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Application of supplementary computer specialist system in CT differential diagnosis of extrahepatic biliary obstructive diseases*

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Abstract Objective: To make CT differential diagnosis of extrahepatic biliary obstructive diseases (EBODs) intellectualized, quicker and more accurate. Methods: The contrastive analysis of CT image features as well as clinical data of 117 cases of proved EBODs were computerized by statistical analysis system (SAS) to establish a SAS data bank and a multivariate stepwise discriminate analysis was performed to select the factors with higher prognostic value in 16 items. Through the parametric discriminate analysis, linear discriminate functions were established by using the 10 items selected from the 16. Results: Resubstitution summary test using linear discriminate function showed that the specificity of the formula predicting benign obstructive jaundice was 89.6% and that predicting malignant obstructive jaundice was 89.9%. Furthermore, another group of 54 cases of EBODs were analyzed prospectively by virtue of the computer software system edited from the above results. Accuracy was 81.8% in the benign and 78.1% in the malignant. Conclusion: Computer aided diagnostic system provides a new aid to accurate diagnosis of EBODs.

Key words CT; obstructive jaundice; computer

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颌面部创伤病人的呼吸道管理

Airway management of patients with maxillofacial trauma

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总结了我院近年来在急诊救治颌面部创伤病人过程中采取的方法和存在的问题,并着重对呼吸道管理方法的有关问题进行讨论,为今后更正确地处理这类创伤提供经验。

1 临床资料

1.1 一般资料

7例患者,年龄 21~ 58岁。术前 X片或 CT片显示: 3例颅底骨折伴上下颌骨粉碎性骨折; 2例上下颌骨粉碎性骨折伴颌面软组织挫伤; 1例下颌骨骨折; 1例舌部咬伤伴颌面部软组织挫伤。其中 3例颅底骨折伴上下颌骨粉碎性骨折病人伤后意识不清,同时伴失血性休克,其余 4例病人神志清楚,基本合作。

1.2 麻醉方法

7例病人麻醉前均示用镇静剂,仅用阿托品 0.5 mg肌肉注射。2例行清醒鼻插管(1例为下颌骨骨折,1例为舌部咬伤),5例行气管切开 3例为颅底骨折伴上下颌骨粉碎性骨折,2例为上下颌粉碎性骨折),气管导管均带气囊。鼻插管或气管切开成功后,静脉注射安定 0.2 mg/kg或异丙酚 2 mg/kg,卡肌肉宁 0.6 mg/kg,芬太尼 0.2 mg,用 Hmeda 210型麻醉机控制呼吸,Colin 508型监测仪监测术中心电、血压、脉搏氧饱和度和呼气末二氧化碳浓度。

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and compared with those of the patients with the same diseases who received total splenectomy. **Results:** No significant differences were found between preoperative and postoperative average values of IgG, IgA, IgM, complements, Fn, TNF and NK activity in patients undergone subtotal splenectomy. T-lymphocyte transformation rate began to be decreased at the 2nd week and then returned to the preoperative level at the 3rd month postoperatively. However, the levels of IgM and Fn were decreased in patients undergone total splenectomy and those of the NK activity and lymphocyte transformation rate in them were significantly decreased at the 2nd week and 3rd month after operation. **Conclusion:** Immunological function, especially cellular immunological function, can be well protected by subtotal splenectomy.

Key words splenomegaly; hypersplenism; subtotal splenectomy; immunological function.

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2 结果

6例病人在行气管切开或清醒鼻插管过程中均较顺利,仅 1例舌部咬伤病人在插管过程中,因口咽部出血较多,引起呼吸不畅,脉搏氧饱和度降至 86%,经及时吸出分泌物及血液并用手指掏出血凝块后,呼吸道始通畅,术中麻醉无特殊。合并失血性休克者给予抗休克处理,病人生命体征基本平稳。鼻插管者术后均拔气导管,气管切开者则更换金属导管。术后随访结果除 1例底骨折伴上下颌骨粉碎性骨折病人死于多器官功能障碍外,余均伤愈出院。

3 讨论

颌面部创伤病人呼吸道梗阻问题常由呕吐物、咽部血凝块、骨碎片或软组织移位、颈和咽后部血肿、气肿或水肿等引起[1],多需吸引或拭除阻塞物。血肿、气肿和水肿进展迅速,受伤初期呼吸道可能通畅,当病人疲劳而安静或肿胀恶化时,可很快使呼吸道梗阻,因此对这类病人一般不主张深度镇静,当需要镇静时,应密切观察,以保持病人安静但又合作。

创伤病人胃排空时间延迟,因此返流和误吸的可能性极大。如行快速诱导插管,建议行环状软骨压迫,最好不用去极化肌松剂;如估计有插管困难,在诱导前应确保呼吸道通畅,并行胃肠减压[2]。

鉴于颌面部创伤病人存在以上问题,故术前必须认真评估呼吸道状况和合并伤,必须考虑可能存在喉/气管偏离、颈椎骨折、眼眶或颅骨骨折,咽后部血肿或气肿等,若认为需经喉插管或通气,应作好环甲膜定位[3]。

呼吸道管理方法的选择有以下几种:① 手术造口:可以是首选,也可以是最后一种选择。严重的挤压伤和广泛的气道伤波及口底和声门下,明显的喉头水肿、异物或其它妨碍使用口或插管的病人多早期作气管造口;多次气管内插管尝试失败,手术造口可作为最后的选择。② 诱导插管:仅适用于单纯的下颌骨骨折,无或仅伴轻度下颌机械活动受限,无喉头创伤和血流持续流向口咽患者。术前呼吸道评估常因疼痛和牙关紧闭使张口受限而不确切,因此快速诱导插管对于颌面部创伤病人应非常谨慎。③ 清醒插管:当呼吸道状况不明或估计有插管困难时应行清醒气管插管。具体方法有纤支镜插管术,特别是估计有插管困难者的首选方法,但颌面部创伤病人因口咽部血液妨碍暴露声门而使其应用有一定限制;鼻腔盲探插管术,该法不需清晰的视野,利用病人的呼吸音作引导,但鼻插管可引起感染、进一步损伤、梗阻或假道形成,中面部骨折和鼻骨骨折特别是同时有颅底骨折者不提倡鼻插;带光管芯插管,该法不需搬动颈部和直视声门,不需清晰视野和大张口,但当口咽部有血时可使灯光模糊不清,从而导致判断困难;手指引导插管,如不能暴露咽后部,插管可在手指引导下进行;奥古斯汀导向器插管,是一种为经口盲插而设计的新设备,该方法较少需要头后仰,对于伴有颈椎骨折的病人可能是一种安全的选择;经喉引导插管,该技术不需清楚暴露声门和病人完全合作,对于呼吸道受累病人,操作时仍能给氧。

在修复面部损伤时,气管导管应在位而且确保能见到面部相互关系以便正确将错位部分复位。估计术后有再出血,组织明显肿胀或喉头水肿者,术后导管应留置数小时至病人保护性反射恢复,完全清醒[1]。

关键词　颌面部创伤;呼吸道管理

中图法分类号　R782.054

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