Bölüm
21

ENDOMETRİOZİS VE JİNEKOLOJİK CERRAHİ

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GİRİŞ

Endometriozis, endomertrial gland ve stromanın uterus dışında olmasıdır. Ektopik endometrial doku genellikle pelvik iç organlar ve periton yüzeyindedir fakat vücudun herhangi bir yerinde de görülebilir. Endometriozis etyopatogenezi çok tartışmalı bir konu olup temel olarak üç ana teori ön plana çıkmaktadır; 1) menstrüel regürjitasyonla endometrial dokunun pelvise implante olması, 2) peritoneal veya müllerian artıkların endometrial hücrelere metaplazisi ve 3) indüksiyon teorisi. Tüm olgulardaki endometriozis lokasyonlarını tek başına tek bir teori açıklayamamaktadır. Pelvik ağrı ve infertilite ile ilişkili olan endometriozis, rekürrens ve ilerleme eğilimi gösteren geniş bir klinik bulgu ve semptom ağına sahiptir. Ayrıca bu semptomlar her zaman hastalığın şiddetini, derecesini göstermeyebilir (1,2). Endometriozis 25-35 yaş arası kadınlarda pik prevalansa sahip iken (3,4) hastalık premenarşal kızlarda (5) ve postmenopazal kadınların %2-5'inde raporlanmıştır (6). Endometriozis tüm etnik ve sosyal sınıf kadınlarında görülmüştür. Endometriozis sıklığı çok farklı oranlarda bildirilmiştir, ancak genel prevalansı % 10 civarındadır (4,7).

Ağrısı olan ve olmayan açıklanamayan subfertilite tanılı kadınlarda endometriozis prevalansı %50 kadar yüksek bildirilmiştir (8). Etkilenen kadınların bir kısmı için endometriozis yaşam boyu ağrı veya infertilite sorunu yaşamak demektir. Endometriozisin tam tedavisi henüz mümkün değil bununla beraber tedavinin 3 temel amacı vardır; 1) ağrıyı azaltmak, 2) gebelik olasılığını arttırmak, 3) rekürrensleri mümkün olduğunca geciktirmek (9). Endometriozis tedavisinde medikal ve/veya cerrahi yöntemler vardır. Fakat endometriozis ilişkili infertilite ve pelvik ağrının medikal ve cerrahi tedavisinin etkinliği tartışma konusu olmayı sürdür-

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ek endikasyonları olan kadınlar için uygun bir seçenektir. Endometriozis tedavisi için histerektomi planlanan hastalarda bilateral salpingo-ooferektomi, reoperasyon riskini erken menopoz riskinden daha fazla önemseyenlere önerilebilir.

Genel olarak, kadın menopoza yaklaşırken ooforektomi tercihinin daha fazla olması muhtemeldir. Ooferektomi ayrıca overleri tutan yaygın hastalığı olan kadınlar için de uygundur. Laparoskopi, ilk prosedür olarak hem teşhis hem de tedavi amacına hizmet eder. İlk adım, pelvis ve karın bölgesinin eksplorasyonudur. Laparoskopide lezyonların vizual incelenmesiyle endometriozisin teşhisi tatminkar kabul edilir, ancak sadece biyopsi yapılan veya eksize edilen lezyonların histolojisi kesin bir tanı sağlayabilir.

İşlemin amacı tüm endometriotik implantları yok etmektir. Diğerine üstün olan tek modalite (ablasyon veya eksizyon) yoktur. Pelvik adezyonların lizisi çoklu prosedür gerektirir. Laparoskopik ablasyon veya endometriozis eksizyonu yapılan hastaların yaklaşık %75'inde ağrı hafiflemesi sağlanır. Bununla birlikte, rekürrens riskinin 10 yıllık takipte %40 kadar yüksek olduğu ve hastaların yaklaşık %20'sinin 2 yıl içinde ek cerrahi geçireceği tahmin edilebilir. Endometriozis nedeniyle cerrahi olarak tedavi edilen kadınlar için, postoperatif medikal supresif tedavi önerilmektedir. Bilateral ooforektomi sonrası, sıcak basması, gece terlemesi ve uyku bozukluğu gibi cerrahi menopoza bağlı semptomları tedavi etmek için hormonal tedavi kullanılabilir. Tekrarlayan konservatif cerrahilerin etkinliği ile ilgili sınırlı veri vardır. Karar vermede rol oynayan faktörler arasında (1) önceki cerrahiye verilen yanıt (yani semptom rahatlama derecesi, semptomların nüksüne kadar geçen süre), (2) medikal tedaviyi tolere etme kabiliyeti ve (3) hasta yaşı vardır.

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