

Geriatrik Böbrek Kanseri Hastalarına Yaklaşım

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GİRİŞ

Renal hücreli karsinom (RHK), hem kadınlarda hem de erkeklerde en sık görülen ilk 10 kanser arasında yer almaktadır. Yaşam boyu RHK geliştirme riski, kadınlarda yaklaşık 80'de 1 (%1,03), erkeklerde ise 46'da 1 (%2,02) düzeyindedir (1). Hastalığın insidansı yaşla birlikte düzenli olarak artmakta olup, en yüksek sıklığa genellikle 75 yaş civarında ulaşmaktadır (2, 3). Küresel ölçekte yaşlanan nüfusun giderek artması, RHK tanısı alan ileri yaş bireylerin sayısının da önümüzdeki yıllarda belirgin şekilde artacağını göstermektedir. Bu durum, yalnızca hastalığın tedavisine değil, aynı zamanda hastaların bireysel özelliklerine duyarlı, özenle kişiselleştirilmiş bir klinik yaklaşımın önemini bir kez daha gözler önüne sermektedir.

RHK'nın klinik seyri heterojen bir özellik göstermektedir. Böbreğe lokalize RHK vakalarının önemli bir kısmı uzun sağkalım süreleri ile iyi bir prognoza sahiptir (4). Özellikle küçük boyutlu RHK'ların genellikle indolent bir biyolojik davranış sergilediği göz önüne alındığında, yaşlı hastalarda tedavi stratejileri belirlenirken onkolojik sonuçların yanı sıra, kanser dışı mortalite nedenleri ve yaşam beklentisi de dikkate alınmalıdır. Tedaviye ilişkin kararların, uzun dönem sağkalım üzerindeki potansiyel olumlu etkisi ile eşlik eden komorbiditelere bağlı olarak artabilecek ölüm riski arasındaki denge esas alınarak verilmesi gerekmektedir (5). Başka bir deyişle, invaziv girişimlerden anlamlı fayda görebilecek ve cerrahi stresin fizyolojik yükünü tolere edebilecek hastalar cerrahiye yönlendirilmelidir.

Metastatik RHK ise genellikle yüksek mortalite ile seyreden agresif bir hastalıktır. Bu tanıya sahip yaşlı hastalarda sistemik tedavi yaklaşımları, hastaların genel sağlık durumu ve fizyolojik rezervleri doğrultusunda bireyselleştirilmelidir (6). Her ne kadar yaşlı birey-

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SONUÇ

Geriatrik hastalarda böbrek kanserine yaklaşım oldukça karmaşıktır ve bu hasta grubunun yönetimine yönelik ideal bir algoritma mevcut değildir. Nihai tedavi kararı verilmeden önce; malignitenin özellikleri, hastanın kırılabilirlik düzeyi, fizyolojik rezerv kapasitesi ile birlikte hastanın bireysel tercihleri ve tedavi hedefleri dikkate alınmalıdır. Bu yaklaşım, geriatrik değerlendirme ile bireyselleştirilmiş bir analiz yapılmasını ve çoğu zaman multidisipliner bir ekip tarafından tartışılmasını gerektirir. Tedaviye başlamadan önce bu değerlendirme süreci ek zaman gerektirse de hasta, ailesi ve bakım verenlerin katılımıyla yürütülen paylaşımlı karar verme süreci sayesinde tedavi hedefleri daha iyi anlaşılabilir ve hastaya özgü, güvenli bir tedavi planı oluşturulabilir. RHK'lı yaşlı bireylerin heterojen yapısı göz önünde bulundurulduğunda, gerçek yaşam verileri bu hasta grubunda sınırlıdır. Bu nedenle, bu hasta grubuna daha iyi bir onkolojik bakım sunulabilmesi için ileriye dönük gözlemsel çalışmalar ve randomize kontrollü çalışmalara olan ihtiyaç devam etmektedir.

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