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結核性迴腸炎(TB Ileolitis)

內科陳錫榮，外科莊永芳

一個 56 歲男性，主訴吃東西之後會有腹賬、想吐及右下腹有壓痛的感覺，約有一個多月的時間，體重在近二年減少 15 公斤。

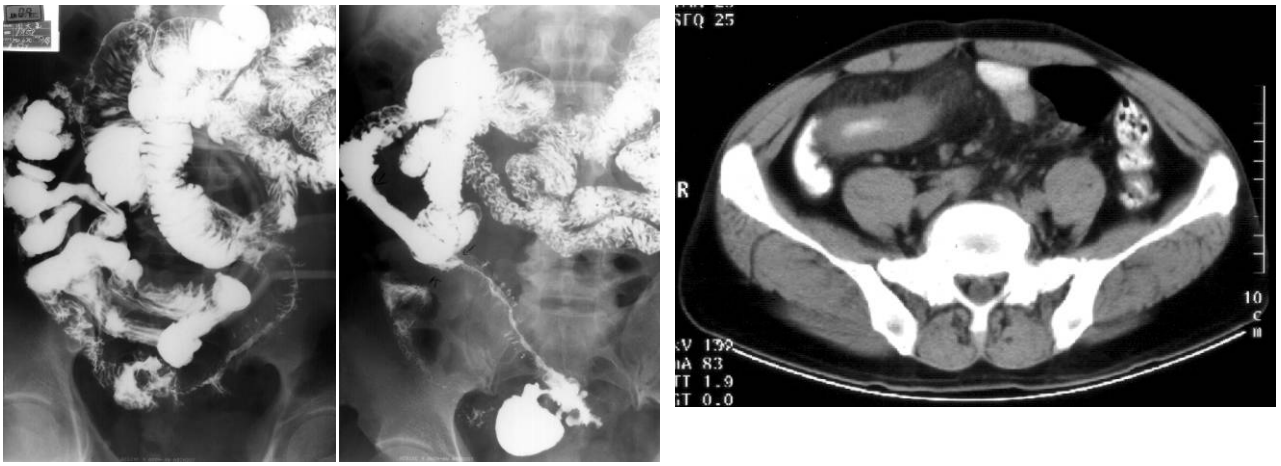
病人的職業是從商，經常往返台灣及中國大陸。過去病史方面，在民國 76 年曾因左上腹部腫瘤,在林口長庚醫院開刀，取出一顆大小像豬心約十多公分的良性腫瘤，位置在降結腸靠近脾臟的位置，包在腸繫膜內，但無大腸阻塞之症狀，切下約 30 公分長之大腸，病理切片不明，手術後一切良好。民國 89 年因左側腎結石，在大陸深圳的醫院作過體外震波碎石術。民國 90 年 1 月 29 日因三個月左右體重減輕十多公斤，合併水性腹瀉二、三個月，於是住進本院腸胃科檢查。當時大便潛血反應是陽性反應（微量）但大腸鏡檢查無異常；胃鏡只有表面胃炎；血清檢查腫瘤指數正常（CEA:0.6；CA19-9:1.6），此外，意外發現甲狀腺機能亢進（T_4:18.3；TSH:＜0.01），經會診新陳代謝及內分泌科，給予 Tapazole 及 Inderal 之後症狀改善，但體重一直未回升，直到今年 5 月感到吃過東西後腹脹、想吐及右下腹壓痛。病人由大陸返台到本院作健康檢查，經由超音波發現小腸末端腸壁肥厚，於是入院作進一步檢查，血液檢查方面：血球數正常，生化檢驗除了白蛋白（Albumin）略低（3.3g/dl）之外，其餘皆正常（CEA＜0.1），大便潛血反應爲陰性，大腸鏡檢作到迴腸末端 10 公分左右皆無異常發現，於是安排小腸鋇劑攝影，發現迴腸之末端有一段相當長的腸壁厚，且有許多深的潰瘍，約距離迴盲瓣 30 公分左右，於是再安排腹部電腦斷層掃描以鑑別診斷，但仍無法區分是淋巴瘤（Lymphoma）、克隆氏症（Crohn's disease）或迴腸結核病，遂會診外科開刀。

術中發現靠近迴盲瓣（Ileocecal valve）四十公分內的迴腸是完好的，但上行約 40 公分的小腸皆肥厚，且腸繫膜上有白色小點，疑似結核病的發現。手術將患部切下之後，將腸腔切開發現黏膜上有鵝卵石樣顆粒（Cobble stone）且有縱走之潰瘍，術後診斷爲疑似克隆氏症（Crohn's disease）或迴腸結核病。病人術後恢復良好，進食不再腹脹、想吐，遂出院門診追蹤，數日之後病理切片報告結果爲迴腸結核病，病理報告描述：檢體有許多縱走及橫向的潰瘍,外觀呈現黏膜腫大,像鵝卵石樣（Cobble-stone）及鵝口瘡樣的潰瘍（aphthous-like ulcers），管腔狹窄嚴重，有許多大的淋巴結散佈在腸繫膜的脂肪上，顯微鏡下呈現慢性發炎細胞浸潤，在黏膜下層從腸肌肉層到漿膜下層有許多肉芽腫（granulomas），且有 Langhans giant cell 及 caseous necrosis，作 Acid-fast stain 發現有 acid fast bacilli。

討論：

在西方國家結核病並不多見，但感染肺部以外之結核病，多與愛滋病（AIDS）有關，有超過 70%的肺部以外的結核病（Extrapulmonary TB）的病人經檢查確定爲 AIDS 患者，但東方國家則未必如此。胃腸道結核病最常侵犯終末迴腸及盲腸（terminal ileum and cecum）且常合併腸繫膜淋巴腺炎（mesentric lymphadenitis），此外也常侵犯橫結腸，至於其他少見的如：侵犯肛門、直腸、胃、肝、食道的也有。英國的一篇報導中指出，90 個腹部結核病的病人只有 5 人有肺結核，因此該作者認爲胸部 X 光及結核菌素試驗（tuberculin skin test）通常

沒有助於診斷。該病人沒有肺結核也無 AIDS，術前及術中診斷是疑似克隆氏症的特徵，如：侵犯終末迴腸且有深的潰瘍、管腔狹窄、黏膜上有縱走之潰瘍及鵝口瘡樣潰瘍及腫脹，有鵝卵石樣變化。但最後的診斷仍須靠病理切片。



小腸鋇劑攝影及腹部電腦斷層掃描發現迴腸末端有一段相當長的腸壁變厚，且有許多深的潰瘍。

參考文獻

Intestinal and peritoneal tuberculosis

Akgun Y, Yilmaz G, Tacyildiz I.

Dicle Universitesi Tip Fakultesi Genel Cerrahi Anabilim Dali, Diyarbakir.

BACKGROUND: Abdominal tuberculosis (tbc) is still a medical problem in developing countries. Since it imitates many abdominal diseases, diagnosis can be easily missed unless the disease is suspected. METHODS: The aim of this study to evaluate the value of clinical, physical and laboratory findings and to discuss the diagnostic and therapeutic options in 121 patients with intestinal and peritoneal tbc. The diagnosis was made by histopathological examination of biopsy material and isolation of mycobacterium bacillus in cultures or smears of ascites fluid. RESULTS: The diagnosis was confirmed with laparotomy in 102, laparoscopy in 4, colonoscopy in 6, and percutaneous aspiration in 9 patients. There were intestinal tbc in 67 (55.3%) patients and peritoneal tbc in 54 (44.6%). Intestinal involvement was commonly located at ileocecal area. Anti tuberculous chemotherapy was started and avoided from extensive resection in surgical treatment. There were a total of 87 complications in 52 patients (42.9%) at the postoperative period. Wound infection was the most frequent complication. Overall mortality rate was 13.2%. The mortality rate in emergency operation was 20.5% while 3.4% in elective conditions. There were no morbidity and mortality in patients whose diagnosis were made by conservative procedures. CONCLUSIONS: Laparoscopic endoscopic and percutaneous aspiration procedures are useful for diagnosis in the selected cases of intestinal and peritoneal tbc. Laparotomy should be performed only when complication develops or diagnosis is uncertain. Extensive resection should be avoided in surgical treatment of intestinal tbc. Early diagnosis and treatment will decrease the complications that can be develop during the progress of the disease and consequently the mortality rates.

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膽石症(Gall bladder stone)

蔡宗賢，黃敬文

一位 71 歲女性病人，主述自三個星期前開始有間接性的腹部疼痛合併放射性的疼痛至背部，無噁心、嘔吐、或腹瀉等症狀。於是她到小港安泰醫院求診並住院治療。在住院期間，該病人被診斷爲膽囊結石合併急性膽囊炎。因病人個人因素，所以轉至本院做進一步診斷與治療。

於本院住院後做身體評估檢查時，該病人生命跡象穩定、無發燒、也無明顯黃疸、及皮膚發癢的現象，只有明顯右上腹部疼痛併放射至背部，Murphy's Sign(+)，Blumberg's sign(+)。

血液檢查異常處如下：GOT/GPT: 50/55、 Alk-P:146，腹部超音波顯示出有：1.膽結石(gall bladder stone)；2.膽氣症(pneumobilia)；3.疑肝內結石(R/O IHD stone)；4.肝硬化(liver cirrhosis)，逆行性內視鏡膽道照影術(ERCP)更顯示出有膽管腸道瘻管(Choledochoenteral fistula)。

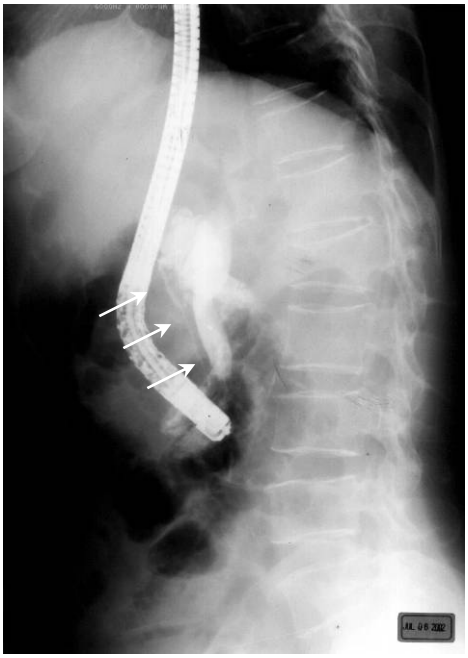
於是在① 膽囊結石合併急性膽囊炎② 總膽管腸道瘻管的診斷下，該病人於７月８日接受了：1.膽囊切除手術；2.Choledochotomy；3.T 型管引流(T-tube insertion)。於術中無發現明顯的膽囊腸道瘻管，術後一週的膽道攝影也沒有發現總膽管腸道瘻管。

討論：

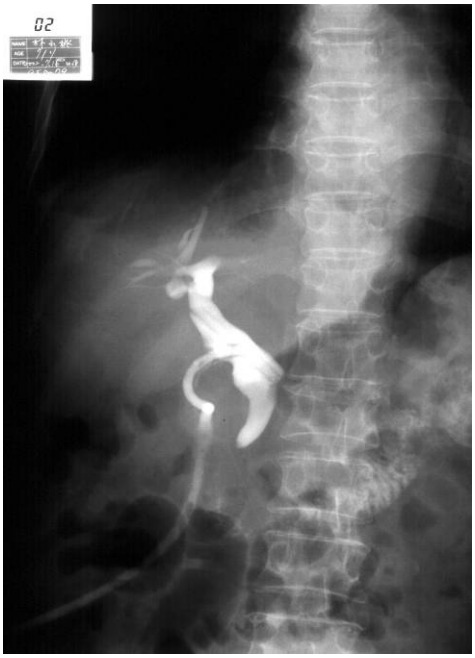
本病例雖在術前 ERCP 中有發現疑似總膽管腸道瘻管，但術中及術後皆無發現，可能因術前 ERCP 只有側面照而無正面照，可能爲胰管的顯影，所以最好術前 ERCP 宜有正面及側面照才好作比較。

膽石症(gall bladder stone)：一般是發生在各年齡層的女性居多，而年齡越高越易發現膽石。腹部超音波是診斷膽囊結石的首選方法。爲了防止合併症的發生、疼痛的惡化、和考慮到膽囊結石與膽囊癌的關係(在外國報告膽石症中之 0.05%會合併有膽囊癌)，大多數的病例，都應接受膽囊切除手術。其中腹腔鏡膽囊切除手術更是本院的首選方式。

膽囊腸道瘻管(Cholecystoenteric fistula)：急性膽囊炎中約有 1%之病例其膽囊會與腸道形成瘻管，最常發生位置是十二指腸約佔 80%、其次是大腸(肝彎處)占 15%、其餘極少見的是空腸及胃等。有這種瘻管發生者，約 13%會合併有膽石腸阻塞。這種瘻管處理方法是膽囊切除術及瘻管閉合。



逆行性內視鏡膽道照影術(ERCP)顯示疑有膽管腸道瘻管。



術後一週的膽道攝影沒有發現總膽管腸道瘻管。

參考文獻：

Clinical analysis of choledochoduodenal fistula with cholelithiasis in Taiwan: assessment by endoscopic retrograde cholangiopancreatography.
Sheu BS, Shin JS, Lin XZ, Lin CY, Chen CY, Chang TT, Chen CY, Cheng PN.
Department of Medicine, National Cheng Kung University, Tainan, Taiwan, ROC.

OBJECTIVES: Choledochoduodenal fistula (CDF) is occasionally found during endoscopic retrograde cholangiopancreatography (ERCP). Cholelithiasis is suspected to be the leading cause in some endemic areas. We focus on this cause of CDF to determine which clinical characteristics are relevant to formation of fistulas and to learn whether CDF of various types would imply different clinical significance. METHODS: In 1882 ERCP starts from 1988 to 1993, we found 27 CDF with cholelithiasis in 1066 patients. Their clinical backgrounds and ERCP findings were compared with those of 492 patients who had cholelithiasis but no CDF. RESULTS: The prevalence of CDF was 2.53%. A longer past history of biliary stones, recurrent biliary tract infection (BTI), and the present of common bile duct stones (CBS) were factors relevant to the formation of fistula. In the case of 24 distal fistula including seven of type Ⅰ and 17 of type Ⅱ, there was concurrent distal CBS. Three cardinal features of fistula of the distal type were: 1. the length of CDF was less than 1.5 cm, 2. its orifice was just around or on the papilla fold, and 3. all cases of distal type Ⅱ had prominent pneumobilia, less jaundice, and larger CBS than type Ⅰ. Aggressive endoscopic or surgical treatment of distal type CDF decreased the recurrence of BTI, as indicated to surveillance for 1 yr. Three fistulas of the proximal type were longer and drained into the duodenum far from the papilla. All of these cases deserved early surgical intervention. CONCLUSIONS: CDF really serves as a chronic sequel of cholelithiasis. Different clinical features of CDF of various types help one to establish diagnosis and treatment. To avoid recurrence of BTI, aggressive therapy to correct CDF is mandatory.
PMID: 85111[PubMed – indexed for MEDLINE]

Laparoscopic cholecystofistulectomy for preoperatively diagnosed cholecystoduodenal fistula
Chikamori F, Okumiya K, Inoue A, Kuniyoshi N.
Department of Surgery, Kuniyoshi Hospital, Kochi, Japan.

The presence of cholecystoduodenal fistula, a rare condition, has been one of the reasons for conversion from laparoscopic cholecystectomy to open cholecystectomy. Here we report a patient with cholecystocholedocholithiasis complicated by cholecystoduodenal fistula, diagnosed preoperatively and treated combined endoscopic sphincterotomy and laparoscopic cholecystofistulectomy. After the removal of multiple duct stones by endoscopic sphincterotomy, the patient underwent laparoscopic cholecystofistulectomy. We were able to resect the fistula preoperatively. The patient is postoperative course was uneventful. We conclude that laparoscopic cholecystofistulectomy by skilled laparoscopic surgeons can be adopted as a first-choice treatment cholecystoduodenal fistula.
PMID: 11227669 [PubMed – indexed for MEDLINE]