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肝細胞癌合併直接侵犯十二指腸及大量出血

HCC with direct invasion to duodenum causing massive bleeding

消化系外科　黃敬文

病例報告 主訴：黑便及上腹痛，大約 3 天

過去病史：(1) 肝細胞癌(S6) 破裂合併腹腔內出血，經皮肝動脈栓塞治療(TAE)：May 2003 (2) 胃潰瘍：May 2003(3) 開刀史：膽結石及膽道結石，大約 20 年前(3 次)

現在病史：62 歲女性病人因為黑便，上腹痛及頭暈，大約 3 天，在 2006 年 3 月 8 日被家屬送到本院急診。在急診，發現病人的血壓較低 (BP:103/60 mmHg) ，血液檢查發現低血紅素 (Hb= 8 g/dl)。緊急胃鏡檢查發現十二指腸潰瘍併大量出血(Fig 1)，所以給予 HSE 注射止血及輸血。腹部超音波檢查發現在 S2-S4 有 1 個大腫瘤(大約 8 公分)及 S8 有另一腫瘤(大約 6 公分)，懷疑為肝癌覆發 (Fig 2)。住院後 2-3 天，反覆大量吐血及血便，重複兩次胃鏡檢查顯示類似發現，也都給予 HSE 注射止血及輸血，但是都無效，病人的血壓不穩定，血紅素仍然較低，所以照會外科。在跟家屬溝通後，決定手術治療。

術中發現，肝臟和十二指腸及腹壁沾黏嚴重，在小心剝離肝臟和十二指腸後，發現肝臟腫瘤(S2-S4)直接侵犯十二指腸，造成十二指腸有一個裂孔(大約 1.5 公分)，而肝臟腫瘤並無大量流血。因為這個肝臟腫瘤太大無法直接切除，而且病人術前及術中血液動力學不穩定，再加上病人的肝功能不好(Child-Pugh classification C) 和嚴重肝硬化，所以並沒有施行肝切除(Hepatectomy)，只將十二指腸裂孔縫合及肝臟腫瘤切片病理檢查(Biposy)。之後的病理報告證實肝臟腫瘤是肝細胞癌(Hepatocellular carcinoma, HCC)。術後 14 天，因為引流管中發現膽汁，所以懷疑十二指腸裂孔縫合處滲漏，因此安排上消化道攝影(使用水溶性顯影劑)，結果證實了十二指腸裂孔縫合處滲漏 (Fig 3)。所以禁食並給予全靜脈營養。之後病人重複大量吐血及血便，胃鏡檢查發現肝細胞癌又直接侵犯十二指腸，併發大量出血(Fig 4)。但是這次我們採取保守療法(禁食並給予全靜脈營養及輸血)。幸運地，大量出血自然止血，但是仍有 3 次小出血。病人狀況逐漸改善，術後 50 天開始嘗試經口飲食，並安排上消化道攝影(使用水溶性顯影劑)，發現已無十二指腸滲漏。之後開始施行放射線療法(Radiotherapy)。病人在術後 70 天出院。出院一個月後，病人又因再度大量出血而住院，但是這次病人因肝衰竭再加上大量出血不止而死亡。

討論 ： 肝細胞癌合併直接侵犯十二指腸並不常見，這些病人的預後常因肝衰竭或大量出血而相當不好。診斷的工具最主要是胃鏡、腹部超音波、腹部電腦斷層，但是通常因為大量出血，所以術前要做正確的診斷很困難。肝細胞癌直接侵犯消化道的機制並不清楚，文獻上曾經有報導推論可能的原因是沾黏，沾黏可能會引起癌細胞直接侵犯消化道，我們的病人因為膽結石及膽道結石接受 3 次手術，肝臟和十二指腸及腹壁沾黏嚴重，所以造成肝細胞癌直接侵犯十二指腸。關於治療的方法，包括經皮肝動脈栓塞治療(TAE)，手術切除肝細胞癌，放射線療法(Radiotherapy)，但是目前並無定論哪種治療才是最好的方法。

因為肝細胞癌合併直接侵犯或轉移到消化道而引起大量出血是非常罕見，但是如果其他常見的原因（如食道胃靜脈瘤或潰瘍）被排除，就必須要考慮這個原因。

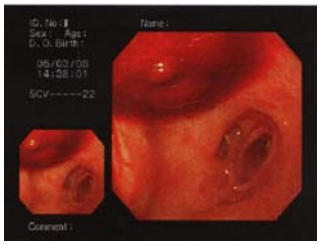

Fig 1: Endoscopy revealed duodenal ulcer with massive bleeding and blood clot

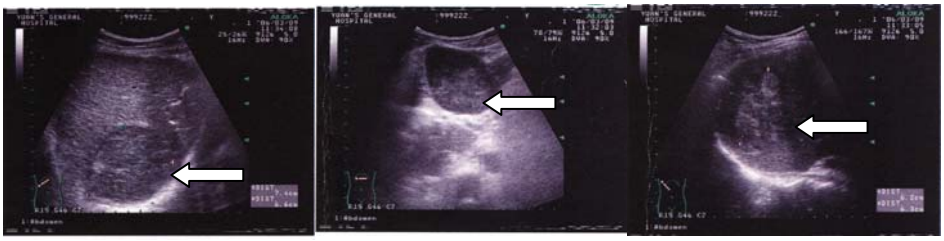

Fig 2: Abdominal ultrasonography: recurrence HCC at S2-4, S3 and S8

Fig 3: Extravasion of soluble contract was noted (Arrow) and leakage of primary repair of duodenum perforation was suspected

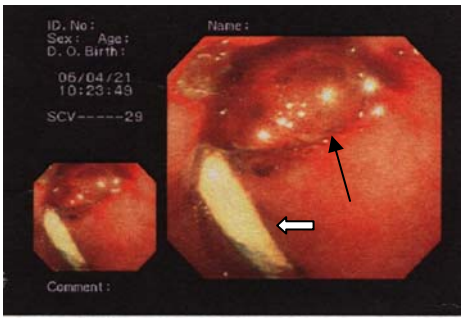

Fig 4. Postoperative endoscopy revealed a tumor mass (Arrow). A drain tube was inserted into the duodenum accidentally postoperatively, which was removed then (White arrow)

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Radiotherapy in the treatment of duodenal bleeding due to hepatocellular carcinoma invasion. Hung HC, Huang YS, Lin CC, Chao Y, Chi KH, Yen SH, Chang FY.

Department of Medicine, Veterans General Hospital-Taipei and National Yang-Ming University School of Medicine, Taiwan.Haemorrhage from an hepatocellular carcinoma (HCC) directly invading the gastrointestinal (GI) tract is uncommon. A 58-year-old man was admitted with upper gastrointestinal (UGI) bleeding and panendoscopy on examination revealed a large duodenal ulcerative bleeding mass. The mass was eventually diagnosed as HCC by pathological examination. The bleeding failed to respond to conventional management of haemostasis, but resolved with an external beam of radiotherapy with a total dose of 6000 cGy over a 5 week period. This unusual presentation of UGI bleeding, due to HCC invading the duodenum and treated by radiotherapy, has not been previously reported.

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Resection for hepatocellular carcinoma with duodenal invasion: report of a case.

Hatano E, Ikai I, Shimizu M, Maetani Y, Konda Y, Chiba T, Terajima H, Yamamoto N, Yamamoto Y, Shimahara Y, Yamaoka Y.

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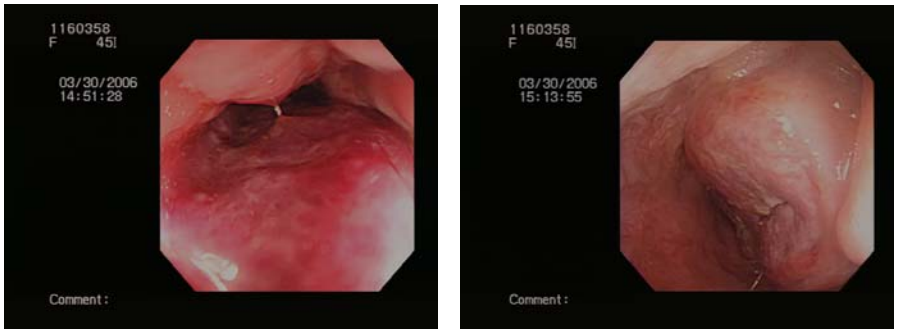
A 73-year-old man was admitted to our hospital on emergency for severe anemia. Upper gastrointestinal endoscopic study revealed a hemorrhagic ulcer in the duodenal bulb. He underwent endoscopic hemostasis. Abdominal ultrasonography and computed tomography showed a huge mass in segment 4 of the liver, growing into the extrahepatic space with direct invasion to the duodenal bulb. Extended left lobectomy and partial gastroduodenectomy was performed, because the endoscopic management of hemostasis was incomplete. He was discharged on the 30th postoperative day. Histopathologically, the tumor cells were moderately differentiated hepatocellular carcinoma with direct invasion to the duodenal mucosa. This report demonstrated the first case with a hepatocellular carcinoma with duodenal invasion, for which hepatic resection was performed successfully.

直腸淋巴瘤(rectal lymphoma)

消化系內科　蕭偉成

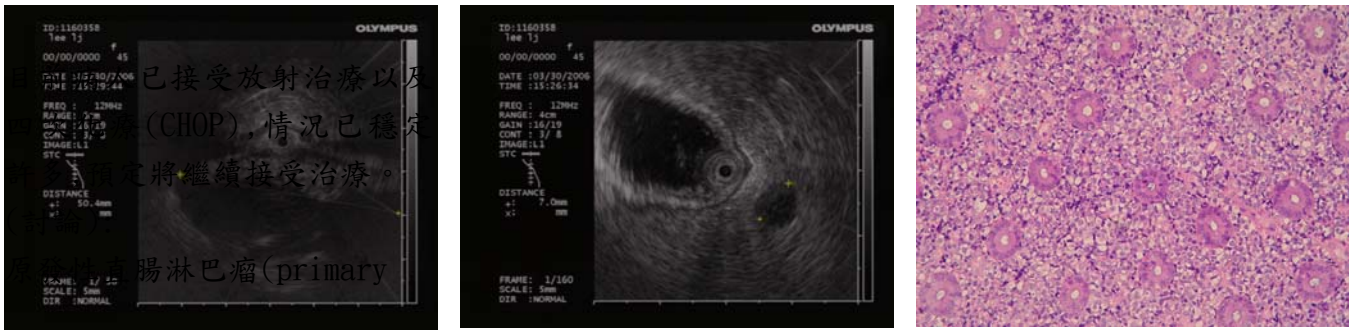
病患李小姐,四十五歲女性,身高一五五公分,體重一零七公斤,已婚,家住高雄市前鎮區,平時在電影院從事清潔工作。病患以往並無特殊疾病之病史;主要是在最近一年內時常有腹脹、下腹痛、解尿困難、食慾不佳、而且體重由一零七下降至九十四公斤(總共十三公斤);尤其是近兩星期以來有排便困難,裡急後重的情形,而且最近一星期內每天都有血便的情形,因此她至當地診所求治。但是情況並沒有改善;而診所醫生建議至大醫院作進一步之檢查,因此到本院消化內科門診求治。經肛診檢查發現有腫塊,因此收入院作進一步診治。

經大腸鏡檢查發現一大腫塊位於直腸末端,離肛門口約一至五公分處,侵犯約二分之一直徑的直腸壁(見圖一)。



圖一

經切片病理證實是瀰漫性大 B 細胞淋巴瘤(diffuse large B-cell lymphoma)(見圖二);後經內視鏡超音波檢查發現已侵犯到直腸壁外側漿膜層,而且直腸周圍的淋巴結也有浸潤的情形,且直腸侵犯長度事實上已有十五公分,(見圖三),臨床分期屬於 T3N1 (stage IIa)。而 PET-CT 檢查亦同意內視鏡超音波之診斷。



圖二　　圖三

rectal lymphoma)是一種罕見的疾病。其絕大多數是非赫金式淋巴瘤(non-Hodgkin lymphoma)。臨床表現與特徵無法與直腸癌區別,症狀包括直腸出血、大便習慣改變、腹痛、嘔吐、發燒、體重減輕等。最有效的診斷工具是內視鏡加上病理切片以及腹部電腦斷層。在內視鏡下表現多樣:單一腫塊、或合併潰瘍、整個直腸壁呈現環狀或局部瘢塊狀增厚、多發性淋巴瘤狀息肉等。有兩個危險因子和原發性直腸淋巴瘤有關:發炎性腸道疾病(inflammatory bowel disease)和免疫缺陷(例如器官移植後、後天免疫不全症候群、免疫疾病等)。對於大腸直腸淋巴瘤的治療因案例太少而無法下定論。一般來說直腸淋巴瘤若以大的息肉樣腫塊、低病理惡性度表現,同時沒有局部或遠部轉移的話,結合化療加上放射治療有一定的效果。而開刀通常保留到有併發症或是化療無效時才使用。

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