BÖLÜM 11

ROTATOR KAF SENDROMU

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GİRİŞ

Rotator kaf, infraspinatus, supraspinatus, teres minör ve subskapularis kaslarının kas gövdeleri ve tendonlarından oluşur. Rotator kaf sendromu, bu kasları etkileyen herhangi bir yaralanma veya dejeneratif durumu tanımlar. Buna subakromiyal sıkışma sendromu (SSS) ve bursit, tendinit, kısmi veya tam kat rotator kaf yırtıkları dahildir. Kronik rotator kaf sendromu, glenohumeral dejeneratif hastalık ve rotator kaf artropatisi gelişme riskini artırabilir (1-4).

ANATOMİ

Omuz, büyük bir eklem hareket açıklığına izin veren en esnek ve hareketli sinoviyal eklemdir. Anatomisi abdüksiyon, adduksiyon, fleksiyon, ekstansiyon ve medial ve lateral rotasyona izin verir, ancak stabiliteden ödün verir. Rotator kaf kasları, omuzun dinamik stabilizatörleridir. Rotator manşonun orijini skapuladır ve humerus başına girerek paralel yapılar oluştururlar. Rotator manşon orijinde ayrı olmasına rağmen, rotator manşon insersiyonun yakınında birbirlerine yaklaştıkları beş katmanlı bir yapıda organize edilmiştir. Bu katmanlı yapı, tabakalara ayrılan yırtıkların görünümünü açıklar. Alt seviyede, korakohumeral ligamanın bir uzantısını temsil eden ve rotator aralıktan supraspinatus ve infraspinatus boyunca uzanan bazı dikey çizgisel lifler vardır. Rotator kablo olarak adlandırılır ve bir asma köprü gibi davranarak stres korumada biyomekanik etkileri vardır. Ultrason (USG) ve manyetik rezonans görüntülemede (MRG) özellikle supraspinatus liflerinin gevşediği ABER (abduksiyon ve eksternal rotasyon) pozisyonunda gösterilebilir (5-11).

Posterior rotator manşon tendonları, bir bursal ve bir artiküler bölgeye sahip olan supraspinatus ve infraspinatus'u içerir. Teres minör nadiren yaralanır ve omuzun biyomekaniği üzerindeki işlevi henüz belirlenmemiştir. Supraspinatus, tuberkulum majus ön kısmına yapışır. Subskapularis tuberkulum minusta sonlanır. İnfraspinatus, skapula'nın alt kısmındaki infraspinatus fossadan kaynaklanır ve trapezoidal bir görünüm ile tuberkulum majusa yapışır (12,13). Subskapularis işlevi, omuzun ve biseps tendonunun uzun başının anterior stabilizasyonudur (14).

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SONUÇ OLARAK

Rotator kaf sendromu, hafif şiddetli sıkışmadan ilerleyici parsiyel ve/veya tam kat yırtıklara yol açabilen çok çeşitli klinik semptomlardan oluşan bir klinik durumdur.

Klinisyenler akut veya kronik omuz ağrısını incelerken, klinik muayeneyi radyografik görüntüleme, MRG ve konservatif tedavi yöntemlerine yanıt ile ilişkilendirmek zorundadır. Nonoperatif tedavi yöntemleri, fizik tedavi, NSAID'ler, dinlenme / aktivite modifikasyonu ve enjeksiyonlardan oluşur.

Konservatif olarak tedavi edilen hastalar için, hasta ağrı yönetimi konusunda eğitilmelidir. Ek olarak, hasta kas gücünü ve eklem hareketliliğini artırabilecek faydalı egzersizler konusunda eğitilmelidir.

Diğer tüm tedavi modaliteleri tükendikten sonra semptomlar düzelmediğinde veya kötüleştiğinde cerrahi tedavi düşünülür.

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