

BÖLÜM 10

YOĞUN BAKIMDA ABDOMİNAL ULTRASON KULLANIMI

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GİRİŞ

Günümüzde yoğun bakım hekimleri tarafından “modern steteskop” olarak da tanımlanan ultrasonografi(USG); yoğun bakım hastalarının abdominal patolojilerini yatak başında hızlı bir şekilde değerlendirmesine olanak sağlar.

Abdominal USG yapılan 400 yoğun bakım hastasının dahil edildiği bir çalışmada hastaların % 31’inde yeni patolojik bulgu saptanmış, % 10’unda ise müdahale gerektirmiştir ⁽¹⁾. Hemodinamik verilerin, asit ve intravasküler volümün değerlendirilmesi, parasentez, abdominal ve retroperitoneal organlara özgü inceleme abdominal USG’nin yoğun bakımdaki en sık uygulama alanlarıdır. Tablo 1’de yoğun bakım hastasında abdominal USG incelemesi için bir algoritma görülmektedir.

Abdominal inceleme için düşük frekanslı, genellikle geniş konveks USG probu kullanılır, çünkü bu prop organ boyutlarını ölçebilecek ve geniş bir alanı görebilecek kadar yeterli penetrasyona izin verir. Yüksek frekanslı lineer prop, sadece yumuşak doku ve vasküler yapılar gibi daha yüzeysel intraabdominal yapıların değerlendirilmesi için yararlı olabilir ⁽²⁾. Tablo 2’de intraabdominal organların ultrasonografik görüntüleme normal boyutları verilmiştir.

UYGULAMA ALANLARI

1.Asit değerlendirme ve parasentez

“Peritoneal kavitede sıvı birikmesi” olarak tanımlanan asit; yoğun bakım hastalarında sık karşılaşılan bir problemdir. Kuzey Amerika’da olguların % 80’inde altta yatan neden siroz olmakla birlikte; malignite, enfeksiyöz peritonit, hipoalbuminemi gibi nedenlerle de oluşabilir ^(2,3). Tanı ve izleminde; yer değiştiren matite, dalgalanma hissi, gibi fizik muayene bulgularının sensitivite ve spesifitesi sınırlıyken, abdominal USG ile 100 ml kadar az miktardaki asit dahi tespit edilebilmektedir

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9. Gastrointestinal perforasyon ve pnömoperitonyumun değerlendirilmesi

Acil servis hastalarında olduğu kadar, yoğun bakım hastalarında da görülebilen akut apandisit, divertikülit, ülser perforasyonu, kolit ve intestinal iskemi gibi akut abdominal ağrı nedenleri, tanı ve tedavide geç kalındığında pnömoperitonyuma veya retropnömoperitonyuma neden olabilir. Gastrointestinal perforasyon tanısı, pnömoperitonyumun genellikle radyografi veya tomografide tespit edilmesiyle konulur. Literatürde USG ile de pnömoperitonyumun tespit edilebileceğine ve % 85-93 sensitivite, % 53-100 spesifiteyle tanı koyulabileceğine dair yayınlar bulunmaktadır⁽⁵¹⁻⁵³⁾. Hatta USG'nin radyografiden daha sensitif olduğu da iddia edilmiştir⁽⁵²⁾.

Pnömoperitonyumda hava distribüsyonu, perforasyon alanına bağlıdır⁽²⁾. Hasta supin pozisyondayken pnömoperitonyum, pertoneal kavitenin anterior kısmında, öncelikle epigastrium veya sağ üst kadranda birikebilir ve serbest hava hasta pozisyonuyla yer değiştirir (Şekil 7)⁽⁵⁴⁾. USG probuyla bastırıldığında da az miktardaki serbest hava görüntü alanından dağılarak çıkabilir⁽⁵⁵⁾. Peritoneal kavitedeki hava, “kuyruklu yıldız artefaktı” olarak da bilinen ekojenik çizgiler veya noktalar şeklinde görülebilir (Şekil 8)⁽²⁾.

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