在293T细胞中检测到了其正确表达,成功感染了人MDS细胞株MUTZ-8且能稳定的表达,国内外尚少见相关报道。为进一步研究RPS14基因在MDS发病发展过程中的作用奠定了良好的实验基础,为寻找MDS新的治疗手段开拓了新思路。

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个案与短篇

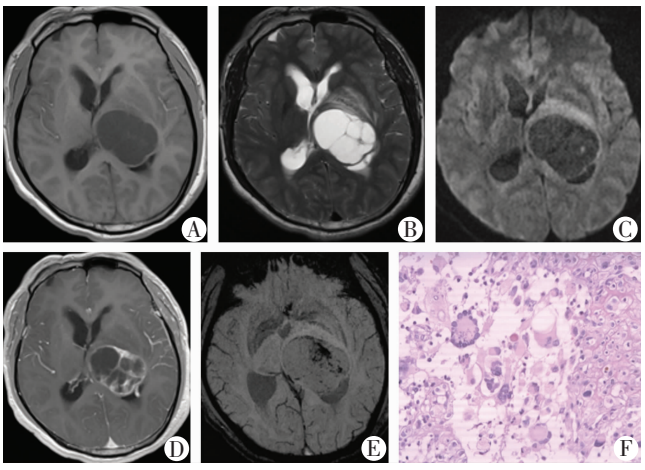
MRI诊断丘脑巨细胞型胶质母细胞瘤1例

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[**关键词**] 巨细胞型胶质母细胞瘤;MRI;丘脑;诊断
[**中图法分类号**] R739.41; R445.2 [**文献标志码**] B

1 临床资料

患者,男性,41岁。因"头昏、右侧肢体无力1周"入我院。近1周出现右下肢无力,头昏、痛,呈胀痛,无眩晕、恶心、呕吐,3 d前出现行走跛行步态。体征:伸舌左偏,右侧下肢远端肌力Ⅳ+级。实验室检查未见异常。MRI检查:左侧丘脑囊实性肿块,以囊性成分为主,囊内见多发分隔,病变境界清楚,边缘尚光滑,大小约5.5 cm×4.9 cm×4.2 cm,左侧基底节区轻度水肿,左侧侧脑室及三脑室受压、变窄,中线结构向右侧移位。信号特点:T_1WI呈等低信号,T_2WI及flair像呈等高信号,DWI示囊壁为等高信号,囊液为低信号,其内见零星点状高信号显示;SWI像肿块内可见小条片状低信号,提示增生血管团;增强扫描囊壁、分隔及壁结节均明显强化。由于病变囊变明显,与侧脑室关系密切且周围水肿较轻,MR诊断为室管膜瘤。入院后第5天在全麻下行左侧三角区入路脑肿瘤切除术,术中所见:肿瘤与脑室及丘脑关系密切,囊性,肿瘤包膜完整,呈白色,切开肿瘤后见其质地较软,易吸除,有部分血供,打开囊腔后见淡黄色囊液流出,行肿瘤大部分切除。术后患者神志清楚,四肢肌力较术前明显好转。病理结果:巨细胞型胶质母细胞瘤(WHO Ⅳ级)(图1)。



A: T_1WI; B: T_2WI; C: DWI; D: 增强扫描; E: SWI; F: 肿瘤组织的光镜观察 (HE ×40)

图1 丘脑巨细胞型胶质母细胞瘤的影像学表现与病理变化

2 讨论

巨细胞型胶质母细胞瘤(giant cell glioblastoma, GC)为胶质

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母细胞瘤的一种少见的亚型[1],发生率不足脑内肿瘤的1%及胶质母细胞瘤5%[2],其临床及影像特点与胶质母细胞瘤均有所差别。病变好发于中老年人,但比多形性胶质母细胞瘤年龄更轻,平均发病年龄42岁[3]。其预后较胶质母细胞瘤更好[4],但如果肿瘤靠近脑室,易沿着脑脊液播散转移[5]。组织起源之前存在较大争议,1970年WHO分类中对本瘤命名采取折中办法,采用了2个名称,即巨细胞型胶质母细胞瘤和怪细胞肉瘤,前者被认为起源于胶质细胞,后者被认为起源于血管。光镜下巨细胞型胶质母细胞瘤由巨大畸形的瘤细胞、小圆形及梭形瘤细胞组成,巨大瘤细胞占优势,直径 > 500μm,核大及核分裂,巨细胞核常为角状,含有明显的核仁。瘤内可见缺血性坏死,瘤内血管丰富,血管内皮增生。免疫组化染色GFAP(+)。

本例患者年龄41岁,与该病发病年龄相符,临床上病程短,进展较快。目前,国内关于巨细胞型胶质母细胞瘤影像诊断报道较少,缺乏较多的诊断经验。本例患者MRI表现为:① 发生于丘脑,与侧脑室关系密切;② 肿瘤呈囊实性,可见较大囊变区,且以囊性为主,信号欠均匀,T_1WI呈等、稍低信号,T_2WI呈等、稍高信号;③ SWI像肿块内可见异常增生血管团;增强扫描壁结节、囊壁及实性部分较均匀明显强化;肿瘤境界清楚,周围水肿较轻。本病例肿瘤位置较深且靠近侧脑室,易误诊为脑室起源的肿瘤,但仔细观察病变,侧脑室为受压改变,且与文献报道的肿瘤可发生于临近脑室的部位一致[5],但也有报道称该病好发于颞叶及顶叶皮层下[2],因此有待大综病例报道予以总结。另外,病变亦表现为体积较大、界限清楚的肿块,特别是病变周围水肿较轻,与文献报道相符。本例加作SWI序列发现有多发增生血管,此种表现可能提示本病为高级别肿瘤。本病需要与以下疾病鉴别:多形性胶质母细胞瘤及间变型星形细胞瘤,它们发病年龄偏大,病灶周边水肿较明显,预后更差;转移瘤,绝大部分具有原发病灶,以灰白质交界处好发,病灶周围水肿明显,增强扫描呈均匀结节样或环状强化;室管膜瘤,常发生于1~5岁及30岁左右年青人,儿童好发于四脑室,成人常发生于侧脑室,增强扫描呈不均匀强化;血管母细胞瘤,病灶常发生于幕下小脑半球,囊壁一般不发生强化,壁结节强化明显且较均匀。本病的临床及影像学有一定的特征,如患者为中老年人,病程较短,脑内发现信号不均匀肿块影,境界清楚,水肿较轻,肿块内见大范围囊变区,增强扫描囊壁、壁结节及实质部分呈均匀明显强化,SWI像见增生血管影,应考虑到巨细胞型胶质母细胞瘤的可能。

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