BÖLÜM 14

NÖROABLATİF TEKNİKLER

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ÖZET

Kanser ile ilişkili ağrı primer patolojiye, metastaz veya tedavi yan etkilerine bağlı gelişmektedir. Kanser ağrısı, kişilerin fiziksel, psikolojik ve sosyal durumunu ciddi şekilde etkilemektedir. Medikal tedavinin tolere edilememesi veya yeterli ağrı kontrolü sağlanamadığı durumlarda girişimsel ağrı tedavileri uygulanmaktadır. Sinir blokları gibi konvansiyonel tedaviler ile etkin ağrı palyasyonunun sağlanamaması durumunda ise nöroablatif tedaviler gündeme gelmektedir. Nöroablatif tedavilerde amaç ağrı yolaklarını kesintiye uğratmaktır. Kanserin ve ağrının lokalizasyonuna göre intrakranial, medulla spinalis, sempatik ve parasempatik ganglionlar ile periferik sinirlerde nörolitik veya ablatif yöntemler uygulanabilir. Nöroablatif uygulamalar ciddi komplikasyonlara neden olabileceğinden uygun koşullarda, alanında yetkin, tecrübeli hekimler tarafından uygulanmalıdır.

GİRİŞ

Üç aydan uzun süren, tedavisi zor, oldukça büyük bir popülasyonu etkileyen ve dünya çapında engelliliğin önde gelen bir nedeni olan kronik ağrı olgularının önemli bir kısmını kanser ilişkili ağrı olguları oluşturmaktadır (1). Ağrı tedavisindeki tüm gelişmelere rağmen, henüz tatmin edici bir şekilde tedavi sağlandığını söylemek güçtür (2). Özellikle kanser hastalarında kitleye bağlı sinir kompresyonları, kemik metastazları ve kırıklarının neden olduğu ağrının medikal tedavi ile palyasyonu oldukça güç olabilmekte ve bu durumda girişimsel ağrı tedavi teknikleri uygun hastalarda alternatif tedavi seçeneği olabilmektedir (3, 4). Dünya Sağlık Örgütü kanser hastalarında basamak tedavisini önermektedir (5). Bu tedavi algoritmasına göre birinci basamakta basit analjezikler, ikinci basamakta birinci basamağa ek zayıf opoidler ve üçüncü basamakta da güçlü opoidlerin eklenmesi önerilir. Ayrıca herhangi bir basamakta adjuvan ajanların da eklenebileceği belirtilmektedir. Ancak çalışmalar, kanser ağrısının tedavisinde %20-40 olguda analjezik basamak tedavisi ile yeterince etkinlik sağlanamadığını gös-

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%60-80 solüsyon olarak uygulanır. Bu yüksek konsantrasyonlarda kan dolaşımına hızla emilir ve sedasyona veya disülfiram benzeri reaksiyona neden olabilir. Ayrıca enjeksiyon sırasında yanma vasfında ağrı yakınmasın neden olur, bu nedenle etil alkol enjeksiyonundan önce lokal anestezik uygulanmalıdır. Fenol, gecikmiş nöroliz sağlar (15 dakika) ve ticari olarak mevcut olmayan ve eczacı tarafından ayrı ayrı birleştirilmesi gereken %4-10'luk çözeltiler hâlinde steril su ile hazırlanmalıdır. Fenol zayıf lokal anestezik etkilidir (156).

Sonuç olarak kanser ağrı tedavisinde tüm nöroablatif prosedürlerde altın standart uygun hasta seçimidir. Bu uygunlukta da konvansiyonel tedavi seçeneklerinin etkisiz olduğu veya yan etkiler nedeni ile uygulanmadığının teyidi önemlidir. Uygun hasta seçimi sonrası uygulama muhakkak uygulama tekniği, görüntüleme kılavuzluğu ve komplikasyonlara hakim, tecrübeli ve gerekli eğitimi almış, yetkin uzman hekimler tarafından gerçekleştirilmelidir.

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