

RAZVOJNI POREMEĆAJ KUKA - PREVENCIJA I LEČENJE

DEVELOPMENTAL DISLOCATION OF THE HIP - PREVENTION AND TREATMENT

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SAŽETAK

Razvojni poremećaj kukova (RKP) je termin koji je devedesetih godina prošlog veka zamenio dotadašnji naziv urođeno iščašenje kukova, i kojim se označava najčešći poremećaj koštano-zglobnog sistema kod dece.

Etiologija RPK je i dalje nejasna, i najverovatnije multifaktorska, kombinovanim dejstvom genetskih, mehaničkih i hormonskih faktor. Ovi faktori mogu delovati prenatalno, peripartalno i postnatalno. Postoje velike rasne, etničke i regionalne varijacije u učestalosti uz značajnu predominaciju ženskog pola, što otežava primarnu prevenciju, usmerenu na sprečavanje nastanka oboljenja. Najvažniji faktor za pravilni razvoj zgloba kuka je sloboda pokreta, pa mere obezbeđenja pune slobode pokreta kukova, predstavlja primarnu prevenciju RPK. Otkrivanje stanja koja su mogla da umanje slobodu pokreta kukova i rano otkrivanje i lečenje RPK predstavljaju mere sekundarne i tercijarne preprevencije. Klinički skrining je prva i obavezna mera rane detekcije RPK. Ultrazvučni skrining, najčešće Grafovim postupkom, je najznačajniji za pravovremenu dijagnostiku RPK. Od prvorazrednog značaja je edukacija za pravilno i pravovremeno sprovođenje UZ skrininga i pravovremeno započinjanja terapije, što omogućava izlečenje - reverziju razvoja zgloba kuka ka normalnom u 96-98% pacijenata. Inicijalno lečenje se sprovodi neoperativno, najčešće Pavlikovim remenićima, a ponekad i rigidnim abdukcijom ortozama. Perkutana trakcija je ponekad neophodna, a nakon nje se često sprovodi repozicija u anesteziji sa plasiranjem koksofemoralnog gipsa u "humanom položaju". Ukoliko je "zona sigurnosti" repozicija mala, potrebno je uraditi i neotomiju adduktora.

Rana hirurška repozicija, je ponovo napuštena zbog visokog procenta komplikacij.

Kod kasno dijagnostikovanih slučajeva ili neuspeha ortopedskog lečenja, hirurška repozicija kuka se izvodi optimalno u uzrastu od 24-30 meseci. Sastavni deo ove procedure je derotativno-abrevaciona osteotomija femural acetabuloplastika, koja se izvodi Salterovom ili San Dijegom osteotomijom. U adolescentnom uzrastu mogu se primeniti i duple, triple i periacetabularne osteotomije karlice kao i Kijarijeva operacija. Kod najtežih slučajeva se u poslednje vreme savetuje i rana ugradnja andoproteze.

Cilj neoperativnog lečenja je razvoj normalnog kuka, a operativnog lečenja odlaganje pojave osteoartritisa za što kasnije životno doba.

Glavne reči: Razvojni poremećaj kukova, ultrazvuk kukova, Pavlikovi remeni, Salterova osteotomija.

ABSTRACT

Developmental disorder (dysplasia or dislocation) of the hips (DDH) is a term that in the 1990s replaced the previous name congenital dislocation of the hips (CDH) to denote the most common disorder of the musculoskeletal system in children.

The etiology of RPK is still unclear, and most likely multifactorial, with a combined effect of genetic, mechanical and hormonal factors. These factors can act prenatally, peri-partal and postnatally. There are large racial, ethnic and regional variations in frequency with a significant predominance of the female sex, which makes primary prevention, aimed at preventing the onset of the disease, difficult. The most important factor for the proper development of the hip joint is freedom of movement, so measures to ensure full range of motion of the hips represent the primary prevention of RPK. Detection of conditions that could reduce the mobility of hips and early detection and treatment of DDH are measures of secondary and tertiary prevention. Clinical screening is the first and mandatory measure of early detection of DDH. Ultrasound screening, most often by Graf's method, is the most important for the timely diagnosis of DDH. Of primary importance is education for proper and early implementation of US screening and timely initiation of therapy, which enables healing - reversion of hip joint development to normal in 96-98% of patients. Initial treatment is always non-operative, most often with Pavlik harness, and sometimes with rigid abduction orthoses. Percutaneous traction is sometimes necessary, and after it, repositioning is often performed under general anesthesia with application of hip spica cast in the "humane position". If the "safe zone" of reduction is small, it is necessary to perform an adductor tenotomy.

Early surgical reposition was again abandoned due to the high percentage of complications.

In late-diagnosed cases or failure of orthopedic treatment, surgical hip reduction is optimally performed at the age of 24-30 months. An integral part of this procedure is derotation and abbreviation osteotomy of the femur and acetabuloplasty, which is performed with Salter's or San Diego osteotomy. In the adolescent age, double, triple and periacetabular osteotomies of the pelvis as well as the Chiari operation can be applied. In the most severe cases, the early endoprosthesis has recently been advised.

The goal of non-operative treatment is the development of a normal hip, and the goal of operative treatment is to delay the onset of osteoarthritis until as late as possible in life.