

• 临床病理讨论 •

Clinicopathological Conference

A 65 year old man with persistent ardent fever and hiccup

(The 19th case)

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Case presentation

A male patient, 65 years old, retired worker, was admitted to the hospital because of persistent ardent fever for about 12 days and hiccup for 7 days 2 months after surgery for cerebral hemorrhage.

In Feb 2006, the patient received surgery because of cerebral hemorrhage in left basilar part, which left action handicap of right limbs and recent memory loss after operation. On March 18, cerebral infarction occurred and was accompanied by seizure. After symptomatic treatment, the patient turned to be better. Eleven days prior to admission (April 7), the symptoms of dizziness, nausea and vomiting accompanied by fever with cold occurred, and were diagnosed as upper respiratory tract infection in local hospital. After anti-infective (with Gatifloxacin, Ornidazole) and nutritional supporting therapy, body temperature kept at above 38°C. Chest X-ray showed right lower lung pneumonia, and persistent hiccup occurred with no obvious predisposing cause on Feb. 11. He was admitted to the hospital for further therapy on Feb. 19, 2006. Laboratory examination showed disorder of electrolyte balance (K^+ 3.33mmol/l, Ca^{2+} 2.09mmol/l, Na^+ 129.1mmol/l). Dignosis on admission: fever of unknown origin, grave pneumonia, sequelae of cerebral hemorrhage, persistent hiccup, hypertensive disease, hyperplasia of prostate gland, coronary artery disease, disorder of electrolyte balance, second-

ary epilepsy. The patient had history of hypertension for 30 years and history of CHD for many years. He smoked one package of cigarettes a day for 45 years and drank about 0.5 kilogram every three days.

On physical examination, vital signs were BP 130/80mmHg, pulse 88 bpm, temp 36.8°C, R 18/min. The patient was normally developed and well nourished. He was restless but alert, and had perologaphasia. His pupils were equal in size, round and reactive to light. Oropharynx was not red. Skin had no rash or petechiae. Lymph nodes were unpalpable. His neck was supple. Thyroids were not enlarged. Breath sounds were rough and decreased at right lower lung. Moist rales were audible at left base. Heart was normal in size on percussion, auscultation of valve areas did not hear mutmurs or rubs. Abdomen was soft, nontender and had no hepatosplenomegaly or evdience for ascites. The examination of nervous system showed that the muscle tension of right limbs was elevated, 0 degree in the right upper extremity and 1 degree in the right lower extremity. Reflex of patella tendon was hyperactive. The muscle tension and heel-knee-tibia test were normal in the left limbs. Both lower extremities had no oedema.

After admission, the patient received anti-infection, cerebral nerve nutrition and correcting acid-base imbalance therapy, and 654-2 injection to Hegu acupucture point. Pulmonary infection was controlled, and no more hiccup occurred. Body temperature dropped to normal on Apr. 26. On Apr. 28, symptoms of restlessness and nausea occurred during the stage of rehabilitation treat-

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ment; therefore the treatment was stopped. On Apr. 29, vomiting occurred half an hour after breakfast. CT examination showed no new changes. On Apr. 30, body temperature elevated to 38°C, and vomiting was still present. Ultrasonographic examination of abdomen and appendix showed no abnormality, and chest X-ray still showed right lower lung pneumonia. Examination of blood cells showed that neutrophilic leukocyte count was elevated. After anti-infection therapy with Levofloxacin, no effect was observed. On May 1st, body temperature was elevated to 39.5°C. Therefore antibiotics were changed into imipenem-cilastatin, and body temperature was maintained at a level of 37°C. On May 8, skin eruption occurred on the back and red and swelling on left leg skin. These were considered to be drug side effect and phlebitis. Then anti-anaphylactic therapy was given, physical therapy and heparin sodium ointment was applied locally. No obvious effect was found. Thereafter fungous infection of oral cavity occurred. It was treated with 1:10 000 fungicidin and antibiotics were changed to penicilin 80×10^5 U bid. On May 11, vomiting occurred during suction of sputum. At the same time, rales were audible and were considered to be due to aspiration. The patient had fever of 40°C. Skin eruption and skin red and swelling had no improvement. The antibiotics were therefore changed to teicoplanin and fluconazole. On night of May 12, frequent diarrhea emerged, especially after meal. Imbalance of intestinal flora was diagnosed and treated with temporal fasting, dioctahedral smectite, Bacillus Licheniformis Capsule and electrolyte balance control. On May 14, from 8:30AM to 12:50PM, the patient's blood pressure decreased from 90/50mmHg to 70/40mmHg. Heart rate fluctuated at 120-130/min. He was considered to have septic shock and filling defect. Blood gas analysis showed pH 7.363, PaCO₂ 31.9mmHg, BE-6.7mmol/L, HCO₃ 17.7mmol/L and PO₂ 59.6mmHg, suggesting metabolic acidosis and hypoxemia. Then the speed of transfusion was increased with injection of glucose and sodium chloride 800ml in half

an hour, pumping of dopamine 10μg/(kg • min) and sodium bicarbonate 125ml were given. BP could be maintained at a level of 100/60mmHg. At 6:30AM of the next day, the breathing frequency increased from 31/min to 45/min. Saturation of blood oxygen decreased to 70%. Blood gas analysis showed pH7.525, PO₂ 49.1mmHg and PCO₂ 26.5mmHg. Ventilatory support with endotracheal intubation and respirator was used urgently. At twelve o'clock, electrocardiosignal disappeared suddenly and the extremities became cool and cyanotic. Pupils were equal in size, dilated and unreactive to light. Breath sounds diminished, and no obvious dry or moist rales were audible. According to the patient's condition, septic shock with possible hypovolemic shock was diagnosed. After receiving antishock treatment such as adrenaline, dopamine, dextran, and cardiac massage, heart rate recovered at 12:46PM. But at 16:05PM, blood oxygen saturation could not be monitored. the heart rate was 74/min, the skin was mottled, the extremities were cyanotic, the pupils were dilated, equal in size and unreactive to light. The patient did not show any sign of resuscitation after utilizing adrenaline, dopamine, and cardiac massage repeatedly, and died at 17:15 PM. During hospitalization examination of bacterial culture of sputum for several times showed fungus (on Apr. 20 and May 3), gram-positive bacteria (on May 3), *Staphylococcus aureus* (on May 14). The examination of bacterial culture of blood showed *Staphylococcus aureus* only once (on May 13).

Clinical and pathological discussion

Dr. ZHU Mei: The therapeutic efficacy of antibiotics was not good in this patient. The patient's condition was exacerbated after suction of sputum on noon of may 11, which was considered to be due to aspiration of sputum. He had taken sodium phenytoin 0.1g tid for a long time in other hospital. The level of the drug was too high to be measured. Following question should be discussed: if the medicine was overdosed or if there was interaction between medicines?

Dr. LI Jiayue: The clinical characteristics of this case were as follows: The patient was an aged male. He had history of hypertension and cerebral hemorrhage. The symptom onset was acute. He was admitted for hyperpyrexia. Septic shock may be the cause of death. Following questions should be discussed: Why pulmonary infection occurred two months after cerebral hemorrhage? Why antibiotics were not effective? It is to say that our consideration can not be limited only to infective factor. The co-existed non-infective factor should also be considered?

Dr. WU Xingli: The patient had sequelae of cerebral hemorrhage, cerebral infarction and secondary epilepsy. The present illness began on Apr. 4. Before admission, various antibiotics treatment for 12 days was not effective. Most of them were anti-gram-negative bacteria medicines. On admission, the patient had poor nutritional status and pulmonary infection. Anti-infection (broad-spectrum antibiotics were selected) and nutritional supporting therapy were given. The patient's condition was improved, which benefited from nutritional support, antibiotics and good nursing care. But during the stage of rehabilitative treatment after transferring from ICU to the ward, symptoms of restlessness and nausea occurred. Whether this was due to blood pressure elevation caused by stress, occurrence of lacunar infarction, or gastrointestinal mucous membrane injury? Then fever began again on Apr. 30. Though body temperature was controlled by imipenem-cilastatin, no other obvious changes can be seen. No attention was paid to correct internal environment. Then skin eruption, phlebitis, fungous infection of oral cavity occurred. The cause of death is considered to be septic shock induced by respiratory tract infection. Some experiences should be stressed: ① Combined therapy is very important, such as control of infection, nutritional support, correcting internal environment disorder, enhancing immunological function. ② For a bedridden old people, nursing service is very important, especially in keeping the respiratory tract unobstructed.

Dr. YAN Muyang: The patient had history of cerebral hemorrhage and cerebral infarction and got

pulmonary infection thereafter. No aspiration pneumonia was displayed on chest X-ray film, and the patient's condition had improved for some time. Following questions should be discussed: ① The patient had persistent high fever, pulmonary infection was exacerbated and severe hypoxemia was present. We should consider whether ARDS existed, which could not be corrected by ordinary O_2 inhalation. ② The level of D-dimer fragments was high, which indicated a hypercoagulation state. Meanwhile, the patient's blood pressure decreased abruptly. If pulmonary embolism existed? ③ Imbalance of bacterial flora, allergy, and erysipelas occurred during the process of antibiotics application. If multiple infections existed?

Dr. SHI Huaiyin: The major pathological findings were as follows: ① Acute edema, congestion and severe infection of lungs, especially in lower lungs. ② Coronary atherosclerotic heart disease. Part of myocardium of left ventricular wall had ischemic change. Stenosis of left coronary artery main stem (grade II~III), anterior descending branch (grade II), left circumflex branch (grade II), right coronary artery main stem (grade I). ③ Atherosclerosis (grade IV), compound pathological change stage. ④ Hypertensive disease: hypertensive heart disease (left ventricular hypertrophy, muscle fiber hypertrophy and degeneration), arteriosclerosis of bilateral kidneys. ⑤ Pleural effusion, 400ml in the left and 200ml in the right. ⑥ Congestion of liver, spleen and kidneys. ⑦ Hyperplasia of prostate. ⑧ Acute gastroenteritis. From the aforementioned pathological changes, we can conclude that the patient's death was caused by septic shock, and respiratory and circulatory failure.

Dr. XING Yubin: The patient's primary disease was serious. It was a combined infection, mainly fungous infection. Now, the department owning the highest prevalence was ICU, attaining 38.71%, and the larger the hospital, the higher the morbidity rate. The main sites of nosocomial infection were lower respiratory tract, upper respiratory tract, urinary tract, operative site, gastrointestinal tract, skin and soft tissue. The characteristics of the patients are as follows:

①Multiple organ dysfunction and low general immunity and resistance often exist. ②Application of various invasive monitoring and treatment techniques, such as respirator, arterial and venous catheterization, indwelling urinary catheter, drainage-tube and so on, can cause nosocomial infection. ③High flowability of patient and realtive concentration of medical staff can increase the density of bacteria in the environment. ④Cross infection between patients should not be ignored. Treatment of critically ill patients with different diseases and infections of different sites in ICU is the potential factor causing cross infection. ⑤Application of great quantities of broad-spectrum antibiotics results in imbalance of bacterial flora, and application of hormone or immunodepressant results in infection of opportunistic pathogenic bacteria.

Dr. LU Caiyi: The patient was an aged male. He had history of hypertension, cerebral infarction and cerebral hemorrhage. The onset of the symptom was acute. He was admitted for persistent high fever. The diagnosis was clear and therapeutic measures were correct. Various antibiotics were not so effective and dysfunction of multiple organs including heart and digestive system appeared afterward. Pulmonary infection was an important initiative factor of multiple organ dysfunction syndrome. The clinical course of this case was consistent with the hypothesis of lung initiating mechanism in multiple organ dysfunction syndrome in the elderly proposed by Wang Shiwen.

Dr. ZHAO Yusheng: According to the autopsy report, the diagnose of hypertension, CHD and cerebral hemorrhage is accurate, but the major diagnosis is pulmonary infection, and its characteristics are as follows: ①Aged male. ②Post-cerebral hemorrhage, intermittent dysphoria, epileptic seizure and incapability of self-care. ③The process of infection is changeable, fluctuating, accompanied by erysipelas and skin rash. ④Bacterial examination; examinations of bacterial cultures of sputum showed fungus(on Feb. 20 and May 3) which was treated with antifungal drugs, gram-

positive bacteria (on May 3) which was treated with imipenem-cilastatin and levofloxacin, only once the examination of bacterial culture of blood showed coagulase-positive *Staphylococcus aureus* (on May 1), repeated sputum culture found *Staphylococcus aureus* (on May 14) and *Klebsiella pneumoniae* (on May 16). ⑤Examination of chest X-ray: after admission, pulmonary infection turned to be better after treatment, no signs of severe infection demonstrated on the last two chest X-ray films when the infection was exacerbated, and no signs of pleural effusion. Our therapeutic measures were right after admission which was indicated by improvement of sputum culture, but the treatment still needs improvement: ①Pulmonary infection of elderly person is often related to cerebral vascular accident and heart failure, and was too complicated, changeable and difficult to be treated. ②Application of antibiotics should be regular. Once fungous infection is found, it is hard to be controlled, intractable and apt to recur and has high fatality rate. the treatment period should not be shorter than two weeks. ③Pathological report indicated infection due to *Staphylococcus aureus*, to which the treatment period is at least 10 to 15 days. From this case we have experiences as follows: ①According to the pathological report, we know that clinicans signs were not coincident with the examination of chest X-ray film, so clinicians should judge the disease comprehensively and use various supplementary examinations as the supporting means. ②The antibiotics treatment should have right strategy and the dosage and course of treatment should be sufficient. The treatment should be complihensive and attention should be paid to protection of organ functions, improvement of internal environment and nutritional support. ③For elderly patient with pulmonary infection, nursing care is very important, including turning over the patient in time, knocking his back, ensuring drainage of sputum and keeping the airway unobstructed.

(Translator: XIAO Tiehui)

65岁老年男性持续发热和呃逆一例

1 病例摘要

患者男性,65岁,主因脑出血术后2个月,持续高热12d,呃逆7d入院。患者于2006年2月因大脑左侧基底出血,行穿刺抽液术,术后遗留有右侧肢体活动障碍,近期记忆丧失。3月18日再次出现脑梗死,伴有癫痫发作,给予对症治疗后好转。4月7日受凉后出现头晕,恶心,呕吐伴发热,在当地医院就诊,考虑上呼吸道感染,给予抗感染及营养支持等治疗,体温持续在38℃以上,胸片显示右下肺感染,且于4月11日无明显原因出现持续呃逆,为了进一步治疗,收入解放军总医院。入院后查水电解质平衡紊乱(K^+ 3.33mmol/L, Ca^{2+} 2.09mmol/L, Na^+ 129.1mmol/L),入院诊断:(1)发热原因待查?脑出血后遗症,肺部重症感染;(2)持续呃逆;(3)高血压病;(4)冠心病;(5)前列腺增生;(6)电解质平衡紊乱;(7)继发性癫痫。

入院查体:体温36.8℃,脉搏88次/min,呼吸18次/min,血压130/80mmHg,发育正常,营养不良。神志清楚,精神差,不全运动性失语。全身皮肤黏膜未见出血点、瘀点、瘀斑,浅表淋巴结未触及肿大。双侧瞳孔同大等圆,对光反射灵敏。咽无充血,扁桃体无肿大。颈软,甲状腺无肿大。胸廓无畸形,双肺呼吸音粗,右下肺呼吸音略低,左下肺可以闻及湿性啰音。心前区无隆起,心浊音界不大,心率88次/min,心律规整,各瓣膜听诊区未闻及杂音。腹部平软,未触及包块,肝脾肋缘下未触及,无移动性浊音。右侧肢体肌张力升高,右上肢肌力0级,右下肢肌力1级,膝腱反射亢进,左侧肌张力正常,跟、膝腱反射正常存在,双下肢无水肿。双侧足背动脉搏动减弱。

诊疗经过:患者入院后,给予抗感染、营养脑神经、调整酸碱平衡治疗,予654-2注射液合谷穴注射治疗呃逆。患者肺部感染控制,体温逐渐降至正常,呃逆停止,一般情况好转,此后患者病情相对平稳,4月28日理疗科进行康复锻炼,锻炼过程中患者烦躁明显,遂中止治疗。4月29日早餐后0.5h呕吐,为非喷射样,急行头颅CT检查并请神经内科会诊,认为无新病灶出现。4月30日体温再次升高至38℃,仍有呕吐症状,急行腹部及阑尾B超检查无异常,胸片检查仍提示右下肺感染,血象升高,急诊生化基本正常,给予利复星静点无效,5月1日体温继续升

高,最高达39.5℃,换用抗生素为泰能0.5g,2次/d,患者体温控制在37℃左右。5月8日患者出现背部皮疹及左小腿皮肤红肿,皮疹考虑药物副作用,给予抗过敏治疗,皮肤红肿考虑静脉炎,应用美得喜乳膏局部涂敷及物理治疗,效果不明显,后发现口腔真菌感染,口腔局部应用1:10 000制霉菌素局部涂抹,换用青霉素800万单位,2次/d,5月11日吸痰时发生呕吐,后肺部听诊出现较多啰音,考虑误吸,患者仍发热,体温波动较大,最高可达40℃,背部皮疹及左小腿皮肤红肿较前无改善,更换抗生素替考拉宁及大扶康治疗,患者5月12日夜间出现频繁腹泻,为黄色水样便,进食后为重,请消化内科会诊后考虑为肠道菌群失调,建议暂禁食,继续应用思密达、整肠生等治疗并维持出入量、电解质平衡,患者于5月14日晨起8:30到12:50血压呈进行性下降,由原来的90/50mmHg下降到70/40mmHg,心率在120~130次/min,呼吸频率31~33次/min,血压下降原因考虑(1)感染性休克;(2)血容量不足。血气分析pH7.363, $PaCO_2$ 31.9mmHg, BE -6.7mmol/L, HCO_3^- 17.7mmol/L, PO_2 59.6mmHg,提示代谢性酸中毒,低氧血症,增加输液速度,0.5h内静脉推注葡萄糖生理盐水800ml,多巴胺注射液3ml/h($10\mu g/kg \cdot min$)速度泵入,血压维持在95~100/60mmHg上下,补充碳酸氢钠注射液125ml,患者于5月15日6:30开始出现呼吸频率加快,41~45次/min,血氧饱和度下降,最低时为70%,急查血气分析结果显示:pH7.525, PO_2 49.1mmHg, PCO_2 26.5mmHg,急请呼吸内科会诊,行经鼻气管插管术,呼吸机辅助呼吸。于12:00心电信号突然消失,患者四肢冰凉发绀,呼吸音弱,双肺无明显干湿性啰音,双侧瞳孔散大等圆,对光反射消失,测不到血压,分析病情后考虑主要原因为感染性休克,同时可能存在低血容量休克,给予胸外按压,多巴胺、肾上腺素、低分子右旋糖苷等药物治疗后,于12:46患者恢复自主心率,心率110次/min,16:05患者血氧饱和度监测不到,心率74次/min,皮肤花斑,四肢末梢发绀,瞳孔散大,等大等圆,对光反射消失,反复胸外按压,使用多巴胺、肾上腺素注射液效果差,患者无自主心跳,病情无好转,于17:15抢救无效宣布死亡。患者入院期间进行多次细菌学检查:4月20日痰培养发现真菌,5月3日痰培养再

次发现真菌,5月3日痰培养发现革兰阳性球菌,5月13日血培养发现一次凝固酶阴性葡萄球菌,5月14日痰培养报告发现金葡萄菌。

2 临床与病理讨论

朱梅医师:患者抗生素使用疗效不佳,于5月11日中午吸痰后病情加重,考虑有误吸转监护室,患者于外院使用苯妥英钠0.1g,3次/d,入院期间苯妥英钠浓度高到测不出,是否存在药物之间的相互影响?药物是否过量?

李佳月医师:病例特点为老年男性,急性起病,既往高血压、脑出血病史,以高热入院,死亡原因考虑为感染性休克。患者病史为肺部感染,于脑出血2个月后发现,抗生素使用效果不佳,考虑不能局限于感染,是否存在非感染因素?

吴兴利副主任医师:患者有脑出血后遗症、脑梗死、继发癫痫病史,此次4月4日起病,院外多种抗生素治疗多为抗革兰阴性菌药物,治疗12d效果不佳,入院时营养状况差,肺部感染,给予抗感染(抗生素主要选用广谱抗生素)、营养支持等治疗,患者病情好转得益于营养支持、抗生素使用及良好护理,患者转出监护室后康复治疗过程中出现躁动不安、恶心等症状,是否因应激状态引起血压升高、腔隙性脑梗死及胃肠黏膜损伤,30日开始发热,应用泰能体温控制,但症状无明显改善,内环境纠正未引起重视,后出现皮疹及静脉炎,口腔出现真菌感染,死亡原因考虑呼吸道感染诱发感染性休克,分析整个治疗过程,经验教训:(1)综合治疗很重要:控制感染、营养支持、纠正内环境、提高免疫功能;(2)长期卧床的老年患者护理工作很关键,尤其要保持呼吸道通畅,及时翻身、叩背、排痰。

晏沐阳副主任医师:患者有脑出血及脑梗死病史,此后出现肺部感染,从胸片上看不到吸入性肺炎表现,治疗期间有一段时间好转。患者持续高热,感染加重,且存在严重低氧血症,普通给氧无法纠正,是否出现急性呼吸窘迫综合征?患者血压突然下降,处于高凝状态,D-二聚体水平很高,有无肺栓塞的存在?抗生素使用过程中出现菌群失调、过敏、丹毒,是否存在多重感染?

石怀银教授:病理解剖诊断(1)双肺急性肺水肿、淤血,双肺重度感染(图1),以双下肺为著。(2)冠状动脉粥样硬化性心脏病:①左心室壁部分心肌呈缺血性改变;②左冠脉主干狭窄Ⅱ~Ⅲ级,前降支Ⅱ级,左旋支Ⅱ级,右主干为Ⅰ级。(3)动脉粥样硬

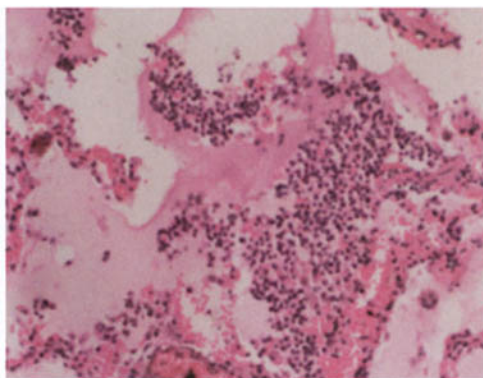


图1 炎症细胞高度浸润

化Ⅳ级,复合病变期。(4)高血压病:①高血压性心脏病(左心室肥厚,心肌纤维肥大、变性);②双侧肾脏细小动脉硬化。(5)双侧胸腔积液,左侧约400ml,右侧约200ml。(6)肝、脾、肾等脏器淤血。(7)前列腺增生症。(8)急性胃肠炎。死亡原因:感染性休克,呼吸、循环衰竭。

邢玉斌教授:原发病严重,以肺部真菌感染为主的多部位多种致病菌混合感染。现患病率最高的科室为综合ICU,达38.71%,而且医院规模越大,现患率越高,与国外有关报道相似。医院内感染部位主要有:下呼吸道、上呼吸道、泌尿道、手术部位、胃肠道、皮肤软组织。病人往往具有以下特点:(1)常有多脏器损伤,全身免疫力、抵抗力低下,病人自身携带的微生物作为条件致病菌导致感染的发生。(2)病人各种侵入性监测和治疗技术的应用,例如使用呼吸机、动静脉插管、留置导尿管、引流管等,均可诱发院内感染。(3)病人流动性强,医务人员相对密集可造成环境中细菌的密度增大。(4)病人之间的交叉感染不容忽视,不同病种、不同部位感染的危重病人集中在ICU治疗是发生交叉感染的潜在因素。(5)大量应用广谱抗生素致菌群失调,应用激素或免疫抑制剂引起条件致病菌感染。

卢才义主任医师:患者老年男性,既往高血压、脑出血、脑梗死病史,急性起病,以持续高热入院,诊断明确,治疗措施正确。患者应用多种抗生素效果不佳,后出现心脏、消化系统等器官功能障碍,符合王士雯院士提出的“老年多器官功能不全肺启动假说”,首先以肺起病,随后依次出现心脏、消化系统等器官功能障碍。

赵玉生主任医师:结合患者尸检报告,患者高血压、冠心病(多支病变)、脑出血诊断成立。主要为肺部感染,特点如下:(1)老年男性;(2)脑出血后,间断

烦躁,癫痫样发作,生活不能自理;(3)感染过程多变,随时波动,期间一段时间好转,后感染加重,伴丹毒、皮疹;(4)细菌学检查:4月20日痰培养发现真菌,给予抗真菌治疗,5月3日痰培养再次发现真菌,5月12日抗真菌治疗,5月3日痰培养发现革兰阳性球菌给予泰能、利复星治疗,血培养发现一次凝固酶阴性葡萄球菌,5月14日痰培养报告发现金葡菌,5月16日痰培养发现肺炎克雷伯菌;(5)胸片:入院后肺部感染治疗好转,感染加重后最后两张胸片未显示出严重肺部感染征象,无明显胸腔积液,多种抗生素使用无法挽救生命。入院治疗措施正确,痰培养结果证明治疗好转,后期治疗积极,关键环节把握待需提高:(1)老年肺部感染患者多与脑血管意外、心衰有关,很难控制,感染的多变、难治与复杂是其特征。(2)抗生素应用:应有规律,老年人一旦发现真菌感染,很难控

制,非常顽固,死亡率很高,一般治疗周期不能少于2周,很容易复发。(3)尸检病理报告征象考虑金葡菌感染,金葡菌治疗时间也不能过短,至少10~15d。经验:通过尸检报告可以看出,患者临床征象与胸片检查结果不完全一致,临床医师应以综合判断为主,辅助检查为支持手段;抗生素治疗应有策略,剂量要足够,疗程要足够;治疗过程中应综合治疗,注意保护器官功能,改善内环境,营养支持;老年肺部感染患者,护理很关键,应及时翻身、叩背,保证痰液及时引流和气道通畅。

(参加讨论医师:朱梅、李佳月、吴兴利、晏沐阳、石怀银、邢玉斌、卢才义、赵玉生)
(肖铁卉 整理)

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噬血细胞综合征临床分为两大类,一类为原发性或家族性,另一类为继发性,后者可由感染及肿瘤所致^[3]。原发性噬血细胞综合征,或称家族性噬血细胞综合征,为常染色体隐性遗传病,常在儿童时期发病,其发病和病情加剧常与感染有关。继发性噬血细胞综合征分为感染相关性噬血细胞综合征和肿瘤相关性噬血细胞综合征。Risda11等^[4]于1979年首先报道19例疱疹病毒感染患者并发噬血细胞综合征。13例是肾移植患者。除具有噬血细胞综合征的共同特征外,病毒检查阳性;在疾病过程中可以发现病毒性皮疹。对症处理预后良好。感染相关性噬血细胞综合征是由于严重感染引起的强烈免疫反应,淋巴组织细胞增生伴吞噬血细胞现象,本病常发生于免疫缺陷者,如接受器官移植、感染艾滋病及长期接受激素治疗的患者。由病毒感染所致者称病毒相关性噬血细胞综合征,但其它微生物感染,如细菌、真菌、立克次体、原虫等感染也可引起噬血细胞综合征。其临床表现除有噬血细胞综合征的共同表现(发热、肝脾肿大)外,有的有皮疹、淋巴结肿大和神经症状。肺部的症状多为肺部淋巴细胞及巨噬细胞浸润所致,但难与感染相鉴别。骨髓检查在疾病早期的表现为中等度的增生性骨髓象,噬血现象不明显,常表现为反应性组织细胞增生,无恶性细胞浸润,应连续多次检查骨髓,以便发现吞噬现象。该病的极期除组织细胞增多外,有多少不等的吞噬性组织细胞,主要吞噬红细胞,也可吞噬血小板及有核细胞。晚期骨髓增生度降低,这很难与细胞毒性药物所致的骨髓抑制相鉴别。有的病例

其骨髓可见大的颗粒状淋巴细胞,胞体延长如马尾或松粒状,这可能是噬血细胞综合征的一种特殊类型的淋巴细胞。半数病例病情进展急剧,预后不良,缺乏特效治疗;重症病例早期异基因骨髓移植优于常规化疗或免疫抑制治疗。由于噬血细胞综合征临床和细胞形态学、组织学与恶性组织细胞增生症十分相似,尚缺乏特异鉴别标记。噬血细胞综合征比恶性组织细胞增生症多见,部分病例被误诊为恶性组织细胞增生症。本文的报道在于提醒移植工作者加强对噬血细胞综合征的认知,了解肝移植术后相关知识。

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