BÖLÜM 9

MALİGN EPİTELYAL TÜMÖRLER -II

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GİRİŞ

Meme kanseri kadınlarda en sık görülen kanser türüdür, kadın kanserlerinin % 23'ünü oluşturur ve kadınlarda kansere bağlı ölümlerin ikinci önde gelen nedenidir. Gelişmekte olan ülkelerde değişen yaşam tarzı nedeniyle meme kanseri görülme sıklığı artmıştır. Geçen yüzyılın başında, hastanın meme kanseri olduğunu bilmek yeterliydi ve tüm meme kanseri hastalarına aynı tür tedavi uygulanıyordu. Ancak zaman içerisinde, aynı kanser tipine sahip hastaların farklı prognozlarının gözlemlenmesi ve son 50 yılda patologlar tarafından farklı morfolojik varyantların tanımlanması, meme kanseri sınıflandırmasının önemini ön plana çıkarmıştır (1).

İNVAZİV MİKROPAPİLLER KARSİNOM

İnvaziv Mikropapiller karsinom (IMPK), ilk olarak 1980 yılında Fisher ve ark.(2) tarafından tanımlanmış ve 1993 yılında Petersen ve ark.(3) tarafından invaziv meme kanserinin bir alt tipi olarak kabul edilmiştir. IMPK, tüm invaziv meme kanseri vakalarının yaklaşık %2-8'ini oluşturan, invaziv duktal karsinomun (IDK) agresif bir varyantı olarak kabul edilmektedir (1). IMPK, meme kanserinin nadir görülen bir patolojik alt tipidir ve IMPK'un saf varyantı daha da nadirdir. Önceki çalışmalar çoğu hastanın (% 80-86) mikst tipte tümörler içinde IMPK'a sahip olduğunu göstermiştir (4). IMPK, yüksek lenfovasküler invazyon (LVI), lenf nodu (LN) metastazı eğilimi gösterir, dolayısıyla IDK'den daha agresif bir davranış sergiler (1,4,5).

Mikroskobik olarak, invaziv papiller karsinom ile karşılaştırıldığında, IMPK genellikle fibrovasküler kor içermeyen, daha küçük epitel yuvaları ve bunların etrafında boşluklardan oluşur (*Resim 1*). Her boşlukta genellikle bir veya seyrek olarak daha fazla mikropapiller yapı bulunur (6). IMPK'nin morfolojisi farklıdır ve immünohistokimyasal olarak epitel membran antijeni (EMA), psödopapiller neoplazm veya glandüler yapının periferinde immünekspresyon gösterir. Çoğu IMPK vakası, en yaygın olarak invaziv duktal karsinomda olmak üzere, diğer invaziv meme karsinom tipleri ile birlikte görülmektedir. % 25'lik nodal metastaz insidansı, hastalarda sık nüks ve kötü prognoz göstergesidir. 5 yıllık genel sağkalım oranı % 87,5'tir. Mikropapiller yapıların oranı <%

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Küçük hücreli karsinomlar, vakaların % 30-60'ında ER ekspresyonu gösterir ve tipik olarak HER2-negatiftir. Memeye metastatik küçük hücreli karsinom, klinik olarak veya belirsiz durumlarda görüntüleme yoluyla dışlanmalıdır (64).

SONUÇ

Yeni WHO 2019 mavi kitaba göre tümör sınıflamasında bazı değişiklikler olmuştur. Nöroendokrin özellik gösteren meme tümörleri, nöroendokrin tümör ve nöroendokrin karsinom olarak primer nöroendokrin tümörler olarak sınıflandırılmıştır. Müsinöz kistadenokarsinom ve ters polariteli tall cell karsinom yeni başlıklar altında sınıflamaya eklenmiştir. Meme kanserli hastalarda, tümör tipi, hormon reseptör durumu (ER,PR), Her 2 skorlaması, tümör boyutu, nodal tutulum ve lenfovasküler invazyon gibi parametreler hastanın prognozunu belirlemede önemlidir. Meme kanserinde doğru tanı konulması, hangi aşamada olduğu ve alacağı tedaviye bağlı olarak günlük hayatı birçok yönden etkileyebilir. Bu nedenle bu yazımızda meme tümörlerine ait tanılar güncel bilgiler ışığında anlatılmıştır.

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