BÖLÜM 48

Erişkin Dikkat Eksikliği ve Hiperaktivite Bozukluğunda Psikofarmakolojik Tedaviler

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GİRİŞ

Dikkat eksikliği ve hiperaktivite bozukluğu (DEHB) erişkin toplumda yaklaşık %2.5-4 oranında görülen (1), birçok genetik ve çevresel risk etmeninin birleşmiş etkileriyle oluşan bir bozukluktur (2). Erişkinde klinik görünümünü dikkat eksikliği veya aşırı odaklanma, hiperaktivite, impulsivite, emosyon düzenleyememe (3) zihinsel aşırı gezinme (4) ve yürütücü işlevlerde bozulma oluşturur (5). Görüntüleme çalışmalarında inferiyor fronto-striyatal ağlar, fronto-striyato-paryetal ağlar ve fronto-serebellar ağlarda aktivite azlığı (6) ve default mod alanlarında anormal aktivite artışı tutarlı şekilde gösterilmiştir (7). Bu çalışmaların kesitsel, sonuçlarının ilişkisel olduğu ve nedensellik göstermediği akılda bulundurulmalıdır (8). Bir pozitron emisyon tomografisi (PET) çalışmasında, dinlenme sırasında, sağ kaudat tonik dopamin (DA) salınımının düşük, bir görev sırasında fazik DA salınımının yüksek olduğu kaydedilmiştir (9). Tonik DA ve norepinefrin (NE) faaliyetlerinin düşük olması düşük uyarılmışlıkla, fazik DA ve NE faaliyetlerinin yüksek olması aşırı uyarılmışlıkla ilgili olabilir (10). DA, metabolizması sırasında presinaptik nörondan sinaptik aralığa salınır. DA taşıyıcıları (DAT) dopamini presinaptik nörona geri alır. DEHB tanılı bireylerde kontrollere kıyasla DAT yoğunluğunun arttığı bildirilmekle beraber (11) stimülan almamış hastalarda DAT yoğunluğunun azalmış olduğunu savunan araştırmacılar da vardır (12, 13). Yeterli nöronal iletim olamadan DA'in hızla hücreye geri alındığı öne sürülmüştür (11).

Klinik uygulama kılavuzlarına göre çekirdek belirtilerin tedavisinde ilk seçenek farmakoterapidir (14, 15). DEHB tedavisinde kullanılan ilaçlar, en az psikiyatri dışı hastalıkların tedavisinde kullanılan ilaçlar kadar etkilidir (16). Farmakoterapi, DEHB ile ilişkili kaza ve yaralanmalar (17), zehirlenmeler (18) travmatik beyin hasarı (19), tütün (20) ve madde kullanımı (21), eğitim hayatında başarısızlık (22), kemik kırıkları (23), cinsel yolla bulaşan hastalıklar, depresyon (24), intihar (25), suça karışma (26) ve erken yaşta gebelik gibi olumsuz sonuçları azaltmaktadır (27). Kanıtlar bilişsel davranışçı terapinin monoterapi olarak kullanılmasını desteklememektedir (28, 29) ancak ilaç tedavisiyle birlikte kullanıldığında tek tedavi yönteminden daha etkindir (30). Kişiselleştirilmiş, düzenli görüşmelerle hastanın ihtiyaçlarına yönelik belirlenen; psikoeğitim, bilişsel davranışçı terapi ve koçluk gibi yaklaşımlarıyla birleştirilmiş

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olduğu gösterilen ilaç grubu stimülanlardır. Uzun etkili ve yavaş salınımlı stimülanlar, günlük tek doz uygulama kolaylığı, tedavi uyumunun daha iyi olması, geri tepme belirtilerine yol açmaması ve kötüye kullanımın düşük olması nedeniyle ön planda tercih edilmelidir. Geniş ölçekli çalışmalar amfetaminlerin etki büyüklüğünün metilfenidattan yüksek olduğunu göstermektedir. Amfetaminler Türkiye'de onaylı değildir. DEHB tedavi başlangıcı ve süresince kan basıncı ve nabız takibi yapılır. Ciddi kardiovasküler sorunlar nadirdir**.** Atomoksetin kötüye kullanım potansiyeli olmadan, stimülan tedaviyi tolere edemeyen, madde kullanım bozukluğu veya tik bozukluğu olan bireylerde kullanılabilen bir seçenektir. Bupropiyon, DEHB + depresyon varlığında uygun olabilir. Trisiklik antidepresanlar erişkin DEHB'de etkilidir ancak başta kardiyotoksisite olmak üzere yan etkileri etkileri kullanımlarını sınırlamaktadır. Tedavide ilerleme, doğru psikofarmakolojik ve psikoterapötik yaklaşımı içeren multimodal tedavi ve ilgili uzmanın derinlemesine bilgi ve eğitimiyle sağlanabilir.

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