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个案与短篇

2例消化道穿孔的内镜治疗

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[**关键词**] 消化道穿孔;内镜;钛夹
[**中图法分类号**] R570.5 [**文献标志码**] B

消化道穿孔的发生率较高,包括自发性穿孔及医源性穿孔,其中前者常见于消化性溃疡、肿瘤等;后者常见于内镜诊治过程中,因此对于其治疗甚为重要,临床常采用外科手术治疗[1]。近年来发展一些内镜下治疗消化道穿孔的案例,但目前对于消化道穿孔内镜治疗的文献报道较少见,故本研究以内镜下钛夹治疗消化道穿孔2例治疗过程予以报告。

1 资料与方法

1.1 研究对象

选择2010年7月至2011年10月在我院消化内镜中心内镜诊疗过程中发生的消化道穿孔,且穿孔直径<0.5 cm,既往无糖尿病、结核等基础疾病,平均年龄为61岁患者为研究对象,并征求患者及家属意见后给予内镜下穿孔封闭治疗,共2例。其中1例为门诊患者,71岁男性,乙状结肠穿孔发生在结肠镜检查过程中;另1例为住院患者,50岁,女性,胃穿孔发生在胃底间质瘤内镜下黏膜切除术(endoscopic mucosal resection, EMR)中。

1.2 器械与方法

1.2.1 器械 胃镜、肠镜、金属钛夹。

1.2.2 方法 ①出现穿孔后,在暴露病灶同时少注气或者适当吸气;若局部伴出血,可适当反复充气、吸气后较充分地暴露病变组织,同时必要时可予以局部止血治疗。②将金属钛夹安装于可旋式夹闭器上,并插至内镜前端后拉塑料外套管,露出钛夹。③缓慢地收紧,使夹子充分张开至最大角度,并根据病灶具体位置将夹子方向进行旋转,同时调整内镜最终使夹子与病灶呈垂直方向接触,确保夹子接触两侧黏膜后收紧钛夹,取出置放器。④根据病灶大小决定放置钛夹数量及方式。

2 结果

2例患者经内镜下钛夹封闭治疗后(图1)住院给予常规禁食禁饮、抑酸、止血、抗感染、营养支持、补液等治疗。并完善血常规、腹部彩超等检查。两患者平均住院时间为8 d,均好转出院。肠穿孔患者出院后2个月来我院门诊随访并复查肠镜;胃穿孔患者出院后15 d来我院门诊复查胃镜,且两者内镜下均未见明显异常(图2)。

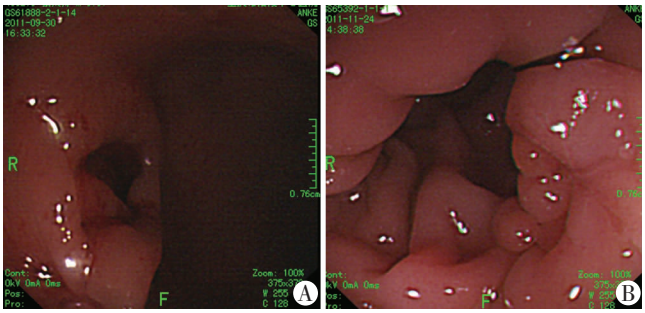
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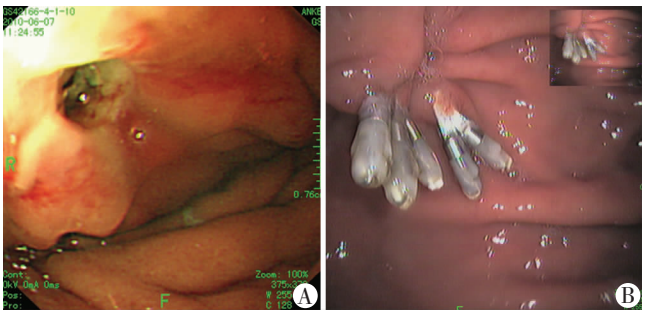
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A:结肠镜检查中穿孔表现;B:钛夹治疗2个月后肠镜观察

图1 结肠镜检查中穿孔治疗前后观察



A:胃底间质瘤EMR术中穿孔表现;B:钛夹治疗15 d后胃镜观察

图2 胃底间质瘤患者EMR术中穿孔治疗前后观察

3 讨论

胃肠道穿孔最常见原因是消化性溃疡,其次是内镜治疗出现的并发症。目前EMR及内镜下黏膜剥离术(endoscopic submucosal dissection,ESD)的内镜治疗早期消化道原位癌、有蒂或无蒂息肉等已在各基层医院较为广泛运用,其中ESD治疗中出血、穿孔的风险大,操作难度较高。不论采取何种预防措施,EMR或ESD导致的穿孔仍不能完全避免,因此掌握内镜下及时有效的补救措施尤为重要。除此以外,内镜检查尤其是结肠镜检查过程中,肠穿孔的发生率随着基层医院内镜技术的不断开展呈上升趋势[2]

胃肠道空腔脏器自发性或医源性穿孔传统的方法是外科手术修补;同时极少数胃十二指肠较小的包裹性穿孔可采用非手术保守治疗。近年来,有研究[3]对胃肠道穿孔的外科手术治疗及内镜治疗进行分析比较,消化道穿孔内镜治疗也存在各种弊端,其治疗成功率主要受穿孔部位、直径,穿孔发生与治疗的时间间隔,术者的技术水平及熟练程度等因素影响。对于医源性穿孔来说其消化道较清洁,发现较及时,病灶炎症反应及水肿较轻,内镜下治疗效果较好。消化性溃疡所致的穿孔,组织水肿、脆性增加、其周围分泌物较多,因此治疗上较前者困难,24 h复查内镜显得十分重要,必要时可再次行内镜治疗。

有学者报道可经内镜在胃肠道瘘口注射生物纤维胶治疗难治性内瘘及外瘘,可达到75%的治愈率。有学者在体外动物实验中设计出内镜封闭装置模型对结肠穿孔进行修补。Sumiyama等[4]设计出使较大胃穿孔全层组织对合性缝合的可曲套管针锚状组织固定装置在动物实验阶段获得预期结果。目前应用最为广泛的是通过内镜下金属钛夹或尼龙绳结扎法治疗闭合穿孔[5]。对于食管良性穿孔还可通过内镜下带膜记忆金属支架植入。

我科已成功完成了数例胃肠医源性穿孔的内镜治疗,注意到在行钛夹或尼龙绳封闭穿孔时务必有较完整的组织支撑,避免出血及穿孔,且可根据穿孔直径选择封闭方式,一般情况下,对于直径>0.5 cm的较大穿孔可通过从裂口两端向中间逐步封闭的方式治疗。且术后常规禁食禁饮、抗感染治疗,减轻病变部位的炎症反应及水肿程度,减少钛夹脱落发生率。

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