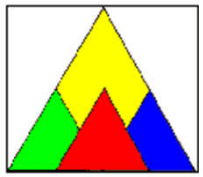
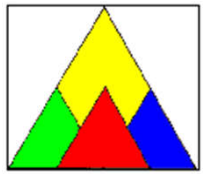


CASE REPORT
BẠCH SẢN DÂY THANH

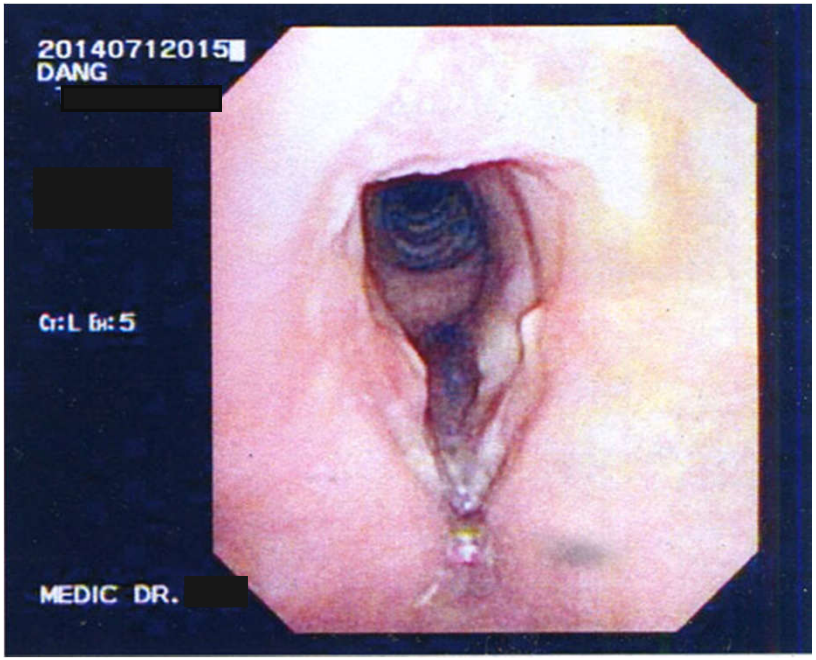
BS TRƯƠNG NGỌC LỄ

CASE REPORT 1



- Bệnh nhân:Đặng .T .L,55 tuổi
- Địa Chỉ:Phú Nhuận
- LDĐK:Khàn tiếng
- BS : Cách nhập viện 2 tháng ,bệnh nhân bị khàn tiếng ,nuốt đau .không ho,không sốt ,không ợ chua .điều trị thuốc không giảm .không tiền căn lao ,không tiền căn bệnh dạ dày ,đến Medic khám.

NỘI SOI VÒM HẦU THANH QUẢN LẦN 1

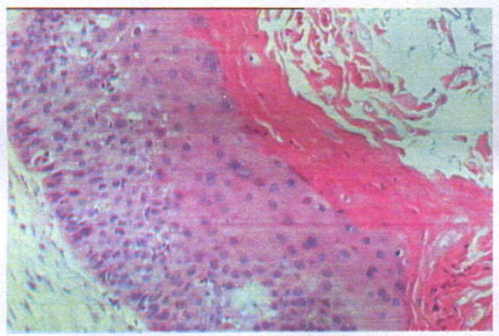


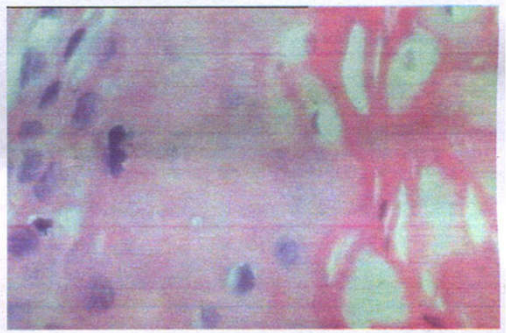
GPB

GPB VI THỂ :

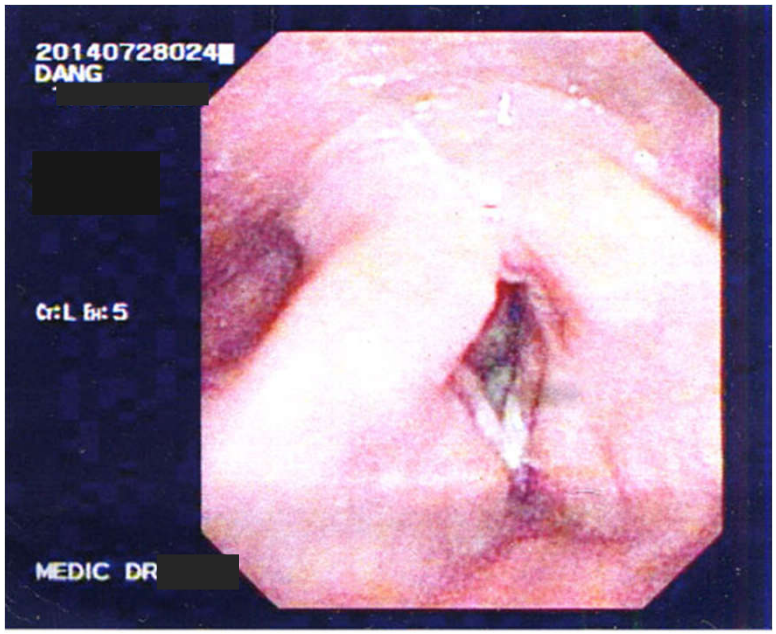
Gồm lớp thượng mô có tăng gai, tăng sừng và nghịch sừng. Mô đệm có thấm nhập viêm mạn.

KẾT LUẬN: BẠCH SẢN DÂY THANH ÂM.

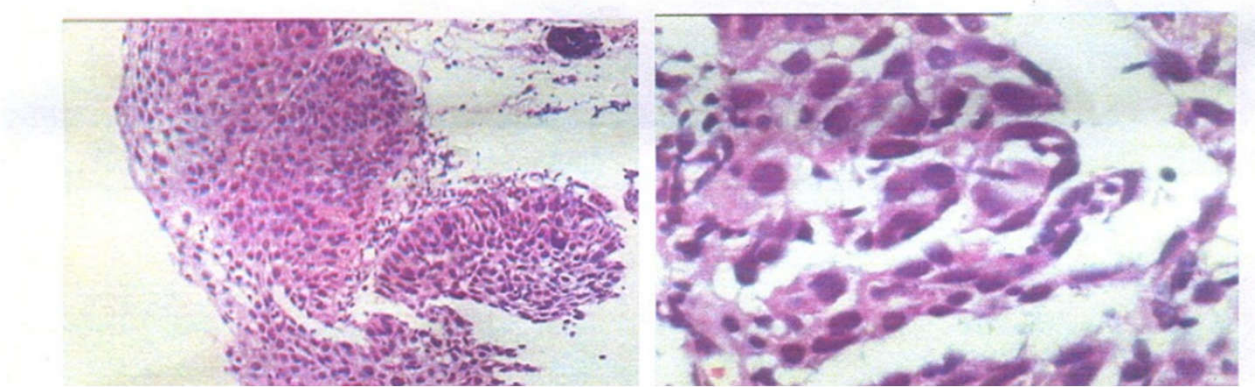




NỘI SOI VHTQ LẦN 2,SAU 2 TUẦN



SINH THIẾT LẦN 2 ,GPB

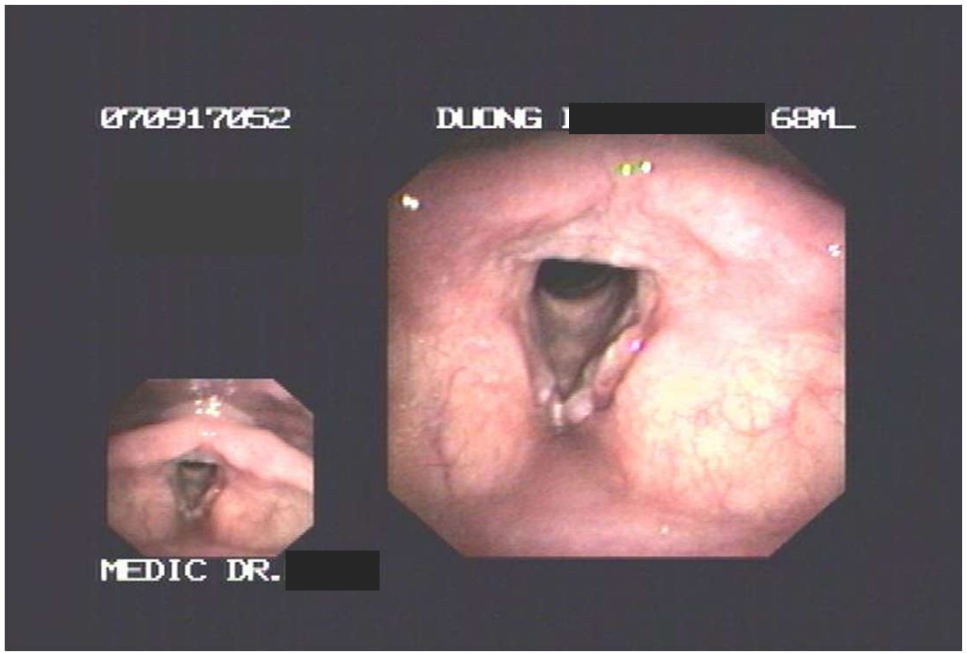


- GPB:nhiều tế bào gai tăng sản,dị dạng,nhiều nhân quái,nhân chia bất thường,hợp thành đám,không tạo sừng,xâm nhập mô đệm.
- KL:Carcinôm tế bào gai,không sừng,biệt hóa kém,độ 3 xâm nhập thanh quản.

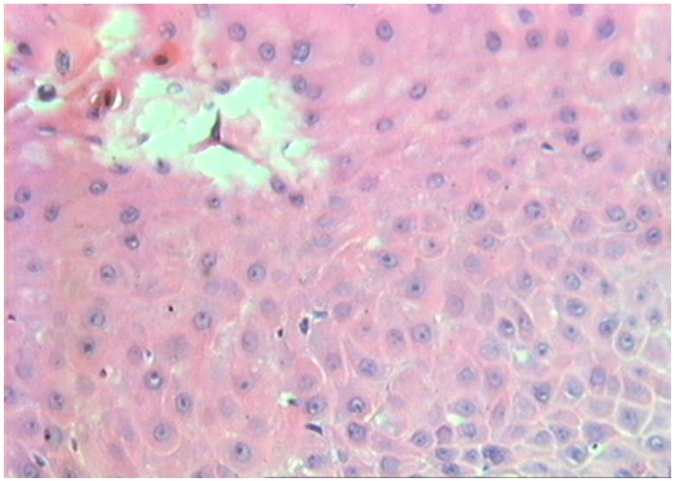
CASE REPORT 2

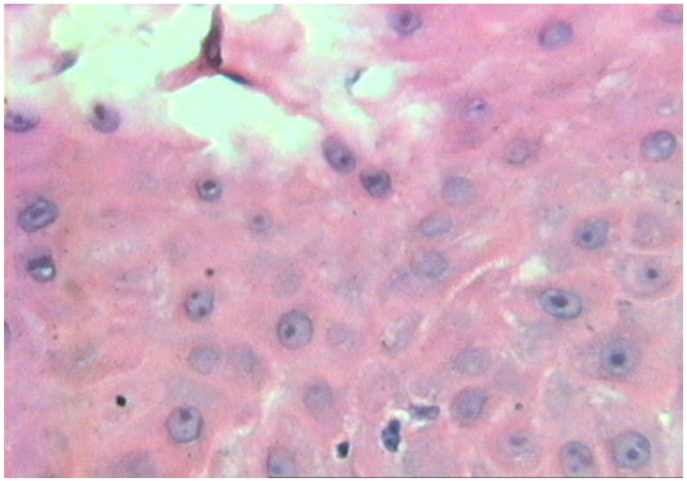
- Bệnh nhân Dương Đ.T ,nam ,69 tuổi.
- Địa chỉ : Bạc Liêu.
- LD NV: Khàn tiếng.
- BS : bệnh nhân khàn tiếng tái diễn 1 tháng ,kèm vướng họng ,điều trị thuốc giảm khàn tiếng sau đó bị khàn tiếng lại. không tiền căn bệnh dạ dày ,không hút thuốc lá,có uống rượu,đến Medic khám.

NỘI SOI VÒM HẦU THANH QUẢN



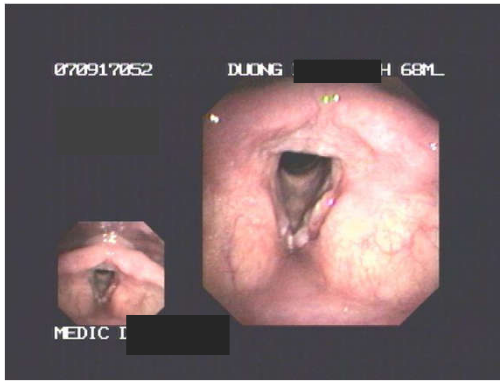
GPB

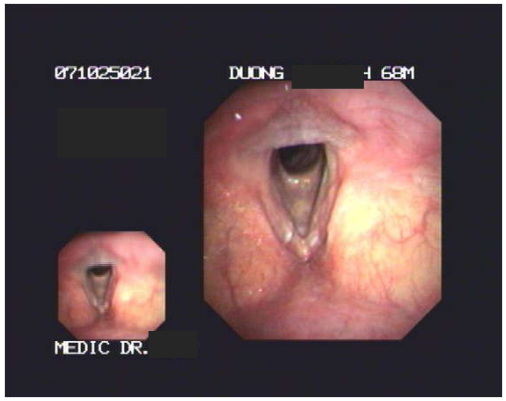


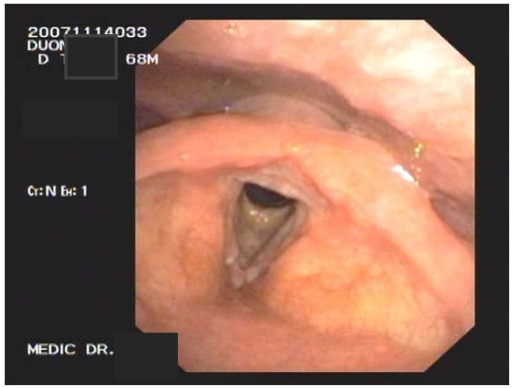


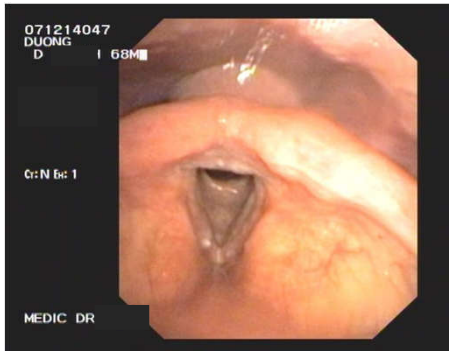
- GPB: Lớp thượng mô có tăng gai,tăng sừng và nghịch sừng.Mô đệm có thấm nhập viêm mạn
- KL: Bạch sản dây thanh âm

NỘI SOI VHTQ 4 LẦN









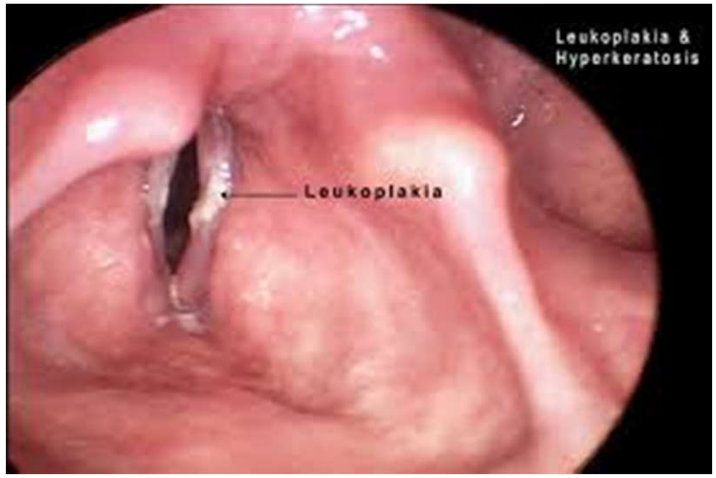
BẠCH SẢN DÂY THANH

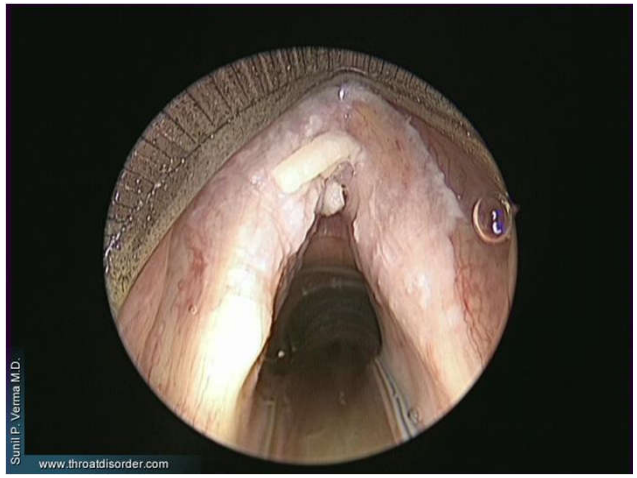
ĐN:

+ Sự quá sản của các gai nhu ,được 1 lớp niêm mạc che phủ.

+có khả năng k hóa.

+Nguyên nhân:hc trào ngược,thuốc lá,rượu..

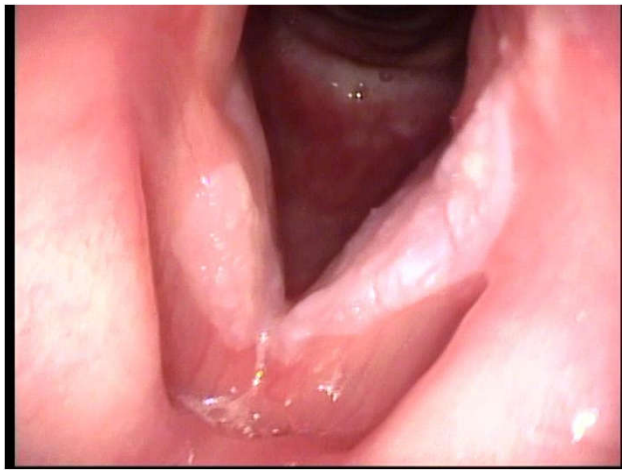




TRIỆU CHỨNG :Khan tiếng..

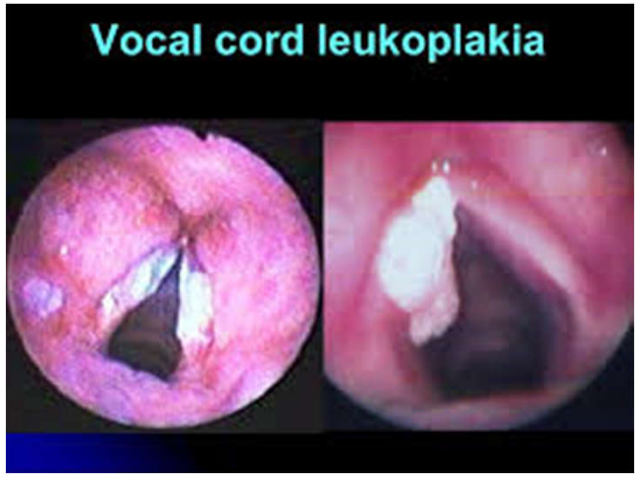
NS THANH QUẢN:

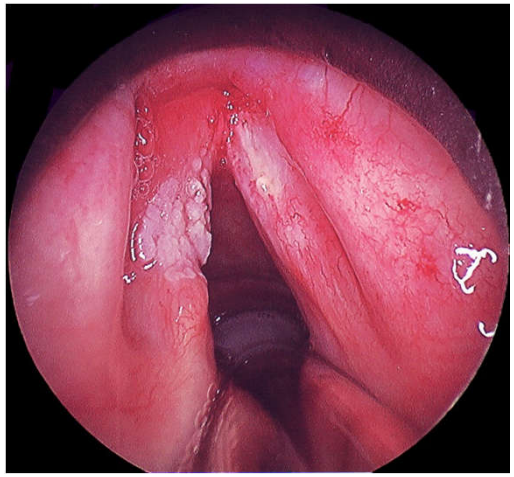
tổn thương ở 1 hay 2 dây thanh:có 1 lớp nhuyễn trắng,hay 1 lớp gai lổn nhổn trắng.



- SINH THIẾT: có thể khó khăn(vì có khi đã K rồi nhưng ST vào chổ sùi lành tính)
- GPB: lớp thượng mô tăng gai,tăng sừng và nghịch sừng.
- ĐIỀU TRỊ :

nội khoa hay sinh thiết lại hay xử trí phẩu thuật (vì xem như là 1 tiền ung thư)





BÀN LUẬN

1/Hai bệnh nhân bạch sản dây thanh:

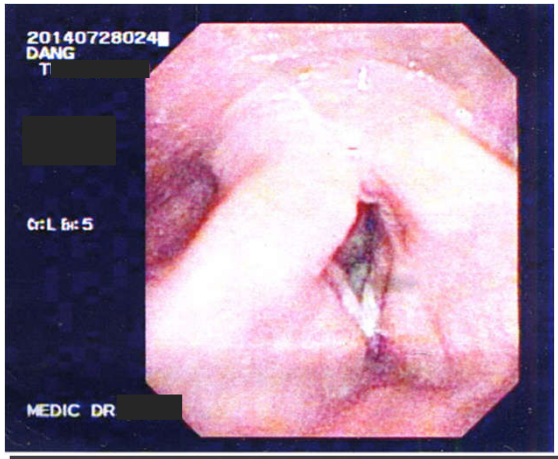
- case 1:theo dõi ,sinh thiết lại,kết quả:k thanh quản.
- case 2: kết quả: bạch sản dây thanh
- Lâm sàng có case điều trị nội,có case sinh thiết sớm lại.

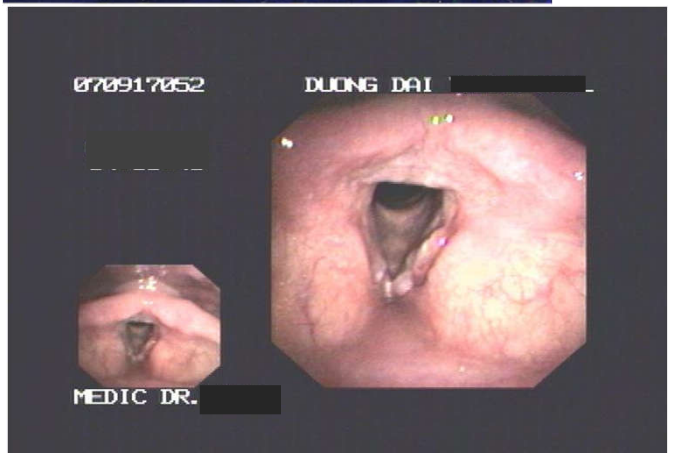
2/ **Theo dõi** để phát hiện sớm K hóa(bn 1 ,bn 2 nội soi 4 lần)

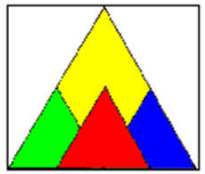
+thời gian,dấu hiệu nghi ngờ (để khuyên bn td sát sao hơn)

+nội soi thanh quản(dấu hiệu cần td)

+sinh thiết (chính xác sang thương,tổn thương K dưới mảng trắng)







› Laryngorhinootologie. 1996 Oct;75(10):611-5. doi: 10.1055/s-2007-997643.

[Multiple biopsy in diagnosis of laryngeal carcinoma]

[Article in German]

A Welge-Lüssen [1], H Glanz, C Arens, P Oberholzer, R Probst

Affiliations + expand

PMID: 9035665 DOI: 10.1055/s-2007-997643

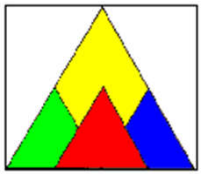
Abstract

Background: The fate of patients suffering from laryngeal carcinoma is influenced strongly by the stage of the tumor at the time of diagnosis. This factor is also critical for preservation of the organ. It may be impossible to diagnose the tumor with the first biopsy even though the clinical and macroscopic aspect suggests a malignancy.

Methods: In a retrospective study, we examined 468 patients with laryngeal carcinoma who were treated at the departments of otorhinolaryngology at the University of Basel (B) (198 patients from 1983-1992) or in Giessen (G) (270 from 1990-1995). The number of biopsies necessary to confirm the diagnosis was analysed and the follow-up of the patients was evaluated. Thirty of 32 negative histologic samples were reexamined.

Results: Of 468 patients, 32 (7%, 27 [B] 14%; and 5 [C] 2%) required two to six biopsies to confirm the clinically suspected diagnosis: Twenty patients (designated as Group 1) were diagnosed within one to three months, and no patient showed a change of tumor stage within that time. Their first biopsies have to be considered as "nonrepresentative". Eight patients (Group 2) were diagnosed within four to 24 months and four patients (Group 3) more than 24 months after the first biopsy. Final treatment and outcome in patients from Group 1 was unchanged by the time delay in diagnosing the tumor. Seven of eight patients in Group 2 experienced an obvious progression of their tumor during the diagnostic period, which led to laryngectomy in several cases. In four patients, diagnosis was confirmed more than two years after the first biopsy. These were special cases such as development of cancer out of a papillomatosis or chronic laryngitis.

Conclusions: A time delay of three months in diagnosing cancer of the larynx does not have a significant influence on organ preservation and prognosis, even though especially in small tumors suspicion of cancer should lead to a new representative biopsy as fast as possible to preserve the larynx.



Blue laser imaging endoscopy system for the early detection and characterization of colorectal lesions: a guide for the endoscopist

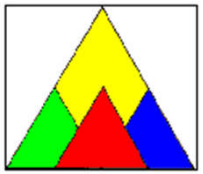
Kazutomo Togashi, Daiki Nemoto, Kenichi Utano, Noriyuki Isohata, Kensuke Kumamoto, Shungo Endo, and Alan K. Lefor

Abstract

Blue laser imaging is a new system for image-enhanced endoscopy using laser light. Blue laser imaging utilizes two monochromatic lasers (410 and 450 nm) instead of xenon light. A 410 nm laser visualizes vascular microarchitecture, similar to narrow band imaging, and a 450 nm laser provides white light by excitation. According to three recently published reports, the diagnostic ability of polyp characterization using blue laser imaging compares favorably with narrow band imaging. No published data are available to date regarding polyp detection with blue laser imaging. However, blue laser imaging has the possibility to increase the detection of colorectal polyps by depicting brighter and clearer endoscopic images, even at a distant view, compared with first-generation image-enhanced endoscopy. A clinical trial to compare the detection between blue laser imaging and xenon light is warranted.

Introduction:Gastrointestinal cancers are a leading cause of death around the world. The introduction of gastrointestinal endoscopy has revolutionized the way we detect and treat gastrointestinal cancers, particularly in patients with early stage disease. Since the early 1960s, white light endoscopy has been widely used for the detection and characterization of colorectal polyps [Wolff and Shinya, 1971, 1973]. In the 1990s, magnification endoscopy using the dye spray technique attracted colonoscopists' attention [Kudo, 1993; Axelrad *et al.* 1996; Togashi *et al.* 1999]. In the 2000s, however, it was replaced by hardware-based image-enhanced endoscopy (IEE) [Machida *et al.* 2004] because the dye-based technique is complicated and inconvenient, whereas hardware-based techniques enable the colonoscopist to easily obtain an enhanced image by simply pushing a button. The original concept of IEE also includes dye-based techniques [Kaltenbach *et al.* 2008b], but hardware-based techniques are most commonly used. IEE can be used throughout the gastrointestinal tract to improve the discrimination of the type of lesions and their malignant potential. Recently, hardware-based IEE has played an important role in not only the detection, but also in the characterization of colorectal polyps.

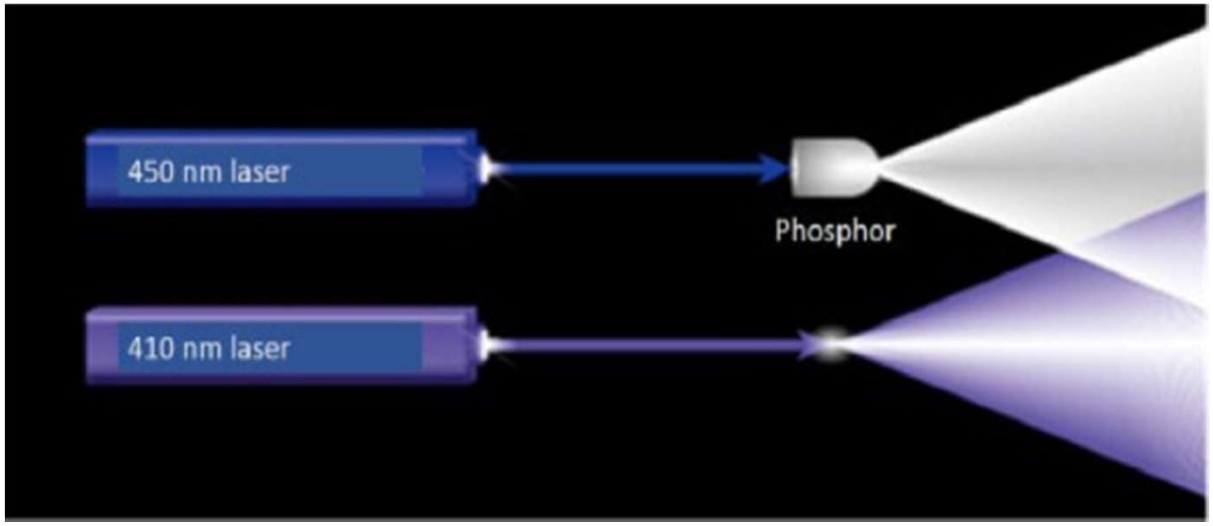
First-generation hardware-based IEE systems include narrow band imaging (NBI) [Machida *et al.* 2004], flexible spectral-imaging color enhancement (FICE) [Togashi *et al.* 2009] and i-SCAN [Hoffman *et al.* 2010a], all of which were initially released in the early 2000s. These systems do not involve injection of any dye and rely solely on hardware-based technology. However, first-generation IEEs have critical drawbacks, e.g. dark images at a distant view and low-resolution images. Thus, first-generation NBI does not demonstrate a higher adenoma detection rate than white light endoscopy in large clinical trials [Rex and Helbig, 2007; Kaltenbach *et al.* 2008a; Uraoka *et al.* 2008; Adler *et al.* 2009]. As for other hardware-based IEE techniques, one large clinical trial failed to demonstrate any objective advantage of the FICE technique over conventional high-resolution endoscopy in terms of improved adenoma detection rates [Aminalai *et al.* 2010], although a relatively small clinical trial (one arm: 100) in a single center showed a significantly higher adenoma detection rate in high-definition colonoscopy with i-SCAN, compared with standard resolution endoscopy [Hoffman *et al.* 2010b].In 2013, blue laser imaging (BLI) was released by the Fujifilm Corporation. BLI has successfully achieved a bright and clear image even at a distant view [Osawa and Yamamoto, 2014]. These capabilities may lead to improved detection of polyps and more accurate diagnoses



Principles of BLI

First, we review the principles of NBI in generating endoscopic images similar to BLI. NBI uses optical filters to change the wavelength of the transmitted light, which in turn targets the microvessels of the mucosa. NBI utilizes two kinds of light: blue light (wavelength of 415 ± 30 nm) and green light (wavelength 540 ± 30 nm). The blue light penetrates the superficial epithelium and visualizes microstructures in the mucosa as well as the submucosa. This selective narrowing of the blue and green light, and the omission of red light, increases the fidelity of the images and improves visualization of microvessels as well as surface patterns resembling pit patterns.

The word 'laser' is an acronym for 'light amplification by stimulated emission of radiation'. Laser light is characterized by spatial and temporal coherence, resulting in clearer images for vessel/surface microstructure of the mucosal surface through 'further narrowing'. BLI uses two monochromatic lasers (410 ± 10 nm and 450 ± 10 nm) instead of xenon light to obtain image enhanced endoscopy, as shown in Figure 1. The 410 ± 10 nm laser is vital to visualize the vascular microarchitecture on the mucosal surface. The 450 ± 10 nm laser provides white light by excitation. This laser stimulates the white light phosphor in the tip of the endoscope to produce broadband white light, providing the standard view obtained with conventional xenon light sources. The brightness of the white light is controlled by the laser output power. In addition, longer wavelength light such as a 450 ± 10nm laser is less absorbed by small vessels and reaches the deeper layers in the tissue, thus depicting larger blood vessels in the deeper layers.



Laser illumination using two lasers and white light phosphor.

A 410 nm laser looks blue light. A 450 nm laser stimulates the white light phosphor in the tip of the scope to produce the broadband white light.

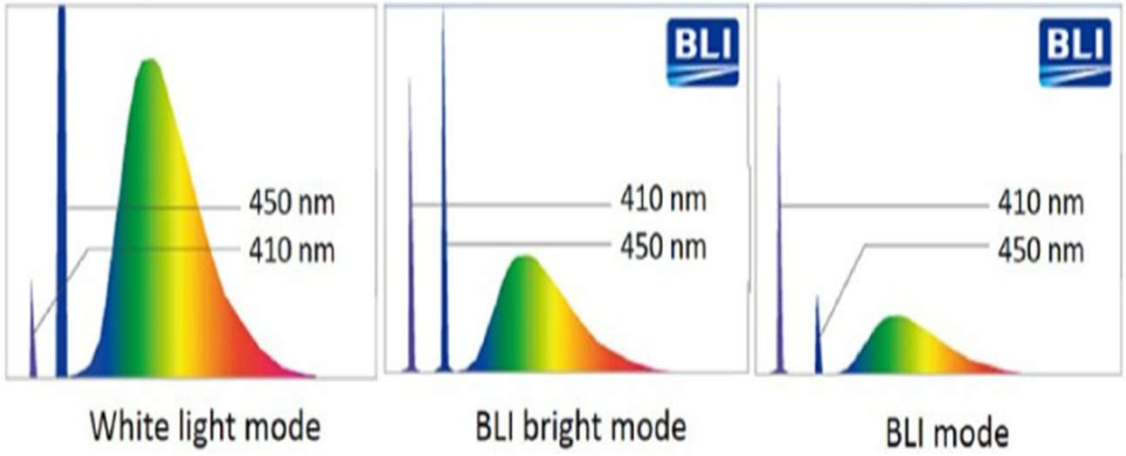


Figure 2.

Light spectrum in each mode.

Note: white light mode contains 410 nm laser light

Recommended approach

It is important to match the mode and application properly. At the beginning, perform an overall observation of the lesion using the white light mode with normal magnification. As mentioned above, white light mode may provide a clearer image than that using xenon light. Next, the BLI-bright mode without magnification is applied. The extent of the lesion should be evaluated using this mode. Then, use the BLI-bright mode to identify the region with advanced histological atypia based on changes in color tone and superficial structure. Finally, apply the BLI mode to obtain magnified images of the surface pattern and vascular pattern by focusing on the region identified. An example of such a region is shown in Figure 3 (adenoma) and Figure 4 (nonadenoma).

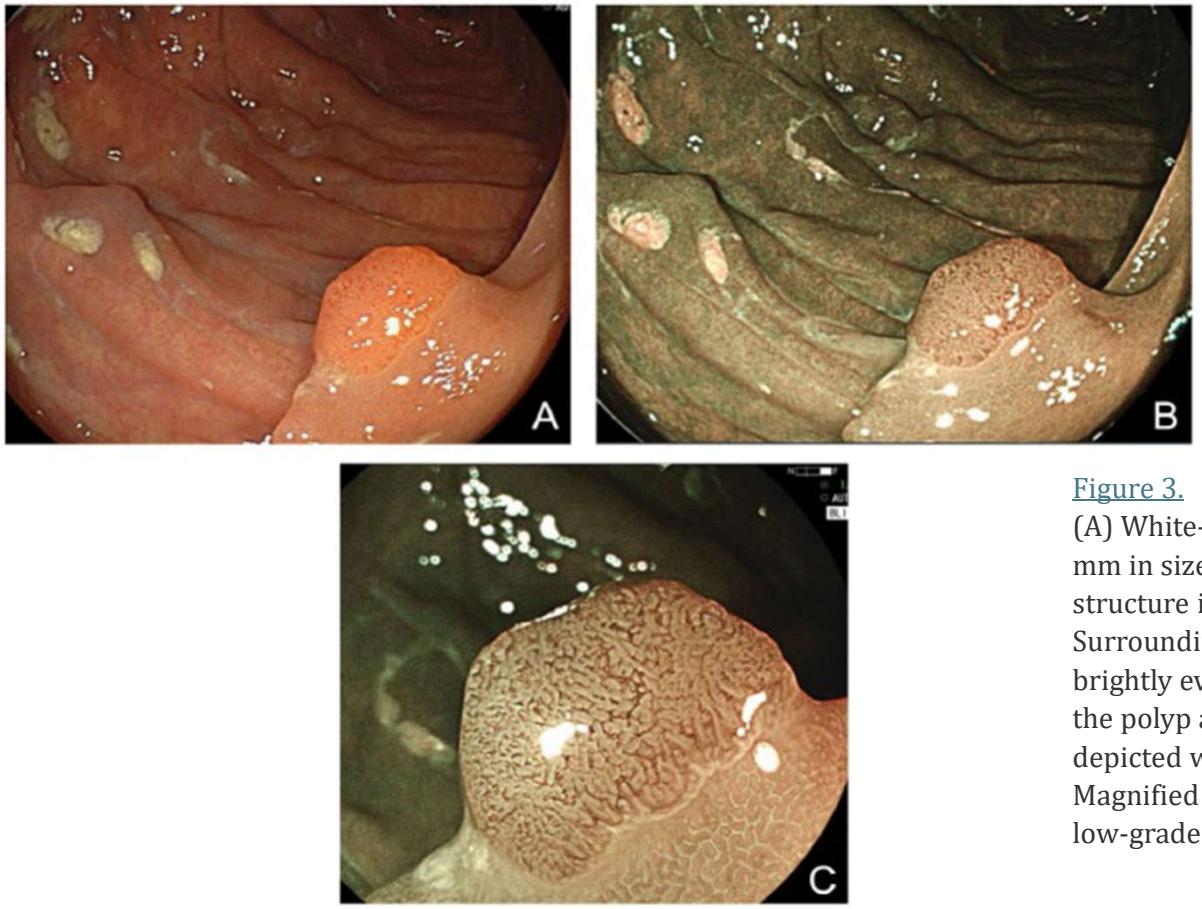


Figure 3.

(A) White-light mode. A sessile adenoma measuring 6 mm in size is clearly identified, but its superficial structure is not depicted clearly. (B) BLI-bright mode. Surrounding normal mucosa is depicted clearly and brightly even in a distant view. The vessel pattern of the polyp as well as the surface pattern is clearly depicted without magnification. (C) BLI mode. Magnified view shows a regular structure, suggesting a low-grade adenoma.

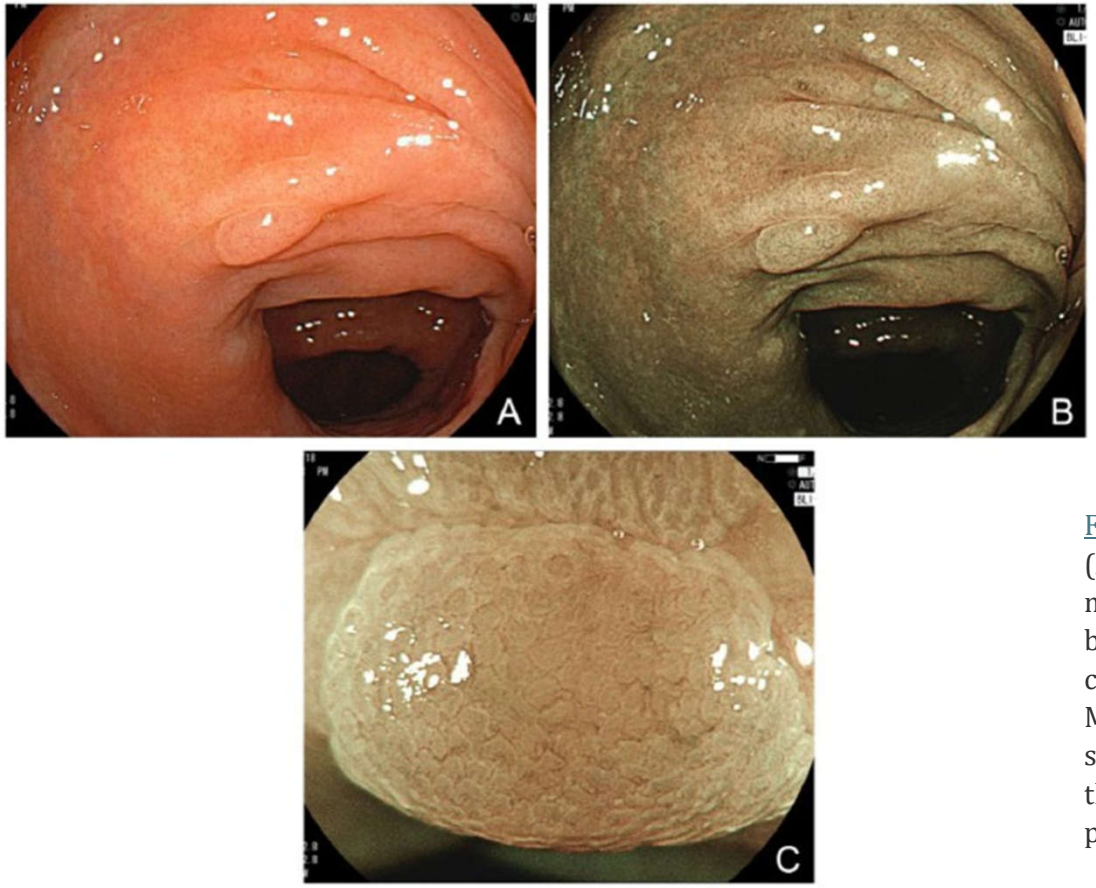


Figure 4.

(A) White-light mode. A hyperplastic polyp measuring 6 mm shows a pale appearance. (B) BLI-bright mode. Demarcation line of the polyp is clearly seen in a distant view. (C) BLI mode. Magnified view does not show any distinct structure, but only small vessels are observed on the polyp surface, suggesting a non-neoplastic polyp.

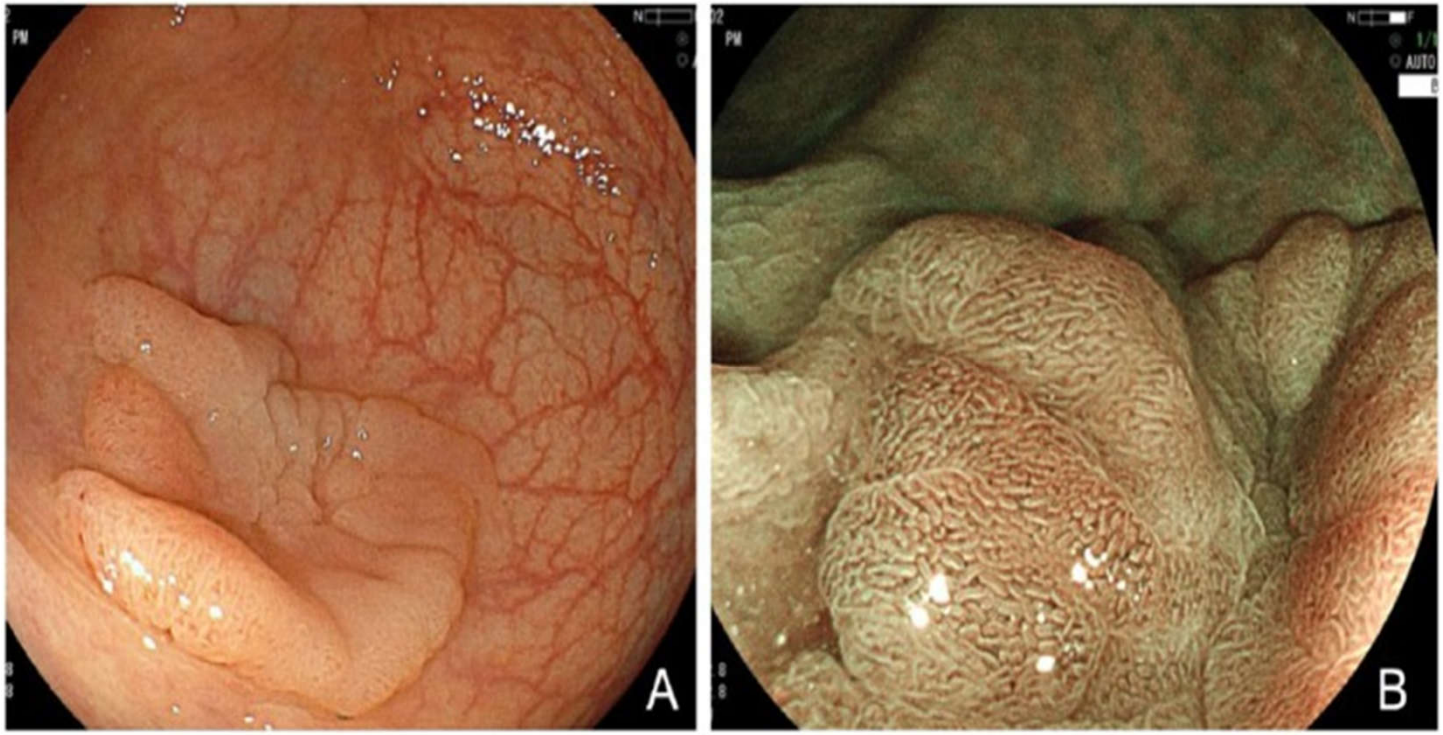


Figure 5.
(A) White-light mode. Laterally spreading tumor measuring 28 mm in maximum size is clearly identified in a plain image. (B) BLI mode. Magnified view shows regularly arranged structure, suggesting a low-grade tubular adenoma.

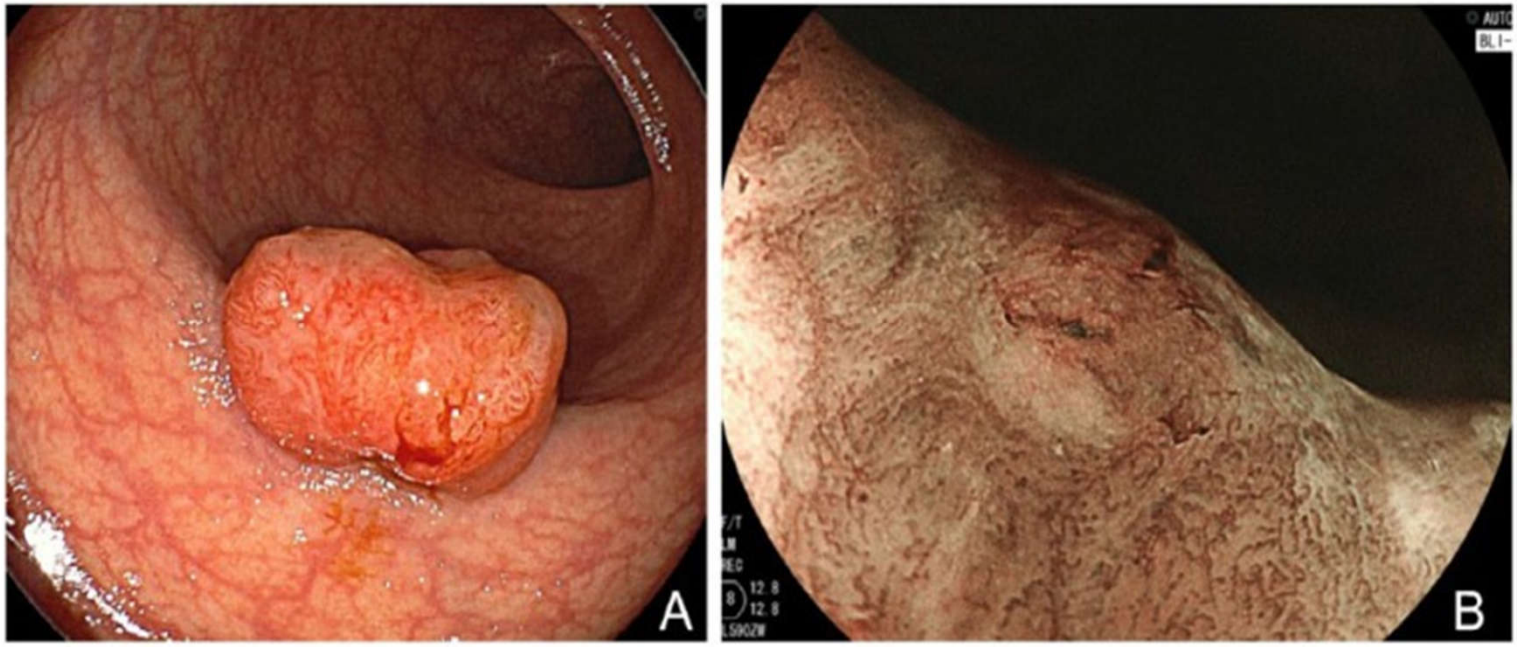
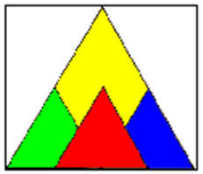


Figure 6.

(A). White-light mode. Protruding tumor measuring 18 mm shows an irregular surface in a plain image. (B) BLI mode. Magnified view shows an irregular vascular pattern and an avascular area can be seen partially. Surface pattern also shows irregularity. These finding definitely indicates substantially invasive cancer.



Ability of a novel blue laser imaging system for the diagnosis of colorectal polyps

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Abstract

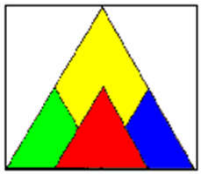
Background: A new endoscope system with a laser light source, blue laser imaging (BLI), has been developed by Fujifilm that allows for narrow-band light observation. The aim of the present study was to evaluate the utility of BLI for the diagnosis of colorectal polyps.

Methods: We retrospectively analyzed 314 colorectal polyps that were examined with BLI observation at Kyoto Prefectural University of Medicine between September 2011 and January 2013. The surface and vascular patterns of polyps detected by published narrow-band imaging magnification: Hiroshima classification were used. Correlations were determined between the classifications and the histopathological diagnoses. Additionally, the ability of BLI without magnification to differentiate between neoplastic or non-neoplastic polyps was analyzed.

Results: A total of 41 hyperplastic polyps, 168 adenomas, 80 intramucosal cancer, 11 shallowly invaded submucosal cancer, and 14 deeply invaded submucosal cancer were analyzed.Hyperplastic polyp was observed in 100% of Type A lesions (39 lesions), adenoma was observed in 89.3% of Type B lesions (159 lesions), intramucosal cancer and shallowly invaded submucosal cancer was observed in 69.6% of Type C1 (92 lesions) and in 84.6% of Type C2 (13 lesions), and deeply invaded submucosal cancer was observed in 81.8% of Type C3 lesions (11 lesions). The overall diagnostic accuracy of BLI with magnification was 84.3%. Additionally, the diagnostic accuracy of BLI without magnification for differentiating between neoplastic and non-neoplastic polyps <10 mm in diameter was 95.2%, which was greater than that of white light (83.2%).

Conclusion: BLI was useful for the diagnosis of colorectal polyps.

Diagnostic value of blue laser imaging combined with magnifying endoscopy for precancerous and early gastric cancer lesions



Yang Zhenming [1], Shen Lei [1]

Abstract

Background/Aims: Blue laser imaging (BLI) is a new technique for detailed examination of upper gastrointestinal lesions. This study aimed to evaluate the diagnostic value of BLI combined with magnifying endoscopy for precancerous and early gastric cancer lesions.

Materials and Methods: A total of 249 gastric lesions detected via conventional white light endoscopy (WLE) based on assessments of mucosal shape and color were included in this study. The accuracy of diagnosis of precancerous or early cancer lesions white light magnification alone, BLI-contrast magnification, and BLI-bright magnification was determined according to the VS criteria.

Results: For white light magnification alone, BLI-contrast magnification, and BLI-bright magnification, the concordance rates for lesions were 76.7%, 85.1%, and 86.7%, respectively, and the Kappa values were 0.571, 0.730, and 0.760, respectively. For the screening of high-grade intraepithelial neoplasia or early gastric cancer, the diagnostic sensitivities of white light magnification alone, BLI-contrast magnification, and BLI-bright magnification were 72.0%, 92.0%, and 92.0%, respectively; the specificities were 95.5%, 98.2%, and 99.1%, respectively; the consistencies were 93.2%, 97.6%, and 98.4%, respectively; and the Kappa values were 0.642, 0.871, and 0.911, respectively. For diagnoses of high-grade intraepithelial neoplasia or early gastric cancer, the concordance between endoscopic and pathological diagnosis was significantly higher for BLI-contrast and BLI-bright magnification than for white light magnification alone ($p<0.05$).

Conclusion: BLI combined with magnifying endoscopy may improve diagnostic accuracy for early gastric cancer and precancerous lesions.

Blue laser imaging-bright improves the real-time detection rate of early gastric cancer: a randomized controlled study

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Background and Aims

Blue laser imaging-bright (BLI-bright) has shown promise as a more useful tool for detection of early gastric cancer (EGC) than white-light imaging (WLI). However, the diagnostic performance of BLI-bright in the detection of EGC has not been investigated. We aimed to compare real-time detection rates of WLI with that of BLI-bright for EGC.

Methods

This was a prospective, randomized, controlled study in 2 Japanese academic centers. We investigated 629 patients undergoing follow-up endoscopy for atrophic gastritis with intestinal metaplasia or surveillance after endoscopic resection of EGC. Patients were randomly assigned to receive primary WLI followed by BLI-bright or primary BLI-bright followed by WLI. The real-time detection rates of EGC were compared between primary WLI and primary BLI-bright.

Results

There were 298 patients in each group. The real-time detection rate of EGC with primary BLI-bright was significantly greater than that with primary WLI (93.1% vs 50.0%; *P* = .001). Primary BLI-bright had a significantly greater ability to detect EGCs in patients with a history of endoscopic resection for EGC, no *Helicobacter pylori* infection in the stomach after eradication therapy, lesions with an open-type atrophic border, lesions in the lower third of the stomach, depressed-type lesions, small lesions measuring <10 mm and 10 to 20 mm in diameter, reddish lesions, well-differentiated adenocarcinomas, and lesions with a depth of invasion of T1a.

Conclusions

BLI-bright has a higher real-time detection rate for EGC than WLI. BLI-bright should be performed during surveillance endoscopy in patients at high risk for EGC. (Clinical trial registration number: UMIN000011324.)

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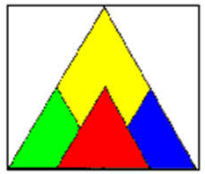


- BLI giúp tăng độ chính xác.
- Xác định rõ hơn,giai đoạn sớm hơn các khu vực nghi ngờ tổn thương,tránh bỏ sót tổn thương K.
- Sinh thiết chính xác vùng nghi ngờ K, vùng rìa tổn thương.
- Theo dõi hiệu quản sau sinh thiết,sau điều trị.

Theo thống kê của Globocan năm 2020, mỗi năm Việt Nam có khoảng 182.563 ca mắc mới và 122.690 ca tử vong do ung thư. Ước tính, cứ 100.000 người thì có 159 người chẩn đoán mắc ung thư mới và 106 người tử vong do ung thư, thường gặp nhất là ung thư dạ dày, ung thư thực quản và ung thư đại trực tràng.

Ung thư đường tiêu hóa có thể chữa khỏi hoàn toàn nếu được phát hiện sớm và can thiệp điều trị kịp thời, đúng cách. Việc thực hiện nội soi tiêu hóa được xem là phương pháp tiên tiến nhất giúp phát hiện sớm các yếu tố nguy cơ, can thiệp kịp thời, ngăn chặn biến chứng nguy hiểm, đặc biệt là nguy cơ đe dọa tính mạng.

xem thêm

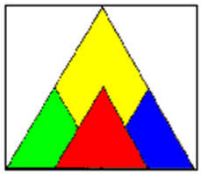
THIẾT BỊ

Trung tâm Nội soi & Phẫu thuật Nội soi Tiêu hóa, Bệnh viện Đa khoa Tâm Anh được đầu tư xây dựng khang trang theo mô hình hiện đại, bố trí hệ thống kiểm soát chất lượng đạt chuẩn quốc tế, đảm bảo các yêu cầu về mặt kỹ thuật và điều kiện vô khuẩn tại phòng nội soi và phẫu thuật.

Hệ thống trang thiết bị, máy móc được nhập khẩu đồng bộ từ các quốc gia tiên tiến như hệ thống nội soi Fuji 7000, hệ thống phẫu thuật nội soi 3D/4K ICG Rubina Karl Storz, đặc biệt là dụng cụ phẫu thuật robot cầm tay cơ học … cho phép Trung tâm Nội soi & Phẫu thuật Nội soi Tiêu hóa, Bệnh viện Đa khoa Tâm Anh tự tin làm chủ các kỹ thuật nội soi và phẫu thuật nội soi hiện đại, khắc phục tối đa những nhược điểm của các phương pháp truyền thống, đem đến kết quả điều trị tốt nhất cho bệnh nhân.

- ***Hệ thống nội soi Fuji 7000***

Sự xuất hiện của hệ thống nội soi Fuji 7000 đến từ thương hiệu Fujifilm (Nhật Bản) được xem là thành tựu to lớn của kỹ thuật nội soi trên thế giới. Dây soi 7000 được trang bị công nghệ hình ảnh mới nhất, có khả năng phóng đại lên đến 140 lần giúp quan sát tất cả các tổn thương có ở đường tiêu hóa, kể cả những tổn thương có kích thước nhỏ và phức tạp mà mắt thường không thể nhận ra.



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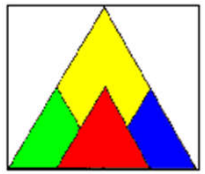

CÁM ƠN QUÝ THẦY CÔ VÀ CÁC ANH CHỊ ĐÃ THEO DÕI