BÖLÜM 30

DİSTAL PANKREATEKTOMİ

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GİRİŞ

Distal pankreatektomi (DP) terimi pankreas gövde ve kuyruğunu içine alan lezyon ve hastalığa göre splenektomiyi de içerebilen bir ameliyat tekniğidir. 1884 yılındaki gövde ve kuyruk rezeksiyonu yapılan ilk vakadan bu yana gövde ve kuyruk lezyonlarının tedavisinde standart cerrahi girişim olarak kabul görmüştür (1). Teknolojideki ilerlemeler sonucunda laparotomiden, laparoskopik günümüzde ise robotik pankreatektomiye ilerleyen devrim niteliğinde değişimler olmuştur (2). Distal pankreatektomide çıkarılması gerekmiyorsa dalağın korunması önemli bir noktadır. Postoperatif pankreatik fistül (POPF) önemli bir sorun olarak halen değerini korumaktadır. POPF insidansı % 10-30 dur (3). Cerrahi teknik, yumuşak veya normal pankreas, pankreas kalınlığı, yaş, obezite ve genişletilmiş lenfadenektomi gibi faktörler hastaları PF gelişimine yatkın hale getirdiği rapor edilmiştir (4).

DİSTAL PANKREATEKTOMİ ENDİKASYONLARI

» Gövde ve kuyruk lezyonları (benign tümörler, nöroendokrin tümörler, pankreasın kistik lezyonları, psödokistler, pankreas gövde ve kuyruk premalign lezyonları)
» Maligniteler (primer adenokanserler, malign musinöz tümörler, malign nöroendokrin tümörler ve pankreas kuyruktaki metastatik malign kitller); burada minimal invaziv cerrahi için hasta seçimi önemli, tümör invazyonu laparoskopi ya da robotik cerrahiye izin vermeyebilir, bu konu tartışmalıdır, diğer lezyonlar da olduğu gibi minimal invaziv cerrahi uygulanabilir ya da hasta seçimi önemlidir gibi görüş ayrılıkları mevcuttur. Tümör, etraf dokuya invazyonu ve hastanın değerlendirilmesi sonrası uygulanması gerektiğini biz de savunmaktayız.
» Kronik pankreatit
» Pankreas travması ya da hasarı
» Pankreas gövdesi ve kuyrukta yer alan arteriovenöz malformasyonlar için de distal pankreatektomi endikedir (5).

AMELİYAT HAZIRLIĞI

Preoperatif değerlendirme, ASA skoru ve Anestezi değerlendirmesi, splenektomi planlandı ise ameliyattan 15 gün önce kapsüllü mikroorganizmalara karşı koruyucu aşıların yapılması, ameliyat öncesi barsak temziliği, ameliyat öncesi profilaktik antibiotik uygulanması dikkat edilmesi

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patoPankretaobilier Derneği (İHPBA) tarafından Brezilya Sao Paulo da yapılmıştır. Gözlemsel ve vaka karşılaştırmalı çalışma sayısı fazla olmasına rağmen randomize çalışma yokluğu kesin kanıt elde edilmesinin önündeki engeldir. Ancak gözlemler Minimal invazif distal pankreatektomi (MİDP) nin açık cerrahi ile karşılaştırarak avantajlarını (daha hızlı iyileşme, daha az hastanede kalış, daha az kan kaybı) ve benzer klinik sonuçlarını ortaya koymaktadır. İki minimal invaziv teknik karşılaştırıldığında ise yani laparoskopi ve robot yardımlı teknik; görüldü ki kan kaybı ve açık cerrahiye dönüş robot grubunda daha düşüktü, ancak tekrar hastane başvurusu robot grubunda daha fazla, POPF dahil diğer komplikasyonlar ise hem robot hem laparoskopi gruplarında benzerdi.

POSTOPERATİF BAKIM

- Kan ve idrar şekeri izlenir, bazı hastalarda postoperatif insüline bağımlı diabet gelişebilir, bu preoperatif dönemde hastaya anlatılmalıdır.
- Postoperatif pankreatit için amilaz, lipaz değerleri ve klinik ve fizik muayene bulguları gözönünde bulundurulmalıdır.
- Postoperatif trombositoz için trombosit sayımı yapılmalı.
- Nazogastrik drenaj; özellikle gecikmiş gastrik boşalım gelişen hastalarda.
- Drenler, drenlerin çalışıtığından emin olunup gelen tamamen kesildiğinde çekilmelidir.

SONUÇ

Minimal invaziv cerrahi (Laparoskopik ve robotik cerrahi), bu konuda da açık cerrahiye üstünlük göstermiştir. En blok rezeksiyon için RAMPS, Appleby ve DP-CAR gibi prosedürler geliştirilmiştir. Dalak koruyucu prosedürler prognozu iyileştirebilir. Pankreatik güdük yönetimi üzerinde durulması gereken en önemli noktadır. Çoğu retrospektif bilgilere dayanan bu teknikte daha çok prospektif ve randomize çalışmalara ihtiyaç vardır.

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