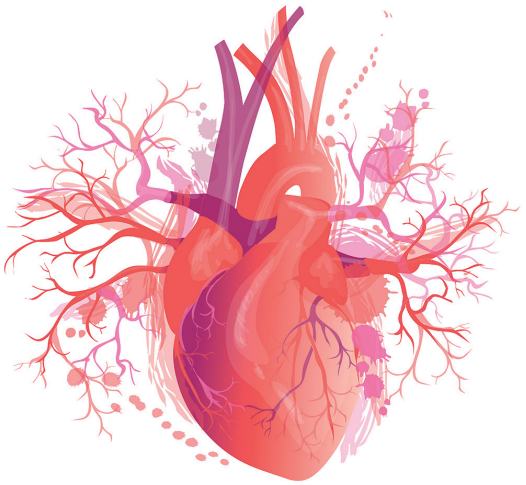

BÖLÜM 50

KRONİK TROMBOEMBOLİK PULMONER HİPERTANSİYON

Musa DAĞLI[1]

GİRİŞ

Pulmoner hipertansiyon dinlenim durumunda invaziv yöntemler ile ölçülen ortalama pulmoner arter basıncının (mPAB) 25 mmHg ve üzerinde olması olarak tanımlanmaktadır(1). ESC (European Society of Cardiology) 2015 pulmoner hipertansiyon tanı ve tedavi kılavuzunda, pulmoner hipertansiyon klinik olarak beş farklı grupta sınıflandırılmıştır. Bu klinik sınıflandırma çok sayıda klinik antiteyi ortak klinik tablolarına, benzer hemodinamik özelliklerine, patolojik bulgularına ve tedavi stratejilerine göre kategorilere ayırmıştır. Kronik tromboembolik pulmoner hipertansiyon (KTEPH) bu sınıflandırmada, pulmoner arter tıkanıklığı oluşturan durumlar (anjiyosarkomlar, diğer intravasküler tümörler, arteritler, doğumsal pulmoner arter darlıkları, paraziter hastalıklar) ile birlikte grup 4 içerisinde yer almaktadır(1).

KTEPH, pulmoner arter yatağında, tekrarlayan tromboembolik süreçler sonrası oluşan ve en az 3 aylık uygun antikoagülan kullanımına rağmen, istirahatte ölçülen pulmoner arter basıncının 25 mmHg ve üzerinde olması olarak tanımlanmaktadır(2). Pulmoner arter basıncındaki artış sonrası gelişen sağ kalp yetmezliği KTEPH kliniğinden sorumlu olsa da, bu klinik tablonun oluşmasına pulmoner emboliye bağlı gelişen solunum yetmezliği ve ölü boşluk ventilasyonu da katkıda bulunmaktadır(3).

EPİDEMİYOLOJİ

Pulmoner emboli çoğunlukla akut gelişen ve uygun medikal tedavi sonrası tamamen iyileşme gösteren bir durum olarak kabul edilir. Ancak yapılan bir araştırma sonucu pulmoner emboli gelişimi sonrası 6. ayda yapılan değerlendirmede, hastaların yaklaşık %50 kadarında rezidüel perfüzyon defekti olduğu görülmüştür(4). Bu açıdan bakılınca, pulmoner emboli sonrası gelişen kalıcı perfüzyon defektleri KTEPH gelişimi için risk faktörü olarak kabul edilmektedir.

İspanya'da yapılan Pulmoner Hipertansiyon Kayıt Çalışması verilerine göre KTEPH yıllık insidansı milyonda 0,9 , prevalansı ise milyonda 3,2 olgu olarak açıklanmıştır(5). Akut pulmoner emboli geçiren hastalarda KTEPH prevalansı %3,8 olarak bildirilmiş olsa da , gerçekte KTEPH insidansı yaklaşık % 0,5-2 arasındadır(6). İsviçre' de 508 pulmoner emboli geçiren hastanın 2 yıl bo-

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düzelme sağlanmakta, hem de semptomlarda belirgin gerileme izlenmektedir. Pulmoner endarterektomiye(PEA) uygun olmayan hastalarda ise deneyimli bir klinik merkezde pulmoner balon anjiyoplasti (BPA) tedavisi uygulanabilmekte ve uygulamadaki son gelişmeler umut vermektedir. PEA veya PBA uygulanamayan distal mikrovasküler hastalık tablosunda ve cerrahi sonrası rezidüel pulmoner hipertansiyon gelişen hastalarda ise riociguat tedavisi uygulanmaktadır. Riociguat etkinliği ve güvenliği CHEST çalışması ile gösterilmiştir. Riociguat çözünebilir guanilat siklazı stimüle ederek hücre içi cGMP miktarını artırarak etkinliğini göstermektedir. Medikal tedavide bunlara ek olarak hayat boyu oral antikoagülasyon ve hastanın ihtiyacına göre diüretikler de önerilmektedir. Bu destek tedavilerinin de mortalite üzerinde azaltıcı etkileri olduğu düşünülmektedir. Güncel kılavuzlarda akut pulmoner emboli sonrası rutin KTEPH taraması önerilmemek ile birlikte , venöz tromboemboli öyküsü olan ve inatçı dispne şikayetleri olan hastalarda KTEPH gelişmesi ihtimali her zaman akılda tutulmalıdır.

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