

Kardiyopulmoner Resüsitasyon (KPR) ve KPR Sonrası Bakım

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Kardiyak arrest kalbin pompa fonksiyonunun ani olarak durmasıdır. Genel olarak havayolu, solunum ve dolaşım ile ilgili nedenlere bağlı olarak görülmektedir. En sık akut koroner sendrom, malign aritmiler, kalp yetmezliği gibi kardiyovasküler nedenler olmak üzere; havayolunu kapatan yabancı cisimler, kitle, aspirasyonlar, pulmoner tromboemboli, bronkospazm, pnömotoraks, hipotansiyon, ciddi travmalar, intoksikasyonlar, serebral fonksiyonu bozan serebrovasküler olay, kanama gibi patolojiler kardiyak arrest gelişmesine neden olabilir (1) (tablo 1). Mortaliteyi ve morbiditeyi azaltmak adına kardiyak arrest gelişen hastaya hızlı ve doğru müdahale ciddi önem taşımaktadır. Ventilasyonun sağlanması, etkili göğüs basıları, şoklanabilir ritimler için erken defibrilasyon ve geri döndürülebilir nedenlerin acil yönetimi kardiyopulmoner resüsitasyon (KPR)'un temelini oluşturmaktadır.

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mesi, gri-beyaz cevher ayırımının kaybolması ve çeşitli bölgelerde infarkt olarak görülebilir (60). Mental fonksiyonlar değerlendirmek için bazı skorlamalar da kullanılmaktadır. Bunlardan bazıları, Glasgow Outcome Score (GOS), modifiye Rankin skalası, Cerebral Performance Category (CPC) skalasıdır (61). Prognoz belirlenmesi için çeşitli biyo-belirteçler de çalışılmıştır. Nöron spesifik enolaz (NSE) en sık kullanılan belirteçlerden biridir. Kardiyak arrest sonrası 72. saatte beyin omurilik sıvısı ve kanda düzeyi pik yapar. 48-72. saatte kandaki düzeyi 33 µg/L'nin üzerinde olması kötü prognoz ile ilişkilidir ama kılavuzlarda prognoz tayini için rutin olarak kullanılması önerilmemektedir (62).

Post-arrest hastada, SDGD sonrası 12. saatte normal veya erken reaktiviteli EEG bulguları, beyin MRG'de DWI sekansında anormali saptanmaması iyi prognoz ile ilişkilendirilmiştir (63). Kötü prognoz ile ilişkili bazı faktörler ise şunlardır: Beyin sapı, pupil, kornea, öğürme ve öksürme reflekslerinin olmaması, gözlerde yukarı aşağı sabit bakış, düzensiz yukarı göz hareketleri, periyodik lateral bakış, yüz kaslarının seğirmesi, Glaskow koma skalasında (GKS) motor yanıtın 1 veya 2 olması, 24. Saat sonrasında N20 SSEP (somatosensory evoked potential) dalgalarının olmaması, malign EEG bulguları, status myoklonus, tedaviye dirençli status epileptikus ve görüntülemelerde difüz yaygın anoksik beyin hasarının bulunmasıdır (28, 64, 65). Nörolojik değerlendirmeler yapılırken, hastalar beyin ölümü açısından da değerlendirilmelidir.

| Kaynaklar

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