Bölüm
14

KONVANSİYONEL HEPATİK REZEKSİYON TEKNİKLERİ

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GİRİŞ

Hepatik rezeksiyon, primer veya metastatik hepatik maligniteleri olan seçilmiş hastalarda birinci basamak tedavidir [(1)]. Son yıllarda, cerrahi tekniklerdeki ve cerrahi hasta bakımındaki gelişmeler, karaciğer rezeksiyonunun güvenliğini arttırmıştır; ancak, karaciğer rezeksiyonu sonrası sonuçları etkileyen en önemli faktör, cerrahın prosedüre ilişkin bilgi ve tecrübesidir [(2)]. Postoperatif morbidite ve mortalite oranları uygun hasta seçimi, karaciğer anatomisine dikkat edilmesi ve rezeksiyon için optimal tekniğin kullanılması ile azaltılabilir. Deneyimli merkezlerde, karaciğer rezeksiyonu sonrası 90 günlük mortalite oranı % 5'in altındadır ve negatif sınırlı cerrahi rezeksiyon oranı % 90'a yaklaşmaktadır [(3)].

Hepatik rezeksiyon için en sık endikasyon malign karaciğer kitleleridir. Benign kitleler ve doğumsal karaciğer lezyonları da hepatik rezeksiyon sebebi olabileceği gibi nadiren tanısal amaçlı da hepatik rezeksiyon yapılması gerekebilir (Tablo 1) [(4)]. Malign tümörler arasında Hepatoselüler karsinom rezeksiyon gerektiren en sık primer karaciğer malignitesi iken kolanjiokarsinom ikinci en sık hepatik rezeksiyon gerektiren malign tümördür.[5]

Tablo 1. Hepatik rezeksiyon endikasyonları

Tanısal	Fokal nodüler hiperplazi, hepatoselüler adenom ayrımında
Semptomatik	Hemanjiom Basit kist
Benign hastalıklar	Refrakter abse/kolanjit Ciddi hepatolithiazis
Premalign karaciğer hastalıkları	Hepatoselüler adenom Bilier kistadenom
Malign karaciğer hastalıkları	Metastaz Hepatoselüler karsinom Kolanjiokarsinom

Rezeksiyon tipi hastalığın tip ve yaygınlığına göre belirlenir. Rezeksiyonlar majör ve minör rezeksiyonlar olarak sınıflandırılabildiği gibi anatomik (segmentel rezeksiyonlar, sağ veya sol hepatektomiler) ve atipik (wedge) rezeksiyonlar olarak da sınıflandırılmaktadır (Şekil 1). Rezeksiyonların çoğunda kolesistektomi ve porta hepatis diseksiyonu, vasküler ve duktal yapıları izole etmek için yapılır. Anatomik rezeksiyonlar daha iyi postoperatif sonuçları olduğundan tercih edilir ancak anatomik rezeksiyon sonrasında yeterli karaciğer volumu sağlanamayacaksa non-anatomik rezeksiyon teknikleri uygulanabilir. Atipik rezeksiyonlarda komplikasyonlar (kanama, safra yolu yaralanması, bilioma) daha sık görülmektedir [(6,7,8)].

Hepatoselüler karsinomlu hastalarda, mikroskobik portal venöz invazyon ve bu hastalıkla

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laparoskopik yaklaşıma pek hassas olmayan karaciğer segmentlerine daha kolay erişebilmesine olanak vermesidir. Bu daha iyi hareket nedeniyle klasik laparoskopik yaklaşıma kıyasla hassas, üç boyutlu kararlı görüş ve daha iyi ergonomi sağlayıp kullanımını artırmaktadır.

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