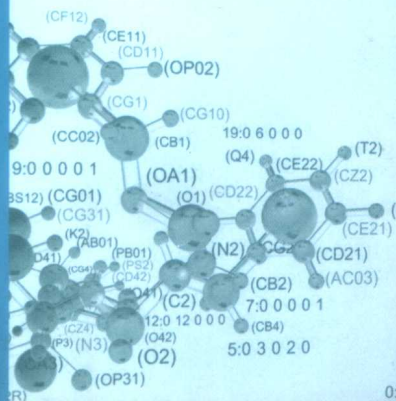




CASE STUDY IN INTERNAL MEDICINE BILINGUAL LEARNING

副主编 刘天舒 陈宗禹



全国高等学校配套教材
供⑧年制及7年制临床医学等专业用

内科临床病例分析 ——双语学习

CASE STUDY IN INTERNAL MEDICINE
—BILINGUAL LEARNING

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序

近半个世纪以来,自然科学和技术科学发展迅速,而医学科学的进展更是日新月异。医学工作者如果不了解医学的新理论、新概念、新方法和新技术,就会落后于时代。及时了解国际的学术和科技进展,只能借助于外语,而全球通用的外语是英语,因此掌握英语已是医学生和青年医生提高学术和业务水平的不可或缺的重要途径。

为了提高医学生和青年医生的英语水平,王吉耀教授组织编写了这本汉英对照的《内科临床病例分析——双语学习(Case Study in Internal Medicine——Bilingual Learning)》,目的是使医学生和青年医生在临床实践中多接触医学英语,从而进一步培养他们阅读医学英语书刊的能力。我认为这种英语学习的方式很好,是一个创举,也说明了掌握一门外语只能在实际应用中达到目的。

为了帮助医学生和青年医生阅读英语医学原著的能力,我曾于1991~1997年间主编了一套英汉对照医学读物,共15册(上海科学技术出版社出版),它们是:解剖学、生理学、病理学、生物化学、药理学、微生物学、内科学、外科学、妇产科学、儿科学以及诊断学、传染病学、五官科学、神经精神病学、皮肤病学。原文均选自英美的该学科名家著作(获得作者同意),出版后深受广大读者的欢迎。但由于这套英汉对照医学读物仅仅是供自学者学习,究竟能发生多大作用,我认为很难达到预期的目的。今天王吉耀教授提出了另一种学习方式,即在临床实践中通过实际应用(英语医疗查房或讨论和英语病例书写)学习英语,深信这种方式更加有效,提高英语水平更快,值得推广。

我个人深深体会到掌握英语的重要性。在参加国际学术会议时,英语是“法定用语”(official language)。掌握英语的所谓“四会”,首先是听,然后是讲。由于不能听懂英语的学术报告,也就无法提出问题,参加讨论,从而使外国学者误认为我国学者的学术水平不高。

英语已被公认为“世界语”、“科学语”,希望医学生和青年医生通过这种双语学习,丰富自己的现代医学知识。王吉耀教授提出的这种学习医学英语方式是一个创举,期望其他专科也与王吉耀教授一样,组织编写“双语学习”,让医学生和青年医生掌握英语,运用英语,从而让中国医学更快地走向世界,而让世界认识中国医学的先进水平。

为此,我欣然命笔作序,并推荐这种学习医学英语的方式给广大的医学生和青年医生。

裘法祖

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2004年除夕

序 二

近二十多年来,我国执行对外开放政策,各行各业与国外的交流日益增多,医学界也不例外。英文和英语是国际上通行和公用的文字语言,其重要性自不待言,由于诸多原因,国内医学院校以往在英语教学方面不够全面,有只重读、写能力而忽略听力和口语的偏向,因此,我们培养的医生与国外同行用英语直接交流的能力较差,现在的状况虽已有所改进,从医学院毕业的医生完全不懂专业英语的已经极少,能读懂也能写英文专业文章的人逐渐增多;但在国际学术会议上能完全听懂国外专家学术报告的较少,而能直接和外宾对话、讨论交流的则更少。

谁都知道,如果能在英语环境里,例如在英语国家里或在只用英语的工作单位里学习英语,通过耳濡目染,经常使用英语,必然会事半功倍地学得更快更好。

为了提高医学生、研究生和临床医生的医学英语程度和使用能力,王吉耀教授积多年教授内科学、编写大学教材和主持日常查房的感受,最近发起、组织并编写了一本中英文对照的《内科临床病例分析——双语学习 (Case Study in Internal Medicine ——Bilingual Learning)》,内容包括病史和检查记录,以及有关诊断、治疗等的讨论文句,作为学习运用英语书写病史记录或口头汇报病情的参考资料,主要在英语医疗查房或病例讨论时参考使用。书中的英文词句主编者已约请在美国工作多年的毕业于复旦大学上海医学院的华裔医生认真仔细修改和审核,力求尽量符合英语国家医生的表达方式。

我觉得本书很有创意,是一本切合当前实际的好书,一定会受内科临床医生和医学生的欢迎。当然在使用过程中,难免会发现这样或那样的缺点、不足,甚至错误,这些都可以通过逐步修正以臻完善。

朱元耀

2004年12月20日

前言

英文病例的书写和英语查房是内科学双语教学中的一个重要组成部分,是培养当今医学生和医师对外交流能力的途径之一。针对目前我国七年制和八年制医学生床旁学习和教学的需要,我们组织了复旦大学上海医学院内科系各临床科室主任编写这本临床中英文对照的病例分析,作为医学生临床见习和实习时辅助材料及英语查房范例。我们根据内科学各系统疾病设计编写大纲,选择病种编写典型病例。在编写时以症状为题,给予初诊时的临床资料,然后逐步深入,根据所给资料和临床思路进行诊断和鉴别诊断,再给予治疗方案,最后给予点评,是以临床问题为线索的床旁学习。同时用中英文对照形式书写,使读者在训练临床思维过程的同时,了解英语病例书写方式,熟悉英语专业词汇及用法,如能配以朗读可提高英语会话能力。本书也可作为临床医师及研究生的参考用书。使用本书时,可以循序渐进,即对于英语基础较差的医师或尚无条件开展双语教学的学校,可以先以中文病史训练临床思维,然后对照中文阅读英文。在此基础上逐渐增加英文病史的朗读并纠正发音,达到熟读及会话,最终达到能针对自己的临床病人、书写英文病史进行英文查房的目的。

本书编写过程中得到了各位编委的大力协助,编写者大多是有研究生学位又在临床第一线工作的医师,有的是留学回国的博士。虽然我和副主编刘天舒副主任对文稿的英文部分作了初步修改,仍担心本书英语部分书写的准确性和能否与国外接轨。2004年5月正值我在美国访问期间,遇见我校英文班毕业生、美国明尼苏达大学医学博士、明尼苏达大学医院消化科陈宗禹医师,我邀请他担任本书副主编,怀着愿为祖国医学教育贡献一份力量的满腔热情,他欣然接受邀请,根据美国医学英语的习惯用法,在百忙中耗费大量时间为本书文稿的英语部分逐字修改。他还邀请了我校另一位英文班毕业生、目前在美国佛罗里达大学医学院任内科助理教授、主治医师的陆颖博士一起参加英文病例的修改工作。另有毕业后留美的刘维田医师(我的博士生),在进入哈佛医学院做消化科医生前夕的繁忙工作中,也抽时间协助中英文病例修改工作,使本书的质量得以保证。我的导师朱无难教授为本书作序;秘书高虹博士努力为本书编写协调和组稿。最使人感动的是我国著名的医学教育家裘法祖院士,在他90岁寿诞前夕看到我们的书稿后,百忙中欣然为本书作序。在此一并表示感谢。由于我们是初次尝试,虽然尽力但因缺乏经验、水平有限,如有错误及疏漏之处,恳请读者不吝赐教,批评指正。

主 编

王吉耀

2005年1月

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第1章

Chapter One

呼吸系统疾病

Disorders of the Respiratory System

慢性阻塞性肺病——反复咳、痰、喘 20 年

Chronic Obstructive Pulmonary Disease (COPD)—repeated cough, sputum production and dyspnea for 20 years

A 87-year-old male patient, retired worker, was admitted because of “repeated cough, sputum production and dyspnea for 20 years with 1 week exacerbation”. Twenty years ago, the patient began to have productive cough with white frothy sputum and dyspnea, mostly in autumn and winter or induced by cold. Its longest lasting time was more than 3 months. His symptoms responded to oral antibiotics and traditional Chinese medications. In the latest 4 years, the patient developed increasing dyspnea after exertion. He had pulmonary function test (PFT) and was diagnosed as “obstructive emphysema”. About 1 week before admission, the patient got a cold and had a productive cough and increasing dyspnea. His sputum turned from white frothy to purulent. He denied fever, night sweat, chest pain, weight loss and limb edema. The blood routine in a local hospital showed “WBC $14 \times 10^9/L$, N 79.7%” and blood pressure was elevated to 200/105mmHg. He was given anti-infection and

患者，男性，87岁，退休工人，因“反复咳、痰、喘20年，加重1周”入院。患者20年前出现咳嗽、咳痰、气喘，痰为白色泡沫样，每年多在秋冬季发作或受凉诱发，每年持续3个月以上。每次发作到医院就诊，予口服抗生素、中药等治疗后症状可缓解。近4年来，患者逐渐出现活动后气促，曾行肺功能测定，诊断为“阻塞性肺气肿”。1周前，患者受凉后出现咳嗽、气喘加重，由白色粘痰转为黄色脓痰，无发热，无盗汗，无胸痛，无消瘦，无下肢水肿，至当地医院查血常规示：WBC $14 \times 10^9/L$ ，N 79.7%，BP 200/105mmHg，予抗感染、降压治疗。次日，患者因症状加重来我院急诊。心电图示“窦性心动过速、肺型P波，偶发室早”，头颅CT示“老年脑改变”。2天后患者体温上升至38.7℃，急诊X线胸片示“肺气肿，慢支感染”，血常规示“WBC $8.3 \times 10^9/L$ ，N 80.2%”，予环丙沙星等抗感染，症状无明显好转，为进一步诊治收入院。

患者有高血压史2年，最高达230/110mmHg。无糖尿病史，无肝病、肺结核

anti-hypertension therapy but his symptoms became worse on the following days. 2 days later, he was sent to our emergency department. EKG showed "sinus tachycardia, pulmonary P wave, occasionally ventricular premature beats". Head CT showed "senile changes". Later, his temperature rose to 38.7℃, and chest X-ray showed "pulmonary emphysema, and chronic bronchitis complicated with infection". The blood routine showed "WBC $8.3 \times 10^9/L$, N 80.2%". After treatment with cyprofloxacin and other antibiotics, he didn't get better and was hospitalized.

He has 2-year history of hypertension, the highest blood pressure was 230/110mmHg. No history of diabetes, liver disease, tuberculosis and other contagious diseases.

He had smoked 20 cigarettes every day for over 40 years and quit smoking about 10 years ago. Denied alcohol use. He is married, having a daughter and a son; his wife and children are in good health. No history of hereditary diseases.

Physical examination: T: 37.1℃, P: 80bpm, R: 22bpm, BP: 170/70mmHg. Conscious, thin, no jaundice, no palpable superficial lymph nodes. The pupils are equal and responsive to light. Mild cyanosis seen on lips. Soft neck. Trachea in midline. Barrel chest with symmetric bilateral respiratory movements. No apophysis or focal tenderness. Positive hyperresonance on percussion. The liver dullness border was at the point of the sixth intercostal space and the right midclavicular line. Decreased breath sounds without obvious rhonchi and moist rales. No precordial heave. PMI (point of maximal impulse) and cardiac border were within

病等传染疾病史。

患者有抽烟史 20 支/日 × 40 余年, 已戒 10 年。不嗜酒。已婚, 育有 1 子 1 女, 妻子与子女皆体健。无家族性遗传疾病史。

入院时体格检查: T: 37.1℃, P: 80 次/分, R: 22 次/分, BP: 170/70mmHg。神欠清, 体型瘦, 全身皮肤、粘膜无黄染, 浅表淋巴结不大。两侧瞳孔等大, 对光敏感。口唇轻度发绀, 颈软, 气管居中, 桶状胸, 胸部呼吸运动对称, 无异常隆起, 无压痛, 两肺叩诊过清音, 肝浊音界在右锁骨中线第 6 肋间, 听诊两肺呼吸音低, 未闻及明显干湿啰音。心前区无异常隆起, 心尖搏动局限, 心界在正常范围内, 心率 80 次/分, 律不齐, 偶及早搏, 心音遥远, 各瓣膜听诊区未闻及病理性杂音。腹平软, 无压痛, 肝脾肋下未及。无杵状指, 双下肢无浮肿。NS (-)。

normal limit. Heart rate was 80bpm with arrhythmia and premature beats. Heart sound was distant. No pathologic cardiac murmur at each valvular area. The abdomen was soft, nontender and without rebound. Liver and spleen were non-palpable below the ribs. No edema of the lower limbs. NS (-)

CLINICAL THINKING (I)

The diagnosis of the patient is “chronic bronchitis and chronic obstructive pulmonary disease (COPD)”. The diagnosis of chronic bronchitis was based on his history of repeated cough, sputum production and dyspnea for 20 years. The sputum was white and his symptoms occurred mostly in autumn and winter and could be induced by cold. Its longest lasting time was about 3 months. No history of tuberculosis, bronchial asthma or bronchiectasis. COPD is characterized by chronic bronchitis and emphysema with airflow obstruction or chronic bronchitis complicated with emphysema. The patient had a long history of smoking and chronic bronchitis and had barrel chest. The pulmonary function test showed “obstructive emphysema”. Therefore the diagnosis of COPD can be established. In the latest 4 years the patient developed progressive dyspnea on exertion. EKG showed pulmonary P wave. Clinically he had entered the stage of pulmonary heart disease. The current treatment priority is to control the infection with antibiotics, relieve bronchospasm, correct hypoxia with supplemental oxygen and reduce the inflammation to prevent the progression of the disease.

CLINICAL COURSE (I)

On the admission day, the blood gas analysis

临床思维 (I)

该病人诊断考虑“慢性支气管炎、慢性阻塞性肺病”。慢性支气管炎的诊断依据：反复咳、痰、喘20余年，痰为白色泡沫样，每年多在秋冬季发作，常持续3个月。排除肺结核、支气管哮喘、支气管扩张疾病。具有气流阻塞的慢性支气管炎、肺气肿或慢性支气管炎合并肺气肿为COPD，而患者有多年的吸烟史，有长期的慢支史，体检示桶状胸，曾行肺功能测定诊断为“阻塞性肺气肿”，故诊断COPD成立。而该病人近4年来进行性呼吸困难，心电图也有肺型P波的表现，根据临床已合并有慢性肺源性心脏病。目前当务之急是加强抗感染治疗，并进行平喘祛痰、吸氧等对症支持治疗，以避免病情加剧。

诊治过程 (I)

入院当天血气分析：pH 7.441，PCO₂

showed pH 7.441, PCO_2 46.2mmHg, PO_2 80mmHg, BE 5.3mmol/L, HCO_3^- 29.2mmol/L, SaO_2 97.4% (while receiving oxygen therapy). Blood routine: WBC $11.2 \times 10^9/\text{L}$, N 91.3%, liver function test showed low albuminemia (29g/L). Normal electrolytes.

CLINICAL THINKING (II)

The blood gas analysis showed mild hypercapnia reflecting the ventilation dysfunction. Because of obvious infection, we should select effective antibiotics and other supportive treatment such as albumin infusion.

CLINICAL COURSE (II)

After admission, the microbiologic culture of sputum showed "Pseudomonas aeruginosa infection", the susceptibility test showed it was sensitive to multiple antibiotics. After effective antibiotic combination therapy, the patient dramatically improved. Pulmonary CT scan showed "increased bilateral pulmonary markings, emphysema and bilateral pleural thickening, but no evidence of infection". And the pulmonary function test showed "FEV₁% 38%, FEV₁/FVC 66.79%, VCmax 50.3%". The patient was discharged two weeks later.

CLINICAL THINKING (III)

When elderly COPD patients had exacerbation with cough productive of sputum and dyspnea, the pathogens are usually Gram-negative bacilli. Once the infection is effectively treated, their symptoms will improve promptly. In this case, the patient's CT scan had showed no signs of infection. According to classification based on pulmonary function (see table), the patient had COPD at

46.2mmHg, PO_2 80mmHg, BE 5.3mmol/L, HCO_3^- 29.2mmol/L, SaO_2 97.4% (吸氧)。血常规: WBC $11.2 \times 10^9/\text{L}$, N 91.3%, 肝功能示: 低白蛋白血症 (29g/L), 电解质正常。

临床思维 (II)

血气分析提示该患者有轻度的二氧化碳潴留, 说明存在通气功能障碍。由于其感染明显, 此时应该加强抗感染治疗, 及给予输白蛋白等支持治疗。

诊治过程 (II)

入院后, 痰菌培养示“铜绿假单胞菌”, 药敏试验示多种药物敏感, 经联合使用有效抗生素后病情稳定, 症状明显好转, 双肺 CT 平扫示“双肺纹理增多, 肺气肿, 双侧胸膜增厚”, 行肺功能检查示“FEV₁% 38%, FEV₁/FVC 66.79%, VC_{max} 50.3%”, 于两周后出院。

临床思维 (III)

老年病人咳、痰、喘反复发作, 其病原菌往往是革兰阴性杆菌, 一旦抗感染有效, 其症状明显好转, 该病人 CT 显示已无感染征象。根据肺功能的分级标准 (参见表 1), 该病人处于 COPD 的 II B 级。

stage IIB.

Table 1 Classification of Chronic Obstructive Pulmonary Disease (COPD) by Severity

stage	spirometry	Clinical features
Stage 0 (At Risk)	Normal	Chronic symptoms (cough, sputum production)
Stage I (Mild)	$FEV_1/FVC < 70\%$ $FEV_1 \geq 80\%$ predicted	With or without chronic symptoms (cough, sputum production)
Stage II (Moderate)	$FEV_1/FVC < 70\%$ $30\% < FEV_1$ $< 80\%$ predicted II A: $50\% \leq FEV_1$ $< 80\%$ predicted II B: $30\% \leq FEV_1$ $< 50\%$ predicted	With or without chronic symptoms (cough, sputum production, dyspnea)
Stage III (severe)	$FEV_1/FVC < 70\%$ $FEV_1 < 30\%$ predicted or $FEV_1 < 50\%$ predicted plus respiratory failure or clinical signs of right heart failure	

(Abbreviations: FVC = forced vital capacity
 FEV_1 = forced expiratory volume in one second)

CLINICAL COURSE (III)

The patient history showed that he had moderate to severe ventilation dysfunction so that there was hypercapnia in his blood gas analysis. As we know, elderly patients with COPD and poor pulmonary function are prone to respiratory failure once contracting pulmonary infection. What preventive measures should be adopted for stable COPD patients?

CLINICAL THINKING (IV)

The underlying injury in COPD is progressive. We should encourage the patient to quit smoking,

表 1 COPD 的分级标准

分级	肺功能检查	临床症状
0 级 (危险期)	正常	慢性症状 (咳、痰)
I 级 (轻度)	$FEV_1/FVC < 70\%$ $FEV_1 \geq 80\%$ 预计值	有或没有慢性症状
II 级 (中度)	$FEV_1/FVC < 70\%$ $30\% < FEV_1$ $< 80\%$ predicted II A: $50\% \leq FEV_1$ $< 80\%$ 预计值 II B: $30\% \leq FEV_1$ $< 50\%$ 预计值	有或没有慢性症状
III 级 (严重)	$FEV_1/FVC < 70\%$ $FEV_1 < 30\%$ 预计值 或 $FEV_1 < 50\%$ 预计值 加上呼吸衰竭或右心衰竭	有或没有慢性症状

(缩写: FVC 即用力肺活量, FEV_1 即第一秒用力呼出量)

诊治过程 (III)

再次回顾病史, 患者有轻度的 CO_2 潴留, 说明其存在中重度的通气功能障碍。我们知道, 对于老年病人, 有 COPD 基础疾病者, 肺功能又差的情况下, 一旦发生肺部感染很容易导致呼吸衰竭。而对于 COPD 稳定期病人, 我们应该采取哪些预防措施?

临床思维 (IV)

COPD 的基本损害是进行性发展的, 我们应该鼓励病人戒烟, 避免职业性污染

avoid occupational dusts and chemicals and avoid environmental pollution. For stable patients in remission but with hypoxemia, low-flow oxygen therapy should be provided. Exercises such as respiratory function training are also encouraged.

COMMENT

COPD is clinically a common disease. The process of COPD is progressive, easy to cause chronic pulmonary heart disease and respiratory failure. It is very important to know how to make an accurate diagnosis and how to manage the exacerbated COPD patient. In our clinic work, strategies selected should be evidence-based.

和环境污染；对于存在低氧血症的缓解期病人，主张长期低流量氧疗；进行康复治疗如呼吸功能锻炼等。

点评

COPD 是临床上的常见病。COPD 进行性发展，易导致慢性肺源性心脏病、呼吸衰竭。如何正确诊断、处理 COPD 急性加重的病人，尤其发生呼吸衰竭的病人，是非常重要的。在临床实践中应贯彻循证医学的观点和方法。

SUGGESTED READINGS

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支气管哮喘——咳嗽、胸闷伴气急

Bronchial Asthma—cough, chest tightness, dyspnea

A 53-year-old male patient was admitted to the hospital because of “cough, chest tightness for 1 week, exacerbated with dyspnea for 3 days”. One week prior to admission, the patient had suffered a cold and developed cough and chest tightness. He took some over-the-

患者，男，53岁，因“咳嗽、胸闷1周加重伴气急3天”入院。患者1周前因受凉出现咳嗽、胸闷，自服日夜百服宁、急支糖浆无效，且加重并出现气急、呼吸困难。痰为少许黄色粘液痰，无发热，无盗汗，无胸痛，遂到医院门诊就诊。查血

1

内科临床病例分析——双语学习