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(收稿日期:2021-07-19)

• 病例报道 •

Ultrasonic manifestations of primary follicular inert small B-cell lymphoma of ureter: a case report

输尿管原发滤泡惰性小B细胞淋巴瘤超声表现1例

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[中图分类号]R445.1

[文献标识码]B

患者女,55岁,因“右侧腰腹部阵发性胀痛不适10+d”就诊。超声检查:右肾窦区分离约2.0 cm,右侧输尿管上段内径约0.8 cm;右侧盆腔(右侧卵巢右侧)探及一大约5.9 cm×2.3 cm×2.5 cm实性占位,上大下小,呈“水滴样”,下方接近输尿管膀胱出口,紧邻右侧卵巢,可见相对运动,包裹右侧输尿管,此处输尿管壁显示不清(图1);CDFI于其内探及丰富血流信号,收缩期峰值流速37.56 cm/s,阻力指数0.74(图2)。超声提示:右侧盆腔实性占位,考虑右侧输尿管来源肿瘤性病变。全腹(含盆腔)CT平扫+增强检查:右侧输尿管盆段走行区见一大约6.0 cm×2.8 cm×3.1 cm梭形软组织肿块影,增强扫描呈不均匀强化,病灶与子宫分界不清,右侧盆腔壁见数个稍大淋巴结,较大者约1.8 cm×1.1 cm。CT提示:右侧输尿管盆段占位,考虑肿瘤占位性病变(输尿管癌?)。后行腹腔镜下右侧输

尿管肿瘤切除术+膀胱瓣右输尿管成形术+膀胱修补术+右侧输尿管支架置入术,术中见:肿块呈灰白色鱼肉样组织包裹输尿管,输尿管壁水肿增厚。组织病理学检查:输尿管黏膜糜烂,淋巴组织增生性病变,增生及浸润的淋巴细胞小或中等偏小,形似小淋巴细胞,并见少数浆样细胞和个别大的转化样细胞相间分布;见少量胶原间质、淋巴细胞浸润及管壁全层,偶见小淋巴

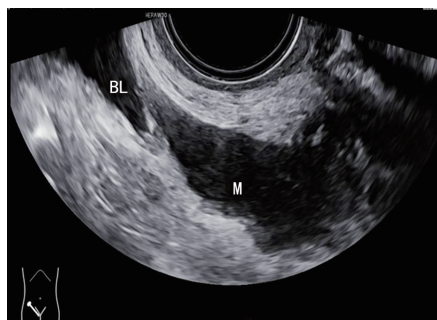


图1 输尿管占位二维超声图像(BL:膀胱; M:占位)

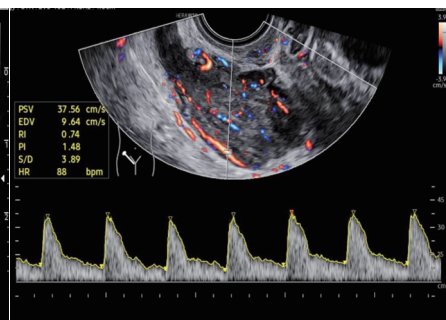


图2 输尿管占位CDFI图

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(收稿日期:2021-10-18)

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滤泡(图3)。免疫组化检查:CD20(+), CD19a(+), CD10(+), CD5(-), CD43(-), CD23(-), Bcl-2(>90%+, 强), Bcl-6(部分+), CyclinD1(-), SOX11(-), CD38/CD138(-), Ki-67(部分+). 见图4。基因重排检测(PCR+基因扫描):检出 IgH 及 IgK 基因重排。FISH 检测:检出 BCL2 基因易位及 BCL2/IgH 基因融合;未检出 BCL-6 和 MYC 基因易位及 lp36 缺失。病理诊断:非霍奇金淋巴瘤浸润, 惰性小 B 细胞淋巴瘤, 滤泡淋巴瘤, 1~2 级。

讨论:滤泡性淋巴瘤是一种较常见的非霍奇金淋巴瘤, 主要累及淋巴结, 也可侵犯胃肠道、甲状腺、乳腺及胰腺等结外器官, 发生于泌尿系统的淋巴瘤极少见, 其中原发于输尿管者罕见。国内外报道的输尿管淋巴瘤主要有弥漫大 B 细胞淋巴瘤^[1]和黏膜相关淋巴瘤^[2], 输尿管滤泡性小 B 细胞淋巴瘤目前尚未见报道。文献^[3]报道, 患有自身免疫性疾病或免疫力低下的患者发生淋巴瘤的风险相对更高。组织病理学作为诊断淋巴瘤或明确淋巴瘤具体分型的“金标准”, 其主要价值在于术后的定性诊断。影像学检查可在术前辅助诊断输尿管占位性质、大小、与周围组织或器官关系及术后有无复发和远处转移, 与 CT、MRI 相比, 超声具有经济、快速、便捷的优势。本例患者超声表现为包裹输尿管下段的连续性“水滴样”不均质团状回声, 输尿管膀胱入口处未探及异常回声, 且血流信号丰富。随着今

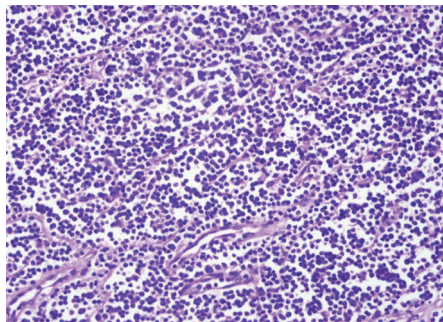


图3 病理图(HE染色, ×400)

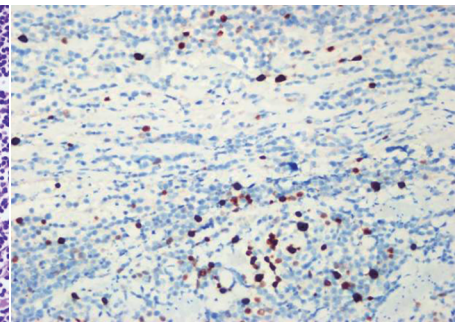


图4 免疫组化检查图(×400)

后临床病例数量和经验的积累, 超声在输尿管淋巴瘤诊断中更具潜在的应用价值。

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(收稿日期:2021-12-29)