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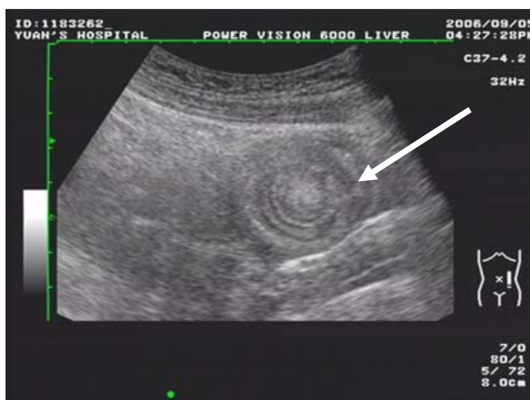
腸套疊
(Intussusception)

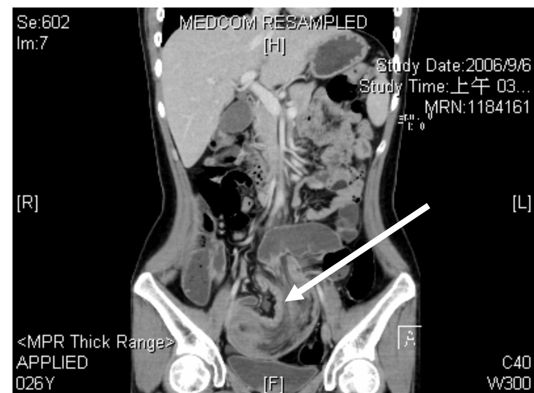
消化系外科　黃 健、曾譯諏

郭小姐，26 歲女性，過去身體狀況良好，無開刀或其他病史，求診的主訴在今年五月初起病人開始有腹痛的情形，每次痛的位置在肚臍周圍，絞痛，並且發作時都持續好幾個鐘頭，病人數次到其它醫院求診，服用藥物後症狀有比較緩解但都找不出主要的原因，自此之後，病人時常有腹脹的感覺，吃完東西後會有噁心感，有時甚至會嘔吐，導致食慾逐漸越來越差，體重減輕 (8~10 Kg/4 個月)，由於一直無法找出病因，所以腹痛就一直困擾著她。

這次住院是因劇烈的腹痛至門診求診，門診腹部超音波顯示 Oninon' skin like target lesion(圖一)診斷疑腸套疊故安排電腦斷層檢查及住院開刀，入院時 WBC：14210/ul ， RBC：498X103/ul　Hgb：12.2g/dl　HCT：37.0 %,　PLT：472 X103/ul, GOT/GPT：24/19 IU/L, BUN/Cr：12/0.7 mg/d, Na/K：134/3.5 mg/d, 電腦斷層上發現小腸有腸套疊的現象(圖二)。

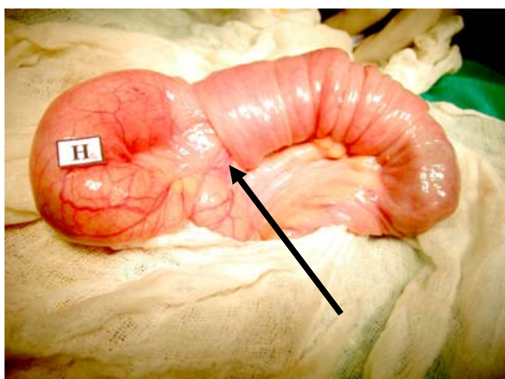


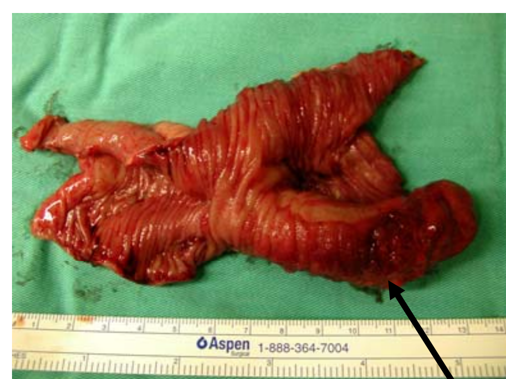
(圖一)Oninon' skin like target lesion



(圖二) Intussusception on CT

手術中發現距離迴盲瓣 100cm 的小腸處，發現了病灶(圖三)，經徒手復位之後仍有一引導病灶(leading point 圖四)，故作了 small intestinal segmental resection with end to end anastomosis, 切開病理後發現原來是小腸憩室內翻後造成之導病灶(leading point 圖四)，病人術後恢復狀況良好順利出院。


(圖三 小腸腸套疊)



圖四 小腸憩室內翻後造成之 leading point

討論：

腸套疊是指某段腸管凹陷入於其遠端的腸管中，是常見的小兒腹部急症，好發在迴腸與盲腸交界處(ileo-cecal junction)，典型的症狀為突發的痙攣性腹痛，常併有嘔吐，另外於發作幾個小時後，有可能會出現粉紅色果膠樣大便(currant jelly stool)，在腹部也可摸到類似香腸之腫塊(mass)，目前現行之治療方式，包含灌腸(又分三種:1.鋇劑灌腸;2.食鹽水灌腸;3.氣體灌腸)或手術治療(徒手復位或切除壞疽之腸子)，若病人有腹膜炎的症狀或是懷疑有腸子壞死的情形則不適宜灌腸，而需用手術治療。 腸套疊雖然是小兒急症，但在一般成人仍然可以發現，由於成人腸套疊大多有引導病灶(leading point)症狀不一，常常只以間歇性腹痛為表現，或只顯不安與焦慮，除非急性阻塞發生時，否則診斷十分困難。但若考慮到腸套疊的可能性時，可安排腹部超音波檢查、小腸攝影或電腦斷層檢查便能早期診斷。因此臨床醫師必須加強警覺性，以免延誤了治療的時機，導致腸穿孔或敗血症等併發症。

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Abstrat

To review clinical, radiological and histopathological findings of adult intussusception and its management, 18 adult patients who had been treated surgically because of intussusception were reviewed. Of the patients, 5 (27.8%) had idiopathic intussusceptions, while the other 13 (72.2%) had a definable intraluminal pathology. The site of the intussusception was more common in the small bowel (83.3%) than the colon (16.7%). Ultrasonography and computed tomography were successful in demonstrating "target lesion" in 80% and 75% respectively. Patients with idiopathic intussusception were treated with simple reduction, while the others underwent segmental resection because of the possibility of malignant tumour. In contrast to intussusception in childhood, intussusception in adults usually has a definable lead point and resection of the involved bowel, rather than simple reduction, is indicated.

肝內膽管乳頭瘤病

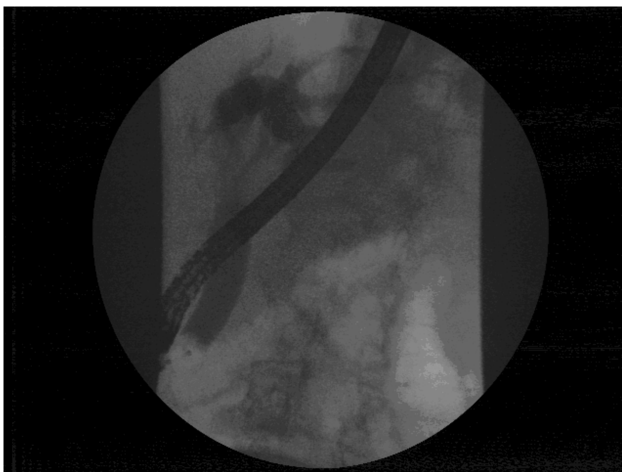
(Intrahepatic duct papillomatosis)

(Biliary papillomatosis)

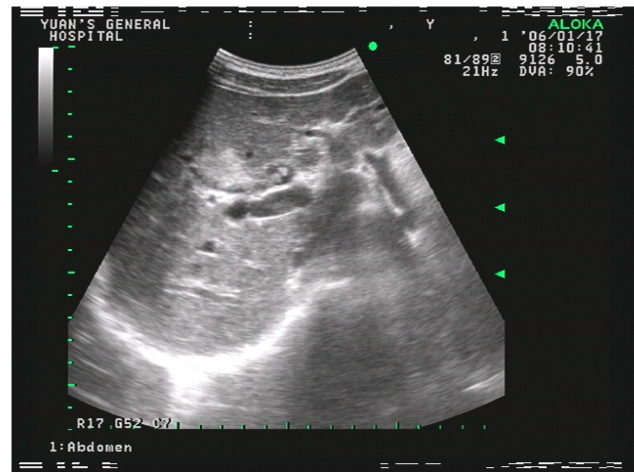
消化系外科肝　蔡毓洲、陳鴻曜、施登富

Case presentation：

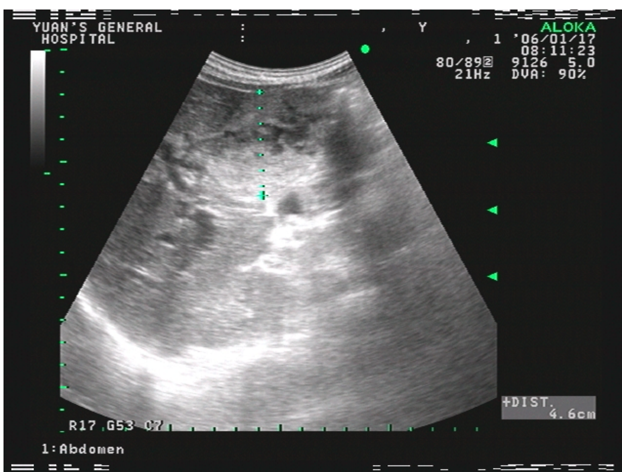
68 歲男性病人，因發燒及排尿困難而來本院急診。生化及尿液檢查後診斷為尿道感染及前列腺炎，但同時發現有肝功能異常及黃疸，AST：50 u/ℓ，ALT：41 u/ℓ，Bilirubin total/ Direct：2.33 / 0.6 mg/d u/ℓ，Alk-P：56 u/ℓ，Albumin：3.2 u/ℓ，因此懷疑有肝膽病灶。病人為一工人，之前曾接受右腹股溝疝氣手術，無糖尿病或高血壓病史。理學檢查如下：身高 154cm，體重 48kg，血壓: 110 / 70 mmHg，體溫 38.7℃，腹部並無明顯壓痛或腫塊，無肝脾腫大。因為以上症狀，安排腹部超音波來進一步詳查，結果在肝 S5 發現一混合高低回音之腫塊約 4.6cm，併雙側肝內膽管擴張，且於其一膽管有高回音之物質。進一步驗腫瘤指標及病毒性肝炎標記，結果 CEA、　CA199、AFP、HBsAg、Anti-HCV 皆呈正常，電腦斷層、ERCP 及 MRCP 則呈現一右肝占位性病灶併膽管阻塞。因為無法排除惡性腫瘤的可能性，予安排肝腫瘤切片，結果則未發現惡性細胞。因此進一步會診外科，手術結果呈現一極度擴張之肝內膽管約 6.5x5cm 大小，內聚集多發性的乳頭狀瘤約 6.5x5.5x3.3cm，病理證實為右肝內膽管乳頭狀瘤病，病人術後狀況良好，在門診追蹤。



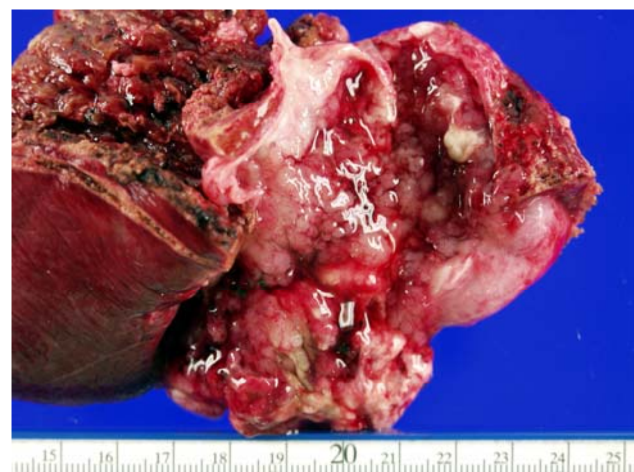
ERCP:左膽管擴張,右膽管組塞



Sono:在膽管內有高回音物質



右側肝內膽管腫瘤



手術切除證實為肝內膽管乳頭狀瘤病

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2. Korean J Radiol. 2002 Jan-Mar；3(1)：57-63：B.P. in imaging Diagnosis：Biliary trees is diffusely dilated in a lobar or segmental fashion, or aneurysmally. Imaging as an intraductal mass with a thickened and irregular bile duct wall. Sloughed tumor debris and mucin plugs may make DDx. with IHD stones became diffcult. If mucin hypersecretion present, DDx with cystadenoma, cystadenocracinoma, abscess is necessary.

3. Endoscopy, 1998. Nov.；30(9)：763-7
ERCP of B.P.：multiple small round to ovoid filling defects in bile duct, wall irregularity, preoperative percutaneous transhepatic cholangioscope is recommended to determine ductal extension or not, and to confirm the histological diagnosis.

編輯顧問：陳寶輝
編委：阮仲洲（主編），羅海韻（副主編），陳明楨，孫盟舜，吳志松，莊永芳，曾譯諏，謝展中