Bölüm

20

İNFERTİLİTE YÖNETİMİNDE LAPAROSKOPİNİN ROLÜ

Özlem KAYACIK GÜNDAY[1]

GİRİŞ

İnfertilite 12 ay veya daha fazla düzenli korunmasız cinsel ilişkiden sonra klinik gebelik elde edilememesi ile tanımlanan, üreme sisteminin bir hastalığıdır (1). Aynı zamanda, önemli bir sosyal ve ekonomik problemdir. İnfertil bir çiftin değerlendirilmesinde, başlangıç tanı testleri, orta luteal faz progesteron testi, histerosalpingografi (HSG) ve semen analizidir.

Pekçok çift çocuk sahibi olmayı ertelemektedir ve artan yaşla beraber çocuk sahibi olma ve gebeliği sürdürme ihtimali de azalmaktadır. Bu noktada, infertil olan çiftlerde, invitro fertilizasyon (IVF) sonrası görülen implantasyon başarısızlığı da önemli bir sorun olmaktadır (2).

İnfertil hastaların değerlendirilmesinde ve tedavisinde cerrahi tedavi tartışmalıdır. Hastaların değerlendirilmesinde, laparoskopi şu anda rutin olarak kullanılmamaktadır ve her hasta ve klinik durum için ayrı ayrı değerlendirme yapılmalıdır.

1990' lı yıllarda, infertilitede laparoskopi son adım olarak kullanılırken, günümüzde üremeye yardımcı tedavi (ÜYT) yöntemlerindeki gelişme ve tanı sırasında verimli ve uygun maliyetin gözönünde bulundurulması nedeni ile minimal invaziv yöntemler ön plana geçmiştir (3).

İNFERTİL HASTALARDA TUBAL CERRAHİNİN ROLÜ

Tubal nedenler, infertilite vakalarının % 25-35' inden sorumludur (4). Pelvik inflamatuar hastalık, tubal hastalığın en sık nedenidir ve fallop tüpünde multipl tutulum yapabilir (5). Geçirilmiş ektopik gebelik, bilinen endometriozis veya önceki pelvik cerrahi öyküsü de tubal faktör infertilitesi için risk faktörüdür. Herhangi bir risk faktörü olmayan hastalarda, klamidya antikor testi negatif ise tubal patoloji olasılığı %15' den daha azdır (6). Ancak pozitif olduğu durumlarda da, chlamydia pneumoniae immünoglobulin G ile çapraz reaktivite gösterebildiği için, gerçek ve persiste enfeksiyon ayrımı yapılamaz ve enfeksiyonun tubal hasarla sonuçlanıp sonuçlanmadığını göstermez (7).

Hull- Rutherford (2002) sınıflandırmasına göre, infertil kadınlarda tubal hasarın derecesi, hafif, orta ve şiddetli olmak üzere üç kategoriye ayrılır (8). Tanı histerosalpingografi (HSG) veya laparoskopi ile doğrulanır (Şekil 1). HSG obstrüksiyonu gösterdiğinde, tubanın açık olma olasılığı yüksek (yaklaşık %60) iken, HSG tubal açıklık gösterdiğinde tubanın tıkalı olma olasılığı düşüktür (yaklaşık %5). HSG' ye göre genellikle tedaviden bağımsız gebelik oranı, her iki tuba da açık olduğunda en yüksektir (3). Büyük araştır-

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pelvik adezyon oluşumunu artırabileceğini ve yumurtalık rezervini azaltabileceğini bildirdiler (115).

Gözlemsel çalışmalar, CC' ye dirençli PKOS' lu kadınlarda, LOD' in spontan ovulasyon ve gebelik oranlarını, sırasıyla %30' dan %90' a ve %13' den %88' e kadar iyileştirebileceğini göstermiştir (116, 117).

Geniş bir RKÇ' da, PKOS hastalarında LOD sonrası döngü başına %70 ovulasyon oranı, %76 kümülatif konsepsiyon oranı ve %64 canlı doğum oranı bildirilmiştir (118). Diğer bir RKÇ' da, PKOS' lu 87 hastada tek taraflı ve iki taraflı LOD karşılaştırılmış ve her iki grupta da ovulasyon, gebelik ve düşük oranları benzer bulunmuştur. Bu nedenle, tek taraflı LOD, bilateral kadar başarılıdır ve daha az zaman alır (119). Yine bilateral ve unilateral LOD' yi karşılaştıran bir meta-analizde, 6 aylık takipte unilateral LOD olanlarda antral folikül sayısı daha yüksek bulundu (116). LOD başarısını etkileyen faktörlerin araştırıldığı bir çalışmada, hasta yaşı (< 35), BMI ve infertilite süresi (<3 yıl), başarı için önemli öngörücülerdi (120).

İşlem sonrası adezyon riski için yapılan bir RKÇ' da, LOD sonrası, ikinci bakış laparoskopisinde, kadınların % 60' ı ve overlerin % 46' sında adezyon izlenmiştir. Delme sayısından bağımsız olarak, sol overde adezyon riski daha yüksek idi (121). Ayrıca diğer önemli bir endişe olan over rezervine etkisi ile ilgili olarak, PKOS' lu kadınlarda LOD ile ilişkili azalmış yumurtalık rezervi veya erken yumurtalık yetmezliği kanıtı olmadığı bildirilmiştir (122). Ancak LOD' nin AMH ve ovaryan rezerv üzerine etkisini değerlendiren bir metaanalizde, takip süresi, kullanılan AMH kiti ve uygulanan enerji miktarına göre bir alt grup analizi yapılmış ve AMH düzeylerinde istatistiksel olarak anlamlı bir düşüş izlenmiştir. Ancak bunun over rezervinde gerçek bir hasarı mı, yoksa preoperatif zaten yüksek AMH düzeylerinin normale dönmesi mi olduğu açık değildir (123).

Farquhar ve ark. , LOD ve gonadotropinler arasında canlı doğum ve klinik gebelik oranları arasında fark bulmadılar ve OR sırasıyla, 1. 04 (%95 güven aralığı, 0. 59-1. 85) ve 1. 08 (%95 güven aralığı, 0. 69-1. 71) olarak bildirdiler (124). Gonadotropin kullanımına benzer gebelik oranları sağlamanın yanı sıra, LOD, döngünün izlenmesini gerektirmez. Tek bir cerrahi tedavi ile birkaç ovulasyon elde edilebilirken, bir gonadotropin döngüsü tek bir ovulasyon sağlar.

Bazı PCOS' lu kadınlarda tubal faktör, endometriozis gibi infertilite için başka cerrahi endikasyonlar olabilir ve bu durumda laparoskopik cerrahi sırasında eş zamanlı olarak LOD kullanımı iyi bir seçenek olabilir, ancak birinci basamak tedavide kullanımı önerilmez (125).

Sonuç olarak, CC' a dirençli PKOS hastalarında, unifoliküler ovulasyonu sağlamak, çoğul gebelik riskini azaltmak ve tedavi maliyetlerini azaltmak için laparoskopik ovaryan drilling önerilebilir.

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