DESCRIBE THE MORPHOLOGIC LESION AND PELVIC INFLAMATORY DISEASE FACTORS IN LAPAROSCOPIC PATIENTS IN NATIONAL HOSPITAL OF OBSTETRICS AND GYNECOLOGY 2015 – 2016

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QUESTION

- Pelvic inflamatory disease (PID) is a fairly common form of infection
- Medical treatment: high dose combination of antibiotics, easy to recurrent chronic PID
- Endoscopic surgery for the treatment of PID is valuable in the evaluation and management of injury as well as the finding of an infectious agent that precisely contributes to the diagnosis, management and prognosis of the best patient. Especially those who still need birth.

QUESTION

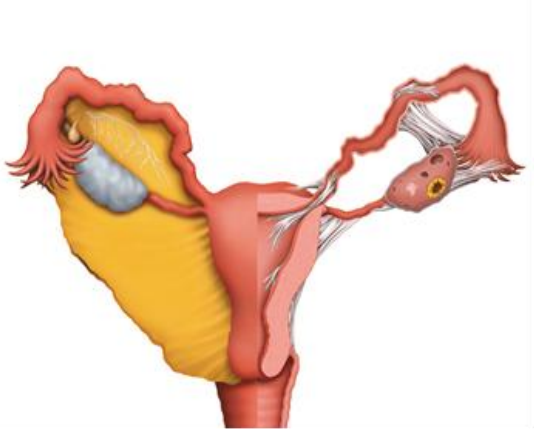
- PID are usually caused by sexually transmitted infections, after abortion, not sterile.
- Common microbiological agents are gonorrhea, tuberculosis, staphylococcus, streptococcus. PID is a acute and chronic PID.
- At the National Hospital Obstetrics and Gynecology from 2007 to 2010 in 425 cases of PID, 129 cases treated by laparoscopy accounted for 30.35%.

OBJECTIVE

- ***"Describe the morphologic lesions and PID factors in laparoscopy patients at the National Hospital of Obstetric and Gynecology 2015 – 2016"***

OVERVIEW

- General damage of the PID
- Fallopian tube:
- Salpingitis and edema.
- Tubal fimbria stick at levels
- + Tightening of the fallopian tube.
- + The stick completely create the bar seal
- + Stick to the pelvis floor or the cut-de-sac.
- + Stick with the organs in the pelvis.
- + Hydrosalpinx.
- + salpingoperitonitis.
- + Tubo-ovarian abscess



OVERVIEW

- Varian and pelvic lesion:

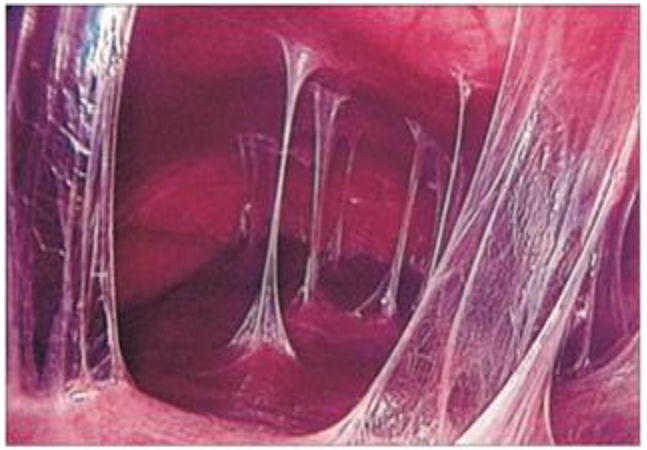
_ Inflammation stick with the uterus.

_ Inflammation sticking to the organs in the sub-frame

_ Inflammation → Follicles do not release ovules , ovarian fibrosis.

_ syndrome

Fitz - Hugh - Curtis



OVERVIEW

- **Pathophysiology** :

_ PID occurs when bacteria move from the vagina or cervix into the uterus, fallopian tubes, ovaries, or pelvis.

_ Less common are neighboring infections such as appendicitis or diverticulitis.

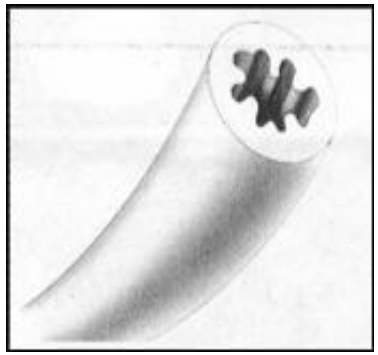
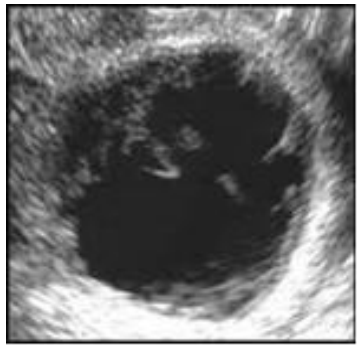
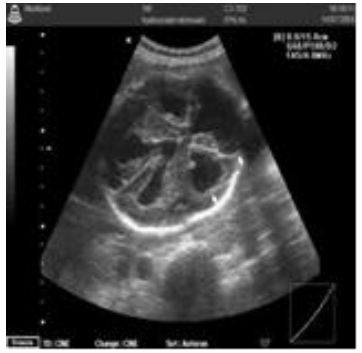
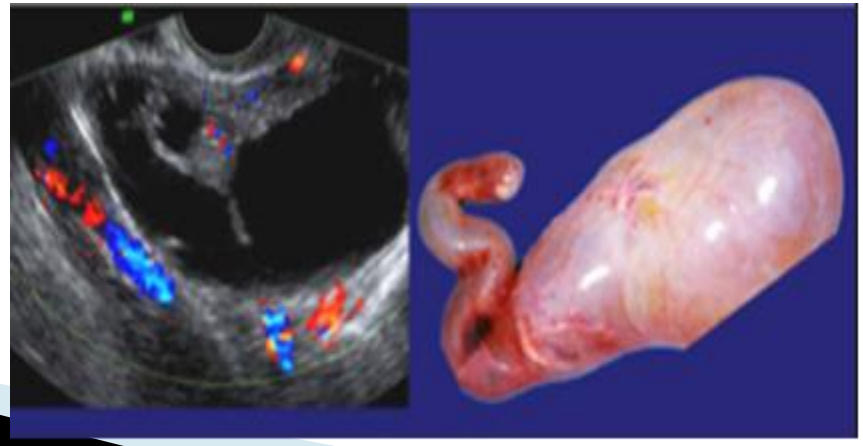
- Pathogen: *Chlamydia trachomatis*, *Neisseria gonorrhoeae* (60 - 75%)
- Less commonly : *Mycoplasma hominis*

  Haemophilus influenzae, *Streptococcus Pyogenes*

  Bacteroides và *Peptostreptococcus*

SUBCLINICAL

- Image diagnosis is very valuable.
- Ultrasound can be seen to dilate the fallopian tube.

SUBCLINICAL

- CT scan

  Early stage

  Thickening of the uterosacral ligaments

  Fallopian tube thick

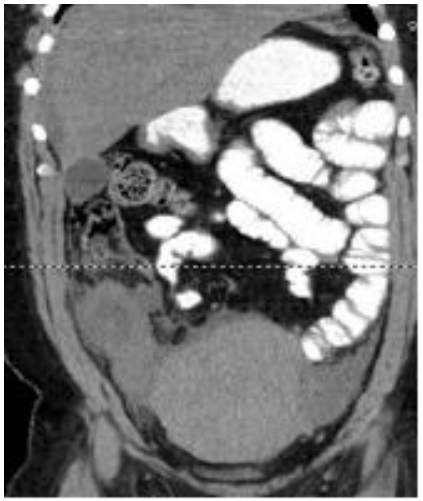
  Ovaries are big

  Fluid in the endometrial canal

  Late Stage:

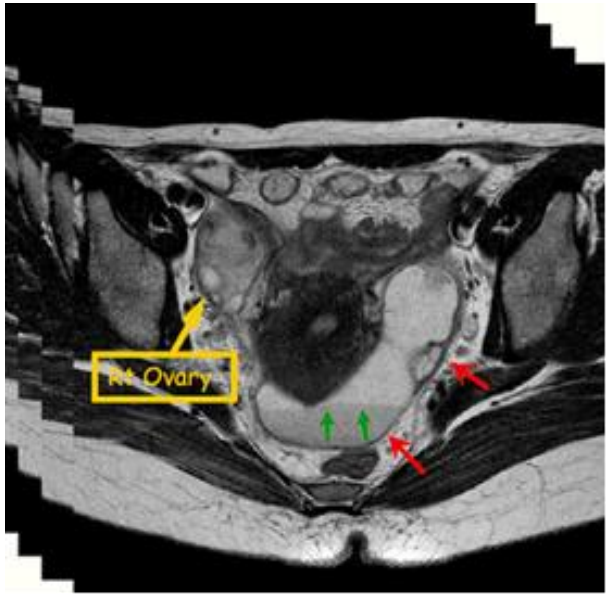
  Tubo-ovarian abcess

  Side structure: bowel obstruction, renal dropsy or hydronephotic, Fitz - Hugh - Curtis syndrome



SUBCLINICAL

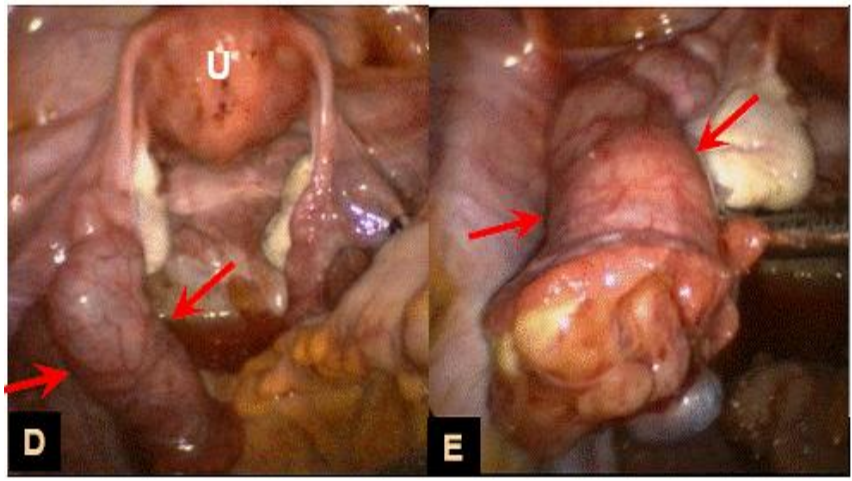
- Magnetic Resonance Imaging (MRI)
- MRI image in diagnosis PID is similar to CT scan
- MRI can distinguish fallopian tube blood stasis and salpingitis. Distinguish tubo-ovarian abscesses and tumor ovarian because of high tissue contrast.



LAPAROSCOPY

- The role of laparoscopy in PID
- Laparoscopy is the gold standard
- Invasive should not be applied regularly
- Indication:
- Did not respond to antibiotic treatment at the health establishment from 48 - 72 hours
- Need to drain the fluid

  In the abscess by the PID
- Cut scar caused by pain

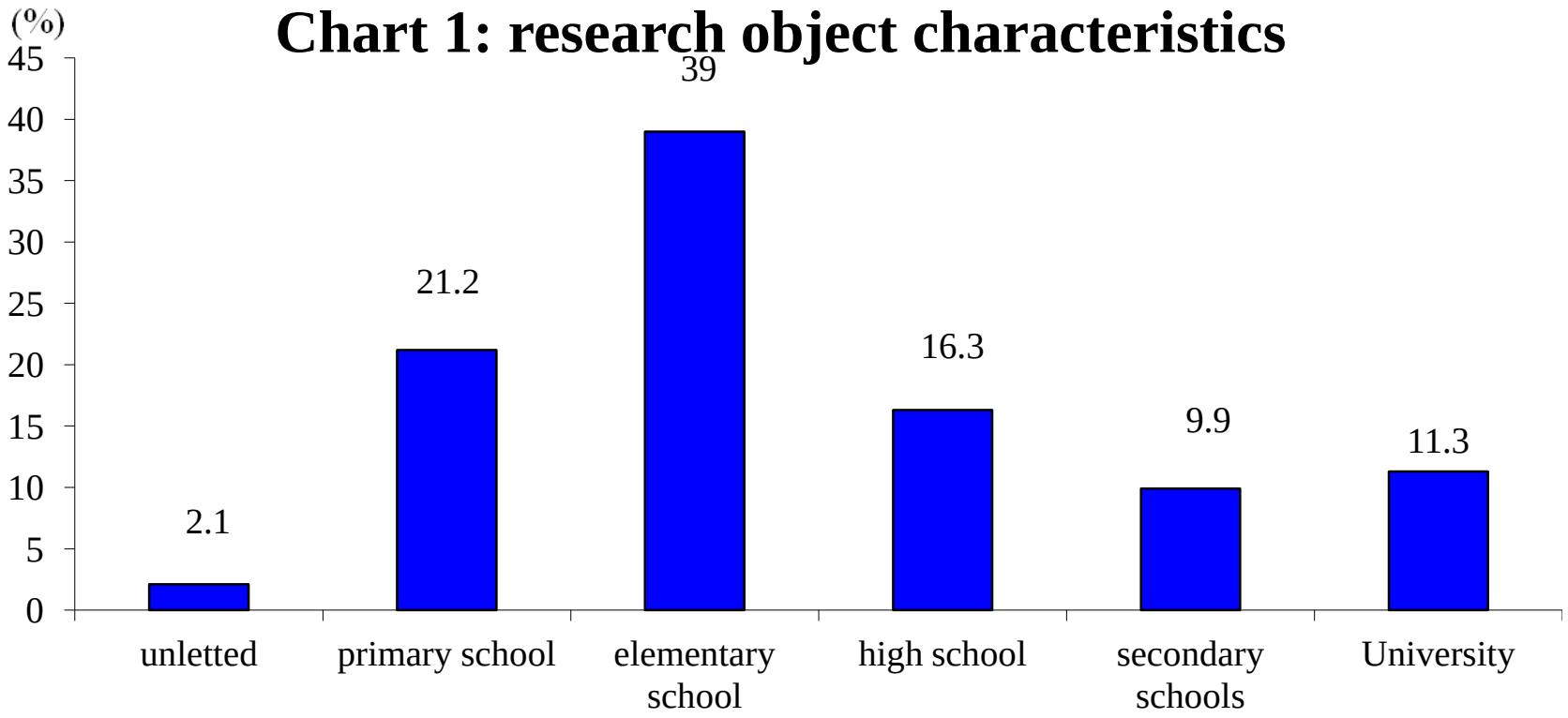


SUBIECTS AND METHODS

- Location and time of study:

  Department of Infectious Diseases and Department of gynecology in National Hospital of Obstetrics and Gynecology
- Research time: from 01/2015 to 12/2016.
- Research subjects:Patients diagnosed with PID are indicated for surgery after medical treatment but little or chronic PID.
- Research method: a cross-sectional descriptive study using quantitative and analytical methods

RESULTS

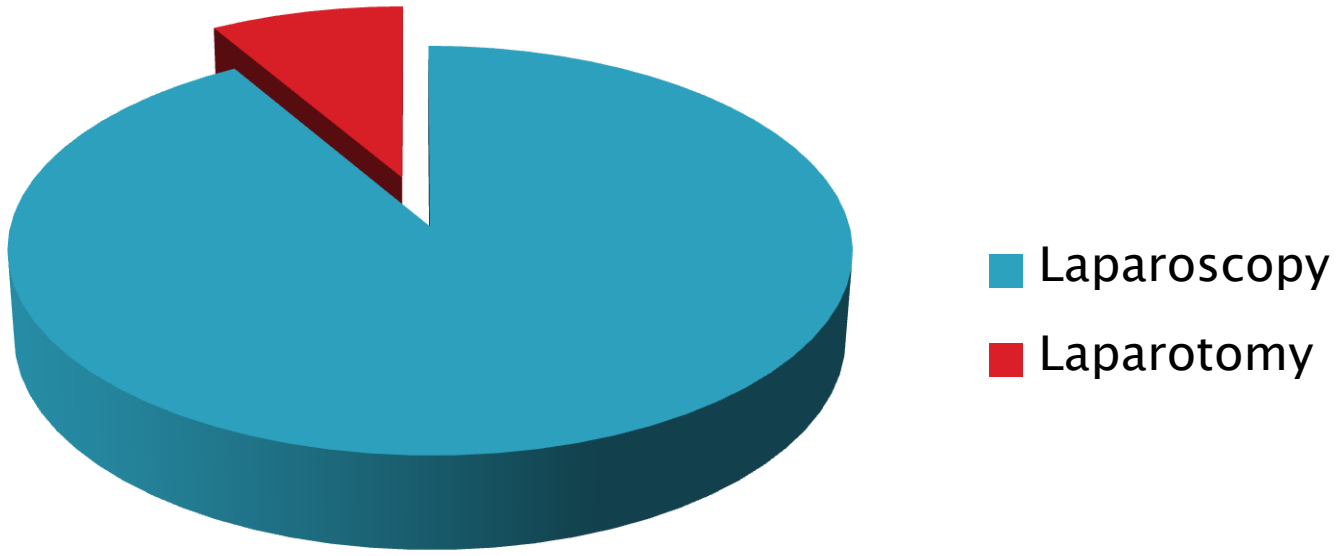


Infections occur mainly in patients aged 20-40 years, accounting for 56.7%. Age 41-50 has a high rate of PID, 32.6%.

Patients with education elementary school or higher accounted for nearly 80%.

RESULTS

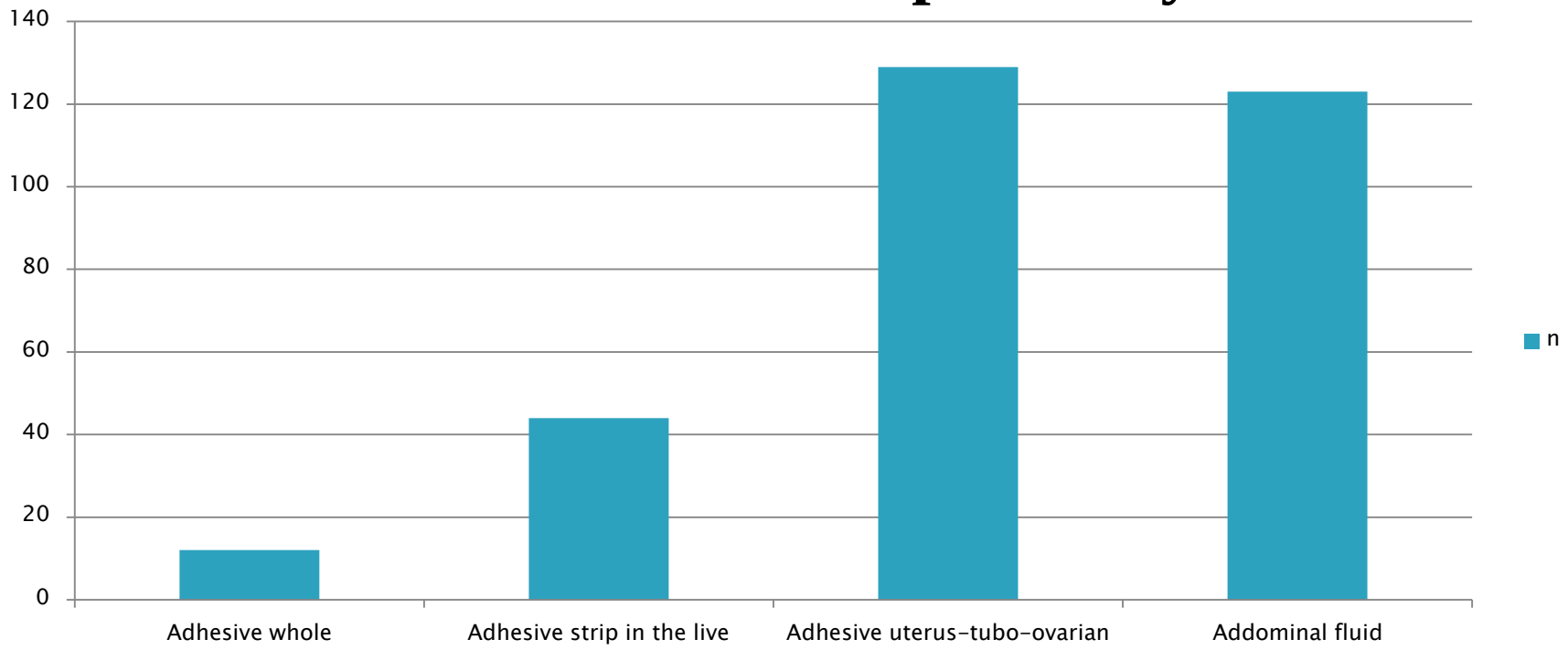
Chart 2: rate of laparotomy



In 141 patients with PID who had surgery for laparoscopic surgery, 12 patients (8.5%) underwent laparotomy because the abdominal cavity was too adhesive to observe the lesions.

RESULTS

Chart 3: Abdominal Laparotomy



-129 patients with laparoscopy: 44 had lesions in the liver (34.1%). 100% of patients had adhesive uterine-tubo-ovarian.

- 123 patients obtained abdominal cavity for bacterial culture accounted for 95%

RESULTS

Table 1: Characteristics of PID

	Group	n	%
Inflammation block location	Right	37	26,2
	Left	29	20,6
	Two side	75	53,2
Property	Full of water	44	31,2
	Pus	66	46,8
	Abcess	31	22
Size	< 2cm	1	0,7
	2 – 5cm	65	46,1
	>5cm	75	53,2

RESULTS
Table 2: Treatment for surgery

treatment	n	%
Open Fallopian tube	44	31,2
Salpingolysis	141	100
Drainage	96	68
Cat a Fallopian tube	32	22,7
Salpingectomy	48	34
Salpingo - ovariectomy	13	9,2
Hystero - oophorectomy	4	2,8
Wash abdomen	141	100

RESULTS

Chart 4: Rate of bacteria culture in abdominal fluid

85.3% of patients with abdominal implant have no bacteria

Most notably Ecoli is 5.7%.

DISCUSS

- PID occurs mainly in patients aged 20 to 40 years: 56.7%, the age of the strongest sexual activity, so susceptible to sexually transmitted infections. Age 41-50 has a relatively high rate of PID (32.6%), often hospitalized with severe infection symptoms.
- There is no link between educational level and PID.
- Of 141 patients who underwent laparoscopic surgery, 12 patients converted into laparotomy Because too adhesive. Nguyen Le Minh (18/129)

DISCUSS

Abdominal condition: 12 patients underwent laparotomy: 3 cases of peritoneal tuberculosis, 9 patients acquired tubo – ovarian abscess sticking attached to the uterus, intestine → MRI scan if the boundary of mass is indistinctive (5/12)

- 34,1 % had liver adhesion by Chlamydia
- 53,2% patients had inflammatory mass on either side
- 46,8% were fallopian tuberosity(clinical: severe infection, antibiotics was used but this condition is unending). fallopian tuberosity and tubo – ovarian abscess: Thorough handling by cutting the fallopian tuberosity cobined or not with ovarian, laving abdomen, drainage. There are no cases of complications after surgery.
- Aqueous fallopian tube was easily confused with ovarian tumors, (Clinical: not intense, gynecology or infertility examination). Gashing on surface of fallopian tube if mass < 3cm and the patients had not enough children.

DISCUSS

Isolation of bacteria :

- Fluid in abdomen of 123 patiens underwent surgery will be made bacterial culture
- 85.3% of cases was not found bacteria when abdominal fluid was cultured, This result is known by all patients taking high doses of antibiotics before surgery.
- The most popular is Ecoli (5.7%).
- Enterobacter, Klebssiela, Spherical, candida albicans , Pseudomonas aeruginosa had low rate and no difference because it is very difficult to isolate these bacteria.

CONCLUSION

- Laparascopy: 99,3% cases got the size of inflammation mass > 3cm, 53,2% patients had inflammatory mass on either side, fallopian tuberosity occupied 46,4%

- 100% of the patients are removed the adhesion, laving abdomen. 68% cases in cases of fallopian tuberosity, tubo – ovarian abscess was drainage

- 34,1 % had liver adhesion by Chlamydia.

- The most popular is Ecoli

- Gashing on surface of fallopian tube was indicated in cases of Aqueous fallopian tube with desire to give birth. Others was indicated salpingectomy (100%). Removing ovarian and hysterectomy if the patients was so old, the size of abscess is too big, and had fibroid combination.


Thank You