BÖLÜM 26

Safra Yolu Kanserlerinde Sistemik Tedavi

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GİRİŞ

Safra yolu kanserleri, tüm malign tümörlerin %0,7'si, tüm gastrointestinal kanserlerin %3'ünü oluşturur (1). İntrahepatik kolanjiokarsinom (IHKK), hiler kolanjiokarsinom, ekstrahepatik kolanjiokarsinom (EHKK) ve safra kesesi kanseri olmak üzere çeşitli kanser gruplarını içerir. Bunlar tek bir klinik tablo olarak kabul edilmişken, günümüzde etiyoloji, moleküler biyoloji ve tedavi açısından oldukça farklı yaklaşımlara sahiptirler.

Kolanjiokarsinomlar ve safra kesesi kanserleri farklı şekillerde karşımıza çıkmış olmasına rağmen lokalize hastalıkta öncelikli tedavi cerrahidir. Komplet rezeksiyondan sonra dahi uzun dönem sonuçların kötü olması adjuvan tedaviyi gündeme getirmiştir. Lokalize hastalıkta cerrahi sonrası nüks oranları %60'a varabilir. Tanı anında hastaların %70'i ileri evrededir (1). Metastatik hastalıkta tedavi yararı kısıtlıdır ve çoğunlukla palyatif kemoterapi veya radyoterapiyi içerir.

Safra Kesesi Kanserlerinde Sistemik Tedavi

Lokalize ve Rezektabl Hastalıkta Adjuvan Tedavi

Safra kesesi kanserinde (SKK) adjuvan tedaviyi destekleyen yeterli prospektif çalışma yoktur. Dünya çapında kabul görmüş kılavuzlar dahi adjuvan tedavi önerisinde farklılık gösterebilmektedir. American Society of Oncology (ASCO) kılavuzu opere SKK olgularının tümünde adjuvan tedavi önerirken National Comprehensive Cancer Network (NCCN) kılavuzu T1b, nod pozitif veya cerrahi sınır pozitif olgularda adjuvan tedaviyi önermektedir (2, 3). Rezeksiyon sonrası adjuvan tedavi ve izlemin karşılaştırıldığı 10 retrospektif çalışmayı içeren bir meta-analizde tek başına rezeksiyona göre adjuvan tedavi ile anlamlı sağkalım avantajı sağlanmıştır (4). Ancak subgrup analizinde evre 1, nod negatif veya tam (R0) rezeksiyon yapılan hastalarda bu avan-

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PFS: hastalıksız sağ kalım, ORR: objektif yanıt oranı, NA: mevcut değil, KCFT: karaciğer fonksiyon testleri, KY: kalp yetmezliği, GGT: gama glutamiltransferaz, IDH1: İzositrat dehidrojenaz 1, FGFR2: Fibroblast büyüme faktörü reseptörü 2, NTRK: nörotrofik tirozin kinaz reseptörü, BRAF: v-Raf murine sarcoma viral oncogene homolog B, HER2: İnsan epidermal büyüme faktörü reseptörü 2.

Sonuç

Safra yolu kanserleri nadir görülen tümörlerdir. Lokal hastalıkta birincil tedavi cerrahi iken uzak metastaz oranları nedeniyle tüm hastalara adjuvan tedavi önerilmektedir. Adjuvan tedavide kullanılan ajanlar kapesitabin, gemsitabin, 5-FU iken özellikle R0 rezeksiyon yapılamayan veya nod pozitif hastalarda kemoradyoterapi de seçenekler arasındadır. Metastatik hastalıkta birinci basamakta gemsitabin/sisplatin kullanılmaktadır. Özellikle palyatif tedavinin önemli olduğu bu aşamada semptomatik tedavi, tedavinin temelini oluşturmalıdır. Son dönemlerde kullanım sıklığı artan yeni nesil dizileme yöntemi ile hedefe yönelik tedavilerin kullanım sıklığı artmış ve kişiye özel tedavinin temelini oluşturmuştur. İkinci seride immünoterapinin kullanımı ise uygun hastalarda denenmelidir. Nadir görülen tümörler olması nedeniyle randomize kontrollü çalışmaların eksikliği safra yolu kanserleri tedavisinde halen birçok soru işaretinin bulunmasına neden olmaktadır.

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