.个案报道.

高龄慢性硬膜下血肿合并急性脑内出血1例

王　鹏　殷尚炯　王志明　程月飞　刘丽娜

【摘要】慢性硬膜下血肿(CSDH)是神经外科常见疾病。临床上,高龄CSDH合并急性多发性脑实质出血,如何处理比较棘手。本文报道1例高龄CSDH,为80岁男性,因突发昏迷8 h入院。部CT示右额颞顶枕CSDH,血肿量约100 ml;合并右侧颞叶−基底节出血(约35 ml)及少量双侧顶叶出血。因高龄、基础病多,无法接受开颅手术,遂先行颅内压监护下CSDH穿刺引流术。次日复查头部CT示硬膜下血肿基本消失,脑组织复位良好,颅内压在正常范围,拔除穿刺针。2 d后颅内压逐渐升高,遂行颞叶−基底节血肿穿刺引流术。术后行气管切开术,病人意识逐步恢复至朦胧状态,出院时遗留肢体偏瘫。随访3个月,意识清楚,遗留轻偏瘫,生活不能完全自理。总之,高龄CSDH,应结合病人具体情况,谨慎选择治疗方法。

【关键词】慢性硬膜下血肿;高龄;脑内出血;穿刺引流术

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One case of chronic subdural hematoma in the elderly complicated with acute intracerebral hemorrhage

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【**Abstract**】Chronic subdural hematoma (CSDH) is a common disease in neurosurgery. Clinically, the treatment of CSDH in elderly patients combined with acute multiple parenchymal hemorrhages is rather perplexing. This paper reports a case of CSDH in an 80−year−old male who was admitted to the hospital due to sudden coma for 8 hours. Head CT showed right frontotemporoparietaloccipital CSDH with a volume of approximately 100 ml; it was complicated with right temporal lobe−basal ganglia hemorrhage (about 35 ml) and a small amount of bilateral parietal hemorrhage. Due to advanced age and multiple underlying diseases, the patient was unable to undergo craniotomy. Therefore, a CSDH puncture and drainage procedure was performed under intracranial pressure monitoring. The next day, a follow−up head CT revealed that the subdural hematoma had almost vanished, the brain tissue was well repositioned, and the intracranial pressure was within the normal range. The puncture needle was removed. Two days later, the intracranial pressure gradually increased, and a puncture and drainage procedure for the temporal lobe−basal ganglia hematoma was carried out. A tracheotomy was performed after the operation, and the patient's consciousness gradually recovered to a drowsy state. At discharge, the patient had hemiparesis. After a 3−month follow−up, the patient was conscious with mild hemiparesis and was unable to take care of himself completely. In conclusion, for elderly patients with CSDH, the treatment method should be carefully selected based on the specific conditions of the patient.

【**Key words**】Chronic subdural hematoma; Elderly patients; Intracerebral hemorrhage; Puncture and drainage; Surgery

1 病例资料

80岁男性,因突发昏迷8 h入院。既往糖尿病史20年;10年前,因"右输尿管癌"行右肾、输尿管切除及部分膀胱切除术,术后合并慢性肾功能不全、肝功能异常;高血压病史约6年;入院前2个月曾有头部外伤史,头部CT示双侧硬膜下积液。入院体格检查:意识呈浅昏迷状态,GCS评分6分,右侧瞳孔较左侧偏大,直接、间接对光反射均灵敏。头部CT示:右额颞顶枕慢性硬膜下血肿(chronic subdural hematoma, CSDH),量约100 ml;右颞叶−基底节(约35 ml)及双侧顶叶出血;中线结构偏移。因高龄、基础病多,无法接受开颅手术,遂先行颅内压监护下CSDH穿刺引流术。使用YL−1型颅内血肿穿刺针,在局麻下实施,穿刺点为血肿侧顶结节。首先,电钻连接带有针芯的穿刺套装,在顶结节附近选择一处穿刺点为颅内压传感器植入点,穿透头皮、颅骨、硬膜直接刺入血肿腔,然后整套针退出,再行慢性血肿穿刺,同样刺入血肿腔,退出针芯,接引流系统并夹闭;将颅内压传感器植入之前的穿刺孔,留置适当深度并固定,监测颅内压,同时开放引流。次日,复查头部CT示CSDH基本消失,脑组织复位良好,颅内压在正常范围,遂拔除穿刺针。2 d后,颅内压逐渐升高,同样在局麻下行颞叶−基底节血肿穿刺引流术,术中用20 ml注射器适当负压抽出部分血肿,复查头部CT,确定其穿刺针位置、估算血肿量,多次注射尿激酶,直至复查头部CT血肿小于15 ml、颅内压在正常范围,拔除穿刺针及颅内压传感器。术后行气管切开术,病人意识逐步恢复至朦胧状态,出院时,遗留肢体偏瘫。随访3个月,意识恢复至清楚,遗留轻偏瘫,生活不能完全自理。

2 讨　论

CSDH是神经外科常见疾病,以老年病人多见[1]。随着我

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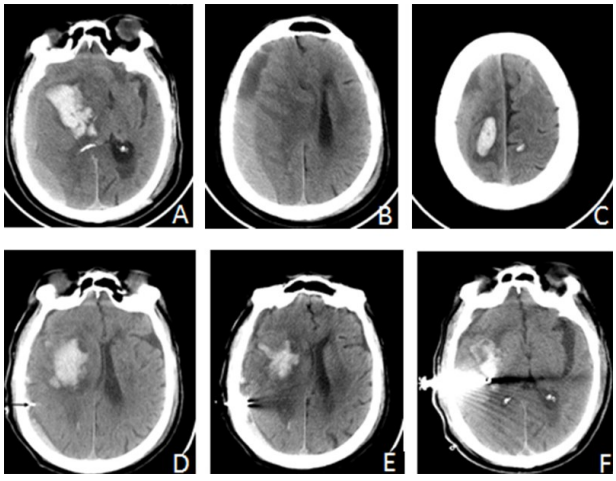

图1 高龄慢性硬膜下血肿合并多发脑实质出血穿刺引流术前后影像表现

A~C. 术前头部CT显示右侧额颞顶枕慢性硬膜下血肿、右侧颞叶-基底节及双侧顶叶出血；D. 硬膜下血肿穿刺引流术后复查头部CT显示植入的颅内压传感器（↑示）；E. 硬膜下血肿穿刺引流术后1 d复查头部CT显示硬膜下血肿基本消失；F. 右颞叶-基底节血肿穿刺引流术后3 d复查头部CT显示血肿大部分消失

Figure 1 Imaging manifestations before and after puncture and drainage for an elderly patient with chronic subdural hematoma combined with multiple cerebral parenchymal hemorrhages

A-C: Preoperative head CT reveals chronic subdural hematoma in the right frontotemporoparietaloccipital region, hemorrhage in the right temporal lobe-basal ganglia and bilateral parietal lobes; D: Postoperative head CT after puncture and drainage of subdural hematoma shows the implanted intracranial pressure sensor (↑ indicates). E: Head CT re-examination 1 day after puncture and drainage of subdural hematoma indicates that the subdural hematoma has essentially vanished. F: Head CT re-examination 3 days after puncture and drainage of the right temporal lobe-basal ganglia hematoma shows that the majority of the hematoma has disappeared.

国社会进入老龄化阶段，高龄CSDH的发病率有逐年上升的趋势[2]，轻微头部外伤为其主要致病原因[3]。高龄病人多伴有基础疾病，如高血压、糖尿病、肝肾疾病、凝血功能障碍等，也是导致CSDH的因素。自发性脑出血多发生于中老年人，是神经外科常见的急危重症之一，病死率、致残率非常高。临床上，高龄CSDH合并急性多发信脑实质出血的处理比较棘手。

目前，钻孔引流术是CSDH的首选治疗方式[4]。与软通道引流术相比，硬通道引流术可在局麻下完成，手术流程简单，可显著缩短手术时间，适合高龄CSDH病人。对于分割型CSDH，神经内镜手术治疗可能更有效[5]。自发性脑内出血因急性颅内压增高，多选择显微镜下或神经内镜下开颅手术，部分不能耐受开颅手术的病人，也可采用硬通道穿刺引流术。临床上，CSDH合并急性脑内出血的病人，比较少见，因病情严重，采用开颅手术清除血肿并行去骨瓣减压术是治疗此类病人的有效方式[6]。本文病例有其独特的临床特点：①高龄，有明确的头部外伤史，双侧硬脑膜下积液转化为单侧CSDH，血肿量大，但并无明显临床症状，因而未被及时发现；②合并有急性多发性脑内出血，血肿总量大，有明显的颅内压增高表现；③基础疾病多而复杂，合并糖尿病、高血压、肝肾功能不全等；④高龄+基础疾病，无法承受开颅手术风险。选择分步穿刺引流术并行颅内监测的手术方式优势在于：①硬通道穿刺治疗CSDH，手术时间短[7]，能在短时间内降低颅内压；②颅内压监测能够实时监测颅内压的变化情况并对脑内出血行血肿穿刺；③总体过程操作简单，在局麻下就可以完成。

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水肿。两者CT和MRI平扫表现相似，CT检查多显示为等或稍高密度[8]；MRI检查T_1WI多表现为等信号或稍低信号，T_2WI多为低信号为主，两者强化表现也呈均匀明显强化。

脑实质内SFT临床诊断困难，误诊率高，术前确诊率几乎为零，主要依靠病理诊断确诊[3]。临床上常需与低级别胶质瘤鉴别，两者MRI信号相似，主要鉴别点在于低级别胶质瘤形态不规则，边界不清。脑实质内SFT还需与一些血管病变鉴别，比如海绵状血管瘤和血管母细胞瘤等，增强MRI有助于鉴别，但最终确诊仍需病理诊断。

手术切除是脑实质内SFT主要治疗方法。SFT多为良性，边界清楚，手术一般能达到完全切除，根据病理检查结果决定后续治疗方案。研究表明，放疗能减少WHO分级Ⅱ、Ⅲ级SFT复发，但并未明显改善病人的总生存期；而且大剂量的累积辐射可导致低级别SFT分化为恶性纤维肉瘤[4,9]。因此，放疗在脑实质内SFT治疗中的作用有待进一步研究明确。对于确定的高级别SFT，系统化疗可能有效[4]。因为脑实质内SFT多为良性，预后较好，但年龄较大、肿瘤呈恶性、肿瘤切除不全及女性病人的预后可能更差[6]。

总之，脑实质内SFT罕见，大多良性生长，临床误诊率高，影像学检查有一定特异性，确诊主要靠病理诊断。手术全切除是脑实质内SFT的主要治疗方法，一般预后较好。而对于脑实质内恶性SFT的诊断与治疗尚需进一步研究。

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