LENFOMALARDA GERİATRİK HASTA YÖNETİMİ

43. BÖLÜM

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GİRİŞ

Dünya nüfusu, uzayan ömür ve düşen doğurganlık sonucu hızla yaşlanma sürecine girmiştir. Yirminci yüzyılın başında ortalama yaşam elli yılın altında iken bugün ortalama yetmiş dokuz yıl olarak hesaplanmaktadır (1). Yaşam süresinin uzaması ile karsinojenezin geç dönemlerine ait hücrelerin dokularda birikimi, immün ve endokrin sistemlerdeki değişiklikler, hücrelerin yenilenme ve apoptozis yeteneğini kaybetmesi ve yaşa bağlı telomeraz instabilitesi gibi mekanizmalarla birçok kanser türünün görülme sıklığı da artmıştır (2,3). Lenfoproliferatif hastalıkların sıklığı da yaş ile artış göstermektedir. Lenfoma teşhisi konan hastaların yarısı 60 yaşın üzerinde ve bunların önemli bir kısmı da 80 yaşın üzerindedir.

Yaşlı hastalarda lenfoma yönetimi özel dikkat gerektirir. Çünkü iyileşme potansiyeli yüksek olan bu hastalıkta; ek komorbid durumlar, organ fonksiyonlarında azalma, ilaç metabolizması değişiklikleri ve hematopoetik kapasitede azalmaya bağlı olarak tedavide kullanılan ilaçlar yaşlı hastada tolere edilememekte ve sıklıkla doz azaltılmasına gereksinim duyulmaktadır (4). Bu nedenle tedavi kararı öncesinde hastanın kapsamlı geriatrik değerlendirmesi (5) yapılmalı; günlük yaşam aktivitesi kaybı değerlendirilmeli, performans durumu, genel yaşam beklentisi, ek komorbiditeleri, organ fonksiyonları ve sosyal desteği belirlenerek hastaya yön çizilmelidir.

Histopatolojik özellikleri, tedavi ve takip parametreleri birbirinden farklı olan Hodgkin ve non-Hodgkin lenfomanın geriatrik hastada yönetimi ayrı başlıklarda incelenecektir.

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Nüks/ Refrakter Geriatrik NHL Tedavisi

Genç relaps/refrakter agresif NHL hastalarında standart tedavi yaklaşımı yüksek doz kemo-immünoterapi ve takibinde otolog kök hücre nakli olmasına rağmen, bu tedavi 70 yaş altı fit hastalar haricinde geriatrik hastalarda genellikle uygulanamamaktadır. Relaps/refrakter yaşlı fit hastalarda R-bendamustin, R-Gem-Ox (rituksimab, gemsitabin, oksaliplatin), dozu azaltılmış R-ICE (rituksimab, ifosfamid, sisplatin, etoposid) ya da lenalidomid, ibrutinib ve venatoclax gibi tedavi seçenekleri kullanılabilir. Unfit ya da kırılgan hastalar ise yeni ilaçlar ile klinik çalışmalara yönlendirilmeli ya da destek tedavisi ile takip edilmelidir.

Relaps/refrakter indolent NHL hastalarında ise önce tedavi ihtiyacı olup olmadığı gözden geçirilmeli; obinutuzumab, ibrutinib, lenalidomide venatoclax gibi yeni tedavi ajanlarından, hastaya ve lenfoma alt-tipine uygun olan tedavi başlanmalıdır.

SONUÇ

Geriatrik popülasyonda multifaktöryel olarak yetersiz tedavi progresyon ve erken relaps ile sonuçlanmaktadır. Hastaların kapsamlı geriatrik değerlendirmesi yapılmalı, hasta komorbiditeleri ve hastalık evresine uygun şekilde tedavi planı oluşturulmalıdır. İlk basamak tedavide antrasiklin kullanılan rejimler hem HL, hem de agresif NHL'de hastalıksız sağkalım ve genel sağkalım açısından üstündür. Genellikle ileri evre ve relaps hastalarda kullanılan yeni ajanlar daha az toksik ve tedavi uyumu daha yüksek görülmekle birlikte veriler geriatrik hastalar için küçük gruplarla sınırlıdır.

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