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# 个案与短篇

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## 胃血管球瘤CT诊断1例

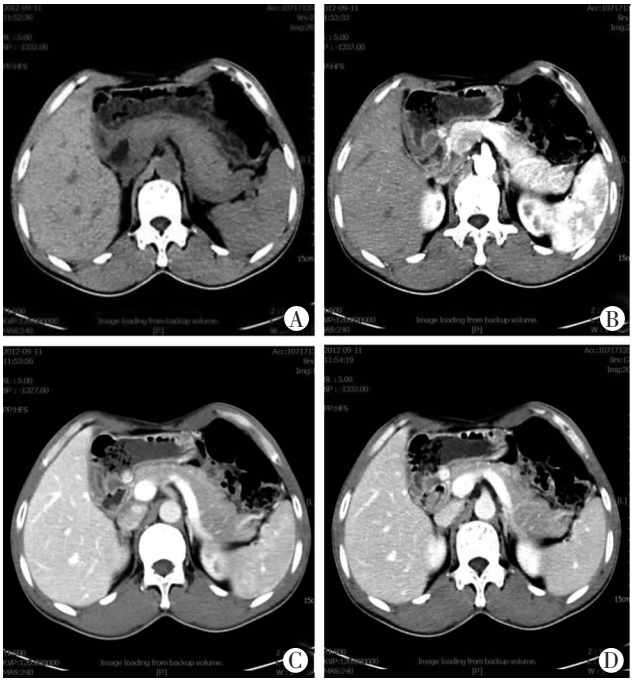
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[**关键词**] 胃;血管球瘤;CT
[**中图法分类号**] R732.2 [**文献标志码**] B

血管球瘤(glomus tumor,GT)是一种少见的软组织肿瘤,原发于胃的血管球瘤更少见,发病率约为同期胃肠间质瘤的1%[1]。我院收治1例,现报告如下。

### 1 临床资料

患者,男性,48岁,10余年前无明显诱因出现上腹部疼痛不适,呈持续性胀痛,伴轻度发热及恶心呕吐,全身乏力,进食后症状有所缓解,无皮肤巩膜发黄,无放射及牵扯痛,无心慌气紧,院外检查后考虑为"胃病",经治疗后疼痛缓解,未进一步诊治,后反复发作;2012年8月上腹部疼痛再次发作,遂于9月9日来我院就诊。自发病以来,患者精神、睡眠可,食欲下降,二便自解,体质量明显减轻。查体:营养较差,腹软,上腹部轻压痛,无肌紧张及反跳痛,未扪及明显包块。实验室检查:血常规、大小便、肝肾功能正常。外院胃镜检查考虑间质瘤可能。我院CT(图1)提示:胃窦小弯黏膜下肌层内见直径约1.0 cm软组织密度结节,平扫CT值为41(30~54) HU,增强扫描明显强化,动脉期CT值为107(82~130) HU,随时间推移持续强化,门静脉期CT值为143(124~158) HU,平衡期CT值为146(126~159) HU。CTA:见结节状肿瘤染色。临床考虑胃窦间质瘤可能性大,于9月17日行"开腹胃间质瘤切除术"。手术所见:在胃窦部后壁触及约2 cm×1.5 cm局限性病灶,边界清楚,质中,移动度好,完整切除病灶。病检:灰褐色不规则组织1块,大小2.0 cm×1.5 cm×1.0 cm,黏膜下见一结节,直径0.8 cm,病理诊断:胃窦血管球瘤。患者术后恢复良好,进食流食后无不适,查体无阳性体征,于2012年9月26日出院。



A:CT平扫横轴位示胃窦小弯侧软组织密度结节影,密度均匀;B:CT增强扫描动脉期横轴位示肿瘤边缘明显强化;C、D:CT增强扫描门脉期及平衡期横轴位示肿瘤呈持续性强化,清楚显示肿瘤位于黏膜下

**图1 胃血管球瘤患者胃部CT表现**

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[**优先出版**] http://www.cnki.net/kcms/detail/51.1095.R.20130910.1812.014.html(2013-09-10)

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综上所述,HO-1可减轻大鼠心肺复苏中全心缺血再灌注引起的心肌损伤,同时抑制炎症因子的释放,其抗炎效应可能是其保护复苏后心肌的机制之一。

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## 2 讨论

血管球瘤是一种起源于血管球细胞的肿瘤,绝大多数是良性,极少数为恶性或潜在恶性,是血管周围球体细胞的肿瘤性增生,属于一种表型转化的特殊平滑肌细胞[2]。多见于成年女性,男女比例约为1∶1.6,发病年龄28~79岁,平均45岁[3]。其好发部位为皮肤、真皮层内,以甲下、指(趾)腹多见,原发于胃的血管球瘤非常罕见[4]。临床症状缺乏特异性,上消化道出血及上腹部疼痛不适为较常见症状,多为偶然发现,表现为单发肿块,直径很少超过3 cm[5],肿瘤多位于胃窦黏膜下或肌层[1]。CT平扫多表现为软组织密度,边界清楚,密度较均匀,偶见钙化[6]。组织学上,因瘤组织内有较多薄壁的血管,故血供丰富,是其增强扫描时明显强化的病理基础,表现为增强扫描早期肿瘤明显强化,延迟扫描持续强化[4]。延迟期扫描肿瘤与肝脏等密度,测量各期CT值,CT增强曲线与下腔静脉、门静脉,甚至降主动脉一致,提示其属于血管源性病变,强化程度显著高于其他良性肿瘤[7]。结合本例及相关文献报道可以看出CT增强扫描时胃血管球瘤具有上述特征,诊断价值较大,也有助于与其他黏膜下及肌层内病变相鉴别。故临床诊断中在发现胃窦部黏膜下或肌层内孤立的富血供肿瘤时,要考虑到胃血管球瘤的可能。鉴别诊断:①胃间质瘤,多位于胃体和胃底,较小的肿瘤密度较均匀,较大者中心易出现囊变、坏死,增强扫描强化程度不如胃血管球瘤。②胃平滑肌瘤,好发于胃体部肌层内,多呈圆形或椭圆形,均匀或不均匀强化,但强化程度亦不如胃血管球瘤。

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