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A clinical evaluation of serological diagnosis for pancreatic cancer

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Abstract Pancreatic oncofetal antigen (POA), minimolecular pancreatic oncofetal antigen (mPOA), pancreatic cancer-associated antigen from normal colonic mucosa (PCAAc), pancreas-specific antigen (PaA), elastase I (E I), human pancreatic elastase I (HPE I), glycylproline dipeptidyl aminopeptidase (GPDA), ribonuclease (RNase) and its isoenzymes (RNase I and RNase II), α1-antitryypsin (α_1AT), CA19-9 and CEA were determined in the serum samples of 270 normal subjects (the control), 143 cases of pancreatic cancer, 125 cases of hepatic or periampullar carcinoma, 120 cases of gut carcinoma and 105 cases of pancreatitis to assess whether serological examinations were valuable for the diagnosis of pancreatic carcinoma. It was found that POA, mPOA, PCAAc, PaA, CA19-9, RNase and RNase I were able to differentiate pancreatic carcinoma from the benign disorders of the pancreas with a sensitivity from 66.75% to 80.8% and a specificity from 88.5% to 96.69%. The determination of 3 or 4 tumor markers combinedly would increase the detection rate of pancreatic carcinoma, which will be an important procedure for the diagnosis of that malignancy.

Key words pancreatic neoplasm; antigen, tumor assiciated; carbohdrate; enzyme

原发性腰椎管硬膜外恶性淋巴瘤一例报告

A case report of primary lumber spinal epidural malignant lymphoma

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恶性淋巴瘤是一类常见的淋巴造血组织肿瘤,但原发于椎管硬膜外者极少见。我院30余年来仅遇到一例,现报告如下:

患者男,29岁。缘于1993年9月开始感腰部隐痛,伴右下肢放散性灼痛。当地医院以"坐骨神经痛"行非手术治疗,效果不佳。1994年4月经X线照片示腰$_3$椎体骨质破坏,于1994年5月17日收入住院。

查体:一般情况好,稍消瘦,腰椎前凸消失,腰$_3$棘突有压痛及叩击痛,并向右大腿后及小腿外侧放散,脊柱活动受限。右股四头肌萎缩,肌张力下降,肌力Ⅱ级,右大腿及小腿外侧感觉迟钝。膝及跟腱反射减弱,未引出病理反射,直腿抬高试验(-)。心肺未发现异常。血沉68 mm/h,血常规、肝肾功能均正常。超声波检查肝、胆、胰、脾均无异常。同位素骨扫描提示腰$_3$椎体核素浓聚。CT显示腰$_3$椎体可见虫蚀状骨质破坏。磁共振成像示腰$_3$椎体破坏,椎体后缘有条状影块向椎管内延伸,压迫硬脊膜囊。入院后3 d,出现腰及双下肢剧烈疼痛,不能站立,肛门坠胀,大小便困难。1994年5月22日在全麻下进行腰$_3$椎体病灶清除椎间植骨术。切取椎体破坏处及压迫硬脊膜腹侧厚约0.5 cm的肉芽样组织。病理检查为大量坏死及炎性组织。全麻清醒后,双下肢感觉运动消失,经使用脱水剂及激素等药物治疗,于5周后双下肢感觉运动有不同程度恢复。CTM揭示造影剂在胸$_{12}$～腰$_1$平面有部分通过,椎管内可见团块状影。脑脊液检查:潘氏试验(+)细胞总数10.81×10^9/L,白细胞0.009×10^9/L,Pro 3.03 g/L,Glu 3.5 mmol/L,Cl 105 mmol/L。奎肯试验提示椎管内不完全梗阻。考虑硬膜外脓肿,再次从原切口探查病灶区,未发现脓肿取硬脊膜表面瘢痕样组织送病检,意见为腰$_3$椎管内组织显慢性炎性伴坏死。2周后切口愈合出院。1994年9月23日因症状加重再次入院。此时颈前屈有抵抗,截瘫平面上升至胸$_4$,且感双肩部疼痛,双上肢握力下降,前臂尺侧感麻痛,手骨间肌萎缩。血沉102 mm/h,血碱性磷酸酶93 IU/L,CT提示腰椎进一步破坏。因截瘫上升至胸$_4$平面,考虑病变广泛,手术改为后入路,切除腰$_1$～腰$_2$椎板探查脊髓。见棘突旁组织及韧带呈炎性改变,椎管内充满肿瘤样组织,环形包绕在硬脊膜外向椎管上下延伸,厚约0.6 cm,瘤组织呈黄白色,用细软胆道刮匙贴硬脊膜表面达胸$_{10}$平面亦刮除大量瘤组织。切开硬脊膜见脑脊液浑浊,量少,脊髓失去光泽,有枯萎感,髓内未见瘤组织。病理检查:灰白与灰红色碎块组织,总体积6.0 cm×4.0 cm×2.0 cm。镜检:见肿瘤由弥漫一致的胞浆稀少的小圆形细胞构成(见附图)。免疫组织标记,L_{CA}阳性,L_{26}阳性。病理诊断:原发性腰$_3$椎管硬膜外非何杰金氏淋巴瘤(B细胞型)。术后使用顺铂、长春新碱等药物进行化疗。2周后出院。3个月后复查,病截瘫平面未继续上升。

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多种复杂基因缺陷的肿瘤疾病
现病情进一步发展其临床预后(PFS
椎管硬膜外恶性淋巴瘤。
恶性淋巴瘤 腰椎管；硬脊膜外；
中图法分类号 R738.1
淋巴瘤指源自淋巴结或淋巴组织的恶性
文献
本病可发于椎管任何节段的硬脊膜外
出现疼痛等神经根性症状前就已确诊
R或行椎板切除减压术(包括T09
②椎管内肿瘤术后复发
单纯性椎管内肿瘤
即其他肿瘤转移至椎管内的病灶
期就已发生椎管内转移而后病情，与

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