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经验交流

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体位压迫预防肝穿刺活组织检查术后出血173例观察

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[**关键词**] 肝活检;体位压迫;预防出血;护理
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肝穿刺活组织检查术有时会引起腹腔内大出血,是术后引起死亡的主要原因。以往预防肝活检术后出血的主要措施为采用腹带和沙袋压迫的方法,但这种护理方法不仅部分限制了患者的活动,使患者不适,且易出现穿刺点疼痛、腰背酸痛、排尿困难等情况,且仍有少部分患者发生出血,国外报道出血的发生率为0.4%~5.3%[1-2],国内报道为0.6%[3],因此探索新的预防出血的方法甚为必要。我院于2010年10月至2012年12月对173例患者进行了肝活检,通过体位压迫替代沙袋、腹带的护理方法,无1例发生出血,且患者舒适度好,现报告如下。

1 资料与方法

1.1 临床资料

2010年10月至2012年12月在我院为明确诊断病情实施肝穿刺患者173例,其中CT引导下穿刺32例,彩超引导下穿刺141例。其中慢性乙型肝炎78例,肝癌25例,自身免疫性肝病22例,药物性肝损害9例,肝脓肿8例,脂肪肝8例,肝硬化7例,淤胆型肝炎2例,急性病毒性肝炎2例,肝包虫病1例,肝豆状核变性1例,慢性丙型肝炎1例,未见异常者9例。其中男性99例,女性74例,年龄15~80岁,平均43.0岁。所有患者均具备肝脏活检的适应证。

1.2 方法

患者取仰卧位,身体右侧靠床沿,右臂上举置于枕后,穿刺点一般取右侧腋中线第8~9肋间或较突出的肝叶病灶处(减弱回声或无回声区)。常规消毒局部皮肤、铺巾后,在彩超或CT定位下,用2%利多卡因局部麻醉,将穿刺针推进至肝包膜,嘱患者深吸气后深呼气末屏气5 s,再次在彩超或CT引导下采用一次性活检枪(美国巴德 Ref. MC1416)快速打枪,钳取出肝组织条即拔针。拔针后立即以无菌纱布按压针眼5~10 min,然后彩超或CT检查肝脏是否有出血,确认无出血,穿刺点局部用安尔碘消毒,再予创可贴覆盖。将穿刺获得的肝活组织条注入10%甲醛固定液标本瓶中及时送检。

1.3 护理

1.3.1 术前心理疏导 术前向患者强调体位护理对预防术后出血的作用,反复说明其重要性,多和患者沟通,指导患者做呼吸屏气训练、床上排便等,针对患者情况强化健康宣教。

1.3.2 术后体位压迫护理 患者术后返回病房途中给予俯卧位,安全返回病房后协助取右侧卧位:双上肢屈肘,左手放于胸前,右手放于枕旁。右腿伸直,左腿屈曲并用软枕或靠垫至与同侧髋部等高或略低。右侧卧位可以使肝脏穿刺点利用肝

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脏自身的重力作用,直接压迫在右季肋部,起到体位压迫预防出血的目的。患者右侧卧位 2 h 后可将床头抬高 30°卧床休息:患者双上肢放于躯体两侧,双下肢伸直或屈曲,将枕头放于膝关节下使腿屈曲,或两腿原样伸展,成自由放置于舒适体位。此体位对循环、呼吸影响小,而且患者也感舒适。

1.3.3 病情观察 术后 24 h 重点观察穿刺点出血、疼痛、排尿困难、腰背酸痛等。指导患者可在床上适当活动双下肢或按摩,但不可坐起,尽量避免体位改变幅度过大及频繁改变体位,24 h 后可下床活动,针对性宣教,保持患者心情舒畅。

2 结果

173 例患者穿刺成功率为 100%,均取得理想肝组织标本。术后无 1 例出血和发热,无其他如肝包膜下出血、胆汁性腹膜炎、血气胸等严重并发症。肝穿后疼痛是最常见并发症,发生率由于评价标准的不同而异。本组 3 例感疼痛较剧,同时感胸闷、心悸,给予吸氧、变换体位等处理后逐渐缓解;其余局部疼痛感较轻,未预特殊处理。2 例有轻微恶心感,未予特殊处理后均逐渐缓解。

3 讨论

肝活检术后出血是最危险的并发症,如何预防出血是肝活检过程中必须解决的关键问题。引起肝活检术后出血的原因多与穿刺者的操作技术有关,如动作粗暴、穿刺过深等、也与患者心情紧张,配合欠佳、穿刺过程中身体移位或穿刺局部有肝硬化结节、肿瘤等因素有关。在护理方面,频繁改变体位、剧烈运动、过早下床活动等均为引发出血的重要因素。传统的肝活检术护理常规为术后 24 h 绝对卧床,沙袋局部压迫 6 h,腹带包扎 24 h,此方法部分限制了患者的活动,使患者不适,且易出现穿刺点疼痛、腰背酸痛、排尿困难等情况。右侧卧位可以使肝脏穿刺点利用肝脏自身的重力作用,直接压迫在右季肋部,起到体位压迫预防出血的目的[4]。本组通过对 173 例采用体位压迫肝活检患者的观察,无 1 例有术后出血等并发症的发生,表明体位压迫有益于肝活检术后出血的预防,并通过体位压迫替代沙袋、腹带的作用,更有利于及时发现病情变化。良好的体位不仅可使患者感到舒适,还可缓解患者的症状。体位压迫护理较肝活检术后传统的护理方法更加简便、易行,减轻患者痛苦,值得临床推广应用。

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