

经腹联合经阴道超声诊断卵巢中肾样腺癌1例并临床病理特征分析

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摘 要

中肾样腺癌(Mesonephric-like Adenocarcinoma)有研究表明其可能来源于苗勒管上皮, 然后沿中肾途径分化, 发生于卵巢中肾样腺癌罕见且诊断困难, 无特异性临床表现。本文报道了联勤保障部队第940医院1例经病理证实的卵巢中肾样腺癌患者, 通过病例报道并分析其临床资料、组织学特征、免疫表型、影像学表现并复习相关文献, 以提高医务人员对该肿瘤的认识, 为临床实践提供参考。

关键词

超声检查, 卵巢, 输卵管, 卵巢肿瘤, 中肾样腺癌

Transabdominal Combined with Transvaginal Ultrasound in the Diagnosis of Ovarian Mesonephric-Like Adenocarcinoma: One Case Report and Analysis of Clinicopathological Features and Imaging Findings

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Abstract

Mesonephric-like adenocarcinoma (MLA) is thought to potentially originate from the Müllerian epithelium, subsequently differentiating along mesonephric pathways. Ovarian MLA is rare and diagnostically challenging, with no specific clinical manifestations. This article reports a case of ovarian MLA confirmed by pathology at the 940th Hospital of the Joint Logistics Support Force. Through this case report, we analyze the clinical data, histological features, immunophenotype, and imaging findings, and review relevant literature to enhance medical professionals' understanding of this tumor and provide reference for clinical practice.

Keywords

Ultrasonography, Ovary, Fallopian Tube, Ovarian Neoplasm, Mesonephric-Like Adenocarcinoma

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1. 引言

卵巢中肾样腺癌是一种表现为中肾分化的腺癌，有研究表明其可能来源于苗勒管上皮，然后沿中肾途径分化。卵巢中肾样腺癌在临床上较为罕见，临床表现与卵巢癌其他类型并无明显差异，术后病理活检为卵巢中肾样腺癌确诊的金标准，首选手术治疗，术后辅助化疗。及早的精准诊断和治疗对于患者保留卵巢功能至关重要。本文描述了经腹联合经阴道超声诊断卵巢中肾样腺癌 1 例，具体报道如下。

2. 临床资料

患者女，58 岁，因“间断全身多关节疼痛 16 年余，加重 1 周”就诊。经腹超声检查：于中腹部腹主动脉浅层处探及大小约 13.6 cm × 6.3 cm 的囊性包块，界限清，形态规则，内可见少许光带分隔，CDFI 未见明显异常(见图 1)；嘱患者排尿后，采用经阴道超声检查：子宫前位，大小约 4.7 cm × 4.0 cm × 4.5 cm，肌层回声均匀，于子宫右前方探及大小 17.0 cm × 9.6 cm 的囊性包块，界限清，形态规则，内部回声不均匀，内可见粗细不均带状分隔，CDFI 未见明显血流信号(见图 2)。超声诊断子宫右前方囊实性包块，右附件区占位癌可能。实验室检查 CA125 187.8 U/ml，CA199 > 12000 U/ml。遂行全子宫及双侧附件切除术、盆腔淋巴结清扫术及大网膜切除术，术后病理 TNM 分期为卵巢恶性肿瘤 III C 期(见图 3)，免疫组化显示 PR(-)、ER(-)、WT-1(-)、CK20(-)、Ki-67(index ≈ 30%)、CEA(局灶+)、CK7(+)、Vimentin(-)、TTF-1(部分+)(见图 4)、CD10(部分腔缘+)、GATA-3(+)(见图 5)。

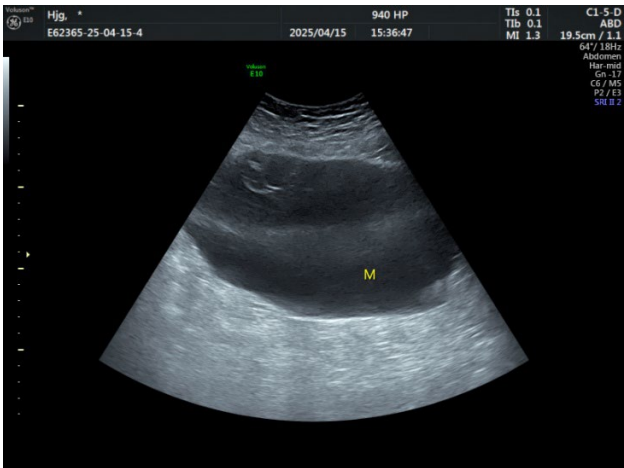


Figure 1. Abdominal ultrasound
图 1. 经腹部超声

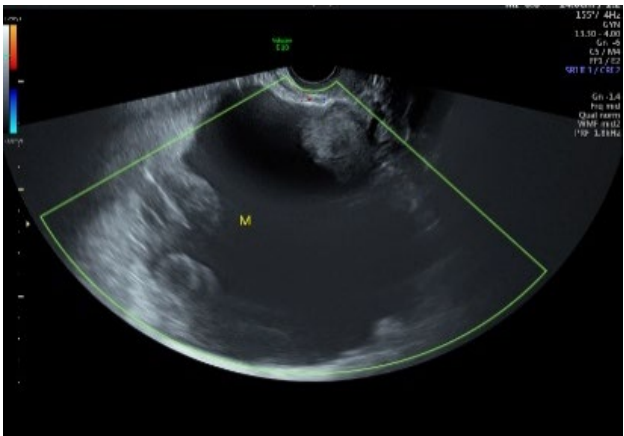


Figure 2. Transvaginal ultrasound
图 2. 经阴道超声

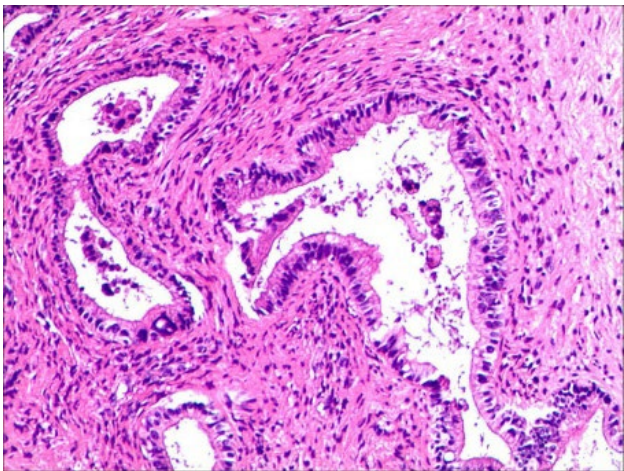


Figure 3. Pathological image with HE staining shows the tumor exhibiting a linear and tubular structure, with eosinophilic material visible in the lumina
图 3. 病理图 HE 染色示肿瘤呈线管状结构，管腔内见嗜酸性物质

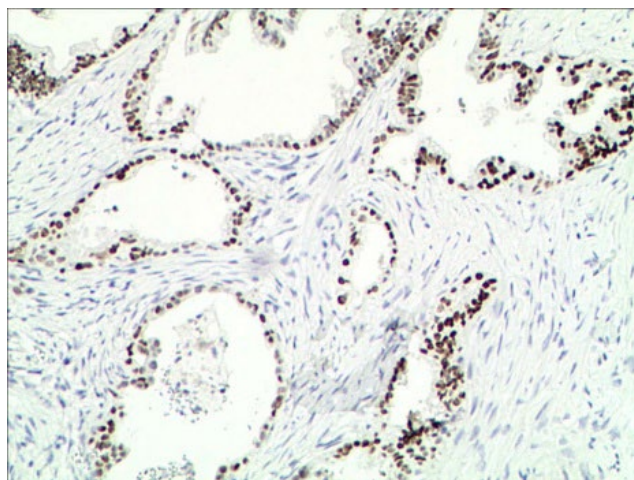


Figure 4. Tumor cells TTF-1 (partially +) EnVision method

图 4. 肿瘤细胞 TTF-1 (部分+) EnVision 法

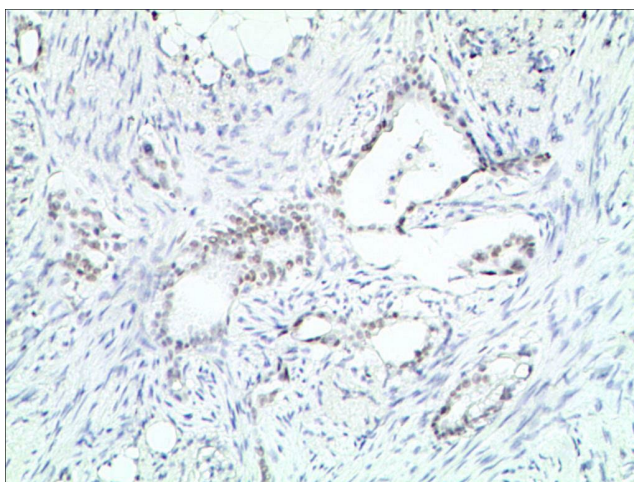


Figure 5. Tumor cells GATA-3 (+) EnVision method.

图 5. 肿瘤细胞 GATA-3 (+) EnVision 法

3. 讨论

卵巢中肾样腺癌(Mesonephric-like adenocarcinoma)是具有中肾样分化特征的罕见女性生殖系统恶性肿瘤,是 WHO 女性生殖系统中新的组织学类型[1], MLA 发病率约占所有卵巢肿瘤的 1%以下,多见于中老年女性,年轻女性罕见。目前其发病机制尚未完全阐明,可能与 KRAS 突变导致丝裂原活化蛋白激酶(MAPK)信号通路异常相关[2]。目前研究认为中肾样腺癌起源于苗勒氏管,并沿 wolffian/中肾线分化[3]。MLA 细胞形态上以结构多样性为特征[2]-[4],可以表现为多种形态的腺癌,如肉瘤样细胞成分的腺癌、低级别或高级别浆液性癌、透明细胞癌、子宫内膜样癌等,呈腺管样、乳头状、筛网状、实性等多种结构混合存在,实性区可呈癌肉瘤样,肿瘤细胞呈立方状或柱状,细胞核圆形、卵圆形、扁平或成角,染色质粗颗粒至透明空泡状,核膜不规则、重叠,细胞核有凹槽,可显示核沟及假包涵体,类似于典型的甲状腺乳头状癌特征。中肾样腺癌免疫表型与中肾管癌相似[5]-[7],免疫组化中 GATA-3、TTF-1、CD10 常呈阳性表达,ER、PR、WT-1 无表达或失表达, P53 呈“野生型”。卵巢中肾样腺癌的临床表现上无明显特异性[8],与其它卵巢恶性肿瘤相似,常见症状包括腹部胀痛、盆腔包块、腹水等,由于缺乏早期

典型症状,患者就诊时肿瘤往往已处于进展期。妇科检查可触及单侧卵巢实性或囊实性包块,质地较硬,活动度较差,晚期可能触及盆腔转移结节或腹水征。大多数患者可长期无症状,主诉为偶然发现盆腹腔占位性病变、骨痛或腹胀腹痛等,当肿瘤体积增大或发生急性并发症时,患者可出现急腹症表现,在实验室检查上 CA125 和 CA199 会升高,卵巢恶性肿瘤患者的 CA125、CA19-9 与 CEA 联合检测有助于提高卵巢癌早期诊断的准确性[9]。在影像诊断上,超声检查作为妇产科疾病筛查首选的影像学检查方法,联合其他影像检查、病理组织学、免疫组化与分子检测在卵巢肿瘤诊断与鉴别诊断方面具有重要的临床价值,经腹超声可见盆腔右侧巨大囊实性肿块,能清晰显示肿块与右侧髂血管、结肠的毗邻关系;经阴道超声则清晰呈现肿块内部细节,实性部分回声不均匀,囊性部分可见大小不等的囊腔,CDFI 显示肿块实性区域及周边可探及血流信号,检测动脉阻力指数,经腹联合经阴道超声检查综合了经腹超声对大病灶整体范围及周围组织关联的观察优势和经阴道超声对病灶内部结构、血流信号的精细显示能力,可以初步提示为卵巢恶性肿瘤。治疗首选手术治疗[10],包括全子宫和双侧附件切除术、大网膜切除术、盆腔及腹主动脉旁淋巴结清扫术、腹腔冲洗液细胞学检查,必要时切除肉眼可见的转移病灶。对于年轻、有生育需求的早期患者,若肿瘤局限于单侧卵巢、无淋巴结转移及远处扩散,可考虑保留生育功能的手术,术后需严密随访。术后辅助化疗是主要辅助治疗手段,尚无统一化疗方案,多参考卵巢上皮性癌方案,常用方案为紫杉醇和卡铂,部分病例可联合贝伐珠单抗等抗血管生成药物;晚期或复发患者可尝试多西他赛、吉西他滨等二线化疗药物,但疗效有限。靶向治疗上基于分子机制,针对 PI3K/AKT 通路的抑制剂(如阿培利司)已在部分 KRAS/BRAF 突变病例中尝试,初步显示一定疗效,但缺乏大样本临床数据。

MLA 需要与多种卵巢及盆腔肿瘤鉴别[11]-[13],主要依赖于病理形态和免疫组化,并结合相应临床表现。(1) 卵巢子宫内膜样癌:临床多合并子宫内膜异位症,免疫组化表达 ER、PR 阳性,不表达中肾样腺癌特征性标志物(CD10、Calretinin)。(2) 卵巢浆液性癌:多为双侧性,典型病理表现为乳头状结构,免疫组化表达 WT-1、PAX8 阳性,CD10 阴性。(3) 卵巢透明细胞癌:常伴有子宫内膜异位症,病理可见透明细胞或鞋钉样细胞,免疫组化表达 Napsin A、HNF-1 β 阳性,CD10 阴性。(4) 宫颈中肾样腺癌:原发于宫颈,多位于宫颈管深部,影像学检查可见宫颈占位,卵巢中肾样腺癌多为卵巢单侧占位,宫颈组织无异常。(5) 输卵管癌:常表现为阴道排液(浆液性),影像学可见输卵管增粗或包块,免疫组化表达 PAX8、WT-1 阳性,CD10 阴性。

4. 总结

经腹联合经阴道超声扫查凭借互补优势可对卵巢肿瘤做出初步筛查诊断,经腹联合经阴道超声的灵敏度和准确率远高于单一的超声检查方式,当超声扫查发现卵巢实性为主的混合性肿块时,内部呈现特征性的“筛孔状”微囊的结构,且彩色多普勒显示血流极其丰富时,应高度警惕卵巢中肾样腺癌的可能,结合病理特征能进一步明确诊断,最终确诊依赖于术后病理及免疫组化分析,其中 PAX8、GATA3 阳性而 WT-1、ER、PR 阴性的免疫谱系是诊断的金标准。卵巢中肾样腺癌是一种侵袭性强、诊断困难的罕见卵巢恶性肿瘤,诊断依赖于影像医师和病理医师的经验及免疫组化的精准应用[14],经腹联合经阴道超声不仅可用于术前诊断,还能为术后复查提供便捷的影像学手段,监测病灶是否复发。未来需要收集更多病例进行多中心研究,以深入理解其病因和发病机制,探索靶向治疗或免疫治疗的可能性,从而改善患者的生存结局。

声 明

本研究经医院伦理委员会批准,该病例报道已获得病人知情同意。

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