Bölüm 15

JİNEOLOJİK KANSERLERDE PELVİK PARAAORTİK LENFADENEKTOMİ

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Endometrium ve over kanseri dahil birçok jinekolojik kanserin evrelemesi için pelvik paraaortik lenf nodu değerlendirmesi gerekmektedir (1)Serviks kanseri klinik olarak evrelenmektedir. Serviks kanserinde pelvik paraaortik lenf nodlarının değerlendirmesi, lenfadenektomi ve/veya görüntüleme ile yapılmaktadır.

Lenf nodu diseksiyonunun cerrahi ve onkolojik amacı hastalığın yaygınlığının tespiti ve böylece tedaviyi planlayabilmektir. Metastatik hastalık içeren düğümlerin çıkarılmasının sağkalımı iyileştirdiği durumlarda lenfadenektomi terapötik bir özelliğe de sahip olabilir (2-5)

Jinekolojik kanser tanısı alan kadınlarda pelvik-paraaortik lenf nodu diseksiyonu 90'lardan bu yana gelişme göstermiştir. Her bir tümör için, diseksiyonun kapsamı (lenf nodu örneklemesine karşı tam lenfadenektomi) ve gerekli olan diseksiyonun anatomik seviyesi (yani, sadece pelvik veya pelvik-paraaortik) hala tartışmalı konulardır. Bu bölümde jinekolojik malignitelerde pelvik ve paraaortik lenfadenektomi teknikleri tartışılmaktadır.

ANATOMİ

1)Retroperitoneal Alan:

Retroperitoneal boşluk, transperitoneal insizyonla veya doğrudan ekstraperitoneal bir yaklaşımla erişilen potansiyel bir alandır. Böbrekler, üreterler, mesane, büyük damarlar, lenfatik kanallar, lenf düğümleri, sinirler ve kaslar peritonun altına ve gevşek areolar bağ dokusu içine yerleşmişlerdir. Retroperitonun anatomisi ve bu potansiyel boşlukları cerrahi olarak disseke edebilme becerisi, radikal jinekolojik cerrahiyi ve pelvik ve paraaortik lenf nodu diseksiyonunu büyük ölçüde kolaylaştırır. Pararektal ve paravezikal pelvik boşluklar ve alt karın retroperitonu, lenf nodlarının sınırlarını tanımlamak ve cerrahi diseksiyonu kolaylaştırmak için cerrah tarafından cerrahi sırasında gözlemlenmelidir.

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kendiliğinden düzelebilirler, ancak sekonder sonuçlar varsa (ağrı, lenfödem, hidronefroz, enfeksiyon), drenaj gerekebilir. Drene gelen sıvı miktarı birkaç hafta sonra yüksek olmaya (> 50 ila 100 mL / gün) devam ederse, doğrudan kistik koleksiyona alkol, iyot, doksisiklin veya talk damlatılmasıyla skleroterapi yapılabilir (54). Laparoskopik marsupializasyon da alternatif bir seçenektir (55).

Ameliyat sonrası dönemde çoğu hastada vajinadan lenfatik sıvı drenajı (lenfore) olabilir. Bu genellikle birkaç hafta içinde çözülür (56). Drenajda düzelme yoksa, bir vezikovajinal veya üreterovajinal fistül dışlanmalıdır.

Lenfatik fistül ve şilöz asit riski bildirilmiştir ancak oldukça nadirdir (57-64). Jinekolojik cerrahi sonrası şilöz assitler çoğunlukla paraaortik lenf nodu diseksiyonu sonrası ortaya çıkar. Genellikle konservatif tedavi ile düzelir, ancak dren yerleştirme, orta zincirli yağ asidi diyeti, somatostatin analogları veya cerrahi düzeltme gerekli olabilir.

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