Bölüm 16

Mezotelyoma

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Epidemiyoloji, Risk faktörleri:

Mezotelyoma, plevral ve peritoneal boşlukların mezotelyal yüzeylerinden, tunika vaginalis veya perikarddan kaynaklanan bir neoplazm olup vakaların yüzde sekseni plevral kaynaklıdır. Amerika Birleşik Devletleri'nde yıllık mezotelyoma insidansının yılda yaklaşık 3300 vaka olduğu tahmin edilmektedir.[1] Başlıca nedeni asbeste inhalasyon yoluyla maruz kalma olup, malign plevral mezotelyoma (MPM) vakalarının yaklaşık %70'i kanıtlanmış asbest maruziyeti ile ilişkilidir. Asbest, endüstride ısıya ve yanmaya karşı direnci nedeniyle değerlidir. Çimento, tavan ve havuz fayanslarında, otomobil fren balatalarında ve gemi yapımında kullanılır. Mesleki maruziyete ek olarak, doğal kaynaklardan asbeste çevresel maruziyet mezotelyoma oluşumuna katkıda bulunabilir. Türkiye'de bazı kırsal bölgelerde toprak oldukça yüksek seviyelerde tremolit asbest lifleri içerir ve bu bölgelerde yaşayanlarda MPM görülme olasılığı oldukça yüksektir.[2-4] Özellikle Kapadokya bölgesinde eriyonit gibi fibröz silikatların solunması da MPM gelişimi için oldukça yüksek bir risk faktörüdür.[5] Bunun dışında radyasyon maruziyeti, viral onkogenler (Simian virus 40), genetik faktörler de etyolojide rol oynamaktadır.

a. Evreleme: Evrelemede TNM evreleme sistemi (AJCCv.8) kullanılmaktadır **(Tablo-1)**

Tanı (histopatoloji) / Ayırıcı tanı / gerekli tetkikler / diğer tedavi seçenekleri

Histopatpoloji/Ayırıcı tanı: MPM üç histolojik alt tipi vardır: epiteloid, sarkomatoid veya bifazik (karışık). En sık epiteloid tip görülür (%60). Ayırıcı tanıda benign inflamatuar hastalıklar (organize ampiyem), sarkom, akciğer adenokanseri, ve solid tümörlerin plevral metastazları yer almaktadır. Immunohistokimyasal yöntemler ayırıcı tanıda yardımcı olur.

Gerekli tetkikler:

- Hikaye, fizik muayene, asbestos maruziyetinin sorgulanması, tam kan sayımı ve biyokimya
- Görüntüleme: Akciğer grafisi, IV kontrastlı

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Riskli Organlar:

- Spinal Kord: ≤45 Gy
- Akciğer: Ortalama Kontralateral akciğer dozu (MLD): 8.5 Gy; V20 ≤ %7; V5 ≤ %75
- P/D sonrası total akciğer ortalama dozu <20 Gy, V20% < 37%
- Kalp: D%50 <25–40 Gy,
- Özefagus: ortalama <34 Gy, 1/3 <60 Gy; 2/3 <55 Gy; 3/3 <45 Gy
- Böbrekler: V18 Gy≤%33
- Karaciğer: Ortalama ≤ 30 Gy

Takip ve yan etkiler

Takip: Standart öneriler olmamakla birlikte ilk 2 yıl 3 ayda bir, 2-5. yıllarda 6 ayda bir hikaye, fizik muayene ve görüntüleme (Toraks-abdomen BT) önerilebilir. Görüntüleme yöntemlerinin sıklığı hastaya uygulanan tedaviye ve hastanın semptomlarına göre değişebilir.

Yan etkiler:

Akut: Halsizlik, bulantı, kusma, disfaji, odinofaji, öksürük, dermatit, akut pnömonitis, pnömoni

Geç: Perikardit, restriktif kardiyomyopati, myokardiyal enfarkt, konjestif kalp yetmezliği, pulmoner fibrozis

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