

BÖLÜM
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YOĞUN BAKIMDA KARDİYAK ARİTMİLER VE MEDİKAL TEDAVİSİ

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Aritmiler yoğun bakım hastalarında sık görülen bazen yoğun bakıma yatışın ana sebebi bazense yoğun bakımda başka bir sebepten yatan hastalarda mortalite ve morbiditeyi artıran genellikle yapısal kalp hastalığı olan hastalarda ortaya çıkmaktadır. Yapısal kalp hastalığı bulunmayan hastalarda ise hipoksemi, enfeksiyon, sepsis, katekolamin seviyelerinde artış, hiperkarbi, ciddi asidoz vb. aritmiyi tetikleyebilir. Aritmiddeki klinik belirtiler aritminin süresi, altta yatan kalp rahatsızlığı ve ventrikül fonksiyonunun etkilenme derecesine bağlı olarak değişmektedir. Klinik belirtileri asemptomatik olabileceği gibi kardiyopulmoner arrest kadar ciddi sonuçlar doğurabilir.

Aritmiler kaynaklandığı bölgeye göre ve kalp hızına göre sınıflandırılabilir. Kaynaklandığı bölgeye göre supraventriküler ve ventriküler olmak üzere ikiye ayrılmaktadır. Supraventriküler aritmi nadiren hemodinamik problemlere neden olurken ventriküler aritmiler ise hasta için mortal olabilmektedir. Kalp hızına göre ise aritmiler bradiaritmi ve taşiaritmi olarak ikiye ayrılmaktadır. Bradiartimilerde kardiyak outputta azalma ve perfüzyon bozukluğuna neden olduklarından hemodinamiyi bozabilmektedir. Taşı-

artmiler ise diyastolik dolumu bozarak kardiyak outputta azalma, hipotansiyon ve miyokardiyal iskemiye neden olarak hemodinamiyi bozabilmektedir.(1)

TAŞIARTİMLER

Taşıartimilerin değerlendirilmesi

Aritmisi olan hastada ilk olarak hastanın hemodinamik değerlendirilmesinin yapılması gerekmektedir. Yapılan değerlendirilme sonucunda hemodinamik bozulma var ise bunun aritmi kaynaklı olup olmadığı sorgulanmalıdır. Aritmiye bağlı olarak hemodinamik bozulma mevcut ise ve farmakolojik tedaviye yanıt yok ise hastada kardiyoversiyon yapılmalıdır.

Değerlendirmede sonraki adım 12 derivasyonlu EKG ile aritminin supraventriküler mi yoksa ventriküler kökenli olduğunu tespit etmektir. Bu tespiti QRS kompleksinin süresine göre karar veriyoruz.(2) Dar QRS kompleksli (<0.12 sn.) taşikardiler arasında atriyal fibrilasyon (AF), sinüs taşikardisi, atriyoventriküler nodal reentrant taşikardi (AVNRT),atriyoventriküler reent-

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b-blokerleri birlikte kullanılabilir, ancak IV amidaron bu durum için tercih edilen farmakolojik tedavidir. Farmakolojik tedavi ve antitaşkardik pacing başarısız olursa, elektrofizyolojik haritalama kılavuzluğunda kateter ablasyonu düşünülebilir.

BRADİARİTMİLER

Yoğun bakım hastalarında bradikardi genellikle altta yatan hastalığın sonucu, artmış vagal aktivite veya intrakraniyal basınç, ilaç tedavisi (beta-bloker, kalsiyum kanal blokerleri, antiaritmik ilaçlar, digoksin, klonidin, opioidler, lityum, dexmedetomidin gibi), solunumsal problemler, metabolik anormallikler (asidoz gibi) ve elektrolit anormallikleri (hiperkalemi gibi) nedeniyle gelişebilmektedir. Bu nedenle altta yatan nedenin düzeltilmesi bradikardinin tedavisi için yeterli olacaktır. Altta yatan neden aydınlatılana kadar semptomatik ve hipotansiyonun eşlik ettiği durumlarda hastaya 0,5-1 mg intravenöz atropin verilmesi uygun yaklaşım olacaktır.(43) Atropine rağmen istenen kalp hızı sağlanamayan ve hemodinamik instabilite gösteren hastalarda internal veya eksternal pacemaker uygulamaları için hazırlıklı olunmalıdır. (43)

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