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个案与短篇

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1例以发热为主的自身免疫性肝炎

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1 临床资料

1.1 病史

患者,女,65岁,因“反复发热3月”于2010年10月25日入院。其体温多在38.5℃左右,以下午、夜间为主,伴畏寒,无寒战。伴乏力、纳差、厌油,偶有夜间汗多,感咽痛,偶感轻微头痛。在外院用头孢类抗生素治疗后,疗效不佳。后试行异烟肼0.3 qd、利福平0.45 qd、乙胺丁醇0.75 qd、吡嗪酰胺0.5 tid抗结核治疗近2月后,症状无好转,体温仍波动于37~39℃,渐感右膝关节隐痛不适,其余症状同前,且渐出现肝区

不适,纳差、乏力有所加重,查肝功有明显损害(ALT 310 U/L、AST 338 U/L),且病程中出现一过性红色皮疹。1年前发现肝功轻度受损(未见具体报告),查甲、乙、丙、戊肝标志物(-),自服保肝药(联苯双酯、护肝宁等)治疗,以后随访肝功能一直轻度异常。

1.2 体格检查

神清,全身皮肤黏膜及巩膜无黄染,臀部及左大腿可见少量散在风团样皮疹,红色,稍高出皮面,压之褪色。咽稍红。心肺未见明显异常。腹部丰满,右下腹见陈旧性手术疤痕,全腹软,无压痛、反跳痛及肌紧张,体检发现肝肋下0.5 cm质硬。肝区叩痛(+),双肾区无叩痛,移动性浊音(-),肠鸣音正常,双下肢无水肿。

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1.3 辅助检查

某医院查: 心脏彩超示左房增大、主动脉瓣少量返流、左室舒张功能降低。胸部 CT 平扫未见明显异常, 肝脏 CT 示肝右叶后下段钙化灶。颅脑 CT 示双侧基底节区少许腔隙性梗塞。骨髓检查示粒红巨三系无明显异常。心脏彩超示左房增大, 三尖瓣轻度返流。肝活检示肝细胞浊肿变性, 汇管区周围肝细胞碎屑样坏死, 汇管区及局部肝细胞间慢性炎症细胞浸润。2010 年 9 月 2 日右侧腹股沟淋巴结活检示反应性增生。

我院检查: 血常规: RBC 4×10^{12} 个/L, HGB 112 g/L, WBC: 5.08×10^9 个/L, PLT 76×10^9 个/L, N 72%, PCT 0.16 ng/L, ESR 77 mm/h, 抗核抗体示 ANA+1:100 胞浆型。CRP 37.7 mg/L。蛋白电泳示 ALB 40.62% (正常值为 57~70)、ALPHA-1 为 6.3% (正常值为 1~5)、ALPHA-2 为 10.2% (正常值为 4~9)、BETA 为 10.1% (正常值为 7~13)、GAMMA 32.7% (正常值为 10~22)。甲状腺功能、甲状腺球蛋白及过氧化物酶蛋白抗体、结核抗体、抗 O、RF、癌谱均阴性。狼疮细胞(-), HIV、丙肝、梅毒阴性。肝功示 ALB 29 g/L, TB/DB 8.2/3.0 mmol/L, AST/ALT 102/35 U/L。骨髓检查示增生性骨髓象, 骨髓培养无致病菌生长。

2 讨论

发热待查是内科学常见疾病^[1], 感染性疾病最为常见 (50%), 结缔组织疾病次之 (20%~30%), 肿瘤性疾病也占了 10%~20%, 另外, 还有 10% 左右的病人未能查找到发热原因^[2]。该患者在外院诊治过程中考虑了细菌感染及特殊感染 (结核) 的可能, 但抗感染及抗结核治疗无效提示其可能性小; 患者做了类似全身检查未查找到肿瘤证据, 同时其甲状腺功能、甲状腺球蛋白等正常, 考虑亚甲炎可能性也不大。另外,

外周血象、骨髓检查不支持血液系统疾病。但在整个诊治过程中, 对患者除了反复发热外, 近 1 年来还存在反复肝功能的轻度异常这一点却忽略了。患者 1 年前曾发现肝功能无诱因出现反复轻度异常, 且甲乙丙戊肝标志物皆阴性, 这次发热后又发现肝功能轻度异常, 蛋白电泳异常, 肝穿活检示“肝细胞浊肿变性, 汇管区周围肝细胞碎屑样坏死, 汇管区及局部肝细胞间慢性炎症细胞浸润”。体检发现肝肋下 0.5 cm, 质硬。参照 AASLD 修订的自身免疫性肝炎评分标准, 该患者评分 18 分, 认为患者自身免疫性肝病诊断可能, 且其 ANA (+), 故考虑患者发热原因由自身免疫性疾病所致可能性大。入院后, 基于以上分析, 考虑患者发热原因不明, 在外院用抗感染、抗结核治疗皆无效, 且肝功受损, 故皆停用。考虑患者自身免疫性疾病可能性大, 开始用激素 (强的松 30 mg qd 治疗), 患者体温于 3 d 左右降至正常, 以后未再反弹。药物治疗有效支持该诊断。

所以, 发热待查病人查找病因是一个非常复杂的过程。需要仔细的病史询问、细致的体格检查 (包括仔细进行肝脏触诊)、充分的辅助检查以及必要时进行有创检查才可能得到确诊。另外, 对于诊断不明的死亡病例应尽可能取得家属同意进行尸检, 以提高我们对疾病的认识水平。

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