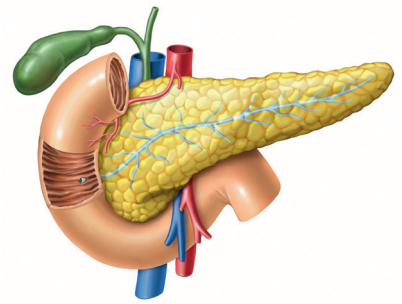
BÖLÜM 36



PANKREAS CERRAHİSİ SONRASI GASTRİK DİSFONKSİYON YÖNETİMİ

Mehmet Can AYDIN[1]

GİRİŞ

Periampuller bölge tümörlerinin tek küratif tedavisi pankreatikoduodenektomidir. Bu kompleks cerrahi prosedür ilk olarak Whipple tarafından uygulanmıştır (1). İlk uygulanmaya başlandığı dönemde % 25'e kadar ulaşan mortalite oranları, artan cerrahi tecrübe ve gelişen postoperatif hasta yönetimi ile birlikte % 5'in altına inmiştir (2-10). Fakat mevcut gelişmelere rağmen, postoperatif morbidite yüksek volümlü merkezlerde dahil yaklaşık % 30-50 oranında görülmekte ve halen prosedürün ilk tanımlandığı dönemdeki oranlarda devam etmektedir (11,12). Postoperatif morbiditenin en sık nedenlerinden biri de yaklaşık % 15-60 oranında karşılaşılan ve en sık meydana gelen komplikasyon olan gecikmiş gastrik boşalmadır (GGB) (13-20). GGB, literatürde 'gastroparezi' olarak da isimlendirilmiştir (21). PD sonrası gastrik disfonksiyon mekanizması net olarak açıklanamamış olmakla birlikte; motilin hormonal reseptörünün azalmış aktivitesi, vagus sinir hasarı, iskemik hasar, intestinal yapıların torsiyonu, duodenumun rezeke edilip edilmemesi (22-26) veya pankreatik anastomoz kaçağı gibi birçok mekanizma ile multifaktöryel nedenlerle açıklanmaya çalışılmıştır (27-29). Özellikle distal pankreatektomi yapılan hastalarda GGB'nın yaklaşık % 24'lük oranla PD'ye göre daha düşük olması bu hipotezleri desteklemektedir (30,31). Hastaların ameliyattan sonra oral beslenmeyi tolere edememesi, nazogastrik drenajın yüksek miktarlarda devamı, bulantı ve kusma ile seyreden ve hayati tehlike oluşturmadığı düşünülen bu durum, hastanede yatış sürelerinin uzaması, hastanın yaşam kalitesinin bozulması, tekrar hastaneye yatış gereksinimi ve artan tedavi maliyetlerine neden olmaktadır (32,33). Bu nedenle pankreas cerrahlarının GGB'un tanısı ve tedavisine tam anlamıyla hakim olması son derece önemlidir.

TANIM

Literatürde GGB için özellikle nazogastrik tüpün çekilmesi ve oral beslenmeye başlanma zamanını baz alan birçok farklı tanımlama yapılmıştır. Fakat bu farklı tanımlamalar nedeniyle yapılan çalışmaların sonuçlarını değerlendirmek zorlaşmıştır. Neticede bu zorluğu ortadan kaldırmak ve GGB için ortak bir literatür dili kullanılabilmesi adına 'The International Study Group of Pancreatic Surgery' (ISPGS) konuyu tanımlayıcı bir çalışma yapmış ve bundan sonra konu ile ilgili yapılan çalışmalar bu tanımlamaya göre dizayn edilmiştir (30).

[1] Dr. Öğr. Gör., Ondokuz Mayıs Üniversitesi Tıp Fakültesi, dr.mca@hotmail.com

matuvar sürecin GGB gelişimi üzerinde en etkili faktör olduğu konusunda hemfikirdir (15). Bu sebeple POPF'ün erken tanısı, doğru tedavisi de dolaylı olarak GGB'yı önlemede ve tedavisinde ön palana çıkmaktadır. Fakat fistül veya intra-abdominal enfeksiyon gelişmeyen hastalada da GGB gelişmesi, bu komplikasyona neden olan başka mekanizmalara yoğunlaşılmasına ve 'izole GGB' olarak tanımlanmasına neden olmuştur. Yani sonuç olarak GGB için POPF veya batın içi koleksiyonun olması bir şart değildir. Ryan ve arkadaşlarının yaptığı çalışmada (15) , POPF'den bağımsız olarak GGB gelişen hastalar incelendiğinde >70 yaş, erkek cinsiyet, pilor koruyucu PD ve uzamış operasyon süresi risk faktörü olarak tespit edilmiştir. Yapılan başka bir çalışmada rutin olarak oktreotid kullanımının da GGB gelişimi için bir risk faktörü olarak tespit edilmesi dikkat çekicidir (35).

TEDAVİ

GGB'nın tedavisinde net bir konsensus yoktur. Ama genel olarak konservatif takip hastaların tamamına yakınında iyileşme ile sonuçlanmaktadır. Süreç nazogastrik drenaj ile sabırla takip edilmeli ve bu esnada gerek halinde hasta mümkünse enteral, değilse parenteral olarak beslenmelidir. Bazen yeterli beslenmenin sağlanabilmesi için ikisi bir arada da verilebilir. Belki de özellikle risk grubundaki hastalarda perioperatif enteral beslenmeyi sağlamak amacıyla nazoenteral tüp veya beslenme jejunostomisi konulması postoperatif yönetim açısından faydalı olabilir (68). Üst gastrointestinal sistemdeki mekanik bir tıkanıklık, endoskopi veya görüntüleme (kontrastlı direk grafi veya bilgisayarlı tomografi) ile ekarte edilebilir. Mekanik obstrüksiyon olmadığında ve GGB prokinetik ilaca yanıt vermediğinde, endoskopik jejunal beslenme tüpünün yerleştirilmesi ve ardından düşük doz enteral beslenme uygulanabilir (31). Enteral nütrisyon maliyet olarak da parenteral nütrisyondan daha düşüktür (69,70).

Özellikle Evre B ve C olan hasta grubunda POPF başta olmak üzere karın içi ek komplikasyonlar olabileceği akılda tutulmalı; bunların medikal, girişimsel veya operatif tedavileri mutlaka uygulanmalıdır. Özellikle Evre C GGB›nın, adjuvan KT başlangıcını geciktirebileceği de unutulmamalıdır.

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