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· 临床医学 ·

乙状结肠新膀胱术治疗肌层浸润性膀胱癌 15 例疗效观察

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[摘要] 目的:观察根治性膀胱切除术后乙状结肠新膀胱术治疗肌层浸润性膀胱癌的效果。方法:对 15 例肌层浸润性膀胱癌的男性患者先行膀胱全切术,然后采用乙状结肠新膀胱术,对其疗效及技术要点进行分析。结果:术后 15 例获随访 6 ~ 72 个月。5 例出现双侧轻度肾积水,1 例单侧肾积水;新膀胱容量达 210 ~ 456 ml,膀胱静压为 18.6 ~ 31.8 cm H_2O,排尿时膀胱内压为 36.21 ~ 71.56 cmH_2O,最大尿流率 10.22 ~ 12.26 ml/s,残余尿量 33 ~ 58 ml。1 例在第 1 年内出现暂时性白天尿失禁,11 例有不同程度夜间尿失禁。结论:乙状结肠新膀胱术贮尿容积大,原位自主排尿,白天控尿效果较好,夜间控尿情况较差。肾功能保护较好,无明显的水、电解质及酸碱平衡紊乱,是较理想的原位膀胱替代术。

[关键词] 膀胱肿瘤;膀胱切除术;乙状结肠新膀胱术

[中国图书资料分类法分类号] R 737.14　　[文献标识码] A

The curative effect observation of sigmoid neobladder in 15 cases with invasive bladder cancer

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[Abstract] **Objective:** To investigate the curative effect of sigmoid neobladder after radical cystectomy in 15 patients with invasive bladder cancer. **Methods:** Sigmoid neobladder was conducted after radical cystectomy in 15 males with bladder cancer. The curative effect and technical points were analyzed. **Results:** Fifteen cases were followed up for 6 to 72 months. Bilateral and unilateral hydronephrosis was found in 5 cases and in 1 case, respectively. The volume of urodochium was 210 to 456 ml, and the static pressure in neobladder was 18.6 to 31.8 cmH_2O. Vesical micturition pressure was 36.21 to 71.56 cmH_2O. Qmax was between 10.22 to 12.26 ml/s. The residual urine volume was 33 to 58 ml. Daytime incontinence was found in 1 case in the first year after operation. Nocturnal urinary incontinence was found in 11 cases. **Conclusions:** The sigmoid neobladder had several advantages including an adequate reservoir capacity, recovery of automatic micturition, good renal function, no acid-base and electrolyte imbalance, and the continence effect was good at daytime, but not good at night. It could be a good choice a better operation in replacing bladder.

[Key words] bladder neoplasms; cystectomy; sigmoid neobladder

根治性膀胱切除术是治疗肌层浸润性膀胱癌的标准方式。尿流改道术目前尚无标准的治疗方案,保护肾功能、提高患者生活质量是治疗的重要目标。原位新膀胱术由于患者术后生活质量高,近年来已被很多临床医生作为尿流改道的首选术式,并为患者所接受[1]。2002 年 3 月至 2009 年 7 月,我科对 15 例肌层浸润性膀胱癌患者施行乙状结肠新膀胱术,现作报道。

1　资料与方法

1.1　**一般资料**　本组 15 例,均为男性,年龄 52 ~ 68 岁。其中 1 例为膀胱腺癌,其余 14 例为移行上皮细胞癌。T2 期 10 例,其中低分级尿路上皮癌 3 例,高分级尿路上皮癌 7 例;T3 期 4 例,低分级尿路上皮癌 1 例,高分级尿路上皮癌3 例;T4a 期 1 例,病理为高分级尿路上皮癌。初发患者 3 例,复发患者 12 例,其中曾行经尿道膀胱肿瘤电切术(TURBT)4 例,膀胱部分切除术 8 例。单发性膀胱癌2 例,多发性膀胱癌13 例。诊断均经病理检查证实。

1.2　**手术方法**　15 例患者均行气静全麻。打开盆腔腹膜反折,探查腹腔。切除膀胱顶部覆盖的腹膜,行根治性全膀胱切除(包括前列腺、精囊切除,保留前列腺远端包膜约 0.5 cm,避免损伤尿道括约肌)。向近端游离双侧输尿管约 4 ~ 6 cm,放入直径 3 mm 硅胶支架管并固定。切除阑尾,距肛门约 16 cm 游离一段 18 ~ 22 cm 的带系膜乙状结肠袢,吻合结肠断端,恢复肠道的连续性。

于肠系膜对侧缘纵行切开游离的结肠肠管,肠片排为 U 形,聚维酮碘冲洗肠腔内容物。2-0 可吸收线连续缝合相邻肠壁成袋状贮尿囊,暂不缝闭新膀胱前壁。行输尿管新膀胱吻合。早期 5 例单纯将输尿管拖入贮尿囊吻合,后期 10 例吻合时建立抗反流机制:在乙状结肠黏膜下与肌层间潜行分离出约 1.5 cm 的隧道,将输尿管引入,新膀胱内输尿管远

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端纵行切开约 1.0 cm 后外翻缝合形成乳头状。

尿道内置入 F22 双腔气囊导尿管,于贮尿囊最低位切开约 1.5 cm 创口与后尿道残端吻合 4~6 针,关闭新膀胱前壁。气囊稍向外牵拉可使吻合口的对合更紧密。另行新膀胱造瘘。

2 结果

15 例患者手术顺利,带蒂贮尿囊均能轻松下拉与后尿道吻合。手术总耗时 210~320 min。术中出血 300~550 ml,平均失血 400 ml,平均输血 520 ml。术后 14~20 天拔除新膀胱造瘘管及输尿管支架管,16~30 天拔除导尿管,无尿瘘发生。

15 例患者均获随访,术后 1 个月复诊 1 次,3 个月1 次,以后半年随访 1 次。随访时间 6~72 个月。患者均能自主排尿,术后 1 个月有 2 例出现白天尿失禁,13 例有不同程度夜间尿失禁。术后 3 个月白天尿失禁全部缓解,仍有 8 例夜间尿失禁。术后半年夜间尿失禁 4 例。新膀胱容量达 210~456 ml,患者每次最大尿量 260~500 ml。新膀胱静压为 18.6~31.8 cmH_2O。排尿时膀胱内压为 36.21~71.56 cmH_2O,最大尿流率 10.22~12.26 ml/s,残余尿量 33~58 ml。1 例出现单侧轻度肾积水,5 例出现对称性双侧轻度肾积水。术后未发现电解质及酸碱平衡紊乱病例,肾功能复查均正常。1 例术后 1 年死于肺转移,2 例分别于术后 36、42 个月死于脑血管意外和心肌梗死。

3 讨论

根治性膀胱切除术后行原位新膀胱术,是目前临床上治疗肌层浸润性膀胱癌的主要方法。国内外文献[2-3]报道采用回肠较多,回肠平滑肌的收缩性较低、顺应性高,控尿率较好,回肠黏膜萎缩后使尿液成分重吸收减少,手术操作较简单。但有一些患者的回肠系膜较短,无法向下拉入盆腔与后尿道吻合,或者勉强拉下,吻合口张力较大;另外,回肠新膀胱的患者早期的残余尿较少,尿潴留少见,但长期随访发现一部分患者出现排尿困难,甚至尿潴留[4-5]。回肠黏膜的吸收作用较强,早期部分患者可出现因重吸收尿液中成分而导致电解质及酸碱平衡紊乱,以高氯性酸中毒为主[6]。因此,需要另外一种新方法的使用以改变这些缺点或作为不能行回肠原位新膀胱手术的备选术式。

乙状结肠位于盆腔,与膀胱的位置相邻,距后尿道较近,尚未见乙状结肠因系膜短不能下拉与后尿道吻合报道[7]。本组 15 例患者术中均可将截取的乙状结肠袢轻松下拉,吻合口无张力,保证了良好的血供;导尿管气囊向外牵拉既使乙状结肠壁与后尿道对合更紧密,又不会引起缺血。15 例患者术后拔除导尿管后均未出现漏尿和吻合口狭窄。乙状结肠平滑肌收缩力较回肠强,可能是新膀胱排空好、远期排尿功能好的原因。15 例术后均能自主排尿,尿线较粗,射程较长,早期测残余尿 11 例 <40 ml,仅 2 例 >40 ml,但 <60 ml。最大尿流率均 >10 ml/s。乙状结肠新膀胱术的操作手术并不复杂,与回肠新膀胱术采用的 W 形缝合相比,U 型缝合节省时间。另外,因其肠壁肥厚,血供良好,输尿管和新膀胱的吻合口出现漏尿更少。本组患者未出现漏尿。

在早期手术中有 5 例行输尿管直接拖入吻合,术后均出现双肾对称性轻度积水,但肾功能、电解质均正常。其中 4 例行膀胱镜检查未发现有输尿管开口狭窄,但新膀胱造影可见双侧输尿管反流;在回肠原位新膀胱手术中,我们采用同样的吻合方法,几乎没有出现输尿管反流、肾积水。这种反流的出现,可能是由于乙状结肠的肠腔内压力较大,高于回肠肠腔的压力。结合国外一组病例的治疗经验[8],我们对后期 10 例患者改良了吻合方式,行黏膜下隧道法建立输尿管的抗反流机制,效果较好,仅 1 例出现肾积水。文献[8]报道的结果未出现 1 例肾积水。另有研究[9]认为,虽然乙状结肠新膀胱内压较高,但未引起肾功能的损害。

乙状结肠新膀胱术另一个主要并发症是夜间控尿情况较差。文献报道[9]认为该术式能提供满意的白天控尿,残余尿量较少,排尿频率适当,但夜间控尿情况较差。本组 15 例中 13 例出现不同程度的夜间尿失禁,持续时间较长,术后半年仍有 4 例未缓解;白天尿失禁较少,且恢复较快,术后 3 个月基本全部缓解。我们对这些患者进行指导,按照排尿计划定时排尿,结合使用尿片,改善了夜间生活质量。

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妊娠合并重度血小板减少 37 例临床分析

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[摘要] 目的:探讨妊娠合并重度血小板减少的病因及对母婴的影响。方法:对 37 例妊娠合并重度血小板减少的孕妇,根据病因、妊娠相关血小板减少症(PAT)为Ⅰ组,妊娠合并再生障碍性贫血、特发性血小板减少性紫癜(ITP)、骨髓增生异常综合征 RA 型(MDS-RA)及 HELLP 综合征为Ⅱ组,观察 2 组的妊娠结局。结果:37 例孕妇中 PAT 23 例(62.16%),ITP 9 例(24.32%);Ⅱ组产后出血率高于Ⅰ组($P<0.05$);Ⅰ组新生儿出生体重、胎龄均大于Ⅱ组($P<0.05 \sim P<0.01$);术后 10 天Ⅰ组产妇血小板恢复优于Ⅱ组($P<0.01$)。结论:妊娠合并重度血小板减少病因以 PAT 为主;其次为 ITP。由 PAT 引起的重度血小板减少患者妊娠结局较好。

[关键词] 妊娠;血小板减少;剖宫产
[中国图书资料分类法分类号] R 714.1 [文献标识码] A

Clinical analysis of 37 cases of severe thrombocytopenia during pregnancy

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[Abstract] **Objective:** To study the etiology and its influence on the mother and infant of severe pregnancy thrombocytopenia. **Methods:** The clinical data of 37 cases of severe pregnancy thrombocytopenia were analyzed retrospectively. The cases were divided into two groups according to the causes of the disease. The cases with pregnancy-associated thrombocytopenia(PAT) were enrolled in group Ⅰ and the cases with idiopathic thrombocytopenic purpura(ITP), aplastic anemia, HELLP syndrome and myelodysplasia(MDS-RA) in group Ⅱ. The outcome was compared between the two groups. **Results:** Twenty-three cases(62.3%) of severe thrombocytopenia during pregnancy were caused by PAT, and 9 cases(24.32%) were caused by ITP. The incidence of postpartum hemorrhage in group Ⅱ was markedly higher than that in group Ⅰ($P<0.05$). The neonate's average birth weight in group Ⅰ was higher than that in group Ⅱ, and the average gestational age of group Ⅰ was senior to that of group Ⅱ($P<0.05 - P<0.01$). The platelet counts in group Ⅰ recovered more quickly than that in group Ⅱ 10 days after the operation($P<0.01$). **Conclusions:** The major causes of severe thrombocytopenia during pregnancy are PAT and ITP; however, the patients suffering from PAT have a better outcome.

[Key words] gestation; thrombocytopenia; cesarean section

妊娠合并血小板减少是常见的产科合并症,可由多种内科合并症以及妊娠并发症引起。若血小板 $<50\times10^9$/L 则为重度血小板减少[1],易引起出血、感染等而危及母婴预后。本研究对在我院就诊的 37 例重度血小板减少的患者进行回顾性分析,旨在探讨妊娠合并重度血小板减少的病因及对母婴的影响,现作报道。

1 资料与方法

1.1 一般情况 2006 年 1 月至 2010 年 6 月因妊娠合并血小板减少在我科住院分娩的孕妇 109 例。其中重度血小板减少 37 例(33.94%),年龄 19 ~ 34 岁;孕周 34 ~ 41 周;初产妇 21 例,经产妇 16 例。37

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