

doi: 10.13241/j.cnki.pmb.2017.16.013

• 临床研究 •

宫颈癌患者行根治性子宫切除术且保留盆腔自主神经的效果观察 *

东 敏 刘建华[△] 张 励 阮正一 陈 燕

(上海市第九人民医院妇科 上海 200010)

摘要 目的:探讨宫颈癌患者行保留盆腔自主神经的根治性子宫切除术的临床效果。**方法:**按照随机数字表法将入选的 48 例宫颈癌患者随机分为对照组和试验组两组,每组患者各 24 例,其中对照组患者均采用传统的宫颈癌根治手术治疗,而试验组患者则采用保留盆腔自主神经的根治性子宫切除术进行治疗,比较两组患者的术中情况和术后恢复情况等。**结果:**两组患者的子宫切除出血量和术中总出血量以及术中输血率均无明显差异(均 $P > 0.05$),但是试验组患者的子宫切除时间和手术总时间显著长于对照组患者($t=2.934, P < 0.05$; $t=3.121, P < 0.05$)。两组患者之间的术后排气、排便时间均无明显差异(均 $P > 0.05$),提示两组患者术后直肠功能无明显差异;对照组患者的术后残余尿量 $< 100\text{ml}$ 时间与术后残余尿量 $< 50\text{ml}$ 时间均显著高于试验组患者($t=2.891, P < 0.05$; $t=3.092, P < 0.05$)。术后试验组患者的首次排尿感和急迫排尿感以及最大腹压等均显著低于对照组患者($t=4.283, P < 0.05$; $t=4.027, P < 0.05$; $t=3.137, P < 0.05$);而最大膀胱压和最大尿流量以及最大逼尿肌压等则显著高于对照组($t=3.192, P < 0.05$; $t=2.938, P < 0.05$; $t=3.572, P < 0.05$)。**结论:**采取保留盆腔自主神经的根治性子宫切除术能够较好地减少宫颈癌患者临床并发症的出现,具有较好的治疗效果,值得加以推广和运用。

关键词:盆腔自主神经;宫颈癌;根治性手术;子宫切除术;临床效果

中图分类号:R737.33 **文献标识码:**A **文章编号:**1673-6273(2017)16-3054-03

The Clinical Effect of Radical Hysterectomy with Reservation of Pelvic Autonomic Nerve for Cervical Cancer Patients*

DONG Min, LIU Jian-hua[△], ZHANG Li, RUAN Zheng-yi, CHEN Yan

(Shanghai ninth people's hospital of department of gynaecology, Shanghai, 200010, China)

ABSTRACT Objective: To explore the clinical effect of radical hysterectomy with pelvic autonomic nerve reservation for cervical cancer patients. **Methods:** 48 cases of patients with cervical cancer were selected in our hospital from January 2011 to January 2016. According to the random number table method, all patients were divided into control group and experimental group, each group with 24 cases. Patients in the control group were treated with traditional cervical cancer radical surgery, while those in experimental group had radical hysterectomy with reservation of pelvic autonomic nerve. Compare intraoperative states and postoperative recovery between two groups. **Results:** There were no significant differences in uterus resection bleeding volume, intraoperative total bleeding volume and intraoperative blood transfusion rate between two groups ($P > 0.05$). However, the experimental group had longer uterus resection time and total operation time than the control group ($t=2.934, P < 0.05$; $t=3.121, P < 0.05$). Between the two groups, there was no significant difference in postoperative exhaust and defecate time ($P > 0.05$), indicating that patients in the two groups had no significant difference in rectal function after operation; The time for patients with postoperative residual urine volume $< 100\text{ml}$ and time for postoperative residual urine volume $< 50\text{ mL}$ were significantly longer in control group than in experimental group ($t=2.891, P < 0.05$; $t=3.092, P < 0.05$). After operation, the urine volume at the first urination sensation and urgent urination sensation and the abdominal pressure were significantly less in experimental group than in control group ($t=4.283, P < 0.05$; $t=4.027, P < 0.05$; $t=3.137, P < 0.05$). Whereas, maximum bladder pressure, maximum urinary flow rate and maximum detrusor pressure all were significantly higher in experimental group than in control group ($t=3.192, P < 0.05$; $t=2.938, P < 0.05$; $t=3.572, P < 0.05$). **Conclusion:** The radical hysterectomy with reservation of pelvic autonomic nerve can reduce the clinical complications of patients with cervical cancer. It had good therapeutic effect, and is worth popularizing and applying.

Key words: Pelvic autonomic nerve; Cervical carcinoma; Radical operation; Hysterectomy; Clinical effect

Chinese Library Classification(CLC): R737.33 **Document code:** A

Article ID:1673-6273(2017)16-3054-03

* 基金项目:上海市科委基金项目(20113140)

作者简介:东敏(1984-),女,硕士,住院医师,研究方向:炎症、生殖道畸形,电话:13817206510, E-mail:live_in_sky@163.com

[△] 通讯作者:刘建华(1963-),男,硕士,主任医师,研究方向:炎症、生殖道畸形, E-mail:81033083@qq.com,电话:13701911503

(收稿日期:2016-10-25 接受日期:2016-11-20)

前言

根治性子宫切除术是临床上治疗宫颈癌患者中最常用的一种治疗方式,对于 I b~II a 期以及 I a 期中出现有脉管浸润和融合性浸润的宫颈癌患者均有较好疗效^[1]。但是由于对患者进行根治性子宫切除术可能会使其盆腔自主神经受到一定的损伤,从而引发患者出现膀胱麻痹等各种并发症^[2]。因此,为了对宫颈癌患者的肿瘤进行最大程度的切除,同时又尽可能地避免对患者的盆腔自主神经造成伤害,我院选取了 48 例宫颈癌患者参与本次研究,探讨宫颈癌患者行保留盆腔自主神经的根治性子宫切除术的临床效果。

1 资料与方法

1.1 一般资料

选取我院于 2011 年 1 月至 2016 年 1 月期间收治的 48 例宫颈癌患者,其中所有患者年龄均处于 26~57 岁之间,平均年龄为(42.1±3.5)岁;临床分期为 I B1 期的患者有 13 例, I B2 期的患者有 16 例, II A3 期的患者 5 例, II B9 期的患者有 14 例;病理分型为:25 例鳞癌患者,18 例腺癌患者,4 例小细胞癌,1 例腺鳞癌患者。按照随机数字表法将患者均分为对照组和试验组两组,且两组患者之间的一般资料具有可比性(P>0.05)。

1.2 纳入与排除标准

所有患者均明确诊断为宫颈癌,并且经过我院医学伦理委

员会同意后,所有患者均知情同意并且自愿参与本次研究;所有患者治疗前均不存在残余尿量异常,并且排除存在泌尿系功能障碍的患者;排除合并有严重心、肝、肾等功能不足的患者;排除因各种原因无法配合完成本次研究的患者。

1.3 研究方法

对照组患者均采用传统的宫颈癌根治手术治疗,而试验组患者则采用保留盆腔自主神经的根治性子宫切除术进行治疗^[3]。根据患者术中残余尿低于 100 mL 和 50 mL 的时间以及患者的术后排气、排便时间来判断患者的膀胱和直肠功能,比较两组患者的子宫切除时间和手术总时间、子宫切除出血量、术中出血量等术中情况,并且比较两组患者的尿流动力学指标和韧带、阴道、淋巴结以及手术并发症等情况^[4]。

1.4 统计学方法

试验所得数据均用($\bar{x} \pm s$)形式表示,组间比较采用 t 检验,计数资料之间对比采用 χ^2 检验,以是否 P<0.05 来比较差异是否具有统计学意义。

2 结果

2.1 比较两组患者的术中情况

两组患者的子宫切除出血量和术中总出血量以及术中输血率均无明显差异(均 P>0.05),但是试验组患者的子宫切除时间和手术总时间显著长于对照组患者(t=2.934, P<0.05; t=3.121, P<0.05)(表 1)。

表 1 比较两组患者的术中情况($\bar{x} \pm s$)

Table 1 Comparison of intraoperative situation between two groups($\bar{x} \pm s$)

Groups	Total operation time (min)	Hysterectomy time (min)	Total amount of bleeding during operation(mL)	Uterine bleeding volume(mL)	Intraoperative blood transfusion rate(%)
Control group(n=24)	221±35	72±14	711±113	566±92	4(16.7)
Experimental group (n=24)	251±42	92±14	739±122	591±93	5(20.8)
t/x ²	3.121	2.934	2.021	2.019	1.532
P	<0.05	<0.05	>0.05	>0.05	>0.05

2.2 比较两组患者术后的膀胱和直肠功能

两组患者之间的术后排气、排便时间均无明显差异(均 P>0.05),提示两组患者术后直肠功能无明显差异;对照组的术后残余尿量<100 mL 时间与术后残余尿量<50 mL 时间均显著高于试验组患者(t=2.891, P<0.05; t=3.092, P<

0.05),提示试验组患者术后膀胱功能明显优于对照组患者。

2.3 比较两组患者术中韧带和阴道切除情况

两组患者的主韧带切除长度和宫韧带切除长度以及阴道前壁切除长度和阴道后壁切除长度等均无明显差异(均 P>0.05)(表 2)。

表 2 比较两组患者术中韧带和阴道切除情况($\bar{x} \pm s$)

Table 2 Comparison of intraoperative ligament and vaginal resection between two groups($\bar{x} \pm s$)

Groups	Syndesmology(cm)		Vagina(cm)	
	Excision length of main ligament	Excision of uterine ligament	Anterior wall resection length	Posterior wall resection length
Control group(n=24)	3.0±0.33	3.2±0.35	3.0±0.41	3.9±0.59
Experimental group(n=24)	2.9±0.39	2.9±0.40	3.0±0.39	3.7±0.61
t	0.243	0.421	0.224	0.483
P	>0.05	>0.05	>0.05	>0.05

2.4 比较两组患者的尿流动力学指标

术后试验组患者的首次排尿感和急迫排尿感以及最大腹压等均显著低于对照组患者 ($t=4.283, P<0.05; t=4.027, P<$

$0.05; t=3.137, P<0.05$); 而最大膀胱压和最大尿流量以及最大逼尿肌压等则显著高于对照组 ($t=3.192, P<0.05; t=2.938, P<$

$0.05; t=3.572, P<0.05$)(表3)。

表3 比较两组患者的尿流动力学指标($\bar{x} \pm s$)

Table 3 Comparison of urinary flow dynamics indexes between the two groups ($\bar{x} \pm s$)

Groups	Bladder filling stage(ml)			urination stage		
	First urination sensation	Urgent urination sensation	Maximum urine flow rate(ml/s)	Maximum bladder pressure(cmH ₂ O)	Maximum abdominal pressure(cmH ₂ O)	Maximum detrusor pressure(cmH ₂ O)
Control group (n=24)	257.2± 38.2	408.2± 63.4	8.8± 1.2	30.1± 5.1	11.2± 1.8	30.1± 5.1
Experimental group (n=24)	160.2± 22.8	328.3± 54.2	12.8± 1.9	37.4± 6.5	5.1± 0.9	39.2± 6.5
t	4.283	4.027	2.938	3.192	3.137	3.572
P	P<0.05	P<0.05	P<0.05	P<0.05	P<0.05	P<0.05

3 讨论

作为妇科最为常见的恶性肿瘤之一,宫颈癌的临床发病有越来越年轻化的趋势^[5]。目前对于宫颈癌的治疗方法主要包括手术治疗和放射治疗以及化疗等三种,通过将患者的年龄、临床分期、生育要求以及全身情况与当地医疗技术水平及设备条件等方面相结合,从而制定出符合患者自身情况的个体化治疗方案^[6,7]。其中手术治疗包括有全子宫切除术、广泛全子宫切除术及盆腔淋巴结清扫术、腹主动脉旁淋巴结切除或取样和次广泛全子宫切除术及盆腔淋巴结清扫术等,主要用于宫颈癌早期患者^[8,9]。对于希望保留生育功能的年轻患者,在发病早期即应该进行根治性宫颈切除术或者宫颈锥形切除术^[10]。随着医疗技术的不断发展,人们对于医疗效果的要求也随之升高。为此,广大科研人员不仅不断地探索如何提升宫颈癌患者行根治性手术后的治疗效果,同时也关注如何更好地改善患者的生活质量。由于在宫颈癌根治性切除手术中会对患者的盆腔自主神经造成一定的破坏,从而使得患者的膀胱功能和直肠功能等收到损伤,影响患者的生活质量^[11]。因此我院选取了48例准备实施根治性手术的宫颈癌患者展开相关研究,探讨保留盆腔自主神经的根治性子宫切除术在临床使用中的治疗效果。

本次研究中,两组患者的子宫切除出血量和术中总出血量以及术中输血率均无明显差异,提示了保留盆腔自主神经的根治性手术并不会比传统根治性手术造成更多的术中出血量,在这方面并不存在额外安全风险^[12]。而试验组患者的子宫切除时间和手术总时间显著长于对照组患者,其结果可能是受操作者的熟练度所影响所致,或者是因为术中中进行拍照或录像等原因,从而使得试验组患者的手术时间长于对照组患者^[13]。此外,通过对两组患者术后的膀胱和直肠功能进行对比分析,结果两组患者之间的术后排气、排便时间均无明显差异,由此提示了两组患者术后直肠功能无明显差异,即采用保留盆腔自主神经的根治手术对患者直肠功能所造成的影响和传统根治性手术相同^[14]。在术后残余尿量<100 mL与术后残余尿量<50 mL的时间方面,对照组患者均显著长于试验组患者,提示了采取保留盆腔自主神经的根治性手术对于患者的膀胱功能具有更好

的保护作用^[15]。通过对患者残余尿量分别小于100 mL和50 mL的时间来作为评估膀胱功能的指标是临床上较为常用的一种方法,从而也可以折射出手术过程中对患者盆腔自主神经的破坏或保护程度^[16,17]。至于不同手术过程中的韧带切除及阴道和淋巴结清扫情况,研究结果显示传统的根治性切除术和保留盆腔自主神经的根治性切除术之间均无明显差异。并且在对患者们的临床资料分析过程中发现,两组不同手术治疗的患者的并发症发生情况不存在明显差异,由此可以推出运用保留盆腔自主神经的根治性子宫切除术治疗宫颈癌患者,其安全性并不会低于传统的根治性子宫切除术^[18-20]。

综上所述,采取保留盆腔自主神经的根治性子宫切除术能够较好地减少宫颈癌患者临床并发症的出现,具有较好的治疗效果,值得加以推广和运用。

参考文献(References)

- [1] Kovac, S.R. Route of hysterectomy: An evidence-based approach [J]. Clinical Obstetrics and Gynecology, 2014, 57(1): 58-71
- [2] Miao L, Wang L, Zhu L, et al. Association of microRNA polymorphisms with the risk of head and neck squamous cell carcinoma in a Chinese population: a case-control study [J]. Chin J Cancer, 2016, 35(1): 77
- [3] Ding Hui, Kong Xiang. Progress in the application of laparoscopic pelvic autonomic nerve preservation in the patients with pelvic autonomic nerve[J]. Shandong medicine, 2015, 55(7): 97-99
- [4] Tong XJ, Tang ZG, Shan ZF, et al. The anterolateral thigh flap for soft tissue reconstruction in patients with tongue squamous cell carcinoma [J]. World J Surg Oncol, 2016, 14(1): 213
- [5] Deng Li, Wei Ye-ping, Shao Shi-qing, et al. Conservative laparoscopic pelvic autonomic nerves were widely hysterectomy surgery curative effect[J]. The Journal of practical medicine, 2014, 30(12): 1921-1923
- [6] Bishop S, Reed WM. The provision of enteral nutritional support during definitive chemoradiotherapy in head and neck cancer patients [J]. J Med Radiat Sci, 2015, 62: 267-276
- [7] Goolab, BD. Vaginal hysterectomy and relative merits over abdominal and laparoscopically assisted hysterectomy [J]. Best Pract Res Clin Obstet Gynaecol, 2013, 27(3): 393-413

- planning and navigation for surgical excision of parasagittal, falx and convexity meningiomas[J]. Br J Neurosurg, 2010, 24(1): 69-74
- [9] Li Jian-bin, Shen Xiao-li, Guo Hua, et al. Old large, large meningioma in 26 cases of microsurgical treatment [J] Chinese Journal of Geriatrics, 2014, 34 (5): 1356-1357
- [10] Ou Ming-liang. Efficacy and neuroprotective effect of microsurgical treatment of large cerebellopontine angle meningiomas in elderly patients[J]. Chinese Journal of Geriatrics, 2012, 32 (8): 1608-1610
- [11] Huang Ling, Zhang Zhe, Yang Yue, et al. Ipsilateral and contralateral longitudinal microsurgical treatment of deep frontal cerebral falx meningioma effect comparison [J]. Guangdong Medical Science, 2016, 37(7): 1049-1051
- [12] Li Zhen, Feng Tianda, Qu Sheng-tao, et al. Medical surgical treatment of senile lateral meningiomas in 12 patients [J]. Chinese Journal of Geriatrics, 2015, 35(6): 1694-1695
- [13] Shim Y, Lee SH. Failed First Craniotomy and Tumor Removal of Parasagittal Meningioma with Severe Peritumoral Brain Edema[J]. Brain Tumor Res Treat, 2016, 4(2): 124-127
- [14] Hwang J, Kong DS, Seol HJ, et al. Clinical and Radiological Characteristics of Angiomatous Meningiomas [J]. Brain Tumor Res Treat, 2016, 4(2): 94-99
- [15] Chen Li-hua, Yang Yi, Wei Qun, et al. Microsurgical treatment of petroclival meningiomas by posterior-inferior sigmoid sinus combined with keyhole approach [J]. Peking University (Medicine Edition), 2016, 48(4): 738-742
- [16] Lee SJ, Hwang SC, Im SB, et al. Surgical Resection of Non-Glial Tumors in the Motor Cortex [J]. Brain Tumor Res Treat, 2016, 4 (2): 70-76
- [17] Wang Nian-hua, Xu Li-xin, Jia Ruo-fei, et al. Top of the occipital sagittal sinus, sickle beside the microsurgical treatment of meningioma[J]. China Modern Medical Journal, 2014, 24 (29): 98-102
- [18] Yang Shengji, Xu Guang-ming. Analysis of preoperative imaging and microsurgical treatment of senile sinus sick meningioma [J]. Chinese Journal of Geriatrics, 2016, 36(15): 3765-3767
- [19] Radwan W, Lucke-Wold B, Cheyuo C, et al. Lipomatous meningioma: Case report and review of the literature [J]. Case Stud Surg, 2016, 2(4): 58-61
- [20] Shen J, Tourje J, Chang EE, et al. Persistent Trigeminal Artery in Endonasal Resection of Skull Base Tumors: A Systematic Review[J]. J Neurol Surg B Skull Base, 2016, 77(6): 449-455

(上接第 3056 页)

- [8] Brehar AC, Terzea DC, Ioachim DL, et al. Cribriform-morular variant of papillary thyroid carcinoma at pediatric age - case report and review of the literature[J]. Rom J Morphol Embryol, 2016, 57: 531-537
- [9] Hospital costs of total vaginal hysterectomy compared with other minimally invasive hysterectomy [J]. American Journal of Obstetrics and Gynecology, 2014, 210(2): 120-120
- [10] Mehanna H, Wong WL, Dunn J. Management of Advanced Head and Neck Cancer[J]. N Engl J Med, 2016, 375: 492-493
- [11] Jacoby, V.L. Hysterectomy controversies: Ovarian and cervical preservation [J]. Clinical Obstetrics and Gynecology, 2014, 57(1): 95-105
- [12] Prestwich RJ, Sen M, Scarsbrook AF. Management of Advanced Head and Neck Cancer[J]. N Engl J Med, 2016, 375: 491-492
- [13] Volpi E, Bernardini L, Angeloni M, et al. Retroperitoneal and retrograde total laparoscopic hysterectomy as a standard treatment in a community hospital[J]. European Journal of Obstetrics, Gynecology and Reproductive Biology: An International Journal, 2014, 172: 97-101
- [14] Dulaney C, Kropp L, Bonner J. Management of Advanced Head and Neck Cancer[J]. N Engl J Med, 2016, 375: 492
- [15] Gaba ND, Polite FG, Keller JM, et al. To err is human; To provide safe, quality, and cost-effective hysterectomy is divine [J]. Clinical Obstetrics and Gynecology, 2014, 57(1): 128-139
- [16] Hassan CE, Webster TJ. The effect of red-allotrope selenium nanoparticles on head and neck squamous cell viability and growth[J]. Int J Nanomedicine, 2016, 11: 3641-3654
- [17] Nesbitt-Hawes EM, Maley PE, Won HR, et al. Laparoscopic Subtotal Hysterectomy: Evidence and Techniques [J]. Journal of minimally invasive gynecology, 2013, 20(4): 424-434
- [18] Braidwood L, Learmonth K, Graham A, et al. Potent efficacy signals from systemically administered oncolytic herpes simplex virus (HSV1716) in hepatocellular carcinoma xenograft models [J]. J Hepatocell Carcinoma, 2014, 1: 149-161
- [19] A randomized trial comparing conventional and robotically assisted total laparoscopic hysterectomy [J]. American Journal of Obstetrics and Gynecology, 2013, 208(5): 368-370
- [20] Cheung KW, Cheung VYT. Hysterectomy for abnormal cervical smear when local excision is not possible [J]. Journal of lower genital tract disease, 2014, 18(3): 235-239