Bölüm 41

Preoperatif Değerlendirme

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Preoperatif değerlendirme ve hazırlık, jinekolojik operasyon geçirecek olan bir kadının cerrahi prosedürünü ve sonrasındaki iyileşme dönemini etkileyebilecek potansiyel durumları incelememizi sağlar. Postoperatif problemlerin birçoğu, preoperatif değerlendirme sırasında öngörülebilir ve doğru hazırlık ile en aza indirilebilir. Bu sayede daha az komplikasyon gelişmesi, hastanede kalış süresinin kısalması ve toplumsal sağlık giderlerinde tasarruf sağlanırken, hasta memnuniyeti de artmış olacaktır. Preoperatif değerlendirme sırasında cerrahın hastayla kuracağı ilişki, hastanın hekimine ve kuruma duyacağı güvenin sağlanmasında çok önemlidir. Değerlendirme muayenesinin ameliyat öncesi anksiyeteyi azalttığı hatta postoperatif ağrı ve hastanede yatış süresini kısalttığı bildirilmiştir. (Egbert,1963)

Preoperatif değerlendirme sürecinde hastanın bireysel ve aile öyküsü alınmalı, fizik muayenesi yapılmalı, gerekli tetkikler ve cerrahi planlama için gerekli ise görüntülemeler yapılmalı, aydınlatılmış onamı alınmalı, mevcut kronik hastalıkları ilgili branş hekimlerine konsülte edilmeli ve hasta anestezi uzmanı tarafından değerlendirilmelidir. Böylelikle gerekli önlemler preoperatif dönemde alınabilir, operasyon zamanındaki gecikme ve ertelemeler önlenebilir. Bu değerlendirme ile hastanın mevcut sağlık durumu daha iyi anlaşılmış olacağından, gerekirse hasta ile tedavi prosedürü üzerinde tekrar görüşülüp değişikliklere gidilmesi de söz konusu olabilir. Örneğin uterin prolapsus şikayeti ile gelen semptomatik konjestif kalp yetmezliği olan bir hastaya, vajinal histerektomi ve sakrospinöz fiksasyon yapmak yerine pesser uygulaması önerilebilir.

Hastanın öyküsü alınırken yaşı, kilosu, bilinen hastalıkları, kullandığı ilaçlar, ilaç alerjileri, daha önce cerrahi işlem geçirip geçirmediği, geçirdi ise herhangi bir komplikasyon gelişip gelişmediği, kendisinde ya da ailesinde anestezi ile ilgili komplikasyonlar yaşanıp yaşanmadığı, yine kendisi ya da ailesinde tromboemboli öyküsü ya da risk faktörü olup olmadığı sorgulanır. Örneğin malign hipertermi nadir bir anestezi komplikasyonu olmakla birlikte, otozomal dominant geçişli olduğu için kişinin aile öyküsünde irdelenmelidir. Bilinen veya şüpheli komorbiditeleri olan kadınlar, ameliyattan önce tanınmalı, perioperatif tedavi planı oluşturulması ve cerrahi prosedürün sorunsuz tamamlanabilmesi için ilgili birimlere konsülte edilmelidirler.

Günümüzde 65 yaş üzeri kadın sayısı ve dolayısıyla jinekolojik cerrahi ihtiyacı duyan ileri yaş kadın hasta sayısı da artmaktadır. 50.000 yaşlı erişkin hastanın dahil edildiği bir incelemede, elektif cerrahi ile ölüm riskinin 60 yaşın altındakiler için %1.3 iken, 80-89 yaş grubunda 11.3'e yükselmiş olduğu gözlenmiştir. (Linn,1982) Yaşlılığın getirdiği eşlikçi rahatsızlıkları ekarte edersek, yaşın perioperatif sonuçlar üzerindeki etkisinin aslında az olduğu görülür. Yaşla ilgili riskin çoğu bilişsel bozulma, fonksiyonel bozukluk, yetersiz beslenme ve frajiliteyi de içeren artan sayıda komorbiditelerden kaynaklanmaktadır. (Oresanya,2014) Yaş, tek başına cerrahi için bir kontrendikasyon değildir. Ameliyat olabilirlik konusundaki karar; hastanın genel sağlık durumu ve ek

mesi ile cildin sıyrılmasına ya da hafif bir basınçla hematom/ülser oluşumuna yol açacak kadar cilt dokusu ve yüzeyel damarların zayıflamasına neden olabilir. Enfeksiyon riskini arttırır, gastrointestinal ülser ve kanamalara neden olabilir, hiperglisemi, hipertansiyon, sıvı retansiyonu gibi yan etkilere yol açarak cerrahi başarıyı olumsuz yönde etkileyebilir. (Anstead,1998; Stuck,1989; Bollet,1955; Schiff,2003)

Perioperatif glukokortikoid dozu ayarlanırken hipotalamo-hipofizer-adrenal aksın suprese olup olmadığı ve planlanan cerrahinin büyüklüğü göz önünde bulundurulmalı; hastanın aldığı inhaler, topikal hatta intraartiküler uygulamalı kortikosteroid tedavilerinin de aksı baskılayabileceği unutulmamalıdır.

Sabah dozu olarak <5 mg/gün prednizon ve eşdeğerleri olan 4mg/gün metilprednizolon, 0.5 mg/gün deksametazon ya da 20mg/gün hidrokortizon alan hastaların; herhangi bir doz glukokortikoidi 3 haftadan kısa süredir alan hastaların ve günaşırı <10 mg prednizon veya eşdeğerini kullanan hastaların hipotalamo-hipofizer-adrenal aksı suprese olmamış kabul edilir ve bu hastalarda perioperatif steroid şemsiyesi uygulamasına gerek yoktur. Söz konusu hastalar perioperatif dönemde rutin günlük dozlarını almaya devam edebilirler. (Cooper,2003; Axelrod,2003; LaRochelle,1993; Harter,1963; Fauci,1978; Ackerman,1968) Daha uzun süreli ve yüksek dozlarda glukokortikoid kullanan, Cushingoid görünüme sahip olan, glukokortikoid tedavisi son 1 yıl içinde kesilmiş olan hastalar hipotalamo-hipofizer-adrenal aksın supresyon durumunun değerlendirilmesi için sabah serum kortizolü, ACTH stimülasyon testi gibi ileri tetkiklere ihtiyaç duyacaklardır. Ancak ondan sonra perioperatif steroid şemsiyesi ihtiyacı ve dozu belirlenebilir.

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