

BÖLÜM 3

EKTOPIK GEBELİKTE TANI VE TEDAVİ

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GİRİŞ

Gelişen blastokistin endometrial kavite dışına implante olmasıdır. Gelişmiş ülkelerde ilk trimester hamileliklerde gebeliğe bağlı ölümlerin en önemli nedenidir [1].

Karın-pelvik ağrı ile başvuran ya da açıklanamayan hipovolemi semptomları olan reproduktif çağıdaki tüm bayan hastalarda ektopik gebelik düşünülmelidir.

Günümüzde yardımcı üreme tekniklerinin yaygın kullanımı ile ektopik gebelik görülme sıklığı artmış olmakla birlikte ektopik gebelik insidansı tüm gebelikler içinde yaklaşık olarak %1.5-2'dir [1].

Risk Faktörleri

Tablo 1: [1].

YÜKSEK RİSK	Odds Ratio ^a
Tubal cerrahi	21.0
Tubal sterilizasyon	9.3
Geçirilmiş ektopik gebelik	8.3
IU DES maruziyeti	5.6

IUD kullanımı	4.5
Tubal patoloji	2.1
Üremeye yardımcı teknikler	4.0
ORTA RİSK	
İnfertilite	2.1
Geçirilmiş genital enfeksiyon	3.7
Çoklu seksüel partner	2.1
Salpinjitis istmika nodosa	1.5
DÜŞÜK RİSK	
Geçirilmiş pelvikenfeksiyon	3.8
Sigara kullanımı	2.5
Vajinal duş alışkanlığı	3.1
İlk cinsel ilişkinin <18 yaş olması	1.6

Ektopik gebelik öyküsü olan kadınlarda normal popülasyona oranla 9 kat daha fazla ektopik gebelik riski vardır. Genel olarak rekürrens riskinin, önceden geçirilmiş bir ektopik gebeliği olan kadınlar için yaklaşık % 10 ve iki veya daha fazla ektopik gebeliği olan kadınlar için en az % 25 olduğu gösterilmiştir [1]. Ayrıca, rekürrens riski tek doz metotreksat tedavisi sonrası %8, salpen-

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[1]. Tedavide amaç, rüptüre olmadan önce gebeliği sonlandırmak, keseyi çıkarmak ve gelecekteki fertilitiyi korumaktır. Sezaryen skar gebeliği için, dilatasyon ve küretaj, lokal veya sistemik methotrexate, laparotomi veya laparoskopi ile trofoblastik dokunun eksizyonu ve uterin arter embolizasyonu gibi bir çok tedavi şekli mevcuttur.

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