Bölüm 3

ENDOMETRİUM KANSERİNDE CERRAHİ TEDAVİ

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GİRİŞ

Endometrium kanseri; jinekolojik maligniteler arasında en sık, kadın kanserleri arasında ise dördüncü sıklıkta izlenmektedir (1).

%80 kadarı malign epitelyal neoplazi şeklindedir. Endometrium kanseri histopatolojik özelliklerine göre iki ana gruba ayrılır Endometriumda gelişen malign patolojilerin; tip1 ve tip 2. Bu gruplar cerrahi tedavi ve cerrahi sonrası tedavi yaklaşımlarını belirler(2-4).

Tip 1: düşük gradeli endometriod karsinom FİGO (international federation of gynecology and obstetrics) grade 1 ve 2 olarak geçen grup endometrium kanserlerinin büyük çoğunluğunu oluşturan gruptur. Bu tümörler östrojen duyarlı olup, atipik endometrial hiperplazi zemininde gelişen erken evrede görülen ve prognozları iyi olan tümörlerdir(5-7).

Tip2: FİGO grade 3 endometrioid karsinom ve nonendometriod karsinomlardır; seröz, berrak hücreli, mikst, andiferansiye. Bu tümörler östrojen duyarlı değillerdir ve obezite ilişkili değillerdir. Genellikle atrofik endometriumzemininde gelişen yüksek gradeli ve kötü prognozlu olgulardır. Karsinosarkomlar bu grubun içerisinde yer alır. Myometrial invazyonu olmasa bile cerrahi evreleme yapılan her üç hastadan birinde ekstrauterin hastalık izlenmektedir(8-10).

Endometrium kanserinin tanısı anamnez, fizik muayene ve endometrial örnekleme ile konulur. Hastanın tedavi planı kanser histopatolojisi, grade ve cerrahiyi tolere edebilmesine göre yapılır.

Abdominal ve pelvik görüntüleme tip 1 endometrial karsinomda genellikle preoperatif olarak yapılmazken, tip 2 olanlarda yapılması laparotomi ya da sitoreduksiyon kararı açısından gereklidir. Cerrahiyi tolere edemeyeceği için ya da fertilite korutucu amaçlı cerrahi planlanmayan hastalarda, kontrastlı MRI (magnetic resonans imagining) myometrial invazyon, serviks tutulumu ve lenf nodu tutulumu göstermesi açısından kontrastsız MRI, ultrason ve BT(bilgisayarlı tomografi) ye göre daha iyi bir radyolojik görüntüleme yöntemidir(11-16).

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FERTİLİTE KORUYUCU CERRAHİ

Endometrium kanserinde fertilite koruyucu cerrahi başlı başına uzunca tartışılabilecek olan özel bir konu olmakla birlikte bir takım önemli noktalarına değinmekte fayda vardır.Endometrium kanserinde reproduktif dönemde düşük oranlarda görülür, ancak yine de oluşursa fertilite koruma isteğinin olup olmadığı hastaya sorulmalıdır. Fertilite koruma isteği olan hastalarda progestin tedavisi verilmeli ve cerrahi evreleme (TAH+BSO) çocuk sahibi olduktan sonraya ertelenmelidir.

Hastalara fertilite koruyucu tedavide, histerektomiye oranla daha fazla rekkurens ve persistans riski olduğu anlatılmalıdır.

Koruyucu tedavideki öncelik, kanserin grade ve myometrial invazyonunu tanımlamaktır. Bunu yaparken anamnez;uterus büyüklüğünün, mobilitesinin ve metastatik hastalık varlığının saptanması için fizik muayene; endometrial örnekleme ve pelvik-abdominal görüntüleme yöntemleri kullanılmaktadır.

Hastalar ayrıca endometrium kanseri gelişme nedeninde potansiyel risk olan Lynch sendromu açısından bilgilendirilmeli ve genetik mutasyon analizi yapılmadıysa bile oluşabilecek ovaryan kanser riski de akılda tutulmalıdır.

İNOPERABLE HASTALAR

Cerrahi prosedür uygulanmayacak olan klinik evre I olan endometrium kanseri hastalarında primer radyoterapi kabul edilebilir bir tedavi seçeneği olarak karşımıza çıkmaktadır. Bu hastalarda klinik evreleme FİGO 1971 göre yapılabilir. Klinik evreleme prosedüründe genel anestezi altında pelvik muayene, endometrial ve endoservikal küretaj, histeroskopi, sistoskopi, proktoskopi ve görüntüleme yöntemleri kullanılabilir.

Yapılan çalışmaların çoğunda myometrial invazyonun saptanmasında MRI sensitivitesi yaklaşık %80-90 civarında, servikal invazyonun saptanması ise %56-100 lük bir aralıkta sensitiviteye sahiptir.

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