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The Reports of Two Cases of Renal Hydatidosis

Guolu Wang*, Fuyong Zhu

Department of Urology, Qinghai Province People's Hospital, Xining Qinghai
Email: *qhmzy2006@126.com

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Abstract

Objective: To explore the clinical, imaging features and treatment of renal hydatidosis. Methods: The clinical data of 2 patients with renal echinococcosis admitted to our department in April 2018 and October 2018 were analyzed retrospectively. Two cases were operated under general anesthesia. One case underwent "left nephrectomy" because a large number of transparent follicles grew in the calyx of the upper, middle and lower poles of the left kidney and the anatomical structure of the normal collecting system was completely destroyed. A case of hydatid lesion located at the lateral margin of the renal parenchyma in the middle and upper poles of the right kidney had complete capsule and protruded the surface of the renal parenchyma. The cystic space-occupying surface was calcified. The "complete exfoliation of the right renal hydatid cyst" was performed. Method: The clinical data of 2 patients with renal echinococcosis admitted to our department in April 2018 and October 2018 were analyzed retrospectively. Two cases were operated under general anesthesia. One case underwent "left nephrectomy" because a large number of transparent follicles grew in the calyx of the upper, middle and lower poles of the left kidney and the anatomical structure of the normal collecting system was completely destroyed. A case of hydatid lesion located at the lateral margin of the renal parenchyma in the middle and upper poles of the right kidney had complete capsule and protruded the surface of the renal parenchyma. The cystic space-occupying surface was calcified. The "complete exfoliation of the right renal hydatid cyst" was performed. Result: Two patients recovered and discharged from hospital. All the pathological reports were renal echinococcosis. No recurrence occurred during the follow-up period from 4 to 9 months. Conclusion: Renal hydatidosis is rare in clinic. It occurs mostly in minority or religious tribes. It is remote and backward. Most cases have been found to have completely destroyed the renal parenchyma, forcing doctors to remove the affected kidney. Therefore, strengthening the medical resources sinking, counterpart assistance, free clinic and precise medical treatment in third-class A hospitals will be helpful to the early detection, early diagnosis and selection of the best treatment opportunity of hydatidosis, and to protect the remaining renal function to the greatest extent.

Keywords

Renal Hydatid Disease, Clinical Characteristics, Early Diagnosis and Treatment

*通讯作者。

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肾包虫病2例报告

王国录*，朱付勇

青海省人民医院泌尿外科，青海 西宁
Email: *qhmzy2006@126.com

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摘 要

目的：探讨肾包虫病的临床、影像学特点和治疗方法。方法：回顾性分析2018年04月及2018年10月我科收治的2例肾包虫病患者的临床资料。2例均在全麻下进行手术。一例因左肾上、中、下极肾盏内见大量透明滤泡生长，正常集合系统解剖结构完全破坏，行“左肾切除术”。一例包虫病灶位于右肾中、上极肾实质外侧缘，包膜完整，并突出肾实质表面，囊性占位表面呈钙化状态，行“右肾包虫外囊完整剥除术”。结果：2例患者痊愈出院，术后病理报告均为肾细粒棘球蚴病。术后随访4~9月未复发。结论：肾包虫病临床较少见，多发于少数民族或宗教部落聚居地，地方偏僻且较落后，多数病例临床发现时肾脏实质已完全破坏，迫使医生切除患肾。故加强三级医院医疗资源下沉、对口帮扶义诊以及精准医疗等工作的大力开展，有助于包虫病的早期发现、早期诊断及选择最佳治疗时机，以最大程度上保护残存的肾脏功能。

关键词

肾包虫病，临床特点，早期诊治

1. 引言

包虫病是全球牧区常见的流行性寄生虫病，以“肝包虫、肺包虫”为常见，而肾包虫相对少见，临床上往往对肾包虫的诊断缺乏特异性的影像学特征，常被误诊为肾囊肿。参考国内文献，多数文献对肾包虫的诊断及治疗仅仅停留在个案报道上，未形成统一的诊断及治疗标准，本文就我院收住的两例肾包虫病做一详细报告，希望对以后肾包虫的进一步研究提供真实依据。

2. 病例 1

患者男，72 岁，汉族，农民，长期居住在青海海东市，因“左侧腰背部间歇性疼痛 6 年，加重 4 天”为主诉，于 2018 年 4 月 8 日来我院就诊，患者既往有“腰椎间盘突出”病史 15 年(具体诊治不详)，疼痛呈持续性钝痛，无恶心、呕吐，无尿频、尿急、尿痛及肉眼血尿，无乏力、纳差、低热、盗汗及消瘦等结核中毒症状。门诊行腰椎 MRI 检查提示：左肾囊性占位。故以“左肾囊性占位(包虫？)”收住我科。患者出生并久居本地，未到过疫区，无牛、羊、犬等密切接触史，但患者家族有食服“生牛、羊肉片”

习俗。查体：左侧肾区叩击痛阳性，左输尿管走行区无压痛。实验室检查提示：血清免疫试验(IHA, ELISA)阳性。B 超检查提示：左肾轮廓不清，相应部位可见大小约 115 mm × 75 mm 包块，形态不规则，其内可见多发无回声区，肿块内未见血流信号。B 超诊断：左肾混合性包块(包虫囊肿待除)。KUB 检查提示左肾“葡萄串样”多子囊钙化影。IVU 提示左肾、输尿管未显影。CT 检查提示：左肾囊性团快影，边界清，其内密度不均匀，可见多发子囊影，边界见钙化影，最大截面约为 82.4 mm × 79.2 mm，增强后病灶未见强化，肝胆脾胰未见明显异常。CT 诊断：左肾囊性占位，考虑左肾包虫囊肿(图 1)。行左肾切除术，术中所见：左肾体积增大，左肾上、中、下极肾实质近外侧缘见大小约 120 mm × 90 mm 之囊性占位，呈不规则形，并突出肾实质表面向外生长，囊性占位下极与侧腹膜粘连著。台下沿肾脏纵轴剖开标本：囊性占位内见大量“胶冻样”液体及囊性透明滤泡，左肾上、中、下极肾盏内见大量透明滤泡生长，正常集合系统解剖结构破坏(图 2)。病理诊断：左肾细粒棘球蚴病(图 3)。

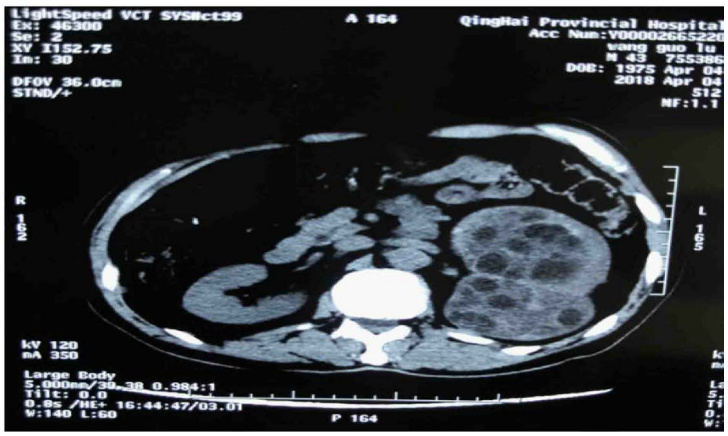

Figure 1. CT sees the left kidney cystic group fast shadow, the boundary is clear, the density inside is not uniform, multiple vesicle shadows can be seen, the calcification shadow is seen at the boundary, the maximum cross section is about 82.4 mm × 79.2 mm, and the lesion is not enhanced after enhancement

图 1. CT 见左肾囊性团快影，边界清，其内密度不均匀，可见多发子囊影，边界见钙化影，最大截面约为 82.4 mm × 79.2 mm，增强后病灶未见强化

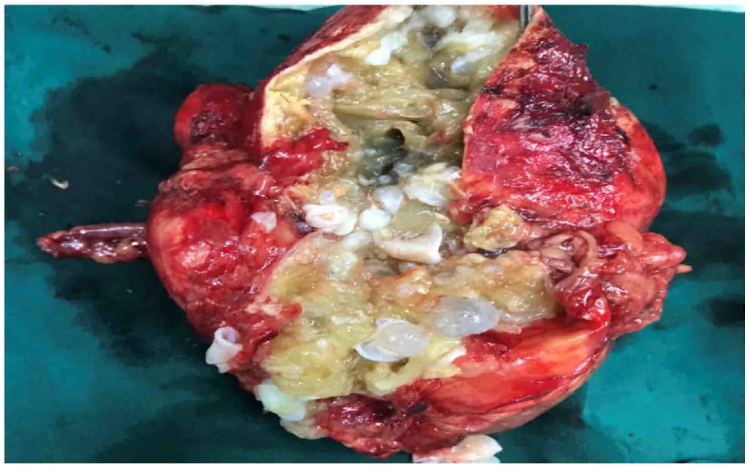

Figure 2. Under the table, see the specimen: see a large number of “gel-like” liquid and cystic transparent follicles in the cystic space, a large number of transparent follicles are seen in the upper, middle and lower renal pelvis of the left kidney, system anatomy is destroyed

图 2. 台下剖开标本见：囊性占位内见大量“胶冻样”液体及囊性透明滤泡，左肾上、中、下极肾盏内见大量透明滤泡生长，正常集合系统解剖结构破坏

Figure 3. Specimens see a large number of powdery skin samples, no special ureter, pathological diagnosis of left kidney echinococcosis
图 3. 标本见大量粉皮样物，相连输尿管未见特殊。病理诊断左肾细粒棘球蚴病

3. 病例 2

患者男，19 岁，回族，学生，家住青海省西宁市，因“发现右肾占位 20 天”为主诉于 2018 年 10 月 24 日收住我院。患者于入院前 20 天剧烈运动后出现全程肉眼血尿，曾就诊于“西宁市回族医院”，行泌尿系 B 超提示右肾囊性占位。建议转上级医院就诊。患者无恶心、呕吐，无尿频、尿急、尿痛，无乏力、纳差、低热、盗汗及消瘦等结核中毒症状。患者出生并久居本地，未到过疫区，无牛、羊、犬等密切接触史。患者既往 7 岁时因“肝包虫、右肾包虫”曾在本地私人诊所行“包虫穿刺治疗”(具体诊治不详)。入院查体：右肾区叩击痛阳性，右输尿管走行区无压痛。实验室检查提示：血清免疫试验(IHA，ELISA)阳性。B 超检查提示：右肾中极可见大小约 43 mm × 31 mm 囊性包块，边界清，囊壁呈双边形，其内见多个子囊回声，未见血流信号；肝右叶可见大小约 52 mm × 41 mm 中高回声影，边界清，其内呈“卷心菜”样改变，未见血流信号。B 超诊断：右肾囊性包块，考虑包虫。KUB 检查提示右肾区钙化影。IVU 提示右肾及输尿管未显影。右侧泌尿系逆行造影检查提示：右肾上盏杯口破坏消失，其内可见不规则充盈缺损，右肾中盏未显影，可见外压型改变。CT 检查提示：右肾增大，其内见大小约 39 mm × 32 mm 混杂密度影，增强后呈明显不均匀强化；肝内见多发混杂密度结节影及钙化，较大者直径约 38 mm × 39 mm。CT 诊断：肝内多发混杂密度结节影，并多发钙化，考虑肝包虫；右肾实质内占位性病变，多考虑肾包虫(图 4)。行右肾包虫外囊完整剥除术，术中所见:右肾中、上极肾实质外侧缘见一大小约 40 mm × 35 mm 之囊性占位，呈“类圆形”，囊性占位包膜完整，并突出肾实质表面，囊性占位表面呈钙化状态。术中阻断右肾血流后行包虫外囊完整整块剥除术，查：右肾囊性病灶近似“葫芦形”，病灶包膜完整无破裂，病灶下 1/2 部分位于右肾肾盂内。台下剖开标本：囊性病灶内见数十个大小不等之子囊，伴少量渗出，部分囊壁钙化(图 5)。病理诊断：右肾细粒棘球蚴病(图 6)。

4. 讨论

包虫病是人感染棘球绦虫的幼虫(棘球蚴)所致的慢性寄生虫病，是一种人畜共患病，多发于少数民族或宗教部落聚居地。在我国，包虫病高发流行区主要集中在高山草甸地区及气候寒冷、干旱少雨的牧区及半农半牧区。包虫病在人体各脏器均可发生，其中以肝、肺多见，但肾包虫发生在人类较少见，约占全身脏器包虫病的 2% [1]，国内文献报道亦较少。包虫性囊肿常起自于肾脏皮质，呈外生性生长，早期无任何临床症状，常被体检发现，部分病例可因上腹部或腰部触及无痛性包块、感染、发热、过敏性休克或囊肿破裂出血致肾绞痛就诊，伴随包虫性囊肿的进一步增大，可出现腰部坠胀不适等症状，若包虫性

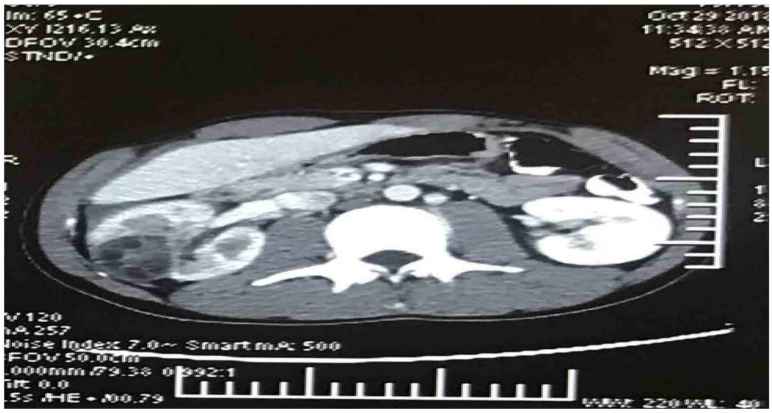

Figure 4. CT shows an enlargement of the right kidney, which shows a mixed density of about 39 mm × 32 mm, which is markedly unevenly enhanced after enhancement
图 4. CT 见右肾增大，其内见大小约 39 mm × 32 mm 混杂密度影，增强后呈明显不均匀强化

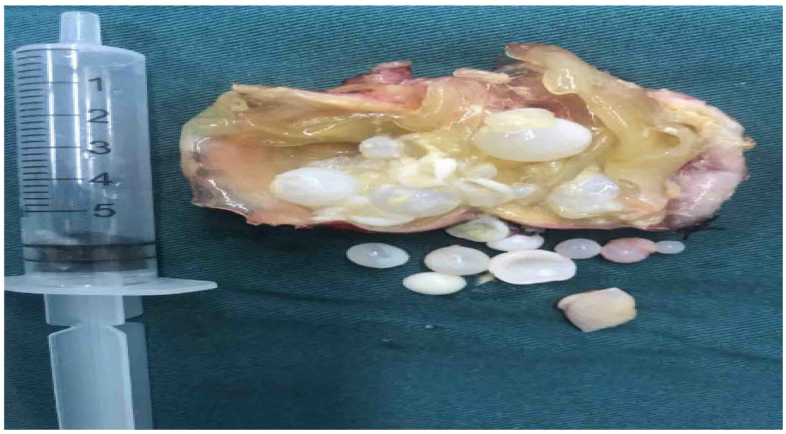

Figure 5. Cut-off specimens under the table: There are dozens of sacs of varying sizes in cystic lesions with a small amount of exudation and partial cystic wall calcification
图 5. 台下剖开标本：囊性病灶内见数十个大小不等之子囊，伴少量渗出，部分囊壁钙化

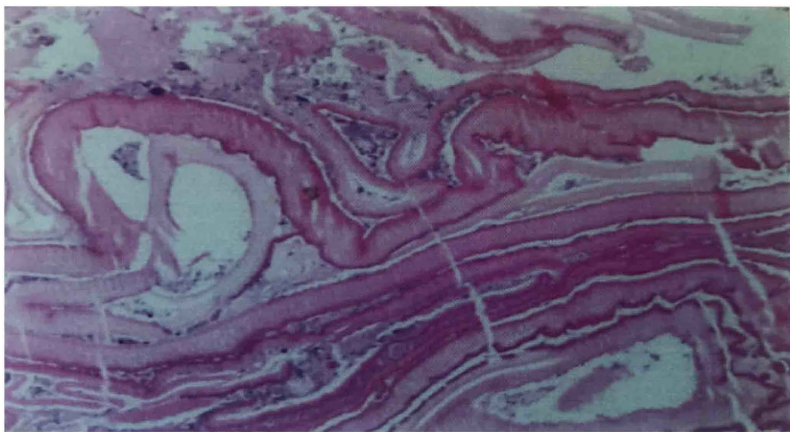

Figure 6. Gray sac wall tissue, size 5.0 cm × 3.5 cm × 3.0 cm, see the powdery skin tissue inside the capsule, pathological diagnosis of right kidney echinococcosis
图 6. 灰白囊壁样组织，大小 5.0 cm × 3.5 cm × 3.0 cm，囊内见粉皮样组织。病理诊断右肾细粒棘球蚴病

囊肿较长时间压迫肾脏，可使肾脏皮质和髓质发生萎缩，进一步导致肾脏功能损害[2]。若包虫囊肿破入

集合系统或并发感染时可导致肾绞痛发生，进而可出现血尿、脓尿甚至尿液中可排出白色粉皮样囊壁及子囊。肾包虫根据其典型影像学表现及血清、免疫学检查，诊断较易，在B超、CT等影像学检查上具有特征性表现，如B超显示肾囊肿具有“花瓣状”分隔声像图等表现，CT显示肾脏多发囊性改变，边缘清楚．囊壁较厚，表现为“囊中囊”征等，但临床上需要与肾多发囊肿、多房性囊性肾癌等疾病相鉴别。根据肾包虫病病理形态及并发症将其分为：① 单纯型：单发或多发边缘光整的圆形液性密度影；② 多子囊型：母囊内见数量不等、大小不一的子囊环形影；③ 破裂型：囊中见漂浮于囊液中各形态的高密度条状影；④ 实质钙化型：囊壁肥厚而伴有弧形钙化[3]。本组两例患者均依靠实验室和影像学相关检查即可明确诊断。肾包虫最终确诊需依靠术中所见及术后病理检验。外科手术切除病灶是肾包虫最有效的治疗方法，术中尽可能在保留残存肾组织、避免包虫囊液外溢及播散之前提下，根据患者具体情况行包虫外囊完整剥除术、肾部分切除、肾全切术，其中，包虫外囊完整剥除术避免了因穿刺造成的包虫囊液外溢或包虫破裂导致的变态反应和包虫播散，同时降低内囊摘除术后残腔感染的发生[4]。近年来，随着腔镜技术的日益成熟，国内学者采用后腹腔镜下行肾包虫内囊摘除术治疗肾包虫，该术式具有创伤小、术中出血少、术后伤口疼痛轻、恢复快、不影响美观以及住院时间短等优点，被认为是肾包虫手术治疗的“金标准”[5]。总之，加强三级医院医疗资源下沉、对口帮扶义诊以及精准医疗等工作的大力开展，有助于包虫病的早期发现、早期诊断及选择最佳治疗时机保护残存的肾脏功能，尤其在高山草甸地区及气候寒冷、干旱少雨的牧区及半农半牧地区更是迫切需要。深入推进此项工作，有望今后在泌尿系统包虫病诊治方面，能够极大限度地降低因包虫病灶进行性发展导致患肾功能完全丧失，进而迫使医生切除患肾等不良类似事件的再次发生。

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