Klinik çalışmalarda İDPL'ların, invaziv kanser gelişimi için değişken seviyelerde risk taşıdığı gösterilmiştir. Bu risk ODH için 1.5 kat iken, ADH için 4-5 kat, DKIS için ise 8-10 kat'tır (7-11). İmmunfenotipik ve genetik çalışmalar ile normal meme epitelinden progresyon ile basitçe ODH, ADH,

[1] Prof Dr., Patoloji, Mersin Üniversitesi Tıp Fakültesi Patoloji AD, karabacaktuba@hotmail.com
[2] Arş. Gör. Dr., Patoloji, Mersin Üniversitesi Tıp Fakültesi Patoloji AD, drderyaerdoğan@gmail.com

Pleomorfik ve Florid LKIS'nün doğal seyri hakkındaki bilgiler son derece sınırlıdır, negatif sınırların önemi ve adjuvan radyasyonun herhangi bir potansiyel yararı olup olmadığı da dahil olmak üzere belirsizliğini korumaktadır. Konservatif cerrahi ve/veya antiöstrojen tedavi alan pleomorfik LKIS'nün bildirilen nüks oranları % 0-57'dir ve tekrarlayan lezyonlar pleomorfik LKIS, DKIS, İLK veya İDK olabilir (70). Pozitif sınır durumunun nüks olasılığını etkileyip etkilemediği açık değildir, ancak bu çalışmalardan elde edilen sonuçlar, Pleomorfik LKIS için mümkünse negatif sınırlara sahip cerrahi eksizyonun yapılması görüşünü desteklemektedir. İğne biyopside pleomorfik LKIS ve florid LKIS'li vakaların yaklaşık %25-60'ının eksizyonunda karsinom saptanmaktadır. Sınırlamalar olmasına rağmen çalışmalardan elde edilen verilere göre, DSÖ iğne biyopsisinde teşhis edilen pleomorfik LKIS ve Florid LKIS için eksizyonu önermektedir (70,71).

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