BÖLÜM 145

YUTMA VE PELVİK TABAN REHABİLİTASYONU

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GİRİŞ

Yeme ve yutma, çok fazla sinir ve kasın istemli aktivitelerini içermektedir. Bunun sebebi özellikle ağız ve farinksin, yutma işlevi dışında çiğneme, tat alma, konuşma ve solunum gibi diğer işlevlerin de gerçekleştirildiği bölgeler olmasıdır. Disfaji, ağız boşluğu, farinks, hipofarinks veya özofagusun işlevsel veya yapısal eksikliklerinden kaynaklanabilir. Disfaji rehabilitasyonunun amacı, beslenme ve yutma anormalliklerini tespit etmek ve tedavi etmektir.

Yeme alışkanlıklarından tamamen bağımsız olarak gerek otçul gerekse etçil, kara memelilerinin solunum ve yutma ile ilgili özellikleri birbirleri ile büyük benzerlik göstermektedir. Bu canlılardaki larinksin kafa tabanına olan uzaklığı temel alınarak boyundaki yerleşimi değerlendirildiğinde, insanlara oranla daha yukarda yer aldığı görülmektedir. Larinksin bu yüksek yerleşimi sayesinde burundan solunan havanın kesintisiz şekilde akciğerlere aktarımı sağlanmaktadır (1).

Yutma Anatomisi

Besinler ağız boşluğundan itibaren farinks, larinks, hipofarinks, özofagus ve oradan mideye uzanan bir yol izlerler. Besinler bu anatomik yola başlamadan önce ağız içerisinde dudaklar, dişler, dil, yanaklar, oral vestibüler, damak ve palatal arklarını da görürler.

Oral Kavite

Ağız boşluğu, gıdanın işlendiği ilk bölgedir. Dudaklardan farinkse kadar uzanır. Ağız boşluğu, dişler tarafından dış ve iç ağız boşluğu olmak üzere iki kısma ayrılır.

Dış Oral Kavite

Diş ile yanakların ve dudakların iç yüzeyleri arasında bulunan kısımdır. Mukoza zarı ile kaplıdır. Parotis kanalı ve labiyal, bukkal ve molar tükrük bezleri bu boşluğa açılır. Anteriorda oral fissür vasıtasıyla dışarıyla, posteriorda iç oral kaviteyle bağlantı kurar.

İç Oral Kavite

Superiorda sert ve yumuşak damakla ve anteriorda dişlerle sınırlıdır. İnferiorda dil ve ağız boşluğunun oluşturduğu kaslı bir diyafragma bulunur. Posteriorda palatoglossal (anterior ark) ve palatopharyn-

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korelasyon bulunamamıştır. Seansların süresi, sürenin 20 dakika olduğu (192) ve bir saatlik uygulamanın 4 saatlik bir uygulama ile karşılaştırıldığı (193) çalışmalar hariç, tüm çalışmalarda 30 dakika olarak seçilmektedir. İkincisinde, her iki grupta da Aİ sonuçlarında iyileşmeler görülmesine rağmen, 4 saatlik grupta tahmin edilen etkiler 1 saatlik gruba göre daha yüksekti. Pulse süresi, dahil edilen tüm çalışmalarda 200 ms'dir. T-PTNS'deki frekans, iki uyarım yöntemini (perkütan ve transkütan) karşılaştıran ve 20 Hz'nin kullanıldığı çalışma ve aynı yöntemin farklı uygulama süreleriyle uygulandığı, frekansın 1 Hz olduğu (193) tarafından yapılan çalışma hariç olmak üzere 10 Hz'di (194). Farklı frekansların yukarıdaki çalışmalarda farklı etkilere sahip olduğu görünmemektedir. Bu nedenle, P-PTNS tedavisinde frekans 10 Hz veya 20 Hz'dir (195).

Meta-analize dahil edilen çalışmaların çoğunda tedavi sırasında herhangi bir advers etki bildirilmemiştir. Advers etkilerin bildirildiği çalışmalarda bu etkiler uygulama sırasında veya 24-48 saat içinde kaybolmuştur ve hiçbir advers olay tedavinin veya çalışmanın tamamlanmasını engellememiştir. P-PTNS modalitesinde, uygulama sırasında alt ekstremitede hafif ağrı, ayakta parestezi ve iğne bölgesinde parestezi, kanama, morarma veya ağrı bildirilmiştir (196). T-PTNS modalitesinde, uygulama alt ekstremitesinde kaşıntı veya hissedilebilir yanma ve cihazın uygulandığı yerde hafif tahriş bildirilmiştir (197).

SONUÇ

Pelvik taban rehabilitasyonunun gastroenterolojik hasta popülasyonunda etkinliğini kanıtlayan çalışmaların artmasıyla, rehabilitasyona verilen önem giderek artmaktadır. Rehabilitasyon uygulamalarının güvenli ve nispeten risksiz olması nedeni ile çoğu kılavuz tarafından pelvik taban rehabilitasyonu önerilmektedir.

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