Bölüm 24

ALLOJENİK KÖK HÜCRE NAKLİ SONRASI NÜKS AKUT MYELOİD LÖSEMİDE TEDAVİ YAKLAŞIMLARI

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GİRİŞ

Akut miyeloid lösemi (AML), Avustralya, Amerika Birleşik Devletleri ve Avrupa'daki yetişkinlerde (Pasquini&Wang, 2012) allojenik hemopoietik kök hücre naklinin (allo-HKHN) en yaygın nedenidir.

2011 yılı kayıt çalışmaları, donör kaynağına ve hastalık riskine bağlı olarak AML'de uzun süreli allo-HKHN sonrası sağkalımının % 20-50 (Gooley, Chien&-Pergam, 2010) olduğunu bildirmektedir. Hastalık nüksü % 40'lar oranında allo-HKHN sonrası AML hastalarında, tedavi başarısızlığının ana nedeni olmaya devam etmektedir. İlk tam remisyonda (TR) AML için allo-HKHN sonrası kümülatif nüks oranı, orta sitogenetik risk AML için % 25-35 (Jourdan &ark, 2005) ve kötü sitogenetik risk AML için % 50-60'tır. (Chevallier &ark, 2012) .

Bir EBMT çalışmasında indirgenmiş yoğunluklu hazırlık rejimi (İYHR) ile yapılan allo-HKHN sonrası nüks AML hastalarında sağkalımı olumlu etkileyen 3 prognostik faktör saptanmıştır. Bunlar, nakil-nüks arası süresinin 5 aydan uzun olması, nüks sırasında kemik iliği blast sayısının <%27 olması ve nakil sonrası akut graft versus host hastalığı (GVHH) olmamasıdır. İki yıllık toplam sağkalım her 3 prognostik faktör varlığında %32, 2 prognostik varlığında %19, 0-1 prognostik varlığında oran %4 olarak bildirilmiştir. Bir uluslararası kan ve kemik iliği nakil araştırma (IBMTR) çalışmasında İYHR kullanılmasının sağkalımı olumlu etkilediği fakat yaş>41, kötü sitogenetik ve nüks sırasında aktif GVHH olmasının sağkalımı olumsuz etkileyen faktörler olduğu saptanmıştır. (Bejanyan&ark, 2015) Nükste, akut GVHH olmasının infeksiyöz komplikasyonları artırdığı ve hücre bazlı tedavilerin (ikinci allo nakil ve donör lenfosit infüzyonu) uygulama şansını azalttığı için sağkalımı olumsuz etkilediği düşünülmektedir.

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ajanlar genellikle geri çekilir ve nadiren bunun kendisi büyük bir hastalık tepkisi doğuracaktır. Daha yaygın olarak, bazı sistemik tedavi ardından allojenik hücresel tedavi uygulanır. Sistemik tedavi, konvansiyonel kombinasyon indüksiyon kemoterapisinden yeni hedefli veya immünomodülatör ajanlara kadar uzanır. Hücresel terapi genellikle DLI veya ikinci bir allojenik HKHN şeklindedir. En iyi prognoza sahip hastalar şaşırtıcı değildir, nükseden önce uzun bir remisyona giren ve hücresel tedavinin verilmesinden önce remisyon elde edebilenler şaşırtıcı değildir. Bu seçilmiş hasta alt grubunda, kalıcı remisyon oranlarının% 20–25'e yaklaşabileceği görülmektedir.

Daha yeni yaklaşımlar, hücresel terapi olmadan GVL'yi geliştirebilecek gibi görünen lenalidomid ve GVHH'den kaçınmak için potansiyel olarak GVL'yi yönlendirebilecek CAR-T teknolojisi gibi ajanların kullanılmasını içerir. Bu yaklaşımların sonuçları merakla beklenmektedir. Önemli olarak, HKHN ‹yi takiben tekrarlayan AML'li hastalar için genel prognozun oldukça zayıf olduğu ve kalıcı remisyon olasılığının oldukça düşük olduğu göz önüne alındığında, palyatif önlemler uygundur ve HKHN ‹den sonra hastalığın erken ve agresif olarak tekrarlayan hastalara önerilmesi gerekir. Devam eden ve gelecekteki araştırmalar, HKHN 'den sonra hastalığın nüksetmesinin daha iyi önlenmesiyle sonuçlanacağını, etkili GVL'den daha iyi yararlanmanın yeni yollarını belirleyeceğini ve zaman içinde daha yüksek kalıcı remisyon ve iyileşme oranlarına yol açacağını umar.

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