doi: 10.13241/j.cnki.pmb.2015.05.040

ERCP 治疗急性胆源性胰腺炎 *

白 宁 臧凤莉 朱孟华 刘爱国 史立军△

（哈尔滨医科大学附属第一医院消化内科 黑龙江 哈尔滨 150001）

摘要：急性胆源性胰腺炎（ABP）是消化内科常见急腹症之一，是急性胰腺炎中最常见的类型，占急性胰腺炎每年发病人数的 40%-60%，病死率较高，常规药物治疗不能从根本上解除病因，易导致复发，手术治疗风险较大，创伤较大，费用较高，住院时间较长，易引起其术后并发症，不利于患者恢复。而经内镜逆行胰胆管造影（ERCP）作为一种内镜与放射技术相结合的诊断治疗方法，对胆管内结石并发急性胰腺炎的诊断率是最高的，诊断结石的敏感性大于 95 %。在 20 世纪 70 年代被认为是急性胆源性胰腺炎的禁忌症，近年来随着 ERCP 技术的不断发展和广泛应用，ERCP 已成为治疗胆胰疾病的一种安全有效的技术。ERCP 可清除胆管结石，从而达到通畅胆道，减少胆汁向胰管反流，迅速改善患者病情，阻断病情进展的目的，并有效缩短住院时间，减轻患者痛苦，减少复发和改善总体预后，为广大 ABP 患者带来了福音，此外，还能减少患者住院费用，节省医疗资源，对于个人及社会均具有积极意义，值得推广。

关键词：ERCP；胆源性胰腺炎；胰腺炎

中图分类号：R576 **文献标识码**：A **文章编号**：1673-6273（2015）05-957-03

Therapy of ERCP in Acute Biliary Pancreatitis*

BAI Ning, ZANG Feng-li, ZHU Meng-hua, LIU Ai-guo, SHI Li-jun△

(Department of Gastroenterology, first affiliated hospital, Harbin medical university, Harbin, Heilongjiang, 150001, China)

ABSTRACT: Acute biliary pencreatit, the most common type of acute pancreatitis, is one of the acute abdomen in department of gastroenterology. Acute biliary pancreatitis accounts for 40% to 60% of the population every year, and its fatality rate is high. Conventional drug therapy can not relieve etiology fundamentally, and easy to relapse. Compared to Surgical treatment, it has a bigger risk, larger trau- ma, higher cost, longer hospital stay, higher possibility of postoperative complications, which goes against patients recovery. As a method combining endoscope with radiography, the diagnosis rate of bile duct stone with acute pancreatitis is the highest, and the sensitivity of diagnosis to stone is more than 95%. In the 1970s, endoscopic retrograde cholangiopancreatography(ERCP) was considered to be contraindications of acute gallstone pancreatitis. In recent years, with the development of technology and the widespread application, ERCP has become a safe and effective technology in the diagnosis and therapy in pancreatic and biliary diseases. ERCP can remove bile duct stones, then open biliary tract, reduce the bile reversing flow to pancreatic duct, rapidly improve patients' condition and break off illness development, ERCP could also shorter hospital stay effectively and reduce pain in patients, reduce the recurrence and improve the overall outcome, the technology has brought the Gospel for the majority of patients with ABP. In addition, ERCP can reduce the patients in hospital costs, save medical resources, have positive significance for individuals and society all, so it is worth popularizing.

Key words: ERCP; Biliary pancreatitis; Pancreatitis

Chinese Library Classification(CLC): R576 Document code: A

Article ID: 1673-6273(2015)05-957-03

前言

急性胆源性胰腺炎（ABP）是指胆结石在向胆总管远端移动时，结石嵌顿在壶腹部引起胆道梗阻或是在通过壶腹时，由于暂时或一过性梗阻而引起十二指肠乳头水肿或 Oddi 括约肌痉挛，造成胆汁逆流或胰管高压，继而引发的急性胰腺炎。急性胆源性胰腺炎是消化系统常见的急腹症之一，占急性胰腺炎的 15 %-50 %，病死率高达 20 %-35 %。

根据中华医学会外科学会胰腺学组关于急性胰腺炎的临床诊断及分级标准，ABP 患者具有以下临床特征：1).症状及体征：急性腹痛，腹胀或伴恶心、呕吐，上腹压痛或伴反跳痛 2).实验室化验结果：血清淀粉酶及血清胆红素升高 3).影像学检查：超声、CT 或 MRCP 检查提示肝内、外胆管结石或占位、胆总管扩张 4).根据病史或检验结果排除其他原因引起的胰腺炎。

1 急性胆源性胰腺炎的发病机制

急性胆源性胰腺炎的发病机制尚不明确，多数学者认为是多方面的，解剖的、遗传的以及结石相关因素均参与到该病的

* 基金项目：黑龙江省公关课题(WB07C04)

作者简介：白宁(1987-)，女，硕士研究生，医师，慢性肝病的研究，E-mail: baining0217@163.com

△通讯作者：史立军，E-mail:sljmail@yahoo.com.cn

(收稿日期：2014-06-08 接受日期：2014-06-30)

发病过程,副胰管的不开放也可能是一个原因。目前普遍接受的观点有两种,一种是先天性的胰胆管汇合异常引起的胰酶提前激活导致胰腺炎,第二种是胆囊内小结石排出或胆总管内原有结石引起的胆道及胰管梗阻导致胰腺炎。胆总管末段结石嵌顿引起胆道梗阻时,胆道内压力增高,引起胆汁或胰液排除不畅,是急性胆源性胰腺炎的主要原因。治疗胆源性胰腺炎的目标不仅是控制胰腺炎症,更重要的是针对病因治疗,从而减少胰腺炎的复发。急性胆源性胰腺炎根据患者病情可采取不同的治疗方法:保守治疗,外科手术治疗,内镜介入治疗。保守治疗严格按照禁食水,持续胃肠减压,应用抑酸、抑制胰酶分泌的药物,控制感染,纠正电解质紊乱,营养支持,必要时可给予镇痛药物以减轻患者痛苦,根据患者症状体征,血淀粉酶、胆红素、血白细胞及超声或 CT 来进行动态观察。

2 胆源性胰腺炎常见的病因

但胆源性胰腺炎最常见的病因是胆总管结石, 病因未去除,可导致胰腺炎的复发。一般来说,胰腺组织的病理改变在胰腺炎早期相对较轻,多为水肿型胰腺炎,若胆道梗阻不能迅速解除,病变可进展为急性坏死性胰腺炎,导致住院天数延长,住院费用增加,死亡率升高。手术治疗可去除胆管病因而改变胰腺炎的病理过程,但手术时机的选择尚存在争议,早期选择手术治疗不但不能阻止 ABP 患者的病情进展, 还可能因为手术的创伤和应激反应而加重炎症反应,进而导致局部或全身继发感染,加剧病变进程,增加感染性并发症和死亡风险。ABP 的病变特点是同时存在胆管因素和胰腺损害,手术之前要先进行一定时间(24 -48 h)的非手术治疗,如果病情出现进行性加重或并发其它局部(如胆囊坏疽、穿孔)或全身(高热、休克、腹内高压及严重代谢障碍等)并发症,则及早手术治疗,以去除胆管梗阻,引流胆汁和腹腔灌洗为主,对全身情况差者只行胆总管引流。手术治疗对患者创伤较大,恢复慢,死亡率高,费用较高,ABP 患者多数年龄较大,一般不作为首选治疗方案。而内镜治疗既可以消除病因并具有良好效果,而且创伤小,并发症少,恢复快,花费相对较低,因此 2002 年亚太胃肠病学会发布的诊治规范推荐内镜治疗作为 ABP 的早期治疗措施。

3 经内镜逆行胰胆管造影(ERCP)诊断治疗方法的特点

经内镜逆行胰胆管造影(ERCP)是一种内镜与放射技术相结合的诊断治疗方法,自 1968 年 Mucrme 首先报道,后由日本大井等逐步改进并推广,开展 30 多年来,已成为临床上诊断胰腺、胆管等疾病不可缺少的重要检查手段。ERCP 是一种以非手术方法显示胰管清晰图像的技术, 通过图像显示胰腺位置、主副胰管粗细形态、走行变化及长度,同时能清晰显示胆道图像,明确胆道梗阻部位、性质及范围。多数研究认为 ERCP 对胆管内结石并发急性胰腺炎的诊断率是最高的,诊断结石的敏感性大于 95 %, 尤其是对 B 超难以发现的胆总管下段小结石或微小结石。ERCP 同时也是一种治疗手段,可清除胆管结石,从而达到通畅胆道,减少胆汁向胰管反流,阻止患者病情进展的目的,并可减少复发和改善预后,成功率可高达 90% 以上,由于 ERCP 是有创操作,且随着近年来磁共振胰胆管水成像等影像学技术的发展,ERCP 的诊断作用已经日渐淡化, 逐渐演变为一种专门治疗胆胰疾病的微创技术。在 20 世纪 70 年代,急性胆源性胰腺炎曾被视为 ERCP 的禁忌证,90 年代中期以后对 ABP 患者胆道结石的处理发生了变化, 尤其是近年来随着 ERCP 技术的发展和广泛应用, 使得内镜下括约肌切开术(EST)、内镜下碎石及取出,为胆、胰疾病的诊断和治疗提供了新的手段。

有学者认为 ABP 的严重程度与胆道梗阻的持续时间有关。24 小时内的病变是可逆的,24-48 小时可见部分胰腺组织出血、脂肪坏死,超过 48 小时为广泛的出血及坏死,在发病早期终止胆汁逆流入胰腺是治疗急性胆源性胰腺炎的关键。但有部分学者认为,在原有胰腺炎症的基础上行 ERCP 治疗,会加重胰腺损伤,提倡炎症缓解后再行此操作。而 Fiocca 等研究认为在患者出现症状的 24 h 内行 ERCP 是安全有效的,而且越早对病情恢复越有利,一旦出现多器官功能衰竭等并发症,则丧失内镜治疗机会,预后较差,但若不存在明显胆管梗阻则不需要行急诊 ERCP, 可待胰腺炎治愈后进行。Isogai 等提出 ABP 急诊治疗的评价指标:体温大于 38 度;血清胆红素大于 37. 6 μmol/L;B 超提示胆管结石或胆管扩张大于 11 mm。如果诊断为重症胰腺炎和(或)有胆管炎、黄疸、胆总管扩张,或最初判断为急性轻型胰腺炎但在治疗中病情恶化者, 应行 ENBD 或 EST。Moretti 等研究认为早期内镜治疗对轻型和重型 ABP 病死率无影响,但可以明显降低重型 ABP 的并发症发病率。

4 小结

ERCP 治疗 ABP 有很多优点:1).创伤小、治疗效果好、安全性高 2).对危重及年老患者可以选择放置鼻胆管以降低急诊手术的风险 3). 可在内镜下直接观察十二指肠乳头局部的病变,并取病变组织进行病理检查以协助诊断 4).具有快速缓解症状,缩短病程,降低住院费用等。因此,临床上作为 ABP 首选治疗方案广泛应用。

参 考 文 献(References)

[1] Silverman WB. Medical and endoscopic treatment of acute pancreatitis [J]. Curt Treat Options Gastroenterol, 2007,6(5): 381-387

[2] 李学谦, 江堤, 顾红祥, 等. ERCP 相关技术治疗胰胆道疾病 219 例临床分析[J].赣南医学院学报, 2008, 28(4): 520-521
Li Xue-qian, Jiang Di, Gu Hong-xiang, et al. Clinical analysis of ERCP related techniques for the treatment of 219 cases of pancreatic biliary disease[J]. Jiangxi medical college journal, 2008,28 (4):520-521

[3] Silviera ML, Seamon MJ, Porshinsky B, et al. Complications related to endoscopic retrograde cholangiopancreatography: a comprehensive clinical review[J]. J Gastrointestinal Liver Dis, 2009,18(1):73-82

[4] Isogai M, Yamaguch i A, H arada T, et al. Cholangit is score:a scoring system to predict severe cholangi t is in gallst one pancreatit is [J]. J Hepat obiliary Pancreat Surg, 2002, 9(1): 98-104

[5] Moretti A, Pap IC, Aratari A, et al. Is early endoscopic retrograde cholangiopancreatography useful in the management of acute biliary pancreatitis? Ameta-analysis of randomized controlled trials [J]. Dig Liver Dis, 2008, 40(5): 379-385

[6] Besselink MG, Van Mirmen LP, Van Erpecum KJ. Beneficial efects of ERCP and papillotomy in predicted severe biliary pancreatitis [J]. Hepato Gastroenterology, 2005 ,52 (1): 37-39

[7] 王东,李兆申,张文俊,等.急性胆源性胰腺炎内镜诊治疗效及安全性[J].世界华人消化杂志,2003,11(10):1550-1553
Wang Dong, Li Zhao-shen, Zhang Wen-jun, et al. Efficacy and safety of endoscopic diagnosis and treatment in acute gallstone pancreatitis [J]. The World Chinese Journal of Digestology, 2003, 11(10):1550-1553

[8] Eoptolemos JP, Cart-locke DL, London N, et al. ERCP findings and the role of endoscopic sphinctemtomy in acute gallstone pancreatifis [J]. Br j Surg, 2008,75:954-960

[9] Nowak A, Nowakowska-Dutawa E, Rybicka J. Patency of the Santorini duct and acute biliary pancreatitis: a prospective ERCP study [J]. Endoscopy, 1990,22:124-126

[10] Scholrnerich J, Gross V, Johannesson T, et al. Detection of biliary origin of acute pancreatitis: comparison of laboratory tests, ultra sound, computed tomography, and ERCP[J]. Dig Dis Sci, 2009, 34:830-833

[11] ASGE guideline: the role of ERCP in diseases of biliary tract and the pancreas. Gastrointest Endosc, 2005, 62: 1-8

[12] Van Geenen EJ, Van Der Peet DL, Mulder CJ, et al. Recurrent acute biliary pancreatitis the protective role of cholecystectomy and endoscopic sphincterotomy [J]. Surg Endosc, 2009,23 (5): 950-956

[13] Yu W, Li W, Wang Z, et al. Early percutaneous transhepatic gallbladder drainage compared with endoscopic retrograde cholangiopancreatography and papillotomy treatment for severe gallstone associated acute pancreatitis [J]. Postgrad Med J, 2007,83(977): 187-191

[14] Touli J, Brooke SM, Bassi C, et al. Cuidelines for the management of acute panreatitis[J]. J Gastroenterol Hepatol, 2002, 17(Supp1): 15-39

[15] 曾普元,殷相文,周国华. ERCP 在急性胆源性胰腺炎中的应用[J].中国内镜杂志,2004,10(10):46-48
Zeng Pu-yuan, Yin Xiang-wen, Zhou Guo-hua. Application of ERCP in acute biliary pancreatitis [J]. China Journal of Endoscopy, 2004,10 (10):46-48

[16] 翟启智, 王建宁, 佘维斌, 等. 内镜逆行胰胆管造影术治疗急性胆源性胰腺炎的临床分析[J]. 临床荟萃,2011,26(18):1589-1591
Zhai Qi-zhi, Wang Jian-ning, Yu Wei-bin, et al. Clinical analysis of endoscopic retrograde cholangiopracreatography in treatment of acute biliary pancreatitis[J]. Clinical Focus, 2011,26(18):1589-1591

[17] Baillie J. Should urgent ERCP be performed in patients with acute biliary pancreatitis without acute cholangitis [J]. Nat Clin Pract Gastroenterol Hepatol, 2008, 5(9): 484

[18] Madacsy L, Kurucsai G, Joo I, et al. Rescue ERCP and insertion of a small-caliber pancreatic stent to prevent the evolution of severe post-ERCP pancreatitis: a case-controlled series [J]. Surg Endosc, 2009,23(8): 1887-1893

[19] Jover R, Llach J, Bordas JM, et al. The usefu lness of the timeliness of endoscopic sphinct erotomy in severe acute pancreatit is of biliary origin[J]. Gastroenterol Hepatol, 1997,20(7):344-346

[20] Piskac P, Riebel O, Hnizdil L. Emergency ERCP and acute biliary pancreatitis[J]. Bratisl Lek Listy, 1999,100: 668

[21] Dominguez Fernandez E, Suchan KL, Gerke B, et al. Results of emergency ERCP in the treatment of acute biliary pancreatitis[J]. Zentralbl Chir, 2002,127: 786

(上接第 968 页)

[22] 肖德明,张世权,朱玉华,等. TopoⅡ在骨肉瘤中的表达及临床意义[J].中国骨肿瘤骨病, 2010,9(6): 526-528
Xiao De-ming, Zhang Shi-quan, Zhu Yu-hua, et al. Expression and Clinical Significance of TopoⅡ in Osteosarcoma [J]. Chinese Journal of Bone Tumor and Bone Disease, 2010,9(6): 526-528

[23] Kradewska M, Wang HG, Kradewska S, et al. Immunohistochemical analysis of invivo patterns of CPP32(Caspase-3), a cell death protease [J]. Cancer Res, 1997, 57:1605-1613

[24] Hollstein M , Sidransky D, Vogelstein B, et al. P53 mutatuon in human cancers[J]. Science,1991, 253: 49

[25] L evine AJ, Momannd J, Finlay CA. The p53 tumor suppressor gene [J]. Nature, 1991, 352:45390

[26] Porter PL, GownAM, Kromp SG, et al. Widespread p53 overexpression in human malignant [J]. Am J Pathol,1992, 140: 145-148

[27] Nakase M, Inui M, Okumura K, et al. p53 gene therapy of human osteosarcoma using a transferring-modified cationic liposome[J].Mol Cancer Ther,2005,4:625-631

[28] Ganjavi H, Gee M, Narendran A, et al. Adenovirus-mediated p53 gene therapy in osteosarcoma cell linnes:sensitization to cisplatin and doxorubicin[J]. Cancer Gene Therapy,2006,13:415-419

[29] 李永昊,肖玉周,俞岚,等.P53,P16 基因在骨肉瘤中表达及临床相关性研究[J].中国骨肿瘤骨病, 2007,6(3): 162-166
Li Yong-hao, Xiao Yu-zhou, Yu Lan, et al. The Research on Expression and Clinical Significance of P53,P16 in osteosarcoma[J]. Chinese Journal of Bone Tumor and Bone Disease,2007,6 (3): 162-166

[30] Tutor O, Diaz MA, Ramirez M, et al. Loss of heterozygosity of p16 correlates with minimal residual disease at the end of the induction therapy in non-high risk childhood B-cell precursor acute lymphoblastic leukemia[J]. Leuk Res, 2002, 26: 817-820