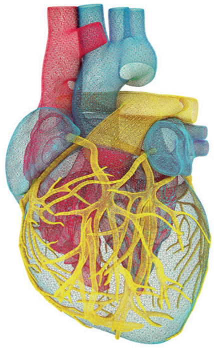

BÖLÜM 40

Diyabetik Hastada Serebrovasküler Hastalık

Gökçe AYHAN ARSLAN [1]

GİRİŞ

Serebrovasküler hastalıklar, dünya çapında mortalite ve erişkin morbiditesinin ikinci önde gelen nedeni olarak kabul edilen önemli bir halk sağlığı sorunudur (1, 2). Tüm inmelerin %87'sini iskemik inmeler, %10'unu intraserebral kanamalar (İSK), %3'ünü ise subaraknoid kanamalar oluşturur (3). Diyabet, nörovasküler hastalıklar için iyi bilinen bir risk faktörüdür (4-6). Diyabetik hastalarda inme riski her yıl %3 artmakta olup, 10 yıldan fazla diyabetik olan hastalarda ise bu risk üçe katlanmaktadır (7).

Benzer şekilde Tip 2 diyabetes mellitus (DM) da serebrovasküler hastalık için belirlenmiş bir risk faktörüdür (8, 9). Kohort çalışmalarında, Tip 2 DM diğer risk faktörlerinden bağımsız olarak hem iskemik hem de hemorajik inme için yüksek risk ile ilişkilidir (10). Tip 2 diyabet tek başına inme riskini 1.5 - 4 kat artırmakla birlikte olumsuz klinik sonlanıma neden olur. (11). Ayrıca, akut inme nedeniyle başvuran hastaların yaklaşık % 20–33'ünün diyabetik olduğu tahmin edilmektedir (5, 12).

Yaklaşık 8,5 milyon diyabetik hastanın izlendiği 102 prospektif çalışmanın değerlendirildiği bir meta-analiz çalışmasında iskemik inme riskinin 2.27 ve hemorajik inme riskinin ise 1.56 kat arttığı gösterilmiştir (10). Diyabet ayrıca geçici iskemik atak (GİA) sonrası inme riskini de artırır ve ABCD2 GİA risk skorlamasına dahildir (13).

Diyabet ve inme riski ilişkisi cinsiyete göre farklılık göstermektedir. Majör kardiyovasküler risk faktörlerindeki temel farklılıklar dikkate alınarak diyabetik erkeklerle karşılaştırıldığında, diyabetik kadınlardaki diyabetik inme rölatif riskinin %27 daha fazla olduğu bildirilmiştir (14).

Diyabet, inme rekürrensi için de bağımsız bir risk faktörüdür. Daha önce inme geçirmiş katılımcıları içeren 18 çalışmanın meta-analiz sonucuna göre diyabetik hastalarda diyabetik olmayanlara göre daha yüksek inme rekürrensi tespit edilmiştir (15). İnme rekürrens riskinin artışıyla birlikte (16) diyabet, özellikle inmeden sonra ortaya çıkan kognitif bozukluk ve demans gelişme riskinin riskini artırmaktadır.(17).

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Yakın zamanda yayınlanan bir meta-analizde diyabetik hastalarda düşük doz ASA kullanımı (≤100 mg/gün) ile inme riskinde önemli ölçüde azalma gösterilmiştir (76). Başka bir meta-analizde ise iskemik inmenin primer önlenmesinde ASA kullanımının rölatif riski %10 azalttığı tespit edilmiştir (77). Ancak, inmenin primer ve sekonder önlenmesinde antiagregan temelli tedavi planı belirlenirken kanama riski göz önünde bulundurulmalıdır (78).

Diyabet hastalarında sistolik kan basıncının 10 mmHg düşmesi inme riskini azaltmaktadır. Sistolik kan basıncının düşürülmesi, bazal sistolik kan basıncı ≥140 mm Hg olan tip 2 diyabet hastalarında inme riskini azaltmaktadır. Öte yandan, sistolik kan basıncının 130 mm Hg'nin altına düşürülmesi daha düşük inme riski ile ilişkilidir ve bu durum, yüksek inme riski olan bireylerde daha yoğun kan basıncını düşürmenin faydalı olduğunu göstermektedir (79).

Yeni nesil antidiyabetik ajanlarla ilgili yakın zamanda yapılan bir meta-analizde pioglitazon ve ayrıca GLP-1RA sınıfı ilaçların diyabeti veya insulin direnci olan hastalarda doğrudan glukoz düşürmeyen mekanizmalarla inme riskini azalttığı gösterilmiştir (80).

SONUÇ

Rehberler doğrultusunda akut iskemik inmeden sonra tüm hastaların DM açısından açlık plazma glukozu, HbA1c veya oral glukoz tolerans testiyle taranması önerilmektedir. Genel olarak, inme sonrasındaki erken dönemde HbA1c ile değerlendirme diğer testlerden daha doğru sonuç verebilmektedir. Diyabet hastalarında inmenin primer ve sekonder önlenmesinde tedavi modaliteleri belirlenirken artmış kanama riski göz önünde bulundurulmalı ve bireysel olarak fayda-zarar oranı belirlenerek tedavi planlanmalıdır. Ayrıca diyabetik hastalarda kısa ve uzun dönemdeki olumsuz etkileri düşünüldüğünde hipoglisemiden kaçınılmalıdır. İnmenin önlenmesinde bütüncül yaklaşım önemli olup mevcut komorbid durumların tedavisi ve yaşam tarzı değişikliği yapılması önemlidir.

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