Med Insights Cardiol, 2011, 5: 35 – 40.
[18] Tumelero R T, Duda N T, Tognon A P, *et al*. Prevalence of renal artery stenosis in 1, 656 patients who have undergone cardiac catheterization[J]. Arq Bras Cardiol, 2006, 87(3): 248 – 253.
[19] 张颖, 刘寅, 孙根义, 等. 冠心病患者肾动脉狭窄相关危险因素的分析[J]. 天津医药, 2009, 37(9): 756 – 758.
[20] 徐敏雯, 韦凡平, 袁高辉. 冠脉造影患者中动脉粥样硬化性肾动脉狭窄的临床研究[J]. 浙江医学, 2008, 30(5): 444 – 446.
[21] 汤日宁, 刘必成, 尹莲芳, 等. 冠心病患者肾动脉造影的临床意义[J]. 中华老年医学杂志, 2005, 24(5): 336 – 338.
[22] 王明生, 洪衡, 洪学义, 等. 行冠脉造影患者中肾动脉狭窄的检出率及相关危险因素分析[J]. 中国医药导刊, 2007, 9(6): 464 – 465, 467.
[23] 祖秀光, 崔炜, 武宇洲, 等. 冠状动脉病变与肾动脉粥样硬化性狭窄[J]. 高血压杂志, 2006, 14(6): 458 – 460.
[24] 陈水龙, 王焱, 王挹青, 等. 动脉粥样硬化性肾动脉狭窄的早期发现[J]. 中国动脉硬化杂志, 2004, 12(1): 93 – 95.
[25] Ozkan U, Oguzkurt L, Tercan F, *et al*. The prevalence and clinical predictors of incidental atherosclerotic renal artery stenosis[J]. Eur J Radiol, 2009, 69(3): 550 – 554.
[26] El-Mawardy R H, Ghareeb M A, Mahdy M M, *et al*. Prevalence and predictors of renal artery stenosis in hypertensive patients undergoing elective coronary procedures[J]. J Clin Hypertens (Greenwich), 2008, 10(11): 844 – 849.
[27] Xing D, Nozell S, Chen Y F, *et al*. Estrogen and mechanisms of vascular protection[J]. Arterioscler Thromb Vasc Biol, 2009, 29(3): 289 – 295.
[28] Barton M, Meyer M R, Haas E. Hormone replacement therapy and atherosclerosis in postmenopausal women: does aging limit therapeutic benefits? [J]. Arterioscler Thromb Vasc Biol, 2007, 27(8): 1669 – 1672.
[29] Davidson P M, Mitchell J A, DiGiacomo M, *et al*. Cardiovascular disease in women: implications for improving health outcomes[J]. Collegian, 2012, 19(1): 5 – 13.
[30] Gupta D, Wenger N K. Guidelines for the prevention of cardiovascular disease in women: international challenges and opportunities[J]. Expert Rev Cardiovasc Ther, 2012, 10(3): 379 – 385.
[31] 董晓云, 钱薇薇, 张磊, 等. 超声检测糖尿病患者无名动脉分叉处的临床意义[J]. 科技信息, 2012 (31): 426 – 427.
[32] 姚昆, 白丽. 动脉硬化性肾动脉狭窄临床危险因素分析[J]. 第四军医大学学报, 2009, 30(13): 1216 – 1218.

(**收稿**:2014-02-05;**修回**:2014-05-20)
(编辑 栾 嘉)

文章编号:1000-5404(2014)19-2043-04

个案与短篇

肺类癌误诊为支气管结核 1 例

王文伟,罗 虎,黄 英 (400038 重庆,第三军医大学西南医院呼吸内科)

[**关键词**] 肺类癌;支气管结核;误诊
[**中图法分类号**] R734.2 [**文献标志码**] B

1 临床资料

患者,男性,13 岁,因"间断咳嗽、咳痰近 1 年,加重伴活动后气促 10 余天"于 2014 年 4 月 16 日入住本科。患者于 2013 年 5 月初受凉后出现咳嗽、咳少许白色粘痰,同时左颈部可见直径约 2 cm 肿大淋巴结,伴有胸部隐痛不适,伴有潮热不适,无其他不适,至重庆某儿童医院诊治,行胸部 CT 提示:右肺门淋巴结钙化,右中下肺叶不张,伴相邻胸膜局限性增厚。行纤支镜提示:右中间支气管阻塞(肉芽、结核?)。临床考虑"支气管结核",并予以"异烟肼、利福平、吡嗪酰胺、链霉素"诊断性抗痨治疗。2014 年 4 月初,患者感咳嗽较前明显并出现活动后气促不适,复查胸部 CT 提示右肺病灶较前显著增多,不张范围较前增大,复查纤支镜提示:右中间支气管可见团块样组织阻塞管腔。右中间支气管阻塞(肉芽肿组织? 肿瘤?)。为进一步诊治到我院就诊。

入院后查体:左颈部可扪及一直径约 1 cm 肿大淋巴结,质中,活动度可,表面无压痛及破溃,余全身浅表淋巴结未扪及肿大,正常呼吸,呼吸动度两侧对称,双肺语颤正常两侧对称,右肺叩诊浊音,右肺呼吸音低。实验室检查:血常规:WBC 14.58 × 10^9/L, HGB 110 g/L, Neu% 76.6%;血沉 97.00 mm/h;CEA 3.92 ng/mL;肝肾功、结核 T 细胞斑点实验(T-SPOT)、抗酸染色、大小便常规均正常。行纤支镜检查:右中间支气管被新生物完全阻塞,活检时质硬,不易出血。病理诊断为:(右中间支气管)典型类癌。免疫组化染色:CD56(+), Syn(+), CD68(+), CD34 血管(+), CD3(−), CD20(−), S-100(−), Ki67 阳性细胞数 1%, CK(+), P63(−), TTF1(−), CgA(+), CK8/18(+), SMA(−), Vim(−)。行 PET/CT 等检查进行全身评估后未见确切转移,经多学科会诊后转胸外科,于 2014 年 5 月 6 日行右中下肺癌根治术,手术顺利,术后病理结果:右中下肺叶典型类癌;淋巴结慢性炎症伴反应性增生(图 1)。目前患者已出院,正随访中。

(下转 2047 页)

[**通信作者**] 黄 英, 电话:(023)68765680, E-mail:hga_83@sina.com
[**优先出版**] http://www.cnki.net/kcms/detail/51.1095.R.20140916.1648.003.html(2014-09-16)

teine levels with B vitamins on cardiovascular disease, cancer, and cause-specific mortality: meta-analysis of 8 randomized trials involving 37 485 individuals[J]. Arch Intern Med, 2010, 170(18): 1622 – 1631.

[7] Study of the Effectiveness of Additional Reductions in Cholesterol and Homocysteine (SEARCH) Collaborative Group, Armitage J M, Bowman L, *et al*. Effects of homocysteine-lowering with folic acid plus vitamin B12 *vs* placebo on mortality and major morbidity in myocardial infarction survivors: a randomized trial[J]. JAMA, 2010, 303(24): 2486 – 2494.

[8] Wald D S, Law M, Morris J K. Homocysteine and cardiovascular disease: evidence on causality from a meta analysis[J]. BMJ, 2002, 325(7374): 1202.

[9] Gudrun B, Thomas B, Hanne C, *et al*. Homocysteine and risk of recurrent stroke[J]. Stroke. 2003;34: 1258 – 1261.

[10] Ribo M, Montaner J, Molina C A, *et al*. Admission fibrinolytic profile is associated with symptomatic hemorrhagic transformation in stroke patients treated with tissue plasminogen activator[J]. Stroke, 2004, 35(9): 2123 – 2127.

[11] Keles T, Yeter E, Durmaz T, *et al*. Relation of homocysteine levels with patency and flow rate of infarct-related artery in patients receiving fibrinolytic therapy[J]. Anadolu Kardiyol Derg, 2010, 10(5): 410 – 415.

[12] Kim O J, Hong S H, Oh S H, *et al*. Association between VEGF polymorphisms and homocysteine levels in patients with ischemic stroke and silent brain infarction[J]. Stroke, 2011, 42(9): 2393 – 2402.

[13] Kietadisorn R, Kietselaer BL, Schmidt HH, *et al*. Role of tetrahydrobiopterin (BH4) in hyperhomocysteinemia-induced endothelial dysfuction: new indication for this orphan-drug? [J]. Am J Physiol Endocrinol Metab 2011, 300(6): E1176 – E1178.

[14] Zou C G, Banerjee R. Homocysteine and redox signaling[J]. Antioxid Redox Signal, 2005, 7(5/6): 547 – 559.

[15] Wang X, Rosell A, Lo E H. Targeting extracellular matrix proteolysis for hemorrhagic complications of tPA stroke therapy[J]. CNS Neurol Disord Drug Targets, 2008, 7(3): 235 – 242.

[16] Kim J, Hajjar K A. Annexin II: a plasminogen-plasminogen activator co-receptor[J]. Front Biosci, 2002, 7: d341 – d348.

[17] Fan X, Yu Z, Liu J, *et al*. Annexin A2: a tissue plasminogen activator amplifier for thrombolytic stroke therapy[J]. Stroke, 2010, 41(10 Suppl): S54 – S58.

[18] Hajjar K A, Jacovina A T, Chacko J. An endothelial cell receptor for plasminogen/tissue plasminogen activator. I. Identity with annexin II [J]. J Biol Chem, 1994, 269(33): 21191 – 21197.

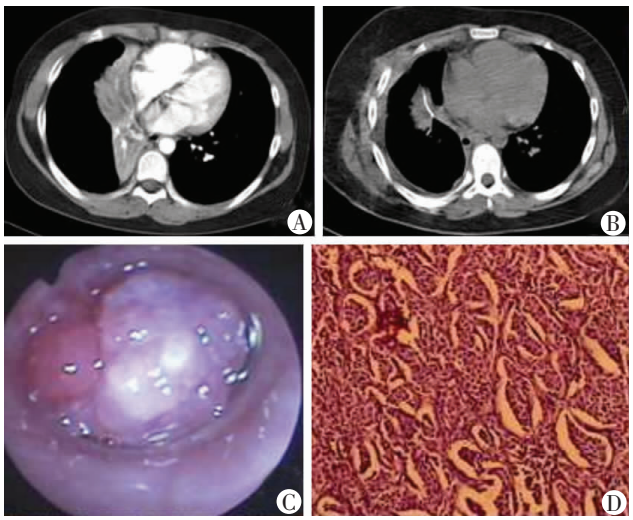
[19] Jacomo R H, Santana-Lemos B A, Lima A S, *et al*. Methionine-induced hyperhomocysteinemia reverts fibrinolytic pathway activation in a murine model of acute promyelocytic leukemia[J]. Blood, 2012, 120(1): 207 – 213.

[20] Kristensen B, Malm J, Nilsson T K, *et al*. Hyperhomocysteinemia and hypofibrinolysis in young adults with ischemic stroke[J]. Stroke, 1999, 30(5): 974 – 980.

(**收稿**:2014-04-23;**修回**:2014-07-11)

(编辑　王小寒)

(上接 2043 页)



A:术前;B:术后; C:纤支镜见右中间支气管完全堵塞;D:肺类癌组织病理学变化 (×40)

图 1　肺类癌手术前后 CT 表现、纤支镜观察与病理观察

2　讨论

原发性肺类癌是起源于支气管肺黏膜及黏膜下的神经内分泌细胞的肿瘤,文献[1]报道原发性肺类癌占肺部原发肿瘤的 1% ~2%。组织学上将类癌分为典型类癌和非典型类癌,其中典型类癌占 80% ~90%。在诊断方面,该类肿瘤的影像学特征不典型,需与肺结核等疾病相鉴别。肺类癌是低到中度恶性的神经内分泌肿瘤,典型的神经内分泌肿瘤的病理形态学特点伴 CK 阳性,CG A、SYN、CD56 不同程度的表达以及 Ki-67 指数的高低是与腺癌、小细胞肺癌等鉴别诊断的要点[2]。类癌的自然病程较长,典型类癌术后 5 年生存率达 95% ~100%。鉴于较好的疗效和预后,积极争取手术是适宜的临床决策[3]。

该患者 13 岁,以咳嗽、咳痰起病,有潮热等结核相关症状,胸部 CT 示肺门淋巴结有钙化。外院 2 次纤支镜检查提示右支气管新生物,但并未活检寻求病理学证据。鉴于重庆地区较高的结核发病率,结合患者年龄、临床症状、影像学表现、纤支镜所见等因素,外院考虑支气管结核可能性大,给予了诊断性抗结核治疗,但未及时复查观察治疗效果,导致误诊误治。为此,我们建议:由于目前恶性肿瘤尤其是肺癌年轻化趋势愈发明显,对于支气管或肺部新生物,获取病理学证据是进一步诊断和治疗的重要基石;在进行诊断性治疗的过程中,及时督促患者复查,观察治疗效果以调整治疗方案,优化治疗决策,对于减少误诊、误治率至关重要。

参考文献:

[1] Chen L C, Travis W D, Krug L M. Pulmonary neuroendocrine tumors: What (little) do we know? [J]. J Natl Compr Canc Netw, 2006, 4(6): 623 – 630.

[2] 朱蕾, 申屠阳, 张杰, 等. 肺类癌的病理特质与临床决策[J]. 中国肺癌杂志, 2013, 16(5):246 – 251.

[3] Yao J C, Hassan M, Phan A, *et al*. One hundred years after "carcinoid": epidemiology of and prognostic factors for neuroendocrine tumors in 35,825 cases in the United States[J]. J Clin Oncol, 2008, 26(18): 3063 – 3072.

(**收稿**:2014-06-17;**修回**:2014-09-02)

(编辑　邓强庭)