Bölüm 16

Hirsutizm

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Hirsutizm üreme çağındaki kadınların %5-10'nu etkileyen, vücudun özellikle androjene bağımlı bölgelerinde (yüz, göğüs, karın, alt sırt, üst kol ve uyluk) terminal tipteki kılların aşırı artışıdır. Psikososyal iyilik hali ve hayat kalitesini negatif etkileyen bu durum genellikle hiperandrojenizmin bir bulgusudur ve sıklıkla akne ve yağlı cilde eşlik eder.

Irk ve etnik kökenin terminal kıl gelişimi üzerinde etkisi vardır. Saçlı derideki kıl folikülleri beyaz ırkta siyah ırka göre daha fazla iken, Asyalılar'da en azdır (Willenberg, 2008). Kıl folikülleri lanugo, vellus ve terminal olmak üzere üç tipe ayrılabilir. Lanugo, fetüsün tüm cildini kaplayan yumuşak ve erken postpartum dönemde dökülen kıllardır. Vellus, puberteden önce tüm cildi örten ince, kısa (2-5 mm) ve pigmente olmayan kıllardır. Terminal kıl ise, erişkinde görülen kalın pigmente kıldır. Hirsutizm, yaygın ve seksüel dağılım göstermeyen, androjenlere bağımlı olmayan vellus tipi kılların artması olarak tanımlanan hipertrikozisten ayrılmalıdır. Hipertrikozis, herediter faktörler, metabolik ya da sistemik hastalıklar (porfiri, anoreksia, malnutrisyon, jüvenil dermatomyozit, tüberküloz, hipotiroidizm, paraneoplastik sendrom) ve ilaçlara (fenitoin, diazoksid, asetazolamid, sitalopram, kortikotropin, siklosporin, glukokortikoid, metaklopramid, metildopa, minoksidil, penisilamin, fenotiazin, streptomisin, valproik asit) bağlı olarak gelişebilir (Bode, 2012, Vulink 2007). Hipertrikozis androjenlere bağlı olmasa da, hiperandrojenizm varolan tabloyu ağırlaştırabilir.

Virilizasyon, ses kalınlaşması, temporal kellik, meme atrofisi, vücut yapısında maskülinizasyon ve kliteromegalinin eşlik ettiği şiddetli hiperandrojenizme işaret eder ve sıklıkla androjen salgılayan tümörlere bağlıdır.

KIL BÜYÜMESİ

Embriyoloji

Kıl folikülleri gebeliğin yaklaşık 8-10. haftaları arasında diferansiye olmamış mezenkim üzerindeki epidermal hücre gruplarından gelişir. Gelişen epidermis ve altındaki mezenkim tabakasının arasındaki ilişkide hedge hog proteini, transforming growth faktör-beta ailesi, bone morfojenik proteini, fibroblast growth faktör proteini ve tümör nekrozis faktör ailesi gibi birçok faktörün etkisinin olduğu gösterilmiştir (Andi, 2002; Schneider, 2009). Kıl folikülü, epidermisin bazal tabakasından köken alan ve dermisin içine doğru gelişen solid hücre kolonları ve gelişen hücre kolonlarının dermis içinde karşılaştıkları mezenkimal hücre kümeleri olan dermal papilladan oluşur. Solid hücre kolonlarının son kısmı bulbus olarak adlandırılır ve bu yapı dermal papillayı sarar. Pilosebase ünite ise kıl folikülü, sebase bez, erektör pili kasından oluşur ve solid epitelyal hücre kolonlarının kıl kanalının oluşturacak şekilde delinmesi ile meydana gelir (Figür 1).

gerektiği, herhangi bir topikal ya da medikal tedavinin hemen sonuç vermeyeceği, tedavinin uzun sürebileceği, şiddetli hirsutizm durumlarında kombine tedavilerin uygulanabileceği anlatılmalıdır. Adolesanların hirsutizm tedavisi erişkinlerden pek farklı değildir. Yaşam tarzı değişiklikleri, kalıcı ya da geçici kozmetik yöntemler önerilebilir.

Medikal tedavide 1. basamak tedavi OKS'dir fakat tedaviye menarştan önce başlanmamalıdır. Tedaviye cevabın görülmesi için en az 6 ay beklenmelidir, yanıt yetersiz ise tedaviye antiandrojenler eklenebilir. Antiandrojenler ve özellikle düşük doz OKS'in adolesanlarda kullanımındaki en önemli endişe, kemik mineral yoğunluğuna olabilecek negatif etkilerdir (Krishnan ve Mathusami, 2017; Gersten, 2016). İnsülin duyarlaştırıcı ajanların obez ve hiperinsülinemik hastalarda faydalı olduğu, adolesan PCOS'lu hastalarda OKS ve metforminin karşılaştırıldığı çalışmalarda hirsutizm tedavisinde benzer etkinlikte oldukları görülmüştür (Al Khalifah, 2016). Adolesanlarda yaşam tarzı değişikliklerine ek olarak kahverengi yağ dokusunu aktive ettiği ve enerji metabolizmasını arttırdığı ileri sürülen, düşük doz spironolakton, pioglitazon ve metformin kombinasyonundan (SPIOMET) oluşan ajanın, ovulasyon oranlarını 2.5 kat arttırdığı ve hirsutizm skorlarını iyileştirdiği gösterilmiştir (Ibanez, 2017). Bununla beraber rutin kullanımına dair yeterli bilgi yoktur.

TEDAVİ İZLEMİ

Tedavinin başarısı çoğunlukla klinik olarak mFG skorları takip edilerek, hasta tarafından kıl büyümesinde azalma olup olmadığı ya da kıl temizlenmesi için kullanılan metotların sıklığının takibi ile yapılabilir. Tedavinin başlangıcında ya da izleminde alınan fotoğraflar izlemde yardımcı olabilir. Tedavi sırasında serum androjen seviyelerinin takibinin yararı tartışmalıdır. Eğer hirsutizm şiddetinde artma varsa serum androjen seviyeleri görülmelidir. Medikal tedavi başlandıktan sonra, kıl folikülünün siklüs süresine uygun olarak ilk 6 ay içinde düzelme görülmeyebilir. İdeal olarak 1 sene sonunda hasta tedaviye cevabın suboptimal olduğunu düşünürse tedavi değiştirilebilir ya da tedaviye ikinci bir ajan eklenebilir. Gebelik istenildiğinde tüm ilaçlar kesilmelidir, tedavide kullanılan çoğu ajanın erkek fetüsün seksüel gelişimi için kontraendike olduğu unutulmamalıdır.

Hirsutizm tedavisinin başarısı, hirsutizm nedenine de bağlıdır. Anovulatuar hastalarda uygulanan tedaviler sonucu ovulatuar siklüsler sağlanabilir ve androjen seviyeleri tedavi kesilse dahi bir müddet düşük seviyelerde kalabilir. Kaçınılmaz olarak altta yatan patoloji düzelmedikçe hirsutizm tekrar gelişecektir. Bu kronik sorun hayat boyu devam edebilir.Hirsutizm tedavisine uyum ve devam, hastaların psikososyal iyilik halini de destekleyecektir.

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