

Bölüm 47

İMMÜNÖTERAPİ İLİŞKİLİ AKUT BÖBREK YETMEZLİĞİ VE YÖNETİMİ

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GİRİŞ

Bağışıklık sistemi, kanser hücrelerinin kontrol altına alınmasında ve eradikasyonunda kritik bir rol oynamaktadır ⁽¹⁾. T-lenfositler; anti-tümöral immün yanıtı, inhibitör kontrol noktaları ve aktive edici sinyaller arasındaki, hassas ve karmaşık bir denge sayesinde sağlamaktadırlar ⁽¹⁾. Günümüzde immünite kontrol noktalarının blokajı, kanserle mücadelede en etkin tedavi yöntemi olarak kabul edilmektedir ⁽¹⁾. İmmünite kontrol noktalarını bloke eden bu antikorların tümüne “İmmün Checkpoint İnhibitörleri” (ICPI) denir ⁽¹⁾. Hastanın bağışıklık sistemine katılarak tümörle savaşan ICPI, son on yılda kanser tedavisinde büyük bir devrim yaratmıştır ⁽¹⁻⁴⁾. İmmünoterapiye cevap veren malignitelerin spektrumu, ileri evre malign melanomdan hodgkin lenfomaya, küçük hücre dışı akciğer kanserinden renal hücreli karsinomaya kadar uzanmaktadır ^(1,3).

Anti-tümör aktiviteleri için bugüne kadar en çok çalışılan iki önemli immünite kontrol noktası reseptörü “Sitotoksik T-lenfosit ilişkili protein-4 (CTLA-4)” ve “Programlanmış hücre ölüm proteini-1 (PD-1)” reseptörleridir ⁽¹⁻³⁾ (**Tablo 1**). ICPI in, hedef dışı yan etkilerine “İmmünite ile ilişkili yan etkiler (irAEs)” denir ⁽³⁾. irAEs belirtileri otoimmün hastalıklara benzer ve neredeyse tüm organ sistemlerinde görülebilir ⁽³⁾. Şimdiye kadar ICPI ile indüklenen renal parankimal hasarın iki farklı formu bildirilmiştir ⁽¹⁾. Akut tubulointerstisyel nefrit (ATIN) ve immün kompleks glomerülonefriti ⁽¹⁾. Bu bölüm, ICPI bağlı akut böbrek yetmezliği (ABY) gelişimi hakkında bilinen mevcut bilgileri özetlemektedir. (İmmün kompleks glomerülonefriti için bakınız bölüm 7, İmmünoterapi İlişkili Nefropatiler ve Yönetimi).

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