Bölüm
40

YANIK HASTASINDA BESLENME

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YANIK

Yanma hasarı dermis ve deri altı dokulara verilen hasar derinliği ve buna bağlı vücut yüzey alanı yüzdesi ile kategorize edilir. Yüzeysel yanıklar (birinci derece) yalnızca epidermisi içerir ve önemli morbidite veya mortaliteye neden olmaz. Kısmi kalınlıkta yanıklar (ikinci derece) sadece dermis ve epidermis içerir. Tam kalınlıkta yanıklar tüm cilt katmanlarını içerir. En az ikinci derece yanık içeren toplam vücut yüzey alanının (TBSA) yüzdesi, yanık hastalarında morbidite derecesinin güçlü bir göstergesidir (1). Toplam vücut yüzey alanı Lund Brower şeması kullanılarak hesaplanabilir. Basitçe, dokuzlar kuralı da alternatif olarak kullanılabilir (2). Şiddetli yanık, çocuklarda %10, yetişkinlerde> %25' den fazla TBSA tutulumu olarak sınıflandırılmıştır.

Ciddi yanık, önemli doku tahribatı ve acil bir sistemik inflamatuvar yanıtla sonuçlanır (3). İlk yaralanma, vücudun enfeksiyonlara karşı doğal bariyerini yıktığı gibi sıvı ve ısı değişimi dengelerine de zarar verir. Yanık yüzeyindeki buharlaşma ile kaybın yanı sıra artan damar geçirgenliği nedeniyle hızlı sıvı kayıpları meydana gelir. Hastalarda hem buharlaşma ile kayıp hem de homeostatik ısı regülatörlerin kaybı nedeniyle önemli derecede hipotermi gelişebilir. Sistemik cevap sadece yanmış dokuyu değil, tüm vücut dokularını etkiler. Artan damarsal geçirgenlik pulmoner ve beyin ödemine neden olurken sıvı kaymaları ve ciddi hipovolemiye bağlı akut solunum sıkıntısı sendromu (ARDS) ve böbrek yetmezliği gelişebilir. Yanık hasarına sistemik cevap iki aşamada açıklanabilir. İlk etabı (ebb fazı = hemen başlar ve yaklaşık 48 saat sürer). Sonraki dönemde ise aylarca sürebilen hipermetabolik (flow fazı) bir faz başlar. Bu değişiklikler hastaların yaralanma seyri boyunca tedavi basamaklarının temel unsurlarını belirler.

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markerleri, hastanın klinik durumu ve genel eğilim göz önünde bulundurularak yorumlanmalıdır. 2007 yılında beslenme izleme uygulamalarına ilişkin 65 yanma merkezi araştırılmış ve en sık kullanılan parametreler prealbümin (merkezlerin %86'sı), vücut ağırlığı (%75), kalori sayımı (%69), serum albümin (%45,8), azot dengesi (%54) ve transferrindir (%16) (88). Hiçbir bireysel yöntem, yanık hastalarının beslenme izlemesi için evrensel olarak güvenilir veya uygulanabilir değildir. Genel klinik tablo değerlendirmeye dahil edilmelidir.

Sonuç olarak, Hipermetabolizma ve katabolik bir dönemden oluşan ciddi yanıklarda besin gereksinimleri çoğu zaman diğer yaralanmalara maruz kalan hastalarla kıyaslandığında önemli ölçüde daha yüksektir. Beslenme desteğinin verilmesi, yanık bakımının hayati bir unsurudur ve asıl amaç sadece beslenme komplikasyonlarından kaçınmaktır. Beslenme ihtiyaçları sıklıkla karmaşık ve hastaya özgüdür. Etkili değerlendirme ve yönetim yara iyileşmesini optimize edebilir ve komplikasyonları ve mortaliteyi azaltabilir. Yanık bakımı ve tedavideki ilerlemeler son yirmi yılda hasta sonuçlarını önemli ölçüde iyileştirmiş olsa da ciddi yanıklar hala yüksek mortalite ile ilişkilidir. Yüksek karbonhidrat formülü olan EN, beslenme desteğinin bireyselleştirilmesi, izlenmesi ve geri kazanım boyunca ayarlanması gerekmesine rağmen faydalıdır. Patolojik metabolik değişiklikler homojen olmadığından, bu hastaların tedavisi sadece beslenme odaklı düşünülmemelidir. Bu nedenle, beslenme desteği gibi çeşitli tedavileri farmakolojik ajanlarla birlikte birleştirmeyi hedefleyen yanık bakımı ve yönetimi konusunda daha bütünsel bir yaklaşım benimsenmelidir. Yanık sonrası metabolik değişikliklerin temel bilim analizi, yanık hastası için ideal beslenme desteğini belirlemek için randomize prospektif klinik çalışmalarla birleştirilmelidir.

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