BÖLÜM 7

BARİATRİK CERRAHİ SONRASI GEBELİK YÖNETİMİ

Şebnem KARAGÜN [1]

GİRİŞ

Obezite global bir salgın olarak katlanarak artmaktadır. Dünya Sağlık Örgütü'nün 2016 yılı verilerine göre kadın populasyonun %40'ında vücut kitle indeksinin (BMI) 25 ve üzerinde, aşırı kilolu olduğu bildirilmiştir (1). Aynı yılda BMI' ın 30 ve üzerinde olması olarak tanımlanan obezite sıklığı kadınlarda %15 olarak raporlanmıştır ki obezite sıklığı erkek cinsiyette %11'dir (1).Yalnızca kozmetik bir problem olmayan obezite, diabetes mellitus, hipertansiyon, aterosklerotik kalp hastalıkları, dislipidemi, nonalkolik yağlı karaciğer, astım ve bazı kanserlerin de aralarında bulunduğu pek çok komorbiditeye neden olmaktadır (2). Üreme çağındaki kadınlarda obezite hipotalama - hipofiz – ovaryan (HHO) aks bozuklukları üzerinden anovulasyona, kronik düşük dereceli inflamasyon oluşturak implantasyon bozukları ile infertilite ve abortusa neden olabilmektedir (3). Gebelik öncesi ve gebelikte artmış BMI, gestasyonel hipertansiyon, gestasyonel diyabet (GDM), preeklampsi, makrozomi, gelişim geriliği (FGR), ölü doğum ve erken doğuma neden olduğu gibi çocukluk çağı obezitesi ile de yakından ilişkili olduğu kanıtlanmıştır (4). Bu bakımdan fertil çağda kadın obezitesi gelecek nesilleri de etkileyen bir problem olarak değerlendirilmeli ve önlem alınmalıdır.

Obezlerde yaşam tarzı değişikliklerinin etkisi çoğu zaman sürdürülebilir değilken, medikal tedavilerinin faydası da yakın geçmişe dek oldukça sınırlıydı. Bu amaçla bariatrik cerrahinin (BC) ilk örnekleri 1950'li yıllarda jejenoileal bypass ile başladı (5). Dr. Viktor Henrikson'ın kilo kaybı amacı ile yaptığı ince barsak rezeksiyonu, başta beklenen kilo kaybını sağlamasa da obezite tedavisinde cerrahi seçenekleri gündeme getirmiştir. Zamanla prosedürler gelişip değişerek, vertikal band gastroplasti, laparoskopik gastrik band, Roux-en-Y gastrik bypass (RYGB)

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büyümenin yakın takibi, olumsuz perinatal sonuçları önlemede kritik rol oynar. Ayrıca, cerrahi tipine özgü komplikasyonlar (internal herniasyon, bant kayması gibi) konusunda farkındalık yüksek olmalı ve şüphe durumunda hızlı tanı-tedavi süreçleri uygulanmalıdır.

Sonuç olarak, BC sonrası gebeliklerin yönetimi, hem obezitenin olumsuz etkilerini azaltma hem de cerrahiye bağlı potansiyel riskleri minimize etme amacıyla kişiselleştirilmiş ve kanıta dayalı bir yaklaşım gerektirir. Bu süreçte hasta eğitimi, düzenli laboratuvar takipleri ve uygun doğum planlaması ile maternal ve fetal sağlık en üst düzeyde korunabilir. Gelecekte bu alanda yapılacak prospektif çalışmalar, mevcut kılavuzları daha da geliştirerek klinik uygulamaları optimize edecektir.

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