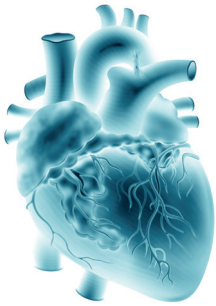
BÖLÜM 21



PULMONER EMBOLİ

Uğur TAŞKIN[1]

GİRİŞ

Derin venöz tromboz (DVT) ve pulmoner emboli (PE) içeren venöz tromboembolizm, en sık görülen üçüncü kardiyovasküler bozukluktur ve nüfusun %5'ini etkiler (1). Görüntüleme yöntemlerinin artan duyarlılığı, son 10 yılda pulmoner emboli için hastaneye başvuru oranlarının iki katından fazla artmasına neden olmuştur, ancak vaka ölüm oranı sabit kalmıştır veya azalmıştır (2-4). Alt ekstremitedeki DVT'nin akciğer arterlerine embolizasyonu pulmoner emboli için en yaygın mekanizmadır.

Pulmoner emboli tanısı için dikkatli klinik değerlendirmeye ihtiyaç vardır, çünkü klinik başvuru diğer yaygın tıbbi durumları taklit edebilir. Pulmoner emboli derhal teşhis edilmesi ve tedavi edilmesi gereken yaygın ve potansiyel olarak ölümcül bir hastalıktır. Klinik olasılık düzeltilmiş veya yaş ayarlı D-dimer yorumunun kullanılması, pulmoner emboliyi dışlamak için tanısal görüntüleme ihtiyacını azaltmaktadır (10-12).

Akut pulmoner embolili olan hastaların sadece küçük bir kısmı kısa süreli klinik bozulma ile ilişkili yüksek risk özelliklerine sahiptir, ancak bu tür hastaların tanımlanması ve tromboliz gibi antikoagülasyona ek tedavilerin de göz önünde bulundurulması önemlidir. Çeşitli risk tahmin skorları, serum biyobelirteçleri ve sağ ventrikül yüklenmesi gibi görüntüleme anormallikleri, mortaliteye neden olan nedenler için yüksek risk altındaki hastaları tanımlayabilir (9,13,15).

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sini gerektiren acil cerrahi ile sınırlandırılması önerilmektedir. Bu hastalarda, antikoagülasyona başlamanın veya devam ettirmenin güvenliği sıklıkla değerlendirilmelidir. Tam doz antikoagülasyon, majör kanamanın tekrarı olmadan yeniden başlatılabildiğinde, zamanla artan komplikasyon olasılığını azaltmak için VCI filtresi derhal çıkarılmalıdır (5,67).

Pulmoner Emboli İçin Tedavi Süresi

Oral antikoagülan tedavinin optimal seyri, tedaviyi durdurduktan sonra tekrarlayan venöz tromboemboli riskine ve antikoagülana bağlı kanama riskine göre belirlenir. Klinik risk faktörleri nüks riskini öngörmede önemli görülürken, biyokimyasal ve morfolojik testlerin etkisi belirsizdir. Tekrarlayan venöz tromboemboli riski, ilk atak geri dönüşümlü bir majör risk faktörü (cerrahi) tarafından provoke edildiğinde düşüktür: 3 aylık antikoagülasyon yeterlidir. Tersine, venöz tromboembolizm provoke edilmediğinde veya kalıcı risk faktörü (kanser) ile ilişkili olduğunda risk yüksektir: 6 ay veya daha uzun süreli antikoagülasyon gereklidir. Bu ilk tahminden sonra, antikoagülasyon süresi, bazı ek risk faktörlerinin (majör trombofili, kronik pulmoner hipertansiyon, masif pulmoner emboli) varlığına veya yokluğuna göre modüle edilebilir: pulmoner emboli provoke edilmişse 6 ay ve pulmoner emboli provoke edilmemişse 12 ila 24 ay. Antikoagülanla ilişkili kanama riski yüksekse, antikoagülasyon süresi kısaltılmalıdır (pulmoner emboli provoke edilmişse 3 ay, provoke edilmemişse 3 ila 6 ay). Son olarak, pulmoner emboli kanserle birlikte ortaya çıktıysa, kanser aktifse veya tedavi devam ediyorsa antikoagülasyon 6 ay veya daha uzun süre yapılmalıdır (72).

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