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（收稿日期：2022-10-26）

·病例报道·

Ultrasonic manifestations of decidualized ovarian endometrioma cyst: a case report

蜕膜化卵巢子宫内膜异位囊肿超声表现1例

宋 勇 熊秀勤

[中图法分类号]R445.1；R711.71 [文献标识码]B

患者女，34岁，因“停经24周，发现盆腔包块3个月余”入院。自述3年前于外院行妇科超声体检未见明显异常。3个月前于外院行妇科超声提示：宫内早孕，左附件区见一大小约35 mm×28 mm囊实性包块。实验室检查：甲胎蛋白（AFP）5.8 U/ml，糖类抗原（CA）125 53.4 U/ml。外院超声随访提示包块逐渐增大，今于我院就诊。妇科超声检查：左附件区见一大小约75 mm×31 mm囊实混合回声包块（图1），边界清晰，形态规则，囊壁不光滑。囊壁见多个强回声突起，较大者约34 mm×30 mm；CDFI示其内可探及较丰富血流信号（图2）；频谱多普勒测得阻力指数0.28（图3）。超声提示：左附件区囊实混合性包块，卵巢囊腺瘤？卵巢交界性肿瘤？输卵管肿瘤？肿瘤标志物检查：人附睾蛋白4（HE4）42.4 pmol/L，AFP 94.9 U/ml，CA125 42.1 U/ml。临床诊断：妊娠（24周）合并卵巢肿瘤？输卵管肿瘤？遂行手术切除治疗，术中见子宫孕6月大小；左侧附件暴露较困难，与盆壁粘连，暴露过程中见左附件区包块破裂，流出咖啡色囊液；左侧卵巢增大，大小约9 cm×5 cm×4 cm，部分表面尚光滑，其内见一直径约7 cm包块；左侧输卵管走行迂曲，伞端黏膜红润。分离左侧附件与盆壁粘连处，见左侧卵巢囊包块内壁较多菜花样组织，质脆，左侧盆壁与卵巢粘连部分亦为菜花样组织，行患侧附件及肿物切除术。术后病理诊断：卵巢子宫内膜异位症并间质蜕膜（图4）。

讨论：妊娠期时，卵巢子宫内膜异位囊肿（endometrioma cyst，EMT）在孕激素的作用下，异位的内膜间质细胞出现过度增生，可导致囊肿增大及其内形成血管化的乳头状突起或实性隆起物，称之为卵巢EMT的“蜕膜化”改变。蜕膜化卵巢EMT临床少见，其典型的超声表现为单房或多房囊肿内出现圆形血管化的乳头状突起或大范围的低回声实性隆起，边缘光滑，囊腔内液体呈毛玻璃样或呈低回声，突起内血流信号丰富[1]。本例患者超声表现为左附件区囊实混合回声包块，边界清晰，形态规则，囊壁可见多个强回声突起，其内可探及较丰富血流信号。分析本例患者误诊原因：患者数年前妇科超声检查未见异常，妊娠后随访发现左附件区包块逐渐增大，囊壁内多发血供丰富的突起，且突起物血流阻力指数较低；加之本病临床少见，超声医师对其认识不足，缺乏经验。本病需与卵巢交界性或恶性肿瘤鉴别[2]，蜕膜化卵巢EMT在妊娠状态下出现，有卵巢EMT病史，且囊腔内的乳头状突起边缘光滑，形态规则；卵巢交界性或恶性肿瘤的乳头状突起边缘不光滑，形态欠规则[3]。但蜕膜化卵巢EMT表现不典型时，超声难以鉴别。HE4与卵巢恶性肿瘤相关[4]，本例患者HE4表达呈阴性，在一定程度上可排除卵巢恶性肿瘤。MRI及弥散加权成像可用于蜕膜化卵巢EMT与卵巢恶性肿瘤的鉴别[5]。总之，蜕膜化卵巢EMT易误诊，导致不必要的手术干预，故对其诊断时不能局限于超声图像的分析，应

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(收稿日期:2022-09-01)

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进一步了解患者病史,同时结合血清学及MRI检查综合评估。

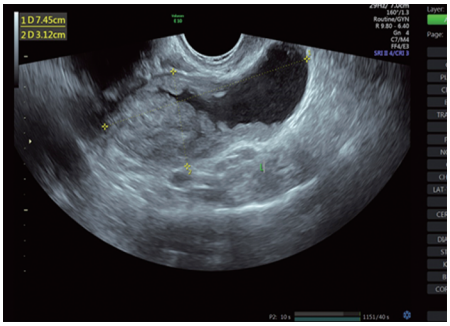

图1 二维超声示左附件区见一大小约75 mm×31 mm囊实混合回声包块

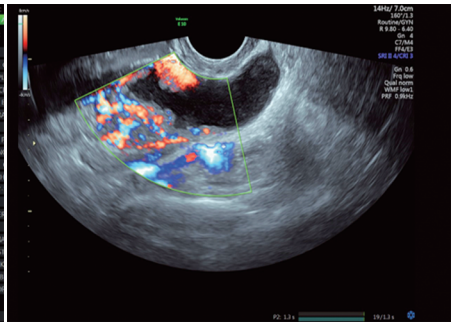

图2 CDFI示左附件区包块内囊壁的强回声突起可探及较丰富血流信号

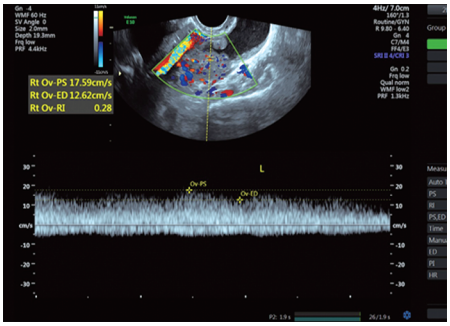

图3 频谱多普勒示左附件区包块内囊壁的强回声突起的血流阻力指数为0.28

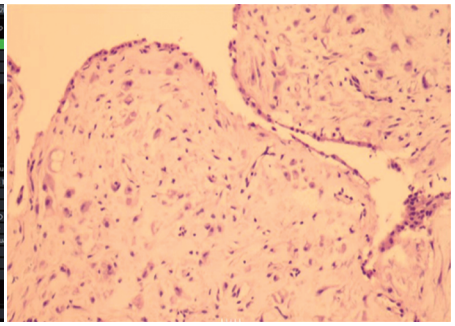

图4 病理示卵巢子宫内膜异位症并间质蜕膜(HE染色,×100)

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(收稿日期:2022-09-23)