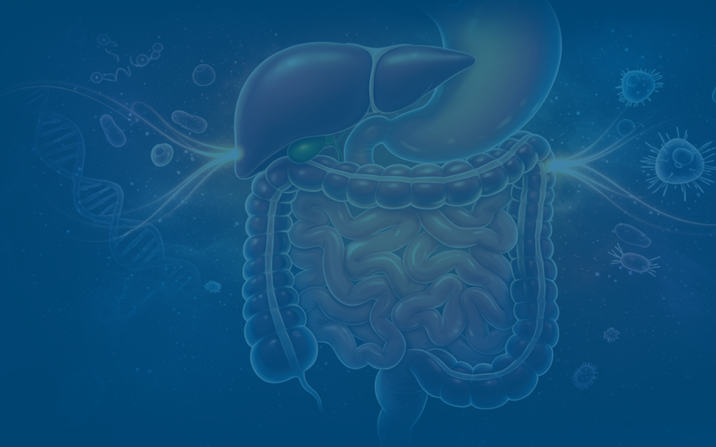




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GİRİŞ

İnsanda ilk karaciğer nakli (KN), 1963 yılında Amerika Birleşik Devletleri (ABD)'nde Thomas Starzl ve ekibi tarafından gerçekleştirilmiştir, fakat başarılı olunamamıştır. Bir yıl sonra 1967'de yine Starzl ve ekibi tarafından ilk başarılı KN gerçekleştirilmiştir. Avrupa'da ilk ortotopik KN ise 1968 yılında Cambridge'de Roy Calne ve ekibi tarafından gerçekleştirilmiştir. Ülkemizde ilk başarılı KN ise 1988 yılında Prof. Dr. Mehmet Haberal ve ekibi tarafından gerçekleştirilmiş kadaverik KN'dir (1-5). Cerrahi tekniklerdeki ilerlemeler, operasyon sonrası yoğun bakım takiplerindeki gelişmeler ve yeni geliştirilen immünsüpresif ilaçlar gibi olumlu faktörler sayesinde; nakil yapılan hasta sayısı ve nakil yapılabilen merkez sayısı artmış, greft ve hasta sağkalım süresi giderek uzamıştır. Dünyada yakın zamana kadar 80000'den fazla KN yapılmış olup, akut ve kronik karaciğer yetmezliği için en efektif tedavi seçeneği haline gelmiştir (5,6). Nakil sonrası hayatta kalma oranları son yıllarda önemli ölçüde artmış olup; 1 ve 10 yıllık sağ kalım sırasıyla %96 ve %71 oranlarına ulaşmıştır (7). Bu büyük başarı; yeni immünsüpresif ajanların bulunması ile greftin çok yönlü korunması, cerrahi tekniklerdeki gelişmeler ve nakil sonrası komplikasyonların erken tanı ve tedavisindeki birçok gelişmeye bağla-

nabilir (8). Bu başarıların bir sonucu olarak nakil endikasyonları genişletilmiş ve bu da nakledilebilir greftlere olan talebin artmasına ve dramatik bir donör/organ yetmezliğine yol açmıştır. Bu nedenle, nakil bekleyen hastaların karşı karşıya kaldığı bu önemli zorluğu aşmak ve bekleme listesindeki hasta ölüm oranını en aza indirmek için donör havuzunu genişletmek önemli bir hedef haline almıştır (9). Öte yandan sayıları hızla artan nakilli hastaların ameliyattan sonra hayatta kalma oranı ve ortalama yaşam süresi de artmakta olup, bu durumun uzun vadeli sonuçları, farklı klinik komplikasyonlar, immünsüpresif tedavinin doğrudan ve dolaylı yan etkileri klinisyenler için ayrı bir sorun haline gelmiştir. Her ne kadar dünya çapında 2020 ve 2021 yıllarında yüzden fazla ülkede en az bir KN gerçekleştirilmiş olsa da, hayatı tehdit eden karaciğer hastalığı olan hastaların çoğunun nakle erişimi sınırlıdır (10). ABD'de, KN'e sınırlı erişimin nedenleri; siyah ırk, yoksulluk, kırsalda yaşamak, yetersiz sağlık bilinci ve sağlık sigortası eksikliği ile ilişkilendirilmiştir. KN, çoğu karaciğer hastalığının başlangıç veya ilk tedavi yöntemi olmasa da, akut karaciğer yetmezliği (AKY), son dönem karaciğer hastalığı ve primer karaciğer malignitesi olan hastalar için en etkili tedavi seçeneğidir. KN nadiren altta yatan hastalığı iyileştirir; nakilden

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birlikte, uzun dönem hasta ve greft sağ kalım oranları da artmaktadır. Bu başarıda; etkili immünsüpresif ajanların varlığı, nakil öncesi donör ve hastanın kapsamlı değerlendirilmesi, nakil sonrası etkin yoğun bakım takipleri ve sonrasında yakın klinik takip ile komplikasyonların erken tanı ve tedavisindeki birçok gelişme önemli faktörlerdir. KN, bu nedenlerle mutidisipliner tıbbi birimlerin bulunduğu, organ naklinde deneyimli merkezler tarafından yapılmalıdır. Keza nakil sonrası oluşabilecek belli başlı önemli komplikasyonlar olan; greft rejeksiyonlarının, immünsüpresif ilaç yan etkilerinin, vasküler komplikasyonların, safra yollarında ve anastomoz alanlarında oluşacak tıkanıklık ve kaçakların medikal, endoskopik, girişimsel veya cerrahi tedavileri bu konuda tecrübeli tıbbi ekiplerce yapılabilir. Gelecekte daha az toksik immünsüpresif ilaçların bulunması, cerrahi, endoskopik ve girişimsel tanı ve tedavilerdeki gelişmeler nakil sonrası greft ve hasta sağ kalımını daha da artırabilir. Bu tüm gelişmelere rağmen, beklenen ortalama yaşam süresi artan, ancak doğurganlığın azaldığı batı ülkelerinde ve ülkemizde artan greft ihtiyacına yönelik, kadaverik organ bağışının artırılması ve canlı donör sayısının azaltılmasına yönelik çalışmalar yapılması önemli bir başka hedef olmalıdır.

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