17. BÖLÜM

İNME REHABİLİTASYONU

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Giriş

İnme beyin kan akımının aniden azalması veya durmasıyla meydana gelen motor kontrol ve duyusal fonksiyon kaybı, denge problemleri, konuşma ve kognitif fonksiyon kaybı, görme bozuklarından komaya kadar gidebilen klinik bir tablodur (1-2). Dünya Sağlık Örgütü tarafından inme, vasküler kaynaklı olup ölüme sebebiyet verebilen veya hızla gelişen ve 24 saatten daha uzun süren serebral fonksiyonların bozulması nedeniyle ortaya çıkan fokal veya yaygın klinik tablo olarak tanımlanmaktadır (3).

Serebrovasküler hastalıkların insidansı ülkelere göre değişmekle beraber son verilere göre dünya genelinde 100000'de 258, ülkemizde ise 100000'de 177 kişi olduğu bildirilmektedir. İnme ülkemizde de dünyada olduğu gibi ölüm nedenleri arasında 2. sırada engellilik nedenleri arasında 3. sırada yer almaktadır (4, 5).

İnme insidansı ilerleyen yaşla birlikte artış göstermekle beraber erkek cinsiyette daha sık görülmektedir (6).

Beklenen yaşam süresi tüm dünyada artmaktadır. Gelişen tedavi yöntemleri ile birlikte SVO sonrası sağkalım oranlarının artması bu sürece katkıda bulunmuştur. İnme rehabilitasyonunda amaç bireye en yüksek seviyede fonksiyonel bağımsızlığı kazandırabilmek ve yaşam kalitesini arttırmaktır. Rehabilitasyon programında hasta ile beraber, hastanın ailesi ve bakıcısı da sürece dahil edilmelidir (2).

1.Risk Faktörleri

İnme risk faktörleri açısından iyi bilinen bir klinik tablodur. Bu nedenle risk faktörlerini analiz ederek inmenin ortaya çıkmasını engellemek çok önemlidir. Yaş, cinsiyet, ırk ve genetik gibi değiştirilemeyen risk faktörleri olmakla beraber bir kısmı da değiştirilebilir özelliktedir (7).

Hipertansiyon değiştirilebilen risk faktörleri arasında bilinen en önemli risk faktörüdür. Normotansif hastalardan farklı olarak hipertansif hastalarda serebral infarkt 7 kat daha sık tespit edilmiştir (8).

Atriyal fibrilasyon (AF) olan hastalarda iskemik inme riskinin 5 kat arttığı saptanmış olup antikoagülan tedavi ile beraber bu riskin azaldığı gösterilmiştir (9).

Diyabetes mellituslu hastalarda inme riski 2,5 kat daha fazladır (10). Diyabet bir zamanlar laküner infarkt için risk faktörü olarak düşünülse de artık genel anlamda iskemik inme ile ilişkili olduğu gösterilmiştir. Ayrıca hipertansiyon, lipid bozuklukları, sigara ve AF gibi klasik risk faktör-

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rında konvansiyonel rehabilitasyon yöntemlerine kıyasla daha anlamlı bir iyileşme sağladığı belirtilmiştir (106).

9. İnme Rehabilitasyon Sonuçları, Prognoz ve İzlem

Hastalarda rehabilitasyon sürecinin olası sonuçlarının ve prognozun tahmini çok önemlidir. Buna göre hasta ve ailesi bilgilendirilir, uygun rehabilitasyon yöntemleri belirlenir ve hastanın kronik dönemde izlemi planlanmalıdır (2).

Rehabilitasyondan sonra hastalarda fiziksel performans, fonksiyonel yetenek ve yaşam kalitesinde önemli gelişmeler kaydedilebilir. Geniş ve kapsamlı bir çalışma olan Framingham çalışmasında inmeli hastaların %69' u kişisel bakım aktivitelerinde, %80'i de mobilizasyonda bağımsızlık kazandığı belirtilmiştir (107).

Yapılan bir derlemede koma varlığı, kognitif fonksiyonlarda bozukluk, ciddi hemipleji, tekrarlayan inme atakları, inatçı inkontinans, ihmal sendromu, algısal yetilerde kayıp, motor fonksiyonlarda düzelmenin 1 ay içinde başlamaması, önemli bir KVS hastalığının bulunması, serebral lezyonun büyük olması ve birden fazla nörolojik bozukluk olması gibi faktörler varlığında prognozun kötü olacağını savunmuşlardır (108).

İnme sonrası hastalar ko-morbid problemler açısından detaylı irdelenmeli ve olabildiğince erken dönemde rehabilitasyon programına alınmalıdır. Özellikle ilk 6 ay-1 yıllık süreç hastanın fonksiyonellik kazanması açısından ciddi öneme sahiptir. İnme hastalarında engellilik takibi açısından da bu süreler dikkate alınmalıdır. Engellilik kararı için rehabilitasyonda ulaşılan maksimum fonksiyonellik durumu göz önüne alınmalıdır. Ancak en az 6 ay- 1yıl süre ile rehabilitasyon sonrası değerlendirme daha doğru yol gösterecektir.

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