



# Anormal Uterin Kanamada Histeroskopi

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## Postmenopozal kanama

- Karsinom, atrofi , polip, myom
- Malignite insidansı %1-14 (menopoz süresi, obezite,DM)

## Premenopozal AUK

- **Menoraji**
  - *Artmış kaviter yüzey* : multiparite, myom, polip, adenomyosis
- **Metroraji**
  - **disfonksiyonel, hiperplazi, karsinom, myom, polip**

## Perimenopozal dönem

- Disfonksiyonel: metroraji

# AUK değerlendirme - amaç

Malignite

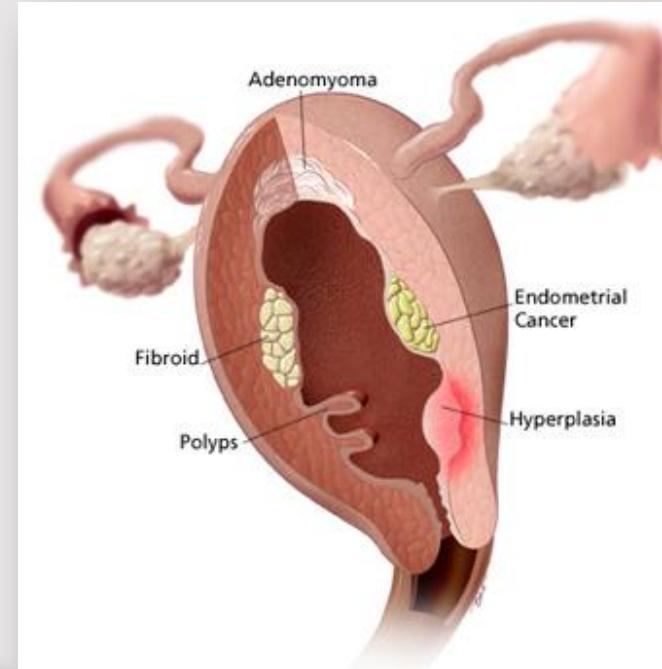
Premalign hiperplazi

Anatomik patolojiler

- Polip, myom, adenomyozis

Anatomik olmayan patolojiler

- Disfonksiyon
- postmenopozal atrofi



# III Asemptomatik - TVUS

## Postmenopozal

- Kanser %5-20 asemptomatik
- Asemptomatik 5 mm : kanser %6.7 (sensitivite %83)
- **Asemptomatik: 5 mm / Sıvı koleksiyonu: 3 mm**

## Premenopozal

- Standart eşik değer yok

## Tedaviler

- HRT
- TMX: Kanser riskinde 1/1000 artış

# PMK - TVUS

PMK- endometrial kalınlık ve kanser – prospektif çalışmalar

Çalışma	End. Kalınlık (mm)	Olgı sayısı	Kanser sayısı	NPD (%)
Ferrazzi, 1996	4 ya da az	930	2	99.8
Ferrazzi, 1996	5 ya da az		4	99.6
Gull, 2000	4 ya da az	163	1	99.4

5 mm

# PMK – TVUS

Smith-Bindman et al. JAMA 1998 Endovaginal ultrasound to exclude endometrial cancer and other endometrial abnormalities.

- TVUS End $<5$  mm, PMK'da ortalama risk :%1
- TVUS end kalınlık arttıkça / kanama tekrarında risk artar

Timmermans et al. Obstet Gynecol 2010 Endometrial thickness measurement for detecting endometrial cancer in women with postmenopausal bleeding: a systematic review and meta-analysis.

- 4 mm : sens % 95
- PMK'da atrofik zeminde gelişen kanser olgularının %4'ü atlanır
- **PMK = invaziv değerlendirme**

## D&C / Pipelle

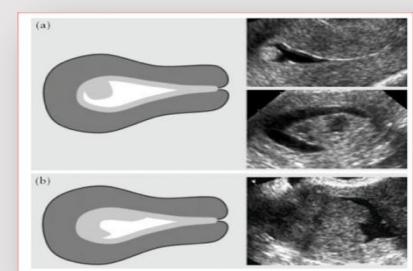
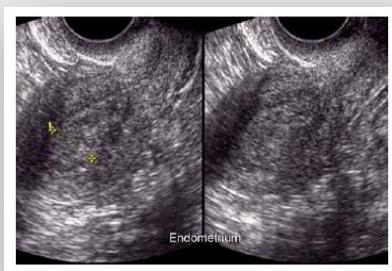
- D&C :%60'nda kavitenin yarıdan azı örneklenir
- Pipelle: endometriumun %4 (0-12)'ü örneklenir
- **Genellikle fokal** ( %50 / %5 )

## Endometrial KANSER

- Pipelle – sensitivite %67 - %83

# III Endometrial patolojilerin tanısında histeroskopi

	Sensitivite	Spesifite
Histeroskopi	%100	%95
TV USG	%85	%84
SIS	%90	%60



# Histeroskopİ

ENDİKASYONLAR	OLGULAR	
	N	%
Sonografik şüphe	1747	50
Metroraji / menoraji	1422	40.7
Patolojik end. biyopsi	54	1.5
Hiperplazi kontrolü	9	0.2
İlaçların end etki kontrolü	5	0.1
Diğer	6	0.1

PATOLOJİLER	N	%
Polip	1223	63
Submuköz myom	263	14
End. adenoca	148	8
Adenomyozis	14	0.7
Piyometra	10	0.5
Trofoblastik Hst	2	0.1

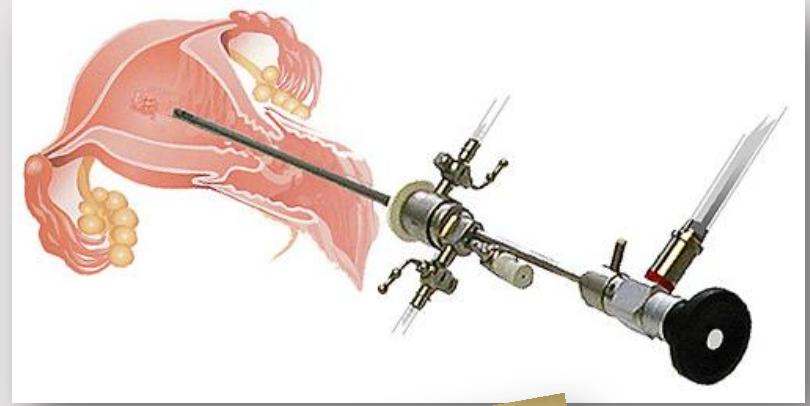
# Histeroskopi - AUK

Diagnostik

- GÖR

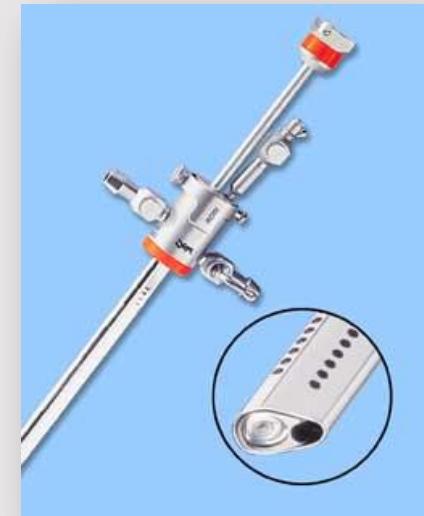
Operatif

- TEDAVİ ET

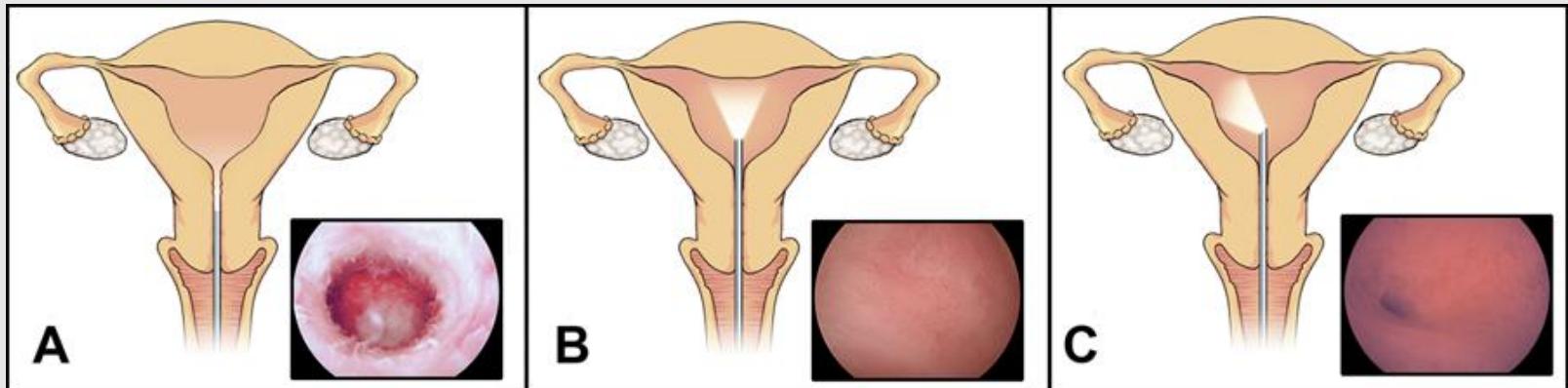


# III Ofis histeroskopi - teknik

- oval şekilli (servikal kanala uyum)



- çapı 4 - 5 mm (internal servikal orifis 5 mm)
- 30 derece açılı teleskop (ağrısız kavite değerlendirme)



# III Ofis histeroskopi

**office continuous flow operative hysteroscope**

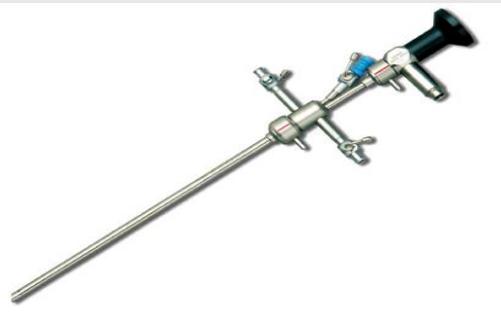
(irrigation - suction kanallı - sabit basınç ve temiz görüntü)

**electronic suction/irrigation pump (endomat) 30-40 mm Hg**

(ağrısız işlem, yeterli görüntü, tubalardan sıvı geçışı olmaması)

**minyatür operatif enstrümanlar, monopolar koter,**

**versapoint**



# III Ofis histeroskopi tekniği

Erken proliferatif faz

Outpatient prosedür

(anestezi, spekulum, tenakulum) (-)

# || Ofis histeroskopi tekniği

\*vajinoskopi

\*endoservikal değerlendirme

\*uterin kavite değerlendirilmesi

(hidrodiseksiyon)

# III Ofis histeroskopı

En önemli sınırlayıcı faktör **ağrı:**

- servikal kanal ve özellikle internal ostium geçisi
- distansiyonda myometrial kontraksiyonlar
- uterin duvara temas

düşük distansiyonla (**no touch**) teknik

'Operatif Girişimde Genel Analjezi  
**tramadol** (contramal) / **paracetamol** (perfalgam)

III

## Review Article

# Hysteroscopy without Anesthesia: Review of Recent Literature

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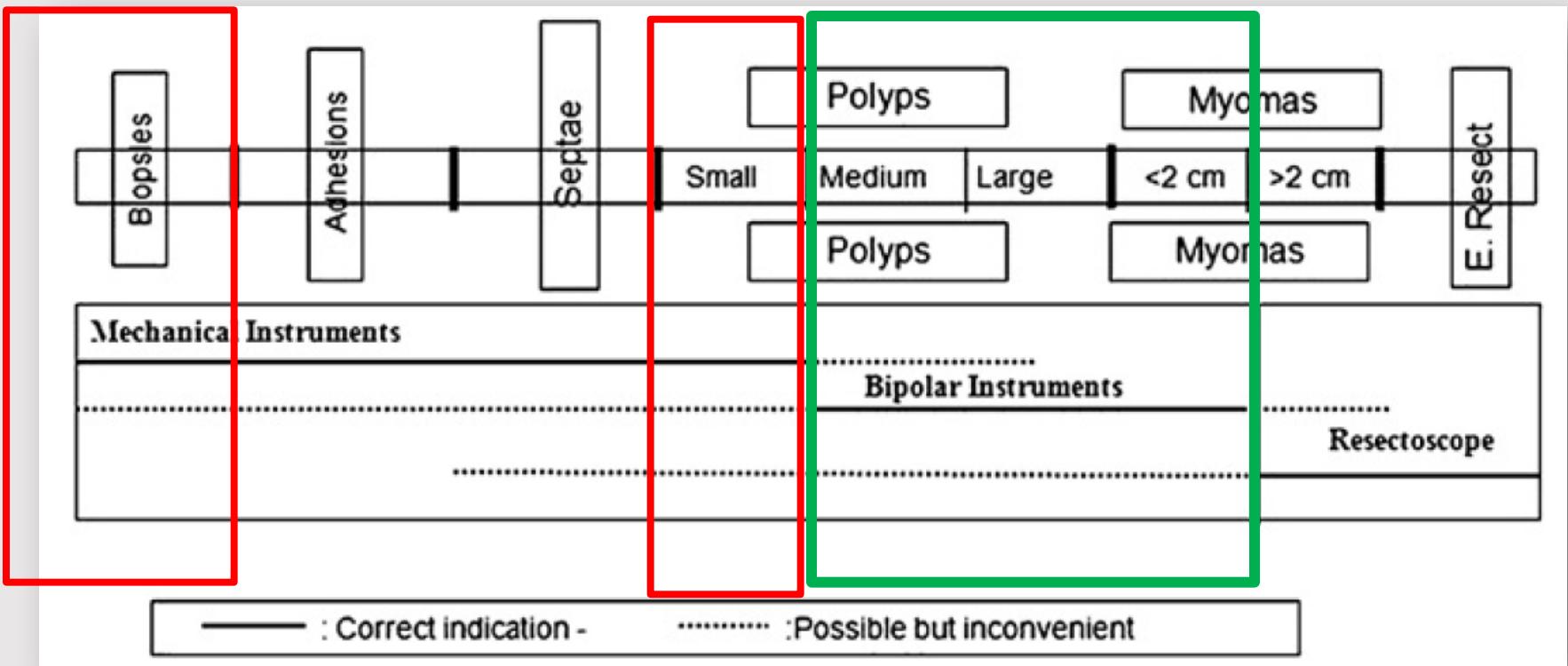
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**ABSTRACT** The need for anesthesia or analgesia for performing hysteroscopy is still matter of debate. Many factors explain the lack of agreement about anesthesia in hysteroscopy depending on the instrumentation, technique employed, need of performing surgical procedure, operator skill and patients' characteristics. Diagnostic minihysteroscopy (3.5 mm or less in size) is less painful and easier to perform than hysteroscopy performed with instruments sized around 5 mm. Thanks to miniaturized instruments, office hysteroscopy allows a growing number of women to be treated in an office setting avoiding the operating room. The main limitation to its widespread use is pain and low patient tolerance. Intrauterine surgical procedures involving only the endometrial mucosa (biopsies, adhesiolysis, cervical and endometrial polypectomies) are not painful. For endometrial polypectomy size of polyps (<2.2m) and duration of the procedure (more than 15 min) are limiting factors. Most literature suggests that office hysteroscopy in experienced hands is a well-tolerated technique and requires the use of analgesics only in selected patients like women with previous caesarean section, history of chronic pelvic pain, anxiety and in menopause.

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# Operatif histeroskopi



# Adenomiyozis

(pencereler, subendometrial kist, hipervasküler odaklar )



National Comprehensive Cancer Network® NCCN Guidelines Version 1.2014 Staging Uterine Neoplasms		
Staging-Endometrial Carcinoma		
<b>Table 4: Lymph Node Metastasis (TNM) and International Federation of Gynecology and Obstetrics (FIGO) Surgical Staging System for Endometrial Carcinoma</b>		
<b>Anatomical Tumor (T)</b>	<b>Surgery-Pathologic Findings</b>	<b>Regional Lymph Nodes (N) TNM Stages</b>
<b>Categories</b>	<b>Stages</b>	<b>Surgeon Pathologic Findings</b>
T0		Regional lymph nodes cannot be assessed
T1		No evidence of primary tumor
T1a		Cervix involved by endometriosis
T1b		Tumor confined to the corpus uteri
T1b1	<b>a</b>	Tumor involves cervical stroma less than or equal to 7 mm in thickness
T1b2	<b>b</b>	Tumor involves cervical stroma greater than 7 mm in thickness
T2		Tumor involves cervical stroma or uterine wall
T2a	<b>a</b>	Tumor involves cervical stroma or uterine wall (direct extension or infiltration)
T2b	<b>b</b>	Tumor involves cervical stroma or uterine wall (involvement of parametria or infiltration of parametria)
T3		Tumor invades myometrium
T3a	<b>a</b>	Assessable to full thickness of myometrium
T3b	<b>b</b>	Assessable to full thickness of myometrium, wider stromal invasion
T4		Tumor invades adjacent organs or extends beyond uterus or is not adherent to directly to bowel or T3
T4a		Used with the permission of the American Joint Committee on Cancer (AJCC), Chicago, Ill. The original source for this information is the AJCC Cancer Staging Manual, 7th edition, published by Springer Science & Business Media, Inc.
T4b		Information and support are available from the AJCC, One Park Ave, Suite 1000, Chicago, IL 60611, telephone 312/699-0300.
		Reprinted from: Paavola, J., Dargent, L., Lepage, A., et al. (2013). [Risk factors for peritoneal dissemination after hysteroscopy in patients with endometrial cancer]. Gynecological Oncology, 127, 105-110, 104. Copyright © 2013, International Federation of Gynecology and Obstetrics.
		Used with the permission of the American Joint Committee on Cancer (AJCC), Chicago, Ill. The original source for this information is the AJCC Cancer Staging Manual, 7th edition, published by Springer Science & Business Media, Inc.
		Information and support are available from the AJCC, One Park Ave, Suite 1000, Chicago, IL 60611, telephone 312/699-0300.
		Reprinted from: Paavola, J., Dargent, L., Lepage, A., et al. (2013). [Risk factors for peritoneal dissemination after hysteroscopy in patients with endometrial cancer]. Gynecological Oncology, 127, 105-110, 104. Copyright © 2013, International Federation of Gynecology and Obstetrics.

# Histeroskopi - AUK

- Int J Gynecol Cancer. 2010 Feb;20(2):261-7.
- **Intraperitoneal dissemination of endometrial cancer cells after hysteroscopy: a systematic review and meta-analysis.**
- Polyzos NP<sup>1</sup>, Mauri D, Tsioras S, Messini CI, Valachis A, Messinis IE.
- **CONCLUSIONS:**
- **Hysteroscopy in patients with endometrial cancer hints a risk for cancer cell dissemination within the peritoneal cavity.** Prospective and sufficiently powered trials are needed to clarify whether the risk of cancer cell spreading is correlated with worse prognosis.

## III Sonuç

- Tr vag US da kavite patolojisi / kanama = histeroskopi
- Polip, myom, end malignite-premalignite, atrofi, adenomyosis, disfonksiyon
- TMX kullanımı sıkılıkla polip
- Postmen asemptomatik end kalınlıkda **cutt off 5 mm**
- **Postmenopozal kanama = İnvaziv değerlendirme**
- Kavitenin % 50 altındaki end patolojide D&C ile tanı %50 den az %5 altında tanı % o
- **Fokal lezyon** tanısı histeroskopi ile konur
- Aynı anda güvenli olarak **tanı ve tedaviye** olanak tanır



