

中西医结合治疗脑梗塞 141 例

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内容提要 中西医结合治疗 141 例急性脑梗塞, 其显效率与有效率: 低中组 (低分子右旋糖酐加中药) 分别为 65%、84%; 低蔡组 (低分子右旋糖酐加蔡草酸) 分别为 29%、41%; 中药组分别为 40%、81.8%。显示低中组疗效好, 低蔡组疗效差。对重型病例, 低中组疗效亦优于其它两组。脑梗塞发作 1 周内, 脑血管扩张剂会加重脑水肿。脑梗塞早期应用甘露醇, 然后用脑血管扩张剂可提高疗效。低分子右旋糖酐对风湿性心脏病脑梗塞易诱发心衰。复发性脑梗塞疗效差。

我们曾对收住院的 141 例急性脑梗塞病人, 进行了中西医结合治疗总结, 现报道如下。

对象与方法

一般资料: 对近 10 余年来我院所收住院的脑梗塞病人中, 选择发病在 1 周以内, 且符合下述诊断标准者共 141 例, 其中脑血栓 107 例 (包括动脉硬化 103 例, 动脉炎 2 例, 溶血性贫血 2 例); 脑栓塞 34 例 (包括风湿性心脏病 28 例, 动脉硬化性心脏病 5 例, 亚急性细菌性心内膜炎 1 例)。其中 5 例脑血栓发作 2~3 次, 1 例同侧, 4 例异侧, 均合并假性球麻痹。2 例脑栓塞发作 2~5 次, 1 例同侧, 1 例异侧伴假性球麻痹。性别: 男 79 例, 女 62 例。年龄: 一般脑血栓多为 50~70 岁之间, 脑梗塞多在 20~40 岁之间。

诊断标准: 主要参考 1986 年第二届全国脑血管病会议拟定的诊断标准。脑血栓: (1) 在安静状态下发病, 病情进展缓慢; (2) 无明显头痛和呕吐; (3) 有颈动脉系和/或椎-基底动脉系症状、体征; (4) 腰穿脑脊液一般为非血性。脑栓塞: (1) 发病急骤, 意识清楚或短暂意识障碍; (2) 有颈动脉和/或椎-基底动脉系症状、体征; (3) 腰穿脑脊液一般为非血性; (4) 有栓子来源的原发病。少数不典型病例, 头部 CT 应为低密度影。

病情程度分级: 按肌力六级分类法分为三型: (1) 重型: 主要为患侧肌力 0~1 级, 或伴有不同程度意识障碍; (2) 中型: 患侧肌力为 2~3 级, 可搀扶站立, 不能步行, 患侧无

握力; (3) 轻型: 患侧肌力 4~5 级, 可搀扶步行, 握力低于健侧。

疗效判定标准: 主要参考 1986 年第二届全国脑血管病会议讨论的疗效标准, 本文统一在治疗后 1 个月判断疗效: (1) 基本治愈: 意识清楚, 瘫痪肢体肌力恢复达 5 级, 无病残; (2) 显效: 瘫痪肢体肌力恢复达 2 级以上, 生活基本自理, 或部分需人照料; (3) 有效: 患侧肢体肌力恢复达 1 级以上, 能坐起, 或自行站立, 搀扶步行困难; (4) 无效: 患者卧床或伴意识障碍, 肌力恢复不到 1 级, 或病情继续恶化, 死亡。

治疗分组: (1) 低分子右旋糖酐加中药组 (简称低中组): 即低分子右旋糖酐 250~500ml 加丹黄注射液 (丹参、黄芪、葛根组成, 本院配制, 每毫升相当于生药各 1.0g) 12~15ml, 静脉滴注, 每日 1 次; (2) 低分子右旋糖酐 250~500ml 加蔡草酸 200ml, 静脉滴注, 每日 1 次; (3) 中药组: 丹黄注射液 12~15ml 加 10% 葡萄糖 500ml, 静脉滴注, 每日 1 次。上述三组均为 10~15 日为 1 疗程, 一般应用 1~2 疗程。

结 果

一、疗效分析: 低中组 81 例, 总有效 68 例占 84%, 其中基本治愈 33 例 (40.7%), 显效 20 例 (24.7%), 有效 15 例 (18.5%); 无效 13 例占 16%。低蔡组 27 例, 总有效 11 例占 40.7%, 其中基本治愈 1 例 (3.7%), 显效 7 例 (25.9%), 有效 3 例 (11.1%); 无效 16 例占 59.3%。中药组

33例,总有效27例占81.8%,其中基本治愈4例(12.1%),显效9例(27.3%),有效14例(42.4%);无效6例占18.2%。三组比较:低中组与中药组疗效高于低剂组(P 均 <0.01);低中组与中药组无显著差异(P 值 >0.05)。

二、三组显效率(包括基本治愈与显效)分析:低中组81例,显效53例占65.4%;低剂组27例,显效8例占29.6%。此8例均在治疗前3~5天内给以甘露醇,每次250ml,1~2次/日,然后用低剂组药物治疗;中药组33例,显效13例占39.4%。三组经统计学处理,低中组显效率高于低剂组与中药组, P 值分别 <0.01 , <0.05 ;中药组与低剂组比, P 值 >0.05 。

三、病情程度与疗效关系:低中组重型42例,有效33例占78.6%;轻、中型39例,有效35例占89.7%。低剂组27例重型17例,有效5例占29.4%;轻、中型10例,有效6例占60%。中药组33例重型12例,有效8例占66.7%;轻、中型21例,有效19例占90.5%。三组比较,低中组与中药组疗效轻、中、重型均高于低剂组,其中除重型病例,低中组与低剂组 P 值 <0.01 外,其余 P 值均 <0.05 ;低中组与中药组 P 值 >0.05 。

讨 论

一、本文对141例急性脑梗塞中西医结合疗效进行了分析,结果三组中以低中组疗效好,显效率高,低剂组疗效差。中药组三味中药配伍具有活血化瘀、补气升阳等作用,但单独应用,显效率为39.4%;低分子右旋糖酐有降低血粘度,改善微循环等作用,而单独应用显效率仅26.6%^[1]。本文将两者组合为低中组,显效率提高到65.4%,显示有相加或协同作用,临床使用安全,是目前疗效较好的方法。

二、血管扩张剂对脑梗塞的疗效评价:本文病例均在发病1周以内,从三组疗效分析以低剂组(以扩张脑血管为主)效果最差,尤其急性期重型病例更为突出。后者共17例经低剂组治疗后,无效或加重者占12例,多表现意识障碍和/或脑疝形成。从发病到给药时间,48小时以内者5例,5天以内者7例。5例有效者多

于发病1周以上开始治疗。过去认为脑梗塞在24小时以内为绝对脑缺血期,是脑血管扩张剂的应用期,而本组有2例于发病后,短至4~5小时即开始给以脑血管扩张剂,结果24小时后,1例进入昏迷,1例发展为钩回疝。根据Sage等^[2]动物实验表明,脑动脉闭塞数分钟~4小时,即出现早期脑细胞水肿;4~6小时进入血管源性脑水肿^[3]。可见,临床上对急性大面积脑梗塞,尤其伴有不同程度意识障碍者,在发病后5~7天内应用脑血管扩张剂,会加重脑水肿。为此,本文曾对8例急性期重型脑梗塞进行了试验治疗,即开始3~5天用甘露醇,然后用低剂组药物治疗,均已显示良好的治疗反应。近来,大量动物实验与临床研究表明,甘露醇不但有清除氧游离基,抑制与消除缺血区脑水肿的作用,还能降低血粘度与收缩病变区以外的脑血管,促使血液流向梗死区^[4~6],此观点与本文临床观察相一致。可见,在适当时机与控制脑水肿的前提下,脑血管扩张剂对脑梗塞仍有一定的疗效。

三、本组风湿性心脏病并发脑梗塞者,心功能均处于代偿期,多数病人对低分子右旋糖酐效果不好,容易诱发心衰与脑水肿,很可能与低分子右旋糖酐扩充血容量,增加心负荷有关,故对此类患者应以慎用或不用该药为好。此外,本文7例再发性脑梗塞,对治疗效果多不理想,其中2例无效,3例死亡。

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and resist thrombosis. Thus, it could promoted the injured cerebral cells to be recovered.

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Cerebral Infarction of 141 Cases with TCM-WM Treatment

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Acute cerebral infarction of 141 cases with treatment combining TCM and WM was reported. The significant effective rate and the effective rate were 65% and 84% in the LT group (low molecular dextran+TCM) respectively; in the LN group (low molecular dextran+Nicotinic acid) were 29% and 41% respectively; in the T group (*Salvia miltiorrhiza*+*Astragalus*+*Puraria*) were 40% and 81.8% respectively. Among them the therapeutic effect in the LT group was the best. The LT group was also superior to the other two groups in serious cases.

Cerebral edema developed following cerebrovascular dilator in a week after cerebral infarction; in the early stage, the therapeutic effect could be improved by giving mannitol first and then cerebrovascular dilator. Heart failure could be easily induced by low molecular dextran in the cerebral infarction following rheumatic heart disease. The therapeutic effect was poor in those cases with recurrent cerebral infarction.

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Observations of MEFV on 66 Cases of Asthmatics in the Convalescent Stage and After Treatment with Chinese Herbs

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This paper reported the measurement of maximal expiratory flow-volume curve (MEFV) for 66 cases of asthmatics in the convalescent stage. Among which the data of FEV, PEF, $\dot{V}_{75}$, $\dot{V}_{50}$, $\dot{V}_{25}$ in 35 cases (53.03% of the total) gave different abnormal as compared with healthy persons. It showed that in the convalescent stage, most of the asthmatics still possessed obstruction of airways, and chiefly of small airways. 35 cases of asthmatics in the convalescent stage was given the Chinese herbal decoction of chiefly invigorating Kidney (*Viscum coloratum* 15g, *Psoralea corylifolia* 15g, *Eucommia ulmoides* 15g, *Lycium chinense* 9g, *Tussilago farfara* 15g, *Artemisia capillaris* 9g, and *Pogostemon cablin* 9g as daily dosage) for treatment of 10 weeks and measuring MEFV curves to observe their changes before and after treatment. The results showed that different parameters of MEFV was improved in some extent which suggested that the airway obstruction of asthmatics in the convalescent stage was reversible. In discussion, the authors indicated that the prompt treatment for asthmatics in the convalescent stage was conductive early to prevent emphysema and confirmed that the treatment with Chinese herbs of chiefly invigorating Kidney deserved to be propagated.

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Observation on Some Parameters for Blood-Stasis, Yin(阴) Deficiency, and Yang(阳)Deficiency Types' Patients of Old Myocardial Infarction

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This paper demonstrates some investigations on the differentiation of symptom-complex for old myocardial infarction patients (OMI). Among total 100 cases, 20 cases of blood-stasis type, 28 cases of Yin deficiency type and 52 cases of Yang deficiency type. Several laboratory investigations had been carried out for them. The results indicated the level of HDL-C was decreased, LDL-C was