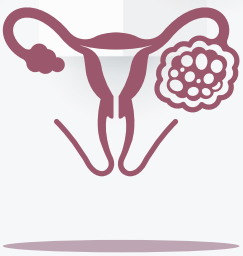

Bölüm 31

Over Kanserleri ve Radyoterapi

Zümre ARICAN ALICIKUŞ [1]

Epidemiyoloji, Risk faktörleri

Over kanserleri (OK), jinekolojik maligniteler içinde mortalitesi en yüksek olan grup olup 2020 yılında 21.750 yeni vaka ve Amerika'da 13.940, Avrupa'da ise 29.000 ölüm gerçekleşme tahmini rapor edilmiştir (1). Over kanserlerinin prognozları, patolojik tip, ilk tanı anındaki hastalık evresi ve uygulanan tedavi modalitesine, alınan yanıta göre çeşitlilik göstermektedir (1,2). Son dekatlarda epitelyal over kanserlerinin tedavisinde birçok önemli ilerleme kaydedilmiş olmasına rağmen, tekrarlayan over kanseri halen fatal olmaya devam etmektedir (2,3). Over kanseri genç yaşlarda nadir görülmektedir (1). Ortalama tanı yaşı 60 üzeri olup yaşla birlikte yaşa özgü insidans artmaktadır. Over maligniteleriinin %90'ından fazlasını epitelyal over kanserleri (EOK) oluşturmaktadır (4). Non-epitelyal OK ise germ hücreli, seks kord stromal kanserler ve sarkomlar olup EOK'ne göre daha düşük morbidite ve mortaliteye sahiptirler. Over kanserlerinde evre ilerledikçe sağkalımlar olumsuz olarak etkilenmekle birlikte genel olarak lokalize OK'da sağkalım oranları daha iyi olup 5 yılda %60-80'dir (2,5,6). Ancak, tanı anında hastaların üçte ikisinde yaygın hastalık bulunmakta ve bu hasta grubunda 5 yıllk sağkalım oranları %20'lere kadar düşmektedir (2,5,6).

Epidemiyolojik çalışmalarda, over kanseri gelişiminde çevresel, hormonal ve genetik bir takım risk faktörleri tanımlanmıştır (3,7). Beyaz ırk, bir ve üzeri gebelik veya doğum yapanlar, oral kontraseptif kullananlar ve emzirenlerde over kanseri gelişme riski %30-60 azalmaktadır. Nulliparite, erken menarş, geç menapoz, ileri yaş, polikistik over hastalığı, postmenapozal hormon replasman tedavisi alanlar, pelvik inflamatuar hastalığı olanlarda ise risk artışı bildirilmiştir. Borderline epitelyal over tümörlerinde invitro fertilizasyon için gerekli over sitimülasyonu sonrası artış rapor edilmiştir (7). Bunların dışında obesite, asbest ve talk maruziyeti, sigara kullanımı da risk artışına neden olmaktadır (3,7). Ailesinde over ve meme kanseri öyküsü olanlarda, özellikle BRCA1 ve BRCA2 gen mutasyonu taşıyanlarda, Lynch sendromu olanlarda artmış risk bulunmaktadır (7, 8). BRCA mutasyonu taşıyıcılarında, profilaktik bilateral salpingoooferektomi (BSO) ile seröz karsinom riskinde azalma

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Tablo 6. Tüm abdomen radyoterapisinde risk altındaki organlar için doz sınırlama önerileri (3B-KRT/YART, konvansiyonel fraksiyonasyon)

Organ	Konturlama	Sınırlamalar	Son Nokta
Kolon	Kalın barsak loopları	V15 <50 Gy, V40 Gy <%10, Dmax ≤ 60 Gy, Mean doz < 50 Gy	Grade ≥ 2 toksite <10%
İnce barsak	İnce barsak loopları	V15 < 120 cc	Grade ≥ 3 akut toksite <10%
	Barsak paketi	V45 < 195 cc	Grade ≥ 3 akut toksite <10%
Böbrek	Tüm böbrek (kombine)	Tek böbrek mean doz <15–18 Gy, Tek böbrek mean doz >18 Gy ise, diğer böbrek maksimum korunmalı: V6 Gy <%30, V12 <%55, V23 <%30, V28 <%20	Renal toksite < %5
Karaciğer	Tüm karaciğer	Mean doz 30-32	Karaciğer toksite <%5
Medulla spinalis	Spinal kord	Dmax 50 Gy	Miyelopati <%0.2

Over kanserli hastaların tedavi sonrası takibinde, pelvik ağrı, kilo kaybı gibi klinik semtom ve bulguların yanısıra biokimyasal (CA 125 yükselmesi gibi) parametreler dikkatle izlenmelidir. Tedaviler sonrası şüpheli durumlarda torako-abdominal tomografi, manyetik rezonans görüntüleme, FDG-PET gibi görüntülemeler takibe eklenmelidir (3, 12).

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