Bölüm
81

KARARSIZ ANJİNA VE ST-SEGMENT ELEVASYONSUZ MİYOKART İNFARKTÜSÜ

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GİRİŞ

Akut koroner sendrom (AKS), kararsız anjina (UA), ST-segment elevasyonsuz miyokard infarktüsü (NSTEMİ) ve ST-segment elevasyonlu miyokard infarktüsünü (STEMİ) içeren bir iskemik miyokardiyal hastalık yelpazesidir. UA ve NSTEMİ patofizyolojisi oldukça benzerdir ve tipik olarak koroner arter lümenini ciddi olarak tıkayan aterosklerotik plak rüptürünü, erozyonunu içerir. Benzer olarak bu hastalar sıklıkla hasta risk sınıflandırmasına dayalı bireysel farklılıklara göre biçimlendirilmiş şekilde tedavi edilirler (1). Bu bölüm UA ve NSTEMİ tanısı, risk sınıflandırması, yönetimi ve sonuçlarını etkileyen stratejilere odaklanmaktadır.

Epidemiyoloji

Koroner arter hastalığı (KAH) dünyada ve ülkemizde en önde gelen ölüm sebebidir. Avrupa'da 75 yaş altı ölümlerin kadınlarda %45, erkeklerde %38'den kardiyovasküler hastalıklar sorumludur (2). Türkiye İstatistik Kurumu'nun ICD 10 ana tanı kodlarına göre yaptığı araştırmada dolaşım sistemi hastalıkları %39.9 ile (kadınlarda %44.4, erkeklerde %36.2) ölüm nedenleri arasında açık ara en üst sıradadır. İkinci sıradaki neoplazmalara bağlı ölüm oranı %21.1'dir (3). TEKHARF çalışması 2007-2008 tarama verileri KAH'nin halkımızda 1990'dan beri yılda %6.4 hızında arttığını göstermektedir (4). KAH prevalansı 1990 yılına kıyasla 50 yaş üstü grupta %80 oranında artmıştır (4). Dünya Sağlık Örgütü eldeki verilere göre KAH'ye bağlı ölümlerin önümüzdeki yirmi yılda kadınlarda %120 erkeklerde %137 artacağını öngörmektedir (5).

AKS, Amerika Birleşik Devletleri'nde yıllık tahmini 1 milyon hastayı etkilemekte olup, bunların yaklaşık dörtte üçünde ST segment elevasyonsuz AKS (NSTE-AKS) söz konusudur (6). Amerika Birleşik Devletleri'nde yaşlanan nüfusun yanı sıra yüksek diyabet ve kronik böbrek yetersizliği (KBY) oranları NSTE-AKS insidansını artırırken, STEMİ insidansında ise bir düşme olmuştur (7,8). TEKHARF 2012 verilerinden yapılan hesaplamaya göre ülkemizde yılda yaklaşık 420.000 koroner olay meydana gelmekte, bunların 120.000'i KAH bilinen hastalarda akut olayın tekrarı, 180.000'i yeni AKS, 120.000'i sessiz olay ve yeni kronik KAH şeklindedir. AKS'ye bağlı olarak gelişen yaklaşık 95.000 ölüm, yıllık %32 mortaliteye karşılık gelmektedir ki bu oran Avrupa oranlarından yüksektir (4).

Patofizyoloji

AKS'nin altta yatan patolojisi, miyokardiyal oksijen sunumu ve ihtiyacı arasındaki uyumsuzluktur. UA, NSTEMİ ve STEMİ trombotik damar tıkanıklığı, miyokardiyal oksijen sunumu ve ihtiyacı arasındaki uyumsuzluğun çeşitli derecelerinin sonuçlarını yansıtır. AKS'de trombotik oklüzyonun en yaygın altta yatan nedeni plak rüptürüdür. Plak erozyonu başta kadınlar, genç hasta-

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SONUÇ

Sonuç olarak, AKS'lerin kısa ve uzun dönem mortalite ve morbiditeleri yüksektir. Mİ sonrası ilk bir yılda kadınlarda %23 erkeklerde %18 olan mortalite, 5 yılda kadınlarda %43 erkeklerde %33'e çıkmaktadır (120). Kanıta dayalı tedavi stratejilerinin uygulanabilirliğinin arttırılması için altyapısal önlemlerin alınması, kılavuzlara uyumun arttırılması, etkinlikleri kanıtlanmış yeni girişimsel ve farmakolojik tedavilere hem hasta hem de hekimlerin daha kolay ulaşabilmesinin sağlanması, birincil ve ikincil korunma önlemlerinin yaygınlaştırılması kuşkusuz bu oranlarda önemli düşüşler sağlayacaktır.

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