BÖLÜM
10

PULMONER EMBOLİZM

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GİRİŞ

Pulmoner embolizm (PE), son 30 yıldaki tanı ve tedavideki ilerlemelere rağmen önemli bir değişiklik göstermeyen, erken ölüm oranlarının yüksek olduğu akut dolaşım sistemi hastalığıdır (1). Pulmoner embolizm ve derin ven trombozu (DVT), venöz tromboembolizm (VTE) tanısı altında birlikte değerlendirilen, nedensel özellikleri genellikle ortak olan klinik tanımlardır (2-4). Bu bölümde PE nedenlerinden sadece VTE'den bahsedilecektir.

PE, DVT başlangıcından 3-7 gün sonra ortaya çıkar ve vakaların %10'unda semptomların başlamasından sonraki bir saat içinde ölümcül olabilir, çoğu ölümcül vakalarda klinik olarak tanı almaz. PE, pulmoner vasküler yatakta ani tıkanıklık nedeniyle, sağ ventrikül (RV) yetmezliğine neden olabilir. Ölümcül olabilen akut sağ kalp yetmezliği (ASKY) dahil tüm klinik evrede erken tanı çok önemlidir. PE, olguların %5-10'unda şok veya hipotansiyon, stabil hastaların % 50'sinde RV dilatasyonu ve / veya laboratuvar bulguları ile kötü prognoz tahmin edilebilir (5, 6).

Bilgisayarlı tomografi pulmoner anjiyografi (BTPA) ile trombüs segmental seviyeye kadar görüntülenebilir. BTPA ile aynı zamanda RV genişlemesi gösterilebilir. Yatak başında ekokardiyografi acil şartlar altında kabul edilebilir bir alternatiftir. Ekokardiyografi genellikle kesin bir teşhis sağlamaz veya PE'i dışlayamaz, RV aşırı yüklenmesini ve işlev bozukluğunu gösterebilir.

Akut masif PE'de öncelikle hemodinamik durum kontrol altına alınmalıdır. PE'de ilk tedavi pulmoner vasküler yatakta yeniden kan akışını sağlamaya ve erken nüksü önlemeye yöneliktir (7). Trombolitik tedavi, yüksek riskli PE tespit edilen hastalarda uygulanır. Kanama riski yüksek olan hastalarda trombolitik ajanlar, fayda zarar dengesi gözetilerek doz düşürülür veya uygulanmaz (4). Ekstrakorporeal membran oksijenasyonu (EKMO) desteği, dolaşım kollapsı olan hastalarda etkili olabilir (8). Hastalığın prognozu, embolinin morfolojik boyutuna, hastanın kardiyovasküler ve pulmoner sistem durumuna, nörohumoral adaptasyon derecesine ve tedavinin potansiyel risklerine göre değişkenlik gösterir (1). PE sonrası tam reperfüzyon hastaların üçte ikisinde meydana gelir ve ölümlerin çoğunun (% 90) tedavi edilmemiş hastalarda, tanınmayan PE nedeniyle gerçekleştiği görülmektedir (9). VTE hastalarının % 5'inde kronik pulmoner hipertansiyon gelişir (10).

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laktik antikoagülan olarak kullanılan DMAH'nin biyolojik birikimi olmadığını bildirdi. İki prospektif gözlemsel çalışmada: birincisi, YBÜ girişinde kreatinin klerensi 30 ml/dk veya üzerinde olan 19 hastadan oluşan ve günlük 5.000 UI subkutan dalteparin alan tek merkezli bir kohort çalışmasıdır (183). İkinci çalışma, tahmin edilen kreatinin klerensi 30 ml / dakika altında olan 138 YBÜ hastasının çok merkezli prospektif kohort çalışmasıydı (177) ve tromboprofilaksi nedeniyle günde bir kez 5.000 UI deri altı dalteparin almıştır. Her iki çalışmada da hiçbir DMAH biyobirikim oluşmadı. Dalteparin ağır böbrek yetmezliği olan kritik hastalarda kullanımının önerilmesine karşın, Dalteparin dışındaki DMAH'lerin böbrek yetmezliği olan hastalarda etkisi tartışmalıdır.

YBÜ Hastalarında Mekanik Tromboprofilaksi

YBÜ hastalarında antikoagülan tedavi kontrendike olduğunda, alt ekstermite DVT önlenmesi amaçlı kademeli kompresyon çorapları (KKÇ) veya aralıklı pnömatik kompresyon (APK) kullanımı önerilmiştir (79, 137). YBÜ hastalarında DVT profilaksisi için KKÇ veya APK içeren randomize kontrollü 5 çalışma (192); bunlardan biri akut miyokard enfarktüslü hastalarda yapıldı (193) ve diğer üçü travma hastalarında yapıldı (193-195). Bu dört çalışmada mekanik profilaksi yapılan veya DMAH alan 791 hasta değerlendirildi. Bir diğer çalışmada hasta tek bacağına KKÇ uygulandı. Tüm çalışmalarda DVT insidansı KKÇ ile daha düşüktü (% 10'a karşı % 0) (193). APK'yı KKÇ ile birleştirilerek tedavi uygulanan YBÜ hastalarında, sadece KKÇ uygulananlardan daha etkili bulunmadı (196). Diğer bir çalışmada mekanik proflaksi beraberinde DMAH verilen YBÜ hastalarında, sadece mekanik proflaksi uygulanlara nisbeten DVT daha düşük gözlendi (197). DVT tespit edilmiş ise KKÇ veya APK kullanımı kontrendikedir (83).

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