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Pancreatic pseudocyst 胰臟假性囊腫病

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一名31歲男性患者，過去有慢性胰臟炎病史在其它醫院追踪治療。此次因上腹痛大約一星期左右至其它醫院就診並安排住院。經腹部電腦斷層掃描檢查後，被診斷為胰臟假性囊腫，故被安排轉診至本院接受進一步的檢查治療。

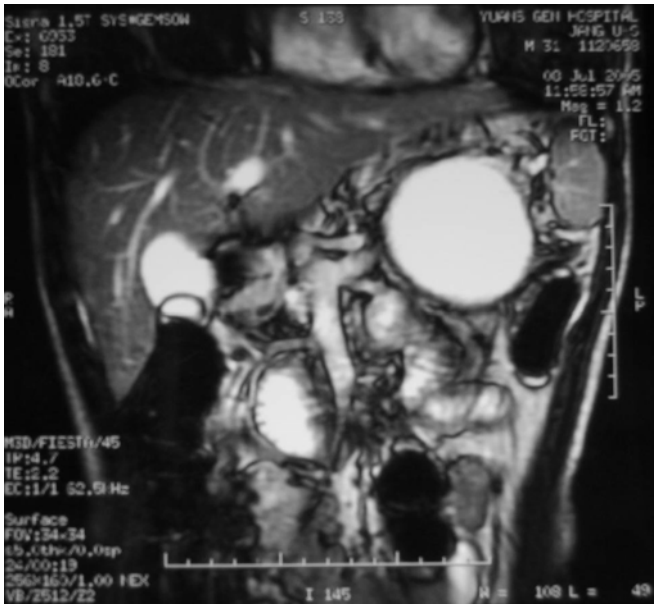
住院時，理學檢查可見上腹部會壓痛。血液檢查：WBC:6100, Hb:12.0g/dL, Plt:262000, GOT:44U/L, GPT:24U/L, BUN:8mg/dl, Cre:0.9mg/dl, Na:136meq/L, K:4.1meq/L, Cl:99meq/L, Amylase:24U/L, Lipase:27U/L. MRCP可見一巨大的胰臟囊腫。手術安排病人進行囊腫空腸吻合術及Roux-en-Y吻合術。目前在門診追踪治療中。

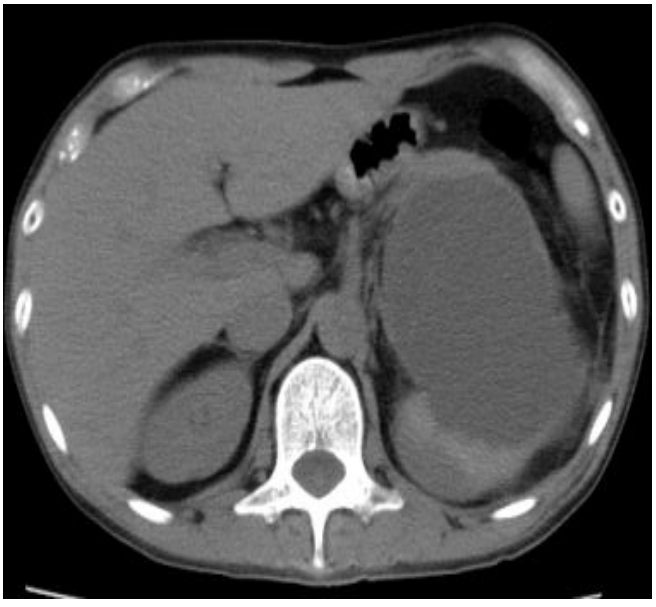
討論：

急性胰臟炎會合併有胰分泌液積存在胰臟周圍，這種積液有時會含有血液及壞死組織物。一般急性胰臟炎發生液體積在胰臟皮表膜之下稱“胰臟內積水"(Intrapancreatic fluid collection)，此種有時會自然再吸收而消失的，若積在胰臟表皮膜之外稱“胰臟外積水 "(Extrapancreatic fluid collection)，如液體積堆在小網膜腔內而有纖維組織壁包圍完整形成囊狀腫瘤，此時可以稱之為假性囊腫，而且在一個月後檢查仍然有時會維持原狀。如果囊腫大於4-6公分，或者囊腫持續3-4週無法改善，則較不易消失。

診斷上，急性胰臟炎之症狀如果持續7-10天或者慢性胰臟炎有腹痛或嘔吐之症狀時，則宜懷疑有囊腫形成。最常當為診斷工具的是超音波及電腦斷層掃描。另外可以安排逆行性內視鏡膽道造影術(ERCP)來檢查胰管情形，假性囊腫約 60~90%與胰管有關有相通，可以發現胰管被阻塞或壓迫變形等。一般而言，ERCP會加重胰臟炎及引致細菌感染，所以並不要每一病例皆以ERCP來檢查。常見的合併症有出血、細菌感染、總膽管末端阻塞及囊腫破裂。

治療可分經皮穿刺引流術、內視鏡引流術及手術治療。手術治療包含胰尾部切除術、手術體外引流術及手術腸內引流術(囊腫胃竇吻合術、囊腫十二指腸吻合術及囊腫空腸吻合術併 Roux-en-Y 吻合衛)。





參考文獻:

J Gastrointest Surg.2005 Jan;9(1):15-20; discussion 20-1.

A national comparison of surgical versus percutaneous drainage of pancreatic

pseudocysts: 1997.2001.

Morton JM, Brown A, Galanko JA, Norton JA, Grimm IS, BehrnsKE.
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Case series results indicate that a surgical approach is superior to percutaneous drainage of pancreatic pseudocysts. To determine if this surgical advantage is persistent, national outcomes for both approaches were compared fkom1997 through 2001.The National Inpatient Sample, a 20% sample of all nonfederal hospital discharges, was searched for patients who had a pancreatic pseudocyst diagnosis, an ICD-9 diagnosis code 577.2, and an ICD-9 procedure code of 52.01 for percutaneous drainage (PD) or 52.4 and 52.96 for the surgica1approaches. Variab1es were compared by using either t test or chi2 analysis. Confounding variables were controlled for by linear or logistic regression models. No clinically significant demographic, comorbidity, and disease-specific severity-of-illness differences existed between the two groups. Significant differences in complications, length of stay (15+/-15versus 21+/-22 days, P<0.0001), and inpatient mortality (5.9% versus 2.8%, P<0.0001) favored the surgical approach. In addition, endoscopic retrograde cholangiopancreatography use had a protective effect on mortality (odds ratio, 0.7), whereas percutaneous drainage had an increased risk of mortality (odds ratio, 1.4).This population-based study suggests that surgical drainage of pancreatic pseudocysts, particularly when coupled with use of endoscopic retrograde cholangiopancreatography, leads to decreased complications, length of stay, and mortality in comparison with percutaneous drainage.

JOP. 2004 Sep 10;5(5):338-47.
Pancreatic pseudocysts following acute pancreatitis: risk factors infIuencing therapeutic outcomes.
Soliani P, Franzini C, Ziegler S, Del Rio P, Dell'Abate P, Piccolo D, Japichino GG, Cavestro GM, Di Mario F, Sianesi M.
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CONTEXT: The natural history of pancreatic pseudocysts has become well known in recent years, but the choice of a proper treatment still remains controversial. OBJECTIVE: This study aims at establishing whether predictive factors influencing therapeutic outcomes exist. SETTING: Patients with pancreatic pseudocysts following an episode of acute pancreatitis treated from January 1980 to December 2001 at the Department of General Surgery and Organ Transplantation of the University of Parma, Italy. PATIENTS: Seventy-four patients were studied: 12 had a spontaneous resolution, 37patients were treated surgically, 15 were treated endoscopically and in l0, percutaneous drainage was used. MAIN OUTCOME MEASURES: Epidemiological, clinical and pathological characteristics of patients with pancreatic pseudocysts were related to morbidity, recurrence rates and hospital stay. RESULTS: At univariate logistic regression, our data reveal a significant increase in morbidity related to age (P=0.013), etiology (alcoholic vs.biliary, P=0.024), Ranson score of previous pancreatitis (P=0.006), nutritional assessment (P=0.001), residual necrosis (P<0.001) and modality of treatment (P=0.009), whereas none of these parameters has been shown to be significantly correlated to recurrence. At multivariate logistic regression, only residual necrosis was significantly related to morbidity. CONCLUSIONS: Some factors, such as epidemiological (age, etiology), clinical (severity of previous pancreatitis, malnourishment), pathological (residual necrosis), and therapeutical factors (emergency/urgency treatment) are predictive of worse outcomes for invasive treatment of pseudocysts. In particular residual necrosis appeared to be the most important factor influencing invasive treatment outcomes, confirming that this pathological aspect deserves particular attention from surgeons. No risk factors predicting pancreatic pseudocyst recurrence emerged.

以肝膿瘍來表現的肝內膽管癌

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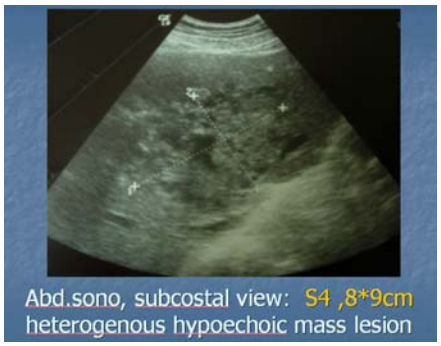
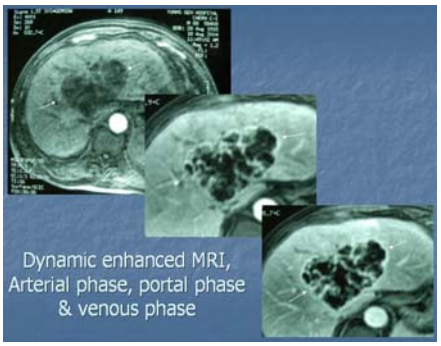
一位76歲男性病人主訴發燒畏寒、上腹不適四天。過去有冠狀動脈及鬱血性心臟疾病、糖尿病、慢性腎功能不全和高血壓。住院時，血壓150/86mmHg 、心跳98下/分鐘、體溫38.9℃。理學檢查發現右側下前胸有敲擊痛，無腹部壓痛。實驗室檢查報告：WBC:22000/ul,(NE:77% ,band: 14%), Hb:12.3g/dl , GOT/GPT:94/76U/L, Alk-p:165U/L, Bil(T):1.56mg/dl, Alb:2.7g/dl, BUN/dl:74/4.6mg/dl, CRP:279mg/dl。

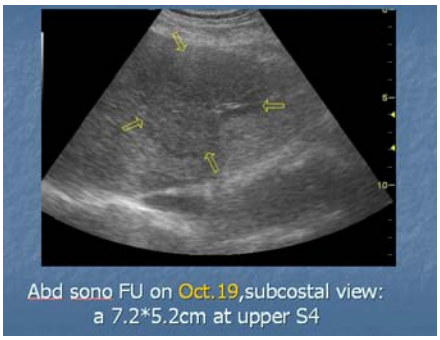
胸部X光心臟擴大、無肋膜積水。腹部超音波可見肝臟S4有一８×９cm，不均低回音病灶（圖一），並接受核磁共振檢查（圖二）。在超音波指引下，行經皮穿肝病灶抽吸，及置放引流管。抽吸物為淺黃色具臭味膿液，血液及膿液細菌培養陽性，為Klebsiella pneumoniae 。病人經抗生素、膿瘍引流後，臨床症狀改善，出院診斷為產膿性肝膿瘍。出院後二個月的肝臟超音波顯示該S4病灶稍變小，不明顯（ill-defined ）及均質低回音，似肝膿瘍緩解中的變化（圖三）。出院後五個月，因上腹不適3-4星期，腹部超音波追踪，發現有肝臟兩葉多發性肝結節（圖四），包括原來S4低回音病灶。病患後接受腹部MRI檢查（圖五）。理學檢查可觸摸到胸骨下的肝臟3-4cm，並有輕微壓痛，肝功能及腫瘤指數（CA19-9, CEA, AFP）均正常。胸部X光、胃鏡、大腸鏡無惡性病變。肝生檢的病理報告為腺癌（Adenocarcinoma)（圖六），有明顯的fibrons stroma。從病史、影像及病理來看，最後診斷為肝內膽管癌併肝內轉移。



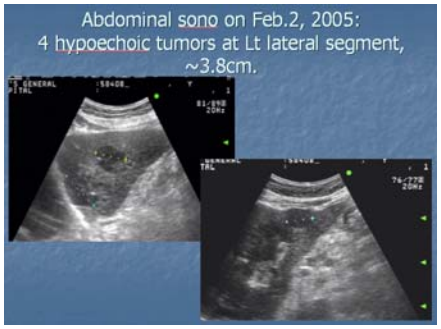
圖一



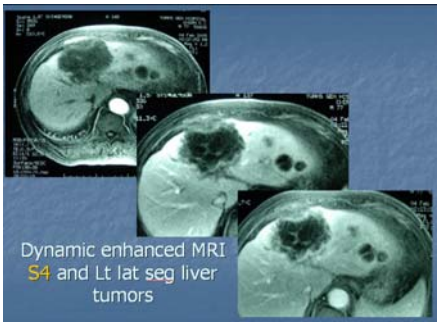
圖二



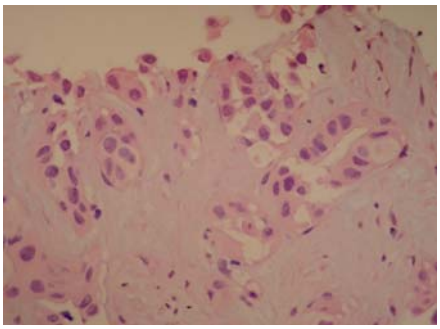
圖三



圖四



圖五



圖六

討論：

肝內膽管癌相對於肝細胞癌，是較少見的，且預後較不好。有許多的肝內膽管癌的危險因子被提出來，其中在東亞國家，肝內結石是最常見的危險因子。5% 的肝內結石患者同時合併有肝內膽管癌，66% 肝內膽管癌，含有肝內結石。三分之二含肝內結石的肝內膽管癌患者，以急性膽管炎來表現(發燒、腹痛)，不含肝內結石者則以漸進的肝腫大來表現。臨床上以肝膿瘍表現的則很少見，約 2.4--3.6% ，其症狀和一般肝膿瘍無法區別；對合併有貧血及體重異常下降的肝膿瘍患者要特別留意有無合併肝內膽管癌。所有以肝膿瘍表現的肝內膽管癌患者的住院死亡率(住院後 30 天內)為 54.5% ，而有 84.2% 的病患在六個月內死亡。因此以肝膿瘍為臨床表現的肝內膽管癌其預後相當不好。

參考文獻：

THE AMERICAN JOURNAL OF GASTROENTEROLOGY Vol.93.No. 2, 1998:253-255
Cholangiocarcinoma Presenting as Pyogenic Liver Abscess:
Is Its Outcome Influenced by Concomitant Hepatolithiasis？
Yi-Yin Jan, M.D., Ta-Sen Yeh, M.D., and Miin-Fu Chen, M.D.
Department of Surgery, Chang-Gung Menorial Hospital, Chang-Gung University, Taipei, Taiwan
The etiology of pyogenic liver abscess is changing. Malignant biliary obstruction has emerged as one of the most important causes. We explored the clinical course of pyogenic liver abscess caused by cholangiocarcinoma. Methods: The medical records of 19 patients with cholangilcarcinoma presenting as pyogenic liver abscess were reviewed. Of them, 57.8% （11of 19）had concomitant hepatolithiasis. Escherichia coli and Klebsiella pneumoniae were the most common pathogens isolated from aspirates of the abscesses. Eight patients received percutaneous drainage, whereas 11 patients initially underwent surgical drainage because of the presence of ascites of coagulopathy or lack of awareness of the underlving cholangiocarinoma. Results: Overall, the hospital mortality rate was 36.8% （sever of 19）.Patients with hepatolithiasis had a hospital mortality rate of 54.5% （six of 11）, compared with 12.5% （one of eight）in those without （p<0.01）.Notably, 84.2% （16 of 19）of the patients died within 6 months after the diagnosis was made.Conclusions:Cholangiocarcinoma presenting as liver abscess has a dismal prognosis. Concomitant tepatolithiasis worsened the infectious process and adversely affected the survival. （Am J Gastroenterol 1998; 93:253-255.
□ 1998 by Am. Coll. Of Gastroenterology）