Bölüm
46

SAFRA YOLLARININ DİĞER BENİGN HASTALIKLARI

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GİRİŞ

Benign biliyer hastalıklar , konjenital ya da edinsel etyolojilere bağlı gelişebilir. İntrahepatik ve/veya ekstrahepatik safra yollarının etkilendiği ;akut ya da kronik seyirli ,karaciğer parankim hasarına sebep olabilen ve bazı durumlarda malignite ile sonuçlanabilecek hastalıkları kapsamaktadır (1,2).

Olgularda başvuru semptomu sağ üst kadran ağrısı , ateş, sarılık ya da her üç semptomun bir arada görüldüğü kolanjit tablosudur.Asemptomatik hastalarda başka hastalıklar nedeniyle yapılan labaratuar tetkikleri ya da görüntüleme yöntemlerinde insidental olarak saptanabilir (1,2).

Safra yolları benign hastalıklarını teşhis etmede hasta öyküsü , fizik muayene , radyolojik görüntüleme ve ERCP (Endoskopik Retrograd Kolanjiyopankreatikografi) önemli yer teşkil eder (1,2).

Koledokolitiazis

Koledok taşı insidansı literatürde yaklaşık olarak % 7-20 arasında bildirilmiştir (3-6) . Semptomatik kolelitiazis olgularında %3-15 oranında koledok kanalında taş görülme riskinden dolayı bu olgular koledokolitiazis yönünden mutlaka değerlendirilmelidir. Koledokolitiazis safra yolu tıkanıklığına sebep olarak kolanjit, sarılık ,biliyer strüktür ve biliyer pankreatite sebep olabilir (4-7).

Semptomlar sağ üst kadran ağrısı, bulantı, kusma ,iştahsızlık , sarılık , ateş ,idrar renginde koyulaşma ve gayta renginde açılmadır. Koledokta taşın oluşturduğu tıkanıklığa bağlı olarak direkt billurubin yüksekliği , Alkalen Fosfataz (ALP) , Gama Glutamil Transferaz (GGT) , Aspartat Aminotransferaz (AST) , Alanin Transaminaz (ALT) yüksekliği görülür. Koledokolitiazisi teşhis etmede labaratuar değerlendirme ile birlikte Ultrasonografi (USG) ve Bilgisayarlı Tomografi (BT) önemli bir yer teşkil etmesine rağmen ; Manyetik Rezonans Kolanjiyopankreatikografi (MRCP) ve Endoskopik Ultrasonografi (EUS) koledokolitiazisi görüntülemede spesifik metodlardandır. Pahalı metodlar olduğu için seçili olgularda kullanılmalıdır (6-10) . IV Kolanjiyografi son zamanlarda nadiren kullanılmaktadır (6) . Kolesistektomi öncesi koledokolitiazis varlığında ERCP , maliyet yüksekliği ,invaziv bir işlem olması ve pankreatit riskinin % 1-13,5 olması nedeniyle rutin olarak değil , seçilmiş hastalarda kullanılmalıdır (11-14) . Koledok taşı olan hastalarda operasyon öncesi ERCP yapılması kolanjit , akut pankreatit , hepatik abse gibi komplikasyonları önlemede yararlıdır (15). ERCP nin başarısız olduğu durumlarda;kolesistektomi ile birlikte koledoktan taş ekstraksiyonu uygulanmalıdır.Taş ekstraksiyonunu takiben primer onarım, T-Tüp , Kolodokoduodenostomi veya Hepatikojejunostomi ile safra yolu devamlılığı sağlanabilir (4-15).

Koledokolitiazis varlığında kolesistektomi uygulanır ise postoperatif dönemde sistik kanal-

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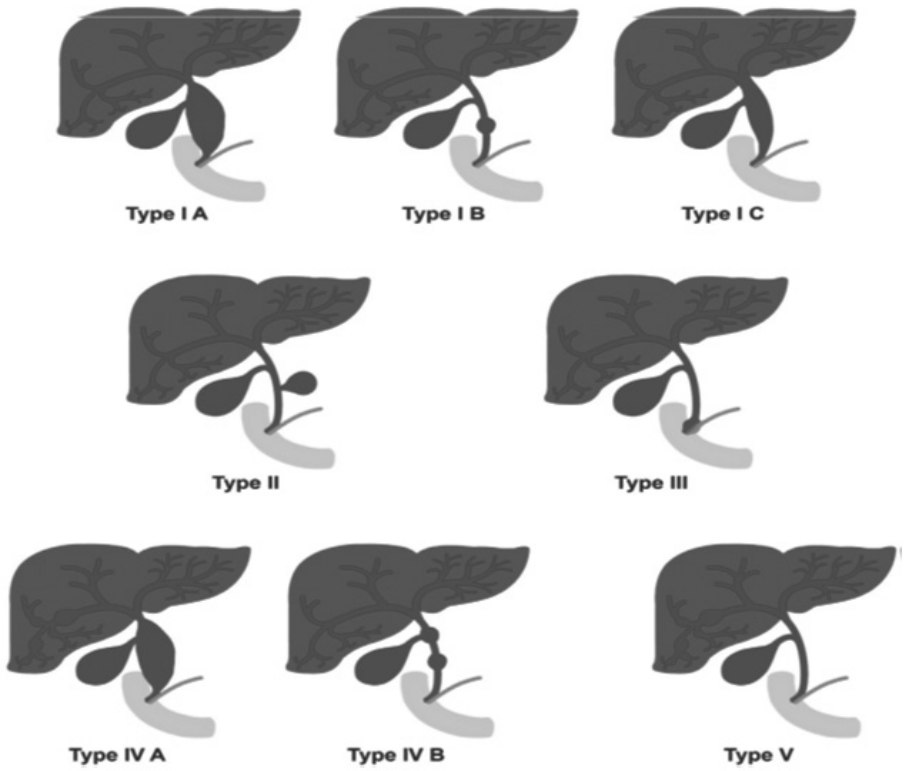

Şekil 1. Koledok kistlerinde Tadoni sınıflaması. Canella R.ve ark. (120)

Koledok kistlerinin tedavisi kist tipine, eşlik eden komplikasyon durumuna göre belirlenmelidir.Parsiyel kist eksizyonu ve kistoenterostomi gibi yaklaşımlar uzun dönem komplikasyon risklerinden dolayı yerini total kist eksizyonunu içeren yaklaşımlara bırakmıştır. Özellikle ekstrahepatik safra yolunu içeren kistlerde ekstrahepatik safra yolu rezeksiyonu ve Roux-N-Y anastomoz standart cerrahi prosedürlerden birisidir. İntrahepatik biliyer lokalizasyonlu kistlerin tedavisinde segmentektomi,diffüz karaciğer segment tutulumu olan olgularda ise karaciğer transplantasyonu uygulanabilir (116-122).

Sonuç

Benign biliyer hastalıklar teşhis edilmesi güç olabilen , benzer klinik ve radyolojik görünüm nedeniyle malign hastalıklardan ayırıcı tanısının iyi yapılması gereken ve tedavi süreci olgu bazlı düşünülmesi gereken hastalıklardır.

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