KANSERDE HİPERTANSİYON YÖNETİMİ

8. BÖLÜM

Hızır OKUYAN[1]

I. GİRİŞ

Modern kanser tedavileri ile birçok kanser kür olabilmekte fakat kür olmayan kanserler de kronik hastalık olarak tedavi edilmektedirler. Dünya genelinde bu kronik hastalık sınıfında çok sayıda hasta mevcut olup, giderek de bu hasta populasyonu artmaktadır. Kanser tanısı alan hasta sayısı Amerika Birleşik Devletler'inde 1970'lerde yaklaşık üç milyon iken 2019'da yaklaşık on yedi milyona artmıştır. [1] Bu hastalarda genel populasyon ile kıyaslandığında kardiyovasküler risk (hipertansiyon, hiperlipidemi, diyabetes mellitus, obezite), kardiyovasküler hastalık [2-4] ve pulmoner hastalık insidansında artış gözlenmiştir. [5,6] Hipertansiyon kronik böbrek hastalığı, kardiyovasküler hastalık ve kanser; sigara, diyabetes mellitus ve obezite gibi ortak risk faktörlerine sahiptir. Buna paralel olarak yapılan çeşitli çalışmalarda hipertansiyonun renal kanser, ağız, gırtlak ve yemek borusu kanseri ve meme kanseri için risk faktörü olduğu gösterilmiştir. [7-9] Kanser hastalarında en sık eşlik eden kardiyovasküler hastalık hipertansiyondur. [10] Çeşitli kanserler hipertansiyon gelişimine ya da mevcut hipertansiyon kliniğinde kötüleşmeye neden olabilmektedir. Ayrıca kanser tedavisi için kullanılan bazı ilaçlar, direkt olarak veya mikroanjiyopatik ve nefrotoksik etkileri aracılığı ile dolaylı olarak hipertansiyona neden olmaktadırlar. Kemoterapi alan kanser hastalarında hipertansiyon gelişmesi en ciddi yan etkilerden biridir. Yaklaşık 25000 solid malign tümörlü hastadan oluşan retrospektif bir analizde üçte bir hastada yeni başlagıçlı hipertansiyon gelişmesi izlenmiştir. [11] Orta derecede hipertansiyon (150-160/100-110 mmHg) gelişme oranı en sık renal kanserde, ciddi hipertansiyon (160-180/110-120 mmHg) gastrik kanserlerde, kriz seviyesinde hipertansiyon (>180/120 mmHg) gelişmesi ise en sık oranda over kanserlerinde görülmüştür. İlk kanser tanısı konulmasından hipertansiyona kadar ortalama zaman 96 gündür. Hipertansiyon gelişiminde ke-

[1] Uzm. Dr., Kardiyoloji Kliniği, hizirokuyan@gmail.com ORCID iD: 0000-0001-5091-1687

etmekte, bu nedenle klinik uygulamada kullanılması istenmeyen farmakokinetik etkileşime neden olabilmektedir. [84] Psikolojik stres ve ağrı sempatik sistem aktivasyonu aracılığı ile hipertansiyonu kötüleştirebilmektedir. Kronik ağrının artmış hipertansiyon riski ile ilişkili olabileceği saptanmıştır. [85] Bu nedenle kronik ağrı uygun bir şekilde tedavi edilmeli kontrol altına alınmalıdır. [13]

Sonuç olarak, ACE inhibitörleri, ARB'ler ve dihidropiridin olmayan CCB'ler, kemoterapiye bağlı hipertansiyon için ilk tercih edilen ilaçlar olarak kabul edilmektedir. [13] Beta-blokerlerin ise özellikle sol ventrikül sistolik disfonksiyonu olan veya bundan dolayı yüksek risk altında olan hastalarda ACE inhibitörleri veya ARB'ler ile kombinasyon halinde kullanılması faydalı olabilir. [13] Olumlu bir hemodinamik profile sahip olduğundan ve NO biyoyararlanımını geri kazanabildiğinden [75,86] nebivolol tercih edilebilir. Diğer vazodilatatör beta-blokerler de seçenek olarak kabul edilebilir. [87] Kemoterapinin kanser üzerinde olumlu bir etkisi olabilmekte; bu nedenle hipertansiyon nedeni ile kemoterapi tedavisinin kesilmesi nadiren olabilir. Yaşamı tehdit edebilen hipertansif kriz, posterior geri dönüşümlü ensefalopati sendromu (PRES) ve hipertansif ensefalopati durumlarında kemoterapi kesilmesi düşünülmelidir. Tıbbi tedaviye rağmen kan basıncı kontrolü sağlanamamış ise kardiyovasküler istenmeyen olayların riski ve kemoterapinin faydası iyi tartılmalı ve ona göre karar verilmelidir. Antineoplastik ilaçların geçici olarak kesilmesi veya dozunun düşürülmesi hipertansif kriz durumlarında ve hastanın hipertansiyona bağlı istenmeyen majör kardiyovasküler olaylarda düşünülebilir. [14,88]

V. SONUÇ

Kanser tanısı alıp kronik olarak takip edilen hasta popülasyonu artmaktadır. Kanserli hastalarda hipertansiyon sıklığı normal popülasyona göre daha fazladır. Hipertansiyon istenmeyen kardiyovasküler olaylar için en yüksek risk faktörünü oluşturmaktadır. Bu nedenle tüm kanserli hastalar sağlıklı bireylerde olduğu gibi toplam kardiyovasküler risk açısından değerlendirilmelidir. Özellikle kemoterapi başlanması öncesi bu değerlendirilme önemlidir. Hastanın tam değerlendirmesi yapılırken başlangıç kan basıncı mutlaka ölçülmeli ve kayıt altına alınmalıdır. Özellikle hem hasta kaynaklı hem kullanılacak kemoterapi ve primer tümörün hipertansiyon için risk içermesi durumu varsa yakın kan basıncı takibi yapılmalıdır. Bu takip hastanın kendi ev ölçümleri ile ya da her tedavi döneminde ambulatuvar kan basıncı monitorizasyonu ile yapılabilir. Düzeltilebilir en önemli risk faktörü olan hipertansiyonun tanı ve tedavisi istenmeyen kardiyovasküler olayları önlemekle kalmayıp, ek olarak hastanın hayat kalitesini arttıracaktır.

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