30. BÖLÜM

GASTROENTEROPANKREATİK NÖROENDOKRİN TÜMÖRLERDE LOKAL CERRAHİ TEDAVİ SEÇENEKLERİ

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GİRİŞ

Gastroenteropankreatik nöroendokrin tümörlerin (GEP-NET) insidansı son üç dekadda belirgin artış göstermiştir. Bu durum görüntüleme yöntemlerinin yaygın kullanılmasına ve asemptomatik lezyonların tespitinin artışına bağlıdır (1). Surveillance, Epidemiology, and Results (SEER) verilerine göre teşhis anında hastaların %53'ünde lokalize hastalık, %20'sinde bölgesel hastalık ve %27'sinde uzak metastaz saptanmıştır (2).

Cerrahi tedavi tümörün yerleşim yeri, büyüklüğü, derecesi (grade, G), fonksiyonel olup olmaması, hastalığın evresi ve hastanın özelliklerine göre belirlenir. Yakın takip ve endoskopik rezeksiyonları (ER) içeren konservatif tedavi, küçük boyutlu (<1-2cm), tesadüfen saptanmış, iyi differansiye erken evre tümörlerde lenf nodu (LN) metastaz oranının düşük olması nedeni ile uygulanabilir. Lokalize hastalığın tedavisinde lenfadenektomi ile birlikte cerrahi rezeksiyon primer tedavi şeklidir. Bunun yanında laparoskopik veya robotik cerrahi gibi minimal invaziv yaklaşımlar lokalize hastalığın cerrahi tedavisinde uygulanabilir. Bölgesel ve metastatik hastalıkta ise tümör yükünün azaltılması ve hormonal aşırı salınım varsa onun kontrolü amacı ile, ek organ ve/veya vasküler rezeksiyon ile birlikte sitoredüktif cerrahi önerilmektedir (1,3). Metastatik hastalık varlığında ise cerrahi tedavi seçenekleri rezeksiyon ve ablasyondan, karaciğer (KC) transplantasyonuna kadar değişkenlik gösterir (4).

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lıkta karaciğer transplantasyonuna kadar değişen geniş bir yelpazededir. Cerrahi tedavi temel küratif tedavidir. Bölgesel ve metastatik hastalıkta palyatif cerrahi rezeksiyonların da hastalığın yöneteminde katkısı bulunmaktadır. Cerrahi tedavi tümörün ve hastanın özelliklerine göre planlanmalıdır.

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