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## 胃惡性平滑肌肉瘤

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患者是一位 62 歲男性從未住院。三個月前他開始感覺厭食不適，兩星期前因解黑便到他院檢查，發現左上腹部摸得腫塊，而轉入本院住院做進一步檢查。這三個月來病患體重減輕 6 公斤。

入院後病理學檢查：身長 163 公分，體重 66 公斤，體溫 36.2°C，脈搏 79 次/分，呼吸 19 次/分，血壓 128/80 mmHg。左上腹部可摸到大腫塊約 10×7 公分，超音波內視鏡及上消化道 X 光攝影檢查診斷為：胃粘膜下腫瘤最可能為胃平滑肌惡性肉瘤。血液生化檢查顯示：WBC  $8.4 \times 10^3$ ，RBC  $3.44 \times 10^6$ /cc，Hb 10.5g/dl，PLT  $4.31 \times 10^6$ /cc，Hct 31.5%，GOT 15u/L，GPT 9u/L，Alk-P 58 u/L，Bilirubin 0.42/0.07 (T/D) mg/dl，Protein 6.7 mg/dl，Albumin 3.6 mg/dl，BUN 21 mg/dl，Creatinine 1.3 mg/dl。腹部斷層掃描顯示為胃之巨大腫瘤，病患接受次全胃併腫瘤切除術，脾臟切除術。手術後第七天順利出院，病理報告為惡性 Gastro-intestinal stromal tumor 體積 19×17×11 公分。重量 2100 公克。現病患仍在門診追蹤中。

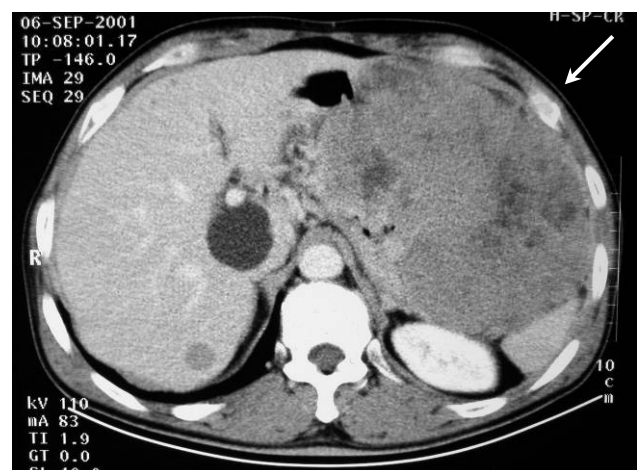


上消化道攝影檢查胃體部有一巨大腫瘤。

結論：

惡性胃腸間質細胞瘤，或稱惡性上皮狀細胞瘤，或稱惡性平滑肌肉瘤，同屬由胃腸道之間質部位細胞發展出的瘤。在文獻記載，男性約佔 53%，女性約佔 47%。初期的腫瘤除早期有侵襲黏膜發生潰瘍出血外，大多缺乏症狀，後期症狀包括不明體重減輕，食慾不振，腹脹，易疲倦或摸到腹部腫塊。

生化檢查除可能輕度貧血外，都在正常範圍。主要診斷方法包括上消化道內視鏡，上消化道 X-光攝影，電腦斷層攝影或核磁共振檢查。手術切除是最佳治療，腫瘤小於 6 公分直徑，手術切除後預後大多良好，超過 10 公分直徑的腫瘤經常會有多處轉移病灶，預後不良。



腹部電腦斷層掃描可見胃有一巨大腫瘤。

## 參考文獻：

Title: Stromal tumors of the stomach. Review of our experience and reclassification of a series of patients.

Authors: Cuberes R, Rivera T, Picardo A, Martinez-Penalver I, Medina M, Jara A, Alias D, de la Plaza R, Pacheco E, Suarez A.

General and Digestive System Surgery Service, Mostoles General Hospital, Madrid, Spain.

Rev Esp Enferm Dig 2000 Jan;92(1):13-26 Related Articles, Books, LinkOut, Article in English, Spanish.

OBJECTIVE: To retrospectively review a series of 12 patients operated on in our department for stromal tumor of the stomach. Clinical and morphological data, and the patients' postoperative course, were analyzed. METHODS: Medical records for 12 patients (mean age 63.3 years) were retrospectively reviewed to obtain data on clinical presentation, diagnosis and treatment. Surgical morbidity and mortality were analyzed. A pathologist reviewed the resected specimens to determine the morphological factors of prognostic value. The biological nature of the tumor was reclassified based exclusively on mitotic index, and all tumors were staged according to the TGM system. Recurrence and survival rates were also calculated. RESULTS: The most frequent clinical presentation was abdominal pain and gastrointestinal bleeding. The most sensitive diagnostic methods were computerized tomography and echographic endoscopy. Operability and resectability rates were 100% and 91.6% respectively. Local resection was done in 5 patients, partial gastrectomy in 5, and extended total gastrectomy in 1. Histologically, 6 cases were muscular tumors (2 leiomyomas, 3 low-grade leiomyosarcomas and 1 high-grade leiomyosarcoma), 2 were gastrointestinal autonomic nerve (GAN) tumors, and 4 were pure stromal tumors. The morbidity rate was 33.3% and the mortality rate was 8.3% (1 patient). All patients were followed up: 1 patient each died after 9 months and 4 years, 1 developed liver metastases after a disease-free interval of 14 months, and the other 9 patients were still alive and free of disease after intervals ranging from 4 months to 7 years. CONCLUSIONS: Stromal tumors include a group of tumors which may present muscular differentiation (the most frequent type), neural differentiation (GAN tumors) or no differentiation at all (pure stromal tumors). The mitotic index is the most valid parameter to determine biological nature, considering that classification as a benign tumor requires the total absence of mitoses. Treatment was mostly surgical, and local resection with adequate safety margins was effective. Prognosis was relatively good, but long-term follow-up is needed to assess the malignant potential of these tumors.

PMID: 10749594 [PubMed - indexed for MEDLINE]

Title: Gastrointestinal stromal tumors: current diagnosis, biologic behavior, and management.

Authors: Pidhorecky I, Cheney RT, Kraybill WG, Gibbs JF.

Department of Surgical Oncology, Roswell Park Cancer Institute, State University of New York at Buffalo 14263, USA.

Ann Surg Oncol 2000 Oct;7(9):705-12 Related Articles, Books, LinkOut.

Gastrointestinal stromal tumors (GIST) are rare tumors of the gastrointestinal (GI) tract that arise from primitive mesenchymal cells. GISTs occur throughout the GI tract but are usually located in the stomach and small intestine. The majority of GISTs are immunohistochemically positive for c-kit protein (CD 117) and CD34. GISTs express a heterogeneous clinical course not easily predicted by standard pathological means. The most important prognostic factors are size > 5 cm, tumor necrosis, infiltration and metastasis to other sites, mitotic count > 1-5 per 10 high-powered fields, and most recently, mutation in the c-kit gene. Surgical resection remains the mainstay of treatment, as chemotherapy and radiation are ineffective. Long-term follow-up is imperative, as recurrence rates are high.

PMID: 11034250 [PubMed - indexed for MEDLINE]

## 小腸扭轉性腸阻塞(Intestinal Volvulus)

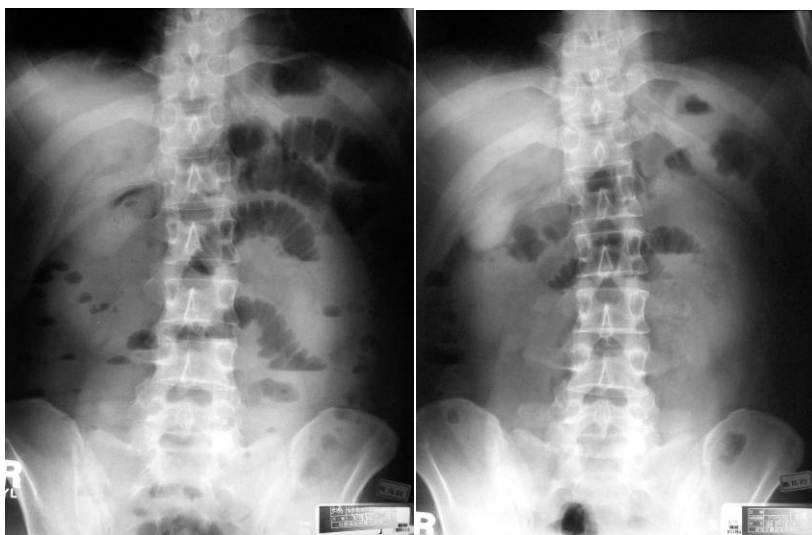
曾逸豪，陳錫榮，羅海韻

本案例為 36 歲男性從事金融業，過去無任何特別病史。住院前天曾因急性腹痛、噁心和嘔吐，到附近診所求診。因為腹痛持續，故轉至本院急診就醫。該名病患並無發燒、畏寒或黃疸等全身性症狀，但有解軟便三次。在急診時，抽血檢驗並無異常，腹部 X 光檢查(plan abdomen)發現左側空腸有局部阻塞(bowel loop dilatation)，並有空氣-液體介面(air-fluid level，圖一)，初步診斷為機械性腸阻塞。故禁食並追蹤影像學檢查(圖二，三)。住院後，腹部電腦斷層(CT scan)發現一段空腸呈類似鳥喙影像(beak sign，圖四)，故疑似小腸扭轉性腸阻塞(intestinal volvulus)，並安排腹腔鏡手術復位。因為病患在期間接受內科保守治療後，症狀完全緩解，故原訂手術取消並出院門診追蹤。

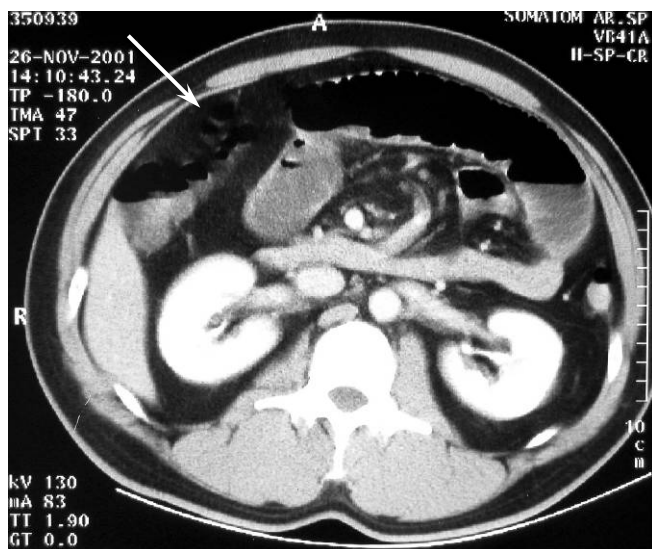
討論：小腸扭轉較常發生於嬰兒與小孩，成人少見。其原因常因為腸繫膜(mesentery)的異常，無法固定小腸而形成扭轉(malrotation)。腹部 X 光、超音波、電腦斷層皆可幫助診斷(Ref.1)。治療除了禁食、靜脈水份補充等內科治療外，常需要外科手術緩解腸阻塞，目前可利用腹腔鏡將腸扭轉復位並固定。本例因自行緩解而無需手術，不過將來仍有復發之可能性。



圖一：腹部 X 光檢查發現左側空腸有局部阻塞，並有空氣-液體介面。



圖二，三：禁食並追蹤腹部 X 光檢查發現持續有局部阻塞。



圖四：腹部電腦斷層(CT scan)發現一段空腸呈類似鳥喙影像。

**參考文獻：**

Title: Small bowel volvulus - Radiological findings.

Authors: *Lassandro F, Giovine S, Pinto A, De Lutio Di Castelguidone E, Sacco M, Scaglione M, Romano L.*

Radiol Med (Torino) 2001 Jul-Aug;102(1-2):43-7

**Purpose:** We retrospectively evaluated the radiological findings observed at plain abdominal film, abdominal sonography and abdominal CT performed in 66 patients with surgically proven small bowel volvulus. **Material and Methods :** Sixty-six patients (35 women and 31 men, ranging in age 38-77 years) with surgically proven small bowel volvulus were submitted to plain film, sonography and CT of the abdomen. Abdominal plain film was performed in the upright position (postero-anterior view) in 46 cases, and in the supine position in 20 cases. On plain abdominal film we evaluated the following findings: bowel loops dilatation, air-fluid levels and site of obstruction. At abdominal US, performed with 3.5 e 7.5 MHz probes, we retrospectively searched for: bowel loop dilatation, bowel wall thickening, peristalsis alteration, extraluminal fluid. CT was performed with a helical unit (thickness 4 mm, reconstruction interval 4 mm, pitch 1.5), after intravenous contrast agent (120 ml) infusion (3 ml/s, 55 s acquisition delay from bolus starting) and using a power injector. The following CT findings were searched for: whirl sign, beak sign, extraluminal fluid, bowel loop dilatation, bowel wall thickening, bowel wall or mesenteric alterations. **Result :** Plain abdominal film showed the following findings: air-fluid levels (92.4% of cases), bowel loops dilatation (71.2%), site of obstruction (42.4%). Abdominal sonography demonstrated bowel loop dilatation (48.5%), extraluminal fluid (48.5%), peristalsis alteration (27.3%), bowel wall thickening (27.3%). The most frequent CT findings were: bowel loop dilatation (95.5%), bowel wall thickening (78.8%), beak sign (69.7%), mesenteric alterations (66.7%), extraluminal fluid (54.5%), whirl sign (13.6%). **Conclusion :** Air-fluid levels and bowel loop dilatation were the most frequent radiological findings in our series. Plain abdominal film allowed us to identify signs of obstruction, whereas signs of bowel wall necrosis were accurately shown by abdominal CT.

Title: Laparoscopic repair of intestinal malrotation complicated by midgut volvulus.

Authors: *Yamashita H, Kato H, Uyama S, Kanata T, Nishizawa F, Kotegawa H, Watanabe T, Kuhara T.*

Surg Endosc 1999 Nov;13(11):1160-2

**Abstract:** Intestinal malrotation is rare in older children and adults. We performed laparoscopic repair and treatment for a 13-year-old girl diagnosed as having intestinal malrotation complicated by midgut volvulus. Under laparoscopic vision, the midgut volvulus was untwisted by grasping and pulling the intestine; Ladd's band was divided and broadened; hepatic and splenic flexure of the colon was fixed; and finally an appendectomy was performed. The patient was walking and able to resume oral intake on the first postoperative day. There was no complaint in 6 months of follow-up, and the small incisional scar satisfied the patient and her parents.

編輯顧問：陳寶輝

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