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GİRİŞ

Osteoporoz (OP) sıklığı uzayan yaşam süresinin sonucu olarak giderek artmaktadır. Bunun yanında, tanı ve tedavisindeki gecikmeler sonucunda da önemli morbidite nedenlerinden bir olmaya devam etmektedir. Gastroenterolojik hastalıklardan inflamatuvar bağırsak hastalığı, çölyak hastalığı, kronik pankreatit, postgastrektomi-gastrik bypass ve diğer malabsorbsiyon sendromları, kronik karaciğer hastalıkları (KKH) gibi klinik durumlarda osteoporoz sıklığı artmıştır ve kemik mineral yoğunluğunda azalma sıklıkla gözlelenebilmektedir. Bu durumun bozulmuş kalsiyum metabolizması ve kronik inflamasyon gibi bir çok nedene bağlı olabileceği düşünülmektedir.

OSTEOPOROZ

Tanım olarak OP, kemik yapıdaki mikromimari yapının bozulması, kemik fragilitésinin artışı ve sonuç olarak artan kemik kırık riski ve iskelet yapısındaki güç azalışı ile ilişkilidir. Azalan kemik gücü yalnızca kemik mineral dansitometresinin ölçümü ile değil, kemik yapının şekil, boyut ve iç yapısını da içine alan bir bütün olarak değerlendirilmelidir. İlk olarak OP tanımı 1993 yılında toplanan konsensüs tarafından “Kemik yapısında mikro mima-

ride bozulma ve kemik kütlelerinde kayıp ile tanımlanan bir kemik hastalığı” olarak bildirilmiştir. OP kelime anlamı olarak ‘gözenekli kemik’ anlamına gelmektedir ve bu konsensüste osteoporotik kemik kırılabilirliğinin artışı vurgulanmıştır (1). Daha sonrasında Dünya Sağlık Örgütü (DSÖ) (World Health Organization-WHO) tarafından OP kavramsal olarak “Kemik kitlesinin düşüklüğü ve kemik yapısının mikro mimari bozukluğu şeklinde tanımlanan ilerleyici bir iskelet hastalığı - sonuç olarak kemik kırılabilirliğinde ve kemik yapıda kırılmaya artan duyarlılık” olarak tanımı yapılmıştır. Tanıda esas olarak kemik mineral yoğunluğunun azalması vurgulanmıştır (2). OP ilişkili kemik kırıkları, yaşam kalitesinde azalmanın yanı sıra özellikle geriatrik popülasyonda önemli bir mortalite nedenidir (3). Kırık gelişimini önlemede, risk altındaki popülasyon taramaları yapılmalı, kemik kırığı geçiren kişilerin yönetiminde tutarlı tıbbi müdahaleler geliştirilmeli ve ikincil kırık gelişimini önleyici yaklaşımlar benimsenmelidir. Kemikte yapı bozukluğunu objektif olarak ölçmek mümkün olmadığından bunu göreceli olarak yansıtan kemik mineral dansitesi (KMD) ölçümleri hala klinik pratikte önemini korumaktadır. Ancak glukokortikoid kullanımı, malabsorbsiyon sendromları gibi sekonder OP nedenleri olan veya kırılabilirlik kırı-

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