Bölüm
8

GASTROİNTESTİNAL STROMAL TÜMÖRLERDE ENDOSKOPİK TANI VE TEDAVİ YÖNTEMLERİ

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GİRİŞ

Girişimsel endoskopi son dekatta cerrahideki doğal açıklıklardan translüminal endoskopik cerrahi (NOTES) alanının ortaya çıkmasıyla birlikte hızlı gelişme göstermiştir. Girişimsel gastrointestinal endoskopi uygulamaları bu doğrultuda genişlemekte ve gastrointestinal sistemin lümeninin önüne geçmektedir.

Gastrointestinal traktın subepitelyal lezyonları (SEL'ler), muscularis mukoza, submukoza veya muscularis propriya kaynaklı tümörlerdir. Çoğu zaman rutin endoskopi ve kolonoskopi sırasında tesadüfen bulunurlar. Genellikle normal mukozaya sahip kitleler olarak tanımlanırlar. Çoğunlukla küçük (2cm çapından daha küçük) ve asemptomatiktirler; ancak, SEL'ler, tümörün büyüklüğüne, konumuna ve histopatolojisine bağlı olarak semptom verebilirler(1).

Üst gastrointestinal kanalda tespit edilen SEL›lerin çoğunluğu gastrointestinal stromal tümörlerdir. Daha az sıklıkta leiomyom, nöroendokrin tümörler, granüler hücre tümörleri gibi diğer patolojiler gözükmektedir. Rektumda tespit edilen SEL›lerin çoğunluğu SEL›i taklit eden epitelyal tümörler (adenokarsinom, skar) veya NET›tir (2). Kolon kaynaklı olanlar nadir gözükürler ve epidemiyolojileri hakkında kısıtlı bilgi mevcuttur.

GASTROİNTESTİNAL STROMAL TÜMÖRLER

Gastrointestinal stromal tümörler(GIST), gastrointestinal sistemden kaynaklanan en yaygın mezenkimal tümörlerdir. Bu tümörler, gastrointestinal sistemin myenterik pleksusunda bulunan ve gatrointestinal sistem motilitesini ayarlayan Cajal'ın interstisyel hücrelerinden kaynaklanırlar(2,3). Genellikle 5-7 dekatta görülür. K/E

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ENDOSKOPİK REZEKSİYON SONRASI TAKİP

Gastrointestinal stromal tümörler, endoskopik olarak rezeke edildikten sonra, yara iyileşmesine gözlemek, herhangi bir rezidüel tümör varlığını kontrol etmek için tedaviden 3-12 ay sonra kontrol endoskopi yapılması önerilir.

Orta ve yüksek riskli hastaların 3-4 ayda bir abdominal BT veya EUS ile , düşük riskli hastaların ise ilk 5 yıl için, 6 ayda bir BT veya EUS ile kontrolü önerilmektedir(58,59).

Sonuç

Gastrointestinal stromal tümörler için, endoskopik mukozal rezeksiyon, endoskopik submukozal rezeksiyon gibi yöntemler küçük tümörler için minimal invaziv, konforlu, düşük komplikasyonlu, işe dönüş süreleri kısa işlemler olması karşın, derin yerleşimli tümörler için yetersiz kalabilen yöntemlerdir.

Submukozal tünel endoskopik rezeksiyon, Endoskopik tam kat rezeksiyon gibi daha invaziv yöntemler ise R0 rezeksiyon için daha avantajlıdırlar. Ancak tümör ekilmesi, kanama, enfeksiyon gibi komplikasyonlar daha sık görülebilir. Ayrıca bu teknikler ileri endoskopik beceri gerektiren deneyimle merkezler tarafından uygulanabilen özellikli işlemlerdir. EFTR'nin literatür verileri çoğunlukla Asya kaynaklı ve retrospektiftir. Ancak çalışmalarda lezyonların bir bütün olarak çıkarılma oranları net değildir. Takip süreleri kısadır. Yine STER'de benzer şekilde takip süreleri kısa ve genellikle retrospektif vaka serileridir. Ayrıca Çoğu GİST'in düşük riski ve yavaş büyümesi göz önüne alındığında bu tekniklerin uzun vadeli başarısını kanıtlamak zor olacaktır. Eş zamanlı endoskopik ve laparoskopik işlemlerinde kendine göre avantajları ve dezavantajları mevcuttur.

Hastanın genel durumu, tümörün lokalizasyonu, boyutu, cerrahın deneyimi göz önünde tutularak multidisipliner bir yaklaşımla en doğru tedavi seçeneği tercih edilmelidir. Gastroenteroloji, medikal onkoloji, genel cerrahi, radyoloji ve moleküler biyoloji gibi birçok branş bu disiplinin bir parçasıdır(1).

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