

# BÖLÜM 12

## COVID-19'LU HASTALARIN ACİL SERVİSTE KRİTİK BAKIMI VE HAVAYOLU DENETİMİ

Emre GÖKÇEN<sup>1</sup>

### Giriş

2019'un sonlarında Çin'in Wuhan kentindeki bir grup zatürre vakasının nedeni olarak yeni bir koronavirüs tespit edildi. O zamandan beri hızla yayıldı ve pandemiye neden oldu. Dünya Sağlık Örgütü, hastalık terimini COVID-19 (yani Koronavirüs Hastalığı 2019) olarak belirledi (1). COVID-19'a neden olan virüs, şiddetli akut solunum sendromu koronavirüs 2 (SARS-CoV-2) olarak adlandırılır. COVID-19'un başlıca morbidite ve mortalitesi büyük ölçüde, akut solunum sıkıntısı sendromuna (ARDS) dönüşen akut viral pnömoniye bağlıdır (2).

Raporlar, şiddetli akut solunum sendromu koronavirüs 2 (SARS-CoV-2) ile enfekte olanlar arasında % 20'ye varan oranlarda hastaneye yatmayı gerektiren ciddi hastalık geliştirdiğini göstermektedir (3–5). Oranlar değişmekle birlikte, hastaneye yatırılanlar arasında dörtte birine kadar yoğun bakım ünitesine (YBÜ) yatışa ihtiyaç duyulmaktadır, bu da toplam enfekte nüfusun yaklaşık % 5 ila 8'ini temsil etmektedir (3,6,7). YBÜ'ye kabul oranlarındaki farklılıklar, uygulamadaki kültürel farklılıklar ve YBÜ için kabul kriterlerinin yanı sıra, hizmet verilen popülasyonlarda yaş ve ko-

morbiditeler ve test imkanı gibi predispozan faktörlerdeki farklılıklarla ilgili olabilir.

### Kritik Hastalarda Klinik Özellikler

Bu bölümde COVID-19 hastalarının genel klinik özellikleri ve progresyon için risk faktörleri yerine kritik derecede hasta olanlardaki klinik özelliklere yer verildi. Kritik hastalığı olan hastaların geriye dönük çalışmaları, akut solunum sıkıntısı sendromu (ARDS) dahil olmak üzere kritik hastalık geliştiren hastalar arasında dispne başlangıcının nispeten geç olduğunu (semptom başlangıcından ortalama 6.5 gün sonra), ancak ARDS'ye ilerlemenin daha sonra hızlı olduğunu göstermiştir (dispne başlangıcından ortalama 2,5 gün sonra) (3,6,8,9).

Kritik olarak hasta olanlar arasında, ARDS'den kaynaklanan derin akut hipoksemik solunum yetmezliği baskın bulgudur ve hiperkapni nadirdir (3,6,8,10,11).. YBÜ'ye kabul sırasında vücut ısısı değişken olup artma veya azalma eğiliminde olabilir. Kritik olarak hasta olanlarda mekanik ventilasyon ihtiyacı % 30 ile % 100 arasında değişmektedir (3,7,12,13).

Erken klinik raporlar, yoğun bakım ünitesinde

<sup>1</sup> Dr. Öğr. Üyesi Emre GÖKÇEN, Yozgat Bozok Üniversitesi Tıp Fakültesi, Acil Tıp AD. emregokcenaci@gmail.com



video laringoskopi uygulanmalıdır. Entübasyon- da fiberoptik cihaz kullanımından kaçınılmalıdır. Gerekli indüksiyon ajanları ve kas gevşeticiler eşliğinde hızlı seri entübasyon tercih edilmelidir. Entübasyon öncesi %100 oksijen ile uygulanacak 3-5 dakikalık preoksijenasyon gereksiz ambu ve maske kullanımının önüne geçilebilir. Zorunlu hallerde büyük hacimde maske ventilasyonu yerine küçük hacimde uygulamalar tercih edilebilir. Supraglottik cihaz kullanımı ve mapleson-c devreleri gibi uygulamalar virüs yayılımını en aza indirmek için düşünülebilir. Ayrıca işlem esnasında endotreakeal tüp klemplenmesi de unutulmamalıdır (38–42).

## Sonuç

COVID-19 yüksek bulaştırıcılığı nedeniyle sağlık personeli ve hasta güvenliği açısından daha sıkı önlemler alınmasını gerektirmektedir. Pandemi sürecinde COVID-19 ile edilen bilgi ve tecrübeler arttıkça yeni güvenlik protokolleri ve yaklaşımlar oluşturulacaktır.

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