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Vol 5， No 2. Apr，2004

急性胰臟炎併僞囊腫

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48 歲，家庭主婦，有糖尿病、高血脂病史，曾幾個月前因急性高血脂胰臟炎住院，因發生上腹痛、嘔吐，再度至急診抽血檢查，Amylase 246，Lipase 684，Blood sugar 252，WBC 20300，超音波檢查有胰臟水腫及少量腹水，於是病人再度因急性胰臟炎入院。

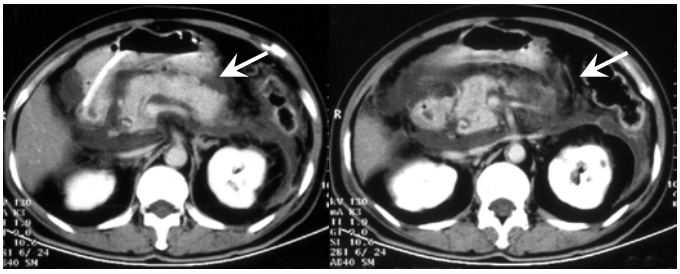
入院時，理學檢查，體溫 36.6℃，BP140/80 mm/hg，PR90/min，RR 21/min 無貧血、黃胆，腹部有膨脹現象，上腹壓痛，下肢無水腫。

生化檢查 GOT 28 GPT 38 BUN 22 Cre 0.8 TG 1346 Chloesterol 979 Na^{+} 128 K^{+} 3.8 Cl^{-} 92 Ca^{+2} 9.2 LDH 254 ， 電腦斷層顯示胰臟水腫並有週邊組織浸潤及體液聚積情形（圖一）。

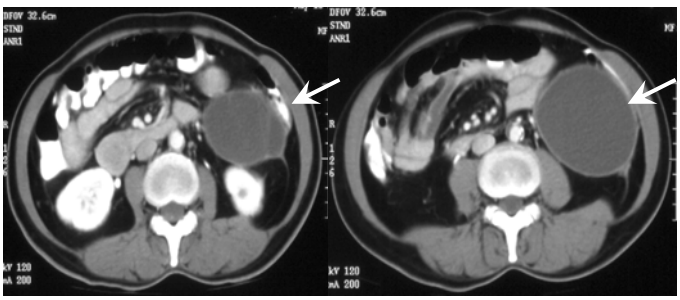
住院中給予保守療法，禁食及體液補充，因有貧血情形，Hb 8.2 給予輸血，輕微發燒給予抗生素預防感染，病人情況改善，18 天後出院。出院後病人在門診追踪當中，病人有時候覺得左側腹脹，三個月後的超音波及電腦斷層檢查發現左側腹部有個超過 10 公分大的囊腫（圖二），於是建議病人住院接受囊腫引流術。

病人在接受 ERCP 確定胰管和囊腫無相通後施行經皮囊腫引流術，囊腫消失後出院。

討論：嚴重之急性胰臟炎可導致僞囊腫之發生，大部份之僞囊腫可自行消失，但較大之僞囊腫無法自行消失時便需考慮加以處理，處理之方式依病人之情況及僞囊腫之位置而不同，目前之方法有外科手術、內視鏡囊腫引流術及經皮囊腫引流術，本病例爲經皮囊腫引流術成功之案例。



圖一: 電腦斷層顯示胰臟水腫並有週邊組織浸潤及體液聚積情形。



圖二: 電腦斷層顯示檢查發現三個月後左側腹部有個超過 10 公分大的囊腫。

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Pancreatic pseudocysts: 10 years of experience.

Naoum E，Zavos A，Goudis K，Sarros C，Pitsargiotis E，Karamouti M，Tsikrikis P，Karantanas A.

Surgical Department，District General Hospital of Larissa，Tsakalof 1 Str，Larissa 41221，Greece.

BACKGROUND: Pancreatic pseudocysts（PP）are considered to be one of the major complications of acute， chronic ，and posttraumatic pancreatitis. Their treatment has always been a surgical challenge. Surgical treatment was for many years the only choice in the management of PP. However， technological development has provided new alternatives in their management.

PURPOSE: The purpose of this retrospective study is to present our experience in the treatment of PP and to define the criteria for the selection of the treatment method. METHODS:During the past decade，14 patients were treated for PP in our clinic. We classified our patients in three groups based on the treatment: A，conservative treatment; B，surgical treatment with internal drainage; and C，percutaneous external drainage （PED）under CT guidance.

RESULTS: Conservative treatment had excellent outcome when it was applied in patients with small cysts. Internal drainage was always successful， but patients needed more hospitalization and showed increased morbidity compared to PED. PED was successful in two of three patients.

CONCLUSIONS: Conservative treatment is a good choice for small asymptomatic cysts， particularly for patients who are poor candidates for operation. Internal drainage is a good method of treatment and should be used as the first choice by experienced surgeons. Finally，PED is a good first choice for patients with a unilocular cyst and contraindications for surgery.

PMID: 14598138 [PubMed – indexed for MEDLINE]

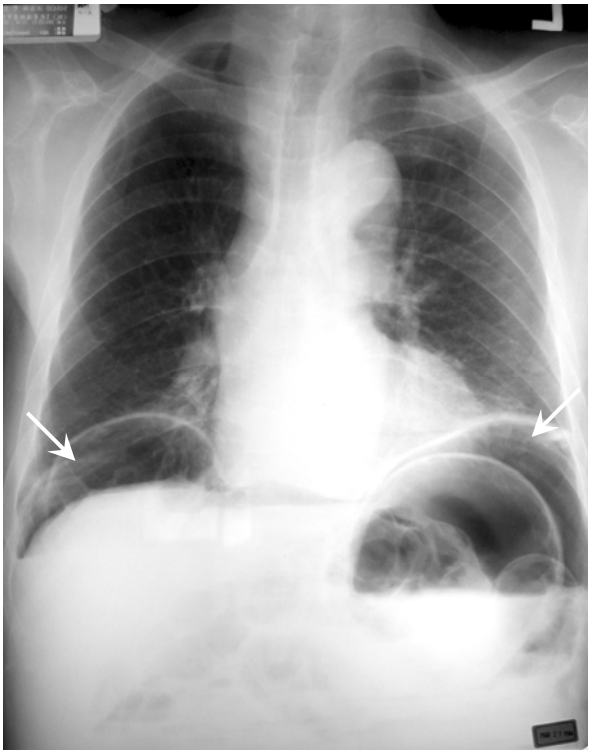
穿孔性邊緣性潰瘍

Parforated hlarginal Uker

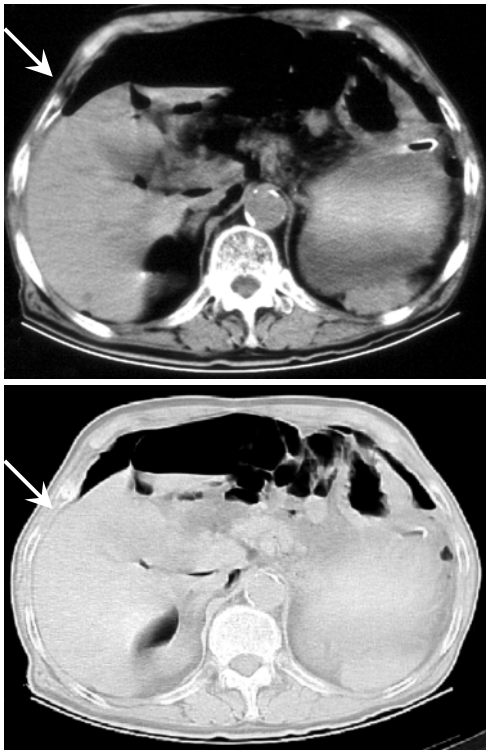
外科 倪宗亨

病患是一位 73 歲，男性，主訴因三天前突發性腹痛，症狀持續沒有改善，至本院急診就診，過去病史爲穿孔性消化性潰瘍，於一年前至他院接受手術治療（手術方式不明），理學檢查爲腹部廣泛性壓痛及腹脹，血液生化檢查 WBC: 13000，Neut: 90% ，BUN/Cre 54/1.6，其他大致正常，胸部 X 光兩側明顯橫膈下游離空氣(subphrenic free air) (圖一)，腹部電腦斷層亦檢視出橫膈下游離空氣和腹內積水(debris ascites) (圖二)，基於術前診斷爲中空器官穿孔合併腹膜炎，緊急實施剖腹探查，術中發現病患曾接受胃部份切除及 Billroth Ⅱ anastomosis， 並在吻合處發現一個 2X2 公分之穿孔，而吻合處也出現潰瘍現象，實於 Revision of billroth Ⅱ anastomosis。病患術後接受全靜脈營養(TPN)及空腹禁食 9 天，第 10 天開始進食流質食物，術後狀況回復良好，於第 14 天出院，並於門診追踪治療。

討論：對於曾接受潰瘍治療手術的病患，復發性潰瘍大致是因爲前次手術減酸治療不足或粘膜抗酸功能不良。造成 marginal ulcer 的原因①incomplete vagotomy ②retained antrum③zollinger-ellison syndromes ④gastric stasis⑤nsaid abuse ，margina uker 對內科治療效果不佳，外科治療包括：重新切除及吻合。



圖一: 胸部 X 光兩側明顯橫膈下游離空氣(subphrenic free air)。



圖二:腹部電腦斷層亦檢視出橫膈下游離空氣和腹內積水 (debris ascites)。

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Surg Endosc. 1994 Feb;8(2):107-10
Giant marginal ulcer.
Gowen GF, Campbell RE, McFarland MM, Alman BA.
Department of Surgery, Pennsylvania Hospital, School of Medicine, University of Pennsylvania, Philadelphia 19106.
Marginal ulcer is a well-known complication of gastroenterostomy. It occurs in 3% of patients post-Billroth II subtotal gastrectomy; it occurs in less than 1% if truncal vagotomy is included but in up to 30% of patients with gastroenterostomy without vagotomy. These ulcers occur at the anastomosis, but always on the jejunal side, and are known to develop complications of their own--e.g., intractable pain; hemorrhage, obstruction, perforation, and fistula formation. Prior to the advent of upper-GI endoscopy the main method of diagnosis was by history and upper GI series but the accuracy of the upper-Gi series was about 50% or less. Now that upper-GI endoscopy is available, the accuracy of diagnosis is 95% or better. Since truncal vagotomy has been widely adopted as an integral part of gastric surgery--e.g., antrectomy, hemigastrectomy, subtotal gastrectomy, and gastroenterostomy--the incidence of marginal ulcer has declined. The use of cimetidine, ranitidine, famotidine, omeprazole, sucralfate, and antacids has improved the medical management of duodenal ulcer to such a degree that in recent years there is much less need for surgical intervention and thus the incidence of marginal ulcer has declined even more. In addition, the H-2 blockers and omeprazole can be used in patients with marginal ulcer and achieve healing; therefore complications that so frequently required surgical intervention are much less frequent.

PMID: 8165479 [PubMed - indexed for MEDLINE]

Acta Chir Hung. 1995-96;35(1-2):77-85.
Complicated marginal ulcers after surgery for duodenal ulcer.
Alhan E, Calik A, Cinel A, Kucuktulu U.
Department of Surgery, Karadeniz Technical University, Medical School, Traozon, Turkey.
During a period of 10 years, 10 cases of marginal ulcer (MU) after surgery for duodenal ulcer were evaluated retrospectively. The most common cause of MU was inadequate gastric resection plus incomplete vagotomy; the second common cause was incomplete vagotomy. In one case, the MU could be ascribed to malignant gastrinoma. In eight of the ten cases epigastric pain was a major symptom. MU was complicated with perforation, massive bleeding, gastrojejunocolic fistula and afferent loop obstruction in 2, 2, 2, and 1 cases, respectively. Gastroscopy was very useful for the diagnosis except in emergency cases. Hollander test was used in six of the 10 patients to evaluate if the vagotomy had been complete. The mean acid output by insulin induction was found 32 meq/h. As a surgical therapy, total gastrectomy (2 cases), truncal vagotomy (2 cases), truncal vagotomy plus 60% gastric resection or reresection and Roux Y gastrojejunostomy were performed. Postoperative complications (enterocutaneous fistula, intraabdominal abscess and delayed gastric emptying) occurred in 33 patients. One patient was lost after total gastrectomy in the malignant gastrinoma and gastrojejunocolic fistula case, due to sepsis. The patients were followed up for 4.4 years on the average. No recurrence was seen.

PMID: 8659242 [PubMed - indexed for MEDLINE]