# PSİKOSTİMÜLANLAR

101. BÖLÜM

Gözde ULAŞ[1]

## GİRİŞ

Stimülanlar, "Dikkat Eksikliği ve Hiperaktivite Bozukluğu" (DEHB) tedavisinde güvenli olduğunu gösteren geniş verilerin bulunması, etkisinin hızlı başlaması, tedavinin güçlü etkileri, bireysel tedaviye izin veren birçok formülasyonun mevcudiyeti nedeniyle oldukça yaygın kullanılmaktadır. Literatür, DEHB'nin temel semptomlarının yönetiminde uyarıcı ilaçların ve davranışsal müdahalelerin etkinliği üzerinde hemfikirdir (1). Çalışmalarda stimülan tedavilerle dikkatte %75, bilişsel işlevlerde %50 ve sınıf içindeki davranışlarda %90 iyileşme olduğu gösterilmiştir (2). Farmakolojik olan ve olmayan müdahaleyi tercih kararı, hastanın yaşı, semptomların profili ve hastalığın ciddiyeti, yan etkiler için bireysel risk, tedaviye devam sorunları, komorbid hastalıklar, ebeveynlerin ve çocuğun tercihi, maliyet, ilaca erişimine dayalı olmalıdır.

## TARİHÇE

Klinik çalışmaların izleri 1930'lara dayansa da stimülanların DEHB tedavisinde kullanılmasına yönelik kanıtlar 1970'lerde netlik kazanmaya başlamıştır. O zamandan beri, güvenlik ve etkinliklerini destekleyen veri tabanı giderek büyümüştür (1, 3-5). Başlangıçta klinik çalışmalar, hızlı salınan uyarıcıların (IR) kısa vadeli klinik etkilerine odaklanmıştır. Çok sayıda büyük ölçekli klinik çalışma, uzun etkili uyarıcıların (ER) etkinliğini göstermiştir. Uyarıcı ilaç kullanımı son 20 yılda hızla artmıştır. DEHB ilaçlarının küresel kullanımının 1993'ten 2003'e kadar üç kat arttığı bilinmektedir. Amerika Birleşik Devletleri (ABD) dışında da kullanım artmakla birlikte, dünya genelinde stimülan tüketiminin %80'inden fazlası ABD'de ortaya çıkmaktadır (6).

## FARMAKOKİNETİK

Genel olarak, stimülanlar düşük plazma protein bağlanması, hızlı emilim ve hızlı metabolizmaya sahiptir (7) ancak plazma seviyesinin tepe noktasına çıkması, etki süresi ve yarı ömrü formülasyona bağlı olarak değişmektedir. Bununla birlikte, plazma seviyelerinin süresinin, uyarıcı ilaçların hiçbiri için klinik yanıt ile korele olmadığı gösterilmiştir. Bunun yerine, artan serum konsantrasyonları ve tonik ateşlemeyi taklit eden yavaş, sabit yükselen dopamin (DA) seviyelerinin terapötik etkileri ortaya koyacağı söylenmektedir (8). IR-metilfenidat (MPH) ve amfetaminin (AMPH) emilimi, alımdan sonra hızlıdır, etki uygulamadan 30 dakika sonra görülür ve yaklaşık 4 saat sürer. ER preparatların etki süresi, belirli bir ilaca bağlı olarak 7-13 saattir (Karşılaştırma için Tablo 1, 2 ve 3). Maksimum plazma konsantrasyonuna (Tmax) ulaşma süresi 1,5-2 saat arasındadır. Aksi belirtilmediği sürece, bütün MPH formülasyonları rasemik formülasyonlardır (1:1 yani d ve l-MPH) (9-11).

Hem MPH hem AMPH, D ve L enantiyomerlerini içeren rasemik karışımlardır. Çeşitli uyarıcı preparatların birbirinden farklılık gösterme yollarından biri, bazılarının sadece bir enantiomer,

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### *Epileptik Nöbetler*

Uyarıcıların epileptik durumlarda kontrendike olduğu ilaç kutularında dâhi yazmaktadır, ancak bu uyarının spesifik temeli net değildir. Son zamanlarda iyi bilinen epileptik bir hastalığı olan ve nöbetleri iyi kontrol altına alınan çocuklarda MPH tedavisinin güvenli olabileceği öne sürülmüştür (70). Yine de MPH'nin çocuklarda nöbeti şiddetlendirdiğine dair raporlar olmuştur, bu nedenle bu özel popülasyonda daha da dikkat edilmesi önerilmektedir (71).

## SONUÇ

Stimülan tedavi planlandığında hem riskler (uykusuzluk, iştahsızlık, büyümede gecikme, kardiyovasküler riskler) hem faydalar (çekirdek belirtileri çözme, okul performansında, akran ve ebeveyn ilişkilerinde iyileşme) göz önünde bulundurulmalıdır. Ek olarak, tedavi edilmemiş DEHB'nin okul başarısızlığı, davranış sorunları, sosyal zorluklar, kaza sonucu yaralanma, madde kötüye kullanımı, işsizlik, araba kazası, planlanmamış hamilelik gibi problemlerle karşımıza çıkabildiği de göz önünde bulundurulmalıdır (43). Stimülan tedavide faydalar, iyi klinik izlem ve tedavi planı ile risklerden daha ağır basmaktadır.

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