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·临床研究·

肝假性淋巴瘤的影像学特征及文献回顾

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[摘 要] **目的** 总结肝假性淋巴瘤(HPL)的影像学检查特征,为临床诊断 HPL 提供影像学依据。**方法** 回顾性分析 2017 年 12 月 28 日我院收治的 1 例 HPL 患者的临床资料,并结合相关文献,总结 HPL 的影像学特征。**结果** 超声显示右肝稍低回声,动脉相浅淡增强,门脉相及延迟相呈低增强。腹部 CT 显示肝Ⅷ段稍低密度影,动脉期轻度强化,强化方式为快进快出。Gd-EOB-DTPA MRI 检查示肝Ⅷ段可见结节状 T1WI 稍低 T2WI 稍高信号影,边界清楚,大小 2.0 cm×1.9 cm,弥散受限,增强扫描后动脉期轻度强化,强化方式为快进快出,肝胆期呈低信号。**结论** HPL 长径小于 2 cm,其影像学表现边界清楚,回声、密度或信号均匀,弥散受限,动态增强动脉期整体轻度强化,门静脉期和平衡期强化程度减低,肝胆期呈均匀低信号。

[关键词] 肝肿瘤;假性淋巴瘤;断层成像;X 射线计算机;钆塞酸二钠

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Imaging features and literature review of hepatic pseudolymphoma

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Abstract: Objective To summarize the imaging characteristics of hepatic pseudolymphoma (HPL), and provide imaging evidence for clinical diagnosis. **Methods** The data of patient with HPL who had admitted to our hospital on December 28, 2017 was retrospectively analyzed. Combined with relevant literature, the radiographic features were summarized. **Results** Ultrasonography showed a slightly low-echo in the right liver. Arterial phase slightly enhanced, while signals on portal phase, and delayed phase were hypoecho. Abdominal CT examination showed low density shadow in liver Ⅷ segment, relatively mild enhancement in the arterial phase, the enhancement pattern was wash-in and wash-out. Gd-EOB-DTPA MRI showed a visible nodule in the segment Ⅷ of the liver, slightly lower signal on T1WI and high signal on T2WI, clear border, size 2.0 cm×1.9 cm, water diffusion was limited, a nodule with slight enhancement in the arterial phase, the enhancement pattern was wash-in and wash-out. **Conclusion** HPL with small size (less than 2 cm), clear border on imaging findings, echoes, uniform density or signal, a restricted of diffusion, slight enhancement in the arterial phase, the intensity of portal vein and equilibrium phase decreased, uniform low-intensity signal during hepatobiliary phase.

Keywords: liver neoplasms; pseudolymphoma; tomography; X ray computed tomography; Gd-EOB-DTPA

肝假性淋巴瘤(hepatic pseudolymphoma, HPL)是临床上较为罕见的良性肿瘤。术前难以与其他肝肿瘤区分,尤其是 HPL 的影像学表现与肝细胞肝癌(hepatocellular carcinoma, HCC)非常类似。有学者发现绝大多数患者 HPL 在术前被误诊为 HCC 而行肝部分切除术[1]。目前关于此病的国内外文献报道较少,且多为个案报道。本研究回顾性分析 2017 年 12 月 28 日我院收治的 1 例 HPL 患者的临床资料,总结超声、CT 以及钆塞酸二钠动态增强 MRI(Gd-EOB-DTPA MRI)检查的影像学特征,为临床诊断 HPL 提供有价值的影像学依据。

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1 资料与方法

1.1 临床资料

患者,男,44 岁,以肝占位病变 10 d 收入院。患者于 20 年前体检发现乙肝,间断口服中药治疗,近 2 年劳累后出现右上腹隐痛不适伴乏力,无皮肤巩膜黄染。实验室检查 HBsAg、HBcAb、HBeAg(+),肝肾功正常,肿瘤标记物糖链抗原 CA125、CA199、癌胚抗原 CEA、甲胎蛋白 AFP 均正常。

1.2 检查方法

超声检查:超声诊断仪探头频率 3.0 MHz。造影剂为 SonoVue,先行常规超声观察病灶特点,再行超声造影检查。

CT 检查:患者空腹 8 h,并于检查前 5 min 饮水 600~800 mL 以适度充盈胃腔。扫描设备为增强 DSCT。MDCT 扫描参数如下:140 kV,300 mAs,层厚

5 mm,扫描范围为膈肌至耻骨联合。平扫后,经肘正中静脉由高压注射器注射造影剂碘海醇 90 mL,注射速度为 3.0 mL/s。将触发扫描感兴趣区设置于腹主动脉腹腔干分支水平,感兴趣区 CT 值大于 140 HU 后行动脉期扫描,90 s 行门静脉期扫描,180 s 行平衡期扫描。动脉期和门静脉期原始图像由后处理工作站行横断位、矢状位及冠状位重建,重建图像层厚为1.25 mm。

MRI 检查:采用3.0 T 的全身 MRI 系统,经肘静脉注射 0.1 mL/kg 钆塞酸二钠,速度为 1 mL/s,MRI 增强前扫描序列包括定位像,半傅里叶采集单次激发快速自旋回波序列(HASTE)冠状位、矢状位,化学位移成像及三维容积内插快速梯度回波(VIBE)平扫。MRI 动态增强扫描,当对比剂到达胸主动脉下段水平,患者屏气进行动脉期扫描,门静脉期扫描延时 70 s,平衡期扫描延时 180 s,延时 15 min 行肝胆期扫描。完善术前相关检查后遵循患者家属意愿行手术治疗,术后行病理学检查和免疫组织化学染色检测。

1.3 观察指标

影像学检查记录肿瘤的部位、大小、形态、回声、密度或信号、强化特征、继发表现。记录手术治疗情况、病理学检查、免疫组织化学染色检测结果、术后恢复情况、随访期间肿瘤复发情况。

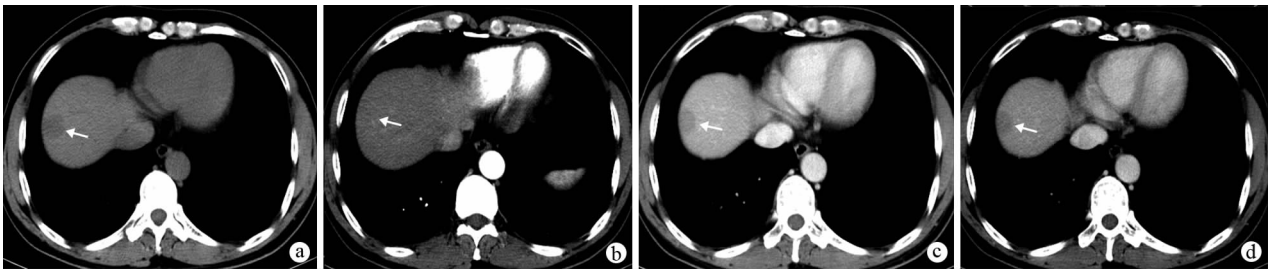
2 结果

2.1 影像学检查结果

2.1.1 超声造影 右肝前叶上段可见范围约 2.0 cm×1.7 cm 的稍低回声,边界欠清,CDFI 其内未见明显血流信号。动脉相轻微增强,门脉相及延迟相呈强化程度减低,超声造影支持肝细胞肝癌诊断。

2.1.2 腹部 CT 检查 肝Ⅷ段见结节状低密度影,最大截面积约 2.0 cm×1.9 cm(图 1a),边界较清,CT 值37 ~ 40 Hu,邻近肝包膜无明显外凸。动态增强动脉期轻度强化,与肝实质强化较一致,CT 值 57 ~ 63 Hu(图 1b);门静脉期持续性强化,强化程度低于正常肝实质,CT 值82 ~ 83 Hu(图 1c);平衡期强化程度减低,CT 值 70 ~ 73 Hu(图 1d)。CT 检查诊断考虑肝细胞肝癌。

2.1.3 Gd-EOB-DTPA MRI 检查 肝Ⅷ段包膜下见一异常信号结节,T1WI 呈稍低信号、T2WI 呈稍高信号,信号均匀,邻近肝包膜无明显外凸或凹陷,边界清楚,大小约 2.0 cm×1.9 cm。其内未见脂质成分、出血及钙化,弥散整体受限,增强扫描后动脉期轻度强化,门静脉期、平衡期强化程度减低,肝胆期呈低信号。小结节型肝硬化结节表现。MRI 检查诊断为 HCC(图 2)。



a:肝Ⅷ段见结节状低密度影(箭头);b:动脉期病灶轻度强化(箭头);c:门脉期病灶持续性强化(箭头);d:平衡期病灶强化程度减低(箭头)

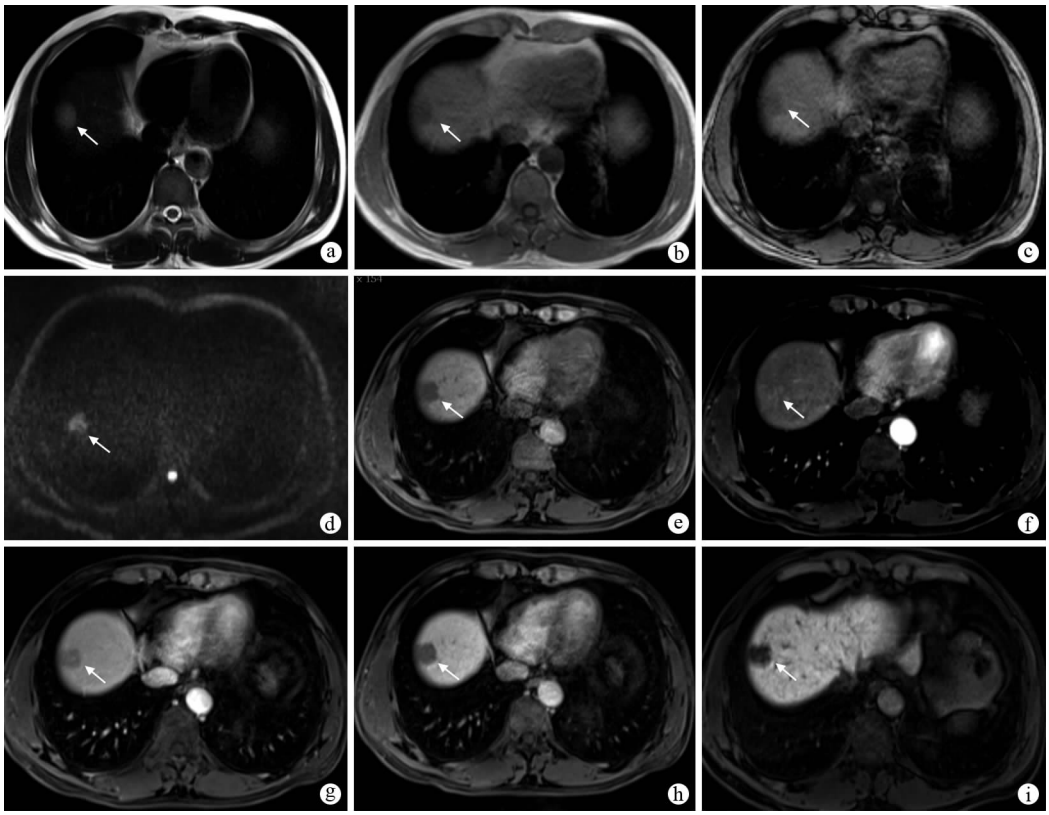
图 1 患者腹部 CT 资料

2.2 治疗及预后

腹腔镜下右肝肿瘤切除术,腹腔内未见腹水,肝呈肝硬化表现,肝Ⅷ段表面可见灰白色肿块,与周围界限清楚。病理学检查:肿块处取材,见大量增生淋巴组织伴淋巴滤泡形成,淋巴细胞沿汇管区增生,与周围肝组织分界清楚,周围肝细胞显轻度肿胀。免疫组织化学染色检测:CD3(+),CD20(+),CD21FDC(+),CD10(-),免疫球蛋白 κ(-),免疫球蛋白 λ(-),CD45(+),CD35(-),CD7(+),CD4(+),CD8(+),CD23(+),细胞增殖活性标记 Ki67 阳性细胞数 5%,B 细胞淋巴瘤 Bcl-2(-),B 细胞淋巴瘤 Bcl-6(-),最终病理诊断为 HPL(图 3)。叮嘱患者出院后继续口服抗病毒药物,定期复查。术后随访至今未见肿瘤复发。

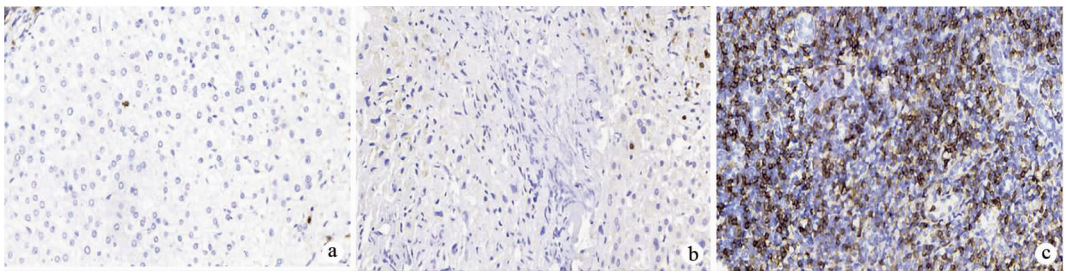
3 讨论

HPL 又称反应性淋巴组织增生,可发生于人体多种脏器,如皮肤、眼眶、肺、脾、胰腺、胃等,但发生于肝的 HPL 极为罕见,且患者多为中老年女性,男女比例约 1:7.4[2-4]。其临床表现无特异性,常为偶然发现。其发病机制尚不明确,有学者认为可能与自身免疫性疾病、硬化性胆管炎或非酒精性脂肪性肝炎有关,也有学者认为部分 HPL 常常伴有恶性肿瘤病史[4-7]。本例患者可能与乙肝感染有关。HPL 术前诊断极为困难,尤其是伴有慢性肝炎或恶性肿瘤病史的患者,极易误诊为肝细胞肝癌或转移瘤,确诊必须依靠术后病理学检查和免疫组化[8-9]。病理学表现为由多克隆的淋巴



a:MRI T2WI 轴位示肝Ⅷ段包膜下见稍高信号结节,信号均匀,边界清楚(箭头);b、c:MRI 同相位、反相位示病灶内无脂质成分(箭头);d:DWI 序列 b=800 时病灶呈明显高信号(箭头);e:T1WI 轴位平扫示病灶呈稍低信号结节(箭头);f:MRI 动态增强示动脉期轻度强化(箭头);g、h:门静脉期、平衡期强化程度减低(箭头);i:15 min 肝胆期示病灶呈低信号(箭头)

图 2 患者 MRI 资料



a:CD20(+);b:CD3(+);c:CD4(+)

图 3 术后病理免疫组化染色(×40)

滤泡形成,中央为生发中心,另有数量不等的淋巴细胞以及其他的炎性细胞,淋巴细胞无明显异型性。

总结 Pubmed 和知网上国内外近 5 年相关文献资料发现:HPL 多位于肝包膜下,可能与病灶沿血管末梢生长有关[1,2,7,9-18]。HPL 一般较小,多数病灶长径小于 2 cm,国内有学者报道最大的 HPL 达 8 cm,可能与此病灶无明显临床症状以及该患者未定时体检密切相关,本例病灶最长径约 2.0 cm,与文献报道一致[19]。超声常表现为低回声,CT 平扫相对于肝实质呈稍低密度影,边界清楚,增强扫描动脉期表现为轻度强化,强化程度稍低于或类似正常肝实质,门脉期和平衡强化程度明显低于肝实质,边缘可见环形强化,病理基础可能是淋巴细胞沿着门静脉浸润,导致门静脉细小分支狭窄或闭塞,提示 HPL 血供并不丰富。多数文献报道 MRI 表现为 T1WI 稍低、T2WI 稍高信号,边界清楚,同反相位、SWI 序列无明显脂质、出血以及钙化成分,DWI 序列整个瘤体弥散受限,可能是由于大量增生、紧密排列的淋巴滤泡和淋巴细胞替代正常肝实质,导致水分子运动受限。MRI 强化方式类似 CT 强化,由于正常肝细胞被大量淋巴细胞以及其他炎性细胞代替,肝胆期常表现为低信号。本例患者超声、CT、MRI 均与文献报道大致相同,但在增强扫描各期未见环形强化,可能与淋巴细胞及炎性细胞分布有关。HPL 有一定的影像学特点,但由于病例数极少,临床认识不

足,术前常诊断为 HCC 或转移瘤。针对本病例影像学表现,本研究总结发现 HPL 与 HCC 影像学表现有所不同,前者表现为缺乏血供,动脉期强化程度没有 HCC 强化明显。还有学者认为 ADC 值对区分两者有非常重要的意义,可能是由于 HPL 细胞数量以及密度明显高于脾,因此 ADC 值往往较脾低,而 HCC 的 ADC 值常大于脾[13,20]。本例患者病理测得 ADC 值为 $0.563\times10^{-3}/mm^2$,低于脾 $1.042\times10^{-3}/mm^2$,与文献报道一致。此外 HCC 常合并甲胎蛋白和(或)异常凝血酶原升高。肝转移瘤影像学表现往往会与 HPL 重叠,但肝转移瘤密度或信号常不均匀,边界不清,中心常伴有坏死[21]。典型转移瘤增强扫描可见靶征,弥散序列常表现为环状高信号。HPL 还需与淋巴瘤相鉴别,淋巴瘤发生于肝非常罕见,常表现为肝肿大,如果肝内出现肿块且合并"血管漂浮征"而血管本身无明显受侵犯时,则强烈提示肝淋巴瘤的可能,但最终两者的诊断必须依靠病理学检查。目前认为 HPL 是一个良性肿瘤,因术前容易误诊,绝大多数患者采取手术治疗,术后极少出现复发或转移[22]。本例患者术后随访至 2018 年 11 月,未见复发征象。

综上所述,HPL 在临床上非常罕见,尤其对于慢性肝炎病史患者的诊断极为困难。随着影像检查技术的发展,肝上的小病灶越来越容易被发现,对于伴有自身免疫性疾病、慢性病毒性肝炎的患者,尤其中年妇女,多肿瘤标志物阴性,肝发现单个小病灶(小于 2 cm),发生于肝包膜下,回声、密度或信号均匀,弥散整体受限,动态增强扫描表现为缺乏血供的结节,动脉期轻度强化,门脉期和平衡期强化程度明显低于肝,肝胆期呈低信号,应该考虑到 HPL 的可能。由于术前影像学诊断困难,仍需术后行组织病理学检查。

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·临床研究·

硬膜外麻醉镇痛对 COOK 双球囊引产效果和母婴结局的影响

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[摘 要] **目的** 探讨足月妊娠初产妇硬膜外麻醉镇痛对 COOK 双球囊引产效果和母婴结局的影响。**方法** 回顾性分析我院 2017 年 12 月至 2018 年 12 月行 COOK 双球囊引产的 91 例足月妊娠初产妇的临床资料,按照是否接受硬膜外麻醉镇痛分为无痛分娩组和常规分娩组。观察比较 2 组患者的分娩方式以及阴道分娩患者的产程、母婴并发症和抗生素使用情况。**结果** 无痛分娩组的阴道分娩率为91.67%,常规分娩组为 50.91%。阴道分娩患者中无痛分娩者的第一产程、第二产程均比常规分娩者长;球囊后 24 h 内阴道分娩率、破水后 12 h 内阴道分娩率均低于常规分娩患者;产前发热率、抗生素使用率和产后出血量均明显高于常规分娩患者,差异均有统计学意义($P<0.05$)。2 组患者的新生儿窒息率比较差异无统计学意义($P>0.05$)。**结论** 无痛分娩可提高 COOK 球囊引产成功率,但延长了产程,会对分娩造成不良影响,应予重视和预防。

[关键词] COOK 双球囊;硬膜外麻醉;引产;产程;无痛分娩;抗生素使用

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Influence of epidural analgesia on effect of labor induction by COOK double ballon and maternal and neonatal outcomes

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Abstract: Objective To explore the influence of epidural analgesia(EA) on the effect of term labor induction of primiparous women by COOK double ballon, and evaluate the maternal and neonatal outcomes. **Methods** The data of 91 primiparous women who received COOK double ballon for induction of term labor were retrospectively analyzed. The cases received EA were named as group EA + COOK and others were named as group COOK. The mode of delivery was observed and compared between the two groups. The duration of labor, maternal complications, infant complications and medication of antibiotic of the patients delivered vaginally were observed and compared between the two groups. **Results** The vaginal delivery rate was 91.67% in the group EA + COOK and 50.91% in the group COOK. The first stage of labor and the second stage of labor in group EA + COOK were longer than those in group COOK, the vaginal delivery rate within 24 hours after balloon delivery and the vaginal delivery rate within 12 hours after rupture of membrance in group EA + COOK were lower than those in group COOK, and the rate of prenatal fever, the usage rate of antibiotics and the amount of postpartum hemorrhage in group EA + COOK were significantly higher than those in group COOK, the differences were significant($P<0.05$). There was no statistical difference in the incidence of neonatal asphyxia between the two groups. **Conclusion** EA can promote the effectiveness of COOK double ballon for induction of term labor of primiparous women, whereas, more attention and interventions were needed because EA will prolong the labor stage and result in some adverse events.

Keywords: COOK double ballon; epidural analgesia; induction of labor; duration of labor; painless labor; medication of antibiotics

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