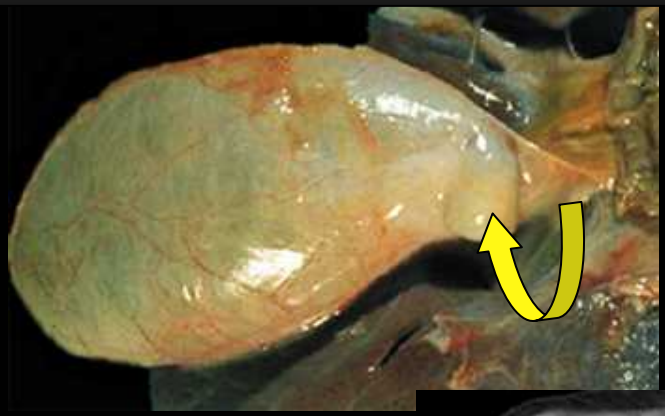
points clés et pièges du diagnostic des urgences de l'étage sus-mésocolique

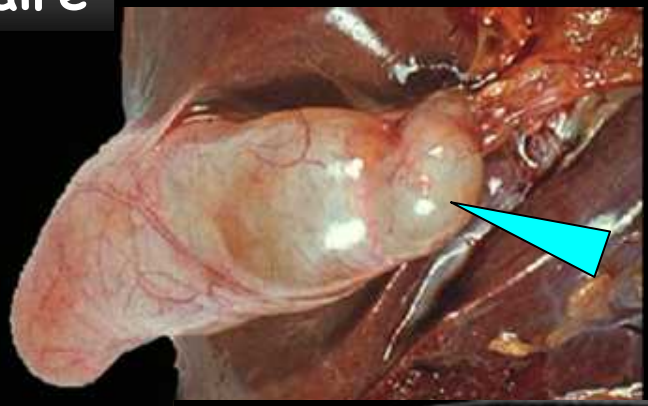
-cholécystites aiguës lithiasiques et acalculeuses

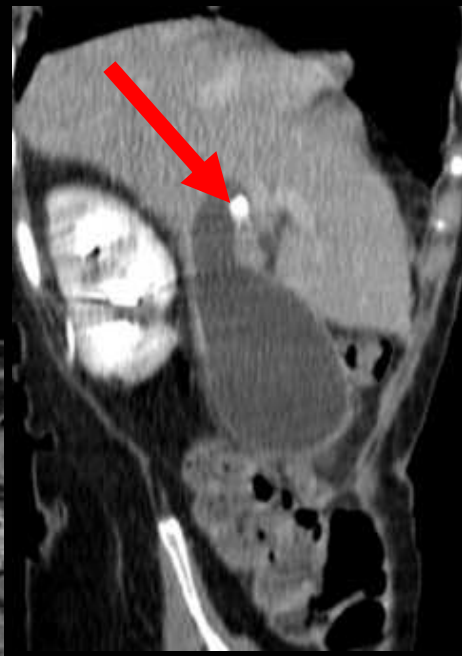
- pancréatites aiguës et poussées aiguës sur pancréatite chronique

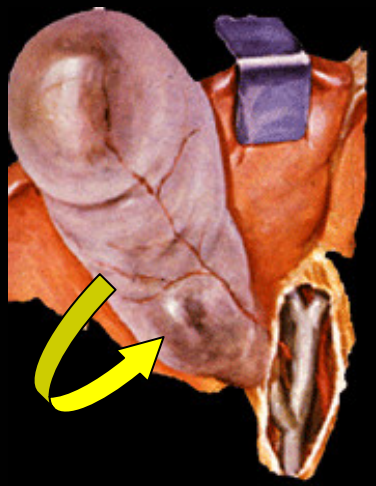
- urgences abdominales d'origine hépatique et splénique

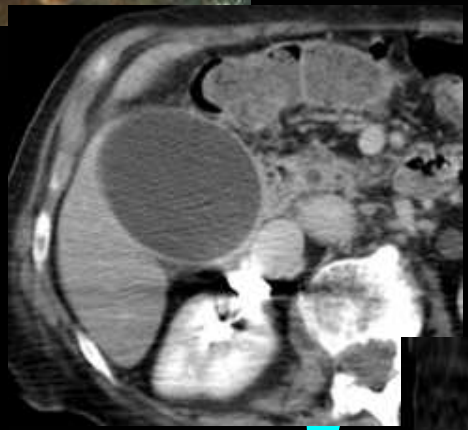
.abdomens aigus d'origine biliaire

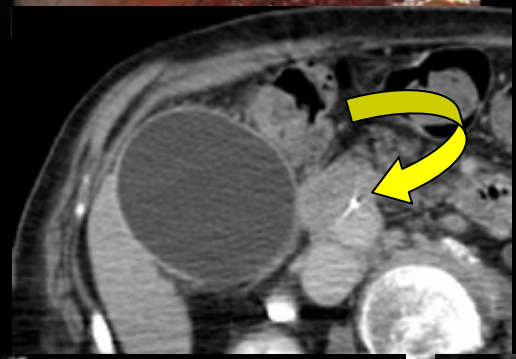


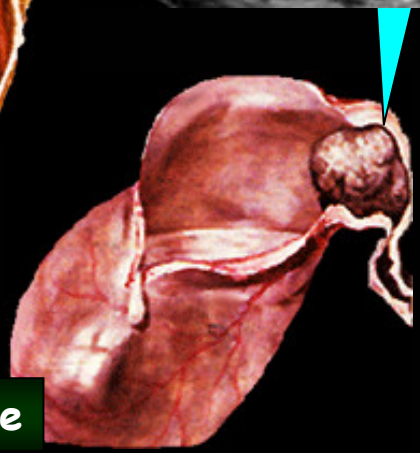


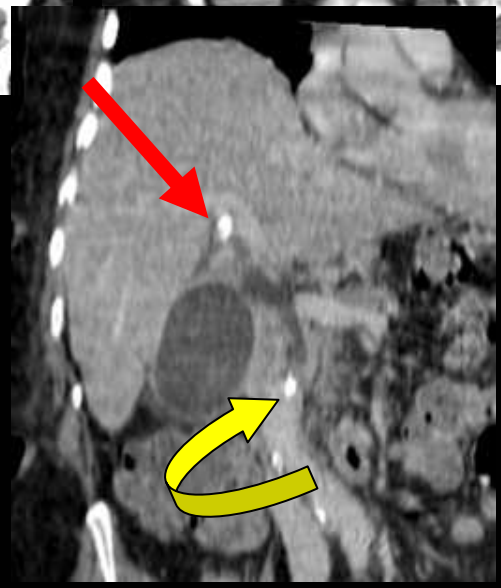


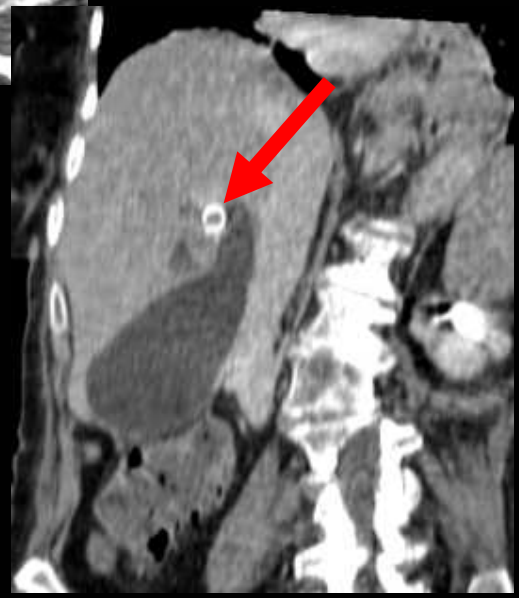




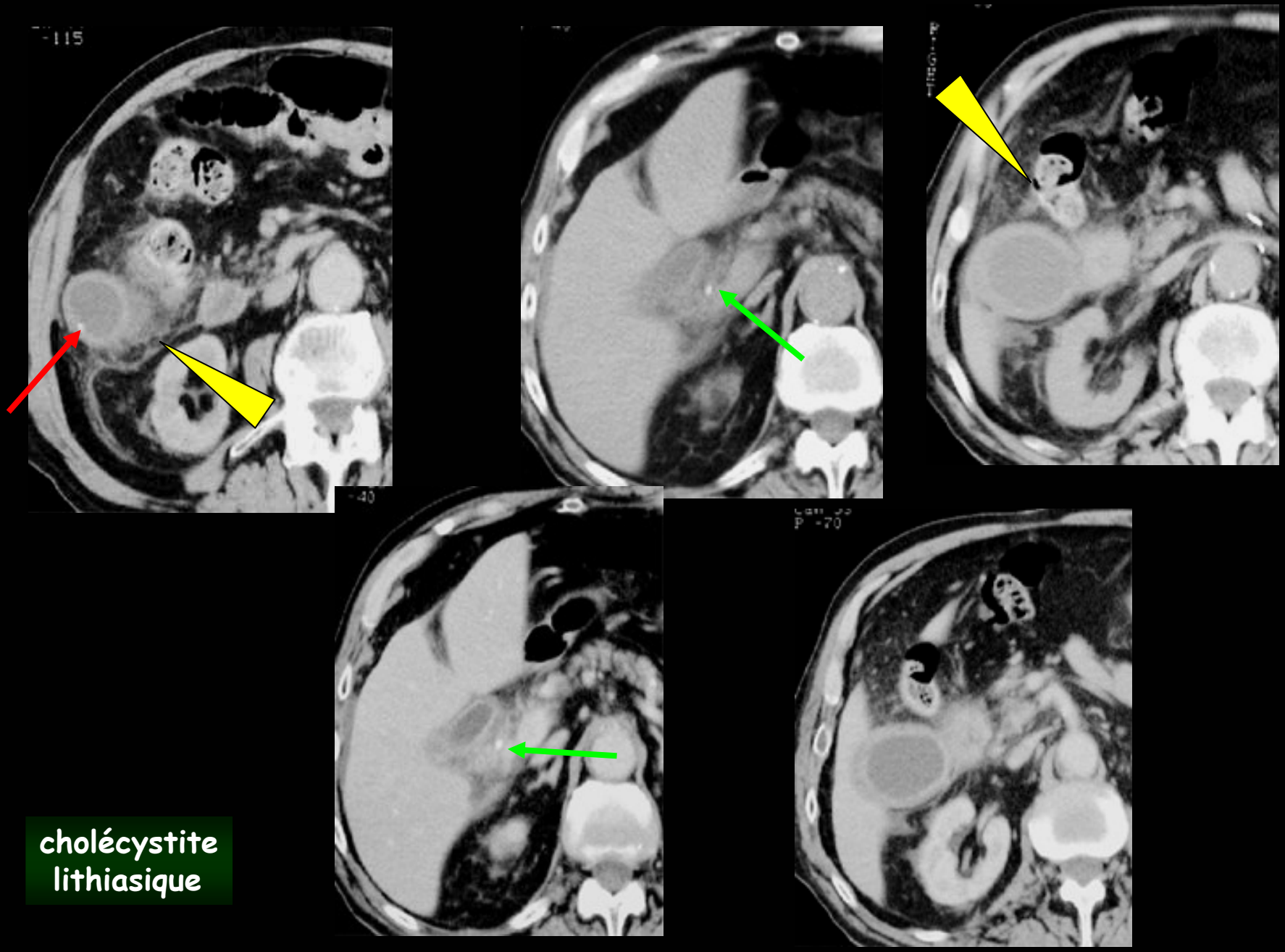




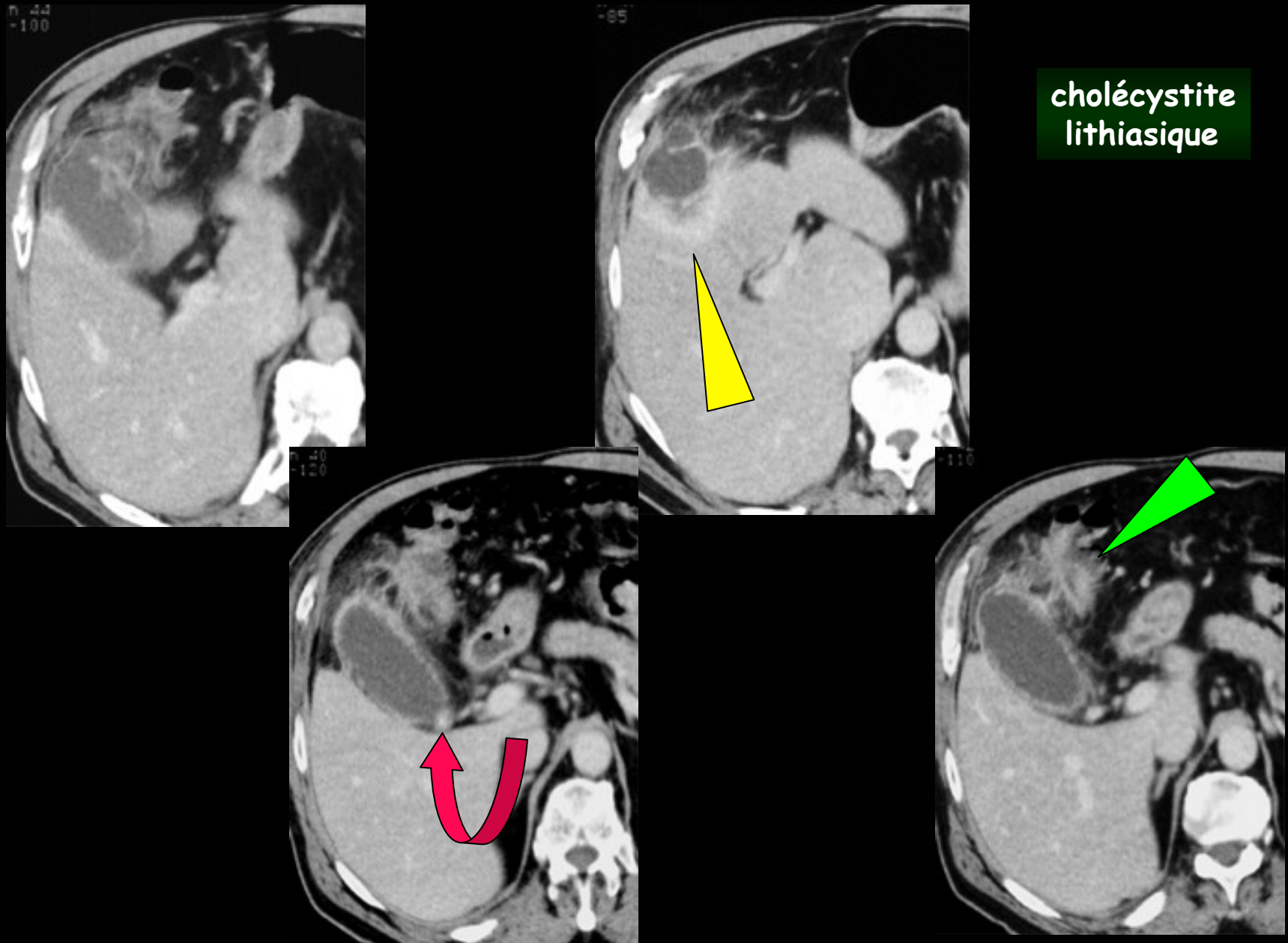


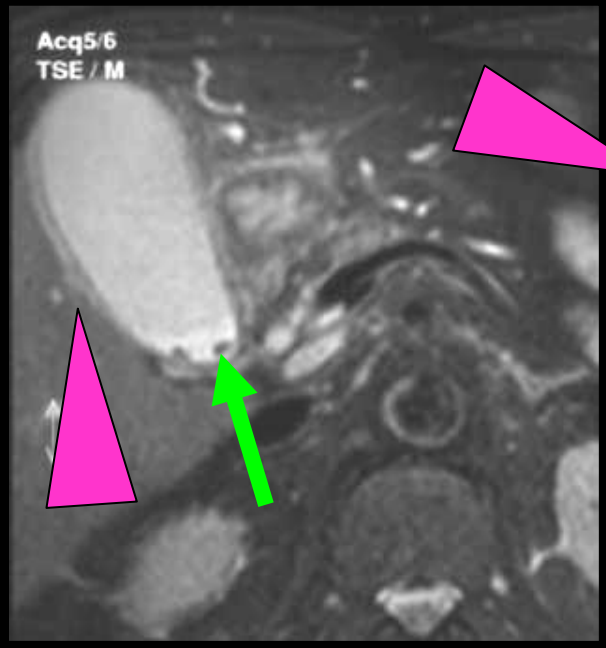


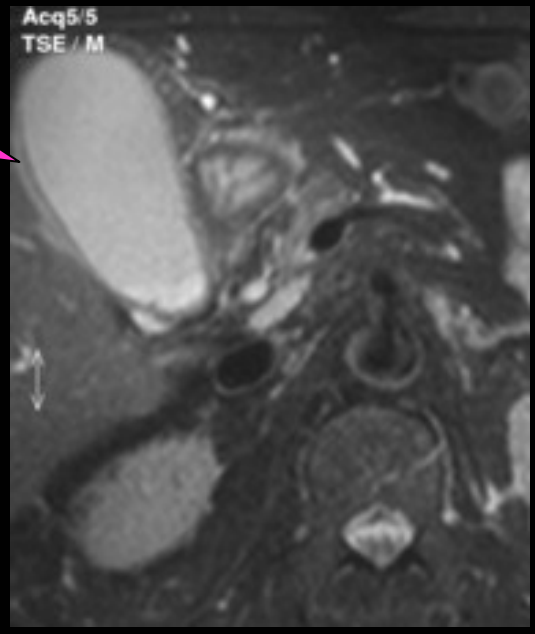
hydrocholécyste

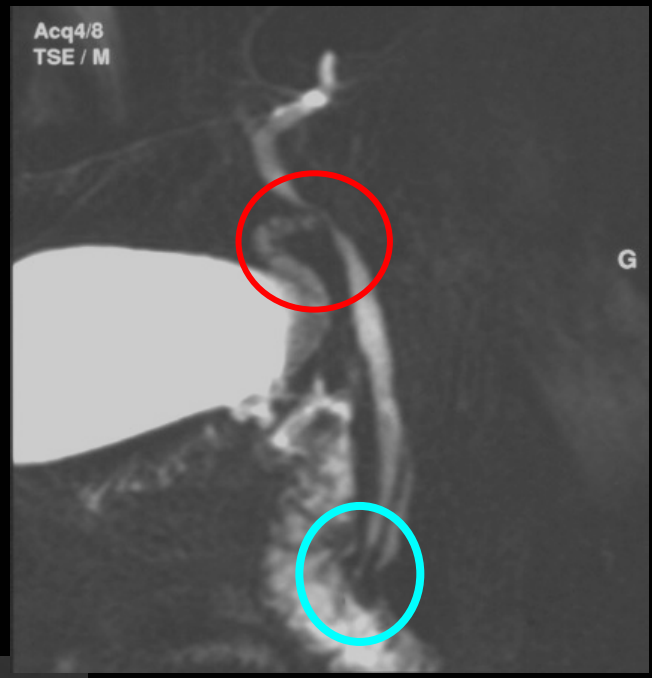


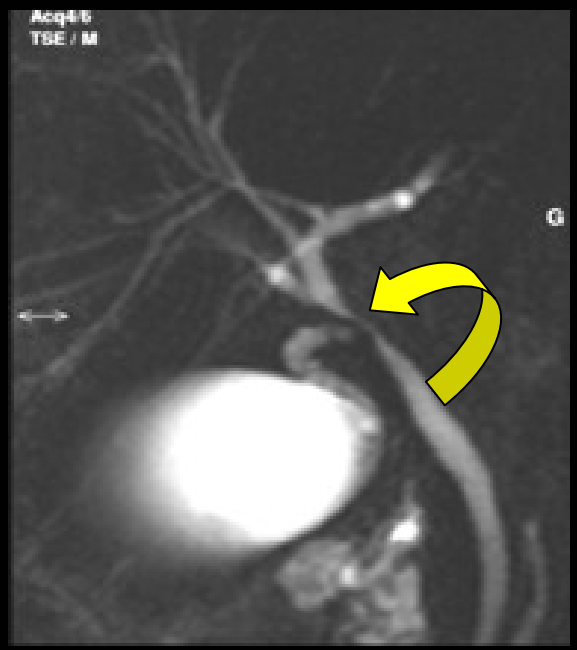
cholécystite lithiasique

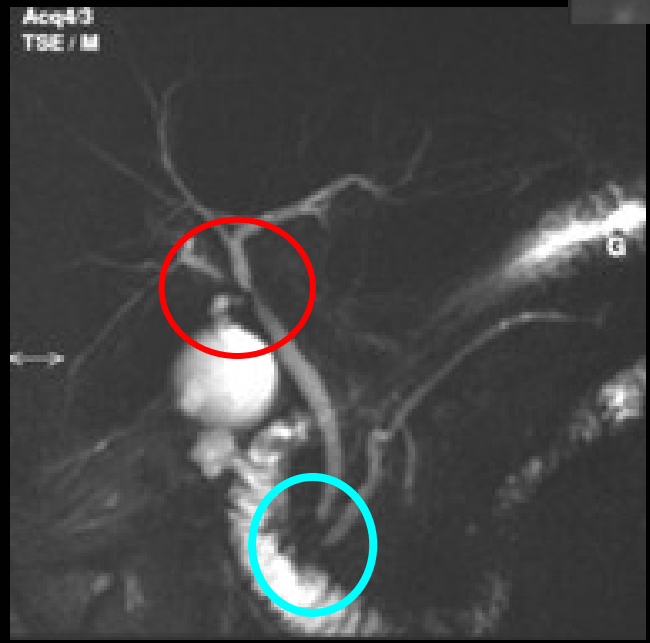

cholécystite
lithiasique





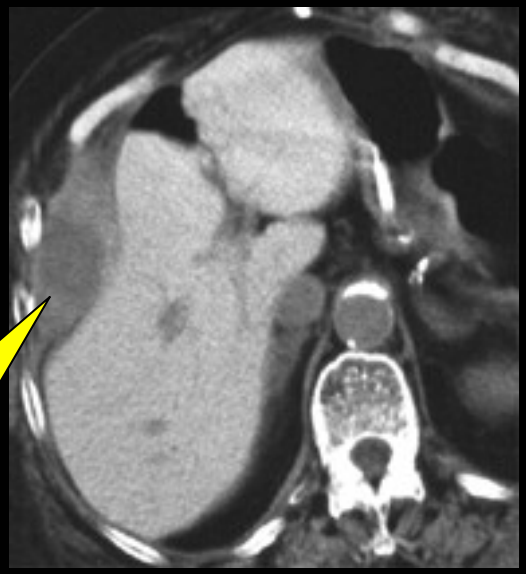


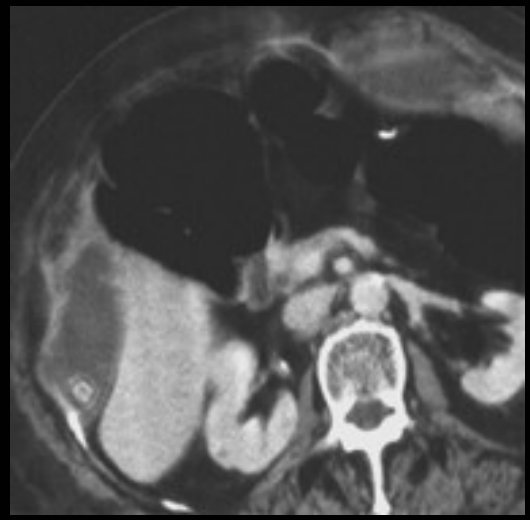


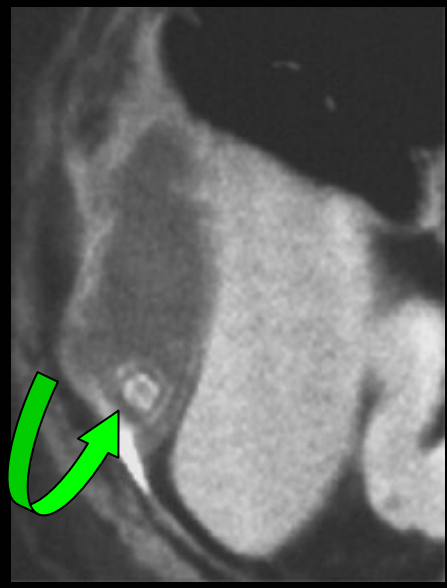


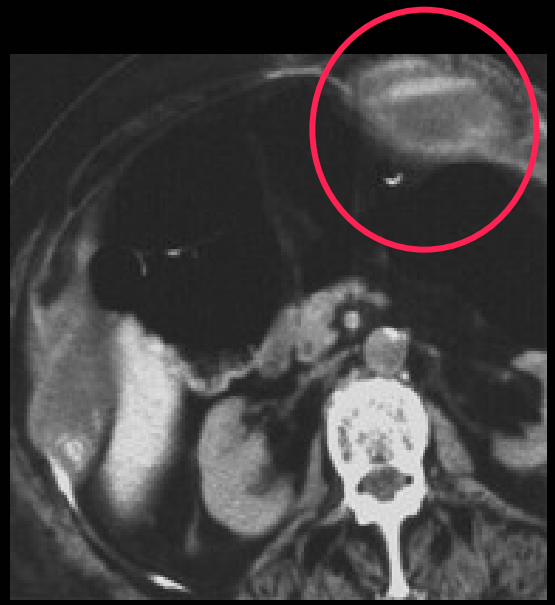
cholestase et cholécystite lithiasique

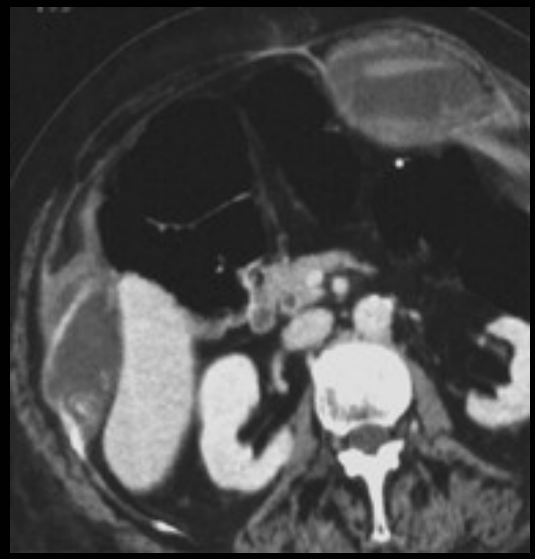
patiente
cholécystectomisée
depuis plusieurs années



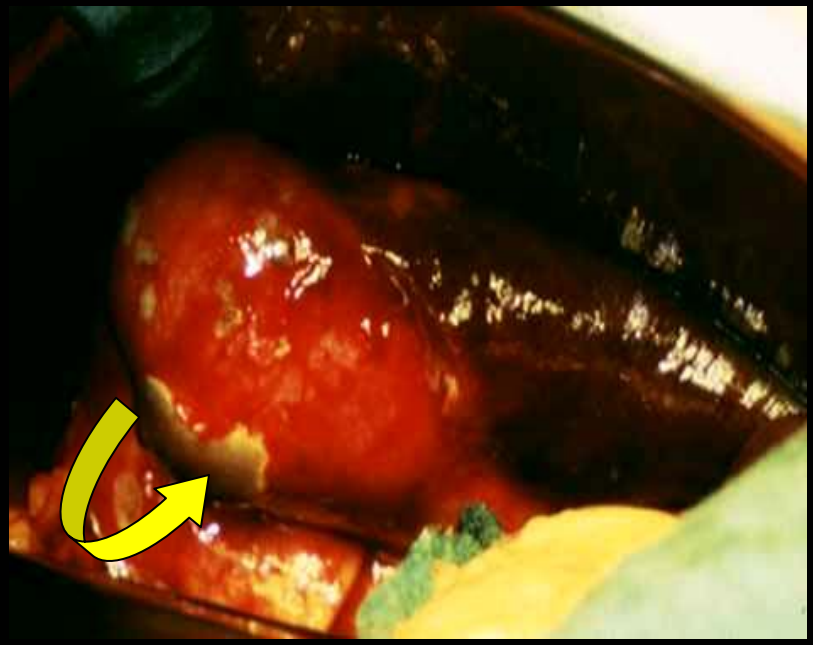


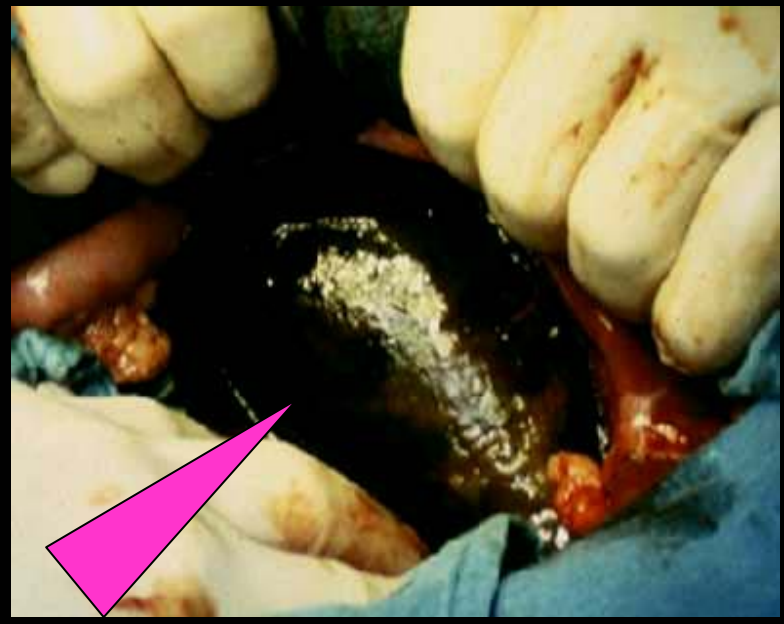




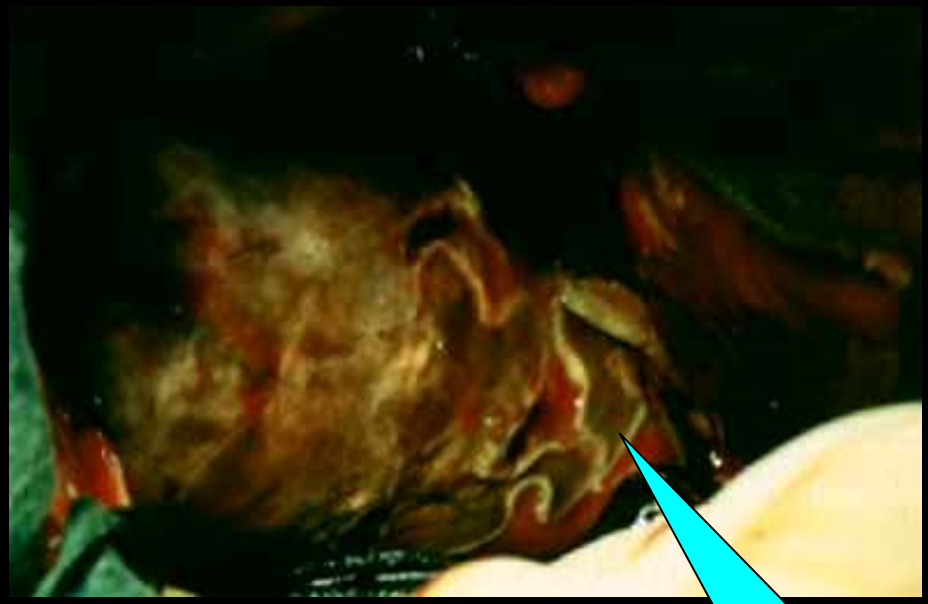


abcès sous phrénique sur calcul « perdu » lors de la cholécystectomie

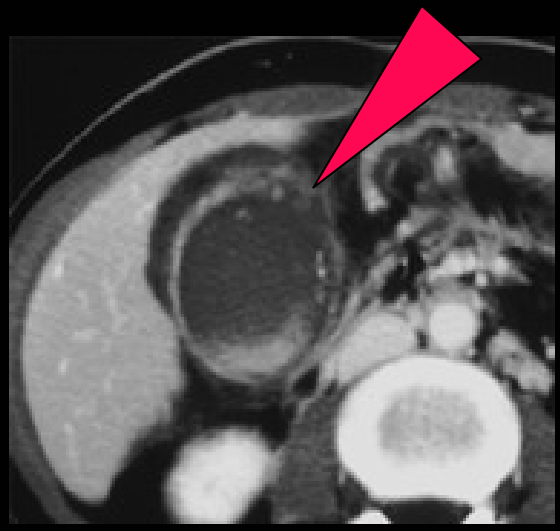


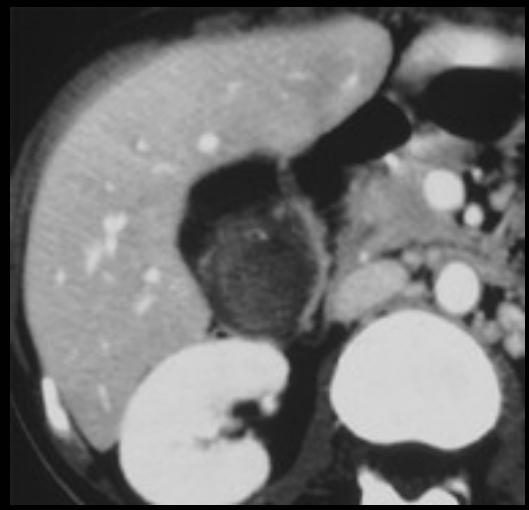


cholécystite
hémorragique

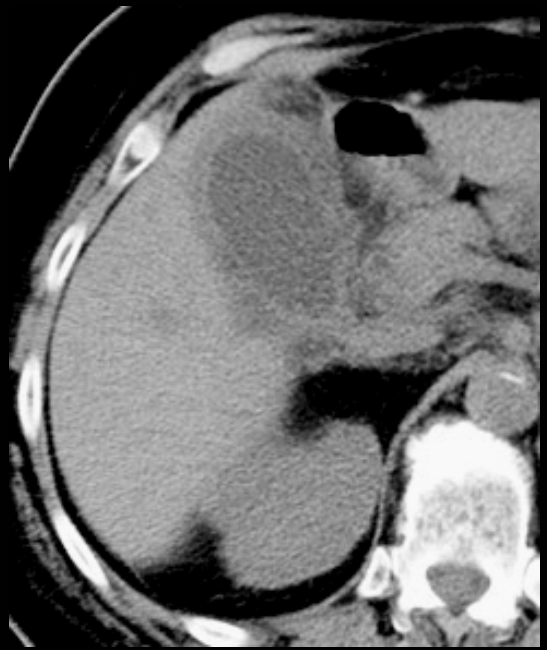


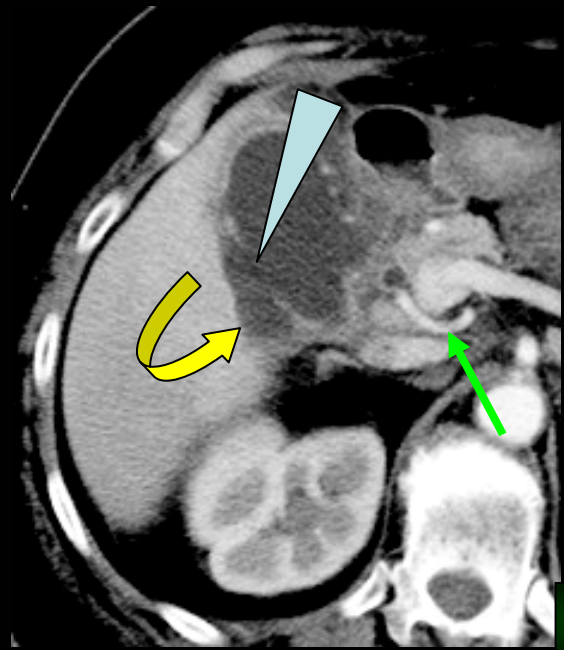
cholécystites
gangreneuses

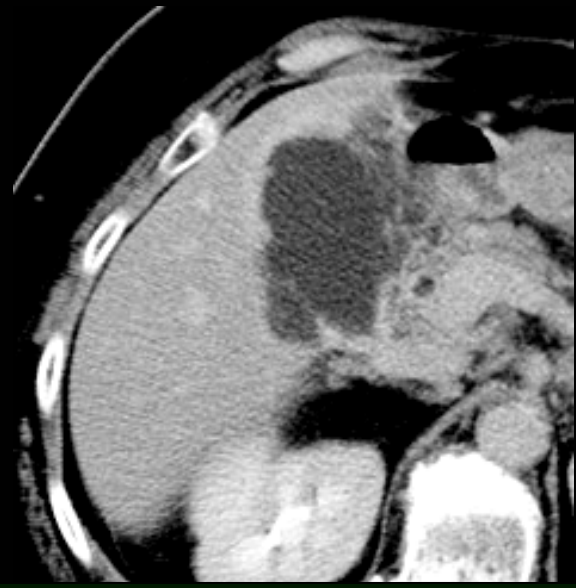




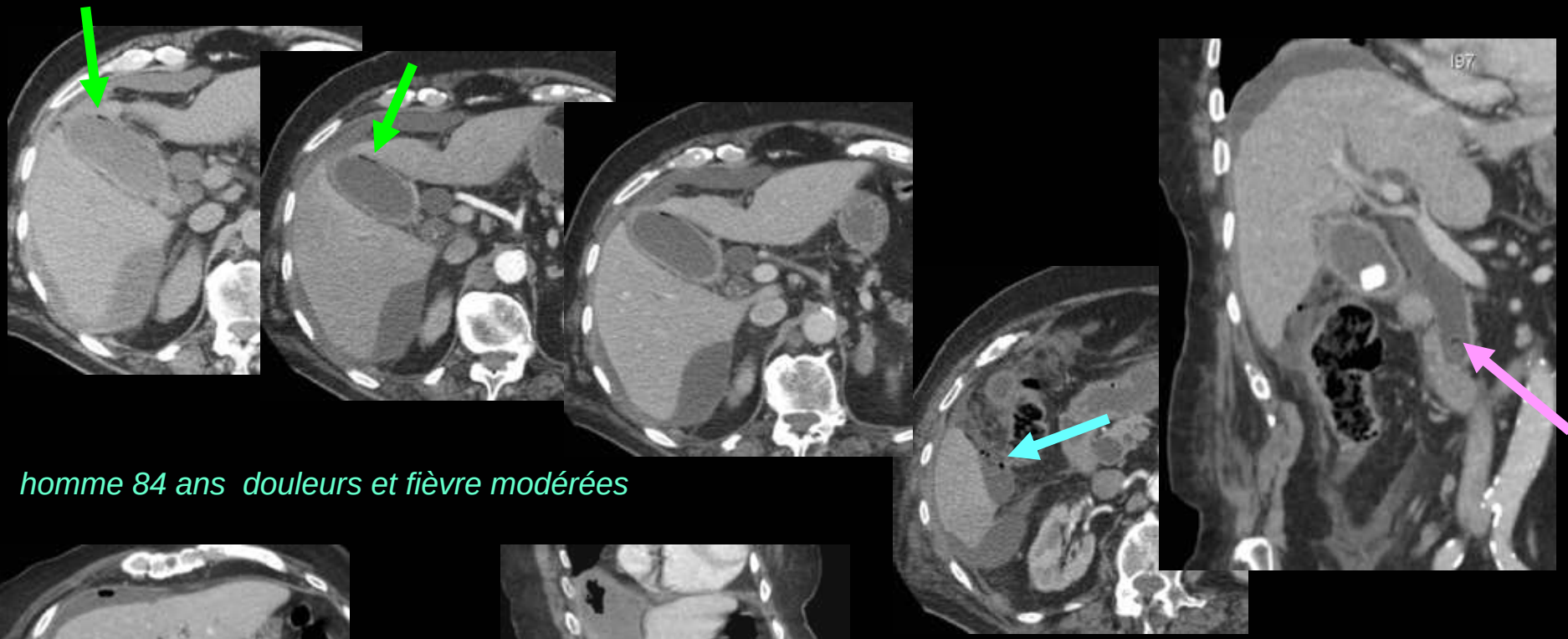
cholécystite gangreneuse



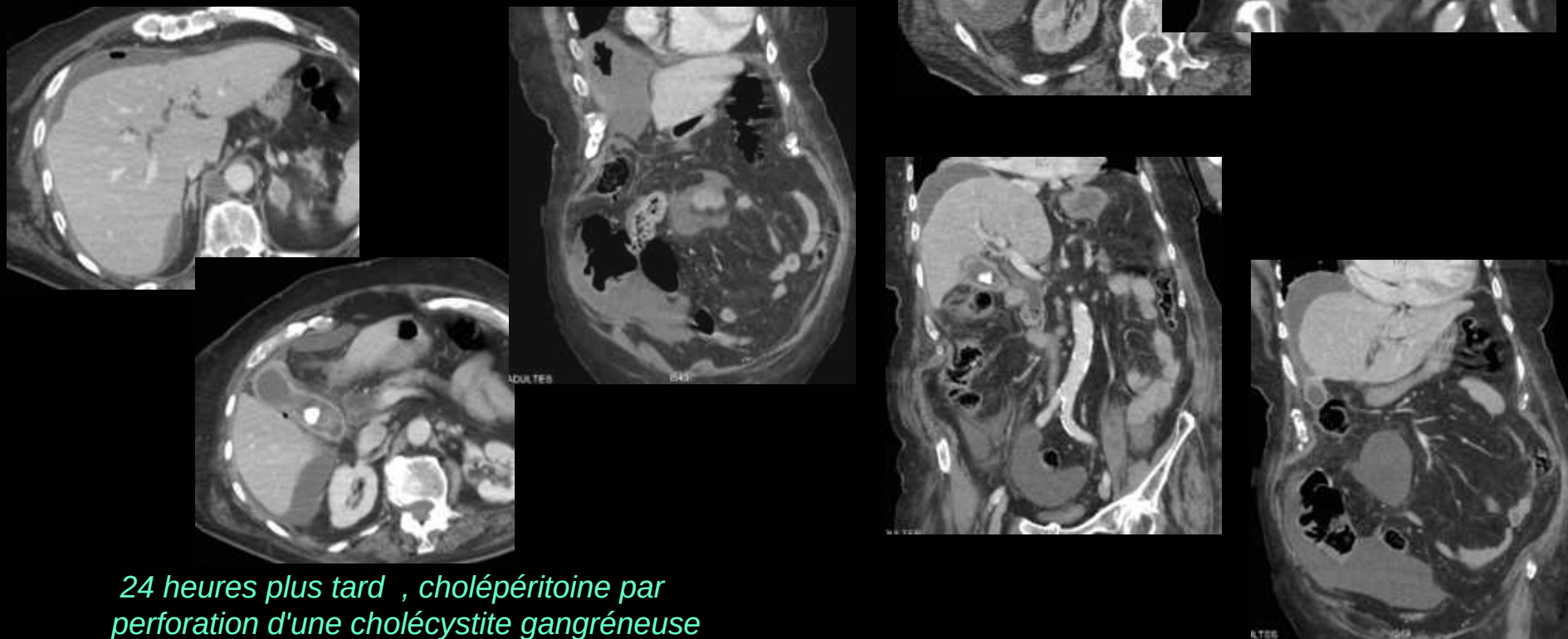




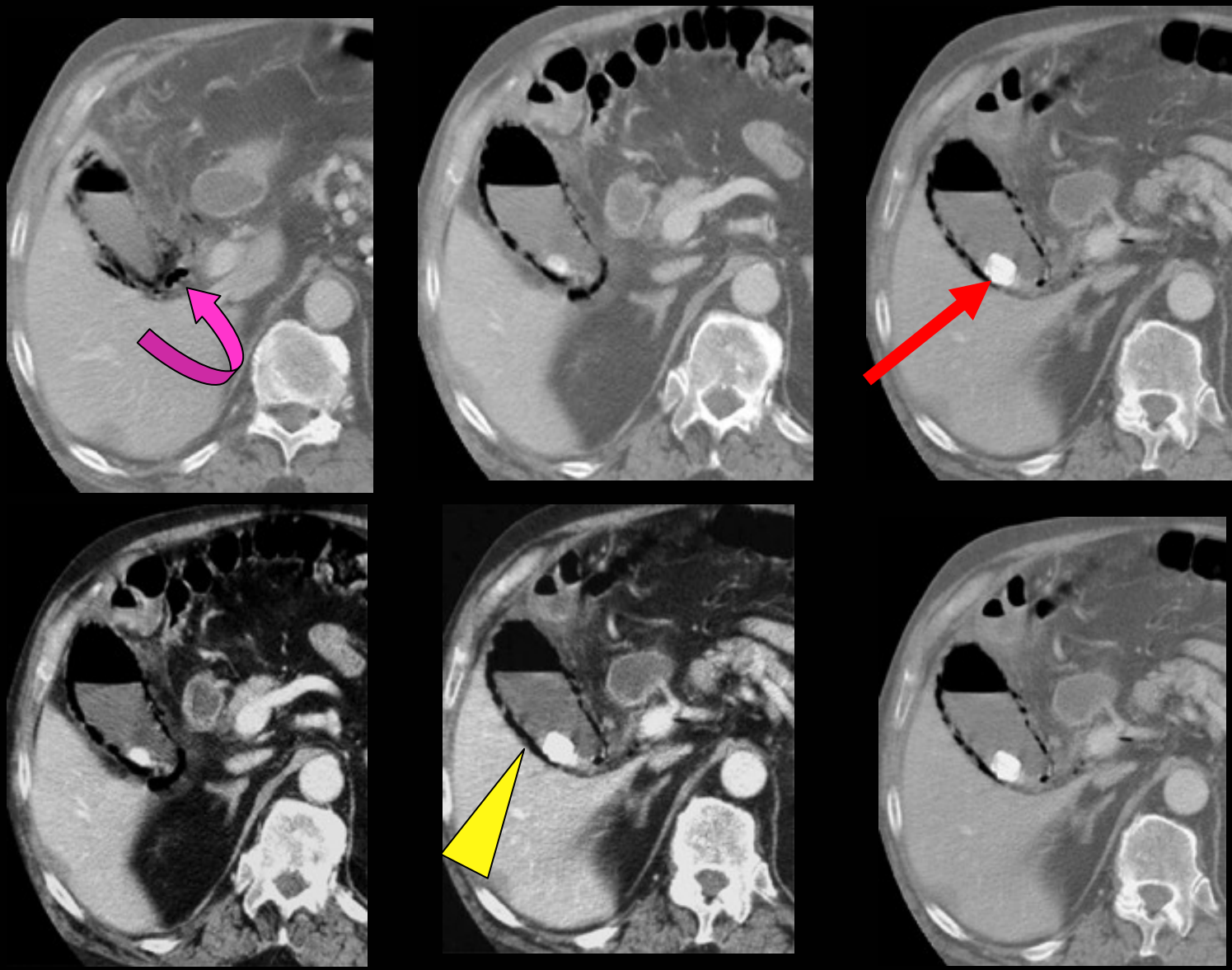
cholécystite gangreneuse



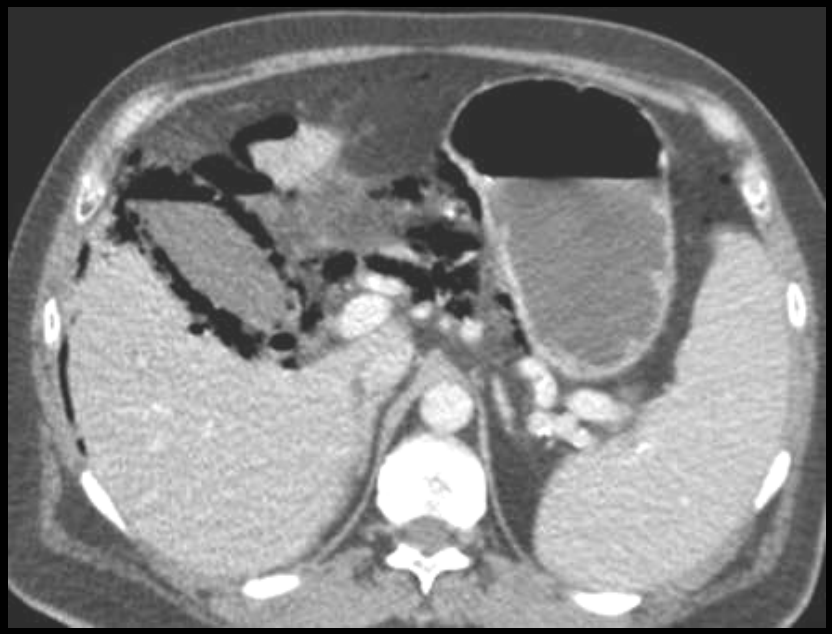
homme 84 ans douleurs et fièvre modérées

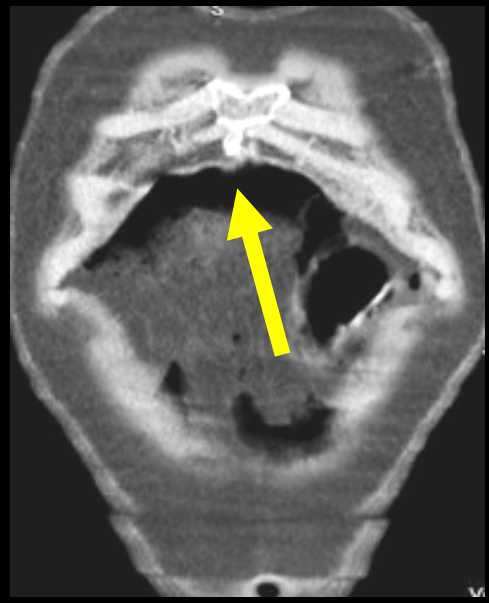


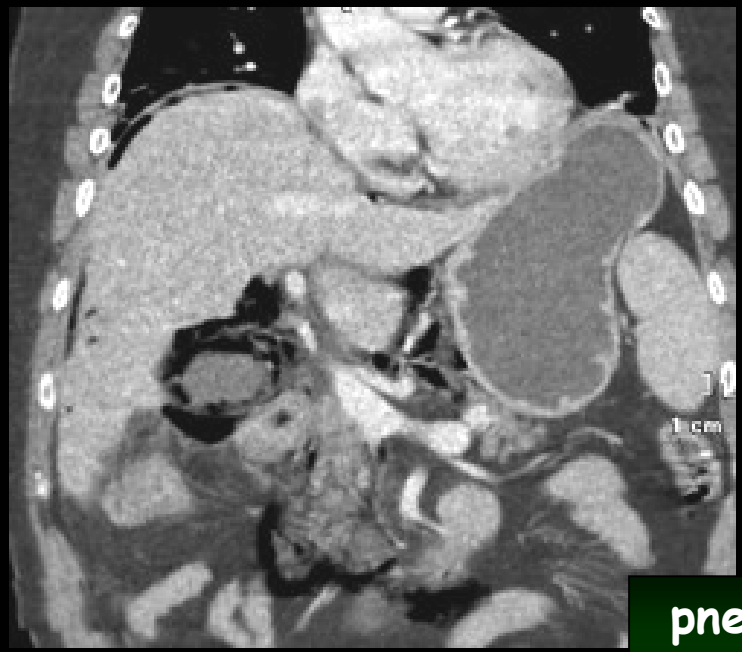
24 heures plus tard , cholépéritoine par perforation d'une cholécystite gangréneuse

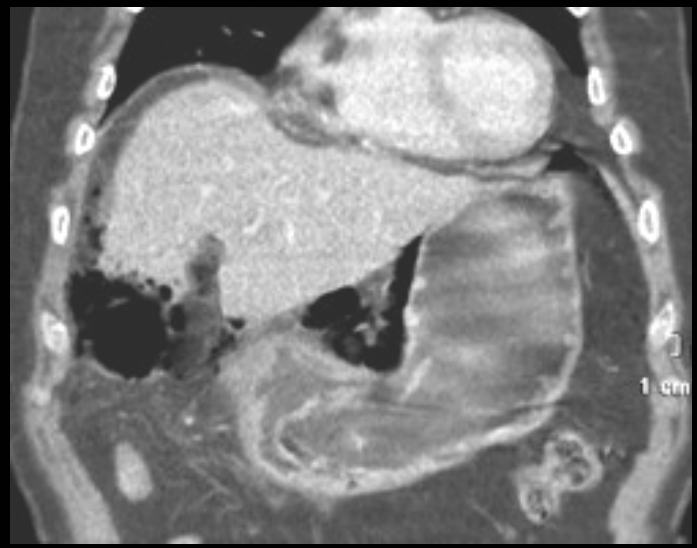


cholécystite emphysémateuse





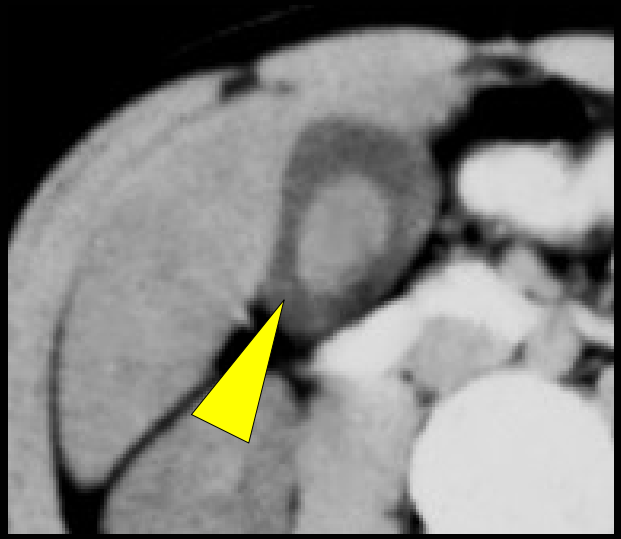




pneumopéritoine sur cholécystite emphysémateuse

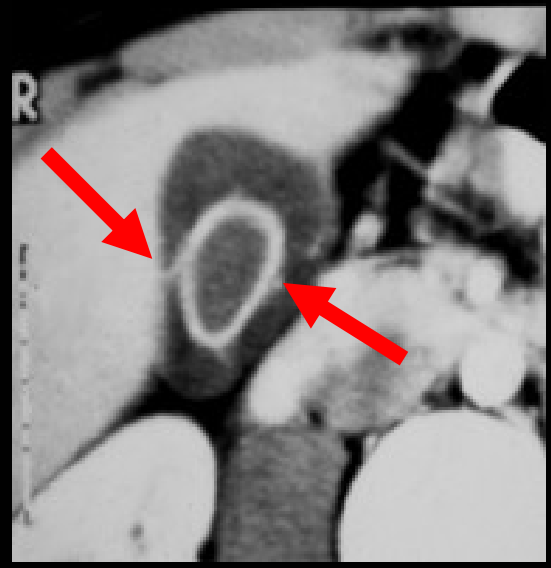
Obs.M Deneuville
CHR Metz

avant injection

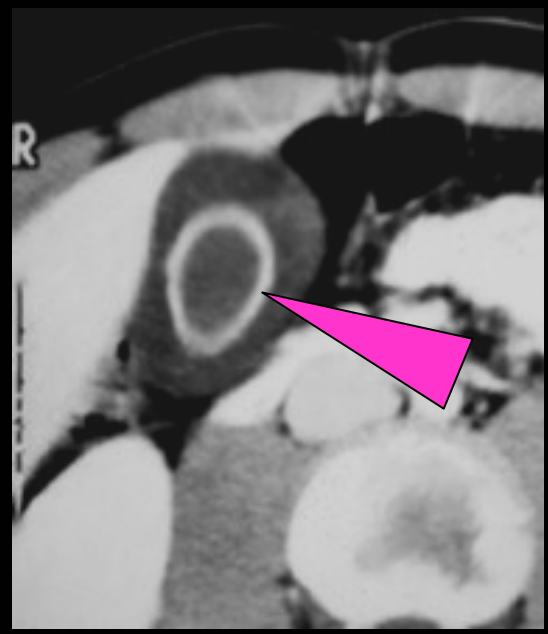


avt. inj.

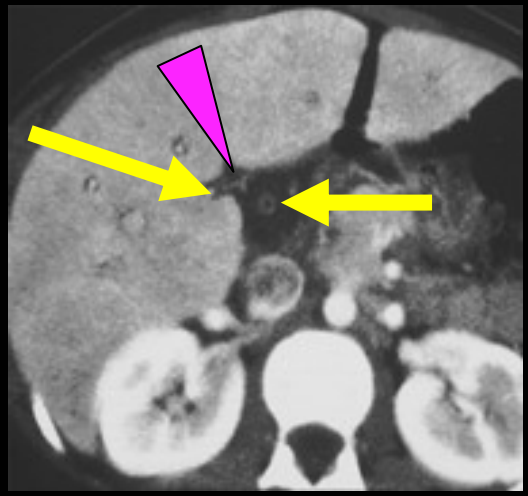
après injection

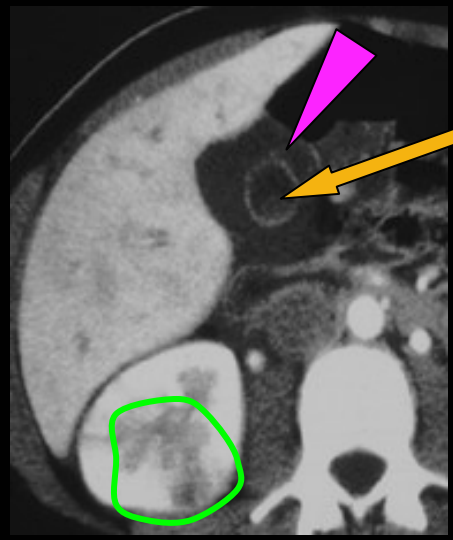


70"

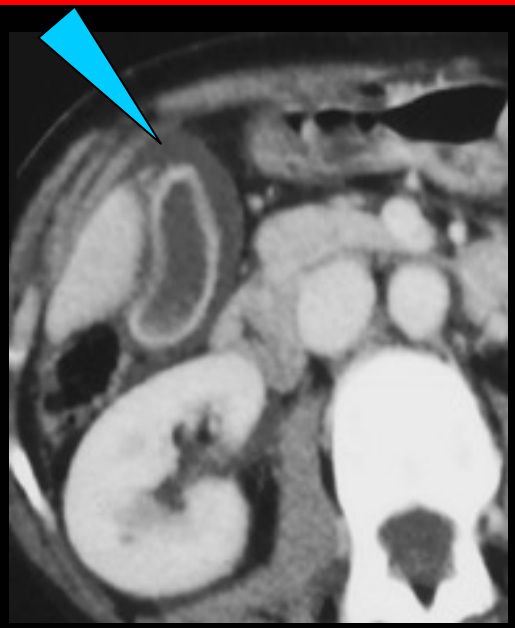


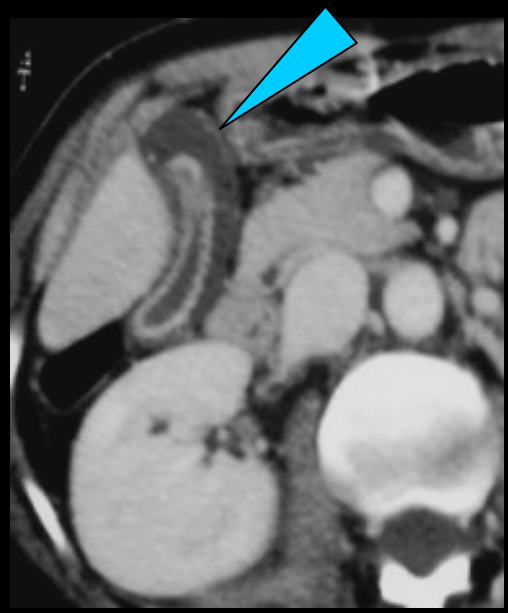
œdème de la paroi
vésiculaire
hépatite A, phase pré-ictérique



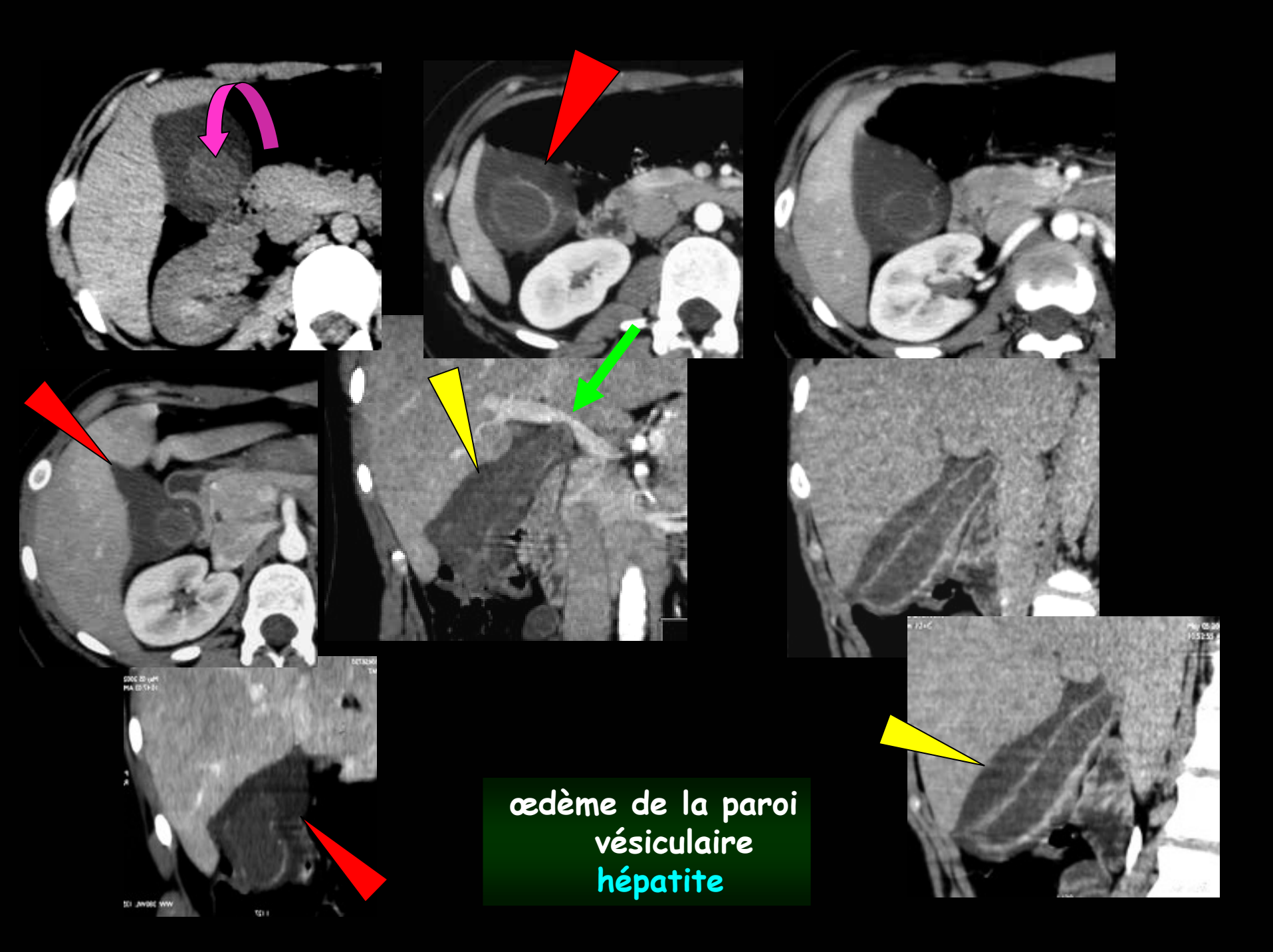


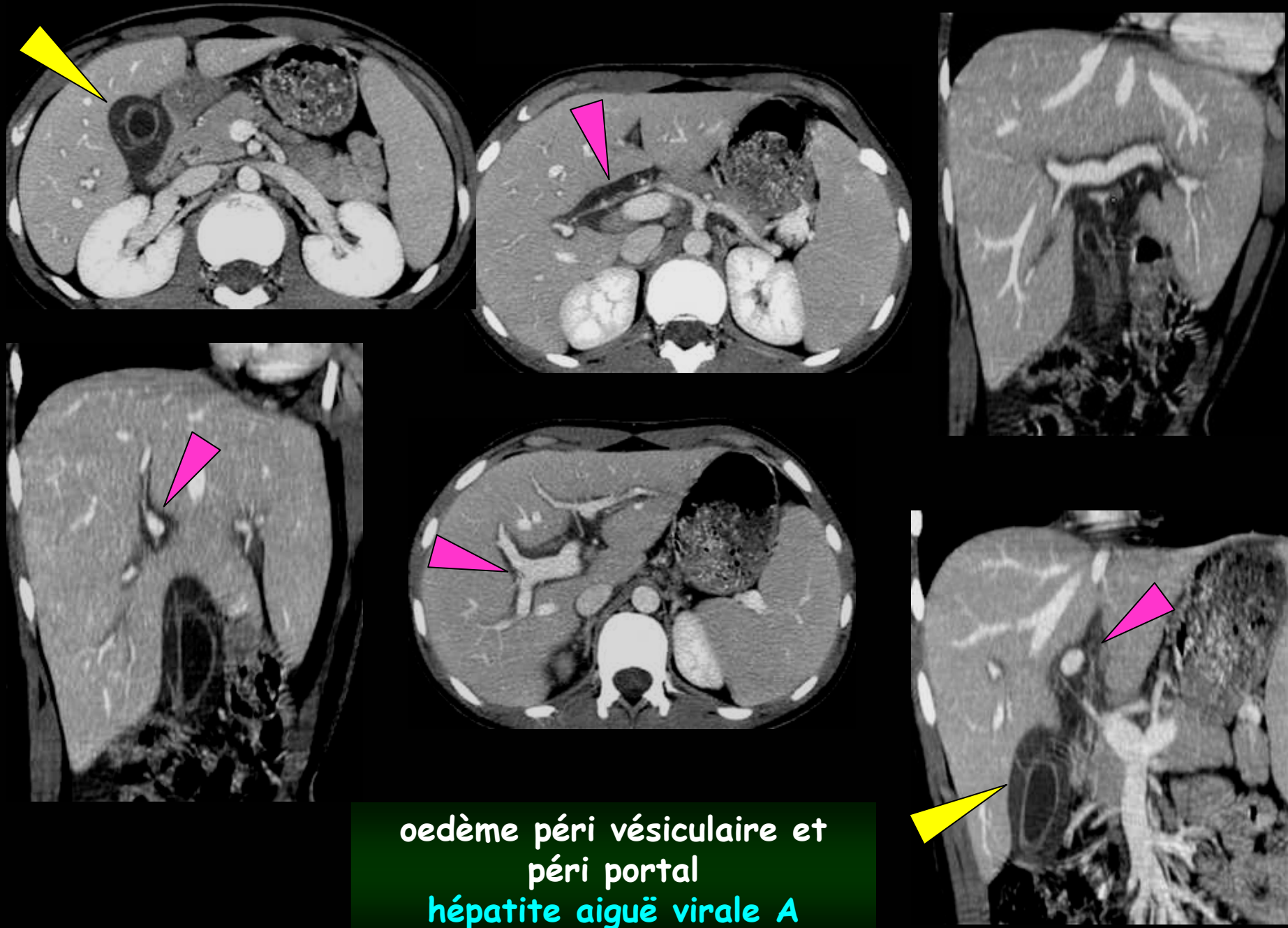
œdème de la paroi vésiculaire
pyélonéphrite droite





œdème de la paroi vésiculaire
insuffisance cardiaque droite


œdème de la paroi
vésiculaire
hépatite

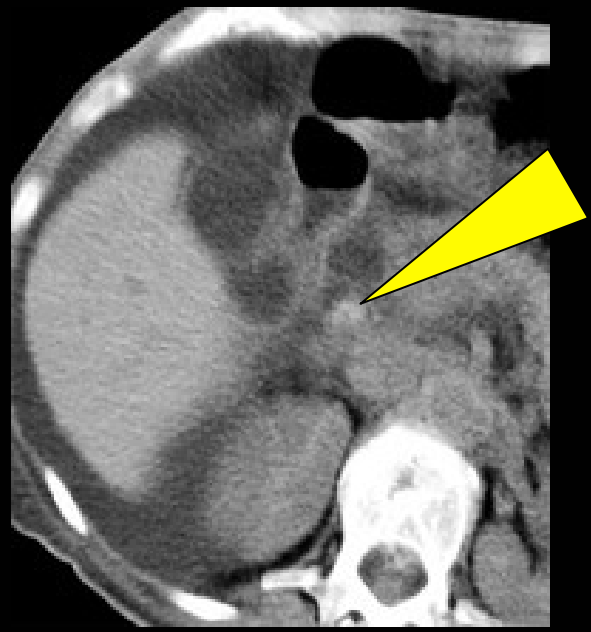


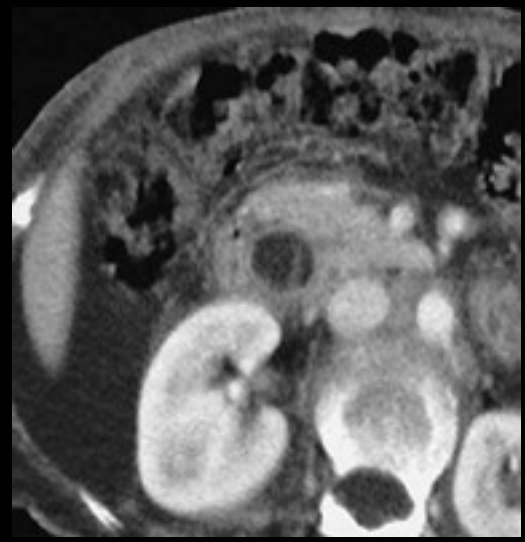
oedème péri vésiculaire et
péri portal
hépatite aiguë virale A

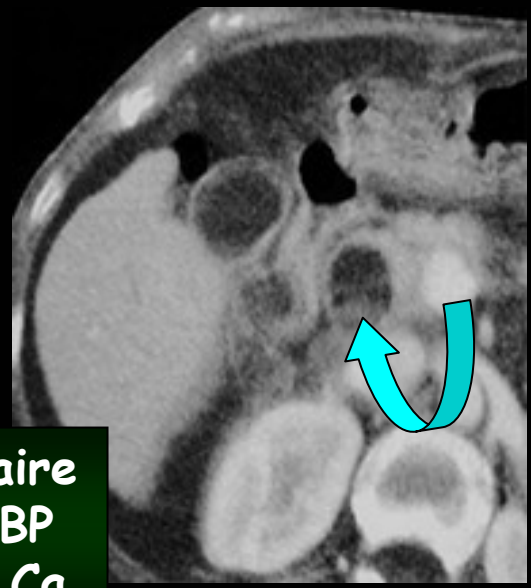
avt. inj.

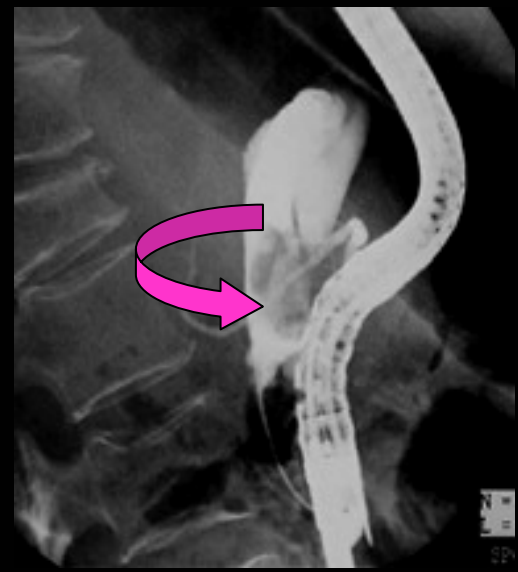
50"

calculs cholestéroliques vésiculaires





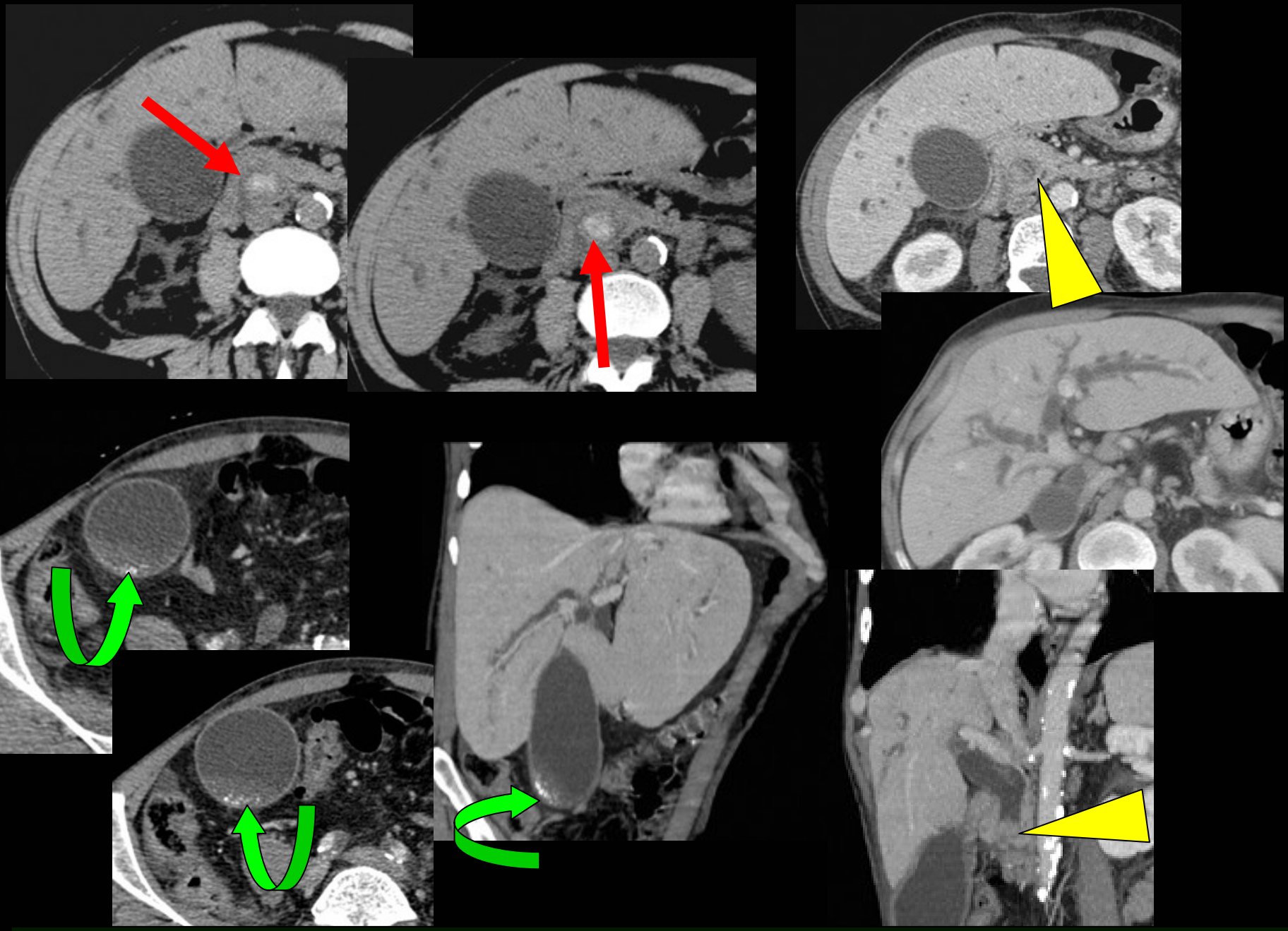




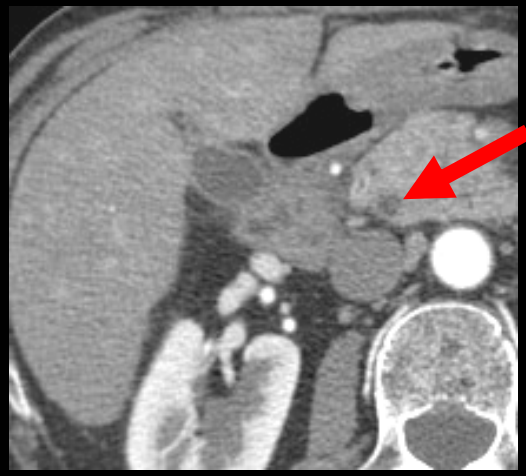
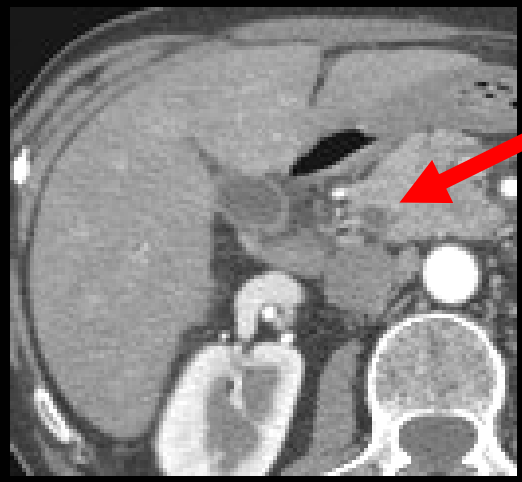
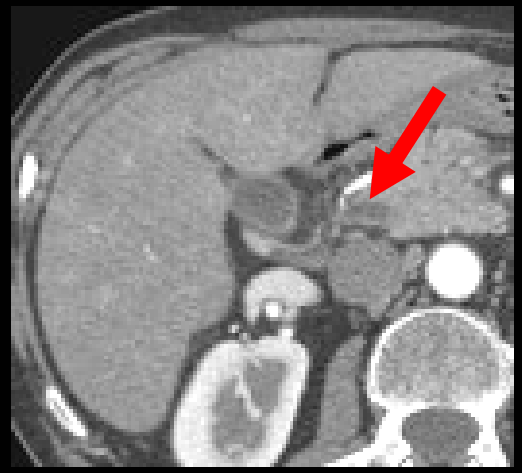
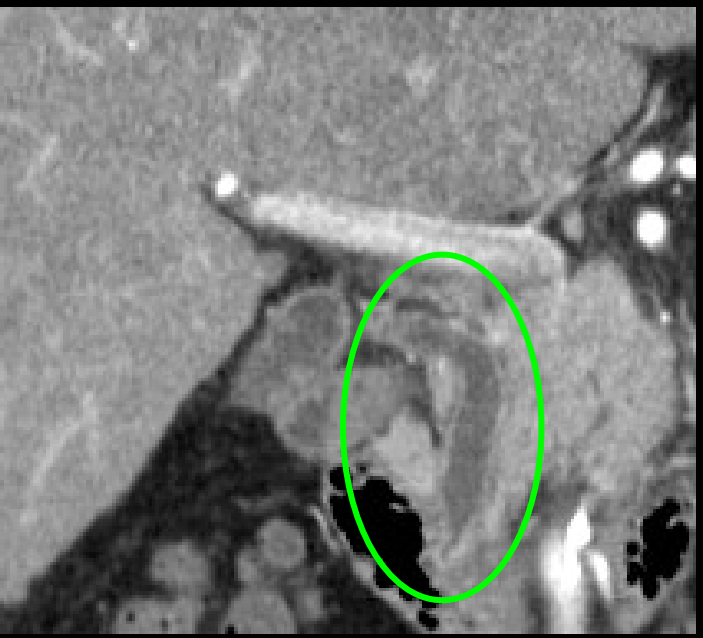
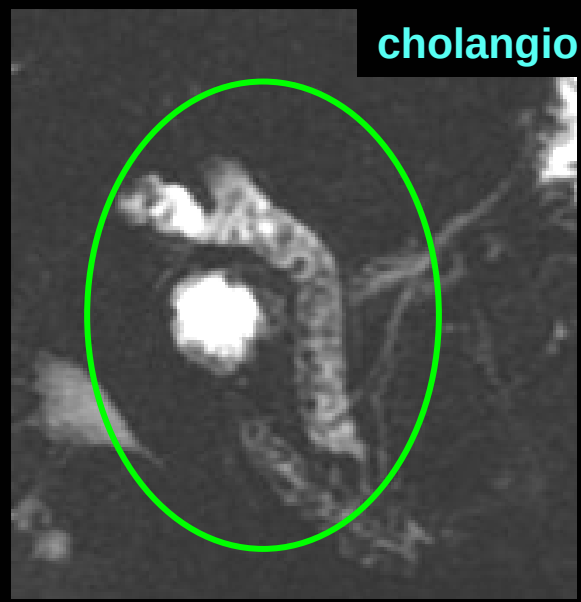
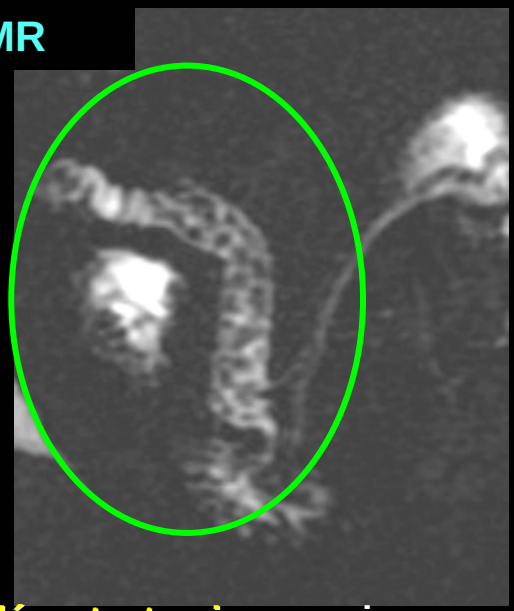
calcul pigmentaire brun de la VBP bilirubinate de Ca

1'30

CPRE

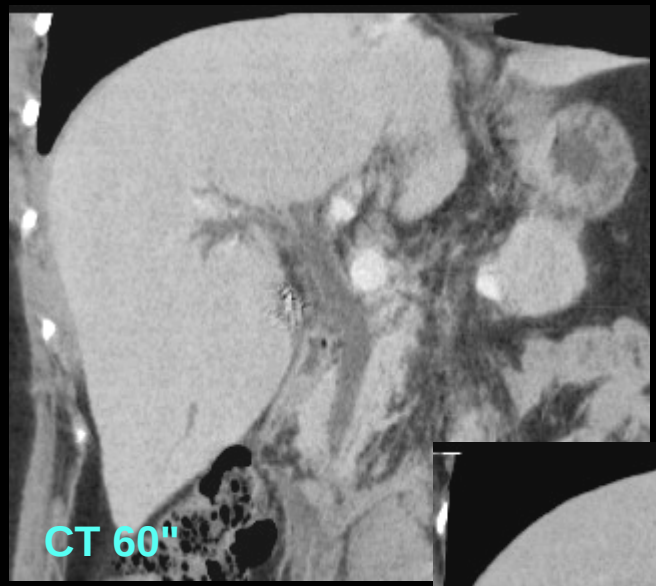


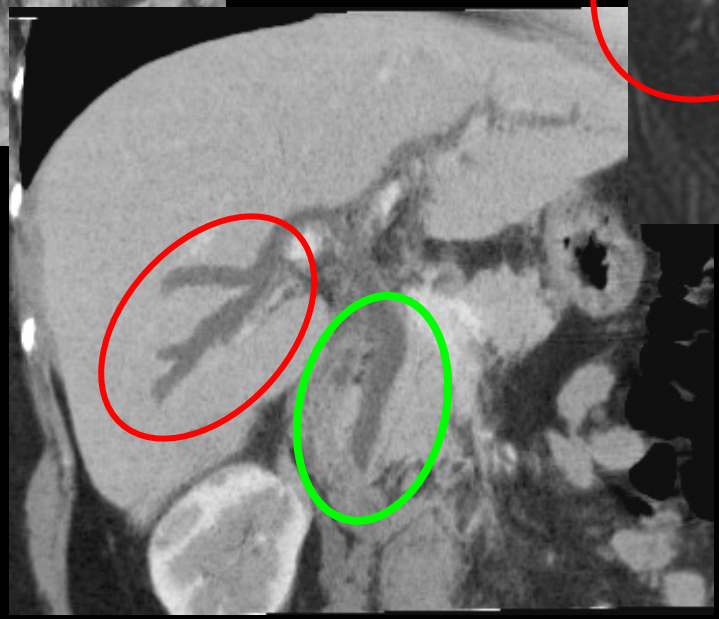
calcul pigmentaire brun de la VBP et petits calculs mixtes de la vésicule

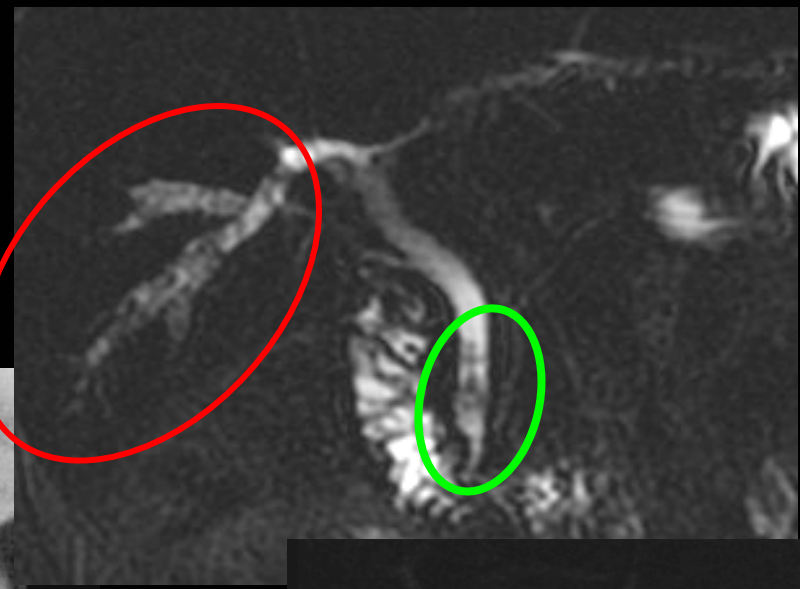







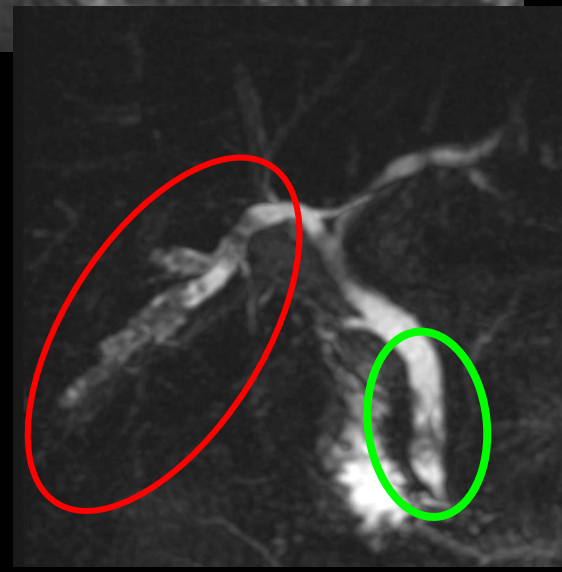
cholangio MR

femme 65 ans ; douleurs hypochondre droit – fièvre – ictère ; ATCD cholécystectomie ; empierrement lithiasique cholestérolique de la VBP

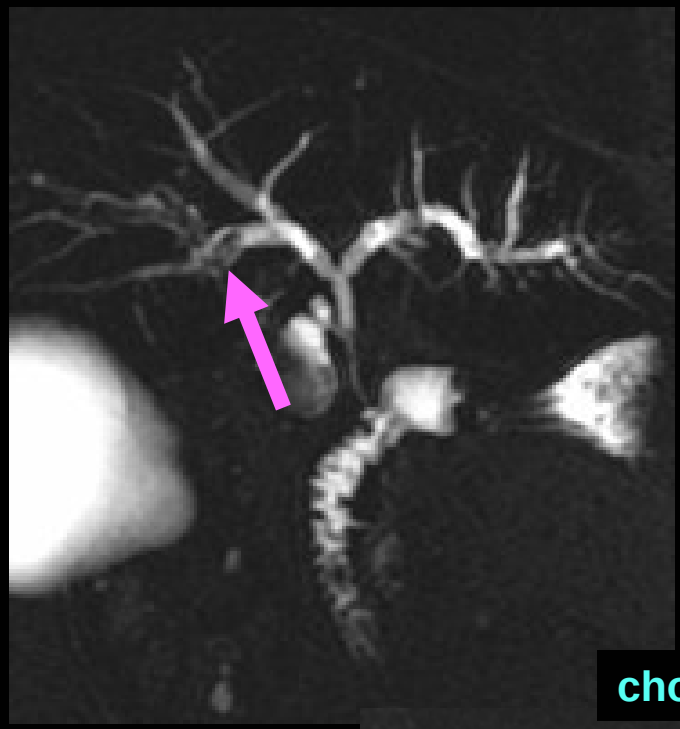


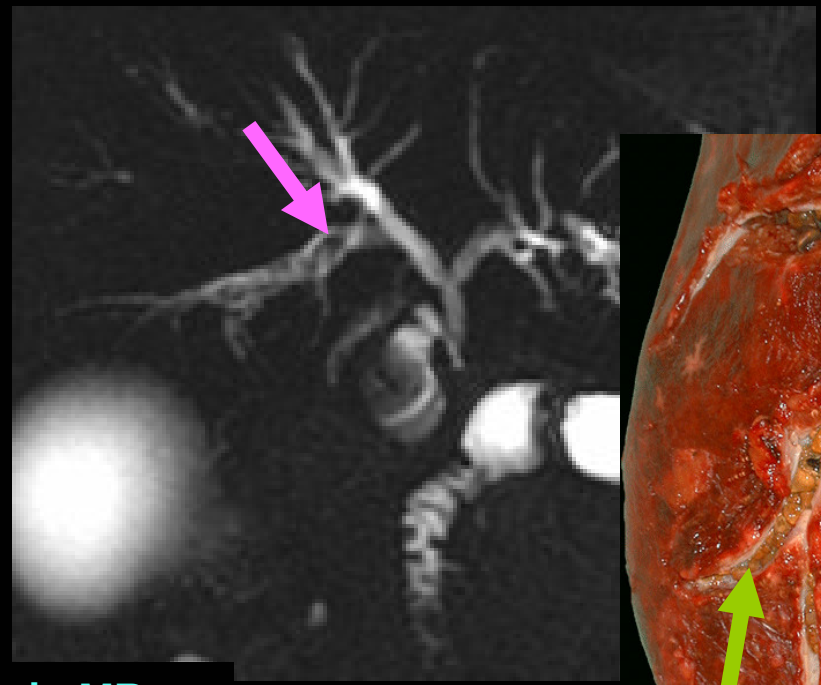




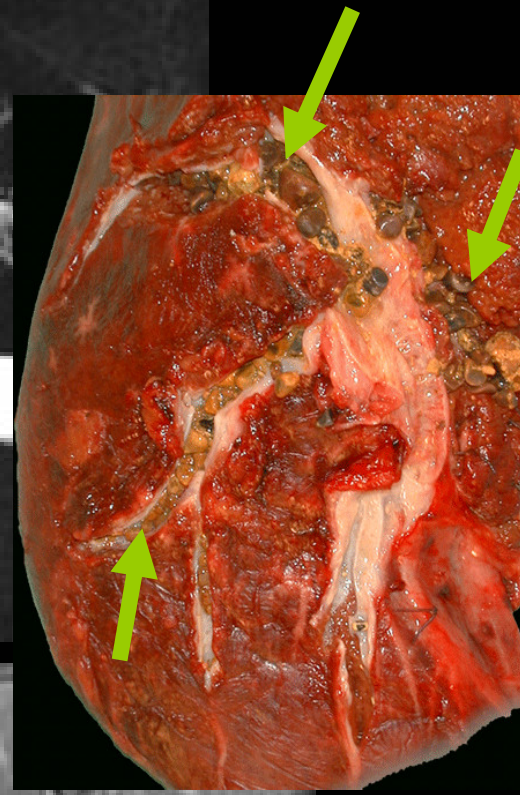


femme 32 ans ; ATCD cholécystectomie sous coelioscopie ; J30 post op :récidive de douleurs hypochondre droit – fièvre – ictère ; lithiase des VBIH droites et de la VBP



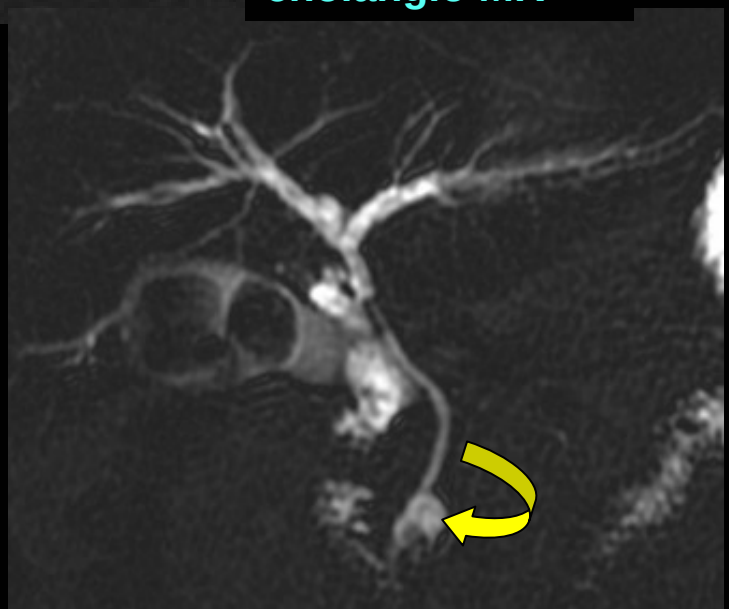


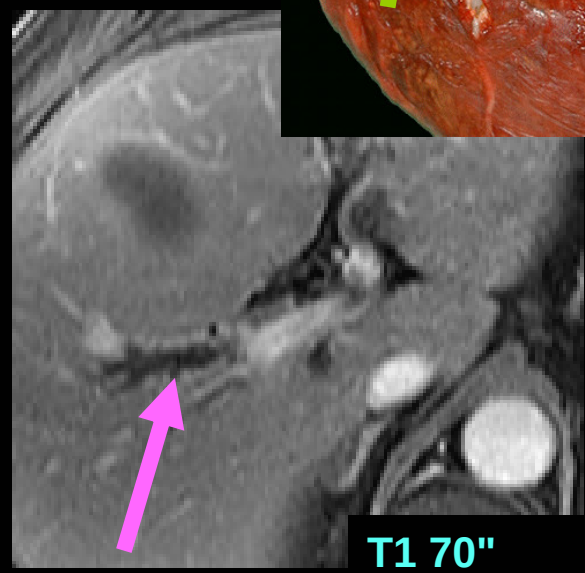
cholangio MR



femme 60 ans, douleurs de l'hypochondre droit ; fièvre et sub ictère.

lithiase cholestérolique des VBIH et de la vésicule biliaire





T1 70"

la lithiase cholestérolique des VBIH

la lithiase cholestérolique "primitive" des VBIH est maintenant bien identifiée.

les principaux éléments clinico-biologiques du diagnostic sont :

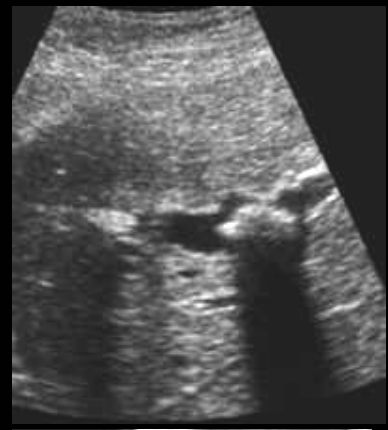
-un début des symptômes avant l'âge de 40 ans

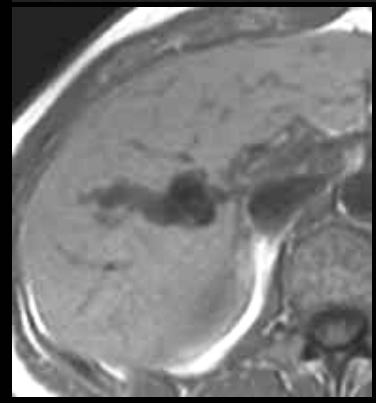
-des douleurs biliaires souvent associées à des complications (angiocholite,cholécystite aiguë, pancréatite aiguë)

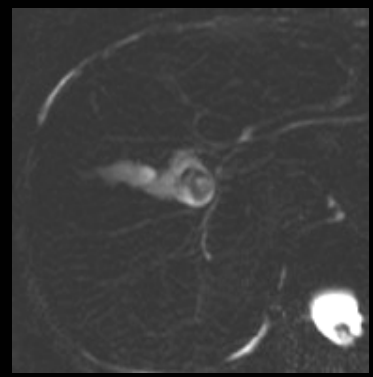
-la récidive des symptômes après cholécystectomie

-une élévation des GGT et des phosphatases alcalines et une augmentation modérée des transaminases

-un antécédent de cholestase gravidique et le début des troubles à la fin ou après une grossesse





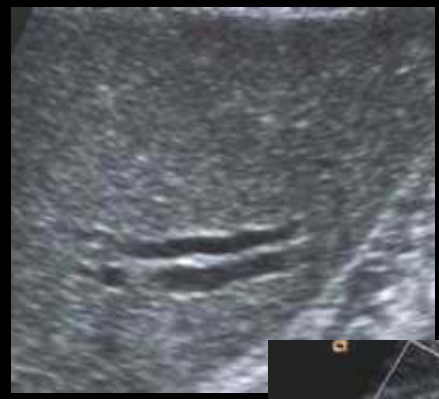


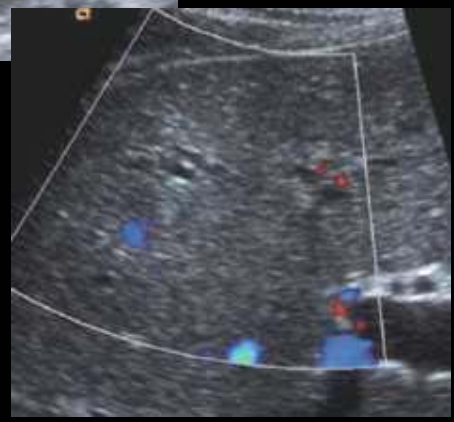
lithiase des VBIH du segment V

Ce syndrome est lié à une mutation du gène ABCB4 qui code le transporteur canaliculaire des phopsholipides ou mutation MDR 3 (R. Poupon et coll.)

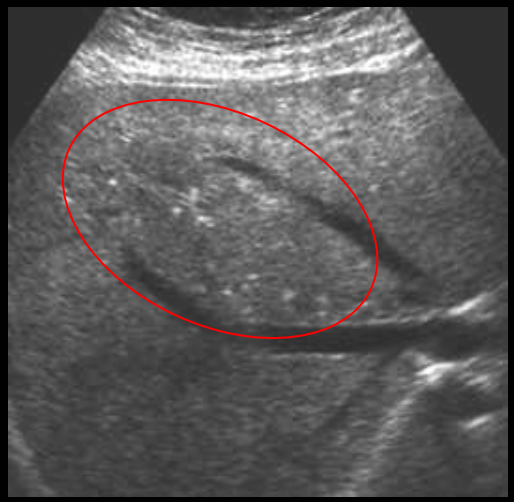
le traitement médical par l'acide ursodésoxycholique améliore les symptômes cliniques et biologiques

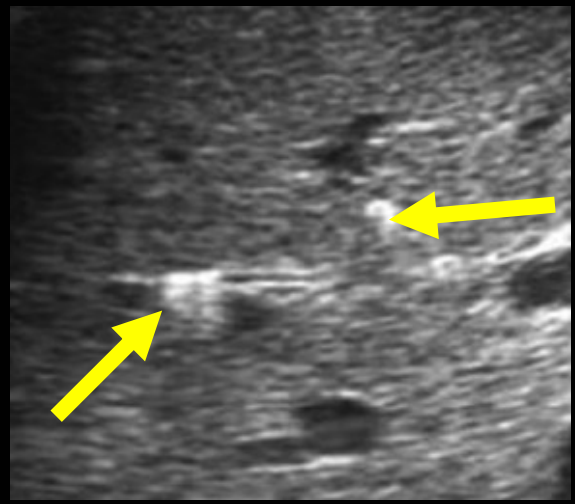
le diagnostic est essentiellement échographique ,sensibilisé par le Doppler pour les " twinkling artefacts " (scintillement en arrière des calculs)



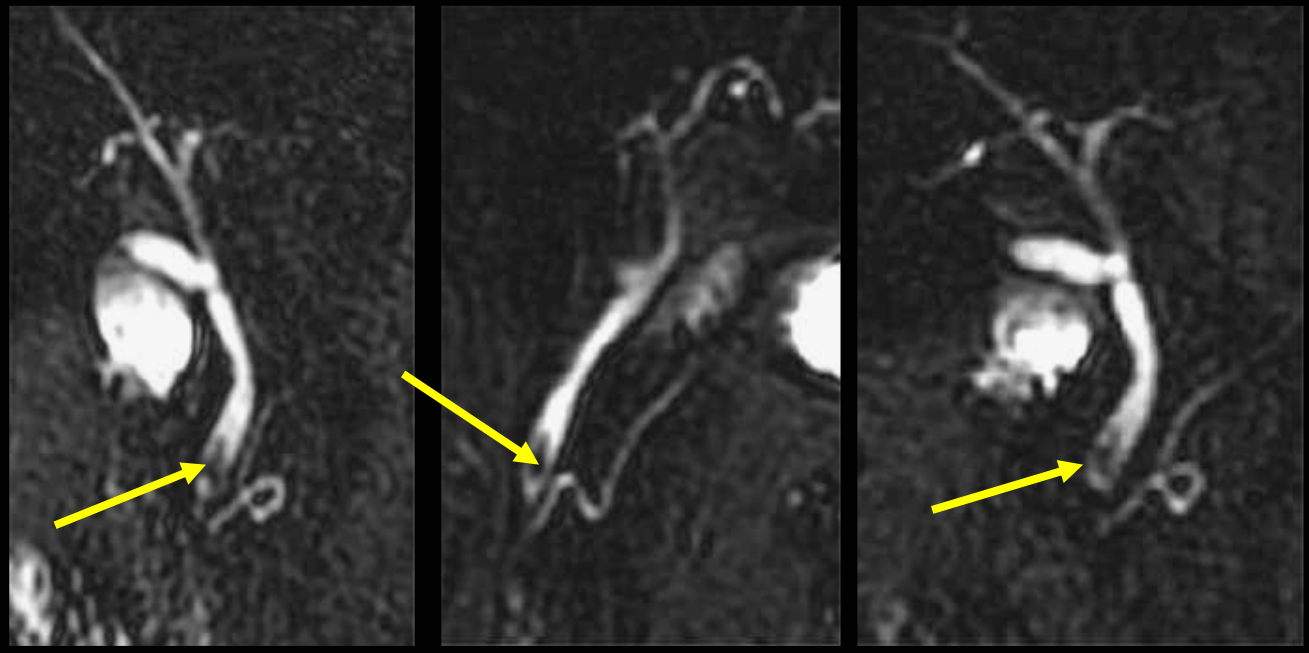


dilatations distales des VBIH du lobe G et du segment IV



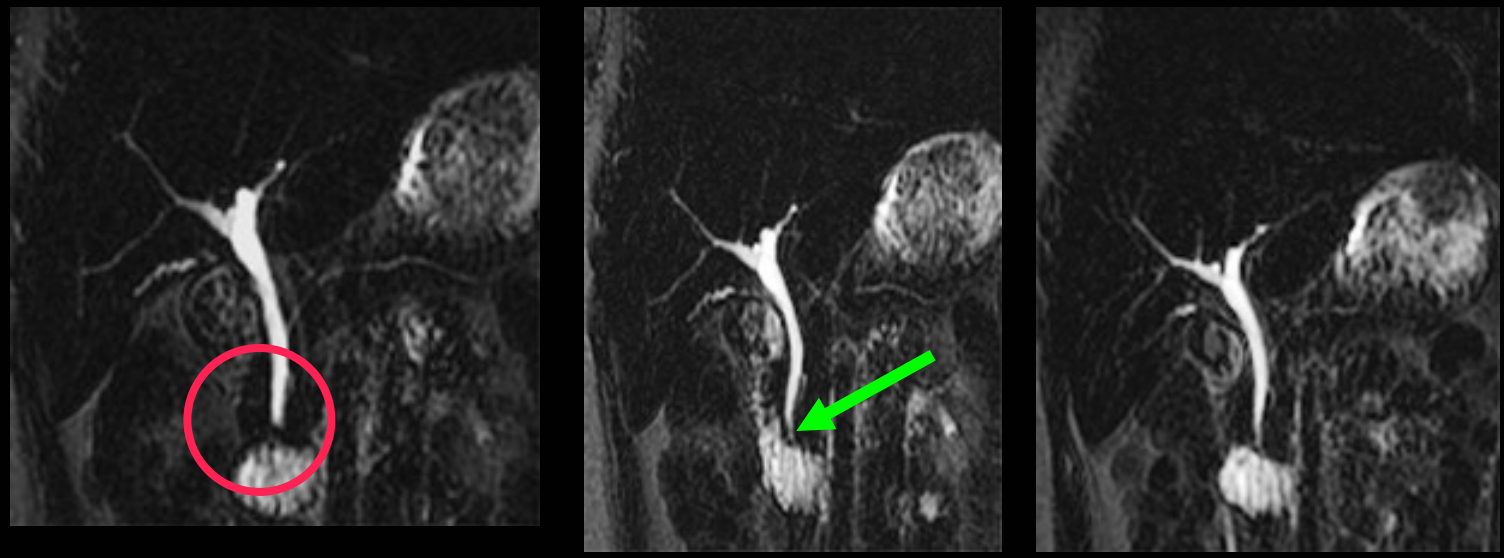


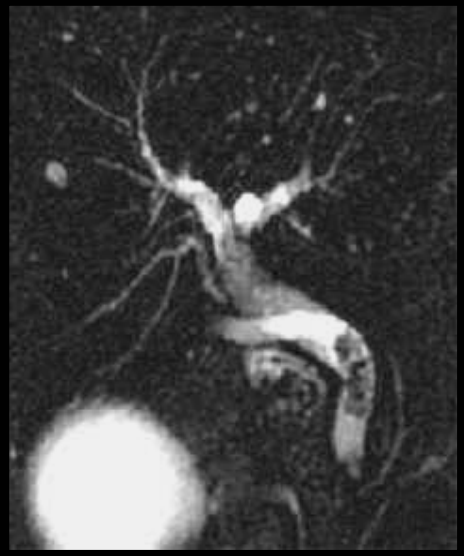
images "en queues de comète" au niveau du lobe droit et de la paroi ou des lumières des VBIH



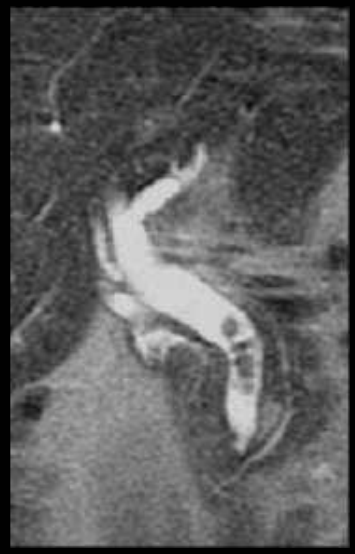
calculs
de la VBP

jeu
sphinctérien



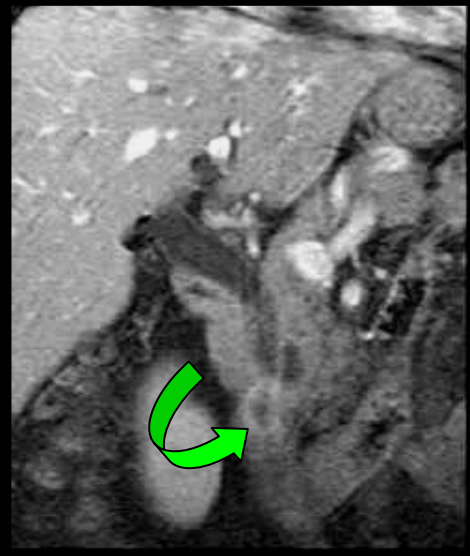


TE long 20 mm

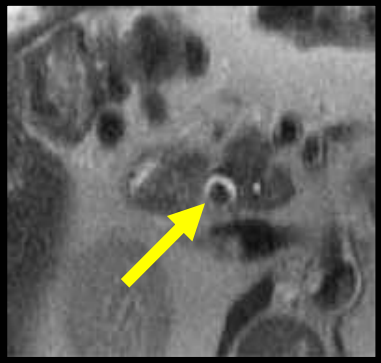


TE court 5 mm

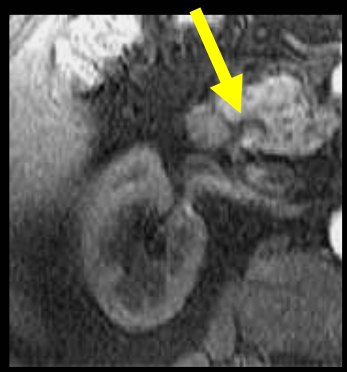
TE long 20 mm
sagittale



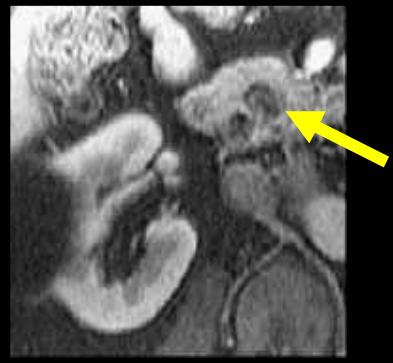
T1 gado 6'



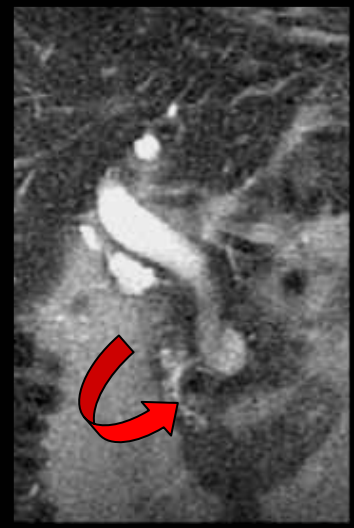
TE court 5 mm



T1 avt inj

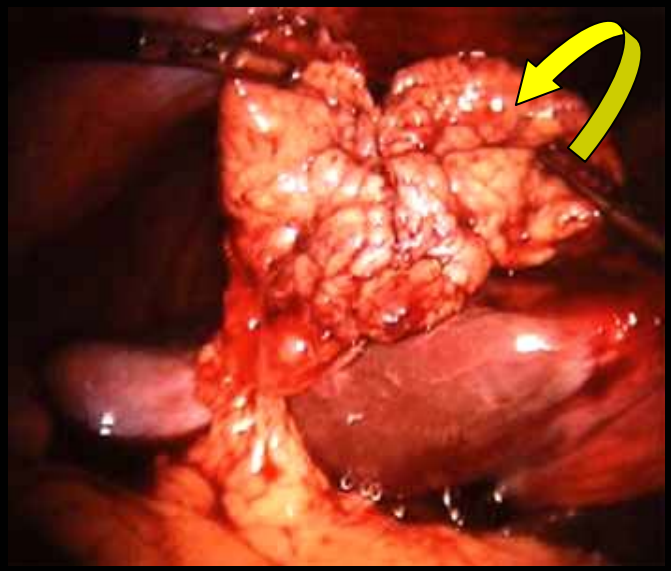


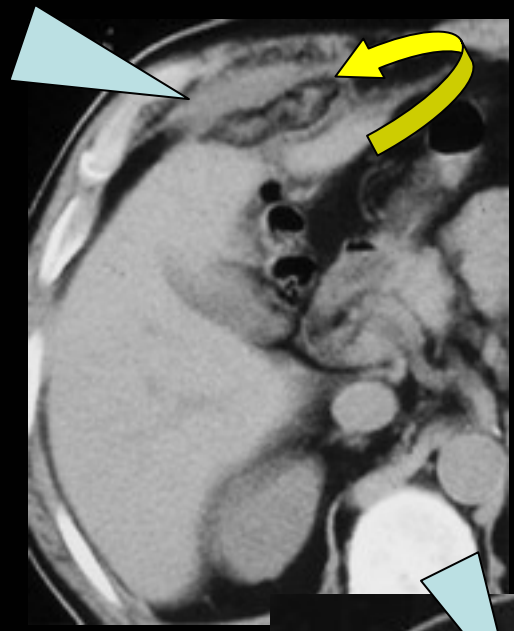
T1 gado 60"

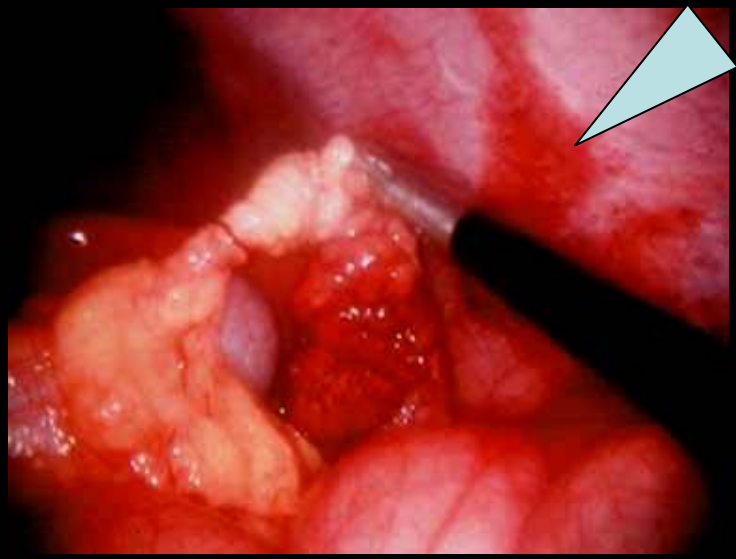


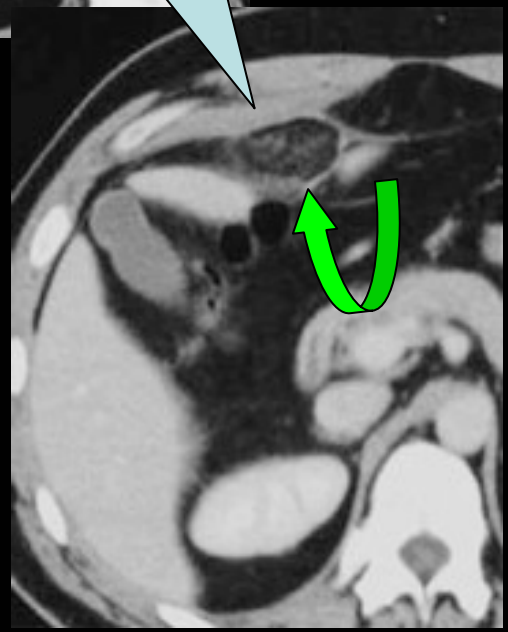
TE court 5 mm

calculs de la VBP et "Oddite" vs ampullome vatérien





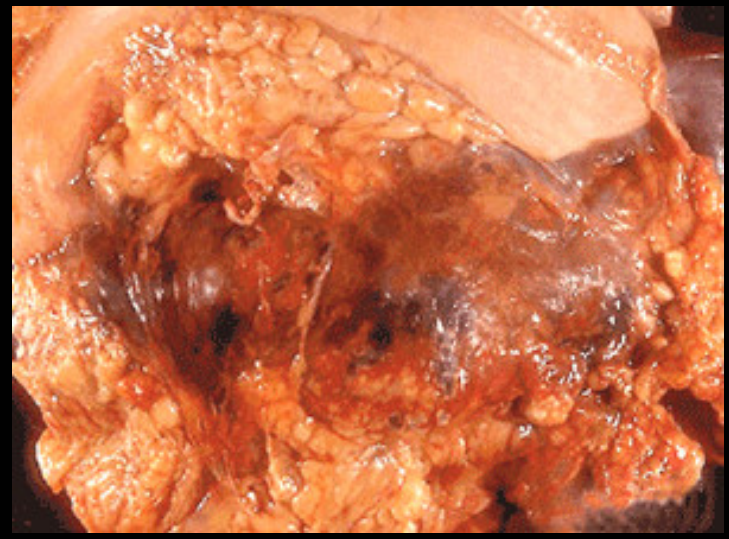


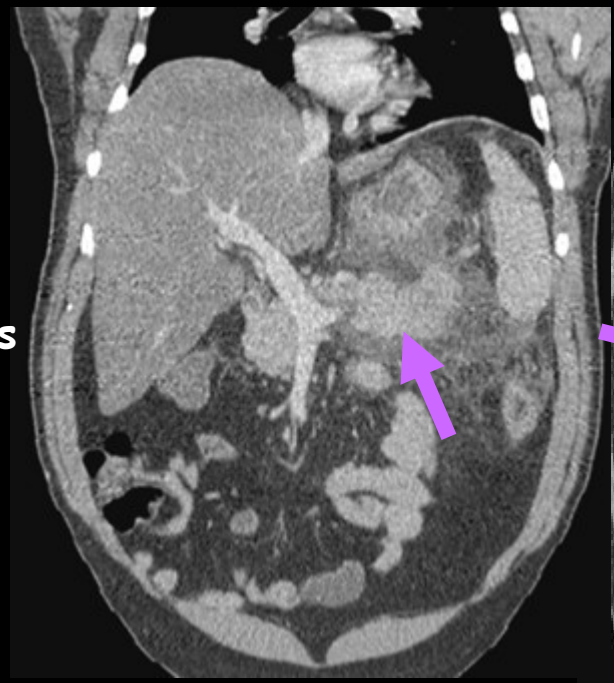


infarctus épiploïque droit

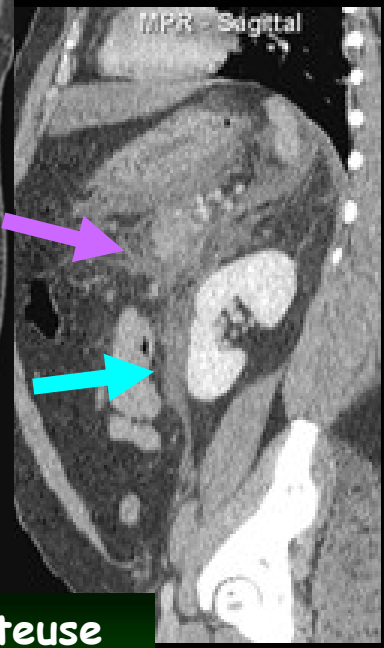
pancréatites aiguës

- ✓ PA « symptomatiques » +++:
  adénocarcinome ductal +++
  ;TIPMP …
- ✓ indice de sévérité de Balthazar
  "corrigé"
- ✓ anomalies congénitales canalaires pancréato-biliaires :
  pancréas dorsal dominant et
  pancréas divisum ;
  canal commun long …
- ✓ complications vasculaires artérielles des pancréatites (faux anévrysmes)





CT 70"

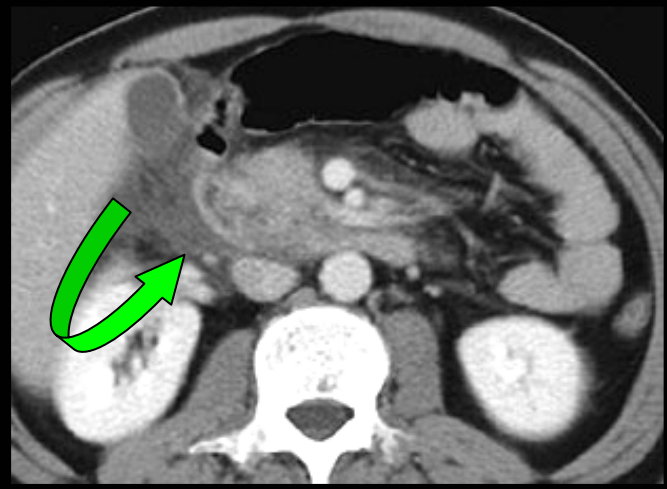


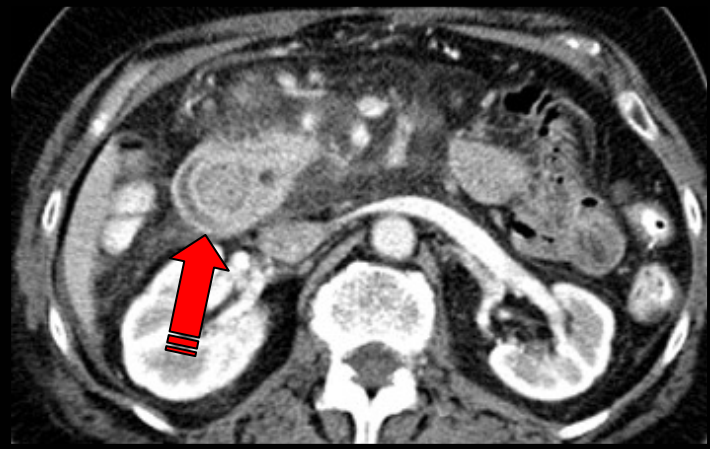
pancréatite aiguë oedèmateuse
indice de gravité modifié : 4/10

diagnostic

- « Toute douleur abdominale aiguë évocatrice associée à une élévation de la lipasémie supérieure à 3 N dans les 48 premières heures suivant le début des symptômes fait porter le diagnostic de PA. »

- « Lorsque le diagnostic de PA est porté sur des signes cliniques et biologiques, il n'y a pas lieu de réaliser un examen d'imagerie pour le confirmer. »



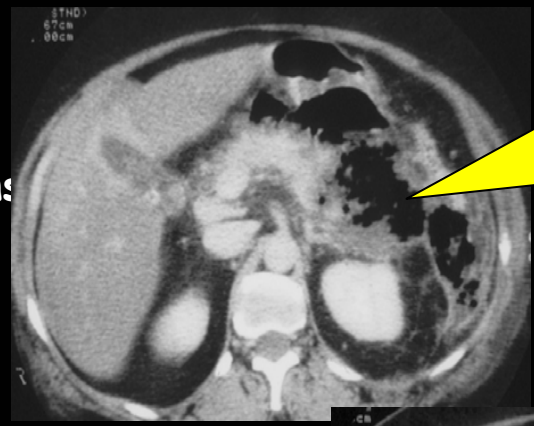


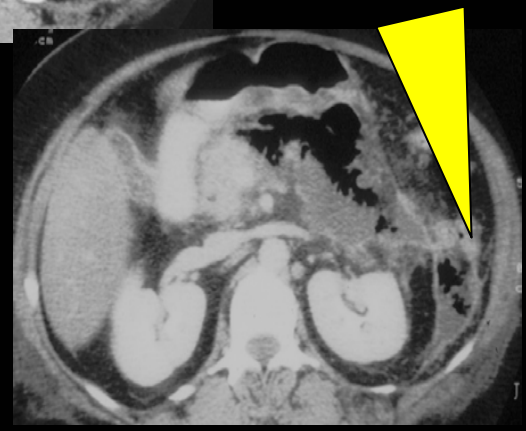
Conférence de Consensus janvier 2001

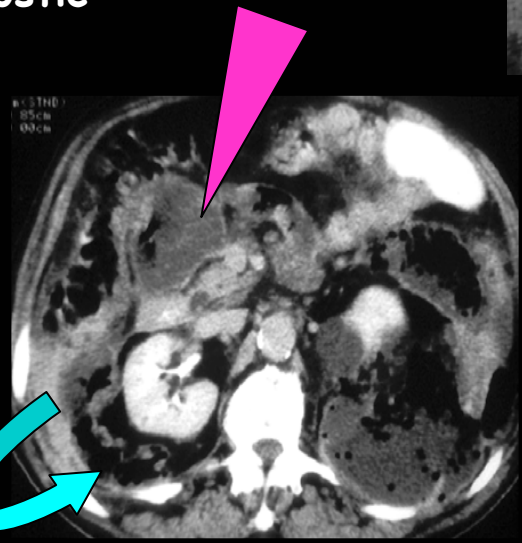
- échographie :
  - peu performante (pancréas visible dans 40% des cas)
  - diagnostic de lithiase biliaire (+++)

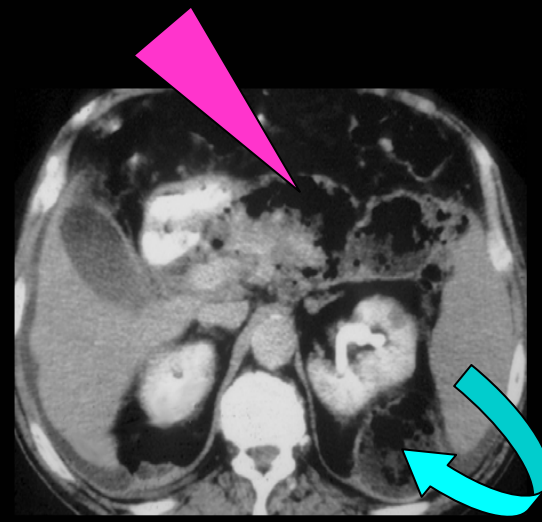
- TDM en urgence +++
  - uniquement si doute diagnostic
    ou formes très sévères (pré-op)
  - avec injection d 'iode
  - recherche de coulées / diagnostic différentiel

- IRM ?

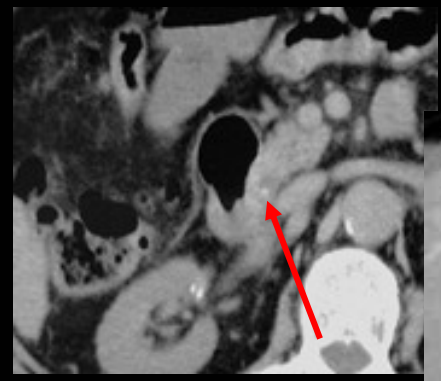


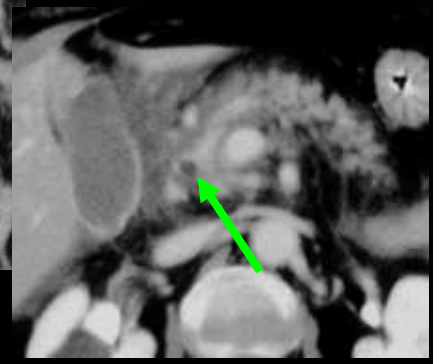


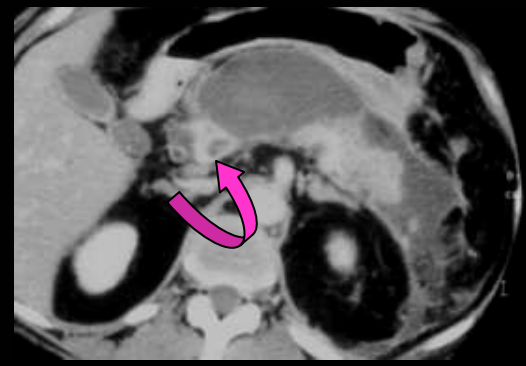


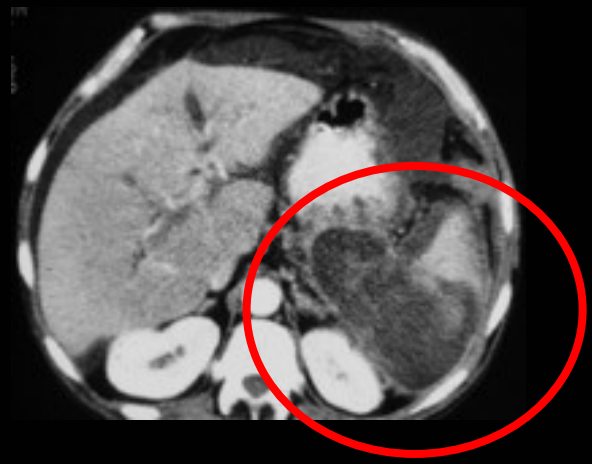


- sans injection avec éventuellement coupes fines sur la papille : calcul ?
- IV iode en bolus 1,5 ml /kg à 3 ml/s
- phase précoce 40 s sur le pancréas < 5mm (8 ou 16 x 1.25 mm)
- couverture large pour les coulées :
- mesure de densité du pancréas sans / avec injection : quantification de l'étendue de la nécrose
- ascite, dilatation des VB ...

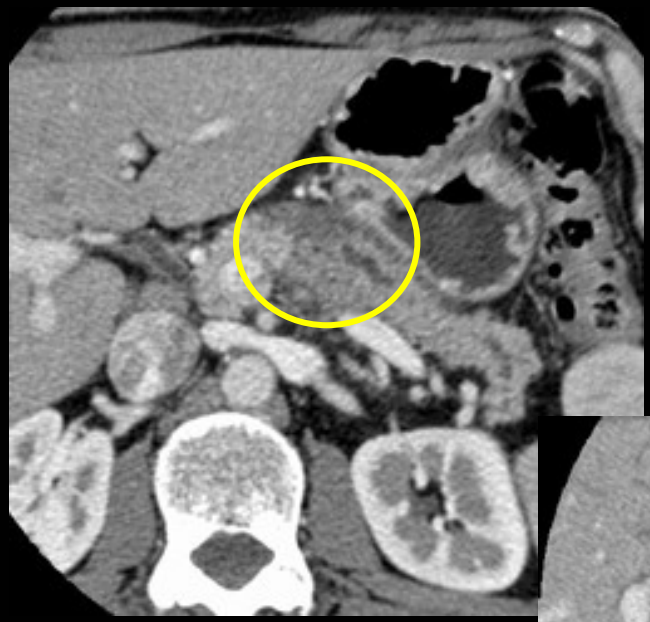


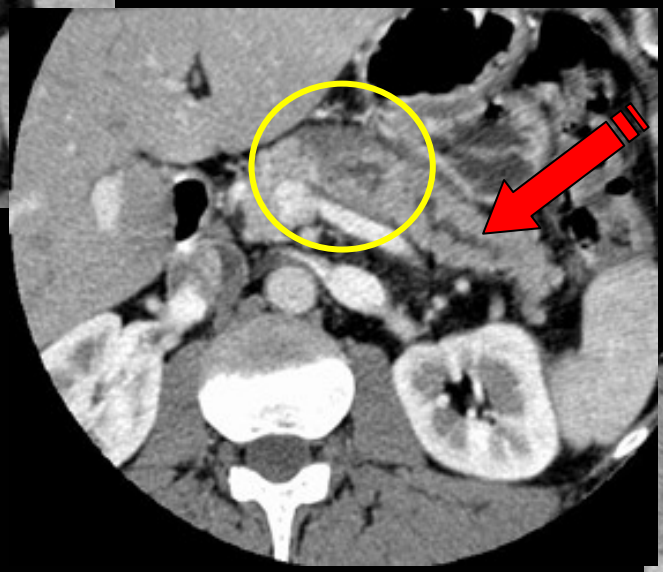




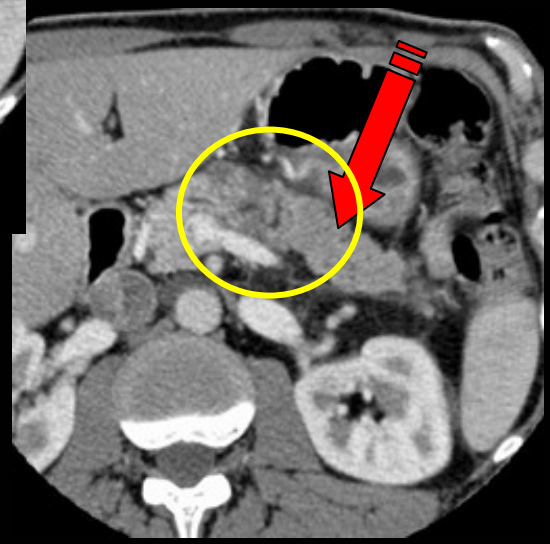


pancréatites aiguës "symptomatiques"

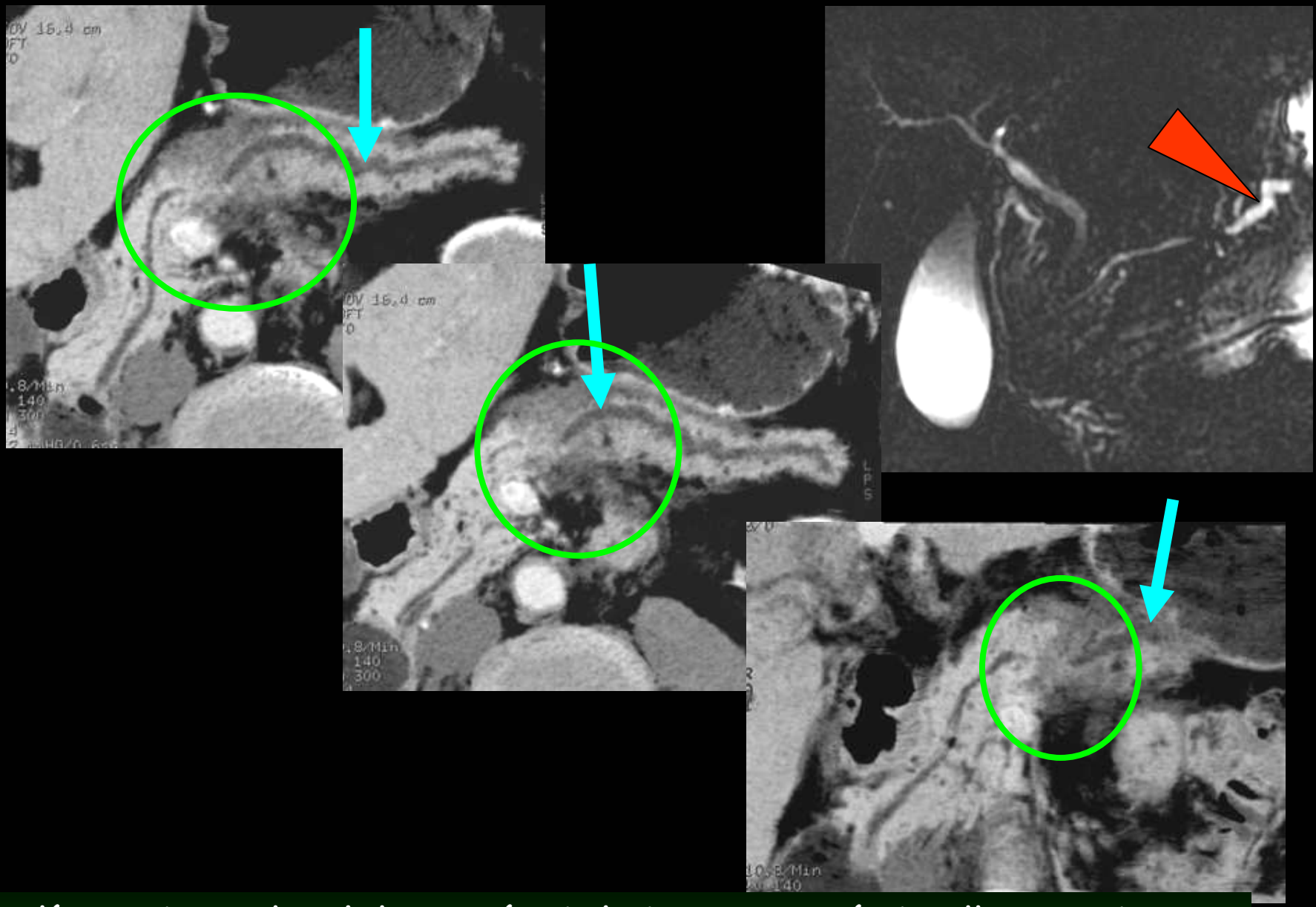




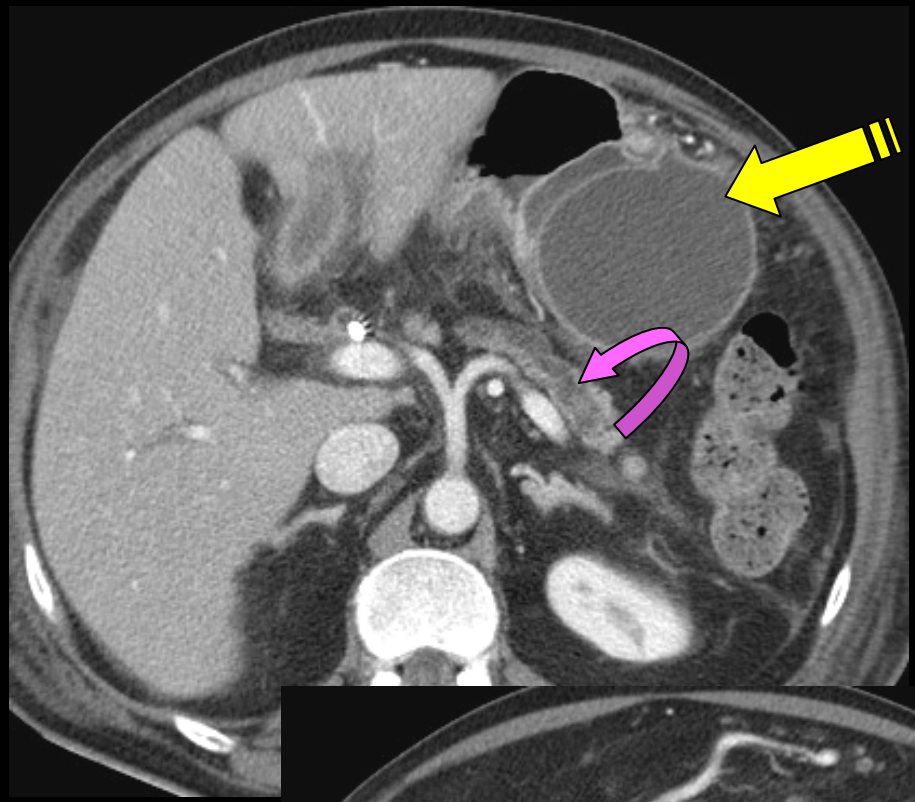
CT 45"

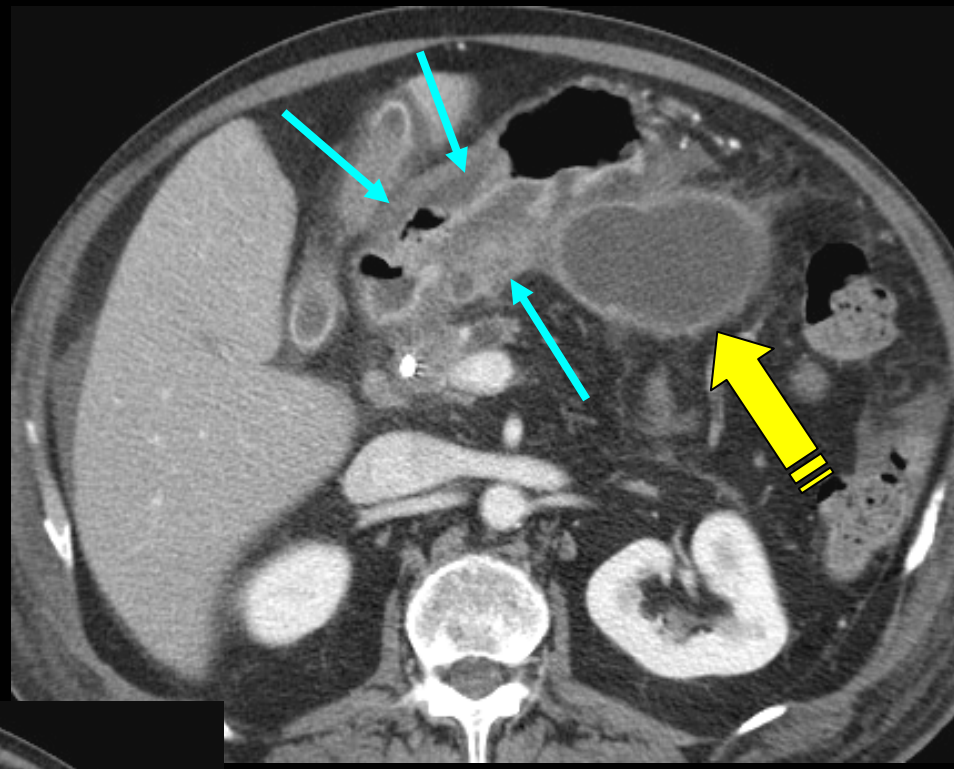


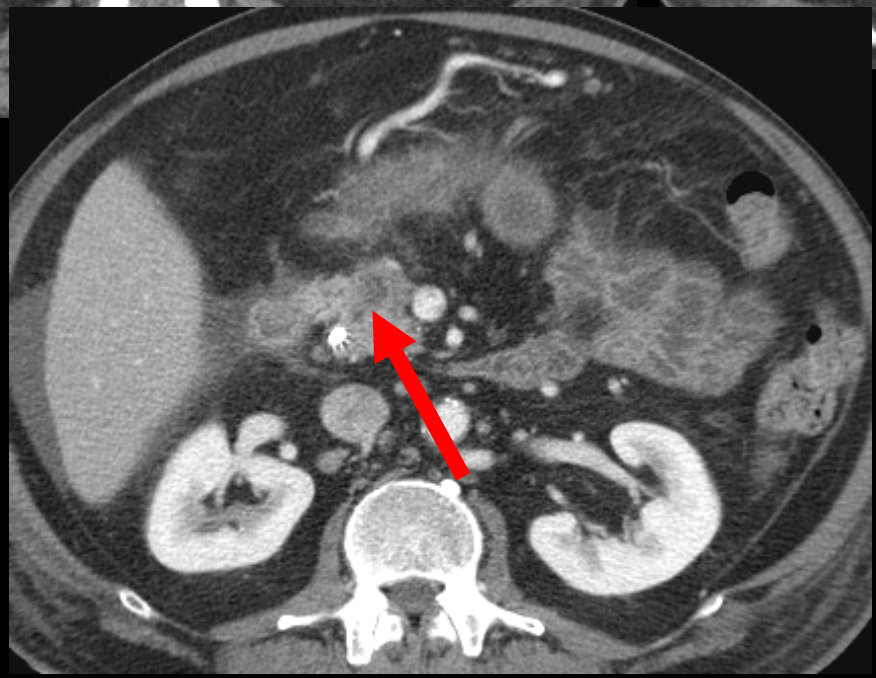
adénocarcinome ductal du pancréas isthmique sans modification des contours de la glande !
pancréatite d'amont (obs M Zins Paris)



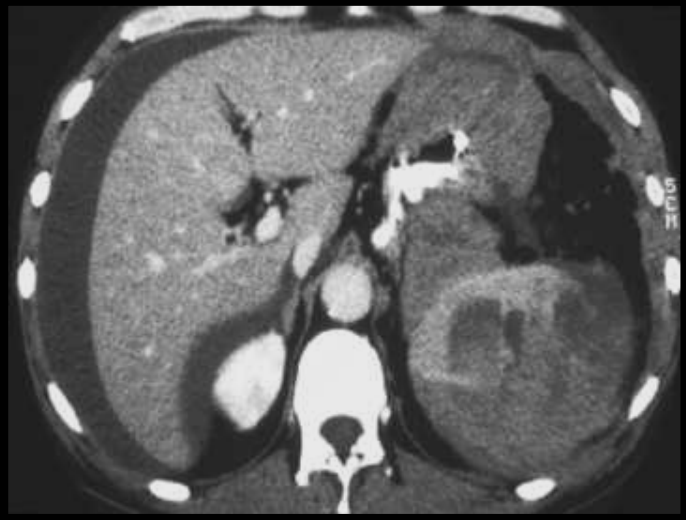
adénocarcinome ductal du pancréas isthmique et pancréatite d'amont ; image MinIP (obs.M. Zins Paris)

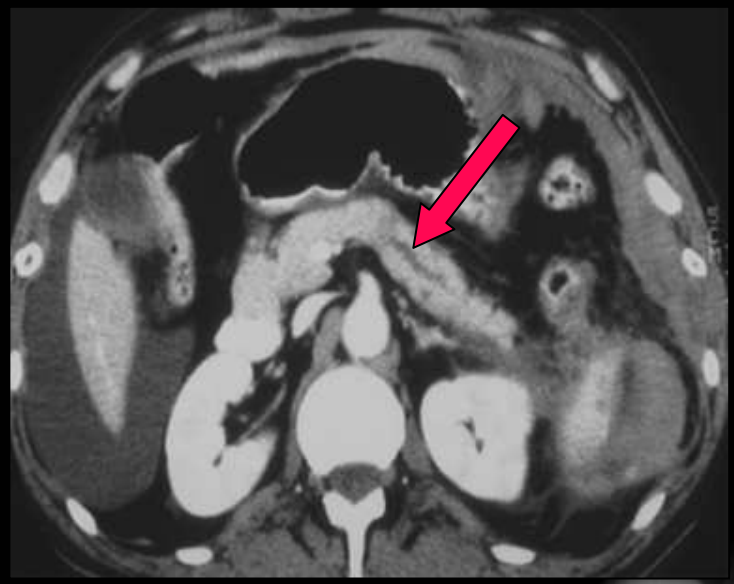


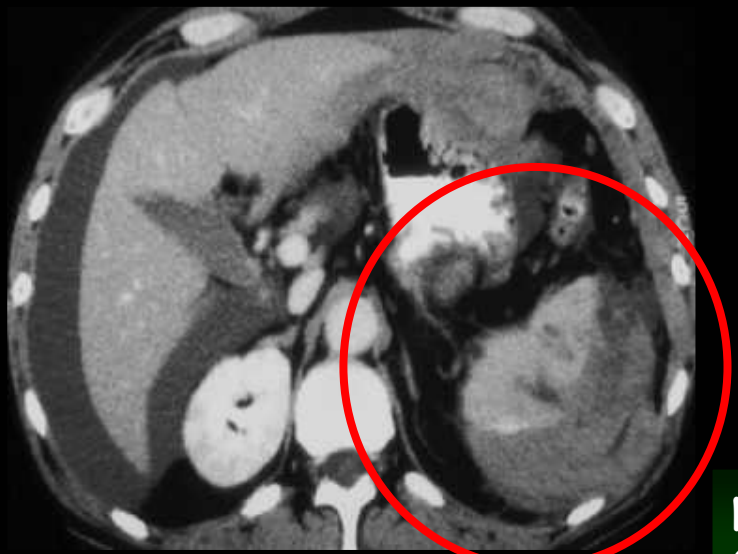


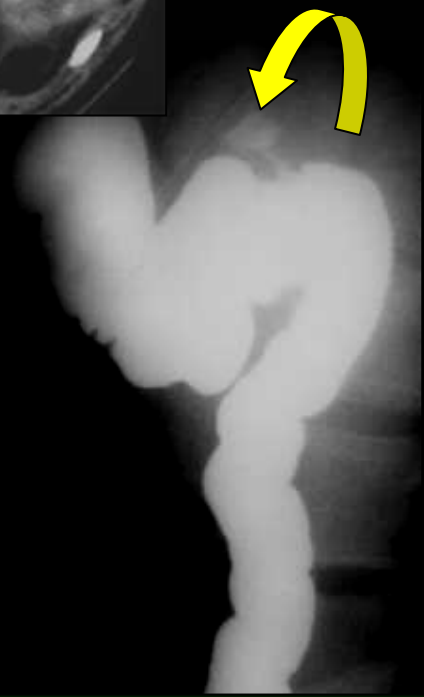


adénocarcinome ductal du pancréas céphalique et pseudo kyste de la cavité omentale









pancréatite aiguë avec ruptures splénique et colique gauche , symptomatiques d 'un ADK du corps du pancréas

indice de sévérité de Balthazar "corrigé"

American Journal of Roentgenology

ARRS YOUR LINK TO CME

AJR 2004; 183:1261-1265

A Modified CT Severity Index for Evaluating Acute Pancreatitis: Improved Correlation with Patient Outcome

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OBJECTIVE. This study was conducted to assess the correlation with patient outcome and interobserver variability of a modified CT severity index in the evaluation of patients with **acute pancreatitis** compared with the currently accepted CT severity index.

MATERIALS AND METHODS. Of 266 consecutive patients diagnosed with **acute pancreatitis** during a 1-year period, 66 underwent contrast-enhanced MDCT within 1 week of the onset of symptoms. Three radiologists who were blinded to patient outcome independently scored the severity of the **pancreatitis** using both the currently accepted and modified CT severity indexes. The modified index included a simplified assessment of pancreatic inflammation and necrosis as well as an assessment of extrapancreatic complications.

Le "score corrigé" se veut plus simple et de meilleure valeur pronostique

addition d'une évaluation simplifiée de la présence et du nombre de collections péri pancréatiques (4 pts) et de l'extension de la nécrose pancréatique (4 pts)

et de différents éléments de pondération (2 pts) selon la présence :

- d'anomalies extra- pancréatiques (épanchement pleural,ascite ; infarctus ,hémorragies et collections sous capsulaires spléniques et/ou hépatiques)

- de complications vasculaires (thrombose veineuse , hémorragies artérielles , pseudo anévrysmes)

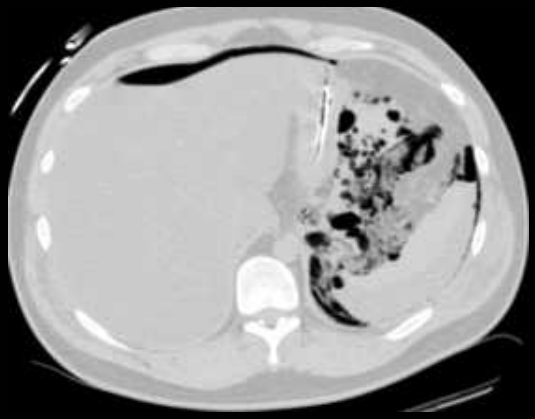
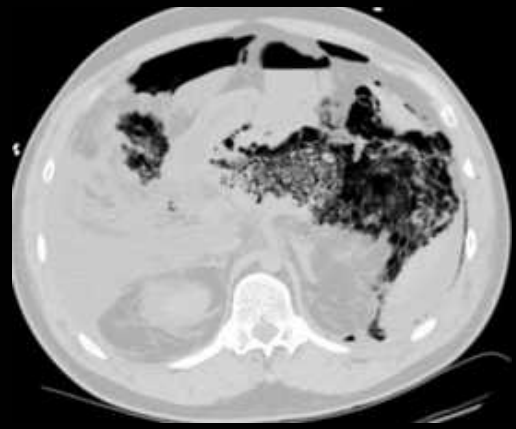
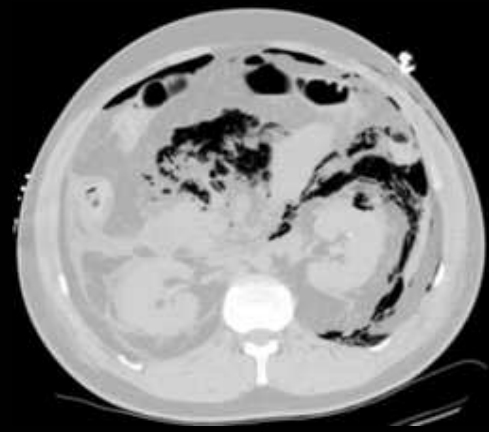
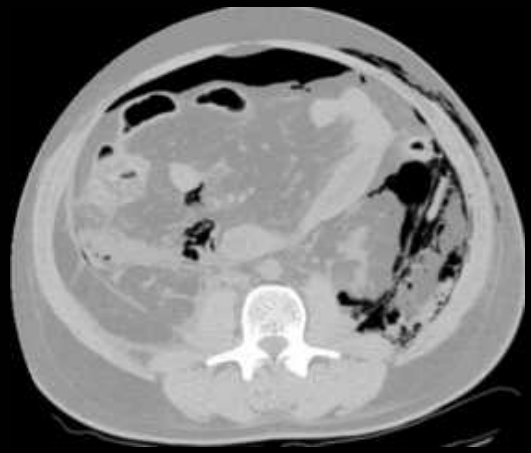
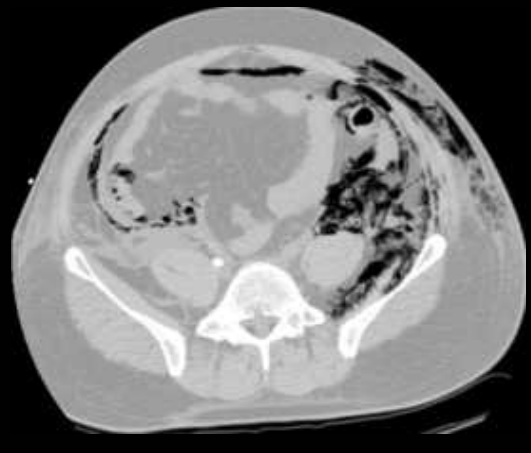
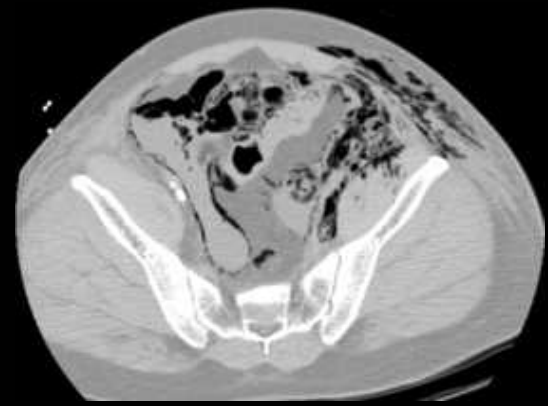
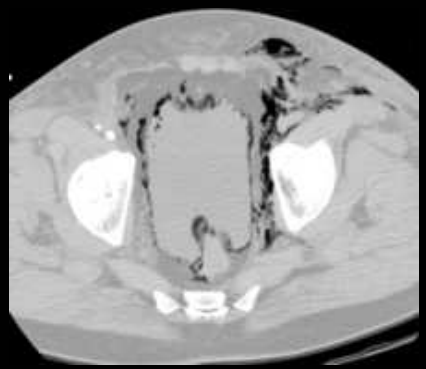
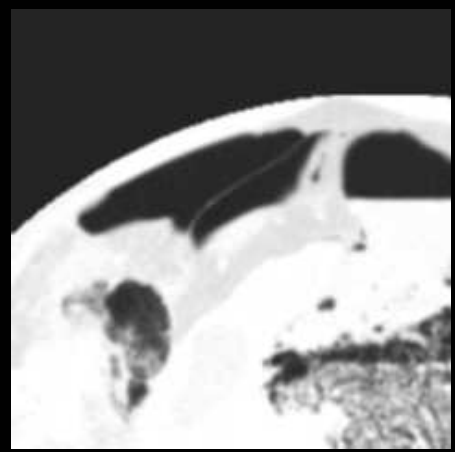
- d'atteintes du tractus gastro-intestinal (inflammation, perforations, ou collections intra pariétales)

TABLE 2 Modified CT Severity Index

Prognostic Indicator	Points
Pancreatic inflammation	
Normal pancreas	0
Intrinsic pancreatic abnormalities with or without inflammatory changes in peripancreatic fat	2
Pancreatic or peripancreatic fluid collection or peripancreatic fat necrosis	4
Pancreatic necrosis	
None	0
≤ 30%	2
> 30%	4
Extrapancreatic complications (one or more of pleural effusion, ascites, vascular complications, parenchymal complications, or gastrointestinal tract involvement)	2

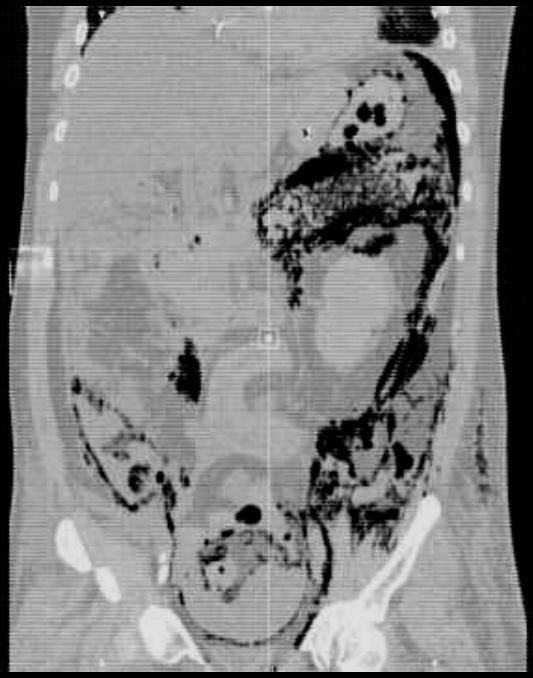
pancréatitis mild: 0 à 2 pts ; moderate : 4 à 6 pts ; severe : 8 à 10 pts

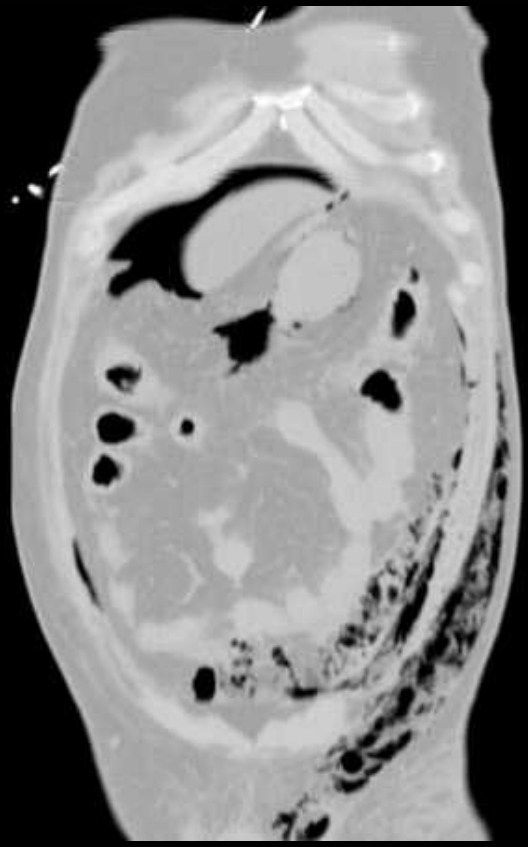
formes graves : pancréatites "gazeuses"

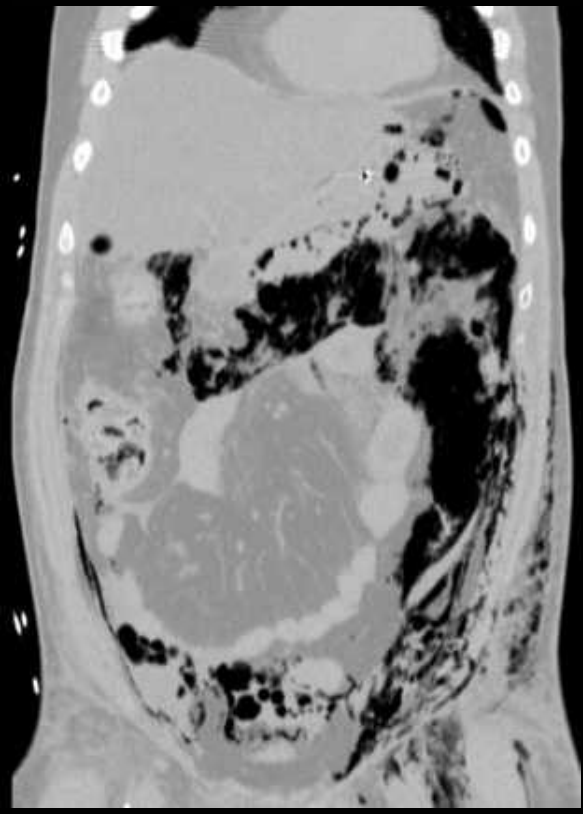









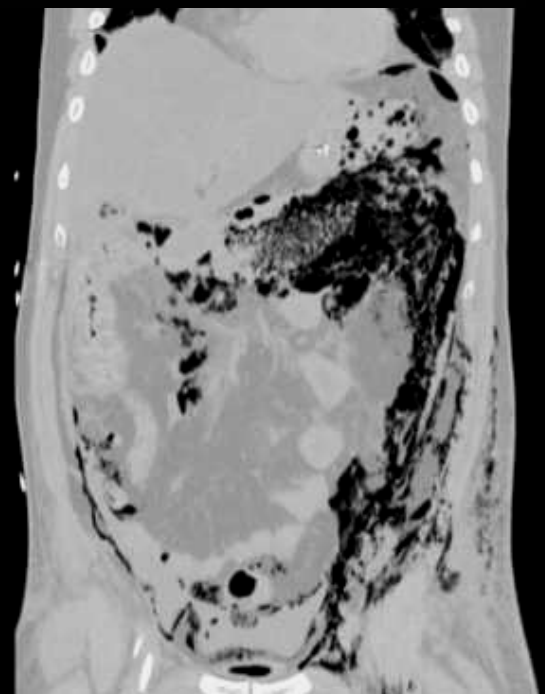
homme 33 ans ,tahitien , sd douloureux abdominal à début brutal, évoluant depuis 48 heures ,tableau occlusif , défaillance polyviscérale, fièvre ;ethylisme ,suspicion de minilithiase vésiculaire à l'échographie

GGT 808 UI N:2-34 UI

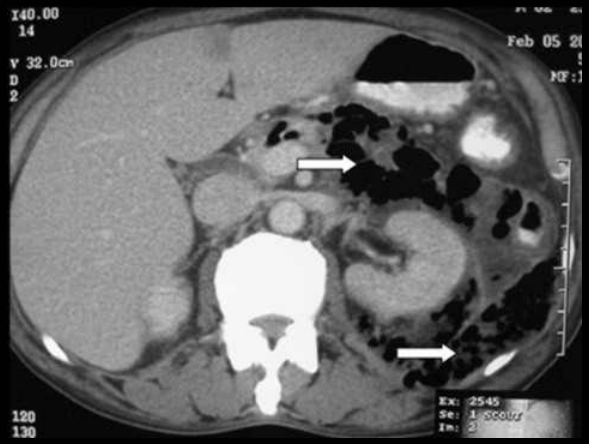


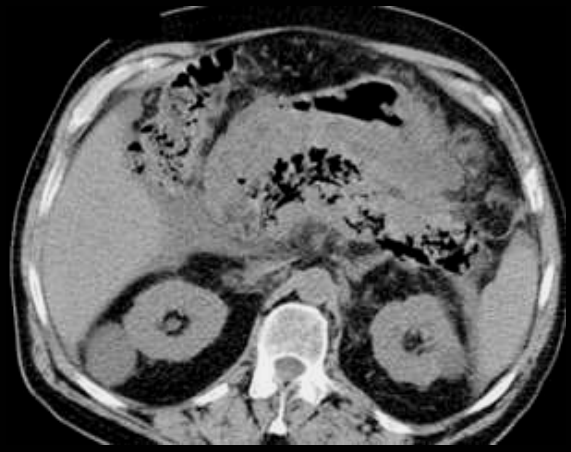






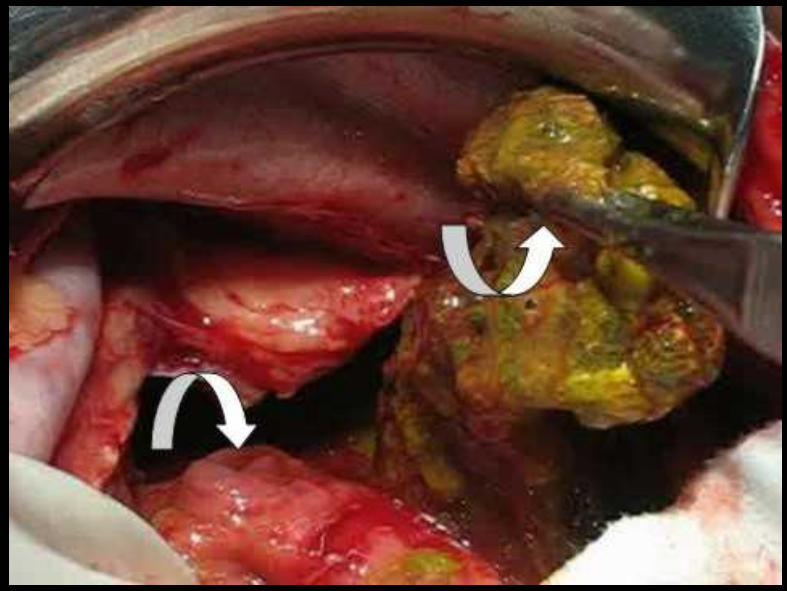
pancréatite emphysémateuse (E. Coli, pyocyanique ..) ou parfois gangrène pancréatique (Cl. perfringens) ou…perforation viscérale (fistule avec colon transverse +++)

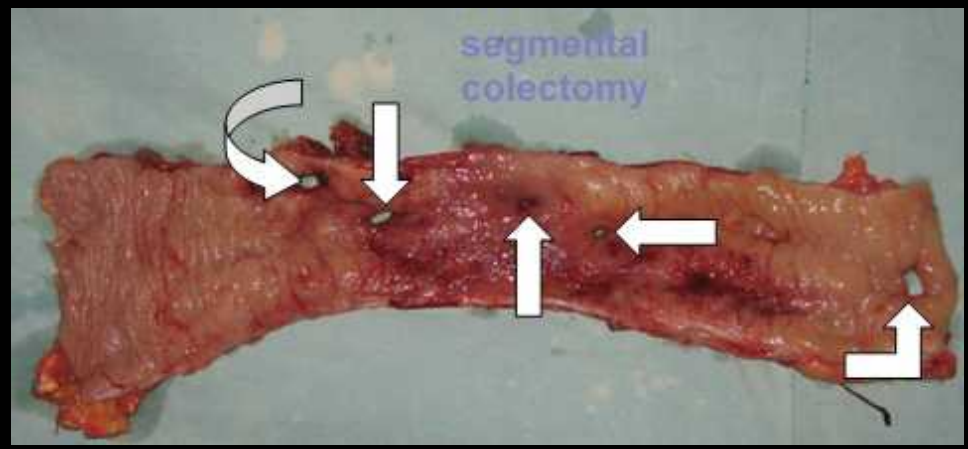


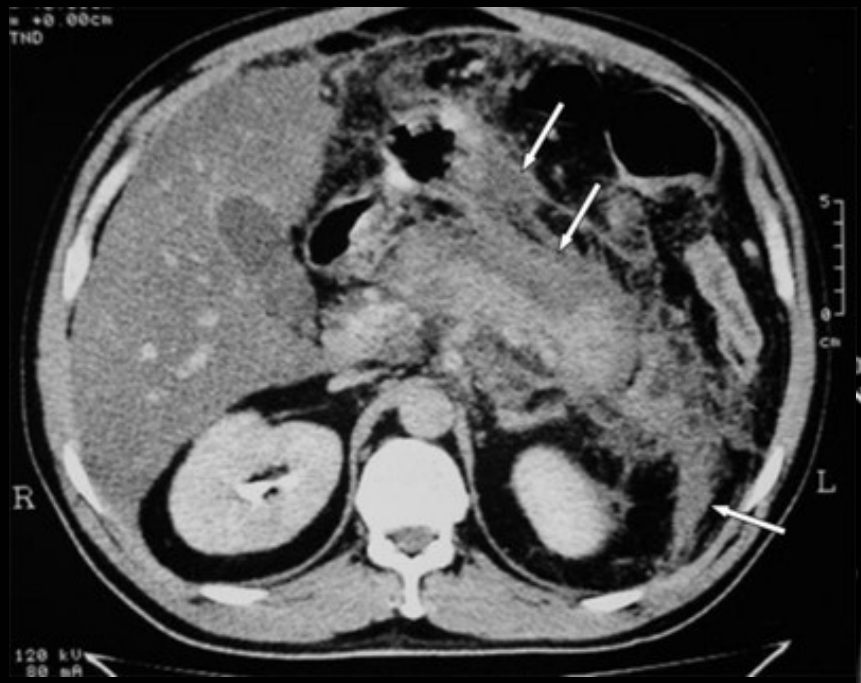


pancréatite aiguë "gazeuse"

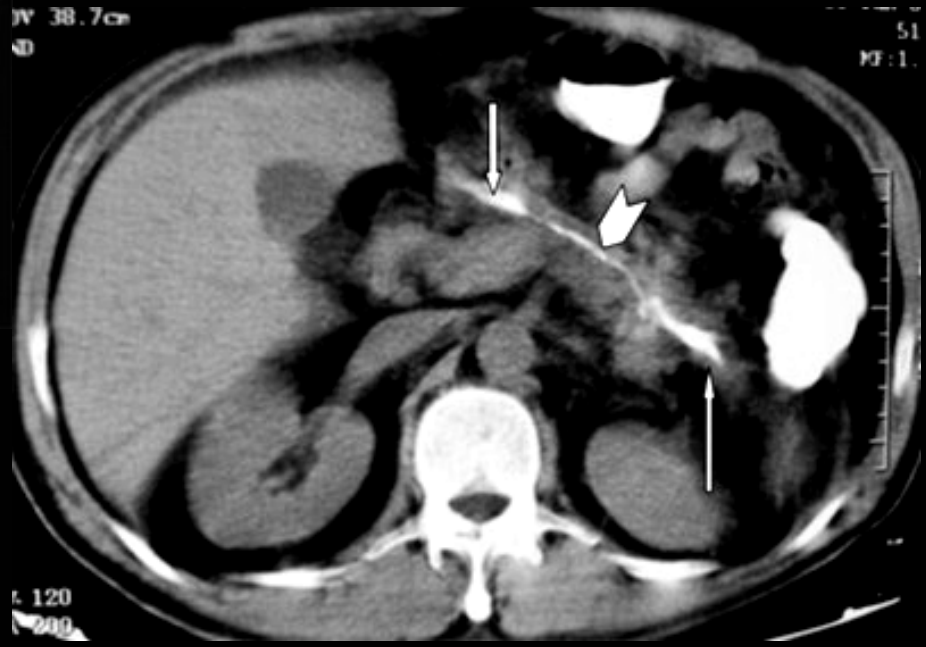
une cause fréquente de gaz au sein de remaniements pancréatitiques : la fistule pancréatico-digestive et en particulier la fistule pancréatico-colique ; la proximité du colon transverse et des lésions pancréatiques est un facteur potentiel de gravité

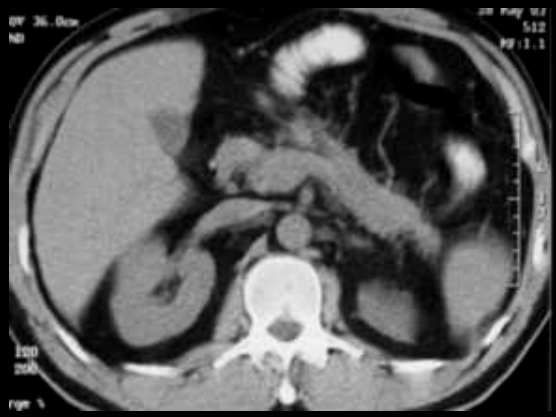






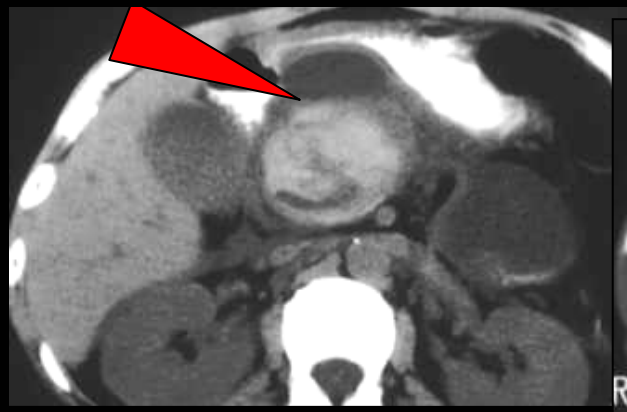
comment confirmer la fistule pancréatico-colique





contrôle

complications artérielles graves (faux anévrysmes) des pancréatites



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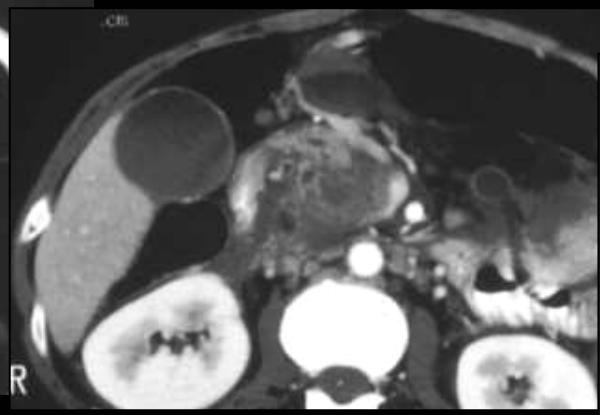

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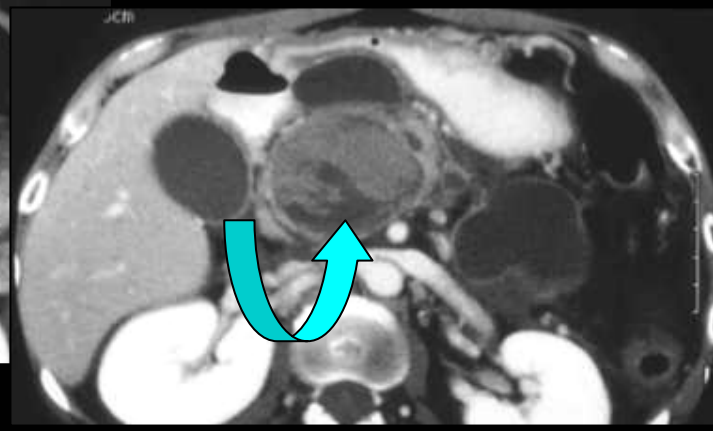
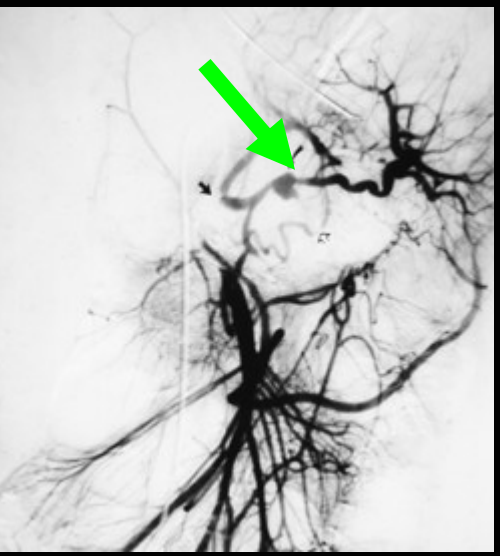
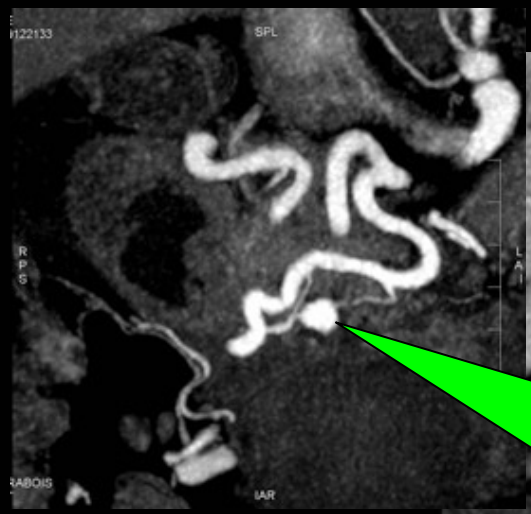
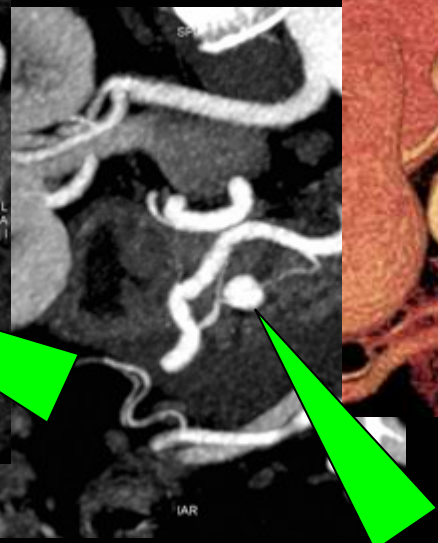


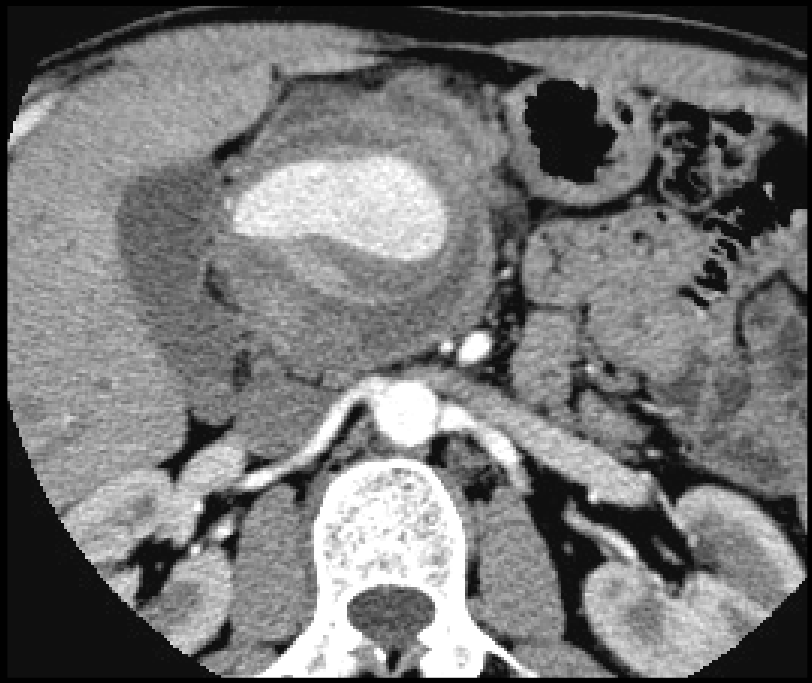
pseudo-kyste hémorragique

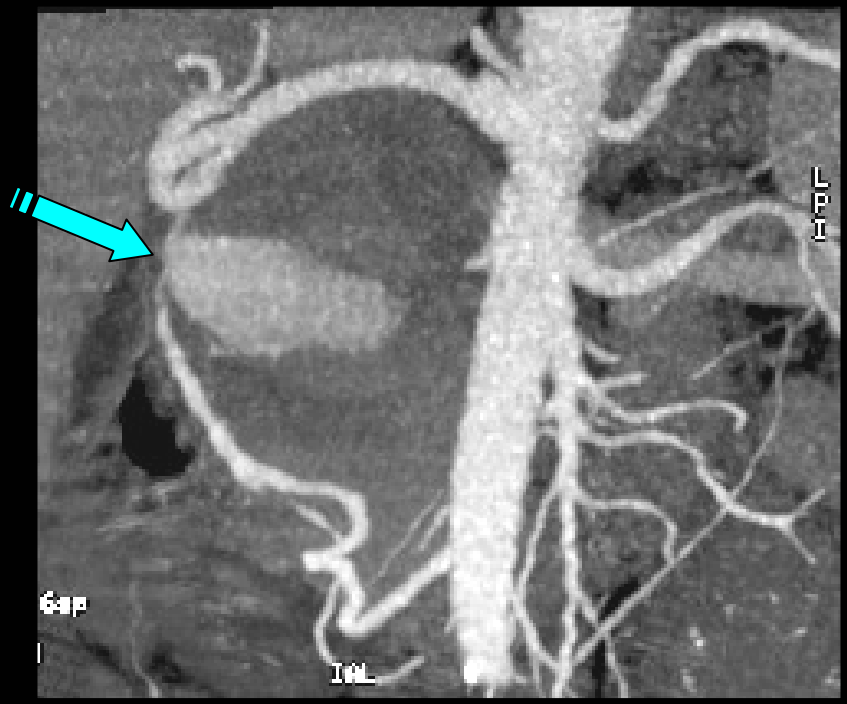
faux-anévrysmes hémorragiques



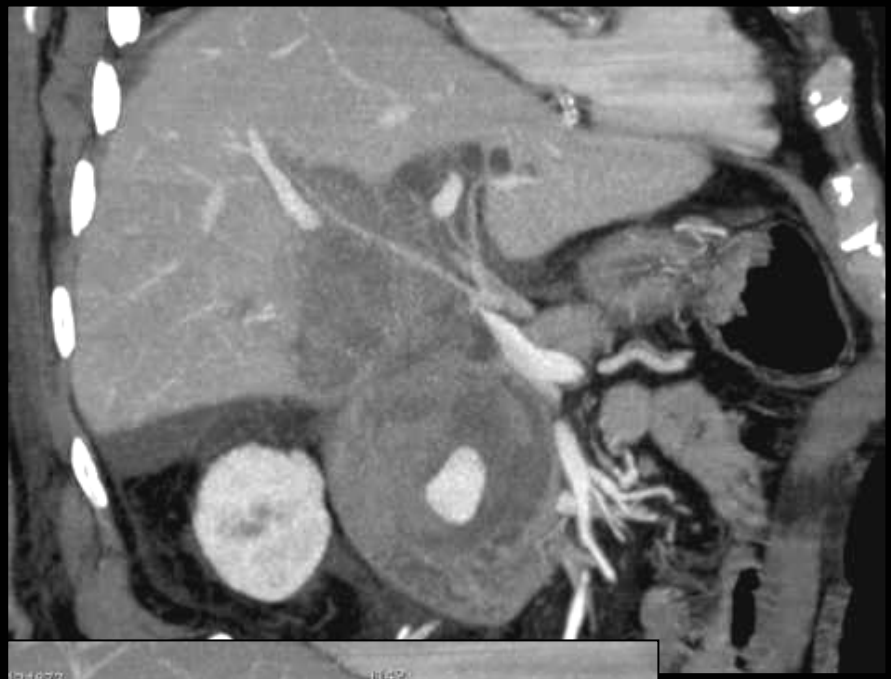


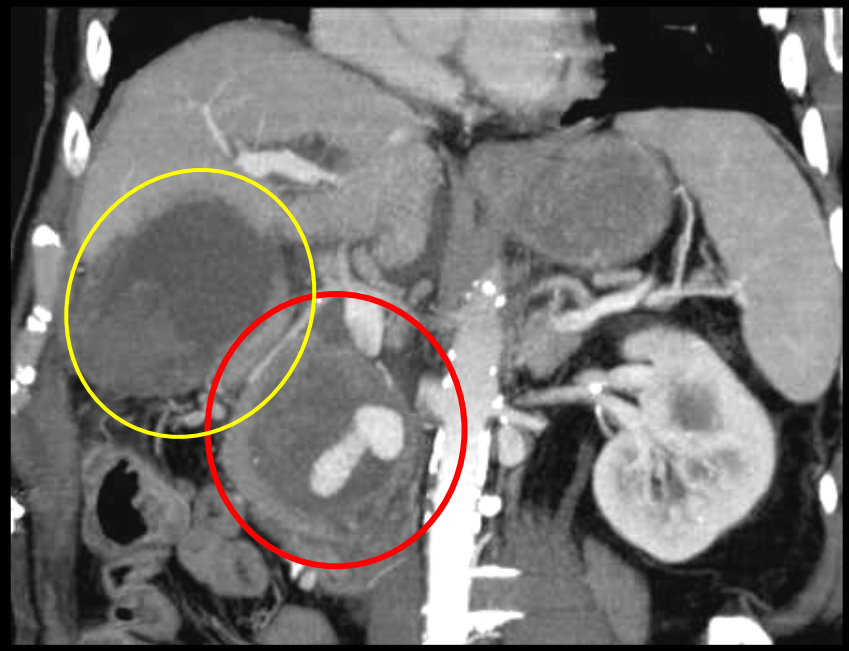


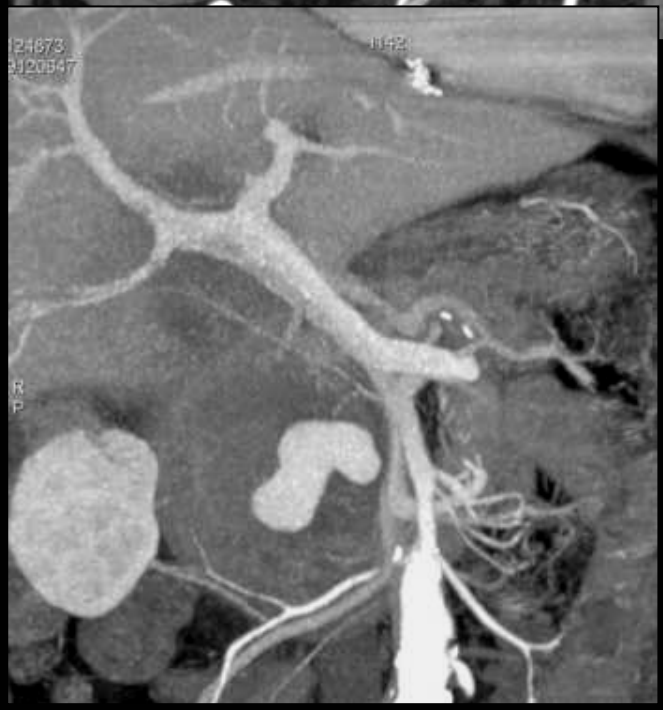


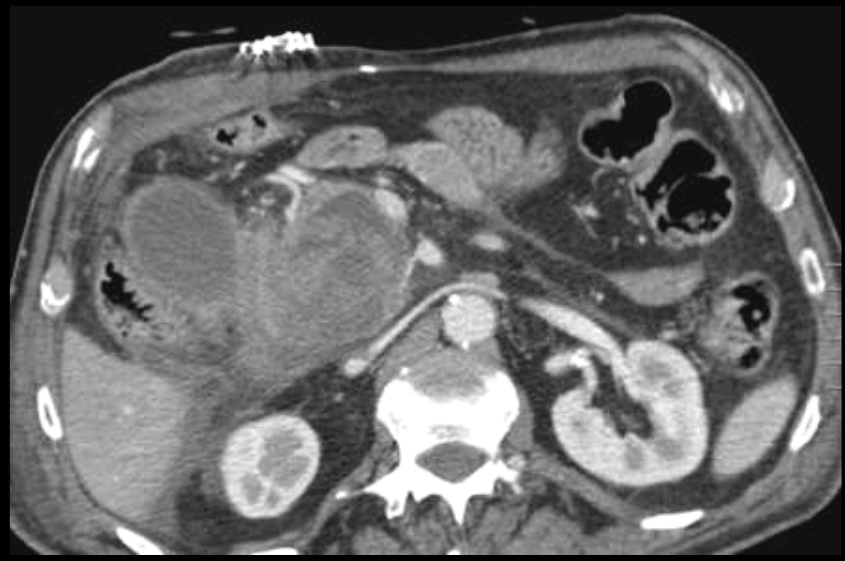


pancréatite aiguë + faux anévrysme de l'artère gastro- duodénale (obs. M Zins Paris)

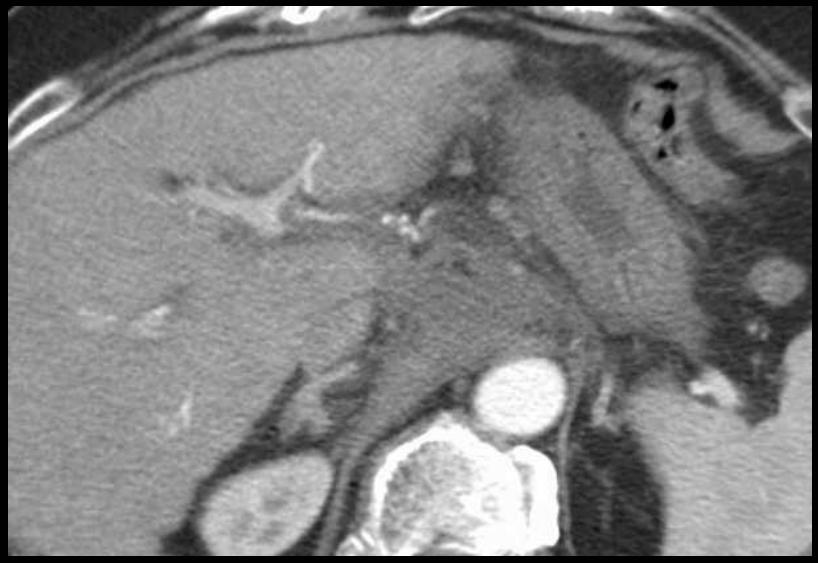


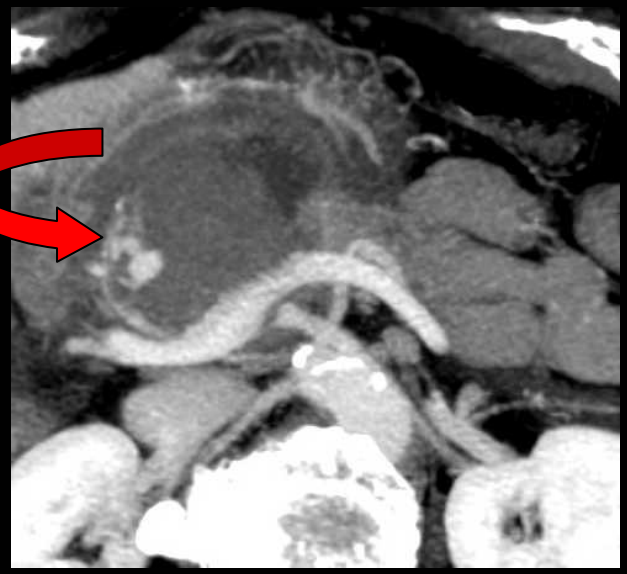


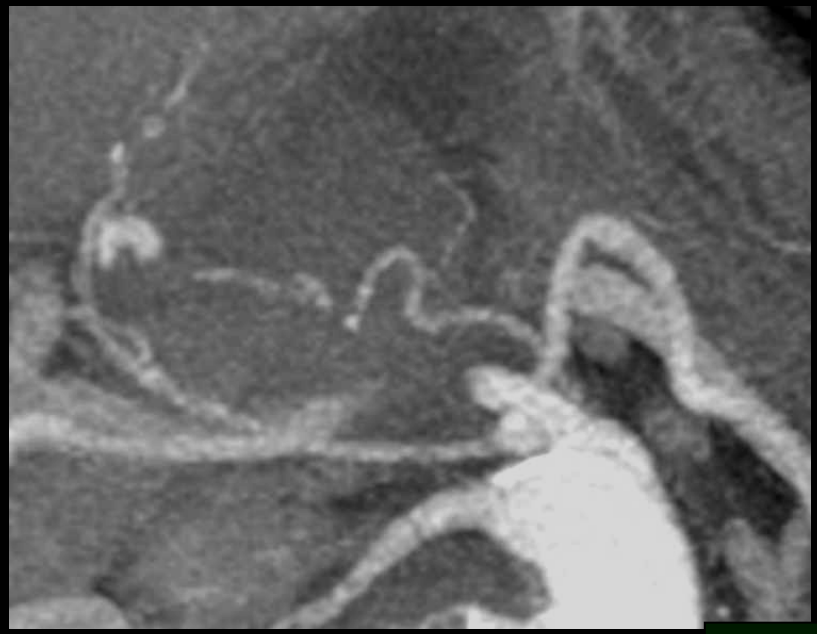


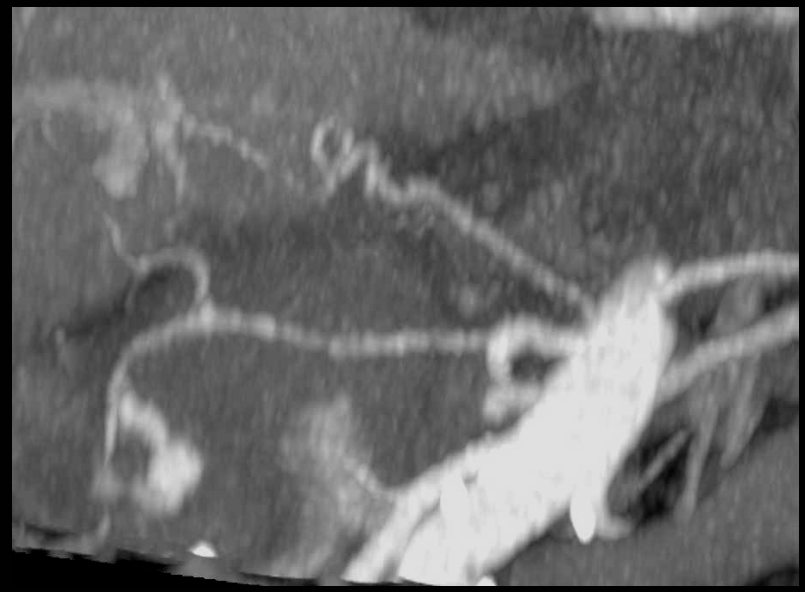


très gros faux anévrysmes compliquant un pseudo kyste céphalique bilobé.

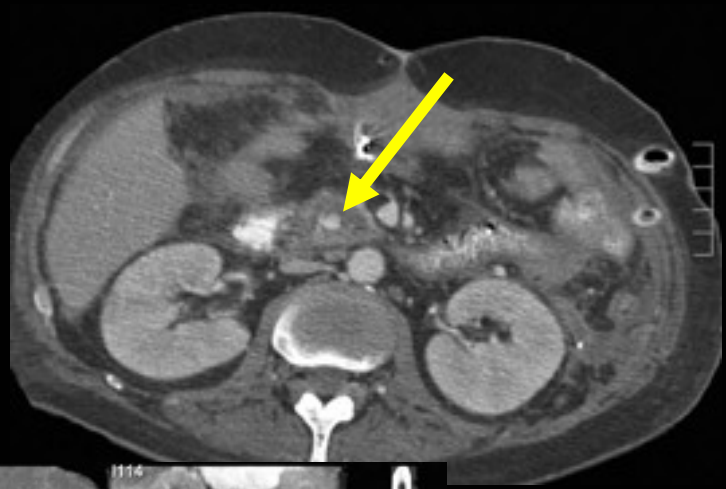


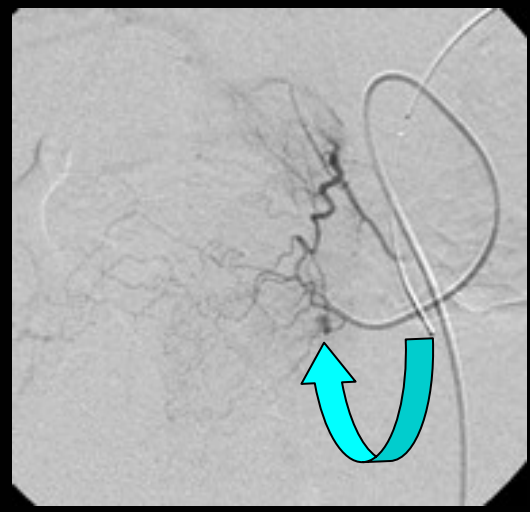


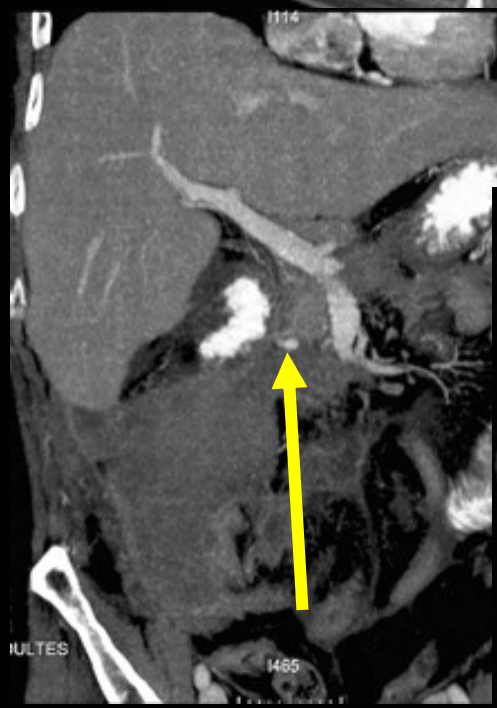


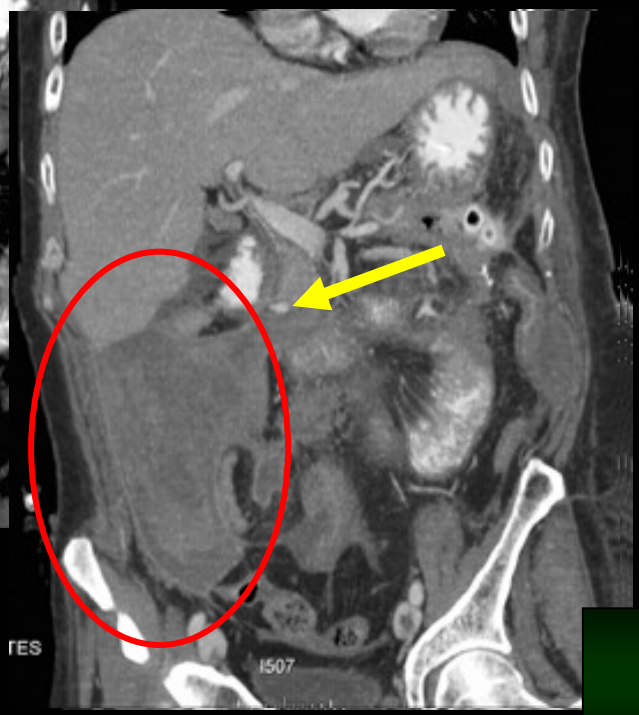


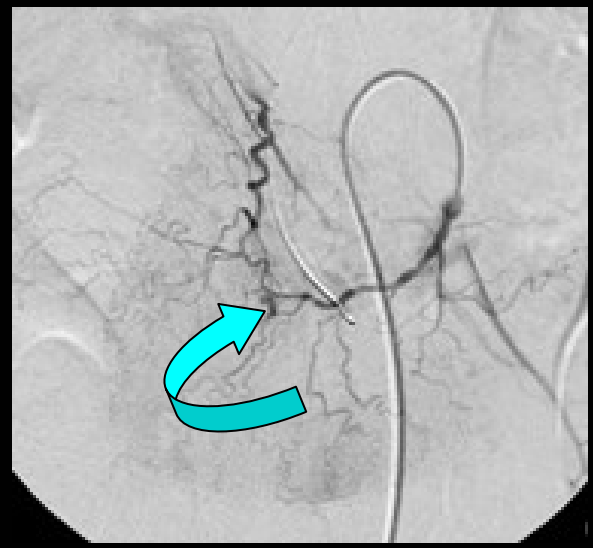
faux kyste hémorragique ; faux anévrysme d'une branche pancréatico-duodénale





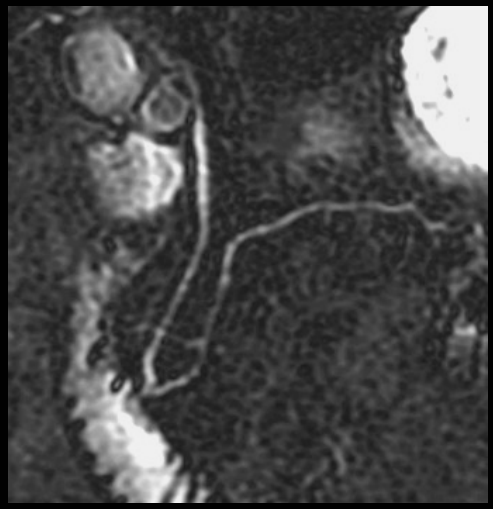




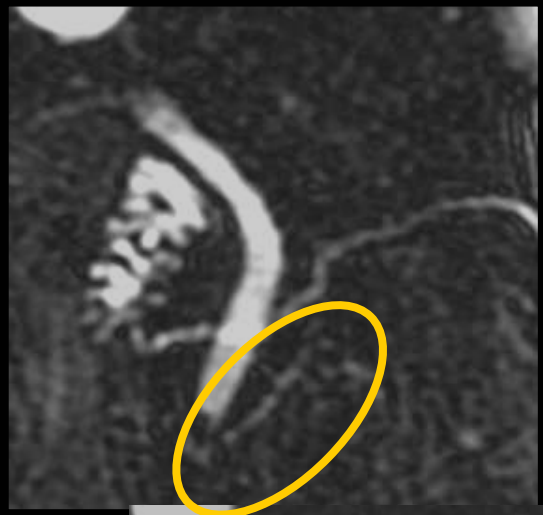


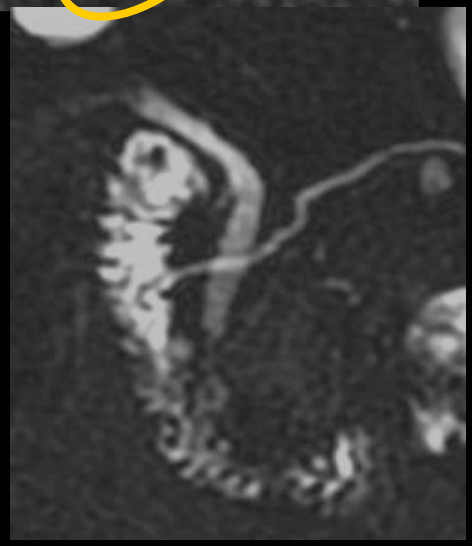
faux anévrysme d'une branche pancréatico-duodénale

pancréatites en relation avec des anomalies anatomiques canalaires

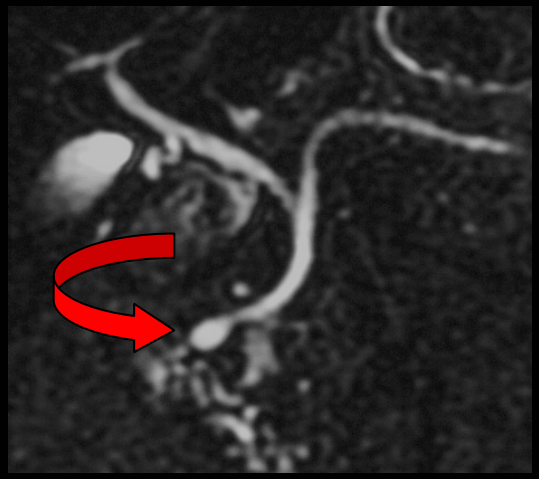


aspect normal

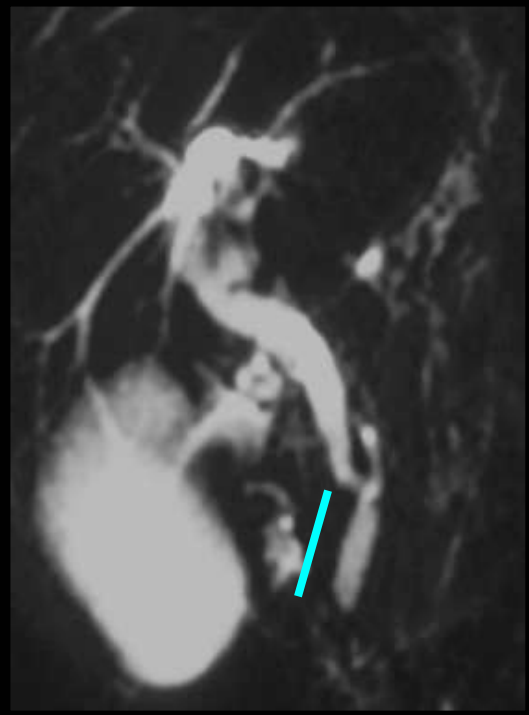




pancréas divisum



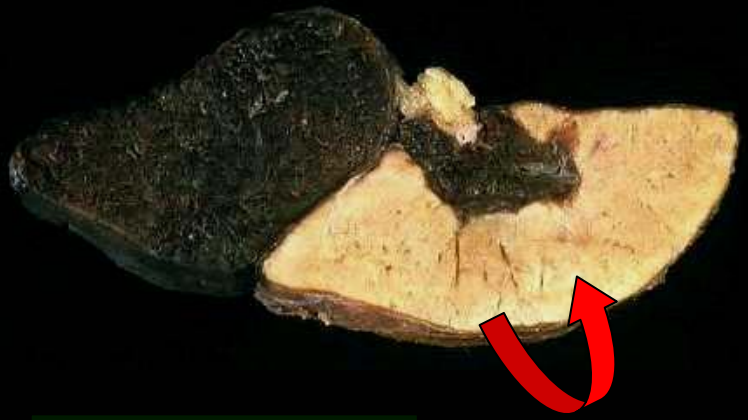
pancréas dorsal dominant



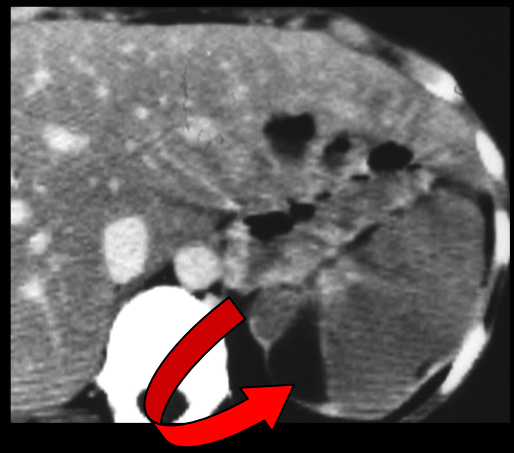
canal commun long (≥15 mm)

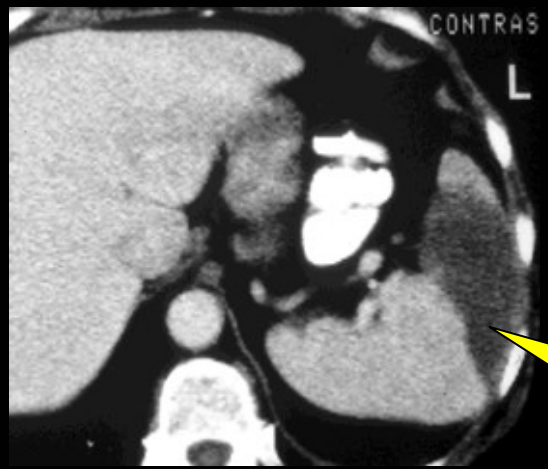
abdomens aigus d'origine splénique

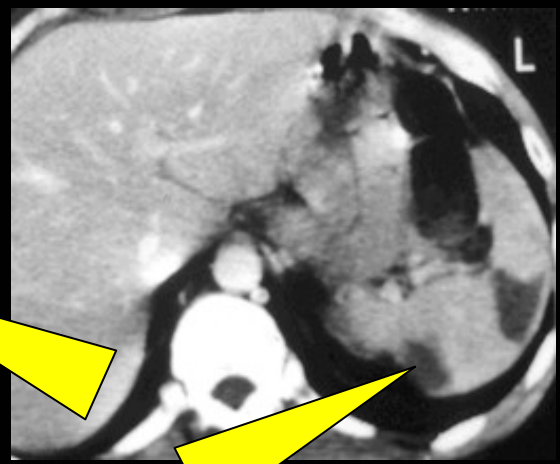
infarctus et ruptures "spontanées" de la rate

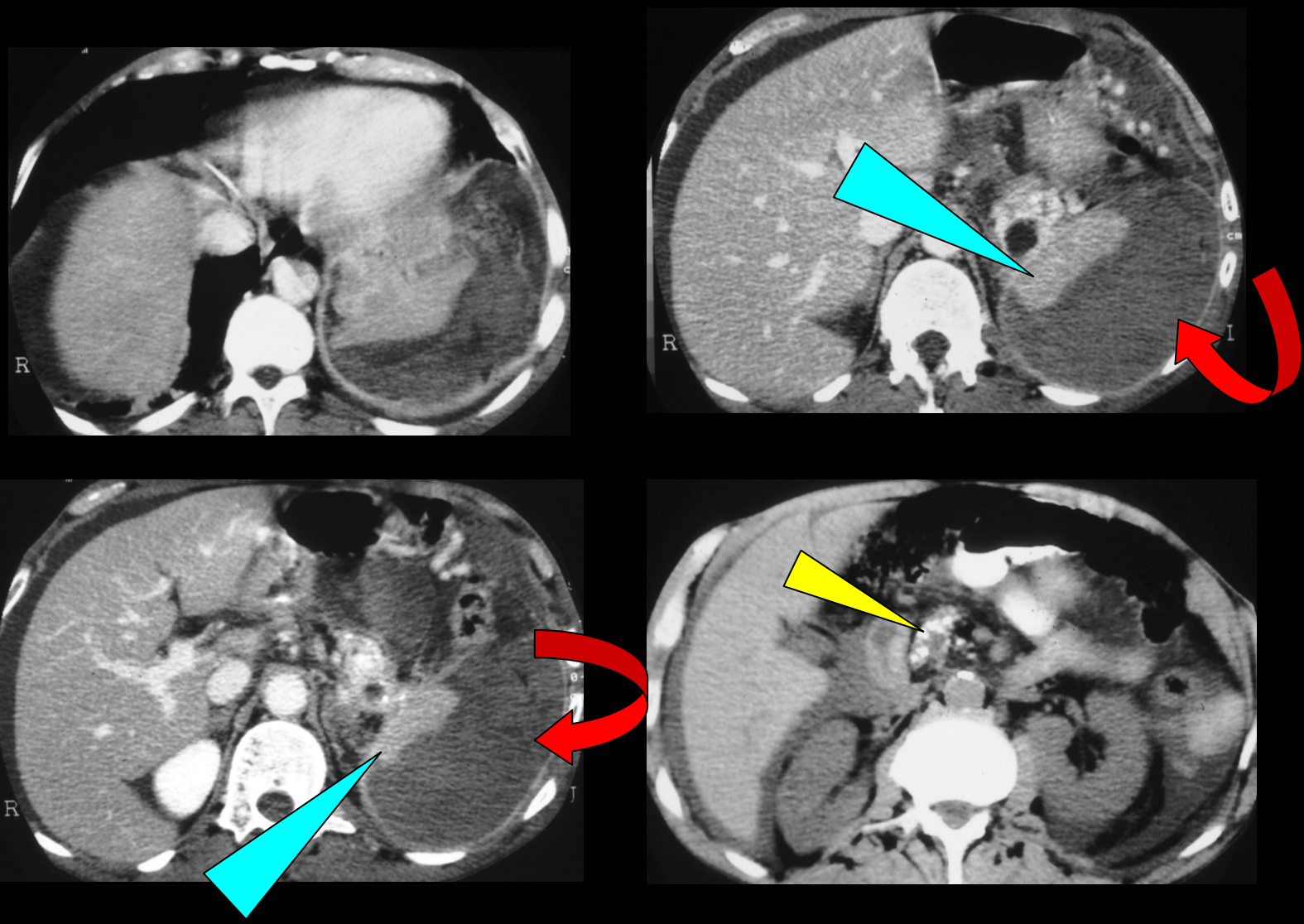


infarctus blanc

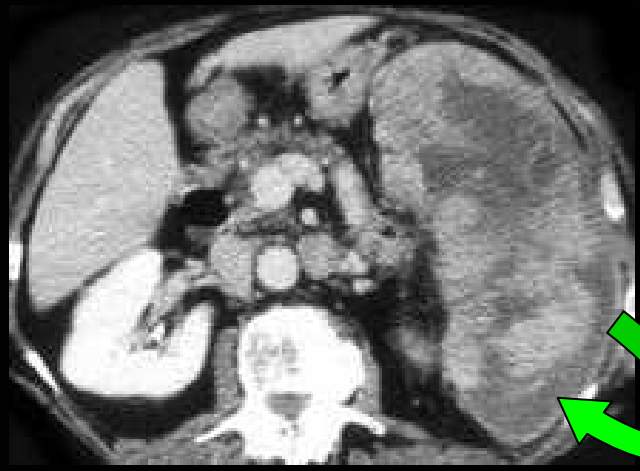


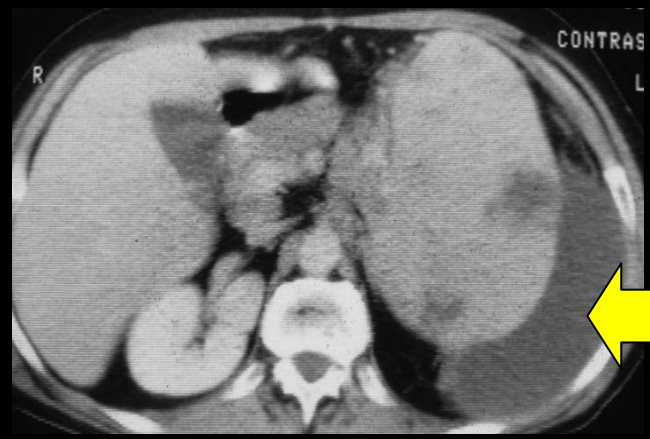


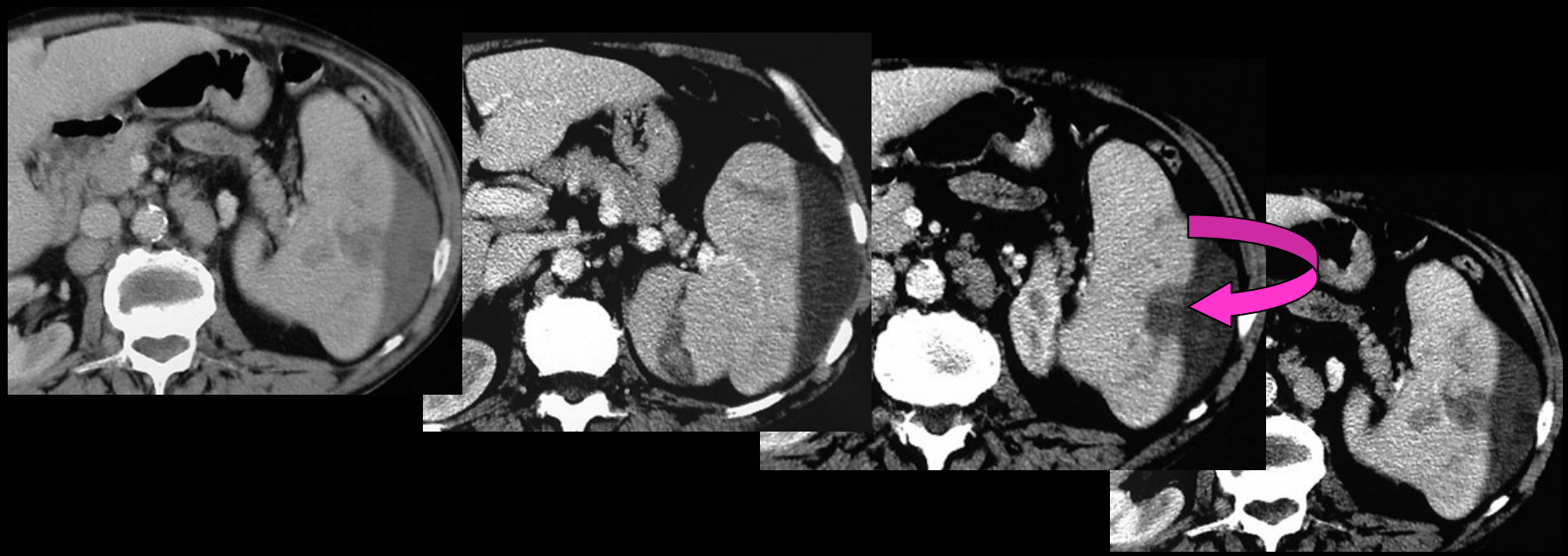




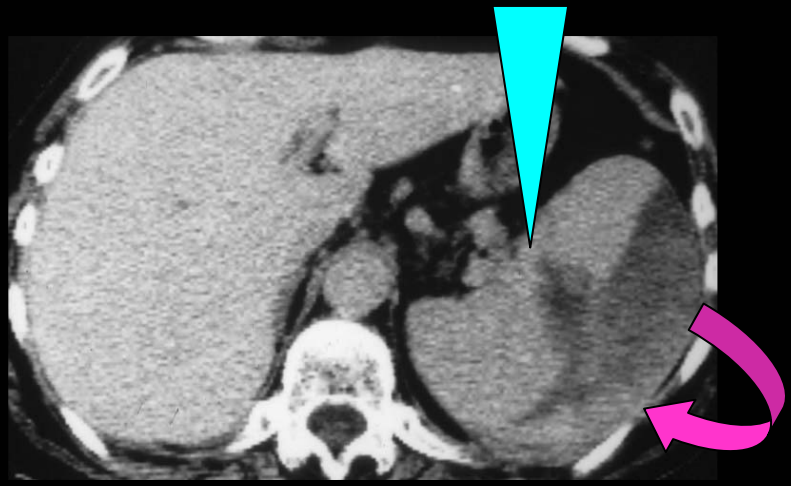
infarcissement splénique compliquant une thrombose veineuse splénique sur pancréatite chronique calcifiante

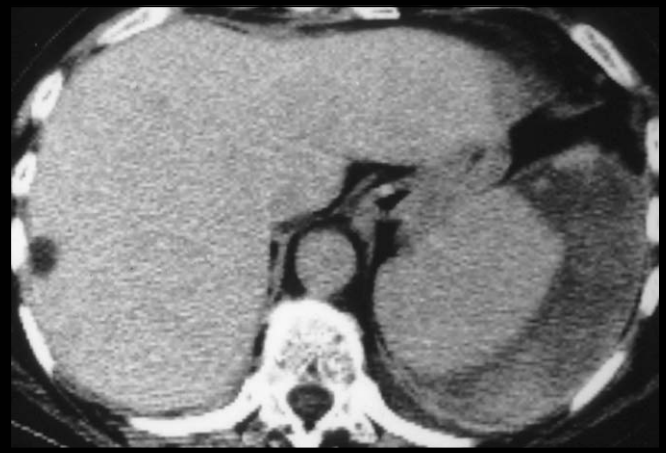


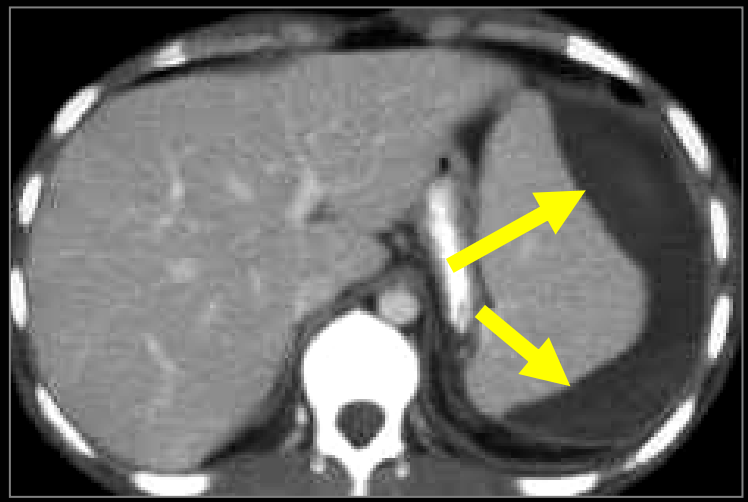


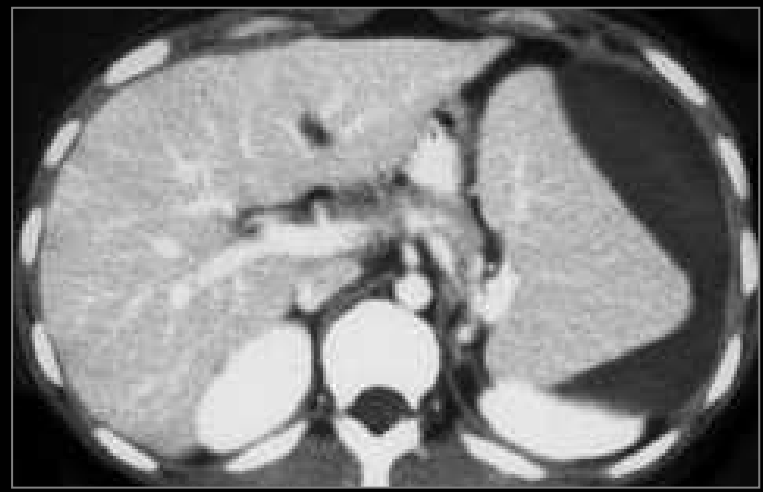


localisations lymphomateuses spléniques compliquées de ruptures



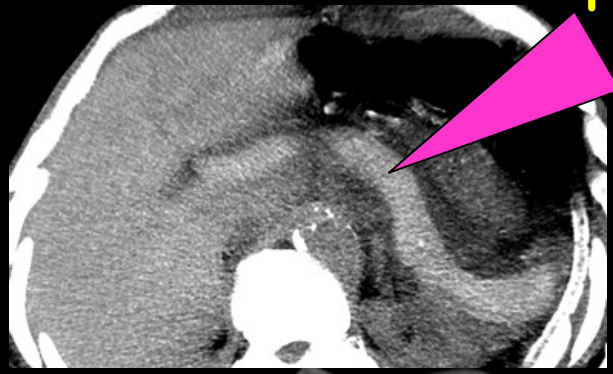


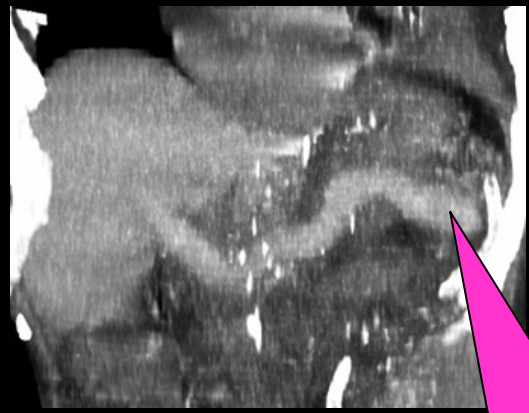




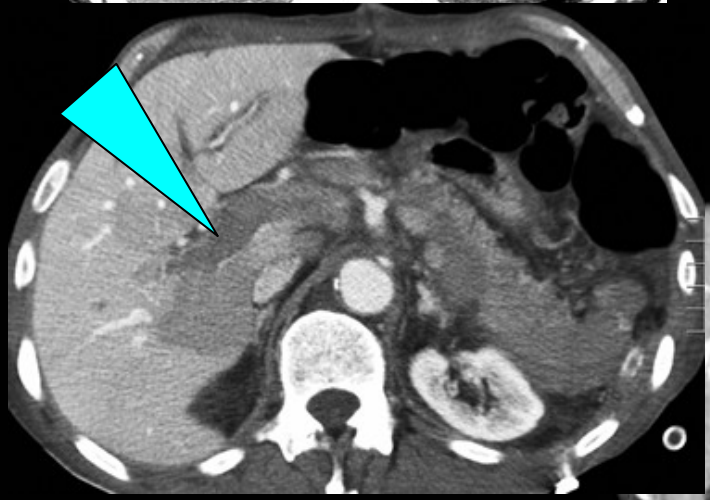
ruptures de rate compliquant une mononucléose infectieuse

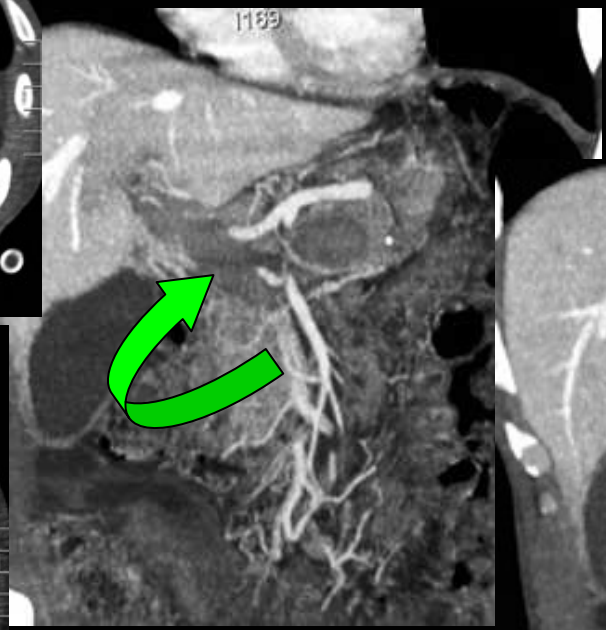
thromboses veineuses spléniques aiguës

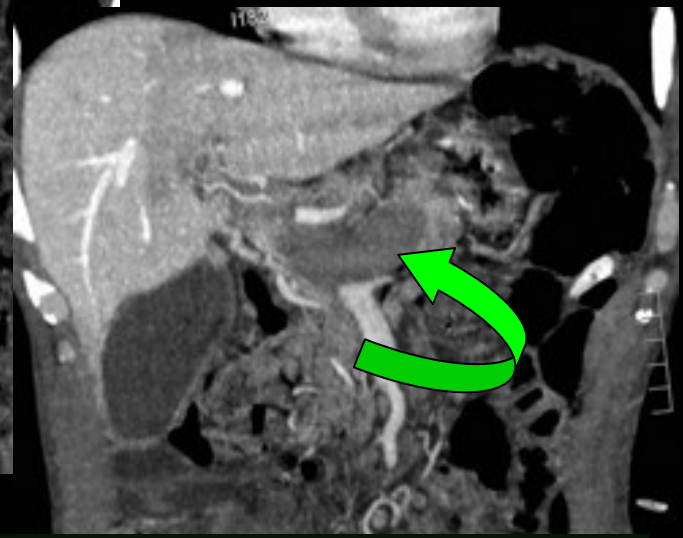


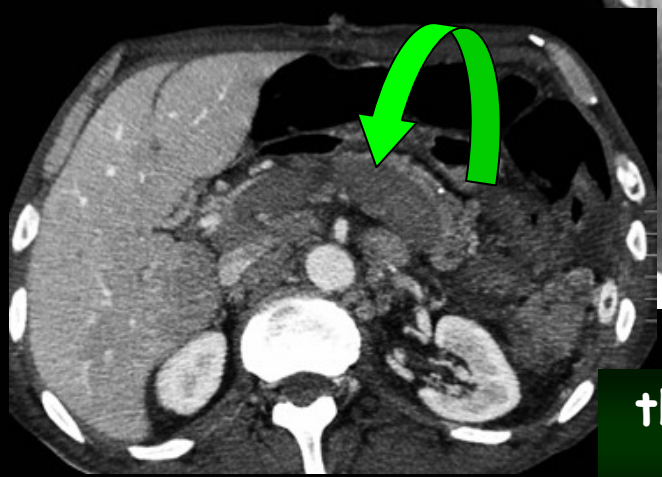


MIP MPVR sans injection ; post splénectomie





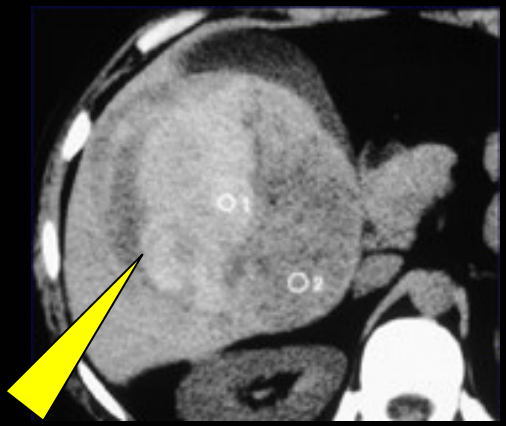




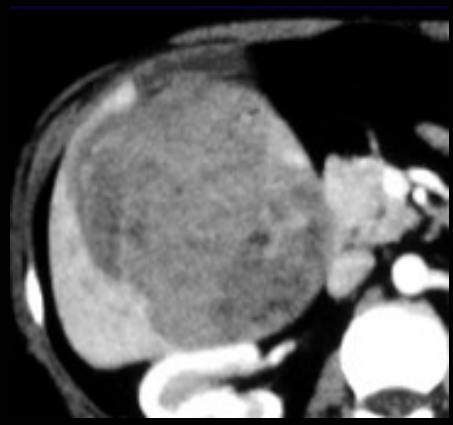
thrombose veineuse splénique post splénectomie pour purpura thrombopénique idiopathique

abdomens aigus d'origine hépatique

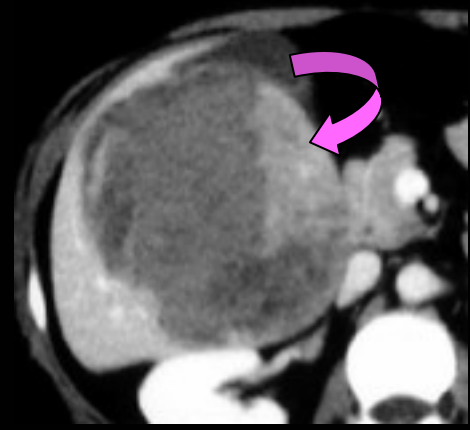
lésions focales hémorragiques



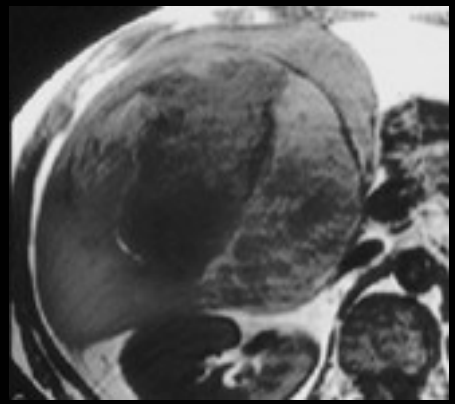
CT avant injection



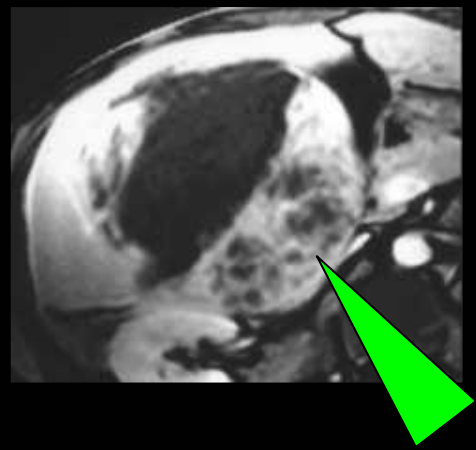
CT 45 "



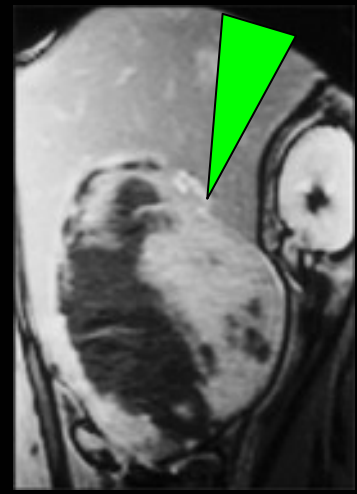
CT 1'30



SE T1

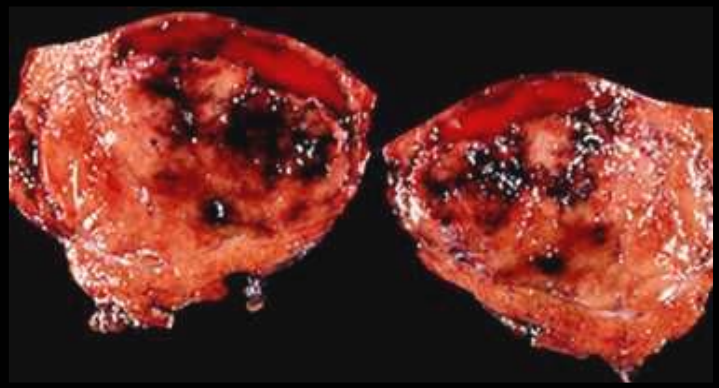


SE T1 2'

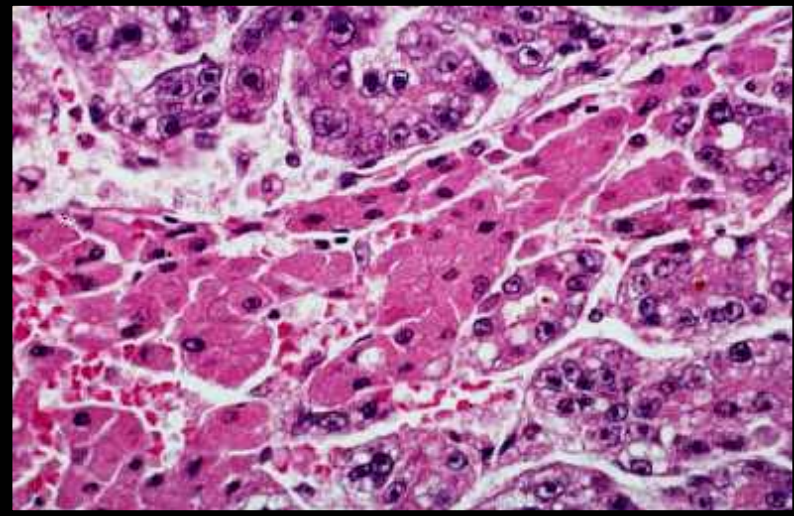


SE T1 6'

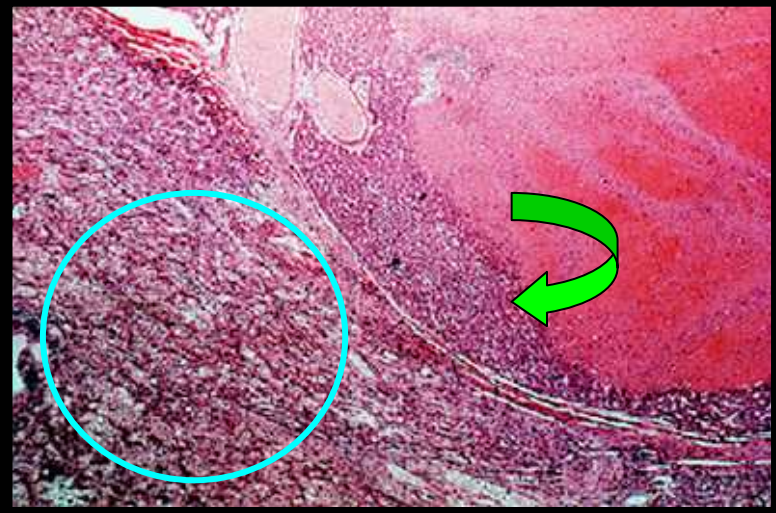
adénome hépatique hémorragique, femme 34 ans



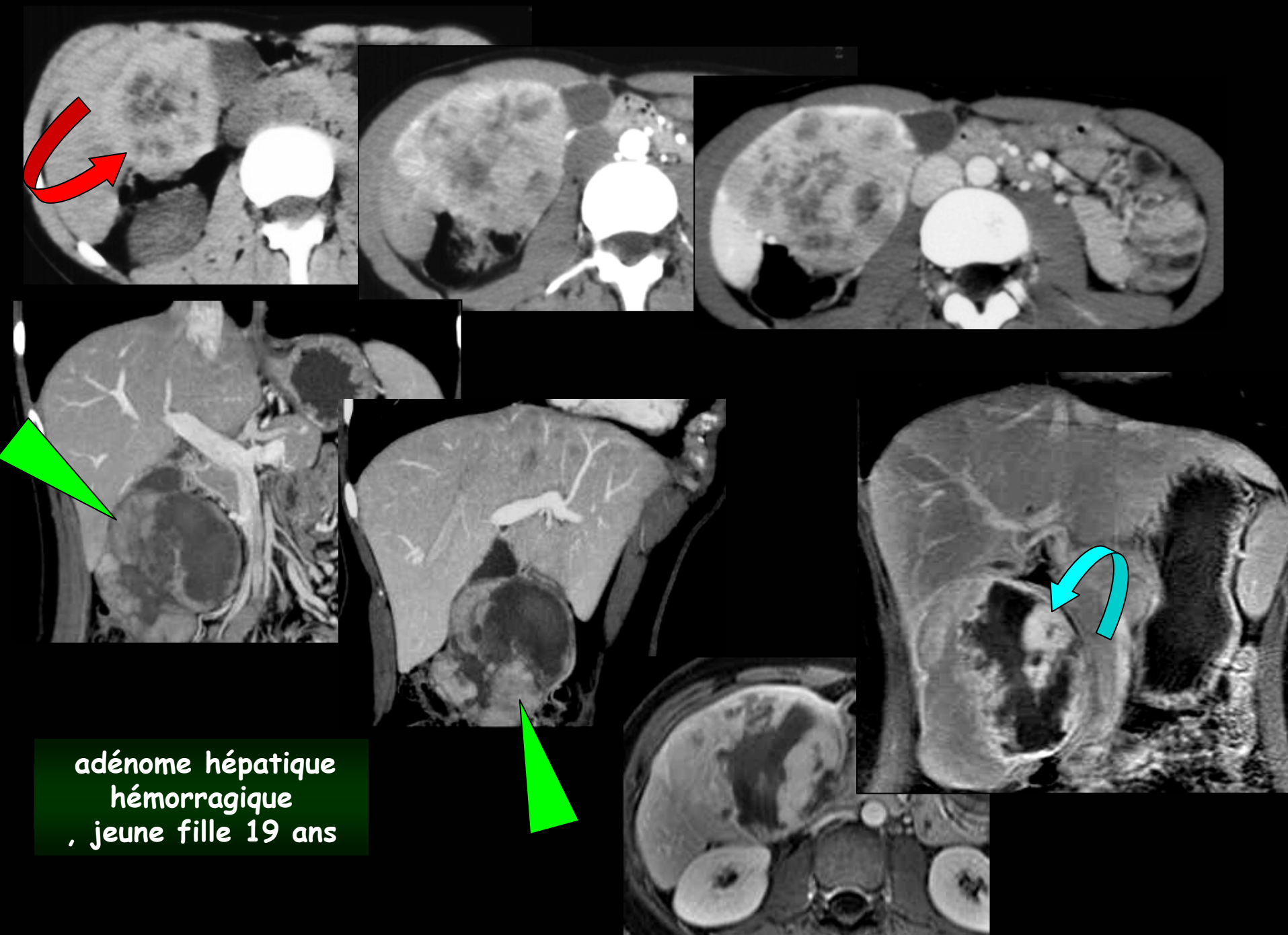
adénome hépatique



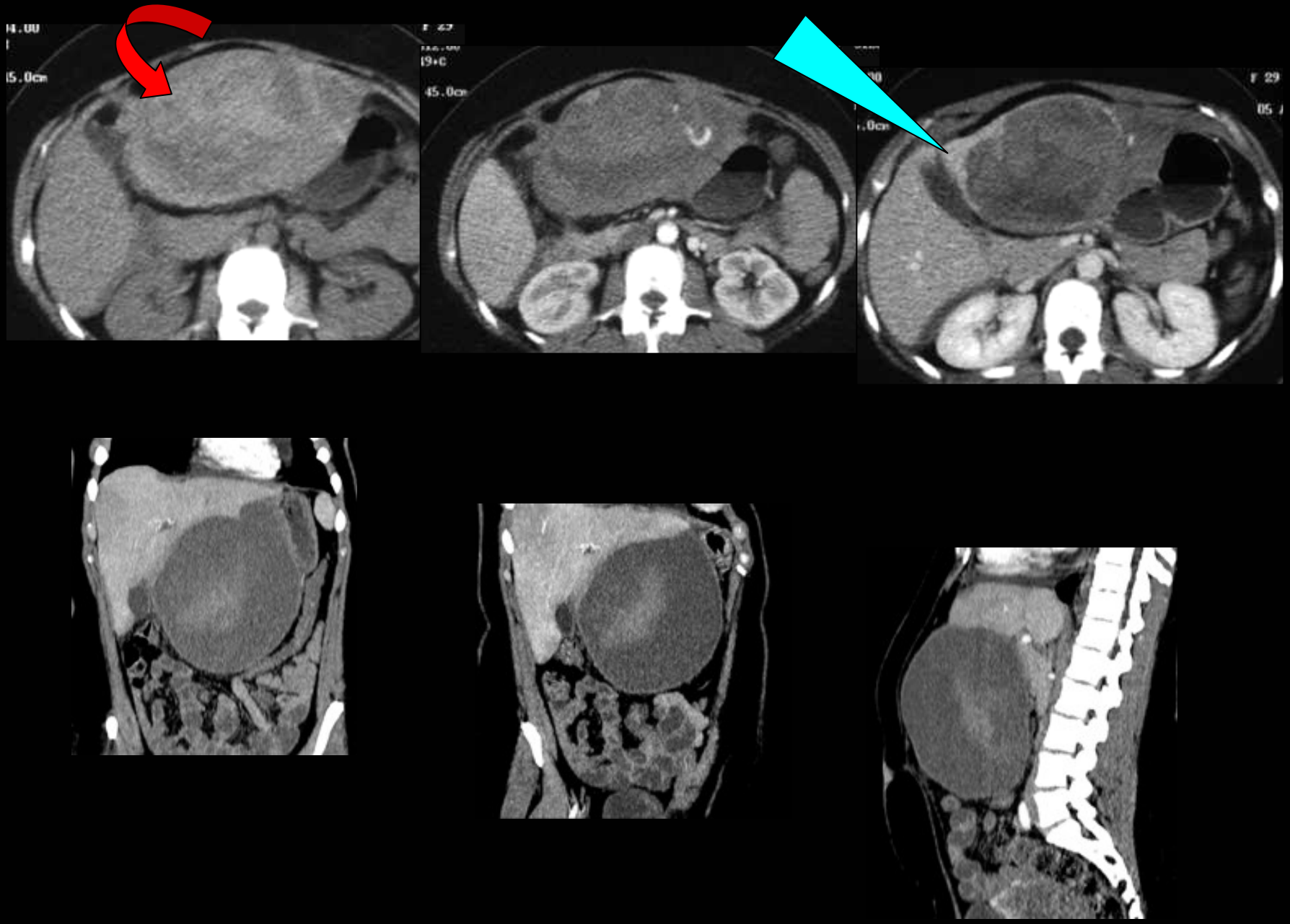
péliose hépatique ;formes kystiques et/ou phlebectasiques



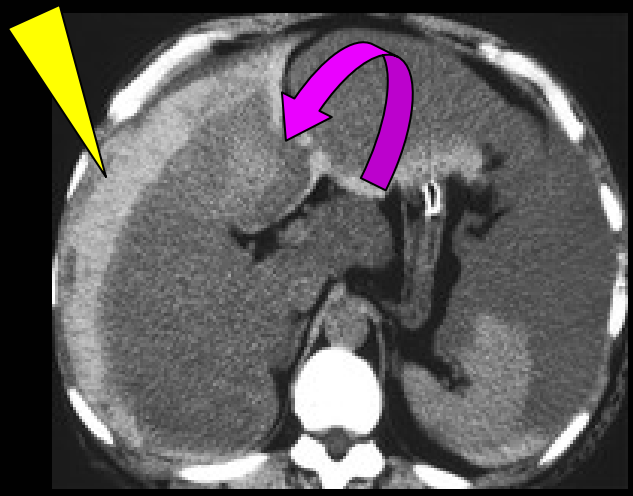
la **péliose** explique le caractère hémorragique de l'adénome

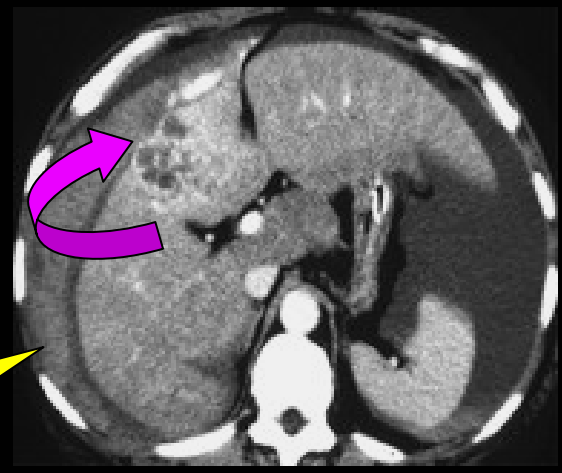


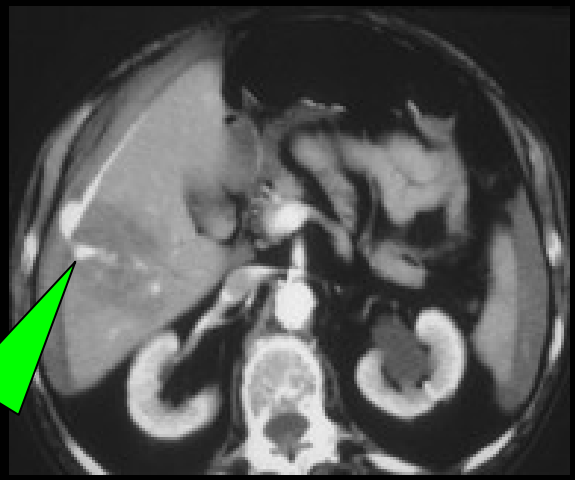
adénome hépatique
hémorragique
, jeune fille 19 ans

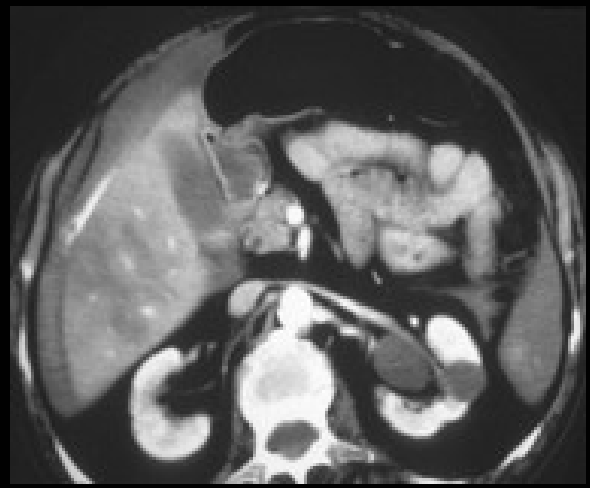


adénome télangiectasique , femme 34 ans



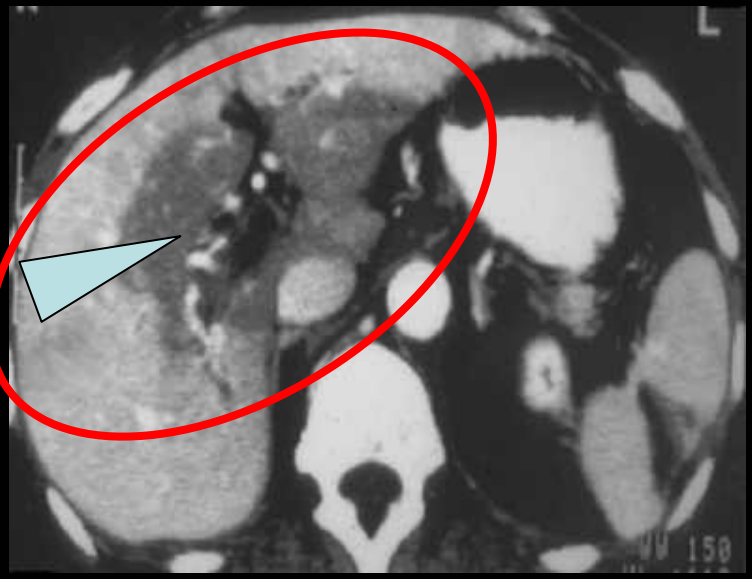


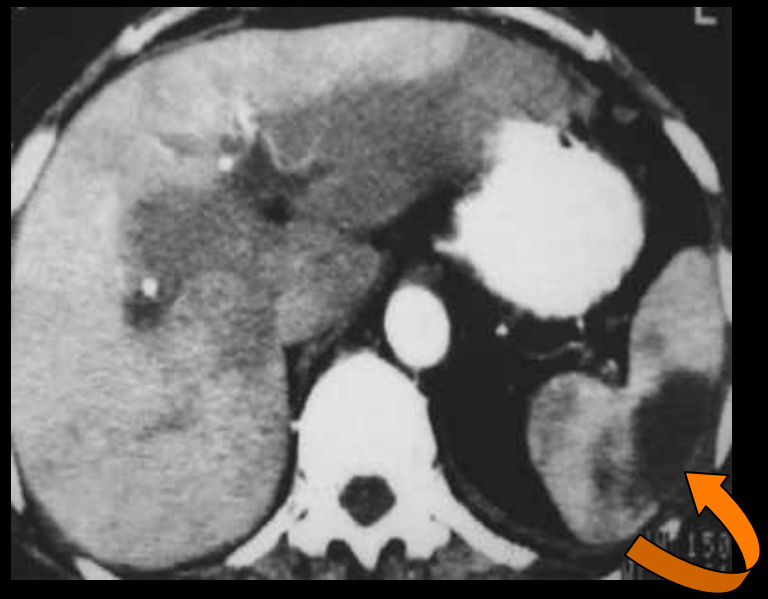


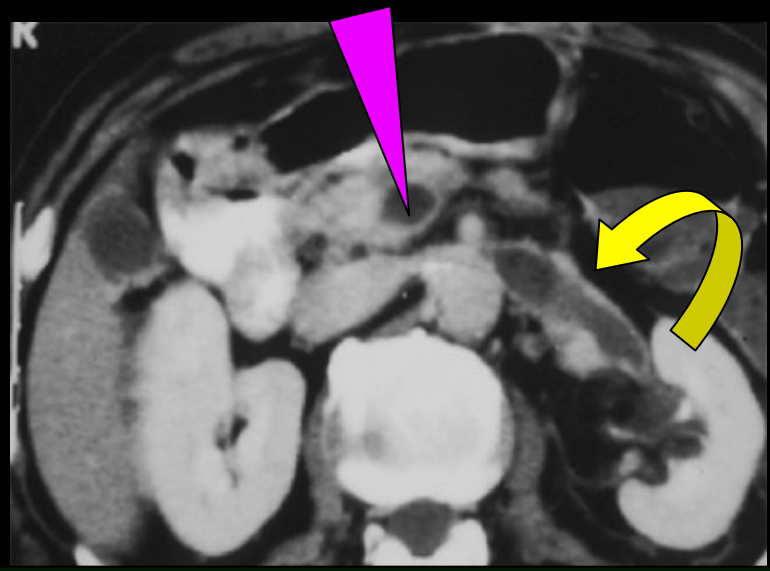


CHC sous-capsulaires hémorragiques

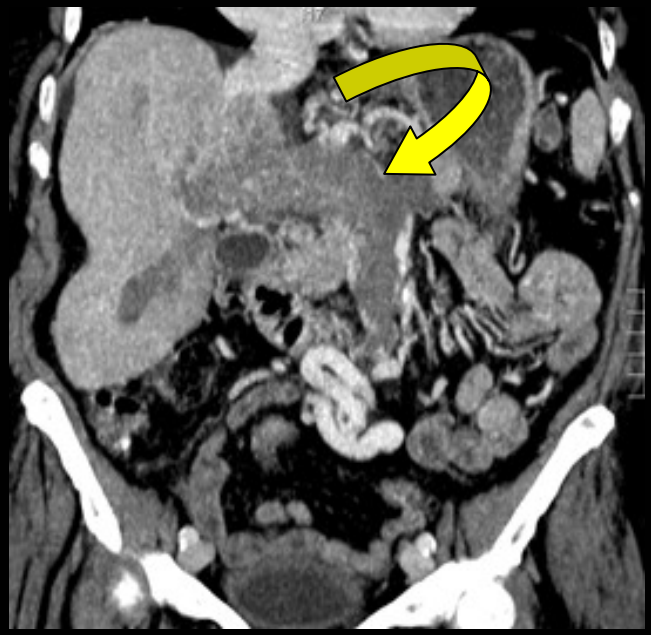
urgences hépatiques "vasculaires"

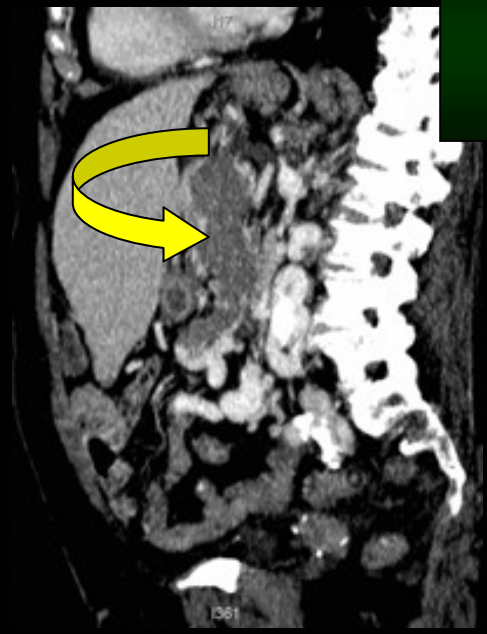




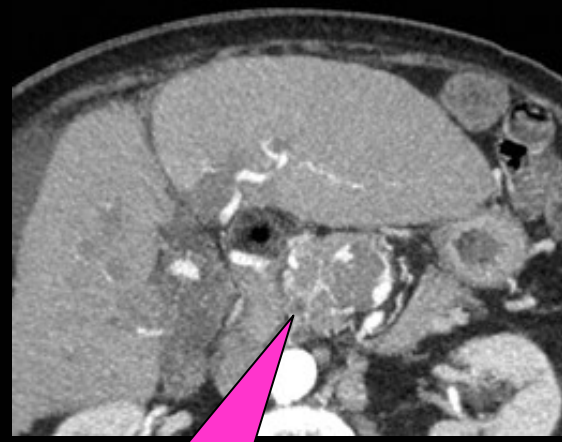


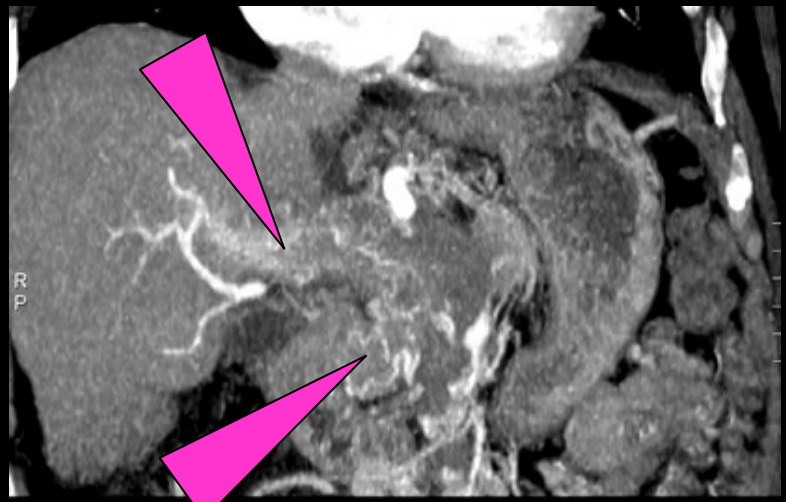
thromboses veineuses portale (pyléphlébite) et rénale aiguës, thrombophilie

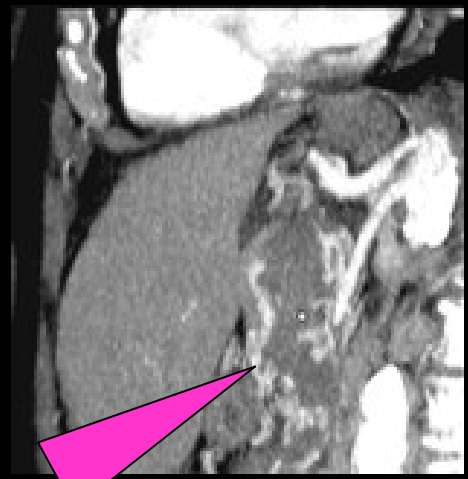


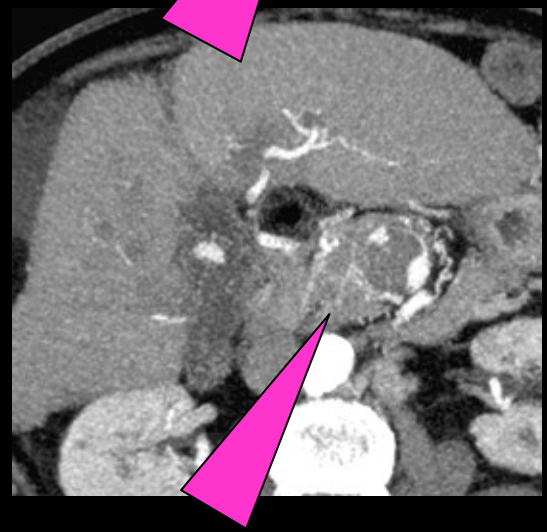


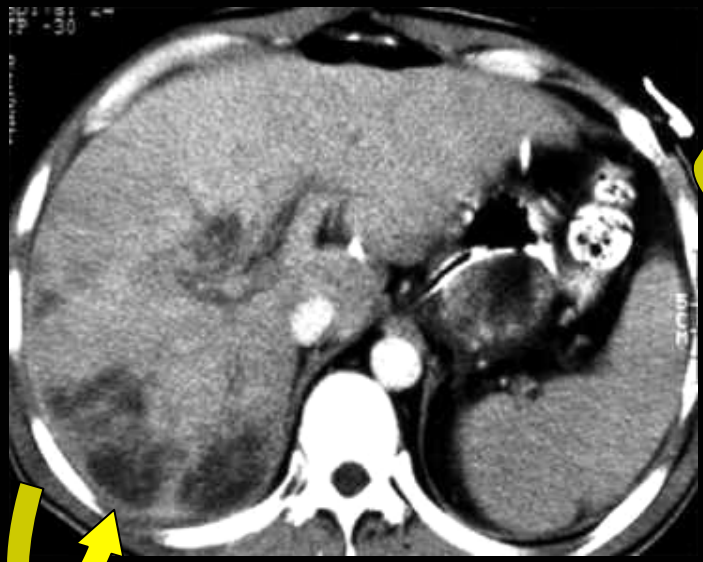
bourgeon tumoral
mésentérico-portal ;
CHC sur cirrhose VHC

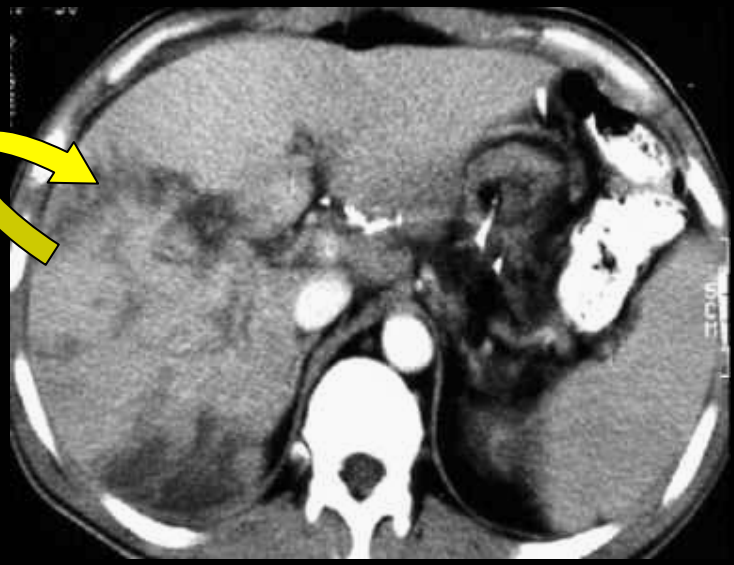


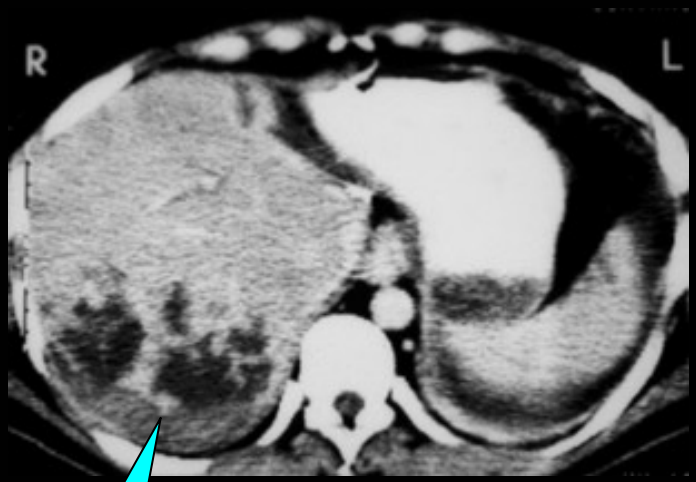


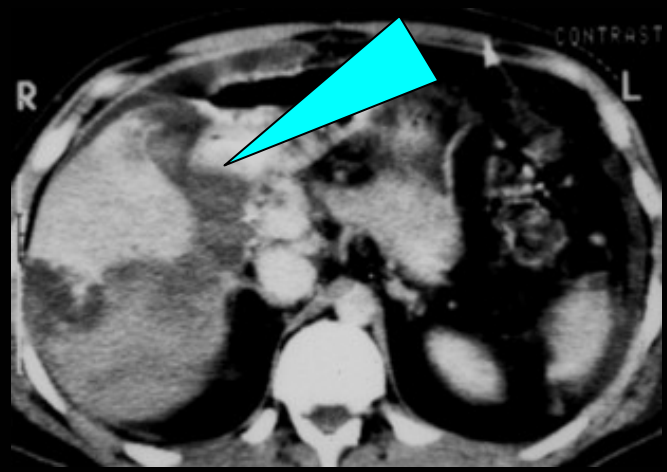




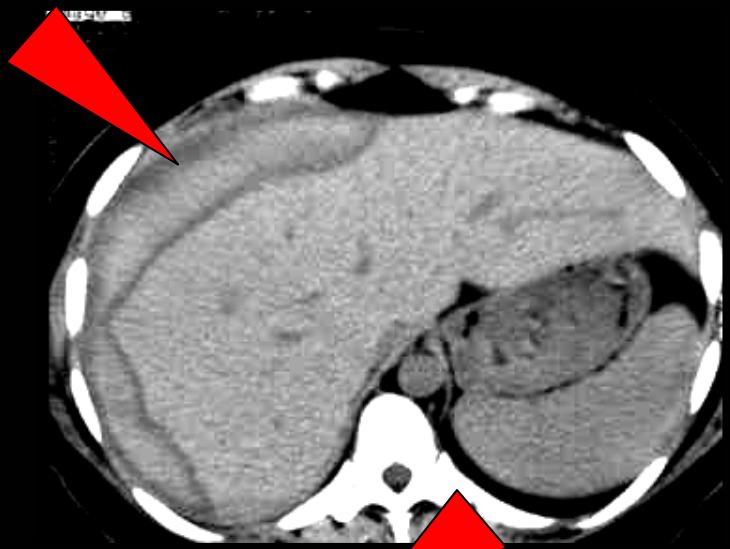


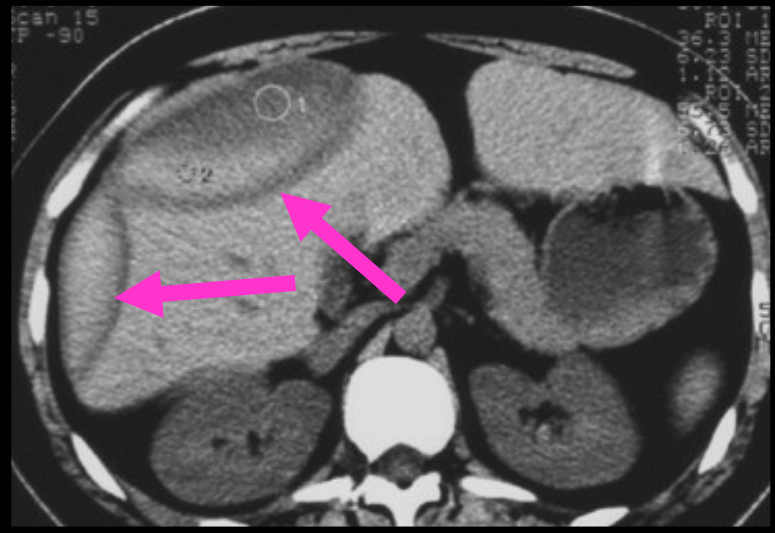


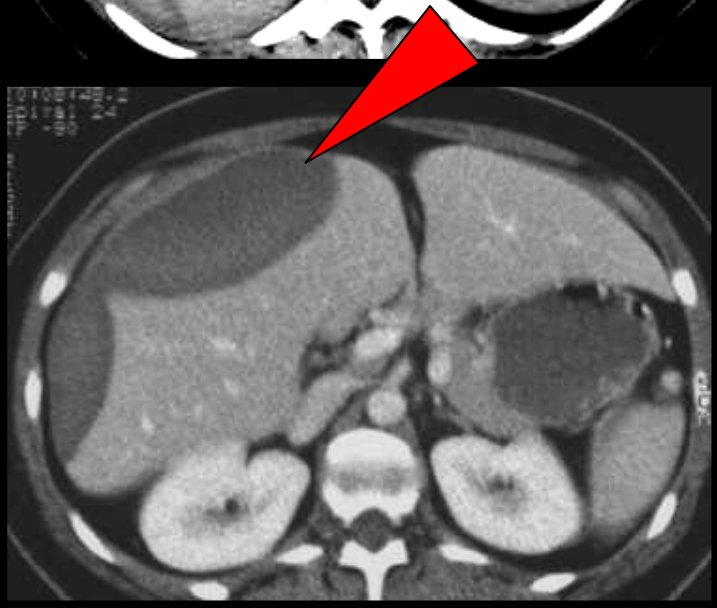


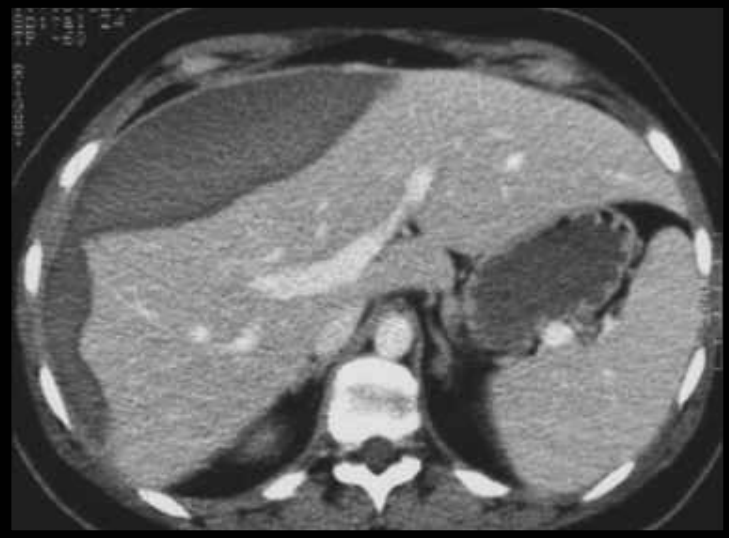


infarctus hépatiques

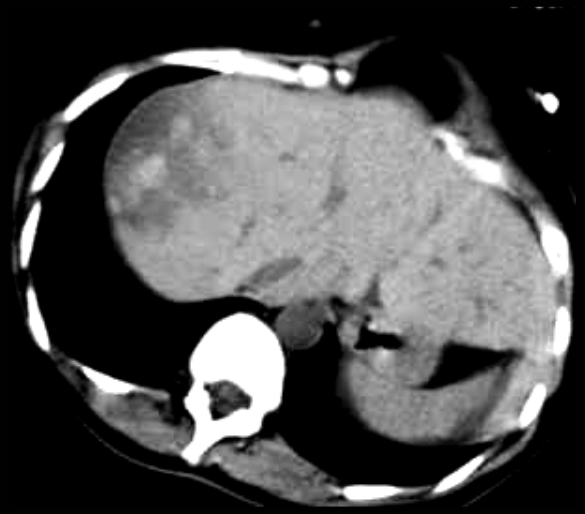


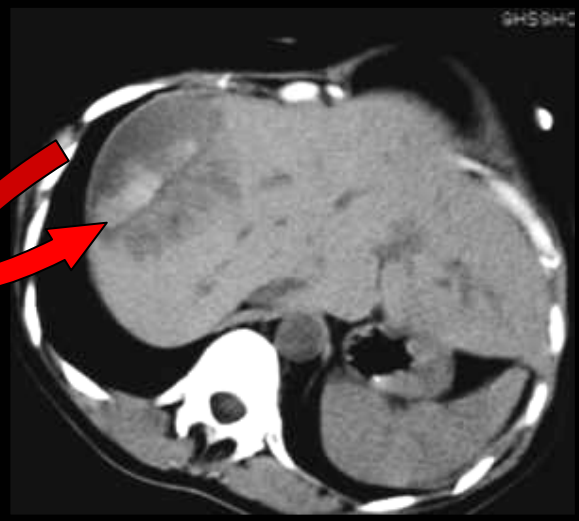


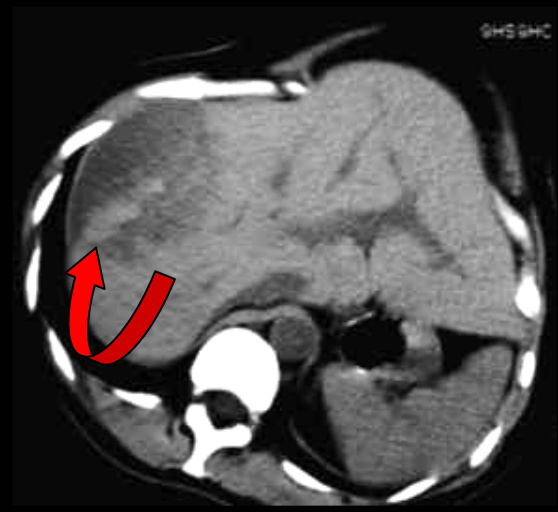


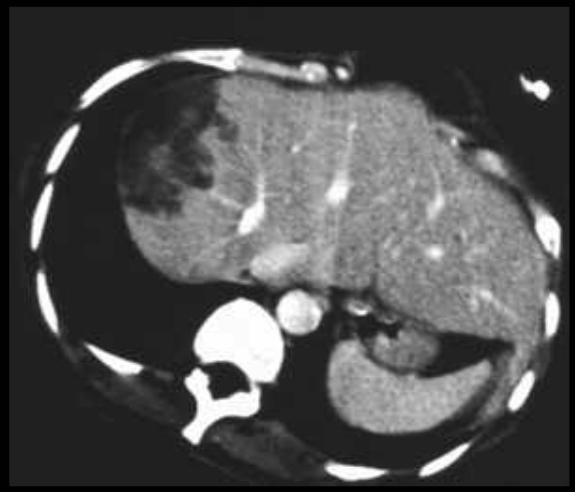


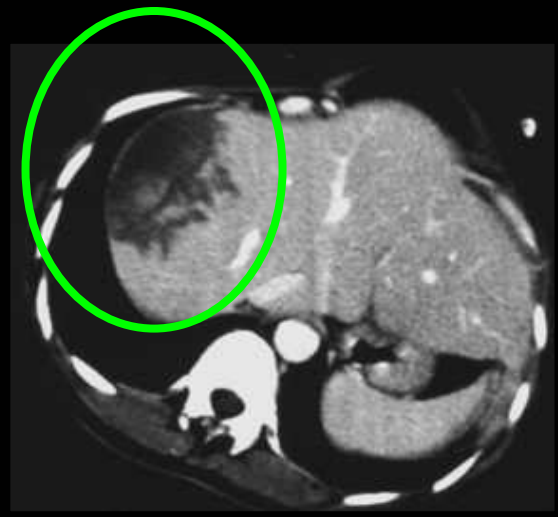
HELLP syndrome : **H** (hemolysis) ; **EL** (elevated liver enzymes)
LP (low platelet count).
pré éclampsie : HTA , protéinurie ,oedèmes…

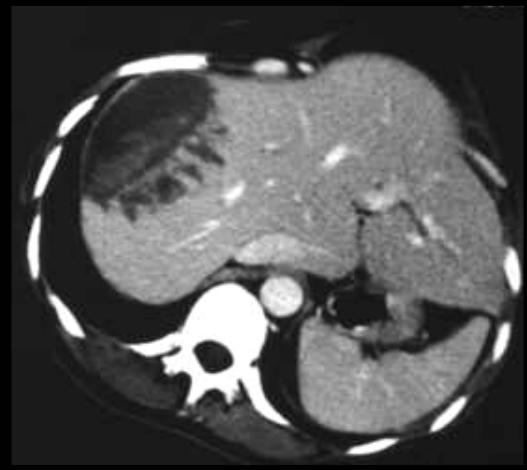






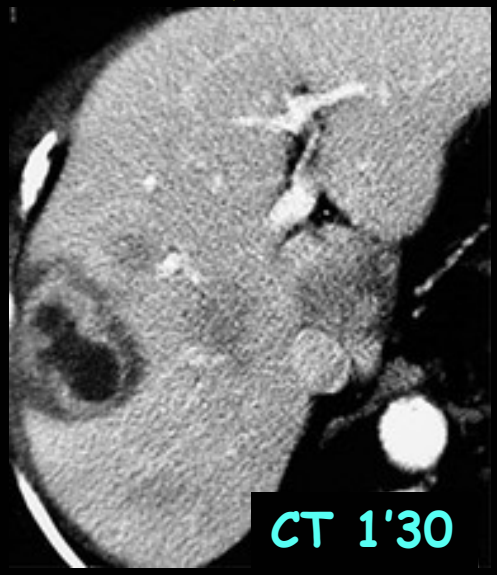


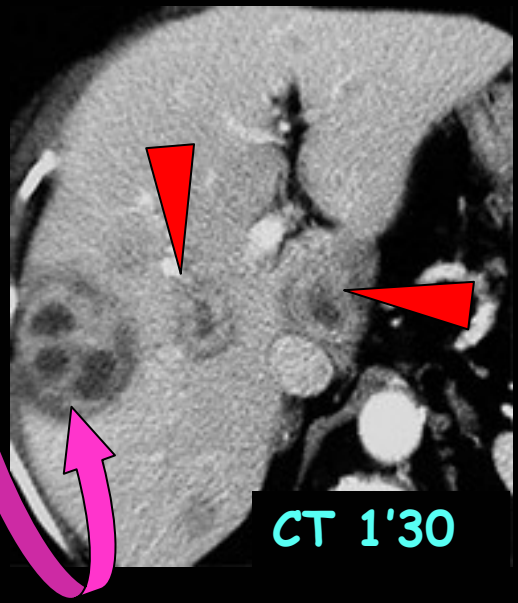




HELLP syndrome
pré-eclampsie

abcès hépatiques


CT 1'30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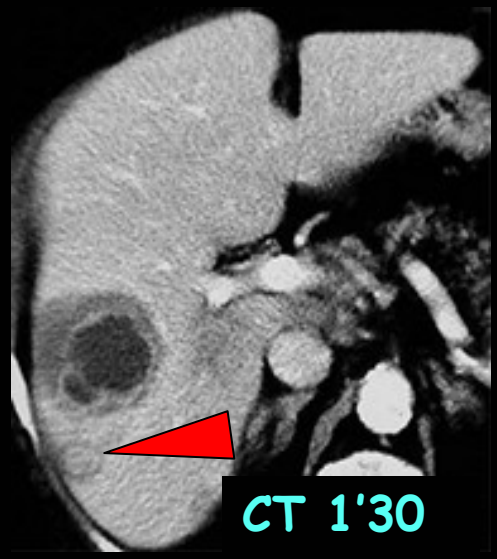
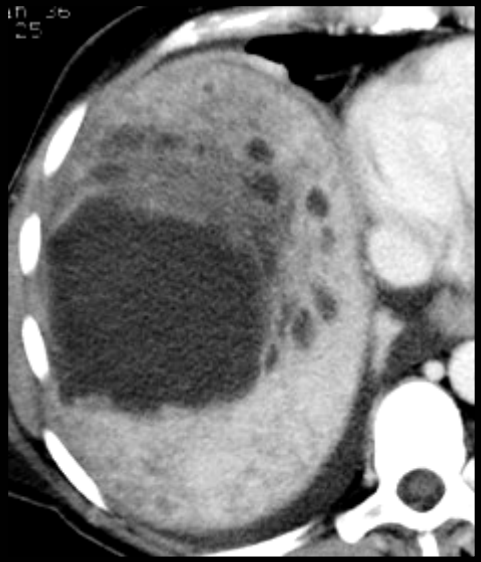

CT 1'30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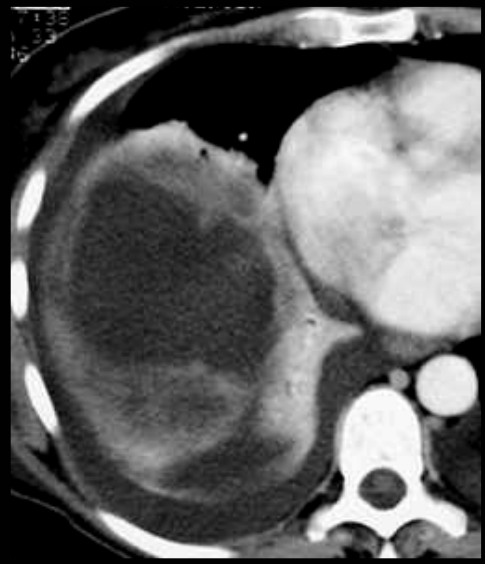
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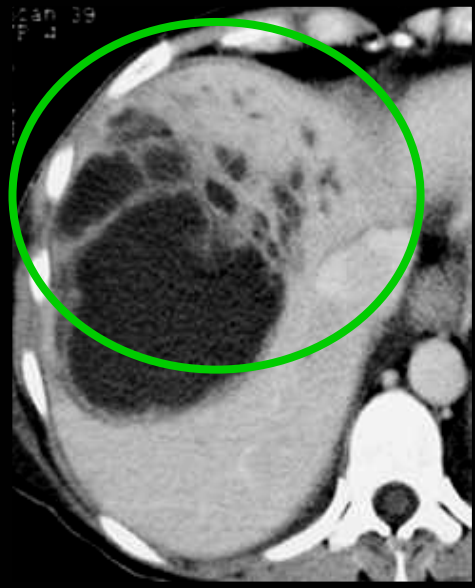
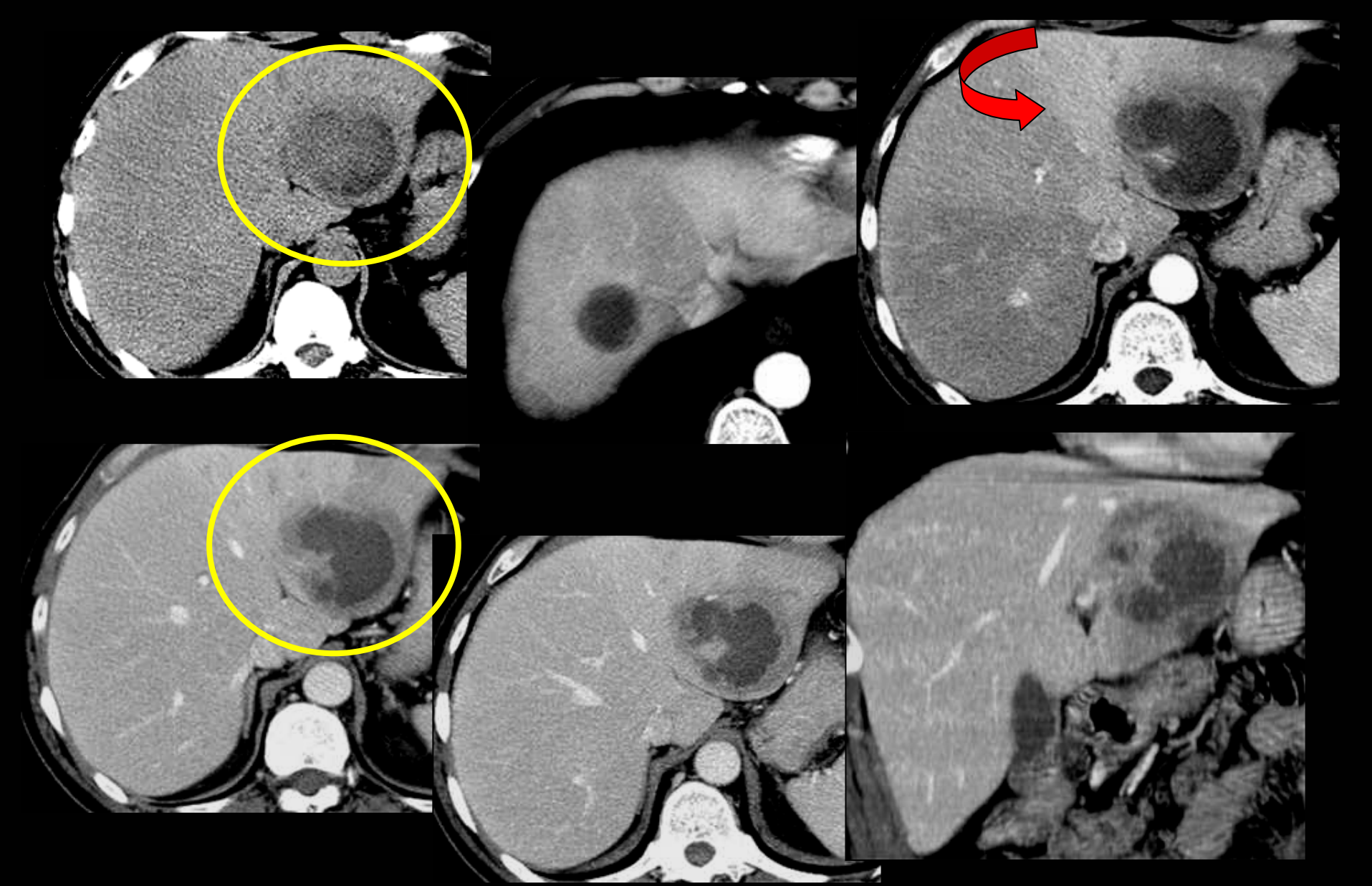
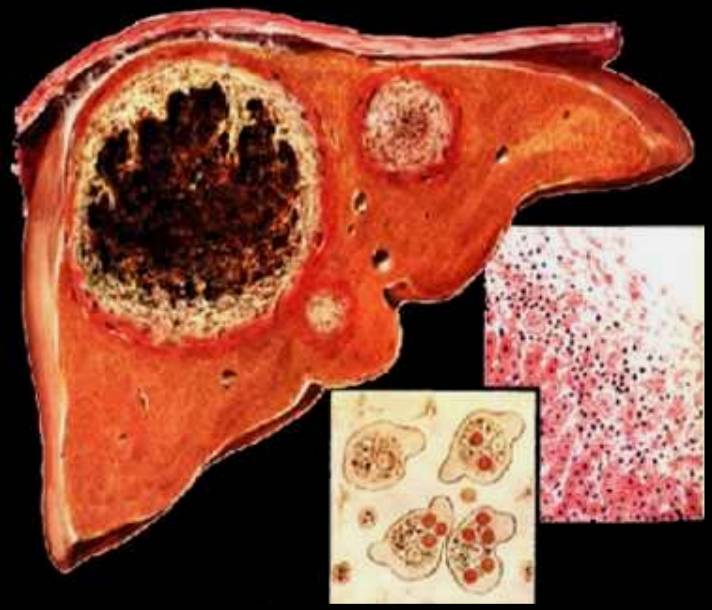

CT 3 '

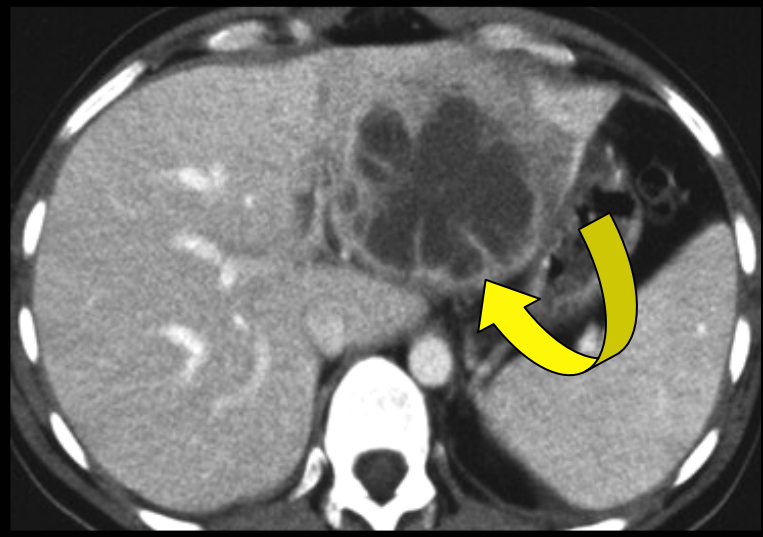
abcès à pyogènes (appendicite aiguë compliquée)

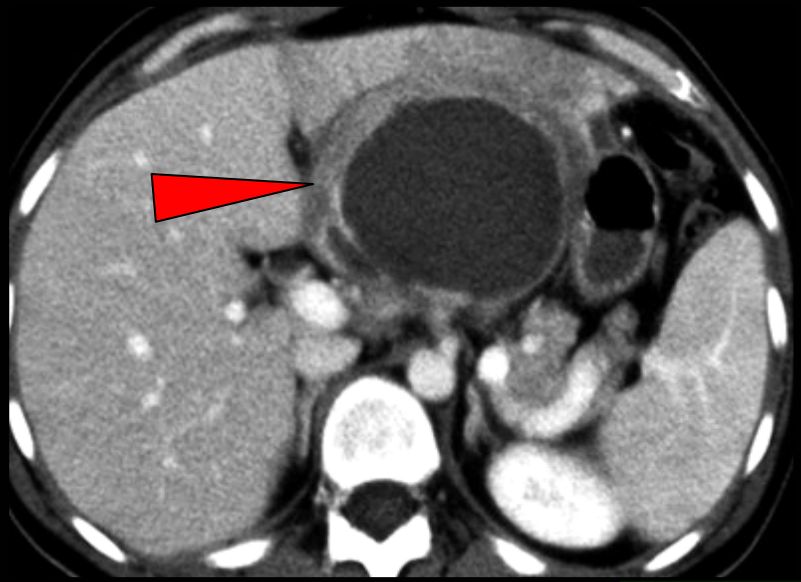


abcès amibien (avec THAD : transcient hepatic attenuation differencies)

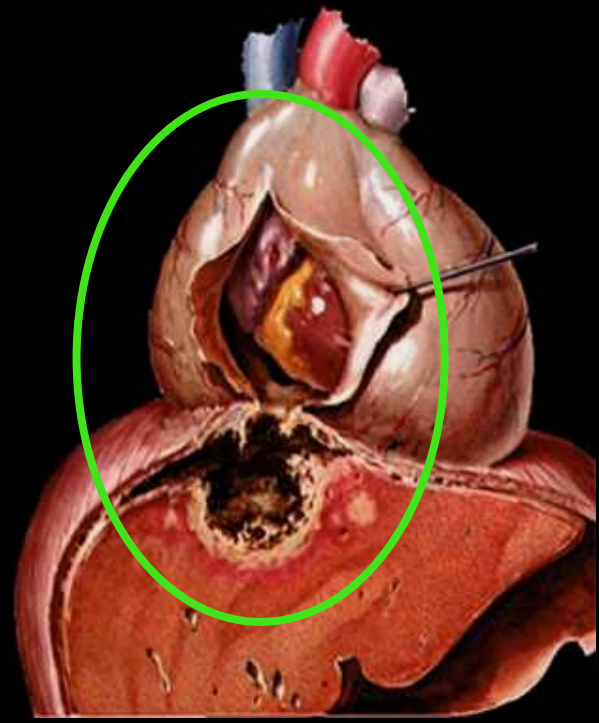
CT 70 "



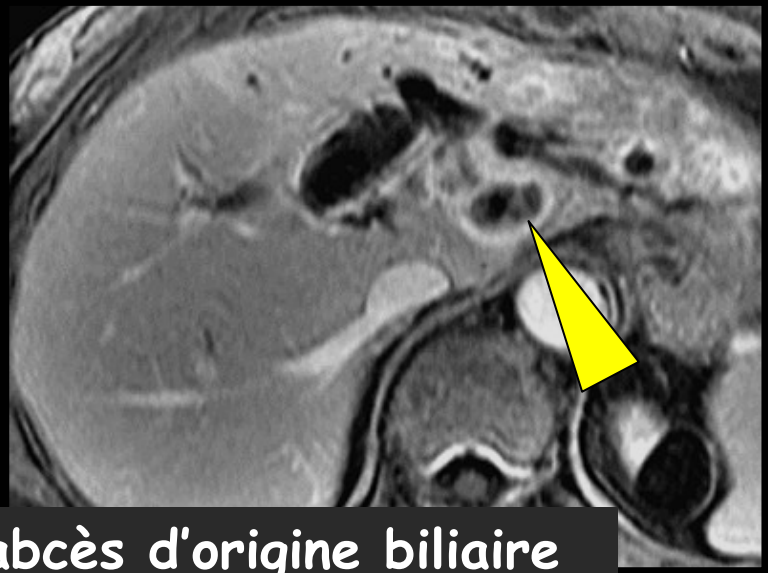


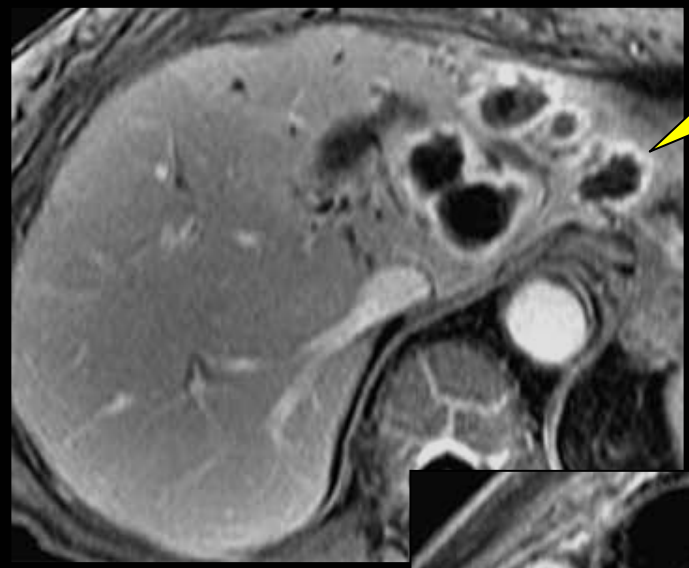


CT 70 "

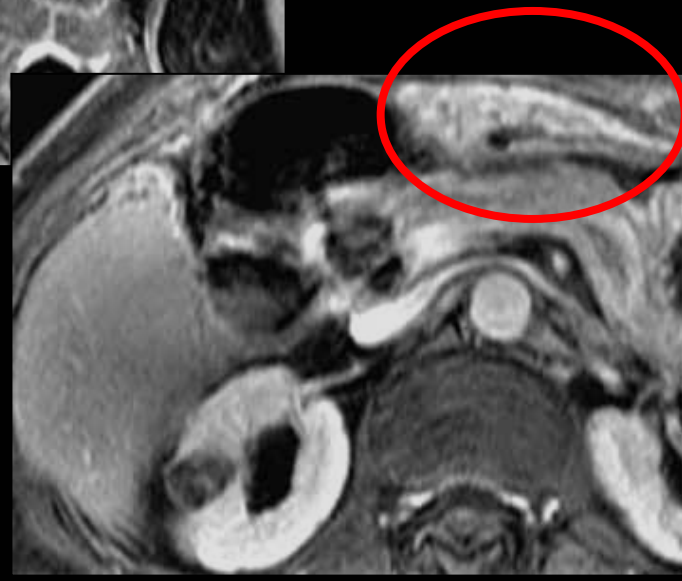


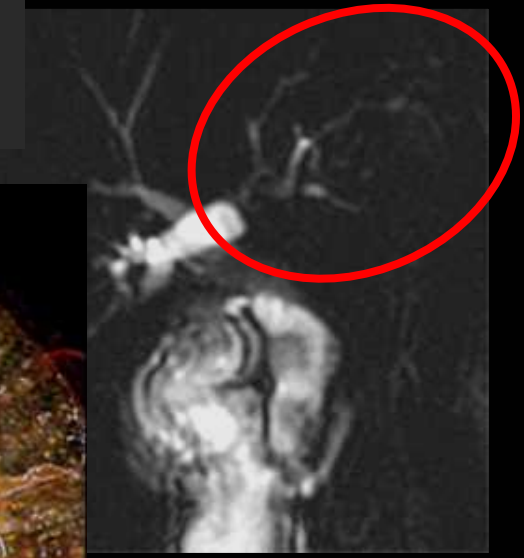
amibiase hépatique

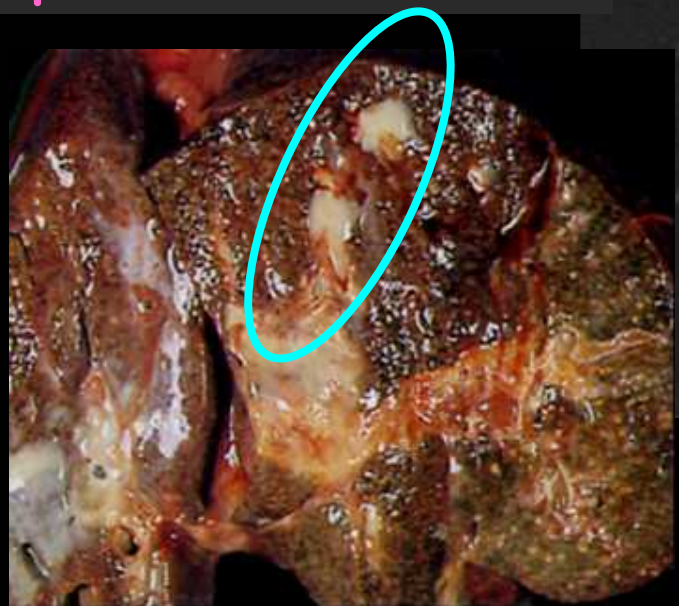




abcès d'origine biliaire ;souvent multiples avec formes allongées et répartition évocatrices

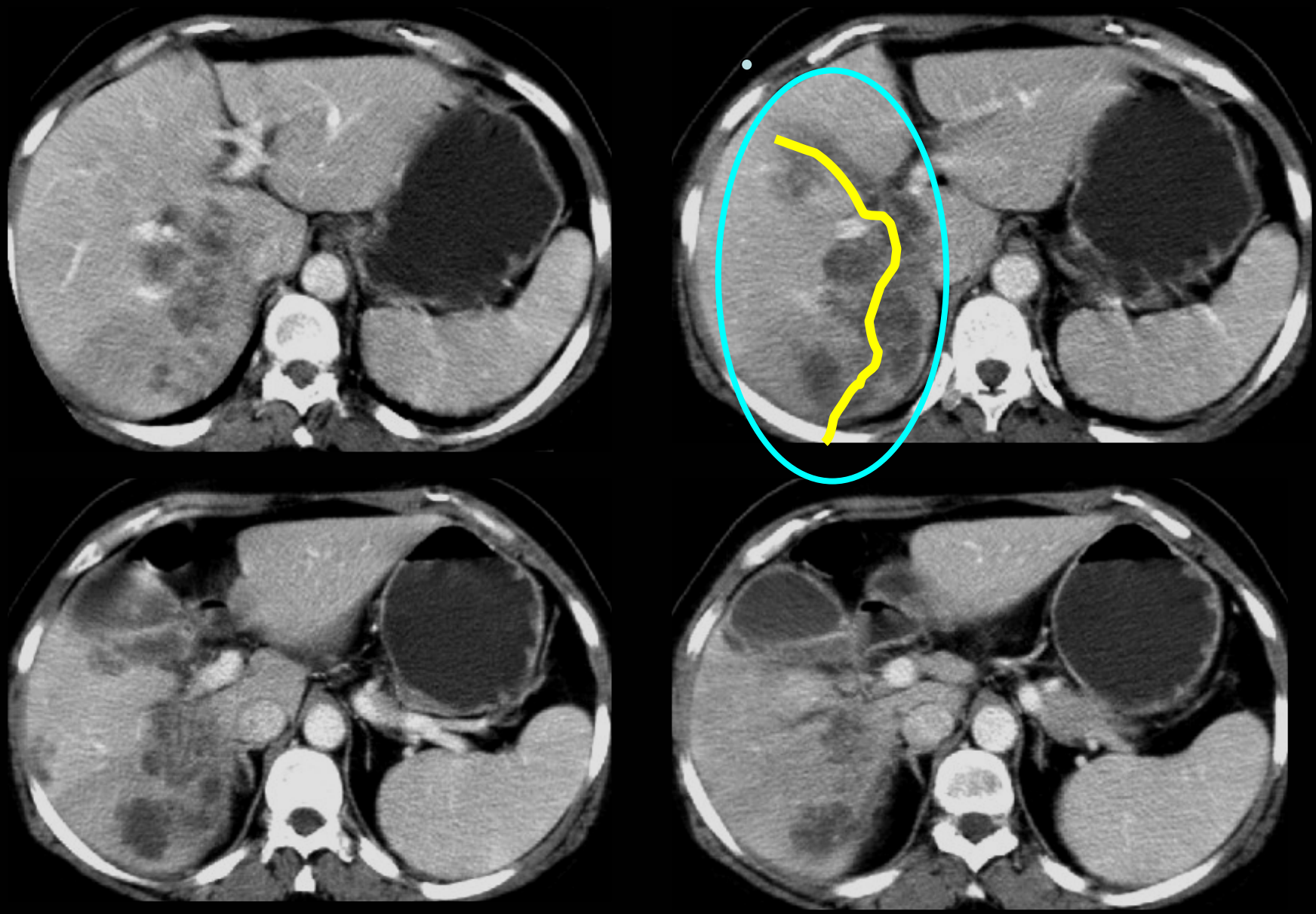






angiocholite par voie ascendante

post sphinctérotomie



diagnostic

distomatose à Fasciola Hepatica ! ! !

MERCI DE VOTRE ATTENTION