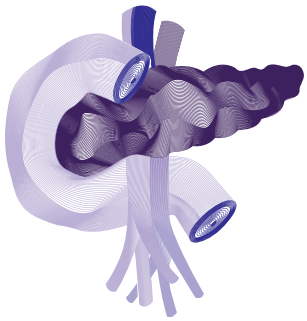
Bölüm 42

Pankreas Cerrahisinde Preoperatif Hasta Yönetimi



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Giriş

Pankreas kanserleri yüksek morbidite ve mortalite oranlarına sahiptir. Kansere yönelik direkt bir tedavi şansı alamamış hastalarda 5 yıllık sağ kalım oranları 1-5% arasında değişkenlik gösterir. Kansere spesifik teadvi almış olan hasta popülasyonlarında ise bu oran 15-25% arasındadır (1). Günümüzde pankreas kanserlerindeki tek küratif tedavi seçeneği cerrahidir. Malign etkenler haricinde benign lezyonlarda pankreas lezyonlarında cerrahi tedavi endikasyonları daha sınırlı kalmakta iken, lenfoma, otoimmun pankreatit gibi hastalıklarda ise cerrahi tedavi endikasyonları daha nadir konulur. Bu hasta gruplarında cerrahi tedavi, postoperatif morbiditenin daha az olacağı ayrıca tedaviden fayda görme ihitmali daha fazla olan hasta gruplarına uygulanır. Son 10 yılda majör pankreas cerrahisinin mortalitesi azalmış olsa da morbidite oranları aynı seviyede seyretmektedir (2) Günümüzde majör pankreas cerrahisi geçiren hastalarda mortalite etkenleri değerlendiriliğinde artık cerrahi komplikasyonlardan daha fazla sistemik komplikasyonların primer etken olduğu belirlenmiştir (1).

Görüntüleme Tetkikleri

Pankreas cerrahisinde uygulanacak görüntüleme tetkikleri arasında Bilgisayarlı Tomografi (BT), Ultrasonografi (USG), Endoksopik Ultrasonografi (EUS),

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Tablo 3: *Devamı (9)*

Başlık	Öneri Özeti	Kanıt Düzeyi	Öneri Düzeyi
Postop IV analjezi	Opiad kullanımının kaçınılması	Orta	Güçlü
Tranversus Abdominal Block	Açık cerrahi geçiren hastalarda epidural alternatifi analjezi	Yüksek	Güçlü
Postop emesis profilaksisi	Tüm hastalarda kullanım, Risk faktörü varsa çoklu	Orta	Güçlü
Hipotermiden Korunma	36°C üzerinde takip	Yüksek	Güçlü
Glukoz takibi	Hipoglisemiden kaçınılarak kan şekeri regülasyonu	Orta	Güçlü
NG dekompresyon	Önerilmemektedir	Orta	Güçlü
Sıvı resüstasyonu	Monitörizasyon ile yakın takip	Orta	Güçlü
Dren kullanımı	<5000 u/lt amilaz değerlerinde 72 sa içinde çekilmesi	Yüksek	Güçlü
Somatostatin kullanımı	Yeterli veri yok, kullanılmaması önerilir	Orta	Zayıf
Üriner katater	En erken dönemde çekilmesi	Zayıf	Güçlü
Gecikmiş gastrik boşalma	Parenteral nutrisyon	Düşük	Güçlü
Erken mobilizasyon	Postoperatif ilk günden itibaren teşvik edilmeli	Düşük	Güçlü
Minimal invaziv cerrahi	Tecrübeli ve yüksek vaka sayıları olan merkezlerde	Orta	Güçlü
Prokinetik destek	Sakız çiğneme[1], Alvimopan kullanımı[2], Mosapride[3], Metoklopramid[4], Eritromisin[5]	Orta[1,2] Çok Düşük[3,4] Yüksek[5]	Zayıf[1,2] Zayıf[3,4] Güçlü[5]

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