# 24. Bölüm

# KORUNMUŞ EJEKSİYON FRAKSİYONLU KALP YETERSİZLİĞİNDE TEDAVİ

Murat AKÇAY[1]

Sol ventrikül ejeksiyon fraksiyonunun normal sınırlarda olmasına rağmen kalp yetersizliği semptom ve bulgularının olduğu klinik tabloya "Korunmuş Sistolik Fonksiyonlu Kalp Yetersizliği (KEF-KY)" adı verilir. Korunmuş sistolik fonksiyonlu kalp yetersizliği olan hastalarda EF genellikle normal sınırlarda kabul edilen %50'nin üzerindedir. KEF-KY, oldukça heterojen bir hastalık olup, tedavide hastanın ko-morbiditelerine yönelik tedavinin gerektiğine dair kanıtlar artmaktadır. Klavuzlarda mortalite ve morbiditeyi azalttığına dair net kanıtların olduğu hiçbir tedavi olmamasına rağmen, semptomların azaltılmasına, yaşam kalitesinin arttırılmasına, ek hastalıkların taranarak en uygun şekilde tedavisine yönelik öneriler Sınıf IC kanıt düzeyinde endikedir [(1)]. KEF-KY sıklığı yaş ile birlikte artar, 60 yaş üstü kalp yetersizliği olgularının yarısından fazlasını oluşturur. Kadınlarda daha sık görülür (%60-80). Hastaların, hipertansiyonu (%60-80), obezitesi (vücut kitle indeksi >30kg/m2) (%30-50), diyabeti (%30-50), atriyal fibrilasyonu (%20-40), koroner arter hastalığı, pulmoner hipertansiyonu başta olmak üzere birçok ko-morbiditesi vardır [(1,2)]. Artan ko-morbidite yükü ile hastalığın mortalite hızı artmaktadır. Hastalarda semptomların kontrolü amaçlı diüretikler Sınıf IB kanıt düzeyinde önerilirken, düşük ejeksiyon fraksiyonlu kalp yetersizliğinde morbidite ve mortalite faydası kanıtlanmış olan beta-blokerler, anjiyotensin converting enzim inhibitörleri (ACEİ) ya da anjiyotensin reseptör blokerleri (ARB) ile mineralokortikoid reseptör antagonistlerinin (MRA) semptomların kontrolü ve mortalite üzerindeki rolleri tartışmalıdır [(1,2)]. Biz burada son kanıtlar ışığında KEF-KY'nin meydana geliş mekanizmalarından hedeflenen tedavi basamaklarını özetledik.

## KEF-KY'NDE SEMPTOMLAR VE TETİKLEYEN FAKTÖRLERİN TEDAVİSİ

KEF-KY'nin acil tedavisinde konjesyonun azaltılması ve semptomların tedavisi için ilk basamak diüretikler önerilmektedir. İkinci basamak olarak, tetikleyen faktörlerden atrial fibrilasyonda etkin hız kontrolü, mümkünse ritim kontrolü, etkin bir şekilde hipertansiyonun kontrol altına alınması önerilmektedir. Hem HYVET çalışması hem de SPRINT çalışmasında, agresif kan basıncını düşürülen hastalarda, daha az agresif kan basıncı kontrolü olan hastalara kıyasla kalp yetersizliğine bağlı hastaneye yatışlar, anlamlı derecede daha az olmuştur [(3-5)]. Son olarak, gözlemsel verilerde bu hastalarda koroner arter hastalığı sık olup, uygun şekilde revaskülarizasyon kötü klinik sonuçları engelleyebilmektedir [(3)].

[1] Dr. Öğretim Üyesi, Ondokuz Mayıs Üniversitesi Tıp Fakültesi Kardiyoloji Ana Bilim Dalı, drmuratakcay@hotmail.com

Mevcut veriler ışığında klinik tedavinin temelinde; etkin konjesyon tedavisi, semptomları tetikleyen ko-morbiditelerin etkin tedavisi (obezite, kontrolsüz hipertansiyon, atrial fibrilasyon gibi) ve ko-morbiditeleri artırıcı inflamasyonla optimal mücadele, riskli hastaların erken belirlenerek önleyici kardiyovasküler risk stratejilerinin geliştirilmesi olmalıdır.

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