

13. BÖLÜM

Mesanenin Skuamöz Hücreli Neoplazileri

Gülsüm Seyma YALÇIN¹

NON-İNAZİV SKUAMÖZ LEZYONLAR

Skuamöz Metaplazi

Skuamöz metaplazi ürotelyumun (transizyonel epitelin) yerini çok katlı skuamöz hücre tabakasının almasıdır (1). Genel olarak iki ana kategoriye ayrılmaktadır: non-keratinize tip ve keratinize tip skuamöz metaplazi (2). Non-keratinize skuamöz metaplazi (N-KSM) (vajinal subtip) ürotelyal mukozanın normal bir varyantı olarak kabul edilmektedir. Özellikle kadınlarda trigon ve mesane boynunda görülebilir (3). Postmortem inceleme yapılan bir çalışmada, makroskopik olarak normal görünümdeki mesanelerde kadınlarda %46, erkeklerde ise %7 oranda N-KSM görüldüğü bildirilmiştir (4). Kadınlarda yapılan başka bir çalışmada ise %72 sıklık tespit edilmiştir (5). Tekrarlayan idrar yolu enfeksiyonu veya karın ağrısı gibi şikayetlerle hastaneye başvuran ve sistoskopi yapılan çocuklarda %7,5 oranda N-KSM izlenmiş, bu gruptaki erkek çocuk oranı ise %2,5 olarak tespit edilmiştir (6).

Keratinize skuamöz metaplazi (KSM) ise enfeksiyon, taş, kalıcı kateter veya Schistosomiasis parazit yumurtaları gibi kronik irritasyon oluşturan durumlara verilen patolojik bir yanittır. Batı toplumlarında sık görülen enfeksiyöz etkenler Escherichia coli, proteus ve Streptococcus faecalis'tir. Daha nadir görülür (2, 7, 8). Hematüri, dizüri gibi non-spesifik klinik bulgular olabilir (9). Sistoskopik olarak hiperemi zemininde inci benzeri gri-beyaz renkli plaklar şeklinde izlenir, bu nedenle klinik olarak lökoplaki olarak da isimlendirilebilmektedir (1,

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tabakalarından oluşurlar. Yüzeye doğru uzamiş projeksiyonlar şeklinde papillomatozis ve tabanda ise infiltratiften ziyade, geniş tabanlı itici sınırlarla karakterlidir. Hücreler geniş sitoplazmali, üniform özellikte olup, anaplasti bulguları içermezler. Tümörün tabanında kronik inflamatuar hücreler görülebilir (53, 54). Tipik verrüköz karsinom alanları yanı sıra infiltratif özellikte SCC alanları içeren olguların verrüköz karsinom olarak sınıflandırılması uygun değildir, bu nedenle lezyonun tüm alanlarının örneklenmesi gerekmektedir (17).

Tedavisi cerrahidir, radyoterapi kullanımı önerilmemektedir (53). Rapor edilen bir olguda intravezikal mitomisin sonrası 5. ayda rekürrens görülmüştür (56). Diğer organlarda görülen verrüköz karsinomlar iyi прогнозlu olmakla birlikte, mesane verrüköz karsinomlarına ait veriler kısıtlıdır. Schistosomiasis ilişkili olsun veya olmasın, mesane verrüköz karsinomlarının minimal progresyon riskine sahip olduğu belirtilmektedir (17).

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