ANKARA MEME HASTALIKLARI DERNEĞİ

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METASTATİK HASTALIĞIN DEĞERLENDİRİLMESİ VE PRİMER CERRAHİ TEDAVİ

Doç. Dr. Serap EREL
Ankara Eğitim ve Araştırma Hastanesi
Genel Cerrahi Kliniği

Yeni tanı alan meme kanserlerinin % 3.5– % 7

% 50'si lokal olarak operabl (T1–T3)

Geleneksel :

MMK prognozu kötü: 1-2 yıllık yaşam süresi

Optimal tedavi: palyatif tedavi

Agresif yaklaşımlar: gereksiz, hastaları gereksiz strese sokar

Yeni modern ve sistemik tedaviler

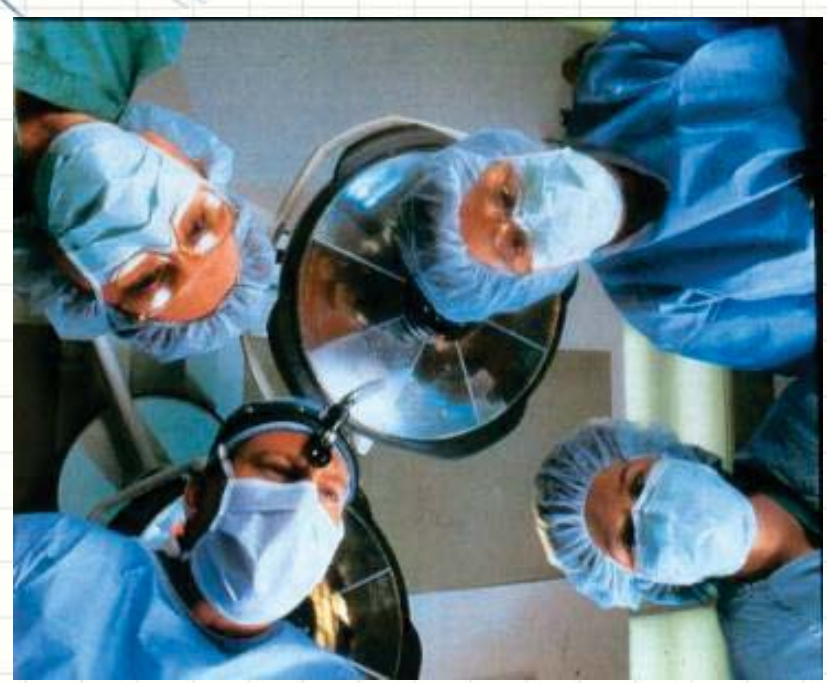
Her yıl %1-2 sağ kalım iyileşmekte

	Ortalama sağkalım Ay	3 y GS %	5 y GS %
1974-1979	15	15	10
1995-2000	51	61	40

Amaçlar:

- 1. Palyasyon-semptomlar/ QOL
- 2. «Progresyon free survival» da düzelme
- 3. Cerrahi ile karşılananan yaşam hedefleri
- 4. Tedavi amaçlı

HANGİ EVREDE HANGİ GÖRÜNTÜLEME İLE TARAMA YAPILMALIDIR?



NCCN Guidelines Version 2.2016
Invasive Breast Cancer

CLINICAL STAGE	WORKUP
Stage I **T1, N0, M0** **or** **Stage IIA** **T0, N1, M0** **T1, N1, M0** **T2, N0, M0** **or** **Stage IIB** **T2, N1, M0** **T3, N0, M0** **or** **Stage IIIA** **T3, N1, M0**	• History and physical exam • Diagnostic bilateral mammogram; ultrasound as necessary • Pathology review • Determination of tumor estrogen/progesterone receptor (EP/PR) status and HER2 status • Genetic counseling if patient is high risk for hereditary breast cancer • Breast MRI (optimal), with special consideration for mammographically occult tumors • Counseling for fertility concerns if premenopausal • Assess for distress For clinical stage I-IIB, consider additional studies only if directed by signs or symptoms:[a] • CBC • Liver function tests and alkaline phosphatase • Bone scan indicated if localized bone pain or elevated alkaline phosphatase • Abdominal ± pelvic diagnostic CT or MRI indicated if elevated alkaline phosphatase, abnormal liver function tests, abdominal symptoms, or abnormal physical examination of the abdomen or pelvis • Chest diagnostic CT (if pulmonary symptoms present) If clinical stage IIIA (T3, N1, M0) consider: • CBC • Liver function tests and alkaline phosphatase • Chest diagnostic CT • Abdominal ± pelvic diagnostic CT or MRI • Bone scan or sodium fluoride PET/CT[b] (category 2B) • FDG PET/CT[c,d] (optional, category 2B)

See Locoregional Treatment (BINV-2)

[a]Routine systemic staging is not indicated for early breast cancer in the absence of symptoms.

[b]If FDG PET/CT is performed and clearly indicates bone metastasis, on both the PET and CT component, bone scan or sodium fluoride PET/CT may not be needed.

[c]FDG PET/CT can be performed at the same time as diagnostic CT. The use of PET or PET/CT scanning is not indicated in the staging of clinical stage I, II, or operable stage III breast cancer. FDG PET/CT is most helpful in situations where standard staging studies are equivocal or suspicious, especially in the setting of locally advanced or metastatic disease.

[d]FDG PET/CT may also be helpful in identifying unsuspected regional nodal disease and/or distant metastases in locally advanced breast cancer when used in addition to standard staging studies.

CLINICAL STAGE	WORKUP
Stage I T1, N0, M0 or Stage IIA T0, N1, M0 T1, N1, M0 T2, N0, M0 or Stage IIB T2, N1, M0 T3, N0, M0 or Stage IIIA T3, N1, M0	**For clinical stage I-IIB, consider additional studies only if directed by signs or symptoms:[a]** • **CBC** • **Liver function tests and alkaline phosphatase** • **Bone scan indicated if localized bone pain or elevated alkaline phosphatase** • **Abdominal ± pelvic diagnostic CT or MRI indicated if elevated alkaline phosphatase, abnormal liver function tests, abdominal symptoms, or abnormal physical examination of the abdomen or pelvis** • **Chest diagnostic CT (if pulmonary symptoms present)**

→ See Locoregional Treatment (BINV-2)

[a]Routine systemic staging is not indicated for early breast cancer in the absence of symptoms.

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[d]FDG PET/CT may also be helpful in identifying unsuspected regional nodal disease and/or distant metastases in locally advanced breast cancer when used in addition to standard staging studies.

CLINICAL STAGE

WORKUP

Stage I
T1, N0, M0
or
Stage IIA
T0, N1, M0
T1, N1, M0
T2, N0, M0
or
Stage IIB
T2, N1, M0
T3, N0, M0
or
Stage IIIA
T3, N1, M0

Klinik Evre I-IIB - Preoperatif Hazırlık

- Tam kan sayımı, KCFT ve ALP
- SADECE, semptomların varlığında,
  - Kemik Sintigrafisi; Lokalize kemik ağrısı veya Yüksek ALP
  - Abdomen/ Pelvik CT, MR; KCFT yüksekliği, ALP yüksekliği, karın semptomları,bulguları
  - Toraks CT; pulmoner semptom varlığında
- Tümör belirteçleri ÖNERİLMİYOR

See Locoregional Treatment (BINV-2)

[a]Routine systemic staging is not indicated for early breast cancer in the absence of symptoms.

[b]If FDG PET/CT is performed and clearly indicates bone metastasis, on both the PET and CT component, bone scan or sodium fluoride PET/CT may not be needed.

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[d]FDG PET/CT may also be helpful in identifying unsuspected regional nodal disease and/or distant metastases in locally advanced breast cancer when used in addition to standard staging studies.

CLINICAL STAGE	WORKUP
Stage I T1, N0, M0 or Stage IIA T0, N1, M0 T1, N1, M0 T2, N0, M0 or Stage IIB T2, N1, M0 T3, N0, M0 or Stage IIIA T3, N1, M0	**If clinical stage IIIA (T3, N1, M0) consider:** • CBC • Liver function tests and alkaline phosphatase • Chest diagnostic CT • Abdominal ± pelvic diagnostic CT or MRI • Bone scan or sodium fluoride PET/CT[b] (category 2B) • FDG PET/CT[c,d] (optional, category 2B)

See Locoregional Treatment (BINV-2)

[a]Routine systemic staging is not indicated for early breast cancer in the absence of symptoms.

[b]If FDG PET/CT is performed and clearly indicates bone metastasis, on both the PET and CT component, bone scan or sodium fluoride PET/CT may not be needed.

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[d]FDG PET/CT may also be helpful in identifying unsuspected regional nodal disease and/or distant metastases in locally advanced breast cancer when used in addition to standard staging studies.

CLINICAL STAGE

WORKUP

Stage I
T1, N0, M0
or
Stage IIA
T0, N1, M0
T1, N1, M0
T2, N0, M0
or
Stage IIB
T2, N1, M0
T3, N0, M0
or
Stage IIIA
T3, N1, M0

Evre IIIA (T3 N1 M0) - Preoperatif Hazırlık

- Tam kan sayımı
- KCFT ve ALP
- Toraks CT
- Abdominal ± Pelvik CT veya MR
- Kemik sintigrafisi veya PET (Kategori 2B)
- FDG PET/ CT (Kategori 2B)

See Locoregional Treatment (BINV-2)

[a]Routine systemic staging is not indicated for early breast cancer in the absence of symptoms.

[b]If FDG PET/CT is performed and clearly indicates bone metastasis, on both the PET and CT component, bone scan or sodium fluoride PET/CT may not be needed.

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PREOPERATIVE SYSTEMIC THERAPY FOR INOPERABLE OR LOCALLY ADVANCED BREAST CANCER (NON-INFLAMMATORY): WORKUP

CLINICAL STAGE	WORKUP
Stage IIIA **T0, N2, M0** **T1, N2, M0** **T2, N2, M0** **T3, N2, M0** **Stage IIIA patients with T3, N1, M0 disease, see BINV-1** **Stage IIIB** **T4, N0, M0** **T4, N1, M0** **T4, N2, M0** **Stage IIIC** **Any T, N3, M0**	• **History and physical exam** • **Diagnostic bilateral mammogram; ultrasound as necessary** • **Pathology review** • **Determination of tumor EP/PR status and HER2 status** • **Genetic counseling if patient is high risk for hereditary breast cancer** • **Breast MRI (optimal), with special consideration for mammographically occult tumors** • **Fertility counseling if premenopausal** • **Assess for distress**

→ **See Preoperative Systemic Therapy For Inoperable or Locally Advanced Breast Cancer (Non-Inflammatory) (BINV-15)**

[a]**Routine systemic staging is not indicated for early breast cancer in the absence of symptoms.**

[b]**If FDG PET/CT is performed and clearly indicates bone metastasis, on both the PET and CT component, bone scan or sodium fluoride PET/CT may not be needed.**

[c]**FDG PET/CT can be performed at the same time as diagnostic CT. The use of PET or PET/CT scanning is not indicated in the staging of clinical stage I, II, or operable stage III breast cancer. FDG PET/CT is most helpful in situations where standard staging studies are equivocal or suspicious, especially in the setting of locally advanced or metastatic disease.**

[d]**FDG PET/CT may also be helpful in identifying unsuspected regional nodal disease and/or distant metastases in locally advanced breast cancer when used in addition to standard staging studies.**

PREOPERATIVE SYSTEMIC THERAPY FOR INOPERABLE OR LOCALLY ADVANCED BREAST CANCER (NON-INFLAMMATORY): WORKUP

CLINICAL STAGE

WORKUP

Stage IIIA
T0, N2, M0
T1, N2, M0
T2, N2, M0
T3, N2, M0

Stage IIIA patients with T3, N1, M0 disease, see BINV-1

Stage IIIB
T4, N0, M0
T4, N1, M0
T4, N2, M0

Stage IIIC
Any T, N3, M0

Evre IIIA, Evre IIIB, Evre IIIC Preoperatif Hazırlık

- Tam kan sayımı
- KCFT ve ALP
- Toraks CT
- Abdominal ± Pelvik CT veya MR
- Kemik sintigrafisi veya PET (Kategori B)
- FDG PET/CT (Kategori B)

See Preoperative Systemic Therapy For Inoperable or Locally Advanced Breast Cancer (Non-Inflammatory) (BINV-15)

[a]Routine systemic staging is not indicated for early breast cancer in the absence of symptoms.

[b]If FDG PET/CT is performed and clearly indicates bone metastasis, on both the PET and CT component, bone scan or sodium fluoride PET/CT may not be needed.

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[d]FDG PET/CT may also be helpful in identifying unsuspected regional nodal disease and/or distant metastases in locally advanced breast cancer when used in addition to standard staging studies.

Lokal İleri Meme Kanseri
İnflamatuar Meme Kanseri

Evre IIIA (T3N1M0 hariç)
Evre IIIB
Evre IIIC

Toraks CT
Batın CT
Pelvik CT
Kemik Sintigrafisi
PET (Kategori B opsiyonel)

NCCN 2016

The Yield of ^{18}F-FDG PET/CT in Patients with Clinical Stage IIA, IIB, or IIIA Breast Cancer: A Prospective Study

131 hasta, AC gr±CT, Abd USG±CT, Kemik Sint., PET, 56 ay takip

Evre	n	PET sonrası evre atlama
Evre IIA	36	%5,6
T2N0	34	
T1N1	2	
Evre IIB	48	%14,6
T3N0	20	
T2N1	28	
Evre IIIA	47	%27,6
T3N1	29	%14.2
T2N2	9	%56
T3N2	9	

Evre IIB ile Evre IIIA'nın uzak metastaz oranı aynı

Groheux D, et al. J Nucl Med 2011; 52(10): 1526-1534

Klinik evre (AJCC) ile PET/CT sonrası evrenin karşılaştırılması

		PET/CT stage						
Initial clinical stage	Total	I	IIA	IIB	IIIA	IIIB	IIIC	IV (%)
I	20	17	2					1 (5)
IIA	44		37	3	1		1	2 (5)
IIB	47			34	1		4	8 (17)
IIIA	13				8		1	4 (31)
IIIB	8					4		4 (50)
IIIC	2						1	1 (50)

Riedl CC, et al. J Nucl Med 2014; 55(10): 1578-1583

Özet olarak

- Meme kanseri ≤ T1N1, asemptomatik, KCFT normal

Evreleme tetkiklerine gerek YOK

- **>T1N1, semptomatik, klinik/biyokimyasal anormallik (evreden bağımsız)**

Toraks/batın/pelvik CT yapılabilir

- Tümör çapı >5 cm
- Herhangi bir çapta ve cilt ve göğüs duvarı tutulumu
- N2 Lenf nodu tutulumu
- Yüksek Grad, ki 67
- cErb2 pozitif tümörler
- ER (-), PR (-), cErb2 (-)

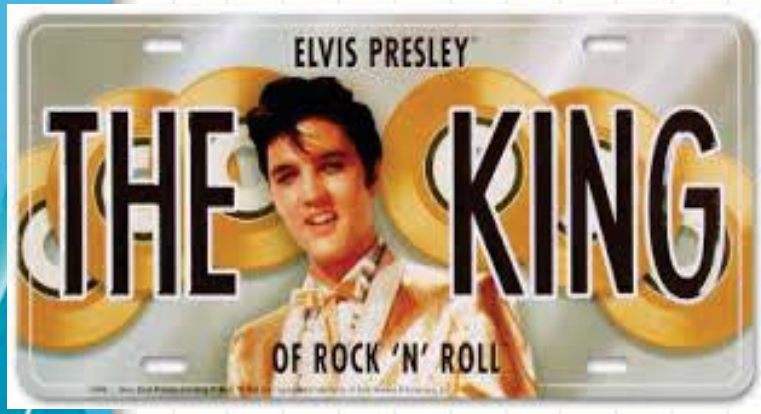
PET/CT yapılabilir

Bozcuk, et al. Breast Cancer Research and Treatment 2001; 68:239-248

Schneider C. Arch Gynecol Obstet 2003; 269: 9-12

- Neoadjuvan kemoterapi alacak yüksek riskli hastalar
- Metastaz riski yüksek olan lokal ileri tümörler
- İnflamatuar meme kanserlerinde

PET/CT görüntüleme geleneksel evreleme tetkiklerinin yerini alabilir.



"In the field of surgical oncology
tumor biology is king,
patient selection is queen, and
technical maneuvers are the prince and princess
who try, but usually fail, to usurp the throne."

Cady Arch Surg 1997

PRİMER KANSERE CERRAHİ

Cerrahiye karşıt görüşler

- Metastatik yayılımın oranı ve organdaki tutulum miktarı sağkalımı belirler
- Bu hastalar sağlıksızdır, cerrahiyi kaldıramazlar

- Risk yarar oranı riskler yönünde ağırlık kazanır
  - «Tümörü kızıştırmak, havanın içeri girmesi» teorileri
  - Anestezi, cerrahi stres, kan transfüzyonu ve diğer faktörlere bağlı olarak VEGF ve diğer anjiojenik faktörlerin salınımı
  - Aslında primer tümör kendisi antianjiojenik ve büyüme faktörlerinin kaynağıdır, tümör çıkarılması hızlanmış relapsa neden olabilir

Cerrahiye yandaş görüşler

- Yaşam kalitesini düzeltir ve semptomların kontrolünü sağlar
- Debulking kemoterapinin etkinliğini artırır

- – Metastatik zinciri kırar
  - – Primer tümör ortadan kalkar
  - – Metastaz da çıkarılabilir

- Tümöre lokal immün cevabı baskılayan inibitör peptidleri /molekülleri ortadan kaldırarak kalan tümör hücrelerinde anti-tümör immüniteyi güçlendirir

National Comprehensive Cancer Network [NCCN] Clinical Practice Guidelines in Oncology,

European Society for Medical Oncology [ESMO] Clinical Recommendations

MMK Tedavisi

- Cerrahi
- Bölgesel radyoterapi
- Kemoterapi

At the European Breast Cancer Conference (EBCC)-6, Mart 2008 ; Berlin,
MMK rehberleri ikinci halk toplantısı

"Metastatik meme kanseri tedavi edilebilir mi?"

- Hangi hastalar (kraliçe)
- Uygun zaman (kral)
- Uygun sistemik tedavi (kral)
- Cerrahi , sistemik tedavi seçenekleri (prens, prenses)

RETROSPEKTİF ÇALIŞMALAR

RETROSPEKTİF ÇALIŞMALAR

- MMK'inde primer cerrahi

  Lokorejyonel kontrolu sağlanır
  Hastalıksız sağkalım artar
  Genel sağkalımı artırmaktadır.

- Cerrahi için seçilen hastalar sıklıkla
- daha genç,
- daha sağlıklı,
- tümör yükü düşük,
- lokalizasyonu daha basit yerlerde olan
- tümör profili olarak daha masum olgulardır.

RETROSPEKTİF ÇALIŞMALAR

- Zayıf noktalar – (eksik bilgi)
  - Radyoterapi ve sistemik tedaviler,
  - Tümörün histopatolojik özellikleri,
  - Primer cerrahinin zamanlaması
  - Aksillaya yönelik cerrahi girişimler
- Hastaların büyük bölümünde Her2neu bilgisi eksiktir.
- Neoadjuvan sistemik tedavilere ait bilgiler hemen hemen yok gibidir.

Ann Surg Oncol (2013) 20:2828–2834
DOI 10.1245/s10434-013-2998-2

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – BREAST ONCOLOGY

Meta-Analysis to Determine if Surgical Resection of the Primary Tumour in the Setting of Stage IV Breast Cancer Impacts on Survival

Elly Harris, Mitchel Barry, and Malcolm R. Kell

- 10 çalışma - 28693 olgu
- 3-yıllık sağkalım oranlarının cerrahi yapılan hastalarda daha iyidir (%40 vs %22).
- Subgrup analizlerinde;
  - Cerrahi grubu daha ufak tümörler, komorbid hastalığı az, tümör yükü fazla olmayan ($p<0.01$).
  - Metastazın lokalizasyonu, tümör gradı, reseptör durumu açısından fark yok.

TABLE 1 Studies selected for meta-analysis

Author	Study period	Stage	Outcome	Follow-up surgery	Follow-up - no surgery	Hazard ratio
Babiera	1997–2002	IV	Overall survival	n/a	n/a	0.5
Bafford	1998–2005	IV	Median survival	3.52 yrs	2.36 yrs	0.47
Blanchard	1973–1991	IV	Median survival	27.1 mo	16.8 mo	0.71
Cady	1970–2002	IV	2- and 5-year survival	24 mo	24 mo	n/a
Fields	1996–2005	IV	Median survival	31.9 mo	15.4 mo	0.53
Gnerlich	1988–2003	IV	Median survival	36 mo	21 mo	0.63
Hazard	1990–1993	IV	3-year survival/median survival	26.3 mo	29.2 mo	0.798
Khan	1990–1993	IV	3-year survival/mean survival	26.9–31.9 mo	19.3 mo	0.61
Rapiti	1977–1996	IV	5-year survival	n/a	n/a	0.6
Ruiterkamp	1993–2004	IV	5-year survival/median survival	31 mo	14 mo	0.62

mo months, *yrs* years, *n/a* not available

‘What can we learn from repeated attempts to pool and analyse the same biased, retrospective data?’*

*Dr Seema Khan, Ann Surg Oncol 2013, May 8, Epub ahead.

PROSPEKTİF ÇALIŞMALAR

Table 2. randomized clinical trials addressing impact of local therapy for the primary tumor.

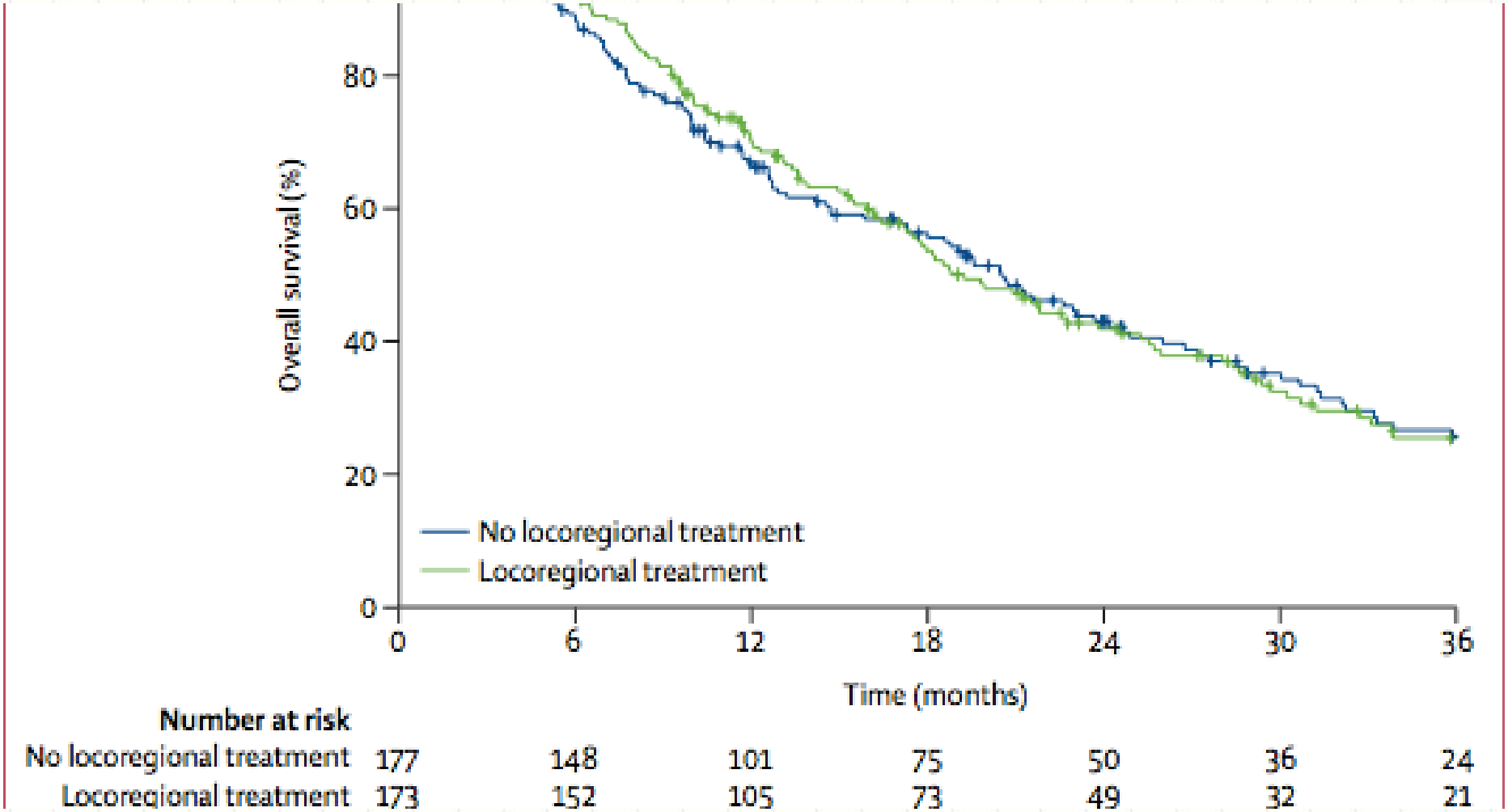
Country	Trial Number	Accrual Period	N	Initial Therapy	Radiotherapy	Primary Endpoint
India	NCT00193778	2005-12	350	AC 6 cycles	If indicated	Time to progression
Japan	JCOG 1017	2011-16	410	Systemic therapy	Not addressed	Survival
USA and Canada	NCT01242800	2011-16	880	Systemic therapy	Per standards for stage I-III	Survival
Turkey	NCT00557986	2008-12	281	Surgery	For breast conservation	Survival
Netherlands	NCT01392586 (SUBMIT)	2011-16	516	Surgery	For positive margins or palliation	2-year survival
Austria	NCT01015625	2010-19	254	Surgery	Per standards for stage I-III	Survival

Badwe RA, ve ark. INDIAN TRIAL (NCT00193778), *Lancet Oncol, 2015; 16: 1380-88*

Locoregional treatment versus no treatment of the primary tumour in metastatic breast cancer: an open-label randomised controlled trial

- 350 hasta – KT (Antrasiklinli) veya HT - %60
- Cerrahi yapılan vs yapılmayan (173 vs 177)
- Median takip 23 ay
- 235 ölüm (118 vs 117)
- Median genel sağkalım (19.2 ay vs 20.5 ay)

Badwe RA, et al. Lancet Oncol, 2015; 16: 1380-88



Number at risk							
No locoregional treatment	177	148	101	75	50	36	24
Locoregional treatment	173	152	105	73	49	32	21

Badwe RA, et al. Lancet Oncol, 2015; 16: 1380-88

- Subgrup analizlerinde de sağkalım avantajı görülmemektedir.

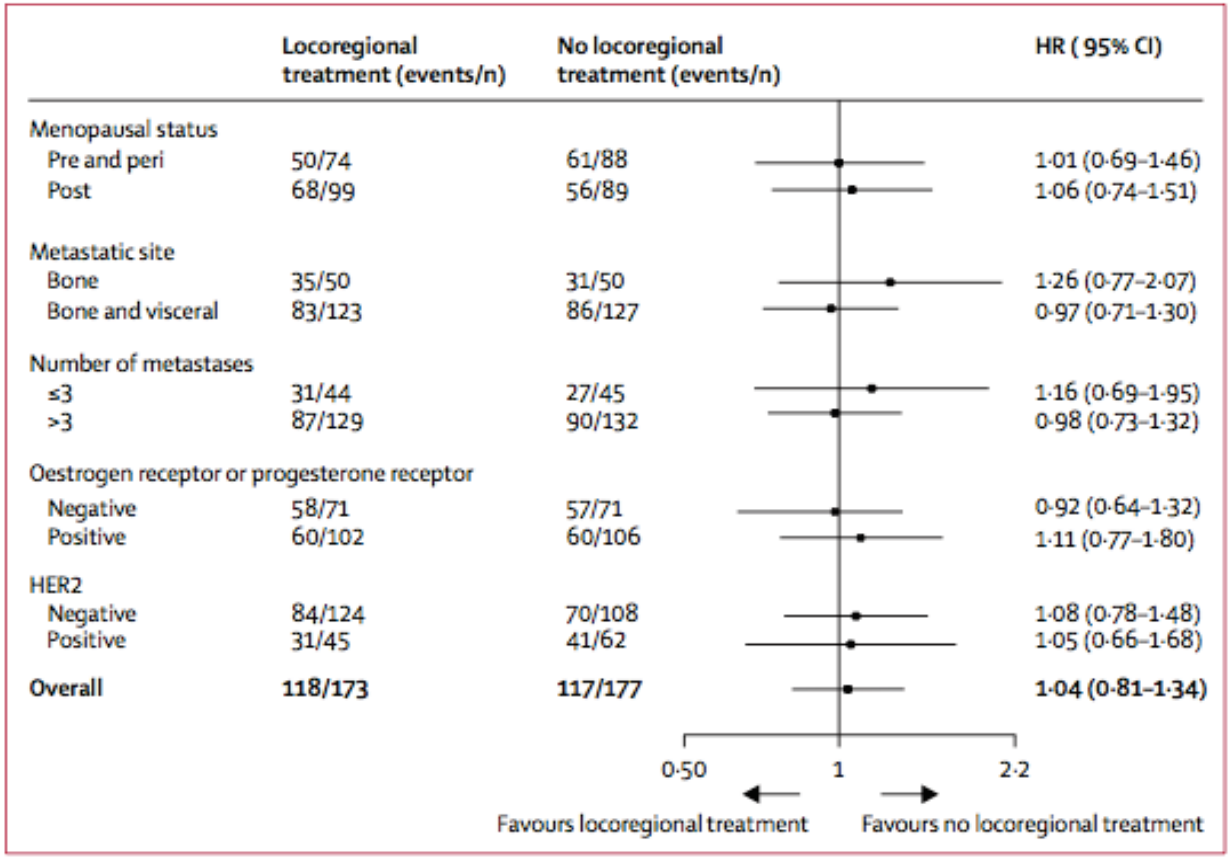


Figure 3: **Forest plot of overall survival subgroup analyses, unadjusted hazard ratios**

Badwe RA, et al. Lancet Oncol, 2015; 16: 1380-88

- Cerrahi yapılan hastalarda uzak progresyonsuz sağkalım daha kötüdür.

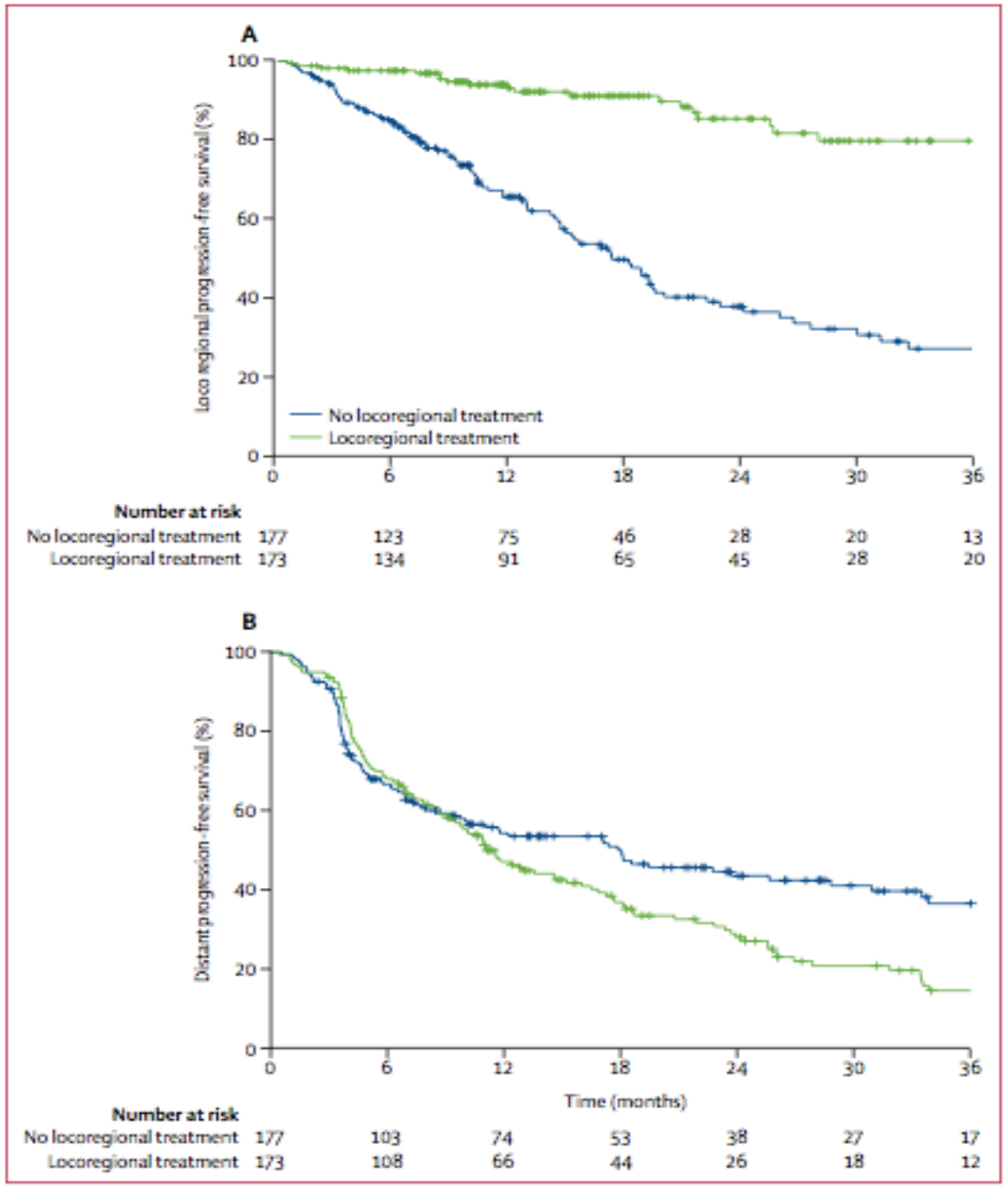


Figure 4: **Kaplan-Meier plot of locoregional progression-free survival (A) and distant progression-free survival (B)**

Badwe RA, et al. Lancet Oncol, 2015; 16: 1380-88

- Lokorejyonel tedavi sağkalım avantajı sağlamamaktadır ve her MMK ile başvuran kadına önerilmemelidir.
  - Subgrup analizlerinde de sonuçlar aynıdır (menopozal durum, metastatik hastalık yükü, ER, PR veya HER2 reseptör durumu, vb)
- Primer tümörün eksizyonu uzak metastazda büyümeye neden olabilir.
- Hastaların aldıkları sistemik tedavilerde farklılık vardır.

MF07-01 ÇALIŞMASI

- TMHDF'nun ilk çok merkezli, prospektif, randomize çalışmasıdır.

- **HİPOTEZ**
  - İlk basvurularında metastatik meme kanseri tanısı alan hastalarda, primer cerrahi tedavi ile tümör yükünün azaltılması sonucunda sağkalım ve hastalığın ilerlemesine kadar geçen sürede belirgin artış olacaktır.

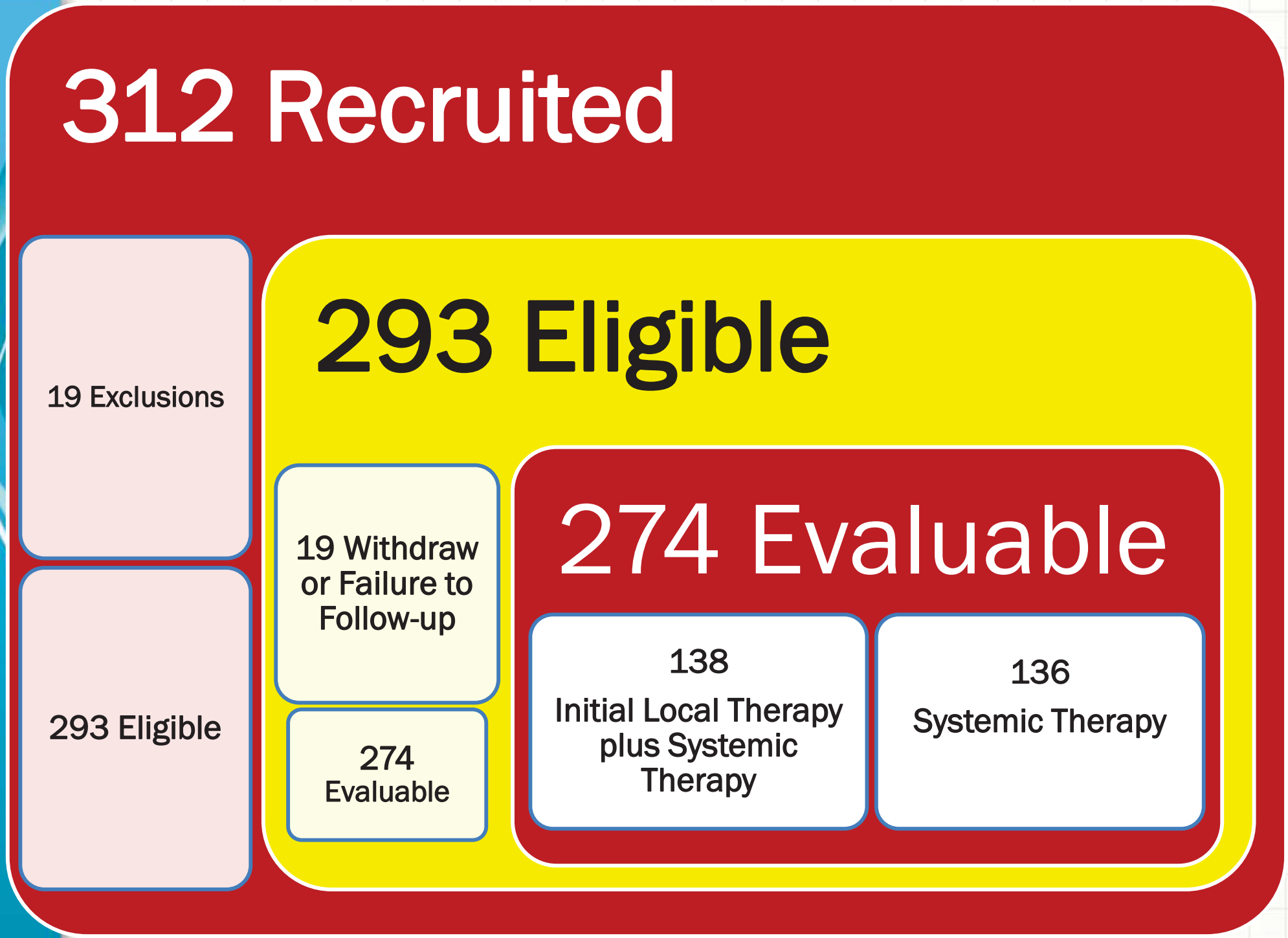
MF07-01 / AMAÇ

- **Primer**
  - Genel sağkalım
- **Sekonder**
  - Lokorejyonel tedaviye ait morbidite
  - Hastalıksız sağkalım
  - Yaşam kalite ölçümleri

A randomized controlled trial evaluating resection of the primary breast tumor in women presenting with de novo stage IV breast cancer; Turkish Study (Protocol MF07-01)

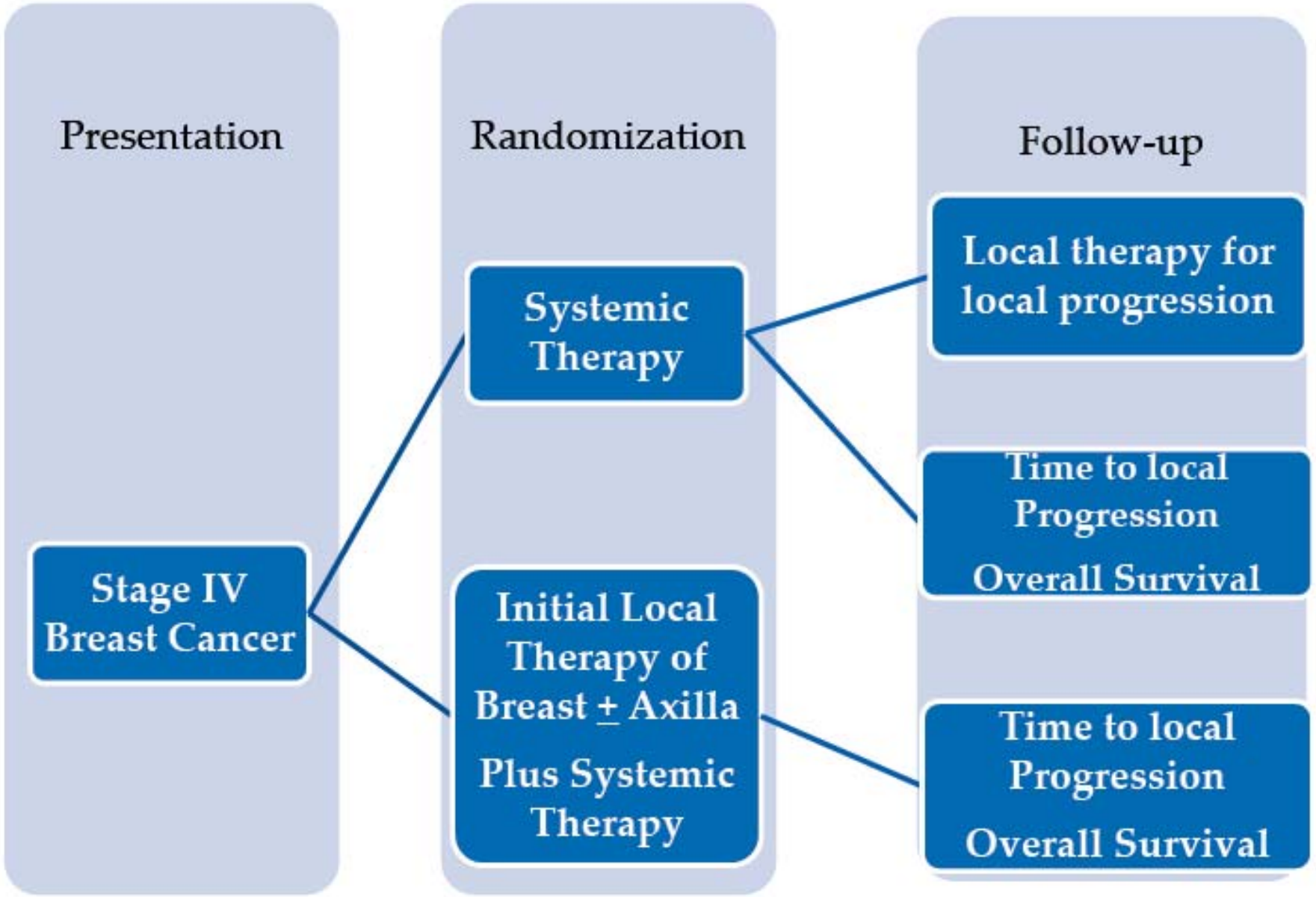
Atilla Soran, MD, MPH, FACS, Magee-Womens Hospital of UPMC
Vahit Ozmen, Serdar Ozbas, Hasan Karanlik, Mahmut Muslumanoglu, Abdullah Igci, Zafer Canturk, Zafer Utkan, Cihangir Ozaslan, Turkkan Evrensel, Cihan Uras, Erol Aksaz, Aykut Soyder, Umit Ugurlu, Cavit Col, Neslihan Cabioğlu, Betül Bozkurt, Efe Sezgin, Ronald Johnson, Barry Lembersky.
On behalf of the Turkish Federation of Societies for Breast Diseases
ClinicalTrials.gov identifier number is NCT00557986

Dr. Atilla Soran'ın izniyle, ASCO 2016



Dr. Atilla Soran'ın izniyle, ASCO 2016

Design MF07-01



Dr. Atilla Soran'ın izniyle, San Antonio 2013

TARTIŞMA

- 36 aylık takipte sağkalım farkı yoktur.
- Daha uzun takipte ortalama sağkalım süresinde istatistiksel anlamlılık çıkmıştır (46 vs 37 ay; HR:0.66) ve 5 yıllık genel sağkalım %41.6 vs %24.4

TARTIŞMA

- ER (+), HER2 neu (-), tek kemik metastazı olanlar ve < 55 yaş olanlarda primer cerrahi ile sağkalım avantajı daha belirgindir.
  - Multiple karaciğer ve /veya pulmoner metastazı olanlarda ise daha kötüdür.
- İlk 30-gün mortalitesine etki etmemektedir.
- Lokorejyonel progresyon KT kolunda 11 kat daha fazladır (Cerrahi %1 vs KT %11).
- Semptomatik olup metastaz bölgesine işlem uygulanan hastalarda, primer cerrahi yapılsın ya da yapılmasın sağkalım benzerdir.

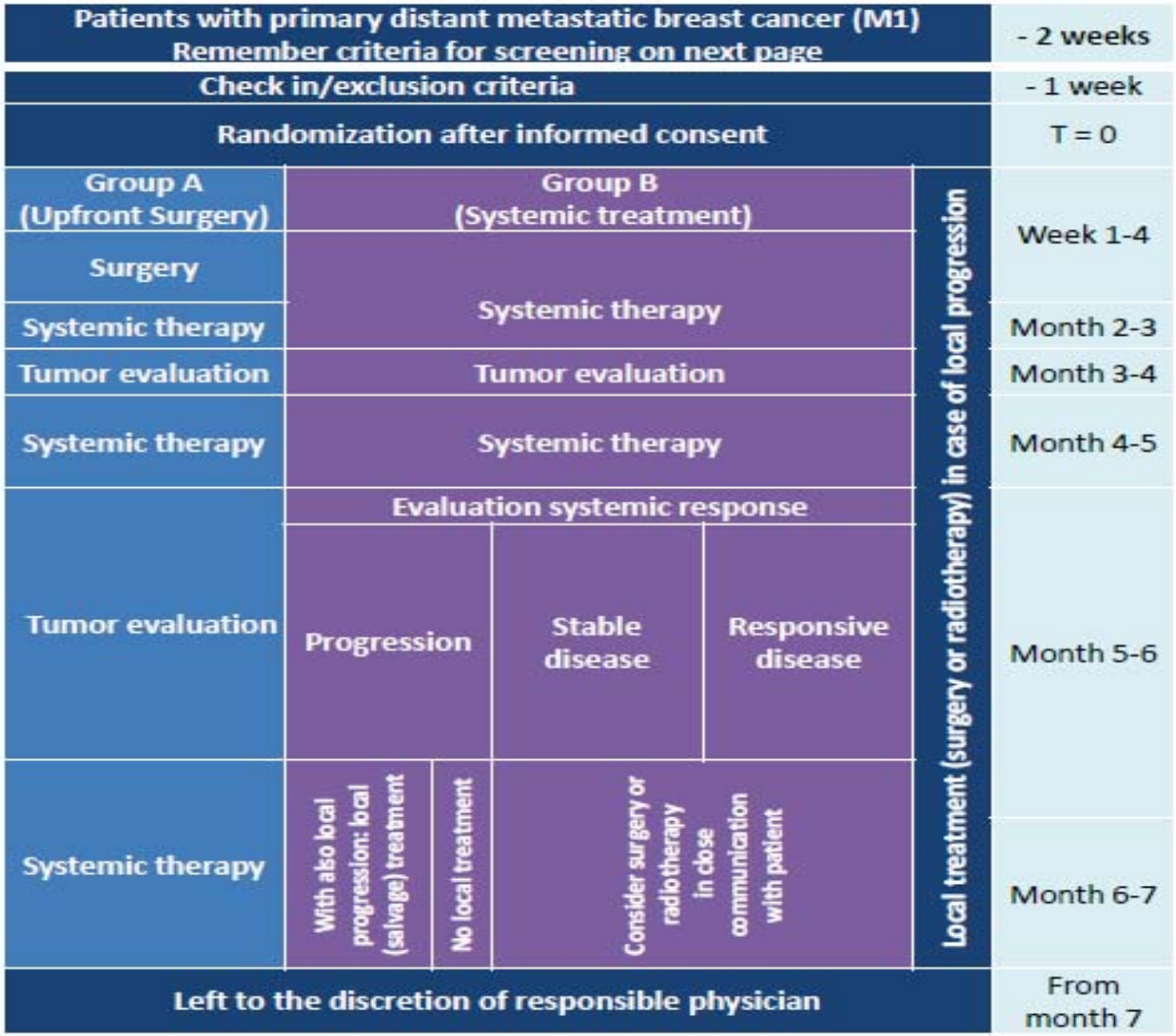
Ruiterkamp *et al. BMC Surgery* 2012, **12**:5
http://www.biomedcentral.com/1471-2482/12/5

BMC Surgery

STUDY PROTOCOL Open Access

SUBMIT: Systemic therapy with or without up front surgery of the primary tumor in breast cancer patients with distant metastases at initial presentation

Jetske Ruiterkamp[1], Adri C Voogd[2], Vivianne CG Tjan-Heijnen[3], Koop Bosscha[4], Yvette M van der Linden[5], Emiel JTh Rutgers[6], Epie Boven[7], Maurice JC van der Sangen[8] and Miranda F Ernst[3,9*], for
In collaboratio



SUBMIT:

- M1 meme kanseri, histolojik tanıdan bir ay içinde metastaz tespiti

- Beklenen yaşam süresi ≥6 ay
  - Hormonal ve HER2 durumu
  - T1-T3 veya rezektabl T4; N0-N3
  - performans statüsü ve yandaş hastalıklar sistemik tedavi için uygun
  - Yaş ≥18 yıl

- Sonlanım

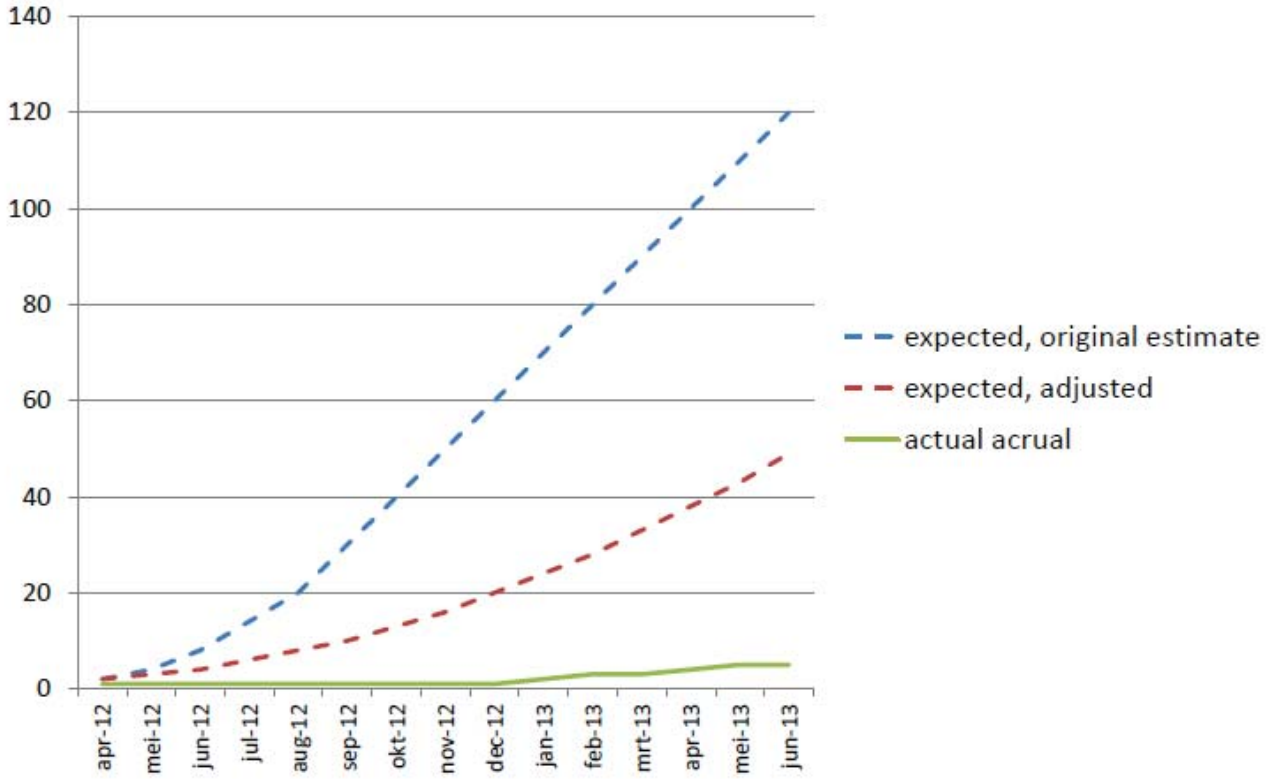
Primer:

- –iki yıllık genel sağ kalım

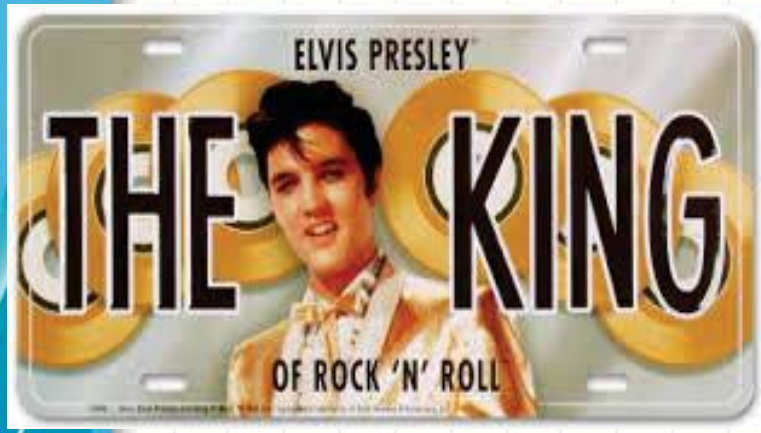
Sekonder:

- Yaşam kalitesi
- –Lokal tümör kontrolü

Patient accrual in SUBMIT does not meet the expectations



SONUÇ...



"In the field of surgical oncology
tumor biology is king,
patient selection is queen,and
technical maneuvers are the prince and princess
who try, but usually fail, to usurp the throne."

Cady Arch Surg 1997

En önemli prediktörler

- Yaş : Genç hasta
- Kemik ve yumuşak doku metastazı olup sistemik tedavi ile tam yanıt alınan

Sonuçlar ve öneriler

- MMK tam kür nerede ise imkansızdır
- Primer tümörün cerrahi eksizyonu
  - Kanama,
  - Ülser
  - Enfeksiyona karşı palyasyon sağlayabilir.

Kanıta dayalı tıp

- Küçük tümör (T1-T2) ve metastazın tek yer ile sınırlı olduğu MMK’ de cerrahi tedavi seçeneği olabilir (Evre 2C)

Çıkarımlar

Cerrahiden fayda görecek hastalar rehberler ile tanımlanmalıdır

Lokal tedavi yaşam süresini etkilemiyor ise optimum sistemik tedavi üzerine yoğunlaşmak bir sonraki prospektif çalışma protokolünü oluşturabilir