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## · 临床医学图像 ·

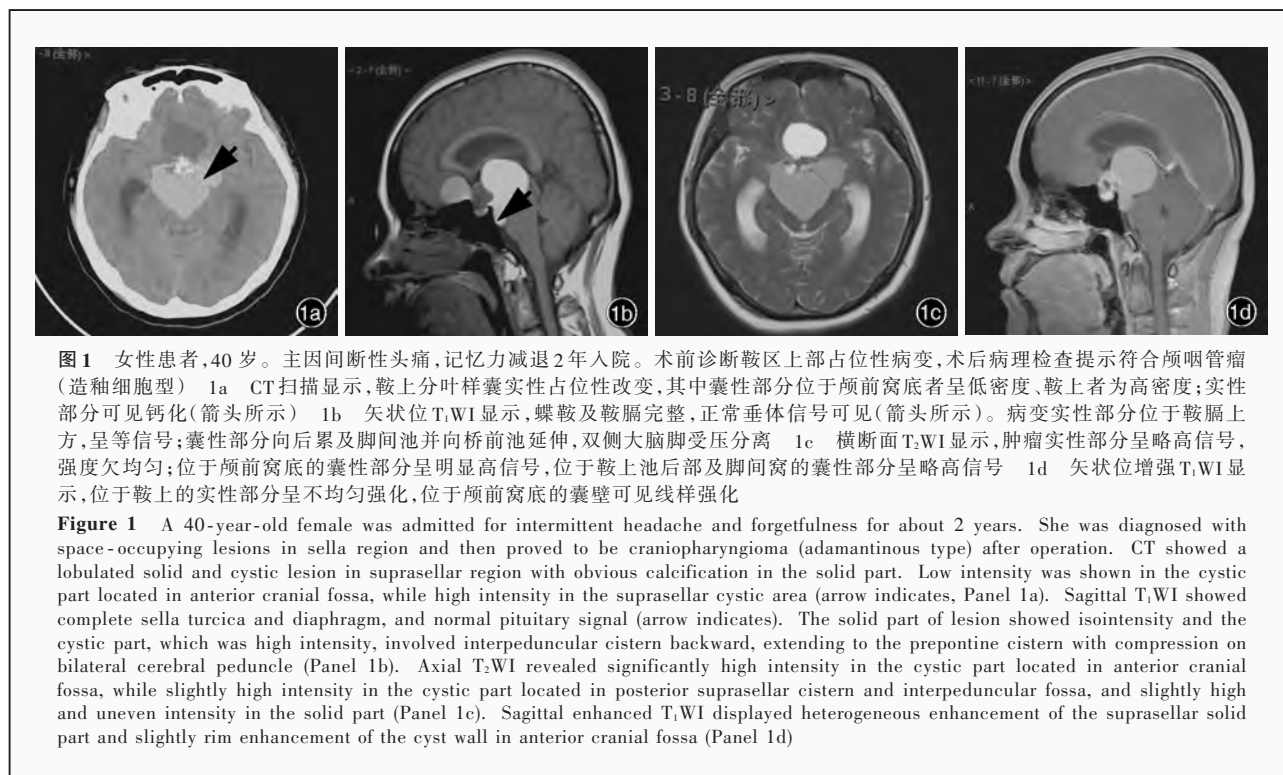
### 颅咽管瘤

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#### Craniopharyngioma

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**图 1** 女性患者, 40 岁。主因间断性头痛, 记忆力减退 2 年入院。术前诊断鞍区上部占位性病变, 术后病理检查提示符合颅咽管瘤 (造釉细胞型) 1a CT 扫描显示, 鞍上分叶样囊实性占位性改变, 其中囊性部分位于鞍前窝底者呈低密度、鞍上者为高密度; 实性部分可见钙化 (箭头所示) 1b 矢状位 T<sub>1</sub>WI 显示, 蝶鞍及鞍膈完整, 正常垂体信号可见 (箭头所示)。病变实性部分位于鞍膈上方, 呈等信号; 囊性部分向后累及脚间池并向桥前池延伸, 双侧大脑脚受压分离 1c 横断面 T<sub>2</sub>WI 显示, 肿瘤实性部分呈略高信号, 强度欠均匀; 位于鞍前窝底的囊性部分呈明显高信号, 位于鞍上池后部及脚间窝的囊性部分呈略高信号 1d 矢状位增强 T<sub>1</sub>WI 显示, 位于鞍上的实性部分呈不均匀强化, 位于鞍前窝底的囊壁可见线样强化

**Figure 1** A 40-year-old female was admitted for intermittent headache and forgetfulness for about 2 years. She was diagnosed with space-occupying lesions in sella region and then proved to be craniopharyngioma (adamantinous type) after operation. CT showed a lobulated solid and cystic lesion in suprasellar region with obvious calcification in the solid part. Low intensity was shown in the cystic part located in anterior cranial fossa, while high intensity in the suprasellar cystic area (arrow indicates, Panel 1a). Sagittal T<sub>1</sub>WI showed complete sella turcica and diaphragm, and normal pituitary signal (arrow indicates). The solid part of lesion showed isointensity and the cystic part, which was high intensity, involved interpeduncular cistern backward, extending to the prepontine cistern with compression on bilateral cerebral peduncle (Panel 1b). Axial T<sub>2</sub>WI revealed significantly high intensity in the cystic part located in posterior suprasellar cistern and interpeduncular fossa, and slightly high and uneven intensity in the solid part (Panel 1c). Sagittal enhanced T<sub>1</sub>WI displayed heterogeneous enhancement of the suprasellar solid part and slightly rim enhancement of the cyst wall in anterior cranial fossa (Panel 1d)

颅咽管瘤 (CP) 为先天性颅内良性肿瘤, 其发病率居儿童鞍区肿瘤首位, 在成人鞍区肿瘤中仅次于垂体瘤。颅咽管瘤多为囊实性、囊性分叶状, 少数为实性。囊实性者囊性部分多位于鞍上, 实质部分位于囊性部分下方邻近蝶鞍处; 囊壁表面光滑, 囊液呈机油样, 为液化的上皮细胞碎屑 (角蛋白样物) 伴胆固醇结晶。组织学上可分为牙釉质型 (多见于儿童) 和鳞状乳头型 (多见于成人)。大多数患者头部 X 线检查可见肿瘤灶钙化、蝶鞍改变和颅内压升高征象。CT 扫描显示, 鞍区高或等密度影像钙化斑, 囊液呈低密度, 囊壁为等密度; 增强后呈环状、多环状或实性强化, 少数不强化。其诊断要点为鞍区病变伴“蛋壳”样及实性钙化、卵圆形或分叶样囊腔, 以及病灶明显强化 (图 1)。MRI 扫描信号强度多变, 与囊液成分相关, 大多数呈短 T<sub>1</sub>、长 T<sub>2</sub> 改变, 也可呈长 T<sub>1</sub>、长 T<sub>2</sub> 改变; 实质性颅咽管瘤呈长 T<sub>1</sub>、长 T<sub>2</sub> 改变; 钙化斑为低信号区; 增强后病灶强化程度与 CT 相同。鉴别诊断包括垂体腺瘤、鞍结节脑膜瘤、鞍区生殖细胞瘤、视交叉胶质瘤及鞍区上皮样囊性病变如表皮样囊肿、皮样囊肿、蛛网膜囊肿及 Rathke 裂囊肿等; 罕见病变包括鞍区动脉瘤和鞍上蛛网膜囊肿等。

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