BÖLÜM 25

OMUZ KIRIKLARI TEDAVİ VE REHABİLİTASYONU

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PROKSİMAL HUMERUS KIRIĞI TEDAVİ VE REHABİLİTASYONU

Proksimal humerus kırığı, tüm kırıkların %4-5'ini, humerus kırıklarının ise %45'ini oluşturmaktadır. Majör risk faktörleri ileri yaş, kadın cinsiyet, osteoporozdur. Humerus üst uç kırıklarının, yaşlılarda kalça ve distal radius kırıklarından sonra en sık görülen üçüncü kırık olduğu bildirilmektedir (1). Erkeklere göre, kadınlarda yaklaşık 2-3 kat daha fazla görülmektedir (2). Sadece izole tüberkulum majus kırığı sıklıkla gençlerde görülmektedir. Yaşlılarda sık görülmesinin nedenleri olarak; osteoporoz, immobilizasyon, fizyolojik rezervin düşük olması, beslenme bozukluğu, nöromüsküler ve denge kontrol yetersizliği vs. düşünülmektedir. Humerus proksimal kısmında humerus başı, tüberkulum majus ve minus, bisipital oluk yer alır. Anatomik boyun; humerus başı ile tüberküller arasındadır. Kırıkları, humerus başının beslenmesinin bozulması nedeniyle, avasküler nekroz riski artar, kötü prognoza sahiptir. Cerrahi boyun; büyük ve küçük tüberküllerin hemen altındaki kısımdır. Kırıkları, anatomik boyun kırıklarından daha sıktır fakat prognozu daha iyidir. Dirsek ya da açık el üstüne düşme veya omuzun lateralden direkt travmaya maruz kalması ile özellikle yaşlılarda görülür. Proksimal humerus kırıklarının %80'ini stabil veya non-deplase kırıklar şeklinde olup, sıklıkla konservatif tedavi ile takip edilmektedir (3). İnstabil veya deplase kırıklar ise cerrahi tedavi ile takip edilmektedir. Cerrahi tedavide, kapalı redüksiyon+ perkutan pinleme, mini-invazif plak, açık redüksiyon ve kilitli plaklama, intrameduller çivileme ve artroplasti en sık kullanılan yöntemlerdir. Tedavi kararında; hastanın yaşı, genel durumu, kırığın tipi, kırık parçaların redüksiyon durumu, kırık morfolojisi, kemik kalitesi, avasküler nekroz riski, eşlik eden ek hastalıklar ve cerrahın tecrübesi gibi parametreler göz önünde bulundurulmalıdır. Yaşlılarda, gençlere göre fonksiyon kaybının daha tolere edilebilir olması konservatif tedaviyi ön plana çıkarmaktadır. Erken dönemde egzersiz başlanması faydalıdır. Hastaların fonksiyonel bağımsızlığını korunması veya arttırılması açısından fizik tedavi ve rehabilitasyon önem taşımakta olup, başarılı bir tedavi için cerrah, fizik tedavi ve rehabilitasyon doktoru ve fizyoterapist koordineli olarak çalışmalıdırlar.

CERRAHİ TEDAVİ

Cerrahi tedavide; minimal invaziv yöntemlerden, osteosentez ve artroplastiye kadar geniş tedavi

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Skapula kırıkları, omuz kompleksinin sakatlığına ve üst ekstremite için kötü bir fonksiyonel sonuca yol açabilir. Başlangıçta önemli yer değiştirmesi olan kırıklar ve ardından kalan skapular deformite, uzun süreli üst ekstremite zayıflığı ve ağrı riskini artırır. Özellikle yer değiştirmiş akromiyon kırıkları, subakromiyal boşluğun daralması ve sıkışmasına sekonder ağrı ve sertlik riskini artırır. Yer değiştirmiş eklem içi glenoid kırıkları ayrıca glenohumeral instabilite ve erken başlangıçlı dejeneratif artrit riski ile ilişkilidir (51). Skapular cisim ve akromiyonu içeren kırıklarda semptomatik kaynamama da meydana gelebilir (66).

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