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个案与短篇

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成功抢救宫外孕失血性休克心跳骤停1例

A case report of successfully rescuing cardiac arrest induced by hemorrhagic shock in ectopic pregnancy

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患者,女,32岁,因停经46 d,阴道不规则流血16 d于2000-01-30 T 0:10急诊入我科。查体:T 37.0 ℃,P 126次/min,R 25次/min,BP 8/6 kPa,急性病容,面色苍白,脉细弱,四肢冰冷,心肺未闻及异常,腹平软,无明显压痛、反跳痛,移动性浊音阳性,肠鸣音活跃8 ~ 10次/min。化验检查:血常规 WBC 23.6×10^9/g,中性93%,淋巴7%,RBC 2.03×10^{12}/g,Hb 65 g/L,生化 K^+ 2.65 mmol/L, Na^+ 133.0 mmol/L, Cl^- 100.2 mmol/L, Glu 23.04 mmol/L,尿糖++,尿酮体±,尿HCG阳性。心电图示窦性心动过速,腹腔穿刺抽出不凝血10 ml,诊断宫外孕,失血性休克,立即建双液路于0:35在全麻下行剖腹探查术。

术中见腹腔内大量积血和血凝块约3 000 ml,右输卵管峡部破裂,无齿卵圆钳钳夹峡部,回收自体血,快速输代血浆及全血,0:45血压突然下降到0,心电图示心室纤颤,立即心外按压,呼吸机正压给氧,重复静脉推注肾上腺素共8 mg,苯丙肾上腺素20 mg,气管内注射肾上腺素1 mg,同时加压输血输液,1:05行电除颤,心电图恢复呈窦性心律,血压波动在(105 ~ 75)/(60 ~ 40) mmHg之间,经多巴胺20 mg泵注维持血压,5%碳酸氢钠100 ml静推纠正酸中毒,颈部大动脉冰敷,甘露醇250 ml、地塞米松10 mg静推防止脑水肿,速尿40 mg、西地兰0.2 mg静推脱水、强心等治疗,2:30患者生命征平稳,继续手术,行右侧输卵管部分切除。3:05患者神志清醒,5:00脱离呼吸机,6:00拔除气管插管。抢救中共输全血1 200 ml,自体血1 700 ml,代血浆2 500 ml,林格氏液1 500 ml,生理盐水1 100 ml,术后8 d痊愈出院。

讨论

异位妊娠是最常见的妇科急症,90%以上为输卵管妊娠,其中壶腹部约占50% ~ 70%,峡部占25% ~ 30%,尤以峡部破裂最凶险[1]。近年来宫外孕发病率有逐步上升趋势[2],但并发心跳骤停报道甚少。心跳骤停的原因错综复杂,多发生于心肌缺氧、低血容量,各种原因的休克和中毒,低钾或高钾血症,体温过低的病人,而手术刺激,牵拉脏器,麻醉深浅不当等都可成为触发因素。本例患者可能因出血量达3 000 ml行紧急手术,打开腹腔、回收自体血使腹腔内压力骤降,加重回心血量减少而诱发心跳骤停。

心跳骤停与心室纤颤是麻醉和手术中最严重的意外事件,两者都使心脏失去排血功能致全身血液循环陷入停顿状态。此例病人心跳骤停复苏成功并痊愈,我们体会如下:①及时迅速的早期复苏是成功的关键,此例病人为全麻,有气管插管、正压给氧,加之有效的心外按压,从而维持有效的呼吸循环;②迅速恰当的给予静脉复苏药物;③电击及药物除颤;④头部、全身降温保护脑组织;⑤调整酸碱电解质失衡;⑥加强抗感染;⑦多科室协同提高了救治水准。重危病人急救是临床基本功,本例救治体会可供借鉴。

关键词:宫外孕;心跳骤停
中图法分类号:R714.22 **文献标识码**:B

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