Bölüm 6

Paraneoplastik Lökositozis

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GİRİŞ

Paraneoplastik sendrom, anemi, hiperkalsemi, eritrositoz, granülositoz ve trombositoz gibi çeşitli hematolojik klinik bozukluklarda ortaya çıkabilir (1). Akciğer kanserinin paraneoplastik sendromlarla ilişkili en yaygın malignite olduğu düşünülmektedir (2).

Lökomoid reaksiyon (LR), hematolojik malignite yokluğunda kalıcı lökositoz (beyaz kan hücresi (WBC) 40 000/ µL'nin üzerinde) olarak tanımlanır (3). LR'ye enfeksiyonlar, zehirlenmeler, maligniteler, şiddetli kanama veya akut hemoliz neden olabilir. (3). Paraneoplastik lökomoid reaksiyon (PLR), hematolenfoid olmayan sitokin salgılayan bir tümörün (CST) varlığına bağlı olarak ortaya çıkan ve bu solid tümör tarafından kemik iliği infiltrasyonunun yokluğunda ortaya çıkan LR olarak tanımlanabilir (4).

CST'ye bağlı ilk PLR, 1977'de akciğer kanserli bir hastada bildirilmiştir (5). O zamandan beri melanom, mezotelyoma, karsinom ve çeşitli kökenlerden (safra yolları, yemek borusu, safra kesesi, baş ve boyun, karaciğer, mide, idrar kesesi ve tiroid) sarkomlu hastalarda bildirilmiştir (1,4,6-17).

PLR'LERİN ALTINDA YATAN MEKANİZMALAR

PLR genellikle bir CST ortamında gerçekleşir. En yaygın olarak salgılanan sitokin, granülosit koloni uyarıcı faktördür (G-CSF). Bununla birlikte granülosit-makrofaj koloni uyarıcı faktör (GM-CSF), interlökin (IL)-1a, b, IL-3, IL-6 ve tümör nekroz faktörü (TNF)-alfa gibi diğer sitokinler de bildirilmiştir (2,17,18). G-CSF, kemik iliği progenitör hücrelerinin tamamen farklılaşmış

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oynarlar. Bu varlık hakkında bilgi eksikliği, gereksiz tanı testleri ve tedavileri de dahil olmak üzere hasta üzerinde dramatik olumsuz etkilere yol açabilir. Açıklanamayan lökositoz ile uğraşırken, PLR genellikle bir dışlama tanısıdır, ancak tedavinin temel dayanağı altta yatan maligniteyi tedavi etmek olduğundan tanı geciktirilmemelidir.

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