Bölüm 7

Amenore

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TANIM: Düzenli menstrüel döngüsü üreme çağındaki tüm kadınlar için fiziksel ve zihinsel iyilik halinin bir göstergesidir. Kadınlarda mensturasyon döngüsü 21 ila 35 gün arası sürer ve iki faza ayrılır: proliferatif faz ve sekrtetuar faz. Yaklaşık 12 ila 49 yaş arasındaki üreme çağındaki kadınlarda mensturasyonun yokluğu amenore olarak bilinir. Amenore primer ve sekonder nedenleri vardır. Primer amenore, adetlerin başlamasının olmamasıdır ve sekonder amenore, daha önce normal adet gören bir kadında adetlerin olmamasıdır. Amenore en sık nedeni gebeliktir, böyle bir hasta araştırılırken ekarte edilmesi gereken ilk şeydir (1). Nispeten sık görülen bir klinik durumdur ve hayatı tehdit eden bir durum olmamasına rağmen kadınları özellikle primer ise her açıdan olumsuz etkilemektedir, sebebine bağlı olarak ve tedavi seçenekleri farklılık göstermekte ve üreme üzerindeki etkileri değişmektedir. Primer ya da sekonder amenore menarşın varlığına göre belirlenir ve çoğunlukla sebepleri benzerdir. Primer amenore bütün amenoreli kadınlarda %5 oranında gözlenir. Sekonder seksüel gelişimi olanlarda 15 yaşa kadar; meme gelişimi 10 yaşından önce başlayan hastalarda ise meme gelişimi sonrası 5 yıl içinde menstrasyon beklenir yoksa primer amenore nedenleri için ayırıcı tanı yapılmalıdır (2). Meme gelişiminin 13 yaşına kadar olmamasıda araştırılması gereken bir durumdur(2). Normal siklusa sahip kadınlarda 1 haftalık geçikmelerde gebelik testi yapılmalıdır. Daha önce adet görmüş kadınlarda üç aydan uzun süren amenore ve ya da bir yıl içinde dokuzdan az menstrasyon sayısı sekonder amenoreyi düşündürür ve tanıya ihtiyaç duyar (3).Gebelik, laktasyon ve menopoz halleri dışında amenorenin insidansı yaklaşık %3-4 dür (3).

Sekonder amenorenin birçok sebebi olmasına rağmen çoğunlukla hastalarda polikistik over sendromu, hiperprolaktinemi, hipotalamik amenore veya ovaryen başarısızlık nedeniyle olur. Sekonder amenorede erişkin kadınların yaklaşık %3-5 inde gözlenir, fonksiyonel hipotalamik amenore sekonder amonerenin yaklaşık %20-30 kısmını oluşturur. (4)

Dünya sağlık örgütü(WHO) nedenleri şu şekilde özetlemiştir: WHO grup I de endojen östrojen üretimi yoktur, normal yada düşük seviyede FSH vardır, normal prolaktin seviyeleri bulunur ve hipotalamik-pitüiter lezyon yoktur, WHO grup II de östrojen üretimi ve normal seviyede prolaktin ve FSH (folliküler stimüle edici hormon) vardır, WHO grup III de yüksek FSH ın bulunduğu gonadal başarısızlık vardır(5). Amenore bazen ambigous genitalya ve virilizasyon ile görülebilir, sebepleri ayrıntılı araştırılmalıdır(6).

MENSTRUEL SİKLUS: Menstrasyonun varlığı için en önemli şart kanamanın görülmesidir. Bunun için genital bölgenin anatomik olarak normal olması gereklidir. Uterine kavite, endoserviks,vajinal kanal ve vajinal orifisin bağlantısının kesintisiz olması gerekmektedir. Overdeki folikül siklusuna ve seks hormonlarına yanıt verebilecek fonksiyon gören bir endometriyumun olması gerekmektedir. Overin anterior hipofiz bezinden salınan gonadotropinler; FSH ve Lutinize edici hormona(LH) yanıt

yon testi), non klasik kongenital adrenal hiperplazi(KAH) (folliküler fazda sabah erken 17 hydroxy progesterone testi) ve androjen üreten adrenal veye ovaryan tümorler. Non klasik KAH PKOS a çok benzeyen nispeten sık görülen bir durumdur. Bazal 17OHP seviyesi >6 nmol/L ise, cosyntropin ile stimulasyon yapıp 17OHP seviyelerine bakmak gerekir(108).

Adölosanta PKOS tanısı koymak zordur, çünkü adölosanda fizyolojik bulguların bir kısmı PKOS'da da vardır. Adölosanda HA, menstruel düzensizlik ve /veya PCOM bulgularının olması gerekir. Adölosana ait menstruel düzensizliklerin değerlendirmesinin menarş yılına göre nasıl yapılacağı iyi bilinmelidir. Eksik tanıda uzun dönemde ortaya çıkabilecek metobolik, üreme, psikoemosyonel komplikasyonlar gibi komorbiteler gözden kaçabilir, fazladan tanı konulduğunda ise aile ve adölosanda anksiyeteye sebep olunabilir. Tedavide birinci seçenek hayat tarzı değişiklikleridir. Adölosanda erişkinlerde olduğu gibi obesite normal popülasyona göre daha fazladır. Hormonal tedavilerde ve antiandrojenik ilaçlarda meme ve kemik yoğunluğuna olumsuz etkiler akılda tutulmalı menarştan 3 yıl sonra başlanmalıdır. Uygun tedavi seçeneği hastanın kliniğine ve şikâyetlerine göre belirlenmelidir. Primer amonereli kızlar yada menstruel sıklığı >90 gün olanlar PKOS açısından dikkatle değerlendirilip takip edilmelidir.

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