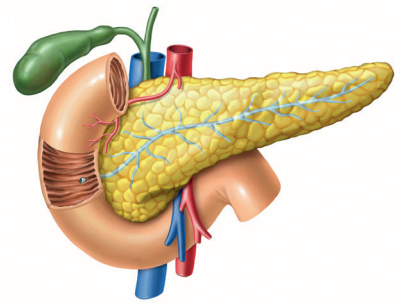
BÖLÜM 24



PANKREATİK KİSTİK NEOPLAZİLER

Yaşar YOĞUN[1]

GİRİŞ

Kesitsel incelemelerin yaygın kullanımı ile birlikte pankreatik kistler giderek artan sıklıkla tespit edilmektedir. Pankreatik kistler, pankreas ile ilişkisiz nedenlerle abdominal Magnetik Rezonans İnceleme (MRI) çekilen hastaların %40-50'sinde saptanabilir ve sıklığı yaş ile artar(1,2). Otopsi serilerinde hastaların %50'sinden fazlasında küçük kistler tespit edilebilmektedir(3-6). Diğer yandan kistlerin tespiti, kullanılan görüntüleme yöntemi ile de ilişkilidir. Ultrasonografik incelemede %0.21, multidedektör bilgisayarlı tomografide (BT) %2.6 ve Magnetik Rezonans İnceleme (MRI)- Magnetik Rezonans Kolanjio-Pankreatografide (MRCP) %2.4-%49.1 oranında pankreatik kistler tespit edilmiştir(2,7-9).

Pankreasın kistik lezyonları genellikle neoplastik ve non-neoplastik, ya da müsinöz ve non-müsinöz olarak sınıflandırılmaktadır. Pankreasın kistik neoplazileri, benign bir durumdan malign hastalığa değişen spektrumu vardır ve aralarında ayırım yapabilmek güçtür(11). Doğru tanı ve tedavi, pankreas kanseri gelişimini önleyerek hastalık ilişkili ölümler ve maliyetler üzerine etkilidir(10).

Psödokistler, sıklıkla akut-kronik pankreatit ya da travma zemininde gelişen kistik lezyonlardır. Neoplastik değildirler ancak özellikle pankreatit öyküsü olan hastalarda psödokistlerin kistik neoplazilerden ayırılması büyük önem taşır. Bilinmelidir ki 40 yaş üstü hastalardaki pankreas kistik neoplazileri, vakaların %20'sinden fazlasında pankreatite neden olabilmektedir. Kistik pankreatik nöroendokrin tümörler nadir görülürler ve sıklıkla fonksiyonel değildir. Solid ve/veya kistik görünümde olabilir. Bu konu içerisinde pankreasın kistik neoplazileri değerlendirileceğinden bu iki konu ayrıntılanmayacaktır.

Pankreatik kistik neoplazilerin (PCN) çoğu yapılan abdominal görüntülemeler ile tesadüfen tespit edilirler(12). Pankreatit öyküsü olan hastalarda bile PCN'ler, pankreatik kistlerin yarısından fazlasını oluşturur(12,13). PCN'ler Dünya Sağlık Organizasyonu (World Health Organisation, WHO) histolojik sınıflamasına göre kategorize edilir. (Tablo 1) (14).

Malignite potansiyeli taşıyan 4 tip PCN mevcuttur. Bunlar, Seröz kistik tümörler (Serous cystic tumors, SCT), Müsinöz kistik neoplazmlar (Mucinous cystic neoplasms (MCN), Intraductal papillary mucinous neoplasms (IPMN), Solid psödopapiller tümörler (Solid pseudopapillary neoplasms, SPN)'dir. IPMN'ler, kendi içerisinde ana kanal (main duct) IPMN (MD-IPMN), yan

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bir seride 17 hastada (%16) yüksek dereceli malign SPN saptanmıştır(135). Tümör boyutunun >5 cm olması ileri evre malignite ile ilişkilidir.

Lezyonun malign potansiyeli göz önüne alındığında, genç bir kadında BT ya da MRI'da pankreasta solid-kistik lezyon saptandığında vaya EUS-FNA ile SPN tanısı konulduğunda, rezeksiyona yönelinmelidir. Malignite mevcut bile olsa malign SPN'ler total eksizyon ile kür edilebilir(133). Metastatik hastalıkta bile cerrahi hacim küçültme ile uzun bir sağkalım elde edilebilir(136,137). Bir çalışmada metastaz olup olmadığına bakılmaksızın yapılan rezeksiyon ile %95 üzerinde sağkalım elde edilmiştir.

Cerrahi Sonrası Takip

Kist rezeksiyonu uygulanmış olan hastalar için takip, patolojik bulgulara dayalıdır. İnvaziv kanser veya high grade displazi tespiti durumunda kalan pankreasın MRI ile takibi 2 yılda bir yapılmalıdır(43). High grade displazi veya malignite yok ise, IPMN veya güçlü ailevi pankreatik kanser öyküsü dışında takip gerekmez.

IPMN vakalarında cerahi sonrasında nüks riski mevcuttur. İnvaziv olmayan IPMN vakalarında, kalan pankreas dokusunda nüks vakaların %5'inde görülür(121,124,138,139). Bu tip hastalarda yıllık MRCP veya BT takibi önerilebilir.

High grade displazi tespit edilen IPMN vakalarında 3 yıllık sağ kalım %60-80 arasındadır ve BD-IPMN vakalarında prognoz daha iyidir(140). IPMN ilişkili adenokarsinom prognozu, pankreatik duktal karsinomdan oldukça iyidir. (5 yıllık sağ kalım %31-62 'ye %9-20) (141-146).

Pankreas cerrahisinin belirgin morbidite ve mortalitesi nedeni ile cerrahi kararı hastanın yaşı, genel sağlık durumu, lezyonun malignite riski ve malignite şüphesine göre belirlenmelidir.

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