BÖLÜM
9

AKUT SOLUNUM SIKINTISI SENDROMU (ARDS-ASSS)

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GİRİŞ

İlk kez 1967 yılında Ashbaugh tarafından yapılan çalışmada yetişkin solunum sıkıntısı sendromu tanımlanmıştır (1); çalışmaya dahil edilen 12 hastada tedaviye yanıtsız hipoksemi ve akciğer grafisinde yaygın infiltratlar gözlenmiştir. Hastaların yedisi ölmüş ve yapılan otopsilerinde akciğerlerde inflamatuar eksüdasyonla yoğun infiltrasyon gözlenmiştir.

Zaman içinde şok akciğeri, Da Nang akciğeri, katı akciğer sendromu, sızdıran kapiller pulmoner ödem, nonkardiyojenik pulmoner ödem, akut akciğer hasarı gibi isimler de almıştır ve son olarak akut solunum sıkıntısı sendromu (ARDS) olarak adlandırılmaktadır. Bu adlandırmaların hiçbiri akut solunum yetmezliğinin en önemli nedenlerinden biri olan ve akciğerlerde yaygın inflamatuar hasarla seyreden bu hastalığı tarif etmede yeterli değildir.

RİSK FAKTÖRLERİ

ARDS hemen her zaman predispozan klinik risk faktörleri varlığında gelişir (Tablo 1); çoklu risk faktörü varlığı gelişim riskini artırır (2,3). ARDS gelişiminin altta yatan sebebinden bağımsız olarak, ARDS' li hastalarda akciğerle sınırlı olmayan, inflamasyon ve organ disfonksiyonu ile seyreden sistemik hastalık tablosu görülür (4).

Sepsis indirek akciğer hasarı gelişiminin en sık nedenidir. Yoğun bakım ünitesinde (YBÜ) takip edilen, ciddi sepsisli hastalarda ARDS gelişme riski %30-40 civarındadır (2,5,6). Sepsis kaynağı pnömoni olan hastalarda ARDS gelişim riski diğer sepsis nedenlerine göre daha yüksektir (7). Şokla seyreden ciddi travma, çoklu kan ürünleri transfüzyonu gibi durumlar da indirek akciğer hasarının YBÜ'lerindeki sık sebeplerindendir. Direk akciğer hasarının en sık nedeni olan pnömoni, viral, bakteriyel veya fungal kaynaklı olabilir. Ek problemler de riski artırabilir: kronik akciğer hastalığı (6), alkol kötüye kullanımı (8,9), sigara (10-12), ileri yaş (13), kan ürünü transfüzyonu (14,15), akciğer rezeksiyonu (16), obezite (13). YBÜ'nde yatan her hastanın ARDS gelişimi açısından risk altında olduğu düşünülmeli, tanı ve tedavide ihtiyatlı yaklaşılmalıdır.

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göstermektedir; bu faktörler: yaş, APACHE skoru, PaO2/FiO2 ratio, organ yetmezliği, septik şok, immunsupresyon, kardiyovasküler yetmezlik ve kronik karaciğer hastalığıdır (15,128). Birçok çalışmada kısa dönem mortalitede iyileşme görülmüştür ancak 641 hastalı bir çalışmada 1 yıllık mortalite belirgin olarak yüksek bulunmuştur (%24-%41) (129). ARDS mortalitesinde kısa dönem sonuçlarda iyileşme sağlansa da uzun dönem sonuçlar açısından henüz tedavide istenilen düzeyde değiliz.

ARDS'yi atlatan hastalarda sıklıkla fonksiyonel yetersizlik, kognitif disfonksiyon ve psikososyal problemler görülür (130). İlginç olarak pulmoner fonksiyon sıklıkla normale döner. ARDS'yi atlatan 109 hastanın 1 yıllık gözleminde, akciğer volümü ve spirometrenin 6. ayda normal değerlere ulaştığı gözlenmiştir (67). Sistemik kortikosteroid ile tedavi edilmiş olmak, YBÜ' de gelişen ek hastalık, akciğer hasarı ve multiorgan disfonksiyonunun iyileşme oranı gibi faktörler fonksiyonel kapasitenin düzelme oranını etkileyen önemli parametrelerdir. Fiziksel ve sosyal zorluklara ek olarak, ARDS'yi atlatan hastalarda yüksek oranda depresyon ve anksiyete görülür (131).

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