BÖLÜM 5

KRİPTOJENİK İSKEMİK İNMEDE TEDAVİ YAKLAŞIMI

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GİRİŞ

Dünya Sağlık Örgütünün tanımlamasına göre inme; vasküler nedenler dışında görünür bir neden olmaksızın, fokal serebral fonksiyon kaybına ait belirti ve bulguların hızla yerleşmesi ile karakterize klinik bir sendromdur. İnme, iskemik ve hemorajik kökenli olmak üzere iki başlık altında incelenmektedir. Tüm inmelerin yaklaşık %80-85 'i iskemik, %15-20'si hemorajiktir (1).

İskemik inmelerin çoğu kardiyoemboliye, büyük damar aterotromboembolisine, küçük damar oklüzyonlarına veya diğer bilinmeyen mekanizmalara bağlı olarak oluşmaktadır. Standart değerlendirmelerde muhtemel bir etiyoloji saptanamayan grup ise kriptojenik inme olarak sınıflandırılmaktadır (2). İnme sınıflamasında Trial of Org 10172' in Acute Stroke Treatment sınıflaması yaygın olarak kullanılmaktadır. Bu sınıflamada inme etiyolojileri; büyük damar hastalığı, kardiyoembolik inme, küçük damar hastalığı, diğer sebepler ve kriptojenik iskemik inme (Kİİ) şeklinde sınıflandırılmıştır (3).

TOAST sınıflamasında da belirtildiği üzere iskemik inme hastalarının yaklaşık %15-40'ında bir inme nedeni bulunamamaktadır. Bu grup kriptojenik inme hastalarını oluşturur. Kİİ' de nedenin bulunamamasını 3 başlık altında toplamak mümkündür. Bunun birinci nedeni yapılan tüm araştırmalara karşı inmeden sorumlu bir etyolojinin saptanmamasıdır. Kİİ grubundaki hastaların bir kısmında beynin farklı arter sulama alanlarında emboli, sistemik embolizm veya intrak-

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2019'da Nouh ve ark. iskemik inme ile başvuran hastalarda gizli maligniteyi düşündüren radyografik "üç bölge işareti"ni tanımlamıştır (66). Raporlarında, bilateral hemisferlerde ve arka dolaşımda çakışan iskemik lezyonlarının varlığının, AF dahil diğer inme etiyolojileriyle karşılaştırıldığında gizli kanser için %96.4'lük bir özgüllüğü vardı (67). 2014'te Guo ve meslektaşları, görüntülemede çoklu bölge enfarktlarının kombinasyonunu D-dimer seviyeleri ≥0,55 mg/L ile kanserle ilişkili inme için %99,7 özgüllük ve %92,9 pozitif öngörü değeri ile ilişkilendirdiler (68). Bu nedenle, birden çok vasküler bölgede enfarktüs kanıtı, anormal inflamatuar belirteçler ve hastayla ilgili bir veya daha fazla yüksek riskli faktör (örn. yaş≥ 65 yaş, açıklanamayan kilo kaybı, sigara veya aile öyküsü) varsa yaşa uygun kanser taraması ve ayrıca göğüs, karın ve pelvis tomografi ile başlayabilir. Bununla birlikte, malignitesi olduğu bilinen hastalarda değerlendirme, olası derin ven trombozunu değerlendirmek için üst ve alt ekstremite ultrason flebografisini (sağdan sola şant varsa) ve marantik endokardit kanıtı aramak için TEE' yi içermelidir. Çünkü bu bulgulardan herhangi birinin varlığı antikoagülasyon tedavisini gerektirecektir.

Antikoagülasyon tedavi endike ise, düşük moleküler ağırlıklı heparin (LMWH), varfarin tedavisine kıyasla etkin ve güvenli olduğundan, kanserle ilişkili venöz tromboemboli için tercih edilen birinci basamak tedavi olmuştur. Bununla birlikte, son yıllarda, YOAK grubu ilaçlara karşılaştırılabilir etkinlikleri ve kullanım kolaylıkları nedeniyle büyük önem verilmiştir. İlk araştırmalar rivaroxaban ve edoxaban gibi ajanların kanserle ilişkili tromboz için kullanımını destekledi, ancak majör kanama endişeleri nedeniyle sınırlı kaldı. Bununla birlikte, apixabanı LMWH(dalteparin) ile karşılaştıran yeni bir çok uluslu randomize çalışma, artmış majör kanama riski olmadan apiksabanın etkinliğinin deltaparinden aşağı olmadığını göstermiştir. Bu nedenle apiksaban, kansere bağlı tromboembolizm için DMAH'ye bir alternatif olarak düşünülebilir. Bununla birlikte, net bir emboli kaynağının yokluğunda, antiplatelet tedavi, malignite ve iskemik inmeli hastalarda standart tedavi olmaya devam etmektedir (69, 70).

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