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输尿管内翻性乳头状瘤一例

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1　病例摘要

患者女性，66 岁，教师，因右腰酸痛 1 年余入院。无发热，无尿频、尿急、尿痛及肉眼血尿。体检无明显阳性体征。血尿常规及生化检查基本正常。尿脱落细胞学检查 3 次均未找到肿瘤细胞。B 超示右肾重度积水伴右输尿管上段扩张。KUB＋IVP：右肾至 120 min 仍未显影，左肾显影良好。输尿管插管逆造影示右输尿管上段充盈缺损约 2～3 cm，右肾积水明显。CT 检查：输尿管上段占位，右肾盂扩张积水，左肾小囊肿。ECT 提示右肾基本无功能。

在连续硬膜外麻醉下，经右第 11 肋间腹膜外途径行右输尿管上段探查术。术中见右肾明显增大，皮质变薄，表面凹凸不平，周围粘连较重，肾盂扩张积水，积水呈咖啡样。输尿管上段扩张，管壁增厚僵硬，距右肾盂 3 cm 处输尿管内可见一乳头样肿瘤，大小约 1 cm×3 cm，距肿瘤 3 cm 以下输尿管外观基本正常。术中行输尿管肿瘤冰冻切片，报告为内翻性乳头状瘤。行右肾及输尿管大部切除术，手术经过顺利。

术后病理示右输尿管肿瘤(下转第 260 页)

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给予技术上的协助。)

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(上接第251页)大小约1 cm×3 cm,表面大部披覆移行上皮,上皮下为Brunn巢样结构的上皮巢,巢间结缔组织少,部分瘤细胞呈乳头状排列。输尿管炎症细胞浸润明显,并见局灶性鳞状上皮化生。诊断为输尿管内翻性乳头状瘤伴局部癌变。

2 讨 论

内翻性乳头状瘤绝大多数发生于膀胱,尤其是膀胱颈部、三角区及两侧输尿管口周围,发生于输尿管者少见。

输尿管内翻性乳头状瘤术前明确诊断比较困难。肉眼血尿与腰酸、腰痛为最多见的临床症状,也有部分患者症状不明显,本例患者无明显血尿而以腰部酸痛为主要表现。影像学检查可行B超、KUB+IVP、输尿管插管逆造影等检查,若肾功能较差者可考虑磁共振尿路造影以期得到较好显像。此外输尿管薄层CT扫描有时可显示肿瘤情况及其浸润深度。在诊断时,必须同时评价整个尿路系统情况。因为其可多中心生长,也可与其它泌尿系肿瘤并存。

鉴别诊断上主要与Brunn巢和移行上皮乳头状癌加以鉴别。前者一般体积较小,不外突形成肿块可以鉴别。后者则呈绒毛乳头状,切面无腔隙,表面无正常移行上皮披覆,瘤细胞巢不内翻,常侵犯肌层,中心有纤维血管轴心。

治疗以手术切除为主,并最好行术中冰冻切片检查以除外输尿管癌可能。但有时由于部分肿瘤细胞可外生性生长,以及对于是否存在细胞的异型性较难定论而易误诊。本例术中冰冻切片与术后病理不甚一致。手术方式上,大多数情况下可行病变段输尿管切除输尿管端端吻合术,若肿瘤位于输尿管下段可考虑行输尿管部分切除膀胱再植术。也有人采用输尿管镜下肿瘤电切取得了较好的疗效。对输尿管梗阻时间较长肾功能较差者,如本例患者,则可行肾输尿管切除术。

输尿管内翻性乳头状瘤的生物学行为为良性,但也可复发与恶变,因此良好的随访,包括定期IVP、尿脱落细胞学、膀胱镜等检查是十分必要的。

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