

KONU 18

Kalça Eklemi

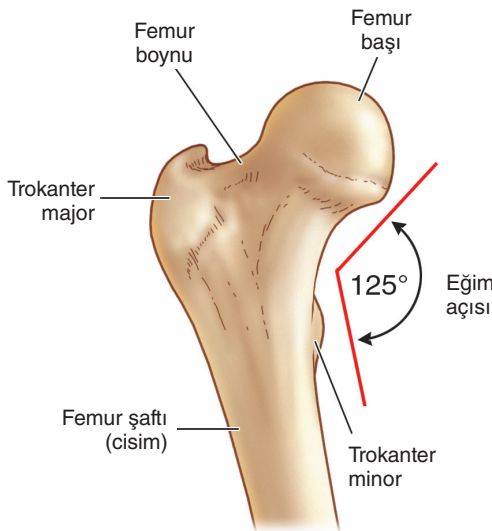
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GİRİŞ

Proksimal femur, femur başı ve boynu ile birlikte büyük ve küçük trokanterden oluşmaktadır (Şekil 18-1). Kalça eklemi, femur başı ve asetabulumdan oluşan top ve yuva tipi bir eklemdir. Bu eklemün birçok palpabl kemiksel işaretleri vardır. Anterosuperior iliak çıkıntı ve büyük trokanter lateralde, simfizis pubis ve pubik tüberkül (simfizisin yan tarafında) orta hatta kolaylıkla elle hissedilir. Kalça eklemi çok geniş bir eklem hareket açıklığı kapasitesine sahiptir.

Eklem, asetabulum ve femur boynunun etrafına tutunan bir kapsül ile çevrelenmiştir. Kapsüller kalınlaşma ile oluşan üç bağ: anteriorda yerleşmiş, üç bağın en kalın ve en güçlü olanı iliofemoral ligament; inferiorda bulunan pubo-femoral ligament, posteriora yerleşmiş ve üç bağın en geniş olan iskiyfemoral ligamanttır. İliofemoral ligament, oblik olarak aşağıdan geçen alt bant ve üst bant olmak üzere iki banda ayrılır. Bu bağ, kalça ekstansiyona getirildiğinde gerilir. Ek destek, asetabular kenarı tamamen çevreleyen ve asetabular fossayı derinleştiren, kırkırdak kalın bir bant olan labrum asetabulare tarafından sağlanır. Düz, ince biçimli bir ligament olan ligamentum teres, femur başını asetabulumuna merkezi olarak bağlar.

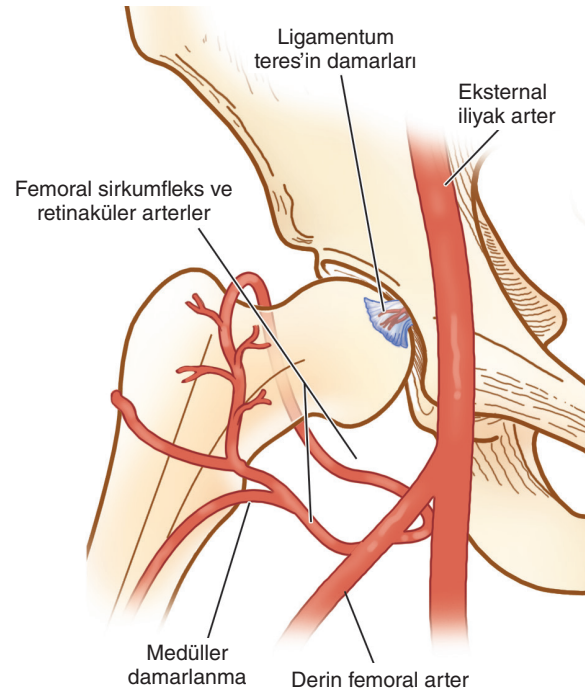


Şekil 18-1. Tüm şüpheli kırıklarda boyun-şaft açısı değerlendirilmelidir. Açı normal olarak, 120 ila 130 derece arasındadır.

Kalça eklemünü çevreleyen kaslar büyük ve güçlüdür. Femur başına etkili olan kuvvetlere önemli katkıda bulunurlar. Bu kaslar, anterior, medial ve posterior olmak üzere üç ana gruba ayrılabilir. Anterior kaslar, iliopsoas, tensör fascia lata, sartorius ve quadriceps femoris'i içerir. Medial kompartmandaki kaslar arasında pektinus, grasilis, obturator eksternus, adduktor magnus, brevis ve longus bulunur. Medial kasların ana görevi uyulğu adduksiyona getirmektir. Posterior kaslar arasında semitendinosus, semimembranosus ve biceps femoris bulunur. Arka kasların görevi kalçayı ekstansiyona getirmektir.

Proksimal femurun riskli damar yapısını anlamak çok önemlidir. Damar anatomisi, önem sırasına göre aşağıda sıralanan üç ana kaynaktan oluşur.(Şekil 18.2)

1. Femoral sirkumfleks ve retinaküler arterler
2. Medüller damarlanma
3. Ligamentum teres'in damarları



Şekil 18-2. Femur boynunun etrafındaki vasküler halka, femur başına, kanlanmanın sürdürülmesinde önemli olan, intrakapsüler damarları (retinaküler damarlar) gönderir.

dereceye kadar abduksiyon, dış rotasyon ve bazen fleksiyonda sabitlenmiş bir ekstremiteyle sonuçlanır.

Travmatik kalçanın, ekstansiyonda tutulması, pubik veya iliak bir çıkığa neden olabilir. Pubik çıkıklarda ekstremitede, belirgin dış rotasyon, tam ekstansiyon ve bazen abduksiyon bulunur.¹²⁰ Pubik çıkık, dış rotasyonla şiddetli hiperekstansiyonun sonucunda da olabilir ve bu durum femur başının anteriora zorlanmasına neden olabilir. Ön dislokasyonlar femur başının makaslama kırığı ile ilişkili olabilir.¹³⁵

Muayene

Anterior obturator dislokasyonlar genellikle etkilenen ekstremitenin, abduksiyon, dış rotasyon ve fleksiyonu ile gelir. Ön iliak veya pubik çıkıklarda kalça ekstansiyonda hafif abduksiyonda ve dış rotasyondadır. Femur başı, iliak çıkıkta, anterosuperior iliak çıkıntı yakınında, pubik çıkık sonrası pubise yakın olarak palpe edilebilir. Ekstremitenin nörovasküler durumu, kalça çıkığı olan tüm hastalarda belgelenmelidir.

Görüntüleme

Rutin kalça ve pelvis grafleri genellikle hasarı göstermede yeterlidir. Etkilenen tarafta femur başı, anterior konumundan dolayı daha büyük görünecektir. Kalça yaralanmasından şüphelendiğinde Shenton çizgisi değerlendirilmelidir (Şekil 18-3). İpsilateral ekstremitenin ek filmleri fizik muayeneyle dayanarak istenilebilir.

İlişkili Yaralanmalar

Kalça çıkığı birkaç önemli yaralanma ile ilişkili olabilir. Eşlik eden yaralanmalar posterior çıkıkla benzerdir. Bununla birlikte, damar hasarı anterior çıkıkta daha sık görülürken, siyatik sinir hasarı posterior çıkık sonrasında daha sıktır.

Tedavi

Yukarıdaki redüksiyon yöntemleri bazı vakalarda denemesine rağmen, çoğu vakada ameliyathanede redüksiyon gerekmektedir. Kapalı redüksiyon girişimleri başarısız olursa, açık redüksiyon gerekmektedir.

Komplikasyonlar

Ön kalça çıkıklarının, uzun dönem komplikasyonları posterior çıkıklara benzer şekilde ve femur başı AVN'si ve travmatik artrittir.

KAS GERİLMESİ VE TENDİNOPATI

İliopsoas Gerilmesi

Öncelikle dansçılar ve jimnastikçilerde oluşan nadir bir yaralanmadır. İliopsoas gerilmesi, trokanter minöre yapıştığı yerde ya da muskulotendinal kavşakta ortaya çıkabilir. Normal yaralanma mekanizması, iliopsoas üzerindeki aşırı gerilmedir. Muayenede, hasta tipik olarak uyluğunu

flexiyonda, adduksiyonda ve dış rotasyonda tutar. Uyulğun ekstansiyonu ve iç rotasyonu ağrısı arttırır.

Bu yaralanmanın tedavisinin temeli, buz torbaları ve yatak istirahatidir. Tendon tamamen yerinden kopmuş veya birleşmiş kemik parçaları olsa dahi cerrahi olarak tamir edilemez.

Gluteus Medius Gerilmesi

Daha çok genç atletlerde görülür; ancak, bu grupta bile nadir bir yaralanmadır. Gluteus medius'un gerilmesi genellikle, gluteus mediusun over ekstansiyonu sonucunda olur. Ağrı, abduksiyon tekrarına dirençle belirir ve hasta direnç karşısında uyluğunu medial rotasyona getirir. Bu yaralanmanın tedavisi de diğerleriyle aynıdır; istirahat, nemli ısı uygulaması ve analjeziklerdir.

Kronik kalça ağrısı olan genç hastalarda gluteus medius tendon yırtığı veya rüptürü düşünülmelidir. Bir çalışmada, kronik kalça ağrısı olan hastaların % 46'sında bu durum etyoloji olarak yer almıştır. Tanı, bu durum için en duyarlı test olan Trendelenburg testi yapılarak en iyi şekilde konulabilir.^{136,137}

Ekstansör Rotator Tendinopatisi

Akut veya kronik olabilen bu durum, sıklıkla ekstansör rotatorleri içerir. Uyluğun dış rotatorları arasında piriformis, gemellus superior ve inferior, obturator internus ve eksternus, quadratus femoris ve gluteus maximus bulunur. Bu kasların tendinopatisi, aktif dış rotasyonda ağrı ve hasasiyet ile karakterizedir. Tedavisinde, lokal nemli ısı uygulaması, antiinflamatuvar ajanlar ve analjezikler kullanılır. Dış rotatorların aşırı kullanım yaralanması olan genç hastalarda, günde birkaç kez 20 dakika buz torbası uygulamanın yanı sıra, ultrason ve iyonofrez gibi yöntemlerle de tedavi edilebilir.¹³⁷

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