Bölüm 13

HODGKİN LENFOMADA OTOLOG VE ALLOGENEİK KÖK HÜCRE NAKLİNİN YERİ

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Hodgkin Lenfoma (HL) lenfositik sistemi ve lenf nodlarını tutan yaygın olmayan kanserdir (NCCN 2018). Çoğu hasta 15-30 yaş arası tanı almakla birlikte diğer sık görüldüğü yaş grubu 55 yaş ve üzeridir (NCCN 2018). WHO sınıflaması HL'yi 2 ana tipe ayırır: klasik HL (KHL) ve nodüler lenfosit predominan HL (NLPHL) (WHO classification, 2008). Batı ülkelerinde tüm HL'lerin içinde KHL %95, NLPHL %5 oranındadır (NCCN 2018).

KHL'de hastalar tanı ve tetkikler sonrası evre 1-2 ve evre 3-4 olarak gruplara bölünürler. NCCN olumsuz faktörlerin varlığına göre evre 1A-2A (olumlu), evre 1-2 olumsuz nonbulky, Evre 1-2 olumsuz bulky hastalık olarak ayrılır. Kombine modalite tedavisi ABVD (adriamisin, bleomisin, vinblastin, doksorubusin) veya Stanford V kemoterapi + tutulu alan radyoterapi (TART) evre 1-2 olumlu hastalarda tercih edilir. Genç hastalarda kemoterapinin uzun süreli risklerinden kaçınmak için ABVD tek başına tercih edilir. Kombine modalite tedavi (ABVD + tutulu bölge RT (TBRT) [kategori 1] (Engert & ark., 2010) veya Stanford V kemoterapi) (Advani & ark., 2013) veya kemoterapi (sadece ABVD) stage 1A-2A olumlu hastalığı olanlarda tedavi seçeneklerindendir.

HD 11 çalışmasına göre evre 1-2 olumsuz hastalık tanımı: En az bir risk faktörünün bulunması, bulky mediastinal kitle, ekstranodal tutulum, sedimentasyon≥50 veya sedimentasyon≥30 B semptomları ile, 3 veya daha fazla tutulu lenf nod ve bulky mediastinal kitle veya ekstanodal tutulum olmadan evre 2B – ABVD sonrası + TBRT (Eich & ark., 2010) veya AVD (Johnson & ark., 2016), ABVD sonrası BEACOPP ve/veya TBRT (Raemaekers & ark., 2014), Stanford V + TBRT (Horning & ark., 2002, Gordon & ark., 2013) veya escalated BEACOPP (2 siklüs) sonrası ABVD (2 siklüs) veya 60 yaş altı seçilmiş hastalarda TBRT tedavi seçenekleri arasındadır (NCCN önerilerine göre)

Uluslararası prognostik skor (IPS), evre 3-4 hastalarda prognozu belirleme ve tedavi yaklaşımını değerlendirmede yardımcı olur. Tanı anında kötü prog-

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geçirdi, 3 hasta aGVHD ile hayatını kaybetti (Merryman & ark., 2017). Donor lenfosit infüzyonu (DLI) içeren en büyük çalışma MD Anderson Kanser Merkezi tarafından 27 hasta ile yapılmış olup toplam cevap oranı (ORR) %37 ve ortanca cevap zamanı 7,5 ay olarak bulunmuştur. Tüm hastalar GVHD geçirmiş ve 4 yıllık TS %20 bulunmuştur. (Anderlini & ark., 2004). Peggs ve arkadaşları relaps hastalıkta ORR %79, dört yılık PS %59 bulmuşlar. Tüm hastalarda hazırlama rejiminde alemtuzumab kullanıldığı için DLI'a cevap oranlarının yüksek oluşu bununla ilişkili bulunmuştur (Peggs & ark., 2007).

Yirmi dokuzu HL olan 31 lenfoma hastasının bulunduğu çok merkezli bir çalışmada allonakil sonrası relaps olan nivolumab veya pembrolizumab verilen hastalarda ORR %77 idi. (Haverkos & ark., 2017). Tedavi ilişkili GVHD %55 bulunmuş, konvansiyonel GVHD yaklaşımına dirençli ve %26'sı GVHD nedeniyle kaybedilmiştir (Haverkos & ark., 2017). Başka bir çalışmada allonakil sonrası nivolumab verilen 20 HL hastasında %30 GVHD insidansı ile ORR %95 ve hastaların %10'u da GVHD nedeniyle hayatını kaybetmiştir (Herbaux & ark., 2017).

Otolog nakil sonrası relaps hastalarda daha önceden BV verilmemişse mutlaka BV uygulanması önerilmekte. TR 1/3'de elde edilmesine rağmen hemen allo nakile almaktansa 16 doz BV verilmesi önerilir. Çünkü bu hastalarda tedavi sonu 1/3'ü TR durumunu korumaktadır. Ancak BV ile PR sağlandığı takdirde bu cevabın korunması kısa süreceğinden ileri tedavi planı yapılmalıdır. Allo nakil öncesi CPI ile devam edilebilir. Allonakil öncesi metabolik tam yanıt alınması önemli değildir. Öncesinde otolog HKHN yapılmış hastalar relaps durumunda RIC ile allo nakile alınmalı. Çünkü myeloablatif hazırlama rejimi ile allonakil sonrası NRM'deki azalma daha önceden otolog nakil yapılmamış hastalarda sağlanmıştır. Karşılaştırmalı sağ kalım sonuçlarına göre haploidentik nakil UAD ve UADD nakillerine göre azalmış cGVHD oranları nedeniyle güçlü bir alternatiftir. Eğer uyumlu akraba veya tam uyumlu akraba dışı donör mevcut değilse UCB veya UADD ile nakil değil haploidentik nakil önerilir. UAD, UADD veya haploidentik donör yoksa UCB düşünülebilir. CPI allonakil öncesinde verilmemişse dahi nakil sonrası artmış oranlarda toksisite görülebilir. Allonakil sonrası relaps halinde DLI'yı takiben sitoredüktif tedaviye cevap sınırlıdır. CPI nakil sonrası anlamlı GVHD riski nedeniyle büyük bir dikkatle uygulanmalı.

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