Konu 7

Asherman Sendromu (İntrauterin Adezyon)

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I. GİRİŞ

Adezyon, genellikle cerrahi travma, enfeksiyon, iskemi ve yabancı cisim reaksiyonu vb. bir dizi etkenden dolayı gelişen doku hasarına bağlı olarak (1), olağandışı lokalizasyonlarda ortaya çıkan ve doku yüzeylerini yaklaştırarak birbirine yapışmasına yol açan veya karşı karşıya getiren anormal fibröz bağlar olarak tanımlanır (2). Adezyonlar, **"primer veya *de novo*" ve "sekonder veya yeniden oluşan"** şeklinde başlıca ikiye ayrılır (3,4). "Primer veya *de novo* adezyon" tanımı, önceden adezyon bulunmayan bir lokalizasyonda yeni oluşan adezyonları; "sekonder veya yeniden oluşan adezyon" ise, önceden adezyolizis yapılmış bir lokalizasyonda, aynı yerde yeniden ortaya çıkan adezyonları tanımlamak için kullanılır.

Jinekolojide adezyonlar, bulundukları yere göre intraabdominal veya intrauterin olarak tanımlanabilirler. Adezyon oluşma eğiliminin kişiye özgü olduğu düşünülmektedir. Bireye özgü çeşitli etkenler, örneğin beslenmeye ilişkin sorunlar, diabet, enfeksiyonlar hepsi lökosit ve fibroblast işlevini bozarak potansiyel olarak adezyon oluşumunu artırlar (5). Cerrahi girişim ardından gelişen adezyonların, hastanın yaşı, geçirilmiş laparotomi sayısı ve cerrahi işlemin tipi ve kompleksliğine koşut olarak arttığı bilinmektedir (6). Açılmasının hemen ardından adezyonlar günler ve yıllar içinde yeniden oluşmaya büyük bir eğilim gösterir (1). Endometriuma yönelik herhangi bir travma, uterusun ön ve arka duvarı arasında minimal adezyonlardan, intrauterin boşluğun tamamen kapanmasına yol açacak denli fibröz bantların oluşmasına yol açabilir (7,8).

Günümüzde Asherman Sendromu (AS) (7-10) olarak bilinen bu intrauterin adezyon (İUA) veya sineşi sorununa (11), **uterin atrezi, travmatik amenore ve endometrial skleroz** da denmiştir (12). Asherman Sendromu, menstrüel anormallik, infertilite veya tekrarlayan gebelik kayıplarına yol açan ve intrauterin kaviteyi tam ya da kısmi olarak daraltan adezyonlarla karakterize bir sendromdur (13).

Tarihçe

İntrauterin adezyon sorununu ilk olarak gözlemleyip tanımlayan aslında Joseph Asherman değildir. Asherman Sendromunun, **Heinrich Fritsch** tarafından ilk olarak bildirildiği 1894 yılından, günümüzdeki adıyla anıldığı 1950 yılına kadar olan kronolojisi, Tablo 1'de (14) özetlenmiştir.

JG Asherman, 1948 ve 1950 yılında İUA'ların

Tablo 1: İntrauterin adezyon olgu serilerinin kronolojisi[a]

Yazar	Yayım yılı	Olgu
Fritsch H. (15)	1894	24 yaşında postpartum küretaj sonrası amenore, 1 olgu
Bass B. (16)	1927	İndüklenmiş abortus sonrası istmik stenoz, 20 olgu
Stamer S. (17)	1946	24 yeni olgu
Asherman JG. (7)	1948	Travmatik amenore, 29 olgu
Hald H. (18)	1949	22 olgu
Asherman JG. (8)	1950	Travmatik intrauterin adezyon, 8 olgu

[a](6) Magos A. Reprod Biomed Online. 2002'den düzenlenerek

Endometrial restorasyonu kötü olgularda strateji

Histeroskopik adezyolizis ile intrauterin kavite boyut ve şekil olarak çoğu kez restore edilebilse de, endometrium restorasyonu aynı oranda başarılı bir şekilde gerçekleştirilemez. Bu durum, hem adezyon dışında geride kalan fonksiyonel endometrium defektlerine hem de adezyonların yoğun olduğu endometrium bölgesinin altındaki veya yakın çevresindeki myometrial dokunun fibrozisine bağlı olabilir. Bu, seks steroidlerinin suprafizyolojik dozlarda bile endometrial dokuya ulaşmasını engelleyecek ve endometrium rejenerasyonunu sınırlayacaktır (56). Bu durumda, embriyo implantasyonu için gerekli minimal endometrial kalınlık olan 7-8 mm'lik (249,250) hedefe ulaşılamayacaktır. **Subendoteliyal kan akımını artırmak için denenen diğer tedavi seçenekleri, düşük doz aspirin (251,252) nitrogliserin (253) ve sildenafil sitrattır (nitrik oksidin vazodilatör etkisini artıran tip 5-spesifik fosfodiesteraz inhibitörü) (254).** Sildenafilin etkisi ile ilgili olarak sadece iki olgudan oluşmuş bir olgu sunumunda (254), 6-14 gün süreyle, günde 4 kez 25 mg vajinal sildenafil sitrat uygulaması sonrası gebelik bildirildi. Bu konuda daha geniş ve kapsamlı araştırmalara gerek olduğu açıktır.

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