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·临床医学图像·

垂体微腺瘤

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Pituitary microadenoma

HAN Tong
Department of Neuroradiology, Tianjin Huanhu Hospital, Tianjin 300060, China (Email: mrbold@163.com)

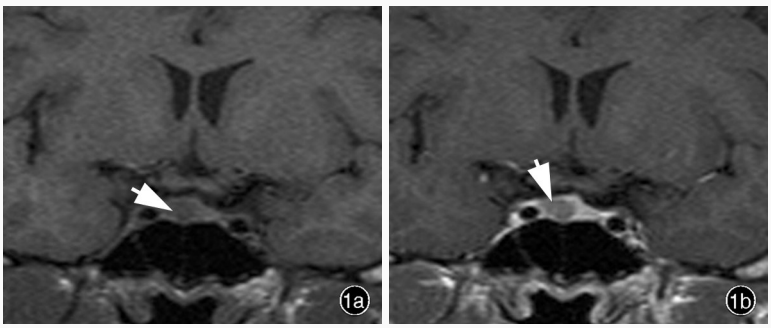

图1 女性患者,34岁。临床诊断:垂体微腺瘤。头部MRI检查所见 1a 冠状位T_1WI序列显示,右侧垂体稍低信号(箭头所示),边界清晰,局部垂体上缘隆起,垂体高度<10 mm;垂体柄向左移位,蝶鞍无扩大、鞍底无凹陷 1b 早期冠状位T_1WI增强扫描显示,正常垂体明显强化,病灶延迟强化,呈相对低信号(箭头所示)

Figure 1 A 34-year-old female had presented with amenorrhea and galactorrhea for 3 months and came to clinic. Cranial MRI findings. Coronal T_1WI showed a well defined, oval lesion with slightly hypo - intensity (arrow indicates) located within the right portion of pituitary. The adjacent superior border of adenohypophysis rose upward and the pituitary stalk shifted to left slightly. The height of pituitary gland was no more than 10 mm without enlargement of sella turcica and subsidence of the floor of sella turcica (Panel 1a). On dynamic contrast coronal T_1WI, the normal portion of pituitary showed marked enhancement at early arterial phase. Meanwhile, the lesion existed delayed enhancement (arrow indicates) and showed relatively low signal compared with adjacent normal tissue of pituitary (Panel 1b).

垂体微腺瘤(pituitary microadenoma)系指起源于腺垂体,直径<10 mm的腺瘤,发病率占颅内肿瘤的10%~15%。按照有无内分泌功能可分为无功能性和功能性腺瘤,前者多在影像学检查或尸检过程中偶然发现;后者以泌乳素瘤多见,发病率为30%~40%,临床主要表现为闭经、泌乳、不孕。生长激素瘤、促肾上腺皮质激素瘤、促性腺激素瘤、促甲状腺激素瘤及混合腺瘤相对少见。

如果未合并出血,垂体微腺瘤在CT上多呈等密度,与正常垂体无法分辨,少部分呈低密度,动态增强扫描多呈相对低密度;由于受较低分辨力及鞍区骨伪影的影响,CT对该病的定性诊断具有局限性。MRI检查可清晰显示病灶信号特征、受累范围及与邻近组织关系,因此为首选检查方法。其诊断要点为:(1)直接征象。相对于正常腺垂体,垂体微腺瘤主要表现为T_1WI稍低信号(图1a)、T_2WI稍高信号,合并出血时呈短T_1、短T_2信号,可位于偏侧、中央或鞍底;边界较清楚或模糊。由于垂体微腺瘤的强化峰值出现时间较正常垂体晚,故早期增强扫描具有诊断意义。动态增强扫描显示,早期强化(<120 s)呈相对低信号(图1b)、晚期强化与正常垂体组织相似;有10%~30%平扫时呈等信号的病灶仅能在动态增强扫描中被发现。(2)间接征象。垂体高度增加(儿童>6 mm、正常成人>8 mm、哺乳期女性>10 mm、妊娠后期及产后女性>12 mm);垂体外形改变[垂体上缘局灶性对称和(或)不对称膨隆、鞍底凹陷];垂体柄偏移(向肿瘤对侧倾斜)。重视MRI间接征象有利于减少漏诊,诊断过程中应注意与以下情况相鉴别:(1)生理性增生的垂体(如青春期、经期和妊娠期女性)。垂体轻度增大且信号不均匀,但增强扫描病灶呈均匀强化,无异常延迟强化区。(2)病理性增生的垂体。由于垂体靶腺器官功能降低导致腺垂体反应性增生,增强扫描病灶强化均匀,无异常延迟强化区。(3)鞍内非肿瘤性囊肿。包括Rathke's裂囊肿、中间叶囊肿、蛛网膜囊肿、表皮样囊肿或皮样囊肿,增强扫描前后信号强度无变化。(4)鞍内颅咽管瘤。呈实性结节,鲜见钙化,T_1WI呈等或低信号,T_2WI呈等或稍低信号,病灶显著强化。垂体微腺瘤的影像学诊断需结合相关临床症状和实验室检查,大部分病例需结合动态增强扫描明确诊断。

(天津市环湖医院神经放射科韩彤供稿)