BEYİN OMURİLİK SIVISI (BOS) RİNORE

BÖLÜM 11

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GİRİŞ

BOS rinore, BOS içeren subaraknoid boşluk ile paranazal sinüslerin mukozal boşluğu arasındaki doğrudan ilişkiden kaynaklanır ve mikroorganizmaların intrakranial boşluğa yayılması için bir yol görevi görebileceğinden, menenjit ve intrakraniyal enfeksiyonlar gibi komplikasyonlara neden olabilmektedir. İlk olarak 17. yüzyılda bildirilmiştir, 20. yüzyılın başlarında Dandy, bifrontal kraniotomi ile fasya lata grefti yerleştirerek ilk başarılı onarımı gerçekleştirmiştir. BOS rinoresi basit bir kavram olmasına rağmen, tanı ve lokalizasyonun saptanması klinisyeni zorlayabilmektedir. Teknolojik gelişmelere paralel olarak tanı ve lokalizasyon problemleri ciddi oranda azalmaktadır. Son yıllarda tedavi modalitelerinde açık tekniklerin yerini minimal invaziv tedavi modalitelerinin almıştır. (1-4)

BOS Rinore Sınıflandırma	
I-Travmatik	
Kazaya sekonder • Hemen • Gecikmeli	**Cerrahi** • Beyin cerrahisi komplikasyonu • Sinüs cerrahisi komplikasyonu
II-Nontravmatik	
Artmış intrakraniyal hipertansiyon • İntrakraniyal neoplazm • Hidrosefali • Bening intrakraniyal hipertansiyon	**Normal intrakraniyal hipertansiyon** • Konjenital anomali • Kafa tabanı neoplazmı • Kafa tabanın erozif hastalıkları • İdiyopatik

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olan hastalarda menenjit riskinde en az 8-10 kat artış vardır. Bu nedenle, uygun koşullara rağmen 7 günden fazla devam eden travma sonrası BOS sızıntılarının cerrahi onarımına önem verilmelidir.

SONUÇ

Birçok BOS sızıntısı, konservatif yönetime yanıt verir (gözlem, artı KİB'i en aza indirecek önlemler); özellikle, travmatik BOS rinoresi tek başına konservatif önlemlerle çözülme eğilimindedir. Buna karşılık, travmatik olmayan BOS rinoresinin özellikle doğrudan operatif onarım gerektirmesi muhtemeldir. Günümüzde ekstrakraniyal yaklaşımlar ve gelişen cerrahi enstrümanlar sayesinde intrakraniyal yaklaşımlar yerine ekstrakraniyal yaklaşımlar büyük ölçüde tercih edilmektedir.

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