

DİZ ALTI ARTER HASTALIKLARINDA GÜNCEL TEDAVİ YÖNTEMLERİ

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GİRİŞ

Tibial damarların ve pedal arkın infra-popliteal steno-okluziv arter hastalığı, özellikle diyabetik ve böbrek yetmezliği olan hastaları etkiler ve ekstremitelere kaybına katkıda bulunan önemli bir faktör olarak geniş çapta kabul görmüştür (1-3). Kronik ekstremitelere tehdit edici iskemi (KETİ) hastalarında, diz altı damarlarla uğraşmadan önce tedavi edilmesi gereken önemli proksimal hastalık ve sıklıkla çok seviyeli hastalık olduğunu bilmek önemlidir. Bu durum genellikle diz altı damar ve pedal ark revaskülarizasyonu elde etmek için karmaşık teknikler gerektirir. Semptomlar, arterlerin ateroskleroz nedeniyle daralması nedeniyle bacak ve ayağa giden kan akışının bozulması sonucu ortaya çıkar. Kan akışında azalma ile birlikte doku perfüzyonu azalır, klinik olarak istirahat ağrısına neden olur veya bir ülser mevcut olduğunda olası sekonder enfeksiyon ve kangrenle birlikte ülser iyileşmesini bozar. Yeterli ayak perfüzyonunun olmaması, daha büyük bir amputasyon riski ve artan bir ölüm oranı ile ilişkilidir. Dolayısıyla bu hastalarda revaskülarizasyon prosedürleri kritik önem arz etmektedir. Günümüzde bilinen kabul edilebilir teknik başarı oranları anlamlı klinik sonuçlar sağlayan revaskülarizasyon tedavi seçenekleri endovasküler

anjyoplasti veya stentleme, açık cerrahi distal venöz baypass uygulamalarıdır (4-6). Çalışmalarla gösterilen artan klinik deneyimin yanı sıra endovasküler cihazların sürekli teknolojik ilerlemeleri, KETİ ve infrapopliteal arter hastalığı olan çoğu hastada artık “önce endovasküler” yaklaşımını desteklemektedir (7).

İnfrapopliteal arter revaskülarizasyonuna ilişkin temel öneriler şu şekildedir:

İnfrapopliteal arter hastalığı için tedavi planı hastaya özgü olmalı ve multidisipliner bir ekip toplantısı ortamında kararlaştırılmalıdır.

Endovasküler tedavi seçenekleri, “seçeneksiz” hastalar için trans-pedal erişim, plantar-loop, transkollateral teknikler, pedal ark rekonstrüksiyonu ve venöz arterizasyon dahil olmak üzere ileri revaskülarizasyon tekniklerini içermelidir.

Optimal olarak, yara iyileşmesine yönelik infrapopliteal arter revaskülarizasyon prosedürleri, yaraya yönelik revaskülarizasyon, > 1 damar tedavisi ve pedal arkı iyileştirme yoluyla mümkün olan maksimum ayak perfüzyonunu sağlamayı amaçlamalıdır.

Konvansiyonel balon anjioplasti, uzun infrapopliteal arter lezyonları ve pedal ark hastalığı

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şik sistolik kan basıncı olan hastalarda dikkatli olunması gerekir. İnfra-popliteal anjiyoplasti sırasında tromboembolik olaylar nadirdir (< %1) ve 5-6 Fr veya daha büyük bir kateter kullanılarak perkütan aspirasyon trombektomi (PAT) ile tedavi edilebilir (68). Ürokinaz veya rekombinant doku plazminojen aktivatörü (rt-PA) ile eşzamanlı kateter yönlendirmeli lokal tromboliz, distal pedal küçük embolilerini tedavi etmek ve akımı artırmak için tavsiye edilirken, mekanik trombektomi ve stentler kullanılarak trombüs «kafesleme»nin de etkili olduğu bildirilmiştir (69). Damar perforasyonu, yanlışlıkla kılavuz telin yanlış yerleştirilmesi veya distale migrasyonu nedeniyle oluşur ve genellikle bağımsızdır. Kanama devam ederse, düşük basınçlı balon şişirilmesi veya manuel kompresyon genellikle hemostaz sağlar. Trans-kateter koil embolizasyonu nadiren gereklidir.

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