BÖLÜM 15

FASİYAL PARALİZİ VE AKUT KRANİYAL SİNİR HASTALIKLARINA YAKLAŞIM

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GİRİŞ

Kraniyal sinir disfonksiyonu; sinirin beyin sapındaki çıkış yerinden başlayarak tüm seyri boyunca gelişen herhangi bir hasara bağlı olarak ortaya çıkabilir.[1] Konjenital nedenler dışında; travma, kanama, iskemi, enfeksiyon, demiyelinizasyon, malignite etiyolojide rol oynar ya da idiyopatik olarak gözlenir.[1–3] Kraniyal nöropatiler izole olarak görülebileceği gibi, daha az sıklıkta multipl kraniyal nöropati şeklinde de karşımıza çıkabilir.[2] Bu bölümde başta fasiyal paralizi olmak üzere, akut kraniyal sinir tutulumları ve ayırıcı tanıları ele alınacaktır.

FASİYAL (VII. KRANİYAL SİNİR) PARALİZİ

Sir Charles Bell ilk olarak 1829 yılında, fasiyal sinir disfonksiyonuna bağlı unilateral fasiyal güçsüzlüğü tanımlamıştır.[4,5] Fasiyal sinir, lezyonun konumuna bağlı olarak onu birden çok nörolojik bozukluğa duyarlı hale getiren karmaşık bir anatomiye ve işleve sahiptir.[1,3] Başlıca motor görevi olan bir sinirdir, az sayıda duyusal sinir lifi taşır. Motor ve duyusal çekirdekleri ponsta yer alır. Sinir beyin sapını terk ettikten sonra petroz kemiğin içindeki fallop kanalına girer. Kanalı geçip foramen stylomastoideum'dan çıkarak yüz kaslarını innerve eder. Dış kulak yolunda ufak bir alanın duyusunu ve dilin 2/3 ön bölümünün tat duyusunu sağlar. Submandibuler ve sublingual tükrük bezlerine parasempatik lifler taşır. Kornea refleksinin de efferent yolunu oluşturur.[1–3]

Santral tip paralizide lezyonun karşı tarafındaki alt yüz kaslarında güçsüzlük gözlenir. Alın kaslarının korunması santral lezyonu düşündürür. Periferik tipte ise hasta lezyon tarafındaki gözünü kapatamaz, alnını kırıştıramaz, kaşını kaldıramaz, nazolabiyal kıvrım kaybolur ve ağız sağlam tarafa doğru kayar. Stapedius sinirinden önceki fasiyal sinir lezyonları hiperakuziye neden olurken; lezyon bölgesine bağlı olarak, gözyaşında azalma ve dilin ön üçte ikilik bölümünde tat duyusu kaybı görülebilir. [2,5,6]

Epidemiyoloji: Periferik fasiyal paralizinin yıllık görülme insidansı 10 yaş altında 2.7/100000 iken, 10-20 yaş arasında 10.1/100000 olarak bildirilmiştir.[7] Çocuklarda erişkinlere göre 2-4 kat daha az sıklıkta görülmektedir.[8] Diyabetik bireylerde de risk dört kat artmıştır.[9] Eş zamanlı bilateral fasiyal paralizi görülme prevalansı ise %0.3-2'dir.[10]

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gözlenebilir. Trigeminal nevraljide olduğu gibi, glossofaringeal nevraljinin idiyopatik ve ikincil formları vardır. İkincil nedenler arasında demiyelinizan lezyonlar, serebellopontin köşe tümörü, peritonsiller apse, nörovasküler bası ve Eagle's sendromu (stiloid proçesin uzaması ve stilo-hiyoid ligamanın kalsifikasyonuna bağlı sinirin sıkışması) yer alır. Çocuklarda oldukça nadir görülür.[170]

XI. KRANİYAL SİNİR (AKSESUAR SİNİR):

Sternokleidomastoideus ve trapezius kaslarını innerve eden, saf motor özelliği olan bir sinirdir. Bir kısım lifleri bulbustan, bir kısmı da servikal medulla spinalisin üst segmentlerindeki önboynuz hücrelerinden çıkar. Kraniyal kaviteyi foramen jugulare'den geçerek terk eder. Aksesuar sinirin felcinde omuzda düşme, ipsilateral kolun kaldırılmasında ve başın karşı tarafa çevrilmesinde güçsüzlük, skapulada kanatlaşma ortaya çıkar.[1,2]

Tek taraflı akut/subakut tutulumunda özellikle aynı taraf foramen jugulare bölgesindeki tümöral nedenler akla gelmelidir. Burada IX. ve X. kraniyal sinirlerle yakın komşuluğu olması nedeni ile; sıklıkla bu üç sinire ait klinik belirtiler görülür. Bazen yakın komşuluğu olan XII. kraniyal sinirin felci de eklenebilir.[1,168] Etiyoloji benzerdir.[3,166,167] Bu sinirin akut hasarı özellikle lenf nodu biyopsisi/boyun diseksiyonu sırasında iatrojenik olarak veya künt/penetran boyun travmalarına bağlı olarak gelişir. Ek olarak; büyümüş lenf nodları, tümör basısı (spinal kord lezyonları, arka fossa tümörleri) ve radyoterapi sonucunda da bulgular ortaya çıkabilir. Motor nöron hastalığı, siringomyeli ve poliomiyelit de daha nadiren aksesuar sinir çekirdeklerini etkileyebilir.[3,167,168]

XII. KRANİYAL SİNİR (HİPOGLOSSAL SİNİR)

Çekirdeği bulbusta olan, dilin motor siniridir. Kafatasından oksipital kemiğin kondili hizasında *canalis nervi hypoglossi*'den geçerek çıkar. Tek taraflı XII. kraniyal sinir felcinde dil paralitik tarafa doğru sapar. Dilin aynı yarısında atrofi görülür İki taraflı lezyonlarında dilin dışarı çıkarılamadığı, hatta ağız tabanında hiç hareket etmediği dikkati çeker.[1,2]

Hipoglossal sinirin tek taraflı felci seyrek görülür. Bulbusun siringomiyeli gibi hastalıklarında rastlanır.[3,167] Hipoglossal sinirin izole veya komşu sinirlerle beraber tutulumu; travma, enflamasyon, karotis anevrizması, karotis arter diseksiyonu, lokal enfeksiyon, radyoterapi, cerrahi/dental girişim veya malignitelere bağlı olarak ortaya çıkabilir.[2,3,171,172]

Travma öyküsü olan olgularda açıklanamayan boyun ağrısı, spazmodik tortikollis ve alt seviye kraniyal sinir tutulumu varlığında; oksipital kondil kırığını dışlamak için BT çekilmesi gerekebilir. Hipoglossal sinir hasarında kırık parçalarının yer değiştirmesine, ödeme ve hematoma bağlı olarak klinik bulgular gecikebilir, klinisyen bu açıdan uyanık olmalıdır.[173]

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