Laparoscopic resection versus myolysis in the management of symptomatic uterine adenomyosis: alternatives to conventional treatment

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Abstrak

Dalam kurun waktu Juni 2003 sampai dengan Juni 2004, pasien-pasien yang menderita adenomiosis berdasarkan ultrasonografi transvaginal dan memiliki keluhan menorhagia, dismenore, mcmpun nyeri pelvis diikulsertakan dalam penelitian. Randomisasi dilakukan untuk mengalokasikan subjek ke dalam kelompok reseksi dan kelompok miolisis. Semua pasien dan kedua kelompok mendapal GnRH analog 3 siklus pasca-laparnskopi operatif. Penilaian dilakukan dalam jangka waktu 6 bulan, baik secara subjektif melalui kuesioner maupun secara objektif melalui evaluasi volume adenomiosis per ultrasonografi transvaginal di akhir semester. Terdapat 20 pasien yang menjalani pembedahan, 10 dalam kelompok reseksi dan JO dalam kelompok miolisis. Komplikasi bermakna tidak ditemukan pada kedua kelompok. Evaluasi subyektif dapat dilakukun pada semua pasien sedangkan evaluasi objektif hanya dapal dilakukan pada 17pasien. Tidak didapatkan perbedaan bermakna antar-kelompok dalam penentuan skor keluhan menorhagia (p = 0.399) dan dismenorea (p=0.213). Tidak ditemukan perbedaan bermakna dalam median penambahan volume adenomiosis (p = 0.630) antara kelompok reseksi (medicui= +15,35% (-100 - 159)) dengan kelompok miolisis (median=+48,43% (-100 - 553)). Lima pasien hamil, 3 dari kelompok reseksi, 2 dari kelompok miolisis, dengan satu kasus ruptur uteri pada usia kehamilan 8 bulan pada kelompok miolisis. Efektifitas reseksi adenomiosis per laparoskopi tidak berbeda bermakna dengan miolisis adenomiosis per laparoskopi dalam penataksanaan adenomiosis bergejala. Miolisis tidak disarankan bagi wanitayang masih ingin hamil. (Med J Indones 2006; 15:9-17).

<hr><i>Effective therapy preserving reproductive function in adenomyosis is warranted. From June 2003 to June 2004, patients diagnosed as having adenomyosis by transvuginal ultrasound and had symptoms of menorrhagta, dysmenorrhea, and pelvic pain were randomly allocated to either receive laparoscopic resection or myolysis. GnRH analog was given for 3 cycles after surgery. Within 6 months, symptoms were evaluated using questionnaires and at the end of follow up, adenomyosis volume was assessed by transvaginal ultrasound. There were 20 patients included, 10 patients had resection and the rest underwent myolysis. Both procedures did not yield significant complications. Subjective evaluation by questionnaires was done in all patients. Three patients could not be evaluated objectively by transvaginal ultrasound, 2 patients resigned and I was pregnant. There was no significant difference in menorrhagia and dysmenorrhea reduction score between the 2 groups (p=0.399 and 0.213, respectively). In both groups, dysmenorrhea was reduced significantly after treatment. No significant statistical difference was found in median adenomyosis volume increment (p=0.630) between the resection (median= + !5.35% (-100-159)) and myolysis groups (median=+48.43% (-100-553)). Five patients were pregnant, 3 from the resection group and 2 from the myolysis group. Uterine rupture was found in I patient (from the myolysis group) at the age of 8 months of pregnancy. The effectiveness of laparoscopic adenomyosis resection was not significantly different compared with la-parascopic myolysis as an alternative conservative surgery in treating symptomatic adenomyosis. Myolysis was not recommended for women who wish to be pregnant. (MedJ Indones 2006;

15:9-17)</i>