Bölüm
24

ENDOMETRİOZİS REKÜRRENSİ VE TEDAVİSİ

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GİRİŞ

Endometrial dokunun uterin kavite dışında yerleşmesi olarak tanımlanan endometriozis üreme çağındaki kadınların ortalama %10-15'inde görülebilmektedir. Endometrioziste, endometriyum dokusu çoğunlukla overlere (endometrioma), fallop tüplerine ve pelvis içi dokulara implante olur ancak nadiren pelvis dışı dokulara da yerleşebilmektedir. En sık belirtilerinden olan pelvik ağrı kadınlardaki kronik pelvik ağrının da en sık sebeplerindendir ancak ağrının şiddeti ile lezyonun yaygınlığı çoğunlukla ilişkili değildir (1). Farklı çalışmalarda kronik pelvik ağrısı olan kadınlarda %5-80 aralığında endometriozis olduğu bildirilmekte ve genel olarak bu oran 1/3 olarak ifade edilmektedir (2). Endometriozisi olan kadınların ise ortalama %55'inde kronik pelvik ağrı şikâyeti vardır (3). Diğer semptomlar olarak dismenore, menstüral düzensizlik, ağrılı cinsel ilişki (disparoni) ve subfertilite/infertilite sıklıkla gözlenir. Endometriozisin belirtileri Tablo 1'de gösterilmiştir. Henüz patofizyolojisi tam olarak açıklanamamakla birlikte kadınlardaki subfertilitenin en sık nedenlerinden biri endometriozistir ve infertilite nedeniyle laparoskopi yapılan kadınların %17-20'sinde çeşitli evrelerde endometriozis saptanmaktadır (4). Ayrıca üreme çağındaki kadınlarda %2-30 aralığında endometriozis olgusu tamamen asemptomatik olarak da seyredebilmektedir ve özellikle düşük beden kütle indeksli kadınlarda daha sık gözlenmektedir (5).

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ğin yaşam kalitesini bozan kronik ağrı durumunda Pelvik de-nervasyon işlemleri -presakral nörektomi (PSN)-uterosakral ligament rezeksiyonu (LUNA)- da dâhil olmak üzere operasyonun planı yapılmalıdır. Operasyon sonrasında hasta gebelik düşünülmemiş ve hormonal supresyona başlanacak ise cerrahiden hemen sonra başlanması ve uzun süreyle devam edip rekürrensin takibi uygun seçenek olarak görülmektedir.

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