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乙状结肠扭转伴局部疝1例报道

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摘　要

本病例报告了一例罕见的病例，涉及乙状结肠扭转并伴随局部疝入肠系膜根部。乙状结肠扭转是一种急性腹痛病症，通常由先天因素、肠道问题、腹腔手术或腹腔内气体积聚引起。这种情况可导致血液供应中断，严重并发症，因此需要紧急处理。为帮助临床医生提高对乙状结肠扭转伴局部疝的诊疗意识，该文结合文献探讨了 1 例乙状结肠扭转伴局部疝如肠系膜根部的诊疗进展。

关键词

乙状结肠扭转，局部疝，肠系膜，手术治疗

A Case Report of Sigmoid Colon Torsion with Local Hernia

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Abstract

This case reports a unique case involving sigmoid colon torsion with concomitant localized herniation into the mesenteric root. Sigmoid torsion is an acute abdominal pain condition usually caused by congenital factors, intestinal problems, laparotomy, or gas buildup in the abdominal cavity. This condition can lead to disruption of the blood supply and serious complications and

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therefore requires urgent attention. To help clinicians improve their awareness of the diagnosis and treatment of sigmoid colon torsion with localized hernia, this article discusses the progress of a case of sigmoid colon torsion with localized hernia such as mesenteric root in the light of the literature.

Keywords

Volvulus of Sigmoid Colon, Local Hernia, Mesentery, Surgical Treatment

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1. 引言

乙状结肠扭转是指乙状结肠沿其肠系膜中轴发生异常旋转，导致部分或全部肠道受阻，这种情况占据肠扭转病例的 90% [1] [2]。乙状结肠扭转通常是由于其特殊的解剖结构所引起的，包括肠袢及其系膜过长、系膜根部附着狭窄或粘连引起的受限，以及肠内容物突然增加、肠管运动异常或体位改变等诱发因素所致[3]。乙状结肠扭转部位常见于系膜根部，以顺时针方向旋转为多见，生理状态下可以发生 180˚的顺时针旋转而不会产生明显的症状。如旋转程度顺时针超过 180˚或逆时针旋转至 180˚时，就可能发生闭袢性肠梗阻，造成肠蠕动增强使其在扭转方向上顺势增加扭转程度，扭转程度轻者通常不超过 360˚，而严重情况下可达 720˚至 1080˚后出现血运障碍继而发生肠坏死可能[4]。疝是指脏器部分或完全脱离其正常位置，穿越自身的固有膜，并进入相邻的腔隙[5]。在这个案例中，乙状结肠扭转和疝同时发生，为临床医生提供了一项复杂的挑战。

2. 病历资料

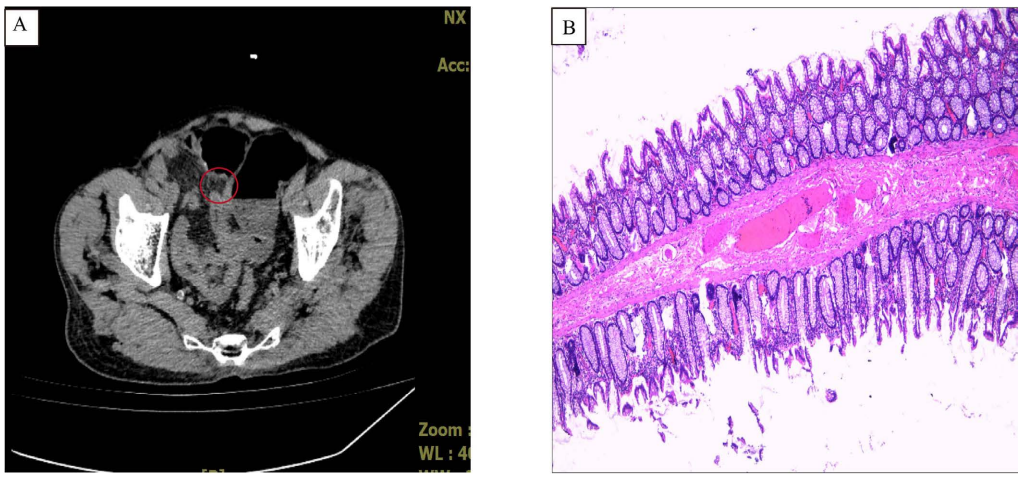

Figure 1. (A) Enhanced CT, (B) Postoperative pathological examination of some colon tissues (4 × 10)
图 1. (A) 增强 CT 结果，(B) 部分结肠组织术后病理检查(4 × 10)

患者男，72 岁，10 日前无明显诱因出现间歇性下腹部胀痛，疼痛不可耐受。伴肛门停止排气排便，余无不适。就诊当地县医院行腹部平片提示右中上腹液气平，考虑肠梗阻，予以灌肠等对症处理，未见

好转且腹痛及腹胀加剧，7 天后于 2023-10-19 日门诊收住入院。查体：体温 36.4℃，脉搏 74 次/分，呼吸 20 次/分，血压 150/74 mmHg。患者既往高血压病史 30 年，50 年前因肠梗阻行手术治疗。查体：腹部呈现高度膨隆状，未观察到胃肠型及蠕动波，腹柔软，全腹压痛，但没有反跳痛。移动性浊音测试结果为阴性，听诊肠鸣音消失。检验：血常规、肝肾功、电解质、凝血未见明显异常。全腹部增强 CT 提示(图 1(A))：1) 乙状结肠局部疝入肠系膜根部，并乙状结肠系膜扭转，致低位梗阻；2) 右侧腹股沟疝，盆腔小肠部分疝入。其他相关检查未发现手术禁忌症，遂于入院第二天紧急进行腹部开刀探查手术，术中见下腹盆腔有淡黄色腹水约 200 ml，乙状结肠自系膜根部顺时针扭转，肠管高度扩张充血，直径约 20 cm，肠管未坏死，梗阻近端结肠明显扩张结存大量粪便，右侧腹股沟疝形成，疝环直径约 2 cm (图 2)。术中逆时针旋转 270 度后复位，遂行“乙状结肠切除术、暂时性结肠造口术、腹股沟疝单侧修补术”。术后患者康复情况良好，病理报告提示(图 1(B))：镜下无异常，于术后 7 天无问题出院。

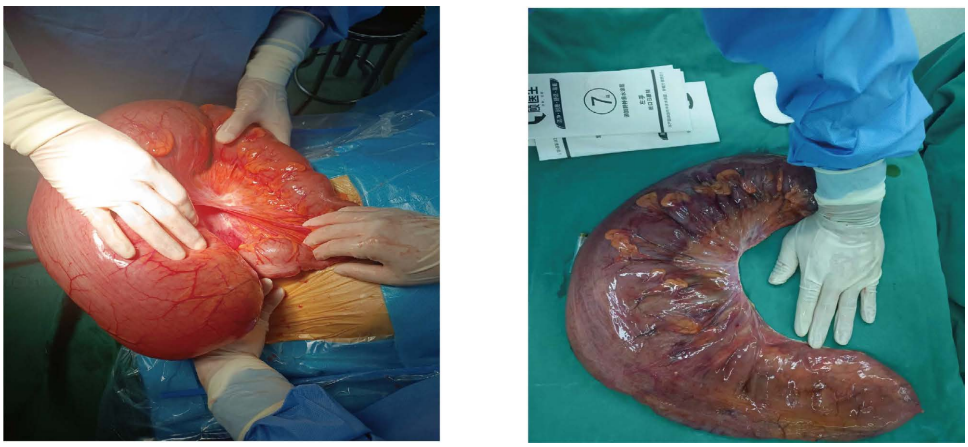

Figure 2. Excited sigmoid colon
图 2. 切除的乙状结肠

3. 讨论

乙状结肠扭转(SV)的解剖基础主要包括乙状结肠冗长和系膜基底较窄。常见诱因有长期便秘、肠道动力异常、术后肠粘连、巨结肠、肠内蛔虫团、肠道肿瘤以及急剧改变的体位[1]。乙状结肠扭转多见于老年男性，发病率国内报告约占肠梗阻的 10% [2] [6] [7]。本例患者术中切除乙状结肠 56 cm，属于乙状结肠冗长症，且既往便秘及肠梗阻手术史。符合发生乙状结肠扭转的解剖、病理、及肠动力改变的因素。乙状结肠扭转(SV)主要症状为腹胀、腹痛和便秘，肠鸣音消失为肠坏死的最重要表现之一[8]。此病例中，患者症状为腹胀、腹痛同时还有既往便秘病史，查体肠鸣音消失。然术中发现肠管未见坏死，考虑由肠腔积气高度扩张致肠蠕动功能严重抑制导致肠鸣音消失。于患者血常规及相关炎症指标未见异常相印证。本人认为对于无腹膜炎且血象及相关炎性指标无明显异常患者，肠鸣音消失不能作为肠坏死的最重要表现之一。乙状结肠扭转(SV)可根据病程的进展速度分为急性爆发型和亚急性型，临床上亚急性型较为常见，但也有很多病例不能明确地归类于这两种分型之一[9] [10]。SV 非手术治疗有直肠、乙状结肠镜复位，直肠插管及钡剂灌肠复位。对于亚急性的 SV，且无肠坏死的患者，可采用上述方法，但据文献报道，非手术复位复发率为 50%，而复发扭转的死亡率接近 10%，所以目前多主张手术治疗为主。非乙状结肠切除术式包括乙状结肠单纯复位术、复位固定术、系膜成形术、系膜成型加固术，其术后复发率 56%，术后便秘 62% [10] [12] [13]。临床实践结果证明彻底治疗本病的是乙状结肠部分切除、吻合术。但据报道也有一定复发率，多在患者患有巨结肠症的情况[3] [11]。其中乙状结肠部分一期切除吻合通常仅适用于

年龄相对年轻、身体状况良好、没有肠坏死、结肠内大便积聚较少、手术中易于清理、无内科并发症的患者[14]。本例病例患者术中虽未见明显肠坏死征象，但是患者年龄大，病程时间长，肠管高度扩张，梗阻近端结肠明显扩张结存大量粪便。进行乙状结肠切除和结肠造瘘，然后进行二期吻合手术不仅可以从根本上解除乙状结肠扭转的解剖基础，还能预防术后吻合口瘘，减少了该患者腹腔感染和死亡风险[15] [16]。相较于一期吻合，在手术过程中不需要进行结肠灌洗，但是这种术式最大缺点是需二次手术，将增加患者经济压力及一段时间的生活质量的下降，但相对于肠瘘、腹腔感染及死亡风险，这些就显得微不足道了[17]。

4. 结论

综上所述，乙状结肠扭转并局部疝除手术切除外尚无其他治疗方法。且疾病进展过程因人而异，临床医生在疾病诊断过程中应结合辅助检查避免漏诊、误诊，以免错过最佳手术时间而导致肠坏死。

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