BÖLÜM 6

GERİATRİ VE ALKOLİK KARACİĞER HASTALIKLARI

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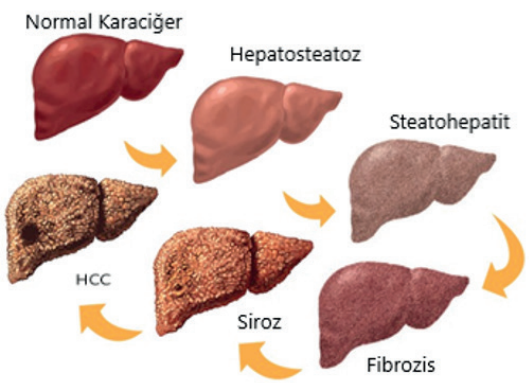
GİRİŞ

Alkollü içecekler; insanlığın yerleşik hayata geçtikten sonra kullanılmaya başlandığı bilinen, %0.5 ten fazla etanol (C_2H_6O) içeren içeceklerdir. Alkole bağlı karaciğer hastalıkları; alkolik steatozis (AS), hepatosteatoz sonrası inflamasyon gelişmesi halinde alkolik steatohepatit (ASH), karaciğer fibrozisi ve sonunda karaciğer sirozu ve hepatosellüler kanser ile sonuçlanabilen geniş bir spektruma sahiptir (Resim 1). Ayrıca akut olarak alkolik hepatit (AH) gelişebilmektedir. Karaciğer hastalığı gelişmesi alınan alkol miktarı ve süresi ile yakın ilişkilidir (1).



Resim 1. Alkole bağlı karaciğer hastalıkları spektrumu (1)

Alkol tüketim miktarının ölçülebilmesini kolaylaştırmak ve standardize etmek için Amerikan Diyet Kılavuzunda ''bir standart içki'' 14 gr saf alkol içeren içecek olarak tanımlanmıştır. Standart bir içki alkol tiplerine göre yaklaşık; 330 ml bira, 140 ml şarap ve 40 ml sert içkilere (viski, cin, votka, rakı) karşılık gelmektedir. Zararlı alkol kullanımı kadınlarda günde 2 standart içki, erkeklerde ise günde 3 standart içkiden fazla alımı olarak tanımlanmıştır (2). Aynı kılavuzda yaşlı bireyler için kadınlarda günde 1, erkeklerde ise günde 2 standart içkiden fazla kullanılmamasının riskleri minimalize edeceği belirtilmektedir (2). Ancak yapılan son çalışmalarda alkolün düşük miktarlarda kullanımında bile kanser gelişim riskini arttırdığı gösterildiği için DSÖ tarafından alkol kullanımında güvenli bir seviye olmadığı bildirilmiştir (3).

Alkole bağlı hastalıkları oluşturan alkol tüketimi ile ilgili 2 önemli faktör bulunmaktadır. Bunlar alınan alkolün toplam miktarı ve alım tarzıdır. Alkol alma süre ve miktarı arttıkça alkolik karaciğer hastalığı gelişme riski artmaktadır (4). Alım tarzı olarak "*binge drinking*" olarak adlandırılan aşırı alkol alımı; 2 saat içerisinde erkeklerde 5 standart içki (70 gr), kadınlarda ise 4 standart

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alım günde 1200 kcal'den az ise besin takviyesi (tercihen ağızdan veya NG tüpü yoluyla) düşünülmelidir (55). Yaşlı hastalarda besin takviyesi sıklıkla eşlik eden malnutrisyon nedeniyle daha da önemli bir hal almaktadır.

Şiddetli AH için hem pentoksifilin hem de prednizolon önerilen diğer tedaviler arasında olup uzun vadeli yararları ise şüphelidir. Steroidlere yanıt vermeyen ve MELD'i 26'dan büyük olan hastalarda ise karaciğer nakli düşünülebilir (55,60). Yaşlı bireylerde tedavi benzer süreçlerle ilerlemekte, komorbid hastalıkların varlığına ve kullanılan ilaçların olası etkileşimlerine karşı daha dikkatli olunmalıdır. Alkol yoksunluğunda benzodiazepinler, yoksunluk semptomlarını tedavi etmek veya önlemek için yaygın olarak kullanılsa da, dağılımları, daha yüksek yağ oranına sahip yaşlılarda düzensiz olabileceğinden uzun süreli sedasyona neden olabilir. Benzodiazepinlerle ilişkili yan etkiler yaşlılarda genellikle daha yaygın olup uyuşukluk, yorgunluk, konfüzyon, ataksi, düşmeler ve inkontinans gibi belirtiler açısından yüksek doz kullanmamaya özen gösterilmelidir (58).

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