BÖLÜM 4

POST-OPERATİF ATRİAL FİBRİLASYON HASTALARINA VAKALARLA YAKLAŞIM

Dursun AKASLAN [1]

GİRİŞ

Paroksismal atrial fibrilasyon (POAF) kardiyak cerrahi sonrası majör komplikasyonlardan biri olup, yüksek mortalite ve morbidite oranlarına ve uzamış hastane yatış süreleri nedeniyle bakım harcamalarında artışa neden olmaktadır. Sıklıkla post-operatif ilk hafta veya hemen sonrasında gelişmektedir.[1-2] POAF herhangi bir kardiyak cerrahi sonrası gelişen ritim bozukluğu olarak tanımlanmış olup, akut, paroksismal, persistant veya permanent olarak farklı gruplara sınıflandırılmıştır.

POAF'a bağlı olarak gelişen inme, akut böbrek yetmezliği, kalp yetersizliği ve ölümü de içeren birçok komplikasyon meydana gelebilir[3]. POAF'ın patogenezi tam olarak bilinmemekle[4] birlikte temel etyolojik faktörler olarak; inflamatuvar süreç, oksidatif stres, otonomik disfonksiyon ve atriyumun yapısal ve fonksiyonel remodelingi düşünülmektedir[5]. Bu aşamada hastada predispozan faktörlerin önceden bilinmesi korunma ve tedavi açısından son derece önem arz etmektedir. Biz bu derlemede POAF patogenezi, epidemiyolojisi, hazırlayıcı faktörleri ve potansiyel tedavi seçeneklerini ayrıntılı şekilde değerlendirilip, örnek 2 vaka üzerinden de hastalara temel yaklaşım algoritmamızı açıklamayı hedefledik.

Vaka-1

- 75 yaşında erkek hasta , 3 aydır artan şiddetle eforla ilişkili göğüs ağrısı mevcut hastanın bilinen HT, Tip2 DM, HL tanıları mevcut. Hasta bu şikayet ile başvurduğu kardiyoloji polikliniğinde yapılan tetkikler neticesinde koroner arter hastalığı evaluasyonu için koroner anjiyografi planlandı.
- Fizik muayene: S1-S2 ritmik düzenli üfürüm yok, solunum normal ral yok ronküs yok ,Pretibial ödem +/+, Göz çevresinde ksantolezma+
- Aile öyküsü-, Sigara+
- İlaç öyküsü: Asetil salisilik asit 1x1, Perindopril 5 mg tb 1x1, Atorvastatin 10 mg tb 1x1, İnsülin preparatları 3x40 Ü
- Lab: Hemogram paneli normal AKŞ: 220mg/dL LDL: 180 mg/dl Kr: 1,1 GFR%50
- EKG: 84/dk sinüs ritminde hipertrofiye bağlı strain paterni mevcut ve anterior leadlerde(V1-V4) simetrik T negatifliği
- EKO: EF%45 ,anterior duvar mid ve bazal seviyede hipokinetik ,hafif mitral yetersizliği, sınırda dilate sol atrium alanı(LAa: 19 cm2)
- Miyokard perfüzyon sintigrafisinde anterior duvar tüm seviyelerde orta-ağır iskemi+
- KAG: LMCA: plaklı LAD : proksimal %99 darlık D1 osteal %70 darlık Cx: mid bölge %60 darlık, distal diffüz hastalıklı RCA : plaklı, dominant

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Tablo 2. POAF yönetim algoritması

Pre-operatif	Predispozan faktörleri kullanarak risk sınıflamasını uygula Hastanın hemodinamik stabilizasyonunu değerlendir Majör risk faktörlerini kontrol et Beta bloker tedavi başla ve pre-operatif tedaviye ara verme Beta blokerler kontrendike ise KKB başla, selektif gruplarda antiaritmik başlanabilir Serum seviyesine göre Mg tedavisi başla Koruyucu olabilecek ilaçlar: vitaminler, ranolazin ve NAC Yan etkisi olabilecek ilaçlar: statinler(akut böbrek hasarı), kolsisin(GİS intoleransı) Önerilmeyen ilaçlar: PUFA, digoksin, steroidler ve vernekalant
İntra-operatif	Volüm dengesini optimize et Kardiyopulmoner baypass zamanını minimalize et Minimal invaziv teknikleri tercih et İlaç kullanamayan hastalarda posterior perikardiyektomi uygula Atriyal pacing önerilmemektedir LAA kapatma işlemi önerilmemektedir
Post-operatif	Sıvı-elektrolit dengesini optimize et Mekanik ventilasyon süresini en aza indirmeye çalış Vazopressör ve İnotropik ilaçları en kısa sürede kesmeye çalış Tekrarlayan veya dirençli AF hastalarında medikal tedaviyi gözden geçir Beta bloker ve antiaritmik ajanlara devam et

SONUÇ

POAF post-operatif kardiyak cerrahisi sonrası sık görülen bir komplikasyon olup yüksek mortalite ve morbiditeye yol açabilmektedir. POAF gelişimindeki ana patofizyolojik mekanizmada şunlar bulunmaktadır; inflamasyon, oksidatif stres, otonomik disfonksiyon ve atriyumun yapısal ve fonksiyonel remodelingi. Bunun yanında majör kardiyovasküler risk faktörlerini de içeren pre-operatif riskler, cerrahi teknik ile ilişkili intra-operatif riskler ve post-operatif risk faktörleri de POAF gelişiminde etkili olabilmektedir. Operasyon öncesi risk faktörlerinin ayrıntılı bir şekilde değerlendirilmesi ve profilaktik tedavilerin başlanılmasının POAF insidansını azaltmada yapılması gereken en önemli önlemler olduğu düşünülmektedir. Bir çok kılavuzda beta blokerler ve amiodaron gibi antiaritmik ilaçların tedaviye eklenilmesi önerilse de yukarıda ayrıntılı bir şekilde açıkladığımız bir çok upstream tedavi mevcuttur. Onlarında rutin tedaviye eklenebilmesinin çok önemli olduğu kanaatindeyiz. Bununla birlikte POAF hastalarında persistan AF gelişen yada POAF gelişen yaşlı hastalarda tromboembolik profilaksi olarak antikoagulan tedavinin başlanılması gerekmektedir, ancak DOAK'ların tedaviye eklenilmesi için yeterli kanıt halen bulunmamaktadır.

Bu derlemede anlatılanları özetleyecek şekilde bir algoritma yapıldı (Tablo 2).

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