Bölüm 7

DEFİBRİLASYON VE KARDİYOVERSİYON

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GİRİŞ

Duran kalbi çalıştırmak veya ritim bozukluklarını düzeltmek amacı ile elektriksel akım kullanımı çok eskilere dayanır. 18'nci yüzyıl sonlarında deney hayvanlarında yapılan çalışmalarda ilk elektriksel uyaran sonrası deneğin kalbinin durduğu, 2'inci elektriksel uyaran sonrası ise aynı deneğin tekrar kalp atımlarının başladığından bahsedilmektedir [(1)].

Yılda ortalama 350 000 Amerikalı kalp hastalıklarından dolayı hayatını kaybetmektedir. Bunların yarısı hastane dışında aniden gelişir. Erişkinlerde ani kalp ölümlerinin en sık nedeni nabızsız ventriküler taşikardi (VT) ve ventriküler fibrilasyondur (VF). Nabız varlığında da VT gelişebilir fakat genelde sonrasında VF gelişir [(2)].

VT genellikle hızlı, 0.12 saniyeden daha geniş QRS kompleksi ile tanımlanır. Supraventriküler Taşikardi (SVT) atım hızı 100 üzerine olan, his demetinin proksimalinden kaynaklanan ritimler için kullanılır. SVT ise hızlı, 0.12 saniyeden dar QRS kompleksleri ile tanımlanır. Ventrikülden kaynaklanmayan taşikardik ritimler genellikle SVT olarak adlandırılır ve sinüs taşikardisi, junctional taşikardiler, reentran taşikardiler, multiple atriyal taşikardiler, multifokal atriyal taşikardiler (MAT), atriyal fibrilasyon ve atriyal flutter bu tanımın içinde yer alır. Farklı supraventriküer ritimler SVT'ye neden olabilir ve hepsi klinik olarak benzer şekilde tedavi edilirler [(3)].

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- Yine hastaya bağlı olarak, transtorasik empedans, aritminin tipi, kullanılan antiaritmik ilaç ve aritminin süresi gibi pek çok faktör de başarılı kardiyoversiyon veya defibrilasyon şansını etkilemektedir.
- Pek çok hastada ped veya kaşıkların yerleştirilmesi için genelde anteroposterior pozisyonun önerilmesine paralel olarak, ICD veya kalp pili olan hastalarda da ICD üzerinde yer alan deri ile temas etmemek şartı ile pedlerin anteroposterior olarak benzer şekilde yerleştirilmesi önerilmektedir. Bu sayede şokun etkisi artar ve olası ICD hasarı riski en aza indirilmiş olur.

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