

BÖLÜM 5

YOĞUN BAKIMDA COVID-19 HASTALARINDA OKSİJENİZASYON YÖNTEMLERİ



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1. GİRİŞ

COVID-19 enfeksiyonu, hafif hastalık tablosundan ağır pnömoni ve akut solunum sıkıntısı sendromuna (ARDS) kadar değişen farklı klinik tablolara neden olabilmektedir. Vakaların %14'ünde ağır hastalık, %5'inde solunum yetmezliği ve yoğun bakım ihtiyacı olmaktadır (1). İleri yaş, erkek cinsiyet, obesite, diyabet, hipertansiyon, kronik kardiyovasküler ve pulmoner hastalıklar, aktif kanser, aktif sigara kullanımı, yüksek di-dimer seviyeleri ağır hastalık gelişimi ve artan mortalite ile ilişkilidir. Son zamanlarda yapılan metaanalizlerde hastanede yatan hastalar arasında mortalite oranı % 2.3 - %17.62 olarak bildirilmiştir (1-3).

Hastalarda görülen solunum yetmezliği hipoksik tipte olup prevalansı %19'dur. Hiperkarbik solunum yetmezliği daha nadirdir (1). Hipokseminin nedeni akciğer parankimindeki non-kardiyojenik pulmoner ödem (ARDS benzeri mekanizma), ventilasyon/perfüzyon dengesizliği ve pulmoner damar yatağındaki mikrotrombüslerdir. Buradan yola çıkılarak H ve L fenotipleri tanımlanmıştır. H fenotipinde akciğer kompliyansı düşüktür; klasik ARDS'de uygulanan yöntemlere (rekrutment manevrası, pron, yüksek PEEP) daha iyi yanıt verir. L fenotipinde ventilasyon/perfüzyon dengesizliği ve mikrotrombüsler ön plandadır, kompliyansları yüksektir, yüksek PEEP, rekrutment, pron pozisyonuna cevap vermezler (4,5). Hastalarda semptomlar başladıktan ortalama 8 gün sonra solunum yetmezliği tablosu gelişir (6). Bazı hastalarda bu dönemde sessiz hipoksemi (dispne hissi olmadan hipoksemi) olabilir ve solunum destek tedavilerinde gecikmeye yol açar. Bu süreçte özellikle riskli hastalarda nabız oksimetreler ile SaO₂ takibi önerilmektedir (7).

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koruyucu ekipman kullanılmalıdır. Önemli olan diğer konu ise; non-invaziv solunum desteği için hastanın kliniği ve oksijen ihtiyacına göre uygun yöntemin seçilmesi, hastanın yakın takip edilerek tedavinin yönlendirilmesi, gerekiyorsa zamanında entübasyon kararı alınmasıdır. Gecikmiş entübasyon artan mortaliteyle ilişkilidir. Ayrıca uzun süreli yüksek oksijen uygulamalarının (>6 saat, FiO₂>%60) oksijen toksisitesine neden olabileceği unutulmamalıdır.

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