BÖLÜM 33

Geriatrik Hastalarda Atriyal Fibrilasyon Yönetimi

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GİRİŞ

Atriyal Fibrilasyon (AF), klinikte en sık karşılaşılan aritmidir. AF insidansı ve prevalansı yaş ilerledikçe artmaktadır (1). 49 yaş ve altında AF prevalansı %0.12- 0.16 arasında iken bu oran 60-70 yaş arasında %3.7-4.2'ye kadar yükselmektedir. 80 yaş ve üzeri bireylerde ise %10-17 arasında olduğu bildirilmiştir (2). Yaş ile birlikte hipertansiyon, konjestif kalp yetmezliği, diabetes mellitus, koroner arter hastalığı ve kapak hastalığı AF gelişimi için bağımsız risk faktörleri olarak kabul edilmektedir (3). Hastaların çoğunda asemptomatik seyretmesine karşın AF tromboemboli riskinde ve buna bağlı olarak inme riskinde artışla ilişkilendirilmiştir. Atriyal fibrilasyonlu hastalar inme, kalp yetmezliği, pacemaker implantasyonu ihtiyacı ve antikoagülan ve antiaritmik tedavilere bağlı istenmeyen olaylar gibi nedenlerle daha sık hospitalize edilmektedir (1). Bunlara ek olarak AF kırılganlık, kognitif bozukluk (demansla birlikte veya demansın eşlik etmediği), fiziksel performansta azalma ve fonksiyonelliğin kaybı gibi durumlarla da yakından ilişkilidir (4-6).

AF riskini arttıran çeşitli faktörler bulunmaktadır, bunlar değiştirilebilir ve değiştirilemez faktörler olarak gruplandırılabilir (7). Vücut kitle indeksi, diabetes mellitus varlığı, obstruktif uyku apnesi varlığı, hipertansiyon varlığı değiştirilebilir risk faktörleri olarak kabul edilirken; genetik yatkınlık, cinsiyet, etnik köken ve yaş değiştirilemeyen risk faktörleri arasındadır. Bu risk faktörleri yapısal ve histopatolojik değişikliklere neden olarak AF'ye yatkınlığı arttırmaktadır (8). AF'nin ortaya çıkması için hem atriyal ektopik atımları tetikleyebilen ve AF paroksizmlerine yol açabilen kritik bir anormal doku kütlesi(anatomik substrat) hem de başlatıcı bir faktör gereklidir. Ektopik tetikleyici odakların ana kaynağı pulmoner venler olabilir(9). Bununla birlikte, yaş ile AF arasındaki patofizyolojik mekanizma tam olarak anlaşılamamıştır. Yaşlı hastalarda, birden fazla komorbiditenin varlığı, yaşlanmanın etkisine karşı çoklu morbiditelerin AF gelişimi üzerindeki etkisini tek başına belirlemeyi zorlaştırmaktadır. Hipertansiyon, iskemik kalp hastalığı, kalp yetmezliği, kapak hastalığı ve di-

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lidir. Kapsamlı geriatrik değerlendirme AF'li yaşlı hastalarda hasta merkezli kararların optimize edilmesine yardımcı olmaktadır(65).

Randomize- kontrollü çalışmalar ve gözlemsel çalışmalar, yaşlı hastaların çoğunda YOAK'ların VKA'ya göre klinik yarar sağladığını gösterse de, kırılganlıkla yaşayan, fonksiyonel kaybı olan ve ciddi kognitif bozukluğu olan hastalarda klinik kanıtlar yetersizdir. Yaşlı erişkinlerde AF tedavisine ilişkin kararlar daha spesifik ve bütüncül bir yaklaşım gerektirir; kapsamlı geriatrik değerlendirme ve uygun kırılganlık araçları yapılan kırılganlık değerlendirmesi tedavinin biryselleştirilmesinde yardımcı olabilir. Oral antikoagülan tedavi başlanmasına karar verilirken kronolojik yaştan ziyade bireyin kırılganlığı, fonksiyonel durumu, kognitif durumu gibi faktörlere dikkat edilmelidir. Fakat bu durumların varlığı oral antikoagülan tedavi için mutlak kontrendikasyonlar olarak görülmemelidir. Düşme riski, YOAK kullanımı için bir kontrendikasyon olarak düşünülmemelidir. Yüksek kanama riski oral antikoagulan tedavi için bir kontrendikasyon olarak değerlendirilmemelidir ve sağlık çalışanlarını değiştirilebilir kanama risk faktörlerini değerlendirmeye ve yönetmeye yönlendirmelidir(65).

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