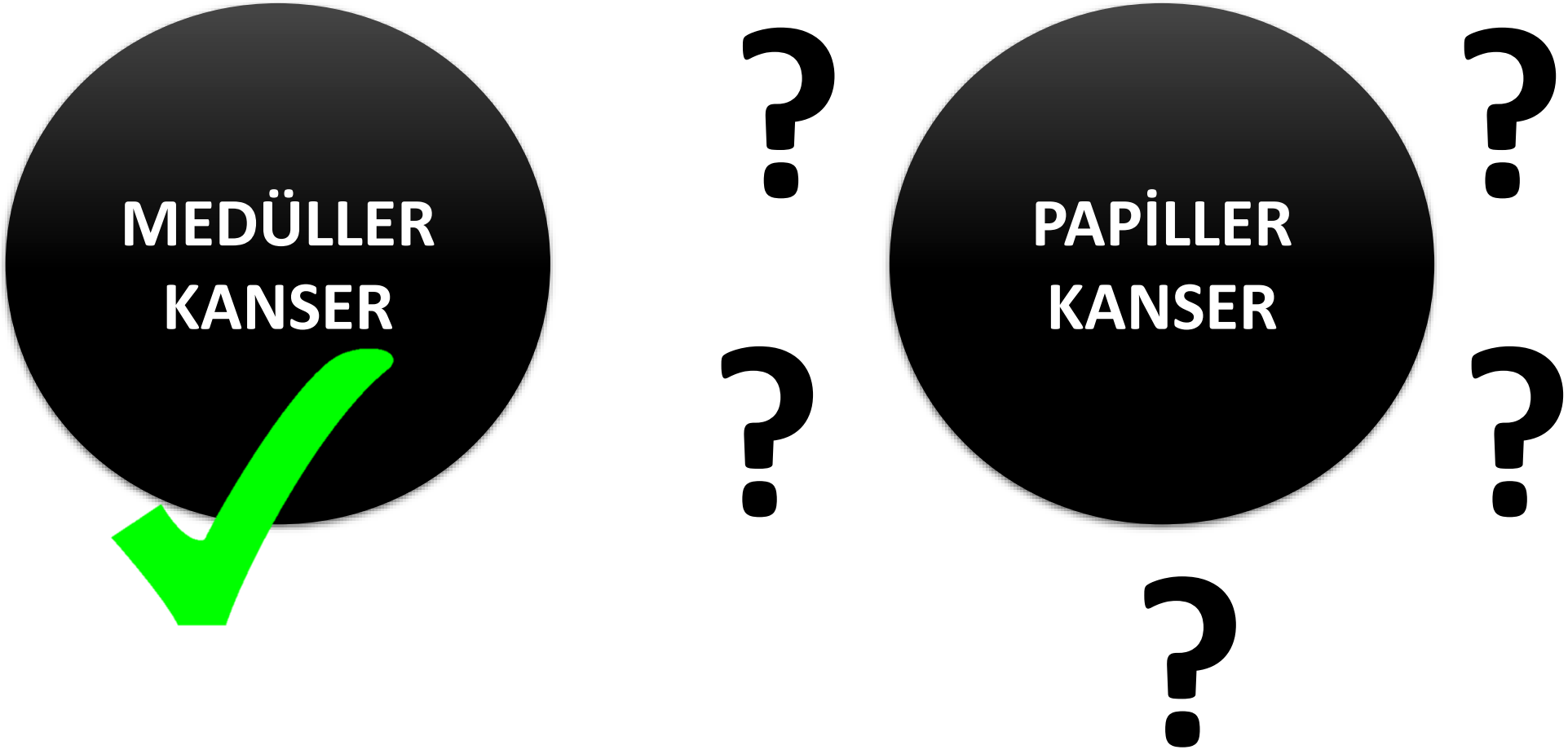
Boyun diseksiyonu - Kime, ne kadar?
- Santral boyun diseksiyonu

Prof. Dr. Yeşim Erbil

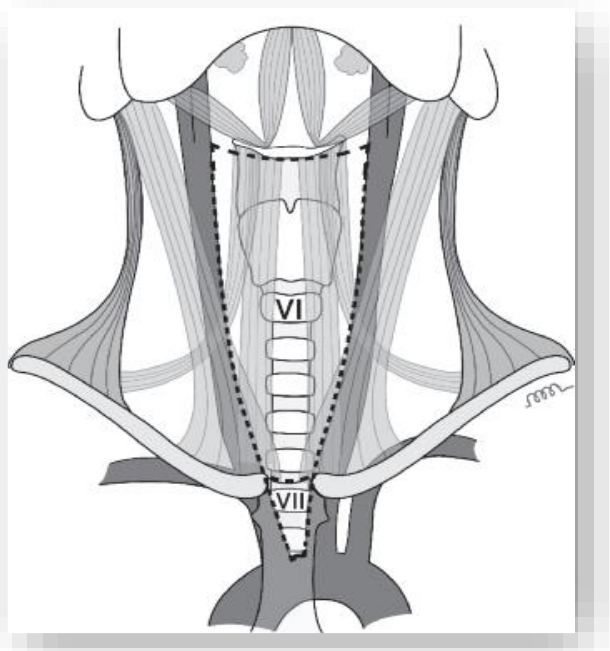
Boyun diseksiyonu - Kime, ne kadar?
- Santral boyun diseksiyonu

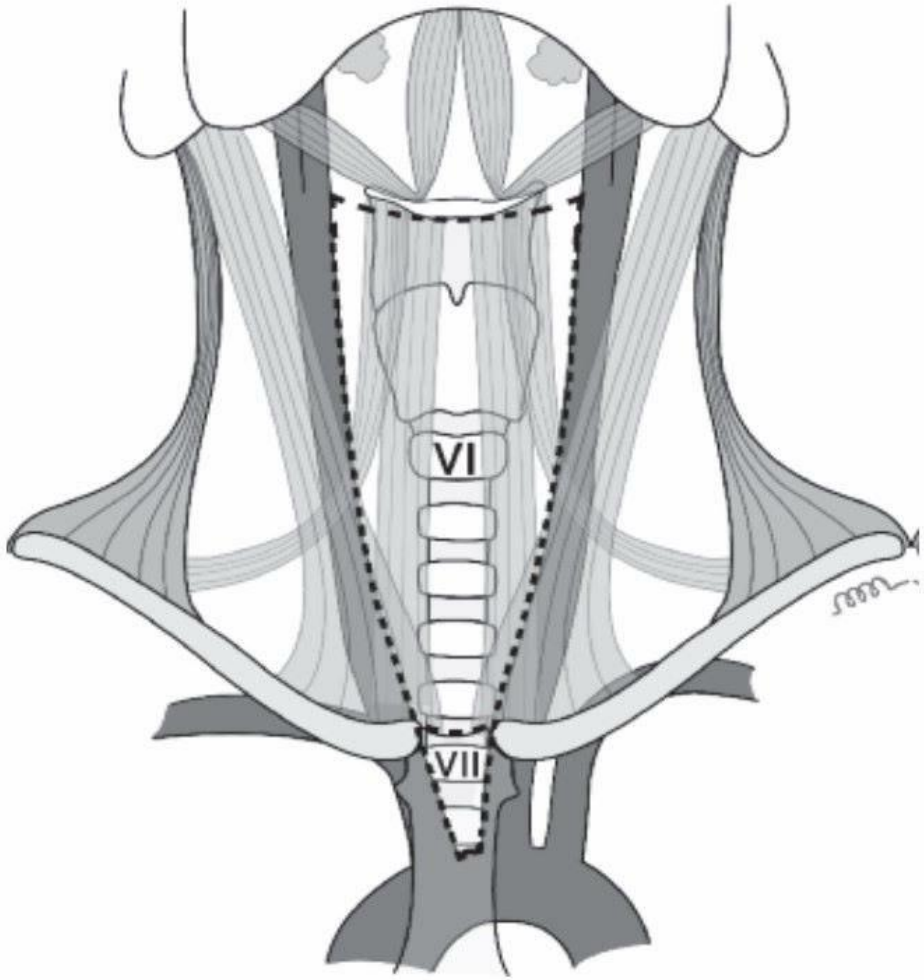


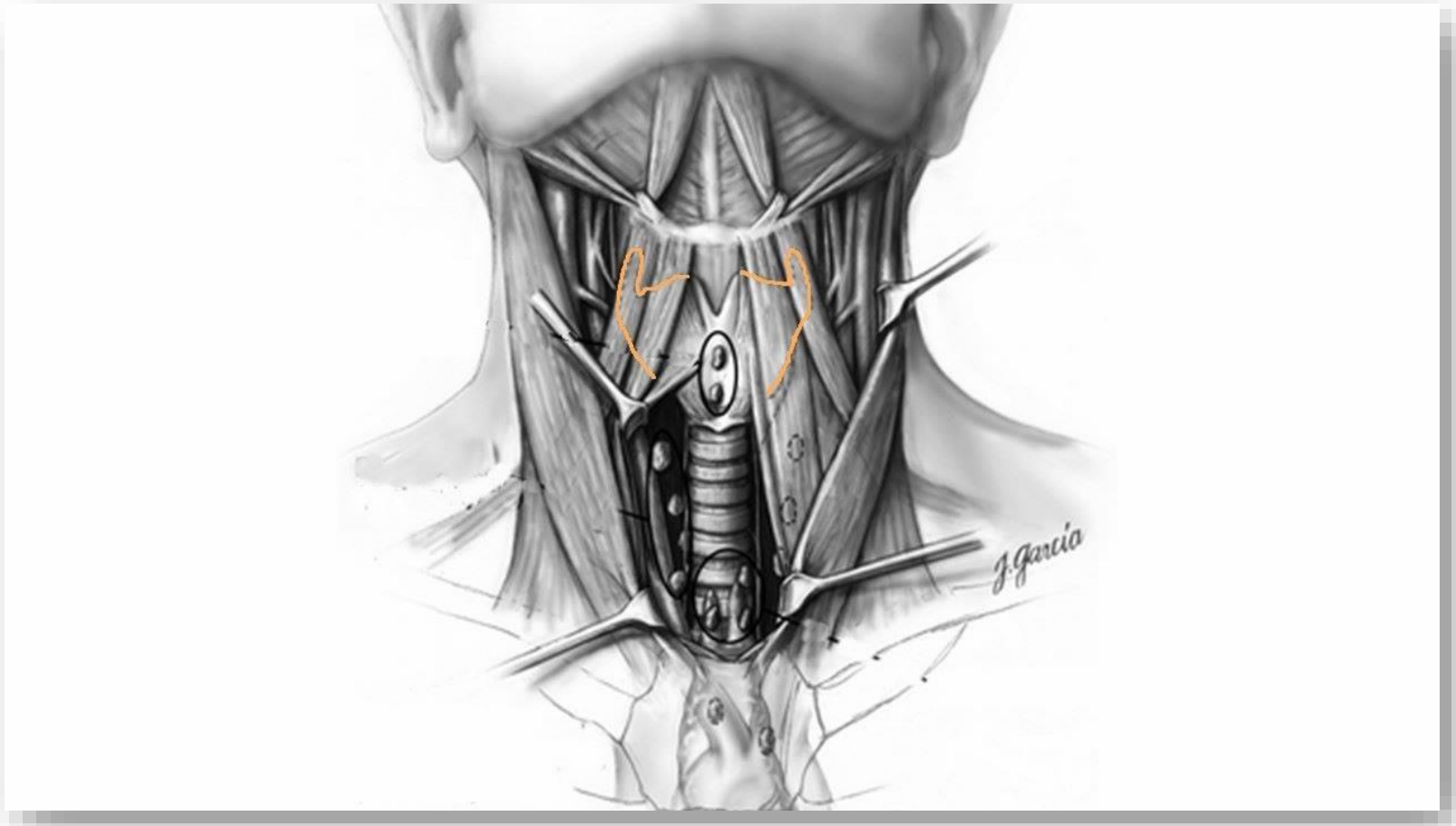
Diferansiye tiroid kanserleri

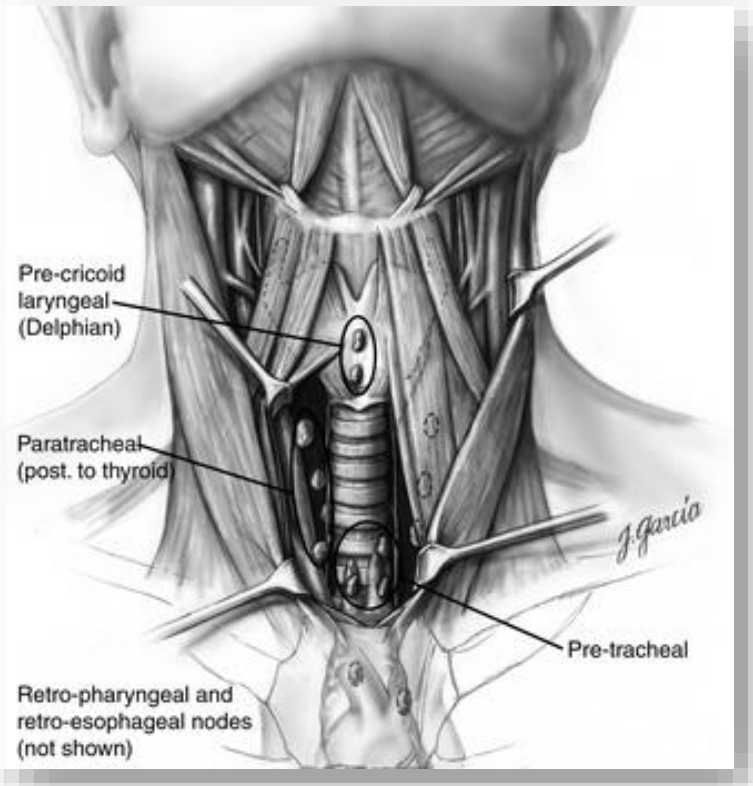
- ✓DTK lerinde 10 yıllık sağkalım %90 ın üzerindedir
- ✓Lenf metastaz oranı %20-50
- ✓Lokal nüks oranı %15

Metastazlar en sık 6. ve 7. kompartmana



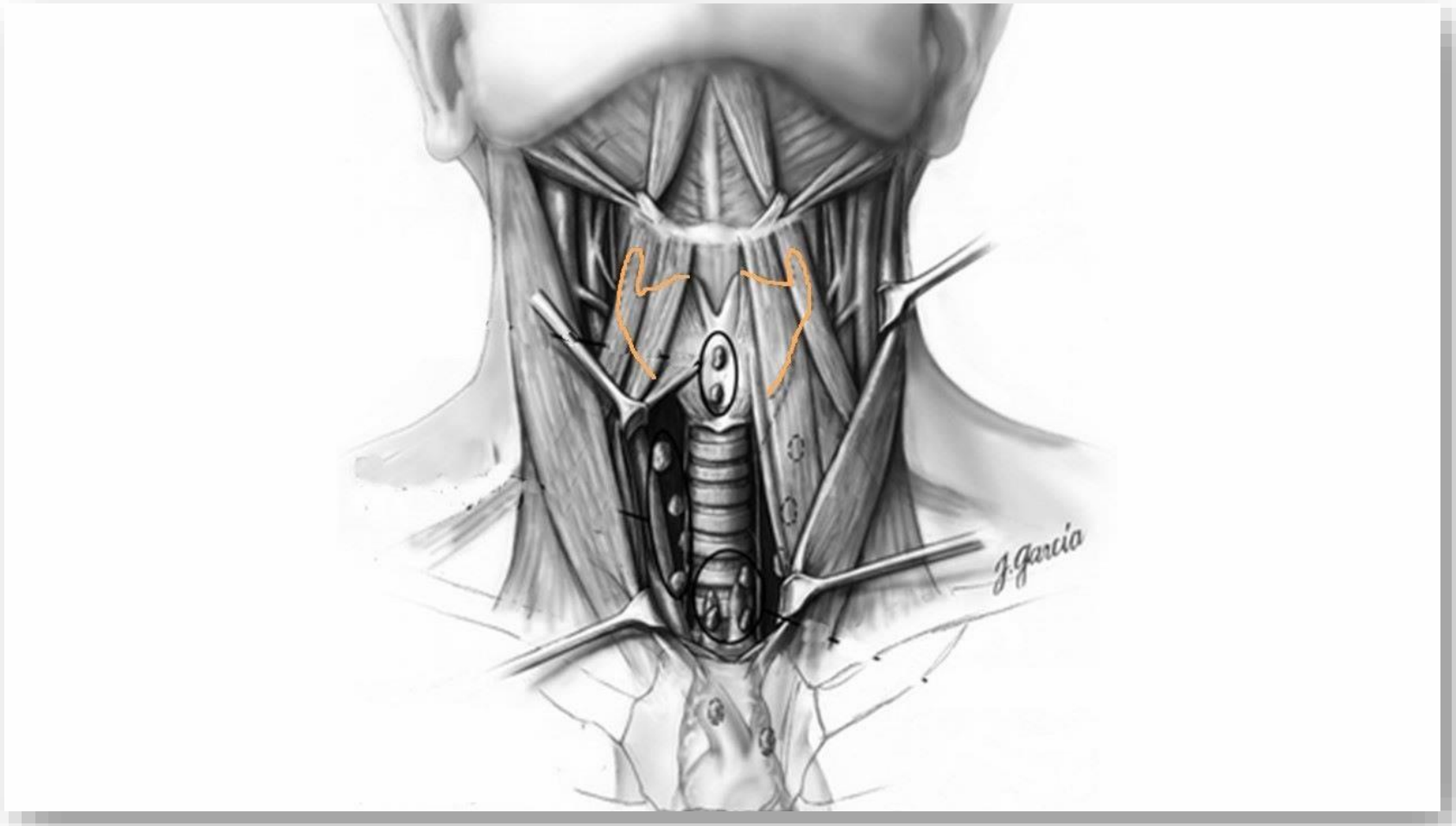




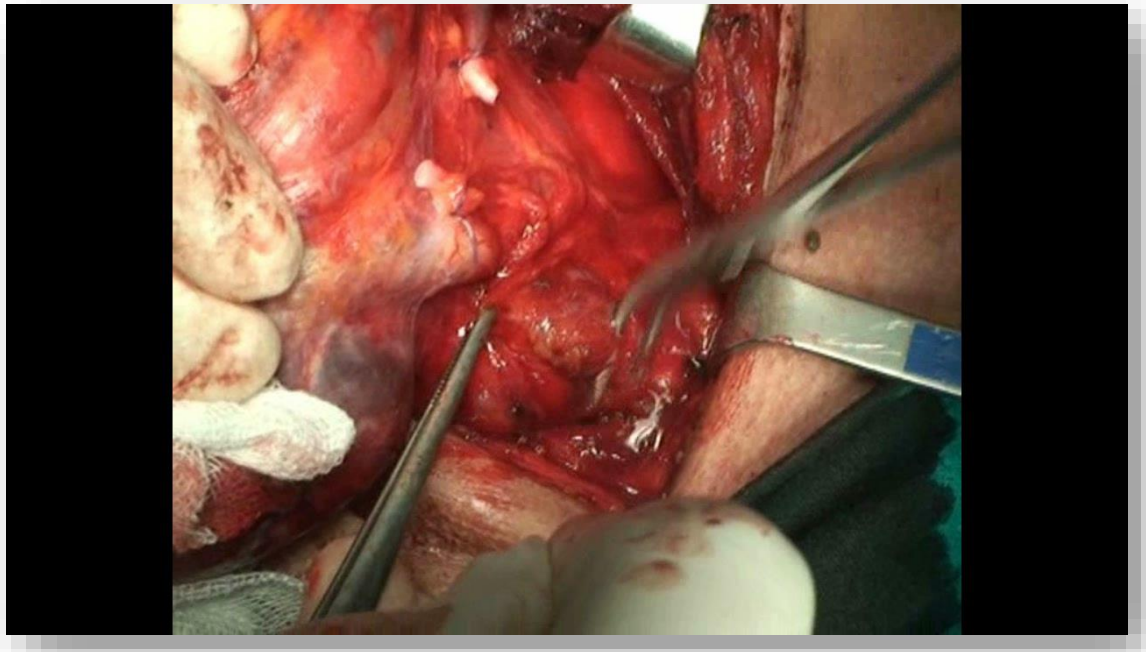


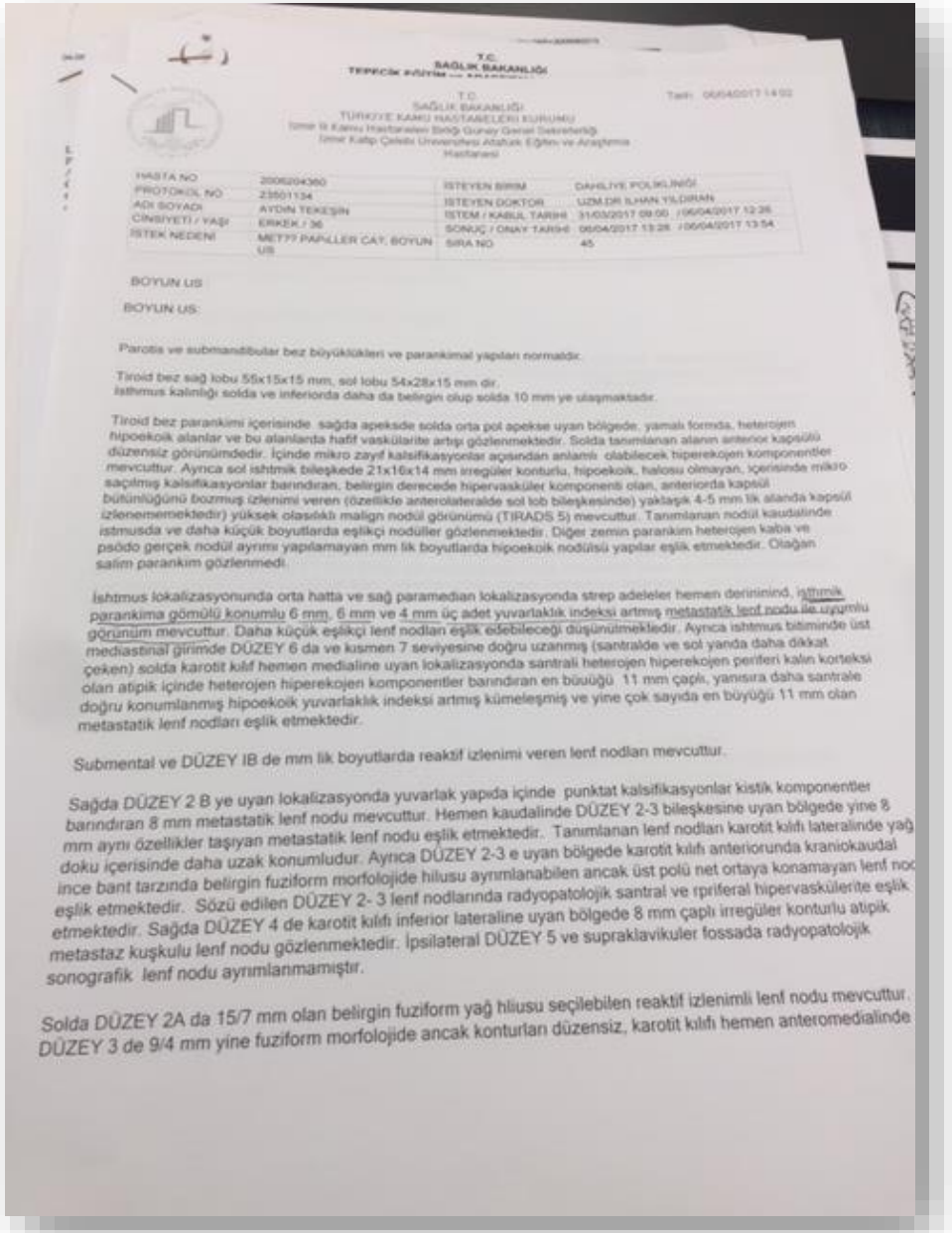
Metastazlar en sık prelaringeal ve paratrakeal alana olur

Metastazlar aşamalı yayılım yapar



Ameliyat öncesi detaylı US ile değerlendirme





T.C.
SAĞLIK BAKANLIĞI

T.C.
SAĞLIK BAKANLIĞI
TÜRKİYE KAMU HASTANELERİ KURUMU

HASTA NO	2005204360	İSTEYEN BİRİM	DAHİLİYE POLİKLİNİĞİ
PROTOKOL NO	23501134	İSTEYEN DOKTOR	UZM.DR İLHAN YILDIRIM
ADI SOYADI	AYDIN TEKEŞİN	İSTEM / KABUL TARİHİ	31/03/2017 09:00 / 06/04/2017 12:26
CİNSİYETİ / YAŞI	ERKEK / 36	SONUÇ / ONAY TARİHİ	06/04/2017 13:28 / 06/04/2017 13:54
İSTEK NEDENİ	MET?? PAPİLLER CA?, BOYUN US	SIRA NO	45

BOYUN US

BOYUN US:

Parotis ve submandibular bez büyüklükleri ve parankimal yapıları normaldir.

Tiroid bez sağ lobu 55x15x15 mm, sol lobu 54x28x15 mm dir.
İsthmus kalınlığı solda ve inferiorda daha da belirgin olup solda 10 mm ye ulaşmaktadır.

Tiroid bez parankimi içerisinde sağda apekside solda orta pol apekse uyan bölgede, yamalı formda, heterojen hipoekoik alanlar ve bu alanlarda hafif vaskülarite artışı gözlenmektedir. Solda tanımlanan alanın anterior kapsülü düzensiz görünümdedir. İçinde mikro zayıf kalsifikasyonlar açısından anlamlı olabilecek hiperekojen komponentler mevcuttur. Ayrıca sol ishtmik bileşkede 21x16x14 mm irregüler konturlu, hipoekoik, halosu olmayan, içerisinde mikro saçılmış kalsifikasyonlar barındıran, belirgin derecede hipervasküler komponenti olan, anteriorda kapsül bütünlüğünü bozmuş izlenimi veren (özellikle anterolateralde sol lob bileşkesinde) yaklaşık 4-5 mm lik alanda kapsül izlenememektedir) yüksek olasılıklı malign nodül görünümü (TIRADS 5) mevcuttur. Tanımlanan nodül kaudalinde istmusda ve daha küçük boyutlarda eşlikçi nodüller gözlenmektedir. Diğer zemin parankim heterojen kabia ve psödo gerçek nodül ayrımı yapılamayan mm lik boyutlarda hipoekoik nodülsü yapılar eşlik etmektedir. Olağan salim parankim gözlenmedi.

İshtmus lokalizasyonunda orta hatta ve sağ paramedian lokalizasyonda strep adeleler hemen derininind, isthmik parankima gömülü konumlu 6 mm, 6 mm ve 4 mm üç adet yuvarlaklık indeksi artmış metastatik lenf nodu ile uyumlu görünüm mevcuttur. Daha küçük eşlikçi lenf nodları eşlik edebileceği düşünülmektedir. Ayrıca ishtmus bitiminde üst mediastinal girimde DÜZEY 6 da ve kısmen 7 seviyesine doğru uzanmış (santralde ve sol yanda daha dikkat çeken) solda karotit kılıf hemen medialine uyan lokalizasyonda santrali heterojen hiperekojen periferi kalın korteksi olan atipik içinde heterojen hiperekojen komponentler barındıran en büyüğü 11 mm çaplı, yanısıra daha santrale doğru konumlanmış hipoekoik yuvarlaklık indeksi artmış kümeleşmiş ve yine çok sayıda en büyüğü 11 mm olan metastatik lenf nodları eşlik etmektedir.

Submental ve DÜZEY IB de mm lik boyutlarda reaktif izlenimi veren lenf nodları mevcuttur.

Sağda DÜZEY 2 B ye uyan lokalizasyonda yuvarlak yapıda içinde punktat kalsifikasyonlar kistik komponentler barındıran 8 mm metastatik lenf nodu mevcuttur. Hemen kaudalinde DÜZEY 2-3 bileşkesine uyan bölgede yine 8 mm aynı özellikler taşıyan metastatik lenf nodu eşlik etmektedir. Tanımlanan lenf nodları karotit kılıfı lateralinde yağ doku içerisinde daha uzak konumludur. Ayrıca DÜZEY 2-3 e uyan bölgede karotit kılıfı anteriorunda kraniokaudal ince bant tarzında belirgin fuziform morfolojide hilusu ayrımlanabilen ancak üst polü net ortaya konamayan lenf nod eşlik etmektedir. Sözü edilen DÜZEY 2- 3 lenf nodlarında radyopatolojik santral ve rpriferal hipervasküler'ite eşlik etmektedir. Sağda DÜZEY 4 de karotit kılıfı inferior lateraline uyan bölgede 8 mm çaplı irregüler konturlu atipik metastaz kuşkulu lenf nodu gözlenmektedir. İpsilateral DÜZEY 5 ve supraklavikuler fossada radyopatolojik sonografik lenf nodu ayrımlanmamıştır.

Solda DÜZEY 2A da 15/7 mm olan belirgin fuziform yağ hliusu seçilebilen reaktif izlenimli lenf nodu mevcuttur. DÜZEY 3 de 9/4 mm yine fuziform morfolojide ancak konturları düzensiz, karotit kılıfı hemen anteromedialinde

Lenf metastazı risk faktörleri

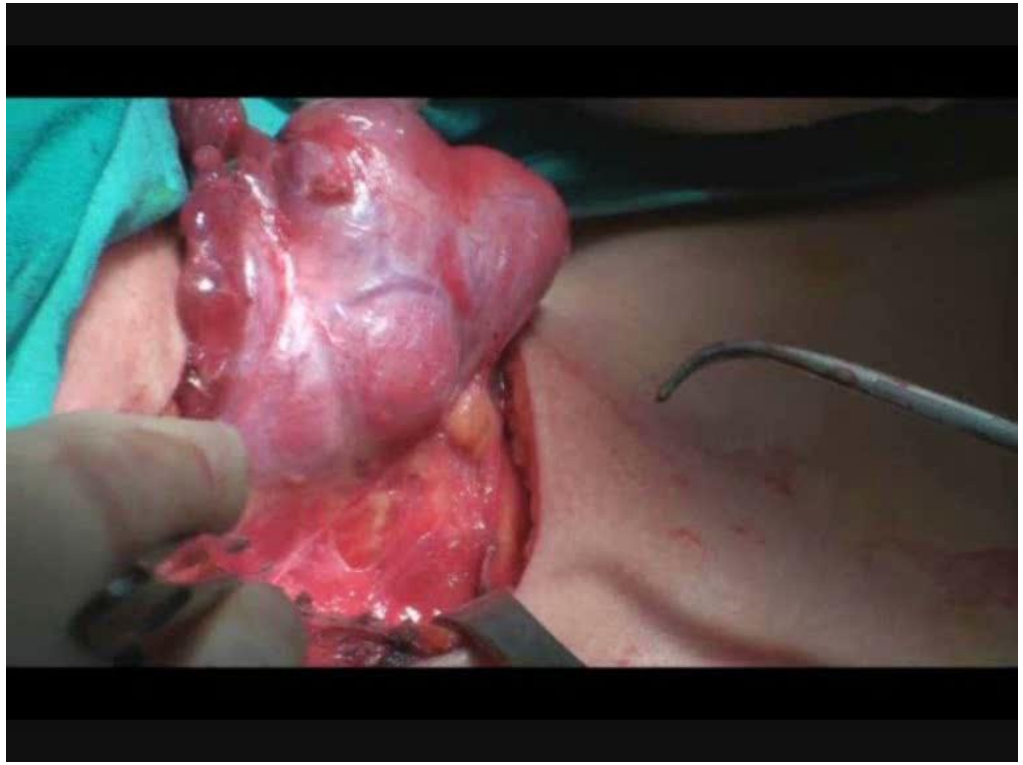
- Yaş
- Ekstratiroid invazyon
- Multifokalite
- Lenfovasküler invazyon
- Agresif varyant
- Bilataral
- Lenfositik tiroidit
- Tümör çapı

The incidence and risk factors for central lymph node metastasis in cN0 papillary thyroid microcarcinoma: a meta-analysis Eur Arch Otorhinolaryngol 2017

Predictive Factors for Central Lymph Node Metastasis in Patients with CN0 Papillary Thyroid Carcinoma: A Systematic Review and Meta-Analysis 2016

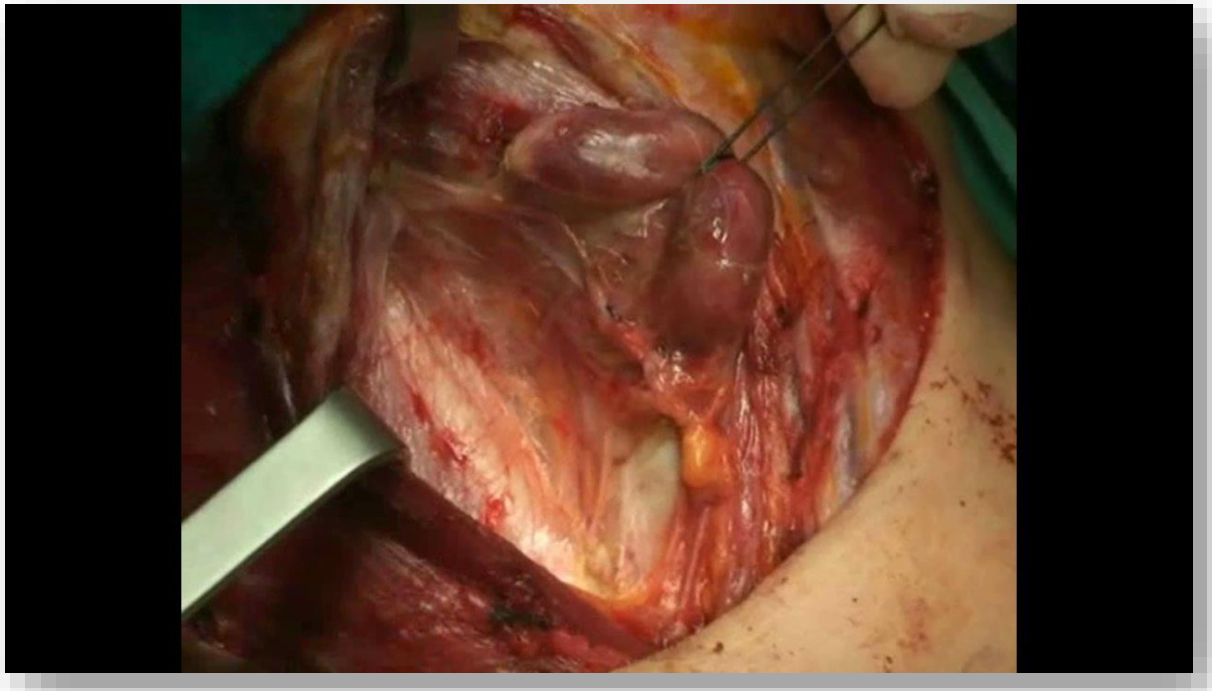
To Identify Predictors of Central Lymph Node Metastasis in Patients with Clinically Node-Negative Conventional Papillary Thyroid Carcinoma International Journal of Endocrinology 2016

Terapötik / Proflaktif santral diseksiyon



1. Ameliyat öncesi
2. Ameliyat sırasında
3. İzlem sırasında

Santral diseksiyon tam olarak yapılıyor mu?



1. **Prelaringeal**
2. **Pretrakeal**
3. **Paratrakeal**

LENF GANGLİON SAYISI !!!!

Proflaktik santral diseksiyon yapılmalı mı ?

Prophylactic Central Compartment Lymph Node Dissection in Papillary Thyroid Carcinoma: Clinical Implications Derived From the First Prospective Randomized Controlled Single Institution Study. *J Clin Endocrinol Metab* 100: 1316–1324, 2015)

Patients: A total of 181 patients with PTC without evidence of preoperative/intraoperative lymph node metastases (cN0) were randomly assigned to either Group A (n 88) and treated with total thyroidectomy (TTx) or Group B (n 93) and treated with TTx pCCND.
Results: After 5 years of followup, no difference was observed in the outcome of the two groups. However, a higher percentage of Group A were treated with a higher number of 131I courses (*P* .002), whereas a higher prevalence of permanent hypoparathyroidism was observed in Group B (*P* .02). No preoperative predictors of central compartment lymph node metastases (N1a) were identified. Only three patients were upstaged, and the therapeutic strategy changed in only one case.
Conclusions: cN0 patients with PTC treated either with TTx or TTx pCCND showed a similar outcome. One advantage of TTx pCCND was a reduced necessity to repeat 131I treatments, but the disadvantage was a higher prevalence of permanent hypoparathyroidism. Almost 50% of patients with PTC had micrometastatic lymph nodes in the central compartment, but none of the presurgical features analyzed, including *BRAF* mutation, was able to predict their presence; moreover, to be aware of their presence does not seem to have any effect on the outcome.

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Proflaktik santral diseksiyon yapılmalı mı ?

Outcomes for patients with papillary thyroid cancer who do not undergo prophylactic central neck dissection Br J Surg. 2016 **A. R. Shaha**

Methods—All patients who had surgery between 1986 and 2010 without CND for PTC were identified. All patients had careful clinical assessment of the central neck during preoperative and perioperative evaluation, with any suspicious nodal tissue excised for analysis. The cohort included patients in whom lymph nodes had been removed, but no patient had undergone a formal neck dissection. Recurrence-free survival (RFS), central neck RFS and disease-specific survival (DSS) were calculated using the Kaplan–Meier method.

Results—Of 1798 patients, 397 (22·1 per cent) were men, 1088 (60·5 per cent) were aged 45 years or more, and 539 (30·0 per cent) had pT3 or pT4 disease. Some 742 patients (41·3 per cent) received adjuvant treatment with radioactive iodine. At a median follow-up of 46 months the 5-year DSS rate was 100 per cent. Five-year RFS and central neck RFS rates were 96·6 and 99·1 per cent respectively.

Conclusion—Observation of the central neck is safe and should be recommended for all patients with PTC considered before and during surgery to be free of central neck metastasis.

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Bilateral ? / İpsilateral ?

Total thyroidectomy alone versus ipsilateral versus bilateral prophylactic central neck dissection in clinically node-negative differentiated thyroid carcinoma. A retrospective multicenter study

Methods: The clinical records of 163 clinically node-negative consecutive DTC patients treated between January 2008 and December 2010 in three endocrine surgery referral units were retrospectively evaluated. The patients were divided into three groups: patients who had undergone TT alone (group A), TT with ipsilateral CND (group B), and TT with bilateral CND (group C).
Results: The respective incidences of transient hypoparathyroidism and unilateral recurrent nerve injury were 12.6% and 1% in group A, 23.3% and 3.3% in B, and 36.7% and 0% in C. Node metastases were observed in 8.7% in group A, 23.3% in B, and 63.3% in C. Locoregional recurrence was observed in 3.9% of patients in group A and in 0% in B and C.
Conclusions: We found no statistically significant differences in the rates of locoregional recurrence between the three groups. Therefore, TT appears to be an adequate treatment for these patients; CND is associated with higher rates of transient hypoparathyroidism and cannot be considered the treatment of choice even if it could help for more appropriate selection of patients for RAI. Ipsilateral CND could be an interesting option considering the lower rate of hypocalcemia to be validated by further studies.

Mikrometastazların klinik önemi yok, komplikasyon oranı yüksek

Bununla ilgili yeterli kanıt yok

Doğru ancak bunun için fazla risk alınıyor

Evre yükseliyor ve gereksiz RAI tedavisi alınıyor

Güvenli ellerde makul oranlar

TT yaygın uygulanıyor ve çok deneyimli cerrahlar değil

- ✓Çelişkili sonuçlar
- ✓Karşıt ve yandaş görüşlerin doğru yönleri var
- ✓ATA T3 tümör !!!
- ✓Her klinik bir strateji belirleyebilir