GEBELİKTE SİSTEMİK KEMOTERAPİ PRENSİPLERİ

12. BÖLÜM

Bermet JUNUSHOVA [1]

GİRİŞ

Geçtiğimiz kırk yılda, çocuk doğurmayı geciktirme eğilimi artmıştır [1]. Kanser insidansının

yaşla birlikte arttığı göz önüne alındığında, daha fazla sayıda kadına ya gebelik sırasında kanser teşhisi konulmakta ya da kanser teşhisini takiben gebeliğin fizibilitesi ve güvenliği araştırılmaktadır.

Gebelikle birlikte kanser tedavisi, hem anne hem de bebek sağlığını ilgilendiren çok özel bir öneme sahiptir. Gebelik malignensi riskini arttırmamaktadır, kanser insidansı aynı yaştaki gebe olmayan kadınlarla aynı. Ancak gebelik sırasında annede olan fizyolojik değişiklikler ve, invaziv tanı yöntemleri ve radyolojik görüntülemenin çoğunlukla kullanılamaması nedeniyle tanı gecikebilmektedir. Gebeliğin kanser seyrinde ve sağkalım süresi üzerine olumsuz bir etki gösterilememiştir.

HAMİLELİK SIRASINDA KANSER İNSİDANSI

Hamilelik sırasında kanser teşhisi nadirdir. Her 1000 hamile kadından birine kanser teşhisi konduğu tahmin edilmektedir. Meme, melanom ve rahim ağzı kanserleri gebelikte en sık teşhis edilenler olup, bunu hematolojik maligniteler izlemektedir (2-4).

TANI VE BİYOLOJİK ÖZELLİKLER

Kadın doğum uzmanları ve pratisyen hekimler, meme kitlesi, atipik vajinal akıntı, değişen ben veya genişleyen lenf nodunun kanser teşhisi ile ilişkili olabileceği konusunda iyi bilgi sahibi olmalıdırlar. Endike olduğunda, şüpheli lezyon-

[1] Dr., Özel Gazi Hastanesi, Medikal Onkoloji bermet.junushova@gmail.com

da kognitif bozukluklar tanımlanmaktadır. Annede veya bebekte hayati bir risk olmadıkça erken (34-37) veya çok erken (<34 hafta)doğumlar engellenmelidir. Gebelik terme kadar bekletilmelidir.

Kemoterapi, tahmini doğum tarihinden 3 hafta önce kesilmelidir. Hematolojik toksisiteyi azaltmak amacıyla haftalık kemoterapi uygulamaları tercih edilmelidir.

Kemoterapi alan annelerin emzirmesi önerilmez

Gebelik ve kanser birlikteliği olan her olgunun bildirilmesi ve uzun süreli takibi, bilgi birikiminin artmasını sağlayacaktır.

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