

BÖLÜM

21

PARATİROID CERRAHİSİ

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Giriş

Paratiroid bezinin varlığının, fonksiyonlarının ve hastalıklarının fark edilmesi ve tedavi protokollerinin oluşturulması yüzyıllarca süren zorlu bir süreç sonrasında gerçekleşebilmiştir. İlk kez 1850'de Sir Richard Owen tarafından bir gergedanın otropsisiyle tiroid bezine bağlı bir doku olarak tanımlanmış olsa da muhtemelen bazen gözle fark edilemeyecek kadar küçük ancak fonksiyonel olarak yaşamsal öneme sahip paratiroid bezinin varlığına inanmak bilim tarafından kabulü oldukça sancılı bir süreç sonrasında gerçekleşebilmiştir(1). Şöyled ki, henüz bir tıp öğrencisi iken hayvanlarda paratiroid bezinin varlığını fark etmiş olan Ivar Victor Sandström daha sonra insanlarda yaptığı anatomiç çalışmalar sonucunda tiroid bezinin çevresindeki vaskülerize küçük bezleri fark etmiş ve bunları 'glandulae parathyroidea' olarak adlandırarak paratiroid bezinin isim babası olmuştur(2). Ancak Sandström'ün bu çalışması meslektaşları arasında yankı bulamamış ve konu ile ilgili makalesi birçok dergi tarafından

reddedilmiştir. Uzunca uğraştan sonra Sandström makalesini kendi ana dilinde yayınlayıabilmiştir. Belki de keşfinin kabul edilmemesi nedeniyle 37 yaşında intihar etmiştir. Bu yaşam öyküsü 'Ivar Sandström için zafer ve trajedi' olarak literatürde yerini almıştır(3).

Keşfedilen son endokrin bezleri olan paratiroid bezlerinin hastalıklarının tanı ve tedavisi ile ilgili çalışmalarıyla mihenk taşı olan birçok araştırmacı sıralanabilir. Ancak bu bölümün konusu ile ilgili öncelikle zikredilmesi gereken iki isim bulunmaktadır. İnsanda paratiroid cerrahisine 1925 yılına kadar hiçbir cerrah cesaret edemedi. İnsanda ilk paratiroid cerrahisi denemesi bir Kulak Burun Boğaz Uzmanı olan Oscar Hirsch tarafından 1925 yılında, Viyana'da, von Recklinghausen Hastalığı olan bir hastaya paratiroidektomi (PTx) yaklaşımlarından ilki olan bilateral boyun eksplorasyonu (BBE) şeklinde uygulandı ancak paratiroid bulunamadı. İlk başarılı paratiroid cerrahisi ise aynı yıl Oscar Hirsch'ten sonra, aynı şehirde, aynı hastalığı olan bir başka hastaya

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mi kazanmış bez veya bezlerin tamamen çıkarılması, SHPT'de ise hiperplazik ve hiperaktif bütün bezlerin çıkarılıp normal PTH salgılayacak kadar bir bez kısmının bırakılması/ototransplantasyonu tedavi edicidir. Preoperatif radyolojik ve sintigrafik yöntemlerle tespit edilen adenomların bulunması ve çıkarılması, cerrahın tecrübeşine bağlı olarak, önemli bir zorluk göstermez. Preoperatif lokalizasyon tespit çalışmaları sonuçsuz ise ve cerrahi endikasyon kesin ise; ektopik ve inmemiş PTH bez lokalizasyonlarını da eksplorasyon edecek ve gereklirse BBE yapacak şekilde cerrahi planlama yapılmalıdır. SHPT cerrahisinde ise postoperatif kalıcı hipokalsemiyi önleyecek şekilde cerrahi uygulanmalı; total PTx (4 bez) ve ototransplantasyon veya subtotal (3/4 bez) PTx dikkatli bir şekilde gerçekleştirilmelidir. Bu cerrahiler sırasında RLS hasarından kaçınılacak her türlü tedbir alın-

meli, mümkün olan en az diseksiyon ve eksplorasyonla hedef dokular çıkarılmalıdır. Rekürren cerrahilerde olası komplikasyon oranlarının artacağı unutulmamalıdır. Komplikasyonsuz ve başarılı bir HPT cerrahisi için cerrahın tecrübesinin yanısıra endokrinolog, nükleer tıp ve radyoloji hekimlerinin tecrübeşesi ve multidisipliner anlayışla ve mümkünse konsey yaparak çalışılması çok önemlidir. Cerrahın uygulayacağı cerrahi yöntem ise yine tecrübe ve mevcut teknolojik imkanlarla göre farklılıklar gösterebilir. Burada önemli olan, yöntemden çok başarılı bir HPT cerrahisini komplikasyonsuz gerçekleştirebilmektedir.

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