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# 个案与短篇

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## 产前超声诊断胎儿期肾上腺出血2例

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[**关键词**] 肾上腺出血;产前诊断;超声检查,多普勒
[**中图法分类号**] R714.5 [**文献标志码**] B

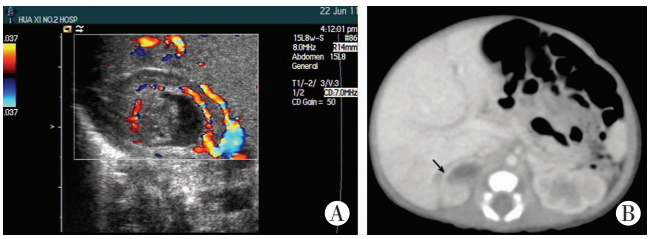
肾上腺出血(adrenal hemorrhage, AH)是由于肾上腺皮质不可逆损伤而致的一种以出血为临床表现的少见疾病,主要依靠影像学检查、临床治疗及随访观察诊断,预后较好,多行保守治疗,极少采取手术治疗。新生儿期AH并不少见,但是国内外鲜有产前诊断胎儿期AH的报道。

### 1 临床资料

病例1采用西门子Sequoia 512彩色多普勒超声诊断仪,线阵探头,频率8.0~15.0 MHz;病例2采用GE E8、Phillips HD11彩色多普勒超声诊断仪,分别为凸阵探头,频率2.0~5.0 MHz及线阵探头,频率3.0~12.0 MHz。因胎儿体位影响超声成像不理想者,嘱孕妇活动15~30 min后再检查;因患儿哭闹不配合检查者,予水合氯醛1~3 mL镇静后,于两侧肋下按冠状、矢状和横断面等多个切面扫查。

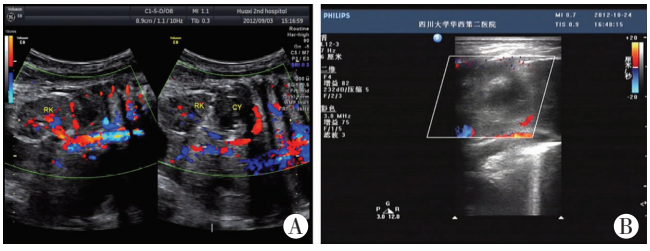
病例1:孕妇25岁,孕2产0,孕前期检查无特殊。孕$22^{+6}$周、孕$30^{+1}$周产前超声检查无特殊。孕$32^{+1}$周因胎膜早破于外院超声检查发现:胎儿右肾与肝脏间见囊性占位,大小约1.6 cm×1.3 cm×1.5 cm,无血流。住院期间发现孕妇肝内胆汁淤滞症。保守治疗后因胎儿窘迫于$33^{+2}$周行剖宫产。女婴出生后1 d于我院复查超声(图1A)见:右肾上腺区囊实性占位,边界清楚,内无血流,周边有环状血流,大小与胎儿期无变化。出生后5 d CT(图1B)见:双侧肾上腺增大,右侧见囊性占位,形态不规则,密度不均匀,可见液液平,前份密度低,后份密度高。超声与CT均提示右肾上腺出血可能性大,未予特殊处理。住院期间伴新生儿肺炎、呼吸性酸中毒、病理性黄疸、心肌损伤,予对症支持治疗后病情好转出院。出生后8个月当地医院复查超声见占位消失。

病例2:孕妇27岁,孕1产0,孕前期检查无特殊。孕$24^{+2}$周、孕$32^{+5}$周产前超声检查无特殊。孕$36^{+2}$周外院超声检查发现胎儿右肝肾间隙一2.4 cm×2.7 cm×2.6 cm囊性占位,壁薄液清,无血流。1周后我院复查超声(图2A)见:胎儿右侧肾上腺区紧贴肾上极囊实性占位,以囊性为主,内见网絮状稍强回声漂浮,无血流,大小无变化。诊断:胎儿右肾上腺出血? 孕妇足月产一女婴。婴儿34 d龄复查超声(图2B)见:右肾上腺区一2.5 cm×2.5 cm×2.3 cm不均质回声团,无血流。临床予保守治疗。出生后5个月当地医院复查超声提示团块较前明显缩小。



A:出生后1 d彩色多普勒超声声像图; B:出生后5 d增强CT图像 箭头示病灶

**图1 胎儿期肾上腺出血病例1彩色多普勒超声和增强CT表现**



A:孕$37^{+2}$周彩色多普勒超声声像图 RK示右肾;CY示囊性病灶;B:出生后34 d彩色多普勒超声声像图

**图2 胎儿期肾上腺出血病例2彩色多普勒超声表现**

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## 2 讨论

肾上腺出血在胎儿期发生率极低,病因尚不清楚。文献报道称可能与解剖有关[1]:胎儿肾上腺体积较大,在妊娠中晚期与肾脏体积接近,在新生儿期约为肾脏的1/3,毛细血管丰富,血管壁菲薄;供给肾上腺血液的3条动脉中只有1条肌层纤维束能产生较大血流阻力的中央静脉引流肾上腺,故任何导致肾上腺静脉压力增高的因素都致毛细血管超负荷产生出血。右侧肾上腺静脉较短,长约4 mm,直接汇入下腔静脉;左侧肾上腺静脉长2~4 cm,与左膈下静脉汇合后注入左肾静脉,故右侧发病率是左侧的3~4倍[2]。另外,围产期胎儿窒息缺氧、酸中毒、应激、凝血机制障碍及维生素K缺乏都可能使血液在新生儿体内向心、脑、肾上腺重新分布,导致出血[1],而胎儿AH高危诱因尚需进一步研究。本组2例均为产前超声诊断病例,出生后进一步检查并长期随访观察,均为女性,右侧单发,与文献报道一致。

胎儿AH常因常规产前超声检查被发现,孕妇无特殊不适,胎儿各超声生物物理指标无特殊,可随访观察或出生后行超声、CT及MRI进一步明确,非手术对症治疗效果好。AH超声声像图有特征性改变:新鲜出血时可表现为囊性团块,随病情病程进展至血凝块形成后可表现为混合性团块,无血流,随访观察可见团块进行性缩小,并产生强回声钙化线或钙化环,直至肾上腺恢复正常形态[3]。本组2例胎儿AH均首次以囊性团块被超声发现,随病情进展二维超声表现为囊实性至不均质实性,彩色多普勒超声均表现为内部无血流,周边有或无血流。产前超声诊断AH需与肾上腺单纯囊肿、肾上腺肿瘤相鉴别,胎儿期单纯囊肿也可在新生儿期演变为肾上腺出血,需长期动态观察以提高诊断准确率[4]。彩色多普勒超声因其简便、无创、无辐射、可重复、实时动态等优点,是新生儿AH诊断的首选影像学检查[5],并在其动态监测中发挥重要作用。

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