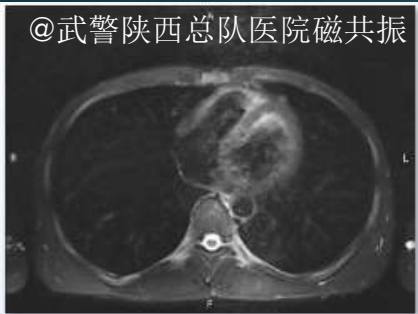


病例讨论

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- ▶ 患者：男性 32岁 职业为农民
- ▶ 主诉：发现腹部胀大9天，腹痛伴发热7天，近3天体重每天增加约1斤。
- ▶ 专科检查：腹膨隆，无胃肠型及蠕动波，无腹壁静脉曲张，全腹轻压痛，无反跳痛，腹部张力高，Murphy征阴性，全腹扪及质软包块，肝脾肋下未及，双肾区无扣击痛，移动性浊音阴性。听诊肠鸣音减弱。
- ▶ 既往史：既往体健，无免疫缺陷，无其它特殊。

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lt0001.jpg



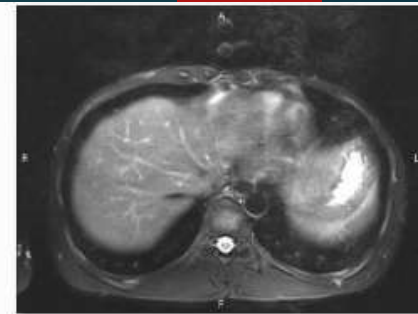
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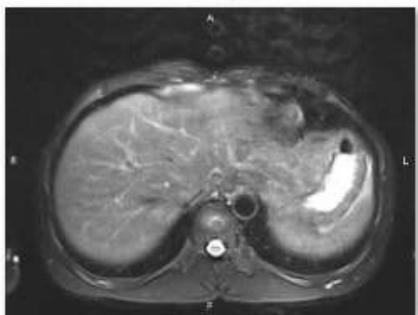
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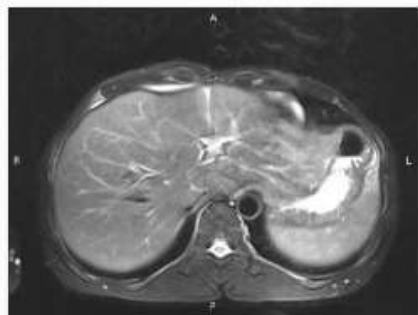
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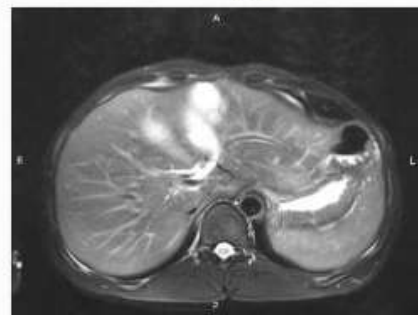
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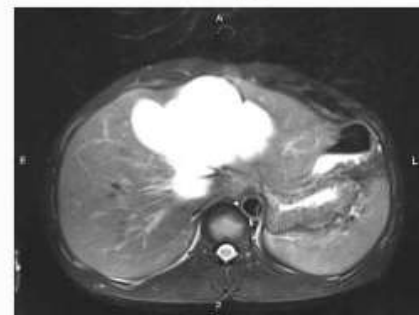
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lt0007.jpg



lt0008.jpg



lt0009.jpg



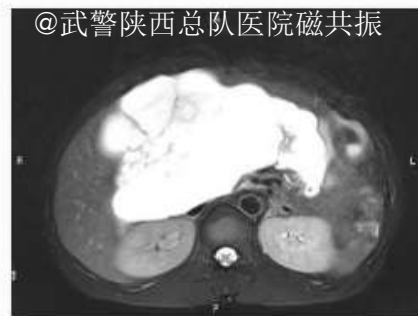
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lt0011.jpg



lt0012.jpg



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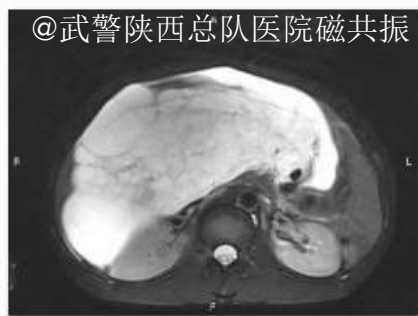
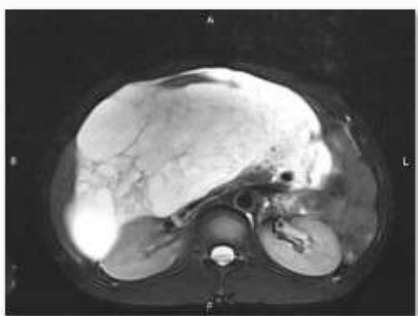
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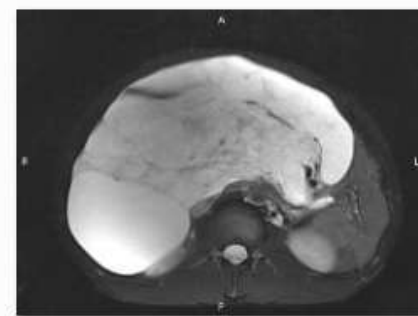
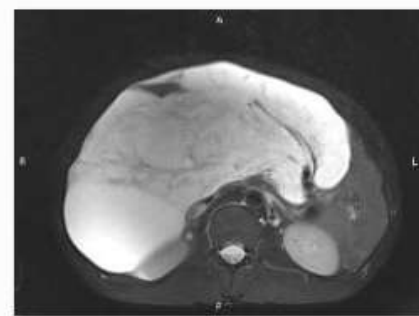
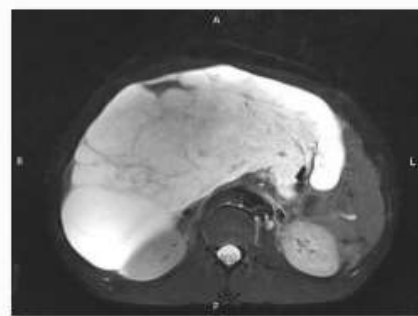
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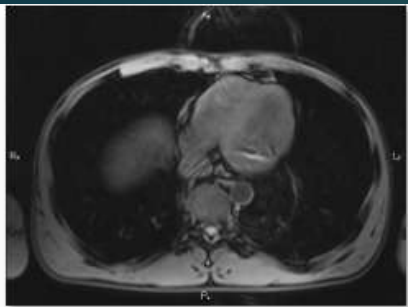


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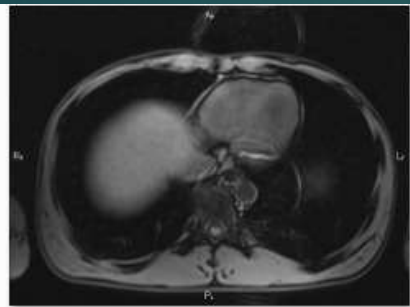


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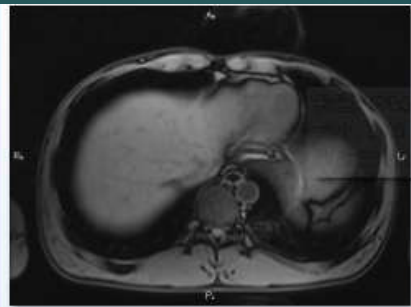




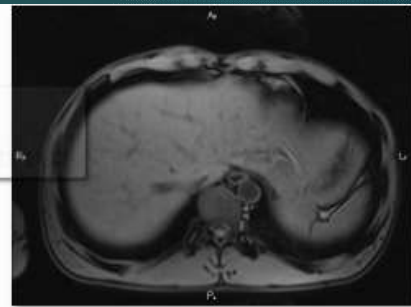
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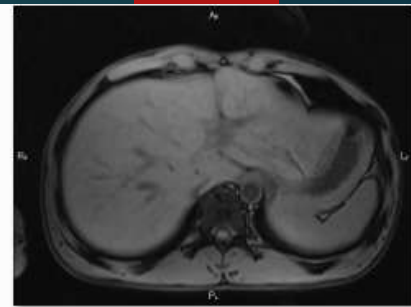
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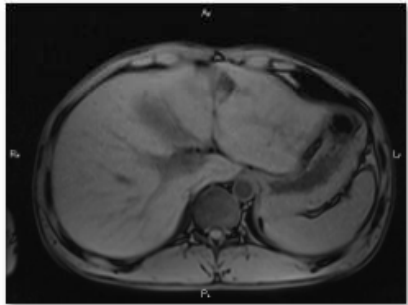
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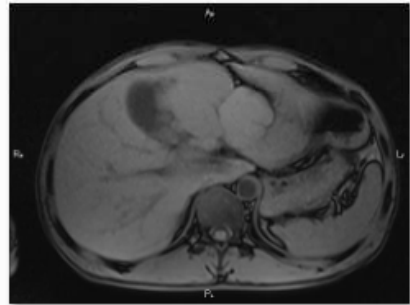
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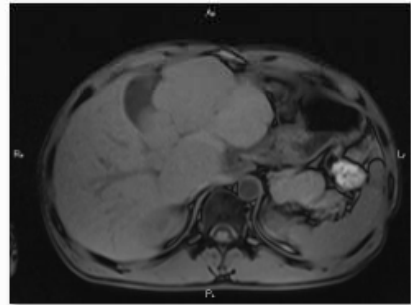
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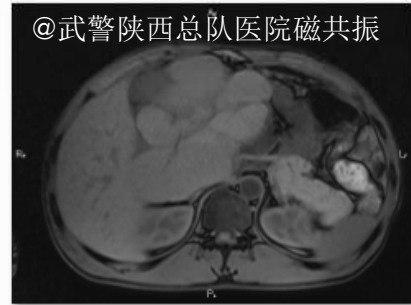
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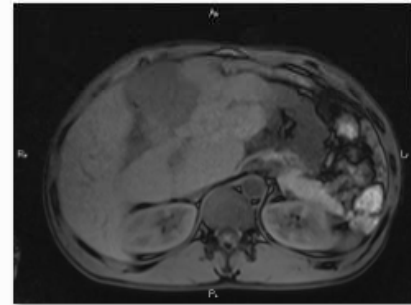
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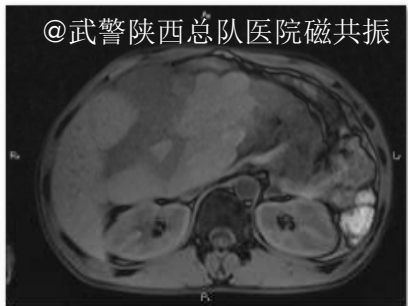
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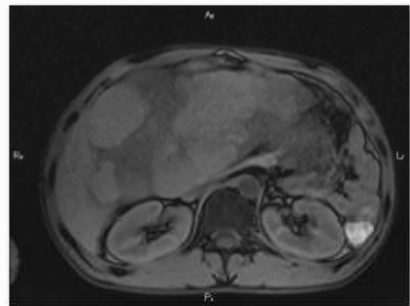
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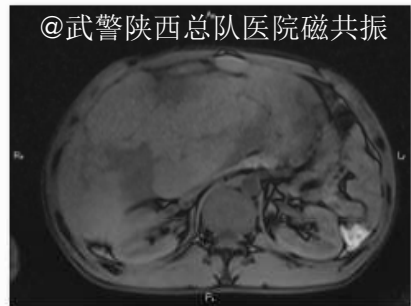
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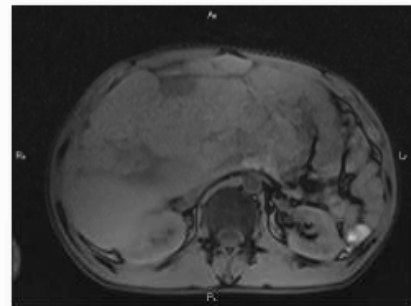
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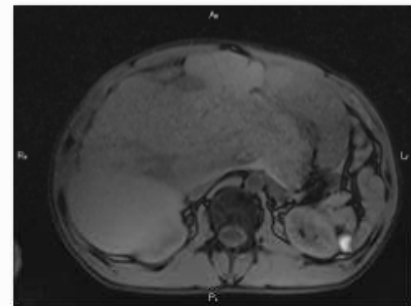
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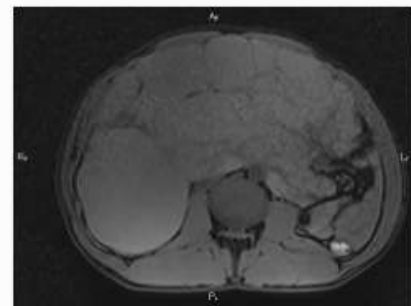
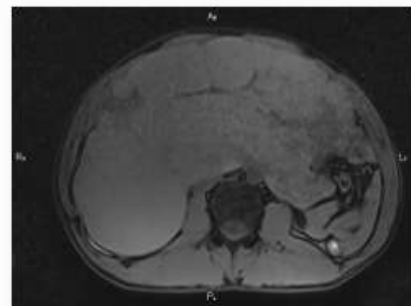
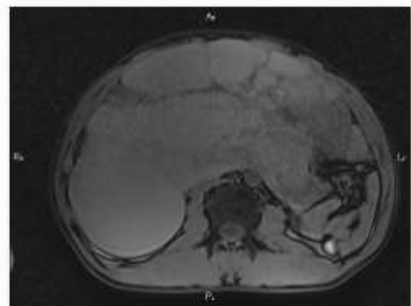
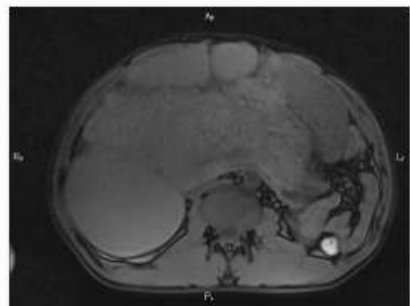
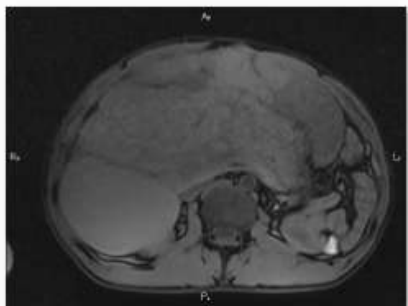
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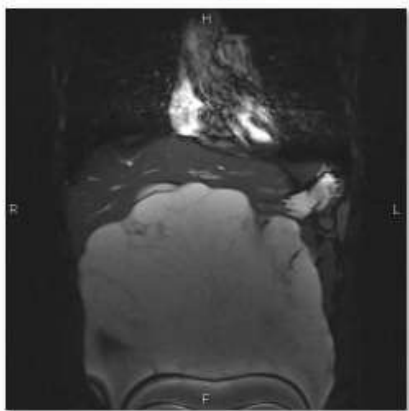


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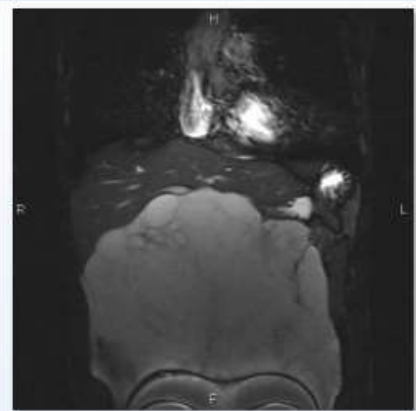


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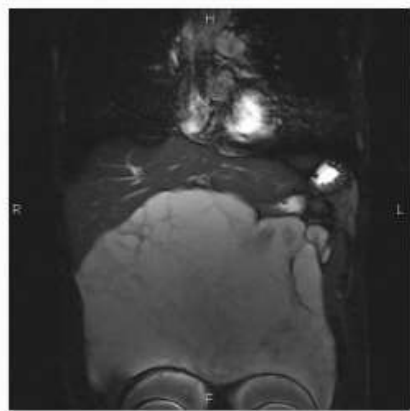




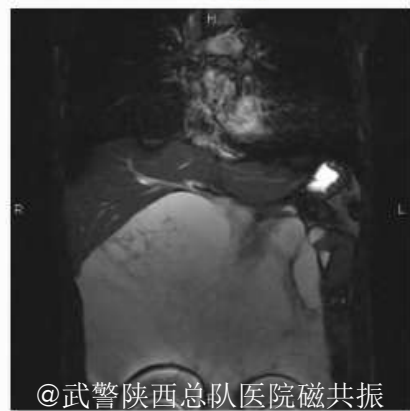
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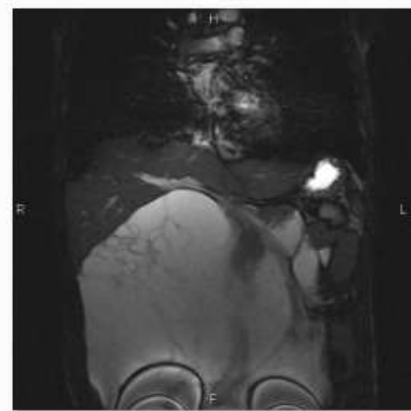


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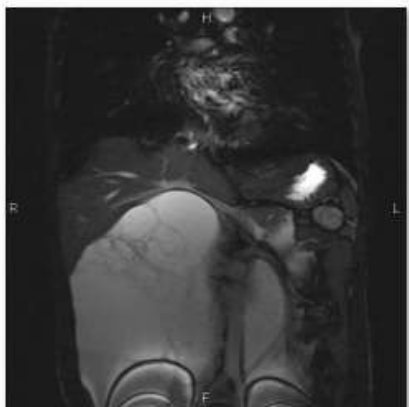


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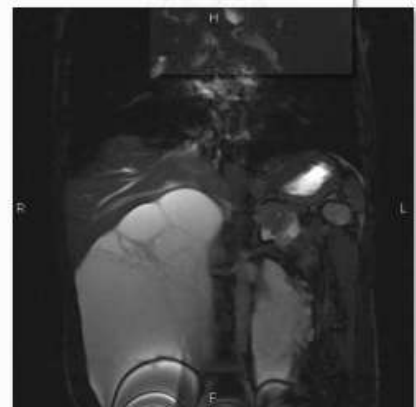
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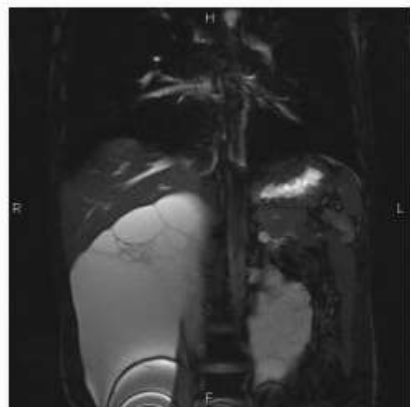
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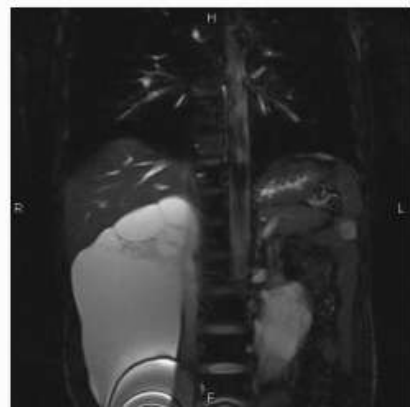
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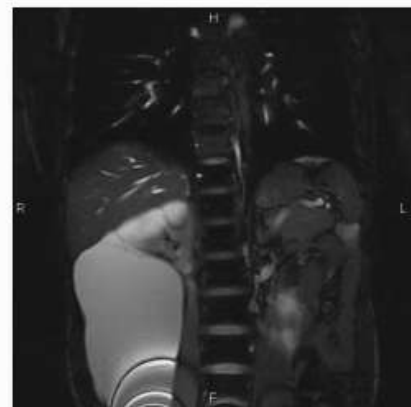
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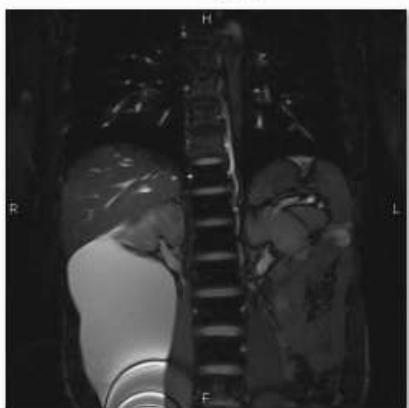
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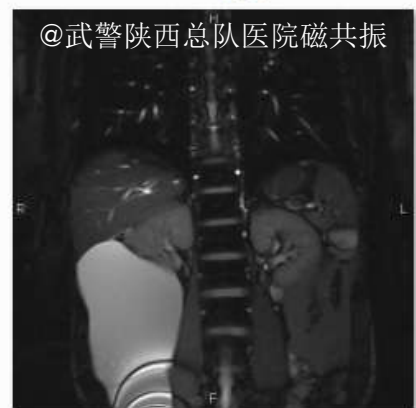
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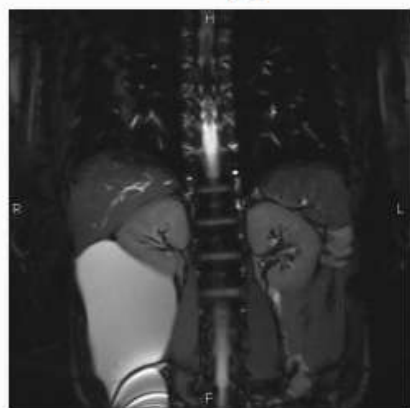


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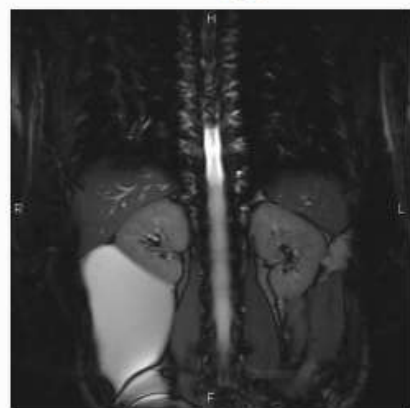


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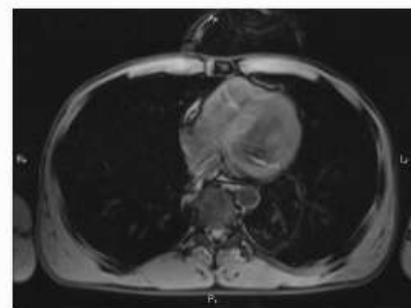
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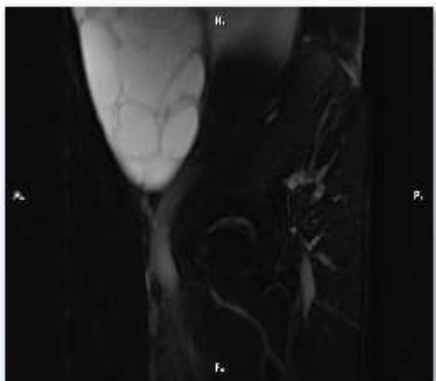
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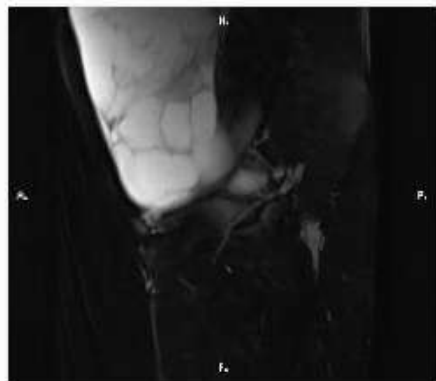


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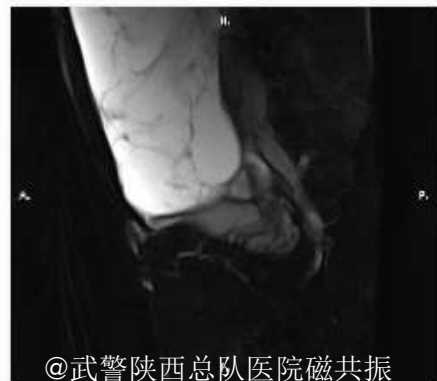


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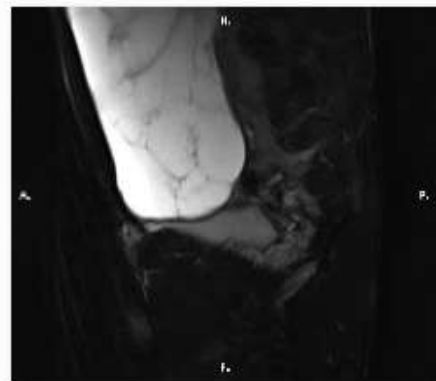


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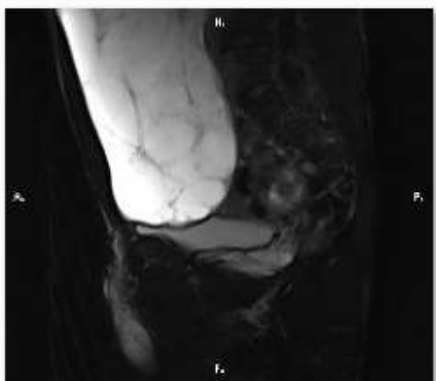


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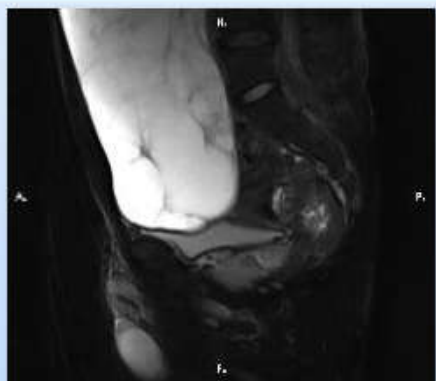
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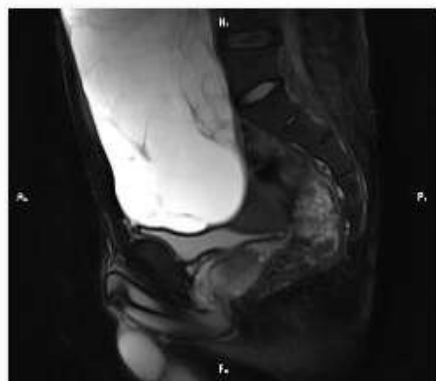
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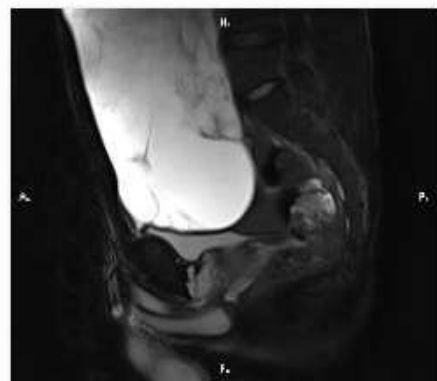
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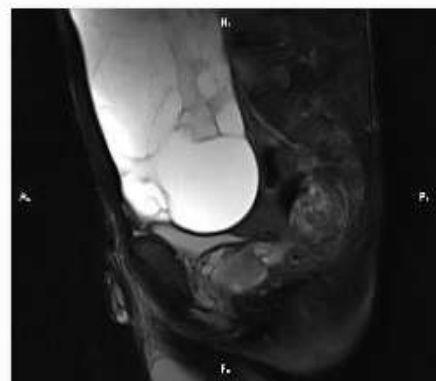
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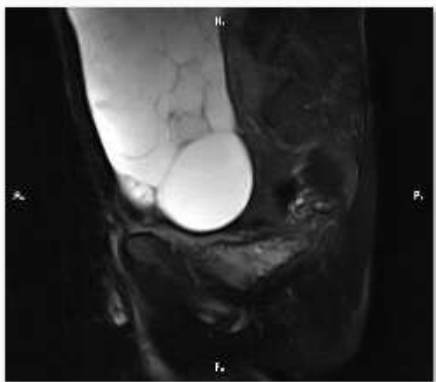
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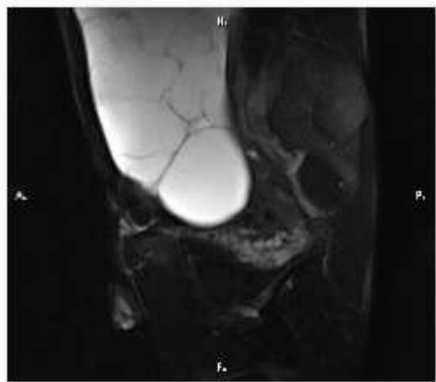
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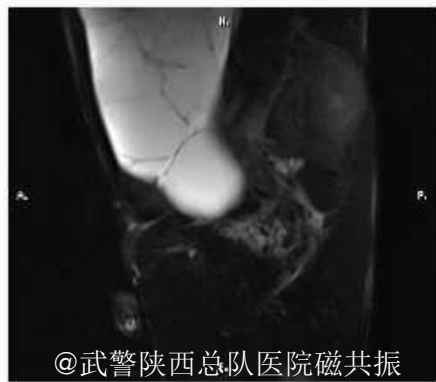
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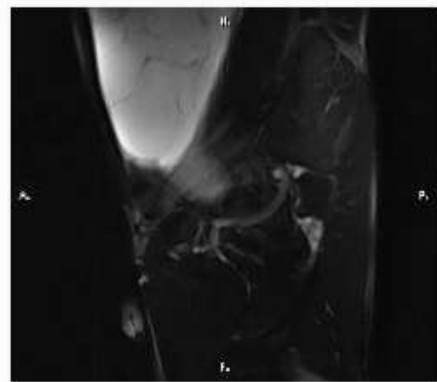


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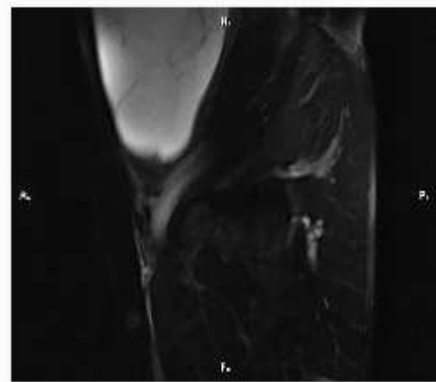


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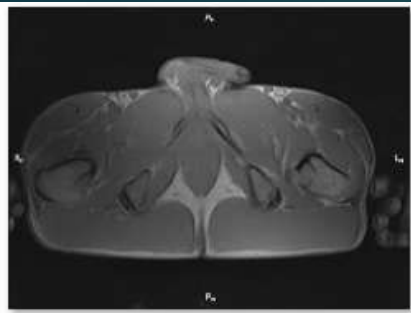
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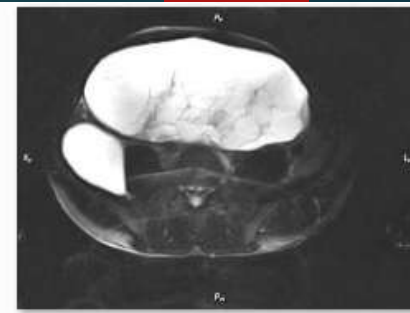
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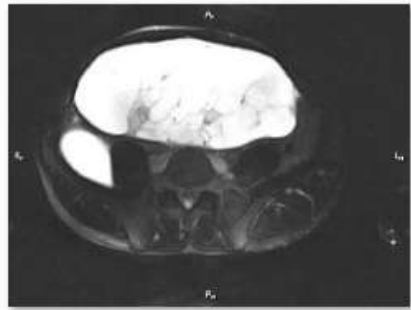
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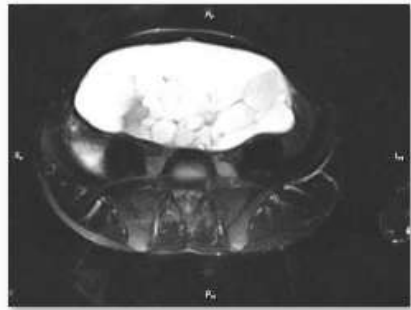
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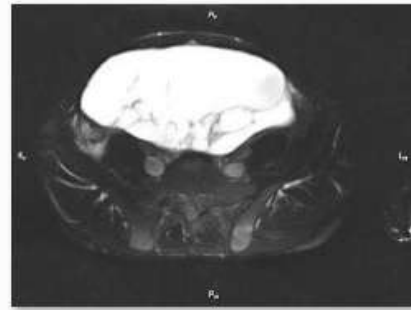
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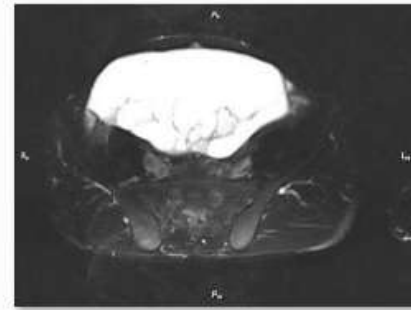
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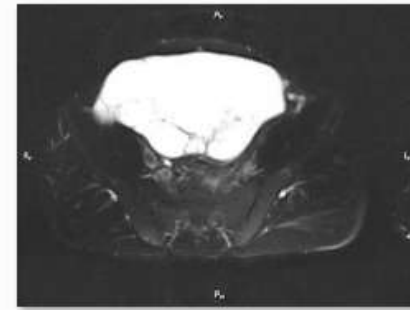
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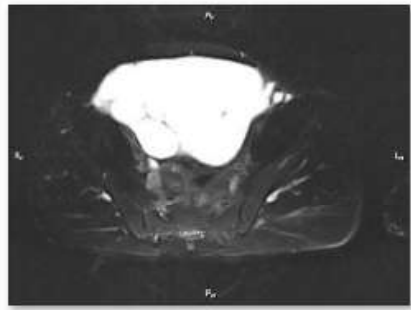
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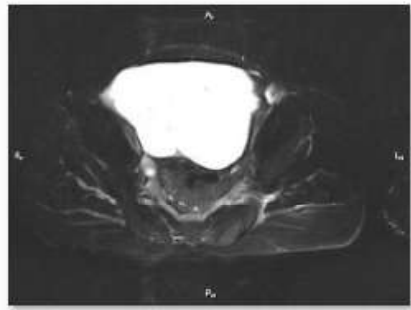
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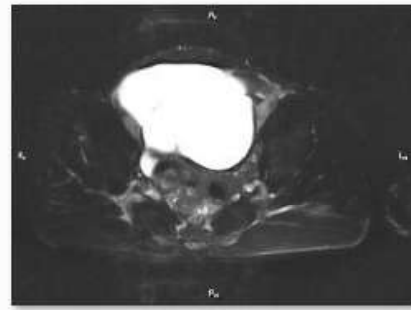
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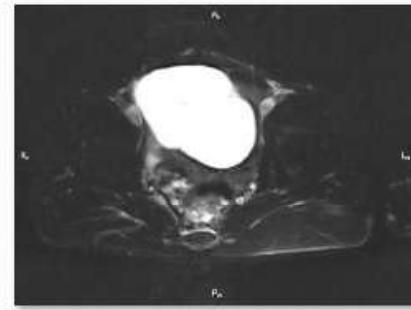
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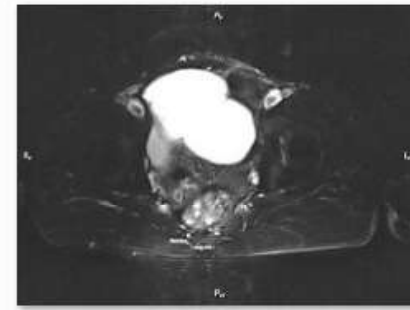
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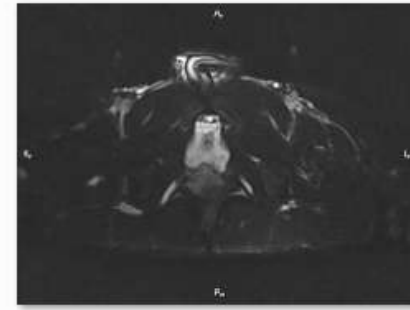
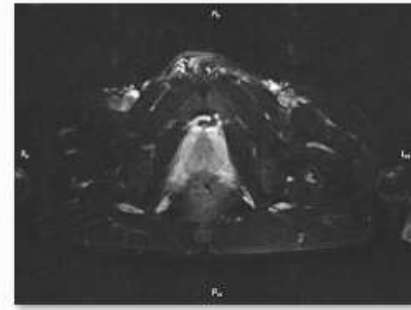
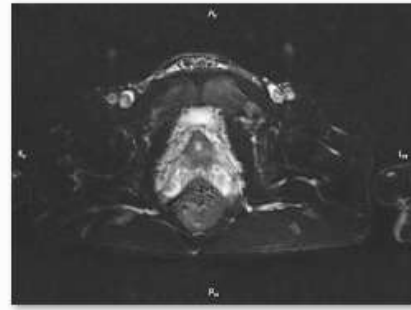
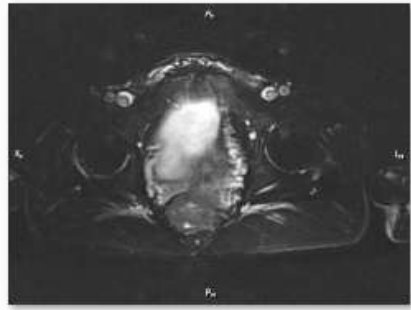
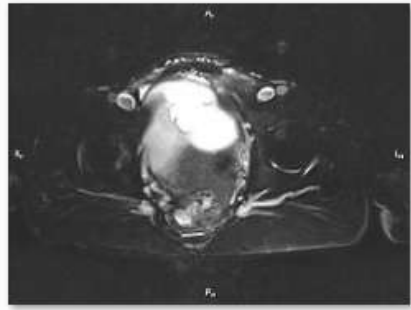
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lt0134.jpg



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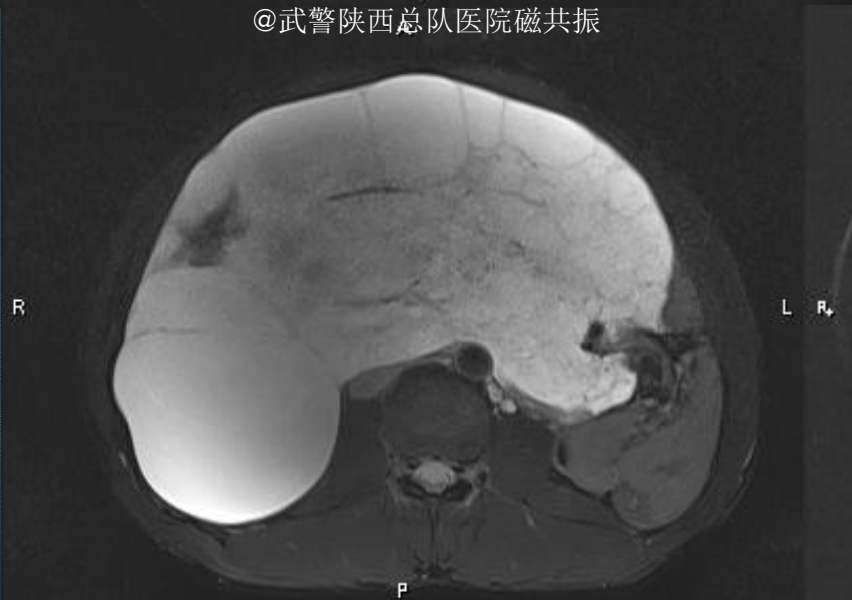




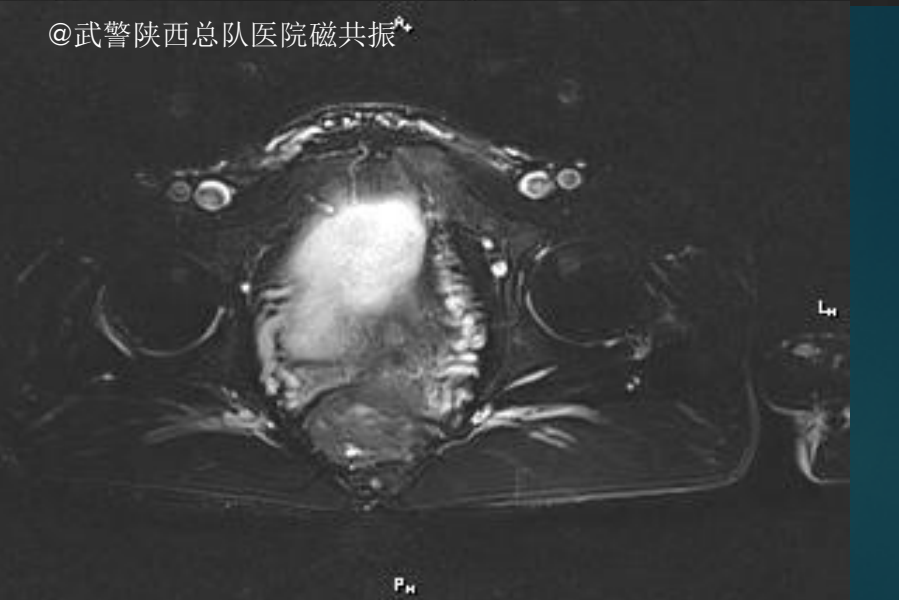
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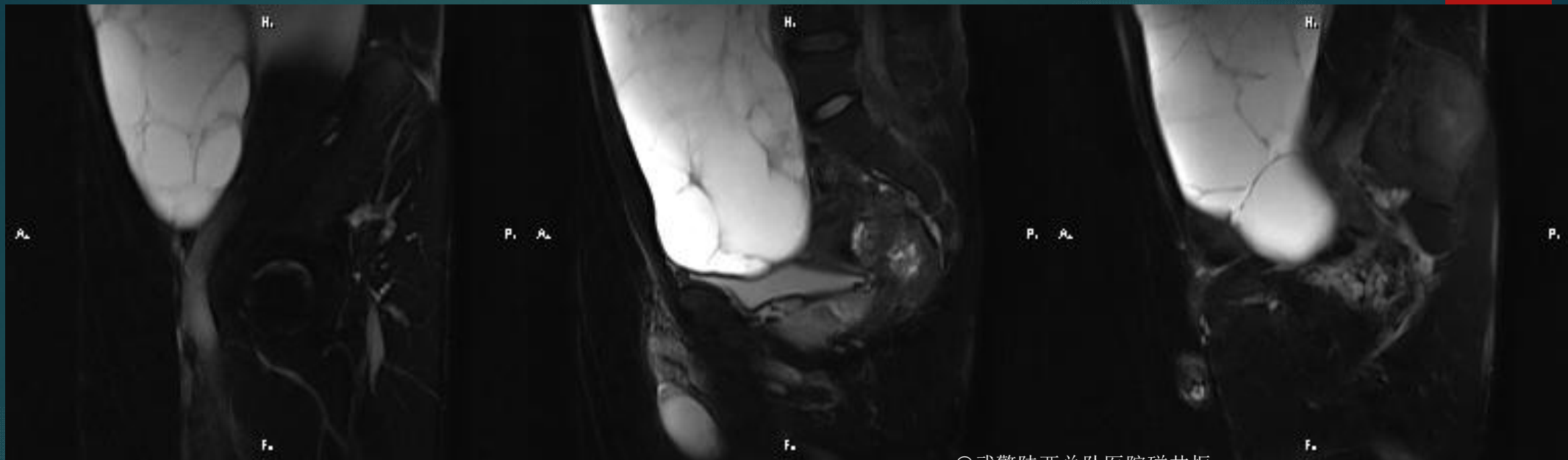


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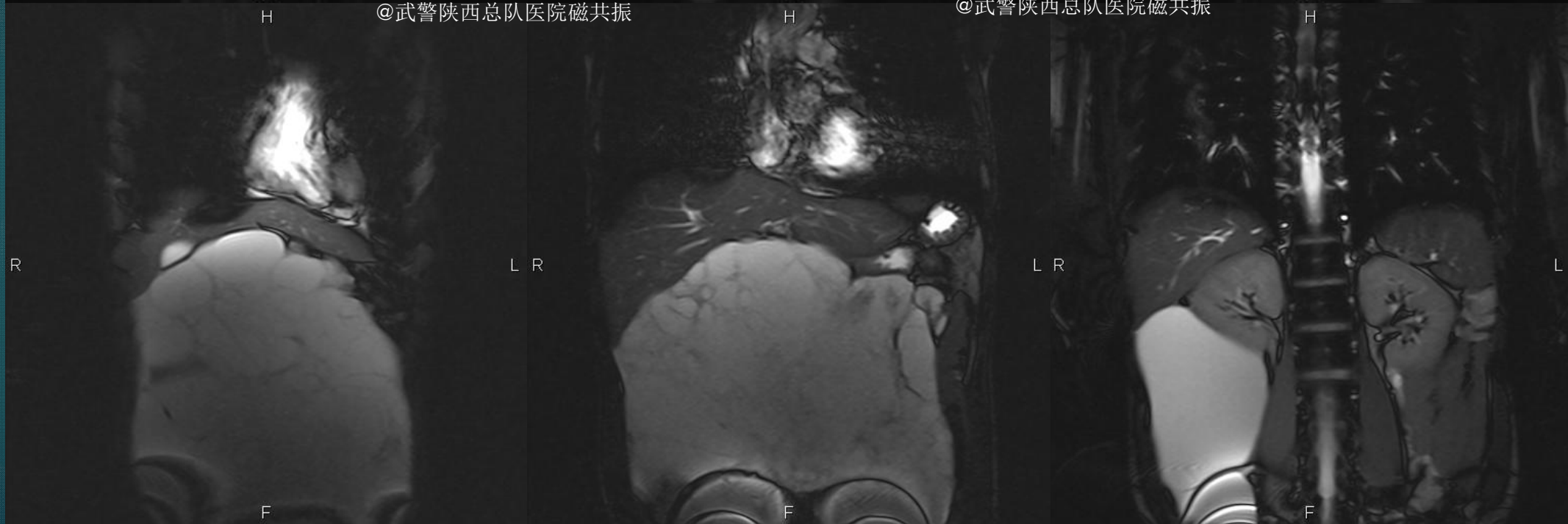
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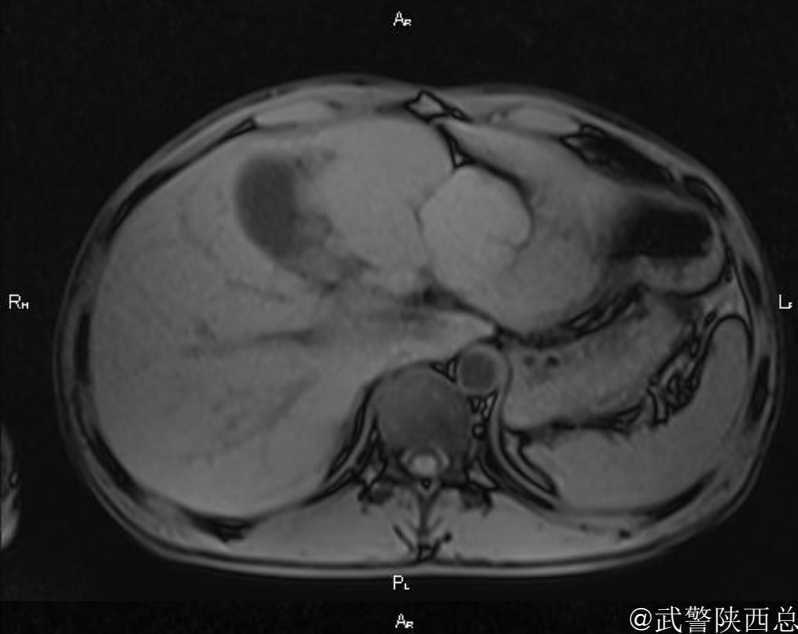




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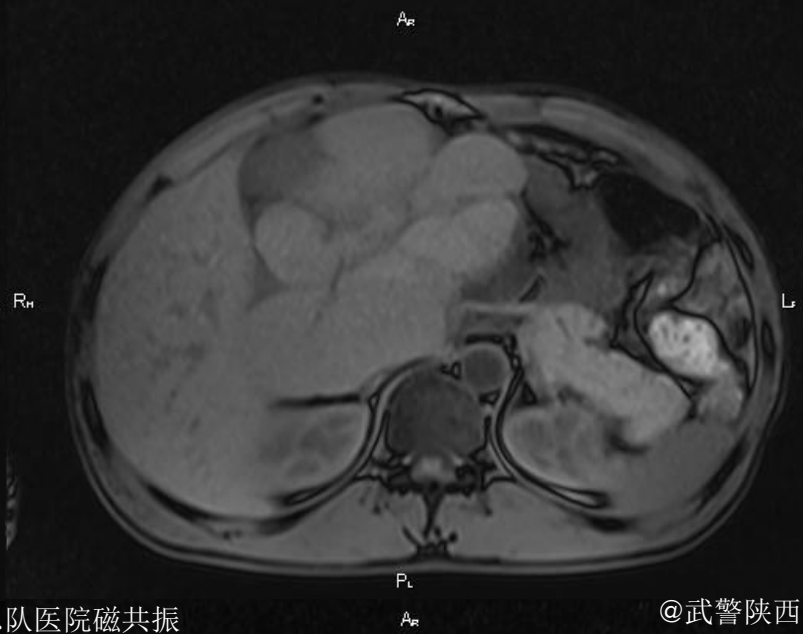




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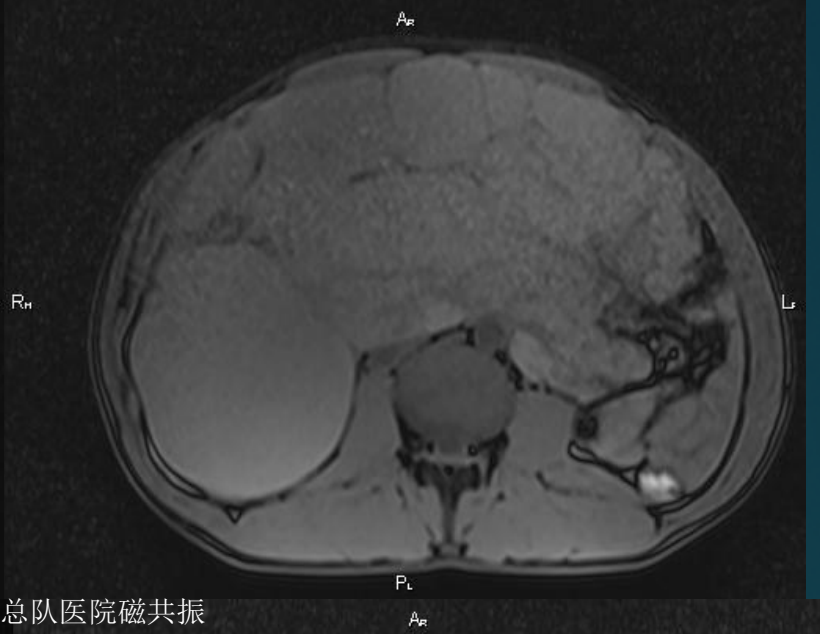
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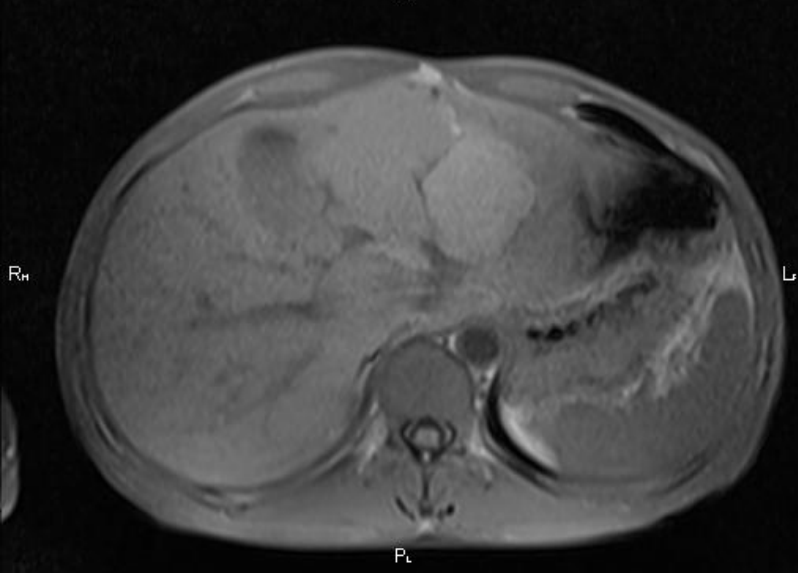
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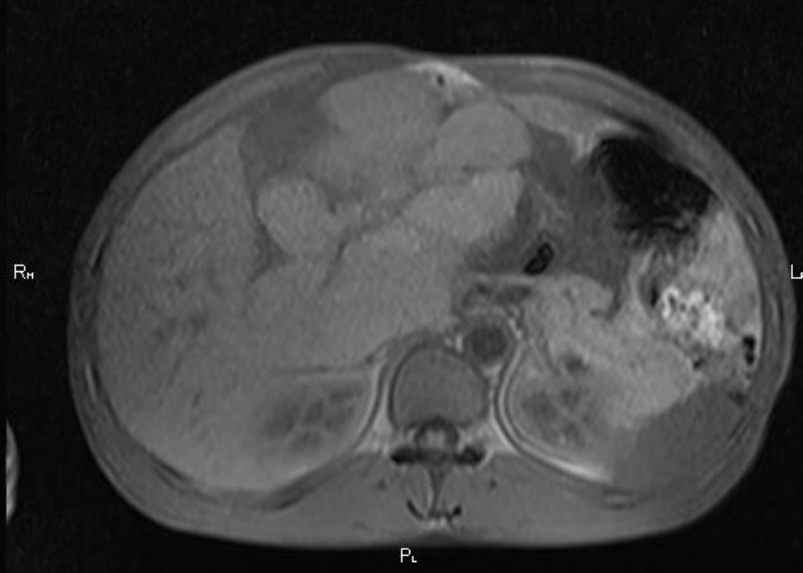


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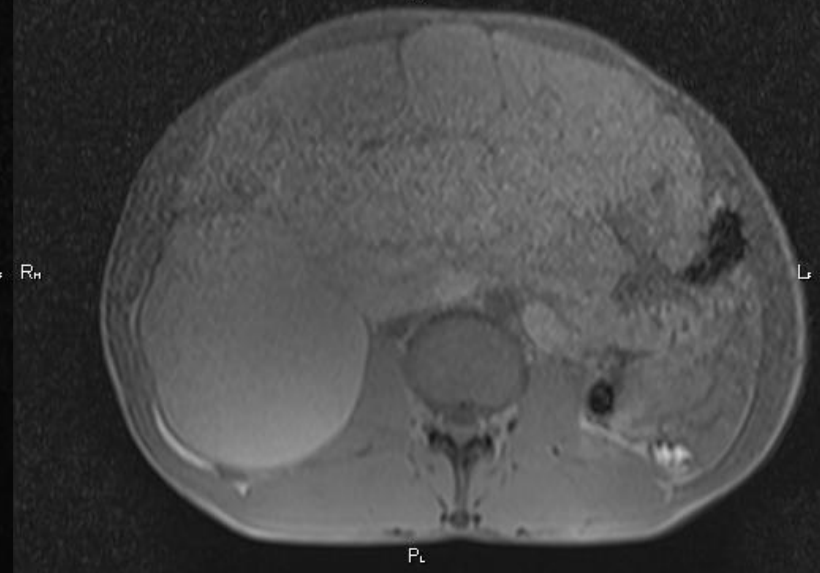
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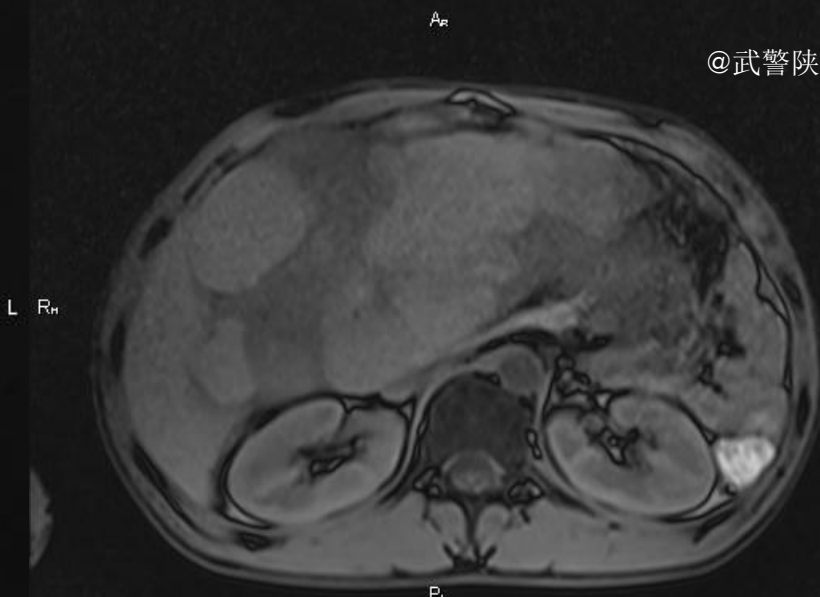
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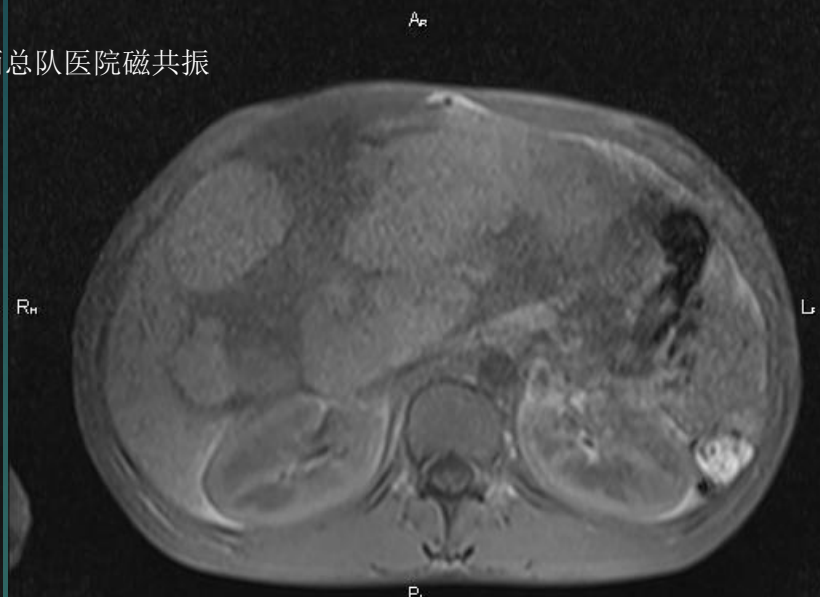
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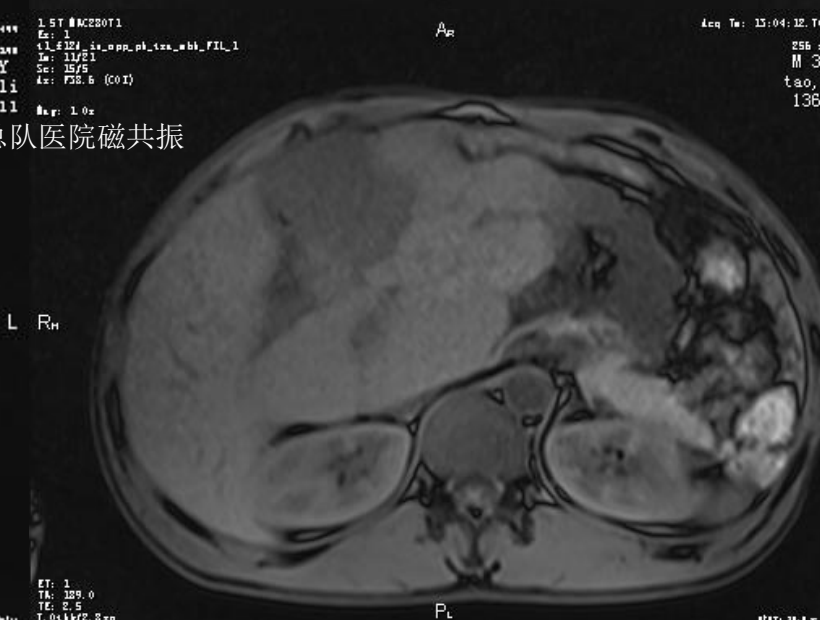
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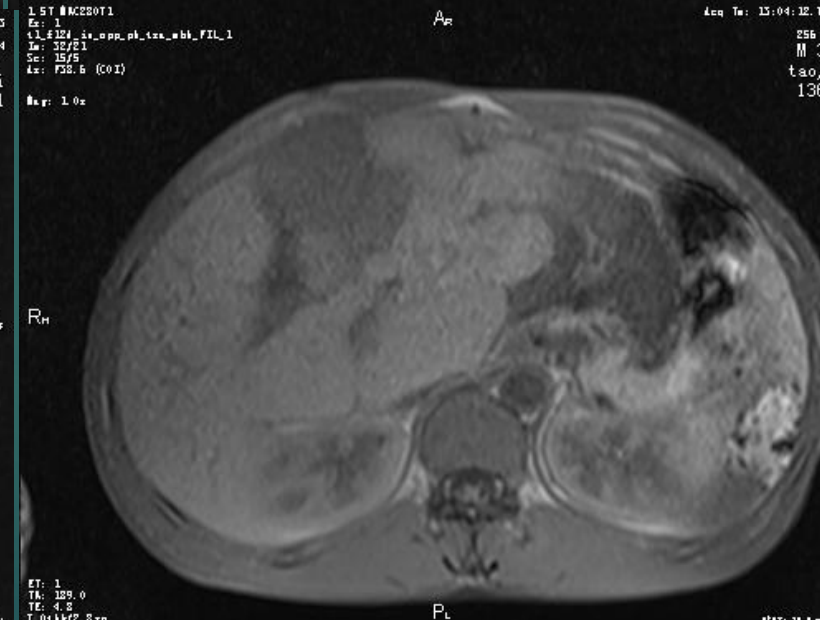
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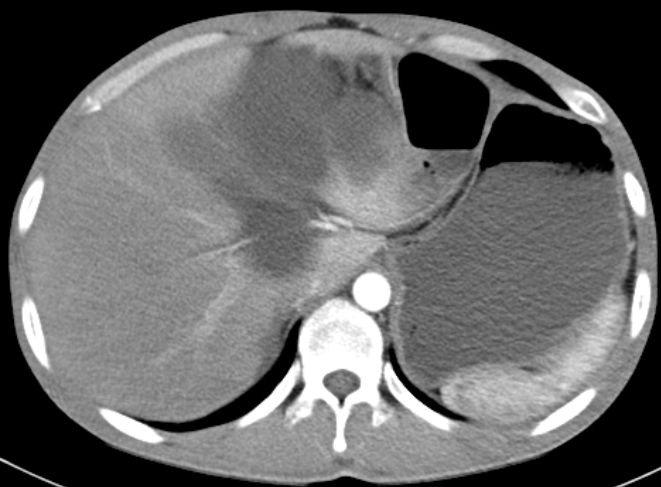


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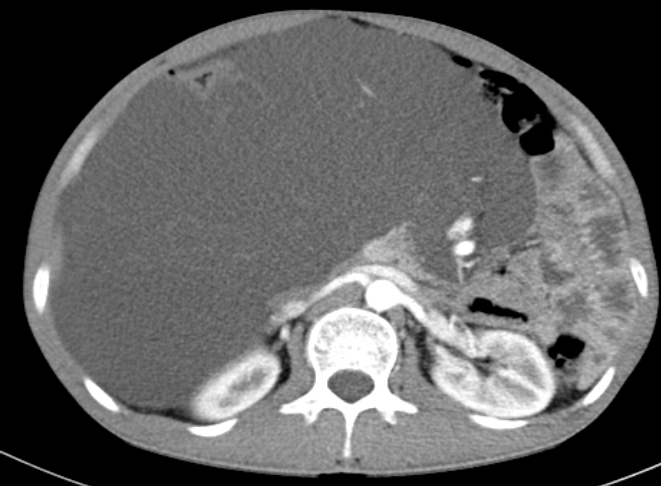
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动脉期



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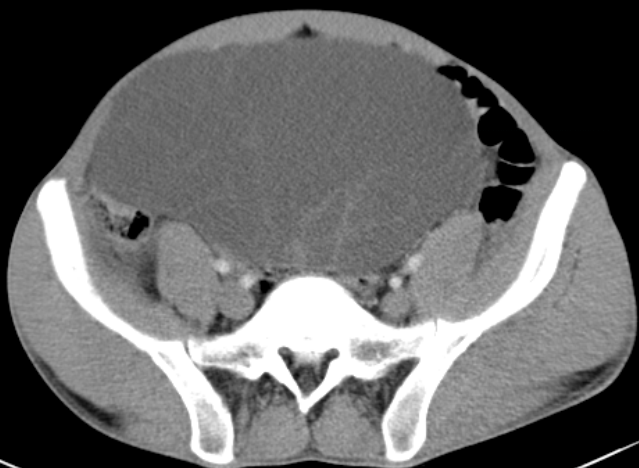


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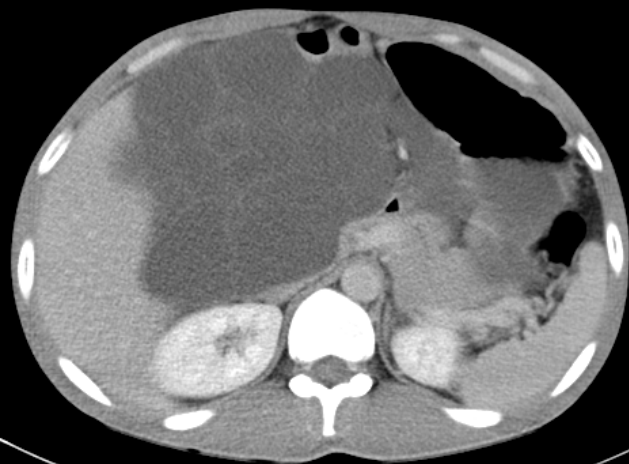


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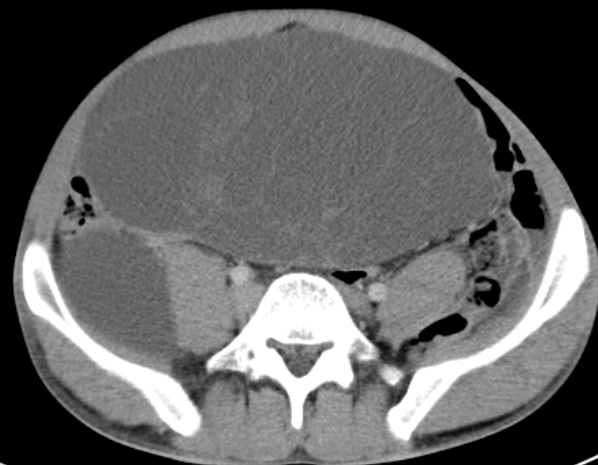


延迟期



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定位：来源于胰腺？腹膜后？阑尾？

定性：囊肿？肿瘤性病变？脓肿？

胰腺囊性病变，根据病变来源，分为两大类：

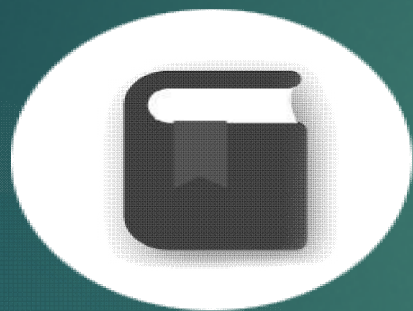
(1) 胰腺原发性囊性病变：胰腺假性囊肿、浆液性囊腺瘤、粘液性囊腺瘤（癌）、导管内乳头状粘液性肿瘤等

(2) 实性肿瘤囊变：胰腺癌囊变、胰腺假乳头状肿瘤。

临床上第一类更为多见。

胰腺假性囊肿：

胰腺假性囊肿远较先天性囊肿、潴留性囊肿及肿瘤性囊肿多见，根据其发病过程可分为急性期和慢性期。大多数胰腺假性囊肿病人有上腹痛或不适、厌食和体重下降。在有胰腺炎症或胰腺外伤病史又持续有上述症状者，应当怀疑是否有假性囊肿形成可能。



病因

急性胰腺炎 慢性胰腺炎
胰腺外伤 胰腺术后 其他



胰液 渗出液 坏死组织 血液
聚集在网膜囊内



刺激周围组织器官的腹膜产
生炎症及纤维组织增值反应
形成一层纤维包膜的囊壁

胰腺假性囊肿

可以发生在胰腺实质内、胰腺外小网膜内或胰腺周围腹膜后间隙内，最多见于胰腺体尾部。囊肿的内壁仅为一层纤维性囊壁，并无上皮覆盖，以上，产生较完整的纤维性囊壁需6周以上。故是假性囊肿。囊肿形成时间一般在2周。囊壁厚薄不均一、形态不规则，囊内液体依成分不同而成不同信号，若为血性或蛋白成分较高时，T1WI为高信号。增强扫描囊壁及囊内一般无强化。

姓名:DingShiJian
编号:CT00056425
日期:24-JAN-2015
时间:08:28:14
序列号:4
图像号:3

[A]

LIXian County People Hospital

姓名:DingShiJian
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日期:24-JAN-2015
时间:08:28:34
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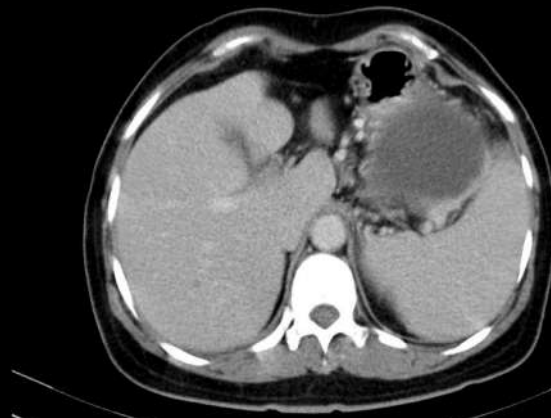
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LIXian County People Hospital

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编号:CT00056425
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[A]

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SIEMENS

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编号:CT00056425
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LIXian County People Hospital

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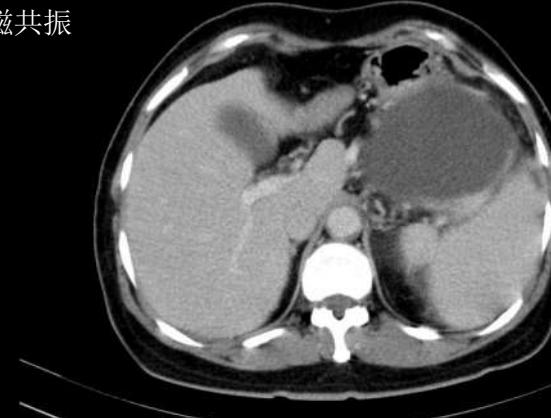
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LIXian County People Hospital

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WI_20150124_005544CA.jpg
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W:300 L:40

层厚:8.0mm
床位:-681.0mm

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浆液性囊腺瘤

最常见的胰腺囊性肿瘤，良性，不发生恶变

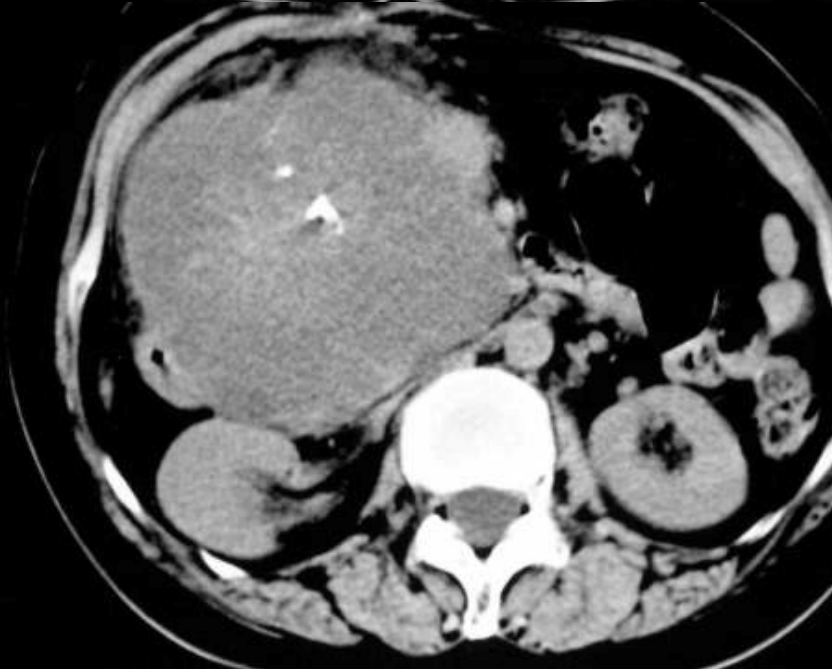
好发年龄30~50岁，女性多见，男女比例1: 6

一般无症状，可有上腹部不适，疼痛等，有时可及肿块

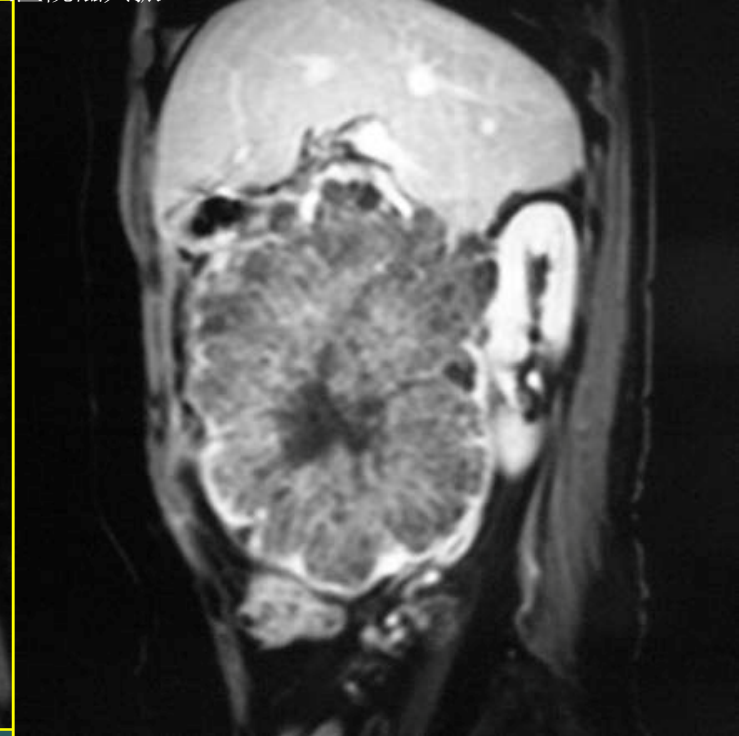
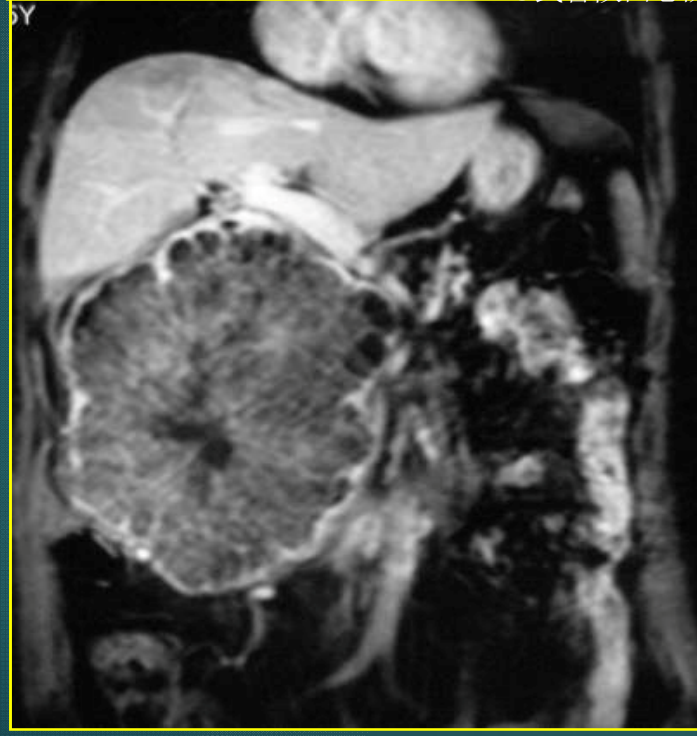
大部分病例，由多个小囊（直径0.2-2cm，>6个）构成，平均直径5cm（1.4-27cm），呈浅分叶状
约20%病例，病变呈蜂窝状、海绵状；少于20%病例，可表现为单囊或少囊（单囊直径>2cm）
约30%病例，可见中央不规则纤维瘢痕伴或不伴星芒状钙化，本特征具有特异性
多个小囊及纤维组织的量较多时，也可表现为实性肿物



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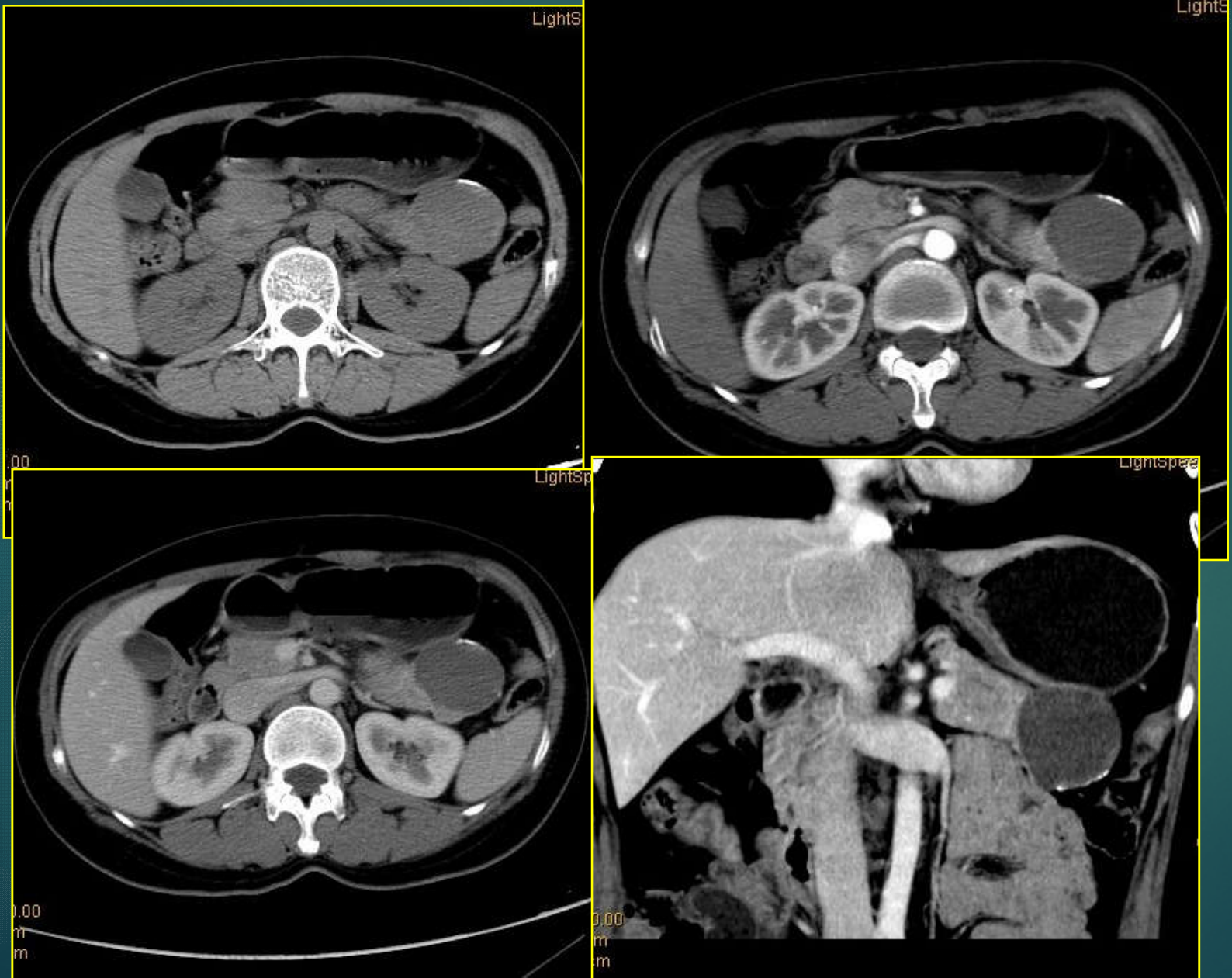
女性，42岁。胰头部浆液性囊腺瘤。



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Fo

女 39岁体检B超发现胰尾部囊肿。浆液性囊腺瘤。



粘液性囊腺瘤（癌）

多见于女性，男女比例1:2

40—60岁多见

常见症状为上腹部疼痛，腹部肿块等，不具特征性。

粘液囊腺癌为恶性肿瘤，而粘液囊腺瘤有潜在恶性；囊腺瘤和囊腺癌为疾病发展的两个阶段

以往认为起源于胰腺外周导管柱状上皮；而现在认为可能起源于原始卵巢细胞。

多发生于胰腺体尾部（90%以上）；肿瘤基质有卵巢样的基质支持

一般较大，直径2—20厘米，平均10厘米

单囊或多房性，囊腔多在2厘米以上，内含粘液

囊腺瘤包膜完整，边界清楚，内衬分泌粘液的高柱状上皮；

囊腺癌则常与周围脏器有粘连或侵蚀囊腺瘤，局部可有乳头状突起；囊腺癌的上皮常不完整，可混杂有分化程度不同的上皮，囊内常有菜花样物，有明显间质浸润，肿瘤细胞核大、深染。

影像学表现

边界清楚圆形或卵圆形肿块

CT为低密度，T2WI上为高信号，T1WI上一般为偏低信号，偶可呈高信号。

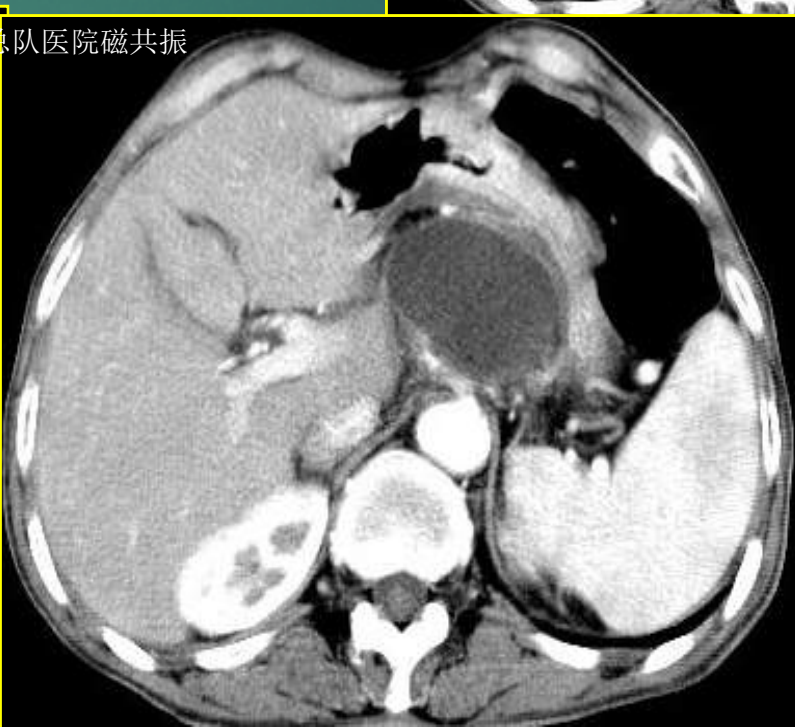
可有纤维间隔，间隔可强化。

一般较明确的壁（浆液性囊腺瘤壁很薄）

有时可见囊壁或囊内钙化。

一般不累及主胰管，病变囊腔与主胰管不通。

女性，49岁。胰腺粘液性囊腺瘤



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鉴别诊断

	浆液性囊腺瘤	粘液性囊腺瘤
好发部位	胰腺的任何部位（头部略多于体尾部）	胰体或尾部
囊壁	薄（ <2 mm）	厚（至少25% >2 mm）
	无强化	有强化
边缘	分叶状	圆形或类圆形

腹膜假性黏液瘤

腹膜假性粘液瘤(pseudomyxoma peritonei, PMP)是一种少见的腹膜低度恶性肿瘤，其主要特征为腹腔弥漫性粘液性物质的大量堆积，并伴腹膜表面和网膜上粘液种植。

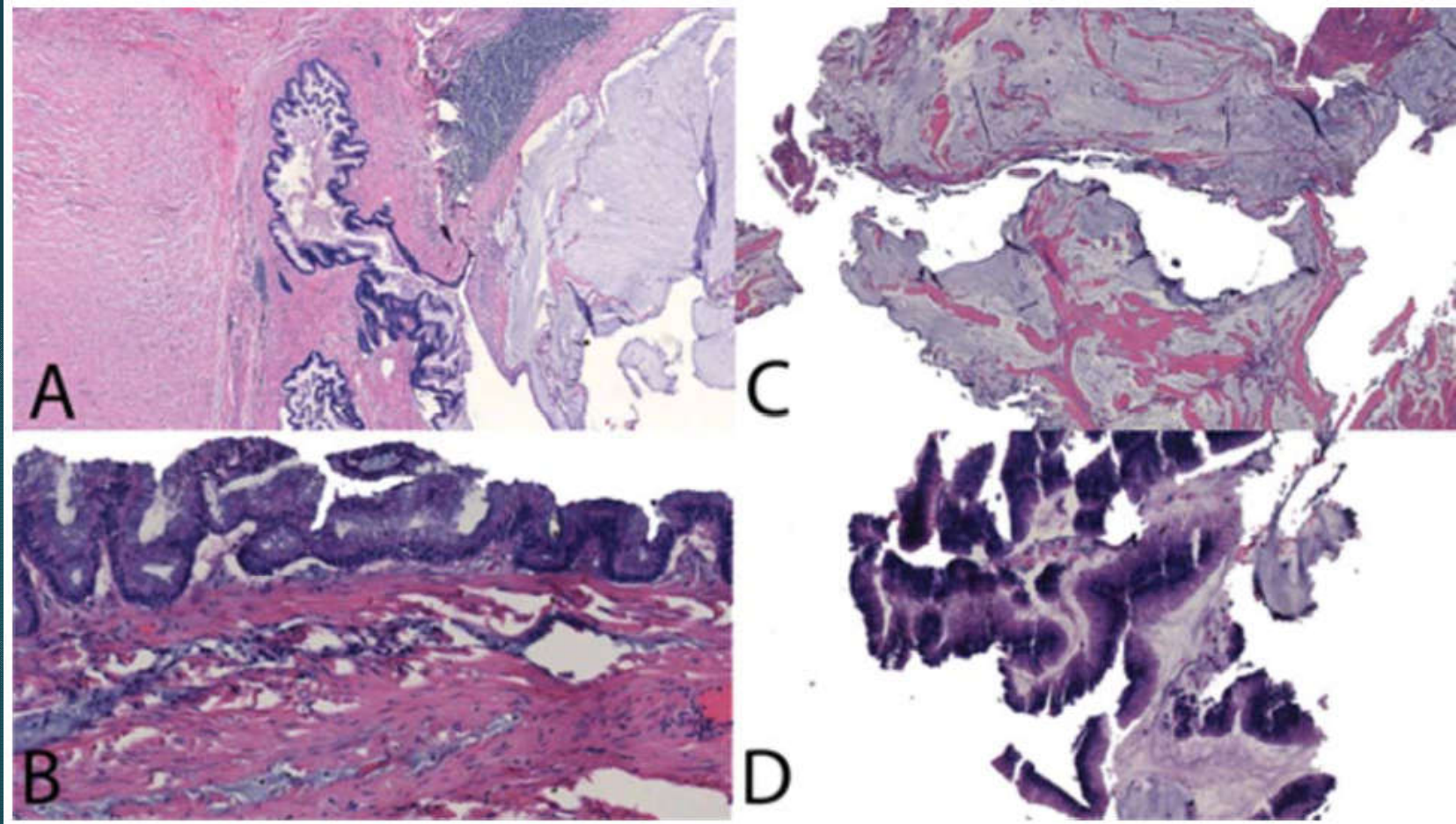
其特征是粘蛋白性腹水和粘蛋白分布于腹膜表面、网膜和肠祥。

PMP多源于阑尾或者卵巢，也可见胃肠道、胰腺胆囊。少数无法确定来源。女性通常伴有卵巢粘液瘤。

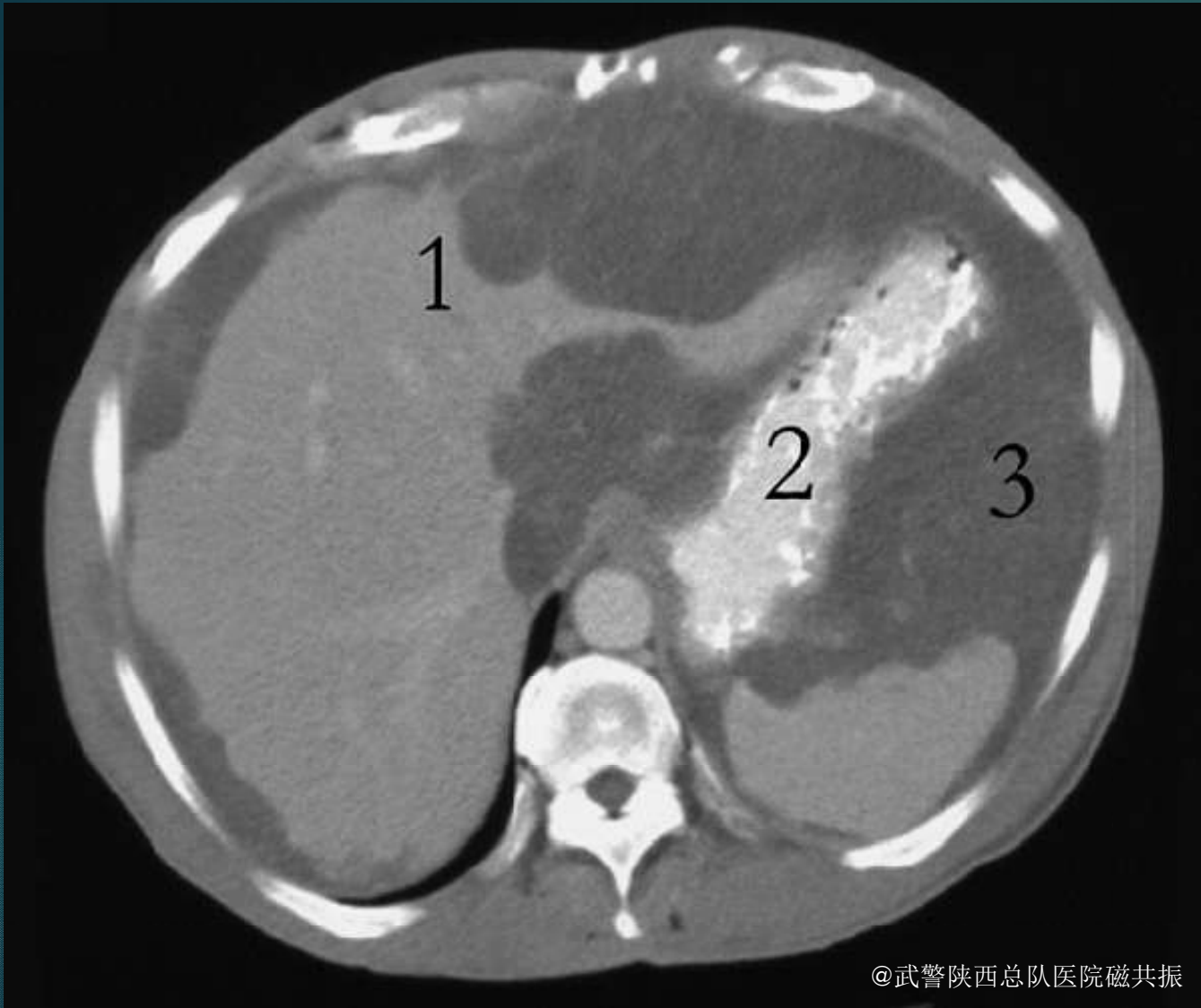
诊断-临床表现

- ▶ 腹水相关症状：腹围增大（50%），“果冻”腹，小肠梗阻症状。
- ▶ 肿瘤引起的局部症状（原发和转移）：阑尾炎，30%的女性首发症状是卵巢肿瘤（术后方能明确）。
- ▶ 偶然发现（20%）：因其他原因行腹腔镜或开腹手术发现（如疝气修补）。

病理：主要来源是低级别阑尾粘液性肿瘤

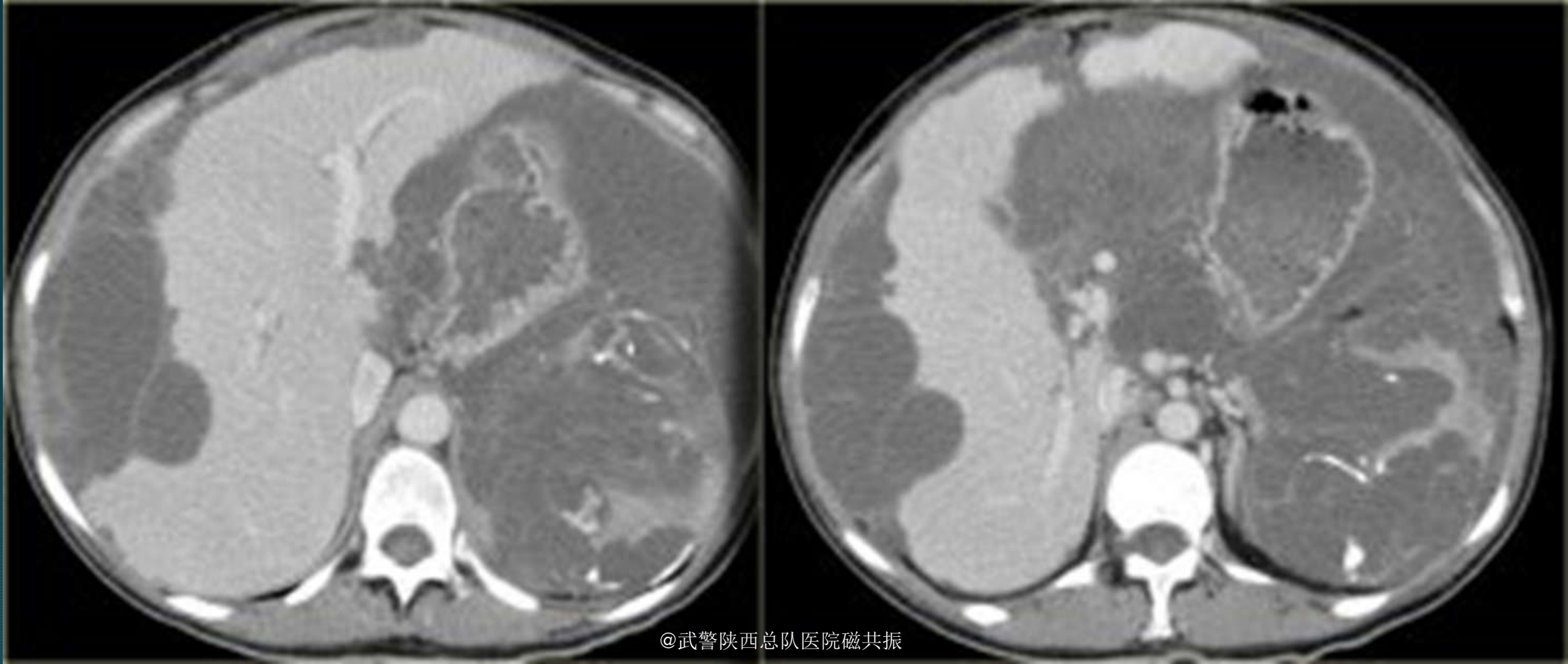


A, 阑尾腔充满粘液。 B, 低级别阑尾粘液腺癌。
C, 少细胞成分的粘液腹水。 D, 粘液中的条状上皮成分



粘液性腹水的HU值在5-20.

大量的粘液腹水（3）挤压导致肝脏表面“拇指症”（1），和肠管挤压（2）



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腹膜假性黏液瘤：肝脏呈扇形凹陷，脾脏几乎全部破坏。请注意钙化点。

果冻腹

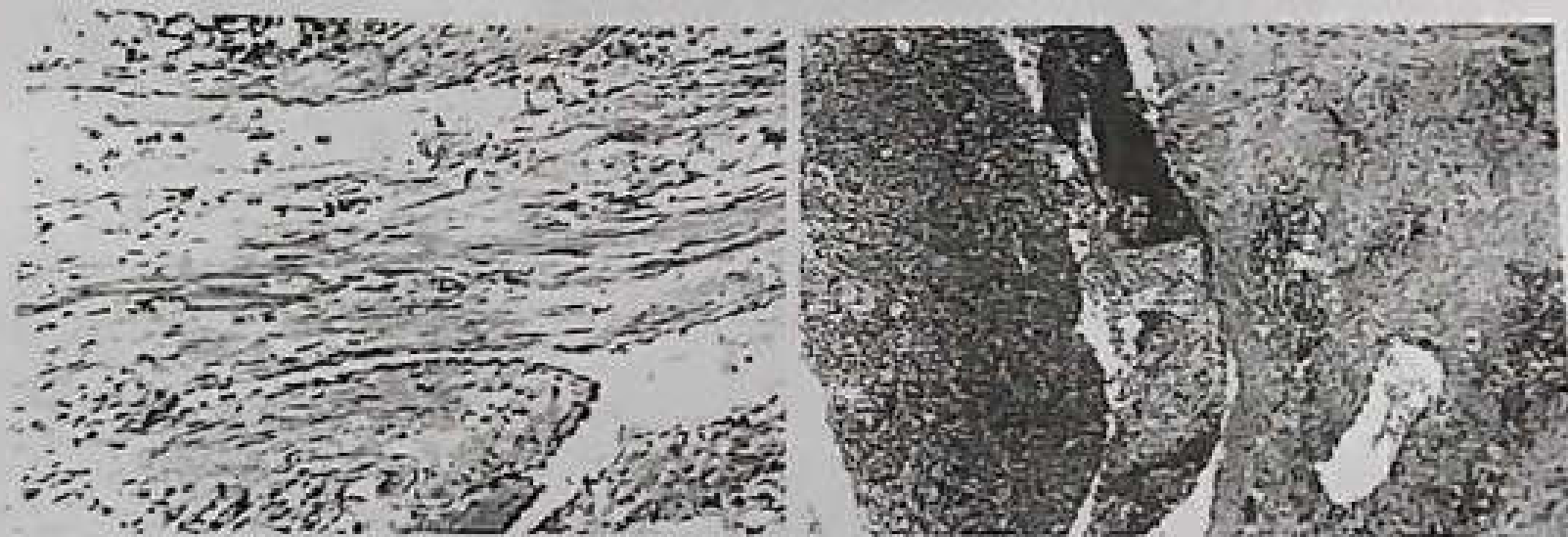


手术记录:

手术及病理情况:麻醉成功后,患者取平卧位。常规消毒铺单,取右侧经腹直肌切口,长约20cm,逐层入腹,探查:腹腔巨大肿瘤,呈囊实性,多发分隔,多处囊肿减压,吸引出暗红色囊性液,部分囊内伴有胶冻样物,减压抽出囊液量约5500ml。进一步探查,腹腔巨大包块上至肝后,下至盆腔,左至降结肠后,右至升结肠后,小肠及肠系膜主干受压移位于左下腹,将结肠肝区推向前腹壁。术中考虑腹膜后巨大包块,沿包块周围间隙仔细分离粘连,分离包块与小肠系膜、升结肠、横结肠、肝脏、十二指肠周围的粘连,分离开大部分肿块后见肿块与胰腺有致密联系,分界不清,考虑病变源于胰腺,过多切除胰腺有胰痿发生风险,将包块从胰腺锐性分离,移除标本。另结肠肝曲血供不确切,考虑术中出血量达3500ml,手术时间长,创伤大,病人耐受性差,另胰腺包块缺乏病理,暂不行结肠切除吻合及根治性胰腺切除。术中大量生理盐水冲洗腹腔,仔细检查无明显出血及肠痿、胰痿后,行回肠造痿术。距回盲部约30cm将回肠从右下腹造痿切口拉出,玻璃管穿过肠系膜无血管区支撑,小肠浆肌层与腹膜及皮肤真皮层缝合固定数针,完成回肠双管造痿,开放痿口约3cm,暂缝合关闭。放置二根血浆引流管于胰腺上下缘从右侧腹壁引出固定。另放置二根血浆引流管于左侧结肠旁沟,从左侧腹壁引出固定。清点器械、敷料无误后缝合腹膜,冲洗切口,逐层缝合切口。术中出血3500ml,输悬浮红细胞7u、血浆950ml。标本家属已过目,送病检。

大体所见: 灰红囊实性巨大包块1个, 体积: 25cm × 50cm × 6cm, 切面呈灰黄囊性结节状, 切面囊实性蜂窝状, 局部可见灰黄胶冻样物。(标本已固定)

光镜所见: 瘤组织由大小不一的薄壁管腔构成, 内衬单层扁平上皮, 局部管腔内可见血液及血栓形成, 间质纤维组织增生伴较多淋巴细胞、浆细胞及嗜酸性粒细胞浸润。



病理诊断:

【腹腔包块切除标本】(胰腺)形态结合免疫组化支持血管淋巴管瘤。
免疫组化结果显示: 瘤细胞CD34(+), CD31(+), F8因子(+), D2-40(+), AE1/AE3(-), Ki-67标记指数 < 3%。

病理结果

血管淋巴瘤

讨论及文献复习

- ▶ **血管淋巴瘤** 是起源于间胚叶组织的一类良性肿瘤，属于比较罕见的淋巴管和微静脉的混合畸形，为良性占位，无性别与年龄倾向，可发生于身体的任何部位，病因学上分为原发性及继发性血管淋巴管瘤，原发性血管淋巴管瘤是脉管系统先天发育异常，胚胎塑形不良的血管组织与大循环之间的静脉淋巴管通路闭塞导致肿瘤形成。继发性血管淋巴管瘤可由外伤或手术引起淋巴管损伤，导致淋巴液引流不畅最终发展而成。
- ▶ 病理学上血管淋巴管瘤内既有静脉，又含有淋巴管。因此，有学者将其定义为血管错构瘤，如“海绵状血管淋巴管瘤”，本病较少见，累及胰腺的血管淋巴管瘤更为少见。
- ▶ 治疗本病以手术切除为主，对于向胰腺内侵犯或者已经累及其他器官，应一并切除相应部位。虽然该病是一种良性疾病，复发率低，但术后仍需要行B超、CT或MR检查随访。

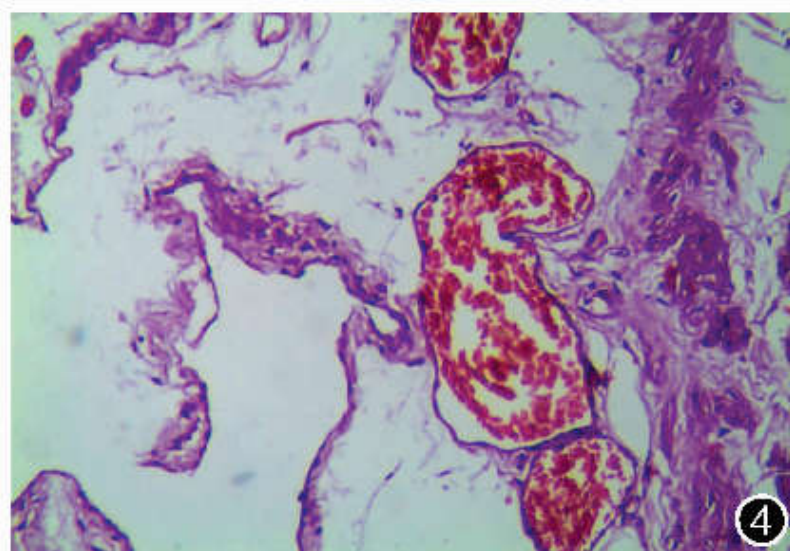
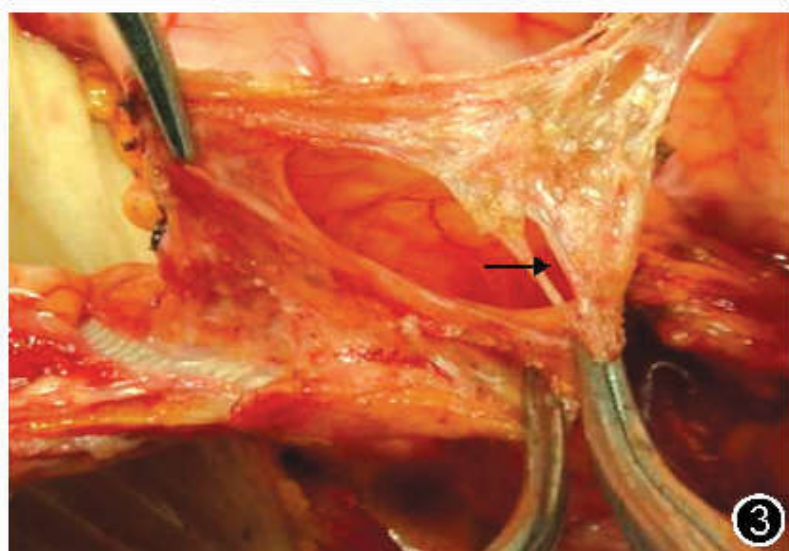
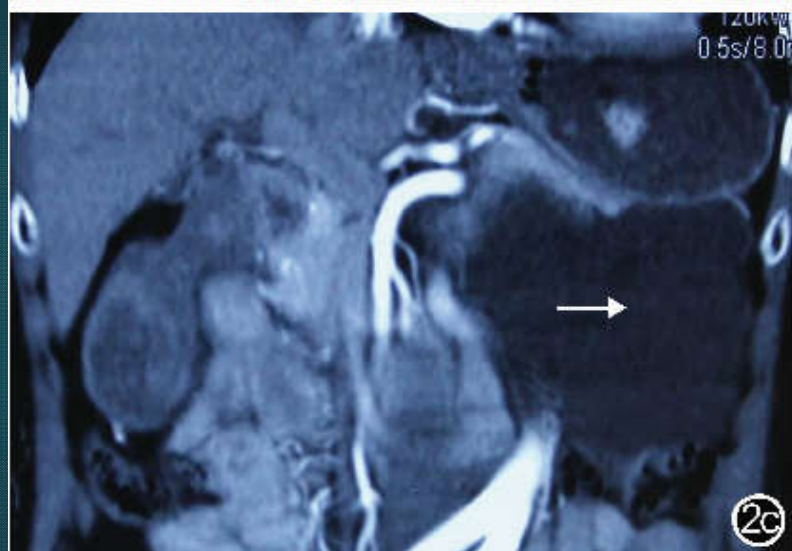
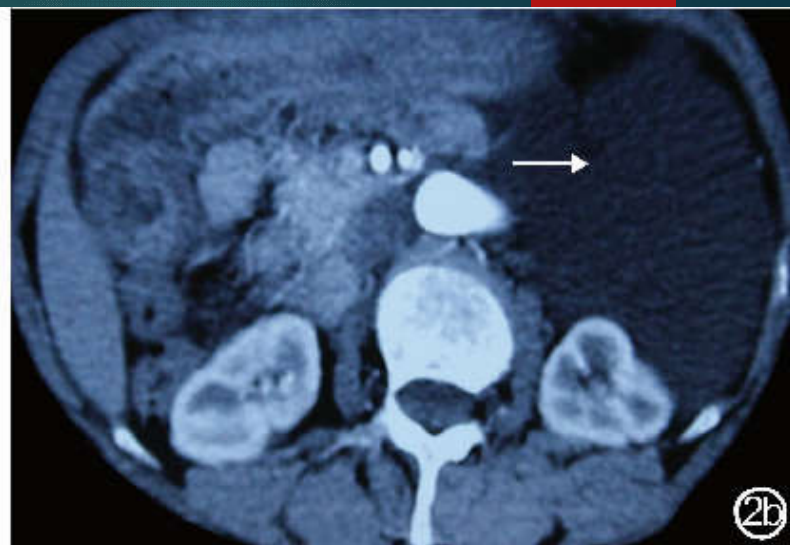
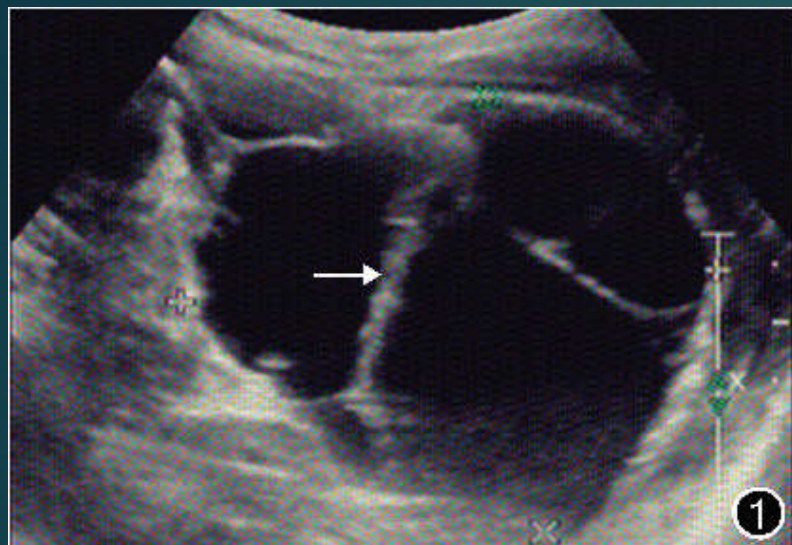


图1 B超检查结果 左上腹可见一巨大的无回声区,边界清晰,有壁回声,呈多房性分隔状(→) 图2 CT检查结果 胰腺体尾部可见囊性占位性病变(→),紧邻左肾及腹主动脉,增强后动脉期及静脉期囊壁无明显强化,其内分隔亦未见强化 a:平扫;b:增强扫描;c:冠状位
图3 胰体尾部不规则囊性占位性病变呈多房性分隔(→) 图4 病理学检查结果 血管淋巴管瘤,其内可见淋巴管和静脉成分

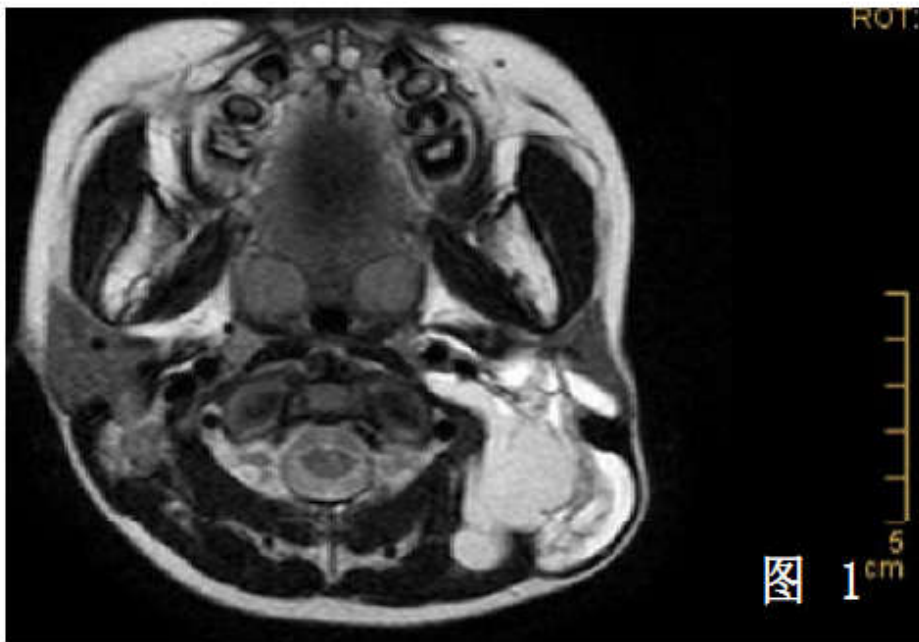


图 1

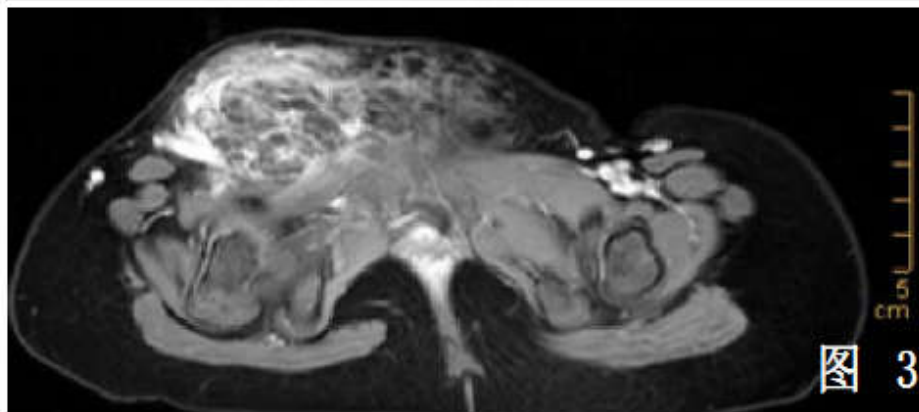


图 3

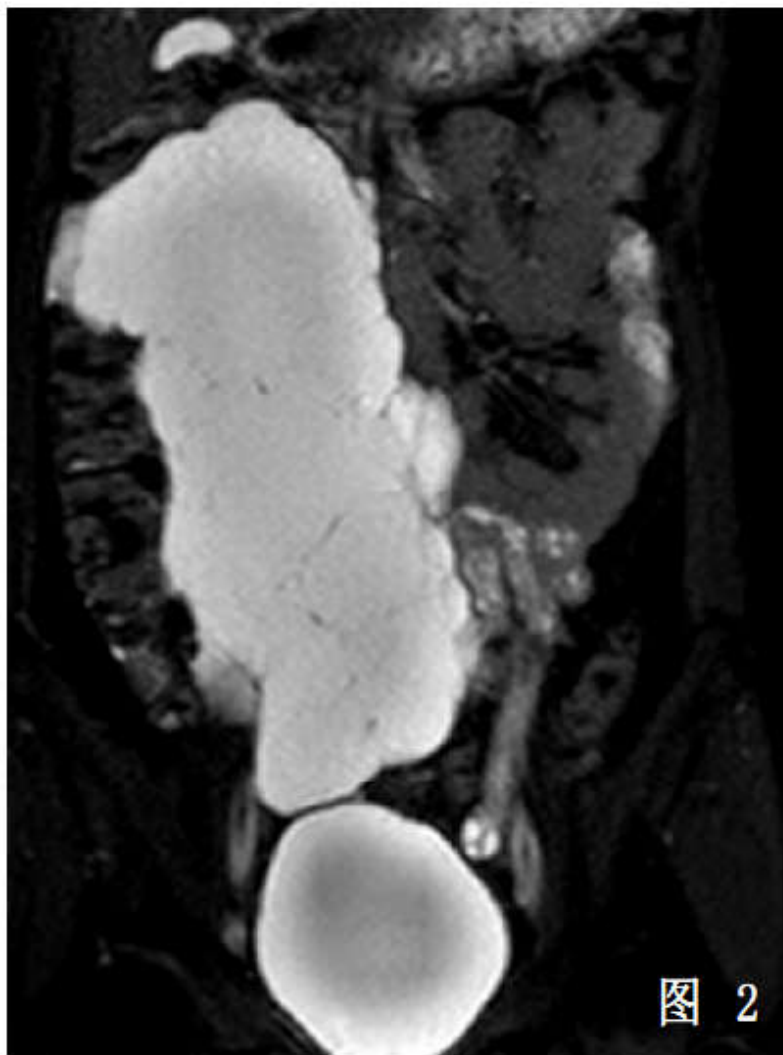


图 2

图 1 T2WI 左上颈部多房囊性病灶，呈混杂长T2 稍长T2 信号，沿疏松结缔组织间隙蔓延，横截面呈海星状，部分包绕胸锁乳突肌，并深达颈动脉鞘后方，与周围组织略粘连。图 2 STIR 腹膜后多房囊性占位，边界清楚，呈均匀高信号，囊壁及囊内间隔菲薄。病灶沿腹膜后间隙塑形生长，上缘达肝脏下缘，下缘进入盆腔。图 3 增强扫描 位于图 2 下方层面，病灶囊壁及囊内间隔中重度不均匀强化，右侧部内见明显强化的异常增粗血管影。

▶ 参考文献

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