

SEMPATİK BLOKLAR

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ÖZET

Kanser ağrısı; tümörün çevresine verdiği doğrudan zarara, oluşan organ disfonksiyonuna veya kanser tedavisinin komplikasyonlarına bağlı olarak ortaya çıkabilir. Kanser ağrısına yönelik girişimsel algolojik tedaviler söz konusu olduğunda akla ilk gelenlerden biri de sempatik bloklardır. Presinaptik sempatik sinirlere ait hücre gövdeleri medulla spinalisin T1-L2 segmentleri arasındaki intermediolateral kolonda bulunmaktadır ve bu sinirler paravertebral ganglionlarda sinaps yapmaktadır. Paravertebral ganglionlar vertebral kolon boyunca kranialden kaudale uzanan sempatik zinciri oluşturmaktadır ve torakal, abdominal ve pelvik iç organlardan kaynaklanan ağrılı uyaranlar bu sempatik ganglionlar üzerinden medulla spinalise iletilmektedir. Dolayısıyla visseral organlardan kaynaklanan kanser ağrısının tedavisinde; baş-boyun-üst ekstremiteler için stellat ganglion, torakal-mediastinal yapılar için torakal sempatik ganglion, batin bölgesi için çölyak plexus veya splanchnik sinirler, pelvis bölgesi için superior hipogastrik plexus, perine ve yakın yapılar için impar ganglionu bloğu etkili olabilmektedir. Sempatik bloklar sonrasında ağrı dışı sempatik fonksiyonlardaki geçici veya kalıcı kayıplara bağlı hipotansiyon, diyare gibi konularda dikkatli olunmalıdır. Genel yaklaşım öncelikle ilgili olduğu düşünülen sempatik ganglion veya sinirlere diagnostik amaçlı lokal anestezi blok uygulamak ve elde edilen olumlu-olumsuz sonuçları gözönünde bulundurarak sempatik yapılara kalıcı (destruktif) girişim yapılmasına karar vermek şeklinde olmaktadır. Sempatik bloklar ciddi komplikasyonlara neden olabilecek girişimsel işlemler olup yeterli bilgi ve deneyime sahip algoloji uzmanlarınca, resusitasyon geçişlerinin hazır tutulduğu bir ortamda, tam monitorizasyon ve sedoanaljezi altında, hipovolemiyi engelleyecek yeterli sıvı hidrasyonunun sağlanması ön koşuluyla uygulanmalıdır.

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Floroskopi Eşliğinde İmpar Ganglion Bloğu

İmpar ganglion anatomik olarak anokoksigeal ligament yoluyla, sakrokoksigeal veya intrakoksigeal eklemi geçerek ayrıca parakoksigeal yaklaşım (koksiksin sağ veya solundan) ile ulaşılabilir. Bu nedenle İGB'da birçok teknik tanımlanmıştır (transdiskal, transkoksigeal, transartiküler, intrakoksigeal ve parakoksigeal teknik) (89-95). Burada transdiskal teknikten bahsedilecektir.

Transdiskal teknik

Hasta yüzüstü yatırılır, batın yastık ile desteklenir. C-kollu lateral pozisyonda iken sakrokoksigeal, koksigeal eklemler ve disk aralıkları saptanır. İğne seçilen disk aralığında yavaşça ilerletilir, disk geçildiğinde durulur. İğne ucu prekoksigeal boşlukta koksik ön duvarının hemen arkasındadır. Kontrast madde verilir, prekoksigeal alanda düz bir çizgi halinde dağılmalıdır (Şekil 8). Ardından lokal anestezi ve steroid karışımı verilir. İmpar ganglion nörolizi için nörolitik solüsyon enjekte edilir. İğne serum fizyolojik ile yıkandıktan sonra geri çekilir (96).



Şekil 9. Floroskopi eşliğinde impar ganglion bloğu

Komplikasyonlar

Enfeksiyon ve fistül oluşumu: Bağışıklığı baskılanmış veya perine radyasyon tedavisi almış hastalarda dikkat edilmelidir.

Rektal ponksiyon/perforasyon

Sakral sinir kökü hasarı/ Kauda equina sendromu

İntravasküler enjeksiyon (96)

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