



ADOLESANDA ENDOMETRİOZİS

Doç Dr R Emre OKYAY

Dokuz Eylül Üniversitesi Hastanesi
Kadın Hast. ve Doğum Anabilim Dalı
Üreme Endokrinolojisi, İnfertilite ve Tüp Bebek Merkezi

GİRİŞ / TANIMLAR

ADOLESAN*

10 – 19 yaşlarında ortaya çıkan
çocukluk çağından erişkinliğe
geçiş dönemi



**World Health
Organization**

* *World Health Organization, 2007*

Endometriozis



- Endometrial gland ve stromanın uterusun dışında bulunması
- Reproduktif yaş kadınlarda **% 10**
- **KRONİK, BENİGN** bir hastalık
- **PROGRESYON** ve **REKÜRRENS** eğiliminde
- **KÜR YOK....**

PATOGENEZ ???

ETYOLOJİ ???

**SIKTIR
ANCAK
TANISI ZORDUR**

Delay in the diagnosis of endometriosis: a survey of women from the USA and the UK

The stage of disease did not affect from the USA was 11.73 ± 9.05 years, significantly higher than the equivalent delay of 7.96 ± 7.92 years for women

Table II. Delay in the diagnosis of endometriosis and the relationship with age at diagnosis. Values are means \pm SD. NS = not significant.

Age at diagnosis (years)	Average delay in diagnosis (years)				t-value	P
	UK		USA			
	n	Mean \pm SD	n	Mean \pm SD		
≤ 20	6	4.83 ± 3.37	8	4.38 ± 2.39	0.279	NS

**Endometriozisli erişkin kadınların
yaklaşık 2/3'ünde
endometriozis ilişkili semptomlar
20 yaşından önce başlamaktadır***

* ACOG Committee Opinion, 2005

Length of time from consultation in primary care to referral to secondary care	1-264	36	21-105
Length of time from referral to secondary care to diagnosis	0-84	9	0-12

Questioning patients about their adolescent history can identify markers associated with deep infiltrating endometriosis

Charles Chapron, M.D.,^{a,b,c} Marie-Christine Lafay-Pillet, M.D.,^a Elise Monceau, M.D.,^a
Bruno Borghese, Ph.D.,^{a,b,c} Charlotte Ngô, Ph.D.,^{a,b} Carlos Souza, M.D.,^{a,b} and Dominique de Zeevel, M.D.^a

Endometriotic patients: characteristics according to the existence of DIE lesions.

Group A

Group B

ENDOMETRİOZİS

Sadece erişkin kadınları değil
adolesan dönemi de etkileyen

kronik, rekürrent, progresif bir hastalıktır



Family history of endometriosis	6 (4.6)	13 (13.3)	.02	3.2 (1.2–8.8)
Age at menarche (y)	13 ± 1.5	13 ± 1.6	NS	
Absenteeism from school during menstruation	33 (25.2)	37 (37.7)	.04	1.7 (1–3)
Prescription of OC pills because of severe primary DM	15 (25.8)	29 (36.0)	.001	4.5 (1.5–10.4)
Age (y)	18.1 ± 3.2	16.5 ± 2.4	.07	
Duration of use (y)	5.1 ± 3.8	8.4 ± 4.7	.02	

Note: Data are presented as mean ± SD or n (%). DM = dysmenorrhea; DP = deep dyspareunia; OC = oral contraceptive; NS = not significant; OR = odds ratio; 95% CI = 95% confidence interval.

^a Visual analogue scale.

^b Sometimes more than one for the same patient.

Chapron. Adolescent history and deep endometriosis. Fertil Steril 2011.

PubMed.gov
 US National Library of Medicine
 National Institutes of Health

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Abstract - | Send to -

J Am Med Assoc. 1946 Aug 24;131:1405.
Endometriosis in youth.
 FALLON J.
 PMID: 2094364 [PubMed - OCLMEDLINE]



Am J Obstet Gynecol. 1967 May 1;98(1):116-20.
Endometriosis in young women.
 Hanton EM, Malkasian GD Jr, Dockerty MB, Pratt JH.
 PMID: 6024722 [PubMed - indexed for MEDLINE]



Referans	n (olgu sayısı)	Referans	n (olgu sayısı)
Goldstein, 1980	66	Emmert, 1998	37
Thomas, 1987	17	Harrison, 2000	43
Telimaa, 1987	12	Bai, 2002	39
Vercellini, 1989	18	Abbott, 2004	18
Mahmood, 1990	11	Ventolini, 2005	28
Davies, 1993	36	Stravroulis, 2006	11
Overton, 1994	15	Vicino, 2010	38
Sutton, 1994	24	Roman, 2010	20
Reese, 1997	49	Yang, 2012	63
Laufer, 1997	32	Audebert, 2015	55

PubMed; the keyword "Adolescent endometriosis"*

< 1980: < 10 yayın /yıl
 > 2010: 70'in üzerinde yayın

* Sandogan E, Womens Health, 2015

PREVALANS

Asemptomatik olgular

+

TANI: L/S eksizyon + Histolojik doğrulama

+

Semptomatolojideki farklılıklar

+

Farklı lezyon görünümü

+

Epidemiyolojik çalışmaların azlığı

SONUÇ: PREVALANS VE İNSİDANSI NET BİLİNMEMEKTEDİR



1. Bu dönemde tanı alan olgular tüm endometriozis olgularının yaklaşık %2'lik kısmı
3. Aile öyküsü olmayan olgularda genel endometriozis saptama oranı yaklaşık %2
4. Literatürde sadece 1 çalışmada insidental %10 saptama oranı (Bai ve ark., 2003)

SONUÇ = ASEMPATOMATİK OLGULAR İÇİN DATA YOK

PREVALANS

(SEMPTOMATİK – SEÇİLİ OLGULAR)

The menstrual disorder of teenagers (MDOT) study: determining typical menstrual patterns and menstrual disturbance in a large population-based study of Australian teenagers

MA Parker,^a AE Sneddon,^a P Arbon^b

- DİSMENORE (menstruasyon sırasında ağrı) --- **%70-90**
Şiddetli dismenore --- **%15-60**

Adolesan jinekolojik problemler arasında AĞRI sıklıkla görülen bir problemdir*



* ACOG Committee Opinion, 2009

günlük aktivite kısıtlılığı ---
%15-60

DİSMENORE



Primer

Sekonder

- Pelvik patoloji yok
- Ovulatuvar siklusların başlamasıyla veya
- Menarş sonrası 6-12 ay içinde başlar.
- NSAID ve KOK yanıtı (+)

- Menstruasyondan 1 yıl sonra ortaya çıkan tüm ağrılar
- Pelvik patoloji (+)

Table 1. Causes of secondary dysmenorrhea.

Endometriosis
Congenital obstructive mullerian malformations
Cervical stenosis
Ovarian cysts
Uterine polyps
Uterine leiomyomata
Adenomyosis
Pelvic inflammatory disease
Pelvic adhesions

Expert Opin. Pharmacother. (2012) 13(15):2157-2170

Table 2. Dysmenorrhea-associated symptoms.

Cramps	Genitourinary symptoms
Nausea	Facial blemishes
Vomiting	Flushing
Loss of appetite	Weakness
Headaches	Sleeplessness
Backaches	Dizziness
Leg aches	Depression
Abdominal pain	Irritability
General aching	Nervousness
Dyschezia	Dyspareunia
Diarrhea	

Pelvik Ağrı ve Endometriozis PREVALANS

		n	PREVALANS
Goldenstein ve ark., 1980	Kronik Pelvik Ağrı	140	%47
Emmret ve ark., 1998	Kronik Pelvik Ağrı	105	%35.2
Kontoravdis ve ark., 1999	Kronik Pelvik Ağrı	98	%25

Reese ve ark., 1996 --- NSAİD ve KOK'a yanıt vermeyen

Laufer ve ark., 1997 --- Konvansiyonel tedaviye
yanıt vermeyen

AĞRI %69 -%73

Prevalence of endometriosis diagnosed by laparoscopy in adolescents with dysmenorrhea or chronic pelvic pain: a systematic review

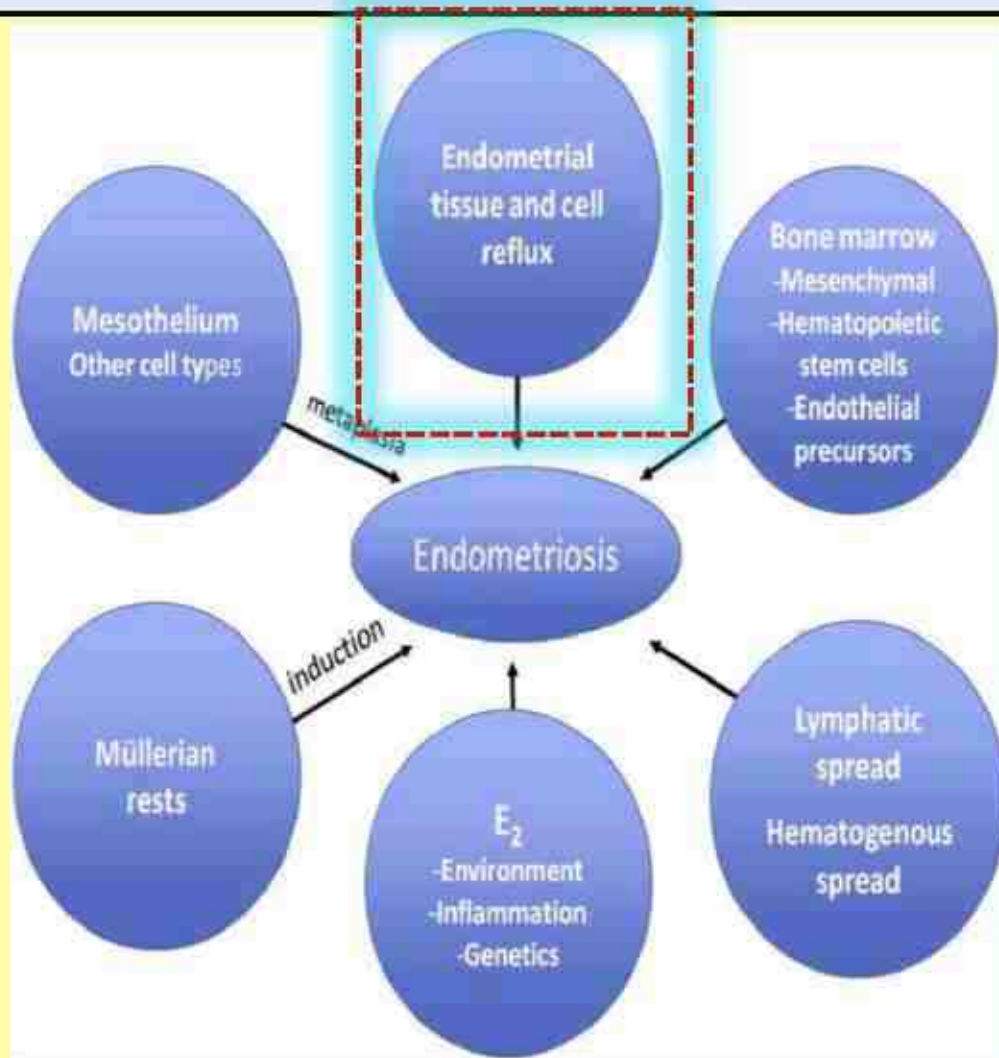
E.B. Janssen^{1†}, A.C.M. Rijkers^{1†}, K. Hoppenbrouwers², C. Meuleman^{1†}, and T.M. D'Hooghe^{1†*}

- **15 makale**
- **880 olgu**
 - **Dismenore**
 - **Kronik pelvik ağrı ve**
 - **Medikal tedavi dirençli kronik pelvik ağrı olguları**
 - **Tümü L/S doğrulanmış endometriozis**

- **Ağrı nedeniyle L/S yapılan adolesanlarda GENEL PREVALANS = %62 (25-100)**
- **Medikal tedavi rezistans kronik pelvik ağrıda PREVALANS = %75**
- **Dismenore olgularında PREVALANS = %70**
- **Kronik pelvik ağrıda PREVALANS = %49**

PATOGENEZ

PATOGENEZ ???



Theories regarding endometriosis pathogenesis.

Burney. Pathogenesis and pathophysiology of endometriosis. Fertil Steril 2012.

Endometriosis in premenarcheal girls who do not have an associated obstructive anomaly

Erica E. Marsh, M.D.^{a,b} and Marc R. Laufer, M.D.^{a,b}

TABLE 1

Visible and pathologic findings on premenarcheal and postmenarcheal laparoscopy.

Subject	Visible lesions	Pathologic findings on premenarcheal laparoscopy	Pathologic findings on postmenarcheal laparoscopy
1	Clear and red lesions of endometriosis	<u>Fibroconnective tissue focally lined by mesothelium with multiple areas of granulation tissue on the surface,</u> possibly representing early adhesions	
2	Clear and red lesions of endometriosis	<u>Mesothelium-lined fibroconnective tissue of peritoneum and fragments of inflamed granulation tissue</u>	Fibrous tissue with focal glandular structures with decidualization, chronic inflammation, and hemosiderin pigment consistent with endometriosis
3	Clear and red lesions of endometriosis	<u>Chronic inflammation</u> with associated vascular proliferation and reactive mesothelial cells	Endometriosis with decidualized stroma
4	Clear and red lesions of endometriosis	Reactive mesothelial hyperplasia and psammomatous calcifications	
5	Clear and red lesions of endometriosis	Multiple focal areas of granulation tissue with lymphocytic infiltrates, no glandular structures identified	

Marsh. Premenarcheal endometriosis. *Fertil Steril* 2005.

The presence of endometriosis before the onset of menarche supports the theory of coelomic metaplasia or the theory of müllerian embryonic rests.

Endometriosis from Thelarche to Midteens: Pathogenesis and Prognosis, Prevention and Pedagogy

Ronald E. Batt, MD, and Mohamed F. M. Mitwally, MD, PhD
 Department of Gynecology-Obstetrics, University at Buffalo, The State University of New York, Buffalo, New York, USA

Relating endometriosis to thelarche has fundamental implications for pathogenesis, early diagnosis, prognosis, treatment, education, and long-term care of adolescents.

Placenta

The perinatal origins of major reproductive disorders in the adolescent: Research avenues

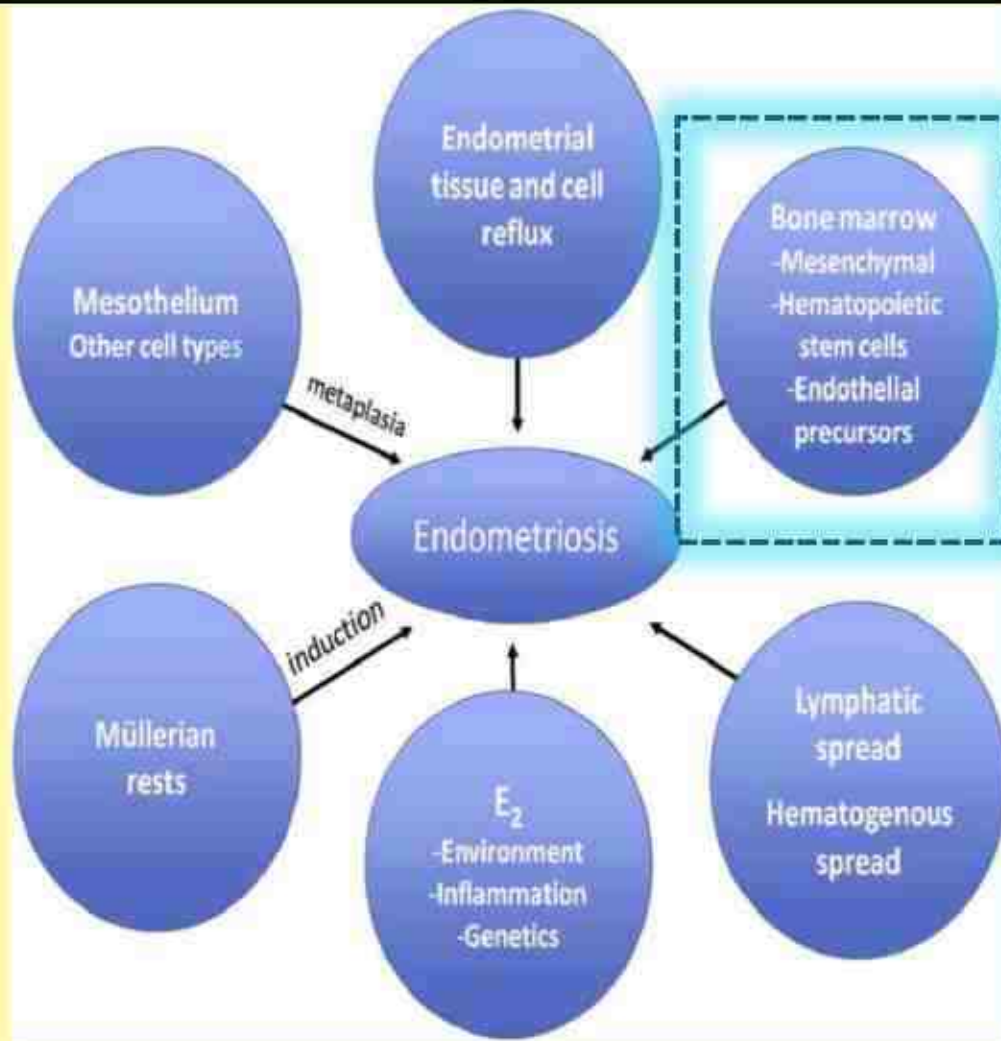
I. Brosens ^{a,*}, A. Ćurčić ^b, T. Vejnović ^b, C.E. Gargett ^{c,d}, J.J. Brosens ^e, G. Benagiano ^f

Data suggesting neonatal origins of adolescent endometriosis.

Date	Finding	Authors [reference]
1955	The endometrium is decidual or menstrual-like in 5% of the newborns.	Ober and Bernstein [5]
1960	Functional cervical obstruction in the neonate favouring tubal reflux at the time of menstrual.	Fluhmann [15]
1960	Functional cervical obstruction in the neonate favouring tubal reflux at the time of menstrual shedding explains 3 days delay of neonatal bleeding.	Fluhmann [15]
1985	Uterine bleeding occurs in 0.1% of preterm newborns.	Berić et al. [6]
2013	ENDO study finds that <i>for unknown reason</i> endometriosis is rare in preterm born women	Wolff et al. [19]
1996	Case report describes neonatal endometriosis.	Arcellana et al.
2005	Case reports of premenarcheal endometriosis	Marsh and Laufer [20]

early-onset endometriosis may be caused by menstruation-like bleeding in the neonate leading to tubal reflux ectopic implantation of endometrial stem/progenitor cells.

PATOGENEZ ???



Theories regarding endometriosis pathogenesis.

Burney. Pathogenesis and pathophysiology of endometriosis. Fertil Steril 2012.

RISK FAKTÖRLERİ

1. OBSTRUKTIF TIP MULLERIAN ANOMALİLER

- Artmış retrograd menstruasyon kaynaklı
- Adolesan endometrioziste konjenital uterin anomali insidansı **%11-40** (Dovey ve Sanfilippo, 2010)
- Konjenital uterin anomali varlığında endometriozis daha erken yaşta başlamakta

Yang ve ark., 2012.; 63 olgu serisi, $16,21 \pm 2.12$ vs $19,04 \pm 1.10$

Adolescent Endometriosis in China: A Retrospective Analysis of 63 Cases

Yunpeng Yang MD¹, Yin Wang MD¹, Jie Yang MD, Shu Wang MD, Jinghe Lang MD^{*1}

Department of Obstetrics and Gynecology, Peking Union Medical College Hospital, Peking Union Medical College, Chinese Academy of Medical Science, Beijing, China

Am J Obstet Gynecol. 1986 Jan;154(1):39-43.

Endometriosis in association with uterine anomaly.

Sanfilippo JS, Wakim NG, Schikler KN, Yussman MA.

Aksi kanıtlar olsa da uterin anomali cerrahisi sonrası endometriozis regrese oluyor gibi gözükmektedir

Case Report

Persistence of Endometriosis after Correction of an Obstructed Reproductive Tract Anomaly

Sharon A. Silveira MD, MS, Marc R. Laufer MD^{*}

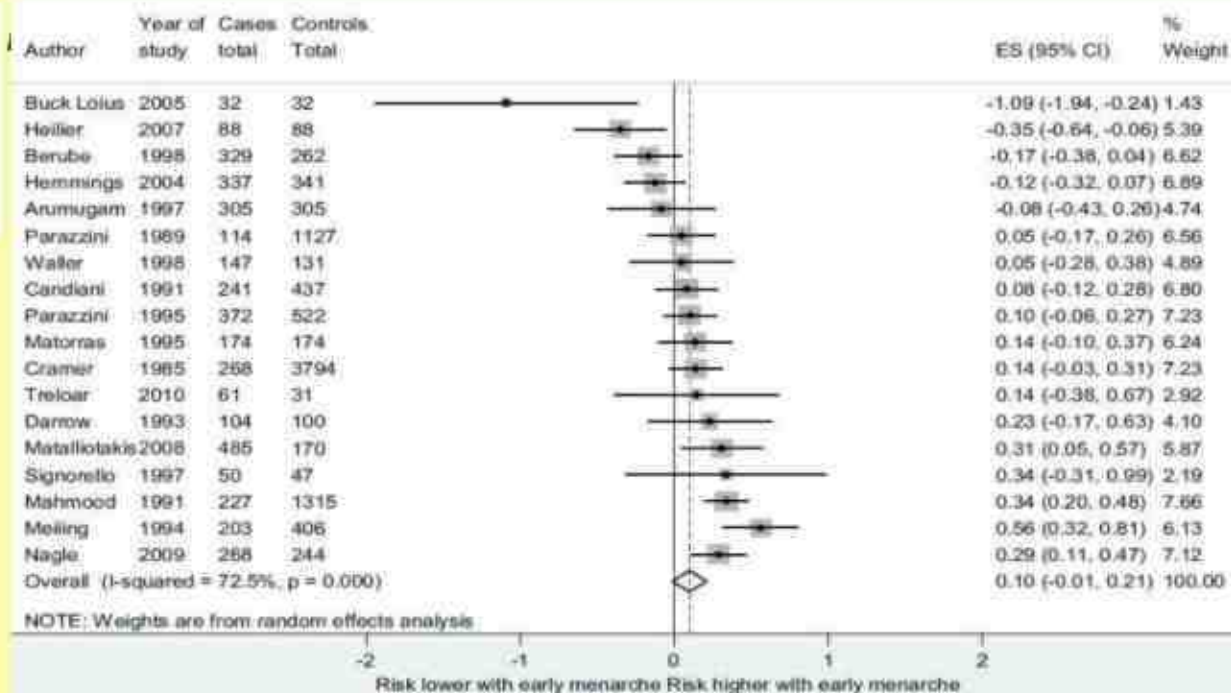
2. MENSTRUASYON KARAKTERİSTİKLERİ

- Erken menarş ve erken başlangıçlı dismenore öyküsü endometriozis için bir risk faktörü olarak öne sürülmüştür

Is early age at menarche a risk factor for endometriosis? A systematic review and meta-analysis of case-control studies

Kandari E, Brubaker M.D.,¹ Freedle Robert M.D.,² James Kurlberg M.D.,³ Bapat R. Kennedy M.B.B.Ch.,⁴ and Ellen F. Zandbergen D.Phil.⁵

Fertility and Sterility® Vol. 98, No. 3, September 2012 0015-0282



GENERAL GYNECOLOGY

Early menstrual characteristics associated with subsequent diagnosis of endometriosis

Susan A. Treloar, PhD; Tanya A. Bell, PhD; Christina M. Nagle, PhD; David M. Purdie, PhD; Adele C. Green, MBBS, PhD

TABLE 2

Association between endometriosis and early menstrual cycle characteristics in cases and matched controls

Characteristics	Cases, ^a n (%)	Controls, ^a n (%)	Adjusted ^b OR (95% CI)	P trend
Age at menarche, y ^c				
<12	61 (23)	31 (13)	1.3 (0.5–3.4)	
12–13	143 (53)	126 (53)	1.0	
≥14	64 (24)	83 (35)	0.3 (0.1–0.6)	.003
Cycle length, d ^d				
≤24	15 (15)	9 (11)	5.0 (0.8–30.6)	
25–29	66 (66)	42 (51)	3.8 (0.8–18.8)	
30–34	15 (15)	22 (27)	1.0 (0.2–5.7)	
≥35	4 (4)	9 (11)	1.0	.008
Length of natural menses, d ^e				
≤4	17 (16)	12 (13)	0.3 (0.03–2.6)	
5–6	55 (51)	53 (58)	1.0	
≥7	35 (33)	27 (29)	1.0 (0.2–5.1)	.48

CI, confidence interval; OR, odds ratio.

^a Numbers may not sum to total, because some data are missing. ^b Adjusted for state of residence. ^c Additionally adjusted for painful menses, days, and heaviness of flow (natural menses); all before symptom onset. ^d Additionally adjusted for variation in menstruation and pelvic pain from menarche, weight at 10 y, and age at menarche. ^e Additionally adjusted for days of flow, painful menses, and variation in menstrual flow.

Treloar. Early menstrual characteristics associated with endometriosis. *Am J Obstet Gynecol* 2010.

TABLE 3

Association between endometriosis and early pelvic pain during menstruation and ovulation and menstrual flow in cases and in matched controls

Characteristics	Cases, ^a n (%)	Controls, ^a n (%)	Adjusted ^b OR (95% CI)	P trend
Dysmenorrhea ^c				
Never/seldom	35 (30)	54 (48)	1.0	
Sometimes	20 (16)	19 (17)	1.7 (0.6–5.1)	
Often	65 (54)	39 (35)	2.6 (1.1–6.2)	.03
Pelvic pain during ovulation ^d				
No	83 (67)	87 (78)	1.0	
Yes	40 (33)	25 (22)	0.9 (0.4–2.0)	
Menstrual flow ^e				
Light	12 (11)	12 (12)	1.0 (0.3–3.9)	
Average	59 (52)	63 (63)	1.0	
Heavy	42 (37)	25 (25)	1.6 (0.6–3.9)	.40

CI, confidence interval; OR, odds ratio.

^a Numbers may not sum to total, because some data are missing. ^b Adjusted for state of residence. ^c Additionally adjusted for age at menarche, cycle length, and pelvic pain during bowel movements. ^d Additionally adjusted for painful menses and pelvic pain during bowel movements, age at menarche. ^e Additionally adjusted for days of flow (natural menses), age at menarche, and regularity of menstrual cycle.

Treloar. Early menstrual characteristics associated with endometriosis. *Am J Obstet Gynecol* 2010.

3. AİLE ÖYKÜSÜ

Human Reproduction, Vol.28, No.8 pp. 2284–2288, 2013

Reproductive prognosis in daughters of women with and without endometriosis

T. Dalsgaard^a, M.V. Hjordt Hansen, D. Hartwell, and Ø. Lidegaard

Table I Prevalence of endometriosis in first-degree relatives of women with endometriosis and in controls reported in previous studies.

Authors (year)	Country	n	Sisters (%)	Mothers (%)	Mothers or sisters (%)	Controls (%)
Simpson et al. (1980)	USA	123	5.8	8.1	6.9	1.0
Lamb et al. (1986)	USA	43	3.8 ^a	6.2 ^a	4.9 ^a	1.9 ^a
Moen and Magnus (1993)	Norway	515	4.8	3.9	4.3 (OR: 7.2)	0.7
Coxhead and Thomas (1993)	UK	64	—	—	9.4	1.6
Kennedy et al. (1998)	UK	29	—	—	14.3	—
dos Reis et al. (1999)	Brazil	81	—	—	8.6	0
Stefansson et al. (2002)	Iceland	750	(RR: 5.2)	—	—	—
Kashima et al. (2004)	Japan	339	8.8 (RR: 5.7)	—	—	1.5
Mataliotakis et al. (2008)	USA	485	5.6 ^b	3.9 ^b	9.5 ^b (OR: 10.2) ^b	1.0 ^b

Table II Prevalence of endometriosis in daughters of mothers with (exposed) and without (non-exposed) endometriosis.

Exposure	Daughters, n	Endometriosis n (%)	Rate ratio (95% CI)
Mother with endometriosis (n = 24 691)	12 389	455 (3.7)	2.12 (1.89–2.37)
Mother without endometriosis (n = 98 764)	52 371	908 (1.7)	

Questioning patients about their adolescent history can identify markers associated with deep infiltrating endometriosis

Charles Chapron, M.D.,^{a,b,c} Marie-Christine Lafay-Pillet, M.D.,^a Elise Monceau, M.D.,^a
Bruno Borghese, Ph.D.,^{a,b,c} Charlotte Ngô, Ph.D.,^{a,d} Carlos Souza, M.D.,^{a,e} and Dominique de Ziegler, M.D.^b

Endometriotic patients: distribution of OR and 95% CI between control and study groups for VAS and age at prescription of oral contraceptive pills for primary dysmenorrhea.

Characteristic	Group A No DIE (n = 131)	Group B DIE (n = 98)	P value	OR 95% CI
Preoperative painful symptoms scores ^a				
VAS >7				
Dysmenorrhea	44 (35.6)	55 (56.1)	.0001	2.8 (1.6–4.6) ^b
Deep dyspareunia	12 (9.2)	20 (20.4)	.015	2.5 (1.2–5.5) ^b
Noncyclic chronic pelvic pain	5 (3.8)	12 (12.2)	.016	3.5 (1.2–10.3) ^b
Gastrointestinal symptoms	6 (4.6)	28 (28.6)	.0001	8.6 (3.4–21.7) ^b
Lower urinary tract symptoms	0 (0)	15 (15.3)	.0001	—
Prescription of OC pills because of severe primary DM				
Age <18 y	8 (6.1)	21 (21.4)	.001	4.2 (1.8–10.0) ^c

4. 18 YAŞIN ALTINDA ŞİDDETLİ PRİMER DİSMEORE NEDENİYLE OKS KULLANIM ÖYKÜSÜ

Big Picture of Endometriosis Helps Provide Guidance on Approach to Teens: Comparative Historical Data Show Endo Starting Younger, Is More Severe

Mary Lou Ballweg, Founder
Endometriosis Association, Milwaukee, Wisconsin

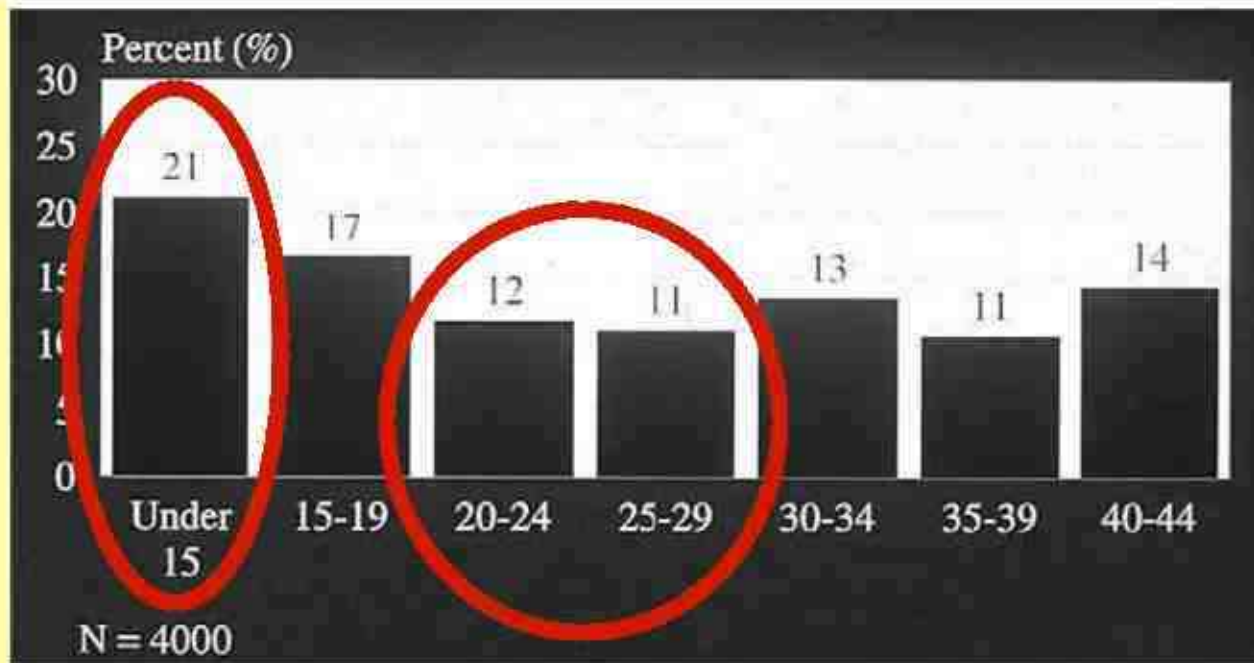


Fig. 2. Percentage reporting pain is **severe** by age at first symptoms.

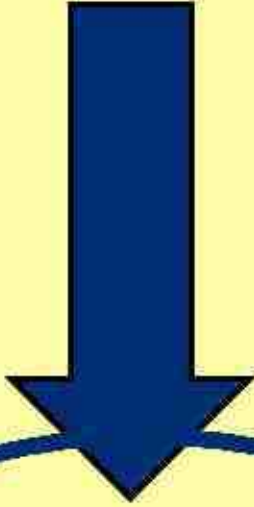
- 14 yaştan geç menarş ↓
- Aile öyküsü ↑
- Erken başlayan dismenore ↑↑
- < 18 yaş ağrı nedeniyle KOK
kullanımı ↑↑↑



KLİNİK
PREZANTASYON
-SEMPTOMATOLOJİ-

SEMPTOMATOLOJİ

Klinik semptom ve bulguları geniş bir dağılım gösterir



AĞRI



İNFERTİLİTE

ADOLESAN ENDOMETRİOZİS

Tanısı ile İlişkili Ana Semptomlar

1. KRONİK PELVİK AĞRI

Erişkinlerden **FARKLI** olarak
(siklik ağrı veya dismenore)

NON-SIKLIK veya **SIKLIK/NON-SIKLIK AĞRI**
ADOLESANLARA

DAHA ÖZGÜ AĞRI TİPIDİR*

*Saridoğan E, Womens Health, 2015

3. AKUT AĞRI

Çalışmalar	n (olgu sayısı)	Endometriozis (%)
Tsikouras, 2007	120	9

Çalışmalar	n (olgu sayısı)	Endometriozis (%)
Elsheikh, 2001	54	22.2
Seckin, 2011	79	11.4

ADOLESAN ENDOMETRIOZIS

Diğer Semptomlar

Complete laparoscopic excision of endometriosis in teenagers: is postoperative hormonal suppression necessary?

Patrick Yeung, Jr., M.D.,^a Ken Sinervo, M.D.,^b Wendy Winer, R.N.,^b and Robert B. Albee, Jr., M.D.^b

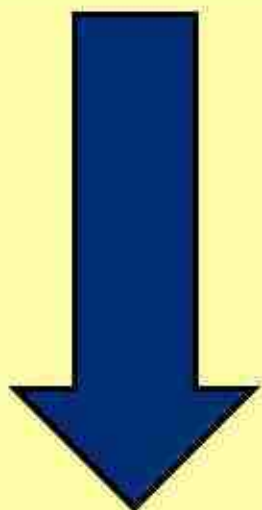
TABLE 1

Percent of teenagers with symptoms before and after complete excision.

Symptom	Before surgery (%)	After surgery (%)
Pelvic pain	76.5	53
Dysmenorrhea	82.4	41.2
Dyspareunia	17.6	5.8
Dyschezia	76.5	17.6
Constipation	41.2	5.8
Tender exam	52.9	0
Painful exercise	70.6	5.8
Intestinal cramping	58.8	5.8
Bladder pain	52.9	11.8

Yeung. Complete laparoscopic excision of endometriosis in teenagers. Fertil Steril 2011.

SEMPTOMATOLOJİ



AĞRI



İNFERTİLİTE



Long-Term Fertility After Laparoscopy for Endometriosis-Associated Pelvic Pain in Young Adult Women

Brittaney M. Wilson-Harris, MD, Benjamin Nutter, MS, and Tommaso Falcone, MD*

Table 1

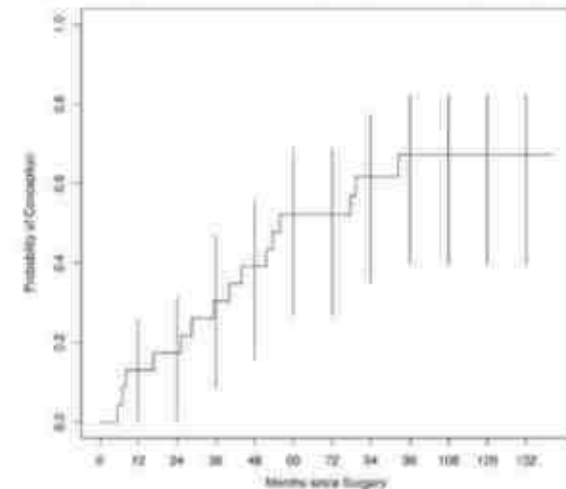
Patient demographic data (1 record per woman)^a

Variable	Non-assisted pregnancy (n = 23)	Assisted pregnancy (n = 5)	p value
Had at least 1 pregnancy			>.99 ^b
No	3 (35)	0	
Yes	20 (65)	5 (100)	
Median No. of pregnancies a patient had	2 (1-3)	2 (1-2)	.58 ^c
Pregnancy resulted in a live birth			.61 ^b
No	6 (26)	2 (40)	
Yes	17 (74)	3 (60)	
Median No. of live births	1 (0.5-2)	1 (0-1)	.38 ^c
Age at surgery, yr	23 (22-24.5)	24 (24-24)	.27 ^c
Disease stage			.46 ^b
I/II	21 (91)	4 (80)	
III/IV	2 (9)	1 (20)	

In conclusion, this retrospective case series of young women undergoing laparoscopic surgery to treat endometriosis-associated pelvic pain at the Cleveland Clinic demonstrated a long-term pregnancy rate of 71.4% of which >80% were achieved without ART. Although this is encouraging for both patients and providers, prospective studies in this area are warranted.

Fig. 1

Kaplan-Meier curve for time to pregnancy after laparoscopy. Probability of conception without assisted reproductive technology after laparoscopic surgery to treat endometriosis-associated pelvic pain is shown. Not all patients were actively trying to conceive during the entire follow-up period.



No. at risk	23	21	20	17	16	12	12	8	7	4	4	2
No. of pregnancy events	0	3	4	7	8	12	12	14	15	15	15	15

KLİNİK
PREZANTASYON

- EVRE -

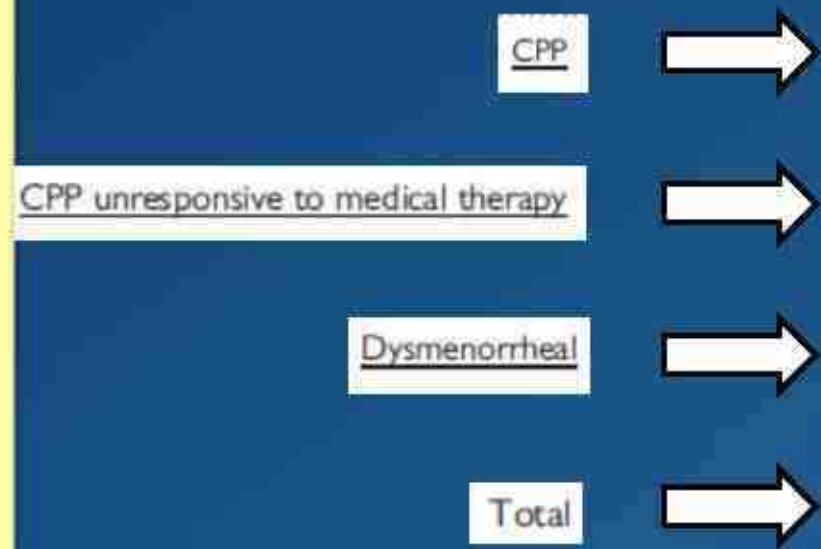
	Nr	Age range	Staging	I (%)	II (%)	III (%)	IV (%)
Goldstein <i>et al.</i> (1980)	66	10–19	K ^a	58	38	0	4
Vercellini <i>et al.</i> (1989)	18	11–19	r-AFS	67	33	0	0
Davies <i>et al.</i> (1993)	36	13–20	r-AFS	28	22	19	31
Reese <i>et al.</i> (1997)	49	11–19	r-AFS	80	12	6	2
Laufer <i>et al.</i> (1997)	32	13–21	r-AFS	77	23	0	0
Emmert <i>et al.</i> (1998)	37	11–19	M ^b	92	8	0	0
Bai <i>et al.</i> (2002)	39	14–21	r-AFS	10	44	28	18
Ventolini <i>et al.</i> (2005)	28	12–18	r-AFS	14	39	43	4
Stavroulis <i>et al.</i> (2006)	11	13–20	r-AFS	45 ^c		55 ^d	
Vicino <i>et al.</i> (2010)	38	15–21	r-AFS	18	13	34	34
Roman (2010)	20	14–20	r-AFS	40	45	5	10
Yang <i>et al.</i> (2012)	63	12–20	r-AFS	8	3	52	37

Brosens *et al.* **Human Reproduction**, Vol.28, No.8 pp. 2026–2031, 2013

Erken çalışmalar adolesan endometrioziste hafif hastalığı göstermekte iken son yıllarda yüksek oranda orta-şiddetli hastalık belirtilmiştir.....

Prevalence of endometriosis diagnosed by laparoscopy in adolescents with dysmenorrhea or chronic pelvic pain: a systematic review

E.B. Janssen^{1†}, A.C.M. Rijkers^{1†}, K. Hoppenbrouwers², C. Meuleman^{1‡}, and T.M. D'Hooghe^{1‡*}



Classification [n patients/total rAFS (%)]				
	I	II	III	IV
CPP	11/77 (14%)	22/77 (29%)	24/77 (31%)	20/77 (26%)
CPP unresponsive to medical therapy	134/ 198 (68%)	24/108 (22%)	15/108 (14%)	2/108 (2%)
Dysmenorrheal	30/74 (41%)	23/74 (31%)	8/74 (11%)	13/74 (18%)
Total	175/ 349 (50%)	69/259 (27%)	47/259 (18%)	35/259 (14%)

KLİNİK
PREZANTASYON
- LEZYON -

Peritoneal Endometriosis

TİPİK LEZYONLAR



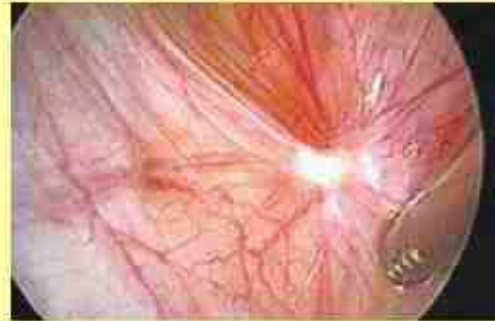
SIYAH



MAVİ



A. Typical black lesions amongst red lesions



ATİPİK (SUBTLE) LEZYONLAR*

KIRMIZI
LEZYONLAR

BEYAZ
LEZYONLAR

"CLEAR"
LEZYONLAR

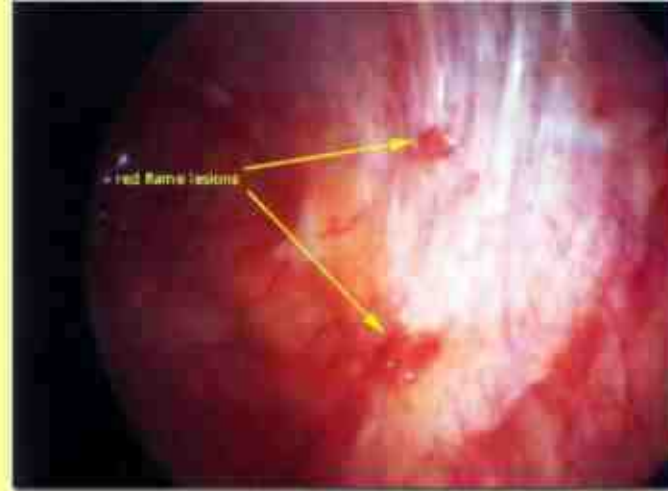


Table 2. The Presence and Appearance of Lesions Consistent With Endometriosis in a Series of Adolescents Presenting With Chronic Pelvic Pain

Lesion Type	Percent
Clear	76
Red	84
White	44
Black	22
Peritoneal pockets	18

1. Adolesanlarda lezyonlar erişkinden farklı görünümde dir
2. ATİPİK "CLEAR" VEZİKÜLER VE "RED FLAME" LEZYONLAR çok daha sık olarak görülür
3. KIRMIZI LEZYONLAR ----- ERKEN ENDOMETRİOZİS
4. AKTİF, AĞRI İLE İLGİLİ LEZYONLAR

ADOLESANDA ENDOMETRIOMA

Endometriomas in Adolescents and Young Women

Şebnem Özyer MD*, Özlem Uzunlar MD, Nagihan Özcan MD, Hüseyin Yeşilyurt MD, Rana Karayalçın MD, Ayla Sargın MD, Leyla Mollamahmutoglu MD

Clinical Characteristics of Adolescent Endometrioma *J Pediatr Adolesc Gynecol 26 (2013) 117–119*

Dong-Yun Lee MD, PhD, Hyo Jeong Kim MD, Byung-Koo Yoon MD, PhD, DooSeok Choi MD, PhD*

Clinical Characteristics of Endometrioma According to Age

Characteristics*	Group 1 (n = 35)	Group 2 (n = 176)	Group 3 (n = 135)	Group 4 (n = 30)
Site, n (%)				
Left	11 (31)	66 (37)	42 (31)	12 (40)
Right	7 (20)	49 (28)	40 (30)	11 (37)
Bilateral	17 (49)	61 (35)	53 (39)	7 (23)
Coexisting gynecologic problems, n (%) [†]				
None	35 (100)	151 (86)	93 (69)	16 (53)
Myoma or adenomyosis	0	25 (14)	42 (31)	14 (47)
Stage, n (%) [‡]				
III	17 (49)	100 (57)	78 (58)	16 (53)
IV	18 (51)	76 (43)	57 (42)	14 (47)
Type of lesions, n (%)				
Peritoneal endometriosis	26 (74)	134 (76)	93 (69)	24 (80)
Posterior cul-de-sac obliteration	20 (57)	90 (51)	63 (44)	19 (63)
Tubal or ovarian adhesion	11 (31)	56 (32)	34 (25)	11 (37)
Deep endometriosis	0	0	0	0
CA-125, IU/L	99.2 ± 194.9	115.1 ± 443.4	55.3 ± 53.9	69.7 ± 67.2
Size, cm	6.1 ± 2.6	6.3 ± 3.1	5.9 ± 2.6	6.1 ± 1.8

* Group 1, aged ≤20 years; group 2, aged 21–30 years; group 3, aged 31–40 years; group 4, aged 41–45 years.

TANI

1. ÖYKÜ : - Semptomların varlığı

MEDİKAL TEDAVİYE REZİSTANS
AĞRI

2. VAJİNAL MUAYENE / REKTAL MUAYENE

(Seksüel aktivite ?)

- Mobilitesi az retrovert uterus
- Hassas RV – US nodularite

3. USG

- Endometrioma güveniir**
- Yüzeyel periyoneal hastalıkta yeri yok**

NORMAL UTRASON MUAYENESİ ENDOMETRİOZİSİ EKARTE ETTİRMEZ

L / S TANIDA GOLD STANDARTTIR

KLİNİK SEYİR
PROGRESYON ???

Değerlendirmek zor.....

- i. L/S nin major klinik neden olmaksızın second-look yapılması açısından hala yeterince invaziv olması
- ii. 2. L/S bulguları = Adezyon ? vs Progresyon ?
- iii. Atipik peritoneal lezyonlar

Progression of Endometriosis in Non-medically Managed Adolescents: A Case Series

Cecile A. Unger MD, MPH/Marc R. L  ufer MD*

Questioning patients about their adolescent history can identify markers associated with deep infiltrating endometriosis

Endometriosis in adolescents is a hidden, progressive and severe disease that deserves attention, not just compassion

I. Brosens^{1,*}, S. Gordts¹, and G. Benagiano²

Absenteeism from school during menstruation	33 (25.2)	37 (37.7)	.04	1.7 (1–3)
Prescription of OC pills because of severe primary DM	15 (25.9)	29 (58.0)	.001	4.5 (1.9–10.4)
Age (y)	18.1 ± 3.2	16.5 ± 2.4	.07	
Duration of use (y)	5.1 ± 3.8	8.4 ± 4.7	.02	

Chapron. Adolescent history and deep endometriosis. Fertil Steril 2011.



1. Derin infiltratif ve/veya ileri evre endometriozisin k  kleri adolesan d  neme dayanır
2. Adolesan d  nemde bařlayan endometriozis uzun zaman s  resince derin infiltratif ve/veya ileri evreye progresyona uęrar

Is adolescent endometriosis a progressive disease that needs to be diagnosed and treated?

J.L.H. (Hans) Evers

Editor-in-Chief

Table: Natural course of disease between first and second look laparoscopy in untreated patients.

Reference	n patients	Regression	Stable	Progression
Thomas, 1987	17	9	0	8
Telimaa, 1987	12	1	8	3
Mahmood, 1990	11	3	1	7
Overton, 1994	15	8	3	4
Sutton, 1994	24	7	10	7
Harrison, 2000	43	27	12	4
Abbott, 2004	18	4	6	8
TOTAL	140	59 (42%)	40 (29%)	41 (29%)



İLERİ EVRE / DIE ENDOMETRİOZİS ADOLESANDA BAŞLAYAN VE

PROGRESYON SONUCU ORTAYA ÇIKAN BİR HASTALIK İSE :

- 1.ADOLESAN DÖNEMDE İLERİ EVRE HASTALIĞI PREDİKTE EDEBİLİR MİYİZ ?
- 2.ADOLESANLARI TARAMALI MIYIZ ?
- 3.ADOLESAN TANI ŞÜPHE (+) İSE AGRESİF TEDAVİ İLE ERİŞKİN İLERİ EVRE HASTALIĞI ÖNLEYEBİLİR MİYİZ ?

1.

PREDİKTİF BELİRTEÇLER

- **Non-invaziv diagnostik test yok**
- **Bu nedenle semptomatoloji endometriozis prediksiyonunda öne sürülen belirteçtir**

Markers of Adult Endometriosis Detectable in Adolescence

Charles Chapron MD ^{1,2}, Bruno Borghese MD, PhD ^{1,2}, Isabelle Streuli MD ^{1,2}, Dominique de Ziegler MD ^{1,*}

¹ Université Paris Descartes—Assistance Publique Hôpitaux de Paris, CHU Cochin, Dept of Ob Gyn and Reproductive Medicine, Paris, France

² Cochin Institute, CNRS UMR 8104, ISERM U1016, Paris, France

Markers at Adolescence Associated with the Development of Endometriosis

Family history of endometriosis (especially in first-degree relatives)

Primary severe dysmenorrhea

Absenteeism from school at time of menses

Dysmenorrhea resistant to nonsteroidal anti-inflammatory drug treatment

Noncontraceptive use of oral contraceptives for dysmenorrhea

C. Chapron et al. / J Pediatr Adolesc Gynecol 24 (2011) S7–S12

2. TARAMA

- SEMPTOM BAZLI TARAMA

Human Reproduction, Vol.25, No.8 pp. 1863–1868, 2010

Advanced Access publication on June 2, 2010 doi:10.1093/humrep/deq141

human
reproduction

OPINION

Non-invasive diagnosis of endometriosis: the goal or own goal?

Edgardo Somigliana^{1,2}, Paolo Vercellini^{1,2,3}, Paola Vigano^{1,2,*},
Laura Benaglia^{1,3}, Pier Giorgio Crosignani⁴, and Luigi Fedele^{1,3}

non-invasive test is for
the diagnosis of endometriosis should remain indicated (and used)
in the only two groups of women who may benefit from the diagnosis:
those with unexplained subfertility and those with unexplained severe
pelvic pain refractory to oral contraceptives and NSAIDs.

PELVİK AĞRI İÇİN TANI/TARAMADA ADOLESANA SORULACAK SORULAR

1. Menstrual Öykü

Menstrual history

a) When did you have your first period (year) and how old were you?

i) <12 years ii) 12–14 years iii) >14 years

Other symptoms/complaints and diseases

a) Pain on defecation?

If yes: Location? Associated menstruation?

b) Pain during sex (if sexually active)?

c) History of benign ovarian cysts?

Family history

a) Family members (maternal and paternal side) with:

i) Diagnosed endometriosis?

ii) Pelvic pain/pain during menstruation?

iii) Problems getting pregnant/involuntary childlessness?

2. Ağrı Öyküsü

Pain anamnesis

- | | |
|--|--|
| a) When did you first experience the pain? | (Age, year) |
| b) When does the pain come? | Cyclic (during menstruation) or non-cyclic? |
| c) Where is the pain? | Symmetrical or unilateral?
Radiation? |
| d) Quality and characteristics of pain? | Intensity (Grade between 0 and 10)? |
| e) How long does the pain last? | |
| f) Does anything make the pain better? | Paracetamol, Ibox, non-steroidal anti-inflammatory drugs (e.g. Naproxen) etc.? |
| g) Does anything make the pain worse? | Movement, exercise? |
| h) Does the pain affect your daily living? | Participation in school, sports, social events? |
| i) How does the pain make you feel? | Disadvantaged compared with others at the same age?
Affecting your quality of life? |

3. TEDAVİ

ENDOMETRIOSIS AWARENESS



MEDİKAL



CERRAHİ



KOMBİNE



YUT

If you cry, I will wipe
away your tears.
If you stumble, I will help
you stand.
If you feel like you're
alone, I will remind you
that we have felt the
same pain x



PRİMER AMAÇ



Endometriotik implantların azaltılması veya çıkarılması



Normal anatominin restorasyonu



Progresyonun engellenmesi



Semptomların giderilmesi

MEDİKAL TEDAVİ

1. NSAİD

2. HORMONAL TEDAVİ

NSAİİ

Drug	Dosage
Ibuprofen	800 mg initially, followed by 400 - 800 mg every 8 h as needed
Naproxen sodium	440 - 550 mg initially, followed by 220 - 550 mg every 12 h as needed
Mefenamic acid	500 mg initially, followed by 250 mg every 6 h as needed
Celecoxib ^(w,†) ?	400 mg initially, followed by 200 mg every 12 h as needed

*For girls > 18 years.
†Cyclooxygenase-2 specific inhibitor.
h: Hours; NSAIDs: Nonsteroidal anti-inflammatory drugs.

NSAI ilaçlar arasında birinin diğerine üstünlüğü yoktur

AĞRI TEDAVİSİNDE HORMONAL TEDAVİ

BİLİNEN ETKİLER

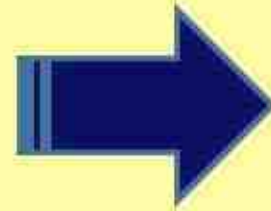
- Ovaryan supresyon
- Menstruasyonun azaltılması
- EM'ü inceltir
- EM'ü desidualize eder ↓
ATROFİ

OLASI ETKİLER

- CNS aktivitesini değiştirir
- Ağrı algılamada değişiklik
- Kan akımında ↓

AMPİRİK MEDİKAL TEDAVİ VERİLEBİLİR Mİ?

1. Endometriozis şüphesi
olmalı
2. Başka cerrahi endikasyon
olmamalı
3. Ağrı şikayeti olmalı



**AMPİRİK
MEDİKAL
TEDAVİ**

*** AMPİRİK TEDAVİYE AĞRI YANITININ ALINMASI
ENDOMETRİOZİS TANISINI KOYDURMAZ !!!**

HORMONAL TEDAVİ



**Primer dismenore ve
adolesan endometriozis-
ilişkili ağrıda
3 AYLIK NSAİ +/- KOK
tedavisi 1. basamaktır...**

Table 1. Options for menstrual suppression^a

Medication	Dosing	Frequency
Progestin-containing intrauterine system	LNG release 20 µg/d	5 years
Depot medroxyprogesterone acetate	150 mg intramuscularly; 104 mg subcutaneously	Every 12 weeks
COCs	Multiple formulations; monophasic formulations; discarding placebo pills or dedicated packaging for extended cycle	Daily
Oral progestins	Varies by progestin, e.g., norethindrone acetate 5 mg twice daily to three times daily; medroxyprogesterone acetate; megestrol	Daily
GnRh analogs	Formulation-dependent: intramuscular, subdermal implants, intranasal	Formulation- dependent: daily or more, to every 12 weeks

KOK

- E eşik değer hipotezi
- Siklik – sürekli – uzamış kullanım
- Siklik yanıt yok ise sürekli kullanıma geçilir
- 24/4 rejim ağrı için daha etkili olabilir*

Long-term oral contraceptive pills and postoperative pain management after laparoscopic excision of ovarian endometrioma: a randomized controlled trial

Renato Scavelloni, M.D., Mohamed Mahomed, M.D., Clarissa Francis, M.D., Linda Monezi, M.D., Luca Savelli, M.D., and Stefano Venturoli, M.D.

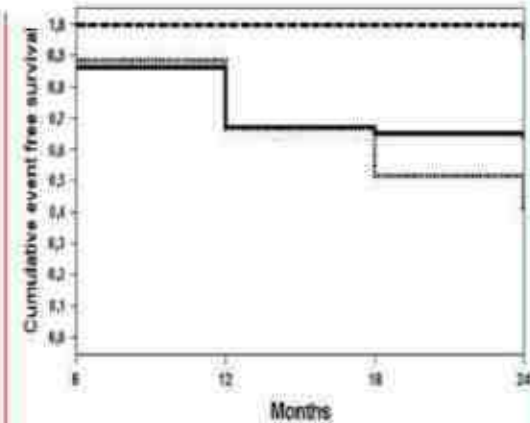
FERTILITY AND STERILITY®
VOL. 80, NO. 3, SEPTEMBER 2003
Copyright ©2003 American Society for Reproductive Medicine
Published by Elsevier Inc.
Printed on acid-free paper in U.S.A.

Continuous use of an oral contraceptive for endometriosis-associated recurrent dysmenorrhea that does not respond to a cyclic pill regimen

Paolo Vercellini, M.D., Giada Frontino, M.D., Olga De Giorgi, M.D., Giuliana Pietropaoli, M.D., Roberta Pisan, M.D., and Pier Giorgio Crosignani, M.D.

FIGURE 3

Cumulative pain-free survival in nonusers (....), cyclic users (—), and continuous users (- - -).



Scavelloni. OC in painful endometriosis recurrence. Fertil Steril 2011.

Week beginning DD / MM / YY	Are you on your period?	Describe your pain* and where it is	How does it feel** and how long does it last? e.g. 3 hours	Do you have any other symptoms? e.g. bloating, bleeding, bowel or urinary problems	Did you take or do anything to help with the pain or symptoms? If so, what did it help?	What affect did it have on you?***
Mon						
Tues						
Wed						
Thurs						
Fri						
Sat						
Sun						

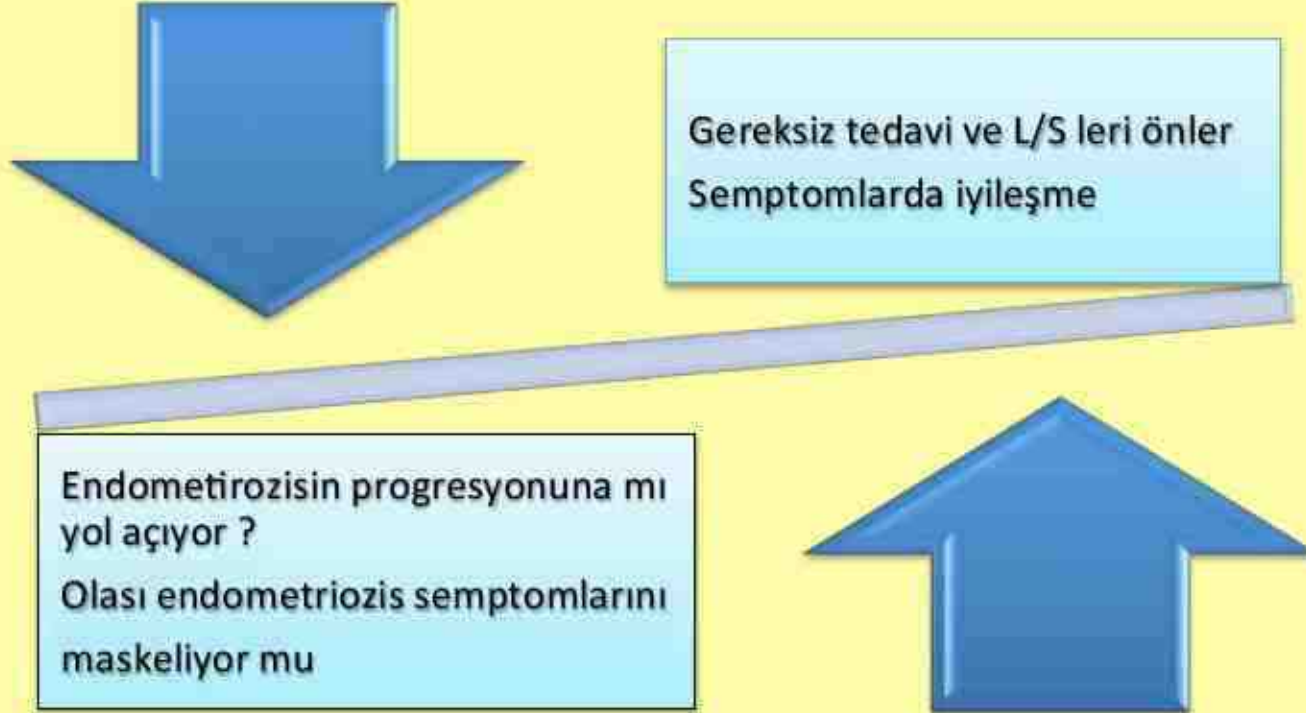
*: Please rate your pain on a scale of 1-10. Where 1 = tolerable and 10 = the worst pain imaginable

** Please use the words listed on question 6 under "pain", or add your own.

*** Please state whether these symptoms affected your work, education, relationships, social activities, sleep, exercise, food intake, sex life, stress levels, quality of life that day

- 3 AYLIK DÖNEMDE TEDAVİ MONİTORİZASYONU ve AĞRI GÜNLÜĞÜ TUTULMASI ÖNERİLMEKTEDİR.....
- Semptomatik iyileşme olması endometriozis tanısını ekarte ettirmez...

Ampirik NSAI/KOK TEDAVİSİ



**UZUN DÖNEM FAYDA / POTANSİYEL DEZAVANTAJLAR
AÇISINDAN RKÇ'LARA ÇOK CİDDİ İHTİYAÇ VAR....**

PROGESTİNLER

ORAL FORM

- Noretindron Asetat 15 mg/gün
(Primolut-N 5 mg x3)

- Günlük ilaç alımı
- Yan etki profili



Uzun süreli kullanımda adolesanlarda uyumluluğu düşük

- “Add-back” uygulamada ilk seçenek (FDA)
- Erişkin gözlemsel çalışmalar ağrıda %70-100 azalma

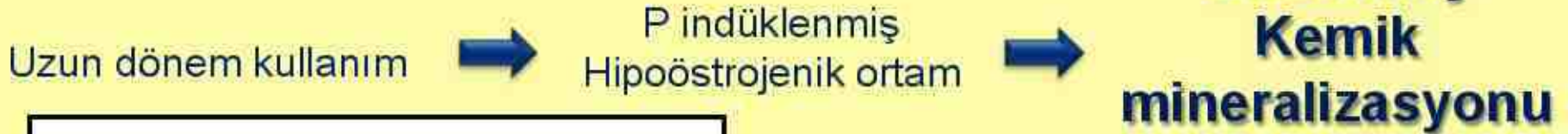
* Aitshuler and Hillard, *Curr Opin Obstet Gynecol*, 2014

** Vercellini ve ark., *Obstet Gynecol.*, 1997.

PROGESTİNLER

DEPO MPA

- Depo Provera 150 mg IM veya Depo sub-Q Provera 104 mg s.c.
3 aylık uygulama
- Adolesan grup için kompliansı yüksek. ANCAK;



KASIM 2004, FDA, "BLACK BOX"

Women who use Depo-Provera Contraceptive Injection may lose significant bone mineral density. Bone loss is greater with increasing duration of use and may not be completely reversible.

It is unknown if use of Depo-Provera Contraceptive Injection during adolescence or early adulthood, a critical period of bone accretion, will reduce peak bone mass and increase the risk of osteoporotic fracture in later life.

Depo-Provera Contraceptive Injection should be used as a long-term birth control method (eg, longer than 2 years) only if other birth control methods are inadequate (see WARNINGS).

PROGESTİNLER

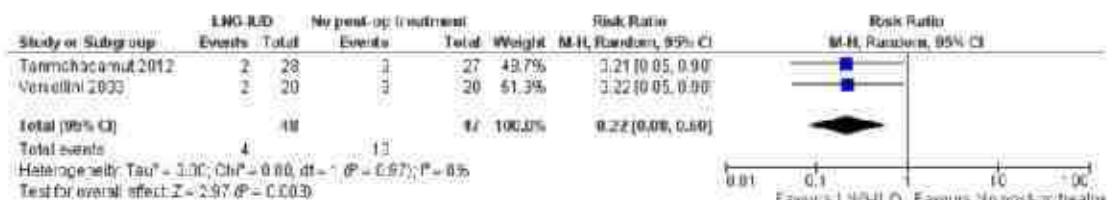
LNG-RIA (MIRENA)

- 20 mcg/gün LNG salınımı, 5 yıl.

Levonorgestrel-releasing intrauterine device (LNG-IUD) for symptomatic endometriosis following surgery (Review)

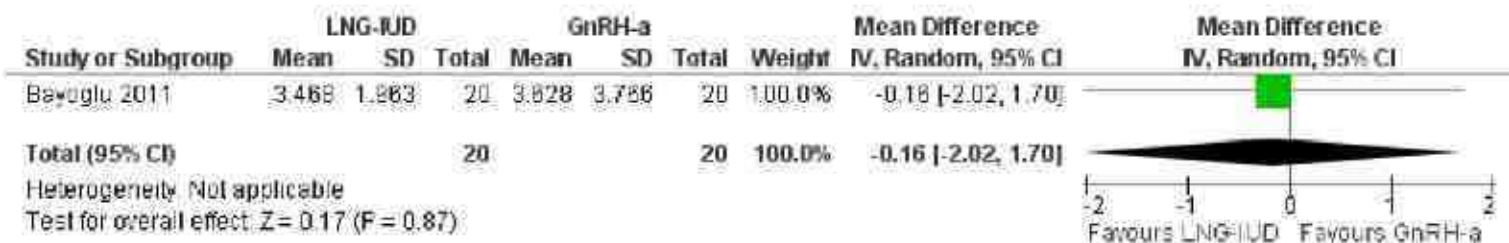
Abou-Setta AM, Houston B, Al-Inany HG, Tarquhar C

Figure 1. Forest plot of comparison 1 Postoperative use of LNG-IUD compared with expectant management in women with endometriosis, outcome 1.1: painful symptoms.



2013, Issue 1

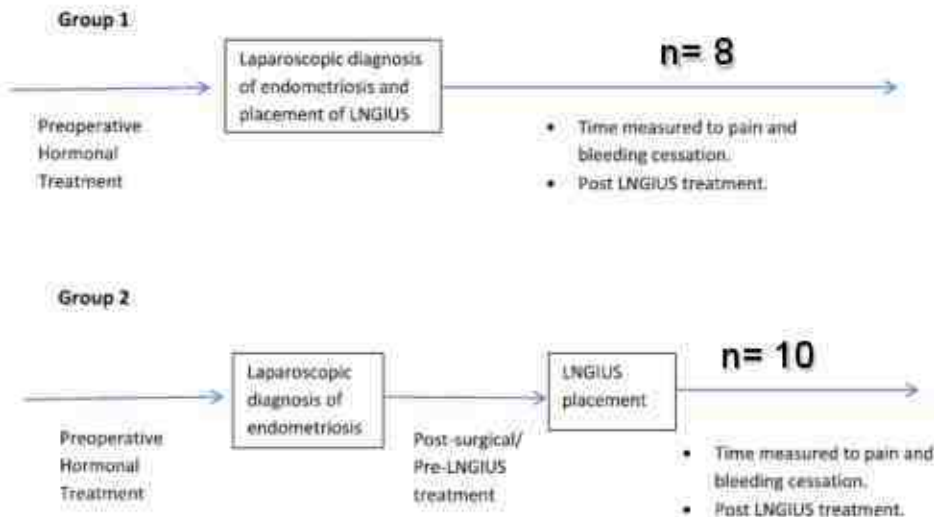
Figure 5. Forest plot of comparison: 2 Postoperative use of LNG-IUD compared with GnRH analogue in women with endometriosis, outcome: 2.1 Painful symptoms.



PROGESTINLER

LNG-RIA (MIRENA)

Use of the Levonorgestrel Intrauterine System in Adolescents with Endometriosis



Conclusion

There is a paucity of data regarding the use of the LNG-IUS in adolescent for the specific treatment of endometriosis. Our results indicate that the LNG-IUS plays a role in decreasing the time to pain and bleeding cessation. A prospective study with standardized measurements is needed to further assess these outcomes.

PROGESTİNLER

LNG-RIA (MIRENA)

- Adolesan için yeterli data yok
- 1. basamak ampirik tedavi için uygun olmayabilir. ANCAK;
- Seksuel aktif, geç adolesan grupta kabul edilebilir bir tedavi seçeneđi olabilir

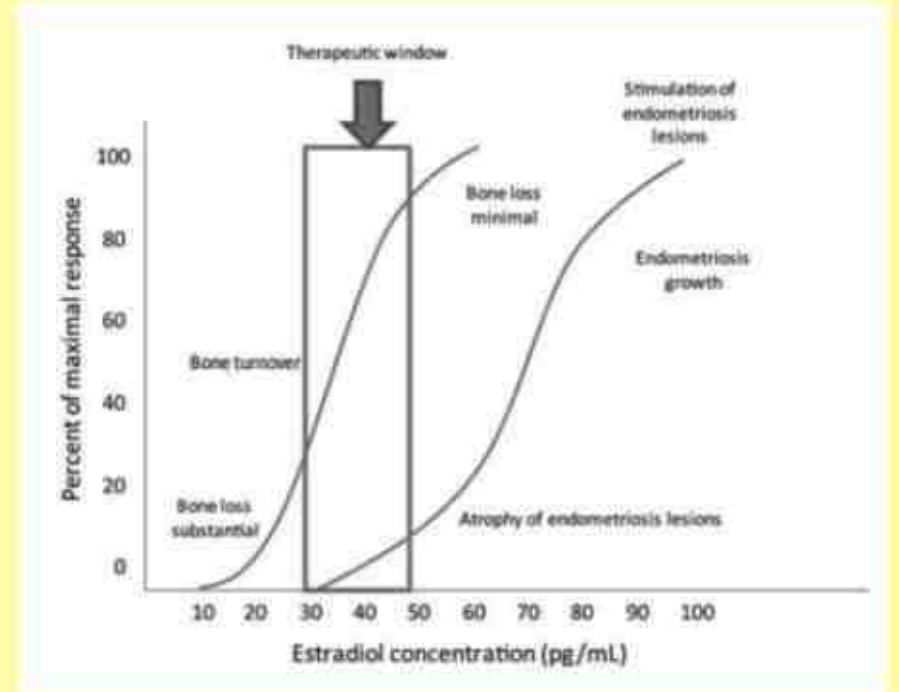
**ÖZELLİKLE
L/S TEDAVİ SONRASI UZUN DÖNEM
İDAME TEDAVİSİ**

GnRHa

**ADOLESANDA GNRH
CERRAHİ DOĞRULANMIŞ 18 YAŞ VE
ÜZERİ ENDOMETRİOZİS OLGULARI İÇİN
SAKLANMALIDIR.**

Add Back Tedavi

- GnRH-flare etkisinden sonra başlanabilir
- Başlangıç **ilk 3 haftayı** geçmemelidir
- **FDA** NETA 5 mg/gün
- **2 yılda 1** KMD ile takip



T skoru değil Z skoru kullanılır.....

Ca-D vit destek tedavisi önerilmektedir.



*ACOG Committee Opinion on Adolescent
Endometriosis (2005) :*

**“ After surgery, all adolescents who have
endometriosis should be treated with medical
therapy until they have completed child bearing”**

CERRAHI

ESHRE guideline: management of women with endometriosis[†]

G.A.J. Dunselman^{1,*}, N. Vermeulen², C. Becker³, C. Calhaz-Jorge⁴, T. D'Hooghe⁵, B. De Bie⁶, O. Heikinheimo⁷, A.W. Horne⁸, L. Kiesel⁹, A. Nap¹⁰, A. Prentice¹¹, E. Saridogan¹², D. Soriano¹³, and W. Nelen¹⁴

When endometriosis is identified at laparoscopy, clinicians are recommended to surgically treat endometriosis, as this is effective for reducing endometriosis-associated pain, i.e. 'see and treat' (Jacobson *et al.*, 2009).

A

Clinicians may consider both ablation and excision of peritoneal endometriosis to reduce endometriosis-associated pain (Wright *et al.*, 2005; Healey *et al.*, 2010).

C

Laparoscopic treatment of endometriosis in teenagers

A.I. Stavroulis^{*}, E. Saridogan, S.M. Creighton, A.S. Cutner



- Retrospektif
- < 21 yaş, 11 olgu
- Cerrahi sonrası % 80 ağrı tam yanıt

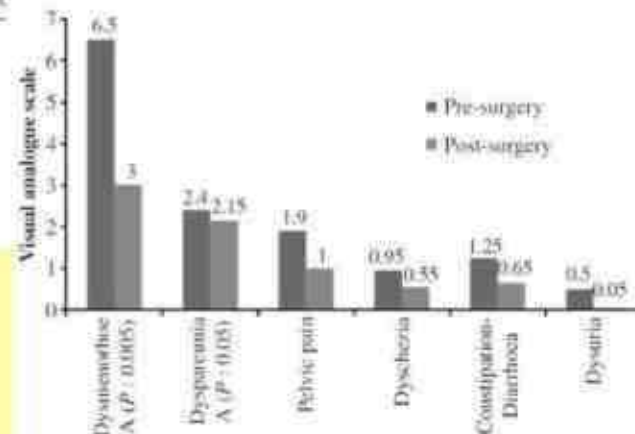
Australian and New Zealand Journal of Obstetrics and Gynaecology 2010; 50: 179-183

DOI: 10.1111/j.1479-828X.2010.01141.x

Original Article

Adolescent endometriosis in the Waikato region of New Zealand –
A comparative cohort study with a mean follow-up time of 2.6 years

Jose D ROMAN¹



Complete laparoscopic excision of endometriosis in teenagers: is postoperative hormonal suppression necessary?

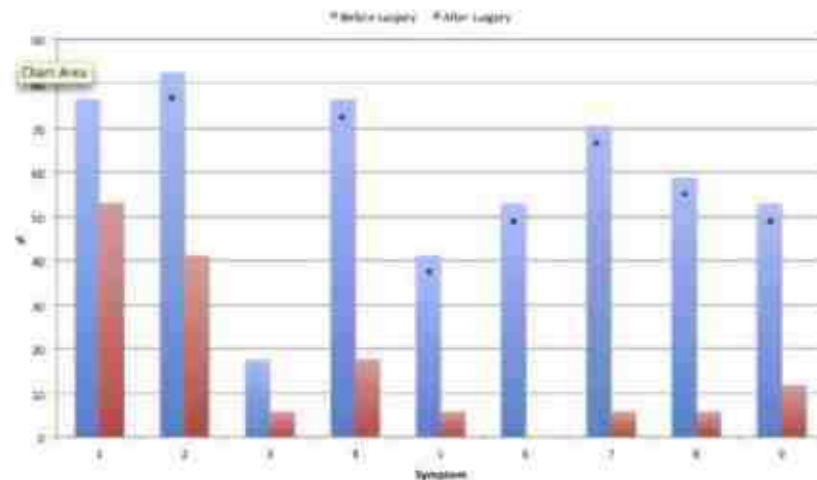
Patrick Yeung, Jr., M.D.,^a Ken Sinervo, M.D.,^b Wendy Winer, R.N.,^b and Robert B. Albee, Jr., M.D.

Symptoms before and after complete excision in teenagers. 1 – pelvic pain; 2 – dysmenorrhea; 3 – dyspareunia; 4 – dyschezia; 5 – constipation; 6 – tender examination; 7 – painful exercise; 8 – intestinal cramping; 9 – bladder pain. *P<0.05.

Percent of teenagers with symptoms before and after complete excision.

Symptom	Before surgery (%)	After surgery (%)
Pelvic pain	76.5	53
Dysmenorrhea	82.4	41.2
Dyspareunia	17.6	5.8
Dyschezia	76.5	17.6
Constipation	41.2	5.8
Tender exam	52.9	0
Painful exercise	70.6	5.8
Intestinal cramping	58.8	5.8
Bladder pain	52.9	11.8

Yeung. Complete laparoscopic excision of endometriosis in teenagers. Fertil Steril 2011.



Yeung. Complete laparoscopic excision of endometriosis in teenagers. Fertil Steril 2011.

REKÜRRENS

High Rate of Endometriosis Recurrence in Young Women

Iacopo Tandoi MD¹, Edgardo Somigliana MD, PhD², Jennifer Riparini MD³, Stefania Ronzoni MD³, Paola Vigano' PhD¹, Massimo Candiani MD^{1,*}

A total of 32 (56%, 95%CI: 43%-68%) recurrences of endometriosis were diagnosed. A second laparoscopy to treat the recurrence was performed in 11 of these cases (34%) and the presence of the disease was confirmed in all of them (ovarian cyst in 6 cases, deep endometriosis in 3 women, and superficial peritoneal implants in the remaining 2 cases). In the remaining 21 women (66%), the recurrence was based on the reappearance of symptoms, clinical assessment, or ultrasound findings.

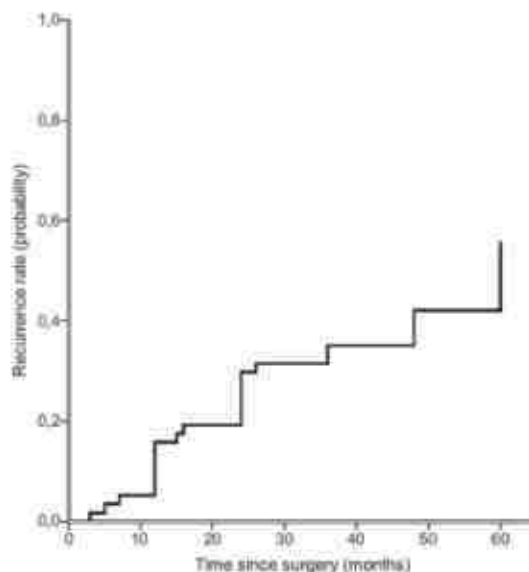


Fig. 1. Cumulative 5-year risk of endometriosis recurrence in 57 women who underwent conservative surgery for endometriosis.

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Retrospektif

17 olgu, tümüne L/S total eksizyon uygulanmış

66 ay takip süresi

6 olguya tekrar L/S (%47)

REKÜRRENS YOK.....

Postoperatif medikal tedavi gerekli mi ???

The Effect of Combined Surgical-Medical Intervention on the Progression of Endometriosis in an Adolescent and Young Adult Population

J.O. Doyle, MD^{1,2}, S.A. Missmer, ScD^{2,3}, and M.R. Laufer, MD^{1,2}

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Table 1. Patient Statistics

	Median	Minimum	Maximum
Age (years)	17	12	24
Stage at 1st Surgery	1	1	3
Stage at 2nd Surgery	1	1	3
Stage at 3rd Surgery	1	1	2
Duration between 1st and 2nd Surgeries (months)	29	6	112
Duration between 2nd and 3rd Surgeries (months)	27	9	62
Medical Therapies Used Between 1st and 2nd Surgeries			
	n	%	
Continuous combined oral contraceptives	82	91%	
Progesterone only	11	12%	
Leuprolide acetate +/- addback	70	78%	

Table 2. Change in Stage of Endometriosis between Surgeries

	Between 1st and 2nd Surgery	
	n	%
Improved by Two Stages	1	1%
Improved by One Stage	17	19%
Stage Unchanged	63	70%
Worsened by One Stage	9	10%
Total	90	100%
Likelihood of increase (worsening) in disease stage		$P = 0.29$
Likelihood of decrease (improvement) in disease stage		$P < 0.0001$

Progression of Endometriosis in Non-medically Managed Adolescents: A Case Series

Cecile A. Unger MD, MPH, Marc R. Laufer MD*

Children's Hospital Boston, Division of Gynecology, Boston, Massachusetts, USA

Cases: This is a case series of three adolescent patients who presented at 13 to 16 years of age with complaint of severe pelvic pain and were diagnosed with stage 1 endometriosis at the time of laparoscopy. They were then prescribed menstrual suppressive therapy but did not remain compliant with their regimens.

- **Postoperatif medikal idame tedavisi genel olarak önerilmektedir**

a combined surgical-medical approach actually does thwart disease progression, we should counsel our patient towards this combined therapy in order to treat their symptoms, and most importantly, to protect their fertility.

KONSENSUS YOK

RKÇ İHTİYAÇ

VAR !!!!



THE MOST IMPORTANT
QUESTION

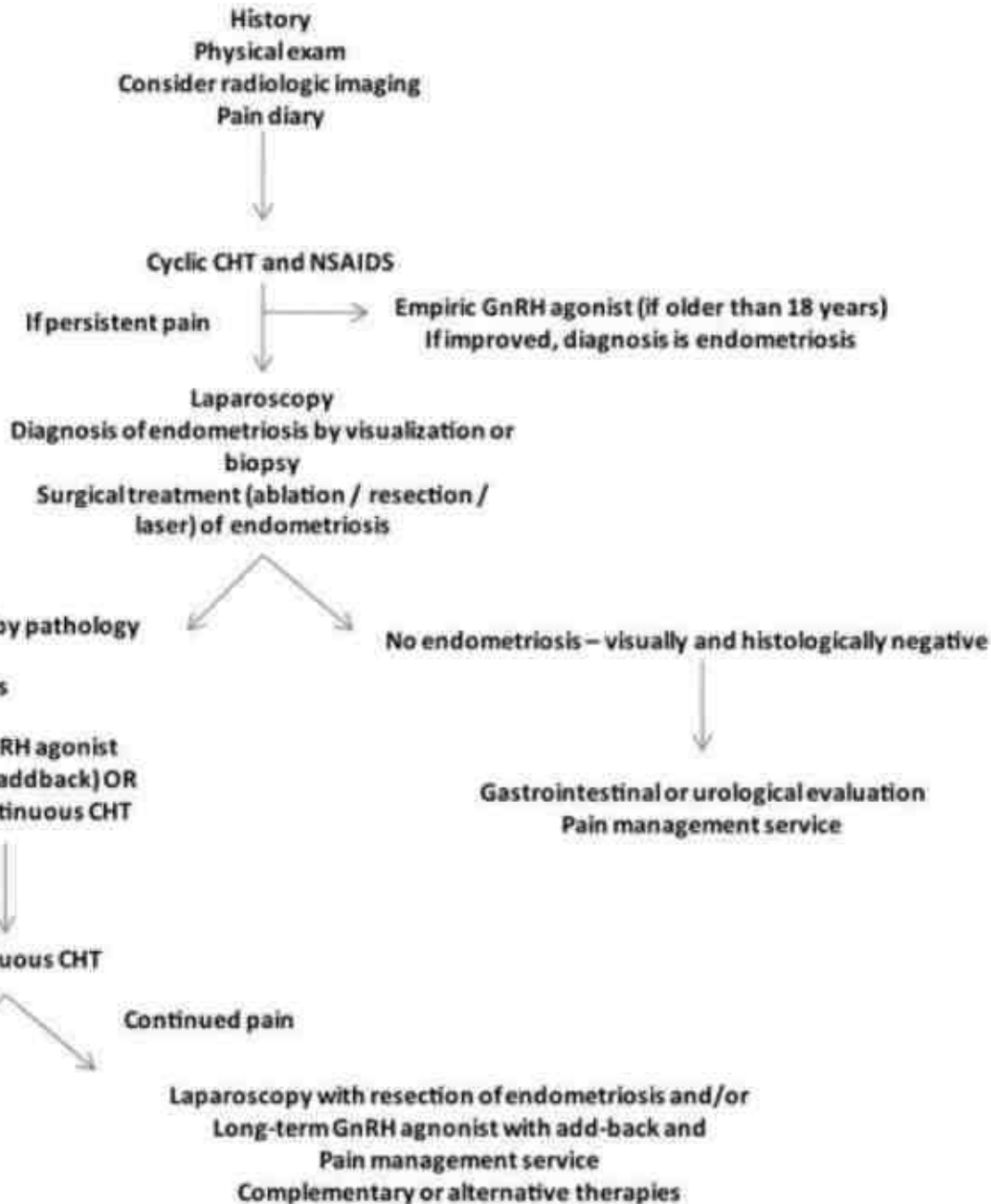
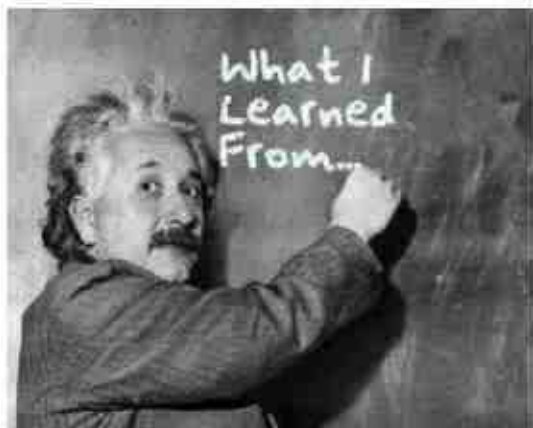
ADOLESANDA
ENDOMETRİOZİS
CERRAHİ +/-

YÜKSEK REKÜRRENS

MUHTEMEL ERKEN EVRE
CERRAHİ YAP

CERRAHİDEN
MÜMKÜN OLDUĞUNCA
KAÇIN

İLERİ EVRE LEZYONLARA
PROGRESYONU
ENGELLE



Abbreviations: NSAIDS, nonsteroidal antiinflammatory drugs; CHT, combination hormone therapy (oral contraceptive pills, estrogen/progestin patch, estrogen/progestin vaginal ring, norethindrone acetate, medroxyprogesterone acetate); GnRH, gonadotropin-releasing hormone.

* Add-back indicates use of estrogen and progestin or norethindrone acetate alone

O'NUN YOLUNDA YÜRÜMEK

Onun ilkelerini yaşıyorsan;
"Egemenlik kayıtsız şartsız milletindir" diyorsan,
Kadın ile erkek eşit ise senin için,
Cumhuriyeti gözün gibi koruyorsan,
Kara çarşafı, peçeyi sildiysen aklından,
Kölelik, esirlik sana göre değilse,
Onun aydınlığında kurtulduysan karanlıktan,
Yurdunun özgürlüğünden taviz vermiyorsan,
Padişahın saltanatı bir yere kadardır diyorsan,
Ufkunu ' bilim ' ile genişletiyorsan,
En hakiki mürşit ilim ise hâlâ,
Bugünleri ona borçluysan,
Onu geriye bıraktıklarıyla yaşıyorsan;
İşte budur Atatürkçü olmak;
İşte budur O'nun yolunda yürümek!

29 Ekim
Cumhuriyet Bayramı
Kutlu Olsun

