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个案与短篇

外伤性肾假性动脉瘤1例

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[**关键词**] 假性动脉瘤;肾外伤;CTA
[**中图法分类号**] R816.2 [**文献标志码**] B

假性动脉瘤(pseudoaneurysm,PSA)为各种原因导致血管损伤,血液自血管破裂口流出在动脉周围组织间隙内形成血肿,动脉瘤壁由动脉外膜和局部血管破裂形成的血肿及周围结缔组织构成,并与动脉腔相通,而无真正的动脉壁结构[1]。肾假性动脉瘤临床少见[2],分肾外型和肾内型两类,以肾内型多见。本院收治1例,报告如下。

1 临床资料

患者,男性,56岁。2012年1月26日患者因高处坠落致腰背部疼痛15 d,加重伴肉眼血尿1 d,于2012年2月10日到我院急诊科就诊。患者行常规治疗7 d后,仍诉血尿不止。体格检查:神志清楚,轻度贫血貌,左肾区叩击痛(+),胸廓挤压征(+)。实验室检查:血常规:白细胞(WBC)11.43×10^9/L,血小板(PLT)331×10^9/L。凝血5项:纤维蛋白原(Fib)4.73 g/L。影像检查:2012年2月10日CT显示:左肾中下份可见新月形稍高密度影,CT平均值60 Hu,增强后无强化,临近肾皮质断裂,肾实质见不均匀低密度影,近肾盂处可见结节状异常强化影,直径7 mm。2012年2月17日患者复查CT显示:近肾盂处异常强化影明显增大,直径17 mm。2012年2月19日CT血管成像(computed tomography angiography,CTA)显示:左肾中下份可见球形高密度影,由左肾动脉前支下段发出。冠状位及矢状位重建:显示部分瘤体进入肾盂。2012年2月19日肾动脉造影术:左肾中下份可见团状造影剂外溢,其内可见涡流征象。确诊为左肾中下份外伤性动脉瘤并行左肾假性动脉瘤栓塞术治疗,术后恢复良好。

2 讨论

肾假性动脉瘤通常由于创伤,或者由于医源性伤害,如经皮肾活检、内窥镜结石手术、经皮肾镜取石术、局部肾切除术等[3]引起,患者通常症状不明显,但有危及患者生命的自发性出血的潜在危险[4],及早的影像学诊断显得尤为重要。

影像学检查主要依靠CT、彩色多普勒超声及肾动脉造影,磁共振成像(magnetic resonance imaging,MRI)应用较少。肾假性动脉瘤在彩超上表现为肾实质或肾窦内的无回声区,其内有丰富的血流信号。CT表现为在增强后瘤体明显强化,与同层大血管强化一致,呈结节状或球形,多位于肾门及肾窦内,CTA能显示瘤体及供血动脉。肾动脉造影敏感性和特异性高,能够直接显示动脉瘤部位与血管的关系,同时进行栓塞治疗。

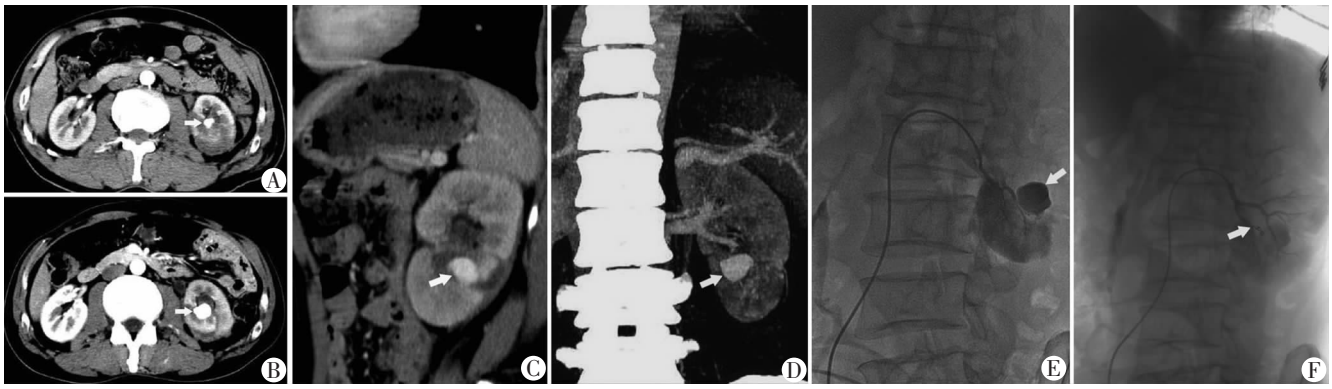
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(上接425页)



A: 入院时,左肾中下份近肾盂处动脉瘤;B:常规治疗7 d后,瘤体明显增大;C:矢状位显示动脉瘤进入肾盂;D:CTA显示瘤体及供血动脉;E、F:肾动脉造影栓塞治疗前、后显示动脉瘤及其血供情况

图1 肾外伤性动脉瘤患者常规治疗及栓塞治疗前后的对比观察

本例患者为典型的外伤后假性动脉瘤,在CTA上呈典型表现,并发肾挫裂伤伴肾包膜下血肿,瘤体入院时较小,常规治疗7 d后复查瘤体明显增大,于2012年2月19日行左肾假性动脉瘤栓塞术治疗。对明确外伤史并有肾实质挫伤或挫裂伤患者,增强CT见到肾实质或肾盂内点状或结节状异常强化影,强化程度与同层大血管相当时,当考虑此病,并行CTA检查。彩色多普勒超声,在显示全肾动脉的走形及病变动脉与瘤体的空间关系上不如CTA。肾动脉造影术为假性动脉瘤诊断的金标准,属有创性检查,且费用较高,一般不用于常规诊断[5]。CTA通过不但能清晰的显示全肾动脉的走形,而且能直观显示瘤体及瘤体与病变动脉间的空间关系,有的患者可能存在肾动脉变异或畸形,CTA能够及时准确的发现,从而为介入治疗或者临床干预提供准确和详细术前的影像资料,且对于治疗后效果评估和随访具有重要价值,故CTA应作为早期诊断此类疾病的首选。

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