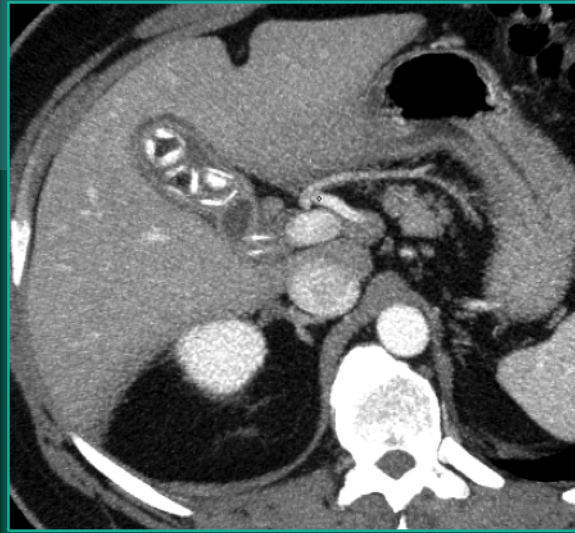


ED Urgences: foie, vésicule, pancréas

Cas N°1



Homme 45 ans
Découverte fortuite



Empiement vésiculaire, Calculs cholestérolo-pigmentaires: mercedes sign..

Calculs cholestéroliques 80- 85 %

- bile sursaturée en cholestérol (50%) cristallise en calculs
- quantité variable de sel de calcium
- radio transparents
- facteurs de risque: âge, femme, obésité, alimentation riche en lipides
nutrition parentérale, oestrogènes,
TTT hypolipémiants

Calculs pigmentaires 15 - 20 %

Noir:

comprennent un polymère de la bilirubine, du phosphate et du carbonate de calcium,
50 % sont radio opaques

Vésicule biliaire, canaux biliaires

Hémolyse et cirrhose

Brun:

constitués en grande partie de bilirubinate de calcium et de sels calciques d'acides
gras

Nature friable

Faible densité

Cholédoque

Infection, inflammation

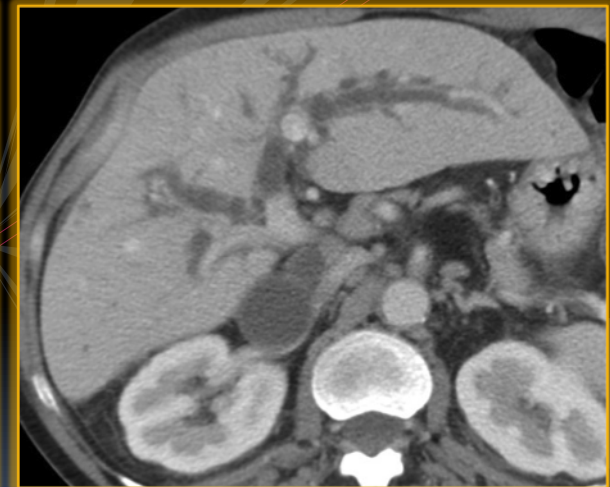
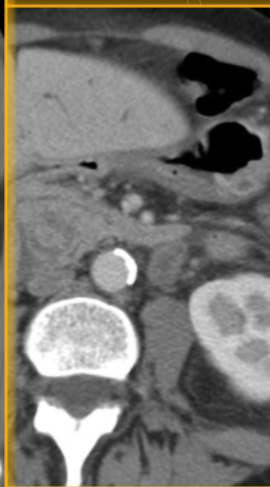
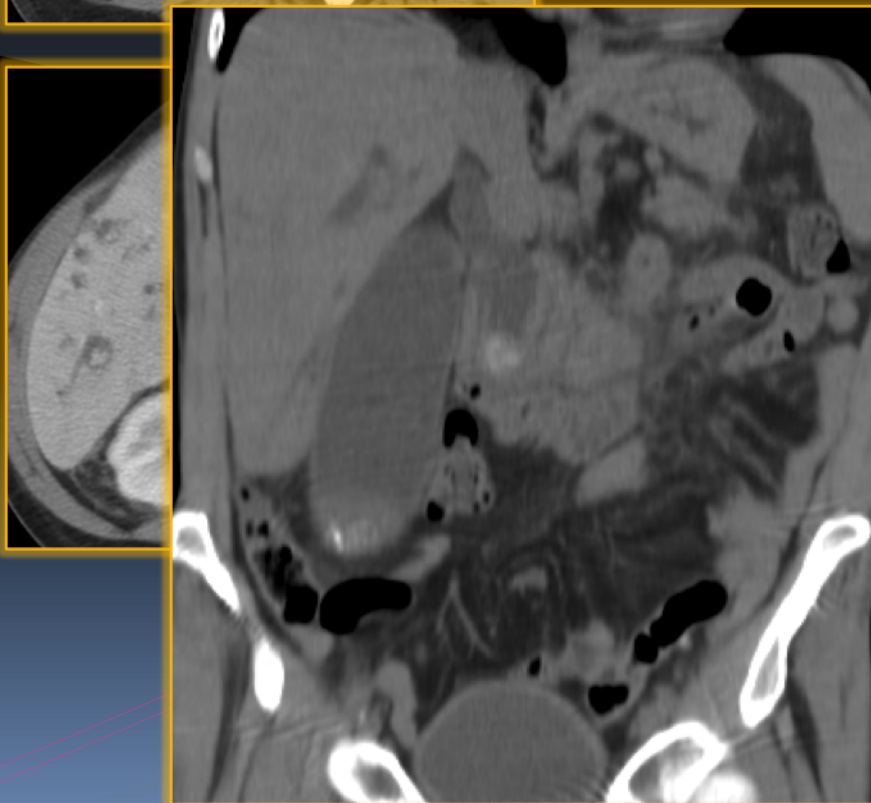
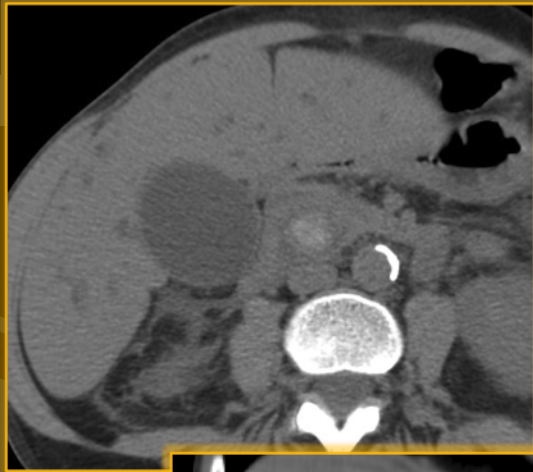
Calculs mixtes

radio opacité fonction de teneur en Calcium

Cas N°2

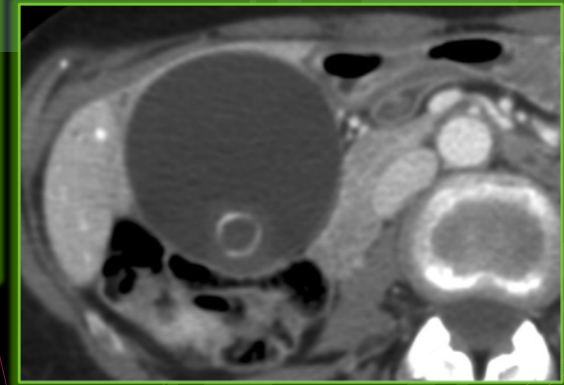
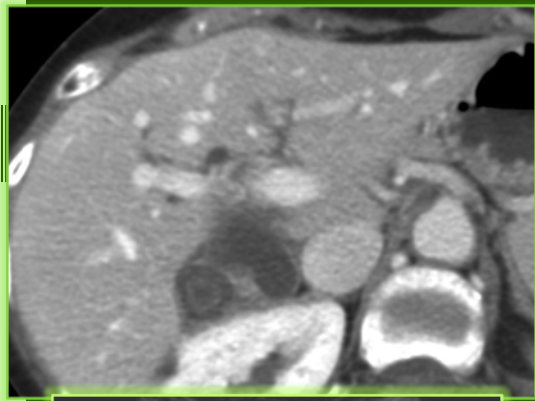


Homme 61 ans
Douleurs abdominales brutales
Hypochondre droit
Murphy positif
Cholestase et Hyperleucocytose

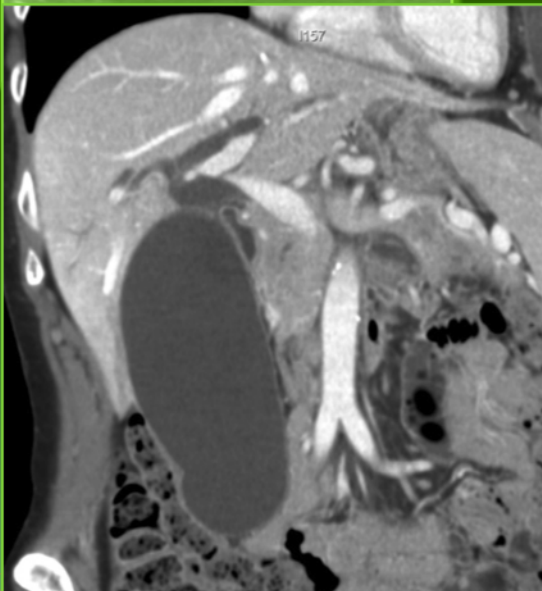
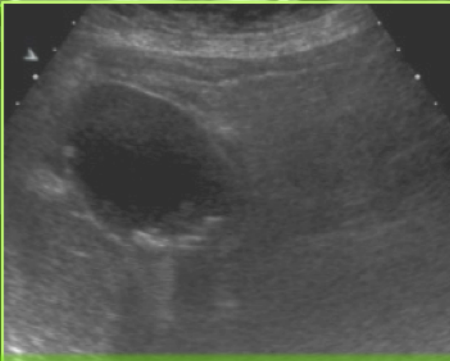


Calcul pigmentaire brun

Cas N°3



Douleurs HCD
Apyrétique

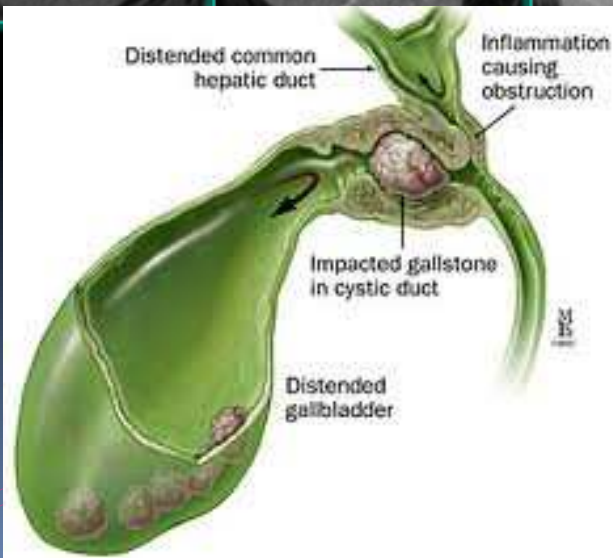
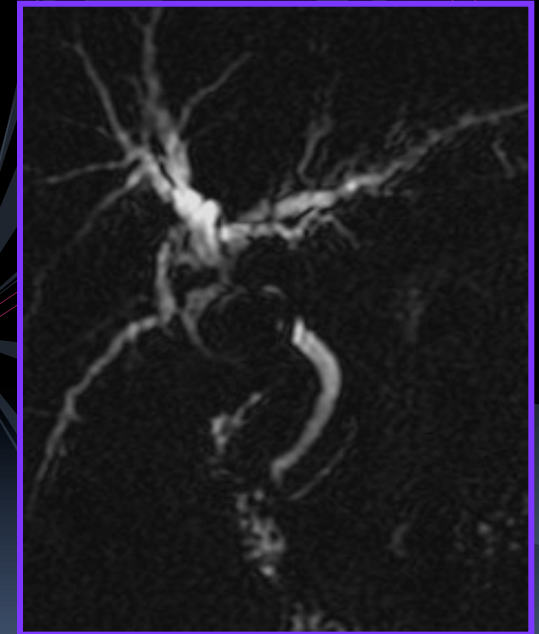
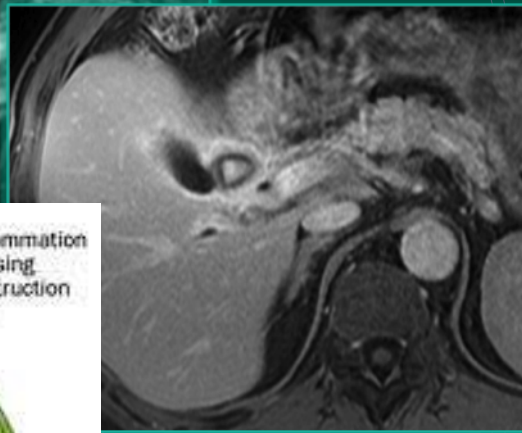
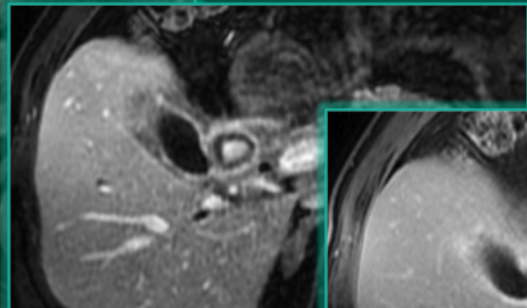
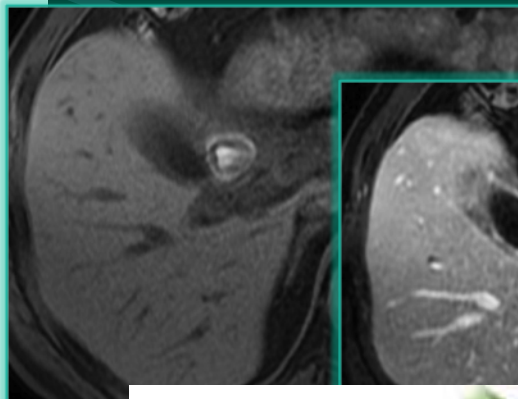
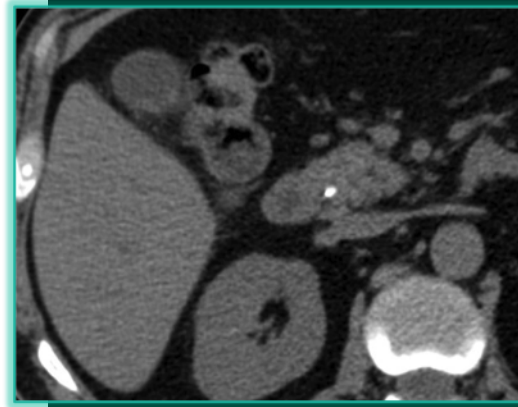


Hydrocholécyste

Cas N°4

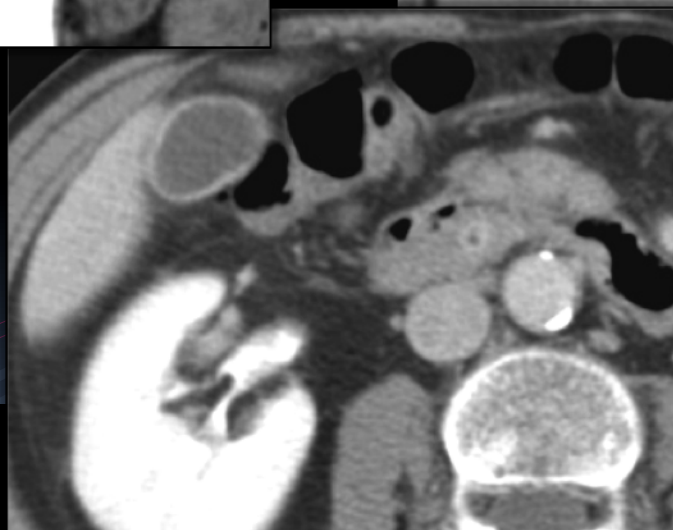
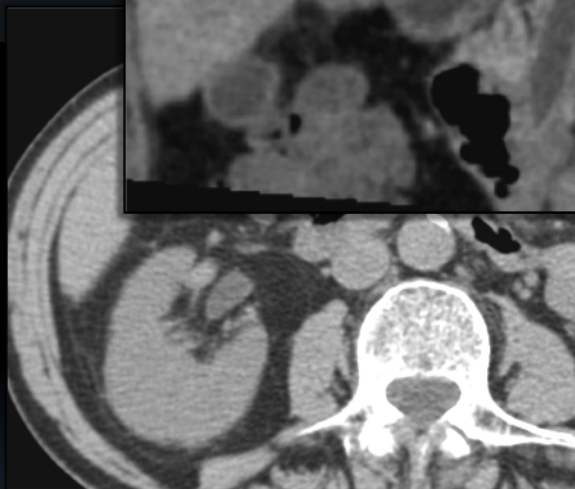
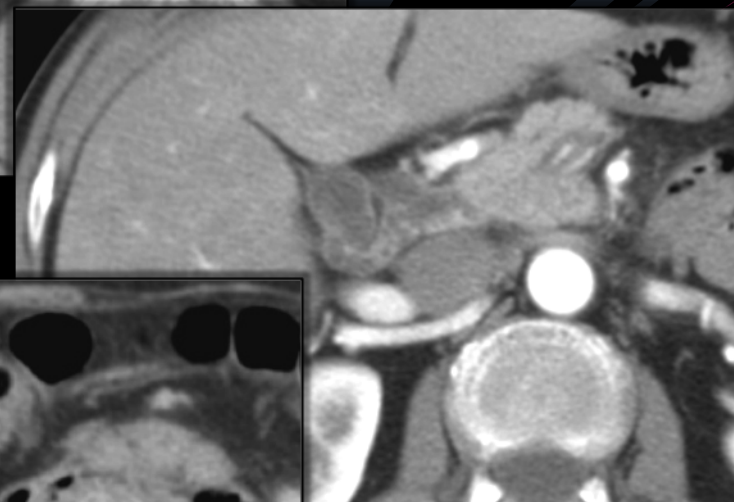
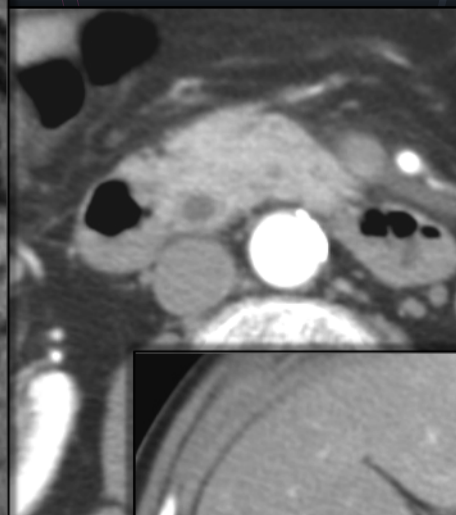
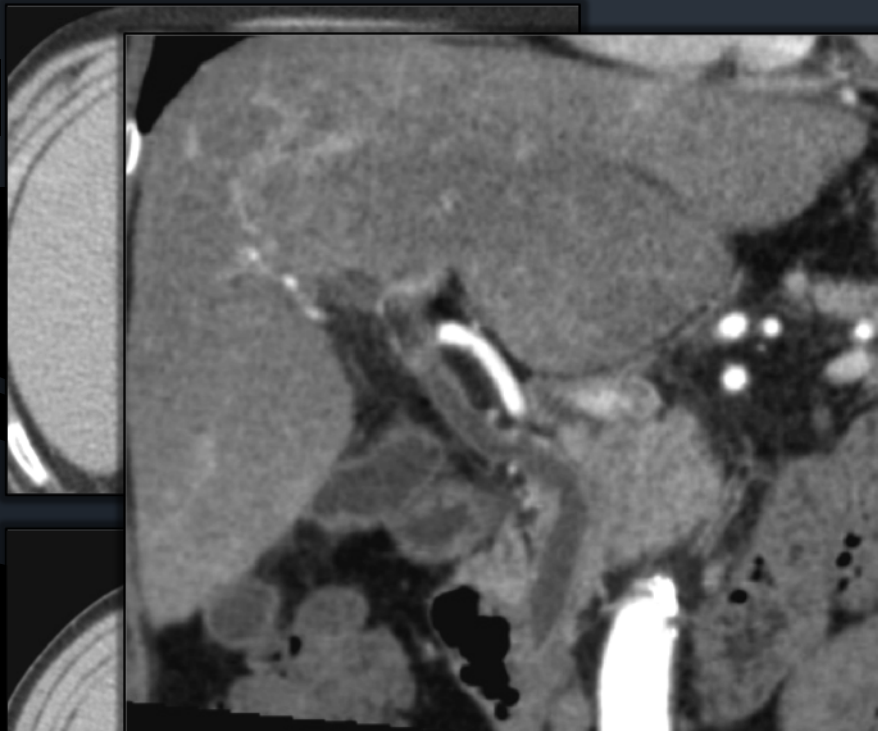


Homme 61 ans
Douleurs HCD
Cholestase



Syndrome de Mirizzi

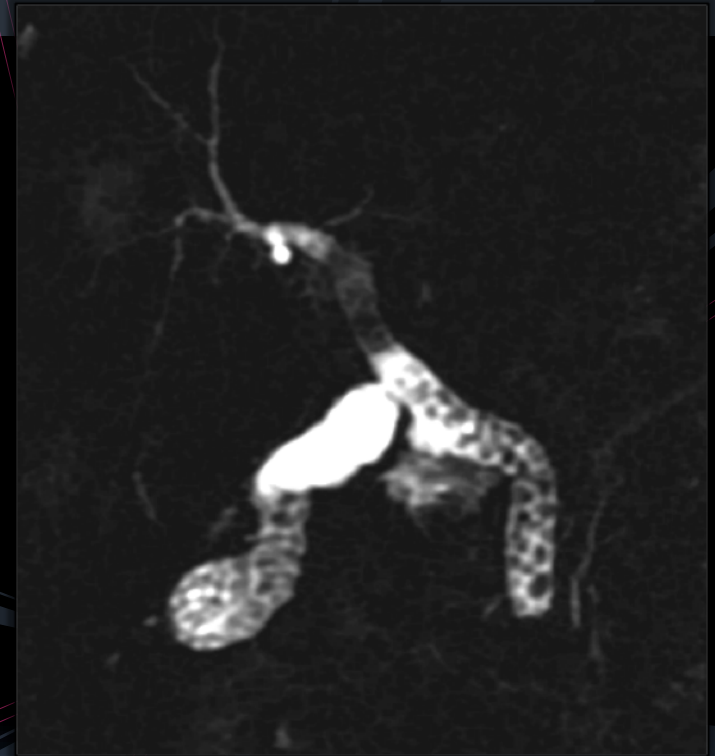
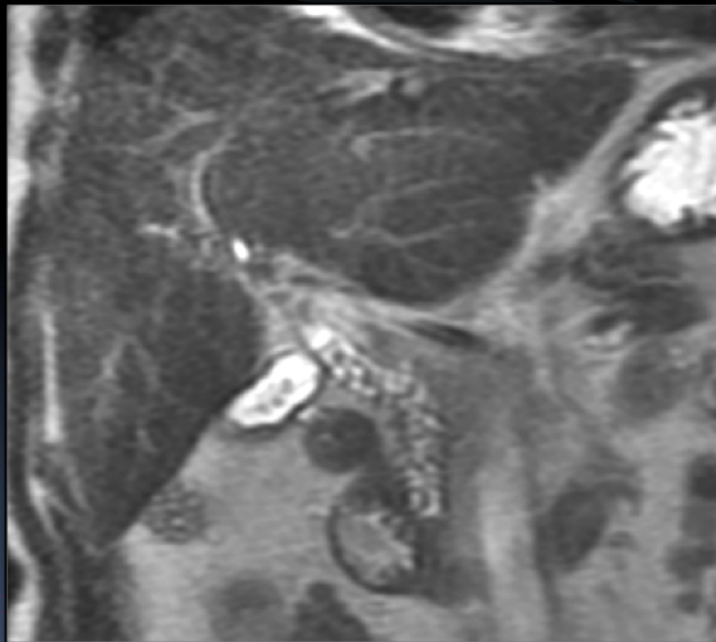
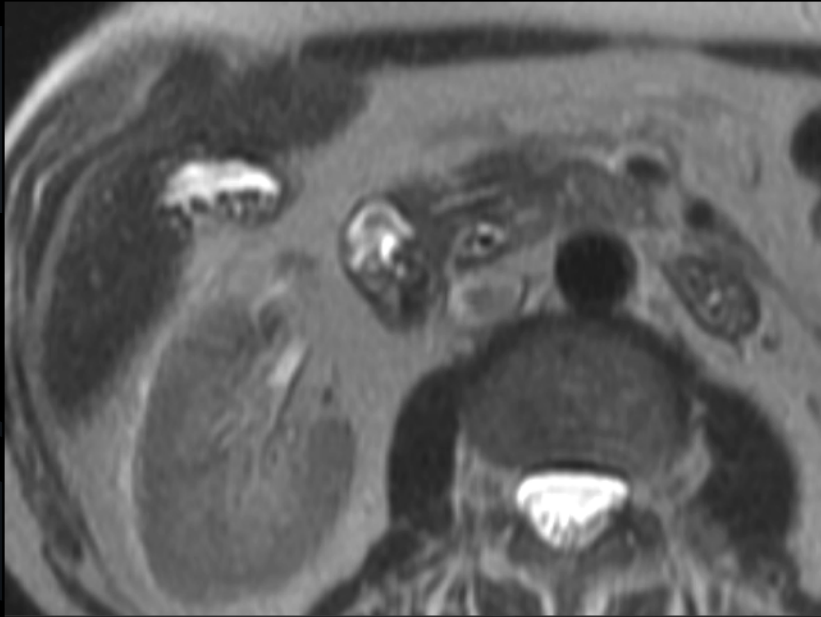
Cas N°5



Patiente 70 ans, Dr HCD
depuis 2 jours, cholestase 2N,
fébricule

Dilatation de la VBP
Oddite
Calculs ?

→ IRM

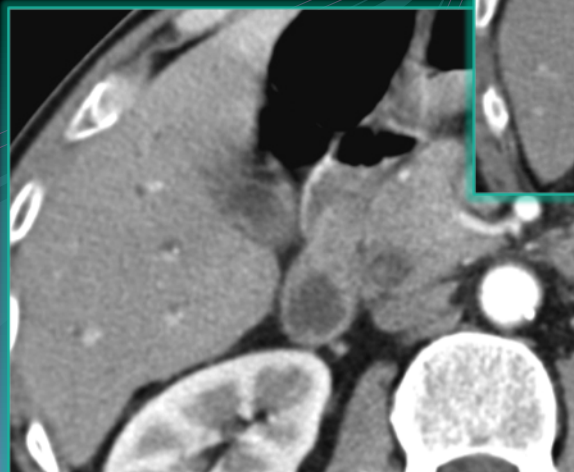
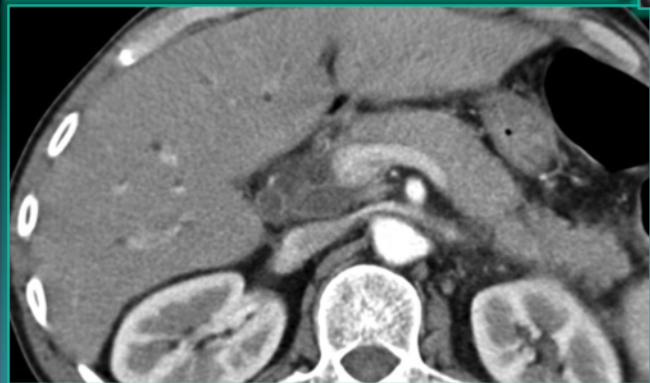
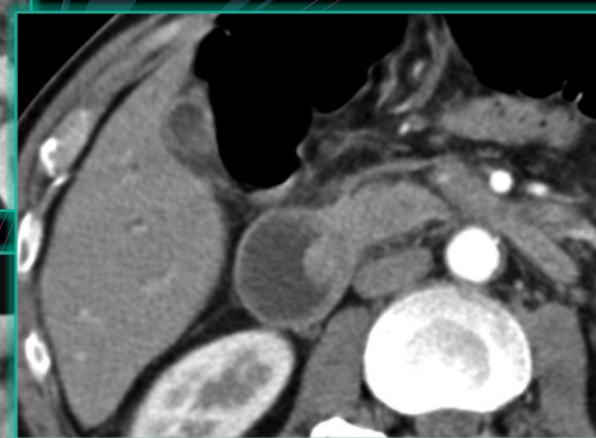
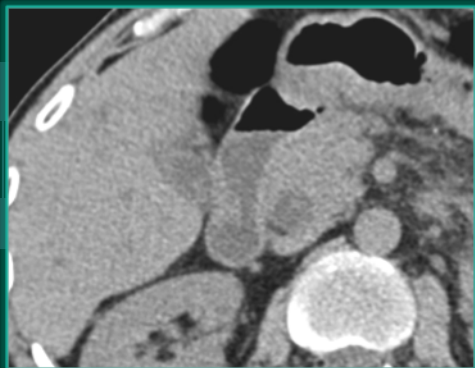


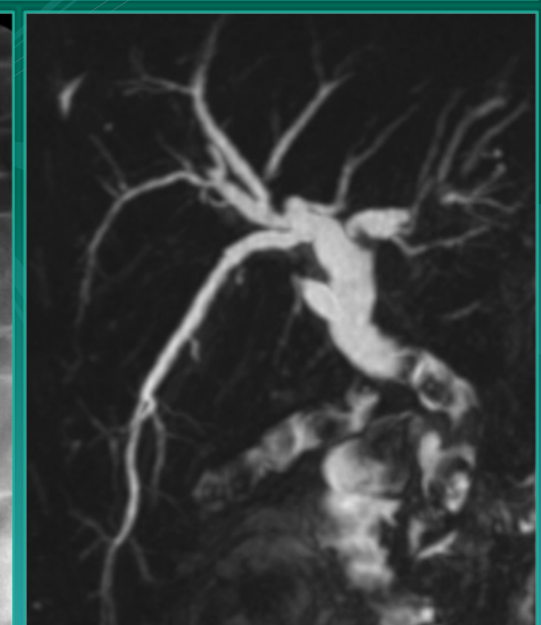
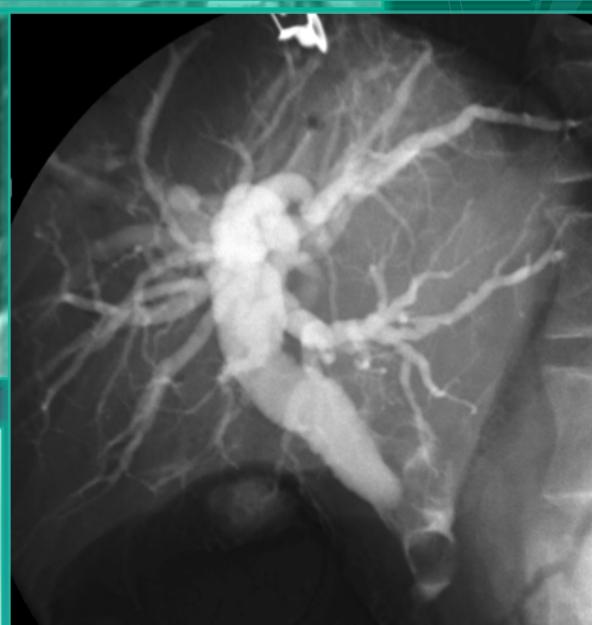
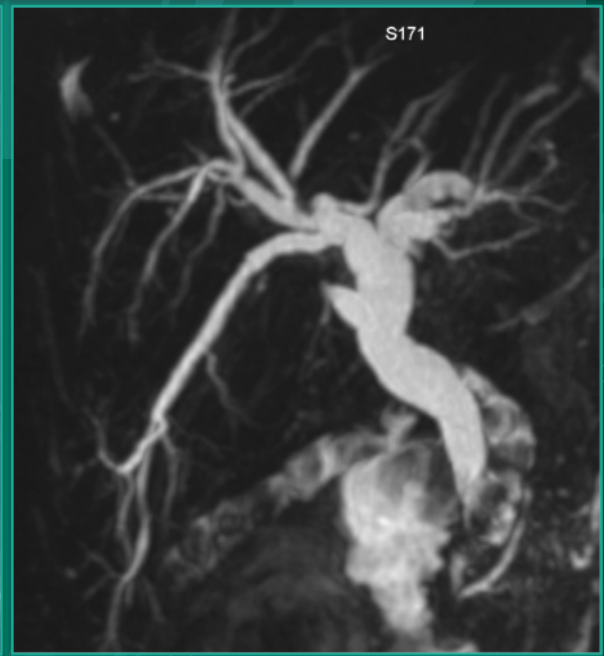
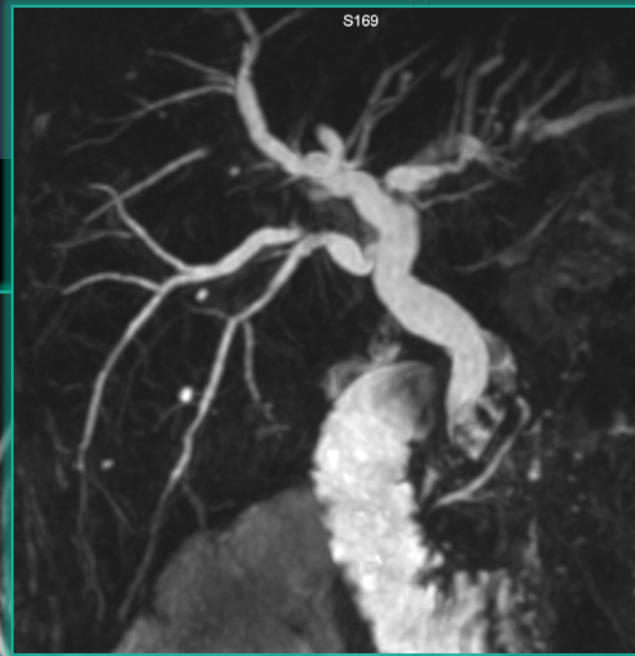
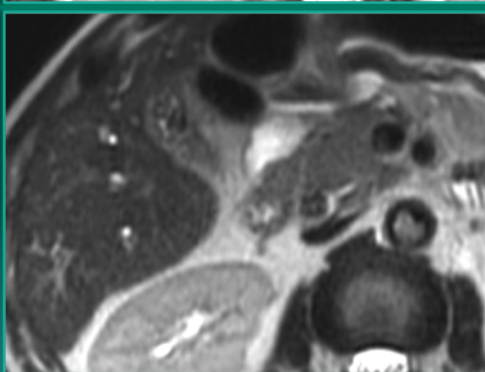
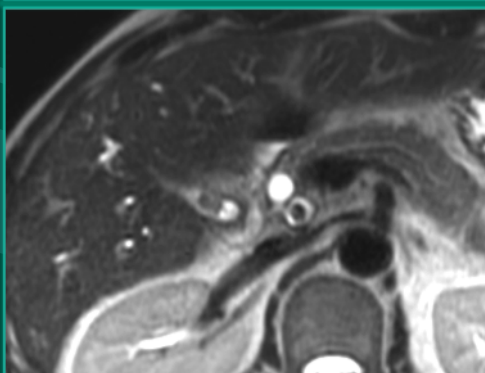
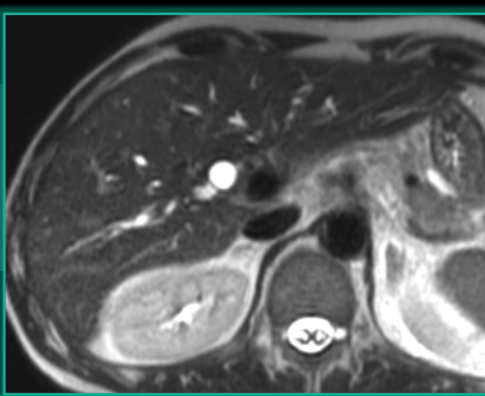
IRM
Empierrement cholédocien
Calculs cholestéroliques

Cas N°6



Douleurs récurrentes HCD
Ictère fébrile
ATCD de cholécystectomie



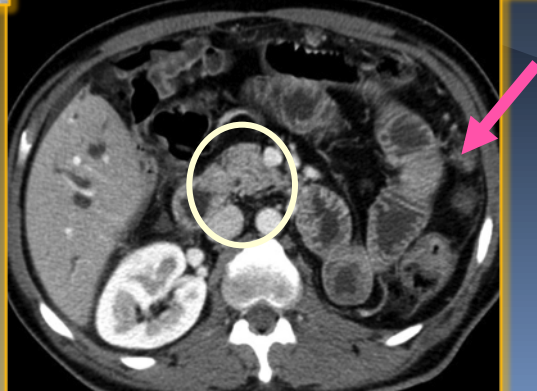
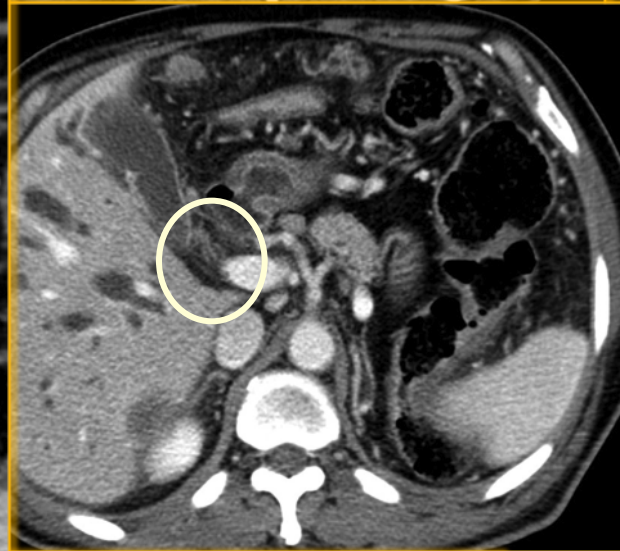
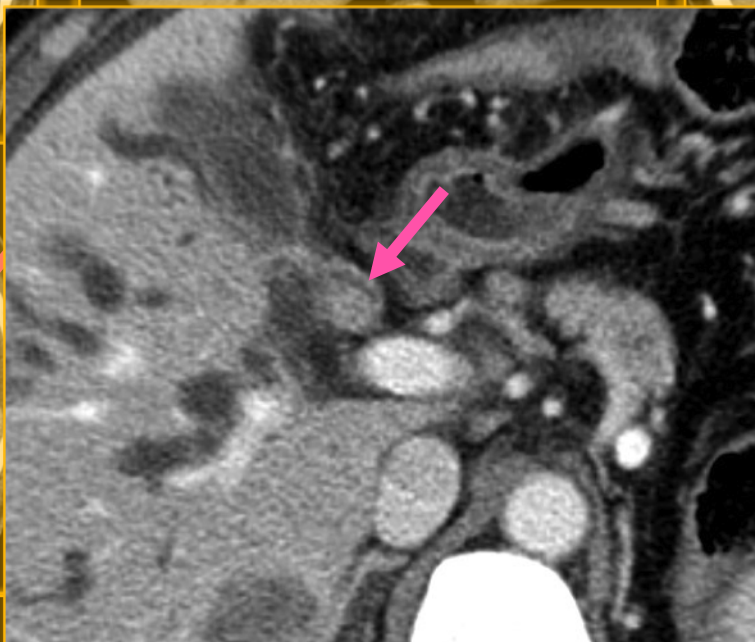
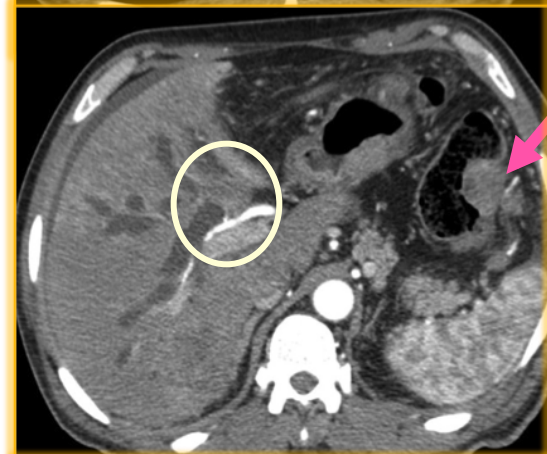
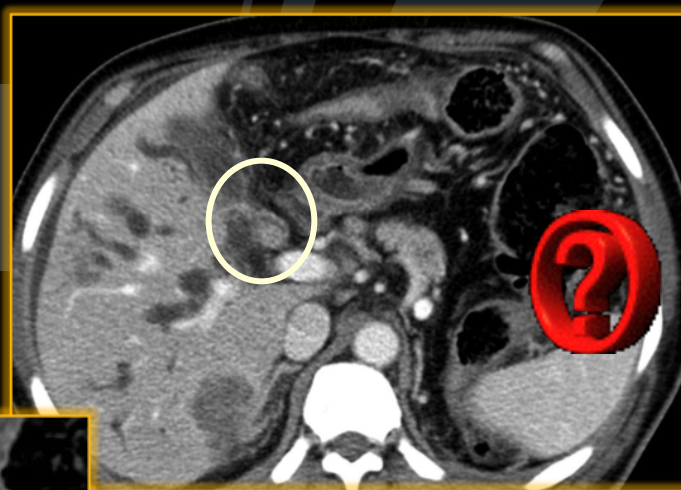
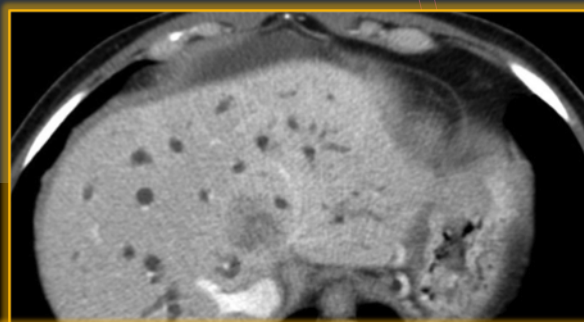


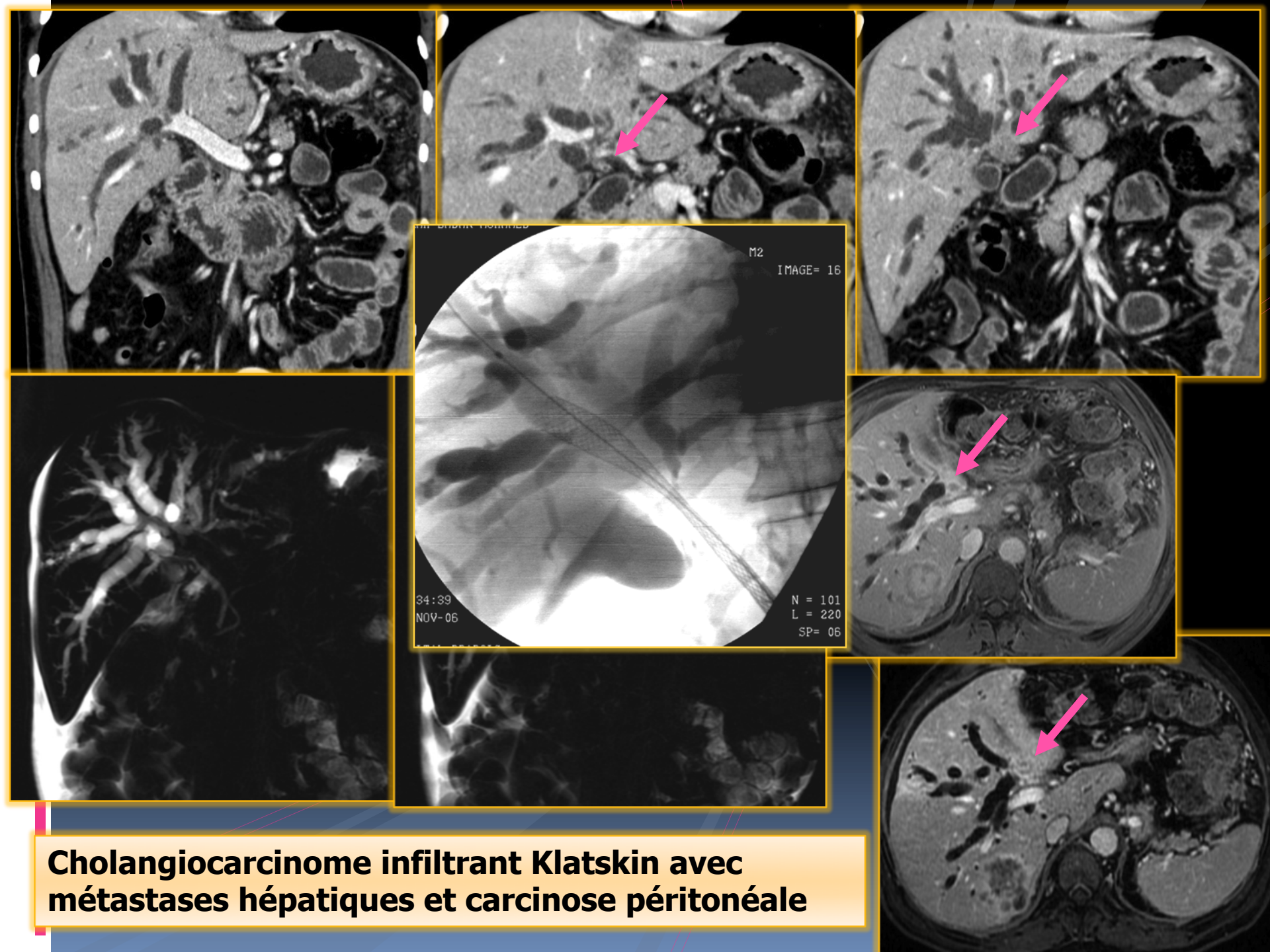
**Empiement d'un moignon
cystique long !!!**

Insertion basse médiale

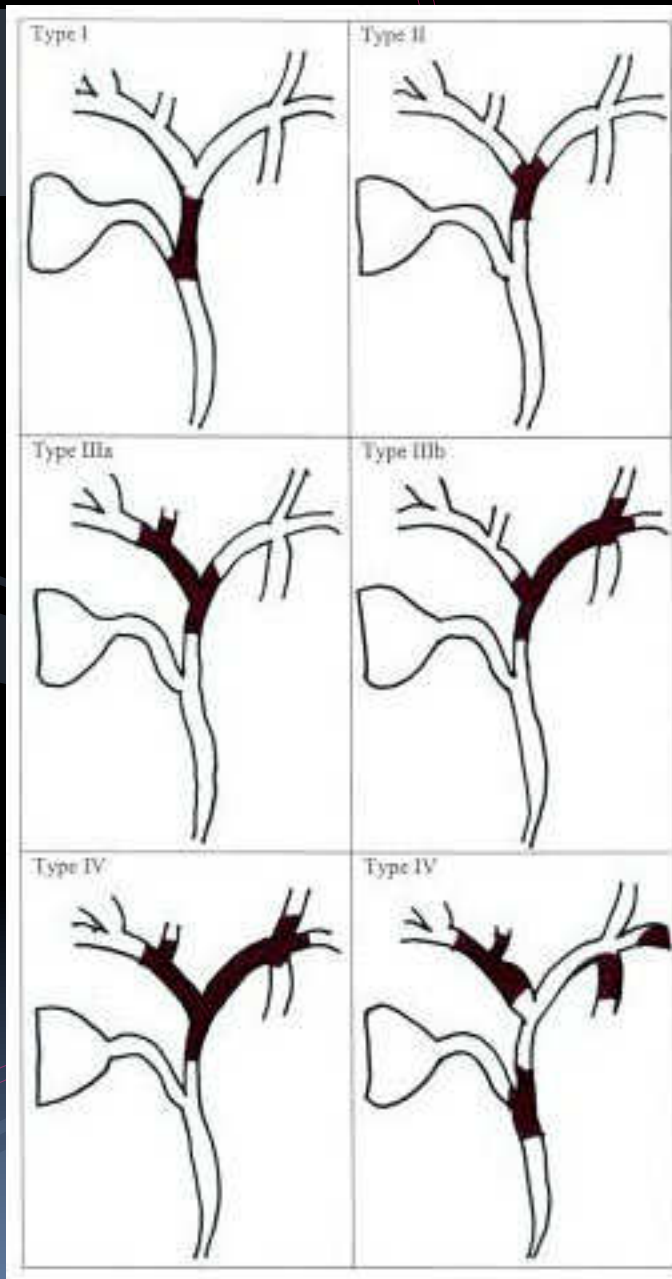
Cas N°7

Ictère fébricule Cholestase

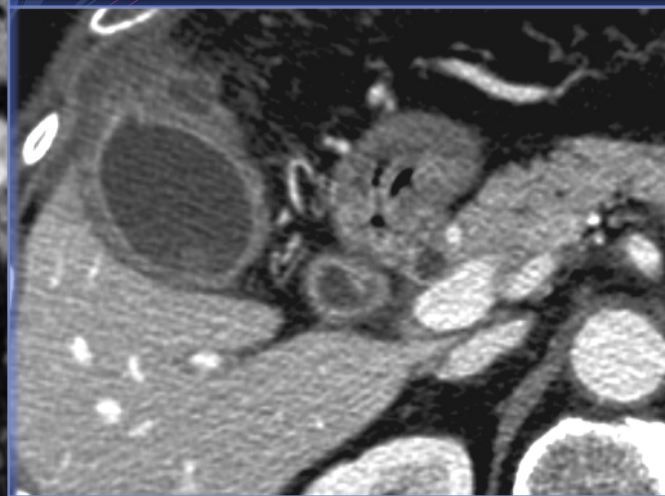
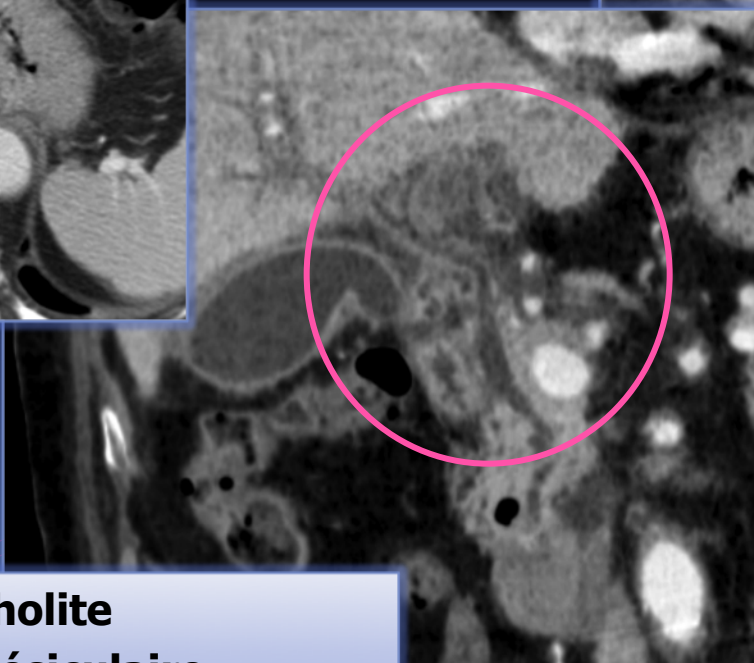
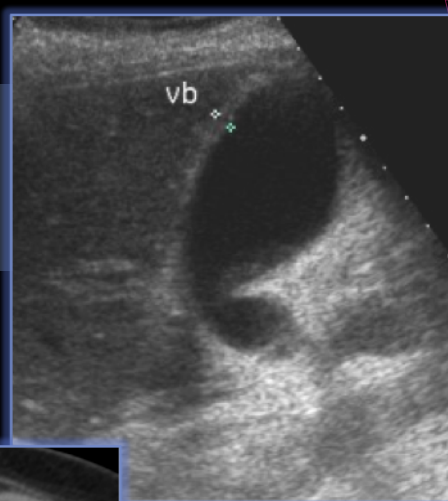
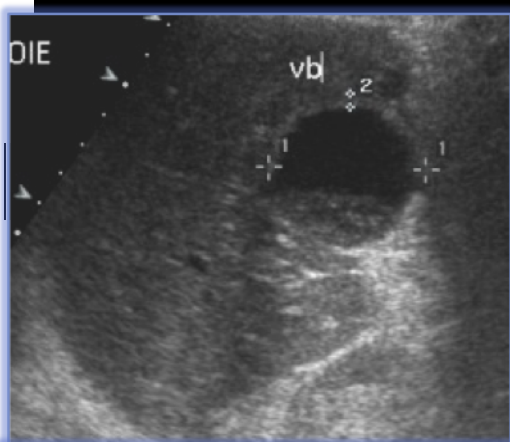




**Cholangiocarcinome infiltrant Klatskin avec
métastases hépatiques et carcinose péritonéale**



Cas N°9

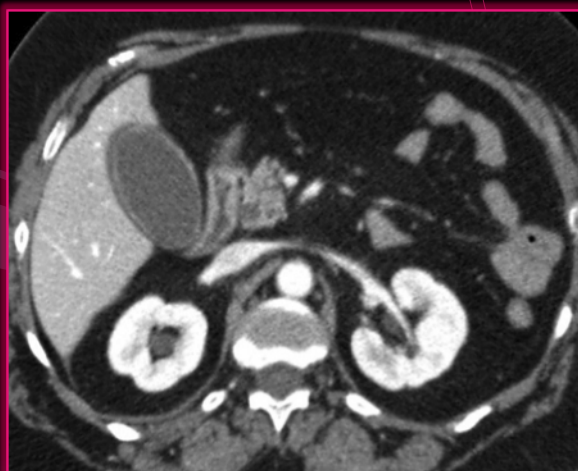
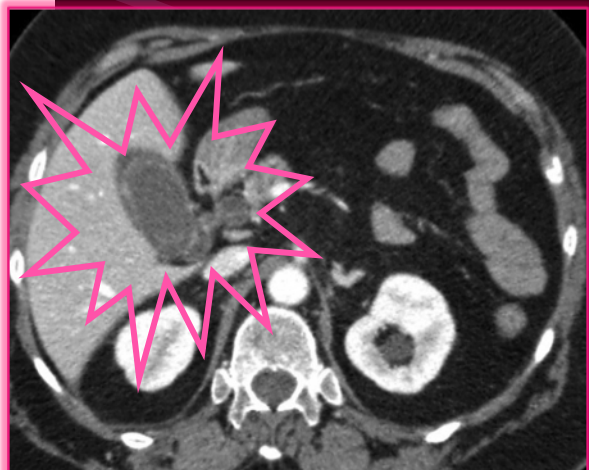
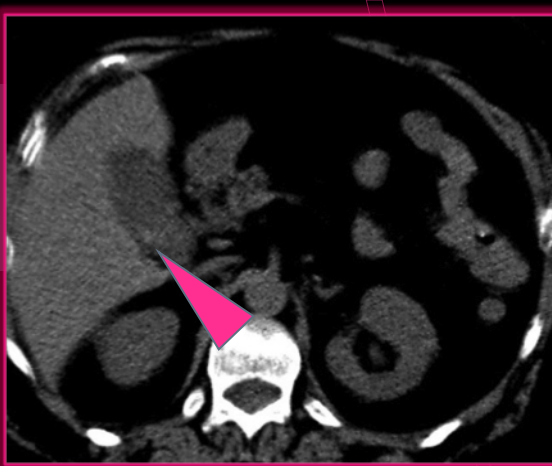
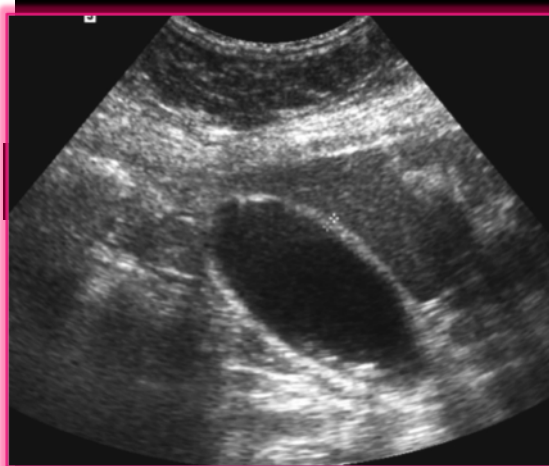


Angiocholite
Abcès périvésiculaire
Pyléphlébite intrahépatique gauche

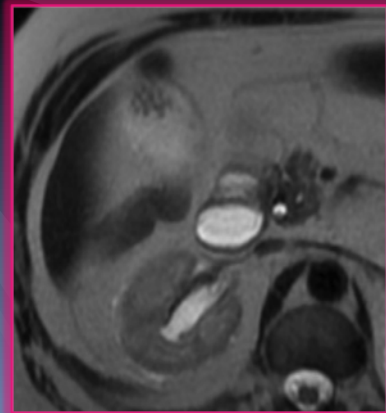
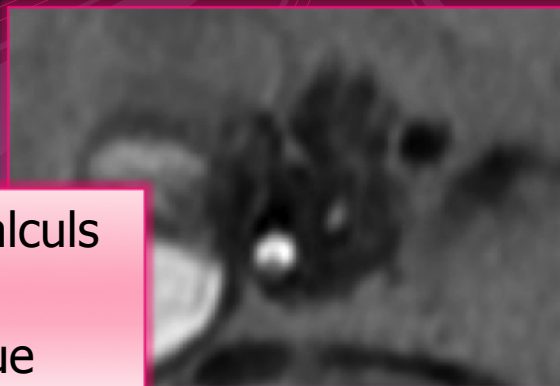
79 ans DI HD Ictère Fièvre à 39°

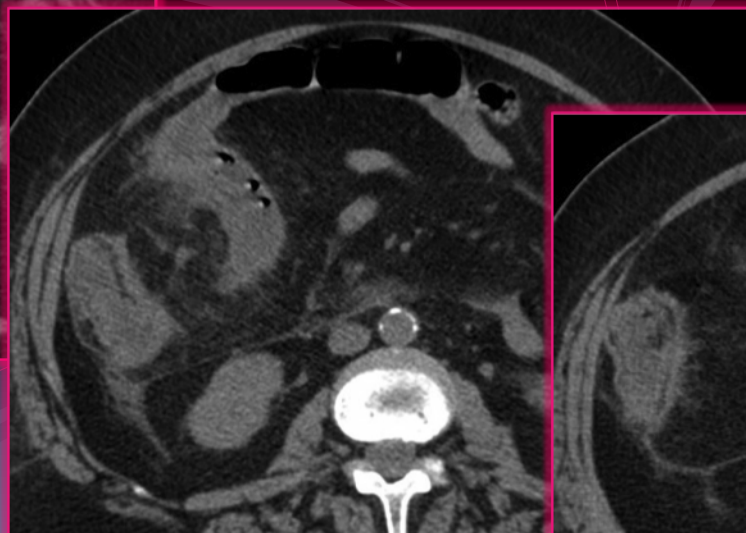
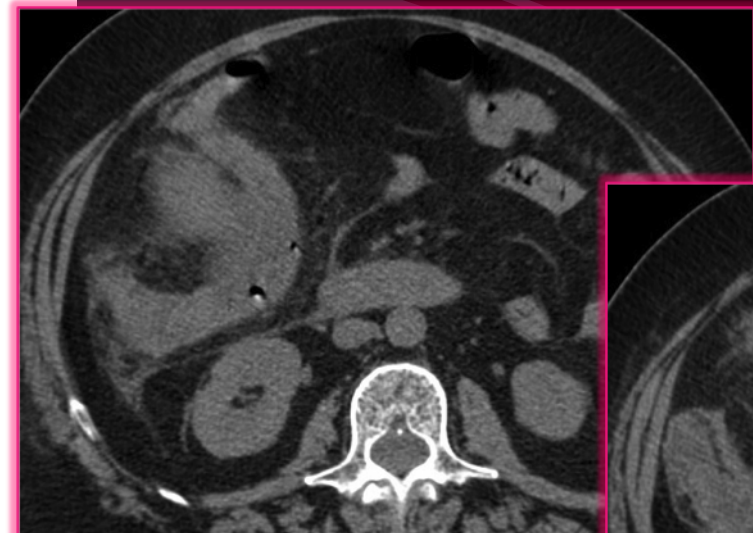
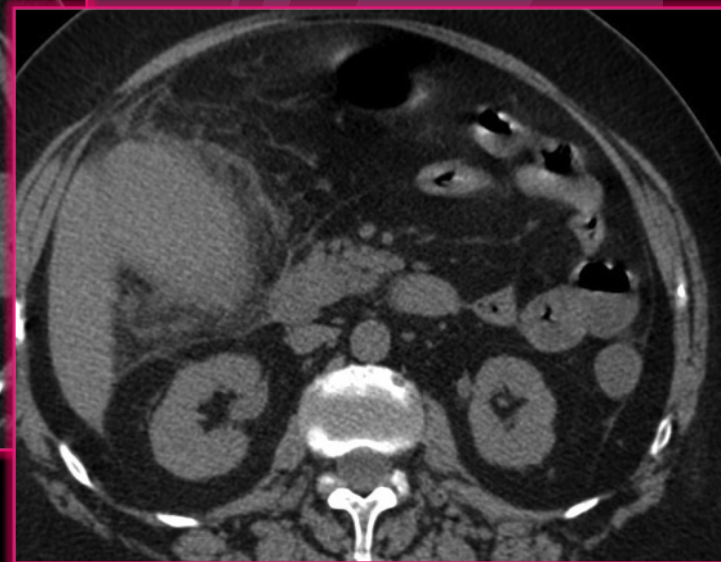
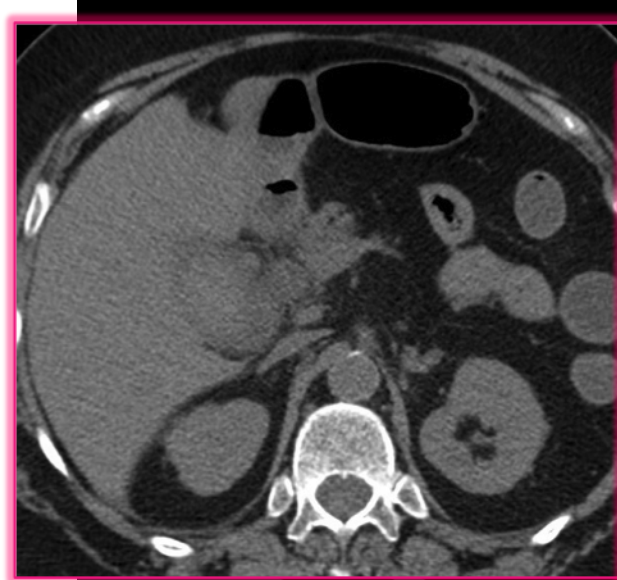
Cas N°10

70 ans, douleurs épigastriques
violentes + ictère, cytolyse,
cholestase

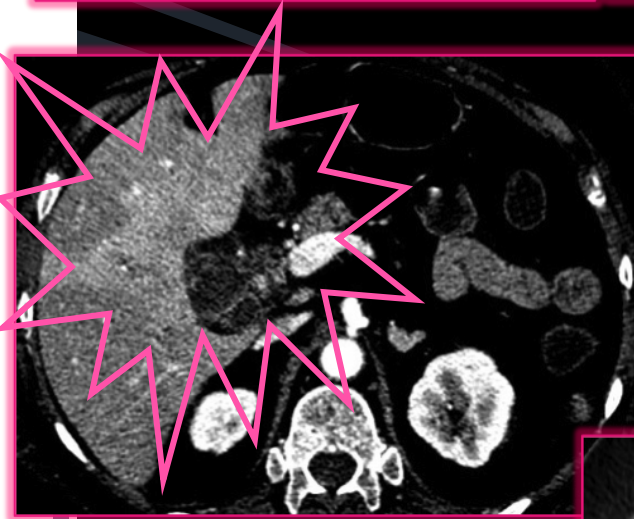
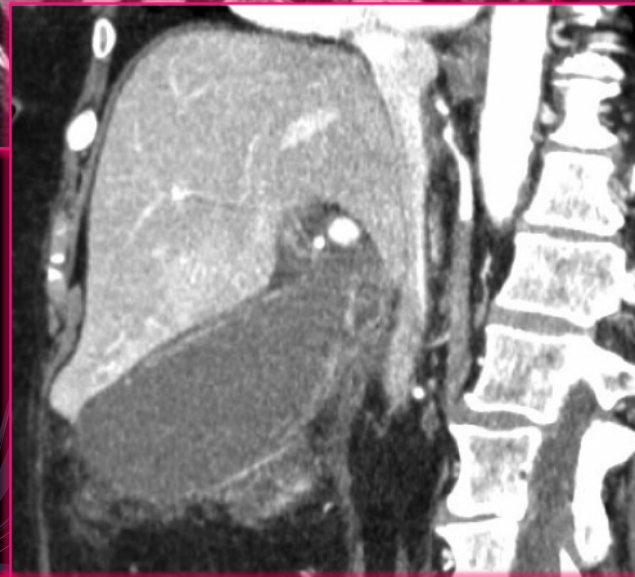
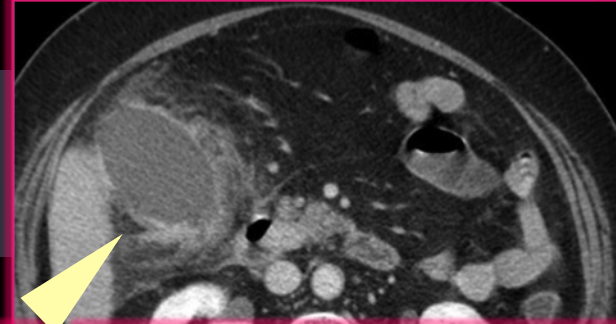
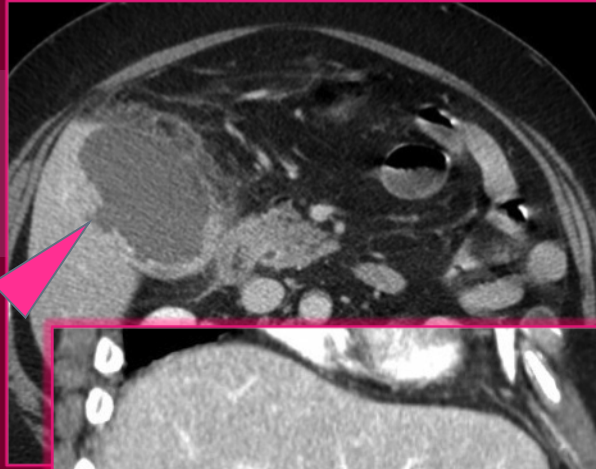
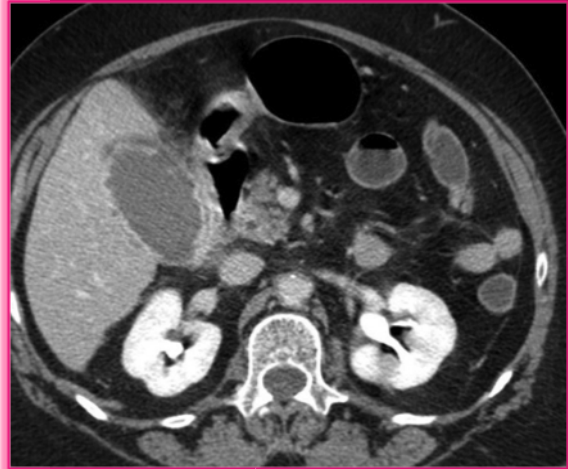


Cholécystite aiguë, calculs
cholestéroliques
Migration lithiasique





1 semaine plus tard...

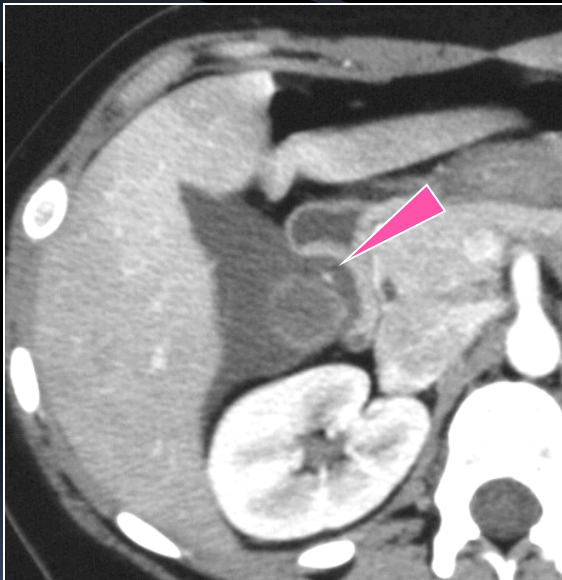
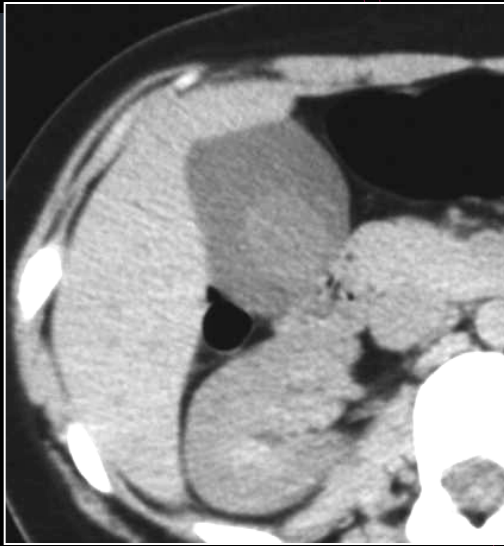


Cholécystite gangréneuse
Troubles perfusionnels

Cas N°11



Œdème de la paroi vésiculaire

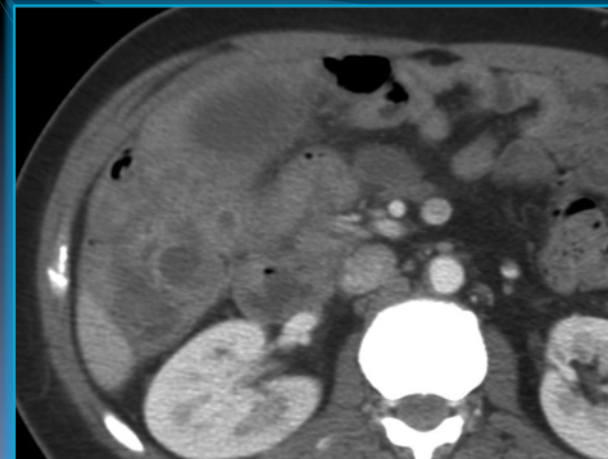
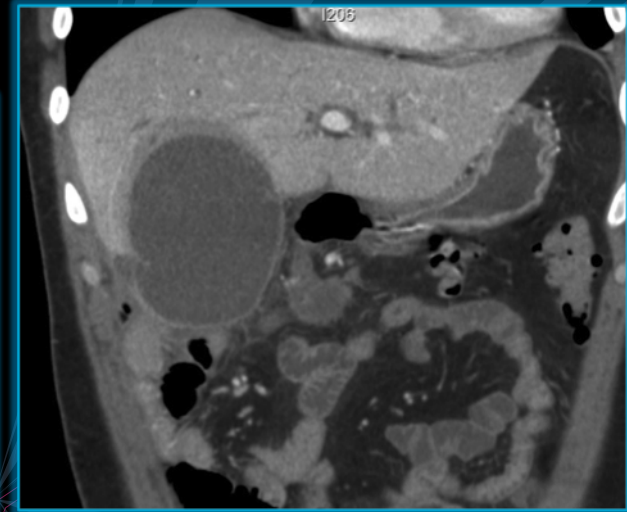
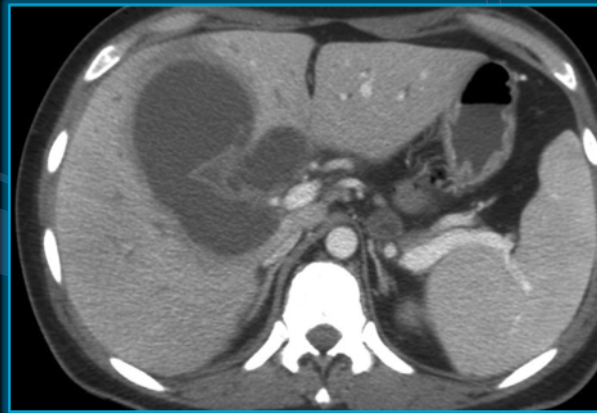
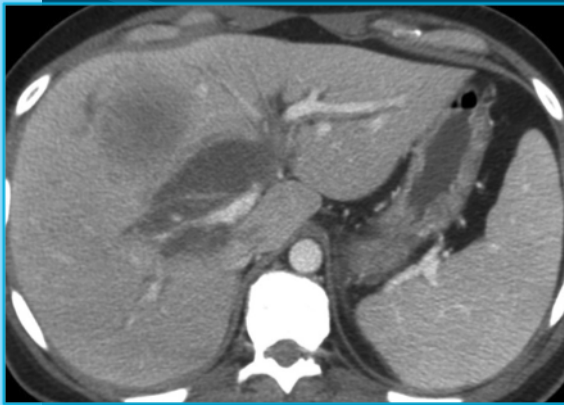
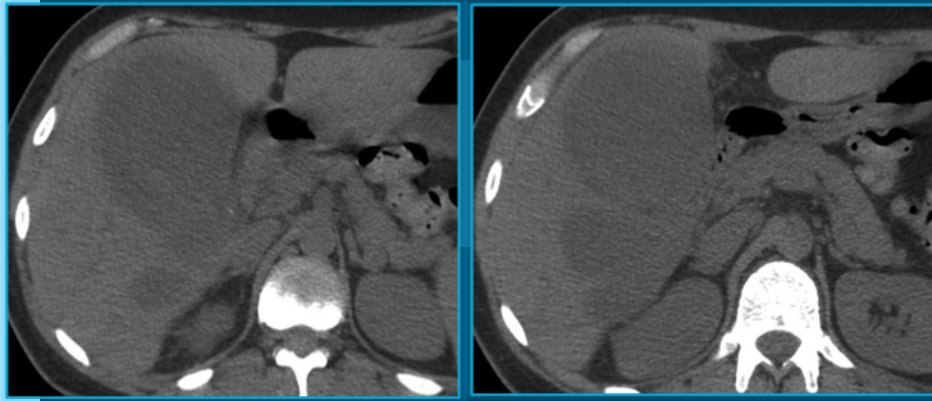


Étiologies :

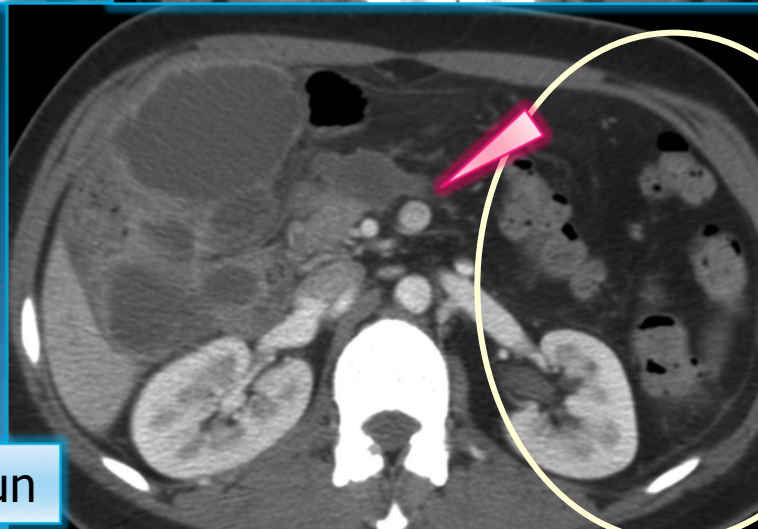
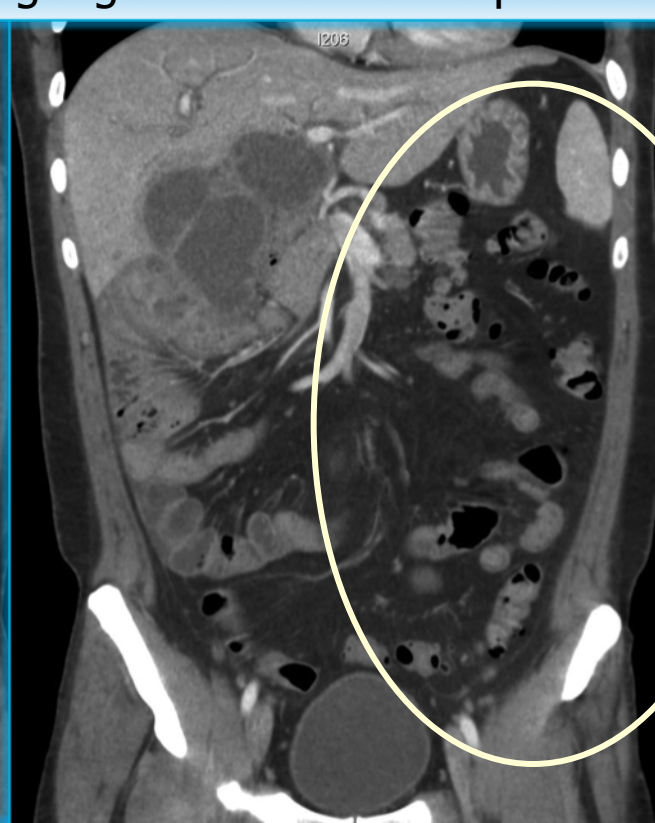
- Hépatite aiguë, hypo-albuminémie, ascite, cirrhose, maladie veino-occlusive, insuffisance cardiaque, pancréatite aiguë
- Muqueuse préservée, branches péri vésiculaires de l'artère cystique

Cas N°12

Douleurs HCD
Syndrome septique franc



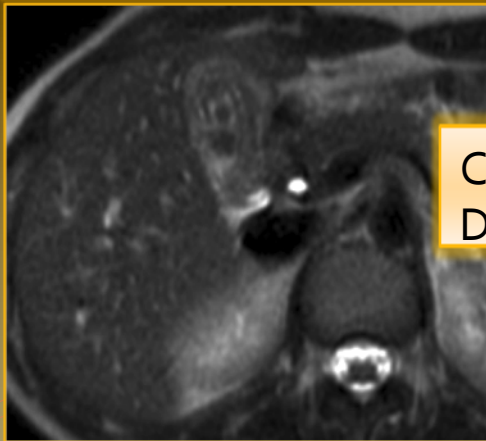
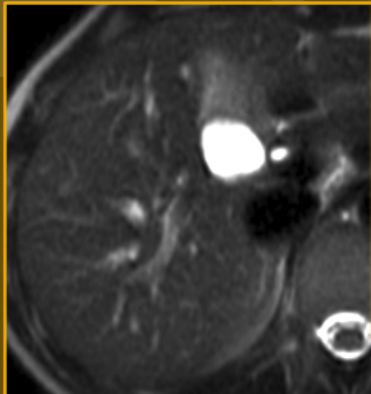
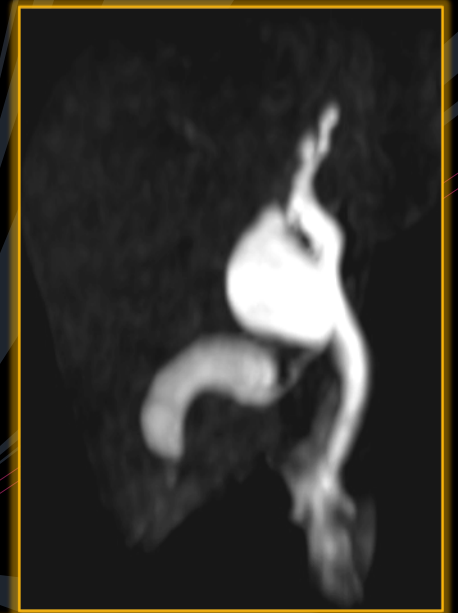
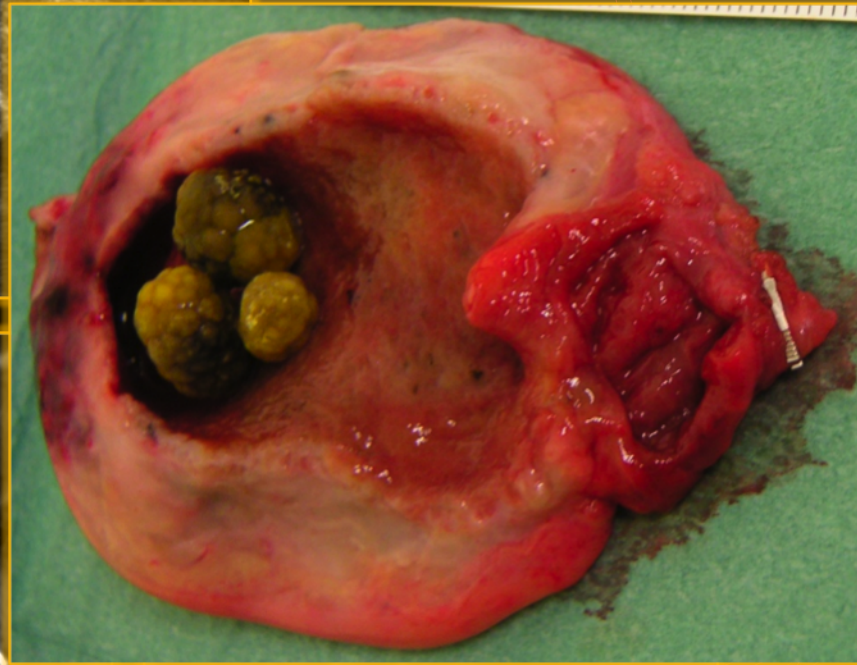
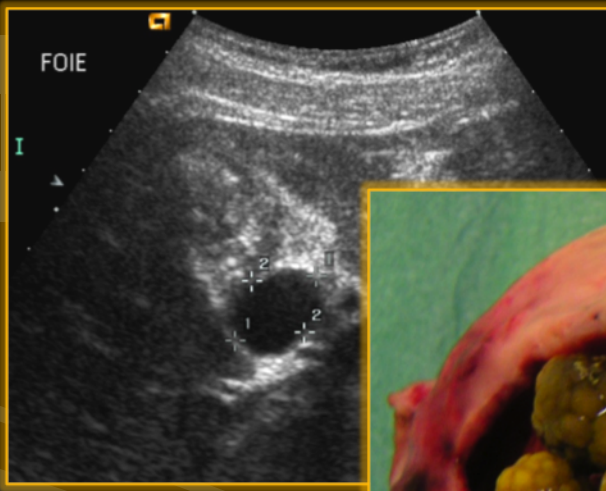
Cholécystite gangréneuse abcédée plastronnée et ?



... mésentère commun

Cas N°13

Jeune fille 23 ans
Douleurs HCD récurrentes

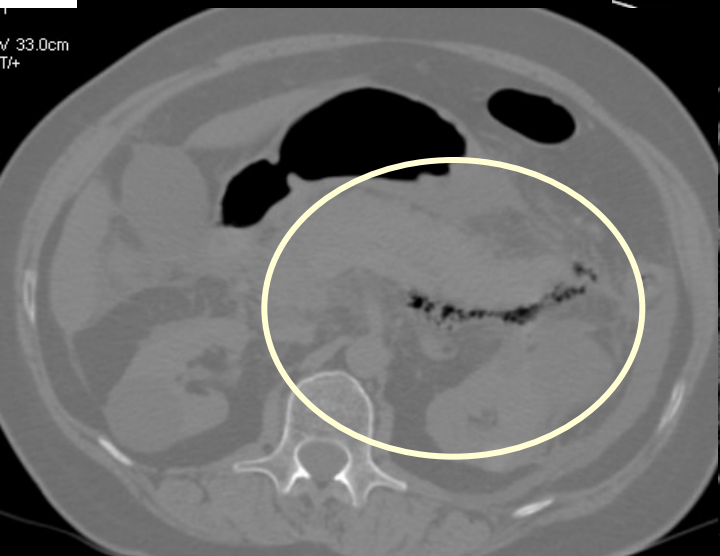
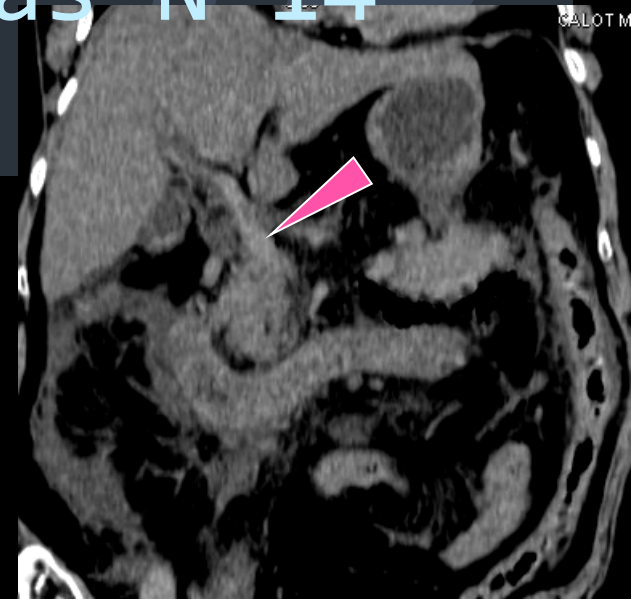
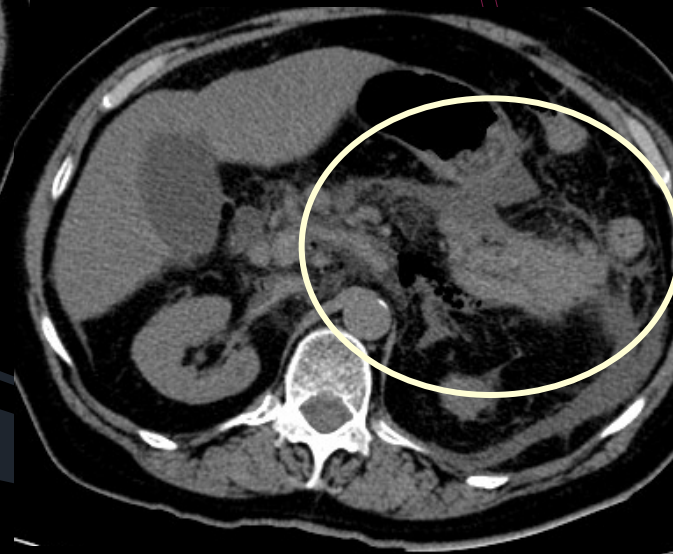
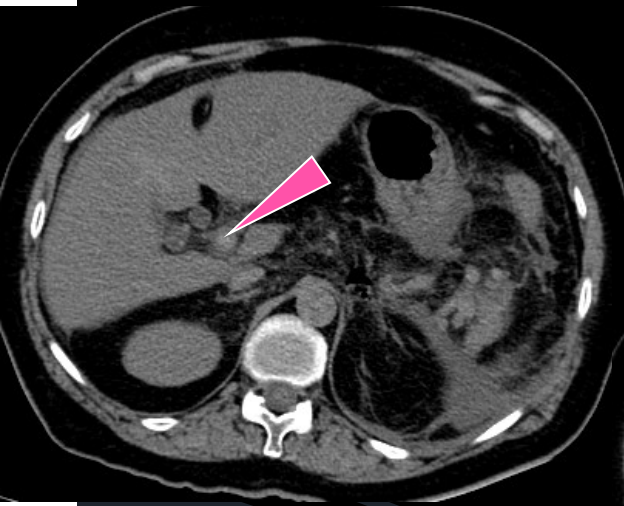


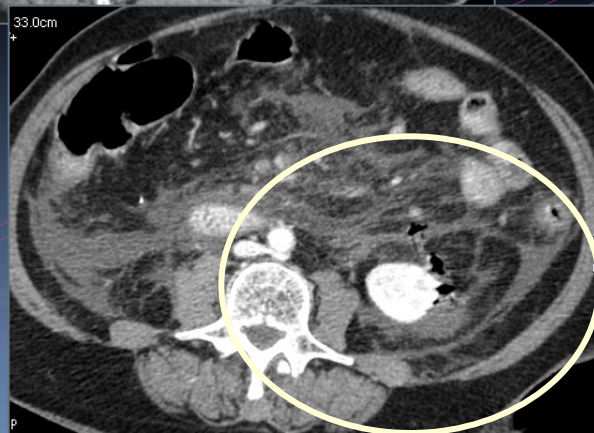
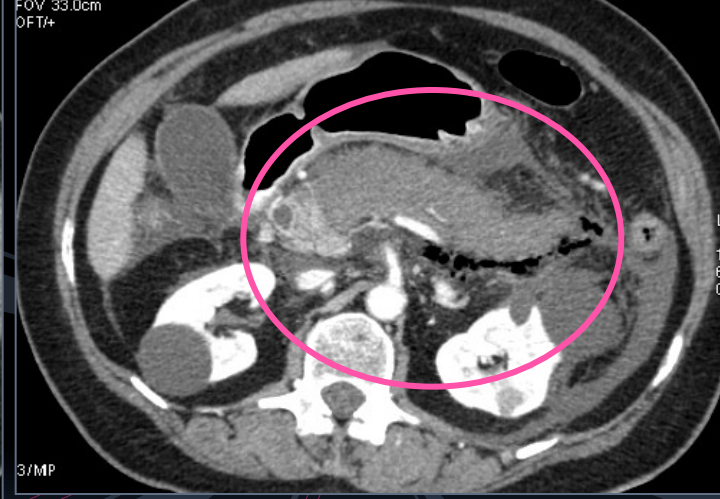
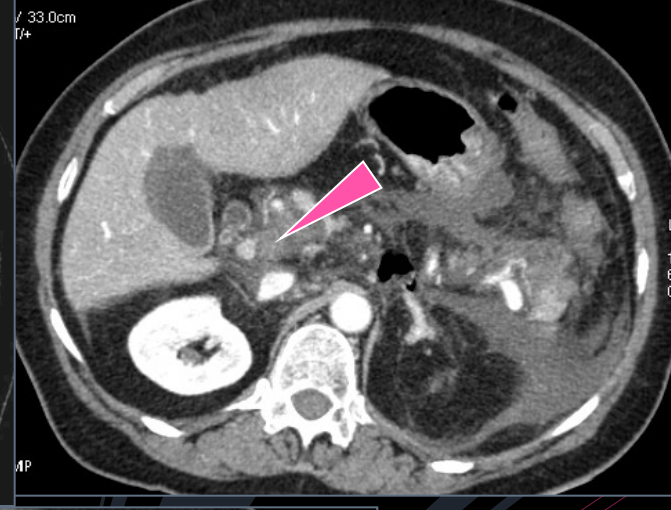
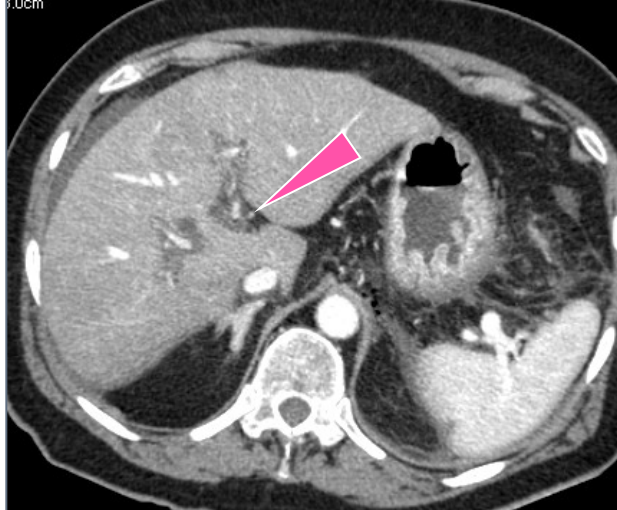
Cholécystite chronique
Diaphragme vésiculaire



Cas N°14

Douleurs épigastriques
depuis 24 h et sepsis





A: 15.7 (co)

DFOV 33.0cm
SOFT+R
P

2.1/Mn

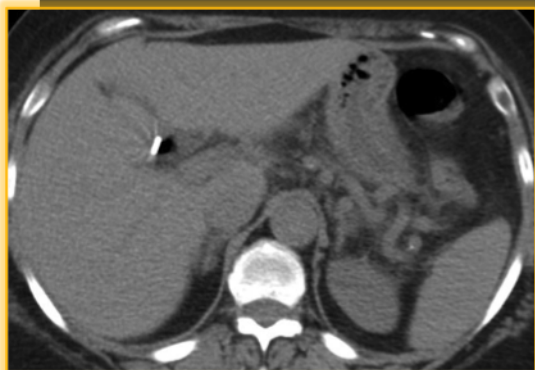
W = 341 L = 45

cm

TABLE 2 Modified CT Severity Index

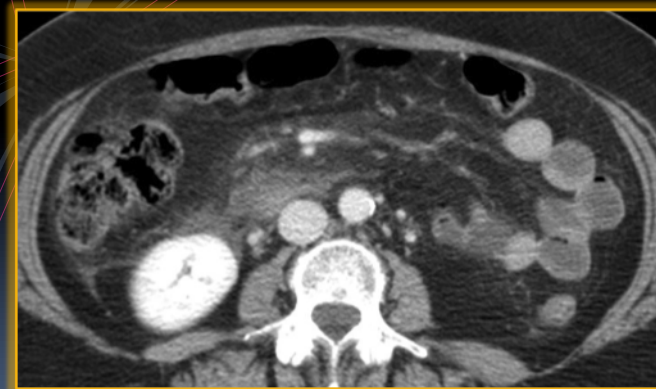
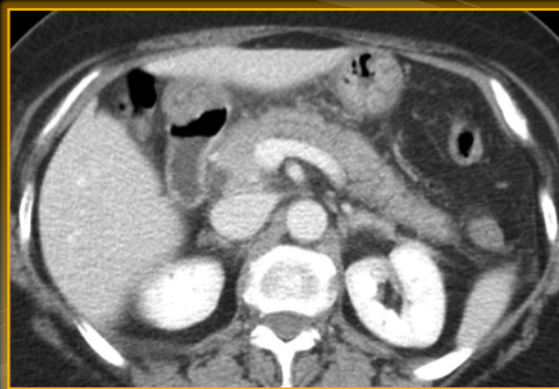
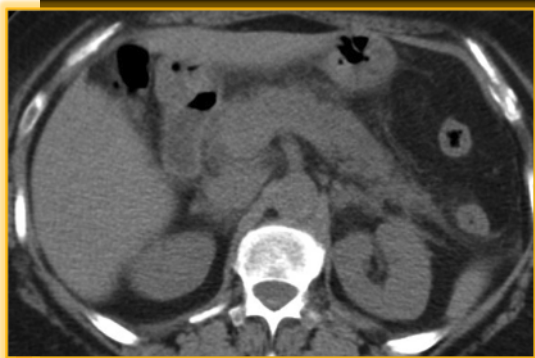
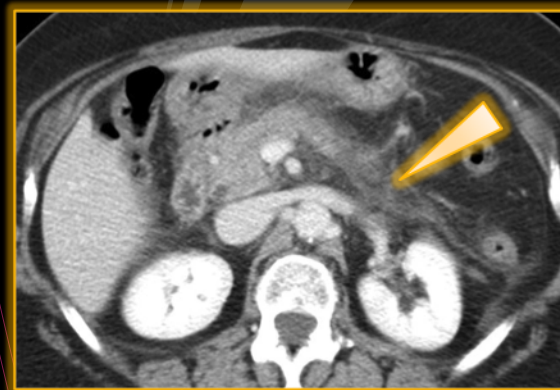
Prognostic Indicator	Points
Pancreatic inflammation	
Normal pancreas	0
Intrinsic pancreatic abnormalities with or without inflammatory changes in peripancreatic fat	2
Pancreatic or peripancreatic fluid collection or peripancreatic fat necrosis	4
Pancreatic necrosis	
None	0
≤ 30%	2
> 30%	4
Extrapancreatic complications (one or more of pleural effusion, ascites, vascular complications, parenchymal complications, or gastrointestinal tract involvement)	2

Pancr atique n crotico h morragique
Thrombose porte
Score de gravit  10/10

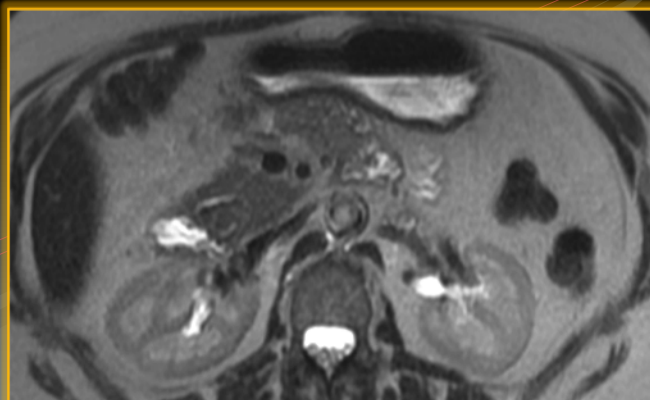
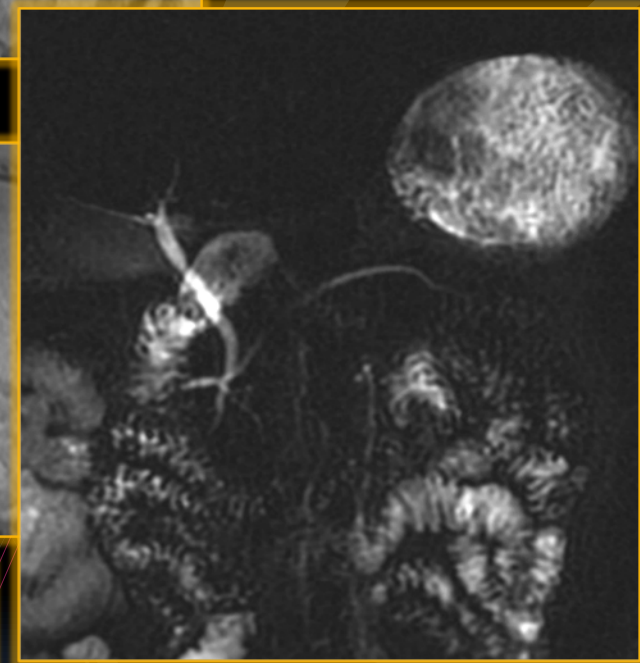
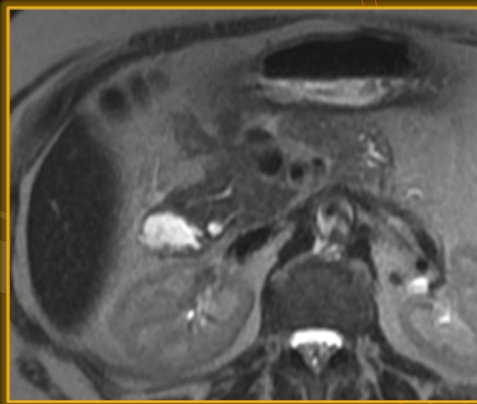
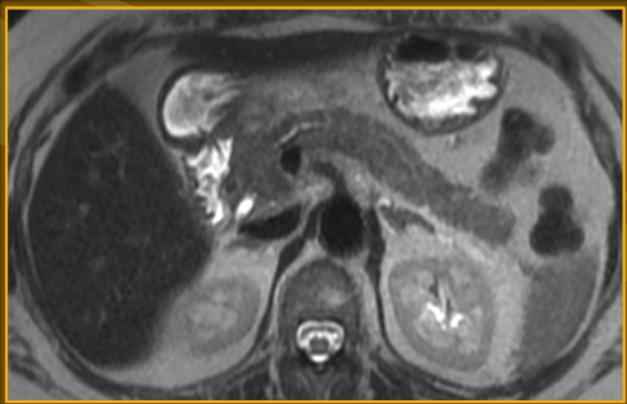
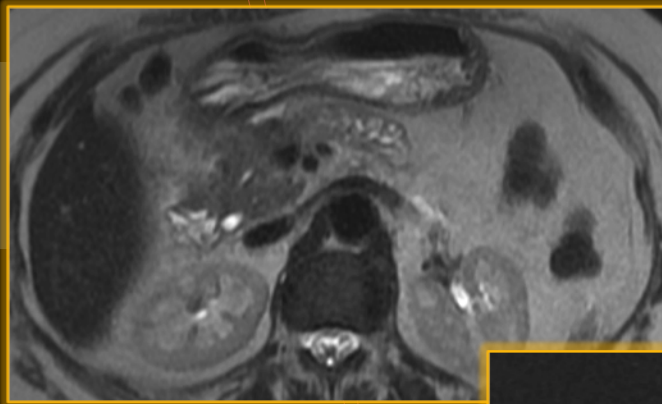
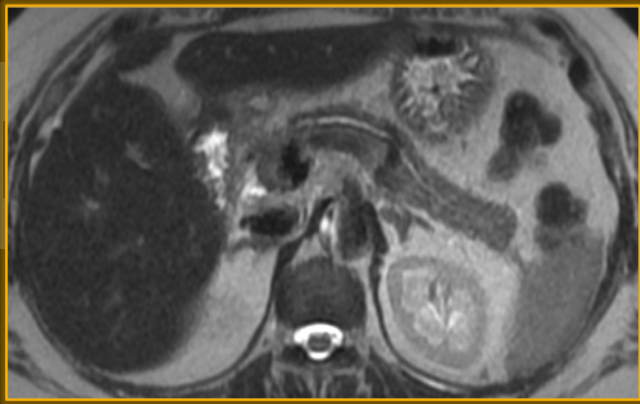


Patiente de 59 ans
Enz pancréatiques +
Atcd: 5 pancréatites aiguës

Cas N°14

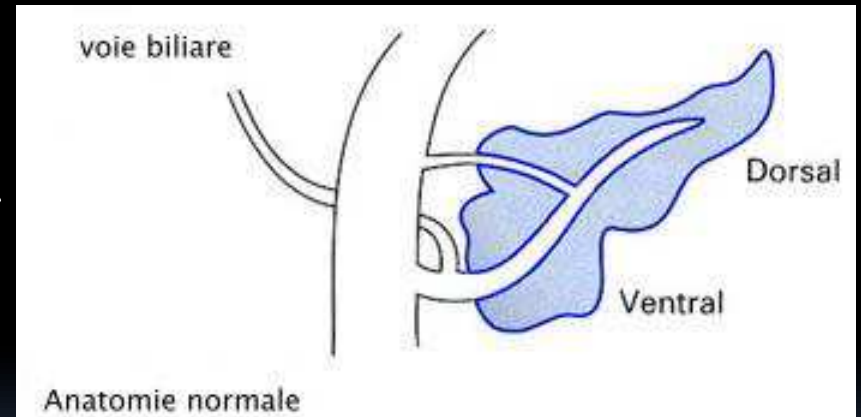
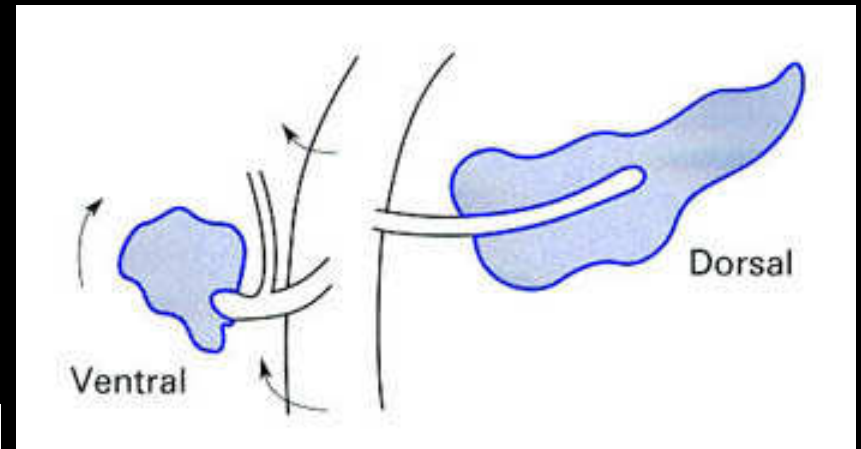
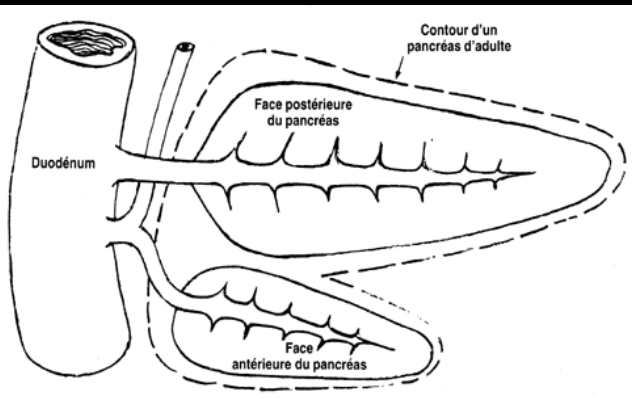


Pancréatite aigue simple 4/10
Etiologie ?



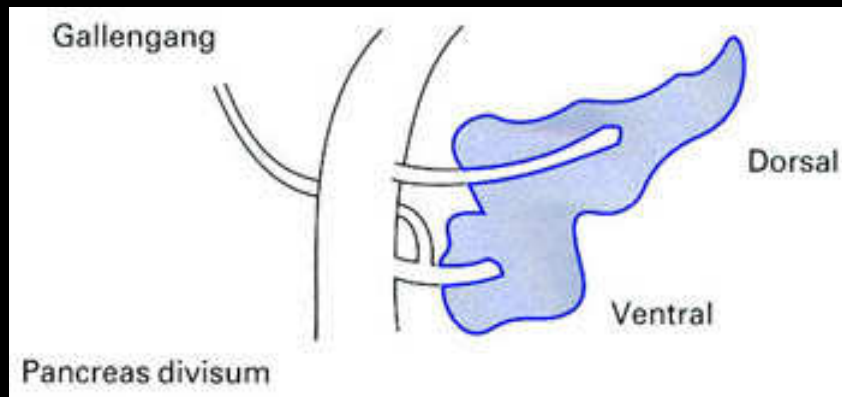
Pancréatite aiguë
et
Pancréas divisum

Embryologie

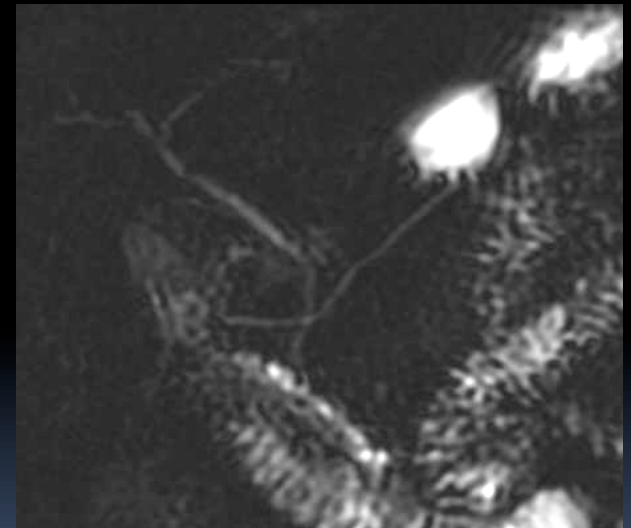


Pancréas normal

2 bourgeons ventral et dorsal
fusionnent à la 7ème SG

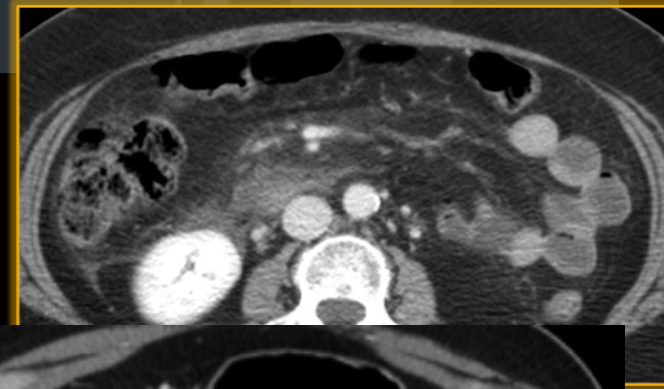
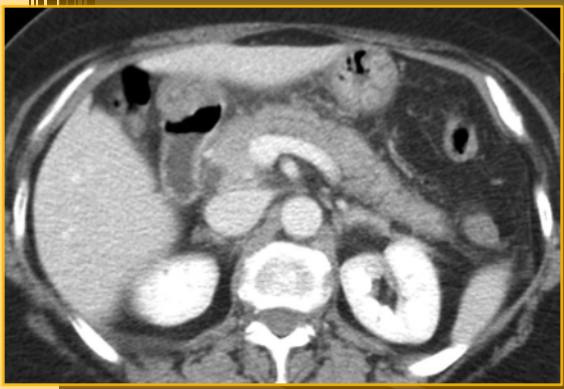


Pancréas divisum



→ 2 conduits pancréatiques séparés qui s'écoulent dans le duodénum

Pancréatite oedémateuse ??



Pancréatite oedémateuse = absence de nécrose du parenchyme

Mais... 2 situations délicates..

① Discrète hétérogénéité de rehaussement

② Défaut de rehaussement < à 30%

Dans la majorité des cas, ce simple défaut de rehaussement n'est pas une véritable nécrose, on assiste à une récupération ad integrum du parenchyme pancréatique.

L'évaluation définitive doit donc être réalisée **à 1 semaine +++..**

Si persistance de ce défaut de rehaussement, on parle alors de **nécrose!**



Révision en 2011 de la conférence d'Atlanta de 1992

Radiology

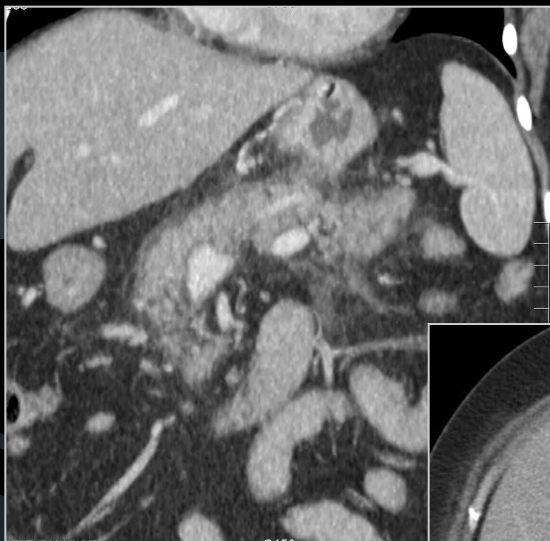
The Revised Atlanta Classification of Acute Pancreatitis: Its Importance for the Radiologist and Its Effect on Treatment¹

Ruedi F. Thoeni, MD

Radiology. Volume 262: Number 3—March 2012 ■ radiology.rsna.org



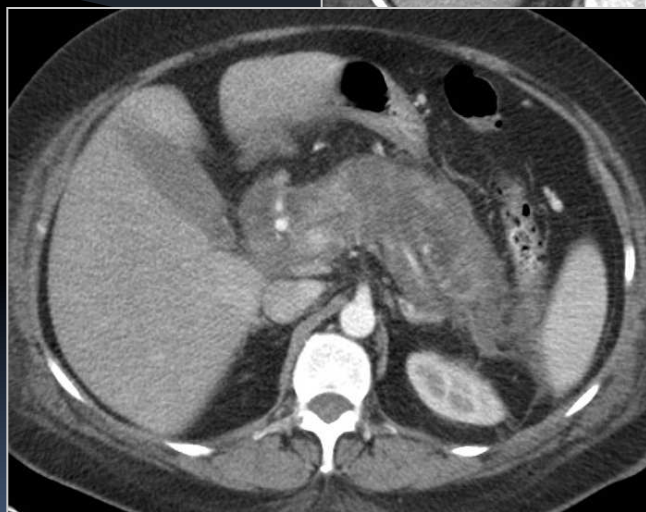
Après 4 semaines, pas de rehaussement.. Liquéfaction de la glande.. Et organisation avec paroi inflammatoire non épithélialisée..



18/02



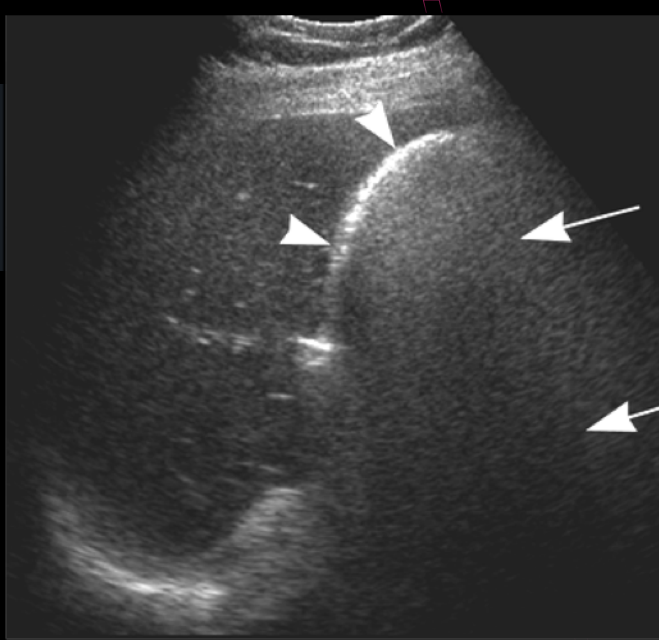
24/02



03/03

Pancréatite aiguë sur hypertriglycémie (135 g/L !), évolution vers la nécrose de la totalité de la glande pancréatique... **Importance du suivi !!!**

Cas N°15

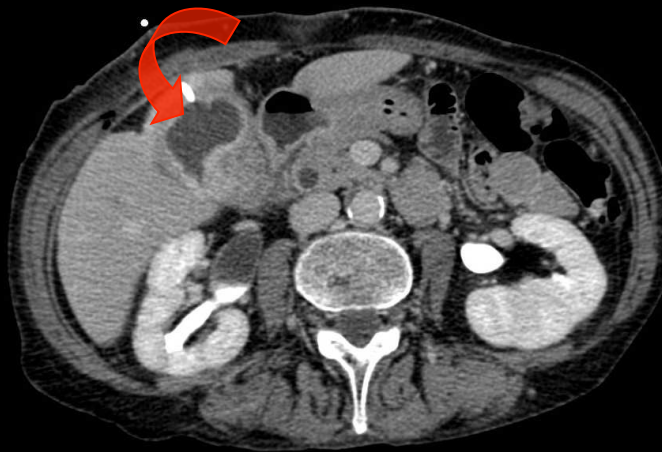
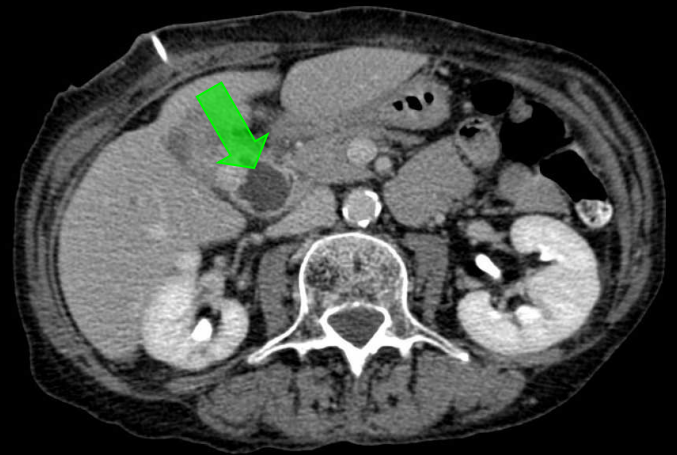


- Bactéries : E Coli, Klebsiella
- Terrain diabétique ++
- Souvent pas de calcul visible
- Evolution possible : cholécystite gangréneuse

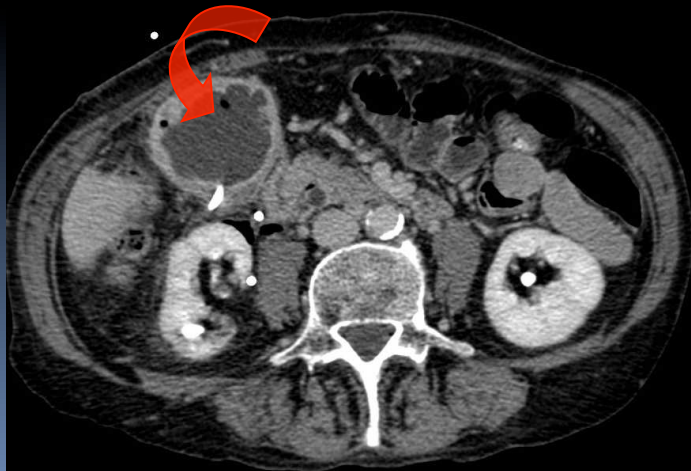


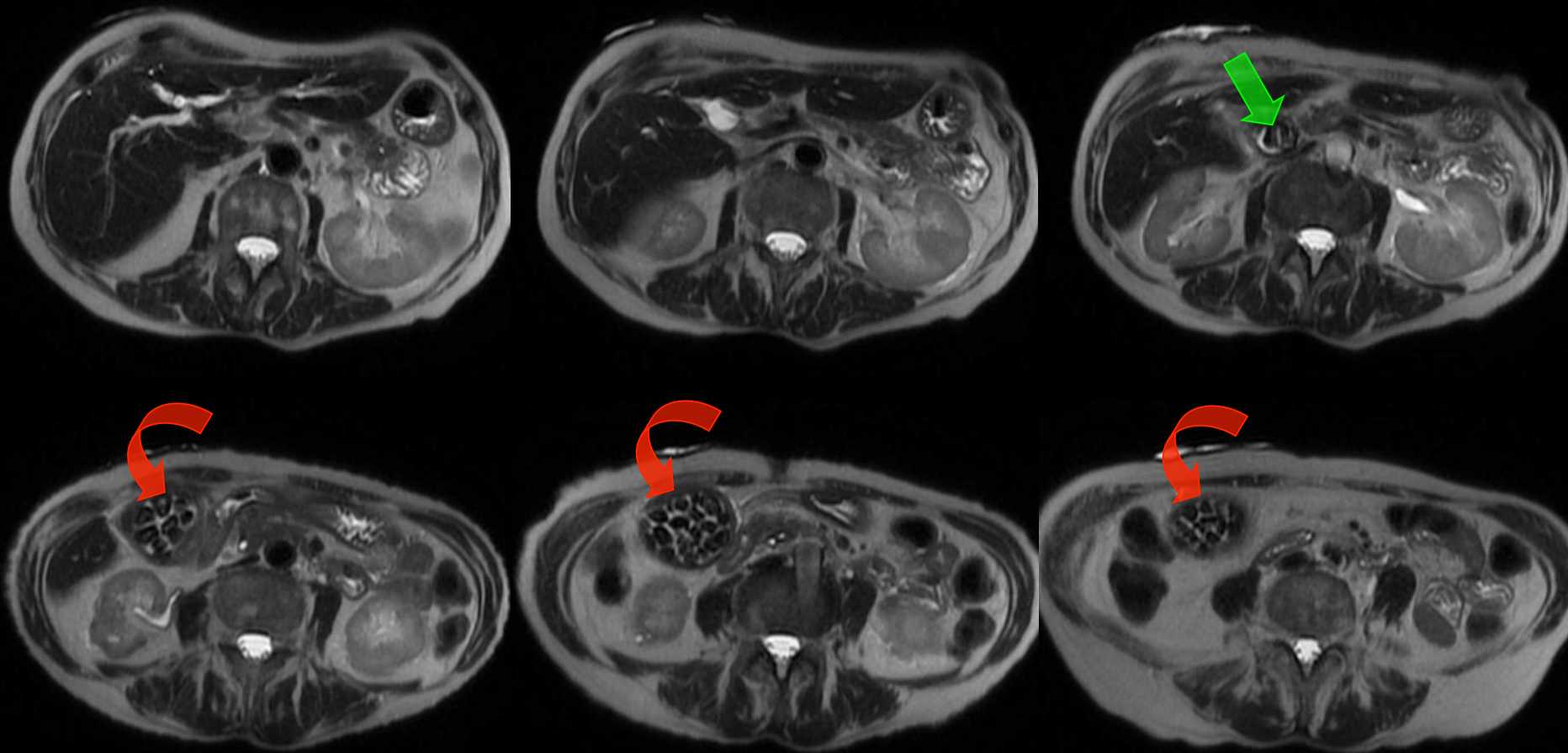
Cholécystite emphysémateuse

Cas N°16

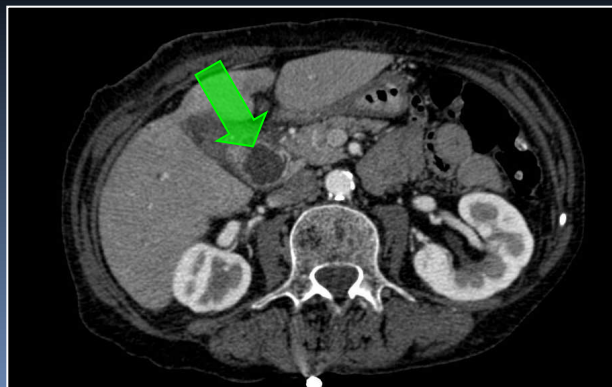
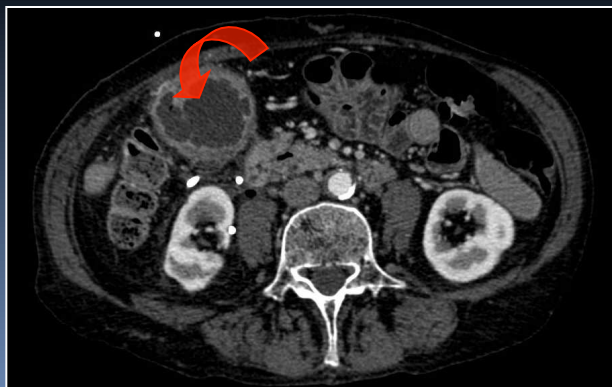


TEMPS PORTAL

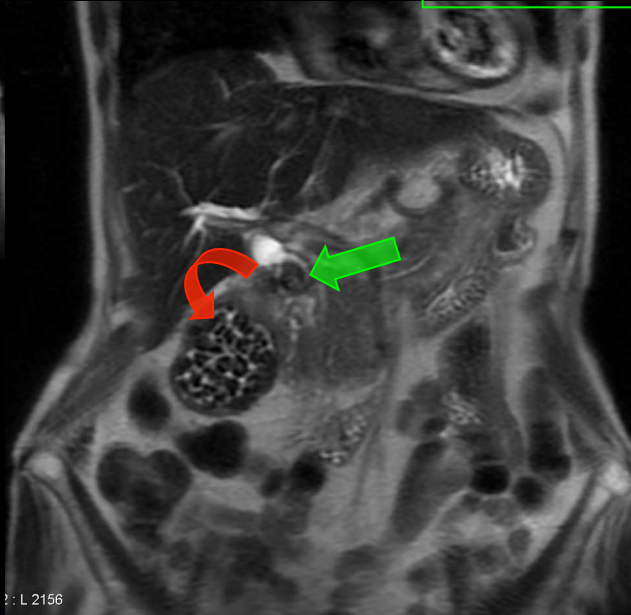
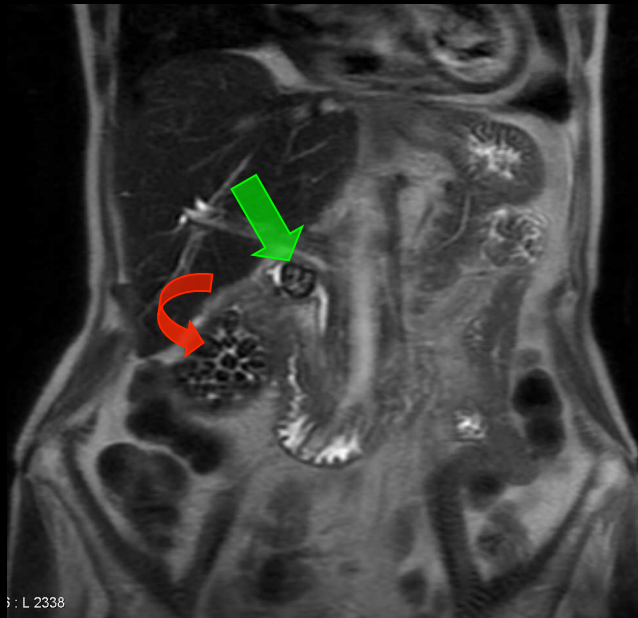


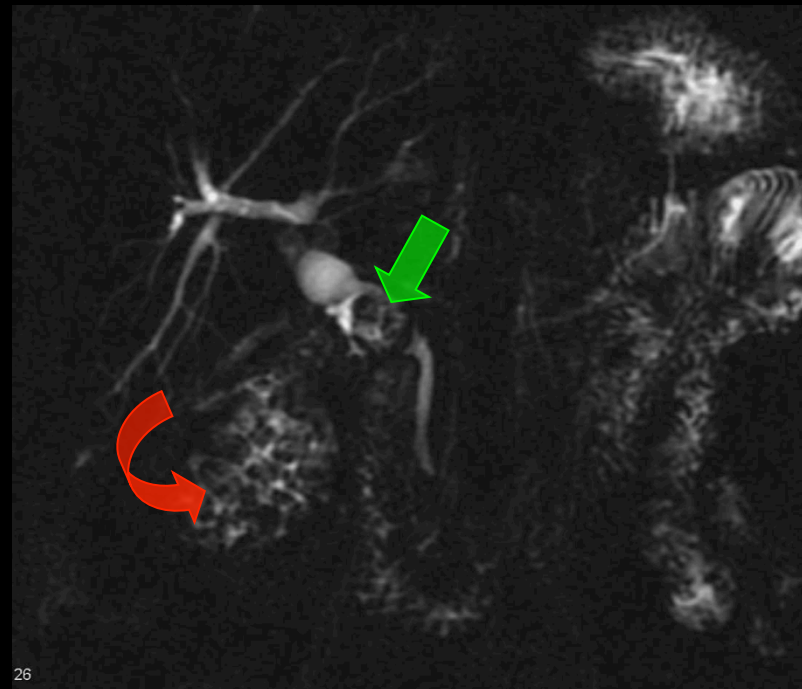


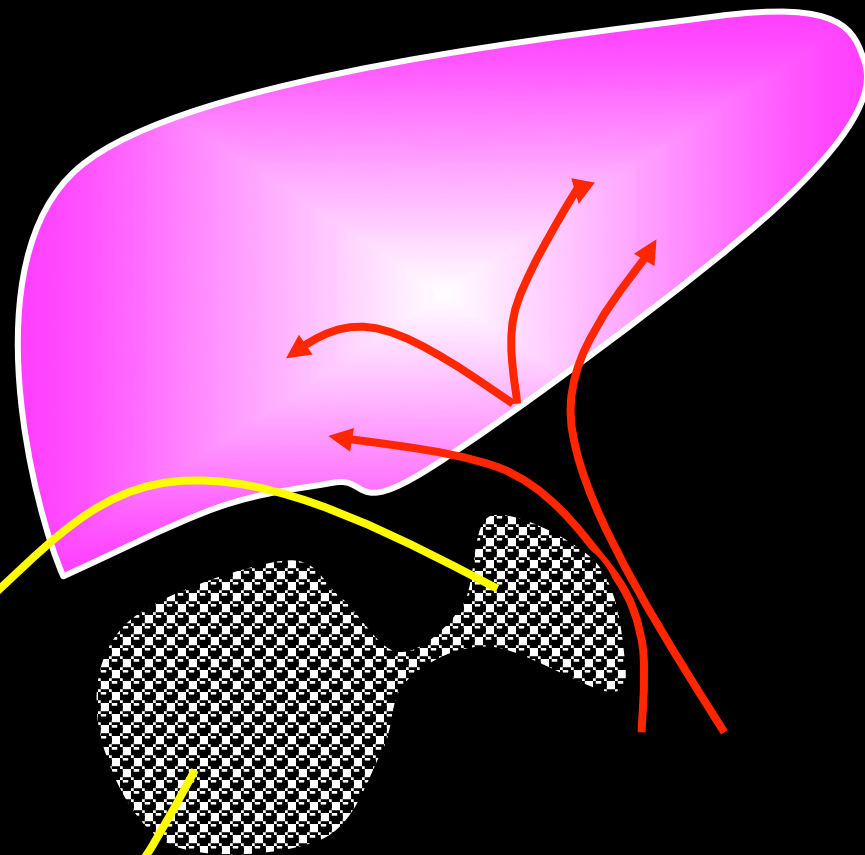
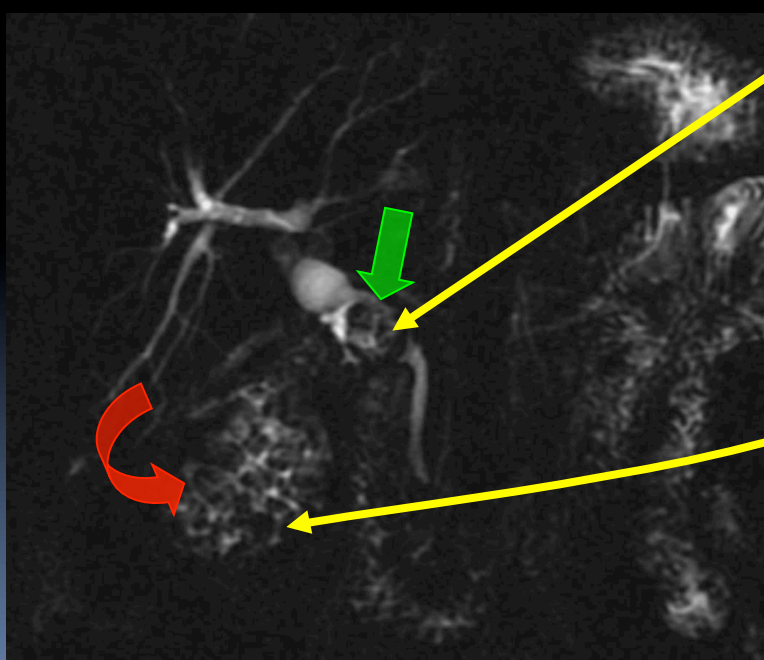
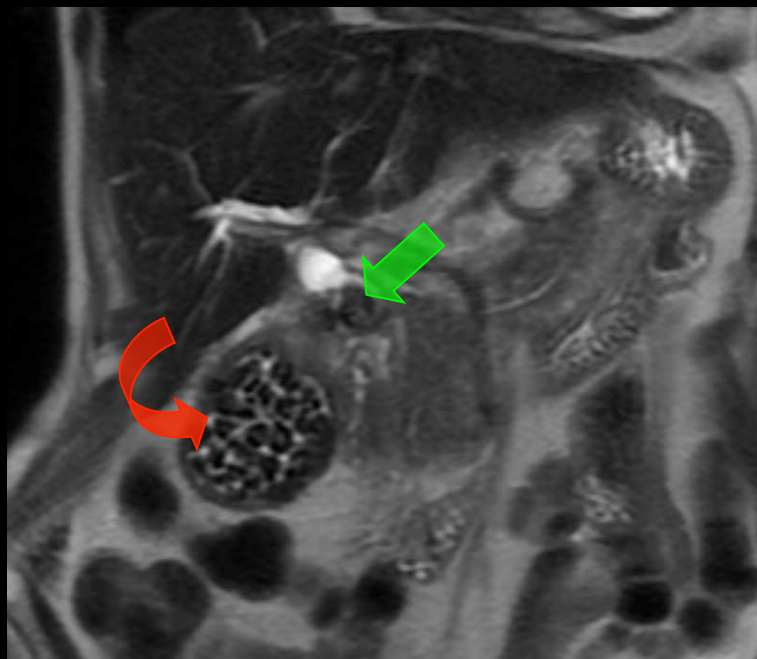
IRM AX T2



**EMPIERREMENT DU
CYSTIQUE
AVEC
SYNDROME DE MIRIZZI**



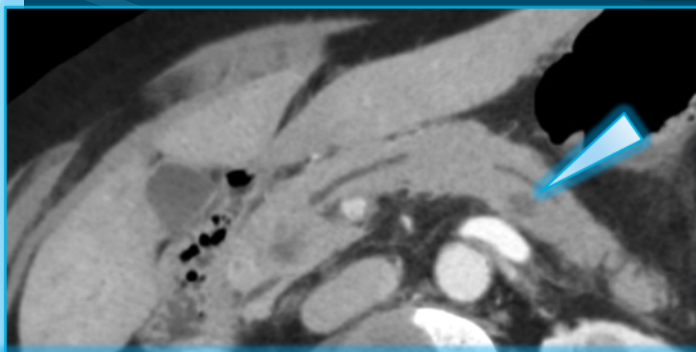
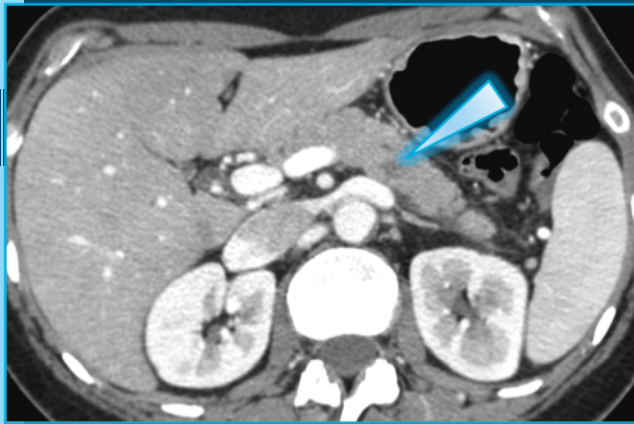




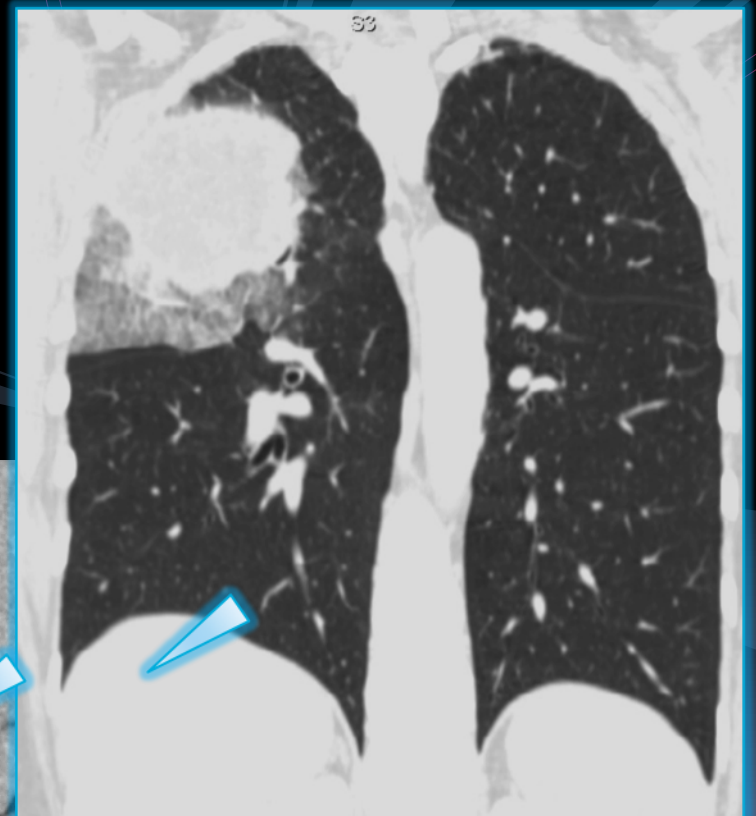
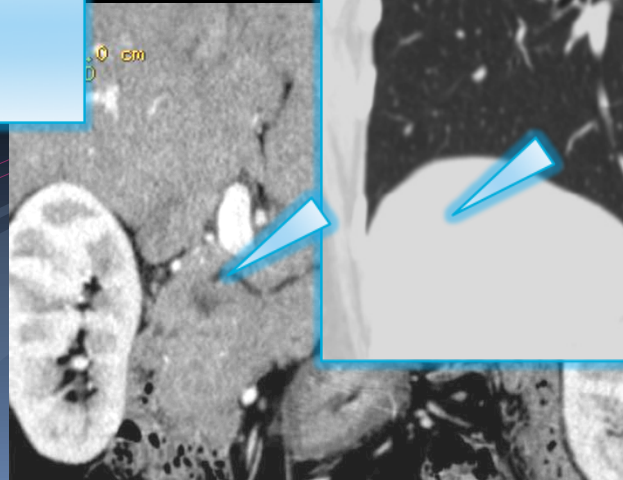
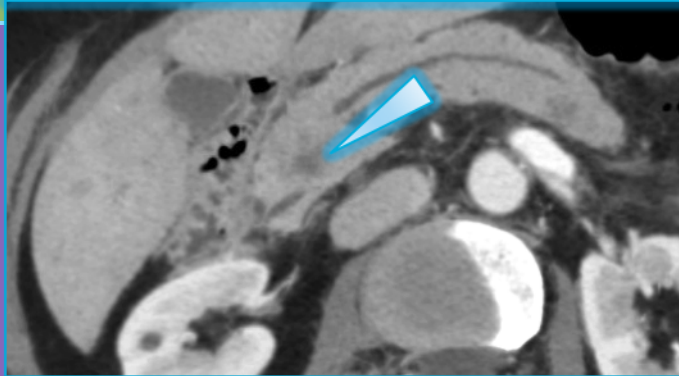
**EMPIERREMENT DU CYSTIQUE
AVEC
SYNDROME DE MIRIZZI**

Cas N°17

Patient 51 ans
douleurs épigastriques
Hyper amylasémie et lipasémie

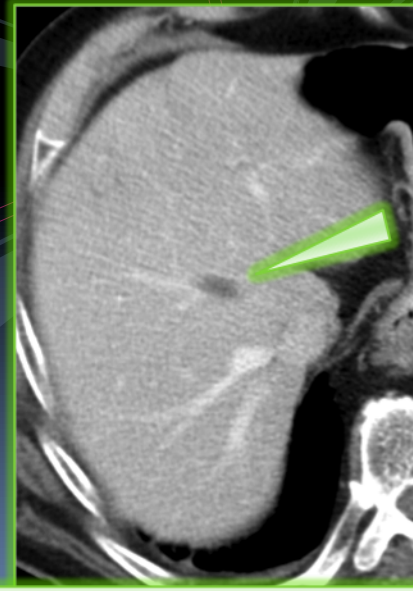
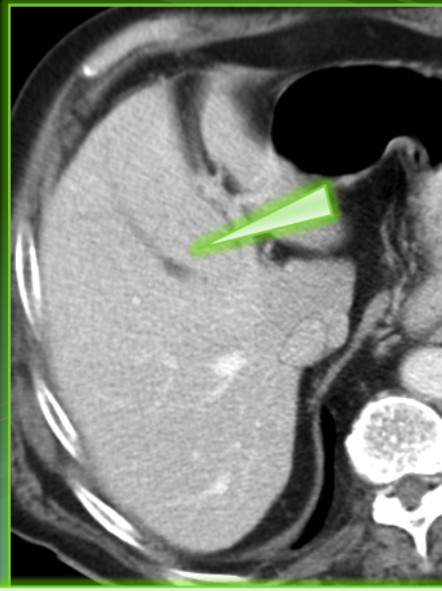
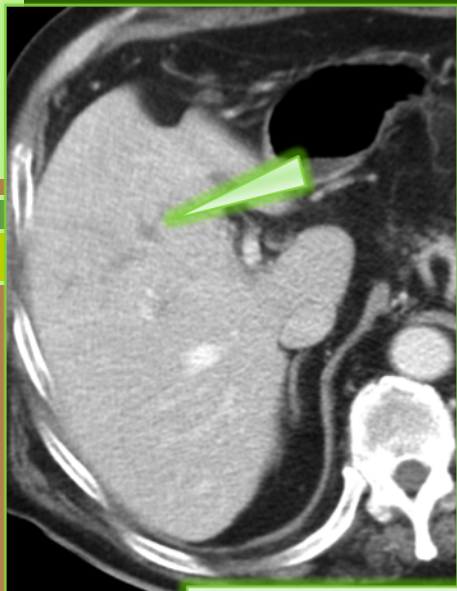
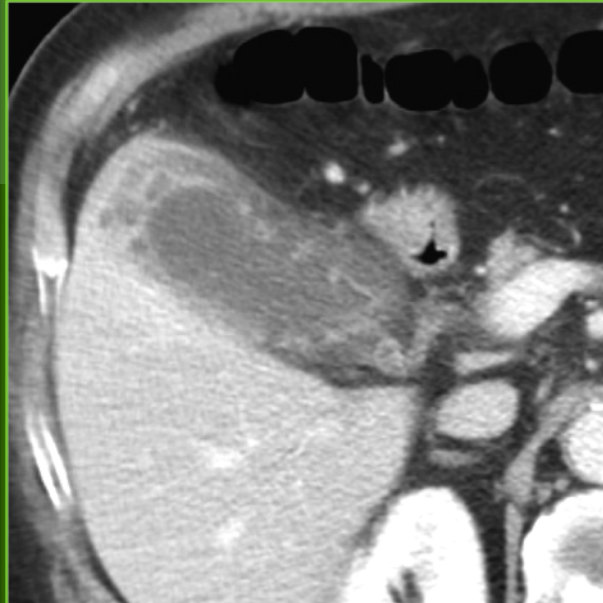


Pancréatite symptôme révélant des
métastases pancréatiques d'un
carcinome bronchique



Cas N°18

Douleurs HCD
Syndrome infectieux



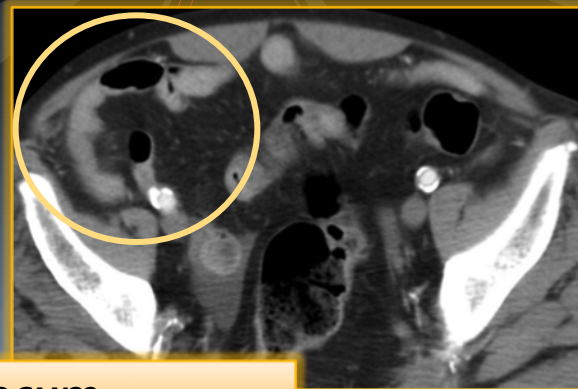
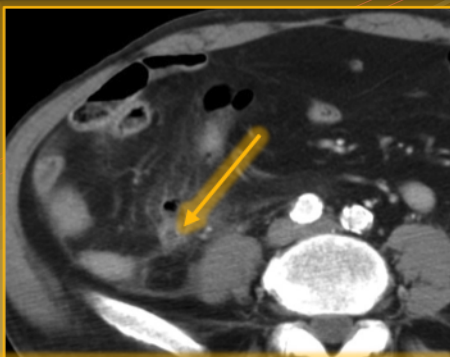
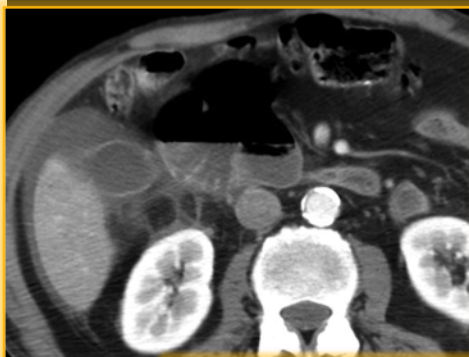
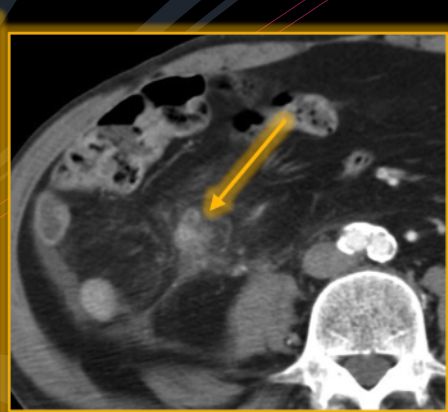
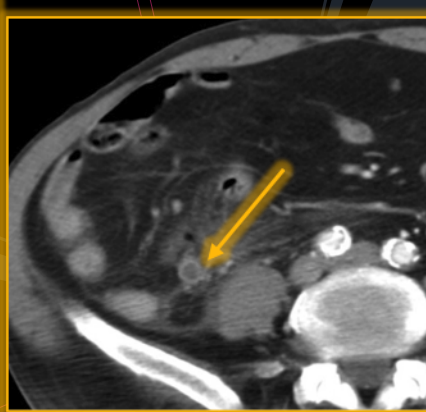
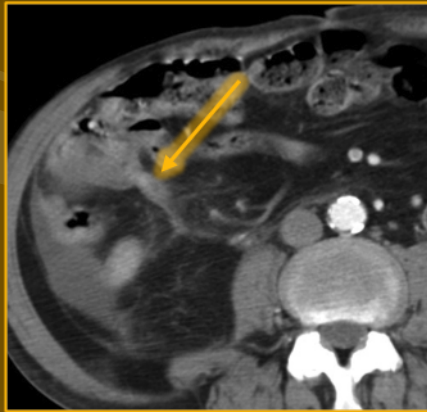
Cholécystite gangréneuse et thrombose VSH médiane distale

Cas N°19

Patient 59 ans
Douleurs hypochondre droit
Murphy +

1=8,5cm
2=2,6cm

5 mm



Appendicite et défaut accolement caecum

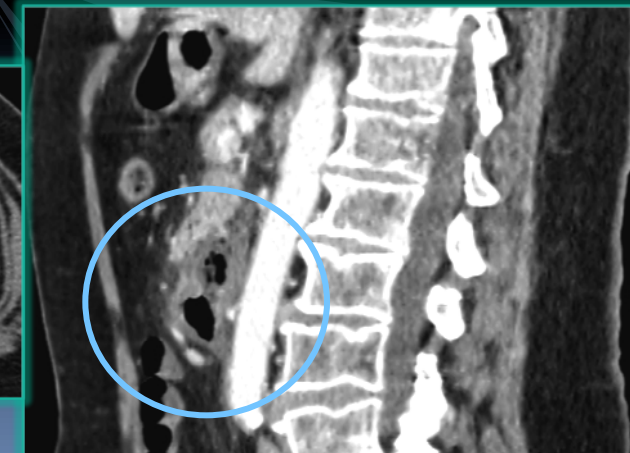
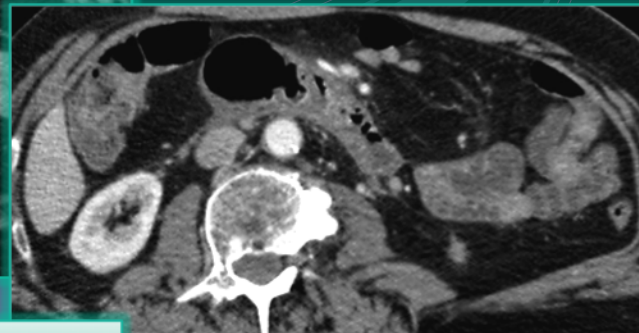
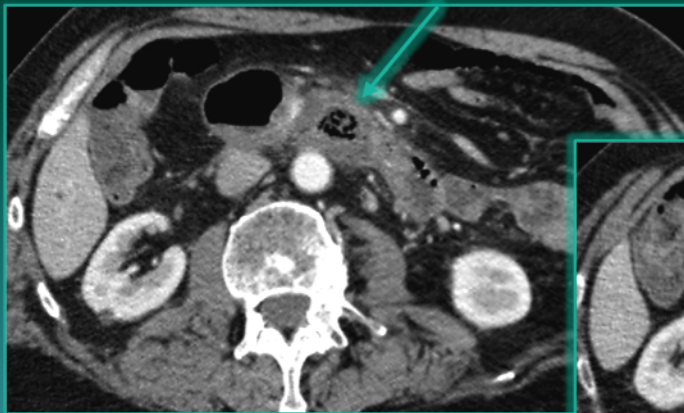
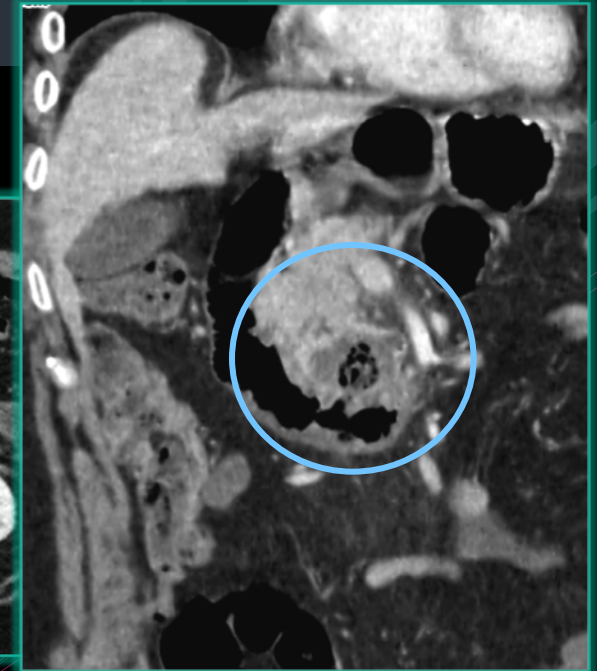
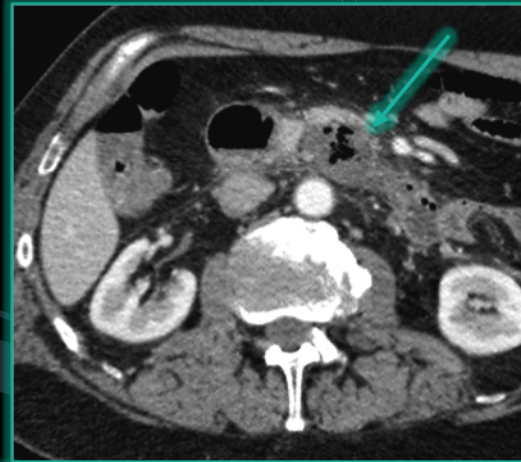
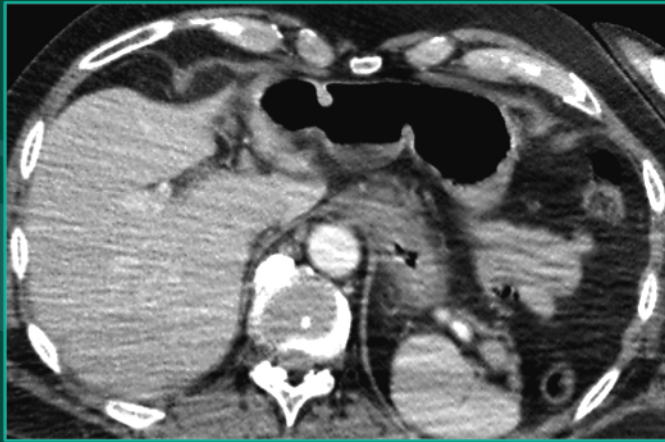
Patient 65 ans

Douleurs épigastriques fébriles 24h

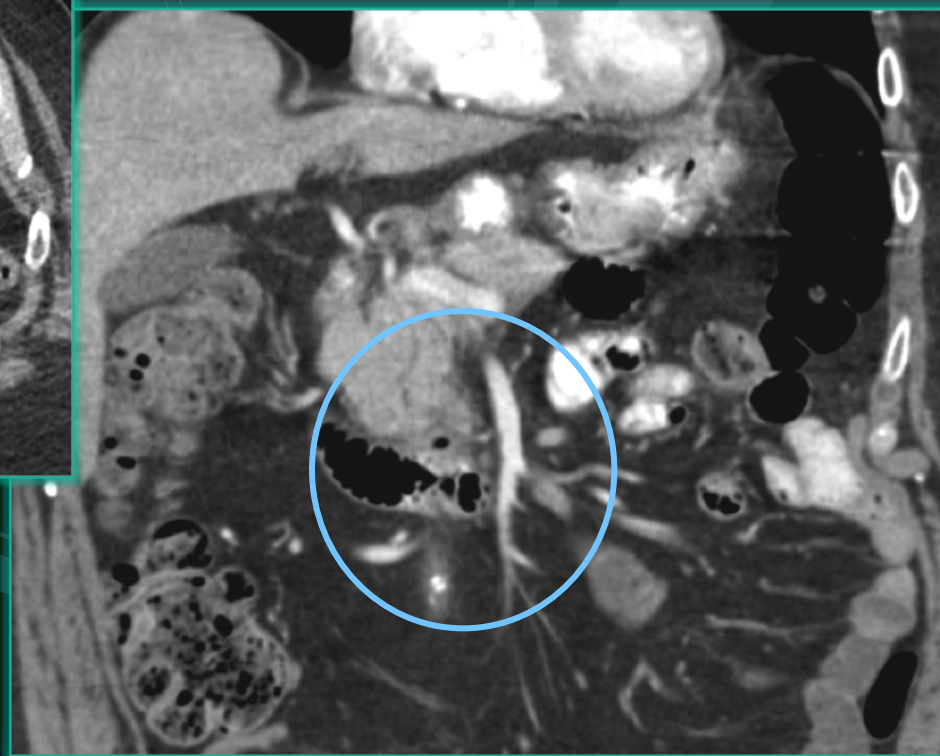
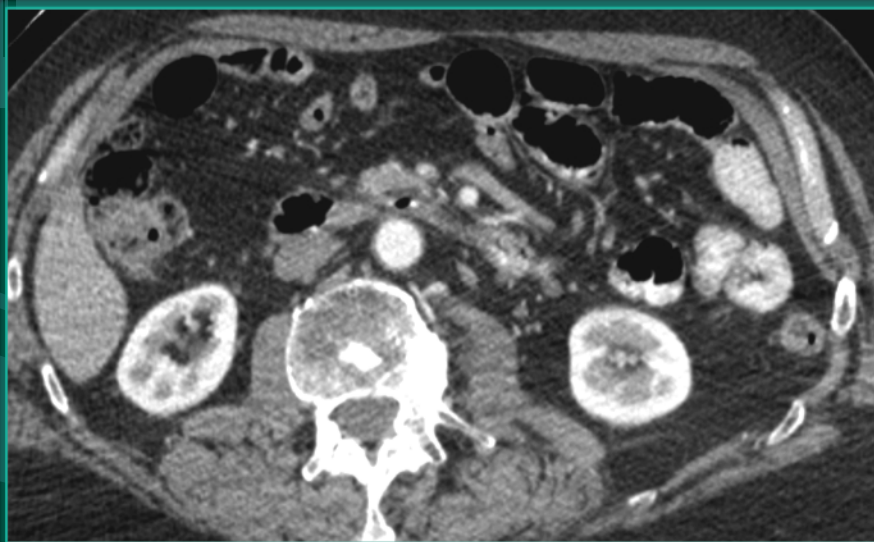
Syndrôme inflammatoire biologique

Pas de perturbation bilan hépatique

Cas N°20



Diverticulite du D3

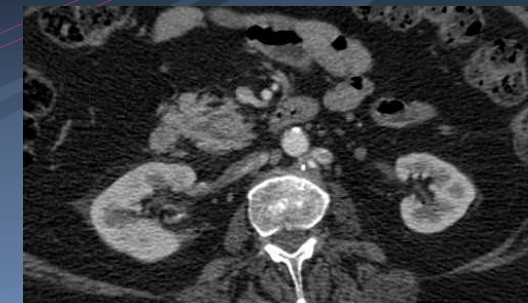
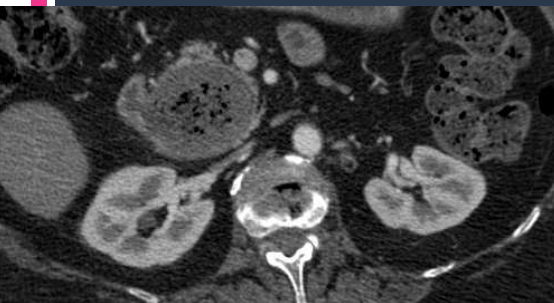
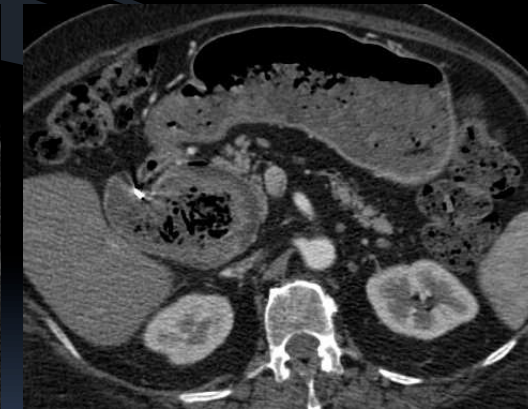
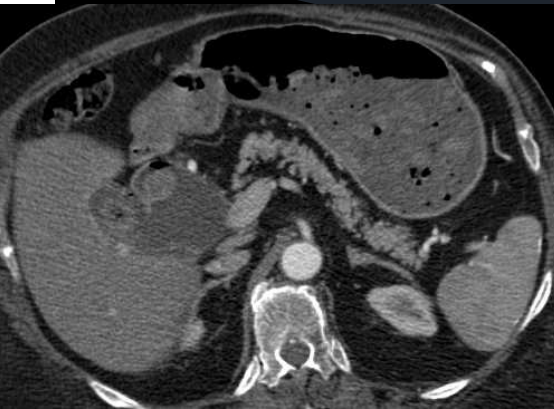


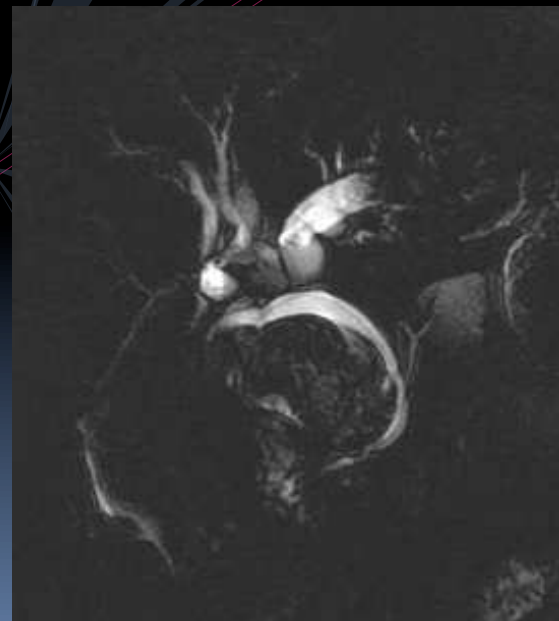
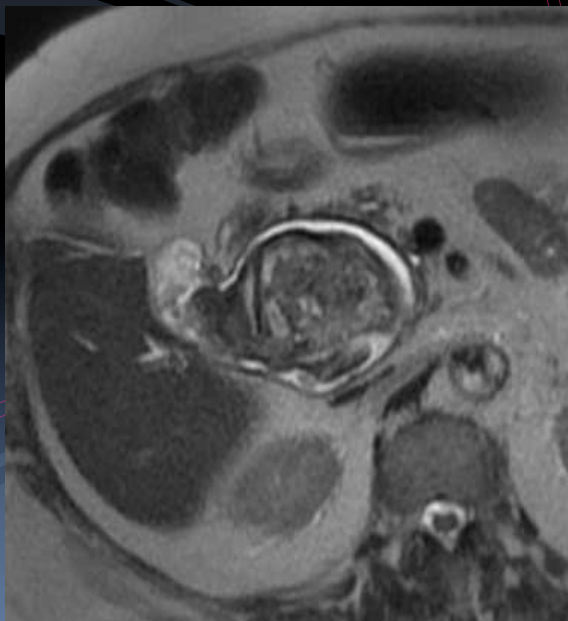
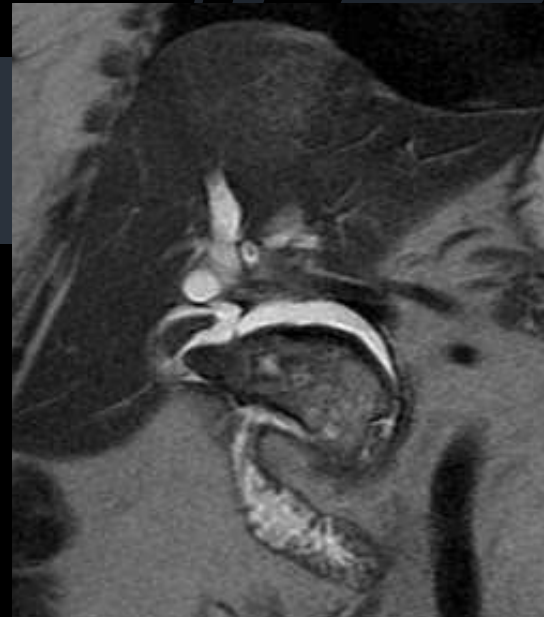
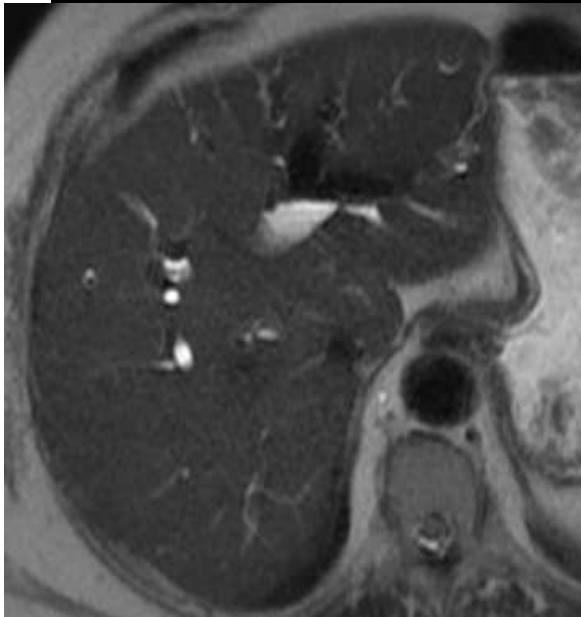
Contrôle à 1 mois après antibiothérapie

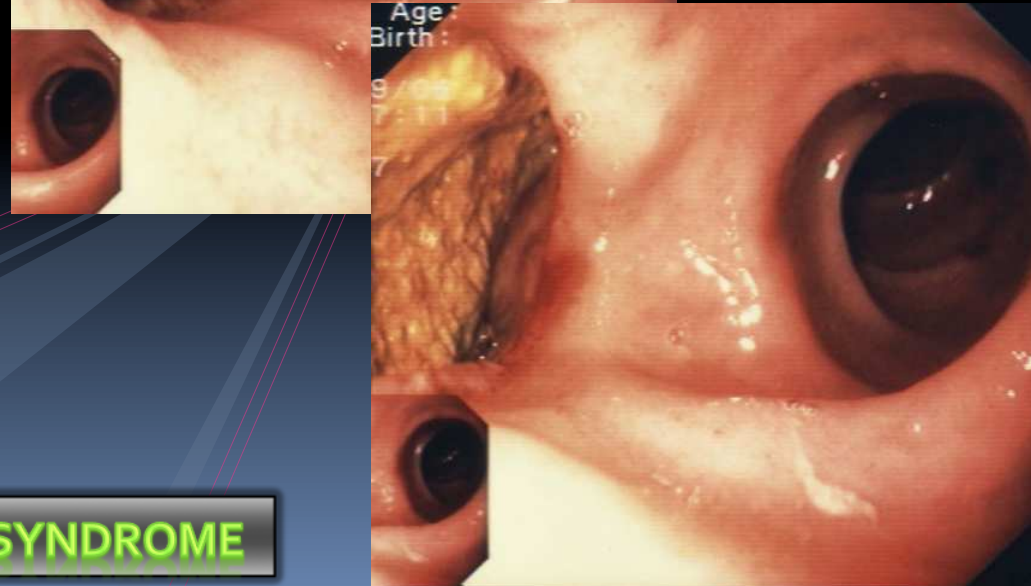
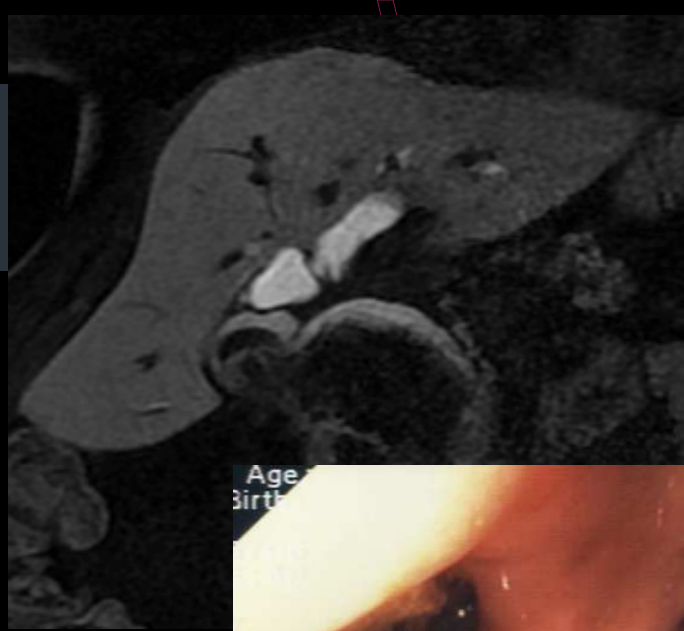
Cas N°21

Femme 75 ans

ATCD cholécystectomie

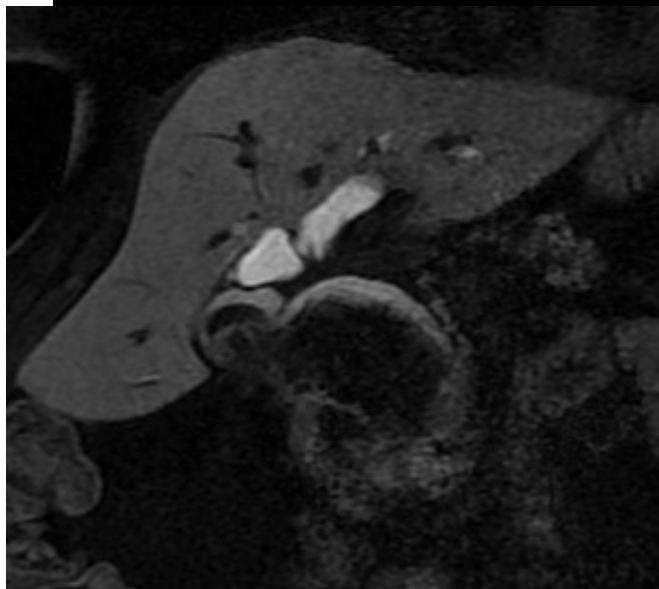
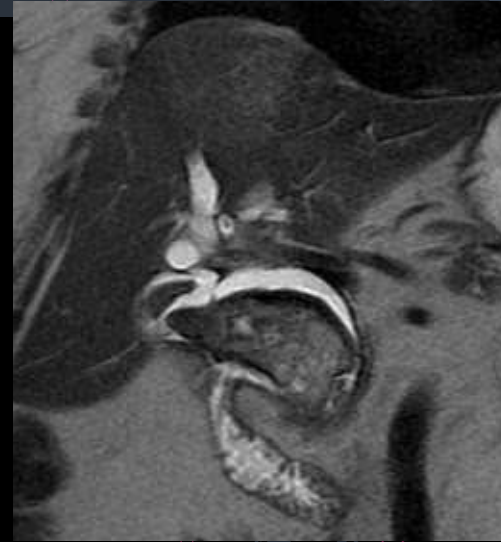
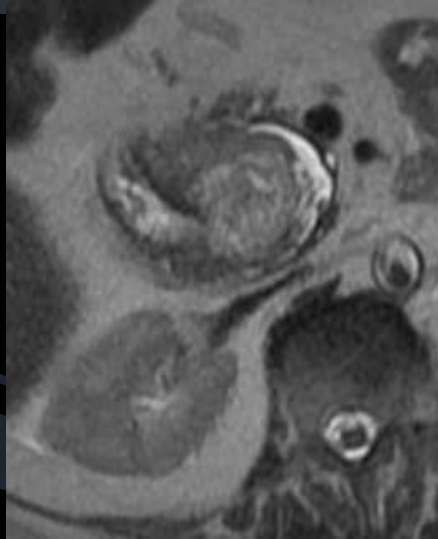
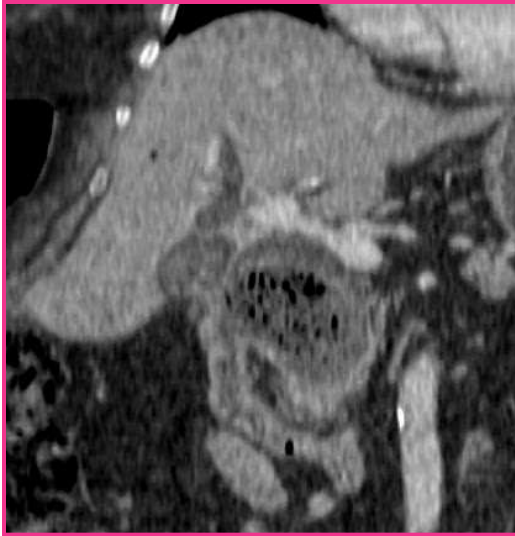






FISTULE BILIO DIGESTIVE : SUMP SYNDROME

SUMP syndrome



Complication des anastomoses cholédoco-duodénales

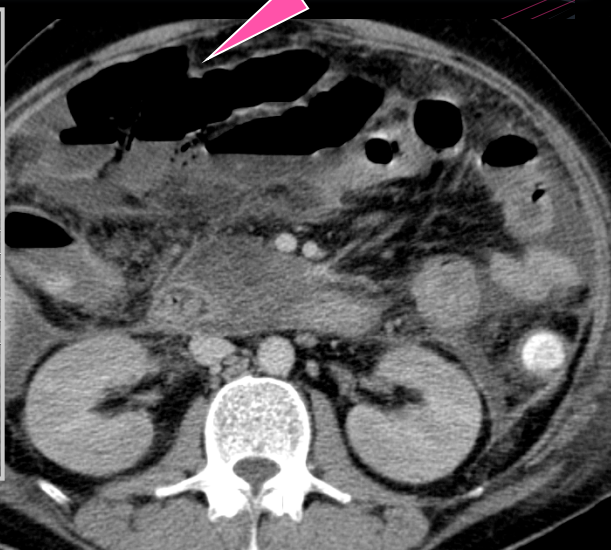
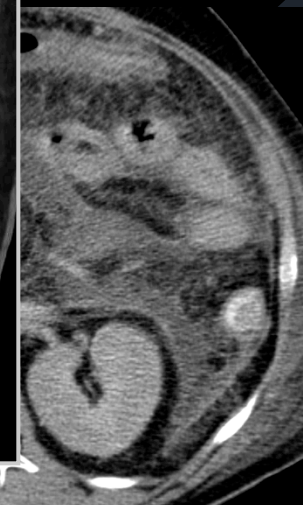
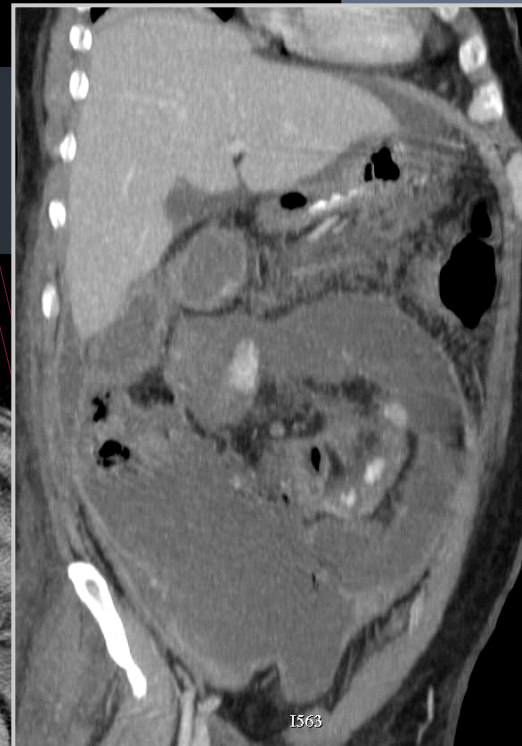
Obstruction biliaire et cholangitique IIaire à accumulation de débris et de matériel ingéré dans les canaux biliaires par reflux

- 0.14 à 1.3%

PANCREAS

s n°22

Pancrétatite aiguë sévère
score: 10 pts
Nécrose et perforation coliques et
iléales !



The Revised Atlanta Classification of Acute Pancreatitis:

Its Importance for the Radiologist and Its Effect on Treatment¹

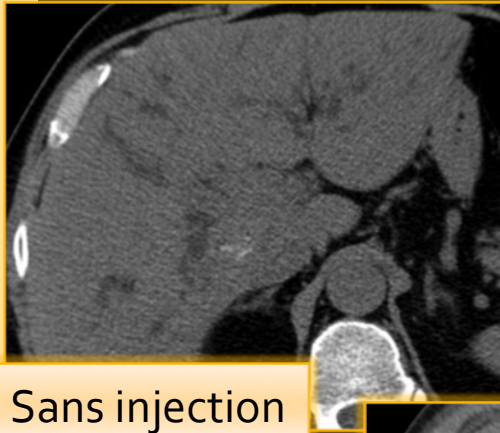
Fluid Collections as Defined in Revised Atlanta Classification of Acute Pancreatitis and Possible Interventions

Type of Collection	Time (wk)	Necrosis	Location	Appearance	Infection	Drainage or Surgery
IEP						
APFC	≤4	No	Adjacent to pancreas, extrapancreatic only	Homogeneous, fluid attenuation, no liquefaction (debris), not encapsulated	Extremely rare	None
Pseudocyst*	>4	No	Adjacent or distant to pancreas	Homogeneous, fluid attenuation, no liquefaction (debris), encapsulated	Rare	Rarely (for infection or symptoms)
Necrotizing pancreatitis						
Sterile ANC	≤4	Yes	In parenchyma and/or extrapancreatic	Heterogeneous [†] , nonliquefied material, variably loculated, not encapsulated	No	Based on clinical, percutaneous drainage at times, surgery rarely [‡]
Infected ANC					Yes	Percutaneous drainage, surgery later if needed [‡]
Sterile WON	>4	Yes	In parenchyma and/or extrapancreatic	Heterogeneous [†] , nonliquefied material, variably loculated, encapsulated	No	Percutaneous drainage based on clinical, surgery to follow if needed [‡]
Infected WON					Yes	Percutaneous drainage/ surgery to follow if needed [‡]

Figure 3: Revised Atlanta classification of fluid collections in acute pancreatitis (4). ANC = acute necrotic collection, APFC = acute peripancreatic fluid collection, WON = walled-off necrosis.

Homme 45 ans
Ictere
Douleurs abdominales

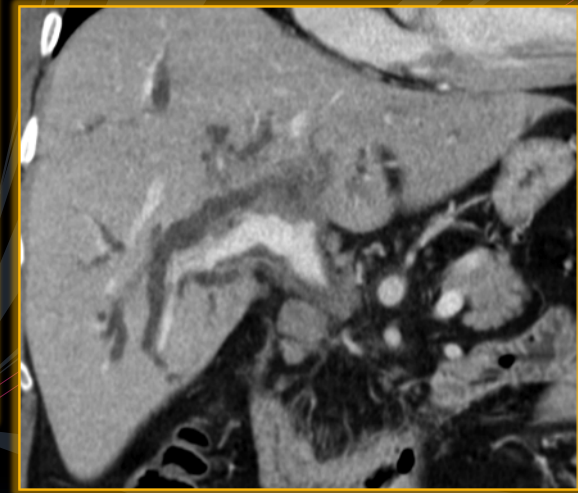
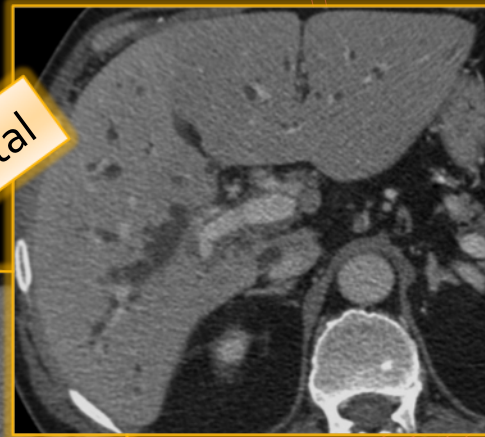
Cas N°23



Sans injection

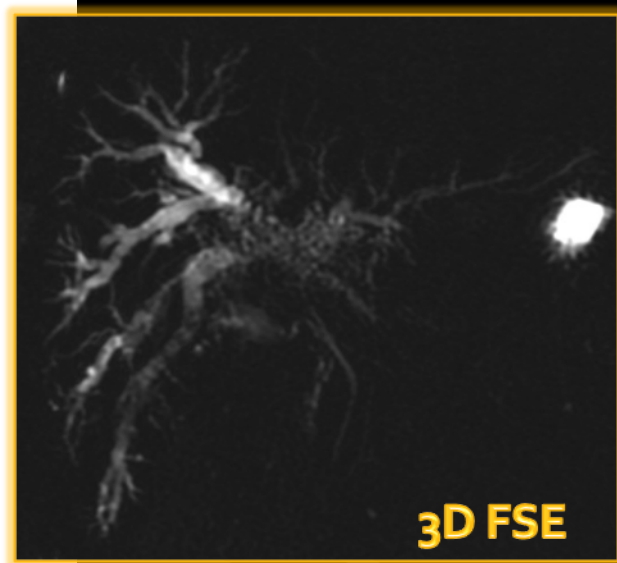


Temps portal

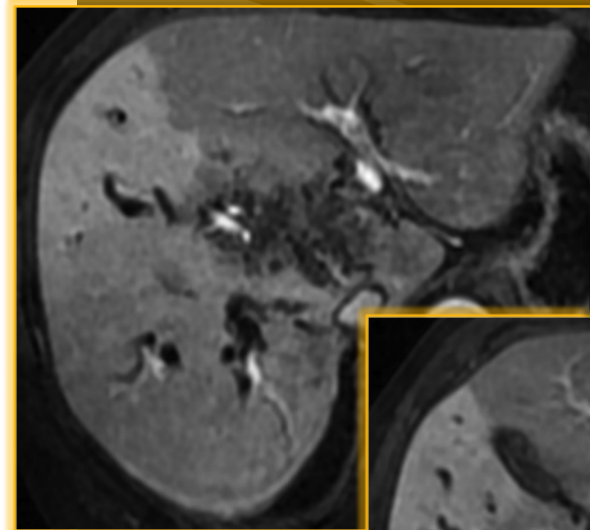
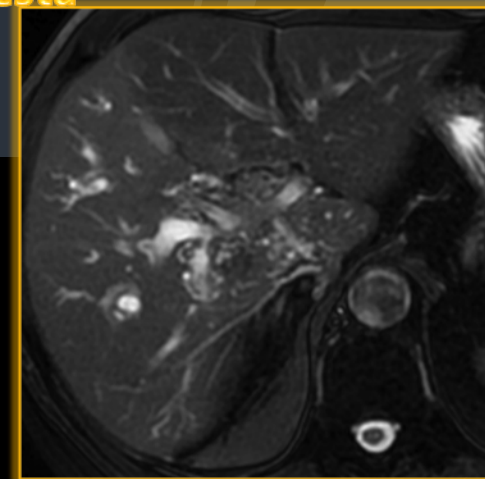
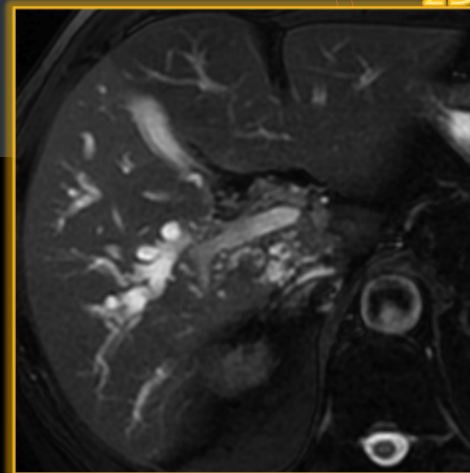


Lésion tumorale du hile
hépatique, compression de la
convergence.
Cholangiocarcinome ?

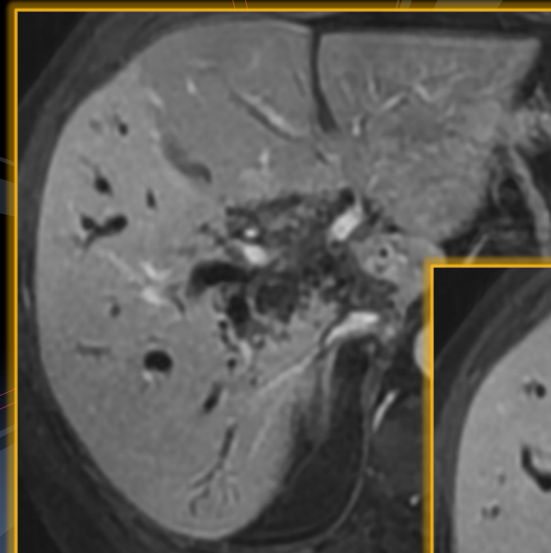
→ IRM



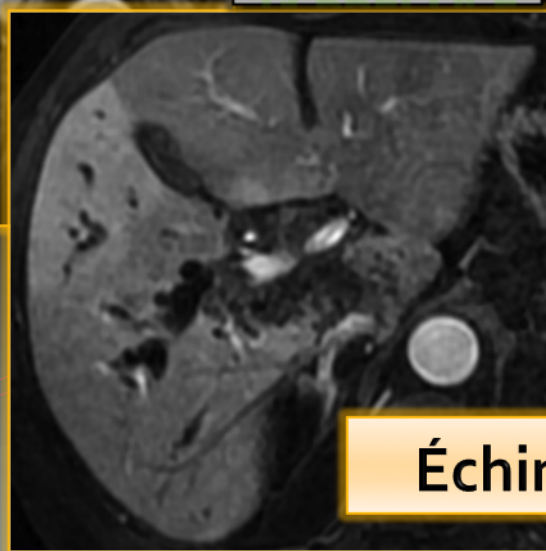
2D Fiesta



T₁ PRÉCOCE



T₁ TARDIF



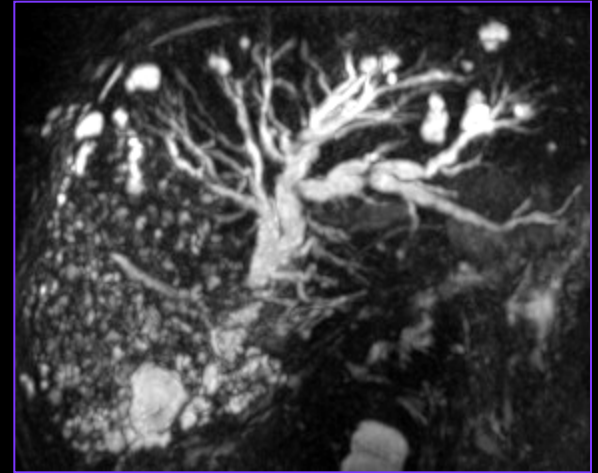
Échinococcose alvéolaire



Échinococcose alvéolaire

Scanner :

- Masse hépatique souvent unique
- Grande taille en général
- Hypodense par rapport au parenchyme sain
- Contours irréguliers
- Calcifications fréquentes (90%)



IRM :

- hyposignal T1 T2 : fibreux
- Aspect multiloculaire : « rayon de miel » ou « mie de pain »