Bölüm 5

SAFRA YOLU KARSİNOMU (KOLANJİOKARSİNOM) VE CERRAHİ YAKLAŞIM

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GİRİŞ

Kolanjiokarsinomlar (KK) safra yolu epitelinden köken alan tümörlerdir ve sıklıkla hepatik duktus bileşkesinde yer almaktadırlar (1). Primer karaciğer maligniteleriniin hepatosellüler karsinomdan (HCC) sonra ikinci en sık görülen maligniteleridir, tüm hepatik kanserlerin %10-20'sini oluşturmaktadırlar (2). Kolanjiokarsinomlar intrahepatik, perihiler ve distal kolanjiokarsinomlar olarak sınıflandırılırlar. %60-80 oranında perihiler bölgeden kaynaklanırken sadece %10'u intrahepatik bölgeden köken alır (3,4). Hastaların çoğu tanı aldığında ileri evrededir ve unrezektabl hastaların büyük bölümü tanı aldıktan sonra 1 yıl içerinde kaybedilir (1,3,5).

EPİDEMİYOLOJİ

Kolanjiokarsinomlar, gastrointestinal sistem kanserlerinin yaklaşık % 3'ünü oluşturur ve otopsi serilerinde prevelansının %0.03-0.46 olduğu bildirilmektedir (6). Son çalışmalarda açıklanamayan nedenlerle insidansın ve mortalitenin arttığı gösterilmiştir. Örneğin İngiltere'de ölüm sayıları artarak 2010-2013 yılları arasında 1720 'den 2161'e yükselmiştir (7,8). Benzer şekilde ABD'de insidans oranları son otuz yılda %165 artarak 100.000'de 0,85'e yükselmiştir (2).

RİSK FAKTÖRLERİ

Batı toplumlarında kolanjiokarsinom vakalarının çoğu sporadiktir. Bilinen en sık risk faktörü primer sklerozan kolanjittir (PSK) ve vakaların %10'ından sorumludur (8,9). PSK'in bilinen tek küratif tedavisi karaciğer transplantasyonudur (10). Karaciğer sirozu rölatif olarak 10 kat risk artışına neden olur (11). Safra yollarının herhangi bir yerindeki taşların kolanjiokarsinom riskini artırdığı bilinmektedir. İntrahepatik safra yollarında taş olması hepatolitiyazis olarak adlandırılır ve bu vakaların %10'unda intrahepatik kolanjiokarsinom gelişmek-

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Rezeksiyon ve adjuvan tedavi sonrasında lokal nüks ve metastaz açısından altı aylık aralarla iki yıl boyunca iv kontrastlı abdominopelvik BT/MRI, toraks BT ile takip uygun görülmüştür. Sonrasında beş yıla kadar yıllık takip gerekmektedir (62).

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