海報論文

個案報告 CR04

緊急主動脈-上腸繫膜動脈繞道手術合併胸腰椎椎板切除手術之麻醉

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前言: 隨著醫療進步，人類的平均年齡上升，越來越多老人接受手術，而對麻醉醫師而言再施行麻醉時需同時考量病人所合併的疾病問題。我們報告一個病例—因為疑似上腸繫膜動脈剝離合併馬尾症候群而在全身麻醉下接受主動脈-上腸繫膜動脈繞道手術以及胸椎第十二節至腰椎第二節椎板切除手術之麻醉。 病例報告: 一位 74 歲男性有著雙膝退化性關節炎而已經使用數年的止痛藥來緩解其疼痛。然而，隨著疼痛的增加以及關節變形，此病患於脊髓麻醉合併硬脊膜外的術後止痛麻醉之下接受左膝關節置換手術。但出院一個禮拜之後，由於急性的解尿困難、雙下肢無力以及腹脹等問題持續了兩天，他至急診求診。在急診理學檢查顯示雙下肢肌肉力量為 3 分以及肌腱反射減少，實驗室檢查顯示有白血球增加以及 C 反應蛋白增加的情形。核磁共振檢查顯示在胸椎第十二節至腰椎第二節之脊髓外區域有葉狀且節段分部的病灶合併馬尾神經發炎，除此之外，腹部電腦斷層顯示上腸繫膜動脈剝離。所以在疑似上腸繫膜動脈剝離以及胸椎第十二節至腰椎第二節硬脊膜外膿瘍造成馬尾症候群的診斷下，此病人於全身麻醉下接受主動脈-上腸繫膜動脈繞道手術以及胸椎第十二節至腰椎第二節椎板切除手術。我們使用了標準的監視設備(心電圖、壓脈帶及血氧濃度)以及動脈血壓偵測、中央靜脈導管來作術中血液動力學監測以及輸液給予。病人首先以平躺的姿勢接受了主動脈-上腸繫膜動脈繞道手術，之後再俯臥接受胸椎第十二節至腰椎第二節椎板清創手術，手術後病人轉送至加護病房接受更進一步的照護，再接受了數天的抗生素治療及加護中心照護，病人順利的拔除氣管內管並轉到普通病房做後續的復健。 討論: 對麻醉醫師來說，在病人接受以平躺姿勢執行腹內血管手術接這以俯臥的姿勢執行脊椎手術的同時，維持病人心血管的穩定性是一件挑戰。在敗血症的病人以 Early-goal direct therapy 來穩定長時間手術加上不同的姿勢改變的病人的生命徵象是相當重要的。

Case Report CR04

AN OLD MAN RECEIVED EMERGENCY AORTO-SUPERIOR MESENTERIC ARTERY BYPASS PLUS T10-L2 LAMINECTOMY UNDER GENERAL ANESTHESIA

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Me me elders receive operations we anesthesiologists have to deal with me complicated patient's underlying diseases. We repted an old man received ato-superi mesenteric artery(SMA) bypass plus T10-L2 laminectomy at same time under general anesthesia f suspecting SMA dissection cauda equina syndrome(CES).The 74-year-old male patient had bilateral knee osteoarthritis with analgesia f pain relief f years. The pain was progressing with severe joint defmity, thus he received left total knee replacement under spinal anesthesia epidural patient-controlled analgesia f postoperative pain control. By the patient's statement, the operation was smooth he disged uneventfully. One week later he came to our emergency room because of acute urine retention, bilateral lower limbs weakness abdominal distention f 2 days. The muscle power was 3-degree of the bilateral lower limbs with decreasing deep tendon reflex. Labaty data revealed high level CRP leukocytosis with left shifting. MRI of lumbar spine was perfmed showed long segmental lobulated lesion in the extramedullary spinal canal T10- L2 level the neuritis of cauda equine nerve. In addition, abdominal CT revealed SMA dissection. Under the impression of CES caused by T10-L2 epidural abscess SMA dissection, emergency surgery was arranged. General anesthesia with stard monit (ECG, NIBP, SpO2) was set. Besides, the arterial line central vein catheter were also placed f moniting hemodynamic fluid replacement. Ato-SMA bypass was perfmed in supine position, then laminectomy of T10-L2 with abscess debridement was done in prone position.