

19.

BÖLÜM

TAMİR EDİLEMEYEN ROTATOR MANŞET YIRTIKLARI

Mete GEDİKBAŞ¹

GİRİŞ

Rotator manşet patolojileri, omuz eklemінде görülen ağrı ve fonksiyon kaybının en yaygın kaynağıdır ve ortopedi cerrahları tarafından tedavi edilen en yaygın durumlar arasındadır(1-3). Rotator manşet yırtıkları akut ve kronik başlangıçlı olabilmektedir. En sık kronik dejenerasyona bağlı oluşur. 66 yaşından sonra hastaların yaklaşık yarısında rotator manşet yırtığının radyolojik bulguları görülmeye başlar(1). Hastalarda konservatif ve cerrahi tedaviler ile başarılı sonuçlar elde edilebilmektedir(4). Konservatif tedavinin başarısız olduğu durumlarda hastanın mevcut halinin iyileştirilmesi için operatif tedavi çoğu vakada bir seçenek olarak kullanılır. Eğer tamir edilebilecek bir yırtık mevcut ise açık ve artroskopik tamirler iyi ve mükemmel sonuçlar veren tedavi yöntemleridir. Ancak açık ve artroskopik tamirlerin başarılı olabileceği bir sınır mevcuttur ve bazı durumlarda rotator manşet yırtıklarının tamamen tedavisi mümkün olmayabilir (2, 4, 5). Bu hastalarda deltoid kasının ve rotator manşetin kalan kısmının kuvvetlendirilmesi önem kazanır. Eklem kıkırdağının sağlam olduğu genç hastalarda debridman, parsiyel tamir, tendon transferi, superior kapsüller rekonstruksiyon gibi çeşitli yöntemler ile eklem koruyucu tedavi uygulanmaktadır(6). Rotator manşet yırtığına bağlı artropati gelişen ve konservatif tedavinin başarısız

olduğu yaşlı hastalarda ters omuz protezi başarılı sonuçları olan alternatif tedavi yöntemidir(7, 8).

TANI

Ameliyat öncesi, onarılamaz yırtıkların, belirli kriterler önerilmiş olmasına rağmen, tek başına inceleme ve görüntüleme çalışmalarına dayalı olarak büyük veya masif onarılabılır yırtıklardan ayırt edilmesi zor olabilir(9, 10). Tamir edilemeyen yırtıklar genellikle AP. koronal ve sagittal planlarda büyük çaplı, retrakte görünümde ve azalmış doku kalitesi ve atrofi olan yırtıklardır(10, 11). Ameliyat esnasında tendonun mobilizasyonu ve gevşetilmesi sonrasında tendonun tamir edilebilirliği değerlendirilebilmektedir. Burkhart yaptığı çalışmalarda masif rotator manşet yırtıklarının %85'inin tamir edilebilir olduğunu belirtmiştir. Ancak Gouttalier evre 3 ve 4 hastalarda bu oranın %57'ye düştüğünü bildirmiştir(12, 13).

Muayene

Omzunda ağrı ve fonksiyon kaybı ile başvuran hastanın travma öyküsü, sigara kullanımı, dominant ekstremitesi ve eşlik eden hastalıklarını içeren detaylı anamnezi alınmalıdır. Rotator manşet yırtığının büyüklüğü ile ağrı ve fonksiyon kaybının büyüklüğü her zaman korele olmayabilir(14). Travma varlığı ve semptom sürekliliği değerlendirilmesi gereken önemli değişkenlerdir. Çünkü

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Anterior latissimus dorsi

Pektoralis major ve minör kasları toraksın anteriorunda yerleşmiş olan kaslardır ve çekme kuvvetleri subscapularis kasını tam olarak taklit etmemektedir(6). Bazı durumlarda humerus başının anteriora subluksasyonunu artırabilmektedirler(95). El-hassan tarafından rotator manşetin anterosuperior yerleşimli tamir edilemez yırtıklarının tedavisinde bir yöntem olarak tanımlanmıştır (96). Tendon yapışma yerinden ayrılırken ve implantasyon alanına alınırken bu bölgede bulunan aksiler, radial ve muskulokutanöz sinirler üzerinde düşük baskı riski oluşturur(6).

Ters Omuz Protezi

Hamada evre 3 veya daha yüksek artropatisi olan, 65 yaşından büyük, anterosuperior çıkış veya psödoparalizi varsa ters omuz protezi uygulanabilir. Yaş genellikle göreceli bir kontrendikasyondur ve hastanın fonksiyonel durumuna göre ayarlanır (15). Yaşlı hastalarda ters omuz protezinin uzun dönem sonuçlarının ağrının azaltılmasında ve fonksiyonların iyileşmesinde başarılı olduğu görülmüştür(97). Artroz olmaksızın onarılamaz rotator manşet yırtığı için yapılan ters omuz protezi sonuçları, kısa ve orta vadeli takiplerde ümit vericidir ve çoğu çalışma, psödoparalizli 65 yaş üstü hastaları ele almaktadır(98, 99). Ernstbrunner ve ark tarafından yapılan bir çalışmada 60 yaşından genç hastalarda yapılan ters omuz protezleri 11.7 yıl süreyle incelenmiştir(100). Hastalarda subjektif ve fonksiyonel skorlarda iyileşme saptanmıştır. Ancak hastaların %39'unda komplikasyon görülmüştür. Bu nedenle, minimal artrozu ve iyi preoperatif işlevi olan genç hastalarda tamir edilemeyen rotator manşet yırtığı tedavisinde ters omuz protezi yapılması konusunda daha çekimser olunmalıdır. Çünkü bu hastalarda istenen fonksiyonel iyileşme elde edilemeyebilir. Ayrıca erken gevşeme, daha yüksek aktivite seviyeleri ve mesleki talepler nedeniyle sorun yaşanabilmektedir(15).

SONUÇ

Tamir edilemeyen rotator manşet yırtığı tanısı için yırtığın büyüklüğünün yanı sıra kronik baş-

langıcı olması, tendonlarda yağlı dejenerasyonun ileri evrede olması gerekmektedir. Tamir edilemeyen rotator manşet yırtıklarının tedavisinde ilk basamak daima konservatif tedavi olmalıdır. Konservatif tedaviye yanıt alınamayan durumlarda hastanın yırtığının, kıkırdak hasarının durumuna ve hastanın beklentisi ve fonksiyonel durumuna göre tedavi seçimi yapılmalıdır.

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