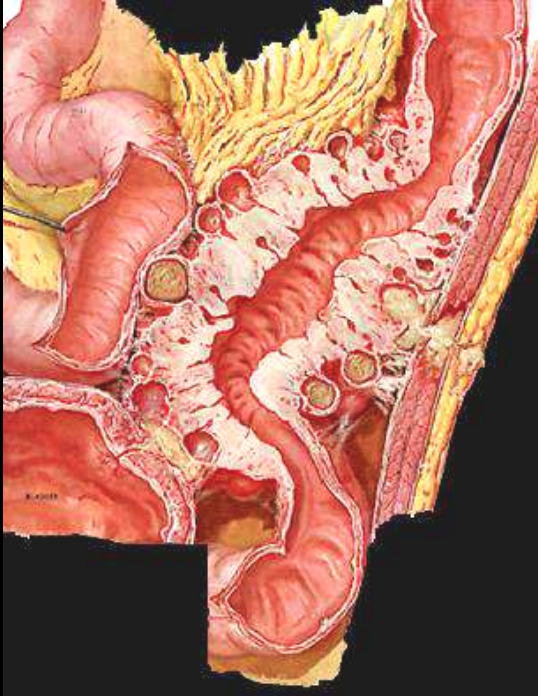


la diverticulose du sigmoïde et ses complications



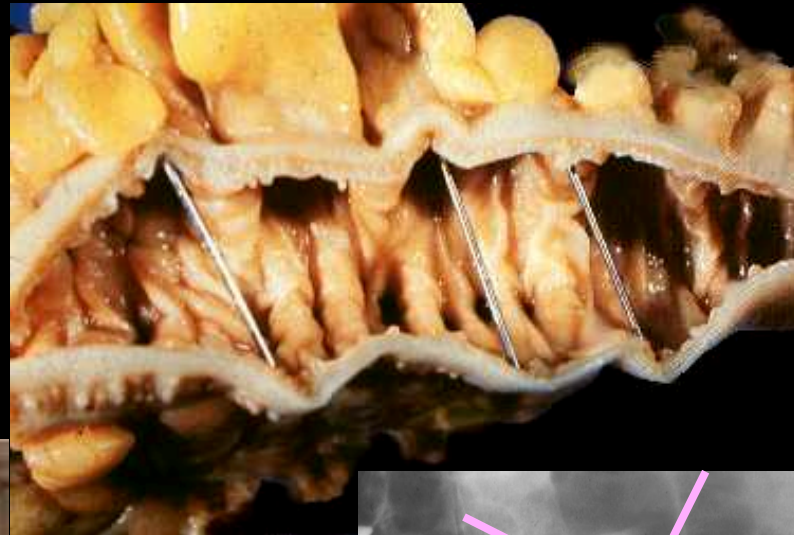
la diverticulose du sigmoïde est très fréquente dans les pays "riches" (europe de l'ouest , amérique du nord..) ; on l'observe à partir de 35 ans et sa fréquence augmente avec l'age (> 75% à 80 ans)

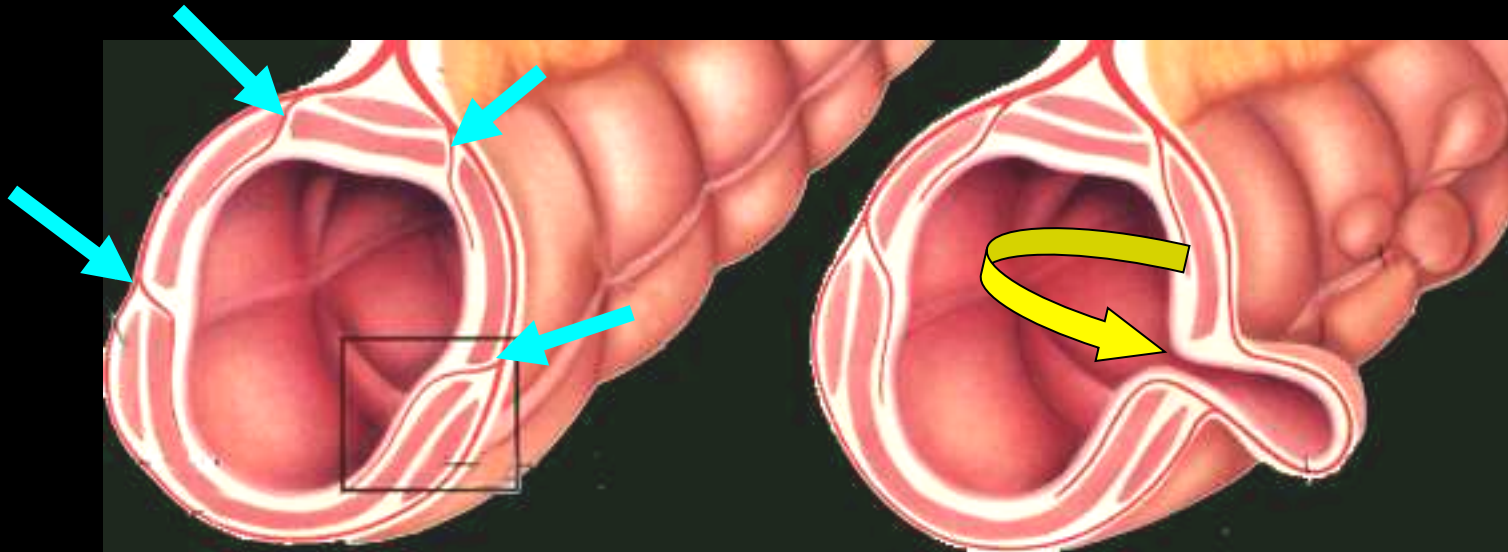
L'alimentation trop riche (en graisses) et surtout trop pauvre en fibres végétales) est un facteur essentiel



la première manifestation de la diverticulose du sigmoïde est l'hypertrophie de la couche circulaire interne du colon sigmoïde (myochose)

Elle est responsable de l'hyperpression endoluminale ; à l'origine des diverticules



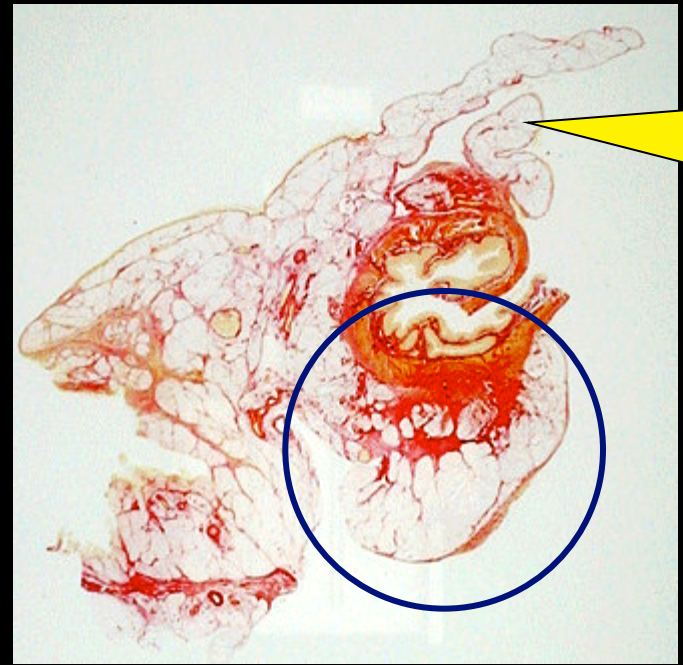
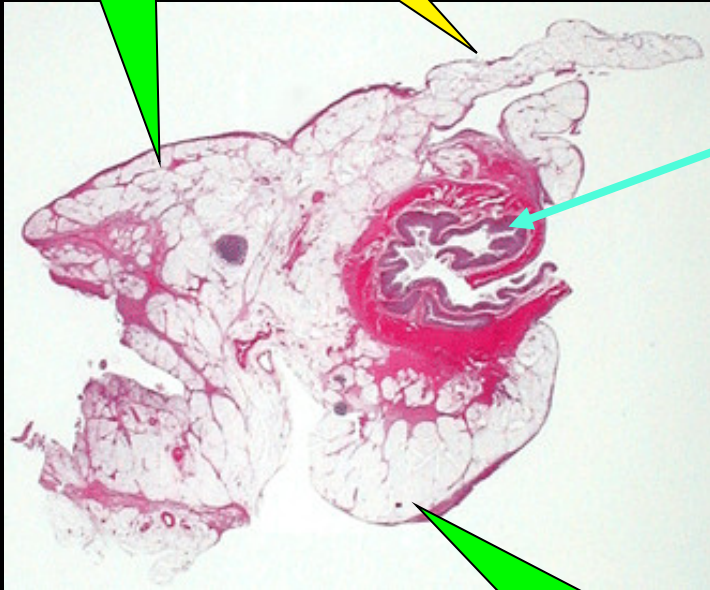


Les diverticules sont des évaginations de la muqueuse et de la sous-muqueuse dans les **zones de faiblesse de la paroi** qui sont les **points de pénétration des vaisseaux** (rameaux courts et rameaux longs des vaisseaux droits)

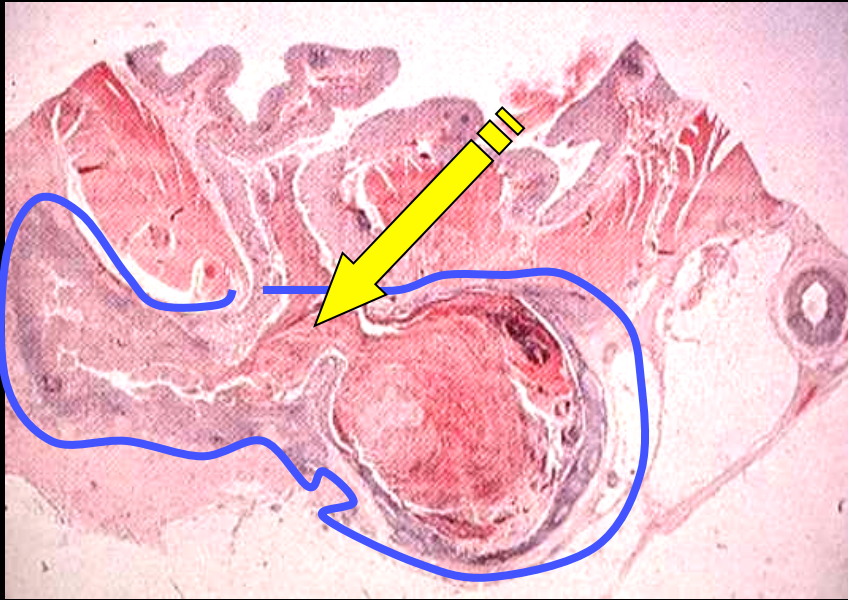
Les diverticules siègent donc préférentiellement du coté du mésosigmoïde

appendice
épiploïque;
"appendage"

diverticule



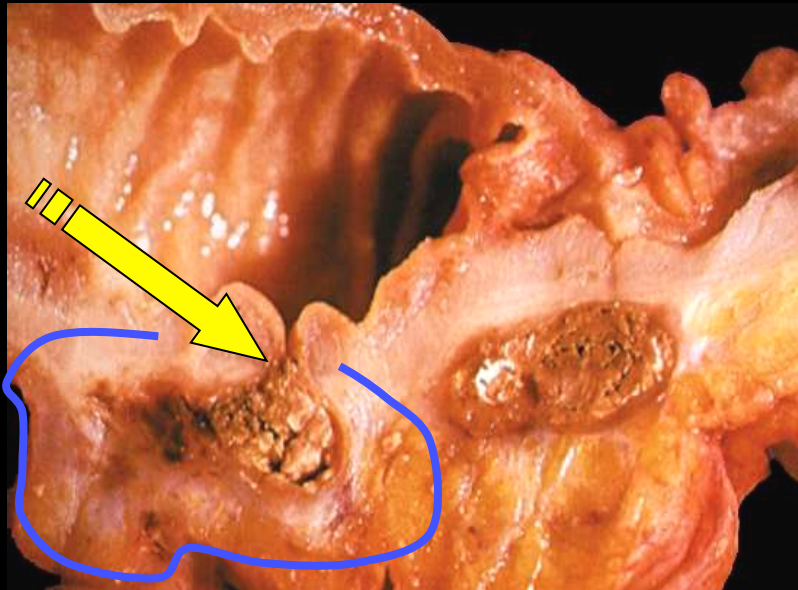
le **mésosigmoïde** toujours très gras **entoure le sigmoïde sur 270° ou plus** chez les sujets porteurs d'une maladie diverticulaire et obèses

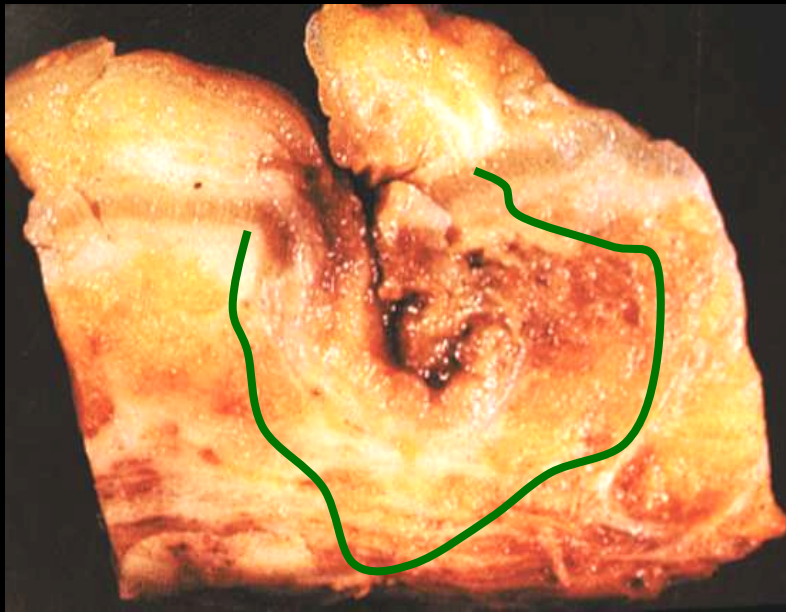


-la perforation d'un diverticule est due à la **stase stercorale** à l'origine d'une **pullulation microbienne** qui détruit la muqueuse .

-elle **siège** généralement **au collet** du diverticule

-l'infection se développe **dans le méso sigmoïde**



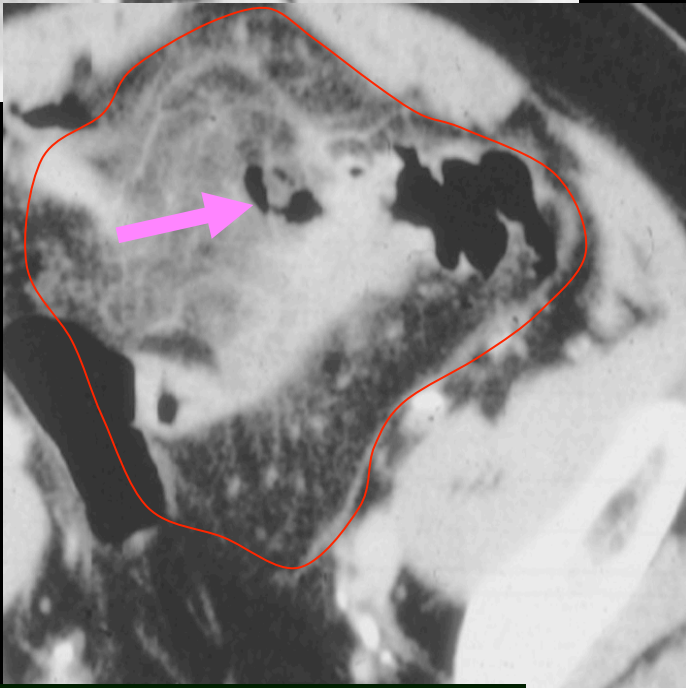
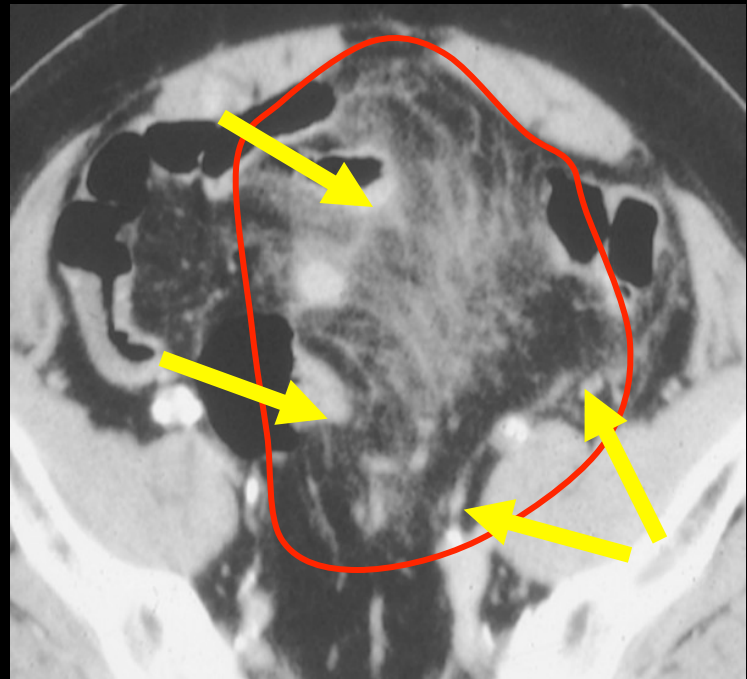
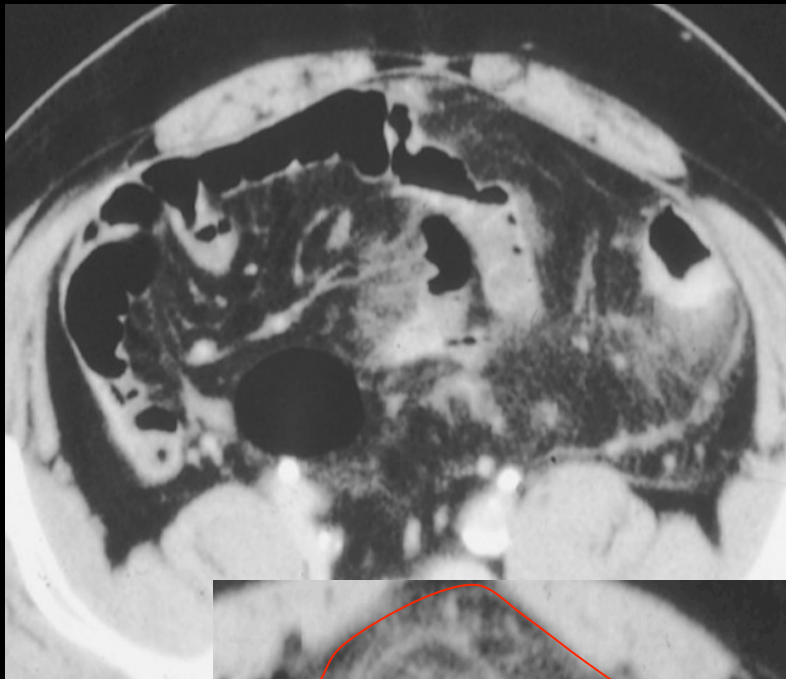


seules 10% des diverticuloses se compliquent .

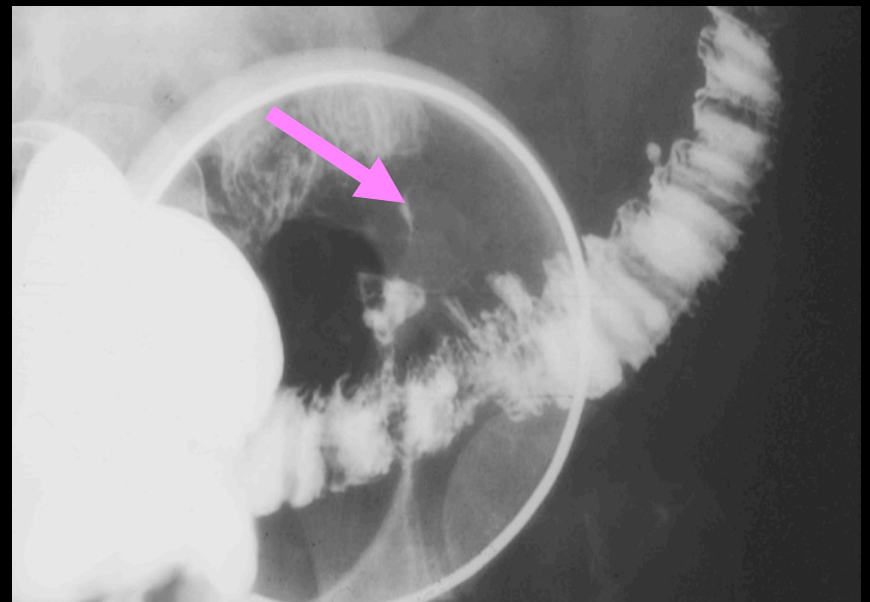
80% des diverticulites sont des perforations "bouchées" éventuellement compliquées d'abcès , traitées médicalement.

On réalise généralement une sigmoïdectomie à froid, 6 à 8 semaines après la fin de la poussée, pour la prophylaxie des récurrences

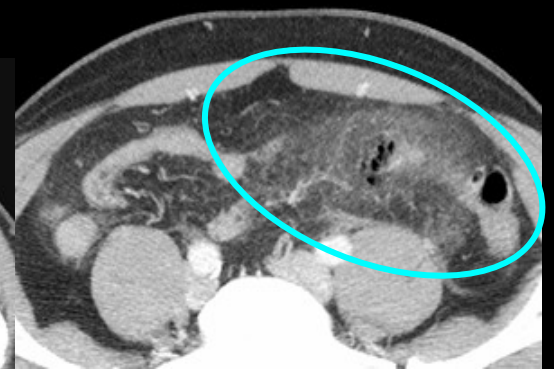
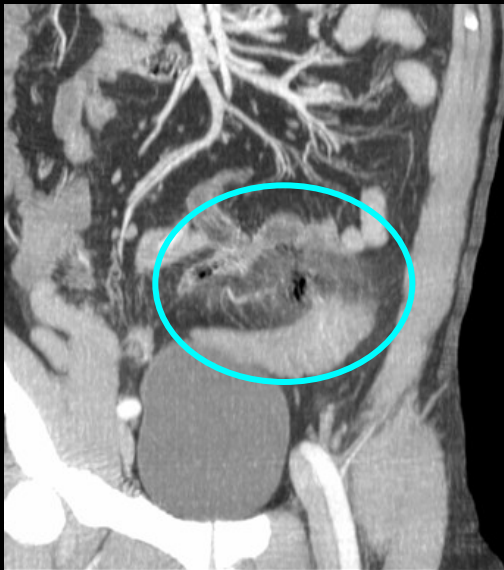
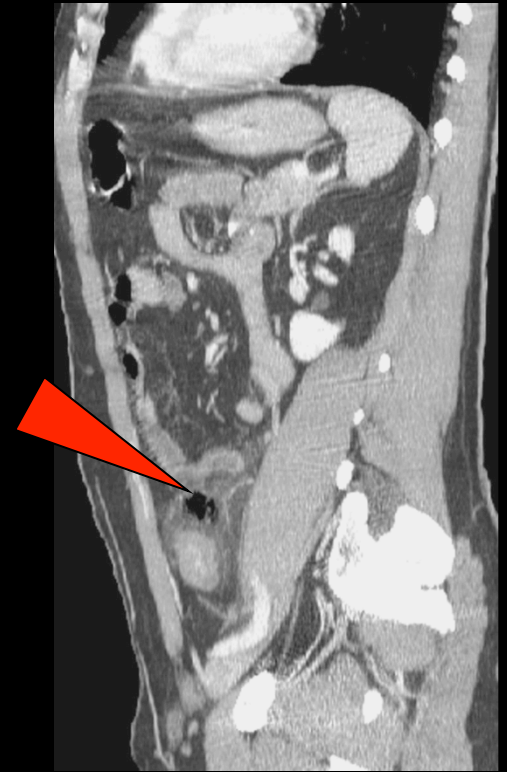
20% des complications sont des formes graves qui comportent en général une péritonite par perforation ou par diffusion d'un abcès péri colique .



diverticulite perforée bouchée dans le mésosigmoïde

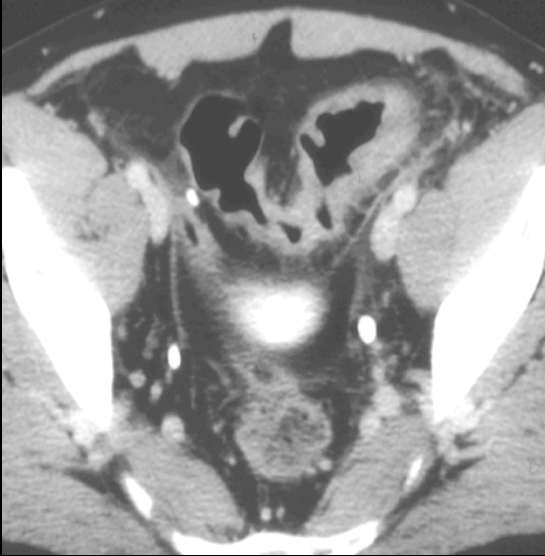


lavement aux hydrosolubles iodés

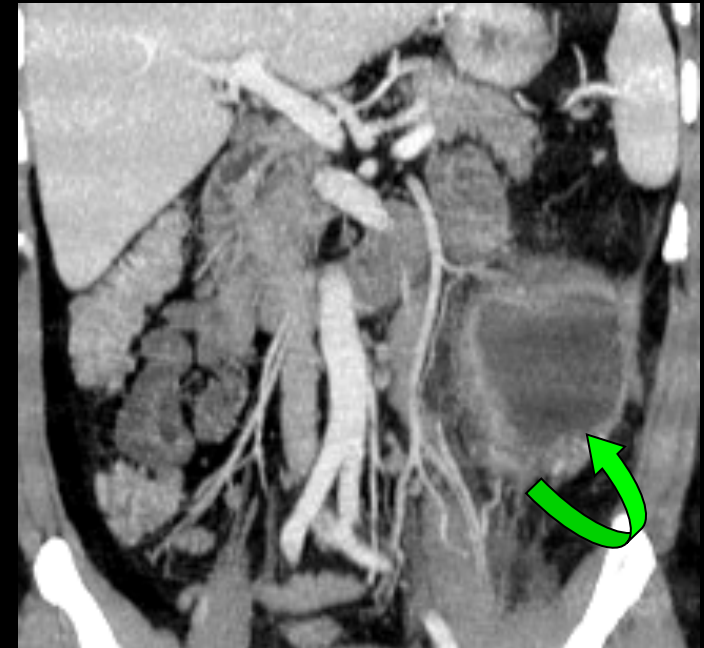
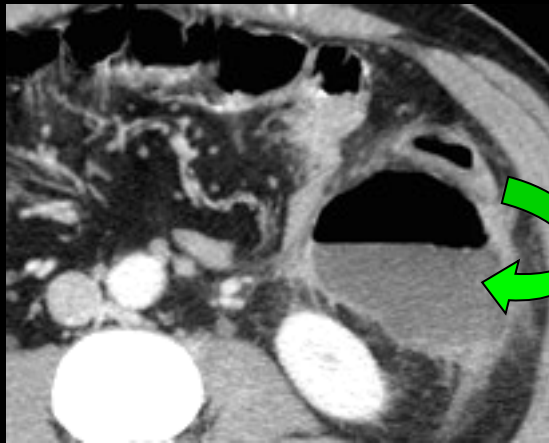
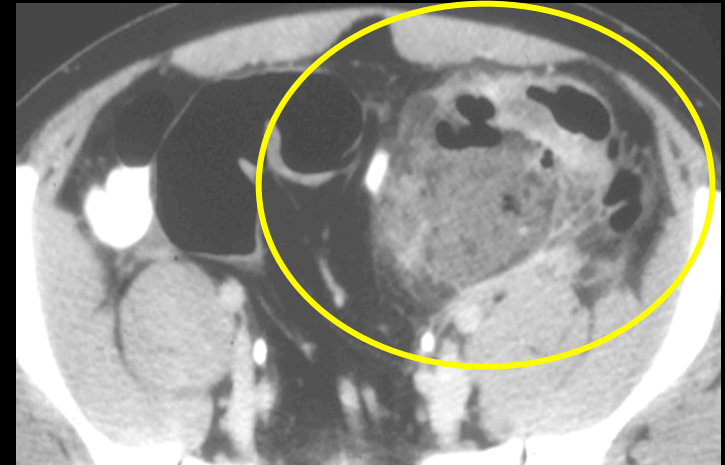


diverticulite perforée bouchée dans le mésosigmoïde

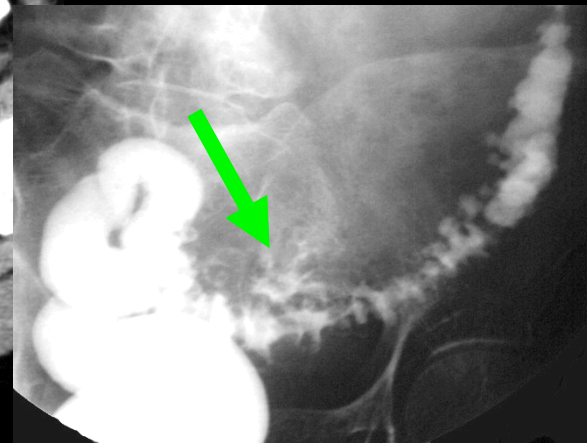
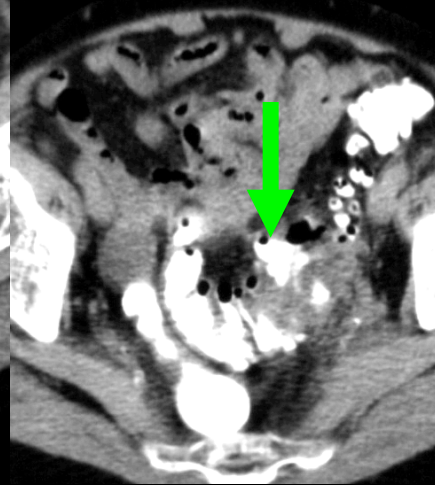
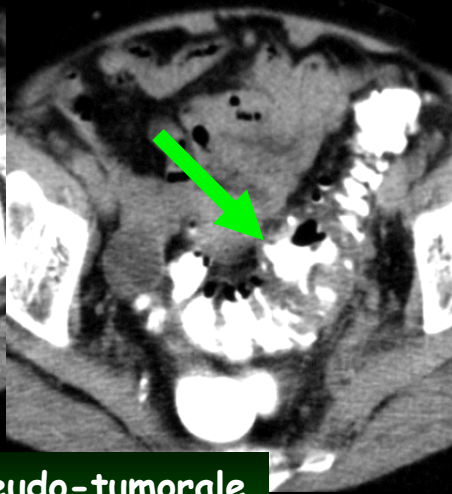
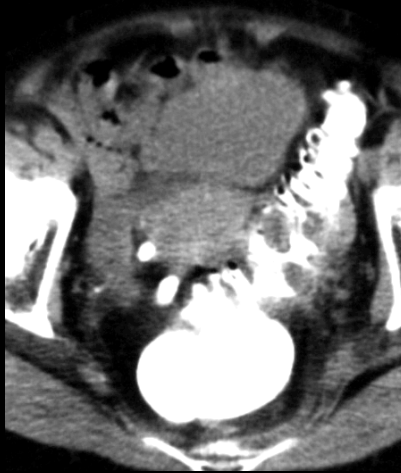
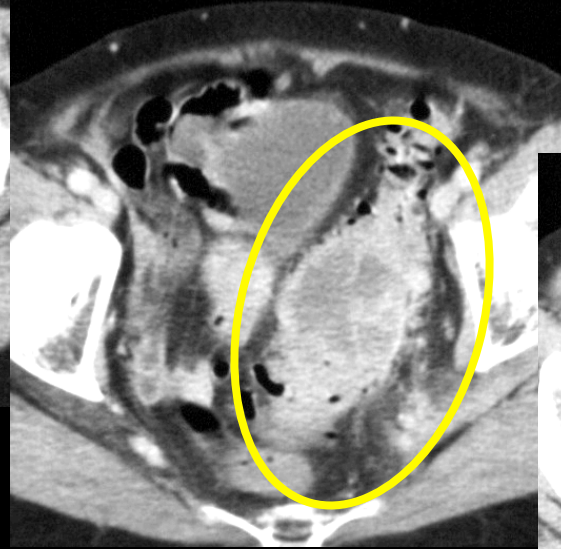
Quand faut-il drainer les infections péri-coliques ?



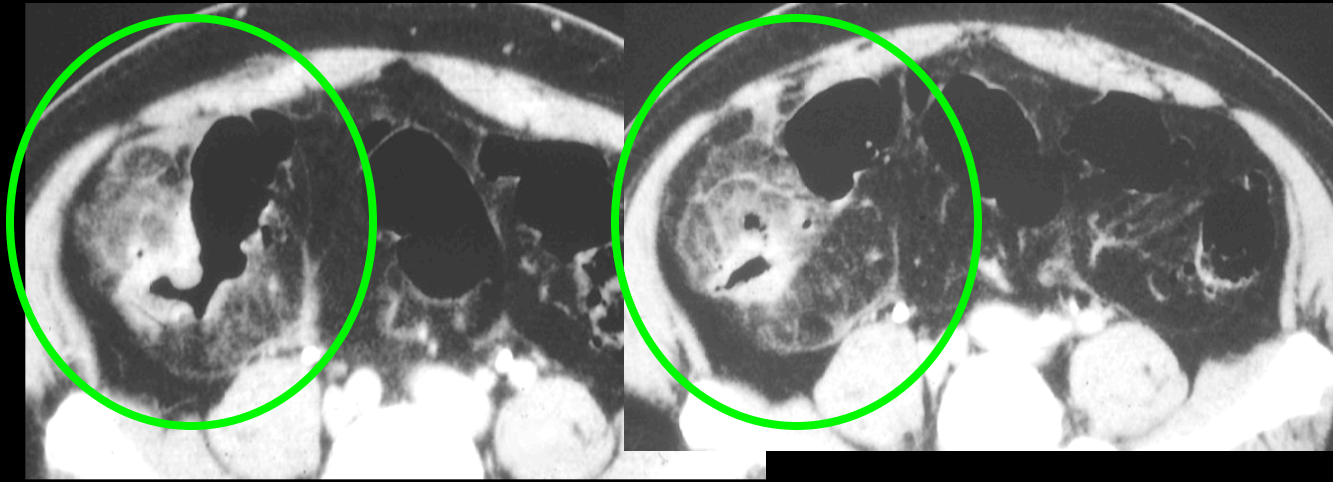
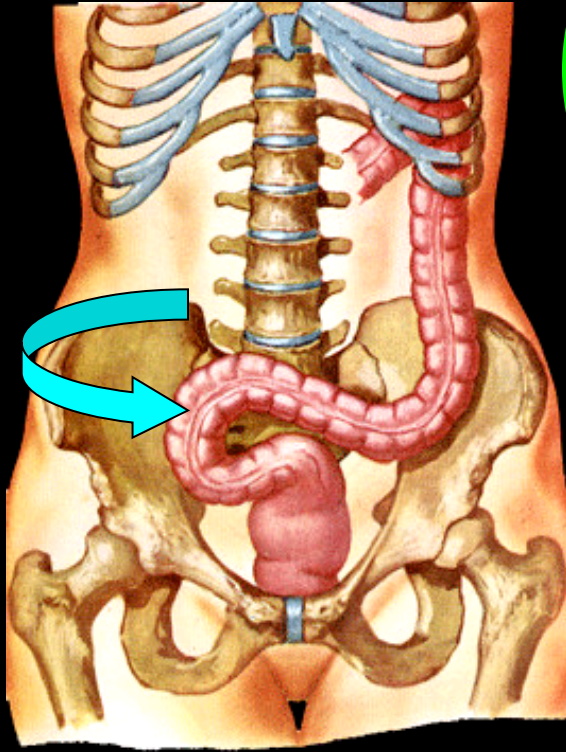
" phlegmon " du
mésosigmoïde :
traitement médical



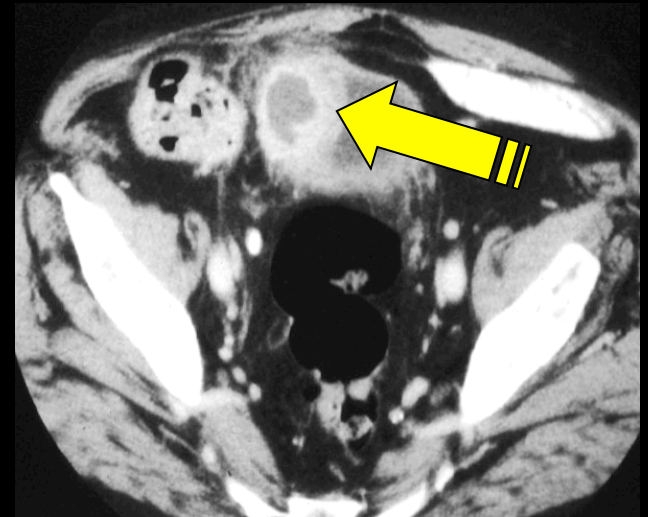
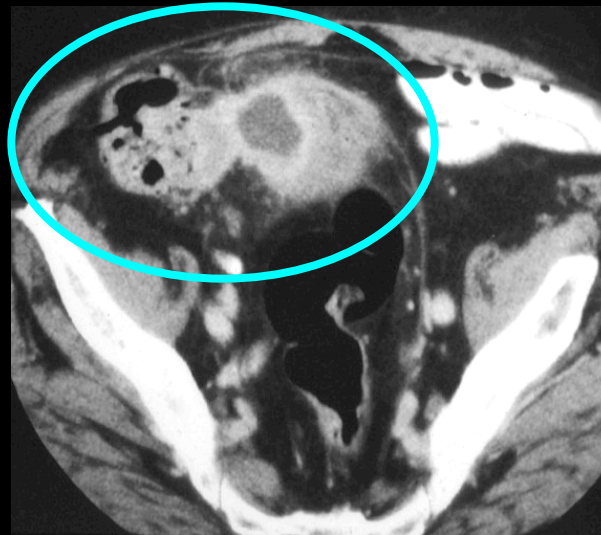
abcès para colique gauche : drainage



sigmoïdite pseudo-tumorale
intérêt du colo CT opaque

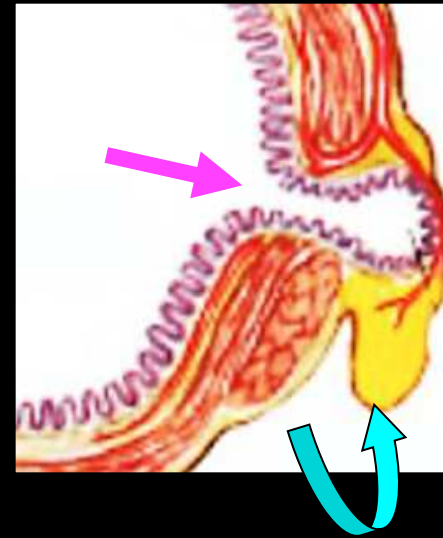
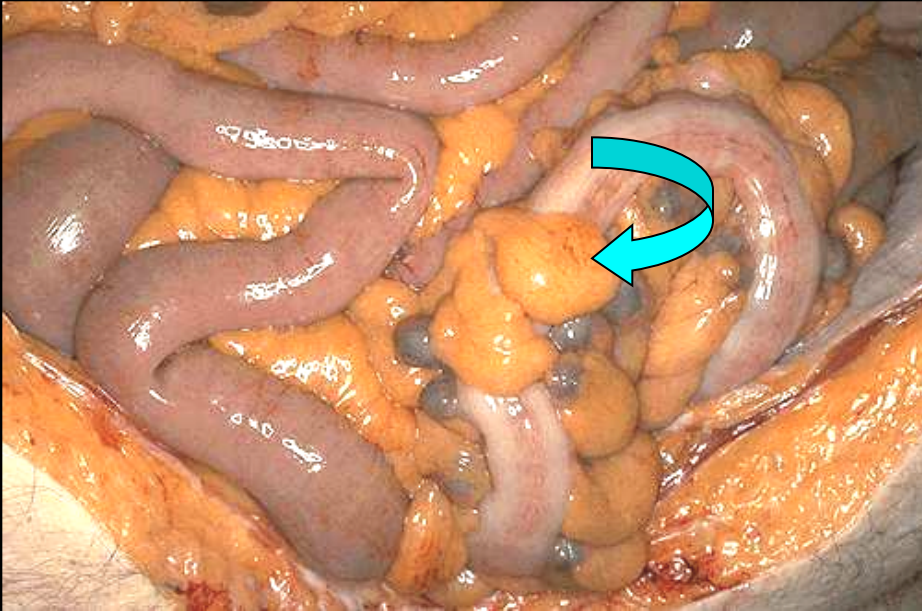


diverticulite de la FID sur dolichosigmoïde



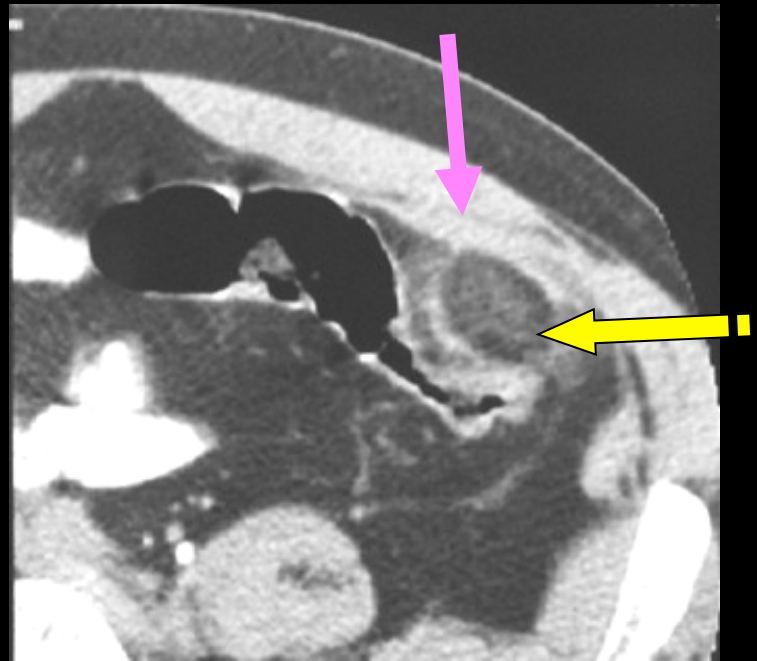
abcès inter sigmoïdo-vésical sur diverticulite de la FID ; dolichosigmoïde

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



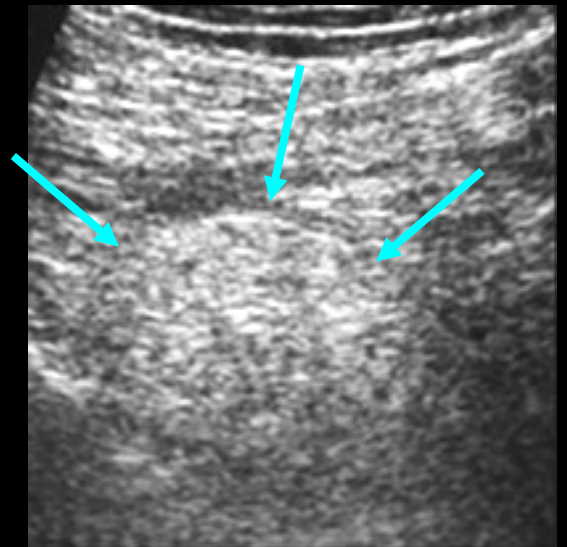


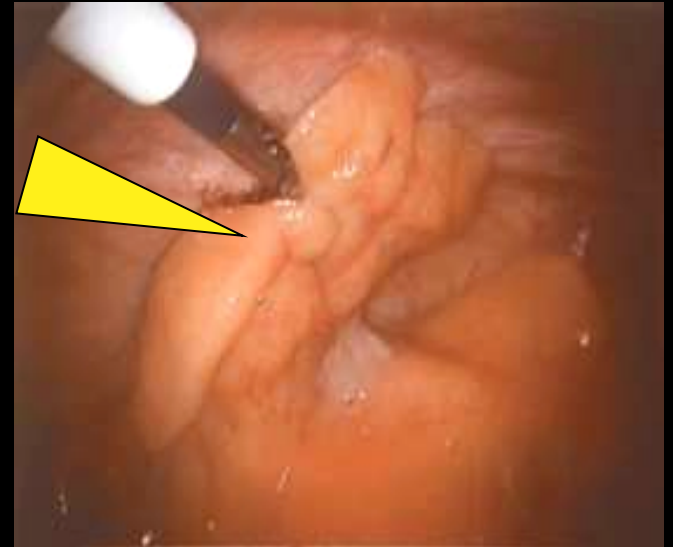
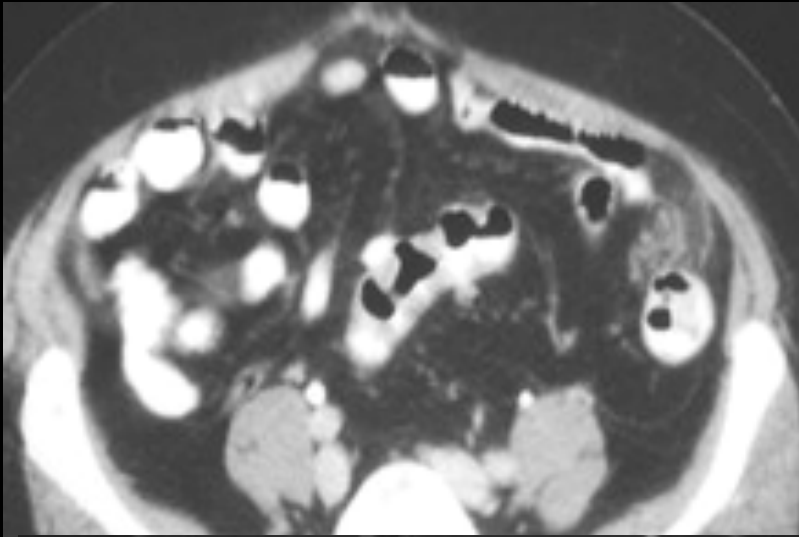
appendices épiploïques
(appendages) bien visibles en
raison d'une ascite



"appendagite" primitive typique; 24 ans

- image "en navette" juxta colique
- centre dense (granulome lipophagique)
- épaississement inflammatoire réactionnel du
péritoine pariétal
- masse hyperéchogène "fixée" à la paroi +++





torsion d'appendice épiploïque ; " appendagite " primitive

l' appendicite aiguë et ses complications



1-l'obstruction de la lumière appendiculaire est le primum movens de l'appendicite aiguë

2-elle est due

.à un **stercolithe**(coprolithe) endoluminal

.à une **hypertrophie des plaques de Peyer** (formations lymphoïdes) de la paroi appendiculaire





- éléments anatomiques importants

participation du méso-appendiculaire à la réaction inflammatoire régionale

prédominance distale fréquente de l'atteinte inflammatoire

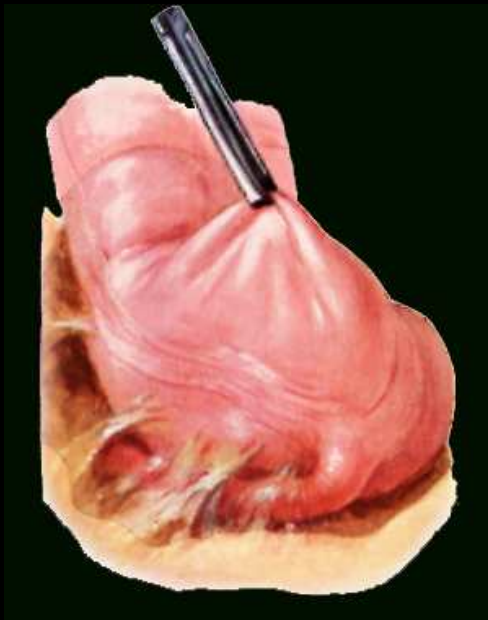
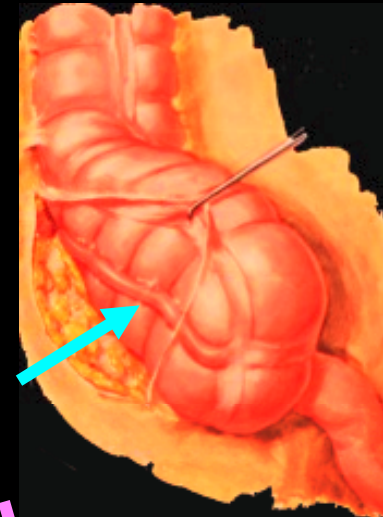


l'appendicite distale épargne les 3 centimètres proximaux de l'appendice : difficulté potentielle de l'imagerie

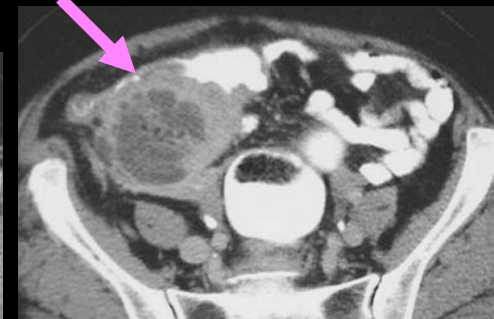
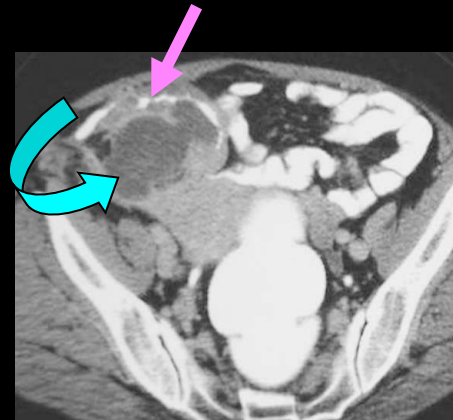


- éléments anatomiques importants

le type de complication rencontré en cas de retard diagnostique dépend de la **situation anatomique de l'appendice inflammatoire** (en particulier de son extrémité distale)



appendicite rétro-caecale

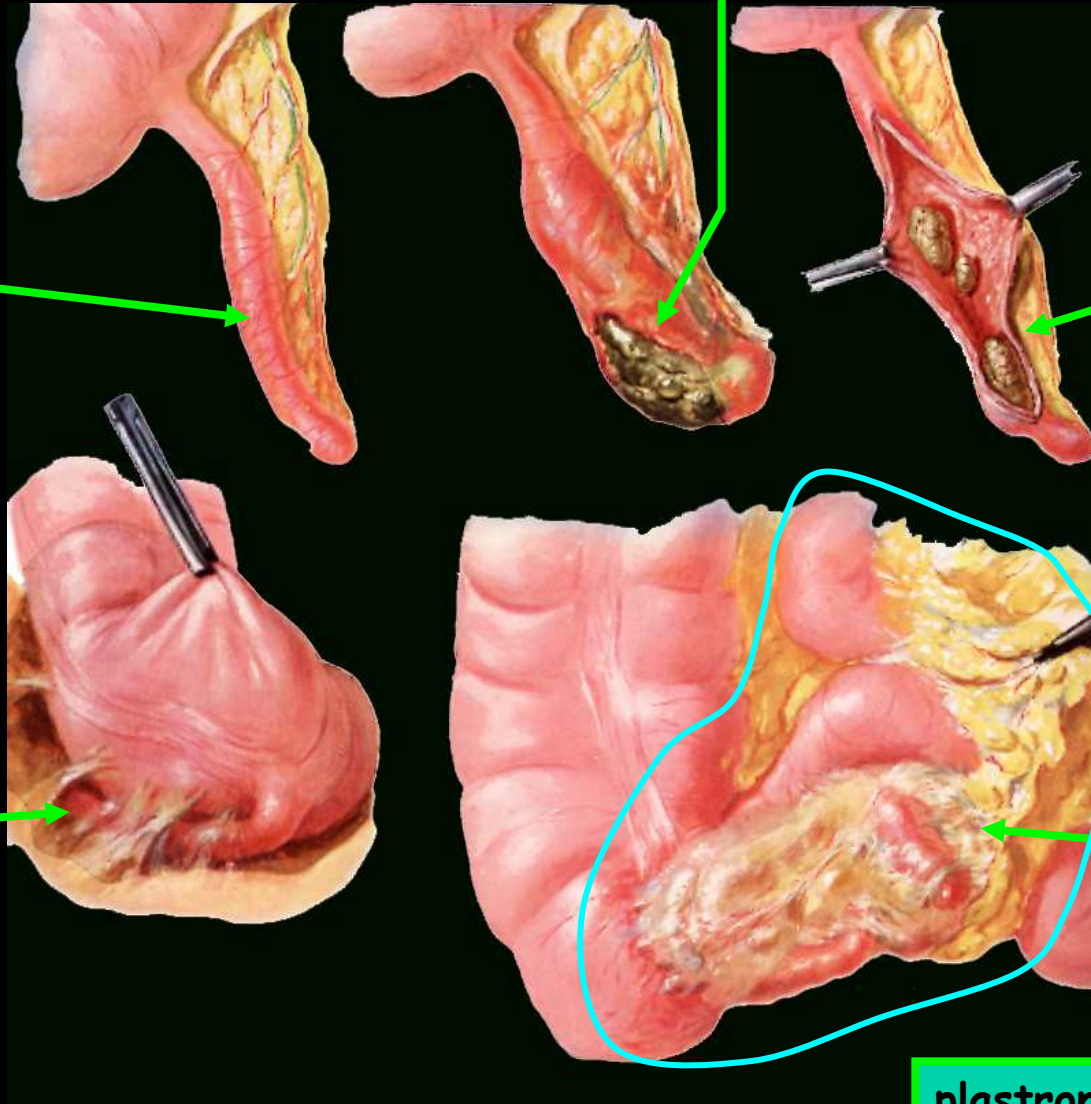


abcès appendiculaire rétro-caecal

appendicite
aiguë
catarrhale

appendicite
gangréneuse
(perforée)

appendicite
aiguë sur
stercolithes

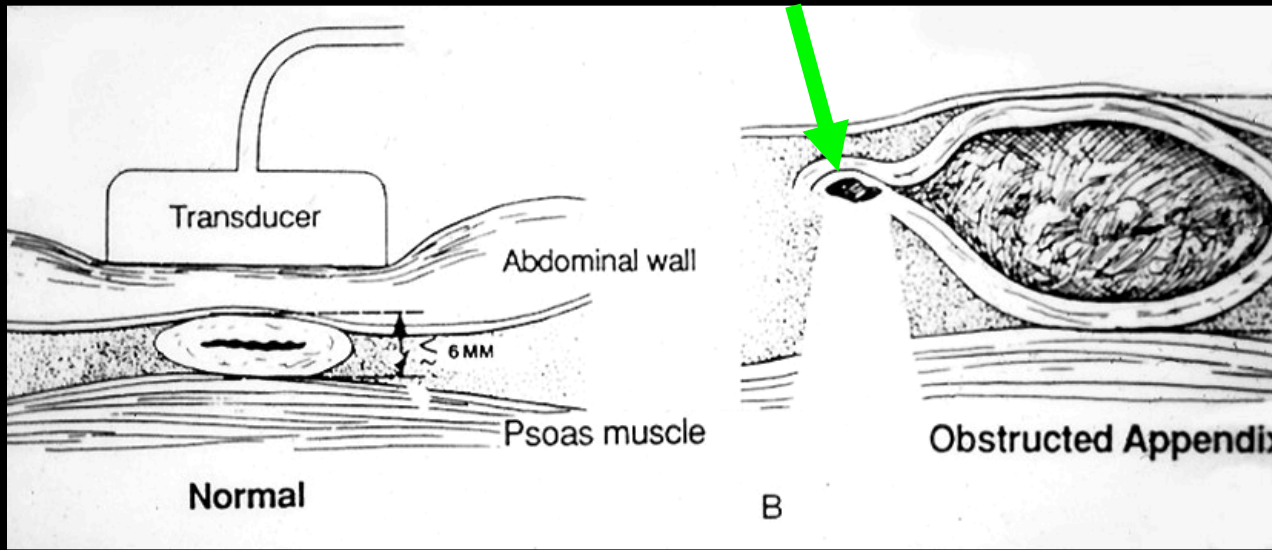


appendicite
aiguë rétro
coecale

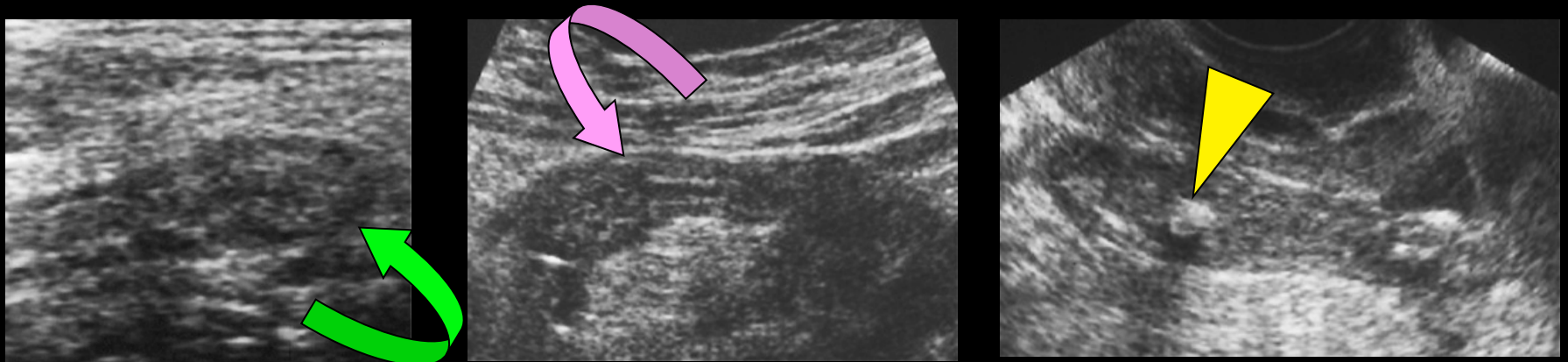
plastron ± abcès
appendiculaire

échographie de l'appendicite

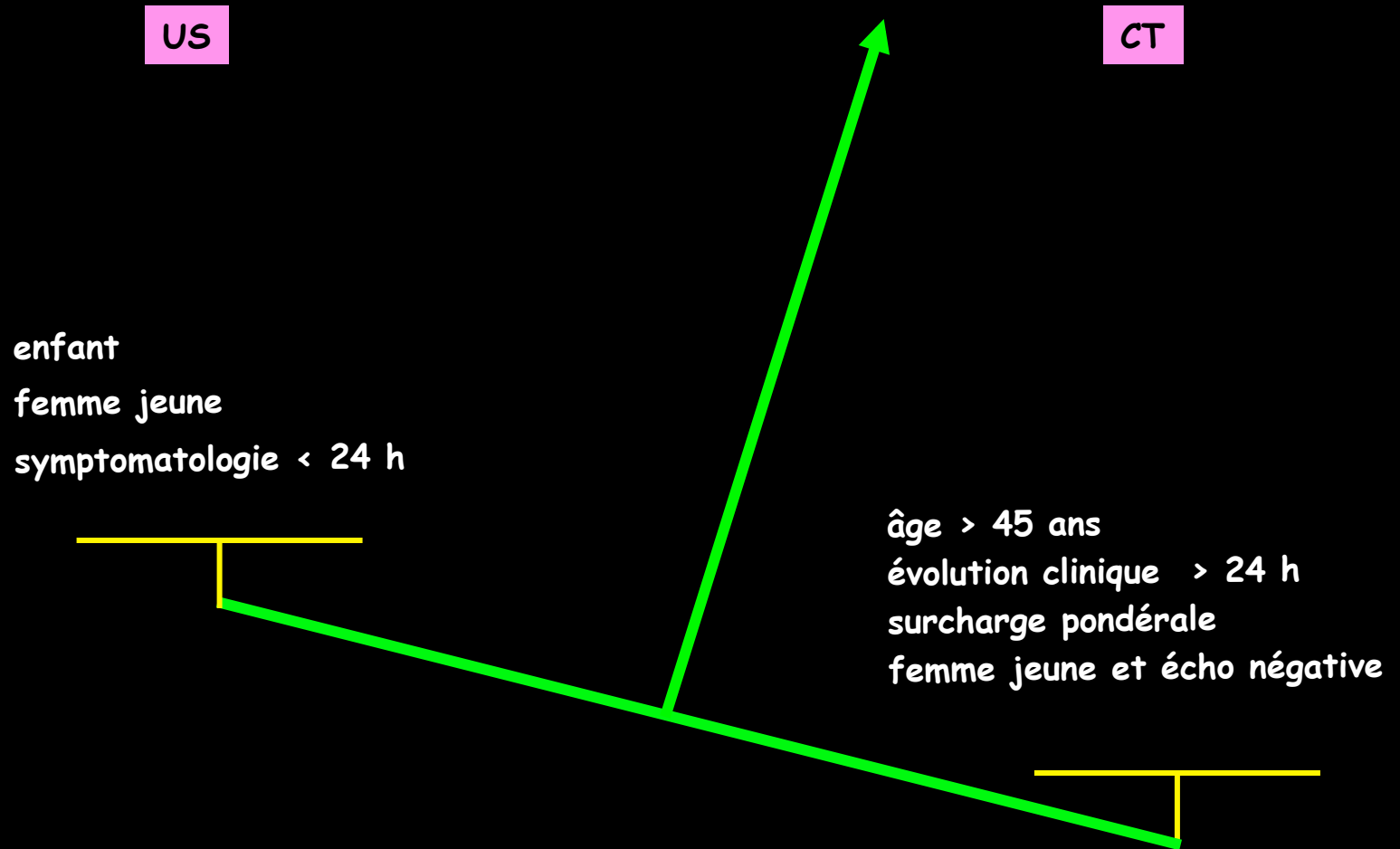
sonde de haute fréquence +++

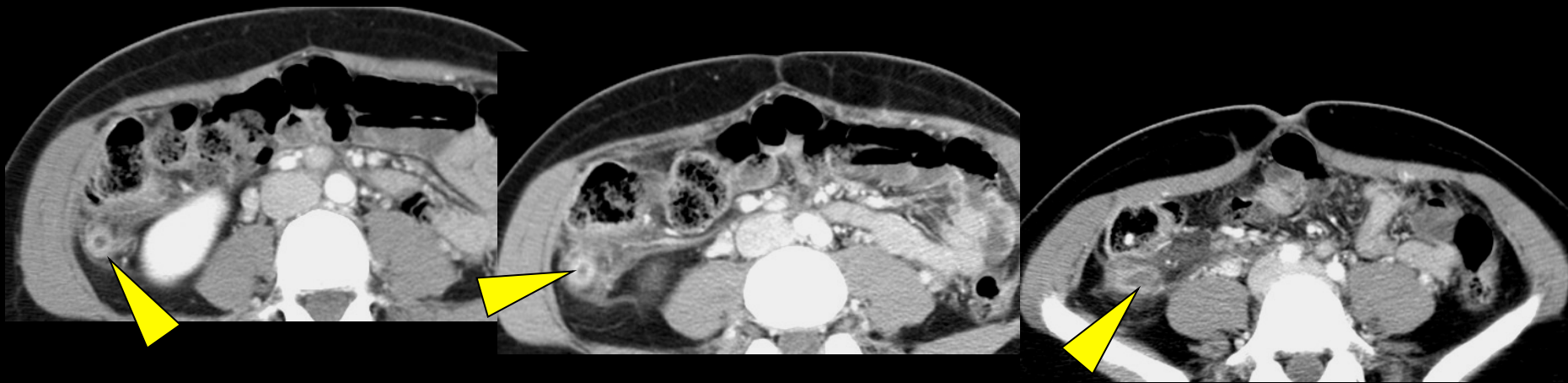


- appendice diamètre $> 6\text{mm}$; paroi $> 3\text{mm}$
- non compressible
- stercolithe

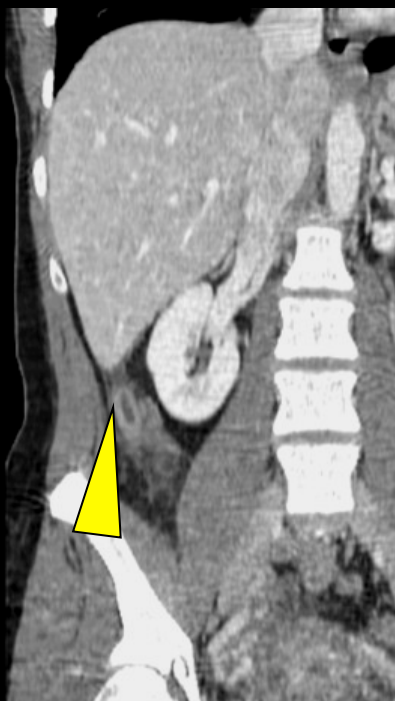


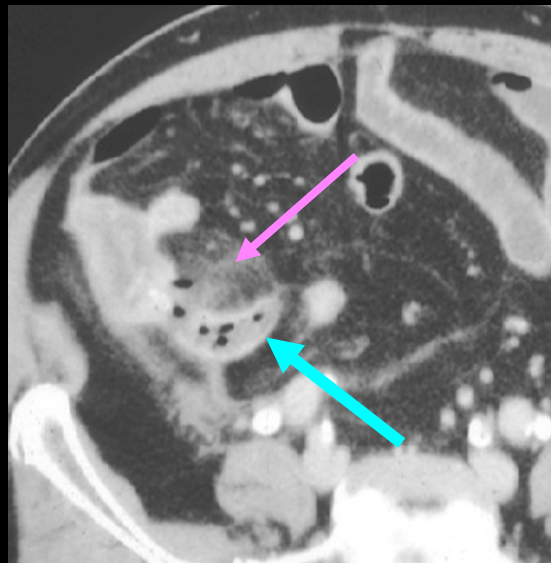
scanner de l'appendicite



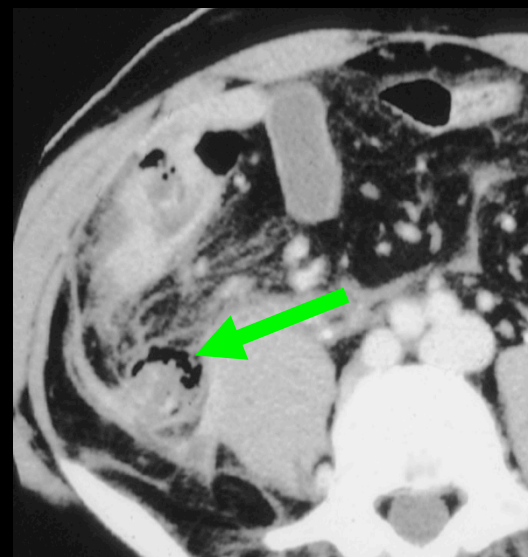
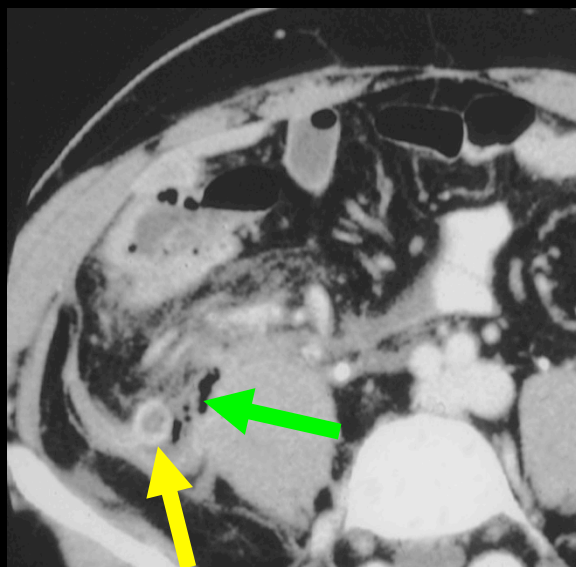
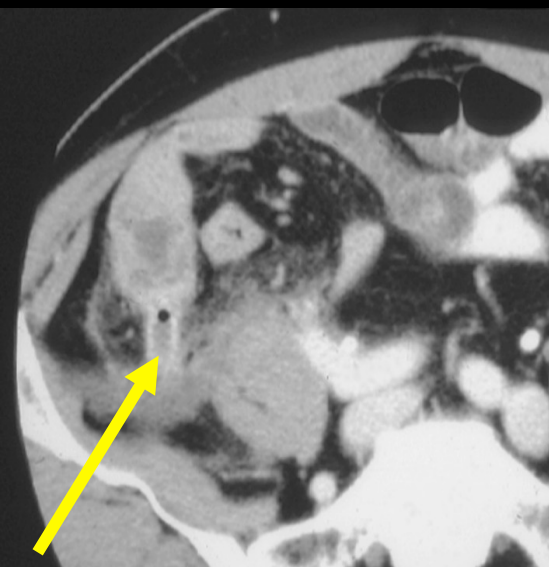


appendicite **rétro-caecale** , sous hépatique

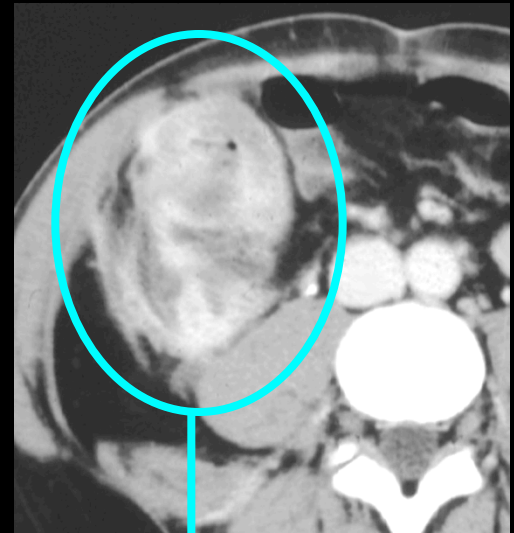
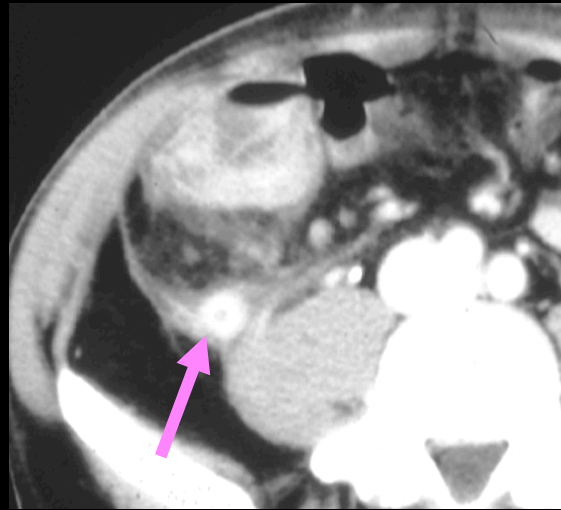
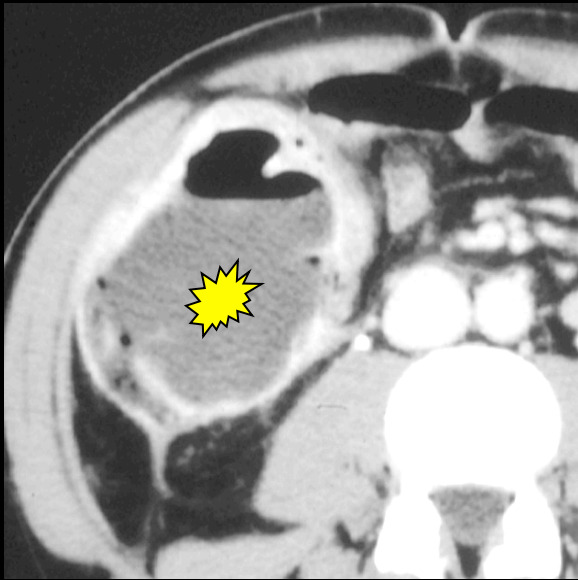




appendicite perforée



appendicite gangréneuse perforée rétro-caecale vue à J 3
diagnostic clinique de gastro-entérite !!!

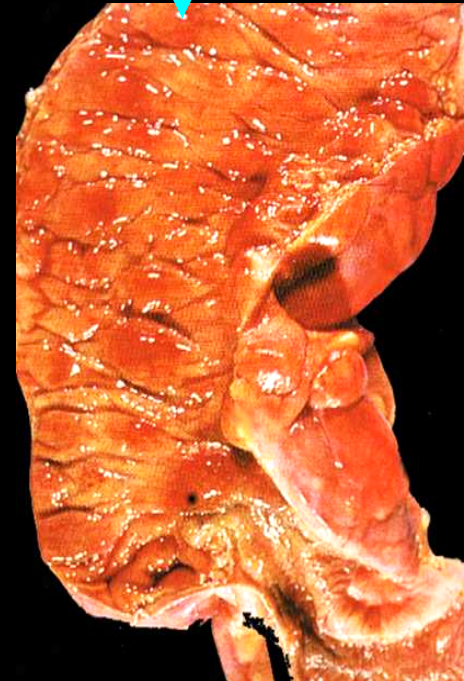


diagnostic

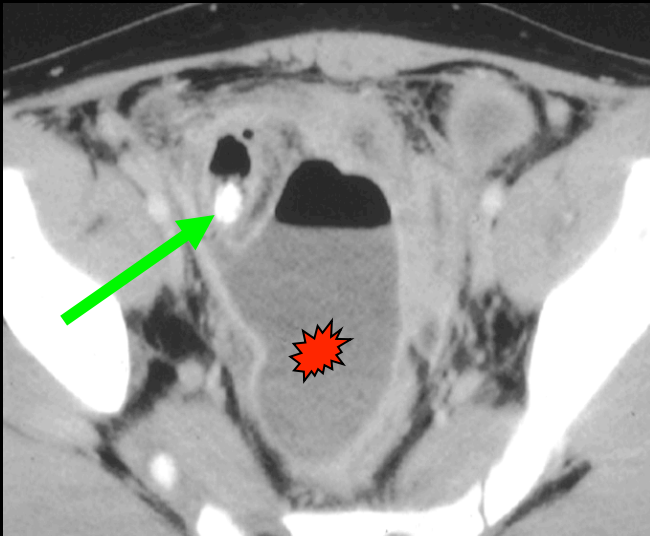


abcès sous-hépatique compliquant une
appendicite rétro caecale ; fièvre depuis
18 jours

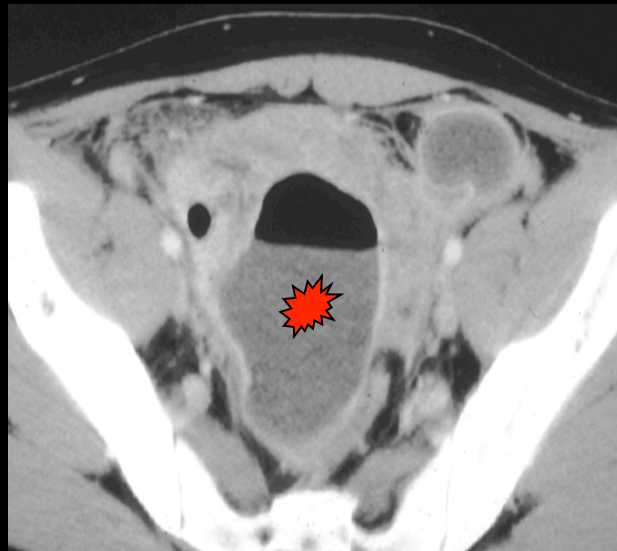
inflammation trans séreuse de la paroi
caecale accolée à l'abcès = "typhlite"
réactionnelle



diagnostic

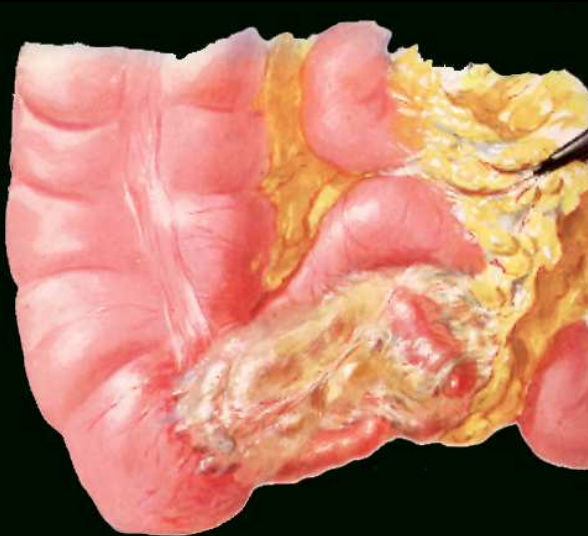
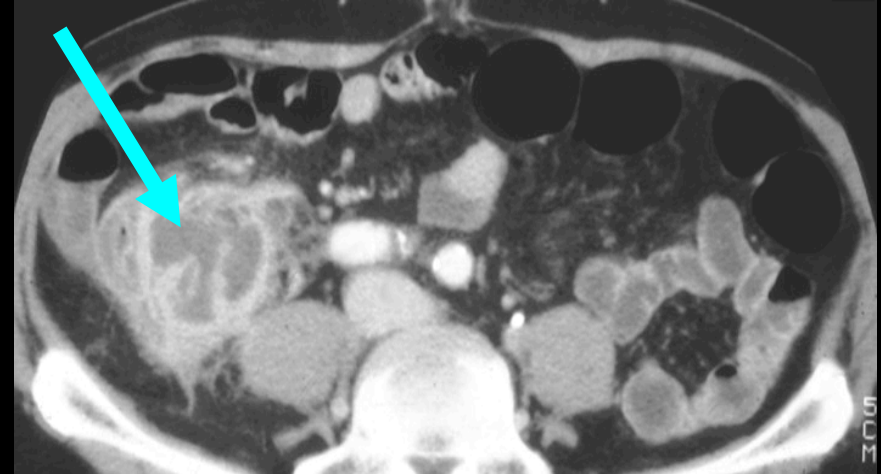
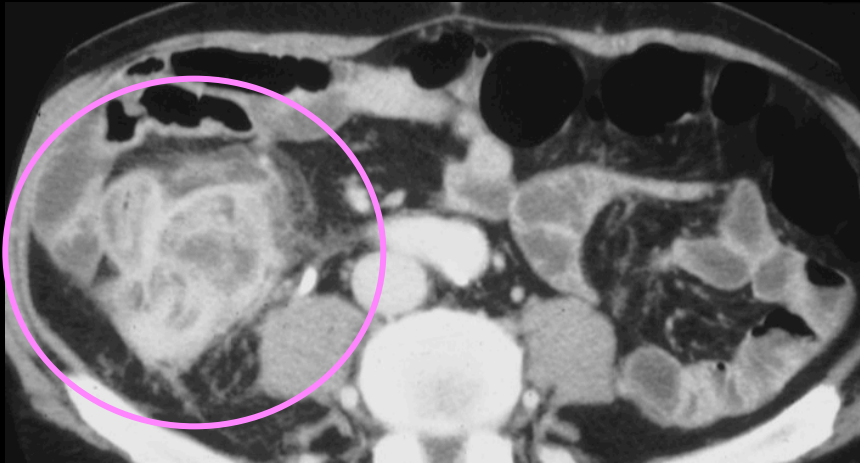


étudiant en médecine, soigné par son père, médecin, depuis 3 jours pour gastro-entérite...



abcès appendiculaire pelvien

diagnostic

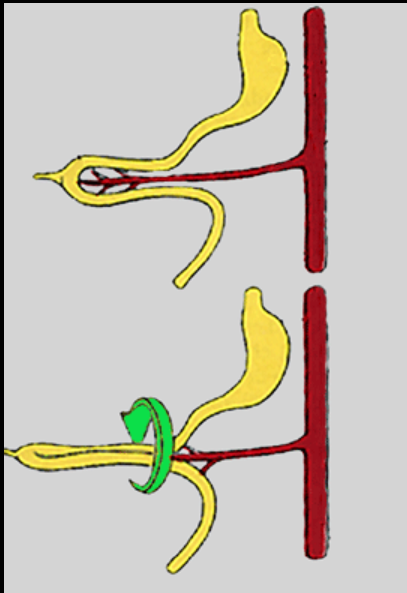


plastron appendiculaire abcédé; tableau clinique évoluant depuis plusieurs jours

- pas d'intervention chirurgicale ;
- drainage de l'abcès s'il est de taille suffisante et traitement médical (antibiotiques, antalgiques, glace sur le ventre . . .)
- appendicectomie différée (6 semaines à 2 mois)

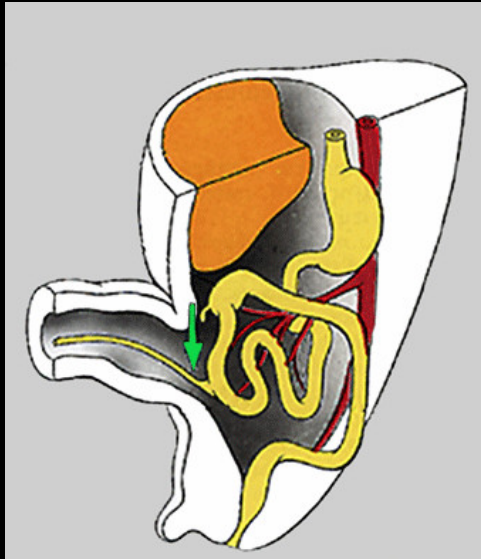
Les appendicites ectopiques

- les défauts d'accolement du péritoine et les malrotations de l'anse intestinale primitive sont les principales causes des appendicites ectopique



3

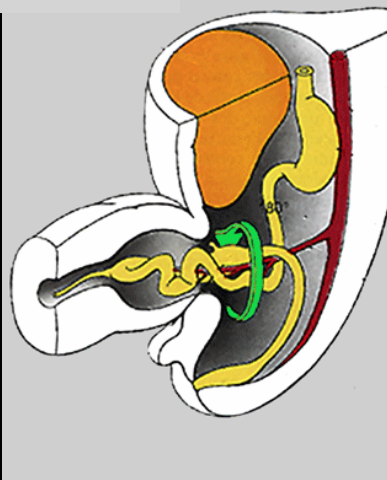
180°



1

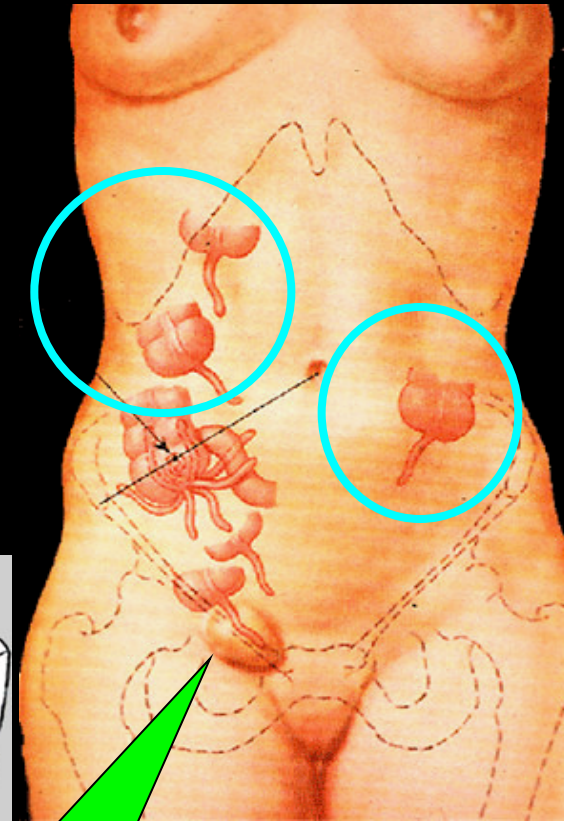
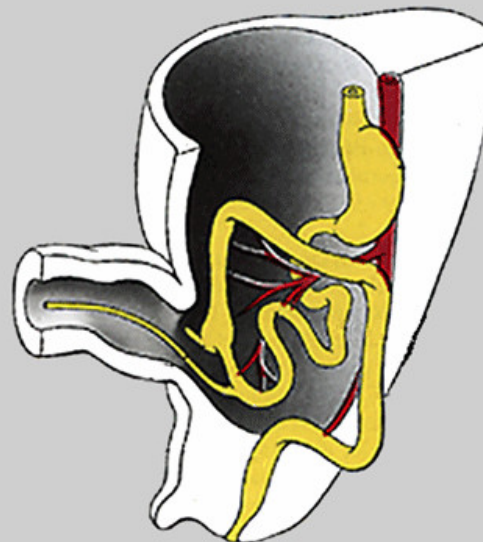
2

90°

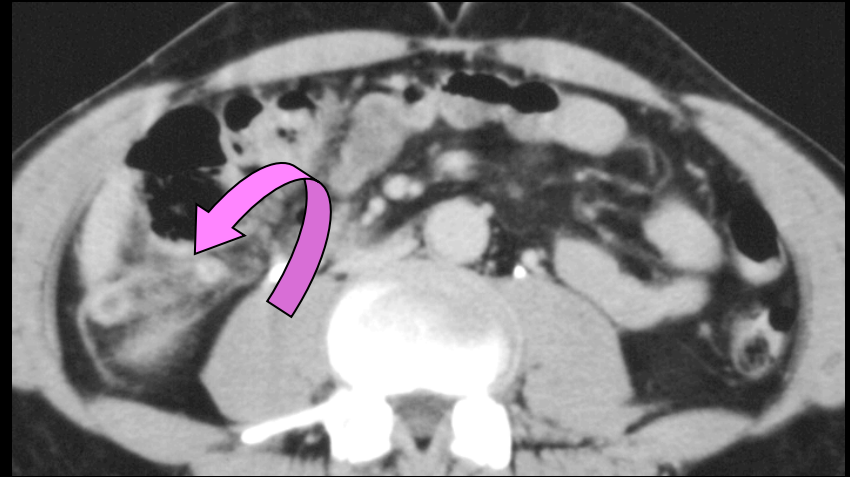


4

270°

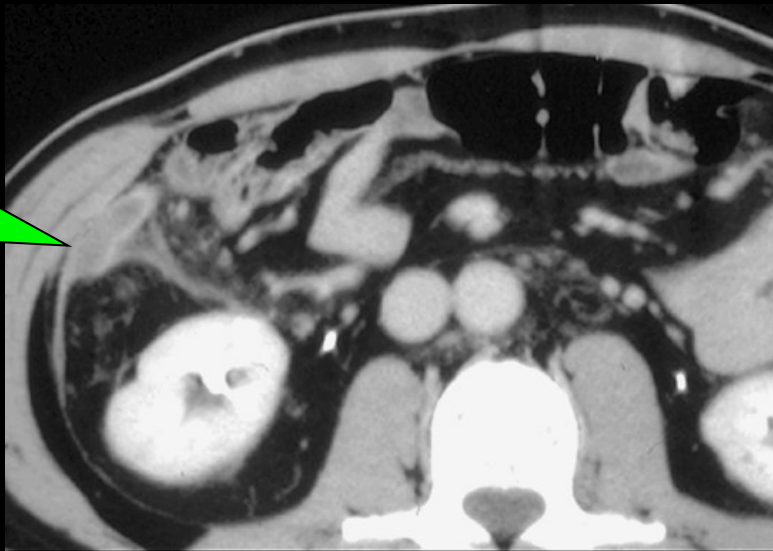
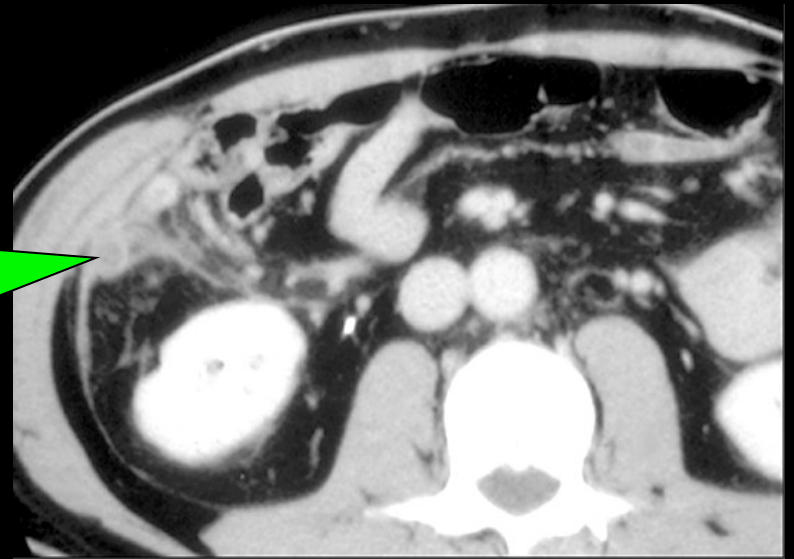
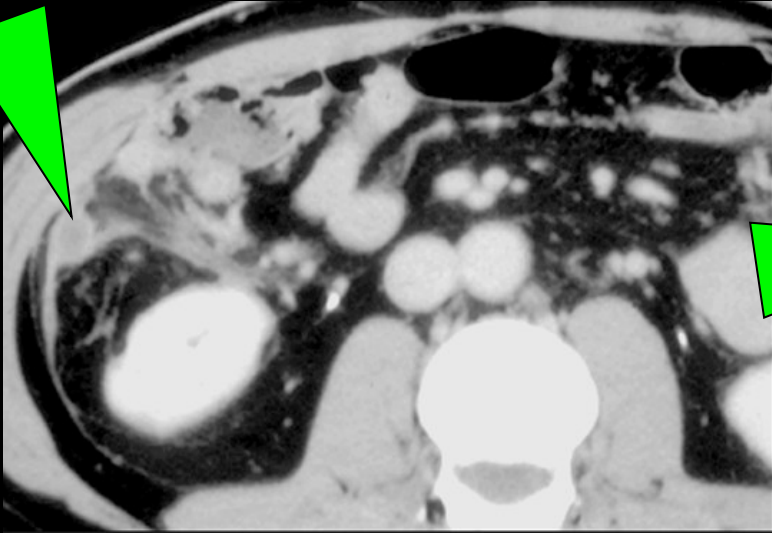


diagnostic



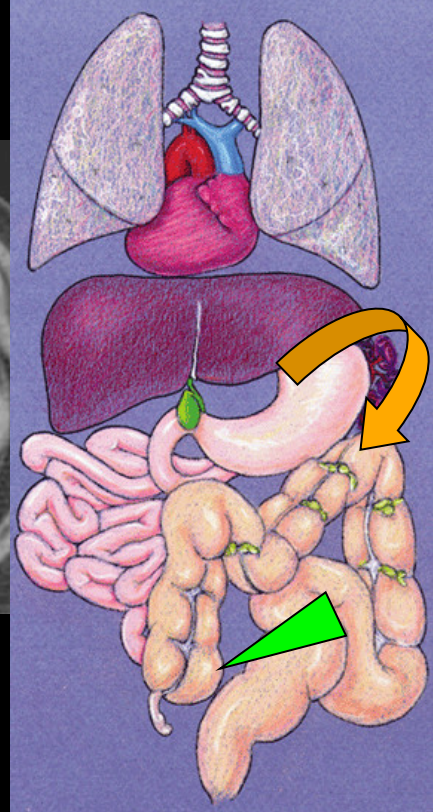
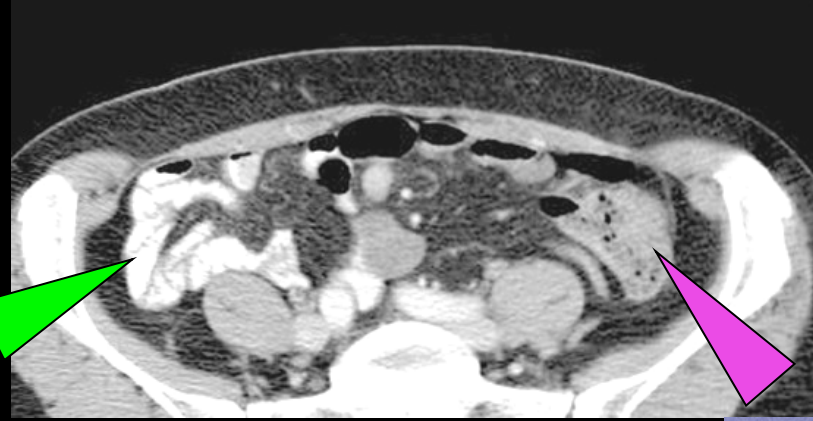
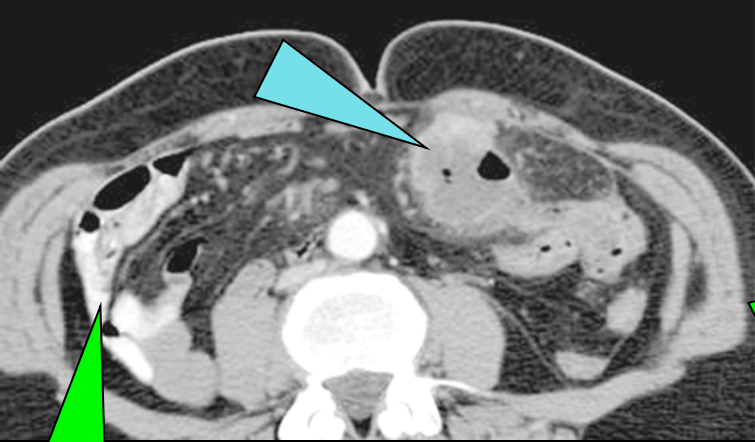
appendicite sous-hépatique
rétro-colique

diagnostic



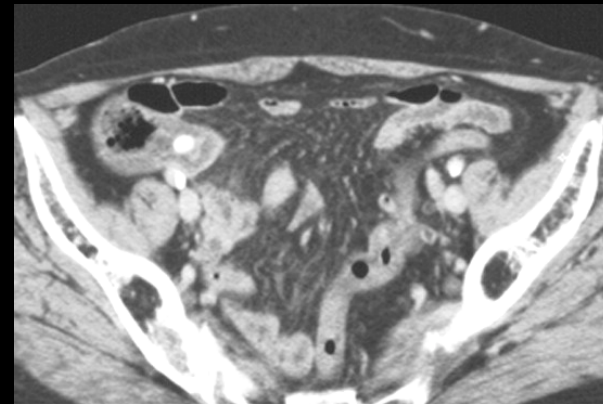
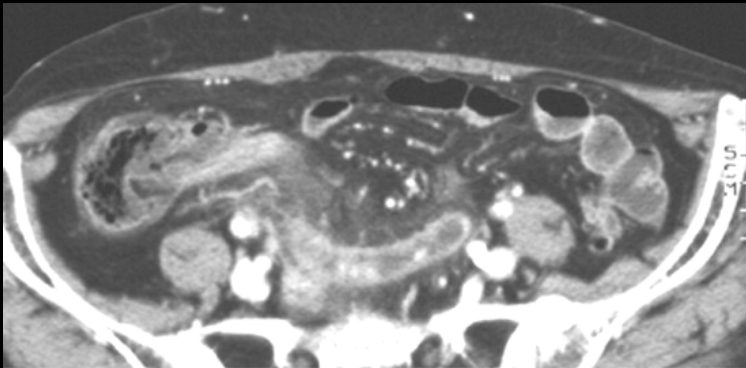
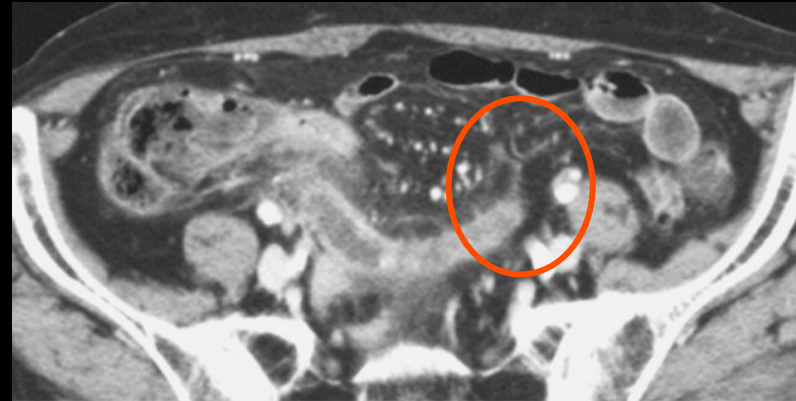
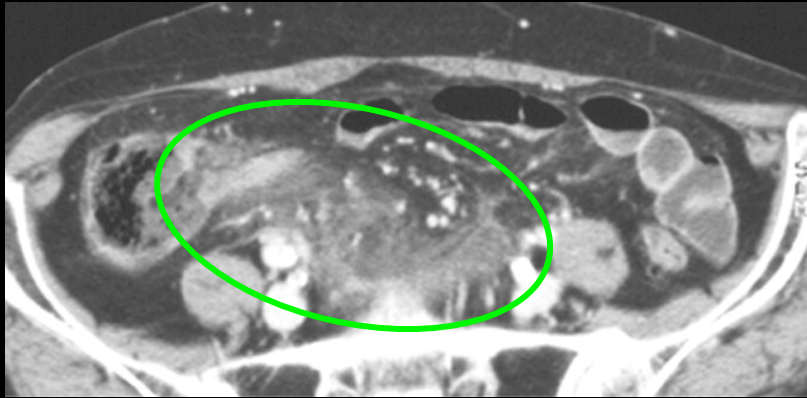
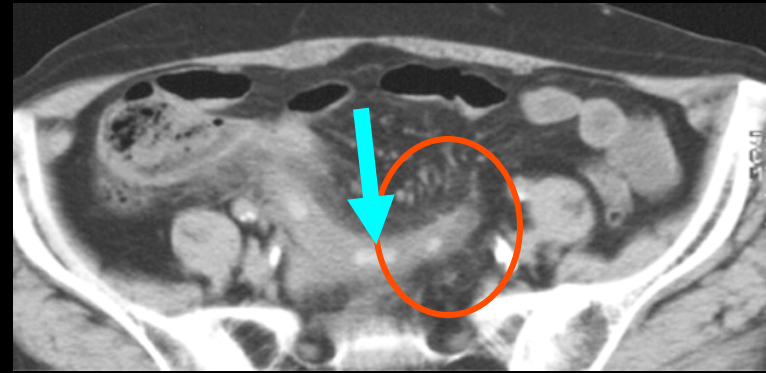
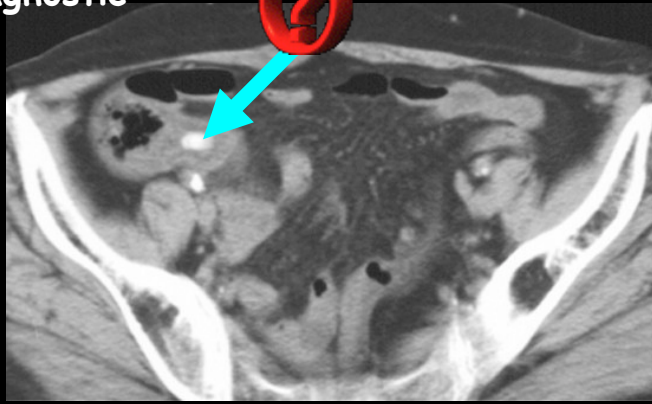
appendicite
sous-hépatique
pré-colique

diagnostic

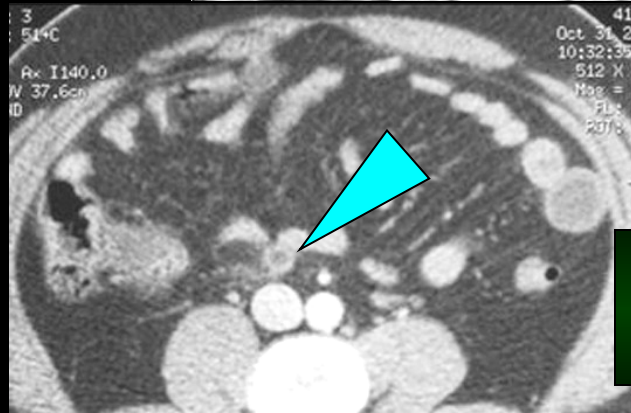
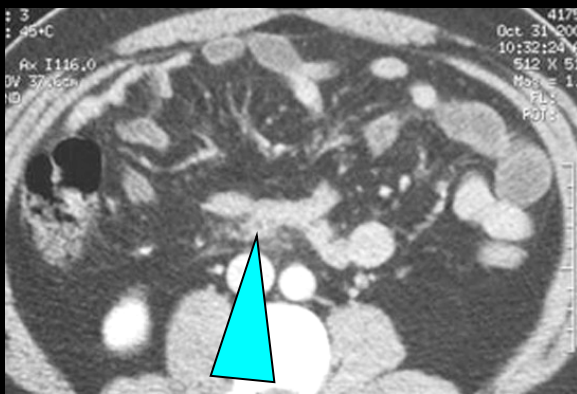
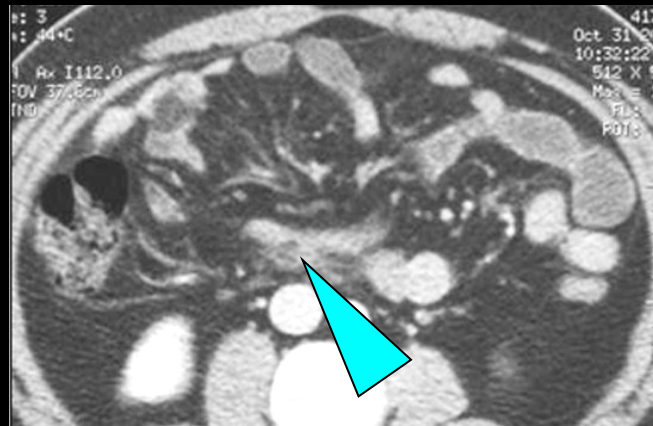


cæcum ectopique : appendicite méso-coélique sur
mésentère commun

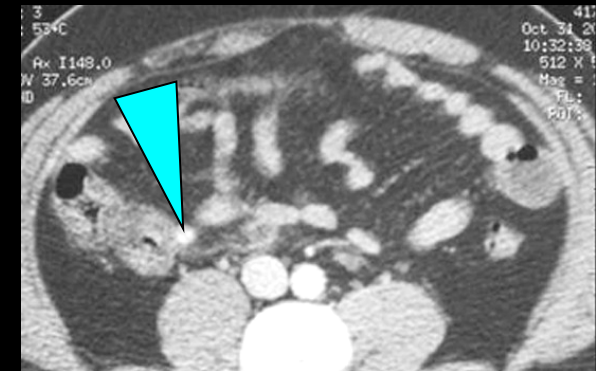
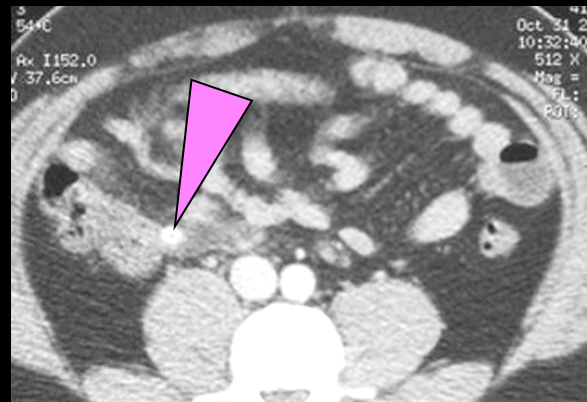
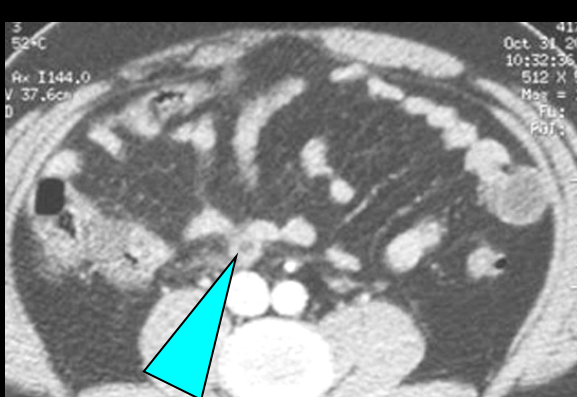
diagnostic



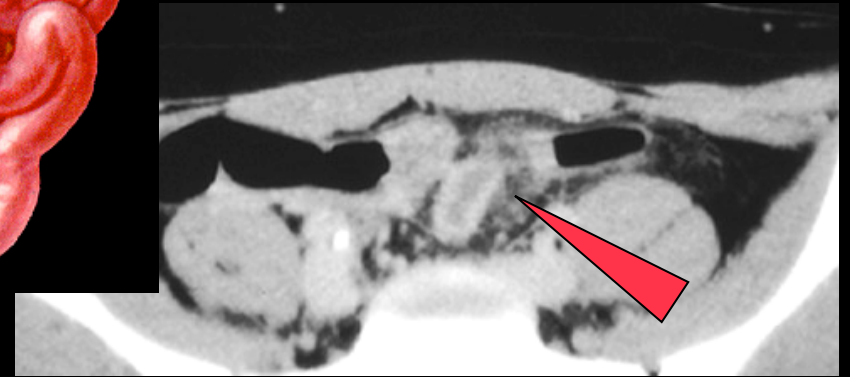
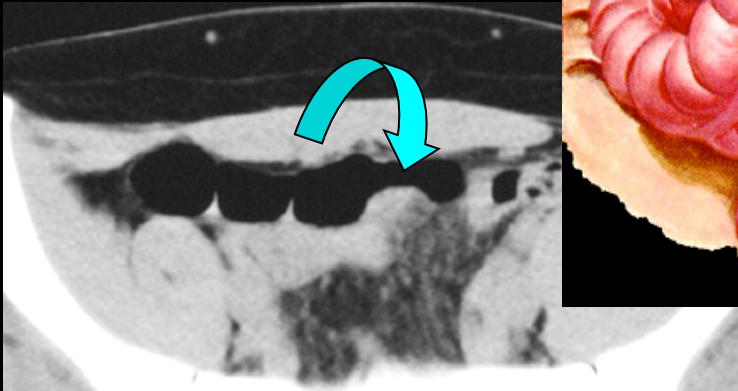
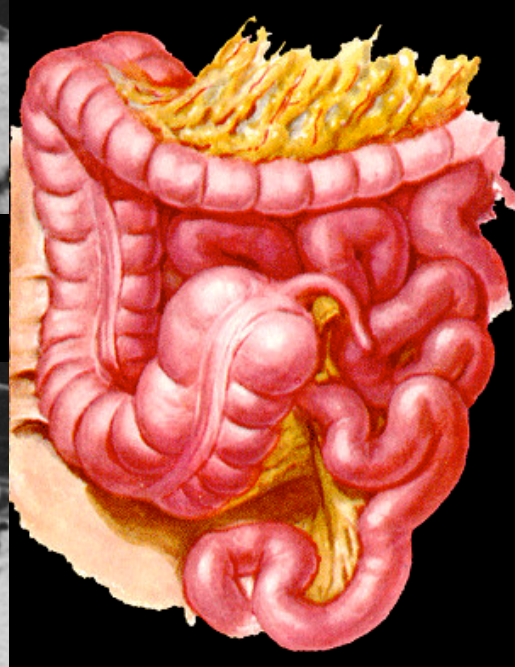
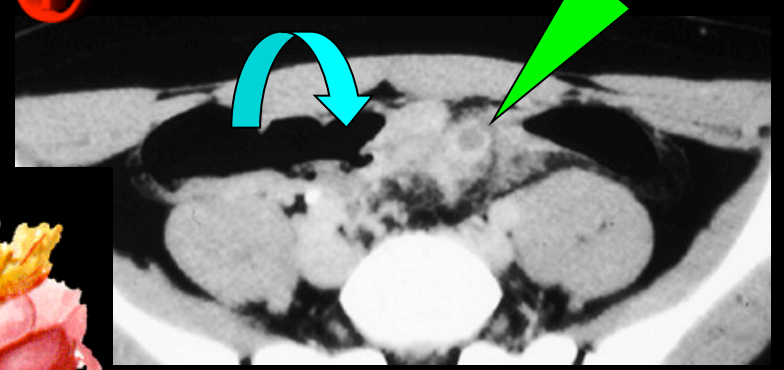
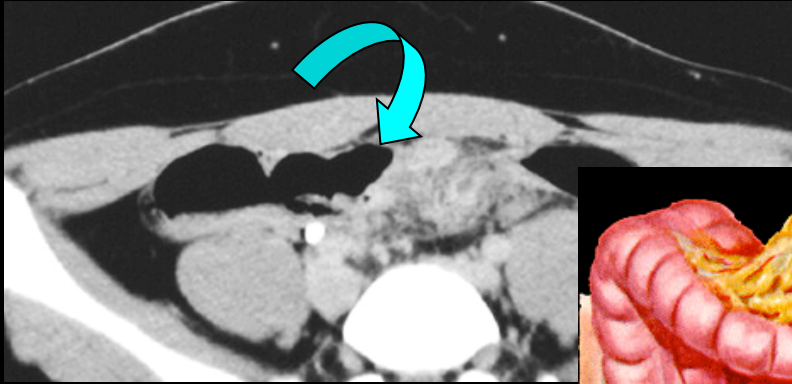
cæcum orthotopique : appendicite méso-cœliaque sur **appendice très long**



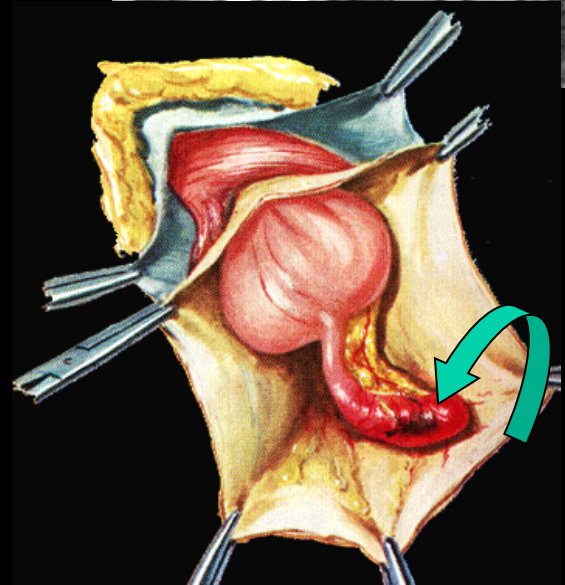
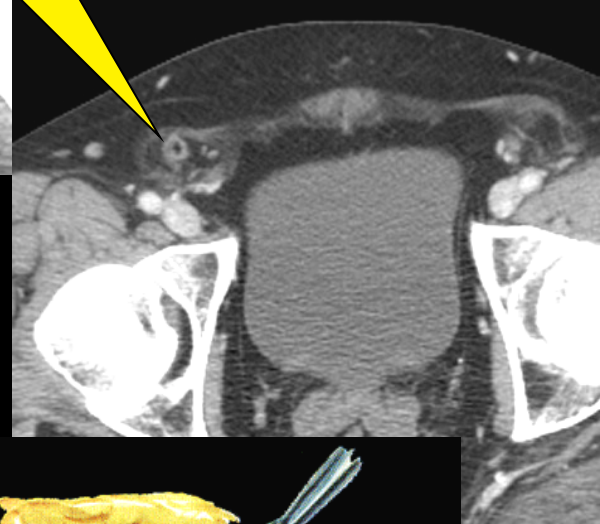
**cæcum orthotopique :
appendicite méso-cœliaque sur
appendice long**



diagnostic

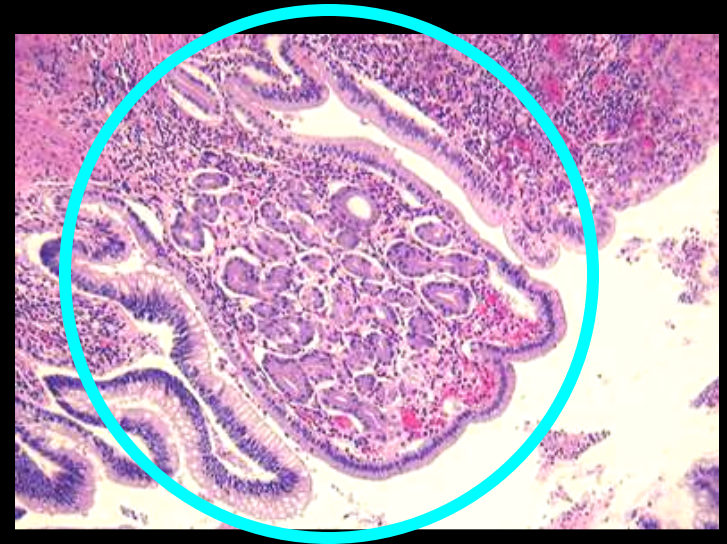
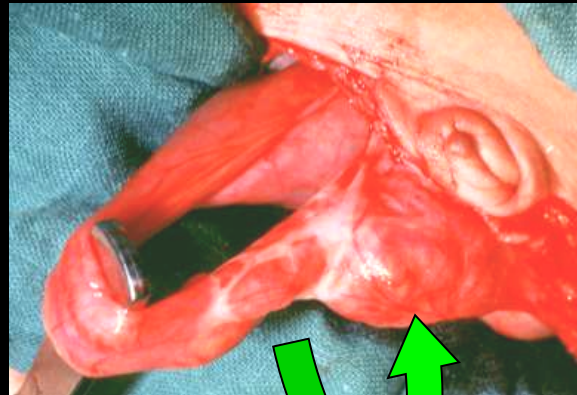
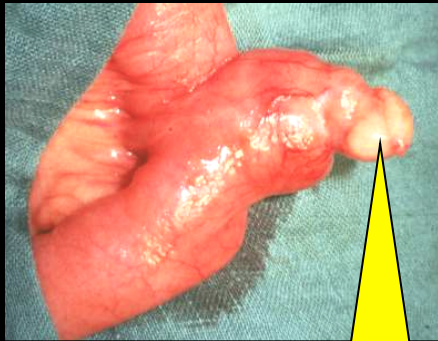
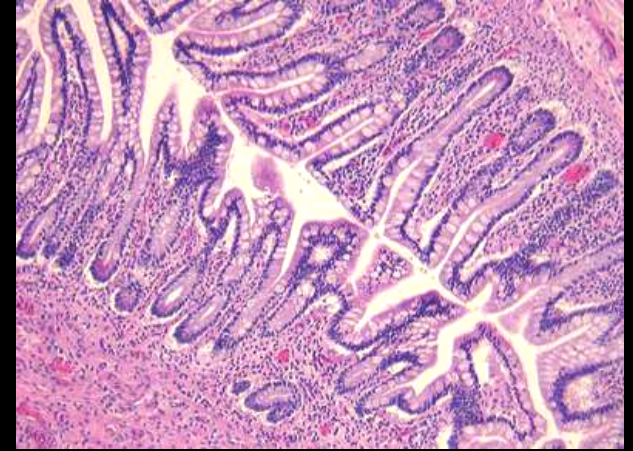
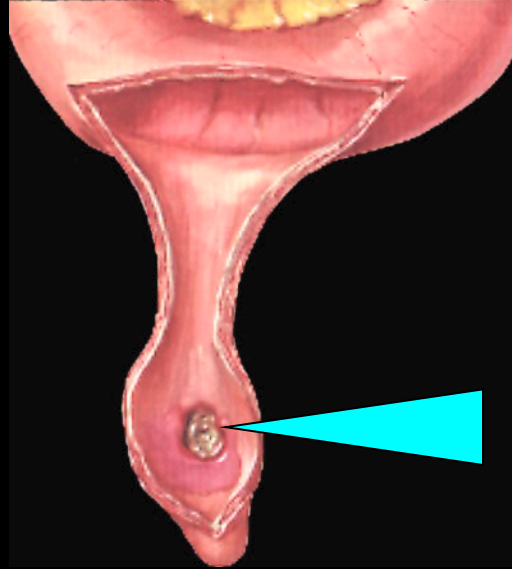


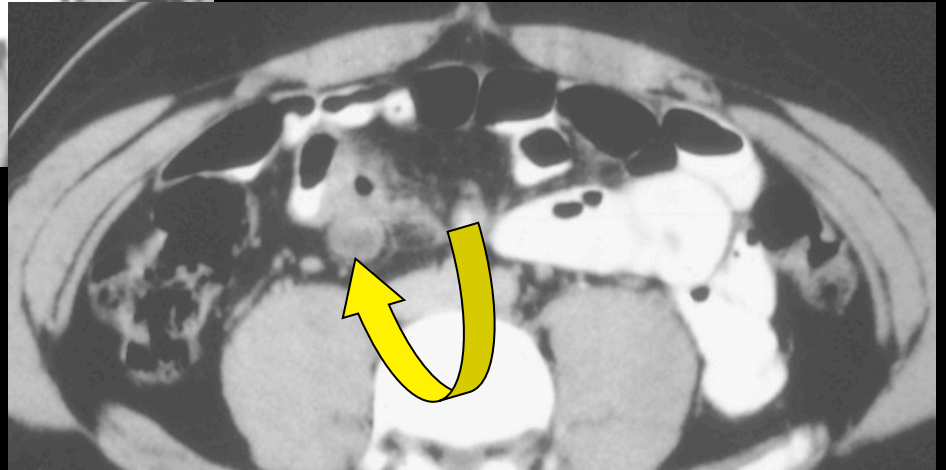
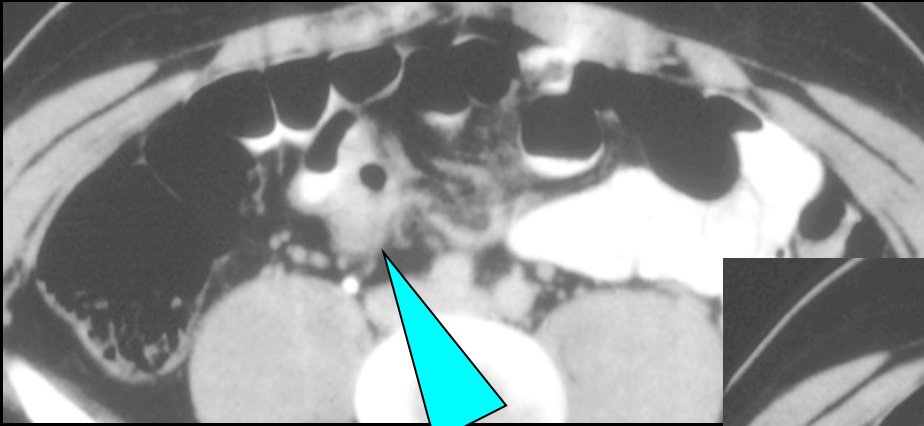
cæcum ectopique : appendicite méso-coeliaque sur défaut d'accolement du fascia de Toldt droit (cæcum mobile)



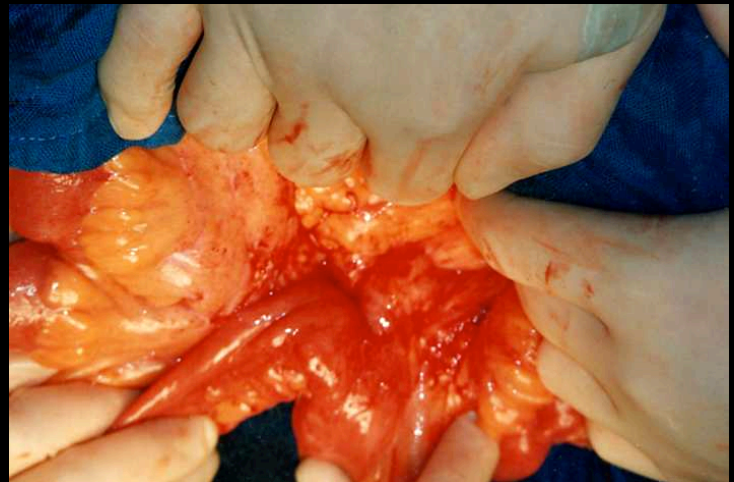
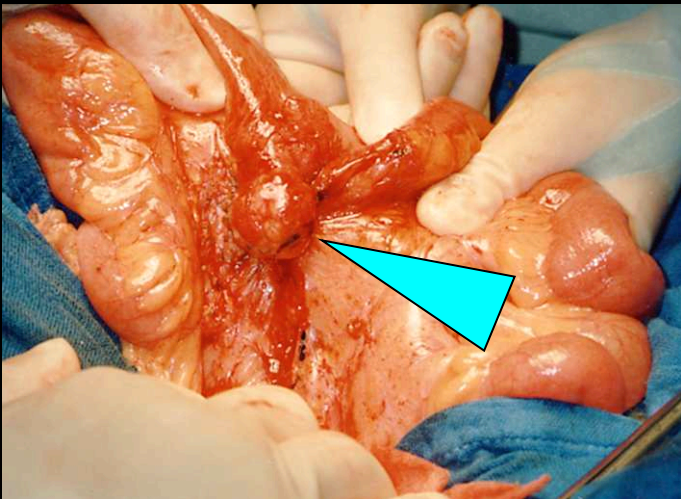
appendicite herniaire (hernie de Claudius Amyand)

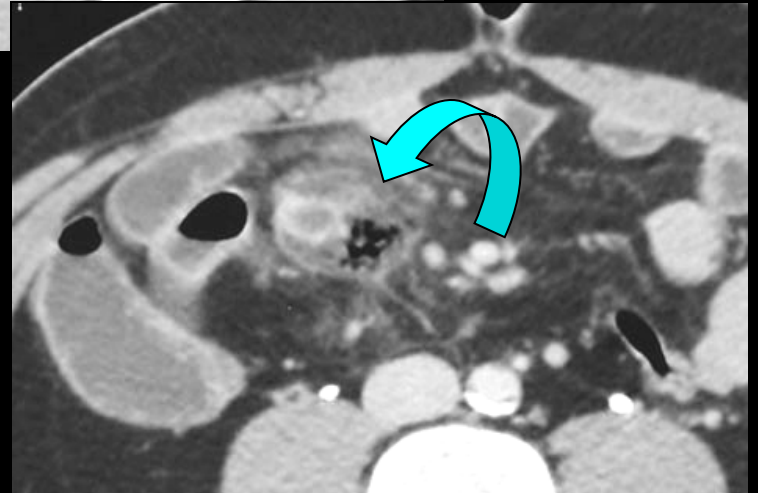
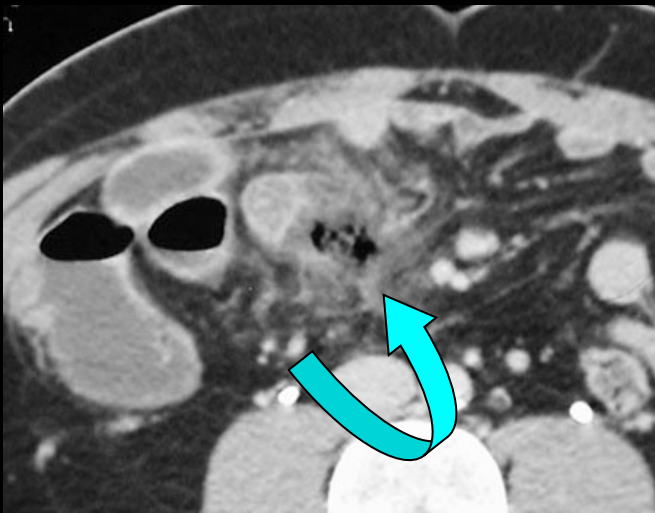
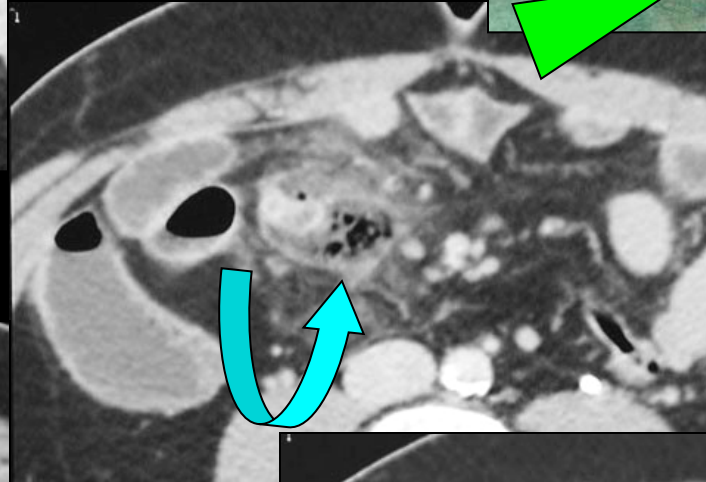
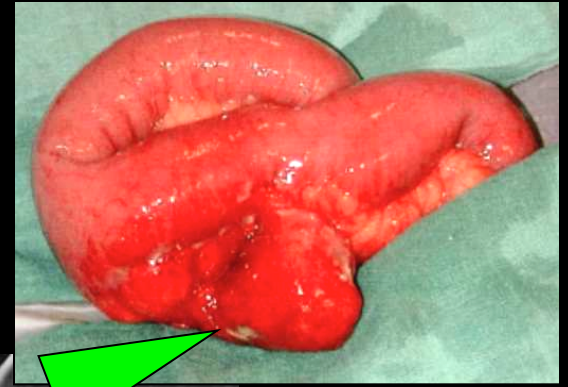
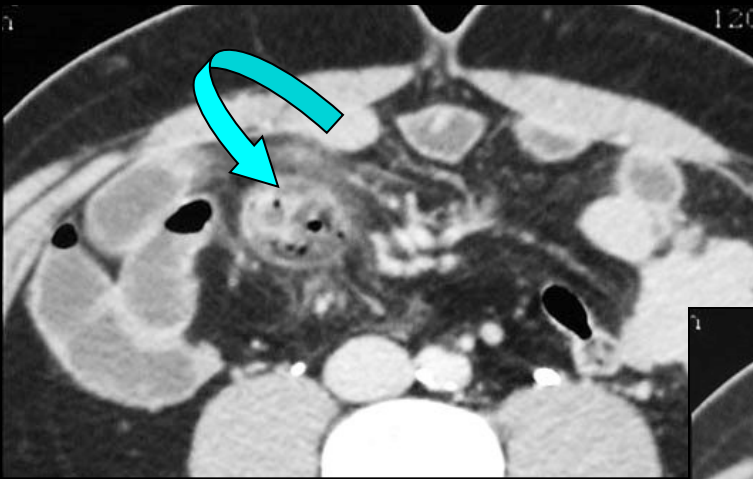
complications du diverticule de Meckel





"diverticulite" de Meckel



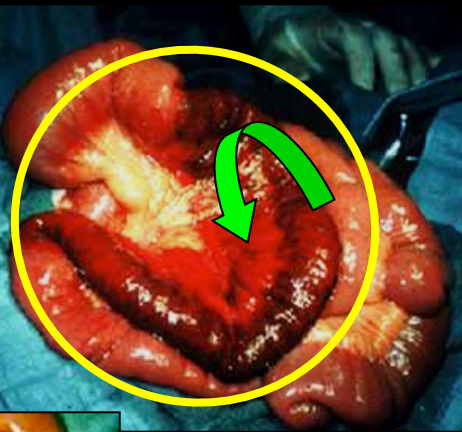


diverticulite de Meckel

les ischémies intestino-mésentériques

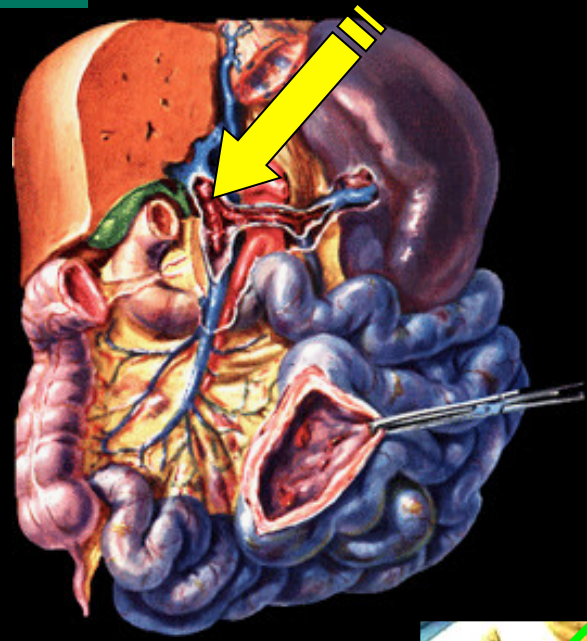


ischémie artérielle
aiguë

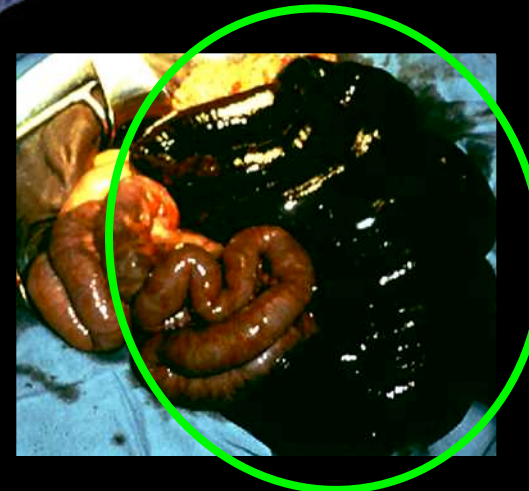


entéro-colite
hémorragique

80% des ischémies intestino-mésentériques
résection chirurgicale d'urgence
lorsqu'elle est possible



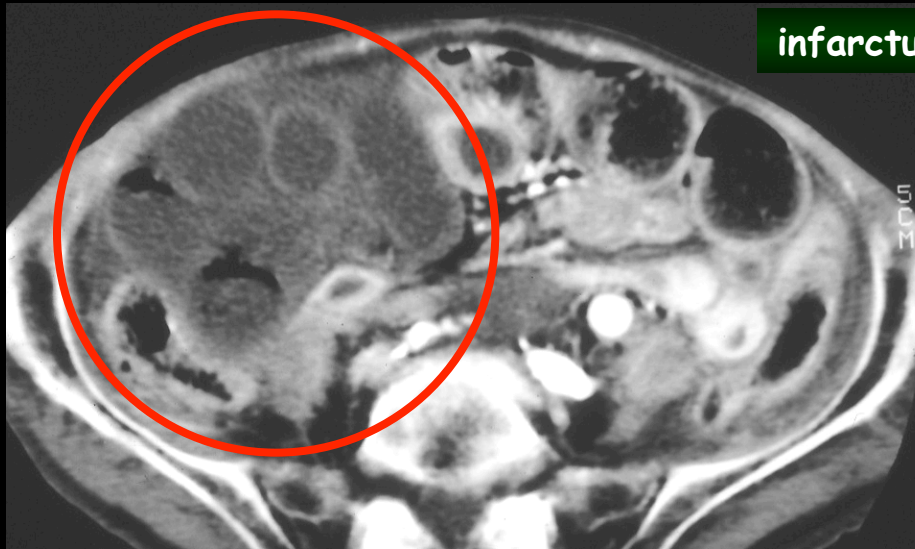
ischémie veineuse
aiguë



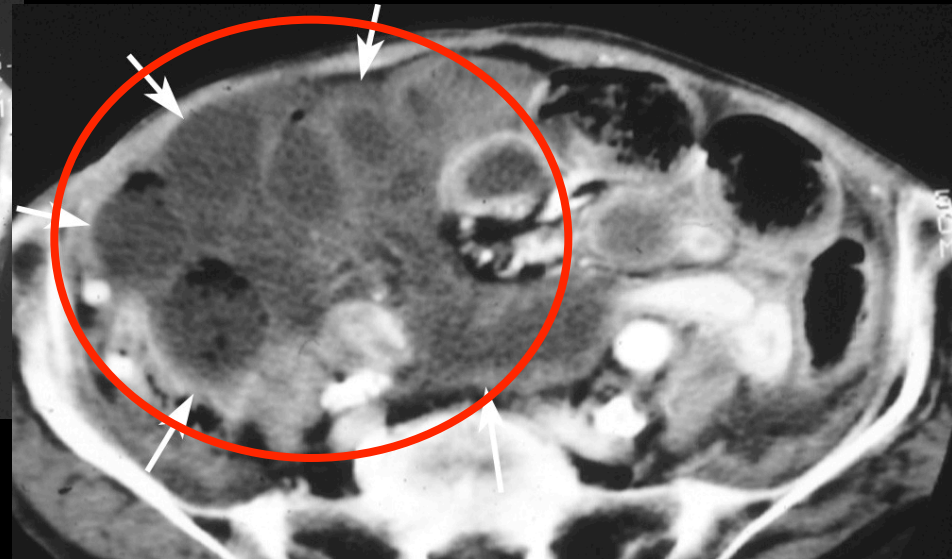
20% des ischémies intestino-mésentériques
80% de bons résultats sous traitement
anticoagulant

infarctus transmural : 2 signes majeurs

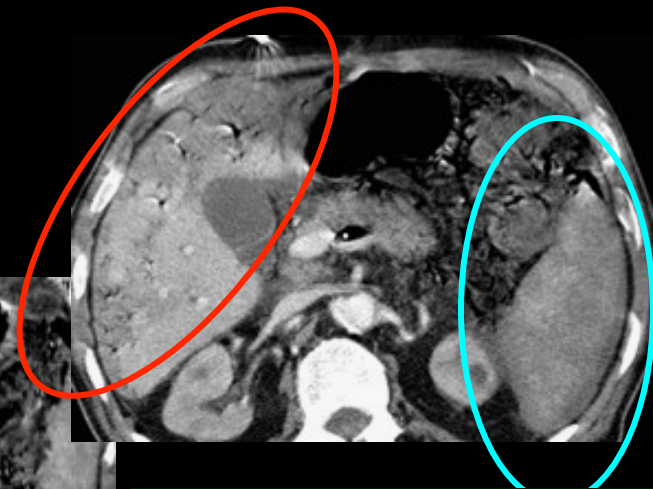
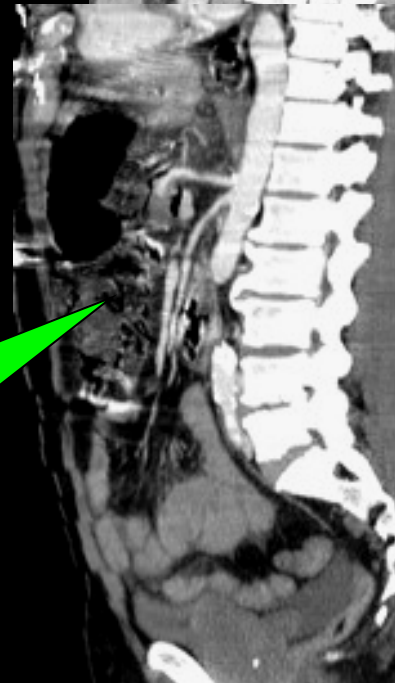
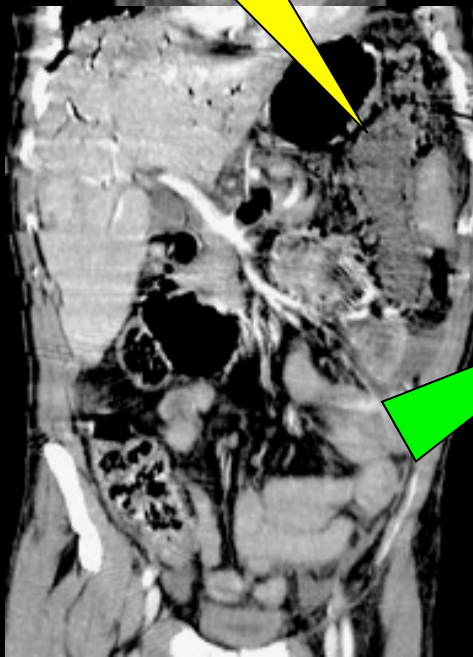
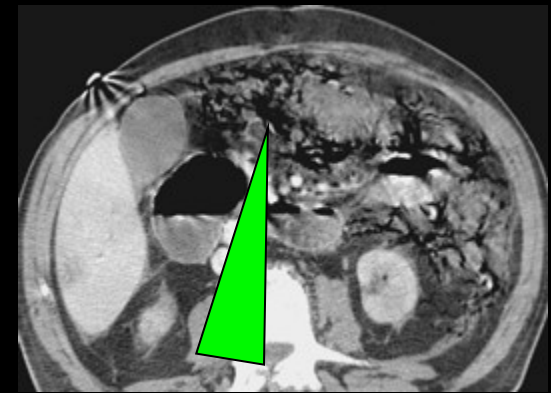
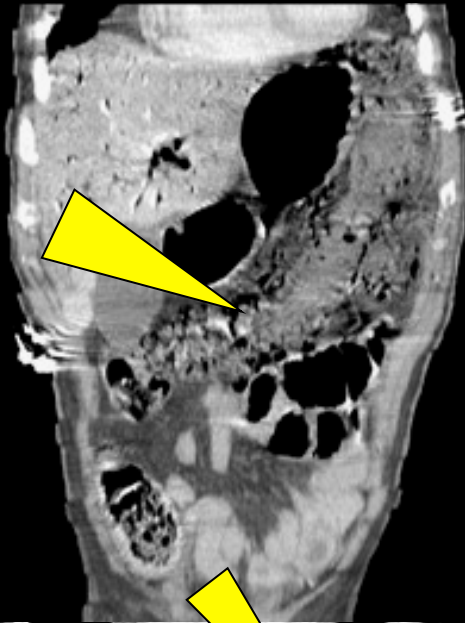
- . paroi amincie
- . défaut de rehaussement persistant+++
= paroi « virtuelle »



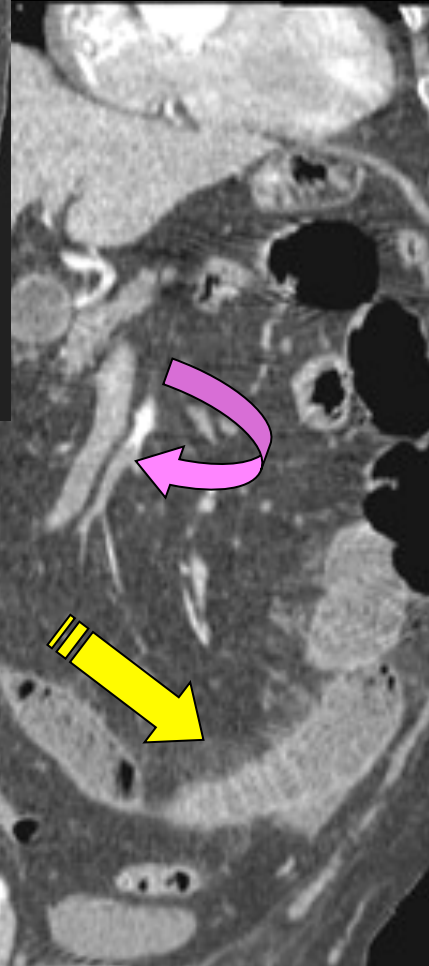
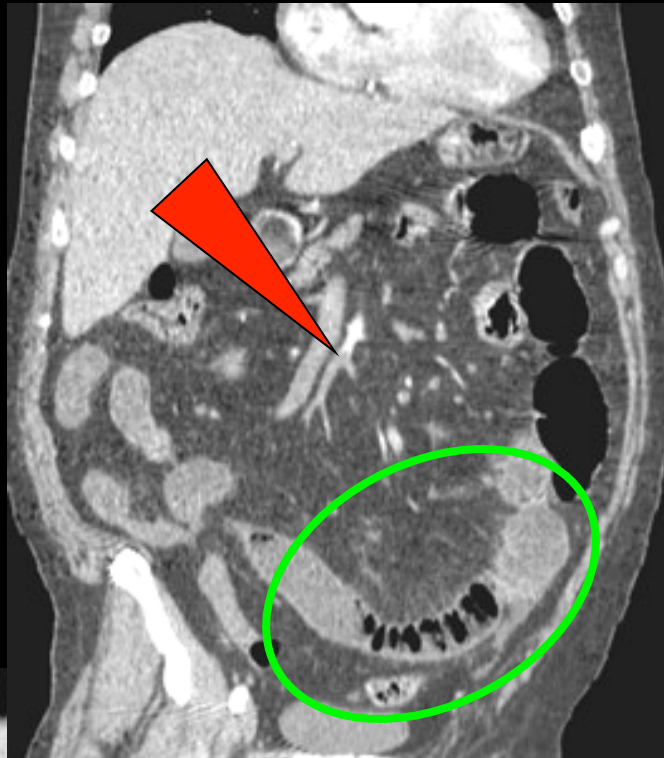
infarctus massif du territoire de l'AMS



NB: pas ou peu d'épanchement liquidien péritonéal , sauf si perforation intestinale

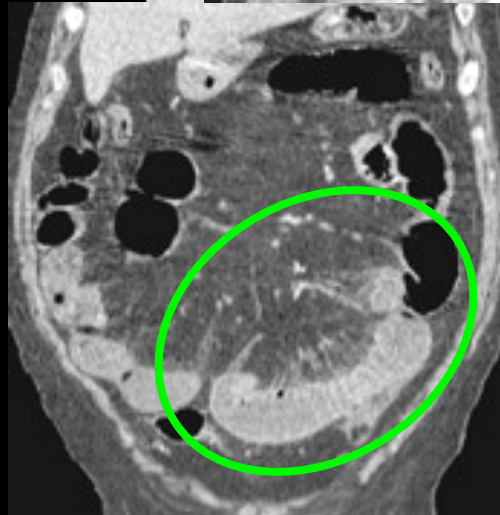


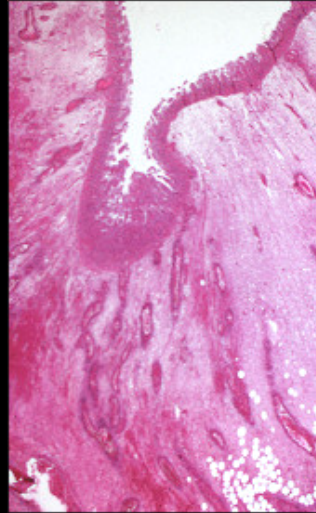
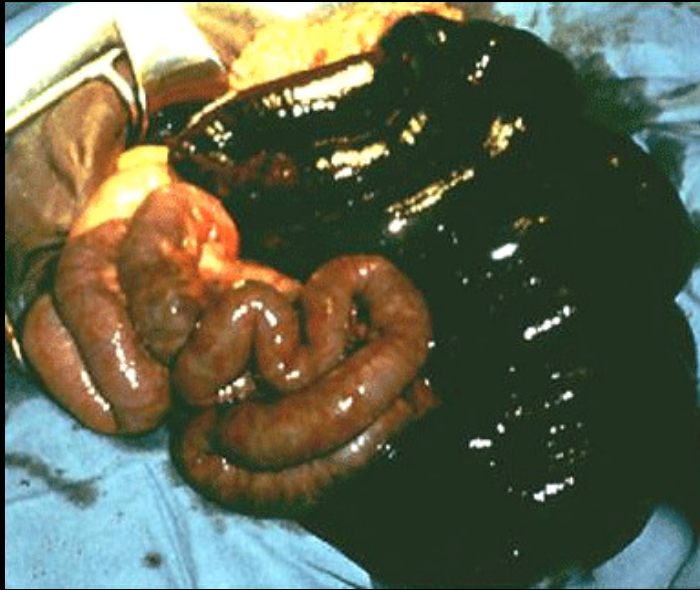
pneumatose pariétale
colique étendue et
aéroportie ; infarctus
hépatique et splénique
bas débit circulatoire



embolie de l'AMS

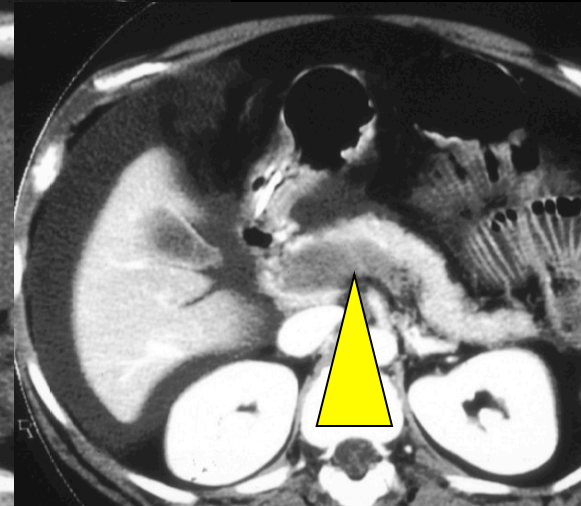
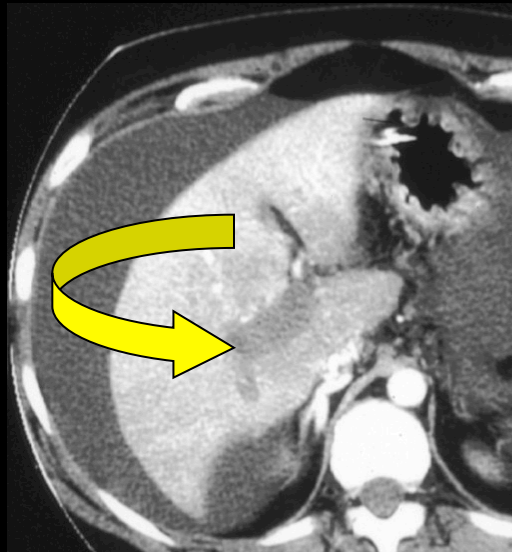
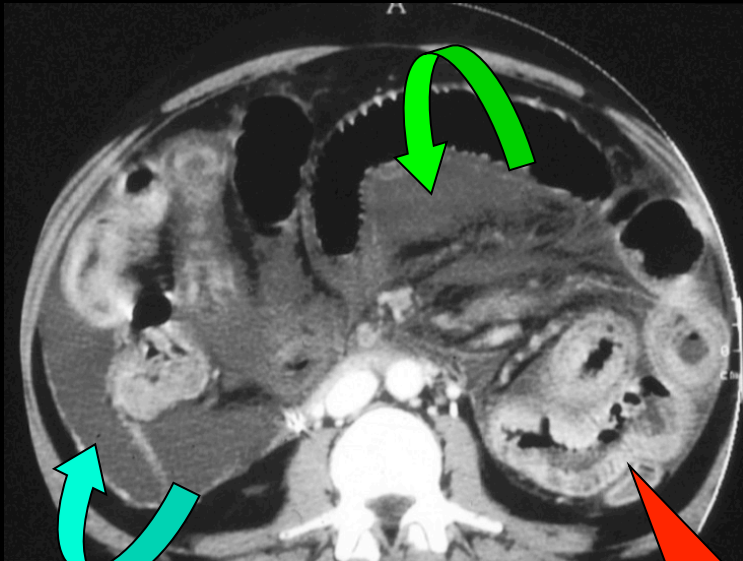
TACFA en cours de régularisation ; embolie de l'artère mésentérique supérieure





- . étendue des remaniements pariétaux
- . congestion du mésentère

- . épanchement liquidien péritonéal abondant
- . thrombose tronculaire de l'axe veineux mésentérique ± portal



des occlusions intestinales



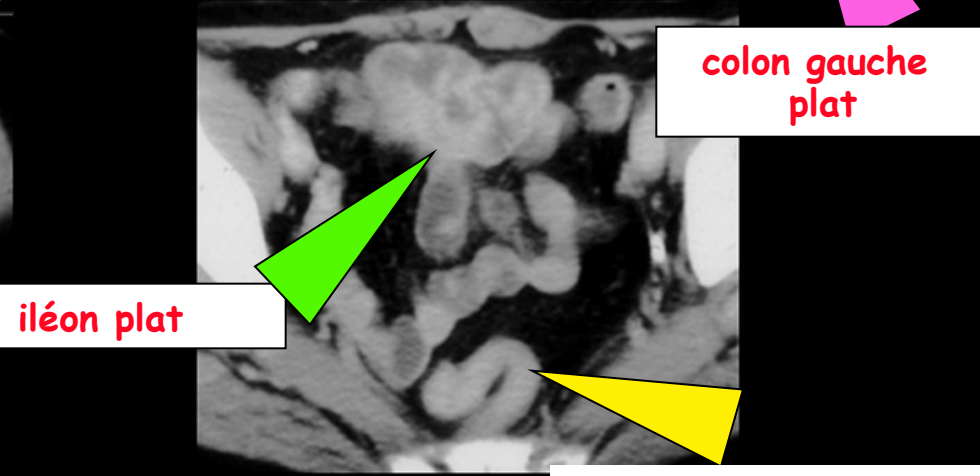
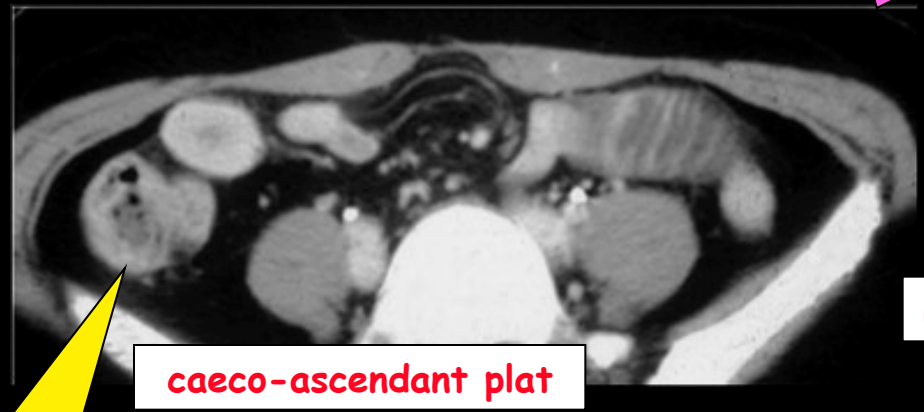
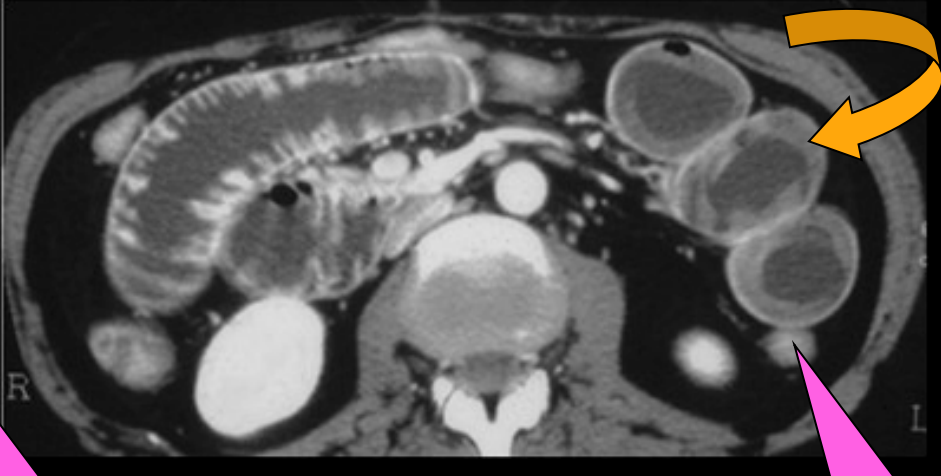
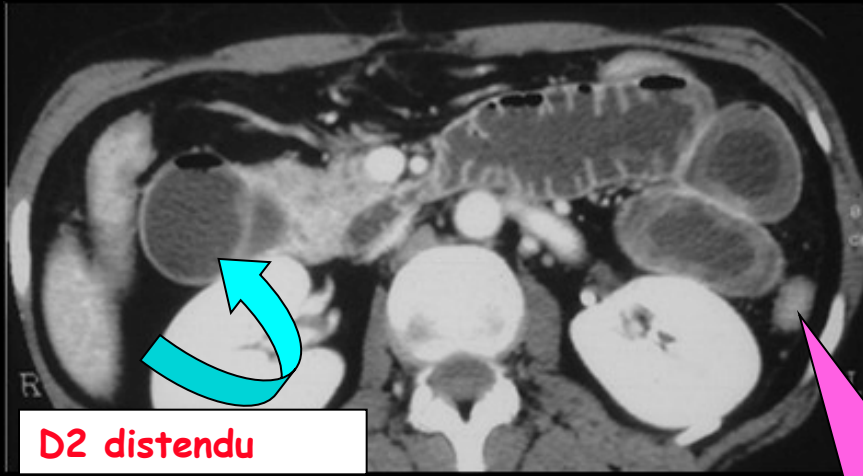
occlusion sur bride ou adhérences **sans** strangulation vasculaire = **problème "mécanique"** (compression extrinsèque de la paroi digestive)



volvulus sur bride **avec** strangulation vasculaire = **problème "ischémique" dominant** (immédiat ou différé)

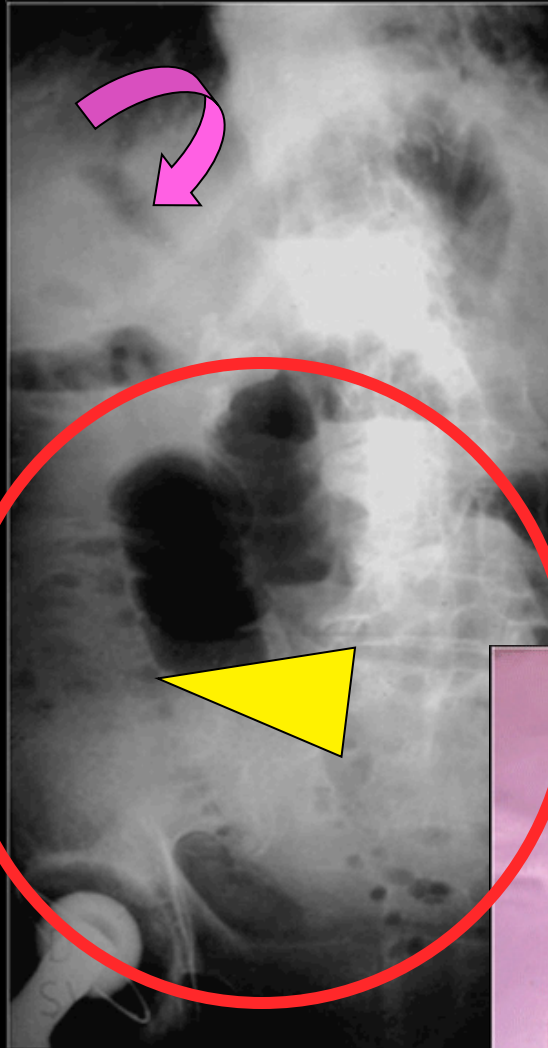
1. diagnostic positif et topographique

anses jéjunales distendues ($\varnothing > 25 \text{ mm}$)

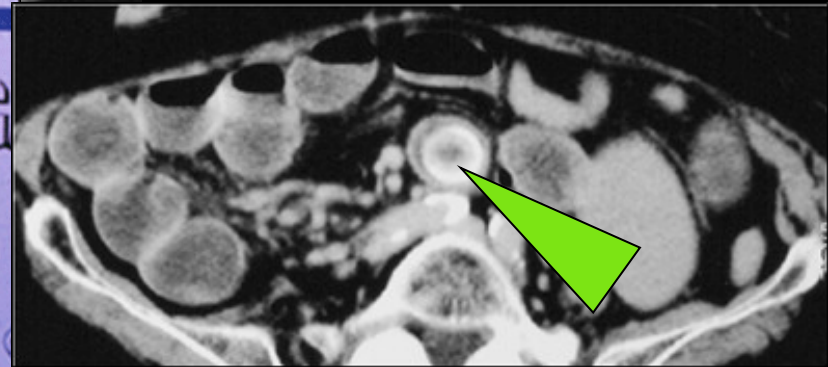
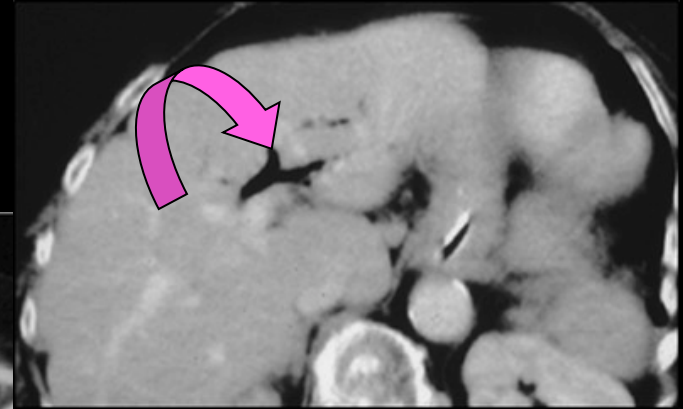
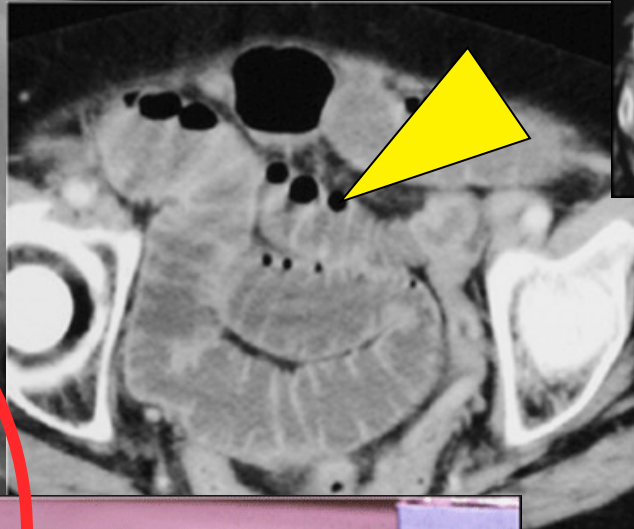


2. diagnostic étiologique :

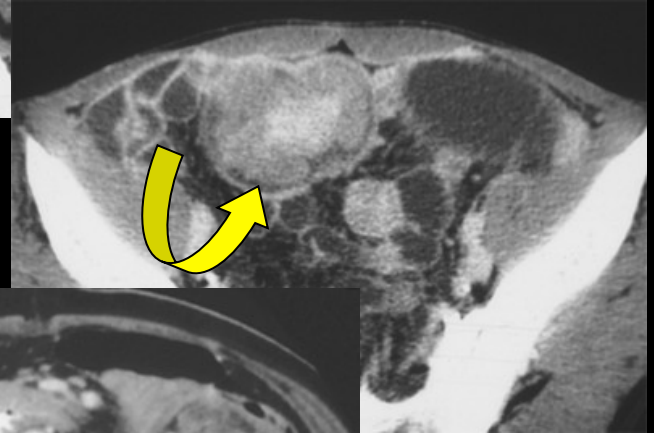
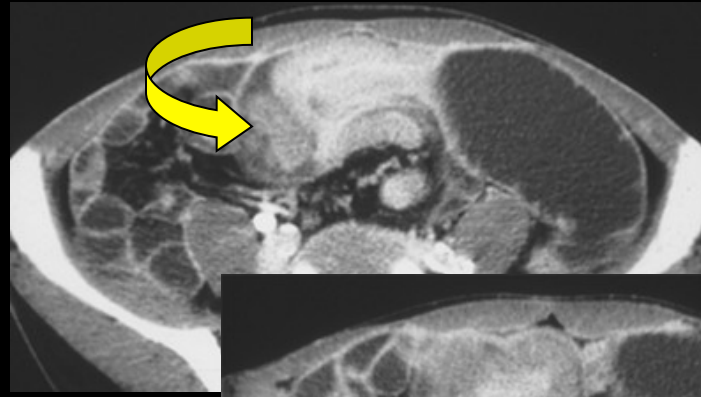
a. les causes « évidentes » d'occlusion du grêle



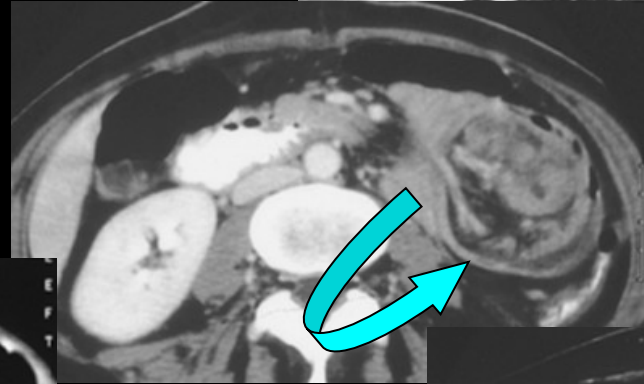
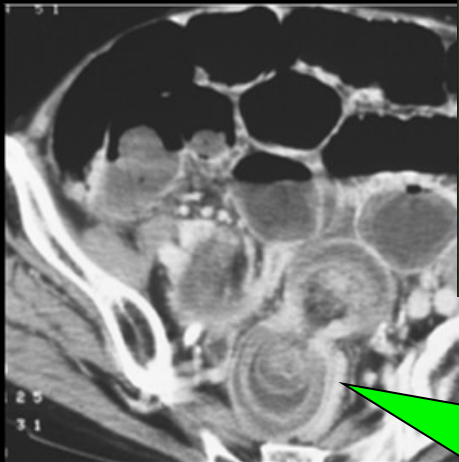
ileus biliaires



invaginations aiguës

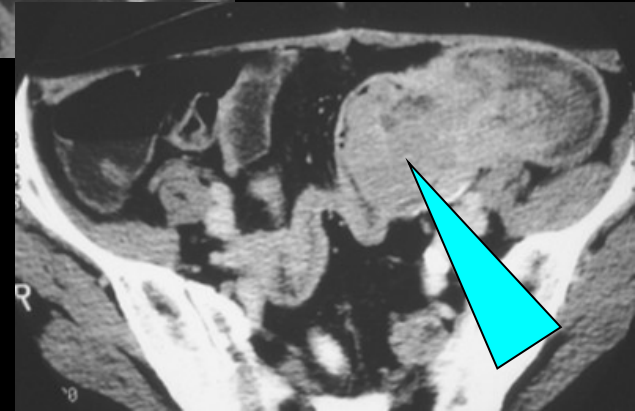
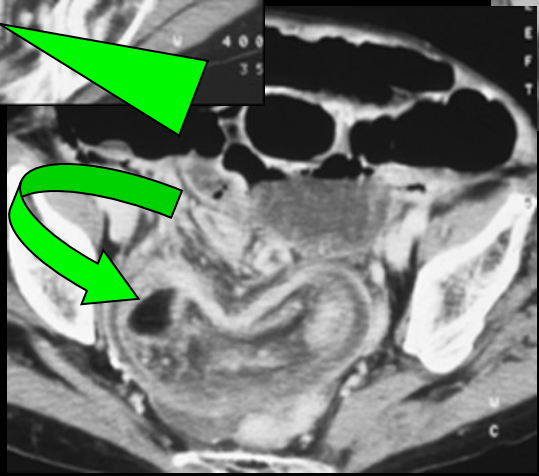


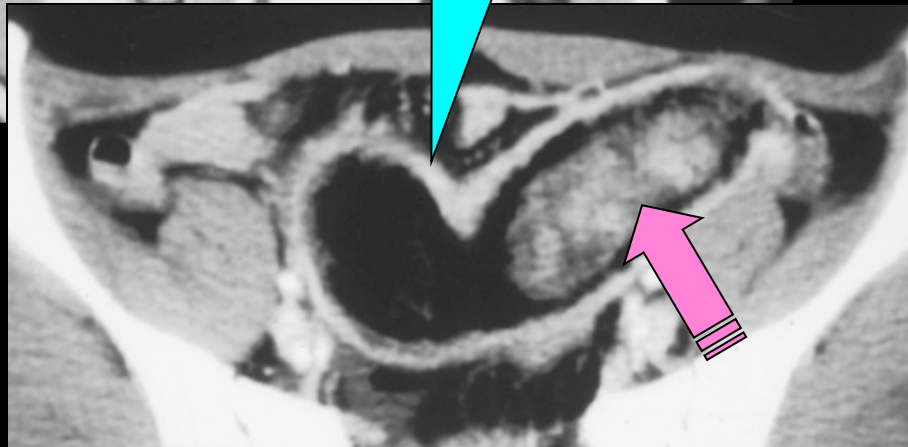
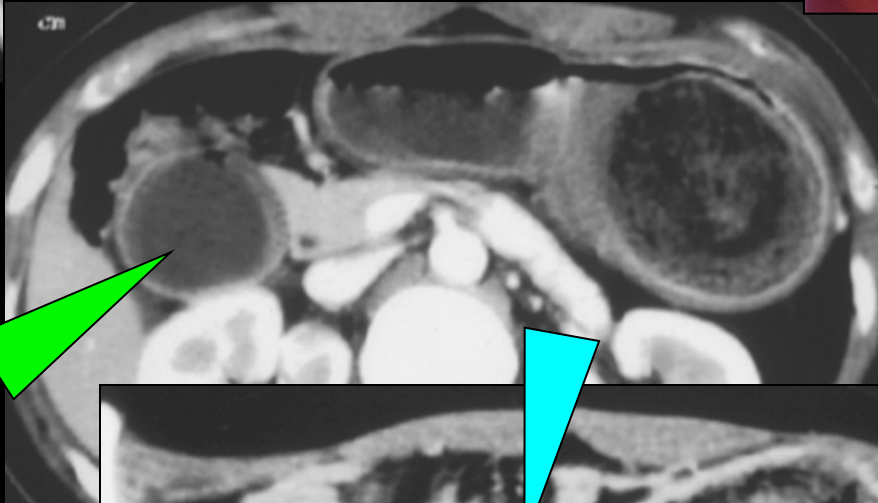
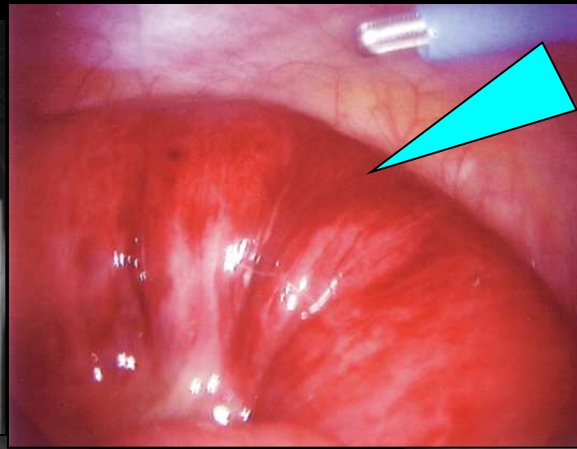
lmnh



métas
mélanome

lipome



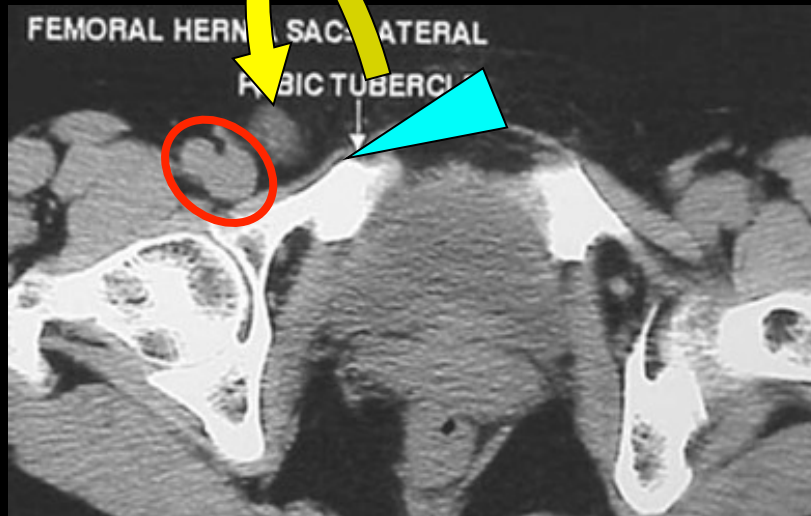
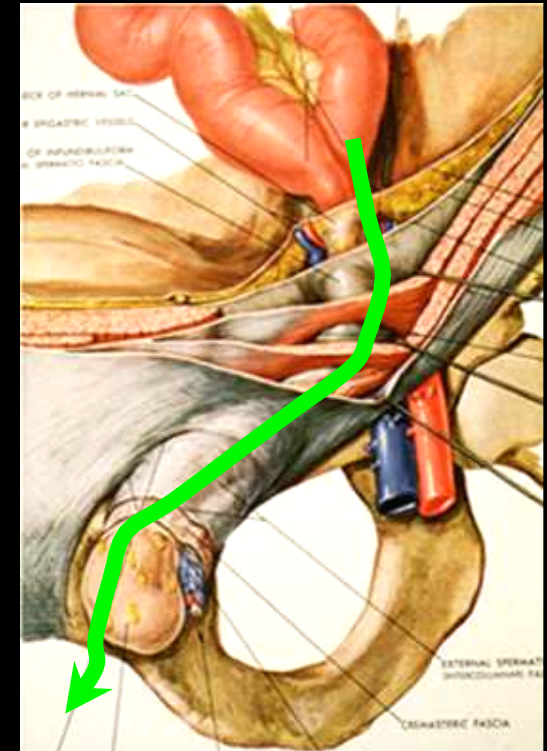
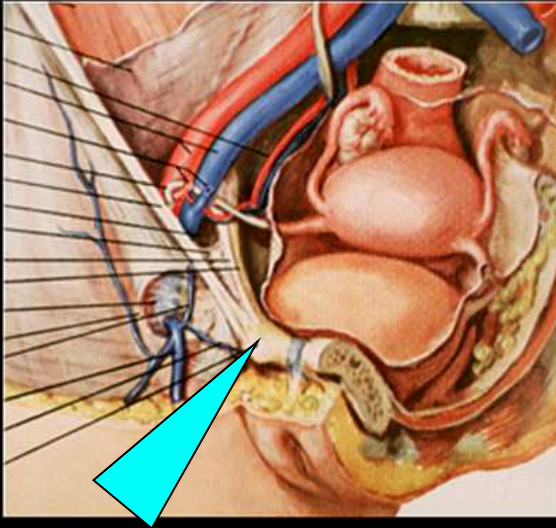


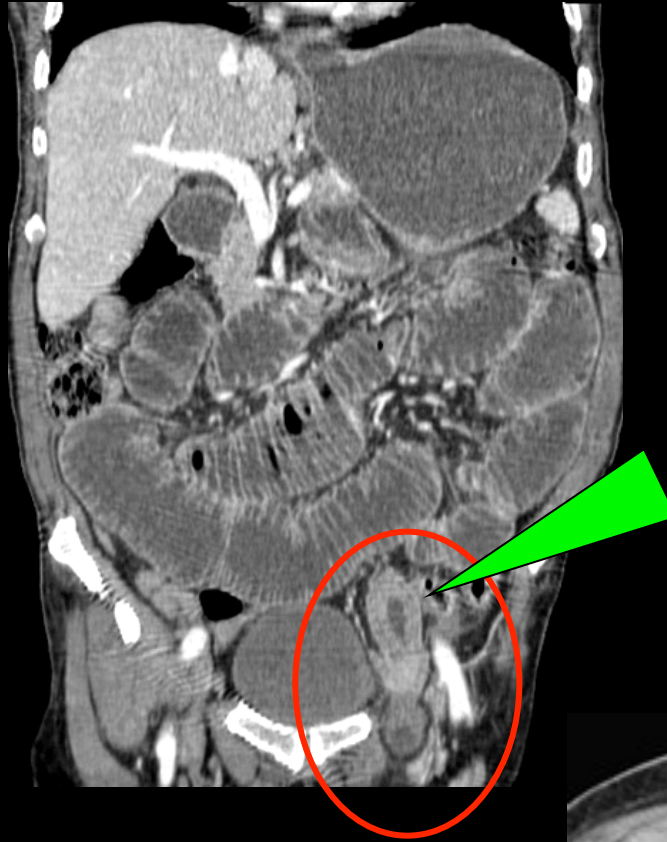
bézoards
trichobezoard
jeune fille
trichotillomaniaque

Sd de Rapunzel ou de Raiponce

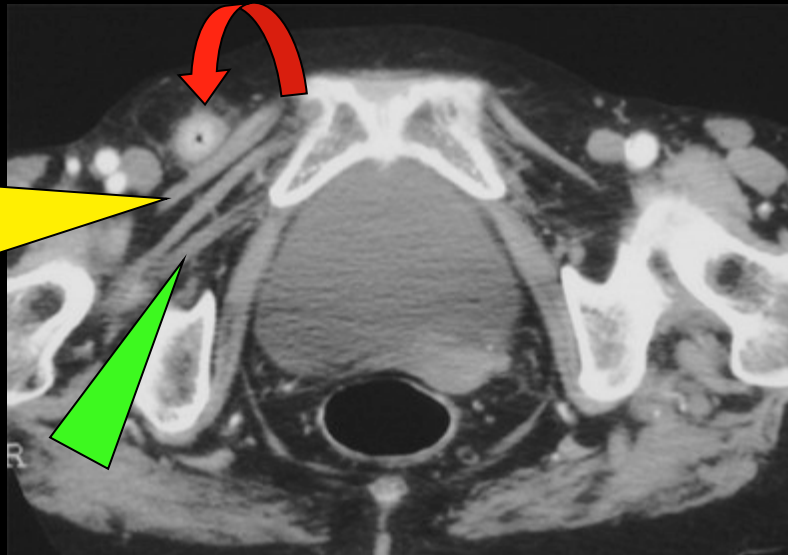
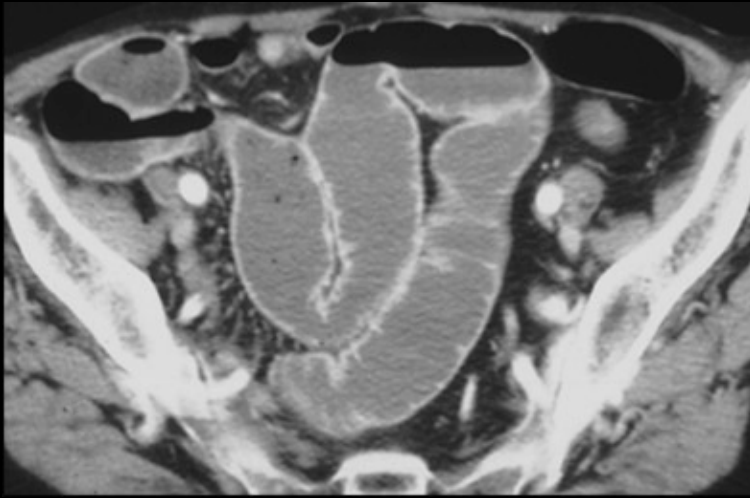
b. l' examen des orifices herniaires +++

région inguino-scrotale ; trous obturateurs ; ligne blanche; hernies incisionnelles

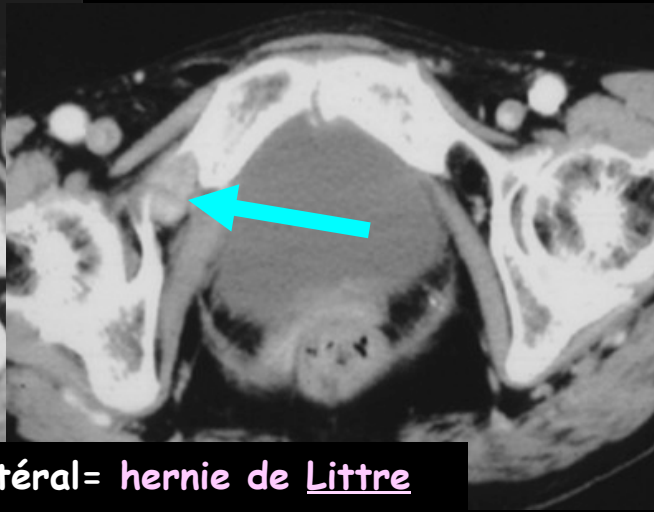
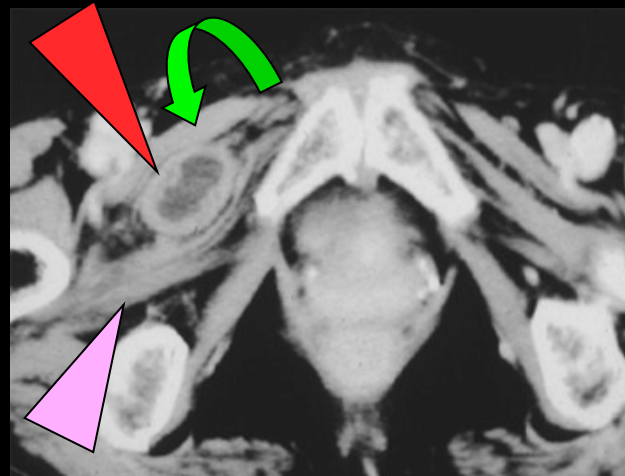




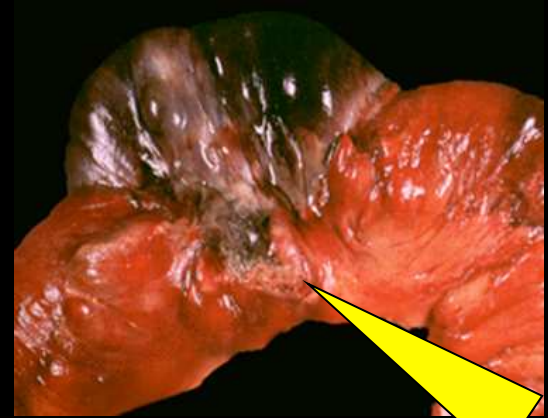
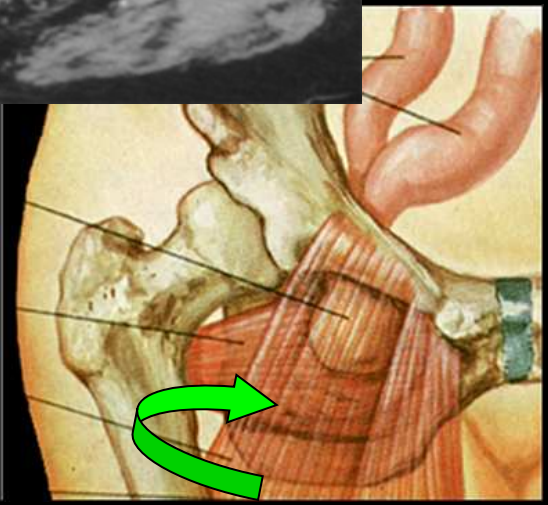
hernie inguinale



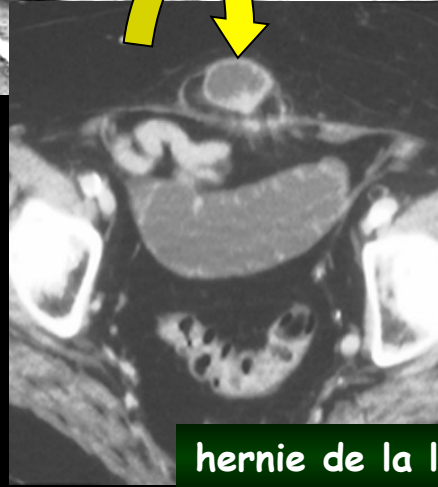
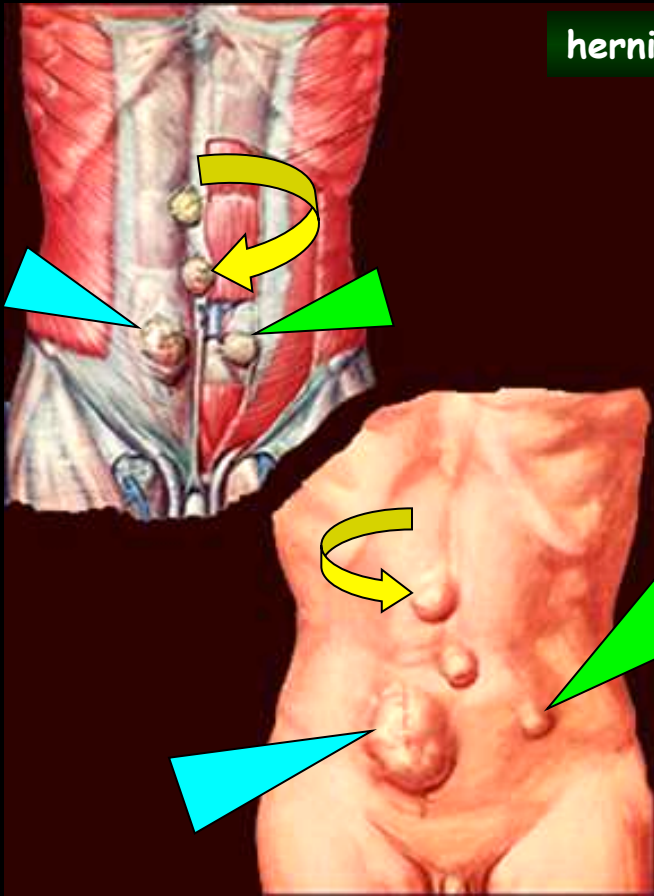
hernie **crurale**, en avant du muscle pectiné !!!



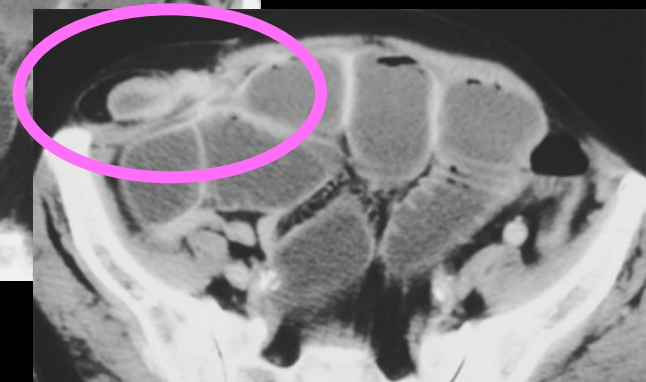
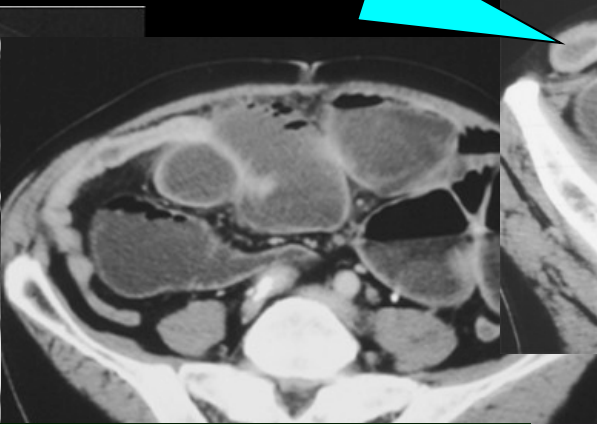
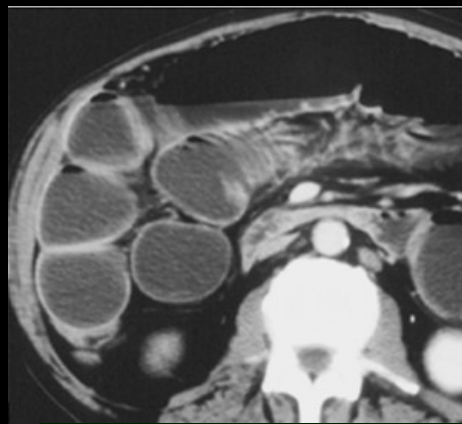
hernie **obturatrice**; pincement latéral= hernie de Littre
"little old ladie's hernia"
signes de Howship-Romberg et de Hannington-Kiff



hernie de Spiegel



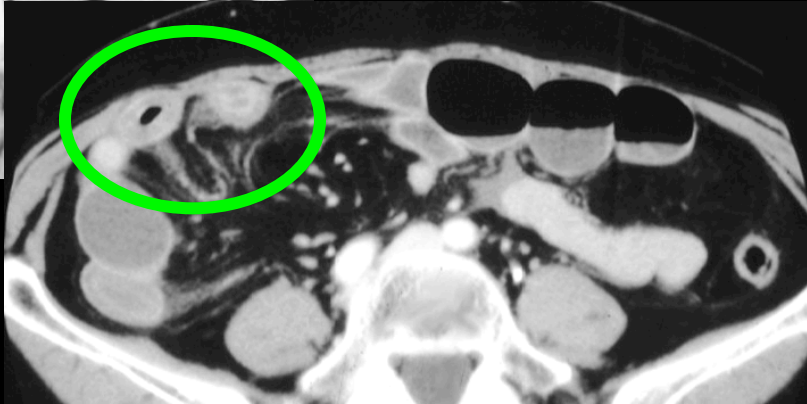
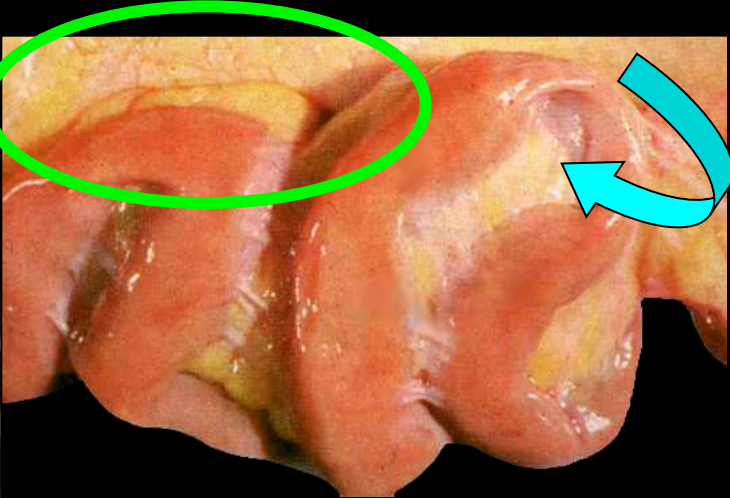
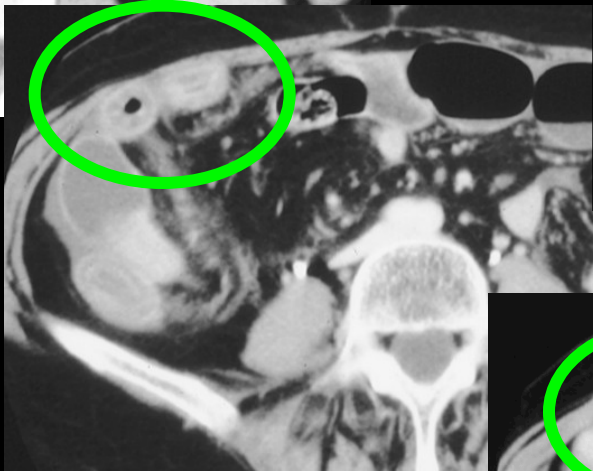
hernie de la ligne blanche



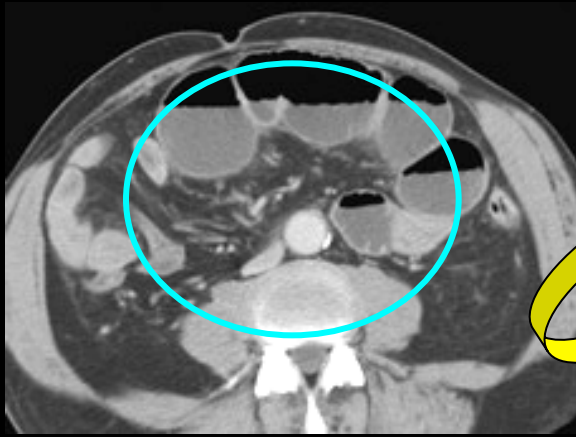
hernie incisionnelle para rectale droite

c. recherche d'une occlusion sur bride et évaluation des signes de "souffrance" intestino-mésentérique

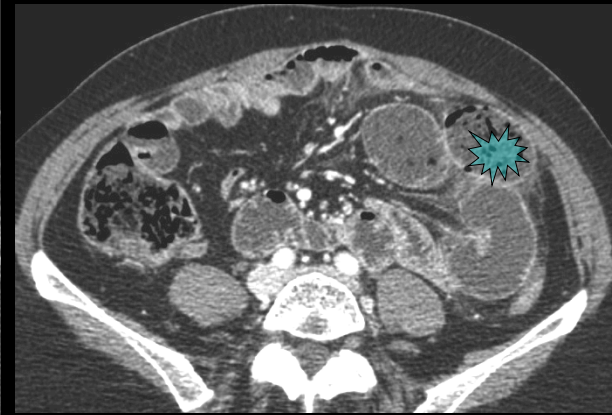
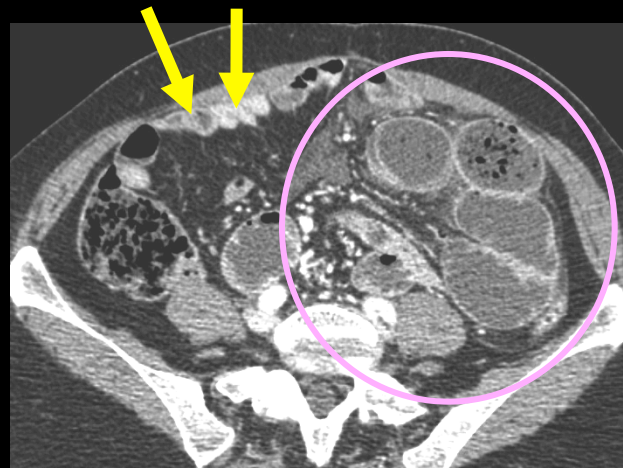
compression extrinsèque simple : adhérences et brides



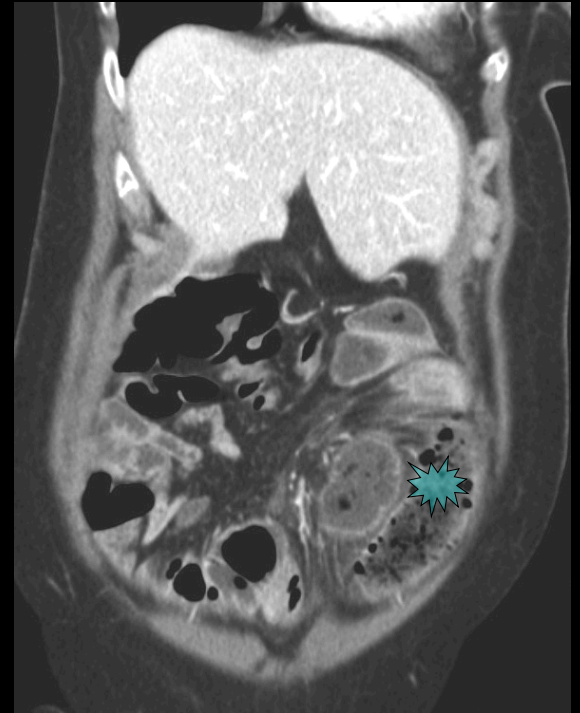
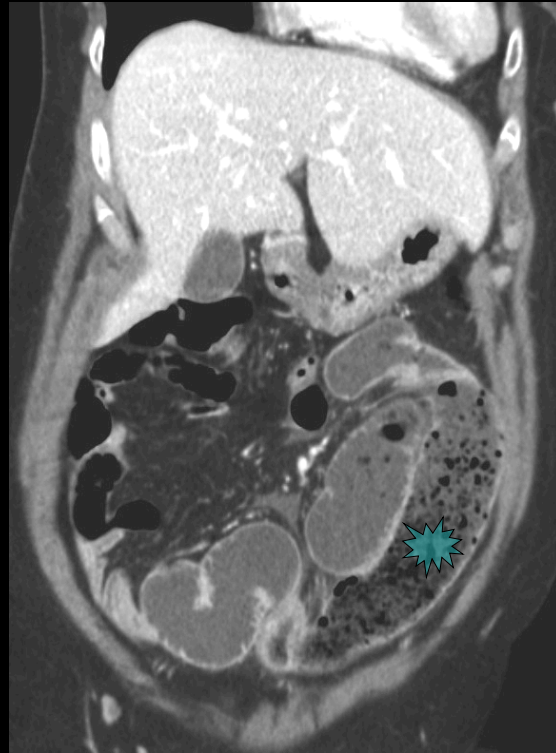
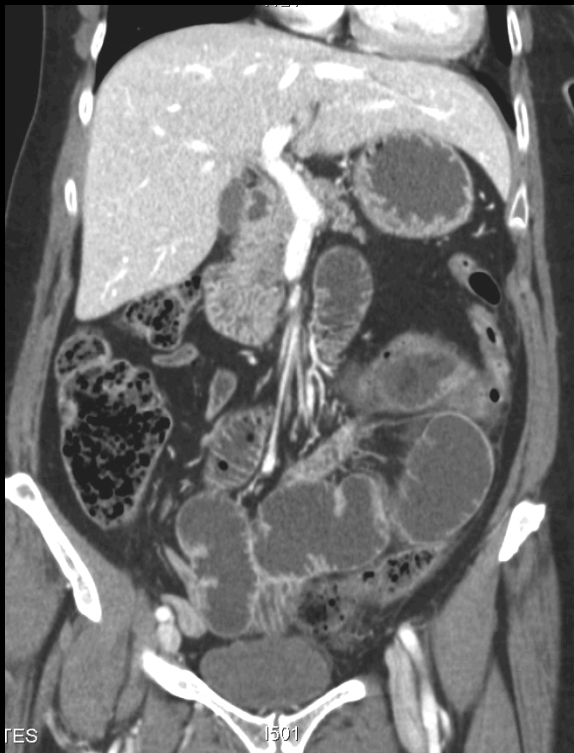
occlusion sur adhérences intestino-mésentériques



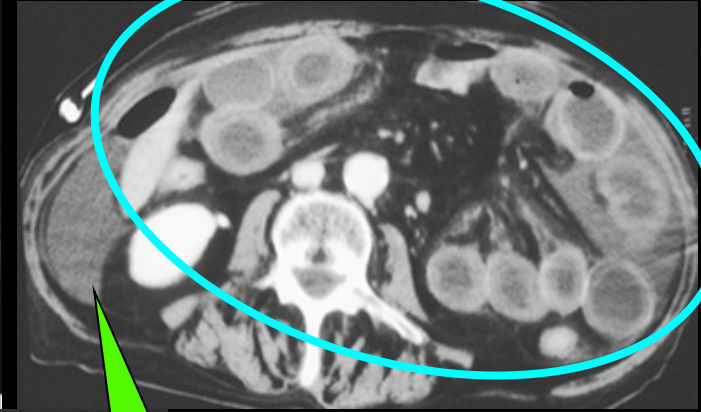
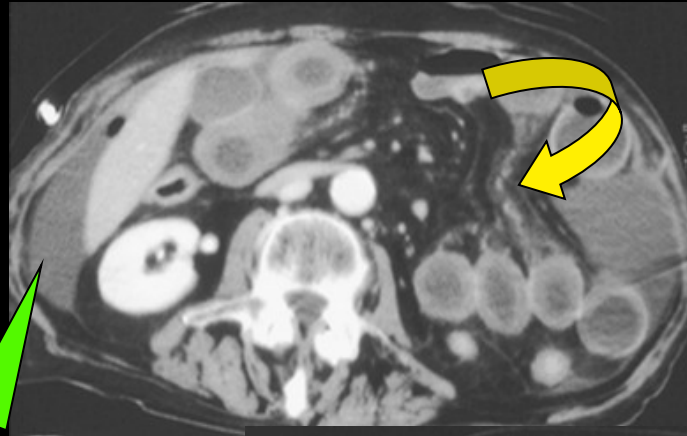
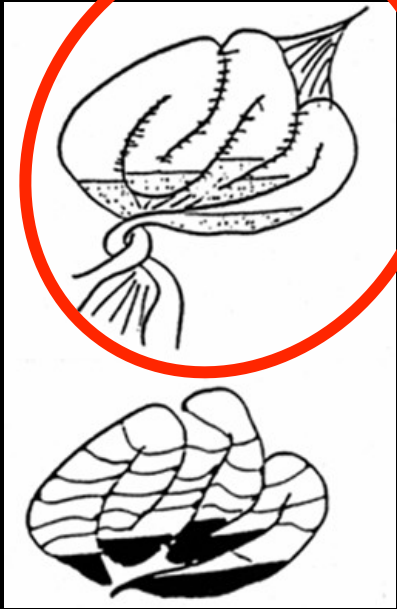
occlusion sur **adhérences** intestino-mésentériques ; volvulus chronique
sans images de strangulation ; "pseudo-fèces "



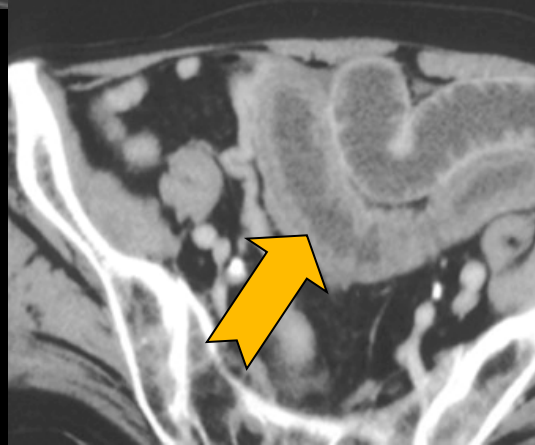
occlusions à répétition ,par compression extrinsèque simple, en relation avec des adhérences intestino-mésentériques post-chirurgicales (appendicectomie et hystérectomie subtotale)



volvulus sur bride

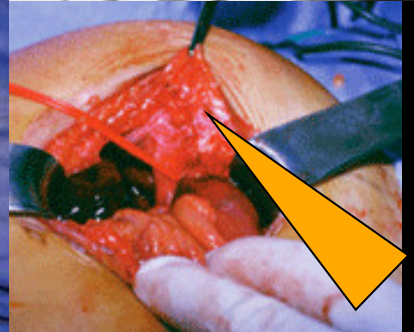
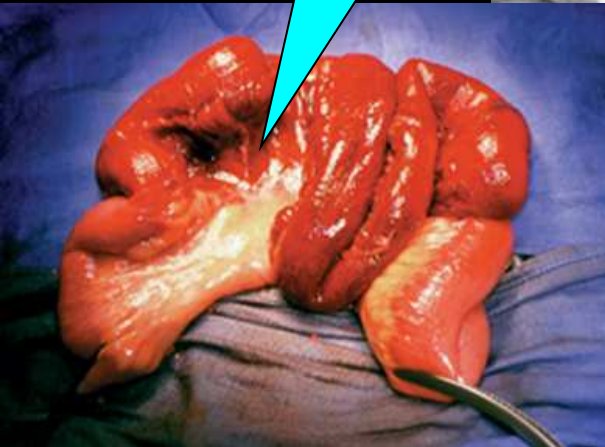
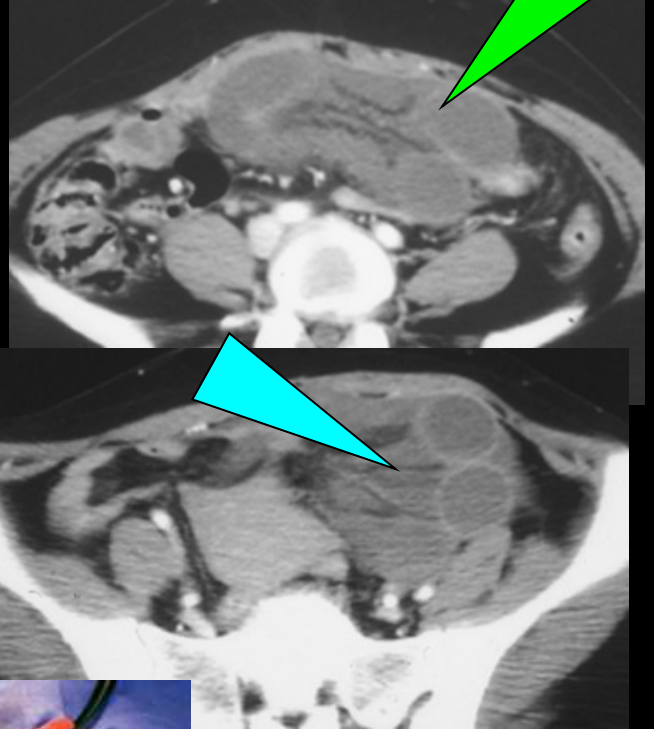
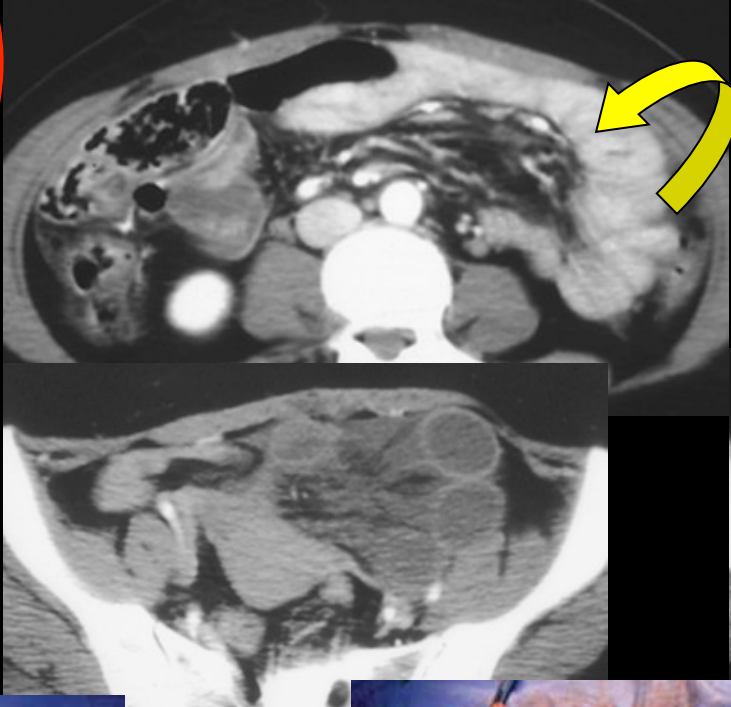
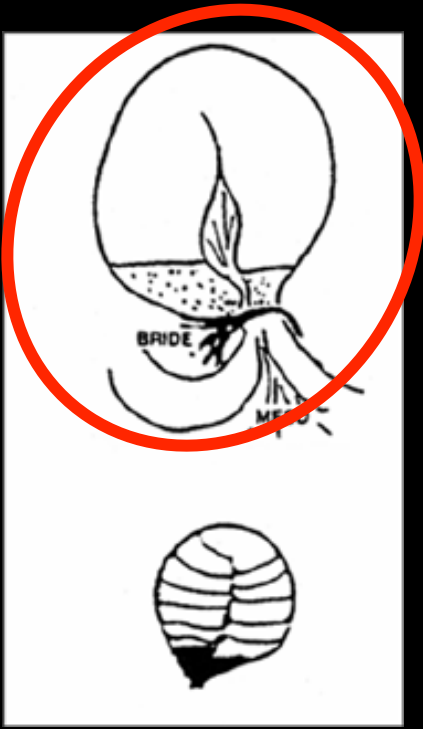


volvulus sur bride
avec signes de congestion veineuse

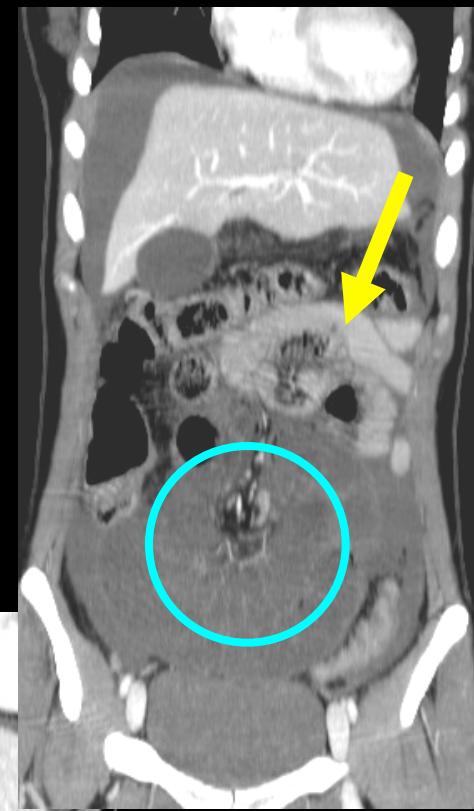
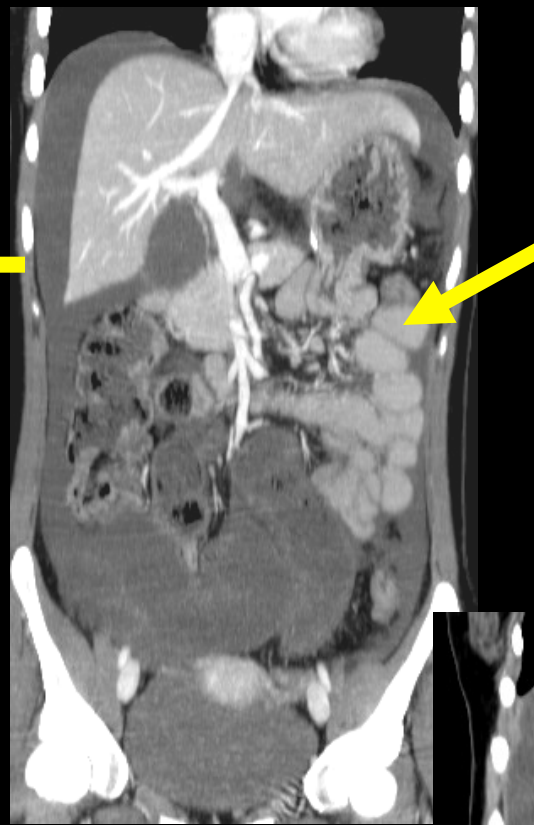


- congestion (oedème) modérée du mésentère(vaisseaux identifiables)
- épaississement circonférentiel des parois (oedème sous muqueux)
- épanchement liquidien péritonéal abondant

anse fermée ; anse en C ; anse incarcerated (closed loop obstruction) = occlusion "à ventre plat"



signes majeurs de nécrose ischémique intestino-mésentérique



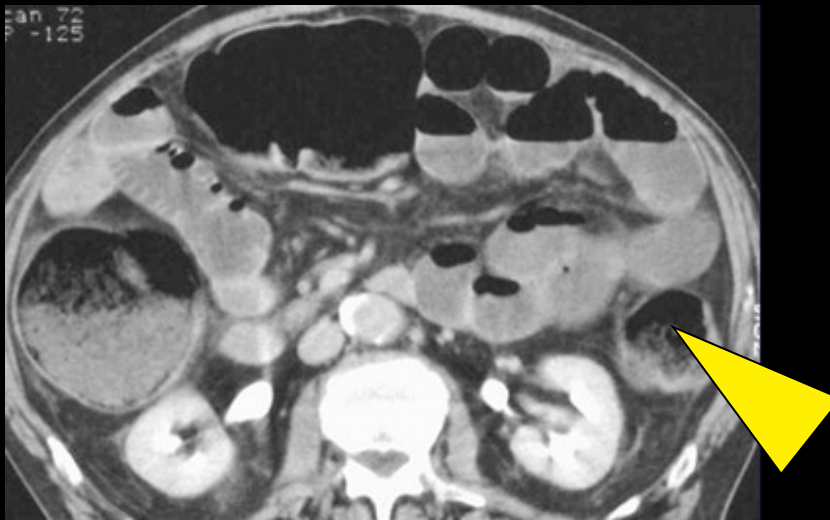
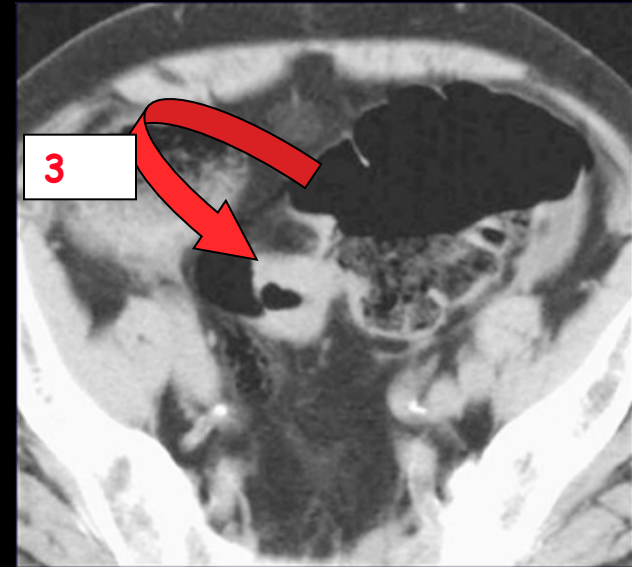
occlusion "à ventre plat", hyperalgique, par volvulus sur bride post appendicectomie; nécrose transmurale étendue; résection



diagnostic différentiel d'un valvulus sur bride :
hernie interne transmésentérique étranglée

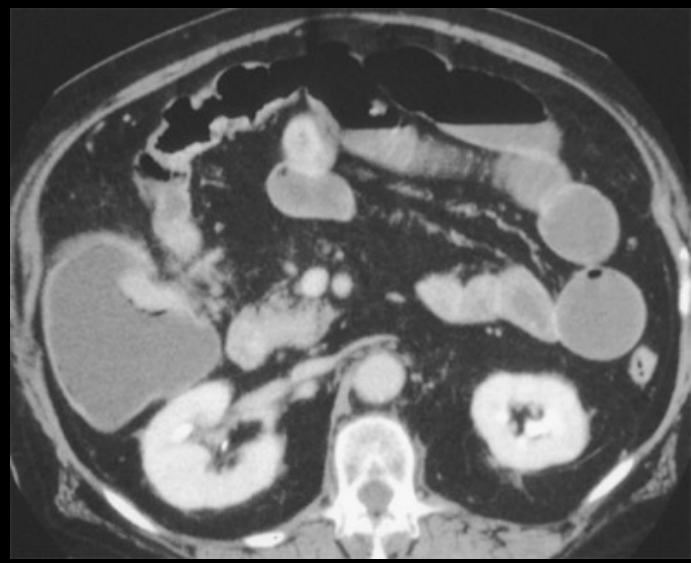
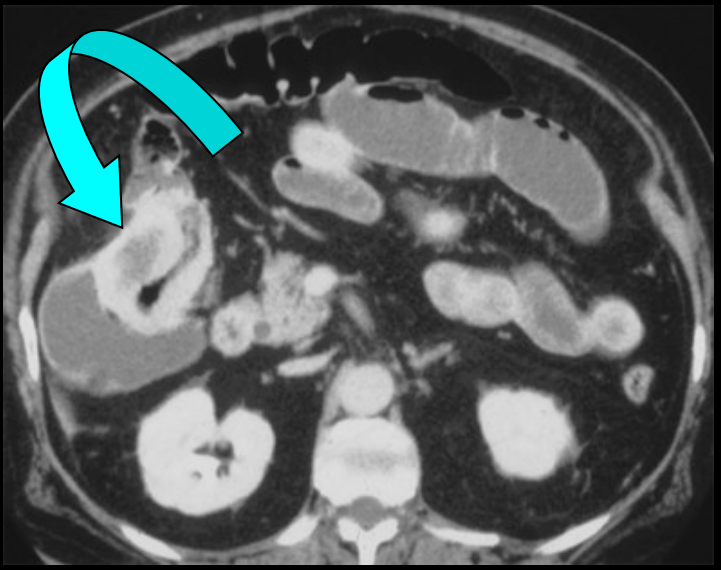
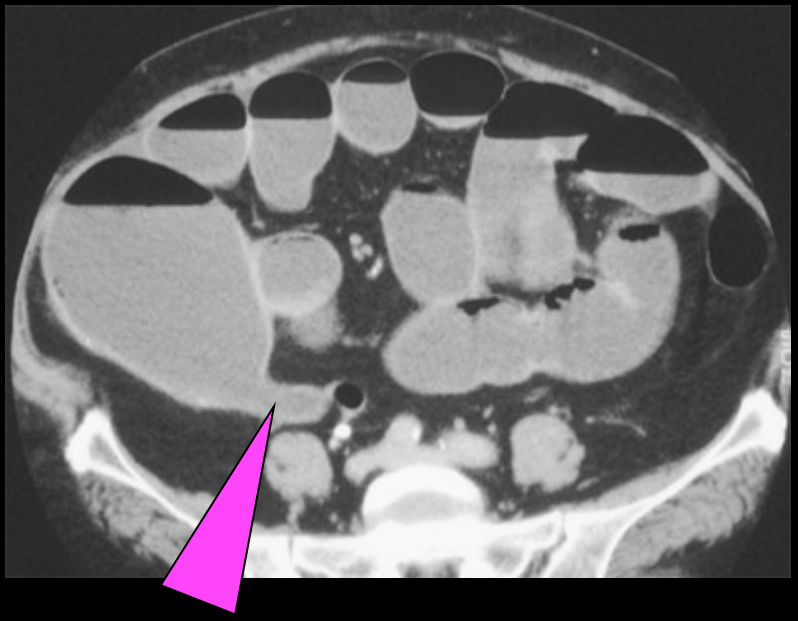
d. diagnostic des occlusions coliques

ne pas méconnaître une occlusion basse devant un abdomen ballonné avec "dyspepsie" ± constipation récente !!!



la distension cœcale avec stase stercorale est la clé du diagnostic des occlusions basses !!!

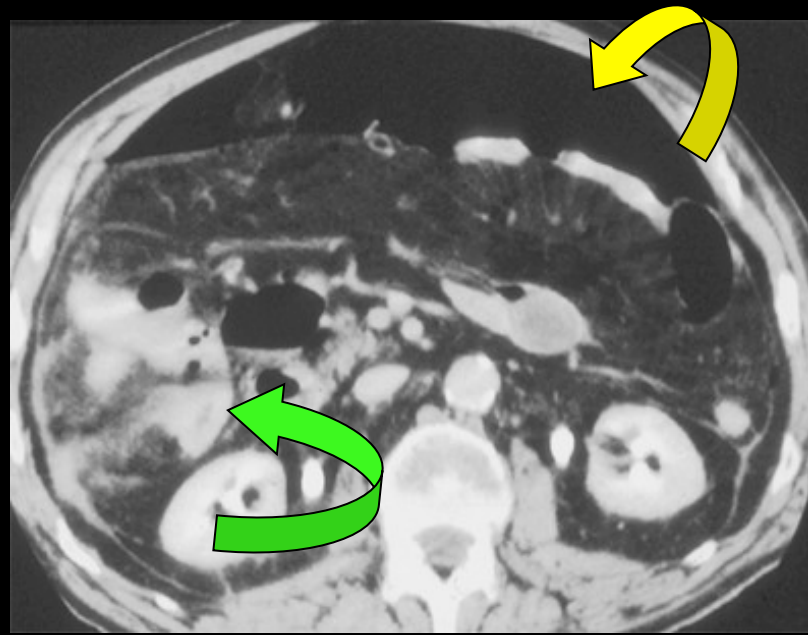
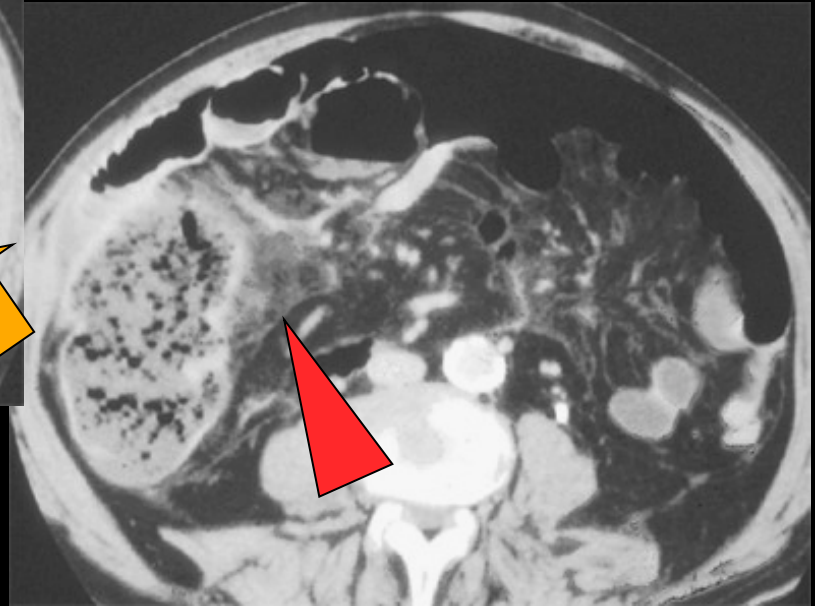
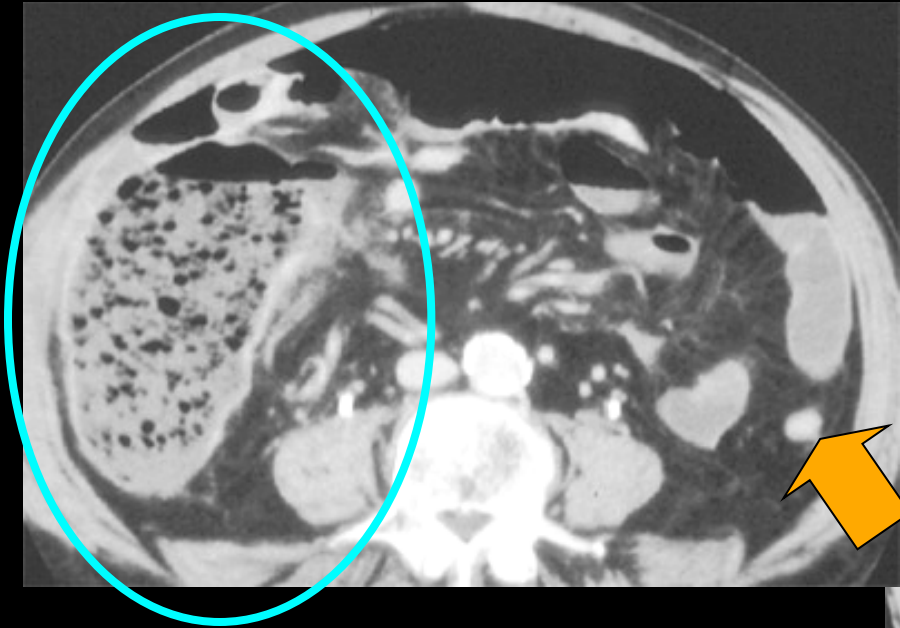
occlusion sur ADK du sigmoïde



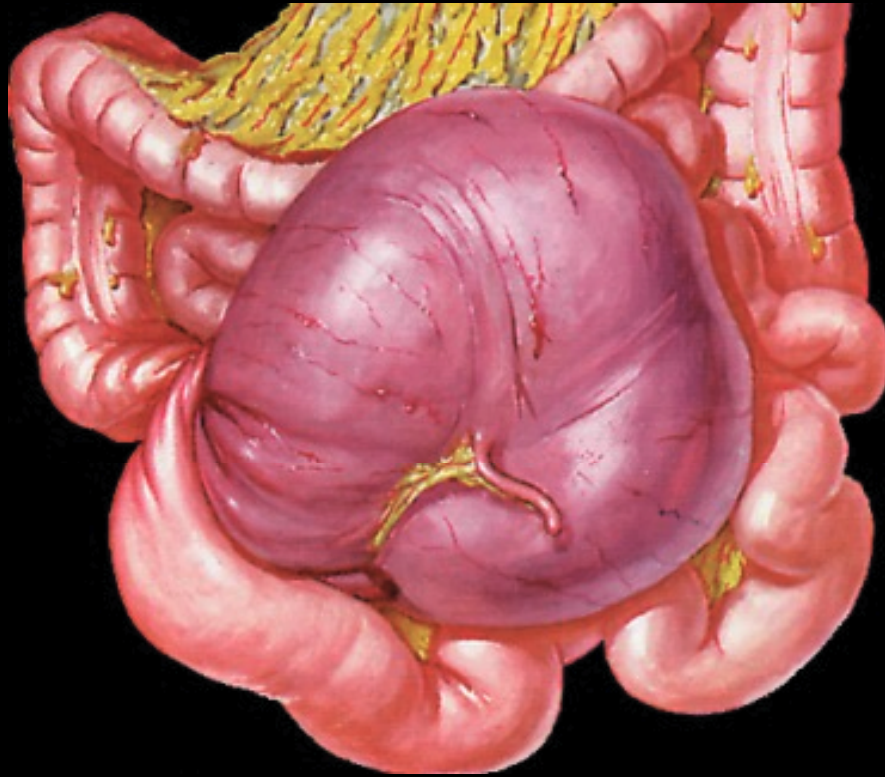
occlusion sur ADK de l'angle droit

occlusion colique avec valvule de Bauhin continentente :

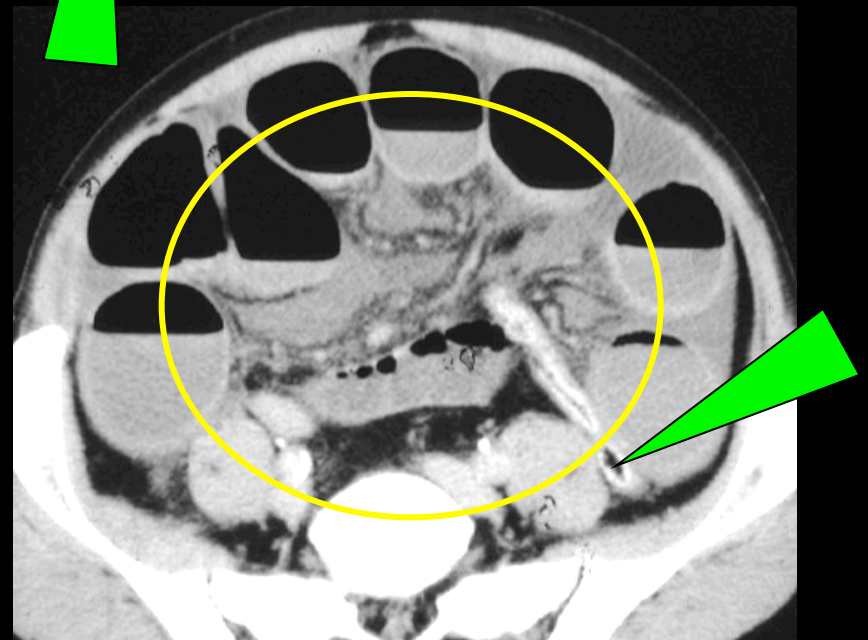
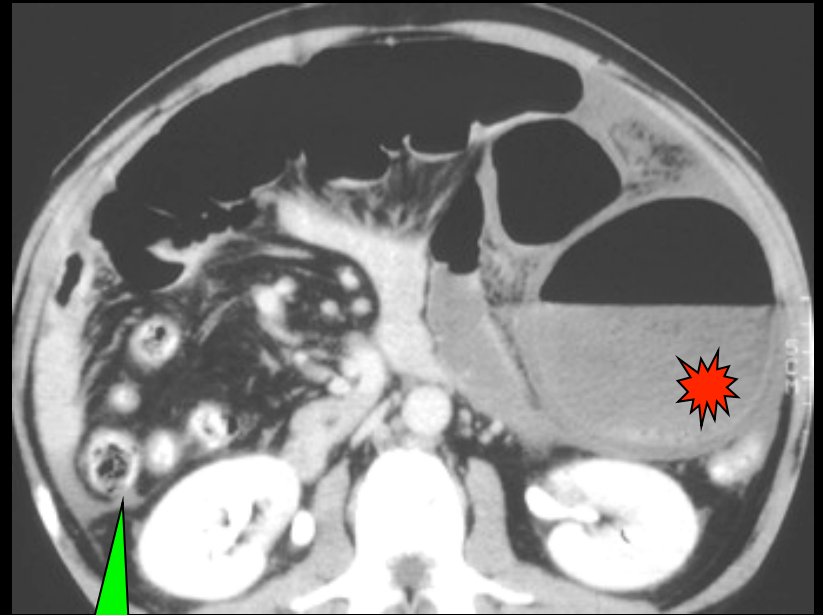
ATTENTION !!!

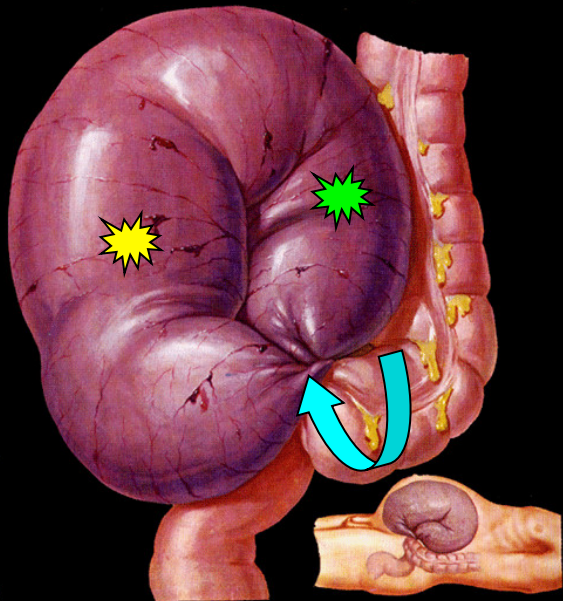
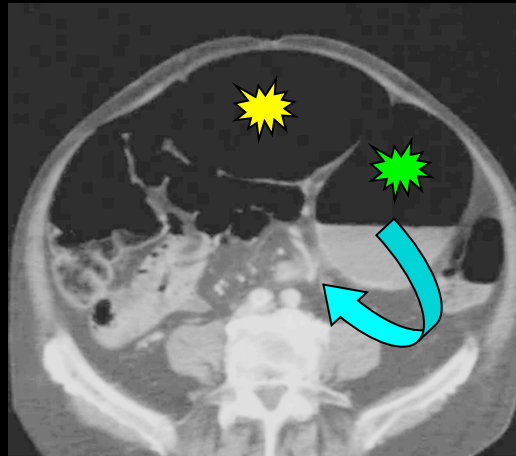
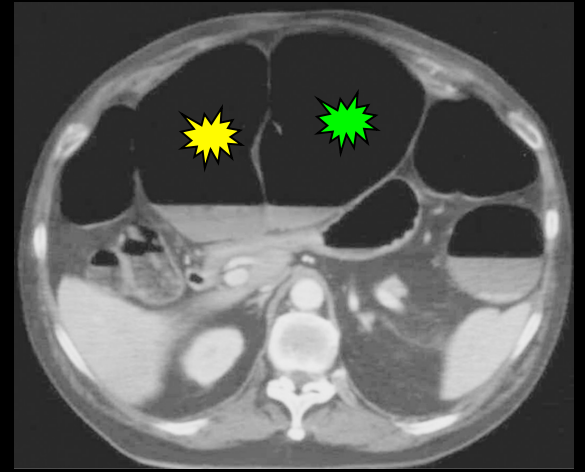
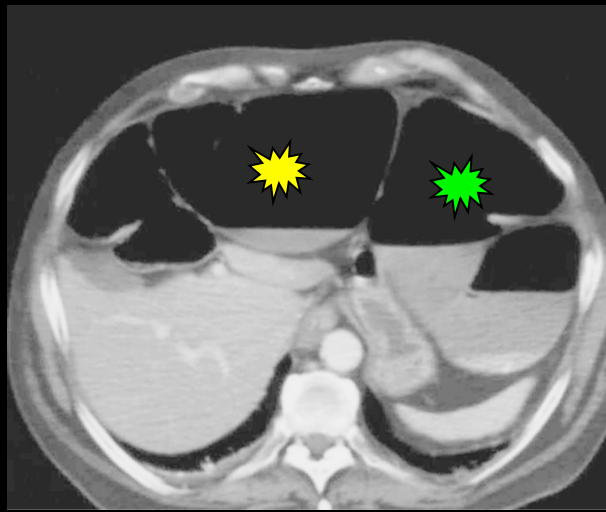
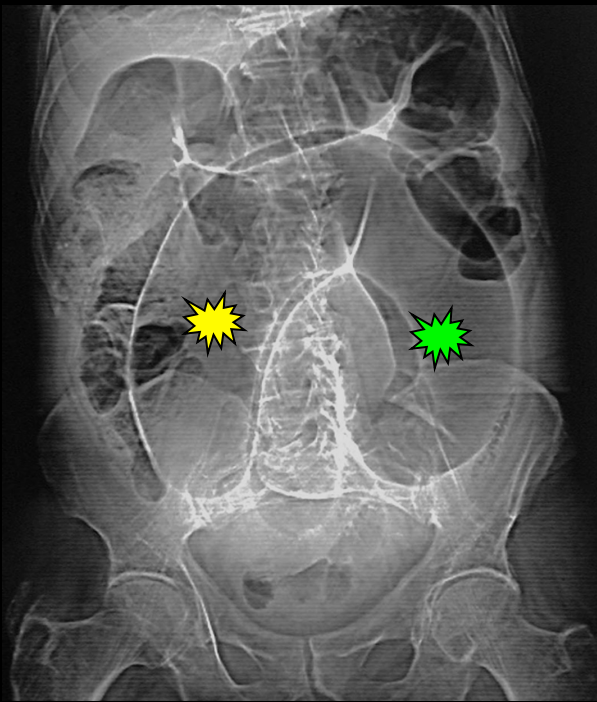


perforation diastatique sur adénocarcinome de l'angle droit



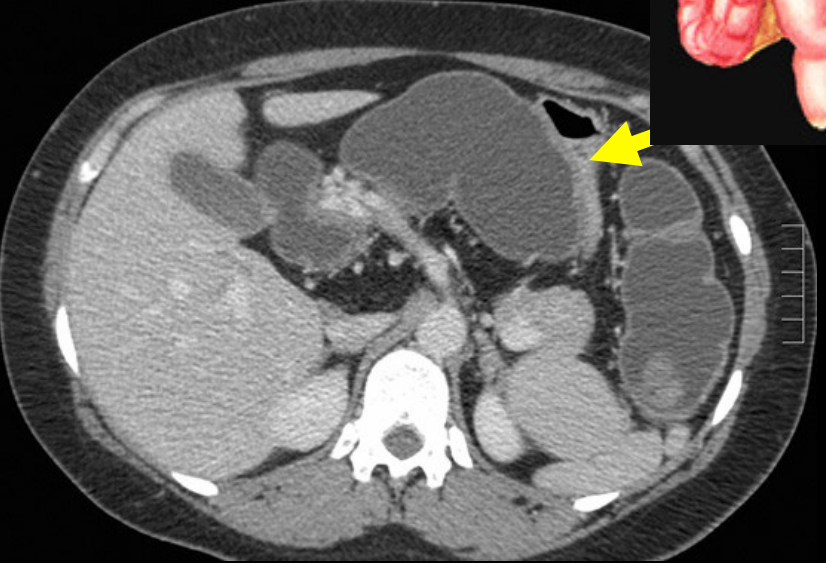
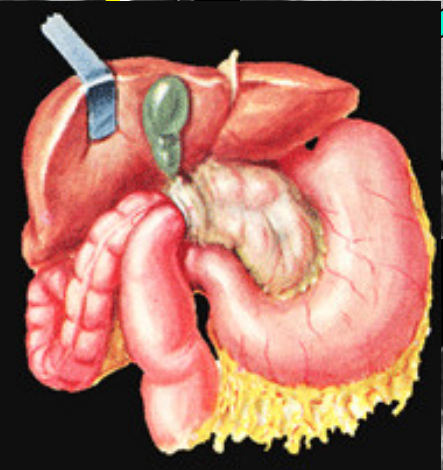
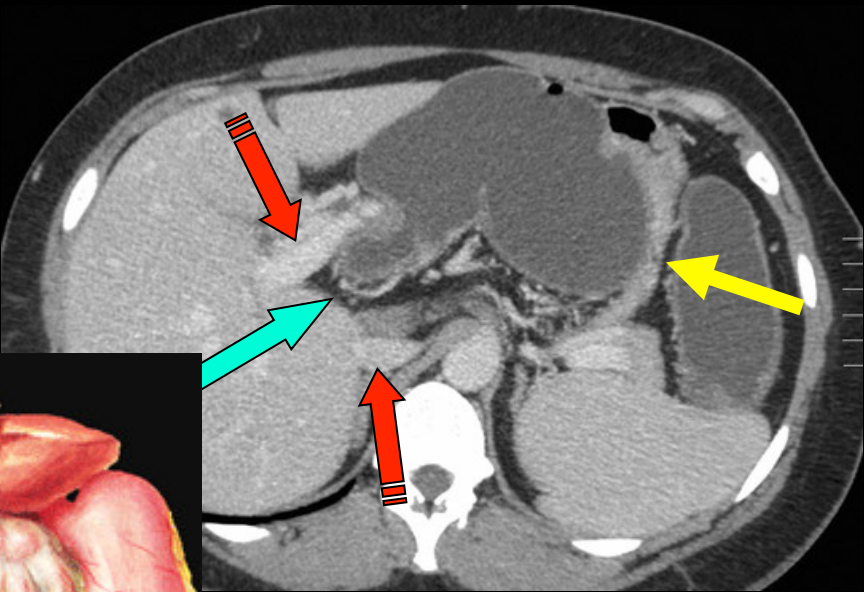
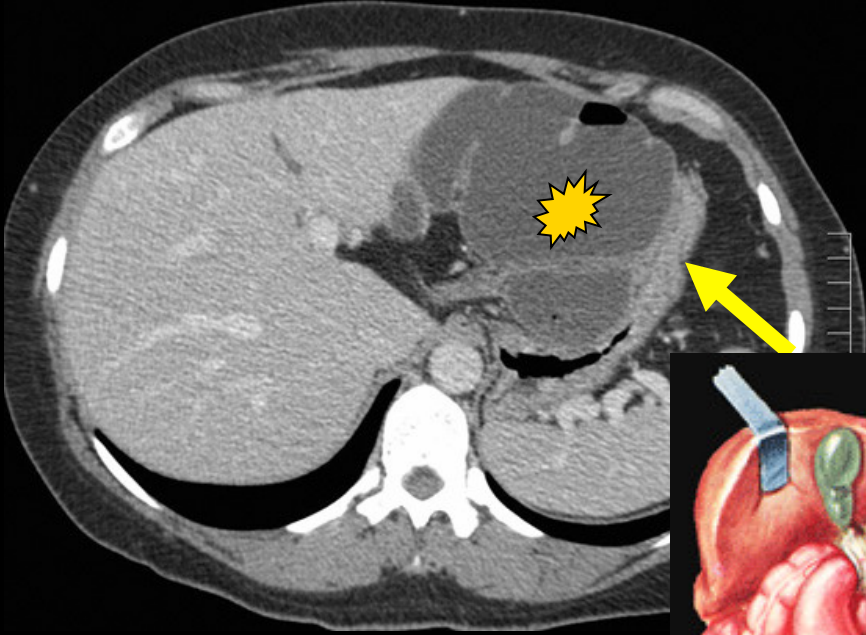
volvulus du cæcum (et du grêle)

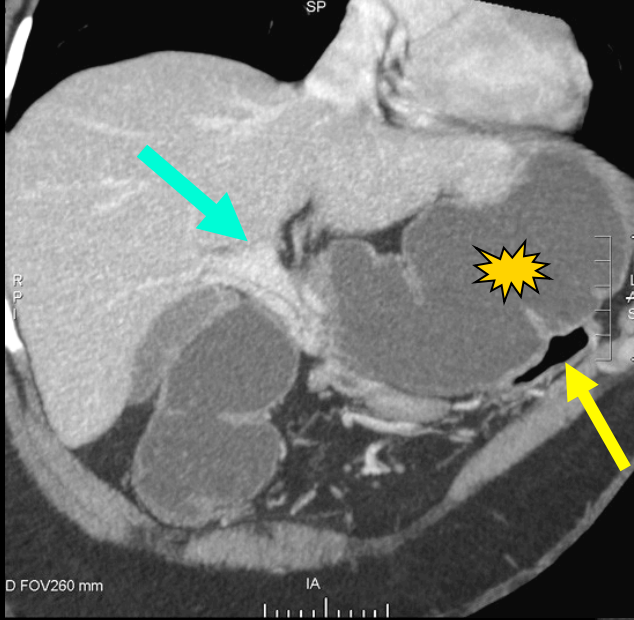
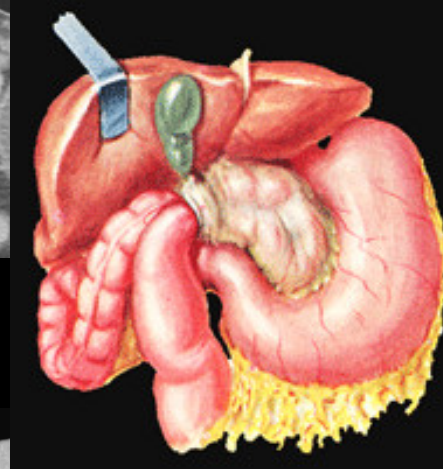
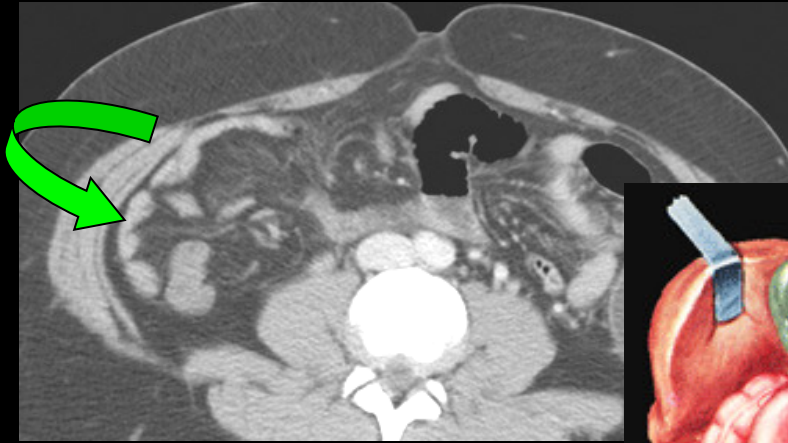




volvulus du sigmoïde

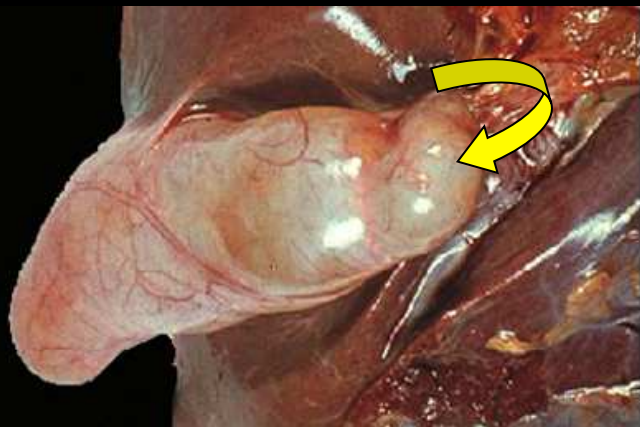
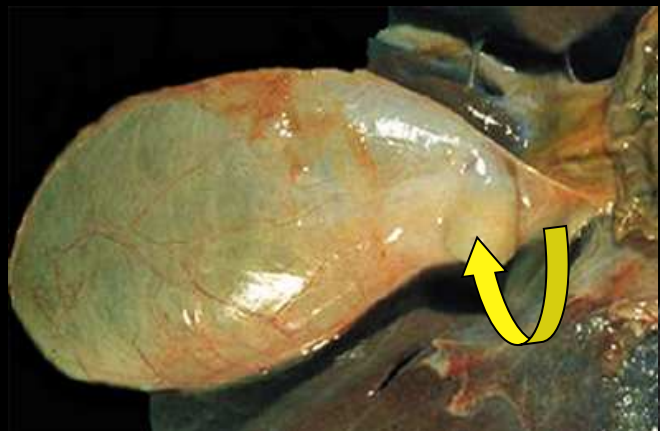
colo-CT (répletion colique à l'eau)



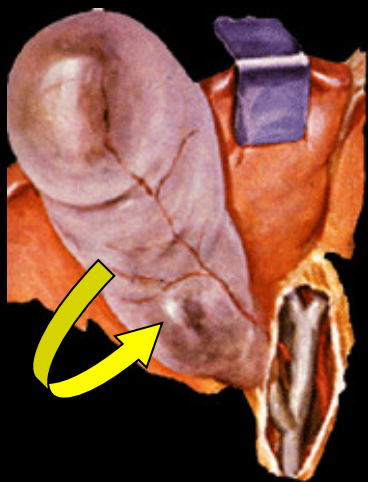


hernie du hiatus de Winslow (hernie de Blandin)

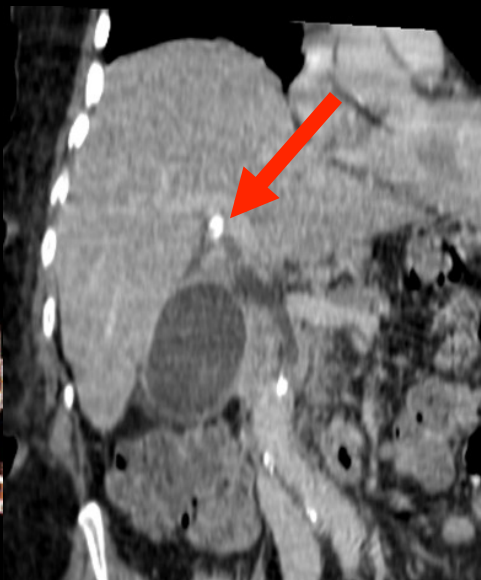
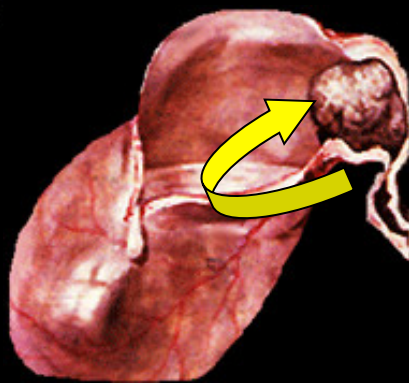
syndromes douloureux et fébriles de l'étage sus-mésocolique



pathologies aiguës biliaires

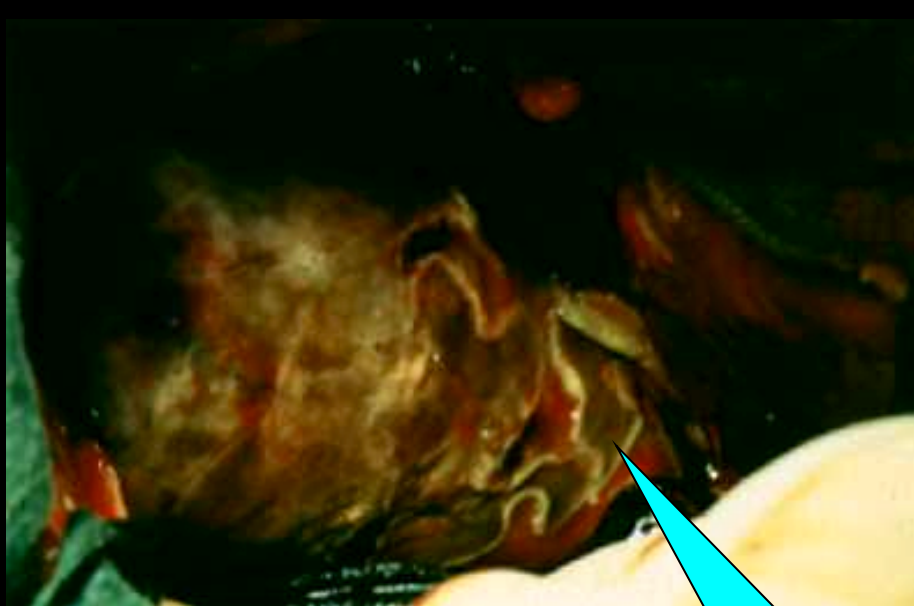


hydrocholécyste
(hydrops vésiculaire)

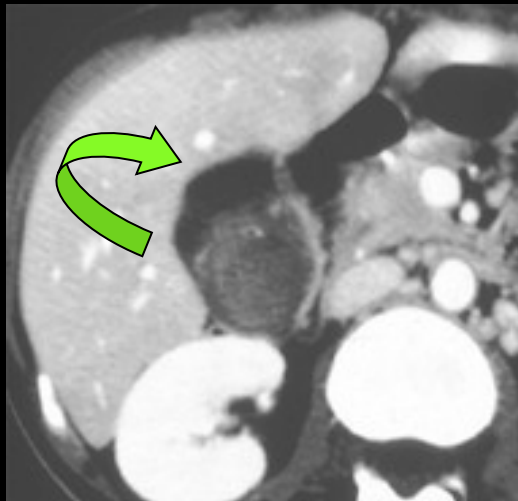
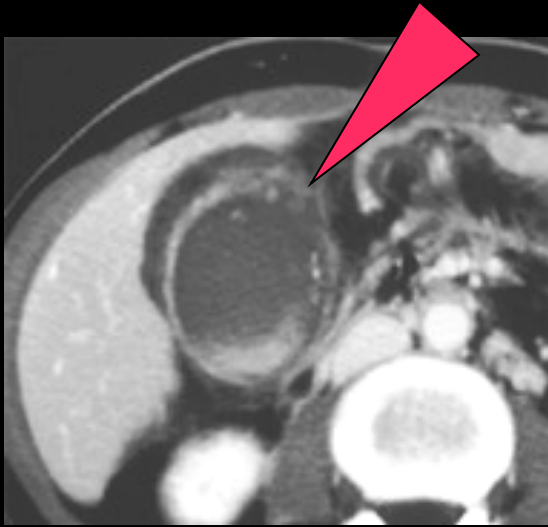




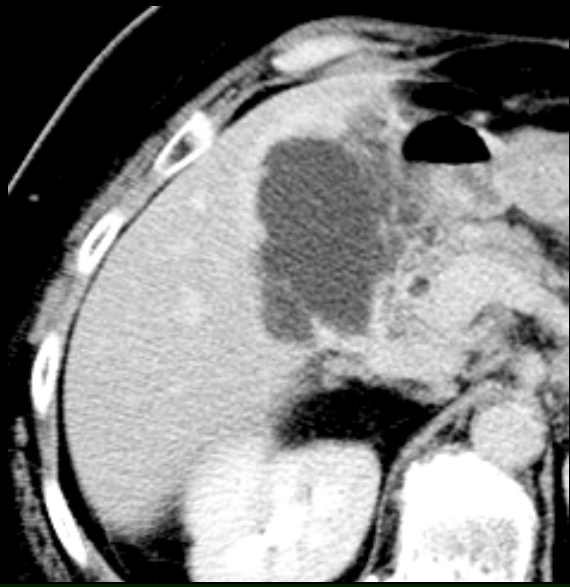
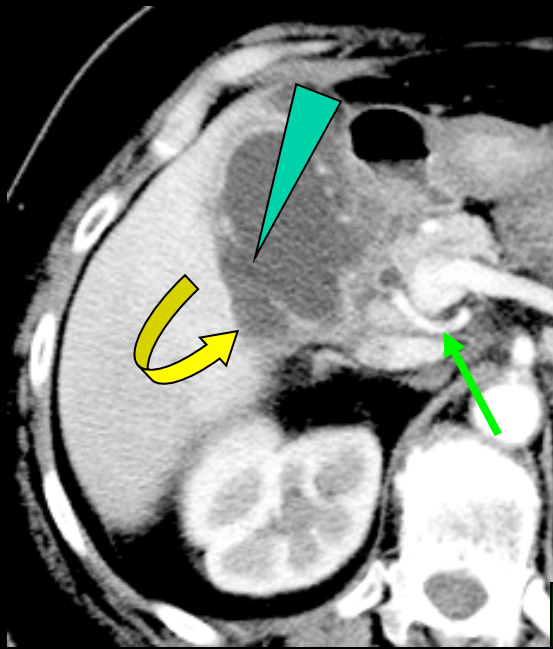
cholécystite
hémorragique



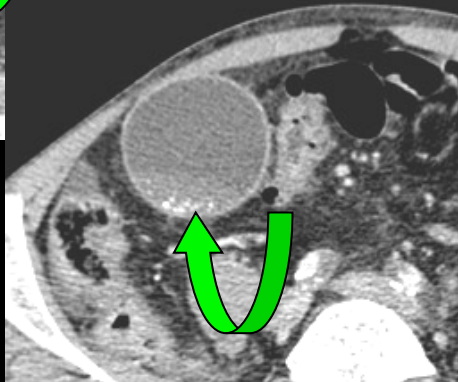
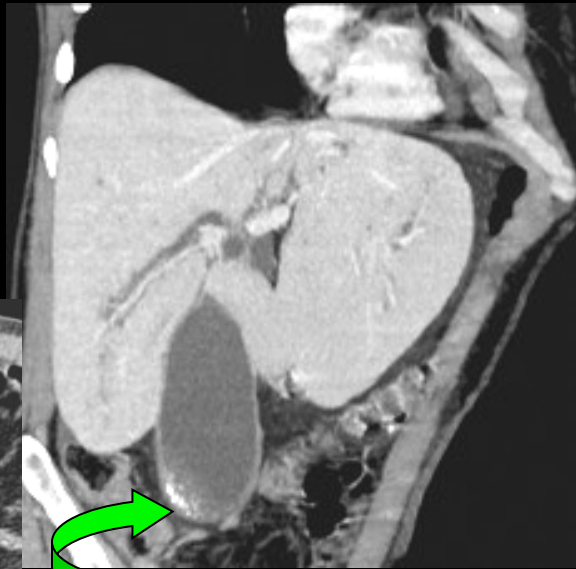
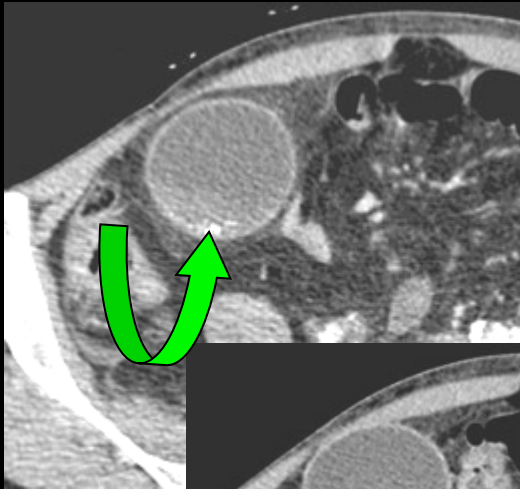
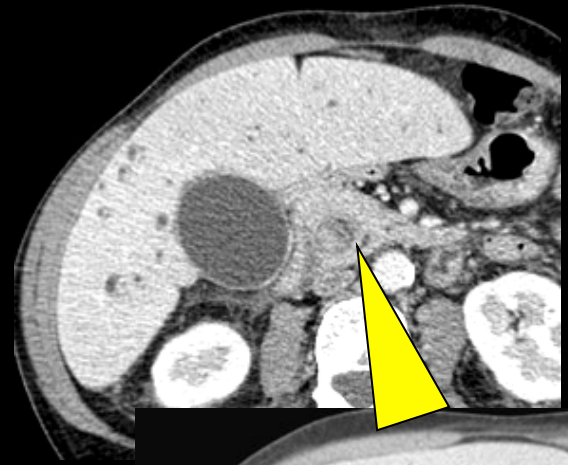
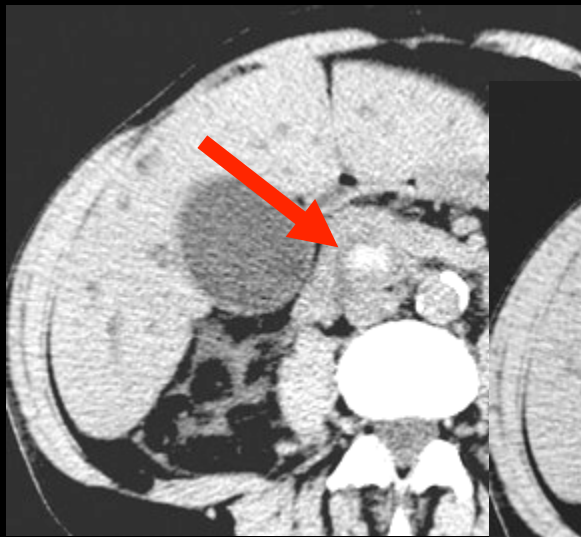
cholécystites
gangreneuses



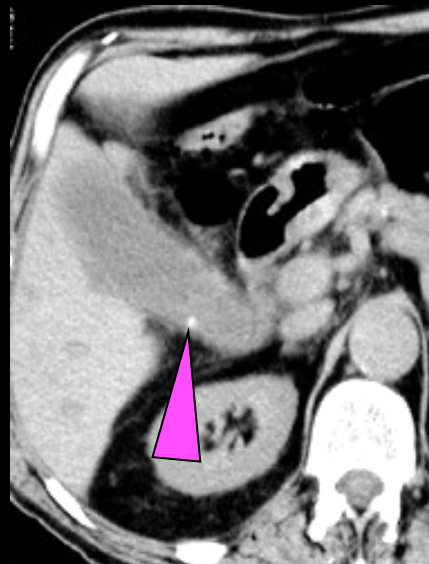
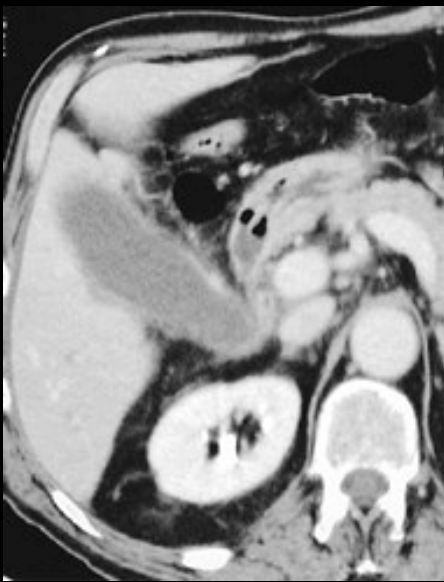
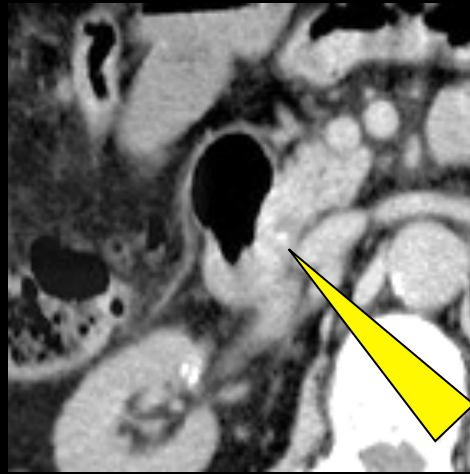
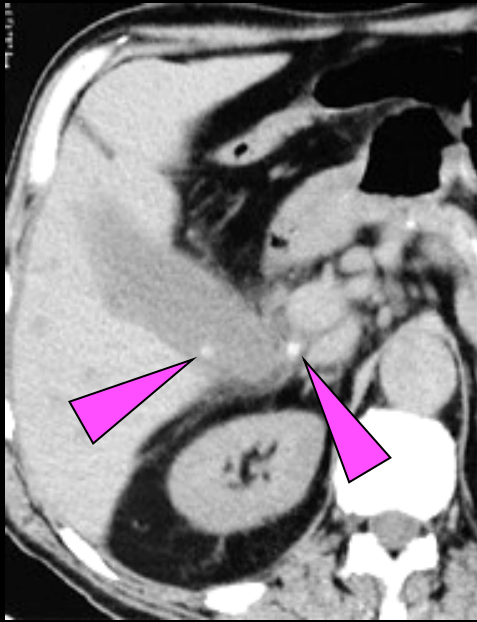
cholécystite
gangreneuse



cholécystite gangreneuse



calcul pigmentaire brun de la VBP et petits calculs mixtes de la vésicule



calculs de la VBP et cholécystite lithiasique



TE long 20 mm



TE court 5 mm



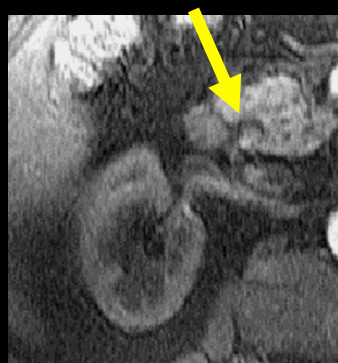
TE long 20 mm
sagittale



T1 gado 6'



TE court 5 mm



T1 avt inj

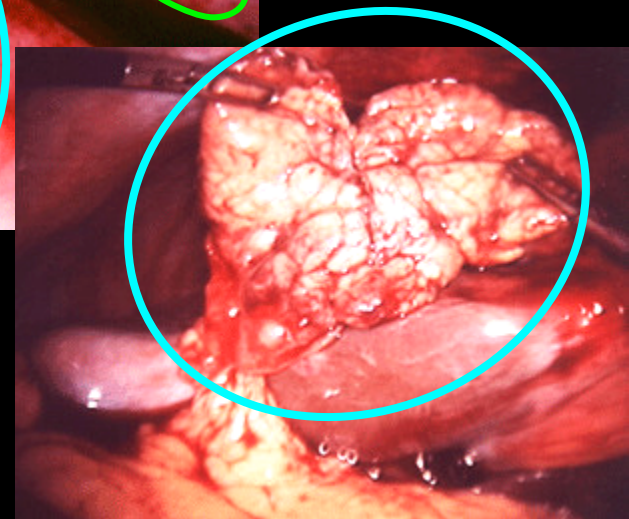
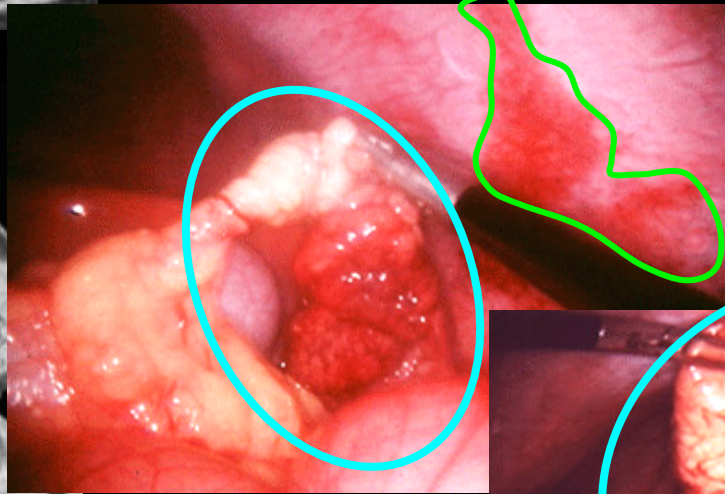


T1 gado 60"



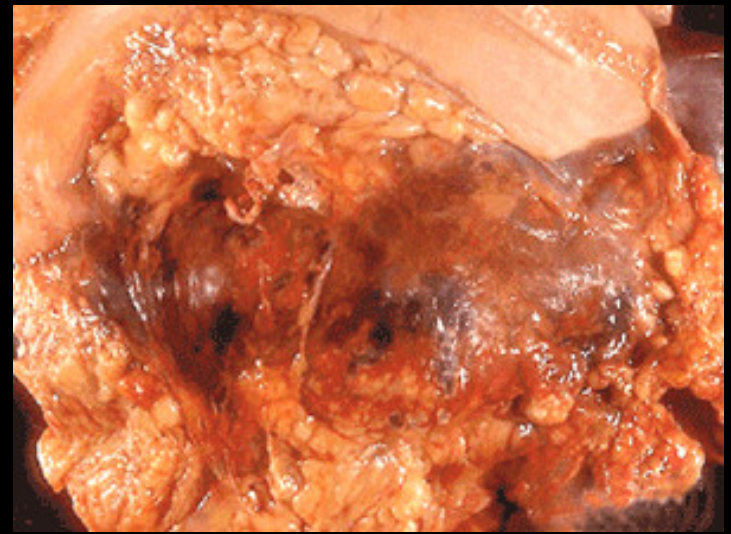
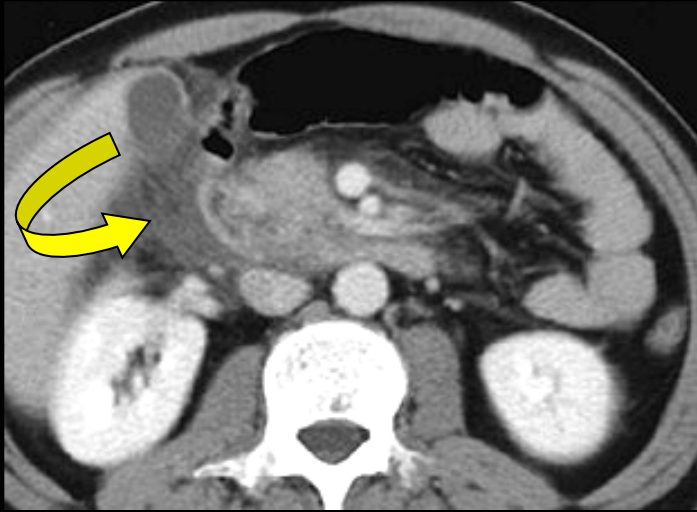
TE court 5 mm

calculs de la VBP et " Oddite" ; échoendoscopie ±
biopsies pour éliminer un ampullome vaterien

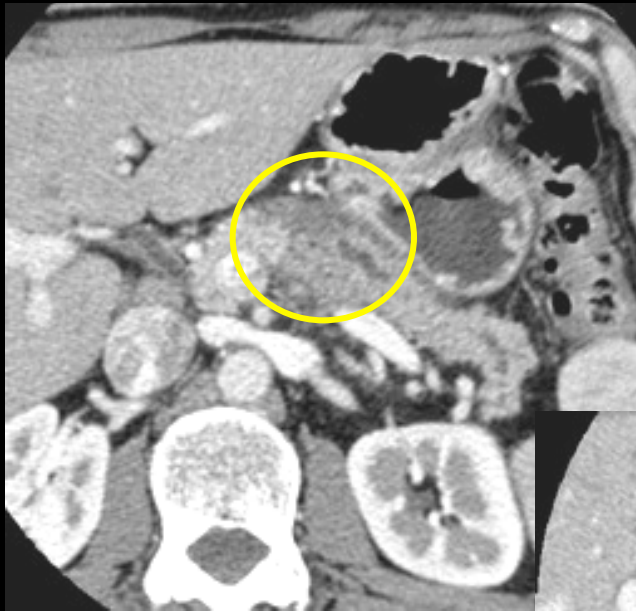


infarctus du grand omentum

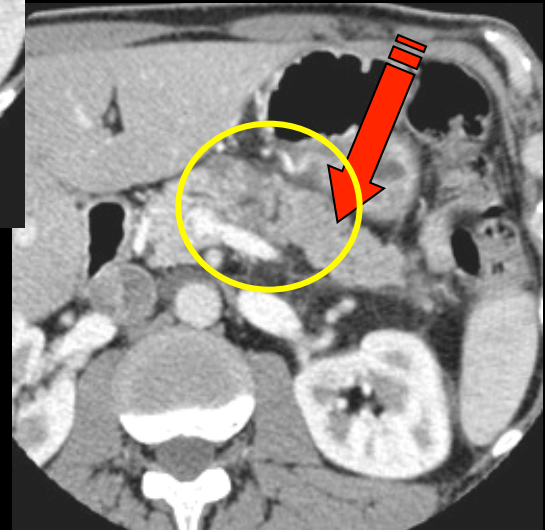
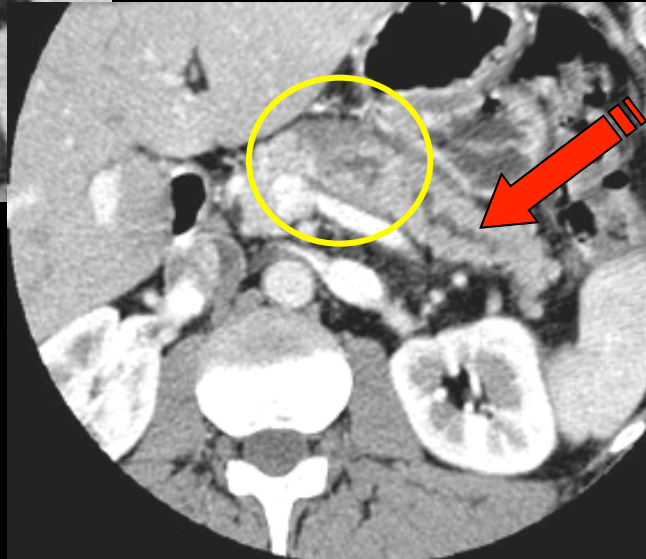
pancréatites aiguës



pancréatites aiguës "symptomatiques"



CT 45"



adénocarcinome ductal du pancréas isthmique sans modification des contours de la glande !
pancréatite obstructive corporéo-caudale d'amont

10 à 30 % des pancréatites (TIPMP+++;carcinome exocrines ou endocrines du pancréas)

Au total : le scanner ; pourquoi ? et quand ?

- bilan **anatomo-pathologique**
macroscopique complet abdomino-
pelvi-thoracique

- plus souvent pour **optimiser** et
sécuriser les choix thérapeutiques
que pour confirmer un diagnostic

- rapide et facile à **lire** ou à
comprendre pour tous les
intervenants

- chaque fois que les autres
méthodes d'examen ont peu de
chances d'apporter des éléments
déterminants pour le **diagnostic** et/
ou la **conduite thérapeutique**.



merci de votre attention