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Intestinal tuberculosis 小腸結核病

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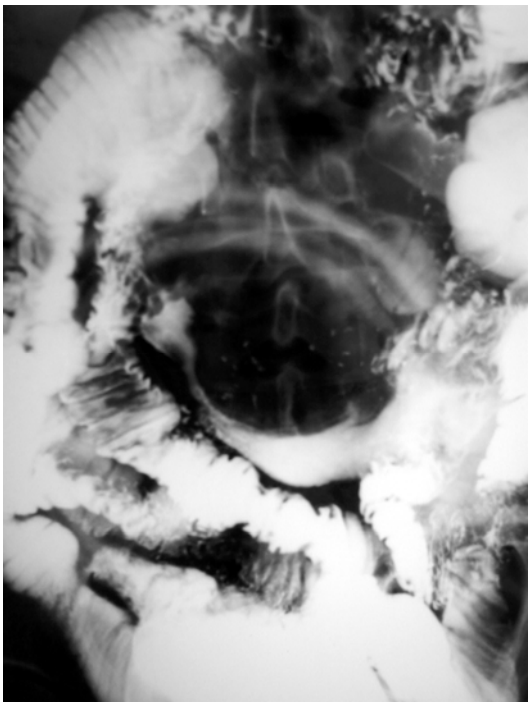
一位男性 44 歲主訴腹痛併偶有嘔吐現象由急診住院治療，回顧腹痛病史已經有一年多但最近三個月開始加劇且有嘔吐情形，也曾因為腸阻塞而多次住院治療，但除了腸阻塞外並無其他病兆，而且經過支持性治療既恢復。

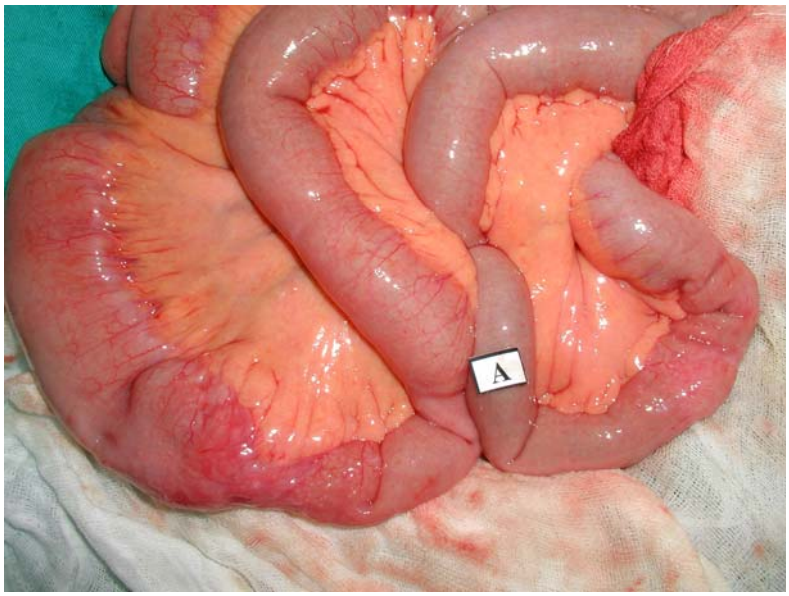
本次住院也是以腹痛腸阻塞嘔吐來表現，在過去病史方面他有糖尿病、氣喘、阿米巴腸炎、精神分裂、多次腸阻塞病史，仍於門診治療中。本次住院時理學檢查發現，腹部廣泛性輕微壓痛並無可觸摸之腫塊，但明顯腹脹且腸蠕聲增高，鞏膜無黃疸現象，結膜無貧血現象，生化學檢查除 GOT:86 GPT:178 BUN：10、Cr：1.0 血液檢查方面除 WBC:16100 外其餘均在正常範圍，腫瘤標記方面為正常，腹部超音波顯示腸阻塞外並無其他病兆，胸部 X 光並無明顯病兆，腹部 X 光顯示腸阻塞，腹部電腦斷層顯示腸阻塞。

住院中鼻胃管引流兼治療，並安排小腸攝影，發現腸阻塞併有狹窄之情況，於 2004 年 10 月 19 日開刀行部分小腸切除併吻合手術，術中冷凍切片病理報告結果為小腸結核，在術後開始結核藥物治療，恢復良好，目前門診治療中。

討論:

在台灣小腸結核在肺外結核中比例並不高約 1.5%（86 胸腔醫學），少於 25%病人合併胸部 X 光病兆，診斷上主要是病人接觸病史加上高度懷疑，Ultrasonography guide aspiration of intraabdominal fluid, colonfiberoscope, barium enema, small intestinal series, laparoscopy 皆是很好的診斷工具，治療上仍以抗結核藥物六個月以上為主，外科治療以保守為主，主要在腸道發生狹窄超過一半以上甚至近端腸道擴張時，以 Strictureplasty（5-6 公分縱切橫縫）或大於 5 公分以上之部份腸道切除。





Stricture with proximal dilatation

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Tuberculosis can involve any part of the gastrointestinal tract and is the sixth most frequent site of extrapulmonary involvement. Both the incidence and severity of abdominal tuberculosis are expected to increase with increasing incidence of HIV infection. Tuberculosis bacteria reach the gastrointestinal tract via haematogenous spread, ingestion of infected sputum, or direct spread from infected contiguous lymph nodes and fallopian tubes. The gross pathology is characterized by transverse ulcers, fibrosis, thickening and stricturing of the bowel wall, enlarged and matted mesenteric lymph nodes, omental thickening, and peritoneal tubercles.

Peritoneal tuberculosis occurs in three forms : wet type with ascitis, dry type with adhesions, and fibrotic type with omental thickening and loculated ascites. The most common site of involvement of the gastrointestinal tuberculosis is the ileocaecal region. Ileocaecal and small bowel tuberculosis presents with a palpable mass in the right lower quadrant and/or complications of obstruction, perforation or malabsorption especially in the presence of stricture. Rare clinical presentations include dysphagia, odynophagia and a mid oesophageal ulcer due to oesophageal tuberculosis, dyspepsia and gastric outlet obstruction due to gastroduodenal tuberculosis, lower abdominal pain and haematochezia due to colonic tuberculosis, and annular rectal stricture and multiple perianal fistulae due to rectal and anal involvement.

Chest X-rays show evidence of concomitant pulmonary lesions in less than 25 per cent of cases. Useful modalities for investigating a suspected case include small bowel barium meal, barium enema, ultrasonography, computed tomographic scan and colonoscopy. Ascitic fluid examination reveals straw coloured fluid with high protein, serum ascitis albumin gradient less than 1.1 g/dl, predominantly lymphocytic cells, and adenosine deaminase levels above 36 U/l. Laparoscopy is a very useful investigation in doubtful cases. Management is with conventional antitubercular
therapy for at least 6 months. The recommended surgical procedures today are conservative and a period of preoperative drug therapy is controversial.

胰 臟 癌

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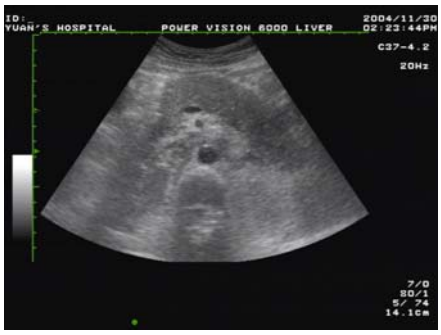
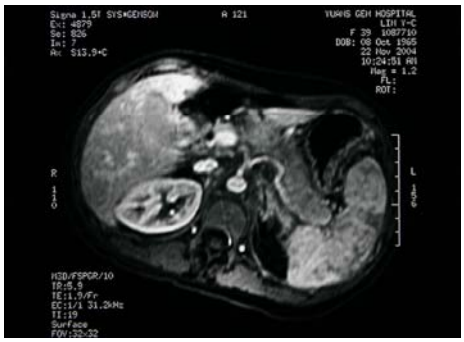
一 39 歲女性病人，因反覆左上腹及背部疼痛於外面診所求診，胃鏡無特殊發現，但腹部超音波卻發現胰臟腫大及腹水產生，於是懷疑有急性胰臟炎而轉介至本院進一步檢查及治療。

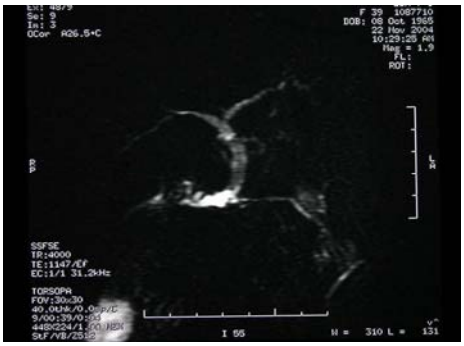
入院後腹部超音波(圖一)發現胰臟呈瀰漫性腫大併伴隨有些許腹水產生，生化學檢查：肝及腎功能比皆正常，sugar ac：84 mg/dl，serum amylase: 82 u/l，lipase：121u/l，serum WBC: 7.6×103 u/l，Hb: 9.9 g/dl, platelet: 269×103 u/l，AFP:3.4ng/ml，CEA: 0.8 ng/ml，CA19-9：1043.3u/ml ，因懷疑有胰臟惡性病變，故進一步安排核磁造影(MRI)(圖二),及 MRCP（圖三）檢查，核磁造影顯示胰臟呈瀰漫性腫大，但無確切腫瘤可以發現，於是再進一步安排內視鏡超音波（圖四）檢查。



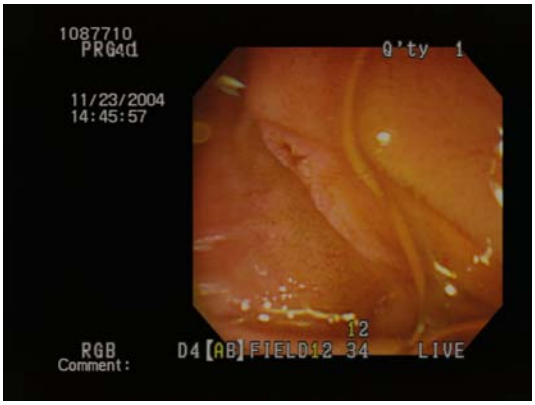
圖一

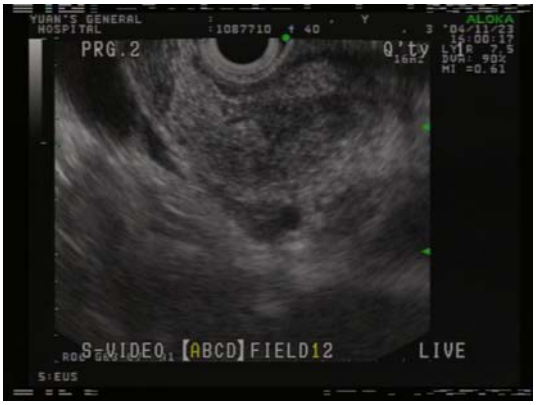


圖二



圖三





圖四

內視鏡超音波亦發現胰臟呈瀰漫性腫大但無法發現有任何腫瘤，於是在內視鏡超音波指引下作胰臟細針抽吸檢查（FNA)，結果病理檢查結果為胰臟腺體癌（Adenocarcnoma of Pamcreas)。

討論

胰臟癌依腫瘤部位不同，臨床上常以黃疸、上腹痛及體重減輕等症狀來表現，生化學檢查會呈現 CEA 及 CA19-9 值異常升高，大體及影像學最常見以腫瘤型態(tumor type，實質或囊狀腫瘤）表現，極少數以瀰漫型態（diffused type）來表現，本例即屬於 diffused type pancreatic cancer，胰臟癌診斷工具包括：腹部超音波、電腦斷層、核磁共振造影術及內視鏡超音波，本例為瀰漫型胰臟癌，幾乎無法以傳統腹部超音波、電腦斷層及核磁共振造影術來診斷，而以內視鏡超音波指引下作胰臟細胞抽吸檢查（EUS with FNA）卻為本例提供一最佳診斷工具，故特提出此病例以供參考。

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