

## BÖLÜM 30

# SERVİKAL DİSK ARTROPLASTİ



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### GİRİŞ

Servikal omurgayı meydana getiren yedi vertebra, aralarında bulunan diskler ve zigapofiziyal eklemler ile birlikte başın gövde üzerindeki hareketini sağlarken, aynı zamanda spinal kord, sinir kökleri ve vertebral arterler için de korunaklı geçit oluştururlar. Bu anatomik yapılarıdaki yaşa ve travmaya bağlı dejeneratif değişiklikler, servikal omurga biyomekaniğini etkileyip, sinir kökü veya spinal kord basısına yol açabilir. Radikülopati veya miyelopatiye neden olan servikal dejeneratif disk hastalığının en yaygın cerrahi tedavi yöntemi 1950'lerde Smith Robinson (1) ve ardından Cloward (2) tarafından tanımlanan anterior servikal diskektomi ve füzyon (ASDF) tekniğidir. ASDF, servikal radikülopati veya miyelopati hastalarda herniye diskin sebep olduğu bulguları %90'ın üzerinde oranda giderebilen güvenilir bir yöntemdir (3). Ancak, nöral bası semptomlarını gidermesi açısından oldukça başarılı olsa da, ASDF servikal omurga biyomekaniğine olan olumsuz etkileri nedeniyle omurga cerrahisinde tartışmalı bir alan yaratmıştır.

Füzyon uygulanan seviyenin bir üst ve/veya bir alt seviyesinde semptom olmaksızın radyografik olarak gösterilen dejeneratif değişikliklere tanım olarak 'komşu segment dejenerasyonu'

(KSD) denilmektedir. 'Komşu segment hastalığı' (KSH) ise ağrı ve/veya nörolojik kusurların eşlik ettiği klinik bulgular varlığında komşu segmentlerdeki dejeneratif değişikliklerdir. Başarılı ASDF cerrahisinin ardından füzyona komşu segmentlerde, özellikle inferior diskte, artmış stres yüküne bağlı olarak ileride semptomatik disk hastalığı gelişme ihtimali de artar. İki farklı kadavra çalışmasında C5-C6 seviyesine ASDF uygulanmadan önce komşu segmentlerdeki intradiskal basınçlar ölçülmüş ve füzyon uygulanmasının ardından yapılan ölçümlerle karşılaştırılmıştır. C4-C5 ve C6-C7 seviyelerinde intradiskal basınçların belirgin olarak arttığı bildirilmiştir (4,5). Füzyon sonrası karşılaşılan bir diğer durum ise komşu seviyelerde segmental hareketliliğin artmasıdır (6). Kadavra çalışmaları ile fleksiyon esnasında kranial, ekstansiyon esnasında kaudal komşu seviyede daha fazla olmakla birlikte her iki seviyede hareketin arttığı gösterilmiştir (5).

KSD en sık C5-C6 ve C6-C7 seviyelerinde görülmektedir. ASDF sonrası yıllık kümülatif %2-3 oranında KSD'na bağlı yeni semptomatik radikülopati geliştiği bilinmektedir (7,8). 5-10 yıllık takiplerde KSH %25 oranında olup, hastaların %7-15'inde ikinci cerrahi prosedüre gerek duyulmaktadır (9). Diğer yandan literatür-

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