

不明原因的消化道出血

American Society of Gastrointestinal Endoscopy

编者按 本指南是消化内镜在临床常见情况下应用的系列讨论之一. 由美国消化内镜学会提供. 在该指南的撰写过程中, 除MEDLINE检索到的文章外, 还参考了一些专家推荐的文章. 本指南基于目前的一些重要综述及专家共识. 尚需大量的临床对照研究对此进行进一步明确和必要的修订. 临床实际情况和指南有差异时应进行适当调整.

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0 引言

不明原因的消化道出血(OGIB)指消化内镜(包括结肠镜和/或上消化道内镜)检查阴性, 不明来源的持续或反复发作的出血^[1]. 有关OGIB的资料(包括预后和临床结果)很少, 因此, 对此类患者的治疗尚无有效方法.

据估计, 约5%消化道出血发生于Treitz韧带和回盲瓣之间^[2]. 另有资料显示, 小肠血管异常占消化道出血的30-40%^[3], 且为老年患者消化道出血的主要原因^[4]. 30-50岁之间的患者, 肿瘤为主要原因, 例如平滑肌瘤、类癌、淋巴瘤和腺癌; 年轻患者主要为与Meckel憩室相关的溃疡^[5]. 非甾体类抗炎药(NSAID)已证实与直肠糜烂、溃疡和狭窄有关, 因此, 可能也是OGIB的潜在因素之一^[6-7]. OGIB的其他少见诱因包括胰腺出血性疾病^[8]、类圆线虫感染^[9]、盆腔放射性治疗^[10]、弹性纤维性假黄瘤^[11]、Dieulafoy损伤^[12]等.

OGIB分为隐匿性和显性两类, 前者表现为反复发作的缺铁性贫血和大便隐血阳性. 后者表现为反复发作肉眼可见的出血, 如黑便、血便. 在评价小肠出血前, 应重复进行上、下消化道内镜检查, 因为首次内镜检查有较高的漏诊率. 上消化道内镜检查容易漏诊的有Cameron糜烂、消化性溃疡及血管病变. 需行大肠镜检查以排除隐匿性回肠病变及易漏诊的结肠病变, 包括血管扩张和异常新生物.

1 诊断性检查

1.1 上消化道内镜 即食管胃十二指肠镜(esophagogastroduodenoscopy, EGD), 为疑似上消化道出血的初步检查手段. 初次EGD检查结果阴性时可重复检查以提高阳性率^[13-16]. 研究表明推进式小肠镜检出的病变中, 64%是常规内镜可检查到的^[13]. 据研究, OGIB患者行小肠镜检查前重复EGD检查, 可提高EGD检查阳性率, 包

括肠癌患者和有NSAID病史者^[14]. 如果消化道出血患者伴缺铁性贫血(IDA), 必须在行EGD检查时予以小肠活检, 尽管对此类患者行小肠活检结果的报道众说纷纭^[17-18].

1.2 推进式肠镜(PE) PE是利用一条长的内镜经口插入空肠腔中, 用以检查小肠中的大段病变, 尤其适用于OGIB患者. PE诊断率可达40-65%^[13, 16, 19-20]. PE的优点在于不仅可诊断性检查, 还可进行介入治疗. 可对病变进行活检, 在发现出血点时可利用电凝法止血. 一项前瞻性试验在常规结肠镜诊断IDA后比较PE与EGD的诊断价值^[21], 结果PE将诊断率从41%提高到67%, 而且费用相对少, 一项回顾性研究提示PE检查, 78%的患者有阳性结果, 而且从住院天数和输血情况来看, 临床结果可获得改善^[22]. 另有研究表明OGIB患者行PE检查比全小肠钡剂造影(SBFT)诊断价值高^[23]. PE改善了40-73%患者治疗疗效^[14-15]. 对83例隐匿性OGIB患者的回顾性调查研究表明, PE诊断率达59%^[24]. 血管扩张是一种常见的病变, 通常以双极电凝法及激素治疗, 长期临床随访(平均随访12.2 mo)提示获得较好疗效的为50%. 然而, 应用PE可减少输血量并提高生活质量^[25].

探测肠镜(SE)是一条长约270-400 cm的内镜, 他利用小肠的正常蠕动插入^[26]. 这项检查技术要求高, 为非常规检查, 因为其操作时间太长、即使发现了病变也无法进行治疗或活检.

1.3 胶囊内镜(CE) 无线视频的胶囊内镜是一项新技术, 通过内镜检测小肠病变^[27-28]. 这种胶囊长26.4 mm, 直径11 mm, 在空腹8 h后服下, 小肠蠕动推进胶囊前进. 胶囊由一个镜头、一个光源、一个CMOS芯片(互补的金属氧化物半导体芯片, 成像所需)、一个电池和一个发送装置组成. 以2次/s的速度发送信息到系在腰带的记录装置上, 然后下载到计算机工作站, 人们可以在电脑上用相应的软件查看^[29]. 这项新技术有助于诊断OGIB和IDA^[30-31]. 早期一些研究表明CE对小肠疾病的OGIB诊断率高, 优于PE和SBFT^[32-37]. 也有资料表明CE可作为PE的补充, 因为胃食管病变尚有较大的漏诊率^[32]. 在包括PE在内的检查阴性的患者中有近一半可通过CE检查发现潜在出血点. CE的不足之处为无法进行治疗及对病变部位进行精确定位. 胶囊可能被卡住而需外科手术取出, 并且对可能有阻塞性病变、狭窄、吞咽困难或有腹部手术史的患者使用时要十分谨慎^[38]. 推荐CE检查前对小肠进行对照研究以排除阻塞

性病变, 尽管目前尚不清楚这是否能减少CE的并发症^[39]。至于CE对OGIB的作用及其对临床结果的影响尚需更深入的研究。

2 影像学

2.1 小肠的影像学对照研究 SBFT被用于对小肠潜在出血来源的筛选检查。一项对SBFT和PE的比较研究表明, 在对OGIB的评估上PE的诊断率更高^[23]。SBFT对OGIB的诊断率0-5.6%^[40-41]。与SBFT比较, 灌肠法可对小肠的细节获得更好显影, 通过在近端小肠插入鼻肠管, 灌入对比剂后即可获得较好的效果^[42]。一组128例OGIB患者的回顾性研究发现, 在确定明显或高度怀疑的病变时此法有21%的诊断率^[43], 其中13%是小肠肿瘤^[44]。另一项研究显示虽然其中一小组患者通过常规上消化道内镜检查和结肠镜检查诊断率有所提高, 但总体诊断率较低。许多研究都表明, 灌肠法比SBFT可获得更高的诊断率^[45-46]。对于检测血管扩张, 灌肠法的诊断率较低^[43]。在PE阴性的患者中, 灌肠法可确定其中8%患者的出血灶^[47]。但患者的明显不适可能会限制此法的临床应用。

2.2 核素扫描 显性OGIB患者如果出血速度保持在0.1-0.4 mL/min之间, 放射性同位素扫描可能会有帮助。Tc^{99m}标记的红细胞扫描最常用。活动性出血患者经常规上消化道内镜检查和结肠镜检查仍无法确定出血灶时, 此法使用最多。通过扫描可以定位出血点, 然后可通过内镜检查或血管成像验证, 也可用来指导外科手术^[48]。虽然属于相对敏感的检测方法, 但核素扫描只能确定大致出血区域, 在指导治疗方面具一定的局限性。在一项评估Tc^{99m}标记红细胞闪烁扫描法的研究中, 85%的病例无法定位出血灶, 且无法进行充分的血管成像^[49]。在进行适当设置后, 对OGIB来说, 对Meckel憩室扫描也是一种较好的检查, 使用Tc^{99m}-高锝酸盐, 灵敏度为75-100%^[50]。然而, 阳性扫描只能显示胃黏膜的存在, 而非明确的出血灶。

2.3 血管成像术 在显性OGIB中, 若出血速度大于0.5 mL/min, 血管成像技术可能也有帮助, 出血表现为向肠腔内的活动性渗出。很遗憾, 在OGIB中相关的数据很少。虽然就技术而言核素扫描更敏感, 但血管成像可能在定位上更为有效^[51]。一项对36例患者进行的内脏血管成像研究, 诊断率为44%, 没有假阳性, 但3例为假阴性。有研究表明, 若初次血管成像为阴性, 那么有必要进行复查^[52]。血管成像技术也可用于对栓塞的定位或外科手术前的检查。对于即将手术的患者, 术前通过联合使用亚甲蓝染料选择性放置血管成像导管, 可更精确地对出血点进行定位, 从而可切除最少的小肠^[53]。血管成像还可用于诊断无出血的血管扩张和肿瘤组织。

螺旋CT成像是项更新的技术, 通过将导管插至腹主动脉, 然后注入造影剂显影。如造影剂外渗在肠腔

内形成大片高密度区, 即可定为出血位置。一项有13例患者的对比螺旋CT血管成像和传统血管成像研究发现, CT血管成像在定位OGIB时更快更简易, 并且对随后的选择性常规血管成像具指导意义^[54]。

2.4 激发测试 为了避免假阴性, 有人提出对出血点进行扫描或血管成像时使用血管扩张药物(如妥拉唑林、硝酸甘油)、抗凝剂(肝素)、纤溶蛋白酶(尿激酶、链激酶)来诱导出血。有些研究报道诊断率有所提高^[55], 也有人发现效果并不明显^[56], 并且会由此导致成本-效果和安全方面问题^[57]。

3 外科手术

对于需大量输血和/或反复住院的OGIB患者, 通过剖腹术进行术中内镜检查(IOE)是常规使用的最后检查方法^[58]。术中内镜可通过口、直肠或行肠造口术进行检查。目前尚无一种可控制的试验可用来比较IOE和其他OGIB检查方法, 但IOE看起来不仅安全而且有效^[59]。早期的一项有44例患者的研究显示, IOE可以发现70%的出血点, 尽管其治疗效果只有41%^[60]。尚有研究显示联合使用IOE和其他定位检查时可获得82%的成功率^[61]。一项对12例患者的研究显示, 有93%的病例可探查至末端结肠, 并且诊断率为58%^[62]。近期对25例病例的报告显示, IOE在20例术前不明出血原因患者中可检测到16例病灶, 平均19 mo的随访中, 出血率为30%^[63]。

4 诊断方法

隐性OGIB患者, 若反复的常规上消化道镜和结肠镜检查仍未发现病变, 且不管如何补铁仍有复发的贫血, 就有必要对小肠进行进一步检查。方法包括CE, PE或钡剂放射成像(SBFT或灌肠法)。目前, 如何选择上述检测方法以及对检测的先后进行排序仍未确定。若上述检测呈阴性, 再进一步检查就需权衡利弊了。若临床需反复住院或反复输血就需进行进一步检查, 可考虑血管成像和术中内镜检查。

显性OGIB时, 若患者在检查时无活动性出血, 就应采取和上述隐性OGIB相同的检查步骤。若患者有活动性出血, 应该重复进行EGD、PE或结肠镜检查。若检查结果为阴性, 接着应基于出血率和实用性考虑核素扫描、血管成像和CE。年轻患者尤其应考虑Meckel憩室扫描。若出血仍在继续, 就应考虑重复进行血管造影或IOE。

5 治疗措施

OGIB治疗主要为对症治疗。若确诊为肿瘤, 则建议外科切除。血管扩张可通过内镜下电烙术或氩血浆凝结治疗, 前提是病变部位在内镜可达范围内。有证据表明减少血液丢失和输血对临床结果有积极的效应^[64-65]。若胃肠道广泛存在血管扩张, 治疗包括适当地补铁(口服或胃肠外补充)、输血或激素治疗。前瞻性观察研究显示

予以雌激素/孕酮也是一种有效治疗^[66-67]。但是, 近期一项多通道随机试验发现激素治疗无明显效果^[68]。奥曲肽有一定疗效, 但尚未被广泛研究^[69]。

总之, 研究显示, 约5%的胃肠道出血为OGIB, 大部分病变位于小肠, 通常小肠病变包括血管扩张、肿瘤、NSAID 肠道病变、Meckel 相关溃疡。专家认为, OGIB 可以是隐性出血, 表现为缺铁性贫血, 或显性出血, 表现为黑便或便血。经仔细重复EGD和达末端回肠的结肠镜检查仍为阴性时, 就需进行小肠检查。诊断性检查包括PE、CE、钡剂检查(SBFT或灌肠), 核素检测, 血管造影和术中内镜检查。虽然缺少大量的对照研究, 前瞻性对照研究证明PE检查优于EGD和SBFT, 同样CE优于SBFT, 与PE类似。专家认为, 这些检查方法如何选择尚未明确, 需综合临床情况、可行性和临床医生来进行选择。术中内镜检查为反复发生严重出血需输血治疗的患者或者病变不能用PE或肠镜治疗的最后选择。一旦诊断成立, 治疗方法的选择尚需遵循个体化原则。

6 参考文献

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