Bölüm 14

NONHODGKİN LENFOMADA OTOLOG VE ALLOGENEİK HEMATOPOETİK KÖK HÜCRE NAKLİ

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Kemoterapi agresif lenfomalar için birinci sıra standart tedavidir. Nonhodgkin lenfomaların (NHL) %20-30'u R-CHOP (rituksimab, siklofosfamid, doksorubusin, vinkristin, prednol) gibi standart indüksiyon tedavileri ile tam remisyona girememektedir (Coiffier & ark.; 2002). Relaps refrakter (R/R) NHL hastalarda salvaj tedavi sonrası yüksek doz tedavi ile konsolidasyon olarak otolog hematopoetik kök hücre nakli (HKHN) küratif olabilir (Philip & ark.; 1995, Schmitz & ark.; 2002). 1995 yılında Philip ve arkadaşları yüksek dereceli B ve T lenfoma hastalarında yüksek doz tedavi (YDT)/HKHN grubu ile salvaj tedavi alanlarını karşılaştırmış ve beş yıllık takipte toplam sağkalım (TS) %53'e %32 olarak tespit edilmiştir (Philip & ark; 1995). T hücreli lenfomalarda otolog HKHN rolü güçlü randomize kontrollü çalışmalar olmaması nedeniyle daha az dile getirilmiştir. D'Amore ve arkadaşlarının 2012 yılında prospektif faz 2 çalışmasında sistemik periferal T hücreli lenfomalar CHOEP-14 veya CHOP-14 (60 yaş üzeri) ile tedavi edilmiştir. YDT/otolog HKHN ile konsolide edilen hastalarda 5 yıllık TS %51 olarak bulunmuştur (d'Amore & ark; 2012). 2015 yılında Beitinjaneh ve arkadaşlarının T hücreli lenfoma ile ilgili çalışmasında hastalara otolog HKHN veya allonakil uygulanmış ve 76 hasta da ilk relapslarında nakil olmuştur. Otolog HKHN hastaları BEAM tedavisi, allonakil hastaları hazırlama rejimleri almış, 4 yıllık TS ve progresyonsuz sağ kalım (PS) her 2 grupta da birinci tam remisyonda (TR1) olan hastalarda daha yüksek bulunmuştur. TR1'de ASCT yapılan hastalarda 4 yıllık sağ kalım %84, parsiyel remisyonda (PR) alınanlarda %44 bulunmuştur (Beitinjaneh & ark; 2015).

2016 yılında B hücreli NHL'ler tüm lenfomaların yaklaşık %86'sı idi. En sık görülen difüz büyük B hücreli NHL (DBBHNHL) idi (Teras & ark; 2015). Çeşitli alt gruplarına bağlı olarak marjinal zon lenfomada 5 yıllık sağ kalım oranları %83-%91'den, Burkit lenfomalarda %44-48'e kadar değişebilmekte idi (Teras & ark; 2015). DBBHNHL'lerin %50 civarı RCHOP ile tedavi edilebilirken %30-40'ında R/R hastalık gelişebilir (Camicia & ark; 2015). Agresif DBBNHHL'lerin

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Barts Kanser Enstitüsünden John G. Gribben KLL'de alloSCT yaklaşımını çok güzel özetlemiştir (Gribben, 2018). Birinci sıra tedavi hastanın yaşı, komorbidite durumu, del17P/TP53 mutasyonu varlığı, mutasyona uğramamış IGHV-durumuna göre karar verilmeli ve kemoimmunoterapi – ibrutinib arasında seçim yapılmalı. Birinci sıra ibrutinib tedavisinin başarısı ve sonraki venetoklaks, rituksimab + idelalisib salvaj tedavisinden yanıt alınması halinde del17p pozitif hastalara allonakil önerilmemekte. Nakile karar verilen tam uyumlu akraba donöre KLL veya monoklonal B hücre lenfositozu açısından immunofenotipik analiz yapılması gerekmektedir.

En kompleks durum kuşkusuz çoğu hematologların karşılaştığı ikinci ya da üçüncü sıra yeni ajanla mükemmel cevap MKH negatifliği varken, yani allo nakil için en düşük tümör yükü halinde, nakilden optimal cevabın alınabileceği zamanda nakil yapılmalı mı? Tedaviye devam mı edilmeli?

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