

Bölüm 1

ST SEGMENT YÜKSELMESİZ MİYOKARD İNFARKTÜSÜ

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GİRİŞ

Kardiyovasküler hastalıklar, günümüzde sanayileşmiş ülkelerde önde gelen ölüm nedeni olmaya devam etmektedir (Murray & Lopez, 1997). Bu hastalıklardan en sık görüleni koroner arter hastalığı (KAH) olup, mortalite ve morbidite ile yakından ilişkilidir. KAH kendini sessiz iskemi, kararlı anjina pektoris, kararsız anjina pektoris, miyokard infarktüsü (MI), kalp yetersizliği ve ani ölüm gibi değişik klinik tablolar ile gösterebilir.

Göğüs ağrısı ile acil servislere başvuran hastaların önemli bir kısmını akut koroner sendromlar (AKS) oluşturmaktadır. AKS'ler unstabil anjina (UA), ST yükselmesiz miyokard infarktüsü (NSTEMI) ve ST yükselmeli miyokard infarktüsü (STEMI) gibi heterojen bir gruba sahiptir. NSTEMI kardiyak biyobelirteçlerin yükselmesi ile UA'dan ayırt edildiğinden AKS ile gelen hastalarda mutlaka seri biyobelirteç ölçümleri yapılmalıdır. Bu bölümde Avrupa Kardiyoloji Cemiyeti (ESC) klavuzları eşliğinde, NSTEMI konusu üzerinde durulacaktır.

Epidemiyoloji ve Doğal Seyir

NSTEMI/UA aynı zamanda ST yükselmesiz AKS (NSTEMI-AKS) olarak adlandırılmaktadır. Hastane kayıtlarında elde edilen veriler NSTEMI-AKS hastalarının STEMI hastalarından daha fazla olduğunu bize göstermiştir (Yeh & ark., 2010). STEMI hastalarında hastane içi mortalite NSTEMI-AKS hastalarından daha yüksek olmakla birlikte, 6. ayda bu oranlar birbirine oldukça benzemektedir (Savonitto & ark., 1999; Mandelzweig & ark., 2006). Uzun süreli takiplerde ise NSTEMI-AKS hastalarında STEMI hastalarına göre mortalitenin daha yüksek olduğu tespit edilmiştir. Dördüncü yıllardaki mortalite farkı iki katına çıkmıştır (Terkelsen & ark., 2005). Bu farkın NSTEMI-AKS hastalarının daha yaşlı ve komorbiditelerinin daha fazla olmasından kaynaklandığı düşünülmektedir.

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Koroner anjiyografi sonrası koroner girişim planlanan hastalarda PKG ve KABG seçenekleri bulunmaktadır. Hastanın yaşı, komorbid özellikleri, yaşam beklentisi ve özellikle koroner anatomi yapısı girişim tekniği kararında dikkate alınan unsurlardır. Hastaların yaklaşık %50'sinde tek damar hastalığı olup bu hasta grubunda PKG tercih edilmektedir. NSTEMI vakalarında, çoklu damar hastalığı kişilerin çoğunda suçlanan lezyona PKG uygulaması ilk tercih olmaktadır. Çok damar hastalığı veya sol ana koroner lezyonu olan kararlı KAH hastalarında ise SYNTAX (Perkütan Koroner Girişimle Taxus ve Kalp Cerrahisi Arasındaki Sinerji) skoru da göz önünde bulundurularak kalp ekibi tarafından PKG veya KABG karar verilmesi daha sağlıklı olacaktır.

NSTE-AKS'de MI'de progresyon, tekrarlayan MI ve ölüm genellikle erken dönemde olsa da bu riskler ilk 3-4 ayda yüksek düzeyde kalmaktadır. Malign aritmi riski nedeniyle bu hasta grubun revaskülarizasyon sonrası en az 24 saat hastanede takip edilmesi gerekmektedir. Yaşam tarzı değişikliği önerilerinde bulunmak ve risk faktörü modifikasyonu bu hastalarda uzun dönem tedavinin önemli unsurlarıdır. Uygun ve gerekli görülen hastalara ASA, P2Y12 reseptör inhibitörü, statin, beta blokerler, ACE/ARB (özellikle LV disfonksiyonu olan hastalar) ve spironolakton (özellikle LVEF < %40 olan hastalar) uzun dönem sonuçları iyileştirmektedir.

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