

EXPLORATION IRM DU  
PANCREAS

L.CANNARD

## Indications actuelles

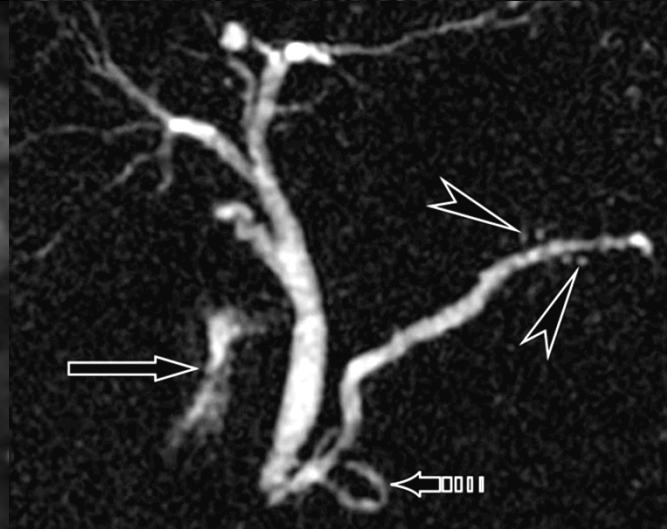
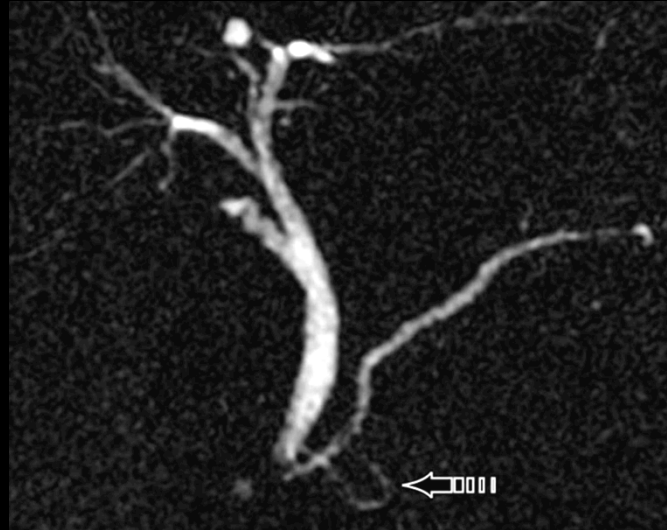
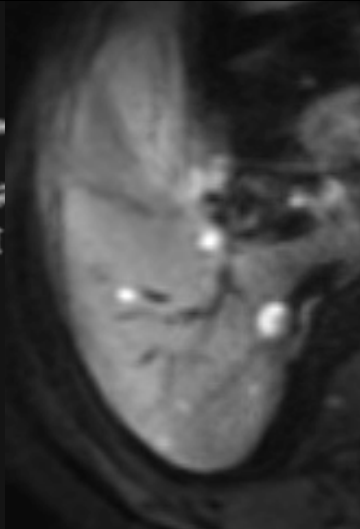
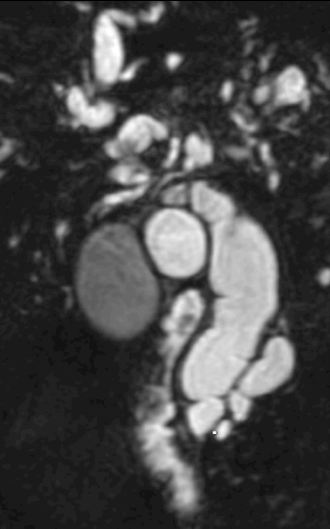
- Caractérisation d'une masse kystique / solide
- Bilan étiologique des pancréatites aiguës
- Pancréatite chronique

⇒ Si adénocarcinome  
pancréatique typique\*

????

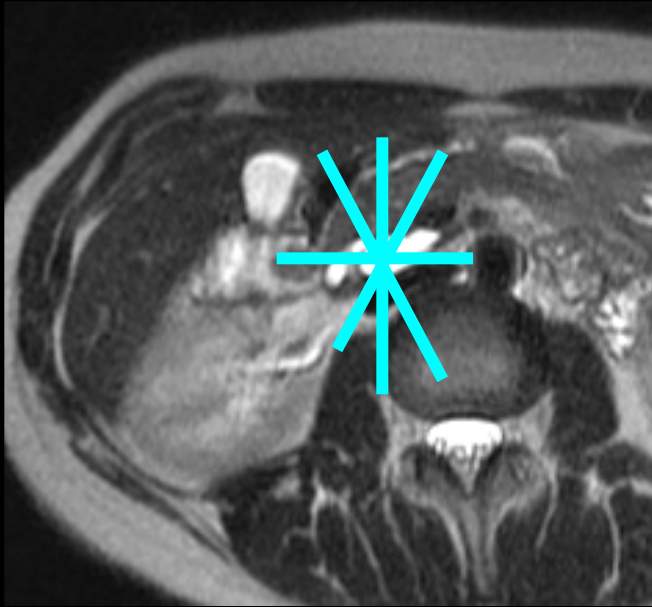
# Protocole d'exploration

- 3D FR FSE T2
- 2D FIESTA
- séquence de diffusion +++
- S-MRCP

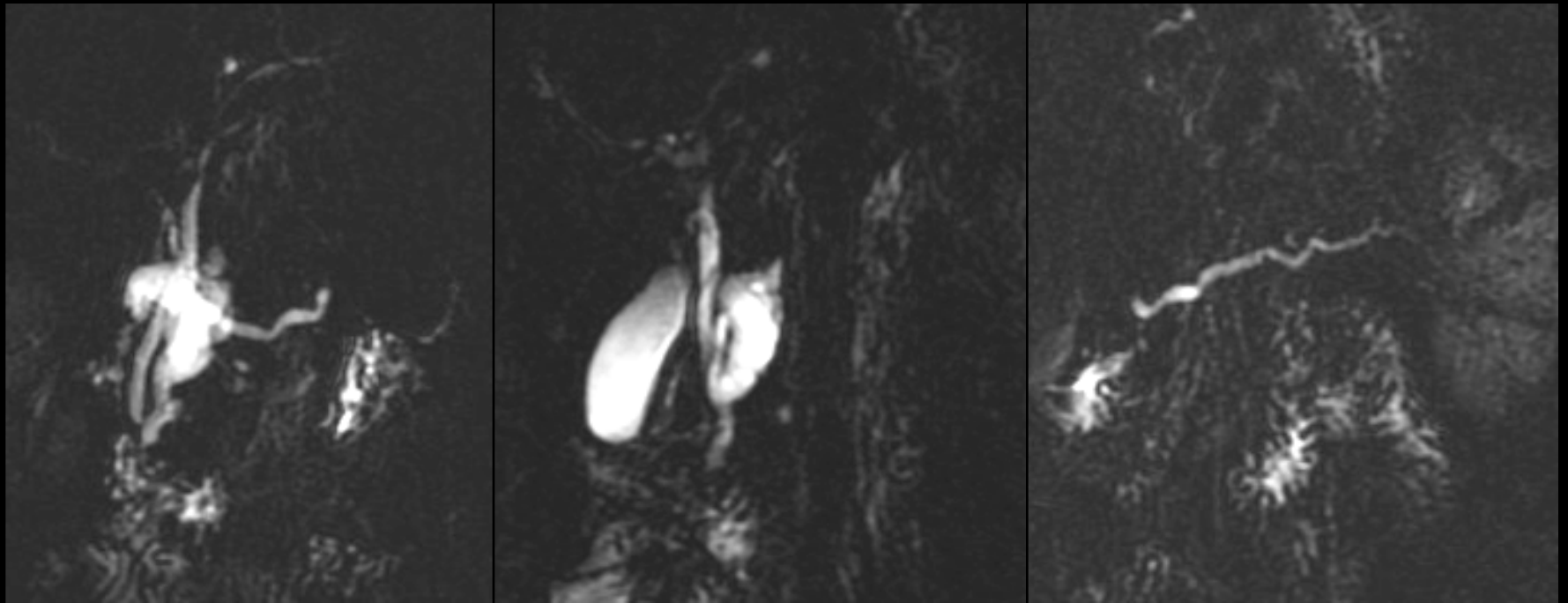


# Sémiologie

SS FSE TE court +  
trigger



# SS FSE TE long

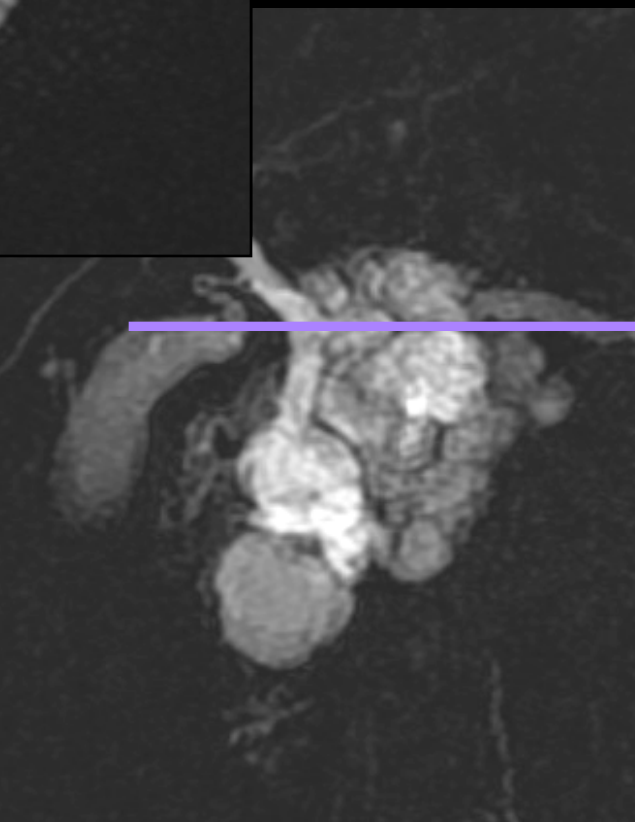
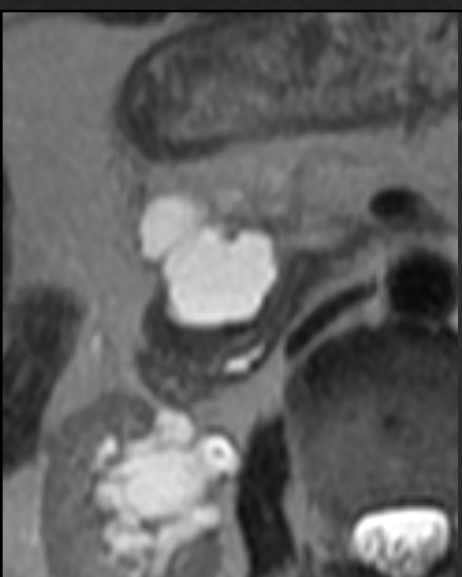
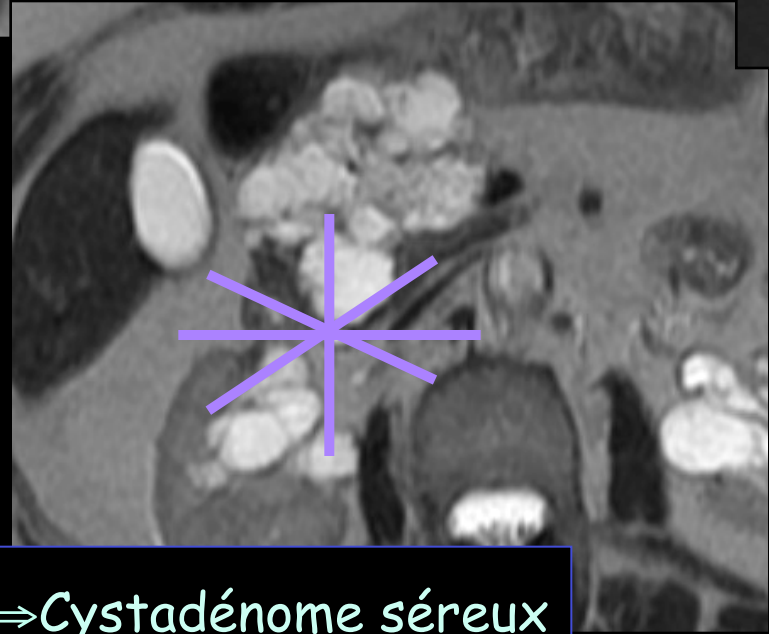
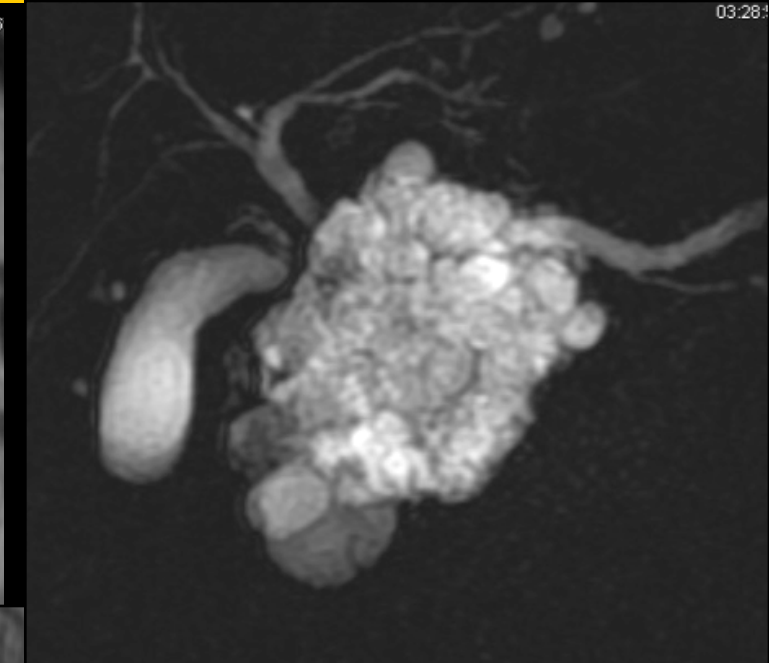
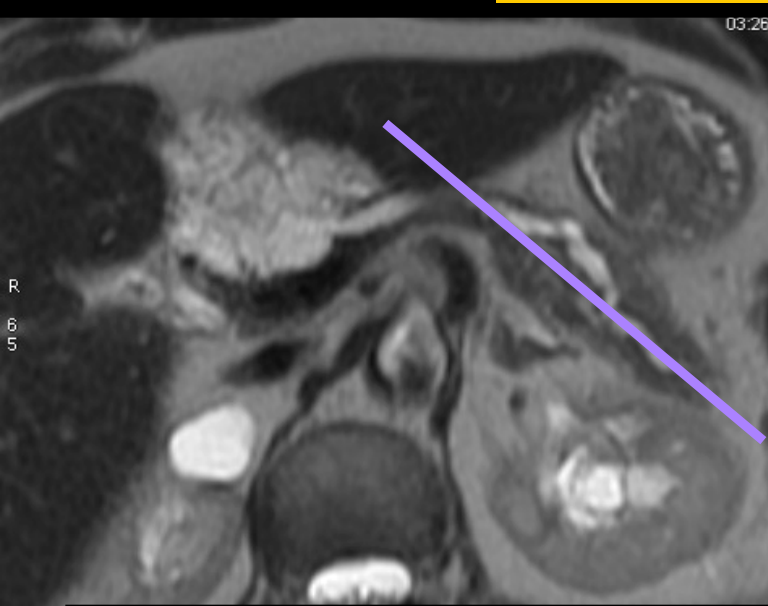


# 3F FrFSE T2

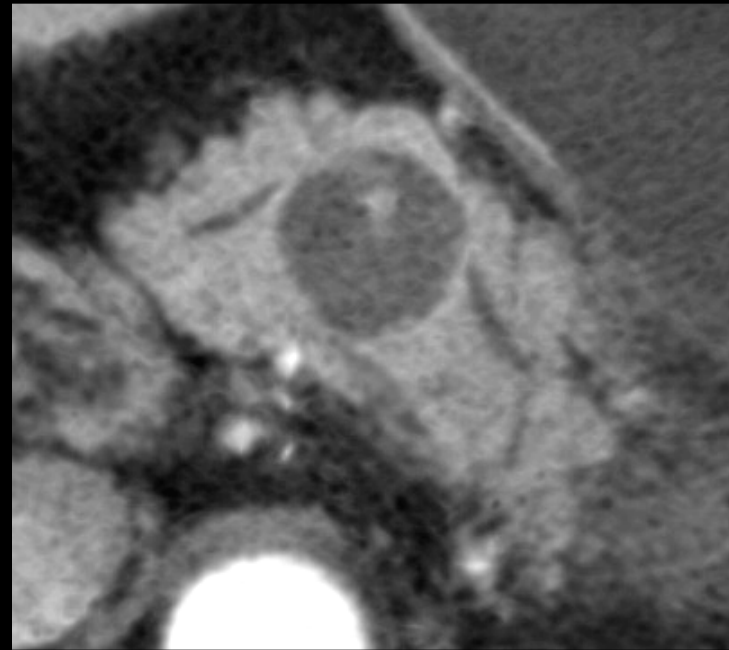
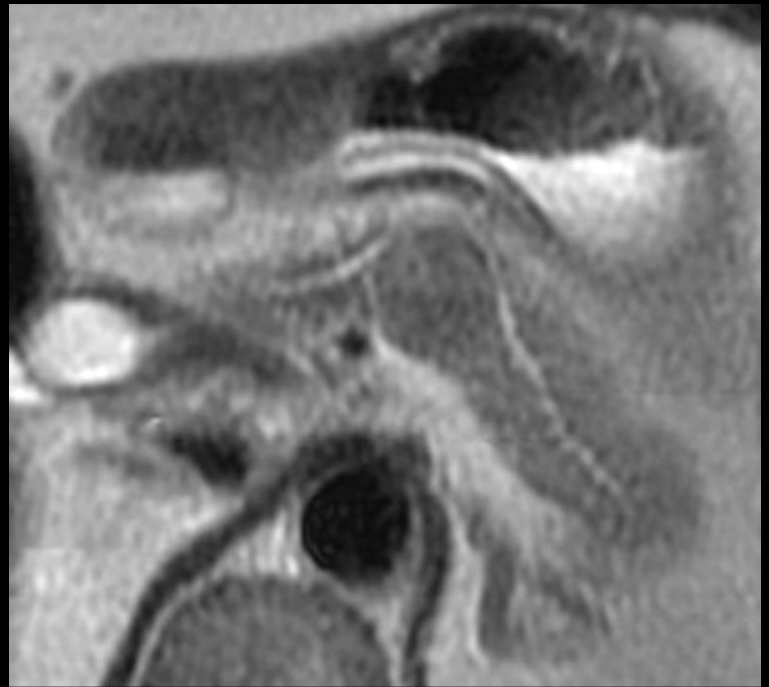


TIPMP canaux secondaire

# PONDÉRATION T2

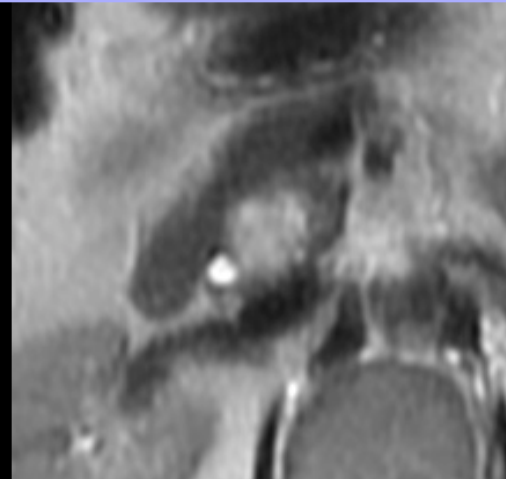
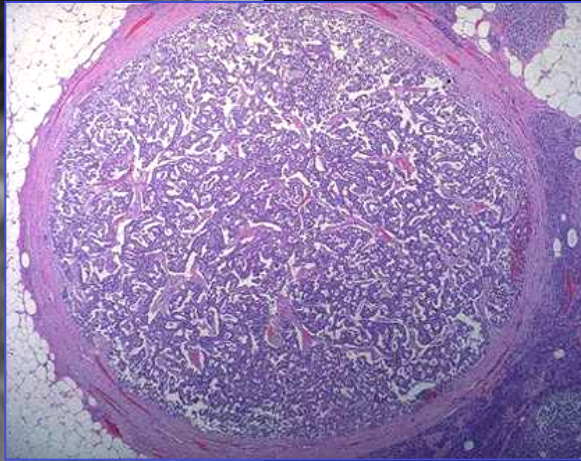
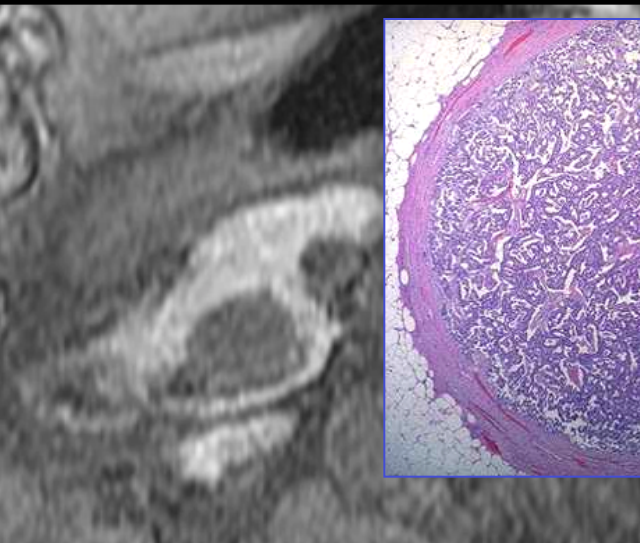
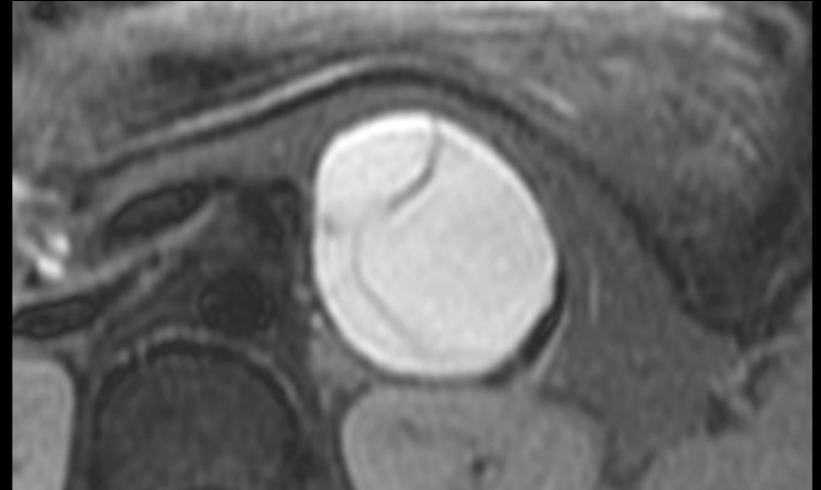
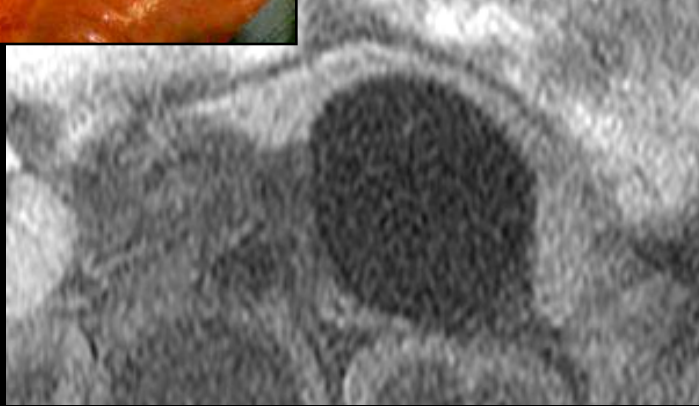
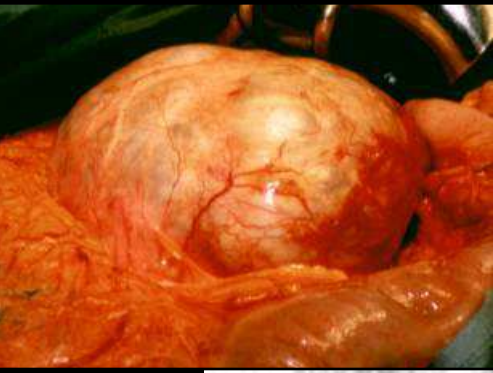


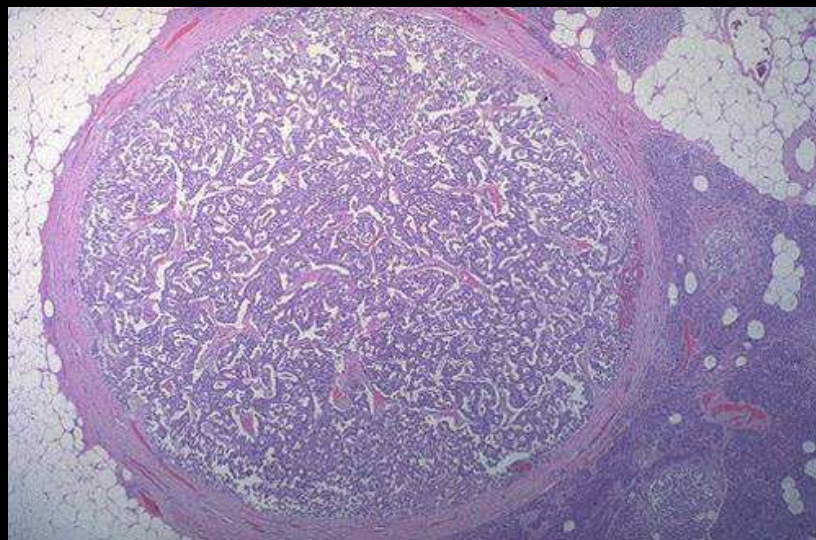
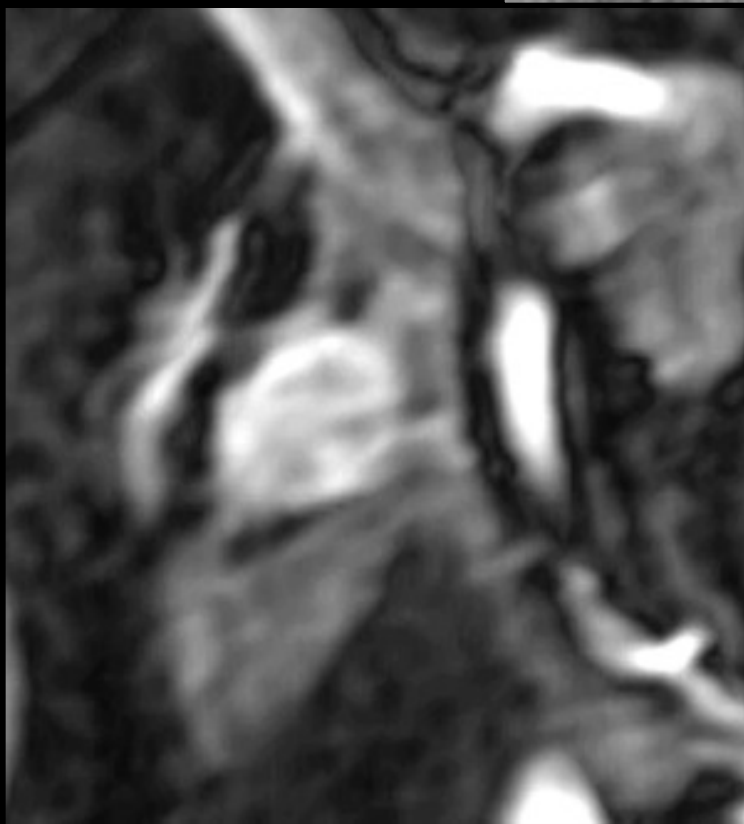
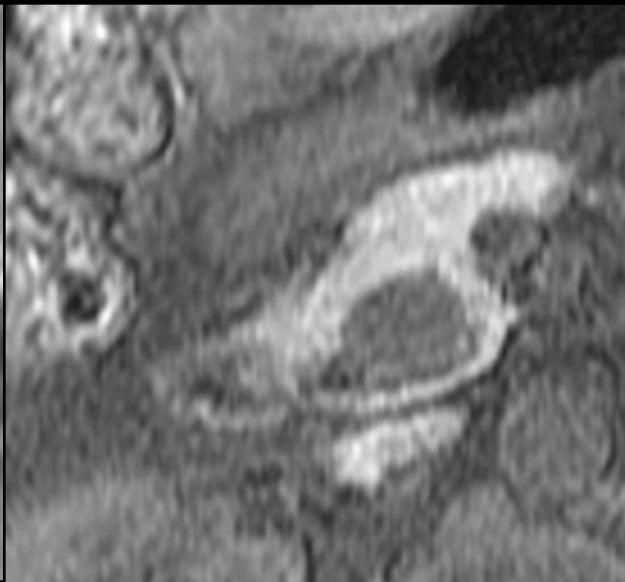
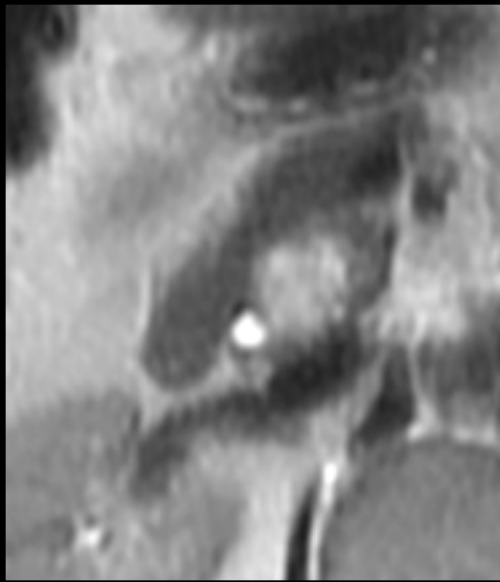
⇒ Cystadénome séreux



⇒ T solide du pancréas

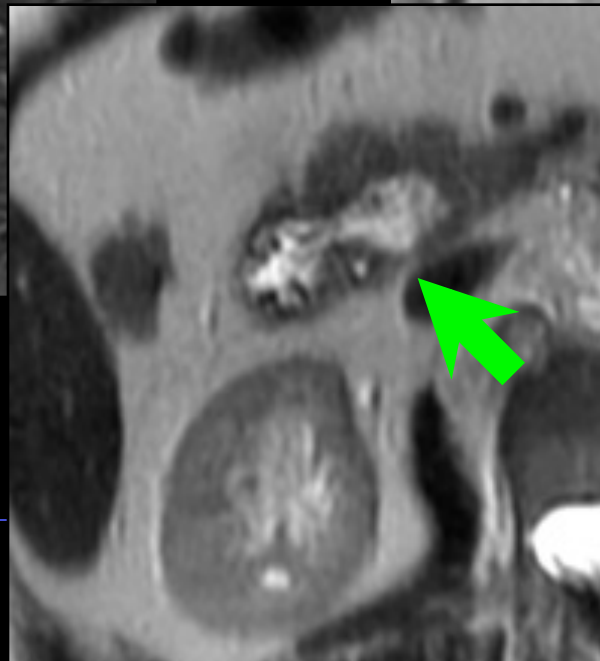
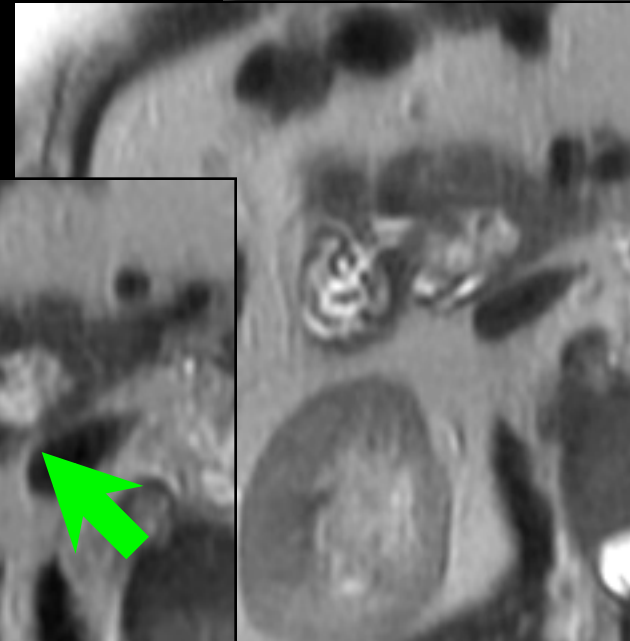
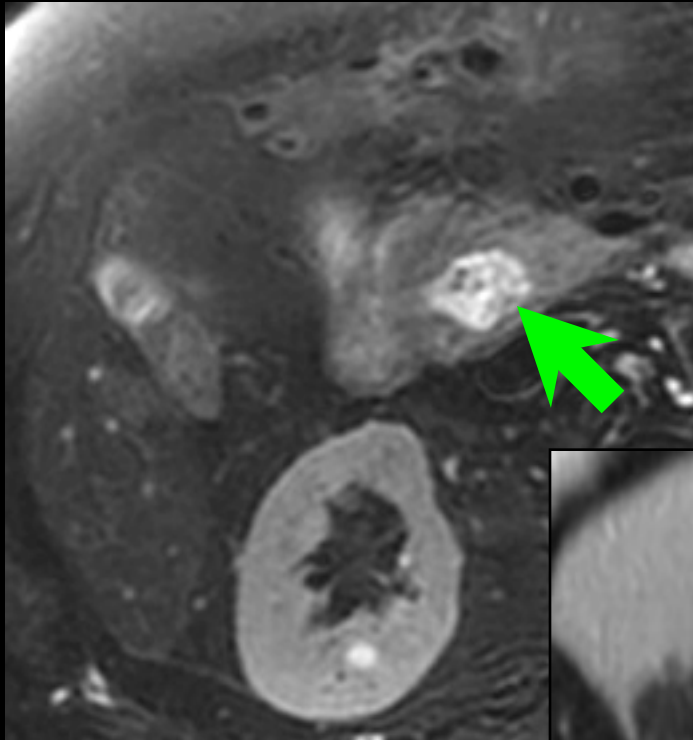
# PONDÉRATION T2





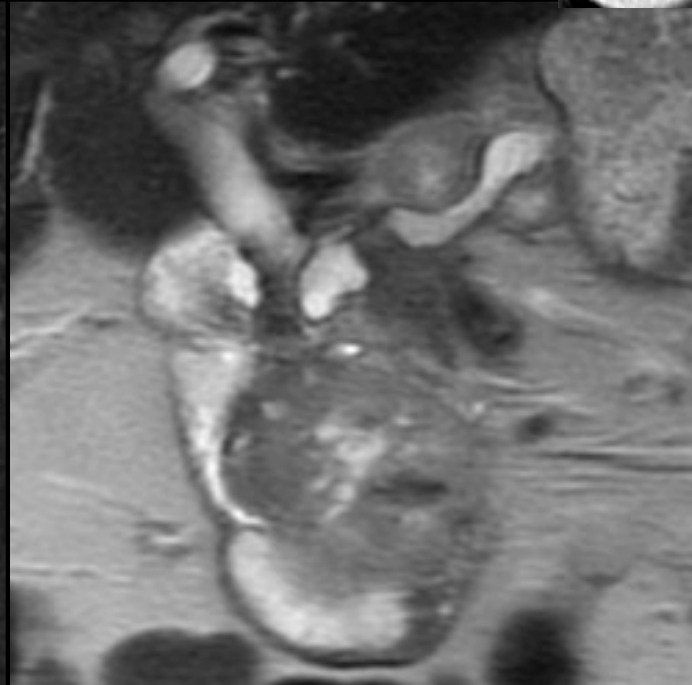
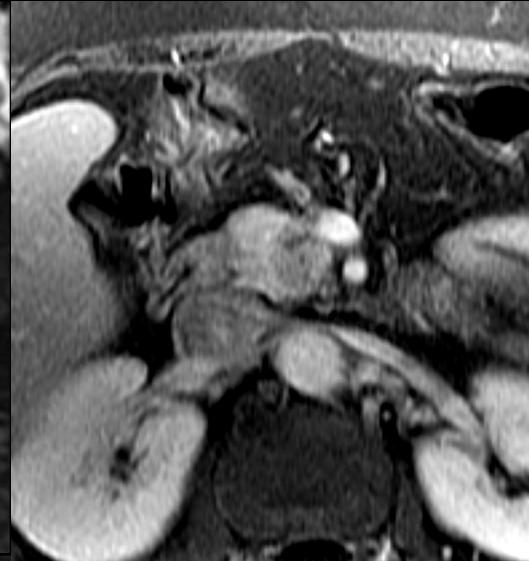
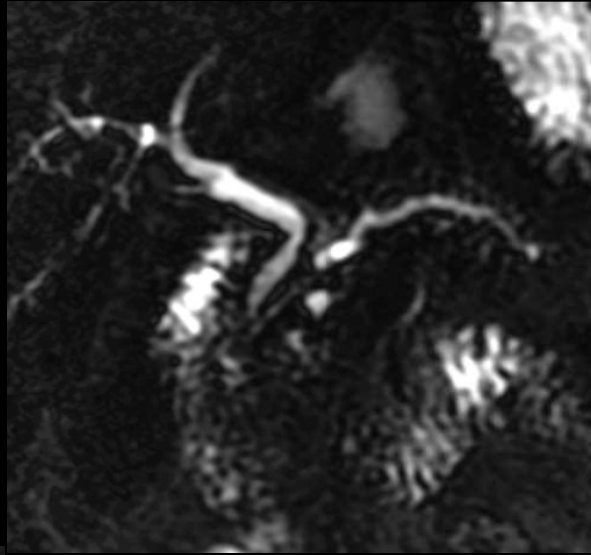
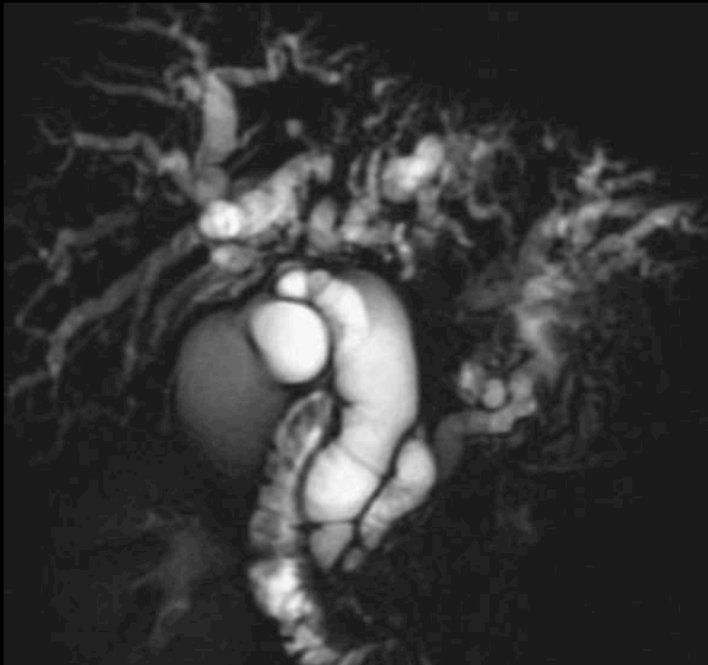
Insulinome

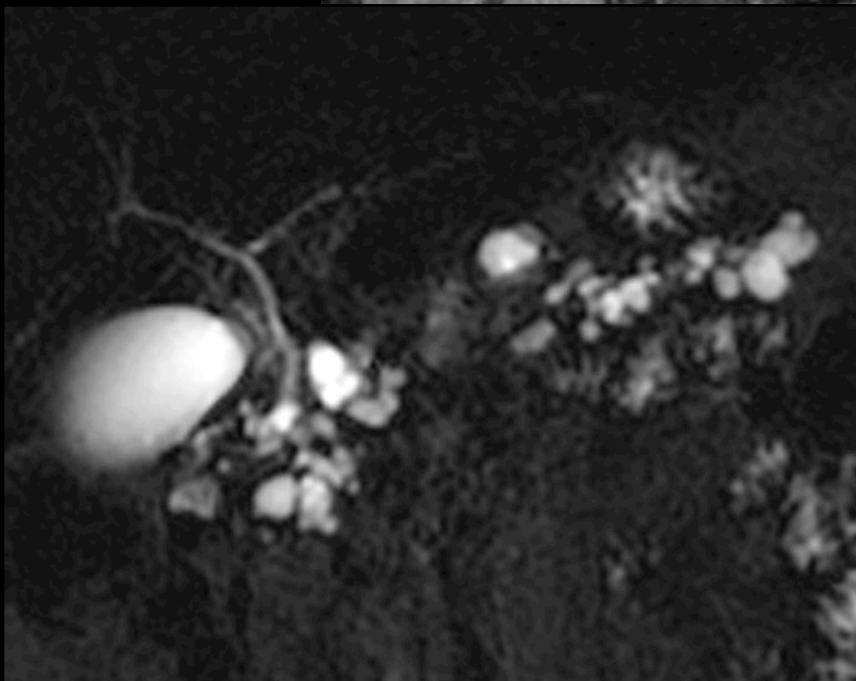
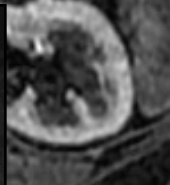
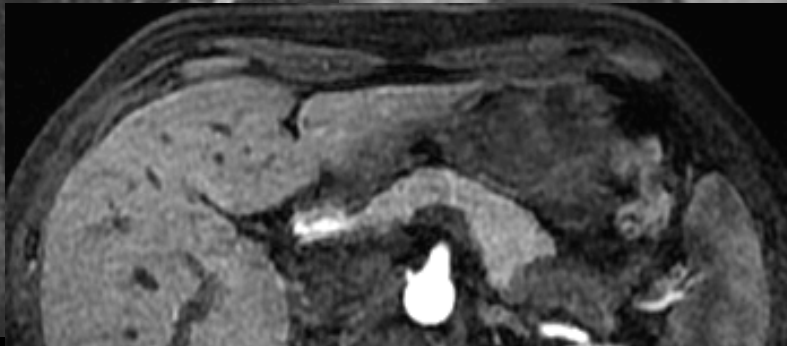
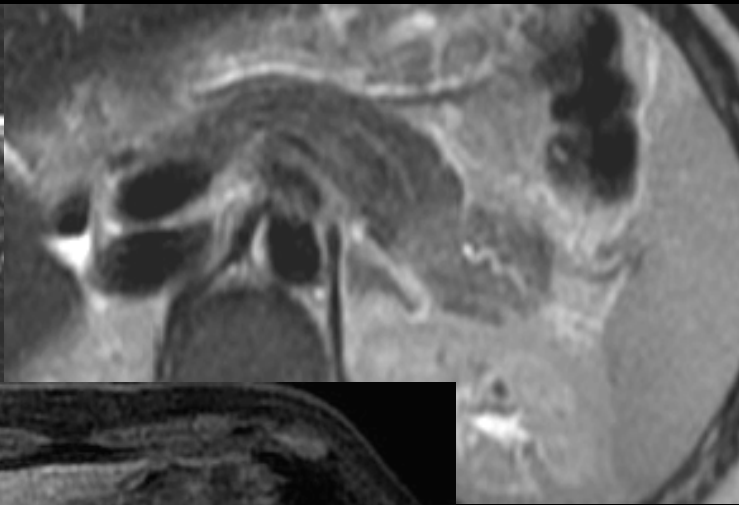
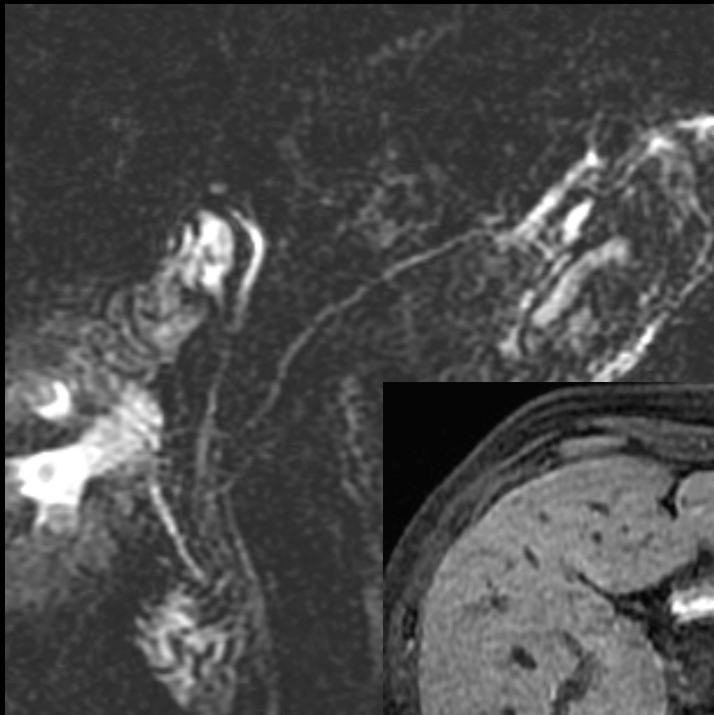
# Pièges



DIVERTICULE  
Juxta papillaire

SS FSE TE Long



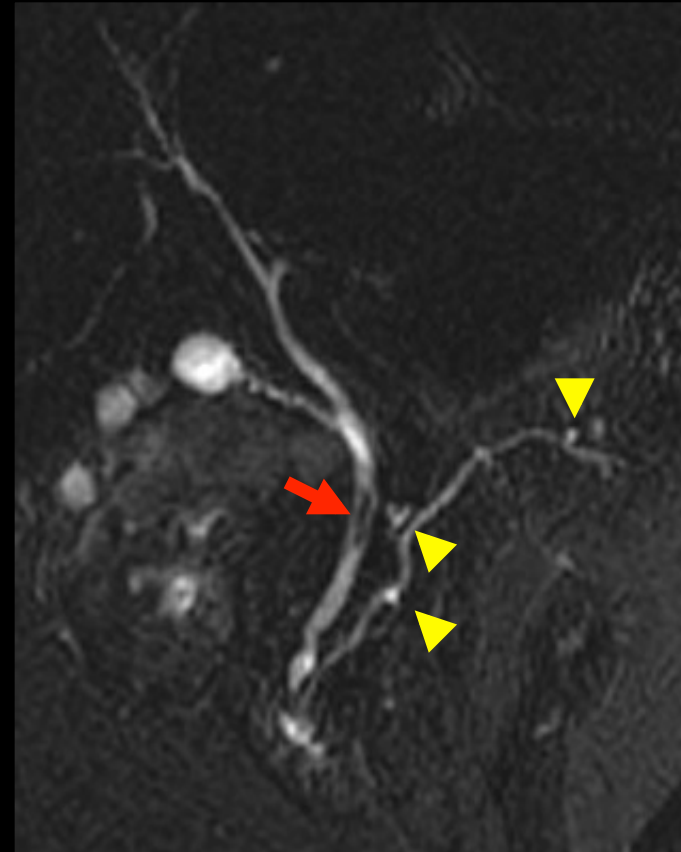


# CANAUX SECONDAIRES

- Canaux secondaires normaux non visibles
- nombre : 15 à 30
- quelques dilatations dans population N (< 3)

⇒ dilatation =

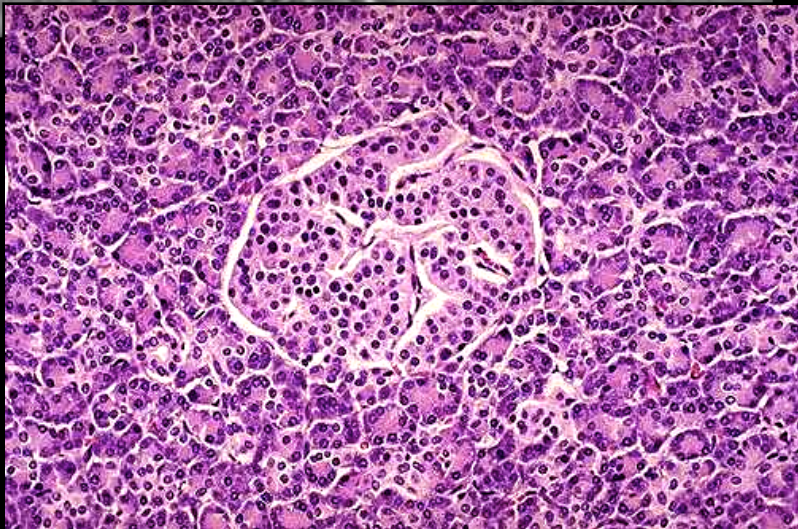
- pancréatite chronique ( $\geq 3$ )
- TIPMP

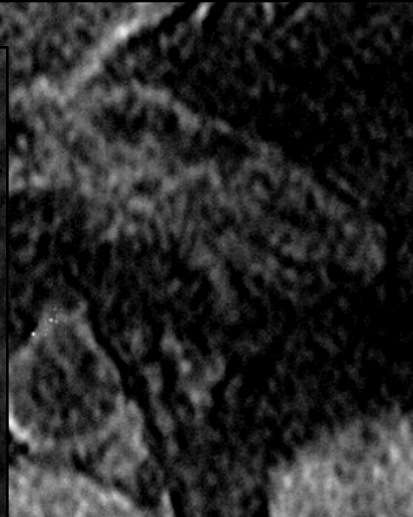
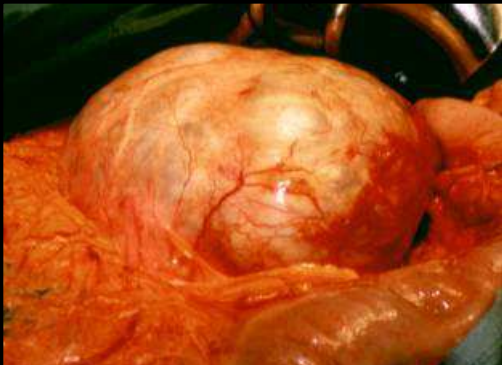
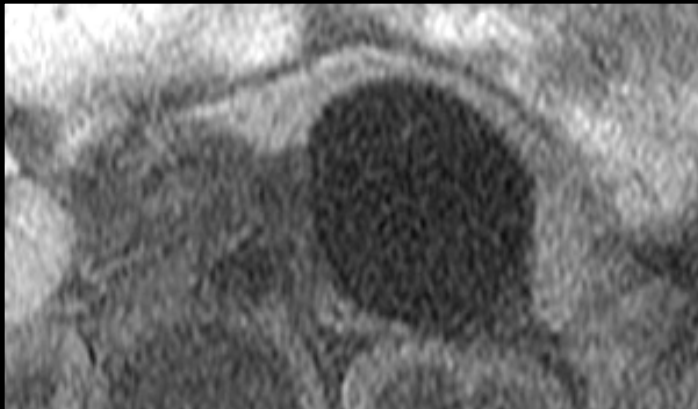
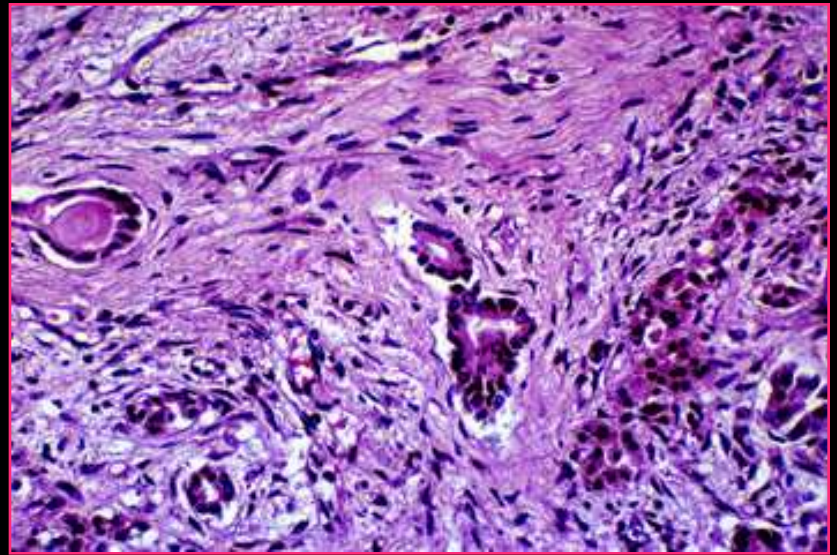
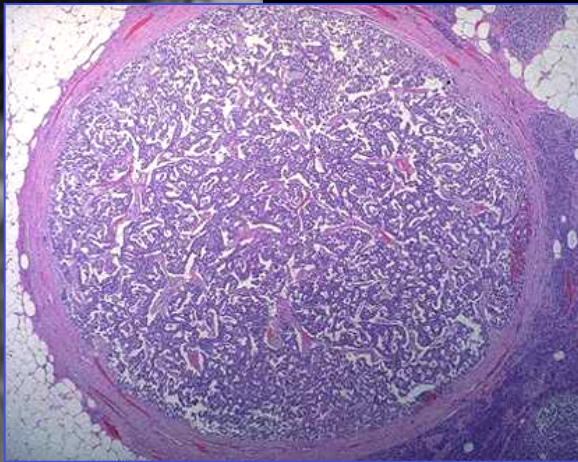
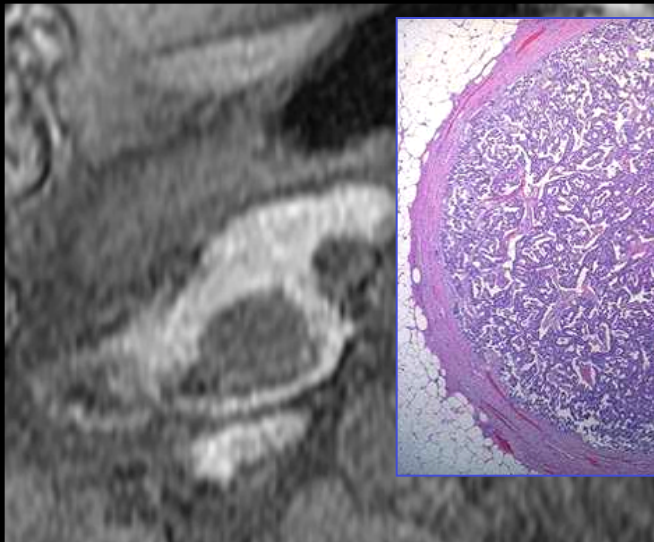


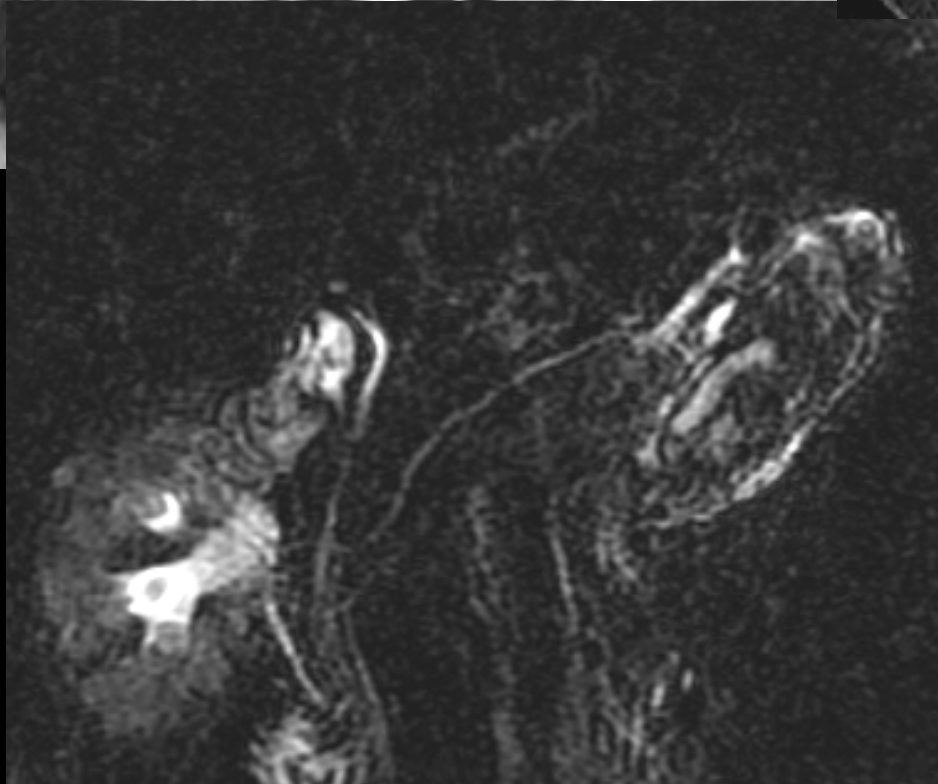
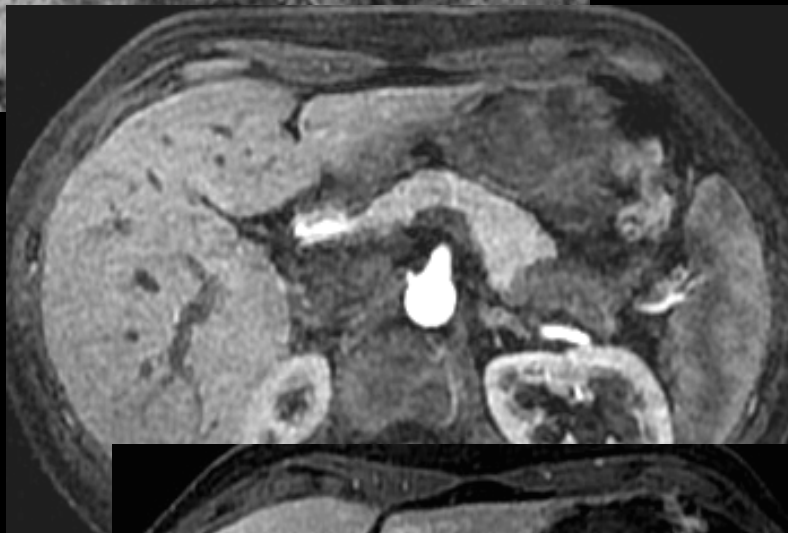
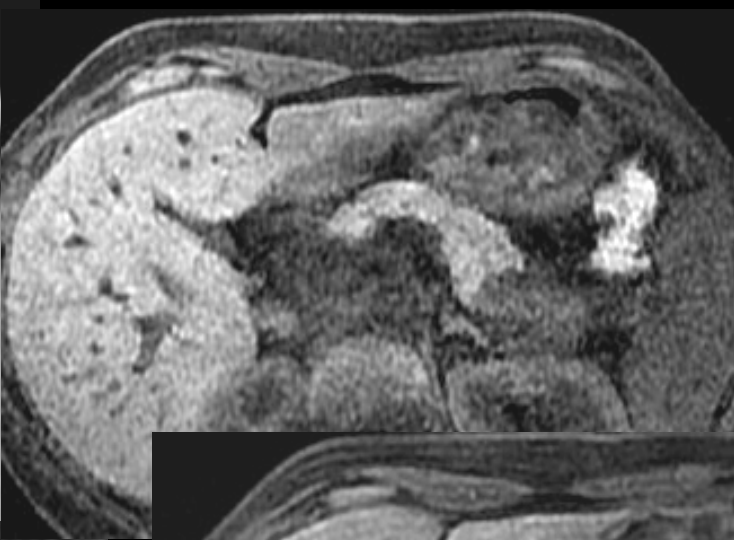
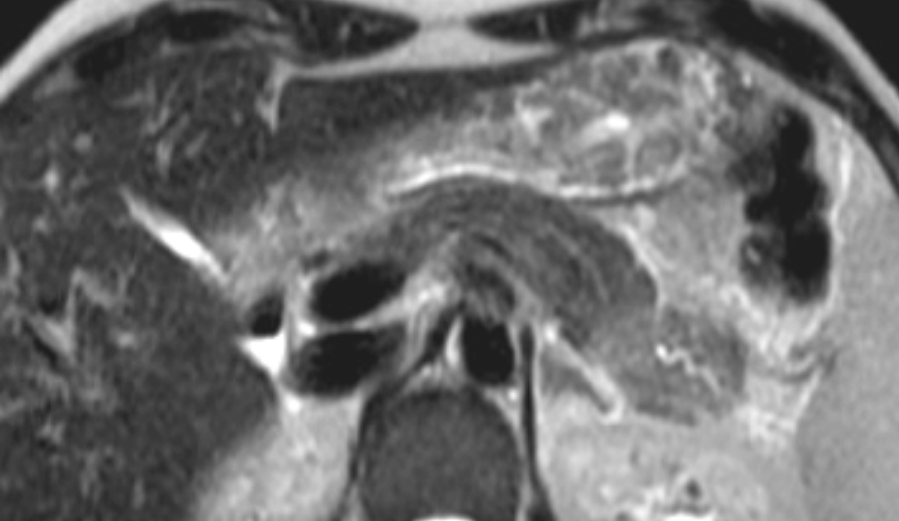
# PONDÉRATION T1



FAT SAT !!!







Pancréatite chronique localisée

# PONDÉRATION T1



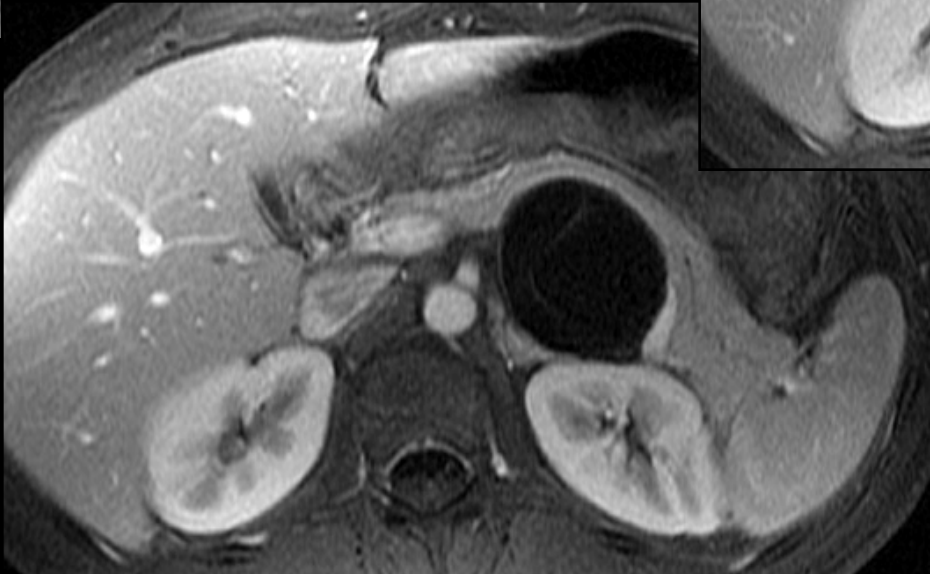
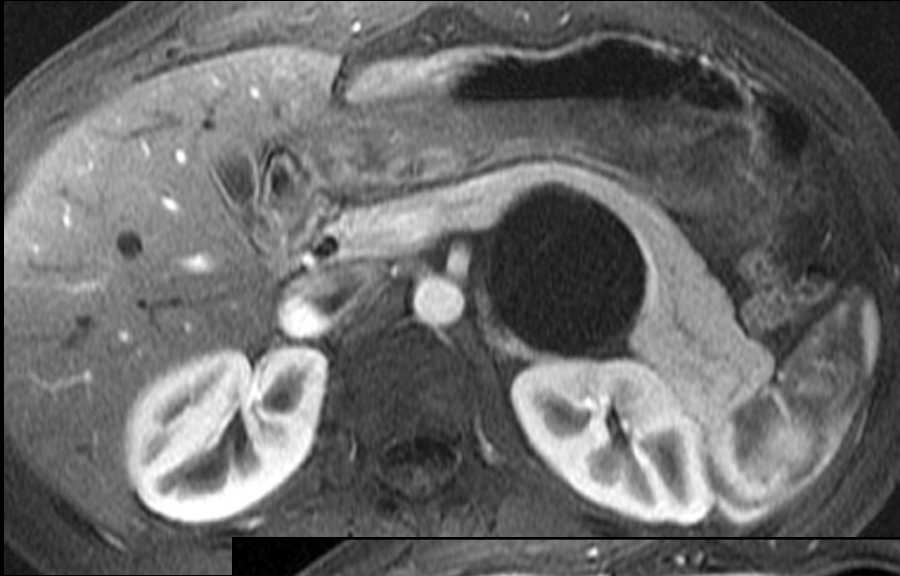
⇒ Détection des lésions

- séquence écho de gradient rapide avec saturation de graisse

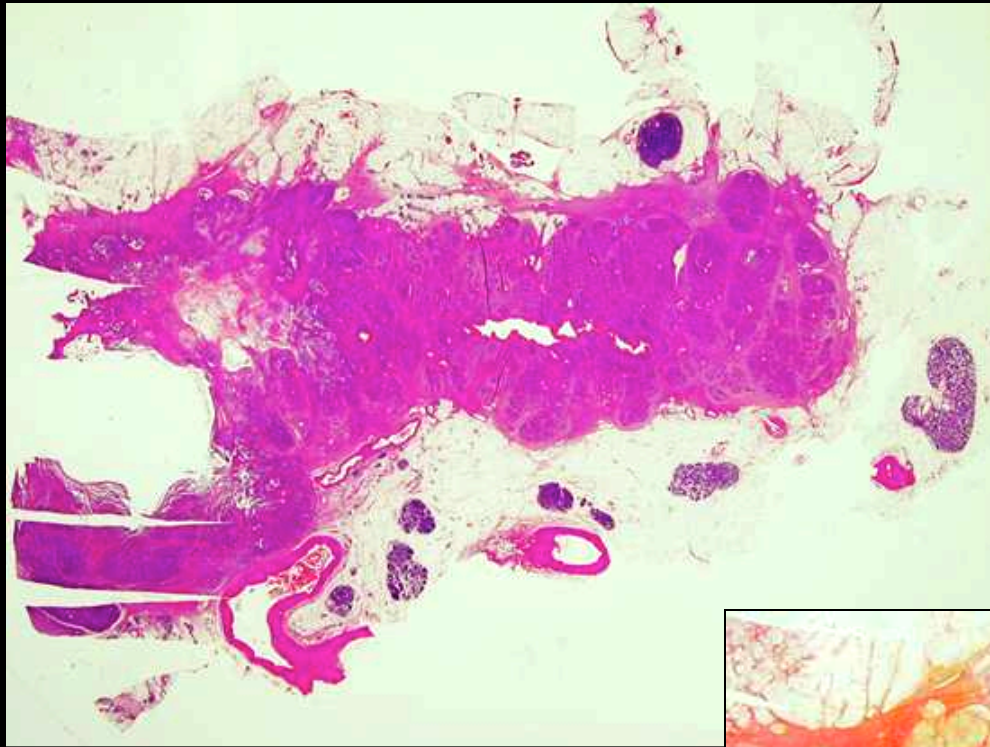


(agent de contraste hépatobiliaire : Teslascan)

# T1 gadolinium

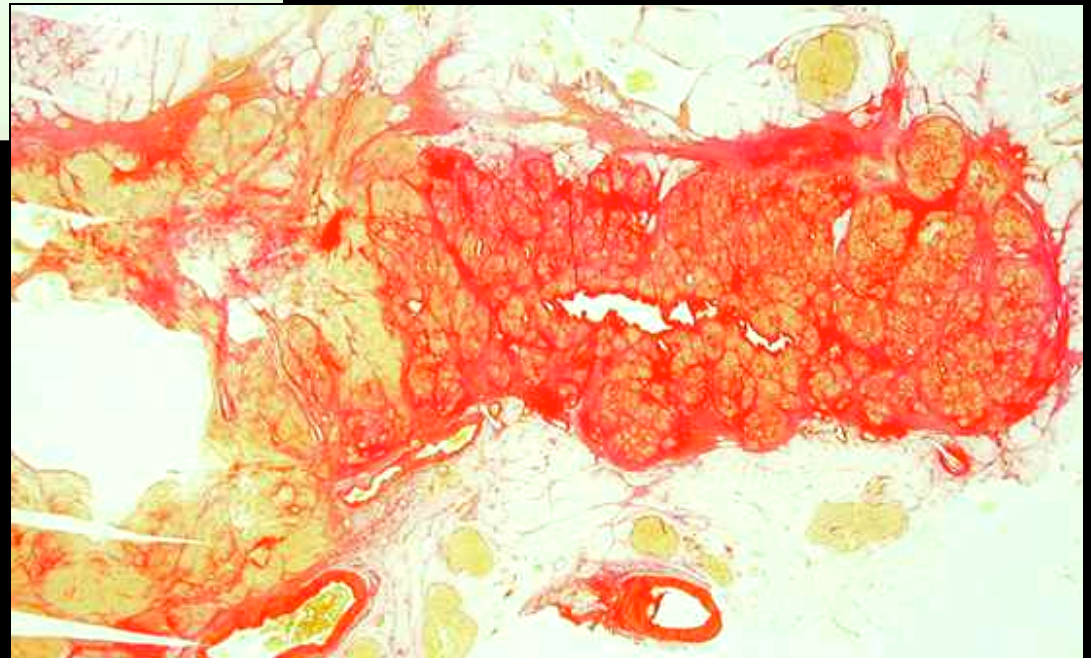


Temps parenchymateux  
pancréatiques

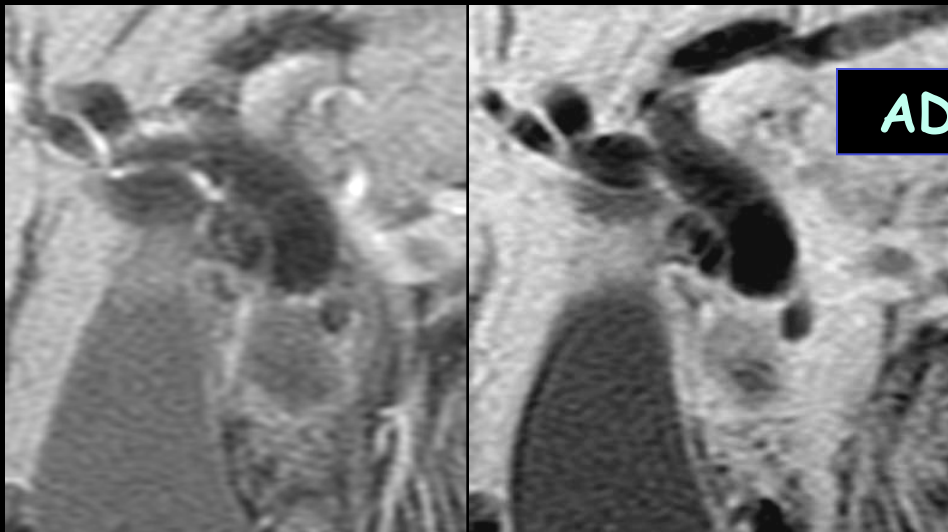


coloration HES  
t.fibreux collagène rose

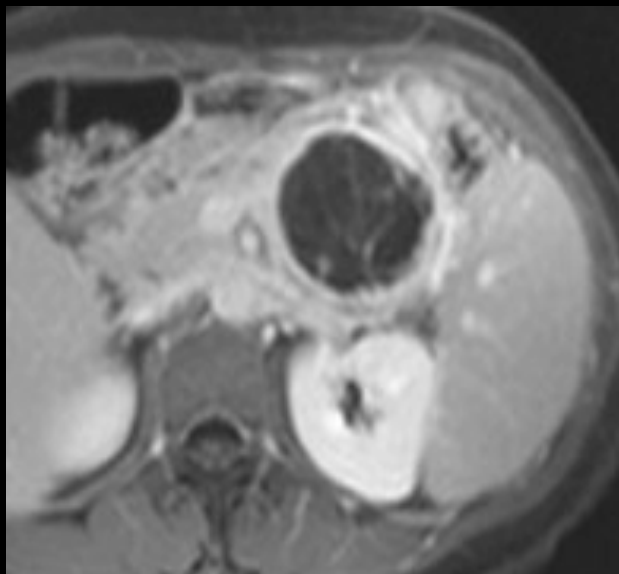
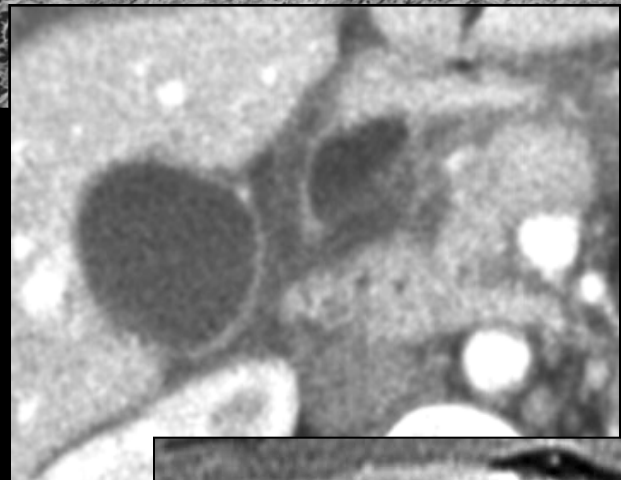
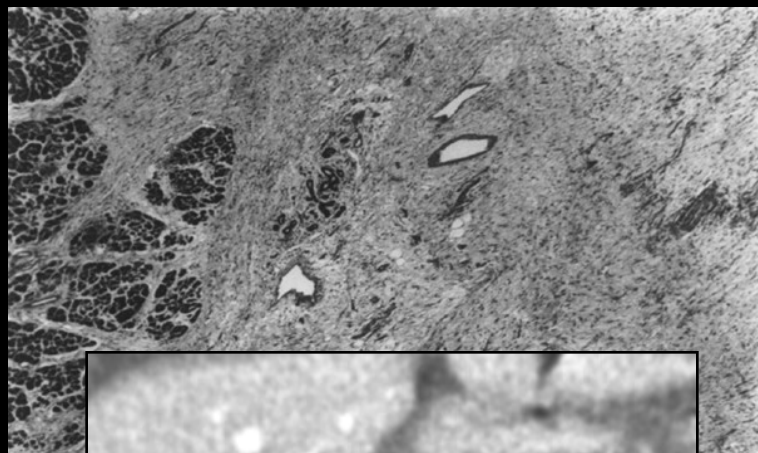
coloration rouge Sirius  
t.fibreux collagène rouge



adénocarcinome ductal du  
pancréas corporéo-caudal

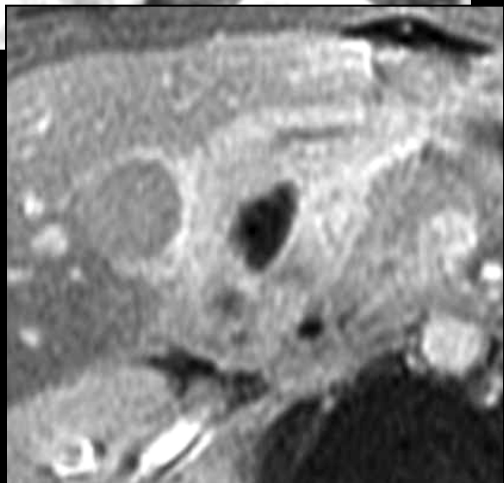


ADK



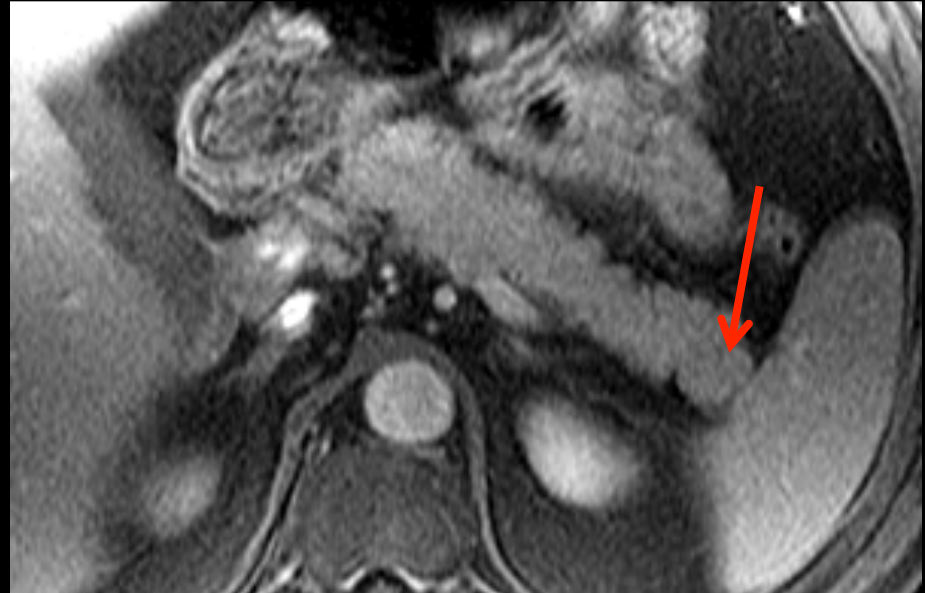
COUPES  
TARDIVES !!!

CYSTADÉNOME  
MUCINEUX

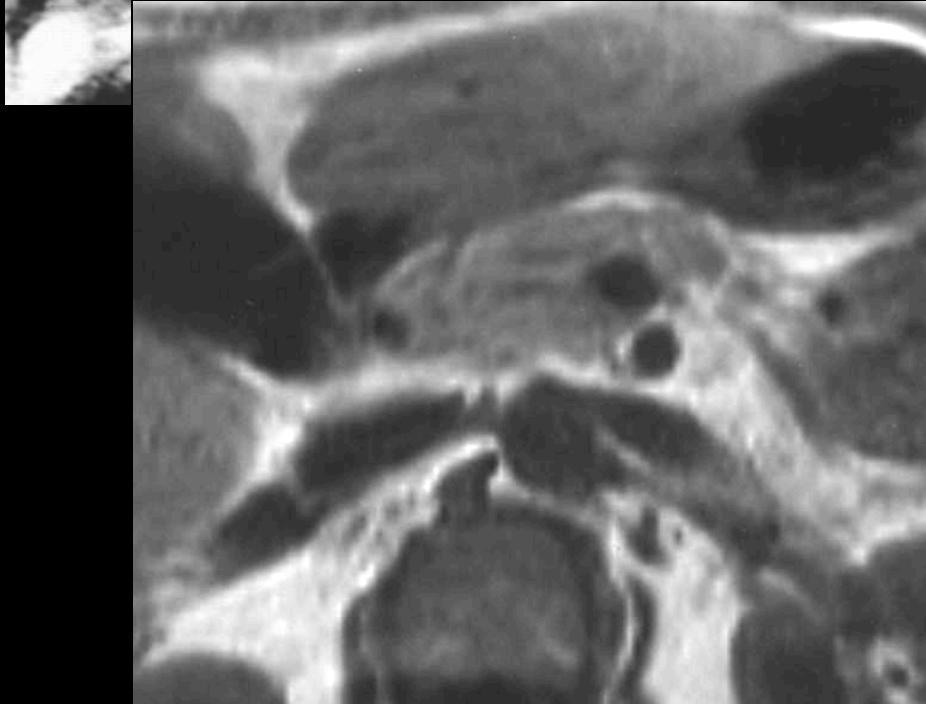


PANCRÉATITE  
AIGÜE DU SILLON

# Pièges I



Rate surnuméraire



Lipomatose Ia

# Pièges II : LIPOMATOSE

- diffuse ou focalisée

- étiologies :

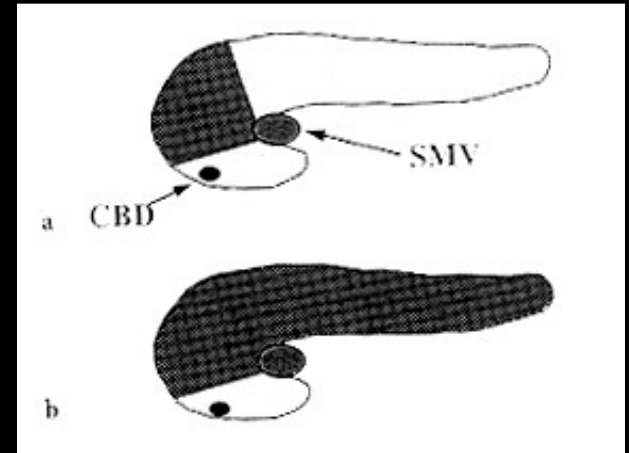
- mucoviscidose/ diabète
- obésité
- âge

- classification : Matsumoto S. ⇒

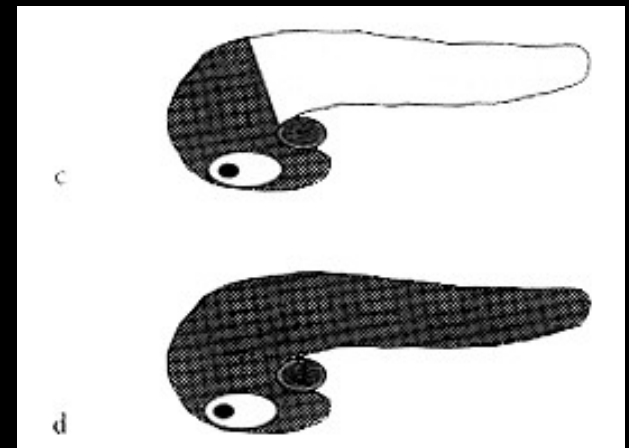
- Faux diagnostic de tumeur !!!!

- Risque de fistule post-op après  
chir du pancréas

Type 1



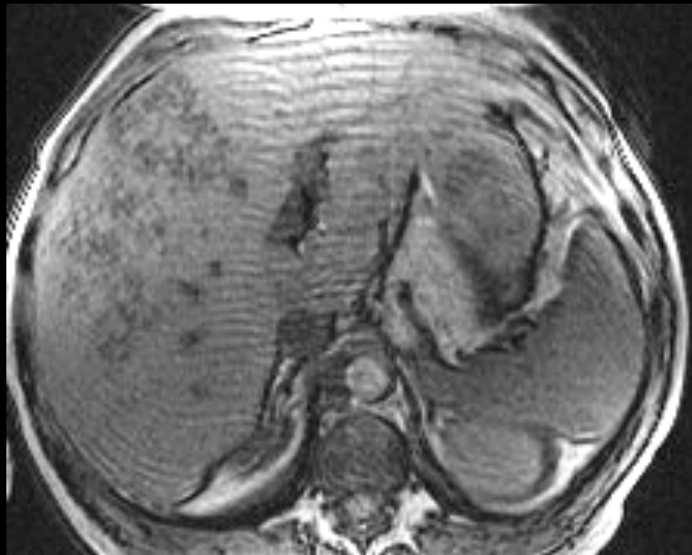
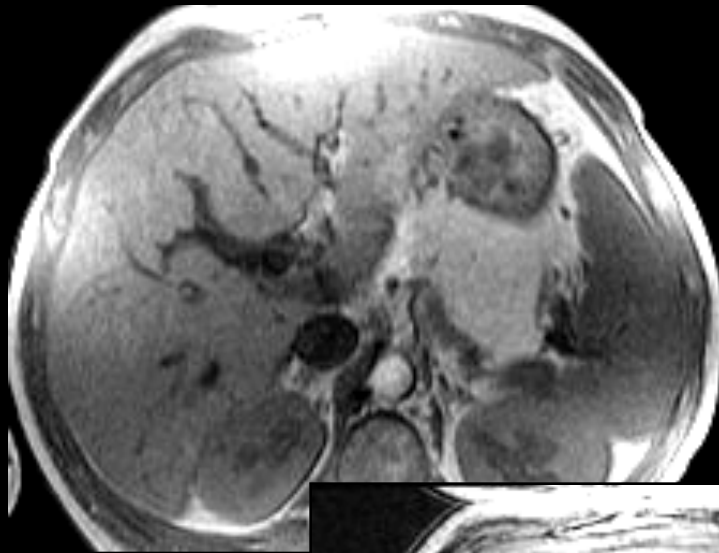
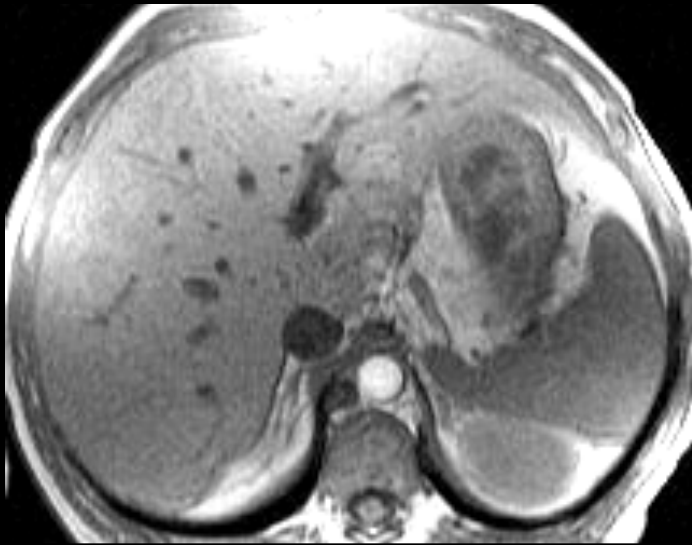
Type 2



Matsumoto S. Radiology 1995

Kim HJ AJR 2007

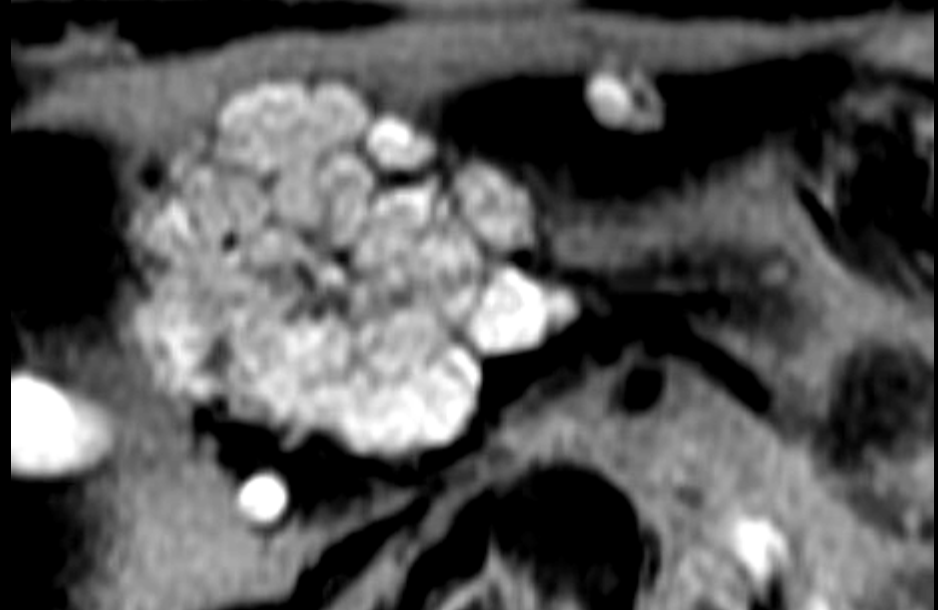
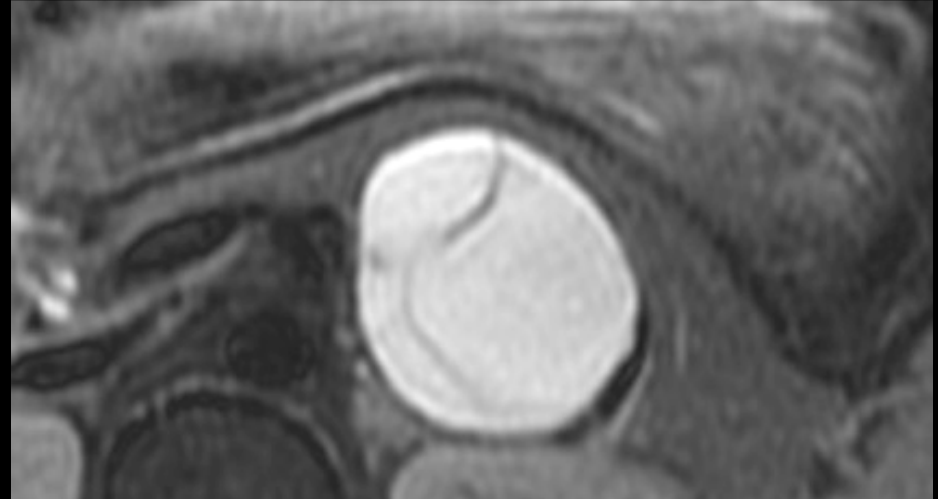
# Lipomatose IIb



# LESIONS KYSTIQUES

# TUMEURS KYSTIQUES\*

- Kystes cong :
  - Polykystose rénale
  - kyste séreux
- Kystes Inf°/ infl° :
  - Faux kystes +++
  - kyste hydatique
- T exocrine :
  - cystadénome (K) mucineux (10/45%)
  - cystadénome (K) séreux (32/39%)
  - TIPMP +++ (21/33%)
- T endocrine\*
- Métastases
- T épithéliale solide et papillaire
- Lymphangiome, maladie von Hippel Lindau\*,  
tératome, mucoviscidose
- Kyste lympho-épithéliale

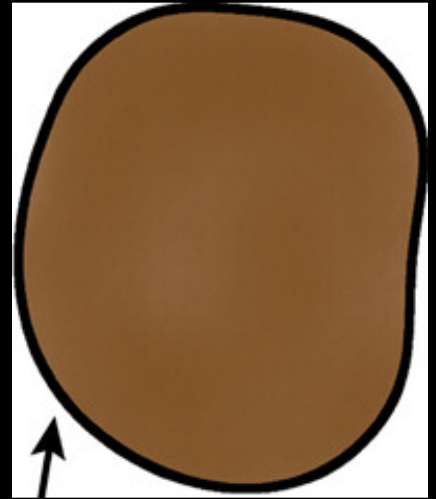


# Lésions KYSTIQUES du pancréas

- Architecture tumeur kystique
  - forme ronde
  - forme polylobée
- Communication avec canaux pancréatiques
- Calibres des canaux pancréatiques principaux
- Contexte : sexe -âge - ATCD pancréatite aiguë

# Lésions KYSTIQUES rondes

- forme ronde
- paroi fine sans prise de contraste
- sans septa ni végétation
- taille ?



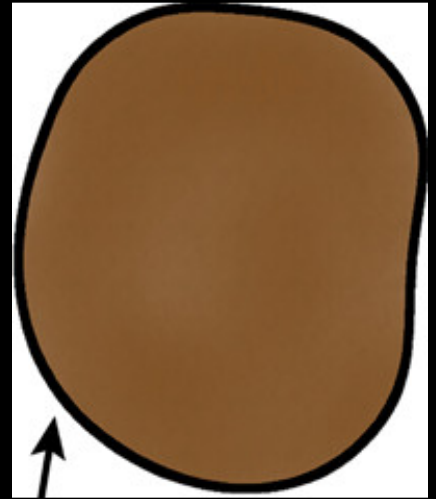
< 1 cm = kyste séreux

2699 IRM - 20% kystes, dont 16% < 1 cm - homme = femme - > 70 ans multiples et taille > 2cm

Zheng radiology 2002

# Lésions KYSTIQUES rondes

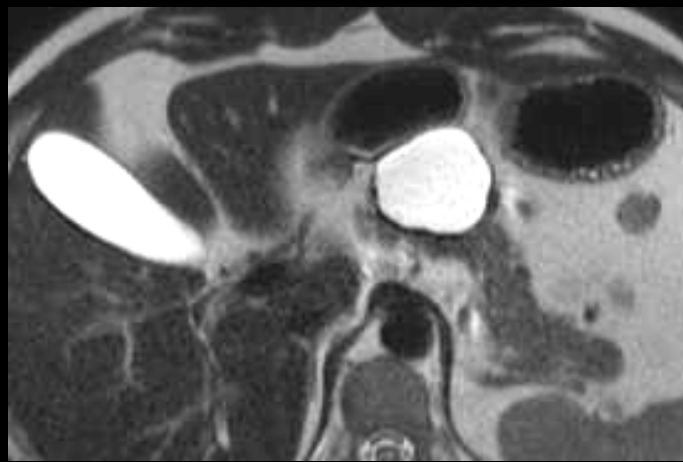
- forme ronde
- paroi fine sans prise de contraste
- sans septa ni végétation
- taille ?



>1 cm = cystadénome séreux macro-oculaire  
(10% des séreux)

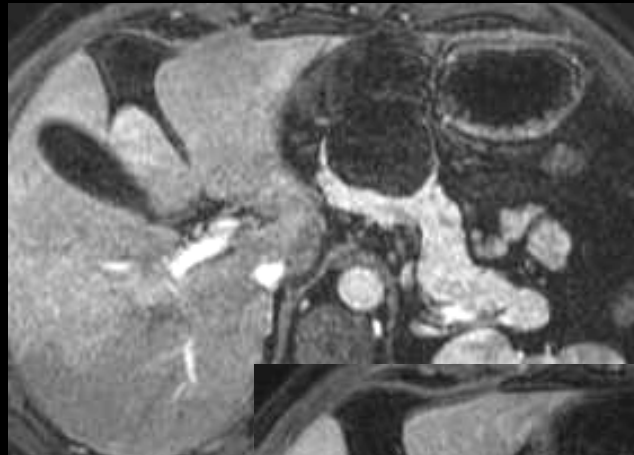
Pb diagnostic différentiel avec Pseudokystes et Cystadénome mucineux :

- paroi fine et sans réhaussement
- cytoponction : Amylase, CA19.9, ACE (< 5ng/ml), glycogène



Homme 31 ans  
asymptomatique

Cystadénome  
séreux macro-  
loculaire



Tête - contour lobulé - paroi fine - sans PdeC :

2 critères = 82% de spécificité

3 ou 4 critères = 100% de spécificité

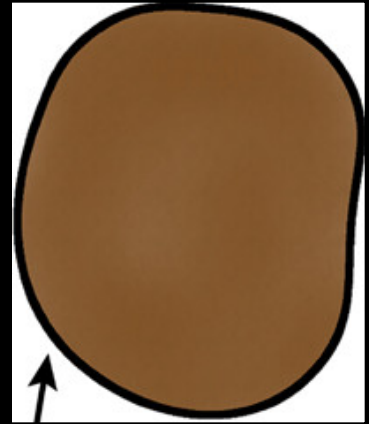
Cohen-Scalli, Radiology 2003

# Lésions KYSTIQUES rondes

- Paroi épaisse et/ou prise de contraste

⇒ contenu homogène /hétérogène sans bourgeon :

- Faux kyste
- Cystadénome mucineux
- Tumeur neuro-endocrine



⇒ Intensité du rehaussement

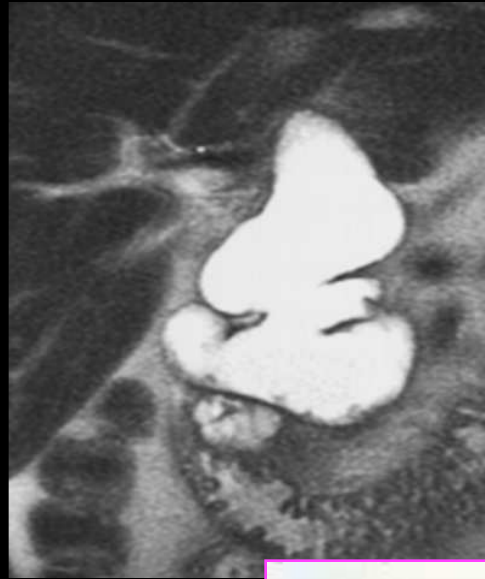
⇒ Ponction sous écho : tx ACE / CA 19-9 / CA 72.4 / amylase / mucine / glycogène

# Cytoponction

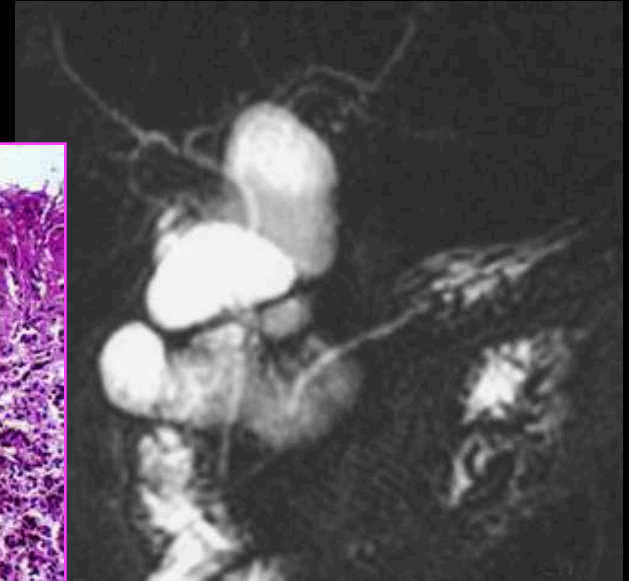
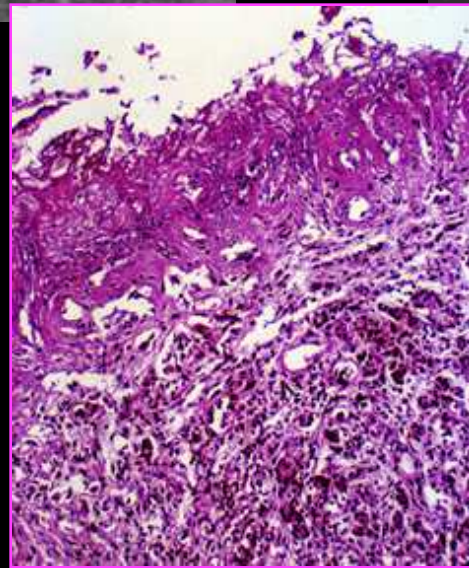
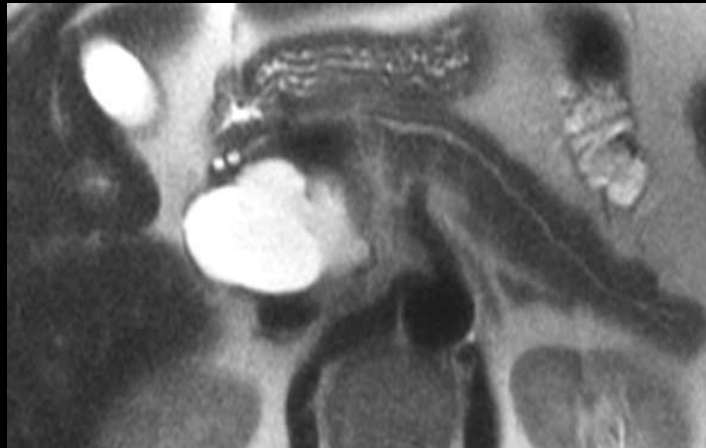
	Pseudokyste	Mucineux
Amylase > 5000U/L	95%	30%
CA 19.9 > 50000U/L	15%	90%
ACE > 200 ng/ml	10%	60%
ACE > 400 ng/ml	0%	Sp : 99%
CA 72-4 > 40 U/ml	2%	Sp : 98%

Taux ACE < 5 ng/ml = Se 100% et Sp 86% pour cystadénome séreux (ou Faux kyste)

# PSEUDOKYSTE



- ATCD de pancréatite, éthyliste
- Paroi épaisse avec PdeC
- Calcification
- Contenu hétérogène
- Tx amylase > 5000 ml



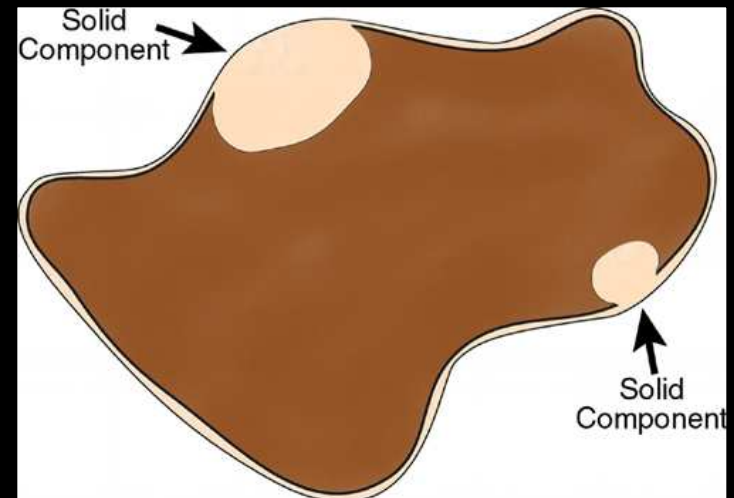
# Lésions KYSTIQUES rondes

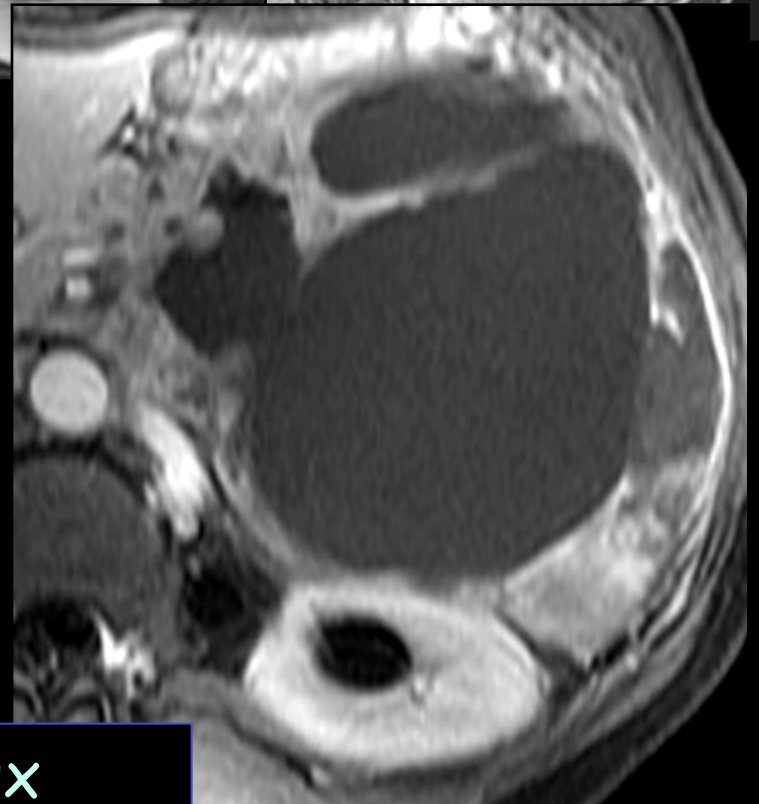
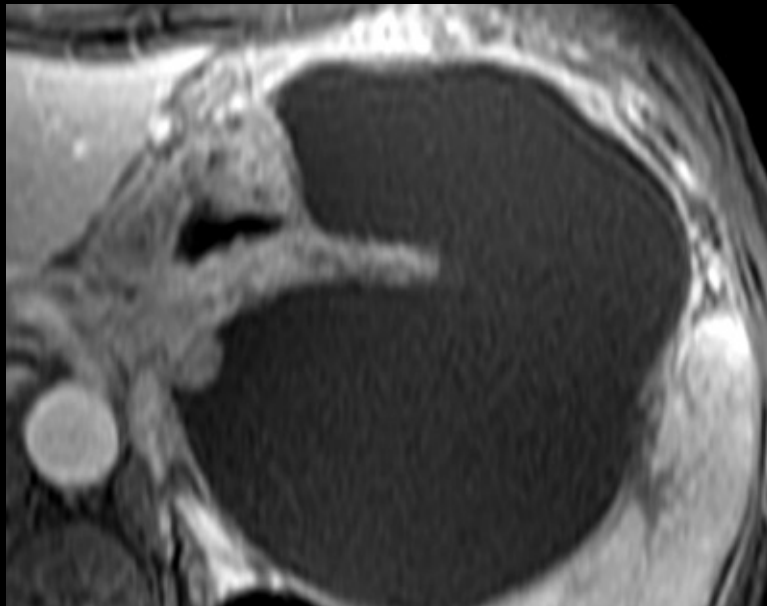
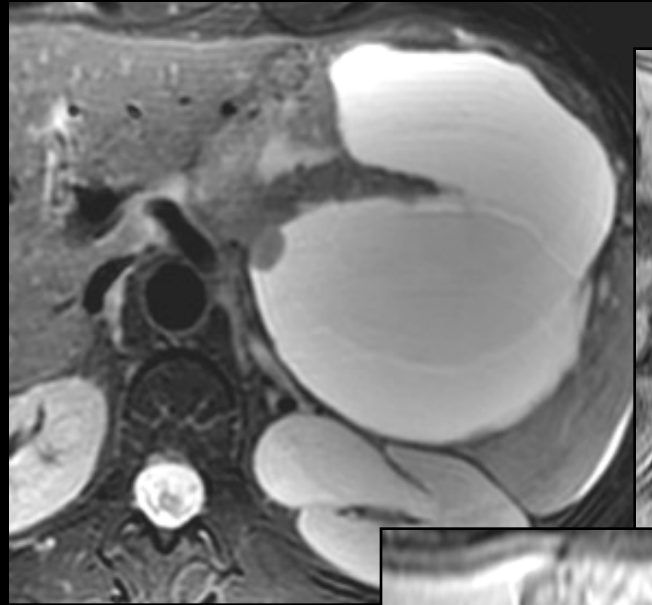
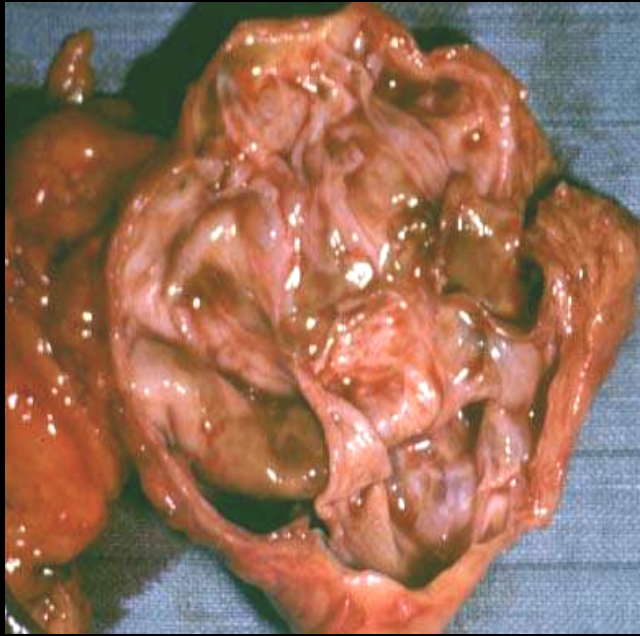
- Paroi épaisse et/ou prise de contraste

⇒ contenu homogène /hétérogène avec bourgeon :

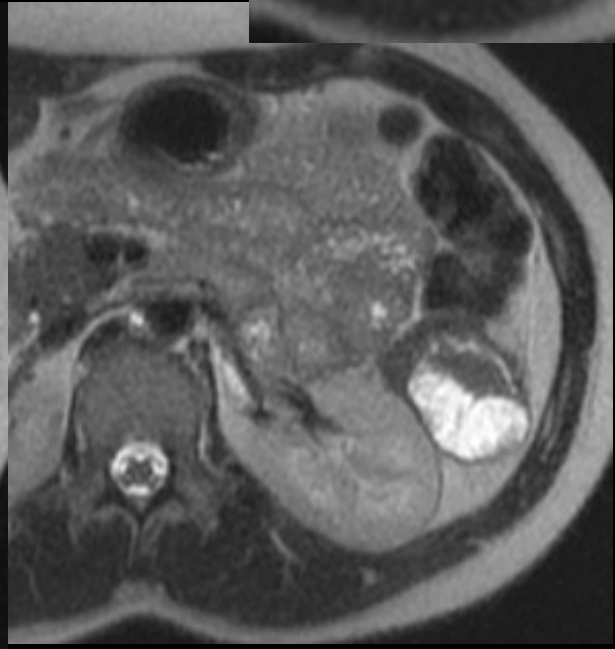
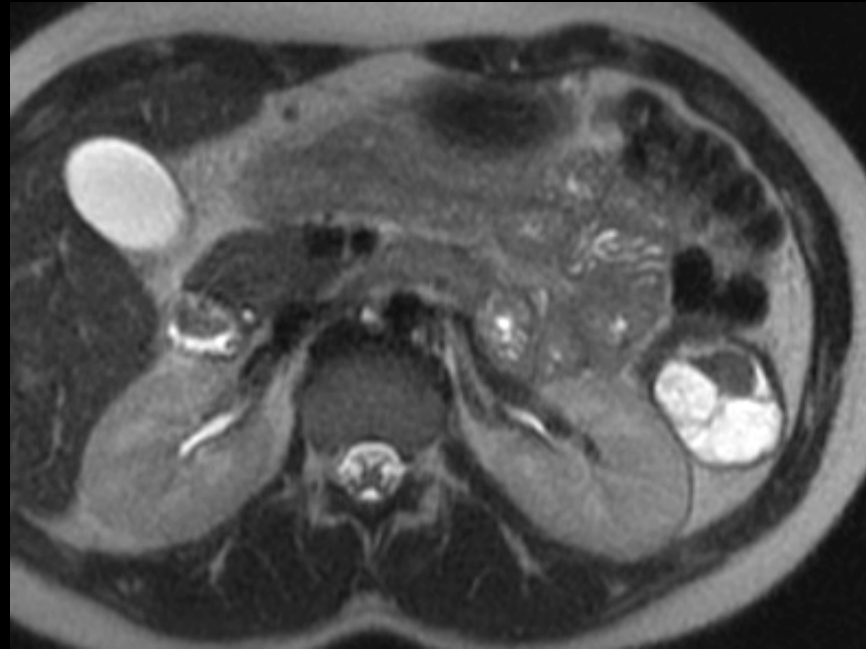
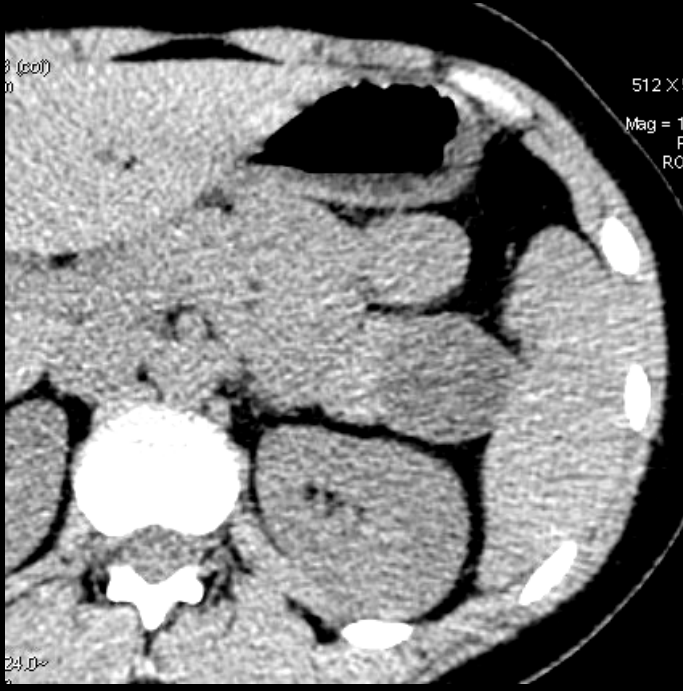
CHIRURGIE : pas de biopsie

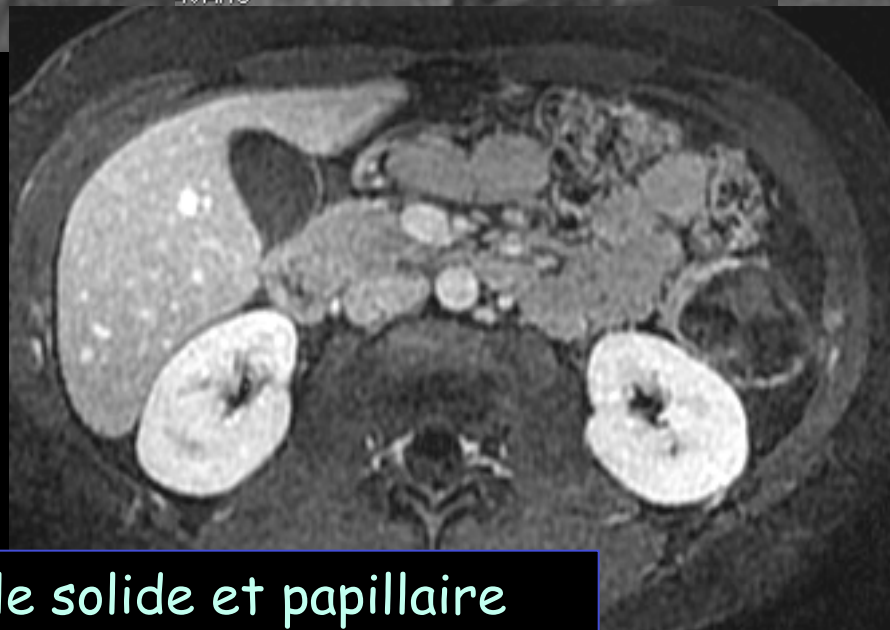
- Cystadénocarcinome mucineux\* (rare)
- Tumeur épithéliale solide et papillaire \*
- Tumeur neuro-endocrine





Cystadénocarcinome mucineux





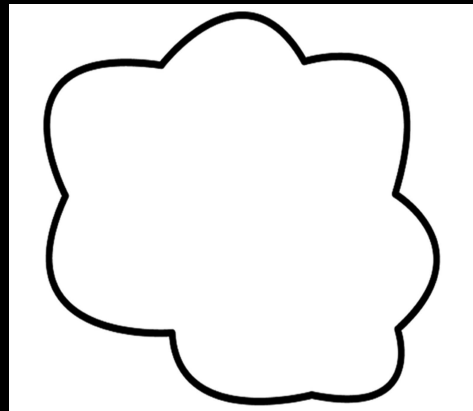
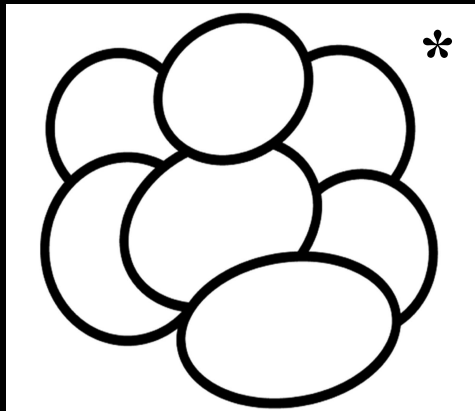
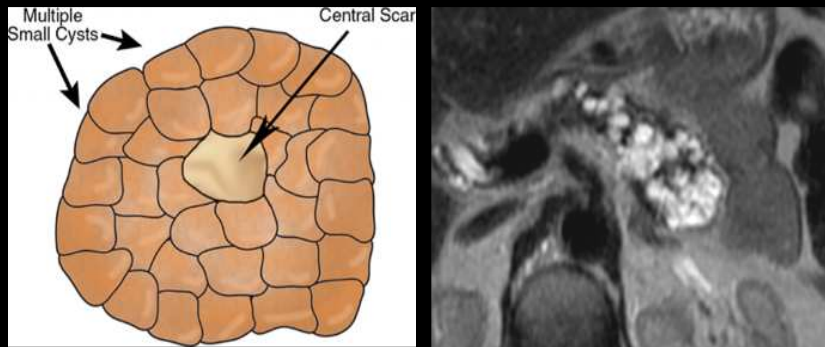
T épithéliale solide et papillaire

# Lésions KYSTIQUES lobulées

• Forme uni ou micro-loculaire / lobulée

- **Cystadénome séreux**

(lobulé - paroi fine - pas de rehaussement - tête)



## Cystadénome séreux typique

- Micro-polykystique 70% : paroi indiscernable, sans rehaussement / multitude de petite logette / cicatrice centrale calcifiée

## Cystadénome séreux atypique

- Macro uni ou multiloculaire 10%

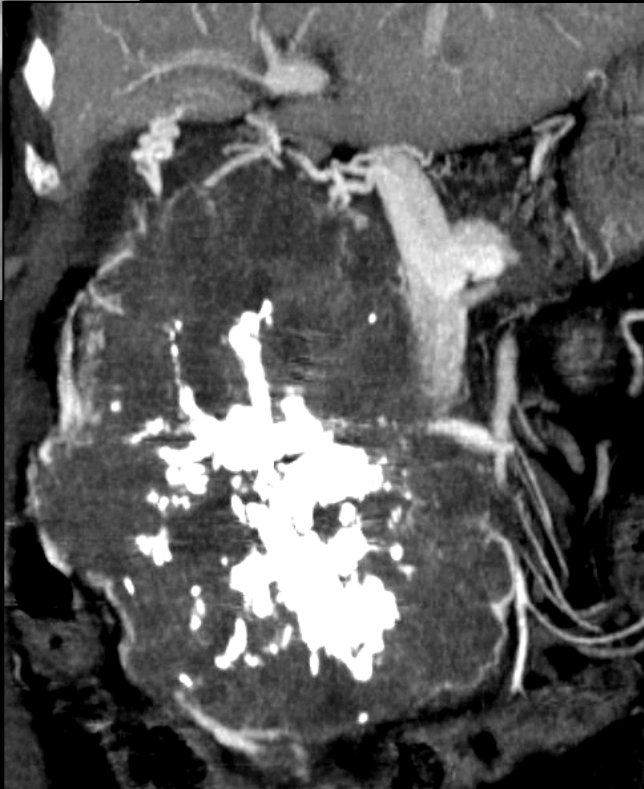
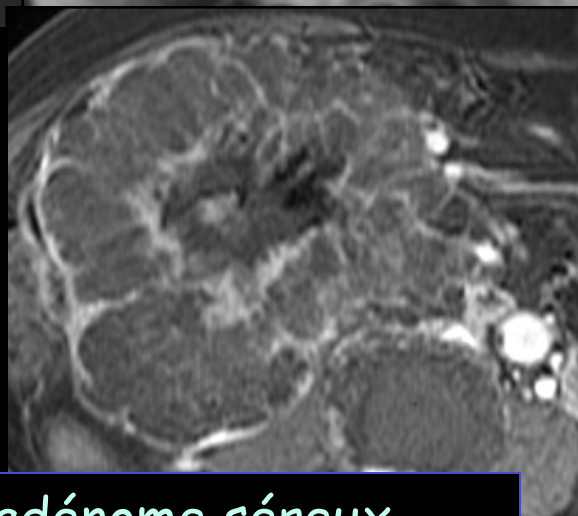
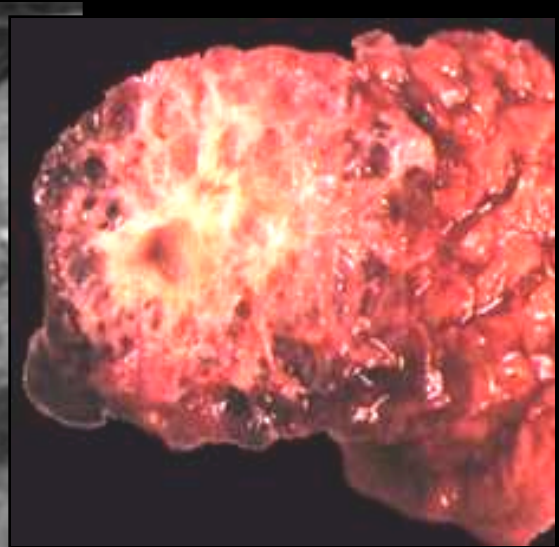
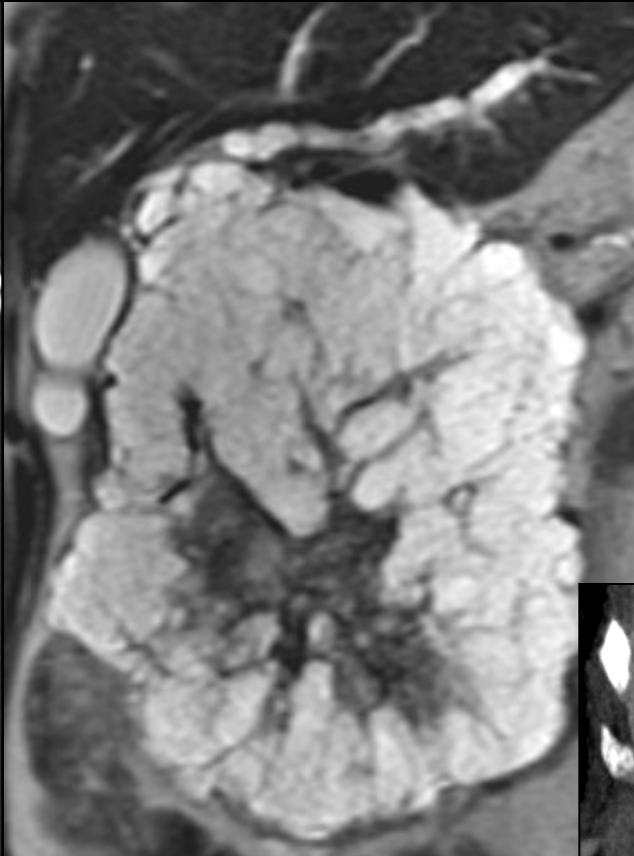
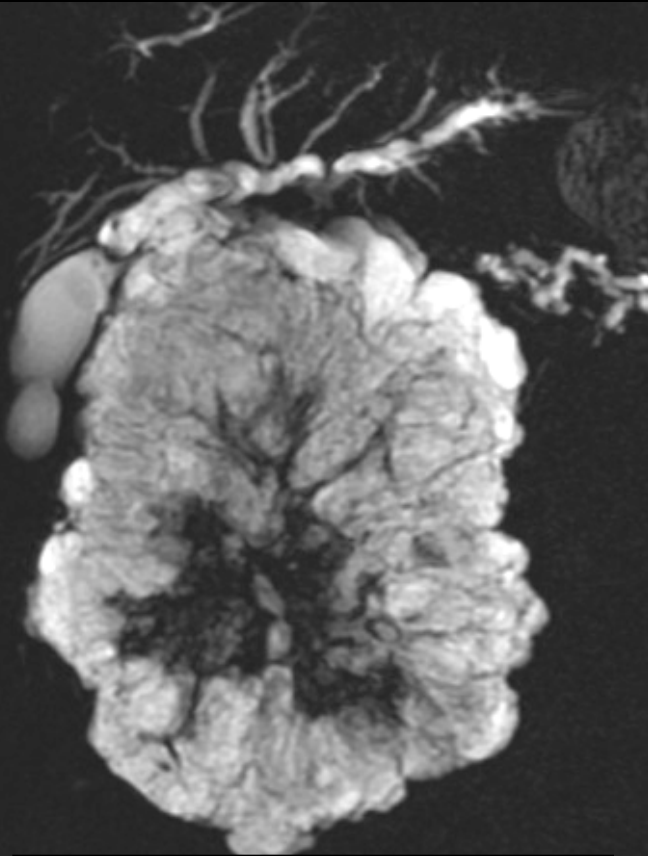
- Forme disséminée = maladie Von Hippel Lindau (hémangioblastome, carcinome rénal, kystes viscéraux)

- Forme pseudo-tumorale : pas de kyste, rehaussement +++, constitué de cellules bordant l'épithélium des kystes comme dans les autres séreux

Diagnostic différentiel : TNE+++

- Forme hémorragique

- Forme à croissance rapide



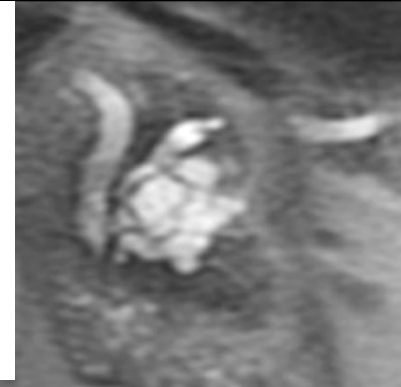
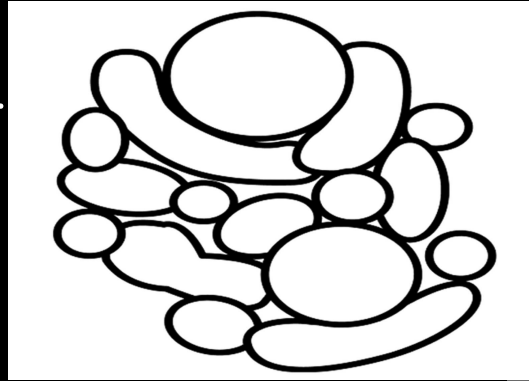
Cystadénome séreux

# Lésions KYSTIQUES lobulées

- Forme uni ou micro-loculaire /lobulée

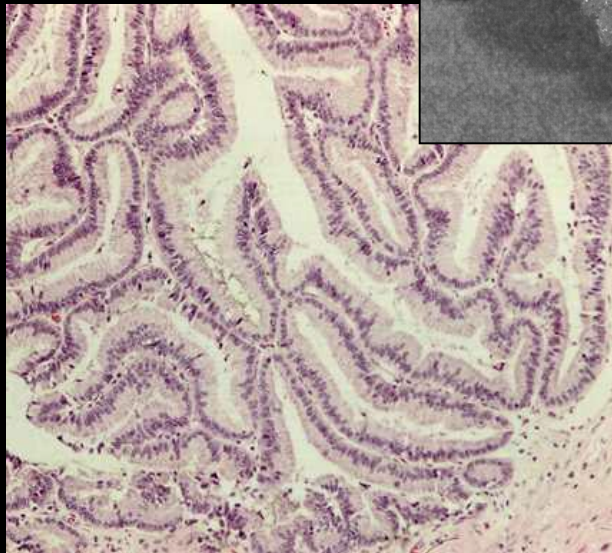
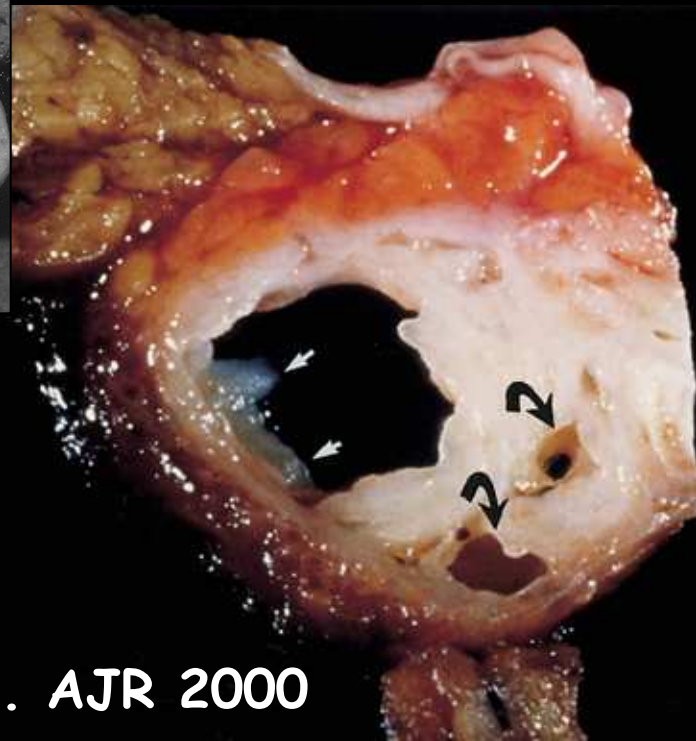
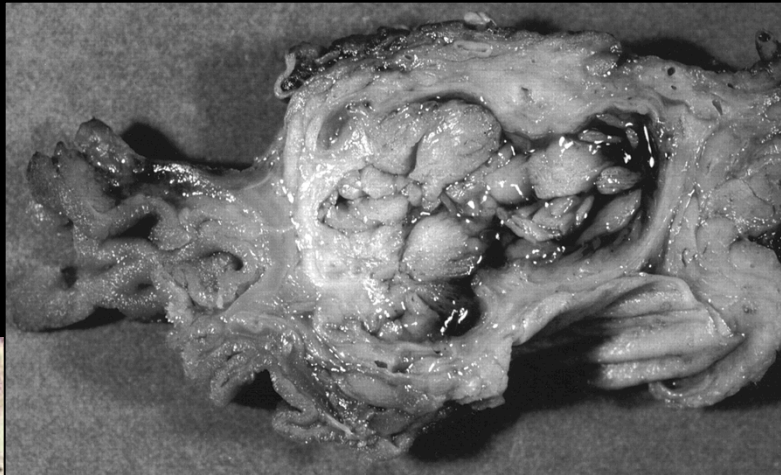
-TIPMP canaux IIaire

⇒ Locules en doigts de gant  
communication



# Tumeur mucineuse intra-canalaire et papillaire TIPMP

- 1982 : Tumeur Mucineuse Intra-canalaire et Papillaire\*
- prolifération de l' épithélium des canaux pancréatiques



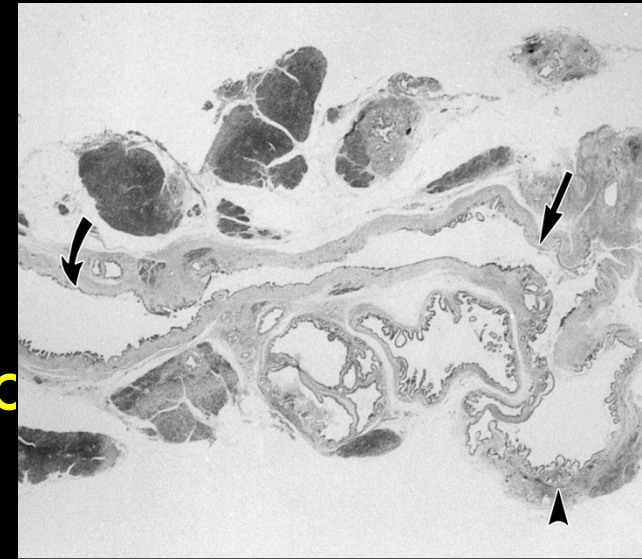
# Tumeur mucineuse intra-canalaire et papillaire TIPMP

Current name	Proposal				
	Full name	Abbreviated names	Groupings (for studies)		T-STAGE
IPMN with low-grade dysplasia	IPMN, Grade 1	<b>G1</b>	<b>NC</b> (Non-ca)	<b>NI</b> (Non-invasive)	0
IPMN with intermediate-grade dysplasia	IPMN, Grade 2	<b>G2</b>			
IPMN with high-grade dysplasia/CIS	IPMN, Grade 3 / CIS	<b>G3/Tis</b>	<b>CA</b>	<b>INV</b> (Invasive)	0 / Tis
IPMN with tubular-type invasive carcinoma	IPMN, invasive, tubular type	<b>Inv-t</b>			< 0.5cm : 1a 0.5-1cm : 1b 1-2cm : 1c > 2cm : 2 Beyond : (Usual TNM)
IPMN with colloid type invasive carcinoma	IPMN, invasive, colloid type	<b>Inv-c</b>			

# TIPMP

## Critères diagnostiques :

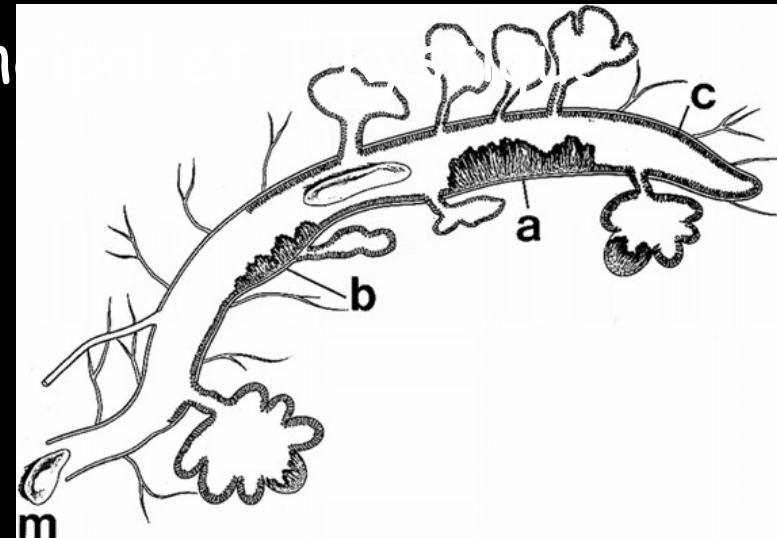
- atteinte des canaux pancréatiques :
  - principaux : main c



- secondaires :

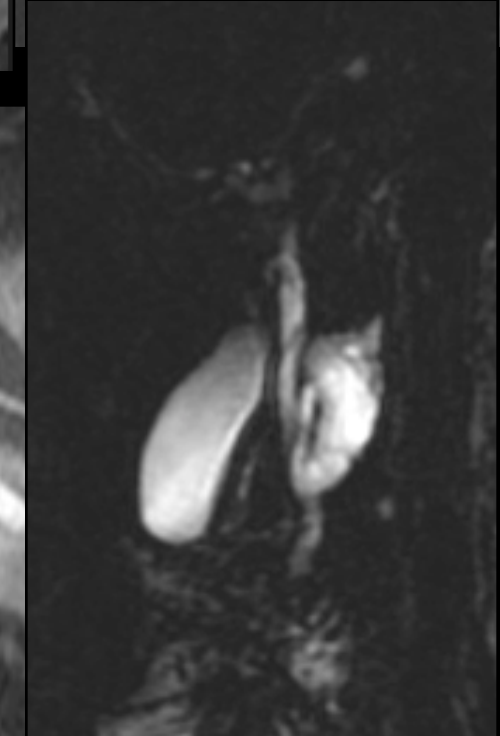
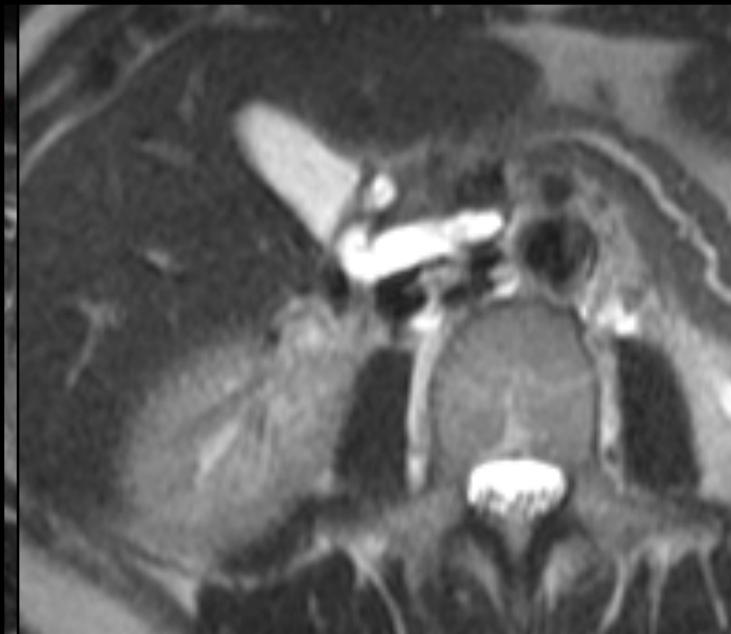
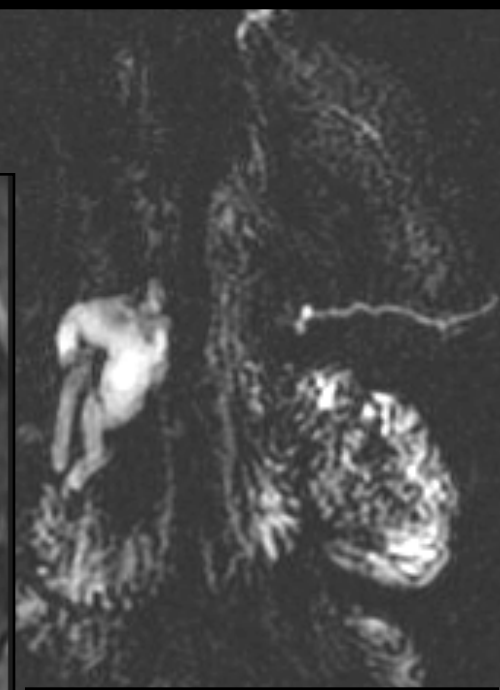
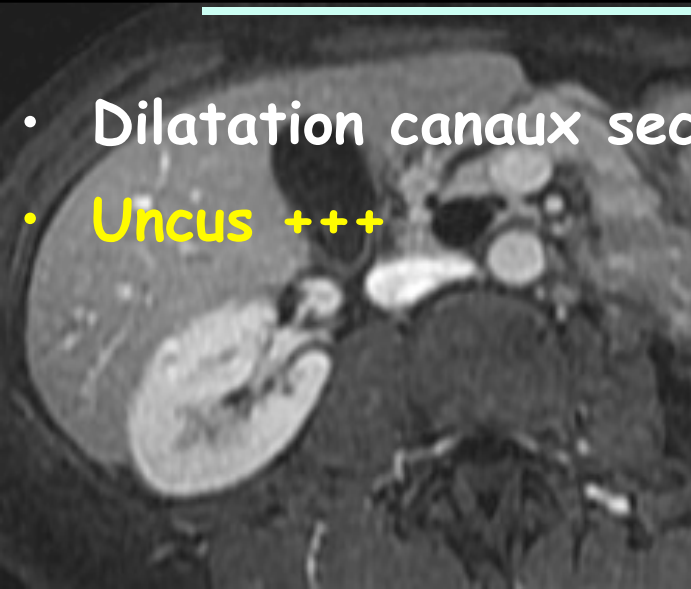
## branch duct

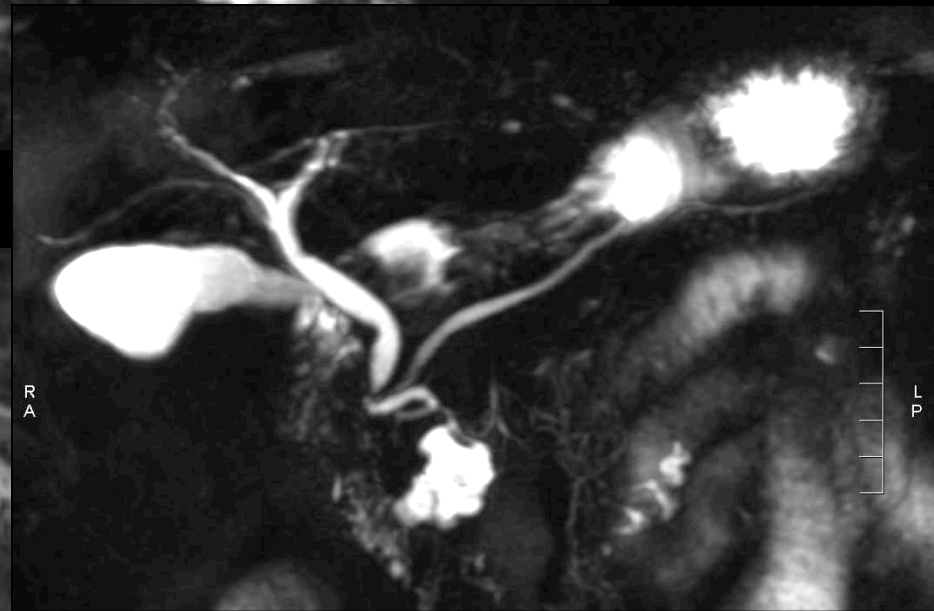
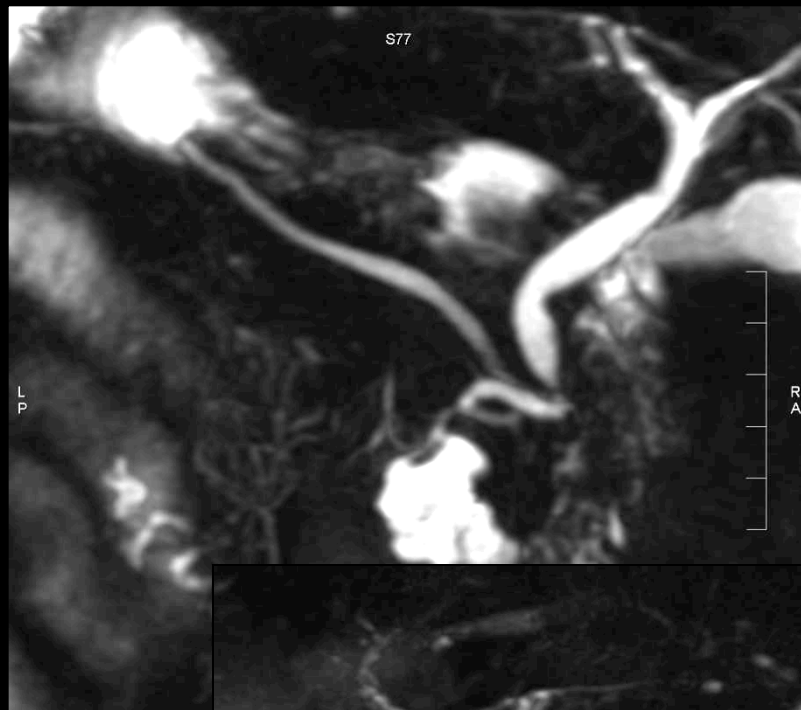
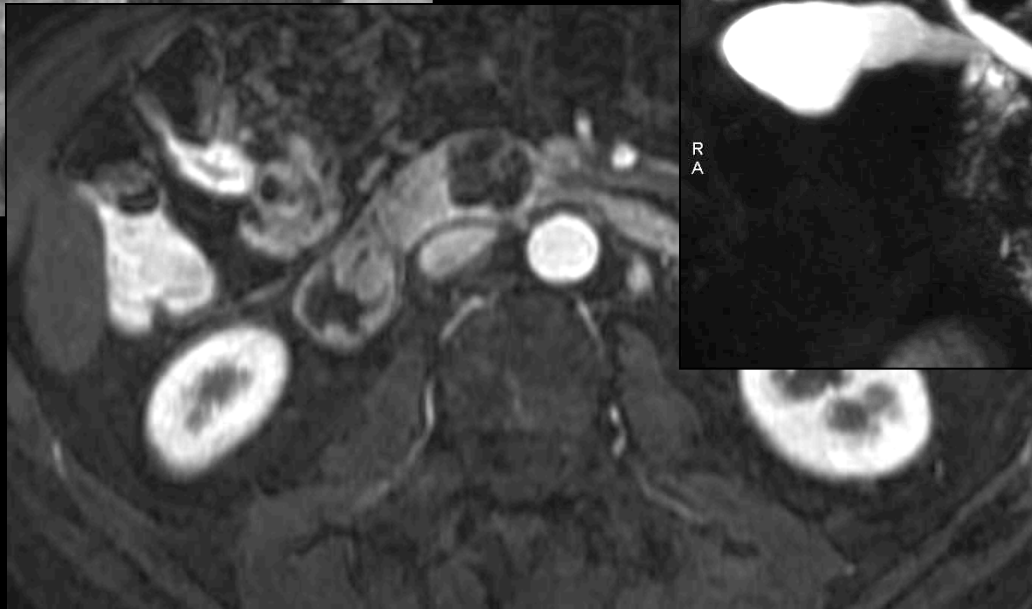
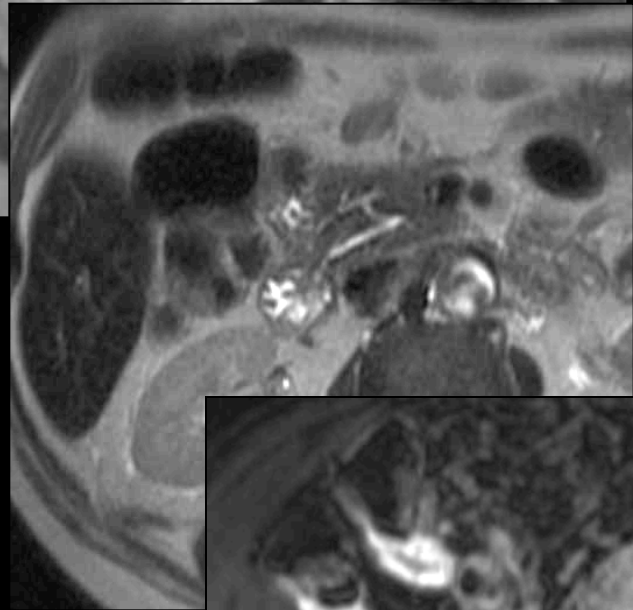
- communication entre canal prin
- bombement de la papille major
- excrétion de mucine
- nodules

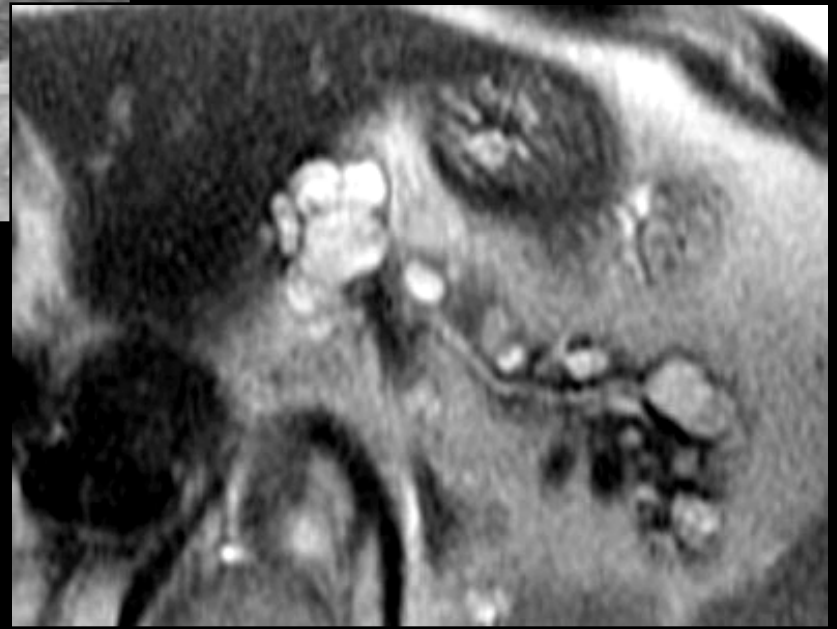
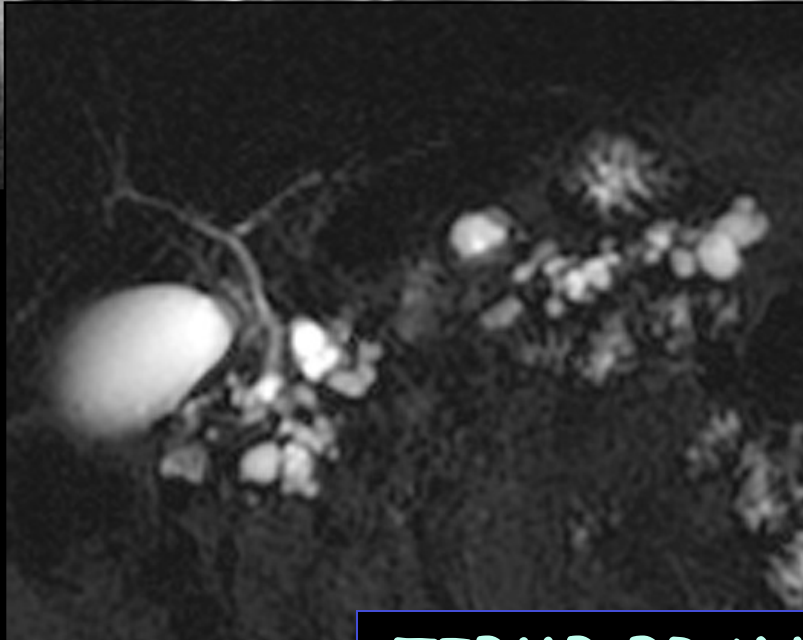
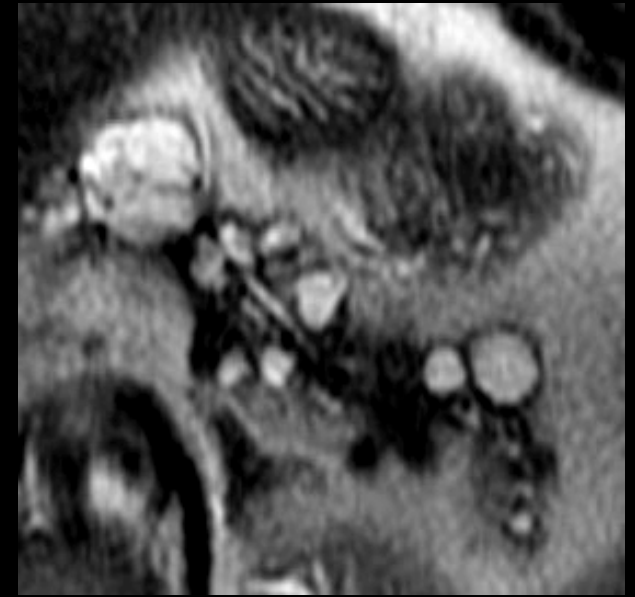
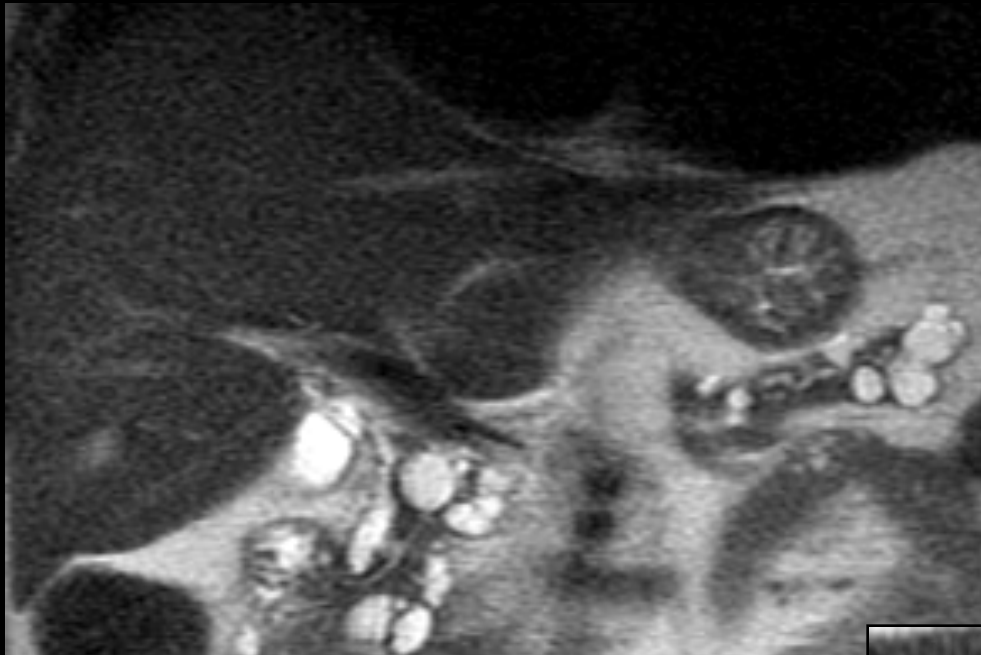


# Branch duct

- Dilatation canaux secondaires
- **Uncus +++**



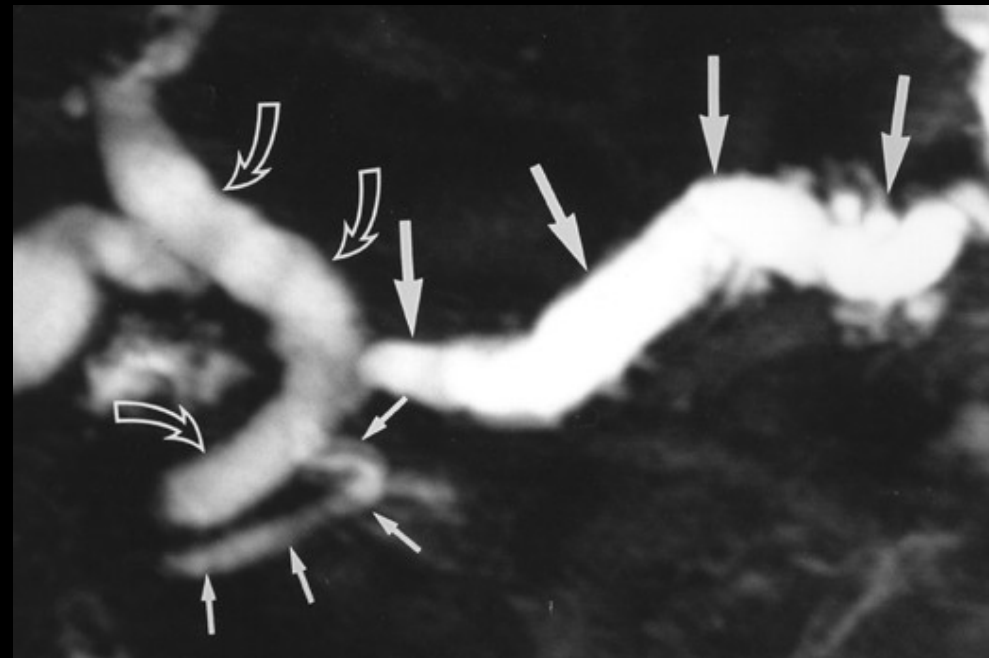
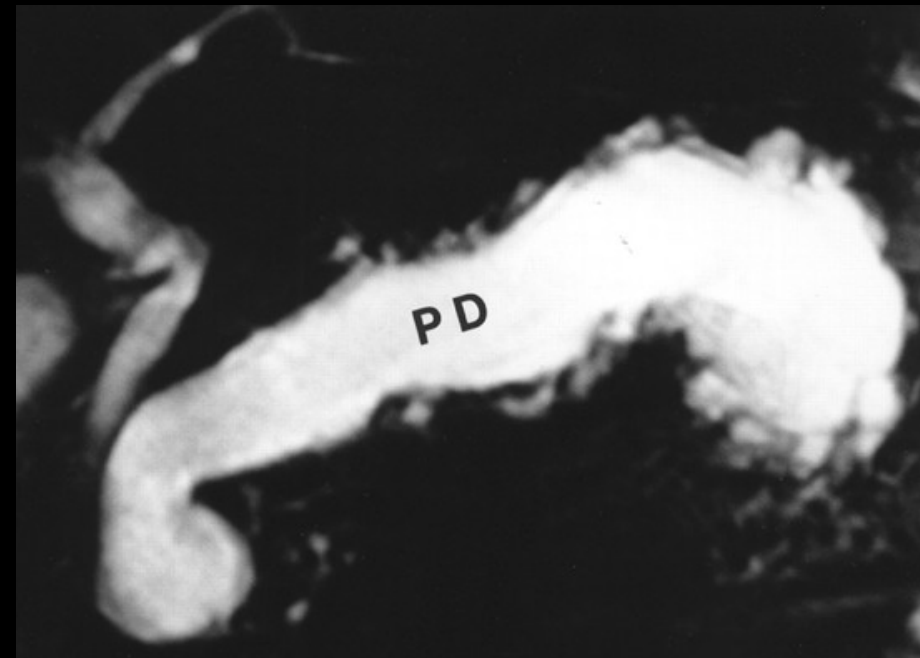




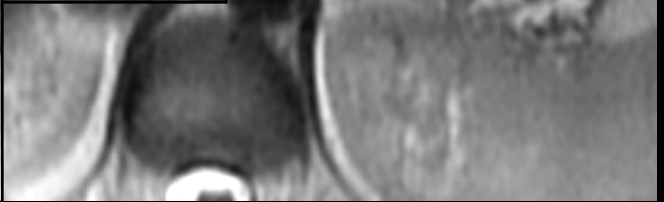
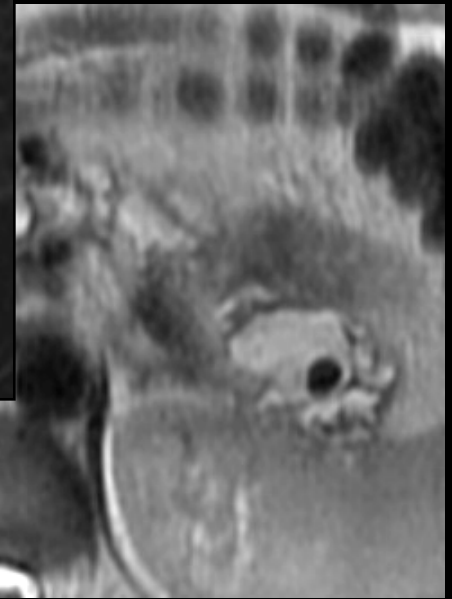
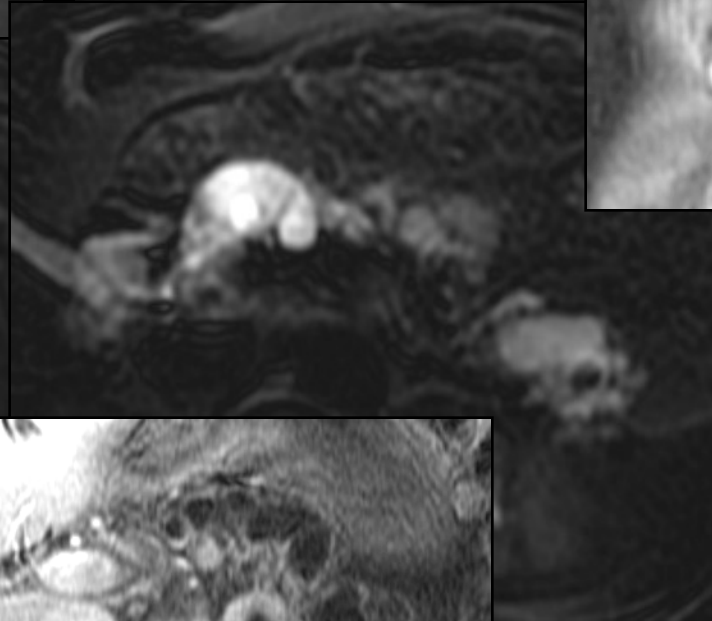
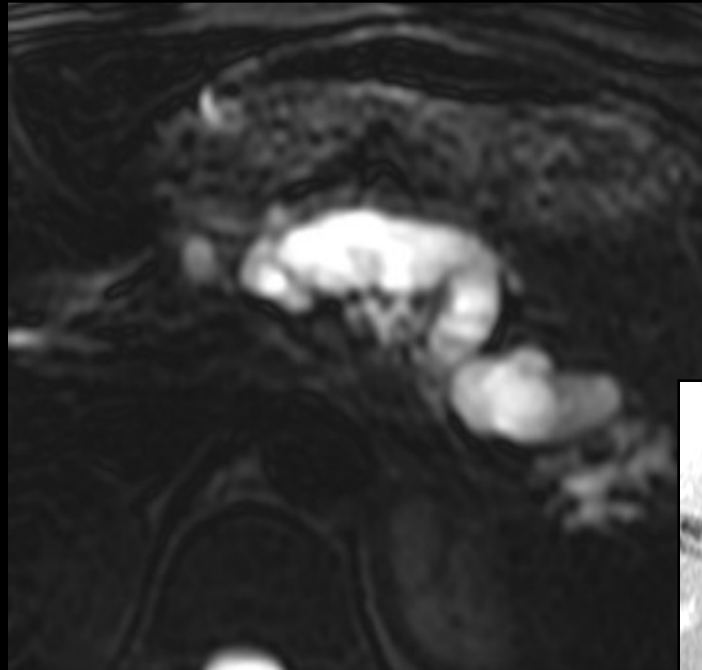
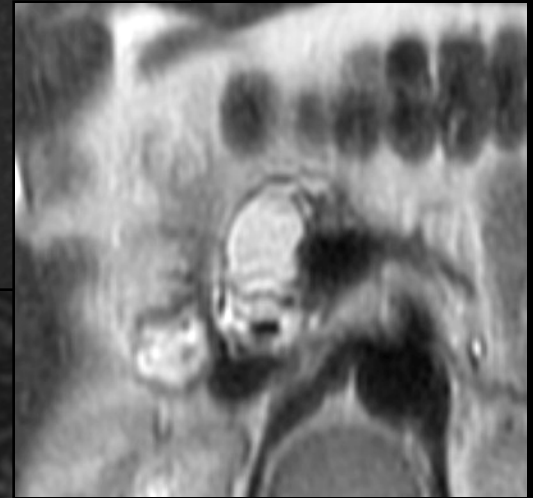
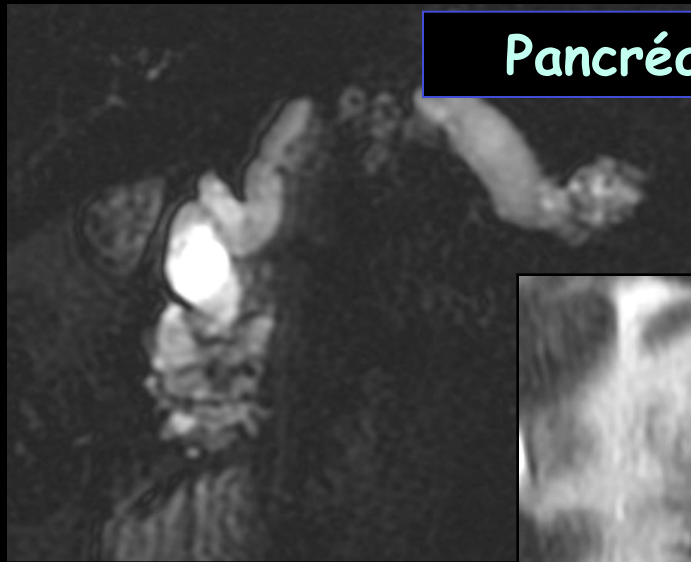
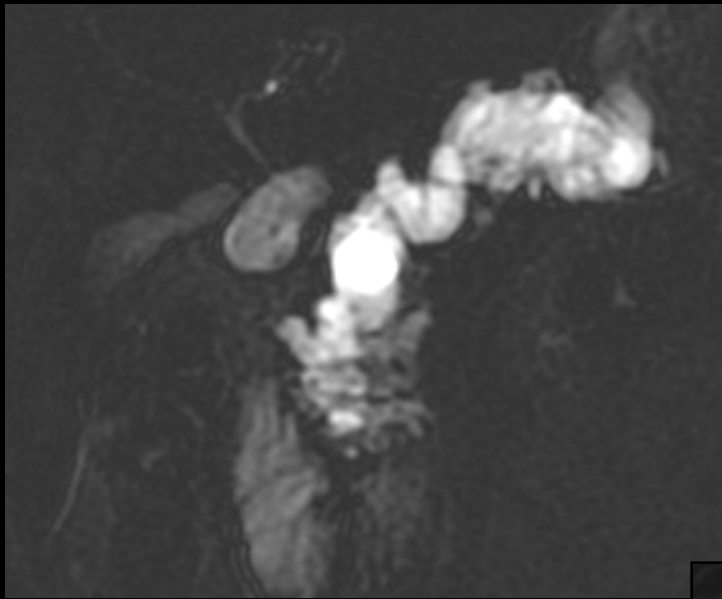
TIPMP BRANCH duct\*

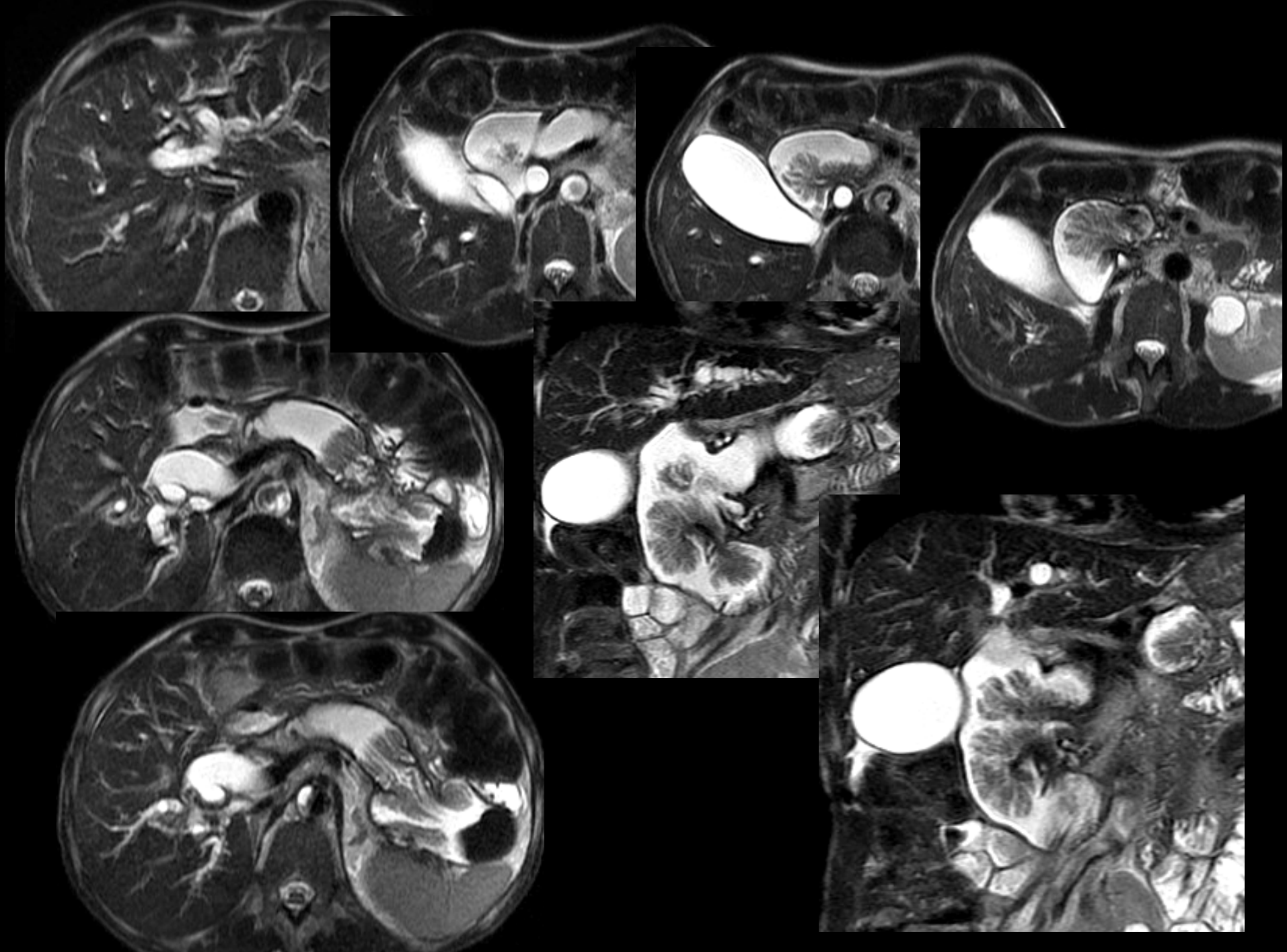
# Main duct

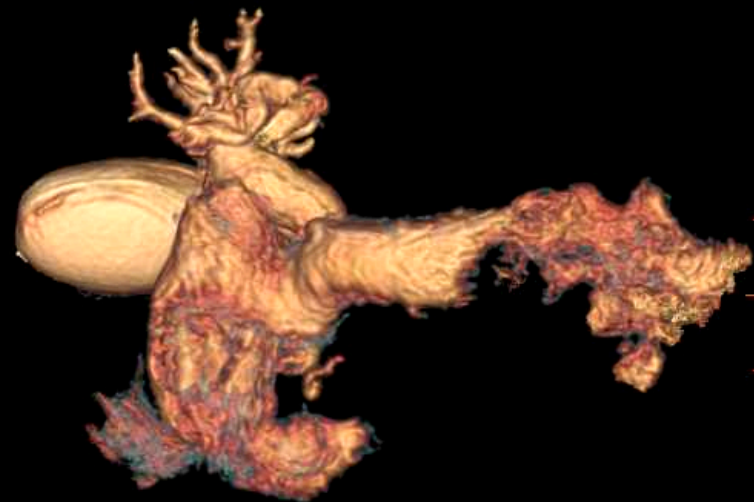
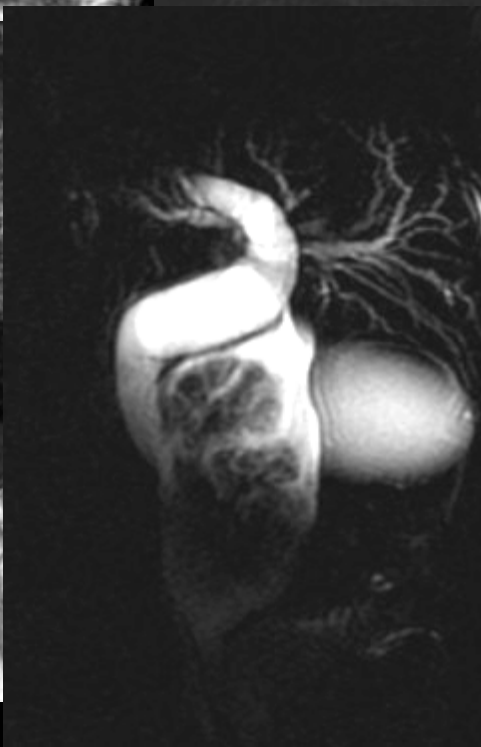
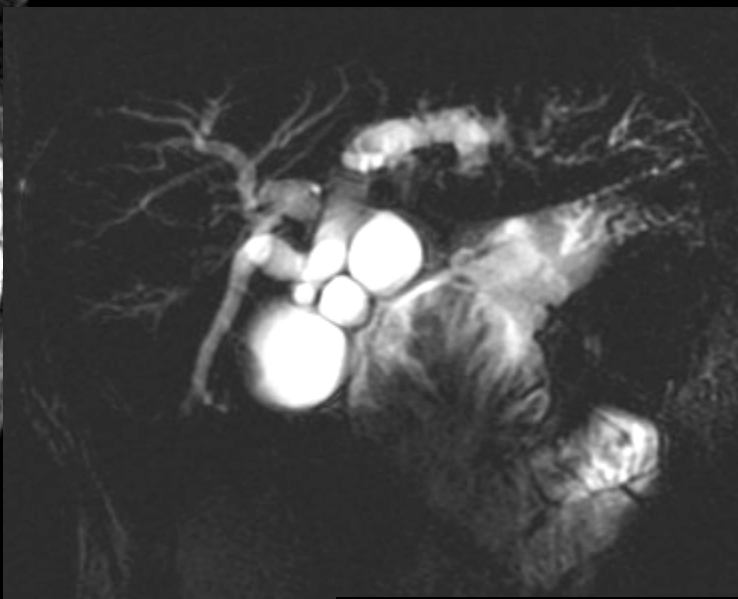
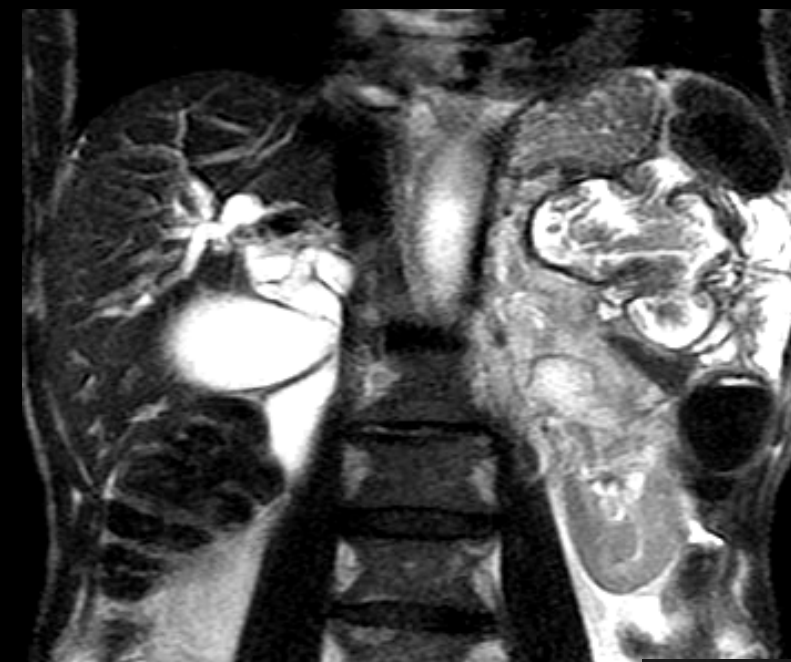
- Dilatation segmentaire / diffuse canaux principaux **SANS STENOSE**
- Ht risque de dégénérescence : 70% (contre 40% branch duct)
- Diagnostic différentiel : **pancréatite chronique\***

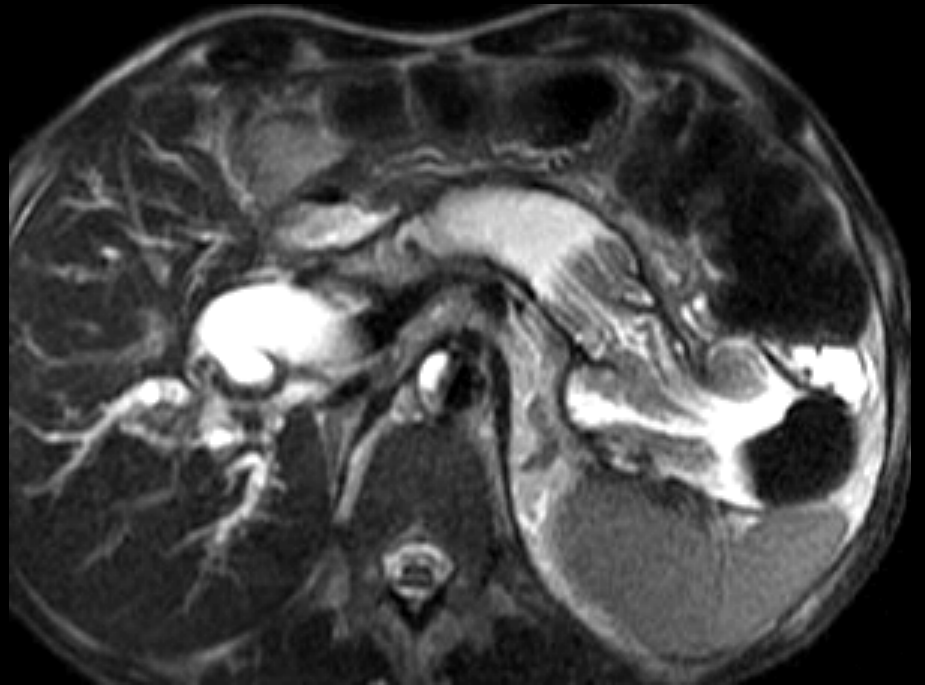
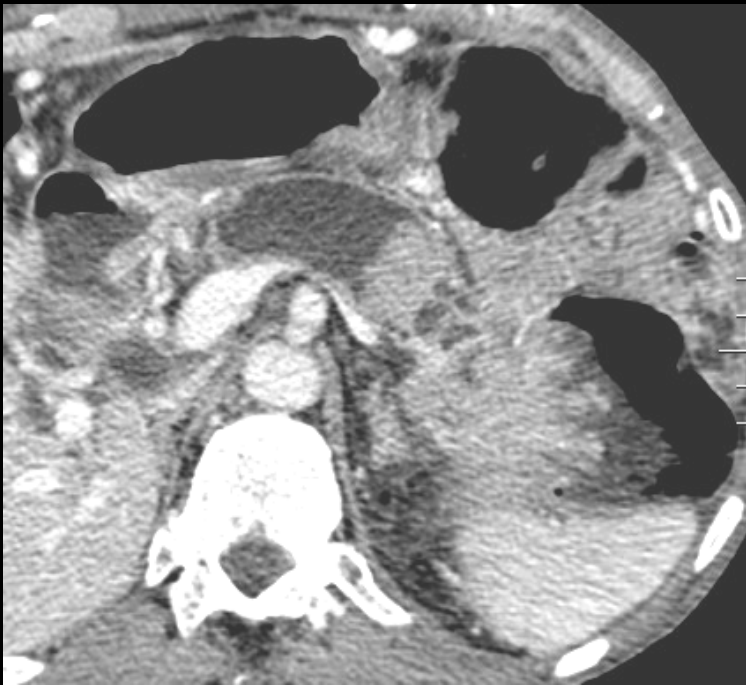


# Pancréatite chronique



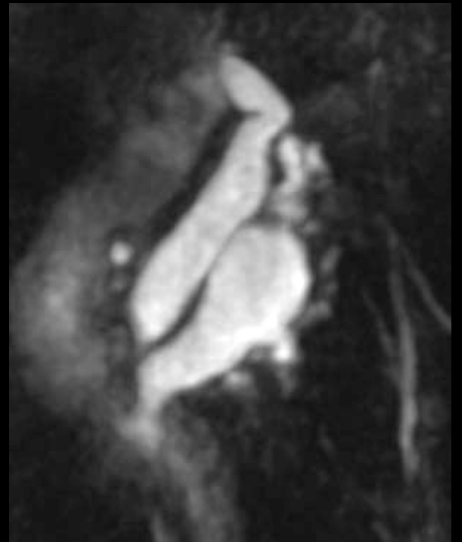
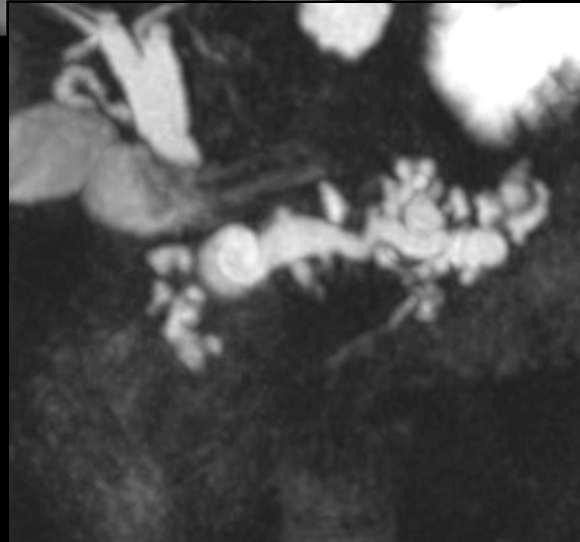
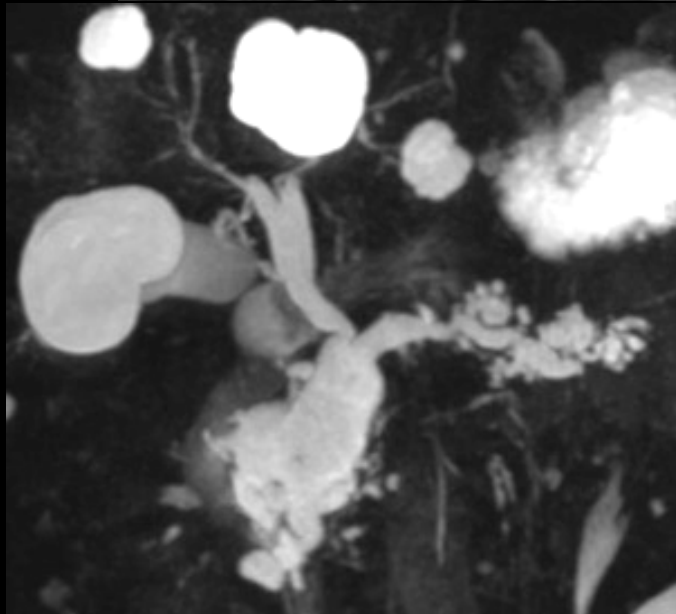
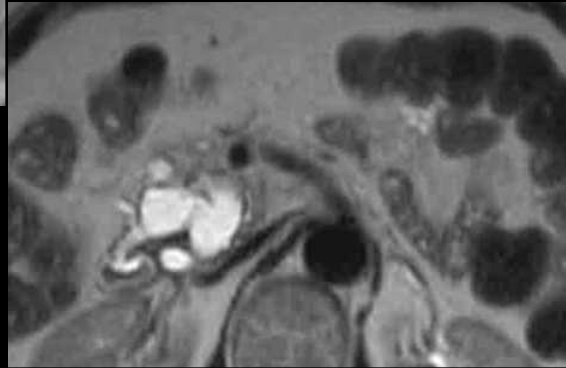
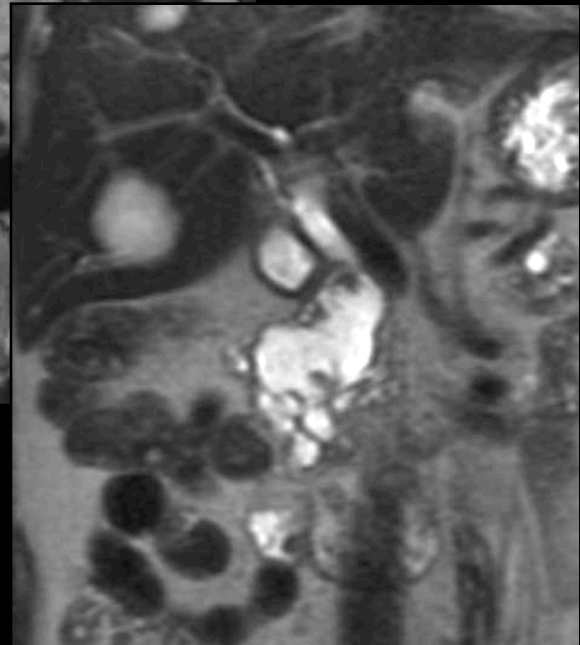
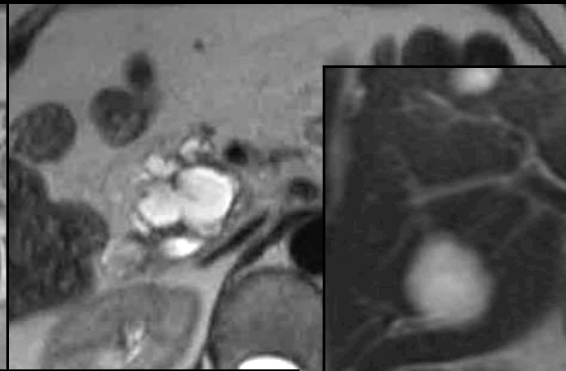
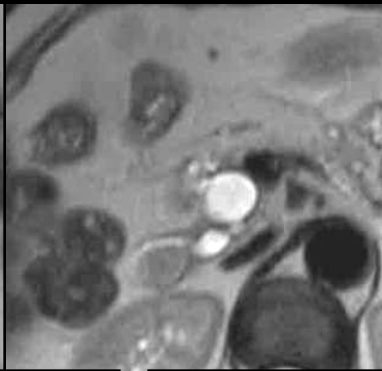


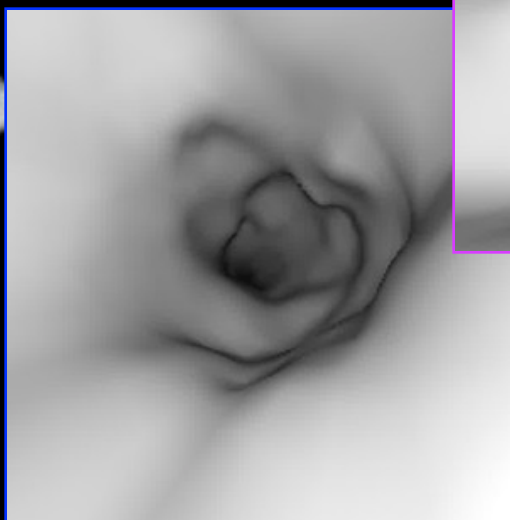
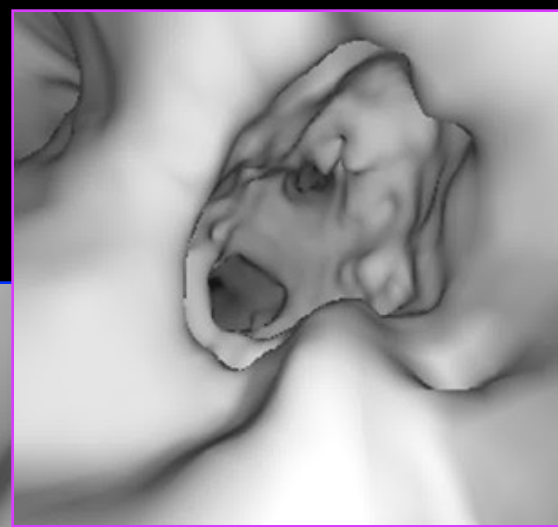
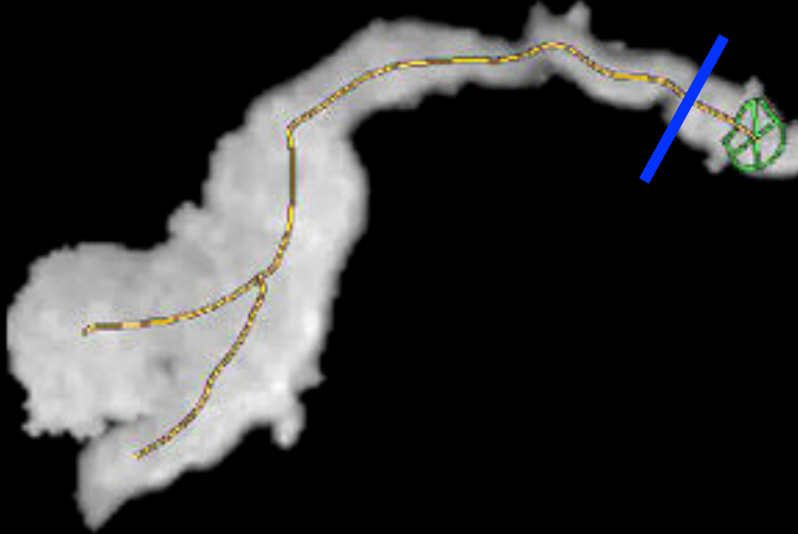
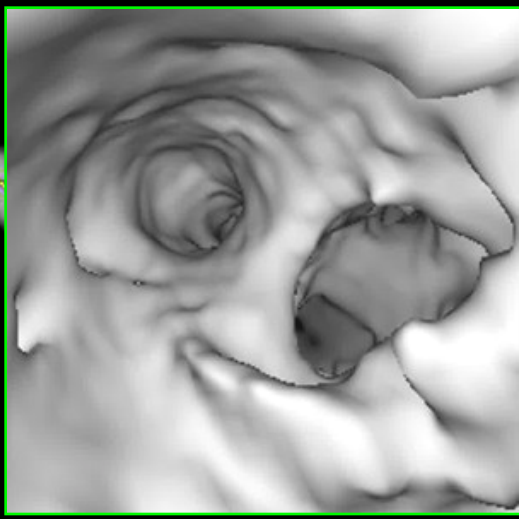
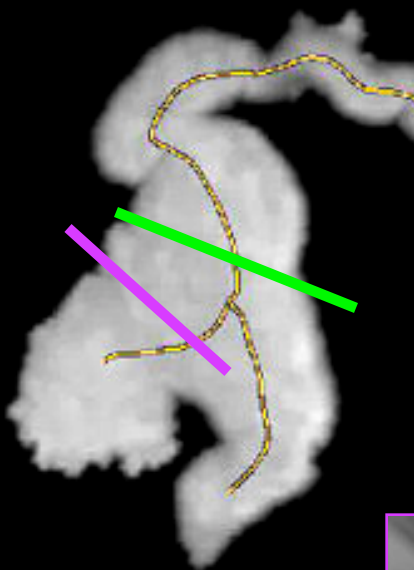
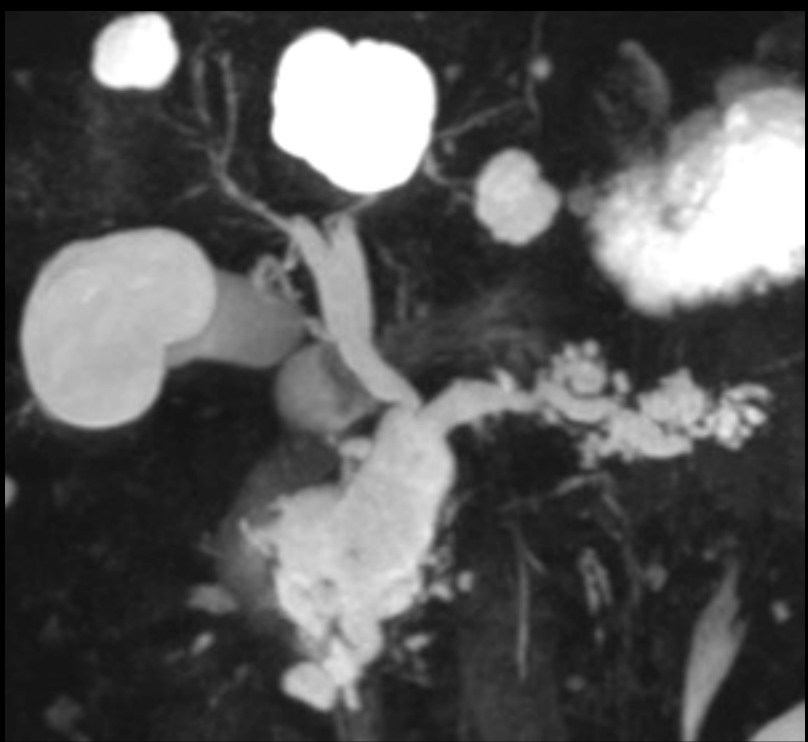


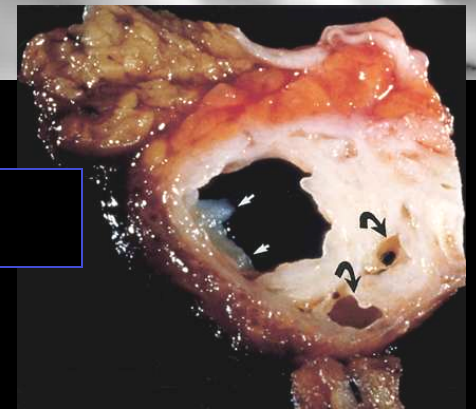
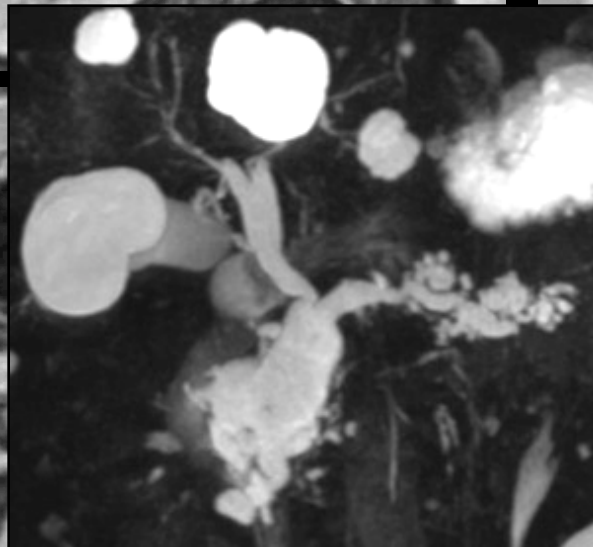
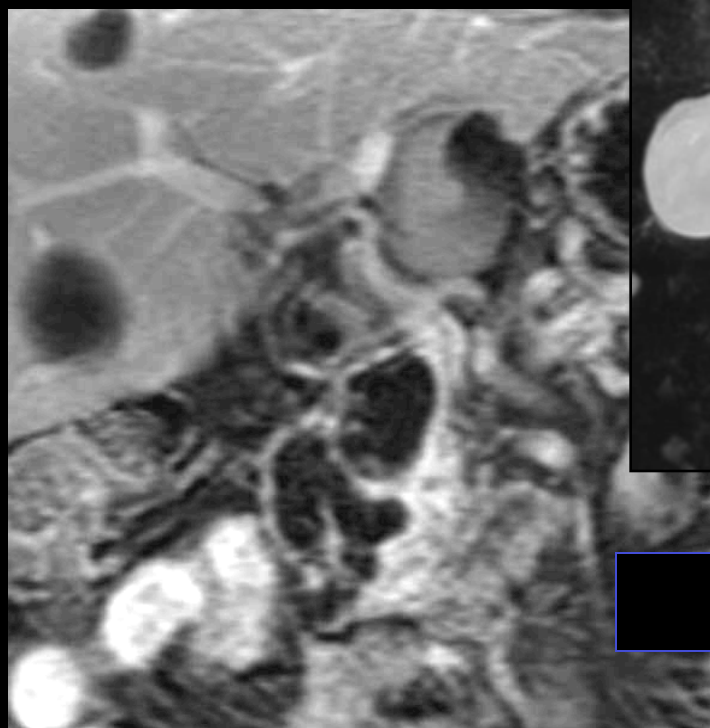
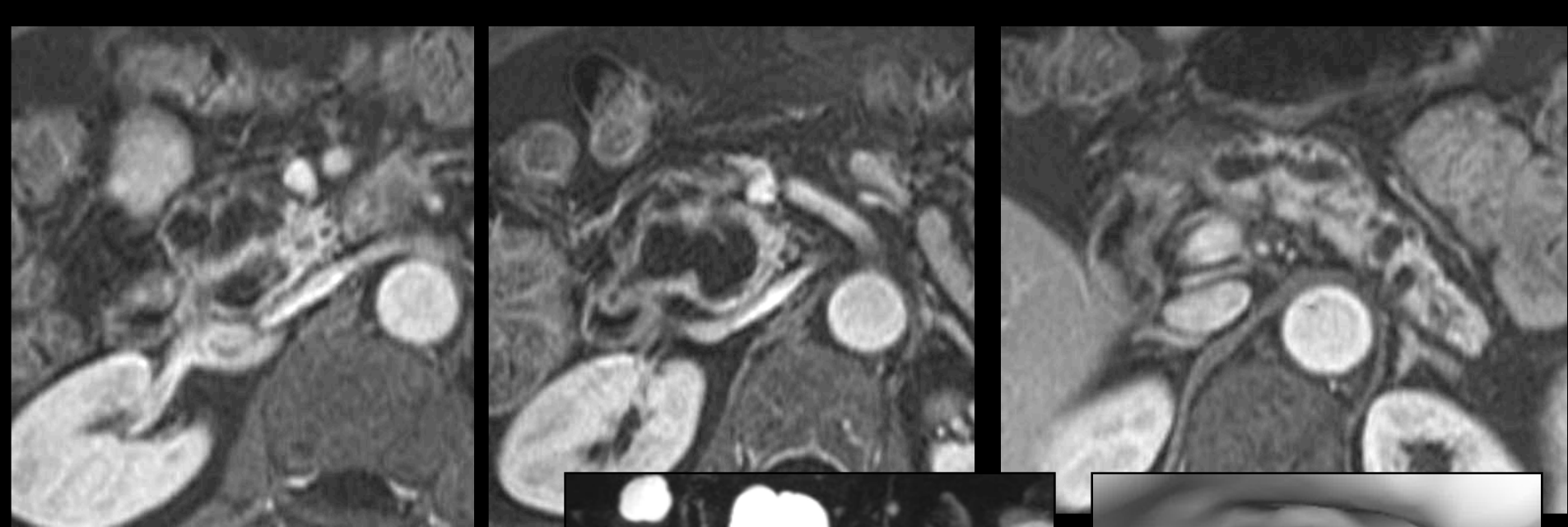


Carcinome intra-canalair papillaire mucineux étendu sur toute la longueur du Wirsung (7cm) avec double foyer d'invasion s'exprimant sous la forme d'une tumeur de 10 cm au niveau de l'ampoule et de 6.5 cm au niveau de la queue. Fistulisation à l'angle colique gauche avec bourgeon endoluminal. Stade pT4NOMx





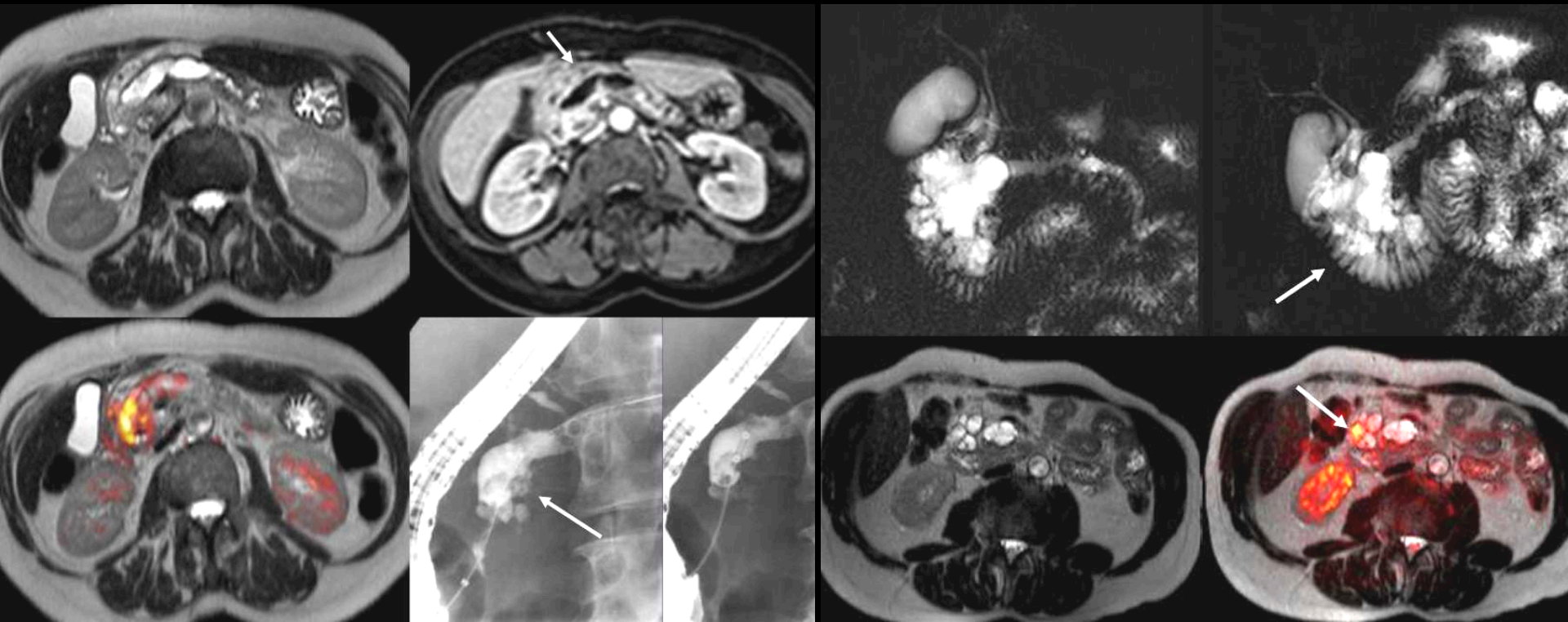




TIPMP F combinée

# Protocole d'exploration

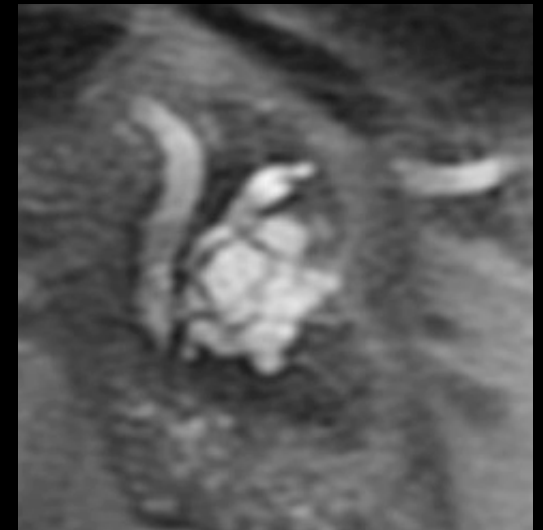
- Séquence de diffusion : Celso Matos JFR 2009



TIPMP

# TIPMP CRITÉRES DE MALIGNITÉ\*

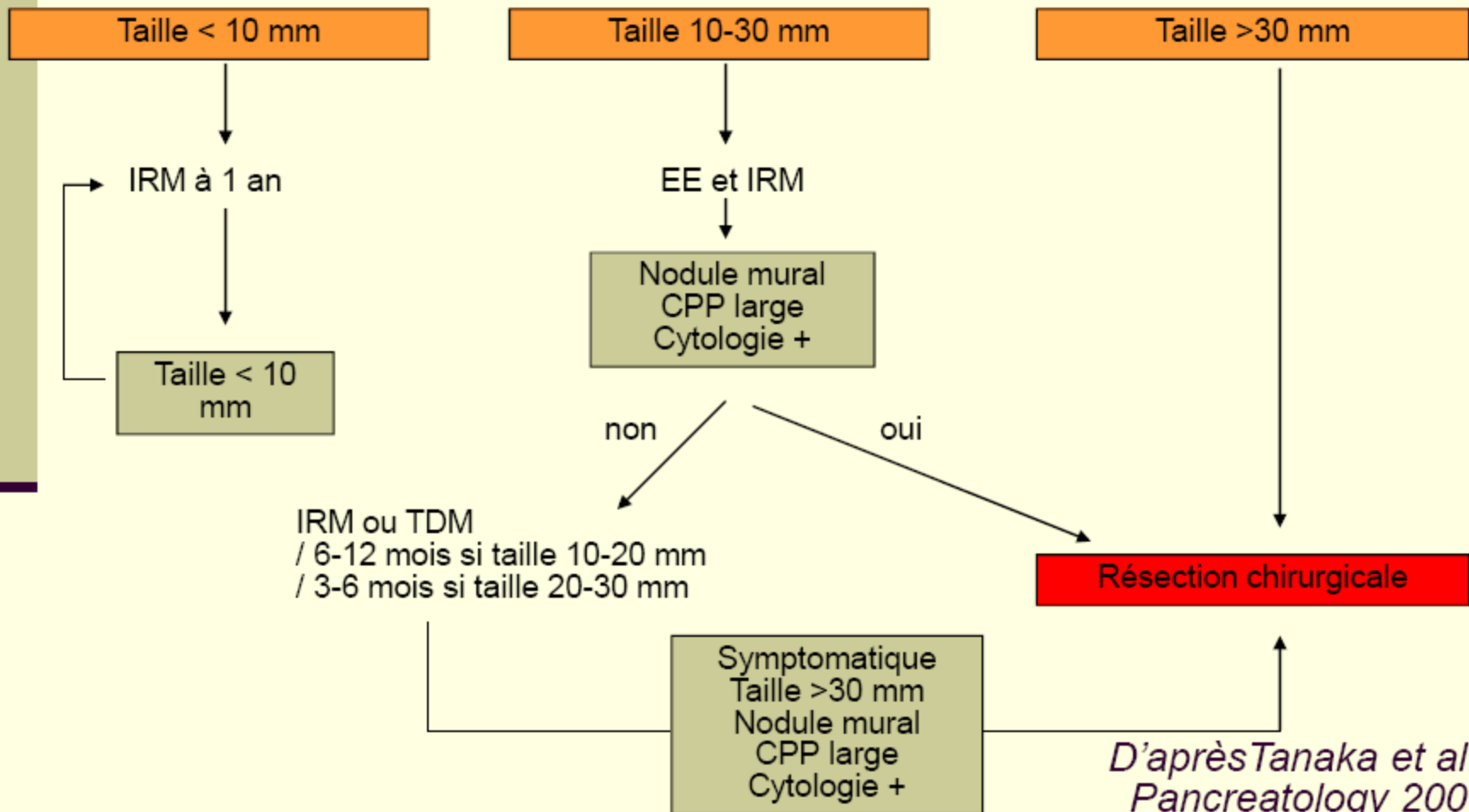
- Nodules
- Branch duct
  - Kyste ( $\geq 30$  mm)
  - symptomatique
- Masse infiltrante = aspect ADK
- Sténose de la VBP
- (Calcifications +++)



Radiology 238 : 560-569 / Fev 2006

Suyama M, Br J Surg 2003

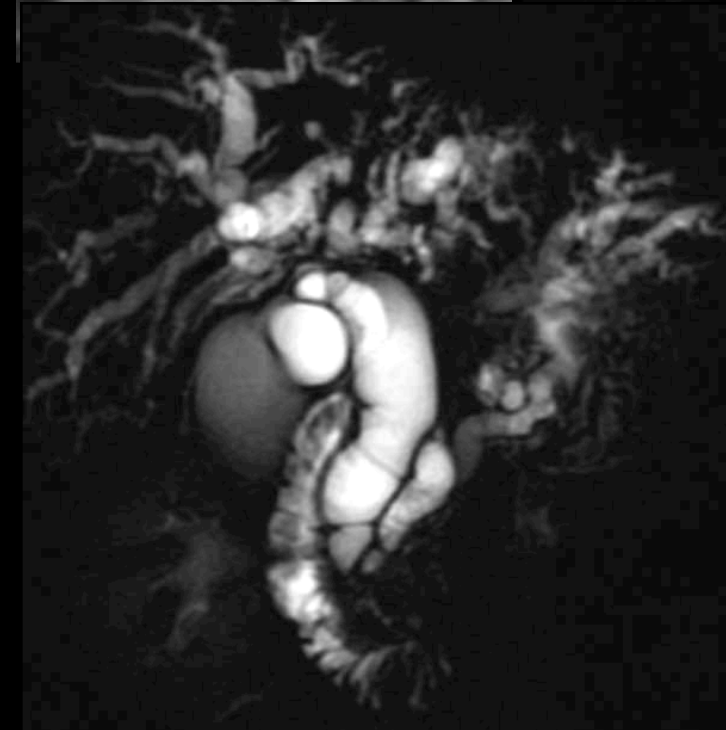
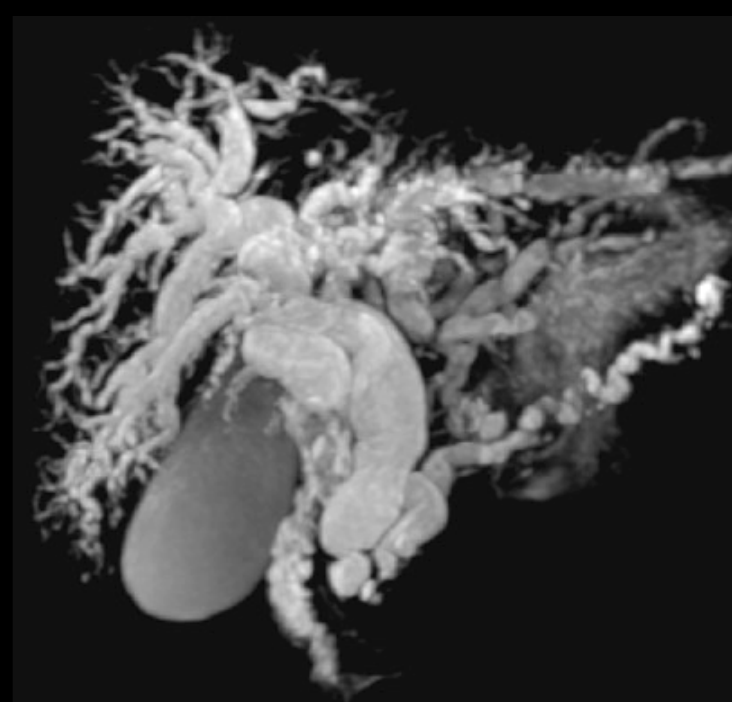
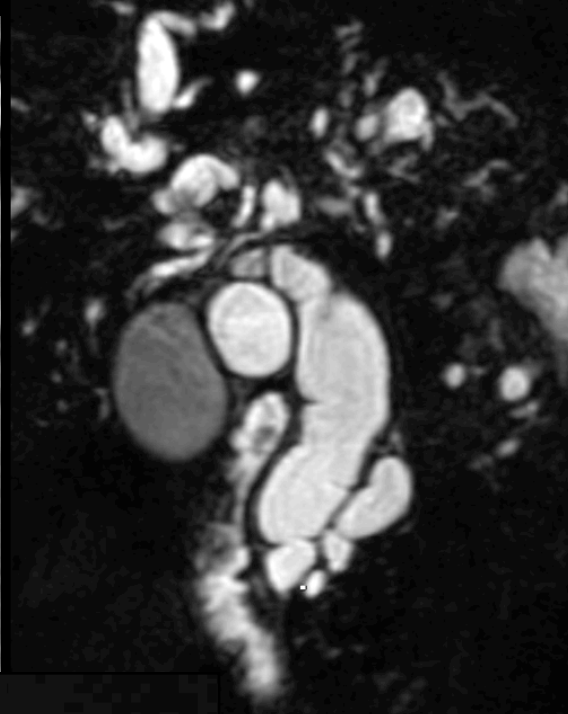
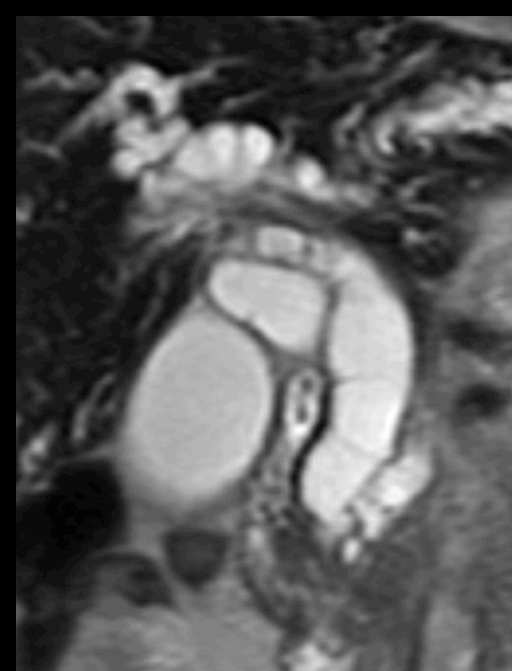
# Branch duct : Conférence consensus Japon, IAP

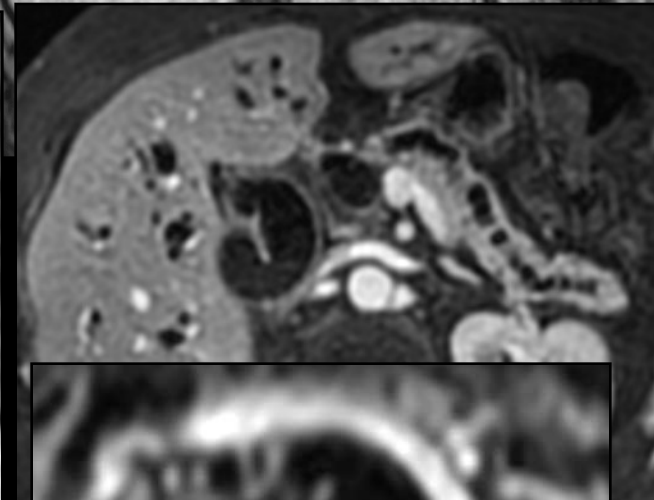
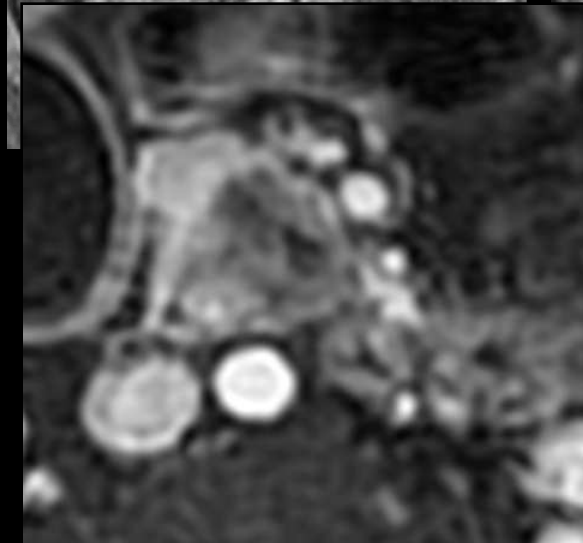
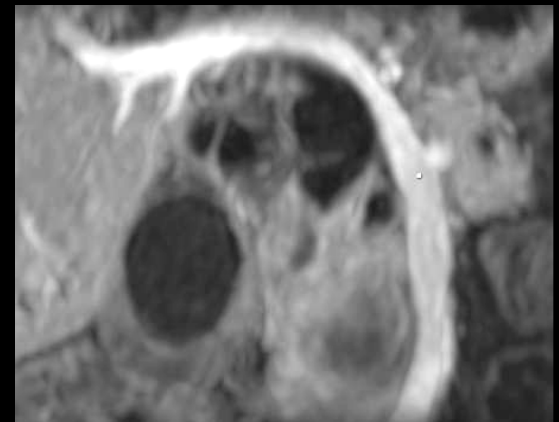
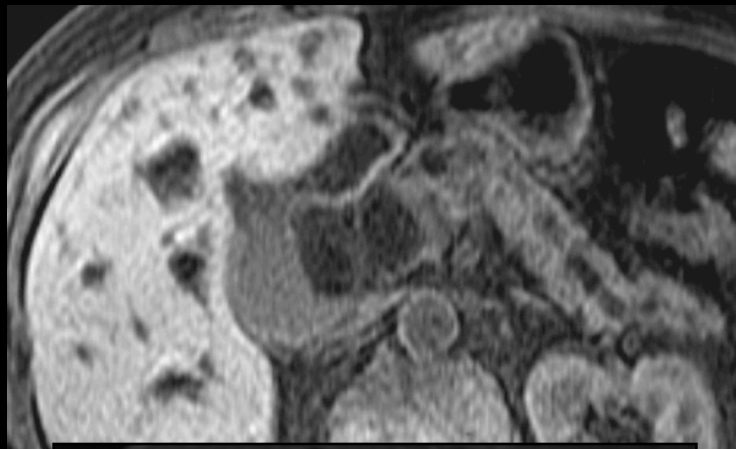


*D'après Tanaka et al.,  
Pancreatology 2006*

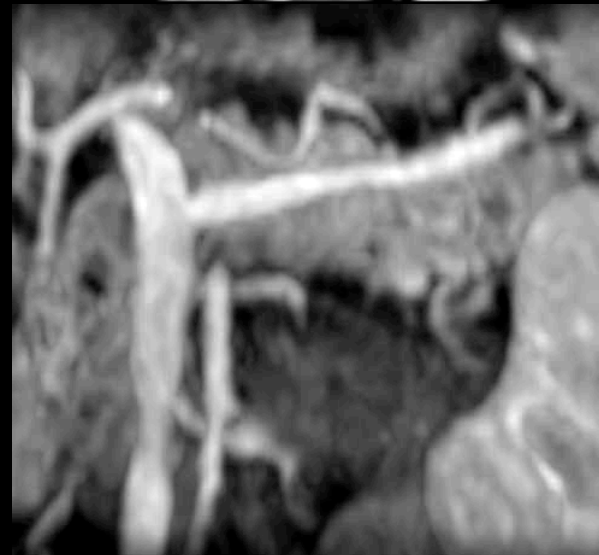
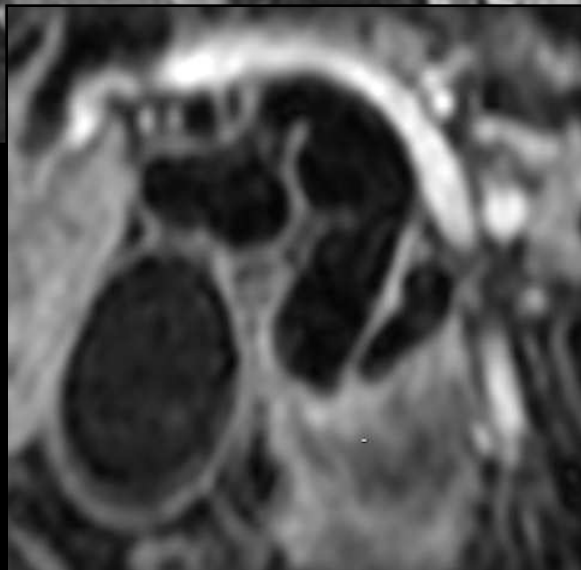
# LESIONS SOLIDES\*

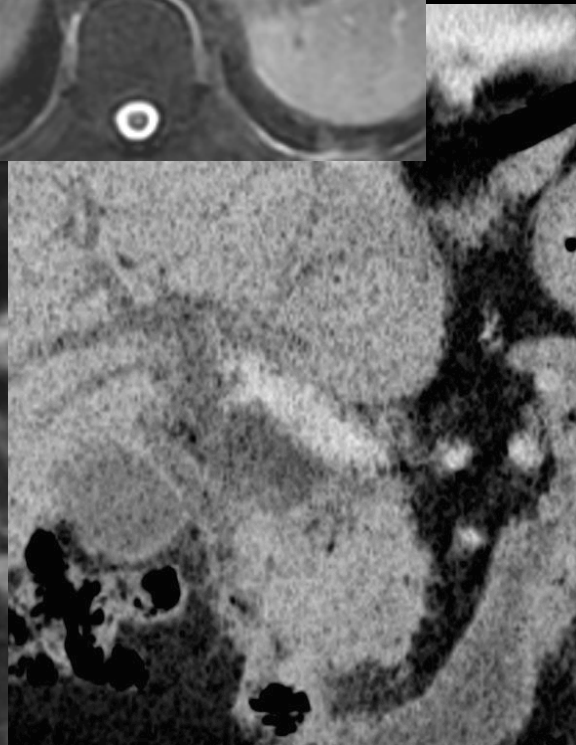
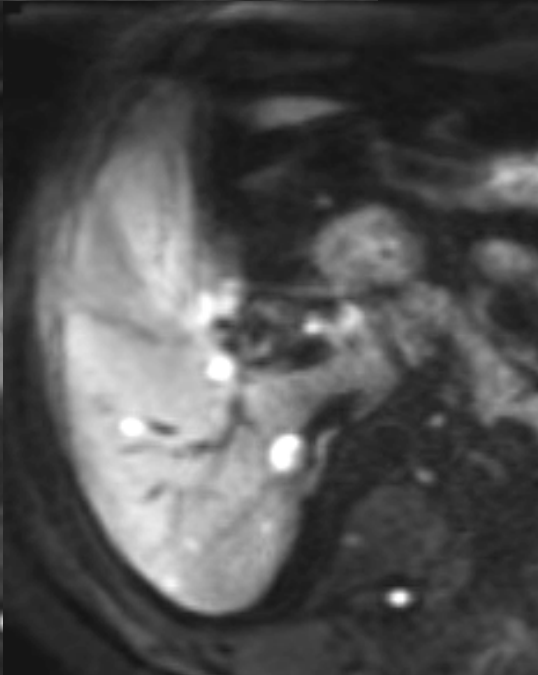
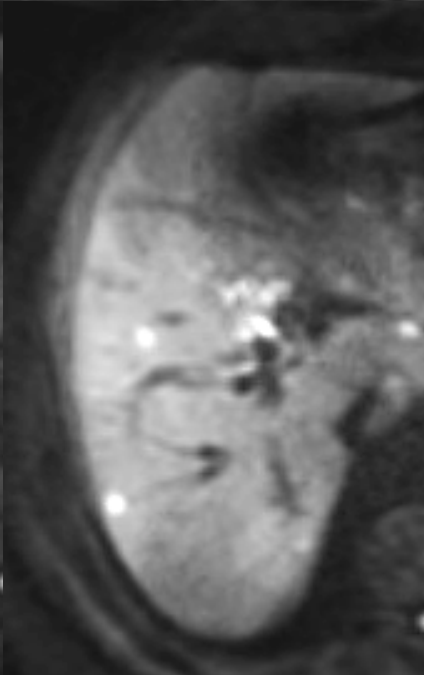
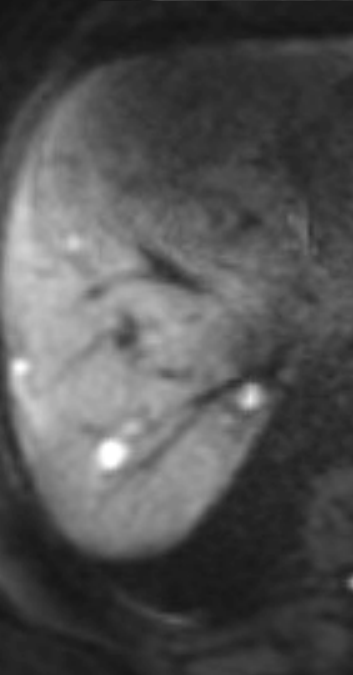
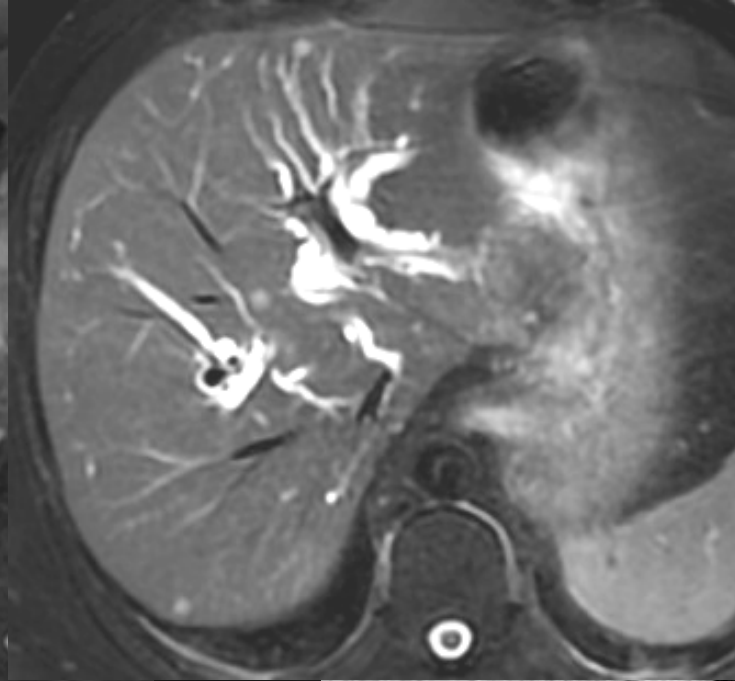
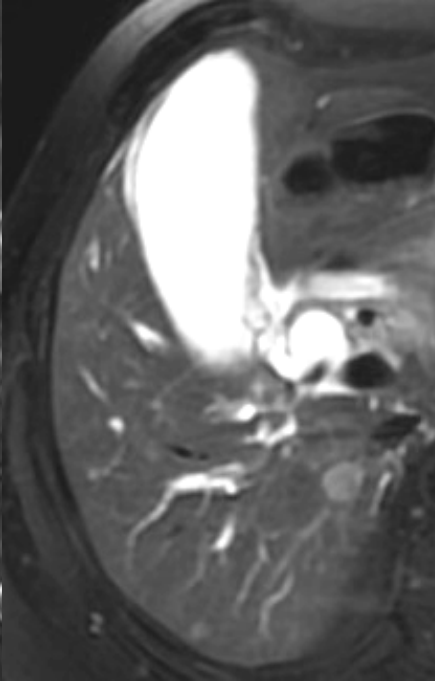
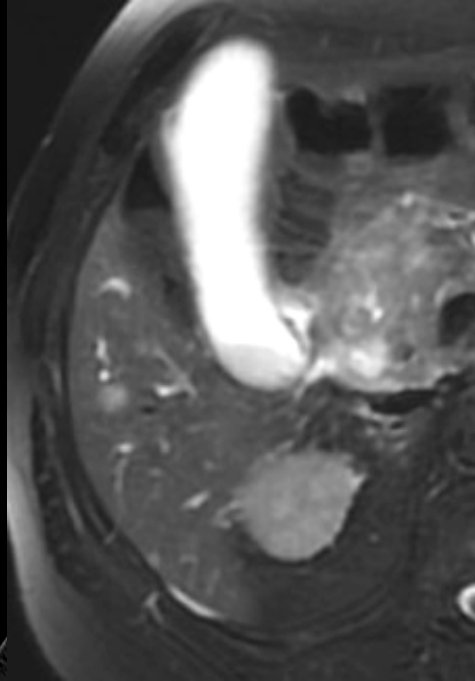
- Adénocarcinome
- Tumeurs neuro-endocrines
- Métastases\*

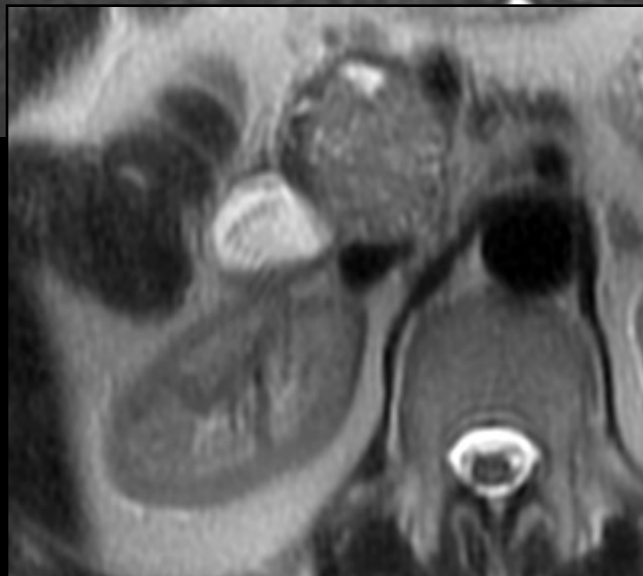
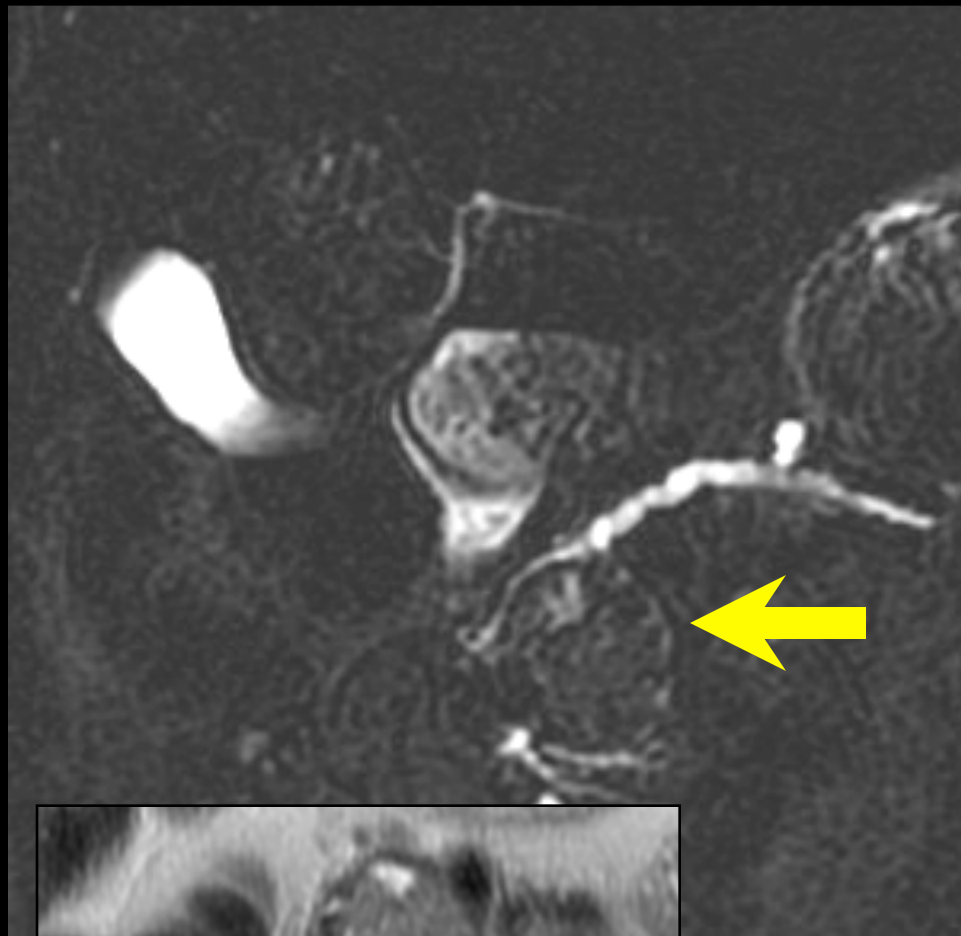
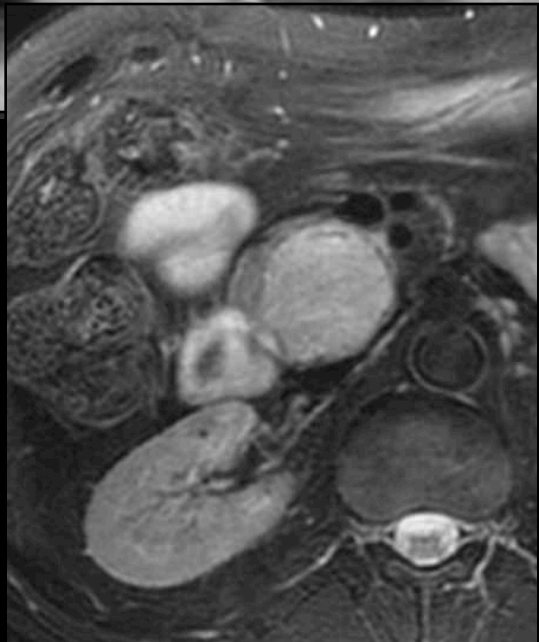


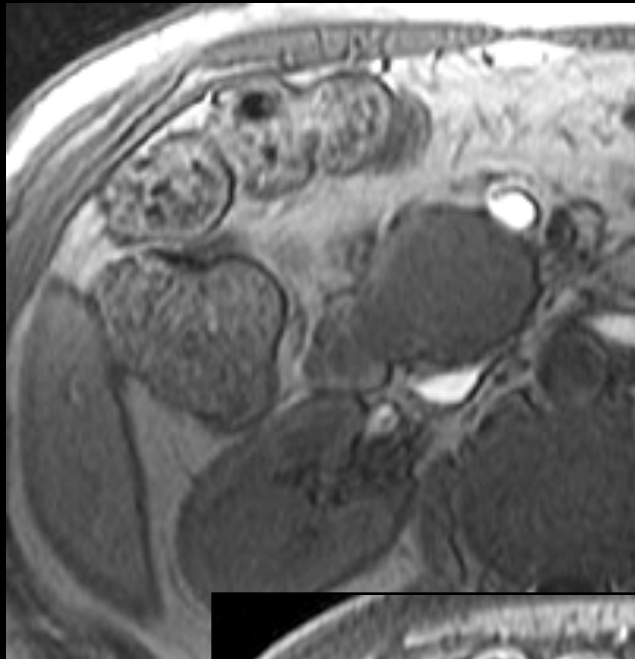


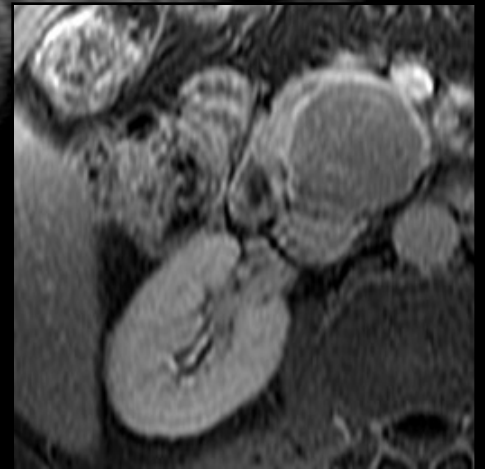
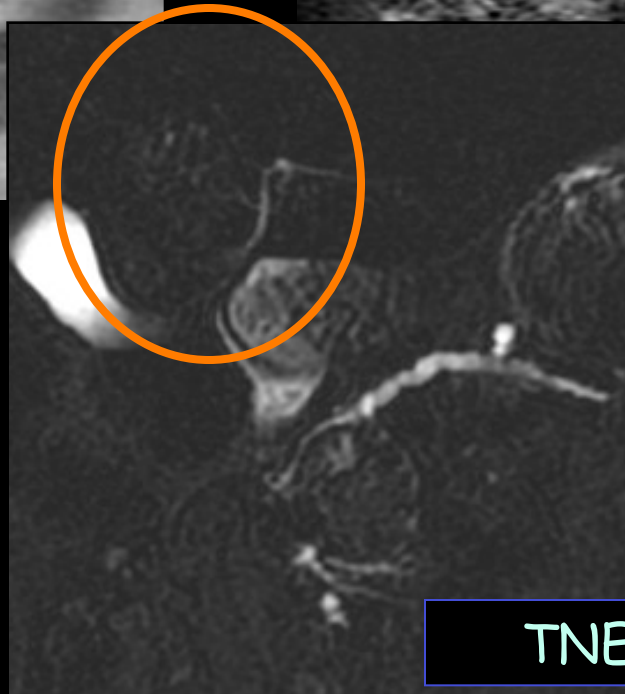
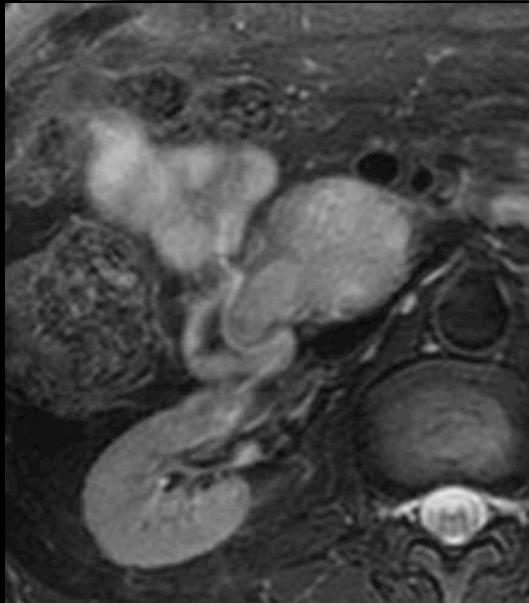
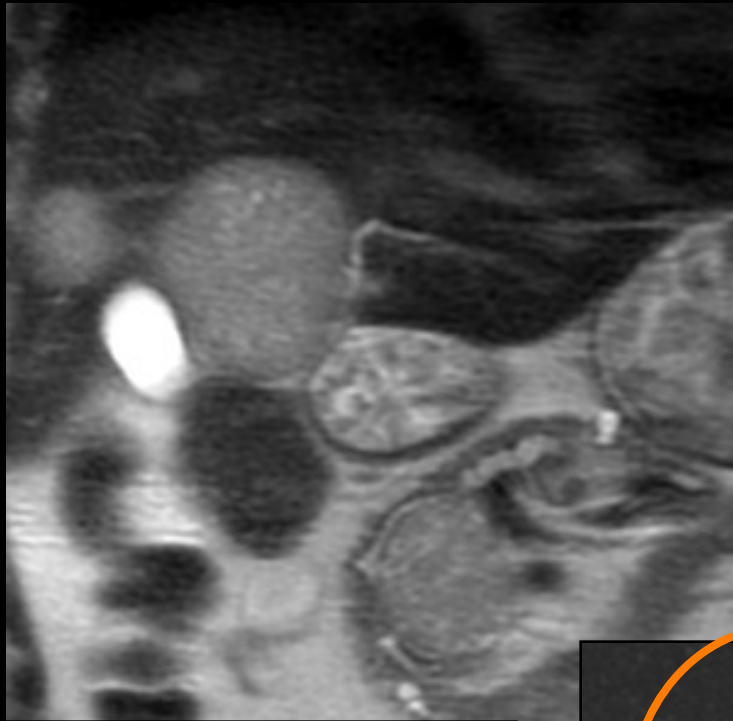
ADK céphalique



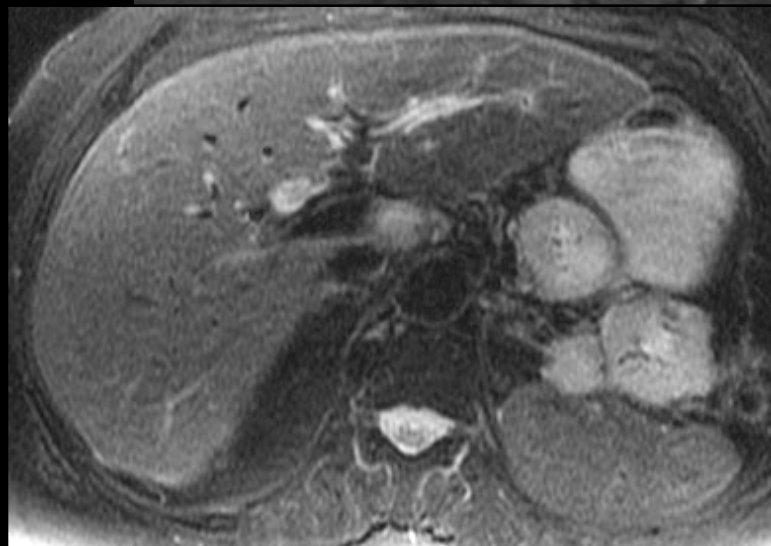
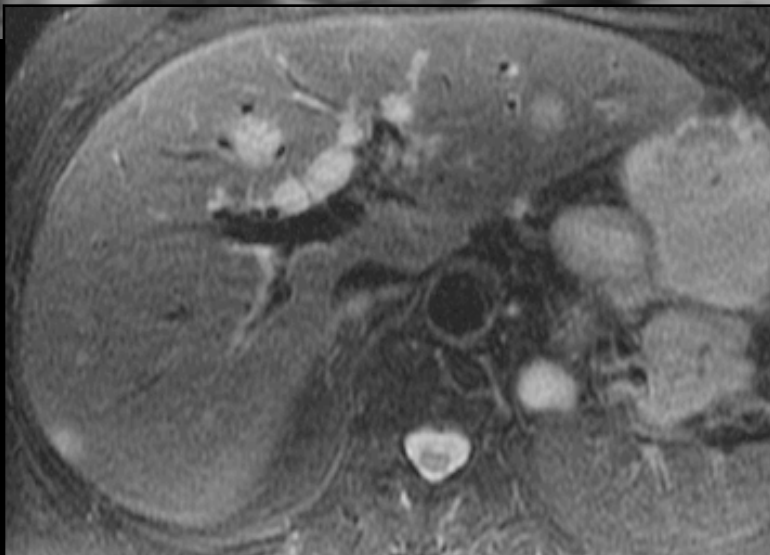
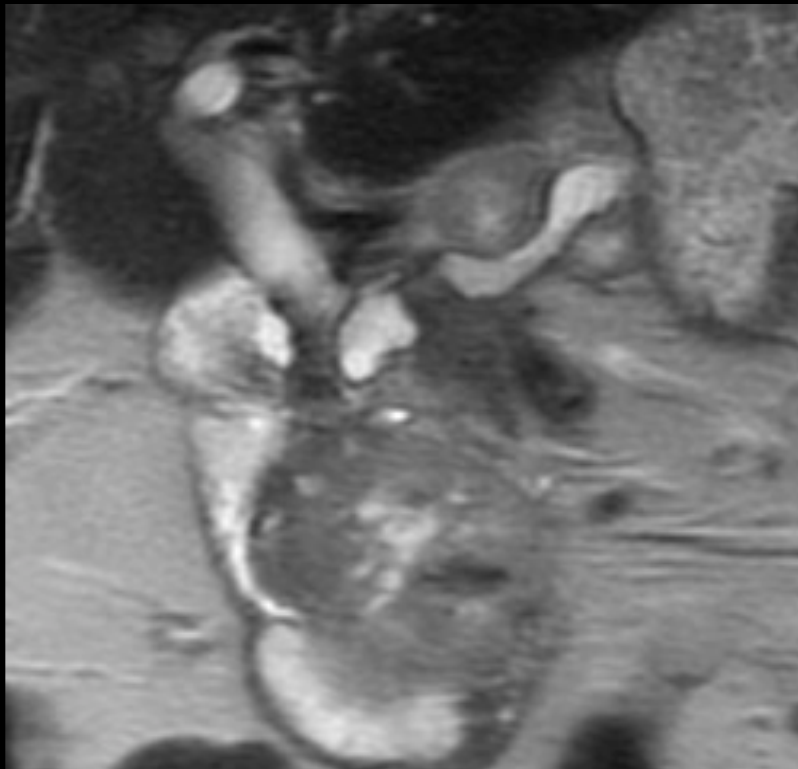




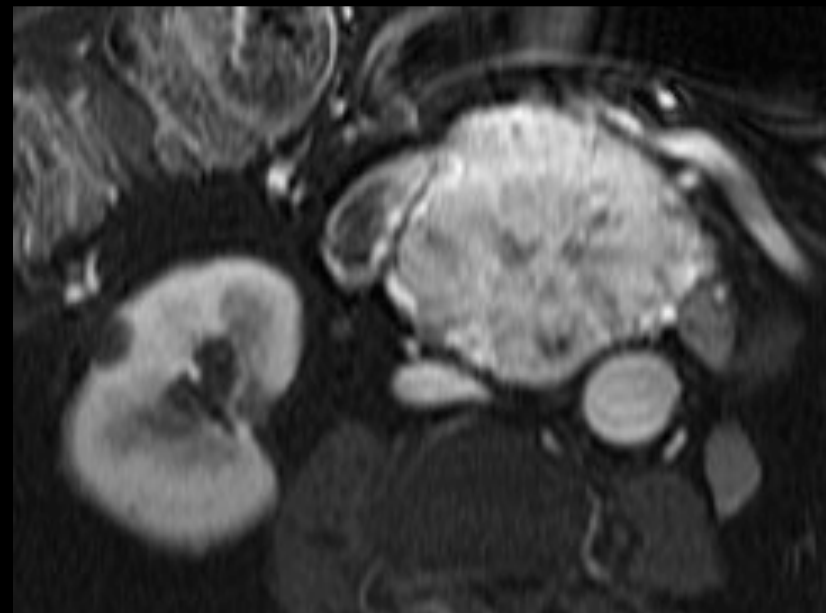
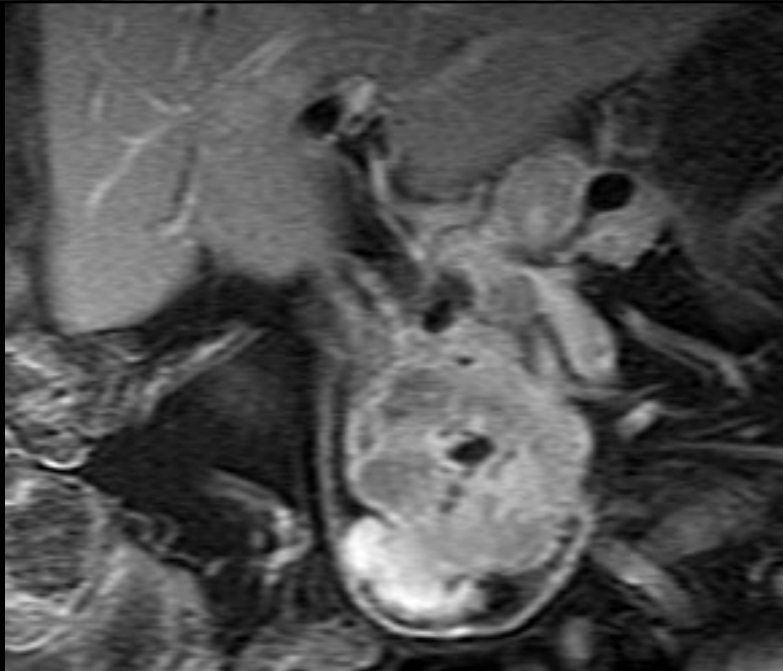
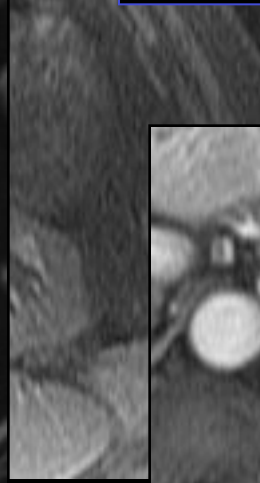
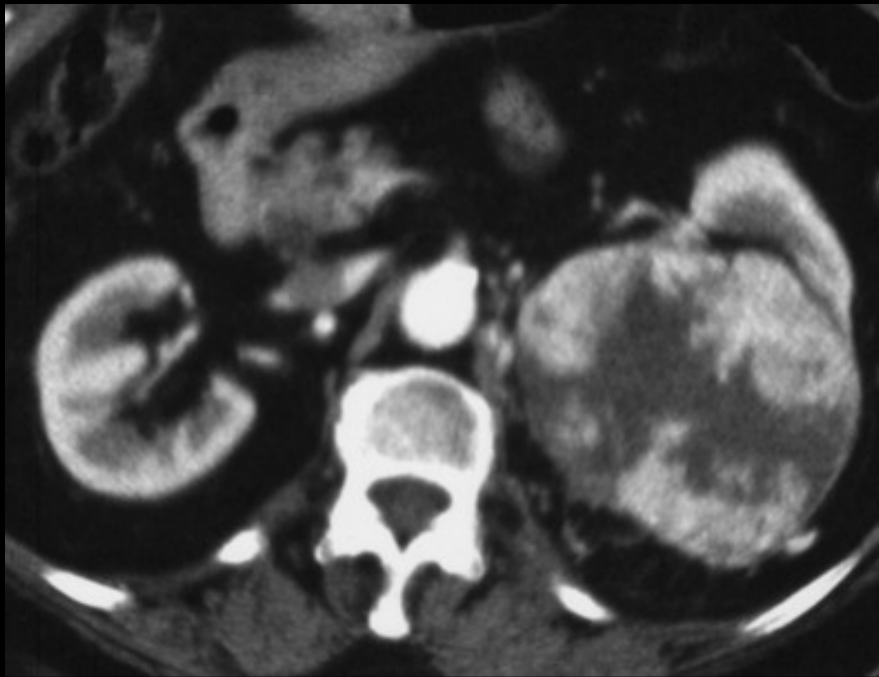




TNE non fonctionnelle \*



# Métastases de Grawitz

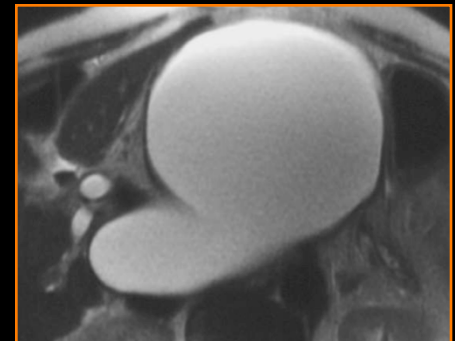
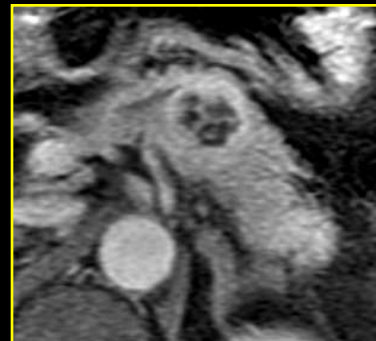
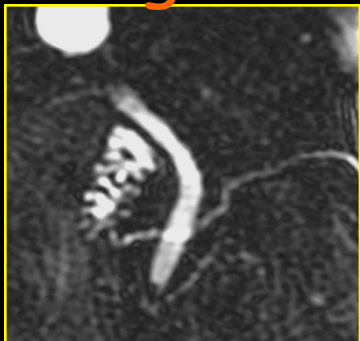
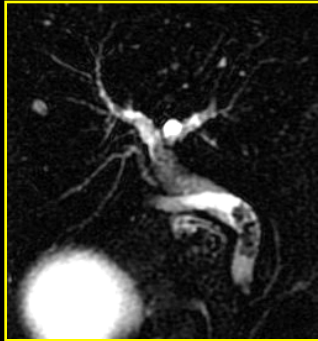
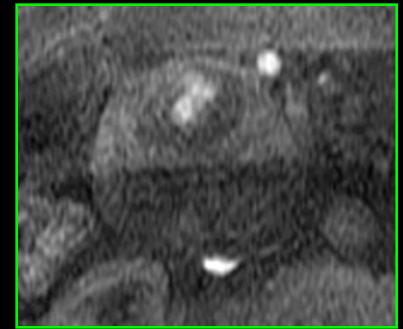
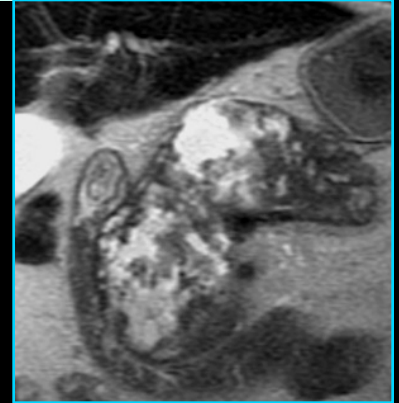


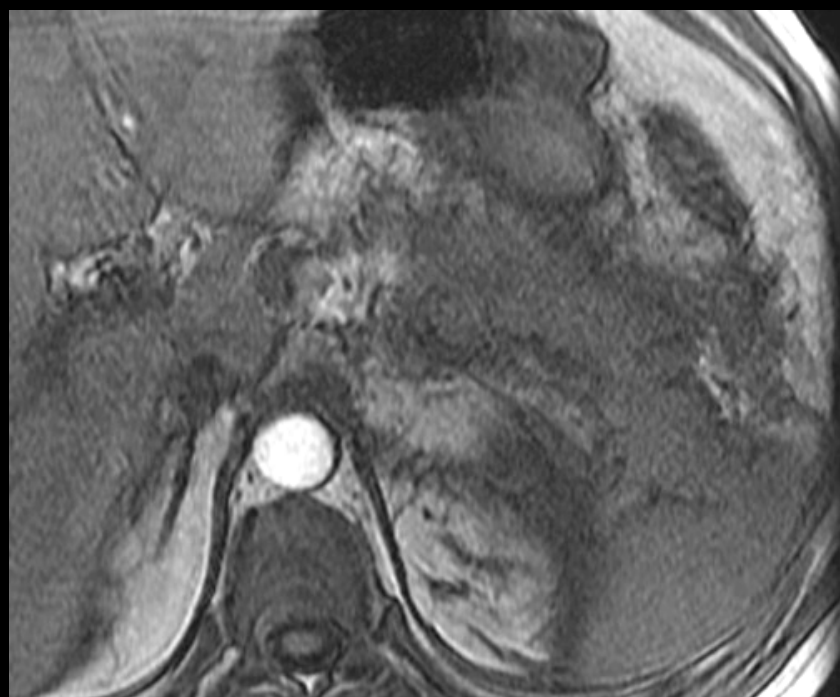
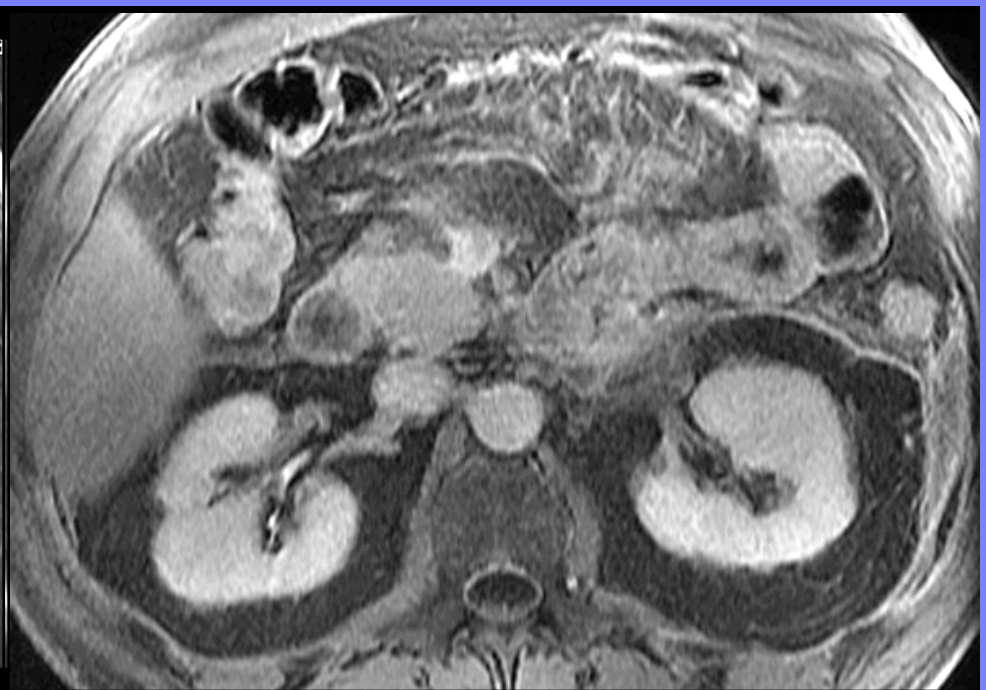
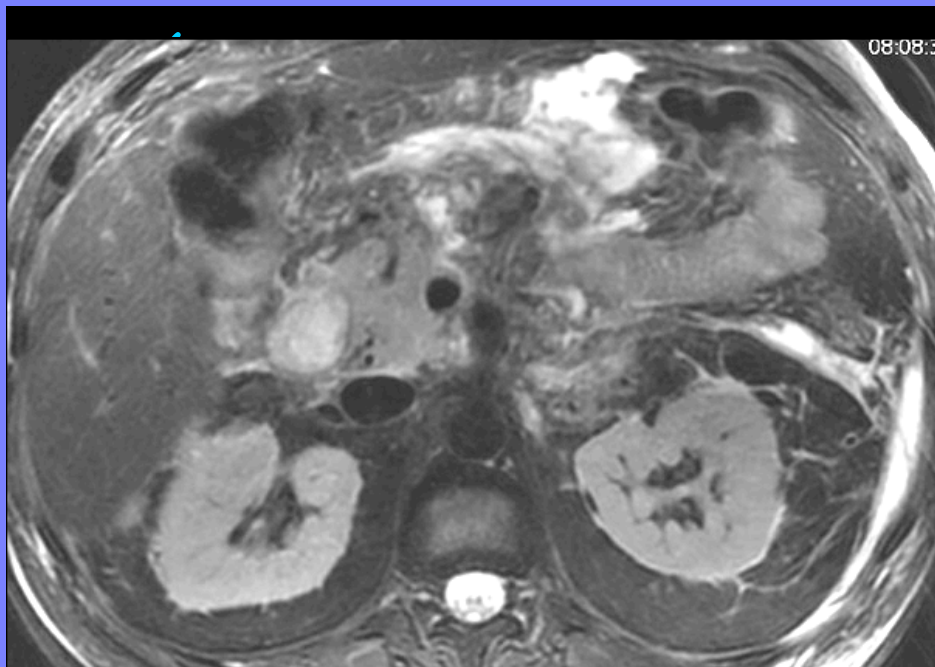
# PANCRÉATITE AIGUE

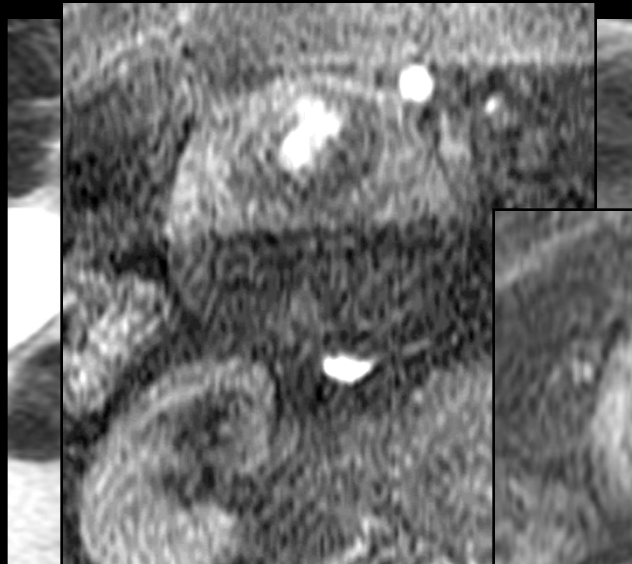
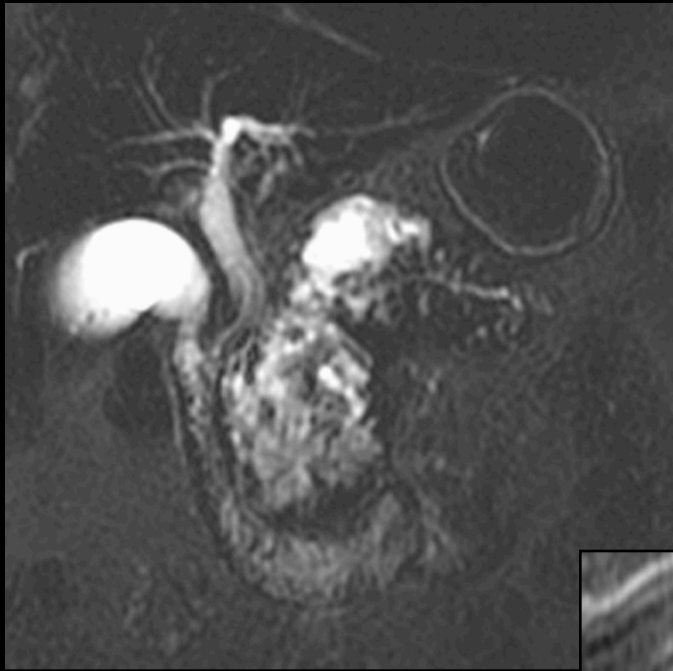
- Établir le diagnostic
- Apprécier la sévérité

## Classification de Balthazar

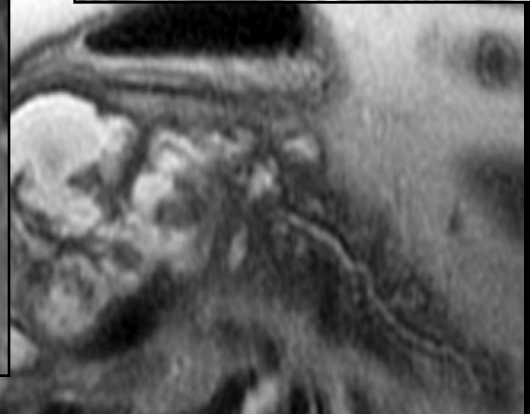
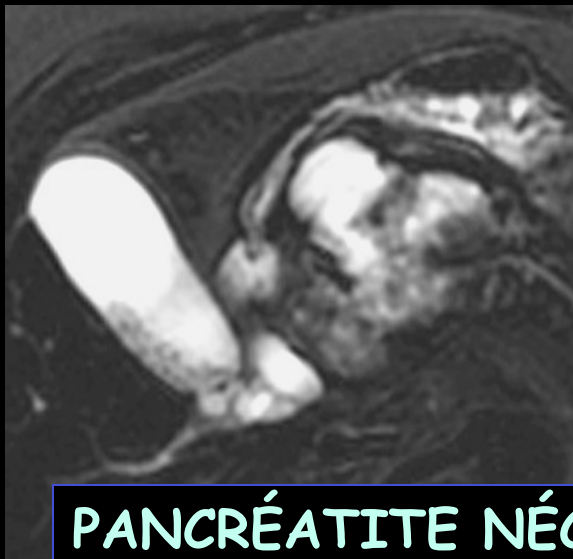
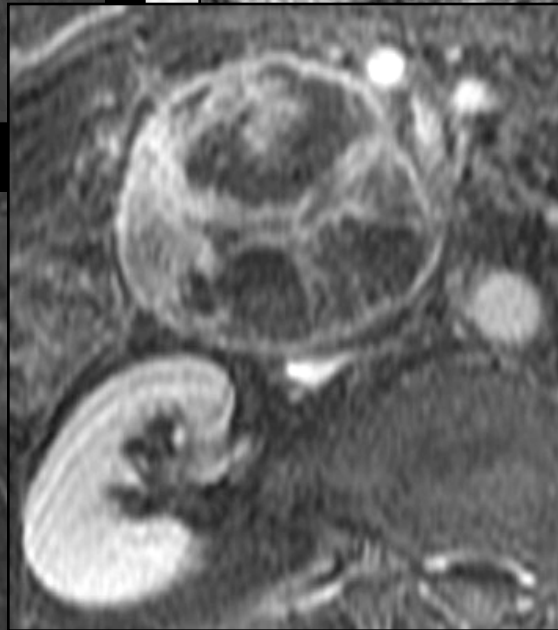
- Bilan étiologique +++
- Poser les indications de drainage ou chirurgie







crité



**PANCRÉATITE NÉCROTICO-HÉMORRAGIQUE** origine biliaire  
sévérité 5/10

# Score scanographique de Balthazar = index de sévérité

1 extension des lésions : 4 points / 10

Grade A : pancréas normal : 0

Grade B : élargissement diffus ou focal de la glande incluant le flou et l'irrégularité des contours , mais sans l'inflammation péri pancréatique : 1

Grade C : anomalies intrinsèques du pancréas avec infiltration péri pancréatique : 2

Grade D : collection péri pancréatique unique et de petit volume : 3

Grade E : 2 ou plus de 2 collections volumineuses ou présence de gaz dans le pancréas ou le rétro péritoine : 4

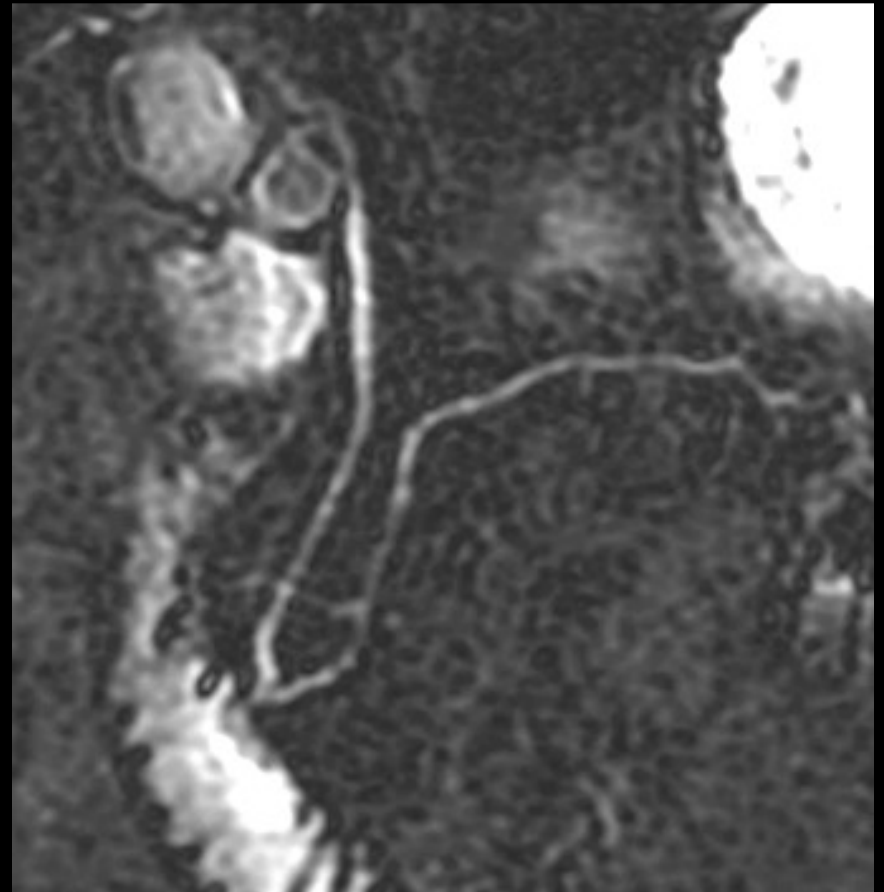
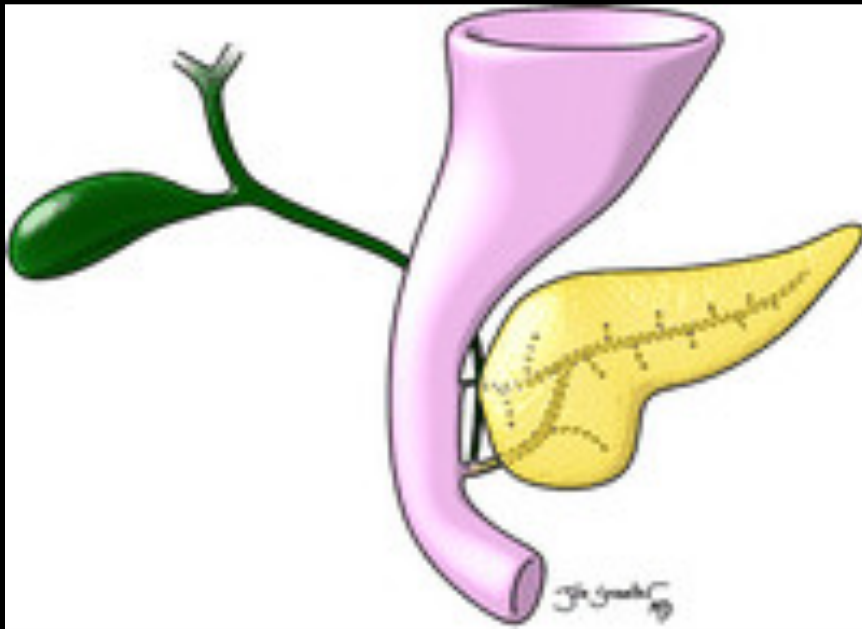
## Score scanographique de Balthazar = index de sévérité

2 extension de la nécrose 6 points / 10

- La nécrose correspond à une absence de rehaussement
- les bornes sont l'atteinte de

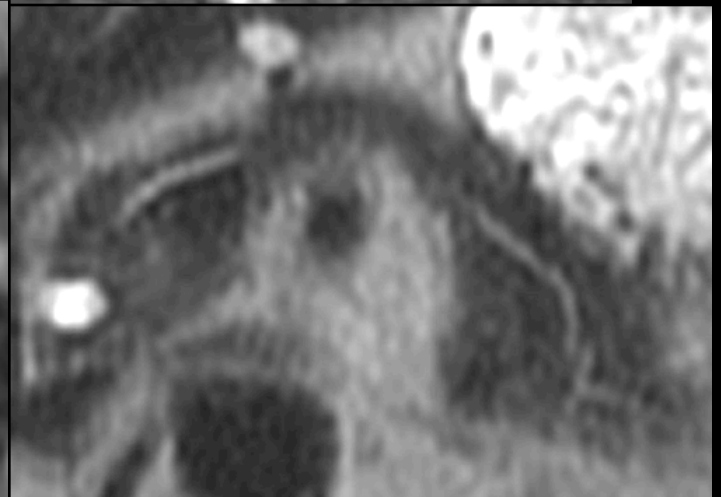
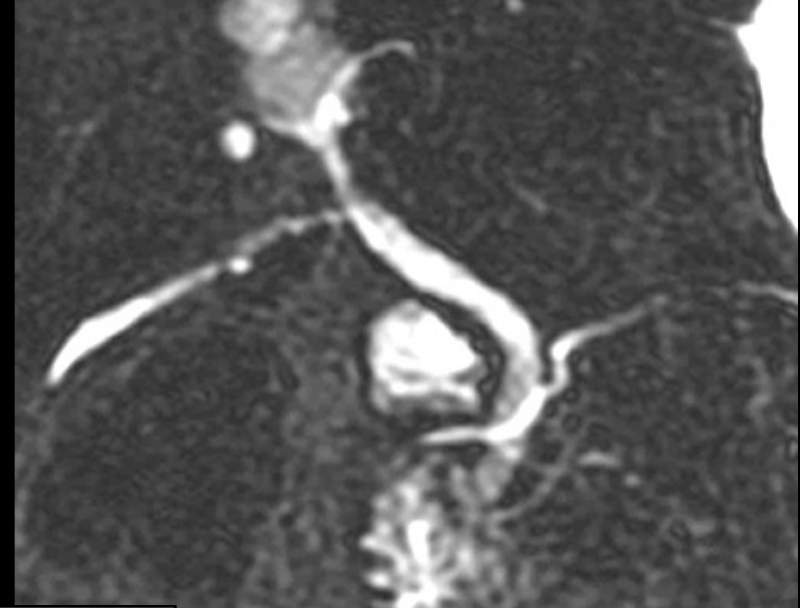
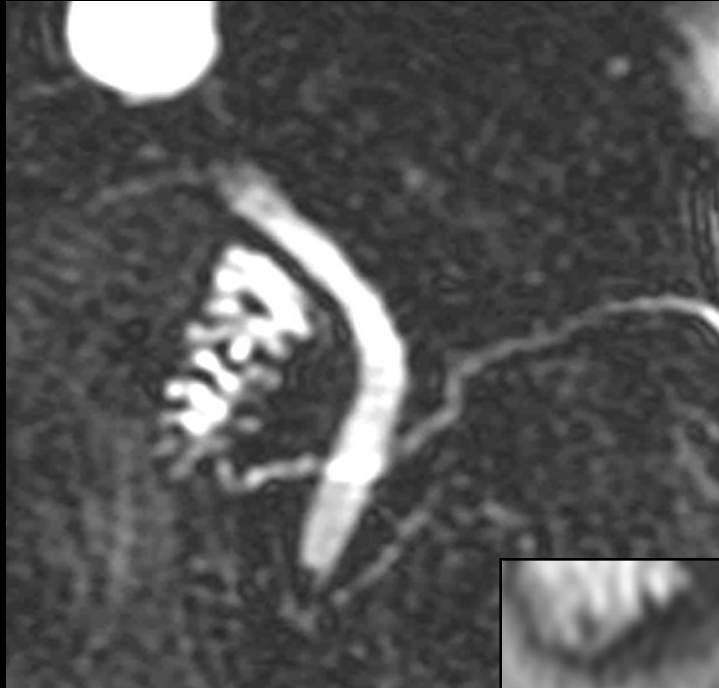
moins de 30% de la glande : 2 points  
30 à 50% de la glande : 4 points  
plus de 50 % de la glande : 6 points

# CANAUX PANCRÉATIQUES

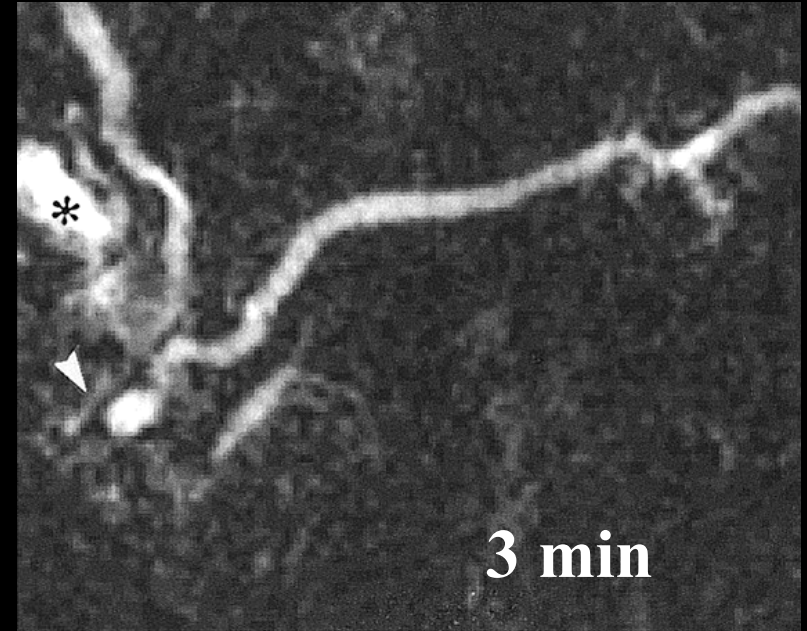
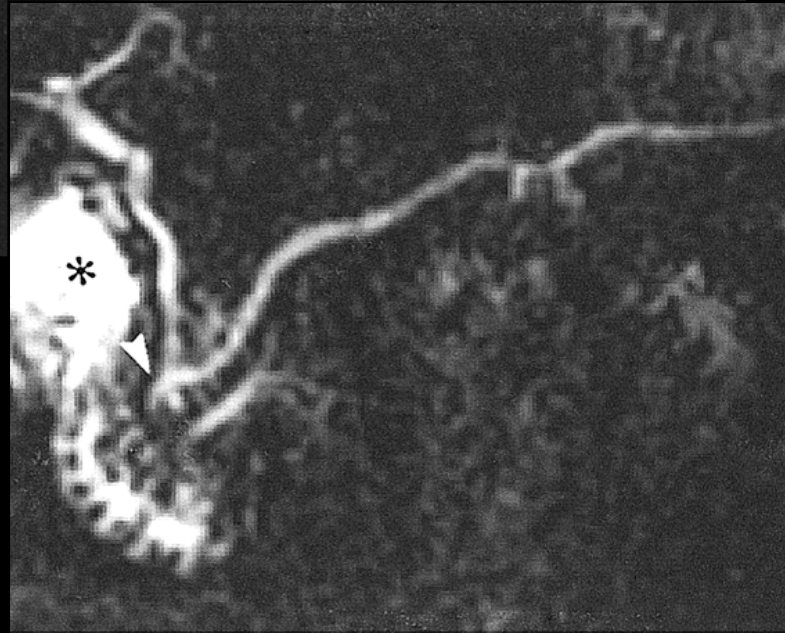
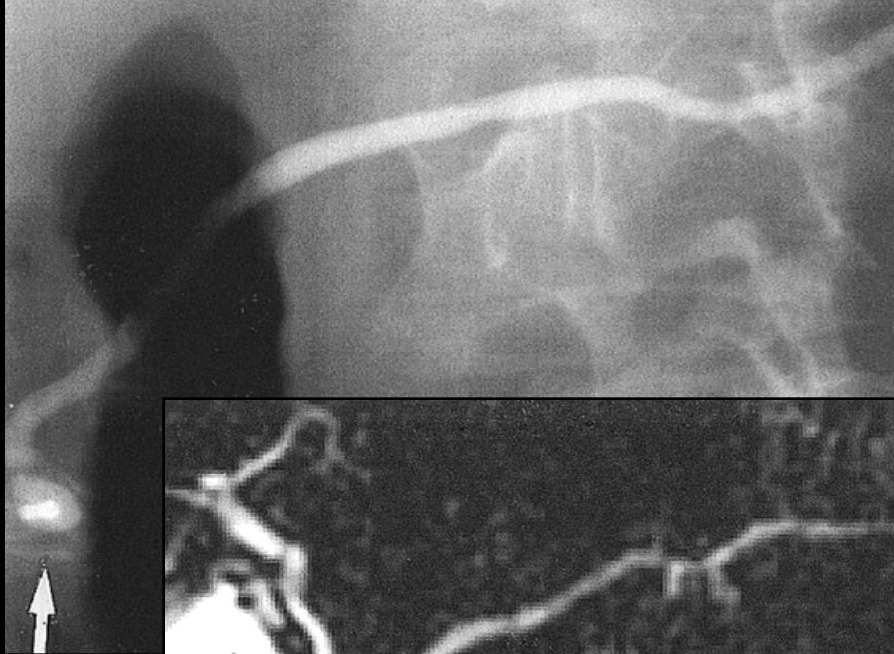


# PANCRÉAS DIVISUM\*

- 5 à 10% pop générale



# PANCRÉAS DIVISUM



## Score de Matos et al

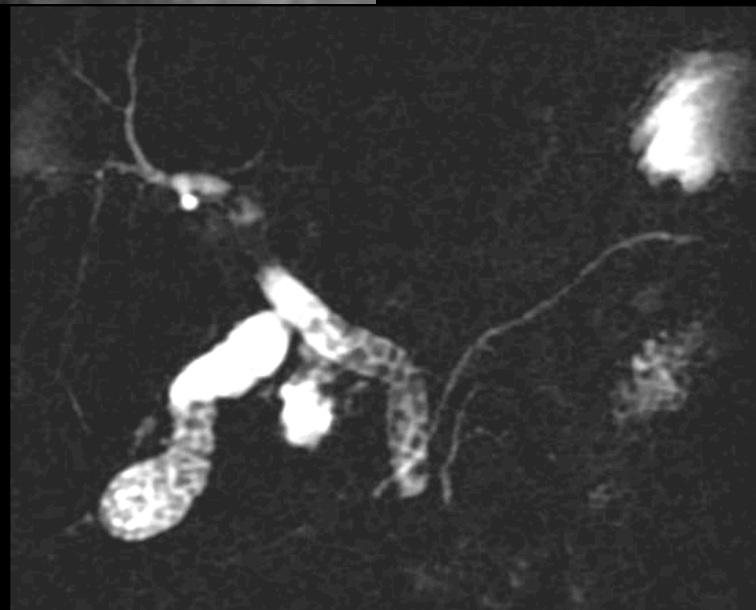
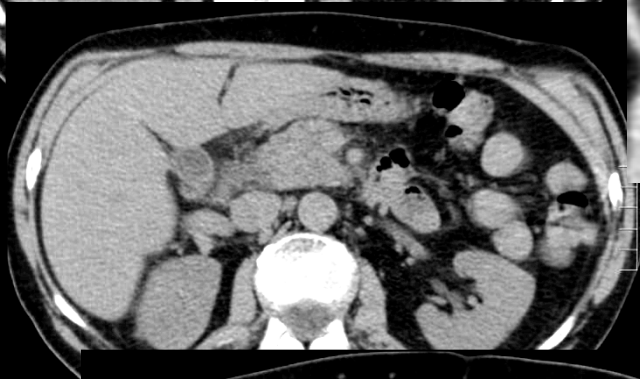
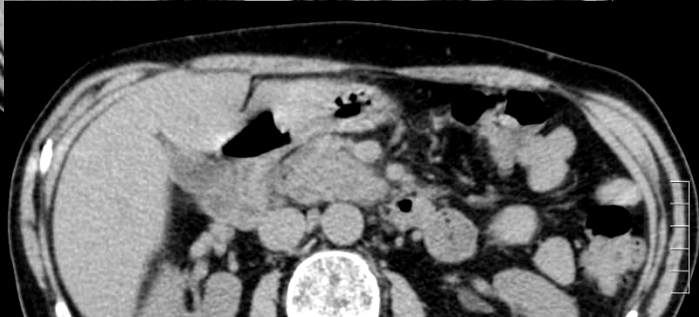
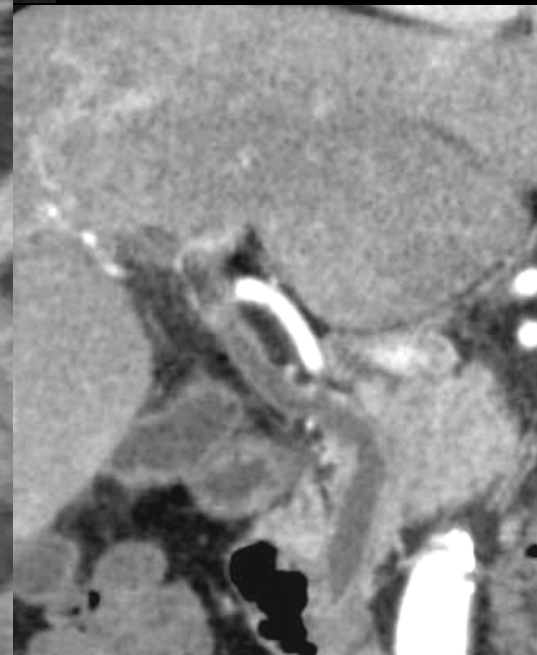
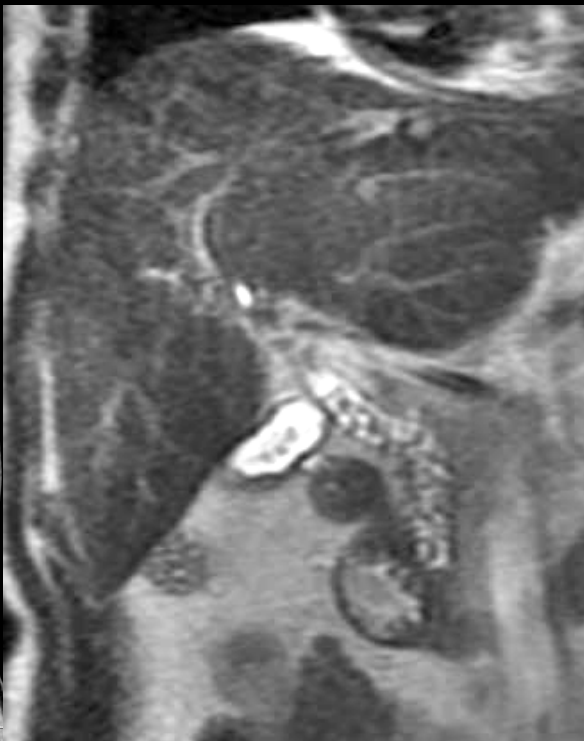
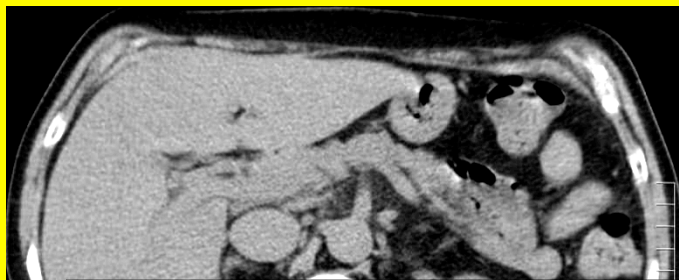
Grade 0 : pas de remplissage

Grade 1 : remplissage limité au bulbe

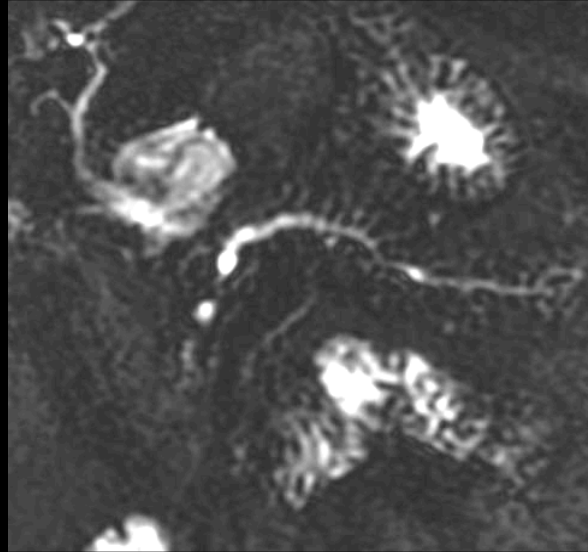
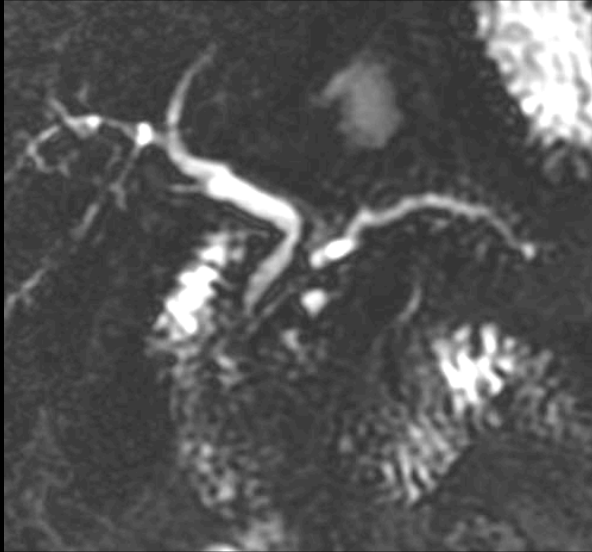
Grade 2 : remplissage jusqu' au genu inferius

Grade 3 : remplissage au-delà du genu inférius

Radiology 1997



## - Analyse canalaire :



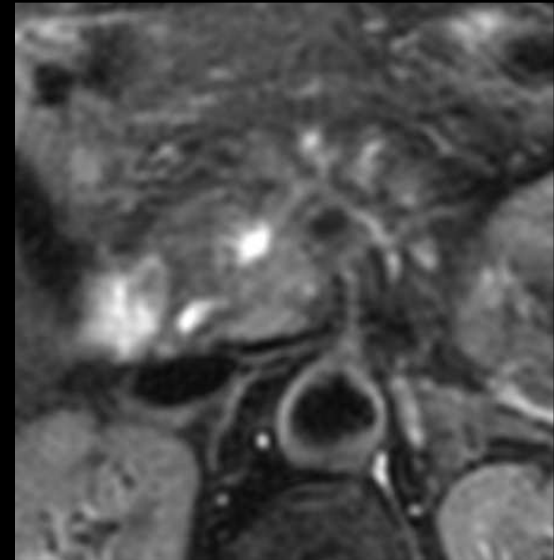
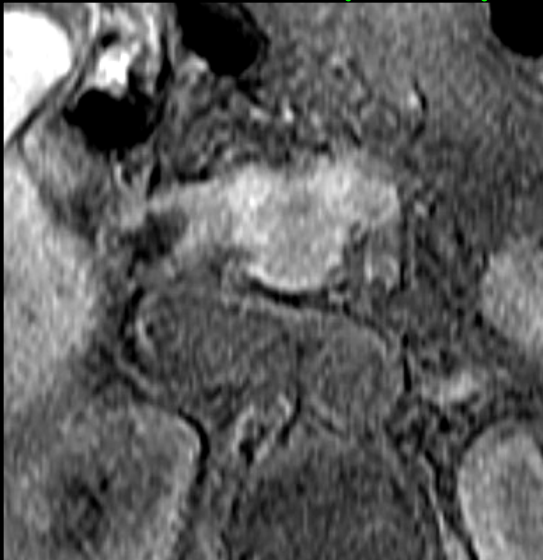
Atcd Cholécystectomie

Douleur et ictère  
persistant

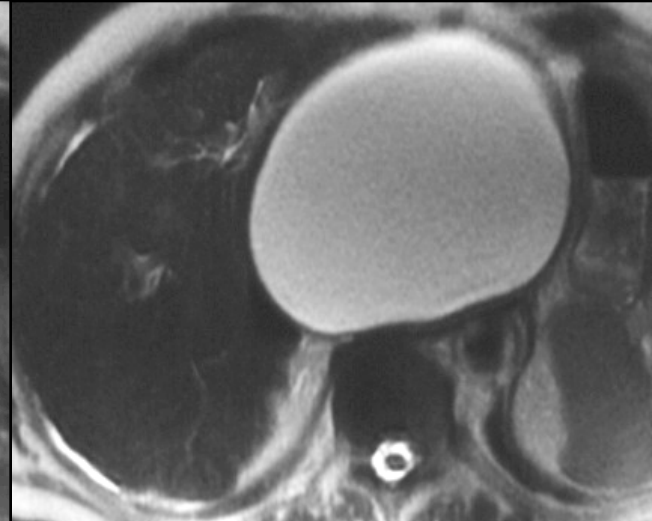
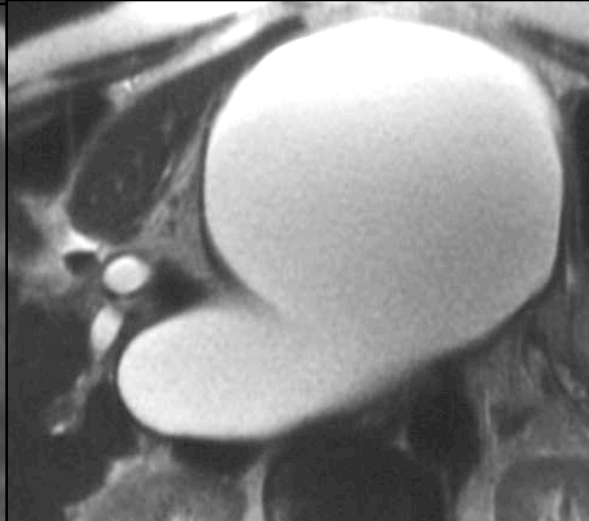
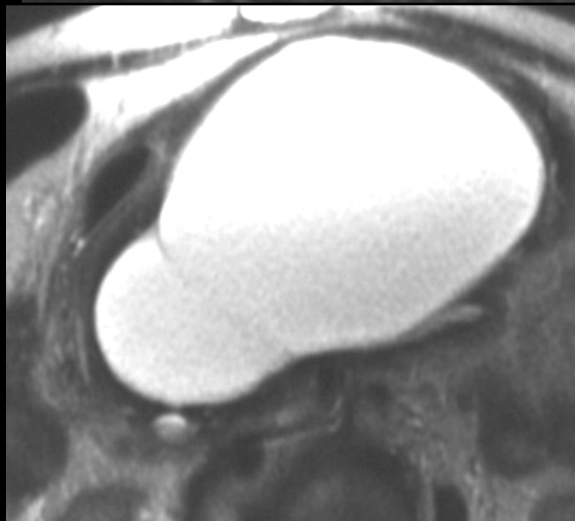
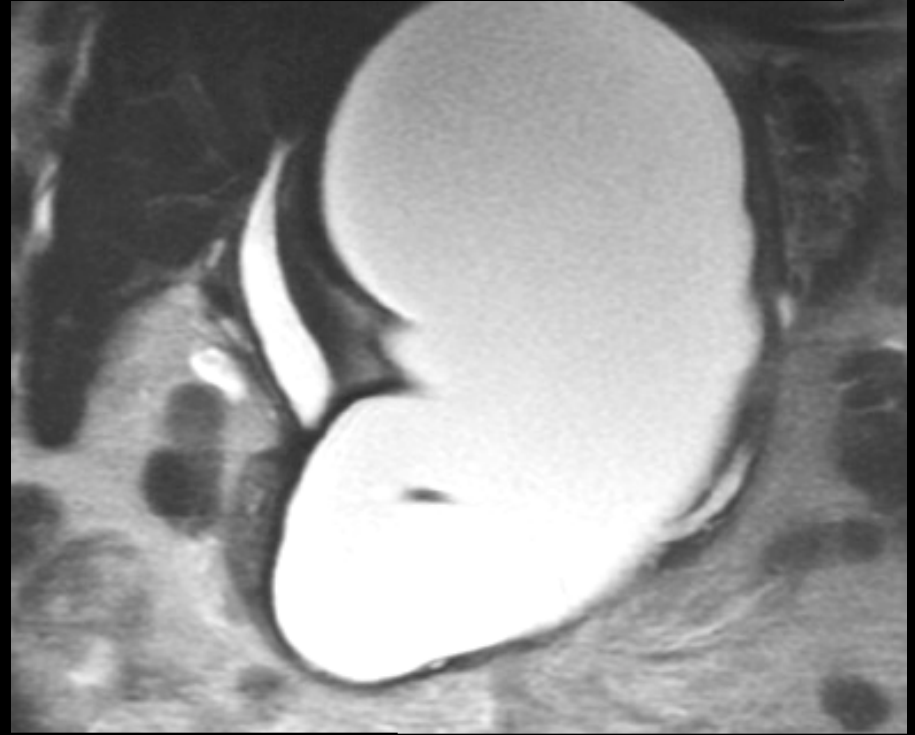
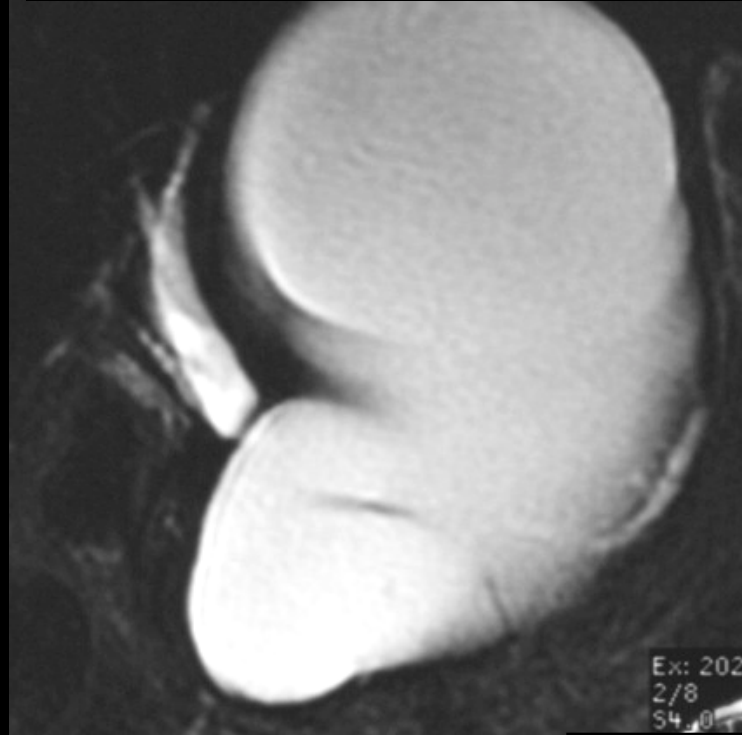
⇒ RCH lithiasie VBP

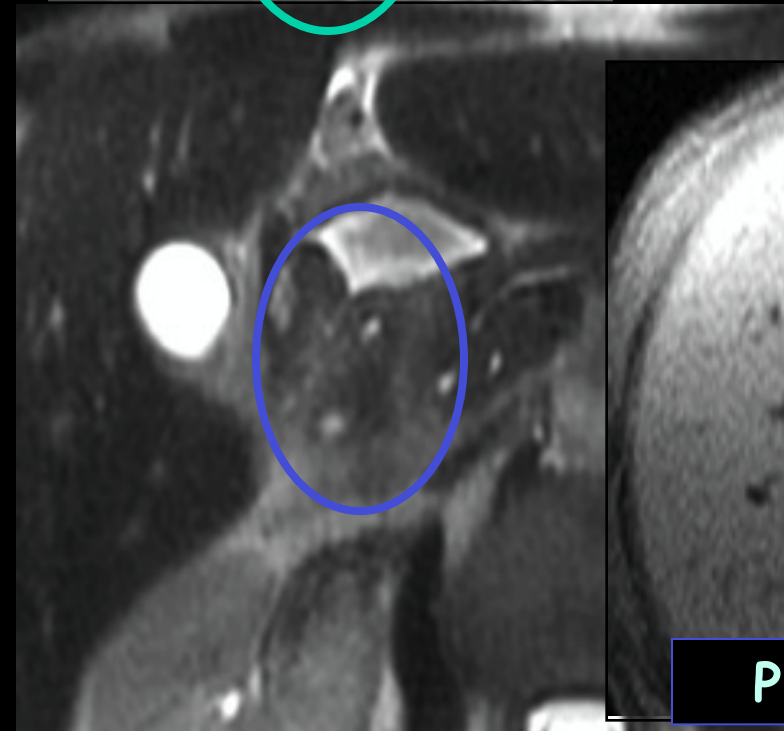
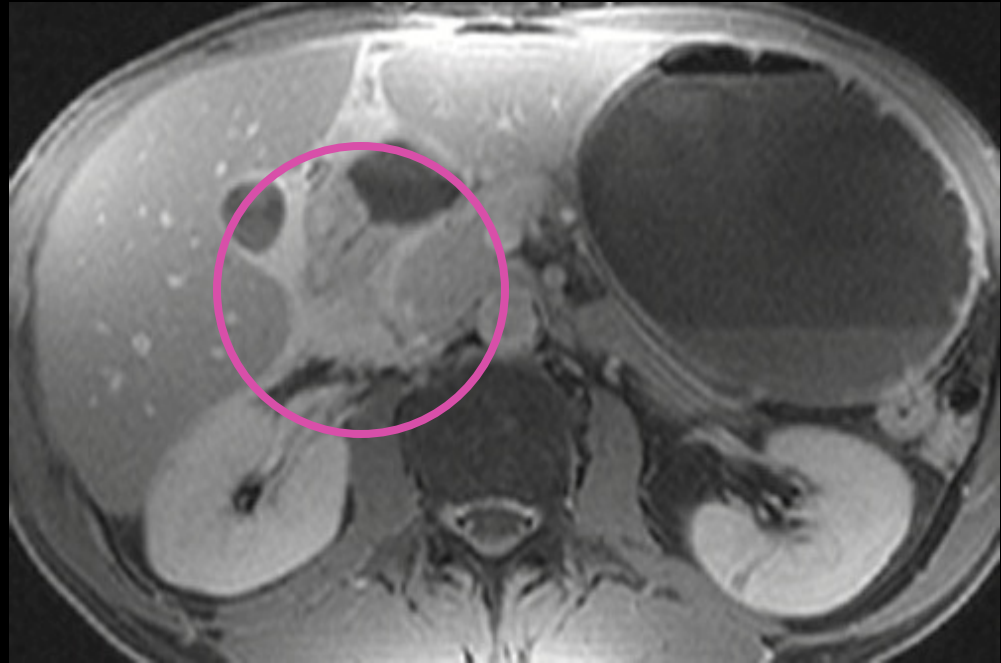
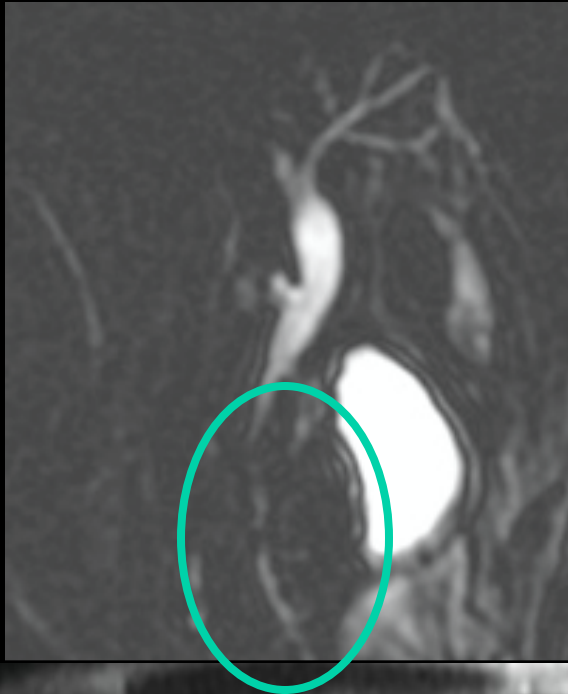
ADK  
pancréas

## - Analyse parenchyme :



# Poser les indications de drainage/chirurgie

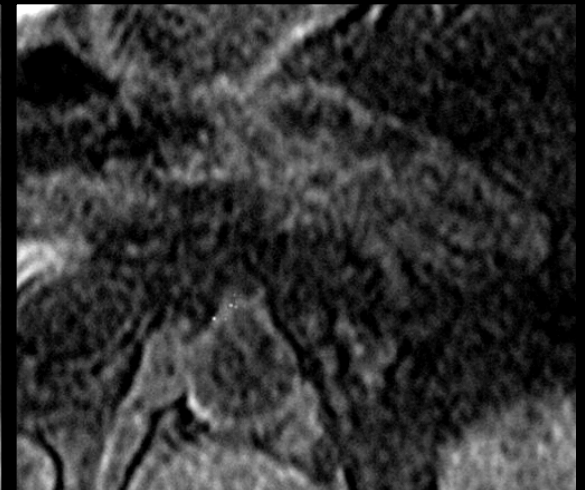
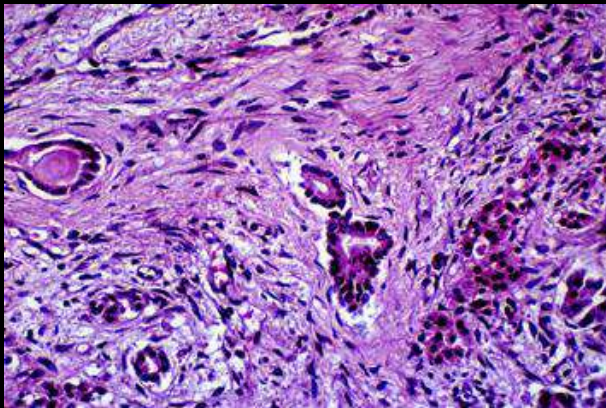
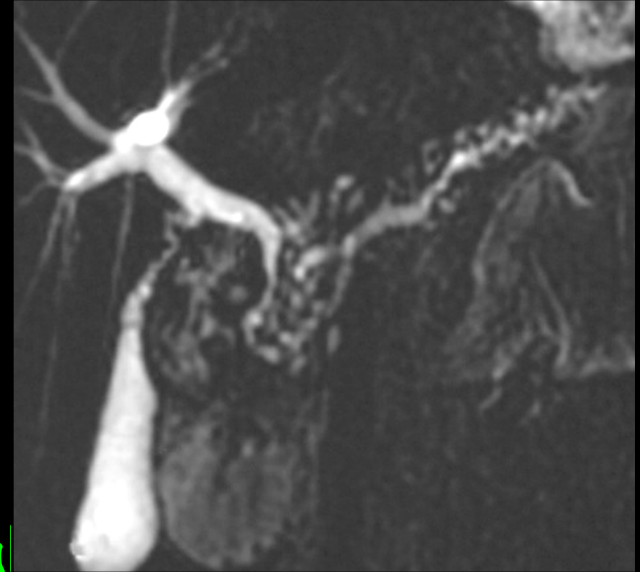




**PANCRÉATITE aiguë du sillon\* F pure**

# PANCRÉATITE CHRONIQUE\*

- atteinte des canaux secondaires  
&  
- atteinte des canaux principaux\*
- concrétions intra-canalaires ⇒ ca
- fibrose



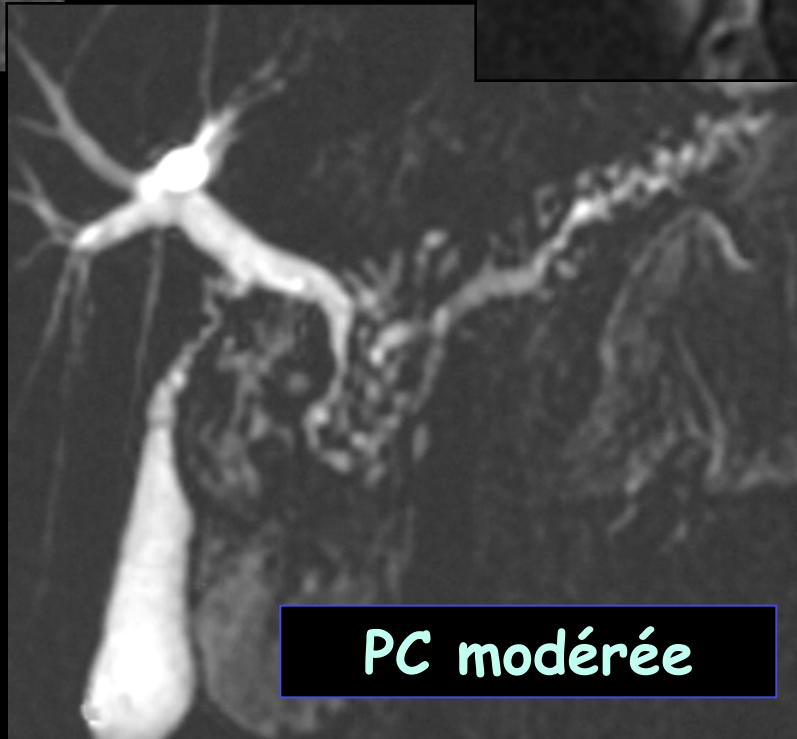
**PC débutante**



**PC sévère**



**PC modérée**



# PANCRÉATITE CHRONIQUE versus ADÉNOCARCINOME PANCRÉAS

## Pancréatite chronique

- dilatation irrégulière canaux

- rétrécissements courts

- Morphologie MPD

- RARE

- anomalie des canaux IIaires

- canaux IIaires au contact des canaux principaux

- arrêt progressif VBP avec attraction (fibrose)

## Adénocarcinome pancréas

- dilatation régulière canaux

- rétrécissement irrégulier long

- Signe " double canal "

- anomalie des canaux IIaires

- canaux IIaires à distance des canaux principaux

- arrêt abrupt VBP sans attraction

- **SIGNES D'EXTENSION !!!!**

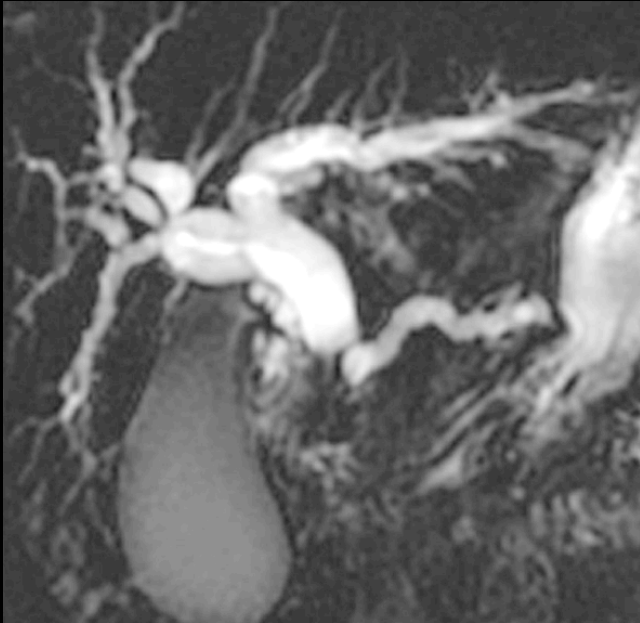
**rehaussement tardif !!!**

M  
P  
D

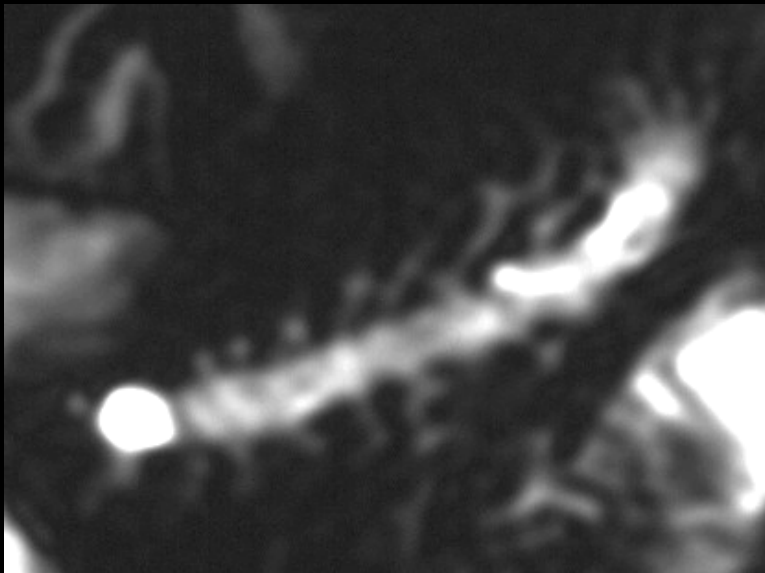
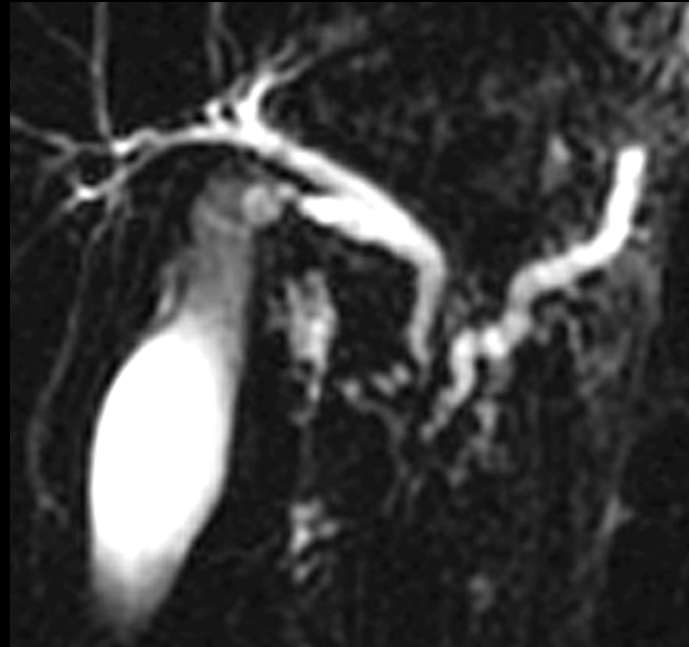
B  
P  
D

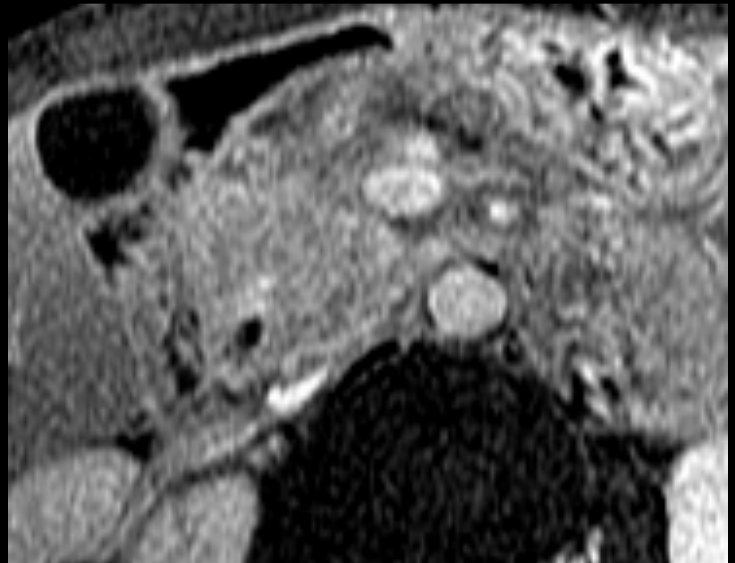
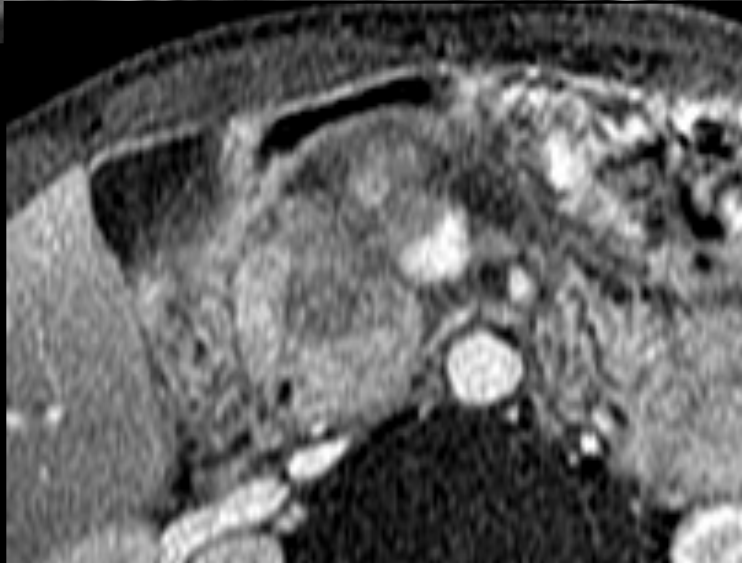
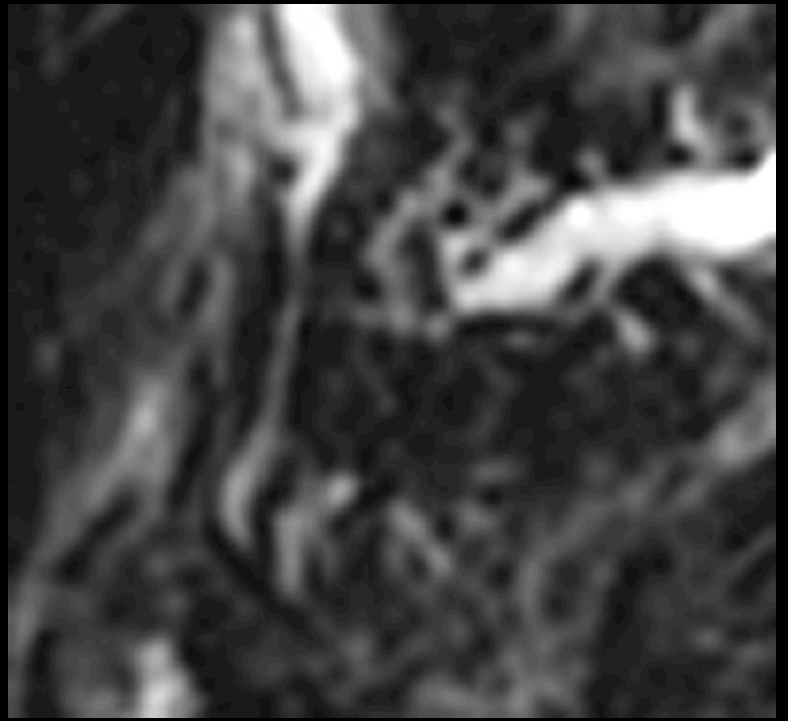
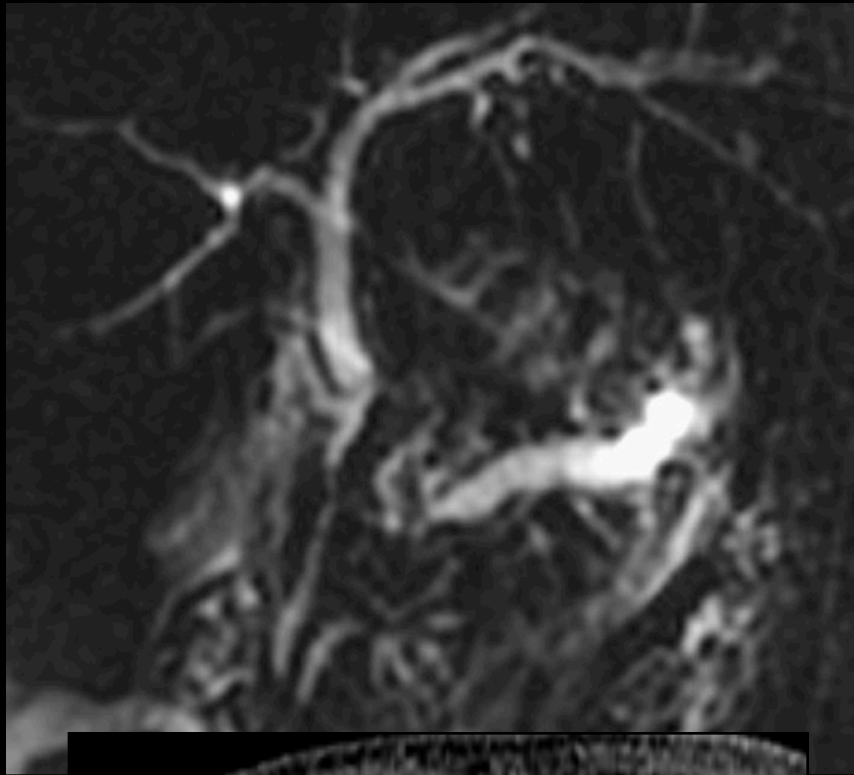
V  
B

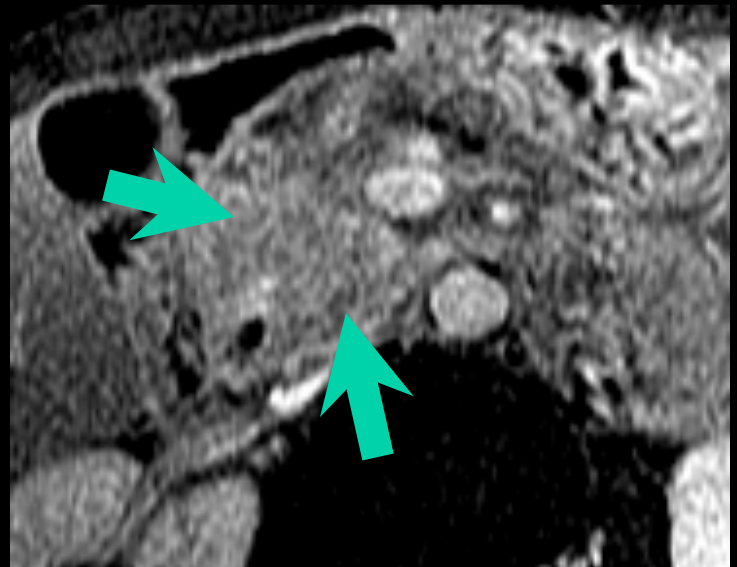
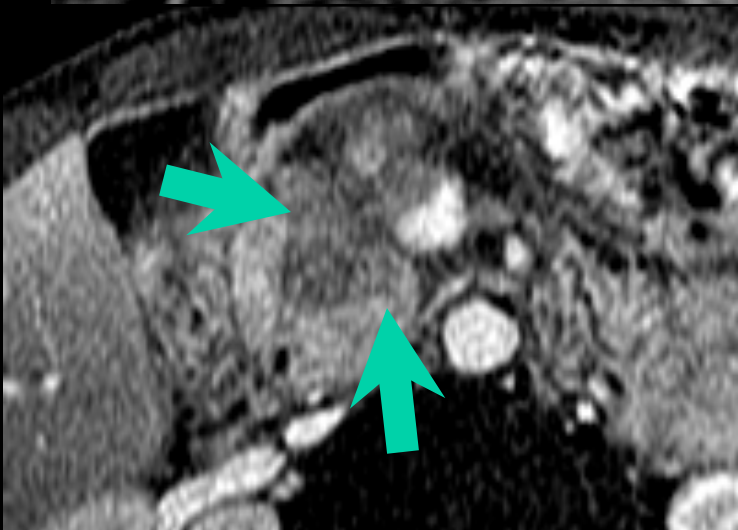
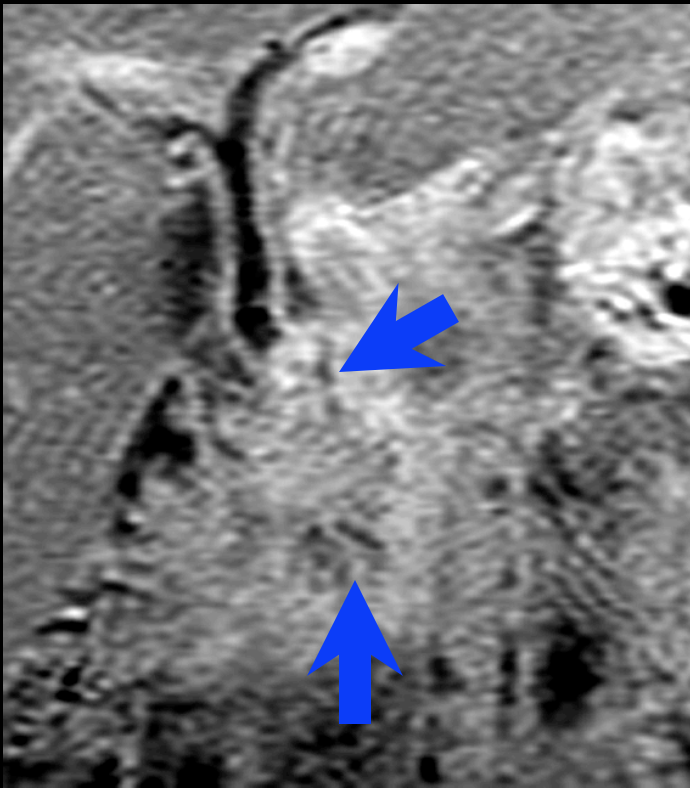
# ADÉNOCARCINOME

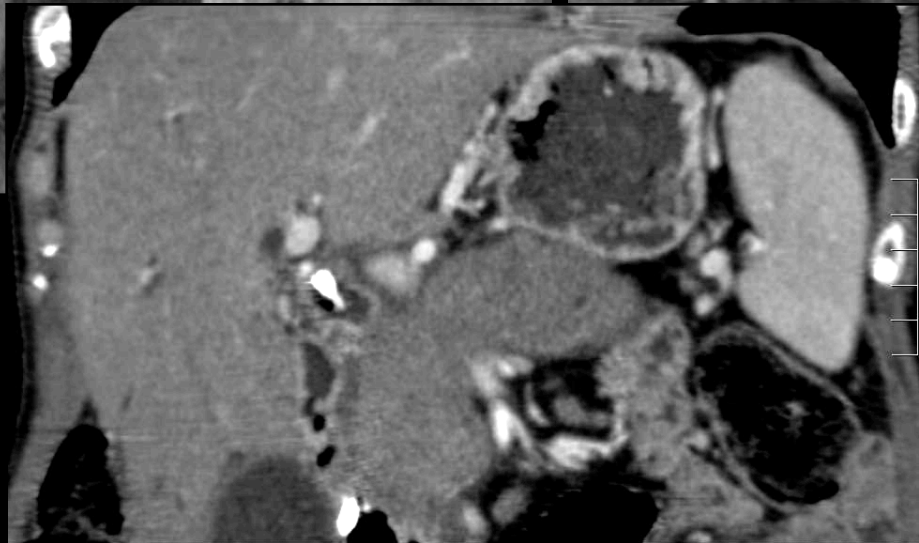
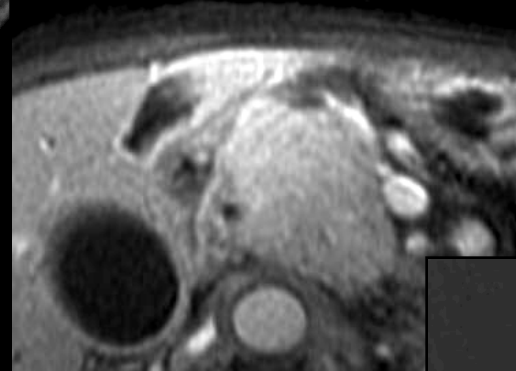
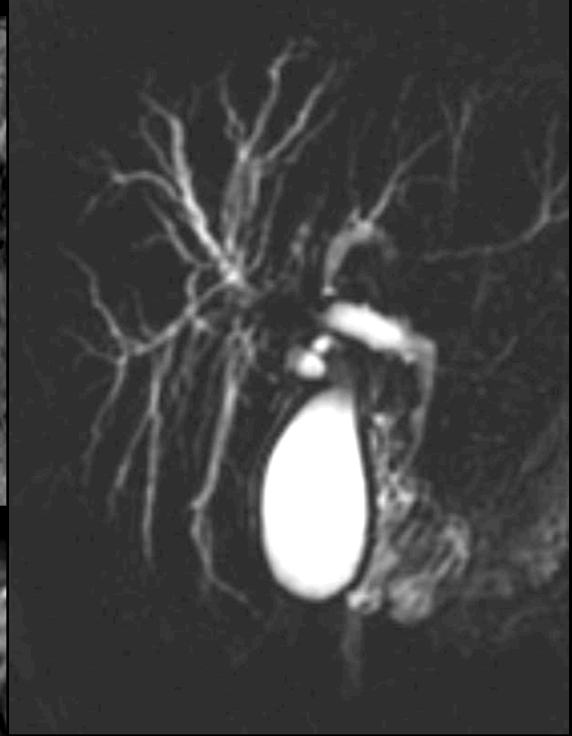
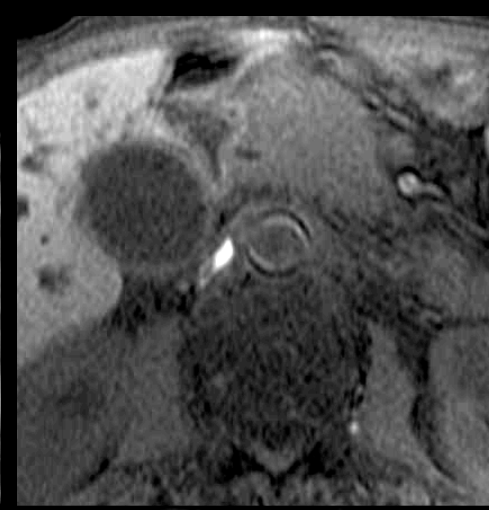
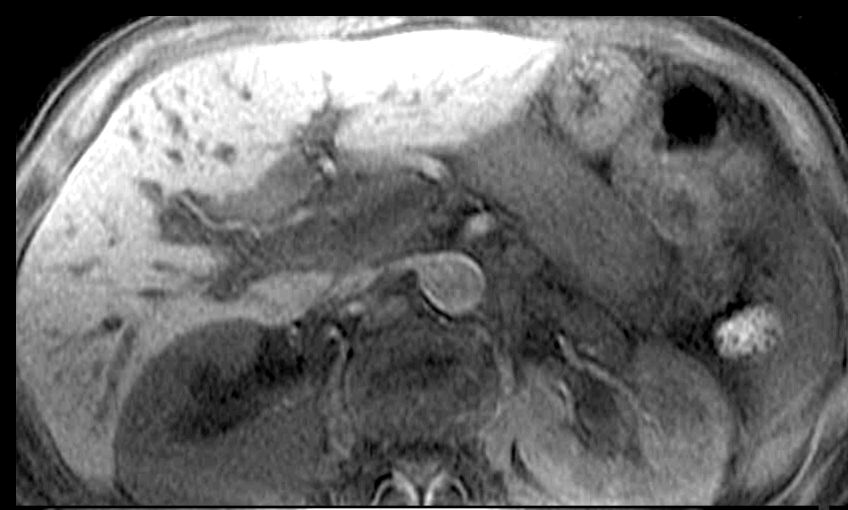


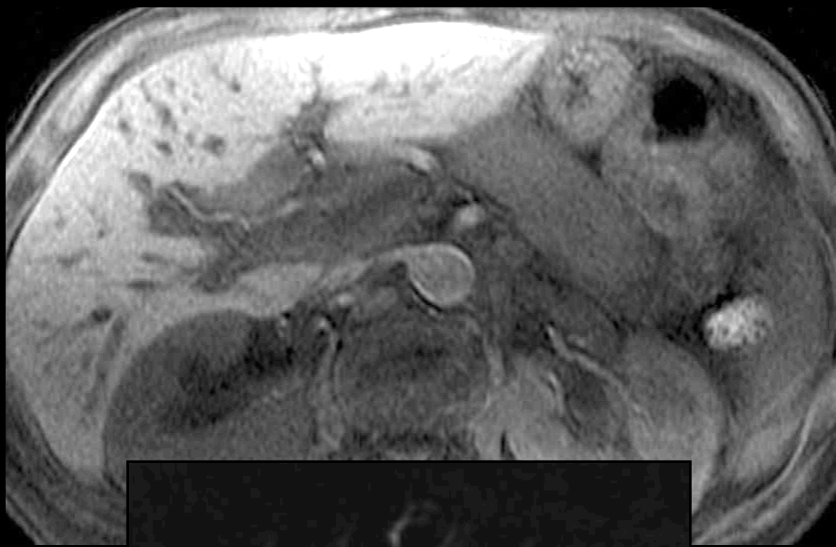
# PANCRÉATITE CHRONIQUE\*











PC auto-immune

IRM 1

IRM 2

# Pancréatite auto-immune

## Historique :

1<sup>er</sup> cas : 1961 Sarles & al

terme de PAI = année 1990

Japon 1991 : Variante de PSC avec atteinte pancréatique réversible sous corticoïde

Hamano 2001 : taux élevé Ig4 dans PAI

Kamisawa : infiltration cellulaire Ig4+ dans pancréas et autres organes  
⇒ maladie de système ass Ig4

## Clinique :

- douleurs, AEG
- cholestase
- diabète (qui peut s'améliorer sous TT)
- aspect pseudo-tumoral : **ATTENTION DANS LES 2 SENS**

⇒ 2 formes

# Pancréatite auto-immune

Classique : LPSP (Japon/Etats Unis)

LymphoPlasmacyticSclerosingPancreatitis

⇒ Nécessité d' un architecture tissulaire : pas de cytoponction

Fibrose storiform

Infiltration lympho-plasmocytaire, riche  
Ig4

(pancréas, autres organes)

Phlébite oblitérante

> 50 ans

H > F (ratio 2:1)

Ig4 >140mg/dl, anticorps\*

Autres organes synchrones ou métachrones

TT : corticothérapie

Nouvelle : IDCP ou GEL (Europe)

IdiopathicDuct-centricChronicPancreatitis

GranulocyteEpithelialLesion

Infiltration de granulocytes dans les lobules et  
les canaux

Inflammation des canaux ⇒ destruction

Sujet jeune

H = F

Ig4 -

MICI (Crohn)

TT : pas de réponse aux corticoïdes

# Pancréatite auto-immune

Classique : LPSP (Japon/Etats Unis)

Lympho plasmacytic sclerosing  
pancreatitis

Nouvelle : IDCP ou GEL (Europe)

Idiopathic duct-centric chronic pancreatitis  
Granulocyte epithelial lesion

⇒ Diagnostic

1/ histologie

2/ biologie : Ig4 >140mg/dl

3/ imagerie

4/ Test aux corticoïdes

Histologie uniquement

Différentes classifications : HISORT 2006 (Mayo Clinic's Histology, Imaging, Serology, Other organ involvement and Response to therapy), Asian Diagnostic Criteria 2008

# Pancréatite auto-immune

Classique : LPSP ou type I

Lympho plasmacytic sclerosing pancreatitis

Sialadénite

Thyroïdite

Gg hiles pulm

Pneumopathie interstitielle

Fibrose rétropéritonéale

Néphrite interstitielle & nodules

MICI

Cholangite

Prostatite

Pseudotumeur infl° (foie, ampoule)

Nouvelle : IDCP ou GEL ou type II

Idiopathic duct-centric chronic pancreatitis

Granulocyte epithelial lesion

Crohn

# Pancréatite auto-immune

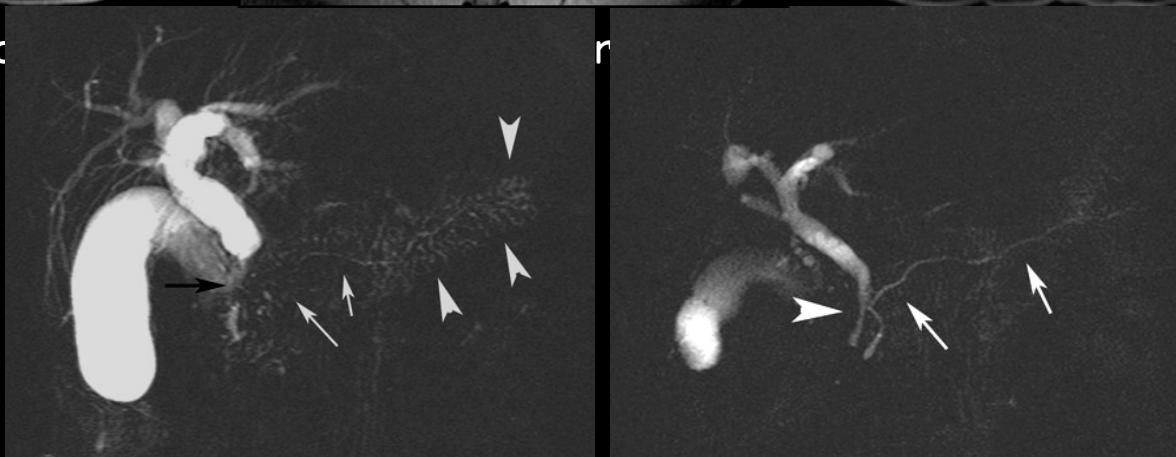
## Classique : LPSP ou type I

### Imagerie PAI

- F typique : ↗ Diffuse vol glandulaire avec irrégularité diffuse du Wirsung
- F atypique : ↗ focale vol glandulaire - masse - sténose localisée du Wirsung - atrophie du pancréas - calcifications



- Echo avec Po r ehaussement



# Pancréatite auto-immune

Classique : LPSP ou type I

Cholangite auto-immune

- Imagerie :

Sténose sus pancréatique intra ou extra-hép

Irrégularité VBP, épaissement diffus de la paroi, Pde C

Sténose et dilatations VBIH

- Histologie :

IIaire infiltration lympho-plasmocytaire

- Traitement et évolution :

Régression sous corticothérapie

Récurrence : atteinte VB extra-pancréatique > atteinte VB intra-pancréatique



# Pancréatite auto-immune

## Evolution sous traitement

### ⇒ Corticothérapie

- Amélioration clinique au bout de 2/3 semaines de traitement
- Amélioration est variable pour les images (infl° versus fibrose) et biologie (quelques mois)

### • Evolution de l'imagerie :

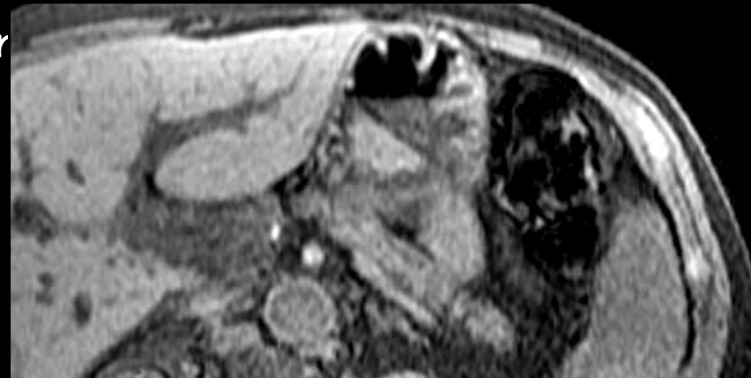
*Restitution ad integrum*

Atrophie du pancréas

### • Possi



### lir



# Pancréatite aigue - étiologies

- Lithiase
  - Alcool
  - traumatique
  - infection virale
  - maladie systémique
  - Pancréatite auto-immune
  - Pancréatite aigue du sillon / DKPA
  - Pancréatite tropicale
  - Pancréatite héréditaire
  - Pancréatite / ascaris
  - Pancréatite / mucoviscidose
  - Anomalie canalaire
  - Cause tumorale
- Adulte
- Enfant

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# CONCLUSION

- Toujours analyser versant canalaire **et** versant parenchyme
  - Protocole de base :
    - **SS FSE TE court axial** ⇒ différencie lésion kystique/solide
    - **SS FSE TE long radiaire** ⇒ analyse canaux : type d'obstacle...
    - **T1 Fat sat axial** ⇒ traque lésion du pancréas (kystique, solide, PC)
  
    - T1 Gd Fat sat ⇒ rehaussement ? Précoce ou tardif ?
    - +/- 3D FSE T2 ⇒ traque une communication (TIPMP)
    - Diffusion ⇒ DETECTION (bilan ou suivi de cancer du pancréas)
- Intérêt dans les TIPMP ?
- sécrétine ⇒ Pancréatite chronique