5.
BÖLÜM

GESTASYONEL TROFOBLASTİK HASTALIK

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GİRİŞ

Gestasyonel trofoblastik hastalık (GTH), plasental trofoblastların anormal proliferasyonundan kaynaklanan heterojen bir grup lezyonu kapsayan bir klinik spekturumdur. Mol hidatiform gibi benign/ premalign lezyonlar ile invazif mol, koryokarsinom, epitelioid trofoblastik tümör (ETT) ve plasental bölge trofoblastik tümörü (PSTT) gibi malign lezyonları kapsar (Tablo 1). Malign lezyonlar gestasyonel trofoblastik neoplaziler (GTN) olarak sınıflandırılır (1).

Tablo 1. Gestasyonel Trofoblastik Hastalıkların Sınıflaması

Gestasyonel Trofoblastik Hastalıklar	
Benign GTH	**Malign GTN**
Komplet mol	İnvazif mol
Parsiyel mol	Koryokarsinom
	PSTT
	Epitelioid TT

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yerini aşmasına yardımcı olur, intratekal metotreksat da kullanılabilir. Bazı merkezlerde radyoterapinin kemoterapi ile birlikte verilmesi de tedavi seçenekleri arasında tercih edilmektedir (61).

Multipl nüks izlenen hastalarda yüksek doz kemoterapi yanında otolog periferal kök hücre desteği de düşünülebilir. Pembrolizumab gibi ajanlarla immünoterapi de ilaç direnci gelişen hastalarda son yıllarda denenen tedaviler arasındadır (62,63).

Gestasyonel Trofoblastik Neoplazide Cerrahi

GTN yönetiminde cerrahinin önemli bir yeri olabilir. Kontrol edilemeyen uterin kanamalarda uterin arter embolizasyonunun yanı sıra histerektomi de düşünülebilir. Laparotomi; karaciğer, gastrointestinal sistem, böbrekler, dalak gibi organların kanamalarını durdurmak için gerekebilir. Beyne kanama varsa ya da kafa içi basıncı artmışsa kranial cerrahi gerekebilir. Varsa, izole ilaç rezistan tümörün rezeksiyonu da tedavi edici olabilir (47).

Gestasyonel Trofoblastik Neoplazide Takip

GTN tedavisinden sonra, en az 12 ay boyunca her ay hCG takibi yapmak nüks gözetimi için şarttır. Artmış hCG düzeyleri rekürrensi arttırabileceği için, tedavi başarısı açısından bu süre içinde gebelikten kaçınılmalı, uygun kontrasepsiyon yöntemleri kullanılmalıdır (47).

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