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个案与短篇

原发性额窦癌侵及颅内、眼眶及筛窦1例

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[**关键词**] 原发性额窦癌;鳞癌
[**中图法分类号**] R739.62 [**文献标志码**] B

原发性额窦癌临床十分罕见,其发病率仅为鼻窦恶性肿瘤的0.3%[1]。该病恶性程度高、进展快、预后极差,加之额窦临近解剖结构复杂,手术全切困难,复发率较高[2]。我科于2012年12月收治1例原发额窦癌患者,现报告如下。

1 临床资料

患者,男性,66岁,因"额部肿物进行性增大4个月伴疼痛1个月"入院。患者入院前4个月前额肿胀,无压痛,当时未予以重视。入院前1个月患者自觉肿块逐渐增大伴疼痛,当地医院行头颅CT检查示:左侧额部大小约4 cm×6 cm肿块影,额骨骨质破坏,患者为求诊治转至我院。入院查体:左侧前额见皮下肿物,右侧眶内侧缘、眶外侧缘,左侧眶内侧缘均可触及肿块,质地硬,活动度差。左侧瞳孔直径3.0 mm,光反射灵敏,左眼视力正常;右眼睑下垂,睁眼困难。头颅MRI平扫+增强示:额窦区不规则肿块,呈长T_1长T_2信号,肿块侵犯颅内伴骨质破坏,大小约54 mm×76 mm;左侧额叶见大片不规则水肿信号;MRI增强扫描见肿块明显强化(图1)。鉴于患者前额部颅内外占位伴颅骨破坏,考虑恶性肿瘤或转移癌。2012年12月患者于全麻下行颅内外占位切除术,牵开皮瓣后见下方肿瘤侵及颅骨并侵犯颅内,颅骨破坏约5 cm×6 cm。全切颅外肿瘤并扩大骨窗至正常骨质约7 cm×8 cm。术中探查并切除侵及左侧额叶、筛窦、右侧眶内及上矢状窦肿瘤。肿瘤切除后,双氧水冲洗筛窦,电凝筛窦黏膜,明胶海绵填塞筛窦,并采用颞肌肌肉浆封堵漏口。术后病理报告示:浸润性鳞状细胞癌。术后患者双眼视力正常,双侧对光反射灵敏。术后患者行胸部、腹部CT、盆腔脏器超声筛查未发现其他病灶,术后4周给予放疗(30 Gy/15F)。结合病理、头颅MRI及术后原发灶筛查结果,本例患者最终诊断为原发性额窦癌。术后2个月复查头颅MRI平扫+增强示肿瘤少部分残留,有复发征象(图2),现随访半年,患者带瘤生存。

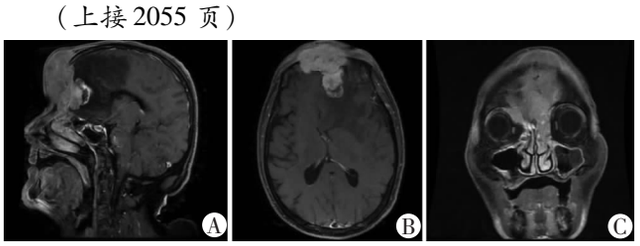
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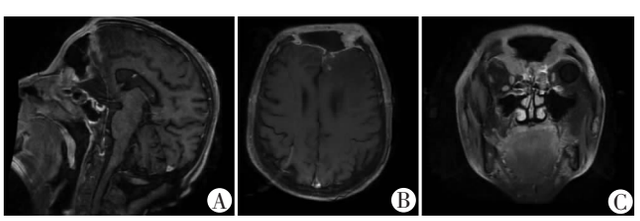
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A:矢状位;B:水平位;C:冠状位

图1 额窦癌患者术前增强头颅MRI表现



A:矢状位;B:水平位;C:冠状位

图2 额窦癌患者术后2个月增强头颅MRI表现

2 讨论

原发性额窦癌多发生于50~60岁,男女比例为5∶1,由于其发病隐匿且无特异性临床症状,早期诊断较困难,使额窦癌患者往往在疾病快速进展时才来就诊。影像学检查可明确肿瘤发源部位和侵及范围,并对手术入路的选择提供重要信息。额窦癌常见病理类型为鳞癌(占所有额窦癌的1/3)、腺癌、基底细胞癌等[3]。

目前临床多采用手术治疗,但额窦及临近解剖结构复杂,加大了手术全切难度,即便采用扩大切除患者预后仍差[4]。本例患者手术次全切实性肿瘤,对侵犯的额骨做扩大切除,切除了侵及额叶和眼眶肿瘤,并在术后辅以放疗。术后2个月复查头颅MRI发现手术切除额骨边缘见多发软组织结节及团块呈明显强化,并侵犯眼眶及两侧筛窦及左侧额叶,考虑肿瘤残留。我们认为额骨边缘多发软组织结节可能因肉眼观察肿瘤边界小于肿瘤实际侵及范围导致手术扩大切除范围不足所致。手术难度大的另一个原因是切除筛窦肿瘤后颅底的重建,本例患者采用自体肌肉浆+生物胶固定修补颅底,效果满意,术后无脑脊液漏发生。在颅底重建时还应注意避免死腔的产生,本病例在术中完全打开筛窦和蝶窦形成引流通道,术后无感染发生,疗效满意。现患者随访半年,仍带瘤生存。

现阶段对额窦癌的临床治疗经验全部来自于个案分析,此病预后极差、复发率较高,带瘤生存也易给患者极大的心理负担。额窦瘤的早期诊断较困难,一般就诊时病变已广泛地侵犯临近结构甚至侵及颅内,对手术切除造成极大困难。我们认为对可疑病例及早行CT或MRI检查以求早期诊断早期治疗,术前尽量明确病变范围及边界,在切除肿瘤基础上行扩大切除。

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