Bölüm
6

GENÇ FİT HASTALARDA KRONK LENFOSİTİK LÖSEMİ İNDÜKSİYON TEDAVİSİ

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GİRİŞ

Kronik lenfositik lösemi (KLL) fonksiyonel olarak yetersiz monoklonal B lenfositlerin progresif birikimi ile karakterize kronik lenfoproliferatif hastalıklardan biridir. KLL'nin, indolent non- Hodgkin lenfomalardan biri olan küçük lenfositik lenfoma (SLL) ile aynı hastalığın farklı tezahürleri olduğu düşünülmektedir. KLL terimi, hastalık öncelikle periferik kanda ortaya çıktığında kullanılır, SLL ise klinik olarak lenf bezi tutulumunun ön planda olduğu durumlarda kullanılır. Erken evre KLL ve SLL tedavisinde bazı farklılıklar olsa da, ileri evre hastalığın tedavisi aynıdır. İleri evre veya semptomatik genç ve fit hastalık için başlangıç tedavisinin seçimi burada gözden geçirilecektir.

TEDAVİ ÖNCESİ DEĞERLENDİRME

Tedavi öncesi hastanın performansı, hastalığın evresi ve varsa komorbiditler belirlenmelidir. Öykü ve fizik muayeneye ek olarak KLL hastalarında tedavi öncesi değerlendirilmesi önerilenler:

1- Aralıklı tam kan sayımı, karaciğer, böbrek fonksiyon testleri, elektrolitler, alkalen fosfataz, laktat dehidrojenaz, beta-2 mikroglobulin ve direkt antiglobulin testi,
2- Tüm hastalara HIV, hepatit B ve hepatit C testi yapılmalı. Sitomegalovirüs (CMV) reaktivasyonu ile ilişkili ajanlarla (alemtuzumab, idelalisib veya allojenik hematopoetik hücre nakli) tedavi edilen hastalar için, CMV (IgM ve IgG) serolojisi,
3- Hastalıkla açıklanamayan sitopenisi olan tüm hastalara tek taraflı kemik iliği aspirasyonu ve biyopsi önerilmektedir. Bazı klinisyenler sitotoksik tedavi baş-

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SONUÇ

KLL oldukça heterojen bir hastalıktır ve tüm hastalar tanı anında tedavi gerektirmez. Tedavi, ileri evre hastalığı, yüksek tümör yükü, ağır hastalıkla ilgili "B" semptomları veya tekrarlayan enfeksiyonları olan hastalar için endikedir. Tedaviye başlamadan önce hastanın performans durumunu, komorbiditeleri değerlendirilmeli ve tedavi seçenekleri üzerinde etkisi olacağından del (17) p gibi laboratuvar parametreleri belirlenmelidir. Başlangıç tedavisi için belirlenmiş tek bir standart rejim yoktur. Mevcut farklı rejimlerle genel sağkalım oranları benzer olsa da, bunlar tam remisyon, progresyonsuz sağkalımlar ve toksisite oranları bakımından farklılıklar gösterir. Seçim, hasta özelliklerine ve tedavinin amaçlarına göre yapılır. Bu rejimlerle toplam sağkalım, hasta ve hastalık özelliklerine, dolayısıyla tedavi tercihine bağlı olarak yaklaşık üç ila sekiz yıldır. Tedavi rejimleri ve sonuçları, genç ve yaşlılar arasında yaşla artan komorbiditeler nedeniyle farklılık gösterebilir. Çoğu çalışmada yaşlı terimi 65 veya 70 yaş üstü olarak tanımlanmıştır, ancak tedavi yoğunluğunu belirlerken hastanın takvim yaşı yerine fizyolojik yaşının dikkate alınması önerilmektedir. IGHV mutant olmayan genç KLL (<70 yaş) hastalarına kemoimmünoterapiden ziyade ibrutinib ± rituksimab önerilmekte. IGHV mutant ve 17p delesyon / TP53 mutasyonu olmayan daha genç hastalar için, ibrutinib bazlı rejimler veya FCR kabul edilebilir seçeneklerdir, bunlar arasındaki seçim hasta tercihine göre yapılabilir. FCR zaman sınırlı bir tedavi, ardından tedavi gerektirmeyen bir süre sunar. FCR, uzun süreli kalıcı remisyon potansiyeli ile daha yoğun, zaman sınırlı bir tedavi sunar. Buna karşılık, ibrutinib ilerlemeye kadar günlük uygulanan daha az yoğun bir oral tedavidir. Del (17p) veya TP53 mutasyonu olan hastalar kemoimmunoterapi ile yapılan ilk tedaviye cevap vermeme veya remisyona girdikten hemen sonra tekrarlama riski yüksektir, bu nedenle klinik araştırmalara katılmaya teşvik edilmelidirler. Bu popülasyon için, hastanın yaşından bağımsız olarak, hedefe yönelik tedavi (ibrutinib veya venetoclax + obinutuzumab kombinasyonu) önerilmektedir. Genş/ fit hastalar herhangi bir tedaviye ilk yanıtı aldıktan sonra potansiyel allogeneik HTC için değerlendirilmelidir.

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