

Bölüm 6

İNTRAKRANİAL ANEVİRİZMA TEDAVİSİNDE GÜNCEL ENDOVASKÜLER YÖNTEMLER

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Anevrizma, damar duvarında herhangi bir nedenle oluşan zayıflık sonucu meydana gelen fokal dilatasyondur. İntrakranial anevrizma tanısında altın standart tanı yöntemi invaziv kateter anjiyografi olmasına rağmen 2000’li yılların başından itibaren bilgisayarlı tomografi (BT) anjiyografi (BTA) ve manyetik rezonans anjiyografi (MRA) gibi invaziv olmayan tanı yöntemleri de bulunmaktadır (White, Teasdale, Wardlaw, & Easton, 2001). İntrakranial rüptüre olmamış anevrizma prevalansı %0,5-3,2 arasında değişmektedir (Brown Jr & Broderick, 2014). İntrakranial anevrizma kadınlarda daha sık olup kadın erkek oranı 3:1’dir (Brown Jr & Broderick, 2014). İntrakranial anevrizma genellikle sporadik olarak görülmektedir ancak intrakranial anevrizma ile ilişkili bazı kalıtsal hastalıklar da mevcuttur. Bunların en bilineni otozomal dominant polikistik böbrek hastalığıdır (OD-PBH). OD-PBH olan hastalarda, sporadik intrakranial anevrizması olan bireylere göre sakküler serebral anevrizma riski daha fazladır (Chapman et al., 1992; Gibbs et al., 2004). OD-PBH olan hastalarda en az 2 yıl en fazla 10 yıl süre ile kontrastsız MR anjiyografi kullanılarak intrakranial anevrizma taramasının yapılması önerilmektedir (Rozenfeld et al., 2014). İntrakranial anevrizma riskinin arttığı diğer ailesel hastalıkların bazıları ise; Ehlers-Danlos sendromu tip IV, Marfan sendromu, nörofibromatosis tip 1 olarak sıralanabilir (Kim, Brinjikji, & Kallmes, 2016).

İnme diğer adıyla stroke, iskemik ve hemorajik olarak ikiye ayrılır. İskemik inme beyin dokusunun ihtiyacı olan kan akımının damar oklüzyonuna bağlı olarak kesilmesidir. Hemorajik inme ise beyin damarlarındaki rüptür sonucu kanın subaraknoid alana ya da beyin parankimine geçmesidir (Lindsay, Furie, Davis, Donnan, & Norrving, 2014). İnmenin yaklaşık %5’ini oluşturan subaraknoid kanama (SAK), iskemik inmeye göre daha genç yaşlarda görülmektedir (van Gijn, Kerr, & Rinkel, 2007). Subaraknoid kanama (SAK) mortalite

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