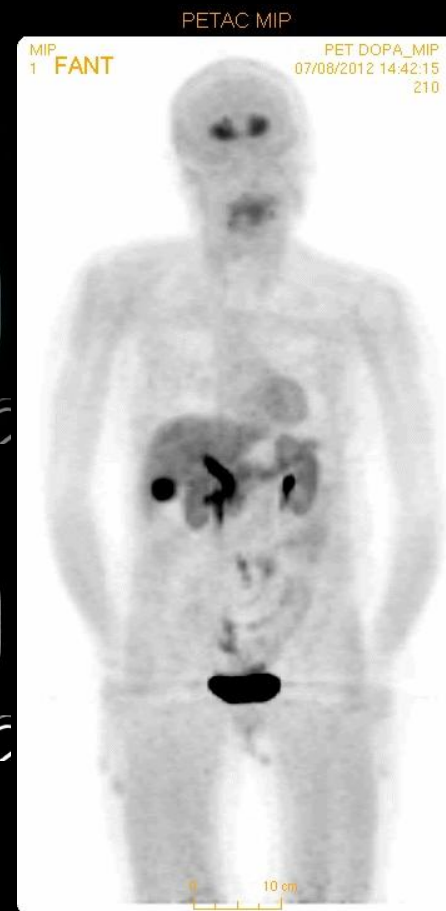
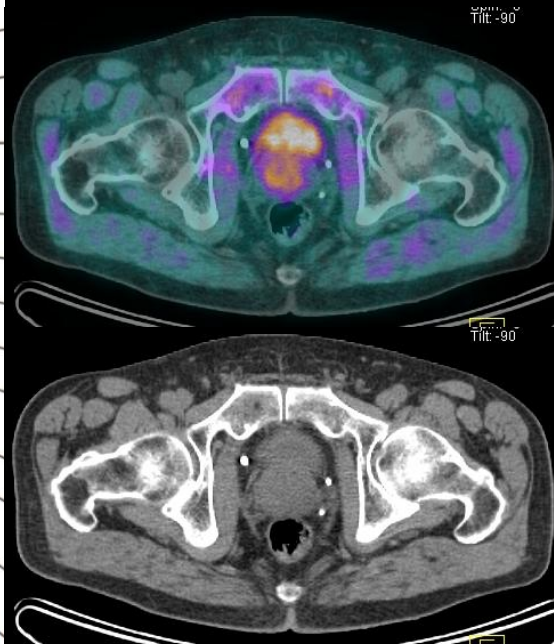
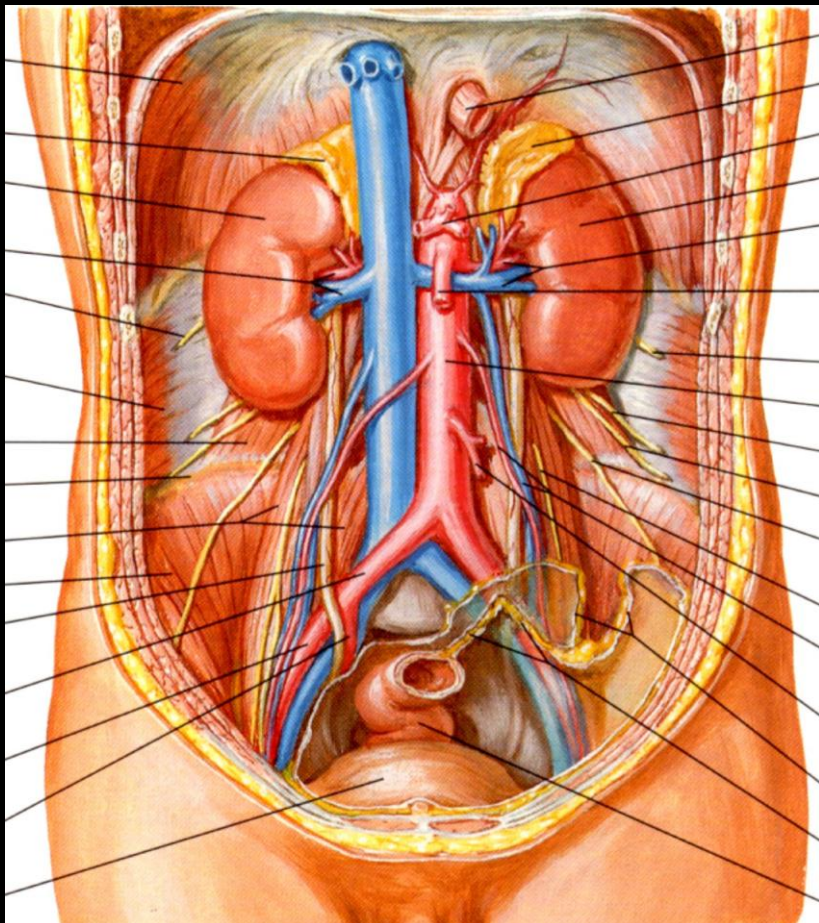


RETROPERITOINE - PELVIS



F. JAUSSET

Service de Radiologie Adultes, Hôpital de Brabois

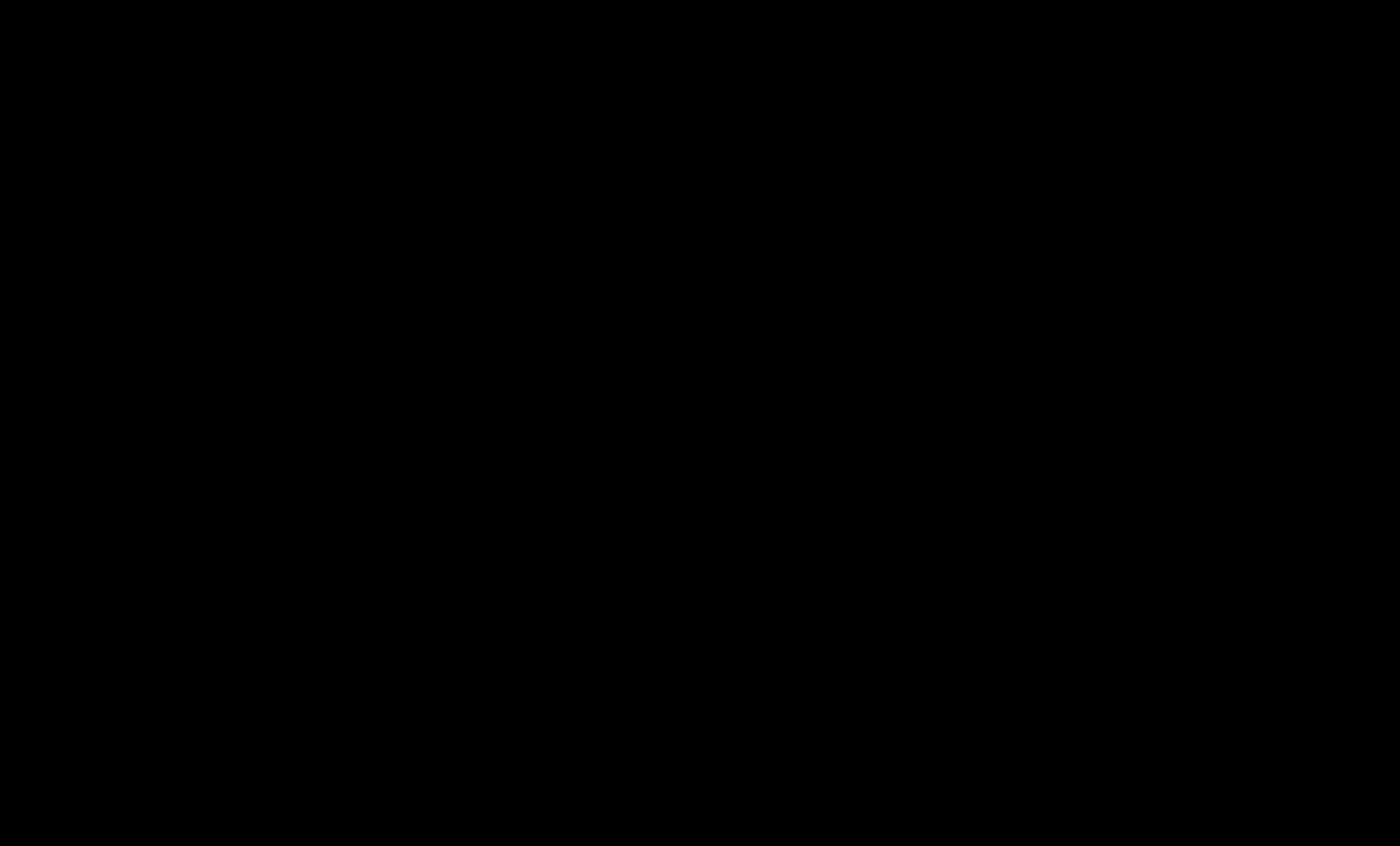
Avril 2013

O. MOREL; N. DIDOT

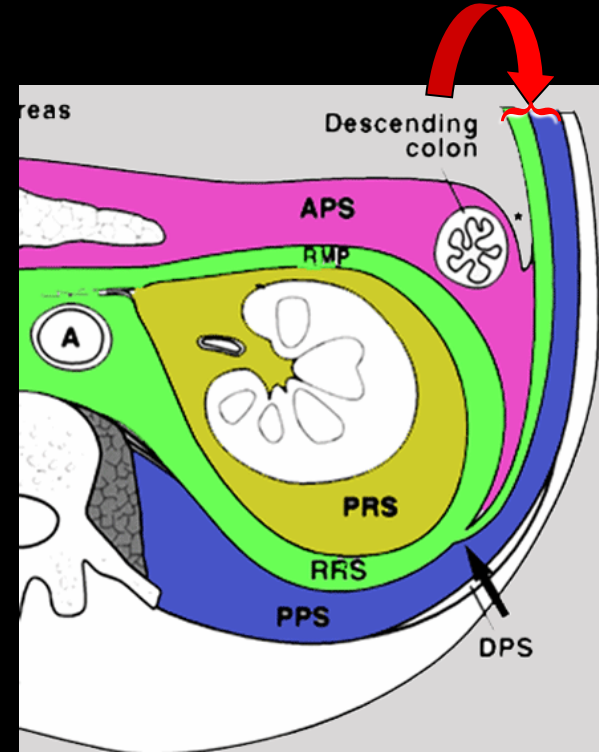
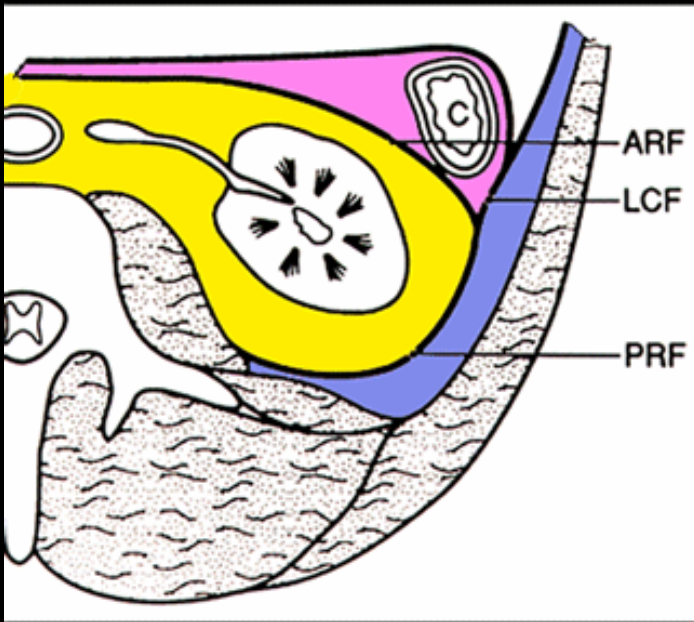
Service de Médecine Nucléaire, Hôpital de Brabois

Avril 2013

Rétro-péritoine



anatomie des espaces rétro-péritonéaux

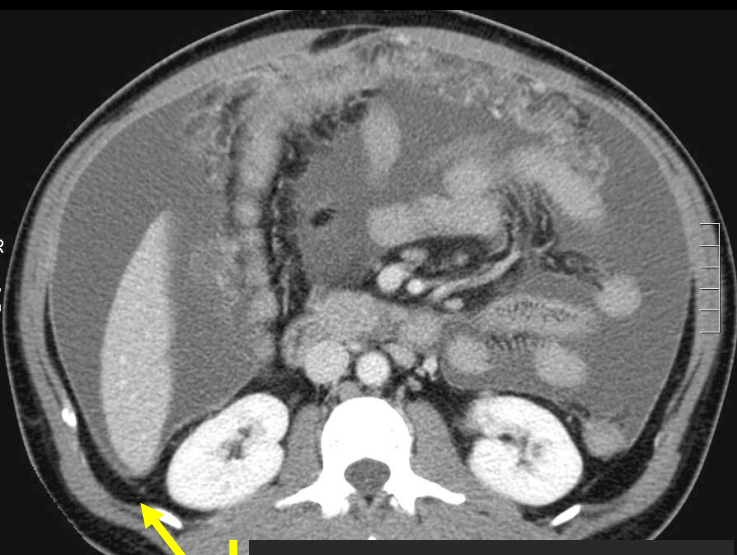


espace para rénal antérieur
 fascia rénal antérieur
 espace péri rénal
 fascia rénal postérieur
 espace para rénal postérieur
 fascia latéro conal

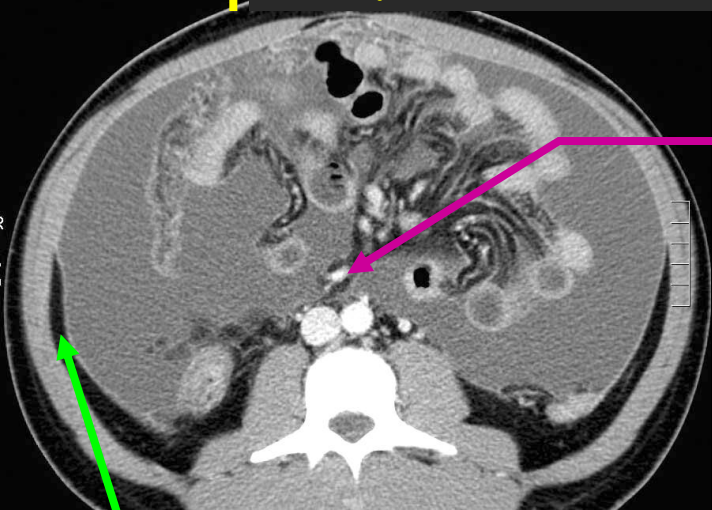
espace interfascial
 antérieur, rétro mésentérique

espace interfascial
 postérieur, rétro rénal

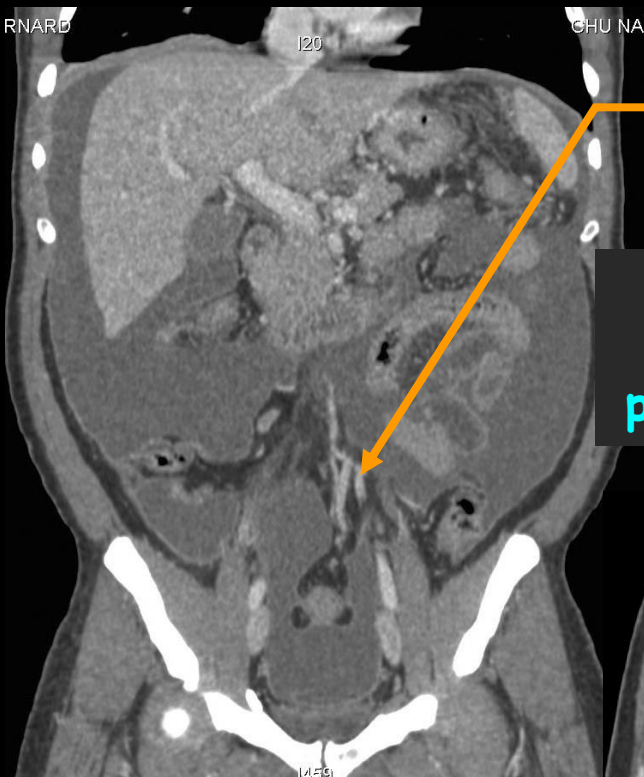
communiquant tous avec l'espace
 sous(pro)-péritonéal antérieur



espace para rénal
postérieur



espace pro
péritonéal



méso
sigmoïde

espace
rétro
péritonéal

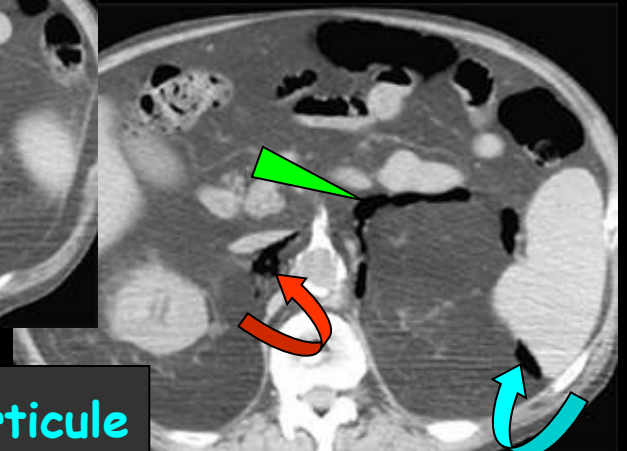
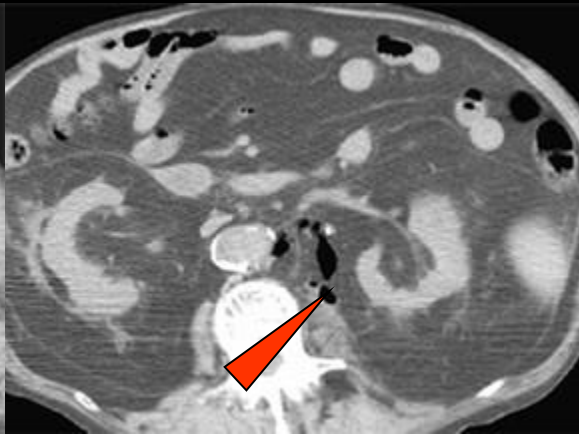
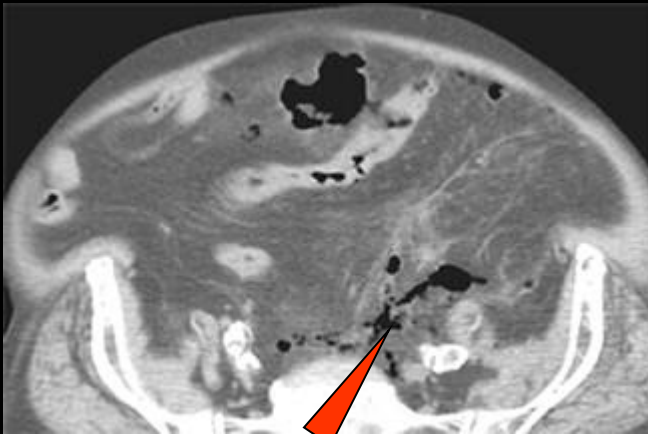
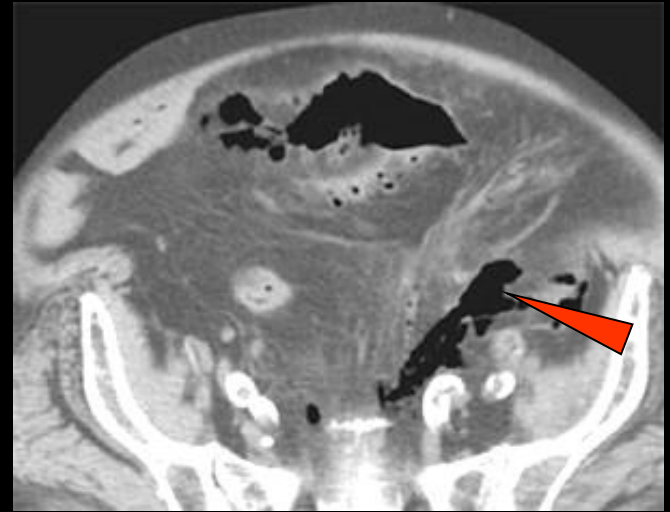
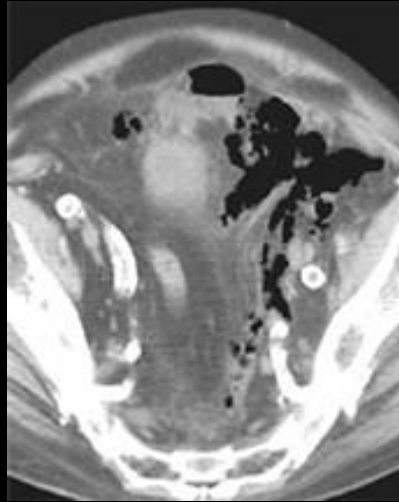
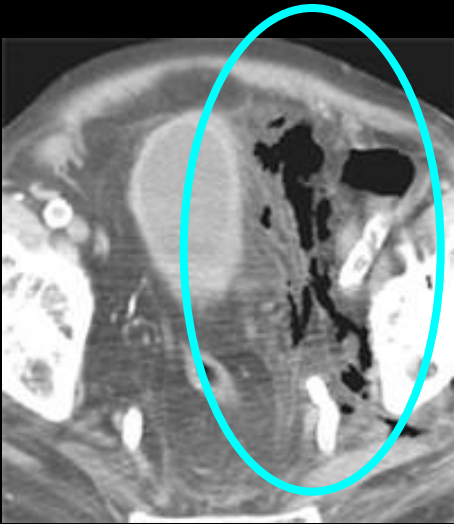
mésentère

mésosigmoïde

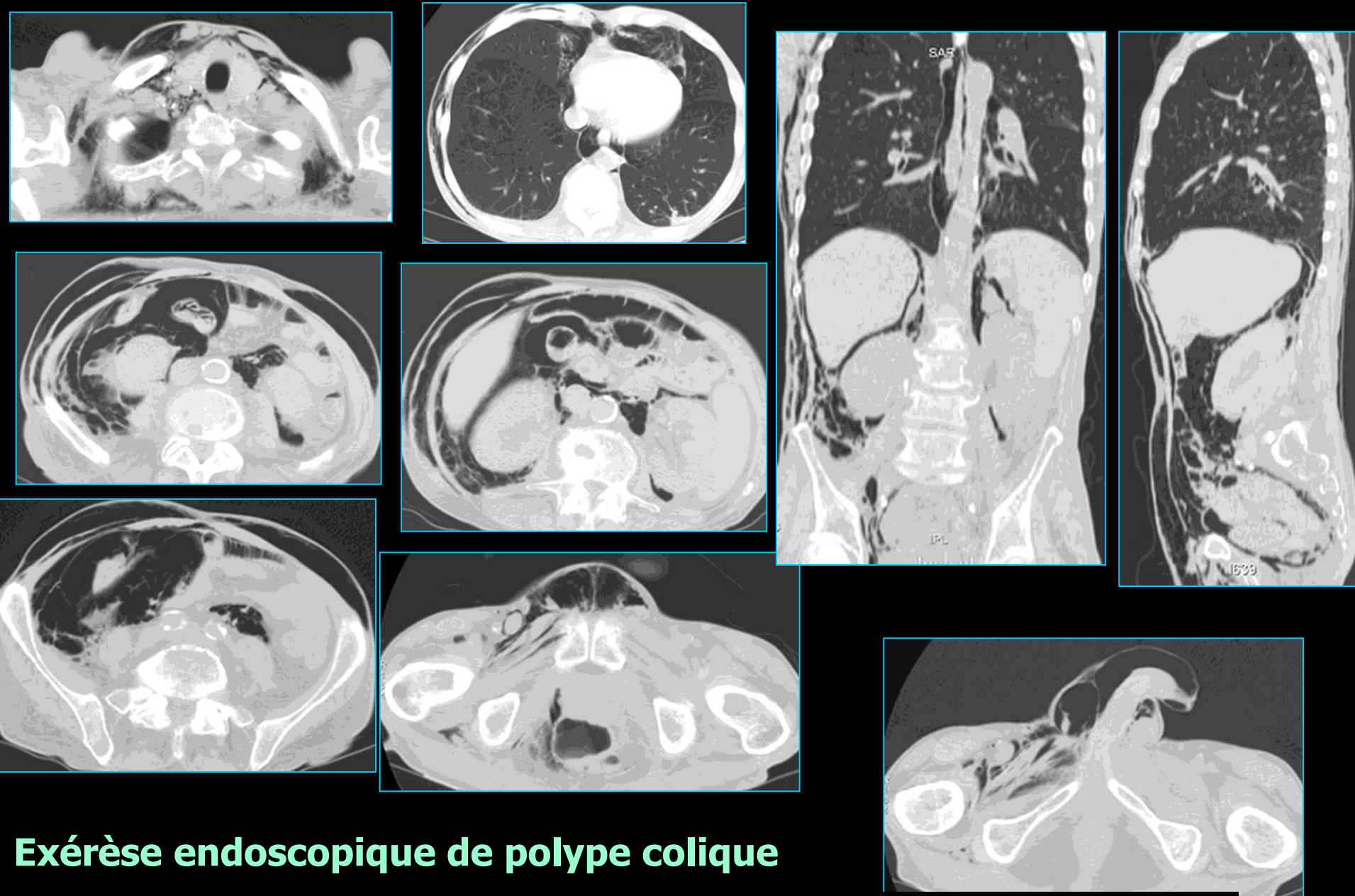


péritonite tuberculeuse

.imagerie de la diffusion des fluides gazeux dans les espaces cellulo-grasieux du tronc



rétro-pneumopéritoine par perforation d'un diverticule sigmoïdien

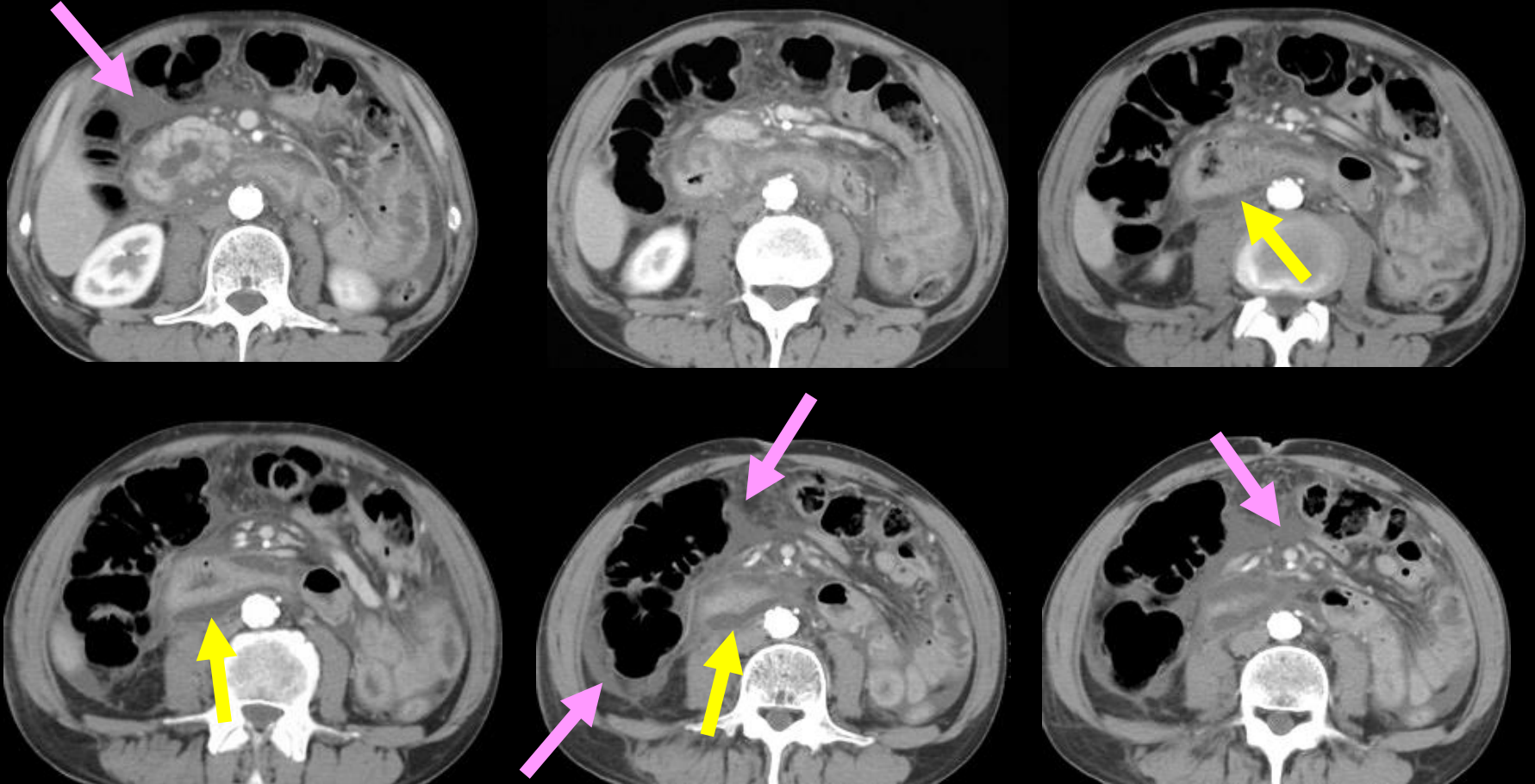


Exérèse endoscopique de polype colique

- Perforation colique
- Diffusion du gaz du mésosigmoïde vers les espaces cellulo-graisseux du rétropéritoine, gagnant le thorax sous forme d'un pneumomédiastin.
- Pas de pneumopéritoine.

applications pratiques

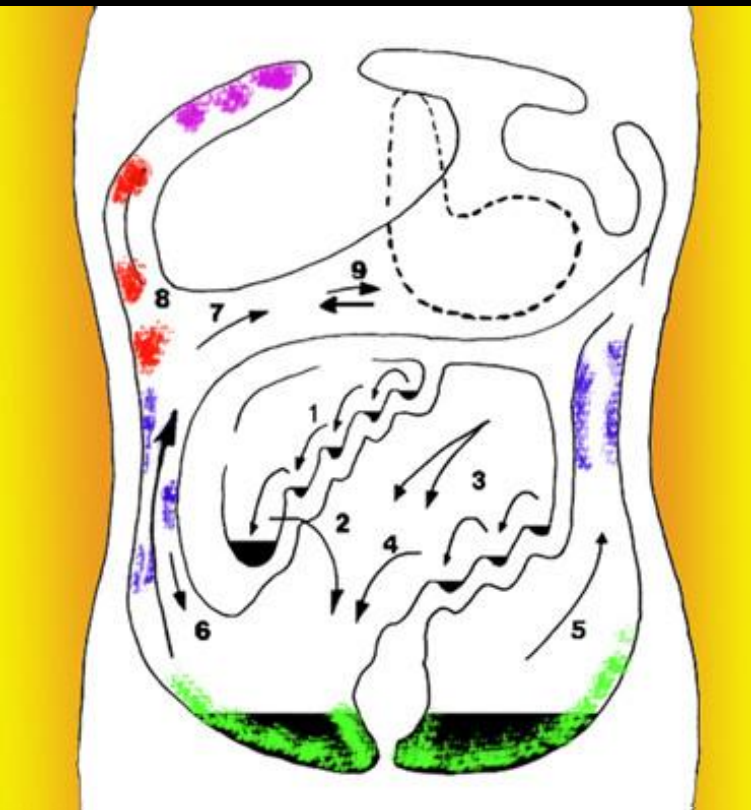
diffusion des fluides liquidiens dans les espaces cellulo-grasieux du tronc



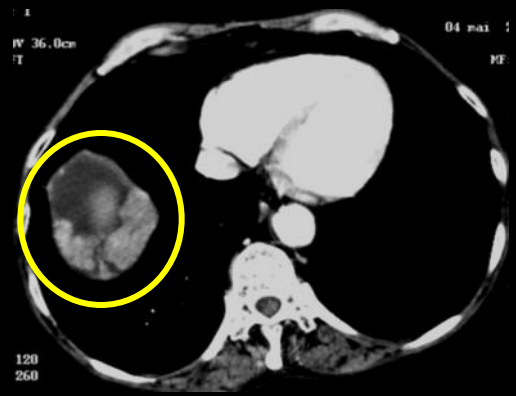
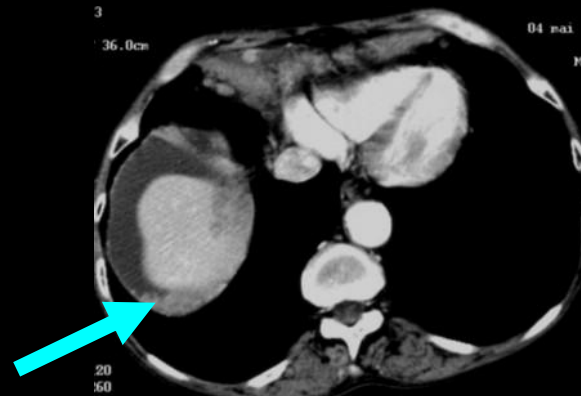
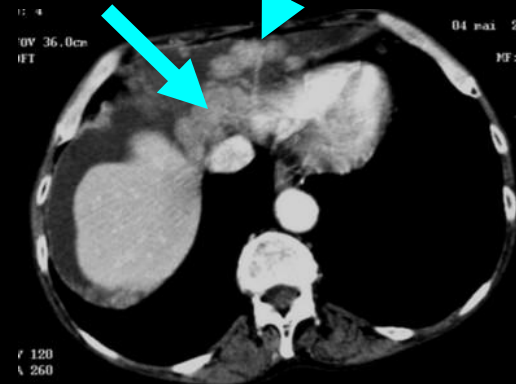
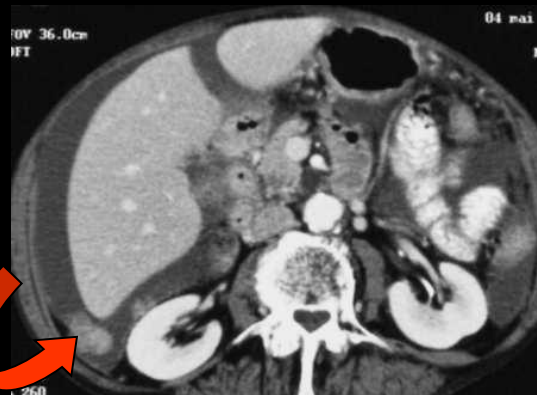
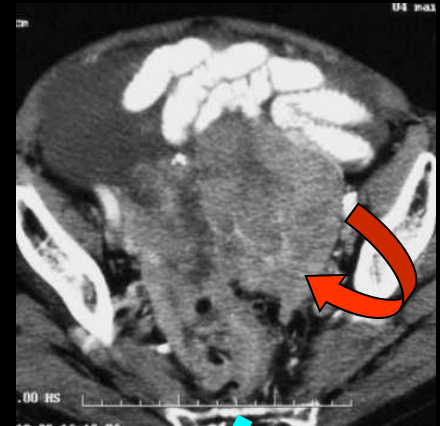
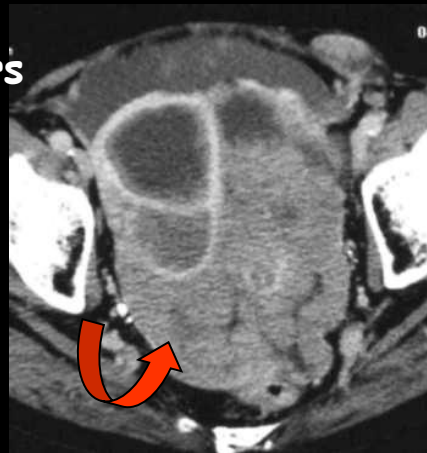
pancréatite aiguë : diffusion des liquides exsudés dans les espaces cellulo-grasieux sous péritonéaux du mésentère et du **rétro péritoine**

applications pratiques

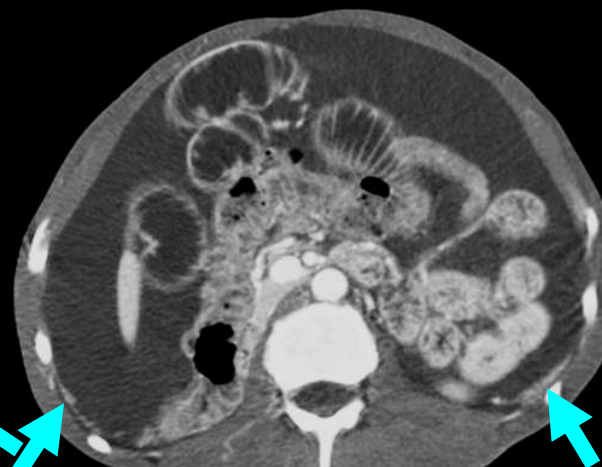
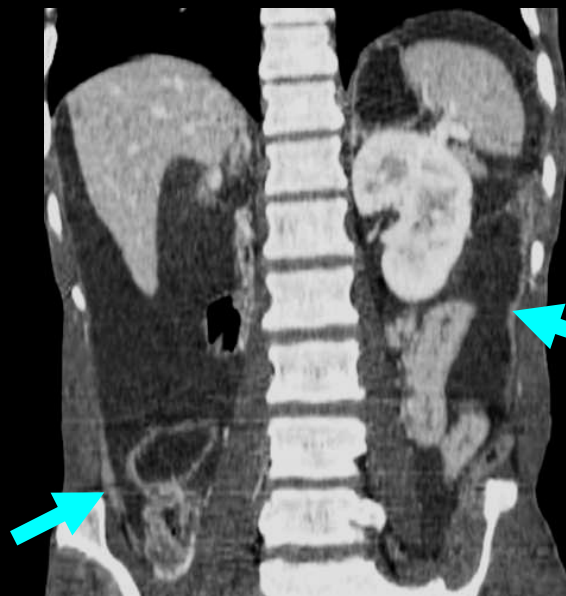
les disséminations péritonéales des tumeurs



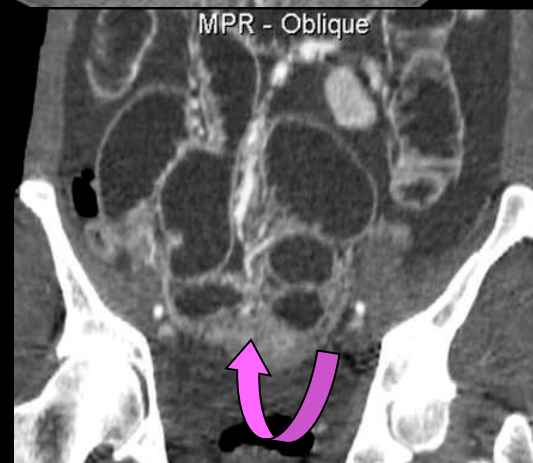
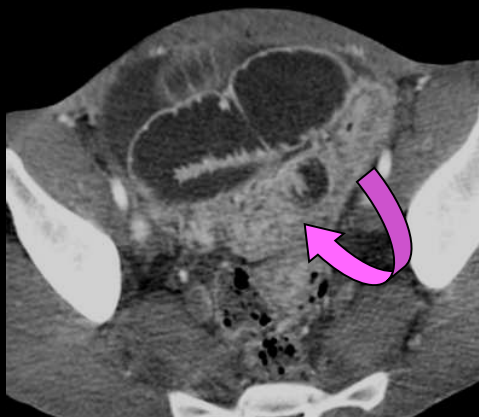
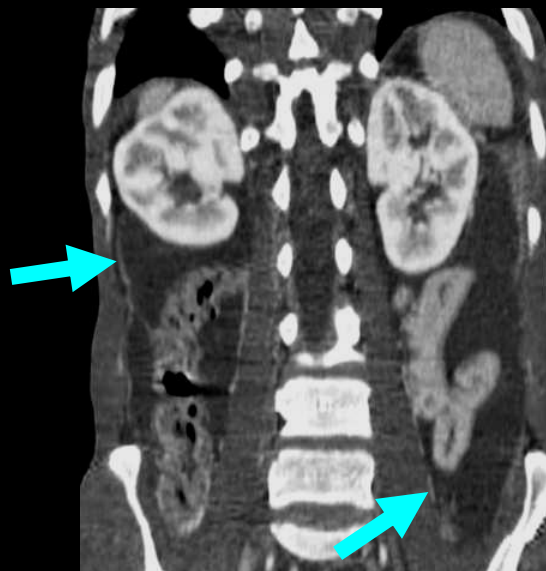
siège des implants dans les
disséminations péritonéales
de surface des cellules
tumorales à faible capacité
d'adhésion

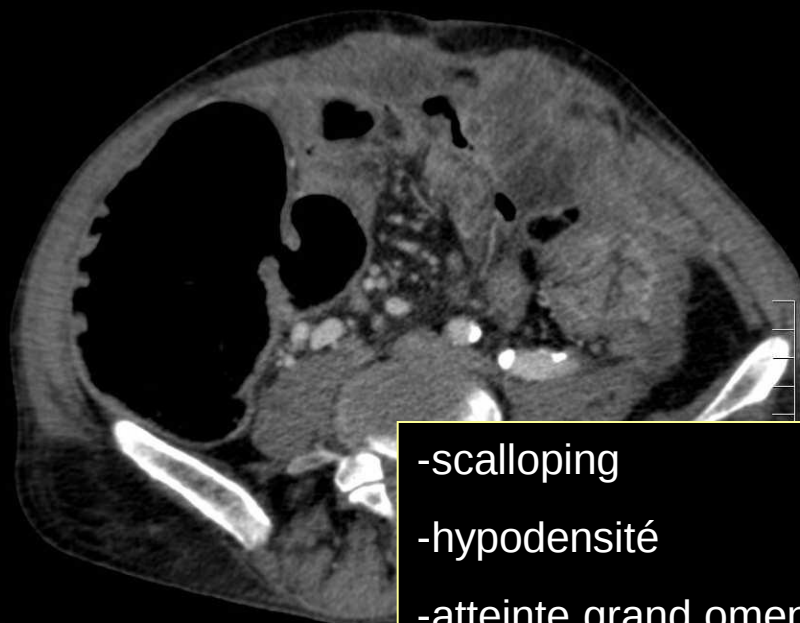
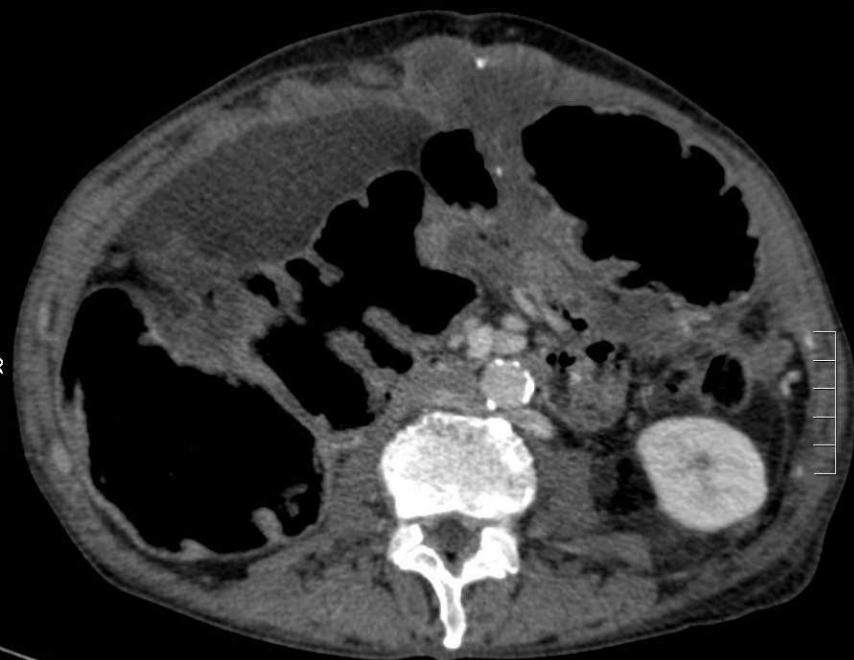


carcinomatose d'origine ovarienne



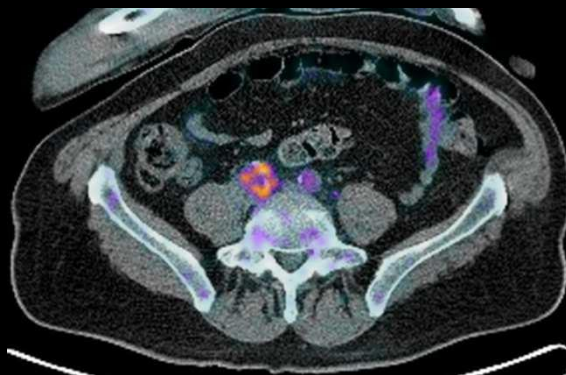
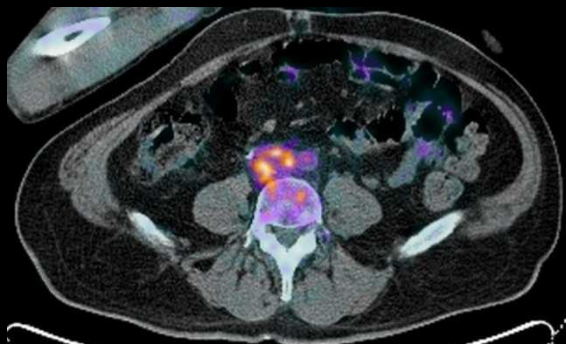
carcinomatose
d'origine gastrique



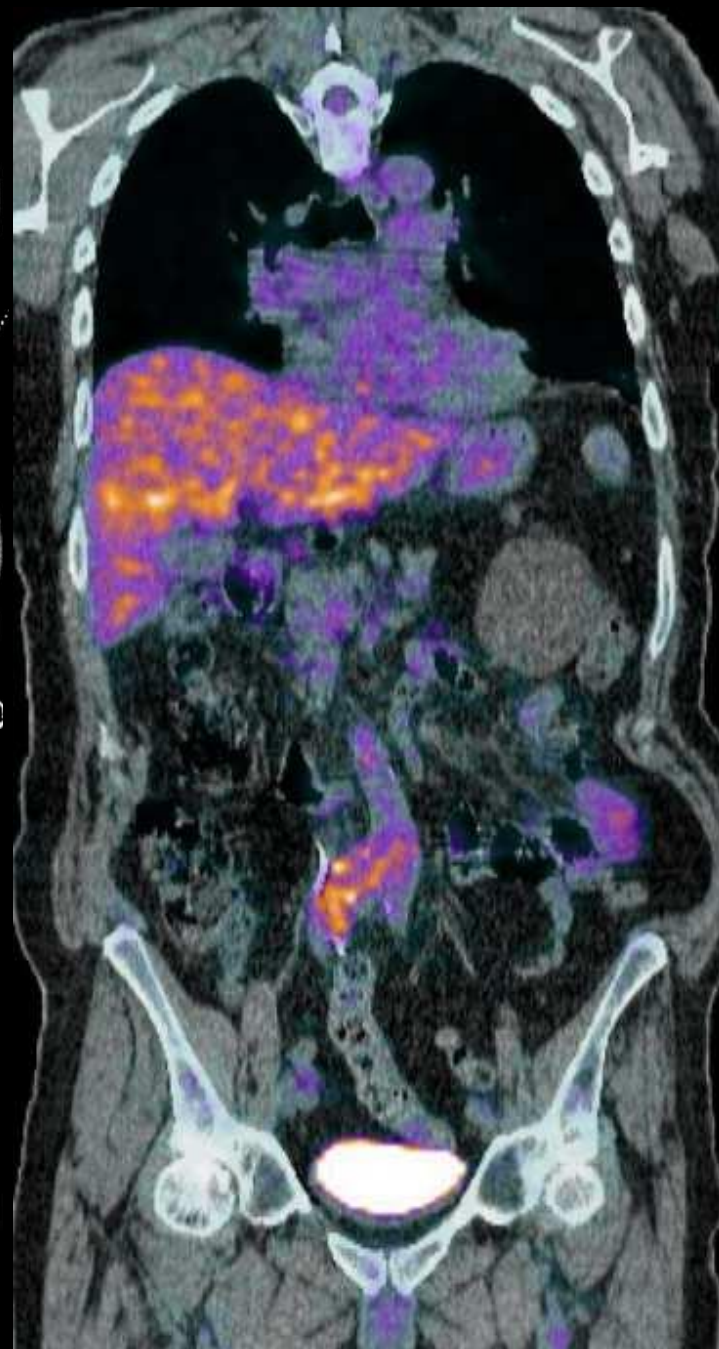
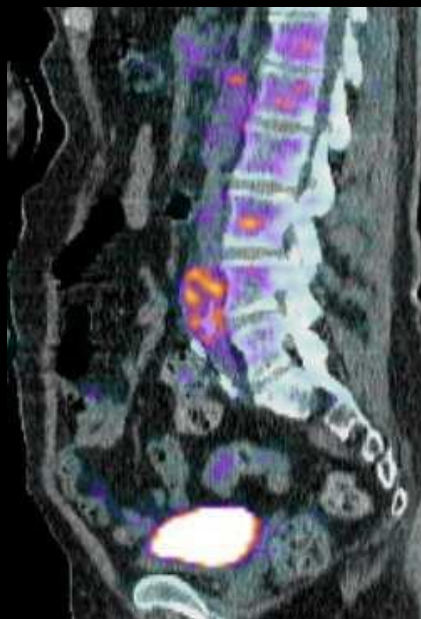


Pseudomyxome

- scalloping
- hypodensité
- atteinte grand omentum
- aspect stratifié échographie



Fibrose rétropéritonéale



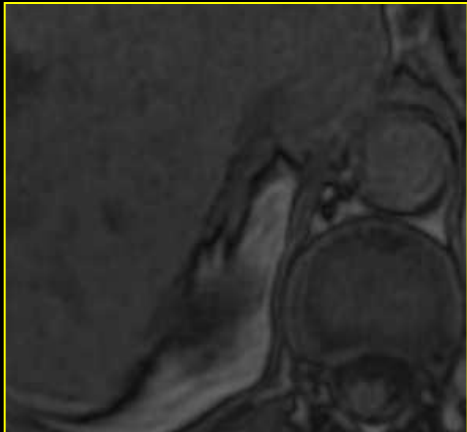
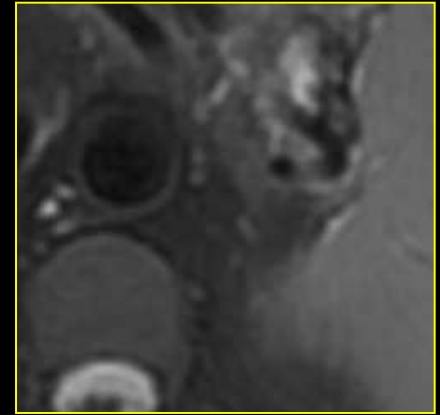
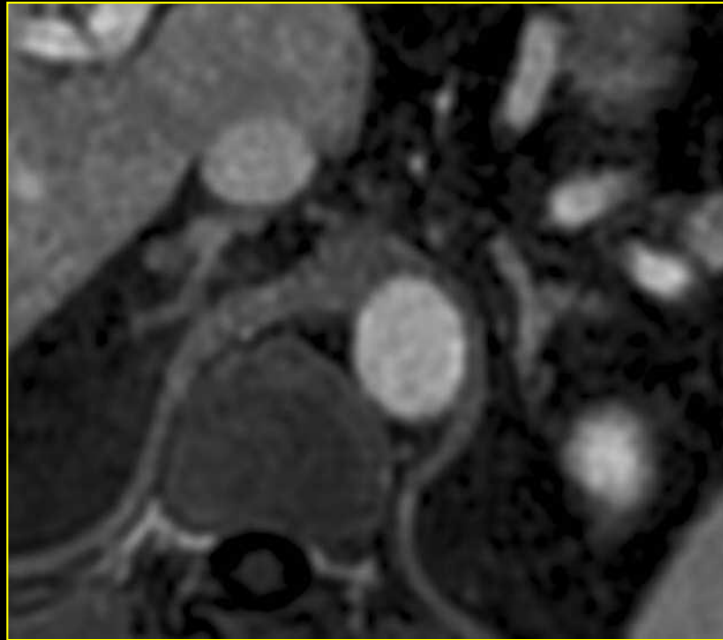
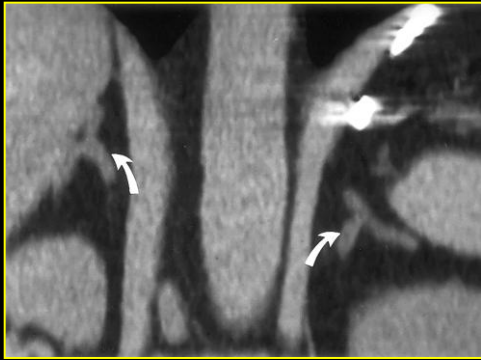
SURRENALES : anatomie



surrénale droite : sus-rénale et rétro-cave
surrénale gauche : pré-rénale

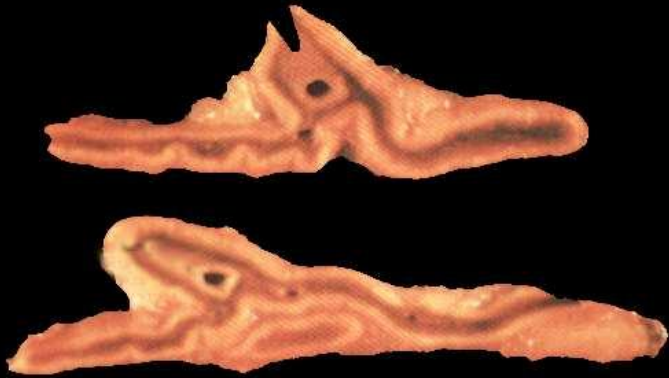
3 pédicules afférents artériels
1 seule efférence veineuse

SURRENALES : anatomie

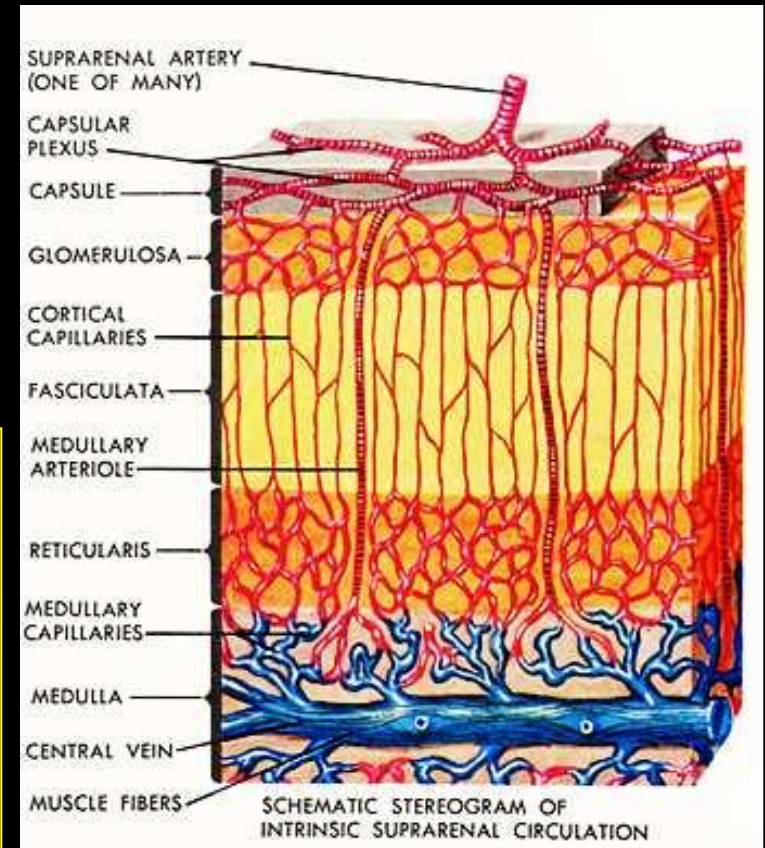


Piège :
diverticule
gastrique





Glomérulée: minéralo-corticoïdes
Fasciculée : glucocorticoïdes
Réticulée : androgènes et
œstrogènes surrénaliens



Structures cortico et médullo-surrénaliennes

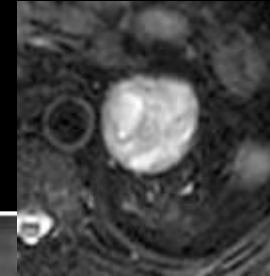
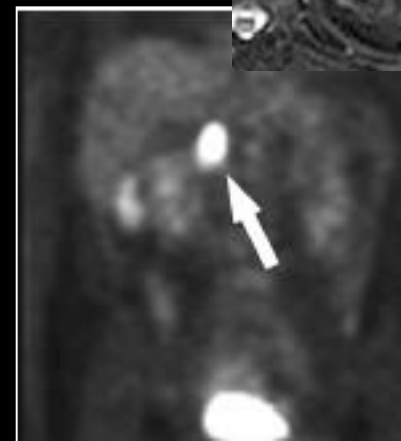
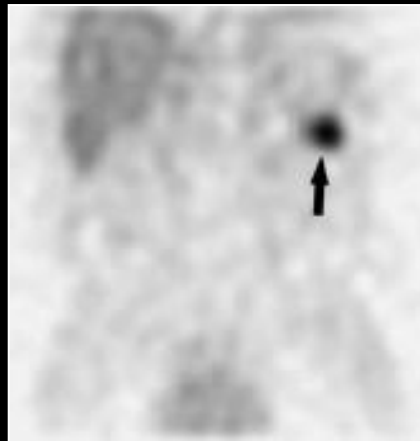
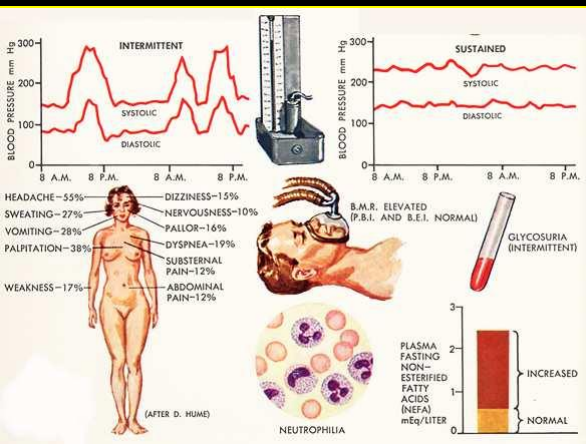
SURRENALES : pathologie

- **Atteintes médullo-surrénaliennes**
 - Phéochromocytome
- **Atteintes cortico-surrénaliennes**
 - Syndrome de cushing
- **Hyperaldostéronisme primaire**
 - Syndrome de Conn
- **Contexte carcinologique**
 - Métastases
- **Incidentalome surrénalien**

Atteintes médullo-surrénaliennes

Phéochromocytome

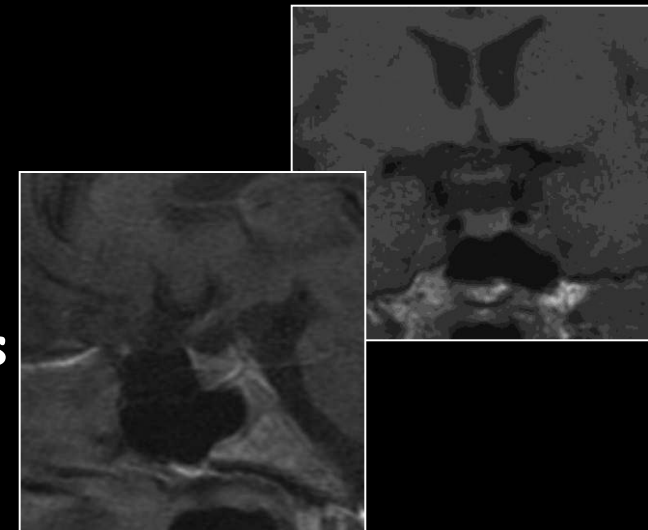
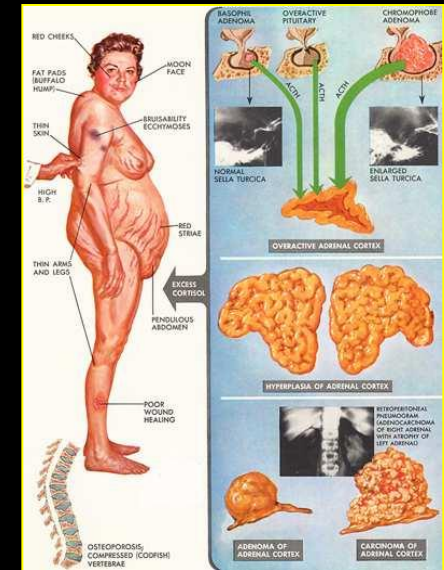
- HTA paroxystique, triade céphalées-sueurs-palpitations-pâleur, hTA orthostatique
- L'imagerie est indiquée devant les **modifications hormonales** caractéristiques des phéochromocytomes (métanéphrines)
- La **TDM ou l'IRM** permettent de localiser un phéochromocytome surrénalien
- La **scintigraphie** à la MIBG permet de déceler des localisations ectopiques (paragangliome) ou secondaires



Atteintes cortico-surrénaliennes

Syndrome de Cushing

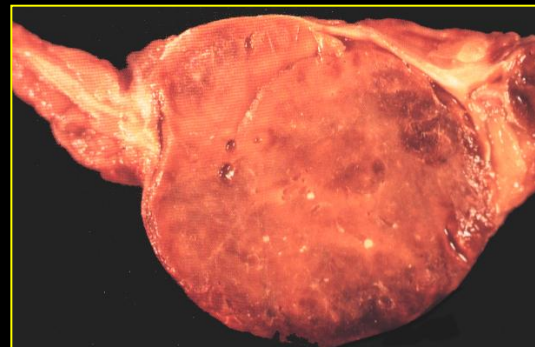
- Le choix de l'imagerie dépend du taux d'**ACTH** plasmatique sans stimulation (8h)
- En cas d'ACTH basse (20%) adénome ou hyperplasie?
la **TDM surrénalienne** doit être réalisée en 1ère intention
- En cas d'ACTH normale ou élevée
il faut discuter la réalisation d'une **IRM hypophysaire** et/ou d'une **TDM TAP**
- La **scintigraphie** au noriodocholestérol est aussi utile en cas d'hyperplasie ou de tumeurs bilatérales



Hyperaldostéronisme primaire

Syndrome de Conn

- Excès de minéralocorticoïdes, rénine basse, HTA+hypokaliémie
- La **TDM** surrénalienne est l'examen de 1ère intention pour identifier un adénome ou une hyperplasie bilatérale.
- La **scintigraphie** au noriodocholestérol est aussi utile pour séparer les adénomes sécrétants des hyperplasies bilatérales.
- Le **cathétérisme veineux** sous contrôle radioscopique pour réaliser des prélèvements étagés n'est plus réalisé.



SURRENALES : protocole d'exploration

- 1. ETUDE SANS INJECTION
 - Mesure de la densité spontanée de la lésion
 - Evaluation de son contenu graisseux
 - Distinction tumeur bénigne et tumeur maligne
 - Si densité $< 10\text{UH}$: lésion bénigne
 - Si densité $< -20\text{UH}$: myélolipome

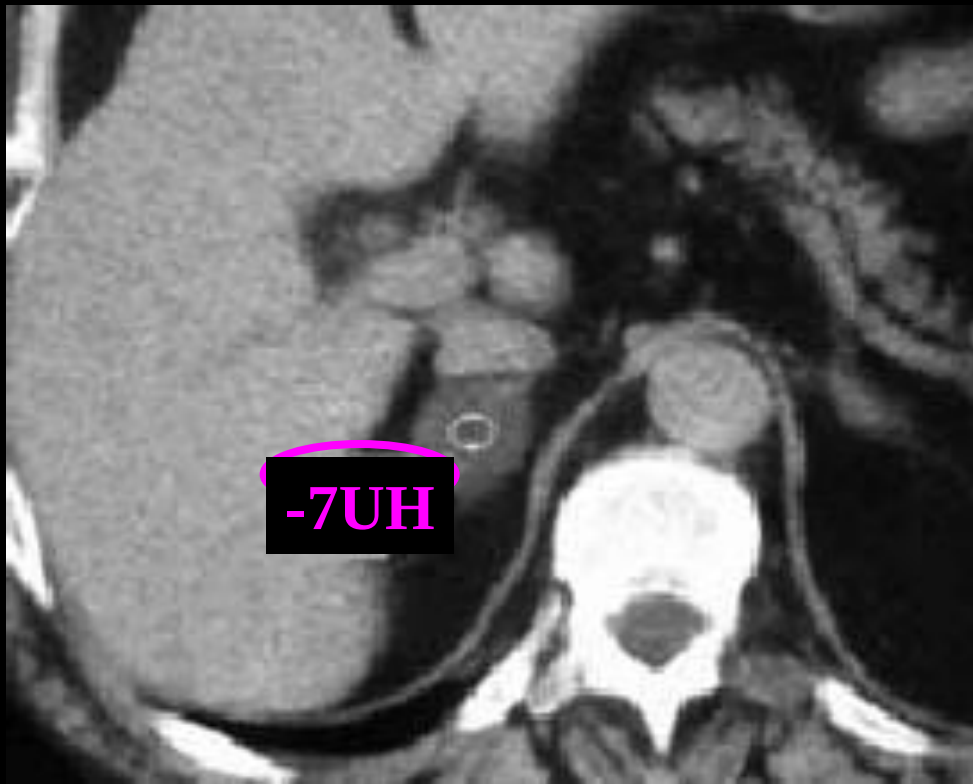
SURRENALES : protocole d'exploration

2. ETUDE AVEC INJECTION

- Nécessaire si densité spontanée >10UH
- 2 spirales: à 60s et à 15min
- 130mL de PDCi à 3mL/s
- Evaluation du rehaussement tumoral
- Calcul du % de lavage absolu: « wash out »
 - $[(UH\ 60s - UH\ 15min) / (UH\ 60s - UH\ ss\ IV)] \times 100$
- Si WO > 60%: adénome
- Si WO < 60%: lésion non adénomateuse

Exemple

- INDICATION: HTA+ sd de Cushing
- Protocole surrénale



CAT?

- Arrêt de l'examen

Exemple

- INDICATION: HTA+ sd de Cushing
- Protocole surrénale

CAT?

IV60s et 15min et
calcul du WO

17UH

90UH

50UH

Diagnostic?

>10UH+WO

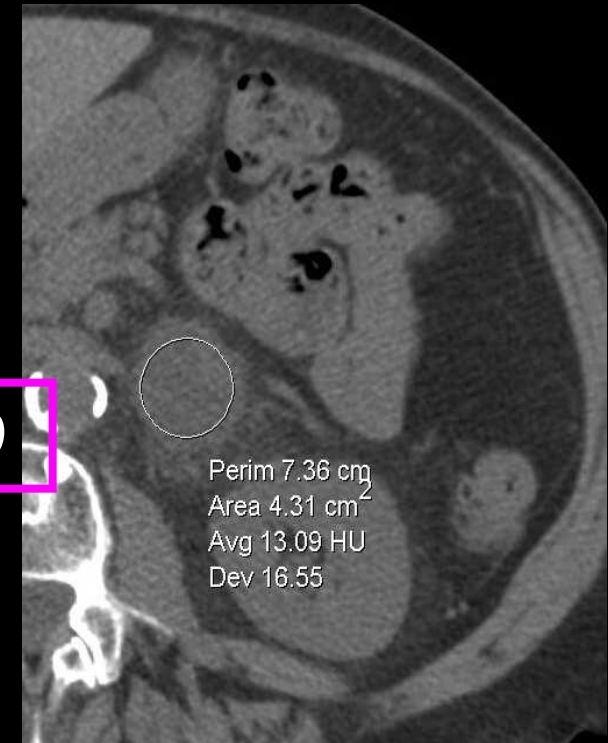
Adénome

Exemple

- INDICATION: HTA+ sd de Cushing
- Protocole surrénale

CAT?

IV60s et 15min et calcul du WO

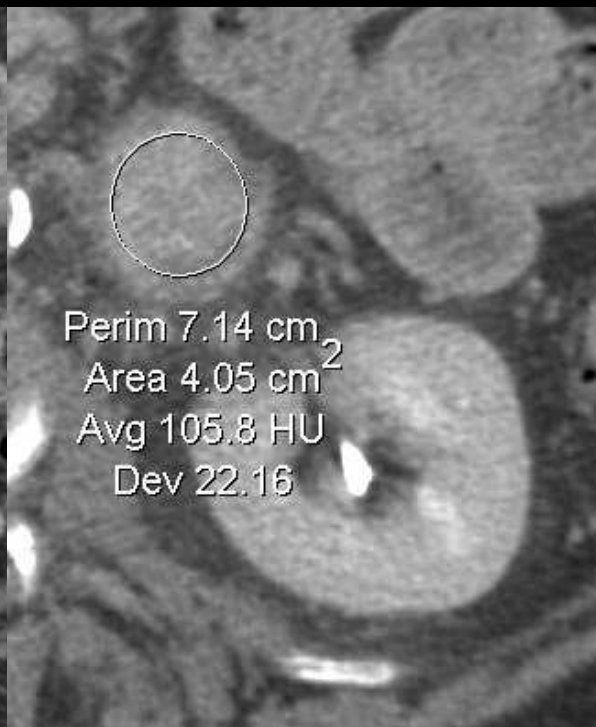
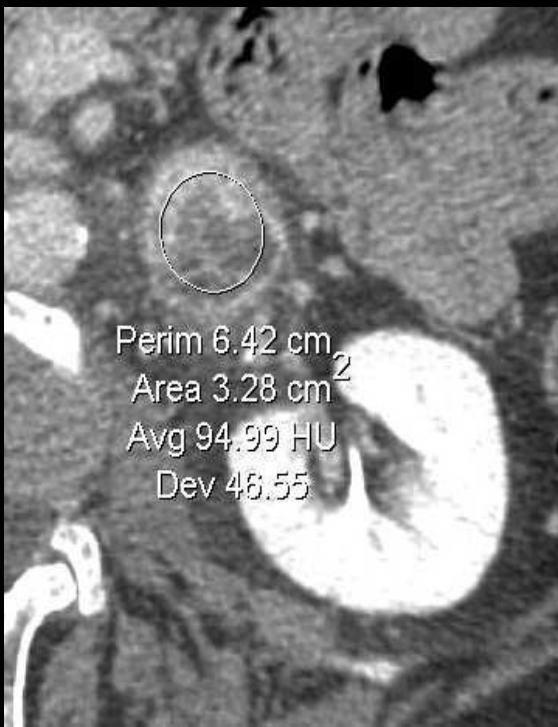


Diagnostic?

$>10UH + WO < 60\%$

Non adénome

Phéochromocytome



Quand faire l'IRM ?

- En cas de doute diagnostique persistant après la TDM ++
- Meilleur contraste tissulaire
- De première intention rarement en raison de la disponibilité de l'imageur et de la bonne sensibilité du scanner SAUF:
 - > Nouveau né
 - > Femme enceinte
 - > Suivi itératif des sujets jeunes

SURRENALES : protocole IRM

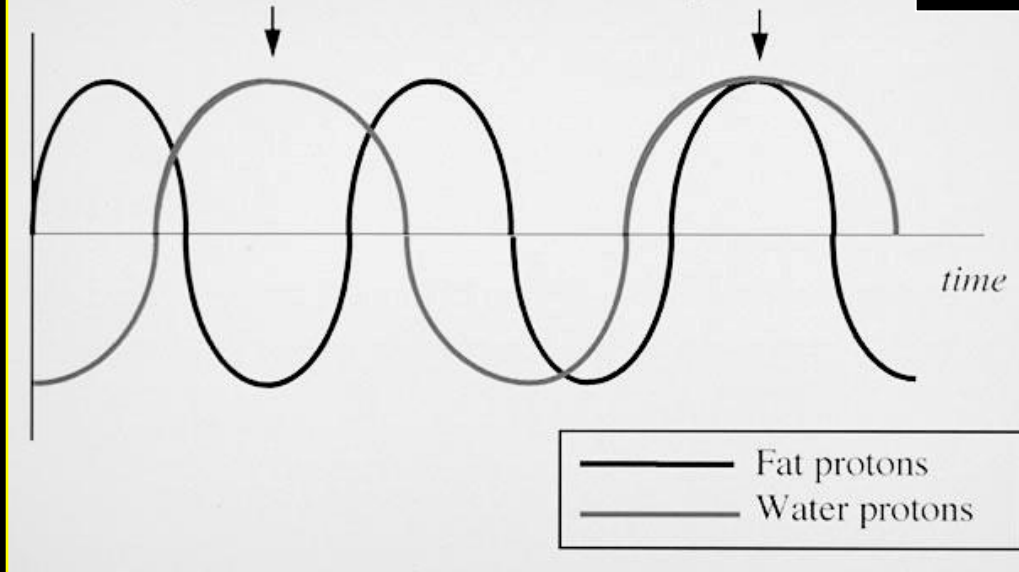
- Séquence « clé » : séquence en déplacement chimique ou dual écho ou écho de gradient T1 in phase et out phase (IP/OP)
- Intérêt pour les lésions avec contingent lipidique intracellulaire micro.
- T2 intérêt pour les phéochromocytomes (typiquement très hyperT2)
Ss>Scortex rénal: phéo- Ss<Scortex foie: bénin
- EG T1 injecté peu discriminant, dynamique identique à celle du scanner

TE=2.1ms

out-of-phase:
signal destructive

in-phase:
signal additive

TE=4.2ms



À TR constant, ne
modifier que le TE

Fenêtrage ++

Abaissement du
signal en OP par
rapport au IP

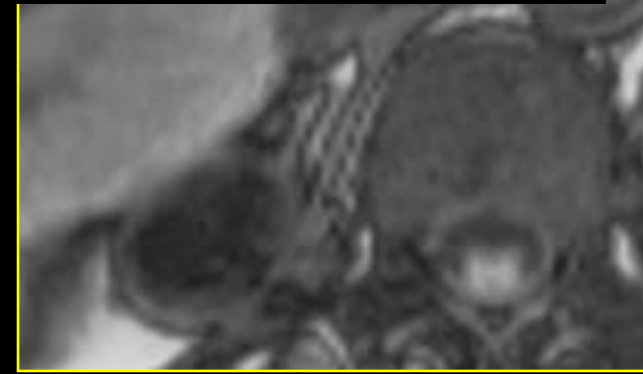
> 20%

en cas de contenu
gras
intracellulaire

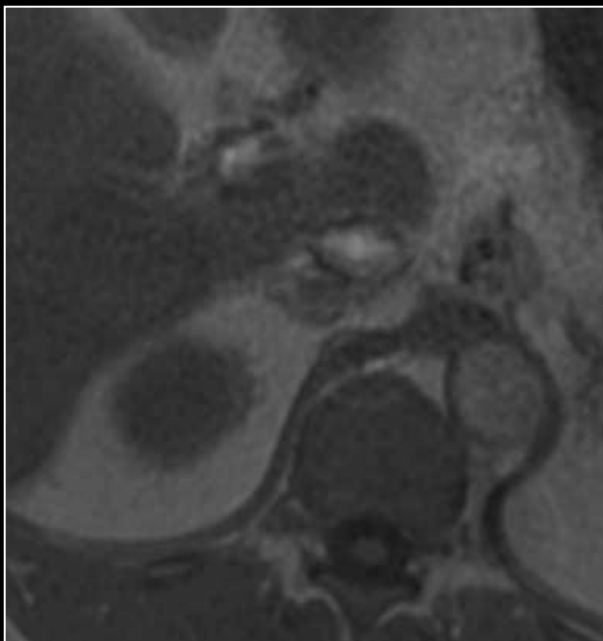
Adénome typique riche en lipide



In phase
TE 4.2ms

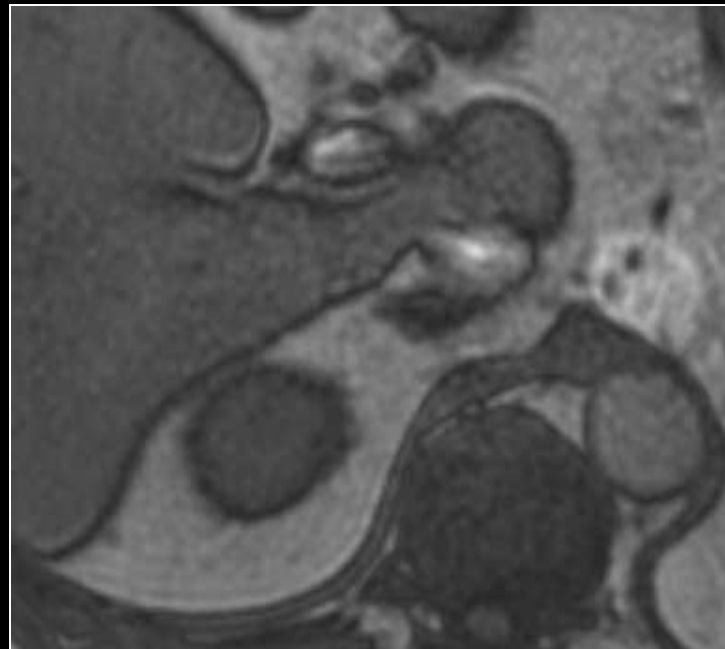


Out phase
TE 2.1ms



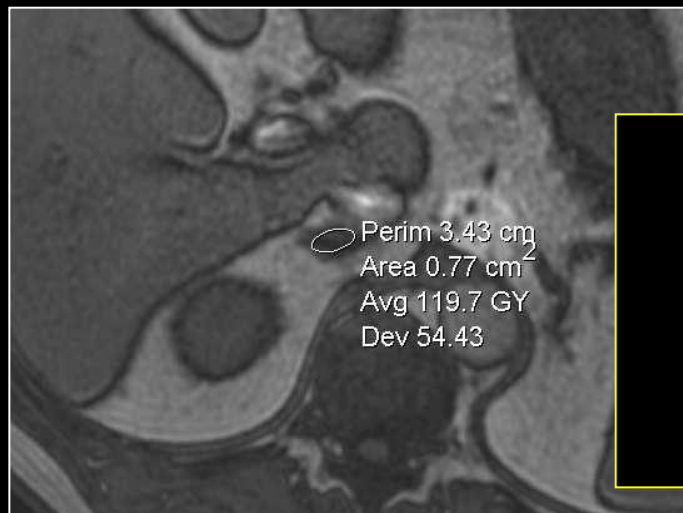
IP

TE 4.4ms



OP

TE 2.2ms



Abaissement du
 signal en OP par
 rapport au IP de
 34.62%

> 20%

Adénome de Conn

Phéochromocytome

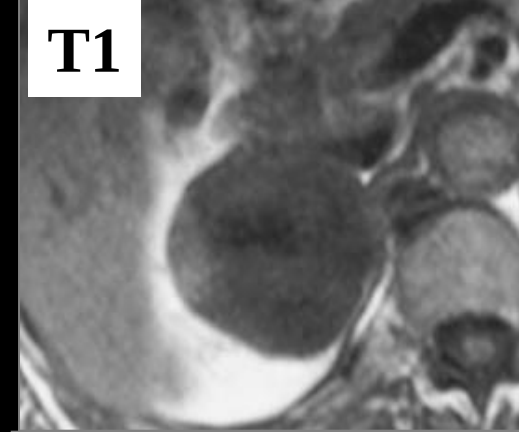
Clinique ++/unilat / 10% asymptomatique / 10% malin
parfois caractéristique en TDM: **hypervasculaire**

Contre-indication à la biopsie

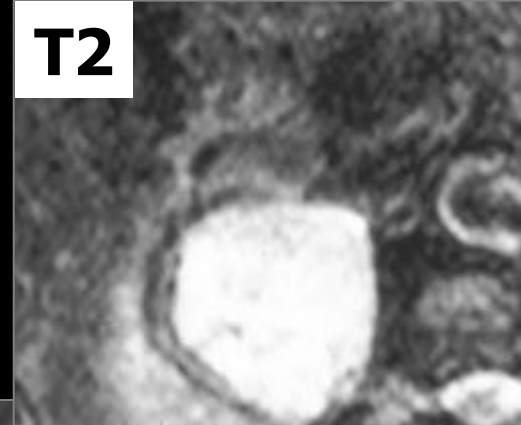
Peut avoir un aspect relativement typique en IRM

Possible nécrose, calcification, kystisation ou graisse

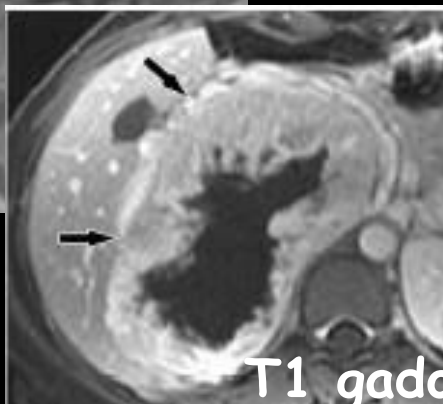
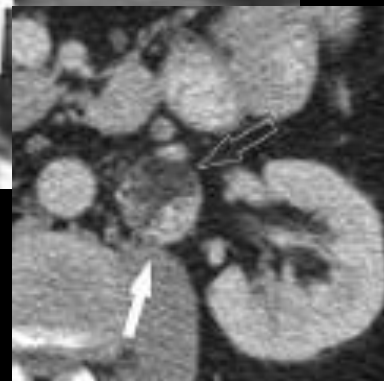
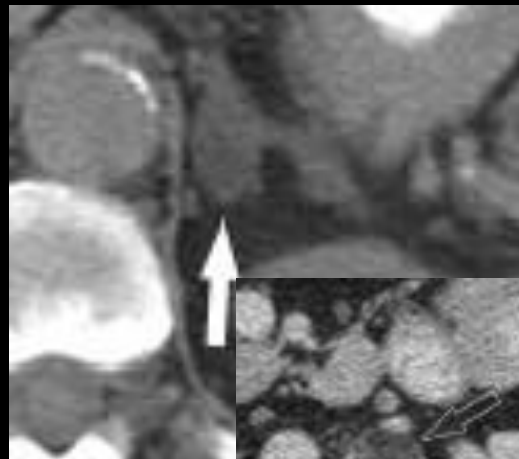
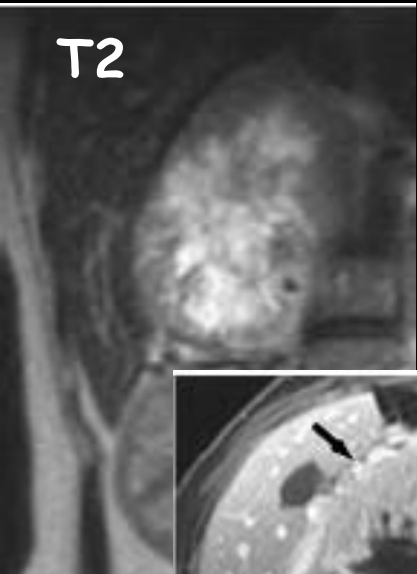
T1



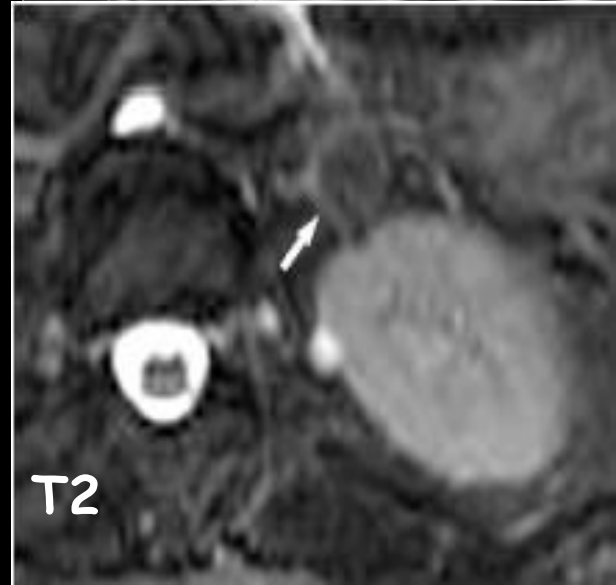
T2



T2



T1 gado



T2

TDM sans IV

TDM avec IV 60s
et temps tardif 15'

< 10UH

> 10UH

> 10UH et
WA < 60%

> 10UH et
WA > 60%

Bénin

Adénome,
Myélolipome

IRM

Séquence IP OP

Bénin

Chute du signal
> 20%

Pas de chute du
signal

Non adénomateux

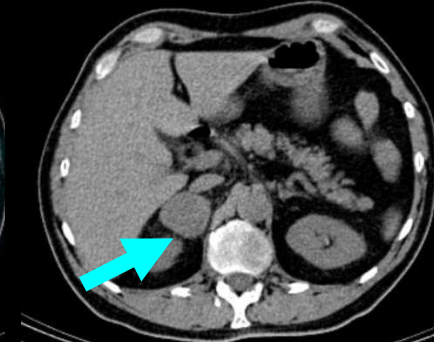
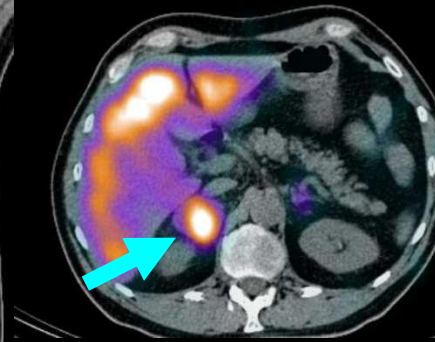
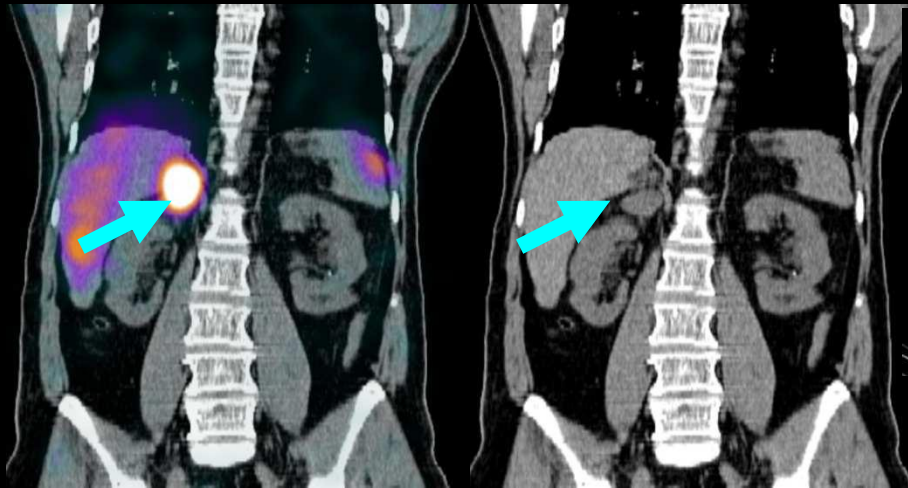
Séquence
T1 FS

Bénin

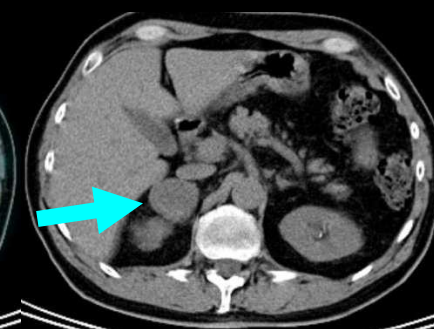
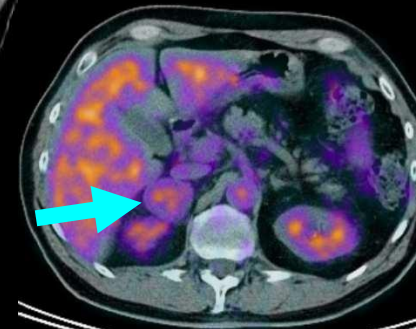
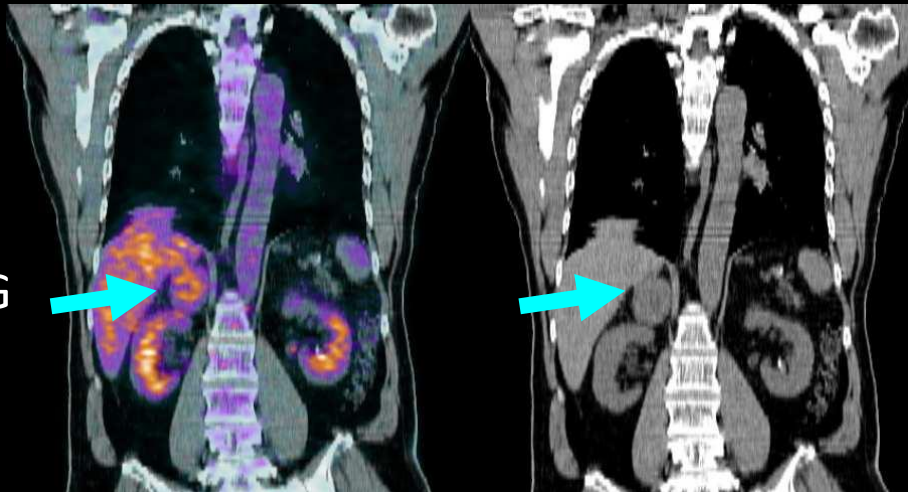
Chirurgie ou
Biopsie ou
surveillance

Masse surrénale D

MIBG



^{18}F FDG



Phéochromocytome

Phéochromocytome

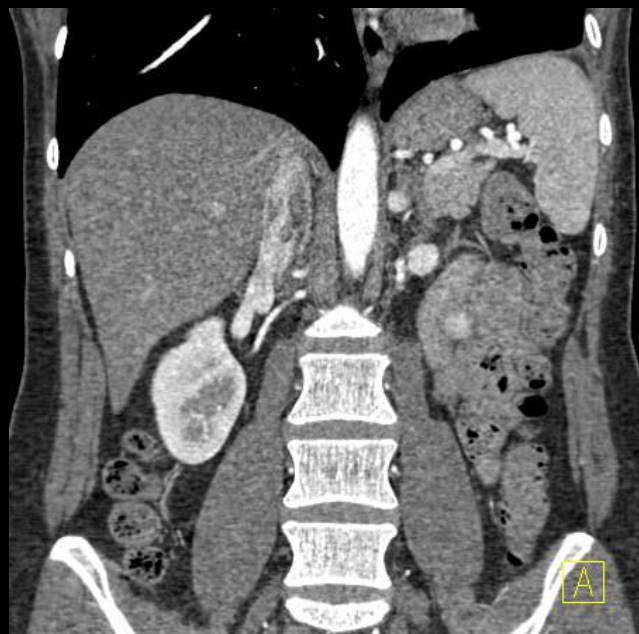


MIBG

FDG

^{18}F -DOPA

Phéochromocytome



TEP ^{18}F -DOPA



Ré

No

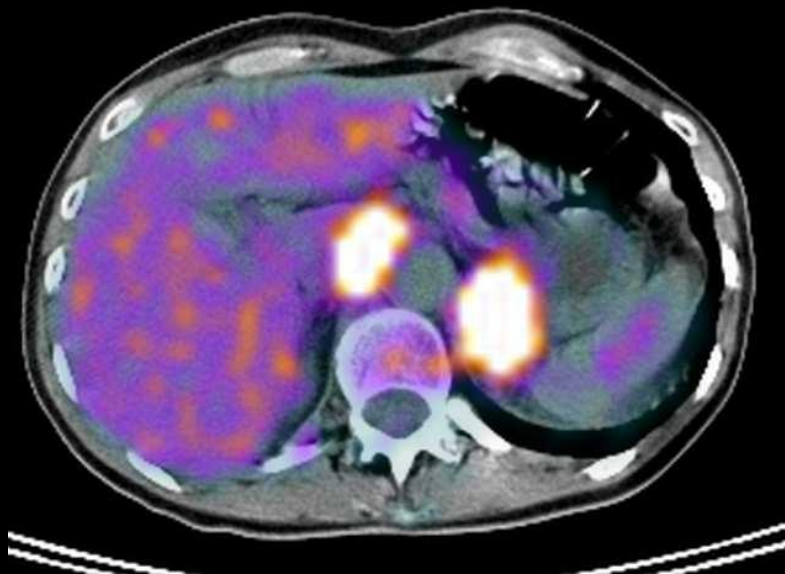
Pa

Vés

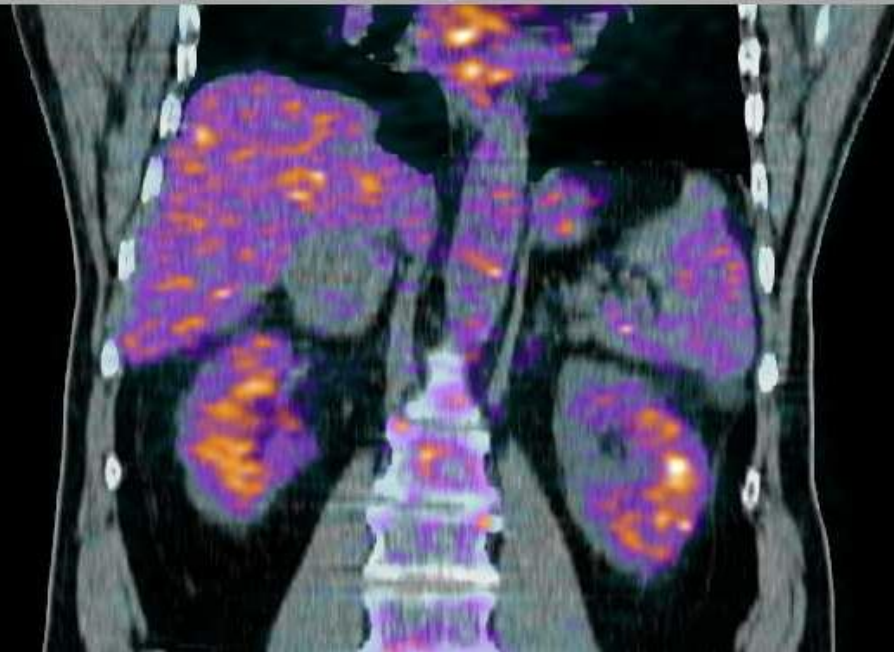
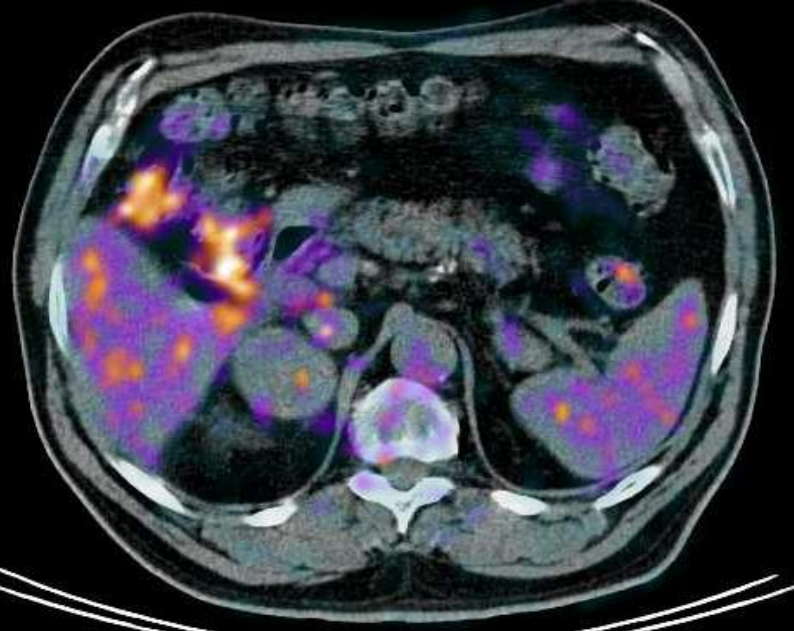
Foi

Sys

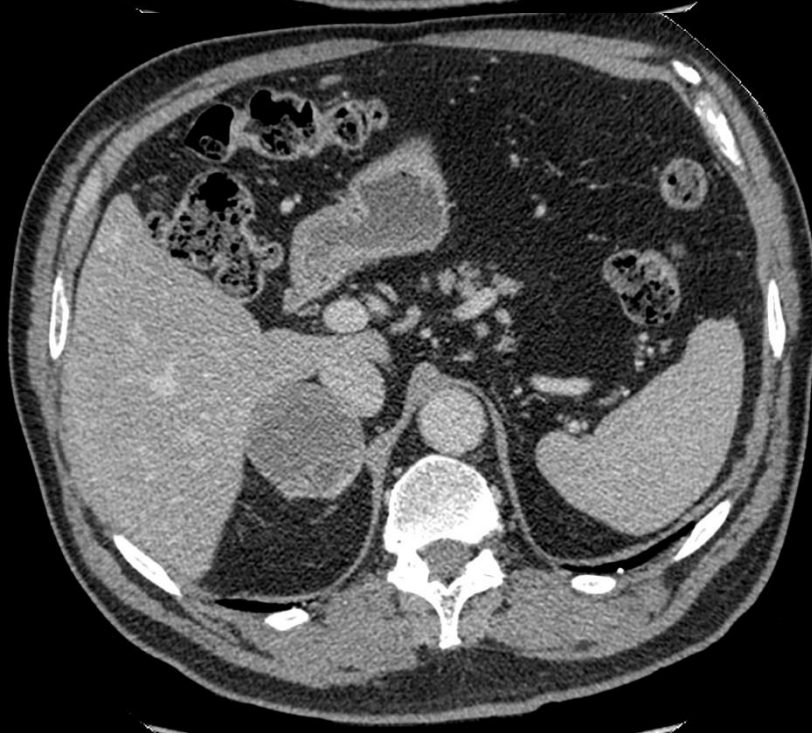
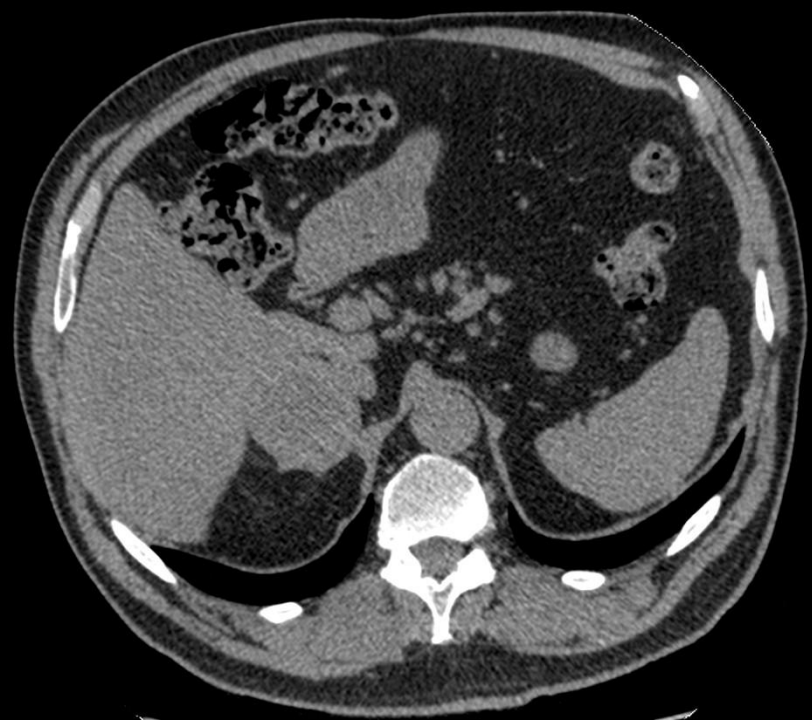


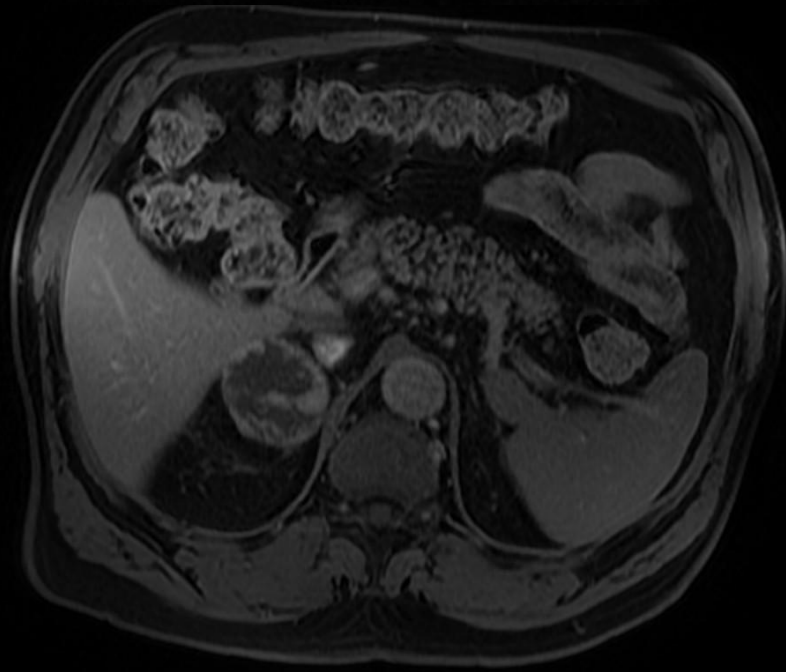
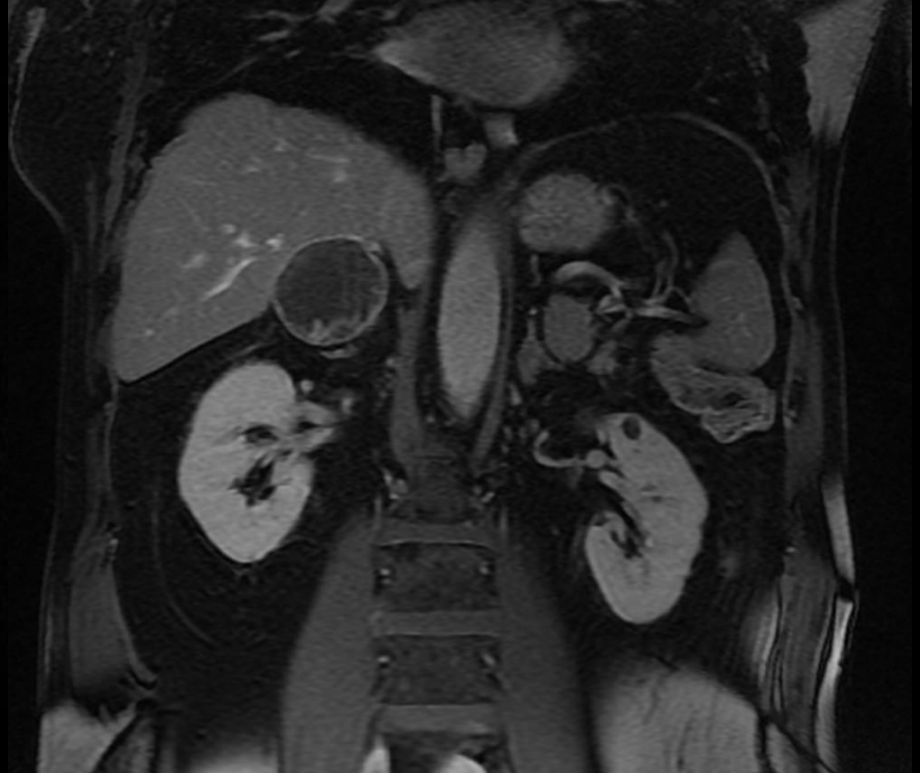


TEP FDG - Métastase surrénalienne G



Bilan d'une masse surrénalienne : TEP FDG



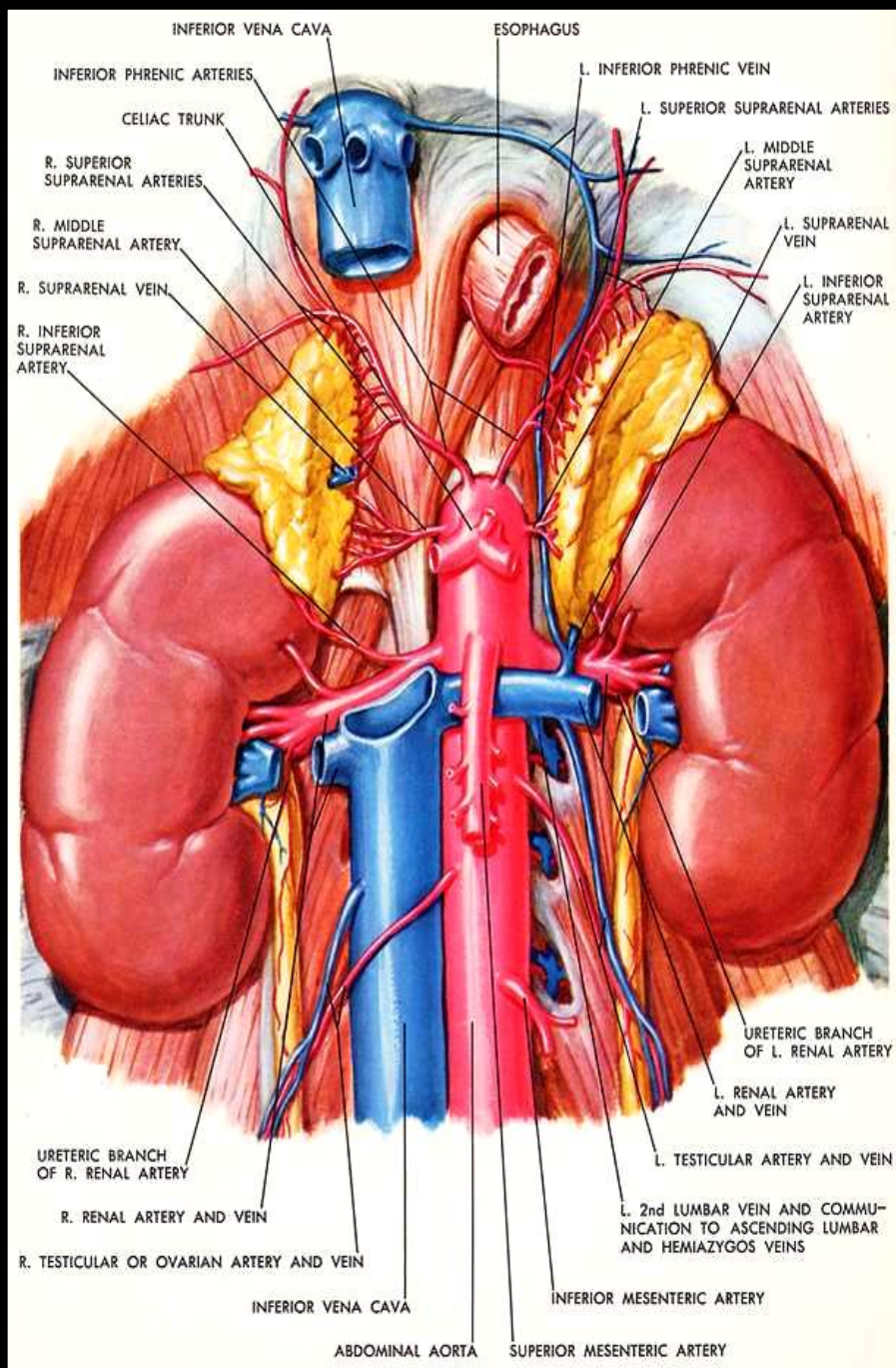


Cortico-surrénalome ?
Phéochromocytome ?

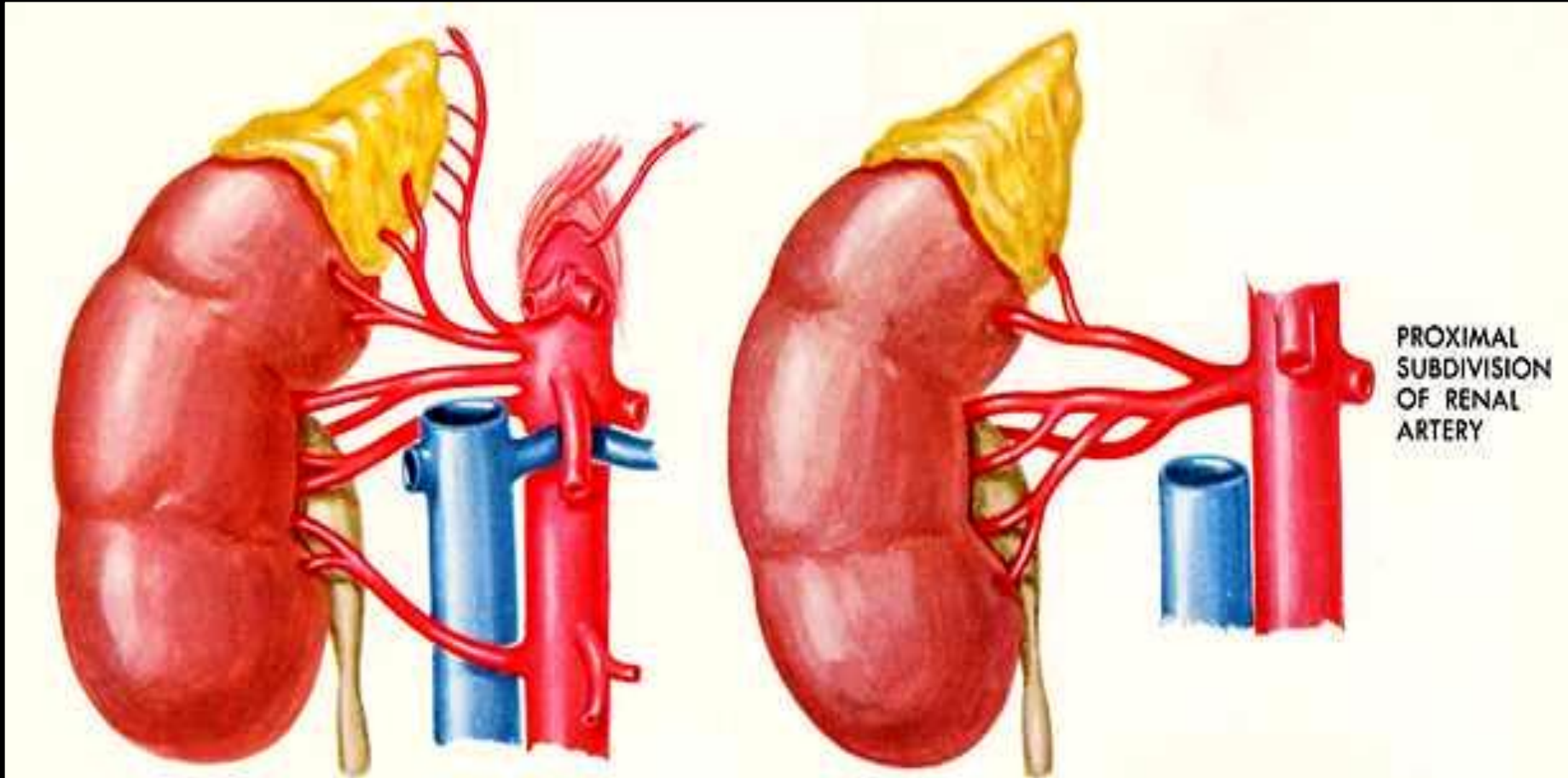
Anapath : hémangiome

REINS : anatomie

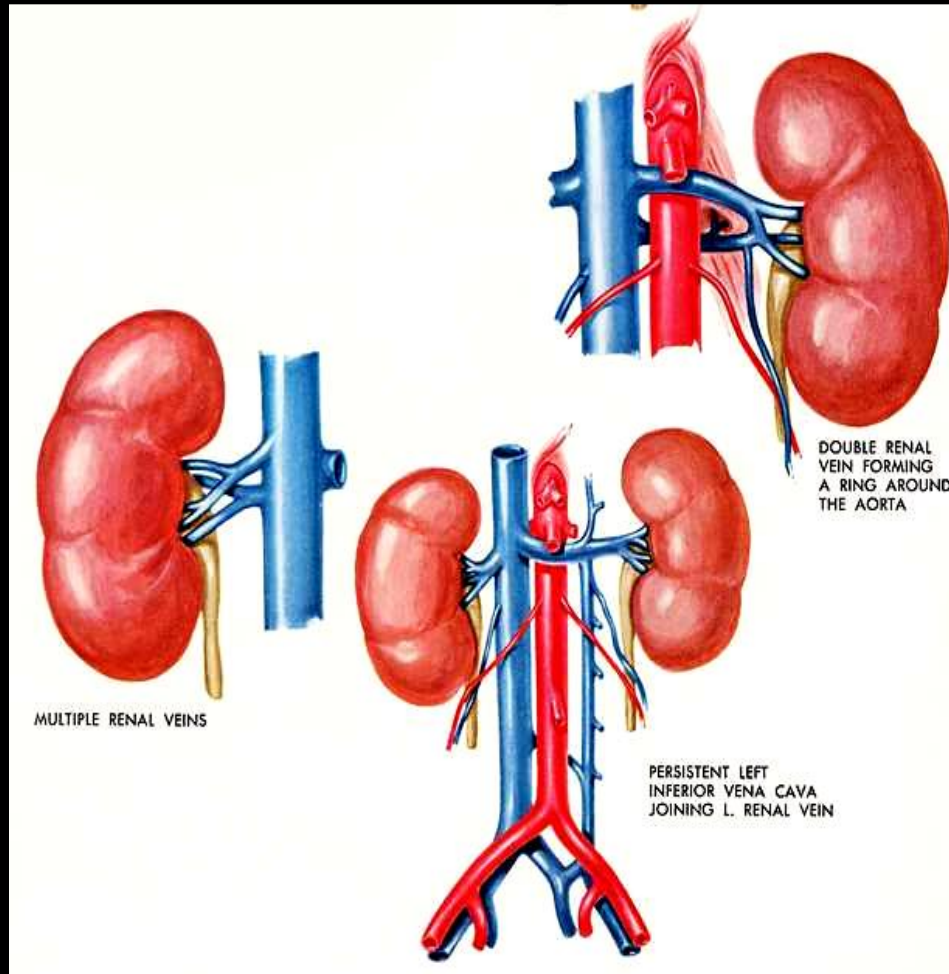


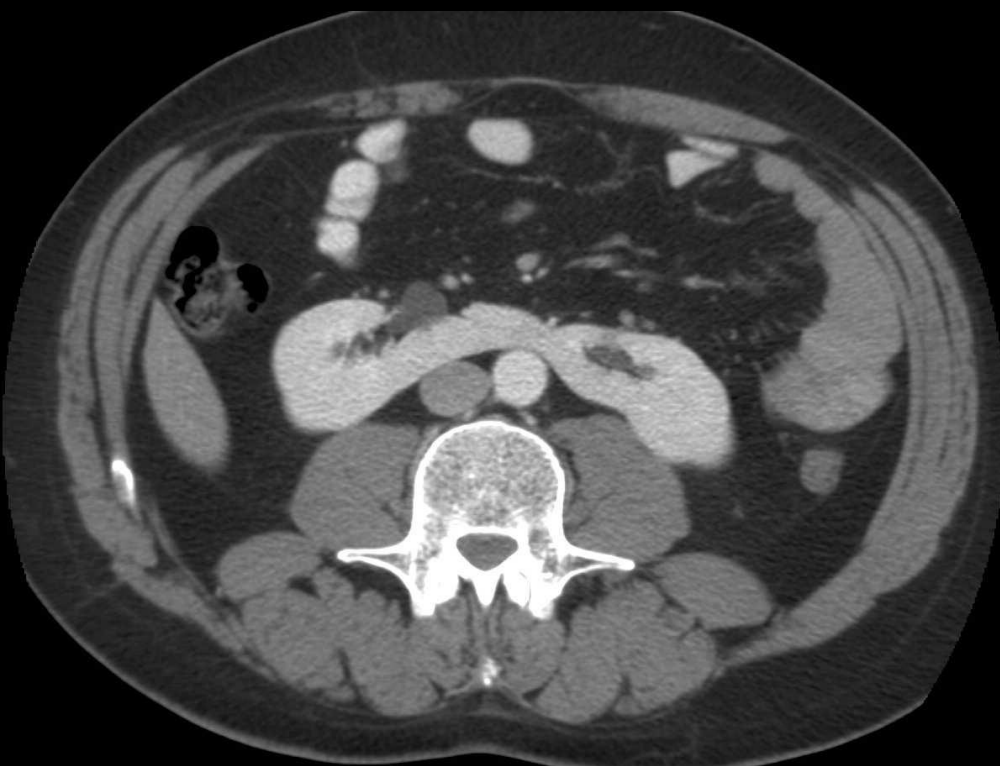


Variantes artères rénales



Variantes veines rénales



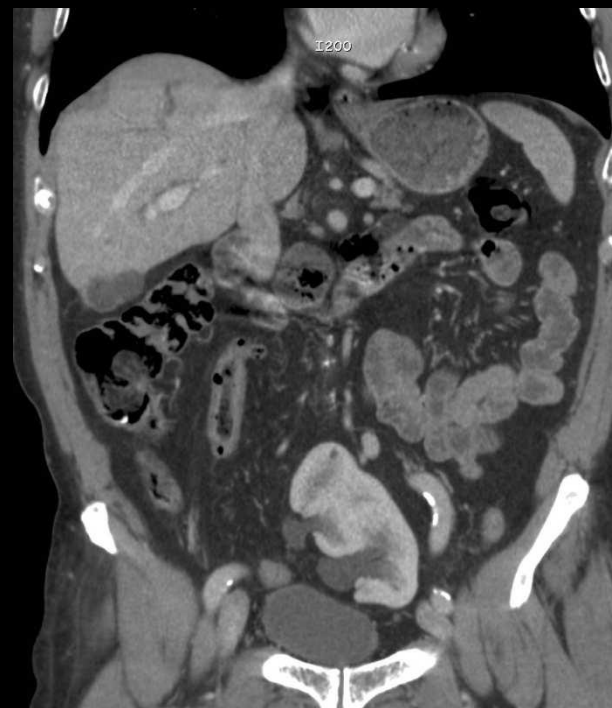


Rein en fer à cheval

26



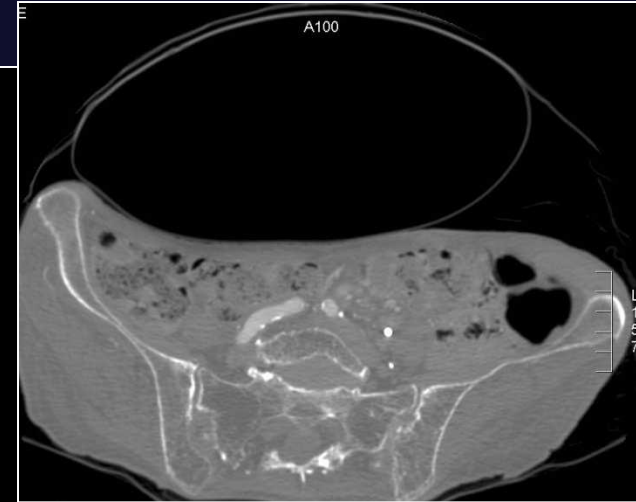
W 400 : L 40



Rein pelvien

URO-scanner

- Méthode non invasive
- Irradiation, **Iode**
- Permet une étude exhaustive des 3 versants
- Etude complète de la cavité abdomino-pelvienne



- Exploration des reins et des voies excrétrices (syndrome tumoral solide et/ou kystique)
- **Indissociable de la vascularisation rénale artères et veines**
- VVP : 250 ml de bicarbonates 1.4% sur 20 mn (avant et pendant l'examen) **hyperhydratation +++**

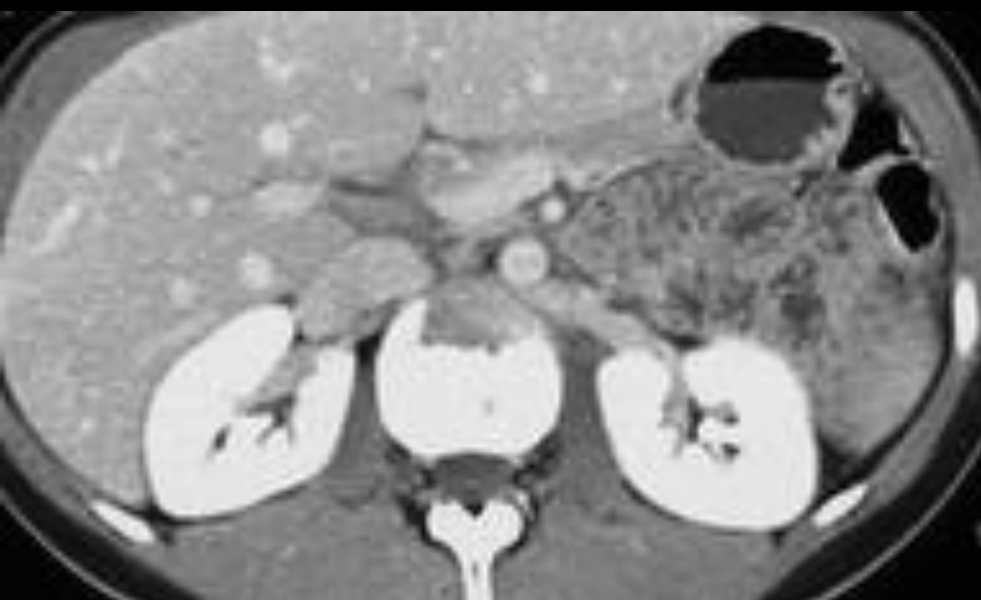


SANS INJECTION



PHASE CORTICALE

15-25s



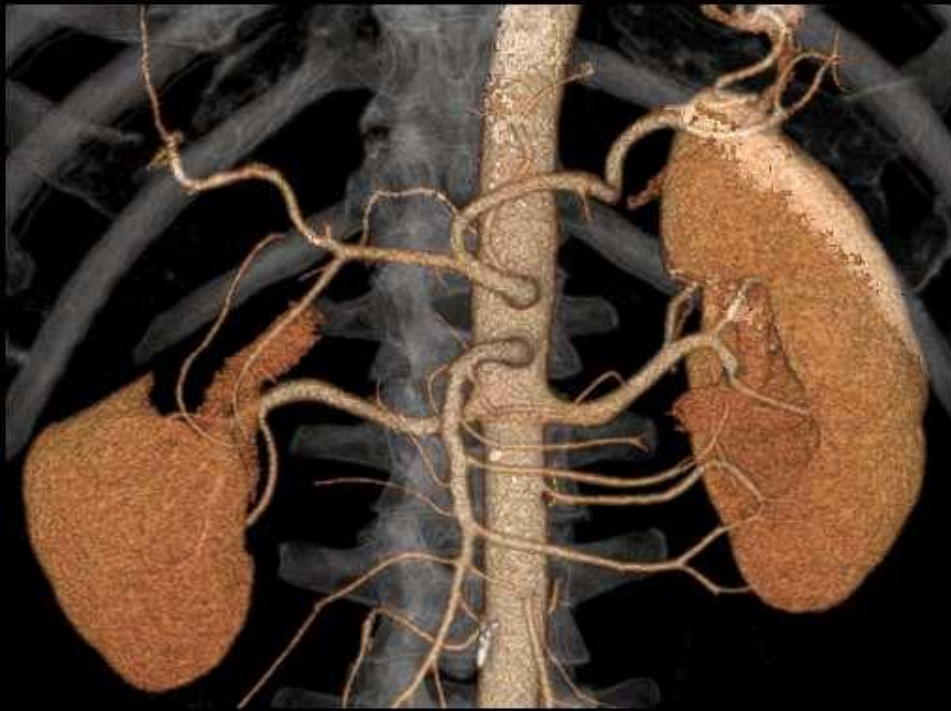
PHASE PARENCHYMATEUSE

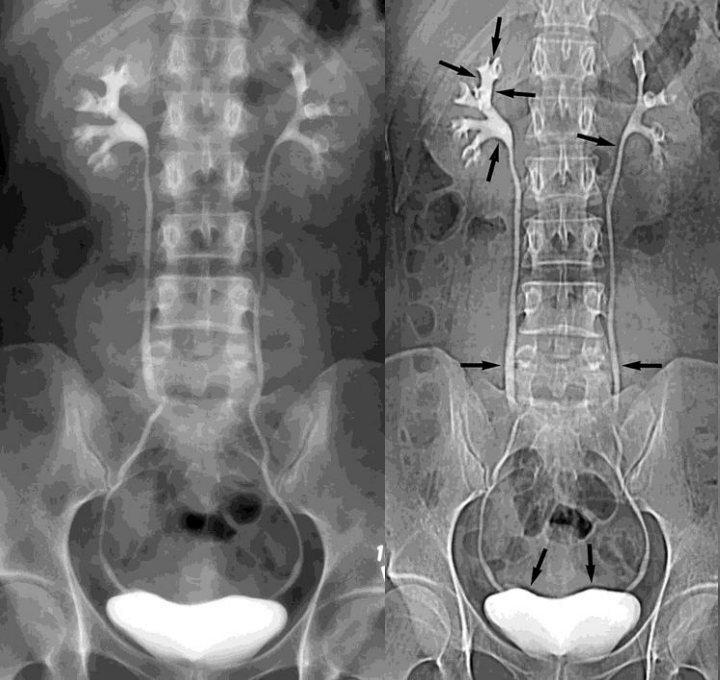
80-120s

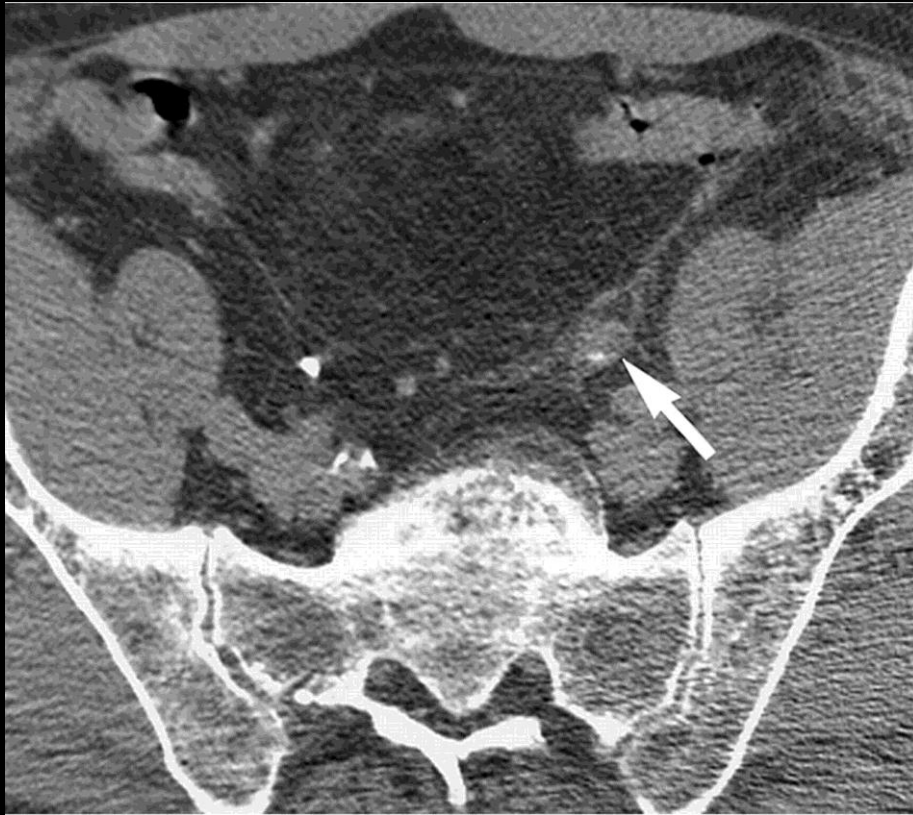


PHASE EXCRETOIRE

180s

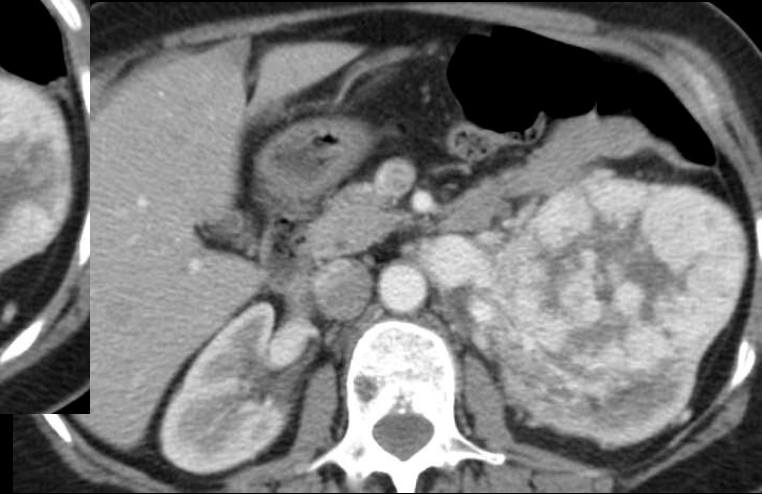


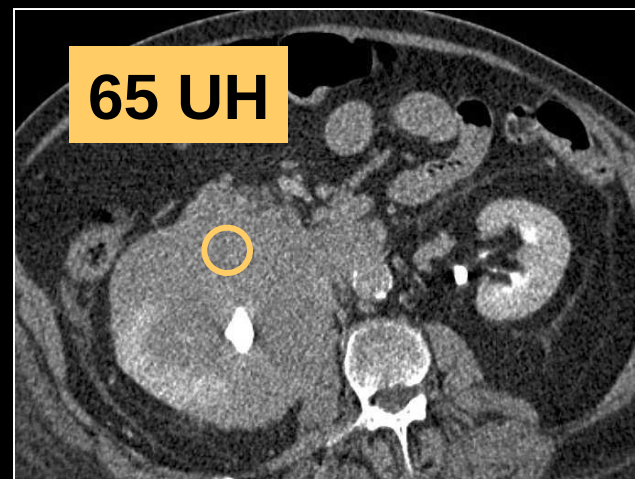
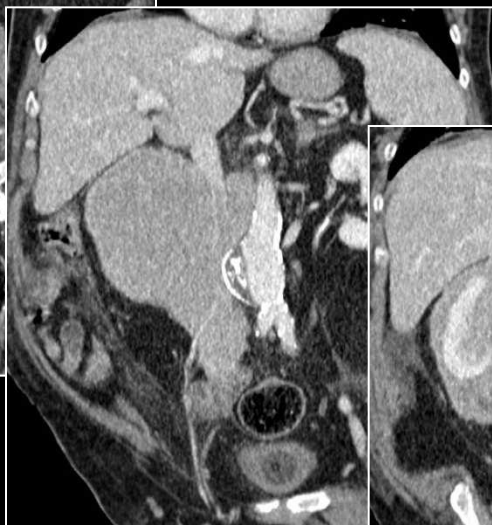
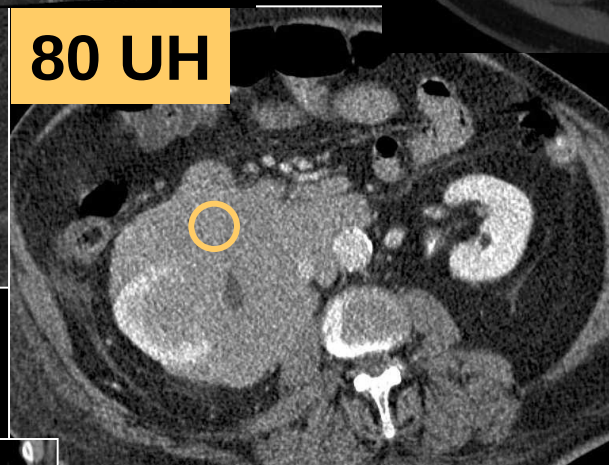
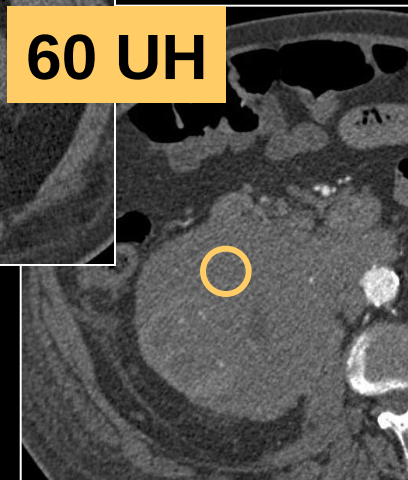
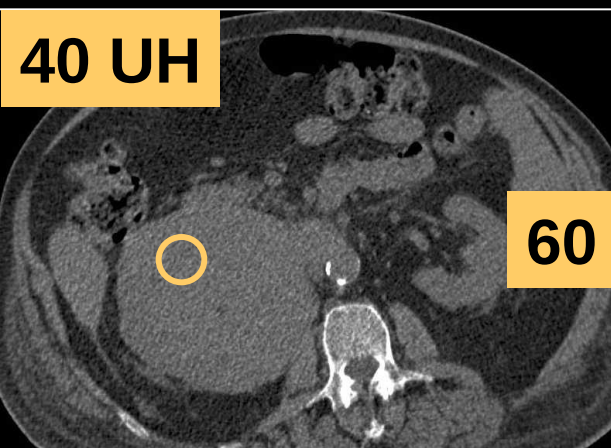




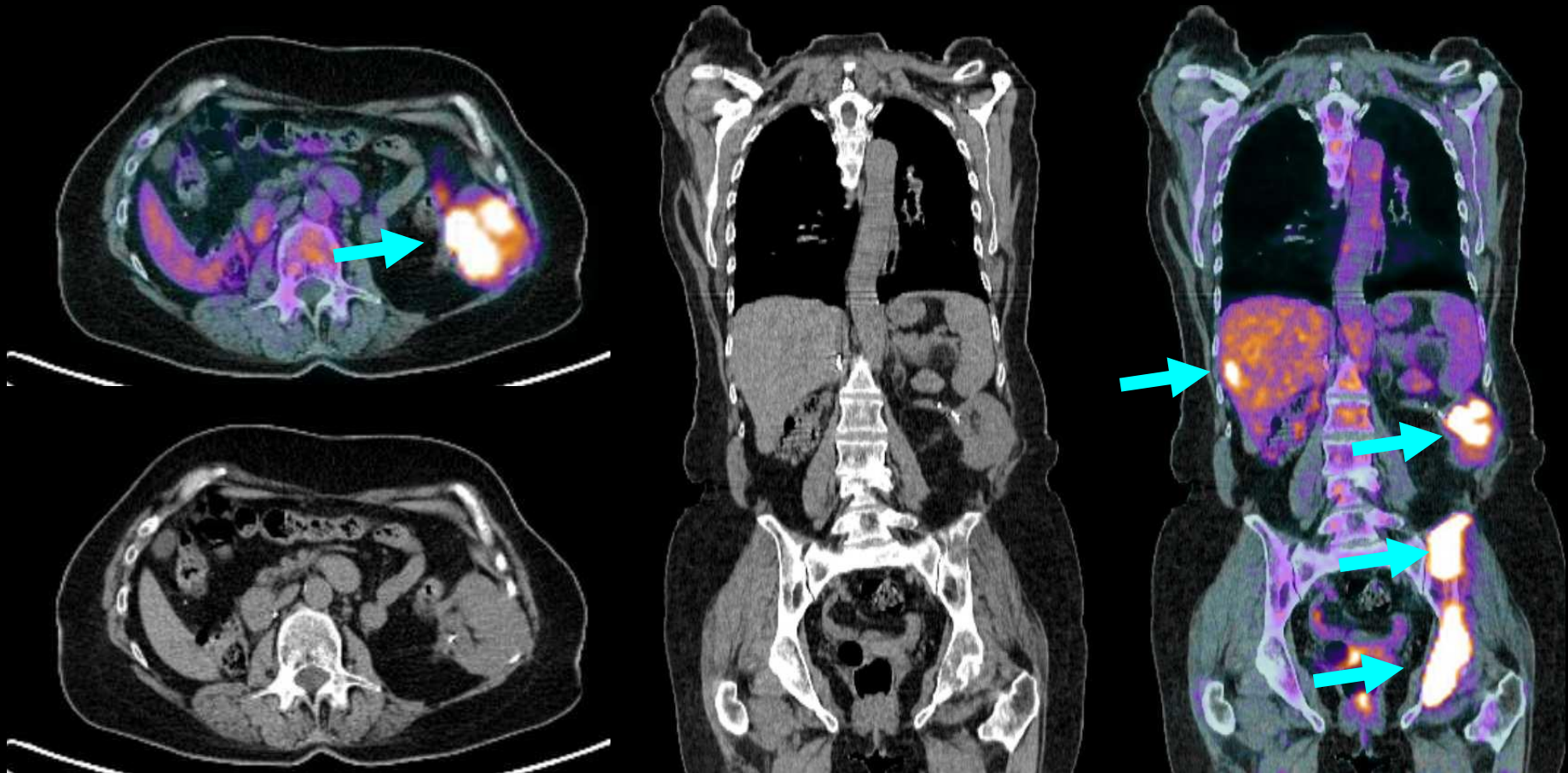
Tumeur urothéliale

Grawitz

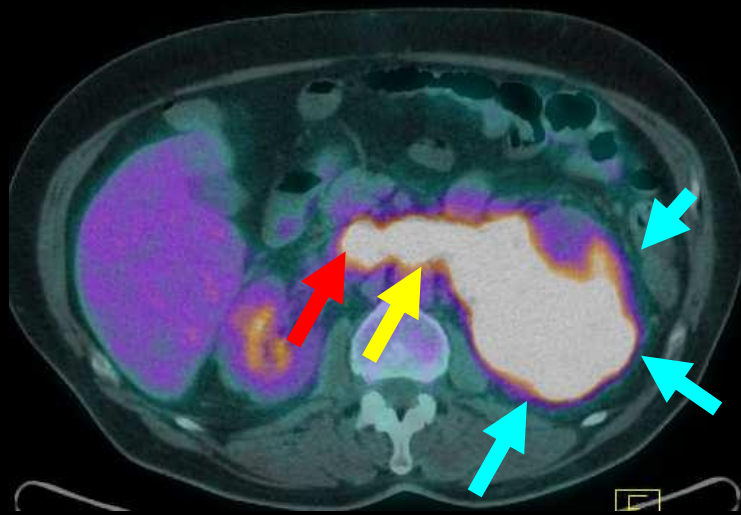




LMNH



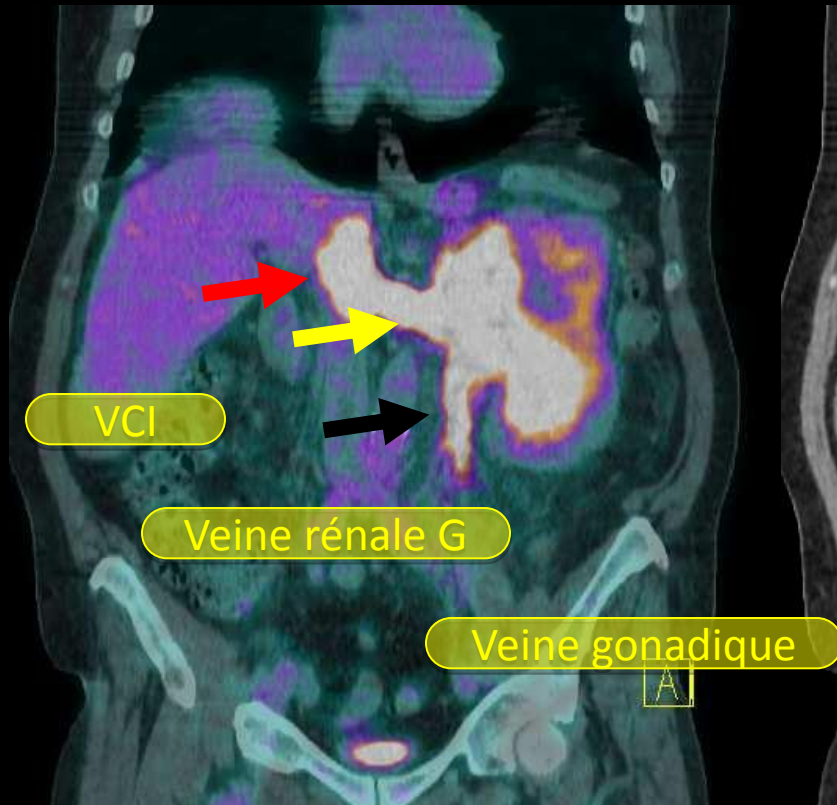
Tumeur de Grawitz du rein G
ATCD de Grawitz du rein D

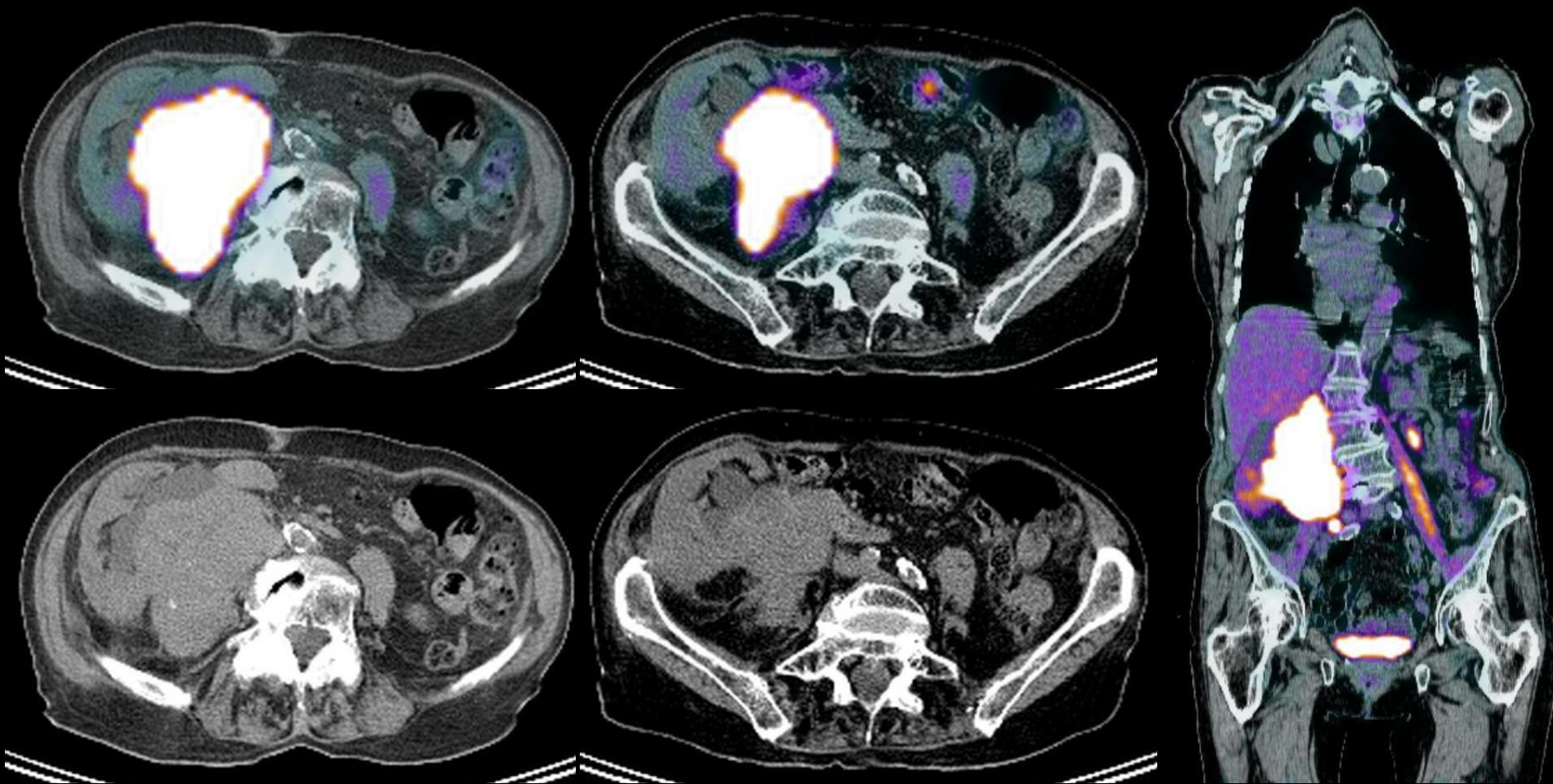


Tumeur de Grawitz

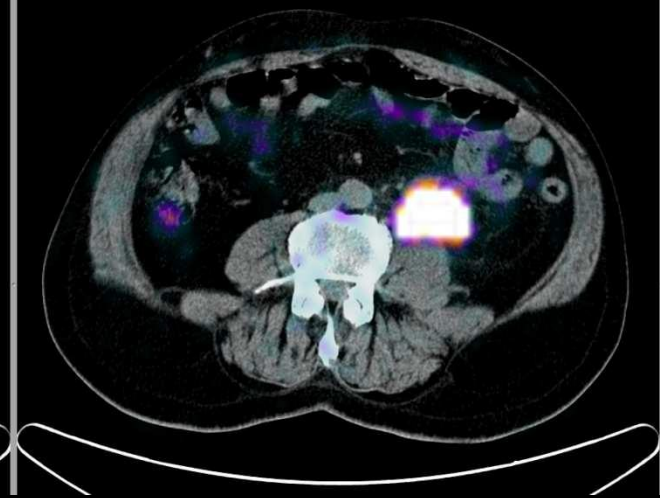
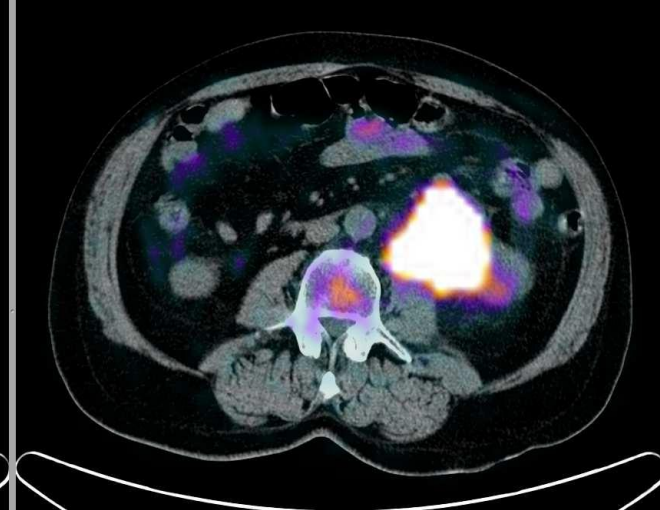
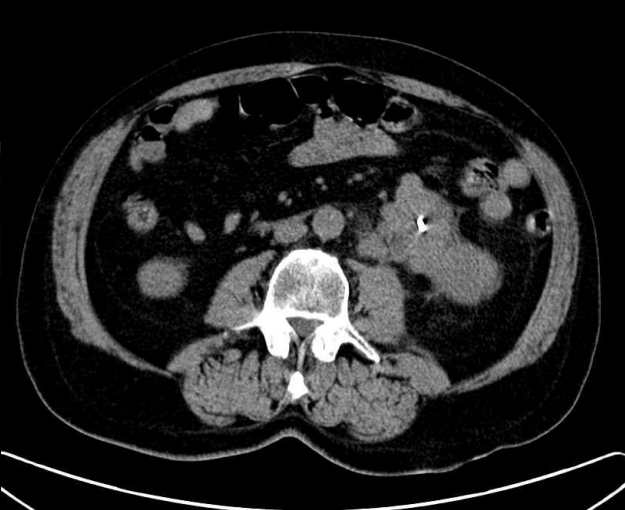


Infiltration veine rénale + VCI +
veine gonadique

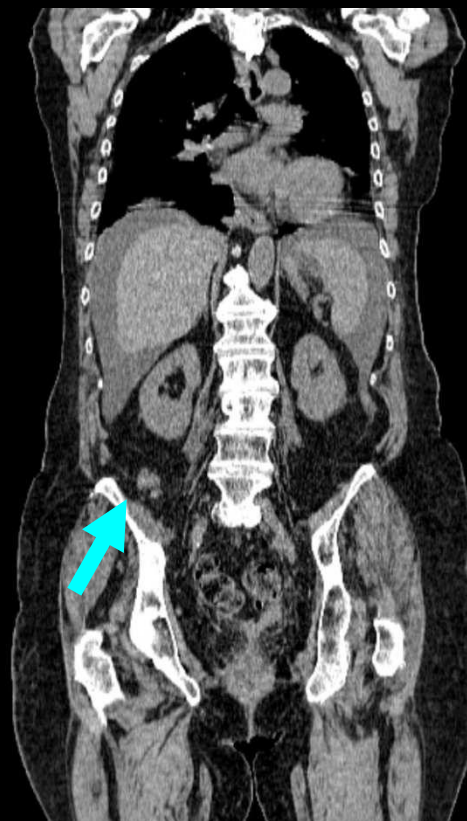
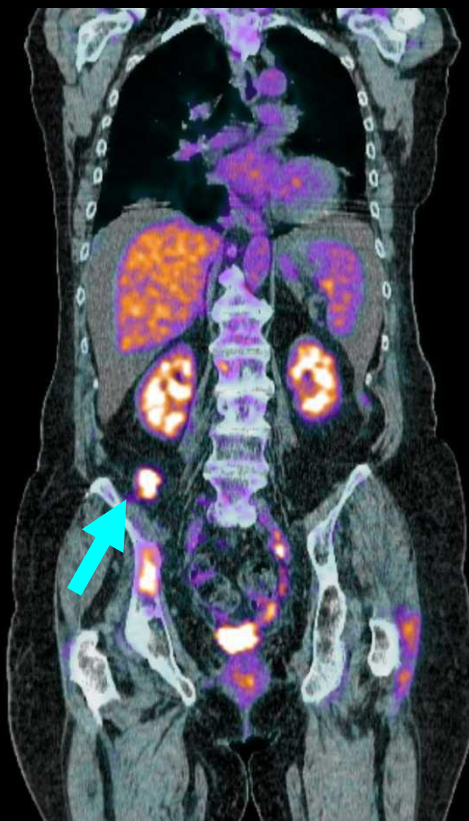




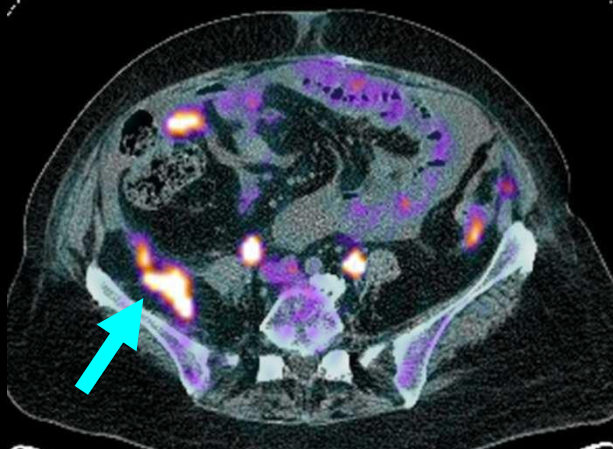
Lymphome rénal

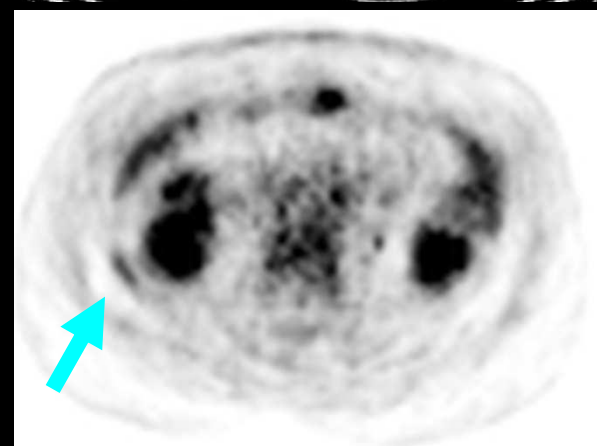
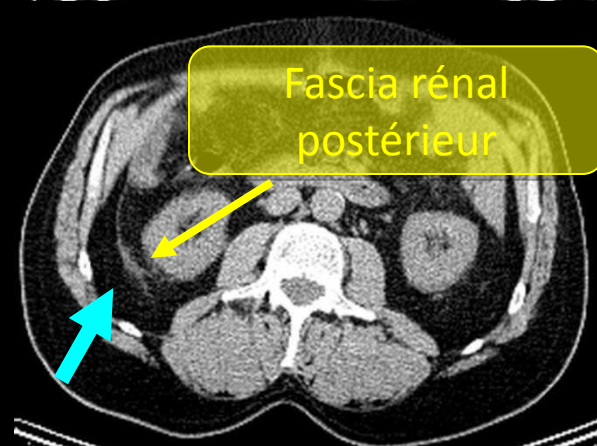
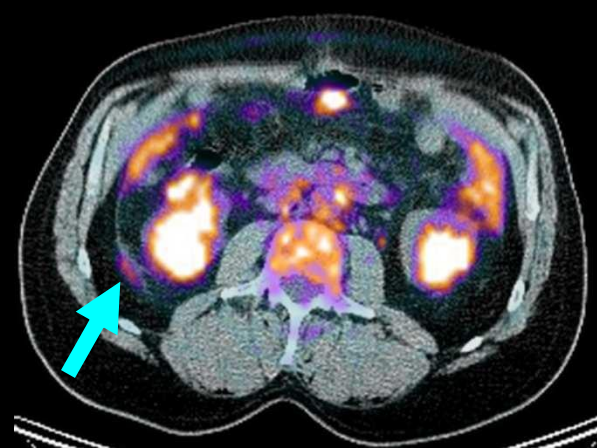


LNH BDGC en réévoluation



Métastase rétropéritonéale





Carcinose rétropéritonéale

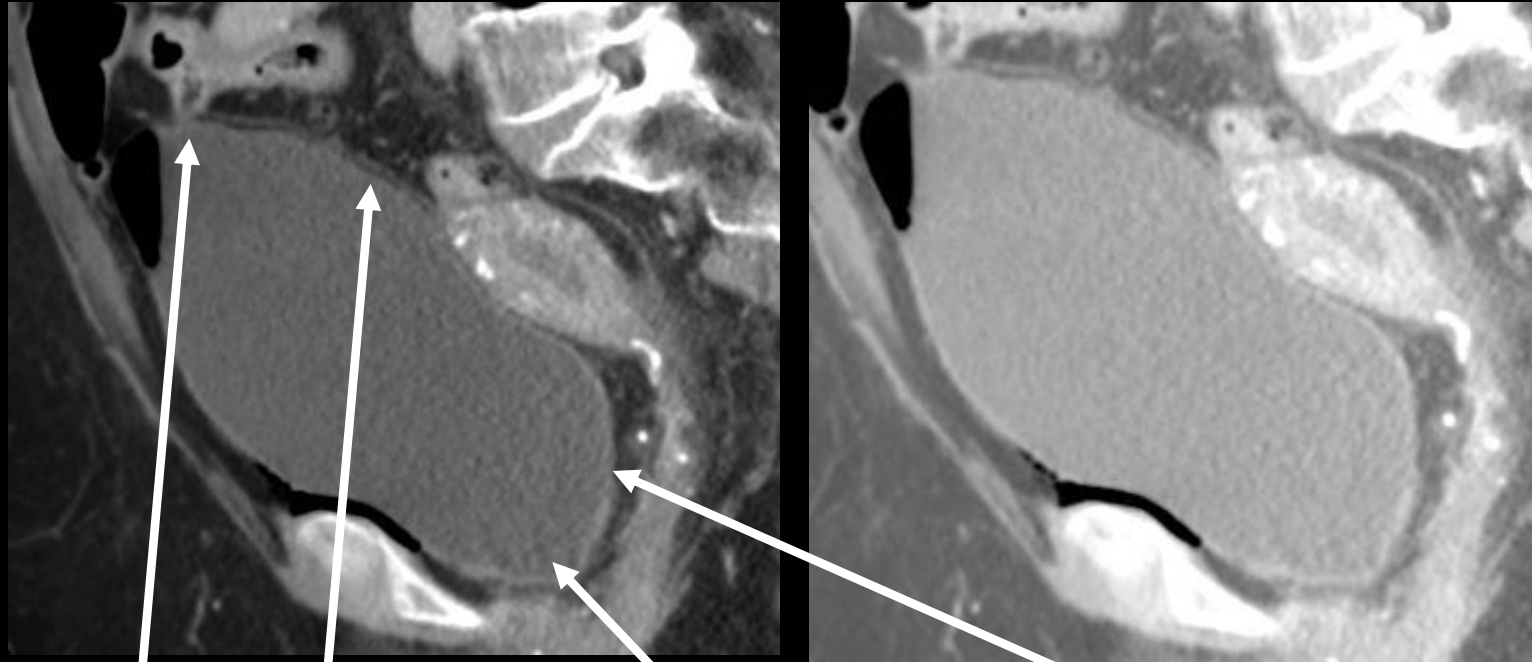


Radioanatomie du Pelvis



Intérêt d'opacifier la
vessie++

Cystite emphysémateuse



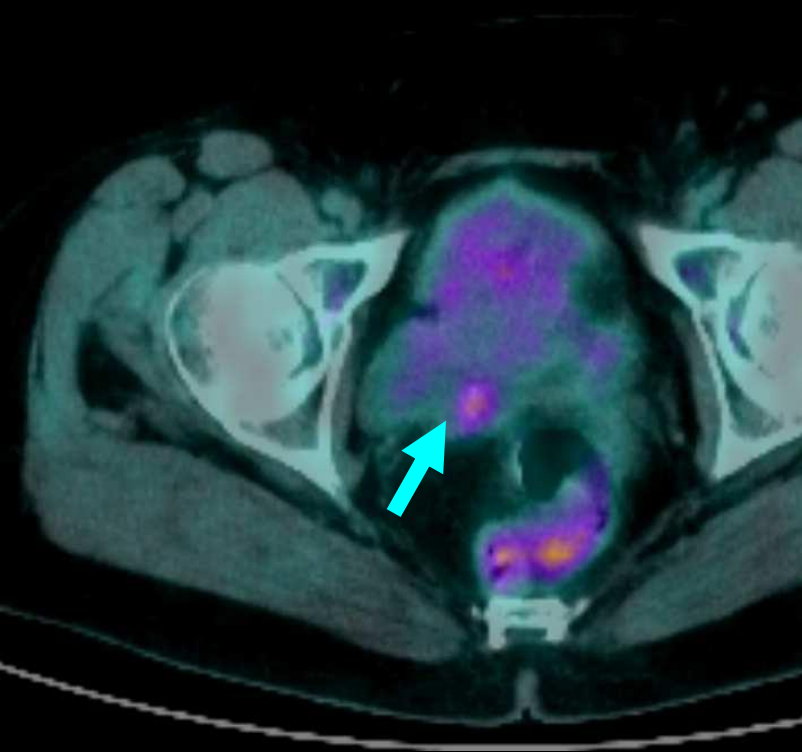
Apex

Dôme

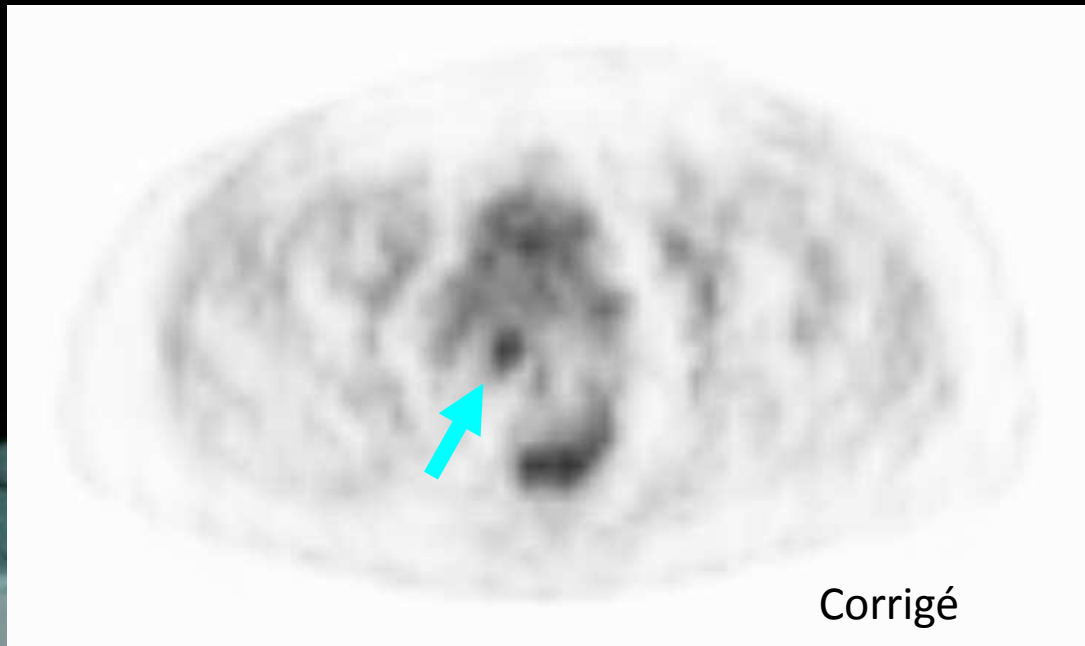
Col

Trigone

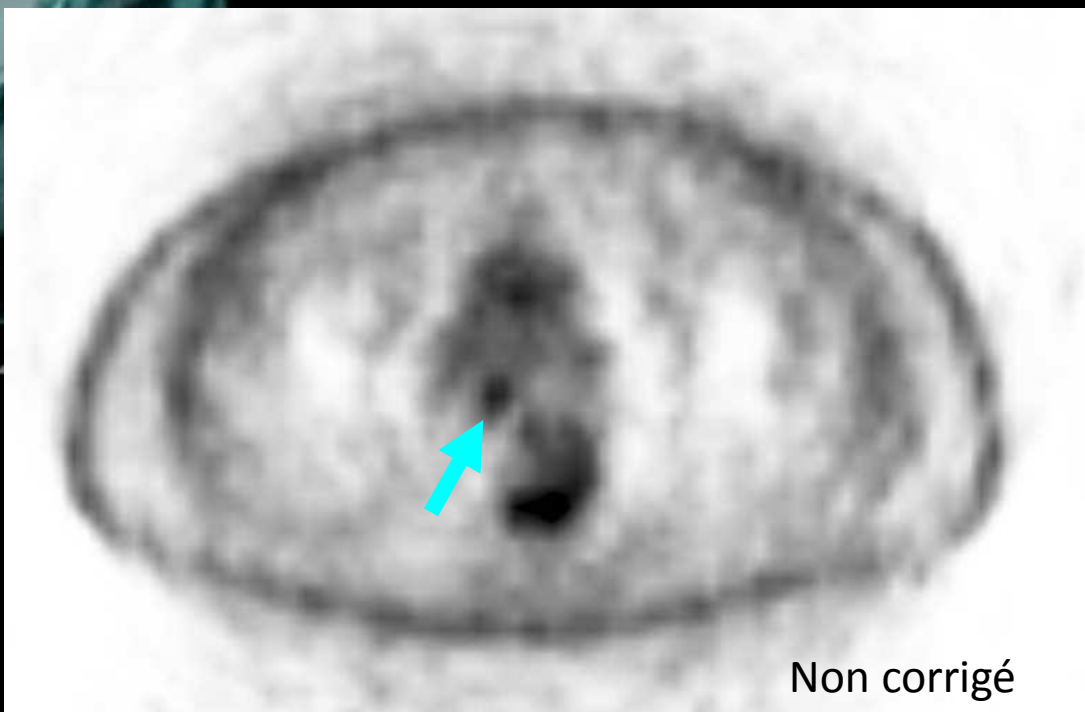
Carcinome urothélial de vessie
Suspicion de récidence



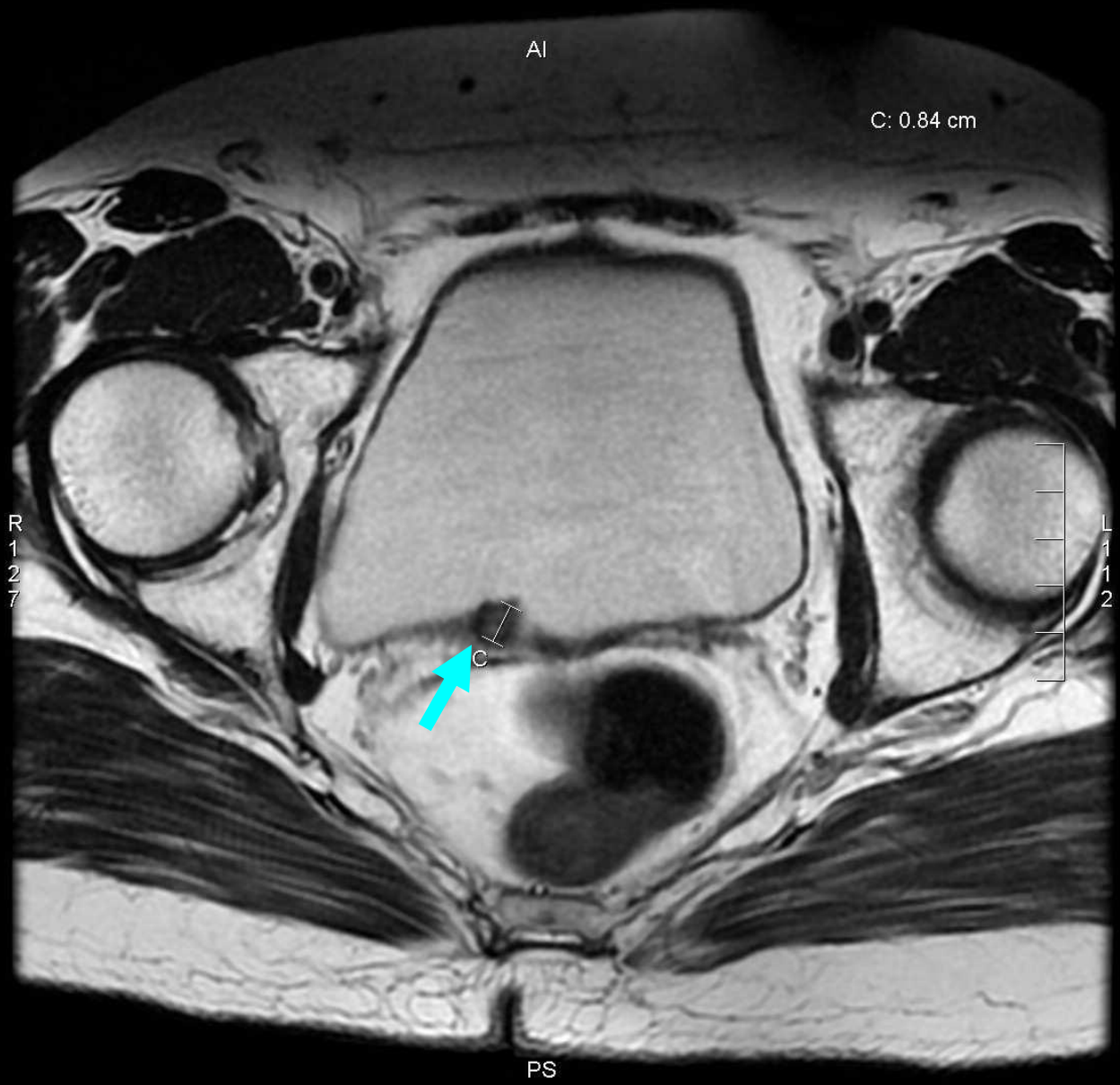
Après vidange vésicale



Corrigé

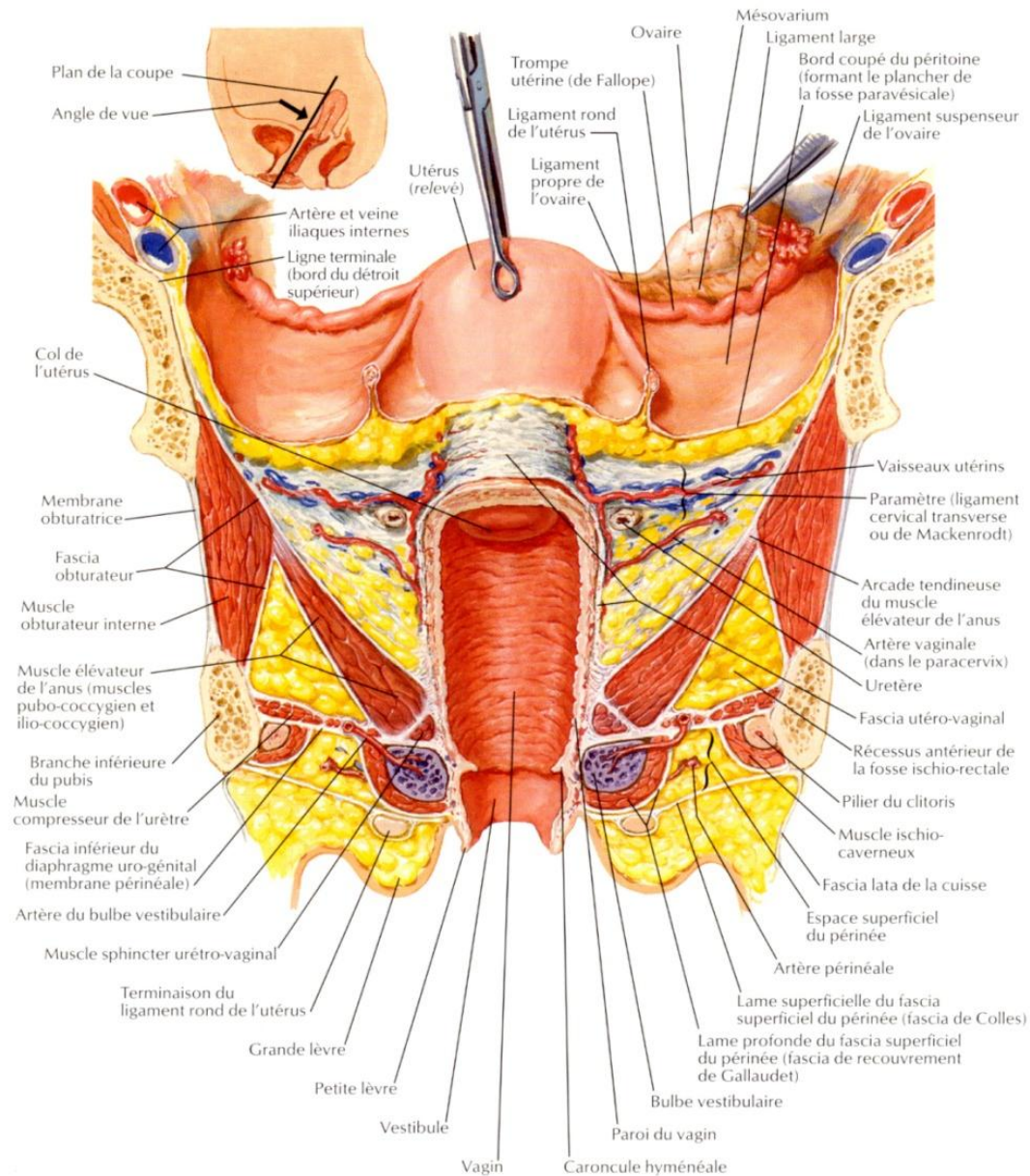


Non corrigé



Corps utérin
Col utérin
Vagin

- Echographie endovaginale
- IRM
- Scanner très limité (d'autant plus si pas d'injection)



Corps

Isthme

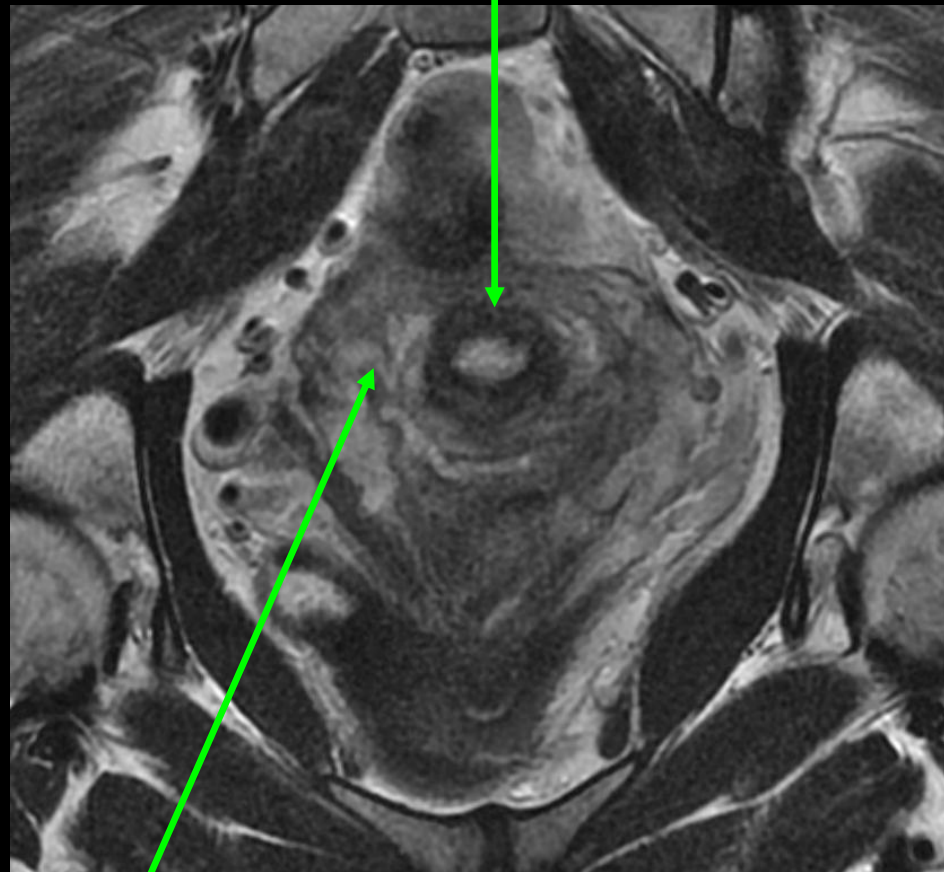
Col



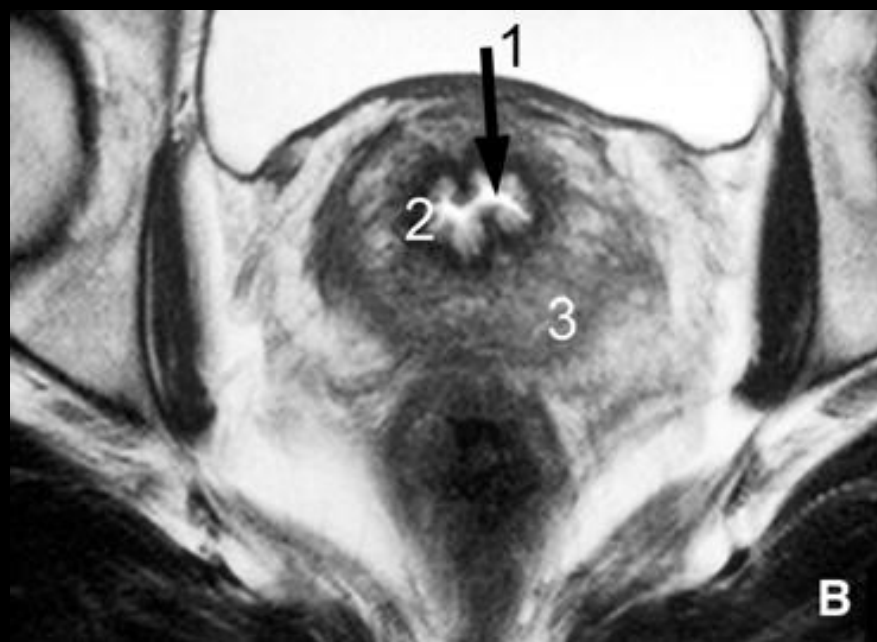
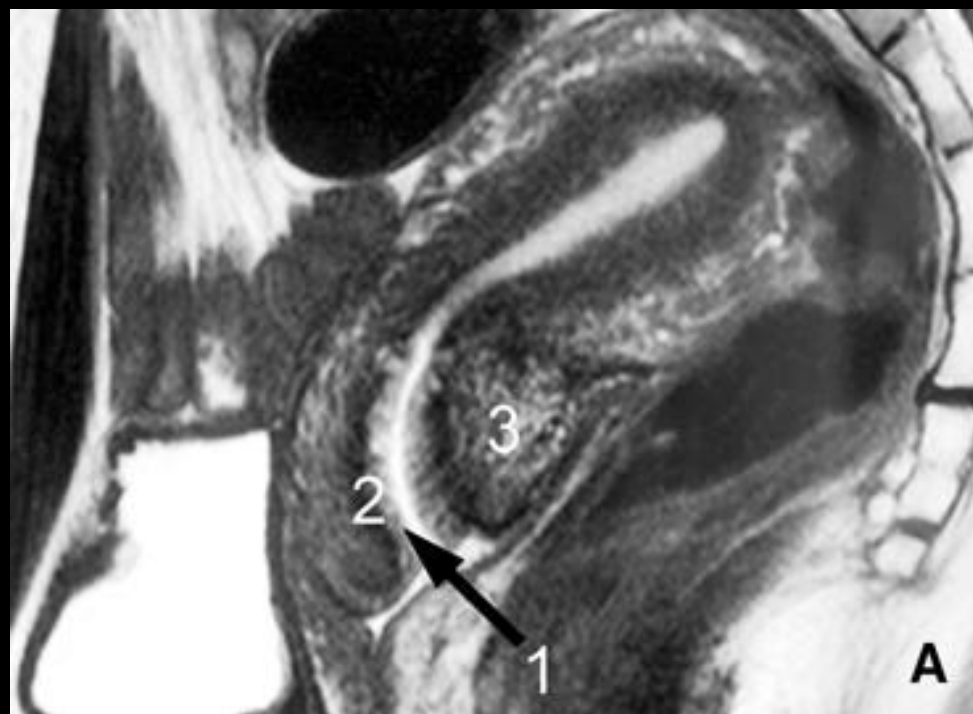
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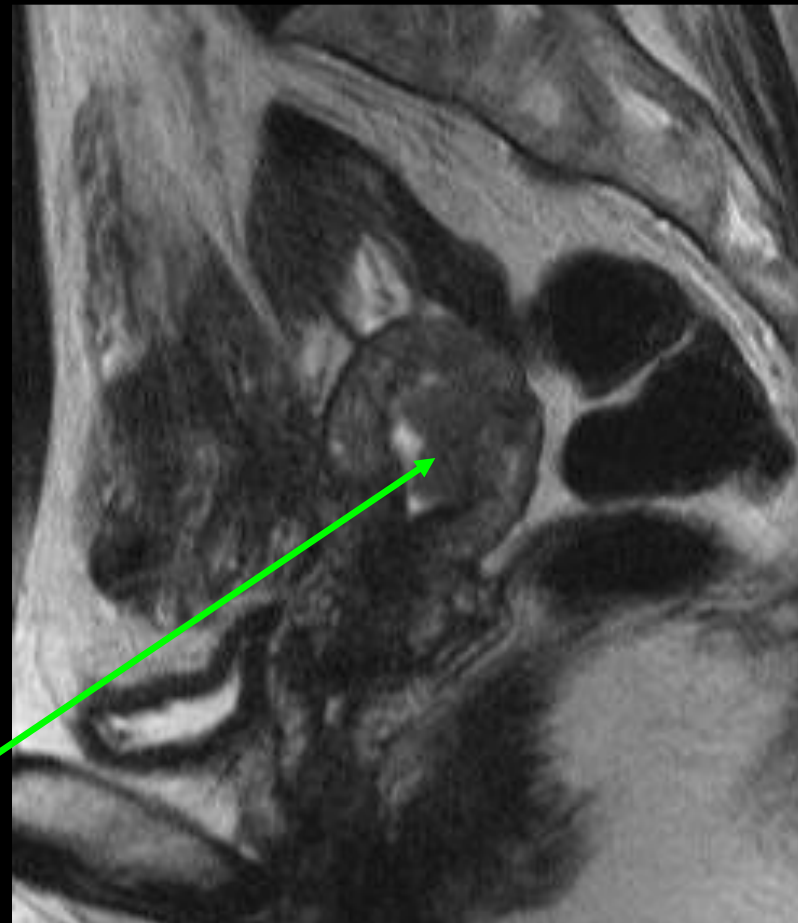
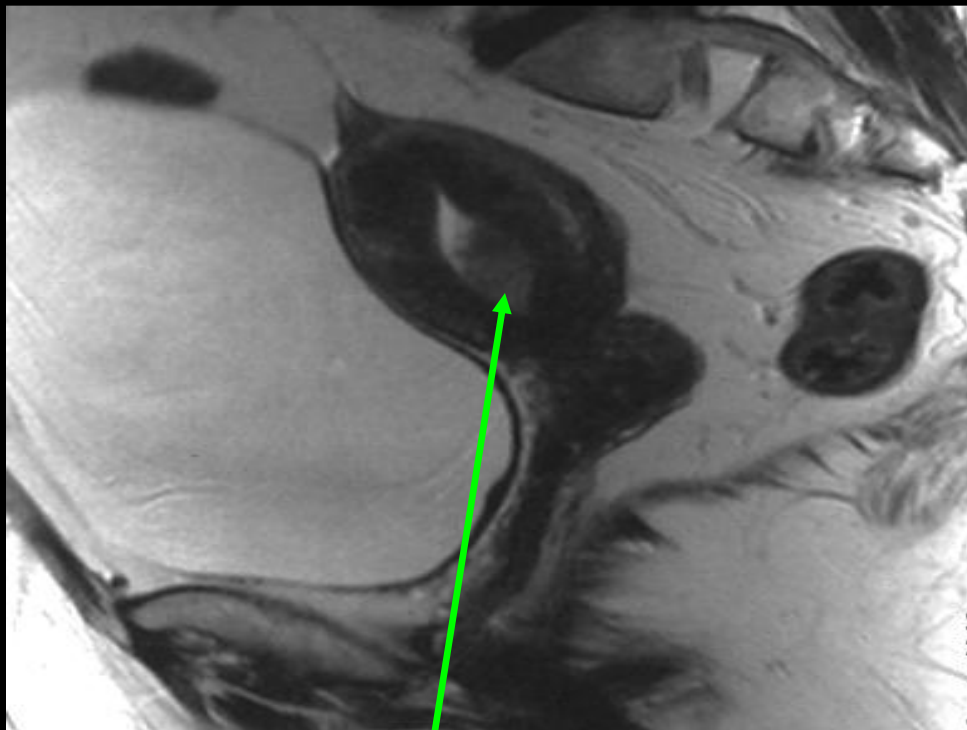
Vagin

Col

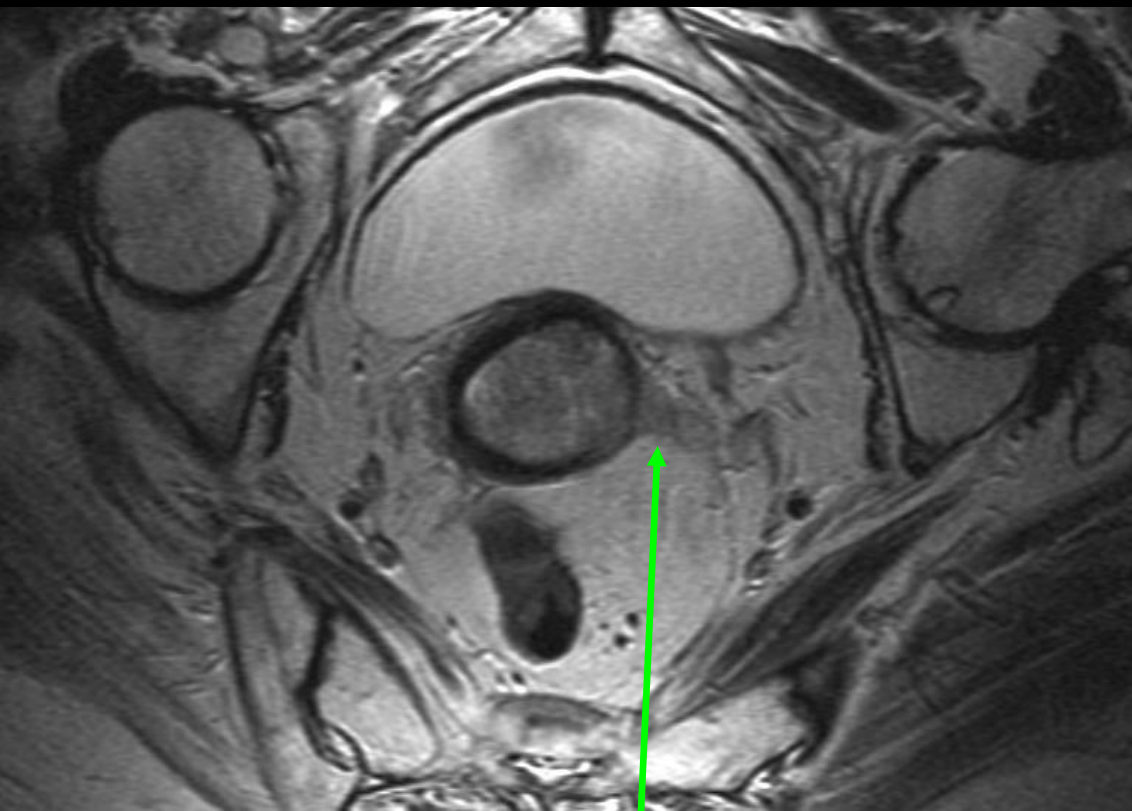


Paramètres



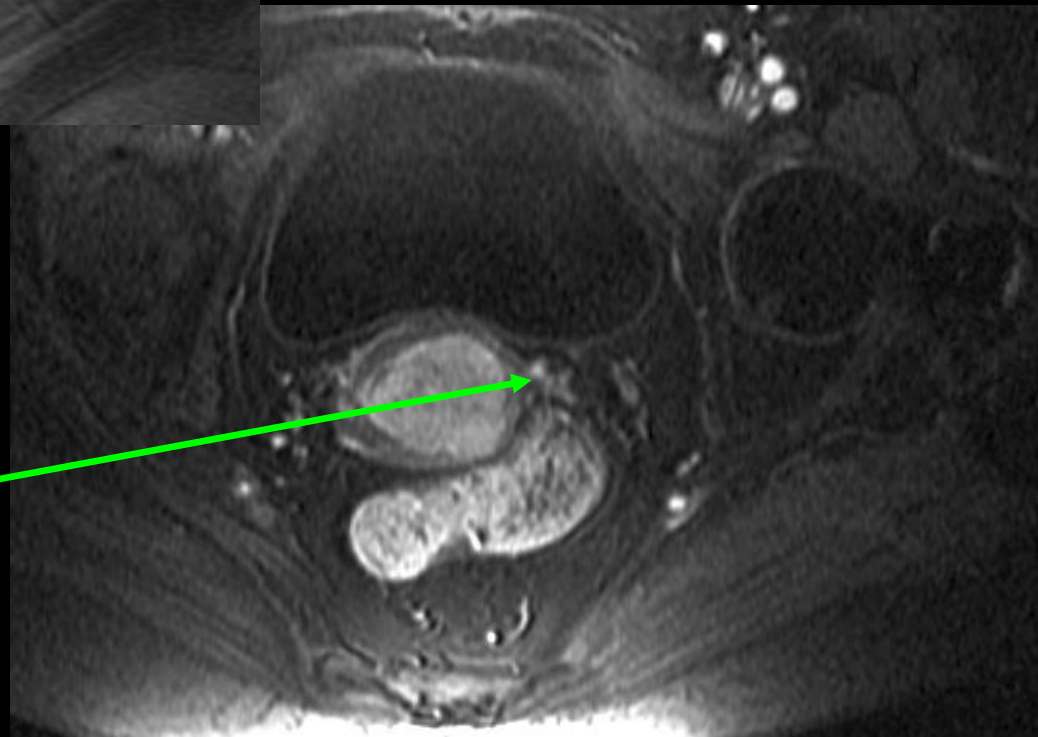


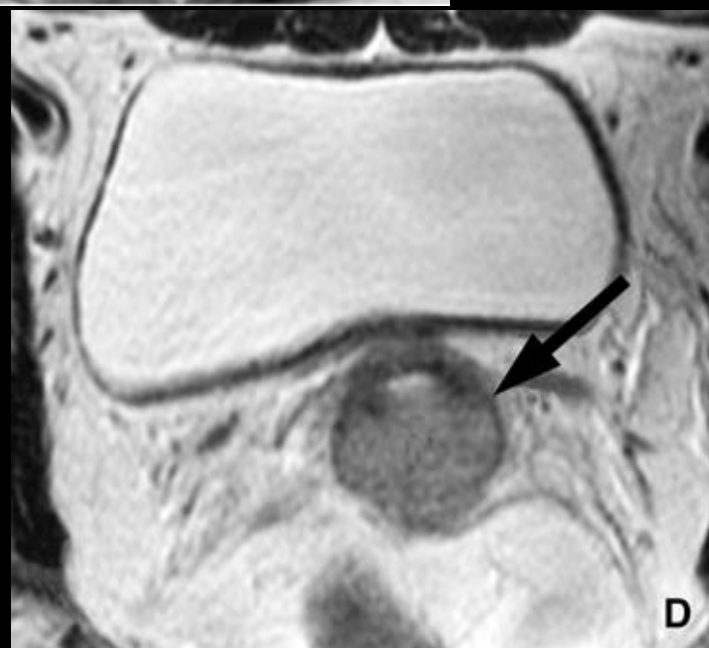
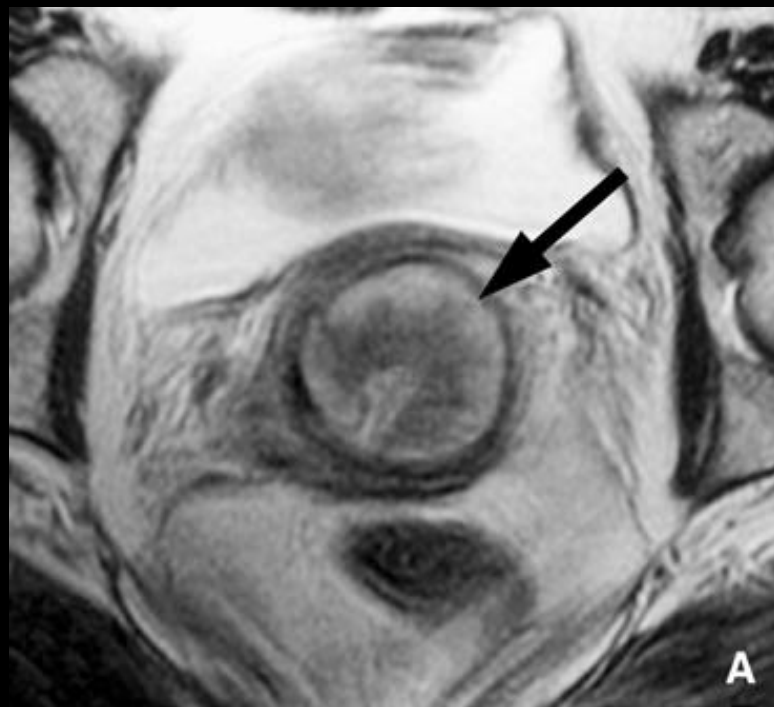
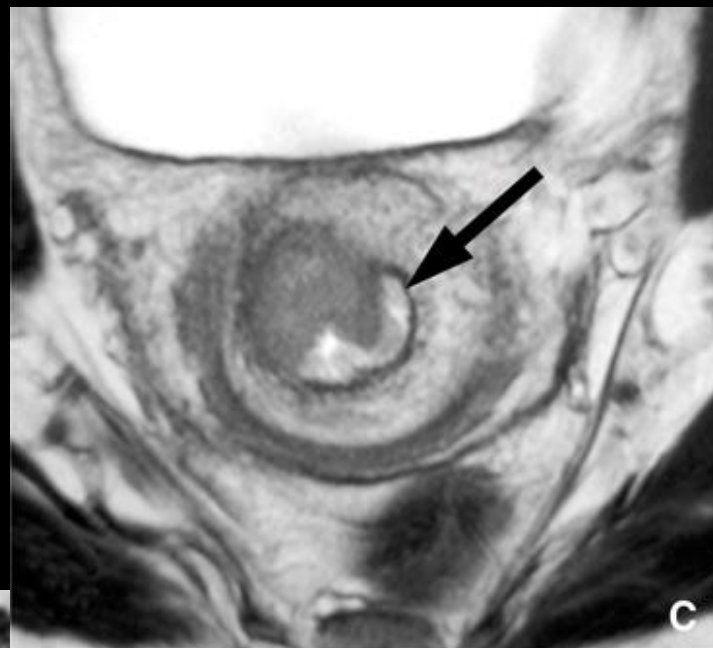
ADK endomètre

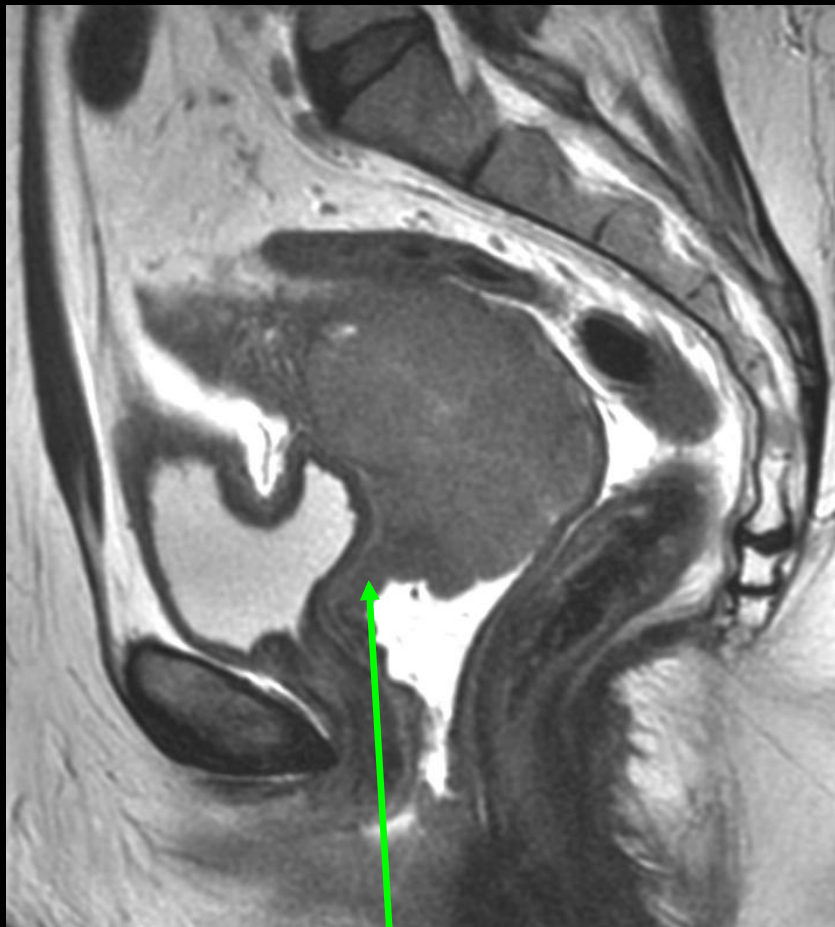


Le paramètre
contient
l'uretère et
l'artère utérine

Extension au
paramètre d'un
cancer du col

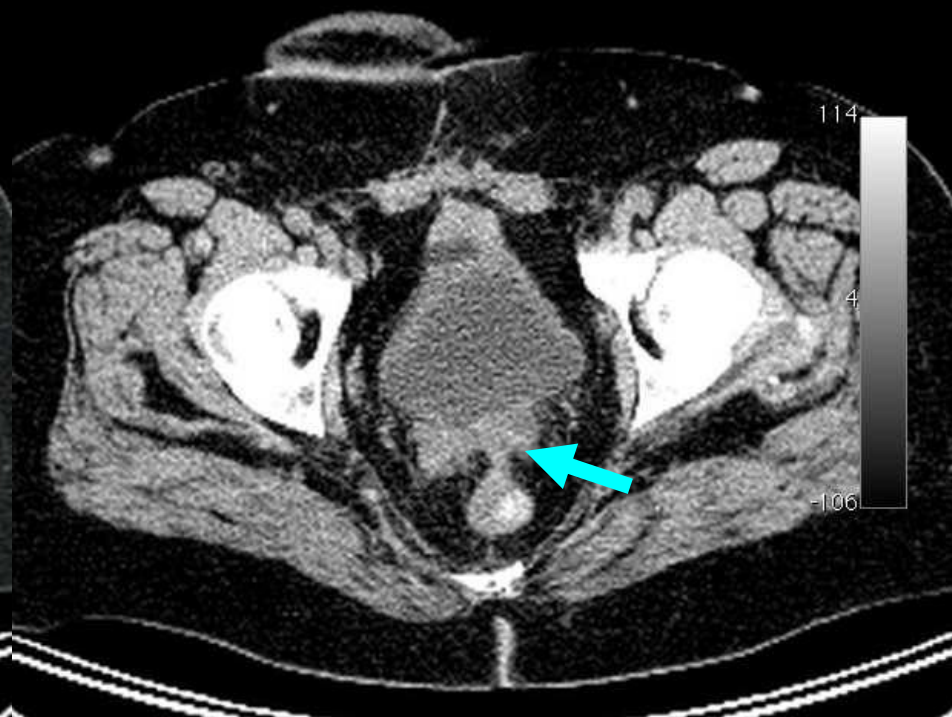
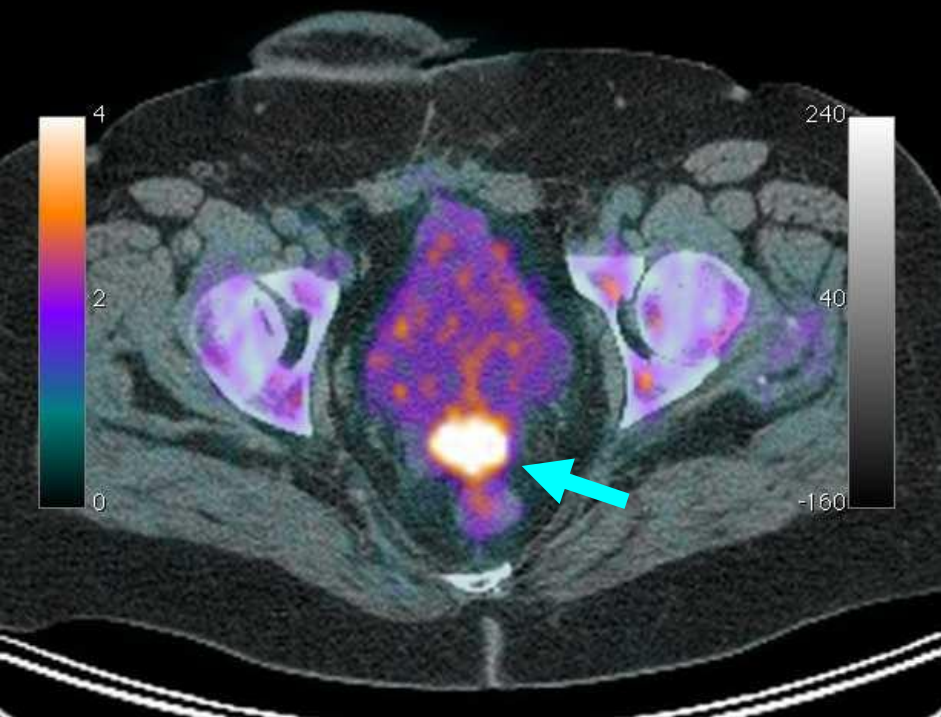




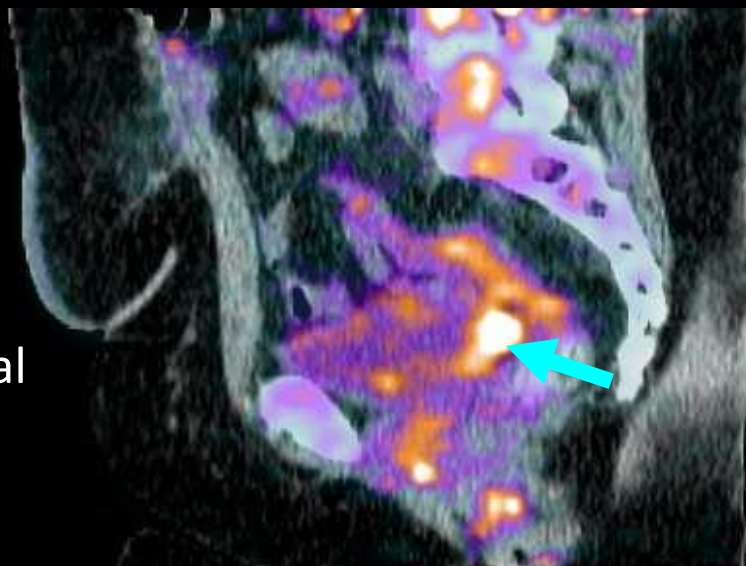


Envahissement des
cul de sac vaginaux

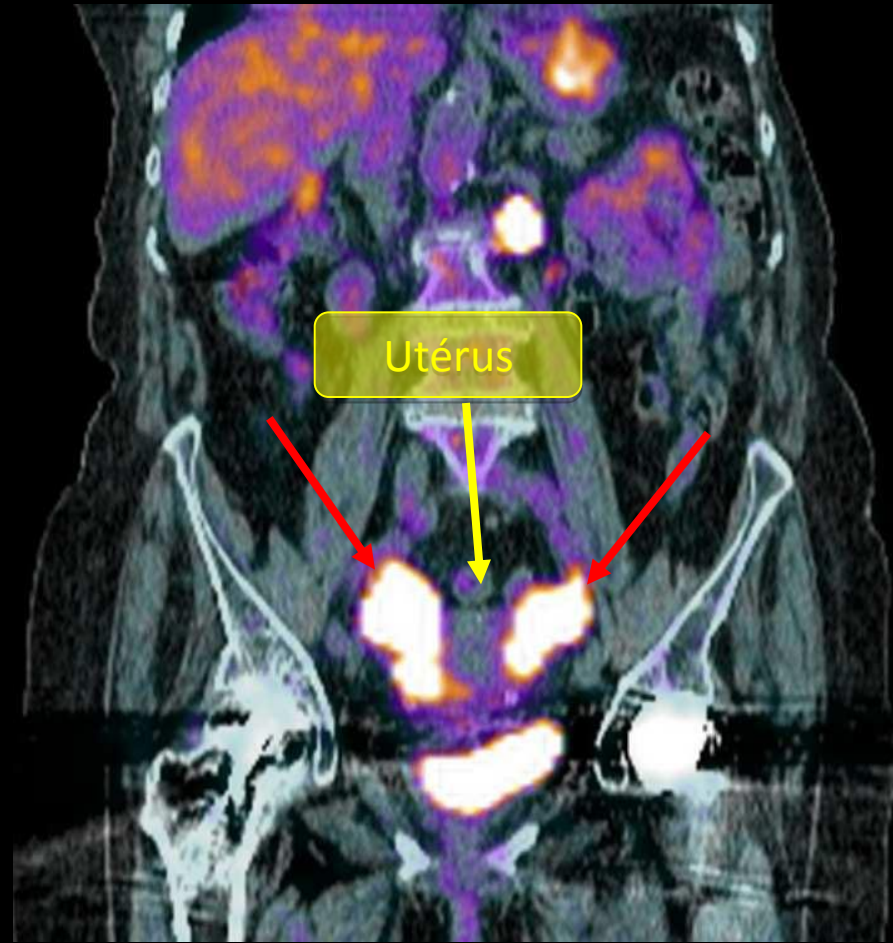




Néoplasie du fond vaginal

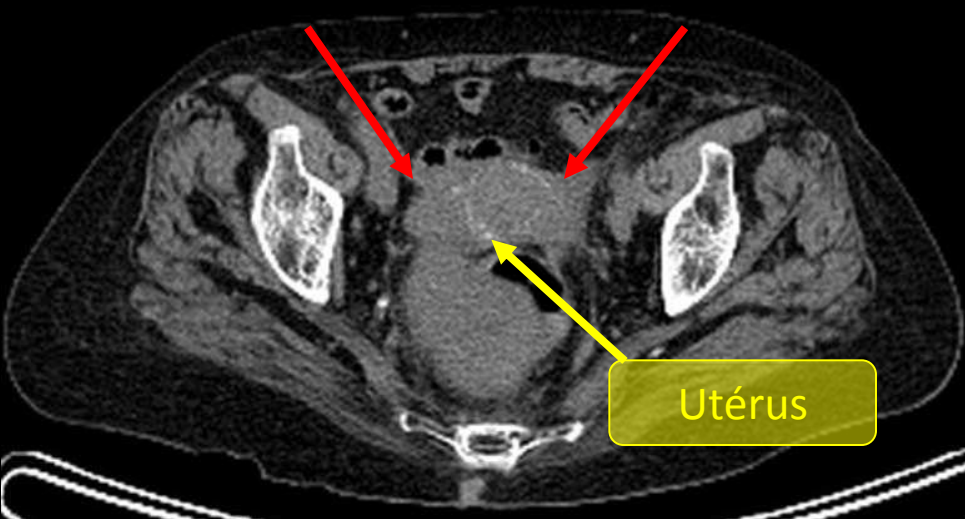


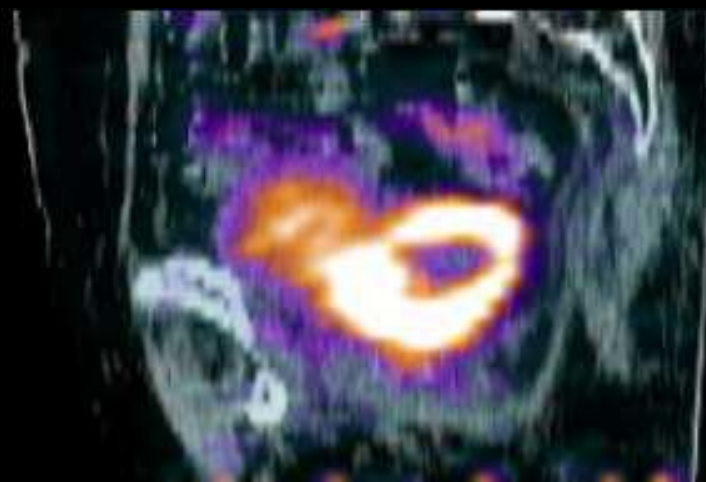
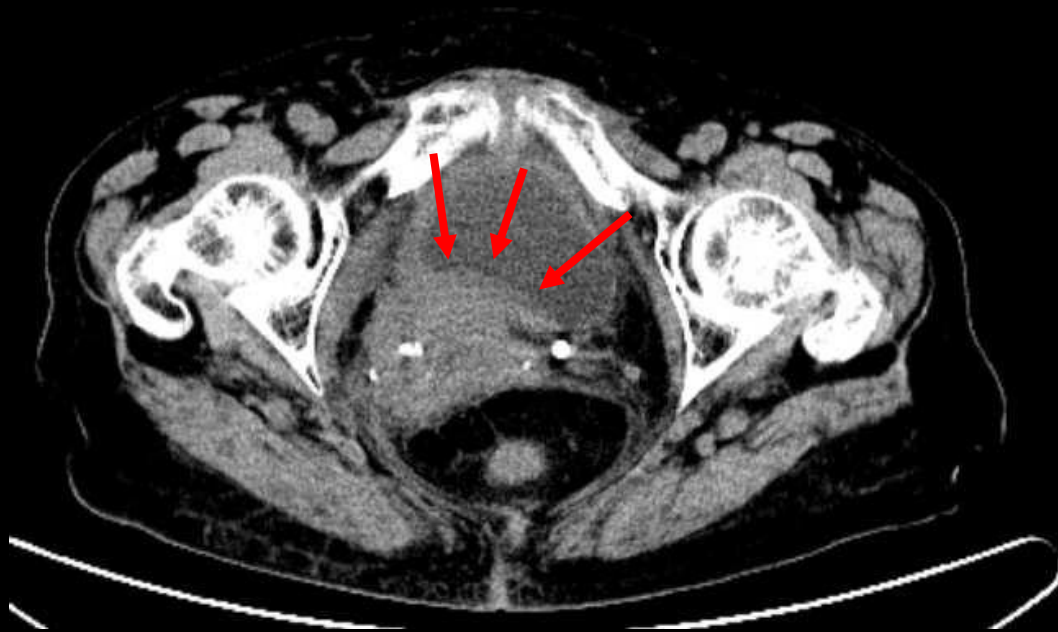
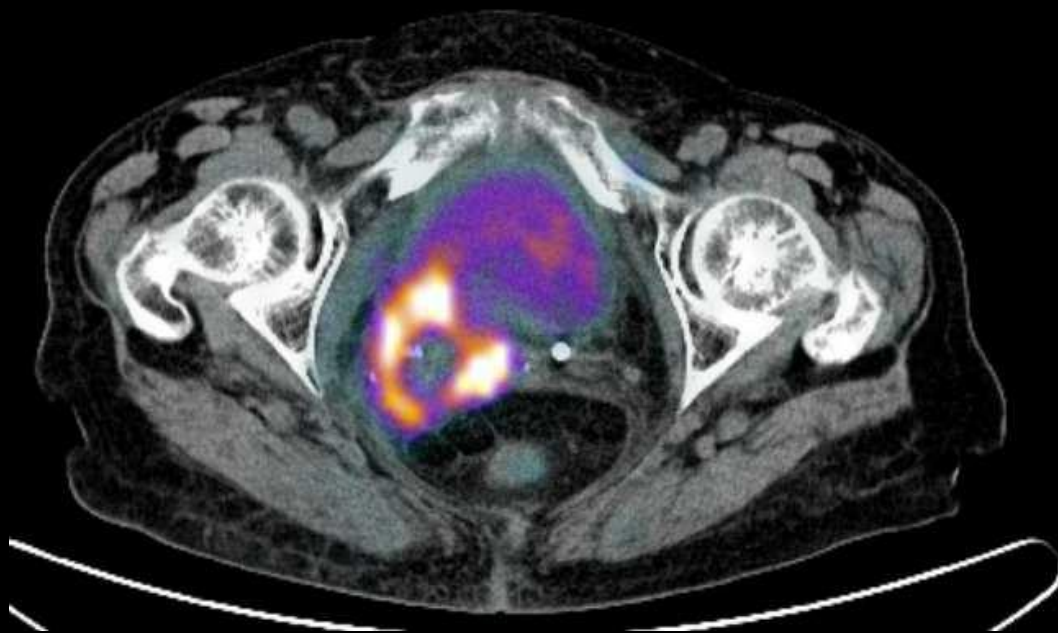
Tumeur du rectum



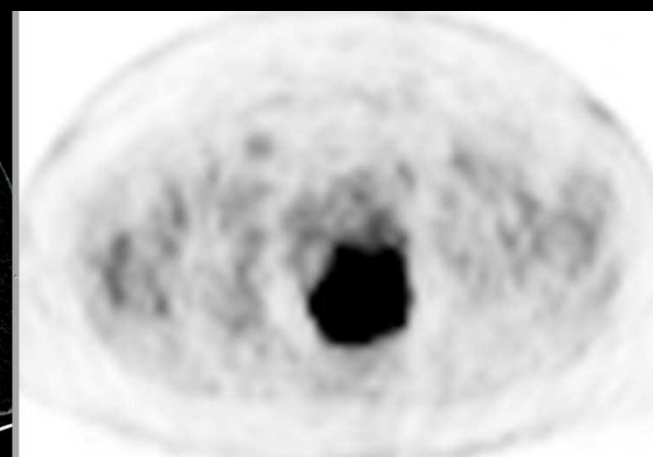
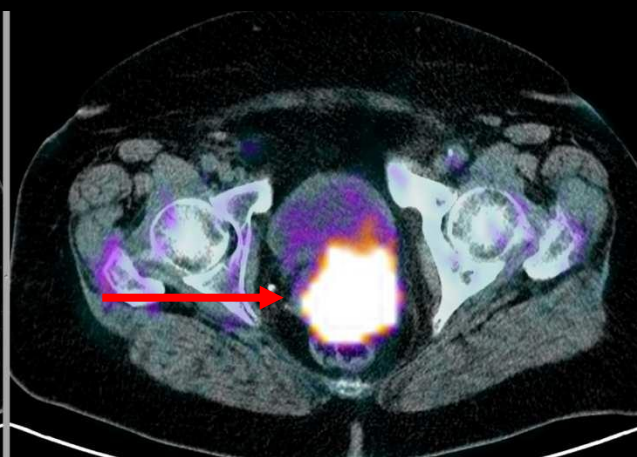
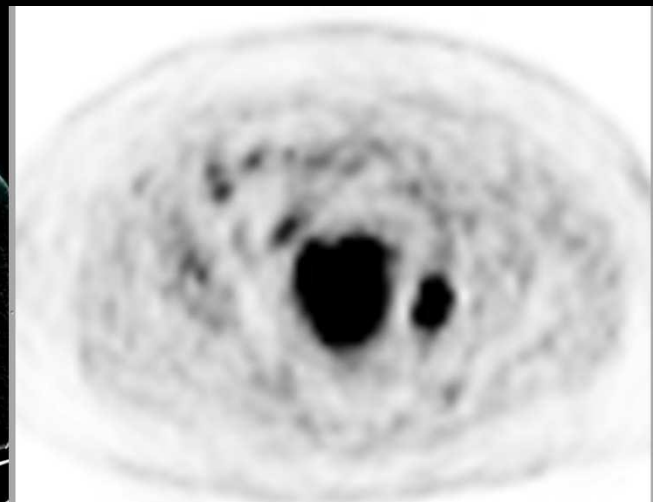
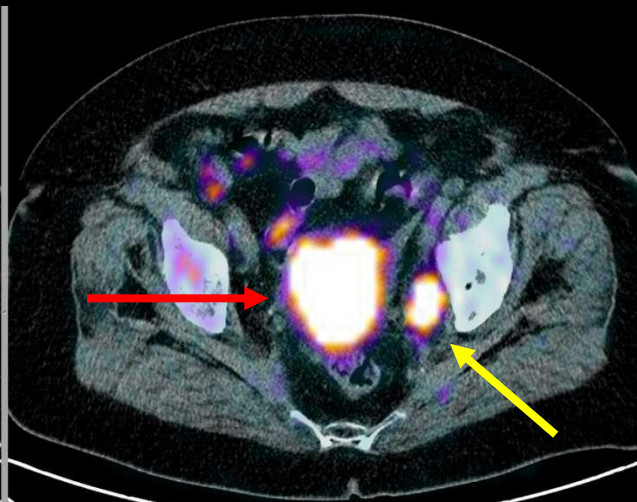
Envahissement des paramètres

Diagnostic ?

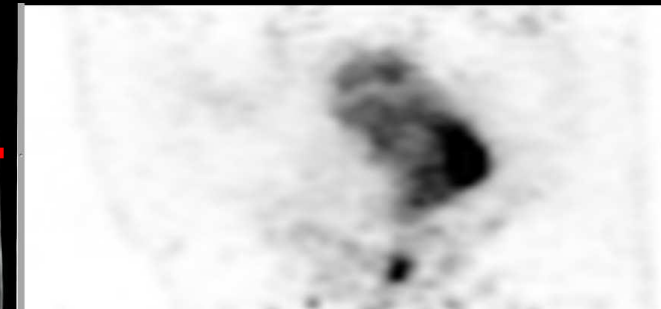
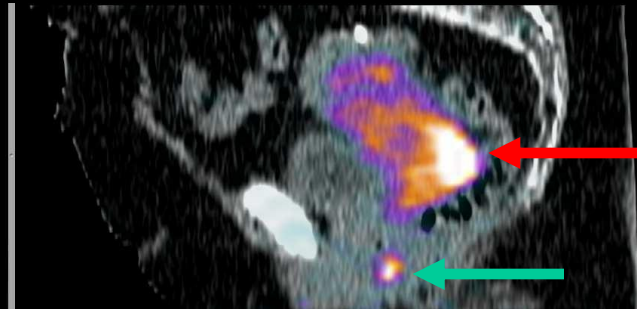
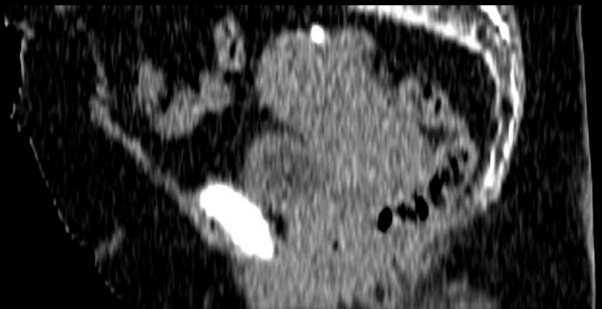
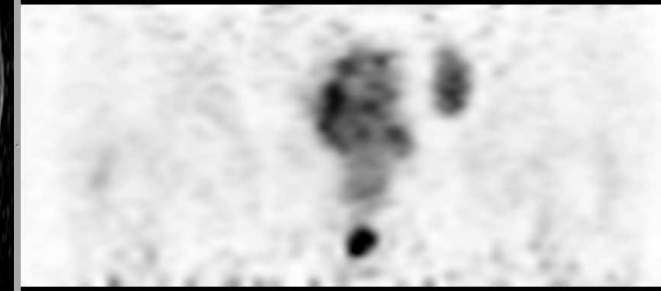
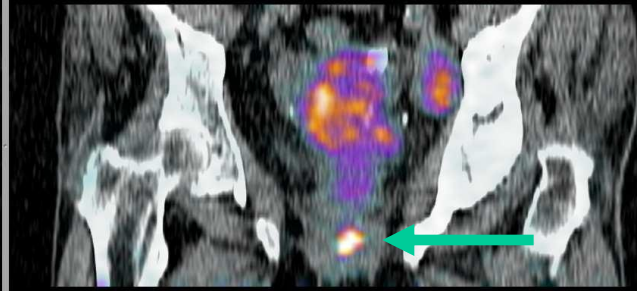
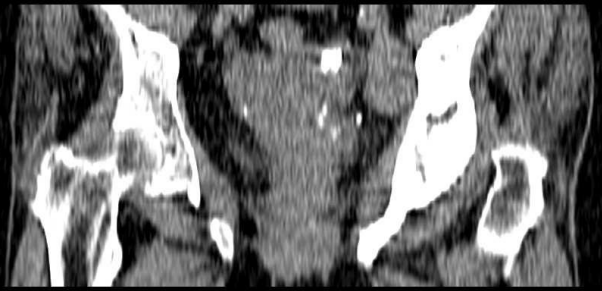




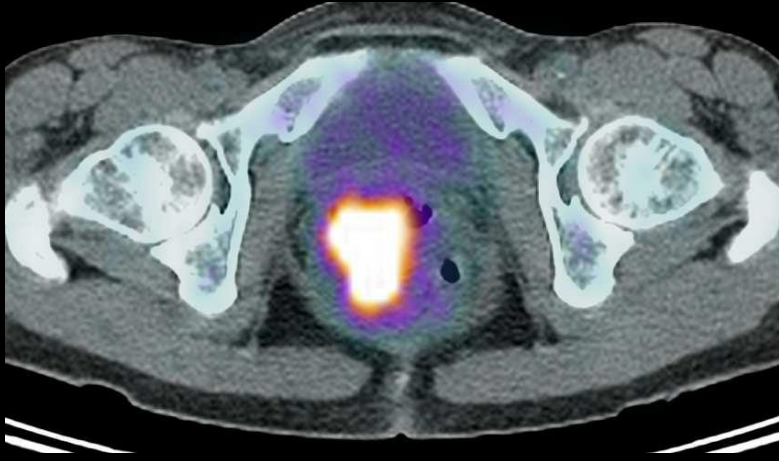
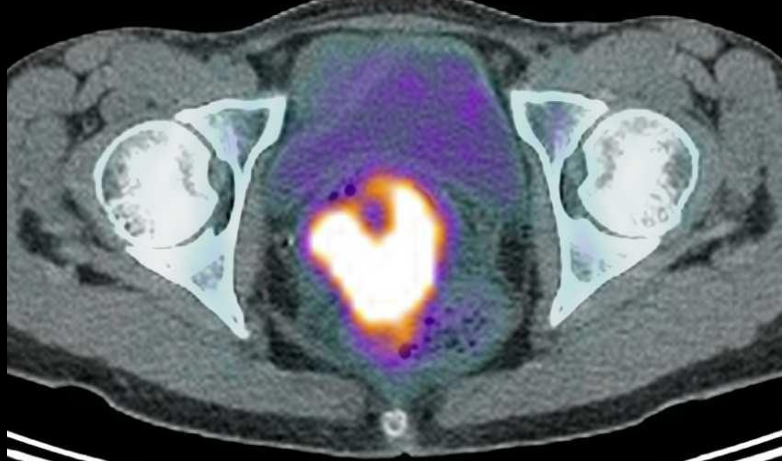
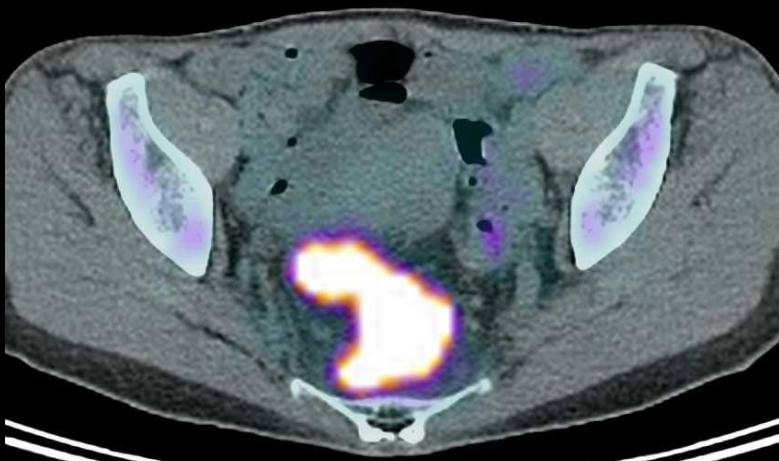
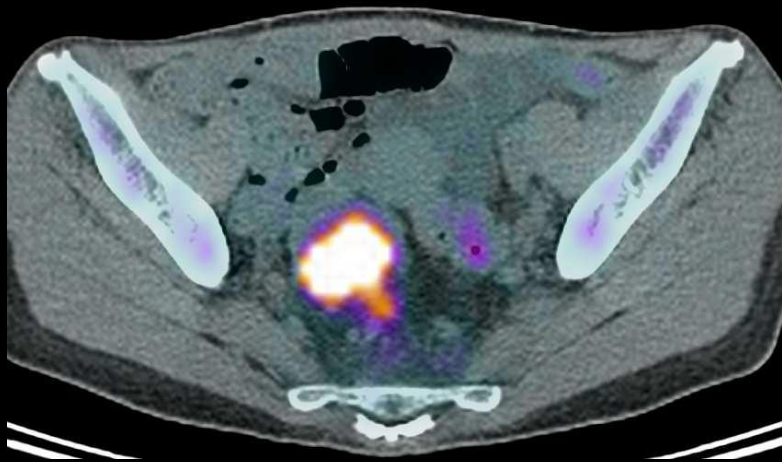
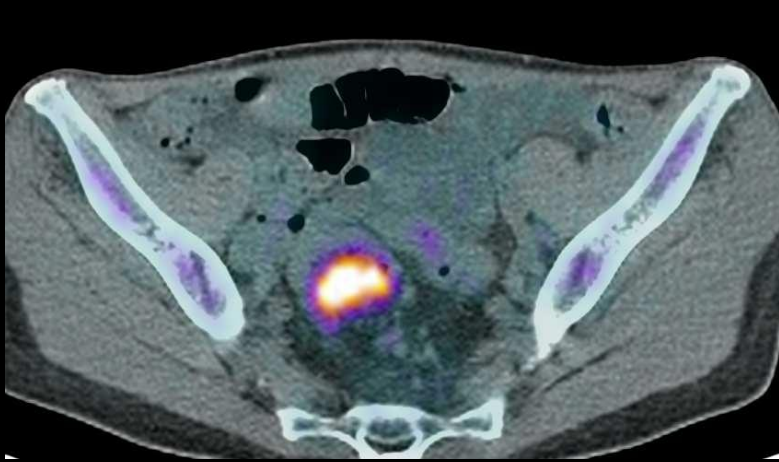
Cancer du col utérin



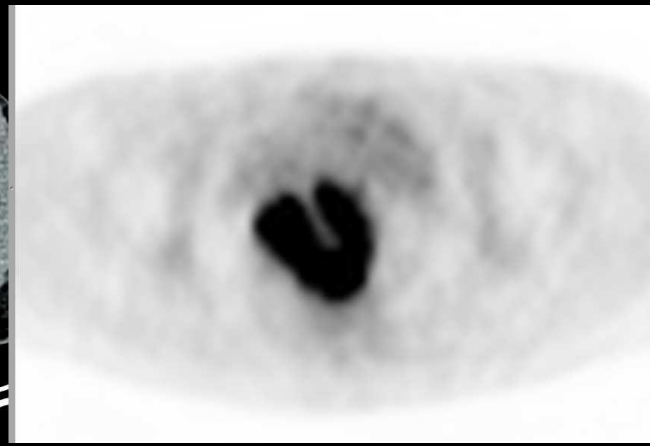
Tumeur du col utérin
ADP iliaque interne G



- Tumeur du col utérin
- Métastase vaginale

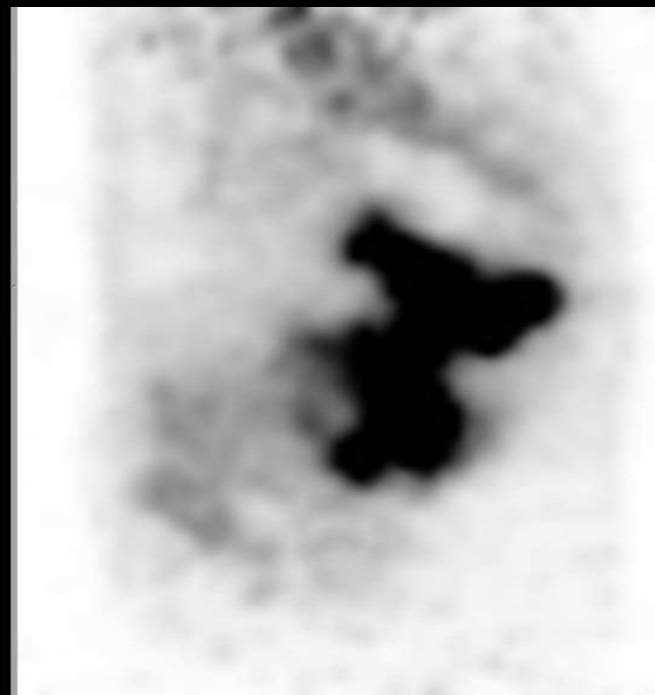
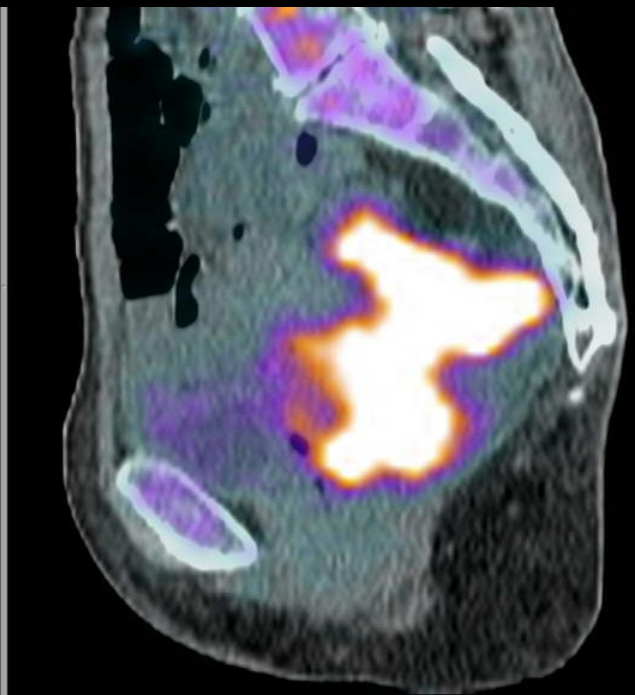


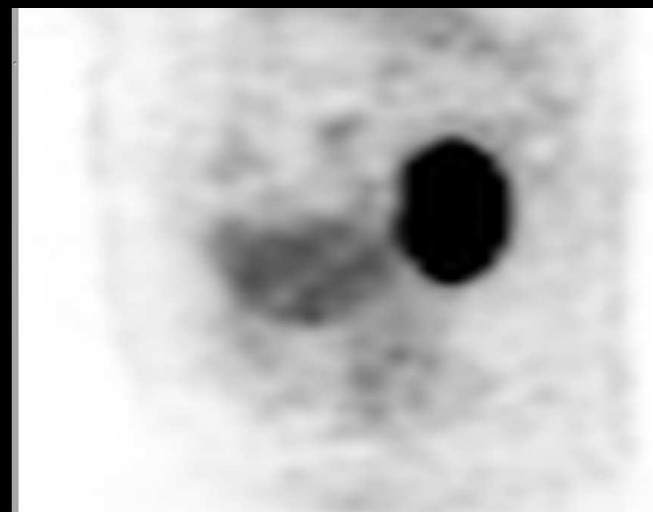
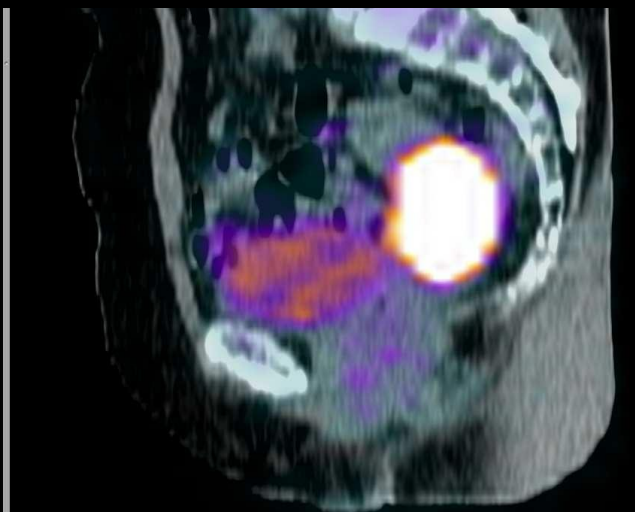
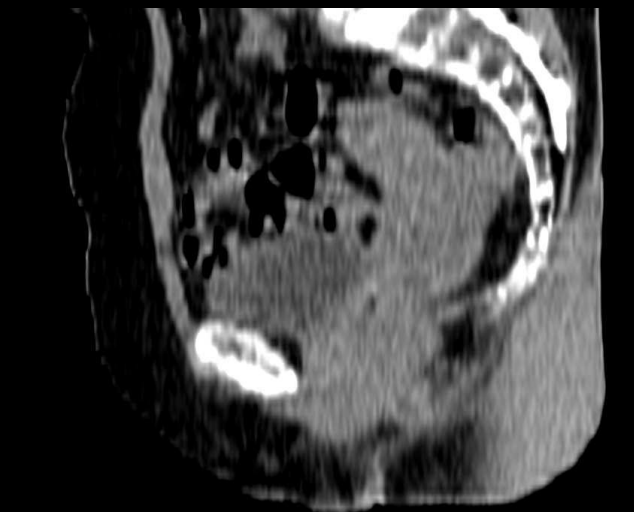
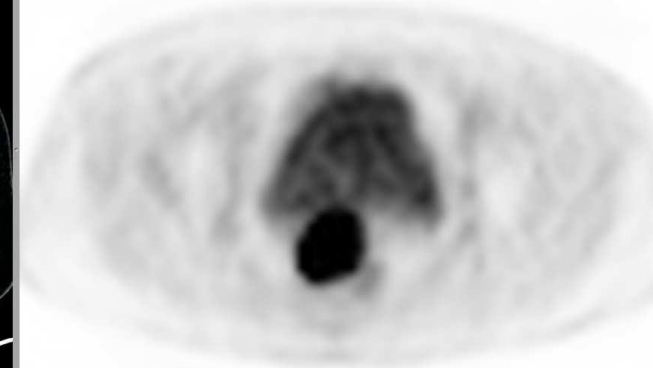
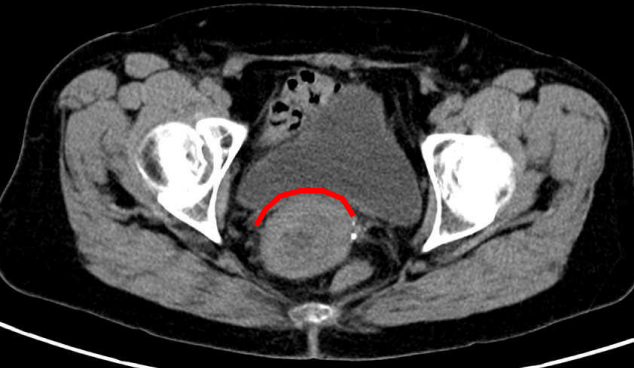
Double ADK :
-recto-colique
-endocol



ADK recto-colique

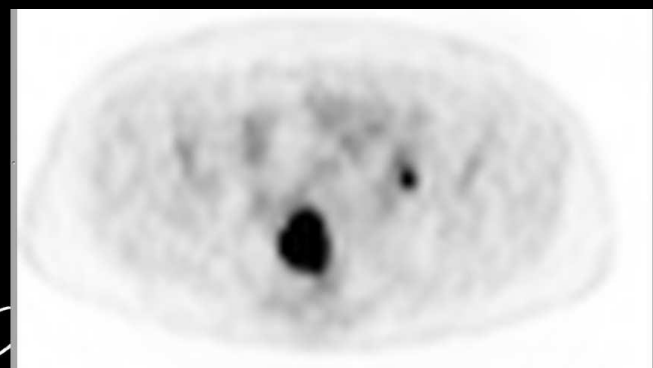
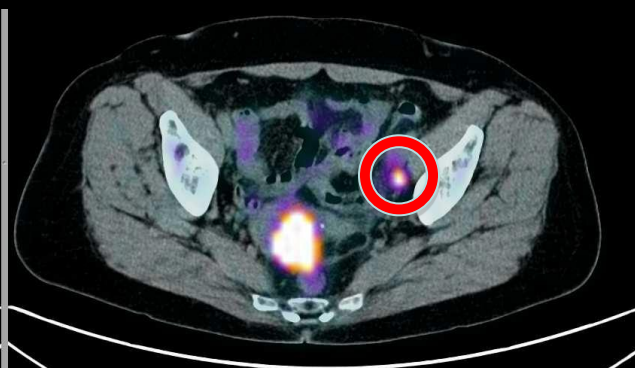
ADK endocol

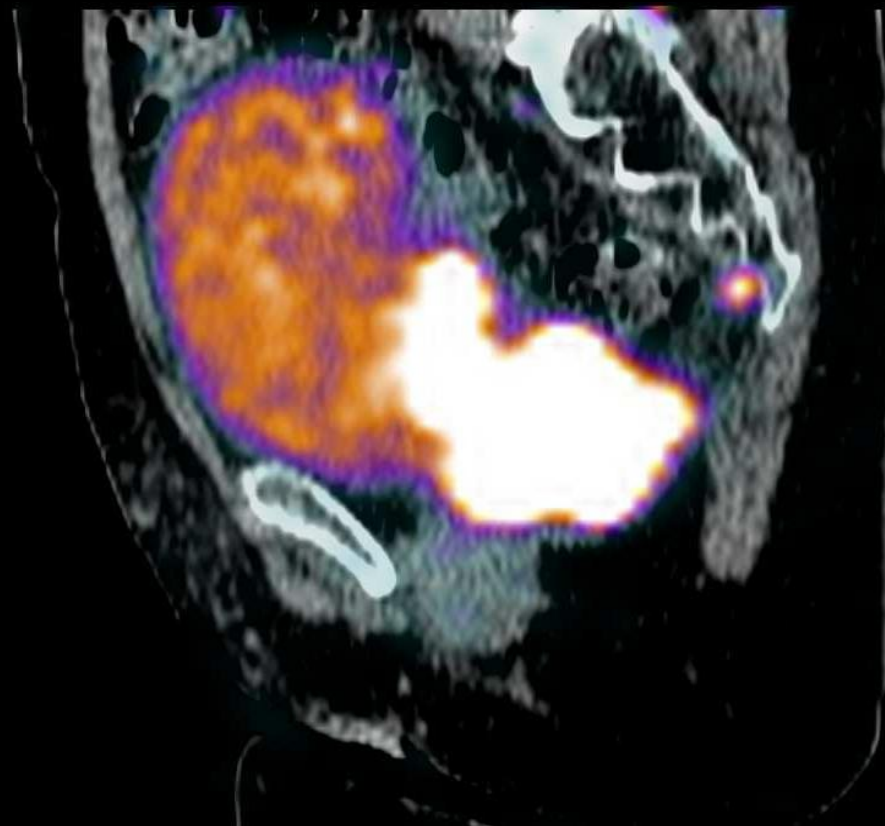
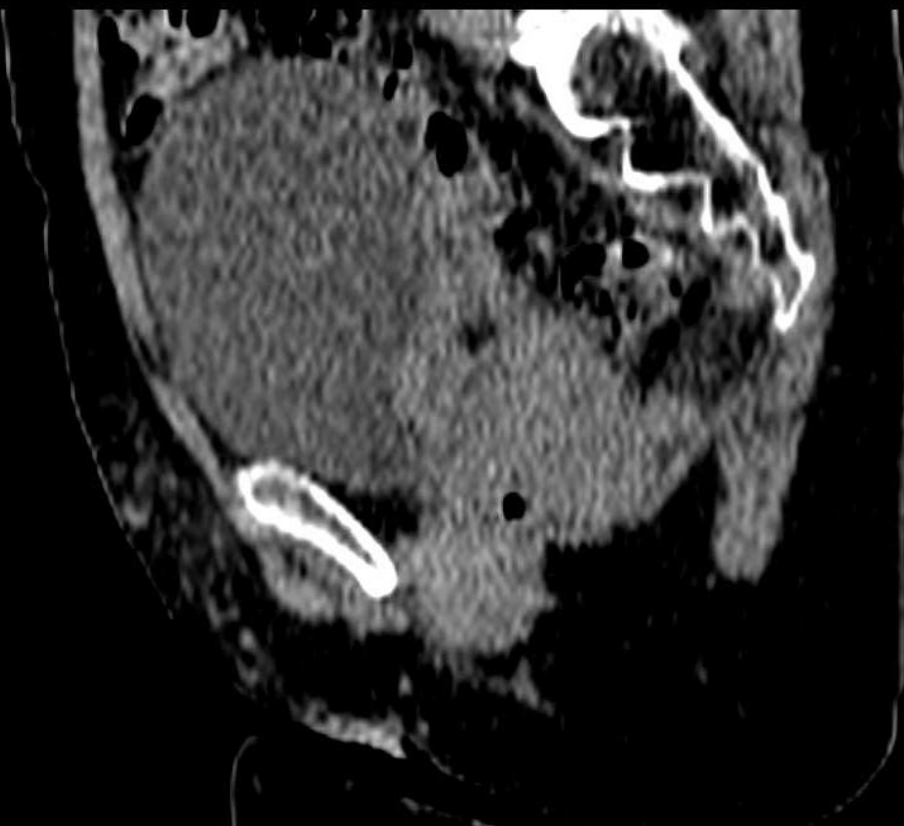




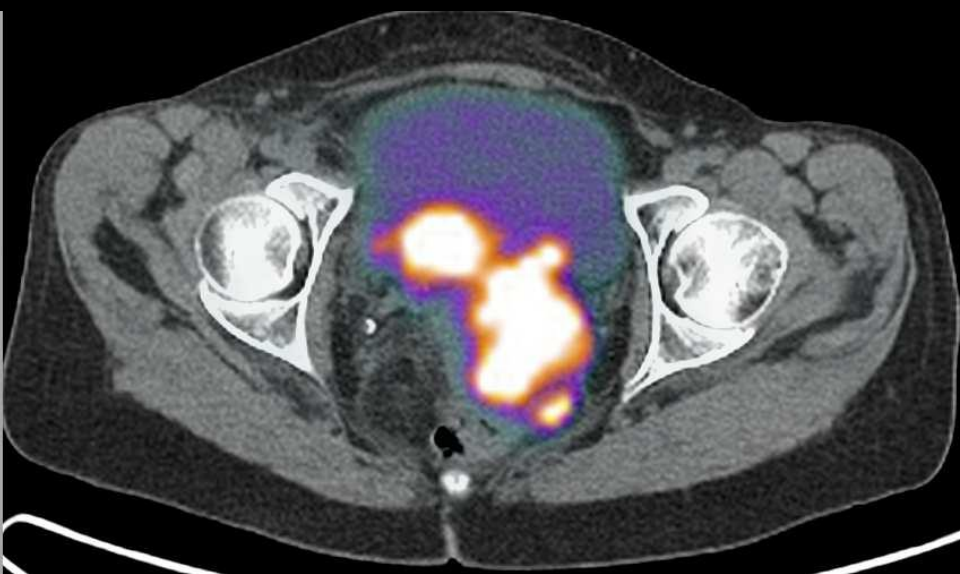
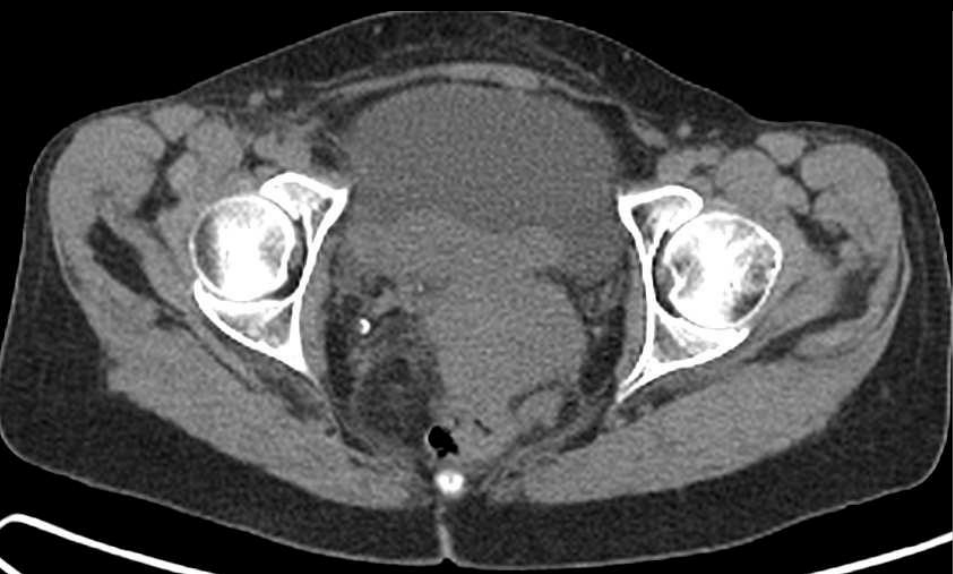
ADK endomètre
Paroi vésicale respectée

ADP iliaque externe G



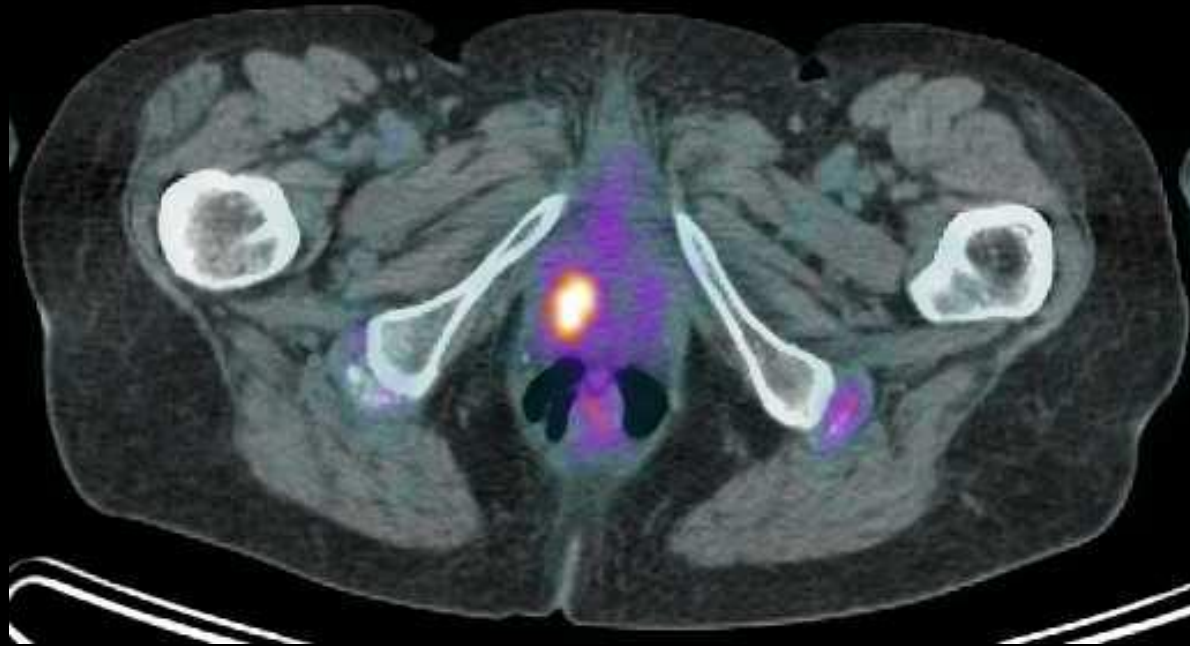


Carcinome du col utérin : bilan d'extension



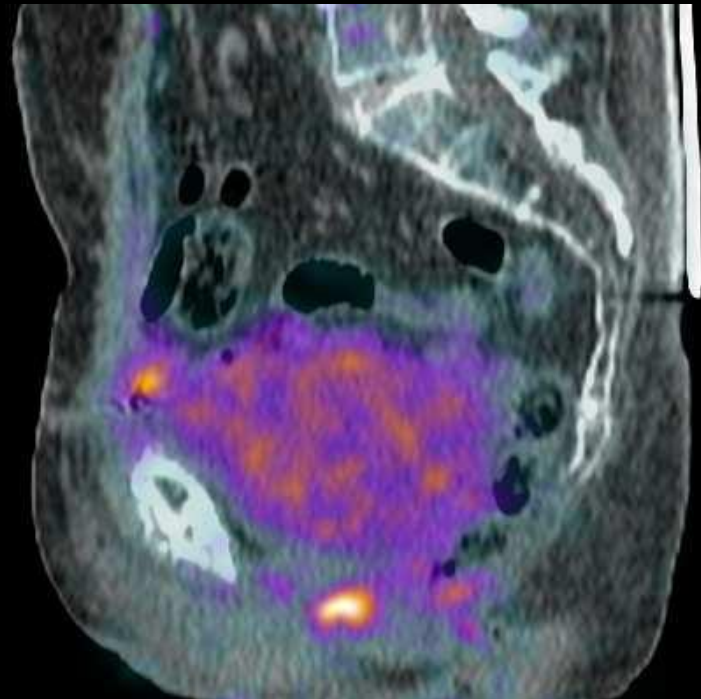
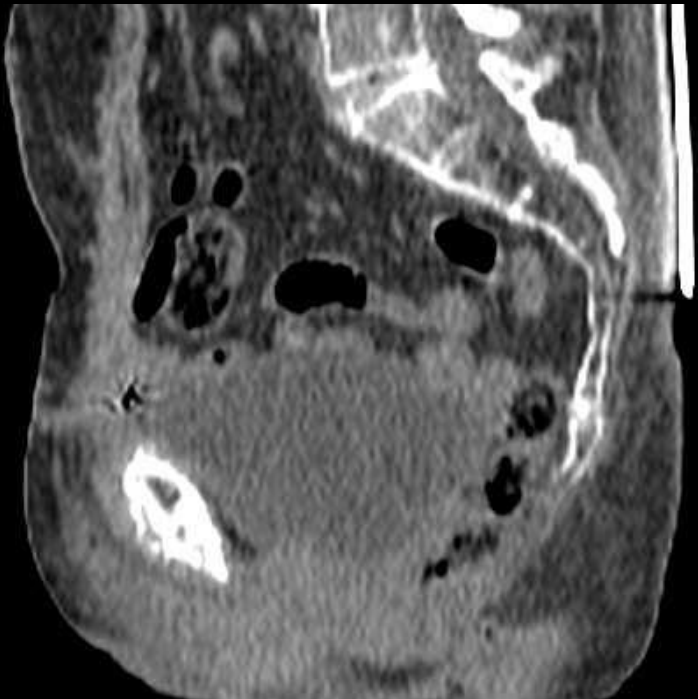
Rapports avec le rectum

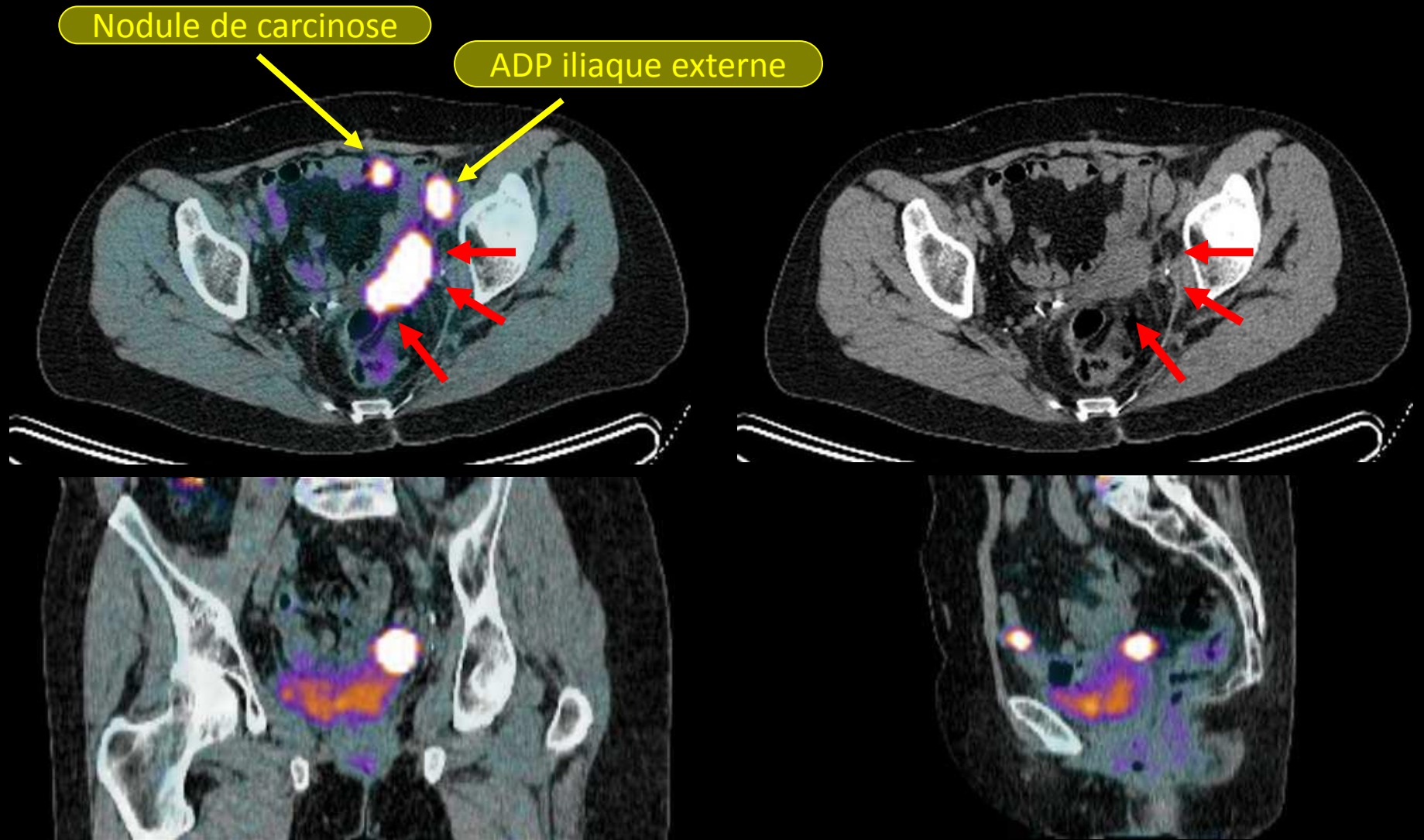
Surveillance d'un ADK à cellules claires de l'utérus traité par hystérectomie totale en juillet 2010





Vidange vésicale. Foyer de récidence vaginale





Cancer du vagin

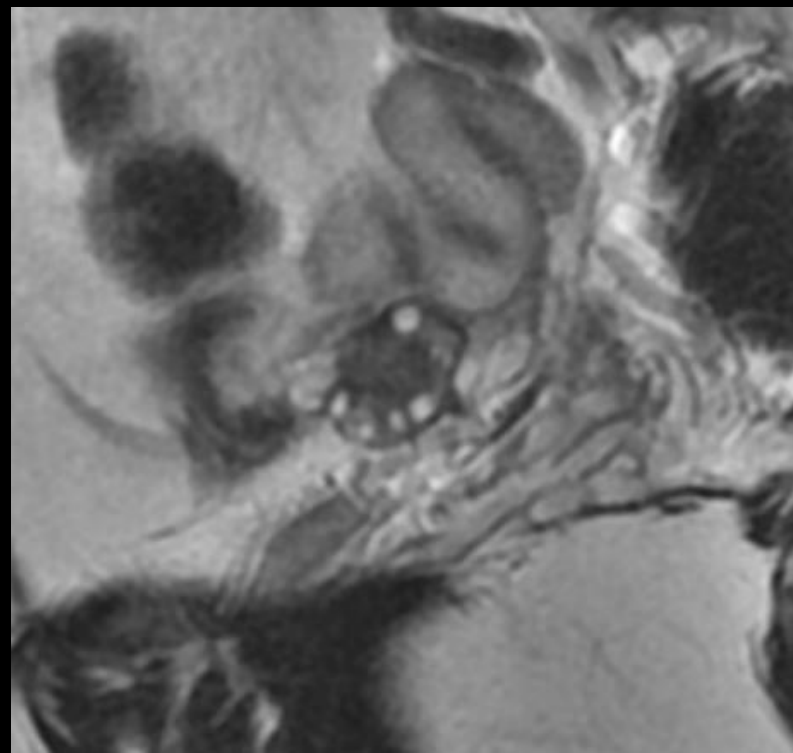
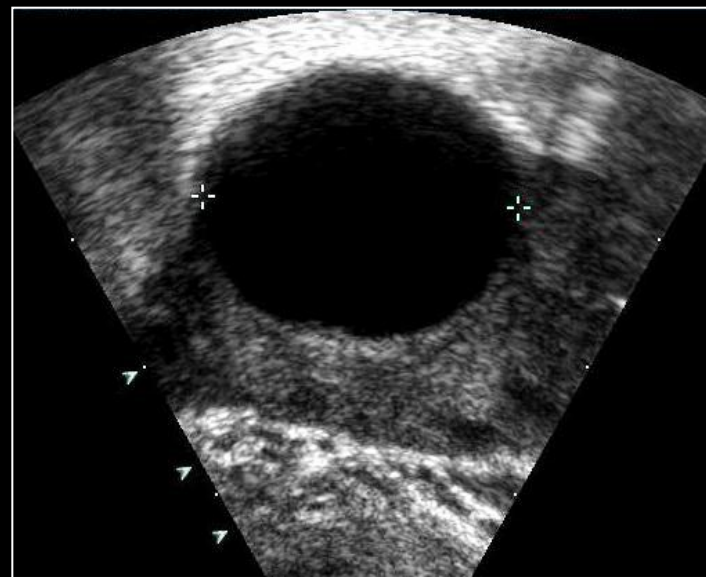
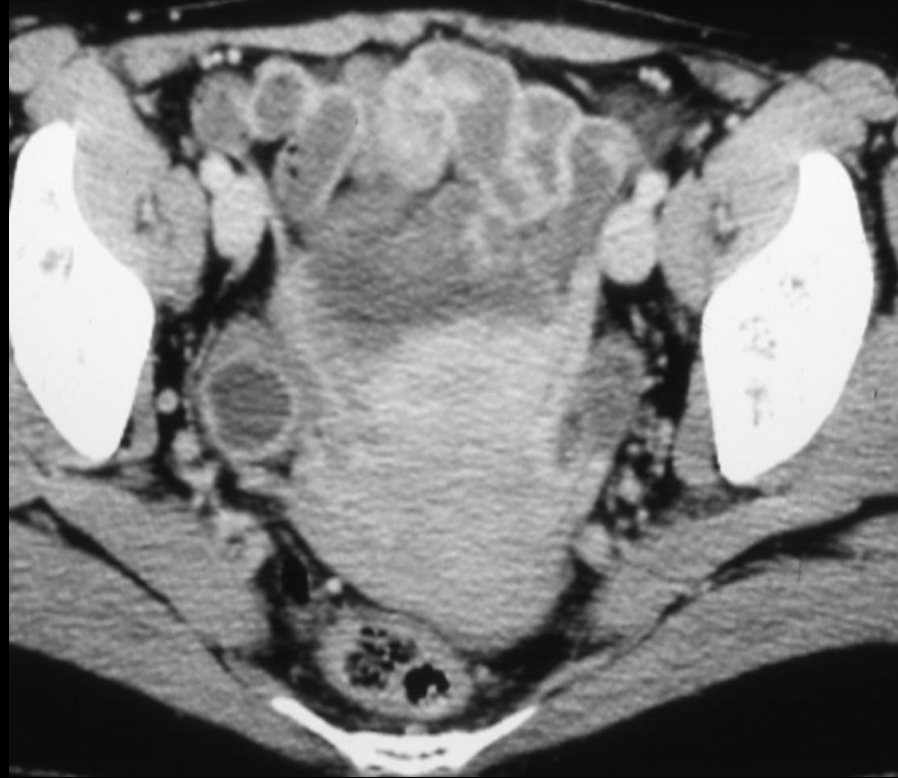
Ovaires

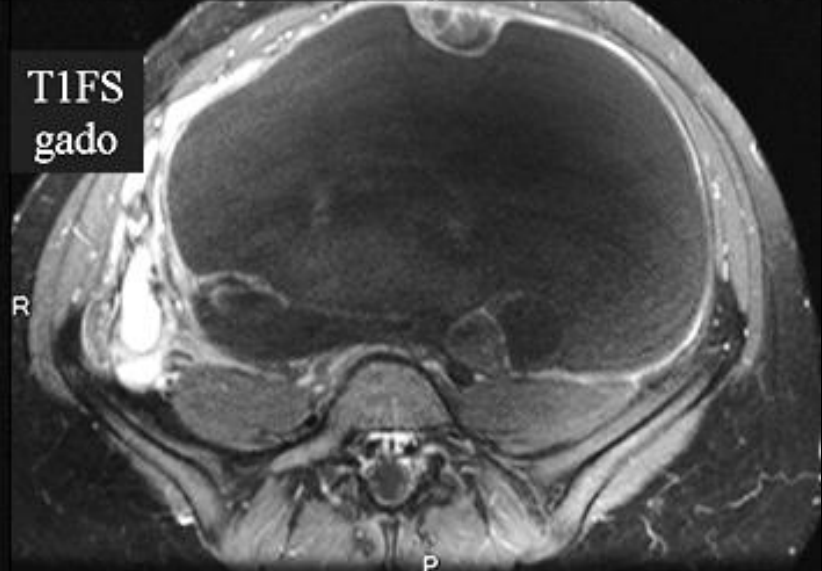
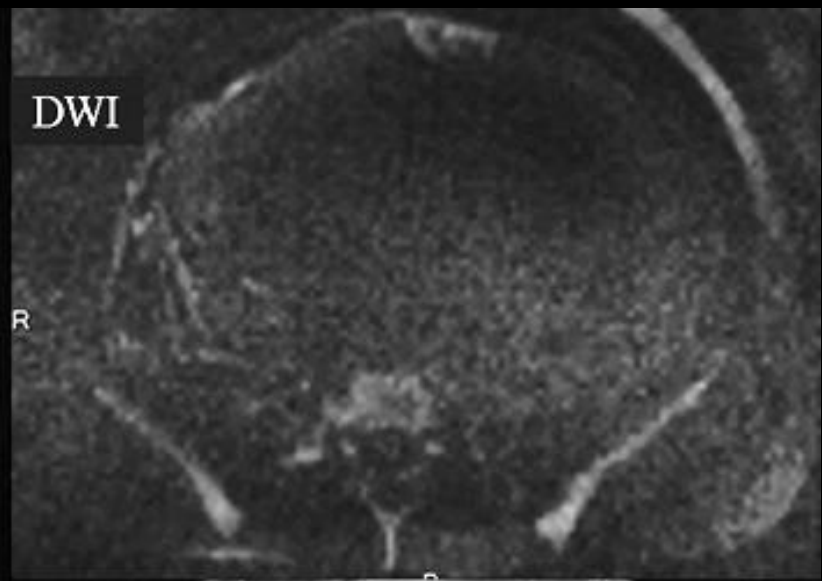
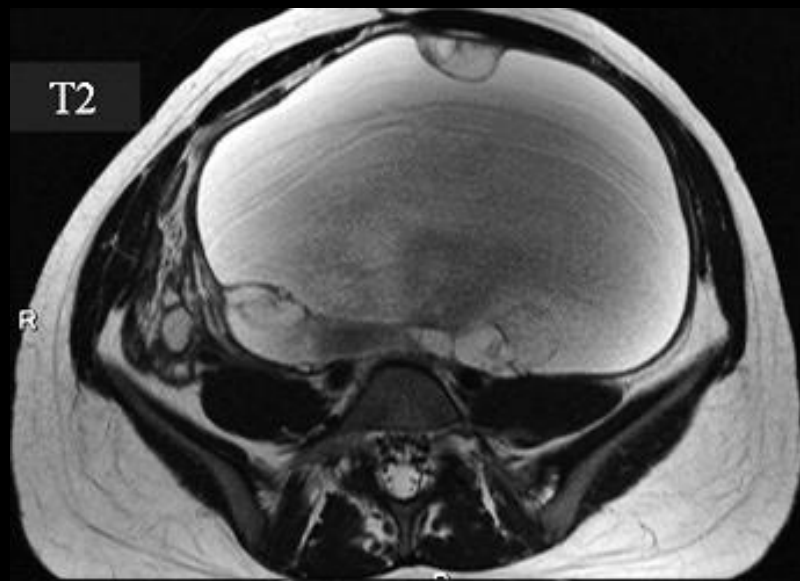
- Echographie endovaginale
- IRM
- Scanner parfois (volumineuses lésions, carcinose, tératomes)

4 à 5cm max en période d'activité génitale
avec des follicules mesurant jusqu'à 30mm
(au-delà on parle de kyste)

Localisés dans la fossette ovarienne (sous
la veine iliaque externe et en avant de
l'artère iliaque interne)

- **Comment les repérer?** Suivre depuis le haut
les **veines ovariennes** (depuis la VCI à
droite et depuis la veine rénale G)





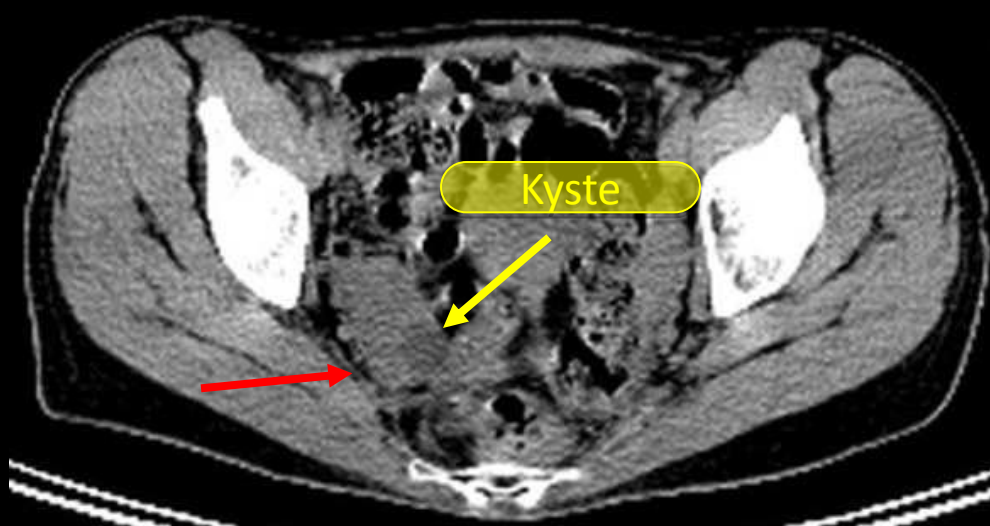
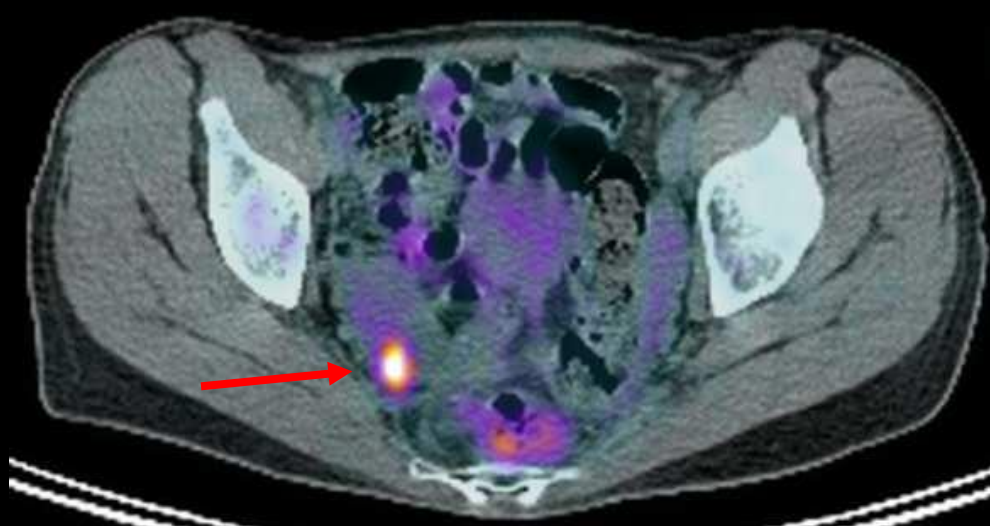
Tumeur mucineuse borderline. Plus la tumeur est volumineuse et plus son origine est difficile à préciser



Graisse macroscopique
+dents = tératome mature

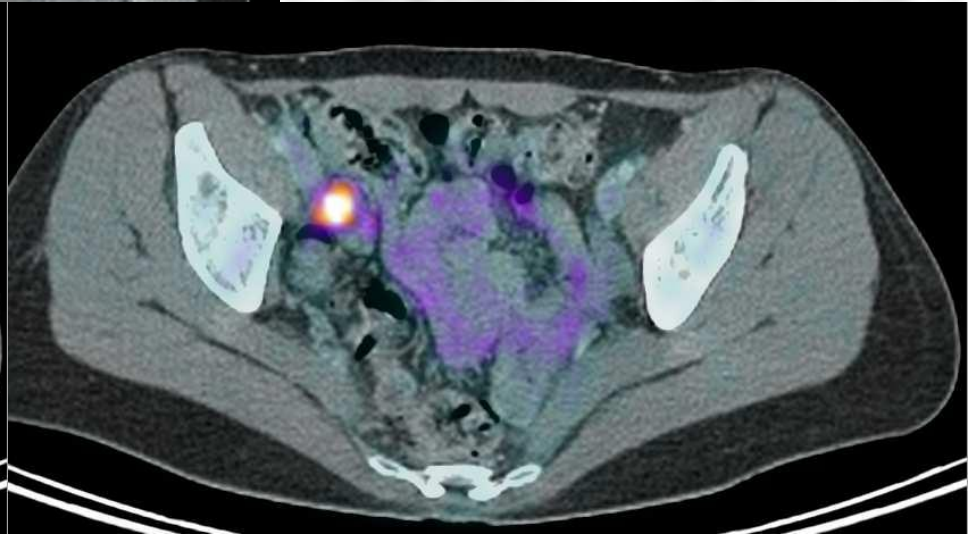
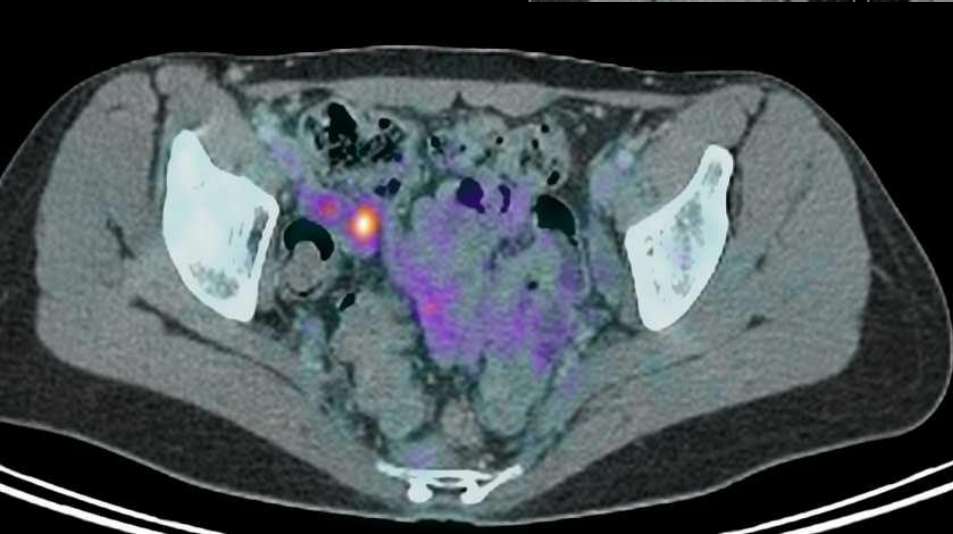
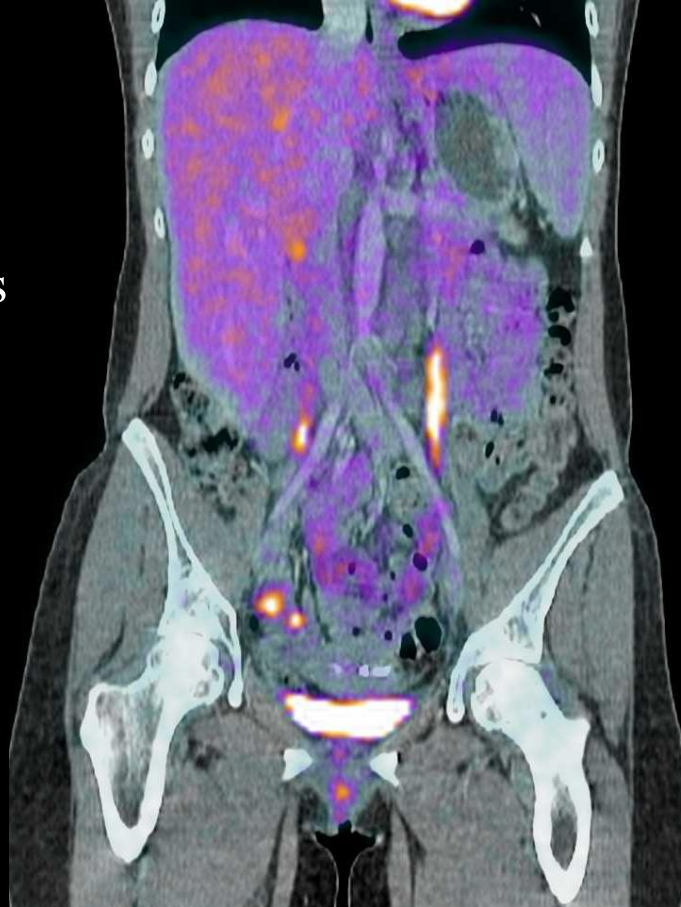


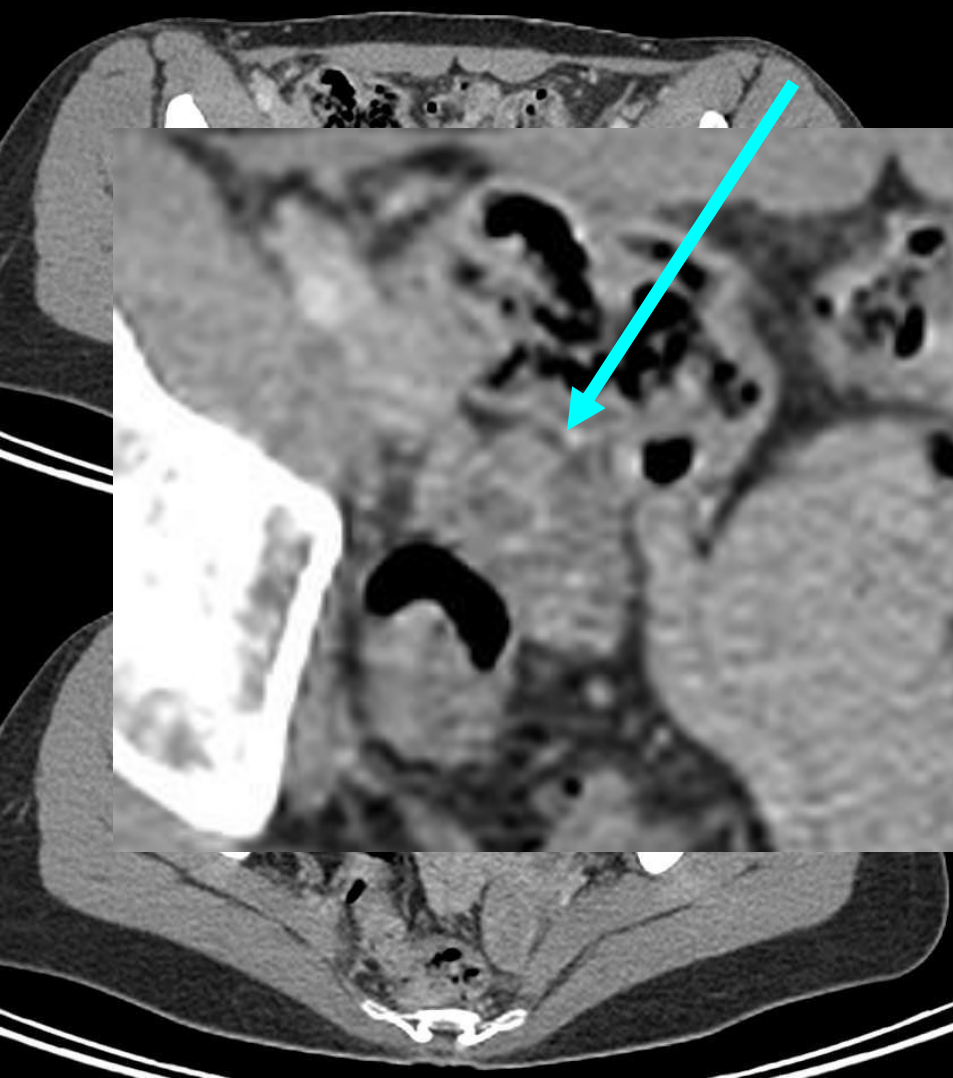
Abcès tubo-ovarien G



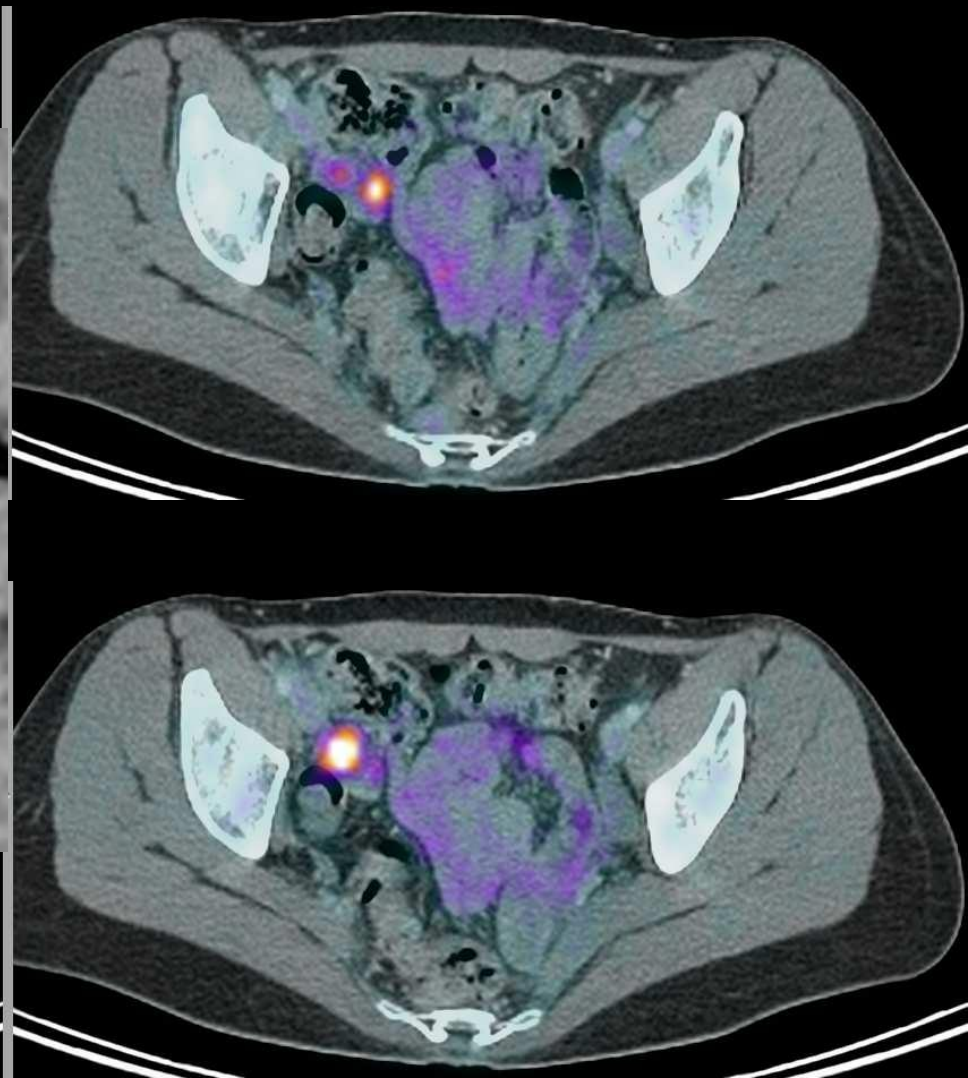
Follicule ovarien ou corps jaune

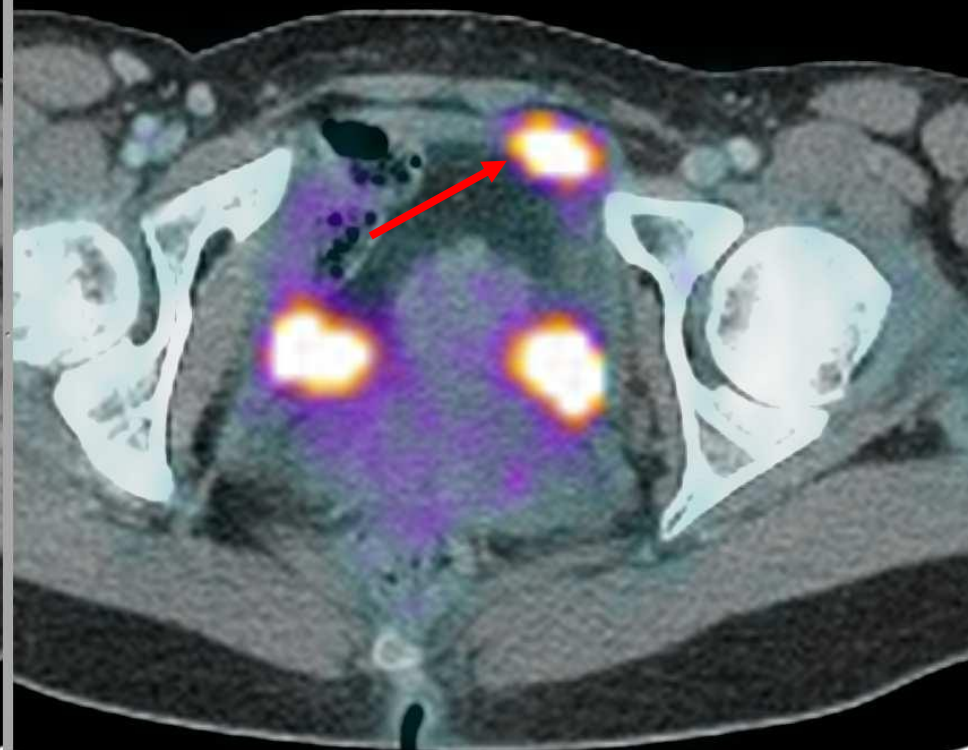
Réévaluation post-
chimio d'un LNH T sus
et sous-diaphr. avec
atteinte splénique et
osseuse.



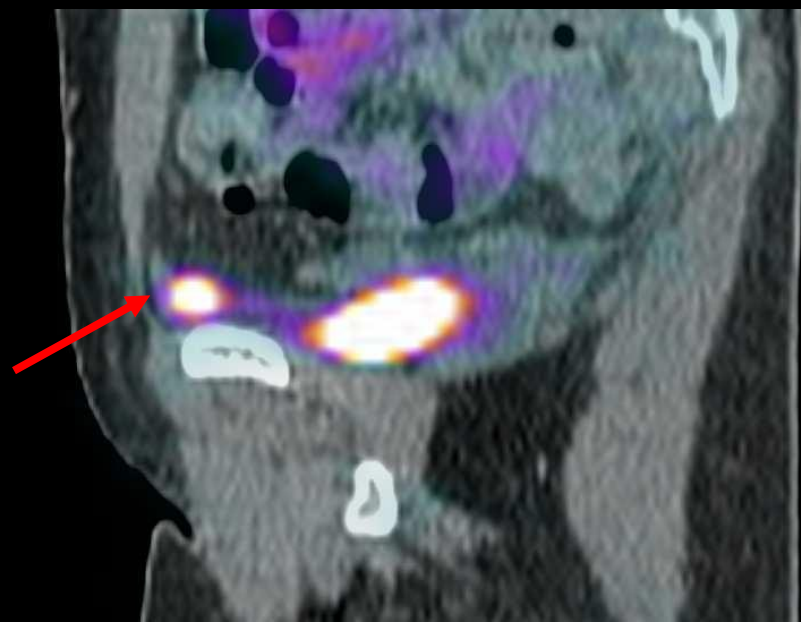
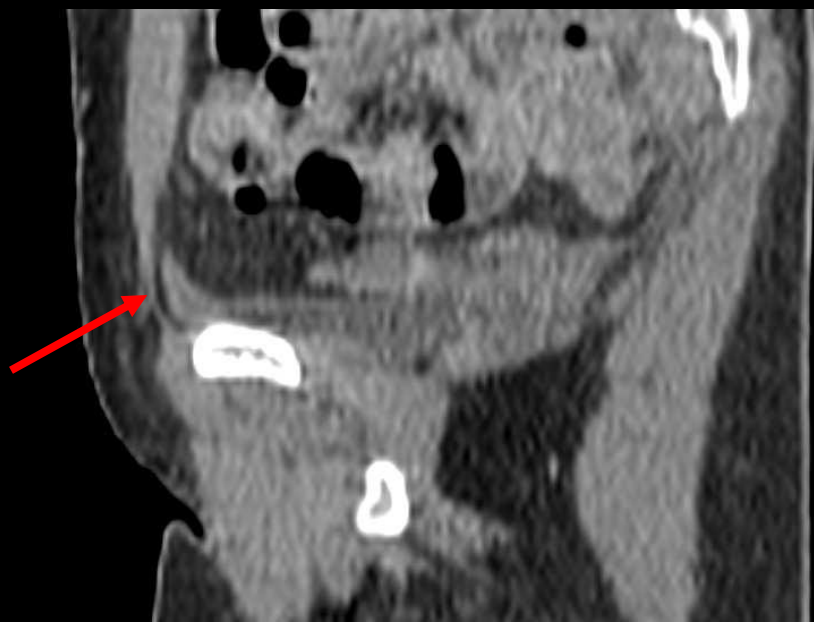


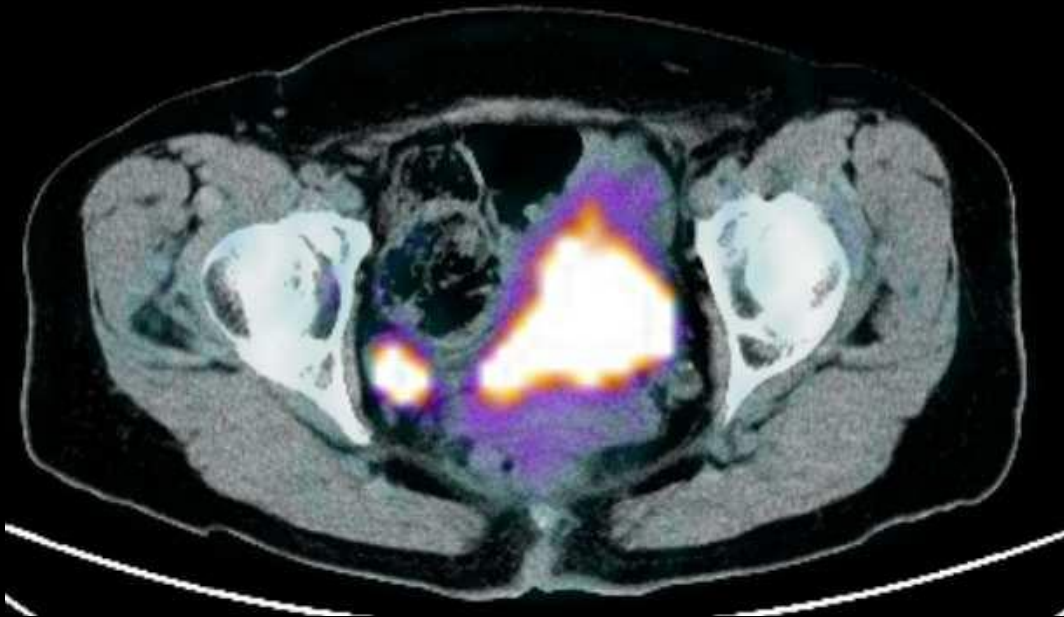
corps jaune





Corne vésicale





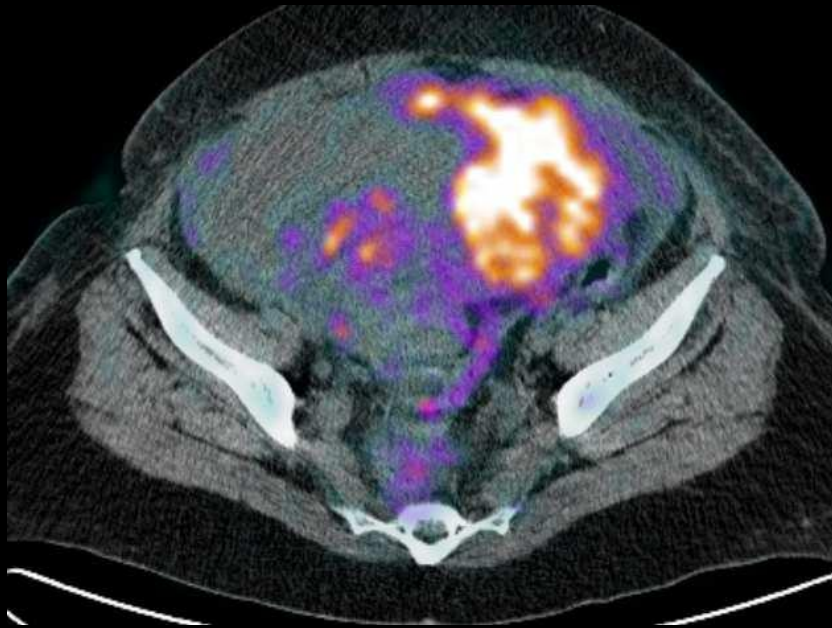
Localisation ?

Corne vésicale



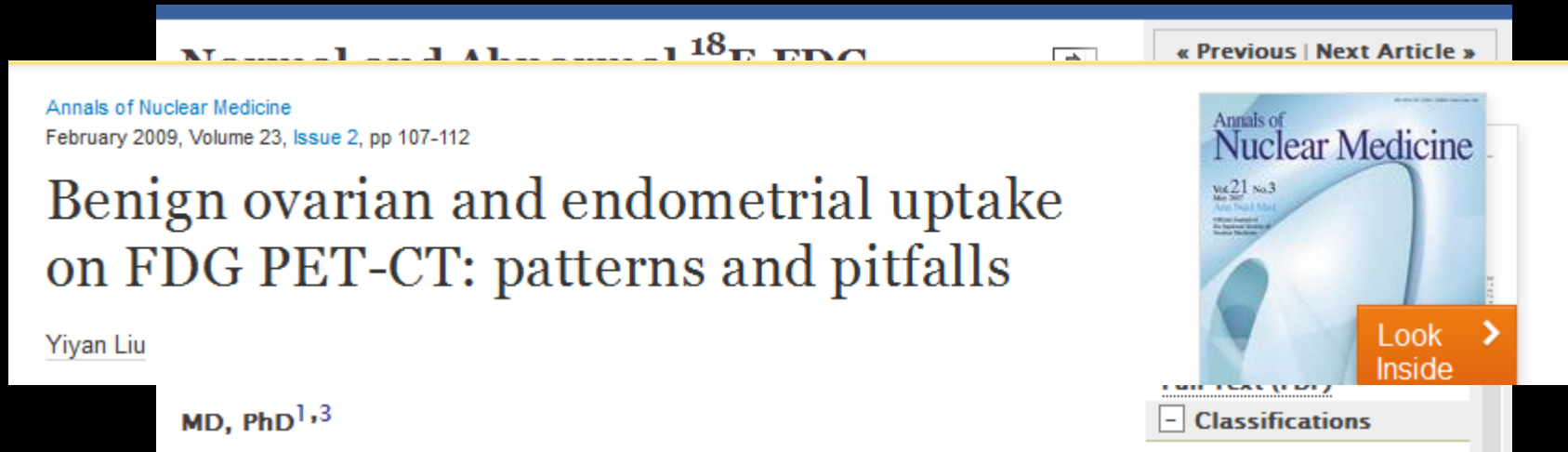


Cancer de l'ovaire



Tumeur de l'ovaire

Foyers utéro-annexiels : lesquels décrire ?



Pré-ménopause :

- Un hypermétabolisme **endométtrial** peut être d'origine **fonctionnelle** (augmente durant la phase folliculaire et se normalise à la **phase lutéale précoce**)
- Un hypermétabolisme **endométtrial** adjacent à une tumeur cervicale ne traduit pas

Post-ménopause :

- Un hypermétabolisme **ovarien** peut être d'origine **fonctionnelle** ou **tumorale**

Post-ménopause :

- Un hypermétabolisme **ovarien** est à considérer comme d'origine **tumorale**

Prostate

TEP à la 18F-CHOLINE

TEP ^{18}F -Fluorocholine

- Choline : précurseur pour la biosynthèse des phospholipides qui sont des composants essentiels des membranes cellulaires
- Études de spectro-IRM ont montré que les cellules cancéreuses de la prostate contiennent davantage de métabolites de la choline que les cellules normales
- Se 80% Sp 96% pour le staging ganglionnaire d'un ADK prostatique
- Localisation de la récurrence biologique dans près de 50% des cas
- Autres applications : CHC...



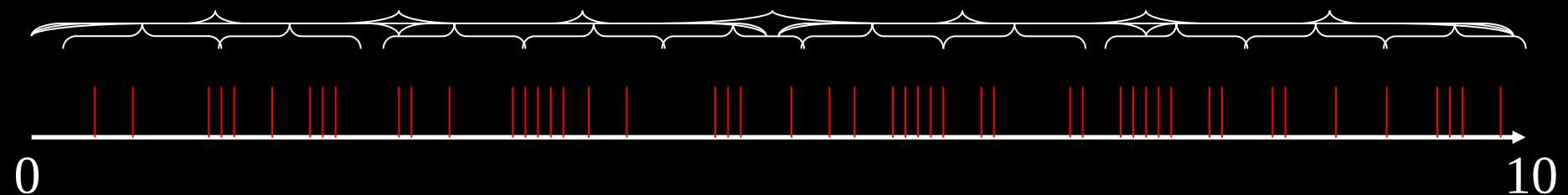
TEP Fluorocholine – Protocole utilisé à Nancy

- Acquisition pelvienne per-injection : LIST MODE
- Acquisition corps entier
- Acquisition pelvienne après vidange vésicale

TEP Fluorocholine – LIST MODE

- LIST MODE :
 - Chaque coïncidence est enregistrée avec son délai de survenue par rapport au début de l'acquisition
 - Puis on reconstruit autant d'images qu'on le souhaite (et qu'on le peut!)

40 images de 10,5 minutes



Transverse

Sagittal

Coronal

FCH 10 IM DE 1 MINUTE 4IT 8S (AC), 11/16/2012, Phase 1, Repeat 1

CT PELVIS 3.0 B40s, 11/16/2012

% 50 HU

Transverse

Sagittal

Coronal

FCH 10 IM DE 1 MINUTE 4IT 8S (AC), 11/16/2012, Phase 1, Repeat 1

CT PELVIS 3.0 B40s, 11/16/2012

% 50 HU

Transverse

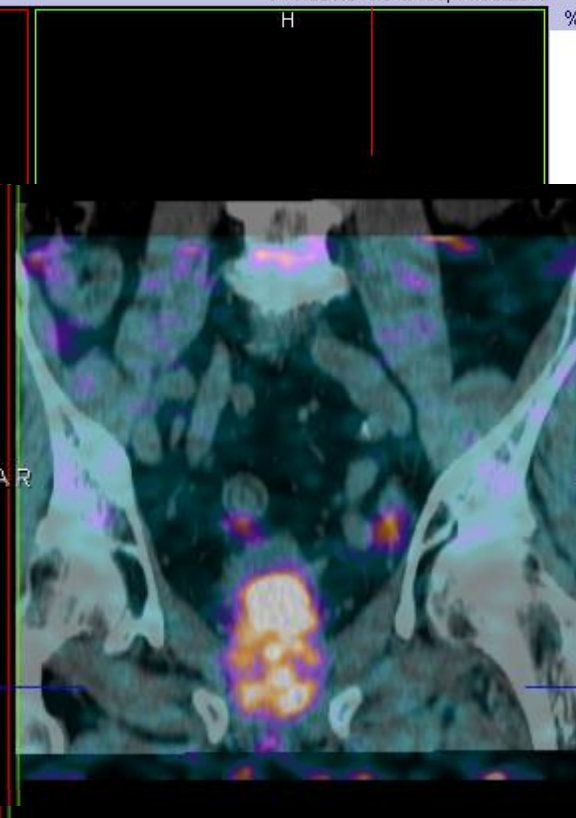
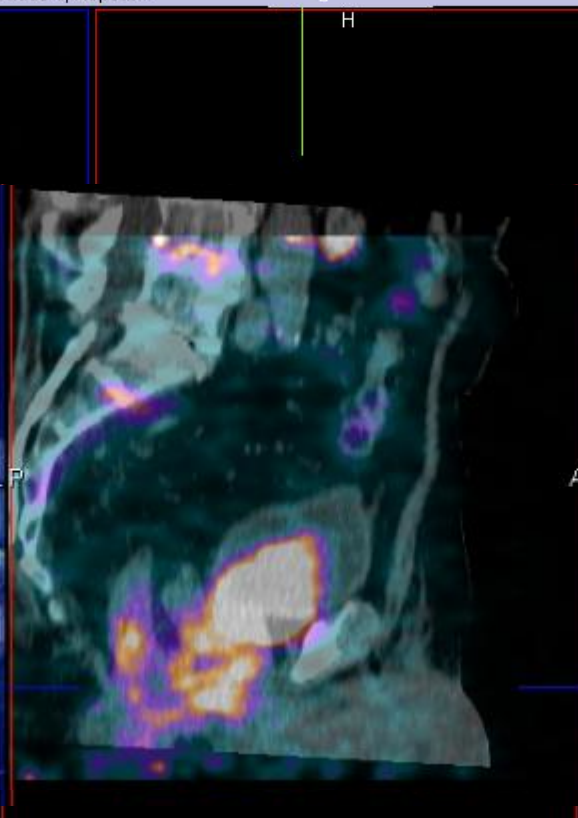
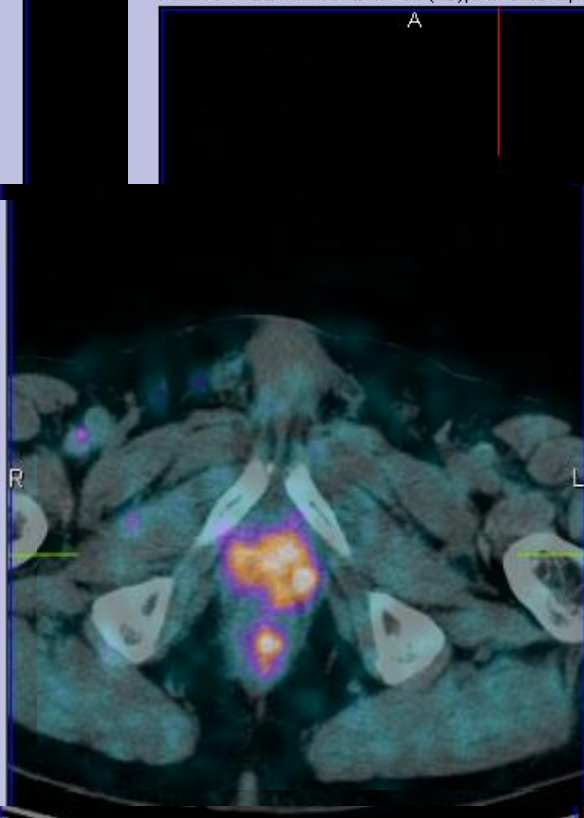
Sagittal

Coronal

FCH 10 IM DE 1 MINUTE 4IT 8S (AC), 11/16/2012, Phase 1, Repeat 1

CT PELVIS 3.0 B40s, 11/16/2012

% 50 HU



B40s

1: (B:

B40s

1: (B:0%,T:3

T: 2.0
P: 142.5

72 B40s

T: 1.0
P: 377.0

367 B40s

T: 1.0
P: 361.9

371

B40s

P

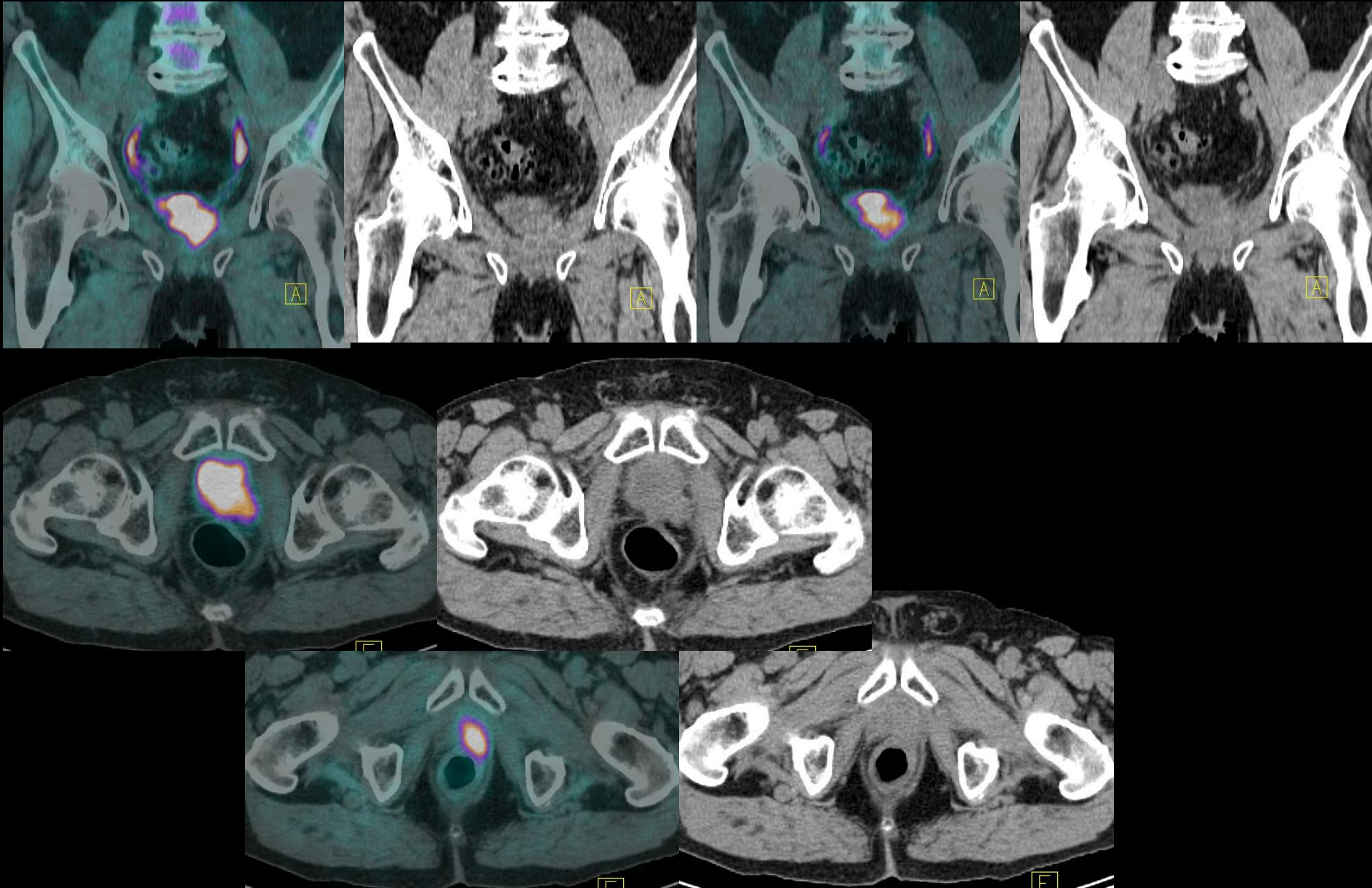
F

F

TEP Fluorocholine – Protocole utilisé à Nancy

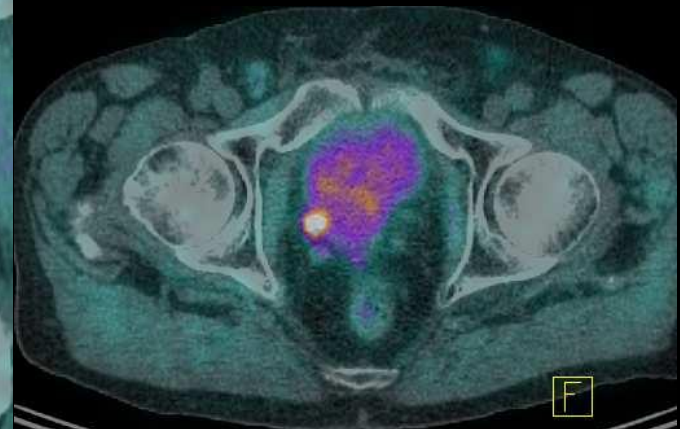
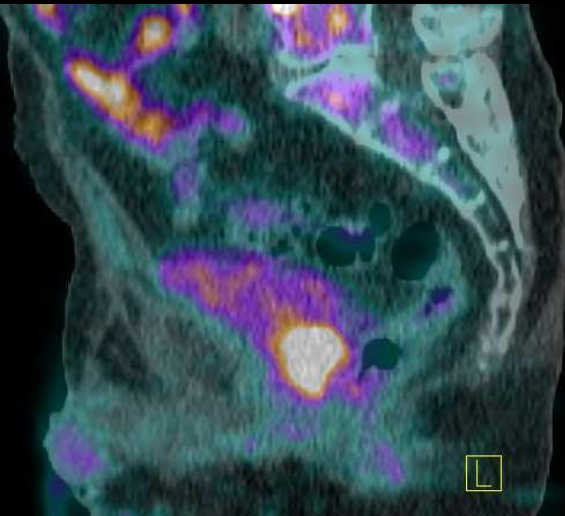
- Acquisition corps entier dans la foulée
- Acquisition pelvienne après vidange vésicale

TEP Fluorocholine - Bilan d'extension initial

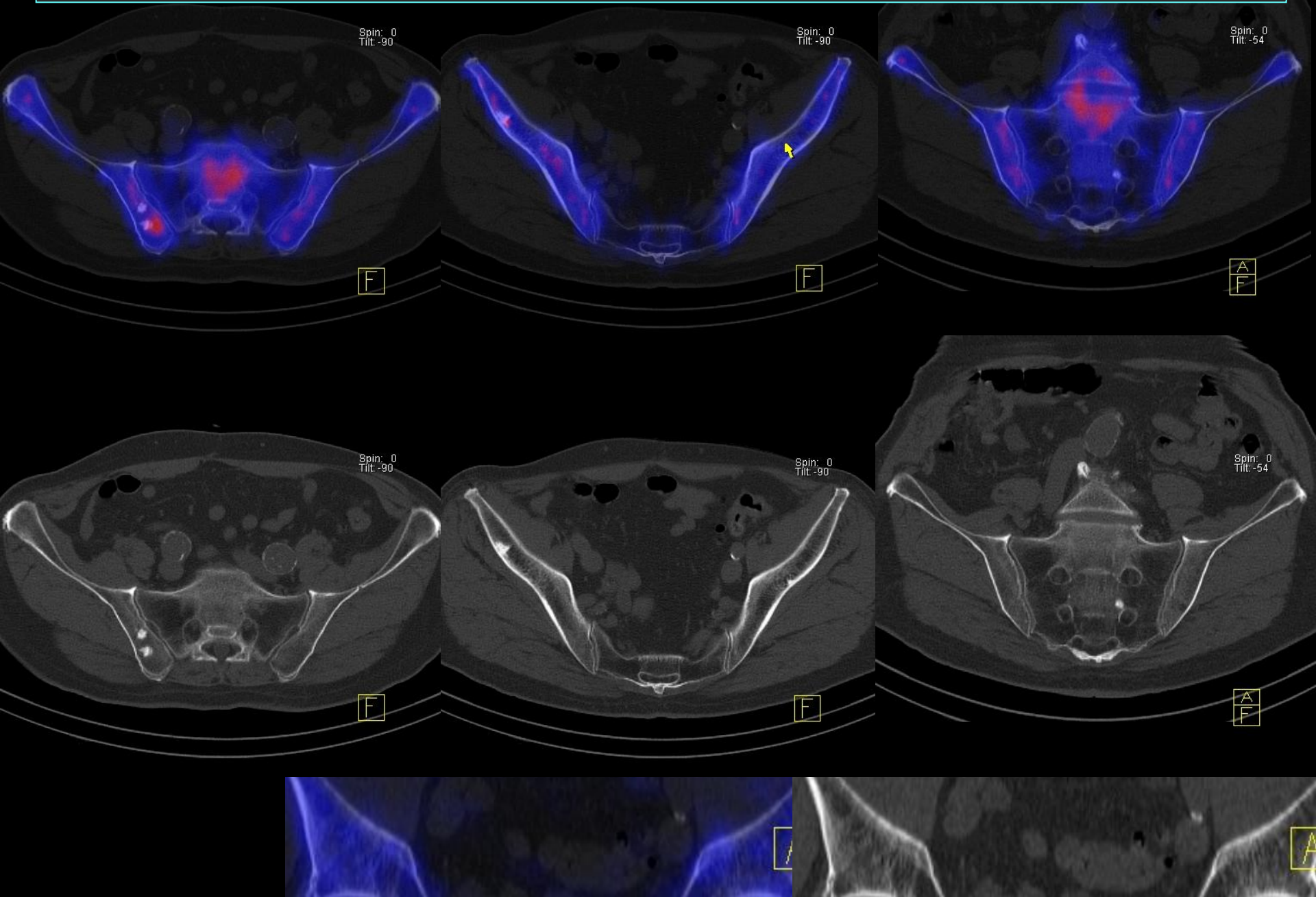


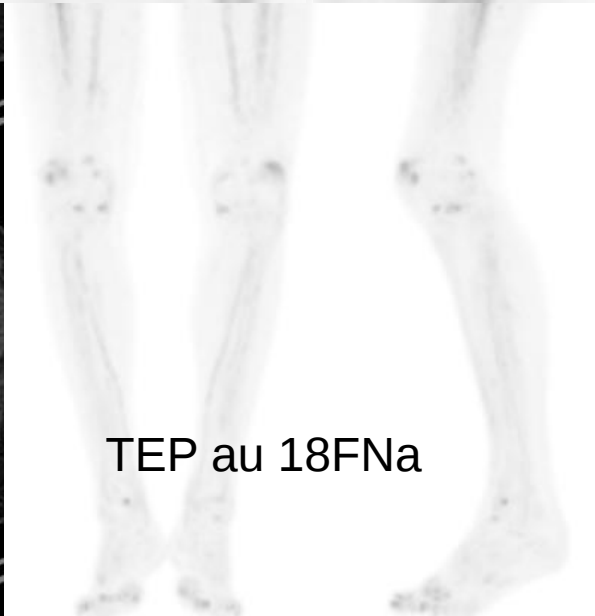
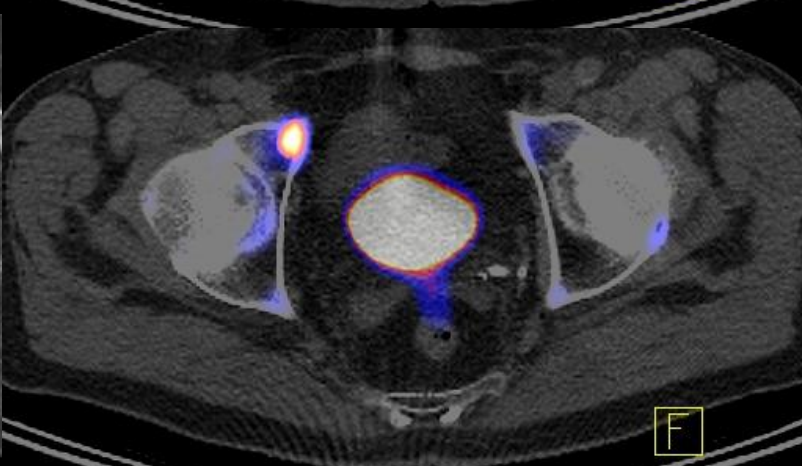
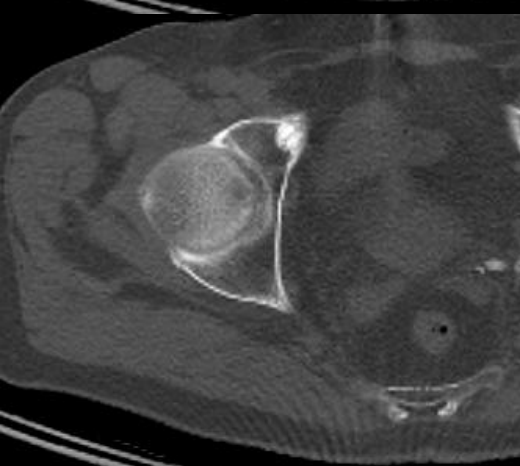
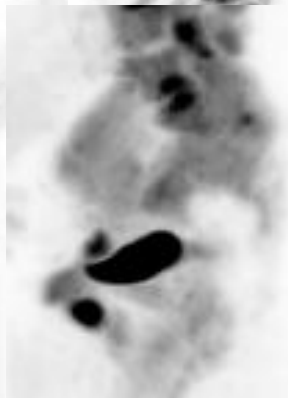
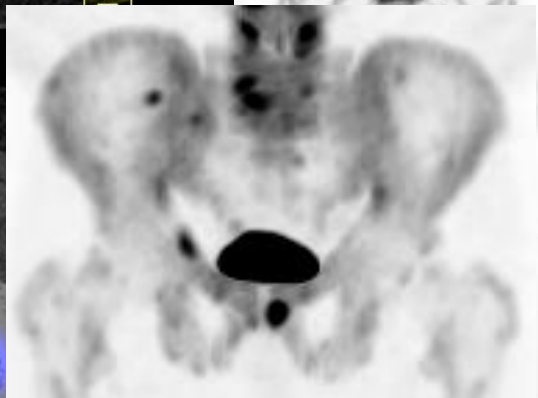
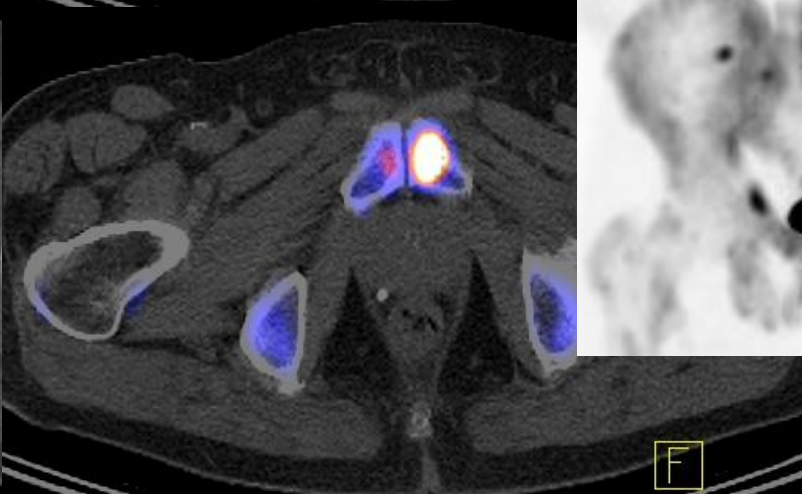
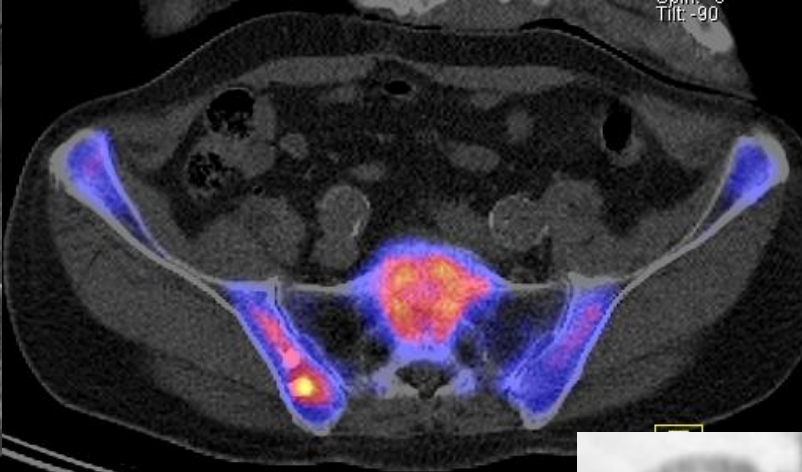
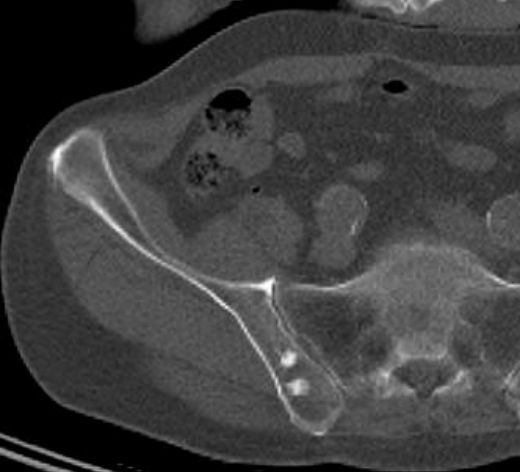
TEP Fluorocholine - Bilan d'extension initial

Acquisition post LASILIX

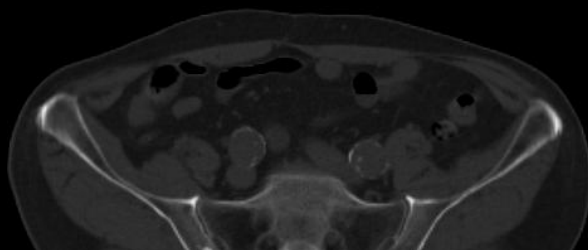


TEP Fluorocholine - Bilan d'extension initial

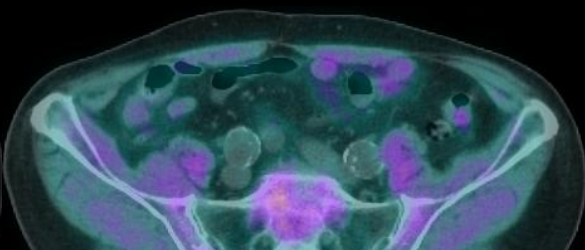




TEP au ^{18}FNa



Transverse



Sagittal



Coronale

FCH 10 IM DE 1 MINUTE 4IT 8S (AC), 16/08/2012, Phase 1, Répétition 1

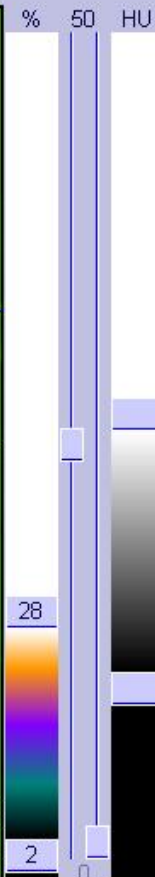
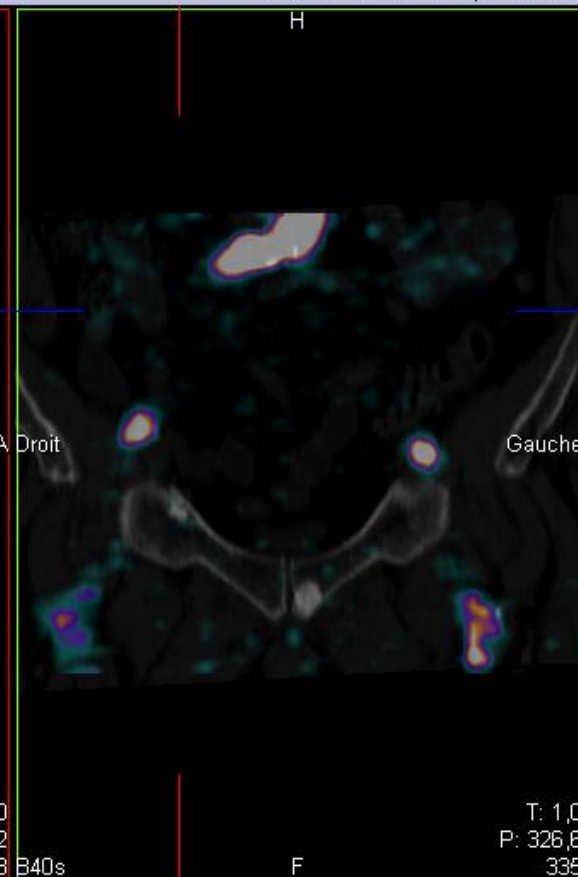
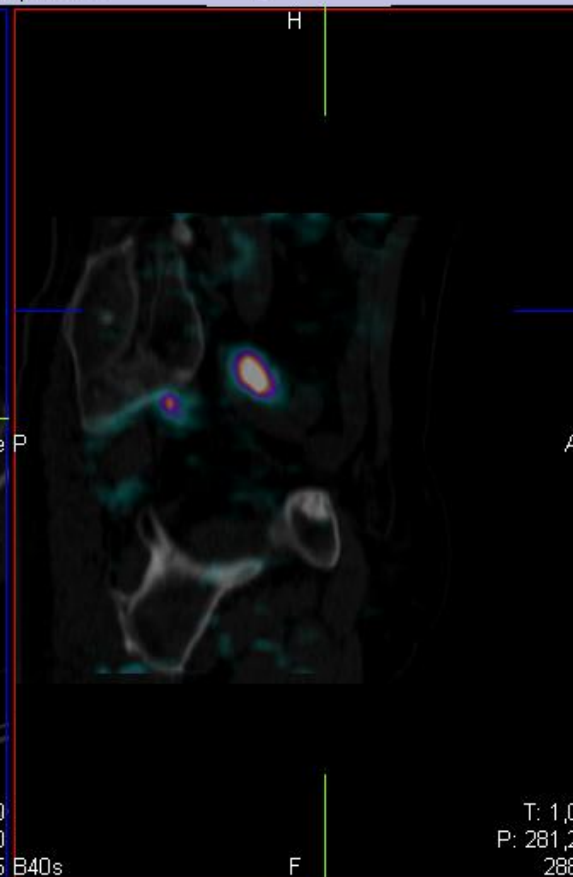
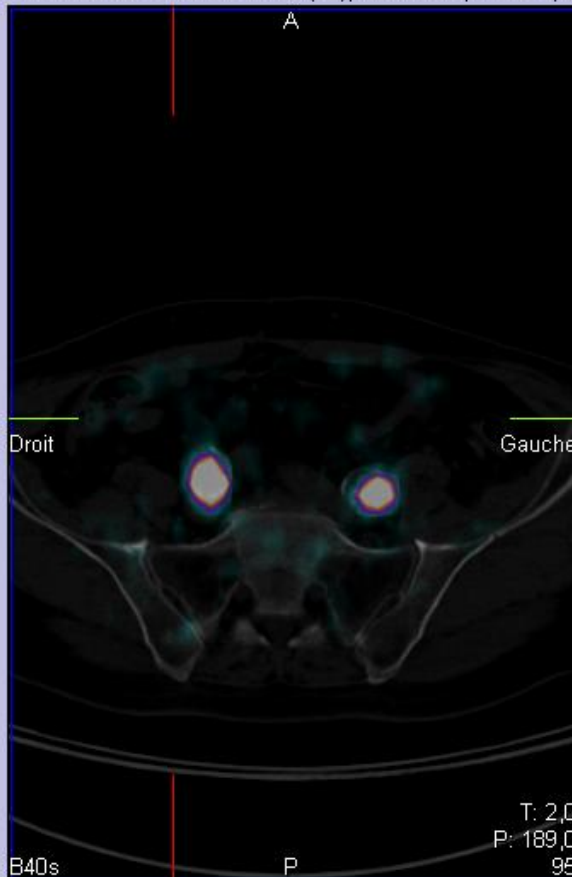
CT PELVIS 3.0 B40s, 16/08/2012

A

H

H

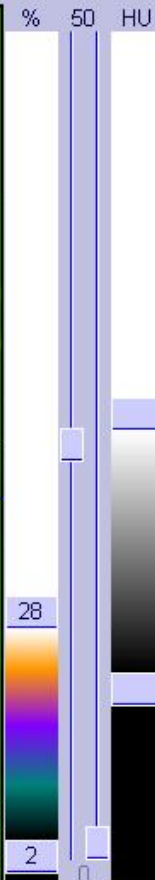
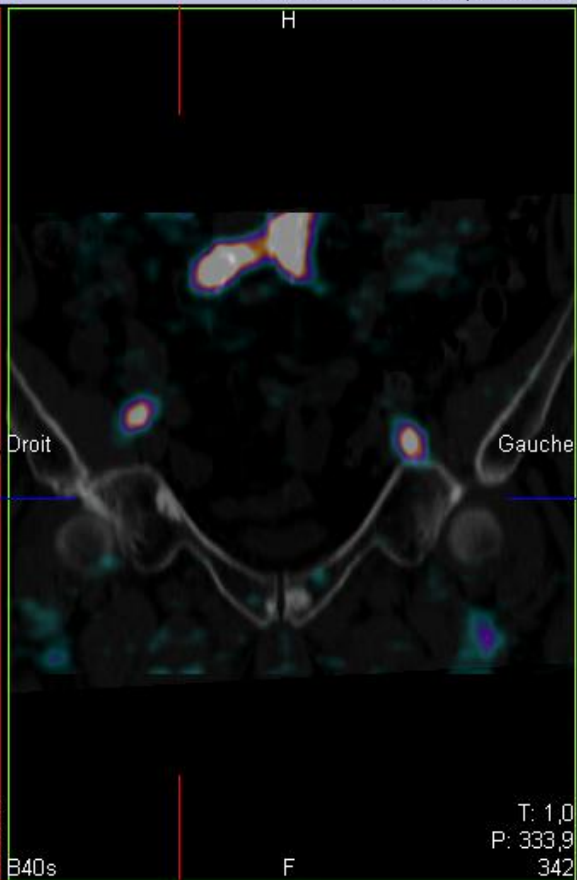
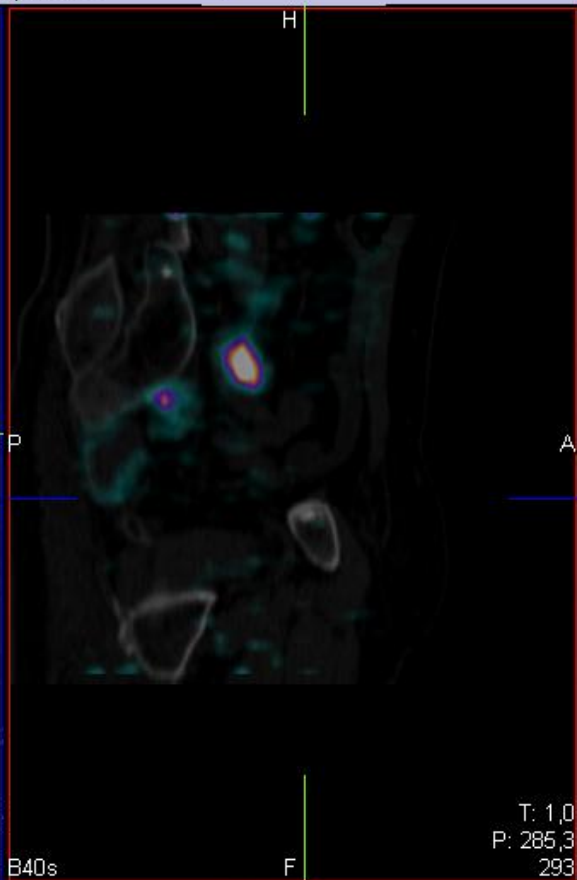
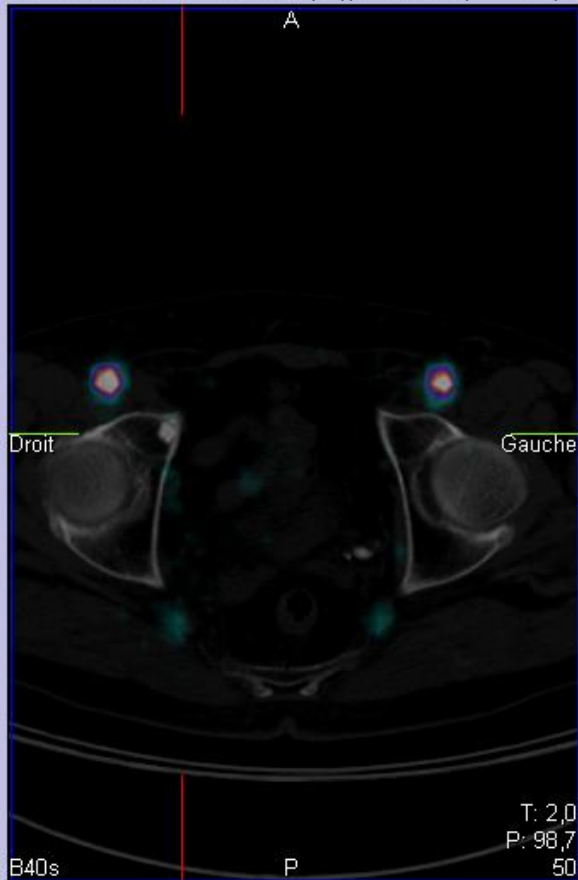
% 50 HU



Transverse
FCH 10 IM DE 1 MINUTE 4IT 8S (AC), 16/08/2012, Phase 1, Répétition 1

Sagittal

Coronale
CT PELVIS 3.0 B40s, 16/08/2012



FCH 10 IM DE 1 MINUTE 4IT 8S (AC), 16/08/2012, Phase 1, Répétition 1

1

CT PELVIS 3.0 B40s, 16/08/2012

% 50 HU

A ~~Droit~~

~~Gauche~~ P

B40s

p

T: 2,0
P: 56,7

29

9 B40s

F

T: 1,0
P: 337,0

346

6 B40s

F

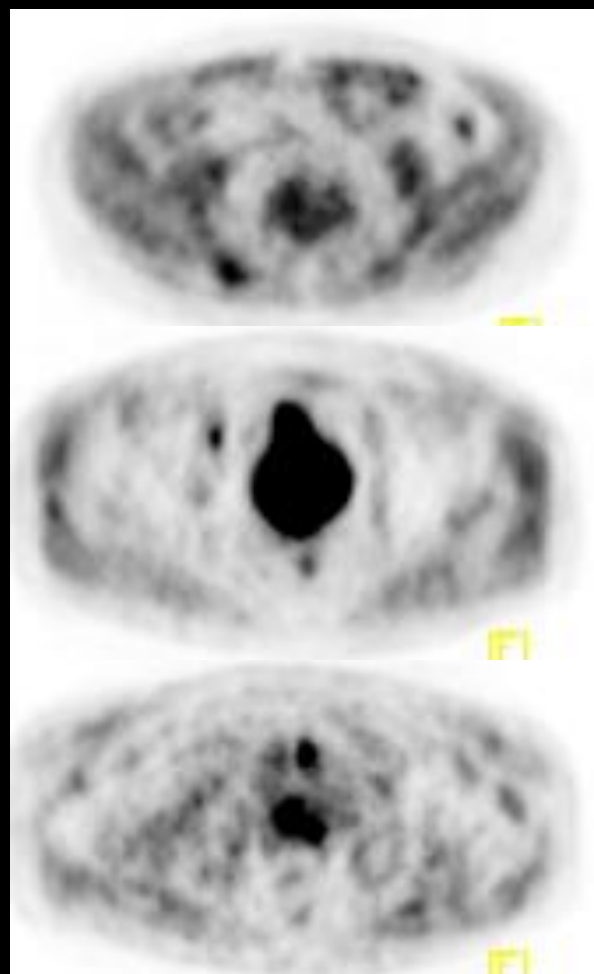
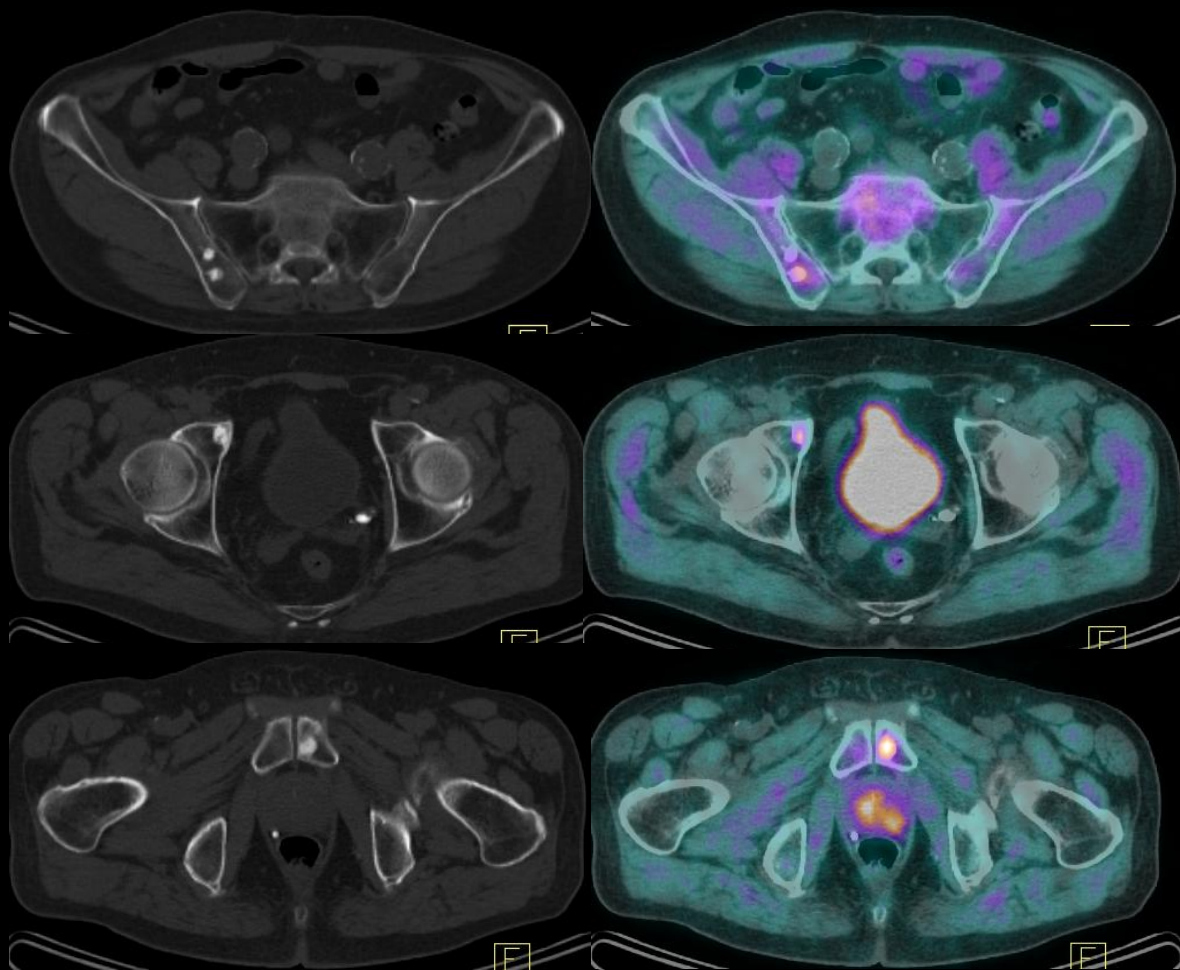
T: 1,0
P: 339,4

348

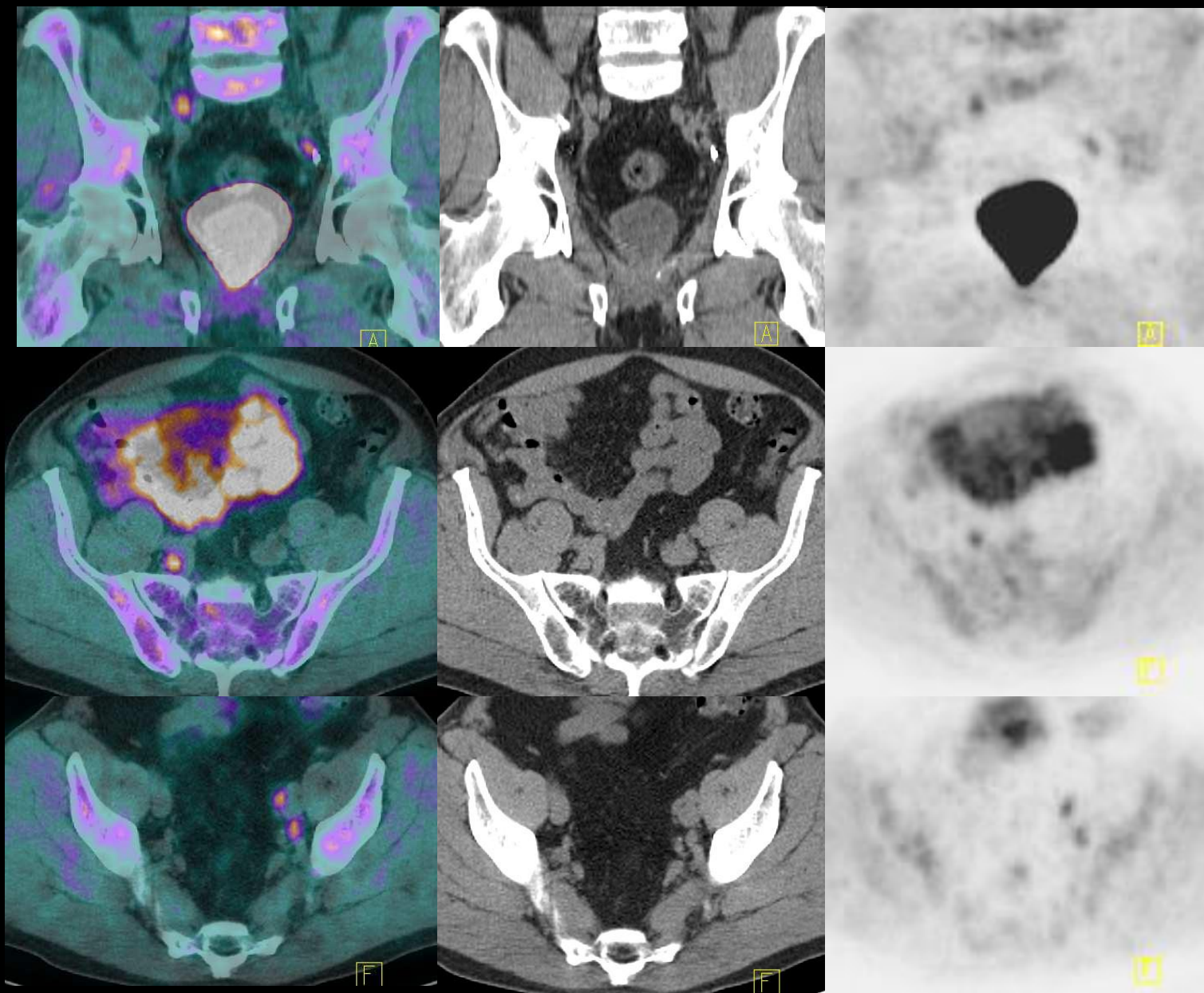
28

2

10



TEP Fluorocholine – M. H - Récidive biologique

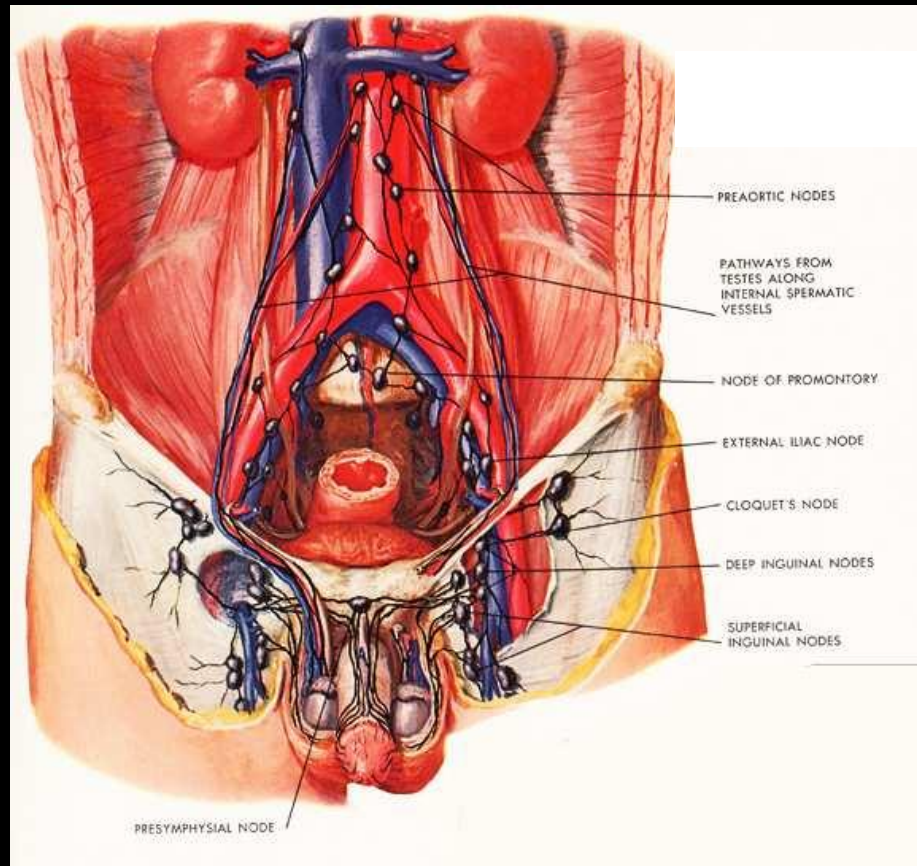


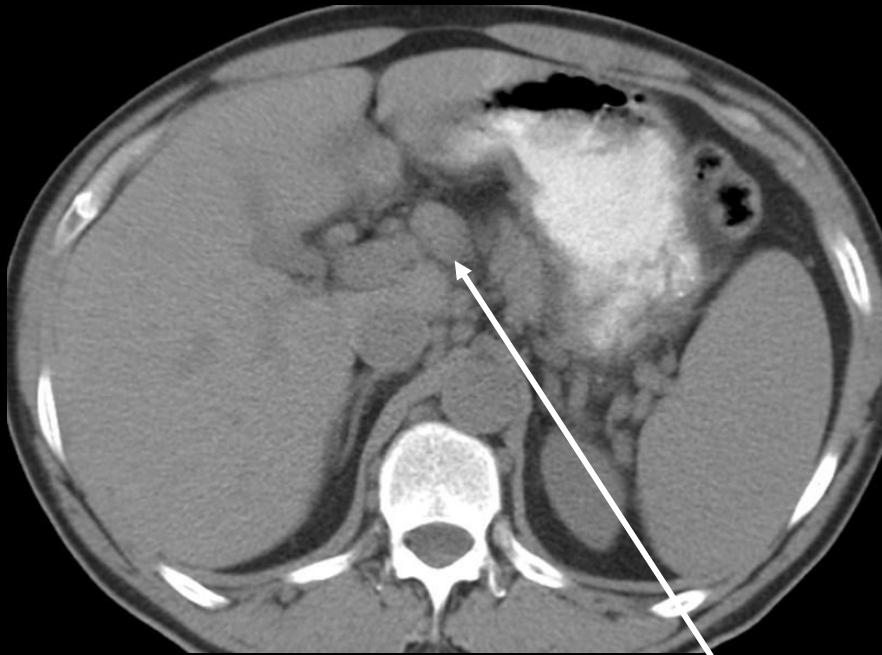
TEP Fluorocholine – M. H - Récidive biologique



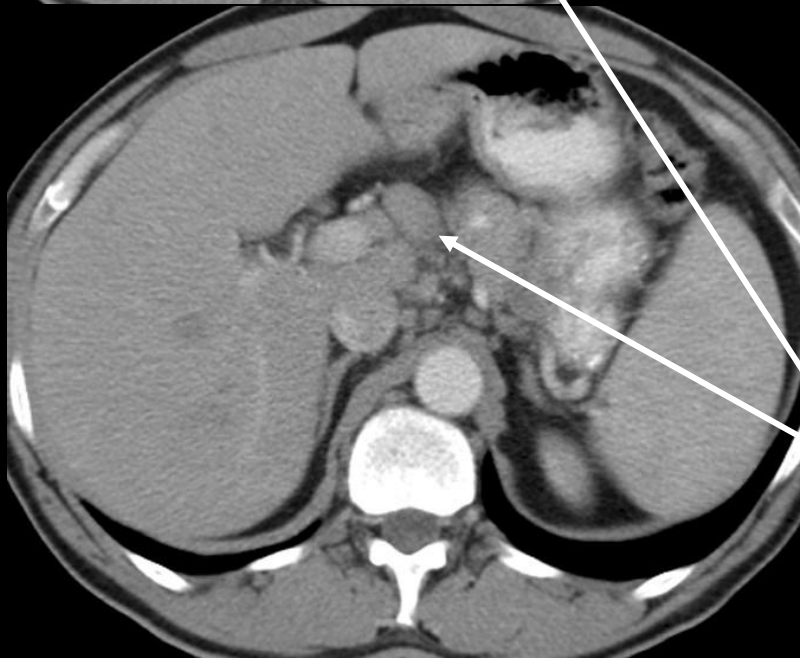
RADIOANATOMIE

Chaînes lymphatiques

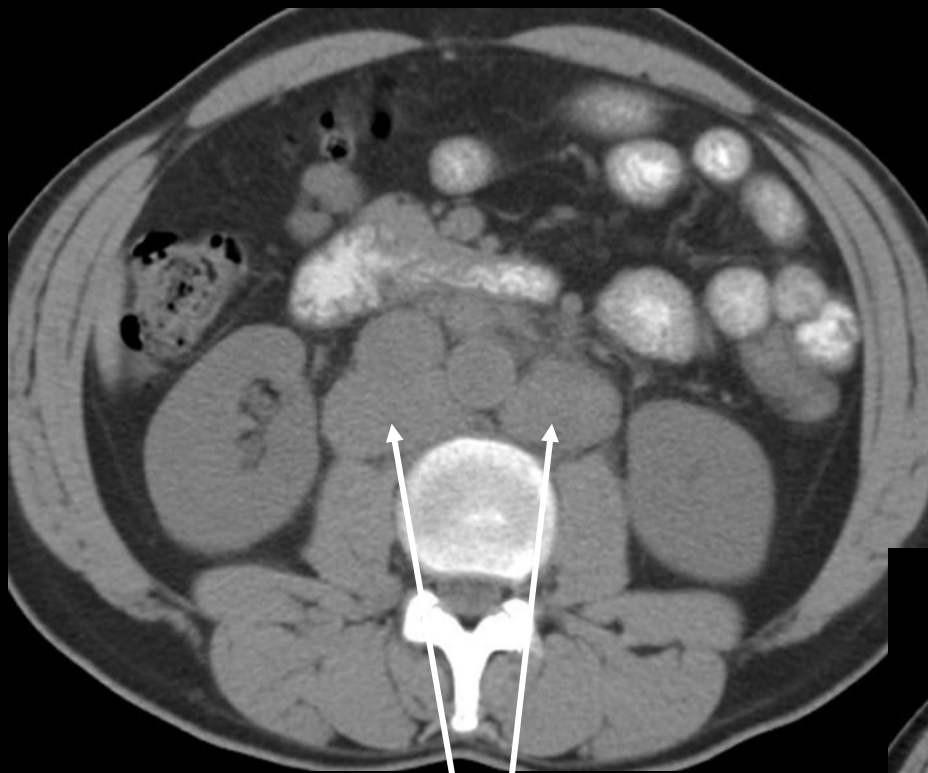




ADP hile rénal



ADP hile hépatique



ADP lombo-aortiques sous-rénales

Latéro-aortique G

Rétro-cave





ADP lombo-aortiques



ADP inter-aorticocave



ADP iliaques primitives





ADP iliaques externes

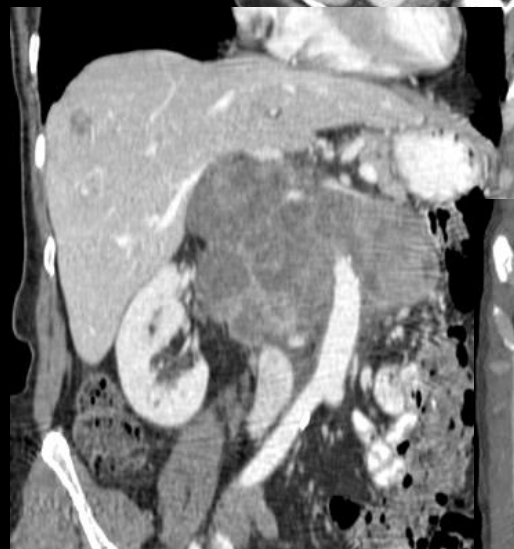




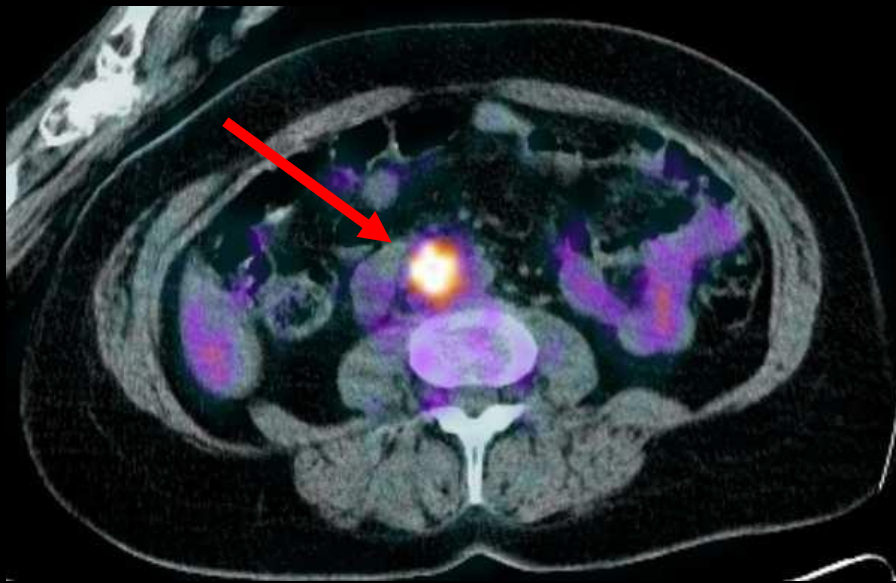
ADP inguinales

ADP inguinales

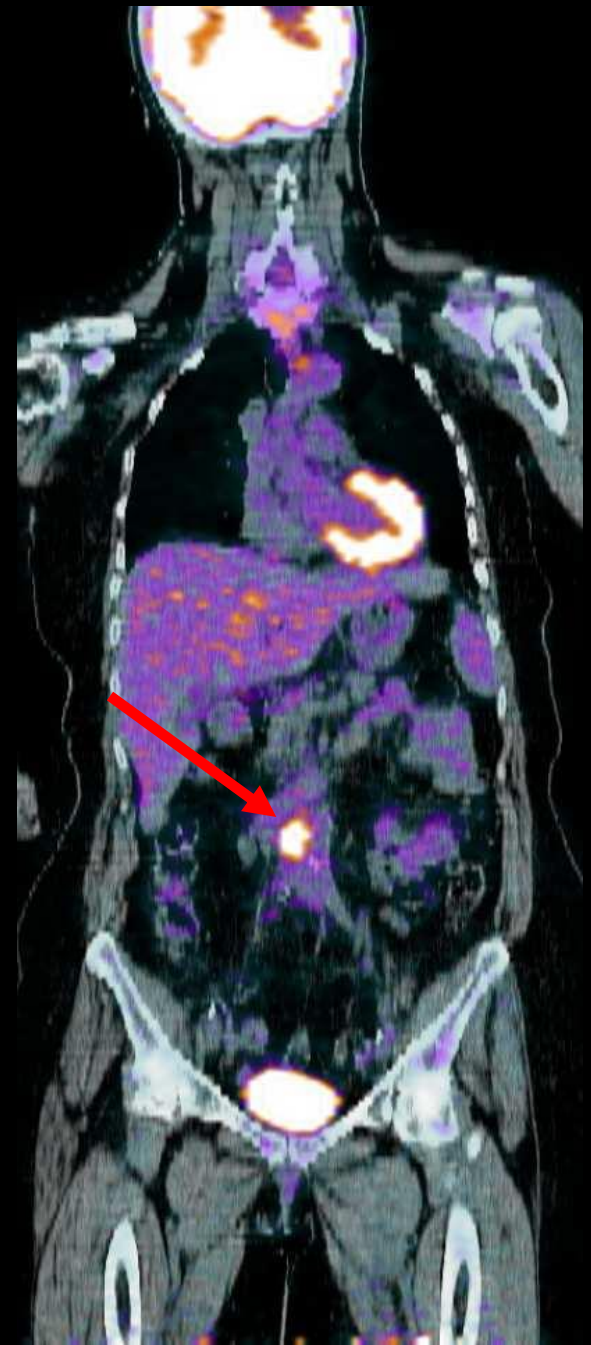
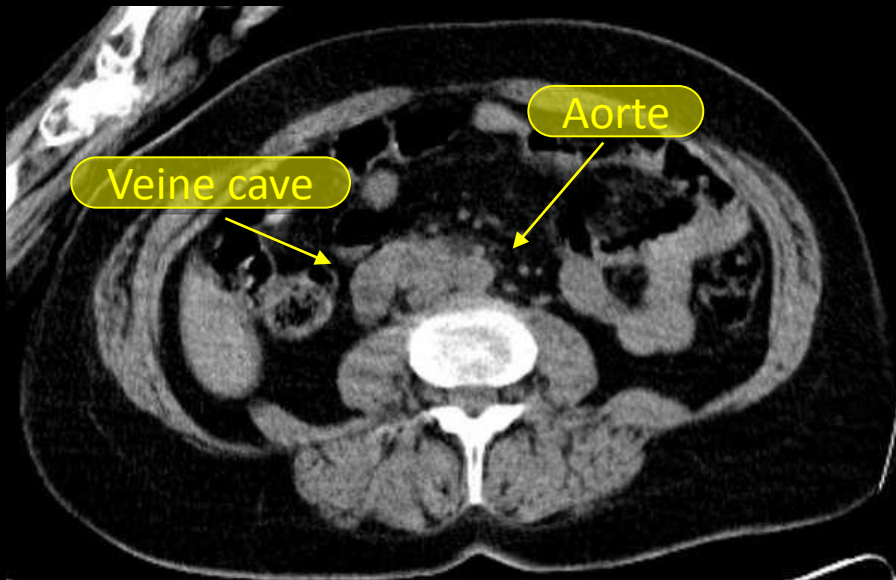




**adénopathies rétro-péritonéales
LMNH de haut grade**



Localisation ? Inter-aortico-cave

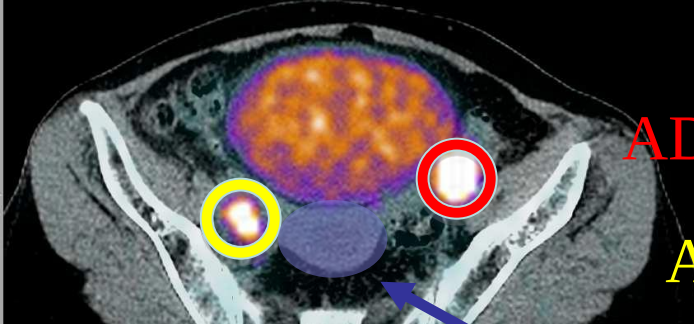
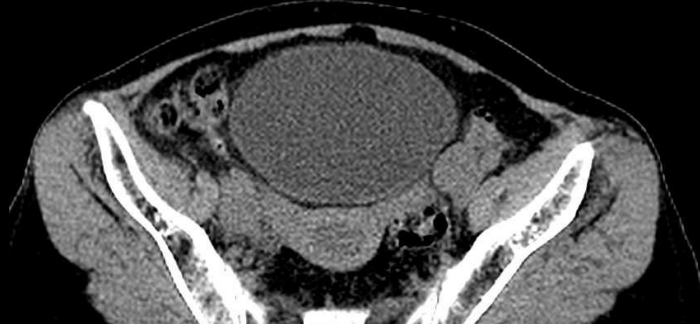




Localisation ?

Iliaque externe D
Iliaque interne D
Obturbateur D

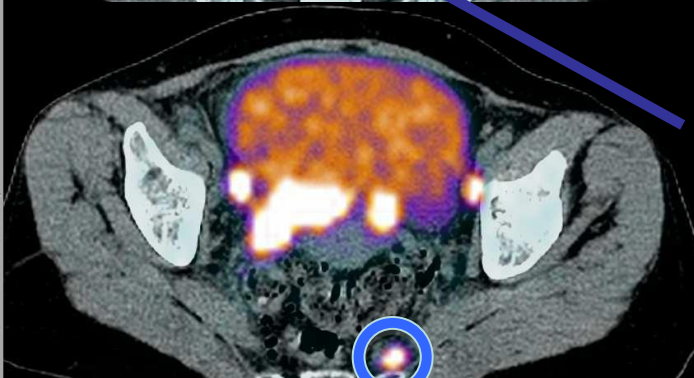




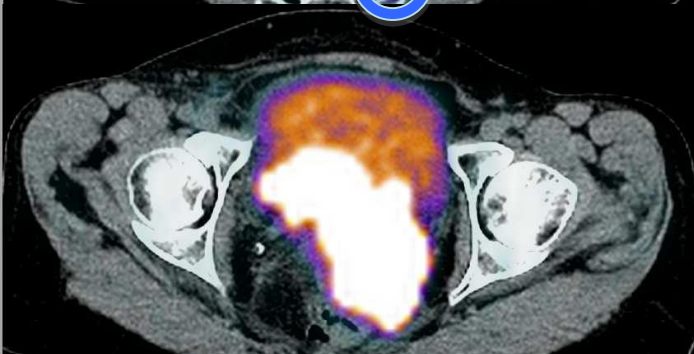
ADP iliaque ext G

ADP iliaque ext D

Corps utérin



ADP présacrée

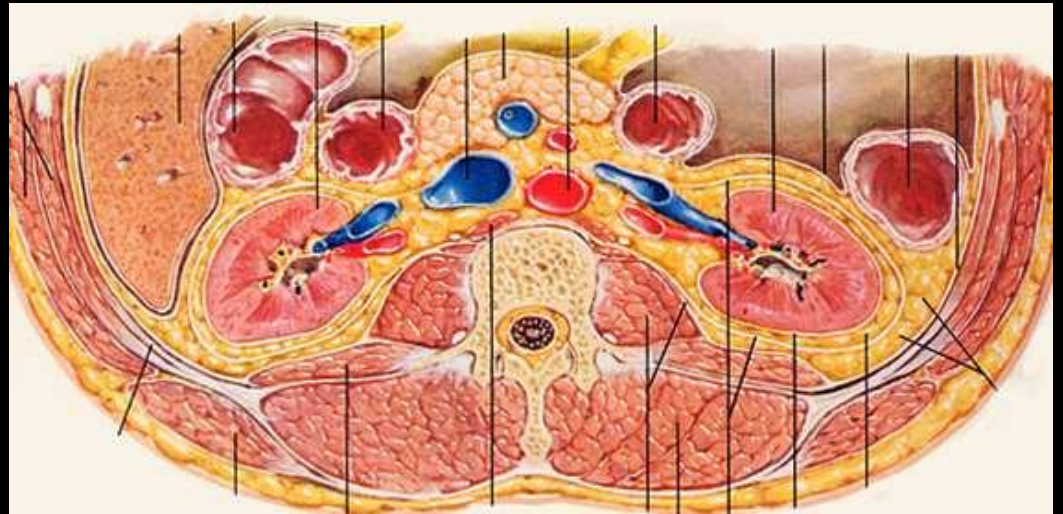
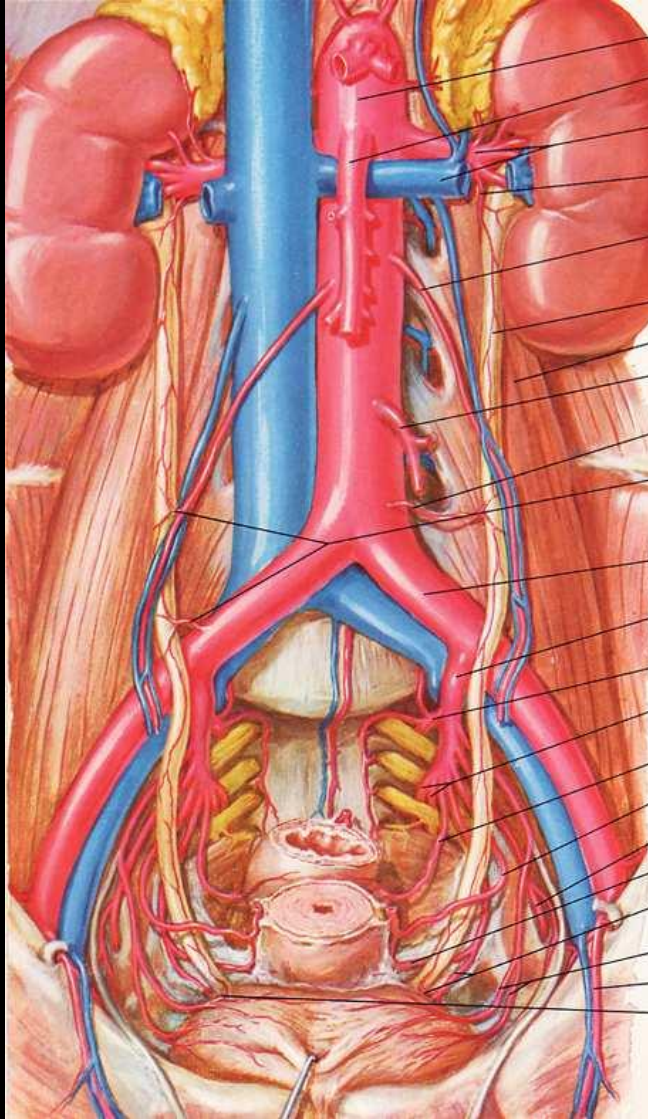


ADP inguinale D



RADIOANATOMIE

Gros vaisseaux



Pathologie des gros vaisseaux rétro péritonéaux

Pathologie de l'aorte

anévrismes

dissections

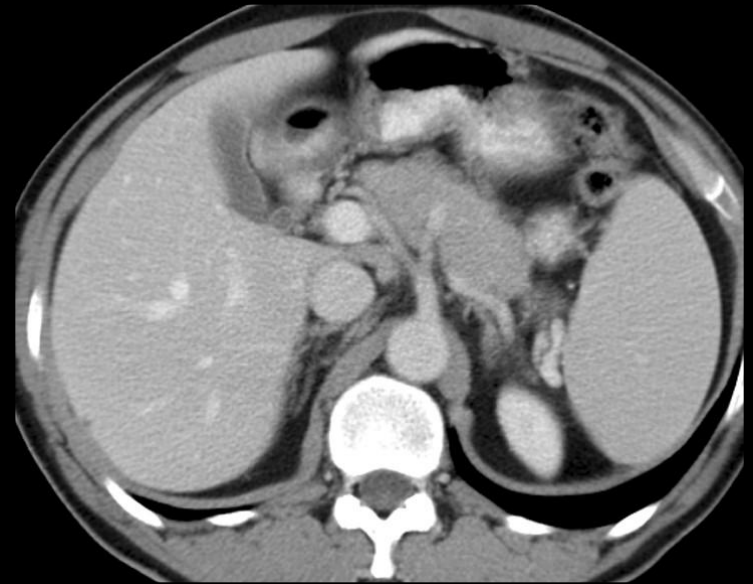
thromboses et thrombus emboligènes

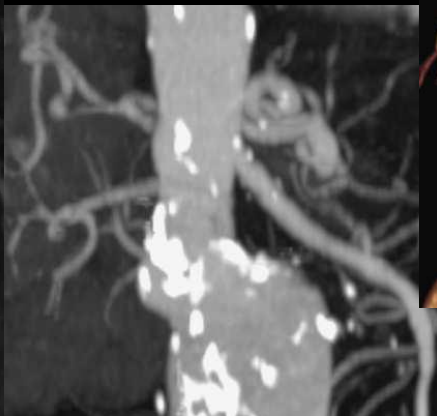
Pathologie de la veine cave inférieure

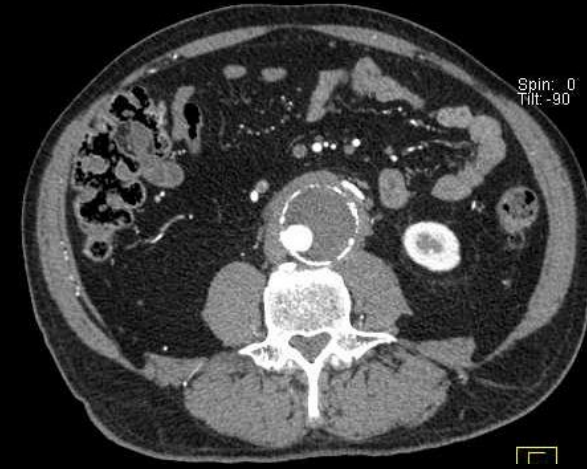
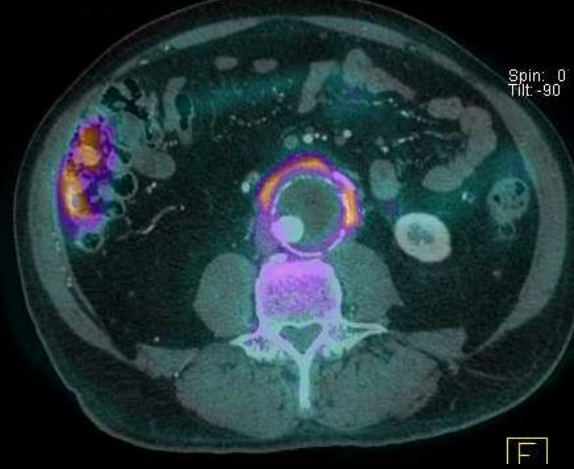
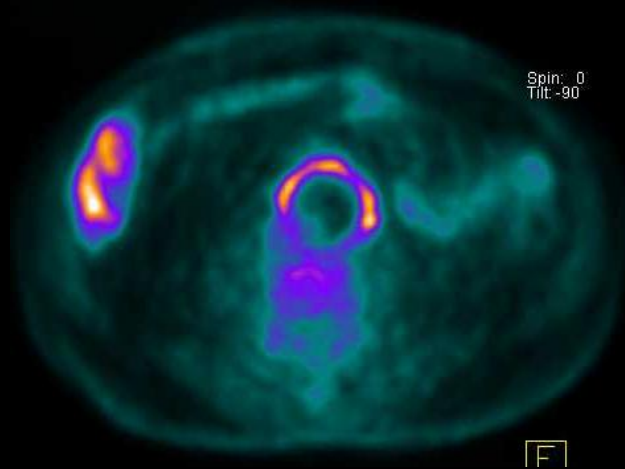
anomalies congénitales

thromboses

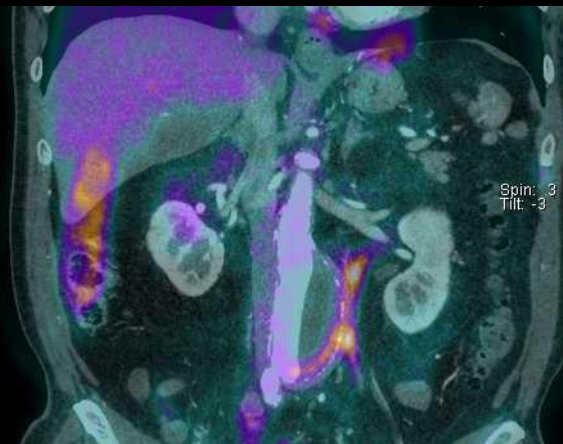
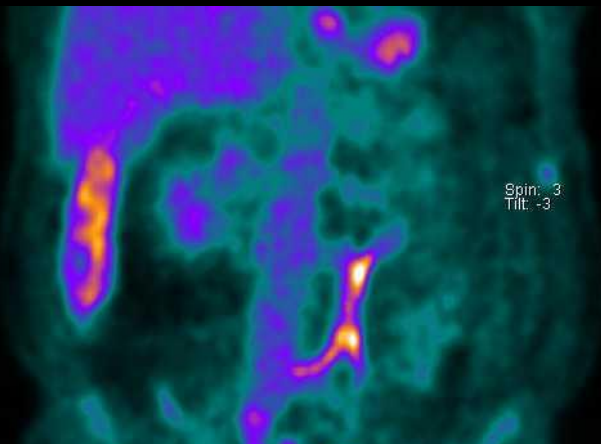
tumeurs







Hypermétabolisme pariétal d'un anévrisme de l'aorte abdominale

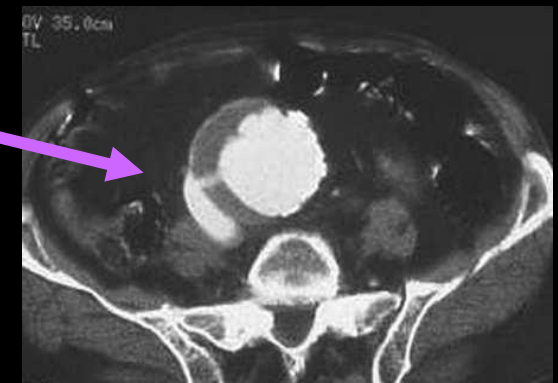


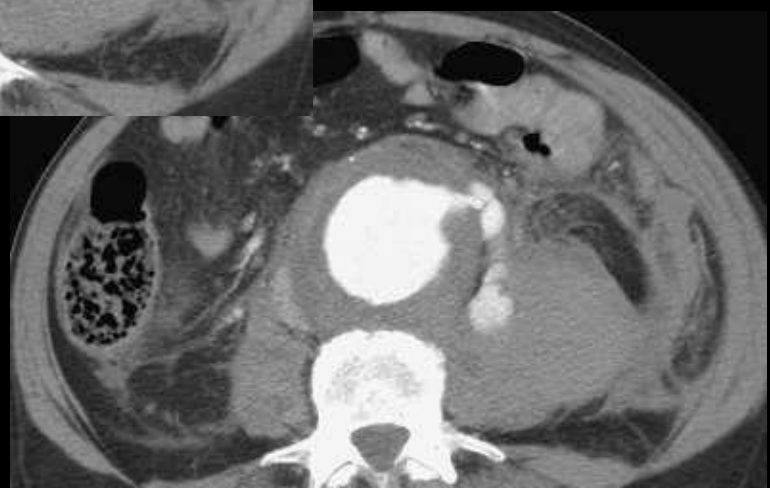
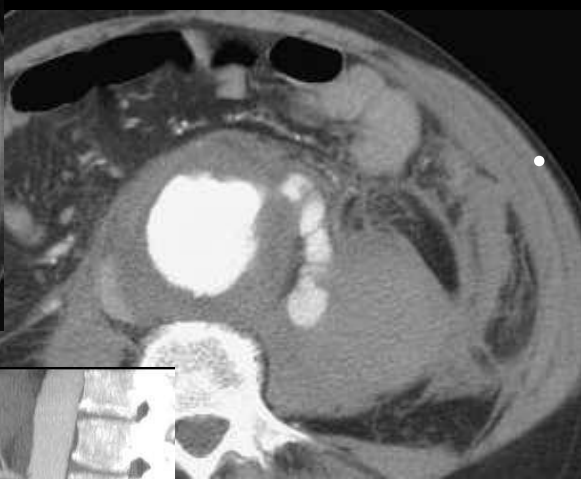
Mise en évidence d'une corrélation entre l'hypermétabolisme pariétal de certains anévrismes et la survenue de complications aiguës nécessitant une chirurgie (douleur, croissance rapide, rupture)

Anévrisme de l'aorte abdominale et inflammation vasculaire : place de la tomographie par émission de positons MEDECINE NUCLEAIRE, vol 33. Pages 279-284 N. Sakalihan, R. Hustinx, P. Gomez, J.-O.

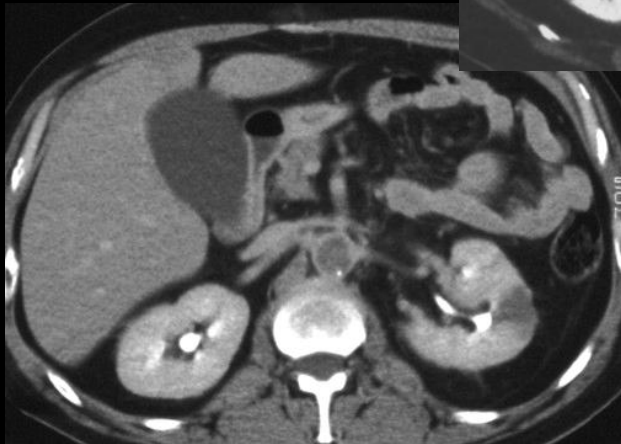
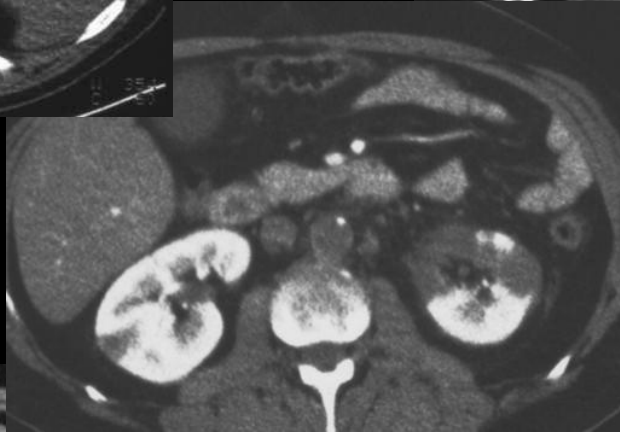
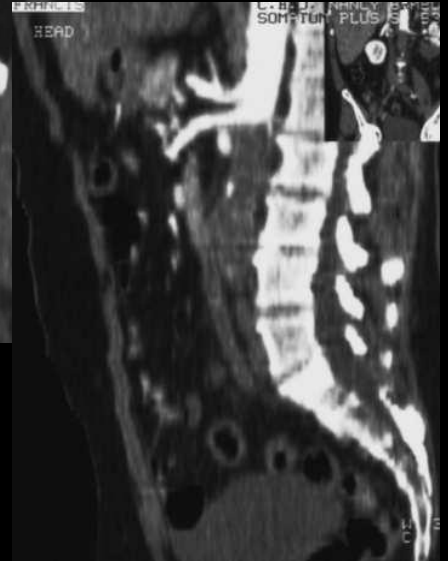
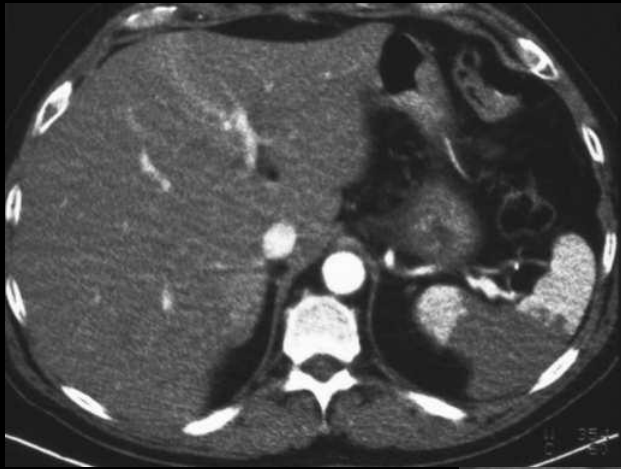
l'AAA. rompu :

- pré rupture ou fissuration
- rupture en péritoine libre (ouverte)
- rupture dans le rétro péritoine
- rupture contenue
- rupture dans un organe de voisinage (VCI, duodénum)

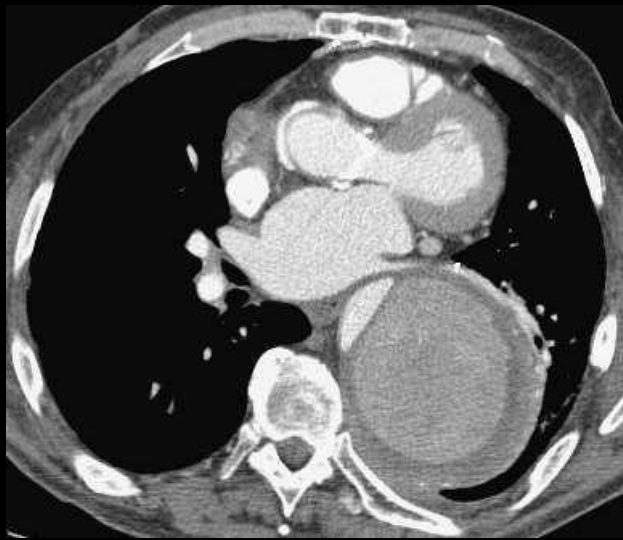




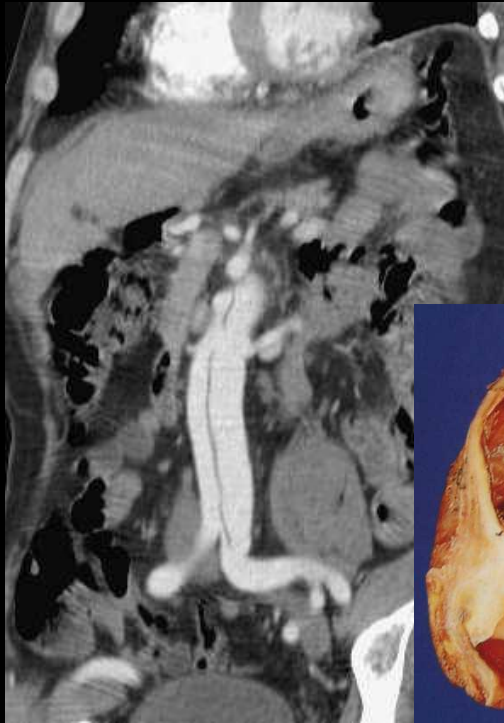
- anévrisme fusiforme de l'aorte abdominale
- rupture dans l'espace rétro-péritonéal (loge rénale gauche),
hémorragie contenue...
- thrombus mural circonférentiel

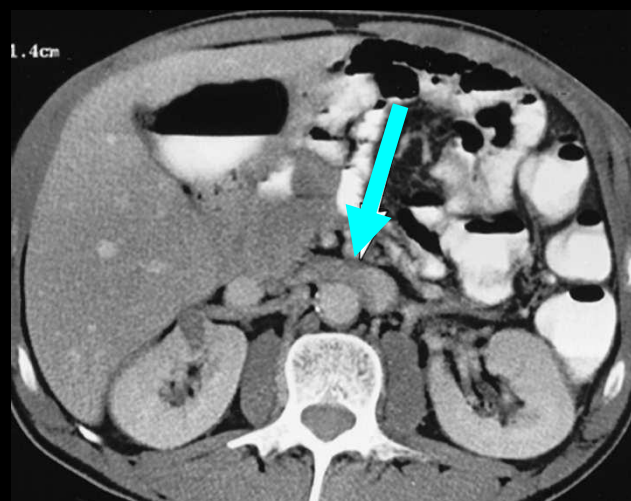
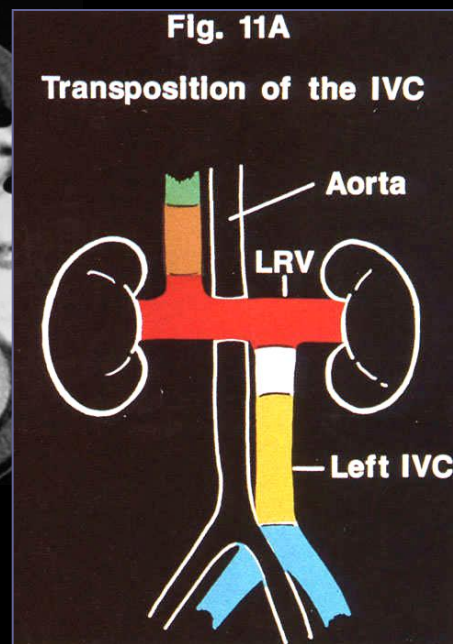
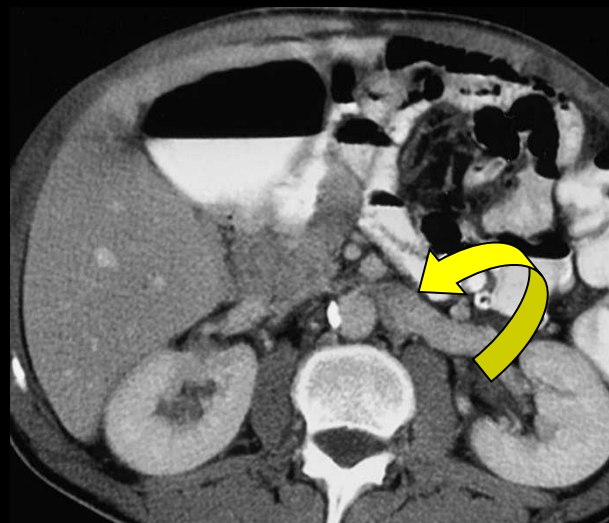


Thrombose
aiguë aortique et embolies viscérales

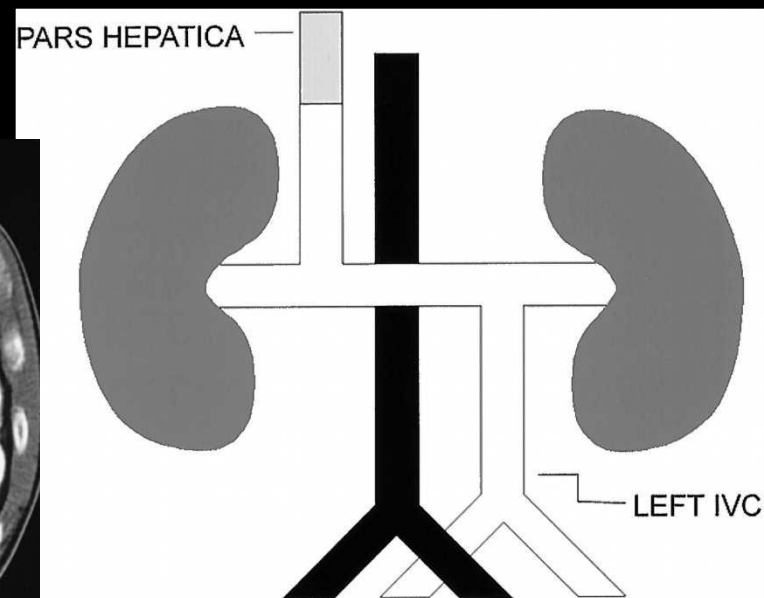


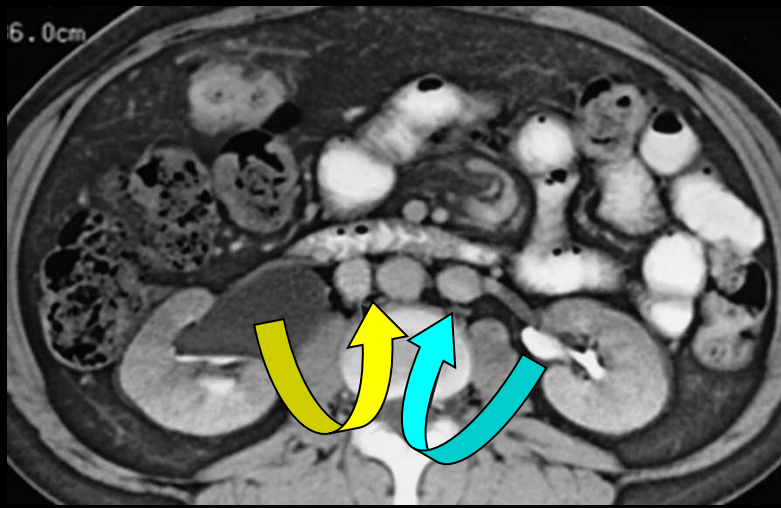
2003



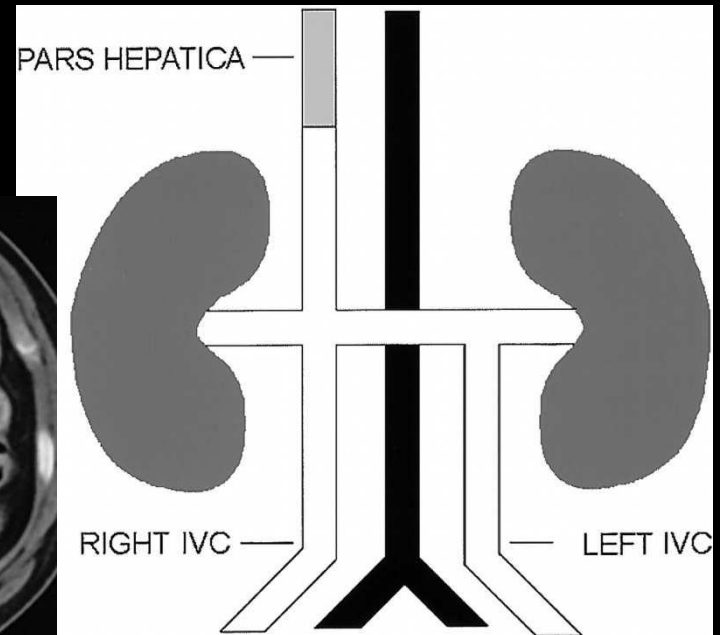
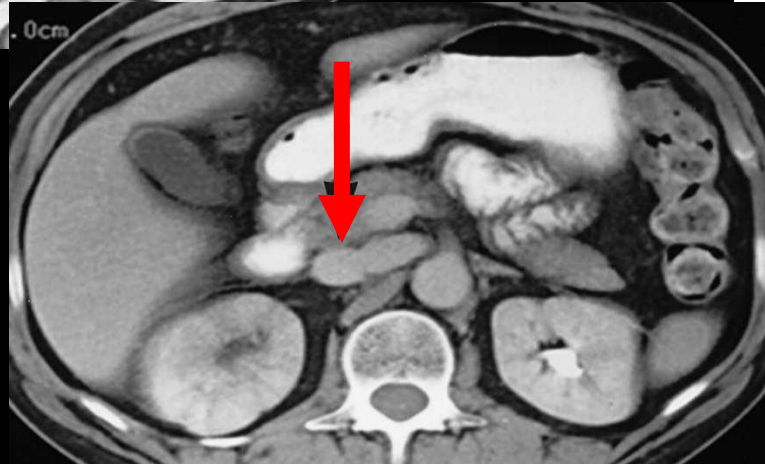
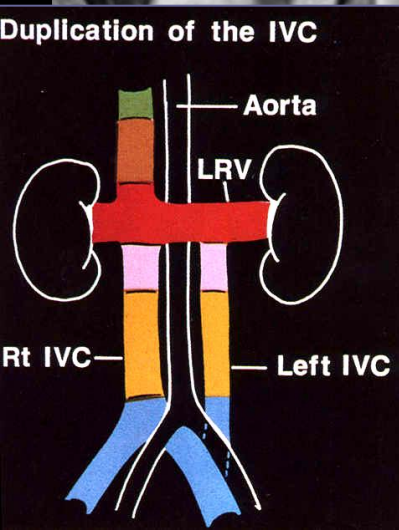


VCI 6

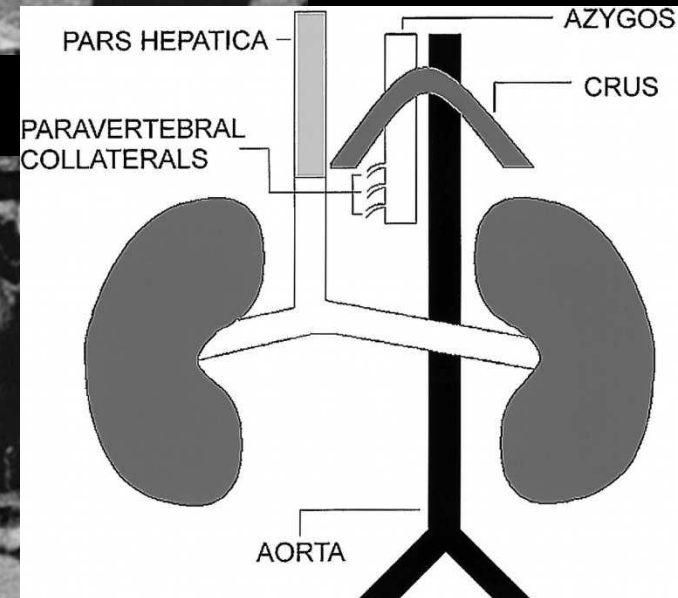
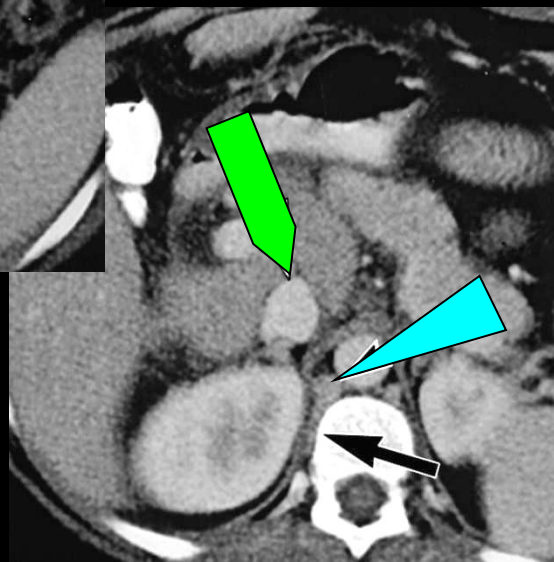
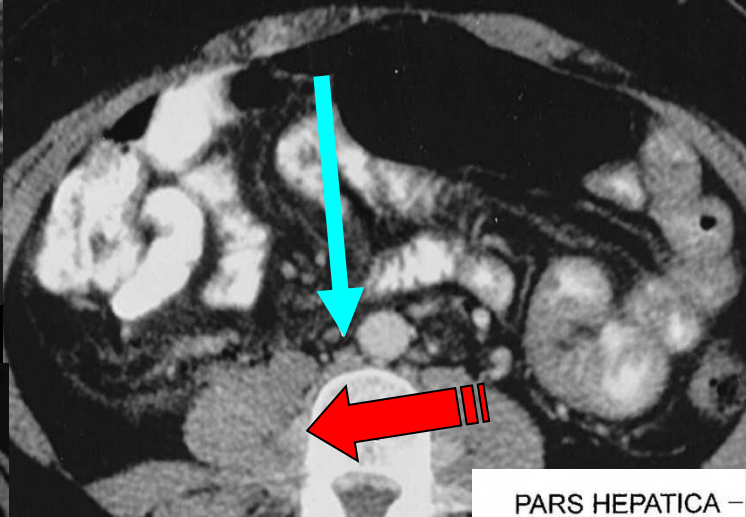
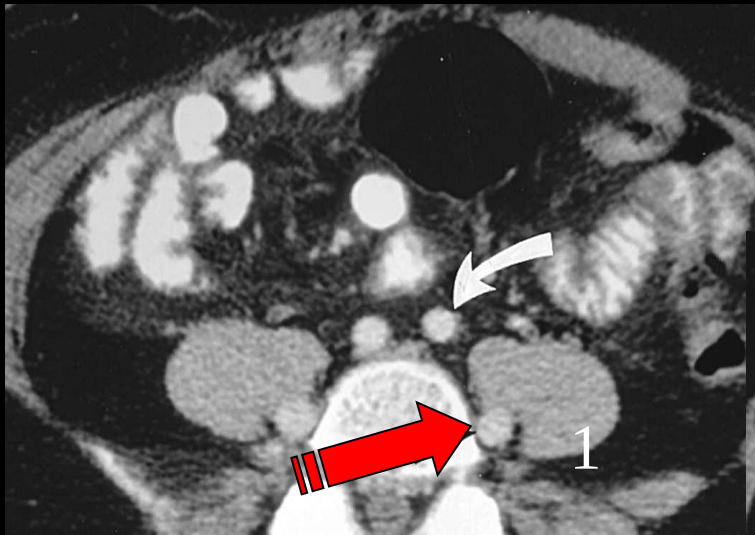


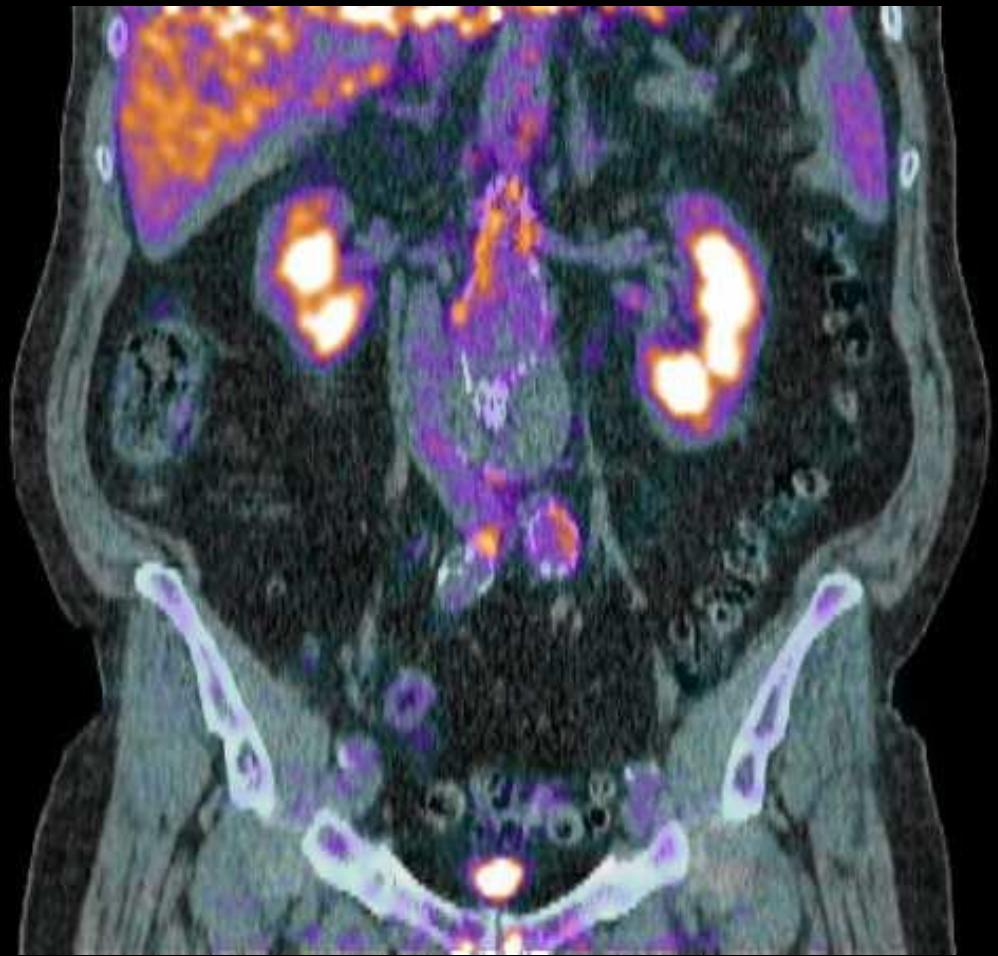


double
VCI

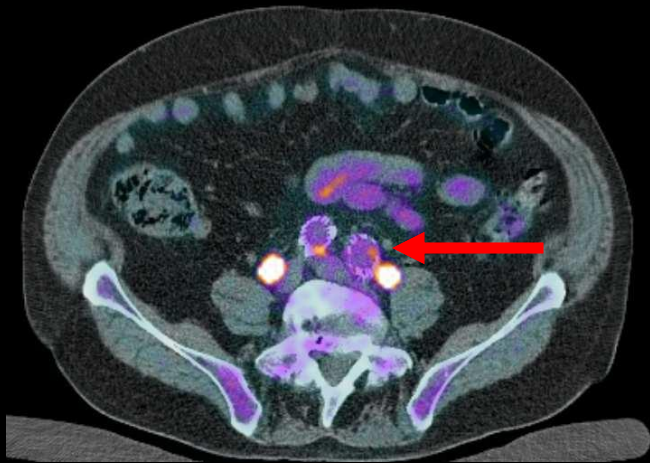
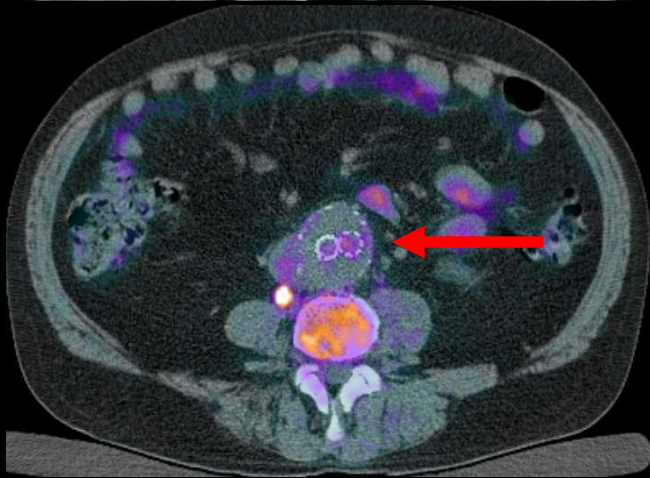
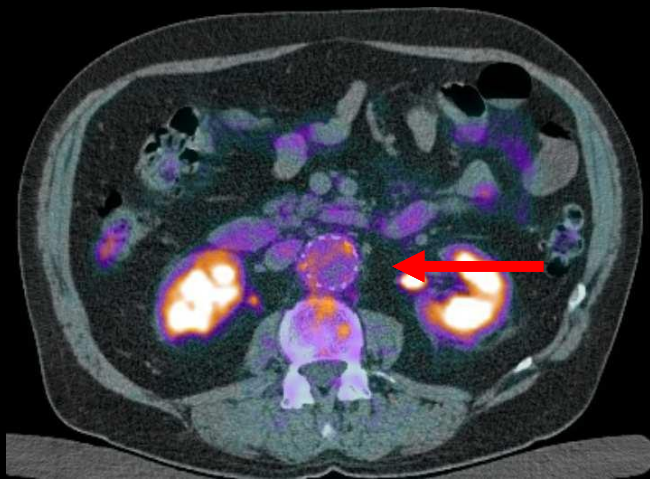


**absence VCI
infra-rénale**





Endoprothèse aortique



Abcès inguinal sur pontage fémoro-fémoral thrombosé

