Bölüm
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METASTATİK MEME KANSERİNDE SİSTEMİK KEMOTERAPİ

Ahmet SEZER[1]

GİRİŞ

Meme kanseri kadınlarda en sık tanı alan kanser olmasının yanında en çok kanser ilişkili ölüm sebebidir(1). Tüm erken tanı uygulamalarına ve uygulamaların başarılarına rağmen günümüzde halen hastaların %5-10'u ilk tanı anında metastatik evrededir. Aynı zamanda erken dönemde tanı alan hastaların yaklaşık %25-30'unda da hayatın bir döneminde metastaz gelişmektedir(2).

Metastatik meme kanserinde sistemik tedavinin hedefi;sağ kalımı uzatmak ve semptomları azaltmakla birlikte yaşam kalitesini iyileştirmek, sürdürmek ve tedavi ilişkili toksisiteleri engellemektir(3-4). Bu nedenle en az yan etkili tedavi rejimlerinin seçilmesi önerilir(5).

Metastatik meme kanserinde sistemik tedavi kemoterapi, endokrin tedavi ve hedefleyici tedavilerden (anti-her 2 tedaviler, PARP inhibitörü, PI3K inhibitörü, CDK4/6 inhibitörü, immunoterapi vb) oluşur (5,6).

Bu tedaviler tek başına veya kombine şekilde kullanılabilmektedir (7,8). Tedavi kararı verirken bazı faktörleri göz önünde bulundurmak gerekir(4). Bunlar arasında; hastanın performans durumu, hastanın yaşı, hastalığın yaygınlığı (viseral kriz olup olmaması), metastaz yeri, tahmin edilen sağ kalım süresi, hastanın denovo metastatik olup-olmadığı, adjuvan tedavi sonrası metastatik hale gelen hastanın daha önce aldığı tedaviler ve bu tedaviler ilgili toksisiteler, adjuvan tedavi sonrası rekürrensiz geçen süre, önceki basamaklarda hormon tedavisi kullanıp direnç gelişmesi, hastalığın hızlı progresyon göstermesi, hastalığın histolojik alt tipi (östrojen-progesteron reseptörü, her2, BRCA 1/2), hastanın tercihi, hastanın ek hastalıkları (diabet, koroner arter hastalığı, kalp yetmezliği vb) sayılabilir.

[1] Doç. Dr. ,Başkent Üniversitesi Tıp Fak.,drasezer@hotmail.com.tr

sının etkisi karşılaştırılmıştır(56). İdame tedavi alan kolda hem PFS hem OS de anlamlı fark gösterilmiştir. Kemoterapiye devam etmeyi düşünürken göz önüne alınması gereken faktörler: Hastanın istek ve beklentileri, başlangıç kemoterapisine olan yanıt, devam edilmesi istenen kemoterapi, hastanın toleransı (toksisite ve maliyet vb diğer sebepler), her-2 durumu/anti-her 2 tedaviye uygunluk, ER durumu ve daha önceki endokrin tedavilere karşı tolerans ve deneyimdir. ESMO klavuzu antrasiklinler hariç genelde tüm rejimlerin hastalık progresyonuna kadar yada kabul edilemez bir toksisiteye kadar kullanılmasını önermektedir(57).

Hangi kemoterapi:

Anti her 2 tedavi alan hastalarda bu tedaviye eklenecek kemoterapi rejimleri bilinmektedir. Örneğin herceptin docetaxel,paclitaxel,nab paclitaxel veya vinorelbine ile kullanılırken, pertuzumab-herceptin kombinasyonu dosetaxel veya paclitaxel ile kullanılmaktadır. Yine bir anti her 2 oral ajan olan lapatinib kapesitabine ile birlikte etkili bulunmuştur. Diğer hastalarda seçim hastanın tercihine (tedavi sıklığı, saç dökülmesi, intavenöz veya oral tedavi vb), hastanın ek komorbiditelerine (nöropatide taksanlar, kalp yetmezliğinde antrasiklinler vb.), elde edilmek istenen terapötik etkiye ve hekimin deneyimine bağlıdır. Tek ajan rejimler olarak taksanlar ve antrasiklinler en etkili ajanlar olarak bilinmektedir(58). Eğer bu ajanlar ile ilgili bir kontrendikasyon yok ise ilk basamaklarda bu ajanlar tercih edilmelidir(24). Bazı histolojik alt tiplerde (triple negatif meme kanseri, BRCA 1-2 mutasyonu) belli etkili kemoterapiler (eribulin, platin, docetaxel vb) vardır.

SONUÇ

Metastatik meme kanserinde sistemik kemoterapinin kullanımı halen belli bir hasta grubunda yerini korumaktadır. Hastalar sistemik kemoterapiden önce endokrin veya hedefe yönelik tedaviler açısından değerlendirilmelidir. Hastalara sistemik kemoterapi seçimi yaparken tüm faktörler göz önüne tutulmalıdır.

Anahtar Kelimeler: metastatik meme kanseri, sistemik kemoterapi.

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