

## 次全大肠切除术治疗家族性腺瘤性息肉病 21 例疗效随访

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**[摘要]** **目的:**评价次全大肠切除术治疗家族性腺瘤性息肉病(FAP)的近、远期疗效。**方法:**回顾性分析我科1985~2000年21例FAP患者行次全大肠切除术后残留结肠(和)直肠的结肠镜随访结果。**结果:**所有患者残留结肠、直肠内都有不同程度的腺瘤复发,发生率100%;残留直肠内腺瘤生长较近端的残留结肠密集;1例术后4年直肠腺瘤癌变,累积直肠癌的发生率4.8%。**结论:**采用保留直肠的手术方式操作简单,术后并发症少,但有残留直肠息肉癌变的危险。

**[关键词]** 腺瘤息肉病,结肠;次全大肠切除术;治疗结果

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### Outcomes of subtotal proctocolectomy for familial adenomatous polyposis: a follow-up study of 21 clinical cases

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**[ABSTRACT]** **Objective:** To evaluate the short- and long-term outcomes of subtotal proctocolectomy for familial adenomatous polyposis (FAP). **Methods:** Twenty-one FAP patients who had undergone subtotal proctocolectomy during 1985-2000 in our department were followed up colonoscopically to observe whether there was any recurrence of polyps in postoperatively residual colon or/and rectum. **Results:** Adenomatous recurrence with variant degrees was detected in the residual colon or/and rectum in all 21 patients, the recurrence rate being 100%. Polypous growth was denser in the residual rectum than in the proximal residual colon. The adenomatous polyp in one patient cancerized 4 years after the initial operation. The cumulative occurrence of colorectal cancer was 4.8%. **Conclusion:** Subtotal proctocolectomy is a simple procedure for FAP with fewer complications, but there is a risk of polyps cancerization in the residual colon or/and rectum.

**[KEY WORDS]** adenomatous polyposis coli; subtotal proctocolectomy; treatment outcome

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目前对家族性腺瘤性息肉病(familial adenomatous polyposis, FAP)治疗手段主要是采取预防性切除病变累及的肠管,以防止息肉癌变。次全大肠切除术是国内较早开展、技术成熟的常用手术方式之一。本研究总结我科收治的21例FAP患者次全大肠切除术后的随访资料,分析、评价其疗效。

### 1 资料和方法

1.1 病例资料 1985~2000年21例FAP患者行次全大肠切除术。男9例,女12例,平均年龄31.2(14~48)岁。14例有家族史;5例无家族史;2例家族史不详。6例无症状患者是通过对患者家系亲属进行肠镜筛选时发现。2例家族中有大肠癌病史。

1.2 手术方法 对术前初步确定无腺瘤癌变的患者,根据息肉在盲肠或直肠分布不明显而选择保留盲肠、部分升结肠或部分直肠,按常规切除其余大肠,进行盲-直或升-直吻合。其中16例吻合口在腹膜返折以上,5例吻合口在腹膜返折以下。均未行预防性回肠造口。

1.3 术后随访 21例患者术后常规进行结肠镜定

期随访,随访时间为23~198个月,平均83个月,随访间隔时间12~24个月。观察残留结肠、直肠内息肉的数目、大小、分布情况,尽量在肠镜下行息肉切除,而对于直径大于1cm的息肉进行病理活检。

### 2 结果

2.1 术后并发症 1例切口感染,1例肺部感染,经保守治疗均治愈。术后7d患者的排便次数平均为2~5次/d,便前有明显便意,能自控。术后3~5d可拔除导尿管。

2.2 结肠镜下观察 所有随访患者中均发现在残留结肠、直肠中有息肉生长,发生率达100%。息肉数量在2枚至近百枚,大小在0.5cm×0.5cm~3.0cm×2.0cm,残留直肠内息肉生长密集程度明显较残留的升/盲肠内严重。大于1cm的息肉多出现在残留直肠上段,其中最大一枚息肉约3cm×2cm大小,表面糜烂,出血,活检提示“腺瘤癌变”。

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2.3 病理诊断 腺瘤性息肉占 42.9%;混合性息肉占 23.8%;增生性息肉占 19.0%;2 例腺瘤性息肉

伴不典型增生,占 9.5%;1 例直肠腺瘤性息肉局部癌变,占 4.8%。见表 1。

表 1 21 例 FAP 患者行结肠次全切除术后肠镜随访结果

Tab 1 Follow-up results of 21 patients with FAP after subtotal procolectomy

No.	Anastomosis	Polyp distribution(n)		Polyp size(d/cm)	Pathological types
		Residual colon	Residual rectum		
1	CRA	2	10-20	0.5	Hyperplastic
2	CRA	0	20-99	0.5-1.0	Adenomatous
3	ARA	1	10-20	0.5-1.5	Adenomatous
4	CRA	4	10-20	0.5-1.0	Adenomatous/hyperplastic
5	CRA	0	20-99	0.5-2.0	Adenomatous
6	CRA	>20	20-99	0.5-2.0	Adenomatous and atypical hyperplasia
7	CRA	2	10-20	0.5	Hyperplastic
8	ARA	3	10-20	0.5-1.0	Adenomatous/hyperplastic
9	CRA	1	10-20	0.5-2.0	Adenomatous and atypical hyperplasia
10	ARA	1	10-20	0.5-1.0	Adenomatous
11	CRA	4	7	0.5-2.0	Adenomatous/hyperplastic
12	CRA	3	3	0.5	Adenomatous
13	CRA	5	10-20	0.5-1.0	Adenomatous
14	ARA	2	20-99	0.5-2.5	Adenomatous/hyperplastic
15	CRA	1	9	0.5	Hyperplastic
16	ARA	7	10-20	0.5-1.0	Adenomatous
17	CRA	3	10-20	0.5-1.0	Adenomatous/hyperplastic
18	CRA	>20	>99	0.5-3.0	Cancerous adenoma in rectum
19	ARA	4	10-20	0.5-2.0	Adenomatous
20	CRA	5	4	0.5-1.0	Hyperplastic
21	CRA	3	10-20	0.5-1.0	Adenomatous

CRA: Cecorectal anastomosis; ARA: Ascending colorectal anastomosis

### 3 讨论

对 FAP 有效的治疗措施是对先证者的家系进行筛选,及时发现患病者,采取预防性手术切除<sup>[1,2]</sup>。本组有 6 例是通过对患者家系进行筛选发现,其中 1 例年龄 14 岁,对这些群体的早期发现,及时治疗,体现了建立一个完整的 FAP 家系调查随访体系的重要性<sup>[2,3]</sup>。

以往治疗 FAP 的主要手术方式是<sup>[4,5]</sup>全大肠切除术+永久性回肠造口,由于手术创伤大,严重影响患者的生活质量,目前已不作为首选治疗方案。对于是选择采用次全/全结肠切除术或全大肠切除、回肠贮袋肛管吻合术仍存在较多争议<sup>[6,7]</sup>。前者由于盆腔损伤小,术后对控便、膀胱及性功能影响较少<sup>[5]</sup>。本组 21 例术后无出血、吻合口瘘等并发症,患者术后均表现出良好的控便能力及膀胱功能。但术后残端直肠有发生直肠癌的危险<sup>[7,8]</sup>。本组 1 例术后 4 年残留直肠息肉癌变。后者不会发生残留大肠癌,但手术并发症相对较多,性、排尿功能受到一定的影响,术后贮袋内有生长腺瘤的危险性<sup>[5]</sup>。

FAP 患者携带 APC 基因胚系突变,残留大肠

黏膜细胞都有可能发生“看家基因”——APC 杂合性缺失,从而导致腺瘤生长,并有癌变倾向<sup>[9,10]</sup>。本组术后残留结肠、直肠息肉的发生率达 100%,其中 1 例直肠癌,占 4.8%,与相关报道类似<sup>[4]</sup>。我们认为在次全大肠切除术的患者中,残留直肠是生长息肉及癌变的危险区域,其息肉生长密度明显较残留结肠严重,直肠上段息肉较密、较大,更易发生癌变。术后残留直肠黏膜的面积以及直肠内微环境的改变是发生残留直肠癌的影响因素<sup>[5]</sup>。随着对致病基因的不断深入了解,基因型-表现型分析及相关修饰基因作用的研究发现存在直肠易受侵的基因突变型<sup>[11]</sup>,突变位点检测可以为治疗方案提供参考依据<sup>[12]</sup>。

FAP 患者术后定期结肠镜随访是预防残端大肠息肉癌变的有效方法。建议术后结肠镜随访间隔期 4~6 个月。本组术后随访问隔均超过 1 年,发现部分患者的腺瘤生长已经较密集,并且有的腺瘤超过 1.5 cm。通过结肠镜不仅能诊断腺瘤严重程度,还可采取镜下治疗<sup>[13]</sup>。本组随访病例中,除 1 例直肠癌行全大肠切除、回肠贮袋肛管吻合术外,其余均定期通过结肠镜进行治疗,对 0.5~1 cm 大小的

腺瘤及有蒂的大腺瘤均予凝除、钳除或圈除,术后无出血、穿孔等并发症。

长期大量口服 NASIDs 类药物能够降低大肠癌的发生率,减少 FAP 患者的息肉量及大小,对术后残端直肠息肉也起到抑制作用<sup>[4,14]</sup>。本组 1 例使用后 6 个月观察残留直肠内腺瘤明显减少并缩小。但目前缺乏药物作用长期随访结果。

次全结肠切除术后排便及生殖功能恢复好,对生活影响较小,患者更易接受,对说服家系其他成员进行筛选检查有积极作用。保留 12~15 cm 直结肠既保留了功能又降低发生直肠癌的危险<sup>[8]</sup>。我们认为术前应慎重选择对象<sup>[4,6]</sup>;患者年轻、对日后生活质量要求高;直肠内息肉少于 20 枚;轻表型(大肠内息肉<100 枚),有条件长期进行结肠镜随访。术后长期随访,在此过程中残留直肠仍有发生直肠癌的危险。

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#### Increased level of polymerase III transcribed Alu RNA in hepatocellular carcinoma tissue

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[ABSTRACT] There have been extensive observations that RNA containing repetitive elements accumulates in transformed cells and tumor tissues. In the present study, we first obtained result consistent with previous observations by in situ hybridization. Then we used primer extension analysis to determine the level of polymerase III directed Alu RNA and found an increased expression of Alu RNA in hepatocellular carcinoma.

[Mol Carcinog, 2005, 42: 93-96]