BÖLÜM 14

ÖZOFAGEAL NÖROMUSKULER FONKSİYONLAR VE MOTİLİTE HASTALIKLARI

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GİRİŞ

Özofagus, orofarinks ve mide arasında bulunan içi boş bir tüp şeklindeki sindirim sistemi organıdır. Kas yapısı sayesinde katı ve sıvı gıdaları mideye ulaştırmak ve bunun dışında içeriğini boş tutmak gibi basit bir fonksiyonu olsa da; serebral korteks ve medulla tarafından kontrol edilen çizgili kaslardan oluşan ve hassas dokunma hissini algılayabilen orofarinks ile vagus ve enterik sinir sistemi tarafından kontrol edilen düz kas yapısındaki mide gibi birbirinden farklı iki bölgeyi birleştirdiği için oldukça karmaşık bir kontrol mekanizmasına sahiptir (1,2).

Erişkinlerde 18-26 cm uzunluğunda olan özofagus; servikal, torasik ve abdominal olmak üzere üç anatomik bölüme ayrılmıştır. Servikal segment krikofaringeus hizasından başlar ve suprasternal çentikte sona erer. Bu segment, gevşek bağ dokuları ile birleştirildiği trakeanın hemen arkasında yer alır. Posteriorda, prevertebral fasya, yemek borusunu C6-8 servikal vertebra gövdelerine bağlar. Lateralde ise karotis kılıfı ve tiroid bezi komşuluğu bulunur. Torasik segment, üst mediastende vertebral kolon ile trakea arasında yer alır ve suprasternal çentikten diyaframa kadar uzanır. T4 ile T5 intervertebral diskler hizasında aort arkının arkasından geçer ve posterior mediastene girer. Son segment olan abdominal segment, T10 vertebra seviyesinde diyaframın sağ krusundan geçer ve T11 vertebra seviyesinde kardiyaya ulaşır (2,3).

ÖZOFAGUSUN YAPISI VE NORMAL YUTMA FONKSİYONU

Özofagusun innervasyonu, sempatik ve parasempatik sinir sistemlerini içerir. Vagus siniri özofagus kas ve bezlerinin parasempatik motor fonksiyonlarından, torasik ve servikal zincirler ise sempatik innervasyondan sorumludur. Sempatik sinir ağrıyı daha doğrudan algılarken, vagus siniri ağrıya dönüşebilen basıncı algılar (2).

Özofagusun yaklaşık proksimal üçte biri esas olarak çizgili kastan oluşurken, distal üçte ikisi düz kastır ve arada bir geçiş zonu bulunur. Tüm özofagus boyunca dış tabaka longitudinal olarak uzanır ve iç tabaka sirküler liflerden oluşur. İçteki sirküler kas tabakası, içeriği bolus şeklinde hareket ettiren peristaltik kasılmaları sağlar ve dış tabakadan daha kalındır. Abdominal özofageal segmentte bu sirküler kas liflerinin kalınlaşması ve üst üste binmesi AÖS'ün şeklini ve işlevini oluşturur.

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malıdır. Baskın semptom olarak disfaji olan hastalarda, mekanik darlığı (Schatzki halkası veya peptik darlık gibi) ampirik özofageal dilatasyon düşünülebilir. Dikkatli çiğneme, pozisyonel yerçekimini koruma ve katı bolusu sıvılarla ilerletme gibi yaşam tarzı değişiklikleri yardımcı olabilir. Prukaloprid gibi yeni ajanlar, GÖRH'li hastalarda primer özofageal kasılmaların genliğini artırabilir ve eş zamanlı gastroparezi veya kronik idiyopatik kabızlığı olan hastalarda bir rolü olabilir, ancak özofageal hipomotilite için primer bir tedavi seçeneği değildir. Karma bir dopamin D2 reseptör antagonisti ve kısmi 5HT-1A agonisti olan buspironun, sklerodermalı hastalarda özofageal kasılma genliğini artırdığı gösterilmiştir ancak İEM'li 10 hastada disfajiyi iyileştirmede plasebodan daha iyi değildi (84-87). Göğüs ağrısının birincil semptom olduğu hastalarda, özofageal aşırı duyarlılık nedeniyle nöromodülatörler veya davranışsal terapiler faydalı olabilir (4).

SONUÇ

Özofageal motilite bozuklukları nadir görülen ve zor tanı konulan hastalıklar olmakla birlikte hastaların hayat kalitesini bozan ciddi durumlardır. Ana semptom genellikle disfajidir. Disfaji ayırıcı tanısı için gerekli tetkikler yapıldıktan sonra özofagus motilite bozuklukları için spesifik tetkikler yapılmalıdır. Özofagus motilite bozuklukları tanısında high resolution manometre altın standarttır. Cerrahi tedaviler ve cerrahi tedavinin prosedürü hastalıklara göre değişmektedir. Cerrahi tedavinin uygulanamadığı ya da hafif semptomlu hastalarda medikal tedavi, dilatasyon ve botilinum toksini gibi tedaviler uygulanabilir.

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