

Bölüm 13

ÜLSERATİF KOLİT EPİDEMİYOLOJİ, TANI VE MEDİKAL TEDAVİ

Tolga ŞAHİN¹

Ülseratif kolit (ÜK), kolon mukozasını rektumdan başlayarak proksimale doğru diffüz olarak tutan, remisyon ve relapslarla seyreden, kronik, idiopatik, inflamatuvar bir hastalıktır. Rektumdan başlayarak proksimale doğru kolonun tüm segmentlerine uzanabilen mukozal inflamasyonun, remisyon ve relapslar halinde tekrarlaması ile karakterizedir. Crohn hastalığı (CH) ile birlikte idiopatik, inflamatuvar barsak hastalıkları (İBH) spektrumunda yer alan iki ana hastalıktan biridir. Bazı ortak özelliklerine rağmen, iki hastalık genetik yatkınlık, risk faktörleri, klinik, endoskopik ve histolojik özellikler açısından birçok farklılık barındırır. İnflamatuvar barsak hastalıklarının kesin nedeni bilinmemektedir. Bununla birlikte, günümüzde genetik olarak duyarlı genlere sahip bireylerin, bağırsak florasına karşı ve abartılı bir mukozal immün yanıt geliştirmesi sonucu hastalıkların ortaya çıktığı görüşü ağırlık kazanmıştır (1). ÜK' te inflamasyon karakteristik olarak mukozal yüzeyle sınırlıdır. ÜK' te inflamasyon, tipik olarak rektumdan başlayıp aralıksız ve diffüz şekilde proksimal kolonik segmentlere doğru yayılım gösterir. Hastalığın tutulum düzeyi, hastalar arasında değişiklik göstermektedir. Hastalık sadece rektum tutulumu ile giden proktit, rektum ve sigmoid kolonun birlikte tutulduğu distal kolit, distal kolite inen kolon tutulumunun da eklenmesi ile oluşan sol kolit ve tüm kolonik segmentlerin tutulduğu pankolit şeklinde seyir gösterebilir. Tutulan kolon segmentine göre vakaların gruplandırıldığı ve Dünya çapında en yaygın kullanılan sınıflandırma **Montreal sınıflamasıdır** (Tablo 1) (2). Tedavide ana amaç klinik, endoskopik ve nihayetinde mukozal remisyonun sağlanması ve bu remisyonun olabildiğince uzun süre idame ettirilebilmesidir. Hafif ve orta derece aktiviteli ÜK'te aminosalisilatlar başlangıç tedavisinde kullanılan ana ilaç grubudur. Kortikosteroidler genelde atakların remisyonuna sokulmasında kullanılan ilk seçenek ilaçlardır. İmmünesupresif ve biyolojik ajanlar ise orta ve ileri derece şiddetli ÜK'te kullanımları daha yaygın olan tedavi seçenekleridir. ÜK vakalarının <%15'nde kolektomi ihtiyacı ortaya çıkar (3).

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ciddi morbidite ve yaklaşık %1 mortalite riskine sahiptir (88). Hastalar hospitalize edilip, direkt başlangıç tedavisi olarak intravenöz kortikosteroid verilir. Vakaların yaklaşık 2/3'ünde (%65) steroid tedaviye iyi yanıt alınmaktadır. Steroid tedavisine 3-5 gün içinde yanıt alınamayan cevapsız olgularda, kurtarma rejimi olarak intravenöz siklosporin ya da infliksimab tedavisi denenmelidir. Her iki ilacın da akut ağır şiddetli ÜK' te etkinlik düzeyleri benzerdir (89). Her 3 tedavi ajanından birine 7 gün boyunca yanıt alınamayan hastalarda cerrahi tedavi opsiyonu değerlendirilmeye alınmalıdır. Burada cerrahi kararının geciktirilmemesi kilit önem taşımaktadır. Yapılan çalışmalar, 7. Günden sonra cerrahi operasyonun geciktirilmemesinin, komplikasyon riski ve mortaliteyi anlamlı derecede arttırdığını göstermiştir (90,91).

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