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（收稿日期：2022-09-22）

·病例报道·

Ultrasonic manifestations of duplex renal with upper tract urothelial carcinoma: a case report

重复肾合并上尿路尿路上皮癌超声表现1例

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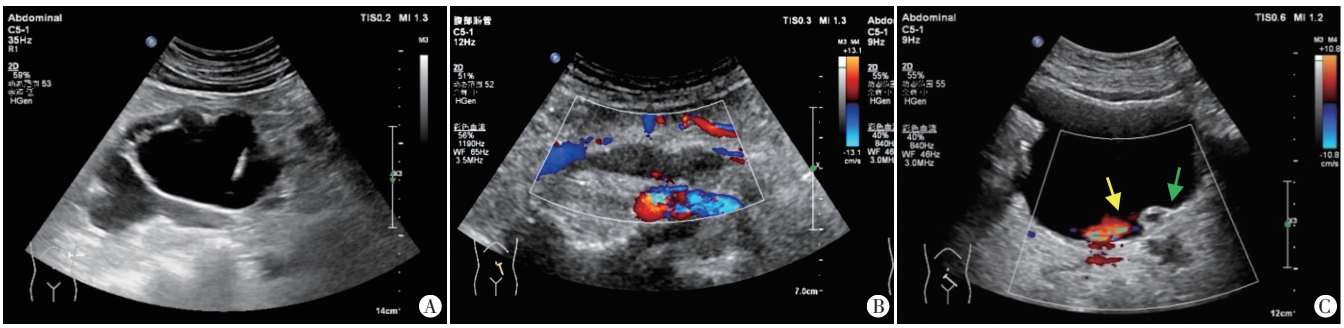
[中图法分类号]R445.1 [文献标识码]B

患者男，83岁，因发现胆管结石2周于我院消化科就诊。肾脏超声检查：左肾皮质变薄，呈纸样，左肾可见2个集合系统，下位肾窦分离48.0 mm，上位肾窦分离30.0 mm（图1A）；上输尿管扩张，内径11.8 mm，其内未见明显团块状回声；下输尿管扩张，中段明显增粗，内径12.7 mm，管腔内见不规则低回声，病变长度48.0 mm，CDFI于其内探及少许血流信号（图1B）；输尿管膀胱开口处壁局部增厚，可见一“管道”样结构，延伸至膀胱内，长度24.0 mm，未见喷尿现象（图1C）；右侧输尿管见喷尿现象。肾脏超声提示：左侧重复肾畸形，上输尿管积水，下输尿管中段异常回声（考虑占位可能伴左肾严重积水，左肾萎缩）。磁共振胰胆管成像提示左侧双肾盂输尿管畸形，下输尿管明显狭窄（图2A），下输尿管中段占位伴狭窄（图2B），左肾积液。腹部增强CT提示：左侧双肾盂畸形，左肾积水，左肾萎缩，膀胱后壁不规则增厚及左侧下输尿管广泛实性软组织，考虑转移可能（图3）。为进一步诊治转入泌尿外科。体格检查：双侧肋脊角对称，局部无压痛及叩击痛，双侧肾脏均未扪及；沿双侧输尿管走行无压痛，未扪及肿块。实验室检查：肌酐126.0 μmol/L，尿白细胞（++），尿隐血（+++），尿蛋白（+++），尿培养（阳性），糖类抗原199 28.70 U/ml，糖类抗原125 96.20 U/ml，角蛋白CYFRA 21-1 10.80 ng/ml，Pro-GRP 79.00 pg/ml。完善术前各项检查，于全身麻醉下行腹腔镜下左肾输尿管根治术+经尿道输尿管膀胱壁内段等离子电切术。术中见左侧下输尿管中段管腔内见一大小为4.5 cm×2.5 cm×0.5 cm隆起型肿块，累及输尿管1周，似浸润全层；左肾大小为10.4 cm×6.0 cm×3.5 cm，肾盂切开灶区见疑似肿瘤多灶性累及。术中诊断：左侧重复肾，左侧下输尿管肿瘤，左肾积水。病理结果：（左肾+输尿管）高级别尿路上皮癌，浸润输尿管壁深肌层，累及肾盂（图4）。

讨论：重复肾是泌尿系统较常见的一种先天性畸形，分为



A：左侧重复肾伴肾积水；B：左侧下输尿管中段增粗，CDFI于其内探及少许血流信号；C：左侧下输尿管膀胱开口处壁局部增厚（绿色箭头示），左侧输尿管未见喷尿现象，右侧输尿管见喷尿现象（黄色箭头示）

图1 本例患者超声图

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衰竭患者左心室收缩功能变化[J].中国医科大学学报,2018,47(7):581-584.
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(收稿日期:2022-11-03)

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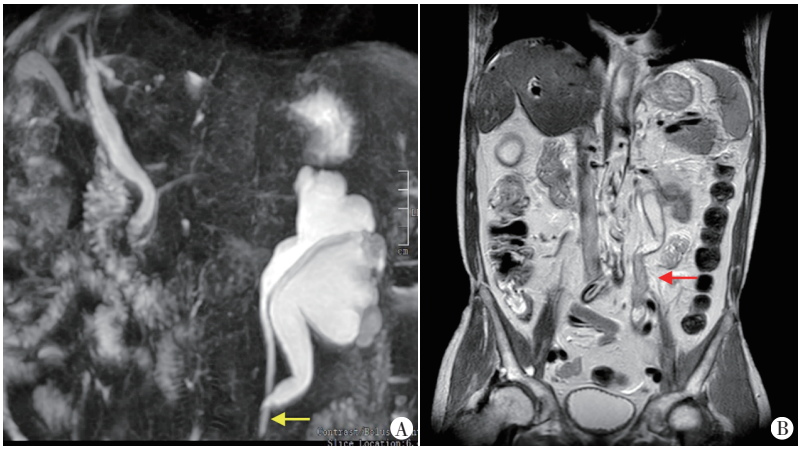

A:左侧双肾盂输尿管畸形,箭头示下输尿管明显狭窄;B:箭头示左侧下输尿管中段占位伴狭窄

图2 本例患者磁共振胰胆管成像图

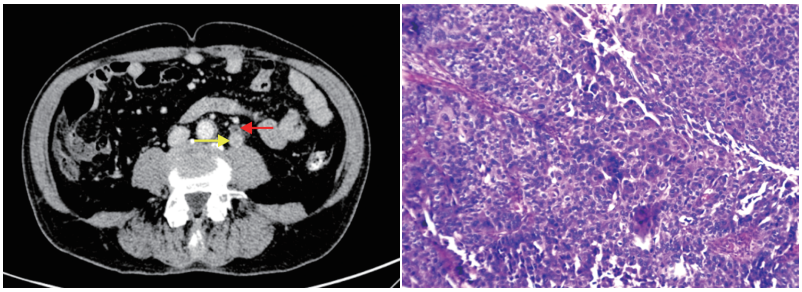

图3 腹部增强CT图示左侧下输尿管广泛扩张(红色箭头示)

图4 上尿路尿路上皮癌病理图(HE染色,×100)

完全性和不完全性两类[1],患者多无明显症状,当合并感染、结石或积水后会出现相应症状。上尿路尿路上皮癌是一种相对少见的泌尿系统恶性肿瘤,其合并重复肾更是少见。本例患者为完全性重复肾合并上尿路尿路上皮癌,伴上尿路积水,术中证实左侧2条输尿管均开口于膀胱内。超声及CT漏诊肾盂肿瘤的原因可能是肾盂病变较小,占位效应不明显。重复肾合并上尿路尿路上皮癌的诊断临床多依赖于输尿管镜、膀胱镜及影像学检查方法(如超声、逆行肾盂造影、静脉肾盂造影、CT尿路造影及MRI尿路成像)[2]。输尿管镜和膀胱镜可以直接观察尿路情况,并对可疑病变进行活检;逆行肾盂造影对于梗阻以上部分显示不佳;静脉肾盂造影可以清楚显示肾盂、输尿管,但对于长期梗阻伴肾功能不全患者可能显影不佳,CT尿路造影及MRI尿路成像可弥补此缺陷。超声具有无创、操作方便、重复性佳等优点,尤其是对于严重肾积水、输尿管扩张的患者,能够准确定位肿瘤位置[3]。对于重复肾合并上尿路尿路上皮癌,不仅需要超声医师掌握重复肾及上尿路肿瘤的超声表现,还应在检查过程中结合患者临床表现及其他检查结果进行多切面扫查,避免漏误诊。

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(收稿日期:2022-12-03)