

tient has return of bowel activity. Activities are gradually increased over the next 4~6 days graduating from bed to chair to walking to discharge from the hospital.

Healing of splenic fractures should be substantial within three weeks. Limitation of physical activity after discharge from the hospital is suggested for a variable length of time. However, there are no good data regarding the optimal duration of restriction of physical activity. I suggest limitation of activity for six weeks for all patients. This should provide sufficient time for most minor and many major parenchymal injuries to heal and most hematomas to resorb and organize. A CT scan is repeated at that time to assess the degree of healing before making any further recommendations to the patient. If CT shows that the injury is healed, I permit the patient to resume full activity including contact sports. If, however, there is residual fracture or hematoma, I advise against full activity and continue a conservative approach. Outpa-

tient CT scans are repeated at six to eight week intervals until complete healing has occurred at which time resumption of complete activity allowed.

In conclusion, nonoperative treatment of splenic injury has been shown to be a safe, effective alternative to operative therapy in hemodynamically stabilized patients. CT improves the diagnosis of splenic injury while also proving the absence of other injuries. It is ideally suited as the first step in this conservative management. However, CT is not very good at predicting when nonoperative management will be successful. The author recommends splenic arteriography to make this determination. If there is no extravasation from the spleen, the nonoperative management will succeed almost always. If extravasation of arterial contrast is seen on angiography, then some treatment is necessary. Embolization of the splenic artery has been shown to be an effective method of controlling splenic bleeding.

• 病例报告 •

肺癌大咯血介入治疗一例

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患者男性, 53 岁。经平片、CT、及支气管纤维镜检查确诊为右下肺中央型、低分化鳞癌。病灶与下后纵隔、横膈及右后下内胸壁粘连。病后共行三次经支气管动脉化疗灌注治疗, 间隔期为 4 周。经 2 次治疗后, 病灶影像表现无明显变化; 但第 3 次治疗后约 10 小时(夜间), 患者突发大咯血, 咯出鲜血约 1000ml。之后 3 小时内反复发作 6 次, 共计出血约 3000ml。间歇期平片示原右下肺大块密影已完全消失, 提示病灶液化排出。

患者行介入诊治: 首次介入诊疗采用选择性支气管动脉、肋间动脉造影, 寻找出血动脉, 发现右侧第九肋间动脉与

肺动脉相通, 右支气管动脉已变细且未见出血迹象, 于是当时对右第九肋间动脉实施了明胶海绵栓塞。术后病情稳定了 20 小时。之后再次复发出血。第二次介入采用主动脉弓降部造影寻找靶血管, 此次发现右侧 7、8、9 肋间动脉及右膈下动脉相互间存在侧支交通, 并与右肺动脉交通, 形成多处体-肺动脉瘘。为避免造成严重栓塞并发症, 故对有关动脉进行了有限栓塞, 复查主动脉造影显示体-肺动脉交通征象已消失。基本达到目的。术后稳定了 4 天无咯血, 拔除了气管套管。但第 5 天又因一次咯血造成窒息, 抢救未能奏效。

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