BÖLÜM 51

BAKTERİYEL VE PROTOZOAN İNFEKSİYÖZ ENTERİTLER

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GİRİŞ

Gastroenterit; ishal ve kusma sendromlarını tarifleyen genel terimdir. İshal ise günde üç veya daha fazla gevşek dışkılama şeklinde tanımlanır (1). Eğer ishal 14 günden daha kısa süreli ise akut ishal, 14 günden daha uzun süreli ise persistan ishal olarak tanımlanır. İnfeksiyöz gastroenteritler, 2015 yılında yaklaşık olarak 2,4 milyar gastroenterit vakasının olduğu ve bunun yaklaşık olarak 1 milyarının 5 yaş altı çocuklarda meydana geldiği, yıllık 800 bin ölüme neden olan önemli bir hastalık nedenidir (2, 3). Gastroenteritler 2015 yılında 5 yaş altı çocuklarda %8,6 ölüm nedeni iken tüm yaş gruplarında 9. en sık ölüm nedenidir (4). Gastroenteritler son yıllarda sanitasyondaki iyileşmeler ve oral rehidratasyon solüsyonlarının kullanımının artmasından dolayı azalmakta olup gelişmiş ve gelişmekte olan ülkelerde halen yaygın olarak görülmektedir (5). Erişkinlerde daha az görülmekte iken çocuklar ve infantlarda daha sıktır (6).

Gastroenteritler bakteri, virüs, parazitler veya protozoan enfeksiyondan kaynaklanabilir ve birden çok klinik prezantasyona sebep olabilir. Hastalık eğer şiddetli ve bir salgın ile ilişkili değilse genellikle mikrobiyal nedene yönelik tanı gerekli değildir. En yüksek ölüm oranlarına sahip patojenler Rotavirus, Salmonella ve Şigella suşları (spp)'dır. En sık gastroenterit yapan patojenler ise Clostridium difficile, Rotavirus, Şigella, Campylobacter ve enterotoksijenik E.Coli (ETEC)'dir (2). Sık görülen gastrointestinal enfeksiyon etkenleri ve epidemiyolojik özellikleri Tablo 1'de verilmiştir.

Gastroenterit vakalarının büyük kısmı etken ve tedaviden bağımsız olarak kendi kendini sınırlar ve genellikle 7 gün içerisinde çözülür. Son yıllarda genellikle etkenin tespit edilmesine yönelik kullanılan moleküler teknikler, kullanılan antibiyotikler ve semptomatik tedavilerin önemi tartışmalıdır (7).

Gastroenterit ile ilişkili semptomlar bağırsağın mikrobiyal invazyonu, mikrobiyal toksinlerin gastrointestinal mukoza veya enterik sinir sistemi üzerindeki etkisine bağlı olarak gelişir. Sistemik semptomlar ise, mikrobiyal materyallerin kan yoluyla yayılması, üretilen toksinlerin sistemik etkileri ve/veya konakçının inflamatuar yanıtı sonucu gastrointestinal enfeksiyonla ilişkili olarak görülebilir. Bu mikroorganizmalar yeterli sanitasyona ulaşamayan toplumlarda özellikle çocukluk çağında önemli morbidite ve mortalitelere yol açan, yerel veya uluslararası öneme sahip salgınlara neden olabilir.

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enfeksiyonlu hastalarda da taşsız kolesistit bildirilmiştir (224).

Özellikle tropikal veya gelişmekte olan bölgelere seyahat sonrası 5-7 günden uzun süren ishal şikayeti olan immünokompetan hastalarda ve inatçı ishal şikayeti olan immün yetmezliği olan hastalarda Cytoisospora tanısı şüphelenilmelidir.Rutin dışkı testlerinde olmadığından klinik şüphe tanı koymada önemlidir. Cytoisospora tanısı, asit-hızlı boyama ile konsantre dışkı örneklerinin ışık mikroskobik incelemesinde büyük, oval oositlerin görülmesi ile konulur. Oositlerin dökülmesi aralıklı olup, birden fazla dışkı örneğinin incelenmesi gerekebilir. PCR testi henüz yaygın olarak kullanılmamaktadır ve serolojik test mevcut değildir. Dışkı örneklerinde Charcot–Leyden kristalleri ve eozinofiller görülebilir (225).

Tedavide öncelikle sıvı-elektrolit ve beslenme desteği sunulmalıdır. Enfeksiyon sıklıkla kendi kendini sınırlayıcıdır. Semptomlar kendiliğinden düzelmezse antimikrobiyal tedavi başlanmalıdır. Trimetoprim/sülfametoksazol 7-10 gün boyunca günde 2 kez 160/800 mg oral olarak kullanılacak şekilde verilir. Bazı kılavuzlar başlangıç dozunu günde 4 kez olarak önermektedir, klinik yanıta göre tedavi 3-4 hafta kadar devam edebilir. Şiddetli malabsorbsiyonu olan hastalarda, terapötik ilaç seviyelerine ulaşmak için parenteral uygulama gerekebilir. Kükürt içeren antibiyotiklere karşı alerjisi olduğu belgelenen hastalarda, sadece pirimetamin kullanılabilir. Diğer alternatifler arasında siprofloksasin ve nitazoksanid bulunur (226).

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