Bölüm
11

GASTROENTEROPANKREATİK NÖROENDOKRİN TÜMÖRLERDE RADYOLOJİK İNCELEMELER VE TEDAVİDE GİRİŞİMSEL RADYOLOJİ

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GİRİŞ

Diffüz endokrin sisteme ait birbirinden farklı fonksiyonlara sahip ve farklı hormonlar üreten özelleşmiş hücrelerden köken alan ve gelişen nöroendokrin tümörler(NET) bu özelliklerinden dolayı çok çeşitli klinik tablolar ile karşımıza çıkabilirler. Bununla birlikte NET görüntüleme yöntemlerinin uygulanmasına temel oluşturan bazı özgün özelliklere de sahiptir. Son 4 dekatta giderek artış bildirilen insidansları güncel olarak 3,0-5,2/100000 olarak tahmin edilmektedir, prevelansları ise 35/100000 olarak hesaplanmaktadır (1,2). NET'ler en sık gastro-intestinal ve bronkopuloner sistemde bulunurlar (3).

NET'ler fonksiyonel olup metabolik olarak aktif hormonlar veya aminler salgılayabilir ve buna bağlı klinik semptomlara sebep olabilirler veya non fonksiyone olabilirler ve bu durumda da sıklıkla lokal ileri evre hastalık ya da metastazlar ile prezente olurlar (4,5). Örneğin gastroenteropankreatik NET'lerden (GEP-NET) ince barsak NET'leri genelde serotonin salgılarken, fonksiyonel pankreatik NET'ler köken aldıkları langerhans hücresine göre farklı hormonlar (insülin, glukagon,gastrin vb) salgılayabilirler. NET'lerin çok büyük bir kısmı yavaş büyürler ve somatostatin reseptörleri eksprese ederler ki bu da fonksiyonel görüntülemenin temelini oluşturur (ki-67 indeks ≤ %2, G1). Diğer küçük bir kısmı ise daha yüksek proliferasyon indeksi ile daha hızlı büyürler ve klinik olarak daha agresif davranırlar (ki-67 indeks: %3-20, G2). Nadiren de kötü diferansiasyon gösteren, yüksek proliferasyon indeksli nöroendokrin karsinomlar (ki67 indeks>%20, G3) görülebilir. Bu farklı klinik tablolar nedeniyle de herbir hastada ihtiyaç duyulan görüntüleme yöntemi de farklılıklar göstermektedir.

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ampulla düzeyinde koledokta bası oluşturan yaklaşık 1 cm boyutlu, arteriyel fazda daha belirgin olmak üzere kontratslanma gösteren lezyon izlenmektedir. Bu lezyonun patoloji sonucu NET olarak gelmiştir.

Resim 7 74 y karın ağrısı semptomu ile başvuran K hastada kontrastlı BT tetkikinde aksiyel ve koronal rekonstrüksiyon imajlarında ileal ans komşuluğunda santral nekrotik dejenerasyon gösteren, heterojen kontrastlanan büyük boyutlu lezyon izlenmiştir. Bu lezyon tespit edildikten sonra opere olan hastada lezyonun komşu ileal ans ile yapışık olduğu görülmüş ve ileal ans içerisinde milimetrik boyutlu NET histopatolojik olarak tespit edilmiştir.

Resim 8: 67 y K hasta akut appandisit şüphesi ve kliniği nedeniyle çekilen kontrastlı abdomen BT'de çekum duvarında da kalılaşmaya yol açan appendiksin tamamını tutan lezyon izlenmektedir. Postop histopatoloji sonucunda bu lezyonun appendiksi tutan NET olduğu raporlanmıştır. Resim 9 84 y K hastada genel durum bozukluğu nedeniyle yapılan tetkiklerinde BT incelemede rektum duvarında duvar kalınlaşması ve karaciğerde arteriyel fazda (b) hafif heterojen kontrastlanmaya başlayan ve portal venöz fazda (c) karaciğer parankimal fazı oluştuktan sonra hipodens hipovasküler multiple lezyon izlenmiştir. Hastanın karaciğer kitle biyopsi sonucu NET ile uyumlu gelmiş ve rektum duvarından alınan biyopsi tanıyı rektum NET olarak kesinleştirmiştir. Resim 10 52 y K hasta karaciğerde multiple primer GIS NET'e sekonder metastazları mevcut (a,b), transarteriyel kemoembolizasyon uygulanan hastada işlem öncesinde alınan anjiografide hipervasküler lezyonlar izlenirken, embolizasyon sonrasında lezyonlarda vaskülaritenin tama yakın kaybolduğunu görülmektedir (c,d).

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