

# Bölüm 41

## ÜRİNER ENDOMETRİOZİS TANISI VE YÖNETİMİ

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ÜNİTE 3

Üriner endometriozis klinik pratiğimizde çok karşılaşmadığımız ancak klinik bulgu verdiği zaman hasta ve yönetimini yapan hekim açısından birçok problemi bünyesinde taşıyan bir tablodur. Tanı ve tedavisi peritoneal ve ovaryan endometriozis olgularına göre farklılık arz eden bu hastalık multidisipliner yaklaşım ile yönetilmeli ve günlük yaşam standartlarını olumsuz etkilemesine izin verilmemelidir. Bölümün Ürolog bir klinisyen tarafından kaleme alınması konuyla ilgili mevcut bilgi ve deneyimlerimizi artıracak ve farklı bir bakış açısı kazanmamızı sağlayacaktır. **Editorial**

### Giriş

Fonksiyonel endometriyum dokusunun uterus dışında bir yerde bulunması endometriozis olarak tanımlanmaktadır. Endometriozis kadın üreme organlarının sık karşılaşılan bir hastalığı olup, kadınlarda kronik pelvik ağrıya neden olmaktadır. Aslında endometriozis histopatolojik olarak benign bir hastalık olmasına karşın, klinik seyir açısından agresif karakterli bir patolojidir. Hastalığın etyolojine yönelik birçok teori öne sürülmesine karşın hala kesin olarak bir neden ortaya koyulamamıştır. Endometriyal implantlar sıklıkla pelvik bölgede overler ve uterosakral ligamanlara yerleşse de, vücudun hemen her yerindeki organları tutabileceği de bilinmektedir. Endometriozis etyolojinde ırk ya da sosyoekonomik durumun önemi olmamasına karşın, ailesel geçişin önemli yeri olduğu bilinmektedir. Eğer kişinin annesi veya kız kardeşinde

endometriozis öyküsü mevcut ise, o kişide endometriozis görülme ihtimali 5-6 kat artmaktadır. Endometriozis genellikle 20- 35 yaş arası üreme çağındaki genç kadınların hastalığı olup, 15 yaş öncesi ve menapoz sonrası dönemde normalde görülmez. Çünkü endometrial implantların oluşumu ve varlığını devam ettirebilmesi için fonksiyonel overlerin varlığı ve östrojen gereklidir. Buna karşın menapoz sonrası rapor edilen nadir vakalarda endometriozise neden olan ve bu patolojik dokunun yerleştiği alanda devamını sağlayan iki önemli faktör karşımıza çıkmaktadır. Bunlardan birincisi menapoz sonrası dönemde yapılan östrojen replasman tedavisi, ikincisi ise özellikle obez hastalardaki yüksek endojen östrojen varlığıdır. Erkeklerde de histopatolojik olarak rapor edilmiş endometriozis olguları mevcut olup bunların tamamı prostat lokalizasyonludur ve prostat kanseri nedeniyle yüksek doz östrojen tedavisi alan hastalardan oluşmaktadır. Sık karşılaşılan bir hastalık olmasına rağmen hastaların büyük çoğunluğunun asemptomatik olması nedeniyle genel popülasyondaki prevalansı hala kesin olarak bilinmemektedir. Ancak elde edilen veriler doğultusunda endometriozis prevalansının genel kadın popülasyonunda %10-20 arasında olduğu, bu oranın 20-45 yaş arası çocuk sahibi olma potansiyeline sahip üreme çağı kadınlarında %3-10 ve infertil kadınlar için ise %15-25 civarında olduğu bilinmektedir. Özellikle 20'li yaşların ortaları hastalığın pik yapma zamanı olup, üreme sistemine yönelik geçirilmiş cerrahiler, menstrüel sikluslarda

bu olguların 1/3'ünde yaptığı üreter obstrüksiyonu nedeniyle sesiz-kalıcı böbrek hasarına neden olabilmesi nedeniyle erken tanı ve tedavi gerektiren bir hastalıktır. Tedavi hedefleri arasında böbrek fonksiyonlarının korunması birinci derece öneme sahiptir. Bunun yanında hastalığın ilerlemesinin durdurulması, hastanın yaşı ve takip eden zamandaki çocuk sahibi olma beklentisine göre fertilitte durumunun devam ettirilmesi ve semptomların ortadan kaldırılması diğer öncelikli hedefleri oluşturmaktadır. Genellikle hastaların çoğunluğunun asemptomatik olması ve buna bağlı olarak hastalığın ileri evrelerinde (fibrotik süreç-darlık) tanı almaları nedeniyle üreter endometriozisi kesin tanısı koyulduğunda bir an önce küratif tedavisi yapılması gereken bir durumdur. Medikal tedavinin genellikle etkisi geçici olup belirgin bir küratif tedavi sağlayıcı etkisi olmadığı için, küratif tedavi temel olarak erken dönemde cerrahi tedavi üzerine kurulmaktadır. Üreter endometriozisi cerrahi tedavisinde temel hedefler, lezyonların tamamının eksize edilerek ortadan kaldırılması ve böylece olası nüks riskinin azaltılması, semptomların ortadan kaldırılması, lezyonlar nedeniyle oluşmuş üreteral darlık veya kinkleşme gibi üreter obstrüksiyonu ve buna bağlı böbrek fonksiyon bozukluğuna neden olabilecek patolojik durumların düzeltilmesidir. Ancak burada unutulmaması gereken en önemli nokta, her ne tür tedavi yapılırsa yapılsın öncelikle böbrek fonksiyonlarının durumunun garanti altına alındıktan sonra küratif tedavi uygulamasına geçmesidir. Üreteral endometriozis olgularının tedavisinde gerekli olduğunda üreteral veya periüreteral lezyonların eksizyonunun gereğinde uygun üreteral rekonstrüksiyon veya re-implantasyon ile combine edilerek yapılması sıklıkla önerilen cerrahi yaklaşım olmaktadır. Bu uygulamalar da laparoskopik veya açık olarak gerçekleştirilebilmektedir.

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