

PANKREAS CERRAHİSİ UYGULANACAK HASTALARIN ANESTEZİ YÖNETİMİ

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GİRİŞ

Pankreas kanseri (PC), kansere bağlı ölüm nedenleri içinde altıncı sıradadır ve dünyadaki hayatta kalma oranı en düşük hastalıktır (1). En ölümcül sindirim sistemi kanseri türüdür. Evreleme ve yerleşim yerine göre beş yıllık hayatta kalma oranı % 5'dir. Bu son derece kötü prognozun başlıca nedeni, hastaların %15'inden daha azında rezektabl tümör teşhisi konmasıdır(2). Günümüzde, PC için tek küratif tedavi, cerrahi rezeksiyondur; ancak rezeke edilebilir tümörler için bile kür halen nadirdir (5 yıllık yaşama oranı yaklaşık% 15-% 20) (3).

Cerrahi komplikasyonlardan çok, sistemik hastalıklar PC ile ilişkili ölümlerin çoğuna neden olmaktadır (4). PC'lerin % 80'inden fazlası 65 yaş üstünde görülmektedir. Pek çok PC hastası yoğun sigara içicisidir veya geçmişte sigara içmiştir (5,6) ve PC hastalarının neredeyse% 80'inde ya diyabet ya da bozulmuş glikoz toleransı (7) mevcuttur. Major komplikasyon olarak venöz tromboembolizm gelişebilir (8). Bu nedenlerden dolayı, PC gibi major abdominal cerrahi ameliyatı geçirecek hastalar, anestezi risk sınıflandırmasında yüksek risk grubundadır. Bu hastaları genel sonucu iyileştirmek için multidisipliner bir yaklaşımın uygulandığı ve deneyimli ekiplerin çalıştığı yüksek işlem hacmine sahip merkezlere yönlendirmek önemlidir. Ayrıca,

dikkatli hasta seçimi esastır. Hastaların morbiditesi, hasta sınıflandırma ve seçiminden başlayarak, anestezi yönetiminden (Tablo 1), cerrahi olarak yapılan işlemlerden, postoperatif yoğun bakım ünitesindeki tedavisinden önemli ölçüde etkilenir.

Tablo 1. Pankreas kanseri için ameliyat olacak hastaların perioperatif yönetimi

Ameliyat öncesi

- Bilgilendirilmiş hasta onayı preoperatif risk değerlendirmesi
- Preoperatif fiziksel durumların ve ilaçların değerlendirilmesi ve optimizasyonu
- Beslenme durumu
- Risk sınıflaması
- Tromboprofilaksi için gerekçe ve öneriler

Ameliyat

- Kombine genel ve epidural analjezi
- Cerrahi alan enfeksiyonunun önlenmesi
- Antimikrobiyal profilaksi
- Hipotermiden kaçınım
- Glikoz kontrolü
- Kan transfüzyonu yönetimi
- İntraoperatif sıvı yönetimi
- İntraoperatif ventilasyonun optimizasyonu
- İntraoperatif tromboprofilaksi

Ameliyat Sonrası

- Erken nazogastrik tüp, kateter ve drenaj çekilmesi
- Erken oral beslenme / glisemik kontrol / hedefe yönelik sıvı tedavisi
- Ağrı kesici / opioid olmayan oral analjezi
- Postoperatif ve venöz tromboembolik önleme yoğun solunum rehabilitasyonu
- Postoperatif yoğun yönetimi

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nün yeterli bir süre olabileceğini düşünmekteyiz. İntravenöz opioidleri kullanan hasta kontrollü analjezi, aynı etkin analjezi sağlamaz ve lokal epidural anestezi tekniklere kıyasla cerrahi stres yanıtları üzerinde daha az faydalı fizyolojik etkiler ortaya çıkarır (129).

Venöz Tromboembolinin Önlenmesi

Erken mobilizasyon alt ekstremitelerde derin venöz tromboz riskini ve pulmoner komplikasyonları azaltabilir (130). Bu hasta popülasyonunda özellikle yüksek olan VTE riski, preoperatif dönemin başlangıcından itibaren yönetilmeli, erken mobilizasyon ve uygun farmakolojik tromboprofilaksi sonucu postoperatif döneme kadar tüm cerrahi operasyon sırasında devam etmelidir.

Solunum Rehabilitasyonu

Pankreas rezeksiyonu sonrası pulmoner komplikasyonlar tüm hastaların yaklaşık dörtte birinde görülür (131). Anestezi altında ve / veya ameliyat sonrası meydana gelen birçok patofizyolojik modifikasyon, birbirleriyle etkileşime girerek solunum komplikasyonlarına neden olabilir. Ameliyat sonrası pulmoner disfonksiyonun temel nedenlerinden biri atelektazidir (132).

Üst abdominal ve torasik cerrahi sonrası, solunum komplikasyonlarının ve atelektazinin önemli bir belirleyicisi olan postoperatif diyafragma disfonksiyonu (133) sıklıkla gözlenir.

Son yıllarda akciğer komplikasyonlarını önlemek için preoperatif dönemde solunum egzersizleri önerilmektedir. Sistemik bir gözden geçirme, postoperatif non-invaziv ventilasyonun, özellikle sürekli pozitif solunum yolu basıncının (CPAP), abdominal cerrahi geçiren hastalarda hem postoperatif komplikasyonları hem de entübasyon gereksinimini azalttığını göstermiştir (130)

Yoğun Postoperatif Yönetim

Ameliyat tekniğinde ve perioperatif yönetimde sürekli gelişen yöntemlere rağmen, büyük abdominal cerrahi uygulanan hastaların artan yaş nedeni ile morbidite, mortalite, hastanede kalış

süresi ve hastane maliyetlerinde artışa yol açar. Pankreatikoduodonektomi sonrası postoperatif yan etki oranının yaklaşık %20'dir (134). Bu nedenlerden dolayı pankreas kanseri ameliyatları geçiren hastaları postoperatif yoğun bakım ünitesinde (YBÜ) takip etmek gereklidir. Bu sayede hedefe yönelik sıvı terapisi, invaziv ve non-invaziv ventilasyon olasılığı, intravenöz ilaçların sürekli uygulanması ve yakın hemodinamik izlem sağlanabilmektedir.

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