BÖLÜM 29

PENİL KANSERLER

Derya DEMİRTAŞ ESMER[1]

EPİDEMİYOLOJİ

Penis kanseri, gelişmiş ülkelerde 100.000 erkekte 0.1-1 prevalansı olan nadir bir kanserdir. Bununla birlikte, küresel insidans, insan papilloma virüsü (HPV) enfeksiyonu, sigara içme ve kötü hijyen gibi risk faktörlerine veya rutin bebek sünneti gibi koruyucu faktörlere bağlı olarak farklı popülasyonlar arasında önemli ölçüde değişmektedir(1,2) .Bu nedenle, bazı Afrika, Asya ve Güney Amerika bölgelerinde penis kanseri erkek malignitelerinin %10'unu oluşturabilir(1)Penis kanseri tipik olarak yaşlı erkeklerin bir hastalığıdır ve görülme oranı yaşla birlikte artar (3)40 yaşın altındaki erkeklerde de penis kanseri görülebilmesine rağmen ortalama tanı yaşı 60'tır (4,5)

Risk faktörleri:

Penisin skuamöz hücreli karsinomu (SCC) veya bir öncül lezyonun gelişmesi bir dizi risk faktörü ile ilişkilidir.

Epidemiyolojik faktörler:

Bir seride, in situ ve invaziv penil kanser için risk faktörlerini belirlemek amacıyla penil kanserli 137 erkek ve kansersiz 606 erkek ile görüşülmüştür (6). Penis kanseri gelişenler daha sık bekar, hiç evlenmemiş ve daha büyük yaşta sünnet edilmiş erkeklerdi. (ortalama yaş, 38'e karşı 20 yıl)

Penisin medikal durumuları:

Bir dizi tıbbi durum, penis kanseri riskinin artmasıyla önemli ölçüde ilişkilidir (6,7)

- Genital siğiller (olasılık oranı [OR 7.6).
- İdrar yolu enfeksiyonu (OR 1.7).
- Penil yırtık (OR 5.2). Çocuklukta sünnet edilen erkekler arasında risk iki kat daha fazlaydı (OR 2.1); hiç sünnet olmamış erkeklerde ise 12 kattan daha yüksekti (OR 12.5).

[1] Uzm. Dr., Ankara Şehir Hastanesi, Tıbbi Onkoloji Kliniği, drderyademirtas@gmail.com

- Patolojik olarak pozitif nodlarla (pN+) LND uygulanan hastalar, lokal ve/veya uzak nüks açısından yüksek risk altındadır. Bu hastalar ilk iki yıl üç ayda bir, 3. yıl dört ayda bir, daha sonra 4. ve 5. yıllarda altı ayda bir fizik muayene ile takip edilmelidir. Nod pozitif hastalar için ilk iki yıldaki tüm ziyaretlerde abdominal-pelvik CT önermeliyiz. Bu dönemden sonra görüntüleme çalışmaları isteğe bağlıdır.

Rekürens

İnvaziv hastalık ilk organ koruyucu tedavi sonrası olumsuz bir bulgudur ve nüksün evresine göre tedavi edilmelidir(86,87). Yakın zamanda yapılan bir çalışma, lokal tekrarlayan ILN metastazları olan penis kanserli hastalarda ILND'nin faydalı olabileceğini düşündürmektedir(88).

Metastatic Hastalık

Yaygın hastalık (M1) ile başvuran veya metastaz gelişen hastalar için, tedaviyi hastanın performans durumu ve semptomlarına göre bireyselleştirmek gerekir [89]. Performans durumu iyi olan erkekler için platin bazlı kemoterai veya varsa bir klinik çalışmaya yönlendirilmesi önerilir. Diğerleri için en iyi destekleyici bakımı(destek tedavi) tercih ediyoruz; bu hastalardan bazıları, paklitaksel ve karboplatin gibi palyatif platin bazlı kemoterapi için de uygun olabilir. Kontrol noktası inhibitörleri de dahil olmak üzere immünoterapinin rolü, DNA onarım eksikliği veya mikro satellit instabilitesi olan durumlar dışında ileri penis kanseri için belirlenmemiştir.

Kemoterapi, uzak metastatik penil karsinomu olan hastalarda yüzde 30 ila 38'e varan genel yanıt oranlarıyla sonuçlanır [90-92]. İlk kemoterapiden sonra progrese olan hastalarda prognoz kötüdür ve medyan sağkalım altı aydan azdır [93].

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