

Heart Circ Physiol, 2005, 289(2): 501-512.
 [7] Chantler PD, Lakatta EG, Najjar SS. Arterial-ventricular coupling: mechanistic insights into cardiovascular performance at rest and during exercise[J]. J Appl Physiol, 2008, 105(4): 1342-1351.
 [8] Holvoet P. Stress in obesity and associated metabolic and cardiovascular disorders[J]. Scientifica, 2012, 2012(1): 205027.

[9] 金文胜,潘长玉,陆菊明,等.代谢综合征人群超声检测的动脉僵硬研究[J].中老年多器官疾病杂志,2006, 5(3): 204-207.
 [10] 陈明,罗建文,王金锐,等.心脏与血管超声生物力学[M].上海:上海科技教育出版社,2014:62-75.

(收稿日期:2018-03-30)

· 病例报道 ·

Ultrasonic misdiagnosis of tubal arcinosarcoma as uterine sarcomatoid transformation: a case report

输卵管癌肉瘤超声误诊为子宫肉瘤样变 1 例

马红英 卢一艳 房敬阳

[中图法分类号]R445.1, R737.32

[文献标识码] B

患者女,54岁,因下腹间断痛1年余,发现盆腔肿物2个月余入院。体格检查:体温、脉搏、呼吸均无异常,血压116/69 mm Hg (1 mm Hg=0.133 kPa)。一般情况可,心肺听诊无异常。腹部膨隆,盆腹腔触及巨大肿物,上缘达脐上4指,两侧达侧腹壁,腹肌紧张度增加,压痛阳性。妇科检查:宫颈光滑;盆腔触及巨大肿物,上缘达脐上4指,两侧达侧腹壁,活动差,压痛阳性。经阴道及经腹超声检查:后位子宫,宫体大小4.4 cm×7.5 cm×2.9 cm,肌层回声欠均,宫腔线居中,内膜厚约0.3 cm,宫腔内未见明显异常回声;子宫周边可见不均质低回声包绕,与子宫分界尚清,范围约20.0 cm×15.6 cm×18.3 cm,边界尚清,形态不规则,内部回声欠均,可见多发无回声区,其内可探及血流信号,阻力指数0.34~0.61;其两侧可见液性区,左侧深约1.2 cm,右侧深约2.6 cm;双侧卵巢显示不清。见图1~5。超声提示:盆腔囊实性肿物,结合病史倾向子宫肉瘤样变可能性大;腹腔积液。后经手术病理证实:双侧输卵管癌肉瘤,由低分化癌及未分化肉瘤组成,以低分化癌成分为主(腺鳞癌,占80%),累及右卵巢表面,未见脉管内癌栓及神经侵犯,见图6,7。免疫组化示肿瘤细胞:HER-1(2+),HER-2(-),Ki-67(+>75%),P53(+>75%),Top IIα(+50%~

75%),CK(癌成分+),Vimentin(肉瘤成分+),ER(2+<5%),PR(-),WT-1(-),PAX(-),NapsinA(-),CK5/6(鳞癌成分+),P40(鳞癌成分+),CDX2(-),AFP(-),CD99(+),HCG-β(-),CD30(-),EMA(癌成分灶+),SMA(-),Desmin(-),MyoD1(-),S-100(-),HMB45(-),MelanA(-),CD68(肉瘤成分灶+),免疫组化结果提示:癌的成分为腺鳞癌,肉瘤未见明确分化方向。

讨论:输卵管癌肉瘤又称输卵管恶性中胚叶混合瘤或恶性苗勒管混合瘤,临床极为罕见^[1]。输卵管癌肉瘤同时含有癌和肉瘤两种成分,具有高度侵袭行为。其癌成分以腺体分化为主,罕见的鳞状细胞分化^[2];肉瘤成分来源可为平滑肌、横纹肌、骨、软骨等。癌肉瘤多发生于绝经后妇女,平均发病年龄66.6岁^[3]。癌肉瘤大体多呈结节状,无完整包膜,肿瘤平均直径15~20 cm,切面呈实性或囊实性,常伴不同程度的出血、坏死。输卵管癌肉瘤最常见的症状有腹痛、不典型阴道流血、腹胀^[4]。本例患者54岁,主因间断下腹痛1年余,发现盆腔肿物2个月余而就诊。绝经未达半年,子宫不是典型的绝经后子宫改变,其横径达7.5 cm,考虑肿瘤压迫所致;而上下径、前后径及内膜为绝经后子宫改变,子宫轮廓尚清晰。癌肉瘤包块达20 cm,包

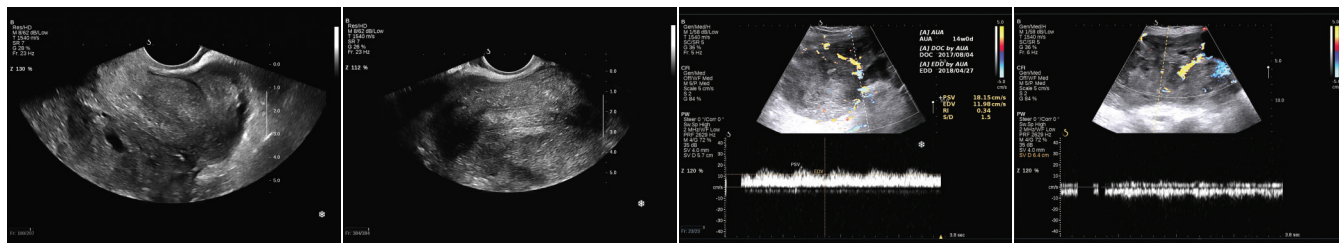


图1 经阴道超声子宫纵切面观示中央为后位子宫,周围被不均质回声包绕
 图2 经阴道超声子宫横切面观示中央为后位子宫,周围被不均质回声包绕
 图3 经腹部超声纵切面观示不均质回声包块,内探及低阻型动脉血流频谱
 图4 经腹部超声横切面观示不均质回声包块,内探及静脉及低阻型动脉血流频谱

(下转第185页)

of incidence and 1-year clinical outcomes from the italian CoreValve registry[J]. J Am Coll Cardiol, 2011, 57(9):1062-1068.

[3] Kappetein AP, Head SJ, Genereux P, et al. Updated standardized endpoint definitions for transcatheter aortic valve implantation: the Valve Academic Research Consortium-2 consensus document [J]. J Thorac Cardiovasc Surg, 2013, 145(1):6-23.

[4] Leon MB, Smith CR, Mack M, et al. Transcatheter aortic-valve implantation for aortic stenosis in patients who cannot undergo surgery[J]. N Engl J Med, 2010, 363(17):1597-1607.

[5] Sinning JM, Vasa-Nicotera M, Chin D, et al. Evaluation and management of paravalvular aortic regurgitation after transcatheter aortic valve replacement[J]. J Am Coll Cardiol, 2013, 62(1):11-20.

[6] 左志良, 赵振刚, 廖延标, 等. 经导管主动脉瓣植入的器械介绍、并发症及其防治[J]. 临床内科杂志, 2015, 32(7):448-450.

[7] Detaint D, Lepage L, Himbert D, et al. Determinants of significant paravalvular regurgitation after transcatheter aortic valve: implantation impact of device and annulus discongruence [J]. JACC Cardiovasc Interv, 2009, 2(9):821-827.

[8] Buellesfeld L, Grube E. A permanent solution for a temporary problem: transcatheter valve-in-valve implantation for failed transcatheter aortic valve replacement [J]. J Am Coll Cardiol Intv,

2012, 5(5):578-581.

[9] Sinning JM, Hammerstingl C, Vasa-Nicotera M, et al. Aortic regurgitation index defines severity of peri-prosthetic regurgitation and predicts outcome in patients after transcatheter aortic valve implantation[J]. J Am Coll Cardiol, 2012, 59(13):1134-1141.

[10] Abdel-Wahab M, Zahn R, Horack M, et al. Aortic regurgitation after transcatheter aortic valve implantation: incidence and early outcome. Results from the German transcatheter aortic valve interventions registry[J]. Heart, 2011, 97(11):899.

[11] Kleczyński P, Dzierżewicz A, Daniec M, et al. Impact of post-dilatation on the reduction of paravalvular leak and mortality after transcatheter aortic valve implantation[J]. Kardiologia, 2017, 75(8):742-748.

[12] Kleczyński P, Zasada W, Bagiński M, et al. Paravalvular leak after transcatheter aortic valve implantation (TAVI): short-term results [J]. Cardiol J, 2016, 23(2):163-168.

[13] Geleijnse ML, Di Martino LF, Vletter WB, et al. Limitations and difficulties of echocardiographic short-axis assessment of paravalvular leakage after corevalve transcatheter aortic valve implantation [J]. Cardiovasc Ultrasound, 2016, 14(1):14-37.

(收稿日期:2018-10-22)

(上接第181页)

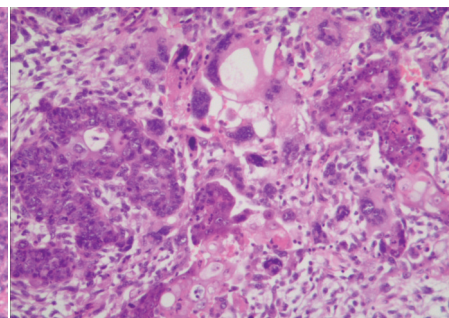
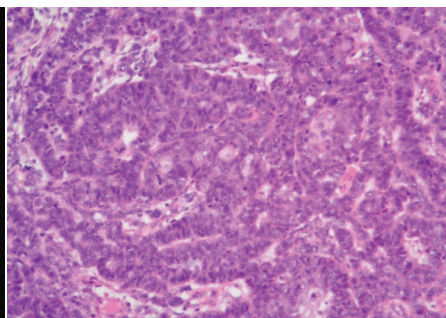


图5 经腹部超声横切面观示不均质回声包块边沿可见液性区 图6 输卵管癌肉瘤病理图显示腺癌成分,排列呈腺样,异型性显著,核分裂易见(HE染色,×10) 图7 输卵管癌肉瘤病理图显示腺癌及鳞癌成分,鳞癌区域细胞异型性显著,可见角化(HE染色,×40)

绕于子宫周围,呈囊实性改变,未见明显骨骼强回声,其内可探及血流信号,血流阻力指数为低阻型,符合肿瘤恶性特征。肿瘤边缘可见极少量无回声区,说明肿瘤局部已有出血坏死。双侧卵巢显示不清,双侧附件区被巨大包块占据,询问病情后得知既往有子宫肌瘤病史,但不清楚具体部位,从回声上考虑子宫肉瘤样变可能性大。分析本例误诊原因:①因40岁以上的女性出现不规则阴道出血,腹部包块,下腹痛,追问病史原有子宫肌瘤增长迅速等症状时要考虑发生子宫肉瘤的可能性,本例虽然未见阴道出血,但腹部包块,腹痛典型,且患者既往有子宫肌瘤史,所以考虑子宫肉瘤样变,以致诊断定位错误;②肿瘤包块大,双侧卵巢、输卵管全部包绕其中,分辨不清;③输卵管癌肉瘤极为少见,对其认识少,思考方向受限;④对自己图像信心不足,过于相信病史,超声表现为子宫与肿瘤分界清晰,应排除子宫病变。

参考文献

[1] Ji J, Zou P, Li L, et al. Primary malignant mixed Müllerian tumor of the fallopian tube after subtotal hysterectomy: a case report and literature review[J]. Arch Gynecol Obstet, 2015, 291(5):1187-1190.

[2] Hudelist G, Unterrieder K, Kandolf O, et al. Malignant mixed Müllerian tumor with heterologous component arising in the fallopian tube—a case report [J]. Eur J Gynaecol Oncol, 2006, 27(5):509-512.

[3] Brown E, Stewart M, Rye T, et al. Carcinosarcoma of the ovary: 19 years of prospective data from a single center[J]. Cancer, 2004, 100(10):2148-2153.

[4] 李元仙, 项尖尖. 彩色多普勒超声诊断子宫肉瘤的价值[J]. 生物医学工程学进展, 2009, 30(4):217-219.

(收稿日期:2018-06-26)