

· 临床研究 ·

急性胸腰段脊神经卡压征 116 例分析

Clinical analysis of acute thoracolumbar spinal nerves compression syndrome: A report of 116 cases

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【关键词】 神经痛; 诊断检查服务 【Key words】 Neuralgia; Diagnostic services

胸腰段脊神经根及近段神经干因其周围组织的急性损伤及炎症水肿而受压刺激后,其突出症状常表现为支配区的放射性痛,且较为剧烈而成为就诊主诉,如下腹部痛、腹股沟或会阴区痛等,易被误诊误治。文献中尚未将胸腰段脊神经受压所产生的这一系列证候群进行归纳,并以独立的诊断名称予以详细陈述。现分析 1982-2001 年间诊治的 116 例该病患者,提出该病的诊断名称和诊断标准供商榷。

1 临床资料

1.1 一般资料 116 例中男 92 例,女 24 例;男女比例为 3.83:1。年龄 22~62 岁,平均 34.8 岁,其中 50 岁以下者 107 例,占 92.4%。山区农民 58 例,占 50%,矿工、建筑工人及其他重体力劳动者 47 例,占 40.5%;其他职业 11 例,占 9.5%。

1.2 病程 发病 48 h 以内就诊者 98 例,48 h~7 d 者 16 例,10 d、12 d 各 1 例。

1.3 临床表现 有明显腰扭伤史或剧烈运动后发病者 101 例。自觉腰痛者 62 例,腰部活动受限者 41 例。下腹痛者 112 例,其中右下腹痛 78 例,左下腹痛 23 例,双侧下腹痛者 11 例。腹股沟及会阴部疼痛或麻木者 34 例,其中睾丸痛伴紧缩感 11 例。上述病例中以腰外症状为主诉者达 89 例,占 76.7%。

全部病例均有十二肋下方、骶棘肌外侧部典型的压痛点,按压此点后疼痛向同侧下腹或会阴区放射者 66 例。有下腹部压痛者 108 例,压痛位置均偏低且较表浅,深压时疼痛无明显加重。伴腹肌紧张者 19 例,均无明显反跳痛。会阴区皮肤感觉功能障碍者 12 例。睾丸痛的 11 例中均未见睾丸肿大、结节或局部红肿等。

1.4 辅助检查 全部病例均行腰椎、髋关节 X 线片

检查、泌尿系 B 超检查、血及尿常规检查,均未见异常。行腰椎 CT 检查者 51 例,椎管 MRI 检查者 20 例,未见特殊。

1.5 诊断情况 78 例被首诊确诊为该病。另 38 例均曾一度被误诊。误诊病种包括:急性阑尾炎 13 例,输尿管结石 8 例,肠梗阻 5 例,睾丸扭转 4 例,急性睾丸炎 2 例,宫外孕破裂 2 例,腹内脏器损伤 2 例,急性盆腔炎 1 例,黄体破裂 1 例。其中 2 例误诊阑尾炎和腹腔脏器破裂而行手术探查。

2 治疗与转归

均在确诊后予以十二肋下方、骶棘肌外侧部压痛点处封闭治疗,配方为 2% 利多卡因 10 ml 加醋酸强的松龙 125 mg。封闭后 1 h 内症状显著减轻或消失者 87 例。另 29 例在 1 d 内自觉症状显著减轻。1 周内痊愈 102 例。余 14 例 1 周后重复封闭 1 次后,均在 2 周内治愈。治愈率 100%。

3 讨论

胸腰段脊柱系指相对固定的胸椎至活动度较大的腰椎间的移行节段,临床上多特指 T₁₂、L₁^[1]。为适应腰椎的旋转、伸屈等运动功能,小关节的关节面由胸椎的冠状结构至 L₁ 立即转变为矢状结构,在 T₁₂ 与 L₁ 之间形成较为突然的过渡,故而可将此节段视为胸、腰椎两运动轴之间的枢纽。这一特殊的解剖结构特点,是胸腰段脊椎及其附属结构易于受损伤的重要原因^[1]。T₁₂、L₁ 神经根分别自 T₁₂L₁、L₁、₂ 椎间孔发出后, T₁₂ 分出部分神经纤维参与至 L₁, 并分别移行为髂腹下神经和髂腹股沟神经,近段神经干穿行于骶棘肌与腰方肌的上段肌间隙,末梢止于下腹壁肌肉及腹股沟外环口附近皮肤。另外 L₁ 神经还分支形成生殖股神经,支配会阴、腹股沟区皮肤和提睾肌。

小关节突及其周围组织因急性扭挫伤而炎性水

肿,可直接压迫和刺激该段神经根;腰方肌的附丽处(十二肋及上位腰椎横突)的牵拉伤及该处骶棘肌的损伤,也可因其肿胀及炎症使穿行于其间的 T₁₂、L₁ 神经干受压刺激^[2,3]。以上两种情况构成了胸腰段脊神经卡压征的主要成因,其放射痛则可表现在其较广泛的支配区域,如下腹痛、会阴区痛等,症状往往比原发灶更加显著而成为就诊主诉,这与腰椎间盘突出症(L_{4/5}、L_{5/S1} 最常见)神经根受压后其下肢症状最突出机理雷同。若对本病认识不足,询问病史不详,则极易被其腰外症状所迷惑而致误诊误治。另外,十二肋下方、骶棘肌外侧部的压痛点十分特异,部分病人在按压此点时疼痛向同侧下腹、会阴区放射,此特点应视为诊断本病的重要体征。

本文提出急性胸腰段脊神经卡压征的诊断标准为:①剧烈运动后尤其是腰扭伤后起病;②伴或不伴疼痛的持续性单或双侧下腹痛,腹股沟、会阴区痛或感觉异常,男性可有睾丸痛伴紧缩感;③十二肋下方、骶棘

肌外侧部有明显固定压痛点,可向同侧下腹或会阴部放射;④单或双侧下腹有压痛,但位置较低,压痛部位较表浅,无其他重要体征;⑤血、尿、大便常规检查以及腰椎、髋关节及腹部影像学检查均无异常;⑥腰部压痛点局部封闭后症状明显减轻或消失。

本病治疗包括:卧床休息,对症处理,局部封闭。穿刺点为腰部压痛点最明显处,进针 3~4 cm 即可,勿过深伤及肾脏^[4],每周 1 次。本组 1 次治愈率达 87.9% (102/116),2 周内全部治愈,说明本病预后良好。

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