Tratamento da Lesão Precursora: Repercussões sobre a Fertilidade

Clique para editar o estilo do subtítulo mestre

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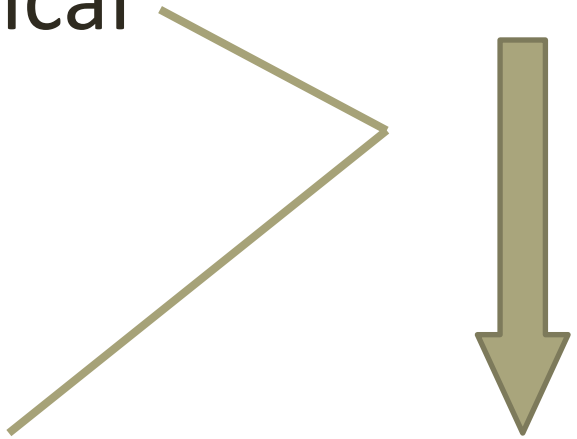
- *IFCPC Member Educational Committee*

- Screening Cancer Cervical

ASSOCIADO



- Tratamento das NICs

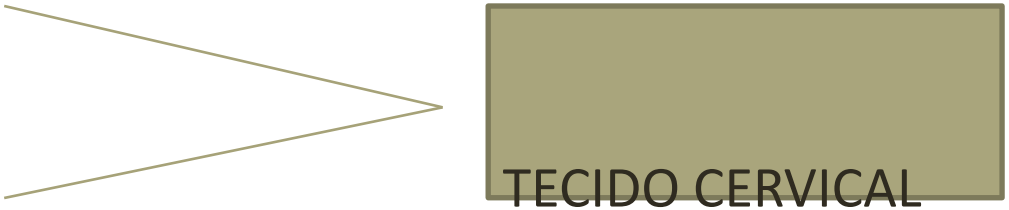
INCIDÊNCIA DE CÂNCER CERVICAL

Tratamento das Neoplasias Intraepiteliais Cervicais

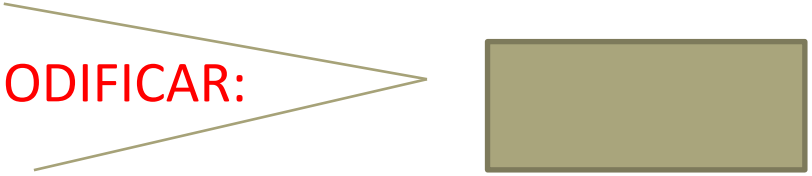
REMOÇÃO

OU

DESTRUIÇÃO



PODE MODIFICAR:



ESTRUTURA

American Society for Colposcopy and Cervical Pathology 2006 consensus guidelines for the management of women with CIN

Pontos a considerar para mulheres que foram submetidas a tratamento eletrocirúrgico para lesão de alto grau:

- Aumento de risco para efeitos adversos, tais como:

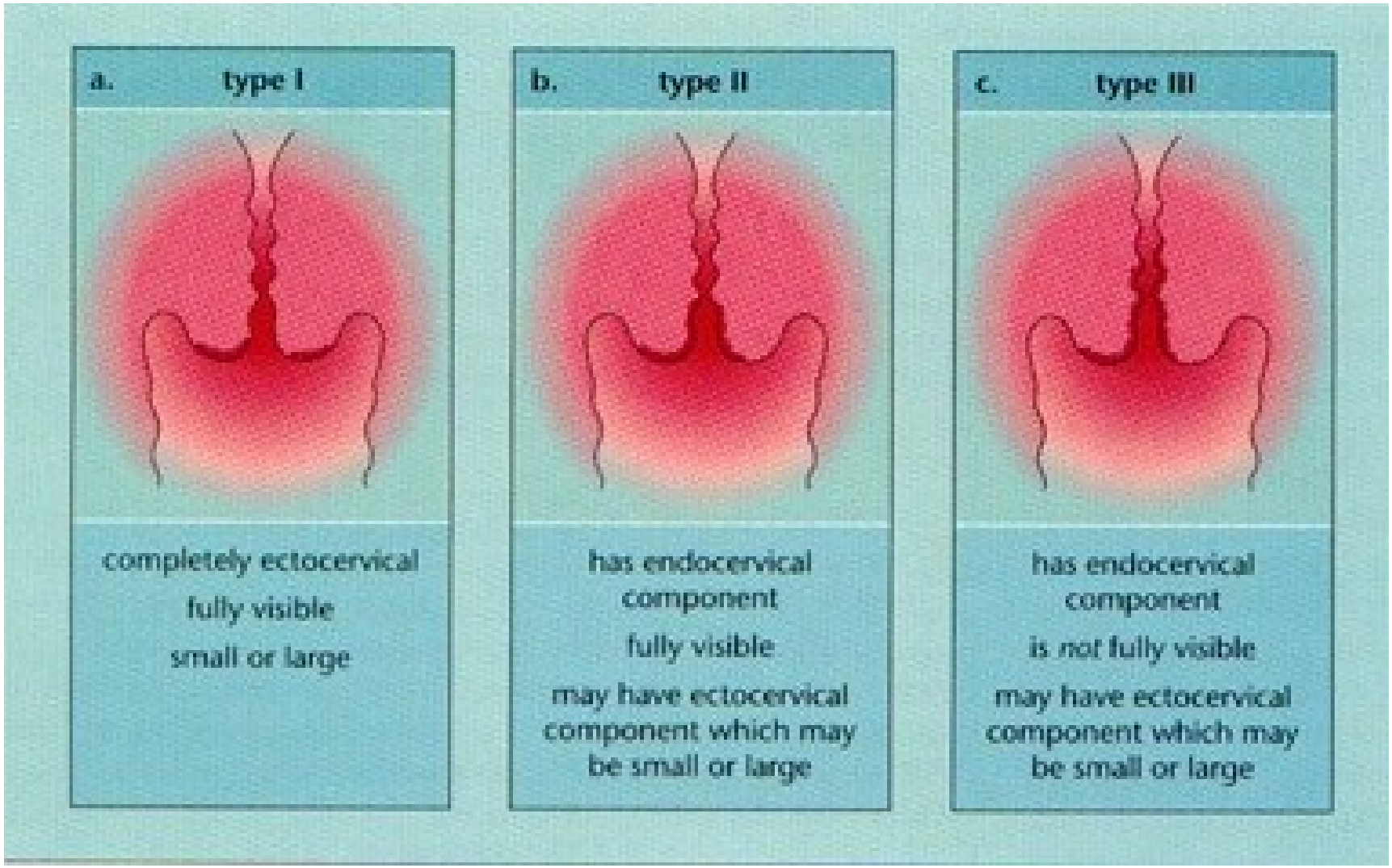
- Parto Prematuro

Risco esta relacionado a:

- Própria paciente
- Profundidade de invasão
- Largura/ extensão da excisão
- Repetição procedimento

TIPOS DE ZONA DE TRANSFORMAÇÃO

IFCPC – International Federation of Colposcopy and Cervical Pathology, 2000

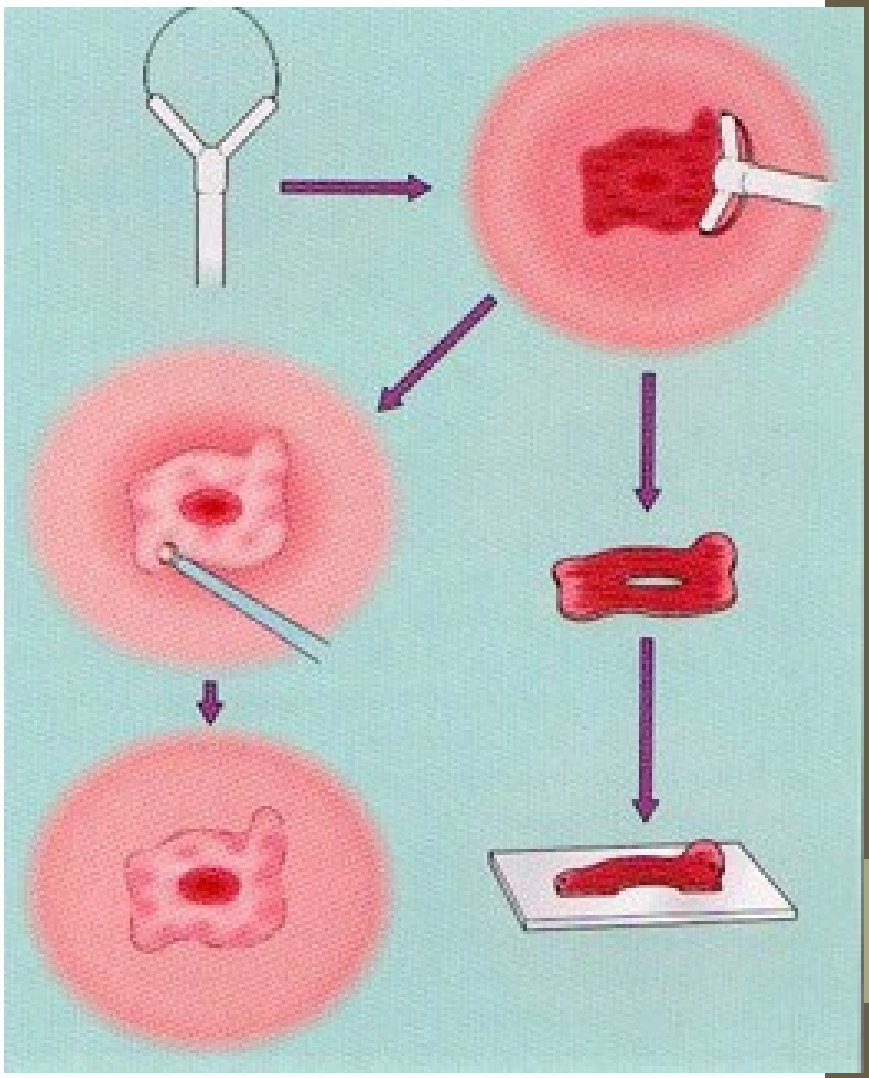


Lesão de Alto Grau - Métodos Excionais

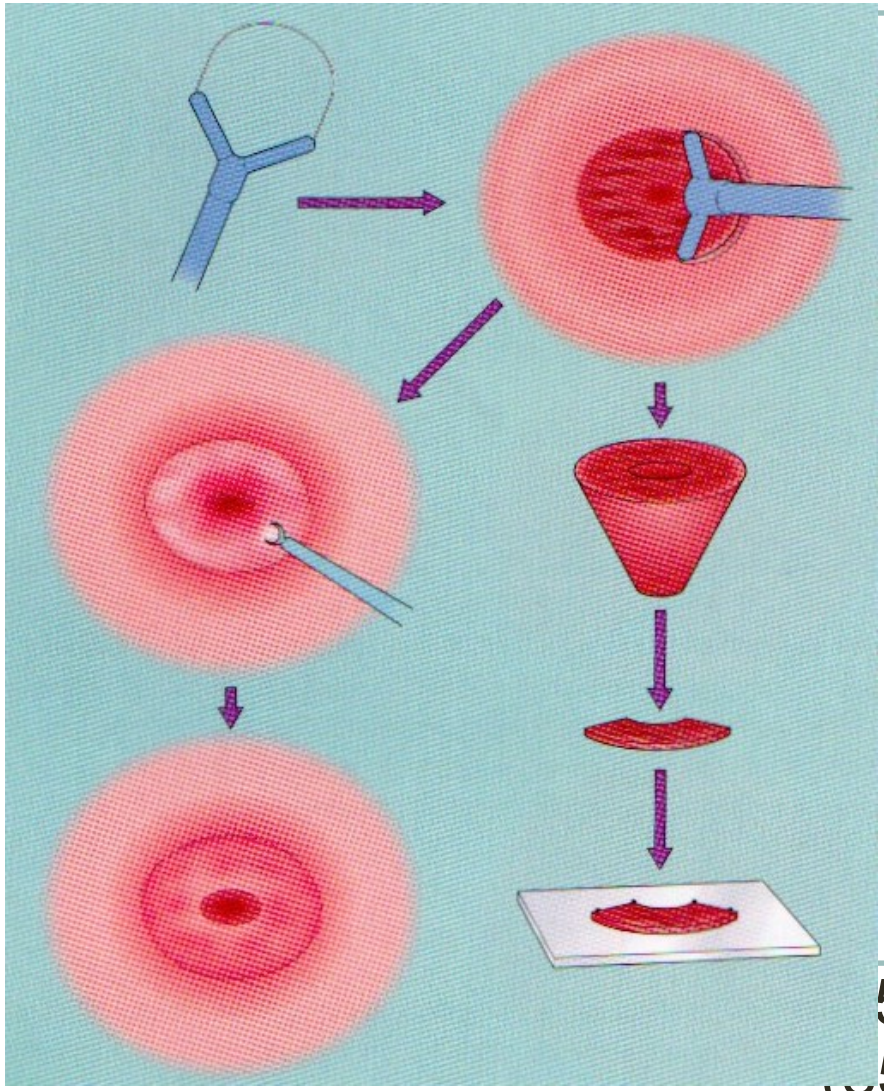
· Excisão da ZT:
EZT/LLETZ/LEEP

·Indicação: ZT do tipo 1

·Profundidade de excisão:
10 mm (1 cm)



Lesão de Alto Grau Métodos - Excionais



- Conização eletrocirúrgica:

LLETZ-Cone(Large loop excision transformation zone)

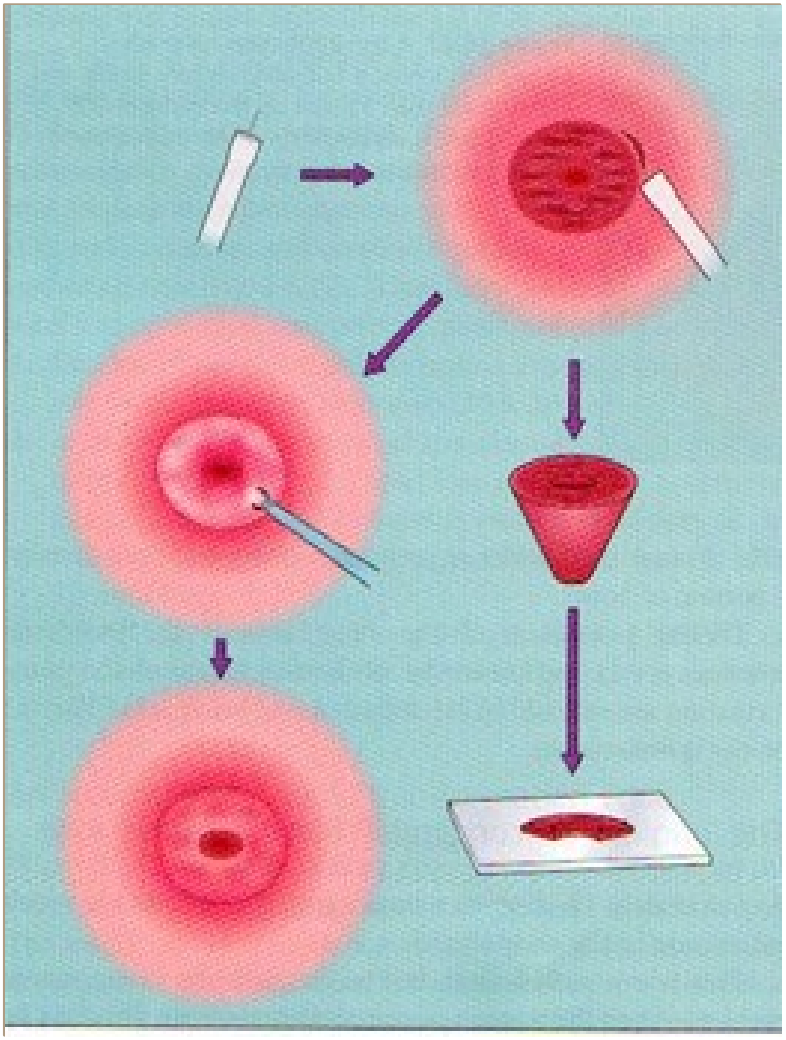
ou

Cone por alça

- Indicação: ZT dos tipos 2 e 3

Profundidade de excisão=2.0 a 5 cm dentro do canal cervical (95%das lesões situam-se no

Lesão de Alto Grau Métodos - Excionais



- Conização eletrocirúrgica:

SWETZ (Straight wire excision transformation zone)

ou

Cone por eletrodo reto

- Indicação: ZT dos tipos 2 e 3

Profundidade de excisão=2.0 a 2.5 cm dentro do canal cervical (85%das lesões situam-se no primeiro cm do canal, incluindo as

Studies about association between cone depth of LEEP and subsequent risk of preterm delivery

- Archarya *et al* (2002)= 79 deliveries with 9 preterm. Found an inverse relationship between cone depth and risk of preterm delivery.

Small size sample.

- Crane (2003)= Systematic review from 5 studies. LEEP appears to be associated with subsequent preterm birth (OR 1.81, 95% CI 1.18-2.76; *P*=.006) and low birth weight (OR 1.60, 95% CI 1.01-2.52; *P*=.04), even when smoking status is matched (OR 2.53, 95% CI 1.42-4.49; *P*=.001), but low birth weight was no longer significantly different.

Studies are needed for potential confounders and depth of the LEEP.

- Status socioeconômico
- História parto prematuro
- Não comparar LEEP com outro tipo de tratamento-crioterapia

Studies about association between cone depth of LEEP and subsequent risk of preterm delivery

- Sadler *et al* (2004)= 331 deliveries with 57 preterm. Found an increasing risk of preterm delivery with increasing cone depth. (RR1.2, 95% CI 0.8-1.8).

Studies about association between cone depth of LEEP and subsequent risk of preterm delivery

- Samson *et al* (2005)= 558 with 44 preterm. Demonstrate an increased risk of spontaneous preterm birth (OR 3.50, 95% CI 1.90-6.95;***P***<.001), preterm delivery after rupture of membranes (OR 4.10, 95% CI 1.48-14.09), and low birth weight neonates (OR 3.00, 95% CI 1.52-6.46; ***P*** .003). **BUT** detected no difference between preterm and term deliveries in cone diameter or depth (***P***.67), although the mean cone depth was 7 mm, and interval from LEEP to delivery. They observed no increased risk in women who had more than one LEEP.

Studies about association between cone depth of LEEP and subsequent risk of preterm delivery

- Kyrgiou *et al* (2006)= Analyzed 8 reports. The combined meta-analytic RR of preterm birth was 1.70 (95% CI 1.24-2.35). They found a significantly increased risk of preterm delivery when the cone depth exceeded 10 mm (OR 2.61, 95% CI 1.28-5.34) compared with cone depths less than 10 mm.

- Bruinsma *et al* (2007)= Increased risk of preterm birth in women with treated and untreated CIN than women in the general population. They suggest that the risk may be intrinsic to the women who develop CIN or an additional effect of the treatment.

Studies about association between cone depth of LEEP and subsequent risk of preterm delivery

- Arbyn *et al* (2008)= Realized a meta-analysis and suggested that most excisions in young women with fully visible transformation zone should not exceed 1 cm in depth.

- Jakobsson *et al* (2009)= Increased risk for preterm birth in women who had had prior LEEP. The risk was increased by large excision and repeat procedures.

Studies about association between cone depth of LEEP and subsequent risk of preterm delivery

- Noehr *et al* (2009)= Identified 8,180 preterm deliveries after LEEP. 273 were subsequent to two or more LEEPs. Increasing cone depth of LEEP was associated with a significant risk of preterm delivery with a 6% increase in risk per each additional millimeter of tissue excised (OR 1.06, 95% IC 1.03-1.09). Two or more LEEPs increased the risk fourfold for subsequent preterm delivery when compared with no LEEP before delivery and doubled the risk when compared with one LEEP before delivery.

Studies about association between cone depth of LEEP and subsequent risk of preterm delivery

- Werner *et al* (2010)= Studied 511 women who underwent LEEP before and 842 submitted to LEEP after pregnancy. They observed no association between LEEP and preterm birth. **BUT** they had no information on some potential confounders such as history of tobacco, alcohol, drug use, socioeconomic status, prior preterm births, depth and volume of tissue excised which are difficulties associated with retrospective analyses.

The effects of loop excision of the transformation zone on cervical length: implications for pregnancy

- Gentry DJ, *et al* (2000)= Realized a prospective study with 20 patients. Each one underwent transvaginal ultrasonography for determination of cervical length before the loop excision of the transformation zone and >/=3 months after the procedure. The mean cervical lengths as measured by transvaginal ultrasonography before and after were 3.1 +/- 0.8 cm and 3.1 +/- 0.7 cm, respectively. The correlation between ultrasonographic measurements before and after loop excision of the transformation zone was r = 0.88 (P <.0001). They concluded that after adequate healing time after loop excision of the transformation zone, the length of the cervix, as measured by transvaginal ultrasonography, does not appear to remain shortened.

Porque o tratamento da lesão precursora ↑ risco de parto prematuro?

- QUESTÕES

- Ressecção de grande quantidade de estroma diminui a integridade estrutural do colo, dificultando que a gravidez chegue ao termo?

- Será que o tecido que regenera (cicatricial) tem a mesma propriedade funcional?

Concluindo

Parecem existir outros possíveis fatores de confundimento importantes na avaliação da associação entre o tratamento da lesão precursora e a ocorrência de parto prematuro, que não foram controlados em vários estudos, tais como:

- Status socioeconomico
- História de parto prematuro
- Fumo
- Álcool
- Drogas
- Profundidade da excisão de canal
- Quantidade de estroma cervical removido

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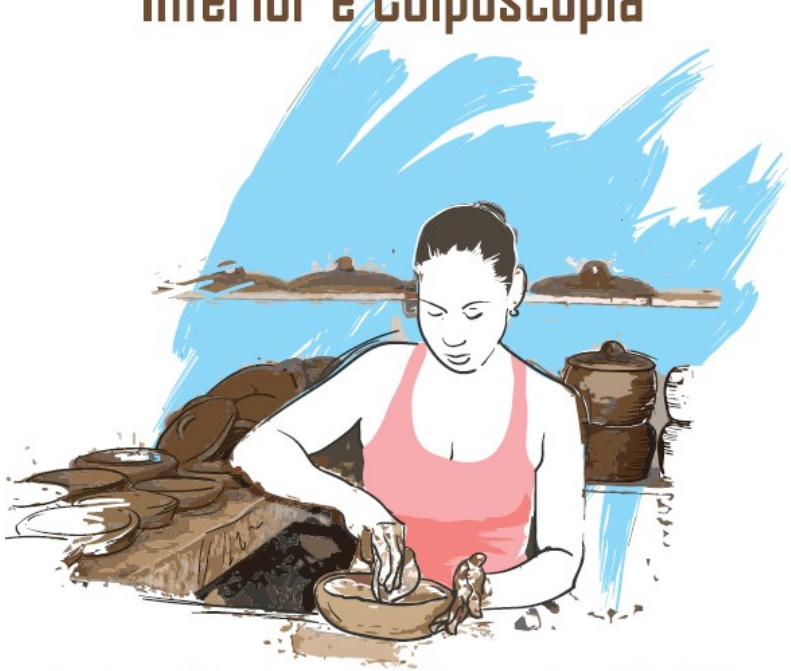

10 a 14 de outubro de 2012

Vitória - Espírito Santo

Realização

ABPTGIC

Associação Brasileira de Patologia do Trato Genital Inferior e Colposcopia

Capítulo Espírito Santo

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