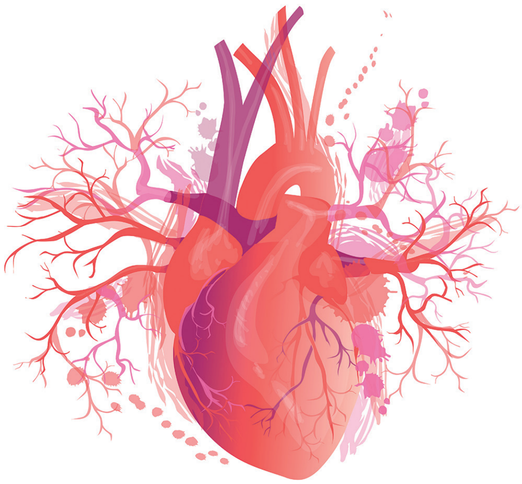

BÖLÜM 22

KORONER ARTER HASTALIKLARININ TANISINDA GELİŞMELER

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GİRİŞ

Koroner arter hastalıkları (KAH) günümüzde dünya genelinde başta gelen ölüm sebebidir. Bu nedenle KAH'ın erken ve doğru teşhisi çok önemlidir. KAH'ın ana sebebi ateroskleroza bağlı gelişen koroner obstrüksiyon olmakla birlikte, uygun endikasyonla anjiyografi yapılan hastaların %50' sine yakınında obstrüktif olmayan KAH tespit edilmektedir (1). Bu hastalarda miyokardiyal iskemiyi belirleyen bir çok mekanizma sorumlu olabilir. Özellikle epikardiyal damarlar ve koroner mikrodolaşımdaki vazomotor koroner bozukluklar miyokardiyal iskeminin olası sebebi olarak tanımlanmaktadır (2,3). KAH obstrüktif, obstrüktif olmayan ve mikrovasküler disfonksiyon olmak üzere 3 grup olarak sınıflandırılabilir. Ayrıca KAH'ın sürekli değişkenlik gösteren doğası gereği değişik klinik prezantasyonlarla sonuçlanabildiğinden akut koroner sendromlar (AKS) ya da kronik koroner sendromlar (KKS) olarak iki gruba kategorize edilebilir (4).

KAH'ın teşhisinde bir çok biyokimyasal testler, elektrokardiyografi (EKG), stres testleri, invaziv olan ve olmayan görüntüleme yöntemleri kullanılmakta ve halen geliştirilmektedir. Avrupa Kardiyoloji Topluluğunun (ESC) 2019'da yayımladığı KKS kılavuzunda temel testler, teşhis yöntemleri ve risk değerlendirmesi için yapılan majör öneriler tablo 1'de verilmiştir.

Hastanın anamnezi alındıktan sonra ilk seçenek olarak temel biyokimyasal testler, istirahat EKG'si, ambulatuvar EKG monitorizasyonu, istirahat ekokardiyografisi ve seçilmiş hastalarda akciğer grafisi gibi testler kullanılır. Şimdi sırasıyla bu testleri özellikle yeni gelişmeler açısından ele alalım.

BİYOKİMYASAL TESTLER

Günümüzde aterosklerotik hastalıkların tespitinde lipit profili, C-reaktif protein (CRP), *high-sensitive* troponin, *brain natriuretic peptide*

(BNP) ve lökosit sayısı gibi laboratuvar testleri halihazırda kullanılmaktadır (5). Fakat bu biyobelirteçler vücuttaki farklı vasküler alanlardaki aterosklerozun hem ilerleme miktarı ve hem de hızını göstermedeki bireysel farklılıklardan dolayı kullanımları sınırlıdır (6). Ayrıca bu belirteçler ateroskleroz sürecini ilerleten hücre içi süreçleri tam olarak göstermeyebilir. Yine bu belirteçler gelecekteki kardiyovasküler komplikasyonları

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olarak anjiyografik çalışmalardan gelen sonuçlar, AKS'nin darlık yüzdeleri ile direkt korele olmadığını ve tıkayıcı trombüsün sık sık yüksek dereceli lezyonlara ikincil gelişmediğini göstermiştir (57). Bu bulgular önemli koroner aterosklerozun belirlenmesinde sadece klasik anjiyografi yapılmasının yetersiz olduğunu kanıtlar. Ateroma yükü darlık derecesinden bağımsız olup plağın total miktarını gösterir (58). Glagov ve arkadaşları, plak yeniden şekillenme sürecinde plak tutulumu damar çevresinin % 40'ına ulaşıncaya kadar lümenin korunduğunu göstermişlerdir (59).

Sonuç olarak IVUS ve OKT anjiyografik olarak belirsiz lezyonları netleştirebilir, hassas plak morfolojisini gösterebilir ve revaskülarizasyon stratejisini değiştirebilir.

Koroner Anjiyoskopi

KAS hastalarda vasküler lümen yüzeyinin direkt olarak görülebilmesini sağlayan tek tanısal yöntemdir. Canlı hastalarda makropatolojik muayenede rol alır. KAS; BT, MRG, IVUS ve OKT gibi görüntüleme yöntemleriyle yapılamayan gerçek zamanlı, tam renkli, üç boyutlu video görüntüsü sağlar.

KAS hem araştırmalarda hem de klinik uygulamalarda geniş bir role sahiptir. Koroner damarlarda plak rengini, yırtığını, erozyonunu ve trombüsü gösterebilir (60-64).

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