



PALYATİF BAKIMDA CERRAHİ GİRİŞİMLER



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DOKUZ EYLÜL ÜNİVERSİTESİ TIP FAKÜLTESİ GENEL CERRAHİ AD, KOLOREKTAL VE
PELVİK CERRAHİ BİRİMİ, İZMİR
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BAŞARISIZLIK ANALİZİ
[ŞİTOREDÜKTİF CERRAHİ(SRC)&HİPEK] TEMELİNDE



PROF. DR. SELMAN SÖKMEN, FACS, FASCRS(Int'l), FASPSM, ESSO Mentor
DOKUZ EYLÜL ÜNİV. TIP FAKÜLTESİ, GENEL CERRAHİ AD
KOLOREKTAL ve PELVİK CERRAHİ, İZMİR
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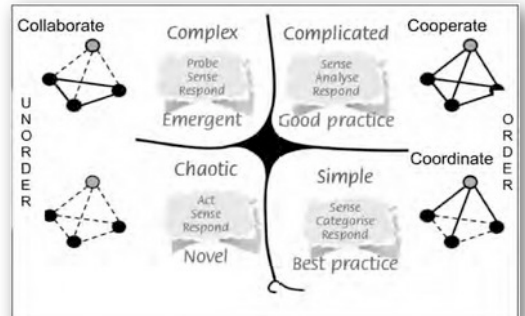
**TÜM OLUMSUZ BULGULAR MEVCUT...
'ÜZGÜNÜM, AMA YAPILAMAZ' DEMELİYİZ
HASTA SEÇİMİNDE BAŞARISIZLIK**



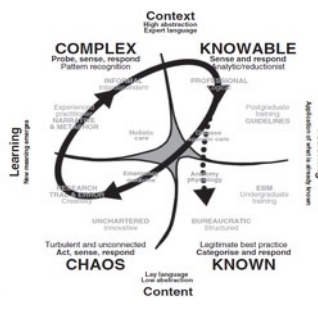
"HASTAYI ÖLDÜREN HASTADA KALANDIR"
PAUL SUGARBAKER

- ÖNEMLİ OLAN DENGEYİ BULABİLMEKTİR...
- HER İŞTE METRİKLER/ÖLÇÜTLER VARDIR
- SÜREKLİ 'ESNETENLER' ÇIKARIN PEŞİNDEDİR
- KOMFOR ZONUNDAN ÇIKMAK İSTEMEYENLER DE YAPILANI KARALAR
- DÜZEN, DISİPLİN VE DAYANIKLILIK GEREKİYOR
- RUHSUZ'A BU KAVRAMLAR ANLATILAMIYOR...
- MENTÖR-MENTİ KAVRAMI DEJENERE OLDU

"Complexity Theory in Medicine & Surgery"
CYNEFİN MODEL
Standart Olgu/Karmaşık Olgu...



Standart Olgu/Karmaşık Olgu...



1. SORUN MASTER A PROCEDURE NEEDS GOOD JUDGEMENT

GOOD JUDGEMENT NEEDS EXPERIENCE

EXPERIENCE NEEDS BAD JUDGEMENT



2. Sorun

J Gastrointest Surg (2015) 22:460–466
DOI 10.1007/s11605-015-3417-6

ORIGINAL ARTICLE

Benefit of Surgical Resection of the Primary Tumor in Patients Undergoing Chemotherapy for Stage IV Colorectal Cancer with Unresected Metastasis

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Abstract
Purpose Resection of the primary tumor in patients with unresected metastatic colorectal cancer is controversial, and often performed only for palliation of symptoms. Our goal was to determine if resection of the primary tumor in this patient population is associated with improved survival.
Methods This is a retrospective cohort study of the National Cancer Data Base from 2004 to 2012. The study population included all patients with synchronous metastatic colorectal adenocarcinomas who were treated with systemic chemotherapy. The study group were patients who underwent definitive surgery for the primary tumor and those who did not. Patients were excluded if they had surgical intervention on the site of metastatic or pathologic other than adenocarcinoma. Primary outcome was overall survival.
Results Of the 65,543 patients with unresected stage IV colorectal adenocarcinomas undergoing chemotherapy, 1595 underwent surgical resection of the primary site. Patients who underwent surgical resection of the primary tumor had improved median survival compared to patients treated with chemotherapy alone (22 vs 13 months, $p < 0.001$). The surgical survival benefit was present for patients who were treated with either multi-agent or single-agent chemotherapy (23 vs 14 months, $p < 0.001$; 19 vs 9 months, $p < 0.001$). Surgical resection of the primary tumor was also associated with improved survival when using multivariate analysis with propensity score matching (OR = 0.863, 95% CI 0.805–0.924, HR = 0.914, 95% CI 0.880–0.942).
Conclusion Our results show that in patients with synchronous unresected stage IV colorectal adenocarcinoma undergoing single- or multi-agent chemotherapy, either adjuvant or palliative, definitive resection of the primary site was associated with improved overall survival. Larger randomized controlled trials are needed to determine if there is a causal relationship between surgery and increased overall survival in this patient population.

ORIGINAL CONTRIBUTION

Surgical Resection of the Primary Tumor in Stage IV Colorectal Cancer Without Metastectomy Is Associated With Improved Overall Survival Compared With Chemotherapy/Radiation Therapy Alone

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Department of Surgery, Duke University Medical Center, Durham, North Carolina

BACKGROUND: Controversy exists over whether resection of the primary tumor in stage IV colorectal cancer with inoperable metastases improves patient outcomes.

OBJECTIVE: The purpose of this study was to evaluate whether resection of the primary tumor without metastectomy in patients with stage IV colorectal cancer is associated with improved overall survival compared with patients undergoing chemotherapy and/or radiation therapy alone.

DESIGN: This was a retrospective review of a multi-institutional dataset.

SETTINGS: This study was conducted in all participating institutions in cancer (CA) accredited facilities.

PATIENTS: The 2003–2006 National Cancer Data Base was reviewed to identify patients with stage IV adenocarcinoma of the colon or rectum who underwent palliative treatment without curative intent, either in the form of surgical resection of the primary tumor without metastectomy consisting of a colectomy or rectal resection with or without

chemotherapy and/or radiation or chemotherapy and/or radiation alone.

MEASUREMENTS AND MAIN RESULTS: Groups were compared for baseline characteristics. Overall survival was compared using Kaplan–Meier analysis before and after propensity matching with a 1:1 nearest neighbor algorithm.

RESULTS: Of the 1446 patients included in the analysis, 231 (16%) underwent surgical resection of the primary tumor without metastectomy. Surgical resection was associated with a significant survival benefit on unadjusted analysis (median survival, 9.2 vs 7.6 months; $p < 0.01$). After propensity matching to adjust for nonrandom treatment selection, surgical resection continued to be associated with a significant survival benefit (median survival, 9.2 vs 7.3 months; $p < 0.01$).

LIMITATIONS: This study was limited by the potential for selection bias regarding which patients received surgical resection. There was also a lack of data regarding the indication for operation, specifically whether a patient was symptomatic or asymptomatic before resection. The inability to account for tumor size or grade among patients who did not receive surgical resection was another limitation.

CONCLUSIONS: Surgical resection of the primary tumor without metastectomy in patients with metastatic colorectal cancer is associated with improved overall survival as compared with chemotherapy/radiation therapy alone. (J. Gastrointest Surg. 2015; 22:460–466.)

Financial Disclosure: None reported.
Podium presentation at the meeting of the American Society of Colon and Rectal Surgeons, Boston, MA, Oct 30 to Nov 3, 2015.

Systematic review

doi:10.1111/col.12286

Palliative resection of the primary tumour in patients with Stage IV colorectal cancer: systematic review and meta-analysis of the early outcome after laparoscopic and open colectomy

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Received: 17 November 2012; accepted: 21 December 2012; Accepted Article online: 23 April 2013

Abstract

Aim Resection of the primary tumour in patients with Stage IV colorectal cancer may be performed to avoid future tumour-related complications whilst on systemic treatment. We compared the safety and efficacy of laparoscopic and open colectomy in this patient group.

Method PubMed, MEDLINE and the Cochrane Library were searched in the English literature for studies between 1990 and October 2012 dealing with laparoscopic resection of the primary tumour in Stage IV disease. Single-arm laparoscopic studies were systematically reviewed. Prospective and retrospective studies were included for meta-analysis. End-points include safety, complications, mortality and cancer specific outcome including 5-year and median survival.

Results Eleven studies comprising 1165 patients undergoing palliative laparoscopic colectomy for Stage IV colorectal cancer were included. Five studies were comparative studies of laparoscopic and open colectomy.

The former took longer (pooled mean difference (MD) = 41.52, 95% CI = 11.47–71.56, $Z = 2.71$, $P = 0.007$), but resulted in a shorter length of stay (pooled MD = -2.41, 95% CI = -3.84 to -0.99, $Z = 3.32$, $P = 0.0009$), with fewer postoperative complications (pooled odds ratio = 0.52, 95% CI = 0.25–0.87, $Z = 2.51$, $P = 0.01$) and lower overall blood loss (pooled MD = -47.71, 95% CI = -80.00 to -15.42, $Z = 2.96$, $P = 0.004$). Median survival ranged between 11.4 and 30.1 months.

Conclusion Palliative colectomy performed laparoscopically is associated with a better perioperative outcome than open colectomy. Survival is dependent on the response to systemic chemotherapy.

Keywords Laparoscopic surgery, open surgery, colorectal cancer, palliative, metastatic, Stage IV

Prognostic Relevance of Palliative Primary Tumor Removal in 37,793 Metastatic Colorectal Cancer Patients

A Population-Based, Propensity Score-Adjusted Trend Analysis

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Objective: To assess whether palliative primary tumor resection in colorectal cancer patients with resectable stage IV disease is associated with improved survival.

Background: There is a heated debate regarding whether or not an asymptomatic primary tumor should be removed in patients with resectable stage IV colorectal disease.

Methods: Stage IV colorectal cancer patients were identified in the Surveillance, Epidemiology, and End Results database between 1998 and 2009. Patients undergoing surgery to metastatic sites were excluded. Overall survival and cancer-specific survival were compared between patients with and without palliative primary tumor resection using risk-adjusted Cox proportional hazard regression models and stratified propensity score models.

Results: Overall, 37,793 stage IV colorectal cancer patients were identified. Of these, 23,004 (60.9%) underwent palliative primary tumor resection. The rate of patients undergoing palliative primary tumor resection decreased from 66.4% in 1998 to 58.7% in 2009 ($P < 0.001$). In Cox regression analysis after propensity score matching primary tumor resection was associated with a significantly improved overall survival (hazard ratio (HR) of death = 0.84, 95% confidence interval (CI) = 0.79–0.89, $P < 0.001$) and cancer-specific survival (HR of death = 0.83, 95% CI = 0.78–0.88, $P < 0.001$). The benefits of palliative primary tumor resection persisted during the time period 1998 to 2009 with HRs equal to or less than 0.87 for both overall and cancer-specific survival.

Conclusions: On the basis of this population-based cohort of stage IV colorectal cancer patients, palliative primary tumor resection was associated with improved overall and cancer-specific survival. Therefore, the degree that an asymptomatic primary tumor never should be resected in patients with resectable colorectal cancer metastases must be questioned.
Keywords: inoperable, metastases, metastatic colorectal cancer, palliative resection.

Ciddi komplikasyon: %7-44, Mortalite: %6-32, Re-obstrüksiyon: %6-47, Yeniden yatış: %38-74, Reop: %2-15

European Journal of Surgical Oncology

Acute malignant obstruction in patients with peritoneal carcinomatosis: The role of palliative surgery

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Abstract
Introduction: Patients with peritoneal carcinomatosis who do not have curative treatment options often develop acute obstructive symptoms and when conservative management fails, surgical treatment is the remaining option. However, palliative surgery is associated with high morbidity and mortality and the chance of success is unclear. The aim of this study was to evaluate response of palliative surgery and to compare the results of palliative surgery with best supportive care.

Methods: All consecutive patients who underwent palliative surgery for acute obstruction caused by peritoneal carcinomatosis between January 2005 and October 2017 were identified.

Results: In total 148 patients underwent surgery. Primary tumour sites were: colorectal cancer (28.4%), pancreatic cancer (26.3%), ovarian cancer (14.2%), liver (7.4%), stomach (7.4%), unknown (10.3%). Median survival was 10.9 days (IQR 48–420). Disease-related mortality was 22.3%. Complications included: wound-healing problems (16.2%), ileus (14.2%), anastomotic leakage (14.2%), and re-obstruction (14.2%). Median survival after re-obstruction was 10.9 days (IQR 48–420). Disease-related mortality was 22.3%. Patients who did not undergo surgery (n = 105) were compared to those who did with chemotherapy longer than 6 months ago, or patients not treated with chemotherapy. Conclusion: Palliative surgery for acute obstruction in patients with peritoneal carcinomatosis is associated with high rates of complications and readmissions, and results in disease progression under conservative treatment with chemotherapy.

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Association for Academic Surgery

Timing of Palliative Care in Colorectal Cancer Patients: Does It Matter?

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Keywords:
Palliative care
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ABSTRACT

Background: Palliative care can improve end-of-life care and reduce health care expenditures, but the optimal timing for initiation remains unclear. We sought to determine the association between timing of palliative care, in-hospital deaths, and health care costs.

Methods: This is a retrospective cohort study including all patients who were diagnosed and died of colorectal cancer between 2004 and 2012 in Manitoba, Canada. The primary endpoint was timing of palliative care, defined as no involvement, late involvement (less than 14 d before death), early involvement (14 to 60 d before death), and very early involvement (60 d before death). The primary outcome was in-hospital deaths and end-of-life health care costs.

Results: A total of 1607 patients were included; 315 (20%) received palliative care and 902 (56%) died in hospital. Compared to those who did not receive palliative care, patients with early and very early involvement experienced significantly decreased odds of dying in hospital (OR 0.39 95% CI 0.06–0.69 $P < .01$ and OR 0.14 95% CI 0.03–0.78 $P < .01$, respectively) and significantly lower health care costs. There were no significant differences in in-hospital deaths and health care costs between patients without palliative care and those who received late palliative care.

Conclusions: Early palliative care involvement is associated with decreased odds of dying in hospital and lower health care utilization and costs in patients with colorectal cancer. These findings provide real-world evidence supporting early integration of palliative care, although the optimal timing (early versus very early) remains a matter of debate.

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Clinical Effectiveness of Endoscopic Stent Placement in Treatment of Acute Intestinal Obstruction Caused by Colorectal Cancer

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Emergency endoscopic intestinal stenting has been applied with increasing frequency in colorectal cancer patients with acute intestinal obstruction. However, its clinical effectiveness as compared to emergency surgery remains controversial. The clinical data of 96 patients with acute intestinal obstruction caused by colorectal cancer from April 2012 to April 2018 were retrospectively collected. Statistical technique success rate, clinical success rate, operative time, average indwelling time of stent, complications, transition time to second-stage surgery, postoperative hospital stay, sputum rate, and postoperative infection rate were studied. Endoscopic colonoscopy was successfully performed in 94 patients. The success rate of stent placement was 97.9%, and the average operative time was 35 minutes (range, 25–85 minutes). Forty-two patients underwent stage I colectomy after relief of the obstruction. The average stent retention time was 7 days (range, 5–15 days). Two patients suffered from anastomotic infection. Their intestinal preparation time, hospital stay, fistula rate, and infection rate were lower than those of patients undergoing emergency operation for colorectal cancer intestinal obstruction. A total of 52 patients with colon cancer underwent palliative stent placement. Three patients had complications, including 1 case of stent displacement in the palliative care group and 2 cases with perforation in the bridge surgery group. Emergency endoscopic placement of an intestinal stent is safe and effective in the treatment of patients with acute intestinal obstruction caused by colorectal cancer. It is also a safe and simple procedure for patients receiving advanced palliative treatment, which greatly improves their quality of life and is easy for patients' families to accept.

Endoscopy • Intestinal Obstruction • Palliative Care • Stents

Palliative Care in Surgery: Defining the Research Priorities

Elizabeth J. Lofth, MS, MPH, Rose Cooper, MD, MSc,† Margaret L. Schwartz, MD, MPH,†† Jane C. Brundage, MD, PhD

ABSTRACT

Palliative care is a multidisciplinary specialty that aims to address the complex needs of patients and their families at the end of life. It is a core component of general surgery, and its integration into surgical practice is essential for providing high-quality care to patients and their families. This paper discusses the importance of palliative care in surgery and identifies key research priorities for the field.

KEYWORDS: Palliative care, Surgery, End of life care, Quality of care, Patient-centered care, Interdisciplinary collaboration.

INTRODUCTION

Palliative care is a multidisciplinary specialty that aims to address the complex needs of patients and their families at the end of life. It is a core component of general surgery, and its integration into surgical practice is essential for providing high-quality care to patients and their families. This paper discusses the importance of palliative care in surgery and identifies key research priorities for the field.

CONCLUSIONS

Palliative care is a core component of general surgery, and its integration into surgical practice is essential for providing high-quality care to patients and their families. This paper discusses the importance of palliative care in surgery and identifies key research priorities for the field.

Yüksek riskli ciddi hastalanmış cerrahi hastalarda palyatif bakım gereksinimi sıklıkla tanınmaz ve karşılık bulmaz.

Nüfus yaşlandıkça ve teknik gelişmeler arttıkça cerrahlar klinik olarak uygun, teknik olarak fizibil ve değer-yümlü bakımın sınırları arasında dolaşır ve cerrahi hastalar daha kompleks hale gelirler.

Cerrahide palyatif bakımın bilimini tesis etmek için interdisipliner işbirliği gerekir.

3. SORUN

Original Article

Data fabrication and other reasons for non-random sampling in 5087 randomised, controlled trials in anaesthetic and general medical journals

J. B. Cook

ABSTRACT

Randomised, controlled trials have been retracted after publication because of data fabrication and inadequate ethical approval. Retraction of data has not been reported for reasons other than fabrication or inadequate ethical approval. We examined the probability of the distribution of reasons for retraction of data in 5087 randomised, controlled trials in anaesthetic and general medical journals. We used a statistical test to examine whether the distribution of reasons for retraction of data is consistent with the expected distribution of reasons for retraction of data in randomised, controlled trials. We found that the distribution of reasons for retraction of data is not consistent with the expected distribution of reasons for retraction of data in randomised, controlled trials.

4. SORUN

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Health Policy

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"What's fair to an individual is not always fair to a population": A qualitative study of patients and their health professionals using the Cancer Drugs Fund

Charlotte Chamberlain*, Amanda Owen-Smith, Fiona Mackichan, Jenny L. Donovan, William Hollingworth

ABSTRACT

Objective: To understand the values attached to cancer treatment at the end of life (EoL) in terms of policy decisions around the Cancer Drugs Fund (CDF) and the National Institute for Health and Care Excellence (NICE) EoL criteria.

Design: Semi-structured interviews with patients and health professionals.

Participants: Patients with incurable prostate and colorectal cancer (n = 22) who received drugs funded through the CDF and oncologists and palliative care physicians (n = 10) receiving patients on CDF drugs.

Setting: Three tertiary care hospitals in the United Kingdom.

Results: While the majority of patients and oncologists participants expressed gratitude for access to the CDF, some patients participants expressed experiencing a sense of guilt, and many oncologists admitted to concerns about the priority of a free-funded drug only for end cancer drugs. For patients and professional participants, cancer drugs were not necessarily seen as a funding priority over other calls on the NHS purse. Overall, patients and health professionals expressed prioritising quality over quantity at the end of life, with only a minority describing improved quality of life at the end of life which added value.

Conclusion: While patients and oncologists expressed the drugs available through the CDF meet expressed concerns about its fairness. Comparing participant views about the added value of the end of life to challenging for research allocation.

5. SORUN

Biology coming full circle: Joining the whole and the parts

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Abstract

The new cover of *Experimental Biology and Medicine* features the hermeneutic circle of biology, a concept we have adapted from the hermeneutic principle that one understands the whole only in terms of each part and the parts only in terms of the whole. Our hermeneutic circle summarizes the course of experimental biology through 2500 years in its achievements of reductionist research (understanding the parts), which culminates in our ability to rapidly sequence the genome. Rather than returning along the same path in a constructionist approach that simply builds upon the knowledge, but in reverse, an alternative is to close the circle with synthetic constructions that seek to integrate the full complexity of biological and physiological systems (understanding the whole), of which organs-on-chips are one example. This closing of the circle cannot be a comprehensively accurate representation of biology, but it can be a synthetic one that effectively defines particular biological subsystems. The illustration of the hermeneutic circle of biology is also intended to suggest both the multiple circles that may be required to reach such a synthesis and the expansion of the circle in an outward spiral as knowledge increases. Our commentary explains the symbolism of the new cover in a philosophical and scientific discussion.

Keywords: Hermeneutic circle, reductionist vs. constructionist, physiology, systems biology, synthetic biology

Experimental Biology and Medicine 2015; 240: 3–7. DOI: 10.1177/1535370214564534

Perspectives in Cell Physiology

The end of "naïve reductionism": rise of systems biology or renaissance of physiology?

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Abstract The end of "naïve reductionism", rise of systems biology or renaissance of physiology? *Am J Physiol Cell Physiol* 2010; 299: C174-C176. doi:10.1152/ajpcell.00000.2010

Physiology is defined as "the study of living organisms and their parts." The discipline of physiology is inherently integrative. This integrative nature is reflected in the numerous benefits of physiological research, which range from the study of single molecules to molecular pathways, cells, tissues, organs, and whole organisms. Physiology and systems biology thus share the goal of understanding the integrated functions of complex, multi-component biological systems. The key question is: how can we best study these systems? This review discusses the challenges and opportunities of systems biology as an emerging discipline that seeks to integrate the insights of molecular biology, genetics, and computational biology into a comprehensive understanding of living organisms. It also discusses the challenges and opportunities of systems biology as an emerging discipline that seeks to integrate the insights of molecular biology, genetics, and computational biology into a comprehensive understanding of living organisms. It also discusses the challenges and opportunities of systems biology as an emerging discipline that seeks to integrate the insights of molecular biology, genetics, and computational biology into a comprehensive understanding of living organisms.

6. SORUN

Perioperative events influence cancer recurrence risk after surgery

Abstract Surgery is a mainstay treatment for patients with solid tumors. However, despite optimal care, many patients relapse and succumb to disease. The biological mechanisms that determine the range of disease outcomes and the pharmacological effects of anticancer drugs, particularly with respect to genetic disease recurrence or the progression of metastatic disease, remain unclear. Perioperative events, such as anesthesiologic events, surgical stress, immunologic stress, and metabolic pathways, or failure to respond to surgery and/or anesthetic agents, may influence cancer progression. A consequence of this effect is that optimal cancer care might thus require modification and progression to metastatic disease. Here, we discuss the most promising approaches for the refinement of perioperative care that might address these challenges. We review the evidence and study evidence for the integration of anesthesiology, oncology, and the development of novel anesthetic agents, including adjuvant therapies. Many of these strategies are currently under evaluation in large clinical trials and hold promise for significantly reducing the risk of cancer recurrence. We will discuss the most promising approaches for the refinement of perioperative care that might address these challenges.

Key points

- Surgery remains the primary treatment for patients with solid tumors, yet perioperative locoregional recurrence and distant metastasis occur frequently and confer high risks of morbidity and mortality.
- Definitive effects of surgery include the isolation of local and/or systemic influences, to include cancer burden, levels, immunosuppression, and a proinflammatory state, and exposure to anesthetic agents; these processes overlap with cancer-promoting signaling pathways.
- Cancer cells that escape resection are subject to perioperative physiological changes and might disseminate and colonize distant organs, thus contributing to postoperative cancer recurrence.
- Perioperative use of adjuvant therapies, including anti-inflammatory drugs, immunosuppressants, and antiemetics, appears to be linked with improved survival outcomes in patients with cancer.
- Many of patients with cancer are treated with surgery, thereby offsetting the deleterious effects of surgery by use of affordable and readily available therapies that might rapidly improve the postoperative survival of patients with cancer.

Pathophysiological response to surgery
Perioperative cancer recurrence frequently takes the form of metastatic disease. In the traditional paradigm, the development of metastasis is seen as a late-occurring event in the stepwise, Darwinian-like evolution of cancer. According to this theory, metastasis occurs only when cells acquire a complementary set of somatic genetic changes that enable dissemination from the primary tumor, entry into the lymphatic or vascular network, survival in the circulation, and an ability to establish malignant growth at distant sites. The parallel progression model challenges this perspective, suggesting that both dissemination and colonization of distant sites can occur early in the development of a cancer. Early support for this model came from genetic analyses of samples from patients with breast cancer, in whom disseminated tumor cells (DTCs) isolated from bone mar-

7. SORUN: 'dünya düzdür, aşı reddi, aids reddi, iklim değişikliği reddi...' homeopati, iridoloji, scientology, eski astronot teorileri...

Science denial as a form of pseudoscience

Sven Ove Hansson
Department of Philosophy and History, Royal Institute of Technology (KTH), Stockholm SE-100 44 Stockholm, Sweden

Abstract
Science denial poses a serious threat to human health and the long-term sustainability of human civilization. Identification of the genes and the proteins that control the function of the immune system is a key to understanding the function of the immune system. The immune system is a complex system that is essential for the survival of the organism. The immune system is a complex system that is essential for the survival of the organism. The immune system is a complex system that is essential for the survival of the organism.

8. SORUN: ÇOK CİDDİ BİR SORUNDUR!

Workload and quality of life of surgeons. Results and implications of a large-scale survey by the German Society of Surgery

Thomas Bohrer · Michael Köller · Hans-Jürgen Schöttel · Harrold Blauer
on behalf of the German Society of Surgery

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Abstract
Background: Quality of life is of vital importance for patients undergoing surgery. However, little is known about the quality of life of surgeons who are facing a stressful and dynamically changing working environment. For this reason, this large-scale study investigated the quality of life (QL) of surgeons in Germany in the context of occupational, private, and system-related risk factors.

Author contributions This study was funded by the German Society of Surgery. The factor was involved in designing the study, provided manuscript for data collection, and was involved in preparing the manuscript. The factor was not involved in data analysis and did not have access to the study data that support the publication and the complete access to the study data that support the publication and the complete access to the study data that support the publication and the complete access to the study data that support the publication.

Seed Soil Hypothesis: Cancer as the "Seed"

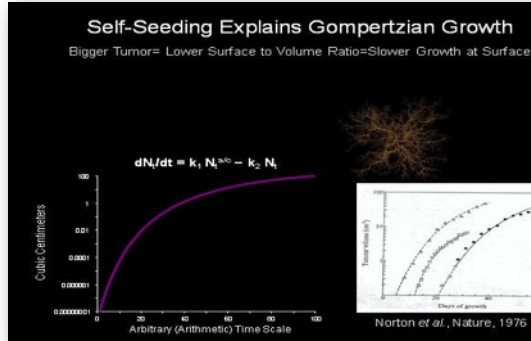
Hospitable Environment **Inhospitable Environment**

The Self-Seeding Model of Epithelial Cancer

PRIMARY TUMOR **METASTATIC SITE**

Norton, Massagué: Nature Med 2006

SELF-SEEDING EXPLAINS GOMPertzIAN GROWTH



'SELF-SEEDING' PHENOMENON

BIOLOGY TRUMPS ANATOMY
Prognosis = Consequence of Seeding

*small aggressive primary tumor → weak self-seeder, efficient distant seeder (poor prognosis)
*large indolent primary tumor → efficient self-seeder, weak distant seeder (good prognosis)

Caron E et al. JCO 20 4

Re-Define the Problem of Cancer
Find New Solutions

Finding new solutions to cancer

- Growth = Self Seeding
- Metastases = Distant Seeding
- Prognosis = Consequence of Seeding
- Therapy = Exploit Seeding
- Microenvironment = Critical for Seeding

• Therapy = Exploit Seeding
*Anti-mitotic treatments vs. anti-seeding therapies (metastasis)

• Microenvironment = Critical for Seeding
*Understanding and manipulating microenvironment

Palyasyon: uygulamada üç türü vardır

- Önceden R0 rezeksiyon yapılamayacağı bilinen, yani mikroskopik ve makroskopik tümör temizliğinin tam yapılamayacağı bilinen hastalarda **semptomları hafifletmek ve hastayı yaşam kalitesi yönünden rahatlatmak**
- Geride makroskopik (R2) veya mikroskopik (R1) tümör kalıntısı bırakarak **tümör rezeksiyonu**
- Birincil tedavinin yetersiz kaldığı durumlarda, **nüks veya büyüyerek devam eden kitlenin rezeksiyonu.**

27

UYGULAMA

- Palyasyon : Semptom giderme
- Destek : Multidisipliner tedavinin bir parçası olarak

28

UYGULAMA / Birincil etkenler

- Yaşam kalitesi
 - Semptom giderilmesi ve önlenmesi
- Girişimin morbiditesi : Hastanede kalış süresi, ağrı ve hareketsizlik
- Girişimi yapamamanın bedeli : kanama, ağrı
- Girişime bağlı morbidite ve mortalitenin beklenen sağkalımla kıyaslanması
- Girişim yapıldığı veya yapılmadığı durumda ölüm şekli
- Maliyet analizi
 - Girişimin direkt maliyeti
 - Komplikasyonların (girişimli veya girişimsiz) maliyeti
 - Bakım maliyetleri

29

UYGULAMA / İkincil etkenler

- Sağkalım
- Bakan kimselerin yaşam kalitesi (girişimli veya girişimsiz)

30

UYGULAMALAR

1. Effüzyonların drenajı
 1. Pleural
 2. Peritoneal
2. Tıkanma
 1. Safra
 2. GIS
 3. Vasküler
3. Ağrı kontrolü
4. Palyatif tümör rezeksiyonu
5. Diğer
 1. Cerrahi dışı ablasyon
 2. Embolizasyon

31

DESTEK GİRİŞİMLER

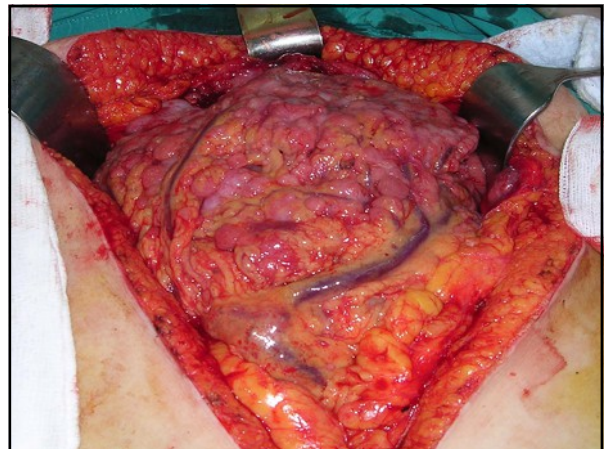
- Doku örnekleme
- Vasküler erişim
- Enteral erişim

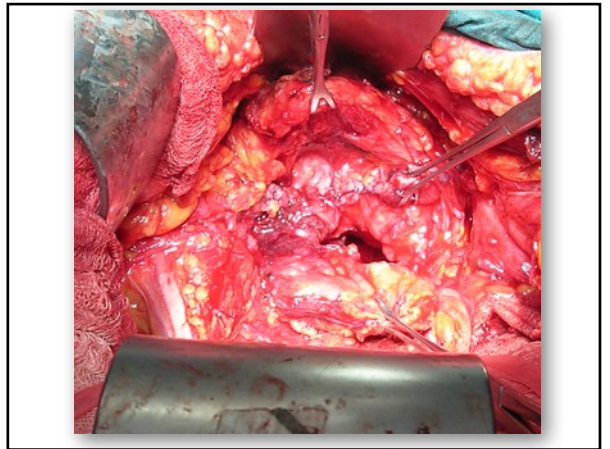
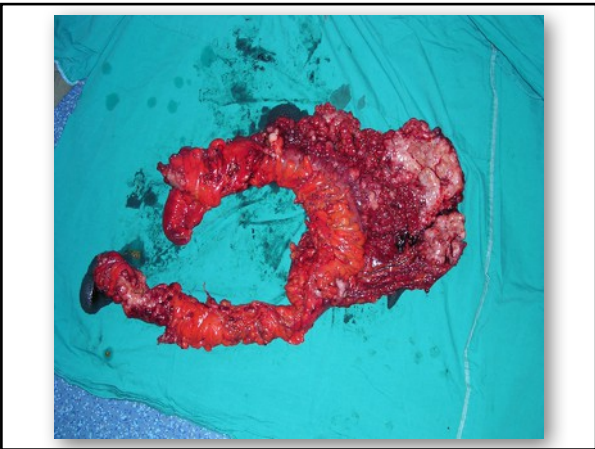
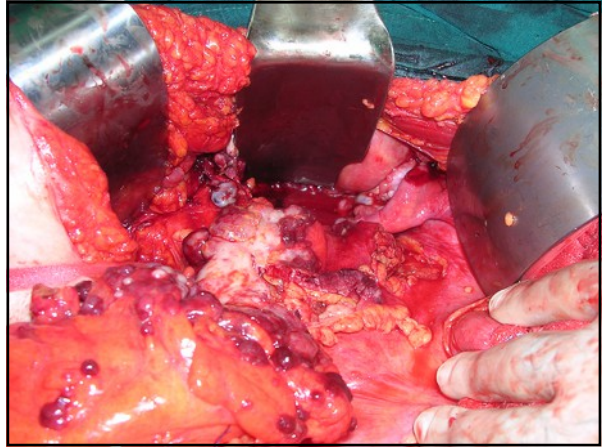
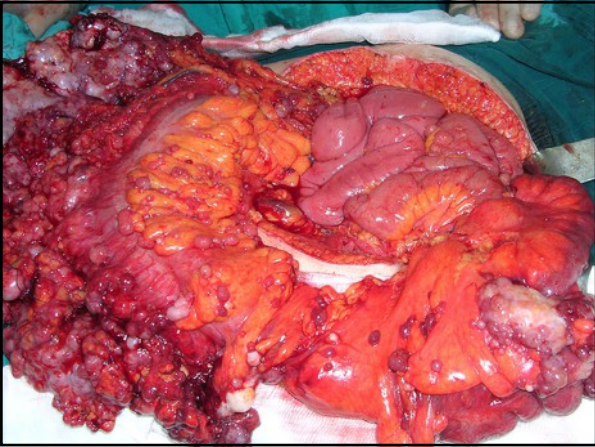
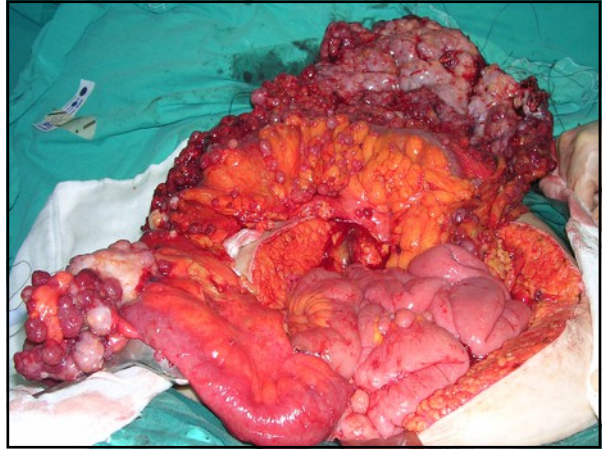
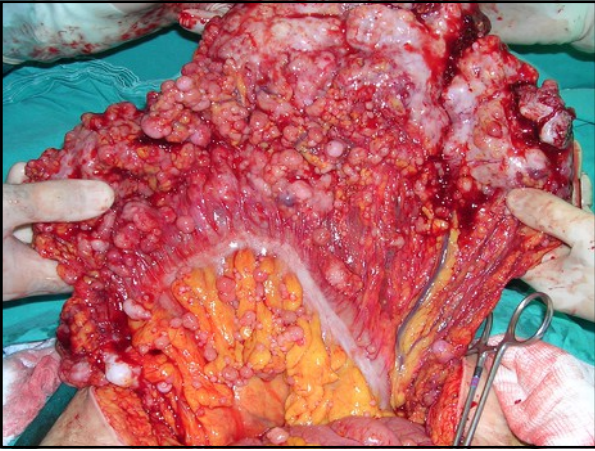
32

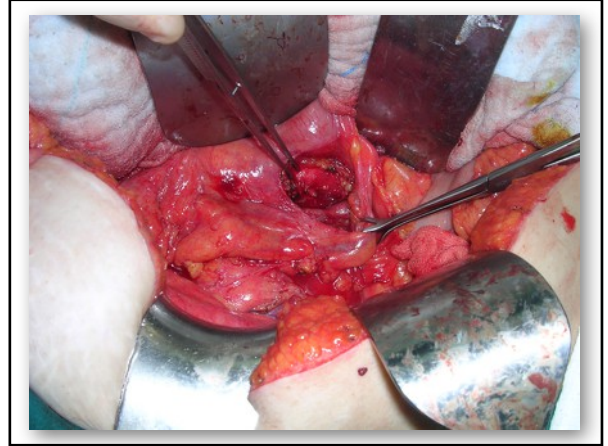
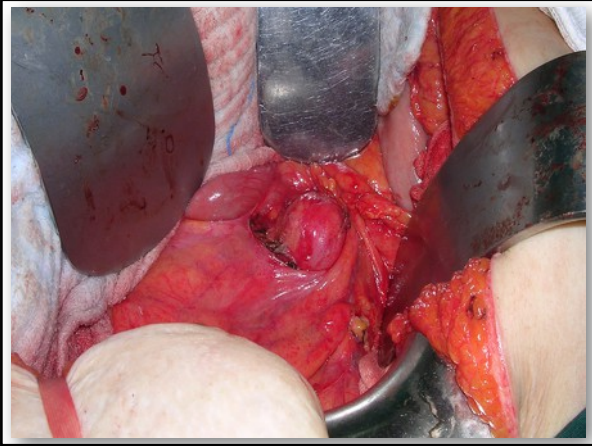
Sağkalımı Etkileyen Faktörler

- Optimum-Tam Rezeksiyon
- Tümör orijini
- Adjuvan kemoterapi
- Nodal tutulum
- Tümör grade
- Performans durumu
- “Compos mentis”: medikal faiki mümeyyiz
- Birkmeyer etkisi: kompleks kanser bakımında merkez deneyimi ve hasta hacmi

OLGU 1. 53Y LN +VE EKSTENSİF OVER CA PM; CC-O+A-I LNDX; 7SAAT







8th ESSO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
 Hamburg (DE), 15-17 February 2018

H.I.C. 68 yr old lady(DEUMF Emergency Unit #4352373)
 Generalized abdominal pain, discomfort, and distention, suspect tenderness and garguyman all over the quadrants
 No specific dz on her antecedant history, no co-morbidity, medically fit; No smoking; rutin lab tests were in N limits; **initial dx abdominal CT revealed disseminated PMs(Nov 21, 2016)**

8th ESSO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
 Hamburg (DE), 15-17 February 2018

PET-CT: large omental cake, numerous peritoneal and serosal deposits, no liver and/or extra-abdominal mets dz, minor ascites
PCI>>20
CA-125: 1287U/ml, the other Tm markers were N
Lap. cytopathologic and tissue bxs were obtained: serous papillary carcinoma

8th ESSO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
 Hamburg (DE), 15-17 February 2018

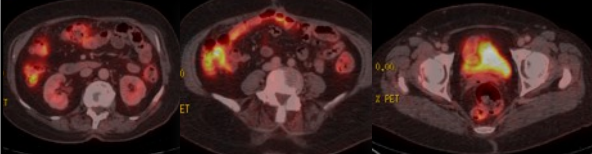
8th ESSO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
Hamburg (DE), 15-17 February 2018

A: Chemotherapy, then CRS+HIPEC
B: Chemo+ IPCT, then CRS+HIPEC
C: Chemo+ Conventional panhisterectomy+PPLND
D: Upfront CRS+HIPEC

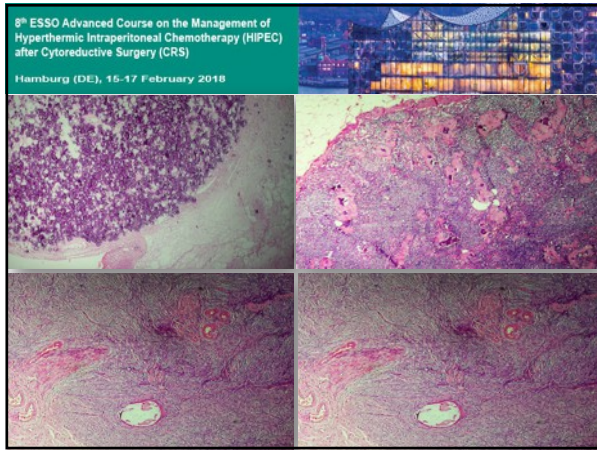
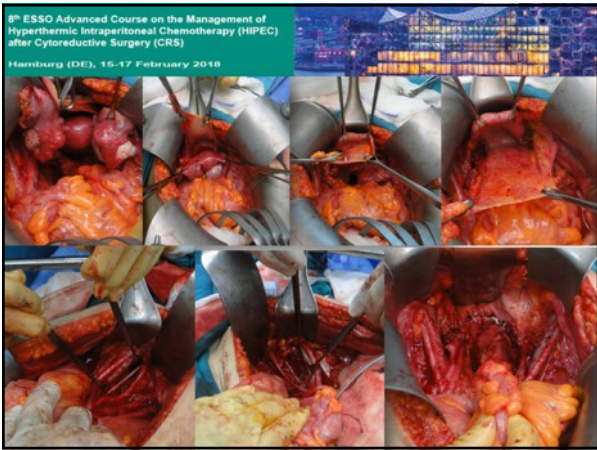
Participants have to vote after 3 minutes discussion within the group
5 minutes discussion in the audience, if necessary.

8th ESSO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
Hamburg (DE), 15-17 February 2018

MDT decision: neoadjuvant Chemo(3-4cycles) first, then reassessment&decision-making
Carboplatin (AUC 6)+ Paclitaxel 175mg/m²
Reassessment(May 17th, 2017) after 6 cycles of neoadjuvant sys. combination CT
Clinical&radiologic complete response; CA-125: 22U/ml



CRS+HIPEC performed(June 6th, 2017)
Total omentectomy, panhisterectomy, PPLNDx+Pelvic Peritonectomy+HIPEC



8th ESSO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
Hamburg (DE), 15-17 February 2018

A: Chemotherapy?
B: watch and see..?
C. Second-look?
D: MDT choice: W-W

Participants have to vote after 3 minutes discussion within the group
5 minutes discussion in the audience, if necessary.

8th ESSO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
Hamburg (DE), 15-17 February 2018

F-U Dec 6th, 2017



8th ESO Advanced Course on the Management of Hyperthermic Intraperitoneal Chemotherapy (HIPEC) after Cytoreductive Surgery (CRS)
Hamburg (DE), 15-17 February 2018

Follow-up

She is doing fine,
Postop. 8th mos
CA-125: 29.9U/ml
Diagnostic work-up for suspected bone mets...!
Possibly, second primary: breast Ca

SRC+HİPEK OLGU 2.

- S.Ö. 32 y Öğretmen(#4352373)
- Sağ alt kadranda ağrısı, şişkinlik, dolgunluk ile DEÜTF Acil Servisi'ne başvuruyor(08.10.2013)
- Klinik bakıda sağ AK'da hafif ağrı, müphem hassasiyet ve garguyman mevcut.
- Öyküsünde bir özellik yok. Yandaş hastalık ve kullandığı bir ilaç bulunmuyor.
- Rutin laboratuvar tetkikleri normal sınırlarda.
- Genel Cerrahi Acil Konsültanı Uzm. Dr. görüşü aynı gün servise yatırıyor.

SORU 1: Hangi radyolojik tetkiki istersiniz?

- A) Abdominopelvik USG
- B)T/A oral-İV kontrastlı BT
- C)PET-BT
- D)Abdominopelvik MR
- E)ADBG

ABDOMİNOPELVİK BT



Psoas'a komşu heterojenite

İleo-çekal valv düzeyi

Sağ Over kisti

10.8.2013

Sağ kolon komşuluğunda, mezenterik yağ doku planları hafif heterojen görünümde olup, sağ parakolik alan ve pelvik bölgede az miktarda serbest peritoneal sıvı izlenmektedir. Sağ alt kadranda mezenterik bölgede paraaortik ve parakaval alanda milimetrik lenf nodları dikkati çekmiştir.

Sağ alt kadrana yönelik yapılan USG'de appendiks vermiformis vizüalizasyon edilememiştir. Perçekal alanda en büyüğünün çapı 9 mm olan sferik şekilli birkaç adet hipoekoik lenf nodu izlenmiştir.

SORU 2: Hangi tanısal çalışmayı yaptırırım?

- A) Abdominopelvik faz sıralı MR
- B) PET-BT
- C)Kolonoskopi ve Bx
- D)Çift kontrastlı Kolon grafisi
- E)Abdominopelvik difüzyon MR

KOLONOSKOPI

- HASTA KENDİ İSTEĞİ İLE TABURCU OLUP ÖZEL BİR HASTANEDE K-OSKOPI YAPTIRIYOR...
- TAMAMEN NORMAL, İLEOÇEKAL'DEN GEÇİLİYOR, MUKOZA NORMAL, RANDOM BX'LER ALINIYOR: HEPSİ OLAĞAN
- ŞİKAYETLERİ ISRAR EDEN HASTA BİR BAŞKA ÜNİVERSİTE GE KLİNİĞİNE BAŞVURUYOR, TEKRAR KOLONOSKOPI-Bx YAPILIYOR: N...
- CERRAHİ KONSÜLTASYON SONRASI CROHN ÖN TANISIYLA TIBBİ TEDAVİ ÖNERİLİYOR

- Cerrahi görüşü Crohn tedavisi uygundur
- Tıbbi tdv başlıyor, şikayetleri ısrar ediyor
- Özel bir tanı merkezinde Abd. MR çektiriyor
- Radyolojik ön-tanı: lokal ileri, uzun segmenti tutmuş bir tümöral süreç lehine.
- Hasta aynı GE tekrar danışıyor, 3. kolonoskopi yapılıyor, çoğul biyopsiler alınıyor., negatif. Cerrahiden görüş soruluyor, tümör düşünülmedi, tıbbi tedaviye devam.

SORU 3: Hastaya ne önerirsiniz?

- A) Başka bir Prof. den kolonoskopi ve bx tekrarı
- B) PET-BT
- C) Eksplorasyon
- D) Stenozan Crohn için tıbbi tedaviye devam
- E) Laparoskopik enobservasyon

- Hastaya tıbbi tedavi devam ediliyor...
- Şubat 2014'de Akut Karın tablosu gelişiyor.
- Karşiyaka'da özel bir hastanede acil ameliyata alınıyor
- Rüptüre lokal ileri çekum kanseri saptanıyor. Lokal kirlenme var. Loko-rejiyonel peritoneal implantlar ve omental depozitler mevcut. Peritoneal metastaz kuşkusuyla frozen yollanıyor, karsinom(+ve).

SORU 4: Ameliyat planı ne olmalı?

- A) Sağ kolektomi+ileo-transversostomi
- B) A+ saptırıcı proksimal stoma
- C) A+omentektomi+ implant içeren peritonun tam rezeksiyonu
- D) Her açıdan sorunlu vaka, ilgili Üniversitenin cerrahi kliniğine sevk ederim
- E) C+Normotermik veya Hipertermik İntraperitoneal Kemoterapi

- Hastaya sadece sağ kolektomi+ileo-transversostomi yapılıyor, sorunsuz iyileşiyor(Mart 2014)
- pT4N+(15/3 LN+) perfore adenokarsinom; gönderilen periton örneği de karsinom mets.
- sKT öneriliyor, 3 seans alıyor, Tıbbi Onkoloji ara değerlendirme olarak PET-BT istiyor.
- Tümör yatağında, anastomoz çevresinde ve peritonda değişik çapta nodüler yapılar: Peritoneal karsinomatoz ile uyumludur

SORU 5: Nasıl bir tedavi önerilmeli?

- A)Sistemik KT'ye devam
- B) İkinci sıra KT'ye geçilmeli
- C) Tüm tümöral odakların tam rezeksiyonu ("Komplet sitoredüksiyon")
- D) C+HİPEK
- E) C+HİPEK+SKT

- Hastaya aynı özel hastanede aynı cerrahi ekip tarafından "Sitoredüktif Cerrahi ve sadece Sisplatin ile HİPEK" yapılıyor (Haziran 2014).
- Sorunsuz iyileşiyor, tüm örneklerde tümör var, sKT öneriliyor.
- 1.5 ay sonra Tıbbi Onkolog tedaviye başlamadan önce tekrar PET-BT çekiliyor.
- Sağ alt kadranda SUV değeri anlamlı yüksek FDG tutulumu mevcut, tümör yatağında retroperitoneal lokal nüks ile uyumludur. Başka kuşku odak yok.

SORU 6: Şimdi nasıl bir tedavi önerilmeli?

- A) Sistemik KT öneririm
- B) Önce XRT, sonra KT öneririm
- C) Tekrar cerrahi(SRC+HİPEK) öneririm
- D) İzlerim
- E) Alternatif tedavi uygulayan Tıbbi Onkolog öneririm

- Hastaya KT öneriliyor
- Hasta ve eşi tükeniyorlar, KT'yi reddediyorlar, hekimlerine gitmiyorlar...
- Alternatif tedavi yöntemleri kullanmaya başlıyor...
- Temmuz 2014'de sağ alt kadranda bele yayılan karın ağrıları artıyor, bulantı-iştahsızlık-halsizlik-düşkünlük başlıyor
- Hastaya bu sefer abdominal BT ve sonra MR çekiliyor sağda psoas ve iliakus kası içine infiltran, ince bağırsak mezenterinde kirlenme oluşturan, karın duvarına invaziv lokal nüks ile uyumlu tümöral kitle saptanıyor

- Sistemik KT açısından danışmak üzere birçok Tıbbi Onkoloğa gidiyor...
- Hastaya SRC ve HİPEK öneriliyor.
- Hasta Eylül 2014 ayında başvurduğunda; Sağ bacak köküne ve beline yayılan ağrı, karında şişkinlik, zaman zaman bulantı ve öğürme, karın duvarında palpabl, hassas dolgunluk-kitle mevcuttu.
- Sağ bacağı germeden sakınarak yürüyordu

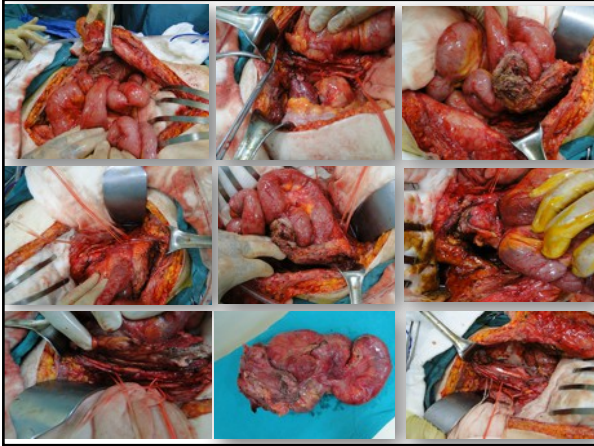
Hastanın durumu kötüleşti ve ayrı yaşamaya başlıyorlar...

SORU 7: NE YAPILMALI?

- A) RE-SİTOREDÜKSİYON+HİPEK
- B) EN İYİ SİSTEMİK KT
- C) RE-SİTOREDÜKSİYON+HİPEK+SKT

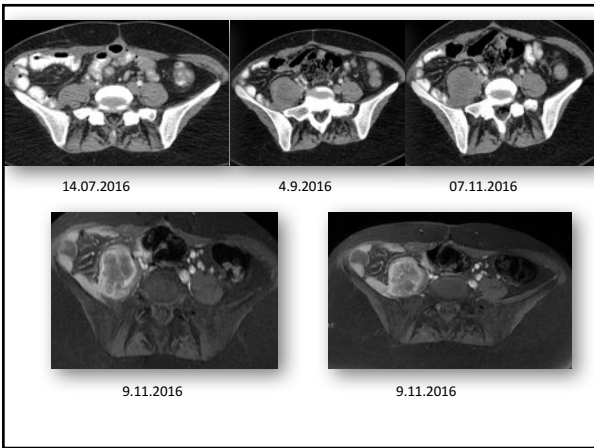


01.11.2014 3. Reoperasyon

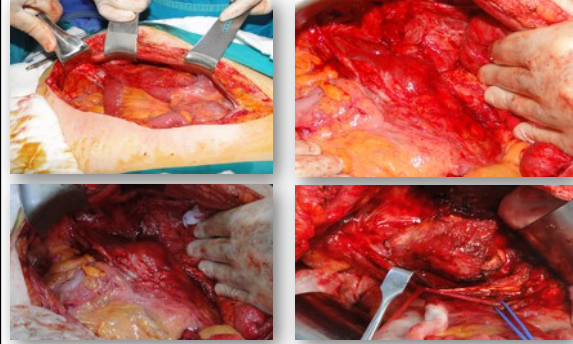


- SORUNSUZ , KOMPLİKASYON GELİŞMEDİ
- SKT ALIYOR
- FİZİK TEDAVİ GÖRDÜ, YÜRÜME DAHA İYİ
- MART 2015 BAŞI PET-BT NORMAL

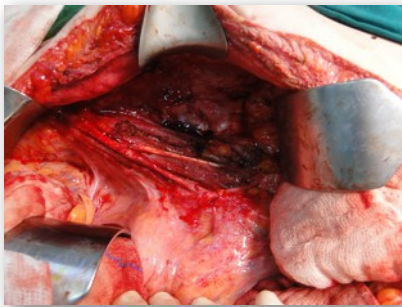
Morali çok iyi, kontrol zamanlarında endişeli-huzursuz, eşinden boşanmış...



...18 AY SONRA SKT ALTINDA TM YATAĞI NÜKSÜ
5 ARALIK 2016 RE-SRC+HİPEK



SKT VERİLİYOR...SON KONTROL NORMAL
45. AYDA YAŞIYOR

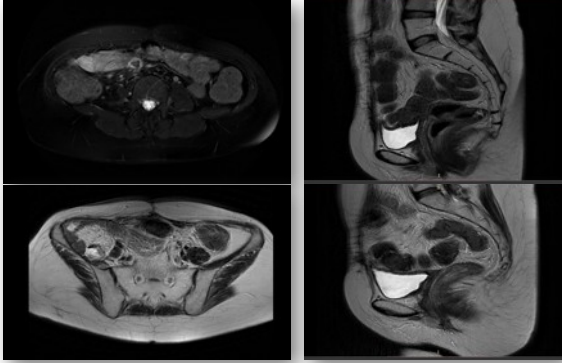


05.12.2016 4. Reoperasyon

İzlemde Postmenapozal kanama...

- Bx: Endometrium Ca(İyi-Orta Differansiye)
- 13.06.2018 Standart TAH+BSO
- Eski cerrahi/tm yatağında lokorejyonel nüks/
peritoneal mets yok
- Endometrium; berrak hücreli adenokarsinom+
musinöz adenokarsinom, reaktif lenf nodülleri
(Pato No: 25490-18 EÜTF)
- CEA<1.8, CA 125: 5; CA 19-9: 9.98 (17.01.2019)

12.10.2018 ve 14.08.2019 izlem A/P MRG
F/U Reküran/Metastatik hastalık yok>6.yıl



Teşekkür ederim

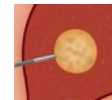


RADYOFREKANS ABLASYON TEDAVİSİ TEKNİK

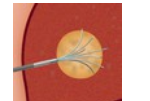
- Perkütan USG eşliğinde
- İntraoperatif açık cerrahi veya laparoskopik
- İntraoperatif USG yapılabilir
- Hedef kitle yok edilerek çevresindeki 5 cm'lik halka da tahrip edilir.
- Tek ablasyon (8-20 dk) 2-5 cm küresel zararlanma

81

RF Ablasyon İşlemi



katater



Probe açılır

RF uygulanır
(~12-25 dak)

- Plak hasta sırtı veya uyluk arkasında
- Lokal anestezi ve/veya sedasyon

82

RF Lezyonu patolojisi



Lezyon bölgesi

Hiperemik bölge
(perfüzyon artışı)

83

RF SONRASI RE-REZEKSİYON?

- Yapılabilir
- Özellikle karaciğere KRK metastazı sonrası KT arasında
- Örnek hasta
 - 1 yıl önce KRK operasyonu
 - 8 ay sonra RF ablasyon
 - Ardından KT (sistemik ve lokal)
 - 14. ayda rezeksiyon

84

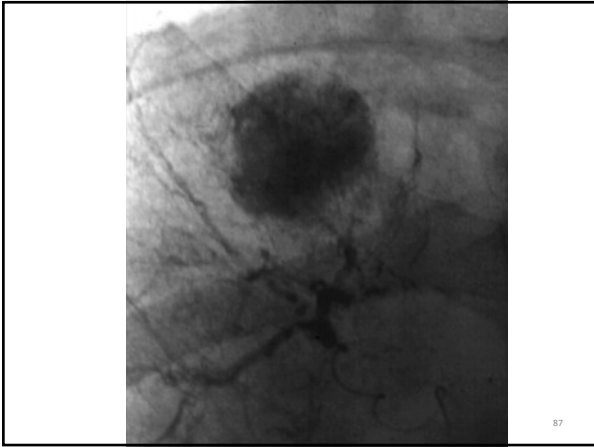


85

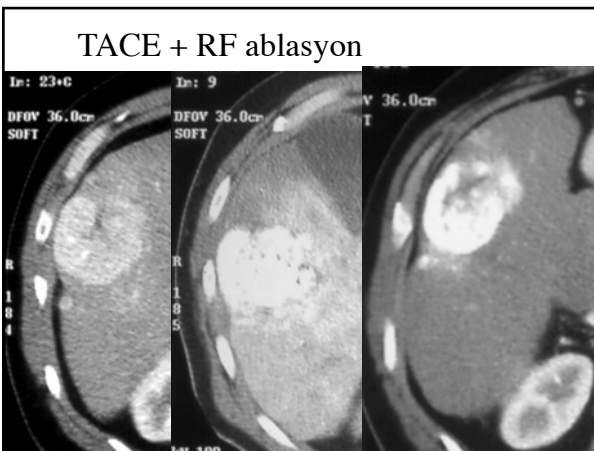
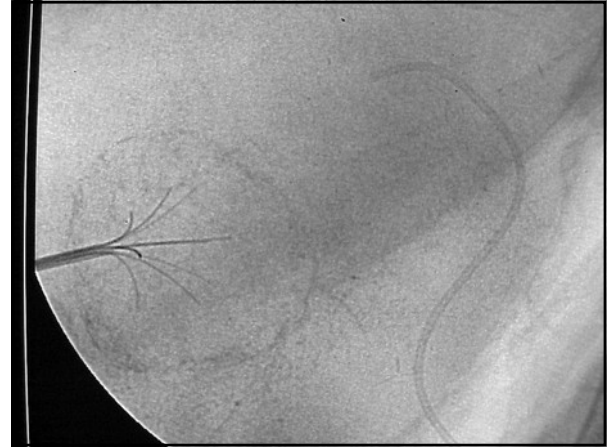
Başka yöntemlerle kombine edilebilir mi?

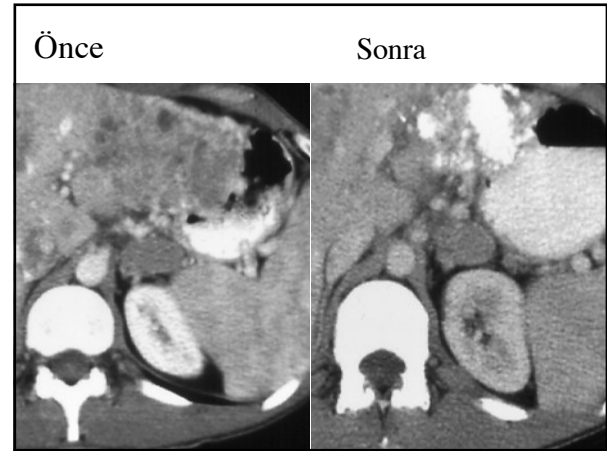
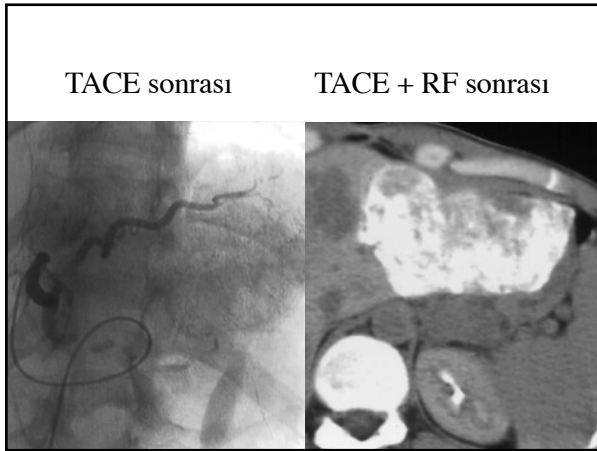
- Başta cerrahi olmak üzere edilebilir.
- Alternatif yöntemler arasında en çok TACE güncel

86



87





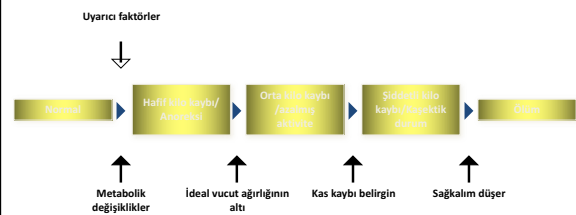
Kilo kaybının nedenleri

- Mekanik tıkanıklık
- Tedavi yan etkileri
- Psikolojik etkiler
- Metabolik değişimler (kanserin induklediği kilo kaybı)

Rivadeneira et al. 1998. CA Cancer J Clin. 48:69

93

Kansere bağlı kilo kaybının ilerlemesi



94

Mevcut seçenekler

- Nutrisyon desteği ve danışma
- Oral ürünler
- Tüple beslenme
- TPN
- Farmakolojik ajanlar

95

Olgu 1: GG

- 41 yaşında erkek
- Dış Merkezde tanı kondu
- TAOnc Hast' e KT için sevk
- Patoloji : NET (Neuroendokrin Tm)
- Fizik Bakı : Belirgin İkter, depresif mood, iştahsızlık
- Psikiyatri : Depresif mood nedeniyle antidepresan ve görüşmeler
- Med Onk : Somatostatin LAR
- G.Cerrahi : Palyatif Cerrahi denenebilir
- Algoloji : Künt ağrı / kapsül gerilme ? Öneri : Contramal ve NSAID

96

Olgu 1: GG

- Palyatif girişim için yapılan konsültasyonlar sonrası karar
 - Cerrahi girişim
 - İkterin çözümlenmesi ile KT sistemik eklenebilir
 - Doku kanıtı elde edilebilir
 - Buna bağlı iştah ve depresif mood düzelebilir

97

Olgu 1: GG

- G.Cerrahi AD' a sevk
- Tanısal laparoskopi planlandı
- Laparoskopide peritoneal karsinomatozis ve bilober yaygın karaciğer metastazı saptandı
- Biyopsi alındı



98

Olgu 1: GG

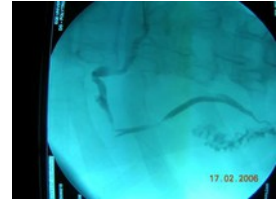
- Serbest sıvıdan sitolojik ve biyokimyasal örnek alındı.
- Gastrointestinal sistem pasajı kontrol edildi.



99

Olgu 1: GG

- Postop dönemde
- Girişimsel Radyoloji
- Safra kanalı geçişi zor
- Eksternal ve internal stent planlandı.



100

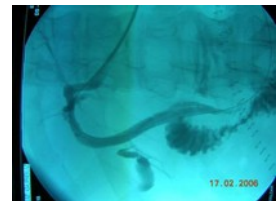
- Önce eksternal stent konup dernaaj sağlandı, Pr Z ve INR düzeldi, K vit ve Mannitol infüze edildi
- T. Bilirubin başlangıç değeri 18mg/dl' den 4 mg/dl altına düştü.



101

Olgu 1: GG

- İnternal stent yerleştirildi.
- İştah ve mood düzeldi.
- Analjezik gereksinimi azaldı
- Fizik etkinlik arttı
- Ayaktan Sistemik KT için taburcu edilip izleme alındı



102

SORUNLAR

1. Sarılık
2. Kardiyopulmoner sorunlar
3. Renal sorunlar
4. Nutrisyonel sorunlar
5. Koagulasyon sorunları
6. Pruritis
7. Kolanjit
8. Antibiyotik
9. Preoperatif drenaj
10. Glukoz metabolizması

103

Olgu 2 : ME

- 62 yaşında erkek hasta
- 26 ay önce Pankreas başı ca nedeniyle Whipple operasyonu
- Patoloji Adenoca T3N1M0
- Adjuvan konkomitant kemoradyoterapi

104

Olgu 2: ME

- Kemoradyoterapi sonrası ağrı
- Sistemik NSAID ve Contramal amp
- Postoperatif 20. ay şiddetli üst GIS kanaması nedeniyle endoskopi
- Eroziyonlar
- NSAID kesildi transdermal fentanil eklendi
- Solunum fizyoterapisi ve göğüs hast kons ile ateletazi ve sıvıya bağlı solunum sorunları giderildi.
- 2 ay sonra kitle ve peritoneal karsinomatozis nedeniyle genel durum bozukluğu

105

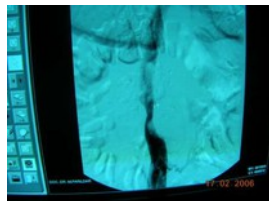
Olgu 2: ME

- Postoperatif 28. ayda şiddetli ağrıya bel altı ödem eklendi.
- Algoloji: TDP infüzyonu sonrası epidural katater
- G.Cerrahiye yatırıldı

106

Olgu 2: ME

- Cavogramda kitle basısı nedeniyle kesinti saptandı



107

Olgu 2: ME

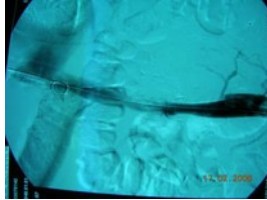
- Önce balon dilatasyon yapıldı



108

Olgu 2: ME

- Kalıcı stent ve antikoagulan verildi.
- Ödem kayboldu
- Beslenme desteğine alındı
- 35 kcal /gün PEN+ EN ile serum albumin 1,9 mg/dl' den 3,4 mg/dl' e yükseldi
- Ayaktan Palyatif kemoterapi için hazır durumda



109

OLGU 3 : DG

- Daha önce DSY'dan köken alan tm nedeniyle peritoneal karsinomatozis tanısı dış merkezde konup refere edildi
- Konsey KT kararı verdi
- Şiddetli ascites nedeniyle solunum sıkıntısı ve gerilme ağrısı
- Algoloji ve FTR konsültasyonları ile ascites giderilmesi gerekliliği
- G.Cerrahi konsültasyonu

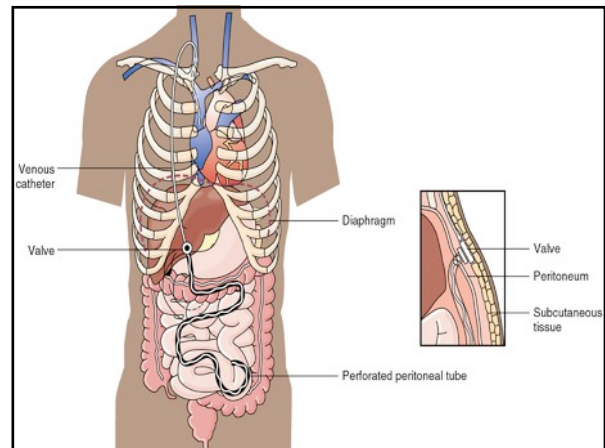
110

Olgu 3: DG

- Önce medikal yaklaşım
 - TDP ve koloid sonrası diüretik + sistemik diüretik, elektrolit replasmanı
 - Peritoneal tab 4 lt/gün
- Sonuçsuz
- Denver shunt planlandı
- Shunt sonrası 14 kg eksildi ve mobilize, fizik aktif, ağrısı yok, sistemik KT için ayaktan izleniyor.



111



113

4. CERRAH İNİSİYATİFİ

İLERİ EVRE HASTALIKTA

- Klasik öğretisi
 - İlk seçim kemoterapi olmalıdır
 - Radyoterapi sadece seçilmiş hastalarda kullanılmalıdır
 - Şifa ya da uzun süreli sağkalım olanaksızdır.

115

İLERİ EVRE HASTALIK

- Cerrahiye karşı çıkma gerekçesi
 - Sağkalım metastatik yük tarafından belirlenir
 - Genel durumu bozuk hasta cerrahi girişimi tolere edemez.
 - Risk / yarar oranı risk tarafına doğru ağırlıklıdır.
 - Teorik olarak tümörün hızlanması riski vardır (angering the tm letting the air in)
 - VEGF ve benzeri anjiyogenetik ajanların anestezi, cerrahi stres ve kan transfüzyonu gibi nedenlerle bozulması.

116

İLERİ EVRE HASTALIK

- Cerrahi girişimi destekleme gerekçesi
 - Yaşam kalitesi artışı ve semptom kontrolü
 - Debulking kemoterapinin şansını artırır
 - Metastatik kaskadı değiştirir
 - Birincil tümör ortadan kalkar
 - Metastazlar azalır
 - Tümöre lokal immün yanıtı baskılayan inhibitör peptid ve moleküller ortadan kalkar
 - Kalan tümör hücrelerinin anti tümör immünitesi kuvvetlenir

117

CERRAHİ VE METASTATİK HASTALIK

- Hedefler erken dönemde belirlenmelidir.
- Hedefler
 - Palyasyon ve semptomlar / QOL
 - İlerlemesiz sapkalımı uzatmak
 - Küratif intent

118

CERRAHİ VE METASTATİK HASTALIK

- Kanser ikinci en sık ölüm nedeni
 - 1/3 tanı konur, 1/3 ölür
- Yaşamın sona ermesi genel sağlık harcamalarının %12'sini, sağlık sigortası harcamalarının %27'sini oluşturur
- Cerrahi girişimlerin %12.5'u palyatif nedenlerle yapılır
 - Krouse, Arch of Surgery 2001

119

CERRAHİ VE METASTATİK HASTALIK

- 348 yayın taranarak
 - M&M odaklı bakılınca
 - %12 ağırı faydası
 - %2 maliyet
 - %17'si yaşam kalitesini incelemiş.
- Gereken nedir?
 - Palyatif girişim daha iyi ve net tanımlanmalıdır
 - Daha anlamlı sonuçlar ve standartlarla daha mantıklı ve doğru çıkarımlar yapılabilir.
 - Miner et al Am J Surg 1999

120

The Surgical Treatment of Cancer: A Comparison of Resource Utilization following Procedures Performed with Curative and Palliative Intent

Cullinane CA Cancer 2003

302 hasta; 58 palyatif 244 küratif girişim

SONUÇ

HARCANAN KAYNAKLAR AYNI
NİTELİĞİ FARKLI
Poliklinik ya da yatarak

HARCANAN KAYNAK

- Palyatif Merkezler mi?
- Geleneksel Klinikler mi?
 - %26 maliyet azalması
 - Sağlıkım aynı

Lewin SN Gyn Oncol 2005

122

Palliative Surgery

| Grade | ECOG/WHO | Major Surgery |
|-------|--|---------------|
| 0 | Fully active, able to carry on all pre-disease performance without restriction | |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work | Yes |
| 2 | Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours | |
| 3 | Capable of only limited self-care, confined to bed or chair more than 50% of waking hours | Maybe |
| 4 | Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair – "Ah he's only mostly dead and mostly dead is partly alive." – Princess Bride. | No |
| 5 | Dead – "The difference between alive and dead is dead can't fog the mirror." – Nathan W. Pearlman, MD | |

A Prospective, Symptom Related, Outcomes Analysis of 1022 Palliative Procedures for advanced Cancer

Miner Ann Surg 2004

SONUÇLAR

- %70 OPERATİF %30 ENDOSKOPİK
- MORTALİTE
 - % 9 VE % 15 (P=0.017)
- MORBİDİTE
 - %39 ve % 18 (p<0,001)
- GENEL
 - %80 BAŞARILI % 20 KAYIP
 - KOMPLİKASYONLU VE KOMPLİKASYONSUZ OLGULAR
 - %67 ve % 89 p<0,001

125

TABLE 8. Clinical and Pathologic Factors Associated With Diminished Overall Survival in Patients Undergoing Initial Palliative Procedure

| Variable | N | Univariate | Multivariate | |
|--------------------------------|-----|------------|-------------------|-----------|
| | | P value | Hazard Ratio (CI) | P value |
| All patients | 823 | | | |
| ECOG ≥ 2 | 264 | <0.001 | 2.2 (1.6-3.0) | <0.001 |
| Albumin < 3.5 | 225 | <0.001 | 1.8 (1.4-2.6) | <0.001 |
| NCI Organ score ≥ 1 | 464 | <0.001 | 1.7 (1.3-2.3) | <0.001 |
| No prior cancer therapy | 113 | 0.004 | 1.4 (1.1-2.3) | 0.006 |
| History of recent weight loss | 263 | <0.001 | 1.5 (1.2-2.0) | 0.020 |
| Hemoglobin < 10.5 | 207 | <0.001 | 1.2 (0.9-1.5) | 0.23 (NS) |
| Age > 65 | 266 | 0.18 (NS) | — | — |
| Type of presenting symptom | 823 | 0.22 (NS) | — | — |
| Type of malignancy | 823 | 0.39 (NS) | — | — |
| Endoscopically based operation | 246 | 0.41 (NS) | — | — |
| Female gender | 461 | 0.99 (NS) | — | — |

Miner Ann Surg 2004

9 neoadjuvan sonrası rezeksiyon PANKREAS CA

- Ortalama sağkalım 10 ay
- En uzun 19 ay
- En kısa 6 ay

127

Stage IV Cancers and Metastectomy

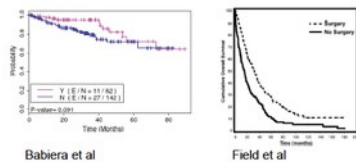
| Author | Year | N | Site/disease | Predictors of survival |
|-------------|------|------|------------------|--|
| Pawlik | 2007 | 52 | Liver/SCCA | Complete resection, longer DFI, Size<5cm, |
| Musunuru | 2006 | 48 | Liver/Neuroendo | Complete resection |
| Pawlik | 2006 | 66 | Liver/Sarcoma | Resection vs RFA, Met<3cm |
| Gutman | 2001 | 251 | Abd/Melanoma | Complete resection, DFI > 36 mos, |
| Chamberlain | 2000 | 65 | Liver/Neuroendo | Complete resection, earlier resection of the primary |
| Bilingsley | 1999 | 719 | Lung/Sarcoma | Complete resection, DFS>12mos |
| Fong | 1999 | 1001 | Liver/colorectal | Complete resection, DFI>12mos, Liver only, Tumor number, node (-) 1 ^o , Met< 5cm, CEA<200 |

KC METASTAZI VE PANKREAS CA

- 22 HASTA
 - %86 tek metastaz, %14 düşük volum
- Sağkalımlar
 - Metastazsız Whipple 14.2 ay
 - Palyatif by pass 5,6 ay
 - Whipple + kc rezeksiyonu 5,9 ay
 - PAWLİK, CANCER 2007

129

| Author | Year | N (resected) | Disease | Conclusions |
|-----------|------|--------------|---------|--|
| Saidi | 2006 | 105(24) | Gastric | Improves OS (13.2 vs. 5.5 mos) |
| Field | 2007 | 409 (187) | Breast | Improves OS(31.9 vs 15.4 mos), not metastatic PFS |
| Babiera | 2006 | 224(87) | Breast | Improves metastatic PFS (p=0.001) and trend toward OS (p=.1) |
| Blanchard | 2008 | 395(242) | Breast | Improves OS (27.1 vs 16.8 mos) |



METASTATİK HASTALIK İÇİN CERRAHİ

- PRAGMATİK YAKLAŞIM
- AKADEMİK YAKLAŞIM

132

PRAGMATİK YAKLAŞIM

- Hasta sigortalı mı?
- Medikal onkolog arkadaşım mı ya da olsun istiyor muyum? (hasta referansı)
- Sürmekte olan bir çalışma için hastaya ihtiyacım mı var?
- M&M için yardıma ihtiyacım mı var?
- Hasta yarar görecektir mi? (en son)

133

AKADEMİK YAKLAŞIM

- YÜRÜMEKTE OLAN BİR ÇALIŞMA MI VAR?
- HASTANIN PERFORMANS DURUMU NEDİR?
- KONTRENDİKASYON VE KO MORBİDİTE VAR MI?
- TÜMÖR BİYOLOJİSİNİ YETERİNCE BİLİYOR MUYUM?
- HASTA YARARI NEDİR?

134