Bölüm
33

KALP YETERSİZLİĞİ TEDAVİSİ

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GİRİŞ

Kalbin, vücudun metabolik ihtiyaçlarını yeteri kadar karşılayamaması olarak tanımlanan kalp yetersizliği (KY) erişkin yaş grubunda mortalite ve hastaneye yatışların en önemli sebeplerinden biri olup toplumdaki sıklığı yaş ilerledikçe artmaktadır (1). Ülkemizdeki prevalansı tam olarak bilinmemekle birlikte yapılan en kapsamlı epidemiyolojik çalışmalardan biri olan HAPPY çalışmasında prevalans %2,9 olarak bulunmuştur (2). Aynı zamanda ülkemizde Avrupa'ya oranla daha genç yaşlarda görülmektedir (3). Batı Avrupa'da tüm sağlık giderlerinin %1-3'ü KY hastalarının yönetimi için harcanmaktadır. Ayrıca kalp yetersizliği nedeniyle hastaneye yatırılan hastaların %17-45'i 1 yıl içinde kaybedilmekte ve ölümlerin en sık nedeninin başta ani kardiyak ölüm (AKÖ) ve KY'nin kötüleşmesi olmak üzere kardiyovasküler (KV) nedenler olduğu bilinmektedir (3).

Kalp yetersizliği tedavisi, altta yatan etiyolojik faktörlerin semptom ve bulgular ortaya çıkmadan düzeltilmesinden kalp transplantasyonuna kadar uzanan geniş bir yelpazeyi içermektedir. En sık etiyolojik neden Koroner Arter Hastalığı (KAH) olmakla birlikte hipertansiyon, kapak hastalığı, sistemik hastalıklar, aritmiler ve metabolik bozukluklar gibi KV ve non-kardiyovasküler birçok sebebi bulunmaktadır. Aşikar KY gelişmiş hastalarda ise temel hedef hayat kalitesinin arttırılması, semptomların kontrol altına alınması ve hastaneye yatışların ve mortalitenin azaltılmasıdır (4,5).

Daha önceki konularda KY'nin patofizyolojisi ve tanısal algoritması detaylı bir şekilde anlatılmıştır. Kardiyak transplantasyon, kalp yetersizliğinde cerrahi yöntemler ve mekanik ventriküler destek cihazları ile KY'de kardiyak rehabilitasyon konuları diğer başlıklar altında irdelenecektir. Bu bölümde sol KY ağırlıklı olmak üzere KY'nin temel farmakolojik ve nonfarmakolojik tedavisi üzerinde durulacaktır.

KALP YETERSİZLİĞİNDE TEDAVİ HEDEFLERİ

Kalp yetersizliğinde tedavi seçenekleri akut ve kronik dönemde farklılıklar gösterebilmektedir. Akut atak döneminde diüretik ve vazodilatör tedavi ön plana çıkarken kronik dönemde mortalite yararı gösterilmiş anjiyotensin dönüştürücü enzim (ACE) inhibitörleri ve beta blokerler (BB) daha önemli rol oynamaktadır. Büyük çaplı KY çalışmalarında primer ve sekonder hedefler mortalite ve hastaneye yatışların azaltılması, semptom kontrolü, hayat kalitesi ve fonksiyonel kapasitenin artırılması üzerinde yoğunlaşmıştır. Tüm bu temel hedeflerin yanında hastalığın ilerleyişini durdurmak ve mümkünse geri döndürmek, konjesyonu önlemek, natriüretik peptid düzeylerini azaltmak, efor kapasitesini arttırmak ve sol ventrikül (LV) sistolik ve diyastolik hacimlerini azalt-

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