Bölüm 3

ATEŞLİ ÇOCUKLARDA GİZLİ BAKTERİYEMİ VE CİDDİ BAKTERİYEL ENFEKSİYON

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1. GİRİŞ

Ateş çocuk sağlığı ve hastalıkları polikliniklerine yapılan ziyaretlerin % 15'ini, acil polikliniklerine yapılan ziyaretlerin ise % 10'unu oluşturur. Bu çocukların çoğu 3 yaşından küçüktür. Çoğu olguda, öykü ve fizik bakıdan sonra (Kuppermann, 1999) ateş için olası bir neden tanımlanır. Ateşli çocukların çoğunda kendi kendini sınırlayan viral enfeksiyonlar bulunur. Ancak geriye açık ya da gizli bakteriyel enfeksiyonlar kalır ki bu küçük gruptaki hastalıklar ciddi bakteriyel enfeksiyonlara (CBE) ilerleyebilir.(Kuppermann, 1999) Gizli bakteriyemi deyimi ilk kez 1970 yılında Torphy ve Ray'in 12 olguyu bildirdikleri makalelerinde tanımlanmıştır.(Torphy & Ray, 2004) Bu tanım bugün de sık karşılaştığımız bir klinik sorunu ifade etmektedir. Mevcut teknoloji ve kanıtlarla olası tüm gizli bakteriyemi olgularını saptamak için mükemmel bir test yoktur. Çocuklarda gizli bakteriyemiyi hafif, kendini sınırlayan viral enfeksiyonlardan ayırt etmek güç olabilir. Her ne kadar gizli bakteriyemi genellikle kendiliğinden düzelirse de sepsis, pnömoni, osteomiyelit, septik artrit, pürülan perikardit ve menenjit gibi pek çok önemli bakteriyel hastalığa da neden olabilir.

Ateşli ve belirgin bir enfeksiyon odağı olmayan bir çocuğu değerlendiren hekim ne tür laboratuvar testleri isteyeceği, antibiyotik tedavisine başlayıp başlanmayacağı, başlarsa seçimin ne olacağı konusunda ikilemlere düşer. Bu durumun çözümlenmesi için çocuklarda ateşin en sık ve önemli nedenlerinin bilinmesi, belirgin bir enfeksiyon odağı saptanamayan çocukların bakteriyemi tehlikesi taşıyıp taşımadıklarının belirlenmesi gerekir. Bundan sonraki aşama izleme seçeneklerinden birine karar vermek olmalıdır.

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rinlerin uygun görülmediği durumda trimetoprim-sulfometoksazol kullanımı düşünülebilir. Ancak seçim bu olduysa kan kültüründe üreme olan hastalar ateşsiz bile olsalar yeniden değerlendirilmelidir. (Lorin & Feigin, 1998)

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