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经验交流

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慢性硬膜下血肿开颅血肿清除并包膜切除术4例临床分析

陈才华,江 川,蔡 敬 (401220 重庆,重庆市长寿区人民医院神经外科)

[**关键词**] 慢性硬膜下血肿;开颅手术;包膜切除术
[**中图法分类号**] R651.15 [**文献标志码**] B

慢性硬膜下血肿(chronic subdural hematoma, CSDH)在临床上较为常见,但伴有厚壁者由于血肿壁坚厚,脑组织受压时间较长,脑复张欠佳,残腔积液、积气和血肿复发常见,在处理上更复杂[1]。我院从2008年1月至2012年6月,共收治慢性硬膜下血肿65例,其中61例行慢性硬膜下血肿钻孔引流术。另4例因术前CT提示血肿包膜增厚,手术行开颅血肿清除并包膜切除,均治愈出院,现报告如下。

1 资料与方法

1.1 基本情况

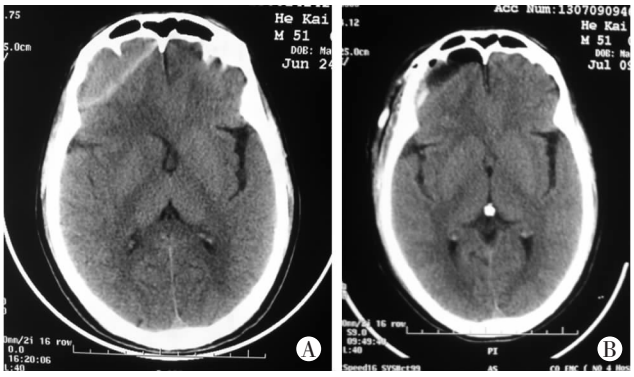
本组男性3例,女性1例,平均年龄65岁,有明确头部外伤史3例,外伤至入院6~11个月;外伤史不明确者1例。术前均无意识障碍,头痛2例,行走不稳1例,反应迟钝1例。头颅CT提示右侧额部、右侧额颞顶血肿各1例;左侧额颞顶血肿2例。血肿量平均67(40~90) mL。血肿呈等或稍低密度改变,形态略呈棱状,包膜增厚明显,增厚内膜表现为脑界面1条弧形线状高密度影。

1.2 手术方式

4例均在全麻下行开颅血肿清除并包膜切除。手术作成形皮瓣起骨瓣开颅。由于CSDH往往较大,皮骨瓣常难以完全覆盖血肿区,故皮骨瓣以血肿中心区域为主,包括血肿范围2/3的面积,以便既能减少手术创伤又能有效清除血肿及包膜。术中见硬膜暗红色,明显增厚2~3 mm,质韧;血肿液呈酱油色,黏稠;血肿腔内壁光滑,质脆软,部分有黄褐色沙粒样组织,与硬膜交界处移行完整。手术先切开一小孔,缓缓排出积血,待颅内压稍降后瓣状切开硬膜及紧贴其下的血肿外膜,一并翻开可以减少渗血。手术清除血肿并部分包膜切除,内侧包膜与脑组织疏松连接,较易分离。术毕回纳骨瓣,放置引流2~3 d。

2 结果

2例患者手术行慢性硬膜下血肿开颅包膜切除后血肿清除满意,包膜消失。1例术后脑组织复张较差,少量积血,7 d头颅CT复查见脑组织复张好,血肿完全消失。1例术后少量硬膜下积液患者随访3个月逐步吸收。随访1年,4例患者均未遗留神经系统缺失体征。患者手术前后CT表现见图1。



A:手术前 血肿略呈棱形,脑界面有明显的包膜;B:手术后 血肿及包膜消失

图1 右额慢性硬膜下血肿手术前后CT表现

3 讨论

虽然钻孔引流被认为是CSDH首选的治疗方法,但对于厚壁血肿效果不佳。厚壁CSDH一般认为是由于血肿形成时间过长,反复少量出血使血肿壁产生无菌性炎症、机化,引起血肿

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[**通信作者**] 陈才华,E-mail:2267411307@qq.com
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壁增厚所致。局部炎性反应在CSDH的发生、发展过程中起重要作用,其常常出现在疾病的早期,并具有始动作用[2-3]。本组3例有明确头部外伤史,且外伤致发病6~11个月,为厚壁CSDH的形成提供了条件。CT对机化的血肿有较高的诊断价值,而包膜较厚的患者CT扫描有一定局限性,但从本4例中可以发现一些诊断线索,即血肿形态略呈棱状而不同于硬膜下血肿特有的新月状,且血肿与脑界面有一条弧形线状高密度影。CSDH机化或包膜增厚者,需开颅手术清除血肿并切除包膜。Park等[4]和刘峥等[5]报道通过切除CSDH外膜治疗钻孔引流失败的患者有较好疗效。不过,也有作者认为CSDH单纯外膜切除术后残腔难以消除,主要原因不在于脑膨出困难,而是在于内膜对脑组织的包裹压迫作用。通过内膜切开,解除了内膜对脑的包裹压迫作用,有利于脑膨出,从而缩小残腔,减少残留积气积液现象,使得脑功能短期内就可明显恢复,从而避免了术后多种并发症及后遗症的发生[6]。但由于血肿范围常很大,包膜紧贴皮层,外膜新生血管丰富,与硬脑膜粘连紧密,尤其是血肿腔边缘返折处,强行全切包膜常导致血肿腔积血或脑组织损伤等手术并发症。许红旗等[7]对36例该类患者行包膜切除后,发现10例因可能的脑皮质损伤致临床症状加重。根据本组4例,我们认为内膜的切除和范围应根据血肿的部位、范围和与脑组织连接紧密程度而定,非功能区、局限、连接疏松应尽量切除,以利于脑组织复位。我们建议术后患者应采用头低位、卧向患侧,多饮水,不用强力脱水剂,必要时适当地补充低渗液体,以保证脑组织的复张。

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