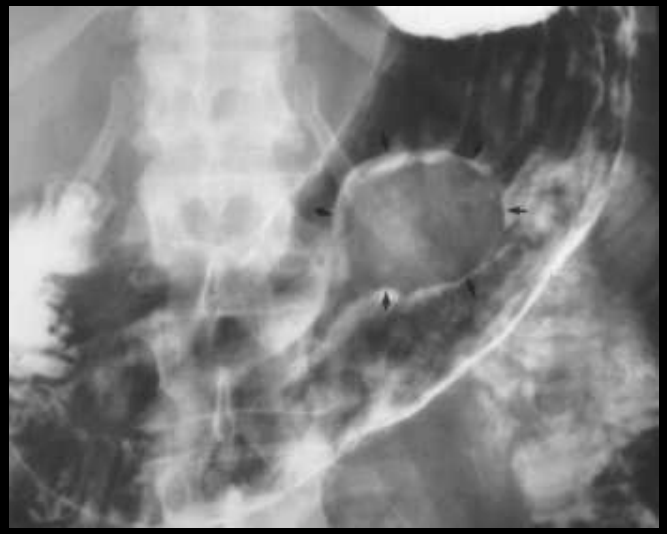
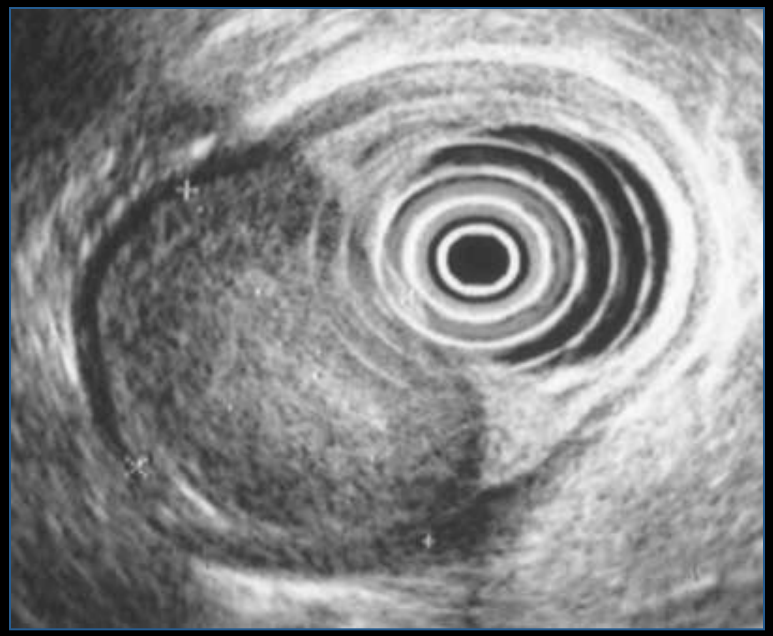
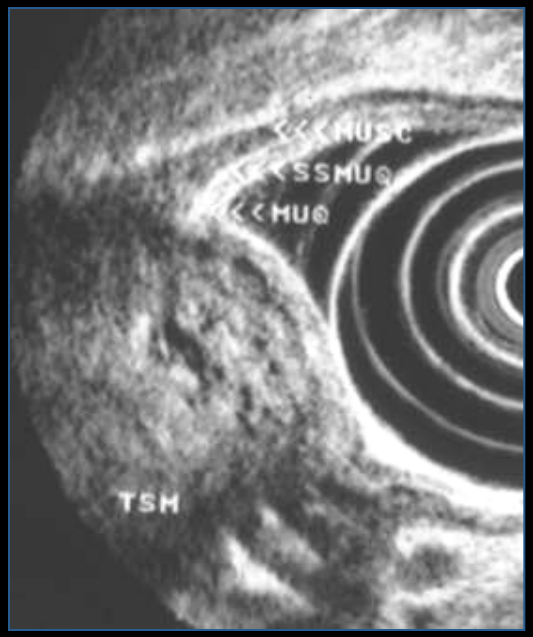
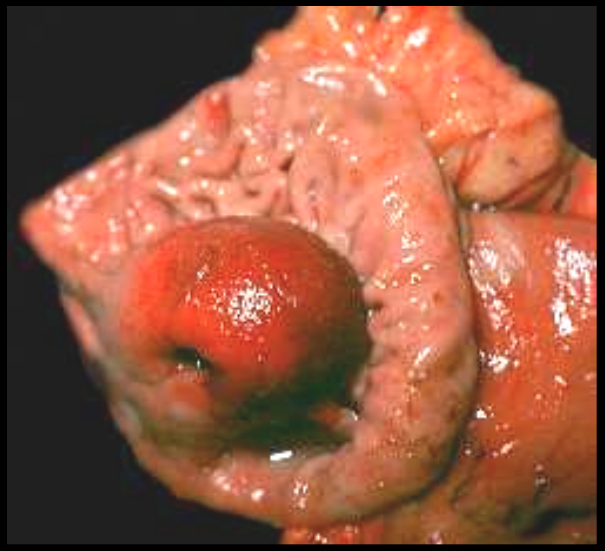
Quelles sont les principales formes de lésions tumorales sous muqueuses de l'estomac

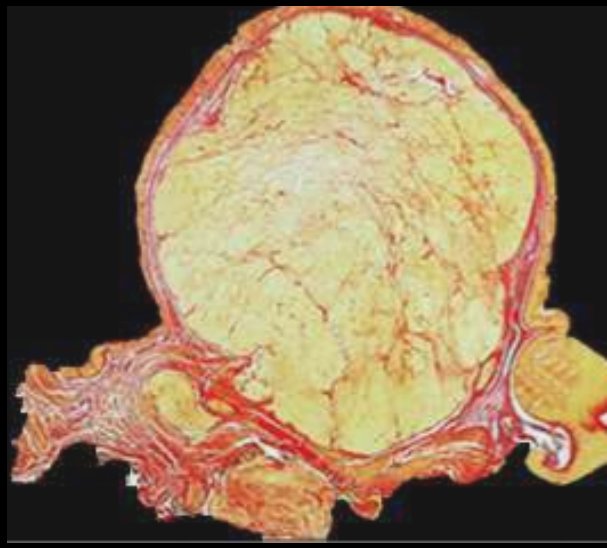


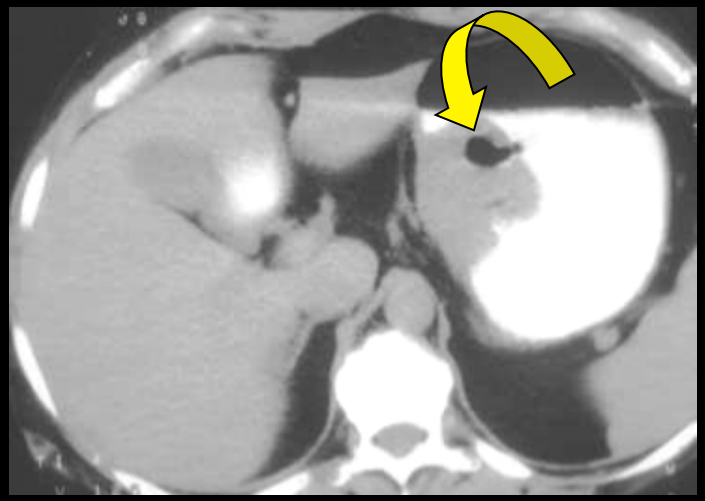


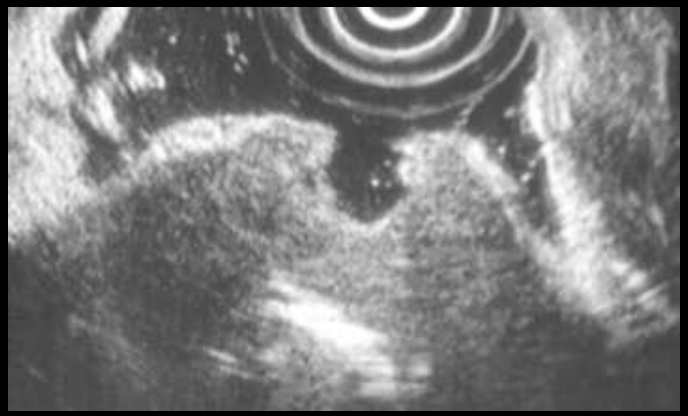


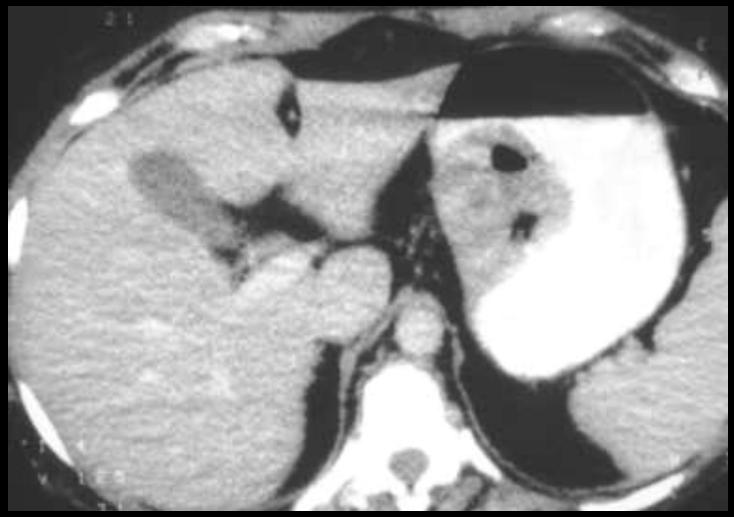


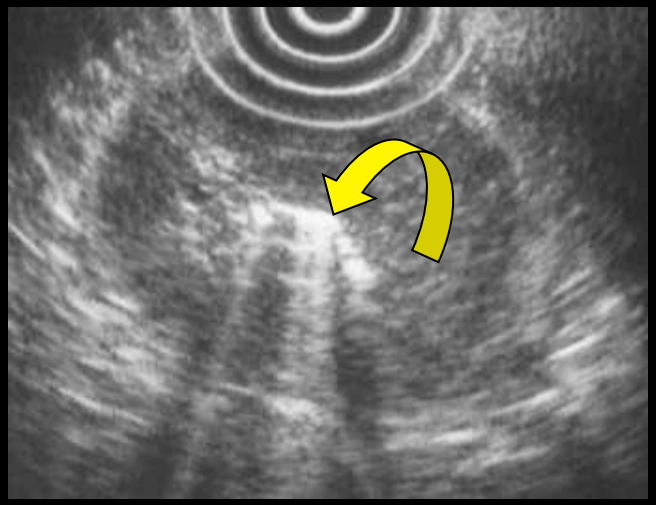
GIST ou léiomyome ou schwannome gastrique

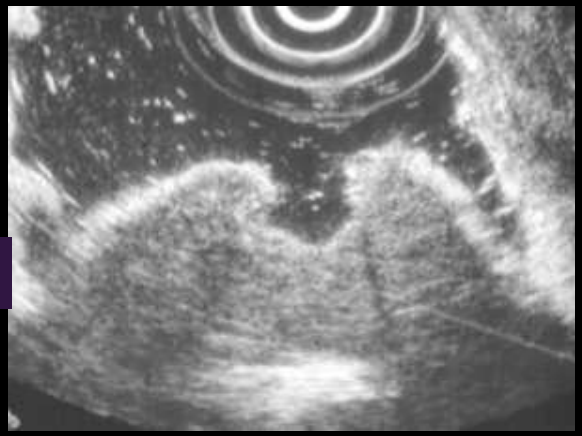




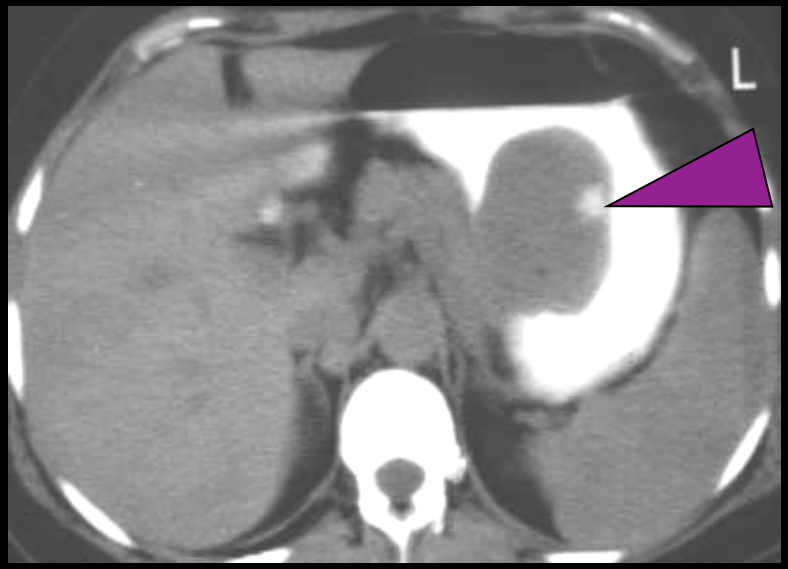


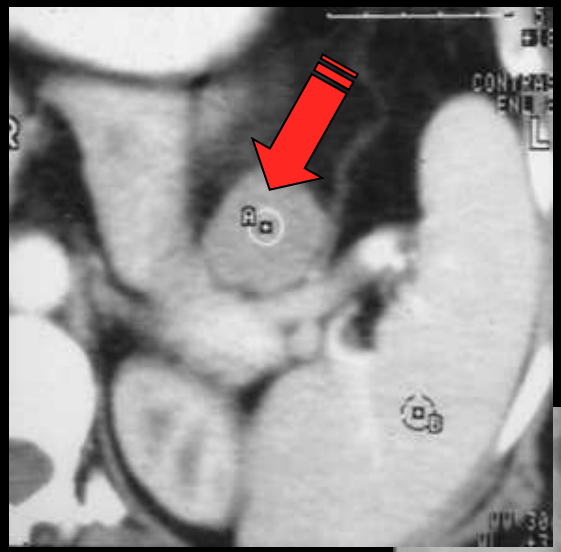


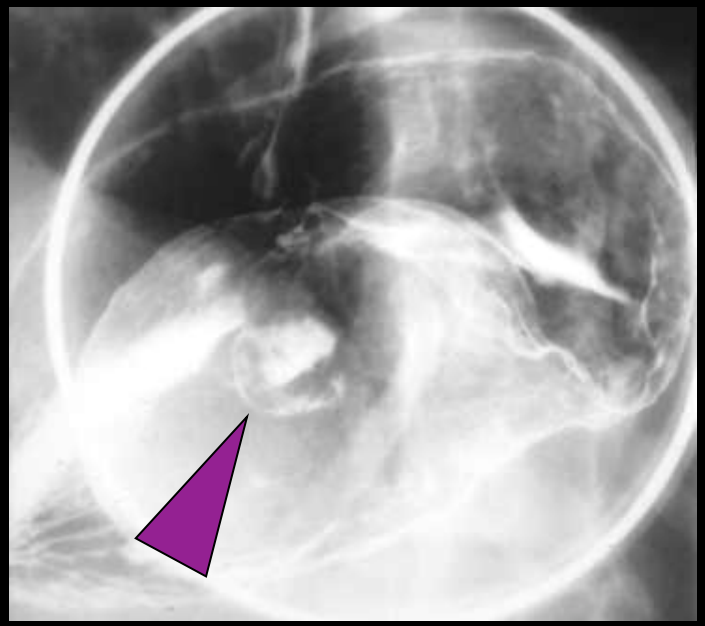


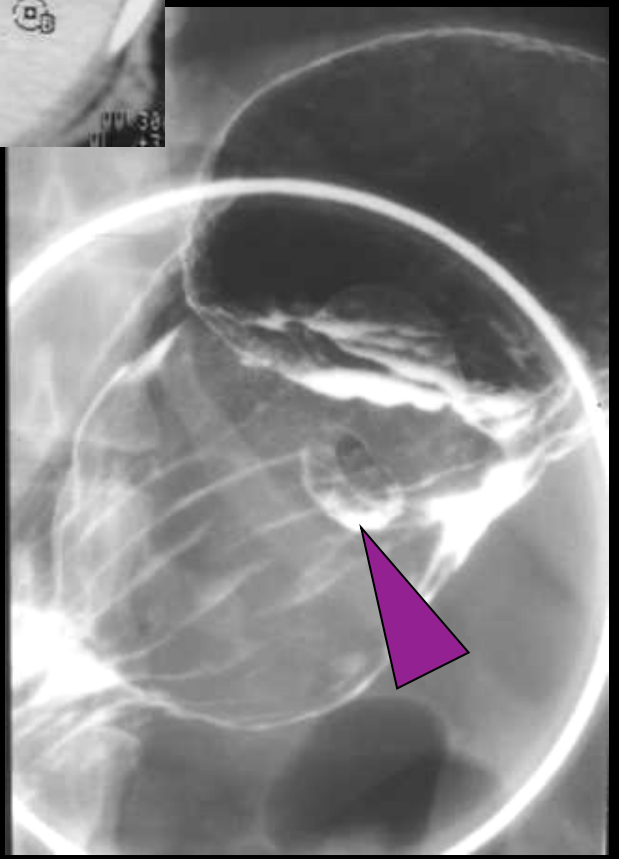


GIST ou léiomyome ouo schwannome gastrique ulcéré

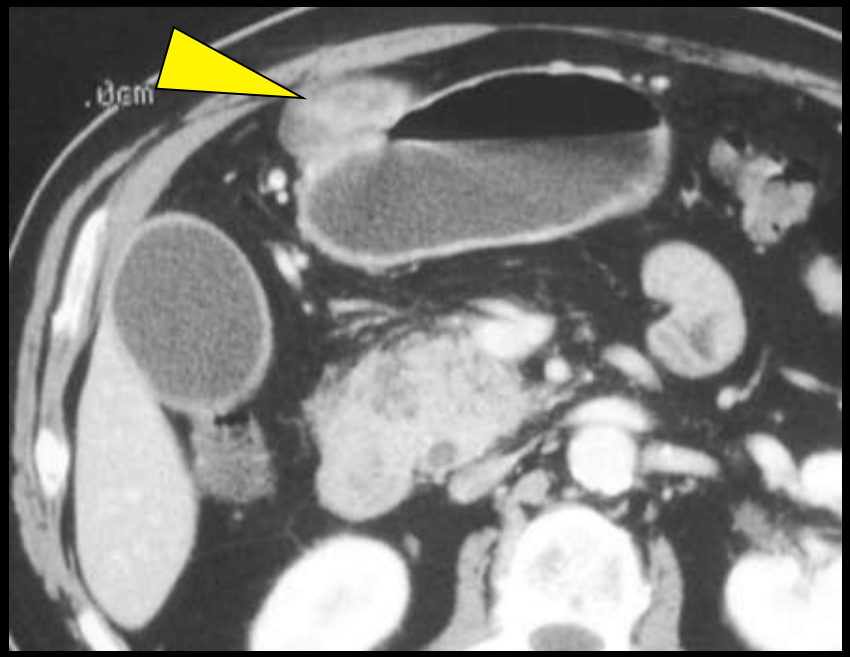


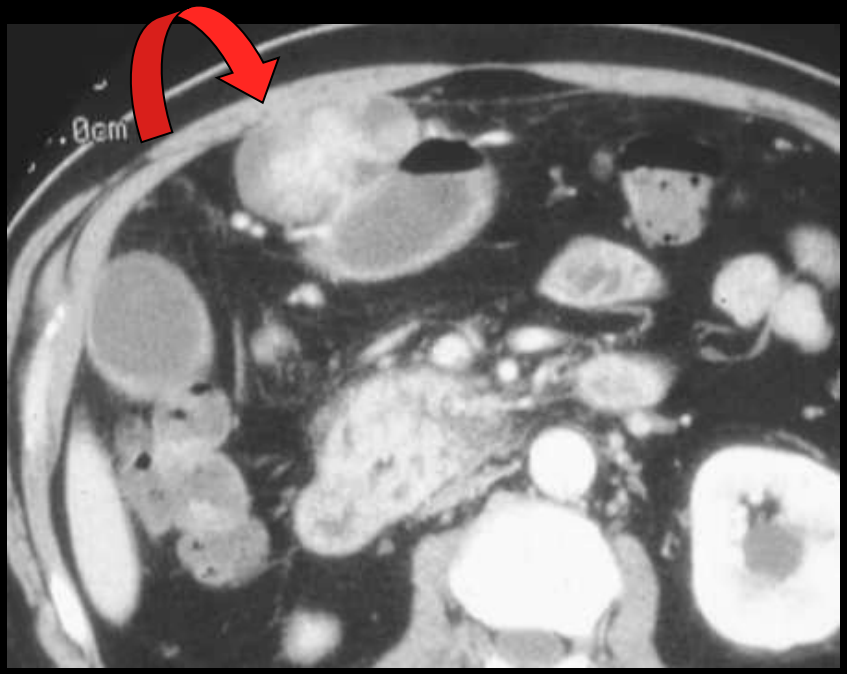


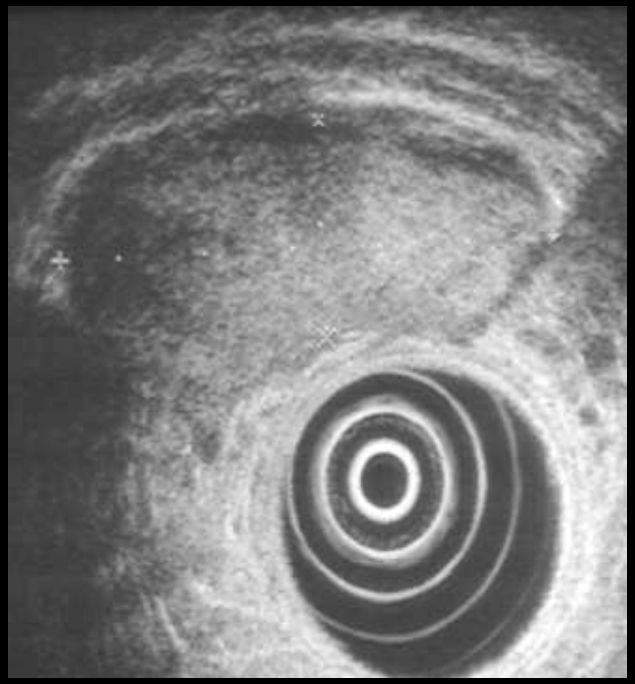




GIST ou léiomyome ou schwannome gastrique ''en sablier''

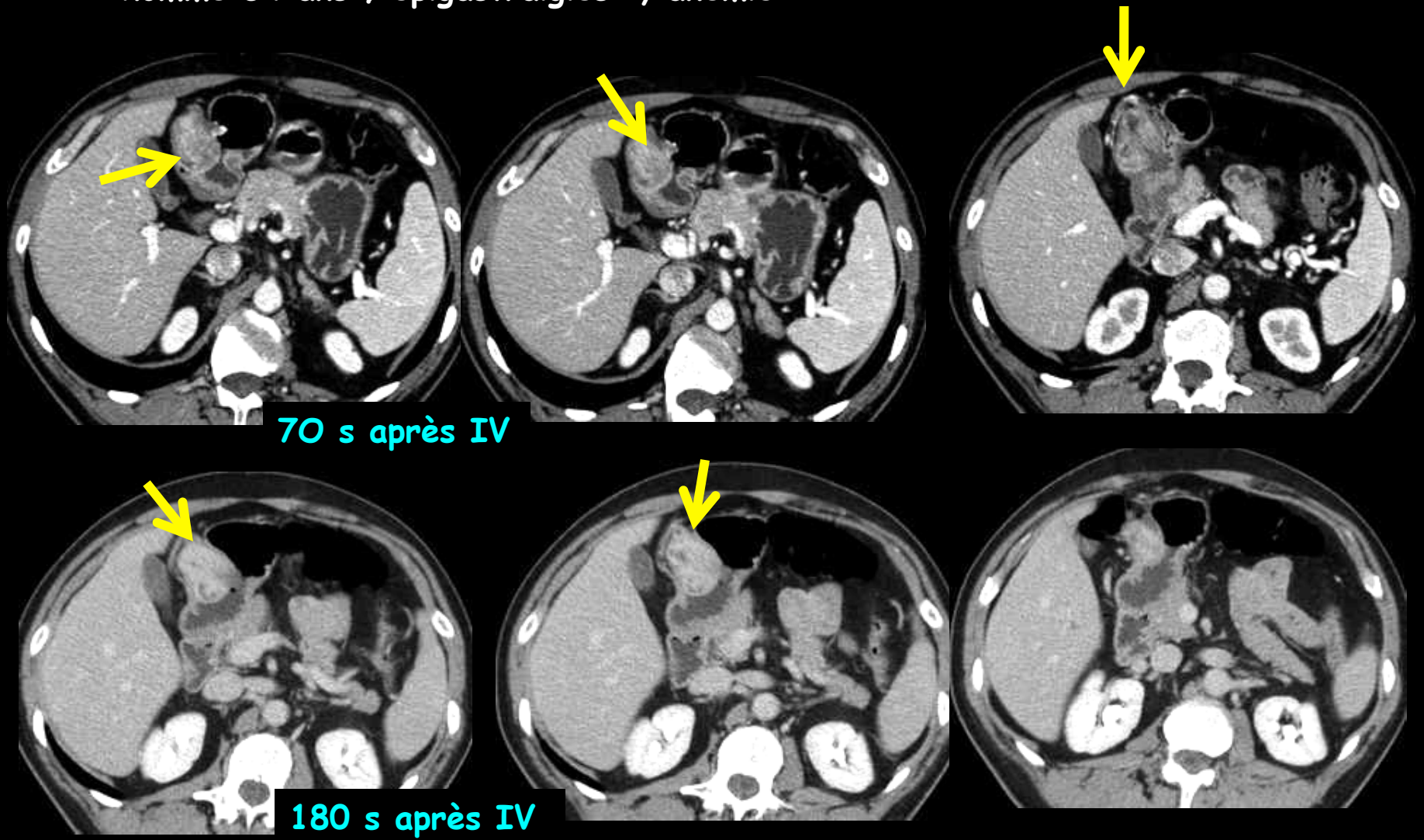






GIST ou léiomyome gastrique antral à développement exoluminal

homme 54 ans ; épigastralgies , anémie

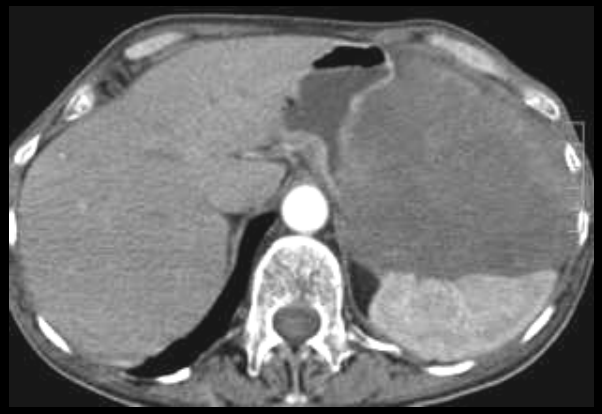


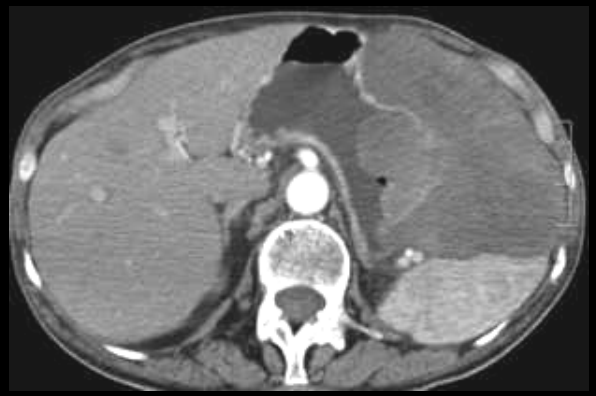
70 s après IV

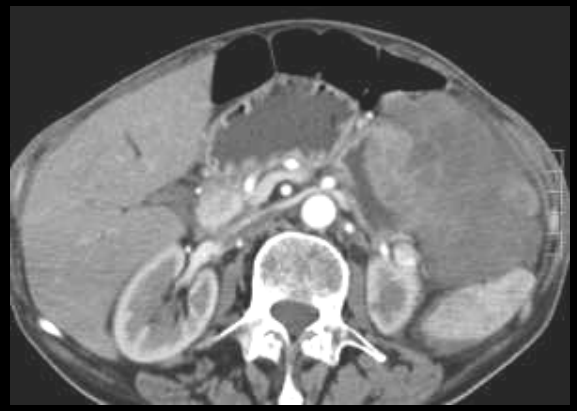
180 s après IV

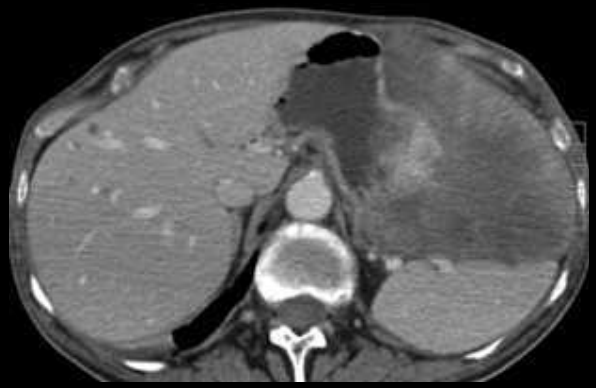
GIST antrale ;hypervascularisation ‘’en volutes’’ (storiforme)

femme 64 ans ,inappétence, asthénie (03 10 2008) ! ! !

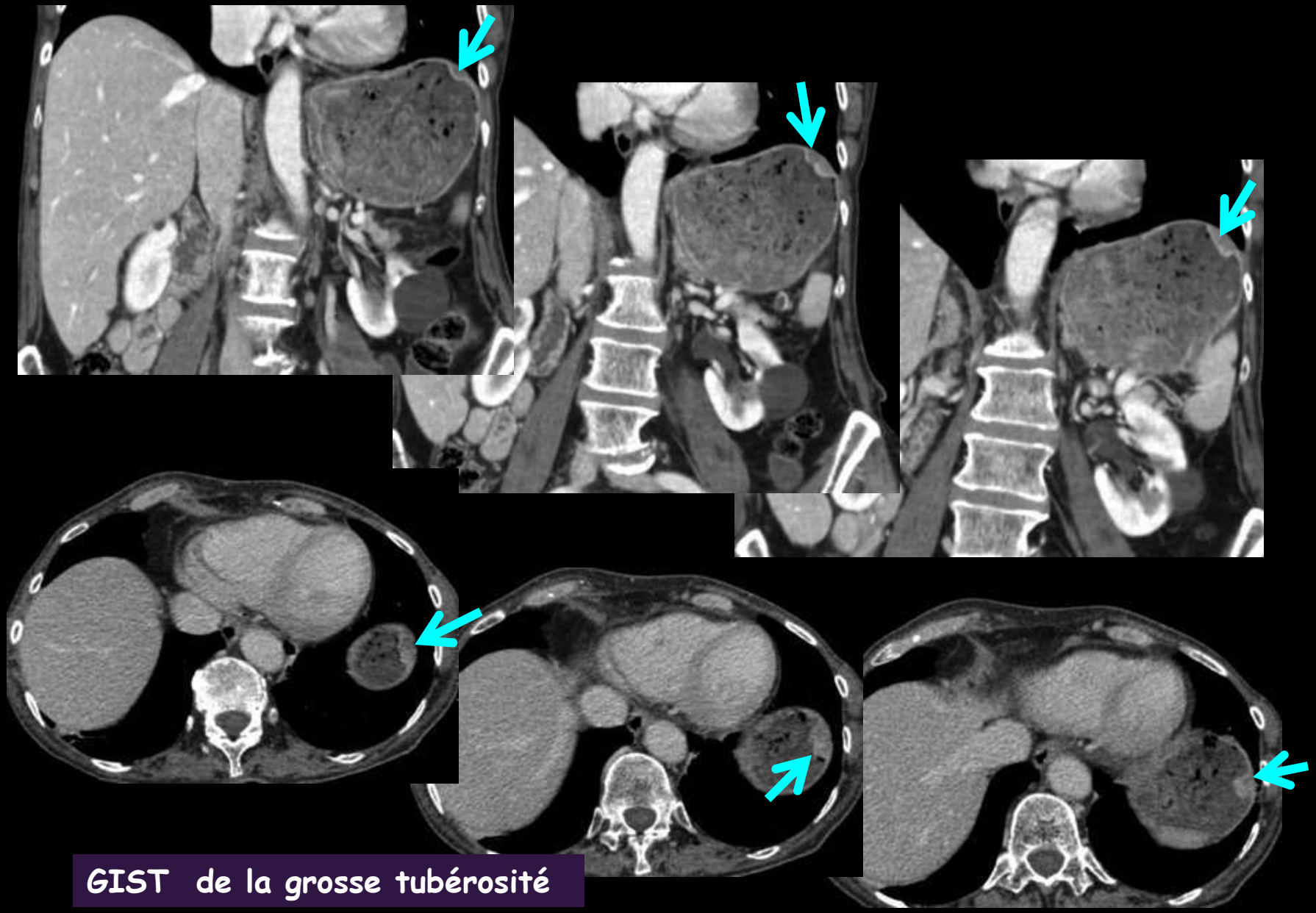






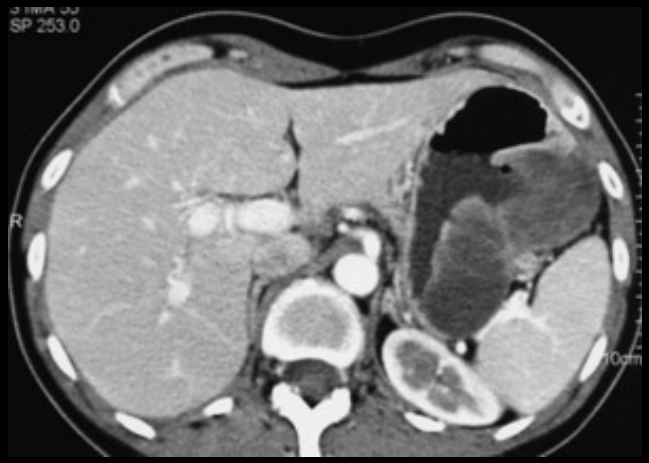


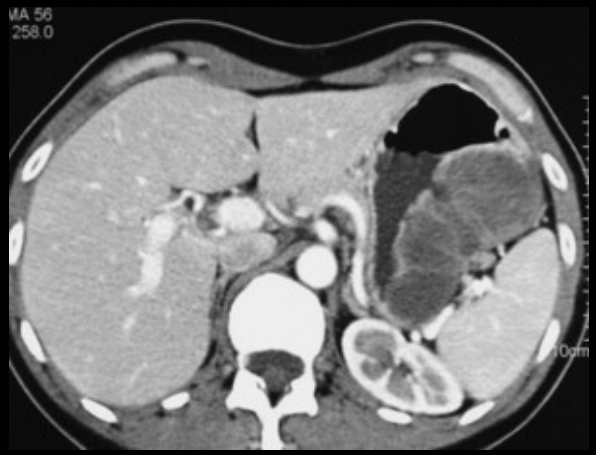
même patiente , 18 mois auparavant (16 08 2007) ! ! !

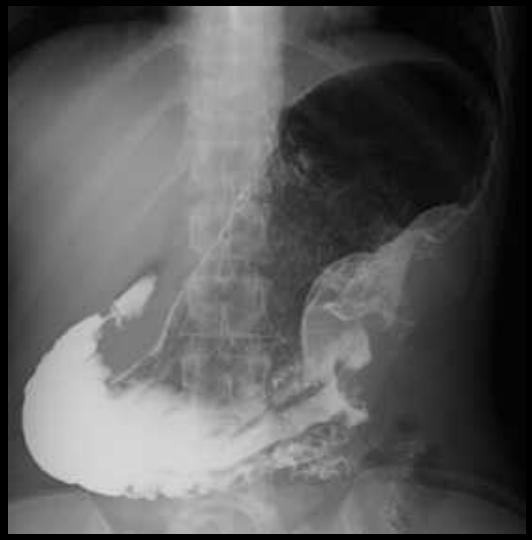


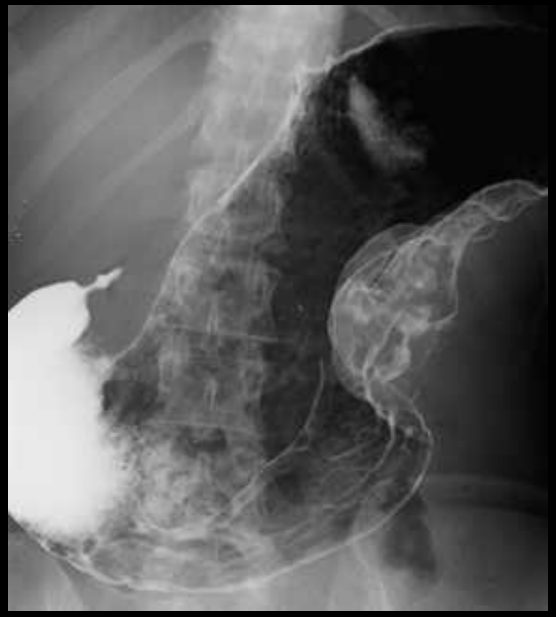
GIST de la grosse tubérosité

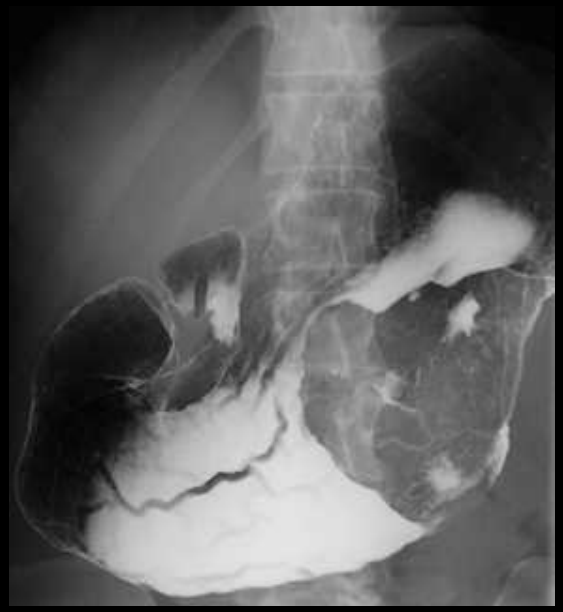
femme 54 ans ; baisse de l'état général ,anémie , VS élevée…

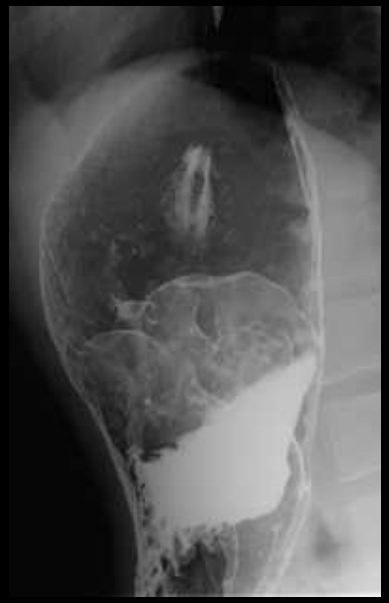


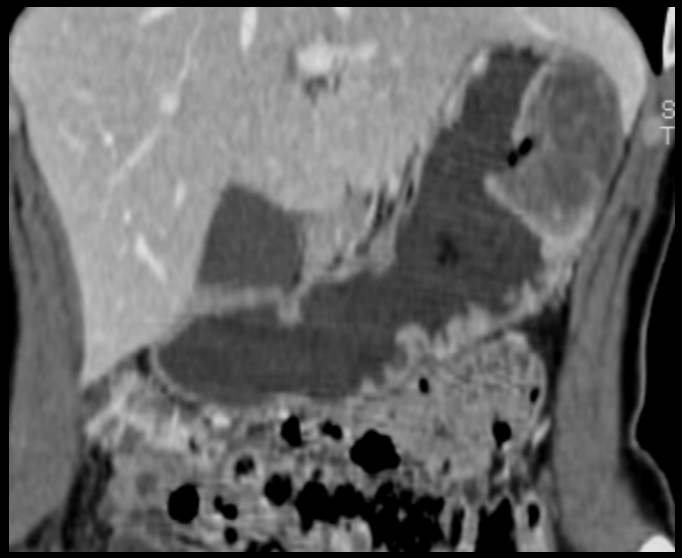


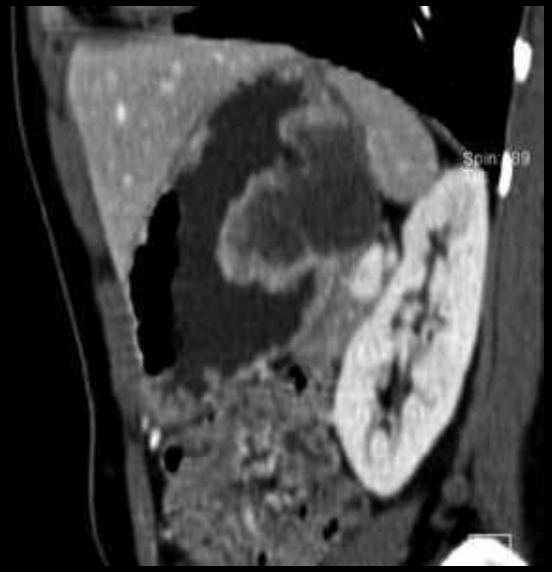


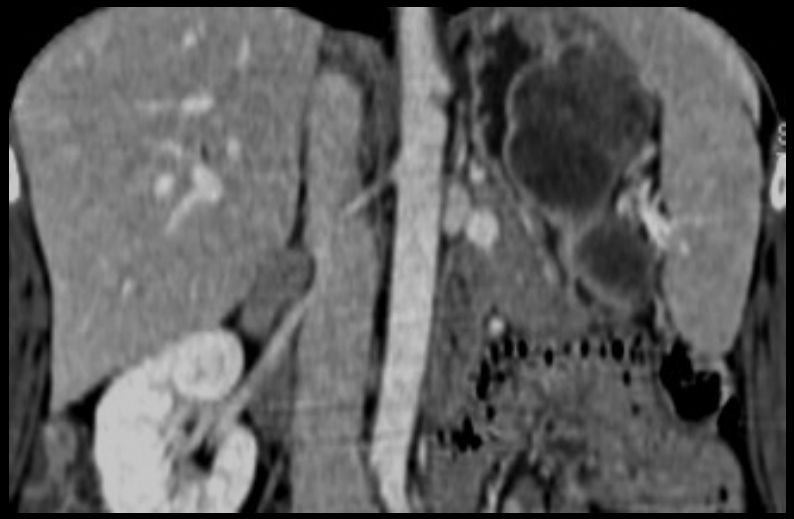


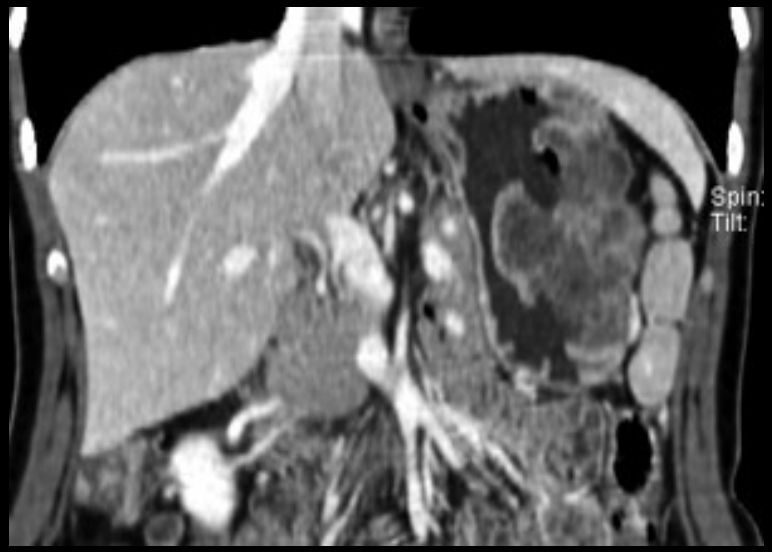






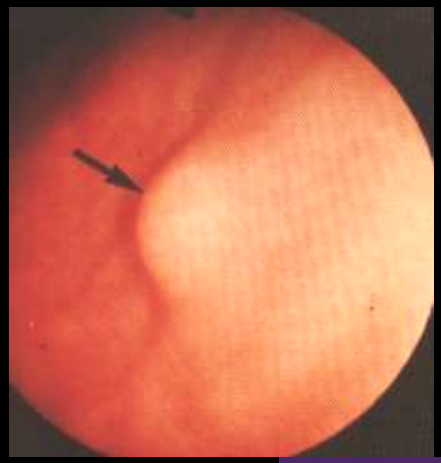


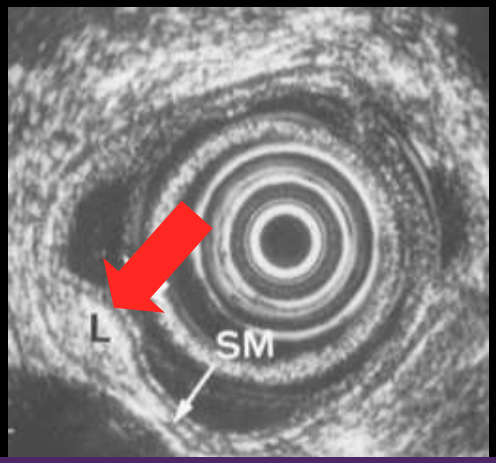


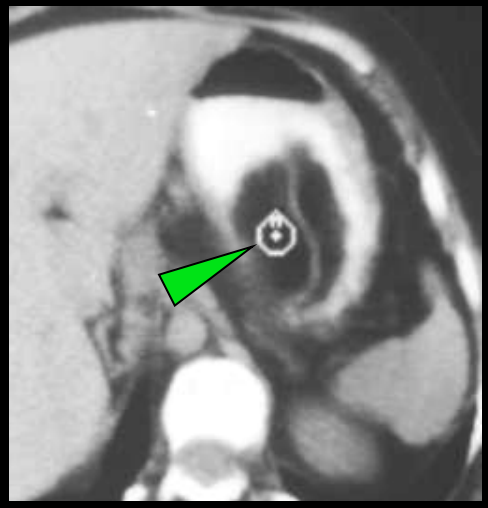


plasmocytome solitaire gastrique …… remarquez l'absence d'hypervascularisation et de structure '' storiforme '' ; bien évidemment le diagnostic n'a été fait que sur la pièce opératoire

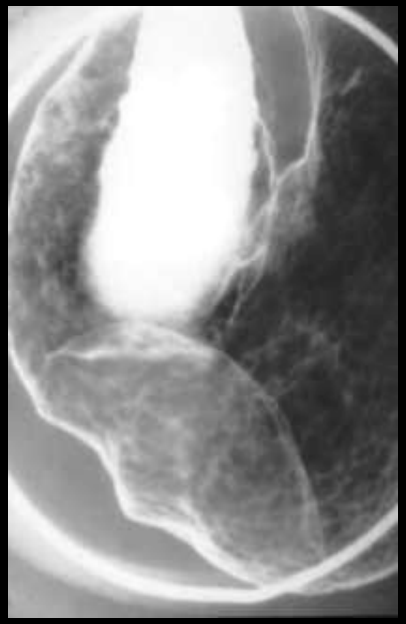
endoscopies gastriques pour troubles dyspeptiques atypiques découverte

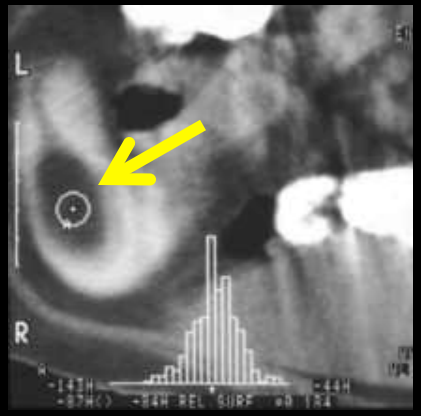


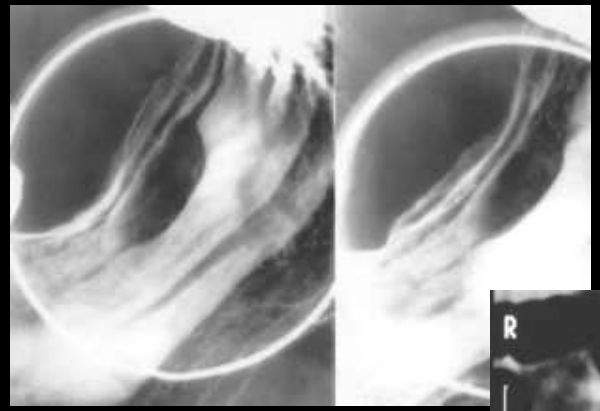


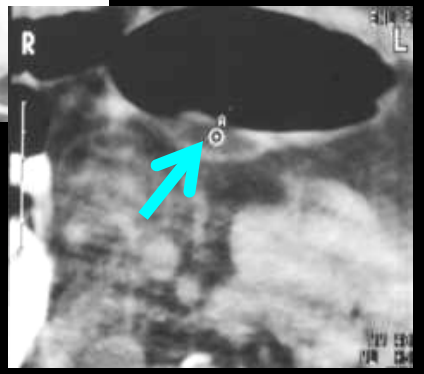


lipome sous muqueux gastrique

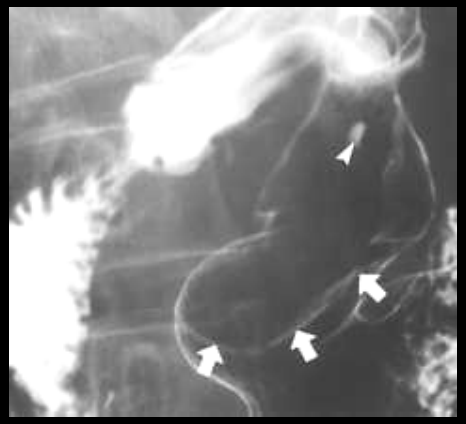


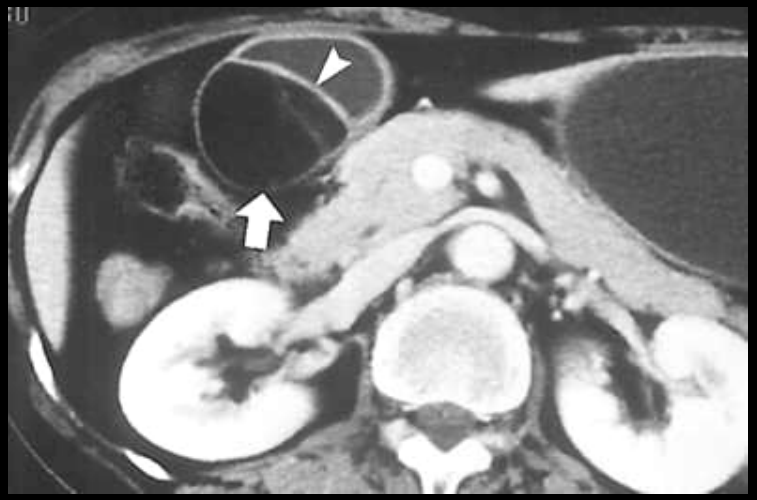


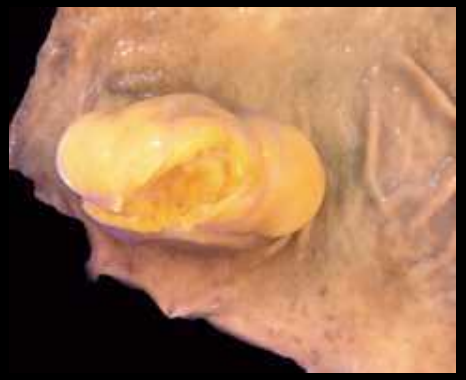




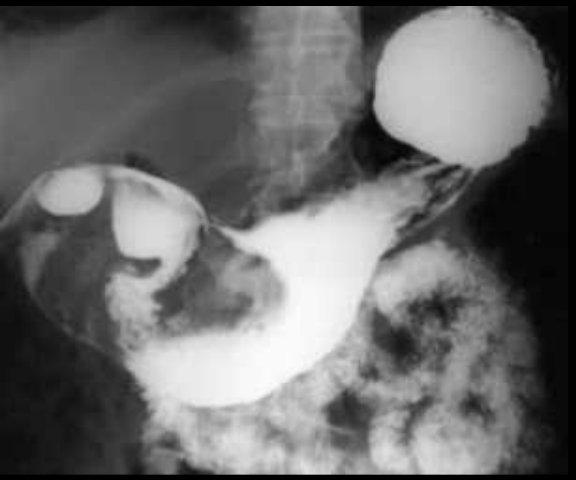
lipomes sous muqueux gastriques

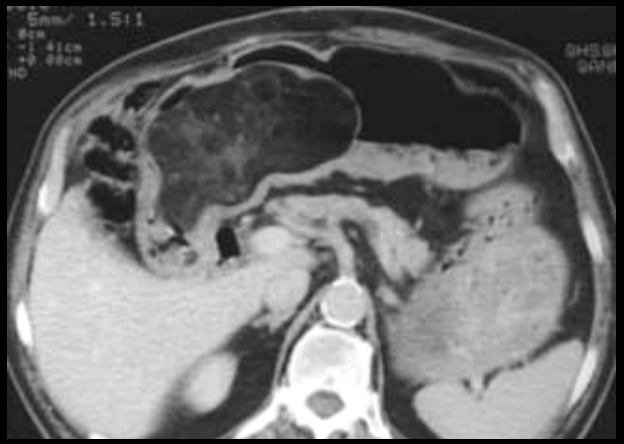


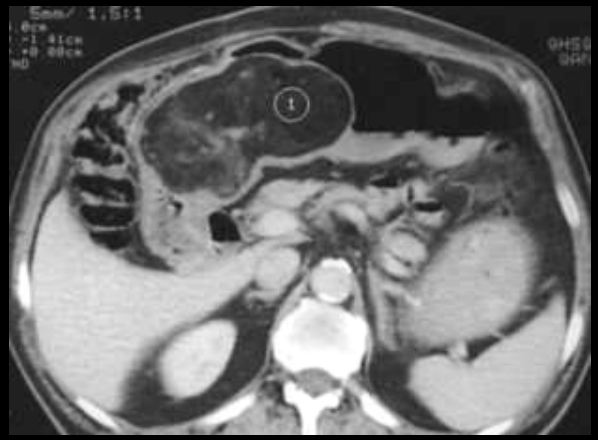




lipome gastrique antral



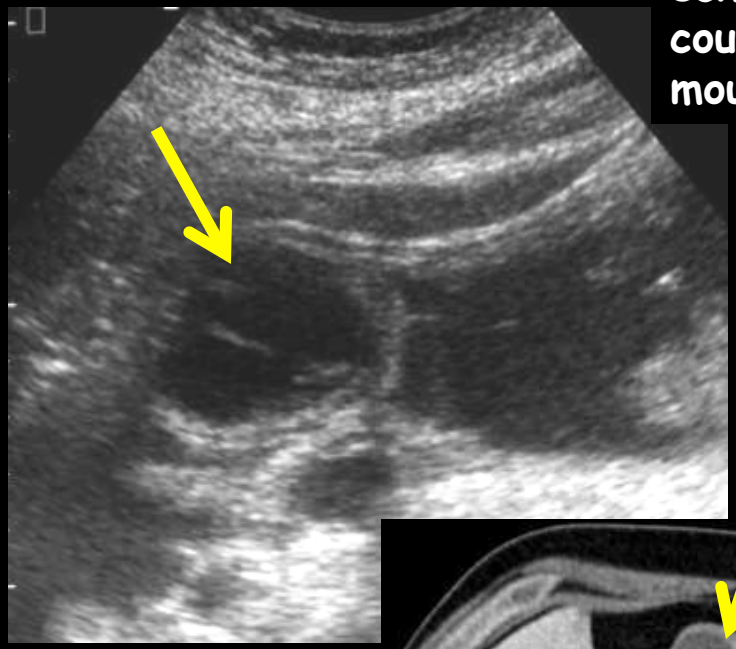


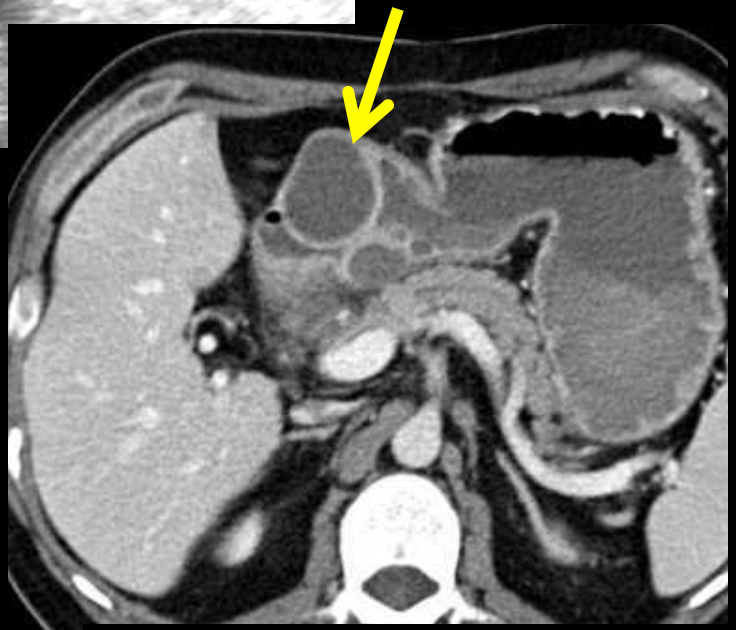


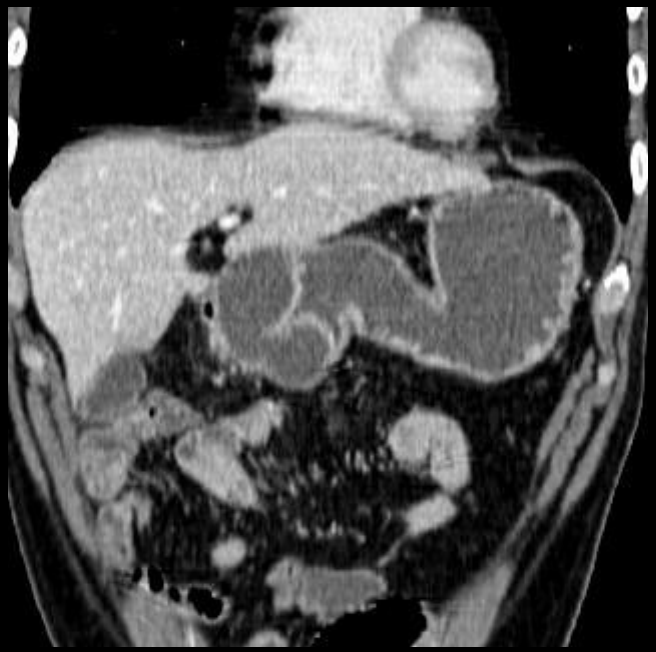
liposarcome gastrique bien différencié

caractérisez les principaux composants tissulaires et identifiez cette lésion pauci symptomatique

échographie:
couches pariétales
mouvements péristaltiques



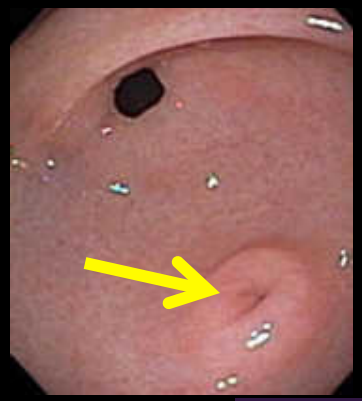


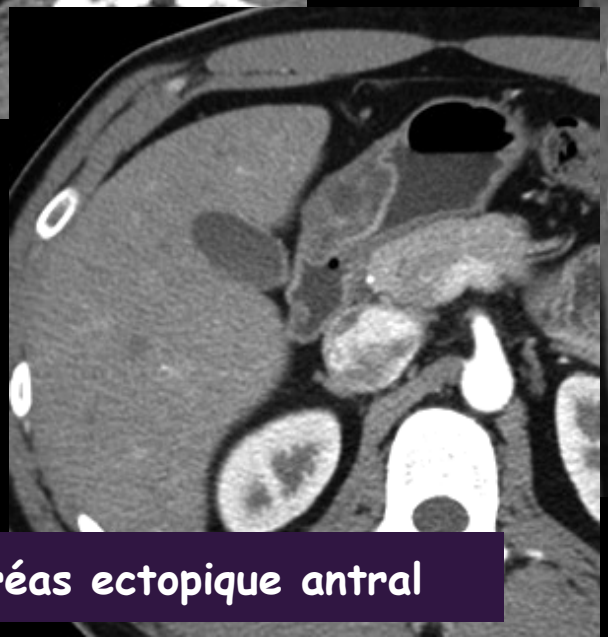


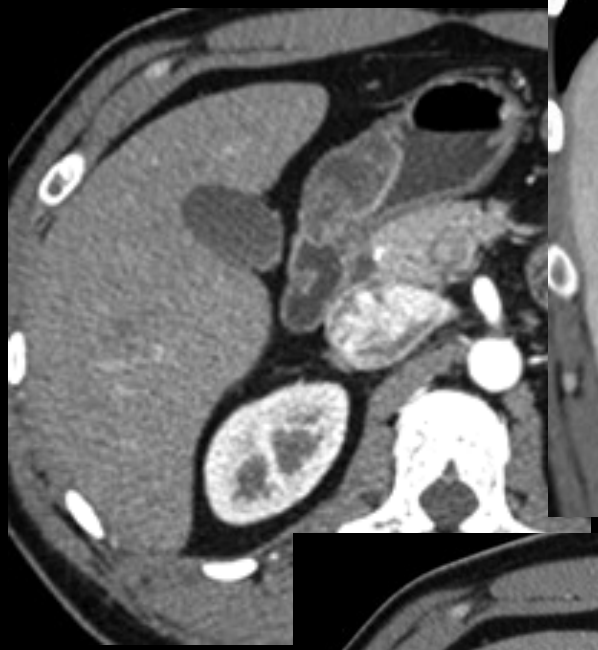
duplication antrale

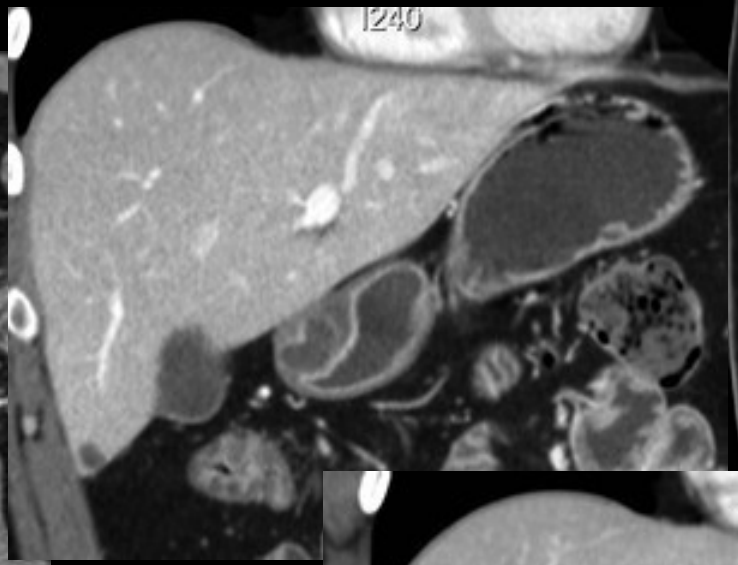
paroi = rehaussement identique à celui de la paroi digestive

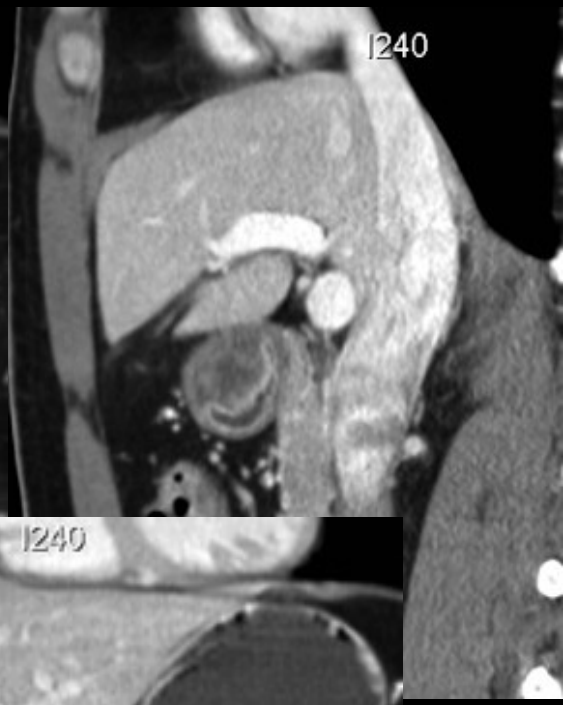
homme 31 ans ,douleurs épigastriques , dyspepsie .Présence d'un petit pertuis à l'endoscopie ,à la surface de la voussure

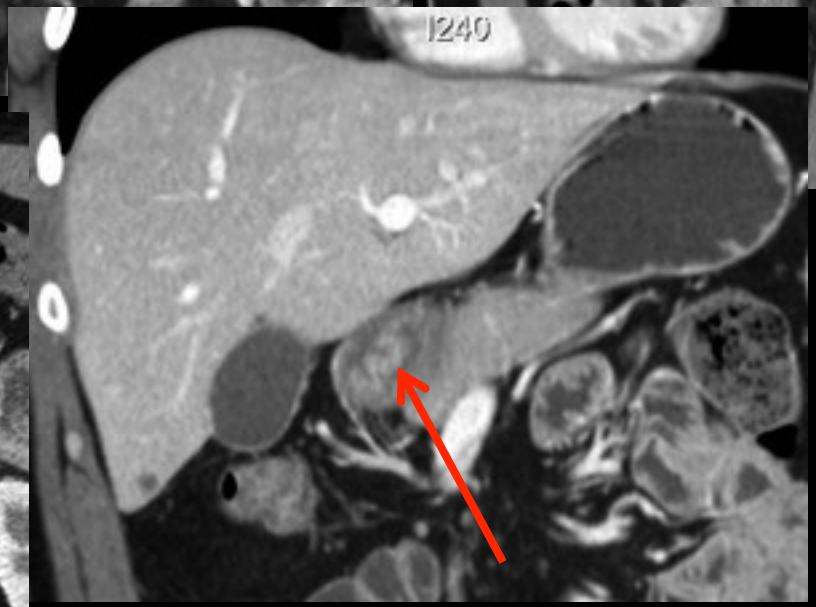




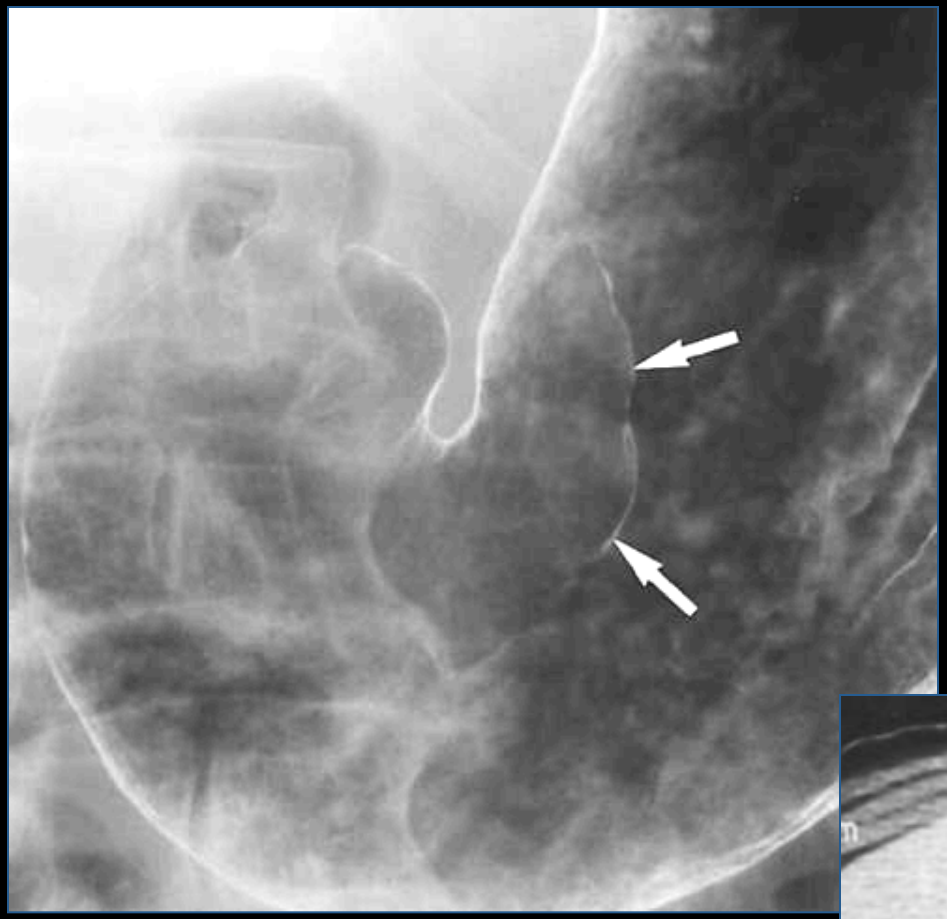


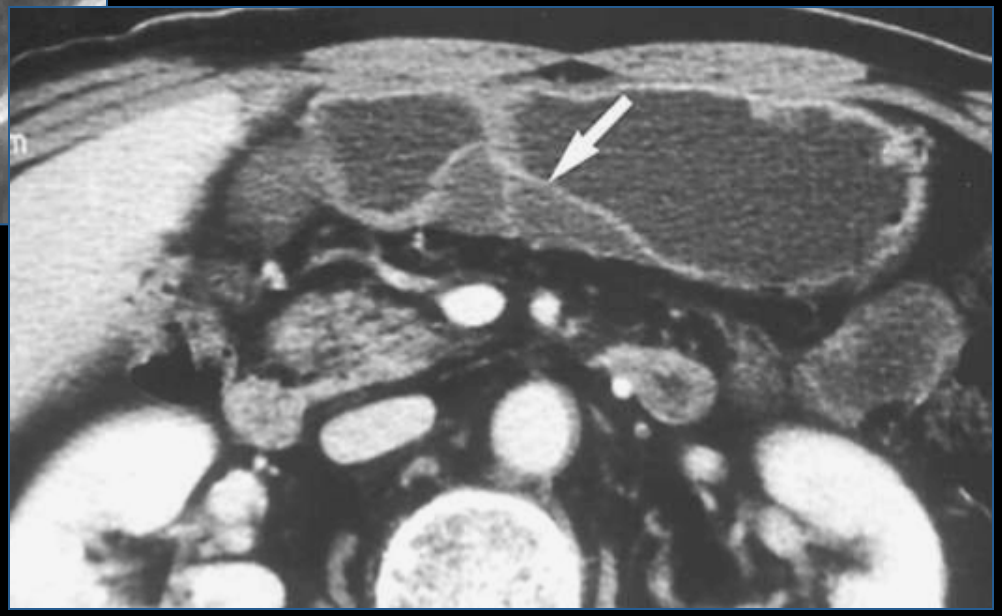






Pancréas ectopique antral

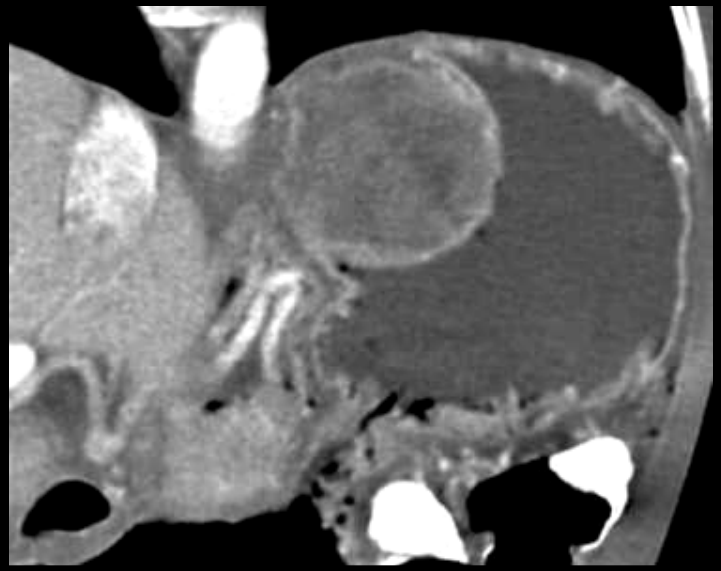


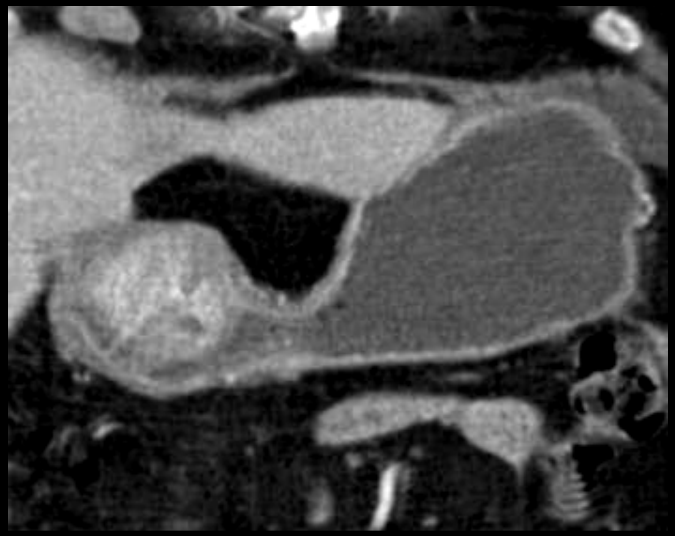


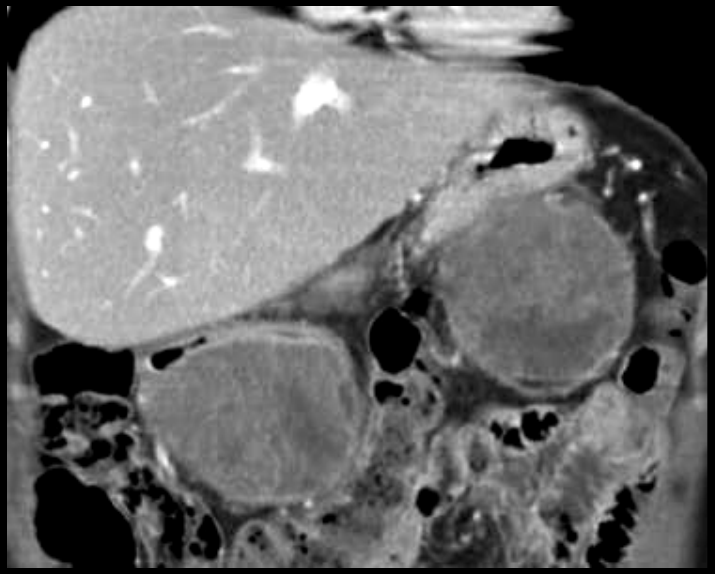
lymphangiome gastrique

RadioGraphics, 1999 19:1435-1446.

femme 62 ans ,abdomen ballonné ,baisse de l'état général ,
antécédent de carcinome mammaire , masse pelvienne à
l'échographie



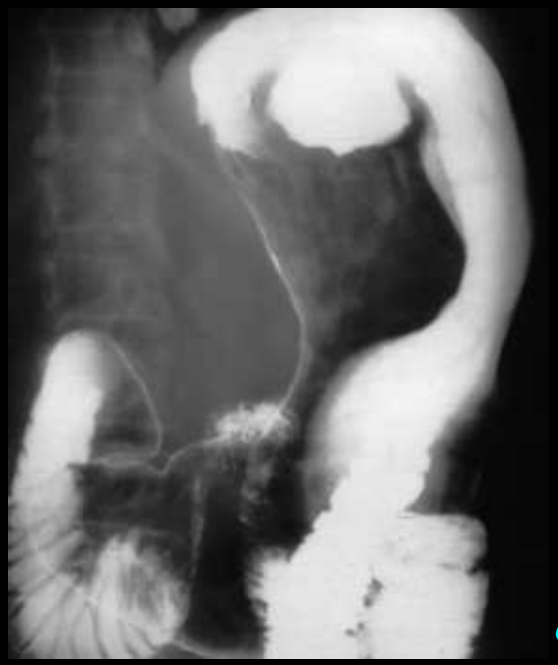


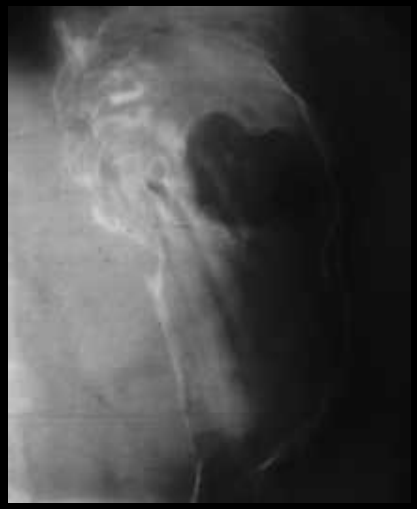


hypothèses diagnostiques

GIST
adénocarcinome lieberkuhnien
LMNH
métastase (mélanome , sein , colon …)

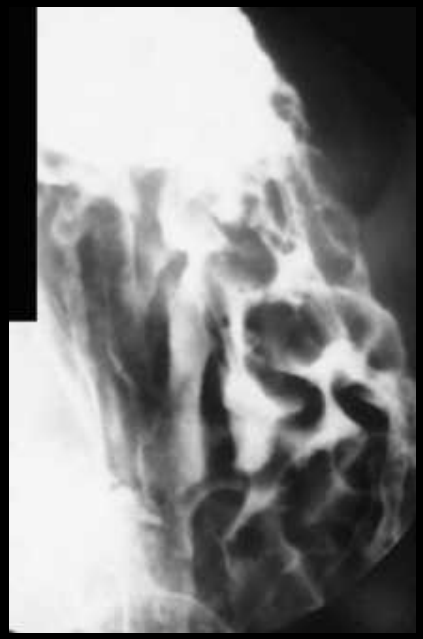
métastases gastriques
d'un adénocarcinome
mucineux de l'ovaire !

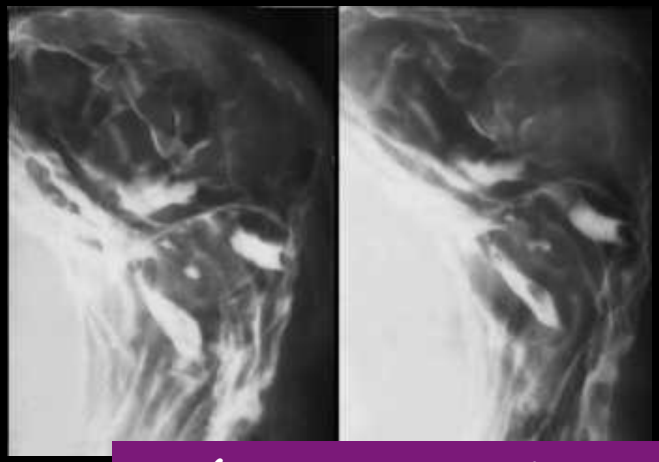


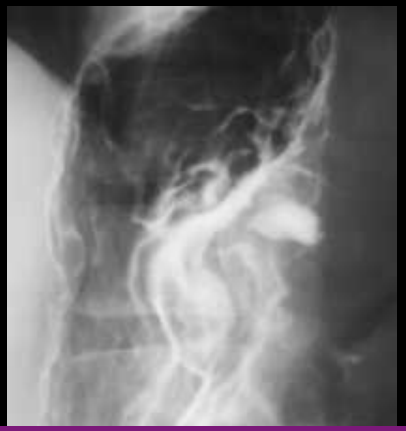


métastases gastriques d'un adénocarcinome de l'ovaire

Clichés Pierre BRET Lyon

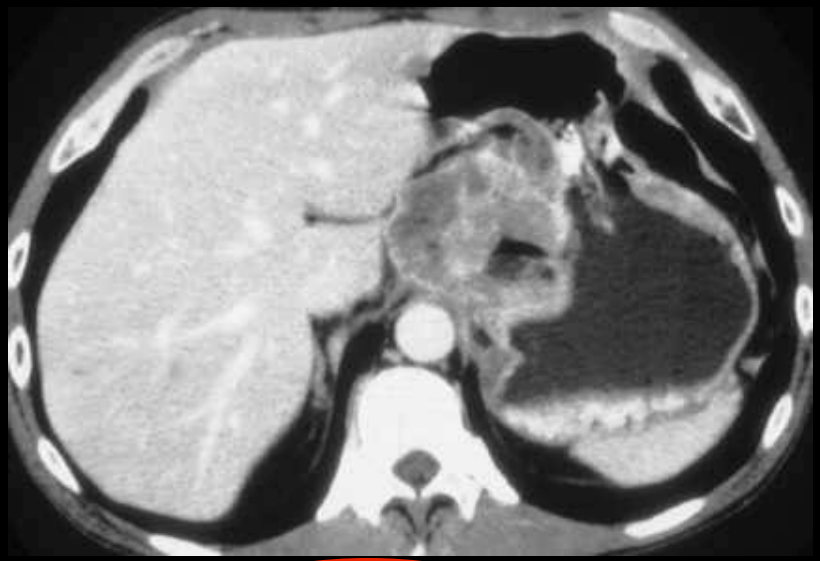


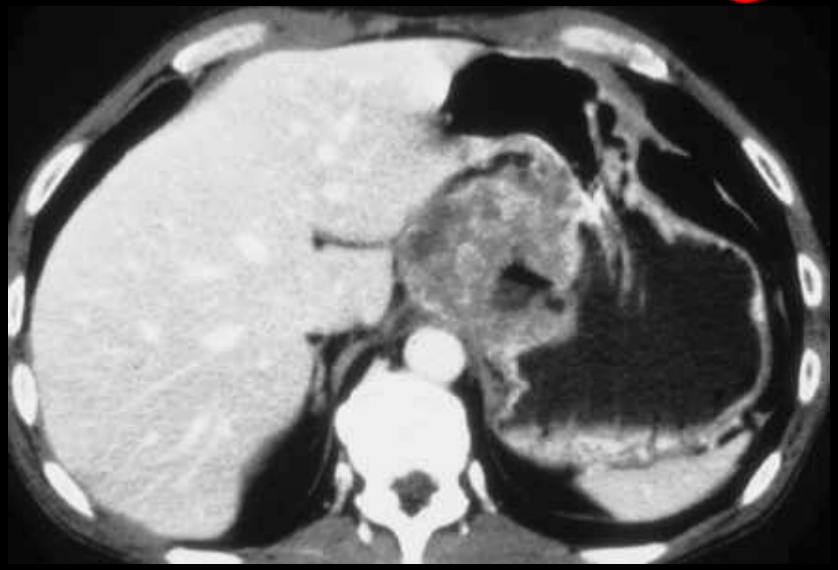


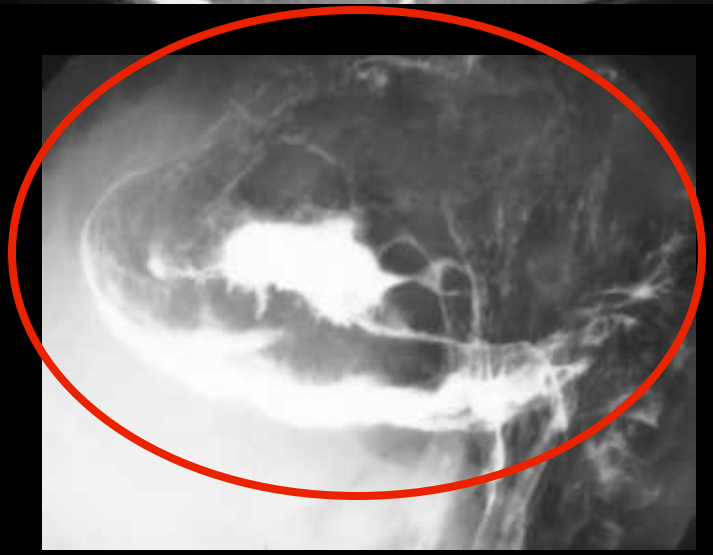


métastases gastriques d' adénocarcinomes coliques

homme 54 ans ,éthylo-tabagique ; dysphagie progressive depuis 2 mois ; quelle est la nature histologique de cette lésion

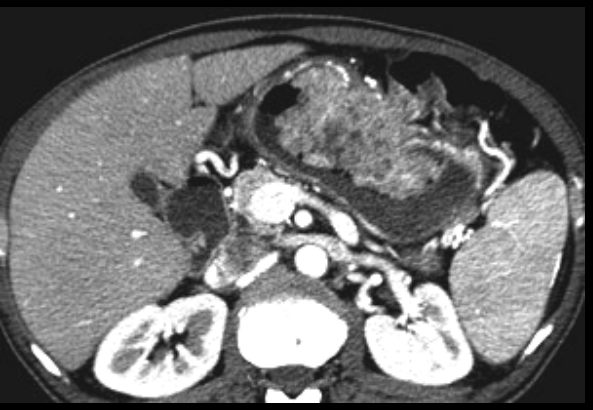


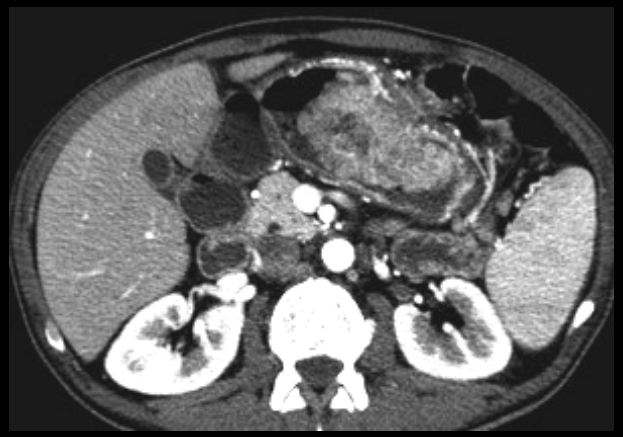


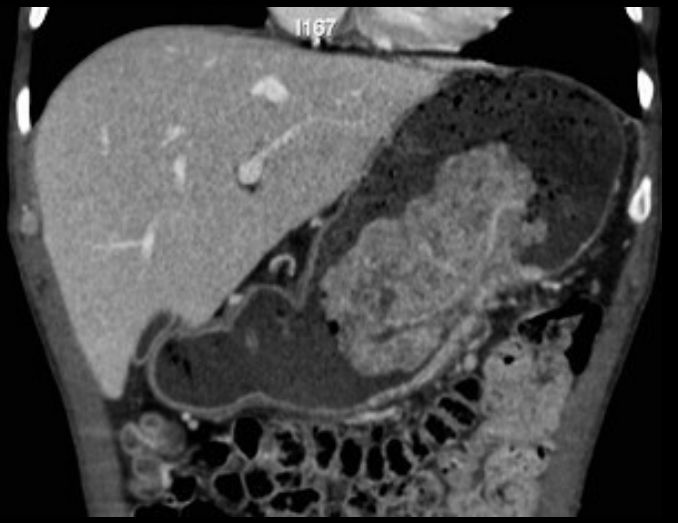


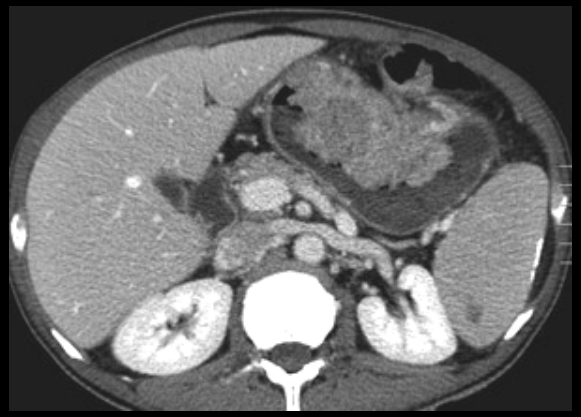
métastase ganglionnaire cœliaque d'un carcinome épidermoïde de l'œsophage , ulcérée dans l 'estomac .

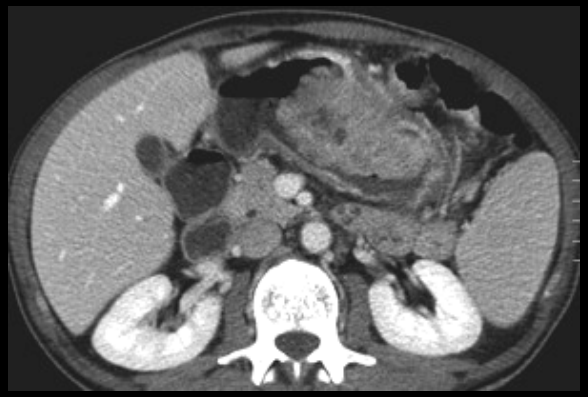
homme 62 ans ,anémie

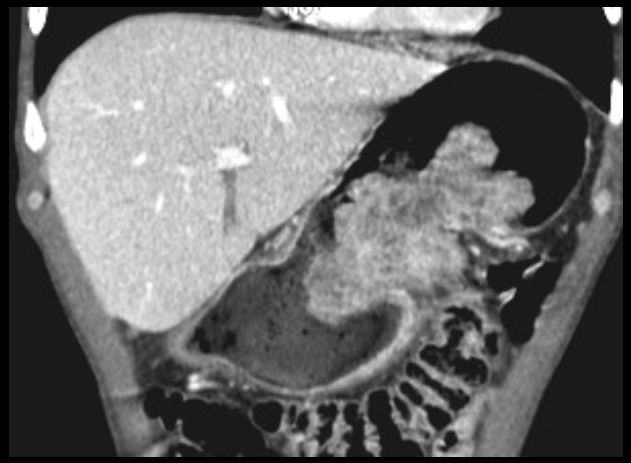






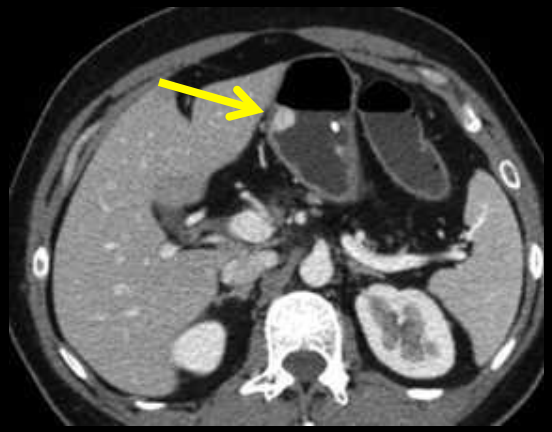
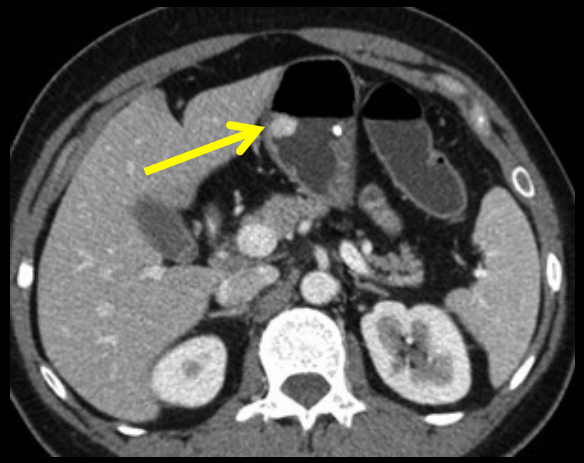
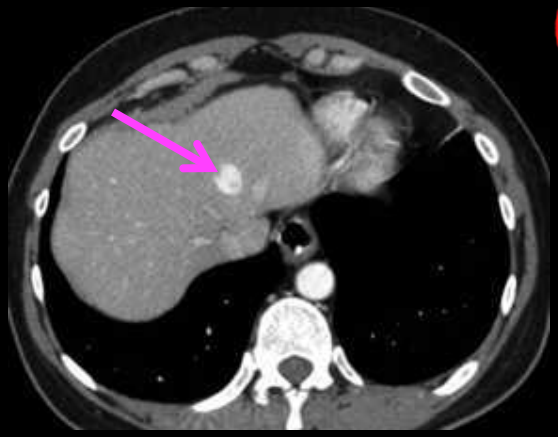
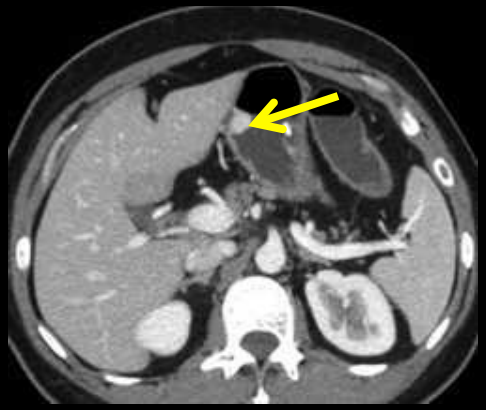
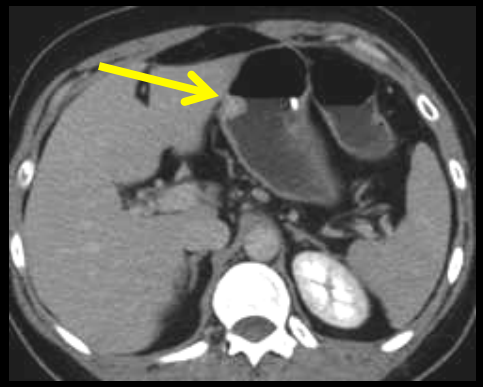
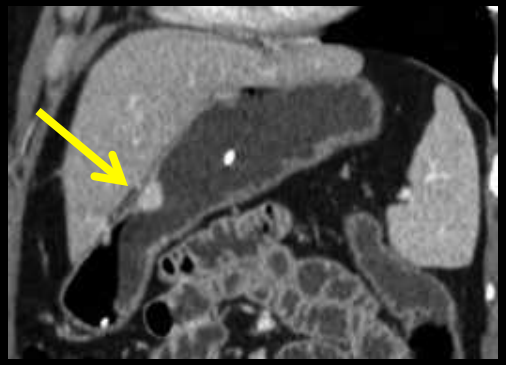
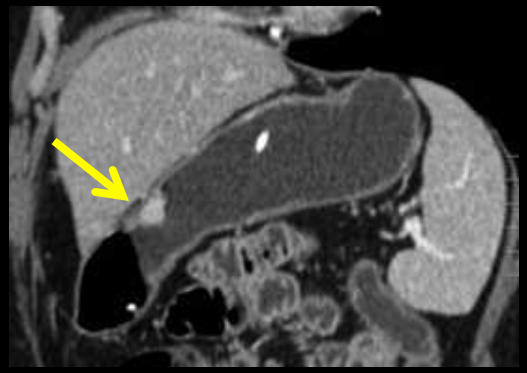
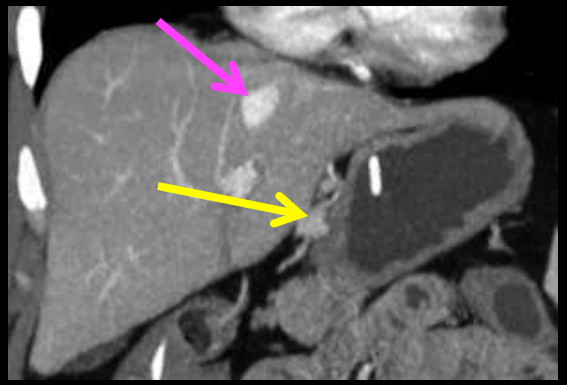






adénocarcinome gastrique bourgeonnant

femme 46 ans , douleurs épigastriques ,diarrhée ,HTA

tumeur (neuro) endocrine
anciennement T carcinoïde

hypervascularisée = bien différenciée (===)

take home message

-l'imagerie en coupes permet la caractérisation des lésions sous-muqueuses dans lesquelles l'endoscopie et les biopsies sont en règle prises en défaut

-pour les contingents liquidiens , l'écho endoscopie et l'IRM sont potentiellement les plus efficaces

-au scanner , les valeurs d'atténuation mais aussi la lecture analogique avec un ''œil densitométrique'' (en se référant aux structures anatomiques à contenu liquidien physiologique) permettent dans la plupart des cas l'identification lésionnelle

-pour les contingents graisseux (et les calcifications!) , le scanner est de toute évidence l'examen le plus performant

-une tumeur ''très'' hypervasculaire doit faire évoquer une tumeur endocrine bien différenciée (ou une métastase de tumeur de Grawitz !)