



Bölüm 20

Pankreas Kanseri

Nergiz DAĞOĞLU SAKİN¹

Epidemiyoloji ve Risk Faktörleri

Pankreas kanseri kanserden ölüm nedenleri sıralamasında beşinci sıradadır. Ancak ölüm oranı olarak ilk sırada yer alır ve hastaların %90'ı tanı konulduktan sonraki ilk yıl içinde kaybedilmektedir. En sık 6.ve 7. Dekatta görülür (1). Hastalığın erken dönemde teşhisi zordur. Erkeklerde, sigara, alkol, kahve tüketimi fazla olanlarda daha sık görülmektedir. Aile öyküsü ve genetik yatkınlık risk faktörleri arasında sayılabilir. Pankreas kanserlerinin yaklaşık %5'i aileseldir. En sık görülen genetik değişiklik p16 ve BRCA2'dir (2).

Tanı

Tanısal çalışmalar anamnez ile başlar. Kırk yaş üzeri kişilerde tıkanma sarılığı, kilo kaybı, karın ya da sırt ağrısı, uzun sürmüş dispepsi, ani başlangıçlı diabetes mellitus, açıklanamayan ishal, idiyopatik pankreatit atağı saptanması pankreas kanserini düşündürmelidir. Pankreas kanseri tanı anında ancak %10'u organa sınırlıdır. Olguların %40'ında hastalık lokal olarak ilerlemiştir, %50'sinde ise uzak metastaz vardır (1,2).

Laboratuvar incelemelerinde serum total ve direkt bilirubini, alkalen fosfataz, gama glutamil transferaz artmıştır. Pankreas kanserine spesifik tanı koydurucu bir tümör belirteci yoktur; ancak takipte en çok kullanılanı karsinoembriyonik antijen (CEA) ve karbonhidrat antijen 19.9'dur (CA 19-9).

Ultrasonografi (USG) tıkanma sarılığının ayırıcı tanısında ilk inceleme yöntemi olarak kullanılır. Kontrast madde kullanılarak yapılan üç fazlı ince kesitli bilgisayarlı tomografi (BT) ile 5mm'in üzerindeki kitleleri göstermek açısından etkindir. BT, aynı zamanda, metastaz, lokal tümör yayılımı ve damar tutulumunu da değerlendirmekte faydalıdır.

Biyopsi için şu yöntemlerden biri kullanılabilir:

- Endoskopik ultrason (EUS) rehberliğinde biyopsi
- BT eşliğinde biyopsi
- Endoscopic retrograde cholangiopancreatography (ERCP)

¹ Doç. Dr. R. Nergiz DAĞOĞLU SAKİN, İstanbul Üniversitesi İstanbul Tıp Fakültesi, Radyasyon Onkolojisi AD., ndagoglu@istanbul.edu.tr

Takip ilk 2 yıl 3-6 aylık aralarla yapılır, 2 yıl sonrasında süre 6-12 aya çıkartılır. Her kontrolde CA 19-9, karaciğer fonksiyon testleri ve abdominal BT ile değerlendirme önerilir.

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