BÖLÜM 6

KALP YETMEZLİĞİ VE AKUT AKCİĞER ÖDEMİ

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TANIM, EPİDEMİYOLOJİ VE PROGNOZ

Kalp Yetmezliğinin Tanımı

Kalp yetmezliği (KY) tek bir patolojik tanı değildir. Yüksek juguler venöz basınç, pulmoner hışıltı ve periferik ödem gibi belirtilerin eşlik edebileceği, nefes darlığı, ayak bileğinde şişme ve yorgunluk gibi kardinal semptomlardan oluşan klinik bir sendromdur. İstirahat veya egzersiz sırasında kalp içi basınçların yükselmesine veya yetersiz kalp debisine neden olan kalbin yapısal ve/veya işlevsel bir anormalliğinden kaynaklanır (1).

Altta yatan kardiyak disfonksiyonun etiyolojisinin belirlenmesi KY tanısında zorunludur çünkü spesifik patoloji sonraki tedaviyi belirleyebilir. KY en yaygın olarak miyokardiyal disfonksiyona bağlıdır: sistolik, diyastolik ya da her ikisi. Ancak kapakçık, perikard ve endokard patolojisi ile kalp ritim ve iletim anormallikleri de KY'ye neden olabilir veya katkıda bulunabilir (1).

Terminoloji

Korunmuş, hafif azalmış ve azalmış ejeksiyon fraksiyonlu kalp yetmezliği

Geleneksel olarak KY, sol ventrikül ejeksiyon fraksiyonu (LVEF) ölçümüne dayalı olarak farklı fenotiplere ayrılmıştır. Bunun arkasındaki mantık, LVEF ≤%40 olan hastalarda önemli ölçüde iyileşmiş sonuçlar gösteren KY'deki orijinal tedavi çalışmalarıyla ilgilidir.

- Azalmış LVEF ≤%40 olarak tanımlanır, yani LV sistolik fonksiyonunda önemli bir azalma olanlar. Bu durum HFrEF olarak adlandırılır.
- LVEF'si %41 ile %49 arasında olan hastalarda LV sistolik fonksiyonu hafif derecede azalmıştır, HFmrEF olarak adlandırılır.

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gibi komorbiditeleri tedavi etmek (132). Üçüncüsü, sonuç üzerinde faydalı etkileri olan oral OMT'yi başlatmak veya yeniden düzenlemek. Dozlar taburculuktan önce ve/veya taburculuk sonrası erken dönemde artırılabilir.

Çalışmalar, tıbbi tedavinin bu şekilde optimize edilmesinin daha düşük 30 günlük yeniden yatış riski ile ilişkili olduğunu göstermiştir, ancak bugüne kadar prospektif randomize çalışmalar yapılmamıştır (97,133,134). Retrospektif analizler, bir AKY hastasının yatış sırasında beta-bloker tedavisinin kesilmesinin veya dozunun azaltılmasının daha kötü sonuçlarla ilişkili olduğunu göstermektedir (135). ACE-I/ARB tedavisi alanlar da dahil olmak üzere yakın zamanda hastaneye yatırılan stabil HFrEF hastalarında ARNI'nin başlatılması güvenlidir (136,137). Yakın zamanda, EF'lerine bakılmaksızın KY nedeniyle hastaneye yatırılan diyabetik hastalarda sotagliflozin ile yapılan prospektif randomize bir çalışmada da güvenlik ve daha iyi sonuç gösterilmiştir (138).

Taburcu olduktan sonraki 1-2 hafta içinde bir takip yapılması önerilir (139,140). Bu takip bileşenleri KY belirti ve semptomlarının izlenmesini, hacim durumunun, KB'nin, kalp hızının ve böbrek fonksiyonu, elektrolitler ve muhtemelen NP'ler dahil olmak üzere laboratuvar ölçümlerinin değerlendirilmesini içermelidir. Taburcu edilmeden önce yapılmadıysa demir durumu ve karaciğer fonksiyonu da değerlendirilmelidir. Klinik değerlendirme ve laboratuvar tetkiklerine dayanarak, HFrEF için daha ileri optimizasyon veya hastalık modifiye edici tedavi başlatılmalıdır. Retrospektif çalışmalar, böyle bir yaklaşımın daha düşük 30 günlük tekrar yatış oranları ile ilişkili olduğunu göstermektedir, ancak bugüne kadar prospektif randomize çalışmalar yapılmamıştır (134,140-142).

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