24. Bölüm

AYAK VE AYAK BİLEĞİ ÇEVRESİ TUZAK NÖROPATİLERİ

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GİRİŞ

Alt ekstremite tuzak nöropatileri nadir ancak önemli bir morbidite kaynağıdır. Radiküler ağrılardan ve diyabet gibi sistemik hastalıkların neden olduğu periferik nöropatilerden ayırıcı tanısının yapılması gereklidir (1).

Ayak ve ayak bileğinin sinirsel innervasyonu beş periferal sinir tarafından sağlanır. Bunlardan dördü (tibial sinir, derin peroneal sinir, yüzeyel peroneal sinir ve sural sinir) siyatik sinirin dallarıyken beşincisi (safen sinir) femoral sinirin terminal dalıdır (2).

Tanı koymak için, kapsamlı bir fizik muayene ve ilgili anatominin tam olarak bilinmesi gereklidir. Anatomik çalışmalar, sinirlerin sıklıkla sıkıştığı alanların belirlenmesine yardımcı olmuştur. Manyetik Rezonans Görüntüleme (MRG) ve ultrasonografi gibi gelişmiş görüntüleme ve sinir iletim hızı çalışmaları, tuzak alanını lokalize etmeyi kolaylaştırmıştır.

TARSAL TÜNEL SENDROMU

Tarsal tünel sendromu; tibial sinirin ayak bileği çevresinde sıkışması sonucu ortaya çıkar. İlk kez 1932'de tanımlanmış ve 1962'de Keck ve Lam tarafından adlandırılmıştır. Kadınlarda daha sık görülür (3).

Tarsal tünel sendromu, tibial sinirin medial malleol posteriorundan, talus ve kalkaneus medialinden geçerken sıkışmasıdır. Tarsal tünelin ön duvarını

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v. saphena magna ile birlikte ayağa kadar devam eder. Medial malleolün önünde subkutan olarak ilerleyen sinir, iki terminal dal verir. Medial ayak bileği ve orta ayağın duyusunu alır (2).

Safen sinir, ayak ve ayak bileği çevresinden çok, daha proksimalde, Hunter kanalı içinde sıkışmaya eğilimlidir. Ama hastalar genellikle ayak ve ayak bileğinde ağrı ve parestezi ile başvururlar (70). Diz çevresindeki akut travmatik nedenlere bağlı infrapatellar dalda izole sıkışma, lokalize semptomlar verir, ve nispeten tanısı kolaydır. Diz cerrahisi sonrası veya varis ameliyatı sonrası iyatrojenik hasar, perinöral fibrozis ile sıkışmaya neden olabilir.

Klinik semptomlar sıklıkla medial diz ve baldır ağrısı ile birlikte, ayak ve ayak bileği medialinde, özellikle 1. metatars dorsalinde parestezidir. Sinir boyunca yapılan Tinel testi ile pozitiflik bulunabilir ve tanıyı güçlendirecektir. Lokal anestezik enjeksiyonu tanı koymaya yardımcı olabilir.

Direkt grafi, bilgisayarlı tomografi veya MRG ile bası yapan kemik ve yumuşak doku lezyonları görüntülenir. Sinir ileti çalışmaları tanı koymada yetersizdir (101). Daha proksimal nedenleri veya radikülopatileri dışlamak için yardımcı olabilir.

Cerrahi müdahaleden mümkün oldukça kaçınılmalıdır. Literatürde Hunter kanalı çevresine lokal anestezik ve kortikosteroidlerin akıllıca kullanılması önerilmektedir. Konservatif tedavi ile başarı sağlanamazsa dekompresyon, nöroliz ve nörektomi cerrahi seçenekler arasında düşünülebilir. Nörektomi kalıcı duyu kaybına neden olacağı için ilk sırada düşünülmez (92).

SONUÇ

Sık görülmemesi ve anatominin iyi bilinmesi gerekliliği nedeniyle ayak ve ayak bileği çevresi tuzak nöropatiler sıklıkla atlanabilmektedir. İlgili sinirlerin ve anatominin bilinmesi hem tanı hem de tedavi aşamasında ortopediste yol gösterecektir.

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