GEBELİKTE BAŞ – BOYUN TÜMÖRLERİ VE YÖNETİMİ

33. BÖLÜM

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GİRİŞ

Skuamöz hücreli baş-boyun kanserleri(SHBBK) dünyada en sık görülen 6. kanserdir ve tüm kanserlerin %6'sını oluşturur.[1] Başvuruda olguların üçte ikisi ileri evrededir.[2] Lokal ileri evre hastalıkta tedavi sonrası ortalama iki yıl içerisinde %50-60 oranında lokal nüks ve %20-30 oranında da uzak metastaz gözlenir.[3,4]

Baş-boyun kanserleri dudak, oral kavite, farinks, larinks, paranazal sinüsler, tükrük bezi kanserleri ve mukozal melanomları içerir. Genellikle baş-boyun içindeki nemli, mukozal yüzeyleri (örneğin ağız, burun ve boğaz) kaplayan skuamöz hücrelerden başlar. Histolojik olarak bu kanserlerin %90'ından fazlasını skuamöz hücreli karsinomlar oluşturur. Tipik olarak ileri yaş erkekleri etkileyen bir hastalık olarak kabul edilir ve erkek-kadın oranı yaklaşık 4:1'dir.[5] Alkol ve tütün kullanımı oral kavite, hipofarinks, larinks ve HPV ilişkisiz orofarinks kanserlerinde en sık görülen etiyolojik faktörlerdir. Son zamanlarda bu risk faktörlerine sahip olmayan genç hastalarda da skuamoz hücreli baş-boyun kanserleri insidansında bir artış olduğu görülmüş ve bunların daha agresif bir seyir gösterip göstermediği konusunda tartışmalar başlamıştır.[6] Özellikle reprodüktif kadınlarda görülen dil kanserleri bu artışın önemli kısmını oluşturmaktadır.[7]

Gebelik esnasında kanser görülme sıklığı düşüktür, tüm gebelerin yaklaşık % 0.02 ila % 0.1'inde kanser gelişir.[8] Ancak bu oran son zamanlarda gebelik yaşının artması ve yaş ile kanser arasındaki ilişkiden dolayı artmaktadır.[9]

Gebelikte skuamoz hücreli baş-boyun kanseri (SHBBK) teşhisi konulduğunda, klinisyenler anne ve fetüs sağlığını korumada zorlukla karşılaşırlar. Annenin yaşamı önceliklidir, ilk trimesterde gebelik sonlandırılabilir veya erken doğum planlanabilir. Hasta etik karar vermede zorlanabilir ve klinisyen hem optimal kanser tedavisini yapmak hem de fetüsü korumakla görevlidir.

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SONUÇ

Gebelikte baş-boyun kanserleri yönetimi ile ilgili sınırlı sayıda çalışma vardır. Kılavuzlar retrospektif çalışma ve vaka sayılarından ibarettir. Epidemiyolojik değişiklikler ve gebeliğin geç üreme yıllarına kadar gecikmesi nedeniyle, hamilelik sırasında daha fazla baş ve boyun kanseri vakası beklenebilir. Tedavinin zamanlaması, fetal etkinin önemli bir belirleyicisidir. Tedavi bireyselleştirilmelidir. Buradaki zorluk, bir yandan kanserin optimal tedavisini diğer yandan sağlıklı bir fetüsün korunmasıyla dengelemektir. Tedavi kararı anne ve fetüs sağlığı gözetilerek multidisipliner bir yaklaşımla alınmalıdır.

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