



临床研究

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在过去的几年中,有许多中心推荐内镜下胆道扩张、置入支架治疗吻合口狭窄,治愈较高^[2]。对7例单纯吻合口胆道狭窄患者中的5例最初行ERCP治疗,包括胆道扩张、置入支架、乳头肌切开等,其中4例治愈,而另外1例效果不佳,行再次手术取出内支架并防治T管引流后,梗阻性黄疸症状才获得缓解。另外2例单纯吻合口狭窄的患者,最初采用手术修补,也均获得治愈。

与单纯吻合口胆道狭窄的患者相比,有肝内胆管狭窄的胆道狭窄患者的内镜介入治疗效果较差,死亡率较高^[3]。有报道,发生在肝门部和肝内胆管的非吻合口狭窄,内镜下球囊扩张和置入支架治疗的有效率仅有28.6%,而吻合口狭窄内镜治疗的有效率为75%^[4]。我们对3例单纯肝内胆管狭窄的患者和3例吻合口狭窄合并肝内胆管狭窄的患者行ERCP或PTC等介入治疗,仅1例肝内胆管狭窄的患者获得治愈,5例患者死亡,包括其中一例行再次肝移植的患者,死亡率为83.3%,明显高于单纯吻合口狭窄患者的死亡率($P=0.005$),与报道的基本一致。发生肝内胆管狭窄的胆道狭窄患者预后较差,可能与其发生原因有关,肝动脉血栓形成、供肝缺血时间过长、胆道内胆汁残留、ABO血型不合、巨细胞病毒感染、慢性排斥及原发性硬化性胆管炎的复发等因素是肝内胆管狭窄发生的危险因素^[10-11]。早期的研究发现,大约有25%~50%的非吻合口狭窄患者需要行再移植或死亡^[12]。而有学者提出,随着ERCP和PTC技术的提高和经验的积累,对严重患者只要及时的行胆道重建或再移植术,非吻合口狭窄患者的生存率与那些未发生胆道狭窄的移植术后患者已无明显差异^[9]。对于那些无法行ERCP或PTC介入治疗,或者反复介入治疗效果不佳者以及复发性胆管炎的患者,可以手术行胆道重建。由于供肝匮乏和再移植的风险增高,只有在那些无法行胆道重建的患者,才考虑行再次肝移植术^[13-14]。

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