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Az Diferansiye ve Anaplastik Tiroid Kanseri

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Özet

Az diferansiye tiroid kanseri (PDTC) ve anaplastik tiroid kanseri (ATK) tiroidin nadir görülen ancak tiroid kanserine bağlı ölümlerin çoğunluğunu oluşturan tiroid tümörleridir. Her iki tümör de, tiroid follikül hücrelerinin orijinal özelliklerinin kısmen veya tamamen kaybolduğu kanserlerdir. Bu tümörlerin genetik analizinde, ATK'de ve daha az olarak da PDTC'de farklı onkojenik değişikliklerin olduğu saptanmıştır. En sık değişiklik TERT promotör mutasyonu ve TP53 tümör supresör geninde görülmektedir. Bununla birlikte, BRAF ve RAS mutasyonları PDTC'de, diferansiye tiroid kanseri (DTK) ve ATK'e benzer şekilde en yaygın driver (sürücü) mutasyonlar olmaya devam etmektedir. Bu tümörler, hızlı tümör büyümesi, trakea obstrüksiyonu ile birlikte solunum yetmezliği, ve sıklıkla uzak metastaz ile karakterlidirler.

PDTC'de tüm büyük hastalığın ilk cerrahi ile temizlenmesi tümör kontrolünün önemli bir belirleyicisidir ve böylece yeterli lokorejyonel kontrol elde edilebilir, ancak hastalık spesifik sağkalım düşüktür (%66) ve tedavi başarısızlığı vakaların çoğunda uzak metastazlardan kaynaklanmaktadır. Adjuvan tedavinin yararları belirsiz olmakla birlikte radyoiyot tutan hastalığı olan hastalarda düşünülebilir. Büyük rezidüel lokorejyonel hastalığı olan veya rekürrens riski yüksek olan hastalarda yoğunluk ayarlı radyoterapi (IMRT) verilebilir. PDTC hastalarında ileri yaş (>45 yaş), tiroid dışı yayılım, ileri yaşla birlikte nekroz ve mitoz olması, evresinin pT4a ve M1 olması sağkalımın anlamlı derecede azalması ile ilişkilendirilmiştir. Sekanslama teknolojilerinin daha da ilerletilmesi ve moleküler profilin klinik-patolojik özelliklerle korelasyonu ile PDTC'de morbidite ve mortaliteyi azaltmak için yeni etkin tedaviler gelişmeye devam etmektedir.

ATK'nin tipik prezentasyonu, sıklıkla yaşlı hastalarda görülen ve acil olarak değerlendirilmeyi gerektiren hızlı büyüyen boyun kitlesidir. Değerlendirme hızlı bir şeklide yapılmalı ve en kısa sürede tedavi planı tamamlanmalıdır. Doğru tanı için yeterli doku örneği gerekir, ancak çoğunlukla ince iğne aspirasyonu yeterli olmaz kalın iğne biyopsisi gerekir ve eğer mümkünse deneyimli bir endokrin patoloğun değerlendirmesi önerilir. Ayrıca ATK'nin görüntüleme özelliklerinin bilinmesi radyografik olarak DTK veya tiroid lenfomasından ayrımını destekler ve potansiyel olarak tanıyı hızlandırır. DTK ve medüller

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