

SAFRA YOLU TÜMÖRLERİ

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GİRİŞ

Biliyer sistem tıkanıklıklarının bulgu ve semptomları yıllardır biliniyor olsa da safra yolu hastalıklarının tanı ve tedavisinde son yıllarda ciddi gelişmeler olmuştur. Tıbbın her dalında olduğu gibi, non-operatif ve daha az invazif yöntemler biliyer sistem hastalıklarının tanı ve tedavisinde çok daha sık ve etkili bir biçimde kullanılmaktadır. 1924'te oral kolesistografi ile safra yolu darlıklarına tanı konmaya başlanmış, 1950 yıllarında kolesintigrafi, endoskopik ya da transhepatik kolanjiografi ile safra yollarının görüntülenmesi kolaylaşmıştır. Bu gelişmeler safra anatomisinin ortaya konması, varyasyonların belirlenmesi ve safra ağacından kaynaklanan tıkaçıcı lezyonların tespit edilmesini sağlamıştır. Yakın zamanlarda ultrasonografi, bilgisayarlı tomografi, manyetik rezonans ve endoskopik ultrasonografi gibi yöntemler safra yollarının görüntülenmesini kolaylaştırmaktadır. Bu gelişmeler hızla devam etmekte ve birçok hastaya çok daha erken dönemde tanı konmasını sağlayarak yaşam konforunu artırmakta ve süresini uzatmaktadır.

ANATOMİ

Ekstrahepatik safra kanalları sağ hepatic kanal, sol hepatic kanal, ana safra kanalı, sistik kanal ve ana safra kanalından (koledok) oluşturmaktadır. Ka-

raciğerden gelen sağ ve sol hepatic kanallar birleşerek ana hepatic kanalı oluşturur. Sol hepatic kanal karaciğerin II, III ve IV. segmentlerinden gelen kanalları, sağ hepatic kanal ise karaciğerin VI, VII, VIII. segmentlerden gelen sağ anterior ve sağ posterior hepatic kanalların birleşmesi ile oluşur. Sol hepatic kanal 2 cm veya daha fazla ekstra hepatic seyir gösterirken sağ hepatic kanal kısa bir seyir izler. Genellikle portal ven birleşim yerinin önünde birleşerek ana hepatic kanalı oluştururlar. Ana hepatic kanal 1-4 cm uzunluğunda ve 4 mm genişliğindedir. Portal venin önünde yer alır. Sistik kanal ana hepatic kanalla birleşerek ana safra kanalını (koledok) oluşturur. Sistik kanalın boyu ve genişliği çok fazla çeşitlilik göstermektedir.

Ana safra kanalı yaklaşık 7-11 cm uzunluğunda 5-10 mm genişliğindedir. Hepatoduodenal ligamanın içinde aşağı doğru seyrederek duodenum 1. kısım posterolateralinde ilerler ve pankreas başı arkasında kıvrılarak duodenum 2. kısma girer. Burada genellikle pankreatik kanalla birleşerek duodenum duvarı içinde 1-2 cm ilerledikten sonra papilla ile (ampulla vateri) duodenum lümenine açılır. Burada kalın sirküler bir kas tabakası bulunur ve Oddi Sfinkteri adı verilir. Safranın ve pankreatik sıvının duodenuma akışını kontrol eder. Safra yollarının kanlanması gastroduodenal ve sağ hepatic arterden sağlanır (1).

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ludur fakat sağ kalım üzerinde anlamlı etkiye sahip değildir. Stent sayısı ve stent tipi tümörün anatomik yerleşimine göre ve beklenen sağ kalım süresine göre bireyselleştirilmelidir. Stent yerleştirilirken endoskopik veya perkutan yol kullanılabilir. Hem plastik hemde metalik stentler kolanjiyokarsinomlu hastalarda başarı ile kullanılmıştır. Metalik ve plastik stentlerin kullanımını karşılaştıran birçok çalışma yapılmıştır (139). Plastik stentler daha küçük çapa sahiptirler ve kolaylıkla tıkanabilirler. Bu nedenle yaklaşık 3 ayda bir değiştirilmeleri gerekir. Oysa metalik stentler daha geniş çapa sahiptirler ve daha uzun süreli biliyer drenaj sağlarlar. Hastanın yaşam beklentisi 6 aydan daha fazla ise metalik stent daha uygun bir seçimdir. Çünkü bu hastalarda metalik stent daha az süre hastanede kalma ve daha düşük maliyet sağlamaktadır. Metalik stentler tıkanıklarında lümen içerisinden yeni metalik ya da plastik stent takılmasına olanak sağlarlar (140).

FOTODİNAMİK TEDAVİ

Fotodinamik tedavi malign obstrüksiyonlu hastalarda sarılığın palyasyonunda kullanılmıştır. Serum bilirubininde anlamlı azalmalar ve performans skorunda düzelmeler görülmüştür. Ancak halen deneyselemdir ve işlem oldukça pahalıdır. Fotodinamik tedavinin faydasının tespiti için daha geniş ve kontrollü çalışmalara ihtiyaç vardır (128,141) Fotodinamik tedavi porfiryası olanlar, dematotoksik ilaç kullananlar, yerleştirilmiş kaplı metalik stenti olanlar, ciddi hepatik ya da böbrek yetmezliği olanlar, peritoneal karsinomatosisliler, biliyer ampiyemi ve karaciğer apsesi olanlarda kontrendikedir.

Sonuç

Safra yolu tümörleri tanı ve tedavisi özellik arzeden ve nadir görülen lezyonlardır. En sık görülen benign tümörleri adenom, papillom ve leiomyomlardır.

Kolanjiokarsinomlar ise ekstrahepatik veya intrahepatik safra duktuslarının herhangi bir yerinden köken alan malign tümörlerdir. Kolanjiokarsinomlar için risk faktörlerinin çoğu enfeksiyon, biliyer staz ve karsinogenler ile ilişkilendirilmiştir. Kolanjiokarsinomların klinik prezentasyonu tümörün lokalizasyonuna bağlı olup hastalar genel-

likle karın ağrısı, ağrısız sarılık, kaşıntı ve koyu renkli idrar şikayetleri ile başvururlar. Tanıda en sık başvurulan görüntüleme methodları MRI ve MRCP' dir. Cerrahi tedavi kolanjiokarsinomu olan hastalar için tek küratif tedavi metodudur. Cerrahi tedavinin başarısı tümörün biliyer sistemdeki lokalizasyonuna ve yayılımına bağlıdır.

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