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梗阻性低位直肠癌保肛手术可行性探讨

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摘要 目的:探讨梗阻性低位直肠癌保肛治疗(直肠癌前切除术(dixon 手术))的可行性及术后肠痿的防治。**方法:**回顾性分析我科 2009 年 1 月-2012 年 1 月梗阻性低位直肠癌的保肛治疗(dixon)24 例手术患者(梗阻性保肛组)临床资料及非梗阻性低位直肠癌保肛治疗(dixon)的 24 例患者(非梗阻性保肛组)临床资料,比较梗阻性与非梗阻性低位肠梗阻保肛治疗的临床疗效,分析梗阻性低位肠梗阻保肛治疗的可行性。**结果:**梗阻性保肛组住院天数:11.9 天,非梗阻性肠梗阻保肛组 8.7 天 $P<0.05$;梗阻性保肛组发生肠痿:4 例(16.7%),非梗阻性肠梗阻保肛组发生肠痿:1 例(4.2%) $P<0.05$,经充分引流后肠痿愈合,无 1 人死亡,两组术后至出院期间死亡人数:0 例;梗阻性保肛组肠功能恢复(以排气排便为指标):5.1 天,非梗阻性保肛组肠功能恢复:3.8 天, $P<0.05$;术后 6 个月腹泻便秘患者两组相同为 24 人;术后 6 个月梗阻性保肛组肿瘤复发 6 人(25%),非梗阻性保肛组肿瘤复发 5 人(20.8%), $P>0.05$ 。**结论:**梗阻性低位肠梗阻保肛治疗住院期疗效较非梗阻性保肛组差,中远期疗效无明显差异。梗阻性低位直肠癌可行保肛治疗。

关键词: 直肠癌;梗阻性;低位;保肛手术

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Study on Feasibility of Anal Function Preserving Operation for Patients with Obstructive Low Rectal Cancer

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ABSTRACT Objective: To explore the 64-slice volume CT digital subtraction angiography (the Volume computed tomography digital subtraction angiography, VCTDSA) combined with CT perfusion imaging in the diagnosis of acute ischemic stroke value. **Methods:** Retrospective analysis of 45 patients with clinically diagnosed as clinical data of patients with acute ischemic stroke, respectively to give VCTDSA and CT perfusion imaging processing, and analysis of diagnostic sensitivity and specificity of these two technologies in patients with acute ischemic stroke. **Results:** 45 patients check intracranial bleeding lesions in different parts, more common in the ventricles, are associated with varying degrees of abnormal vascular network formation, which VCTDSA image quality is superior to CT perfusion imaging, VCTDSA than DSA can accurately display and measurement of arteriovenous fistulae size, VCTDSA, and MRA was no significant difference in tumor long axis, the comparison of the aneurysm neck. **Conclusions:** The other subtraction CTA VCTDSA combined with CT perfusion imaging in the diagnosis of acute ischemic stroke patients have an advantage.

Key words: Low rectal cancer; Bowel obstruction; Low; Anus-preserving operation

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前言

直肠癌是我国最常见的恶性肿瘤之一,近年来我国低位直肠癌呈上升趋势,约占所有直肠癌的 3/4^[1]。直肠癌位置低、易被直肠指检及肠镜检查发现,但由于其深入盆腔,手术难度大,术后局部复发率高,中、下段直肠癌与肛管括约肌接近,保肛难度较大。手术治疗仍然是直肠癌首选治疗方法。直肠癌有不同的手术方式,可分为保肛手术和非保肛手术两种。随着人们对生活质量追求的提高,越来越要求保肛治疗。直肠癌浸润转移规律的深入研究^[2-3],吻合器的应用以及(Total mesorectal excision

TME)^[4-5]理论的提出,使低位直肠癌保肛治疗成为一种可能。以及实验表明保肛手术与非保肛手术间肿瘤复发率无明显差异,保肛手术并发症较非保肛手术少^[6,7],这些使保肛手术^[8]逐渐取代传统的 Miles 手术。但对于梗阻性低位直肠癌行保肛治疗的研究,目前较少。本文就我科近 3 年来对梗阻性低位直肠癌保肛治疗的 24 位患者资料及非梗阻性保肛组 24 患者资料进行回顾性的总结、比较和分析,并报告如下:

1. 资料与方法

1.1 一般资料

选择 2009 年 1 月-2012 年 1 月我科收治的梗阻性低位直肠癌的 24 例手术(Dixon)患者资料:男 16 例女 8 例,年龄 45-65 岁 平均年龄 57.9 岁,肿瘤距肛缘 4-7 cm,13 例病理确诊为高分化腺癌,10 例病理分型为中分化腺癌,1 例为低分化腺癌,在 200 个 Duckes 分期与梗阻保肛组无统计学差异的非梗阻性低位肠梗阻患者中,随机抽取的非梗阻性低位直肠癌 24

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例手术(Dixon)患者资料:男 17 例 女 7 例,年龄 43-68 岁 平均年龄 56.9 岁,肿瘤距肛缘 4-7 cm,14 例病理确诊为高分化腺癌,9 例病理分型为中分化腺癌,1 例为低分化腺癌全肠系膜全切除;两组术后病理检查示吻合口两端未见肿瘤残留。梗阻性保肛组与非梗阻性保肛组在性别、年龄、肿瘤分型、Dukes 分期上无明显统计差异,具有可比性。

1.2 手术方法

行直肠癌手术常规行肠道准备(梗阻性保肛组无法行肠道准备,手术中行全结肠灌洗),常规直肠癌低位前切除术(Dixon 手术),保证严格无瘤操作及全肠系膜全切除(TME),检查吻合器上下两切割圈完整情况,必要时加固缝合,自低位直肠癌患者的肛管向肛门注气,观察吻合口情况,有无渗漏,注意关闭盆腔腹膜,留置骶前两引流管,1 根自肛周引出,1 根自腹引出。留置时间视引流流量而定,一般留置 9-14 天较安全。

1.3 术后临床评估指标

近期评估指标:住院平均天数、肠瘘发生率(低位直肠癌保肛术后的主要、最严重并发症)、肠管功能恢复情况(以术后排气排便时的天数为指标),死亡率(两组术后至出院期间);中远期评估指标:术后 6 个月腹泻便秘发生率、术后 6 个月肿瘤复发率。

1.4 术后肠瘘的防治

对于低位直肠癌保肛术后肠瘘的防治,主要是加强肠外营养,补充白蛋白,尽快减轻肠管水肿;肠瘘发生后早期诊断很关键,肠瘘主要表现为发热、引流管引流出浑浊大便秘带粪臭味液体、白细胞升高,治疗主要是引流充分^[9],可从经腹骶前引流管缓慢滴注奥硝唑等液体,经肛周骶前引流管持续负压吸引。对于保守治疗 3-5 天,肠瘘未局限者,可考虑回肠末端或结肠造瘘^[10]。

2 结果

梗阻性保肛组住院天数:11.9 天,非梗阻性肠梗阻保肛组 8.7 天 $P<0.5$;梗阻性保肛组发生肠瘘:4 例 (16.7%),3 例经保守治疗治愈,1 例肠瘘发生腹膜炎,经回肠造口治疗后治愈。非梗阻性肠梗阻保肛组发生肠瘘:1 例 (4.2%) $P<0.5$,经充分引流后肠瘘愈合,无 1 人死亡,两组术后至出院期间死亡人数:0 例;梗阻性保肛组肠功能恢复(以术后排气排便时的天数为指标):5.1 天,非梗阻性保肛组肠功能恢复:3.8 天, $P<0.5$,住院天数、肠瘘、肠功能恢复有统计学差别,死亡率(术后至出院期间)无统计学差别(见表 1);术后 6 个月腹泻便秘患者两组相同为 24 人;术后 6 个月梗阻性保肛组肿瘤复发 6 人 (25.0%),非梗阻性保肛组肿瘤复发 5 人 (20.8%), $P>0.5$,无统计学差别。见表 2:

表 1 两组患者近期疗效

Table 1 The short-term curative effect of the two groups

Groups\ Items	Number of patients (N)	Duration of hospitalization	Anastomotic fistula	Intestinal function recovery time	Mortality rate
The obstructive group	24	11.9± 0.3	4(16.7)	5.1± 0.6	0
The nonobstructive group	24	8.7± 0.4	1(4.2)	3.8± 0.5	0

Note: anastomotic fistula and anastomotic fistula use χ^2 test; $P(\text{anastomotic fistula})<0.05$, $P(\text{Mortality rate})>0.05$;

Duration of hospitalization and Intestinal function recovery time use t test; $P(\text{Duration of hospitalization})<0.05$, $P(\text{Intestinal function recovery time})<0.05$.

表 2 梗阻性保肛组与非梗阻性保肛组中远期疗效

Table 2 The mid-term and long-time curative effect of the two groups

Groups\ Items	Number of patients (N)	Diarrhea or constipation in 6 months after the operation	Recurrence rate in 6 months after the operation
The obstructive group	24	24(100)	6(25.0)
The non-obstructive group	24	24(100)	5(20.8)

Note: Diarrhea or constipation and recurrence rate in 6 months after the operation use χ^2 test, $P(\text{Diarrhea or constipation})>0.05$, $P(\text{recurrence rate})>0.05$.

3 讨论

3.1 梗阻性保肛组肠瘘发生率较非梗阻性保肛组高的原因

梗阻性保肛组因为肠梗阻时间长(4-8 天),肠管及周围组织水肿严重,易造成吻合不严密。对于梗阻性低位直肠癌患者,术后尽早适当补充白蛋白,减轻组织水肿,能减少肠瘘的发生;肠管吻合处血运差、吻合处张力过大也是引起肠瘘的原因,因此术中保证肠管吻合处血运及减少吻合口处张力,能减少肠瘘的发生。

3.2 梗阻性保肛组术后近期恢复情况(平均住院天数、肠瘘发生率肠功能恢复情况)较非梗阻性保肛组差的原因

主要是由于梗阻性低位直肠癌患者术前自身条件差一大

多数患者有较严重的低蛋白血症(<25 g/L),有不同程度的贫血及肠管麻痹,所以术后恢复慢。

3.3 梗阻性保肛组与非梗阻性保肛组近期恢复情况比较的意义

通过两组数据的比较及数据差距原因的分析,可以帮助我们更好的把握梗阻性低位直肠癌的保肛治疗术后的治疗:如加强肠外营养,尽早纠正低蛋白血症。

3.4 梗阻性保肛组与非梗阻性保肛组直肠癌复发率无明显统计学意义的原因及意义

直肠癌复发与多种因素有关^[11],随着 TME 概念被逐渐接受并运用于手术中,明显降低直肠癌的复发^[12-14]。直肠癌环周切缘(CRM)^[15]的概念的提出,显著降低了直肠癌术后局部复发

率、改善了预后^[16]。TME 手术方式的应用及 CRM 概念的提出,降低了梗阻性直肠癌术后复发,使保肛治疗具有临床意义。

3.5 术后营养的意义

对于肠梗阻患者,术前营养状态较差,有低蛋白血症,代谢率高,电解质失衡等不利因素,这些能增大术后并发症的发生,尤其是肠痿的发生^[17,18],Alves A 的一项前瞻性研究表明,术后营养不良能增大患者的死亡率^[19,20]。因此术后予以高糖、高能量饮食、纠正低蛋白血症很重要,能有效的降低并发症的发生,降低死亡率。

远期治疗效果差异需进一步的研究,需要我们进一步追踪 5、10 年生存率及肿瘤复发转移情况。对于梗阻性低位直肠癌患者,尽管由于术前有低蛋白血症、贫血、肠管麻痹、术前无法很好的完善肠道准备等不利因素,引起术后肠痿风险较一般低位直肠癌大,但切忌不要轻言放弃保肛,采用手术中全结肠灌洗、预防性回肠造口等治疗手段,结合术后合理的营养支持,尽可能的保留肛门。

4 结论

梗阻性低位肠梗阻保肛治疗住院期临床疗效较非梗阻性保肛组差,住院期间死亡率无明显差异,中远期疗效无明显差异,梗阻性低位直肠癌可行保肛治疗。

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