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## · 病例报道 ·

## Three-dimensional transvaginal ultrasound in diagnosis of single horn uterus combined with residual uterine horn pregnancy: 2 cases report

### 经阴道三维超声诊断单角子宫合并残角子宫妊娠2例

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[中图法分类号]R445.1

[文献标识码]B

病例1,患者女,27岁,因外院超声检查示宫内双胎妊娠并胎儿死亡,引产失败转入我院。体格检查:生命体征平稳,子宫增大如孕4个月。超声检查:宫腔未见妊娠囊。双侧卵巢正常,腹、盆腔无积液。子宫右后方与右卵巢间见10.6 cm×9.7 cm×10.0 cm混合性团块(图1),边界清,内见两个变形胎儿及胎盘,均无胎心,头臀径分别为7.3 cm、6.8 cm,团块周边见子宫肌层回声,最薄处厚0.3 cm;CDFI可探及丰富血流信号。二维超声矢状切面示子宫似呈长梭形,横切面示子宫底部较窄,扫查包块与宫颈不相通。三维多平面成像:宫腔呈柳叶状偏向宫底左侧(图2)。超声诊断:单角子宫合并残角子宫双胎妊娠,双胎均停止发育。行经腹右侧残角子宫及右侧输卵管切除术,术中于子宫右后方见10 cm包块,其基底与子宫右侧相连,右侧卵巢

固有韧带及输卵管位于其上,内见两个孕14周变形胎儿。

病例2,患者女,18岁,因停经3个月,外院超声检查发现腹腔妊娠入院。体格检查:左附件区扪及大小约6 cm×5 cm包块。超声检查:宫腔内见3.5 cm×1.1 cm无回声区;双侧卵巢正常,腹、盆腔无积液,紧贴子宫左前方见7.7 cm×7.5 cm×7.0 cm混合性团块(图3),边界清,内见一胎儿及胎盘,胎心可见,头臀径6.4 cm,团块周边见子宫肌层回声,最薄处厚约0.2 cm;CDFI可探及丰富血流信号。二维超声矢状切面示子宫似呈长梭形,横切面示子宫底部较窄,包块与宫颈不相通。三维自由解剖成像:宫腔呈单一管状略偏向宫底右侧(图4)。超声诊断:单角子宫合并残角子宫妊娠,宫腔少量积液。行经腹左侧残角子宫及左侧输卵管切除术,术中于子宫左侧见8 cm包块,其基底与

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部分可呈条状,当时考虑其为跨过骶髂关节的髂动脉分支小血管;而本研究解剖学实验证实,这些血管均位于骶髂关节前方,超声下不可能显示;后经US-CT融合图像发现上述高阻的血流信号位于骶后孔背侧开口内,且显示清晰。因此认为其并非髂血管分支,而是从骶后孔穿出的营养血管,由于其穿出后分布于靠近关节后部周围,易与异常血流信号混淆,仅能通过血流频谱加以区分。

综上所述,结合骶髂关节解剖学特点,本研究证实骶髂关节背侧异常血流信号可根据US-CT融合图像较为准确地定位于关节韧带部或滑膜部。骶髂关节背侧异常血流信号可作为评价AS的可靠指标之一。后期本课题组将进一步研究MRI与超声的图像融合,为进一步证实超声是诊断AS的有效手段提供理论依据。

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子宫左侧相连,左侧卵巢固有韧带及输卵管位于其上,内见孕13周胎儿。

讨论:残角子宫妊娠发生率为万分之0.10~0.82<sup>[1]</sup>。病例1为残角子宫内双胎妊娠,更为罕见。残角子宫分3型: I型,残角子宫有内膜,与单角子宫宫腔相通; II型,残角子宫有内膜,与单角子宫宫腔不通; III型,残角子宫无宫腔<sup>[2]</sup>。病例1前期误诊正常宫内妊娠,可能是由于增大的子宫遮挡,盆腔解剖结构及毗邻关系显示不清。病例2误诊腹腔妊娠,可能是未注意包块与宫颈关系及包块周边子宫肌层。为避免漏误诊,临床可采用经阴道联合腹部超声检查,明确包块与子宫的关系;二维超声观察横切面子宫底部内膜,当内膜短小、不对称,应警惕子宫畸形;应用三维超声成像技术可有效避免漏误诊。病例1采用多

平面成像,能显示子宫冠状切面,完整观察宫腔形态;病例2因患者子宫弧度较大,故采用自由解剖成像,可更清晰完整显示宫腔形态,说明自由解剖成像不受正交平面的限制,适用于弧度较大的子宫成像。总之,二维超声联合三维成像技术可提高子宫畸形合并妊娠的诊断率,降低误诊率,有助于对子宫畸形的分类,为临床提供准确信息。

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图1 二维超声子宫横切面示右侧残角子宫妊娠(UT:子宫;F:胎儿) 图2 三维超声多平面成像示单角子宫宫腔呈柳叶状(UT:子宫;END:子宫内膜)

图3 二维超声子宫横切面示左侧残角子宫妊娠(UT:子宫;M:包块) 图4 三维超声自由解剖成像示单角子宫宫腔呈管状伴宫腔积液

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