Bölüm 11

PULMONER EMBOLİ VE TEDAVİSİ

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Giriş

Venöz tromboembolizm (VTE), pulmoner emboli (PE) ve derin ven trombozu (DVT), şeklinde prezente olan, tüm dünyada miyokard infarktüsü (MI) ve inmeden sonra en sık akut kardiopulmoner durumdur (1). Her ikisi de benzer predispozan faktörlere sahiptir ve PE genellikle DVT'nin bir komplikasyonu olarak gelişir. DVT insidansı 53-162/100.000 olarak saptanmış iken, PE yıllık insidansı epidemiyolojik çalışmalarda 39-115/100.000 arasında saptanmış ve yaş ilerledikçe insidansın arttığı, 80 yaşın üzerinde 1/100'e yükseldiği gözlenmiştir. Ancak sessiz seyreden ya da tanı konulamadan kaybedilen olgular göz önüne alındığında gerçek insidansın daha yüksek olduğu düşünülmektedir (2,3).

İnsidanstaki artışa karşılık, hem tanısal yöntemlerdeki gelişmeler, hem de tedavi seçeneklerindeki ilerlemeler, PE'ye bağlı mortalite oranlarında yıllar içinde düşüş göstermiştir (4,5). Ulusal çapta yapılan birçok çalışmada, %30'lara varan hastane içi mortalitenin son yıllarda %5-7 seviyelerine düştüğü gösterilmiştir (6,7).

Predispozan Faktörler

VTE patogenezindeki majör faktörler 1856'da Virchow tarafından tanımlanmış olan damar endotel hasarı, hiperkoagulabilite ve stazdır. VTE geçiren hastalar dikkatli araştırıldığında olguların %75'inde patogenezdeki bu faktörleri tetikleyen genetik ve çevresel birçok etken tanımlanmıştır (8). Bu etkenler kalıtsal ve kazanılmış olarak sınıflanabileceği gibi (Tablo 1), VTE olasılığına göre de sınıflanabilir (Tablo 2).

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Yeni Oral Antikoagülanlar	
Rivaroxaban	İlk 3 hafta 2x15 mg sonrasında 1x20 mg
Apixaban	İlk 7 gün 2x10 mg sonrası 2x5 mg
Dabigatran	İlk 5-10 gün parenteral tedavi sonrası 2x150 mg
Edoxaban	İlk 5-10 gün parenteral tedavi sonrası 1x60 mg

Sonuç

Pulmoner tromboemboli tedavisinde esas olan multidisipliner yaklaşım (PERT) ile risk sınıflamasına göre karar vermektir. Yüksek riskli grubun tedavisi trombolitik tedavi iken düşük riskli grubun tedavisi antikoagülan tedavidir. Orta riskli grubun tedavisi klinik, radyolojik ve labaratuar sonuçları ile prognostik değerlendirme yapılarak şekillendirilmelidir. Düşük risk grubu yatarak tedavi edilebileceği gibi Hestia kriterleri ile değerlendirildikten sonra uygunsa ayaktan da tedavi edilebilir. Uzun süreli tedavide kontrendike durum söz konusu değilse güncel yaklaşım YOAK kullanımı yönündedir.

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