

MALİGNİTEYE SEKONDER ADRENAL YETMEZLİK

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Giriş

Adrenal yetmezlik, hipotalamik - pitüiter - adrenal aksta meydana gelen herhangi bir bozukluk nedeniyle glukokortikoidlerin, mineralokortikoidlerin ve androjenlerin yetersiz salınımı sonucu oluşan klinik tablodur. Primer adrenal yetmezliğin en sık sebebi otoimmünitedir. Sekonder adrenal yetmezlik ise hipotalamo-hipofizer aks bozukluğuna yol açan hipofiz hastalıkları ve uzamış steroid tedavisinin kesilmesi nedeniyle görülebilmektedir. Adrenal yetmezlik, yaşam kalitesinde önemli ölçüde azalma ve artmış mortalite ile ilişkilidir.

Maligniteli olgularda adrenal yetmezlik nadir görülmektedir. Bu durum, onkolojik olgularda fiziksel ve mental stresin, hipotalamik - pitüiter - adrenal aksı aktive etmesi ve dolayısıyla artmış bazal kortizol düzeyleriyle açıklanabilir (1 – 3). Ayrıca, onkolojik pratikte birçok tedavi protokolü içerisinde steroidlerin yer alması adrenal yetmezliğin maskelenmesine yol açmaktadır. Büyük ve bilateral adrenal metastaz tespit edilen olgularda, adrenal korteksin %90'ından fazlasının hasar görmesi durumunda adrenal yetmezlik gelişebilmektedir (4, 5).

Etiyoloji

Maligniteli olgularda adrenal yetmezlik en sık iyatrojenik nedenlere bağlı görülmektedir. Cerrahi adrenalectomi, aminoglutetimid, mitotan veya kronik kortikosteroid kullanımı en sık görülen iyatrojenik nedenler arasındadır. Ad-

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Tartışma: Klinik ve laboratuvar bulguları değerlendirilerek glukokortikoid dozu 1 - 3 gün içinde azaltılmalı ve oral idame tedavisine geçilmelidir. Tedavisine 0,1 mg fludrokortizon tedavisi eklenmelidir. Meme karsinomunun adrenal metastazına bağlı adrenal yetmezlik düşünülen olguda meme karsinomu-na yönelik tedavi düzenlenmelidir.

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