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(收稿日期:2018-09-25)

·病例报道·

Ultrasonic diagnosis of internal hernia caused by abdominal adhesion after cesarean section: two cases report

超声诊断剖宫产后腹腔黏连带致腹内疝2例

韩志勤　王　菲

[中图法分类号]R445.1　　[文献标识码]B

病例1,患者,37岁,孕2产1,月经周期正常。因下腹部持续性胀痛20+ d,加重1 h入院。既往史:8年前行子宫下段剖宫产术。体格检查:急性痛苦面容,腹部平坦,未见肠型及蠕动波,下腹部见一长约8 cm剖宫产术横切口,下腹部腹肌紧张,有压痛和反跳痛,移动性浊音可疑。入院2 h后腹部持续胀痛并加重。经腹部急诊超声检查:右下腹腹腔内见大量肠管扩张,较宽处约30 mm,肠壁增厚约6 mm,肠腔内见液性回声,未见往返流动(图1)。于其左侧扫查见少量萎瘪肠管纠集于一束,其近段肠管稍扩张,远段肠管无扩张;CDFI:增厚的肠管壁未见明显血流信号,纠集萎瘪的肠襻上可探及少许短棒状彩色血流。肠间见一深约10 mm的游离液性无回声区。腹腔实质脏器未见异常。超声提示:①小肠梗阻(考虑部分回肠坏死);②右下腹异常萎瘪固定肠襻,腹内疝可能;③腹腔少量积液。我院普外科以"肠梗阻"收入院,于全身麻醉下行剖腹探查术,术中腹腔见少量淡黄色液体,小肠系膜与左侧腹膜形成黏连带束,压迫部分小肠绞窄坏死,扩张,无活力,近端小肠扩张,切除坏死小肠送病理,病理结果:回肠出血坏死性炎。患者10 d后痊愈出院。

病例2,患者,40岁,孕2产1,月经周期正常。无明显诱因出现下腹疼痛12 h,呈绞痛,间断性疼痛,阵发性加剧,无放射性疼痛,伴恶心、呕吐,症状进行性加重。既往史:5年前行子宫剖宫产术。体格检查:急性痛苦面容,下腹见一长约10 cm剖宫产术横切口,无腹肌紧张,压痛和反跳痛明显,可扣及移动性浊音,肠鸣音减弱。实验室检查:尿妊娠(-),尿常规(-),肝肾功能均未见异常。经腹部急诊超声检查:左下腹肠管略宽,约32 mm,呈"琴键"征(图2)。肠壁变薄,肠腔内为液性回声,未见往返流动。其下方见少量萎瘪肠管纠集束,纠集肠管位置固定,观察3 min形态未见改变,其近段肠管明显扩张,远段未见扩张。CDFI:纠集萎瘪的肠襻上可探及少许血流信号。其周边肠间见一深约24 mm的液性无回声区(图3)。超声提示:①小肠梗阻(部分小肠坏死待除外);②左下腹异常萎瘪固定肠襻,腹内疝可能;③腹腔积液。我院普外科以"肠梗阻"收入院,行剖腹探查术,术中见血性腹水500 ml,左下腹团块状绞窄肠管,呈暗红色,表面温度低,肠管扩张,无活动,沿肠管右侧肠系膜与子宫左侧卵巢系膜形成一三角裂隙,部分空场疝入该裂隙,形成绞窄。松解肠管,遂将坏死肠管切除,术后患者恢复良好。

讨论:腹腔内脏经由腹腔内正常或异常的孔隙转离原有位置进入腹腔另一腔隙内即构成内疝。临床上腹内疝发生率不

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(收稿日期:2018-09-07)

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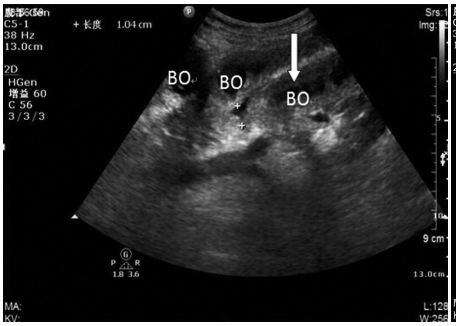

图1 声像图示肠腔内见液性回声(BO:肠管;箭头示肠壁增厚)

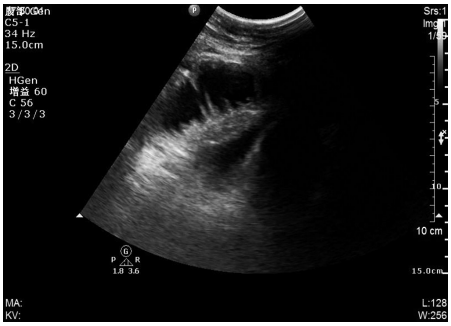

图2 声像图示左下腹肠管略宽,呈"琴键"征

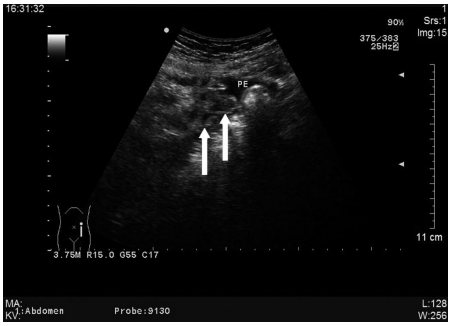

图3 声像图示萎瘪肠襻(箭头示)周边肠间见一液性无回声区(PE:积液)

超过1%,但其引起小肠梗死的发病率高达58%[1],故及时准确地诊断极为重要。腹内疝的病因可分为先天性,如十二指肠旁疝、肠系膜疝、网膜孔疝等;也可以分为后天性,多为手术或外伤时造成异常的空腔或肠系膜黏连、缺损而出现的并发症。本组2例均为后天性,为剖宫产术后引起黏连带束,压迫小肠坏死出血。黏连性带致肠梗阻患者70%~90%有腹部手术史[2],主要以阑尾、妇科和下腹部手术为主,黏连梗阻部位大部分位于小肠。腹内疝临床上易与肠扭转、宫外孕、盆腔炎、卵巢肿物破裂、扭转等混淆。本组2例超声均提示肠梗阻、腹内疝可能,临床再行手术治疗,术后患者恢复良好。

超声对肠梗阻的诊断和鉴别诊断均有重要参考价值,当发现腹腔有梗阻征象时应注意寻找梗阻点,临床医师准确掌握腹内疝的声像图特点有助于及早做出准确诊断。

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(收稿日期:2018-07-09)