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急性壞死性胰臟炎 (Acute Necrotizing Pancreatitis)

曾秋德　倪宗亨

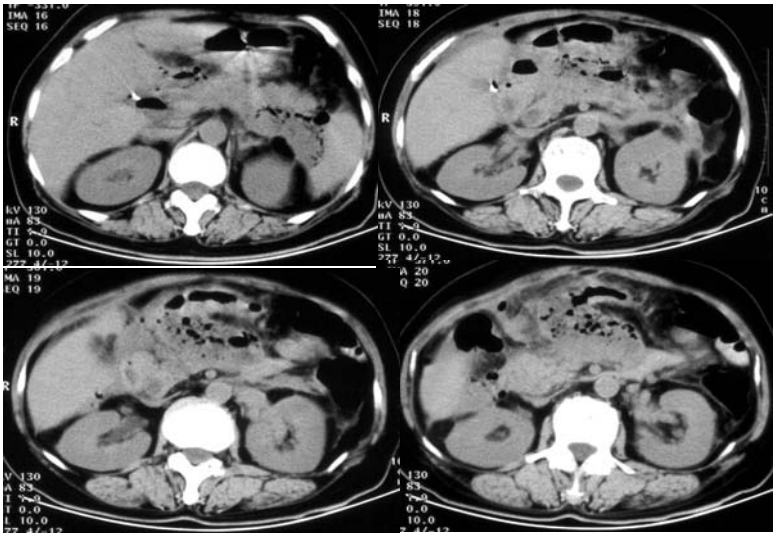
本案例爲一 58 歲女性，主訴右下腹疼痛約有一個月，追述其病史病人於一個多月前，因爲膽結石於某家醫院接受腹腔鏡膽囊切除手術。術後沒多久即有右下腹疼痛現象。病人曾到多家院所求診，但症狀並沒有改善。然後病人因爲有嘔吐、發燒及畏寒等情形到我們醫院求診而收住院治療。血液生化檢查發現 WBC:18900u/l, NE:76.6%, Bilirubin (T/D):1.61/0.4 mg/dl, CRP:19.1, Na:130 meq 異常外其它都在正常範圍。Amylase:31 mg/dl, Lipase:28 mg/dl 也都在正常範圍內。影像學檢查中，逆行性膽道鏡攝影(ERCP) 發現總膽管擴大及胰管有顯影劑滲漏，腹部電腦斷層檢查、胰臟有瀰漫增大，邊緣模糊的現象，及胰體發現含氣泡性膿瘍等情形。診斷疑爲總膽管損傷，腹內膿瘍及急性胰臟炎，於是進行剖腹探查術，術中發現腹內胰臟膿瘍與一囊腫殘株(Cystic stump)，遂進行清創引流並作一總膽管切口及 T 型管植入。病人術後再接受抗生素及 TPN 治療後病情穩定，目前病人仍住院治療中。

討論:

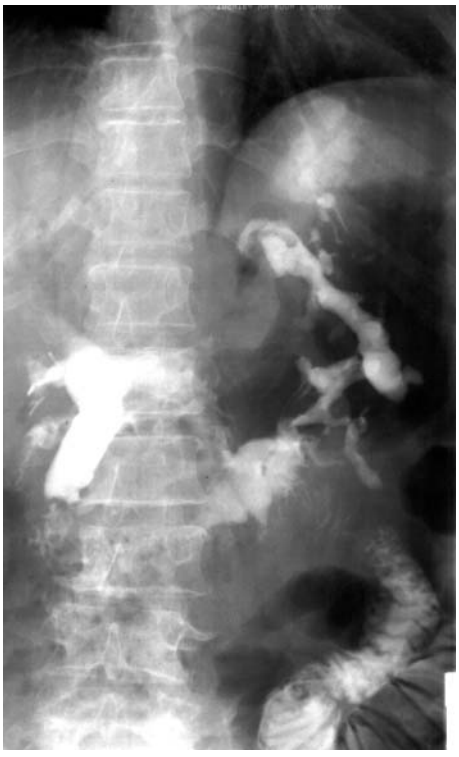
急性壞死性胰臟炎 (Acute Necrotizing Pancreatitis) 病因爲胆源性、感染性、酒精性、ERCP 或胃腸道術後及腹部創傷等均可引起或誘發急性胰臟炎。而壞死性胰臟炎約佔併發症中的 1-5%。

臨床症狀: 發燒, 頻脈, 腹痛 及 腹脹。

治療: 合併抗生素及經皮引流或手術清創。



腹部電腦斷層、胰臟有彌漫增大，邊緣模糊的現象，及胰體發現含氣泡性膿瘍。



逆行性膽道鏡攝影發現總膽管擴大及胰管有顯影劑滲漏。

參考文獻:

Management of patients with extended pancreatic necrosis.
Isenmann R, Rau B, Zoellner U, Beger HG.
Department of General Surgery, University of Ulm, Steinhoevelstrasse 9, D-89075 Ulm, Germany.
BACKGROUND: Extended pancreatic necrosis pose a considerable therapeutic problem in patients with necrotizing pancreatitis. AIM: Factors that limit conservative treatment in patients with extended pancreatic necrosis were analyzed. METHODS: The clinical course of 61 patients with an extent of necrosis of more than 50% of the gland (according to contrast-enhanced CT scan) were analysed with special regard to systemic complications. Indications for surgical treatment were either persistent organ failure or pancreatic infection. RESULTS: 10 patients were managed by conservative treatment, 51 (84%) patients underwent operation. Indications for surgery were sepsis with or without organ failure in 17 patients, persistent organ failure in another 17 patients, persistent SIRS in 13 patients and local complications in 4 patients. Pancreatic infection was present in 25 patients. The incidence of systemic complications did not differ between infected and sterile necrosis, but they occurred earlier in sterile necrosis. CONCLUSIONS: Persistent organ failure is limiting conservative treatment during the early course in patients with sterile necrosis. The latter course is characterized by a high incidence of pancreatic infection and septic organ failure.
PMID: 12120270 [PubMed - indexed for MEDLINE]

Biliary complications of pancreatic necrosis.
Chaudhary A, Sachdev A, Negi S.
Department of Gastrointestinal Surgery, Gobind Ballabh Pant Hospital, New Delhi, India. adarsh@nda.vsnl.net.in
BACKGROUND: Involvement of the biliary tract in pancreatic necrosis is rare. The authors are presenting six patients with this unusual complication. METHODS: Retrospective analysis of a case series. RESULTS: The necrotic process involved the bile duct in four patients (bile duct alone in two and bile duct with duodenum in two) and the gall bladder in two patients. It was not possible to make a preoperative diagnosis of biliary tract involvement in any of these patients. The lesions in the biliary tract were caused by the direct erosion by the necrotic tissue in five patients, and in one patient with gangrene of the gall bladder, it was a "remote" complication of the necrotizing process. All patients underwent surgery. Necrosectomy and cholecystectomy were performed in patients with gall bladder lesions, and proximal biliary drainage was the method of choice in patients with erosion of the bile duct. One patient died postoperatively. During follow-up, another patient who had bile-duct involvement developed a stricture in the damaged part of the bile duct and needed hepaticojejunostomy CONCLUSIONS: Necrotizing pancreatitis can involve the biliary tract, both by direct extension and by its secondary effects. Although cholecystectomy is the treatment of choice in the presence of gallbladder involvement, proximal biliary diversion may be indicated in patients with erosion of the bile duct.
PMID: 12067215 [PubMed - indexed for MEDLINE]

家族性大腸腺腫症 （Familial adenomatous polyposis） 進行全大腸切除及迴腸直腸吻合術 (Total colectomy and ileorectal anastomosis—IRA) 一病例報告

曾建森 羅海韻

陳女士是一位 26 歲家庭主婦，她來本院消化內科求診主要是因爲三個月來陸續有右下腹痛，便秘的症狀。六年前曾因甲狀腺亢進接受手術。病患的母親在三十歲時死於大腸癌。其大姐也發現有直腸癌。理學檢查除右下腹壓痛外無其他特殊發現。眼底檢查正常。實驗室檢查方面：WBC =9300/ul Hb= 12.4g/dl Plt= 225k/ul, ALT=10 u/l , ALP=41u/l, Alb=4.5g/dl, BUN=13 mg/dl Cr=0.7 mg/dl ,Na=137 mEq/L ,K=3.7 mEq/L,TSH =5.67 uIU/ml , Free T4=0.92 ng/dl, CEA= 0.33 ng/ml. Chest PA 及 Skull AP view 也正常。小腸攝影無特別異常。大腸鏡檢查發現全大腸有數目超過一百以上的息肉。升結腸及橫結腸的息肉較小，約 5mm 左右，直腸及乙狀結腸的息肉較大、約 5-13mm。 乙狀結腸息肉病理生檢顯示爲管狀腺瘤（tubular adenoma）。並無高度異常分化或腫瘤浸潤的狀況。根據家族史，大腸內視鏡、及病理切片報告，診斷爲家族性大腸腺腫症（familial adenomatous polyposis）。病患也接受十二指腸內視鏡檢查，十二指腸壺腹部分並無發現腺腫，胃穹隆部則伴有息肉增生（gastric fundal hyperplastic polyps）。病人經過 APC gene test 檢驗並無 truncated protein 產生。之後病患接受全大腸切除及回腸直腸吻合術 （total colectomy and Ileorectal anastomosis — IRA）。術後狀況良好，持續追蹤之中。

討論：

家族性大腸腺腫症（familial adenomatous polyposis）FAP 主要是一種顯性遺傳疾病，病人的大腸佈滿許多息肉，數目多達一百個以上。到了十五歲左右，50%的病人會產生息肉。35 歲時 90%的病人都會有息肉產生。至於癌症的發生，也是隨年齡增長。如果不切除大腸，到 50 歲時有 90%會產生癌症。本病症主要有三種變異型:

(1)Gardner’s syndrome：FAP 合併有 epidermoid cyst，osteoma，desmoid tumor。

(2)Turcot syndrome：FAP 合併 CNS tumor(如 medulloblastoma)。

(3) attenuate FAP：息肉數目少，小於 100，通常爲 30 左右。分布以右側大腸爲多。

FAP 有許多大腸以外的症狀表現，如甲狀腺癌、十二指腸癌、十二指腸乳頭癌、CHRPE 視網膜病變、osteoma、Supernumerary teeth、epidermoid cyst、gastric adenoma、gastric fundic polyps。

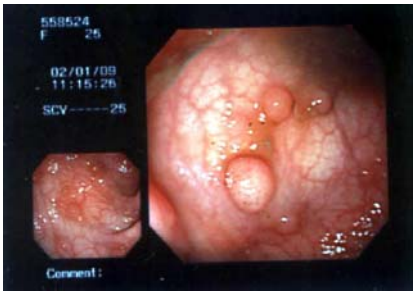
幾乎所有的 FAP 都起因於 APC gene germline 突變。APC gene 位於 chromosome 5q21，是一種 tumor suppressor gene。具有 15 exons。最常見的突變是發生在 codon 1309 的位置。診斷 APC gene 突變有許多方式，最常用的方法是 protein truncation test（PTT ），突變的基因無法做出完整的蛋白，利用這樣的原理間接診斷 APC 基因突變。

由於 FAP 發生大腸癌的機會極高，治療以大腸切除爲主。對於症狀較輕微的病人，建議做 total colectomy + ileorectal anastomosis(IRA)。症狀嚴重的病人則做 restorative

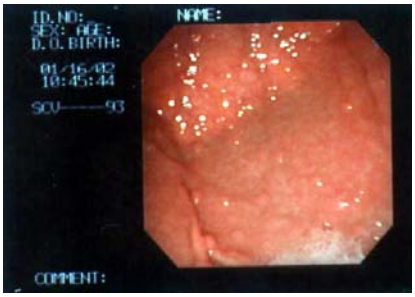
proctocolectomy + ileal pouch anal anastomosis(IPAA)。如果發生非常低位的直腸癌，或是無法做 IPAA 則只好做 totoal proctocolectomy +ileostomy。

根據 AGA 的準則，做 IRA 手術後的病人，每 6 個月做內視鏡檢查，早期偵測剩餘直腸黏膜發生息肉或癌化的可能性。同時也要進行上腸胃道內視鏡檢查。甲狀腺檢查則每年做一次。病人術後可考慮使用 Cox-2 inhibitor 預防息肉發生。

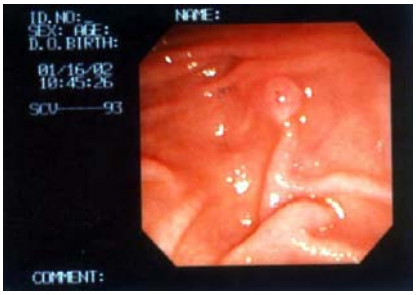
圖例：



Sigmoid colonic polyps

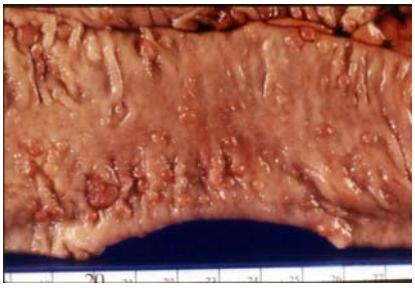


Gastric fundic polyps

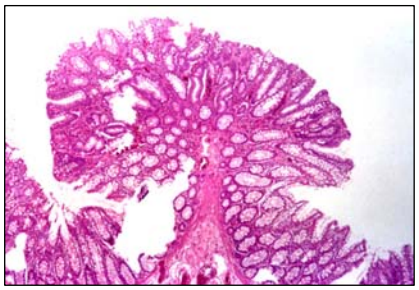


Ampula of Vater

Total colectomy specimen



Magnifying image



Microsopic view

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Giardiello FM, Brensinger JD, Petersen GM.

Department of Medicine, Oncology Center, The Johns Hopkins University School of Medicine, Baltimore, MD, USA.

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PMID: 11438509 [PubMed - indexed for MEDLINE]