CMF化疗方案耐受。

本研究表明,乳腺癌MRI形态学表现与癌细胞是否表达C-erbB-2之间存在一定相关性,乳腺癌的MRI征象从一定程度上反映了癌细胞的生物学行为。因此,通过MRI扫描清晰地显示乳腺癌内部有无坏死灶存在,可推测癌细胞是否表达C-erbB-2,为临床评估乳腺癌的生物学行为和预后、内分泌治疗和化疗方案的选择提供有价值的信息。

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个案与短篇

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急诊救治胸部创伤420例的疗效分析

Emergency treatment of chest trauma: a report of 420 cases

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创伤是中青年死亡的主要原因,胸部创伤因容易导致严重后果,危及病员的生命,故其快速诊断和有效治疗就显得尤其重要。我院自1998年6月至2002年6月共救治胸部创伤患者420例其疗效分析,现报告如下。

1 临床资料

1.1 一般资料

本组420例患者中,男性332例,女性68例,年龄16~78岁,平均年龄47岁。致伤原因:交通意外损伤占21例(51.0%);高空坠落伤99例(23.7%);刀刺伤62例(14.7%);硬物击伤43例(10.2);枪伤3例(0.4%)。在损伤类型中,开放性胸部损伤172例(41.2%);闭合性胸部创伤248例(58.8%)。

入院后迅速查体,同时简要询问致伤史;危重病例在抢救的同时进行体检,对伴有休克及局部体征,怀疑血胸者,立即进行胸腔穿刺。危重病例首选CT检查,在医师陪同下行CT扫描,在屏幕上观察结果,立即回科处理,以免等待结果延误抢救时间。较轻病例可行X线胸片检查。

1.2 治疗方法

危重病例入科后,立即开始抢救,进行建立静脉通道、气管插管和抗休克等处理。心脏穿透伤和肺内大血管损伤血压降低在抗休克无好转的,在5~10 min内开始开胸手术治疗(直接在抢救室手术);肺裂伤及气管部分断裂、胸壁血管断裂、膈肌损伤在30 min内开胸手术治疗。分别行开胸心脏修补或血管裂口缝合及肺修补等手术。采用胸腔闭式引流治疗者,多为单侧或双侧气胸,血胸或血气胸,血胸出血量在1 500 ml以内。在采用保守治疗的病例中以单纯性胸壁损伤为主,包括单纯胸壁软组织挫伤,闭合性单根或双根肋骨骨折,无移位的胸骨骨折,肺压缩少于30%的气胸,出血量< 100~200 ml的血胸。部分病例伴有其它脏器损伤,如四肢骨折,颅脑损伤等,均给予相应处理。

2 结果

手术治疗69例(16.4%),胸腔闭式引流249例(59.3%),保守治疗102例(24.3%)。全组治愈414例(98.5%),死亡6例(1.5%),其中4例是心脏损伤,另2例死于失血性休克、心力衰竭。

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3 讨论

及早确定诊断是抢救治疗的基础，对血压不稳定的危重病例尤其重要；我们对心脏刀刺伤及严重休克病例根据体检确定诊断，立即开始抢救及手术治疗。对于休克经抢救血压平稳的病例，由医生陪同直接到 CT 室检查，从 CT 荧光屏直接观察结果，立即回科抢救，以免等待 CT 报告及 X 线片结果影响抢救。文献[1]报道 90%胸部创伤是通过病史询问及物理检查得出初步诊断，本组病例大部分经胸片确诊。胸片检查也可作为动态检诊措施，发现迟发性血胸。其优点是设备简单，可多次重复，对复合伤昏迷的病人，依据胸片结合临床做出正确处理，避免漏诊。胸外伤病人宜动态观察。肋骨骨折但无血气胸表现者应留院观察。本组有 2 例为迟发性血胸，在受伤后 24～48 h 发生，初诊为多发性肋骨骨折，后入院监测生命体征，多次胸腔穿刺、复查胸片，使患者得到及时的救治。

对确诊病例，选择手术及其他有效措施尽快治疗。结合文献资料，我们认为重度胸外伤，应在积极抗休克的同意及时作出判断，进行手术治疗。下列情况为剖胸探查指征：①心脏大血管损伤；②气胸经胸腔闭式引流后仍持续漏气，呼吸困难；③怀疑支气管断裂；④血胸行闭式引流术，出血量＞ 200 ml/h，持续 3 h 无明显减少，经输血等处理，血压仍不稳定，应考虑胸腔内活动性出血[2]；⑤胸腹联合伤，心包填塞，穿刺证实有积血，穿刺后症状加重；⑥心肺或大血管异物存留。对于心脏大血管损伤等危重病例不应进行复杂检查等待检查结果，应通过简单检查立即开始抢救，争取抢救时机。胸腔闭式引流仍然是治疗血气胸的主要措施。早期胸腔闭式引流可以解除呼吸困难，有利于肺的及时膨胀，防止凝固性血胸的形成及减少感染机会。本组 249 例患者采用单纯胸腔闭式引流治疗后均获痊愈。文献[3]报道胸外伤需剖胸探查者一般为 10%～15%，本组为 16.4%，可能和本地区的高层建筑较多和高速公路交通事故较多有关。

总之，胸部创伤病因明确，病情轻重不一，变化发展迅速，不宜作过多辅助检查及留院观察，把握抢救时机，处理要简单、快速、有效。

关键词：胸部创伤；救治；急诊
中图法分类号：R655 文献标识码：B

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