



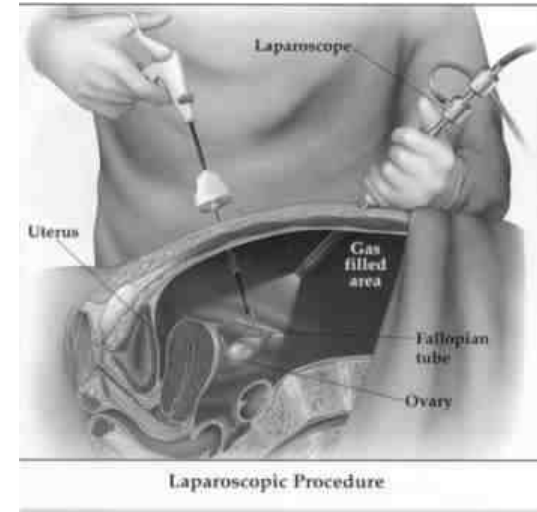
Laparoskopik Myomektomi, İntramural Myomlarda Laparoskopi mi ? Histeroskopi mi?

S.Temel CEYHAN

Doç.Dr.

Gülhane Askeri Tıp Akademisi

Kadın Hst ve Doğ AD



Laparoskopi vs Abdominal

Gebelik oranları-Fark yok

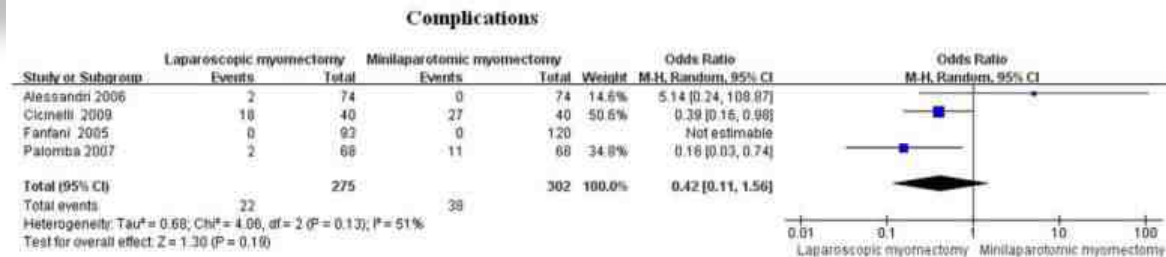
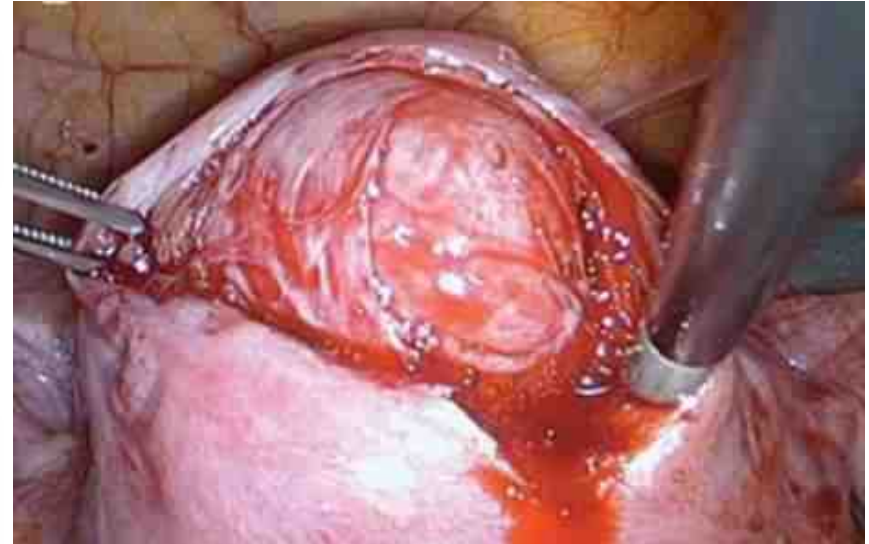
- Malzoni, Fertil Steril, 2010
 - Retrospective
 - %56 vs%50

Komplikasyonlar-Fark yok

- Shen Q, JMIG, 2015
 - Meta analiz

Adezyon: LT:%71-100,
LS:%29-64

- Malartic et al. JGOB 2007



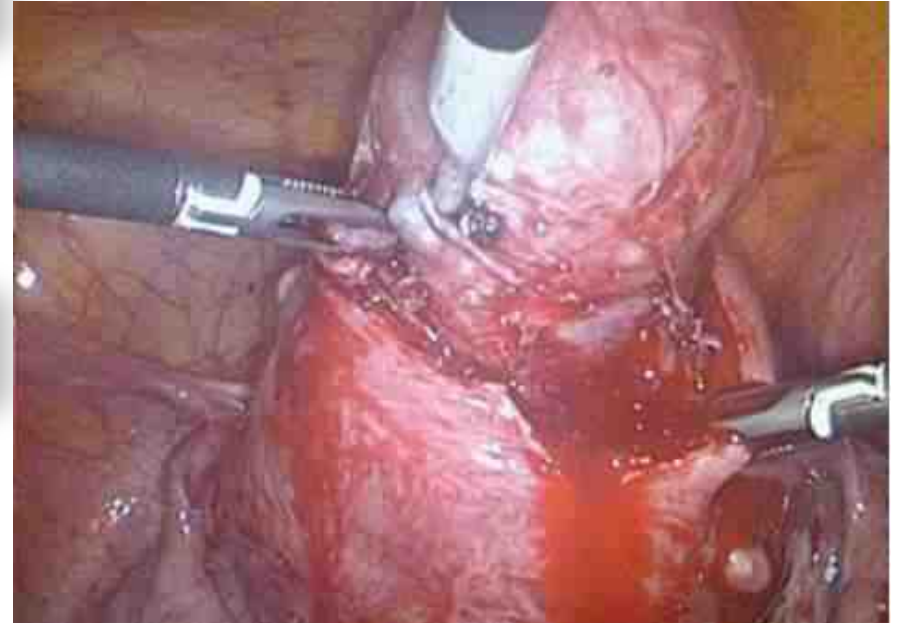
|| Laparoscopi vs Abdominal

Rekürrens Riski

- Rosetti, Human Reprod, 2001
 - RCT
 - LT:%23, LS:%27

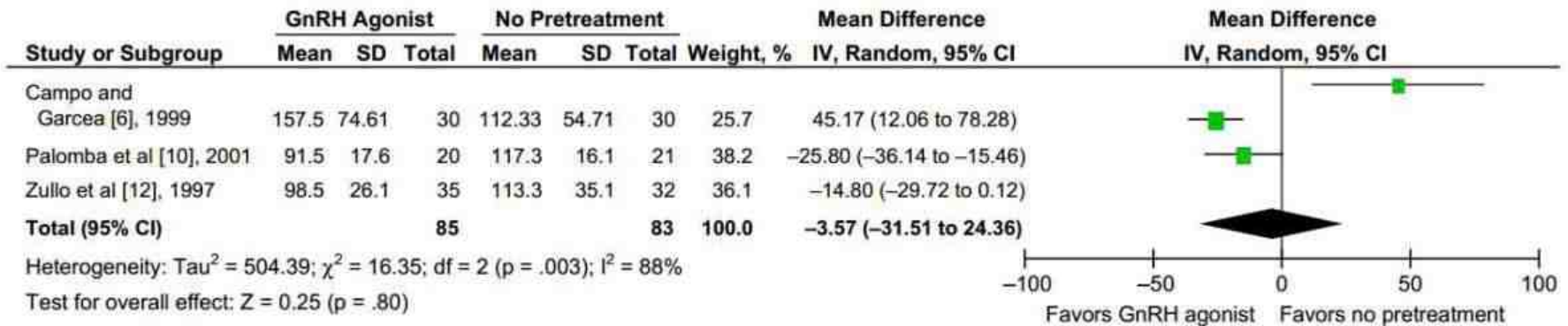
Rekürrens risk faktörleri

- Yaş
- Preop myom sayısı, OR:1.47
- Preop uterin boyut, OR:1.077
- Eşlik eden pelvik hastalık: %36
- Postop doğum, OR:2.7

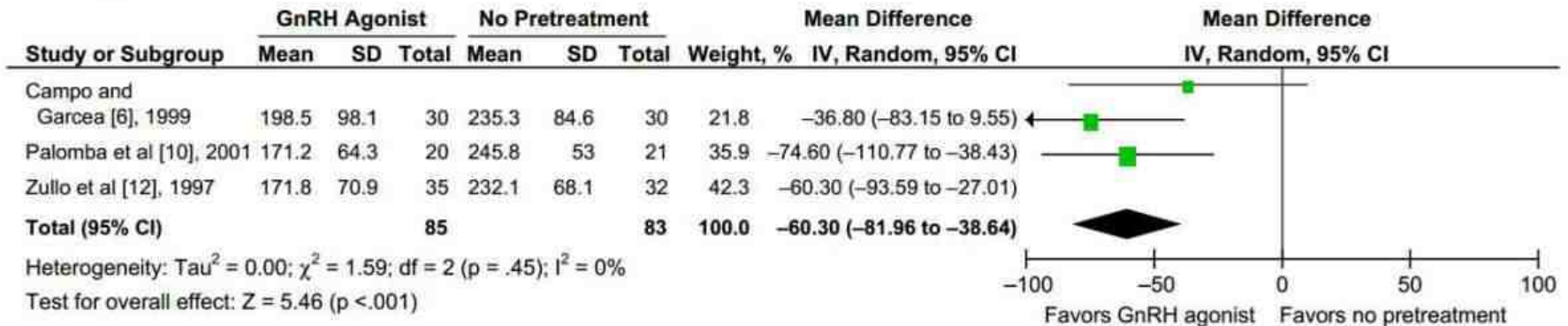


Preop GnRHa Kullanımı

Operative time, min



Intraoperative blood loss, mL



Pathologic changes in gonadotropin releasing hormone agonist analogue treated uterine leiomyomata

Liane Deligdisch, M.D.*

Scott Hirschmann, M.D.†

Albert Altchek, M.D.‡

Table 1 Pathologic Findings in LA-Treated and Untreated Leiomyomata

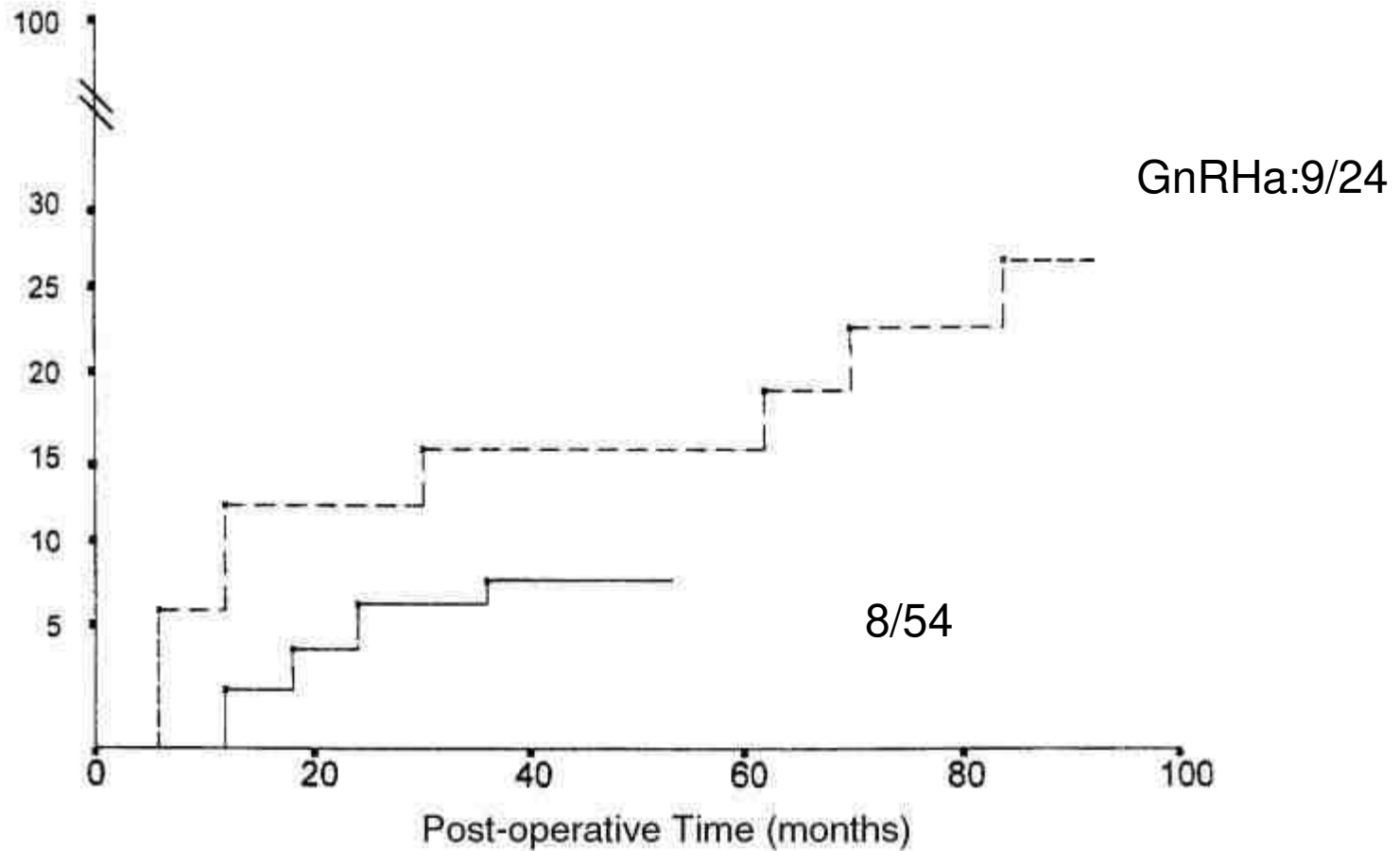
Pathologic finding	Proportion of treated patients with finding	Proportion of untreated patients with finding	P
Nodular hyalinization	19/30	1/30	0.05
Geographic hydropic degeneration	15/30	5/30	0.05
Necrosis	11/30	5/30	0.05
Obliteration of cleavage plane	21/23	4/8	0.05
Edema	14/30	10/30	NS
Lymphocytic infiltrate*	5/30	0/30	NS
Abnormal color and/or consistency*	8/30	7/30	NS
Nuclear atypia-moderate*†	2/30	1/30	NS
Hypercellularity	2/30	1/30	NS

* Significance evaluated with Fisher's exact test; all other findings evaluated with Pearson χ^2 test with Yates' correction.

† Severe nuclear atypia was not observed in entire sample space.

Preop GnRHa Kullanımı

Cumulative rate of recurrence (%)



III Endikasyon ve Limitasyonlar

Anormal Uterin Kanama

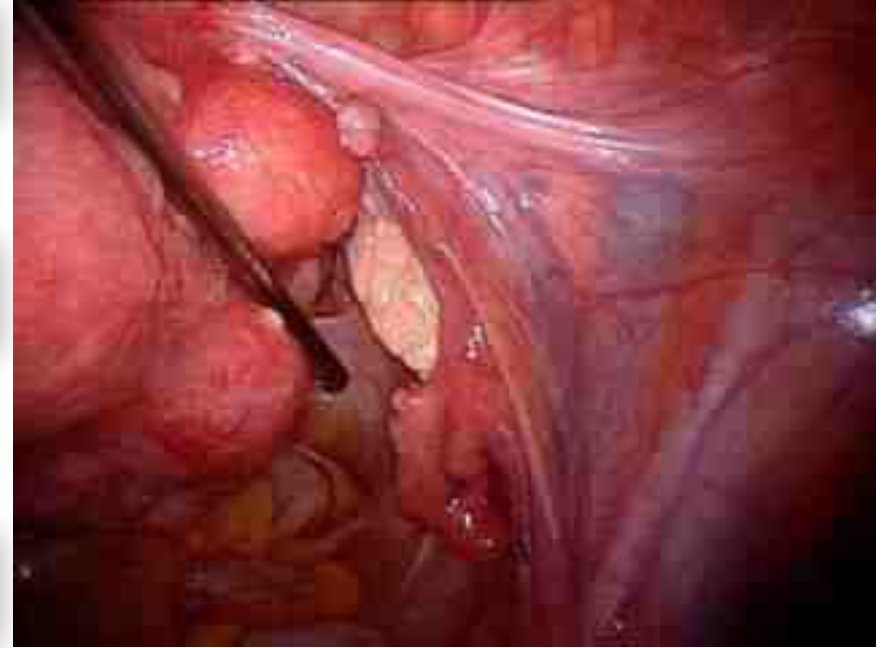
- Malignite şüphesi

Menopoz sonrası büyüme

- İnfertilite, endometrial kavite bozukluğu

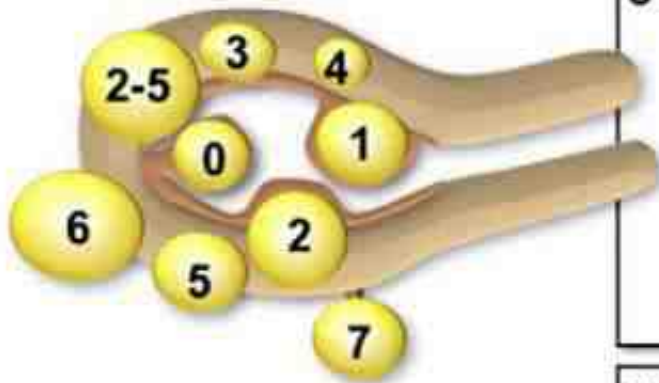
Ağrı ve basınç hissi

- Uriner tract semptomları veya tıkanıklık

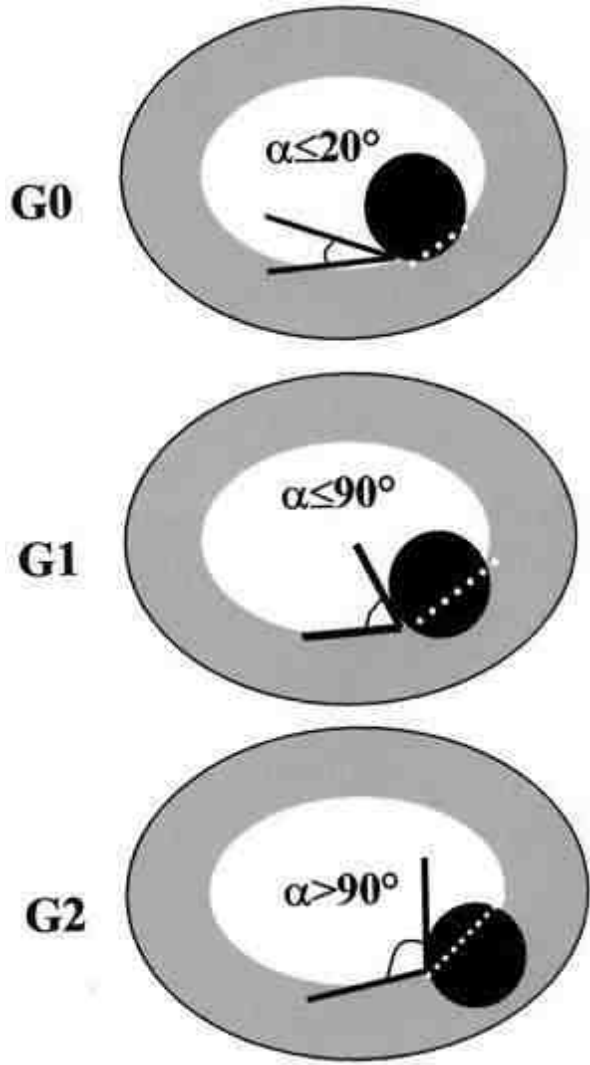


FIGO SINIFLAMA

Leiomyoma subclassification system



SM - Submucosal	0	Pedunculated intracavitary
	1	<50% intramural
	2	≥50% intramural
O - Other	3	Contacts endometrium; 100% intramural
	4	Intramural
	5	Subserosal ≥50% intramural
	6	Subserosal <50% intramural
	7	Subserosal pedunculated
	8	Other (specify e.g. cervical, parasitic)
Hybrid leiomyomas (impact both endometrium and serosa)	Two numbers are listed separated by a hyphen. By convention, the first refers to the relationship with the endometrium while the second refers to the relationship to the serosa. One example is below	
	2-5	Submucosal and subserosal, each with less than half the diameter in the endometrial and peritoneal cavities, respectively.

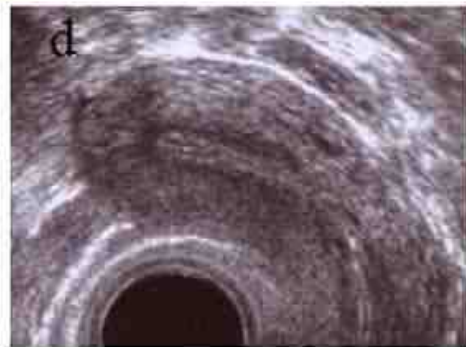
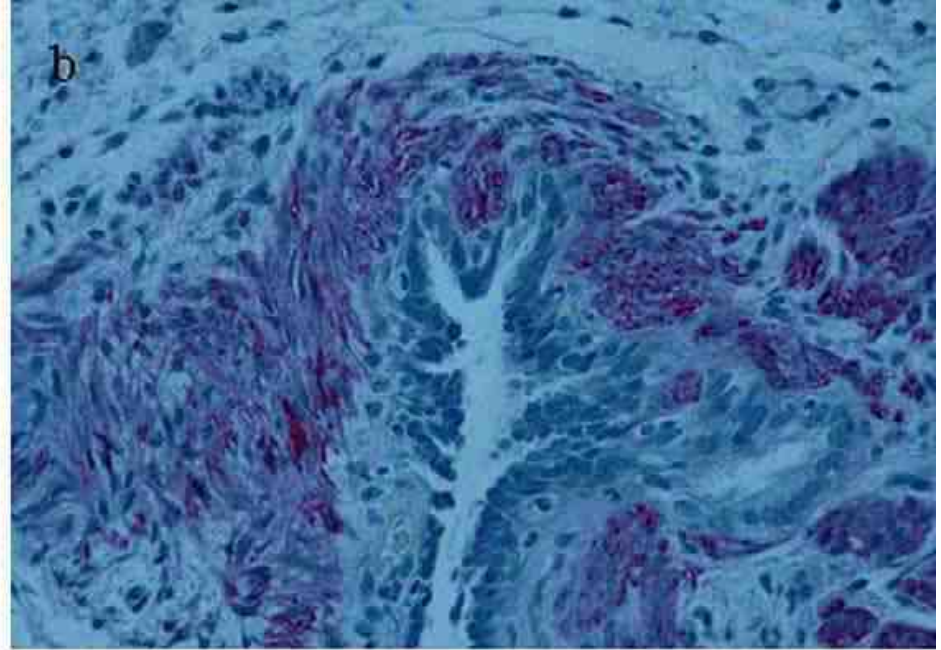
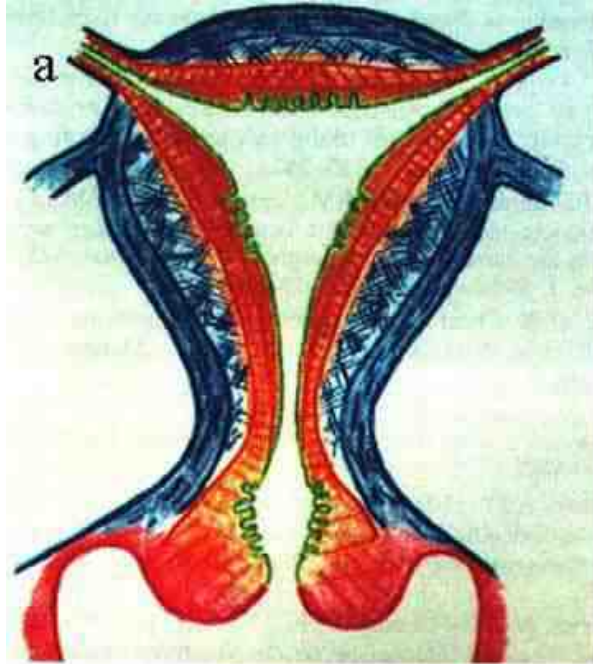


İleri intramural komponentli myomlar:

“ iki-basamak prosedür “ ile rezekt edilirler.

Gimpelson RJ, Obstet Gynecol CI North Am, June 2000

|| Intramural myomlar



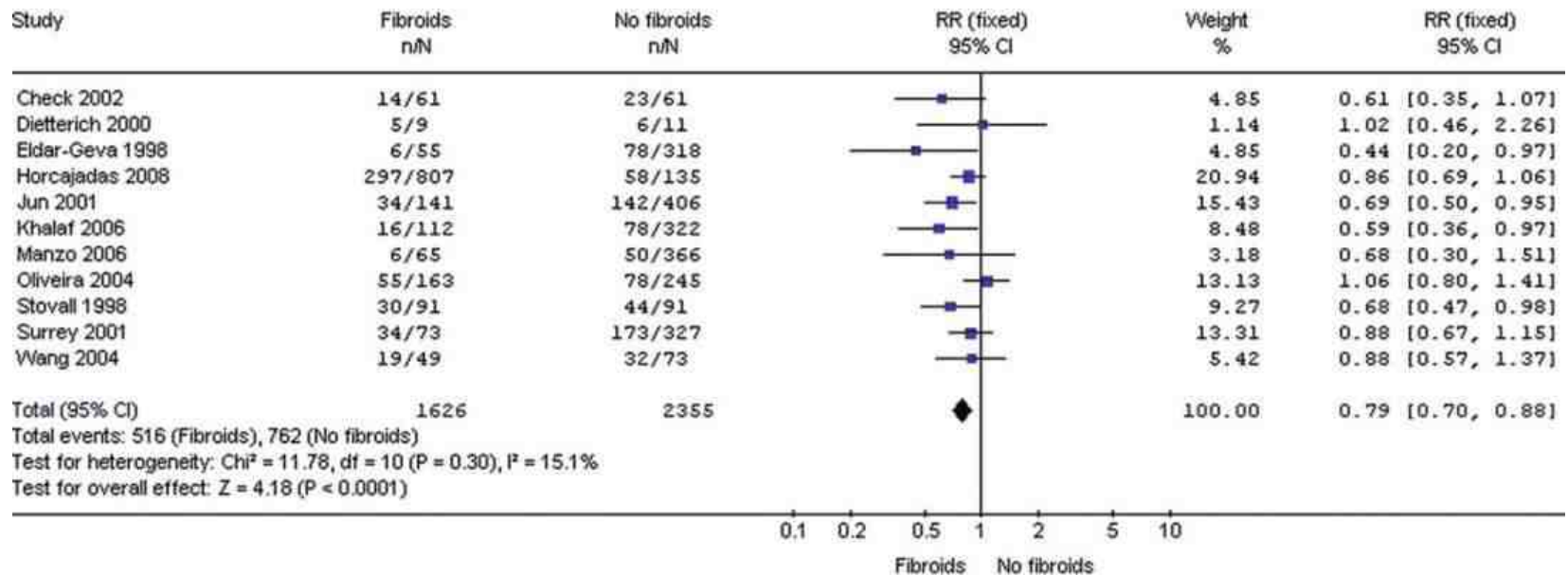
JZ

- JZ genellikle reguler ve $\leq 5\text{mm}$
- 20- 50 yaş arası artar
- Ovarian aktivitenin azalması ile azalır (OKS, GnRH)
- Menopozda azalır
- HRT alanda tekrar belirebilir
- Tamoksifen alanda adenomyozis insidansı artar

JZ

- Uterin peristaltik aktivite buradan köken alır ve siklusa bağlıdır
- Peristaltik aktivite sperm transportu, fundo-cornual implantasyon ve menstruasyonda rol oynar
- Trofoblast invazyonu ve spiral arterlerde fizyolojik değişikliklere yol acar
- JZ spiral arterlerin defektif remodelling
 - Preeklampsi
 - Geç abort
 - Preterm dogum
 - SGA

Forest plot of studies of non-cavity-distorting intramural fibroids versus no fibroids in women undergoing IVF treatment for outcome of live birth rates.



III Endikasyon ve Limitasyonlar

Faktör	Skor
Myom boyutu >7 cm	2
Preop GnRHa	1
İntramural	1
Alt 1/3 lokalizasyon	1
>2 previous cerrahi	2
BMI >30	1
Uterus mobilizasyonu azalmış ise	1
Kavite deformasyonu	1
Myom sayısı >2	2
Total	12

≥10 :LT

Kan kaybını azaltma

[Cochrane Database Syst Rev. 2014 Aug 15;8:CD005355. doi: 10.1002/14651858.CD005355.pub5.](#)

Interventions to reduce haemorrhage during myomectomy for fibroids.

[Kongnyuy EJ¹](#), [Wiysonge CS](#).

Misoprostol compared to placebo to reduce blood loss during myomectomy for fibroids

- 2 RCTs, 89 women: MD -97.88 ml, 95% CI -125.52 to -70.24; $I^2 = 43\%$; moderate-quality evidence

Vasopressin versus placebo to reduce blood loss during myomectomy for fibroids

- 3 RCTs, 128 women: MD -245.87 ml, 95% CI -434.58 to -57.16; $I^2 = 98\%$; moderate-quality evidence

Bupivacaine plus epinephrine compared to placebo to reduce blood loss during myomectomy for fibroids

- 1 RCT, 60 women: MD -68.60 ml, 95% CI -93.69 to -43.51; low-quality evidence

Kan kaybını azaltma

[Cochrane Database Syst Rev. 2014 Aug 15;8:CD005355. doi: 10.1002/14651858.CD005355.pub5.](#)

Interventions to reduce haemorrhage during myomectomy for fibroids.

[Kongnyuy EJ¹](#), [Wiysonge CS](#).

Peri-cervical tourniquet compared to no treatment to reduce blood loss during myomectomy for fibroids

- 1 RCT, 93 women: MD -240.70 ml, 95% CI -359.61 to -121.79

Gelatin-thrombin matrix compared to placebo or no treatment to reduce blood loss during myomectomy for fibroids

- 1 RCT, 50 women: MD -545.00 ml, 95% CI -593.26 to -496.74; low-quality evidence

Ascorbic acid compared to placebo or no treatment to reduce blood loss during myomectomy for fibroids

- 1 RCT, 102 women: MD -411.46 ml, 95% CI -502.58 to -320.34; low-quality evidence

There was no good evidence of an effect on blood loss with oxytocin or clipping of the uterine artery

|| Vazopressin

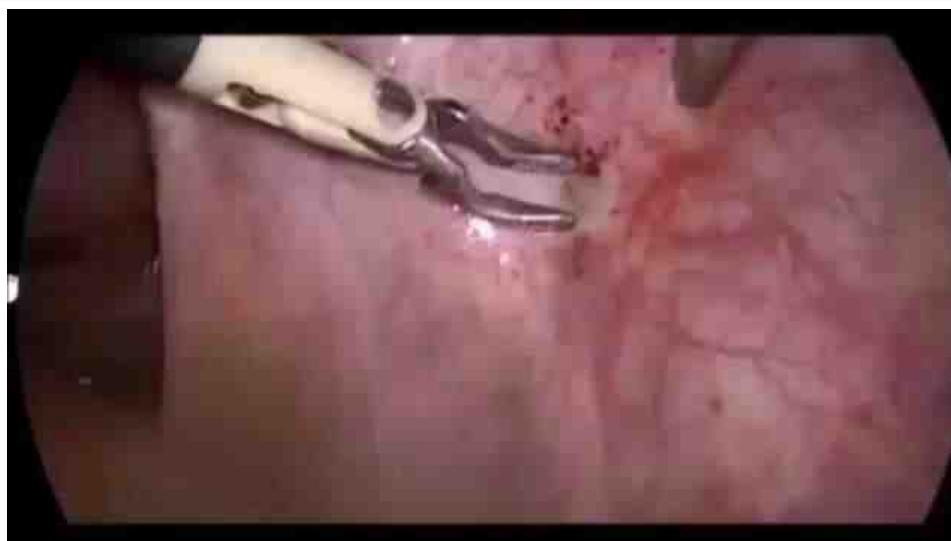


A comparison of combined laparoscopic uterine artery ligation and myomectomy versus laparoscopic myomectomy in treatment of symptomatic myoma.

Alborzi S¹, Ghannadan E, Alborzi S, Alborzi M.

Surgical data and short-term follow-up results.

Group	Operation time (min)	Blood loss (mL)	Febrile morbidity	Postoperative hospital stay (days)	Need for blood transfusion (%)
1	95.52 ± 14.27 (70–130)	402.87 ± 131.57 (200–900)	18 (20.7%)	2.25 ± 0.73 (1–4)	17.2 (15/87)
2	112.54 ± 18.88 (80–160)	173.62 ± 91.47 (50–400)	12 (18.5%)	2.05 ± 0.62 (1–4)	0
<i>P</i> value	.0001	.0001	.733	.069	.00036

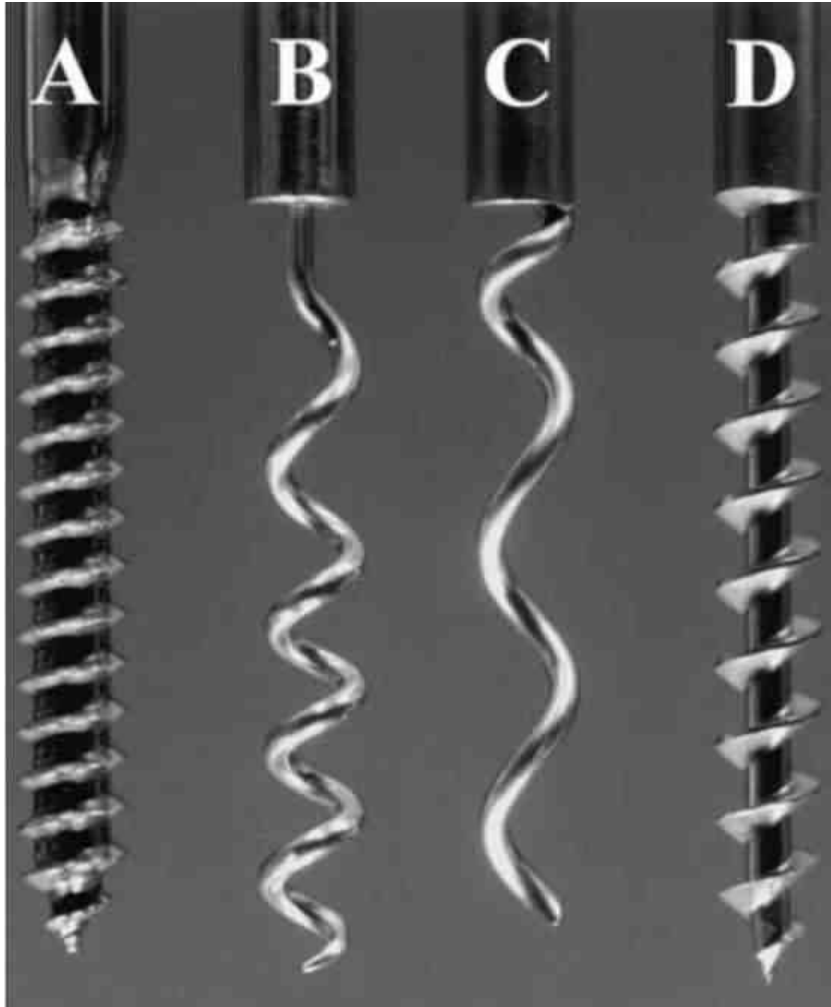


İnsizyon

- Bir kural yok
- Serozal insizyon
 - Boyut
 - Sayı
 - Lokalizasyon
 - Uterin artere yakınlık
 - Kornuya yakınlık
- Her zaman nasıl suture atarım diye düşün
- İyi insizyon her zaman en iyi sonucu verir
- Kornual alandan ve mesaneden uzak dur

Assessment of the physical properties of laparoscopic myoma-fixation devices.

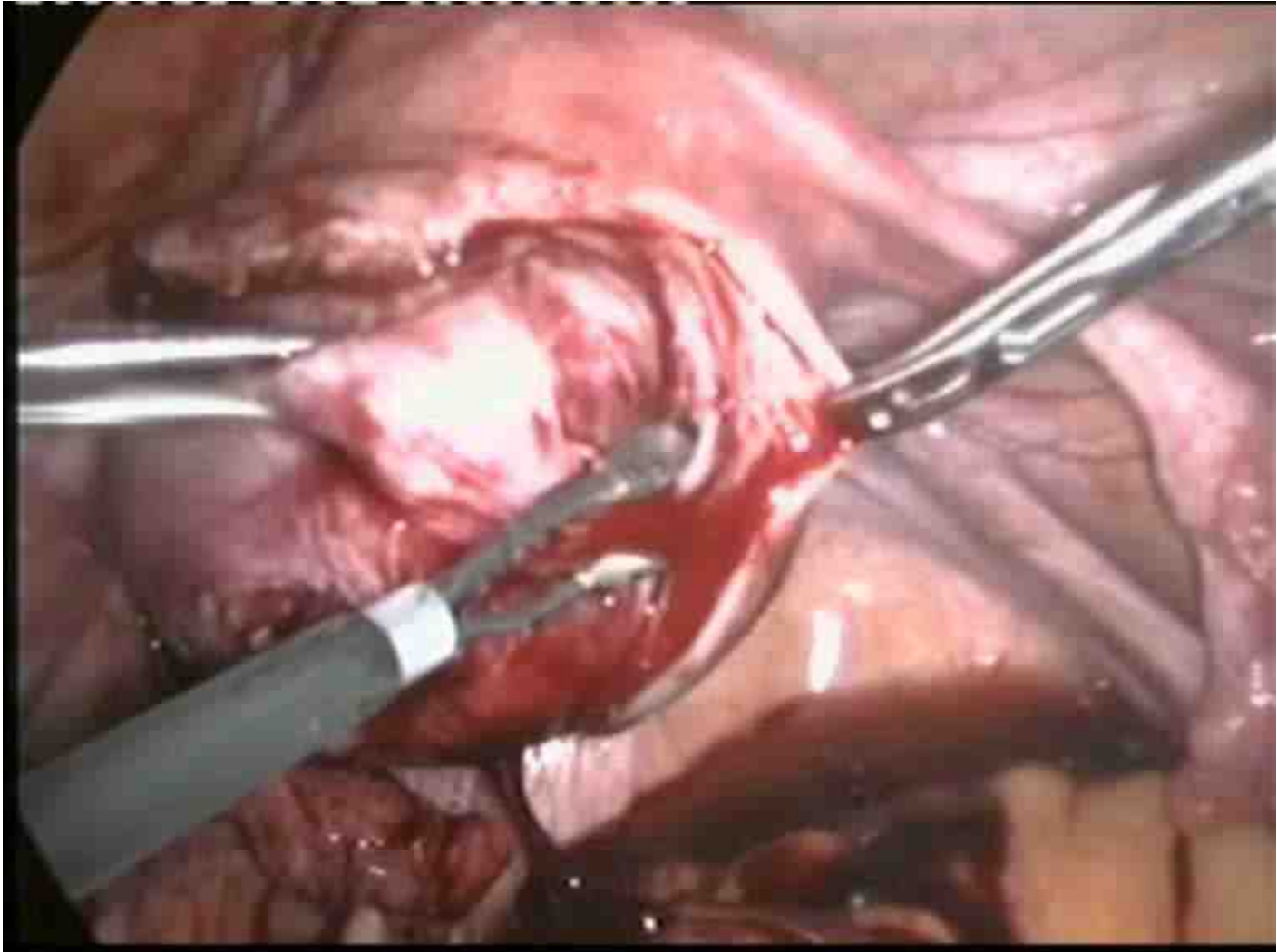
Tintara H¹, Aiyarak P, Mitarnun W, Geater A.



İnsizyon-Diseksiyon



Kapatma



KAVİTE



Ekstraksiyon

- <3cm direct çıkarma
- Elektrik morsellasyon
- Bıçak ile morselasyon
- Posterior culdotomy

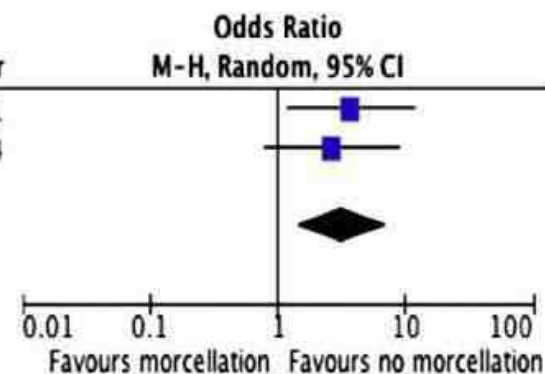


Impact of Morcellation on Survival Outcomes of Patients with Unexpected Uterine Leiomyosarcoma: A systematic review and meta-analysis.

Boqani G¹, Cliby WA², Aletti GD³.

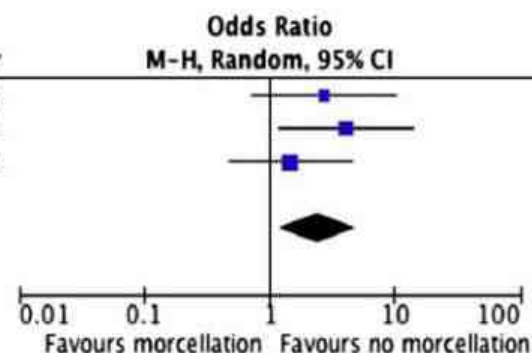
Overall recurrence rate

Study or Subgroup	Morcellation		No morcellation		Weight	Odds Ratio M-H, Random, 95% CI	Year
	Events	Total	Events	Total			
Park 2011	13	25	7	31	52.0%	3.71 [1.18, 11.74]	2011
George 2014	14	19	20	39	48.0%	2.66 [0.80, 8.82]	2014
Total (95% CI)		44		70	100.0%	3.16 [1.38, 7.26]	
Total events	27		27				
Heterogeneity: Tau ² = 0.00; Chi ² = 0.16, df = 1 (P = 0.69); I ² = 0%							
Test for overall effect: Z = 2.72 (P = 0.007)							



Overall survival

Study or Subgroup	Morcellation		No morcellation		Weight	Odds Ratio M-H, Random, 95% CI	Year
	Events	Total	Events	Total			
Perri 2009	10	16	8	21	27.9%	2.71 [0.71, 10.36]	2009
Park 2011	11	25	5	31	32.6%	4.09 [1.18, 14.13]	2011
George 2014	8	19	13	39	39.5%	1.45 [0.47, 4.49]	2014
Total (95% CI)		60		91	100.0%	2.42 [1.19, 4.92]	
Total events	29		26				
Heterogeneity: Tau ² = 0.00; Chi ² = 1.49, df = 2 (P = 0.47); I ² = 0%							
Test for overall effect: Z = 2.45 (P = 0.01)							



Insidans:0.36/100000, Hister/Myom:1/350



AAGL MEMBER UPDATE: Disseminated Leiomyosarcoma With Power Morcellation



Located in Association News (click link to see other articles).

A recent case of dissemination of an occult uterine leiomyosarcoma in a patient with uterine fibroids has given rise to a discussion about the use of power morcellators in gynecology. We understand the concerns that have been raised and we sympathize deeply with those individuals who have been seriously impacted.

The AAGL is reviewing the scientific evidence and best practices reported by our members to provide readily accessible, comprehensive information to our members. Look for an announcement about this in the near future. We recognize that in rare cases the use of power morcellators can lead to the dissemination of an occult malignancy of endometrial or myometrial origin, and also of dissemination of benign morcellated tissues. We encourage our members to fully research and understand the risks of power morcellation and to learn more about when alternative methods of tissue extraction may be appropriate.

We trust that our members will appreciate that the AAGL is taking a cautious and measured approach to this serious issue. As the leading medical society for gynecologists who practice minimally invasive procedures, the AAGL supports current efforts to mitigate and/or eliminate the potential risks associated with tissue extraction. We are establishing a task force to examine this issue. We encourage members to submit descriptions of tissue extraction methods to TissueExtraction@aagl.org.

The AAGL's primary role is to provide information and training opportunities for our members. We plan to provide comprehensive education on all methods of tissue extraction in webinars, *NewsScope*, *SurgeryU*, *The Journal of Minimally Invasive Gynecology*, and hands-on workshops.

Since our founding in 1971, AAGL has been committed to advancing safe minimally invasive procedures for the benefit of women. We remain committed to this cause and, in particular, to ensuring the safety and efficacy of minimally invasive gynecological surgery.

SGO Position Statement: Morcellation



December 2013

Uterine morcellation is commonly performed intracorporeally by gynecologists to remove the uterus through small incisions. Most commonly, morcellation is performed to reduce the size of an enlarged uterus so that it may be removed through small laparoscopic incisions or through the vagina, thus minimizing the morbidity of a larger "open" incision. However, power morcellation or other techniques that cut up the uterus in the abdomen have the potential to disseminate an otherwise contained malignancy throughout the abdominal cavity. For this reason, the Society of Gynecologic Oncology (SGO) asserts that it is generally contraindicated in the presence of documented or highly suspected malignancy, and may be inadvisable in premalignant conditions or risk-reducing surgery.

Patients being considered for minimally invasive surgery performed by laparoscopic or robotic techniques who might require intracorporeal morcellation should be appropriately evaluated for the possibility of coexisting uterine or cervical malignancy. Other options to intracorporeal morcellation include removing the uterus through a mini-laparotomy or morcellating the uterus inside a laparoscopic bag.

Uterine leiomyomas are a common indication for power morcellation. Fewer than one out of 1000 women who undergo hysterectomy for leiomyomas will have an underlying malignancy. The SGO recognizes that currently there is no reliable method to differentiate benign from malignant leiomyomas (leiomyosarcomas or endometrial stromal sarcomas) before they are removed. Furthermore, these diseases offer an extremely poor prognosis even when specimens are removed intact.

Patients and doctors should communicate about the risks, benefits and alternatives of all procedures so that a patient is able to make an informed and voluntary decision about accepting or declining medical care (ACOG Committee Opinion 439 Informed Consent).

FDA

Laparoscopic Uterine Power Morcellation in Hysterectomy and Myomectomy: FDA Safety Communication

FDA issued an [updated safety communication](#) on November 24, 2014

Date Issued: April 17, 2014

Audience:



- Health Care Providers
- Medical Professional Associations
- Cancer Advocacy Organizations
- Health Care Facilities/Hospitals
- Women with Symptomatic Uterine Fibroids who are Considering Surgical Options
- Manufacturers of Devices used for Minimally Invasive Surgeries

Medical Specialties: Pathology, Internal Medicine, Nursing, Obstetrics/Gynecology, Oncology

Product:

Laparoscopic power morcellators are medical devices used during different types of laparoscopic (minimally invasive) surgeries. These can include certain procedures to treat uterine fibroids, such as removing the uterus (hysterectomy) or removing the uterine fibroids (myomectomy). Morcellation refers to the division of tissue into smaller pieces or fragments and is often used during laparoscopic surgeries to facilitate the removal of tissue through small incision sites.

Purpose:

When used for hysterectomy or myomectomy in women with uterine fibroids, laparoscopic power morcellation poses a risk of spreading unsuspected cancerous tissue, notably uterine sarcomas, beyond the uterus. Health care providers and patients should carefully consider available alternative treatment options for symptomatic uterine fibroids. Based on currently available information, the FDA discourages the use of laparoscopic power morcellation during hysterectomy or myomectomy for uterine fibroids.

Summary of Problem and Scope:

Uterine fibroids are noncancerous growths that develop from the muscular tissue of the uterus. Most women will develop uterine fibroids (also called leiomyomas) at some point in their lives, although most cause no symptoms¹. In some cases, however, fibroids can cause symptoms, including heavy or prolonged menstrual bleeding, pelvic pressure or pain, and/or frequent urination, requiring medical or surgical therapy.

Many women choose to undergo laparoscopic hysterectomy or myomectomy because these procedures are

Adezyon önleme/Solid Bariyerler

Materyal

- Expanded polytetrafluoroethylene

Market

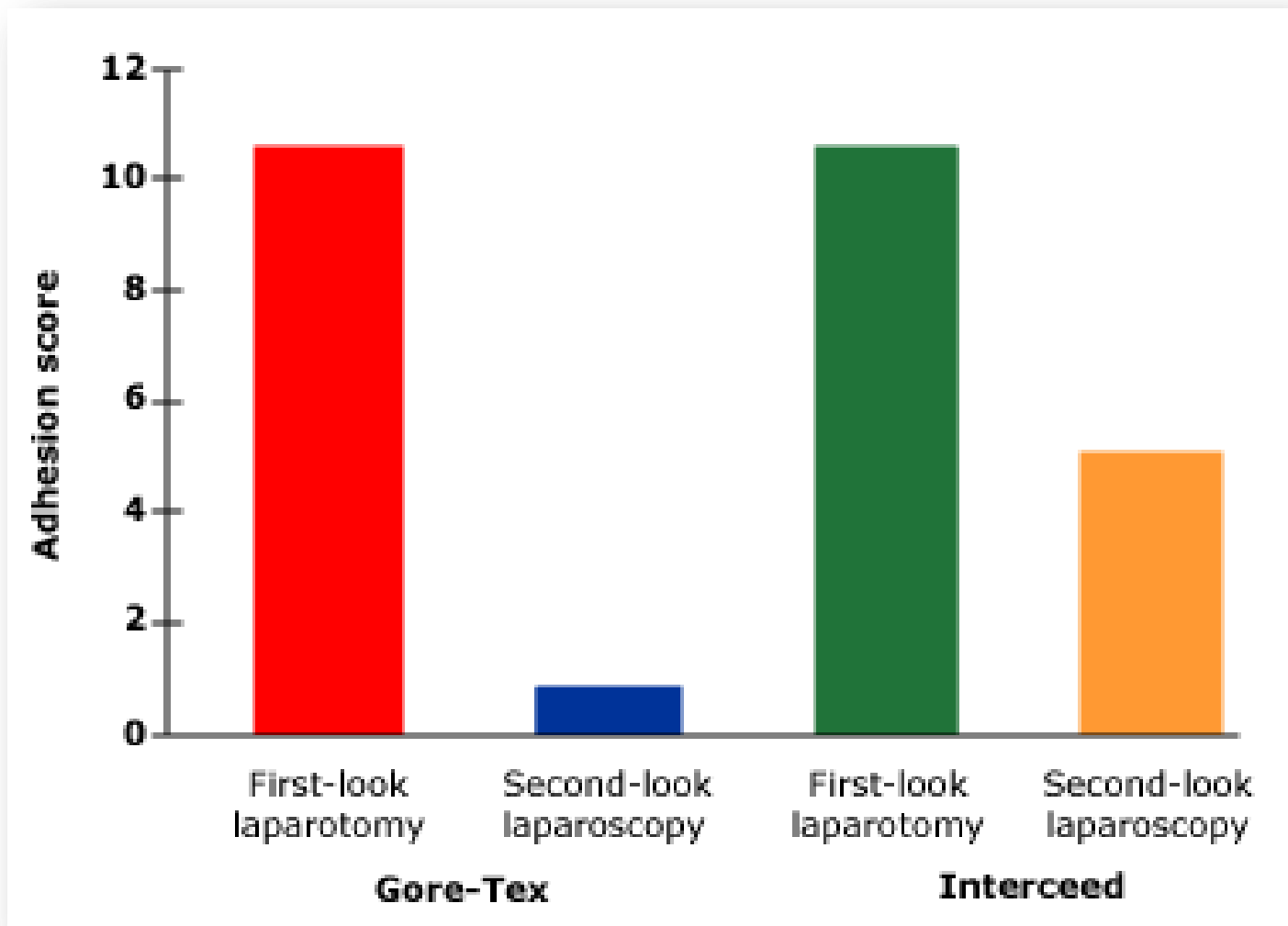
- Preclude (Gore-Tex)

Etkinlik ve Özellikler

- İnsan çalışması mevcut,
- Hayvan deneylerinde seprafilminden daha kötü
- Tutması zor
- Sütürasyon gerekir,
- L/S uygulanması zor,
- Non reaktif
- Nondegradable
- Fertilité sonuçları, barsak obstrüksüyon insidansı, KPP çalışması yok



Gore-Tex vs Interceed



Solid Bariyerler

Materyal

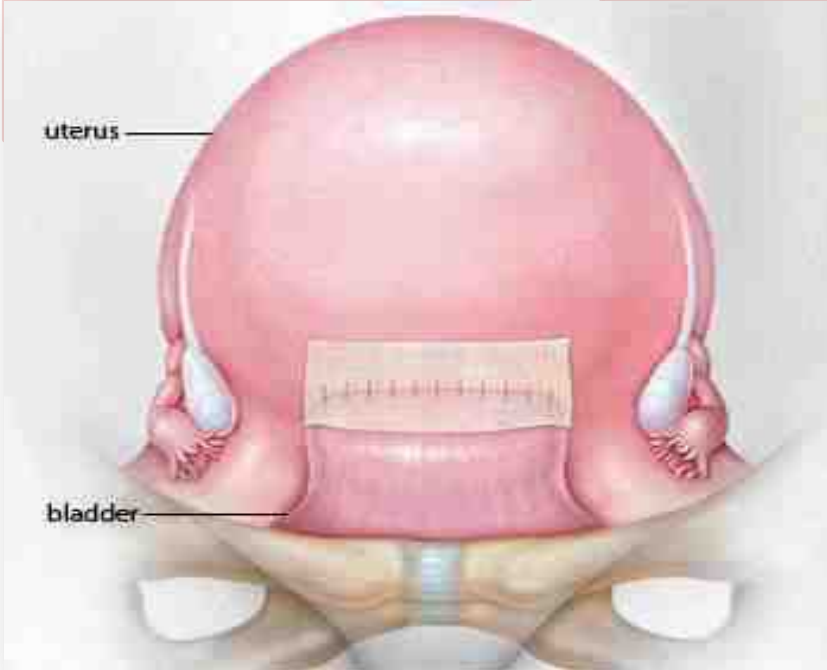
- Oxidized regenerated cellulose

Market

- Interceed, FDA
- 1-2 hafta

Etkinlik ve Özellikler

- En çok çalışılan materyal,
- Sonuçlar seprafilmden daha iyi
- Tutması kolay
- Blood-sensitive,
- L/S uygulayanlar var ama kontrol grubuna göre adezyonda artış,
- Dikkatli aplikasyon



Solid Bariyerler

Materyal

- Hiyaluronik asit
- Karboksimetil selüloz

Market

- Seprafilm, FDA
- Marketin %58
- 5-7 gün

Etkinlik ve Özellikler

- Literatür sonuçları tutarsız
- İnsidansta azalma yok şiddette azalma var
- Kan-Duyarsız
- narin ve yapışkan
- L/S uygulanamaz
- Barsak anastomozlarında kullanılmıyor, enfeksiyon riski ?

Sıvı ve Jel Bariyerler

Materyal

- %4 İcodextrin

Market

- Adept
- FDA ve Avrupa
- ≥ 4 gün hidroflasyon
- α -amilaz ile glukozaya metabolize

Etkinlik ve Özellikler

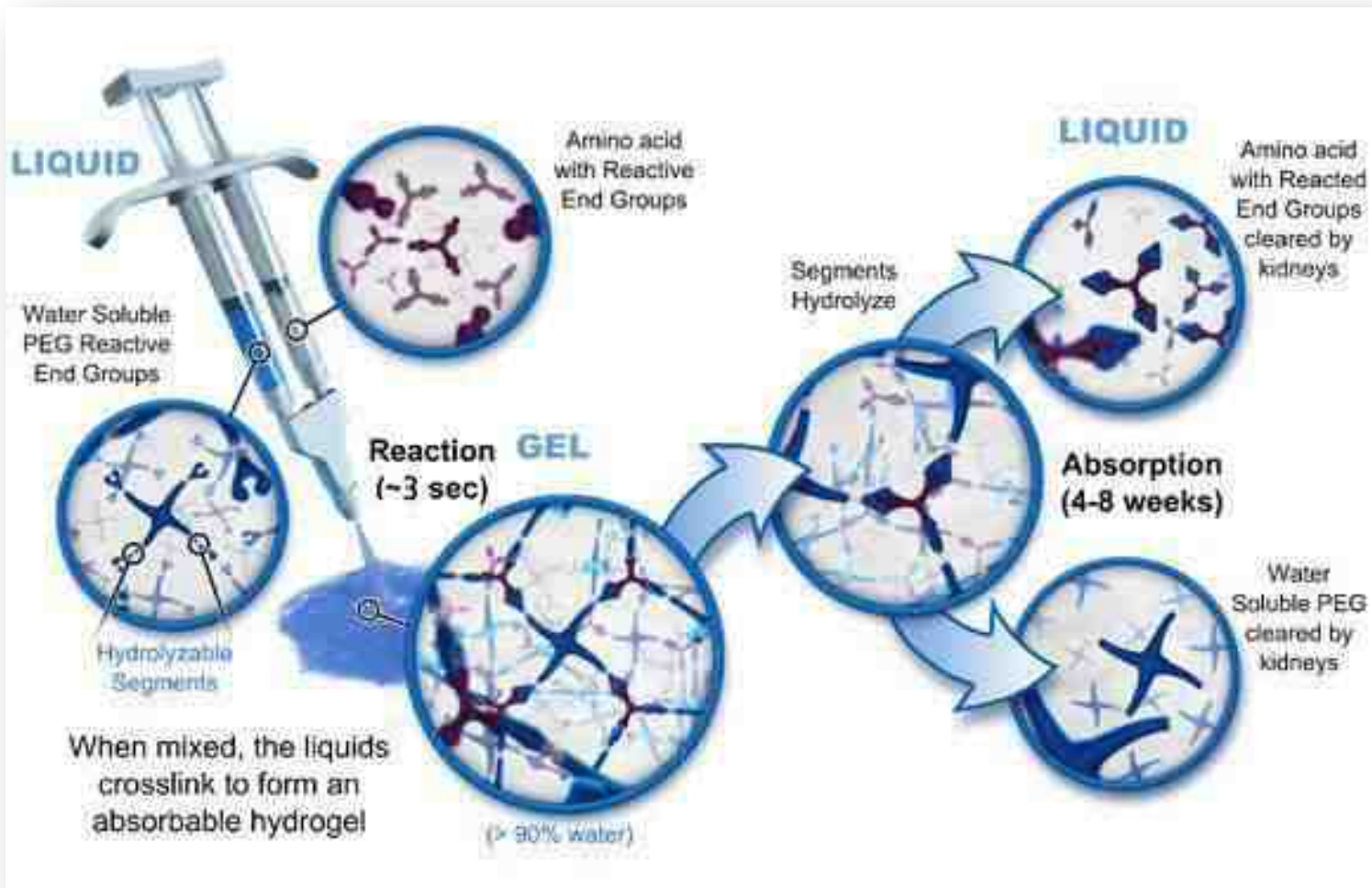
- İnsan çalışması mevcut,
- Hayvan deneylerinde seprafilminden daha kötü
- Enfeksiyon ve mısır nişastası allerjisi olanlarda KE (Barsak rezeksiyonu, appendektomi)
- L/S uygulanabilir,
- Kullanımı sınırlı



Sıvı ve Jel Bariyerler

Materyal	Market	Etkinlik ve Özellikler
Ringer L %32 Dextran 70	Hyskon	<ul style="list-style-type: none">-İnsan ve hayvan çalışması etkili değil,-Kötü hasta tecrübesi(insizyondan sızma, şişkinlik, ağrı, kilo alımı)-Enfeksiyona eğilim-Alerji
Polyethylene glycol hydrogel	<ul style="list-style-type: none">-SprayGel-FDA onayı henüz alınmadı-2 sentetik sıvı prekürsörü-5-7 gün	<p>Myomektomide %60 adezyonda azalma ama etkinlik için daha büyük çalışmalara ihtiyaç duyulmakta</p> <p>Cochrane meta analiz etkinlik yok</p>

Spreygel



Adhesion prevention agents for gynaecological surgery: an overview of Cochrane reviews.

Hindocha A¹, Beere L, Dias S, Watson A, Ahmad G.

⊕ Author information

Abstract

BACKGROUND: Intraperitoneal adhesions are associated with considerable co-morbidity and have large financial and public health repercussions. They have secondary effects that include chronic pelvic pain, dyspareunia, subfertility and bowel obstruction. In women with adhesions, subsequent surgery is more difficult, often takes longer, and is associated with a higher complication rate (Broek 2013). The significant burden of adhesions has led to the development of several anti-adhesion agents, although there is disagreement as to their relative effectiveness.

OBJECTIVES: To summarise evidence derived from Cochrane systematic reviews on the clinical safety and effectiveness of solid agents, gel agents, liquid agents and pharmacological agents, used as adjuvants to prevent formation of adhesions after gynaecological pelvic surgery.

METHODS: The Cochrane Database of Systematic Reviews was searched using the keyword 'adhesion' up to August 2014. The Cochrane information management system was also searched for any titles or protocols of reviews in progress. Two review authors independently extracted information from the reviews, with disagreements being resolved by a third review author. The quality of the included reviews was described in a narrative manner, and the AMSTAR tool was used to formally assess each review included in this overview. The quality of evidence provided in the original reviews was described using GRADE methods.

MAIN RESULTS: We included two reviews, one with 18 studies comparing solid agents (oxidised regenerated cellulose expanded polytetrafluoroethylene, sodium hyaluronate and carboxymethylcellulose, and fibrin sheets) with control or with each other. The other review included 29 studies which compared liquid agents (4% icodextrin, 32% dextran, crystalloids), gel agents (carboxymethylcellulose and polyethylene oxide, polyethylene glycol gels, hyaluronic acid based gel, 0.5% ferric hyaluronate gel, sodium hyaluronate spray) and pharmacological agents (gonadotrophin-releasing hormone agonist, reteplase plasminogen activator, N,O-carboxymethyl chitosan, steroid agents, intraperitoneal noxytioline, intraperitoneal heparin, systemic promethazine) with control or each other. Both reviews met all of the criteria of the AMSTAR assessment. The reviews included as outcomes both the primary outcomes of this overview (pelvic pain, pregnancy, live birth rate and quality of life (QoL)) and our secondary outcomes (adverse effects, presence or absence of adhesions at second-look laparoscopy (SLL) and adhesion score). However, neither of the reviews identified any primary studies of solid, gel or pharmacological agents that reported any of our primary outcomes. The only studies in either review that reported any of our primary outcomes were studies comparing liquid agents versus control (saline or Hartmann's solution), which reported pelvic pain (two studies), live birth (two studies) and pregnancy (three studies). An external source of funding was stated for 25 of the 47 studies across both reviews; in 24 of these studies the funding was commercial. Solid agents (18 studies) None of our primary outcomes were reported. Adverse events were reported as an outcome by only 9 of the 18 studies. These reported no adverse events. Liquid agents (nine studies) There was no evidence of a difference between liquid agents and control (saline or Hartmann's solution) with respect to pelvic pain (odds ratio (OR) 0.65, 95% confidence interval (CI) 0.37 to 1.14, 1 study, n = 286, moderate quality evidence), pregnancy rate (OR 0.64, 95% CI 0.36 to 1.14, 3 studies, n = 310, moderate quality evidence) or live birth rate (OR 0.67, 95% CI 0.29 to 1.58, 2 studies, n = 208, moderate quality evidence). No studies of liquid agents reported QoL. Adverse events were not reported as an outcome by any of the nine studies. Gel agents (seven studies) None of our primary outcomes were reported. Adverse events were not reported as an outcome by any of the seven studies. Pharmacological agents (seven studies) None of our primary outcomes were reported. Adverse events were reported as an outcome by only one of the seven primary studies. This study reported no evidence of difference in ectopic pregnancy rates between intraperitoneal noxytioline and no treatment (OR 4.91, 95% CI 0.45 to 53.27, 1 study, n = 33, low quality evidence).

AUTHORS' CONCLUSIONS: There is insufficient evidence to allow us to draw any conclusions about the effectiveness and safety of anti-adhesion agents in gynaecological surgery, due to the lack of data on pelvic pain, fertility outcomes, quality of life or safety. A substantial proportion of research in this field has been funded by private companies that manufacture these agents, and further high powered, independent trials will be needed before definitive conclusions can be made.

Myomektomi sonrası uterin rüptür oranları

Genel Katagori	Alt Katagori			Uterin Rüptür		Veri toplama yılları	Çalışma sayısı	Referanslar
	Major	Minor	Total Doğum	Oran	Alt Katagori-total sayı			
Normal uterus, previous myomektomi	NA	NA	1,001	1/143 (0.70%)	7	1930-2006	10	Brown, 1956, Garnet 1964, Dubuisson 2000, Seiner 2000, Nezhat 1999, Seracchioli 2000, Seracchioli 2006, Kumakiri 2008, Sizzi 2007, Makino 2008
	Abdominal myomektomi	NA	179	1/60 (%1.7)	3	1930-1960	2	Brown 1956, Garnet 1964
	LS Myomektomi	NA	822	1/206 (%0.49)	4	1989-2006	8	Dubuisson 2000, Seiner 2000, Nezhat, 1999, Seracchioli 2000, Seracchioli 2006, Kumakiri 2008, Sizzi 2007, Makino 2008

Laparoskopik myomektomi sonrası uterin rüptür için risk faktörleri: 19 vaka



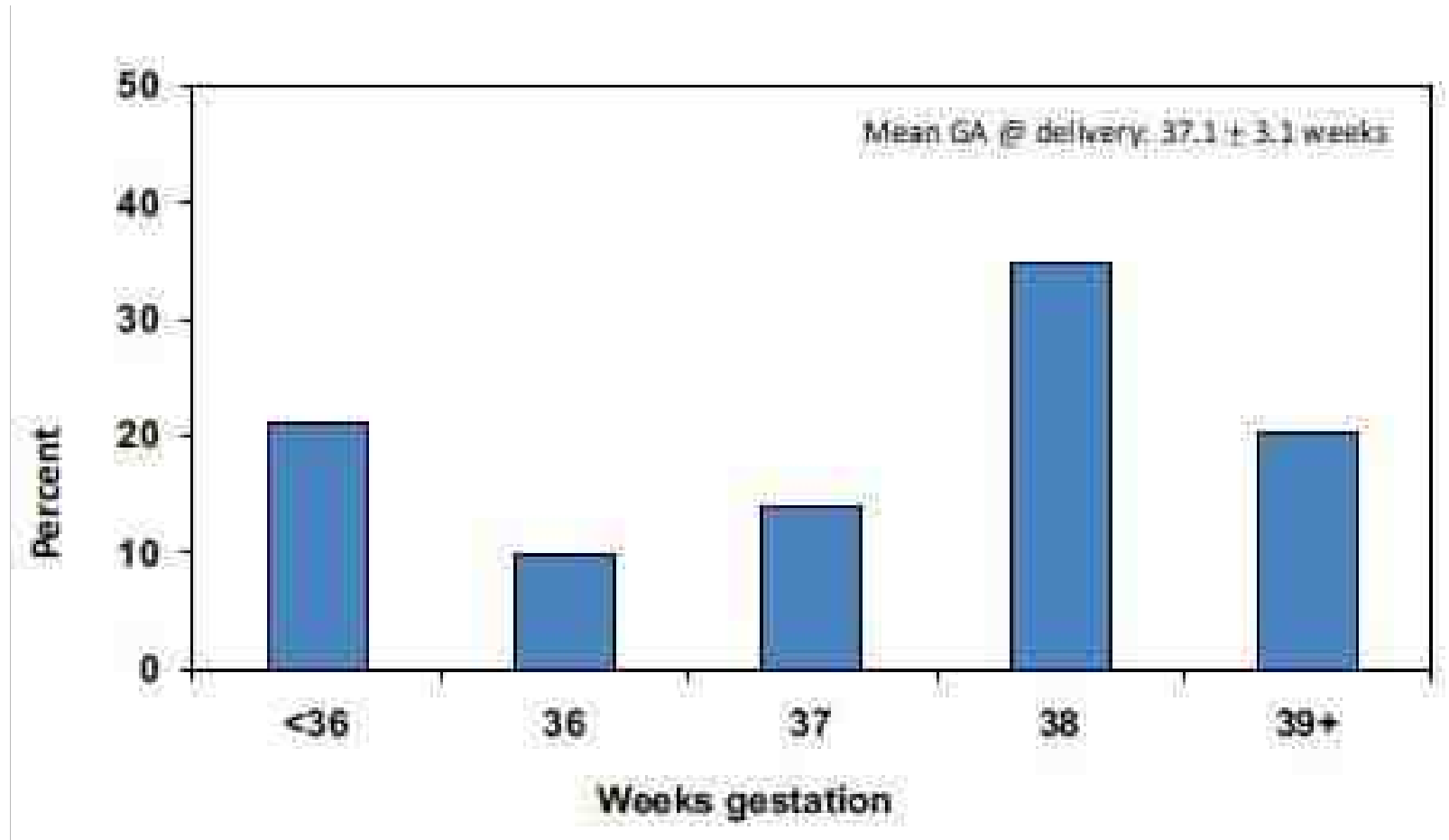
Case [reference]	Year of Surgery	Myoma size, cm	Myoma type	Cavity entered	Uterine incision	Hemostasis	Closure	Uterine rupture, wk	Fetal survival	Maternal survival
1 [5]	1992	DM	IM	Yes	Sharp	ENC	1 Layer	28	DM	Yes
2 [6]	1992	3	SS	No	MP	MP	Serosa	34	Yes	Yes
3	1995	3	IM	No	MP	BP, S	1 Layer	34	Yes	Yes
4 [7]	1998	5	IM	Yes	MP	BP, S	1 Layer	28	Yes	Yes
5 [8]	1996	5	IM	Yes	DM	S	DM	28	Yes	Yes
6 [9]	1996	DM	IM	Yes	MP	BP	2 Layers	29	Yes	Yes
7	1997	9	IM	No	MP	BP, S	2 Layers	33	Yes	Yes
8 [10]	1997	5	SS	No	MP	BP	No	33	No	Yes
9 [11]	1997	11	SS-P	No	MP	MP	No	34	Yes	Yes
10 [12]	2000	4	SS	No	MP	MP	No	17	No	Yes
11	DM	2.5	DM	No	UC	S	3 Layers	28	No	Yes
12 [13]	2000	8	SS	No	BP	BP	No	40	Yes	Yes
13 [14]	2001	1.2, 1.2	SS-P	No	MP	MP	No	29	Yes	Yes
14 [15]	2001	3	IM	Yes	DM	BP	1 Layer	26	Yes	Yes
15	2002	2	SS	No	MP	BP	1 Suture	33	Yes	Yes
16	2002	4	SS-P	No	BP	BP	No	35	Yes	Yes
17 [16]	2003	4	SS-P	No	MP	MP	No	36	Yes	Yes
18 [17]	DM	2.5	IM	No	MP	MP	1 Figure-of-8	36	Yes	Yes
19 [18]	2004	4	IM	No	MP	BP	1 Figure-of-8	35	Yes	Yes

Gebeliğe Bağlı Ölümler

Ölüm Nedenleri	Sayı	(%)
Direkt Nedenler	46	73.0
Hipertansiyon	11	17.5
Obstetrik enfeksiyonlar	9	14.3
Uterin rüptür	9	14.3
Anemi	8	12.7
CS	5	7.9
Potpartum Kanama	2	3.2
Abruptio plesanta	2	3.2
İndirect Nedenler	14	22.2
HIV komplikasyonları	6	9.5
Malaria	4	6.3
Respiratory Distres	2	3.2
Menegitis	2	3.2
Bilinmeyen	3	4.8
Total	63	100

Optimal Timing and Mode of Delivery After Cesarean with Previous Classical Incision or Myomectomy: A Review of the Data

Mark B. Landon, MD,* and Courtney D. Lynch, PhD, MPH[†] 2011



Optimal Timing and Mode of Delivery After Cesarean with Previous Classical Incision or Myomectomy: A Review of the Data

Mark B. Landon, MD,* and Courtney D. Lynch, PhD, MPH[†]

Table 4 Management of Pregnancy After Previous Myomectomy: Risks by Timing of Delivery

	38 Weeks, %	39 Weeks, %
Rupture	—	0.5-1.0
Hysterectomy	—	0.05-0.1
HIE/NND	—	0.025-0.05
Stillbirth	—	0.2
NICU admit	8.1	5.9
TTN	3.9	2.7
RDS	1.9	0.9

HIE, hypoxic ischemic encephalopathy; NICU, neonatal intensive care unit; NND, neonatal death; RDS, respiratory distress syndrome; TTN, transient tachypnea of the newborn.



Sonuç

- Vakaya göre 6-12 ay gebelikten uzak dur
- Doğru endikasyon
- Endometrial kavitenin post op kontrolü
- Doğru sütürasyon
- İyi SET-UP