

6. BÖLÜM

ANA KORONER LEZYONLARDA PERKÜTAN KORONER GİRİŞİM

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GİRİŞ

Sol ana koroner (LMCA) hastalığı ilk kez 1912 yılında akut miyokart enfark-tüsü (MI) nedeniyle hayatını kaybeden bir hastada James Herrick tarafından tanımlanmıştır (1). Günümüzde koroner anjiyografi (KAG) yapılan hastaların %5-7'sinde kritik öneme sahip korumasız LMCA lezyonu görülmektedir (2).

Tarihsel olarak kritik öneme sahip korumasız LMCA hastalığı yönetiminde koroner arter bypass greft (CABG) cerrahisi altın standart tedavi iken stent tek-nolojisindeki ve antitrombotik farmakoterapideki gelişmelere paralel, düşük ve orta anatomik kompleks risk skorlarına sahip hastalarda perkütan koroner giri-şim de (PKG) optimal revaskularizasyon modaliteleri arasındaki yerini almıştır.

Bu bölümde, yakın zamanda yayımlanan randomize kontrollü çalışmalar ve güncel kılavuzlardan elde edilen veriler ışığında, LMCA lezyonlarında optimal PKG sonucunu elde etmek için gerekli teknik ve ipuçları tartışılacaktır.

ANATOMİ VE FİZYOLOJİ

LMCA, sinotubuler bağlantı noktasının hemen altında sol aortik sinüsten köken alır ve üç anatomik bölgeye ayrılır: Ostium, orta kısım ve distal kısım. LMCA ostiumu adventisya tabakasına sahip değildir ve daha yüksek elastik re-coil (büzüşme) özelliği gösterir. Orta ve distal LMCA ise koroner ağacın diğer kısımları gibi trilaminar damar anatomisine sahiptir (3).

Olguların 2/3'te sol ön inen koroner arter (LAD) ve sirkumfleks koroner ar-tere (LCx), 1/3'nde LAD ve LCx yanında ramus intermediusa ayrılır. LMCA, sağ

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