Bölüm 6

PRİMER OMURGA TÜMÖRLERİ

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En sık torakal omurgada görülür. Servikal omurga en az tutulan bölgedir. Primer omurga tümörleri kemik, kıkırdak, fibröz yapılardan köken alır ve hepsinin malign ve benign formları vardır ancak kemik iliği kökenli olanlar daima malign olup sistemik bir hastalığın omurga bulgusudur (1).

BENİGN TÜMÖRLERİ

- Osteoid osteoma
- Hemanjiom
- Anevrizmal kemik kisti
- Osteoblastom
- Kemiğin dev hücreli tümörü
- Eozinofilik granülom

MALİGN TÜMÖRLERİ

- Kondrosarkom
- Multpl myelom-Soliter plazmositom
- Osteosarkom
- Kordoma
- Ewing sarkom
- Lenfoma

BENİGN TÜMÖRLERİ

Osteoid Osteoma

Osteoid osteoma (OO) terimi, ilk olarak Jaffee tarafından 1935 yılında, benign bir kemik tümörünü tanımlamak için kullanılmıştır (2, 3). Kemiğin en sık benign, osteoid üreten tümörüdür. En çok 2. ve 3. dekatta görülür. Daha çok uzun ke-

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Lenfoma

Primer kemik lenfoması, ilk başvuru sırasında sistemik hastalık bulgusu olmaksızın kemik veya kemik iliğine sınırlı ve iskelet bulgularının başlangıcından itibaren sistemik hastalık gelişinceye kadar en az 4-6 aylık bir süre geçen bir lenfoma olarak tanımlanmaktadır. Parker ve Jackson (93) 1939'da lezyonu 'kemiğin retikulum hücreli sarkomu' olarak tanımlamışlardır. Görülme sıklığı 5. ve 6. dekadlarda pik yapmakta olup (ortalama yaş: 44), erkek/kadın oranı yaklaşık 1.5/1'dir (94). Primer kemik lenfomasının bütün primer malign kemik tümörleri içindeki insidansı %3-7'dir. Primer omurga yerleşimli oldukça nadirdir. Primer omurga lenfoması tüm lenfoma olgularının %0,1-6,5'ini tüm primer kemik lenfomalarının ise %1-9'unu oluşturur. En sık lomber ve alt torakal omurgayı yutar (95, 96, 97). Omurga lenfoması sinsidir ve nörolojik bozukluk olana kadar belirti vermeyebilir. Belirti verdikten sonra ise bulgular hızla ilerler (97). Genellikle hastaların başvuru sebebi patolojik kırık veya nörolojik bozukluktur (98).

Lenfoma radyolojik olarak düzensiz sınırlı osteolitik lezyonlara sebep olur, bu lezyonlar direkt grafide görülmeyebilir (96, 97). BT, MRG'de lenfomaya has bulgular yoktur sadece kitleyi gösterir. MR'da T1 görüntülerinde izo veya hipointens, T2 ağırlıklı görüntülerde hiperintens görünümdedir (99). İğne biyopsi histolojik tanı için gerekli, primermi metastazmı diye taramak için de PET yapılmalıdır (99, 100).

Tedavide temel prensip kaliteli yaşam sürülmesidir. Kemiği tutan lenfomalarda KT, RT, cerrahi veya bunların kombinasyonu uygulanır. Lenfomalar RT ve KT oldukça duyarlıdır. Cerrahi tedavinin amacı nöral dekompresyon yapmak, histolojik tanı almak, omurganın stabilitesini sağlamak ve tümör kitlesini çıkarmaktır. Nörolojik bozukluğu olanlarda tedavi tartışmalıdır. Literatürde yeterli seri olmadığı için kesin tedavi protokolüde yoktur (97, 100, 101). Bazı yazarlara göre orta veya hafif nörolojik bozukluğu olanlarda eğer ki omurga unstabilitesi yoksa KT, RT uygulanabilir. Bu tedaviye rağmen 2 hafta içinde nörolojik bozukluk düzelmiyorsa veya tam tersi artıyorsa, kitle küçülmüyorsa cerrahi tedavi yapılmalıdır (100).

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