

·论著·

眶内电针治疗Fisher综合征所致眼肌麻痹临床观察

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基金项目
国家自然科学基金
(No. 81674052);
黑龙江中医药科
研项目(No. ZHY1
2-W031)
收稿日期
2019-12-21
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摘要 **目的:**回顾分析眶内电针(IEA)治疗Fisher综合征(MFS)眼肌麻痹疗效及MFS眼肌麻痹患者的临床特点。**方法:**收集接受IEA治疗的MFS患者27例的资料,对一般资料、受累颅神经、感染情况、治疗前后最大复视角度、治疗及恢复情况进行回顾分析。**结果:**患者从发病到开始接受IEA治疗的平均时间为(31.04±46.23)d,接受治疗后达到临床痊愈的平均天数为(33.67±21.96)d。临床痊愈(无复视致残)24例(88.9%)。治疗后,左眼和右眼的最大复视角度均较治疗前显著降低($P<0.01$)。MFS眼肌麻痹特点:100%患者有外展神经病变,其中11.1%为单侧病变,88.9%为双侧受累;37.0%合并III、VI对颅神经麻痹,无孤立的III或IV对颅神经麻痹患者。70.3%有感染史;11.1%伴发高血压、7.4%伴发高脂血症、3.7%伴发2型糖尿病。22.2%伴有Bell征,双侧受累4例,单侧受累2例。25.9%眼睑下垂,双侧受累5例,单侧受累2例。3.7%伴有双侧瞳孔散大。**结论:**IEA治疗可加快MFS眼肌麻痹症状恢复,MFS眼肌麻痹的临床特点可提示临床诊断。

关键词 眶内电针;Fisher综合征;眼肌麻痹

中图分类号 R741;R741.02;R741.05;R745 **文献标识码** A **DOI** 10.16780/j.cnki.sjssngncj.2020.04.006

周凌云,郭晓雪,苏畅,等.眶内电针治疗Fisher综合征所致眼肌麻痹临床观察[J].神经损伤与功能重建,2020,15(4):204-206.

Clinical Observation of Intra-Orbital Electroacupuncture against Miller Fisher Syndrome Ophthalmoplegia ZHOU Ling-yun¹, GUO Xiao-xue², SU Chang¹, LIU Wei², WU Xiu-ting², WANG Jia-yun², LIU Tie-juan¹, LI Xue-mei¹, ZHAO Ming¹, JI Xiao-jie¹. 1. Harbin Medical University Affiliated First Hospital, Harbin 150001, China; 2. Heilongjiang University of Chinese Medicine, Harbin 150040, China

Abstract **Objective:** To review the effectiveness of intra-orbital electroacupuncture (IEA) in the treatment of Miller Fisher Syndrome (MFS) ophthalmoplegia and the clinical characteristics of MFS ophthalmoplegia. **Methods:** We reviewed the medical records of 27 MFS ophthalmoplegia patients who received IEA therapy and retrospectively analyzed the general data, infection status, maximum diplopia deviation before and after treatment, and treatment and recovery status. **Results:** The mean time from onset to the start of IEA treatment in patients was (31±46.23) days, and the mean time from treatment to recovery was (33.67±21.96) days. The number of patients clinically cured (no diplopia) was 24 (88.9%). After treatment, the average maximum diplopia deviation of the left and right eye was significantly decreased ($P<0.01$). Abducens nerve (CN VI) paralysis was seen in 100% of patients with 11.1% being unilaterally affected and 88.9% bilaterally affected. Combined CN III and VI paralysis occurred in 37.0% of patients, and isolated CN III and CN IV paralysis was not seen. Infection was seen in 70% of patients. Concomitant disease included hypertension (11.1%), hyperlipemia (7.4%), and type 2 diabetes (3.7%). Bell's phenomenon was seen in 22.2% of patients including 4 bilateral and 2 unilateral cases. Ptosis occurred in 25.9% of patients including 5 bilateral and 2 unilateral cases. Bilateral pupil dilation was seen in 3.7% of patients. **Conclusion:** IEA therapy may accelerate the recovery from MFS ophthalmoplegia, and the clinical features of MFS ophthalmoplegia may aid diagnosis.

Key words intra-orbital electroacupuncture; Miller Fisher Syndrome; ophthalmoplegia

Fisher综合征(Miller Fisher Syndrome, MFS)是吉兰-巴雷综合征(Guillain-Barré Syndrome, GBS)的一种变异型,主要表现为共济失调、腱反射消失、眼肌麻痹^[1]。眼肌麻痹作为MFS的典型症状于发病早期出现,在亚洲患者中更为多见,即使患者接受恰当的治疗,眼肌麻痹也会持续很长时间^[2]。现有的MFS主要治疗方式包括静脉注射免疫球蛋白和血浆置换,但其疗效有限^[3]。尚无治

疗MFS眼肌麻痹的有效方法。眶内电针(intraorbital electroacupuncture, IEA)用于治疗不同类型的眼肌麻痹均能明显改善甚至消除复视及眼球运动障碍^[4-6]。本研究对IEA治疗MFS眼肌麻痹27例进行回顾性分析,为临床治疗MFS眼肌麻痹提供帮助。

1 资料与方法
1.1 一般资料

纳入2011年1月至2017年12月于哈尔滨医科大学附属第一医院眼球运动障碍治疗中心接受IEA治疗的MFS眼肌麻痹患者的27例。所有患者均诊断明确,均接受标准化管理,包括一般治疗和静脉注射免疫球蛋白治疗。当患者危及生命的症状消失并经神经内科主管医师同意后,进行标准化IEA治疗^[6]。

1.2 方法

收集患者临床资料,对年龄、性别、病程、受累颅神经、感染情况、治疗前后最大复视角度、治疗时间、相关症状(如上睑下垂、瞳孔功能异常和Bell征等)进行回顾性分析。将“无复视所致残疾”定义为临床痊愈^[6]。

1.3 统计处理

所有数据均采用SPSS19.0软件进行统计分析,计量资料以($\bar{x}\pm s$)表示,治疗前后最大复视角度值采用Mann-Whitney U比较分析;计数资料以率表示; $P<0.05$ 为差异有统计学意义。

2 结果

本组27例患者中,男16例,女11例,男女比例为1.45:1;平均年龄为(39.48 ± 16.13)岁。患者从发病到开始接受IEA治疗的平均时间为(31.04 ± 46.23)d,接受治疗后达到临床痊愈的平均天数为(33.67 ± 21.96)d。临床痊愈(无复视致残)24例(88.9%),3例仍存在眼肌麻痹。治疗前,左眼和右眼的最大复视角度分别为(16.41 ± 8.29)°和(16.39 ± 8.41)°;治疗后,左眼和右眼的最大复视角度分别为(8.84 ± 7.18)°和(8.72 ± 7.69)°,均较治疗前显著降低($P<0.01$)。

MFS眼肌麻痹特点:27例(100%)患者均有外展神经病变,其中3例(11.1%)为单侧病变,24(88.9%)为双侧受累;10例(37.0%)合并Ⅲ、Ⅵ对颅神经麻痹,无孤立的Ⅲ或Ⅳ对颅神经麻痹患者。19例(70.3%)有感染史,包括上呼吸道感染和胃肠道感染。伴发高血压3例(11.1%)、高脂血症2例(7.4%)、2型糖尿病1例(3.7%)。伴有Bell征6例(22.2%),双侧受累4例,单侧受累2例。眼睑下垂7例(25.9%),双侧受累5例,单侧受累2例。伴有双侧瞳孔散大1例(3.7%)。本研究中有4例患者出现不良反应,表现为局部水肿、青紫,予以冷敷对症处置;不良反应均于1周左右消失。

3 讨论

MFS眼肌麻痹的自然病程约为90~180 d^[2]。但本研究中,7.4%的患者病程超过了180 d。本课题组的临床观察显示,MFS眼肌麻痹的持续时间确实长于文献

的描述。这可能是由于MFS在不同种族中的变异及英文文献对眼肌麻痹的关注较少所致^[7]。与欧美患者相比,MFS在亚洲患者中更常累及颅神经^[3],尤其是眼运动神经^[8]。研究发现,MFS的3种主要症状中,共济失调的平均恢复时间约为39 d,眼肌麻痹的平均恢复时间约为82 d^[3],但其危害被大大低估^[9]。

IEA疗法能够快速改善甚至消除各种原因引起眼肌麻痹所致的复视及眼球运动障碍症状^[4-6]。本研究显示,IEA治疗MFS眼肌麻痹,临床痊愈率为88.9%;且实现临床痊愈的时间较自然病程减少约1/3^[2]。此外,左眼和右眼的最大复视角度均较治疗前显著降低($P<0.01$)^[10]。3例经IEA治疗后仍存在复视患者的均伴有高血压、高脂血症或2型糖尿病。这可能与3例患者未临床痊愈有关^[11,12],也不排除IEA对于某些患者来说可能无效。

目前MFS的诊断仍以临床症状为主,并与许多其他不典型的抗GQ1b抗体综合征有所重叠^[13]。部分学者认为,眼肌麻痹和共济失调在诊断中更为重要^[14]。在MFS不完全型(如急性眼肌麻痹、急性上睑下垂、急性瞳孔散大等)中,眼肌麻痹更是重要的一部分^[7]。有时,眼肌麻痹的特点甚至可作为诊断的主要依据。MFS作为抗GQ1b抗体综合征的一种,与GBS具有相似的发病机制^[7]。两者有3个相同的临床特征:急性或亚急性起病、有前驱的感染史^[15]、发病年龄轻^[16]。本组数据亦显示,患者的年龄范围为(39.48 ± 16.13)岁,70%的患者发病前有感染史。眼肌麻痹还具有如下特点:①眼肌麻痹可累及单侧或双侧,双侧受累更为常见。本组88.9%患者双侧受累,11.1%患者为单侧受累,且仅累及外展神经。对称性周围神经病变被广泛的认为是MFS甚至GBS的典型特点,但本组有11.1%为单侧受累。当患者仅表现为眼肌麻痹,并伴有“更可能的原因”如糖尿病周围神经病变等,MFS的诊断往往可能被忽略,需要引起临床医生注意。②3对眼运动神经可以同时或先后受累,外展神经最常受影响。本组100%患者累及外展神经,33%合并Ⅲ、Ⅳ对颅神经受累,无孤立性Ⅲ或Ⅳ神经麻痹的患者。支持GQ1b在展神经上表达数量最多的研究结果^[17]。部分患者同时或先后合并Ⅲ、Ⅳ对颅神经受累说明另2条眼运动神经中该类特异性抗原的表达存在个体差异。无孤立性Ⅲ或Ⅳ对颅神经麻痹的患者,提示特异性抗原如GQ1a、GD1a、GM1等可能也在疾病过程中起到一定作用^[18]。③除3对眼运动神经外,Ⅶ神经是最常被累及的颅神经^[19]。5例Bell征阳性的患者均合并眼睑下垂。患者

提上睑运动部分依赖于额肌的作用,而不是单纯提上睑肌收缩,患者的动眼神经麻痹导致眼睑下垂与面神经的额支损害导致眼睑不全下垂易于混淆。此外,仅有1例合并瞳孔异常,这与眼内肌支配纤维的解剖层次有关。当患者的眼肌麻痹具有上述6种临床特征时,应高度的怀疑MFS或MFS不完全型。

综上所述,IEA治疗可加快MFS眼肌麻痹症状恢复,MFS眼肌麻痹的临床特点可提示临床诊断。

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(本文编辑:唐颖馨)

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更大样本的研究来进一步评估cTnT是否是比CK更敏感的评估骨骼肌疾病活动度的标记物。

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(本文编辑:唐颖馨)