BÖLÜM
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TİROİD CERRAHİSİ ÖNCESİNDE PREOPERATİF HAZIRLIK

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GİRİŞ

19. yüzyılın sonları ve 20. yüzyılın başlarında tiroidektomi %50 mortalite ve benzer oranda morbidite ile ilişkili idi. Bu nedenle tiroid cerrahisi barbarca kabul ediliyordu ve Fransız tıp derneğince yüksek mortalitesi nedeni ile yasaklanmıştı (1).

Aseptik teknik ve tiroid fizyolojisinin anlaşılması ile tiroid cerrahisi güvenli hale geldi. Theodor Kocher %1'lik mortalite elde ederek 1909 'da tiroid cerrahisini ilerletmesi nedeni ile Nobel Tıp ödülünü kazandı (1). Uygun endikasyon, hazırlık ve teknik ile günümüzün beklentilerini karşılayacak tiroid cerrahisi artık gerçekleştirilebilir durumdadır.

TİROİDEKTOMİ ENDİKASYONLARI

Tiroidektomi endikasyonları genel olarak lokal bası semptomları, kötü kozmetik görünüm, malignite riski ve hipertiroidi olarak ele alınabilir (2-4).

Benign Sitolojili Nodüller

Çoğu tiroid nodüllerinin ince iğne aspirasyon biyopsisi (İİAB) sonucu benigndir (Bethesda II). Yinede yutma zorluğu veya solunum sıkıntısı gibi belirgin lokal bası semptomları olan hastalarda tiroidektomi düşünülmelidir (2, 3).

Bethesda II olup progresif büyüme gösteren nodüllerde de tiroidektomi endikedir. Büyüme kriteri takip ultrasonografisinde ya en az iki düzlemde %20 artış ile en az 2 mm lik büyüme veya %50 den fazla hacimsel büyüme olmasıdır, bu hastalara İİAB tekrarı veya rezeksiyon önerilir (2).

Nodül boyutu ile ilgili kati sınır olmamakla birlikte genel görüş Bethesda II nodüllerin ≥3 veya ≥4 cm olması durumunda rezeksiyon düşünülmesi yönündedir (%5-22.8 oranında artmış malignite riski mevcuttur) (2).

Bethesda II nodüllü hastaların bir kısmı da kozmetik nedenlerle ameliyat olma talebinde bulunur (2, 3).

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