

右侧输卵管同时合并左侧卵巢妊娠一例暨文献复习

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摘要 目的:总结输卵管合并卵巢妊娠的诊治经验教训和治疗方法。方法:回顾性分析我院2010年11月9日入院右侧输卵管同时合并左侧卵巢妊娠患者临床资料。B超检查、急诊腹腔镜探查术并送病理组织检查。结果:行右侧输卵管切除术+左侧卵巢囊肿剥除术+粘连分解术后病检结果为(右输卵管)腔内变性绒毛及滋养细胞,符合异位妊娠(左卵巢囊肿)羊膜、绒毛及滋养叶细胞,符合异位妊娠。术后3、6和8天患者血HCG浓度水平分别为19.61ng/ml、4.47ng/ml和1.84ng/ml,术后顺利恢复出院。结论:输卵管合并卵巢妊娠发生较为罕见,极易漏诊和误诊,及时行腹腔镜探查术是有效的诊治手段。

关键词 输卵管妊娠;卵巢妊娠;β-HCG

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Right Fallopian Tube and Left Ovarian Pregnant in the Same Time

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ABSTRACT Objective: To discuss diagnosis and treatment of tubal pregnancy with ovarian pregnant in the same time. **Methods:** Retrospective analysis of one patient clinical data about the right tubal pregnancy and left ovarian pregnancy in November 9, 2010. **Results:** After right salpingectomy, left ovarian cystectomy and adhesion decomposition technique, pathological examination of right tubal pregnancy and left ovarian pregnancy showed that they coincide ectopic pregnancy. The level of blood β-HCG in the 3th, 6th and 8th day after operation were 19.61ng/ml, 4.47ng/ml and 1.84ng/ml respectively. Successful recovery. **Conclusion:** Tubal ovarian pregnancy is rare, and easily missed and misdiagnosed, immediate surgery is an effective means of diagnosis and treatment.

Key words: Tubal pregnancy; Ovarian pregnant; β-HCG

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前言

卵巢妊娠系受精卵在卵巢组织内着床和发育,属罕见的异位妊娠。因其缺乏特异性症状和体征,与输卵管妊娠临床表现相似,故术前易误诊。输卵管妊娠是妇产科常见的急症,近年来发病率有上升趋势,及时诊断正确治疗是取得良好预后的关键。但是输卵管妊娠和卵巢妊娠就非常罕见了,本文就我院收治的1例侧输卵管同时合并左侧卵巢妊娠进行回顾性总结,就临床表现、诊断及治疗进行分析的探讨。

1 病例报告

患者29岁,孕2产0。因停经34天,阴道流血4天,突发性下腹痛一天于2010年11月9日急诊入院。患者平素月经规律,末次月经时间是2010年10月1日。停经以来,有恶心反应,未呕吐。4天前无诱因出现阴道流血,量少于平时的经量,呈暗红色,无血块及肉样组织,无腹痛。一天前无诱因出现下腹痛,呈阵发性胀痛,并有一约肉样组织自阴道排出,之后腹痛消失。但仍有少许阴道流血,无头昏、心悸,无肛门坠胀,故至我院

就诊。查尿HCG阳性,B超提示:盆腔偏左侧囊肿(10 cm×7 cm×6 cm),子宫左侧卵巢无异常。入院查体:体温37℃,脉搏73次,血压100/80 mmHg。一般情况可,神清,心肺检查无异常。妇科检查:外阴婚型,阴道畅,少许血性分泌物,宫颈光滑,无举摆感,宫体后位,正常大小,无压痛,左附件区可触及一约10 cm×7 cm包块,活动可,囊性,无压痛,右附件未触及明显包块,无压痛。入院诊断:1.异位妊娠可能 2.左卵巢囊肿可能。

入院后予监测血HCG水平,预防感染。11月10日血β-HCG:16.46 ng/ml,11月15日血β-HCG:24.02 ng/ml,复查B超示:1.右侧附件混合回声团(考虑异位妊娠),大小约1.6 cm×1.2 cm 2.左侧卵巢囊肿(大小约10.8 cm×8.2 cm),盆腔少量积液。11月12日阴道排出物病检显示:分泌反应子宫内膜,间质脱落样变未伴炎症(图1)。完善术前检查后,于11月16日在全麻下行腹腔镜下行右侧输卵管切除术+左侧卵巢囊肿剥除术+粘连分解术,术后组织送病检(右输卵管)腔内变性绒毛及滋养细胞,复合异位妊娠(左卵巢囊肿)羊膜、绒毛及滋养叶细胞,复合异位妊娠。术后3、6和8天患者血HCG浓度水平分别为19.61 ng/ml、4.47 ng/ml和1.84 ng/ml,术后顺利恢复出院。出院诊断:右侧输卵管壶腹部妊娠合并左侧卵巢妊娠。

2 手术记录

2010-11-16在全麻下行腹腔镜探查术,术中见(图2):子宫大小正常,表面充血,右输卵管壶腹部增粗约2 cm×1.5 cm,紫

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蓝色,部分与右卵巢形成粘连,右卵巢大小正常,张力大,见黄体。左卵巢增大 $10\text{ cm} \times 8\text{ cm}$,表面光滑,囊壁薄。左输卵管外观正常,覆盖与左卵巢囊肿表面,子宫直肠凹积血性液 20 mL 。双极电凝右侧输卵管系膜至输卵管峡部。单极电切系膜,切下右

侧输卵管。单极电切开左侧卵巢囊壁,剥除囊肿壁。双极电凝止血,可吸收缝线缝合并成形卵巢。取出举宫器,术中出血 50 mL 。术中麻醉满意,手术顺利,安返病房,标本请病人家属过目后送病检。

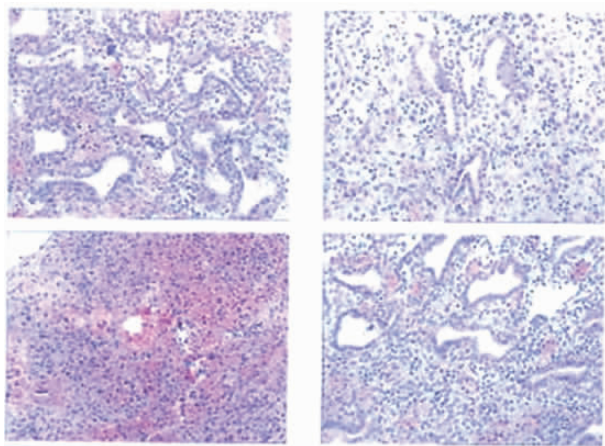


图1 宫腔渗出物病检:分泌反应性子宫内膜,间质蜕膜样变伴炎症

Fig. 1 Pathological examination of the exudate from uterine cavity:

Secretory response of the endometrium, decidual degeneration with interstitial inflammation.

3 病检结果

巨检:右输卵管一段 $5.5\text{ cm} \times 1.5\text{ cm} \times 1\text{ cm}$ 大小,左卵巢囊肿壁,粉白囊壁样物一堆 $3.5\text{ cm} \times 2\text{ cm} \times 1\text{ cm}$,其中似见绒毛。(图3)

病例诊断:(右输卵管)腔内变性绒毛及滋养细胞,符合异位妊娠;(左卵巢囊肿)羊膜、绒毛及滋养细胞,符合异位妊娠。

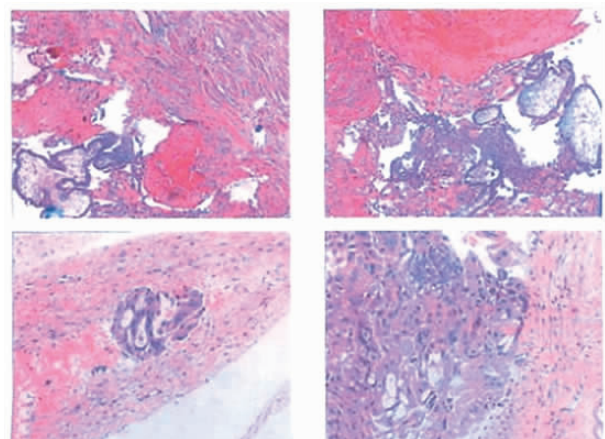


图3 右输卵管和左卵巢囊肿组织病检

Fig. 3 Pathological examination of right tubal pregnancy and left ovarian pregnancy

4 讨论暨文献复习

异位妊娠为妇科常见病,但卵巢和输卵管同时妊娠实属罕见^[1]。植入在卵巢内受精卵的发育与植入于子宫内或输卵管内

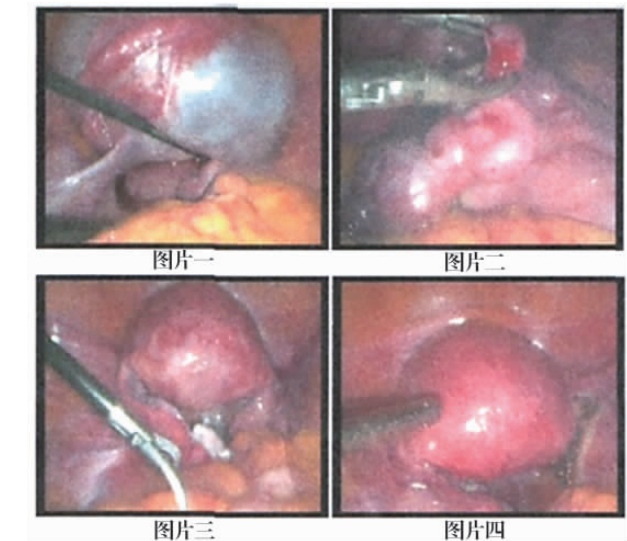


图2 右侧输卵管切除术+左侧卵巢囊肿剥除术+粘连分解术

Fig. 2 Right salpingectomy, left ovarian cystectomy and Adhesion decomposition technique

者相似,故卵巢内可找到滋养细胞及绒毛,但没有蜕膜。虽然卵巢环境比输卵管容易适应妊娠发展,但多以破裂出血而告终。卵巢妊娠诊断标准:患侧输卵管正常,胚囊位于卵巢内,卵巢与胚囊经卵巢韧带与子宫相连,胚囊处有卵巢组织。卵巢妊娠临床表现与输卵管妊娠相似,术前诊断均较困难,误诊率高^[2]。卵巢妊娠的腹痛、休克等表现较输卵管妊娠明显,且本次观察病例由于术前应用阴道彩超,确诊率大大提高,达 73% ,可见阴道超声在卵巢妊娠诊断中的重要作用^[3]。

卵巢妊娠并发输卵管妊娠二者临床表现相似:停经,腹痛及阴道不规则流血^[4]。如破裂后,因卵巢妊娠易在早期发生破裂,且卵巢组织缺乏肌性组织,一旦出血,不易止血,易致腹腔内出血甚至休克。因此术前二者很难确诊,B超及腹腔镜可辅助检查,术中经仔细探查及病理检查方能最后明确诊断。该患者有盆腔炎病史及行腹腔镜输卵管再通术史,也可能是导致异位妊娠的一个因素。

异位妊娠的临床表现可因发生部位,病程长短不同,差异变化多样,病变早期易与先兆流产等混淆,其危险在于异位的胚胎或滋养细胞存活,种植于输卵管等部位黏膜,直接侵蚀或穿透黏膜层,破裂造成腹腔内出血,引起休克,直接危及患者生命安全。特殊部位的异位妊娠孕卵在输卵管运行过程中受阻或外游,并在特殊部位着床发育^[5-10]。辅助检查有:①HCG测定是目前早期诊断异位妊娠的重要方法;②孕酮测定。异位妊娠的血清P水平偏低,但在孕5~10周时相对稳定,单次测定即有较大的诊断价值,尽管正常和异常妊娠血清P水平存在交叉重叠,难以确定它们之间的绝对临界值,但血清P水平低于 10 ng/ml ,常提示异常妊娠,其准确率在 90% ;③B型超声检查

对异位妊娠的诊断尤为常用,阴道B超检查较腹部B超检查准确性更高;④诊断性刮宫;⑤后穹窿穿刺;⑥腹腔镜检查;⑦其他生化标记。

黄体是人体内含血流最高的组织,妊娠黄体血流更加丰富。宫内孕合并卵巢黄体囊肿破裂时发病急,当腹腔内出血不多、无休克、也不再继续出血者,可行保守观察,若患者无生育要求,应行诊刮术。因为手术切除黄体,往往导致宫内孕流产。保守治疗效果不确切,在保守治疗期间HCG持续升高,或发生内出血仍需手术治疗^[1]。若出血量大,血压进行性下降,患者出现休克者,急诊开腹手术止血是挽救生命的最好方法^[12]。手术方式可行病灶切除后卵巢修补,或卵巢楔形切除,尽量保留卵巢功能。因此手术时要常规仔细探查双侧卵巢、输卵管,甚至其它盆腹腔脏器,以免漏诊或误诊,防止术后继续内出血导致严重后果。

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