

## 25. BÖLÜM

# OBSTETRİK DIŐI KARIN AĐRISI NEDENLERİ- ACİL CERRAHİ DURUMLAR

Orhan ŐAHİN<sup>1</sup>

### GİRİŐ

Gebelikte acil non-obstetrik acil cerrahi gerektiren durumlar, gebeliklerin yaklaşık %2 sinde görölmektedir (1). Gebe hastanın deđerlendirilmesi, tanısıl metodolojisi ve tedavisine karar verilirken, anne ve fetüs üzerindeki riskleri ve yararları özellikle deđerlendirilmelidir. KarmaŐık bakım, gebelikte meydana gelen normal fizyolojik ve anatomik deđiŐiklikler, genellikle acil durumların erken teŐhisinde kullanılan bulguların yorumlanmasını zorlaŐtırabilmektedir. Gereksiz iŐlem ve tetkik korkusu nedeniyle gebe hastada tanı ve tedavide gecikme yaŐanması, bu hasta popölasyonunda yüksek komplikasyon oranlarına katkıda bulunmaktadır. Detaylara dikkat, artan Őüphe, seri fiziksel muayene, klinik farkındalık ve sistematik deđerlendirme, acil cerrahi koŐullardan kaynaklanan gereksiz maternal komplikasyonları ve fetal kaybı önlemeye yardımcı olacaktır.

<sup>1</sup> BaŐasistan, Uzm. Dr., Prof. Dr. Cemil TaŐcıođlu Őehir Hastanesi, drorhansahin@gmail.com

terilmiştir (67). Temel ve ileri yaşam desteğinin ABC'lerini takiben, annelik durumunun değerlendirilmesine yönelik algoritmalar hamile olmayan kadınlarda olduğu gibi aynıdır. Hamile kadınlarda ek değerlendirme ise fetal durumu içerir. Kardiyotokografi, travma nedeniyle plasental dekolman riskini değerlendirmek için ultrasondan çok daha iyi bir teşhis aracı olarak öne çıkmaktadır. Ultrason, fetal gebelik yaşı, fetal kalp aktivitesi, fetal aktivite, amniyotik sıvı hacmi ve şüpheleniliyorsa maternal intraperitoneal sıvının değerlendirilmesi için kullanılır. Uterus kasılmalarının varlığı, plasenta dekolmanı şüphesini artırmalıdır. Uterus kontraksiyonları, vajinal kanama, uterus hassasiyeti veya rüptüre amniyotik membranlara dair bir kanıt yoksa ve maternal durum stabil ise ve fetal kalp hızı normal ise, 4 saat sonra fetal monitörizasyon kesilebilir (68). Geleneksel olarak, hamilelik sırasında penetran abdominal yaralanmanın varlığı, cerrahi incelemeyi gerektirir. Maternal endikasyonlar için laparotomi yapılması, sezaryen için bir endikasyon değildir. Fetal distres, direk perforan uterus yaralanması veya gravid uterus nedeniyle abdominal eksplorasyon ve cerrahi müdahale yapılmıyorsa, maternal endikasyonlar için sezaryen yapılabilir. Kanamalı travmada özel bir sorun, Rh izoimmunizasyonudur. Anne ve fetüs arasındaki doğrudan kan teması, Rh-negatif kadınlara uygulanacak Rh immünoglobulin miktarının doğru bir şekilde belirlenmesini sağlayan Kleihauer-Betke testi (fetal hemoglobin için asit elüsyonu) ile değerlendirilir. 300 mg D-immünoglobulin içeren bir ampul, 30 ml'den az kanamaya karşı korur. Amerikan Obstetrik ve Jinekoloji Koleji, abdominal travma açısından değerlendirilen tüm duyarlı D-negatif gebe hastalara D-immünoglobulin uygulanmasını önermektedir. Kardiyopulmoner resüsitasyona yanıtız travma hastasında peri-mortem sezaryen ameliyatı düşünülmelidir. Sonuçlar, anne ölümünden sonraki 5 dakika içinde doğan ve hayatta kalan bebeklerin %75'inin nörolojik olarak sağlam olduğunu göstermektedir (68). Öneri olarak 4 dakika resüsitasyon yapmak ve hasta yanıt vermediyse acil abdominal doğum yapmaktır. Bu kurala "5 dakika kuralı" denir (63).

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