

Bölüm 83

VAJENİN PREMALİGN VE MALİGN HASTALIKLARI

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VAJİNAL İNTRAEPİTELYAL NEOPLAZİ (VAIN)

Giriş

Vajinal İntraepitelyal Neoplazi (VAIN), vajen epitelinin premalign bir lezyonudur ve oldukça nadir bir patolojidir. VAIN, vulvar intraepitelyal neoplazi (VIN) ve servikal intraepitelyal neoplazi (CIN)'den oldukça az görüldüğü için hastalığın doğal seyri bilinmemektedir. Ancak vajen kanserlerinin % 90'nın zemininde yavaş gelişen VAIN lezyonu vardır (1). VAIN tanısı, son yıllarda sitolojik taramaların ve kolposkopi kullanımının yaygınlaşmasına bağlı olarak artmıştır.

Klasifikasyon

VAIN, invazyon olmaksızın skuamöz (yassı) epitel atipisidir. Tutulan vajen epitelinin derinliğine bağlı olarak sınıflandırılır. VAIN 1 ve VAIN 2'de sırasıyla vajen epitelinin üçte biri ve üçte ikisi tutulur. VAIN 3'te ise üçte ikisinden çoğu tutulur. Karsinoma in situ, vajen epitelinin tam kat tutulmasıdır.

2012'de terminoloji değişti ve VAIN için 2 nomenklatür tarif edildi: VAIN 1 için vajinal LSIL (Low-grade squamous intraepithelial lesion),

VAIN 2/3 için vajinal HSIL (high-grade squamous intraepithelial lesion) tanımlandı (2).

Glandlardan kaynaklanan intraepitelyal vajinal displazi (atipik vajinal adenozis) ayrı bir antitedir. Bu lezyon inutero dietilstilbestrol (DES) maru-

ziyetinde görülür ve vajinal berrak hücreli (clear cell) adenokarsinoma ileerleyebilir (3).

Epidemiyoloji

VAIN, gerçek insidansı bilinmiyor. Amerika Birleşik Devletleri (ABD)'de yüzbinde 0,2 - 0,3 olduğu hesaplanıyor. Ortalama görülme yaşı 43-60'dır. ABD' de vajinal karsinoma in situ en sık 70 - 79 yaşlarda görülür ve sıklığı yüzbinde 0,1'dir (4).

Risk Faktörleri

Birden çok risk faktörü tanımlanmasına rağmen en önemlisi human papilloma virus (HPV) enfeksiyonudur. Yüksek riskli HPV (16, 18, diğerleri) pozitif olanlarda ve sigara içenlerde VAIN riski sigara içmeyenlere göre daha fazladır (5).

Ayrıca düşük sosyo-ekonomik düzey, vajinal kondilom öyküsü, genetik veya edinsel (human immunodeficiency virus-HIV gibi) immün yetmezlik durumlarında VAIN riski artar (6,7-9). Genç popülasyonda HPV enfeksiyonlarının artmasına bağlı olarak, VAIN artık gençlerde de görülmektedir.

VAIN sıklıkla, alt genital bölgenin neoplazileri ile birlikte. VAIN olgularının % 50 - 90'ı serviks veya vulvanın intraepitelyal neoplazisi veya karsinomu ile birlikte. CIN endikasyonu ile histerektomi olan hastaların % 1 - 7' de ameliyattan hemen sonra veya birkaç yıl sonra VAIN gelişebilir (14-15). Benign lezyonlara bağlı histerektomi olanlarda VAIN gelişme riski oldukça azdır ve ortalama 10 yılda gelişebilir (13).

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- Nüks şüphesinde CT/PET

Fizik muayenede şüpheli alanlardan vajinal kolposkopi veya biyopsi yapılmalıdır

Prognoz

Prognozu etkileyen en önemli faktörler; evre, tümörün büyüklüğü ve invazyon derinliğidir (80). Evre II ve daha ileri evrelerde, tümör boyutu > 4 cm, melanom olgularında mortalite artmıştır. FİGO'ya göre 5 yıllık yaşam oranları Evre I %90, Evre II %78, Evre III %42, Evre IV %20'dir

SONUÇ

Vajen kanserleri nadirdir. Olguların çoğu metastastiktir. En sık görülen histolojik tip yassı (skuamöz) hücreli kanserdir. Vajen arka duvarı üst 1/3 kesimde en sık yerleşir. Çoğu olgu asemptomatiktir. Vajinal kanama en sık semptomdur. Lezyon kit- le, plak, ülser şeklinde görülür. Vajen kanseri için rutin tarama yoktur. Sadece anamnezde jineolojik kanser, karsinoma insitu veya CIN tanısıyla his- terektomi geçiren olgularda vajen kafından rutin smear takibi yapılmalıdır. Tanı biyopsi ile konur. Kanser şüphesinde lezyon görülemiyorsa mutla- ka kolposkopi yapılmalıdır. Tanıdan sonra klinik evreleme yapılır. Tedavi bireysel olmalıdır. Evre I olgularda cerrahi ve/veya radyoterapi, ileri evrede (II-IV) ise kemoradyasyon bazı vakalarda sadece radyoterapi uygundur.

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