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腸道異物阻塞合併出血

(Bezoar with partial small bowel obstruction and bleeding)

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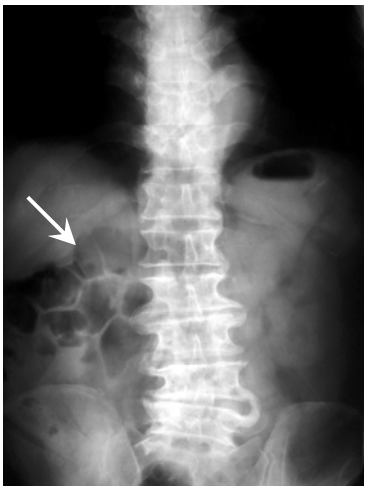
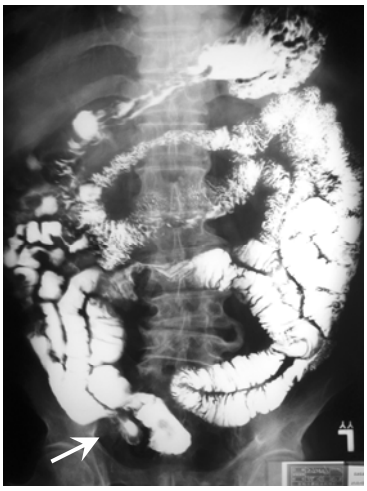
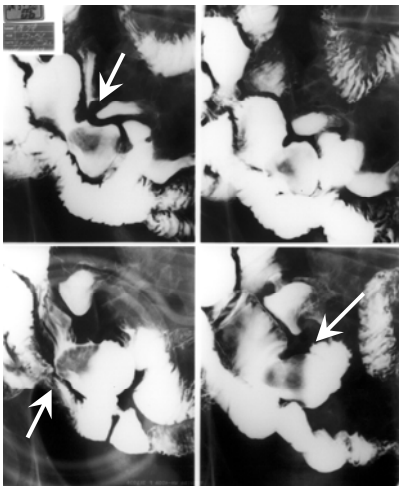
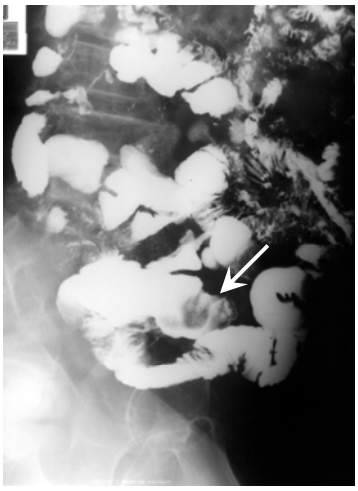
一 68 歲男性病人，主訴腹痛、腹脹、全身虛弱兩天，且在四天前有鮮黑便三次，於住院當天發燒至本院求診。
病人過去有十二指腸潰瘍合併出血的病史（83 年 8 月），90 年 1 月病人因中風導致右側肢體乏力，並於 6 月在本院接受右鼠蹊部疝氣修補術。病患自 91 年 7 月即常抱怨腹脹、腹痛、偶有嘔吐、腹瀉現象，經藥物保守治療，症狀皆可緩解，當初診斷爲 Functional GI disturbance with ileus。此次因有 tarry stool 住院（Hb：6.8 g/dL；MCV：85.3 fL； SOB：+++），plain abdomen showed small and large bowel air in right half abdomen（圖一）；上、下消化道內視鏡與腹部超音波並無異常發現；進一步安排小腸鋇劑攝影，發現右下腹部迴腸區域有一約 1 cm filling defect lesion, 在 lesion 近端有 lumen dilatation 現象（圖二、圖三、圖四），懷疑小腸腫瘤、息肉或異物。經外科行 Laparoscopy，發現在離 ileocecal valve 100 cm 之迴腸有狹窄



圖一: 腹部 X 光顯示右上腹部腸氣鬱積。







圖二、圖三、圖四: 小腸鋇劑攝影，發現右下腹部迴腸區域有一約 1cm 的填充缺陷，懷疑小腸腫瘤、息肉或異物。

現象，作了 segmental resection 發現腸腔有一 stone-like foreign body，且腸壁有多處的潰瘍；病理報告腸壁有 Acute. and Chronic inflammatory cells infiltrate and submucosal fibrosis。病人術後恢復良好，出院後並無再有腹脹現象。

討論：

Bezoars 大致可分爲四個 types：Phytobezoar（composed of vegetable fibers）；Trichobezoar（composed of hair-like fibers）；Pharmacobezoar（與攝取藥物有關）和 Lactobezoar（好發於小孩，與奶類成分有關）。臨床上以前二者較常見，攝取大量不易消化物質不惟是 bezoar 發生原因之一，大部分病人常合併之前曾接受腹部手術病史（如 partial gastrectomy and post-surgical adhesion），因而改變 Gastric motility；造成 Gastroparesis 之 underlying diseases，如糖尿病、長期洗腎與仰賴呼吸氣之病人，皆容易形成 Bezoar。

大部分病人症狀不明顯，臨床徵候以上腹部不適最多（80%），其他如噁心、嘔吐、厭食、易飽足感與腹脹也常見。

以本病例爲例，小腸異物阻塞實屬罕見，診斷工具有鋇劑顯影、超音波與電腦斷層。依據文獻，腹部電腦斷層在診斷小腸 Bezoar 有較高之敏感性；CT 上若見小腸腔內有 Gas-containing mass 且合併 encapsulating wall，要考慮 Bezoar 之可能性。

治療上以胃部 Bezoar 較容易處理，小的 phytobezoar 可投與 cellulase（chemical dissolution）與 Prokinetic agents，成功率約 85%；稍大之 Bezoar 則以 endoscopy with fragmentation 治療，以 biopsy forcep or snare 來作 fragmentation（mechanical disruption），成功率可達 85~90%；外科手術適應症爲 Bezoar-associated complications、如 perforation、obstruction and GI bleeding。在小腸 Bezoar 方面，目前 laparoscopy 應用廣泛，可作 segmental enterectomy or enterotomy，將 bezoar fragmentation 後，再 milking to the cecum。

最後要注意 Bezoar 可能再發，所以腹部手術後病人避免高纖維飲食，糖尿病病人給予 Prokinetic drugs 和有精神疾病之病人避免其吞食毛髮，均是有效預防之措施。

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壞死性胰臟炎

(Necrotizing Pancreatitis)

外科 曾譯諏

這是一位 54 歲男性因敗血症及壞死性胰臟炎由它院轉入；在過去病史方面，病人曾因闌尾炎開過闌尾切除手術，於民國 85 年因中風合併右肢偏癱目前復健治療中。主要病史是在兩週前開始有上腹痛、噁心、嘔吐之情形，於一週前因診斷急性胰臟炎及肋膜積水開始住院治療，但是無明顯進步而轉入本院治療。入院時體溫 38.5^{O}C Bp:158/103 HR:130 腹部觸診顯示明顯瀰漫性壓痛及及回縮痛，兩側下肺部囉音，入院時 WBC: 36300 uL；Hb:12.3 g/dL；GOT/GPT: 17/15 U/L；Amylase/Lipase : 99/120 U/L；Bilirubin T/D : 2.18/0.74 mg/dL，腹部電腦斷層攝影顯示壞死性胰臟炎併胰臟膿瘍(圖 1)Abdominal tapping showing Exudate。病人於入院次日開刀做 1. Cholecystectomy and intraoperative cholangiography 2. Necrosectomy with abscess drainage 術後引流管引流，於術後一個月腹部電腦斷層攝影追蹤(圖 2)，明顯改善，於術後四個月超音波追蹤完全恢復。

討論：

造成急性胰臟炎的原因有飲酒過度約 40%、膽石症約 40%、高脂血症及醫源性造成等約 20%，診斷上主要由 Lab. Data 如 Amylase and Lipase 明顯升高、超音波、腹部電腦斷層攝影等，大部份病人可由保守療法治癒，只有少部份病人會造成 necrotizing pancreatitis or abscess 但 necrotizing pancreatitis 死亡率約 5 – 50 % 平均約 30%；Acute pancreatitis 開刀之 indication (1) uncertainty of diagnosis；(2) treatment of secondary pancreratic infection；(3) correction of associated biliary tract disease；(4) progressive clinical deterioration despite optimal supportive care，手術主要 Complication 有 hemorrhage、pancreaticocutaneous fistula、enterocutaneous fistula、duodenal obstruction、pancreatic insufficiency；prognosis 可由 Ranson's criteria 來評估如表 1 及 表 2 或 APATCHE IIs

表 1 Criteria for Pancreatitis Not Due to Gallstones

At Admission	During initial 48 hours
Age >55 yr	Hematocrit fall >10 percentage points
WBC >16,000 cells/mm^3	BUN elevation >5 mg/100 ml
Blood glucose >200 mg/100ml	Serum calcium fall to <8 mg/100 ml
Serum LDH >350 IU/l	Arterial Po_2 <60 mm Hg
AST >250 U/100 ml	Base deficit >4 mEq/l
	Estimated fluid sequestration >6 l

表 2 Criteria for Gallstone Pancreatitis

At dmission	During Initial 48 Hours
Age >70 yr	Hematocrit fall >10 percentage points
WBC>18,000 cells/mm^3	BUN elevation >2 mg/100 ml
Glucose >220 mg/100 ml	Serum calcium fall to <8 mg/100 ml
Serum LDH >400 IU/l	Base deficit >5 mEq/l
AST >250 U/100 ml	Estimated fluid sequestration >4 1

Score of 0 to 2 mortality rate 1%
Score of 3 to 4 mortality rate 16%
Score of 5 to 6 mortality rate 30%

Score more than 7 mortality rate 100%

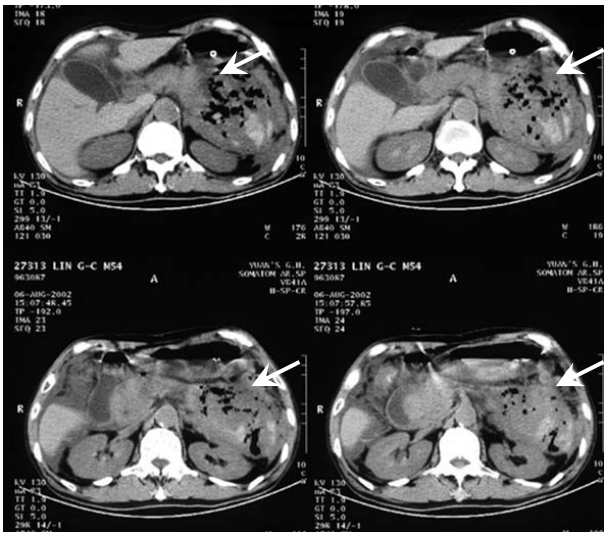

圖 1 Necrotizing pancreatitis with large abscess formation around pancreatic tail and small abscess formation at pancreatic head。

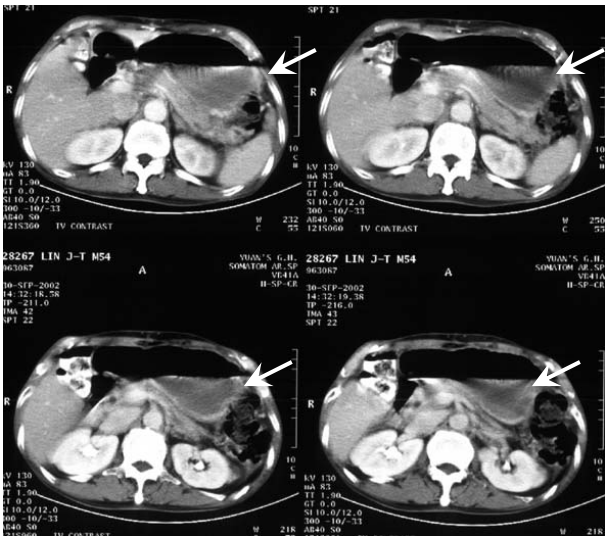

圖 2 Pancreatic abscess post op with still minimal residual peripancreatic fluid。

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Surgical Treatment of Acute Pancreatitis
Werner J, Uhl W, Buchler MW.
Department of General and Visceral Surgery, University of Heidelberg, Im Neuenheimer Feld 110, 69120 Heidelberg, Germany.
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Abstrat: Patients with predicted severe necrotizing pancreatitis as diagnosed by C-reactive protein (>150 mg/L) and/or contrast-enhanced computed tomography should be managed in the intensive care unit. Prophylactic broad-spectrum antibiotics reduce infection rates and survival in severe necrotizing pancreatitis. Endoscopic retrograde cholangiopancreatography and endoscopic sphincterotomy is a causative therapy for gallstone pancreatitis with impacted stones, biliary sepsis, or obstructive jaundice. Fine needle aspiration for bacteriology should be performed to differentiate between sterile and infected pancreatic necrosis in patients with sepsis syndrome. Infected pancreatic necrosis in patients with clinical signs and symptoms of sepsis is an indication for surgery. Patients with sterile pancreatic necrosis should be managed conservatively. Surgery in patients with sterile necrosis may be indicated in cases of persistent necrotizing pancreatitis and in the rare cases of "fulminant acute pancreatitis." Early surgery, within 14 days after onset of the disease, is not recommended in patients with necrotizing pancreatitis. The surgical approach should be organ-preserving (debridement/necrosectomy) and combined with a postoperative management concept that maximizes postoperative evacuation of retroperitoneal debris and exudate. Minimally invasive surgical procedures have to be regarded as an experimental approach and should be restricted to controlled trials. Cholecystectomy should be performed to avoid recurrence of gallstone-associated acute pancreatitis.