

BÖLÜM 26



Kanser Hastasında Atriyal Fibrilasyon

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GİRİŞ

Kardiyovasküler hastalıklar(KVH) ve kanser arasındaki yakın ilişki nedeniyle kardiyo-onkoloji son yıllarda önemi artarak karşımıza çıkmaktadır(1). Kardiyo-onkoloji multidisipliner olarak yürütülmeli gereken bir alandır.Bu alan da kardiyolog, radyasyon onkoloğu, tıbbi onkolog, hematolog birlikte çalışmalıdır.

Kanser dışı mortalitenin tüm dünyada en sık nedenini KVH'lar (%11.3) oluşturmaktadır(2). Atriyal fibrilasyon (AF) en sık görülen kardiyak aritmidir ve artmış kalp yetmezliği, felç, anti-koagülasyona bağlı kanama ve mortalite riski ile ilişkilidir (3). AF prevalansı yaş ile birlikte artar (4). ATRIA çalışmasında, Amerika Birleşik Devletleri'nde 1996 ve 1997'de 2,3 milyon yetişkinin AF'si olduğu ve bunun 2050 yılına kadar 5,6 milyona çıkacağı ve yüzde 50'den fazlasının 80 yaşın üzerinde olduğu tahmin edilmiştir (5). Kanser ve AF komorbidite açısından paydası bir olabilecek pek çok ortak noktaya sahiptir. AF riski yaşla birlikte artmasının yanı sıra, kanserli hastalarda da kanser olmayan hastalara göre daha yüksek olabilir ve kanser has-

talarında yeni başlayan AF daha ileri bir kanser evresini yansıtabilir ve daha kötü bir прогноз belirtisi olabilir (6).

Kanser hastalarında aritmiler kanser tanısından önce bulunabileceği gibi,kanser hastalarında görülen AF'nin pek çok sebebi olabilir. Primer tümörüne bağlı gelişebileceği gibi hastanın aldığı kemoterapi, immunoterapi, he-defe yönelik tedavi ve radyoterapiye sekonder yani tedaviye ikincil olarak da ortaya çıkabilir(7,8,9,10).

Kanser hastasının kardiyovasküler toksisite riski yüksek olduğundan dolayı hastanın tedavi öncesinde mutlaka ayrıntılı değerlendirilmesi önemlidir. Kanser hastasının AF yönünden doğru değerlendirilip takip ve tedavi planının buna bağlı olarak yapılması;kanser ve KVH ile ilişkili morbidite ve mortalitesi açısından önem taşımaktadır. Hastaların tüm kardiyak riskler yönünden ayrıntılı olarak değerlendirilmesi gelebilecek komplikasyon riskini aza indirmek,- hastanın tedavi devamlılığı açısından da önem arz etmektedir.

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Kanser Hastasında Atrial Fibrilasyonda Antikoagülasyon Tedavisinin Yönetimini Etkileyen Diğer Faktörler

Kanser hastasında trombositopeni hem hastalığına ikincil, hem de verilen tedaviye ikincil görülebilir. Her ikisi durumla da ilişkili olarak çeşitli mekanizmalar mevcuttur. Kanserle ilgili (örneğin trombosit sentezinde azalma ile kemik iliği replasmani, splenomegali nedeniyle dalak sekestrasyonu ve immün aracılı trombosit yıkımı) ve tedaviyle ilgili (yani kemoterapi ve radyoterapi) trombositopeniye neden olabilir(67). AF'li hastalarda trombositopeni, artan mortalite riski ile ilişkilidir(68). Trombosit sayısı $50 \times 10^9/L$ 'nin altına düşüğünde genellikle antikoagülasyon için bir kontrendikasyon olarak kabul edilir(69). Bu hastalarda, risk-fayda oranı belirsizdir ve bireysel trombotik ve kanama riski göz önünde bulundurularak tedavi dengelenmelidir. NOAK'ların randomize klinik çalışmaları, atriyal fibrilasyonu ve kanseri olan hastalarda vitamin K antagonistlerine kıyasla benzer bir güvenlik ve etkinlik gösterse de, trombosit sayısı $<100 \times 10^9/L$ olan hastalar çalışmalardan çıkarılmıştır(70).

SONUÇ

Kanser hastasında AF tedavisi kanser olmayan hastalardaki tedavi protokollerini ile aynıdır. Burada kanserli hastanın ek komorbideteleri, kulandığı ilaçlar ve kan tablosunda kanser hastalığından kaynaklanabilecek hızlı değişiklikler nedeni ile dengede bir tedavi planı yapmak ve yönetmek zorludur. Primer kanser tedavisi ile AF'de sinüs ritmine döndürebilecek ve emboliden koruyucu ajanlarla yapılacak tedavide ilaç-ilaç etkileşimi de çok hassas bir konudur. Hastayı hem emboliden, hem kanamadan korumak için ayrıntılı bir tedavi planı oluşturmak öncelikli hedef olmalıdır. Kanser tanılı AF hastalarının tedavisi kardiyolog, onkolog ortak bir algoritma oluşturmalıdır.

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