

心内膜下心肌梗死的常见误诊病例浅析

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摘要 目的 探讨心内膜下心肌梗死的常见误诊原因及对策。方法 回顾性分析 9 例心内膜下心肌梗死患者的病历资料,包括病史、系统体格检查、ECG、心肌酶谱、胸片、超声心动图检查等。结果 9 例心内膜下心肌梗死患者均有临床症状、ECG 及心肌酶学指标的动态变化,诊断明确,以冠状动脉病变为其主要病因,在此基础上由其他因素诱发发病。结论 临床医师对心内膜下心肌梗死认识不足、对 ECG 和心肌酶谱的特异性动态改变未充分认识,是导致误诊的主要原因,建议详细询问病史、系统体格检查及辅助检查,综合判断明确诊断。

关键词 心内膜下心肌梗死 心电图 心肌酶 抗凝 误诊

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Misdiagnosis Analysis on Common Cases of Subendocardial Myocardial Infarction

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ABSTRACT Objective: To explore the common cause and countermeasure on subendocardial myocardial infarction's misdiagnosis.

Methods: Retrospective analysis of nine subendocardial myocardial infarction's cases, including medical history, system physical examination, ECG, myocardial enzymes, chest radiograph, echocardiography and so on. **Results:** 9 cases of subendocardial myocardial infarction all had dynamic changes of clinical symptoms, ECG and myocardial enzyme. The diagnosis was definite, and coronary artery disease was their main cause, induced by other factors on above basis. **Conclusion:** Clinicians didn't pay enough attention to subendocardial myocardial infarction, or were not familiar with dynamic changes of ECG and myocardial enzymes, and they were the main reason on subendocardial myocardial infarction's misdiagnosis. The author suggested inquiring detailed medical history, systemically applying physical and laboratory examinations, and sensibly judging to diagnosis.

Key words: Subendocardial myocardial infarction; ECG; Myocardial enzymes; Anticoagulation; Misdiagnose

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心内膜下心肌梗死(subendocardial myocardial infarction)是指病变仅累及心室壁内侧 1/3 的心肌,并波及肉柱和乳头肌,心电图一般无病理性 Q 波,因此也称为无 Q 波心肌梗死,非透壁性心肌梗死^[1]。心内膜下心肌梗死即时预后佳,但长期预后差^[2],主要表现为再梗死率高、再发急性心绞痛率高、病死率高,容易与急性心肌梗死、心肌缺血、心肌病、心衰等相混淆而导致漏诊或误诊^[3-6]。本文对我科 2006 年 1 月~2010 年 9 月收治的 9 例心内膜下心肌梗死误诊病例加以浅析,现报告如下。

1 资料与方法

1.1 临床资料

本组 9 例患者,均为汉族,其中男性 6 例,女性 3 例,年龄(39~68)岁,平均(54.5±8.6)岁。患者均先后就诊于多家医院,误诊为“冠心病、缺血性心肌病、肥厚型心肌病、心衰”等,来我院就诊时以“胸闷”为主诉者 3 例,“心悸、心慌”为主诉者 5 例,原发性高血压 1 例,门诊以“冠心病、急性心内膜下心肌梗死”或“急性冠脉综合征”收住入院。

1.2 方法

9 例患者均经详细询问病史,系统体格检查、ECG、心肌酶谱、胸片等辅助检查,必要时进行超声心动图检查。

1.3 典型病例

患者李某,男,63 岁,心悸、胸闷 2 年,因发作性胸骨后闷痛 3 天,每次疼痛持续 6~8h,服用硝酸甘油不能缓解,急诊入院。入院查体:BP145/100mmHg,面色苍白,精神差,半卧位,可见颈静脉充盈,双肺可闻及湿啰音,HR100 次/min,心律不齐,可闻及舒张早期奔马律,肝脾肋下未触及,双下肢无浮肿。ECG 示窦性心律 S-T 段:Ⅱ、Ⅲ、aVL、V4-6 下移 0.10~0.15mV, T 波:Ⅱ、Ⅲ、aVL、V4-6 为负正双向。胸片示双肺、膈无异常,主动脉增宽、迂回伴钙化,心胸比值为 0.59。实验室检查:血象中性偏高,肝功、肾功、血糖、血脂大致正常。诊断为冠心病心衰,给予强心活血抗感染治疗,5d 后双肺湿啰音基本消失,心前区疼痛缓解。住院第 7d 患者饱餐后自行下床活动,突感胸闷不适、心悸、出冷汗,血压降低,ECG 示结性逸搏心率 S-T 段:Ⅱ、Ⅲ、aVL、V4-6 下移 0.20~0.35mV, T 波:Ⅱ、Ⅲ、aVL、V4-6 为负正双向、V7-9 倒置。心肌酶谱:AST 65.6 U/L, LDH 321.5 U/L, CK 83.8 U/L, CK-MB 76.0 U/L。次日:AST 83.2 U/L, LDH 385.0 U/L, CK 99.6 U/L, CK-MB 88.4 U/L。诊断为冠心病心衰并急性心内膜下心肌梗死,给予扩冠、抗凝、升压、心肌营养等治疗,7d 后,血压

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降至 140/85mmHg, 心率恢复至窦性心律, S-T 段、T 波逐渐恢复为大致正常心电图, 心肌酶谱恢复正常, 全身情况稳定, 达到临床治愈出院。

2 结果

本组 9 例心内膜下心肌梗死患者均有临床症状、ECG 及心肌酶学指标的动态变化, 心内膜下心肌梗死诊断明确, 以冠状动脉病变为其主要病因, 在此基础上由其他因素诱发发病, 本组 9 例患者可能存在的诱因: 劳累、饱餐、情绪激动、精神紧张(4 例), 严重感染、呼吸、代谢性酸中毒(2 例), 休克(1 例), 严重贫血(1 例), 其他(1 例)。经过治疗, 7 例患者达到临床治愈或缓解, 2 例死亡, 死亡主要原因由于其原发性基础病变较重, 未能有效控制基础病变及并发症。

3 讨论

文献^[7-9]报道心内膜下心肌梗死的发生率占急性心肌梗死(AMI)的 20% 左右, 但临床心内膜下心肌梗死诊断的比率远小于 20%, 这可能临床医师对心内膜下心肌梗死认识不足, 可能存在一定程度的漏诊或误诊有关。心内膜下心肌梗死最常见的病因是冠状动脉粥样硬化引起的冠状动脉狭窄和闭塞, 以及主动脉狭窄或关闭不全影响冠状动脉的血供, 心肌梗厚或严重贫血^[10-12]。其诱因有精神紧张、情绪激动、过度体力活动、饱餐、高脂饮食、感染、手术、大出血、休克等^[13-15]。本组患者发病前的主要诱因均在此之列。本组的典型案例中, 患者自觉已经康复, 饱餐后自行下床活动, 突感不适, 即为饱餐、过早下床活动所诱发的急性冠脉综合征。案例患者原为一般的冠心病病人, 在病变演变过程中, 主治医师及护理人员未充分认识到可能存在的诱因, 以及患者的不良遵医嘱行为, 从而诱发心内膜下心肌梗死。

心内膜下心肌梗死的诊断需结合临床症状、ECG 与心肌酶学的动态改变。目前, 心内膜下心肌梗死的诊断标准尚未统一, 主要有 Madigan 标准、WHO 标准、Chug 标准等^[16], 尚无一个完善的标准得到广泛的认可。综合上述标准, 结合专家共识以及临床实践经验, 大致可以概括为如下内容^[17-18]: ①心肌缺血性胸痛持续 30min 以上; ②ECG 示 S-T 段下降和 / 或 T 波倒置, 持续时间 48h 以上, 无病理性 Q 波; ③血清心肌酶及其同工酶升高, 且符合 AMI 酶谱的动态改变, 并能除外其它原因引起的血清酶水平升高。

分析心内膜下心肌梗死的误诊原因, 主要是部分医师对心内膜下心肌梗死的认识不足, 包括一些心血管专业医师对此缺乏应有的警惕性^[19-20]。部分医师忽视了详细的病史询问、体格检查及辅助检查。在对心内膜下心肌梗死的诊断上, 尤其要注意 ECG 的特异性改变, 本组 9 例心内膜下心肌梗死患者 ECG 特征, 大致可以归纳为: ①S-T 段 S-T 段压低为主者, 除 avR 外, S-T 段广泛压低, S-T 段压低 $\geq 0.10\text{mV}$, S-T 段时间 $\geq 0.08\text{s}$, 可伴有或不伴有 T 波变化。S-T 段抬高为主者, S-T 段呈单向曲线, 抬高 $0.10\sim 0.20\text{mV}$ 以上, 持续 24~48h 以上, 动态演变, 可恢复正常。②T 波除 avR 外, 大部分导联出现深宽而对称倒置的 T 波, 深度 $> 1\text{mm}$, 逐渐加深。部分患者还可有③大致正常的 ECG。另外, 病变进展迅速, 导致临床医师对患者病情分析与判断的依据不充分, 也是误诊的客观原因。因此, 在心血管疾病的

临床诊疗过程中, 一定要详细询问病史, 系统的进行体格检查及辅助检查, 提高对心内膜下心肌梗死的认识, 对少见病不能草率的排除诊断, 应认真思考、综合判断症状和体征相同的不同疾病, 及时明确诊断。

对心内膜下心肌梗死, 首选药物治疗, 轻者可按 AMI 的一般治疗原则处理, 再予以阿司匹林和低分子肝素治疗, 病情多可稳定。张月军、杨承健等人^[21]比较了心梗后普通肝素(UFH)和国产低分子肝素(商品名: 海普宁 Hiparin)不同抗凝治疗方法的疗效和安全性, 发现在临床水平上低分子肝素可提供更为有效而稳定的抗凝作用, 海普宁(Hiparin)较 UFH 更能减少心脏事件的发生, 而出血事件相对较少, 临床应用更加方便和安全。参照急性心肌梗死诊断和治疗指南, 目前 Hiparin 用于抗凝的推荐方案为皮下注射低分子肝素 5000 U, 每日两次, 持续一周。辅助用药: 最初 3 d 阿司匹林剂量为 $300\text{mg} / \text{d}$, 3 d 后改为 $100\text{mg} / \text{d}$, 长期维持, 其它药物如硝酸酯类、 β -受体阻滞剂、ACEI、调脂药物等。病情危重或发生严重并发症者, 如 S-T 段抬高性心内膜下心肌梗死必要时建议 PCI 术, 在早期给予患者合理有效的救治。

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