肾上腺囊肿的误诊分析

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[摘 要] **目的** 提高对肾上腺囊肿的诊断水平。**方法** 回顾性分析9例经手术和病理证实被误诊的肾上腺囊肿的临床资料,复习文献并讨论肾上腺囊肿的误诊原因。**结果** 误诊原因主要有四点:①对肾上腺囊肿的认识和重视程度不足;② B超作为初步诊断对术前诊断的影响较大;③ B超和CT本身的局限性,对病灶来源判断不清;④部分肾上腺囊肿CT值较高,使得对病灶性质造成误判。**结论** 提高对肾上腺囊肿的认识和重视程度对减少误诊率非常重要,合理地联合应用B超、CT、MRI能显著提高肾上腺囊肿的诊断正确率。

[关键词] 肾上腺;囊肿;误诊
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Analysis of misdiagnosis for adrenal cyst

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Abstract: Objective To discuss the cause of misdiagnosis of adrenal cyst, improve the diagnosis for adrenal cyst. **Methods** The clinic data of 9 cases of adrenal cyst were analyzed retrospectively, which were misdiagnosed before surgical operation. Then the causes of misdiagnosis were discussed. **Results** There were mainly four causes: ①It was not enough to recognize and pay attention to adrenal cyst. ② The diagnosis attained by ultrasound B affected obviously the diagnosis before operation. ③It was not easy to determine exactly the location of disease, because of the limitations of ultrasound B and CT. ④The value of some adrenal cysts was relatively large, so the nature of mass was often mistaken. **Conclusions** It is necessary to improve the recognition and attention to adrenal cyst. It can increase the diagnosis rate before operation to utilize ultrasound B, CT and MRI jointly and reasonably.

Keywords: adrenal; cyst; misdiagnosis

肾上腺囊肿是一种少见病,据文献报道该病的尸检发病率为0.064%~0.18%。小囊肿可无任何症状和体征,因而临床发病率更低。1998年至2008年我院共收治手术治疗肾上腺囊肿24例,出现误诊9例,误诊率38%,现结合文献复习报告如下。

1 资料与方法

1.1 临床资料

本组患者9例,其中男3例,女6例,年龄26~54岁,平均42岁。右侧囊肿5例,左侧囊肿4例,囊肿直径4~14 cm,平均7.6 cm。体检时B超发现考虑肾脏占位病变6例,因患侧腰部胀痛就诊2例,因上腹胀满不适等胃肠道症状就诊1例。

1.2 术前检查和诊断资料

9例均行B超检查,4例诊断为肾上极囊肿,2例诊断为胰腺囊肿,1例诊断为肝囊肿,2例诊断为腹膜后实质性占位病变。3例行静脉尿路造影(IVU)检查,可在肾上方见到阴影,肾脏有受压表现,肾盏、肾盂系统改变不明显。8例行CT检查(其中1例诊断为肾囊肿者未行检查),7例CT值为2~26 Hu,增强后囊液无强化,诊断为肾上极囊肿4例;胰腺囊肿2例;肝囊肿1例。1例肿块密度不均,CT值为56 Hu,诊断为腹膜后实质性占位病变。实验室检查:血常规、皮质激素、儿茶酚胺、醛固酮及尿VMA(尿香草扁桃酸)无明显异常。术前诊断:肾上极囊肿5例,胰腺囊肿2例,肝囊肿1例,腹膜后实质性占位病变1例。

2 结果

诊断为肾囊肿者有3例经后腹腔镜手术治疗,其余6例均经开放手术治疗。术中发现为肾上腺囊肿,7例行去顶减压术,2例因囊肿压迫导致肾上腺明显萎缩,行肾上腺切除术,手术均顺利,无手术死亡病例。术中8例囊液为清亮淡黄色,1例为暗红色液体。本组9例患者术后病理检查均证实为肾上腺囊肿样病变:内皮性囊肿5例,假性囊肿2例,上皮性囊肿2例。

3 讨论

肾上腺囊肿的发病女性多于男性,男女之比约为1:3,其临床症状主要取决于囊肿大小,少有肾上腺激素分泌紊乱表现[1-2]。小囊肿可无任何症状和体征,常于体检或因其他脏器疾病检查时意外发现。较大囊肿可出现机械性压迫症状,主要是由于囊肿体积增大,推

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移挤压周围脏器所致。疼痛主要位于腰背部或上腹部。少数患者可有血压增高,原因可能为囊肿压迫肾动脉所致。Foster[3]将肾上腺囊肿分为四种病理类型:内皮性囊肿(45%),假性囊肿(39%),上皮性囊肿(9%),寄生虫性囊肿(7%)。诊断主要依靠IVU、B超、CT及MRI检查,进行定性和定位诊断。IVU可在肾上方见到阴影,同侧肾脏受压下移,但盂盏系统无明显改变。约15%的肾上腺囊肿囊壁有钙化[1],这是囊肿的特征。囊肿在B超中的典型表现为肾上腺区无回声的液性暗区,界限清楚,包膜完整,壁薄而光滑,与肾上极相连,并随呼吸与肾脏一起上下移动。囊肿在CT中的典型表现为肾上腺区边界清楚的圆或类圆形肿块,内为水样密度,壁薄,无增强或轻度增强。囊肿新鲜出血时密度可达50~90 Hu。囊肿在MRI上的典型表现为T1加权像呈低信号,T2加权像为高信号[4]。MRI可同时行冠状位和矢状位扫描,有利于肾上腺囊肿的定位诊断。

在我院收治手术治疗的24例肾上腺囊肿中误诊率达到38%,说明术前正确诊断肾上腺囊肿存在一定困难。分析原因,主要有以下几点:①医务人员对该疾病的认识和重视程度不足。因为临床发生率低,甚至很多泌尿外科专业医师从来没有遇到过此类病例,更不论其他专业的医师了,这种情况下发生误诊在所难免。② B超是目前常用的普查手段,而肾上腺囊肿患者多数无明显症状,一旦对该疾病做出错误诊断,可能极大影响后期的判断。③ B超、CT对囊肿做出定性诊断多无困难。本组7例经B超定性为囊性病变,定性诊断正确率为78%,2例诊断为实质性占位。CT检查8例中7例定性为囊性病变,正确率为88%。但因肾上腺与肾脏、胰尾、肝脏等解剖关系密切,它们在定位囊肿时都有一定困难。而CT检查对囊肿的定性、定位要优于B超。④少数肾上腺囊肿内容物为血性或浊性,纤维素、蛋白及钙盐含量高[5],CT值较高,难以与肾上腺和其他腹膜后实性占位相鉴别。此外,据文献报道,MRI对肾上腺囊肿的诊断准确率可达到93.3%[6],而泌尿外科医师由于CT检查对多数泌尿系疾病的优势,极少采用MRI检查。

综合以上原因,本文认为应该提高医务人员,尤其是泌尿外科医师对该病的认识,掌握它在B超和CT检查中的相对特征性的表现,对以上检查不能明确的病例,联合应用MRI,提高术前诊断准确率。

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风险评估,严格掌握手术适应证,术后应加强肾功能的保护及监测,维持稳定的心脏血流动力学,尽可能避免应用肾毒性药物等。对于出现并发症的患者,在积极治疗并发症的同时,注意肾脏的保护,如达到血液透析标准而无禁忌证,应当积极给予透析治疗。

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