

腹腔镜下输卵管妊娠的保守性手术治疗

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摘要 目的:分析腹腔镜下保守性手术治疗输卵管妊娠的疗效及临床应用价值。方法:对2009年1月~2011年12月就诊于本院妇产科的80例输卵管妊娠患者进行腹腔镜下输卵管开窗术及挤压法清除输卵管妊娠胚胎,患侧输卵管系膜下注射甲氨蝶呤(MTX)50mg及稀释垂体后叶素3IU。结果:80例输卵管妊娠患者腹腔镜下的保守手术均取得成功,均顺利保留了输卵管。无中转开腹的病例,术后未发现有并发症的患者,有2例发生持续性异位妊娠。手术所需时间为(52±14)min,手术过程中出血量(28±16)mL,术后住院天数平均5.5d。术后输卵管通畅率达88.75%。结论:腹腔镜下行保守手术保留生育功能,手术所需时间短,术中出血量少,术后恢复快。

关键词 输卵管妊娠;腹腔镜;保守治疗;异位妊娠;

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Laparoscopic Conservative Treatment of Tubal Pregnancy

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ABSTRACT Objective: To analyze the efficacy and clinical value of laparoscopic conservative treatment of tubal pregnancy. **Methods:** 80 cases of tubal pregnancy were collected in the obstetrics and gynecology in our hospital from January 2009 to December 2011. Laparoscopic tubal fenestration and extrusion method were used to remove the tubal pregnancy. Embryonic ipsilateral mesosalpinx was injected by methotrexate neopterin (MTX) 50 mg and diluted pituitary vasopressin 3IU. **Results:** 80 cases of tubal pregnancy were treated by laparoscopic conservative surgery successfully. The fallopian tube and were retained successfully. After surgery, no laparotomy cases were found with complications. 2 cases had persistent ectopic pregnancy. The operation time was (52 ± 14) min, bleeding (28 ± 16) mL during surgery. The average postoperative hospital stay was 5.5d. Rate of postoperative tubal patency was 88.75%. **Conclusion:** Laparoscopic conservative surgery to preserve fertility was characterized by short operation time, less blood loss and rapid postoperative recovery.

Key words: Tubal pregnancy; Laparoscopic; Conservative treatment; Ectopic pregnancy

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异位妊娠在妇科疾病中极为常见,但病因复杂,是常见的急腹症之一,病因复杂,其中以输卵管妊娠最为常见,其发病率可达90%以上^[1]。近年来,异位妊娠的发病率有不断增高的趋势,且年轻患者均希望能保留输卵管。因此,保守性手术治疗并保留输卵管,以保留其正常生育功能对大部分患者至关重要^[2]。本研究通过对本院妇产科80例输卵管妊娠患者行腹腔镜下保留输卵管的保守手术治疗,疗效满意,为腹腔镜下输卵管妊娠的保守治疗提供了新的思路。

1 对象与方法

1.1 研究对象

选择2009年1月至2011年12月本院就诊的80例输卵管妊娠患者,年龄20~41岁,平均年龄28.2岁。停经天数42~76天,平均停经天数47天。其中无生育史患者68例,有生育

史患者者12例,12例有生育史患者,前次剖宫产史者4例,再次输卵管妊娠患者为3例,80例患者中71例术前出现腹痛、阴道流血等症状,而只出现阴道流血的患者有5例,另外4例未出现任何临床表现。术前辅助检查显示尿HCG均为阳性,血HCG水平>80 IU/ml(正常参考值范围0-70 mIU/ml)。所有患者的B超检查均确定宫内未见妊娠物,宫旁附件区可见包块或回声紊乱。

1.2 手术方法

手术均采用气管插管下全身麻醉,保证充分的腹肌松弛,便于建立和维持稳定的气腹。患者体位取臀高膀胱截石位,顺利建立气腹后腹内压维持在2 kPa左右,腹腔镜(采用德国爱克曼高清晰摄像系统)经脐上或脐下切口插入盆腔内,详细探查盆腔内情况,确诊为输卵管妊娠后,在位于左、右髂前上棘与脐连线外上1/3无血管区选取穿刺点,置入5.0 mm Trocar套管,有粘连者仔细分离粘连。于输卵管妊娠系膜内注射稀释垂体后叶素3IU(高血压患者不使用)。随后行输卵管妊娠切开取胚术或输卵管妊娠挤胚术^[3]。输卵管妊娠切开取胚术需注意在输卵管妊娠薄弱的地方,用单极电钩纵行切开达输卵管腔,反

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复冲洗后取出内容物,取胚后再反复冲洗并间断缝合管腔。输卵管妊娠挤胚术需注意主要用于着床于伞端及部分壶腹部接近伞端者,将胚胎从壶腹部向伞端挤压后,取出胚胎组织后反复冲洗。最后将 50 mg 的甲氨蝶呤腹腔镜下注入病侧输卵管系膜。

2 结果

2.1 疗效

腹腔镜检查后,80 例患者确诊为输卵管妊娠,腹腔镜保留输卵管手术治疗后,无中转行开腹手术的病例。所有病例按输卵管妊娠位置分为输卵管峡部 8 例,位于输卵管壶腹部 62 例,输卵管伞部 10 例。此外,按输卵管破裂与否分为未破裂型和破裂型,未破裂型 70 例,破裂型 10 例。输卵管妊娠破裂者腹腔内出血在 450 mL 以内。所有患者手术所需总时间为 (52 ± 14) min,手术中出血量为 (28 ± 16) mL。

2.2 术后情况

所有患者术后 6 小时进食流质,静脉抗感染治疗 3 日,术后平均住院时间为 5.5 天。80 例患者术后有 71 例患者输卵管通畅,通畅率达 88.75%。术后每 3 日复查血 HCG,80 例患者血 HCG 降至正常需要 6~19 天,平均 10.4 天。所有患者均保守治疗成功。

持续性异位妊娠是腹腔镜下保守手术治疗的常见并发症,本研究中共有 2 例患者术后两次在 72 小时血 HCG 水平下降 $<20\%$,诊断为持续性异位妊娠,以 MTX50 mg 肌注,隔日共两次,米非司酮 50 mg 每日 2 次,共 3 天。2 例患者均于术后 18、21 天血 HCG 下降为正常,保守治疗成功。

3 讨论

3.1 输卵管妊娠保守性手术治疗

异位妊娠的保守性手术治疗已有 100 多年的历史^[4]。1898 年, Kelly 首先提出了输卵管妊娠保守性手术治疗方法,而至今临床已有大量研究报道输卵管妊娠保守治疗成功的病例。腹腔镜检查是异位妊娠诊断的金标准,并且通过腹腔镜检查后确诊的患者可直接进行手术治疗,较开腹手术具有无创、损伤小、术后恢复快等优势^[5]。而一些早期输卵管妊娠临床表现并不典型、血、尿 HCG 和 B 超等无创检查通常无法准确判断是否为输卵管妊娠,而盲目剖腹探查是否为输卵管妊娠或手术治疗通常并不合适^[6]。而行腹腔镜检查,既可早期诊断,给患者赢得足够的治疗时间,又能防止不良结局发生^[7]。在输卵管妊娠的治疗方法中,传统的开腹手术一般选择患侧输卵管全部切除,这样将对生育功能造成巨大影响^[8]。目前,随着大中型医疗机构的医疗条件不断提高,输卵管妊娠治疗更倾向于尽量保留患侧输卵管,尤其那些年轻未育患者。腹腔镜手术具有创伤小、出血少、患者痛苦少、手术时间短、术后恢复快等优势,并且腹腔镜下输卵管挤胚术和输卵管取胚术能保留患者的生育能力,将成为输卵管妊娠的首选方法^[9]。同时,腹腔镜手术由于视野开阔、清晰,对于一些其它的病灶,如小的子宫内膜异位病灶、卵巢小囊肿、子宫小肌瘤等均可于手术中被清晰探查,并在治疗输卵管妊娠保守手术治疗的同时一并切除,从而减少了二次手术给患者带来的痛苦,并获得良好的治疗效果^[9]。

另外,本研究中对非高血压的患者还注入垂体后叶素^[10]。其对平滑肌具有明显收缩作用。在术中切开及取胚前在输卵管系膜内注射稀释垂体后叶素,能有效减少术中及术后出血,减少不良并发症发生,从而提高输卵管妊娠保守治疗的效率。

3.2 腹腔镜下输卵管妊娠保守手术治疗后持续性异位妊娠的防治

腹腔镜下输卵管持续性异位妊娠的防治^[11]:保守手术后如果发现绒毛组织未完全清除或取出绒毛组织细胞散落于腹腔内继续生长,将导致持续性异位妊娠,因此腹腔镜下输卵管妊娠保守手术治疗操作需非常谨慎^[12]。如发现术后血 HCG 持续升高或相隔 3 天内连续两次测定血 HCG 下降幅度 $<20\%$,即可诊断持续性异位妊娠^[13]。因此手术需注意尽量去除血凝块,充分冲洗腹腔。术中预防性使用 MTX50 mg 于输卵管系膜内注射,从而抑制残留绒毛生长^[14]。术后每 3 天复查血 HCG,早期诊断,从而早期实施进一步治疗。

3.3 输卵管妊娠保守性手术治疗方法优势及注意点

不同输卵管妊娠保守手术治疗方法与手术治疗方法对预后影响巨大^[15]。在本研究中腹腔镜下输卵管切开取胚需注意间断缝合,这种操作方法使切口整齐,保证准确对合,对输卵管的平滑肌及内膜损伤小,不易产生切口瘢痕,并且能保留了生理性的输卵管平滑肌蠕动及纤毛摆动,最大程度保留输卵管功能的完整^[16]。

腹腔镜若手术不当造成输卵管创面受损均可造成输卵管不畅而影响再次妊娠的效率^[17]。由于腹腔镜手术能在完全封闭的盆腔内操作,从而避免了空气暴露及组织损伤,从而具有防止盆腔粘连的发生。另外,输卵管再生能力强,即使留在原位的输卵管碎片也可再生变为有功能的输卵管^[18]。本组病例中术后宫腔镜通液术证实术后患侧输卵管复通率可达 80%,治疗效果较好。

综上所述,输卵管妊娠患者选择腹腔镜保守性手术治疗具有安全、微创,术后患侧输卵管复通率高的效果,并有保证术后生育功能的恢复,是要求保留生育功能的异位妊娠患者的最佳手术方式选择。

参考文献(References)

- [1] Stock L, Milad M. Surgical management of ectopic pregnancy[J]. Clin Obstet Gynecol,2012,55(2):448-454
- [2] Craig LB, Khan S. Expectant management of ectopic pregnancy[J]. Clin Obstet Gynecol,2012,55(2):461-470
- [3] Nayama M, Gallais A, Ousmane N, et al. Management of ectopic pregnancy in developing countries: example of a Nigerian reference maternity[J]. Gynecol Obstet Fertil,2006,34(1):14-18
- [4] Marion LL, Meeks GR. Ectopic pregnancy: history, incidence, epidemiology, and risk factors [J]. Clin Obstet Gynecol,2012,55(2):376-386
- [5] Givens VM, Lipscomb GH. Diagnosis of ectopic pregnancy[J]. Clin Obstet Gynecol,2012,55(2):387-394
- [6] Casikar I, Reid S, Condous G. Ectopic pregnancy: ultrasound diagnosis in modern management [J]. Clin Obstet Gynecol,2012,55(2):402-409
- [7] Lipscomb GH. Medical management of ectopic pregnancy. Clin Obstet Gynecol, 2012,55(2):424-432

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- dyeing clear staining method and Papanicolaou staining [J]. Chin J Lab Med, 2010, 33(9): 875-877
- [5] 黄受方, 张长淮, 余小蒙 (主译). 子宫颈细胞学 Bethesda 报告系统 [M]. 北京, 诊断病理学杂志社, 2004:18-19
- Huang Shou-fang, Zhang Chang-huai, Yu Xiao-meng (Primary translator). The Bethesda System [M]. Beijing, Diagnostic Pathology Magazine, 2004:18-19
- [6] Canda MT, Demir N, Sezer O, et al. Clinical results of the liquid based cervical cytology tool, Liqui-PREP, in comparison with conventional smears for detection of squamous cell abnormalities [J]. Asian Pac J Cancer Prev, 2009, 10(3):399-402
- [7] Nygard JF, Sauer T, Skjeldestad FE, et al. CIN2/3 and cervical cancer after ASCUS papsmear. A 7-year prospective study of the Norwegian population based, coordinated screening program [J]. Acta Cytol, 2003, 47(6):991-1000
- [8] Grote HJ, Friedrichs N, Pomjanski N, et al. Prognostic significance of DNA cytometry in carcinoma of the uterine cervix FIGO Stage IB and II [J]. Anal Cell Pathol, 2001, 23:97-105
- [9] Hering B, Horn LC, Nenning H, et al. Predictive value of DNA cytometry in CIN I and CIN 2. Image analysis of 1 93 cases [J]. Anal Quant Cytol Histol, 2000, 22(4):333-337
- [10] Remmerbach TW, Weidenbach H, Pomjanski N, et al. Cytologic and DNA cytometric early diagnosis of oral cancer [J]. Anal Cell Pathol, 2001, 22(4):211-221
- [11] Haroske G, Baak JP, Danielsen H, et al. Fourth updated ESACP consensus report on diagnostic DNA image cytometry [J]. Anal, 2001, 23:89-95
- [12] 孙小蓉, 汪健, Alfred Boecking. DNA 倍体分析系统用于宫颈癌及上皮内瘤变的诊断及预测 [J]. 中华病理学杂志, 2005, 34 (7): 435-437
- Sui Xiao-rong, Wang Jian, Alfred Boecking. Diagnosis and prediction of DNA analysis system for cervical cancer and intraepithelial neoplasia [J]. Chin J Pathol, 2005, 34 (7): 435-437
- [13] 彭敏, 王夷黎, 周东华, 等. 阴道镜在宫颈癌筛查中的应用探讨[J]. 中外医学研究, 2011, 9(13): 110-111
- Min Peng, Yi-li Wang, Dong-hua Zhou, et al. The study on application of Colposcopy in cervical cancer screening [J]. Chinese And Foreign Medical Research, 2011, 9(13):110-111
- [14] Spano JP, Marcelin AG, Carcelin G. HPV and cancer [J]. Bull Cancer, 2005, 92(1):59-64
- [15] 陶林, 贾薇, 杨安强等. 普查方法的联合应用与新疆喀什地区维吾尔妇女宫颈癌的调查分析 [J]. 临床与实验病理学杂志, 2010, 26 (04):397-401
- Tao Lin, Jia Wei, Yang An-qiang, et al. Screening method in combination with the Xinjiang Uygur Kashi Survey of women for cervical cancer [J]. Chinese Journal of Clinical and Experimental Pathology, 2010, 26(04):397-401
- [16] Liu S, Semenciw R, Probert A, et al. Cervical cancer in Canada : changing patterns in incidence and mortality [J]. Int J Gynecol Cancer, 2001, 11(1):24-31
- [17] Horner MJ, Ries LAG, Krapcho M, et al. SEER Cancer Statistics Review, 1975-2006, National Cancer Institute. Bethesda, MD, <http://seer.cancer.gov/csr/1975-2006/>, based on November 2008 SEER data submission, posted to the SEER web site, 2009
- [18] American Cancer Society. Cancer Facts & Figures 2010 [D]. Atlanta, GA: American Cancer Society, 2010
- [19] Jin XW, Sikon A, Yen-Lieberman B. Cervical cancer screening: Less testing, smarter testing [J]. Cleveland Clinic Journal of Medicine, 2011, 78(11):737-747
- [20] Arbyn M, Sasieni P, Meijer CJLM, et al. Chapter 9: clinical applications of HPV testing a summary of meta-analyses [J]. Vaccine, 2006, 24:78-89
- [21] Goldie SJ, Kim JJ, Wright TC. Cost-effectiveness of human papillomavirus DNA testing for cervical Cancer screening in women aged 30 years or more [J]. Obstet Gynecol, 2004, 103:617-618

(上接第 4534 页)

- [8] Zhang J, Hao WM, Wei W, et al. Outcome and relevant factors of tubal pregnancy treated with laparoscopic conservative surgery [J]. Chinese Journal of Obstetrics and Gynecology, 2010, 45(2):84-88
- [9] Degé e S, Dricot JF, Lamborelle S, et al. How I treat: an ectopic pregnancy. Rev Med Liege, 2006, 61(12):797-803
- [10] Parker VJ, Menzies JR, Douglas AJ. Differential changes in the hypothalamic-pituitary-adrenal axis and prolactin responses to stress in early pregnant mice [J]. J Neuroendocrinol, 2011, 23(11):1066-1078
- [11] Van Mello NM, Mol F, Mol BW, et al. Conservative management of tubal ectopic pregnancy [J]. Best Pract Res Clin Obstet Gynaecol, 2009, 23(4):509-518
- [12] Fujishita A, Masuzaki H, Khan KN, et al. Laparoscopic salpingotomy for tubal pregnancy: comparison of linear salpingotomy with and without suturing [J]. Hum Reprod, 2004, 19(5):1195-1200
- [13] Visconti K, Zite N. HCG in ectopic pregnancy. Clin Obstet Gynecol. 2012, 55(2):410-417
- [14] Robinson RD, Ginsburg ES. Persistent tubal pregnancy presenting with delayed hemorrhage from a second implantation of trophoblast on the ovary: a case report [J]. J Reprod Med, 2004, 49(8):693-695
- [15] Andrews J, Farrell S. Spontaneous bilateral tubal pregnancies: a case report [J]. J Obstet Gynaecol Can, 2008, 30(1):51-54
- [16] Stucki D, Buss J. The ectopic pregnancy, a diagnostic and therapeutic challenge [J]. J Med Life, 2008, 1(1):40-48
- [17] Juneau C, Bates GW. Reproductive outcomes after medical and surgical management of ectopic pregnancy. Clin Obstet Gynecol, 2012, 55(2):455-460
- [18] Varma R, Gupta J. Tubal ectopic pregnancy [J]. Clin Evid (Online), 2012, pii: 1406