GEBELİKTE SİSTEMİK HASTALIKLARA YAKLAŞIM

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Gebelikte Sistemik Hastalıklara Yaklaşım

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Gebelikte karşılaşılan sistemik hastalıklar için farklı branşlardan meslektaşlarımızla ortaklaşa hazırladığımız ve en güncel detayları bulabileceğiniz bir kitap yazdık. Kitabımızın değerli meslektaşlarımıza faydalı olması dileğiyle...

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Bölüm 1

GEBELİKTE MATERNAL OBEZİTE

Fatih OMURCA[1]

GİRİŞ

Gebelikte obezite, anne ve çocuk sağlığı için kısa ve uzun vadeli etkileri olan önemli bir halk sağlığı sorunudur. Gebelik sırasında, kilo durumu, bir kadının hamilelik öncesi vücut kitle indeksi (VKİ) kullanılarak değerlendirilir; buna göre, 30 kg/m2'ye eşit veya daha büyük bir VKİ, obez olarak kabul edilir (1). Obezitesi olan gebeler, bir dizi maternal ve perinatal komplikasyon riski altındadır. Örneğin, obez (VKİ ≥30 kg/m 2) olan kadınların gebelikte, özellikle gestasyonel diyabet ve preeklampsi gibi birçok komplikasyon geliştirme riski yüksektir ve sezaryen ile doğum yapma olasılıkları daha yüksektir. Aşırı gestasyonel kilo alımı benzer etkilere sahip olabilir ve annenin doğum sonrası kilo tutma ve obez olma veya uzun vadeli sağlığı üzerinde olumsuz etkileri olabilecek kötüleşen obezite geliştirme riskini artırır (1,2). Gebelik komplikasyonlarından gestasyonel hipertansiyon, makrozomi, preeklampsi, gestasyonel diyabet, erken doğum maternal obeziteye bağlı olabileceği öngörülmektedir.. Obez gebelerin çocuklarında da obezite görülme riski vardır.

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MATERNAL OBEZİTE YAKLAŞIMI ÖZET DEĞERLENDİRME

Obezite ile komplike hale gelen gebeliklerin gelecekteki nüfus ve sağlık hizmetleri maliyetleri üzerindeki etkisinin farkında olmak çok önemlidir. Obezite, gebeliğin her safhasını komplike hale sokar. Gebelik sırasında önleyici stratejiler göz önünde bulundurularak maternal ve fetal komplikasyonlar için uygun tarama programları planlanmalıdır. Bu popülasyonda artan ölü doğum riskinin tanınması, 38 ila 39. gebelik haftaları civarında doğum eyleminin başlatılmasının riskleri ve faydalarının dikkatli bir şekilde değerlendirilmesi gerekmektedir. Maternal obezitesi olan gebelerde ölü doğum nedenlerinin belirlenmesi için ileri araştırmalara ihtiyaç duyulmaktadır. Gebelik öncesi, gebelikte ve postpartum süreçte diyet, fiziksel aktiviteler ve önlemler hakkında danışmanlık verilmesi ve bu süreçte gerekli müdahalelerin zamanında yapılması hayati önem taşımaktadır.

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Bölüm 2

GEBELİKTE HEMATOLOJİK HASTALIKLAR

Işıl TURAN BAKIRCI[1]

Gebelikte trombositopeni

Trobositopeni trombosit sayının 150,000/mm3 altında olmasıdır. Gebelikte trombositopeniye yol açan sebepler preeklampsi gibi gebeliğe özgü olabileceği gibi gebelikle ilişkisiz durumlar da olabilir.

Gebelikte trombositopeniye yol açan durumlar:

- Gestasyonel trombositopeni
- Preeklampsi
- Hellp sendromu
- Dissemine intravasküler koagulasyon
- Gebeliğin akut yağlı karaciğeri
- Trombotrombositopenik purpura (TTP)
- İmmun trombositopenik purpura (ITP)
- Viral ve bakteriyel enfeksiyonlar (HIV, HCV)
- İlaç kullanımı (kinin)
- Sistemik lupus eritematozis, Antifosfolipit sendromu

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aşırı kanama beklenmez (40).Faktör 8 ve vWF ün gebelikte artmasına bağlı olarak gebelikte kanama nadirdir ama doğum sonrası bu düzeyler düşer. Faktör 8 düzeyi %50 den az ise doğum sırasında tedavi verilmelidir. Kanama, doğum sonrası geç dönemde de olabilir. Doğum sonrası faktör 8 düzeyi kontrol edilmelidir.

Tip 1 von Willebrand hastalığında endotelyal hücrelerden vWF salınmasını sağlayan desmopressin kullanılır. İntranazal olarak 12 saatte bir tekrar edilerek kullanılır. Acil veya cerrahi gerektiren durumların öncesinde ıv olarak kullanılır. Desmopressin uterin kontraksiyonlara yol açması nedeniyle ikinci ve üçüncü trimesterde dikkatli kullanılmalıdır.

Desmopressine yanıt vermeyen veya tip 1 dışındaki olgularda antihemofilik faktör kullanılır(41).

Acil durumlarda von Willebrand hastalığının tipi bilinmiyorsa faktör 8/vWF konsantreleri kullanılmalıdır (41)

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Bölüm 3

GEBELİK VE KALP HASTALIKLARI

Fırat ERSAN[1]

Giriş

Kardiyovasküler hastalıklar Birleşik Devletlerdeki yıllık 4 milyon gebeliğin yaklaşık % 1-4'ünü etkilemektedir. Konjenitel veya edinilmiş kalp hastalığı olan kadınlarda gebelik insidansı gittikçe artmaktadır (1). Maternal kalp hastalıkları hem güvenli bir gebelik sürecine hem de uzun dönemde kadınların kardiyovasküler sağlığına önemli bir tehdittir. Birleşik Devletlerde kardiyovasküler hastalıklar, 100.000 canlı doğumda 4.23 oranı ile gebelik ve postpartum dönemdeki anne ölümlerinin major sebebidir (2,3). En son veriler kardiyovasküler hastalıkların gebelikle ilişkili ölümlerin % 26.5'ini oluşturduğunu göstermektedir(4).

Gebelikte Kardiyovasküler hastalıklarla ilişkili maternal mortalite risk faktörleri

1. Irk/Etnisite: İspanyol kökenli olmayan siyahi kadınlarda ölüm riski beyaz kadınlara göre3.4 kat daha fazladır (4).

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Bölüm 4

KRONİK HİPERTANSİYON VE GEBELİK

Mustafa Can SİVAS[1]

1. Giriş

Kronik hipertansiyon gebe kadınların % 0,9 – 1,5'inde bulunur [1]. Kronik hipertansiyon hastaları, tanı almadan önce uzun süre tansiyon yüksekliği ile hayatlarına devam etmiş ve hatta uç organ hasarı gelişmiş olabilir. Kronik hipertansiyon hastalarının gebe kalması, dikkatli takip ve yeri geldiğinde acil tedavi gerektiren, başarılı yönetilmediğinde hem fetüs hem anne için riskli veya ölümcül olabilen bir süreçtir. Hasta; gebeliğin başlangıcından sonlanmasına kadar takip altında olmalı, gerekli durumlarda zaman kaybetmeden medikal tedaviler başlanmalı ve anne ile fetüs için en doğru zamanda gebeliğin sonlandırılmasında tereddüt edilmemelidir.

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laboratuvar değerleri düzelmiş olan hastaların, eklampsi nöbet riskinin de belirgin şekilde azaldığı 72. saatte taburculuğu planlanabilir. Taburculuk sonrası hastalara evde tansiyon değerlerini, tansiyon takip çizelgelerine not etmeleri ve özellikle ilaç kullanmaya devam eden hastaların kardiyoloji bölümüne takip çizelgeleri ile kontrole gitmeleri önerilmelidir.

13. Sonuç

Kronik hipertansiyon hastaları gebeliğin başından ve hatta gebe kalmadan önce sıkı takibe alınmalıdır. Gebelik öncesi tansiyon kontrolleri sağlanmalı, mevcut olabilecek uç organ hasarlarının ortaya çıkarılması için gerekli araştırmalar en başta yapılmalıdır. Tüm bu süreç; kardiyoloji, göz hastalıkları, kadın doğum ve perinatoloji uzmanının bulunduğu multidisipliner bir ekip tarafından yönetilmelidir.

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Bölüm 5

GEBELİĞE ÖZGÜ KARACİĞER HASTALIKLARI

Ferhat OMURCA[1]

HİPEREMEZİS GRAVİDARUM

Erken gebelikte hipovolemi, ketonüri ve vücut ağırlığının %5'i ya da fazlasının kaybına yol açan şiddetli kusmaya hiperemezis gravidarum (HG) denir ve tüm gebeliklerin %0,3-3'ünde görülür (1). Hiperemezis gravidarumun beyaz ırktan olmayan ve sigara içmeyen genç, primipar anneler arasında daha yaygın olduğu görülmüştür.(2,3)

Etyoloji

Hiperemezis gravidarumun etyolojisi net olarak bulunamamış olsa da, psikiyatrik öykü, gastrik dismotilite, genetik ve hormonal faktörler (hCG, östrojen,progesteron), helicobacter pylori ve beslenme yetersizliklerinin etyopatogenezde önemli role sahip olduğu düşünülmektedir. HG gelişiminde artan östrojenin hem mide boşalmasını hem de genel bağırsak geçiş süresini azaltabileceği düşünülmektedir ve prolaktin seviyelerinde düşme ve hipotalamo-hi-

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Tablo 2. Gebelik ilişkili karaciğer hastalıklarının özellikleri			
Hastalık	Görülme zamanı	Klinik özellikleri	Histoloji
Hiperemezis Gravidarum	1. trimester	Bulantı, kusma, kilo kaybı	Belirgin histopatolojik bulgu yok, normal karaciğer dokusu, hepatosit nekrozu, safra tıkaçları, steatozis
İntrahepatik kolestaz	2. ve 3. trimester	Kaşıntı, sarılık, halsizlik, karın ağrısı, steatore	Sentrolobüler kolestaz, inflamasyon görülmez
Gebeliğin akut yağlı karaciğeri	3. trimester	Bulantı, kusma, sarılık, halsizlik, karın ağrısı	Mikroveziküler ya¤lanma
HELLP	3. trimester	Karın ağrısı, bulantı, kusma, ödem, hipertansiyon, proteinüri	Nekroz, periportal hemoraji, fibrin birikimi
Preeklampsi, eklampsi	2. ve 3. trimester	Hipertansiyon, ödem, proteinüri, nörolojik defisitler (baş ağrısı, nöbet, koma)	Periportal hemoraji, nekroz, fibrin birikimi, mikroveziküler yağlanma

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Bölüm 6

KARACİĞER FONKSİYON TESTLERİ YÜKSEK OLAN GEBE HASTALARA YAKLAŞIM

Ferhat OMURCA[1]

GİRİŞ

Gebe hastalarda yüksek karaciğer biyokimyasal ve fonksiyon testleri, danışan jinekologlar ve hepatologlar için zorluk teşkil etmektedir. Hamilelik sırasında saptanan karaciğer anormallikleri, gebe olmayan hastanın değerlendirilmesine benzer bir tanısal değerlendirme gerektirir, ancak aynı zamanda gebelik yaşı ve gebelikte beklenen fizyolojik değişiklikler doğru tanı ve tedavi için yönlendiricidir. Hızlı tanı ciddi vakalarda vazgeçilmezdir, çünkü hemen doğum kararı anne ve fetal sonuç için önemlidir.

Gebelik sırasında karaciğer hastalığı aşağıdaki özelliklere göre kategorize edilebilir:

- Gebeliğe özgü hastalıklar: Bazıları birincil karaciğer hastalıklarıdır (örn. gebeliğin intrahepatik kolestazı, gebeliğin akut yağlı karaciğeri) ve diğerleri hepatik belirtileri olan sistemik hastalıklardır (örn. HELLP sendromu (hemoliz, yüksek karaciğer enzimleri ve düşük trombositler), Preeklampsi, hiperemezis gravidarum)

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Normal hamilelik sırasında, plasental üretimden alkalen fosfataz yükselir (tipik olarak hamile olmayan seviyenin iki katına kadar, ancak bazen belirgin şekilde daha yüksektir. [9,10]); bu nedenle, hafif yükselmiş bir alkalin fosfataz kolestatik karaciğer hasarını düşündürmez.

HELLP (Hemoliz, yüksek karaciğer enzimleri, düşük trombosit) sendromu ve gebeliğin akut yağlı karaciğeri gibi gebeliğe özgü karaciğer hastalıklarının teşhisi için karaciğer biyopsisi nadiren gereklidir. İnvaziv olduğu için, karaciğer biyopsisi yalnızca klinik sunum, laboratuvar çalışmaları ve görüntüleme temelinde bir tanı konulamadığında ve sonuçların tedaviyi veya doğum zamanlamasını bilgilendirmek için gerekli olduğu durumlarda yapılmalıdır.

Karaciğer biyopsisi yapılacak koagülopatili hastalar için transjuguler karaciğer biyopsisi alternatif bir yaklaşımdır.

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Bölüm 7

GEBELİK VE SOLUNUM SİSTEMİ HASTALIKLARI

Gizem Berfin ULUUTKU[1]

Giriş

Gebelikte fizyolojik kardiyovasküler ve pulmoner değişikliklerin sonucu olarak dispne meydana gelebilir.(1) Gebelikte meydana gelen değişiklikler sonucunda özellikle ilerlemiş gebelik haftalarında bazı akciğer hastalıklarının prognozu ve tedavi modaliteleri farklılık gösterebilmektedir. Gebelikte akciğer hastalıklarına titizlikle yaklaşılmalıdır.

Akciğer hastalıklarına tanı koyabilmek için öncelikle gebe olmayan bir hastada olduğu gibi anamnez alınmalı, fiziksel muayene yapılmalı ve ayırıcı tanılar dışlanmalıdır. Taşikardi, takipne, azalmış oksijen saturasyonu, oskültasyonda raller duyulması ve diğer konsolidasyon bulguları gebelikte normal fizyolojik değişiklikler değildir ve mutlaka ileri inceleme gerektirir. Teşhis koyulduktan sonra ise bu tanı ve tedavi planının gebe hasta veya fetüs üzerine olası bir risk taşıyıp taşımadığı göz önüne alınarak tedavi planına geçilmelidir.

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- **Parenteral beta-agonistler:** Astım ataklarında nadiren de olsa parenteral beta-agonsitler kullanılabilir, ancak alfa adrenerjik etkisi nedeniyle uteroplasental vazokonstriksüyona neden olabileceğinden anaflaksi durumu haricinde gebelikte epinefrin kullanımı önerilmemektedir. (81)

- **Intravenöz aminofilin/teofilin:** İnhale beta agonistlere ve intravenöz glukortikoidlere ek fayda sağlamadığından gebelerde akut astım atağının yönetiminde kullanımları önerilmemektedir. (81)(114)

- **Antibiyoterapi:** Akut astım ataklarını tetikleyen solunum yolu enfeksiyonları sıklıkla bakteriyel değil viral olduğundan antibiyotik kullanımı önerilmemektedir. (81)

Doğum indüksiyonu ve postpartum hemorajinin kontrolü için oksitosin tercih edilir. (115) Prostoglandin F2-alfa analogları bronkokonstrüksiyona neden olabileceğinden kullanılmamalıdır. (116)(117) Prostoglandin tedavisi gerekiyorsa bronkodilatör etkileri nedeniyle Prostoglandin E1-E2 daha güvenlidir. (118)

Kistik Fibrozis

Gebelikde kistik fibrozisin mortalite ve morbiditesi artmaz. (119) Ancak olası enfeksiyonlar ve kalp yetmezliğine karşı dikkatli yakın takip planlanamalıdır.

Sonuç

Gebelikte solunum sistemi hastalıklarının teşhis ve tedavisi tittizlikle yapılmalıdır. Gebelikte oluşan fizyolojik dispne ve meydana gelen bir dizi değişiklikler sonucunda özellikle ilerlemiş gebelik haftalarında bazı akciğer hastalıklarının prognozu ve tedavi modaliteleri farklılık gösterebilmektedir.

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Bölüm 8

GEBELİKTE ENDOKRİN HASTALIKLAR

Can TERCAN[1]

Tiroid Hastalıkları

Tiroid hastalığı olan gebelerin değerlendirilmesi ve tedavisi, gebe olmayan bireylerle paralellik göstermekle birlikte, kendine özgü bazı sorunlar içermektedir. Gebelikte tiroid hastalığının teşhisi, gebeliğe eşlik eden tiroid fizyolojisindeki ve tiroid fonksiyon testlerindeki değişikliklerin anlaşılmasını gerektirir. Normal bir gebelik sırasında artan metabolik ihtiyaçları karşılamak için tiroid fizyolojisinde tiroid fonksiyon testlerine yansıyan birtakım değişiklikler vardır (1). Bunlar; Serum tiroksin bağlayıcı globulinde (TBG) artış ve human koryonik gonadotropin (hCG) tarafından tirotropin (tiroid uyarıcı hormon [TSH]) reseptörünün uyarılması şeklinde karşımıza çıkmaktadır.

Gebelik sırasında, östrojen TBG üretimini arttırdığından serum TBG konsantrasyonları neredeyse iki kat artar bu da TBG klirensinin azalmasına neden olur (2). Bu dönemde yeterli düzeyde serbest tiroid hormon konsantrasyonlarını korumak için tiroid bezi tarafından tiroksin (T4) ve triiyodotironin (T3) üretiminin artması gerekir. TBG fazlalığı hem serum totalinde hem de serbest

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Bölüm 9

PREGESTASYONEL DİABETES MELLİTUS

Nihan İLHAN ORUÇ[1]

Pregestasyonel diyabet ile komplike olan gebeliklerin yönetimindeki ana hedefler şunlardır:

- Hipoglisemi ve diyabetik ketoasidozdan (DKA) kaçınarak ideal glisemik kontrolün sağlanması ve sürdürülmesi.
- Annenin glisemik olmayan tıbbi komplikasyonları (örneğin, retinopati, nefropati, hipertansiyon, kardiyovasküler hastalık, tiroid hastalığı) için tarama, izleme ve müdahale.
- Fetal ve obstetrik komplikasyonların (örneğin konjenital anomaliler, preeklampsi, makrozomi, fetal iyilik halinin bozulması) izlenmesi, mümkünse olumsuz sonuçları en aza indirmek için zamanında müdahale.

İLK TRİMESTR

Gebelikte diyabetin sınıflandırılması - Hastalık mekanizmasına dayalı olarak gebelikte diyabet için aşağıdaki sınıflandırma sistemi önerilmiştir [1]:

- Tip 1 diyabet (genellikle mutlak insülin eksikliğine yol açan otoimmün beta hücre yıkımı):

xxxxxxxxxx

lerasyonlar yoktur [35]. Bu anormallikler genellikle DKA›nın çözülmesiyle düzelir [34].

Yönetim — Fetal kalp hızının yakın takibinin dışında, DKA yönetiminin ilkeleri gebe ve gebe olmayan hastalarda benzerdir [34]. Bunlar arasında intravenöz insülin kullanımı, uygun hacim replasmanı, elektrolit anormalliklerinin düzeltilmesi (potasyum, fosfat ve magnezyum dahil), asidozun izlenmesi ve enfeksiyon gibi tetikleyici nedenlerin araştırılması yer alır [17]. DKA tedavisi sırasındaki glikoz hedefleri, gebelerde (100 ila 150 mg/dL), gebe olmayan yetişkinlere (150 ila 250 mg/dL) göre daha düşüktür [17]. Hiperglisemiyi kötüleştireceklerinden DKA sırasında glukokortikoidler ve beta-mimetiklerden kaçınılmalıdır.

Tek başına DKA genellikle doğum için bir gösterge değildir. Maternal stabilizasyondan önce acil doğumdan kaçınılmalıdır, çünkü bu anne morbidite ve mortalite riskini arttırır ve hipoksik, asidotik prematüre bir bebeğin doğumuna neden olabilir ve bu bebek için in utero resüsitasyon daha iyi sonuç vermiş olabilir. Doğumun zamanlamasının, gebelik yaşı, annenin durumu (annenin agresif tedaviye yanıt verip vermediği veya kötüleşip kötüleşmediği) ve fetüsün durumu (fetal kalp hızı trasesinin düzelip düzelmediği) dahil olmak üzere birçok faktöre dayalı olarak kişiselleştirilmesi gerekir. Maternal asidozdan kaynaklanan fetal kalp hızı anormallikleri, DKA tedavi edildikçe ve annenin durumu düzeldikçe sıklıkla düzelecektir [35].

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Bölüm **10**

RENAL VE ÜRİNER SİSTEM HASTALIKLARI

Eralp BULUTLAR[1]

Giriş

Gebelikte fizyolojik olarak intrarenal vazodilatasyona bağlı olarak renal plazma akımı ve glomerüler filtrasyon hızı (GFR) artmaktadır. Bu akım artışına bağlı olarak böbrekler yaklaşık olarak 1-1.5 cm kadar uzar ve hacim olarak yüzde 30'a kadar büyür (1). Ayrıca artan progesterona bağlı olarak; renal pelvis, kaliksler ve üreterler genişlerler (2). Mekanik etkiyle birlikte büyüyen uterusun basısı sonucu genelde sağ üreterde daha belirgin olmak üzere hafif ve orta şiddette hidroüreteronefroz meydana gelir. Üçüncü trimester gebelerin yaklaşık olarak yüzde 90'ında hidronefroz saptanır. Bu değişikliklerin tümünün ortak özelliği hepsinin geri dönüşümlü olmasıdır (3). Tüm bu fizyolojik değişimler düşünüldüğünde aslında vazodilatasyon , progesteron ve uterusun hacimsel büyümesine bağlı mekanik etki olarak üç olayın bu değişikliklerin temelinde olduğu söylenebilir.

Gebelik sırasında GFR'deki fizyolojik artış, erken gebelikteki kreatinin değerlerindeki azalmayla sonuçlanır (4). Bu nedenle de gebe bir kadındaki 0,8

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nin fizyolojisi iyi kavranabilirse hem bu hastalıklarının tanısının koyulması ve daha önemlisi tedavisinin yapılması oldukça kolay hale gelecektir.

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Bölüm 11

GEBELİKTE KAS-İSKELET SİSTEMİ PROBLEMLERİ

Tamer COŞKUN[1]

Giriş

Dokuz aylık gebelik boyunca kadınlar birçok hormanal ve anatomik değişikliklere uğramaktadır. Hamilelikte meydana gelen fizyolojik değişikliklerden biri de ödeme bağlı yumuşak doku şişkinliğidir. Hamile kadınların birçoğu, gebeliklerinin bir döneminde (özellikle son 8 hafta) bu durumu yaşarlar. Bu sıvı artışı yumuşak dokuda kompresyonlara neden olabilir ve karpal tünel sendromu gibi durumlara yol açabilir. Hamilelik sırasında meydana gelen bir diğer değişiklik ise östrojen ve relaksin hormonlarının etkisi ile artan ligament laksitesidir. Bu artan ligament laksitesi hamilelik sırasında meydana gelen kilo alımı ile birlikte eklemlerde çeşitli rahatsızlıklara neden olabilir. Örneğin gebelikte %20 kilo alımı eklemlerde %100 e varan basınç artışına neden olabilir.

Hamilelik sırasında meydana gelen değişiklikler kas-iskelet sistemini önemli ölçüde etkiler ve yeni yaralanmalara neden olabilir. Bu bölüm gebelik sürecinde oluşabilecek birçok yaygın ortopedik durumu gözden geçirmeyi amaçlamıştır.

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Özellikle geceleri elde uyuşma ve karıncalanma ile uyanma, objeleri elden düşürme ve tenar kas atrofisi sık görülen semptomlardır. Doğum sonrası bu durum prolaktin hormonunun salgılanması devam ettiği için çözülmeyebilir ve devam edebilir. Ancak bir çok hastada doğum sonrası karpal tünel semptomları çözülmeye başlar.(11) Tedavide öncelikle gece el bilek splinti kullanılır. Cerrahi tedavi seçeneği doğum sonrasına kadar düşünülmemelidir.

De Quervain Tenosinoviti

El bileği 1.ekstansör kompartmanda yer alan abdüktör pollisis longus ve ekstansör pollisis brevis tendonlarının inflamatuar durumudur. Başparmak hareketleri şiddetli olgularda oldukça ağrılıdır. Fizik muayenede Finkelstein testi pozitiftir ve tanı koymakta yeterlidir. Tedavide soğuk uygulama ve başparmak destekli el bileği ortezi kullanılması ilk tedavi seçeneğidir. Postpartum döneminde semptomları devam eden hastalarda 1.ekstansör kompartmana steroid enjeksiyonu ve kompartmanın cerrahi olarak serbestleştirilmesi planlanabilir.

Sonuç

Son yıllarda gebelikte kas iskelet sistemi problemleri ile ilgili birçok yayın çıkmıştır. Bunların bir çoğu bel ağrısı ile ilgilidir. Bu yayınlar gebelikteki bel ağrısında biyolojik, fizyolojik ve sosyal faktörlerin etkili olduğunu göstermiştir. Gebeleri doğru postür ve periyodik dinlenme konusunda eğitme en önemli tedavi basamağıdır. Bel ağrısının yanı sıra diğer gebelikte sık karşılaşılan ortopedik problemlerin kadın hastalıkları ve doğum uzmanları tarafından genel hatları ve ilk basamak tedavilerinin bilinmesi tedavi için en önemli kısımdır.

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Bölüm 12

GEBELİK VE KONNEKTİF DOKU HASTALIKLARI

Zeynep KAYAOĞLU YILDIRIM[1]

Sistemik Lupus Eritematozuslu Kadınlarda Gebelik

Sistemik lupus eritematozus (SLE) ağırlıklı olarak doğurganlık çağındaki kadınları etkiler; hastalığın kendisinin doğurganlık üzerine etkisi yokken siklofosfamit kullanımı bu kadınlarda over rezervini azaltabilir.

SLE gebelikleri, sağlıklı kadınlarla karşılaştırıldığında daha yüksek maternal ve fetal risk taşır. Gebelik öncesi en az 6 ay sessiz kalan hastalık varlığında, hem anne hem de çocuk için prognoz iyidir. SLE alevlenmeleri, gebeliğin fizyolojik değişiklikleri ile karışabilir. Bu nedenle, hem anne hem de fetüsda en iyi sonuçlar için yakın tıbbi, obstetrik ve neonatal izleme ve multidisipliner bir yaklaşım gereklidir.

İdeal olarak, SLE hastaları, gebe kalmaya çalışmadan önce, gebelikle uyumlu ilaçlar eşliğinde en az altı ay boyunca sakin bir hastalık süreci geçirmiş olmalıdır. Konsepsiyon sırasındaki aktif SLE, kötü maternal ve obstetrik sonuçların güçlü bir öngördürücüsüdür [1-3].

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Bölüm 13

GEBELİKTE NÖROMUSKÜLER HASTALIKLAR

Dilara MERMİ DİBEK[1]

Giriş

Nöromuskuler hastalıklar sinir, kas ve nöromuskuler kavşak alanlarında edinsel veya herediter nedenlerle meydana gelen hastalık grubunu ifade etmektedir. Gebelik gibi bireyin immün sistemi, sıvı elektrolit ve hormon dengesi ile morfoloji değişikliğinin olduğu bir durumun hastalıklar üzerine etkisi olduğu bilinmektedir. Bu değişikliklerin hastalığın seyrinde alevlenme, gebelik süreci, doğum ve postpartum dönemdeki etkileri, kullanılan tedavi ve hastalık sürecinin fetüs üzerine etkilerinin bilinmesi anne ve bebek sağlığı için oldukça önemlidir.

Bu bölümde nöromuskuler hastalıkların gebelik ile meydana gelen değişkenliklerine ve dikkate alınması gereken noktalarına değinilecektir.

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Bölüm 14

GEBELİKTE BAŞ AĞRISINA YAKLAŞIM

Şule DEVECİ[1]

Giriş

Gebelikte baş ağrısı primer ve sekonder olabilir. Sekonder baş ağrısı olduğunda yaşamı tehdit eden bir hastalığın belirtisi olabilir. En yaygın sekonder baş ağrısı sebepleri; preeklampsi, eklampsi, serebral ven trombozu (SVT), bazı iskemik ve hemorajik inme türleri, subarakhnoid kanama (SAK), hipofiz apopleksisi, reversibl serebral vazokonstriksiyon sendromu (RSVS), posterior revesibl ensefalopati sendromu (PRES), idiyopatik intrakraniyal hipertansiyon, arter disseksiyonu, hipofiz tümörü, koryokarsinom ve postpartum başağrısıdır. Migren özellikle vasküler olaylara bağlı gebelik komplikasyonları için bir risk faktörüdür. Baş ağrısı ile kendini gösteren hastalığın erken teşhisi anne ve fetüs yaşamı için önemlidir. Baş ağrısının ciddi bir hastalığın belirtisi olduğunu düşündüren "kırmızı bayrak belirtilerini" belirlemek özellikle önemlidir. Sekonder bir baş ağrısını dışlamak için elektroensefalografi (EEG), baş ve boyun damarlarının ultrasonografisi, kontrastlı beyin manyetik rezonans görüntüleme (MRG) ve MR anjiyografi, oftalmoskopi ve lomber ponksiyon gibi ek çalışmalar gerekli olabilir. Gebelik ve emzirme döneminde primer baş

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için koruyucu farmasötik tedavi gerektiğinde, metoprolol ve propranolol ilk tercihtir, ardından amitriptilin gelir. Botulinum toksini tip A kullanımı için çok az veri mevcuttur.

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Bölüm 15

GEBELİKTE İSKEMİK İNME VE SEREBRAL SİNÜS VEN TROMBOZU

Gülşah ZORGÖR DİNDAR[1]

Giriş

Gebelik sırasında veya doğum sonrası dönemde meydana gelen inme olarak tanımlanan maternal inme, giderek artan bir şekilde maternal morbidite ve mortalitenin ana nedeni olarak kabul edilmektedir. Gebelik ilişkili fizyolojik değişiklikler arteryal iskemik inme (AIS) ve serebral sinüs ven trombozu (SVT) gibi tromboembolik hadiselerin oluşum riskini arttırmaktadır.

Maternal İnme İnsidansı

Gebelik ve puerperiumda maternal inme insidansı reprodüktif çağdaki gebe olmayan kadınlara kıyasla 3 kat artmaktadır [(1)]. Yakın zamanlı bir metaanalize göre gebelik ve puerperiumdaki inme insidansı 30/100.000 olarak saptanmıştır. İnme, gebelik sonrası uzun dönem sakatlığın en sık sebebidir ve maternal inmeye bağlı ölüm oranı %2.7-%20.4 arasında değişmektedir [(1,2)].

Arteriyel ve venöz enfarkt riski antepartum, peripartum ve postpartum periyoda göre değişmektedir. Çalışmalar arasında farklılıklar olsa da genel olarak

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Emzirme ve İnme

Düşük doz aspirin, LMWH ve warfarin emzirmede güvenli bulunmaktadır; ancak diğer antiagreganların ve direkt oral antikoagulanların güvenilirlikleri ile ilgili yeterli veri yoktur.

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Bölüm **16**

GEBELİK VE EPİLEPSİ

Muazzez Gökçen KARAHAN[1]

Gebelik pek çok organ sisteminde değişimlerin izlendiği, kadının hayat gidişatında hem zamansal hem de fonksiyonel olarak kritik pencereler açabilecek, kimi yazarlarca fizyolojik kimi yazarlarca- belki iddialı bir söylem olarak görülse de- patolojik sonuçlar barındırdığı düşünülen bir süreç olarak ele alınır. Bu bölümde nöroloji pratiğinde oldukça sık karşılaştığımız, epileptologlarca adına önemli toplantıların düzenlendiği bir konu olan ***epilepsili gebeye yaklaşımdan*** bahsedilecektir.

Epilepsi insidansı 61.4/ 100.000 ve prevalansı 7.6/1000 olmak üzere düşük sosyoekonomik düzeyli ülkelerde daha çok görüldüğü düşünülen kronik bir hastalıktır (1). Bu durum perinatal risk faktörlerindeki farklılıkla ilişkilendirilmiştir. Her 1000 doğumun 3-5 'ini epilepsili gebeler yapmaktadır (2). International Leauge Againts Epilepsy'nin (ILAE) 2019 yılında yayınladığı son incelemede gebe bir epilepsi hastasında üzerinde dikkatle durulması gereken konular ***gebelikte nöbet kontrolü, anti epileptik ilaçların farmakokinetik değişimleri, anti epileptik ilaçların teratojenik riskleri ve prenatal, gebelik, doğum ve lohusalıkta ideal yönetim stratejileri***dir (3).

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Sonuç olarak gebelik; anne, epileptolog ve kadın doğum hekiminin beraberce yürümesi gereken bir yoldur; bu yol üzerindeki zorlu tümseklerle başa çıkmada bireysel karar alma sistemi devre dışı bırakılmalı, istekler, riskler, planlamalar ortak kararlara tabii olmalıdır. Açık iletişimin gerçekleştiği ve hastaya yeterli zaman ve özverinin ayrılabildiği gelişmiş toplumlarda bu hassas dönemin daha kolay atlatılabildiği görülebilir. Ülkemiz sağlık sisteminde gösterilen emek ve özverinin hiç de az olmadığı düşünüldüğünde epilepsi hastası anne adayları için durumun daha farklı olması beklenmez. Epilepsinin karmaşık doğası gelecek yıllarda daha çözümlenebilir olduğunda bu tarz durumların yönetimine dair daha umutlu olduğumuz günlerin gelmesi yakın görünmektedir.

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Bölüm 17

GEBELİK VE DERİ

Dilek CANAT[1]

Gebelik dönemi, kadın için çok sayıda fiziksel ve psikolojik farklılaşmanın olduğu ve bunlar nedeniyle emosyonel olarak stresli geçen bir dönemdir. Bu dönemde deride fizyolojik ve patolojik olabilecek pek çok değişim izlenir. Aslında bu süreç fetüsün gebelik boyunca büyüme ve gelişimini desteklemek ve annenin uyumunu arttırmak için olumlu bir adaptasyondur. Gebelikte deride meydana gelen değişiklikler, hemen fark edilebilir olması nedeniyle kozmetik kaygılara da neden olabilir (1). Bu nedenlerle gebelikte deride ortaya çıkan değişimlerin ilgili tüm hekimlerce bilinmesi oldukça önemlidir. Gebelik döneminde ortaya çıkan immünolojik mekanizmalı, metabolik, endokrinolojik ve vasküler kaynaklı değişiklikler, deri ve deriyle ilişkili yapılarda değişimlere sebep olur (2). Gebelik döneminde meydana gelen deri değişikliklerini 3 kategoride inceleyebiliriz (3):

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Bölüm 18

GEBELİK VE JİNEKOLOJİK KANSERLER

Nazlı Aylin VURAL[1]

Kanser, gebeliklerin yaklaşık 1000 de 1 ini komplike etmektedir.[1] Yaşamın dördüncü dekatından itibaren birçok malignite insidansının artması ve son birkaç on yılda kadınlarda 30 yaşından sonra gebelik planlamasının artması nedeniyle gebelikte malignite görülmesi insidansı artmaktadır.[2] Jinekolojik maligniteler, meme ve hematolojik maligniteler ile birlikte gebelikte en sık teşhis edilen kanserlerdendir.

Gebelikte kanserlerin tanı ve tedavisine ilişkin kararlar, gebelik fizyolojisi, maternal anatomi ve fetüs göz önünde bulundurularak değerlendirilmelidir. Yapılan çalışmalar arttıkça, daha güvenli onkolojik ve obstetrik sonuçlar elde edilmektedir. Bu bölümde, gebelikte servikal displazi, adneksiyal kitleler ve jinekolojik malignitelerin yönetimi, teşhisi ve tedavisini gözden geçireceğiz.

Gebelikte Serviks Kanseri

Serviks kanseri teşhisi konan kadınların yüzde 1 ila 3'ü tanı anında gebedir veya doğum sonrasıdır .[3] Bu vakaların yaklaşık yarısına doğum öncesi dönemde, diğer yarısına ise doğumdan sonraki 12 ayda tanı konur [4]. Rahim

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Uterin Leıomyosarkom

Reprodüktif dönemdeki kadınlarda en sık görülen jinekolojik tümör olan leiomyom ve gebeliklerin %10-20'sinde bulunur [81]. Asemptomatik fibroidler, kanama ve olası fetal kayıp riski nedeniyle opere edilebilir. Myomların çoğu hamilelik sırasında önemli ölçüde genişlemez. Hızla büyüyen "fibroidlerde" leiomyosarkom insidansı sadece %0.27 olup, preoperatif tanı koymak çok mümkün değildir. MRG görüntülemede; sınırları belirsiz olması, kalsifikasyon yokluğu veya lezyon içi kanama leiomyosarkom açısından şüphelendirici olup, tanısal değildir [82]. En sık görülen semptomlar; anormal vajinal kanama (%40), karın ağrısı (%33) ve büyüyen uterin kitle (%20) olduğu raporlanmıştır [83]. Gebelikte tanısı konan uterin sarkom için ortalama sağkalım 1.5 yıl olarak tahmin edilmekte olup, 3. trimester veya postpartum dönemde (%67) cerrahi önerilmektedir [83].

Vulva Kanseri

Gebelikte vulva kanseri çok nadir görülmekte olup, literatürde 40'tan az vaka bildirimi görülmüştür [69]. Gebelikte radyoterapi kontrendike olması nedeniyle, cerrahi tercih edilmekte olup, FIGO evre I lezyonları için sentinel lenf nodu haritalaması ile radikal lokal eksizyon yeterlidir. Gebelikte artmış kan akışı nedeniyle kanlanması arttığından, elektrokoter dikkatli kullanımıyla kan kaybı minimal düzeyde tutulmalıdır. Vulvar yara açılmasını önlemek için sezaryen ile doğum tercih edilir. Lenf nodu tutulumu histopatolojik olarak doğrulandığı takdirde, birinci veya ikinci trimestrda ise gebelik sonlandırılmalı ve radyoterapi başlanmalıdır; üçüncü trimestrda ise gebelik sonlanması için 6- 8 hafta bekleme seçeneği güvenli sınırlardadır.

Gebelik sırasında vajen kanseri çok nadir görülmekte olup, literatürde sadece 12 primer invaziv vajinal kanser olgusu yayınlanmıştır.

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Bölüm 19

GEBELİKTE ENFEKSİYON HASTALIKLARI

Çisem ERTOK[1]

1.1. Citomegalovirüs (CMV) Enfeksiyonları

Kalıtsal olmayan sensörinöral işitme kaybının önde gelen nedenidir ve serebral palsi, zihinsel engellilik, görme bozukluğu ve nöbetler dahil olmak üzere diğer uzun vadeli nörogelişimsel defektlere neden olabilir.

CMV, DNA herpes virüs ailesinden bir virüstür. CMV, son yıllarda %0,48 ile %1,30 doğum prevalansı ile en yaygın konjenital viral enfeksiyondur (1) Virüs tüm vücut sıvılarında bulunur. Fetal bulaş transplesental viremi, doğum ve emzirme ile olmaktadır. CMV pozitif gebelerde yapılan bir çalışmada amniosentez(AS) sonrasında iyatrojen fetal bulaş izlenmemiştir (2). Düşük sosyoekonomik durumu olan kadınlarda seropozitiflik olma oranı %85'e kadar görülmektedir. Daha yüksek sosyoekonomik sınıflarda ise bu oran %50 civarındadır.

Gebelerde CMV enfeksiyonu, primer veya nonprimer olarak gruplandırılır. Primer enfeksiyonda fetal enfeksiyon ihtimali %40'tır. Non-primer enfeksiyon: rekkürren veya sekonder enfeksiyon olarak da adlandırılır. Maternal antikorlar rekkürrens ve reaktivasyonlarıdan koruyucu değildir. Maternal antikorlar fetüsü de enfeksiyondan korumamaktadır. (3) Fetal bulaş ihtimali %0,15-1 'dir.

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lışılması için AS önerilmektedir (79). Mümkünse testin başarısını iyileştirmek için AS, serokonversiyonun belgelenmesinden iki hafta sonraya (veya tahmini maternal primer enfeksiyon tarihinden dört hafta sonraya) kadar ertelenir.

1.10.4. Tedavi Korunma ve Yönetim

İlk 14 haftada toksoplazmozis saptanması halinde gebeye spiramisin başlanır, danışmanlık verilir ve 18. Haftada AS yapılır. AS sonrası PCR+ olan hastaya primetamin+sülfodiazin+ folik asit kombinasyonuna geçilir ve aylık USG ile takip yapılır. Gebeliğin 14.haftası ve sonrasında tespit edilen toksoplazmoziste ise primetamin+sülfodiazin+ folik asit başlanır ve >=18. Haftada AS yapılır. PCR+ olması durumunda tedavi devamı ve aylık USG takibi önerilir.

Annenin tedavisi, doğuştan enfekte olan bebeklerde ciddi nörolojik sekel veya ölüm riskini azaltmaktadır. Primetamin-sülfadiazin ile tedavi, spiramisin'den daha etkilidir.

T. Gondii aşısı bulunmamaktadır. Korunma için içme sularının temiz olmasına dikkat edilmesi, etlerin iyi pişirilmesi, çiğ sebze meyvelerin iyi yıkanması ve hijyenine önem verilmesi, kedilerin çöplerini temizlerken eldiven giyilmesi önerilmektedir.

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Bölüm 20

PERİNATAL DÖNEMDE GÖRÜLEN RUHSAL BOZUKLUKLAR

Hasan Mervan AYTAÇ[1]

Giriş

Literatürde "perinatal dönem" denilince çoğunlukla gebelik ve doğum sonrası ilk yıl kastedilmekte olunup doğum sonrası dönemin zamansal çerçevesi halen tartışma konusudur. Bazı araştırmacıların, doğumdan sonraki 4 hafta ile doğumdan sonraki 3 ay arasında değişen süreleri bu dönemi tanımlarken kullandıkları görülmektedir (1). Gebelik sırasında veya doğum sonrası dönemde ortaya çıkan ruhsal bozukluklarla birlikte gebelikten önce var olan ve bu dönemde nüks eden bozuklukların tümü "perinatal dönemde görülen ruhsal bozukluklar" tanımı kapsamındadır. 150 yıldan daha uzun bir süre önce, Fransız psikiyatrist Louis Victor Marcé, "Traité de la folie des femmes enceintes, des nouvelles accouchées et des nourrices" (Gebe kadınların, yeni doğum yapmış ve emziren annelerin psikozları üzerine inceleme) (Marcé 1858) adlı yazıyı kaleme almıştır (2). Marcé bugün "perinatal psikiyatri" nin kurucu babası ve postpartum psikozu tanımlayan ilk kişi olarak kabul edilmektedir. Yine çeyrek yüzyıl önce, Kendell ve ark., kadınların doğumdan sonraki ilk 3 aylık süreçte ciddi ruhsal bozukluk geliştirme risklerinde önemli artış yaşadıklarını göster-

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Bölüm 21

GEBELİKTE TRAVMAYA YAKLAŞIM

Fatih OMURCA[1]

GİRİŞ

Travma gebe olmayanlarda olduğu gibi gebelerde de mortalitenin önemli sebeplerindendir. Tüm dünyada, her yıl ölümlerin yaklaşık %10'unu oluşturuyor. Travma yaklaşık 12 gebelikten 1'ini etkiliyor ancak kesin görülme sıklığı bilinmemektedir.(1) Travma sonucu anne ölümleri, obstetrik olmayan ölümlerin önde gelen nedenidir. Gebelikte meydana gelen travma kaynaklı komplikasyonlar arasında; kasılmalar, erken doğum, fetomaternal kanama, spontan düşük, erken membran rüptürü, erken doğum, uterus rüptürü, plasental dekolman ve intrauterin fetal ölüm yer alır. Yaralı gebe hastanın ilk değerlendirmesi ve yönetimi, hem anne hem de fetüs için multidisipliner, bir yaklaşım gerektirir. Motorlu araç kazaları gebe travmasının en yaygın kaynağıdır (tüm vakaların üçte ikisi), bunu düşmeler, yakın partner şiddeti, saldırı ve intihar takip eder.

Gebe travma hastasını belirlemek her zaman kolay olmayacaktır, bu nedenle doğurganlık çağındaki tüm kadınlarda gebelik testi yapılması zorunlu-

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