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· 病例报道 ·

Contrast-enhanced ultrasonic manifestations of regeneration after subtotal thyroidectomy: a case report

甲状腺次全切术后再生超声造影表现 1 例

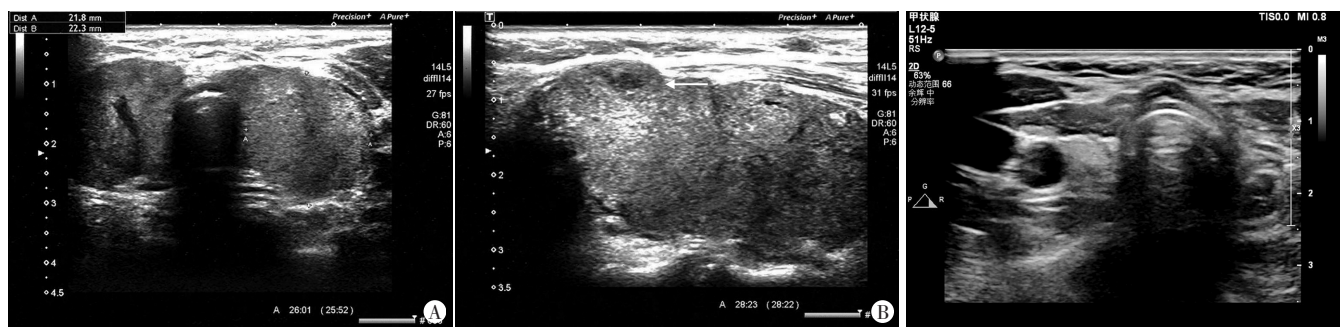
龚柳周平

[中图法分类号] R445.1; R653

[文献标识码] B

患者女, 49岁。2年前因活动后呼吸不畅首次于我院就诊。实验室检查: 促甲状腺激素(TSH) 9.44 μU/ml。二维超声提示: 双侧甲状腺实质呈弥漫性肿大; 甲状腺左侧叶上段见一低回声结节, TI-RADS 4A类(图1)。因气管受压遂行甲状腺左侧叶全切术+右侧叶次全切术。术后病理诊断:(左侧甲状腺)微小乳头状癌;(右侧甲状腺)桥本甲状腺炎。术后接受左甲状腺素替代治疗。1年后复查, 实验室检查: TSH 21.01 μU/ml, 游离四碘甲状腺原氨酸 8.74 pmol/L, 游离三碘甲状腺原氨酸 2.76 pmol/L。超声提示: 右侧叶残余甲状腺回声欠均匀(图2)。予以调整药量改善甲状腺功能减退。近半年患者自觉呼吸困难加重, 遂再次于我院诊治。实

实验室检查: TSH 8.03 μU/ml, 甲状腺过氧化物酶抗体 >1000 U/ml, 甲状腺球蛋白抗体 1706.79 U/ml。常规超声检查: 甲状腺床呈低回声, 内回声欠均匀, 形态不规则, 继发气管狭窄, 左侧范围约 25 mm×18 mm×30 mm, 右侧范围约 27 mm×19 mm×35 mm(图3A); CDFI于甲状腺床低回声内可探及点线状血流信号。超声造影检查: 甲状腺床低回声自 9 s 开始增强, 呈均匀性等增强, 消退缓慢, 未见异常增强灶(图3B)。常规超声及超声造影提示: 再生功能性甲状腺组织。行颈部肿物切除术, 术后病理诊断:(颈部肿物)符合桥本甲状腺炎, 滤泡上皮增生活跃伴非典型增生, 滤泡上皮广泛嗜酸性变, 间质纤维组织增生(图3C)。



A: 二维超声示双侧甲状腺实质呈弥漫性肿大; B: 二维超声示甲状腺左侧叶上段见一低回声结节(箭头示) 图2 甲状腺次全切术后1年复查二维超声示右侧叶残余甲状腺回声欠均匀

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甲减患者心功能损害,左室整体和节段心肌收缩功能异常。此外,本研究结果还显示,左室整体心肌做功参数GWI、GCW、GWW和GWE在观察者内和观察者间ICC均>0.75,表明重复性均良好。总之,LV-PSL技术可早期发现射血分数保留的甲减患者左室收缩功能改变。

本研究的局限性:①样本量偏小;②对于左室节段心肌做功梯度差异的原因未能深入研究;③未对患者左旋甲状腺素替代治疗后进行长期随访,待今后扩大样本量的进一步探讨。

综上所述,LV-PSL技术可早期发现甲减患者亚临床心脏功能异常,定量评估左室整体及节段心肌做功,为临床的早期诊治和疗效评估提供新的、更敏感的影像学指标。

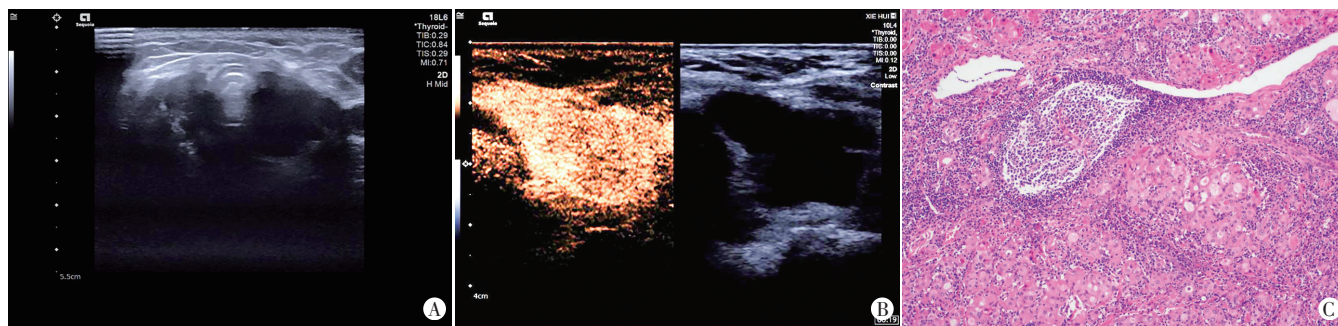
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A: 二维超声示甲状腺床呈低回声; B: 超声造影示甲状腺床呈均匀性等增强; C: 病理图(HE染色, ×200)

图3 甲状腺次全切术后2年声像图和病理图

讨论:甲状腺组织切除后再增生临床罕见,其发病机制为TSH异常增高可刺激甲状腺细胞增殖,导致残余正常甲状腺组织异常增生或肿瘤复发^[1]。超声检查在术后随访中起到关键作用。本病例行甲状腺次全切术后2年复查超声示甲状腺呈不规则低回声,与2年前超声表现相比组织回声较低,分布较不均匀,无法分辨是否为肿瘤复发或转移性淋巴结融合所致,此时超声造影提供了新的信息,其增强方式表现为正常甲状腺组织增强模式,呈均匀性等增强,未见异常增强灶,由此提示可能为甲状腺组织再生,后经术后病理证实。因此,当甲状腺切除术后患者血清TSH控制不佳,且出现新的咽部症状及甲状腺替代剂量变化时,应积极行影像学检查^[2],如甲状腺残余组织呈不

规则低回声,考虑为功能性甲状腺组织再生。临床应注意与转移性淋巴结、肿瘤复发所导致的甲状腺区肿块相鉴别,最终确诊仍需依靠病理学检查。

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