



BÖLÜM 5

SPORCULARDA OMUZ AĞRILARI

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GİRİŞ

Omuz ağrısı genel popülasyonda olduğu kadar sporcu popülasyonunda da önemli bir sağlık sorunudur (tablo 1). Sporcularda omuz yaralanmaları sıklıkla iki mekanizma ile oluşmaktadır. Akut omuz yaralanmaları çoğunlukla çarpışma ve temas içeren sporlarda veya kayak, bisiklet gibi sporlarda kaza sonrası oluşmaktadır. Aşırı kullanim yaralanmaları ise; tenis, beyzbol, yüzme, cimnastik gibi baş üstü aktivite içeren sporlarda daha sık görülmektedir. Aşırı yük, doğru olmayan fırlatma mekanikleri, spora disfonksiyonel

adaptasyonlar gibi sebeplerle oluşan mikrotravmaların yol açtığı kronik yaralanmalardır (1).

Glenohumeral(GH) eklem; statik (eklem kapsülü, ligamentler) ve dinamik (çoğunluğunu rotator manşon grubunun oluşturduğu kaslar ve tendonlar) stabilizatörler ile desteklenmektedir (2). Vücudun en geniş eklem açıklığına izin veren eklemdir. Bu durum güçlü fırlatma ve vuruşlara olanak sağlasa da yapısı gereği zayıf stabilitesi omuz eklemini sportif yaralanmalara açık hale getirmektedir.

Tablo 1. Sporcularda omuz ağrısı nedenleri

Sık	Daha az sıklıkta	Omuz kuşağı dışındaki sebepler
<ul style="list-style-type: none">• Rotator manşet patolojileri• GH instabilite• Bicepsle ilişkili patolojiler ve SLAP lezyonlar• Skapular diskinezi• GH iç rotasyon eksikliği• AK ve SK eklem yaralanmaları, klavikula kırıkları	<ul style="list-style-type: none">• Diğer kas yırtıkları• Adeziv kapsülit• Nörovasküler tuzaklanma veya traksiyon yaralanmaları• Kırıklar• Atlayan skapula	<ul style="list-style-type: none">• Somatik yansıyan ağrı (omurga ve miyofasial yapılar)• Tümörler• Visseral yansıyan ağrı (diyafram, safra kesesi, kalp, dalak, akciğer apeksi)

SLAP=Superior labrum anterior posterior, AK=Akromiyoklaviküler, SK=Sternoklaviküler

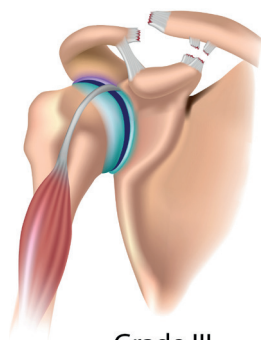
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Omuz travması olan ve özellikle akromiyon, klavikula çevresinde ağrı şikayeti olan atletlerde AK eklem yaralanmalarından şüphelenilmelidir. Akut dönemde lokalize ağrı, ödem, hassasiyet görülebilir. Ağrı abduksiyon ve çapraz addüksiyonda artabilir (64). Yaralanma derecesine göre distal klavikula cillte görülebilir.

Tanı ve sınıflandırmada ilk seçenek radyografilerdir. Zanca grafisi (10°-15°sefalik tittle çekilen ap grafi) AK eklemi gösteren en uygun grafidir (65). AK ve korakoklaviküler bağları değerlendirilmede MRG kullanılmaktadır.

Tip 1 ve 2 (Resim 6) yaralanmalarda konservatif tedavi önerilmektedir. Basit askı ile immobilizasyon, analjezik-antiinflamatuvar tedavi, soğuk uygulama, aktivite modifikasyonu ve tam istirahat başlangıçta uygulanan tedavilerdir. Sıklıkla bir haftalık immobilizasyon yeterli olmaktadır. Hasta asemptomatik hale geldikten hemen sonra askı çıkarılmalı ve pasif ve aktif omuz hareketlerini içeren fizik tedavi başlanmalıdır. Temas sporları ve ağırlık sporlarına ağrısız, simetrik eklem hareket açıklığı ve kuvvet sağlanana kadar izin verilmemelidir. Yaralanma sonrası ağrının 6 ay devam edebileceği, yine hastaların %33'ünde daha uzun ağrı ve instabilite şikayetleri gösterilmiştir (66).

AK ve korakoklaviküler bağların yırtıldığı tip 3 (şekil 7) yaralanmalarda tedavi yöntemi tartışmalıdır. Konservatif tedavi ile güzel sonuçlar alınan çalışmalar mevcuttur, yine inatçı ağrı ve rezidüel semptomların devam ettiği yönünde kanıtlar da vardır. Bu nedenle genç, aktif sporcularda cerrahi tedavi önerilmektedir (67).



Grade III

Resim 7. Grade 3 AK eklem yaralanması

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