6. BÖLÜM

POSTOPERATİF ENDOMETRİUM KANSERİNDE BRAKİTERAPİ

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GİRİŞ

Endometrium kanseri ABD ve Avrupa ülkelerinde en sık rastlanan jinekolojik malignite olup kadınlarda en sık görülen kanserler arasında dördüncü sıradadır(1). Sıklıkla postmenapozal kadınlarda görülmekle birlikte , premenapozal kadınlarda rastlanma oranı % 14 civarındadır (2).

ETİYOLOJİ

Endometrium kanserinin en sık görülen tipi olan endometrioid karsinomun en önemli nedeni eksojen ve endojen östrojen maruziyetidir(3). Erken menarş, geç menapoz, nulliparite, infertilite, obezite, östrojen üreten over tümörleri, tamoksifen kullanımı nedenler arasında sayılabilir. Ayrıca hipertansiyon ve Tip 2 diabetes mellituslu kadınlarda endometrium kanseri riski artmaktadır(4).

Atipik endometrial hiperplazi tanısı alan hastalarda endometrium kanseri gelişme riski %30-40 olarak belirlenmiştir(5).

Aile öyküsünde Lynch sendromu veya Herediter Non Polipozis Kolon Kanseri(HNPKK) olan bireylerde 50 yaştan önce endometrium kanseri görülme riski artmaktadır(6,7,8).

BİYOLOJİK KARAKTERİSTİKLER VE MOLEKÜLER BİYOLOJİ

İki farklı endometrium kanseri tipi 1983'te Bokhman tarafından tanımlanmıştır. Bu tanımlamaya göre Tip 1 tümörler östrojen bağımlı, hiperplazi ile ilişkili, düşük gradeli ve iyi prognoza sahip endometrioid histolojiye sahiptir.

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VBT, gastrointestinal ve genitoüriner yan etkiler açısından EBRT'ye göre daha masum olsa da %0.5-2 arasında değişen oranlarda vajnal stenoz, rektovajinal fistül, vajinal nekroz gibi yan etkilere yol açabilmektedir(63). Endometriyum kanserinin erken tanı konabilen, büyük oranda iyi prognozlu histopatolojik özelliklere sahip, tedavi yanıtı yüksek ve uzun sağkalım beklentisi olan bir hastalık olduğu gözönünde bulundurulacak olursak, bu tip yan etkilerin yaşam kalitesini son derece olumsuz etkileyeceği açıktır. Bu nedenle, ABS tarafından da önerildiği üzere, her hasta için anlaşılır ve açık, tedavi alanı, kaynak, fraksiyon başına verilecek doz, total doz, ve fraksiyonasyon şemasının kaydedildiği, minimum oranda yan etkiye neden olabilecek doz dağılımına sahip tedavi planları oluşturulmalı, tedavi başında aplikatör seçimi iyi yapılmalı, kullanılacak dwell'in pozisyonu, ağırlığı gibi bilgiler fraksiyonlar arasında uyumsuzluğa sebep olmamak için mutlaka kaydedilmelidir(38).

SONUÇ

Endometriyal kanser, tüm dünyada, postmenapozal kadınlarda en sık görülen jinekolojik malignitedir ve insidansı giderek artmaktadır. Primer tedavisi cerrahidir. Genellikle TAH+BSO uygulanır, duruma göre lenfadenektomi cerrahi prosedüre eklenebilir. Rekürrens açısından risk taşıyan olgularda, adjuvan radyoterapi tedaviye eklenir. Bu risk faktörleri, > 60 yaş, grade 3 histoloji, %50 ve daha fazla miyometriyal invazyon, LVI varlığı, non-endometrioid tümör histolojisi, lenf nodu metastazı, ve serviks veya vajene tümör uzanımıdır. Endometriyum kanseri tanısı konan hastaların yaklaşık %70'i, FIGO Evreleme Sistemi'ne göre Evre I olup grade 3 histoloji, LVI veya > %50 miyometriyal invazyon varlığına göre orta risk veya yüksek-orta risk alt gruplarına ayrılır. Çok sayıda prospektif çalışma, uterusa sınırlı hastalıkta,VBT'nin EBRT ile kıyaslandığında, daha düşük toksisite profili ve benzer klinik terapötik etkinliğe sahip olduğunu göstermiştir. Dünya çapında tanımlanan yönergelere uygun şekilde hasta seçimi ve tedavi planlaması yapıldığında VBT ile mükemmel sonuçlar elde edilmektedir.

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