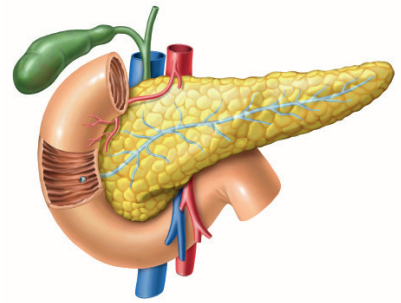
BÖLÜM 41



PANKREASIN PREKÜRSÖR LEZYONLARININ PATOLOJİSİ

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GİRİŞ

WHO 2019 Sindirim Sistemi Tümörleri Sınıflaması'nda pankreasın epitelyal prekürsör lezyonları başlığı altında 5 lezyon bulunmaktadır: 1) Pankreatik İntraepitelyal Neoplazi, 2)İntraduktal Papiller Müsinöz Neoplazm, 3)İntraduktal Onkositik Papiller Neoplazm, 4)İntraduktal Tübülopapiller Neoplazm, 5)Müsinöz Kistik Neoplazm.

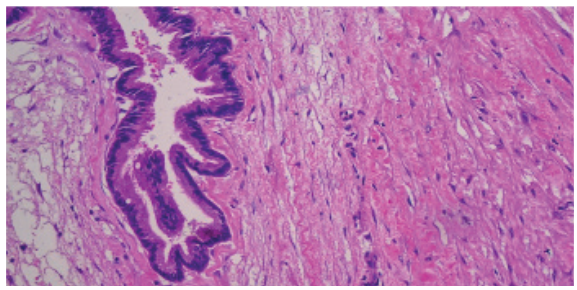
PANKREATİK İNTRAEPİTELYAL NEOPLAZİ

Pankreatik intraepitelyal neoplazi(PanİN), pankreatik duktuslarda sınırlı, noninvaziv, flat ya da mikropapiller yapıda epitelyal bir neoplazmdır. Pankreasın baş kısmında daha sık olarak görülür(1). Neredeyse tamamı başka bir nedenle yapılan pankreas rezeksiyonlarında insidental olarak saptanır(2).

Pankreatik duktal adenokarsinom(PDAK)'a benzer şekilde PanİN'in de ileri yaş, obezite, pankreatik yağlı infiltrasyon ve diabetes mellitus ile ilişkili olduğu öne sürülmüştür(3). Çok sayıda yapılan klinikopatolojik çalışmanın sonuçlarına göre PDAK'un ana prekürsörü PanİN'dir(4)

Mikroskopik olarak değişen miktarlarda müsin içeren küboidal ya da kolumnar hücrelerden oluşan, 5 mm'in altında, papiller ya da flat yapıda lezyonlardır(5). Başlangıçta önerilen derecelendirme sistemi arşitektürel ve nükleer özelliklerine göre bu lezyonları 3'e ayırıyordu: PanİN 1, PanİN 2 ve PanİN 3(6). WHO 2019 Sindirim Sistemi Tümörleri Sınıflaması'nda PanİN 1 ve PanİN 2 düşük dereceli PanİN, PanİN 3 ise yüksek dereceli PanİN olarak sınıflandırılmıştır(4).

Düşük dereceli PanİN, hafif-orta derecede atipi gösteren, bazalde yerleşmiş ya da psödostratifiye nükleusa sahip, flat ya da papiller lezyonlardır. Belirgin arşitektürel değişiklikler (kribriformite, mikropapiller yapılanma, epitelyal hücre gruplarının duktus lümenine tomurcuklanması) yoktur. Mitoz sık değildir.(Resim 1,Resim 2)



Şekil 1. Düşük dereceli PanİN. Bazalde yerleşmiş, hafif atipi gösteren nükleusa sahip hücrelerden oluşan flat epitel ile döşeli lezyon(H&E,x200)

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iki antitenin ayrımında önemlidir. Psödokistin MKN'dan ayrımı sorun yaratabilir. Çünkü bazı MKN'larda bütün epitelde dökülme ile birlikte olan dejeneratif değişiklikler görülebilir. Bu durumda tanıda önemli olan müsin üreten epiteli ya da ovarian tip stromayı gösterebilmek için çok sayıda örnekleme yapmak gerekmektedir(43).

Yeterli sayıda örnekleme ile invaziv karsinomun ekarte edildiği noninvaziv MKN'da prognoz çok iyi olup 5 yıllık sağ kalım oranı %100'dür. Bununla birlikte invaziv karsinom olan vakalarda klinik seyir kötüdür ve 3 yıllık sağ kalım oranı %44 iken 5 yıllık sağ kalım oranı %26'dır. Bu hastalarda prognoz invaziv komponentin çapına, nodal metastaza ve uzak yayılıma bağlıdır(40).

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