ONKOLOJİ HASTALARINDA TROMBOSİTOPENİ YÖNETİMİ

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GİRİŞ

Kanser hastalarında trombositopeni, çok faktörlü patogeneze sahip, sık görülen bir bulgudur (1). Trombositopeni insidans oranları tümör tipine göre değişir. ABD'de 43995 solid organ tümörü vakası raporuna göre, kolorektal kanser, over kanseri, küçük hücreli olmayan akciğer kanseri ve meme kanserinde trombositopeni insidansı oranları sırasıyla %61,7, %0,5, %45,6 ve %37,6'dır (2). Ocak 2016' dan Haziran 2017'ye kadar yapılan bir ön veri analizinde ise, karaciğer kanserinde trombositopeni insidansı oranının %40'ın üzerinde olduğunu, meme kanserinde %3,7, diğer kanserlerde ise %10 ile %20 arasında olduğunu göstermektedir. Çoğunlukla kemik iliği proliferasyonunu azaltıcı miyelotoksik kemoterapi rejimlerinin kullanımı ile ilişkilidir. Akciğer kanseri ve jinekolojik kanser dahil birçok kanser için kullanılan platin içeren kemoterapi rejimlerinde trombositopeni insidansı daha yüksektir (3). Kemoterapiye bağlı trombositopeninin, solid tümörlü hastaların %10-36' sında meydana geldiği tahmin edilmektedir. Kemoterapi alan hastalarda trombositopeni, hastaların %15'inde doz azaltılmasına ve siklusların %6'sında gecikmeye neden olur (4). Kanama, kanser hastalarında görülen trombositopenilerde yalnızca %9'luk bir oranda görülür. Kanama komplikasyonu, kanama geçmişine sahip hastalarda daha yaygındır. Ayrıca başlangıçtaki trombosit sayısının <75,000 / μL olması, kemik iliği metastazları, zayıf performans, sisplatin, karboplatin, karmustin veya lomustin uygulaması durumunda kanama daha fazla görülür (5). Sonuç olarak, trombositope-

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tedavisinde aksaklıklar oluşabilir. Trombopoetik ajanların kullanımı tedavideki gerçekleşebilecek aksaklıkların yönetilmesine yardımcı olabilir. Ancak en iyi zamanlamayı değerlendirmek ve ideal hastaları seçmek için klinik çalışmalara ihtiyaç vardır. Trombosit transfüzyonuna refrakterlik, özellikle trombosit konsantreleri ile sıklıkla tedavi edilen hastalarda görülür. Bu riski aza indirmek için doğru tedavi planı yapılmalıdır.

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