13. BÖLÜM

MUSİNÖZ TÜBÜLER VE İĞSİ HÜCRELİ KARSİNOM

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GİRİŞ

Müsinöz tübüler ve iğsi hücreli karsinom (MTİHK), böbreğin nadir saptanan epitelyal neoplazisidir (1). Dünya Sağlık Örgütü (DSÖ) 2004 üriner sistem tümörleri kitapçığında, düşük dereceli böbrek tümörleri arasında kendine yer bulan MTİHK, aslında ilk olarak 1996 yılında Ordonez ve Mackay tarafından 'Henle kulpundan köken alan ve olağandışı diferansiyasyon gösteren böbrek hücreli karsinom' ve 1997 yılında Maclenan ve arkadaşları tarafından 'Düşük dereceli toplayıcı duktus karsinomu' adı altında tanımlanmıştır (2,3,4). Ayrı bir antite olarak tanımlanması ise 2001 yılında, Parvani ve arkadaşları tarafından gerçekleştirilmiştir (5).

Müsinöz tübüler ve iğsi hücreli karsinom, morfolojik olarak iğsi şekilli hücreler, elonge ve basık görünümde tübül yapıları ve ekstraselüler musin ya da miksoid stroma olmak üzere üç temel yapıdan oluşmaktadır(1). (Resim 1) Genel olarak, düşük dereceli histolojik özellikler ve düşük metastaz riski ile böbrek hücreli karsinomun (BHK) indolan bir subtipi olarak tanımlansa da, literatürde, yüksek dereceli histolojik özelliklere sahip sarkomatoid diferansiyasyon gösteren ve metastatik hastalık oluşturan vakalar da bildirilmiştir (6-9). Atipik morfolojideki vakalar da dahil olmak üzere, literatürde henüz 100'e yakın olgu bildirilen bu tümör, görülme sıklığı olarak tüm böbrek tümörlerinin %1'nden azını oluşturmaktadır (1,10,11).

[1] Uzm. Dr., Bahçelievler Devlet Hastanesi, Tıbbi Patoloji

(1,10). Klasik formunda tümör rekürrensi nadirdir. Literatürde, özellikle yüksek dereceli ve atipik morfolojiye sahip MTİHK'larda lenf nodu metastazı, uzak organ metastazı ve tümör rekürrensi olabildiğini belirten yayınlar mevcuttur (6,7,14,46). Bu tarz metastatik tümörlerde cerrahi tedavi sonrası, hastanın yakın klinik takibi önerilmekle birlikte, sistemik kemoterapi ya da radyoterapi uygulanıp uygulanmayacağı konusunda belirleyici bir konsensus kararı yoktur(1,22).

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