

PEDİATRİDE STATUS EPİLEPTİKUS TANISI VE GÜNCEL YÖNETİMİ

40. BÖLÜM

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GİRİŞ

Çocukluk çağında sık görülen nörolojik acillerden biri olan status epileptikus (SE) yaşamı tehdit eden acil bir durumdur. SE tanımı ve tanımında gerekli olan nöbetin süresi zaman içinde değişmiştir. Epilepsiye Karşı Uluslararası Birlik olan ILAE (The International League Against Epilepsy) ve diğerleri SE'yi 30 dakikadan uzun tek bir epileptik nöbet veya 30 dakikalık bir zaman diliminde nöbetler arasında bilişsel ve motor fonksiyonların tekrar kazanılmadığı bir dizi epileptik nöbetler olarak tanımlamıştır ⁽¹⁾. Tanım süresi bu şekilde olmasına rağmen tedavi kararı için daha kısa zaman aralığı tercih edilmektedir. 2015 yılında ILAE'nin yayınladığı revizyon ile tanı ve tedavi için belirlenen her iki zaman dilimini de içeren bir SE tanımı ortaya çıkmıştır ⁽²⁾. ILAE tarafından SE'de zaman dilimleri şu şekilde tanımlanır:

- Nöbetin sonlandırılmasından sorumlu mekanizmaların başarısızlığından veya uzun süreli nöbetlere yol açan anormal mekanizmaların başlamasından kaynaklanan bir durumun oluştuğu: t1 zaman dilimi,
- Nöbetlerin türüne ve süresine bağlı olarak nöron ölümü, nöron yaralanması gibi uzun süreli sonuçların ortaya çıktığı: t2 zaman dilimi.

Konvulsif SE tanımında, ILAE tarafından t1 süresi 5 dakika, t2 süresi ise 30 dakika olarak belirlenmiştir. Beş dakikalık t1 süresi acil tedavinin başlaması gereken zamana karşılık gelir. Bilinç bozukluğu olan fokal SE için ise t1 süresi 10 dk ve t2 süresi ise 60 dakikadan fazla olarak belirlenmiştir. Diğer SE tiplerinde özellikle SE'nin konvulsif olmayan formları için t1 ve t2 için uygun zaman aralıkları tam olarak belirlenememiştir ⁽²⁾.

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ve refrakter bir dönemin indüksiyonu yoluyla nöbetlerin kesilmesine yol açar ⁽¹²⁴⁻¹²⁶⁾. EKT, beşten fazla antiepileptiğin uygulandığı fokal veya jeneralize RSE'si olan, değişken etyolojiye sahip çocuklarda düşünülmektedir ⁽¹²⁷⁻¹²⁹⁾. Vaka raporlarında hastaların sonuçları; geçici yanıt, nöbet sıklığında hafif iyileşme, klinik iyileşme ve ölümlerle sonuçlanacak kadar değişkendir ⁽¹³⁰⁾. Farmakolojik olmayan başka bir seçenek vagus sinir stimülasyonu olup mevcut verilerle nöbet kontrolü sağladığına dair hiçbir kanıt yoktur ⁽¹³⁵⁾.

Acil epilepsi cerrahisi ise en az iki hafta boyunca maksimum tıbbi tedavide başarısızlık veya yapısal bir anormallik belirlendiğinde RSE ve SRSE tedavisi için düşünülebilir ⁽¹³⁶⁾. Cerrahi genellikle RSE'nin geç seyrinde düşünülse de, hastalar SE'nin başlamasından sekiz gün sonra ameliyata girebilir ⁽¹³⁷⁾. Yoğun bakım ünitesi ortamında kortikal haritalama gibi tipik ameliyat öncesi tanı araçlarının elde edilmesi zor olduğundan, acil ameliyat kararı dikkatli şekilde verilmelidir ⁽¹³⁸⁾.

SONUÇ

SE, çocuklarda yaygın görülen nörolojik acil bir durumdur. SE yönetiminde altta yatan nedenin teşhisi, nöbetlerin kesin ve hızlı tedavisi morbidite ve mortaliteyi engellemek açısından çok önemlidir. Benzodiazepinlerle hızlı tedavi, status epileptikusun ilk basamak tedavisidir, ancak birçok hasta fenitoin, valproik asit, fenobarbital veya levetirasetam dahil ek ilaçlarla ek tedaviye ihtiyaç duymaktadır. Birincil tedavi benzodiazepin ve ikincil tedavi olarak bir antiepileptik ile status epileptikus sonlandırılmadığında refrakter status epileptikus tanısı konur. Bu durumda SE'yi sonlandırmak için acilen farmakolojik koma indüksiyonuna ihtiyaç duyulur.

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