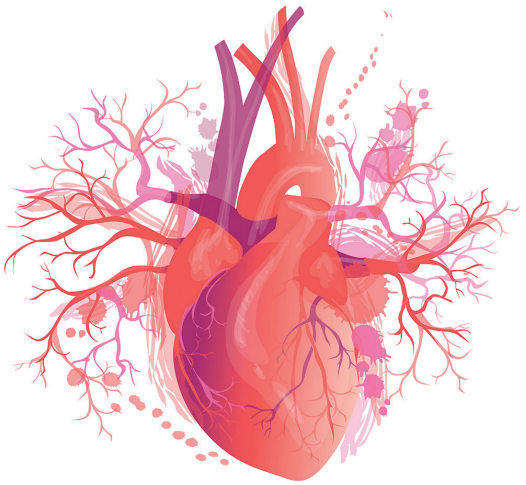

BÖLÜM 26

KORONER REOPERASYONLAR

Begench ORAZGELDiYEV[1]

GİRİŞ

İskemik kalp hastalığının tedavisinde koroner baypas cerrahisi (CABG), gelişmiş koroner girişim (PCI) tekniklerine rağmen hala günümüzde başarılı bir şekilde kullanılmaya devam edilmektedir. Özellikle heparinin keşfedilmesi ve kalp cerrahisinde kardiopulmoner bypass makinesinin yaygın kullanılmaya başlanması koroner cerrahisi için de dönüm noktası olmuştur. İlk kez 1967 yılında Favoloro tarafından safen ven CABG için kullanırken, aynı yıl Kolesov tarafından internal mamarian arter (İMA) grefti kullanılmıştır (1,2). Radyal arter ve gastroepiploik arter (GEA) gibi greftlerin takip eden yıllarda yaygın kullanılması özellikle çok damar kompleks lezyonlu hastalarda uzun dönem olumlu sonuçlar vermiştir. Buna karşın CABG operasyonu sonrası hastalığın doğal seyrinin ilerlemesi ve greft yetmezliği nedeni ile bazı hastalarda tekrar anjina semptomları ortaya çıkmaktadır. Akut koroner sendrom veya hayatı tehdit eden klinik tablo ortaya çıkması halinde bu hastalara optimal medikal tedavi ve PCI gerekmetedır. Buna karşın bir grup hastada redo CABG kaçınılmazdır. Redo CABG operasyonları bazı yönleri ve cerrahi tekniğin farklılıkları dolaysı ile primer CABG'den ayrılmaktadır. Operasyon sırasında diseksiyon, adezyonlar ve eski greftler nedeni ile zorluk yaşanırken, aynı zamanda greft hasarı, kardiyak yaralanma ve açık greftlerden kaynaklanan distal emboliye bağlı miyokard infarktüsü (MI) gibi komplikasyonlar da yüze çıkabilmektedir. Ayrıca redo CABG adaylarının genellikle daha yaşlı ve daha fazla komorbit faktörlere sahip olmaları nedeniyle, operatif mortalite ve morbidite daha yüksektir. Geçmişte redo CABG insidansı 5 yıllık %2,6, 10 yıllık %10,1 ve 20 yıllık takiplerde ise %24,4 olarak bildirilmiş idi (3). Ancak son yıllarda optimal medikal tedavi, daha sık arteryel greft kullanımı, daha agresif PCI uygulanmasına bağlı olarak %10'un altına inmiştir (4,5).

Bu bölümde redo CABG'ye neden olan faktörler, greft yetmezliği sonrası tedavi, cerrahi endikasyonlar, operasyon teknikleri ve stratejileri anlatılacaktır.

PATOFİZYOLOJİ

Safen ven grefti yetmezliği

Safen ven greft (SVG) CABG operasyonunda arterial greftler ile beraber konduit olarak kullanılmaktadır. SVG patensi 10 yılda %50-60 arası ola-

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bolizasyon riski gibi avantajlar söz konusudur. Literatürde konu ile ilgili çalışmaların özeti Tablo-3 de verilmiştir. Dohi ve arkadaşlarının Japan Cardiovascular Surgery Database'ini kullanarak yaptıkları ve 617 hastanın incelendiği bir diğer çalışmada ise mortalite off-pump grubunda % 3,5 iken CPB altında CABG yapılan grupta % 7 olarak saptanmıştır. Ayrıca uzamış ventilasyon, uzamış yoğun bakım ünitesinde (YBÜ) kalış ve transfüzyon ihtiyacı daha az görülmüştür (81). Redo CABG hastalarında off-pump tekniğinin erken dönemde sağ kalımı arttırdığı ve uzun dönem sonuçlarının benzer olduğu bilinmektedir. Ancak unutulmaması gerekirki, redo CABG operasyonunda asıl hedefin primer CABG de olduğu gibi komplet revaskularizasyondur. Di Mouro ve arkadaşlarının yaptığı bir çalışmada redo CABG yapılan hastalarda inkomplet revaskülerizasyon insidansı off-pump grubunda %17,1 saptarken, bu oran on-pump grubunda %5,9 saptanmıştır(82). Ayrıca inkomplet revaskülerizasyonun 5 yıllık kardiyak mortalite için bağımsız bir risk faktorü olduğu unutulmamalıdır.

Bir diğer tartışma konusu da patent olan ancak anastomoz bölgesinde darlık bulunan İMA greftinin tekrar kullanımı üzerinedir. Bu konuda yayınlanmış en geniş retrospektif çalışmada daha önce CABG operasyonu olmuş 60 hasta incelenerek, bu hastalarda eski İMA grefti yeniden kullanılmıştır. Bu seride mortalite gözlenmemişken, revaskülarizasyon ihtiyacı da olmamıştır. Ayrıca 1 yıllık sağ kalım % 93 ve 5 yıllık sağ kalım ise % 85 olarak bildirilmiştir (83).

Günümüzde arteriyal greftlerin primer CABG sırasında yaygın kullanılmasının uzun dönem sonuçları yüz güldürücü iken, redo CABG gereksinimini azaltacağı aşikardır. Buna karşın redo CABG gerekecek hastaların daha fazla komorbiditeye sahip, kompleks koroner anotomisi ve sol ventrikül disfonksiyonu olacaktır. Bu grup hastalarda komplikasyonlardan kaçınmak için çeşitli yenilikler gündeme gelmektedir. Minimal invazif, sternotomisiz ve CPB'sız yaklaşımlar redo CABG operasyonlarının geleceğidir. Primer CABG'nin de minimal invazif olarak yapılmış olması, redo CABG gereksiniminde kolaylık sağlayacaktır. Ayrıca gelişmiş PCI teknikleri ile minimal invazif off-pump cerrahisinin kombine edilerek uygulanacak hibrit yöntemler, hastalar için en iyi seçenek olacağı öngörülmektedir.

SONUÇ

Redo CABG insidansı günümüzde çeşitli sebeplerden dolayı azalmakla beraber hala karşılaştığımız, tecrübe gerektiren zorlu prosedürlerden biridir. Ayrıca mortalitesi primer CABG'den çok daha yüksektir. Erken dönem sonuçları daha iyi olan ve uzun dönemde redo CABG ile benzer sonuçlara sahip olan PCİ revaskülarizasyon için ilk tercihdir. Ancak PCİ için uygun olmayan hastalarda redo CABG ön planda düşünülmelidir. Bununla beraber redo CABG endikasyonu olan hastalarda off-pump tekniğin erken dönem sonuçlarının daha iyi , komplikasyonun daha az olduğu ve uzun dönem sonuçlarının benzer olduğu akılda tutulmalıdır. Donanımlı merkezlerde tecübeli cerrahların geliştirdiği çeşitli stratejiler ile günümüzde redo CABG operasyonunun mortalitesinin azaldığı bilinmektedir.

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