

原发性肺黏膜相关淋巴组织淋巴瘤侵犯心脏1例报道

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【摘要】 原发性肺黏膜相关淋巴组织(mucosa-associated lymphoid tissue, MALT)淋巴瘤是一种罕见疾病。胸片或CT有可能将MALT淋巴瘤与其他肺部疾病相混淆,从而导致误诊或延误治疗,本例患者因为难以诊断而延误5年余。患者因胸痛就诊时发现右侧大量胸腔积液,当时给予抗结核治疗,但肺部病变仍缓慢进展,同时左肺也出现病变,纵膈内淋巴结融合,病变累及心脏,出现心包积液。在复旦大学附属中山医院经超声支气管镜行支气管、淋巴结及心房肿物穿刺病理检查,确诊为MALT淋巴瘤。

【关键词】 黏膜相关淋巴组织(MALT); 淋巴瘤; 胸腔积液; 心房肿物

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Primary pulmonary mucosa-associated lymphoid tissue lymphoma involving the heart: a case report

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【Abstract】 Primary pulmonary mucosa-associated lymphoid tissue (MALT) lymphoma is a very rare disease. Chest radiographs or computed tomography may confuse MALT with other pulmonary diseases, resulting in misdiagnosis or delayed treatment, this can lead to misdiagnosis or delayed treatment. In this case, the patient was delayed by more than five years because it was difficult to diagnose. The patient visited the doctor due to chest pain and found a large amount of pleural effusion on the right side. Anti-tuberculosis treatment was given at that time, but the pulmonary lesion was still progressing slowly. Meanwhile, the left lung lesion was also present, and lymph nodes in the mediastinum were fused, and later the lesion involved the heart, presenting pericardial effusion. The patient went to Zhongshan Hospital for treatment, and underwent bronchial, lymph node and atrial tumor puncture examination by ultrasonic bronchoscopy. It was confirmed as pulmonary MALT lymphoma in the pathological and immune groups.

【Key words】 mucosa-associated lymphoid tissue (MALT); lymphoma; pleural effusion; atrial mass

黏膜相关淋巴组织(mucosa-associated lymphoid tissue, MALT)淋巴瘤属于非霍奇金淋巴瘤,约占非霍奇金淋巴瘤的8%左右。MALT淋巴瘤最常发生部位是胃肠道。在病理生理、遗传学甚至临床特点及疾病发展过程,胃肠道外与胃肠道

MALT淋巴瘤都是不同的。MALT淋巴瘤疾病发展过程通常是惰性的,可向其他黏膜部位扩散,尤其是胃肠道外的MALT淋巴瘤,全身多器官受累可达50%。现报告1例肺原发性肺MALT淋巴瘤并侵犯心脏的病例。

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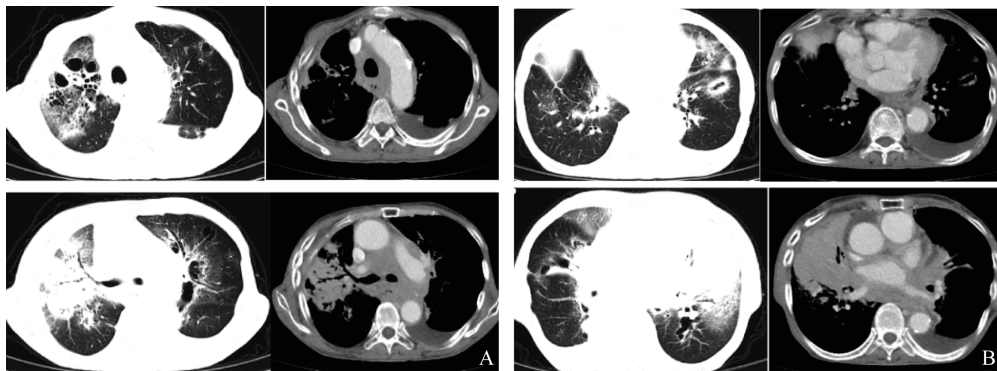
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病例分析 患者男性,72岁,2013年5月因右侧胸痛就诊,外院胸部CT检查发现右侧大量包裹性胸腔积液,纵膈内淋巴结肿大不明显。抽液共约3 000 mL,PET/CT扫描见右肺门肿块,伴18-氟脱氧葡萄糖(18-fluorodeoxyglucose,18F-FDG)摄取增高,考虑可能为肺癌并胸腔积液,胸水及支气管镜检查相关化验检查未找到明确病因,又考虑为结核性胸腔积液,予以抗结核治疗,右侧胸水减少至消失,但右肺大片高密度阴影未见明显变化。2013年12月复查,右肺仍有大片实变影缓慢进展。2016年3月双下肺开始出现片状阴影,病变部位有支气管充气征、晕征、空洞等表现。

2017年8月患者出现乏力、胸闷,行胸部检查发现左侧胸腔积液,放液共约2 000 mL,此时仍继续口服抗结核药物利福喷丁、帕斯烟肼、吡嗪酰胺、乙胺丁醇抗结核治疗5个月,期间复查未见积液减少,但胸闷、乏力、纳差症状逐渐加重,并出现双下肢水肿。2017年12月复查,双肺出现大片高密度影,局部内可见支气管充气征,周围可见磨玻璃影,左侧胸腔出现积液,纵膈内淋巴结融合成片。2018年6

月复查胸部CT,双肺病变范围扩大,病灶内出现空洞。患者出现夜间不能平卧入睡,伴食欲减退、消瘦。2018年9月行支气管镜检查示,左肺上叶各段口开口狭窄,黏膜肥厚、增粗,气管镜不能进入,相关检查仍无果,继续抗结核治疗5个月。2019年2月行B超检查示,左肺大量积液,放液约3 000 mL,建议行支气管镜检查及胸腔镜检查,家属拒绝。除面部皮肤中分化鳞癌病史1个月,无其他病史。吸烟20支/天,约30余年,戒烟6年。

2019年2月就诊于复旦大学附属中山医院,查体发现患者有杵状指,口唇微绀,测手指末梢血氧饱和度仅为75%左右,但患者胸闷症状不是很明显,说明患者已耐受低氧血症。行胸部增强CT检查,两肺见片状高密度斑片及结节影伴实变及支气管扩张、空洞形成,所见各支气管腔通畅,纵膈内见片状稍高密度影,左侧胸腔积液,心包积液,纵膈内渗出可能(图1)。腹部增强CT未见特殊异常。心脏彩超见左房顶及左心耳处中等密度回声,与左心房房壁关系密切,包绕左上及右上肺静脉,形态欠规整并与心包外团块相延续。



CT of the chest demonstrated cavities and consolidation in upper (A) and lower (B) lobes of both lungs. Enlarged mediastinal lymph nodes, pericardial effusion and pleural effusion on the left side were also observed in the CT scan.

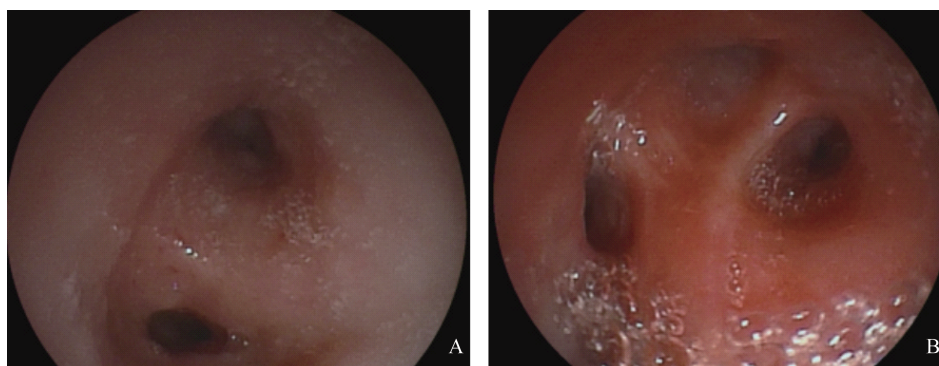
图1 原发性肺MALT淋巴瘤侵犯心脏的患者胸部CT扫描图

Fig 1 The chest CT scan of the patient with primary pulmonary mucosa-associated lymphoid tissue lymphoma involving the heart

血常规示轻度贫血,生化示低蛋白血症,隐球菌荚膜抗原定性、风湿、自身抗体系列等化验均阴性,氨基末端利钠肽前体、肿瘤标志物、凝血功能等基本正常范围。胸水常规化验为渗出液,细胞以单核细胞为主;胸水培养示假肺炎链球菌,胸水涂片见大量淋巴细胞及浆细胞样细胞;胸水其他化验结果未见异常。

中央超声支气管镜检查见气管及左右支气管镜管腔狭窄,黏膜肿胀,未见新生物(图2),外周超

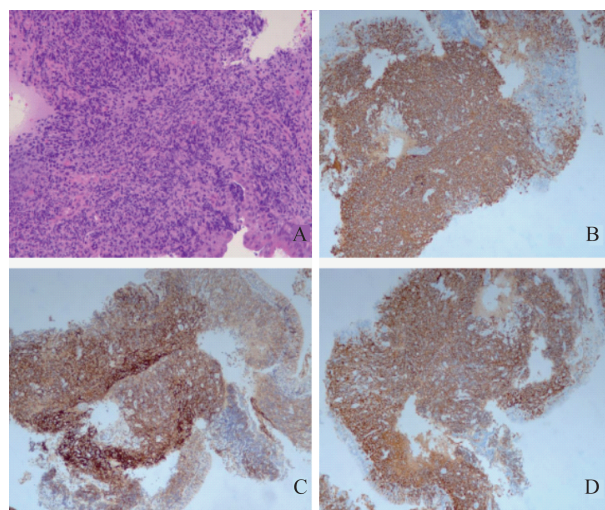
声结合透视下行右上叶后段及气管下段左侧壁心包肿物穿刺活检,结果示右肺上叶后段、右侧支气管黏膜慢性炎伴间质大量淋巴样细胞浸润,考虑MALT结外边缘区淋巴瘤(MALT淋巴瘤),心包肿物考虑MALT淋巴瘤浸润、转移。免疫组化结果显示:CD20(+),CD21(+),CD79a(+),Bcl2(30%+),CD3(部分+),CD10(-),CD5(部分+),CD23(-)(图3),可见IG基因重排。MALT分离探针分离检测结果可见约30%的肿瘤细胞有基因信号分离。



A: The right main bronchus; B: The right upper lobe bronchus. These findings showed the bronchus was obstructed due to mucosal edema.

图2 原发性肺 MALT 淋巴瘤侵犯心脏的患者支气管纤维镜检查图

Fig 2 Bronchofiberscopy images of the patient with primary pulmonary mucosa-associated lymphoid tissue lymphoma involving the heart



A: Diffuse lymphoma cell infiltration; B: CD20 positive cells; C: CD21 positive cells; D: CD79a positive cells.

图3 原发性肺 MALT 淋巴瘤侵犯心脏的患者免疫组化染色结果($\times 100$)

Fig 3 Immunohistochemical staining result of the patient with primary pulmonary mucosa-associated lymphoid tissue lymphoma involving the heart ($\times 100$)

讨论 原发性肺淋巴瘤(primary pulmonary lymphoma, PPL)是一种非常罕见的肺恶性肿瘤,约占肺恶性肿瘤的0.5%~1%,其中MALT淋巴瘤占70%~90%^[1],5年生存率为88.7%^[2]。因为气管中MALT相对较少,所以气管MALT淋巴瘤极为罕见^[3]。该病的诊断标准为:经病理学诊断明确;影像学上肺、支气管受累,伴或不伴肺门、纵隔淋巴结肿大;无其他部位淋巴结或脏器受侵;既往无淋巴瘤病史,且发病3个月后仍无胸外淋巴瘤征象^[4]。肺MALT淋巴瘤的病因及发病机制尚不清楚,可能是机体对各种抗原刺激(包括慢性肺部感染、吸烟、自

身免疫性疾等)^[5]的一种反应,从而引起淋巴组织细胞积聚,尚未发现MALT淋巴瘤特异性的病原体^[6]。一项研究显示,45%MALT淋巴瘤患者有吸烟史,9%有接触有毒物质史,19%有已知的肺部疾病。另一项研究显示,大约有37%的MALT淋巴瘤患者没有症状,低热、咳嗽、呼吸困难、体重减轻、慢性疲劳等是最常见的临床症状^[7]。

在影像学方面,PPL表现为非特异性,包括单发或多发结节、合并支气管充气征的实变团块、肺不张、支气管扩张、细支气管炎和毛玻璃混浊、血管造影征象等^[8-9]。PET/CT在PPL的诊断中作用有限,可能因为MALT对造影剂的亲和力较低^[10]。PPL易误诊为肺癌、肺转移瘤、肺结核等。而高分辨CT(high-resolution computed tomography, HRCT)对于PPL诊断有很大帮助。多灶性结节肿块及实变、支气管充气征、CT血管造影征、晕征、蝶征等可能有助于MALT淋巴瘤与非MALT淋巴瘤的鉴别^[11]。肿瘤细胞累及肺内间质结构,在CT上就表现为间隔增厚、支气管的囊柱状扩张等改变^[12-13]。高达30%的患者存在肺门和纵隔淋巴结肿大,约10%的病例合并胸腔积液^[14]。本例患者也是因大量胸腔积液就诊,支气管镜检查时见管腔狭窄,未见管腔内肿物阻塞等情况。病变一般不累及支气管,所以一般无支气管闭塞。本患者病史较长,后期出现纵膈淋巴结肿大并融合,而且已侵犯纵膈内心脏,导致心包积液和心房病变。

MALT淋巴瘤5年生存率达84%~94%,需要长期随访^[15]。MALT淋巴瘤的最终确诊依赖于病理结果。免疫组化可显示肿瘤的单克隆性,本例患

者的CD20、CD21、CD79a均为阳性,同时可见IG基因重排,约30%的肿瘤细胞有基因信号分离。

总之,MALT淋巴瘤起病隐匿,发展缓慢,临床症状表现因人而异,影像学表现呈多样性、无特异性,病变初期易误诊为结核、肿瘤等,最终确诊依赖于病理结果。确诊后患者才能得到正确的治疗,因此,如发现顽固性胸水伴其他部位转移,应警惕MALT可能,以便快速准确地诊治,避免延误病情。

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