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·病例报道·

Contrast-enhanced ultrasonic manifestations of gallbladder intramural hematoma: a case report

胆囊壁内血肿超声造影表现1例

陈俊杰 敖建阳 李鹏鹏 蒋 栋

[中图法分类号]R445.1; R575.6 [文献标识码]B

患者女,75岁,因体检发现胆囊占位6 d入院。既往有胆囊炎病史;否认外伤、家族病、血液病史。外院MRI提示胆囊占位性病变(恶性不除外),见图1。体格检查:腹软,无压痛,胆囊未触及,墨菲氏征阴性。实验室检查:血常规、凝血酶时间、部分凝血酶原时间均属正常范围;纤维蛋白原5.84 g/L,纤维蛋白降解产物11.4 mg/L,D-二聚体3.92 mg/L;甲胎蛋白、癌胚抗原、CA19-9、CA24-2均呈阴性。超声检查:胆囊大小约67 mm×33 mm,囊壁欠光滑,壁厚约3 mm,胆囊后壁体-底部见一范围约25 mm×15 mm低回声区,表面粗糙不光滑,形态不规则,内回声欠均匀;CDFI于其内未探及明显血流信号,附壁基底宽20 mm(图2)。超声提示:胆囊占位。超声造影检查:胆囊后壁体-底部见一范围约23 mm×9 mm不规则低回声区,增强早期未见造影剂进入,31 s时附壁基底部开始缓慢增强(图3);49 s时达峰,病灶区未完全充填,局部表现为高增强,增强区域呈不规则窄带状(图4);51 s时呈低增强,300 s时仍未完全消失,呈"慢进慢退"模式,胆囊后壁完整连续,肝内胆管未见扩张及压迫现象,肝内未见异常病灶。超声造影提示:胆囊良性占位(血肿?)。后患者行腹腔镜下胆囊切除术,术中见:胆囊剖面见一大小约1.0 cm×0.5 cm质中结节;胆囊大小约8.0 cm×4.2 cm,黏膜粗糙,黏膜面可见一大小约1.0 cm×0.5 cm暗红色结节,壁厚0.2~0.3 cm。病理诊断:慢性胆囊炎,暗红色为血肿样组织,未见实质细胞成分。见图5,6。

讨论:胆囊壁内血肿属胆道出血范畴,是一种罕见疾病,国内外报道少见,发病诱因众多,Sandblom于1948年首次报道了9例因急性腹痛和休克引起胆道出血,而局限性胆囊壁内出血甚为罕见,通常与钝力或医源性创伤、系统性凝血功能异常、胆石症、胆囊炎、肝脏或胆道系统肿瘤、血管异常有关[1]。本例患者既往无明确外伤史,无系统性凝血功能障碍、服用抗凝药物史,甲胎蛋白、癌胚抗原、CA19-9等肿瘤标志物均呈阴性,可见胆囊壁内血肿难以通过临床表现、体征和常规实验室检查进行诊断。超声是诊断胆囊疾病常用的影像学手段,本例患者常规超声表现:胆囊后壁体-底部见一范围约25 mm×15 mm低回声区,形态不规则,内回声欠均匀,CDFI于其内未探及明显血流信号,体位改变不移动,属胆囊占位超声表现,与胆囊癌极其相似,不易区分。超声造影具有动态观察血流起源及灌注分布的优势,弥补了常规超声无法显示病灶内部微循环的局限

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作者单位:200438 上海市,上海东方肝胆外科医院超声科(陈俊杰、蒋栋),胆道一科(敖建阳),普通外科(李鹏鹏)
通讯作者:蒋栋,Email:jiangdong2002317@aliyun.com

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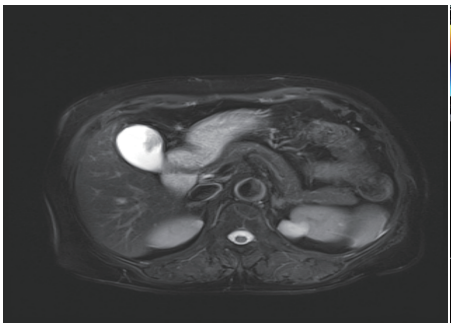

图1 胆囊壁内血肿MRI图

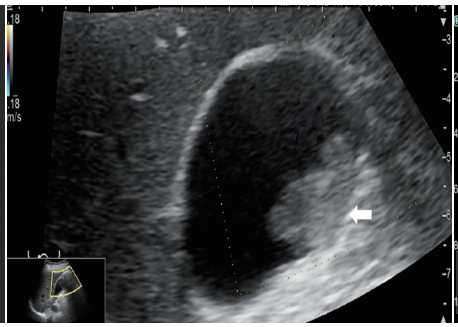

图2 胆囊壁内血肿(箭头示)CDFI图

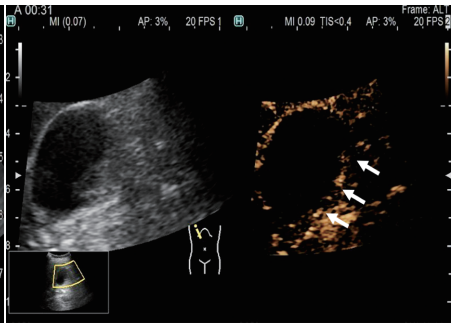

图3 胆囊壁内血肿(箭头示)超声造影图,造影剂注入31 s时附壁基底部开始缓慢增强

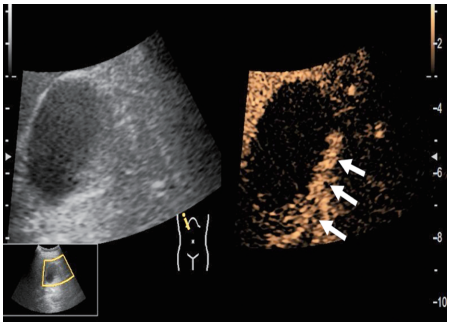

图4 胆囊壁内血肿(箭头示)超声造影图,造影剂注入49 s时达峰,病灶区未完全充填,基底处呈不规则窄带状充填

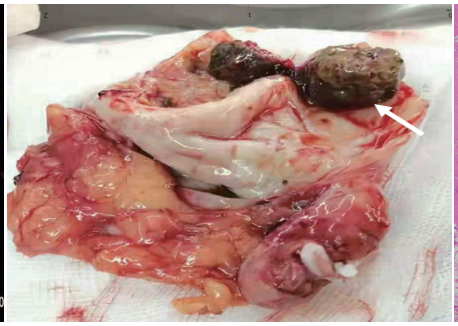

图5 胆囊壁内血肿(箭头示)术后大体图

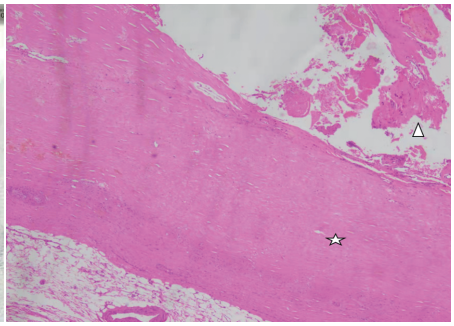

图6 胆囊壁内血肿病理图(HE染色,×40)。☆示胆囊壁;△示血肿处

性[2]。本例患者超声造影表现为典型"慢进慢退"增强模式,符合良性肿瘤造影特点。此外,超声造影可根据血管结构来鉴别胆囊病变的价值。费翔和罗渝昆[3]根据增强早期动脉血管灌注过程中的形态将血管结构分为点状型、单支型、分支型和不规则型。本例患者超声造影表现为不规则窄带状充填造影方式。分析原因为患者多年胆囊炎病史,经反复治疗、炎症刺激导致胆囊壁组织弹性下降,局部微血管壁破损,形成小血肿,与微血供修复相关。目前胆囊壁内血肿的治疗方式以手术为主,最终诊断仍需依靠病理检查。总之,超声造影对胆囊壁内血肿评估有一定价值,特殊造影征象可为临床诊断提供参考。

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