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◇临床医学◇

肝硬化失代偿期并胃窦血管扩张症1例

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摘要: 目的 探讨胃窦血管扩张综合征(GAVE)临床表现、内镜特征、诊治要点,提高对GAVE的认识,减少误诊。**方法** 回顾性分析十堰市太和医院1例误诊GAVE病人临床表现、内镜、实验室检查结果及治疗过程,并行文献回顾。**结果** 病人66岁,男,肝硬化失代偿期,临床表现为长期贫血、反复黑便,检查胃镜提示胃窦可见散在糜烂及出血点,病情活动时可见多处点状渗血灶,病人误诊为门脉高压性胃病,行抑酸、降门脉压、输血及止血等治疗,并行经颈静脉肝内门体分流术(TIPS)治疗,最终死于多器官功能衰竭。结合病人病史及多次内镜检查结果,诊断考虑为GAVE。**结论** GAVE发病率低,易误诊,病史及内镜检查是诊断的重要依据,确诊需要结合病理检查,内镜治疗是重要措施,TIPS治疗可能无效,外科手术是重要治疗手段。

关键词: 胃窦血管扩张; 西瓜胃; 肝硬化失代偿期; 内镜; 误诊

A case of decompensated liver cirrhosis complicated with gastric antral vascular ectasia

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Abstract: Objective To investigate the clinical manifestations, endoscopic features, diagnosis and treatment of gastric antral vascular ectasia (GAVE), improve the understanding of GAVE and reduce misdiagnosis.**Methods** The clinical manifestations, endoscopy, laboratory examination results and treatment process of a patient with misdiagnosed GAVE in Taihe Hospital were retrospectively analyzed, and the literature was reviewed.**Results** A 66-year-old male patient with decompensated liver cirrhosis showed clinical manifestations of long-term anemia and repeated melena. Gastroscopy revealed scattered erosions and bleeding points in the gastric antrum and multiple punctate blood oozing foci when the disease was active.The patient was misdiagnosed with portal hypertensive gastropathy; received acid suppression, lowering portal pressure, blood transfusion and hemostasis; was treated with transjugular intrahepatic portosystemic shunt (TIPS); and eventually died of multiple organ failure. Combined with the patient's medical history and multiple endoscopy results, the diagnosis was considered to be GAVE.**Conclusions** The incidence of GAVE is low, and it is easily misdiagnosed. Medical history and endoscopy are important bases for diagnosis based on pathological examination.Endoscopic treatment is an important measure. TIPS treatment may be ineffective, and surgery is an important treatment method.

Key words: Gastric antral vascular ectasia; Watermelon stomach; Decompensated cirrhosis; Endoscopy; Misdiagnosis

胃窦血管扩张症(gastric antral vascular ectasia,GAVE)也称血管畸形、血管瘤、血管发育不良和血管扩张等,于1953年由Rider等首次提出,1984年学者根据其内镜表现形象地称之为“西瓜胃(watermelon stomach)”。GAVE是一种局限于胃窦部原因不明的病变[1],内镜下表现为胃窦部红斑或红点状病变,可呈线性或弥散性分布,部分病例可出现结节样改变。多数病人伴有基础疾病,包括:自身免疫性疾病、肝硬化伴或不伴门脉高压、结缔组织疾病(如干燥综合征、系统性红斑狼疮和系统性硬化症等)、慢性肾脏疾病及肾功能衰竭、甲状腺功能减退、骨髓移植和心脏病等。GAVE罕见且误诊率高,现回顾性分析1例GAVE临床资料,结合文献探讨该病的临床病例及诊治要点,并分析误诊原因,以期为临床医生提供参考。

1 病例资料

男,66岁。因“腹胀伴黑便10余天”于2016年5月9日首次入住十堰市太和医院消化内科。既往有肝硬化病史,曾多次因“贫血、低蛋白血症”于多家医院血液科行纠正贫血治疗。体检:慢性肝病面容,重度贫血貌,皮肤黏膜及巩膜轻度黄染,无出血点,可见肝掌、蜘蛛痣,浅表淋巴结未扪及肿大。心肺检查未见明显异常,腹部膨隆,未见胃肠型及蠕动波,腹部无压痛及反跳痛,未扪及包块,肝右肋下2 cm,脾左肋下2 cm,Murphy征阴性,移动性浊音阳性,肠鸣音正常,双下肢轻度水肿。门诊资料:肝胆脾胰彩超:符合肝硬化超声改变、胆囊壁增厚、脾脏增大、腹腔积液(中量);凝血功能:纤维蛋白原降低1.43 g/L(参考值2~4 g/L),余未见明显异常;肝功能:总蛋白51.2 g/L(参考值65~85 g/L)、白蛋白23.2 g/L(参考值40~55 g/L)、碱性磷酸酶164.6 U/L(参考值35~100 U/L),余未见明显异常;肾功能、血脂未见明显异常。血液分析:白细胞数2.33 G/L,红细胞数2.05 T/L,血红蛋白66 g/L,平均红细胞体积103.5 fL,平均血红蛋白浓度309 g/L,血小板数68 G/L;上腹部CT示肝硬化,脾脏增大,腹水;胃镜提示门脉高压性胃病,食管、胃底静脉曲张(轻度)。初步诊断为肝硬化失代偿期、腹腔积液、门脉高压性胃病。住院期间行抑酸、保护黏膜、止血、降低门脉并输注红细胞、血浆、白蛋白等治疗,病人仍有间断黑便,住院8 d后复查胃镜可见胃窦多处点状渗血,继续上述治疗1周病人大便转黄后出院。随访病人院外仍有反复黑便,考虑门脉高压性胃病并出血,于2016年6月6日在我院行经颈内静脉肝内门体分流术(TIPS),病人病情缓解,大便转黄后出院,院外随访未再次出血。2016年7月25日再次出现黑便入院,复查胃镜提示门脉高压性胃病,食管黏膜白斑;肠镜:大肠息肉、内痔;胶囊内镜检查未见明显小肠出血性病变。针对病人病情,考虑胃部病变导致出血,请肝胆及胃肠外科联合会诊,建议行胃窦切除术,病人及近亲属不同意手术,出院。随访院外仍有反复黑便,并多次于行抑酸、输血等治疗,期间因TIPS支架内血栓形成行再通术。2019年3月15日因“间断黑便5月,意识丧失2 h”再次就诊我院,入院后行抑酸、护肝、纠正肝性脑病等治疗,病人合并多器官功能衰竭,于18日上午10时呼吸微弱、血压测不出,家属放弃进一步治疗,办理出院。

2 讨论

GAVE确切病因未明,目前认为是机械应力损伤、体液和自身免疫因素、血流动力学改变、微血管损伤和新血管生成等因素引起的综合征[3],其影响因素众多[1,4],包括门静脉高压、胃黏膜脱垂、肠系膜血管栓塞、血管活性物质水平变化、胃黏膜抗体相互作用及药物等。

本病多见于女性和老年人,>70岁者居多,50岁以下者少见[1]。病人可表现为长期消化道隐性出血、轻度或严重出血或慢性缺铁性贫血,病程达数年至数十年。GAVE约占非静脉曲张性上消化道出血4%[5],病变通常位于胃窦,其他如贲门、十二指肠、空肠及直肠也可发病,但近端胃罕见受累[6]。除严重贫血外,体检多无异常,也无先天血管疾病表现。多数病人大便隐血持续阳性,血红蛋白<70 g/L,易疲劳、运动耐量降低,需反复就诊,行输血治疗[1],其相关死亡率为1.4%[7]。

内镜是诊断的重要依据,病变多局限于胃窦或幽门前区,分点状及条状两型:点状病变表现为红色均匀小点弥漫分布胃窦,条状病变表现为多个类似皱襞长条形隆起,自幽门向胃窦沿胃长轴呈辐射状排列,隆起表面布满鲜红或深红色圆形或卵圆形红斑,似“西瓜皮”样外观,但条纹间黏膜正常、完整。红斑按压后可褪色,但取检出血较多,部分病变可自发性出血。

组织病理学是确诊依据。组织学有四个特征[8],即黏膜毛细血管扩张、局灶性血栓形成、纺锤体细胞(平滑肌细胞和成肌纤维细胞)增生和纤维玻璃样变,以上标准GAVE诊断率达80%,有利于区分GAVE与门脉高压性胃病(portal hypertensive gastropathy,PHG)。病理检查[9]见黏膜固有层内血管扩张、微血管血栓形成、纤维素样血栓及增生的纤维肌组织,而炎症极少,但假阴性率高。

当胃镜检查发现胃窦部特殊病变,病理检查固有层血管扩张、淤血,伴或不伴炎症改变应考虑

GAVE。但需与PHG、幽门螺杆菌相关性胃炎、酒精性胃炎、药物相关性胃炎、胃血管发育不良、胃黏膜糜烂及胆汁性胃炎等鉴别,通常上述病变无GAVE特有内镜及组织病理学特点。PHG和GAVE均可见于肝硬化门脉高压病人,二者有区别[8]:(1)PHG病变多位于胃底至胃体,而GAVE主要位于胃窦;(2)PHG内镜下表现为马赛克征、猩红热样疹及樱桃红斑点,而GAVE则表现为条纹样图案(西瓜胃)或弥漫性病变(蜂窝胃);(3)GAVE组织病理学具有特异性,而PHG不具备此特征;(4)PHG经β受体阻滞剂治疗有效,而GAVE无效。肝硬化并发上消化道出血病因中,食管胃底静脉曲张破裂出血占35%~80%,门脉高压性及肝源性溃疡占30%~40%[10-11]。该病人肝硬化失代偿期诊断明确,病程中反复黑便,镜下表现为糜烂出血灶,误诊为PHG,与医师认知不足有关;回顾该病例,病人反复黑便,镜下病变位于胃窦,且有典型"西瓜胃"外观,镜下可见渗血,符合GAVE诊断。

GAVE的理想治疗方案尚不清楚,建议首先基础治疗,包括:抑酸、止血及补液,贫血者需要补充铁剂,严重者需输血。

药物治疗有利于疾病缓解,但尚未统一意见。(1)激素疗法:雌孕激素治疗GAVE有效,但病变无明显改变、剂量减少后易复发,且长期使用有副反应:月经过多、妇科肿瘤如子宫内膜癌的风险增加。(2)奥曲肽:Nardone等[12]采用奥曲肽治疗3例GAVE病人,连续治疗6月后1例出血减少,2例出血停止,病变部分或完全消退;但也有研究者认为奥曲肽治疗GAVE无效[13]。本例病人误诊为PHG,先后采用奥曲肽、生长抑素等治疗后病人仍有镜下出血或黑便,提示此类药物治疗GAVE无明显效果。(3)氨甲环酸治疗GAVE有效,但中心静脉淤滞性视网膜病变、深静脉血栓形成及肺栓塞等副作用限制其广泛应用[8]。(4)环磷酰胺治疗系统性硬化症相关的GAVE有效,但仅限于个案报道,治疗剂量及时间尚未达成共识,长期疗效尚需观察[14]。(5)中药治疗:赵志诚等[15]采用中西医结合治疗GAVE收到较好效果,但也仅限于个案,需要大样本对照研究加以验证。

内镜GAVE是治疗重要手段。(1)氩离子凝固术(argon plasma coagulation,APC)治疗GAVE安全有效、创伤小[16],但需多次治疗,再出血率达60%,约三分之二病人治疗后仍需依赖输血,且可能出现败血症、增生性息肉和胃出口梗阻等并发症[17]。(2)光动力疗法(photodynamic therapy,PDT)通过生物光敏作用损伤病理性增生血管内皮细胞,致使病变血管内血栓形成、达到封闭血管目的。(3)射频消融术治疗GAVE安全有效,病人输血需求显著降低、胃窦病变明显改善。但该治疗耗时,需多次进行,治疗中需移出导管对其清洁并重新放置以消融不同病变区域,如此频繁操作可能引起食管创伤及撕裂伤[1]。(4)冷冻疗法治疗GAVE病人似乎有效[18],但最佳冷冻剂、输送装置和治疗方案尚待确定。此外,胃部的可见度有限和过量冷冻气体的无效排放均可能限制其临床应用。(5)内镜套扎术(EBL):一项EBL与APC治疗的疗效的前瞻性研究[19]显示与APC相比,EBL在治疗儿童GAVE出血方面更有效、更省时。(6)钬激光治疗GAVE出血有效,可减少50%~80%病人再次输血需求,病人需行1~10(平均3)次治疗。术后病人可能出现胃溃疡、增生性息肉、幽门狭窄,进而引起胃排空延迟或胃出口梗阻,甚至可能出现罕见并发症,如胃穿孔、胃癌等。该治疗成本高,对术者要求高,培训周期长,如术者操作不熟练,则可能引起穿孔及死亡频发[8]。

经颈静脉肝内门体分流术(transjugular intrahepatic portosystemic shunt,TIPS)治疗GAVE尚有争议。1997年Egger等[20]首次采用TIPS成功治疗1例GAVE病人,随访10月未出血;Becq等[21]认为TIPS可以消除肝硬化病人腹水,让GAVE病人外科手术更安全。但Ripoll等[22]则认为TIPS治疗GAVE无效,应避免用于治疗GAVE相关胃肠道出血。本例病人行TIPS治疗后尽管病人食管及胃底静脉曲张好转,但仍有黑便,提示TIPS尽管可以降低门脉高压,但对GAVE效果欠佳。

外科手术治疗GAVE相关出血显著有效,最常见的术式是胃窦切除术。此外,腹腔镜次全胃切除术与Roux-en-Y重建术(Billroth Ⅰ)治疗GAVE也有效[23]。肝移植也是GAVE重要治疗手段。阿拉巴马大学伯明翰分校的研究对12例肝硬化并发GAVE病人行原位肝移植后,10例(83.3%)病人中观察到GAVE的完全消退,其中1例(8.3%)病人成功治愈GAVE[24]。提示对肝硬化并发GAVE病人可考虑行肝移植治疗。

本例病人有肝硬化病史,病程中反复出现黑便、贫血,行输血治疗,对GAVE认识不足,误诊为PHG。尽管PHG和GAVE基础治疗一致,但本例病人未尝试内镜治疗。病人行药物治疗效果欠佳,行TIPS术,尽管治疗后病人食管及胃底静脉曲张好转,但仍有黑便,效果欠佳。遗憾的是建议病人行胃窦手术治疗,病人未从,错过最佳治疗时机,最终死于多器官功能衰竭。结合文献,我们认为,临床医师应提高对GAVE的认识,减少误诊和漏诊。病

人一旦确诊可考虑行内镜治疗,如效果欠佳,可考虑行胃窦切除术;对有肝硬化基础疾病者,肝移植也是重要治疗手段。

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