Bölüm 29

KARARSIZ ANGİNA

Tufan ÇINAR[1]

GİRİŞ

Kardiyovasküler hastalıklar dünya genelinde ölümlerin en önemli nedenlerindendir. Ulusal Kardiyovasküler Hastalıklar veri tabanına göre akut koroner sendrom (AKS) yıllık yeni vaka görülme oranı 100,000'de 141'dir ve bu hasta grubunda hastane içi ölüm oranı yaklaşık %7'dir (Ruff &Braunwald, 2011). AKS klinik spektrum içinde, kararsız angina, ısrarcı ST yükselmesi olmayan miyokart enfarktüsü ve ST yükselmeli miyokart enfarktüsü gibi diğer klinik tablolar yer almaktadır. Kararsız angina bu spektrumun tam ortasında yer alarak, istikrarlıanginadandaha fazla, fakat akut miyokart enfarktüsünden daha az bir risk taşımaktadır(Sarkees &Bavry, 2009).

SINIFLAMA

Kararsız angina temel olarak üç grupta sınıflandırabilir:

I- Gittikçe artan ve eskilerden farklı, şiddetti artan angina pektoris,
II- Yeni başlayan (genellikle ilk bir aylık süre) angina pektoris,
III- Çok hafif çaba veya istirahatte bile angina pektoris olması (Roffi &ark., 2015).

Kararsız angina klinik duruma göre aşağıdakilerdekinde birine göre de sınıflandırılabilir:

A- Sekonder-Ekstra-kardiyak hastalık durumunda gelişen kararsız angina,
B- Primer-Ekstra-kardiyak hastalık olmadan gelişen kararsız angina,
C- Post-miyokart-Akut miyokart enfarktüsü sonrası ilk iki haftada gelişen kararsız angina (Roffi &ark., 2015).

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