kinase inhibitor response duration in patients with non-small-cell lung cancer[J]. J Clin Oncol, 2012, 30(4): 433-440.
[5] Oxnard G R, Arcila M E, Sima C S, *et al*. Acquired resistance to EGFR tyrosine kinase inhibitors in EGFR-mutant lung cancer: distinct natural history of patients with tumors harboring the T790M mutation [J]. Clin Cancer Res, 2011, 17(6): 1616-1622.
[6] Yatabe Y, Matsuo K, Mitsudomi T. Heterogeneous distribution of EGFR mutations is extremely rare in lung adenocarcinoma[J]. J Clin Oncol, 2011, 29(22): 2972-2977.
[7] Zhou Q, Zhang X C, Chen Z H, *et al*. Relative abundance of EGFR mutations predicts benefit from gefitinib treatment for advanced non-small-cell lung cancer[J]. J Clin Oncol, 2011, 29(24): 3316-3321.
[8] Jiang S X, Yamashita K, Yamamoto M, *et al*. EGFR genetic heterogeneity of nonsmall cell lung cancers contributing to acquired gefitinib resistance[J]. Int J Cancer, 2008, 123(11): 2480-2486.
[9] 韩如冰,钟巍,赵静, 等. 晚期肺腺癌患者化疗前后血清EGFR基因突变状态的比较[J]. 中国肺癌杂志,2011,14(2):127-131.
[10] Soda M, Choi Y L, Enomoto M, *et al*. Identification of the transforming EML4-ALK fusion gene in non-small-cell lung cancer[J]. Nature, 2007, 448(7153): 561-566.
[11] Choi Y L, Soda M, Yamashita Y, *et al*. EML4-ALK mutations in lung cancer that confer resistance to ALK inhibitors[J]. N Engl J Med, 2010, 363(18): 1734-1739.
[12] Shaw A T, Yeap B Y, Solomon B J, *et al*. Effect of crizotinib on overall survival in patients with advanced non-small-cell lung cancer harbouring ALK gene rearrangement: a retrospective analysis[J]. Lancet Oncol, 2011, 12(11): 1004-1012.
[13] Pirker R, Pereira J R, Szczesna A, *et al*. Cetuximab plus chemotherapy in patients with advanced non-small-cell lung cancer (FLEX): an open-label randomised phase Ⅲ trial[J]. Lancet, 2009, 373 (9674): 1525-1531.
[14] Pirker R, Pereira J R, von-Pawel J, *et al*. EGFR expression as a predictor of survival for first-line chemotherapy plus cetuximab in patients with advanced non-small-cell lung cancer: analysis of data from the phase 3 FLEX study[J]. Lancet Oncol, 2012, 13(1): 33-42.
[15] Sandler A, Gray R, Perry M C, *et al*. Paclitaxel-carboplatin alone or with bevacizumab for non-small-cell lung cancer[J]. N Engl J Med, 2006, 355(24): 2542-2550.
[16] Reck M, von-Pawel J, Zatloukal P, *et al*. Phase Ⅲ trial of cisplatin plus gemcitabine with either placebo or bevacizumab as first-line therapy for nonsquamous non-small-cell lung cancer: AVAil[J]. J Clin Oncol, 2009, 27(8): 1227-1234.
[17] Shi H, Huang Y, Zhou H, *et al*. Nucleolin is a receptor that mediates antiangiogenic and antitumor activity of endostatin[J]. Blood, 2007, 110(8): 2899-2906.
[18] Chen Y, Wang S, Lu X, *et al*. Cholesterol sequestration by nystatin enhances the uptake and activity of endostatin in endothelium *via* regulating distinct endocytic pathways[J]. Blood, 2011, 117(23): 6392-6403.
[19] Kris M G, Johnson B E, Kwiatkowski D J, *et al*. Identification of driver mutations in tumor specimens from 1, 000 patients with lung adenocarcinoma: The NCI's Lung Cancer Mutation Consortium (LCMC)[J]. J Clin Oncol, 2011, 29(Suppl): CRA7506.
[20] Tsimberidou A M, Iskander N G, Hong D S, *et al*. Personalized Medicine in a Phase Ⅰ Clinical Trials Program: The M D Anderson Cancer Center Initiative[J]. Clin Cancer Res, 2012, [Epub ahead of print].

(**收稿**:2012-06-26;**修回**:2012-07-22)
(编辑 王 红)

个案与短篇

文章编号:1000-5404(2012)20-2038-01

银屑病关节炎伴高热、全身淋巴结肿大1例

姚血明[1],唐 芳[1],黄 颖[1],王致宝[2],钟 琴[1],马武开[1]
(550001 贵阳,贵阳中医学院第二附属医院风湿免疫科[1];550100 贵州 罗甸,罗甸县中医医院内科[2])

[**关键词**] 银屑病关节性;高热;淋巴结;肿大
[**中图法分类号**] R758.63 [**文献标志码**] B

银屑病关节炎(psoriatic arthritis,PsA)是一种慢性全身性自身免疫疾病,多呈隐袭发病,临床表现广泛,个体差异明显,容易延误诊断[1],为提高临床医师对该病的认识,现将我院诊治的1例PsA患者报告如下。

1 临床资料

患者男性,21岁,因"反复四肢关节肿痛4年,皮疹1年,加重伴发热10 d"入院。4年前因双膝、双踝对称性肿痛,在院外考虑为类风湿关节炎,予非甾体类抗炎药、强的松等不规律治疗,关节肿痛可减轻,但时有反复。2年前上述症状加重就诊我院,查体:腰臀部及双膝、双踝疼痛,右踝肿胀,腰僵,双4字试验阳性,HLA-B27阳性,骶髂关节CT示双侧骶髂关节面模糊,右侧骶髂关节狭窄,诊断为强直性脊柱炎,予以甲氨蝶呤、柳氮磺胺吡啶及双氯芬酸钠治疗,病情逐渐缓解后自行间断用药维持。1年前出现全身散在红色团块状皮疹,上覆鳞屑,继续予以甲氨蝶呤、柳氮磺胺吡啶治疗,皮疹好转后半年前自行停药。10 d前关节疼痛、皮疹加重,伴发热(体温38~39 ℃),在当地卫生院输液(青霉素、病毒唑等)治疗,病情加重,医师怀疑其患禽流感于2009年2月6日转入我院。

[**通信作者**] 马武开,E-mail:walker55@163.com

(下转2050页)

床观察[J]. 实用癌症杂志, 2008, 23(4): 402-405.
[9] Lee Y J, Choi H J, Kim S K, *et al*. Frequent central nervous system failure after clinical benefit with epidermal growth factor receptor tyrosine kinase inhibitors in Korean patients with nonsmall-cell lung cancer [J]. Cancer, 2010, 116(5): 1336-1343.
[10] Lynch T J, Bell D W, Sordella R, *et al*. Activating mutations in the epidermal growth factor receptor underlying responsiveness of non-small-cell lung cancer to gefitinib[J]. N Engl J Med, 2004, 350(21): 2129-2139.
[11] Zhou Q, Zhang X C, Chen Z H, *et al*. Relative abundance of EGFR mutations predicts benefit from gefitinib treatment for advanced non-small-cell lung cancer[J]. J Clin Oncol, 2011, 29(24): 3316-3321.
[12] Gridelli C, Ciardiello F, Gallo C, *et al*. First-Line Erlotinib Followed by Second-Line Cisplatin-Gemcitabine Chemotherapy in Advanced Non-Small-Cell Lung Cancer: The TORCH Randomized Trial[J]. J Clin Oncol, 2012, 30(24): 3002-3011.
[13] Maemondo M, Inoue A, Kobayashi K, *et al*. Gefitinib or chemotherapy for non-small-cell lung cancer with mutated EGFR[J]. N Engl J Med, 2010, 362(25): 2380-2388.
[14] 王燕, 王颖, 王彬, 等. 吉非替尼治疗非小细胞肺癌脑转移的初步结果[J]. 中国肺癌杂志, 2006, 9(5): 447-451.
[15] Park S J, Kim H T, Lee D H, *et al*. Efficacy of epidermal growth factor receptor tyrosine kinase inhibitors for brain metastasis in non-small cell lung cancer patients harboring either exon 19 or 21 mutation[J]. Lung Cancer, 2012, 77(3): 556-560.
[16] Fekrazad M H, Ravindranathan M, Jones D V Jr. Response of intracranial metastases to erlotinib therapy[J]. J Clin Oncol, 2007, 25(31): 5024-5026.
[17] Freilich R J, Seidman A D, DeAngelis L M. Central nervous system progression of metastatic breast cancer in patients treated with paclitaxel[J]. Cancer, 1995, 76(2): 232-236.
[18] Crivellari D, Pagani O, Veronesi A, *et al*. High incidence of central nervous system involvement in patients with metastatic or locally advanced breast cancer treated with epirubicin and docetaxel[J]. Ann Oncol, 2001, 12(3): 353-356.
[19] Gridelli C, Bareschino M A, Schettino C, *et al*. Erlotinib in non-small cell lung cancer treatment: current status and future development[J]. Oncologist, 2007, 12(7): 840-849.

(**收稿**:2012-07-05;**修回**:2012-07-25)
(编辑 王 红)

(上接2038页)

查体:体温39.7 ℃,双侧颌下、颈部、枕后、双侧腋窝、双侧腹股沟可扪及数个花生米到鸽蛋大小的淋巴结,质软,表面光滑,无粘连,深压痛,四肢及躯干散在分布红色团块状皮疹,上覆鳞屑,刮开后可见刮蜡样皮肤及点状出血。心肺阴性,脾脏于左肋下2指扪及肿大,质稍硬,无压痛,双腕及双手近端指间关节压痛,无明显红肿。查血常规:白细胞21.99×10^9/L,分类中性粒细胞0.927,C反应蛋白(CRP)112.50 mg/L,血沉(ESR)48 mm/h,类风湿因子(RF)、肝炎标志物及结核抗体阴性,胸片正常,腹部CT示脾大、左侧腹膜后增大淋巴结影。入院后持续发热,最高时体温可达40.9 ℃,查血培养无异常,颈部淋巴结活检病理呈反应性增生,骨髓穿刺示骨髓粒系增生。诊断为PsA,予以甲基强的松龙40 mg/d、来氟米特、甲氨蝶呤治疗,体温恢复正常,关节疼痛缓解,皮疹减轻,甲基强的松龙逐渐降至30 mg/d后,改口服强的松30 mg/d,1个月后四肢及躯干红色团块状皮疹好转,呈脱屑样,刮开后可见正常皮肤,全身浅表淋巴结肿大消失,脾脏无肿大,血常规、ESR、CRP正常。出院后逐渐减停强的松,口服甲氨蝶呤、来氟米特,半年后停用来氟米特,口服甲氨蝶呤维持,随访3年,已停用甲氨蝶呤,现病情稳定。

2 讨论

PsA是一种与银屑病相关的关节炎或脊柱关节病,美国风湿病学会在1964年已把PsA作为一种独立的风湿免疫病[2]。一般认为在PsA中皮疹先于关节炎的约为70%,皮疹和关节炎同时发病(1年内)的约为15%,而关节炎先于皮疹1年以上的约为15%,RF多为阴性,实验室检查中也没有确诊PsA的指标,关节炎在皮疹之前出现使诊断十分困难。因此对于RF阴性,而ESR、CRP提示炎症存在的关节炎患者,应警惕PsA的可能,采集病史和查体中应注意寻找相关特征性的症状及体征。该患者出现关节炎3年后才出现皮疹是其被误诊的主要原因,后期因不规范治疗,自行停药后出现高热、全身淋巴结肿大较为特殊,结合淋巴结活检病理呈反应性增生,考虑可能与患者体内过强的自身免疫反应导致免疫反应过度有关。PsA是一种慢性进行性疾病,病程中缓解与加重交替,治疗上要规范并注意防止复发,目前关于PsA的治疗仍缺乏全面的循证医学证据,目标就是要达到PsA最小疾病活动度[3]。对于周围关节炎型PsA治疗方法、疗效评估基本参照类风湿关节炎的"目标治疗"策略,轻度患者建议使用非甾体抗炎药或关节腔内注射糖皮质激素;上述治疗无效或中重度患者建议早期积极使用传统的DMARDs或TNF-α抑制剂;不同于治疗类风湿关节炎的是不建议使用金制剂、氯喹、羟氯喹及全身使用糖皮质激素[4]。

参考文献:

[1] Congi L, Roussou E. Clinical application of the CASPAR criteria for psoriatic arthritis compared to other existing criteria[J]. Clin Exp Rheumatol, 2010, 28(3): 304-310.
[2] Blumberg B S, Bunim J J, Calkins E, *et al*. ARA nomenclature and classification of arthritis and rheumatism (tentative)[J]. Arthritis Rheum, 1964, 7: 93-97.
[3] Coates L C, Fransen J, Helliwell P S. Defining minimal disease activity in psoriatic arthritis: a proposed objective target for treatment[J]. Ann Rheum Dis, 2010, 69(1): 48-53.
[4] 赵岩, 金丽霞. 应规范银屑病关节炎的诊断和治疗[J]. 中华风湿病学杂志, 2011, 15(6): 361-364.

(**收稿**:2012-06-05;**修回**:2012-08-01)
(编辑 吴培红)