

doi: 10.13241/j.cnki.pmb.2015.02.029

腹腔镜辅助阴式全子宫切除术在巨大子宫肌瘤治疗中的应用价值

李文霞 陈德娟 颜爱华 殷金凤 付 琼

(四川省成都市第二人民医院妇产科 四川 成都 610017)

摘要 目的: 研究腹腔镜辅助阴式全子宫切除术(Laparoscopic assisted vaginal hysterectomy, LAVH)在巨大子宫肌瘤(Huge leiomyoma uterus, HLU)治疗中的应用价值。**方法:** 从2012年9月到2013年9月,选择在我院接受手术治疗的HLU患者130例作为研究对象。根据手术方案进行分组,其中LAVH组65例,TAH组65例,对比两组手术情况,术后并发症情况以及两组患者疼痛情况。**结果:** LAVH组的肛门排气时长、下床活动时长、住院时长均显著少于TAH组,但手术时长大于TAH组,差异均有统计学意义(均 $P < 0.05$)。两组在术中出血量方面对比,差异无统计学意义($P > 0.05$)。LAVH组的术后并发症与TAH组相比,差异无统计学意义($P > 0.05$)。LAVH组的VAS评分及VDS评分均显著低于TAH组,差异均有统计学意义(均 $P < 0.05$)。**结论:** LAVH术式在HLU中具有较大的应用价值,临床上应重视其适应症,优先选择此类术式,效果显著,值得临床关注。

关键词: 腹腔镜; 阴式全子宫切除术; 巨大子宫肌瘤; 应用价值

中图分类号: R737.33 **文献标识码:** A **文章编号:** 1673-6273(2015)02-312-04

Application Value of Laparoscopically Assisted Vaginal Hysterectomy in the Treatment of Huge Leiomyoma Uterus

LI Wen-xia, CHEN De-juan, YAN Ai-hua, YIN Jin-feng, FU Qiong

(Department of Obstetrics and Gynecology, Chengdu Second People's Hospital of Sichuan Province, Chengdu, Sichuan, 610017, China)

ABSTRACT Objective: To study the application value of laparoscopically assisted vaginal hysterectomy in the treatment of huge leiomyoma uterus. **Methods:** 130 HLU patients undergoing surgery from September 2012 to September 2013 in our hospital were chosen for the study and were divided into the LAVH group, with 65 patients, and the TAH group with 65 cases, according to the surgery programs. Surgery, postoperative complications and patients' pain conditions were compared between the two groups. **Results:** LAVH group's time of anal exhaust, ambulation and hospitalization were significantly shorter than that of TAH group respectively, but surgery time in TAH surgery group was longer, and the differences were statistically significant ($P < 0.05$). The blood loss in the two groups presented no statistically significant difference ($P > 0.05$). Difference in postoperative complications was not statistically significant when compared between the two groups ($P > 0.05$). LAVH group's VAS score and VDS scores were significantly lower than those of TAH group, and the differences were statistically significant ($P < 0.05$). **Conclusion:** LAVH procedure has great value in treating HLU, so we should attach importance to the clinical indications. The effect of such style of surgery is significant and it is worthy of attention.

Key words: Laparoscopy; Vaginal hysterectomy; Huge uterine fibroids; Application value

Chinese Library Classification(CLC): R737.33 **Document code:** A

Article ID: 1673-6273(2015)02-312-04

前言

伴随社会经济的发展,人们生活习惯的变化,子宫肌瘤作为一种良性肿瘤,如今已多发于中老年女性^[1]。同时,位于子宫浆膜层之下的肌瘤,往往临床症状相对较轻,发现和治疗较晚,肌瘤体积通常很大,若使用传统的手术方案,对患者造成的创伤较大,且恢复时间长,促使临床医务工作者逐渐尝试寻找一种更为有利的手术方案^[2]。而随着腹腔镜技术的广泛应用,目前,LAVH术式更受术者及患者的欢迎,为进一步分析LAVH术式在治疗HLU中的应用价值,本文展开研究,并从中得到了一些结论,现报道如下。

1 资料和方法

1.1 临床资料

从2012年9月到2013年9月,选择在我院接受手术治疗的HLU患者130例作为研究对象。所以患者均由B超和诊刮以及宫颈刮片等方式确诊^[3]。均为女性,年龄22至57岁,平均年龄为 42.8 ± 3.7 岁。其中单发肌瘤72例,多发肌瘤58例。肌瘤位置:肌壁间75例,浆膜下55例。根据手术方案进行分组,LAVH组65例,年龄22至55岁,平均年龄为 43.1 ± 2.8 岁。其中单发肌瘤38例,多发肌瘤28例。肌瘤位置:肌壁间40例,浆膜下25例。TAH组65例,年龄25至57岁,平均年龄为 42.6 ± 4.9 岁。其中单发肌瘤34例,多发肌瘤30例。肌瘤位置:肌壁间35例,浆膜下30例。两组在性别、年龄、肌瘤状态及肌瘤位置等方面相比,差异无统计学意义($P > 0.05$)。具有可比性。本次研究已获得患者及其家属同意,且经过我院的伦理委

作者简介:李文霞(1970-),女,本科,主治医师,从事妇科微创手术方面的研究,E-mail:1137520655@qq.com

(收稿日期:2014-06-21 接受日期:2014-07-13)

员会审核批准。

1.2 研究方法

1.2.1 LAVH 组术式 为患者行气内全麻, 取其膀胱截石位, 在脐孔下缘进行穿刺, 而后建立好人工气腹。经 10 mm 的 Trocar 穿刺放置腹腔镜, 实施盆腹腔探查, 将粘连松解, 明确病变情况, 在宫颈的下移程度 $< 1\text{ cm}$ 时, 将麦氏点和反麦氏点用作 2、3 穿刺点, 如宫颈的下移程度 $> 1\text{ cm}$, 取患者双侧的髂前上棘往内约 3 cm 作 2、3 穿刺点, 依次置入 Trocar。如有需要, 在下腹部的正中耻骨联合之上做出第 4 穿刺孔, 并置入有关手术器械。再经电凝和剪断患者的输卵管峡部和卵巢的固有韧带和圆韧带。将前后叶予以分离, 显露出子宫的动、静脉。而后切开患者膀胱子宫反折腹膜, 再下推膀胱, 经电凝后缝扎血管。通过阴道并经阴道穹窿的黏膜下和子宫膀胱的间隙及膀胱阴道的间隙朝内注入 1:20 万的肾上腺生理盐水。将阴道壁予以切开, 分离出膀胱宫颈的间隙及宫颈直肠的间隙到腹膜反折, 最后切断其子宫骶和主韧带, 将子宫的动静脉予以缝扎, 经其阴道从膀胱子宫的间隙将子宫牵出, 建立气腹, 对盆腔行冲洗处理, 缝合腹膜后术毕。

1.2.2 TAH 组术式 为患者行椎管内麻醉, 取其平卧位, 于耻骨联合之上行横切口。进到腹腔后为其探查子宫和附件, 将子宫提拉后处理附件和膀胱腹膜折返。再分离膀胱, 对各韧带和子宫动静脉实施相应处理, 最后切除其子宫, 并缝合腹膜及关

腹。

1.3 观察指标

对比两组手术情况, 术后并发症情况以及两组患者疼痛情况。

1.4 评分标准^[4]

疼痛评分采用 VAS(视觉模拟评分)标准及 VDS(语言评价量表)标准, 其中 VAS 评定准则^[5]: 无痛为 0 分; 轻微疼痛为 0-3 分; 疼痛会影响休息为 4-6 分; 疼痛较难忍受, 且会影响患者食欲及睡眠: 7-10 分。VDS 评定标准^[6]: 无痛为 0 分; 轻度痛为 0-2 分; 中度痛为 2-4 分; 重度痛为 4-6 分; 极度痛为 6-8 分; 最痛为 8-10 分。两种标准均为疼痛程度越重, 评分值越大。

1.5 统计学方法

采用 SPSS13.0 统计软件分析, 计数数据比较采用 χ^2 检验, 计量数据以 $(\bar{x} \pm s)$ 表示, 实施 t 检验。P<0.05 为差异有统计学意义。

2 结果

2.1 两组手术情况对比

LAVH 组的肛门排气时长、下床活动时长、住院时长均显著少于 TAH 组, 但手术时长大于 TAH 组, 差异均有统计学意义(均 P<0.05)。两组在术中出血量方面对比, 差异无统计学意义(P>0.05)。见下表 1。

表 1 两组手术情况对比(例, $\bar{x} \pm s$)

Table 1 Comparison of surgery condition between two groups(n, $\bar{x} \pm s$)

组名 Groups	例数 N	术中出血量(mL) Blood loss(mL)	手术时长(min) Surgery time(min)	肛门排气时长(h) Anal exhaust length (h)	下床活动时长(h) Ambulation time (h)	住院时长(d) Hospitalization time (d)
LAVH 组 LAVH group	65	91.6 $\pm$ 40.3	118.4 $\pm$ 18.2*	22.3 $\pm$ 5.5*	17.2 $\pm$ 4.5*	4.8 $\pm$ 0.8*
TAH 组 TAH group	65	88.4 $\pm$ 20.8	78.5 $\pm$ 20.6	42.7 $\pm$ 4.5	38.6 $\pm$ 5.6	7.8 $\pm$ 2.3
t	——	0.569	77.703	23.144	24.016	9.932
P	——	0.570	0.000	0.000	0.000	0.000

注: 与 TAH 组相比, *P<0.05。

Note: Compared with TAH group, *P<0.05.

2.2 两组术后并发症情况对比

义(P>0.05)。见下表 2。

LAVH 组的术后并发症与 TAH 组相比, 差异无统计学意

表 2 两组术后并发症情况对比(例, %)

Table 2 Comparison of postoperative complications between two groups(n, %)

组名 Groups	例数 N	发热 Fever	感染 Infection	脂肪液化 Fat liquefaction	输尿管损伤 Ureteral injury	膀胱损伤 Bladder injury	总发生率 Overall incidence rate
LAVH 组 LAVH group	65	1(1.54)	1(1.54)	2(3.08)	0(0)	1(1.54)	5(7.69)
TAH 组 TAH group	65	2(3.08)	2(3.08)	3(4.62)	1(1.54)	1(1.54)	9(13.85)
χ^2 值	——	——	——	——	——	——	1.281
P 值	——	——	——	——	——	——	0.258

注: 与 TAH 组相比, *P<0.05。

Note: Compared with TAH group, *P<0.05.

2.3 两组患者疼痛情况分析

差异均有统计学意义(均 $P < 0.05$)。见下表 3。

LAVH 组的 VAS 评分及 VDS 评分均显著低于 TAH 组,

表 3 两组患者疼痛情况分析(例, $\bar{x} \pm s$)

Table 3 Analysis of pain conditions between 2 groups(n, $\bar{x} \pm s$)

组名 Groups	例数 N	VAS 评分 VAS score	VDS 评分 VDS score
LAVH 组 LAVH group	65	2.49 $\pm$ 0.15*	3.12 $\pm$ 0.79*
TAH 组 TAH group	65	4.68 $\pm$ 0.28	5.07 $\pm$ 0.16
t	—	55.585	19.505
P	—	0.000	0.000

注:与 TAH 组相比,* $P < 0.05$ 。

Note:Compared with TAH group,* $P < 0.05$.

3 讨论

在临床上,子宫肌瘤是女性生殖器中的一种良性肿瘤,治疗方案以手术方式为主,而 HLU 因其具有相应的解剖特点,相关剥离操作较为困难,常需要实施子宫全切术^[7]。而 TAH 术式已在临床应用多年,Fulcher PH Jr 等人报道称^[8],TAH 术式简单易行,且手术视野有较好暴露,然而手术的创伤较大,对患者腹腔脏器的干扰亦较大,患者在手术后恢复较慢。近年来,LAVH 手术逐渐在临床应用,为分析 LAVH 对于 HLU 的应用价值,本文对比 LAVH 与 TAH 术式的疗效和预后情况,旨在为临床治疗提供合适的解决方案。

本文在研究后发现,LAVH 组的肛门排气时长、下床活动时长、住院时长均显著少于 TAH 组,但手术时长大于 TAH 组。两组在术中出血量方面对比,差异不显著。表明 LAVH 组的手术疗效相对更佳。与 Kim TJ 等人^[9]报道结果一致,这可能是由于 LAVH 术式兼具阴式手术及开腹手术优点,手术造成的创伤较小,术者视野清晰,更利于分离组织,患者腹壁结构较为完整,且外观并无明显的疤痕,有效避免了长时间的脏器暴露,因此术后的功能恢复相对更快^[10]。而 LAVH 组的术后并发症发生率 7.69%与 TAH 组的 13.85%相比,虽然更低,但差异不显著,亦表明 LAVH 的安全性较高,国外 Yang YS 等人^[11]报道称,LAVH 手术的术后并发症更少,这可能和样本量的多少有一定联系。此外,在术后疼痛情况方面,LAVH 组的 VAS 评分及 VDS 评分均显著低于 TAH 组,表明接受 LAVH 手术的患者疼痛感相对更小,符合 Dayaratna S 等人^[12]报道结果。这可能和 LAVH 术式的创伤较小等因素有关,LAVH 术式的镇痛效果相对 TAH 而言更加明显,且手术过程极少发生明显的副损伤,对患者的积极预后更加有利^[13]。需要指出的是,LAVH 有一定的适应证,其主要适合于子宫 ≤ 14 孕周的女性患者,而 > 14 孕周者、有恶性肿瘤且需扩大手术的范围以及针对盆腔病变较为严重的患者则应进行 TAH 手术^[14]。实施 LAVH 的患者情况不一,肿瘤大小亦有所差异,使得手术时间不太固定,甚至有部分患者耗时较长,因此在手术前应做到综合评估,合理设计并制定手术步骤,以尽可能地减少不必要的重复操作^[15]。此外,膀胱损伤通常是 LAVH 和 TAH 较为常见的并发症,因此在近膀胱锐

器进行操作之前,应将膀胱放置在安全位置^[16]。对于血管的处理应及时和有效,避免出血量较大,同时应彻底地清洁患者腹腔,避免损伤淋巴管。最后,还应做好中转开腹手术准备,针对以腹腔镜无法处理的患者病例,应及时中转,这可最大程度降低对于患者身体的损伤,国外 Saceanu S 等人^[17-20]亦有类似的报道。

综上所述,LAVH 术式在 HLU 中具有较大的应用价值,临床上可将其作为首选术式,但亦要注意其适应证,值得临床重视。

参考文献(References)

- [1] 王文革.米非司酮治疗子宫肌瘤临床疗效观察[J].辽宁医学院学报, 2009, 30(1): 53-54
Wang Wen-ge. Clinical observation on the therapeutic effect of mifepristone in the treatment of uterine fibroids [J]. Journal of Liaoning Medical University, 2009, 30(1): 53-54
- [2] Shetty J, Shanbhag A, Pandey D, et al. Converting potential abdominal hysterectomy to vaginal one: laparoscopic assisted vaginal hysterectomy[J]. Minim Invasive Surg, 2014, 14(2): 614-615
- [3] 沈捷红. 腹腔镜辅助阴式和阴式全子宫切除术的临床效果比较[J]. 中华全科医学, 2011, 9(9): 1391-1393
Shen Jie-hong. Clinical outcomes comparison of laparoscopic assisted vaginal and vaginal hysterectomy [J] Chinese Journal of General Practice, 2011, 9(9): 1391-1393
- [4] Kim EG, Park HJ, Kang H, et al. Antiemetic effect of propofol administered at the end of surgery in laparoscopic assisted vaginal hysterectomy[J]. Korean J Anesthesiol, 2014, 66(3): 210-215
- [5] Tapper AM, Hannola M, Zeitlin R, et al. A systematic review and cost analysis of robot-assisted hysterectomy in malignant and benign conditions [J]. Eur J Obstet Gynecol Reprod Biol, 2014, 15 (14): 142-144
- [6] 史博宏,郭爽,梁丽娟,等.腹腔镜辅助下阴式全子宫切除术 98 例临床分析[J].中华妇幼临床医学杂志(电子版), 2010, 6(3): 210-211
Shi Bo-hong, Guo Shuang, Liang Li-juan, et al. Clinical analysis of 98 cases of laparoscopic assisted vaginal hysterectomy [J]. Chinese Journal of Clinical Oncology (electronic version), 2010, 6 (3): 210-211

- [7] 石梅,李亚萍.腹腔镜和腹式子宫肌瘤切除术效果对比[J].宁夏医科大学学报, 2011, 33(8): 773-774
Shi Mei, Li Ya-ping. The effect of laparoscopic and abdominal contrast effect of myomectomy [J]. Journal of Ningxia Medical University, 2011, 33(8): 773-774
- [8] Fulcher PH Jr, Granese M, Chun Y, et al. Intraoperative utilization of dexamethasone/bupivacaine/gentamicin solution in laparoscopic assisted vaginal hysterectomy and pain management [J]. W V Med J, 2014, 110(1): 10-15
- [9] Kim TJ, Song T, Choi CH, et al. Comparison of laparoendoscopic single-site hysterectomies: laparoscopic hysterectomy with some vaginal component versus laparoscopically assisted vaginal hysterectomy[J]. J Laparoendosc Adv Surg Tech A, 2014, 24(4):254-259
- [10] Minaglia S. Vaginal trachelectomy following laparoscopic supracervical hysterectomy and sacrocervicopexy [J].Female Pelvic Med Reconstr Surg, 2014, 20(2): 116-118
- [11] Yang YS, Kim SY, Hur MH, et al. Natural orifice transluminal endoscopic surgery-assisted versus single-port laparoscopic-assisted vaginal hysterectomy (NAVH vs. SP-LAVH): A case-matched study [J]. J Minim Invasive Gynecol, 2014, 21(14): 35-41
- [12] Dayaratna S,Goldberg J,Harrington C, et al. Hospital costs of total vaginal hysterectomy compared with other minimally invasive hysterectomy[J]. Am J Obstet Gynecol, 2014, 210(2): 11-16
- [13] DaCosta V, McIntosh A, Wynter S, et al. Total laparoscopic hysterectomy versus vaginal hysterectomy at the University Hospital of the West Indies: a 5-year retrospective study [J]. West Indian Med J, 2012, 61(9): 865-869
- [14] Fanning J, Kesterson J, Davies M, et al. Effects of electrosurgery and vaginal closure technique on postoperative vaginal cuff dehiscence[J]. JSLS, 2013, 17(3): 414-417
- [15] 陈晓萍,唐艳.腹腔镜辅助阴式与经腹全子宫切除术治疗大子宫的临床疗效比较[J].西部医学, 2011, 23(10): 1908-1909
Chen Xiao-ping, Tang Yan. Comparing of laparoscopic-assisted vaginal hysterectomy and abdominal hysterectomy in treatment of large uterus[J]. Medical Journal of West China, 2011, 23(10): 1908-1909
- [16] Smorgick N, Patzkowsky KE, Hoffman MR, et al. The increasing use of robot-assisted approach for hysterectomy results in decreasing rates of abdominal hysterectomy and traditional laparoscopic hysterectomy [J]. Arch Gynecol Obstet, 2014, 289(1): 101-105
- [17] Saceanu S, Cela V, Surlin V, et al. Hysterectomy for benign uterine pathology: comparison between robotic assisted laparoscopy, classic laparoscopy and laparotomy [J]. Chirurgia (Bucur), 2013, 108(3): 346-350
- [18] Lee T, Rosenblum N, Nitti V, et al. Uterine sparing robotic-assisted laparoscopic sacrohysteropexy for pelvic organ prolapse: safety and feasibility[J]. J Endourol, 2013, 27(9): 1131-1136
- [19] Nguyen ML, Kapoor M, Pradhan TS, et al. Two cases of post-coital vaginal cuff dehiscence with small bowel evisceration after robotic-assisted laparoscopic hysterectomy [J]. Int J Surg Case Rep, 2013, 4(7): 603-605
- [20] Choi YS, Park JN, Oh YS, et al. Single-port vs. conventional multi-port access laparoscopy-assisted vaginal hysterectomy: comparison of surgical outcomes and complications[J]. Eur J Obstet Gynecol Reprod Biol, 2013, 169(2): 366-369

(上接第 364 页)

- [25] Kim JK, Lee HY, Song IS, et al. A case of a patient with protein C deficiency presenting with concurrent thromboses in the pulmonary arteries and innominate artery: a suggestive computed tomographic finding of thrombophilia[J]. J Thorac Imaging. 2012, 27(6): W180-1
- [26] Raszeja-Wyszomirska J, Miezyńska-Kurtycz J, Marłucz W, et al. Primary Budd-Chiari syndrome-a single center experience [J]. Hepatogastroenterology, 2012, 59(118): 1879-1882
- [27] Albisetti M, Andrew M, Monagle P. Hemostatic abnormalities. In: Werner E, DeAlarcon P, editors. Neonatal Hematology[J]. New York, NY: Cambridge University Press, 2005: 310-348
- [28] Dreyfus M, Magny JF, Bridey F, et al. Treatment of homozygous protein C deficiency and neonatal purpura fulminans with a purified protein C concentrate[J]. N Engl J Med, 1991, 325(22): 1565-1568
- [29] Marlar RA, Sills RH, Montgomery RR. Protein C in commercial factor IX concentrates and its use in the treatment of "homozygous" protein C deficiency[J]. Blood, 1983, 62: 303
- [30] Marlar RA, Sills RH, Groncy PK, et al. Protein C survival during replacement therapy in homozygous protein C deficiency [J]. Am J Hematol, 1992, 41(1): 24-31
- [31] Sabine Kroiss, Manuela Albisetti, et al. Use of human protein C concentrates in the treatment of patients with severe congenital protein C deficiency[J]. Biologics: Targets & Therapy, 2010, 4: 51-60
- [32] Casella JF, Lewis JH, Bontempo FA, et al. Successful treatment of homozygous protein C deficiency by hepatic transplantation [J]. Lancet, 1988, 27: 435-437
- [33] Angelis M, Pegelow CH, Khan FA, et al. En bloc heterotopic auxiliary liver and bilateral renal transplant in a patient with homozygous protein C deficiency[J]. J Pediatr, 2001, 138: 120-122
- [34] Lee MJ, Kim KM, Kim JS, et al. Long-term survival of a child with homozygous protein C deficiency successfully treated with living donor liver transplantation[J]. Pediatr Transplant, 2009, 13: 251-254
- [35] Monagle P, Ignjatovic V, Newall F, et al. Multi modal management of purpura fulminans due to homozygous protein C deficiency [J]. J Thromb Haemost, 2005, 3(Suppl 1): PO124