35. BÖLÜM

AKROMİOKLAVİKULER EKLEM YARALANMALARI

Emre ÇALIŞAL [1]

GİRİŞ

Akromioklavikuler (AK) (1-3) eklem yaralanmaları omuz çevresinin sık gözlenen yaralanmalarından biridir. Omuz kuşağı yaralanmalarının yaklaşık % 12'sini oluştururlar (4). Özellikle ikinci on yılda ve erkeklerde kadınlara oranla 5 kat daha fazla gözlenir (%43.5) (5). Genellikle spor aktivitesi sırasında direkt akromion üzerine kontakt yaralanmalar ile ya da gergin kol üzerine düşme sonucu meydana gelir (6, 7). Yaralanmaya neden olan kuvvet skapulohumeral kompleksi (klavikulanın yükselmesi yerine) bastırarak, akromioklavikuler (AK) ve/veya korakoklaviküler (KK) bağların kopmasına neden olur (5, 8). Literatürde, akromioklavikuler eklem yaralanmasının sonucu olarak hastada aktiviteyi sınırlayan kronik ağrı ve işlev bozukluğunun ortaya çıkabileceğine dair kanıtlar vardır (9). Ayrıca tedavi edilmediğinde uzun dönemde akromioklavikuler eklemde artrit ve klavikula distalinde osteoliz gözlenebilir (10, 11). Bu nedenle AK yaralanmaları yakın takip ve tedavi edilerek hastaların yaralanma öncesi aktivite seviyelerine hızlıca dönüşü sağlanmalıdır.

AK EKLEM ANATOMİSİ VE BİYOMEKANİĞİ

AK eklem, ince bir kıkırdak yüzey ile arasını destekleyen fibrokartilajinöz meniskoid diskten oluşan diartrodiyal eklemdir. Meniskoid disk, 40 yaş sonrası hızlıca dejenere olarak fonksiyonunu kaybeder (12). Fizyolojik kuvvetler ve kolun ağırlığı AK eklemin vertikal, ön-arka ve aksiyal düzlemde değişimine neden olur. AK eklem stabilitesinden sorumlu statik ve dinamik kuvvetler vardır. Statik kuvvetler; AK bağları (ön, arka, üst ve alt), korakoakromial (KA) bağı ve KK bağları (konoid ve trapezoid) içerir (8). Dinamik kas stabilizatörlerini ise trapezoid ve deltoid (özellikle anterolateral kas grubu) kas grupları oluşturur. Her iki kas lifleri AK bağı güçlendirir. AK eklemin kapsüler bağları öncelikle ön-arka stabilitede rol oynar (13). Kadavra çalışmalarında AK bağların yukarı yönlü migrasyona karşı %20 ila %50 direnç sağlarken ön-arka translasyona %90 oranında katkı sağladığı gösterilmiştir (14). KK bağlar medialde konoid, lateralde trapezoid tarafından oluşturulur. Bu bağlar, klavikula ile ilişkili olarak skapulohumeral kompleksin inferior ve medial translasyonunu kısıtlar(15). Konoid bağ, AK eklemden yaklaşık 4,5 cm uzaklıkta, klavikulanın posteromedial alt yüzeyine tutunur. Bu bağ klavikulayı yukarıya ya da skapulayı aşağıya iten kuvvetler altında gerilir. Trapezod bağ ise, AK eklemden yaklaşık 2,5 cm uzaklıkta, klavikulanın alt yüzeyinin anterolateral proksimal kısmına tutunur ve AK eklemin sıkışması ile skapulohumeral kompleksin medializasyonu altında gerilir (14).

[1] Dr. Öğr. Üyesi, Amasya Üniversitesi Tıp Fakültesi Ortopedi ve Travmatoloji AD calisall@yahoo.com

sıdır. Bu yöntem, kabaca distal klavikula eksizyonu ile KA bağın distal klavikulaya transferini içerir (54). Bu anatomik olmayan greft uygulaması sonrası yüksek oranda redüksiyon kaybı görülmesi üzerine, anatomik greft uygulamalarına geçilmiştir (55). Jones ve ark. ilk olarak klavikulada konoid ve trapezoidin ayak izi olduğu bölgede 2 tünel açmış ve greft korakoidin altından geçirildikten sonra klavikuladaki tünele fikse edilerek anatomik bağ rekonstruksiyonu gerçekleştirmiştir (56). Bu iki demetli bağ rekonstrüksiyonu vertikal stabiliteyi sağlarken horizontal stabiliteye katkısı sağlamaz. Bu nedenle KK bağ tamirinde greft uzun bırakılarak AK bağ tamirini de içeren 3 demetli anatomik bağ rekonstruksiyonu önerilir (57). Greft yetmezliği, implanta bağlı komplikasyonlar, klavikula ve/veya korokoid kırıkları bağ rekonstrüksiyon yönteminde gözlenebilen komplikasyonlardır (58).

SONUÇ

Sonuç olarak AK eklem yaralanmalarında erken tanı ve tedavi önemlidir. Genellikle muayene ve standart grafiler tanı için yeterlidir. Hastanın tedavisindeki ana amaç; hastanın yaralanma öncesi aktivite düzeyine erken dönemde dönmesidir. Yaralanma tipine göre hasta konservatif ya da cerrahi olarak tedavi edilir.

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