

宫腔镜辅助下分段诊刮在子宫内膜癌检查中的应用评价

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摘要 目的:评价宫腔镜辅助下分段诊刮在子宫内膜癌检查中的临床价值,探讨提高子宫内膜癌诊断准确性的检查方法。方法:选择经分段诊刮诊断为子宫内膜癌患者132例,59例患者分为对照组,术前采取单纯分段诊刮的方式,73例患者分为观察组,术前采取宫腔镜辅助下分段诊刮的方式。根据术后患者病理检查结果,比较两组患者术前诊断的准确性及术中腹腔冲洗液细胞阳性率。结果:观察组检查方式的准确性优于对照组,差异具有统计学意义($P < 0.05$),两组术中腹腔冲洗液细胞阳性病例比较,差异无统计学意义($P > 0.05$)。结论:宫腔镜辅助下分段诊刮的方式可提高子宫内膜癌检查的准确性,且不增加肿瘤细胞散播的风险。

关键词 宫腔镜;辅助;分段诊刮;子宫内膜癌;临床评价

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Clinical Evaluation of Hysteroscopy Assisted Segment Curettage in Endometrial Cancer

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ABSTRACT Objective: To evaluate the clinical effect of hysteroscopy assisted segment curettage in the endometrial cancer and research the check methods to improve the diagnostic accuracy. **Method:** Collect 132 endometrial cancer patients with the segment curettage, 59 patients were divided into the control group with the simple segment curettage, 73 patients were divided into the observation group with the hysteroscopy and segment curettage. According to the postoperative pathologic examination results, compare the preoperative diagnosis accuracy and positive rate of intraoperative peritoneal fluid cells. **Result:** The observation group's diagnostic accuracy was better than the control group's, there was a statistical significant ($P < 0.05$) in them, there was no statistical significant ($P > 0.05$) in the positive patients of intraoperative peritoneal fluid cells. **Conclusion:** It could improve the diagnostic accuracy by the hysteroscopy assisted segment curettage in the endometrial cancer, furthermore it could not increase the risk of spreading tumor cells.

Key Words: Hysteroscopy; Assisted; Segment curettage; Endometrial cancer; Clinical evaluation

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前言

子宫内膜癌是最常见的妇科恶性肿瘤之一,占妇科生殖系统恶性肿瘤的15%~20%。近年来,其发病率有逐年上升的趋势。因此术前的早期诊断、早期判断癌灶的浸润程度对于治疗的结果及预后的评估至关重要^[1]。单纯分段诊刮术是临床常用的诊断子宫内膜癌的方法,但是,临床观察发现,由于单纯分段诊刮术操作存在一定的盲目性,诊断性刮宫标本不能包括全部子宫内膜病变,导致手术前后的病理诊断存在一定的差异^[2]。近年来,宫腔镜辅助下分段诊刮越来越多的被使用在子宫内膜癌的诊断中,特别是对于早期子宫内膜癌结合直视下的定位活检,能够克服影像学检查和盲目刮宫对子宫内膜病变诊断的局限性^[3]。作者比较了宫腔镜辅助下分段诊刮与单纯分段诊刮在子宫内膜癌诊断中的准确性及安全性,现报告如下。

1 资料与方法

1.1 一般资料

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选择2009年1月~2010年10月期间,在我院手术治疗的子宫内膜癌患者132例,术后均经病理证实,且就诊前均无子宫内膜癌或其他恶性肿瘤病史,排除了子宫其他恶性肿瘤可能。术后病理组织学分型按照妇产科病理学的分类标准^[4],手术病理分期按照1988年国际妇产科联盟(FIGO)标准^[5]。59例患者分为对照组,术前采取单纯分段诊刮的方式,患者年龄38~71岁,平均年龄 51.2 ± 9.3 岁,术后病理类型腺癌51例、腺鳞癌6例、透明细胞癌2例;手术病理分期:期28例、期14例、期11例、期6例;73例患者分为观察组,术前采取宫腔镜辅助下分段诊刮的方式,患者年龄36~73岁,平均年龄 53.7 ± 10.2 岁,术后病理类型腺癌60例、腺鳞癌9例、透明细胞癌4例;手术病理分期:期39例、期16例、期10例、期8例。两组患者在年龄结构、术后病理类型、手术病理分期等方面比较,差异均无统计学意义($P > 0.05$),病例资料具有可比性。

1.2 检查方法

两组患者诊刮前行常规妇科检查、阴道分泌物检查、血常规检查及各项生化指标检查,排除了生殖道急慢性炎症;时间选择在月经干净后3~7d,对于月经淋漓不净者,随时进行检查。检查时患者取截石位,清洁并消毒阴道后,对照组患者先用

小刮匙刮取子宫颈管内组织,然后进入子宫腔内刮取子宫体前后壁及子宫两侧角组织,颈管组织与宫腔组织分别装瓶后送病理诊断;观察组采用日本 Olympus 公司外鞘直径 7mm 连续灌流的子宫腔镜以及外鞘直径 4.9mm 的纤维软性子宫腔镜,采用 5%葡萄糖液作为膨宫介质,膨宫压力保持在 10~15kPa,扩张宫颈后置入宫腔镜,先仔细观察颈管情况,后伸入宫腔镜观察宫腔内情况,观察过程中对于异常部位重点刮取组织,分别装瓶后送病理诊断。

1.3 观察内容

上述患者子宫内膜癌的诊断以术后病理诊断为标准,比较两组患者术前术后病理类型、宫颈累及的符合率和漏诊率,两组患者术中行腹腔冲洗液冲洗,收集冲洗液送病理细胞学检查

细胞阳性率,比较两种检查方法的安全性。

1.4 统计学方法

两组患者所得数据采用百分率表示,使用 spss16.0 软件行 χ^2 检验,以 $P<0.05$ 计为差异有统计学意义。

2 结果及分析

2.1 两组患者术前术后病理诊断类型符合情况比较

对照组术前病理诊断有 9 例诊断为子宫内膜重度不典型增生,观察组术前病理诊断有 3 例诊断为子宫内膜重度不典型增生,具体术前术后病理诊断类型见表 1。两组患者术前术后病理诊断符合病例数比较 $\chi^2=4.904$ $P<0.05$,差异具有统计学意义。

表 1 两组患者术前术后病理诊断类型符合情况比较(n, %)
Table 1 Comparison of preoperative and postoperative pathological diagnosis

Groups	The number of cases	Preoperative pathological diagnosis			Postoperative pathological diagnosis			The number of consistent cases	Compliance rate
		True positive cases of adenocarcinoma	True positive cases of adenosquamous carcinoma	True positive cases of clear cell carcinoma	Adenocarcinoma	Adenosquamous carcinoma	Clear cell carcinoma		
Control group	59	46(78.0%)	3(5.1%)	1(1.7%)	51(86.4%)	6(10.2%)	2(3.4%)	50	84.7%(50/59)
Observer group	73	59(80.8%)	8(11.0%)	3(4.1%)	60(82.2%)	9(12.3%)	4(5.5%)	70	95.9%(70/73) [△]

Note:compared with control group,△ $P<0.05$

2.2 两组患者术前术后病理诊断宫颈累及符合和漏诊情况比较

两组患者术前病理诊断与术后病理诊断符合病例比较,

$\chi^2=4.769$ $P<0.05$,差异具有统计学意义,两组患者术前病理诊断宫颈累及漏诊病例比较 $\chi^2=4.372$ $P<0.05$,差异具有统计学意义。见表 2。

表 2 两组患者术前术后病理诊断宫颈累及符合和漏诊情况比较(n, %)
Table 2 Comparison of compliance diagnosis and missed diagnosis in two groups' patients

Groups	The number of cases	Preoperative diagnosis and cervical involvement		The number of missed diagnosis cases	Postoperative diagnosis and cervical involvement	The number of consistent cases	The number of missed diagnosis cases
		True positive	False positive				
Control group	59	29(49.2%)	4(6.8%)	10(16.9%)	39(66.1%)	74.4%(29/39)	25.6%(10/39)
Observer group	73	44(60.3%)	3(4.1%)	4(5.5%)	48(65.8%)	91.7%(44/48) [△]	8.3%(4/48) [△]

Note:compared with control group,△ $P<0.05$

2.3 两组患者术中腹腔冲洗液细胞阳性率情况比较

两组患者术中腹腔冲洗液细胞阳性病例比较 $\chi^2=0.049$,

$P>0.05$,差异无统计学意义。见表 3。

表 3 两组患者术中腹腔冲洗液细胞阳性率情况比较(n, %)
Table 3 Comparison of peritoneal fluid cells positive rates in the two groups

Groups	The number of cases	The positive cases of peritoneal fluid cells	Positive rate
Control group	59	5	8.5%
Observer group	73	7	9.6%△

Note:compared with control group,△ $P>0.05$

3 讨论

子宫内膜癌的治疗效果很大程度上取决于早期子宫内膜

癌的诊断,由于解剖学的特点,子宫内膜癌的筛查和确诊远不如宫颈癌方便和可靠,目前尚无成熟、简便、可靠的诊断方法。对有症状或疑似子宫内膜癌的患者,传统的诊断方法是通

过分段诊刮刮取子宫内膜进行病理检查,但这种方法有一定的盲目性,易遗漏一些较小的局限性病灶^[3,6-7]。分段诊刮与手术切除标本病理诊断不完全一致,其原因可能为:(1)少数病例可能病灶较小、且位于子宫内膜表面,诊刮时被全部刮除;(2)一些癌灶生长于宫底、宫角等容易漏刮部位以及癌肿体积小等原因造成漏刮;(3)诊刮的组织标本过少,不足以进行肿瘤分类及组织学分级;(4)对于复杂的子宫内膜不典型增生与分化好的子宫内膜样腺癌,诊刮病理常常难于鉴别^[8]。同时,相关临床调查表明,即使富有经验的妇科专家刮宫时也只能搔刮到宫腔面积的75%~80%,有20%~25%的宫腔疾病被遗漏,子宫内膜癌的漏诊率5.6%~9.6%^[9-10]。

宫腔镜检查能直接观察子宫内及颈管内病灶的外观形态、位置和范围,对可疑病灶进行定位活检,有助于发现较小的或早期病变^[11-13]。吴逸报道^[14],宫腔镜下分段诊刮能提高诊断的阳性率,特别是对于病灶范围<0.5cm的患者能得到早期诊断,此外宫腔镜下在发现内膜息肉及子宫粘膜下肌瘤时较诊刮更为敏感,精确度高于诊刮。子宫内膜癌病理类型,对于患者的预后有一定提示作用,子宫内膜样腺癌中子宫内膜浆乳癌、透明细胞癌具有恶性程度高,提示具有盆腔和腹主淋巴结转移、附件转移、腹腔冲洗液阳性、残端复发和血行转移等更加高的风险^[15]。宫腔镜检查应有其特点,提高了术前分段诊刮诊断的病理类型与术后诊断的一致性。评估子宫内膜癌有否累及子宫颈内口和颈管,对于决定手术范围、治疗方式等的选择至关重要,宫腔镜能在直视下观察宫腔及宫颈管,能清晰显示子宫内病灶大小、部位、形态、及其限定下缘和子宫颈内口、子宫颈管之间的关系,必要时还可在相应的部位作活检或诊刮^[16]。舒文通过临床观察认为^[2],宫腔镜辅助下分段诊刮与单纯分段诊刮相比,能够显著提高宫颈是否累及的符合率。有报道认为宫腔镜检查时需要膨胀宫腔,因此有促使肿瘤细胞经输卵管播散至腹腔的可能性。但到目前为止,多数学者仍然认为宫腔镜检查并不增加肿瘤细胞播散的危险性^[17-19]。Selvaggi等报道^[20],宫腔镜辅助下诊刮腹水细胞学阳性出现的概率与单纯诊刮出现的概率无显著性差异,从而认为宫腔镜辅助下诊刮术并不增加癌细胞腹腔内播散的危险。

作者通过临床检查结果对比证实,宫腔镜辅助下分段诊刮的检查结果优于单纯分段诊刮的检查结果,前者在术前术后病理诊断类型符合率、术前病理诊断宫颈累及符合率及漏诊率方面与后者比较,差异均具有统计学意义($P<0.05$),说明前者检查方式的准确性明显高于后者,同时两组患者术中腹腔冲洗液细胞阳性率比较,差异无统计学意义($P>0.05$),说明术前采用宫腔镜辅助下分段诊刮的方式不会增加肿瘤细胞散播的危险。因此,临床在疑似子宫内膜癌患者检查中,应采用宫腔镜辅助下分段诊刮的方式,可提高检查的准确性,且不增加肿瘤细胞散播的风险。

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