Bölüm
11

MESANE KANSERİNDE CERRAHİ TEDAVİ

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GİRİŞ

Üriner sistemin en sık görülen tümörleri mesane kanserleridir. Dünya genelinde tüm kanserler arasında 9. sırada ve kansere bağlı ölümler arasında 13. sırada yer almaktadır (1). Giderek artan insidansıyla, dünyada erkekler içerisinde en sık yedinci, tüm popülasyonda ise on birinci sırada yer almaktadır (1). Ülkemizde dünya ortalamasının üzerinde bir sıklık göstermesi açısından ayrıca önem teşkil etmektedir. Mesane kanseri görülme sıklığı son 50 yılda ciddi oranda artış göstermiştir. Bu artış özelikle sanayileşmenin kimyasal karsinojen maruziyetine yol açtığı az gelişmiş ülkelerde daha fazladır (1,2).

Mesane kanseri orta ve ileri yaş hastalığı olmasına karşın her yaş grubunda görülebilir. Ortanca tanı koyulma yaşı her iki cinsiyet için de 70 olup insidans ve hastalığa bağlı ölüm yaşla beraber artış göstermektedir. Her ne kadar hastalığın mortalite oranı (100.000 kişi/yıl) coğrafi bölge, genetik , tedaviye ulaşma kolaylığı vb. nedenlere bağlı olarak değişse de 2012 yılı verilerine göre erkeklerde 3.2, kadınlarda 0.9 olarak hesaplanmıştır (3).

Mesane kanseri etyolojisinde genetik, radyasyona maruziyet, boya ve lastik endüstrisinde kullanılan β-naftilamin, beslenme, şistosomiyazis gibi birçok etken suçlanmakla beraber sigara kullanımı en iyi bilinen risk faktörüdür (4).

Tanı konulduğunda mesane tümörlerinin yaklaşık %75'i mesanenin mukozasında (Ta, CIS) veya lamina propriada (T1) sınırlıdır (5). Kısa süre önce bu tümörler "Yüzeyel Mesane Kanserleri" olarak tanımlanmaktayken,artık"Kasa İnvaze Olmayan Mesane Kanserleri (KİOMK)" olarak isimlendirilmeye başlanmıştır. Bu haklı değişikliğin nedeni bu hastalık kapsamındaki hastaların prognozunun çok değişken olmasıdır. (6).

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Metabolik komplikasyonlar

Seçilen gastrointestinal segmente göre metabolik komplikasyonlar değişmektedir. Özellikle ileum rezeksyonlarında malabsorbsiyon ve yağda eriyen vitamin (A,D,E,K) eksikliği izlenebilir. Yine terminal ileumun 20 cm'den fazla rezeke edildiği hastalarda B12 eksikliği izlenebileceğinden dolayı kontrollerde B12 seviyesine bakılmalıdır. B12 eksikiği megaloblastik anemi ve nöropati ile sonuçlanabilir. Vücut depoları bir süre yeteceğinden dolayı sistektomiden 3-5 yıl sonra ölçümlere başlanıp yıllık olarak tekrarlanmalıdır. Eksiği yerine koyma tedavisi ömür boyu devam etmelidir.

Tablo 5: Rezeke edilen barsak segmentine göre görülebilecek metabolik değişiklikler (59)

Barsak segmenti	Metabolik değişikilikler	Klinik semptomlar
Mide	Hipkloremik alkaloz,	Dizüri, hematüri Dehidratasyon, letarji, nöbet, solunum sıkıntısı
Jejenum	Hipokloremik asidoz	Dehidratasyon, bulantı/kusma, zayıflık, letarji, nöbet
İleum	Hiperkloremik asidoz	Yorgunluk, anoreksi, kilo kaybı, diyare, polidipsi B12 ve yağda eriyen vitamin eksikliği, diyare, ürolithazis, kolelityazis
Kolon (Üreterosigmoidostomi)	Hiperkloremik asidoz	Yorgunluk, anoreksi, kilo kaybı, diyare, polidipsi Piyelonefrit, anastomoz hattında adenokanser

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