

# BÖLÜM 33

## Primer ve Sekonder Biliyer Fistüllerde Tomografinin Kullanımı

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### GİRİŞ

Safra fistülleri safra taşının nadir görülen komplikasyonlarıdır. Safra yollarını veya gastrointestinal sistemi etkileyebilirler ve genellikle birincil veya ikincil olarak sınıflandırılırlar. Birincil fistüller safra taşları ile ilişkilidir, ikinciller ise cerrahi komplikasyonlarla ilişkilidir(1).

Karaciğerden safra drenajı sol ve sağ hepatik kanallar ile gerçekleştirilir, bu ikisinin birleşmesinden ortak hepatik kanal oluşur. Safra kesesi içinde biriken safrayı boşaltan sistik kanal ile birleşerek ortak biliyer kanalı oluştururlar. Sistik kanalın ortak hepatik kanala katıldığı noktaya bağlı olarak ortak biliyer kanalın uzunluğu 5 cm ila 15 cm arasında değişmektedir. Koledokun normal çapı 6 mm'dir ve 60 yaşından sonraki her on yıllık yaşam için 1 mm daha eklenir(2,3)

Koledok daha sonra duodenumun ve pankreas başının arkasına doğru ilerler ve duodenumun ikinci kısmına açılan Vater'in ampullasını oluşturmak için ana pankreas kanalına katılır. Drenajı Oddi'nin sfinkteri kontrol eder(4).

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**Resim 3.** Abdomen BT aksiyal kesitte safra kesesindeki hava ok ile gösterilmiştir.

Diğer tanısal testler manyetik rezonans kolanjiyografi (MRCP) ve hepatobiliary iminodiacetic acid (HIDA) taramasını içerir. HIDA MRCP'ye oranla kaçağa daha duyarlıdır ve nükleer maddenin lümen dışına taşmasını ortaya koyar. HIDA varlığı ortaya konmuş bilomada aktif sızıntıyı takip etme amacıyla kullanılabilir. MRCP yaralanma öncesi ve sonrası anatomiye ortaya koymada çok etkilidir. Manyetik rezonans görüntüleri eşlik eden vasküler yaralanmayı ortaya koymada etkilidir. ERCP, hem tanısaldır hem de stent yerleştirmek ve biliyer ağaçtaki basıncı azaltmak yoluyla tedavi edicidir. Obstrüksiyona neden olan ana hepatik kanal hasarına bağlı kolanjiti olan bir hastada acil PTK (perkütan transhepatik kolanjiyografi) hem tedavi edicidir hem de anatomiye ortaya koymada faydalıdır (38).

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