BÖLÜM
14

Diferansiye Tiroid Kanseri Postoperatif Risk Sınıflaması: Risk Sınıflamasına Göre Tedavi Yaklaşımı

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Özet

Diferansiye tiroid kanserli hastaların büyük çoğunluğunda prognoz mükemmel olmakla birlikte; % 10 hastada lokal nüks ve/veya uzak metastaz ve nadiren de mortalite görülebilmektedir. Bu nedenle vakaların çoğunluğunu oluşturan, hastalık spesifik mortalite ve morbidite açısından düşük riskli hastalarda aşırı tedaviden kaçınmak gerekir. Ayrıca yüksek riskli hastalarda yetersiz tedavi durumundan kaçınmaya dikkat edilmelidir. Bunun için uygun ve aktif bir izlem önemli hedeflerden biridir. Günümüzde tiroid kanser tedavisi tek tip bir yaklaşımdan ziyade, riske dayalı tedavi yaklaşımına doğru bir geçiş göstermiştir. Bu değişim, hastalık spesifik mortalite, yapısal hastalığın persistans/nüks riski, tedavi yetersizliği gibi durumları öngören ve erken takibi mümkün kılan risk değerlendirme araçlarının gelişmesi ile gerçekleşmiştir. Tiroid kanseri için birçok farklı sınıflama ve evreleme sistemi geliştirilmiştir. Dahası tanı, tedavi ve takibi için klinik pratikte birçok rehber yayınlanmıştır. Amerikan Tiroid Derneği'nin (American Thyroid Association) (ATA) 2009'da yayınladığı rehber tiroid kanser yönetiminde önemli bir etkisi olan yapısal hastalığın nüks ve persistans riskini dikkate alarak risk sınıflandırmasını kuvvetle önermiştir. 2015 yılında revize edilerek ve ek öneriler ile yeni ATA kılavuzu yayınlanmıştır. Amerikan Ortak Kanser Komitesi (American Joint Committee on Cancer (AJCC) ve Uluslararası Kanser Savaş Komitesi (International Union Against Cancer Committee (UICC)'nin önerdiği TNM sınıflaması ise mortalite riskini saptamak için kullanılır. Bu sınıflama literatürdeki kanıt düzeyine göre periyodik olarak güncellenen tek sınıflama sistemidir. AJCC/TNM Evreleme Sistemi, hastalık spesifik sağkalımı öngörmek için, ATA risk sınıflandırma sistemi ise hastalık nüks riskini tahmin etmek için dizayn edilmiştir. Bu riske dayalı yaklaşımda tedavi ve takip önerileri her hasta için bireyselleştirilmiştir. Diferansiye tiroid kanseri (DTK)'nin yönetimi, başlangıç risk derecesini dikkate alarak planlanmalıdır. Bu plan; riske göre tiroid uyarıcı hormon (TSH) baskı düzeyi, radyoaktif iyot kararı, izlem aralığı ve takip edilecek tetkikleri içermelidir. Diğer önemli ek yaklaşım tedaviye cevap ölçütlerini ve sonuçlarına göre dinamik risk değerlendirmesidir. Bu strateji, her bir hastanın hem klinik durumunun hem de her vizitdeki takip planının sürekli olarak yeniden değerlendirilmesini sağlayarak takibin bireyselleştirilmesini sağlar.

etki profiline ve hastalığı yöneten ekibin tedavi stratejisine ve hastanın tercih ve değerlerinin değerlendirilmesine dayanmalıdır (95)

RAI'nin tedavi hedefleri; remnan ablasyon, adjuvan tedavi veya bilinen rezidüel veya nüks hastalığın tedavisi olarak tanımlanmalıdır (96);

Remnan ablasyon; normal rezidüel fonksiyonel tiroid dokusunun belirtilen amaçlarla I-131 kullanılarak tahrip edilmesidir; (1) takip eden serum Tg seviyelerinin yorumlanmasını kolaylaştırmak, (2) takip eden takip RAI tüm vücut taramalarında lokorejyonel ve/veya metastatik hastalığın saptanmasının duyarlılığının artırılması, (3) takip eden herhangi bir I-131 tedavisinin terapötik etkisini maksimize etmek, (4) ablasyon öncesi taramada tanımlanmayan veya ablasyon öncesi tarama yapılmadığında şüphelenilen durumlarda ek hastalık bölgelerini tanımlayan postablatif taramayı kolaylaştırmak (6,97).

Adjuvan tedavi; tiroid kanserinin potansiyel nüksünü ve mortalitesini azaltmak için bilinmeyen mikroskopik tiroid kanser ve/veya şüphelenilen ancak kanıtlanamayan rezidüel tiroid kanserini tahrip etmek için I-131'in kullanılmasıdır (6,97). Böylelikle hastalık nüksünü azaltır, hastalık-spesifik sağkalım'ı iyileştirir (6,95)

Tedavi; Tiroid kanserinin potansiyel nüksünü ve mortalitesini azaltmak ve/veya palyasyonu amacıyla bilinen lokorejyonel ve/veya uzak metastazların I-131 kullanılarak tahrip edilmesidir (6,97). Böylelikle remisyona girmeyi kolaylaştırabilir, DSS'ı ve progresyonsuz sağkalımı iyileştirebilir (6,95)

Ablasyon ve adjuvan RAİ uygulaması için 2015 ATA rehberinde (6) özetle ; 1- Düşük riskli DTK'de rutin olarak RAI ablasyonu önerilmemektedir (nüks riskini değiştirecek bireysel faktörler, hastalığın takibinde kolaylık sağlamak ve hastanın tercihleri de dikkate alınmalıdır) 2-Kötü özellikler yokluğunda unifokal PTMK'de RAI rutin önerilmemektedir (kuvvetli öneri), 3-Kötü özellikler yokluğunda multifokal PTMK'de RAI rutin önerilmemektedir (zayıf öneri). 4-Orta riskli DTK'de RAI düşünülebilir. 5-Yüksek riskli hastalarda RAI rutin önerilmektedir.

Sonuç

Son 10-20 yılda düşük riskli tiroid kanseri prevalansındaki çarpıcı artış DTK için geleneksel "tek tip yaklaşımının" yeniden değerlendirilmesine bağlanmıştır. Hasta yönetiminde daha bireyselleştirilmiş yaklaşıma doğru olan bu geçiş DTK'li hastalarda tanı, başlangıç tedavisi, adjuvan tedavi ve takipde daha fazla risk temelli yaklaşıma yol açmıştır (6). Bu durum hastalık spesifik mortalite ve yapısal/biyokimyasal hastalık nüks riskini öngörmeye yönelik yaklaşımımızın kapsamlı bir değerlendirmesini gerektirmektedir.

Sonuç olarak, risk sınıflandırması temel ve etkin bir yaklaşımdır. AJCC sistemi ile hastalık-ilişkili ölüm riskinin, ATA sistemi ile nüks/persistans riskinin tahmin edildiği çok basamaklı bir süreçdir. Başlangıç yönetim önerilerine şekil vermek için kullanılmaktadır. Tedaviye cevabın değerlendirmesi ile elde edilen veriler dinamik risk sınflandırmasına olanak sağlamaktadır. Dinamik risk değerlendirmesine göre hasta yönetimi hem yetersiz tedavi hem de aşırı tedavi durumlarını engelleyecektir.

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