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个案与短篇

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左肾盂肉瘤样癌1例

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[**关键词**] 肉瘤样癌;肾盂;手术治疗
[**中图法分类号**] R737.1 [**文献标志码**] B

1 临床资料

患者,男性,83岁,于2012年1月11日因"心累、气促2 d"到我院心内科就诊,肾功检查示肌酐升高,转肾内科就诊,肾内科以"慢性肾功能衰竭(氮质血症期)"收住院。患者入院前1个月,因感冒后出现心累、气促,活动后较明显,同时伴有肉眼血尿,遂到当地医院就诊,行超声提示"肾结石",门诊口服"云南白药、消炎药"等,在个体诊所输液治疗3 d,肉眼血尿好转。患者患病以来精神、食欲、睡眠差,大便较干燥,体质量较前减轻3 kg。入院后反复出现血尿,行泌尿系彩超检查提示:①右肾囊肿;②左肾结石,左肾囊肿,左肾中下及肾窦内及上段输尿管内不均质弱回声,考虑为血凝块;③膀胱壁粗糙,导尿球囊附近絮状弱回声,考虑为血凝块。经我科会诊后转我科,行双肾MRI检查(图1A):①左肾下极占位,结合腹部平片,考虑结石可能,建议CT检查;②左肾盂肾盏扩张积水;③双肾囊肿。CT检查(图1B):左肾及左输尿管上段多发结石伴左肾盂肾盏占位;双肾囊肿。6次脱落细胞学检查2次发现癌细胞。左肾盂输尿管逆行造影:左肾结石,左侧肾盂肾盏未见显影。肾小球滤过率(GFR):35.06 ml/min,左肾:10.32 ml/min,右肾:24.74 ml/min。入院肾功能:尿素(14.63 mmol/L),肌酐(181.70 mmol/L),完善相关检查后在腰硬联合麻醉下行左肾盂探查术,术中冰冻结果考虑左肾盂恶性肿瘤伴坏死出血,遂行左肾根治性切除术(因患者及家属拒绝而未切除残余输尿管及部分膀胱),切除的左肾大小正常,上级可见大小约4 cm×5 cm囊肿,肾脏剖面可见肾盂内一大小约1 cm×0.5 cm灰黄色结石,肾盂肾盏有一直径约2 cm新生物,质地脆。术后组织送检免疫组化结果提示左肾盂肉瘤样癌。患者术后恢复良好后出院,出院前2 d肾功能:尿素11.26 mmol/L;肌酐146.90 mmol/L。

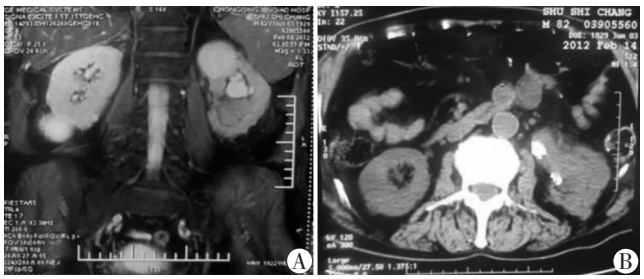
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A:双肾磁共振影像;B:双肾CT扫描
图1 左肾盂肉瘤样癌核磁共振与CT扫描表现

2 讨论

肉瘤样癌最早被认为和癌肉瘤为同一种肿瘤[1],实际上,这2种肿瘤的起源是不一样的。癌肉瘤同时含有上皮成分和肉瘤(软骨肉瘤或横纹肌肉瘤)成分,肉瘤样癌主要起源于上皮成分,但却具有肉瘤的形态学特点。由于二者在形态学上的相似性,显微镜下通过HE染色很难将两种肿瘤区分开来,但免疫组化可将二者区分开;肉瘤样癌能表达上皮细胞的特异蛋白,如细胞角蛋白、EMA等,而不能表达间叶细胞特异蛋白[2]。肉瘤样癌可发生于乳腺、咽喉部、肺和膀胱等不同的器官[3],其预后也各不相同。膀胱的尿路上皮肉瘤样癌约占膀胱肿瘤的0.17%,预后通常较差,而肾盂的尿路上皮肉瘤样癌更是罕见,国内外相关文献报道极少[4];肾盂肉瘤样癌在影像学上无明显特异性,易被诊断为肾盂移行细胞癌,因此,对于其诊断主要依赖于病理检查。有研究认为共表达角蛋白和波形蛋白对诊断肾盂肉瘤样癌非常有用[5]。本例患者肾盂肿瘤免疫组化提示共表达角蛋白和波形蛋白。肉瘤样癌对放疗和化疗都不敏感,因此肾盂肉瘤样癌主要靠手术治疗,虽然手术切除了患侧的肾及肾盂,而且残余的输尿管无瘤,但是残余的输尿管往往是其复发的根源。手术治疗能否改善肾盂肉瘤样癌生存率尚需进一步研究[6]。肉瘤癌患者的预期寿命都比较短,多数患者在诊断后半年内死亡。

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