

PARATİROİD HASTALIKLARININ CERRAHİ DIŐI ABLASYON TEDAVİLERİ

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Giriş

Primer hiperparatiroidinin (PHPT) küratif tedavisi, patolojik paratiroid dokusunun cerrahi olarak çıkarılmasıdır (1). Ameliyat endikasyonlarını karşılayan hastalara öncelikli olarak paratiroidektomi önerilir. Ameliyat iki taraflı boyun eksplozasyonu, minimal invaziv cerrahi veya robotik/endoskopik yaklaşımlar gibi çeşitli yöntemlerle yapılabilmektedir. Deneyimli bir paratiroid cerrahı tarafından yapıldığında hastaların %95-98'inde küratifdir (2). Cerrahi; hemoraji, yara enfeksiyonları, rekürren laringeal sinir (RLN) hasarı, persistan hipoparatiroidi ve hipokalsemi gibi komplikasyonlara neden olabileceğinden yüksek riskli bir işlemdir (3). Gelişmiş cerrahi tekniklere rağmen cerrahi tedaviyi reddeden ya da ameliyat için uygun olmayan hastalar vardır veya bazı hastalarda cerrahi başarısız olabilmektedir (4,5). Maalesef en tecrübeli ellerde bile persistan PHPT hastaların %4.7'sinde görülebilir (6). Bu nedenlerle cerrahi tedaviye alternatif tedaviler araştırılmıştır. Medikal tedaviler etkili olabilir, ancak genellikle uzun süreli kalıcı hiperkalsemi kontrolüne yol açmaz ve ömür boyu tedavi gerektirir (7).

Alkol ablasyonu (EA), 1980'lerde ilk yayınlanan çalışmalarla birlikte uzun süredir kronik böbrek yetmezlikli ve sekonder HPT'li (SHPT) hastalarda, paratiroid hiperplazisinin sklerotapisinde kullanılmaktadır (8,9). EA, nonfonksiyone semptomatik paratiroid kistlerinin (PK) tedavisinde, aspirasyon sonrası rekürrens gelişen hastalarda tiroid kistleriyle benzer şekilde etkilidir. PHPT tedavisi için ilk kullanılan görüntü eşliğinde minimal invaziv tedavi seçeneği alkolle kimyasal ablasyondur (10). Ancak alkol enjeksiyonunun başarı oranının, paratiroid tümörünün boyutu ve takip süresi ile ters orantılı olduğu, ağrı, vokal kord hasarı ve sonrasında gerekebilecek bir operasyon için sıkıntı oluşturacak çevre dokuda fibrozis yaptığı anlaşılınca bu yaklaşımdan uzaklaşmıştır (8,11,12).

Termal ablasyon yöntemleri önemli minimal invaziv tedavi seçeneklerini oluşturur ve cerrahi dışı ablasyon seçeneklerini oldukça genişletmiştir. Karaciğer tümörlerinde, böbrek tümörlerinde ve tiroid nodüllerinde etkili ve güvenli bir tedavi olduğu kanıtlanmış, cerrahinin alternatifi olmuştur (13-15). Şimdiye kadar, mikrodalga ablasyon,

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hastalarda anjiyografik paratiroid ablasyonundan kaçınılmalıdır. Nörolojik komplikasyonların çoğu 1980 öncesinde gelişmiştir. O zamandan beri teknoloji daha iyidir, subselektif enjeksiyonlara izin veren daha fleksibl kataterler geliştirilmiştir. Böylece teorik olarak diğer yapılara zarar verme riski azalmıştır. Pallotta ve ark., 17 kişilik boyun serilerinde 4 komplikasyon gözlemlemiştir (144). Birindeki ses kısıklığı recurren laringeal sinirin tutulumuna bağlıdır. Süperior ve inferior tiroid arterleriyle beslenen boyun bezlerinin ablasyonunun sinir hasarı yapabilme ihtimali nedeniyle boyun bezlerinde anjiyografik ablasyon tedavisi NIH'de yasaklanmıştır. Alkol enjekte edildiği herhangi bir vasküler yatakta infarkta neden olur, bu nedenle kontrast maddede görülmeyen ek risklere neden olabilir. Vagus ve frenik sinirlerde kontrast maddeyle görülebilen geçici bozukluklar embolik ajan olarak alkol kullanılırsa kalıcı olabilir ve mediastende bile kullanılmasından kaçınılmalıdır.

Kronik postablasyon hipoparatiroidi bilinen tek kronik komplikasyondur ve %6-11 sıklığında rastlanmaktadır (143, 145). Re-opere olmuş hastalarda tüm ablasyon işlemleri kalıcı hipokalsemi riski taşır. Hasta zaten paratiroid eksplorasyonundan bir kez geçtiyse, kalan paratiroid bezlerinin sayısı ve kanlanmalarının yeterliliği nadiren biline-

bilir. Ablasyon işleminde otogreftleme için hiçbir doku çıkarılmadığından, geriye kalan tek işleyen bezin ablasyonu, geri dönüşü olmayan hipoparatiroidizme neden olacaktır. NIH serisinde bu, 24 hastanın 2'sinde (%8) meydana gelmiştir (143), ototransplantasyon olmaksızın paratiroid reoperasyonu olanlarda bulunan %0-29 insidansından önemli ölçüde daha azdır (165). Cerrahideki insidansın geniş bir aralıkta yayılması, cerrahın bezin bir kısmını ototransplantasyon yapabilme ihtimali olmasındandır, radyoloğun bu ihtimali yoktur. Geri kalan paratiroid bezlerinin sayısı ve kanlanmalarının yeterliliği, daha önce ameliyat geçirmiş hastalarda nadiren bilinebildiğinden, bu komplikasyonun ortaya çıkışını tahmin etmek çoğu zaman imkansızdır. Bununla birlikte, ablasyon düşünüldüğünde, rezeke edildiği veya biyopsiye tabi olduğu bilinen bezlerin sayısı dikkate alınmalıdır. Üç bezin çıkarıldığı biliniyorsa, anjiyografik ablasyon sonrası hipoparatiroidizm riski çok yüksektir. Ablasyon sıklıkla en az bir kez başarısız paratiroid eksplorasyonu yapılmış hastalarda önerilmektedir. Bununla birlikte, 3 veya daha fazla bezin rezeke edildiği biliniyorsa, öncelikli olarak cerrahinin yapılması, sonrasında ototransplantasyon ihtimali nedeniyle rezeke edilmiş bezin kriyoprezervasyonu önerilmektedir.

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