Bölüm
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UTERUSUN PREMALİGN LEZYONLARI (ENDOMETRİYAL HİPERPLAZİLER, EIN)

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GİRİŞ

Endometriyum; hormonal, vasküler ve stromal değişikliklerle embriyo implantasyonu ve gebelik gelişimi için destek sağlayan dinamik bir dokudur. Endometriyal proliferasyon, östrojen uyarımıyla ilişkilidir. Ovulasyon sonrası korpus luteumdan salınan progesteron endometriyal stromada predesidual değişikliklere neden olur ve endometriyal proliferasyonu baskılar. Konsepsiyon oluşmazsa hCG üretimi olmayacağından korpus luteum regrese olur ve progeston çekilme kanaması olur. Endometriyumun östojene devamlı maruz kalmasıyla normal menstrüel döngü bozulmuş olur.

Endometriyal hiperplazi, östrojenik etkinin progesteron ile karşılanamaması ile oluşabileceği gibi normal östrojenik uyarıma aşırı yanıt sonucu da oluşabilir.

Endometriyal hiperplaziler; östrojen üreten tümörlerle ilişkili olabilmeleri, hormonal tedavi sonucunda oluşabilmeleri ve endometriyal kanserle birlikte ya da endometriyal kanser öncesinde bulunabilmeleri açısından klinik olarak önemlidir.

Endometriyal hiperplaziler premenopozal ve postmenopozal kadınları etkileyebilir.

Endometriyal hiperplazi genelde asemptomatiktir ancak semptomatik olduğunda en sık anormal uterin kanama ile prezente olur. Genellikle rutin muayene sırasında pelvik ultrasonografide endometriyal kalınlık artışı ile tespit edilir. Postmenopozal hastalarda uterin kanamaların % 15'inden endometriyal hiperplaziler sorumludur (1). Perimenopozal ya da postmenopozal dönemde anormal uterin kanama şikayeti olan kadınlarda mutlaka endometriyal hiperplazi akla getirilmelidir.

Endometriyal hiperplazi tanısı histopatolojik olarak nükleer, yapısal ve sitolojik anormalliklerin değerlendirilmesi ile konulur.

ENDOMETRİYAL HİPERPLAZİ

Endometriyal hiperplazi endometriyumdaki glandüler/stromal doku oranının 1'den fazla olması durumudur. Endometriyal hiperplazi, progesteron ile karşılanmayan sürekli endojen ya da ekzojen östrojenik uyarım sınucu ortaya çıkar. Endojen östrojen uyarımının kaynağı polikistik over sendromu olabilir. Obezite de endojen androjenlerin yağ dokuda aromatize olarak estron'a dönüşmesi sonucu kronik olarak östrojen düzeyinin yüksek seyretmesiyle karşılanmamış östrojenik uyarıma neden olur. Östrojen salgılayan tümörler de (granüloza hücreli tümör, tekoma) endometriyal hiperplazi ve endometrioid adenokarsinom'a sebep olabilir.

Progesteron içermeyen östrojen preparatları, artmış endometriyal hiperplazi ve endometriyal adenokarsinom ile ilişkilendirilmiştir (2). Postmenopozal hastalara 0.625mg konjuge etinil östradiol içeren hormon replasman tedavisi verilen bir çalışmada kompleks hiperplazi riskindeki artış %22.7, atipili hiperplazi riskindeki artış %11.8 ola-

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nısında olduğu gibi standardize edilememiştir ancak progestin tedavisi EİN varlığında oldukça etkin gözükmektedir. Hormon tedavisi ile EİN persistans riski %90, endometriyal kansere progresyon riski ise %75 oranında azalmış olarak saptanmıştır (51).

SONUÇ

Endometriyal hiperplazilerin iki farklı sınıflama sistemi mevcuttur. EİN sınıflaması WHO 94'e göre daha güncel ve daha güvenilir bir sınıflamadır.

Endometriyal hiperplazi ve EİN, endometriyum kanseriyle birlikte olabileceğinden veya endometriyum kanserine progrese olabileceğinden saptandığı anda önem gösterilmesi ve tedavi edilmesi gereken durumlardır.

Hastaya uygun tedavi modalitesi belirlemede primer etkenler atipi varlığı ve fertilite arzusudur.

Tedavi modaliteleri olarak hormonal tedavi ya da cerrahi tedavi tercih edilebilir. Hormonal tedavi tercih edileceği zaman hasta daha sıkı kontrol edilmeli ve her zaman için kansere progresyon riski akılda tutulmalıdır.

Anahtar kelimeler: Endometriyal hiperplazi, EİN, endometriyum adenokanseri, uterin premalign lezyonlar

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