Bölüm
4

RENAL HÜCRELİ KANSERDE ADJUVAN SİSTEMİK TEDAVİLER

Emre ÇAKIR

GİRİŞ

Renal hücreli karsinom(RCC) tüm kanserlerin %2.2'sini kapsamaktadır[1]. RCC renal korteksten köken alır ve en sık görülen böbrek tümörüdür. Clear cell karsinom histolojisi en yaygın görülen histyolojisidir. Cerrahi rezeksiyon lokalize ve lokal-ileri RCC için standart tedavidir. Yüksek riskli RCC cerrahi sonrası %40-50 tekrarlama riski ile ilişkilidir[2]. Metastatik tedavide etkin olan sitokin tedavisi ve vasküler endotelyal growth faktör(VEGF) tirozin kinaz inhibitörleri(TKIs) RCC'de adjuvan tedavide incelenildi. Bununla birlikte bu tedavilerin hiçbirisi nefrektomi uygulanan yüksek rekürrens riski olan durumlarda herhangi bir OS katkısı göstermedi. Sadece S-TRACK çalışması sunitinib ile 1 yıl adjuvan tedavi kullanımında DFS'de iyileşmeyi gösterdi; ancak önemli advers olaylar oluştu. Son zamanlarda check-point inhibitörlerinin metastatik RCC(mRCC)'de iyi yanıt oranları elde etmesi, check point inhibitörleri ile adjuvan tedavi çalışmalarının önünü açmıştır.

TÜMÖR TEKRARLAMASI YÜKSEK RİSKLİ OLAN HASTALARI BELİRLEME

Adjuvan tedavideki en önemli şey adjuvan tedaviden fayda görecek tekrarlama riski yüksek olan hastaların seçimi ve düşük riskli hastaları adjuvan tedavinin yan etkilerinden korumaktır. Birçok klinik risk-tahmin modelleri lokalize RCC'li hastalarda tekrarlama riskini değerlendirmek için geliştirildi.

LOKALİZE RCC'DE KLİNİK RİSK TAHMİN MODELLERİ

Tümör, nod, metastaz(TNM) klasifikasyonu, Fuhrman grade ve Eastern Cooperative Oncology Group performance status(ECOG)'u içeren The University of California Los Angeles Integrated Staging System (UISS) postoperatif 5 yıllık OS'yi

bir çalışma(S-TRACK) DFS'de iyileşmeyi gösterdi; ancak OS' de iyileşme göstermedi.Yetersiz ilaca maruz kalınma konusu birçok çalışmada tutarlı olarak VEGFR TKIs'ın DFS'de iyileşmeyi göstermedeki başarısızlığını açıklayabilir; ancak yeterli ilaç alınsa bile DFS'deki iyileşme azdır. Adjuvan durumda VEGFR TKIs'ın limitli etkisini açıklamak için çeşitli teoriler vardır. Birinci teori mikrometastazlar tümör anjiyogenezi desteği gerekli değildir; bu yüzden VEGFR TKIs mikrometastatik hastalığı eradike edemeyecekti. Bir başka teori VEGFR TKIs sitotoksikden ziyade sitostatikdir ve bu yüzden mikrometastatik adatasyonuna olanak sağlar[43-44]. Adjuvan tedavide VEGFR TKIs'ın limitli yararı rekurrensin mekanizmasının daha iyi anlaşılmasının önemi, yüksek riskli hastayı belirleme ve çalışmalara yüksek riskli hastaları katmaya çalışarak daha iyi anlaşılabilir.

NCCN yüksek riskli RCC'de sunitinibi evre 2B kanıt düzeyinde önermektedir. Yüksek riskli RCC'de Adjuvan tedavi onkoloji hekimi ve hastalar için zor bir durumdur. Onkologlar yüksek riskli hastalara tekrarlama riski ve sunitinibin advers olaylarına karşı ılımlı etkisi hakkında bilgilendirmelidir. Yüksek riskli RCC'li hastalar devam eden klinik çalışmalara katılmaya cesaretlendirilmelidir.

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