

KARACİĞER MALİGN TÜMÖRLERİ

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GİRİŞ

Karaciğer malign tümörleri, primer karaciğer kanserlerinden ve diğer organ kanserlerinin metastazlarından oluşur. Primer karaciğer kanserleri hepatositlerden, safra yolu epiteliinden ve bağ dokusu hücrelerinden gelişebilir. Hepatosellüler karsinoma (HCC) ve hepatoblastoma, hepatositlerden; intrahepatik kolanjiokarsinoma, safra yolu epiteliinden; hemanjiyosarkoma ve epitelioid hemanjiyotelioma, karaciğerdeki vasküler yapılardan gelişen primer karaciğer kanserleridir (Tablo ile verilebilir). Primer karaciğer kanseri vakalarının %75-85'i HCC ve %10-15'i intrahepatik kolanjiokarsinoma (ICC) iken, diğer türler ise vakaların geri kalanını oluşturmaktadır (1).

HEPATOSELLÜLER KARSİNOMA

Epidemiyoloji

Uluslararası Kanser Araştırmaları Ajansı GLOBOCAN kanser istatistiklerine göre 2020 yılında primer karaciğer kanserleri, en sık görülen altıncı kanserdir. Her yıl 906.000 kişiye primer karaciğer kanseri tanısı konmaktadır. Primer karaciğer kan-

seri, kansere bağlı ölümlerde ise üçüncü sıradadır. Her yıl 830.000 kişi primer karaciğer kanseri nedeni ile ölmektedir (1,2). İnsidans ve mortalite, erkeklerde kadınlara göre yaklaşık 2-3 kat daha yüksektir (1).

Primer karaciğer kanseri insidansı ve mortalitesi, coğrafi bölgeler arasında farklılık göstermektedir. En yüksek insidans ve mortalite, Güneydoğu Asya (Moğolistan, Kamboçya, Vietnam) ile Güney ve Batı Afrika (Mısır, Nijer) ülkelerinde görülmektedir. Bunun nedeni, primer karaciğer kanseri için risk faktörlerinin coğrafi bölgeler arasında farklılık göstermesidir (1). Etnik farklılıklar da HCC insidansını etkilemektedir. Örneğin; Amerikalı Kızılderililerde, Hispaniklerde ve Afrika kökenli Amerikalılarda insidans, Hispanik olmayan beyazlara göre daha yüksektir (3). İnsidans ve mortalite, zaman içinde değişmektedir. 1990-2019 yılları arasında primer karaciğer kanseri insidansında ve mortalitesinde yavaş, ancak istikrarlı bir azalma görülmektedir. Bu azalma gelişmiş ülkelerde daha belirgindir (4). Bunun yüksek riskli ülkelerde hepatit B virüsü (HBV) ve hepatit C virüsü (HCV) enfeksiyonu prevalansında ve aflatoxin maruziyetinde azalma ile ilişkili olduğu düşünülmektedir (1). Bir yandan HBV'ye karşı global aşılama

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Cerrahi tedavi genellikle tümörün ileri evresi nedeniyle mümkün değildir. Cerrahi yapılsa bile, hastalar genellikle sadece 1 ila 3 yıl yaşar; ancak tekil tümörü olan bazı hastalarda uzun vadeli sağkalım sağlanabilir. Radyoterapi ve kemoterapinin sonuçları ise kötüdür.

SONUÇ

HSK, en sık görülen kanserlerdendir. Son yıllarda özellikle artan MASLD prevalansına bağlı olarak HCC görülme sıklığı artmaktadır. Gerek artan HCC sıklığı gerekse geliştirilen yeni tedavi seçeneklerine paralel olarak tarama, tanı, evreleme ve tedavi yaklaşımı sürekli güncellenmektedir. HCC gelişimi için en önemli risk faktörü sirozdur. Risk altındaki hastalarda 6 ayda USG ile tarama önerilmektedir. USG'nin bazı hasta gruplarında yetersiz olması nedeni ile son yıllarda farklı MRG protokollerinin ve biyokimyasal belirteçlerin de taramada kullanılması önerilmektedir. HCC tanısı; multifazik kontrastlı MRG, multifazik kontrastlı BT ve kontrastlı USG radyolojik tetkiklere dayanmaktadır. Radyolojik olarak tanı konamayan hastalarda ise histopatolojik inceleme önerilmektedir. HCC'li hastalarda kullanılan en yaygın evreleme sistemi, BCLC evreleme sistemidir. HCC'nin tümör biyolojisinin ve klinik özelliklerinin daha iyi tanınması ile BCLC evreleme sistemi sürekli olarak güncellendiği gibi farklı evreleme sistemleri de geliştirilmektedir. HCC'li hastalarda tedavi seçeneğinin belirlenmesinde multidisipliner yaklaşım esastır. Erken evre HCC'li hastalarda karaciğer transplantasyonu ve cerrahi rezeksiyon, başlıca tedavi seçenekleridir. Cerrahi için uygun olmayan hastalarda lokorejyonel tedaviler, transarteriyel tedaviler ve sistemik tedaviler yapılabilir. Lokorejyonel tedavilerden TARE ve EBRT'nin kullanımı giderek yaygınlaşmaktadır. Çeşitli sistemik tedavi seçeneklerinin geliştirilmesi, son yıllarda HCC tedavisindeki en önemli gelişmelerden birisidir. Sistemik tedavilerin kullanımının artması ile özellikle ileri evre HCC'li hastalarda sağkalım süreleri uzamaktadır. Sistemik tedaviler, diğer tedavi seçenekleri için uy-

gun olmayan daha erken evredeki HCC'li hastalarda da kullanılabilir.

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