KONU 22

Ayak Bileği

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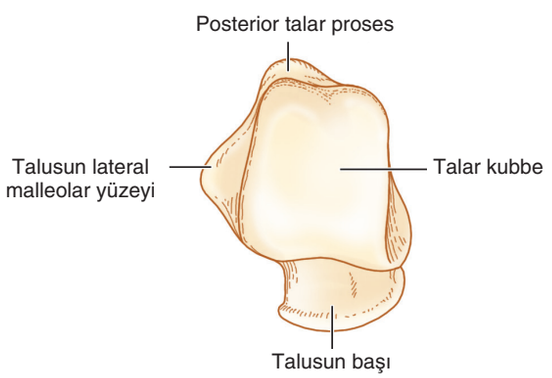
GİRİŞ

Ayak bileği yaralanmaları sık olup tüm spor yaralanmalarının %30'una karşılık gelmektedir.[1] Ayak bileği yaralanmaları, acil servisteki travmatik yaralanmaların %12'sinden sorumludur. Ligaman yaralanmaları kırıklardan 5 kat daha sıktır.[2] Acil hekimlerinin fonksiyonel anatomi, kırık paternleri ve yumuşak doku yaralanmaları hakkında iyi bir bilgi birikimine sahip olmaları önemlidir.

Anatomi

Ayak bileği, talusun içine girdiği mortisi oluşturan tibia ve fibula distal uçlarından oluşur. Ayak bileği eskiden bir menteşe eklem olarak tanımlansa da, daha çok bir eyer türü ekleme benzer[3]. Talar kubbe ya da eyer posteriora göre anteriorda daha geniştir (Şek. 22–1). Dorsifleksiyonda talar kubbe rahatça ayak bileği mortisine oturur, bu da plantar fleksiyon ile karşılaştırıldığında daha fazla stabilite sağlar (Şek. 22–2). Bu durum göz önüne alındığında, neden çoğu ayak bileği yaralanmasının ayak bileği ve ayak *plantar fleksiyonda* iken olduğunu anlamak kolaydır.

Ayak bileği ekleminde olan tek "saf" hareket plantar fleksiyon ve dorsifleksiyondur. İnversiyon ve eversiyon ise talus ve kalkaneus tarafından oluşturulan subtalar eklemde meydana gelir. Subtalar eklem çok kuvvetlidir, ligaman desteği vardır, ve talus daima kalkaneus ile birlikte ve aynı doğrultuda hareket ediyor şeklinde düşünülmelidir. Kalkaneotalar eklemin kuvveti dolayısıyla, inversiyon-eversiyon streslerinin bir çoğu subtalar eklem yerine ayak bileği eklemini zedeler.



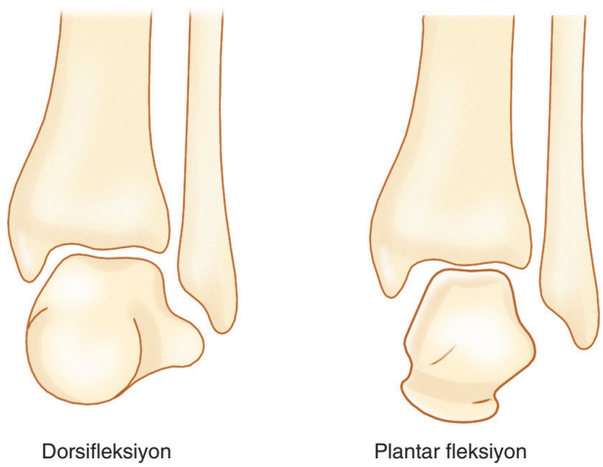
Şekil 22–1. Talar kubbenin anteriorda posteriora göre daha geniş olduğuna dikkat ediniz .

Bu çok önemli eklem etrafında oluşan yaralanmaları anlamak için acil hekimi, bu eklemi saran temel yumuşak dokular ile ilgili iyi bir bilgi birikimine sahip olmalıdır. Bu yapılar eklemi saran üç "tabakaya" ayrılırlar. En derin tabaka *kapsül* olup ayak bileği ligamanlarını içerir; orta tabaka, içinden geçip ayağa ulaşan *tendonları* içerir, en yüzeyel tabaka ise tendonları yerinde tutan *fibröz bantlardan (retinaküller)* oluşur.

Kapsüler Tabaka

Kapsül ayak bileği eklemini çevreler. Anterior ve posteriorda zayıf olup lateral ve medialde ligamanlarca kuvvetlendirilir. *Anterior ligaman* ince olup anterior tibiayı talusun boynuna bağlar ve lateral ligamanların geniş yırtıklarından etkilenir. *Posterior ligaman* ise daha kısa olup posterior tibiadan posterior talusa uzanır.

Lateral ligamanlar vücudun en sık zedelenen ligamanlarıdır. Üç önemli bileşene sahiptirler. *Anterior talofibular ligaman (ATFL)* lateral malleolden talusun boynuna uzanır ve ayak bileğinin en sık zedelenen ligamanıdır. *Posterior talofibular ligaman (PTFL)* lateral malleolden talusun posterior tüberkülüne uzanır. Kalkaneofibular ligaman ise lateral malleolden kalkaneusa uzanır (Şek. 22-3).



Şekil 22–2. Dorsifleksiyonda, talar kubbenin daha geniş olan anterior kısmı ayak bileği mortisine dayanır ve çok az harekete izin verir. Ayak bileği plantar fleksiyonda iken talar kubbenin daha dar olan posterior kısmı mortisin içinde kalır ve eklemde ciddi inversiyon-eversiyona izin verir.

artırır. Özellikle romatoid artriti olanlarda ya da alışılagelmişin dışında aktivite yapanlarda spontan rüptür olabilir.

Tedavi

Akut tenosinovit hafifse aktivite azaltılması yoluyla tedavi edilebilir. Ne var ki, semptomlar orta derecede ise ayak ve bileği dinlenmeye alınır ve antiinflamatuar ilaç ve buz kullanılır. Bazı vakalarda immobilizasyon (Ek A–14) sonrası 4 hafta ağırlık taşıyan diz altı alçı gerekli olabilir. Nadiren bu ilk tedaviye rağmen semptomlar devam ederse cerrahi gerekebilir.[102]

A

B

Şekil 22–42. Kırıksız izole sol ayak bileği çıkığı. ***A.*** Klinik fotoğraf ***B.*** Grafi

KIRIK OLMADAN AYAK BİLEĞİ ÇIKIĞI

Kırık olmaksızın izole çıkık varlığının nadir olduğu düşünülmesine karşın bu durum yaygın olarak bildirilmiştir.[104–108] Kırık olmadan saf ayak bileği çıkığına yol açmak için gerekli kuvvetin genellikle yüksek enerjili olması gerektiği düşünülür ve sıklıkla bu çıkıklar açıktır. Predispozan faktörler arasında ligament gevşekliği, peroneal kasların zayıflığı, medial malleol hipoplazisi ve önceki ayak bileği burkulmaları yer alır.[105] Dislokasyonlar posterior (en sık), anterior, medial, ya da lateral olabilir. Kırık olmaksızın lateralde tibiofibular eklemden rotatuar talar çıkık da bildirilmiştir[109] (Şek. 22–42).

PEDİATRİK VAKALAR

Pediatrik hastalar değerlendirilirken dikkatli olunmalıdır. Açık epifiz plaklarının varlığı ayak bileği yaralanmalarının tanı ve tedavisinde konservatif bir yaklaşımı gerekli kılar. Başlangıç grafiler genellikle epifiz plaklarını tam olarak değerlendiremez. İleri görüntüleme (BT'den daha çok MRG) bu popülasyonda tercih edilmelidir.[110] Salter-harris yaralanmalarından şüphelenilen çocuklarda ağırlık verilmesi, kesin görüntüleme ve ortopedik muayene ve takibi yapılana kadar engellenmelidir.

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