

精囊镜射精管扩张联合经尿道电切 治疗射精管囊肿的效果评价

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摘 要: **目的** 探讨经尿道囊肿电切术联合精囊镜下射精管扩张术治疗射精管囊肿的疗效。**方法** 选取 2014 年 10 月—2019 年 6 月 16 例因射精管囊肿梗阻导致的少精症或无精症患者, 均给予经尿道电切联合经尿道精囊镜下射精管扩张术治疗。**结果** 16 例患者术前精液量 0.6 ~ 1.8 mL, 精浆果糖明显降低, 其中 12 例为无精症, 4 例为弱精症。所有患者均完成手术, 术后随访至少 6 个月。术后 1 年有 5 例患者精囊腺显著缩小, 其中 4 例患者配偶术后 9 ~ 12 个月成功妊娠。患者术后精液量较术前显著增多 ($P < 0.05$), 术后精浆果糖水平显著高于术前 ($P < 0.05$)。**结论** 经尿道囊肿电切术联合精囊镜下射精管扩张术治疗射精管囊肿安全、有效。

关键词: 射精管囊肿; 经尿道电切术; 精囊镜; 射精管扩张

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Effect evaluation in dilatation of ejaculatory duct under semioscope combined with transurethral electrotomy in the treatment for ejaculatory duct cyst

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ABSTRACT: **Objective** To explore the efficacy of dilatation of ejaculatory duct under semioscope combined with transurethral electrotomy in the treatment for ejaculatory duct cyst. **Methods** From October 2014 to June 2019, 16 cases with oligospermia or azoospermia caused by obstruction of ejaculatory duct cyst were selected and treated with dilatation of ejaculatory duct under semioscope combined with transurethral electrotomy. **Results** The semen volume of 16 patients was 0.6 to 1.8 mL before operation, and the fructose of seminal plasma significantly reduced. Among them, 12 cases were azoospermia, and 4 cases were asthenospermia. All patients finished operation successfully and were followed up for at least 6 months. The seminal vesicle glands of 5 patients significantly reduced one year after the operation, and spouses of 4 patients were pregnant successfully at 9 to 12 months after the operation. The amount of semen after operation was significantly higher than that before operation ($P < 0.05$), and the level of fructose in seminal plasma after operation was significantly higher than that before operation ($P < 0.05$). **Conclusion** Dilatation of ejaculatory duct under semioscope combined with transurethral electrotomy is effective and safe in the treatment for ejaculatory duct cyst.

KEY WORDS: ejaculatory duct cyst; transurethral electrotomy; semioscope; dilatation of ejaculatory duct

梗阻性无精子症是导致男性不育的常见原因, 其发生率约 1%, 原因有先天性输精管梗阻

(如先天性双侧输精管缺如或闭锁) 与后天性输精管梗阻(如生殖道感染、创伤和肿瘤压迫等),

其中射精管囊肿在临床上并不多见,多数患者是婚后不育才就诊^[1]。目前,对伴有射精管梗阻症状的射精管囊肿的治疗尚无统一意见。本院自2014年10月—2019年6月共诊治16例此类患者,均采用尿道囊肿电切术联合精囊镜下射精管扩张术,现将结果报告如下。

1 资料与方法

1.1 临床资料

选取2014年10月—2019年6月经本科诊治并随访的射精管囊肿男性患者16例,年龄23~37岁,平均30岁,均为婚后不育1年以上。排除配偶不孕因素,所有患者均行常规体格检查、精液常规检查、精浆果糖的定量检查、经直肠B超检查。连续常规精液检查提示无精或少弱精,精液量0.6~1.5 mL,平均1.0 mL; pH值5.8~6.9,平均6.4;每次射精测得精浆果糖0~16.5 μmol ,平均11.8 μmol ;患者睾丸大小正常,输精管可扪及,外生殖器无异常,性激素相关检查均正常,经睾丸活检证实睾丸内有成熟的精子生成,经直肠彩超(TRUS)及磁共振成像(MRI)提示在近精阜中线或偏离中线处有射精管囊肿,均提示射精管扩张并精囊扩张。

1.2 治疗方法

16例患者均全麻后取截石位,置入电切镜,在精阜部位切开囊肿壁,创面止血;然后改用精囊镜进入精阜部位查找已切开过的射精管。低压缓慢放水并在输尿管导丝的引导下通过已切开管口进入射精管管腔内,通过镜体的扩张来观察双侧输精管及精囊的内部结构,若发现异常则给予稀释碘伏冲洗精囊腔。术后留置尿管1~2 d并预防性应用抗生素。嘱患者术后禁欲3个月,半年后复查相关指标。全部患者治疗并随访至少半年。

2 结果

16例均获随访,术后3个月有4例可查及精子,术后9个月有8例查及精子,剩余4例在术后1年查及精子。术后1年有5例患者精囊腺显著缩小,其中4例患者配偶术后9~12个月成功妊娠。患者术后精液量较术前显著增多($P < 0.05$),术后精浆果糖水平显著高于术前($P < 0.05$)。

3 讨论

射精管囊肿可因先天性射精管开口的异常或后天性因素如生殖道炎症及尿道的医源性损伤而引起^[2]。射精管囊肿临床表现多不典型,可伴有多种临床表现,包括血精、射精痛、射精量减少及会阴部不适等。绝大多数的射精管囊肿体积较小、症状轻,可定期随访,体积较大的囊肿可压迫射精管而引起梗阻,并发结石,轻者射精量减少,重者伴有顽固性血精甚至梗阻性无精,大多数症状明显且难以治愈^[3-5]。

射精管囊肿的治疗主要根据囊肿的大小、临床症状及有无并发症来决定治疗方案。目前的治疗方案包括B超引导下穿刺抽液、硬化剂治疗^[6],如囊肿穿刺注入无水酒精或四环素液,可使囊肿缩小,但并发症较多。手术治疗包括经尿道囊肿切开引流术^[7-8]、开放性囊肿切除术^[9]。单纯经尿道囊肿切开去顶术可导致尿道狭窄及性功能障碍、逆行感染导致精囊和附睾的急慢性炎症^[10],甚至有报道少数少精子、弱精子症患者行单纯囊肿电切手术后发生完全性梗阻,或射精管囊肿再次复发。由于电切术后存在逆行射精的可能,对于未婚、未育或尚有生育意愿的患者,要在充分告知病情后慎重选择。精囊镜射精管扩张具有副作用少、住院时间短、手术更符合人体的生理等优点,但存在精道损伤的可能^[11]。经尿道电切联合精囊镜射精管扩张既可解除输精管梗阻,又可有效减少相关并发症的发生。作者认为在实际手术过程中,应仔细辨认病变部位与周围组织的解剖关系,电切时注意其电切深度、邻近的解剖标志、相关切除范围,精囊镜行扩张时动作尽量轻柔、细致,保证手术安全。

本研究认为此法适用于有临床症状但囊肿不巨大者,尤其适用于合并有射精管结石或囊肿病变者,对于射精管囊肿梗阻所致无精症均能有效治疗,且方法简单、有效、安全,患者住院时间较短。

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生理及免疫功能改变,进一步加剧免疫功能紊乱^[13-14]。本研究发现,2组术后1h各应激反应指标均不同程度升高,但2组WBC、CRP无显著差异($P>0.05$),而ERAS组术后1、3d各指标均显著低于对照组($P<0.05$),说明ERAS模式下的F-URS可通过微创技术显著减轻手术患者的应激反应,促进免疫功能的恢复。

综上所述,ERAS模式下F-URS治疗直径小于2cm的肾及输尿管上段结石患者,可缩短住院时间,减轻应激反应,减少围术期并发症的发生,达到术后快速康复的目的,为泌尿外科围术期全面实施ERAS提供参考依据。

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