Bölüm
13

TEKRARLAYAN GEBELİK KAYIPLARI

Gürhan GÜNEY[1]

TANIM VE EPİDEMİYOLOJİ

Hamilelik kaybı olan çiftlerin empati ve anlayışa ihtiyaçları vardır. Erken gebelik kaybı, özellikle tekrarlayan durumlarda, ölü doğum veya yenidoğanın ölümündekine benzer duygusal bir travmaya sebep olur. Tekrarlayan gebelik kaybı (TGK), üreme tıbbındaki en zor ve sinir bozucu alanlardan birisidir, çünkü etiyolojisi genellikle bilinmemekle birlikte kanıta dayalı teşhis ve tedavi stratejileri sınırlı, değerlendirme ve yönetimi ile ilgili çalışmalar da sıklıkla kusurludur. Yaygın metodolojik kusurlar arasında TGK için genel kabul görmüş kriterlere uyulmaması, belirleme yanlılığı, yanlış kontrol seçimi, kohortların eşit olmayan izlenmesi, anöploid fetüslerin dışlanmaması, önceki gebelik kayıp sayıları, kısa süreli bir analizden sonra çalışmanın erken sonlandırılması gibi bazı önemli faktörler bulunmaktadır (1).

TANIM

TGK'nin tanımı değişken olduğu için hangi çiftlerin ne şekilde tedavi edileceğinin kararını vermek de zordur. Örneğin aşağıdaki değişen tanımlamalar örnek olarak verilmiştir; ultrasonografi veya histopatolojik inceleme ile kanıtlanmış iki veya daha fazla başarısız klinik gebelik veya rahim içi olması gerekmeyen ardışık üç gebelik kaybı gibi (2,3,4). Genellikle, IVF uygulanan kadınlar için araştırmaya biyokimyasal gebelikler de dahil olmak üzere iki başarısız klinik gebelikten sonra başlanır. TGK tanımına biyokimyasal gebeliklerin ve görüntülenemeyen gebeliklerin (ektopik gebelikler) dahil edilmesi, 12 haftalık gebelikten önce üç veya daha fazla ardışık gebelik kaybı olan 587 kadının incelendiği retrospektif bir kohort ça-

[1] Dr. Öğretim Üyesi Gürhan Güney, Balıkesir Üniversitesi, Tıp Fakültesi, Kadın Hastalıkları ve Doğum Anabilimdalı, Balıkesir, Türkiye, gurhan.guney@balikesir.edu.tr

mal olarak normal mi yoksa anormal mi olacağı ile ilgili olarak genetik danışmanlık verilebilir. Karyotipik anormallikleri olan çiftler fetal karyotipi belirlemek için amniyosentez veya koryonik villus örneklemesi gibi bazı prenatal genetik testleri seçebilirler (115).

Eğer gebelik kaybının sebebi uterin septum, intrauterin adezyonlar veya submukozal myom gibi cerrahi olarak düzeltebilen bazı uterin anomaliler ise operatif histereskopiden faydalanılabilir.

Açıklanamayan TGK'sı olan kadınlar için, ek olarak vajinal progesteron kullanımı önerilmemektedir. Gebelik oluştuktan sonra ise vajinal progesteron kullanımının canlı doğum oranlarını iyileştirmediği gösterilmiştir. Kas içi progesteron veya diğer progestin tedavilerinin ise bir fayda sağlayıp sağlamadığı ise henüz bilinmemektedir (116).

TGK tedavisi için immünoterapi veya glukokortikoidlerin kullanımı, elde yeterli veri olmadığı için önerilmemektedir. Bu ilaçlar etkili değildir ve zararlı olabilir (117).

Hiperprolaktinemi ise saptandığı zaman tedavi edilmelidir. Açıklanamayan TGK'sı olan hastalara çok çeşitli tedavi yöntemleri önerilmektedir. Bu tedavi yöntemlerindeki ana prensip düşük riskli, basit ve ucuz olandan başlayarak eğer basarısız olunursa daha riskli daha kompleks ve pahalı yöntemleri seçme şeklindedir. TGK öyküsü olan ve sonrasında gebe kalan kadınlarda, fetal intrauterin gelişme geriliği ve prematur doğum daha sık görülebilir (118).

Erken gebelikte fetal kardiyak aktivitenin saptanması, daha sonrasındaki canlı doğumun güvenilir bir göstergesi olsa da gebelik kaybı oranı yine de genel popülasyonun üzerinde kalmaya devam etmektedir (119).

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