

短 篇

肾脏嫌色细胞癌合并鳞状细胞癌临床特点及文献复习

冷媛媛 黄燕涛* 明志强

杨婧 任通

四川省自贡市第一人民医院放射科
(四川 自贡 643000)

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Clinical Characteristics and Literature Review of Chromophobe Cell Carcinoma of Kidney with Squamous Cell Carcinoma

LENG Yuan-yuan, HUANG Yan-tao*, MING Zhi-qiang, YANG Jing, REN Tong.

Department of Radiology, First People's Hospital of Zigong City, Zigong 643000, Sichuan Province, China

1 临床资料

患者 女，67岁。因“左侧腰痛1月，近期体重降低约2kg”于2020年7月6日来院就诊。1月前无明显诱因开始出现左侧腰痛，呈持续性胀痛不适，能自行缓解，可忍受，无放射痛，伴尿频、尿不尽，不伴有排尿费力、尿急、尿痛，不伴肉眼血尿，不伴有畏寒、发热、恶心、呕吐及腹胀、腹痛等；专科查体：左侧肾区压痛及叩击痛，双侧腰腹部未闻及大血管鸣音。相关检查：我院B超提示：左肾实性占位，大小约8.6cm×7.8cm(图1)；腹部CT扫描示：左肾体积增大，中份区域见一团块影，大小约9.1cm×8.7cm×7.6cm，边界欠清，部分突出于左肾轮廓之外，病灶内密度不均，可见斑片、结节状钙化及坏死液化区，增强扫描呈轻-中度强化，部分皮质期强化较明显，实质期强化稍减低，左侧肾周筋膜增厚，局部与降结肠分界不清(图2~图3)。全麻下行“左肾全切术”，术中见：左侧肾中份实性占位，大小约9.1cm×8.7cm×7.6cm，部分凸出于肾脏表面，质地硬，边界欠清，周围与肾周脂肪粘连，与结肠脾曲严密粘连，与肾上腺粘连紧密；肾门及腹主动脉旁可见多个直径约1.0cm大小的淋巴结(图4)。术后病理诊断：肾嫌色细胞癌合并鳞状细胞癌；镜下观察可见肿瘤含有两种组织学形态(A区和B区)，免疫组化标记结果示：A区呈CK5/6(+)、H-CK(+)、P-CK(+)、Vim(-)、p40(+)、CK19(+)、CD15(-)、EMA(+，部分)、CD10(-)、Villin(-)；B区呈CAIX(-)、CK7(+)、p504S(-)、CD117(+)、HMB45(-)、CK5/6(-)、CD10(-)、SDHB(+)(图5)。

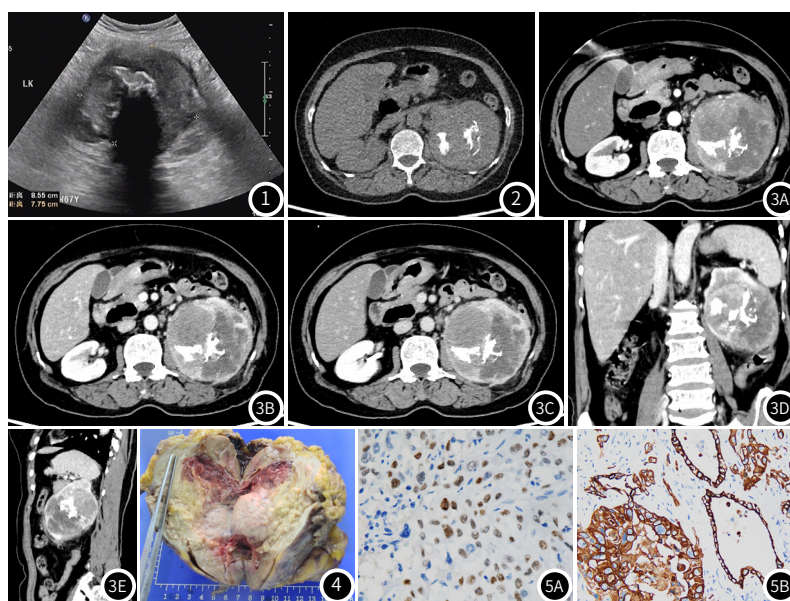


图1 超声图片。超声示左肾中份见大小约8.6x7.8cm的低回声团，推挤周围肾组织，中央可见片、团状强回声伴声影。图2 CT平扫图像。CT平扫示左肾体积增大，见类圆形软组织肿块，其内见斑片及条状钙化灶。图3 CT增强扫描图像。CT增强扫描：图3A(皮质期)示肿块不均匀强化，其强化程度低于肾皮质，病灶内份区域强化程度较外份明显；图3B(实质期)示内份区域强化程度略减低；图3C(延迟期)示外份区域大片坏死囊变区，增强扫描无强化；图3D(冠状面)、图3E(矢状面)示肿块主要位于肾轮廓之内。图4 大体图片。图5 病理图片。图5A: p40呈阳性表达；图5B: CK19呈阳性表达

2 讨论

肾癌为肾脏最常见恶性肿瘤，其病理分型中透明细胞癌约占70~80%，而肾脏嫌色细胞癌约占2~5%。单纯的嫌色细胞癌为低度恶性肿瘤，通常术后良好；据文献报道其可表现为复合形态，以合并肉瘤样结构最为常见，而合并鳞状细胞癌极为罕见，目前仅报道数例^[1]，在此情况下则预后不良。

肾嫌色细胞癌多见于老年人群，性别上无明显差距，起源于集合管的闰细胞；肿瘤细胞主要由嫌色细胞和嗜酸细胞构成，嫌色细胞多围绕在嗜酸细胞周围；当合并鳞状细胞癌时，其病理机制尚不明确，有学者认为其可能起源于肾内未分化干细胞，细胞学

【第一作者】冷媛媛，女，副主任医师，主要研究方向：CT及MRI诊断。E-mail: 231779138@qq.com

【通讯作者】黄燕涛，男，副主任医师，主要研究方向：CT及MRI诊断。E-mail: 46137672@qq.com

上则表现为嫌色细胞与鳞状细胞混合交错存在,具有特征性;本病例肿瘤组织以嫌色细胞癌为主(A区),免疫组织化学中CK7、CD117阳性表达为其典型特征,而部分区域内(B区)CK5/6、H-CK、P-CK、p40、CK19均呈阳性表达,表明肿瘤组织中含有鳞状细胞癌成分,则符合嫌色细胞癌合并鳞状细胞癌病理改变。

肾嫌色细胞癌合并鳞状细胞癌患者临床症状中仍以腰痛、血尿及肾区扣痛等为主要表现,与肾脏恶性肿瘤无特异性。因该病罕见,就目前国内关于其影像学表现的相关文献报道基本为零,本文就以收集到的这一病例的影像学征象为基础,浅谈下肾嫌色细胞癌合并鳞状细胞癌哪些影像学表现对于该病的诊断有所帮助。该病例具有如下影像学表现①病灶大(9.1cm×8.7cm×7.6cm)且主要位于肾轮廓之内;②密度不均匀,可见片状坏死、囊变及不规则钙化灶;③增强扫描呈不均匀强化,病灶内侧区域皮质轻度强化且强化程度低于肾皮质,实质期其强化程度较皮质期略减低;病灶外侧区域以坏死、囊变为主,增强扫描边缘可见强化;以上征象中坏死囊变、钙化及其强化程度变化为其特征,与肾脏其他肿瘤(单纯嫌色细胞癌、透明细胞癌、乳头状细胞癌、嗜酸性腺瘤等)的鉴别具有较大帮助。

鉴别诊断①嫌色细胞癌:为肾脏少血供肿瘤,病灶多较大,呈类圆形改变,很少出现坏死、出血和囊变,较小者密度多较均匀,但约40%病灶内可出现钙化具有特征性,少数可见中央瘢痕,增强扫描时呈轻-中度持续强化^[2-4];肾嫌色细胞癌合并鳞状细胞癌因同时含有两种癌细胞,病灶大小、不规则钙化、轻-中度强化均符合嫌色细胞癌的影像特点,但坏死、囊变表明其有别于单纯嫌色细胞癌。②透明细胞癌:为肾脏最常见恶性肿瘤,多起源于肾皮质而向肾外突出,常合并坏死、囊变,可伴有钙化、但多为点状,大多数病灶可见假包膜;因其为富血供肿瘤,增强扫描呈“快进快出”改变为其主要特征^[5-6];本病中病灶内片状坏死囊变符合透明细胞癌征象,但病灶位置、血供、钙化均不支持。

③乳头状细胞癌:可为多发或双侧发病,可表现为囊性或实性,边界多较清楚,钙化少见,为乏血供肿瘤,增强扫描多为轻度强化^[7]。④嗜酸性腺瘤:为肾脏少见良性肿瘤,其内可见星形中央瘢痕,增强扫描呈现“放射样”或“轮辐样”强化改变,具有特征性^[8-9]。

肾嫌色细胞癌合并鳞状细胞癌极为罕见,临床症状不典型,影像学征象中虽具有一定特征,但由于病例少、对其认识不足,因而病理诊断仍为其“金标准”;该病首选手术切除,但其预后与鳞状细胞分化程度及所占比例相关,其相关性有待进一步研究。

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