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个案与短篇

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产前子痫合并脑疝前期脑水肿1例

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[关键词] 产前子痫;脑疝前期;脑水肿
[中图法分类号] R714.245 [文献标志码] B

1 临床资料

患者24岁,因停经7个月余,抽搐后昏迷12 h,于2009年2月18日21时22分入院,既往血压、末次月经不详。停经30多天尿HCG阳性,停经后无明显早孕反应。停经4个月自觉胎动,活跃至今。孕期未定期产检,2009年2月18日晨起后7点左右突发头痛、呕吐,抽搐1次,即到当地医院就诊,发现血压高,最高达200/120 mmHg,尿蛋白不详,予以降压、镇静、解痉等对症治疗(具体用药不详),病情逐渐加重,随后出现意识改变,昏迷不醒,急诊转入我院,转院途中仍昏迷不醒,抽搐1次,静滴液:5%葡萄糖250 ml+硫酸镁30 ml;另一组:5%葡萄糖250 ml+哌替啶50 mg+异丙嗪25 mg,急诊以"①宫内妊娠7个月余,单活胎,未临产;②产前子痫;③昏迷查因:颅内出血?④发热查因"收入院。入院后查体:体温38.4 ℃,脉搏104/min,呼吸20/min,血压187/126 mmHg,神志昏迷,瞳孔左侧4 mm,右侧3.5 mm,双侧对光反射迟钝,球结膜水肿明显,心肺未见明显异常,疼痛刺激有反应,双膝腱反射减退,Kernig征(+),Brudzinski征(+),Babinski征(+)。产科检查:宫高24 cm,腹围100 cm。胎心音180/min。急诊CT示脑组织弥漫性肿胀并颅内多发低密度灶(图1A)。

肝肾功能:A/G 1.2,丙氨酸氨基转氨酶61 U/L,天冬氨酸氨基转氨酶129 U/L,尿酸535 μmol/L,高密度脂蛋白胆固醇1.77 mmol/L,总胆固醇13.4 mmol/L,甘油三酯16.85 mmol/L,凝血功能、3P试验正常,小便常规示:葡萄糖(－),蛋白(+++),隐血(+),白细胞(++++)。诊断考虑:"①产前子痫;②宫内妊娠7个月余,单活胎,未临产;③昏迷查因:高血压脑病?④发热查因",于2009年2月18日23时30分在急诊全麻插管下行子宫下段剖宫产术。术中见羊水Ⅲ度污染,新生儿体质量500 g,1 min Apgar评分1分,5 min Apgar评分1分,患儿病情危重,成活困难,向家属交代病情,家属签字后放弃抢救,术中血压波动在120～160/70～110 mmHg。术毕回ICU继续观察。患者仍处昏迷状态,予以积极镇静、控制血压、利尿等对症治疗。2月22日患者病情明显好转,查体:体温36.5 ℃,脉搏66/min,呼吸14/min,血压156/95 mmHg,血氧饱和度:95%。2009年2月21日24 h入量5 668 ml,出量11 690 ml,2009年2月22日晨起中心静脉压9～10 cmH_2O。神志清楚,双侧瞳孔等大等圆,直径3 mm,对光反射灵敏,球结膜水肿基本消退。双肺呼吸音粗,未闻及干湿啰音。心率:66/min,律齐。伤口愈合好。肠鸣音4/min,病理征未引出。血气分析:pH 7.450,$p(CO_2)$31.8 mmHg,

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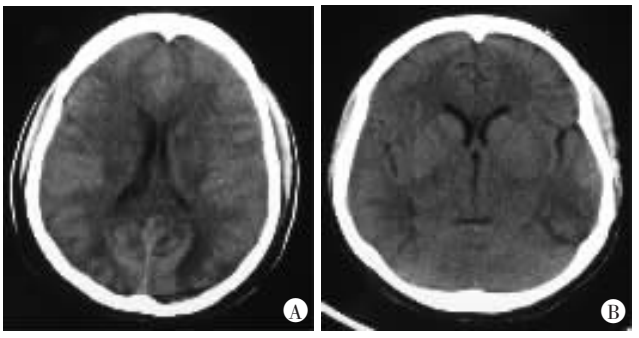
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$p(O_2)$ 88.9 mmHg, HCO_3^- 21.8 mmol/L, BE -1.1 mmol/L, K^+ 3.1 mmol/L, Na^+ 138 mmol/L, Cl^- 111 mmol/L, Ca^{2+} 0.99 mmol/L。3月1日查体:体温36.7 ℃,脉搏89/min,呼吸16/min,血压130/90 mmHg。一般情况好。宫底脐耻之间,腹部切口愈合可。复查CT:脑组织弥漫性肿胀伴多发低密度灶改善,符合机型后循环可复性缺血改变(图1B)。出院诊断:①产前子痫;②脑疝前期;③脑水肿;④宫内妊娠7个月余,枕左前,活女婴,已娩;⑤胎儿生长受限;⑥胎儿窘迫;⑦新生儿重度窒息;⑧低体质量儿。



A:治疗前;B:治疗后

图1 产前子痫合并脑疝前期脑水肿治疗前后CT表现

2 讨论

子痫是妊娠期高血压疾病的最严重阶段,是围产儿及孕产妇死亡的主要原因之一,可发生于妊娠中晚期、分娩期及产后早期,以抽搐为特征,可伴有高血压、蛋白尿及其他全身系统性的紊乱。目前为止,子痫的病因和发病机制尚不明确,其可能的发病机制是:各种原因导致血管内皮激活和损伤,使得血管内皮合成或分泌血管收缩因子和血管舒张因子平衡失调,小动脉痉挛,脏器血液灌流量下降和功能下降,同时血管内皮激活和损伤又可导致凝血因子产生增加,抗凝因子产生减少,纤溶活力下降,抗纤溶活力增强,从而导致血液的高凝状态,甚至血管内凝血,从而进一步使脏器血液灌流量和功能下降[2,3],引起多器官功能障碍,心脏、脑、肝、肾等均可受累。患者各项检验结果提示肝肾功能障碍,头颅CT也提示有脑组织弥漫性的损害。

子痫的预防要从其发病原因出发,定期进行产前检查,若发现胎盘过大,糖尿病、高血压病、胶原血管疾病、多产和高龄产妇,应该及早进行干预和定期监测,若已经出现子痫前期表现要及时就医治疗。本例患者孕期未作定期产前检查,致使疾病发展致最严重阶段(发生子痫),危及孕妇和胎儿生命,因此建立和健全三级妇幼保健网,加强孕产妇的系统管理,定期产检、注意高危妊娠的监测,尤其是妊娠期高血压病,是预防子痫发生的重要措施。子痫一旦发生,病情极其危重,及时有效的治疗是挽救患者及胎儿的重要手段,其处理原则是止痉、镇静、纠正缺氧和酸中毒,控制血压,抽搐后终止妊娠。首选药物是硫酸镁控制抽搐。镇静药物也有助于抽搐的控制。伴有妊娠高血压病者,需控制血压。若出现颅高压的临床表现,加用甘露醇降颅压。在抽搐控制后2 h即可考虑终止妊娠。对于早发性高血压治疗效果较好者,可适当延长孕周,但须严密监护孕妇和胎儿。

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