

ATELIERS D'IMAGERIE DIGESTIVE

URGENCES ABDOMINALES

SIGMOÏDITES, APPENDICITES ET PÉRITONITES PAR PERFORATION

BRUOT Olivier
Clinique Claude Bernard Metz

ATCD/HDM:

Sd appendiculaire depuis 3 jours...,
chez un homme de 32 ans sans ATCD médico-
chirurgical

Clinique:

Défense en FID...

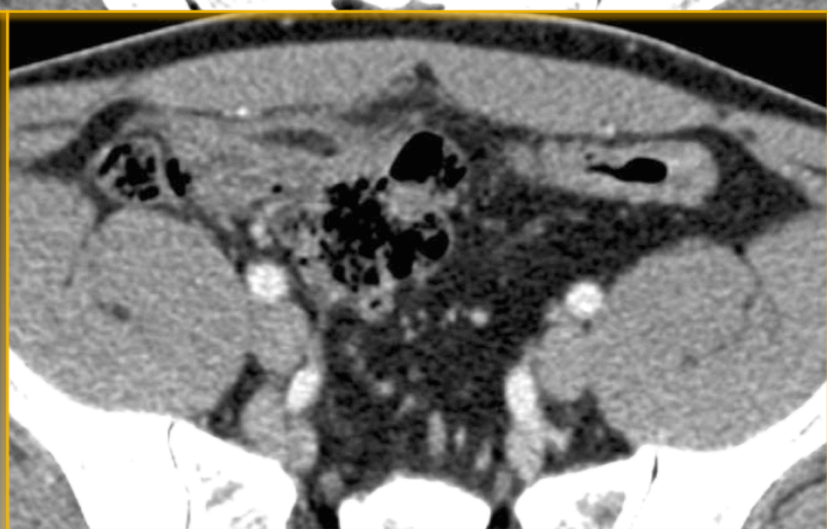
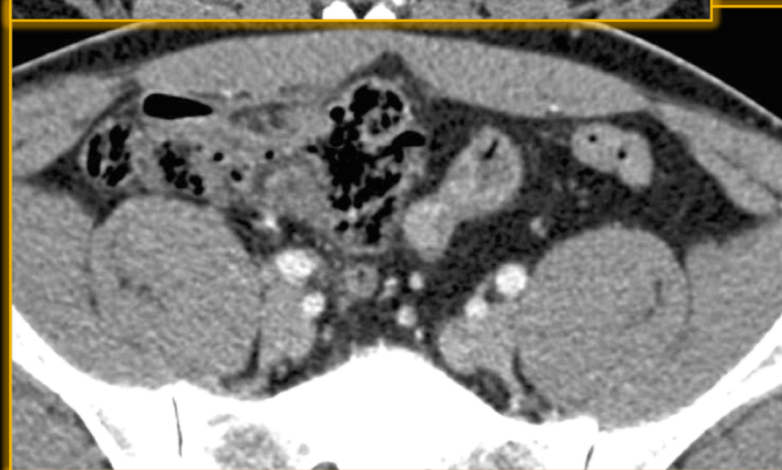
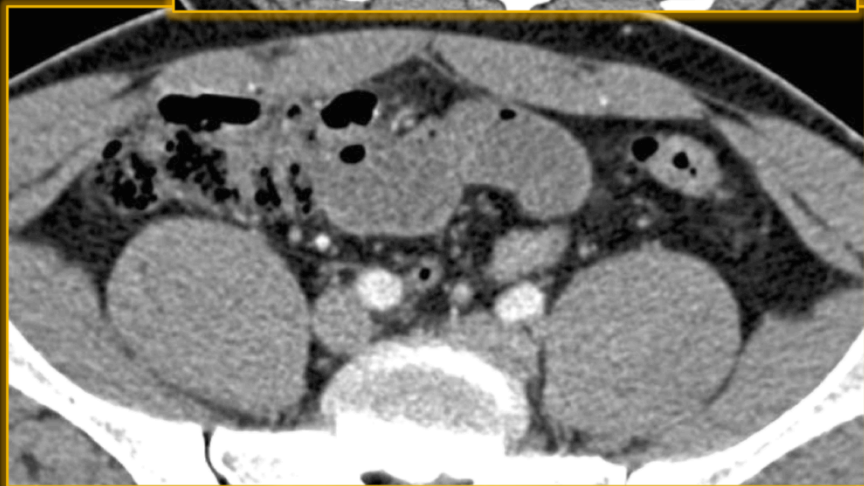
Biologie:

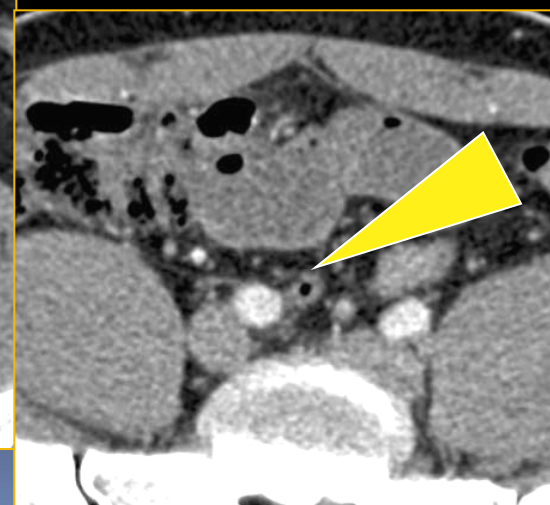
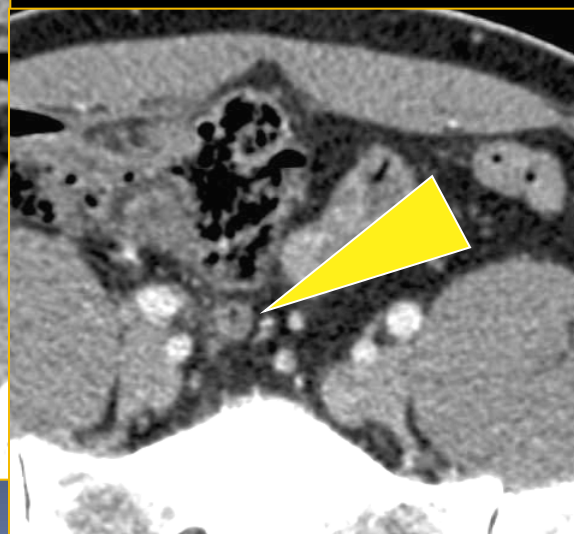
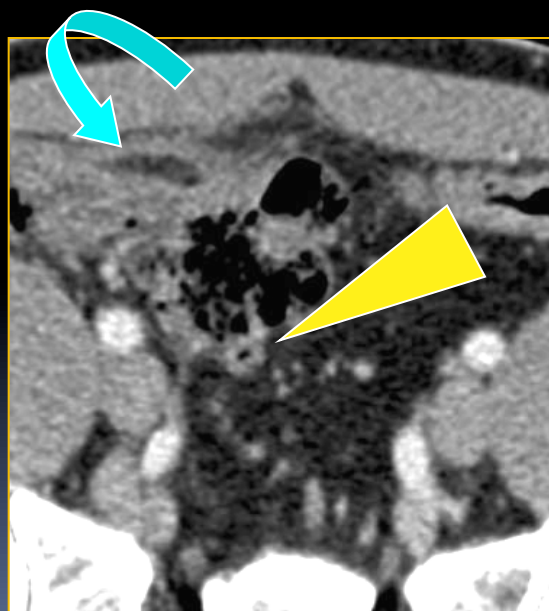
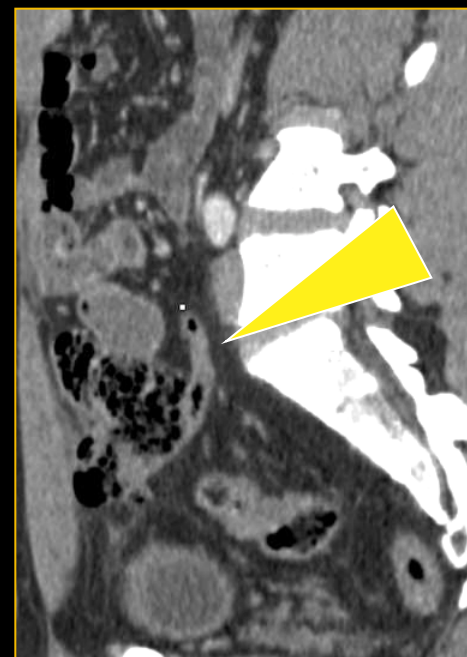
Absence de Sd inflammatoire...

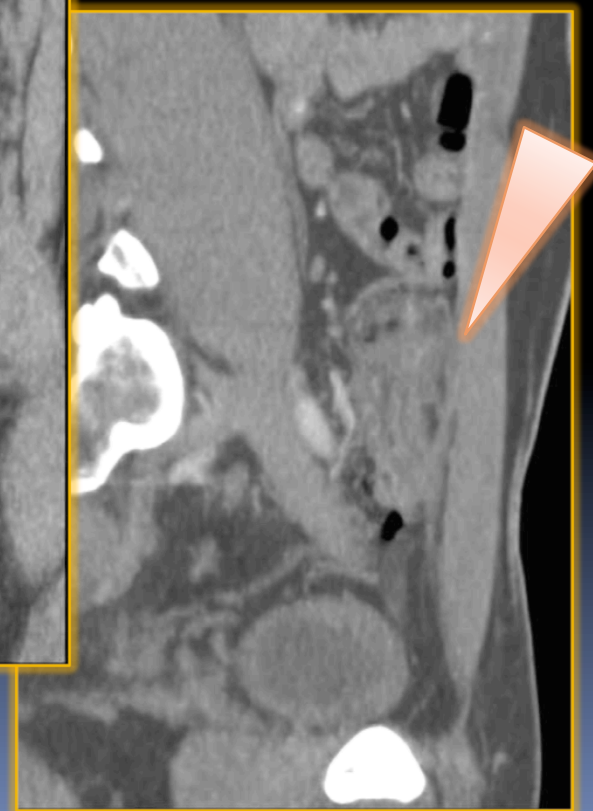
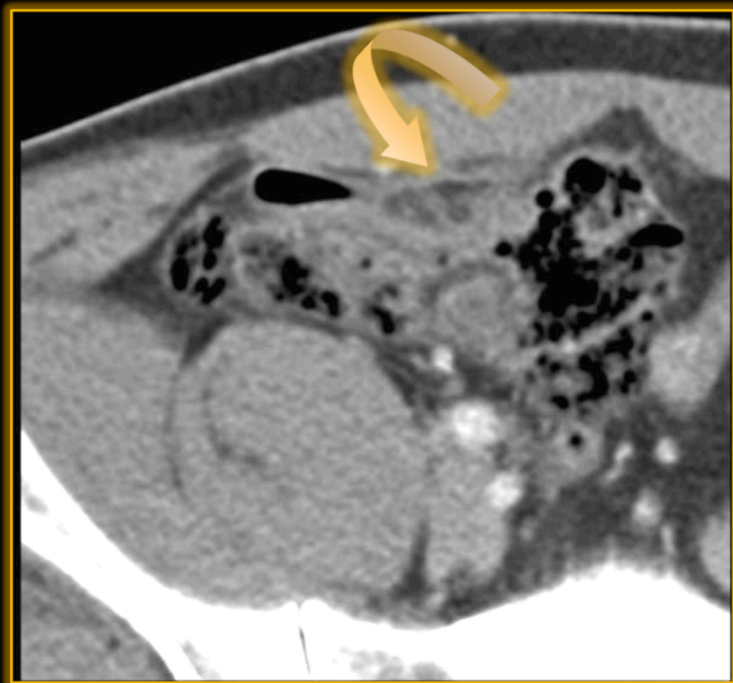
Echographie:

Appendice sain

TDM: ...









APPENDAGITE OU APPENDICITE ÉPIPLOÏQUE

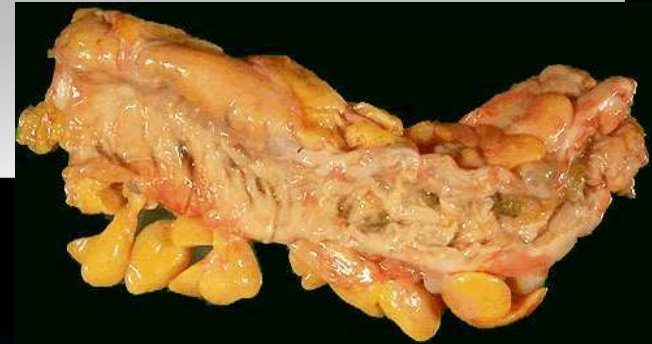
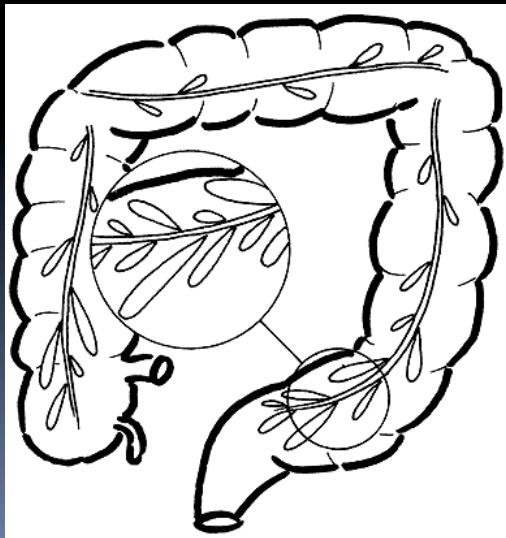
Appendice Epiploïque

Formations graisseuses pédiculées, recouvertes de péritoine disposées en 2 lignes le long des bandelettes coliques, prédominant sur le cæcum et sur le sigmoïde, absentes sur le rectum

Une centaine, de 0,5 à 5 cm

Plus gros et plus nombreux chez les obèses

Vascularisation colique



APPENDAGITE OU APPENDICITE ÉPIPLOÏQUE

Etiologies

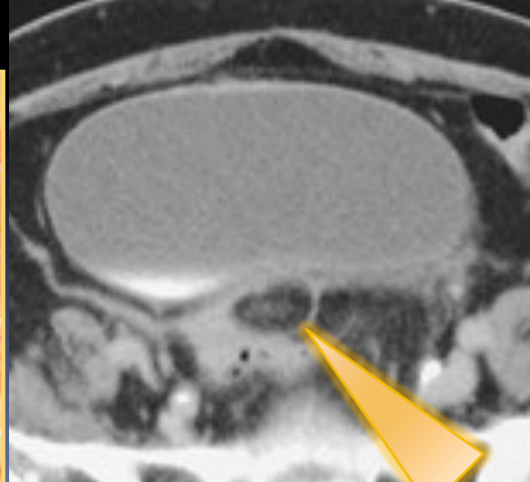
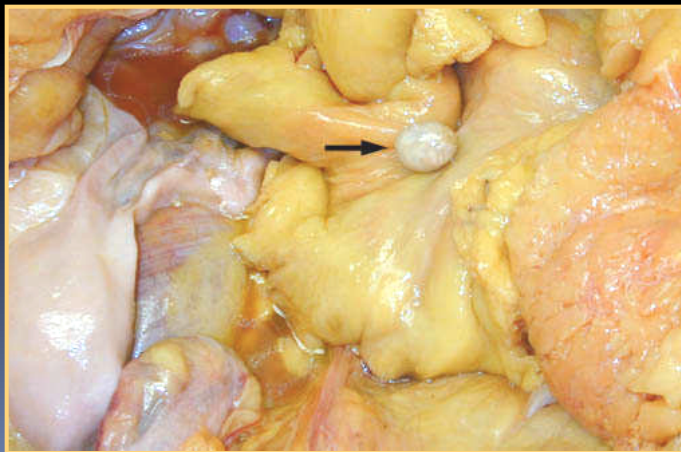
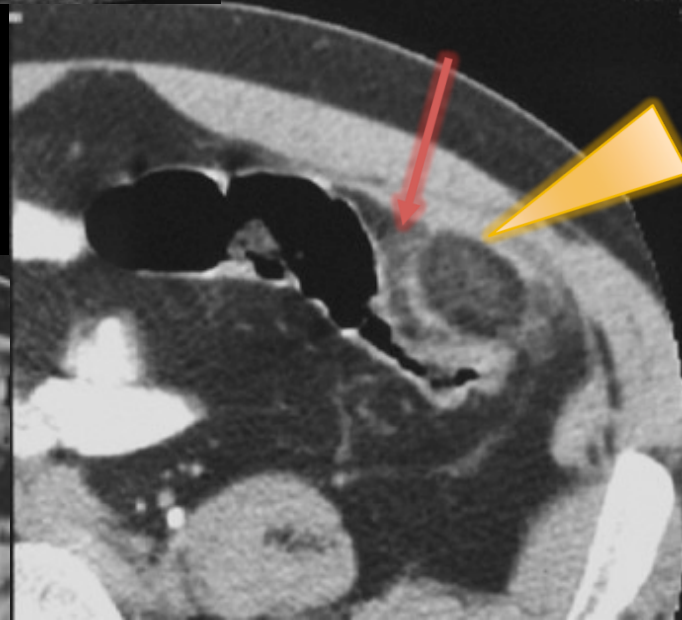
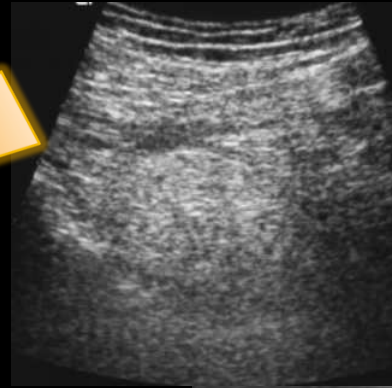
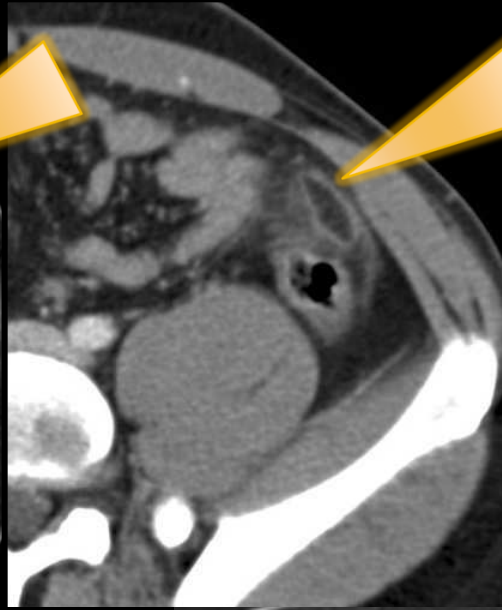
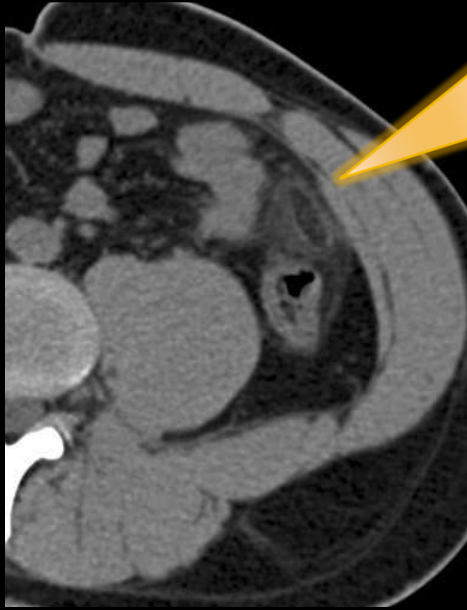
- Primitive : Torsion et inflammation primitive
- Secondaire à un processus inflammatoire adjacent (diverticulite +++, MICI, salpingite, appendicite...) ou une incarceration herniaire

Manifestations

Douleur prédominant en FID ou FIG

- Aspect TDM : lésion oblongue, en "navette", adjacente au colon (cæcum et sigmoïde ++), moins volumineux (20-30 mm)

un diagnostic différentiel de la diverticulite ,
chez le sujet jeune +++ : la torsion d'appendice
épiploïque ou «appendagite» primitive !!!

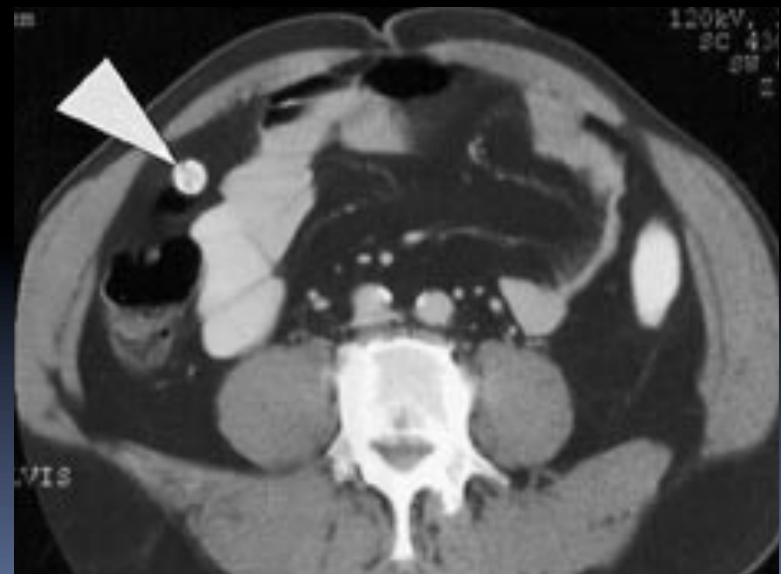
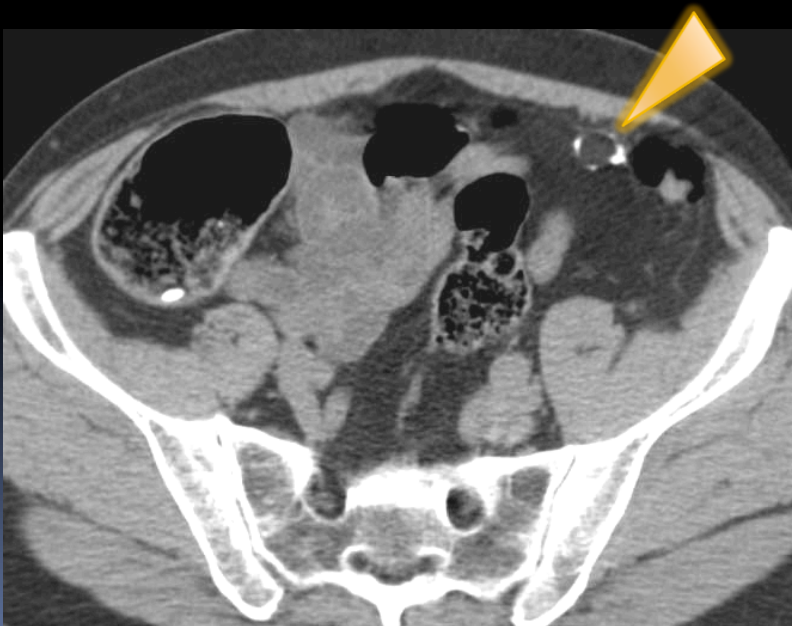


"appendagite" primitive
typique; 24 ans

APPENDAGITE OU APPENDICITE ÉPIPLOÏQUE

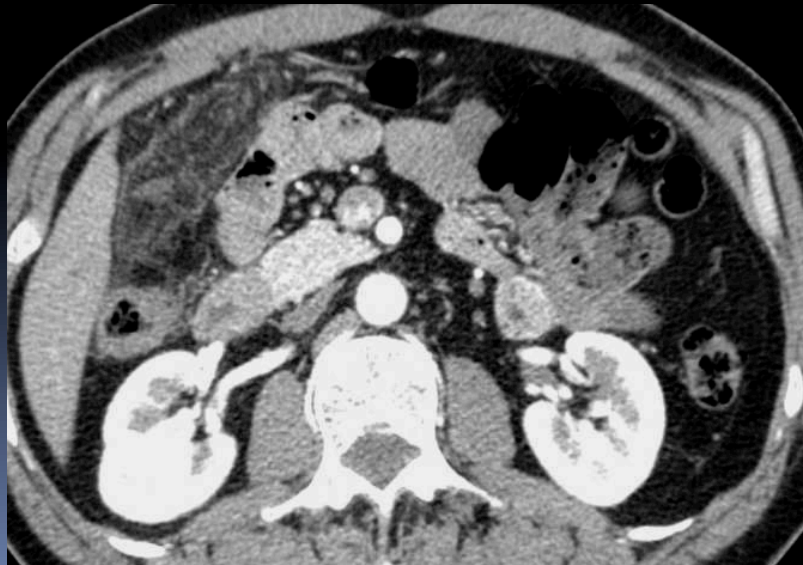
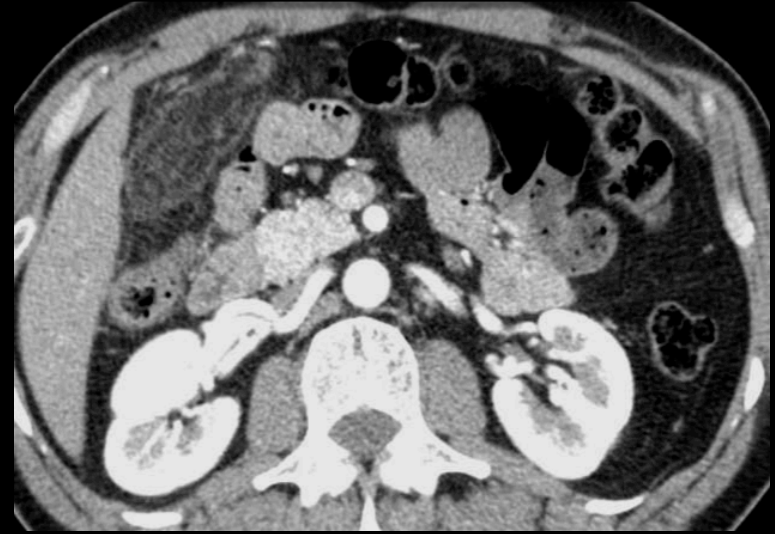
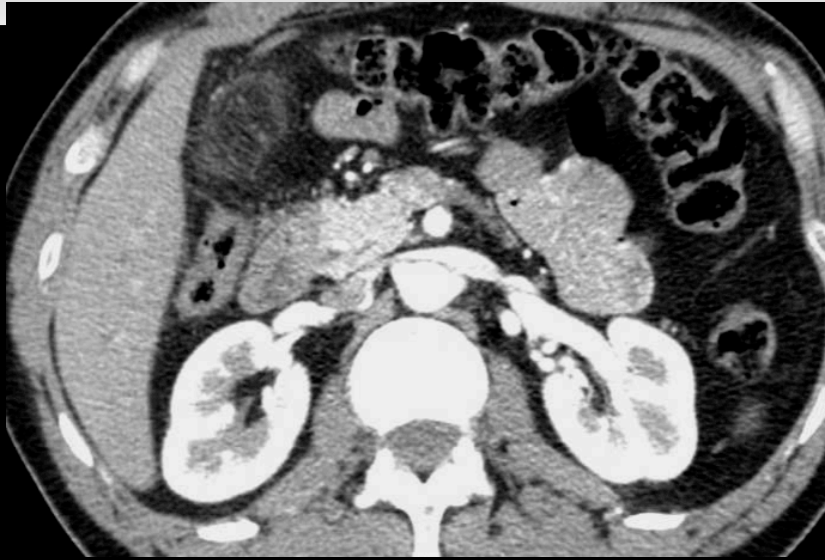
Evolution

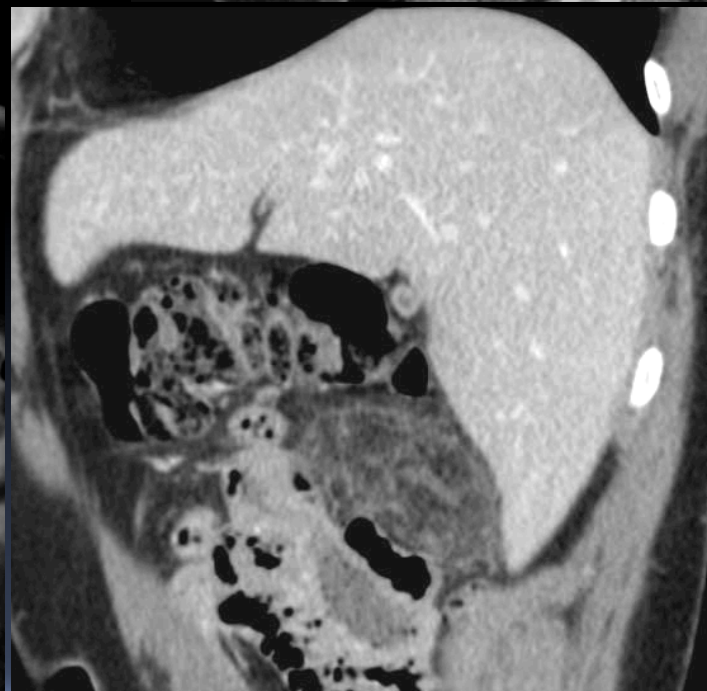
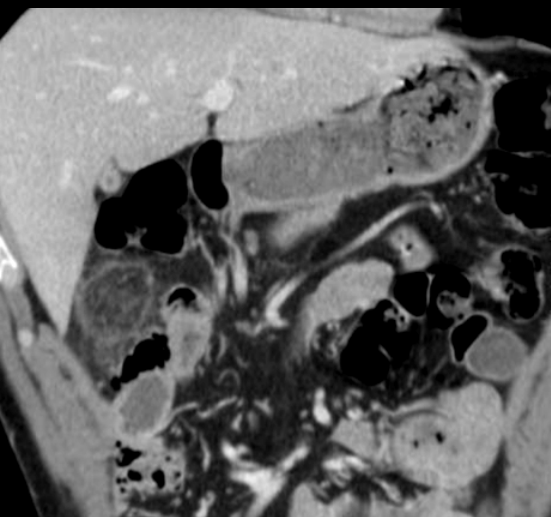
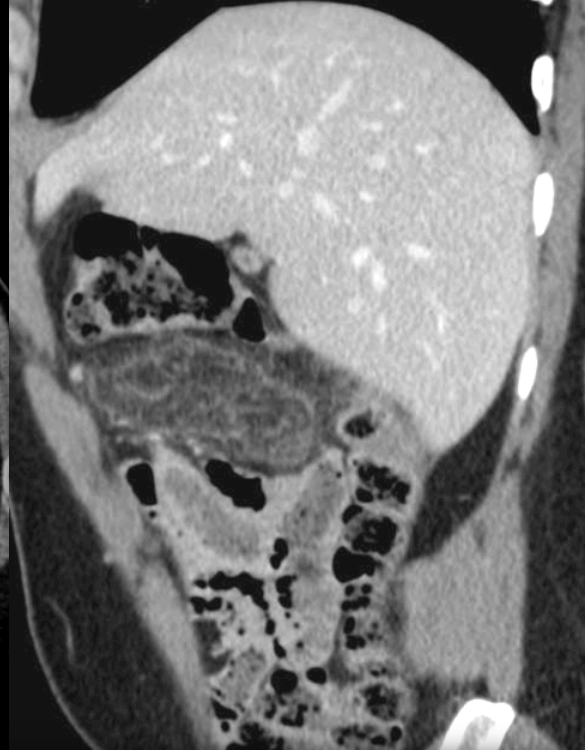
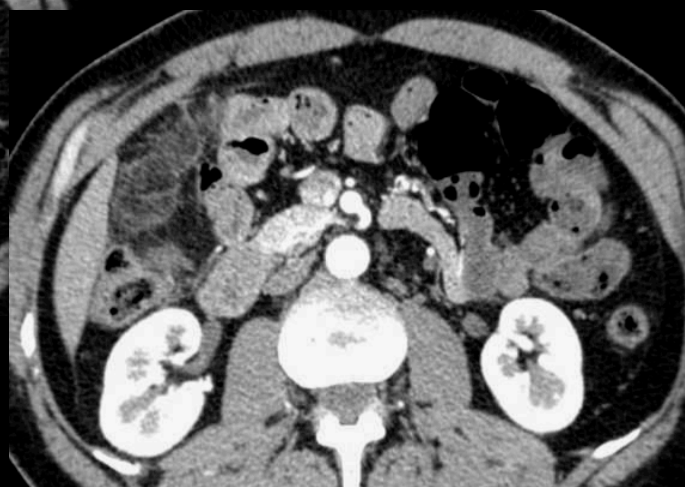
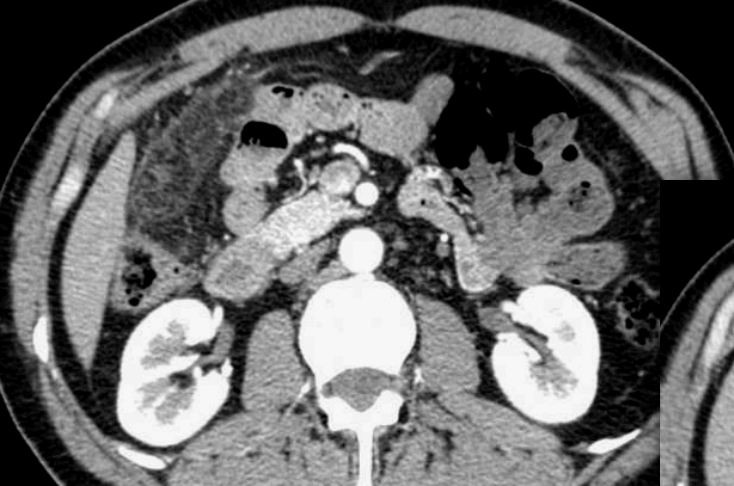
- En général rapidement favorable sous traitement médical
- Infarcissement, fibrose, parfois calcification et libération dans le péritoine (souris péritonéale)

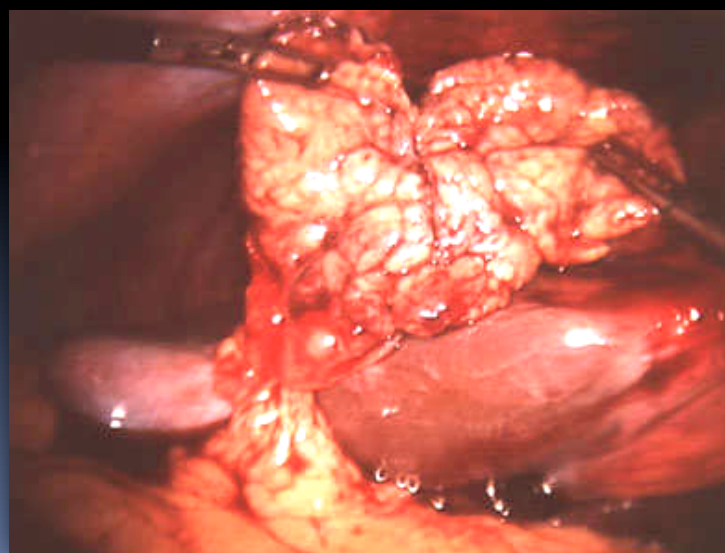
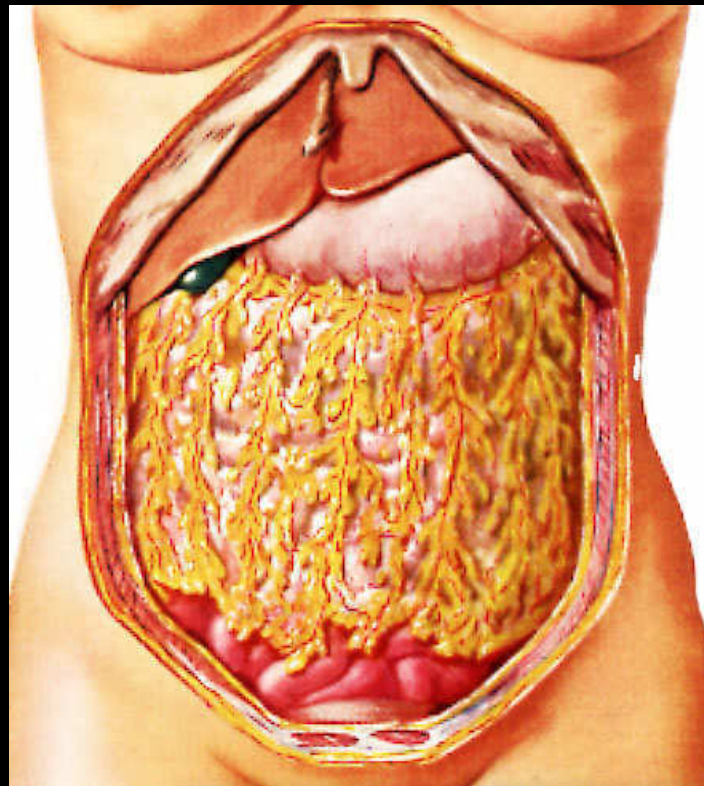


Homme de 45 ans, présentant des douleurs abdominales depuis 1 semaine, prédominant au niveau de l'HCD.

Aucun ATCD notable



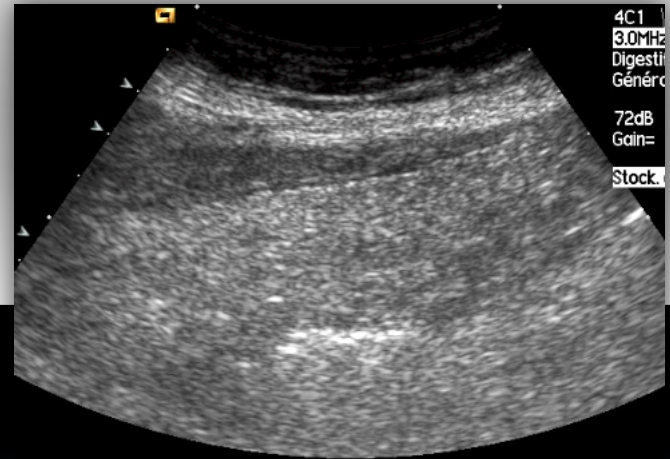




INFARCTUS DU GD EPIPLOON

Manifestations

- Douleur abdo en Hypochondre dt ou flanc dt, avec parfois défense, et $\pm$ masse palpable
- Absence de Trouble du transit
- Apyrexie ou fébricule
- H > F, surpoids
- Sd inflammatoire absent ou discret



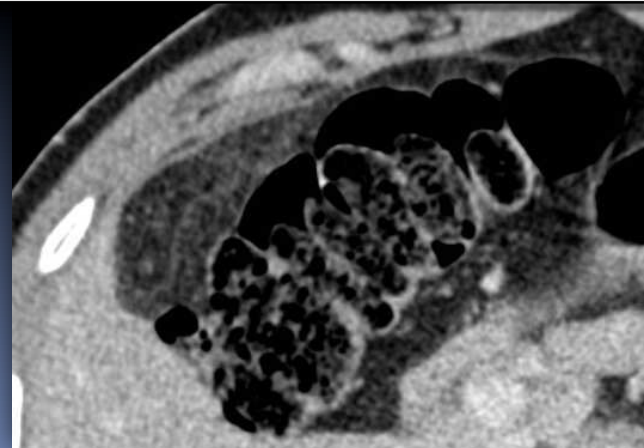
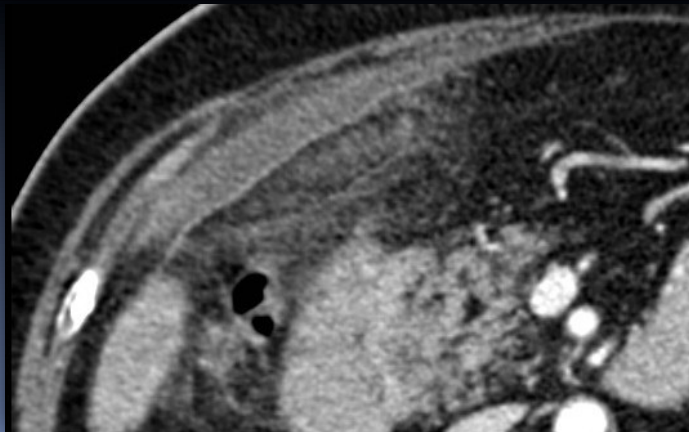
Echographie

- Lésion arrondie de 40 à 60 mm, hyperéchogène cernée d'un liseré hypoéchogène
- douloureux et non compressible
- adhérent au péritoine pariétal, non mobile avec les anses et les structures digestives

INFARCTUS DU GD EPIPLOON

TDM

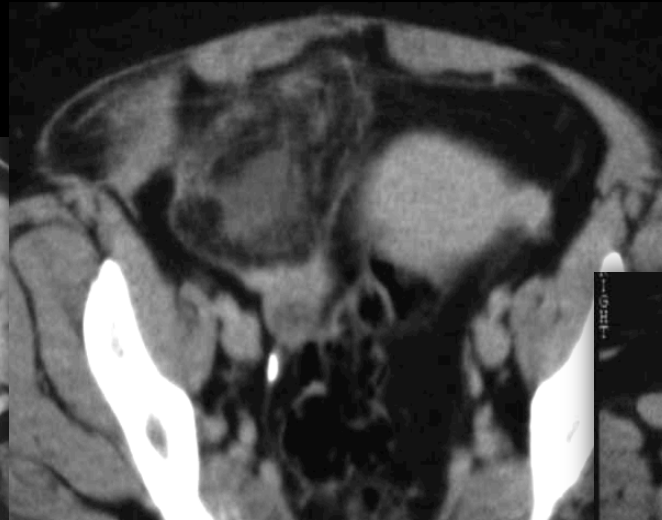
- Lésion oblongue de plusieurs cm, en "navette", sous-pariétale ant ou antéro-latérale droite
- Bien limitée par un liseré périphérique
- Densité grasseuse (-60 UH) discrètement > graisse péritonéale ± hyperdensité centrale linéaire (Vx trombosé) ou arrondie (nécrose hémorragique)
- ± Épaississement du péritoine pariétal ant ou des muscles pariétaux au contact
- Infiltration de la graisse péritonéale adjacente



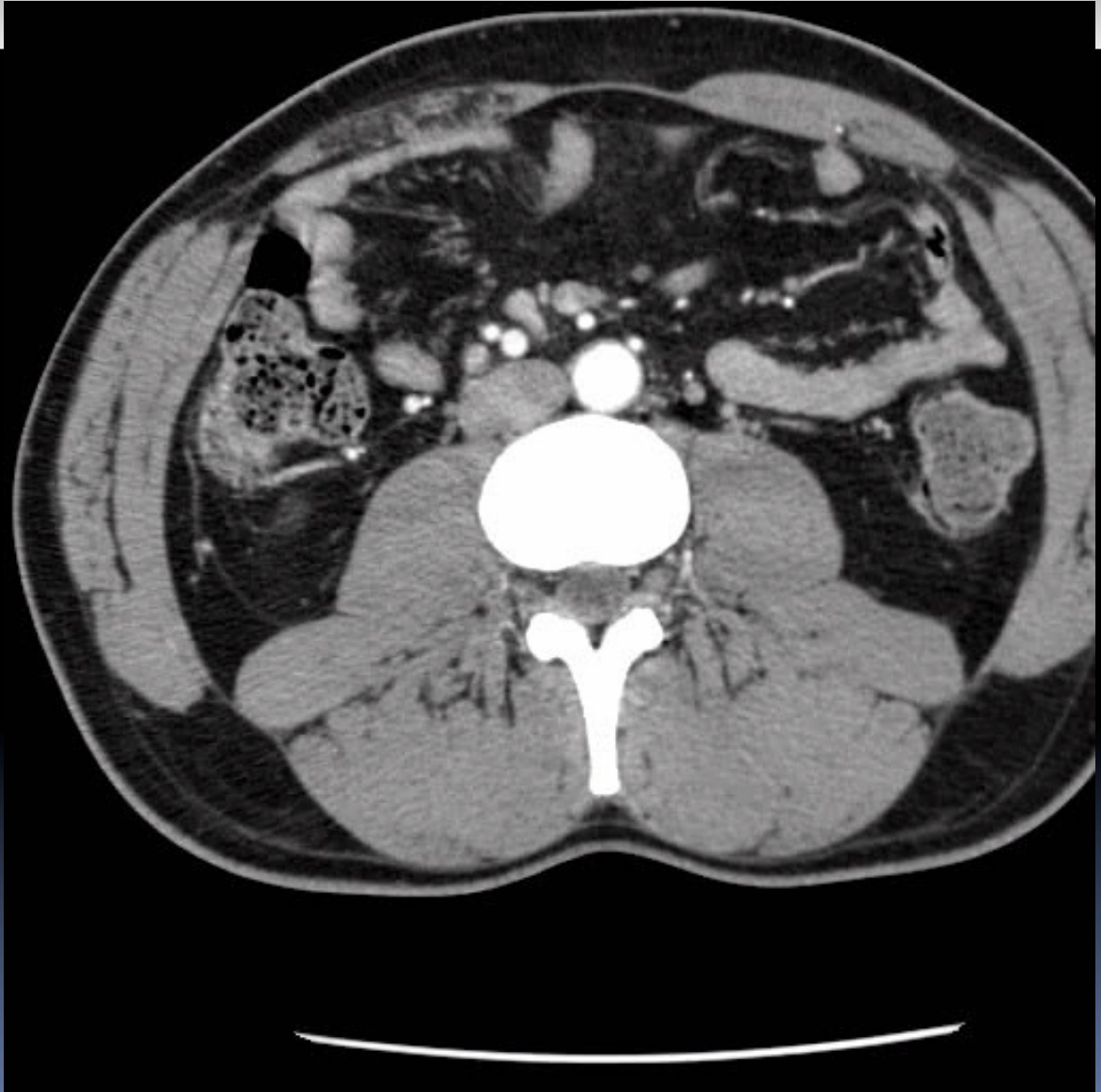
INFARCTUS DU GD EPIPLOON

Evolution

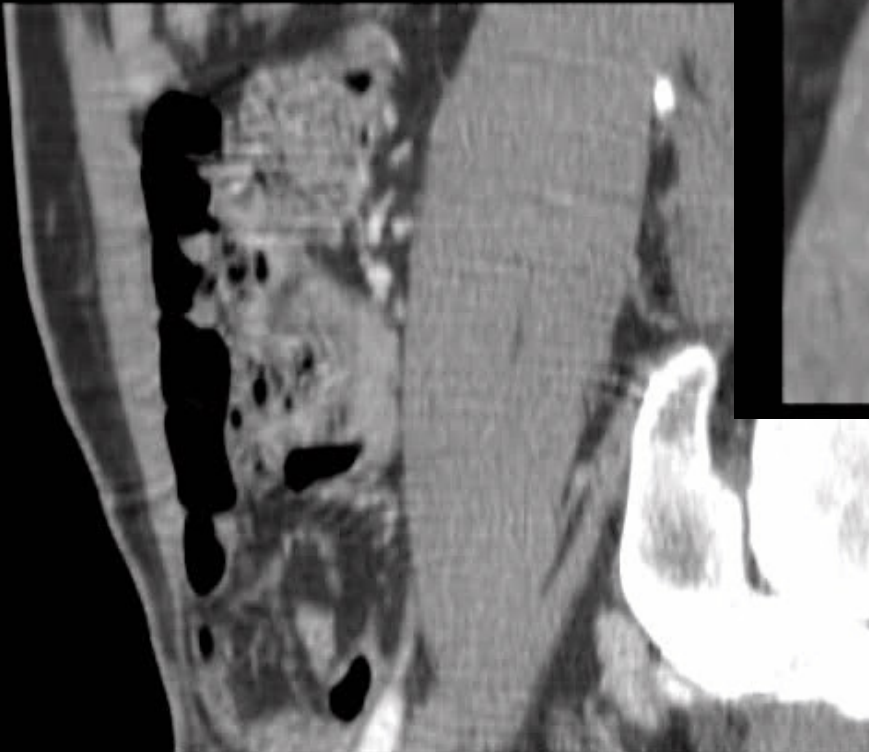
En général rapidement favorable sous trt médical
Infarcissement, fibrose, parfois calcification

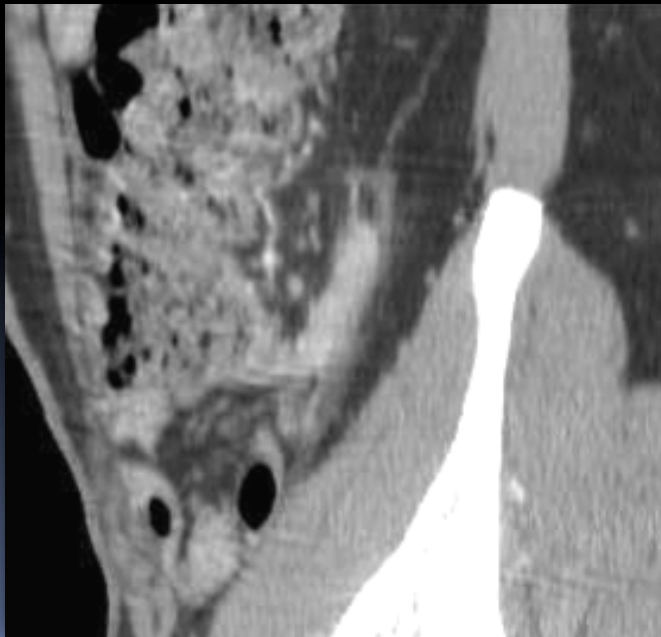
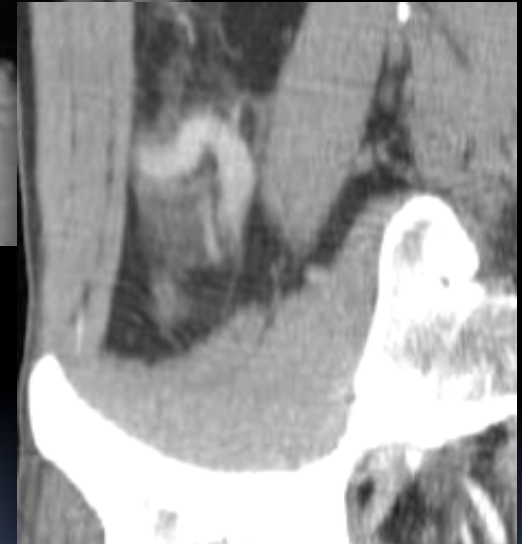
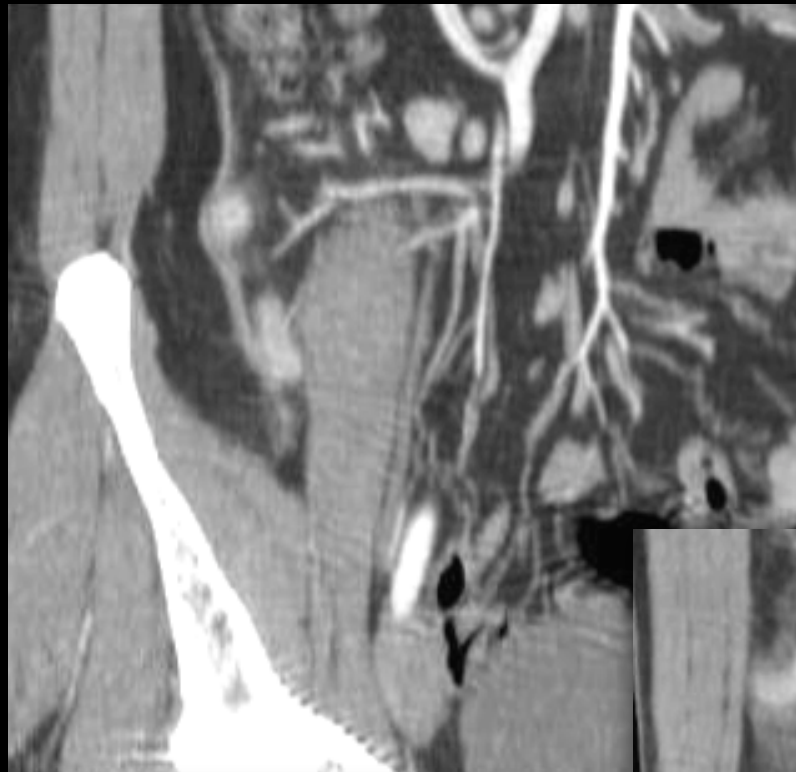


Homme de 25 ans, présentant des douleurs abdominales aiguës fébriles.



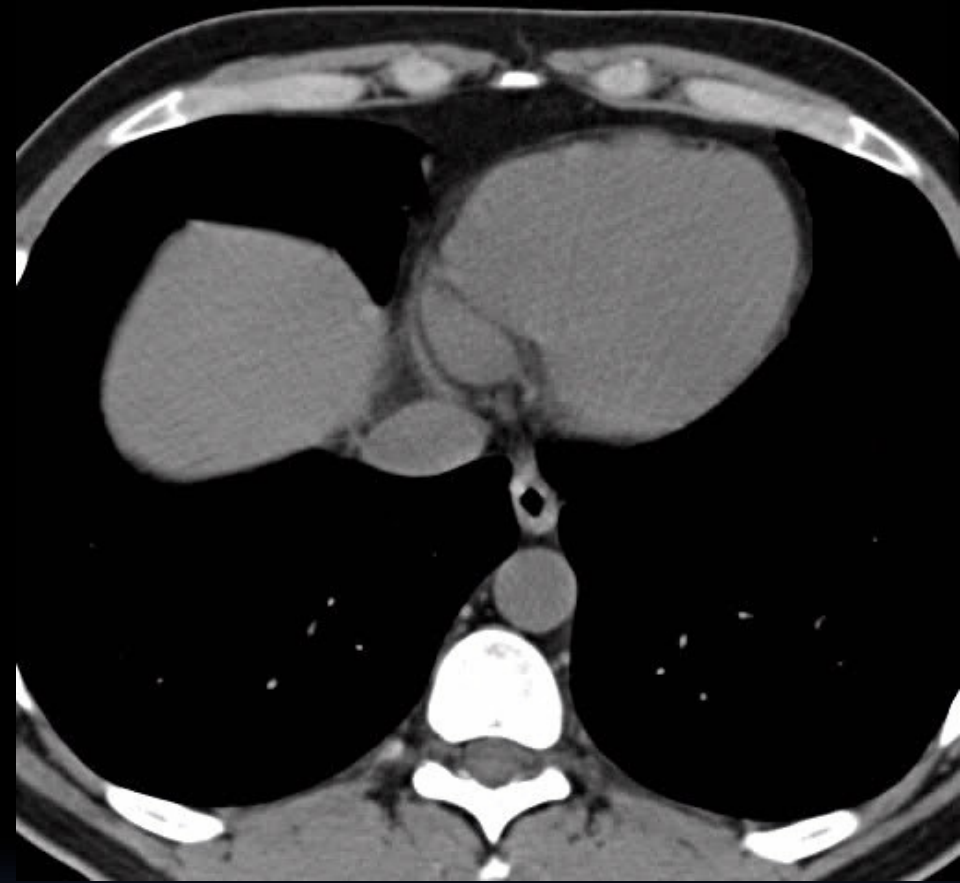
Les douleurs abdominales
aiguës prédominent au
niveau de la FID.

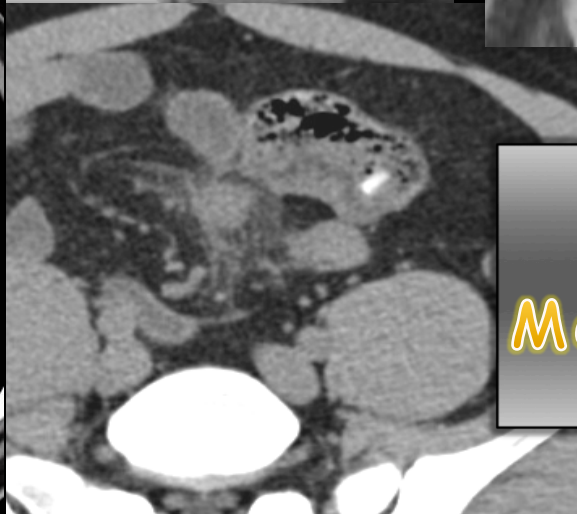
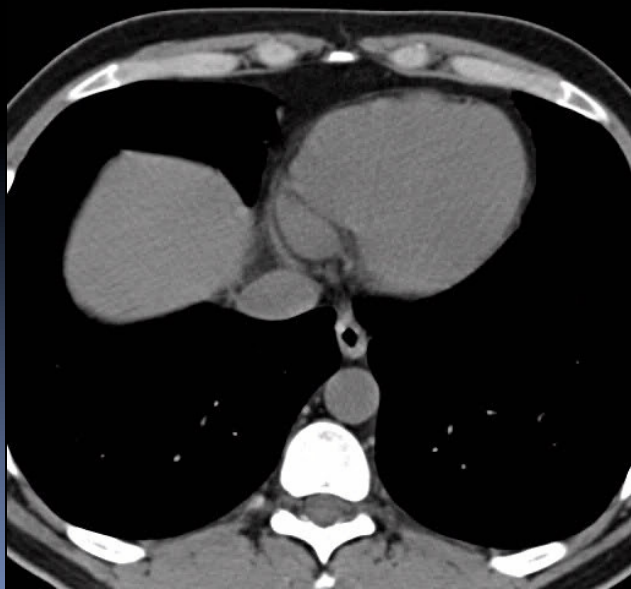
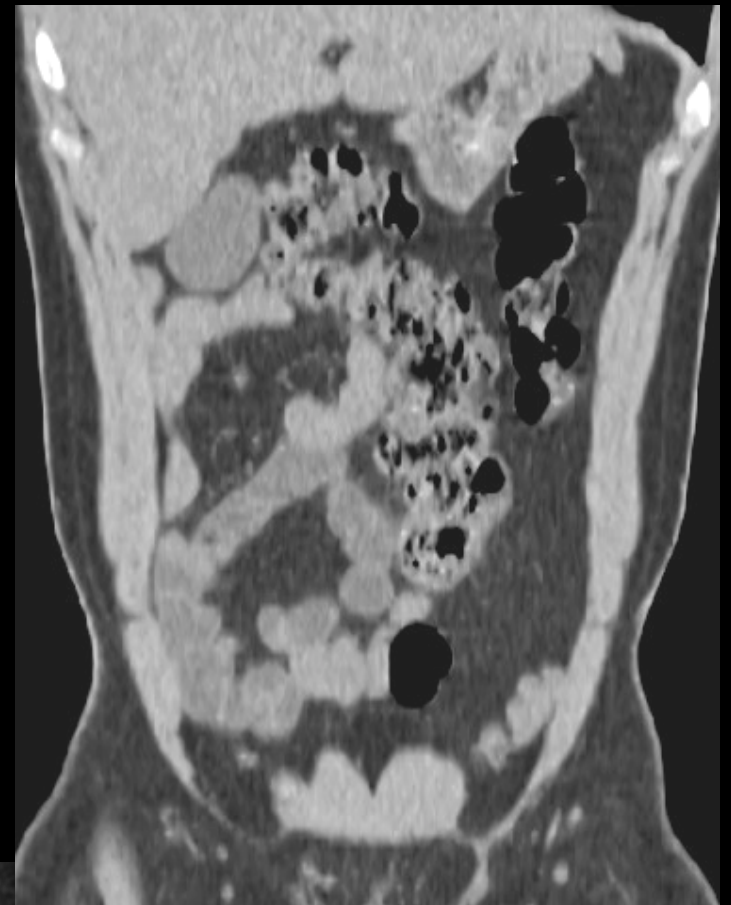
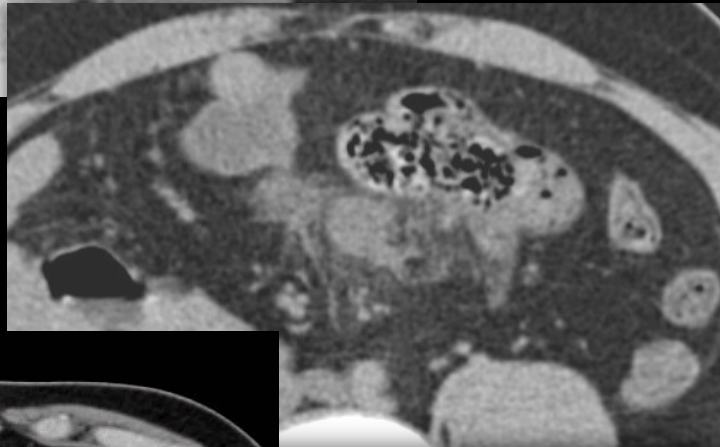
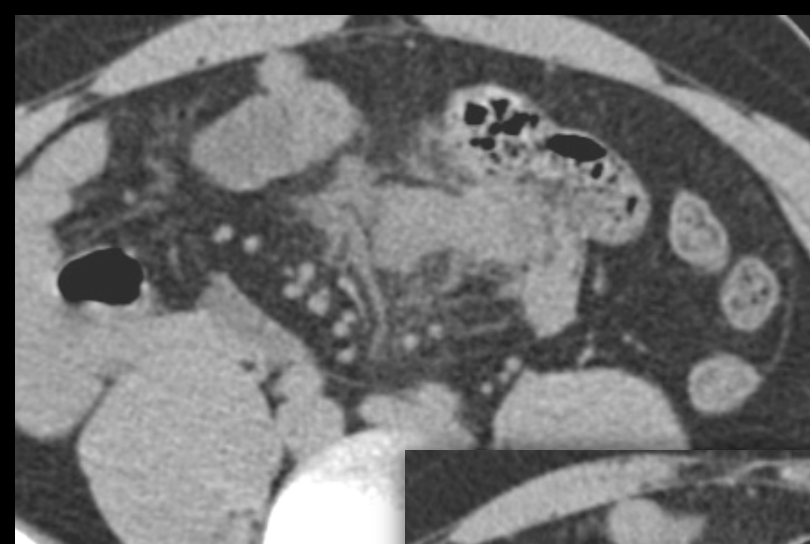




Appendicite
Rétrocaecale
ascendante

Homme de 30 ans,
présentant des douleurs
abdominales aiguës fébriles.

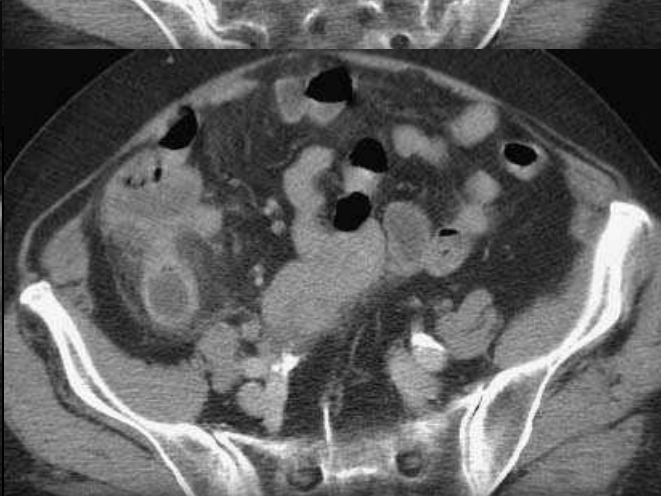
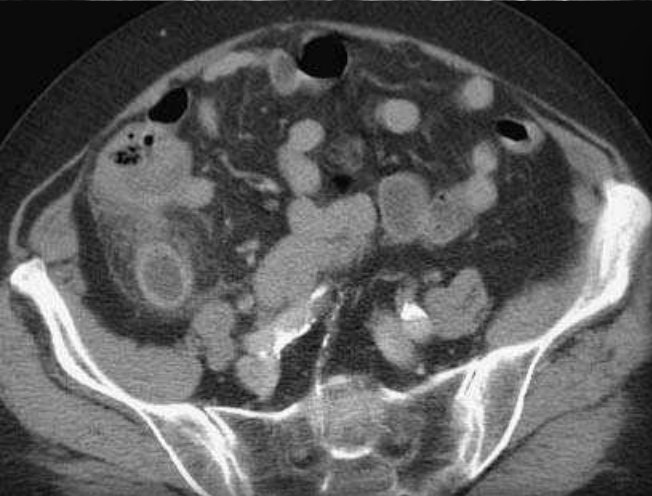
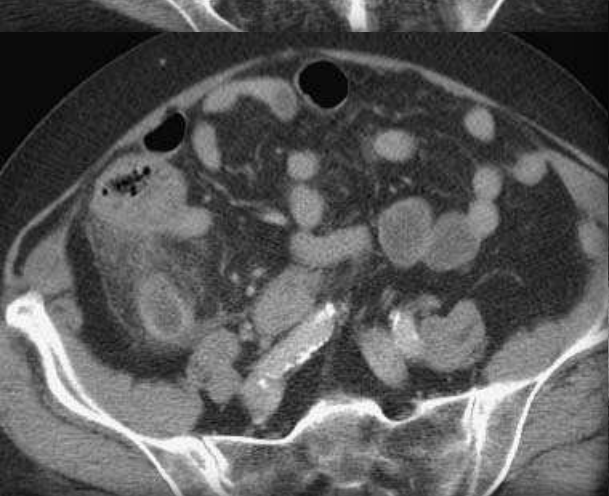
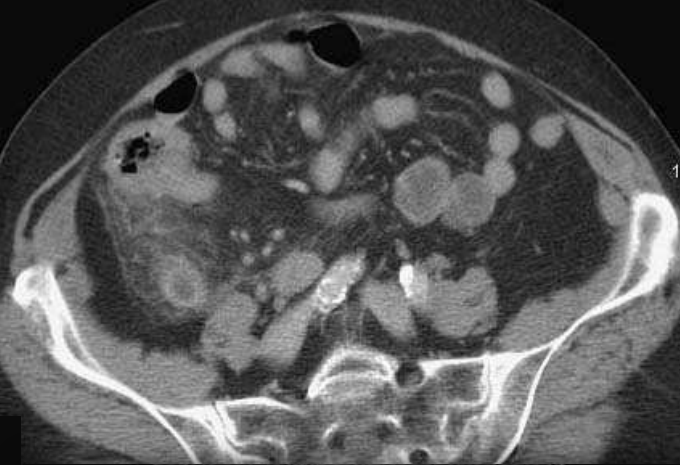
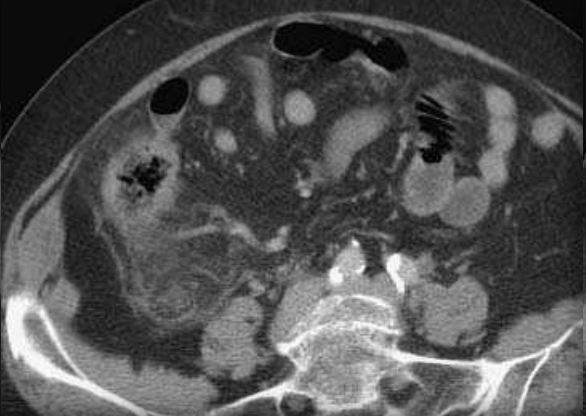
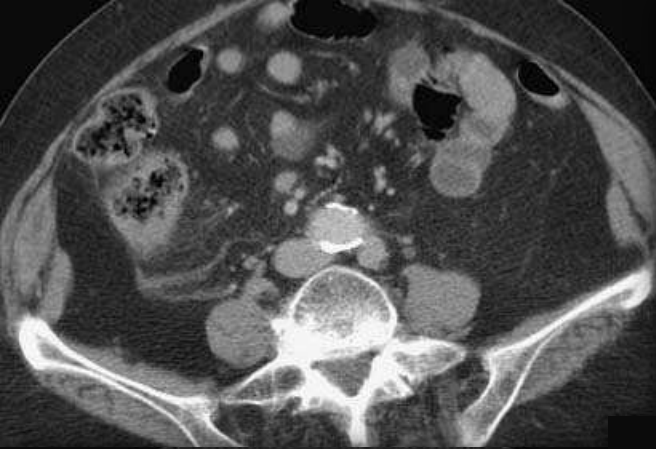


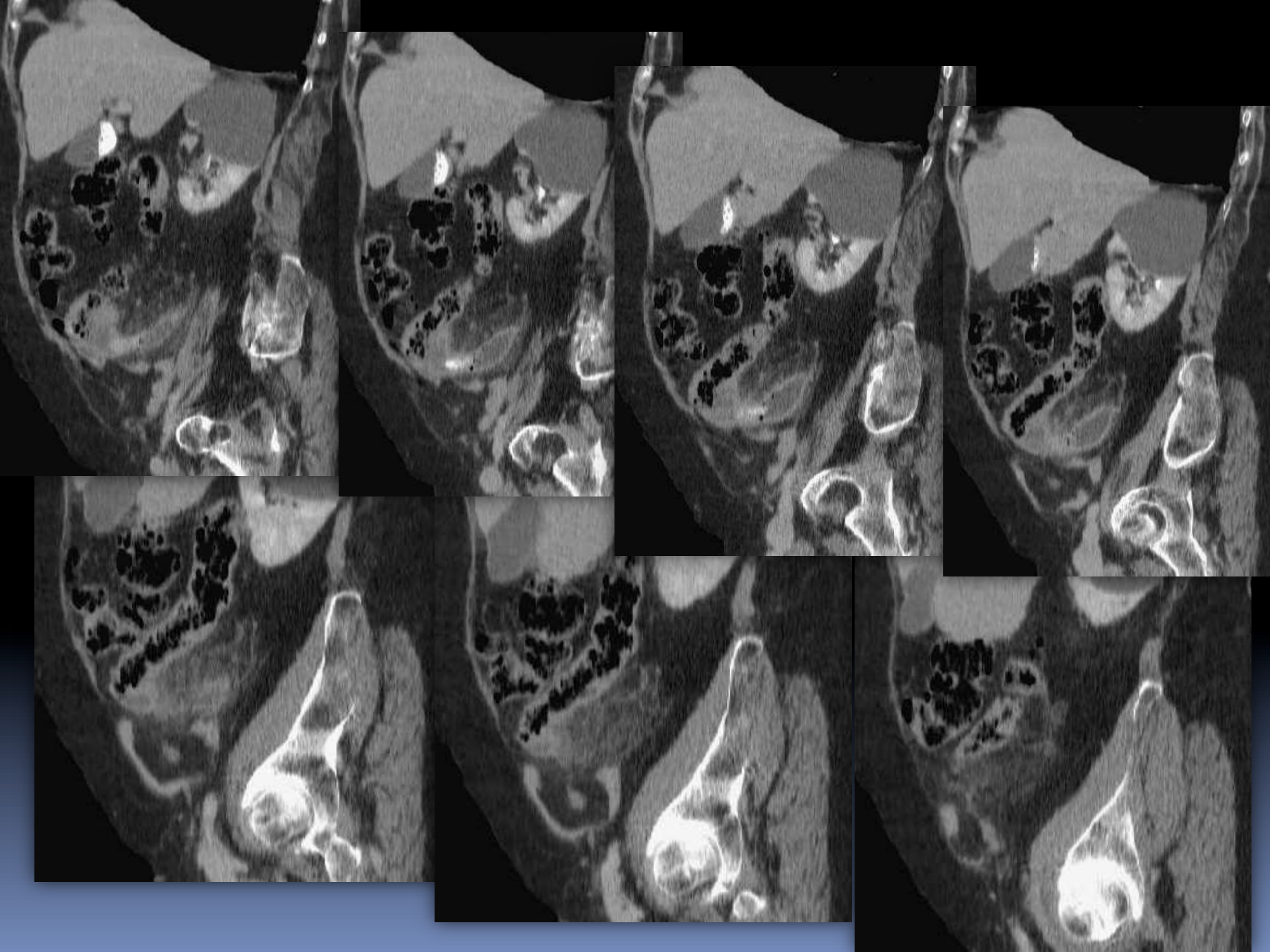


Appendicite
Mésentère commun

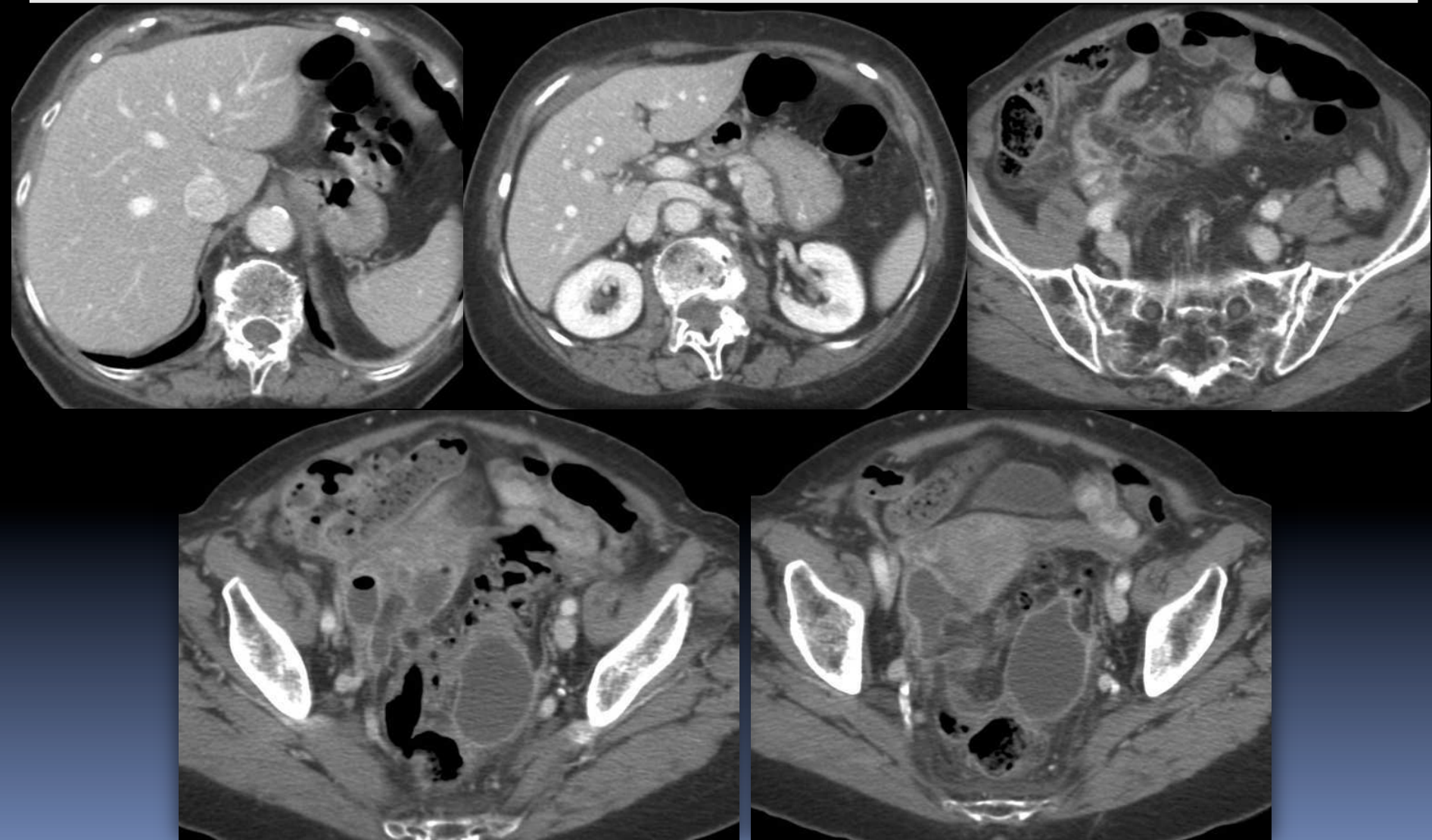
FEMME DE 82 ANS
DOULEUR ET DEFENSE DE LA FID DANS UN CONTEXTE DE FEBRICULE A 38°
ATCDT DE COLITE ISCHEMIQUE ET D'HTA

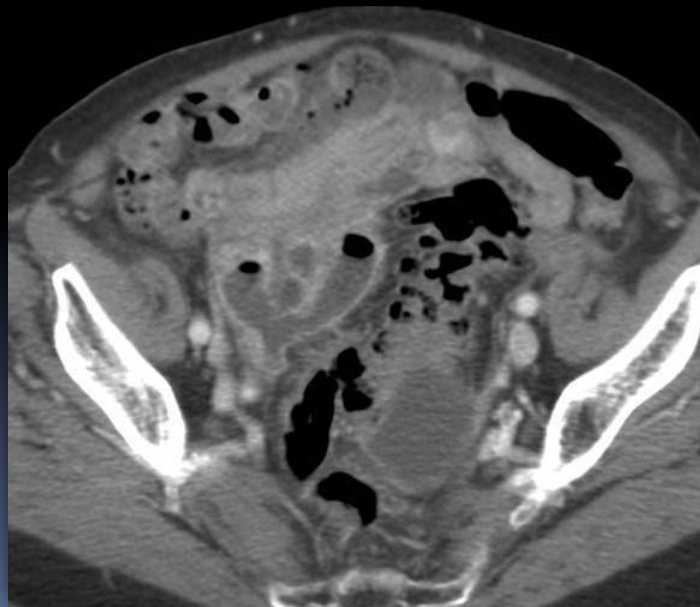
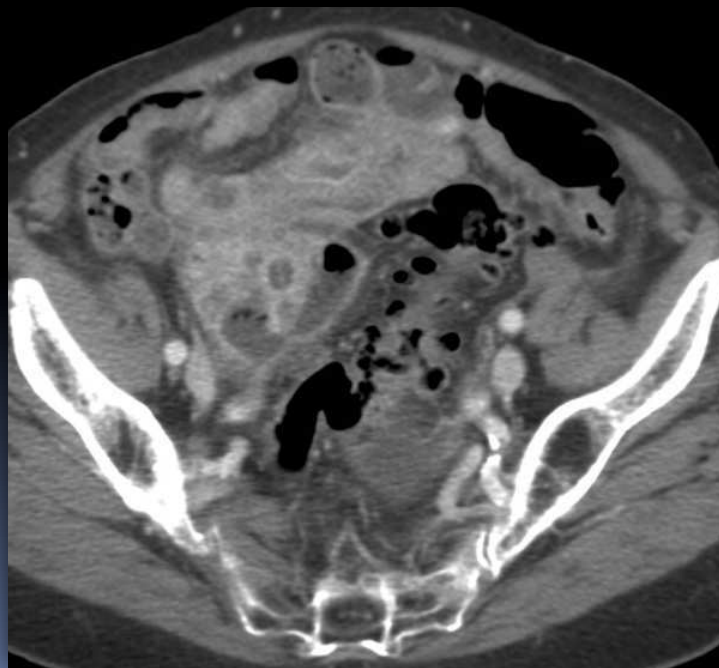
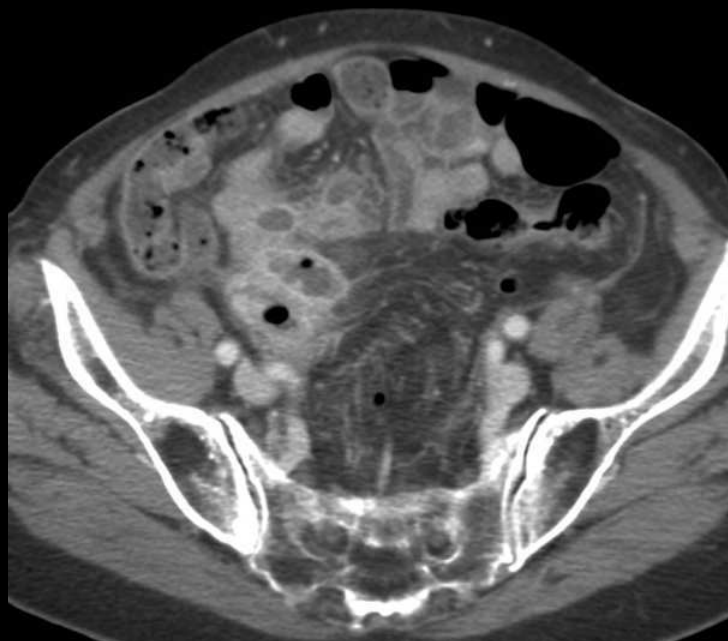


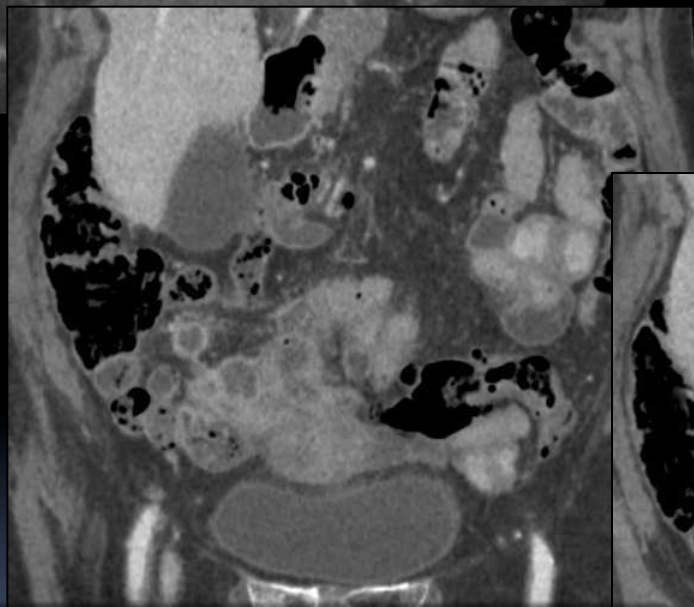
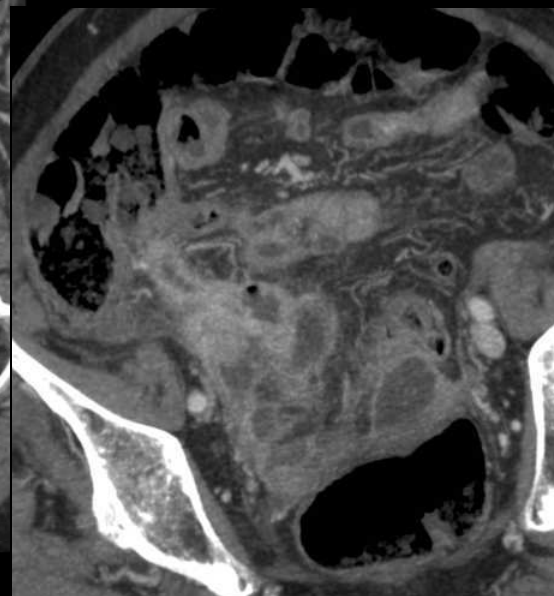
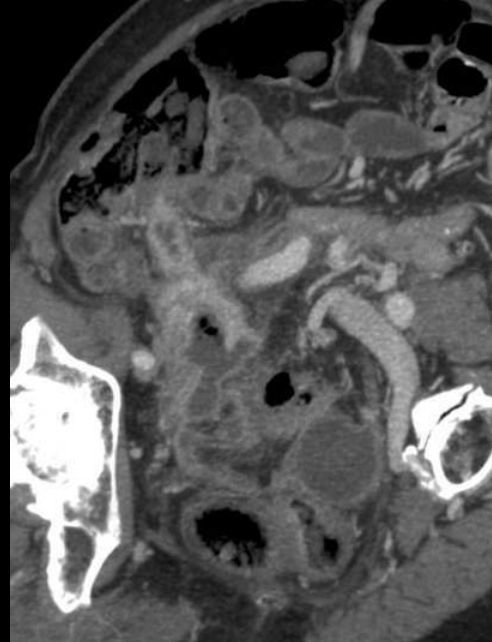
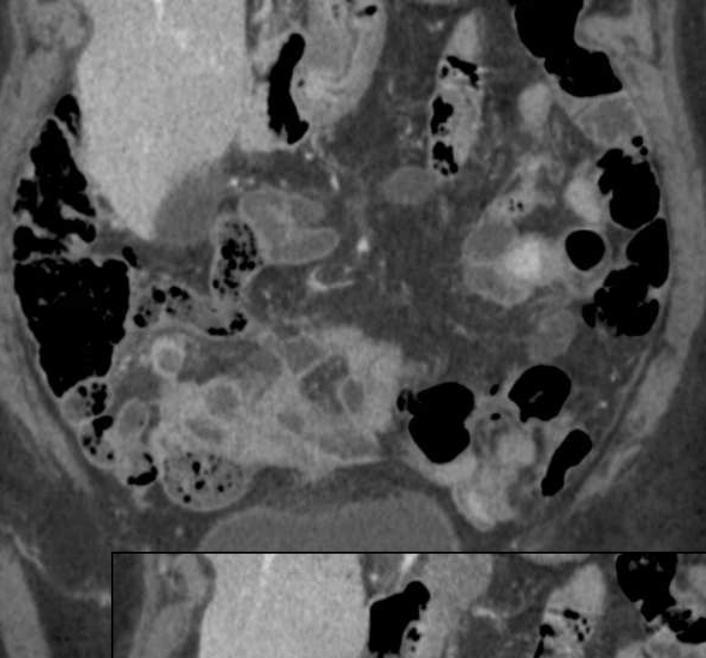




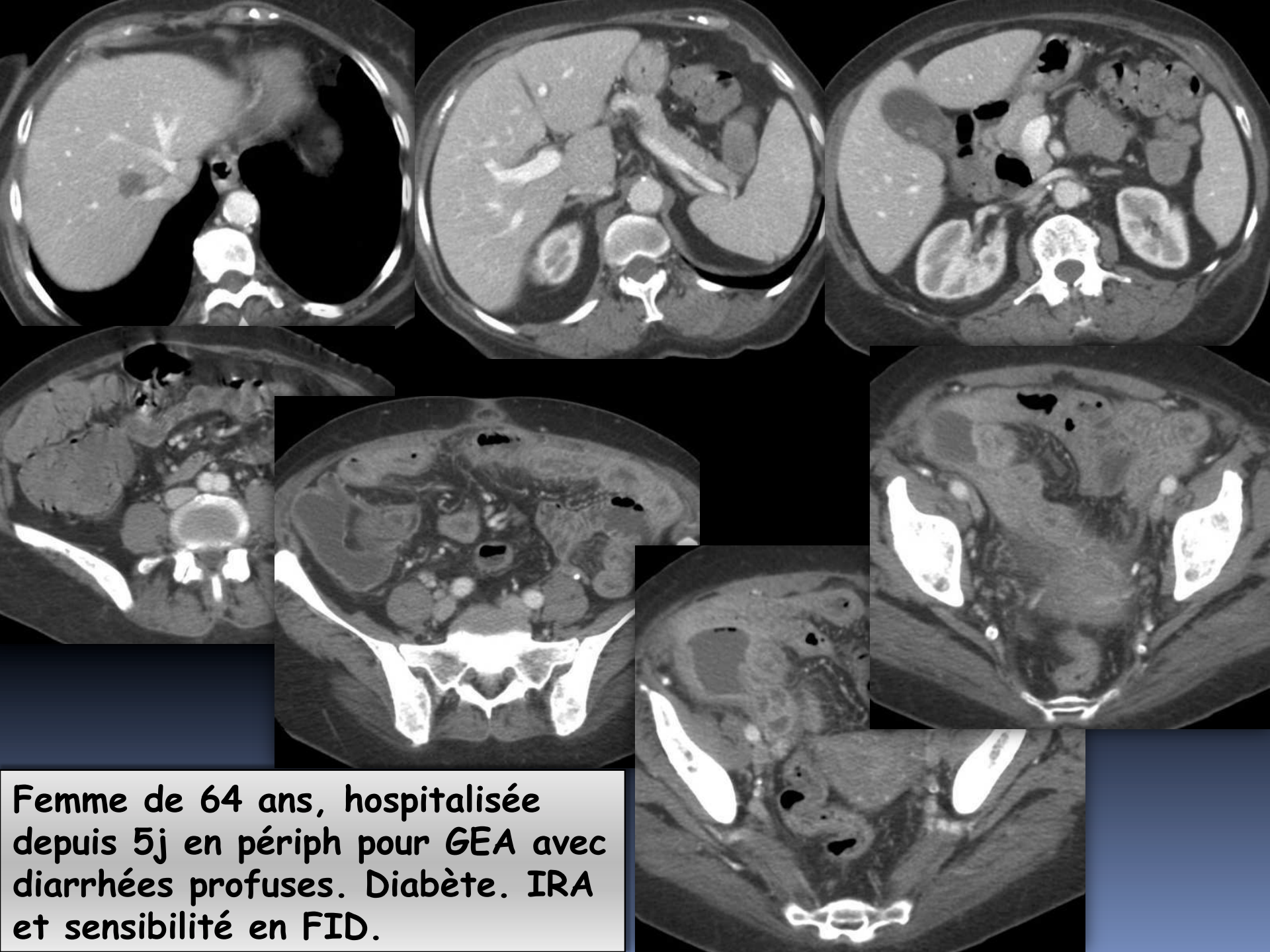
Femme de 85 ans, présentant des douleurs pelviennes aiguës fébriles (40°C) avec une hyperleucocytose et une CRP très élevée.



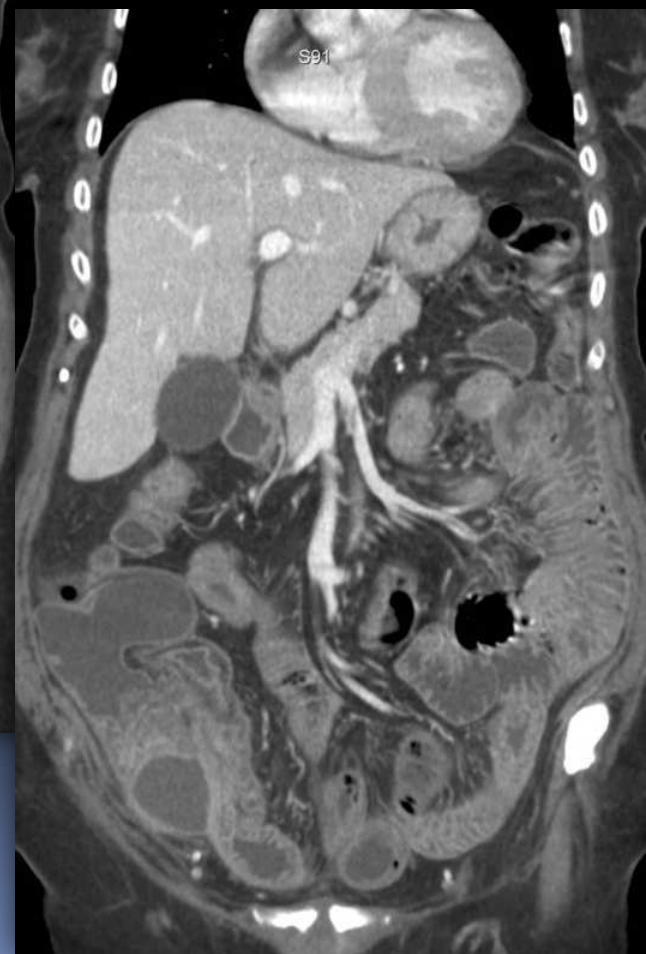
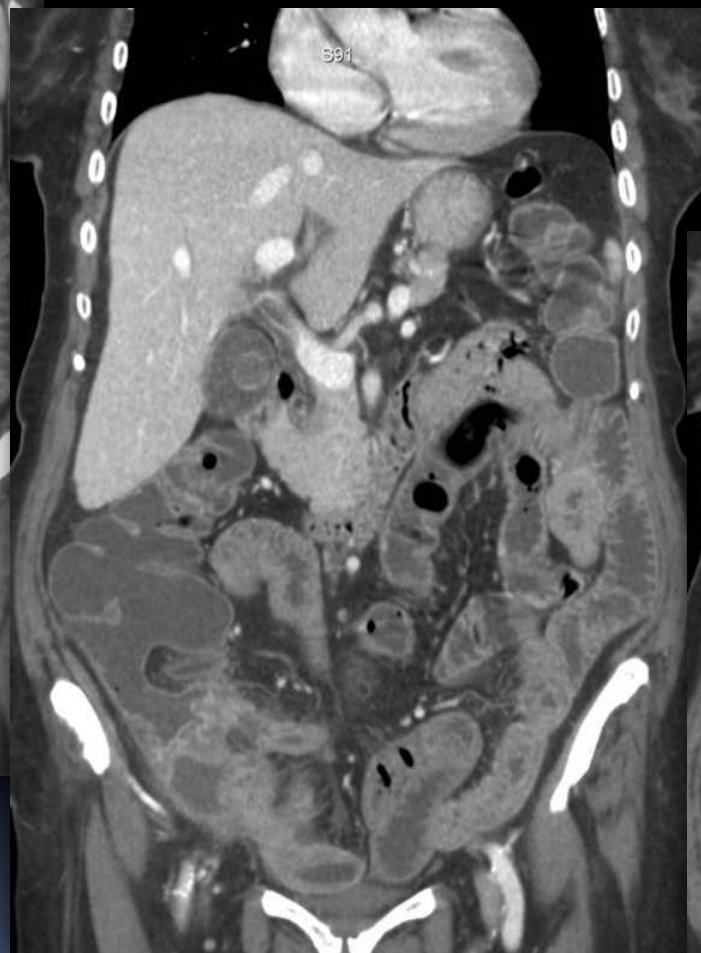
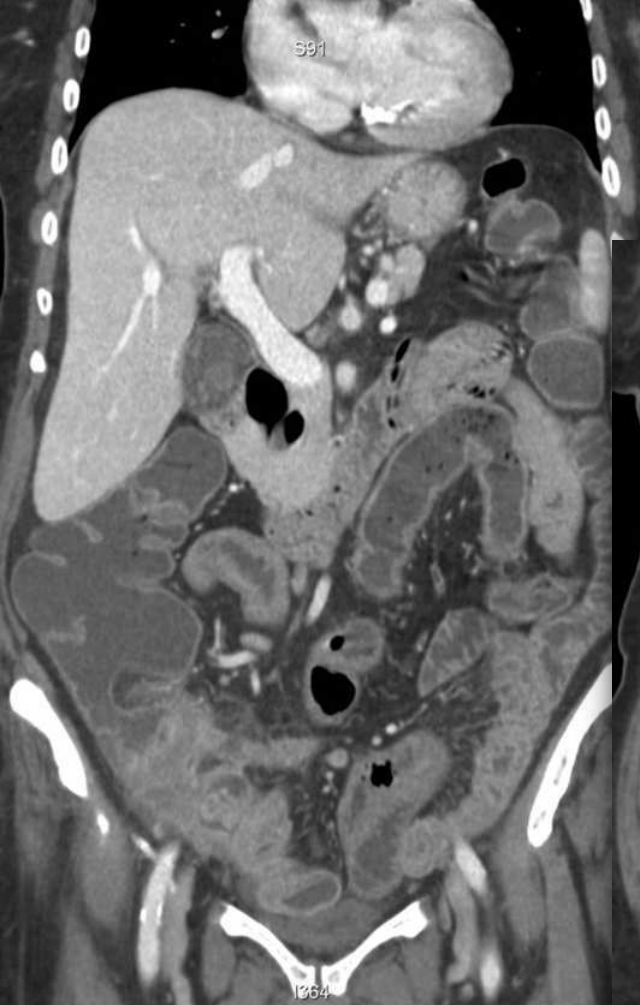


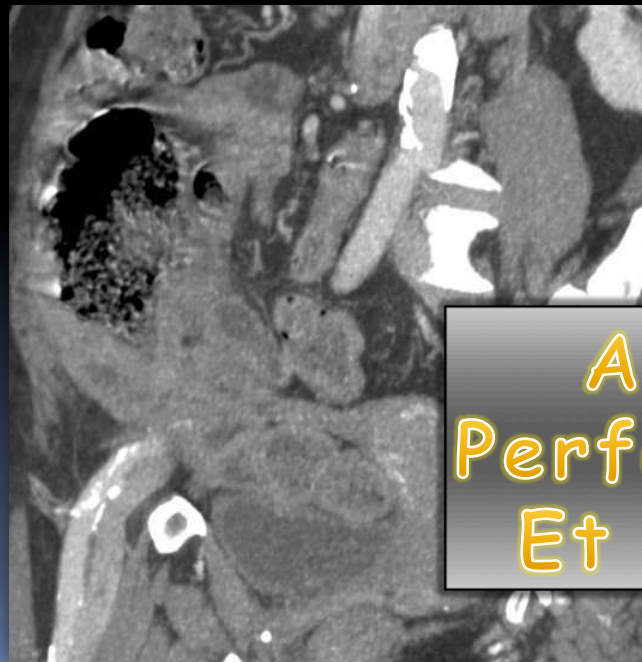
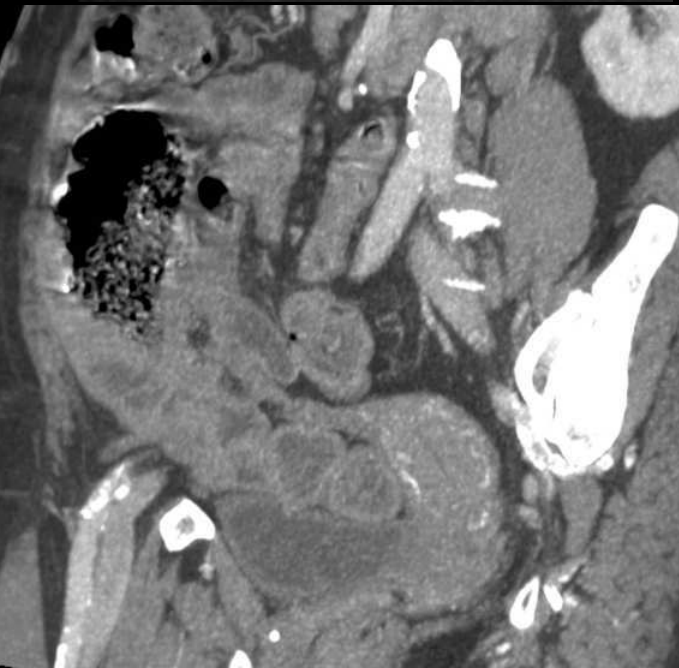
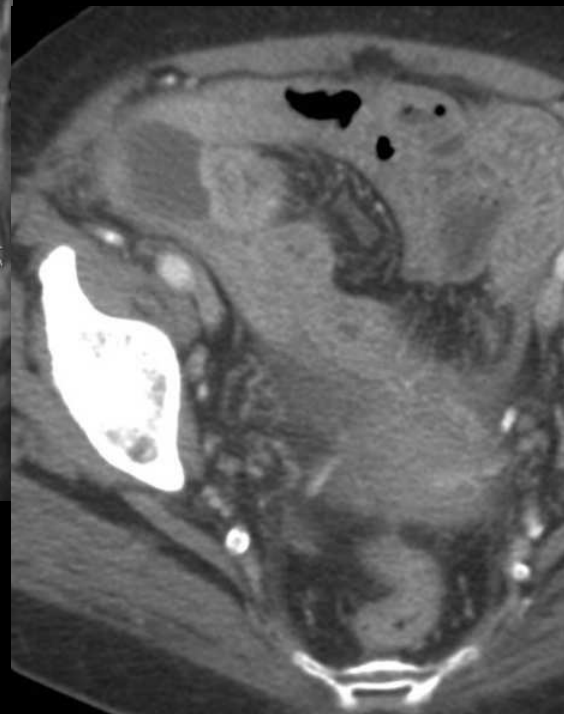
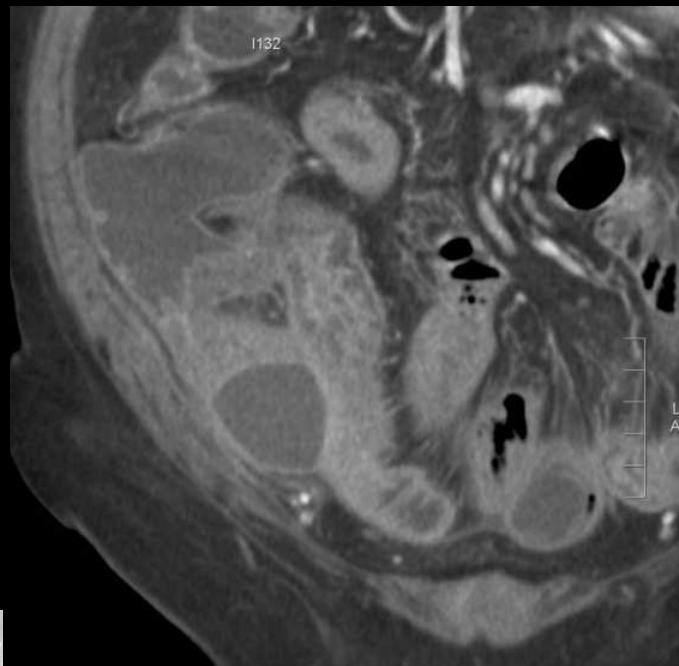
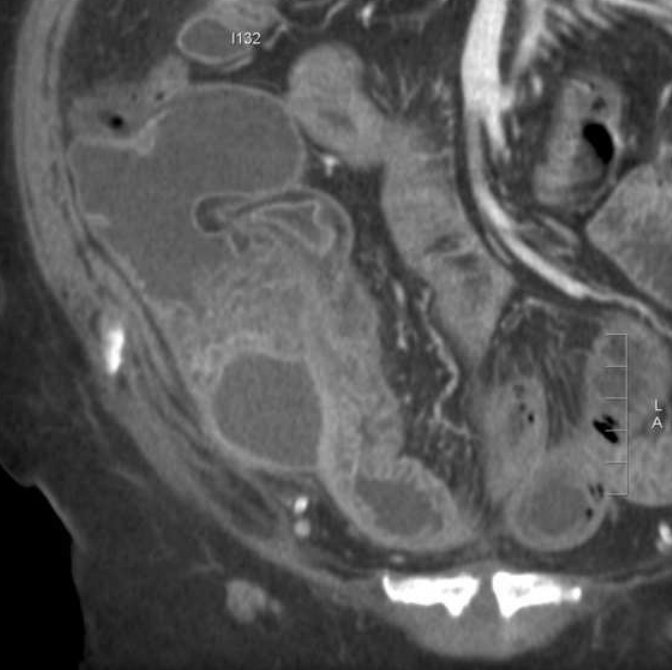


Appendicite
Perforée bouchée
Abcédée

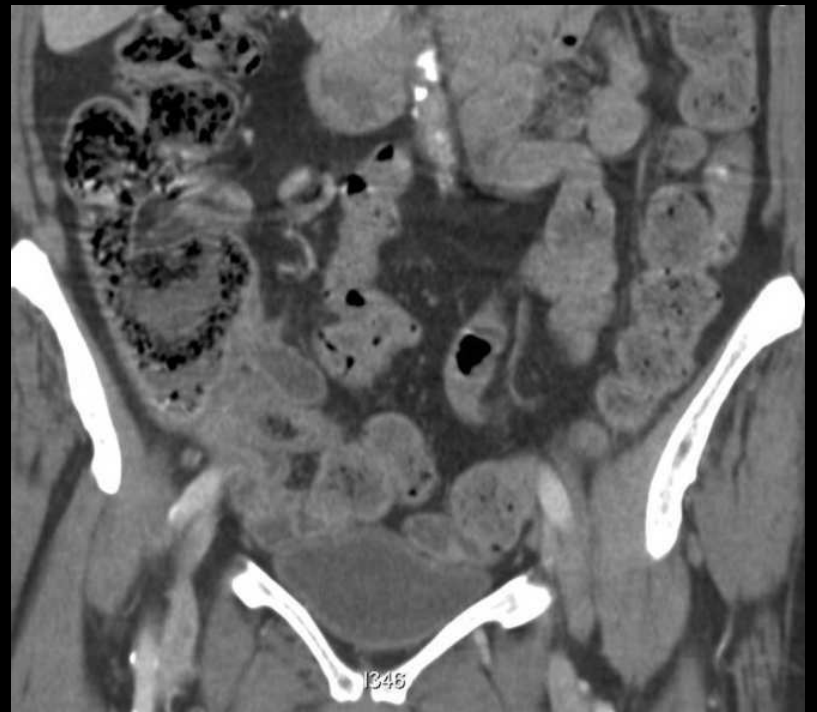
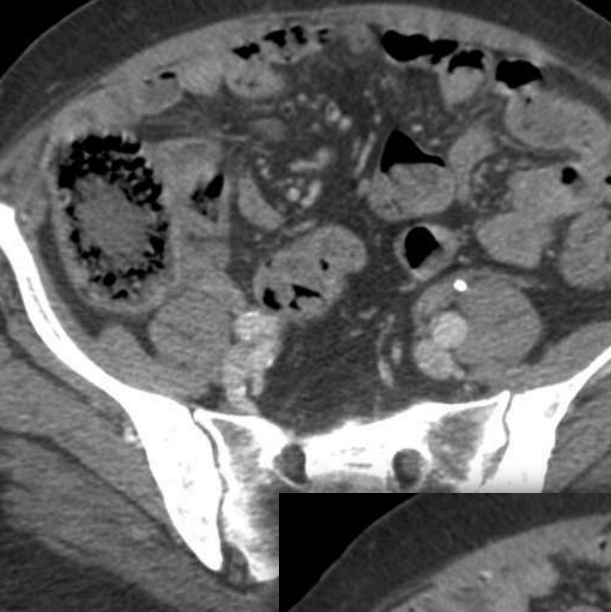


Femme de 64 ans, hospitalisée depuis 5j en périph pour GEA avec diarrhées profuses. Diabète. IRA et sensibilité en FID.

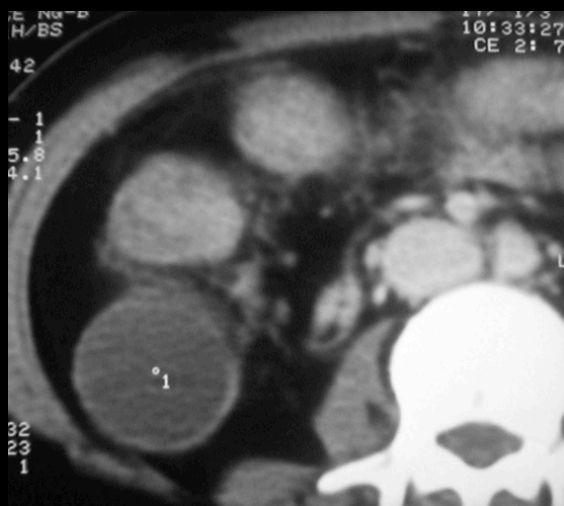




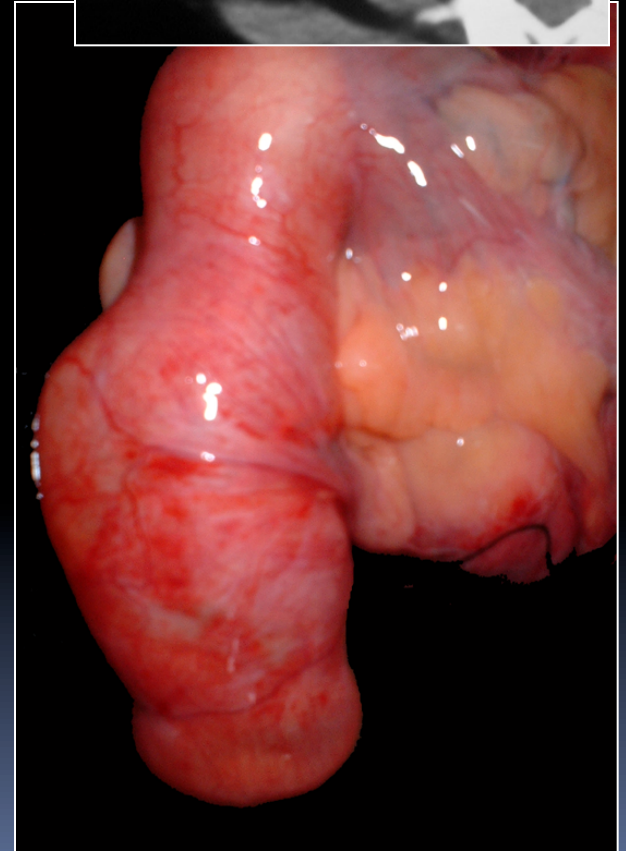
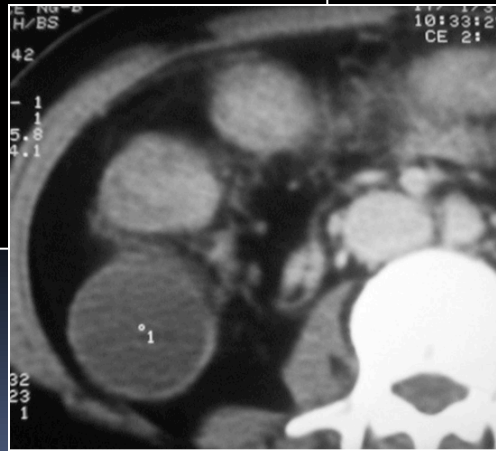
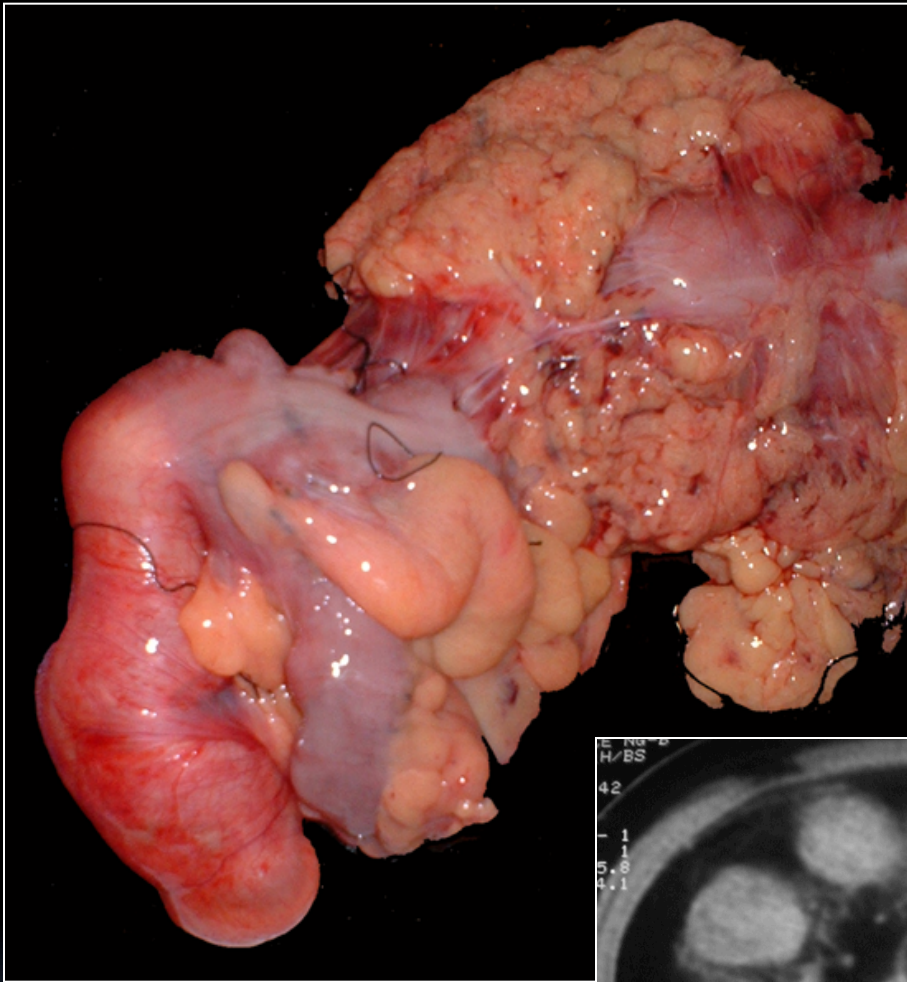
Appendicite
Perforée bouchée
Et plastronnée



Après traitement antibiotique

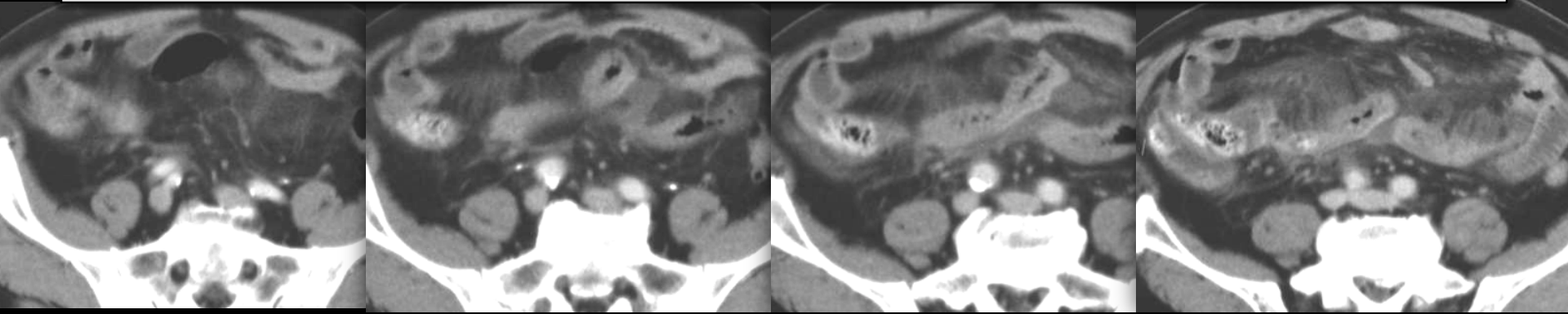


Vietnamien 43 ans masse de la FID

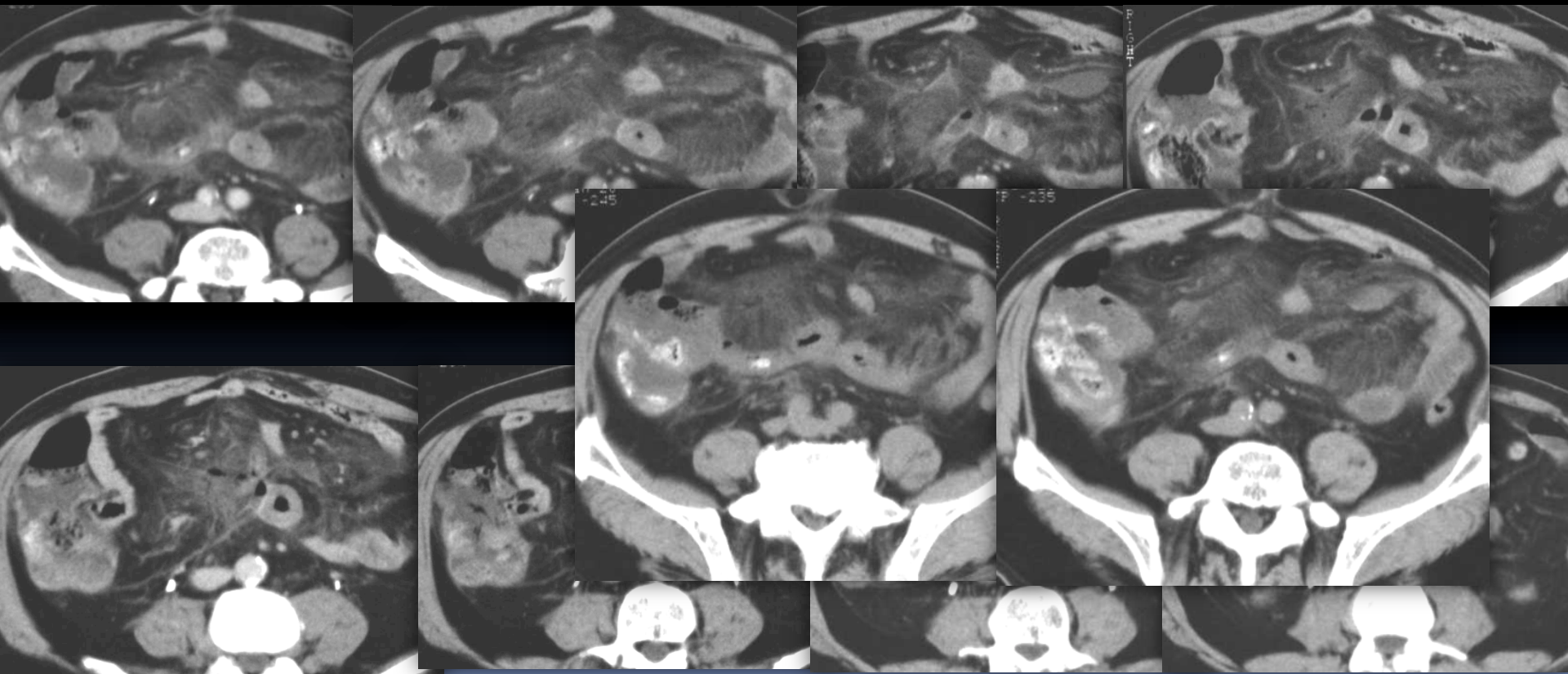


Mucocèle appendiculaire

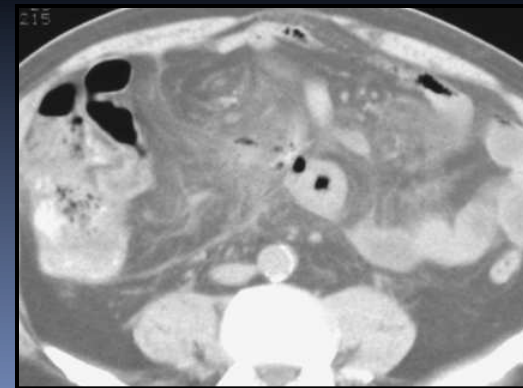
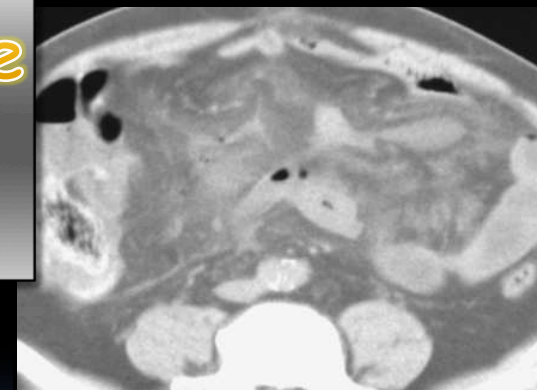
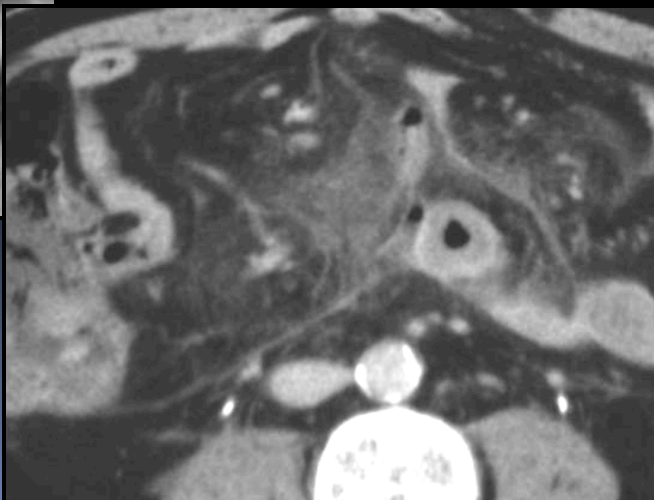
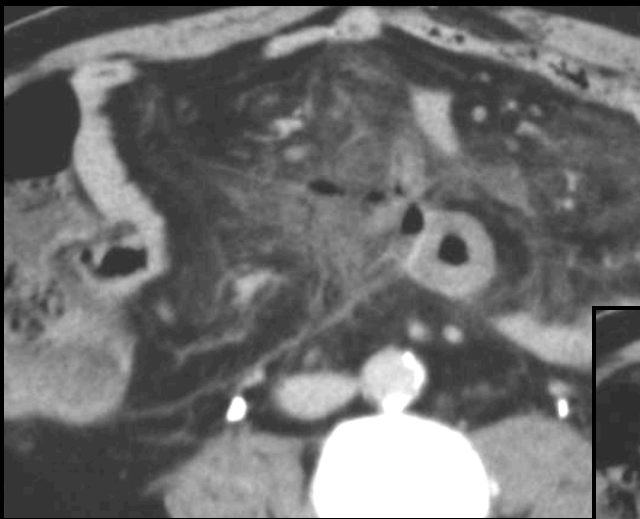
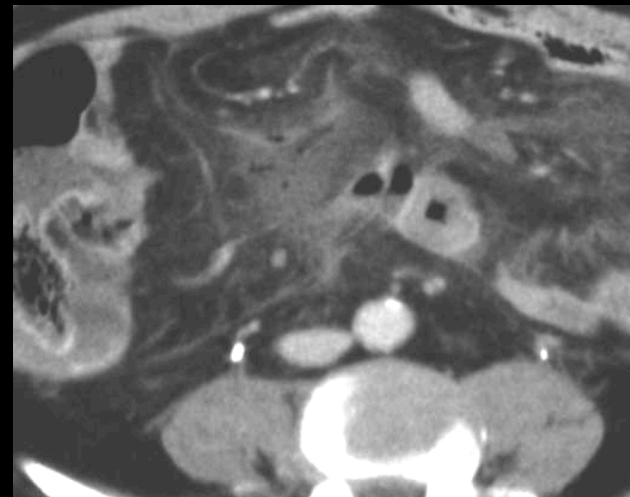
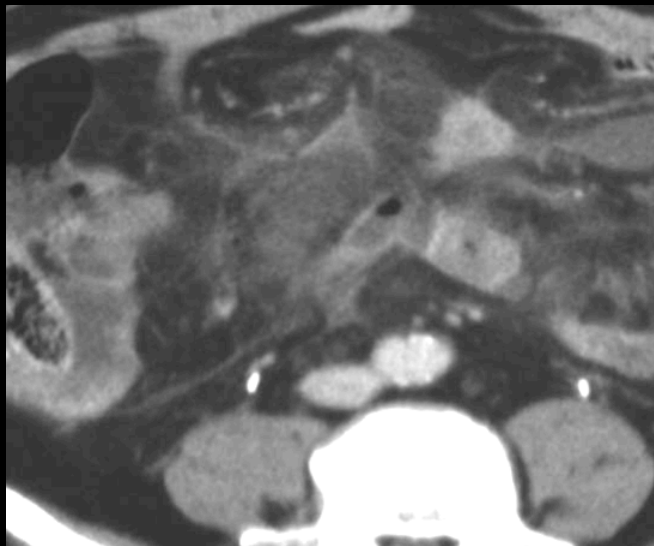
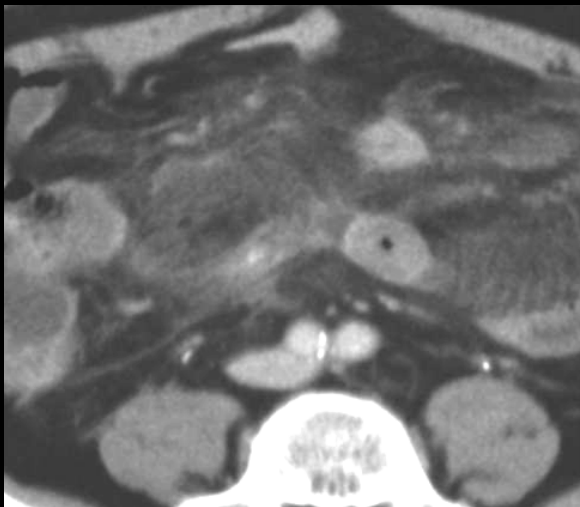
Douleurs abdo violentes paraombilicales vomissements fièvre 38°5

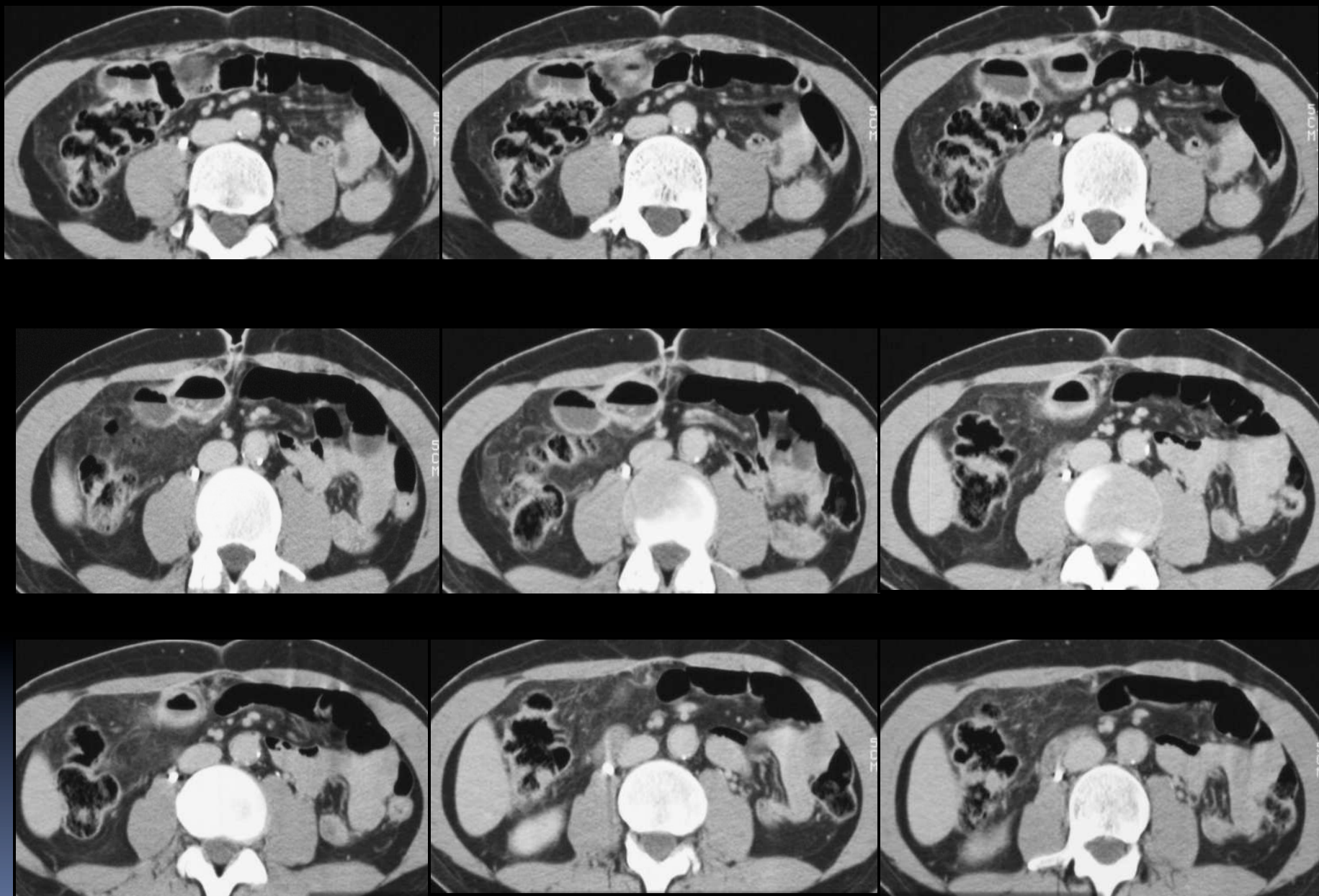


Pas d'antécédents médicaux ni chirurgicaux

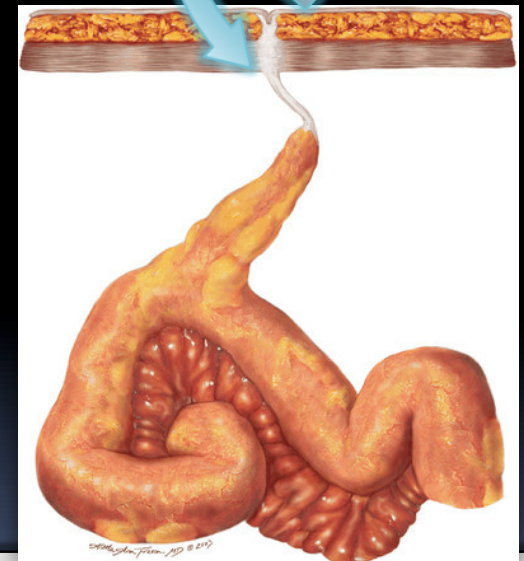
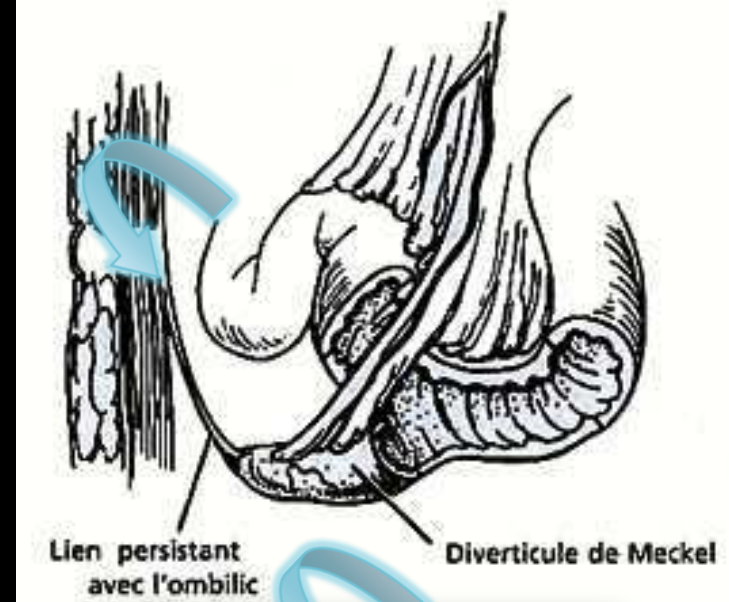


Diverticulite de
Meckel
perforée





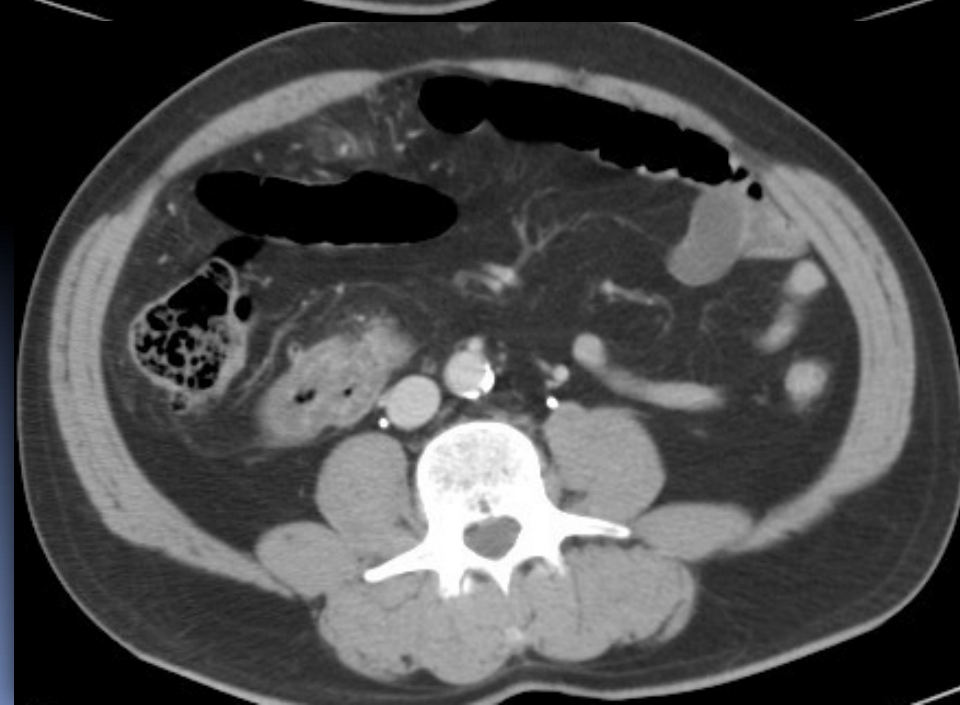
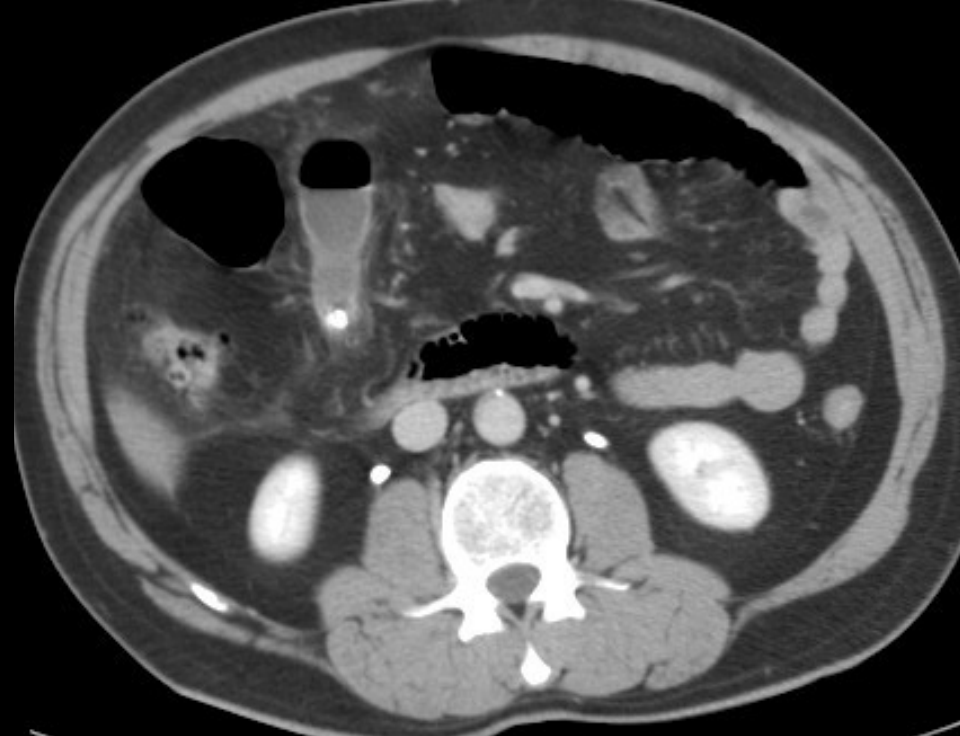
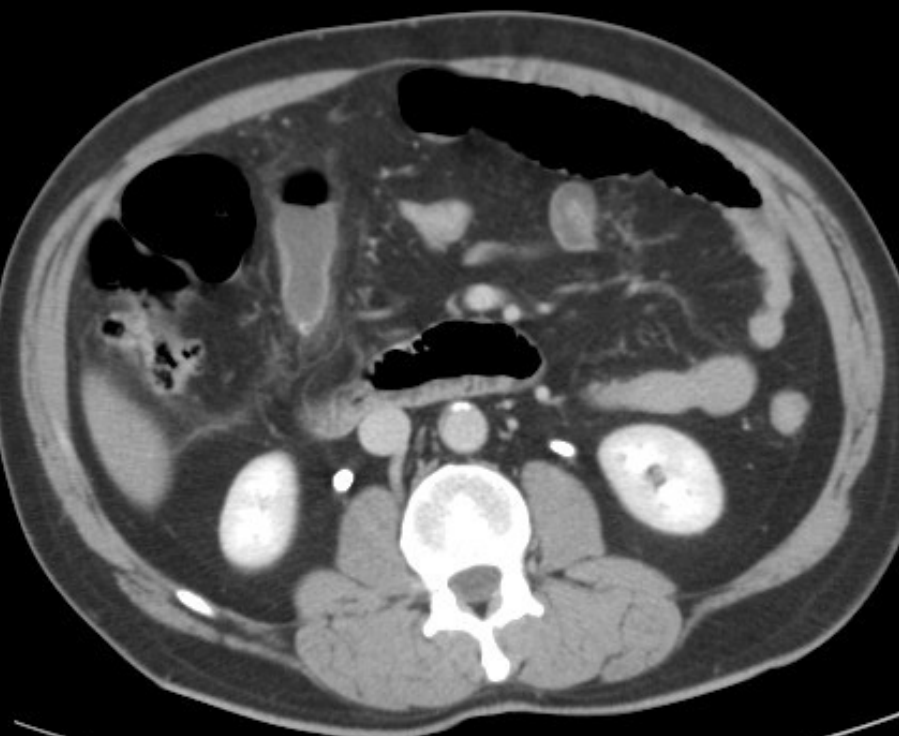
Diverticulite de Meckel

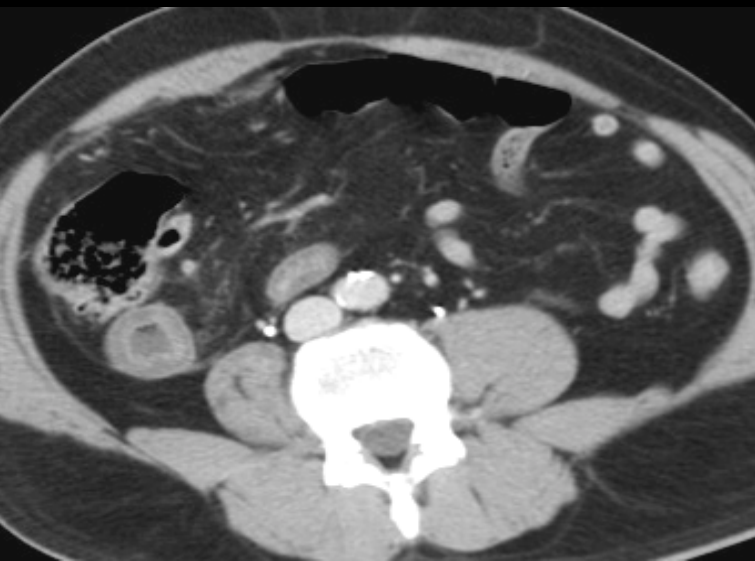


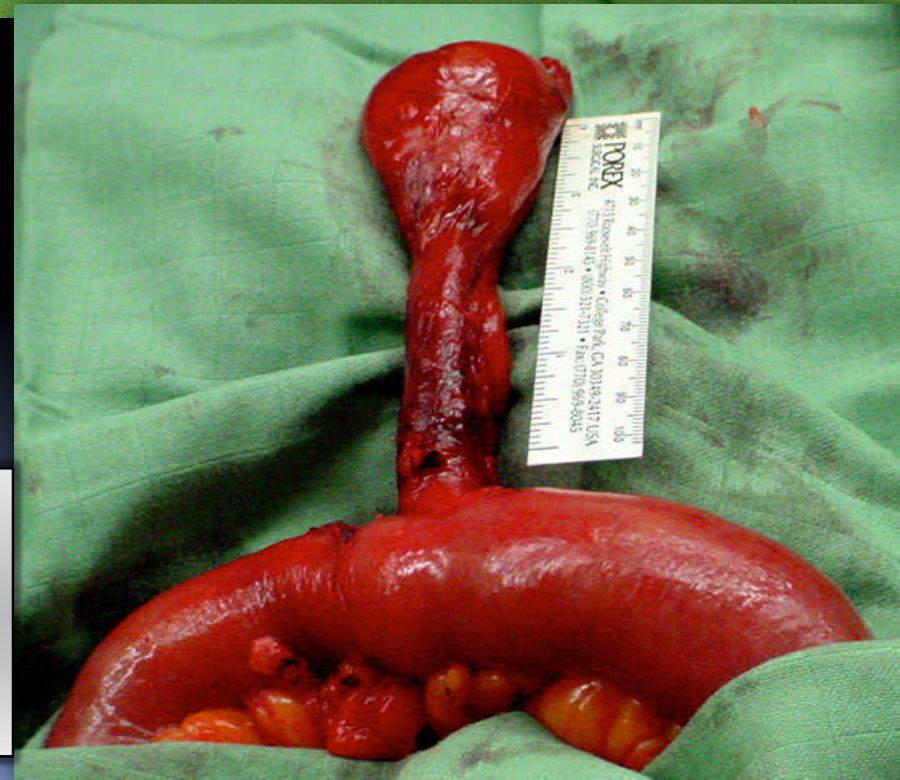
**Résorption incomplète du canal omphalo-mésentérique
pendant la vie embryonnaire
2% de la population générale**

Patient 50 ans douleurs abdominales violentes para ombilicales
Vomissements fièvre 38°5 polynucléose 12 000 éltts/mm3
Pas d'antécédents médicaux ni chirurgicaux

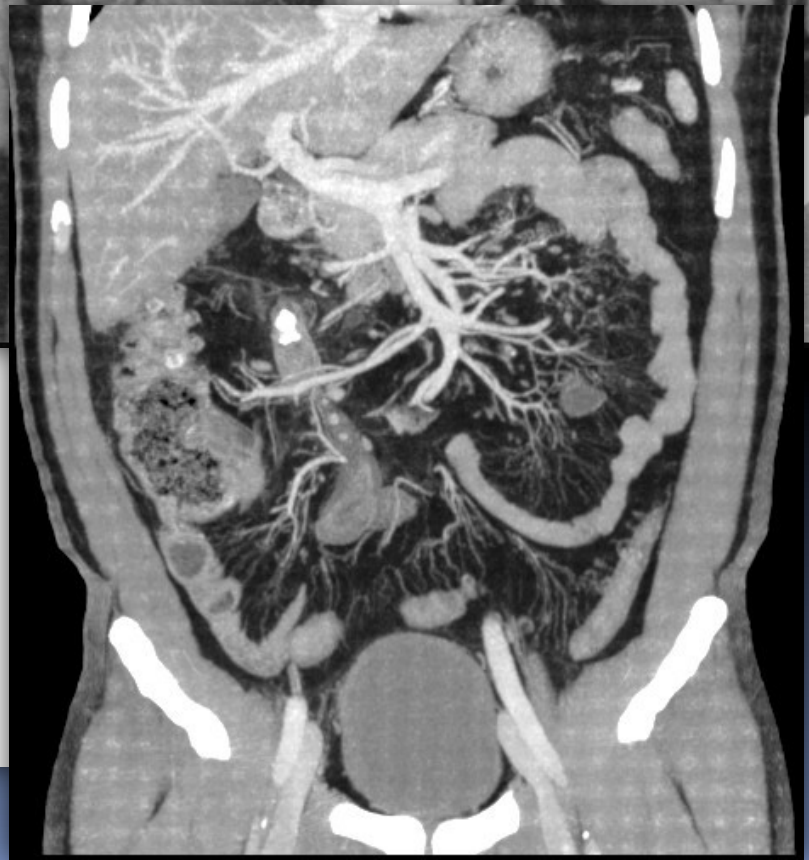
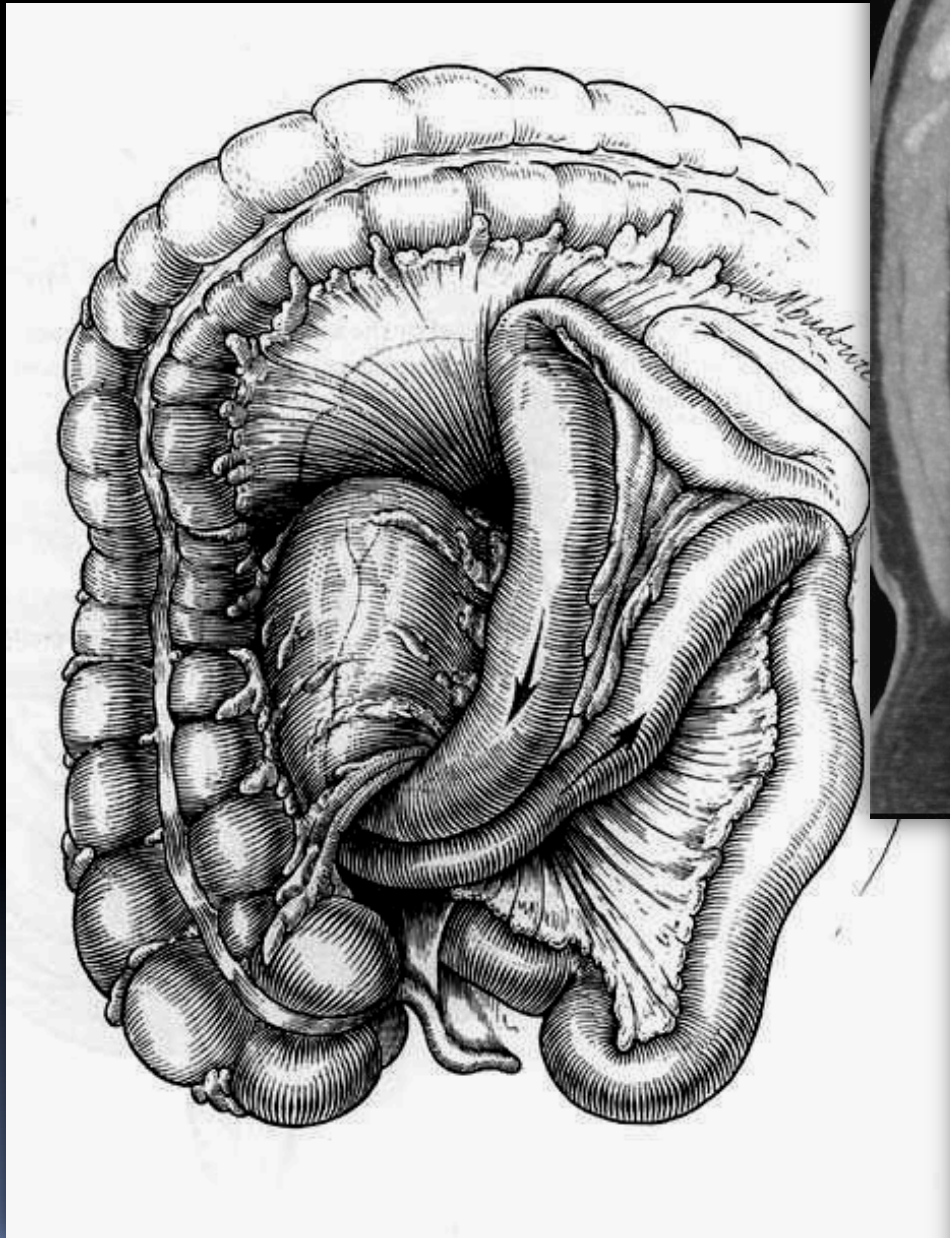






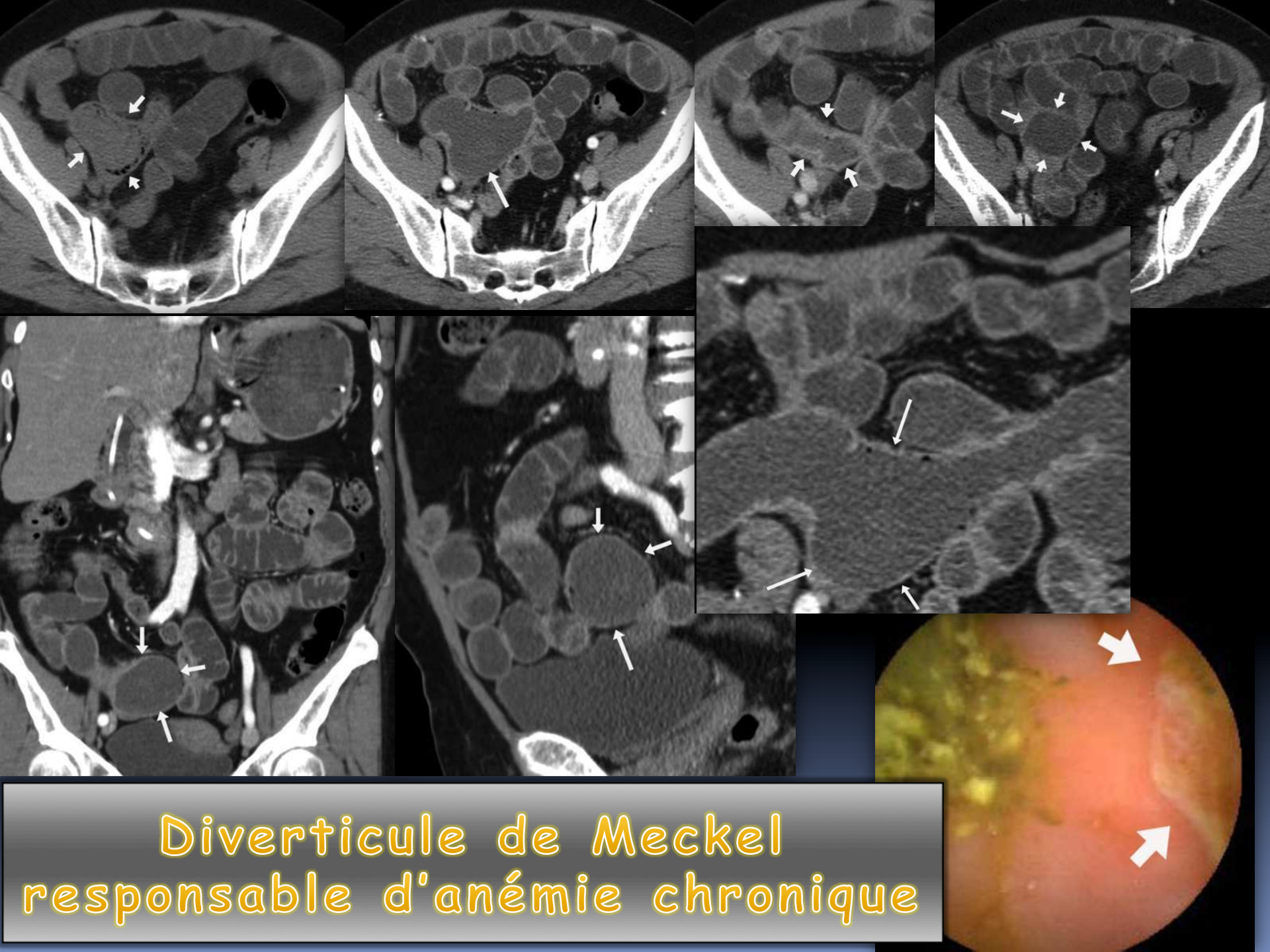


Diverticulite de Meckel
 Entérolithes responsables d'un sd
 occlusif transitoire
 Hernie interne para caecale

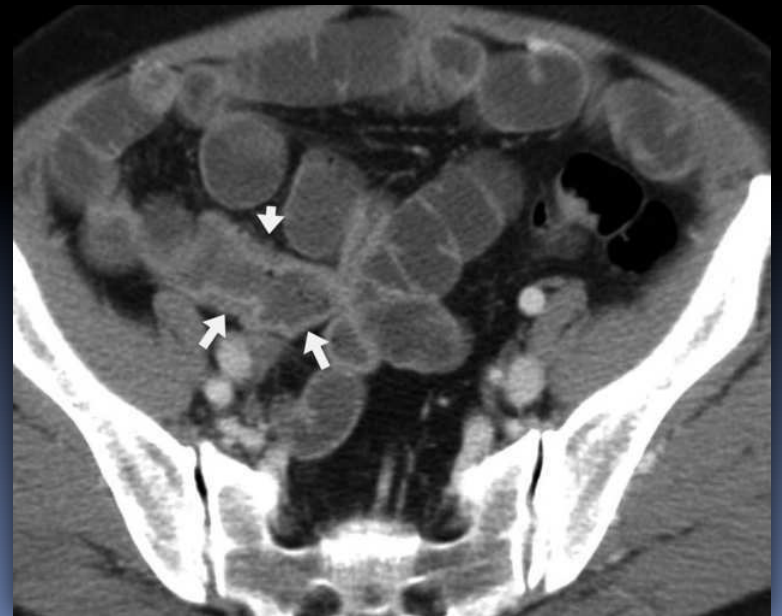
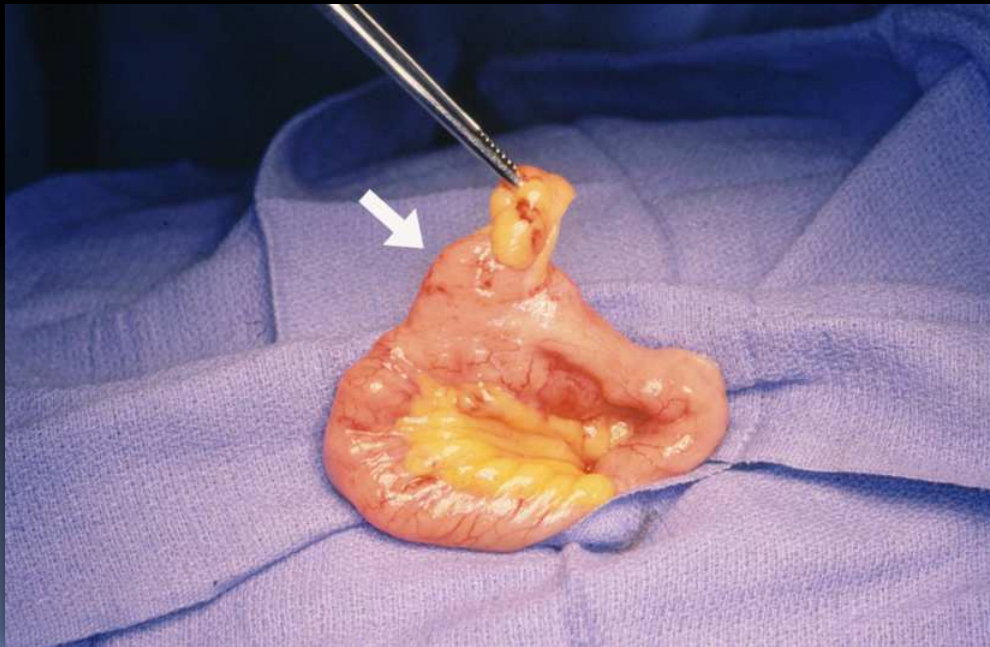
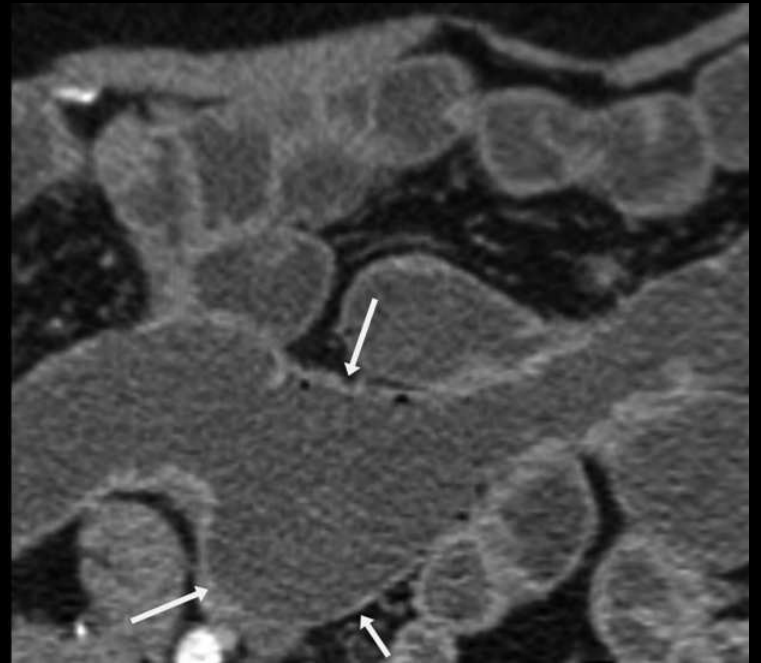
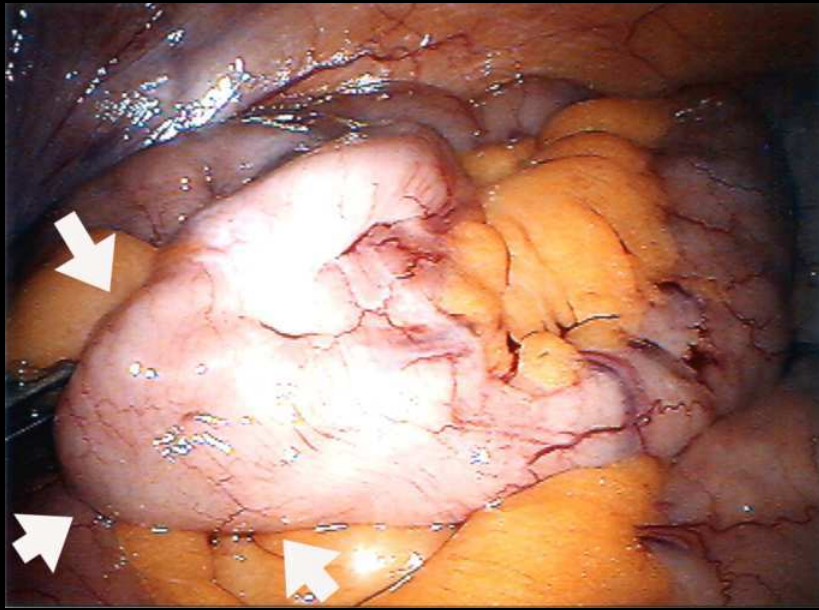


LE DIVERTICULE DE MECKEL

- 2 à 3% de la population (anomalie du canal omphalo-mésentérique)
- Complications : ++ H, 60% avant 10 ans
 - Hémorragie
 - Obstruction grêle
 - Diverticulite
 - Structure tubulaire, borgne
 - Air-liquide, liquide, matières (+ ou - stercolithes)
 - Paroi épaissie
 - Inflammation périphérique, + ou - obstruction grêle
 - Connexion avec grêle/extension vers ombilic/appendice normal
 - Compressible ou pas en écho (Dg diff : duplication)

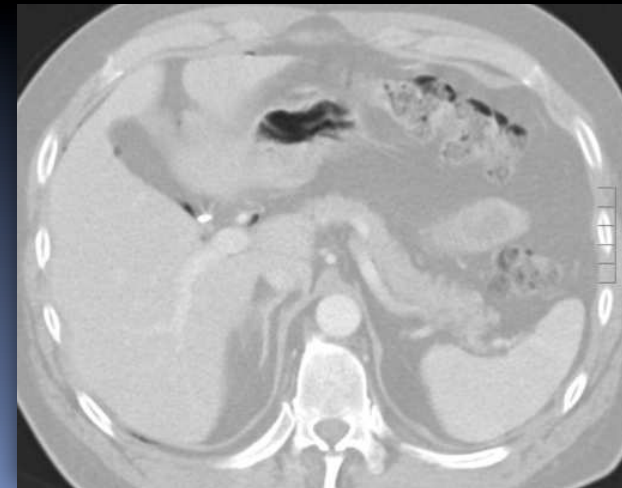
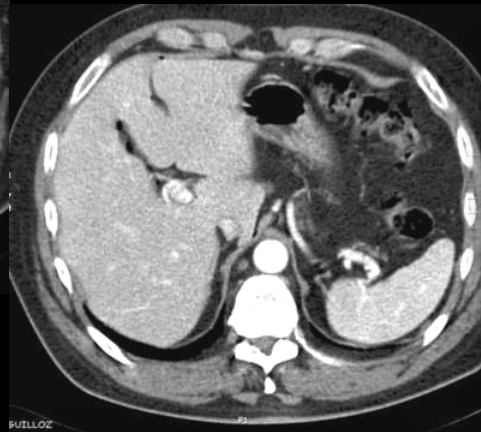
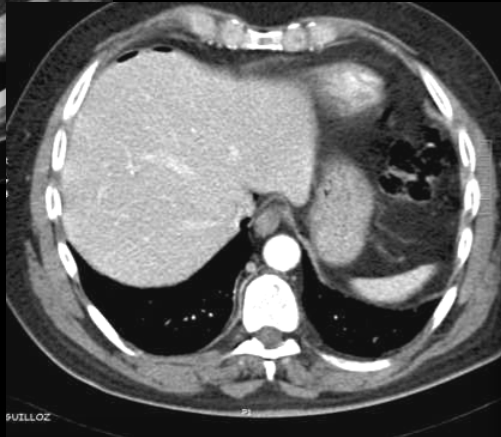
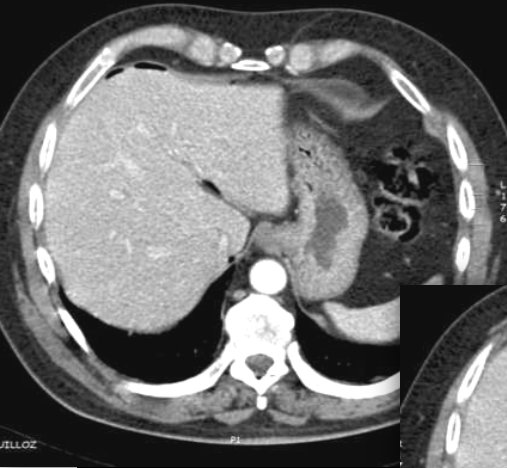


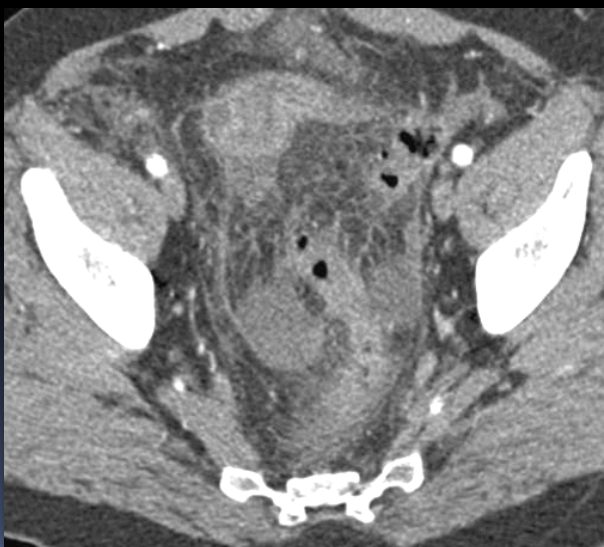
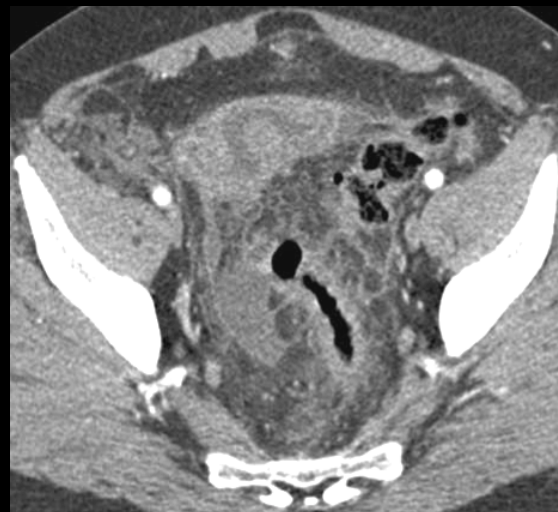
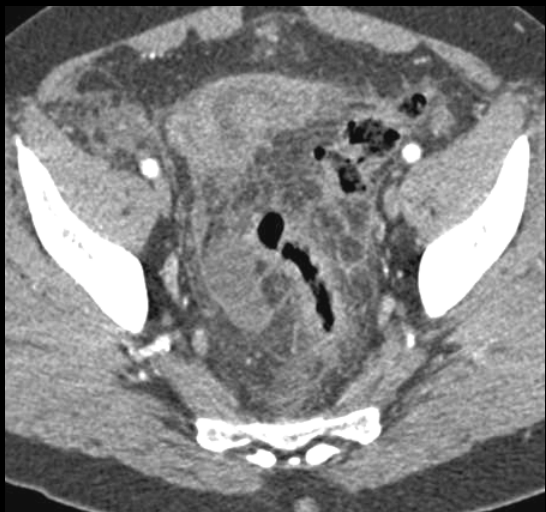
Diverticule de Meckel
responsable d'anémie chronique

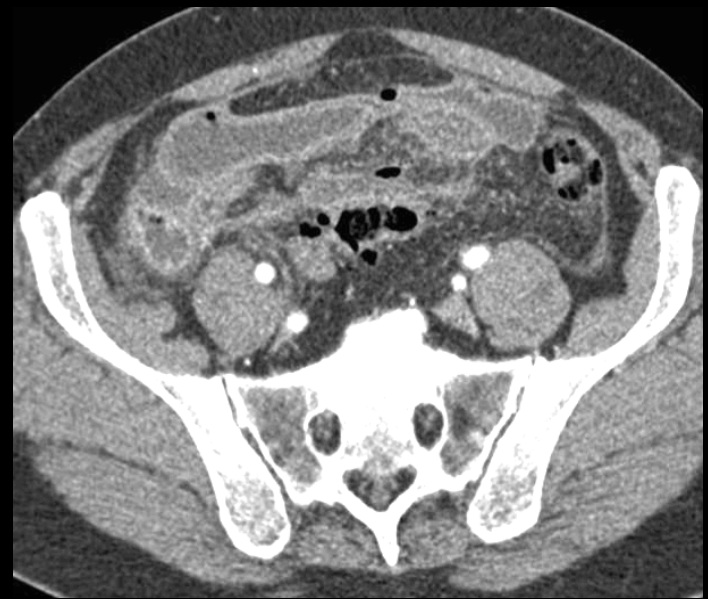


Patient de 58 ans, présentant des douleurs abdominales depuis 1 semaine, majorées ce jour.

Contracture généralisée, T° 38°6,
hyperleucocytose 16800 GB, CRP 68

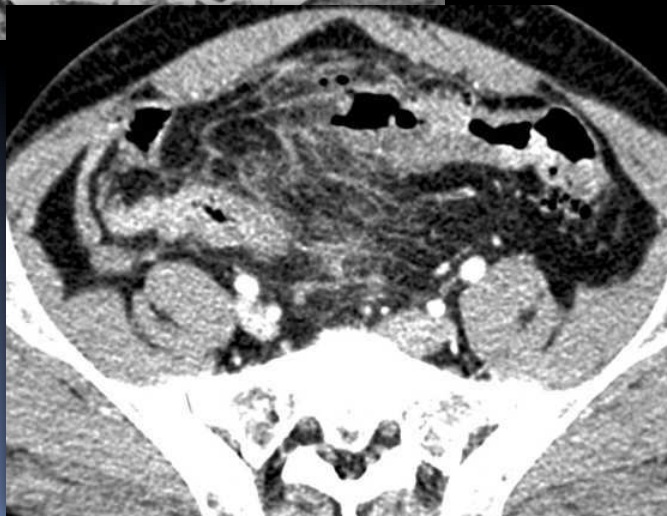
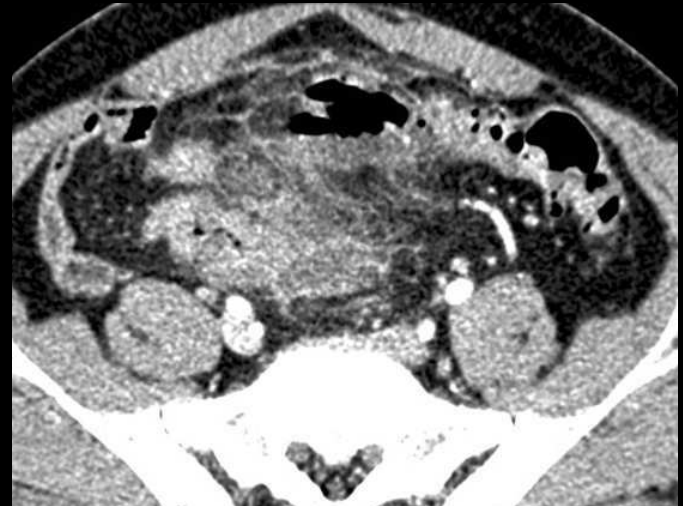


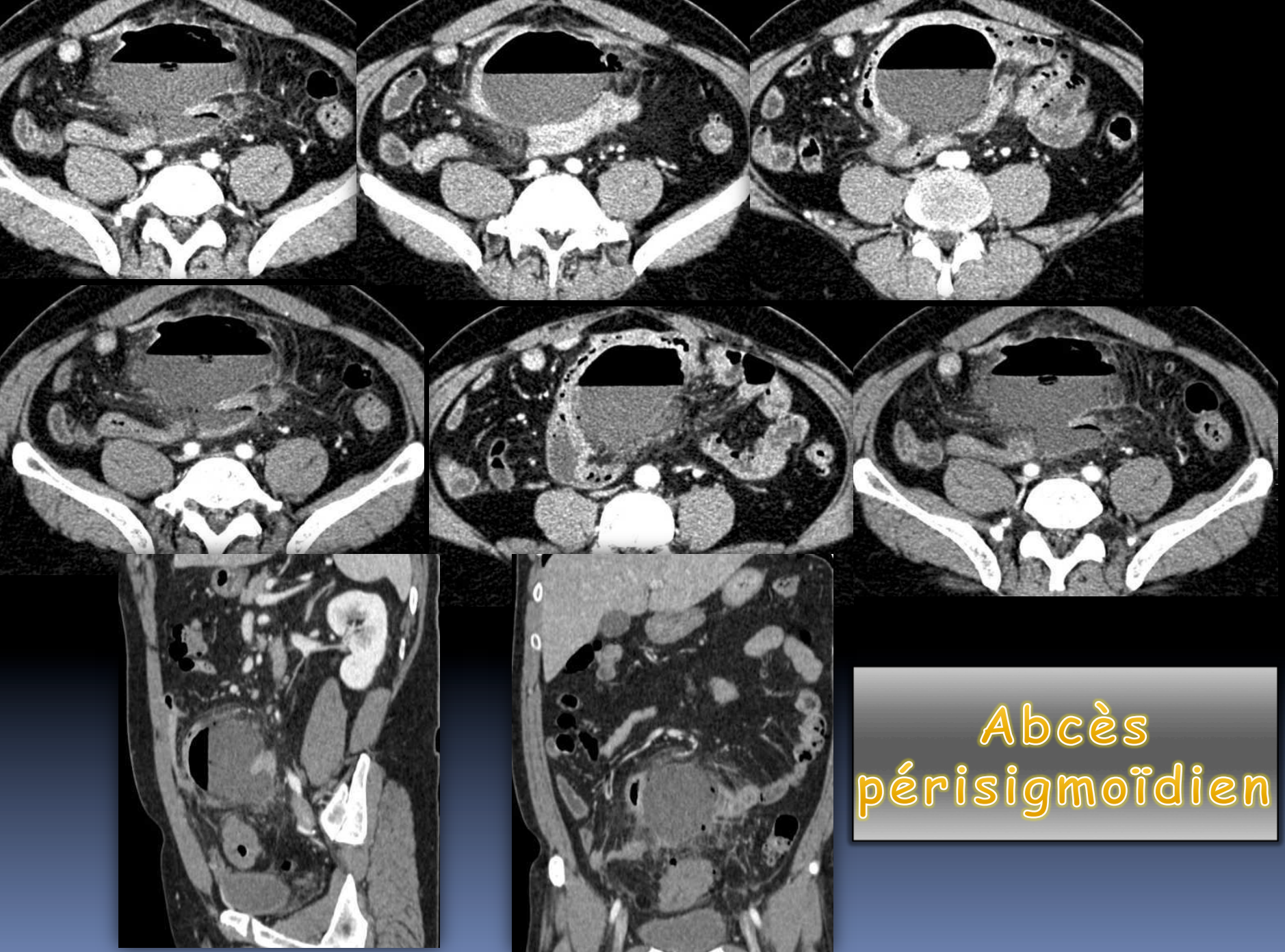




Péritonite sur sigmoïdite diverticulaire perforée

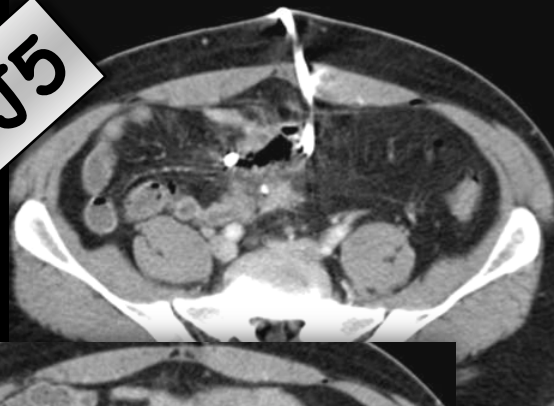
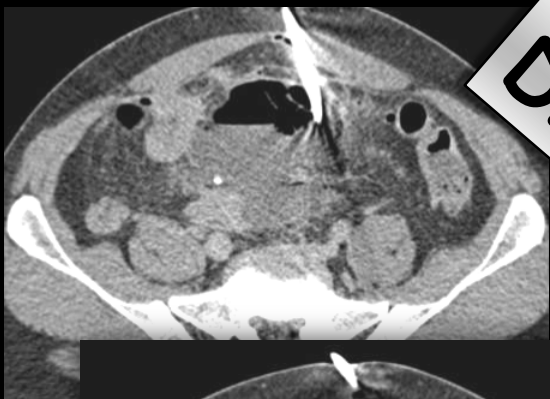
Patient de 49 ans présentant depuis 10 jours des douleurs abdominales en FIG.





DRAINAGE

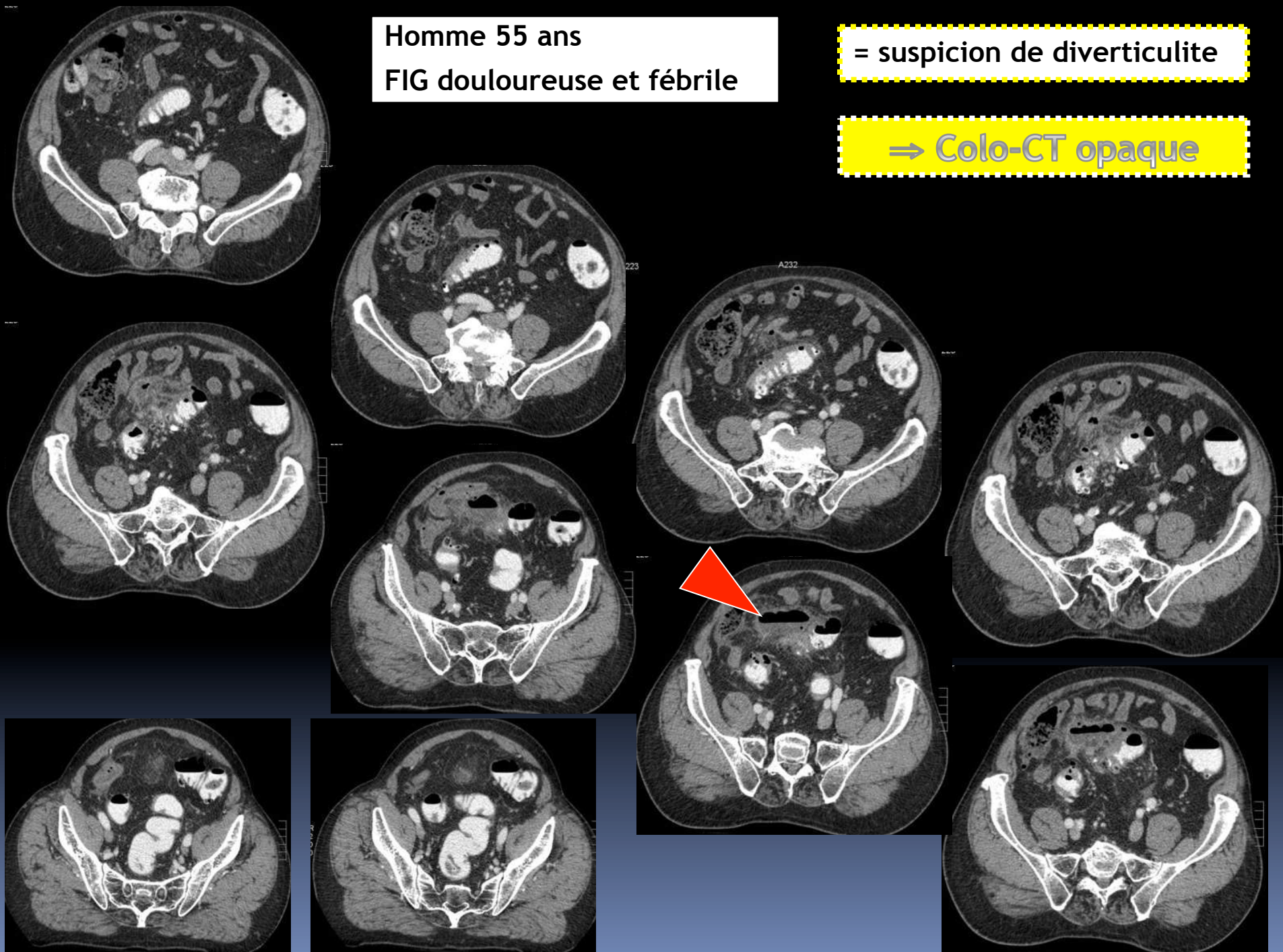
CONTRÔLE J5



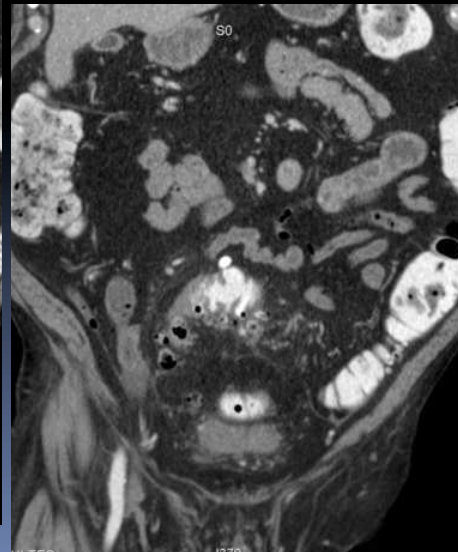
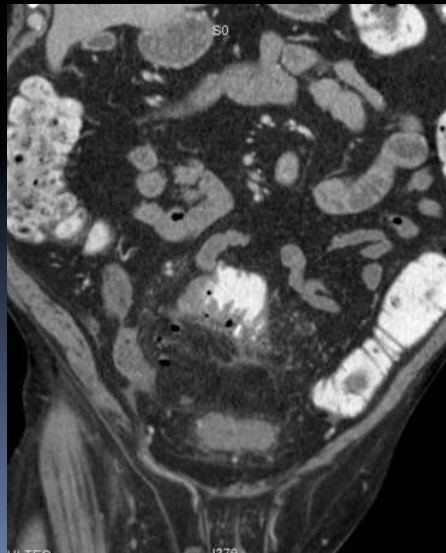
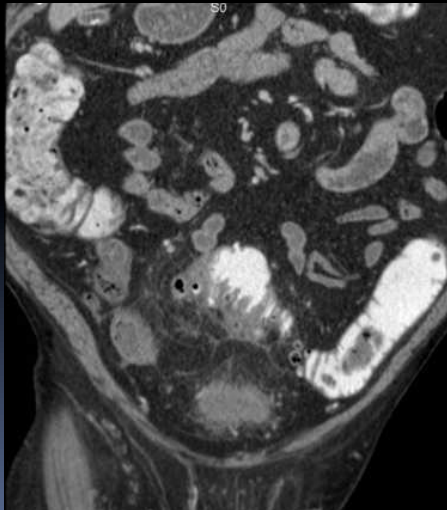
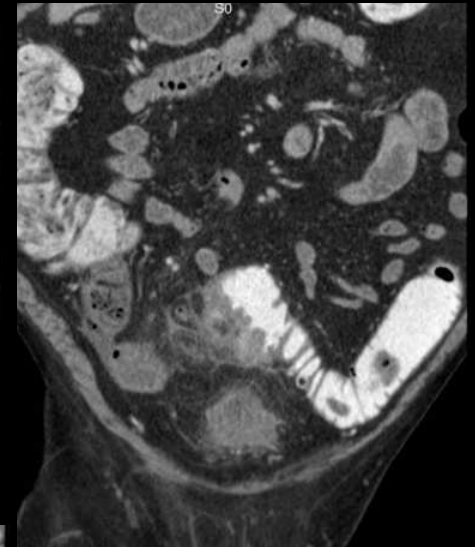
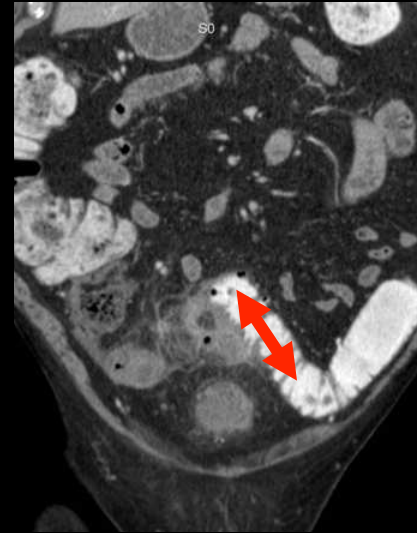
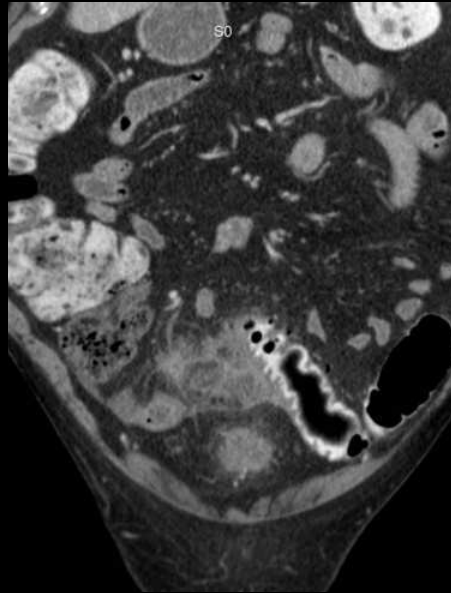
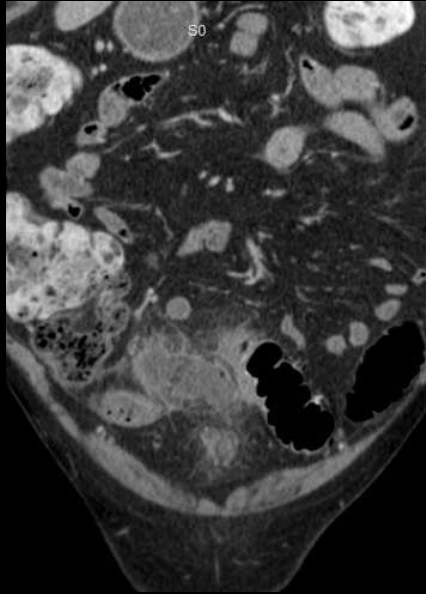
Homme 55 ans
FIG douloureuse et fébrile

= suspicion de diverticulite

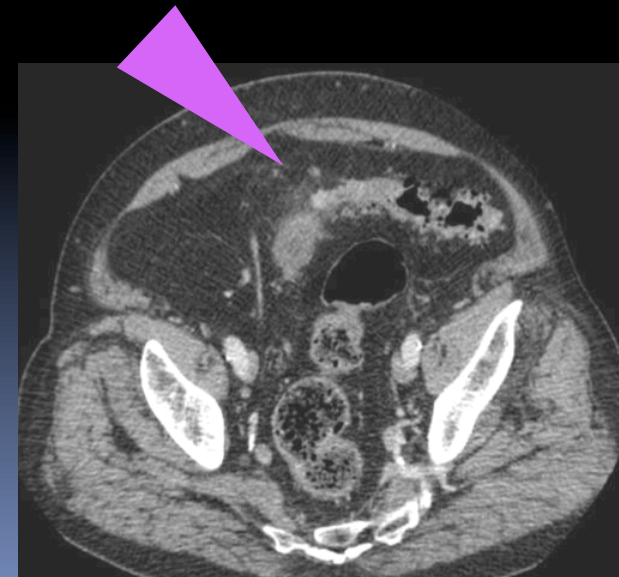
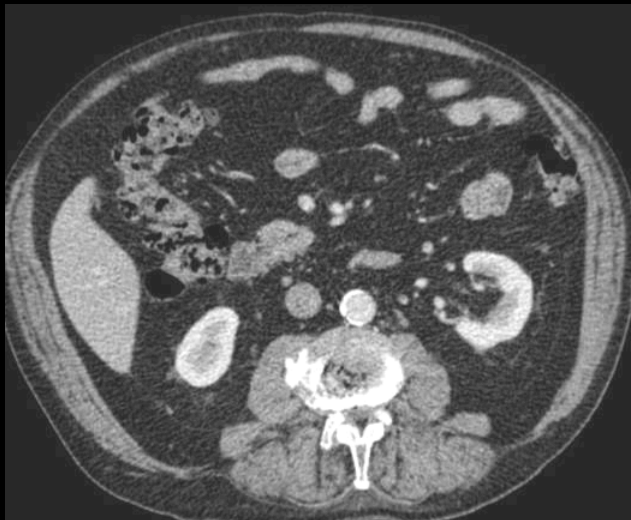
⇒ Colo-CT opaque

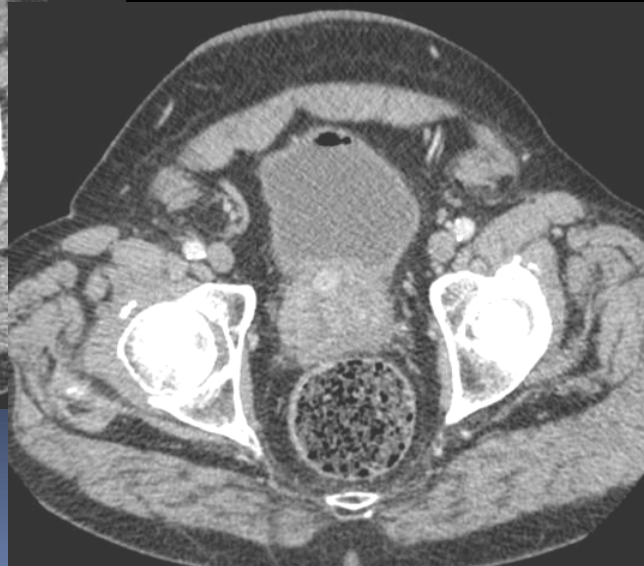


Diverticulite et abcès péri sigmoïdien

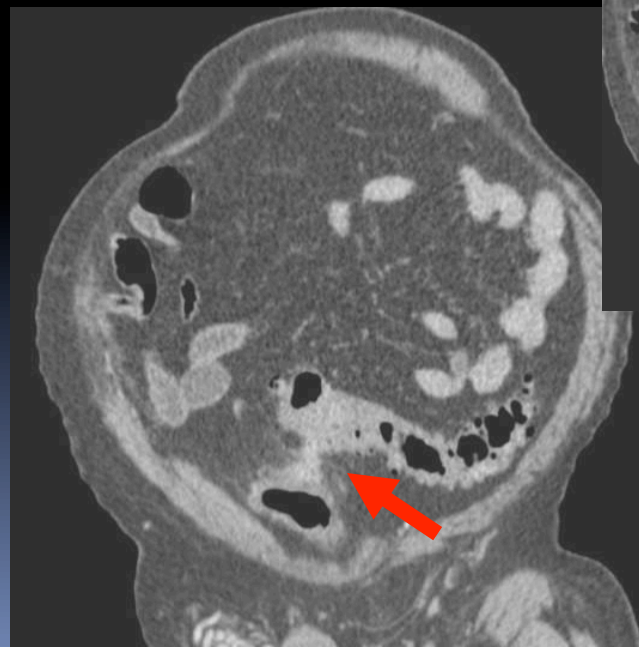
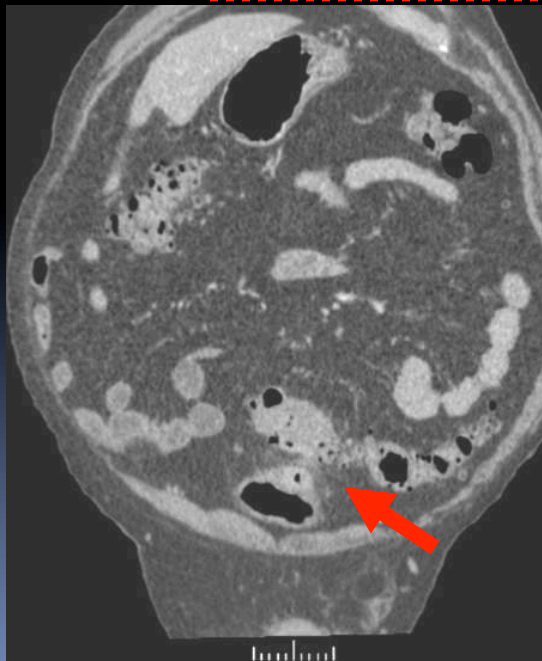


**Patient de 71 ans , douleurs abdominales basses +
infections urinaires à répétition**

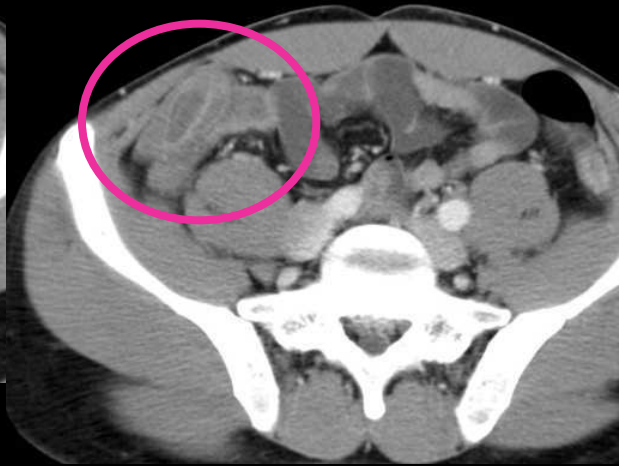
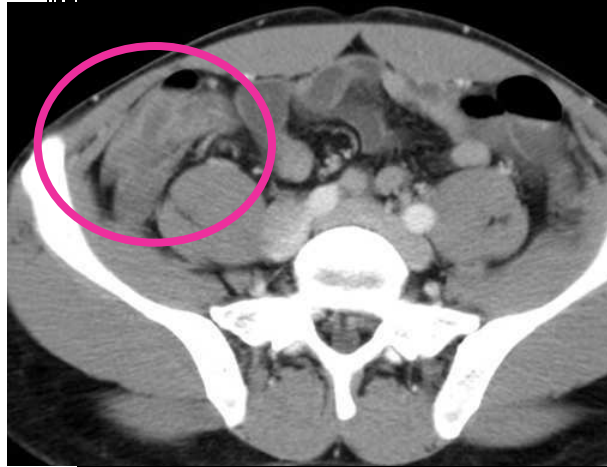




Diverticulite + fistule sigmoïdo-vésicale



Patient de 28 ans, douleur de la fosse iliaque droite, fièvre.



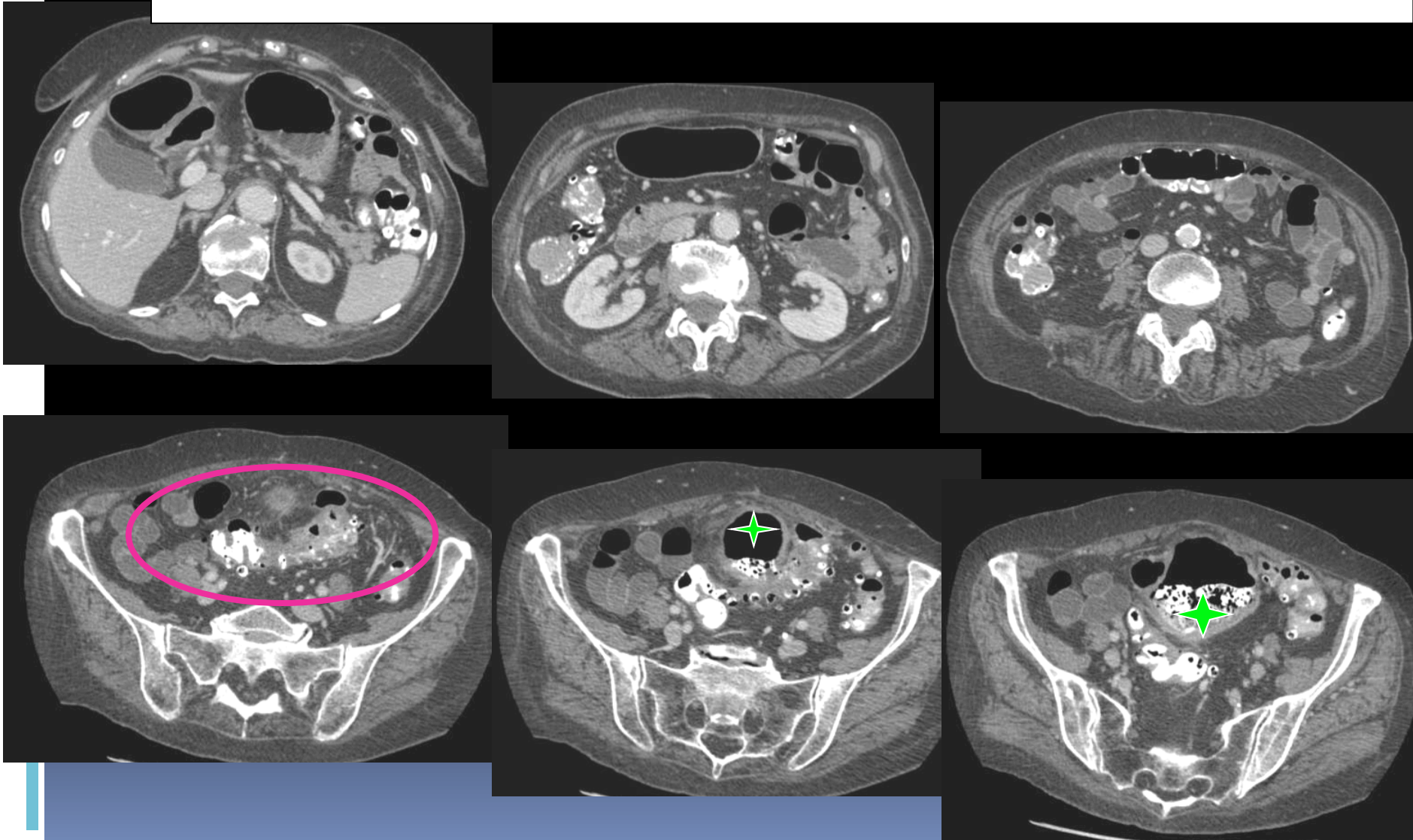
Appendicite aiguë + Typhlite

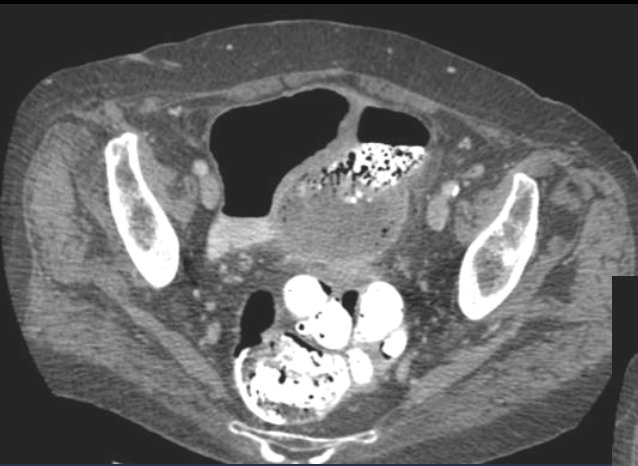
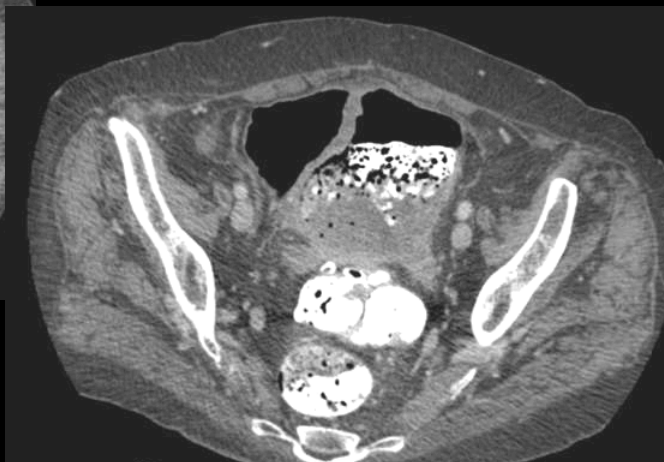
Patiente de 77 ans, AEG sans fièvre

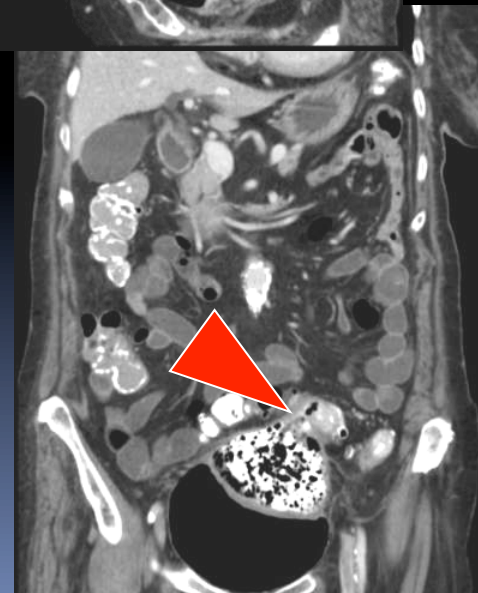
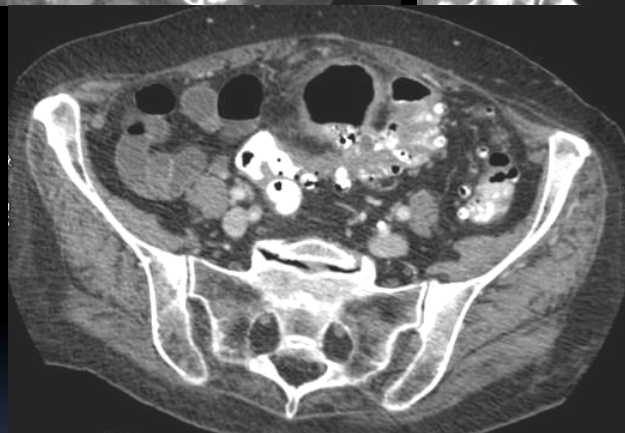
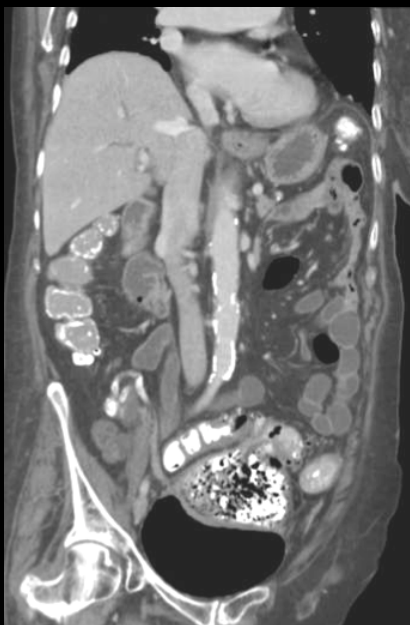
Abdomen non chirurgical, infections urinaires à répétition : fécalurie

Syndrome inflammatoire biologique modéré (10 000 GB, PCR 60)

Un scanner réalisé à l'extérieur aurait montré une collection pelvienne

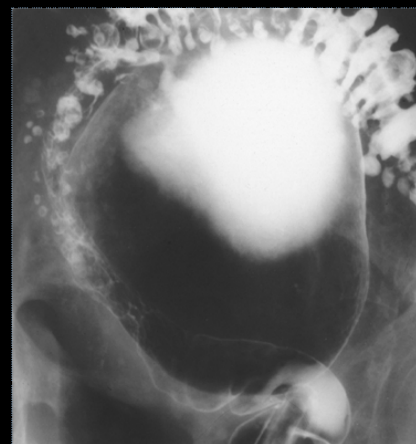
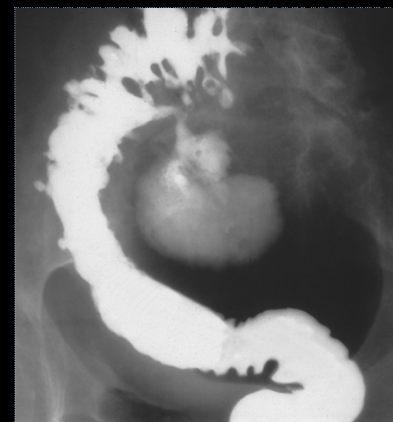
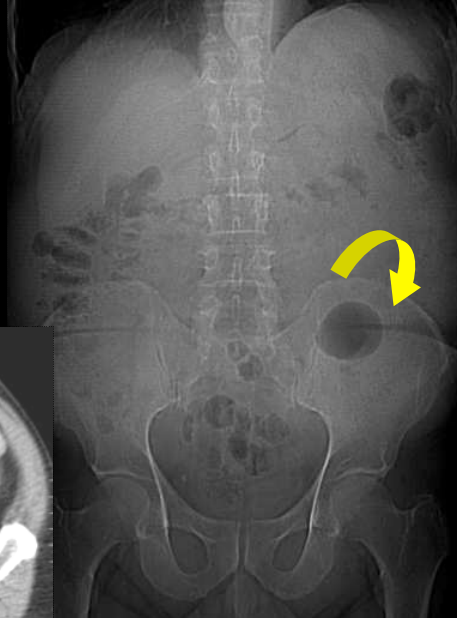
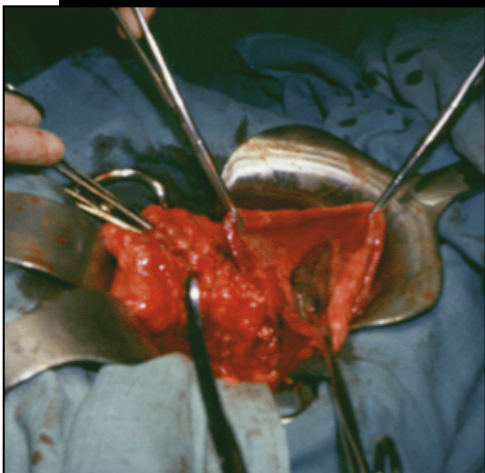
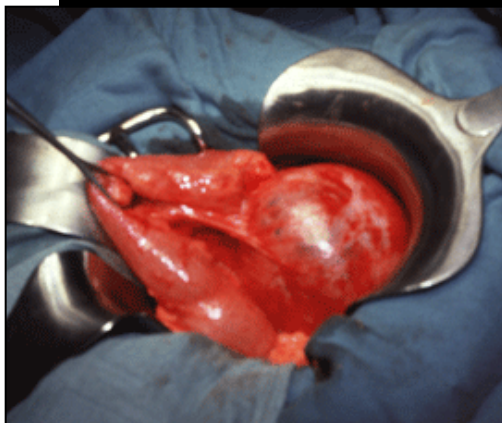






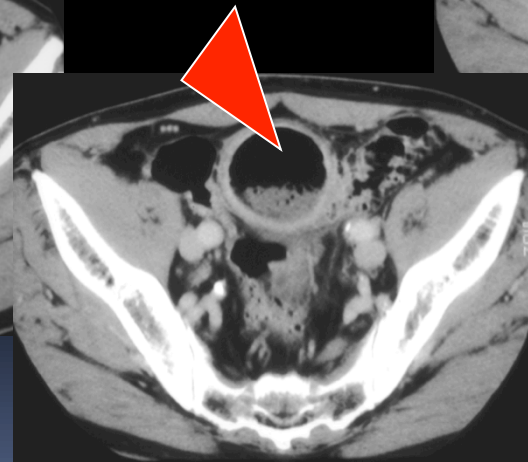
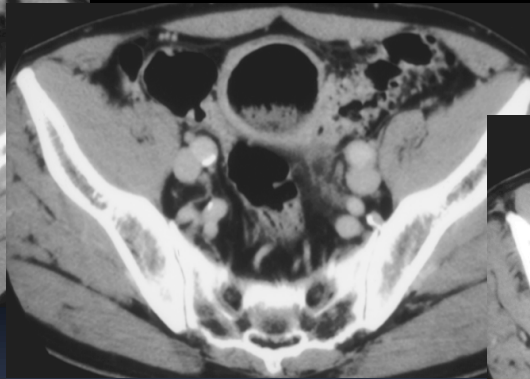
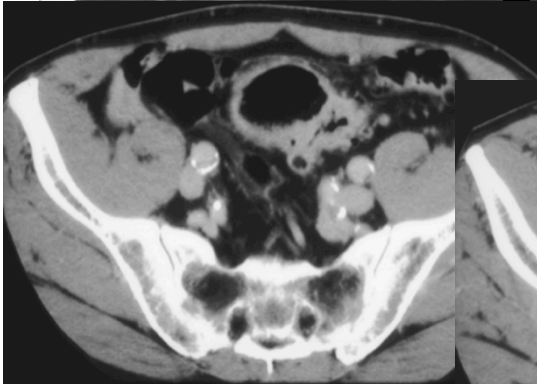
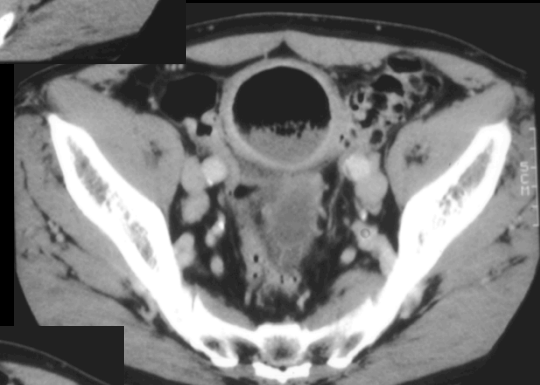
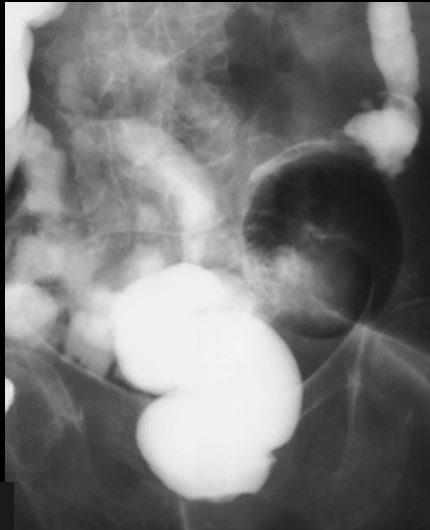
« Abscès sigmoïdien »

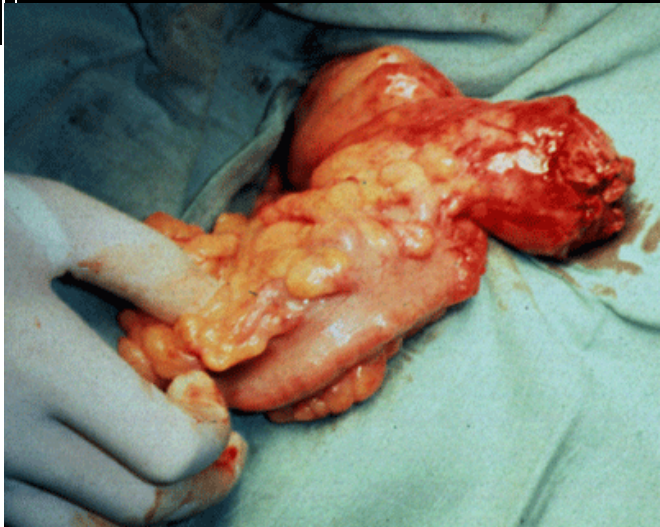
... fistulisé dans la vessie



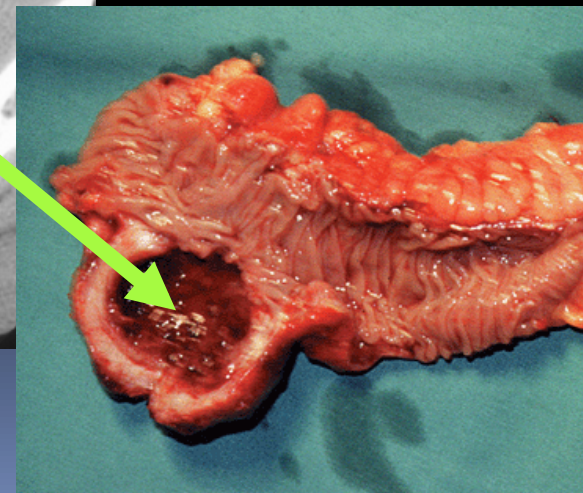
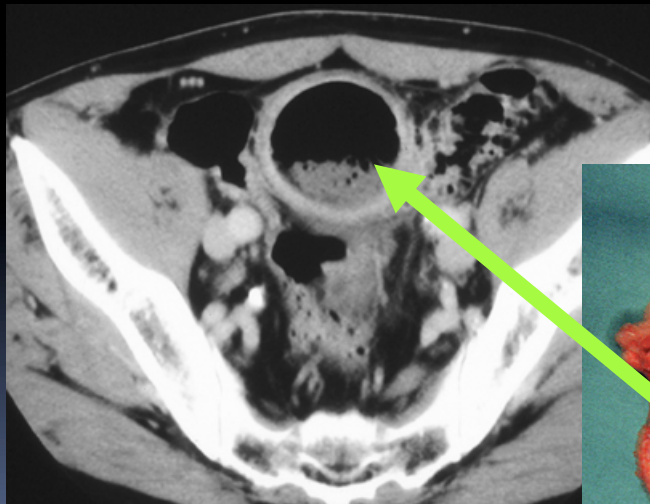
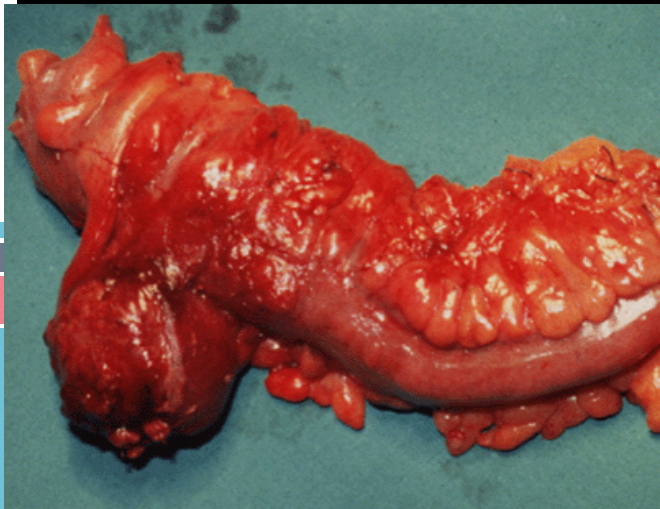
**Diverticule géant du sigmoïde
à parois minces « soufflées ».
Vrai diverticule, mais de taille
inhabituelle !!**

Patiente de 82 ans
Infections urinaires

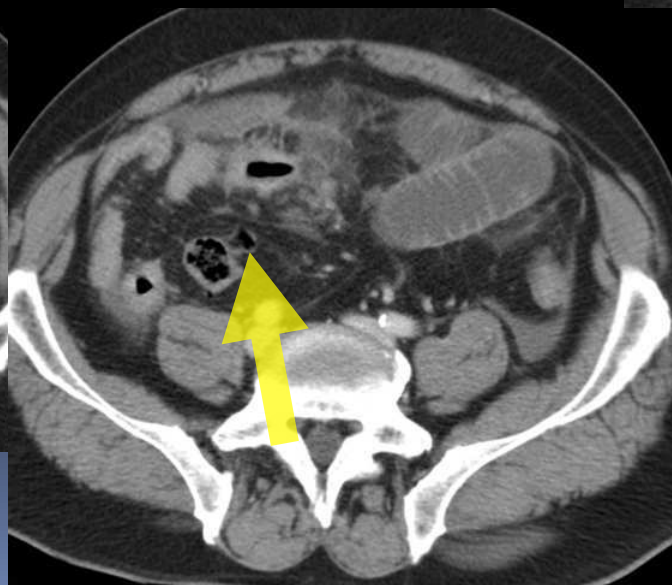
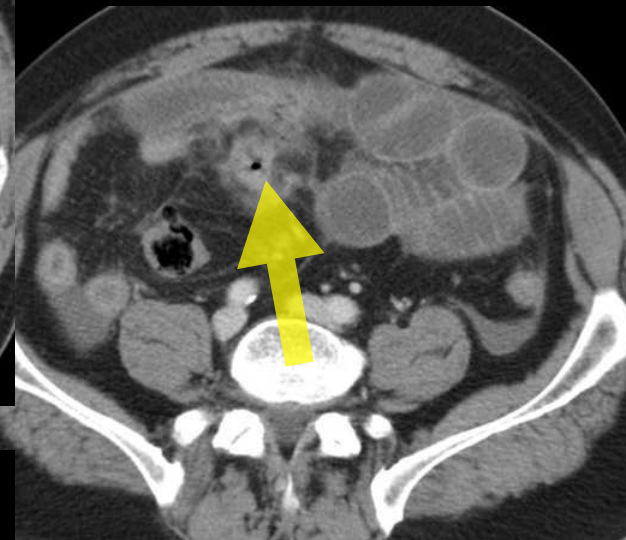
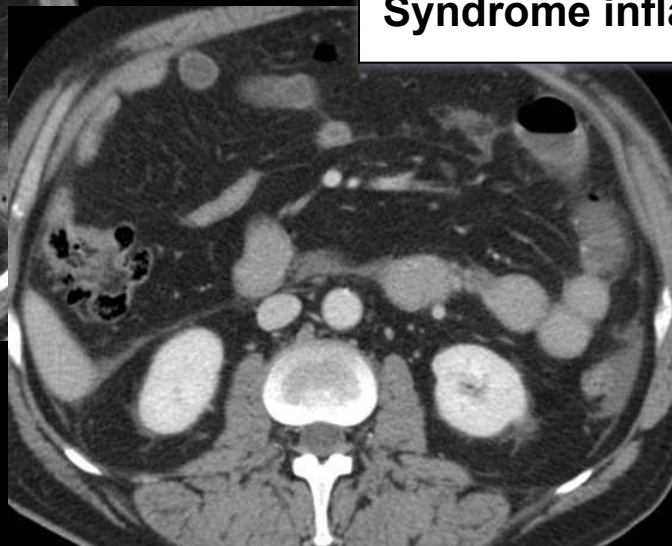
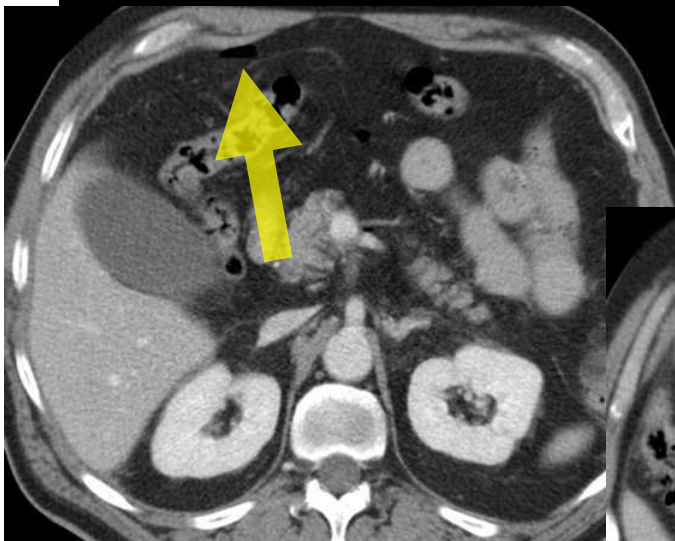


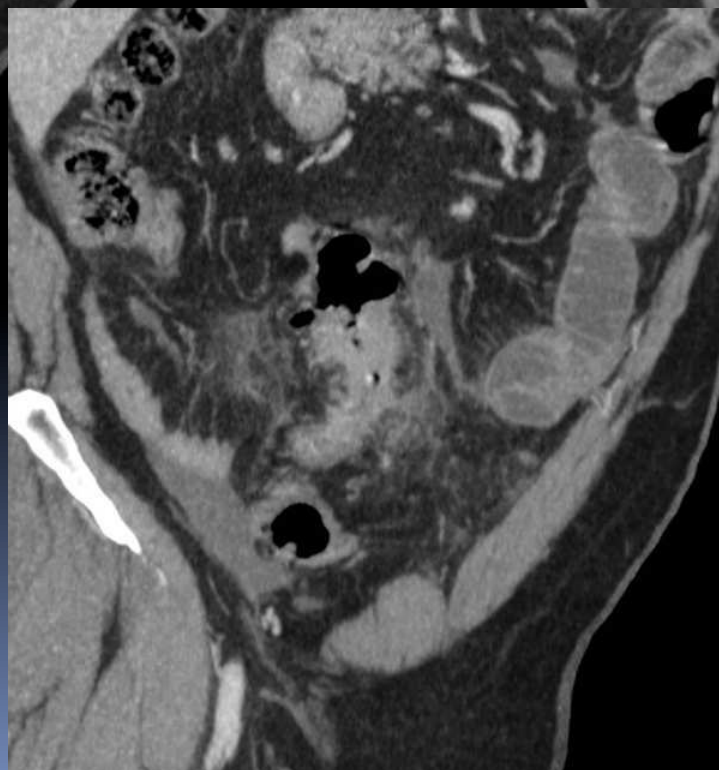
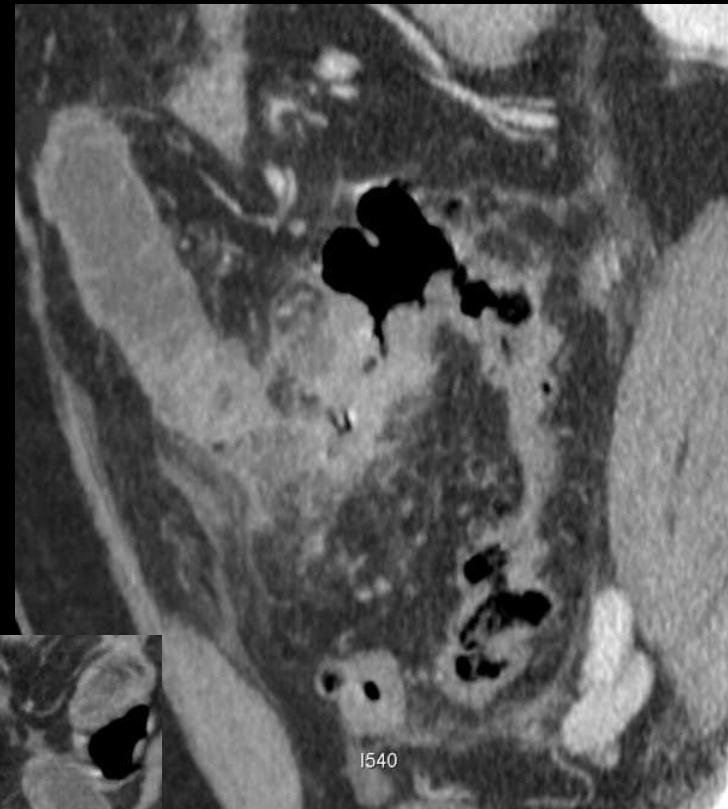


**Collection à
Parois épaisses
Correspond à un abcès péri
sigmoïdien détergé**

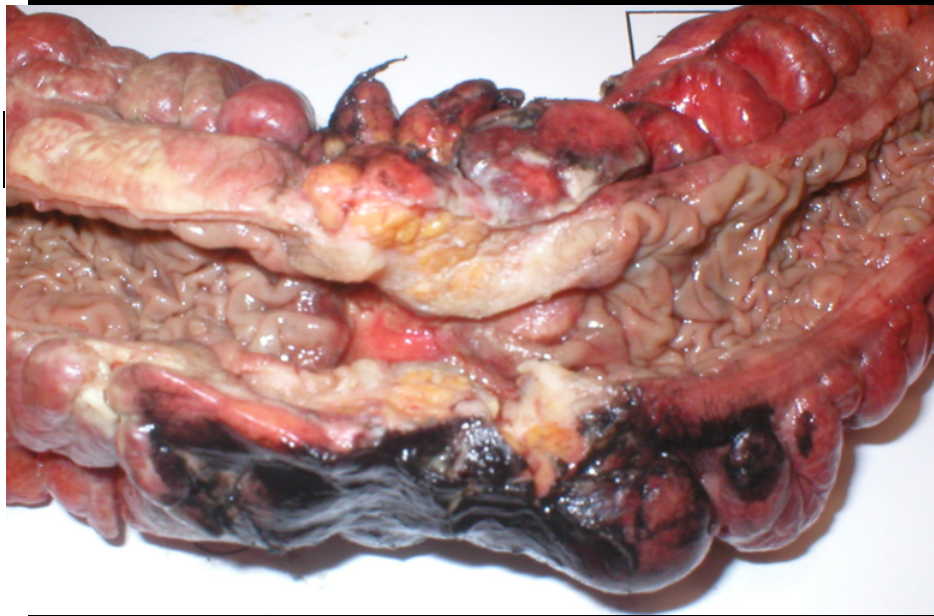


Patient de 61 ans
Douleur abdo croissante depuis 24h, 38°
Contracture abdo prédominant en FID
Syndrôme inflammatoire biologique

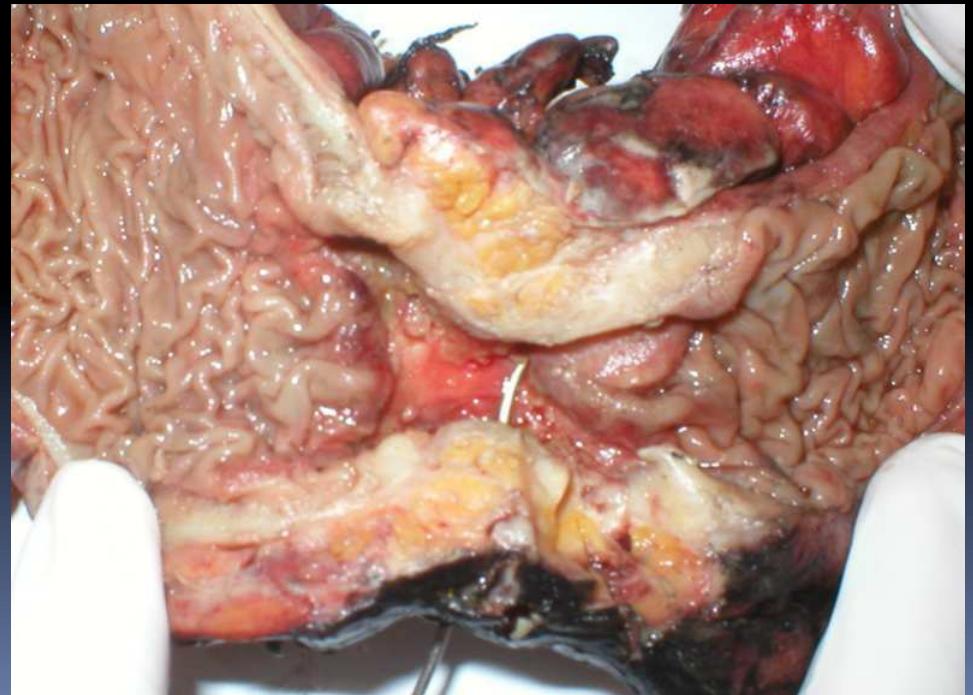


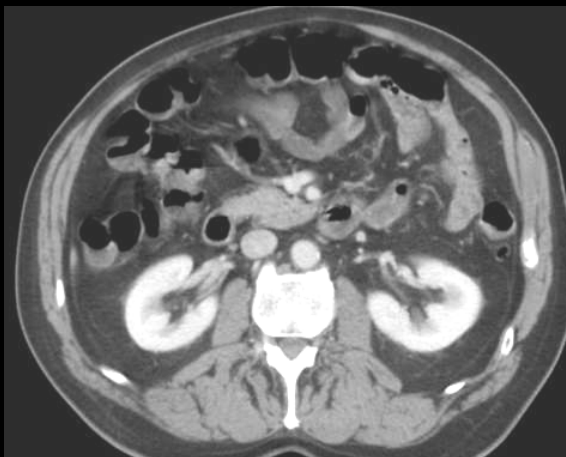


Lésion pariétale
Sous jacente???



Péritonite sur perforation d'un ADK
sigmoïde bien différencié T3N1M0





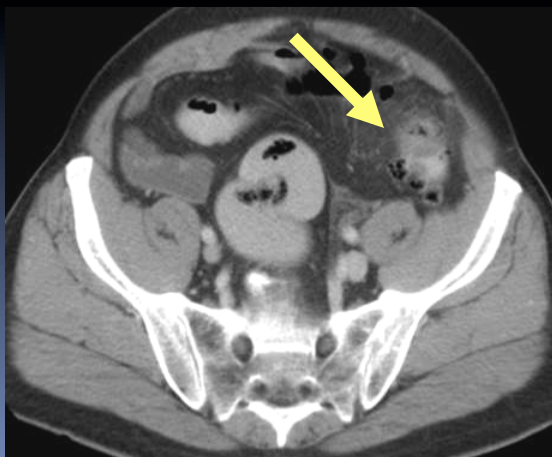
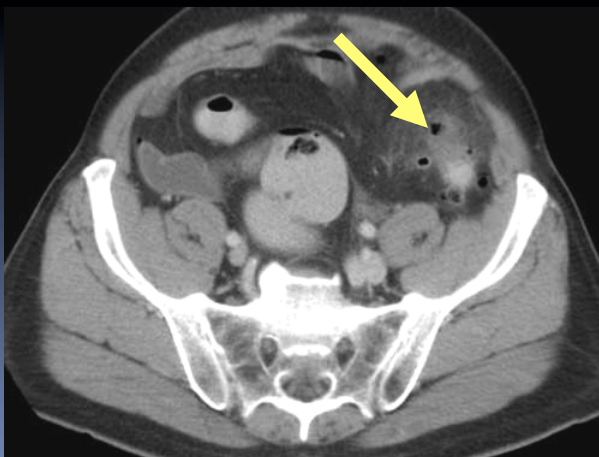
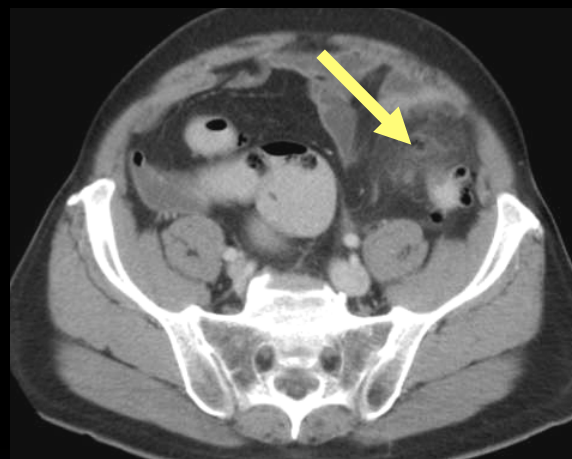
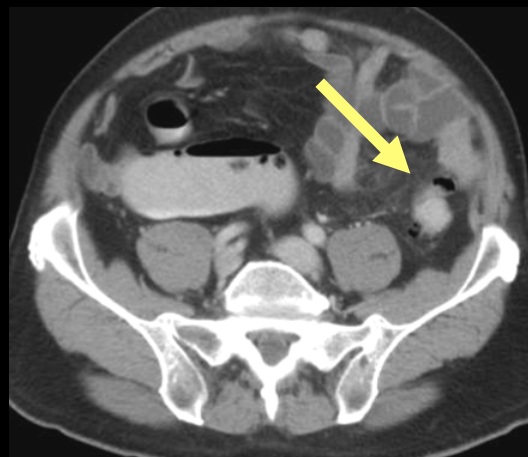
CAS 6

Homme de 63 ans

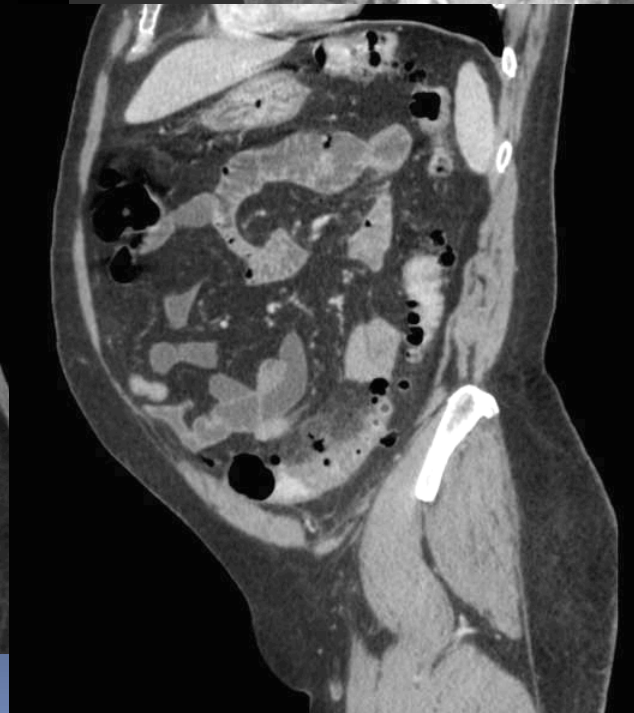
**Douleur fosse lombaire et
fosse iliaque gauche**

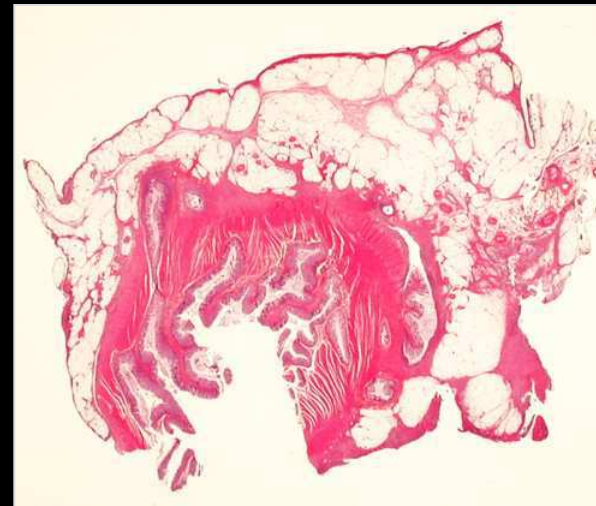
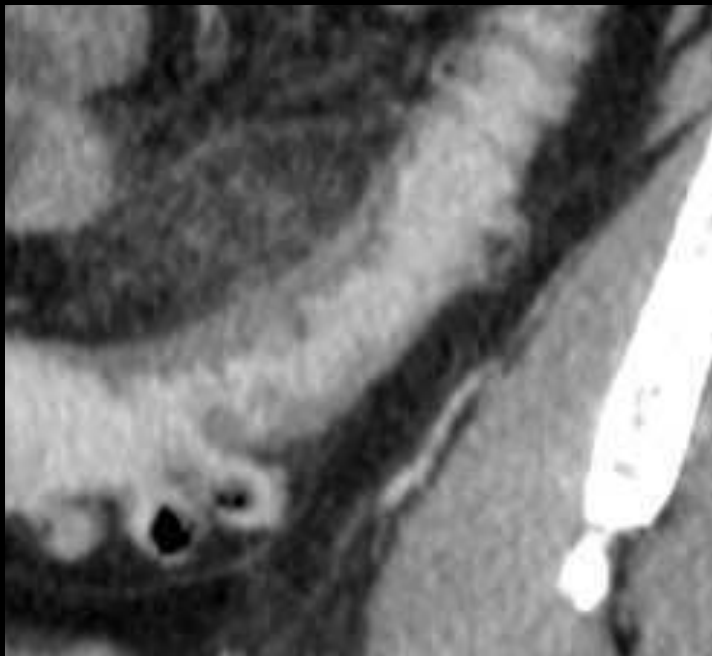
Pas de fièvre

13000GB, PCR 168

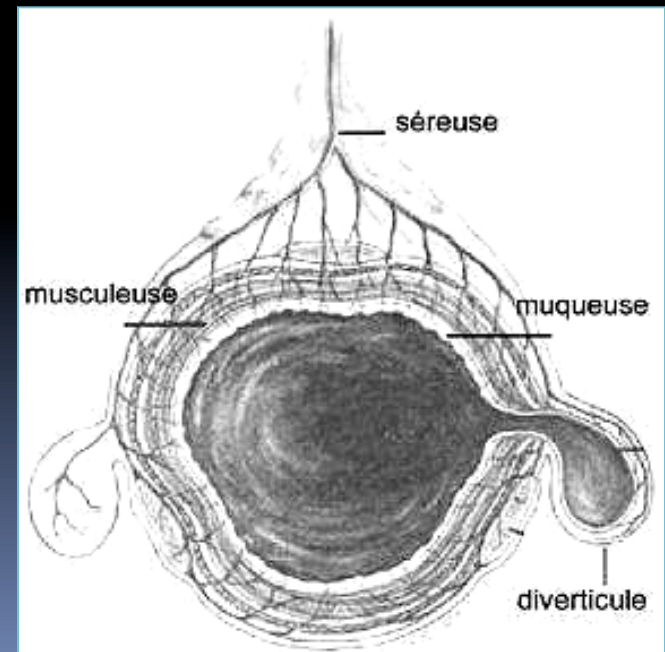
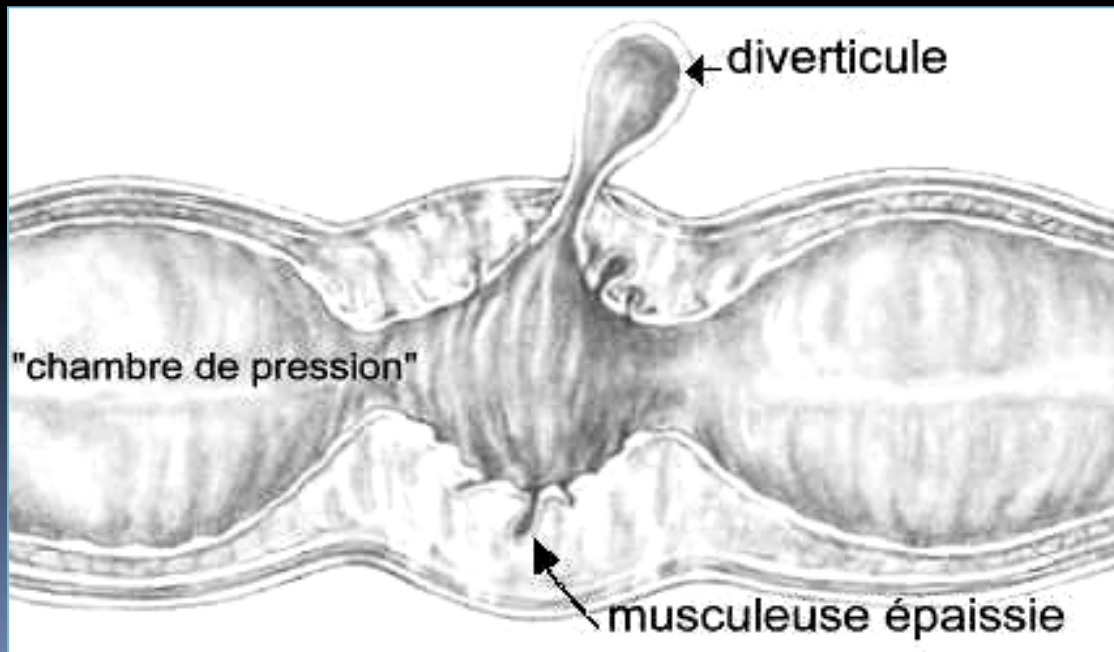




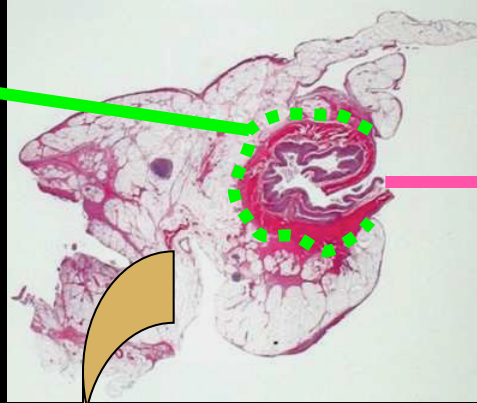




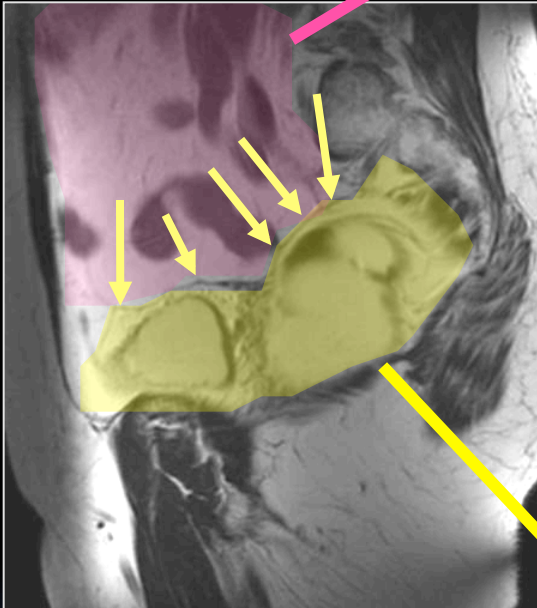
Diverticulite + « myochosis »



Couverture du
mésos : 270°



Perforation en péritoine
libre : pneumopéritoine (1/3)

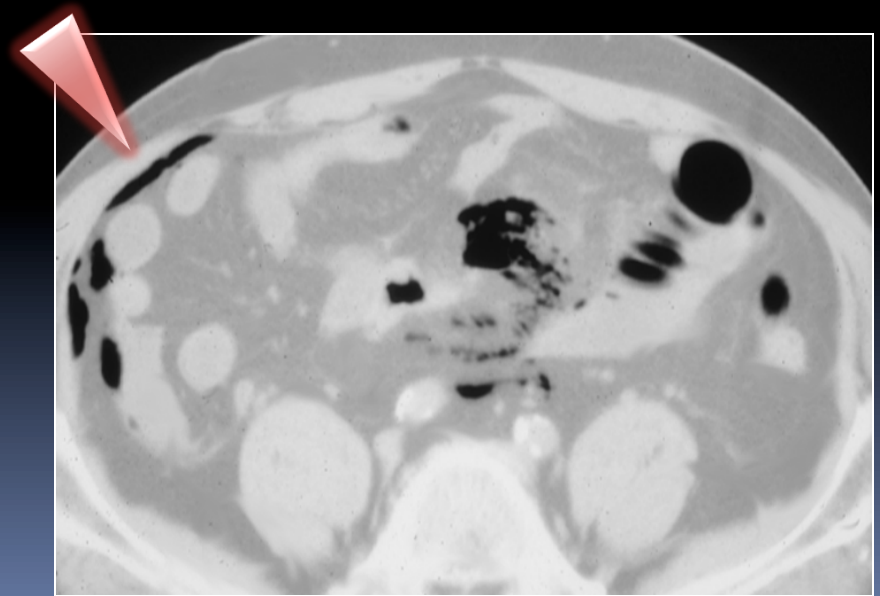
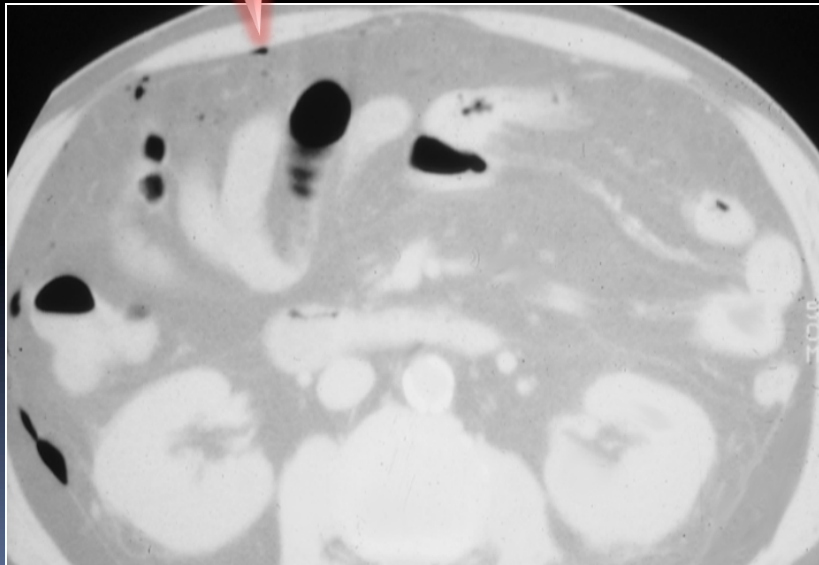
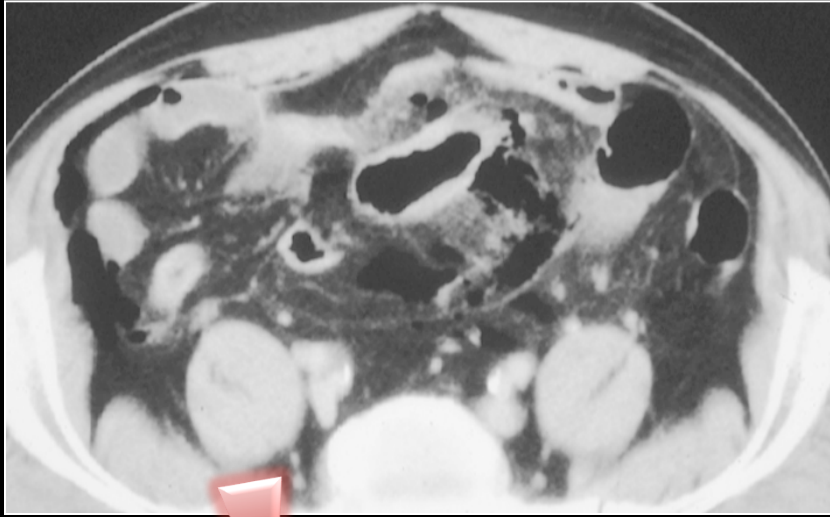


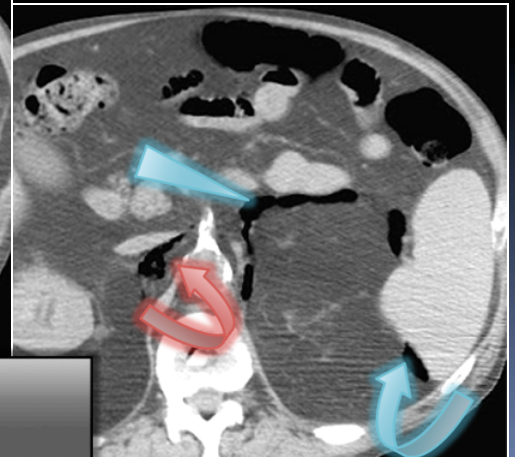
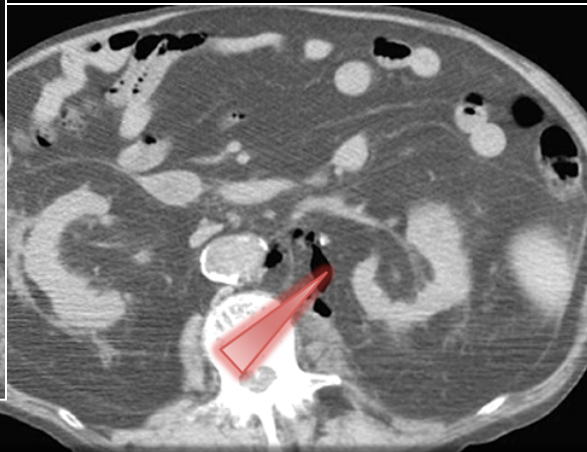
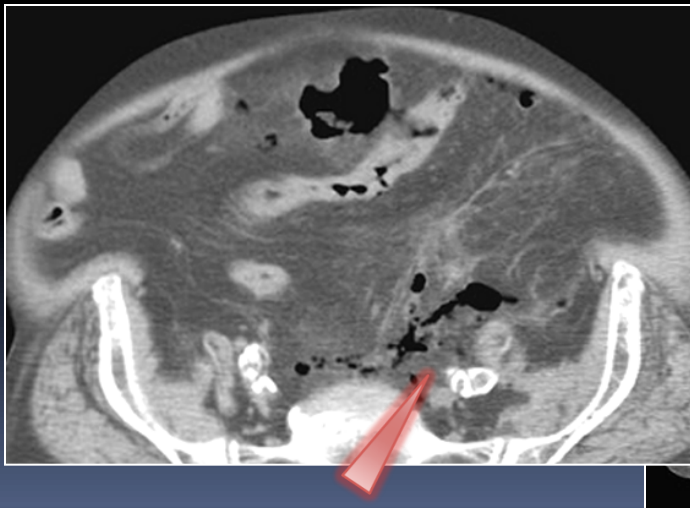
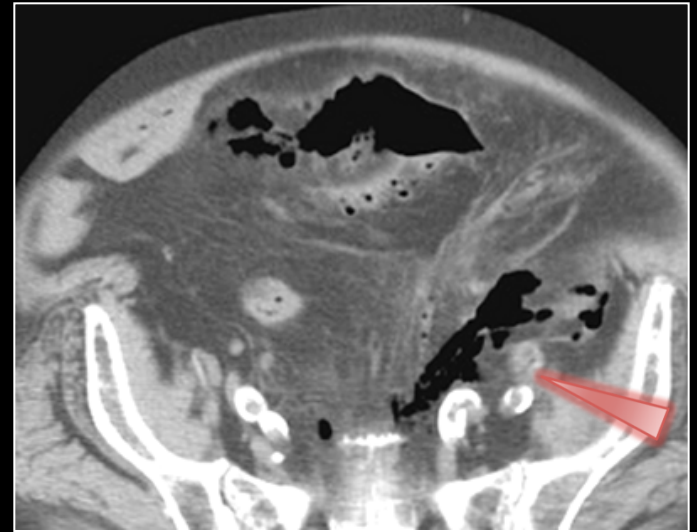
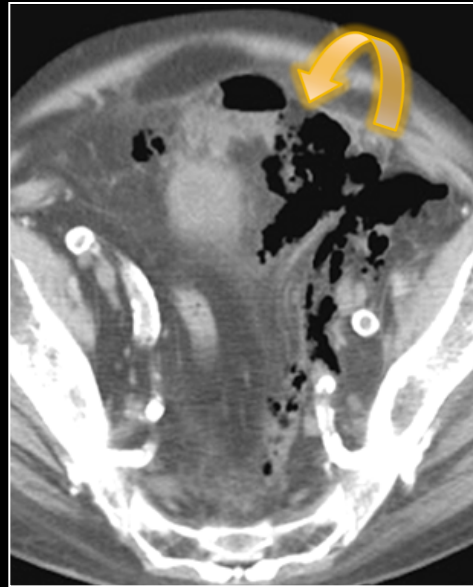
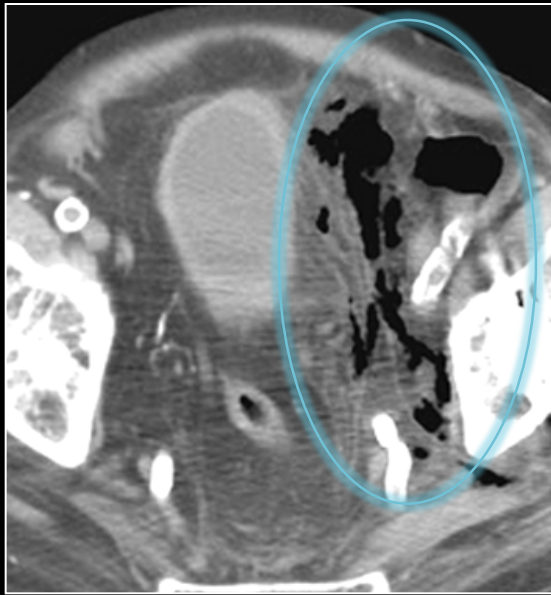
Perforation « couverte » par le
mésos : perforée bouchée (2/3)

Charnière rectosigmoïdienne
Perforation sous péritonéale : rétropneumopéritoine

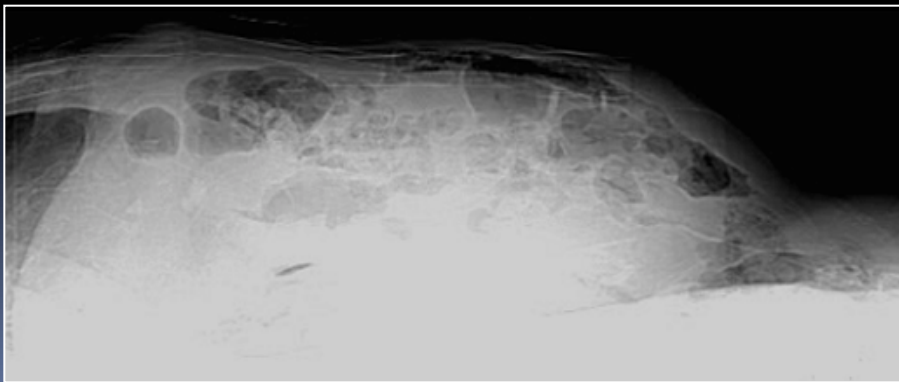
Les diverticules sigmoïdiens ont beaucoup plus de chances de se perforer dans la graisse du mésos qu'en péritoine libre !!!

Douleur abdominale aiguë brutale ayant débuté en FID



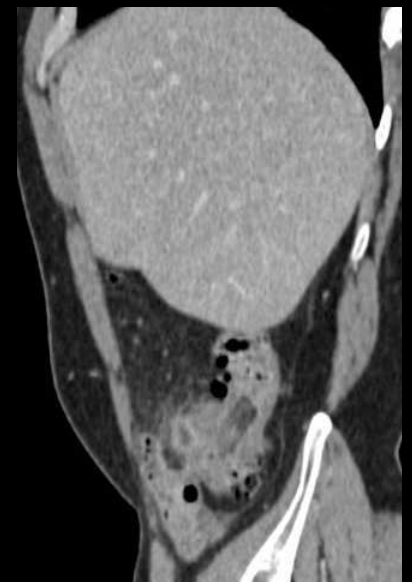
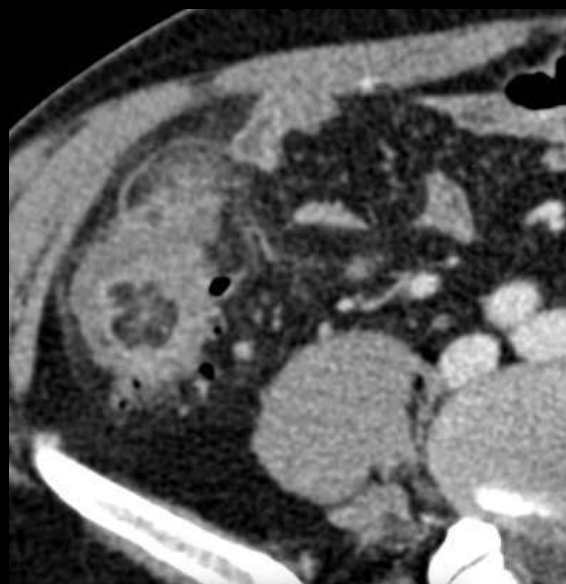


Rétro-pneumopéritoine
par perforation d'un diverticule sigmoïdien

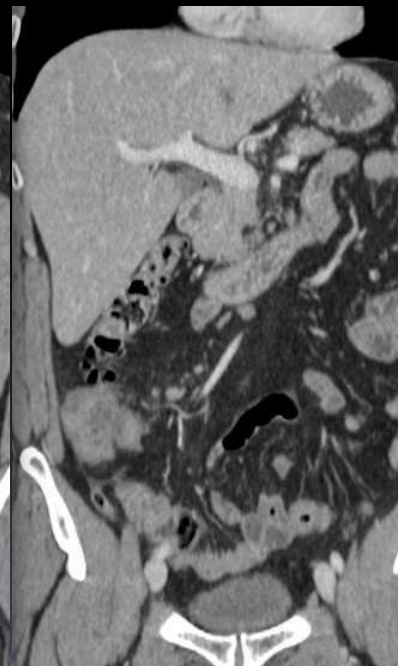
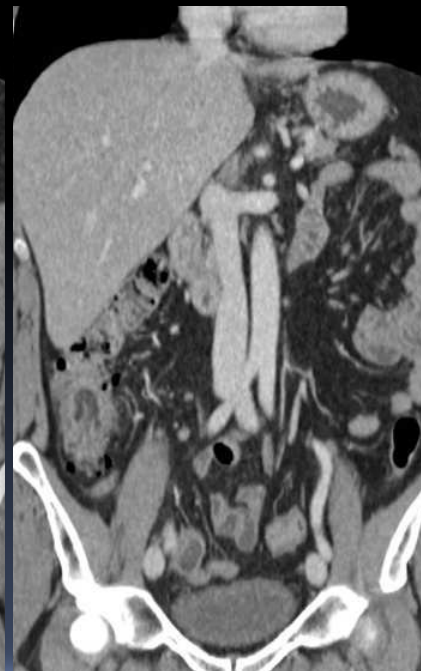
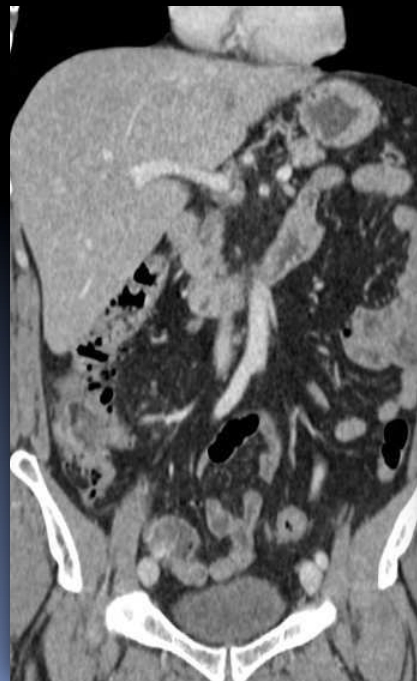
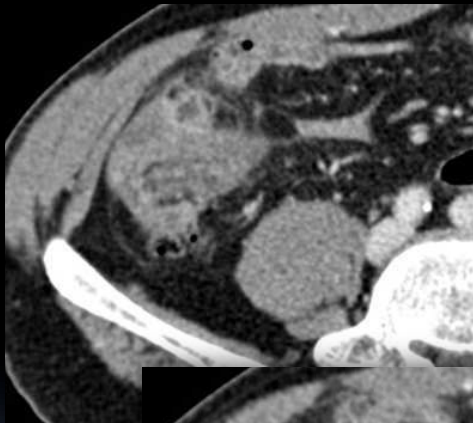


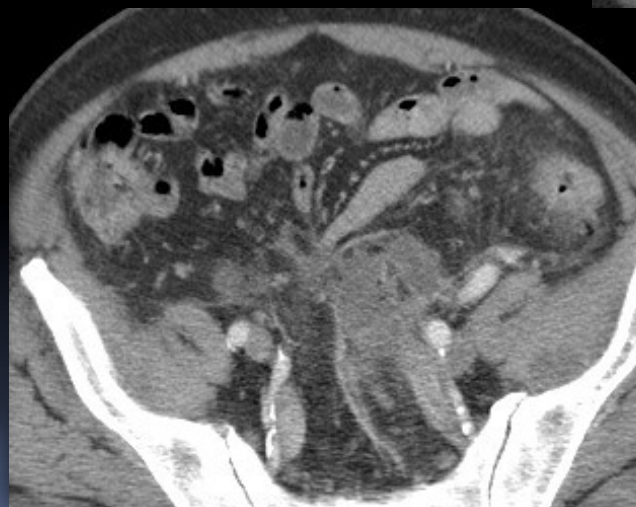
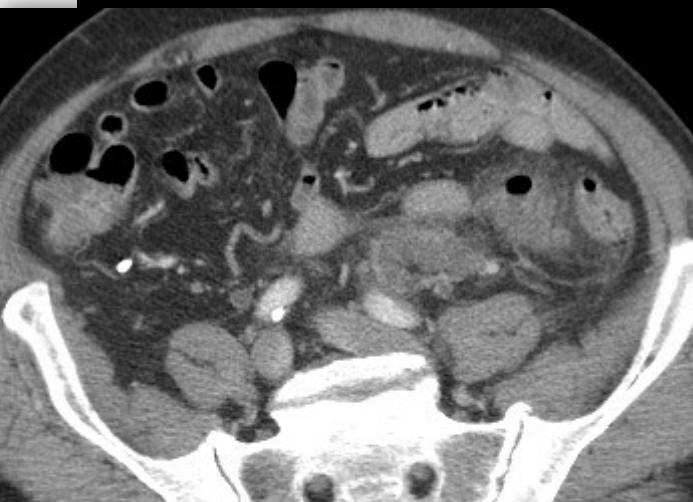
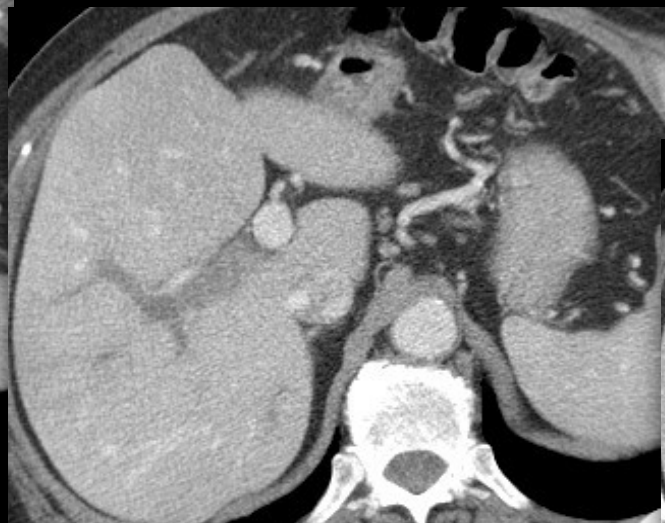
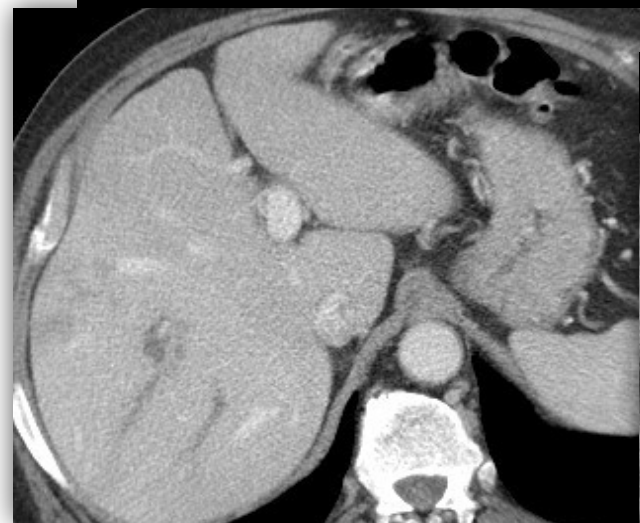
Homme 57ans; tableau septique avec douleurs du flanc dt



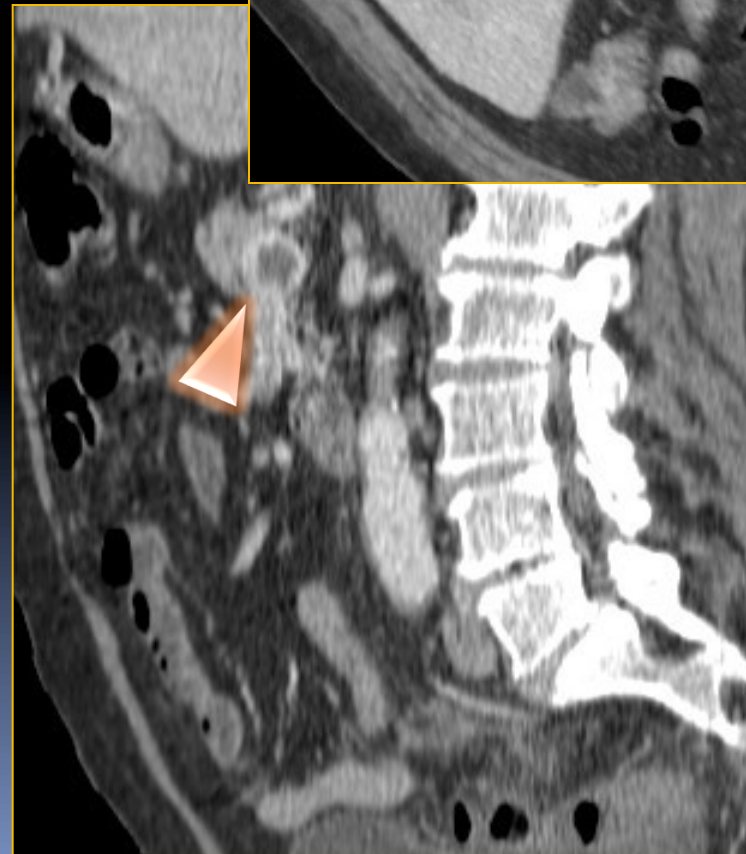
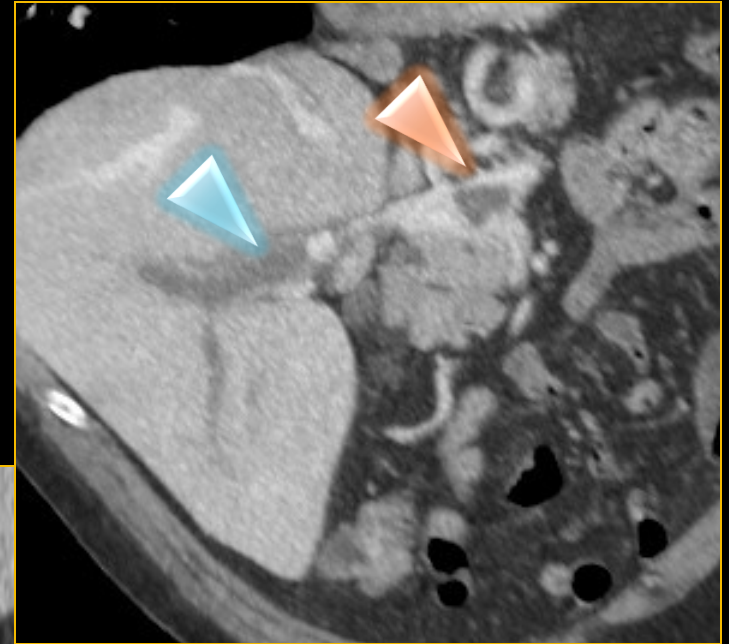
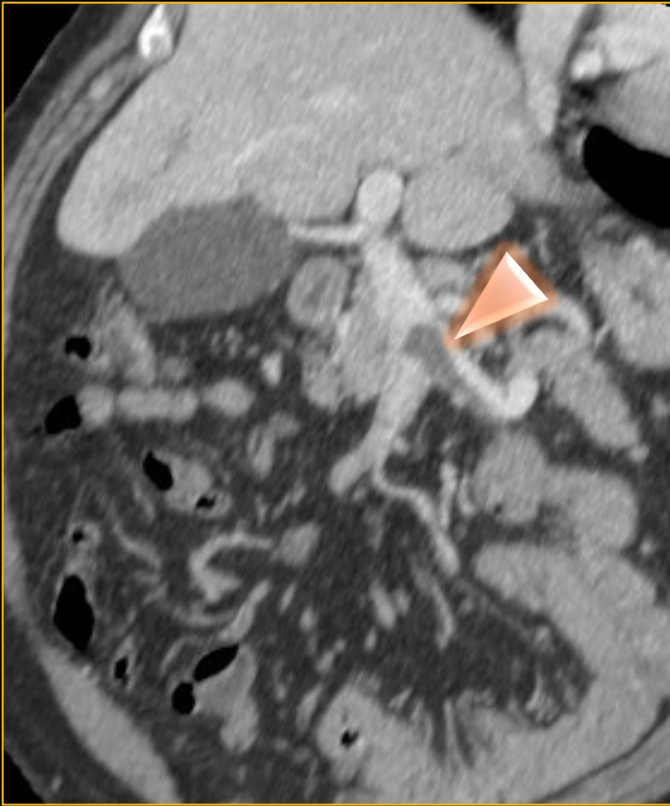


Diverticulite colique droite





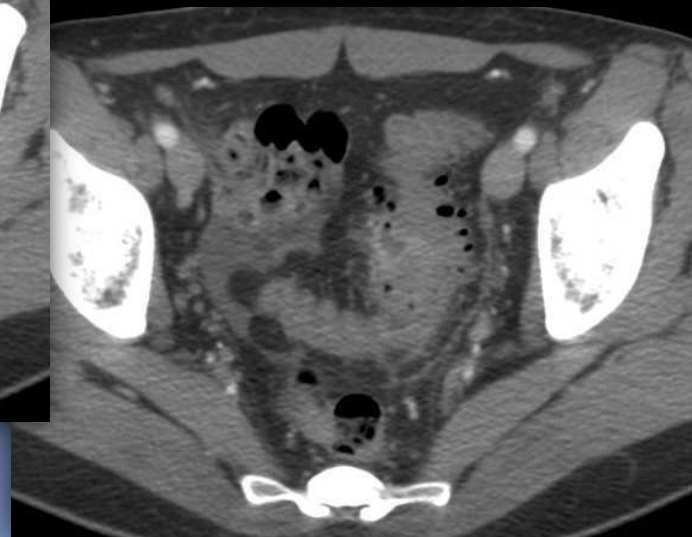
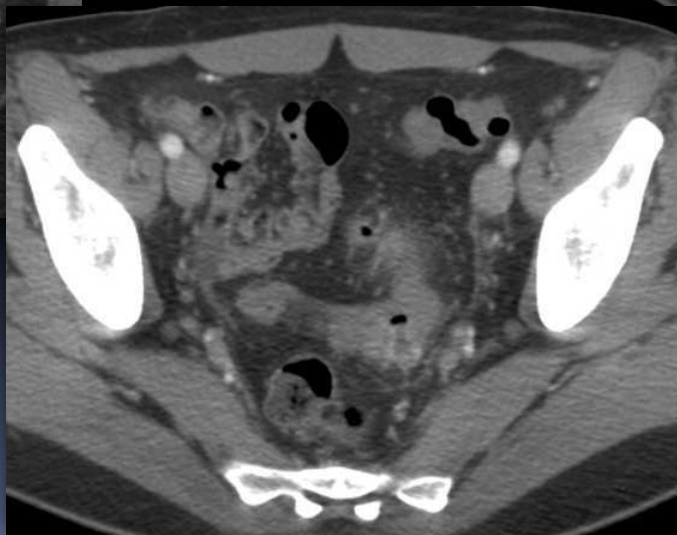
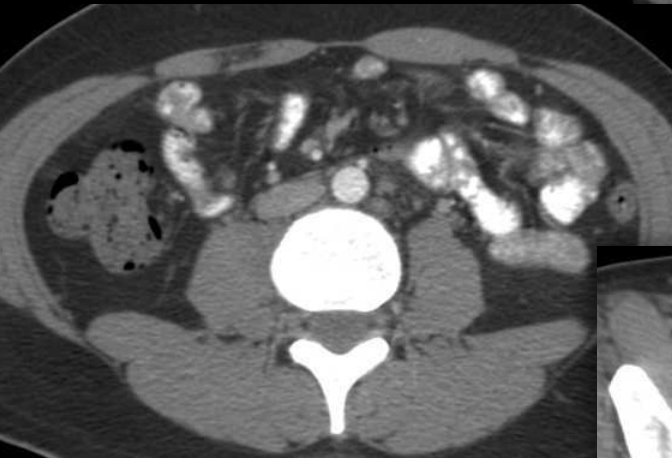
Pyléphlébite sur sigmoïdite



Complications

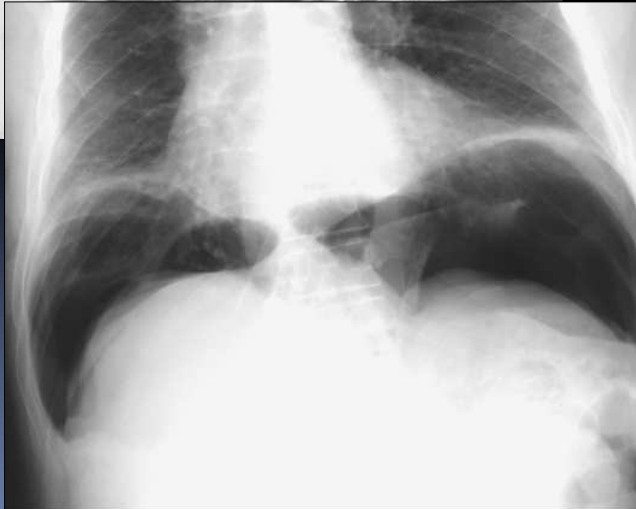
Ischémie mésentérique veineuse
 Abscesses hépatiques
 Thromboses veineuses
 HTP
 Cavernome portal
 Insuffisance pancréatique...

Patient de 45 ans
Douleurs fébriles de l'HCD



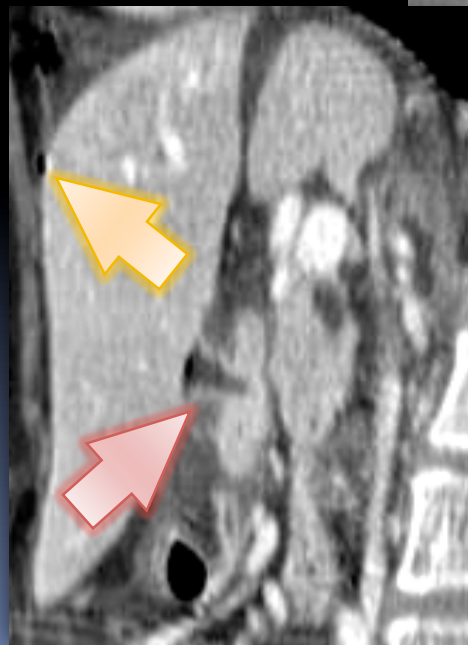
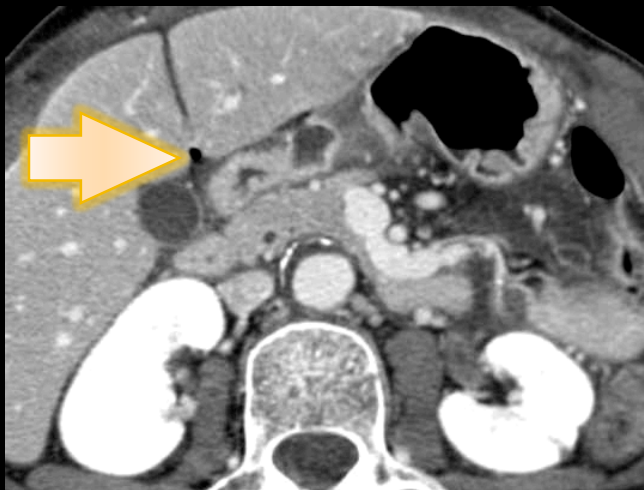
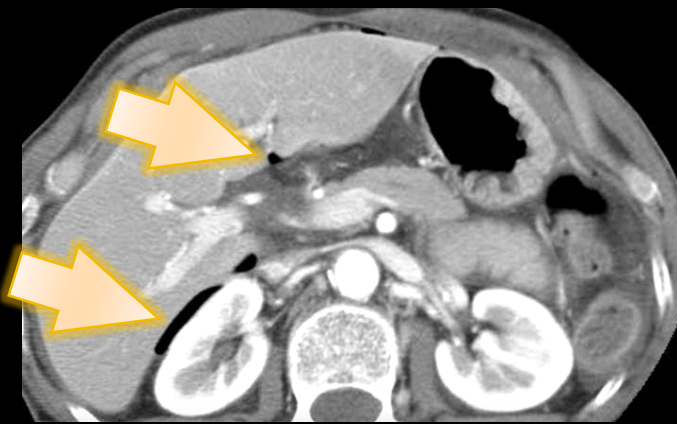


Abcès hépatique sur diverticulite
sigmoïdienne

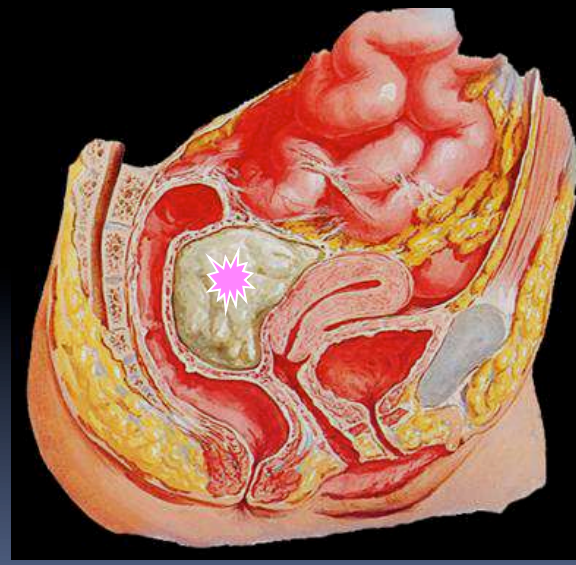
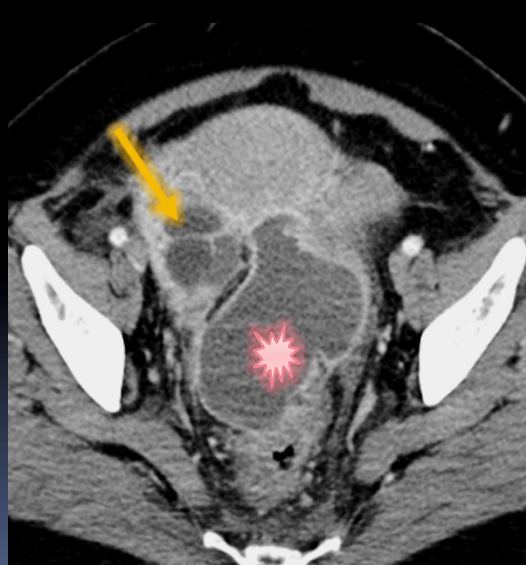
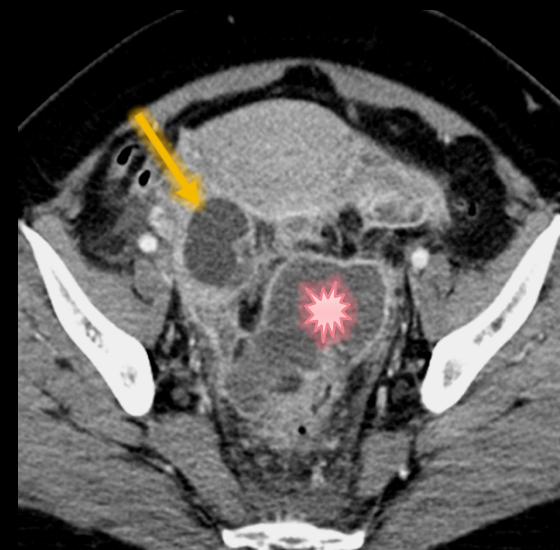
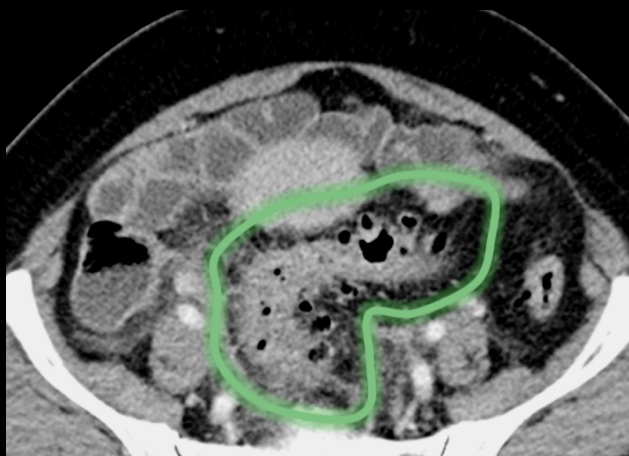


**Pneumopéritoine
Signe de Riegler
Perforation du sigmoïde**

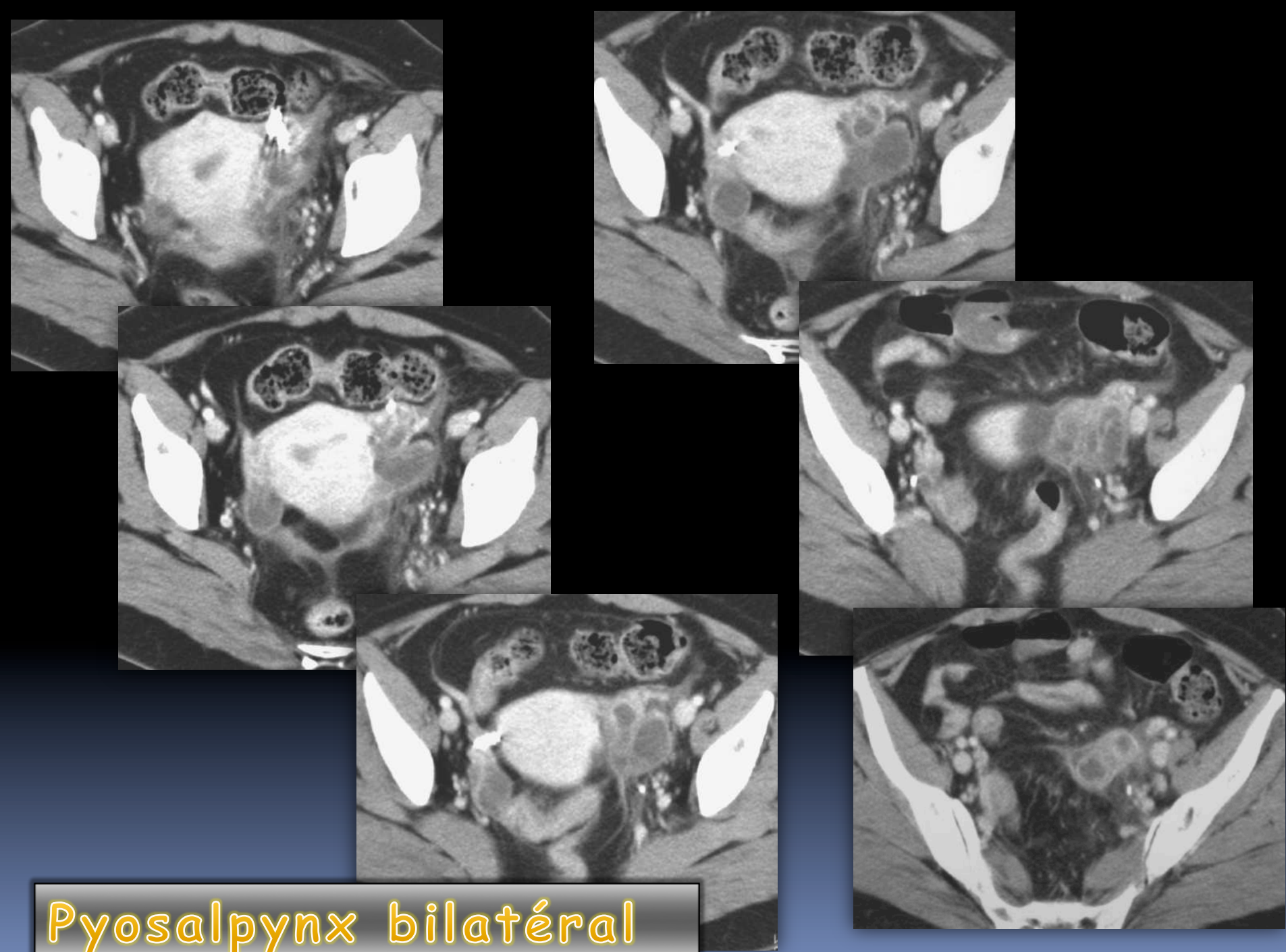




perforation
ulcéreuse en
péritoine libre
ulcère gastrique

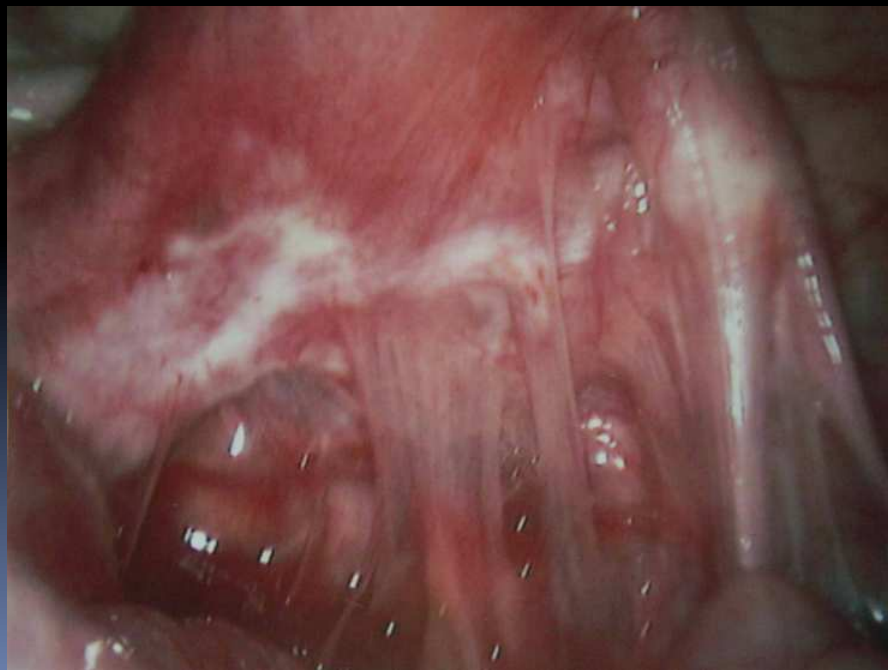
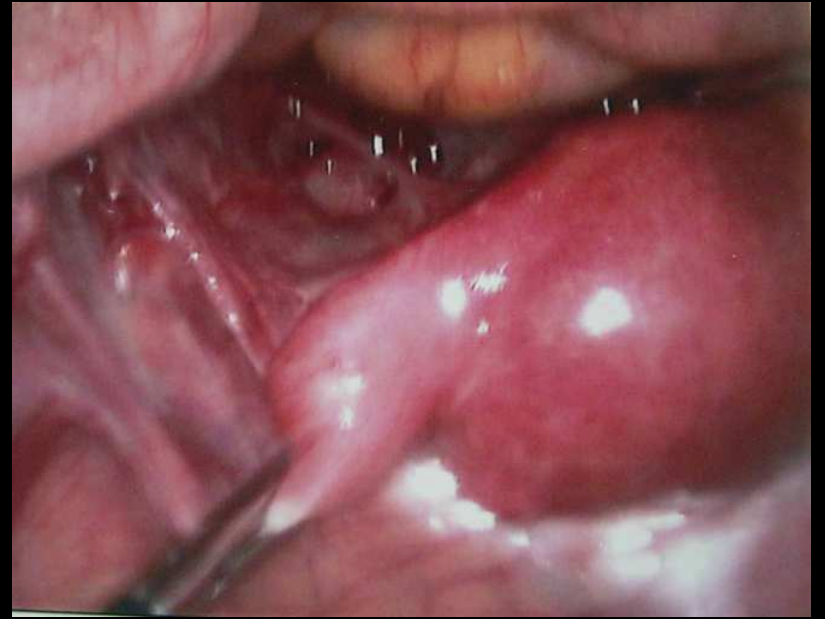


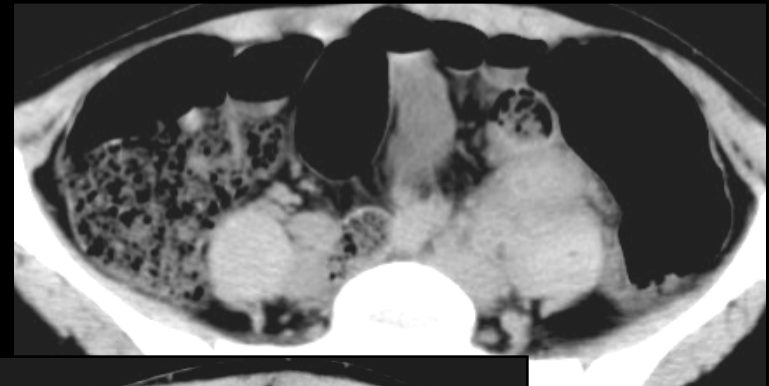
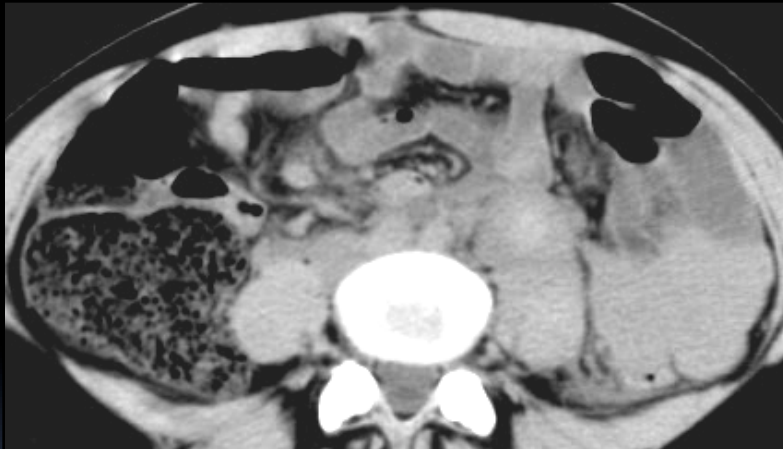
abcès du cul de sac de Douglas sur pyosalpinx droit



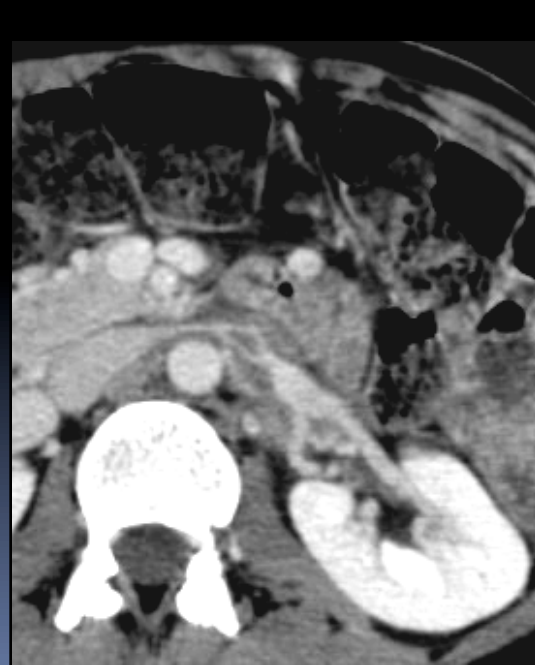
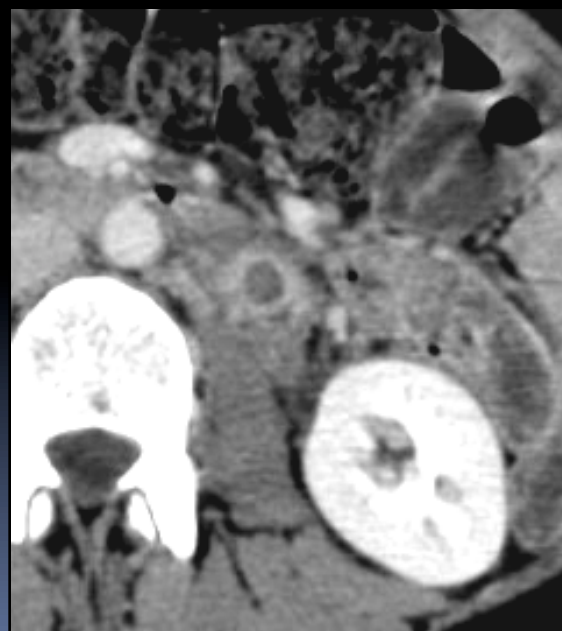
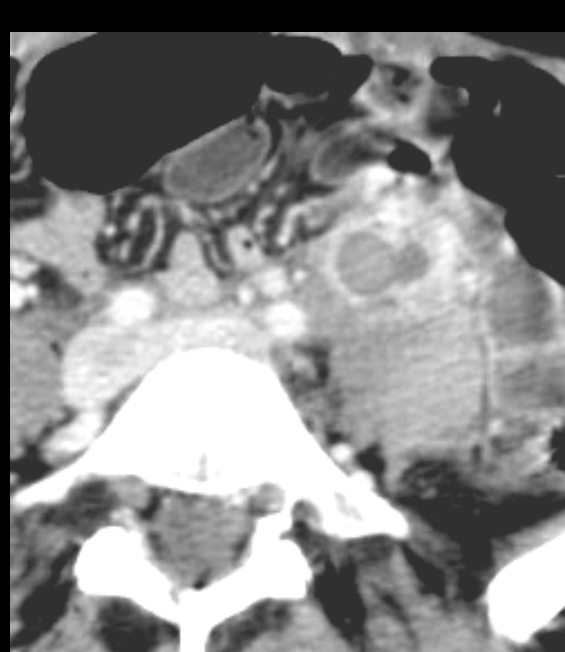
Pyosalpynx bilatéral







**Douleurs abdominales
latéralisées à gauche
en post-partum
Fébricule à 38°C**





Thrombose de la veine
ovarienne G

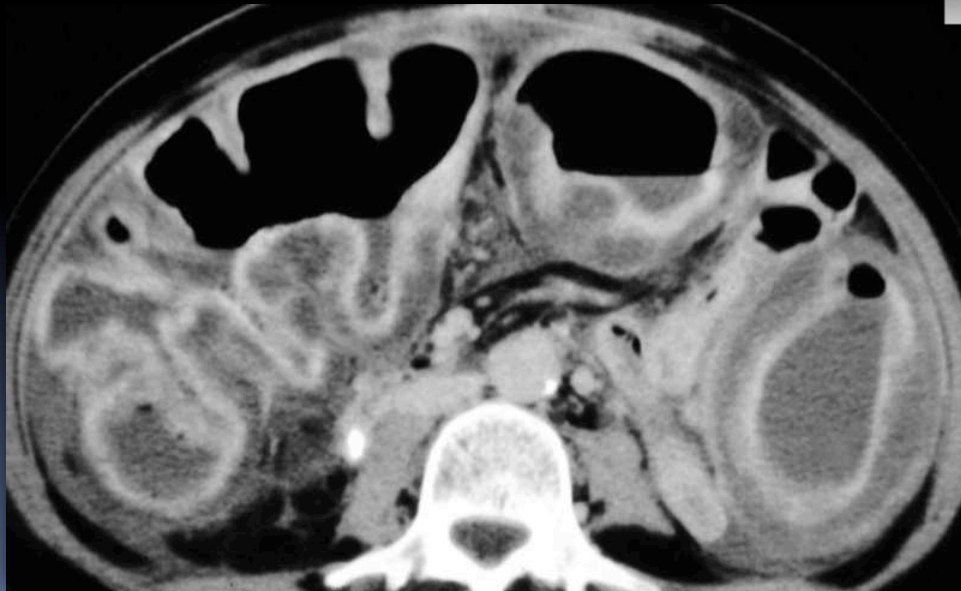
HOMME DE 32 ANS

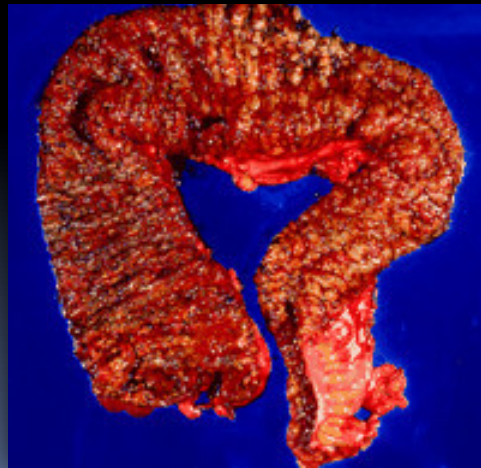
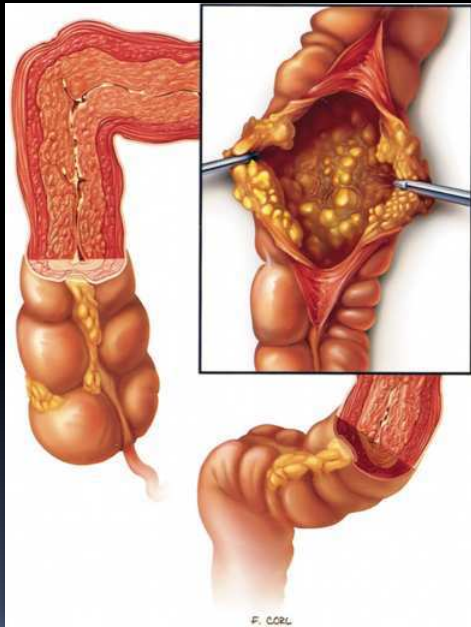
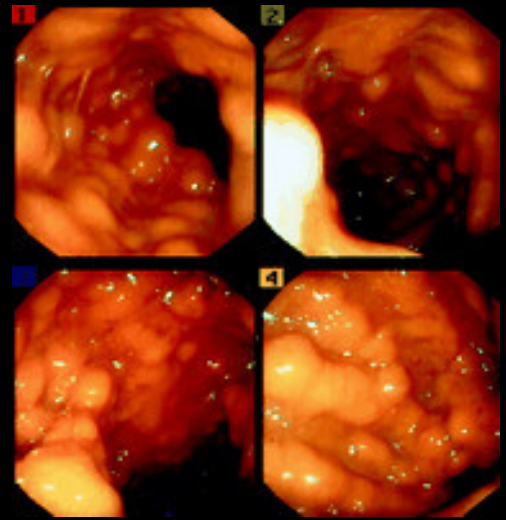
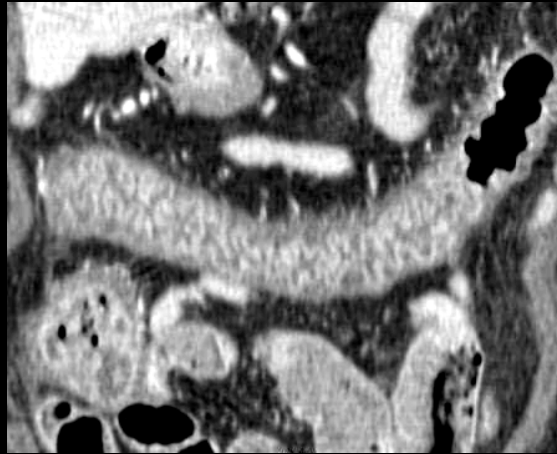
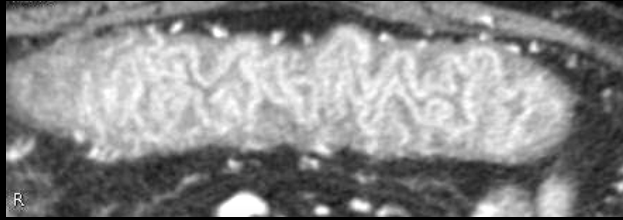
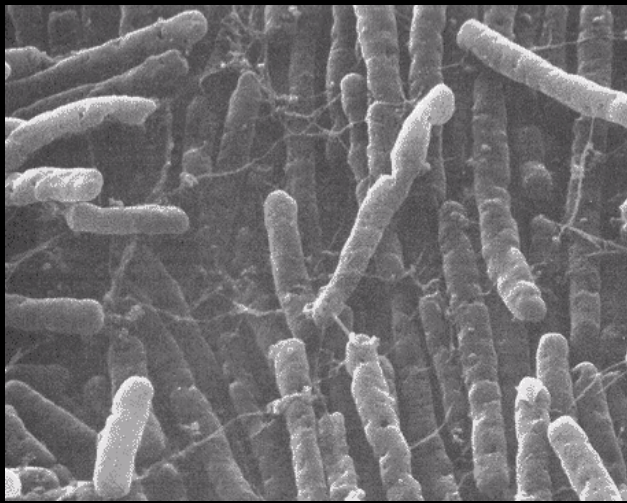






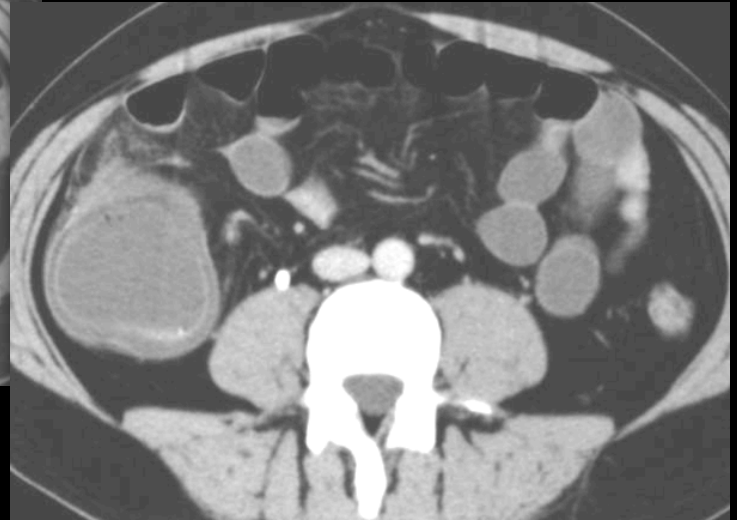
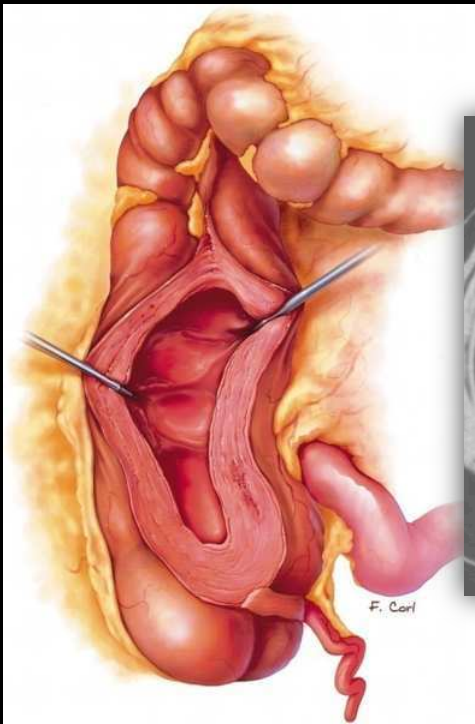
Colite
pseudomembraneuse



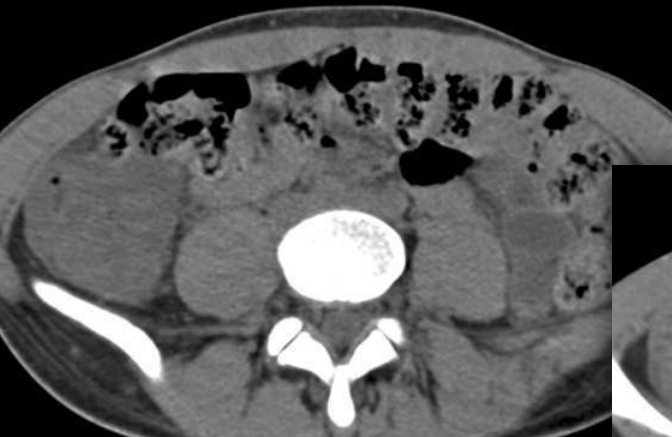
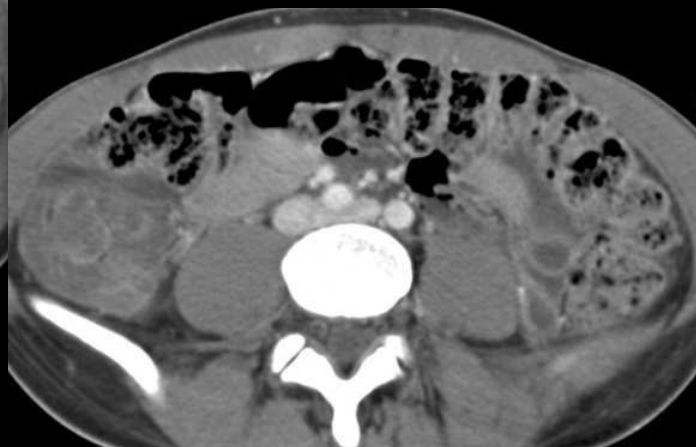
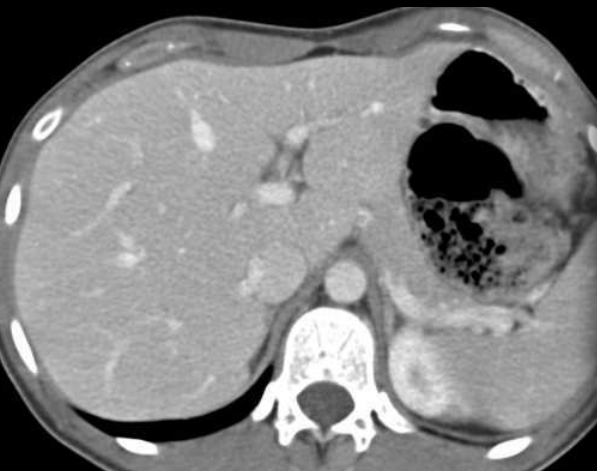


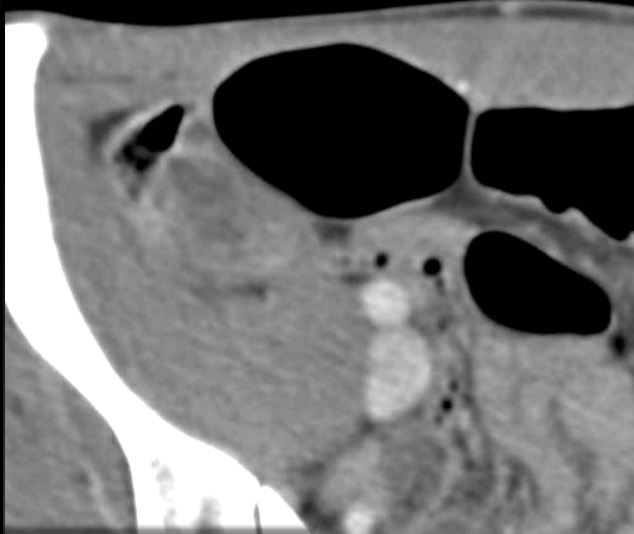
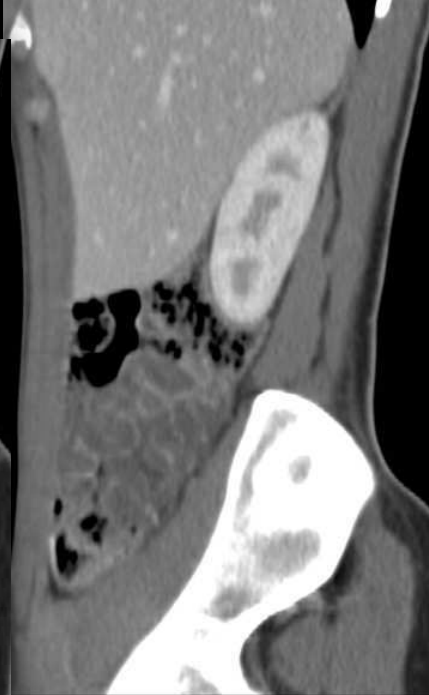
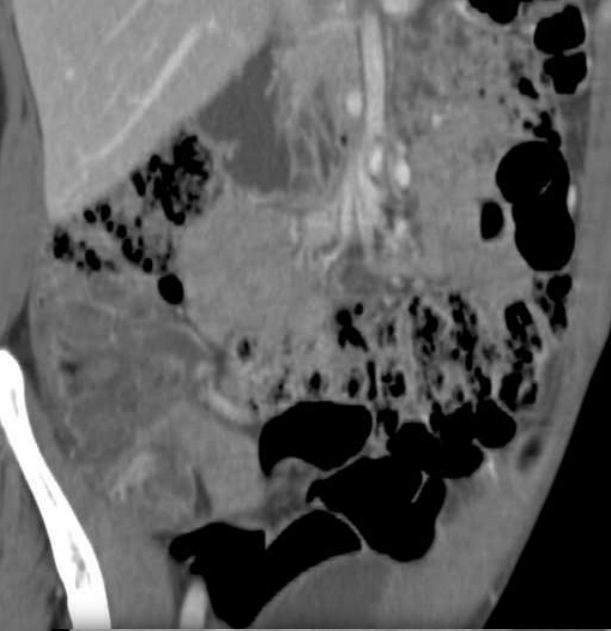
Colite pseudomembraneuse

Typhlite neutropénique



Douleur brutale en FID
Patiente sportive

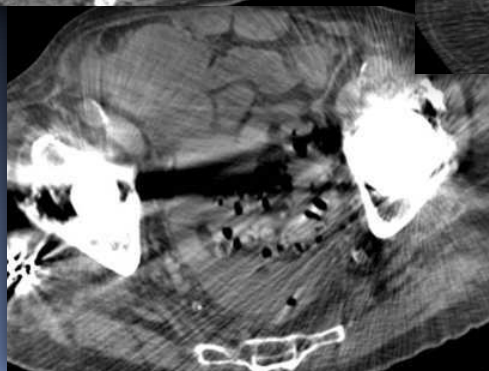
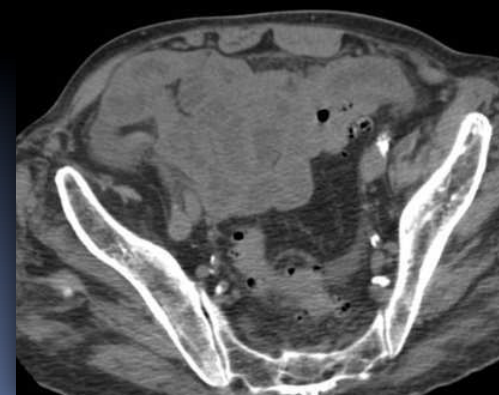
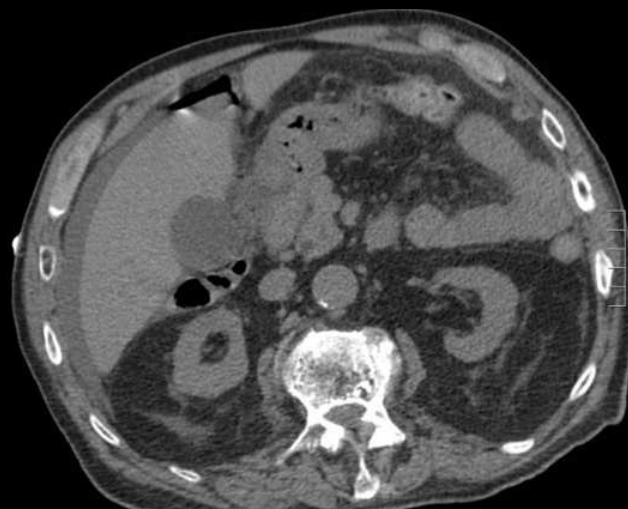
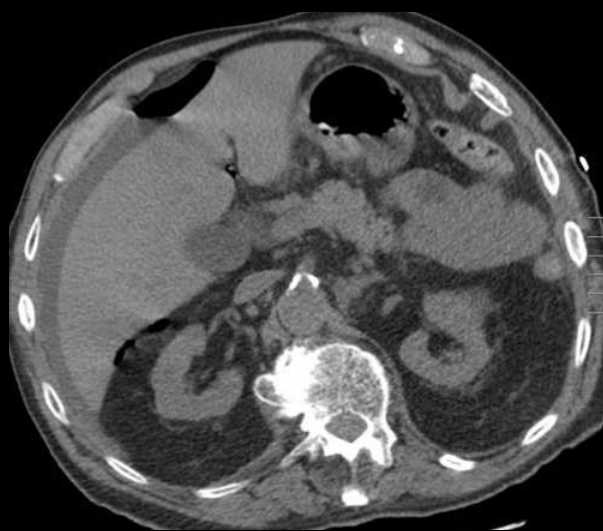


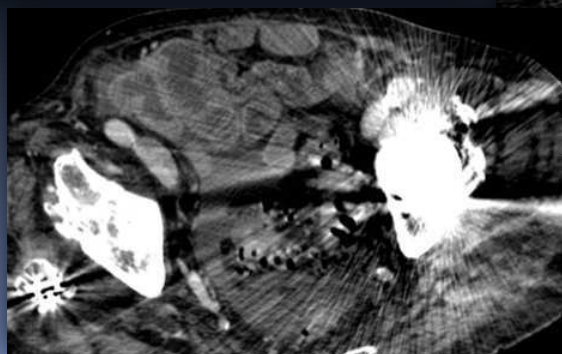
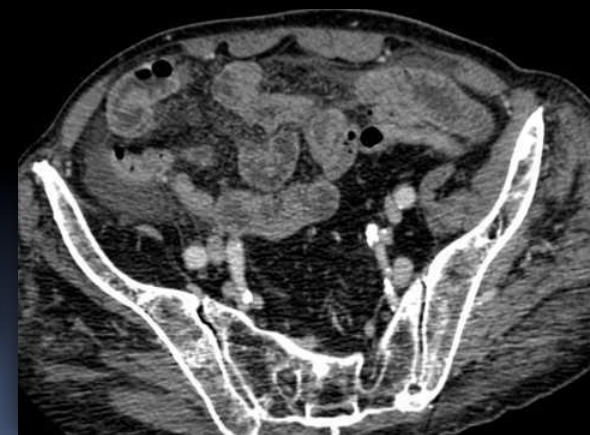
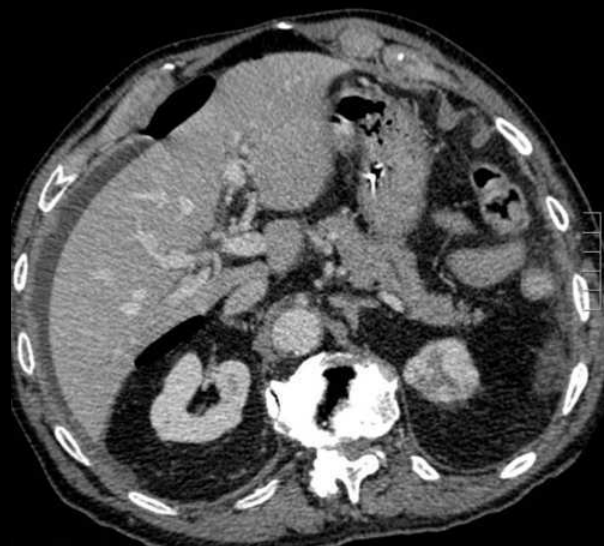


Colite du marathonien

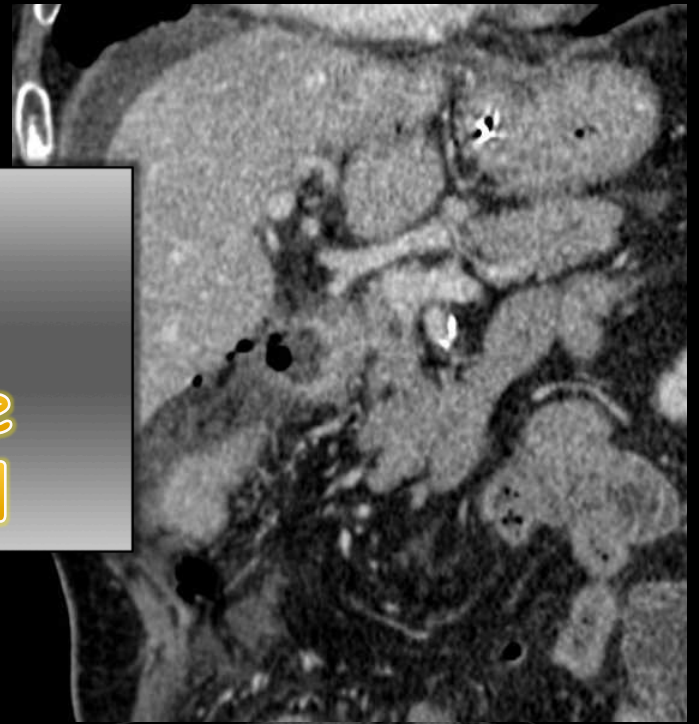
**Douleurs abdo, 83 ans
Ischémie mésentérique ?**



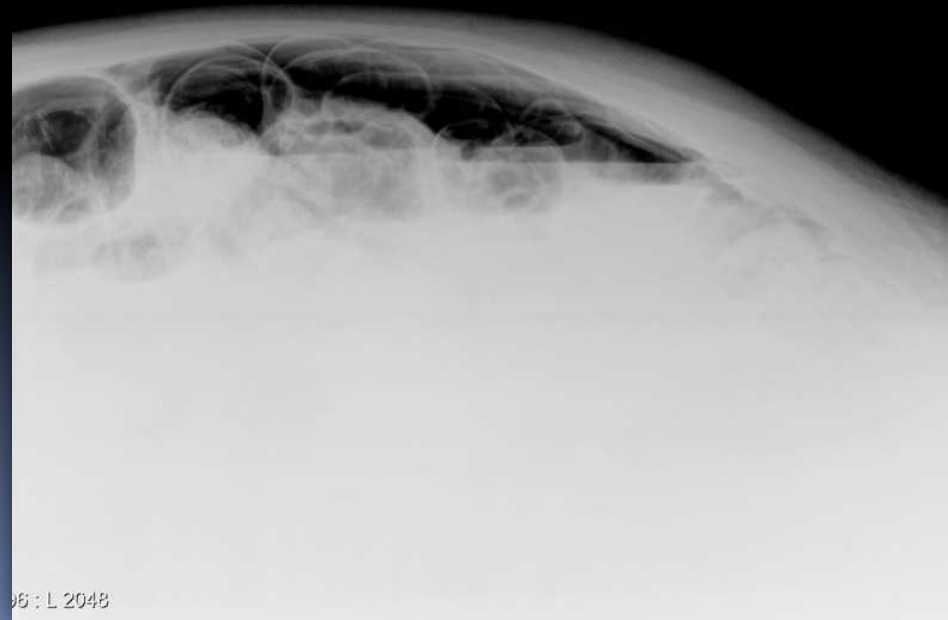


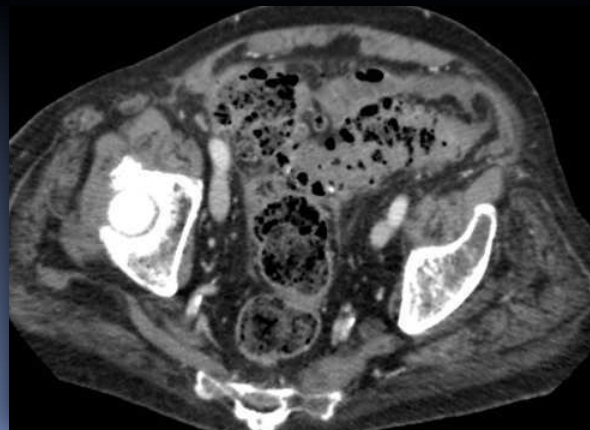
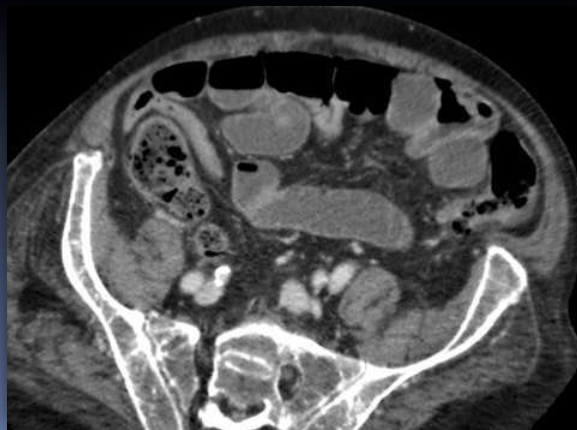
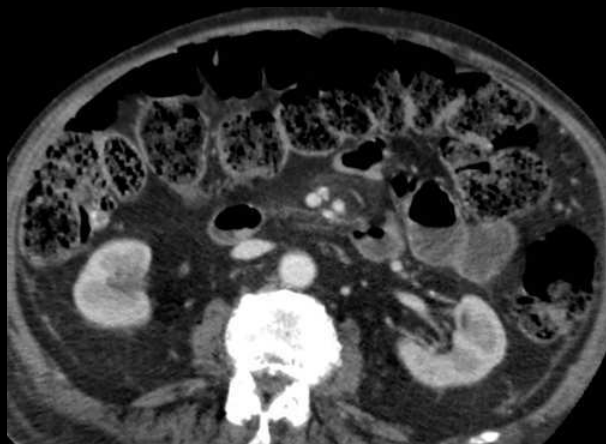
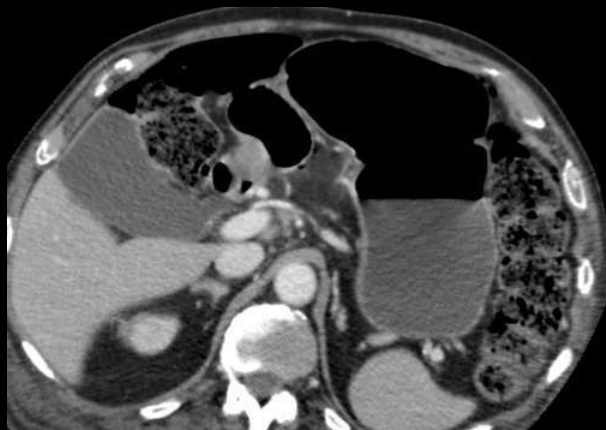
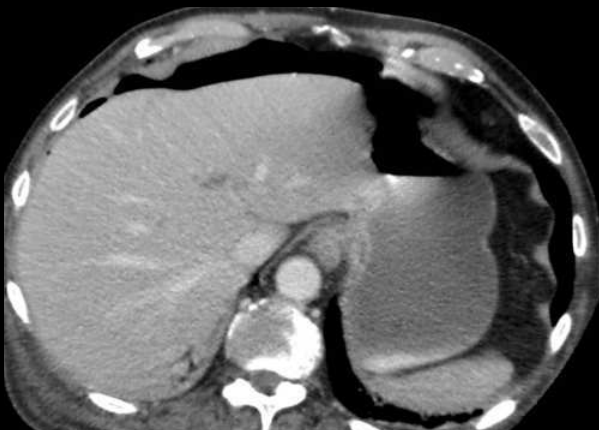


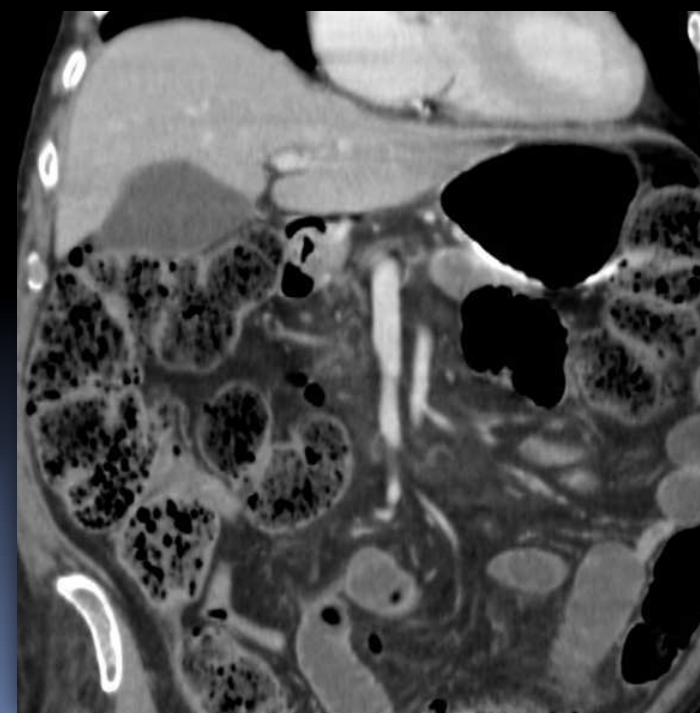
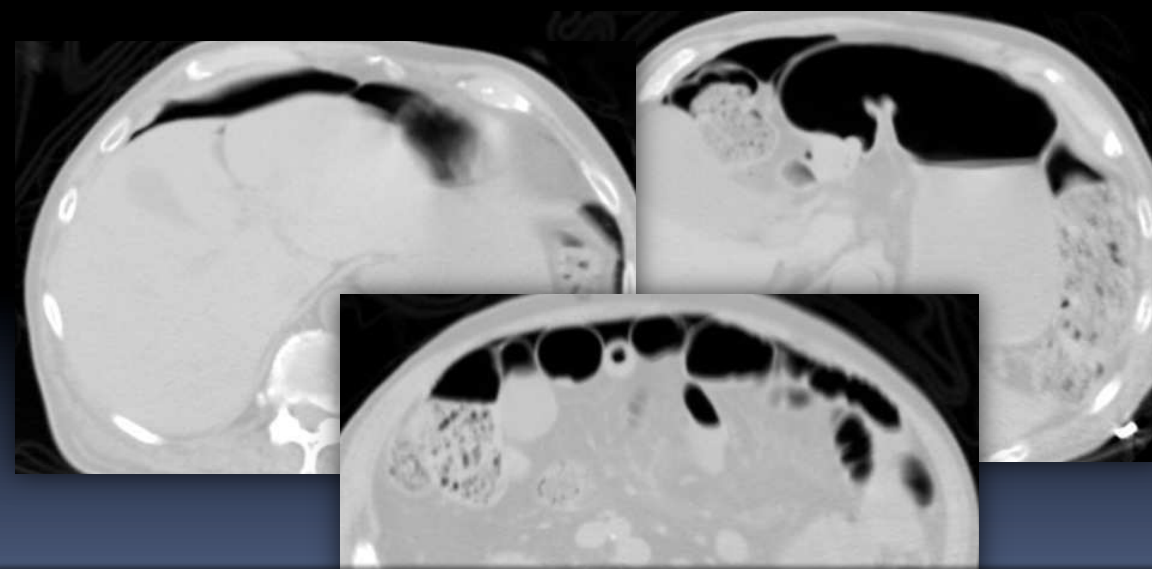
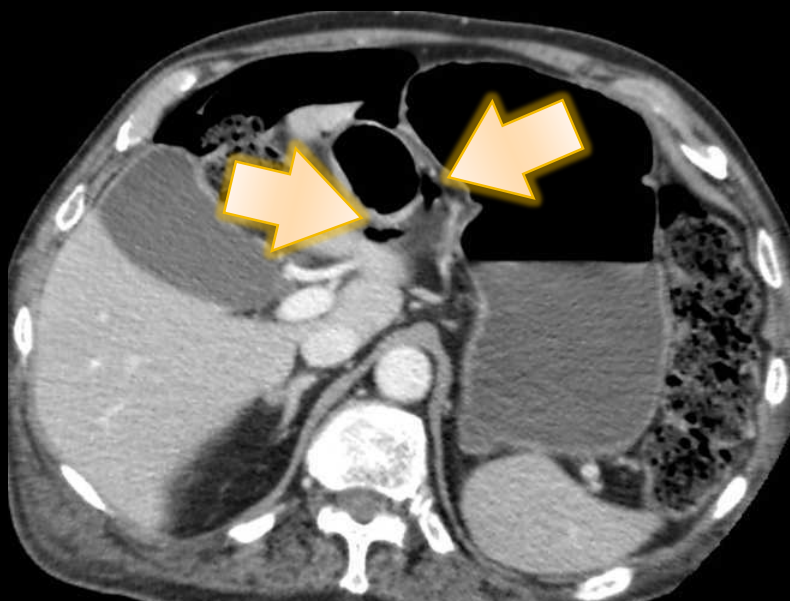
Ulcère
perforé
Du bulbe
duodénal



Homme de 85 ans
Syndrome sub occlusif
Douleurs abdominales
Insuffisance rénale







Ulcère du bulbe perforé,
signe de Riegler