

Geriatrik Mesane (Lokal-Metastatik) ve Üst Üriner Sistem Kanseri Hastalarına Yaklaşım

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GİRİŞ

Dünya sağlık örgütü geriatrik hastayı tanımlarken kronolojik yaşı kullanmıştır (1). Yaşa göre farklı sınıflamalar bulunsun da 2015 de DSÖ tarafından yayınlanan dünya raporunda sadece kronolojik yaşı değil aynı zamanda sosyal, bilişsel, gündelik kabiliyetlerin ve ek hastalıkların da sınıflamaları değiştireceğini belirtmişlerdir (1). Geriatrik hasta değerlendirirken dikkat etmemiz gereken en önemli husus, Hipokrat'ın yüzyıllar öncesinde söylediği “Hastalık yoktur, hasta vardır” düsturudur. Geriatrik hastanın bilişsel durumu, beslenme durumu, hareketlilik seviyesi, sosyal desteğinin olup olmaması, eşlik eden diğer hastalıkları ve kullandığı ilaçlar planlanacak tedavi yöntemini esas belirleyecek faktörlerdir (2-4). Bu nedenle uluslararası ortak bir dili konuşmak ve hastaların tedavisinde standartı yakalayabilmek için geriatrik hastalarda yapılması gereken bazı skorlama sistemleri bulunmaktadır. Bunlardan özellikle “G8 geriatrik tarama ölçeği”, “kırılganlık değerlendirme ve tarama aracı (FRAIL)”, “klinik kırılganlık ölçeği (CFS)”, “Charlson eşlik eden hastalık indeksi (CCI)”, “Performans durumu ölçeği (ECOG)”, “Kapsamlı geriatrik değerlendirme (CGA)” ve bilişsel durumu değerlendirmek için “Mini-Cog” testi sıklıkla kullanılmaktadır (2-4). Bu testlerin geriatrik hastalarda planlanacak cerrahi veya cerrahi dışı tedaviler için yol gösterici olacağını unutmamak gerekmektedir. Geriatrik hasta popülasyonunda sıklıkla birden fazla hastalık olduğu için bu hastalara yaklaşımda multidisipliner yaklaşım gerekliliği de unutulmamalıdır.

Bu bölümde geriatrik mesane kanseri ve üst üriner sistem kanseri olan hastalara yaklaşımı inceleyeceğiz.

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Yüksek riskli hastalarda özellikle seçilmiş hasta gruplarında böbrek koruyucu cerrahiler denenebilir. Onkolojik başarıları radikal nefroüretrektomiye göre düşüktür. Geriatrik hastaların birçoğu eşlik eden hastalıklar, performans düzeyleri, kırılabilirlik dereceleri ve düşük böbrek fonksiyon değerleri nedeniyle radikal nefroüretrektomiye uygun değildir. Küçük, soliter ve hidronefroza neden olmamış üreter tümörlerinde URS ile ablasyon veya üretrektomi gibi böbrek koruyucu tedaviler denenebilir (63-65). Fakat bu hastalar düşük risk hasta grubuna göre çok daha yüksek progresyon riskine sahiptir (63-65). Tedavi sonrası progresyon da bilindiği üzere sağ kalım üzerinde direkt etkisi bulunmaktadır (63-65).

Radikal nefroüretrektomi öncesi verilen sisplatinli neoadjuvan tedavinin hem genel sağkalım hem de kanser spesifik sağkalım üzerinde olumlu sonuçlar verdiği kanıtlanmıştır (69). Mesane kanseri bölümünde anlatıldığı gibi neoadjuvan verilmesi önerilen tek protokol sisplatin içeren protokoldür. Sisplatin uygun olmayan hastalarda önerilen herhangi bir neoadjuvan kemoterapi bulunmamaktadır. Neoadjuvan immunoterapi olarak ÜÜSK hastalarında pembrolizumab denenmiş fakat herhangi bir avantaj sağlanmadığı gözlemlenmiştir (69).

Radikal nefroüretrektomi sonrası T2-T4 veya N1-N3 hastalarda adjuvan sisplatin bazlı kemoterapilerin hem hastalıksız sağ kalımı hem de genel sağkalımı artırdığı tespit edilmiştir (70). Sisplatin uygun olmayan hastalarda bölünmüş doz sisplatin veya karboplatin bazlı tedaviler adjuvan olarak önerilmektedir (70). Platin tedavilerine uygun olmayan PDL1 pozitif olan hastalarda adjuvan nivolumab tedavisi hastalıksız sağ kalım avantajı sağlasa da düşük öneri düzeyindedir (71).

Metastatik ÜÜSK, metastatik mesane kanserine benzer protokollerle tedavi edilmektedir. Fark olarak, tek metastatik lezyonu olan sisplatin bazlı kemoterapiye uygun olan ÜÜSK hastalarında radikal nefroüretrektominin kanser spesifik sağkalıma ve genel sağkalıma avantajı olduğunu gösteren kısıtlı sayıda çalışma bulunmaktadır (72). Şiddetli ağrı, ciddi hematüri gibi nedenlerden dolayı palyatif nefroüretrektominin de metastatik ÜÜSK'de yeri vardır. Literatürde metastatik ÜÜSK'de metastatektomiye öneren herhangi bir randomize kontrollü çalışma bulunmamaktadır.

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