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性分化異常

性分化異常(disorders of sex development, DSD)目前學界的分類，分為三大類：(1) Sex chromosome DSD, (2) 46,XY DSD, (3) 46,XX, DSD 三類 (根據 Hughes IA, et al., J Pediatr Urol, 2006)。三大分類底下有很多小病種，各有小命名。

在大分類與小命名中，為了描述性器官表型(phenotype)異常，有 2 個用詞：Gonadal dysgenesis (指 testis or ovary 發育不良), ambiguous genitalia (指 hypospadias, undescended testes, micropenis, clitoromegaly, labial fusion, labial mass), 常常被提及。

比較熟悉的 DSD, 新舊病名對照如下：

現在病名	過去病名
Sex chromosome DSD	(比較著名者：如下) 45,X Turner 47,XXY Klinefelter
46, XX DSD	Female pseudohermaphroditism (最著名者 congenital adrenal hyperplasia)
46, XY DSD	Male pseudohermaphroditism (著名者 androgen insensitivity syndrome)
	Dysgenetic gonads
Ovotesticular DSD	True hermaphroditism

診斷方面：(1)首要是染色體核型，(2)血清 17-OHP, Testosterone, LH, FSH, AMH, Na, K , Cl, sugar, (3)影像學骨盆腔超音波(或加上 MRI 檢查)。但，時而難以確診。

治療方面，除了 Congenital Adrenal Hyperplasia (先天性腎上腺增生)外，效果有限，提供心理支持為要。

至於能否產前胎兒診斷？sex chromosome DSD 當然沒問題。至於 congenital adrenal hyperplasia, androgen insensitivity syndrome 目前已有成功的文獻報告。

陳子健
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有症狀子宮腫瘤之處置

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Major symptoms caused by uterine tumors (leiomyoma, adenomyosis, mixed, etc) include hemorrhage, pain, and compression. Symptomatic uterine tumors can be managed surgically (uterus-preserving or not; laparotomy; minimally invasive surgery; hysteroscopy) or nonsurgically (analgesics; tranexamic acid; gonadotropin-releasing hormone agonist; ulipristal acetate; dienogest; gestrinone; levonogestrel intrauterine system; uterine artery embilization; radiofrequency ablation; high-intensity focused ultrasound). Althogh the incidence of malignant uterine tumor is low, the potential risk should be kept in mind when symptomatic uterine tumors are managed either surgically or nonsurgically. If the uterine tumor is malignant, the methods chosen for surgical manipulation and specimen retrieval would have impact on survival. Surgical tips and complementary managements for symptomatic uterine tumors will also be briefly reviewed.

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張穎宜

SY27

婦女健康與營養

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Menopause occurs when a woman does not have menstruation for 12 consecutive months and usually begins between the ages of 45 and 55. Menopause can cause some discomfort, such as cold sweating, hot flashes, weight gain and is related to some cardiovascular diseases. Metabolic syndrome increases the odds of developing cardiovascular disease (CVD), due to a wide spectrum of contributing risk factors. Menopause is also regarded as one contribution factor of metabolic syndrome. The proportion of individuals affected by metabolic syndrome has increased in the past few decades, with approximately 25% of the world's adult population currently being affected. According to previous studies, age of 40-59 people has three times of chance to have metabolic syndrome and age more than 60 years old has six times of chance to have metabolic syndrome compared with those 20 to 39 years of age . It has been found that people with metabolic syndrome are almost twice as likely to die from a heart attack or stroke, and are five times more likely to develop type 2 diabetes, compared with those unaffected by metabolic syndrome. In general, nutrition is an important issue for menopausal women in prevention of the postmenopausal symptoms and metabolic syndrome. Here, we would like to report the association of menopause and metabolic syndrome and the role of nutrition for menopausal women.

江岭諭
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子宮切除後對女性健康之影響

Effects of hysterectomy in women’s health

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Hysterectomy is one of the most surgical procedures performed in Gynecological surgery. According to text books, the highest rate of hysterectomy is between the ages of 40 and 49 years and uterine leiomyomas are the major indication. As we knew, for premenopausal women should consider ovarian preservation during hysterectomy to prevent further cardiovascular risk and to keep normal hormone function. However, for these patients with ovarian preserved hysterectomy, have any long term physical condition changed in their lives? Here, we don’t mention about the postoperative complications of hysterectomy or the routes of hysterectomy, but focus on general health condition after hysterectomy. Therefore, we investigated current studies related single hysterectomy and cardiovascular risk, metabolic changes, mental health condition, BMI changes, osteoporosis risk and sexual function. From this review, we hope we could help patients make best choice between the pros and cons of hysterectomy.

林宜珈
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Evaluation of fetal lung abnormalities

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To the newborn, breathing is the first issue after birth. Breathing difficulties are common immediately after birth and during the first few hours of a baby's life. Congenital fetal lung abnormalities, such as bronchial atresia, bronchogenic cyst, congenital high airway obstruction syndrome, congenital pulmonary airway malformation, diaphragmatic hernia, lung agenesis-hypoplasia, pleural effusion and pulmonary sequestration… ect., can be detected under the ultrasound examination.

In this talk, I will focus on fetal lung mass lesions. Not only ultrasonography but magnetic resonance imaging (MRI) can help us to make the differential diagnosis of hyperechogenicity lung masses. MRI is also useful in determining lung volume, which has a prognostic implication on postnatal pulmonary function. Imaging follow up during the prenatal exam is also important to determine when and how to investigate those fetuses. Cooperation with neonatologist to perform Ex-utero Intrapartum Treatment (EXIT) procedure during labor, either vaginal delivery or cesarean section, is the best way to help those predictable breathing difficulty newborns.

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婦女尿失禁的保守性治療

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Urinary incontinence, the involuntary leakage of urine, is often underdiagnosed and undertreated. Besides, nearly 50 percent of those who did receive treatment reported moderate to great frustration with ongoing incontinence.

Determining the classification of urinary incontinence type (stress, urgency, mixed) can be very helpful to treatment. Indications for further evaluation or referral for treatment of urinary incontinence include the presence of associated abdominal/pelvic pain, gross or microscopic hematuria in the presence/ or absence of urinary tract infection, culture-documented recurrent urinary tract infections, new neurologic symptoms, suspected urinary fistula or urethral diverticulum, chronic catheterization, pelvic organ prolapse beyond the hymen, history of pelvic reconstructive surgery or pelvic irradiation, or persistently elevated postvoid residual urine.

Initial treatments for most types of incontinence (stress, urgency, or mixed) include lifestyle modifications and pelvic floor muscle exercise, along with bladder training in women with urgency incontinence and in some women with stress incontinence. Modifying contributory factors would be also very important. Topical vaginal estrogen therapy for peri- or postmenopausal women with either stress or urgency incontinence and vaginal atrophy due to genitourinary syndrome of menopause (GSM) was suggested. Alpha-adrenergic agonists stimulate urethral smooth muscle contraction, had been used previously for the treatment of stress incontinence. Anti-muscarinic drugs and beta-3 agonist were proved to be useful to treat urgent urine incontinence. Overflow incontinence can mimic stress incontinence, urgency incontinence or mixed urinary incontinence (MUI). Women with overflow incontinence also may present with a variety of symptoms including involuntary, intermittent, or continuous urinary leakage with no warning or sensation, dribbling, and incomplete bladder emptying. Treatment of urinary incontinence associated with impaired bladder emptying depends upon the etiology. Some specialty equipments were aslo reported for the treatments of urinary incontinence including transurethral radiofrequency collagen denaturation, intravesical balloon device, electroacupuncture, pulsed magnetic stimulation and the vaginal laser (CO2 or erbium).