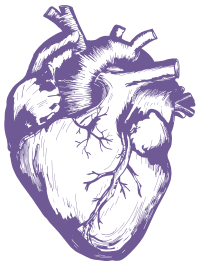

BÖLÜM 10

Antianjinal İlaçlar

Tuğba KAPANŞAHİN [1]

BETA BLOKERLER

β_1 ve β_2 olarak adlandırılan iki ana beta reseptör alt tipi, farklı dokularda farklı oranlarda bulunur. Kalpte β_1 reseptörleri baskındır ve bu reseptörlerin uyarılması kalp atış hızı ve kontraktilitesinde artışa, böbreklerde jukstaglomerüler hücrelerden renin salınımına ve adipositlerde lipolize yol açar. β_2 stimülasyonu ise bronkodilatasyona, vazodilatasyona ve glikojenolize neden olur.

β_1 uyarımının hücre içi ikinci habercisi siklik adenozin monofosfattır (cAMP) ve miyokardiyal kasılmanın hızını ve kuvvetini artırmak için kalsiyum kanallarının açılmasını (pozitif inotropik etki) ve sitozolik kalsiyumun sarkoplazmik retikuluma geri alımını sağlar. Sinüs düğümünde pacemaker akımı artar (pozitif kronotropik etki) ve iletim hızı hızlanır (pozitif dromotropik etki) (1).

Beta blokaj, öncelikle kalp atış hızını yavaşlatarak miyokardiyal O_2 gereksinimini azaltır. Kalp hızının yavaşlamasına bağlı olarak diyastol süresi uzar ve dolayısıyla koroner perfüzyon için mevcut süre artar. Ek olarak, bu ilaçlar egzersize sekonder gelişen kontraktilitedeki ve kan basıncındaki artışları azaltır. Ayrıca beta bloke edici ajanlar, heyecan ve aktivite durumunda olduğu gibi sempatik aktivite artışında miyokardiyal O_2 talebini azaltır. Beta blokerlerin miyokardiyal O_2 talebi üzerindeki bu etkileri, arz ve talep arasındaki dengesizliği olumlu yönde değiştirebilir ve böylece iskemiyi azaltabilir (2).

β-adrenerjik reseptör antagonistleri anjina tedavisinin köşe taşıdır (3). Prinzmetal (vazospastik) anjina dışında, iskemik kalp hastalığının tüm evrelerinin tedavisinde önde gelen ajanlardır. β-adrenerjik reseptörleri bloke etmek efor anjinası, kararsız anjina ve istirahat anjinası için hala standart tedavi olarak kabul edilmektedir (4). Beta blokerler, hem tek başına verildiklerinde hem de diğer antianjinal ajanlara eklendiklerinde anjina ataklarının sıklığını azaltır ve anjinal eşiği yükseltirler (5).

Tüm β -blokerler, anjina pektoris için potansiyel olarak eşit derecede etkilidir ve eşlik eden hastalıkları olmayanlarda ilaç seçimi çok az önem taşır. Bir β-bloker dozunu, 55 ila 60 atım/dk'lık bir istirahat kalp hızı sağlamak üzere ayarlamak geleneksel olsa da, kalp bloğundan kaçınılması ve semptom olmaması koşuluyla, bazı hastalarda 50 atım/dk'dan daha düşük kalp hızları kabul edilebilir (6).

Uzun süreli uygulamadan sonra β blokerlerin aniden kesilmesi, kronik stabil anjinalı hastalarda iskeminin ve anjinanın artmasına neden olabilir.

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