·临床病理讨论·

胃异位胰腺1例并文献复习

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【摘 要】 异位胰腺(HP)是一种少见疾病,是指与正常胰腺完全分离的孤立胰腺组织,与正常胰腺组织间没有组织、神经和血管相连。胃HP无特异的临床表现,常在胃镜检查时发现,由于病变多位于黏膜下层,胃镜病理活检很难确诊,诊断依赖超声内镜及内镜治疗术后的病理结果。HP与黏膜下肿瘤如胃肠道间质瘤难以区分,常行外科手术切除。本文报道了1例胃镜检查示胃部肿块最后确诊为胃HP的病例。

【关键词】 胰腺;胃;胃镜检查
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Gastric heterotopic pancreas: a case report and literature review

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【Abstract】 Heterotopic pancreas (HP) is a rare entity, defined as pancreatic tissue without a true anatomical or vascular connection to the pancreas. Gastric HP often has nonspecific clinical symptoms and is usually detected in the gastroscopy. Its diagnosis by gastroscopic biopsy is difficult as the lesion is mostly located in the submucosa. Its clinical diagnosis depends on ultrasonographic endoscopy and pathologic biopsy after endoscopic treatment. HP is sometimes surgically resected because it can be difficult to distinguish HP from neoplastic submucosal masses such as gastrointestinal stromal tumors. Although not common, HP should be given due consideration in the differential diagnosis of extramucosal gastric masses to avoid unnecessary intervention. We reported a case of gastric HP that was found incidentally as a gastric mass on gastroscopy.

【Key words】 pancreas; stomach; gastroscopy

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1 病例摘要

患者,男性,66岁,干部。因“体检发现胃占位性病变2个月”就诊于解放军总医院健康管理研究院。患者2个月前在当地医院行胃镜检查发现胃体黏膜下隆起病变,位于小弯侧,大小约2.5 cm×2.5 cm,随后行超声内镜(endoscopic ultrasonography,EUS)检查示胃体中部小弯侧病变,呈低回声,位于黏膜下层,考虑胃体占位性病变,性质待定,未予以治疗。患者无恶心、呕吐、反酸、烧心及腹痛等症状。既往体健,否认高血压、冠心病、糖尿病病史。饮酒史15年,每天饮白酒约250 ml,无吸烟史。

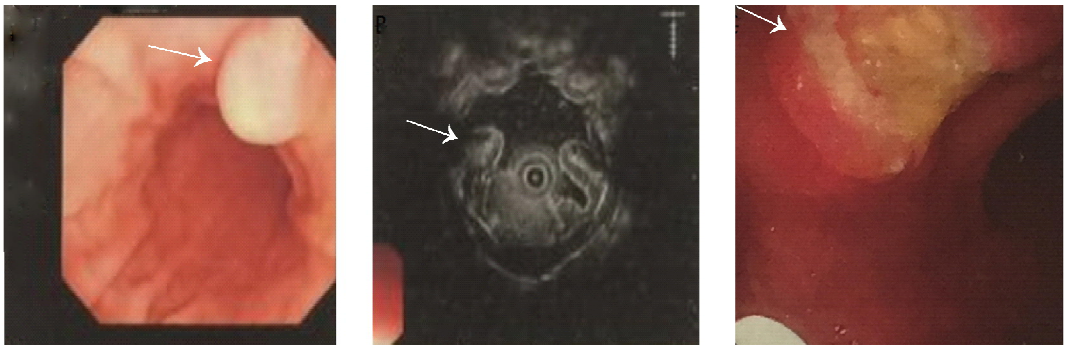
入院查体 体温:36.0℃,脉搏:72次/min,血压124/77 mmHg(1 mmHg=0.133 kPa),一般状况良好,神志清楚,查体合作。心肺无异常。腹平软,肝脾肋缘下未触及,全腹无压痛及反跳痛,移动性浊音阴性,肠鸣音4次/min。

诊疗经过 完善血常规、肝肾功能、电解质、凝血功能、心电图、胸片检查,结果均未见明显异常。腹部CT平扫+增强未见异常。入院2 d后在镇静麻醉下行胃镜检查示:胃体黏膜光滑,小弯侧有一大小约1.0 cm×1.2 cm半球形黏膜下隆起病变,遂行黏膜下肿瘤切除术,圈套后电凝电切,氩气凝固创面,胃窦黏膜光滑,红白相间,以红为主,分泌物少(图1)。病理结果:胃(体小弯)肌层内见异位胰腺(heterotopic pancreas,HP)组织。给予禁食、积极抑酸、胃黏膜保护剂及补充电解质、其他对症治疗,治疗3 d,患者无不适后痊愈出院。目前随访中,病情平稳。

2 临床病理讨论

贺红艳主治医师 本例患者为老年男性,查体发现胃体黏膜下隆起病变,位于小弯侧,大小约2.5 cm×2.5 cm,EUS检查示胃体中部小弯侧病变,性质待定,为求进一步诊治就

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A B C

图1 胃异位胰腺内镜检查和治疗

Figure 1 Endoscopic examination and treatment of gastric heterotopic pancreas

A: esophagogastroduodenoscopy shows a submucosal mass in the distal gastric body along the lesser curvature (arrow); B: under endoscopic ultrasonography, the mass arises from the submucosa(the third layer), and the lamina propria(the fourth layer) is intact; C: successful endoscopic resection and electrocoagulation of the lesion after ringing, and coagulating wound with argon

诊于解放军总医院健康研究院。就诊后给予胃镜检查示胃体HP,内镜下切除。病理结果胃体小弯肌层内见HP组织。术后给予积极的内科治疗,病情好转出院。

孙菁主治医师 HP是一种发育异常疾病,是指与正常胰腺完全分离的孤立的胰腺组织,与正常胰腺组织间没有组织、神经和血管相连[1,2]。1729年,Jean-Schultz首次报道了本病,Klobb证实了它的组织学结构。HP又称为迷走胰腺、异常胰腺和副胰腺等[3,4]。大多数HP患者都无症状,通常在尸检或手术过程中偶然被发现。尸检结果中HP的发生率为0.6%~13.7%[5,6],在上腹部手术中的发生率为0.2%,胃切除术中的发生率为0.9%[7,8]。

韩辉副主任医师 同意前面两位临床医师的分析。关于HP的发病机制尚不清楚,HP可能是从胚胎的胰芽衍生而来。目前主要有两种假说:错位理论和化生理论。错位理论者认为HP来源于前肠转位等运动而使胰腺原基逐渐分离,在邻近的胃、肠壁或肠系膜等处形成。而化生理论者则认为HP是来源于内胚层的胰腺化生,在胚胎发育过程中,内胚层会迁徙到黏膜下层[9]。

HP可发生于任何年龄段,但50~69岁最常见,男性发病率高于女性[6,10]。最常见的部位是胃(25%~38%)、十二指肠(17%~21%)、以及近端空肠(15%~21%)[11],也可见于回肠、Meckel憩室、肠系膜、食管、胆道、脾脏等,极少数可见于肺、纵隔、肾上腺、阑尾、腹壁、大网膜、输卵管和精索等[12]。胃肠道HP最常位于黏膜下层(54%),而黏膜下层和固有肌层均累及(23%)较少,仅发生于固有肌层为8%,浆膜下11%,全层4%[3]。

田万管副主任医师 HP分为4型:含胰腺导管、腺泡和胰岛为Ⅰ型;仅含胰腺导管和腺泡为Ⅱ型;仅含胰腺导管为Ⅲ型;仅有胰岛为Ⅳ型[1,12]。Ⅰ型具有胰腺腺泡、导管和胰岛以及独立血供和导管系统,并且有正常的外分泌和内分泌功能[1]。因此,虽然一般情况下无症状,但是患者易患正常胰腺的各种疾病,包括急性或慢性胰腺炎、囊肿和恶变[7,13,14]。HP由于其大小、位置和组织学类型不同,临床表现也不同。本病例无任何临床症状,胃镜检查发现胃体部黏膜下隆起病变。

胃HP多位于胃窦的后壁和前壁,占85%~95%,多分布于大弯侧[15]。大多数HP患者都无症状,偶然情况下被发现[3]。但有时也会出现一些非特异性症状,这些症状与位置、大小、黏膜受累情况及发生的胰腺疾病有关。据报道直径为1.5~2.0 cm会出现临床症状[16]。常见症状是腹痛,与消化酶分泌引起的组织损伤、炎症或化学刺激有关。较少见的症状包括恶心、呕吐、出血、梗阻性黄疸、溃疡、肠梗阻和肿瘤性病变[6,17]。

黄先勇主任医师 前面各位医师对本病进行了剖析,使我们对本病有了更进一步认识。HP的鉴别诊断主要包括胃肠道间质肿瘤(gastrointestinal stromal tumors,GIST)、胃肠道自主神经肿瘤、胃良性肿瘤、淋巴瘤或胃癌,通过影像学检查或内镜检查难以区分[12,18]。增强CT扫描有助于诊断,可为外科手术提供依据[18],如病灶主要位于胃窦部、表面黏膜明显强化、长短径比值>1.4以及向腔内生长。HP强化的方式和程度反映病变的组织类型。以腺泡组织为主的病变与其他类型相比,强化更均匀和更明显[18]。表面黏膜明显强化与HP引起的炎症反复作用有关。胃镜检查HP表现为管腔内黏膜下隆起性病变,常常诊断为GIST[19]。EUS检查HP特征表现为病灶呈低回声,广基,不均质,中央凹陷有脐,固定,略不规则,边界不清[12],而胃GIST主要表现为低回声、均质、边界清楚。但有时也会出现溃疡和不规则的边缘。HP可累及黏膜下层(73%)、肌层(17%)、浆膜下层(10%),或三者均累及[20]。绝大多数情况下,浅表活组织检查没有诊断价值[21]。据报道,EUS对HP的诊断有帮助;EUS引导下细针穿刺活检对确诊HP尤其有效,文献报道其敏感度为80%~100%[22,23]。尽管诊断方法取得了进展,但是HP与黏膜下肿瘤如GIST的鉴别诊断对临床医师来说仍是难题。

孟庆义主任医师 胃HP的治疗应根据有无并发症或大小和浸润深度决定。无症状患者可长期观察,不需进一步干预[16,24]。但也有学者建议切除HP可预防急性胰腺炎和慢

性胰腺炎及恶变的发生[15]。HP既往的治疗多为外科手术，手术方式视病变位置、大小、程度而定，因为手术本身既有诊断价值，又可避免可能的并发症，但手术创伤较大，随着消化内镜技术的发展，EUS能较准确地判断消化道黏膜下隆起的来源，大部分通过内镜下治疗，如黏膜下切除术、黏膜下剥离术及内镜隧道技术。

综上所述，胃HP需与其他黏膜下病变如GIST相鉴别，术前给予确定性诊断极重要，这样可避免外科干预。由于HP不常见，在鉴别胃黏膜外肿块时应考虑。

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