BÖLÜM 2

AKUT KORONER SENDROMLAR: ACİL SERVİS YÖNETİMİ

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GİRİŞ

Akut koroner sendromlar (AKS) acil servise başvuruların en sık nedenleri arasındadır (1). Çok hızlı bir şekilde tanısı koyulduktan sonra hastaların acil serviste tedavisini başlatmak gerekir. Çünkü akut koroner sendromlarda tedavinin erken başlaması kurtarılabilir kalp kası dokusu açısından önem taşımaktadır (2-5). Genel kabul görmüş Elektrokardiyogram (EKG) bulgularına göre AKS'ı ST-segment yükselmeli miyokard infarktüsü (STEMI), ST-segment yükselmesi olmayan miyokard infarktüsü (NSTEMI) ve kararsız anjina (unstabil angina pectoris, USAP) şeklinde sınıflayabiliriz. USAP ve NSTEMI arasında tedavi bakımından fark olmadığı için STEMI ve NSTEMI olarak iki farklı yönetim şeklinde bahsedilecektir. Bölüm içerisinde aksi belirtilmedikçe NSTEMI tabiri hem NSTEMI hem de USAP hastalarını kapsamaktadır.

TANI ALGORİTMALARI

Acil servise göğüs ağrısı ile başvuran hastalarda öykü ve fizik muayene sonrası başvuru EKG'sinde ST elevasyonu veya eşdeğeri bulguları olan hastanın STEMI tanısını konulup yönetimine geçilebilir. Ancak başvuru sırasında EKG'de STEMI kriterlerini karşılamayan veya tamamen normal olan ancak AKS şüphesi devam eden hastalar için kılavuzlar tarafından konvansiyonel troponin (cTn) ve yüksek duyarlıklı troponine (hs-cTn) dayalı olarak belli başlı klinik algoritmalar geliştirilmiştir. Hayatı tehdit eden acil durumlar dışlandıktan sonra tanı veya dışlama konusunda uluslararası kılavuzlarda da önerilen klinik karar verme algoritmalarının risk sınıflamasına göre örnek yaklaşımı Şekil 1'de gösterilmiştir. Bu klinik risk

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kez 500-1000 mg 1-2 hafta boyunca sonrasında dozu yarıya düşerek 2 hafta daha devam edilir.) ve kolşisin (3 ay boyunca) tedavisidir. Mekanik komplikasyonlara yatkınlığı arttırma ihtimali nedeniyle kortikosteroidler önerilmez.

Tablo 7. Akut perikardit için tanı kriterleri

Akut perikardit tanı kriterleri (≥2 kriter tanı için yeterli)
Plöretik göğüs ağrısı
Perikardiyal sürtünme sesi
EKG bulguları (yaygın hafif ST elevasyonu veya PR çökmesi)
Perikardiyal efüzyon

Kardiyak Arrest

AKS erken dönemde mortalitenin başlıca sebebi VF'a bağlı kardiyak arrest durumudur. STEMI erken döneminde VF gelişme ihtimali sebebiyle hastaların defibrilatör ile monitörize bir şekilde takip edilmesi gerekir. Kardiyak arrest nedeniyle başvuran hastalarda spontan geri dönüş sağlandıktan sonra EKG'de STEMI olması veya belirsiz EKG ancak yüksek şüphe olması durumunda acil PKG önerilmektedir (<2 saat) (4, 52). Başarılı resüsitasyon sonrası hastalarda hedeflenmiş vücut sıcaklığı (diğer bir deyişle terapötik hipotermi) 32-36 *C olacak şekilde en az 24 saat yapılabilir. Ancak bu tedavi AKS asıl tedavisi olan reperfüzyon stratejileri ve adjuvan tedavilerini geciktirmemesi gerekmektedir. Kardiyak arrest yönetimi ileri kardiyak yaşam desteği öneri ve algoritmaları doğrultusunda gerçekleştirilmelidir. Başarılı resüsitasyon AKS hastalarının sağ kalımında önemli rol oynamaktadır.

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