# 25. BÖLÜM

# GASTROİNTESTİNAL KANSERLERDE İNTERSTİSYEL BRAKİTERAPİ

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## GİRİŞ

Radyoterapi (RT) gastrointestinal sistem(GIS) kanserlerinin multimodal tedavisinin vazgeçilmez bir parçasıdır. Görüntü eşliğinde RT, yoğunluk ayarlı RT, stereotaktik radyocerrahi gibi teknik gelişmeler sayesinde eksternal beden radyoterapisi (EBRT) hassasiyetinde ve doğruluğunda artış olmasına rağmen, GIS kanserlerinde terapötik dozlar çevre normal doku tolerans dozları sebebiyle sınırlı kalmaktadır. İnterstisyel brakiterapi (iBT) teknikleri normal doku toksisitesini arttırmadan, güvenli ve etkili bir şekilde hedef dokuda doz yükseltilmesine olanak sağlar. Karaciğer, safra yolları, pankreas ve anal kanserlerde girişimsel radyoloji tekniklerinin yardımı ile etkili ve güvenli iBT uygulamaları mümkün hale gelmektedir[1].

## KARACİĞER TÜMÖRLERİNDE İNTERSTİSYEL BRAKİTERAPİ

Karaciğerin primer ve sekonder malignitelerinin tanı ve tedavisi son yıllarda gelişmekte olan bir konudur[2,3]. Cerrahi hem primer hem sekonder karaciğer tümörlerde başlıca küratif tedavi yaklaşımıdır ancak yalnızca %20 -30'ya uygulanabilir[4]. Hepatoselüler karsinomda(HCC) da küçük bir grup hasta cerrahi rezeksiyon ve karaciğer transplantasyonu için uygun bulunmakta ve bu tedavilerden faydalanabilmektedir [5]. Küçük karaciğer metastazlı kolorektal kanser hastalarında 5 yıllık sağkalım oranları %7-58 arasında değişmektedir[6,7] fakat bu hastaların %25'inden azı potansiyel bir küratif tedavi için uygun bulunmaktadır[8]. Karaciğer malignitelerinde termoablatif teknikler, özellikle radyofrekans ablasyon (RFA) son 10 yılda gelişim göstermiştir; küçük

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HDR ve LDR-iBTboost'un sonuçlarının karşılaştırıldığı en güncel çalışma 2019 yılında Varela Cagetti ve ark. tarafından yayınlanmıştır. Her iki kolda da 50'şer hastanın yer aldığı çalışmanın sonucunda 5 yıllık lokal kontrol oranları LDR kolunda %93 ve HDR kolunda %86 olup istatistiksel olarak anlamlı farklı bulunmamıştır(p=0.38). 5-yıllık hastalıksız sağkalım ve genel sağkalım sonuçları da benzer bulunmuştur(%88 vs %72; %97 vs %93). LDR ve HDR arasında sadece kronik toksisite açısından fark bulunmuştur (sırasıyla %56 vs %34, p=0.03). Bu sonuçlara bakılarak kronik toksisite açısından avantajlı gözüken HDR-iBT önerilmiştir[69].

YHAK tedavisinde pelvik EBRT sonrası iBTboost güvenilir lokal kontrol ve sfinkter koruma oranlarına sahiptir fakat standart tedavi haline gelmesi için geniş prospektif çalışmalara ihtiyaç vardır. Aktif enfeksiyonu, kanama bozukluğu ve yaygın intrapelvik hastalığı olan vakaların iBTboost için uygun olmadığı göz önünde bulundurulmalıdır[1].

## SONUÇ

iBT, farklı teknik ve doz hızları kullanılarak uygulandığında yüksek lokal kontrol oranları bildirilen bir radyoterapi tekniği olarak karaciğer-pankreas primer ve sekonder kitlelerinde, ayrıca yassı hücreli anal kanser tedavisinde yerini almaktadır. Her ne kadar akut ve geç toksisite sonuçları düşük veya kabul edilebilir oranlarda bildirilmiş olsa da deneyimli merkezlerde, uygun hasta seçim kriterleri ile iBT uygulamalarının yapılması gereklidir.

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