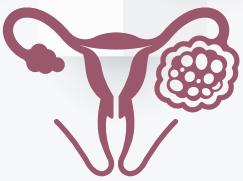

Bölüm 28

Serviks Kanseri

Melis GÜLTEKİN [1]

Epidemiyoloji ve Risk Faktörleri

Serviks kanserleri, kadınlarda en sık görülen kanserler arasında ve kansere bağlı ölümlerde dördüncü sırada yer alır (1). Günümüzde insidansı özellikle gelişmiş ülkelerde Pap smear ile tarama programları ve human papilloma virüse (HPV) karşı geliştirilen proflaktik aşılar ile giderek azalmasına karşın, sınırlı kaynakları olan az gelişmiş ülkelerde halen önemli bir mortalite ve morbidite nedenidir.

Serviks kanserlerinin gelişiminde sıklıkla cinsel yolla bulaşan onkojenik HPV enfeksiyonları (en sık HPV 16 ve 18) rol oynar (2). Persistan HPV enfeksiyonları, servikal intraepitelyal neoplazi (CIN) ya da adenokarsinoma in situ gibi prekanseröz lezyonlara ve bunların %30-70'i de yaklaşık 10-15 yıllık bir sürede invaziv kanserlere dönüşür. Risk faktörleri, HPV-bağımlı kanserlerde; cinsel aktivitenin erken yaşta başlaması (<18 yaş), multiple partner, yüksek riskli partner, cinsel yolla bulaşan hastalık öyküsü (klamidya trochomatis, genital herpes vb.), erken ilk doğum yaşı (<20 yaş), artmış parite, vajinal/vulvar intraepitelyal neoplazi ya da kanser öyküsü ve immünsüpresyondur (HIV vb.) (3). HPV-bağımlı olmayan kanserlerde ise düşük sosyoekonomik düzey, oral kontraseptifler, sigara ve genetik faktörler rol oynar (4).

Serviks kanserleri, sıklıkla skuamökolumnar bileşke olarak adlandırılan skuamöz ve kolumnar hücrelerin kesiştiği transformasyon zonundan gelişir. Serviks kanserlerinin yaklaşık %70'ini skuamöz hücreli kanserler (SHK), %25'ini adeno ve adenoskuamöz kanserler ve %5'lik kısmını ise küçük hücreli kanserler ve lenfomalar gibi nadir görülen diğer histopatolojik alt tipler oluşturur (5). Son yıllarda özellikle genç hastalarda adenokanserlerin insidansı giderek artmaktadır.

Evreleme

Serviks kanserleri klasik olarak "International Federation of Gynecology and Obstetrics (FIGO)" evreleme sistemine göre klinik olarak evrelenir (6). Klinik evrelemede genel anestezi altında fizik muayene ve ulaşımı kolay ve ucuz olan endoskopik tanısal prosedürler (proktoskopi, sistoskopi, histeroskopi) ve görüntüleme tetkikleri (akciğer grafisi ve intravenöz pyelografi) yer alır. Klinik evrelemenin halen yaygın olarak

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Rekürren hastalıkta prognoz; rekürrens paterni, uygulanan önceki tedaviler ve kurtarma tedavisi yaklaşımına bağlıdır. Lokalize ya da santral pelvik rekürrenslerde pelvik egzenterasyon yapılabilir. Pelvik yan duvar tutulumu yok, hastalıksız süre 6 aydan uzun ve rekürren tümör boyutu <3 cm ise prognoz iyidir. Nodal rekürrens ya da uzak metastaz varlığında ise sistemik tedavi gündeme gelir. İmmünoterapi (pembrolizumab, nivolumab vb.) yaklaşımları umut vaat etmektedir.

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