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保肛术与腹会阴联合直肠癌根治术对低位直肠癌疗效及生活质量的比较研究*

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摘要 目的:比较保肛术与腹会阴联合直肠癌根治术(Miles术)对低位直肠癌患者的疗效及生活质量。**方法:**选取我院于2016年1月至2017年7月期间收治的低位直肠癌患者50例,按照乱数表法分为观察组与对照组,两组均为25例。观察组给予保肛术治疗,对照组给予Miles术治疗。对比两组患者围手术期情况以及术后并发症发生率,采用自制评分量表评价并对比两组患者术后的生活质量,随访1年,比较两组患者的复发率和1年生存率。**结果:**与对照组比较,观察组术中出血量、术后恢复正常排便时间、术后排气时间以及住院时间均降低($P<0.05$);与对照组比较,观察组生活质量优良率明显升高($P<0.05$);观察组术后并发症发生率明显低于对照组($P<0.05$);观察组盆腔复发率、吻合口复发率低于对照组,而1年生存率高于对照组($P<0.05$)。**结论:**与Miles术比较,保肛术治疗低位直肠癌患者的临床疗效更好,患者术后恢复快、术后并发症发生率低,可明显改善患者的生活质量以及预后,值得临床推广应用。

关键词:保肛术;腹会阴联合直肠癌根治术;低位直肠癌;生活质量;疗效;预后

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Comparative Study on Curative Effect and Quality of Life of Anus Preserving Surgery and Abdominoperineal Radical Operation of Rectal Cancer for Low Rectal Cancer*

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ABSTRACT Objective: To compare the curative effect and quality of life of anus preserving surgery and abdominoperineal radical operation of rectal cancer (Miles surgery) in patients with low rectal cancer. **Methods:** 50 patients with low rectal cancer who were treated in our hospital from January 2016 to July 2017 were selected, they were divided into observation group and control group according to the random number table method, and two groups were 25 cases. The observation group was given anus preserving surgery, while the control group was treated with Miles surgery. The condition in perioperative period and the incidence of postoperative complications were compared between the two groups. Self rating scale was used to evaluate and compare the postoperative quality of life of the two groups. The recurrence rate and the 1 year survival rate of the two groups were compared after 1 years of follow-up. **Results:** Compared with the control group, the amount of bleeding during operation, the time to return to normal defecation, postoperative exhaust time and hospitalization time in the observation group were all decreased ($P<0.05$). Compared with the control group, the good and excellent rate of quality of life in the observation group was significantly increased ($P<0.05$). The incidence of postoperative complications in the observation group was significantly lower than that in the control group ($P<0.05$). The pelvic recurrence rate and anastomotic recurrence rate of the observation group were lower than those of the control group, and the 1 year survival rate was higher than that of the control group ($P<0.05$). **Conclusions:** Compared with Miles surgery, clinical efficacy of anus preserving surgery is better in the treatment of low rectal cancer, postoperative recovery of patients is more quickly, and the incidence of postoperative complications is lower. It can significantly improve the quality of life and prognosis of patients, which is worthy of clinical application.

Key words: Anus preserving surgery; Abdominoperineal radical operation of rectal cancer; Low rectal cancer; Quality of life; Curative effect; Prognosis

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前言

直肠癌是一种常见的消化道恶性肿瘤,随着人们饮食结构的改变,近年来直肠癌的发病率逐年上升^[1]。其中低位直肠癌是

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指肿瘤病灶位于直肠下约 1/3 段的部位,或距离直肠齿状线短于 8 cm 的肿瘤,尤其以腹膜返折以下最为常见^[23]。由于直肠癌患者需造永久性腹壁结肠口,因此最大程度保留肛门括约肌,维持肛门正常功能是低位直肠癌患者的主要需求^[45]。而临床传统的腹会阴联合直肠癌根治术(Miles 术)为了完全清理低位直肠癌病灶,清扫范围较大,常累及肛门括约肌,从而导致患者预后较差^[67]。相关研究表明,低位直肠癌病灶下缘的安全距离需要保持在 5 cm 以上,同时肛管长约 3 cm 最佳^[8],而 Miles 术是临床手术治疗 8 cm 以内低位直肠癌患者的标准术式^[9],因此,在 Miles 术的基础上进行改进,并在清扫病灶的同时最大程度保留肛门的保肛术已成为临床应用的主要手术方式^[10]。目前如何控制根治术后的局部复发率,提高患者生存率已成为当前研究的热点。鉴于此,本次研究选取我院 50 例低位直肠癌患者,对保肛术与 Miles 术两种手术方式进行比较研究,旨在探讨两种术式治疗低位直肠癌的疗效及对患者生活质量的影响,现将研究结果整理如下。

1 资料与方法

1.1 一般资料

选取我院于 2016 年 1 月至 2017 年 7 月期间收治的低位直肠癌患者 50 例,纳入标准:(1)经病理检查以及实验室检查确诊为低位直肠癌;(2)患者及家属知情同意并签署知情同意书。排除标准:(1)既往有肛门手术史或放、化疗史的患者;(2)有外伤史或者肛门失禁、狭窄患者;(3)失访或无法配合随访者;(4)存在淋巴系统转移者;(5)意识不清,无行为能力的患者;(6)精神系统疾病的患者。本研究符合我院伦理委员会制定的相关规定并获得批准实施。将入选患者按照乱数表法分为观察组(n=25)与对照组(n=25)。其中观察组男 14 例,女 11 例,年龄 33~79 岁,平均(51.51±3.75)岁;肿瘤至肛缘距离为 3~8 cm,平均距离(5.54±1.32)cm;分化程度:高分化 11 例,中分化 9 例,低分化 5 例;Dukes 分期:A 期 13 例,B 期 8 例,C 期 4 例;病理类型:乳头状癌 9 例,管状腺癌 10 例,粘液腺癌 6 例。对照组男 16 例,女 9 例,年龄 30~78 岁,平均年龄(52.39±4.36)岁;肿瘤至肛缘距离为 3~7 cm,平均距离(5.63±1.39)cm;分化程度:高分化 10 例,中分化 8 例,低分化 7 例;Dukes 分期:A 期 10 例,B 期 10 例,C 期 5 例;病理类型:乳头状癌 8 例,管状腺癌 9 例,粘液腺癌 8 例。两组一般资料比较无明显差异(P>0.05)。

1.2 方法

两组患者术前均给予相关常规检查,使用抗生素纠正水电解质紊乱,行全身复合麻醉。两组患者由同一组医师完成手术,辅材为一次性使用。其中观察组给予保肛术治疗,患者取截石

位,常规消毒、铺巾,麻醉后待肛门括约肌完全松弛状态时,以电刀取肛旁切口,钝性分离软组织,探查肠系膜下血肿,行高位结扎。结扎后使用血管钳钝性分离后间隙,严格遵照无瘤操作原则、直肠全系膜切除术原则,两边扩散分离组织并向前进行分离,手术过程中,注意保护患者的输尿管及生殖神经,避免误伤,主刀医师对肿瘤病灶进行清除的过程中,必要时行盆腔侧壁淋巴结清扫。直肠系膜至远端时其生理解剖形态逐渐变细,最终与盆底肌、肛管外括约肌统一组成肌管平面,术中在瘤体下缘约 1.5~2 cm 处使用闭合切割器进行直肠肠管的切断分离操作,术中荷包钳夹于直肠近端距肿瘤病灶 5 cm 以远部,切除分离肿瘤。待确认肿瘤及淋巴结清扫完全后,以吻合器蘑菇头置入保留的直肠管内,冲洗远端直肠,使直肠后壁/肛管与结肠端吻合。对照组行 Miles 术,术中将肿瘤病灶部位游离约 4 cm 左右,残端取左下腹部造瘘口,行残端吻合。两组患者术后进行常规抗炎、抗感染等对症处理。为消除局部感染,患者 5 d 内需进行高锰酸钾坐浴。同时进行扩肛处理,尽早排出肠腔内气体及积液。术后根据患者病理分期决定是否进行放化疗处理。

1.3 观察指标

(1)对比两组患者围术期情况(术中出血量、手术时间、术后恢复正常排便时间、术后排气时间、住院时间);(2)采用自制评分量表评价并对比两组患者术后生活质量,该量表包括抑郁、食欲、焦虑、睡眠质量、排便、日常生活、家属理解、疾病、疲乏、治疗态度等 10 个项目,每个项目 5 分,总分 50 分,得分越高表明生活质量越好,0~5 分记为差,6~20 分记为中,21~38 分记为良,39~50 分记为优。优良率=(优+良)÷病例总数×100%;(3)对比两组患者的术后并发症:造瘘口狭窄/坏死、术后切口出血、性功能障碍;(4)随访 1 年,通过电话或门诊复查等方式统计两组患者的盆腔复发率、吻合口复发率以及术后 1 年生存率。

1.4 统计学方法

采用 SPSS19.0 进行分析,术后恢复正常排便时间、术中出血量等计量资料用均数±标准差($\bar{x} \pm s$)表示,采用 t 检验,生活质量优良率、并发症发生率等计数资料用率(%)表示,采用 χ^2 检验,将 $\alpha=0.05$ 作为检验标准。

2 结果

2.1 两组围手术期情况比较

与对照组比较,观察组术中出血量、术后恢复正常排便时间、术后排气时间以及住院时间均降低(P<0.05),而两组手术时间比较无统计学差异(P>0.05)。详见表 1。

表 1 两组围手术期情况比较($\bar{x} \pm s$)

Table 1 Comparison of condition in perioperative period between the two groups($\bar{x} \pm s$)

Groups	n	Time to return to normal defecation(d)	Intraoperative blood loss(mL)	Operation time (min)	Postoperative exhaust time(d)	Time of hospitalization (d)
Control group	25	118.23±2.29	214.83±51.76	153.23±22.29	3.78±2.76	12.44±2.43
Observation group	25	29.91±3.63	176.73±60.72	148.65±20.63	2.36±1.71	8.18±1.46
t		102.890	13.012	0.754	2.187	7.514
P		0.000	0.000	0.455	0.034	0.000

2.2 两组生活质量比较

与对照组比较, 观察组生活质量优良率明显升高($P<0.05$)。详见表 2。

表 2 两组生活质量比较[n(%)]

Table 2 Comparison of quality of life of two groups[n(%)]

Groups	n	Bad	Secondary	Good	Excellent	Good and excellent rate
Control group	25	0(0.00)	8(32.00)	13(52.00)	4(16.00)	17(68.00)
Observation group	25	0(0.00)	3(12.00)	14(56.00)	8(32.00)	22(88.00)
χ^2						9.265
P						0.002

2.3 两组术后并发症情况比较

观察组术后发生造瘘口狭窄/坏死 2 例, 术后切口出血 1 例, 性功能障碍 2 例, 对照组术后发生造瘘口狭窄/坏死 2 例, 术后切口出血 3 例, 性功能障碍 4 例, 观察组术后并发症发生率为 20.00%(5/25), 明显低于对照组的 36.00%(9/25), 差异有

统计学意义($\chi^2=2.960, P=0.037$)。

2.4 两组复发率与生存率比较

观察组盆腔复发率、吻合口复发率低于对照组, 而 1 年生存率高于对照组, 差异有统计学意义($P<0.05$)。详见表 3。

表 3 两组术后复发率与生存率比较[n(%)]

Table 3 Comparison of postoperative recurrence rate and survival rate between the two groups[n(%)]

Groups	n	Pelvic recurrence rate	Anastomotic recurrence rate	1 year survival rate
Control group	25	5(20.00)	4(16.00)	17(68.00)
Observation group	25	1(4.00)	0(0.00)	23(92.00)
χ^2		15.033	7.510	4.500
P		0.000	0.008	0.034

3 讨论

目前临床上治疗低位直肠癌患者的方式主要以手术为主, 传统的 Miles 术是近半个世纪以来治疗的金标准^[11,12]。Miles 术虽然可以挽救患者生命, 但其造瘘口给患者术后的生活带来较多不便, 导致患者术后的生活质量明显下降^[13,14]。随着医疗技术的不断提高, 对患者病症治疗的同时改善患者的生存质量也已成为了近年来医学界不断探索的热点。临床上直肠癌患者行手术治疗时, 是否保留肛门的主要取决因素在于肿瘤病灶与肛缘的距离^[15,16]。Miles 术首要考虑因素仍旧限制于肿瘤病灶的淋巴结转移情况, 临床上能够保留患者肛门括约肌对于患者术后的生存质量极为重要, 也是进一步保存肛门功能的重要条件^[17-19]。直肠癌患者肿瘤病灶发生在腹膜反折平面以上, 远端扩散较少, 即使是直肠癌晚期患者, 其直肠癌病灶也仅仅向下逆行扩散 2 cm 以内^[20]。肿瘤病灶发生、扩散的特点为保留肛门提供了一定的理论依据, 保留患者盆腔神经是直肠癌根治术的必要遵循原则^[21,22]。双吻合器技术为临床手术中直肠吻合术提供了有效途径^[23], 本次研究中观察组的术式操作保留了患者的肛门括约肌, 术中在瘤体下缘约 1.5-2 cm 处行直肠肠管的切断分离操作, 充分把握了肿瘤发生处于腹膜反折平面以下的特点, 在术中合理区分了术区直肠, 故进一步在直肠近端距肿瘤病灶 5 cm 以远部切除肿瘤, 完好的保留了肛周肌肉, 使得肛门括约肌的功能有助于患者术后的康复。

本研究结果显示, 与对照组比较, 观察组术中出血量、术后恢复正常排便时间、术后排气时间以及住院时间均降低($P<0.05$)。

提示观察组所用的术式出血少, 有助于患者术后的康复。保肛术操作过程中遵循了盆腔自主神经手术的手术规范, 对患者的盆腔自主神经保留效果较好, 最大程度上保留了患者术后的排尿功能及性功能, 有利于患者术后机能的恢复, 缩短住院时间^[24-26]。同时本研究结果还显示, 观察组患者术后并发症显著低于对照组($P<0.05$), 提示低位直肠癌采用保肛术治疗安全、可靠。分析原因为保肛术保留了一定的盆腔自主神经及肛门括约肌, 有利于患者术后肛门及鞍区功能的恢复, 因此可以一定程度的减少术后并发症的发生^[27-29]。本研究结果显示, 与对照组比较, 观察组术后生活质量优良率明显升高, 说明观察组患者术后的生活质量优于对照组, 与 Scheele J^[30]等研究结论相符。复发率和生存率是癌症患者治疗有效性及安全性评价的重要观察指标, 通过对患者进行 1 年的随访观察, 结果显示观察组盆腔复发率、吻合口复发率低于对照组, 而 1 年生存率高于对照组($P<0.05$), 说明低位直肠癌保肛术一定程度上可以改善患者术后预后, 有利于患者术后康复, 提高患者术后的生存质量。

综上所述, 保肛术治疗低位直肠癌患者的疗效优于 Miles 术, 患者围术期情况更好, 术后并发症更少, 患者术后恢复更快, 能够提高患者术后生活质量以及改善患者的预后, 值得临床推广。

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