

GEBELİKTE TİROİD KANSERİNE CERRAHİ YAKLAŞIM

**45.
BÖLÜM**

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GİRİŞ

Tiroid kanseri gebelik döneminde en sık görülen 2. Kanser (meme kanserini takiben) tipidir (1,2). Görülme sıklığı 100.000 doğumda 14 olup, en sık görüldüğü dönem ise 25-30 yaş aralığıdır (3,4). Kadınlarda üreme dönemindeki tiroid kanserlerinin %10'u gebelik sırasında veya erken postpartum dönemde ortaya çıkar (5). En sık saptanan histolojik alt tip 'papiller karsinoma'dır (3,4). Genellikle serbest T4 ve TSH değerlerinin prenatal dönemde normal değer aralığında olmadığı tespit edilmesi üzerine yapılan incelemeler ardından uygulanan ince iğne aspirasyon biopsisi (İİAB) yoluyla tanı konur. Hastalar çoğunlukla asemptomatiktir (6). Klinisyenlerin en büyük sorunu aynı anda hem anneyi hem de gelişmekte olan çocuğu birlikte ele alıp, takip etmektir (7,8). Tiroid kanserinin tanı ve tedavisine dair protokoller, toplumun diğer yaş ve cinsiyet grupları ile ana hatlarıyla aynı olmakla birlikte gebelik döneminde birtakım kısıtlamalar ve farklılıklar da bulunmaktadır, örneğin cerrahının zamanlaması ve radyoaktif iyot ablasyon tedavisinin gebelik devam ederken uygulanması gibi (8). Gebelik sırasında tiroid kanseri teşhisi konulması, hastalarda anksiyete gelişmesine sebep olur (hem kendi sağlıklarını hem de çocuğun durumu açısından). Bu durum cerrahının ve diğer tedavi modalitelerinin zamanlamaları ve uygulama biçimleri konusunda endişe ve tereddüte yol açar (4,5,9). Gebelik devam ederken görülen tiroid kanserini ele alırken; cerrahının zamanlaması, gebelik sürerken tiroid kanserine yönelik sistemik tedavi ve gebeliğin tiroid kanserinin yol açtığı sonuçlara etkileri gibi tartışılmazı gereken birçok konu mevcuttur (8). Radyoaktif iyot ablasyon (RAI) tedavisinin uygulanması ve tiroid kanseri tedavisi gerçekleştirildikten sonra levotiroksin (l-T4) verilmesi hususları değerlendirilirken de gelecekteki olası gebelikler dikkate alınmalıdır (8).

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anlamda kabul gören yaklaşım; diferansiyeli tiroid kanserlerinde; ciddiyet ve risk arz eden durumlarda (hızla büyüyen servikal lenf nodu metastazları, hızla büyüyen tümörler ve ciddi bası bulguları gibi) cerrahi girişimin 2. trimesterde yapılması; riskin ve klinik tablonun daha kabul edilebilir olduğu durumlarda ise cerrahinin, doğum sonrasında yapılması biçimindedir. Hastada kanser tanısından dolayı aşırı anksiyete var ise bu durum sağlık ekibindeki uzmanlar arasında mutlaka değerlendirilmelidir. Literatürde yeterli veri bulunmayan medüller ve anaplastik kanserlerde ise cerrahi, tanıyı takiben uygulanmalıdır.

Radyoaktif iyot (RAI) ablasyon tedavisi de endike olduğu takdirde, doğum sonrası dönemde uygulanmalıdır.

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