Tumeurs malignes des Voies Biliaires

Valérie CROISE-LAURENT

Plan

- **Tumeurs de la vésicule biliaire**
- **CCK IH**
- **CCK hilaires**
  - Diagnostic positif
  - Bilan d'extirpabilité
- **Tumeurs du bas cholédoque**

Points Clés

- Incidence : 2000 nvx cas/an (3% des cancers digestifs)
- Augmentation cste dans les pays occidentaux

- **Classification :**
  - **Tumeurs de la vésicule biliaire**
  - **Cholangiocarcinomes intra-hépatiques**
  - **Cholangiocarcinomes extra-hépatiques**
    - Hilaires :Tumeur de Klatskin (60%)
    - De la voie biliaire principale (25%)

Slattery et al. Oncologist 2006 , 11 : 913-922
Mahli et al. APT, 2006 23 : 1287-1296

Anatomopathologie

Macroscopie

Masse Intraparenchymateuse (« **Mass forming** »)	Infiltration canalaire (« **Periductal infiltrating** »)	Prolifération tumorale endocanalaire (« **Intraductal growth** »)

Aspects en Imagerie

Cholangiocarcinome intrahépatique	**Cholangiocarcinome hilaire**	**Cholangiocarcinome EH**

Microscopie

– ADK glandulaires	– ADK glandulaires	– ADK papillaires

Lim et al. AJR 2003; 181 : 819-827
Khan et al. Lancet 2005, 366 : 1303-14
Sakamoto et al. Ann Surg 1998 , 227 : 405-411

Une dénomination commune mais ....

	Tumeurs de la vésicule	CCK IH	CCK hilaires	CCK de la VBP
FDR	Calculs Long common channel	CSP Hépatopathies Maladies biliaires congénitales	CSP	
Circonstances de découverte	Fortuite Masse segment V	Masse	Ictère	Ictère
Aspects en imagerie	Infiltration diffuse paroi Masse	Masse parenchymateuse	Infiltrante Polypoïde	Infiltrante Polypoïde
Diagnostics différentiels	CCK IH Métastase	LFH	Mirizzi, CSP, cholangite Causes néoplasiques extrinsèques	ADK pancréas...
Preuve du cancer	Possible	Possible	Non (Cytologie sur brossage)	Echoendo.
Stratégie thérapeutique	Cholécystectomie +/- bi ou trisegmentectomie Ou hépatectomie drte élargie au V	Résection segments hép	Résection biliaire et hépatique	DPC

Rôle majeur de l'imagerie

Plan

- **Tumeurs de la vésicule biliaire**
- **CCK IH**
- **CCK hilaires**
  - Diagnostic positif
  - Bilan d'extirpabilité
- **Tumeurs du bas cholédoque**

I.Tumeurs de la vésicule biliaire

- **Masse intrahépatique centrée sur la vésicule**
  - Masse contours irréguliers
  - ***Diagn.différentiels*** :
    - CCK IH
- **Sténose hilaire avec masse, épicentre collet vésiculaire**
  - Masse hilaire et dilatation VBIH +++++++
  - ***Diagn.différentiels*** :
    - CCK hilaire, obstacles hilaires
- **Infiltration diffuse ou localisée de la paroi vésiculaire**
  - Epaississement irrégulier diffus ou focal
  - ***Diagn. Différentiels :***
    - Cholécystite chronique
    - Cholécystite xantho granulomateuse

Uchiyama et al. J Hepatobiliary Pancreas Surg 2009
Yun EJ et al. Abdom Imaging 2004
Kim et al. AJR 2008
Lane et al. Radiographics 1989
Jung et al. Eur Radiol 2005
Choi et al. Abdom Imaging 2004

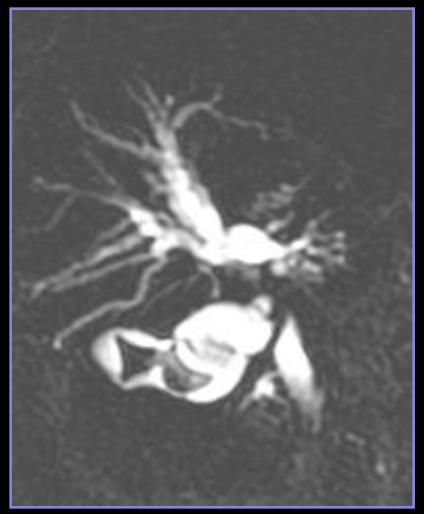
Facteurs de risque

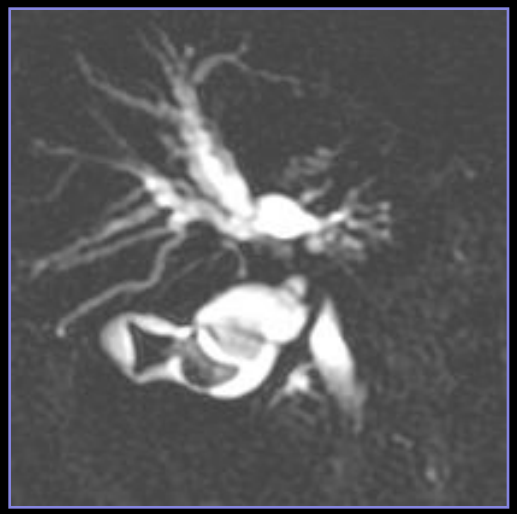
-Calculs

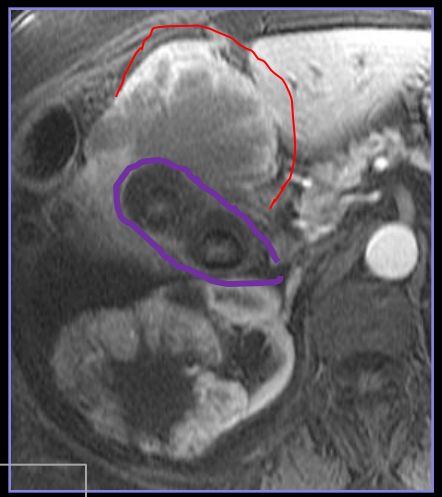
-Long common channel

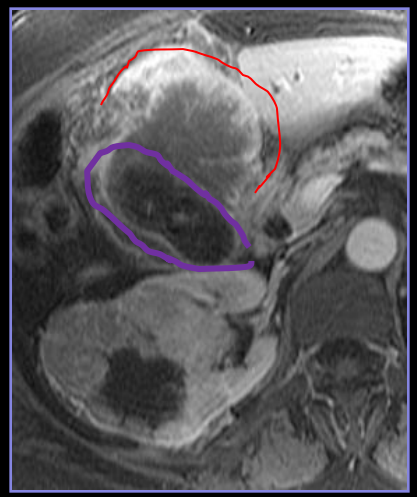
I.Tumeurs de la vésicule biliaire

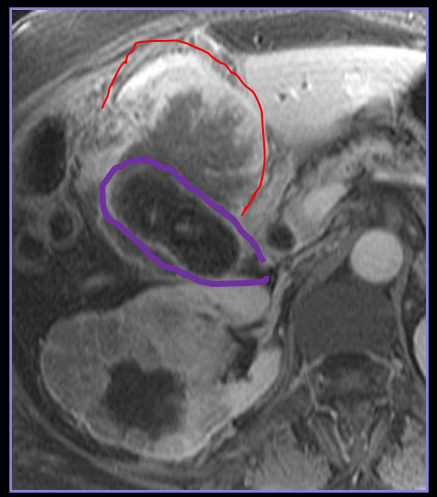
1.Masse hépatique centrée sur la vésicule







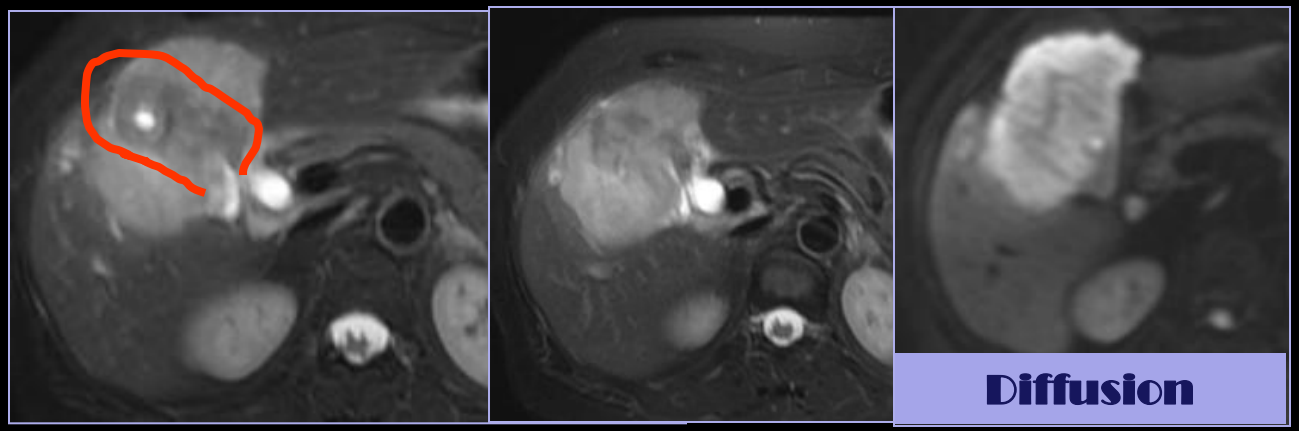




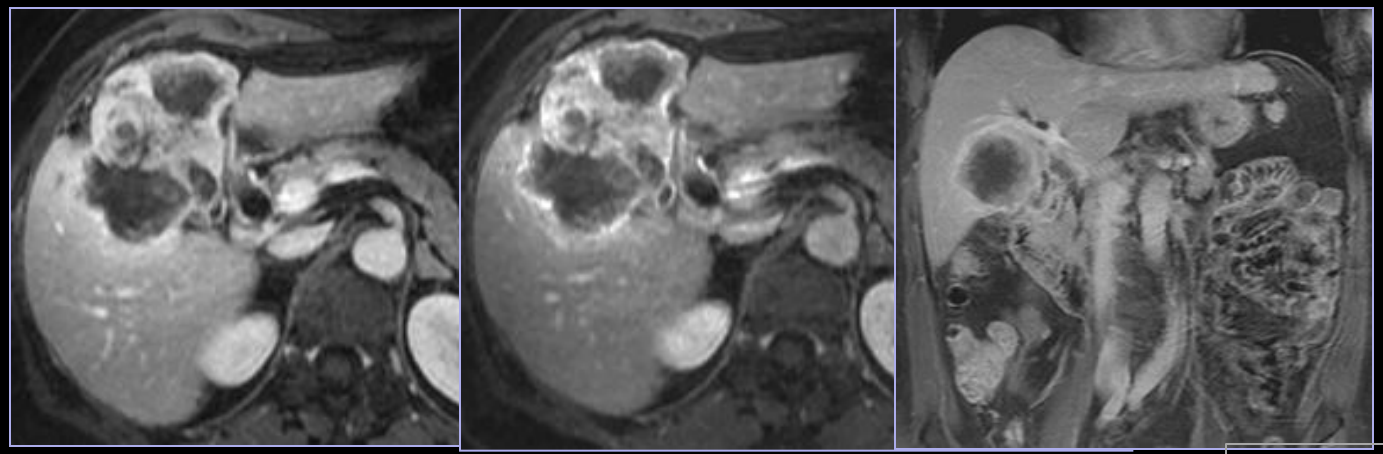
Choi et al. Abdom Imaging 2004

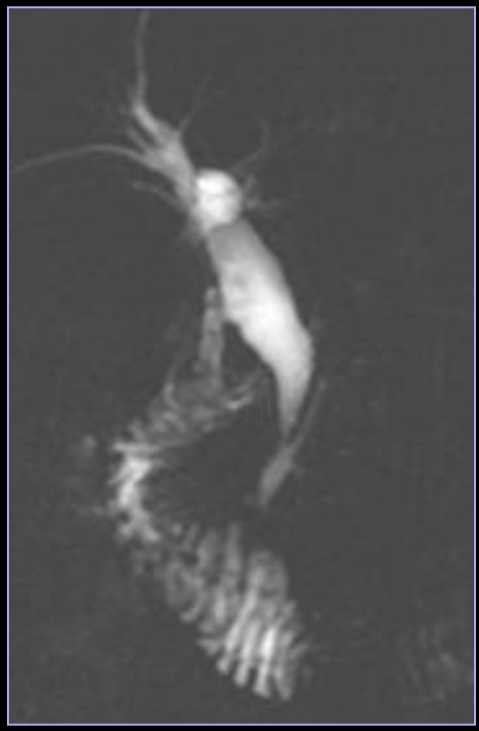
I.Tumeurs de la vésicule biliaire

1.Masse hépatique centrée sur la vésicule



Diffusion



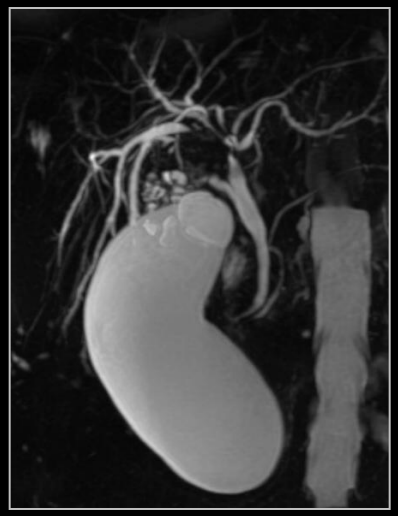


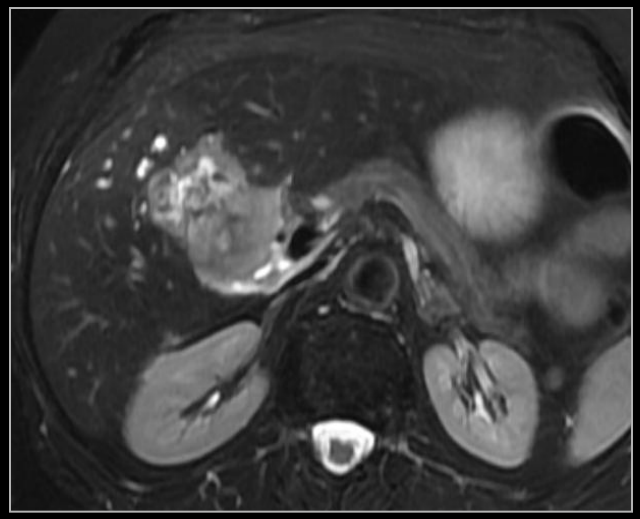
Long common channel

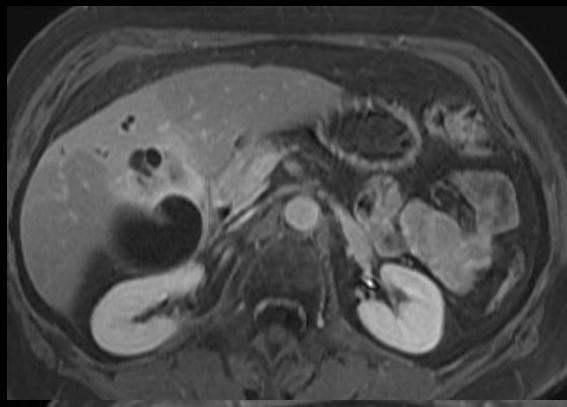
Wistuba et al. Nat Rev Cancer 2004; 4 : 695-706
Randi et al. Int J Cancer 2006, 118: 1591-602
Kamisawa et al. Hepatogastroenteroly 2006

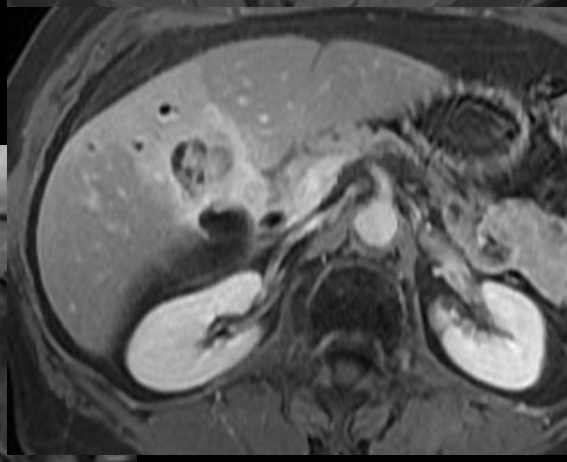
I.Tumeurs de la vésicule biliaire

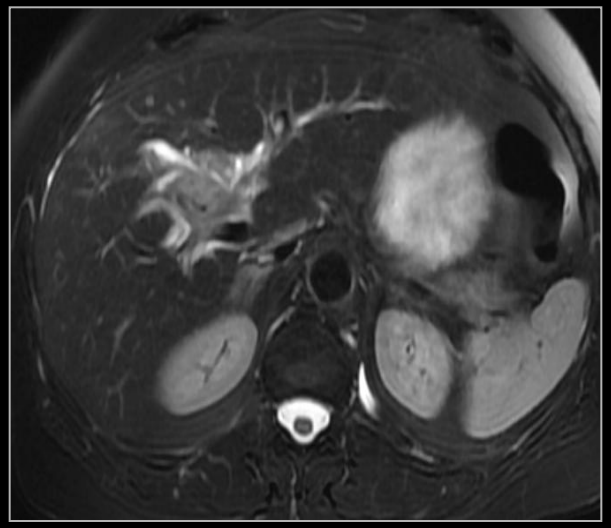
2.Sténose hilaire et masse

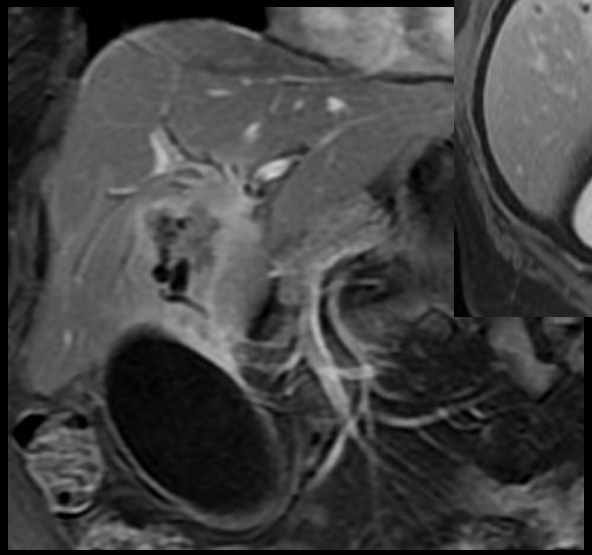










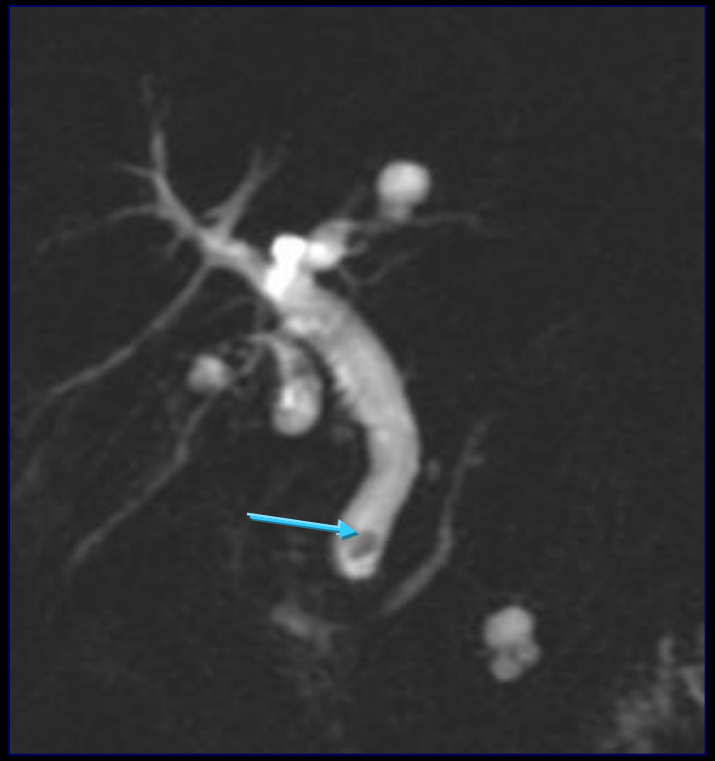


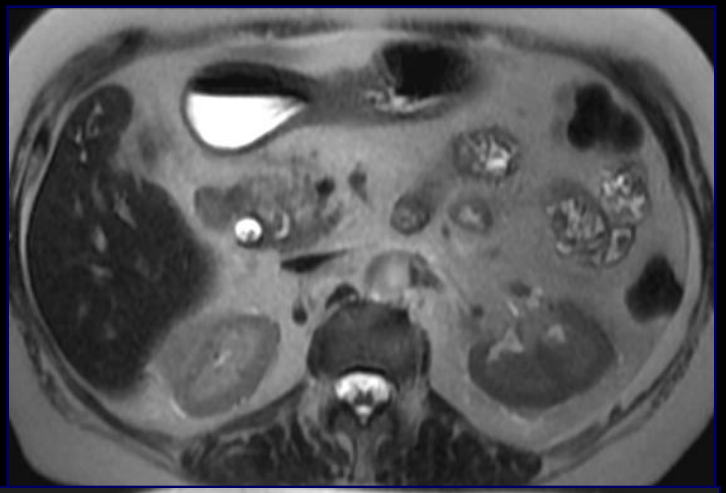
I.Tumeurs de la vésicule biliaire

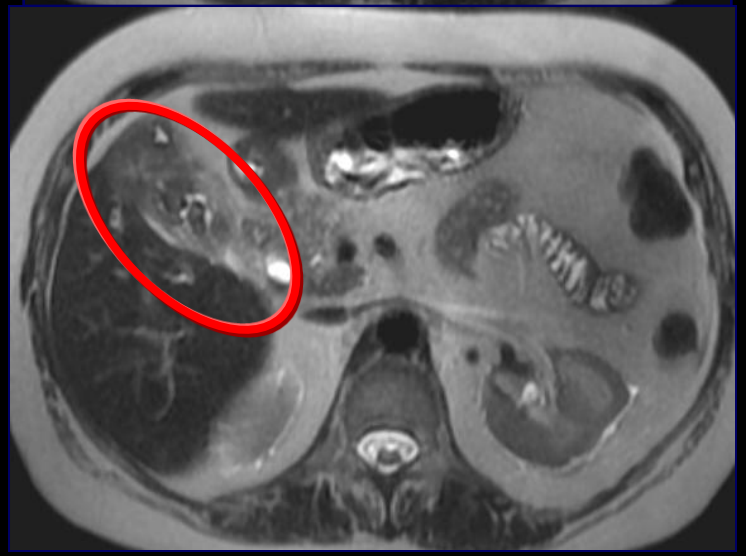
3.Epaississement irrégulier diffus parois vésiculaires

Femme, 82 ans

Ictère, Cholestase biologique







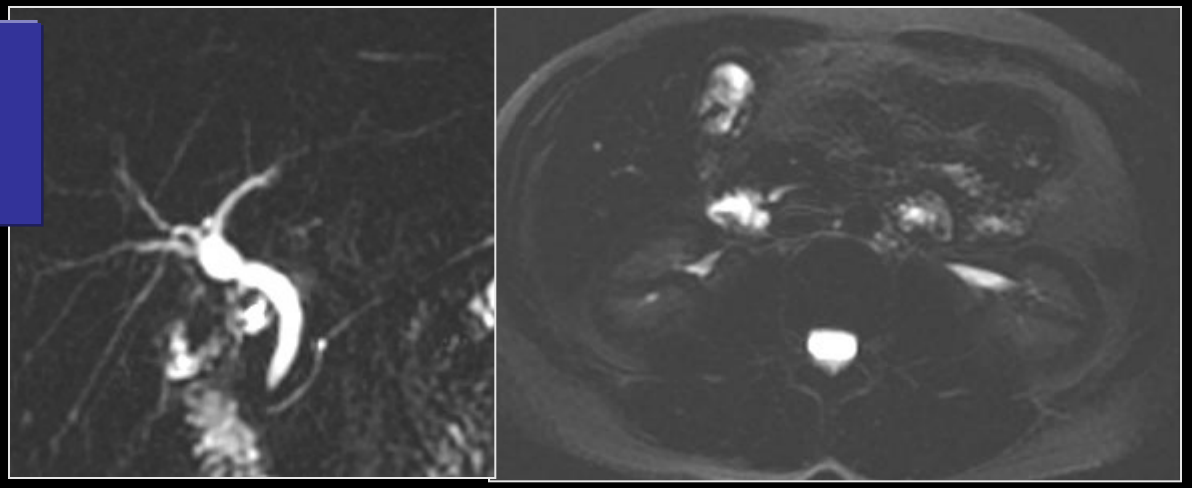
I.Tumeurs de la vésicule biliaire

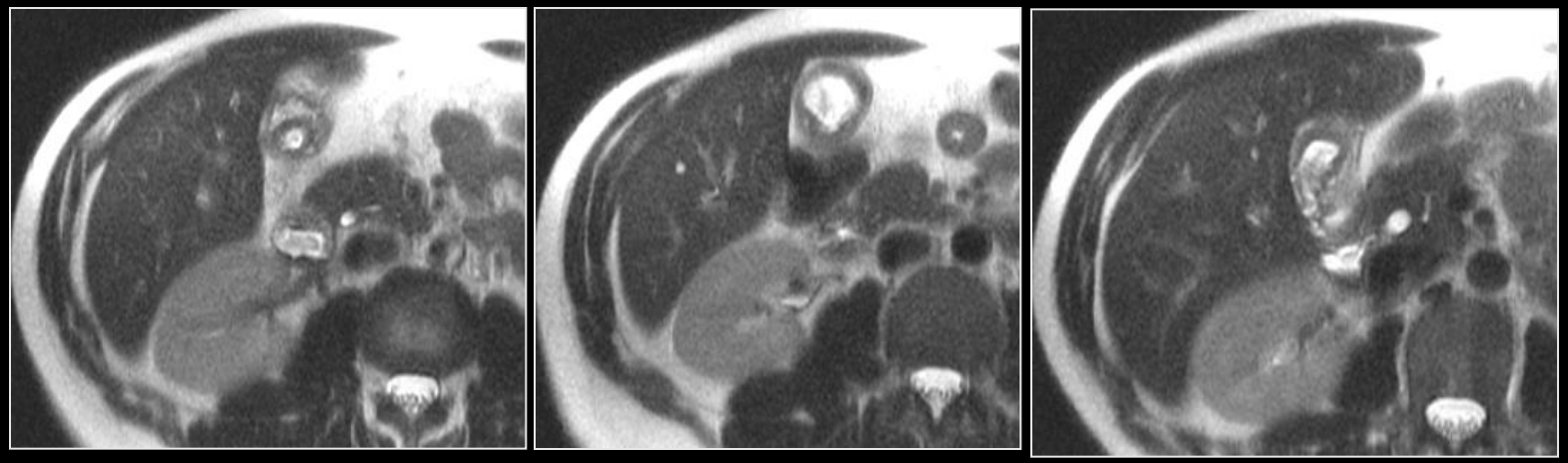
3.Epaississement irrégulier diffus parois vésiculaires

Homme, 38 ans

Douleurs de l'hypochondre droit

Recherche de calculs VBP



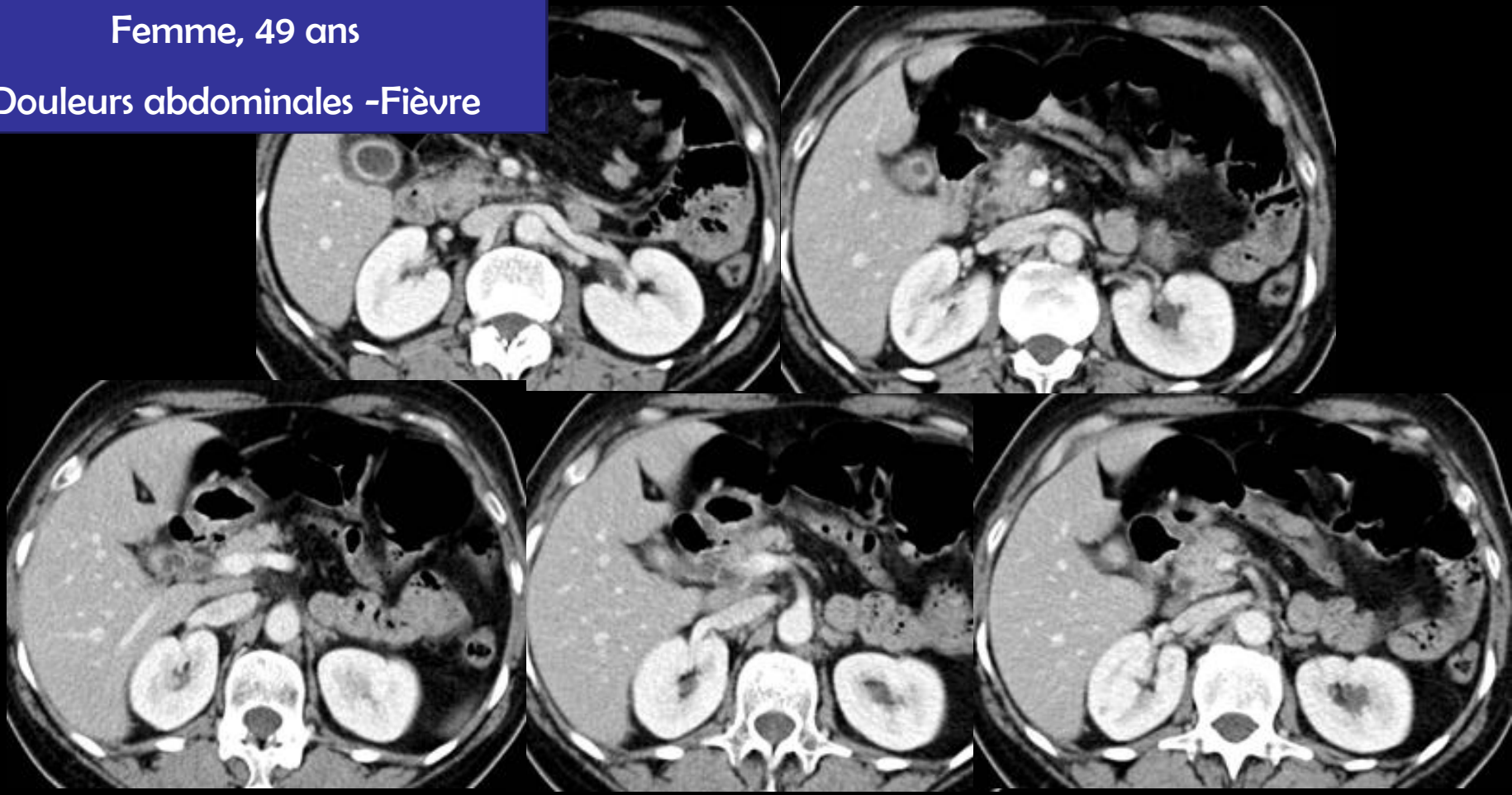


I.Tumeurs de la vésicule biliaire

3.Epaississement irrégulier focal parois vésiculaires

Femme, 49 ans

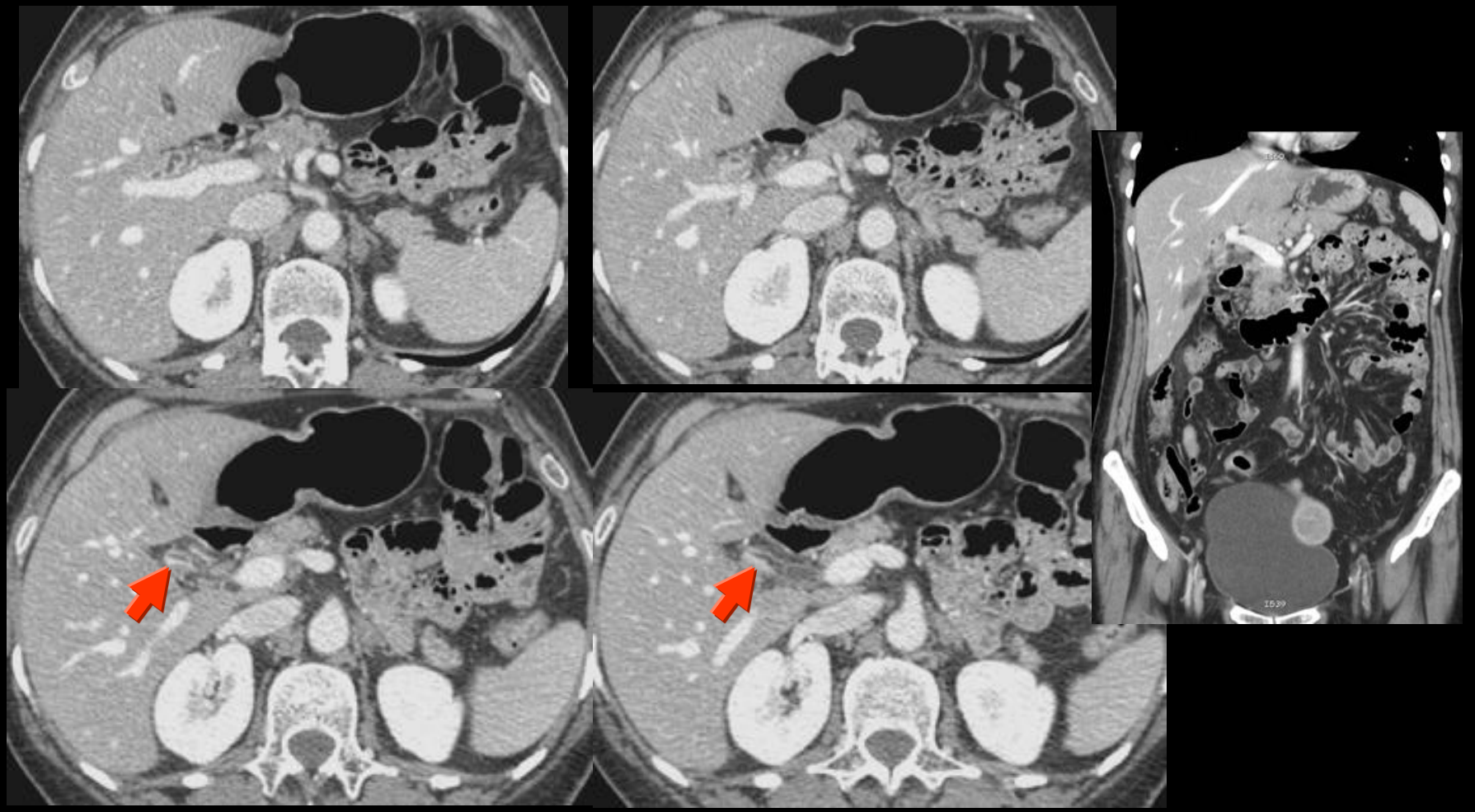
Douleurs abdominales -Fièvre



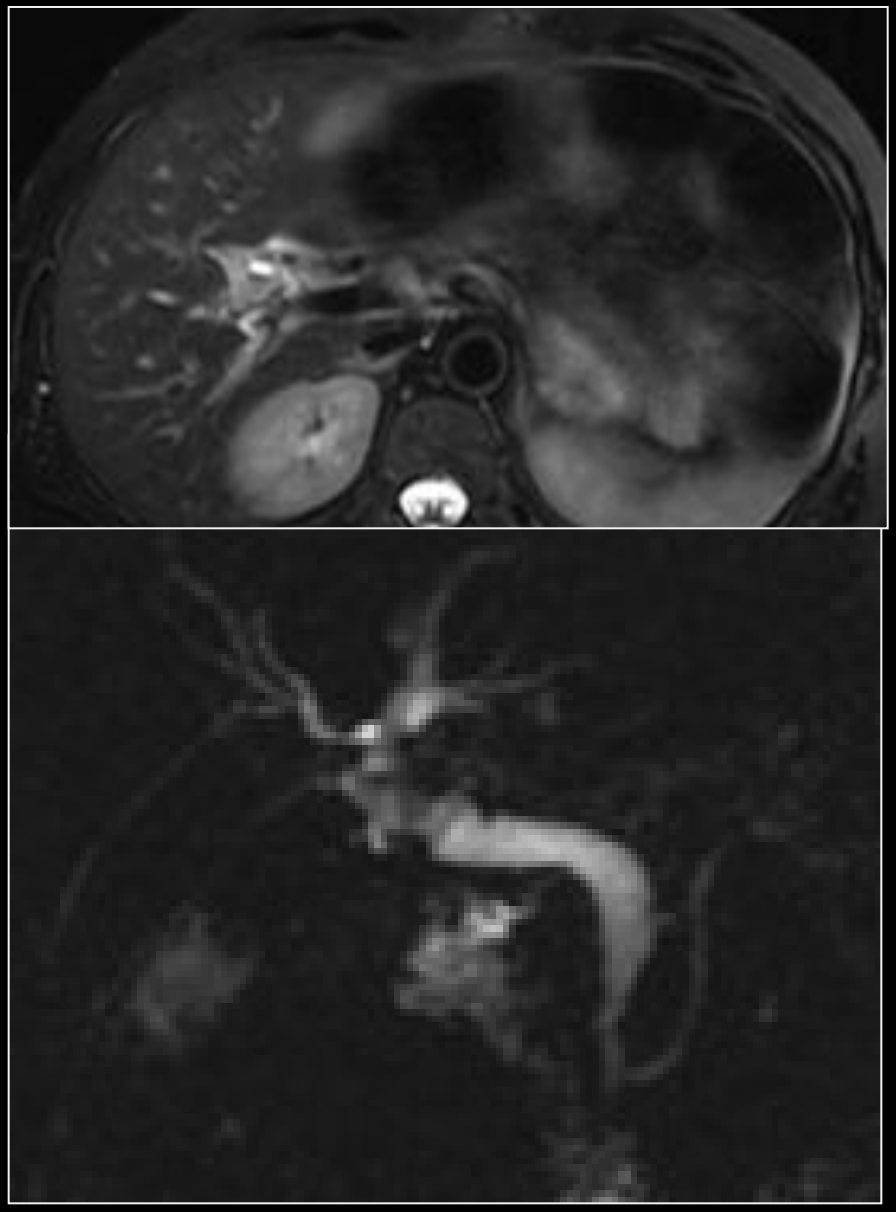
I.Tumeurs de la vésicule biliaire

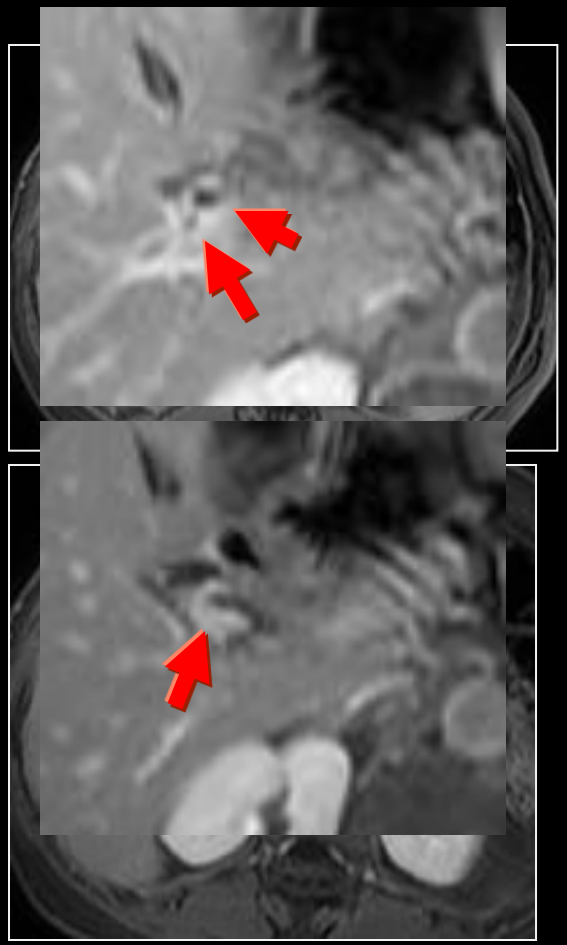
Femme, 49 ans

Cholécystectomie-Anapath: adénocarcinome sur les zones de recoupe chirurgicale



Tumeurs de la vésicule biliaire





Plan

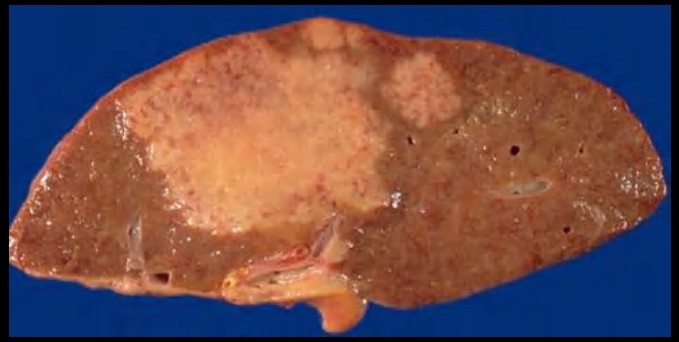
- **Tumeurs de la vésicule biliaire**
- **CCK IH**
- **CCK hilaires**
  - Diagnostic positif
  - Bilan d'extirpabilité
- **Tumeurs du bas cholédoque**

II.Cholangiocarcinomes intrahépatiques

- **Masse parenchymateuse intrahépatique (MF)**
  - Masse contours réguliers
  - ***Diagn.différentiels*** :
    - Lésion focale hépatique

Fibrose

Temps tardifs



Facteurs de risque

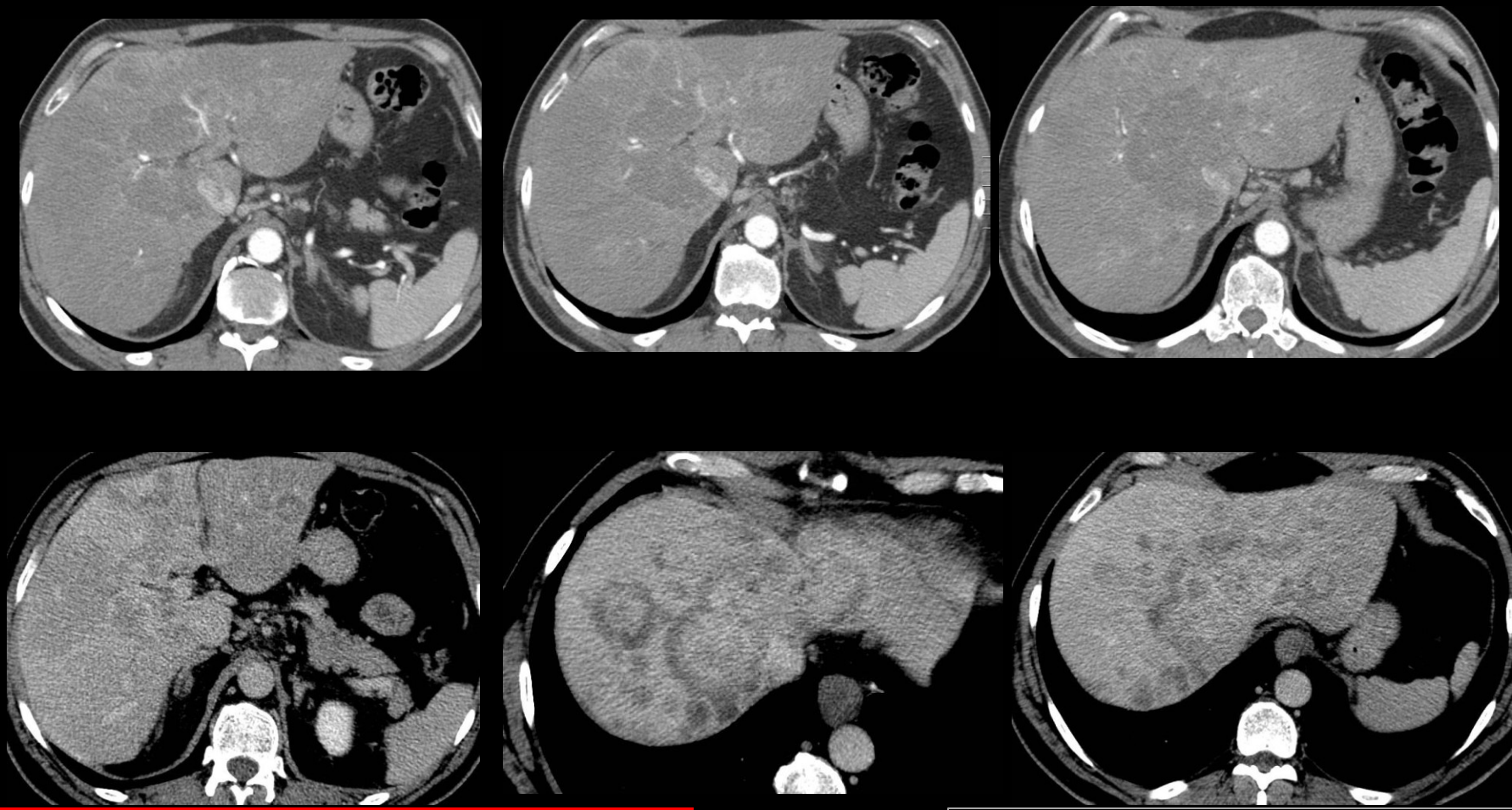
-Cholangite sclérosante primitive

-Hépatites virales

-Maladies biliaires congénitales

- **Dilatation segmentaire des VBIH en amont obstacle**
  - ***Diagn.différentiels*** :
    - Calculs
    - Métastase endobiliaire
    - CHC endobiliaire
    - CSP

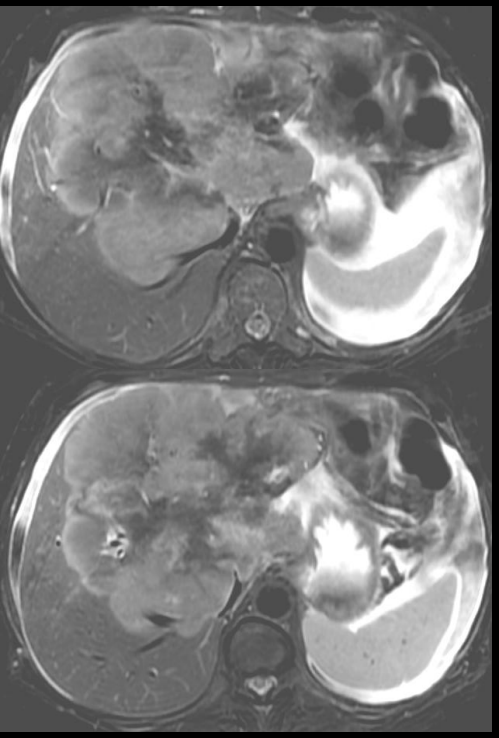
II.Cholangiocarcinomes intrahépatiques



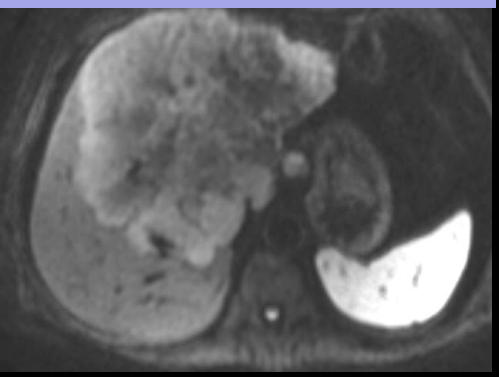
Temps tardifs

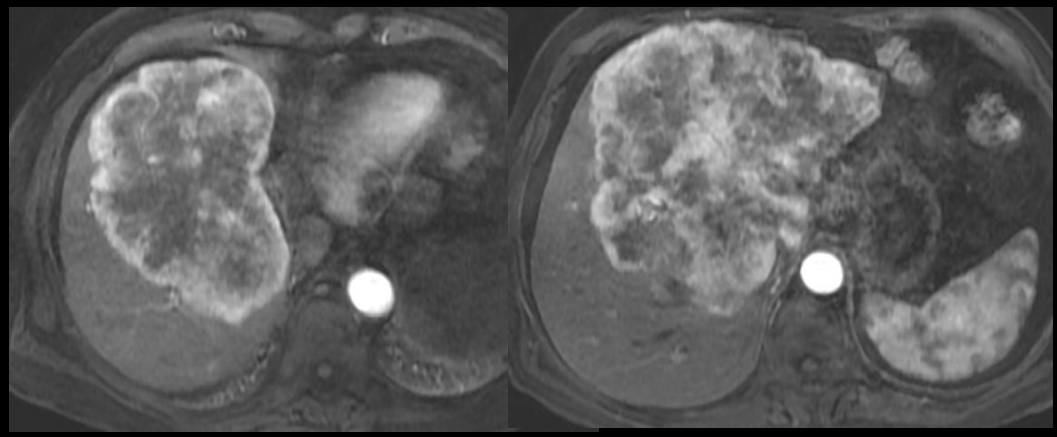
Maetani et al. AJR 2001
Manfredi et al. Semin Liver Dis 2004
Rimola et al. Hepatology 2009

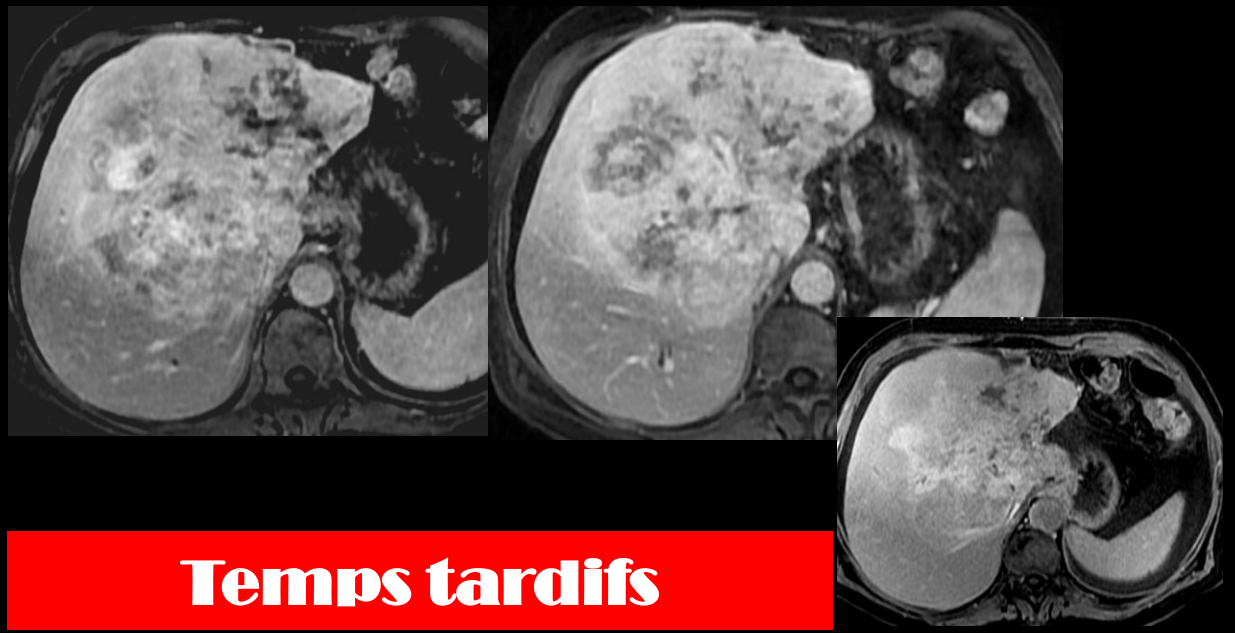
II.Cholangiocarcinomes intrahépatiques



Diffusion

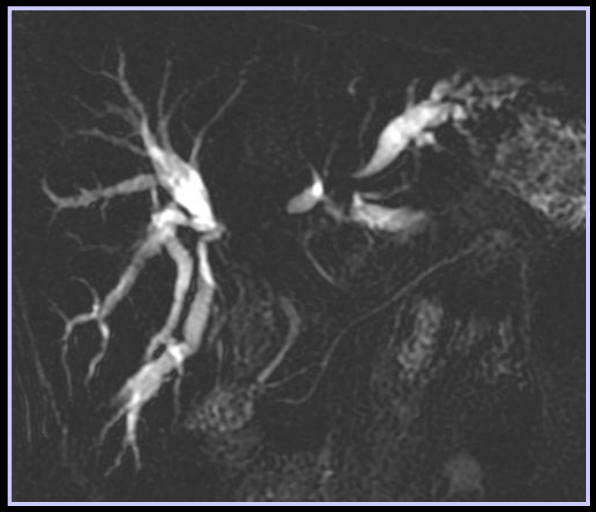
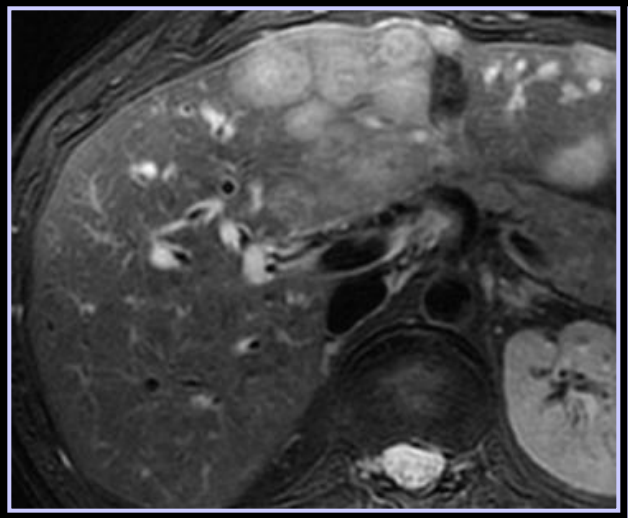
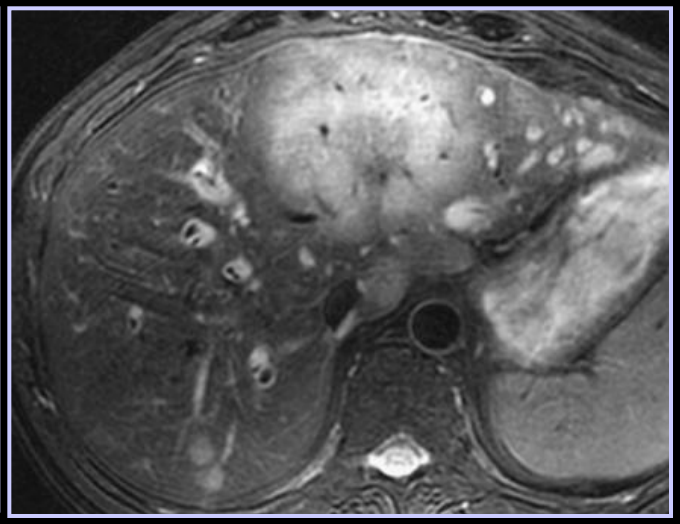
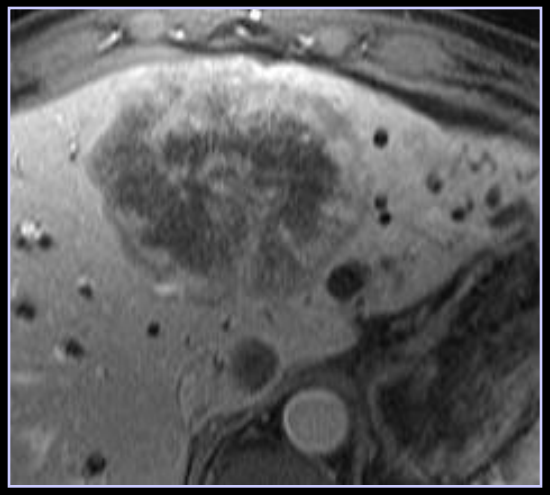
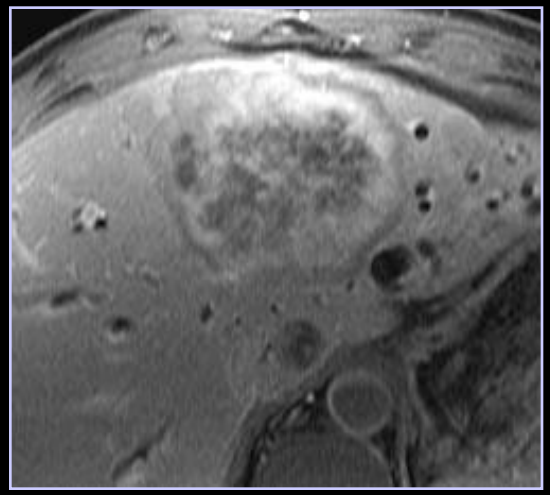
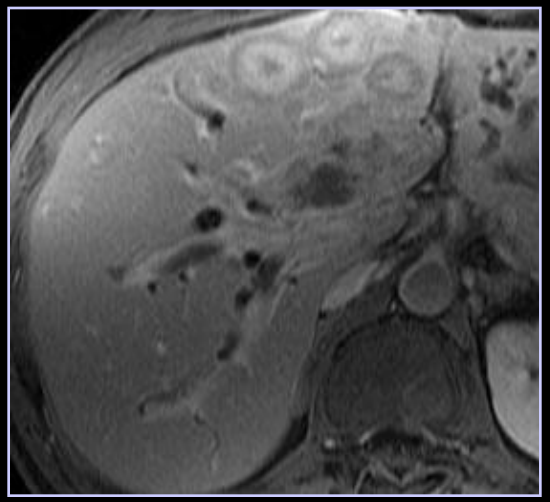






Temps tardifs

II.Cholangiocarcinomes intrahépatiques

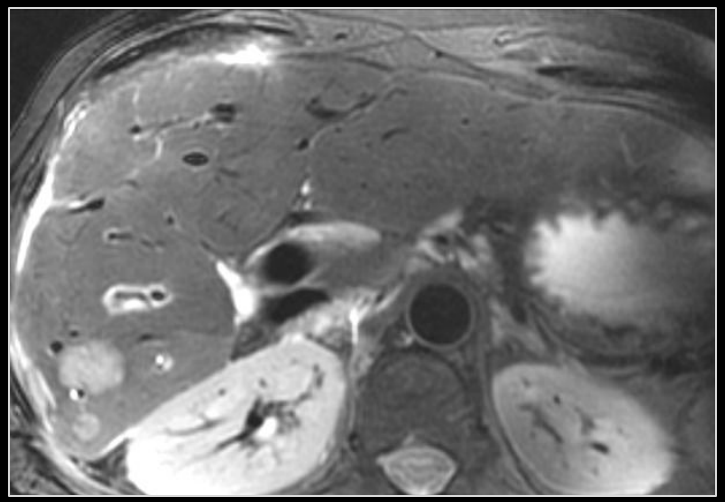







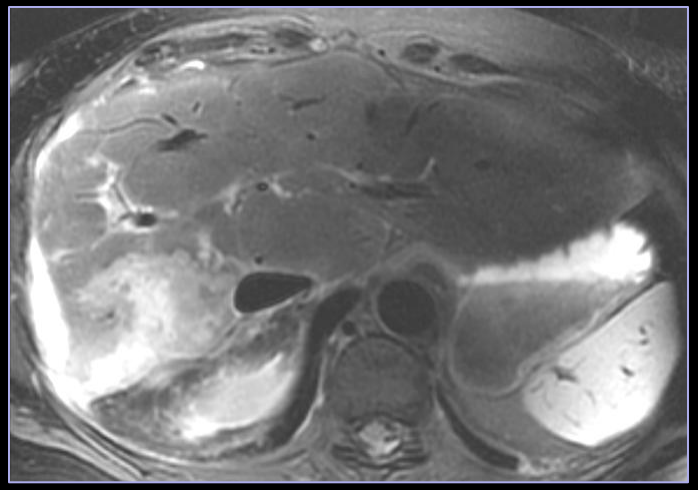
II.Cholangiocarcinomes intrahépatiques

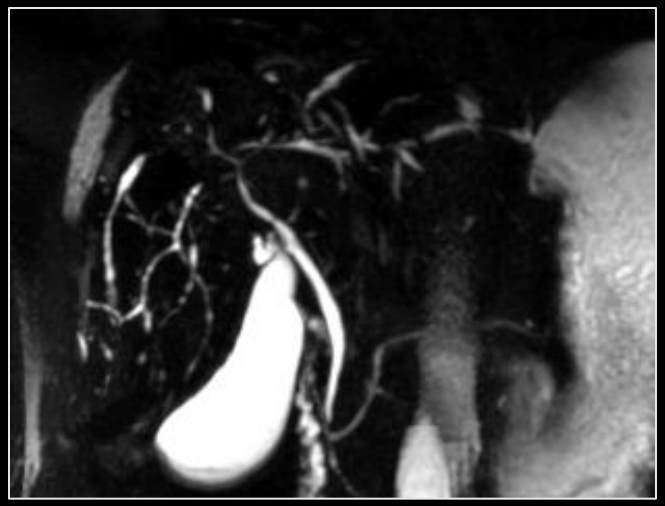
Femme, 52 ans

Perturbations mineures du bilan biologique hépatique depuis 10 ans

Découverte lésions focales hépatiques du foie droit





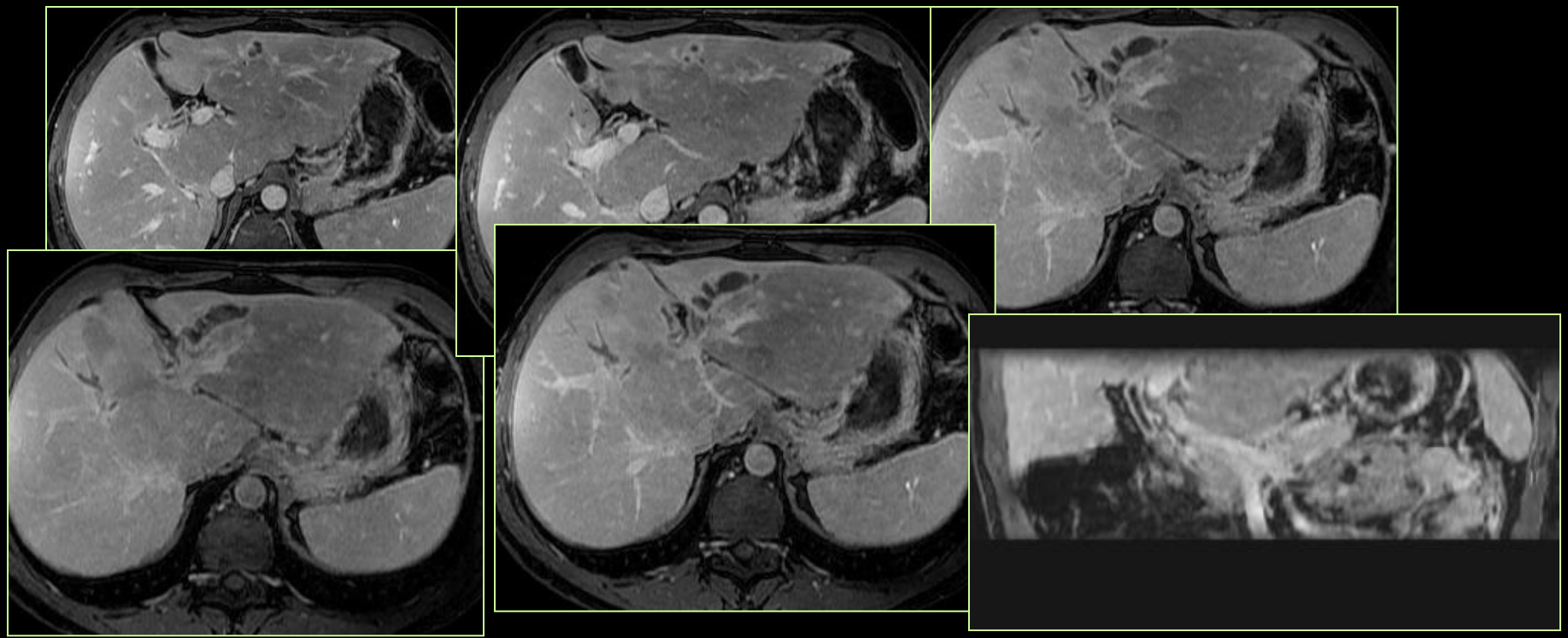


Facteur de risque

-Cholangite sclérosante primitive

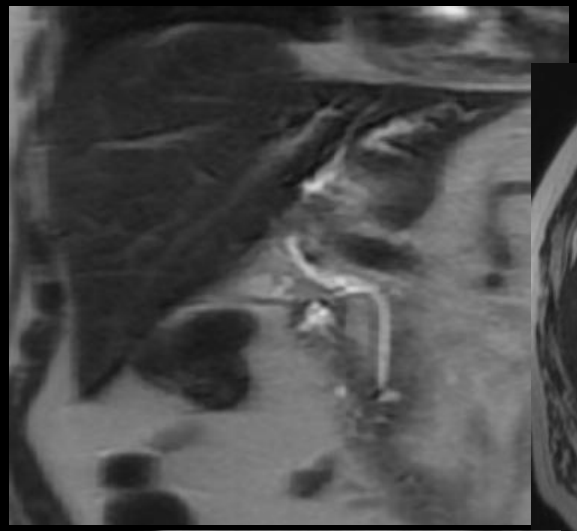
Dilatation segmentaire des VBIH

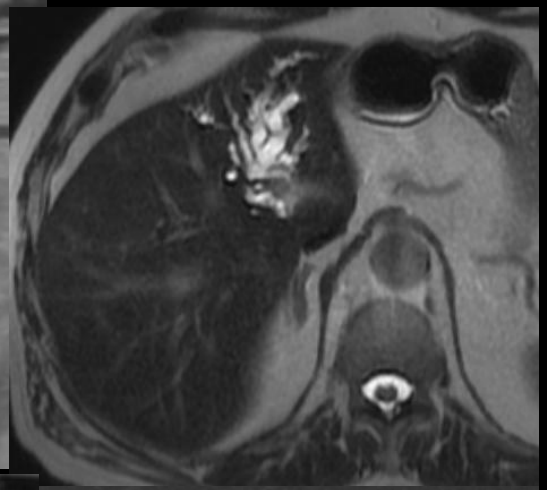
- ***Diagn.différentiels*** :
  - Calculs
  - CHC à développement endobiliaire
  - Métastases à développement endobiliaire (cancers colo rectaux, sein)

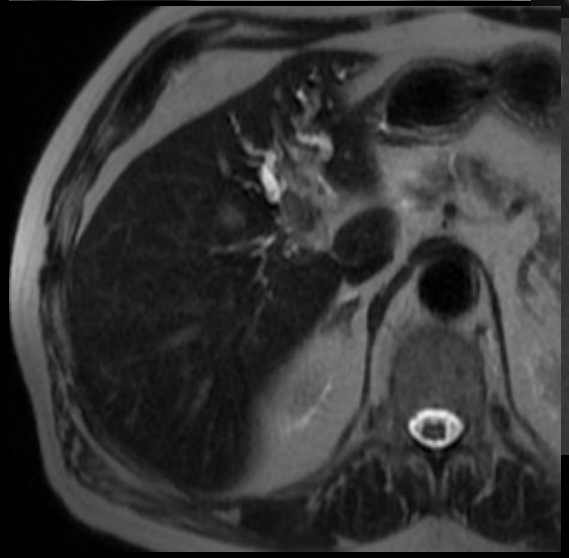


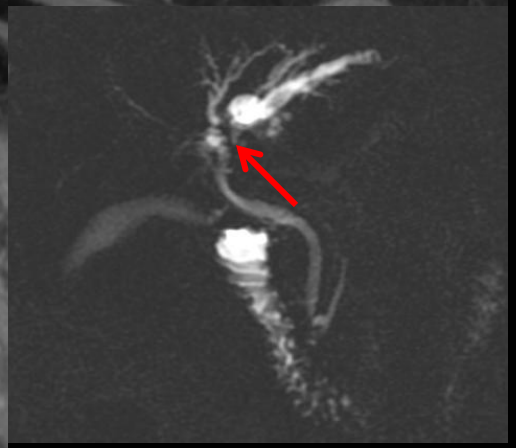
II.Cholangiocarcinomes intra hépatiques

Dilatation segmentaire des VBIH

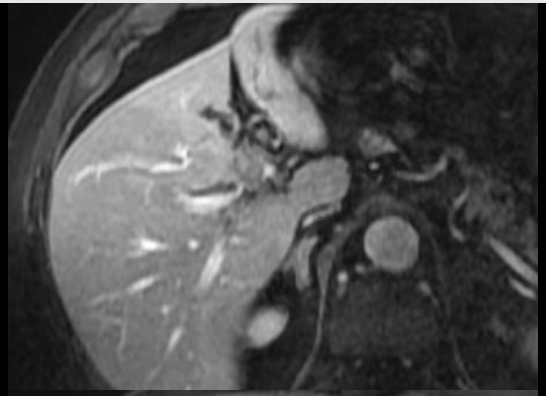


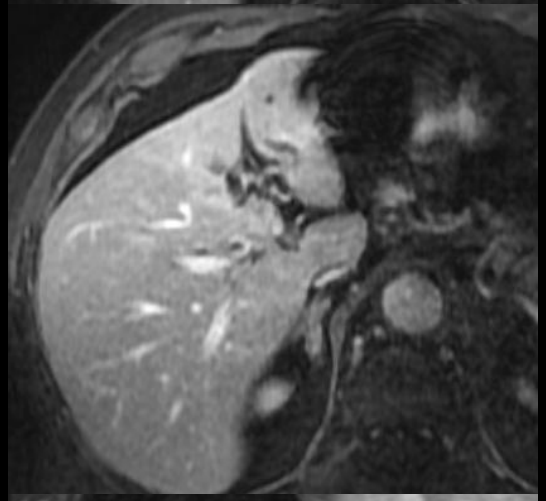


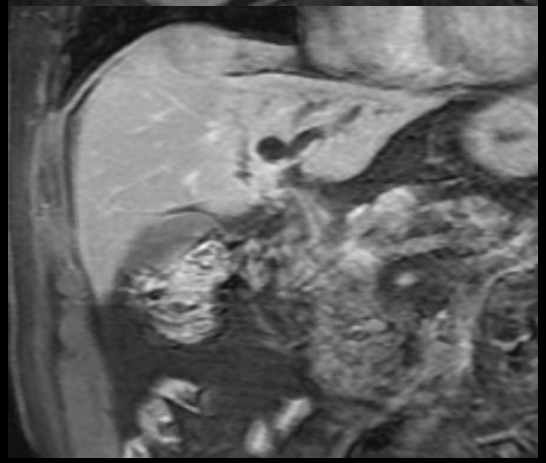




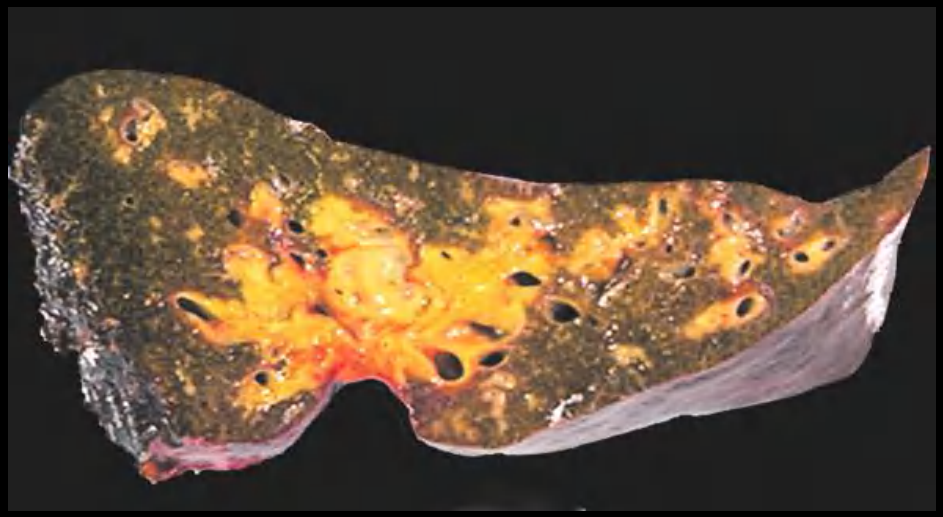
Couple échographie IRM

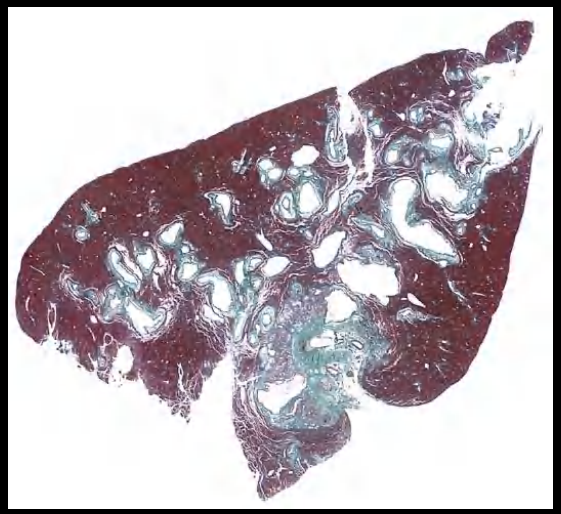






III.Cholangiocarcinomes hilaires





Infiltration pariétale

Prolifération endocanalaire

Diagn.différentiels :

Obstacles de la convergence

Particularités :

-Extension longitudinale

-Extension circonférentielle

Facteurs de risque

-Cholangite sclérosante primitive

Plan

- Tumeurs de la vésicule biliaire
- CCK IH
- **CCK hilaires**
  - Diagnostic positif
  - Bilan d'extirpabilité
- Tumeurs du bas cholédoque

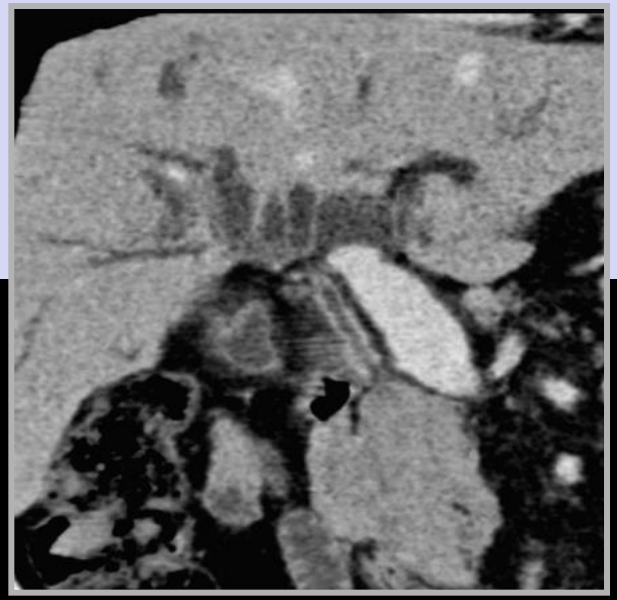
III.Cholangiocarcinomes hilaires

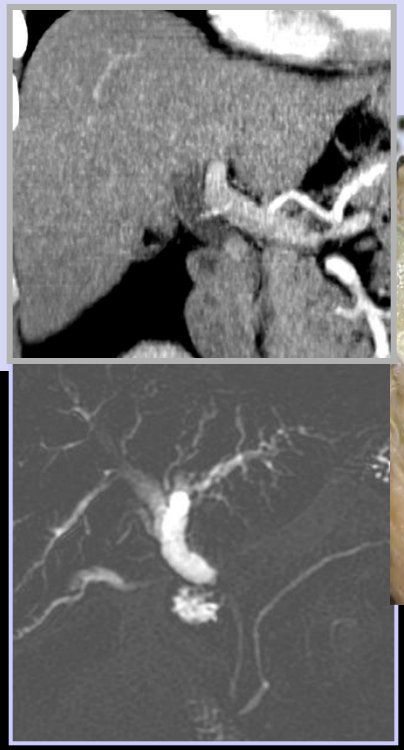
Macroscopie

Infiltration canalaire
(« **Periductal infiltrating** »)

Prolifération tumorale endocanalaire
(« **Intraductal growth** »)

Aspects en Imagerie





Lim et al. AJR 2003; 181 : 819-827
Khan et al. Lancet 2005, 366 : 1303-14
Sakamoto et al. Ann Surg 1998 , 227 : 405-411

III.Cholangiocarcinomes hilaires

Obstacles Hilaires :

Est-ce que c'est un cancer ???

Obstacles Hilaires :

Existe il une possibilité curative ???

Dans quelles conditions ???

III.Cholangiocarcinomes hilaires

Place de l'imagerie : Rôle majeur ++++

- Diagnostic positif:
  - Niveau lésionnel
  - Différentiel malin/bénin
- Evaluation de l'extirpabilité :
  - Biliaire
  - Vasculaire : artériel et veineux
  - Loco-régional parenchymateuse hépatique, organes de voisinage et à distance
- Place de la radiologie interventionnelle
  - Si chirurgie à visée curative : préparation à l'intervention
    - Volumétrie hépatique, évaluation du foie restant après intervention
    - Drainage biliaire
    - Embolisation portale
  - Si traitement palliatif
    - Drainage interne, externe
    - Type de stents,nbre de stents etc...

Obstacle biliaire mécanique : échographie

Explorations radiologiques non invasives

Scanner abdomino-pelvien

IRM : cholangio et séquences injectées

Nature de l'obstacle +++

Bilan d'extirpabilité

Avis chirurgical ++++

- Kim MJ et al. **Radiology 2000, 214: 173-181.**

Explorations radiologiques non invasives

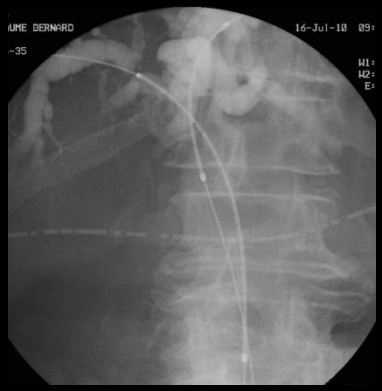
Scanner abdomino-pelvien

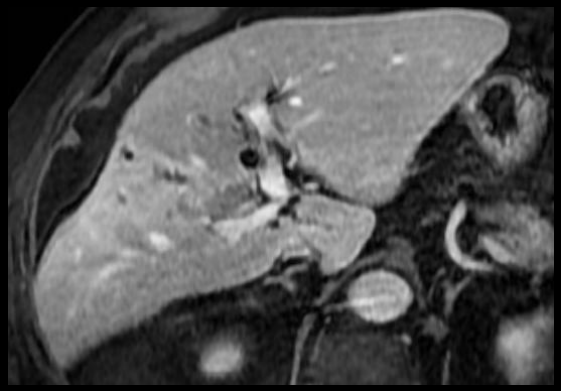
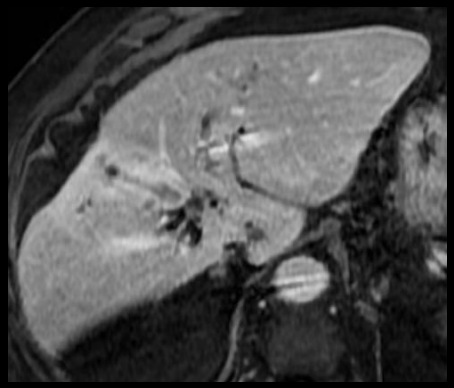
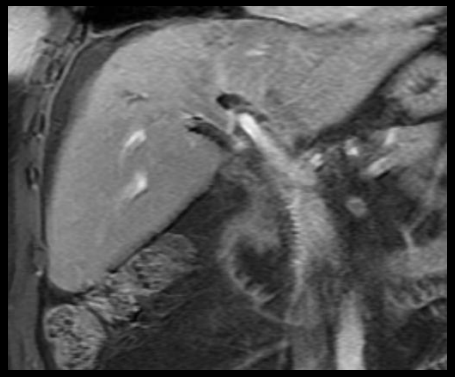
IRM : cholangio et séquences injectées

Si opacifications et prothèse mise en place avant tte exploration radiologique non invasive

- Pas d'analyse des voies biliaires sus jacentes à la sténose
- Pas de bilan d'extirpabilité adéquat pour juger de la résécabilité ou non, et donc du choix de la prothèse ....

- Csq en imagerie
  - Aspect inflammatoire marqué de l'ensemble de la VBP
  - Aérobilie
  - Pas d'analyse possible de la sémiologie de la sténose



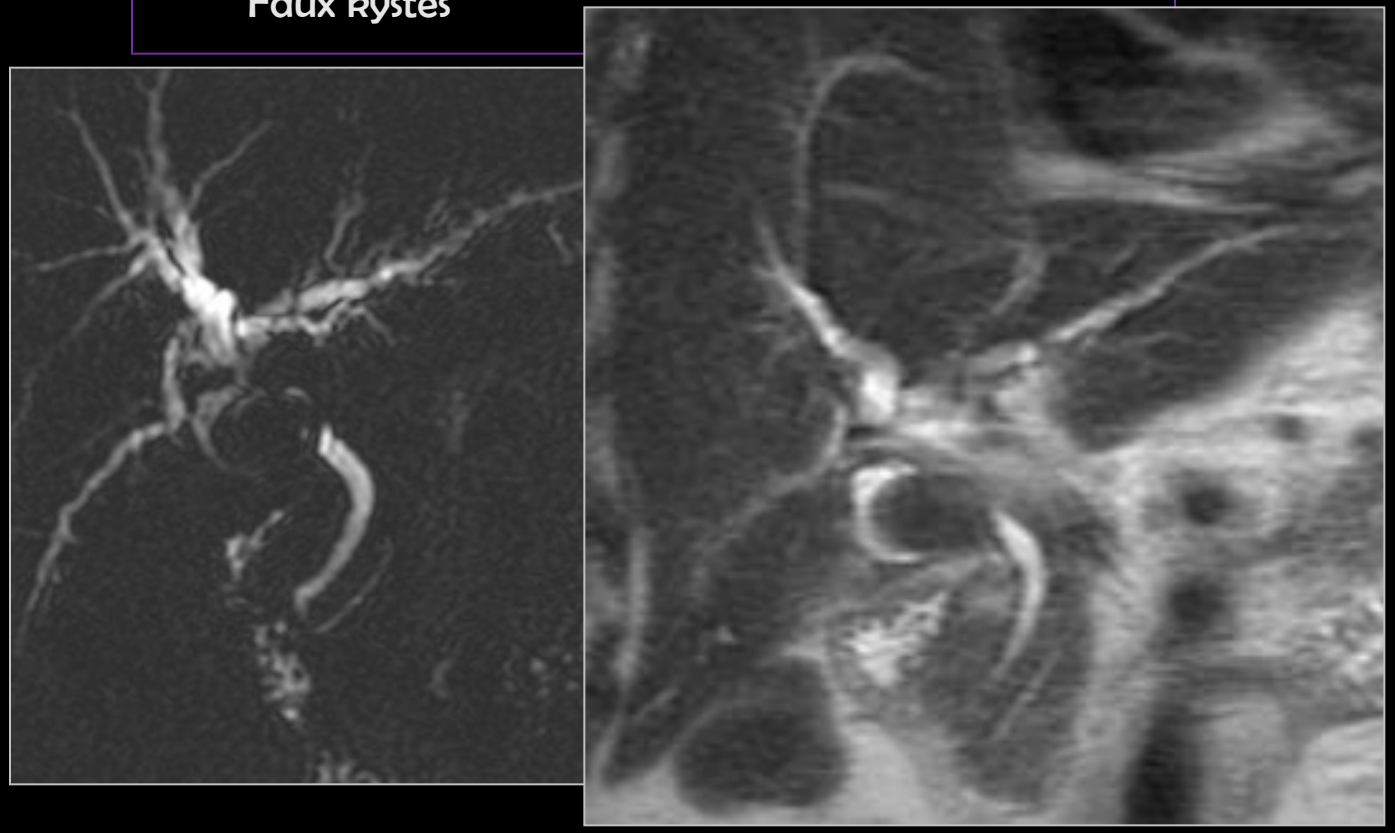
Obstacles Hilaires :

Est-ce un cancer ???

Obstacle hilaire : est ce un cancer ?

Etiologies bénignes

- Syndrome de Mirizzi
- Calculs de la convergence
- Cavernome pseudo tumoral
- Faux kystes

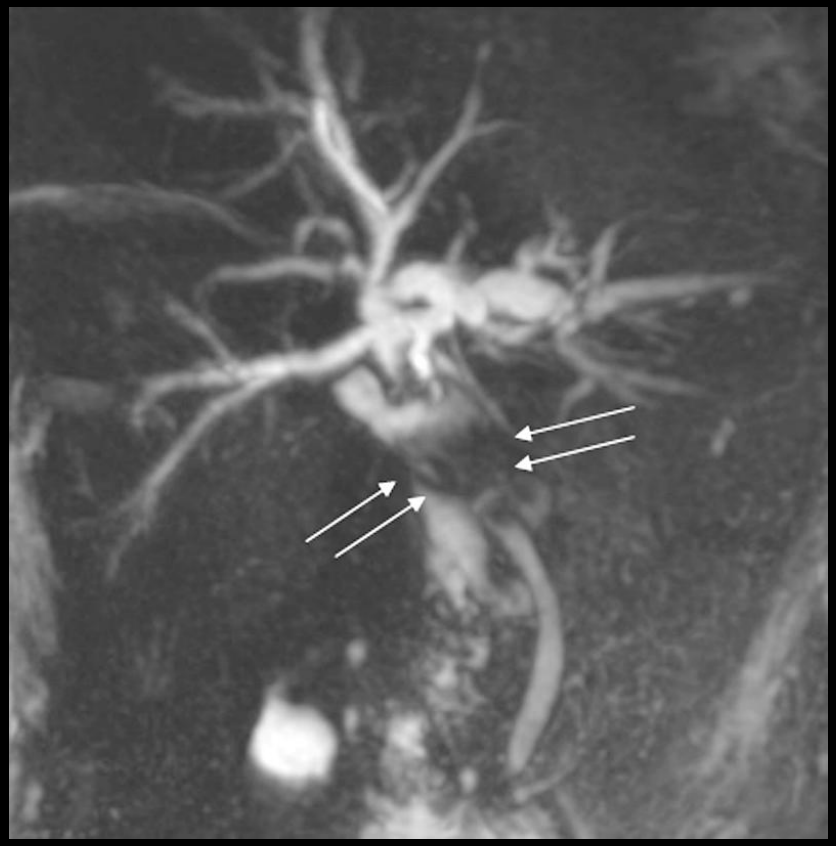


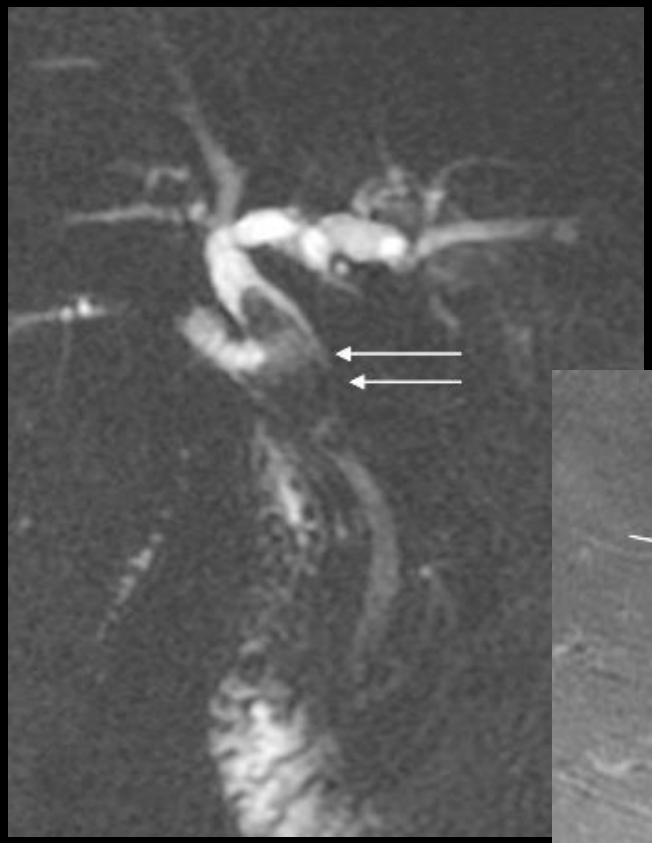
Syndrome de Mirizzi

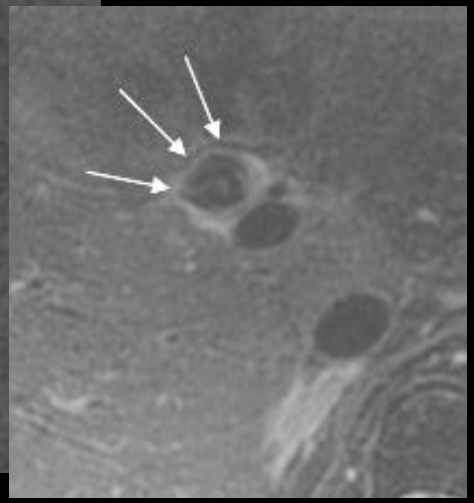
Obstacle hilaire : est ce un cancer ?

Etiologies bénignes

- Syndrome de Mirizzi
- Calculs de la convergence
- Cavernome pseudo tumoral
- Faux kystes



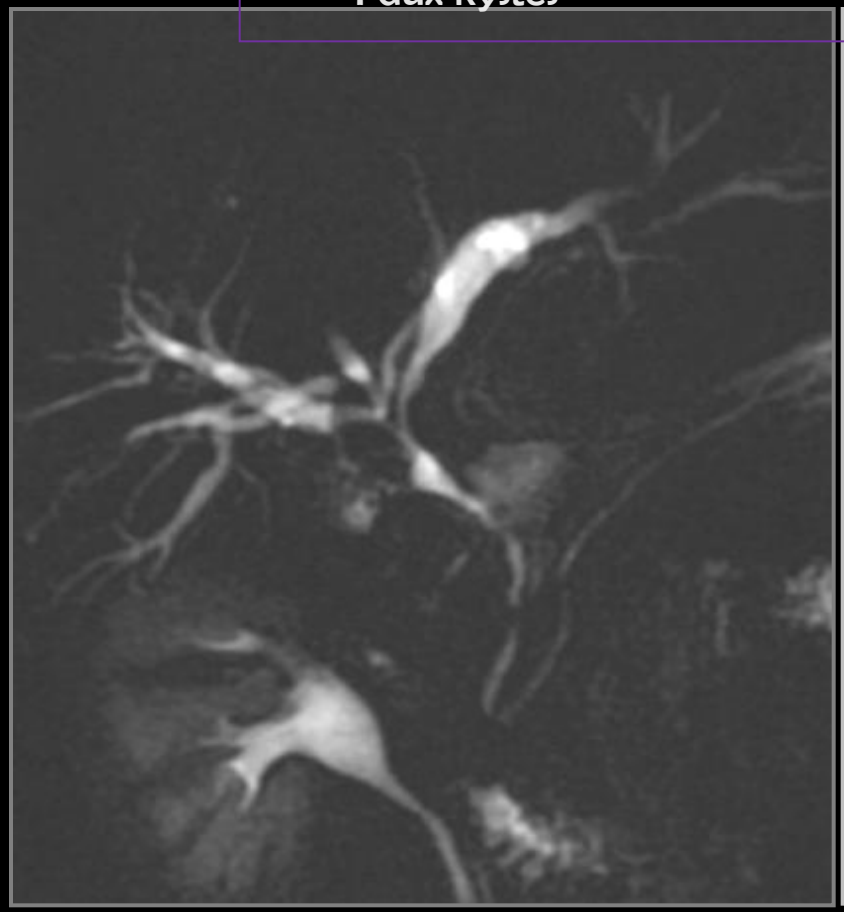


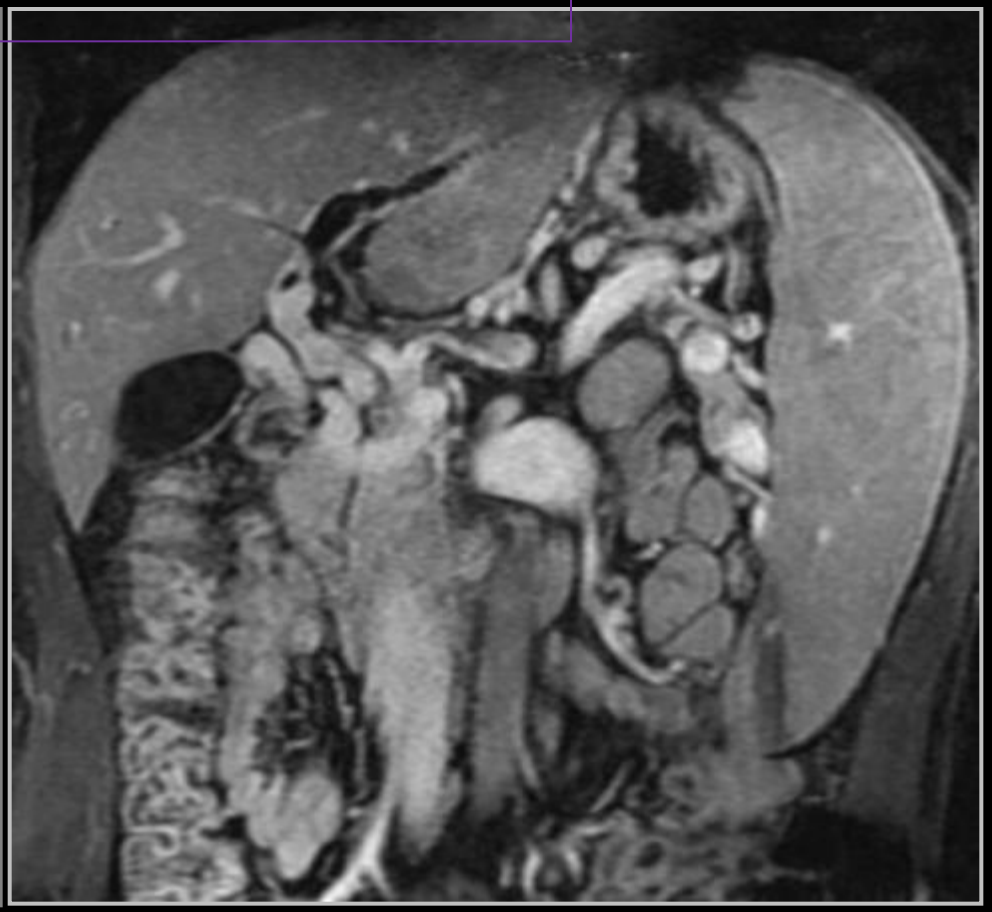


Obstacle hilaire : est ce un cancer ?

Etiologies bénignes

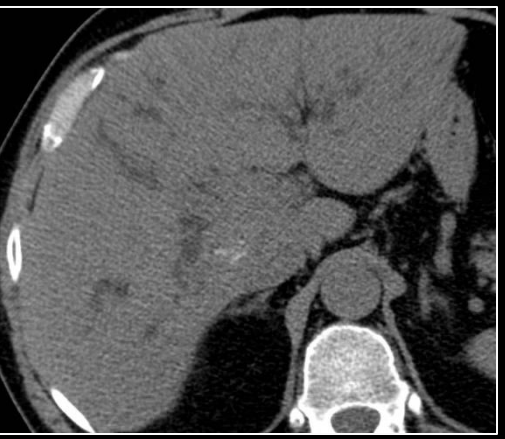
- Syndrome de Mirizzi
- Calculs de la convergence
- Cavernome pseudo tumoral
- Faux kystes

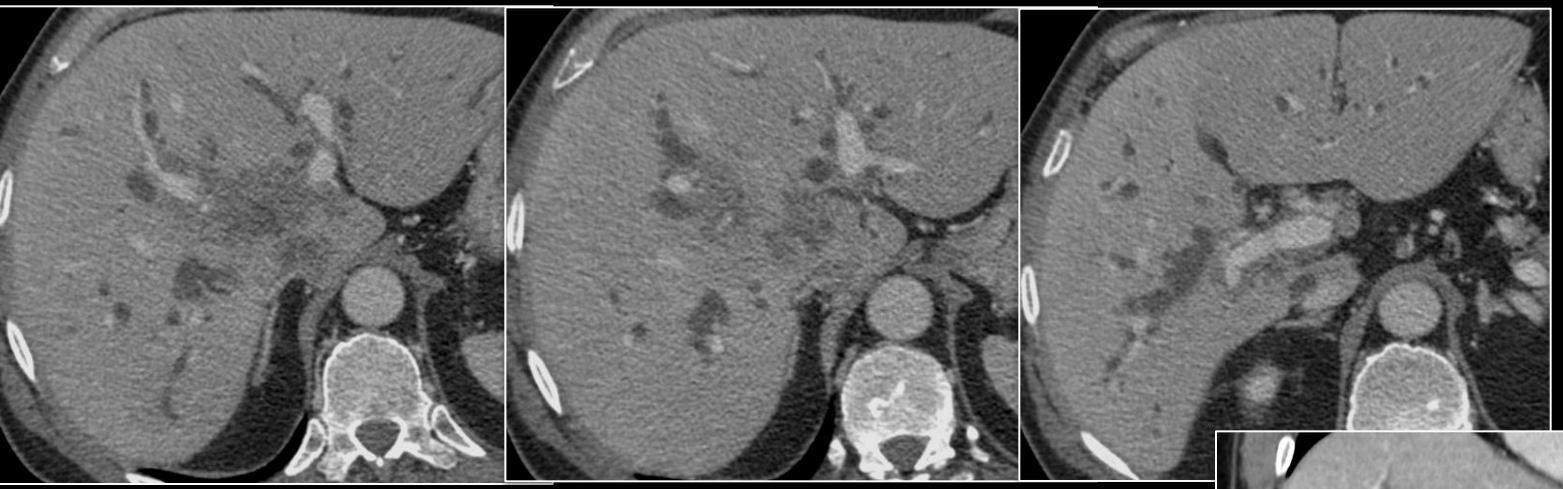


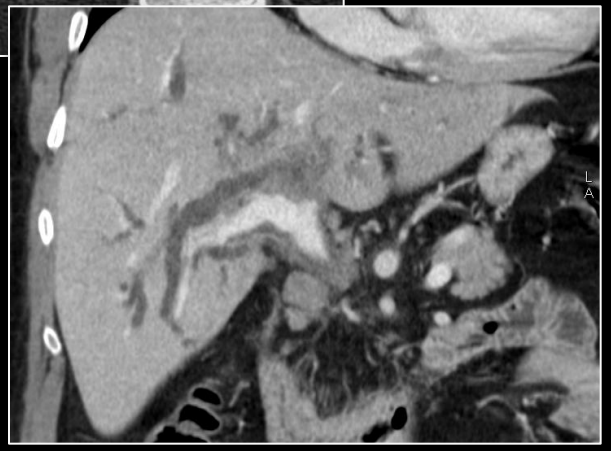


Cholangiopathie portale

Obstacle hilaire : est ce un cancer ?



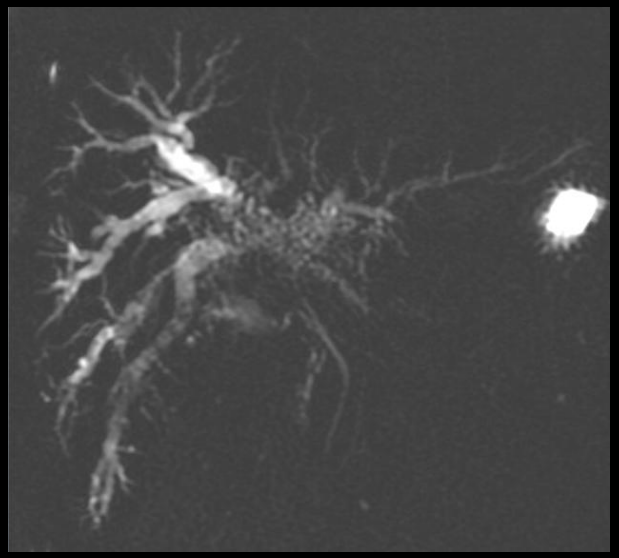
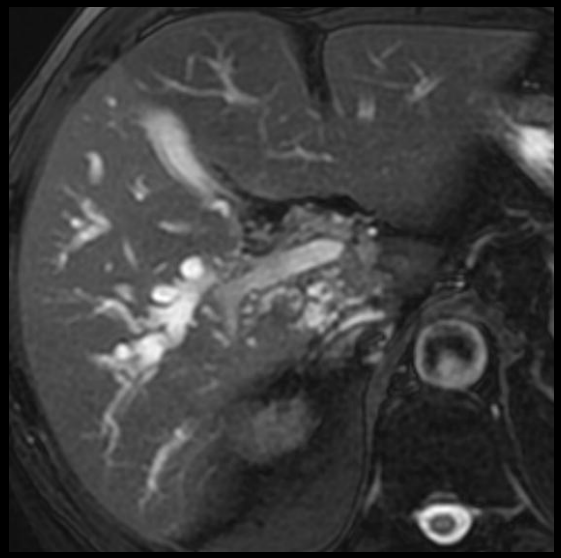
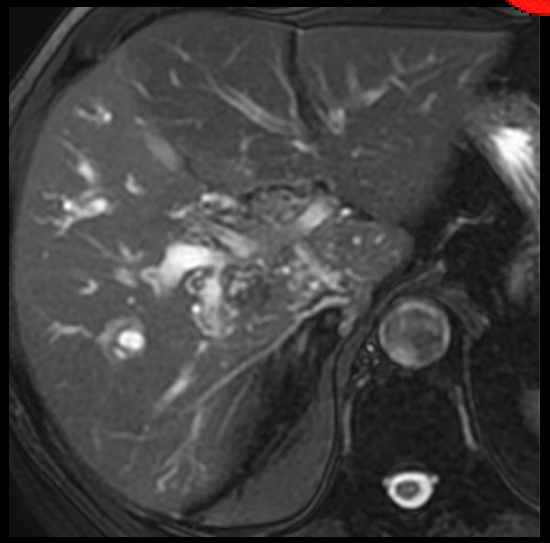
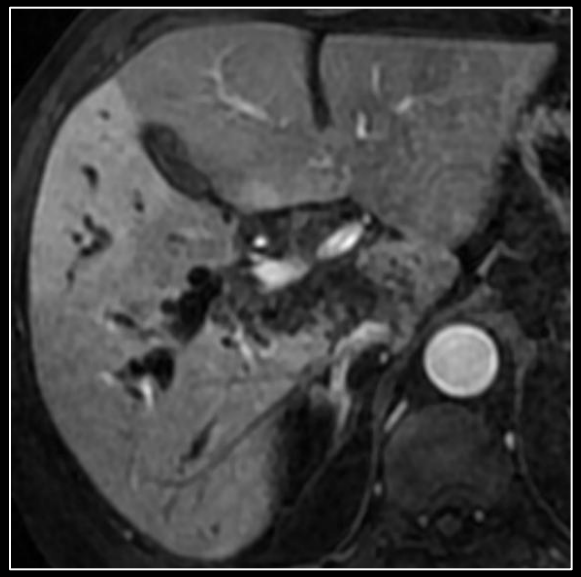
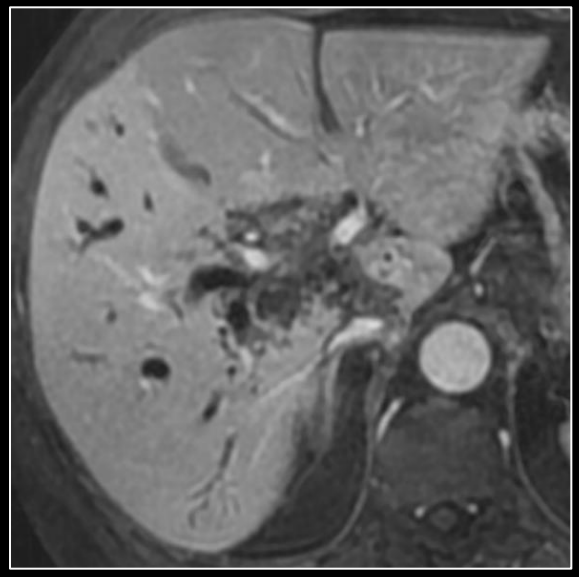
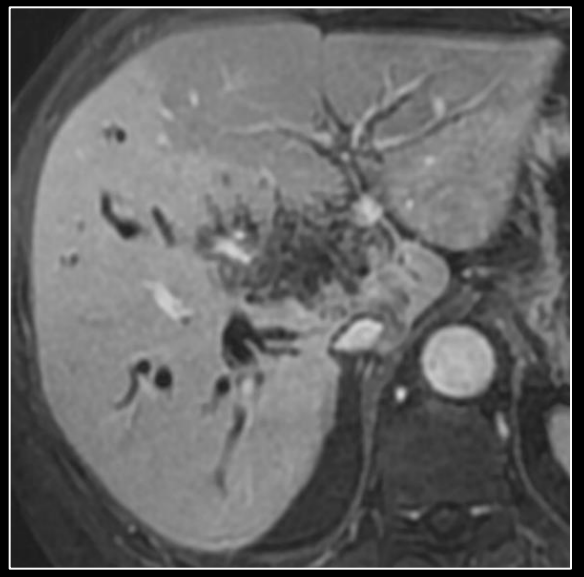




Patient ictère

Vosgien

Obstacle hilaire : est ce un cancer ?

Obstacle hilaire : est ce un cancer ?

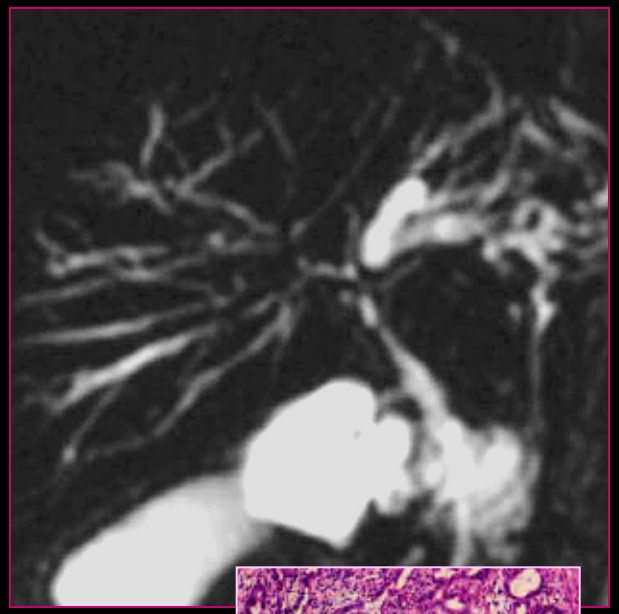
Processus infiltrant pariétal

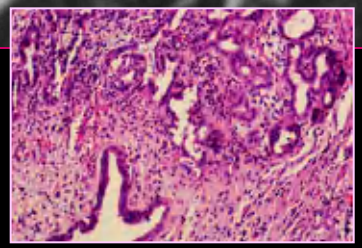
Cholangite sclérosante primitive

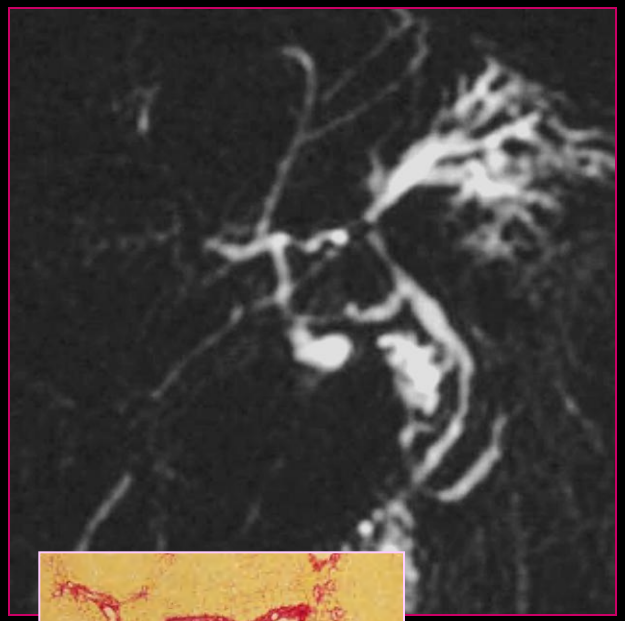
Anomalies conjointes des VBIH

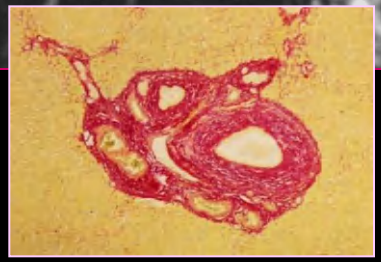
RCH , pancréatite auto immune

Cholangite auto-immune









Obstacle hilaire : est ce un cancer ?

Processus infiltrant pariétal

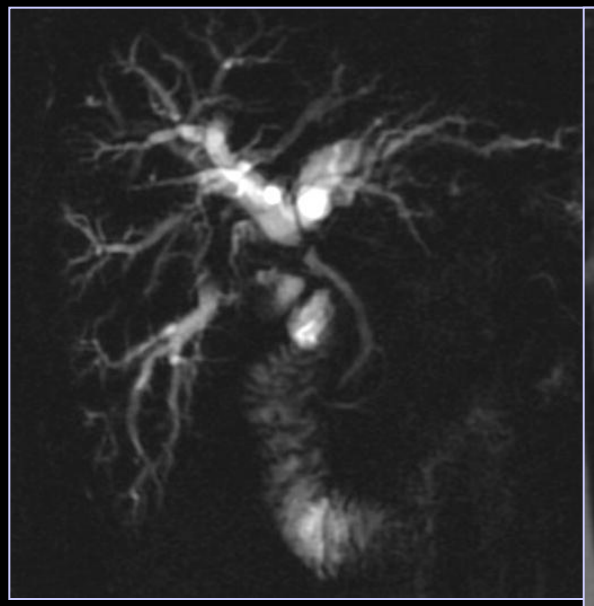
Cholangite sclérosante primitive

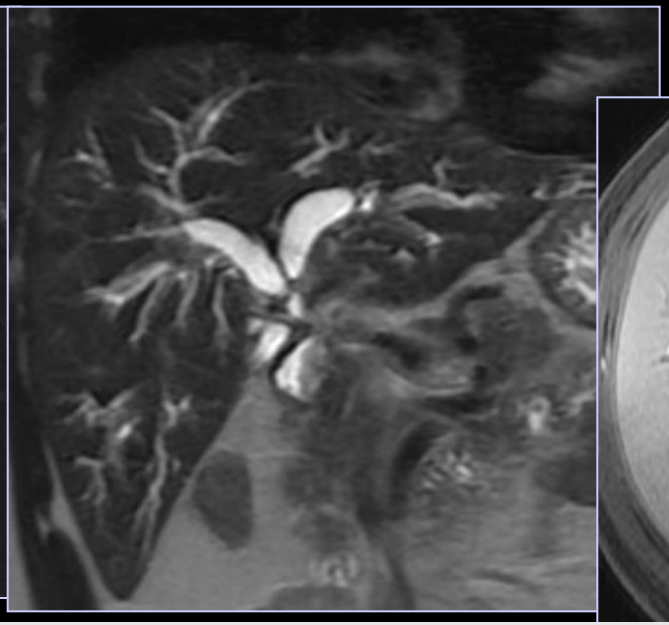
Anomalies conjointes des VBIH

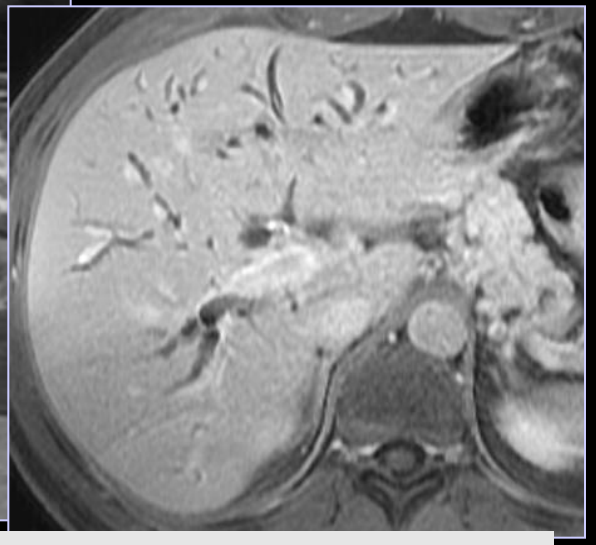
RCH , pancréatite auto immune

Cholangite auto-immune

Koea et al. World J Surg 2004
Rosch et al. Gastrointest Endosc 2002
Gerhards et al. Br J Sur 2001



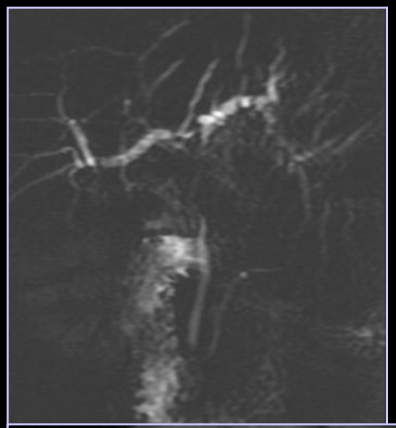


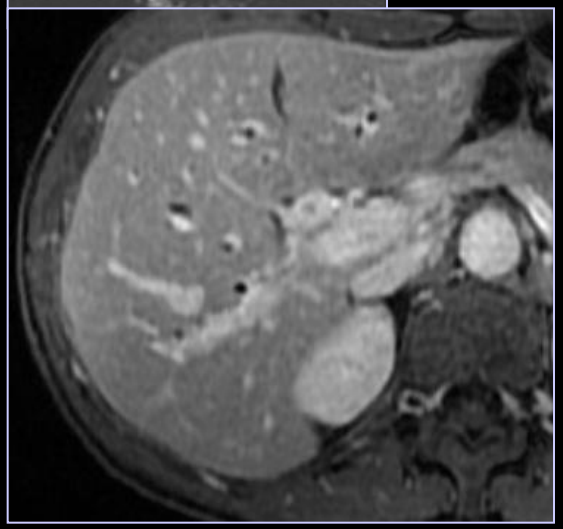


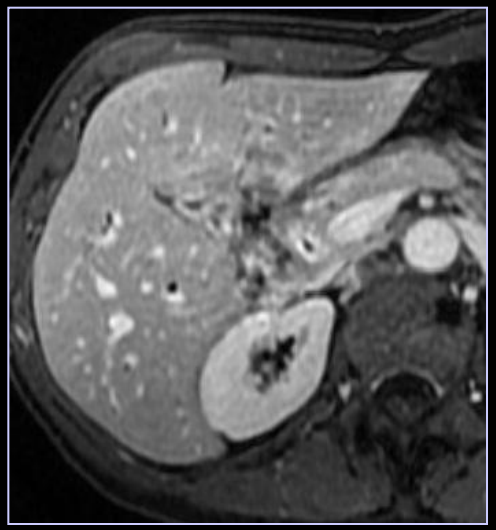
14% des obstacles hilaires considérés comme des CCK périhilaires sont des cholangites

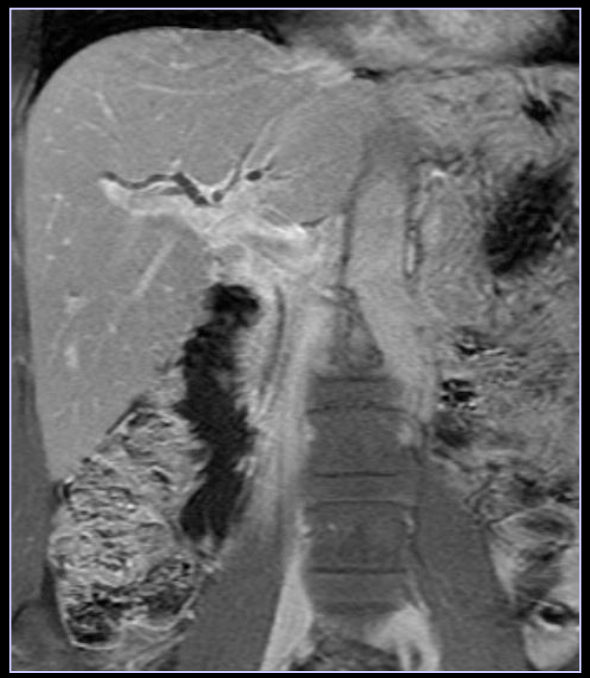
Obstacle hilaire : est ce un cancer ?

Processus infiltrant pariétal





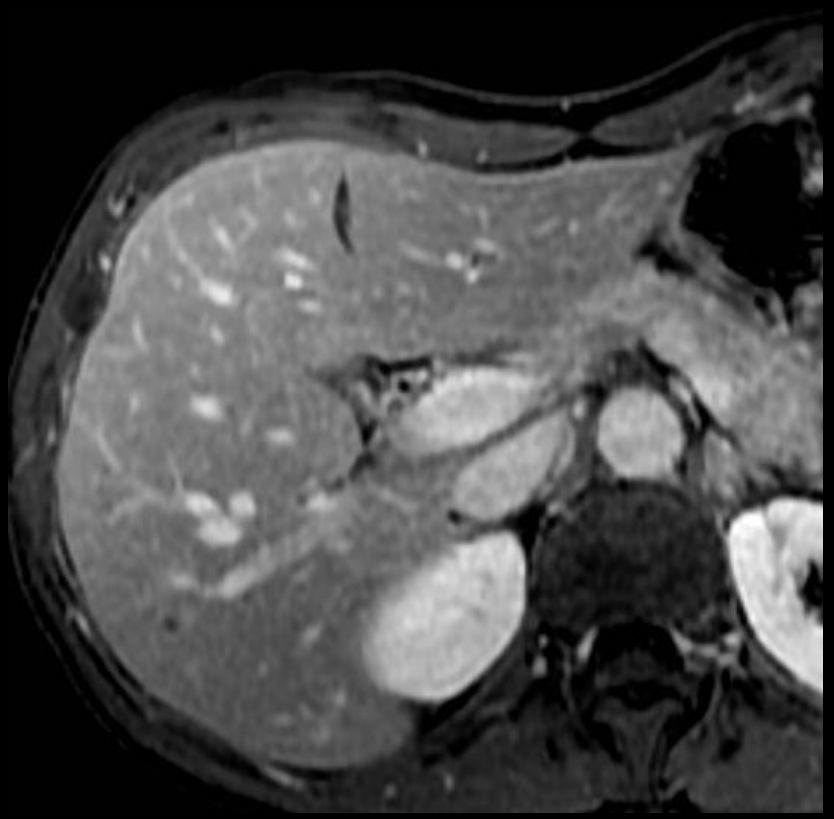




Koea et al. World J Surg 2004
Rosch et al. Gastrointest Endosc 2002
Gerhards et al. Br J Sur 2001

Obstacle hilaire : est ce un cancer ?

Processus infiltrant pariétal



Obstacle hilaire : est ce un cancer ?

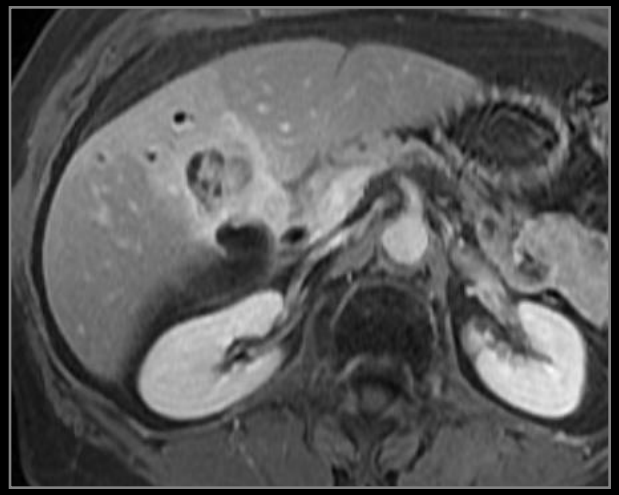
Processus infiltrant pariétal

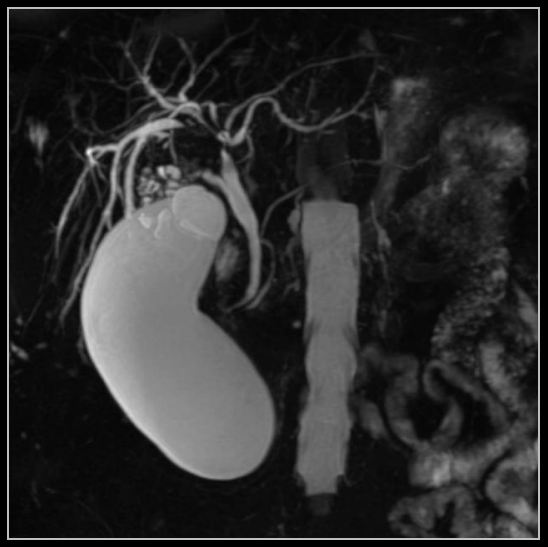
- Knoefel WT et al. *Eur Surg Oncol 2003; 29 : 658-61*
  - 33 patients
  - Echo, CT, ERCP, angiography
  - 27 lésions malignes / 6 patients porteurs d'une cholangite fibrosante
- Uhlmann D et al. */ Gastrointest Surg 2006; 10 : 1144-50*
  - 49 patients / diagnostic radiologique de tumeur de Klatskin
  - **14% (7) : pathologie bénigne.**
  - 6 considérés comme malins à la la laparotomie
  - Anapath : cholangite sévère avec une fibrose extensive périductale

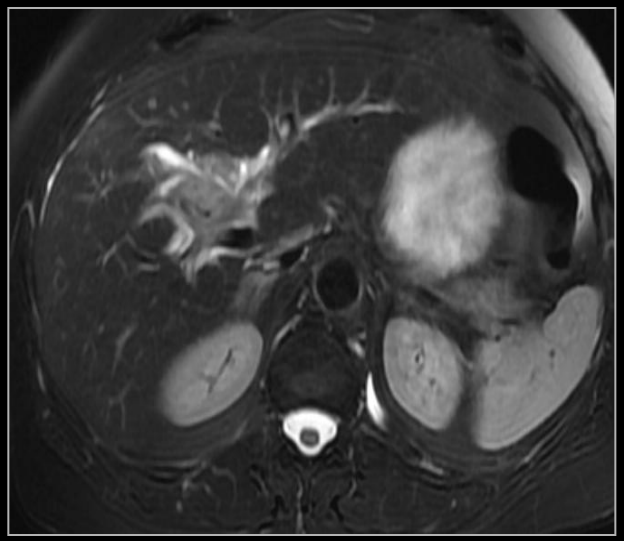
Obstacle hilaire : est ce un cancer d'une autre origine ?

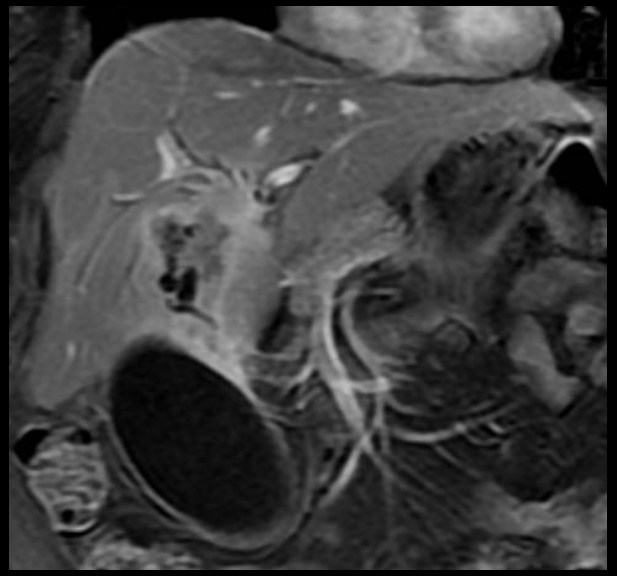
Malins

- ADK pancréas
- ADK sillon
- ADK vésiculaire étendu au hile
- Carcinomatose péritonéale
- ADP métastatiques





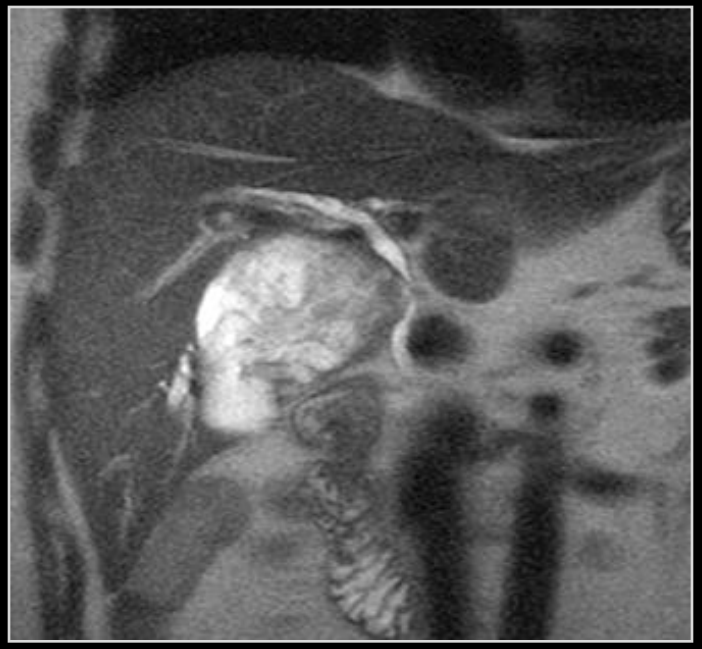


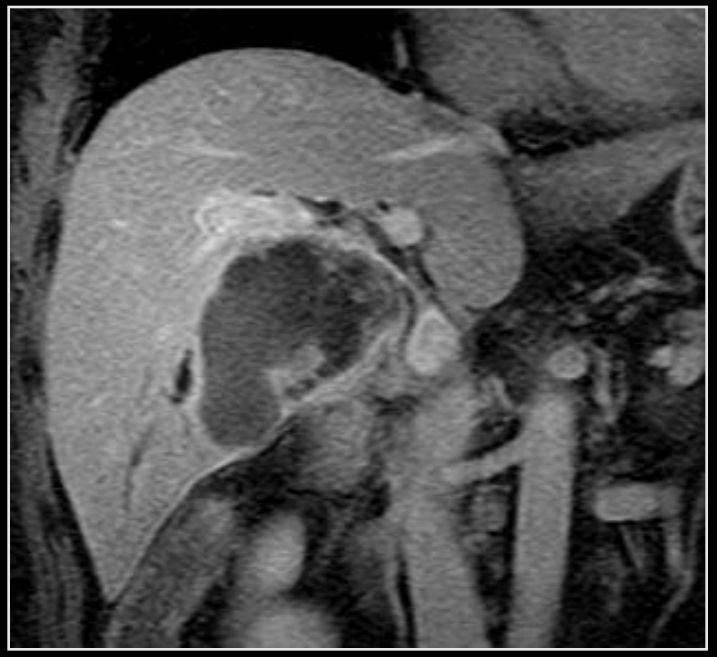


Obstacle hilaire : est ce un cancer d'une autre origine ?

Malins

- ADK pancréas
- ADK sillon
- ADK vésiculaire étendu au hile
- Carcinomatose péritonéale
- **ADP métastatiques**

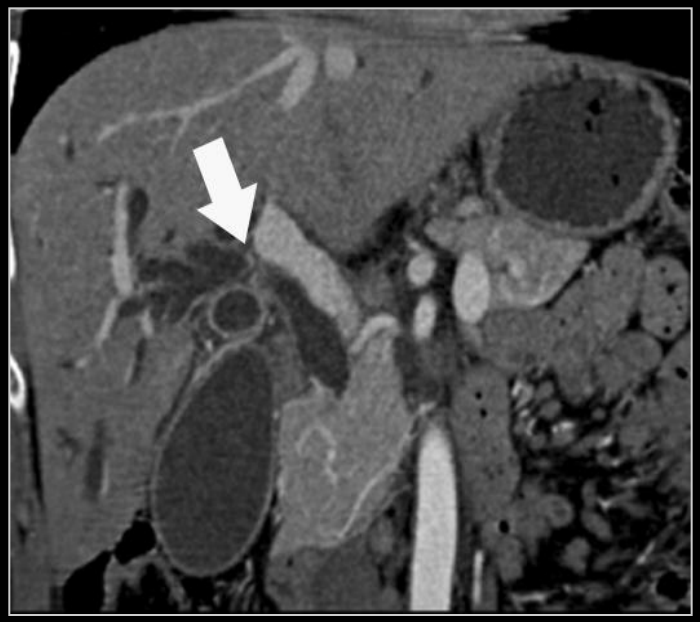


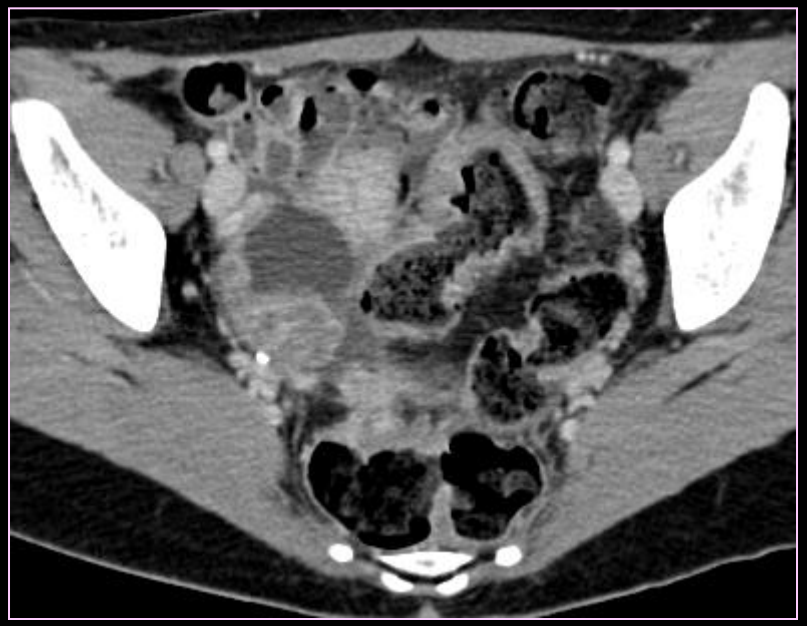


Obstacle hilaire : est ce un cancer d'une autre origine ?

Malins

- ADK pancréas
- ADK sillon
- ADK vésiculaire étendu au hile
- **Carcinomatose péritonéale**
- ADP métastatiques





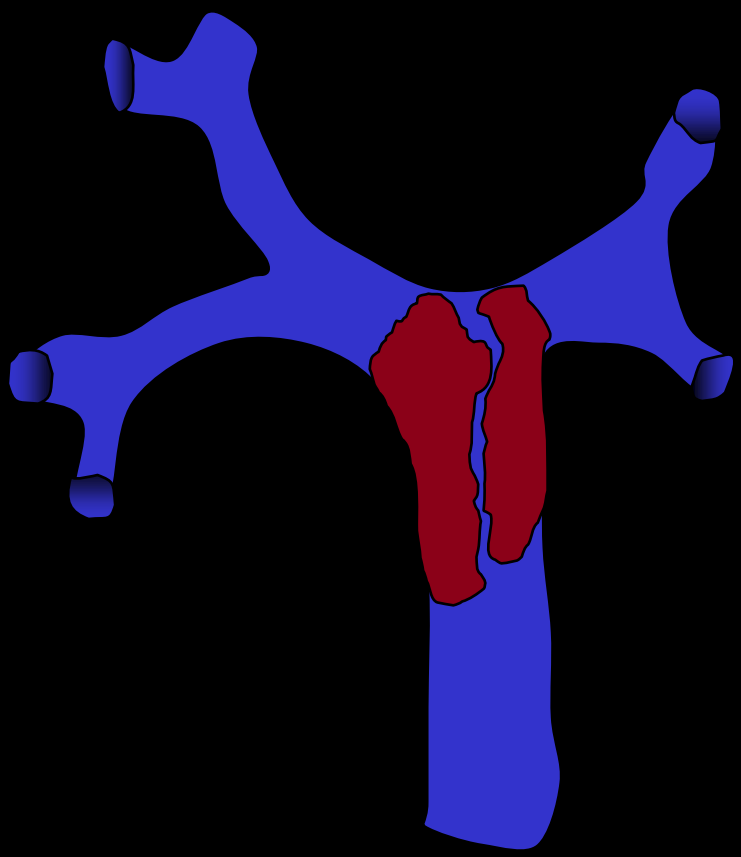
Obstacles Hilaires, c'est un cholangiocarcinome : Existe il une possibilité curative ???

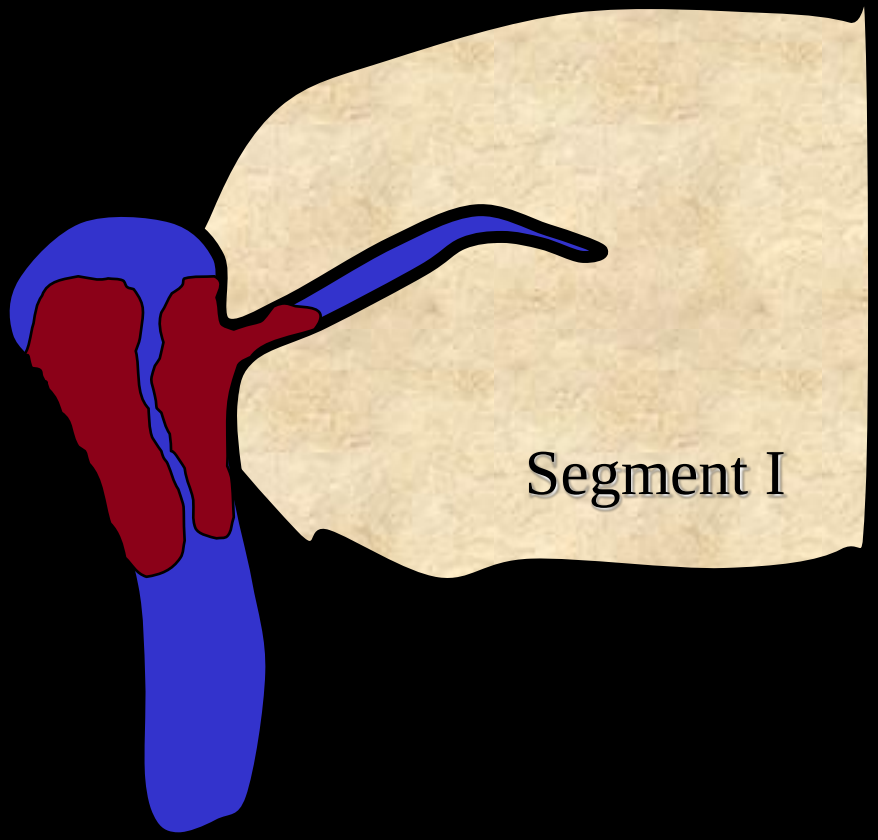
Dans quelles conditions ???

Critères d'irrésécabilité chirurgicale

- Volumineuse masse hilaire
- Critères biliaires
  - Pôle supérieur atteignant les convergences secondaires de façon bilatérale
- Critères vasculaires
  - Atteinte des trois veines sus hépatiques
  - Atteinte artérielle bilatérale
  - Atteinte vasculaire unilatérale associée à une atrophie controlatérale
- Critères parenchymateux hépatiques
- Extension extra hépatique

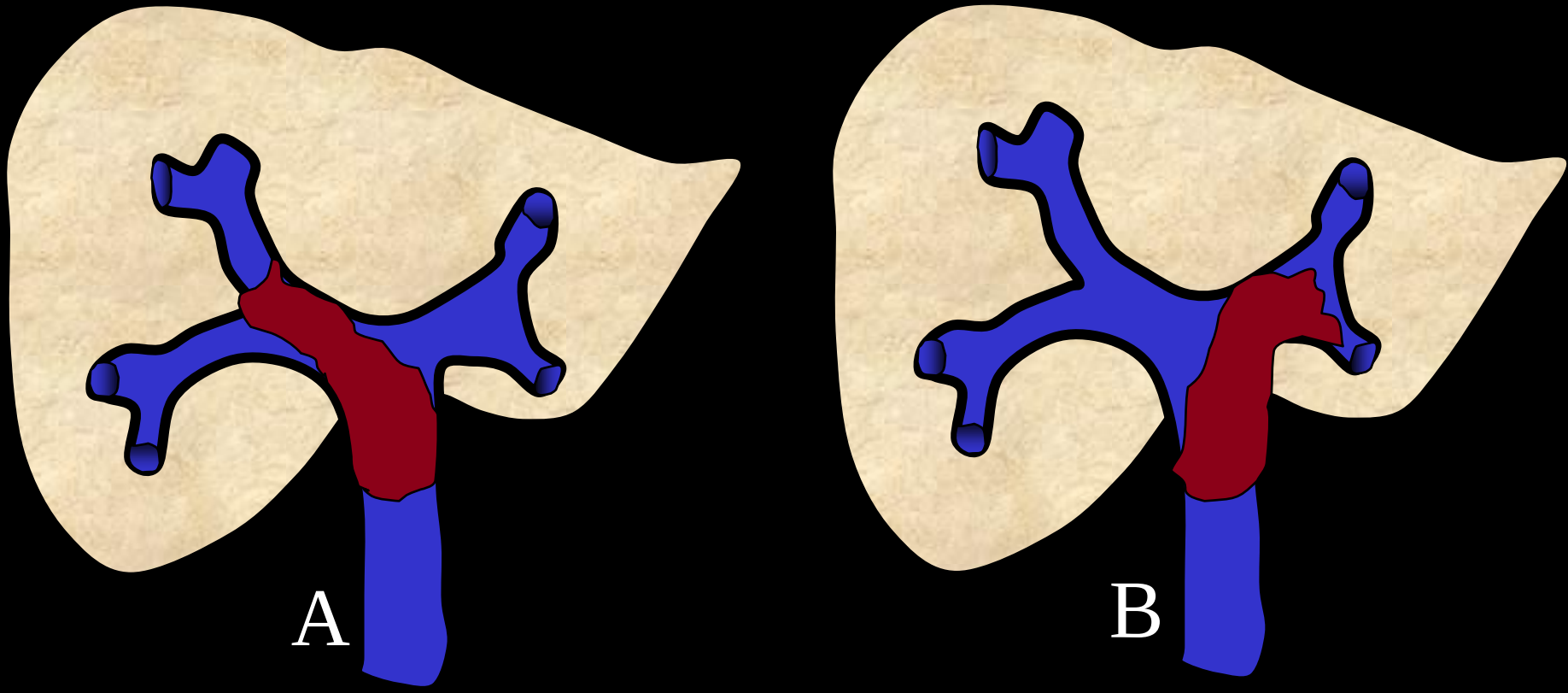
Une seule vraie question:
La convergence est-elle atteinte ?





Type II: la convergence est atteinte. Le segment I doit être enlevé

La convergence est-elle atteinte ?
Si oui: reste-il un canal dérivable ?



Type III : Extension dans 1 seul des deux canaux hépatiques.

Droit (III A) ou gauche (IIIB)

Une hépatectomie homolatérale à l'atteinte, élargie au I, est nécessaire

Evaluation de l'extirpabilité

Extension biliaire

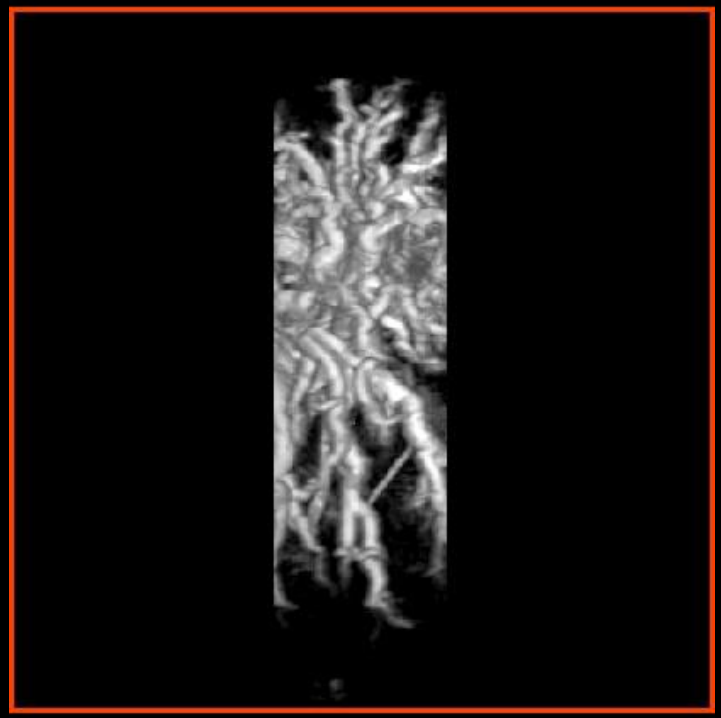
Classification de Bismuth et Corlette

CholangioIRM :

coupes épaisses 20 mm

Limites :

- superpositions ++
- Pas de coupes fines
- Difficulté d'analyse de la zone pathologique



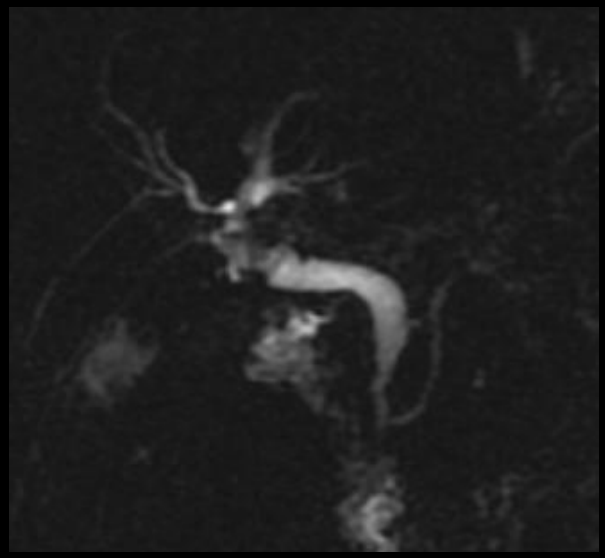
CholangioIRM en 3D

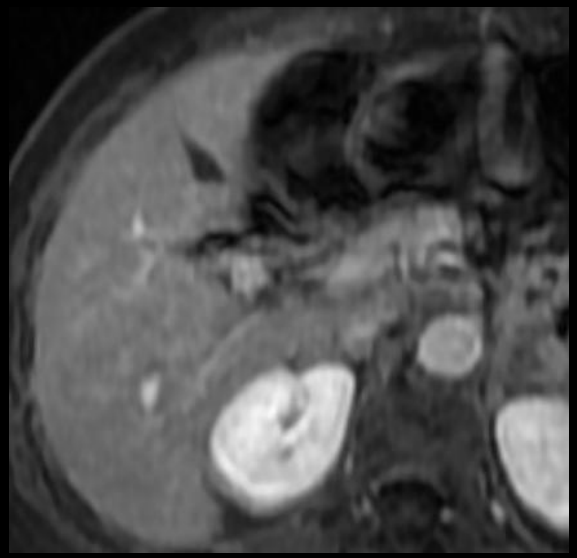
Intérêts :

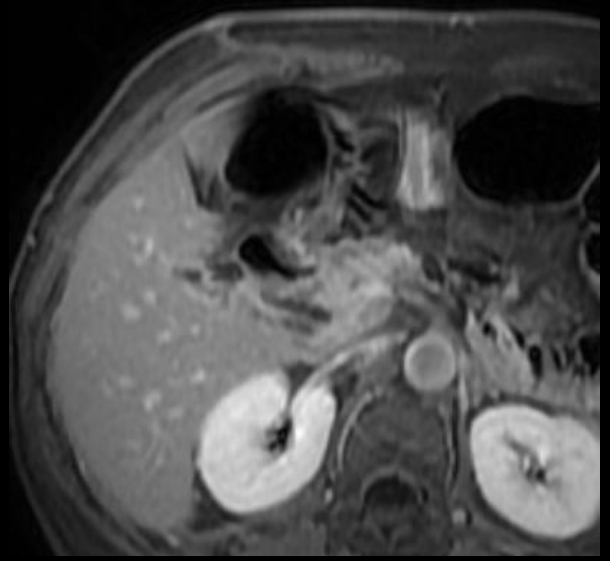
- **Pas de** superpositions ++
- Coupes fines ++++
- Reformations multiplanaires sur la zone intéressante

Extension biliaire

Classification de Bismuth et Cornette

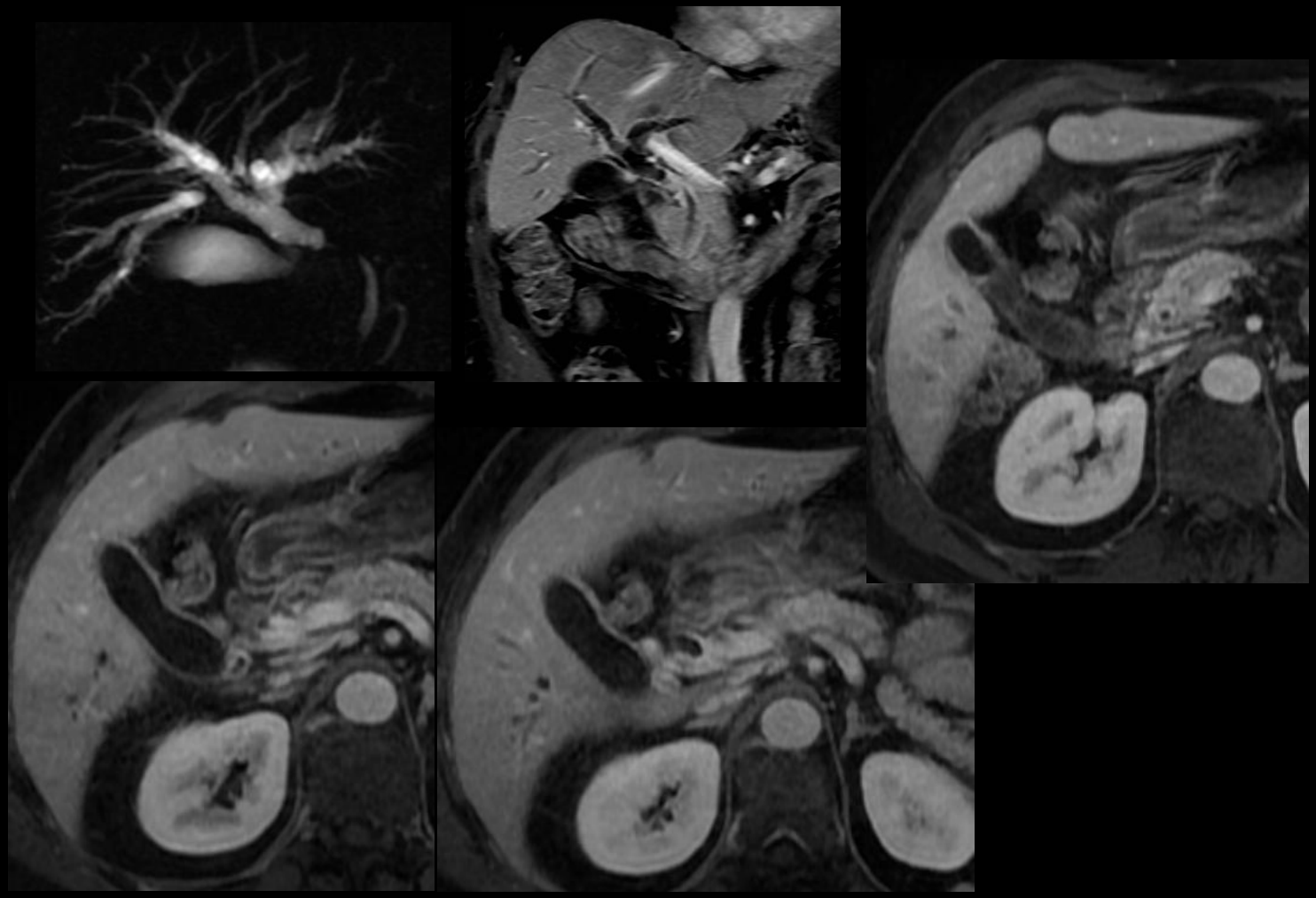






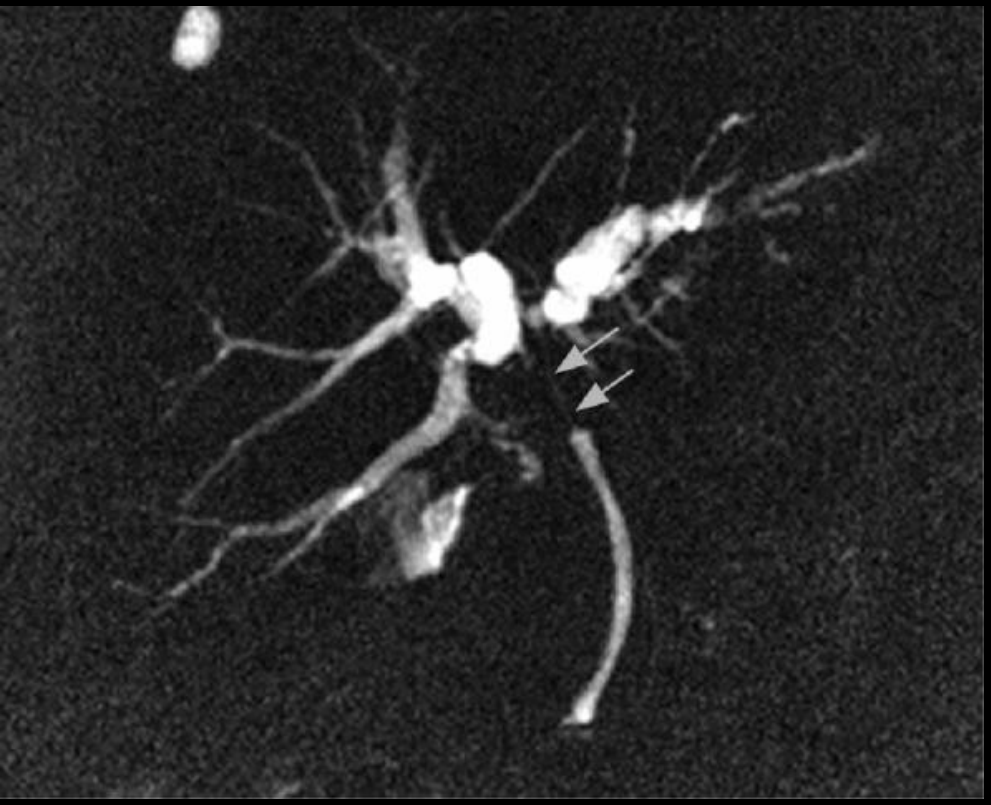
Extension biliaire

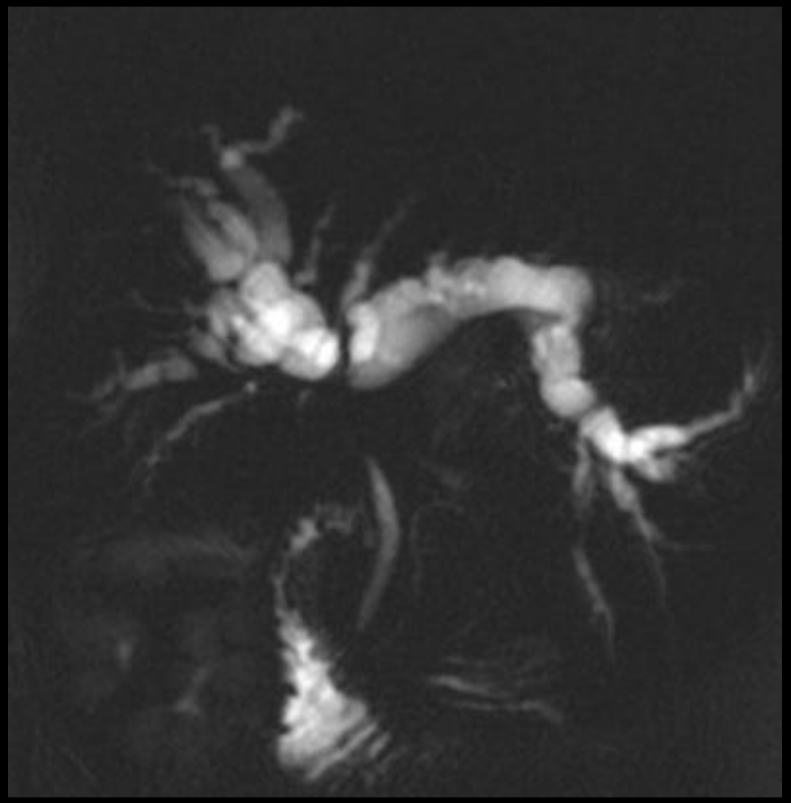
Classification de Bismuth et Cornette



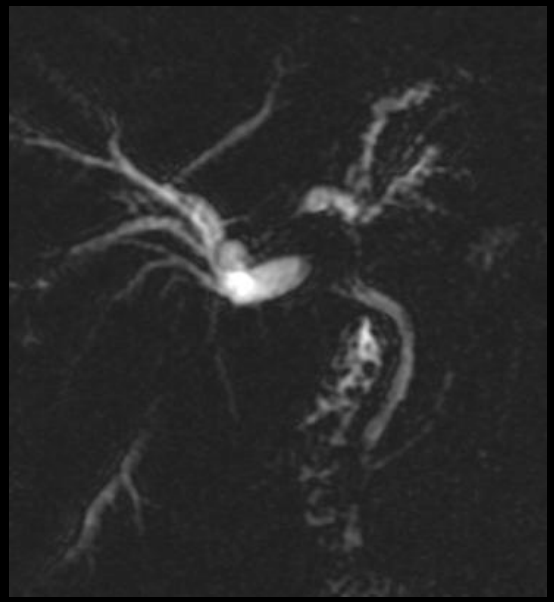
Extension biliaire

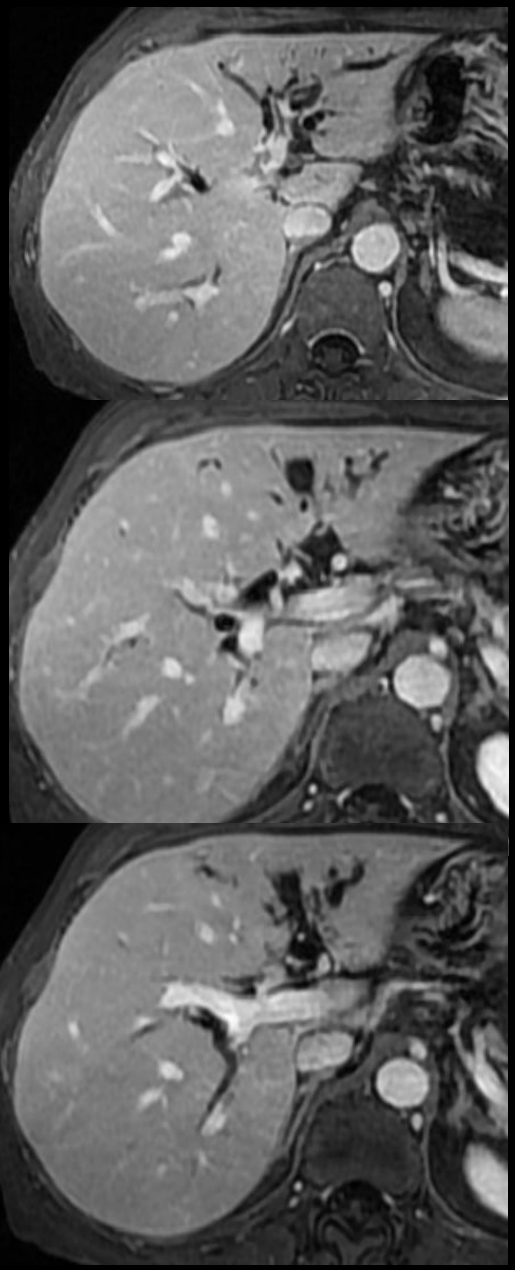
Classification de Bismuth et Cornette



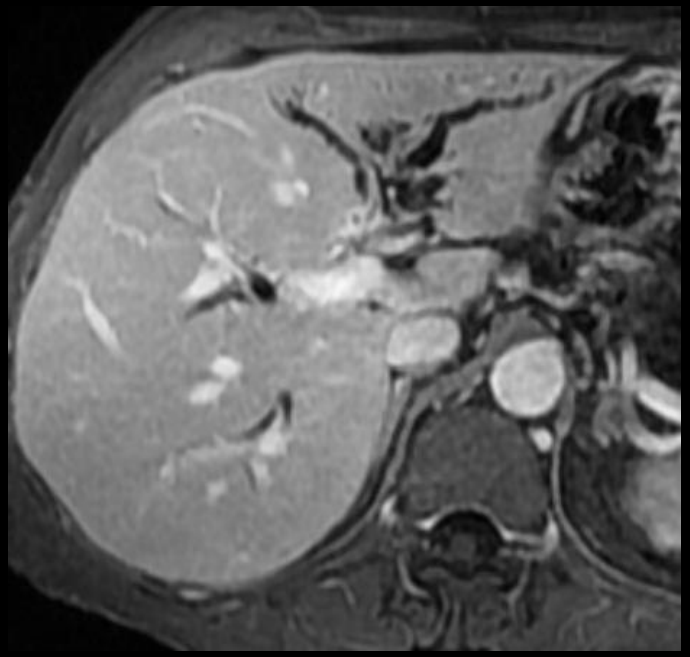


Evaluation de l'extirpabilité



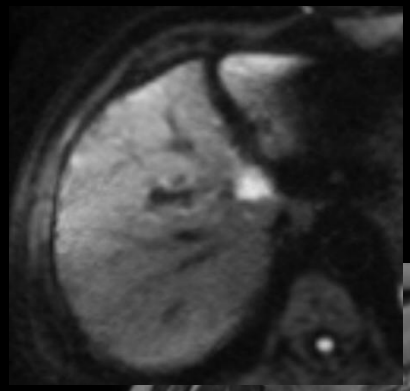


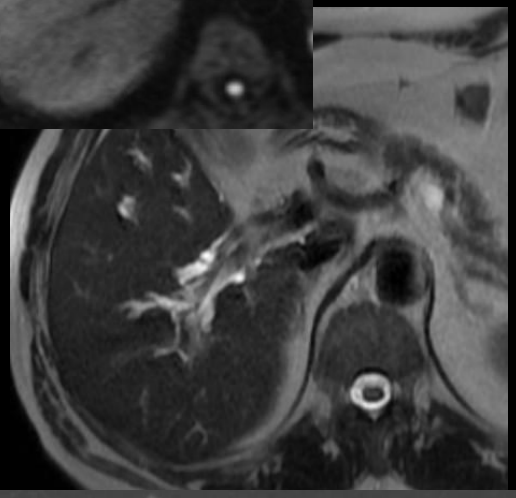
Extension biliaire

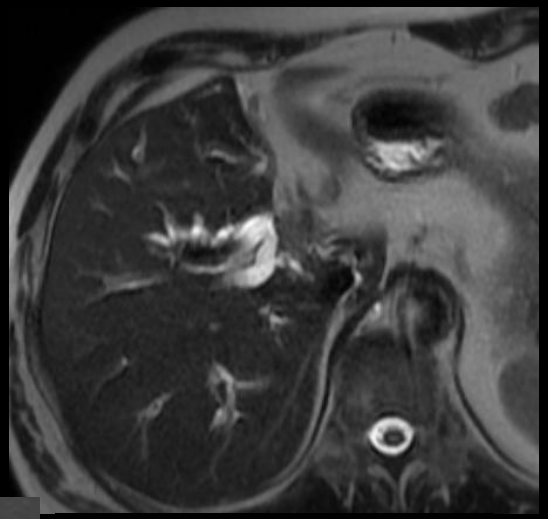


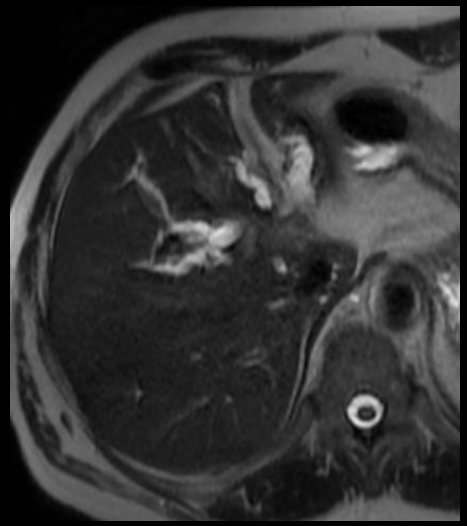
Evaluation de l'extirpabilité

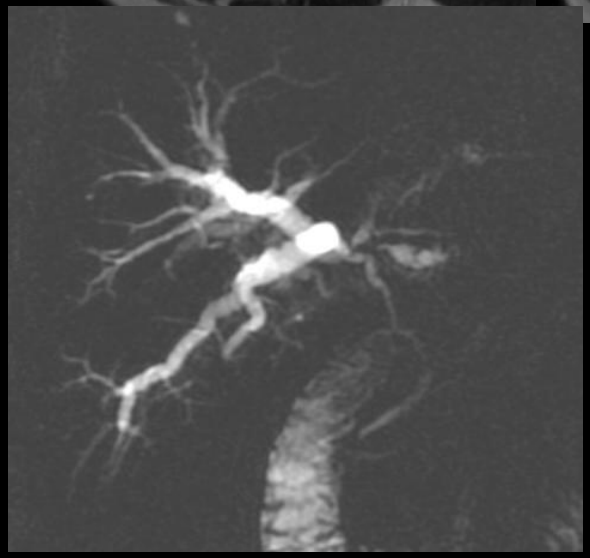
Extension biliaire

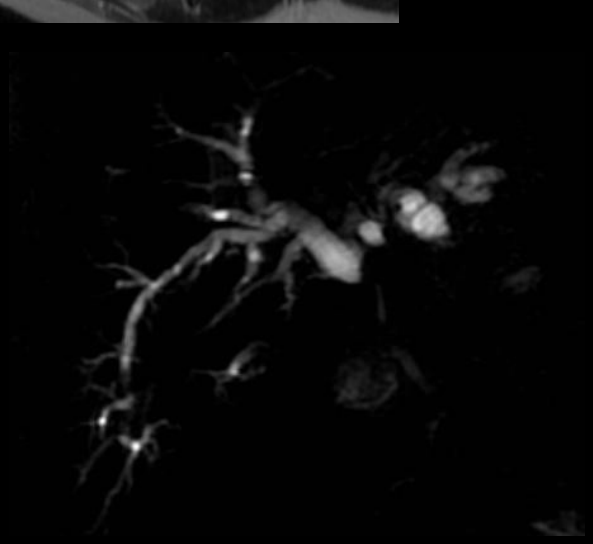




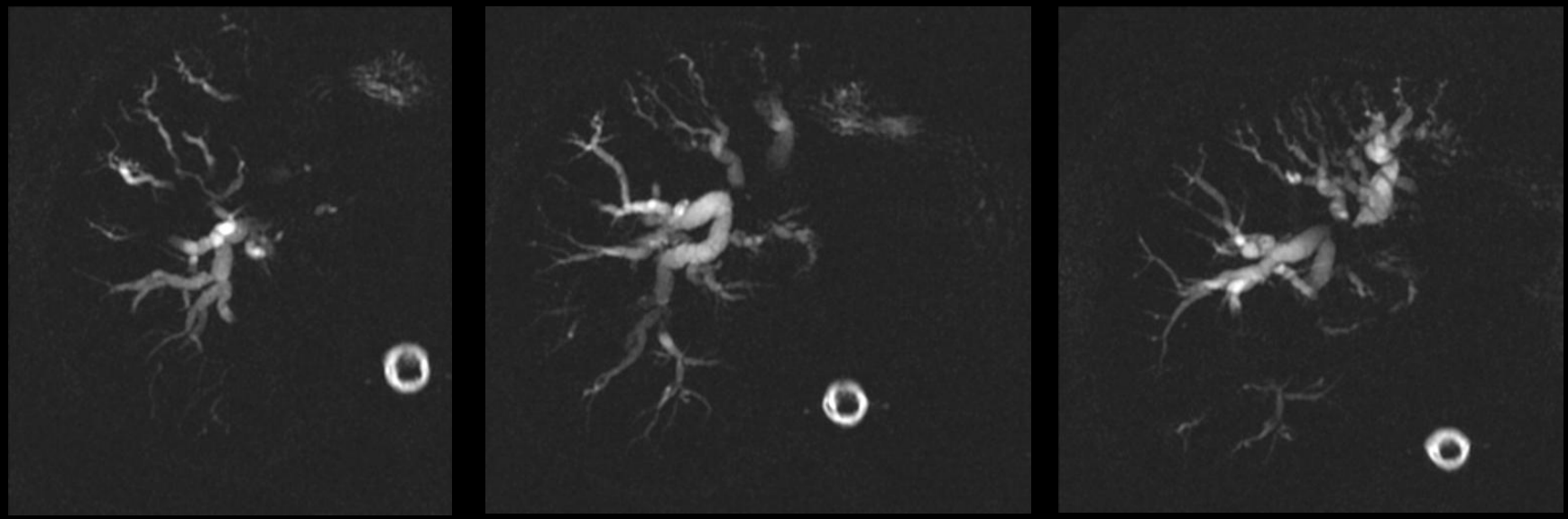






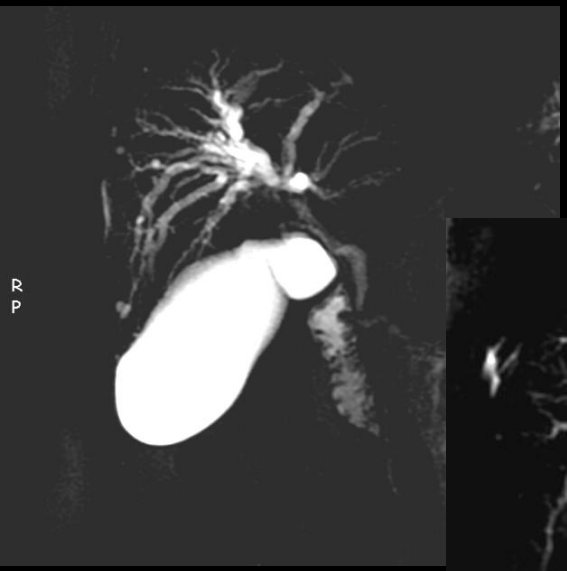


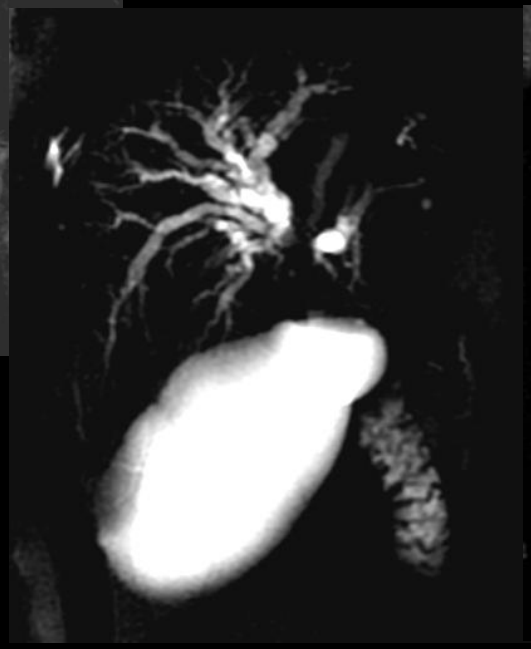
Extension biliaire

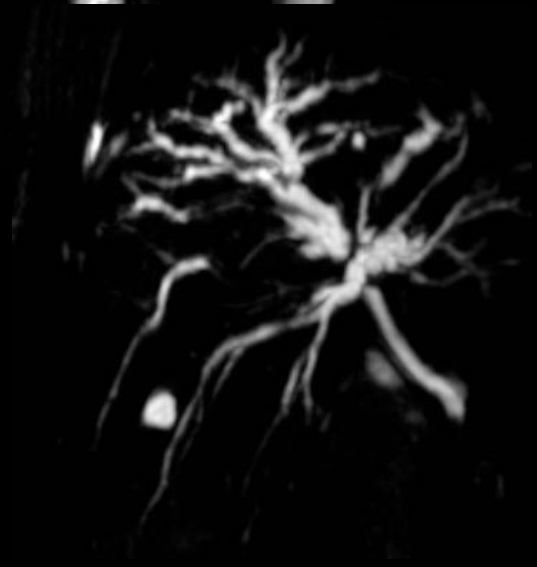


Evaluation de l'extirpabilité

Extension biliaire







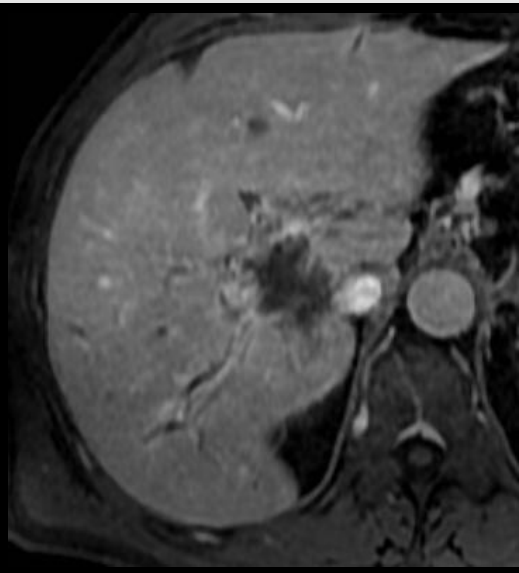
Extension artérielle

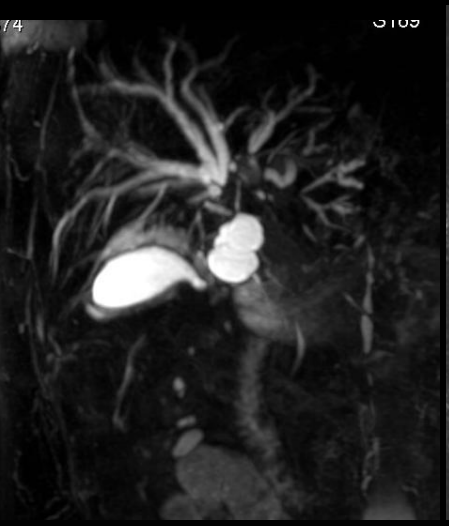
Bilan artériel :

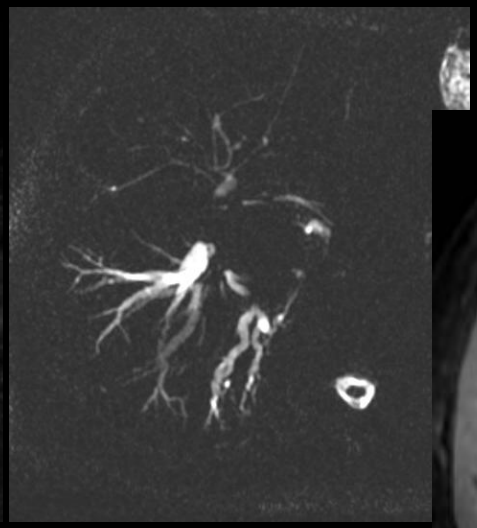
-Siège de la lésion/artère hépatique commune et aux branches de l'artère hépatique

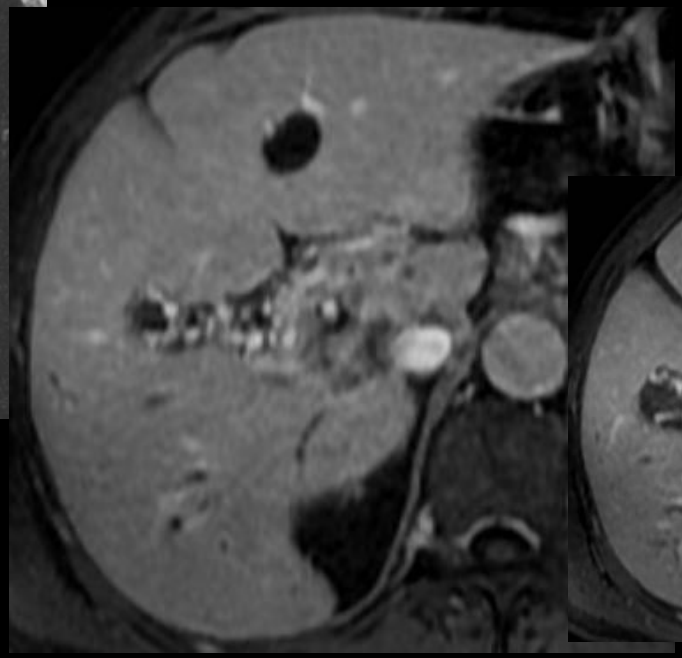
-Préciser si engainement (en degrés), sténose ou thrombose

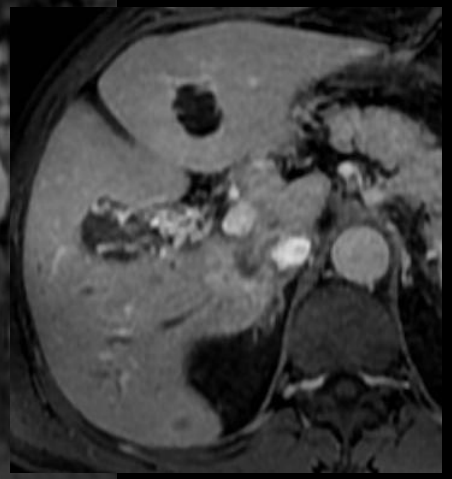
-Préciser si distribution normale ou si présence de variantes anatomiques



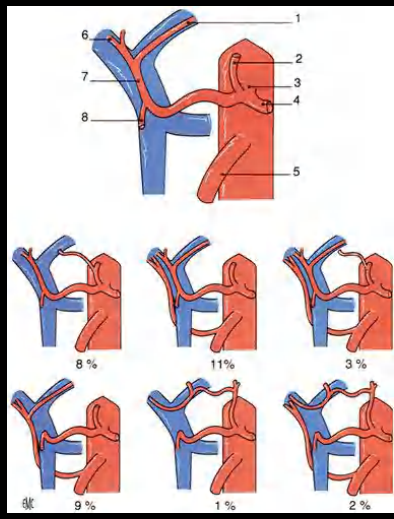


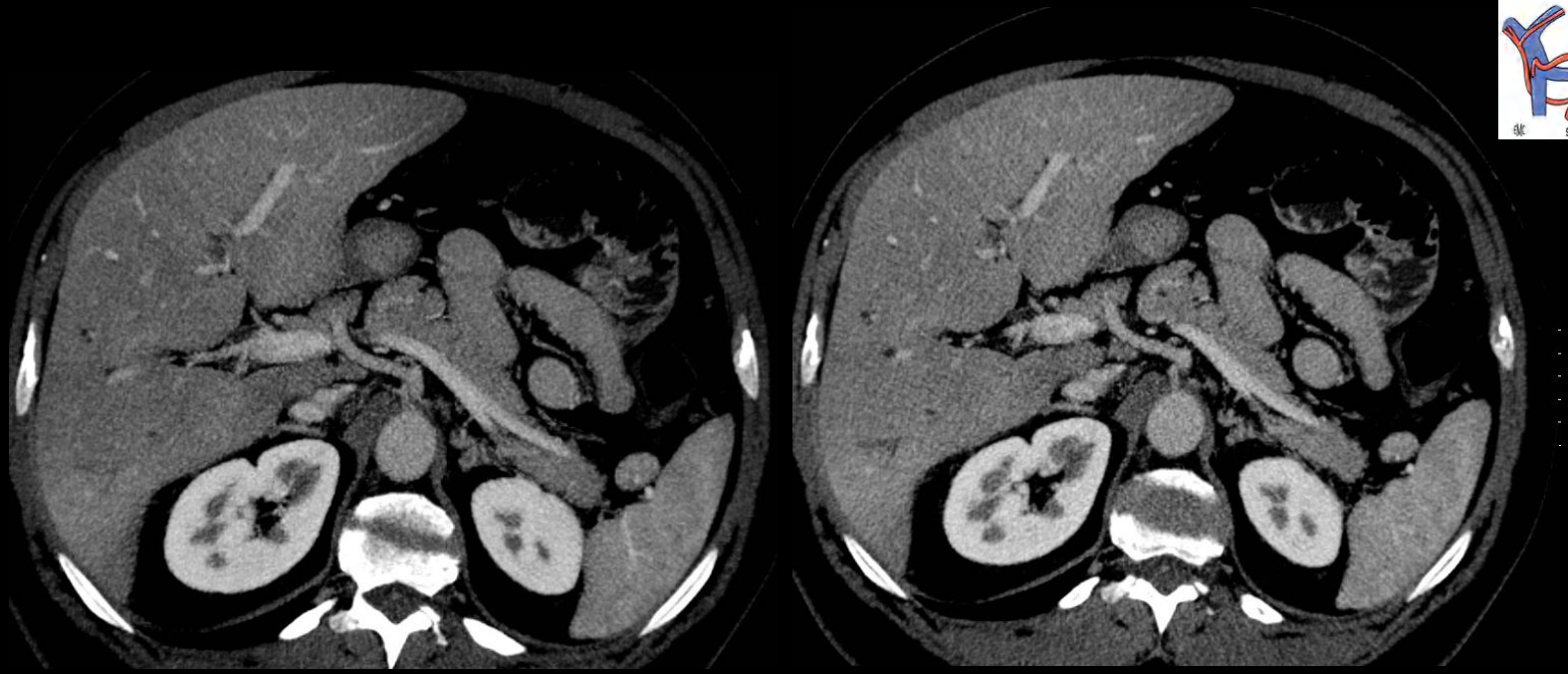




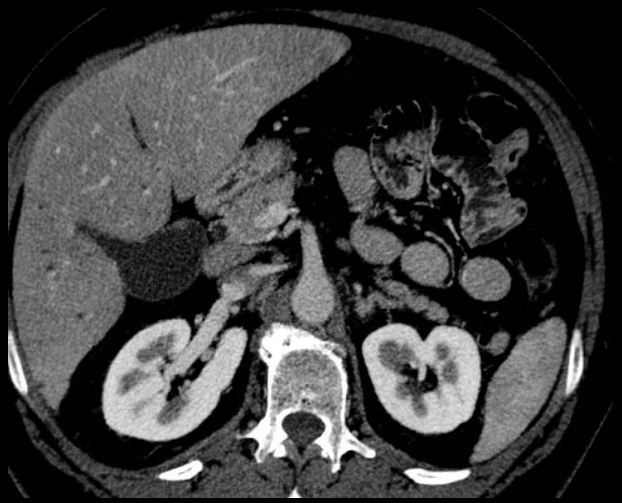


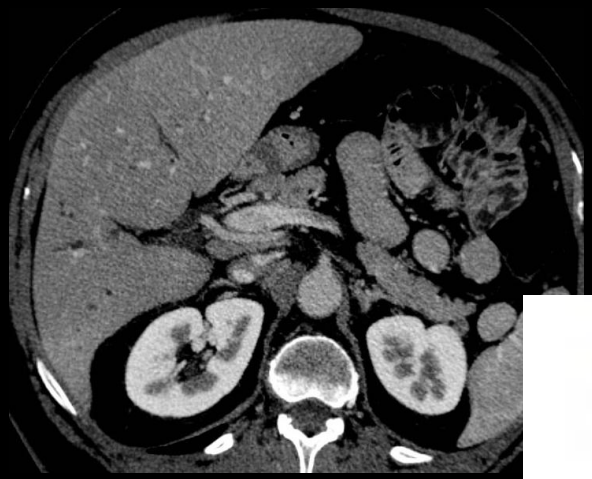
Extension artérielle

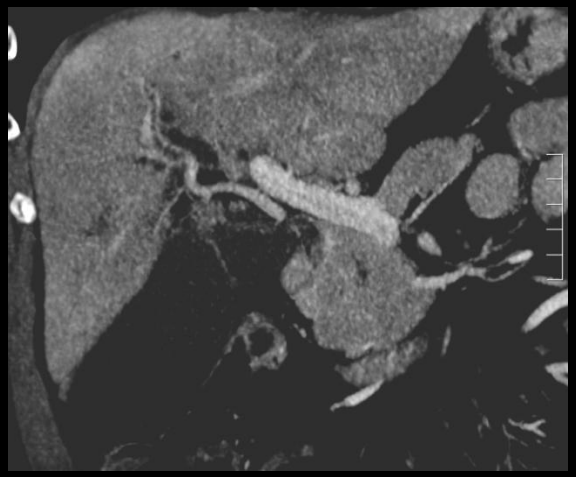


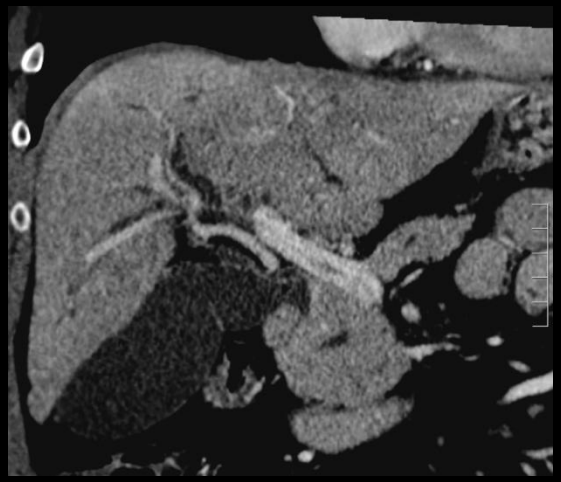


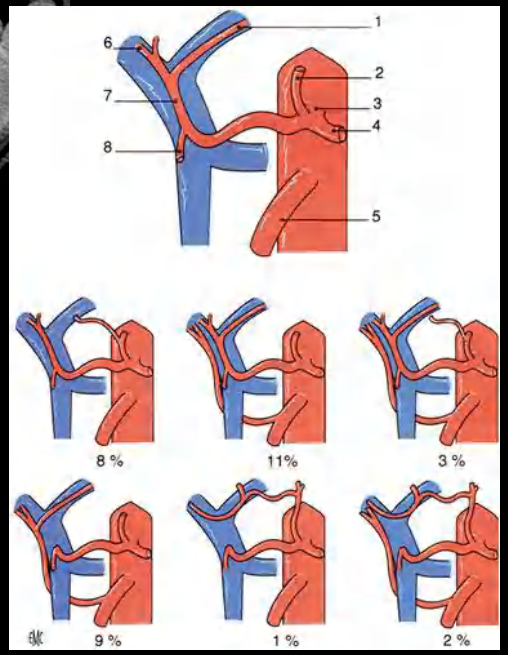
Extension artérielle



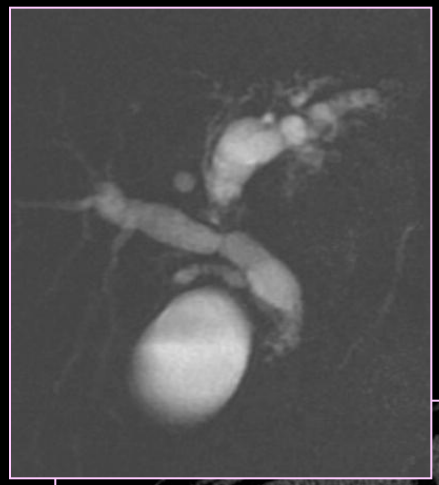


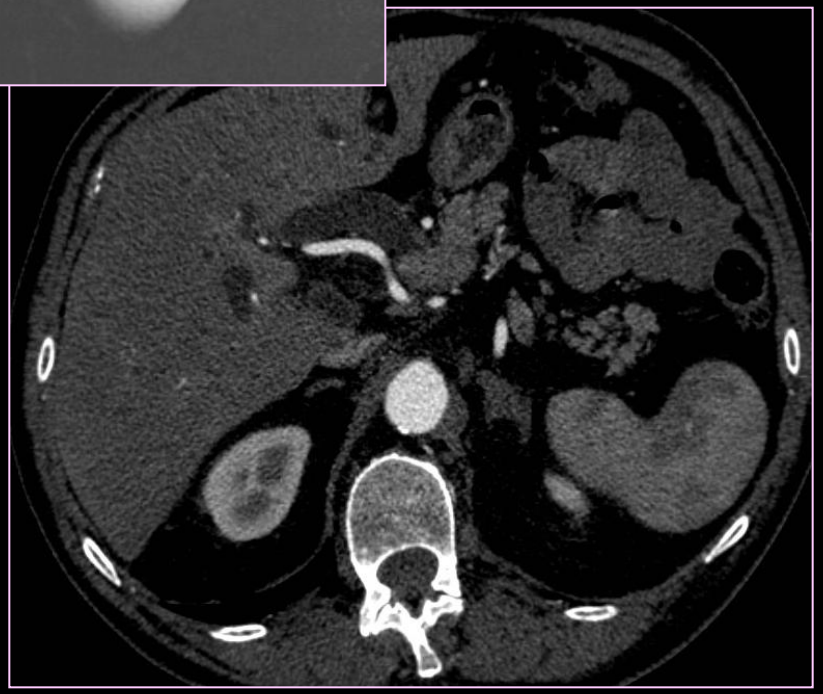


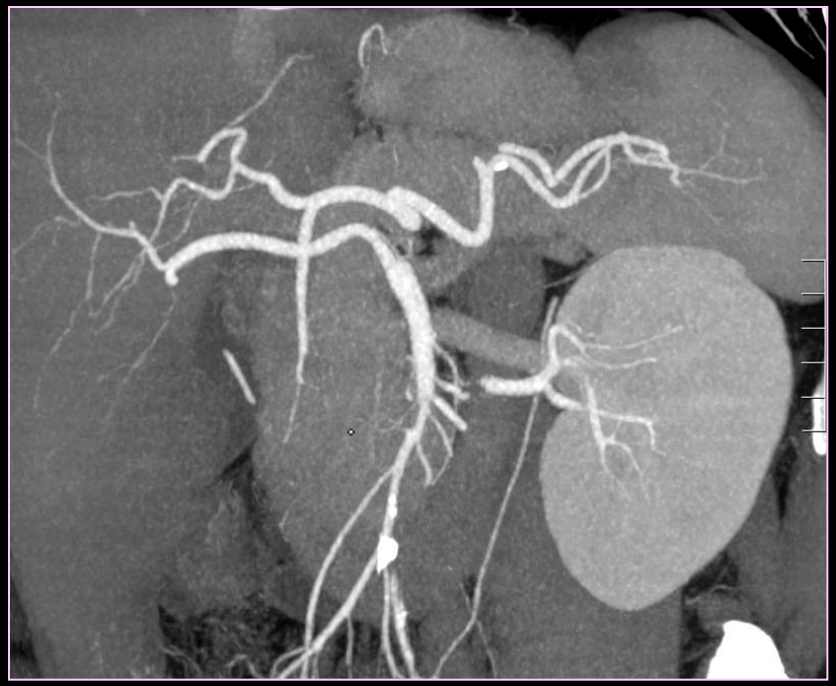




Extension artérielle



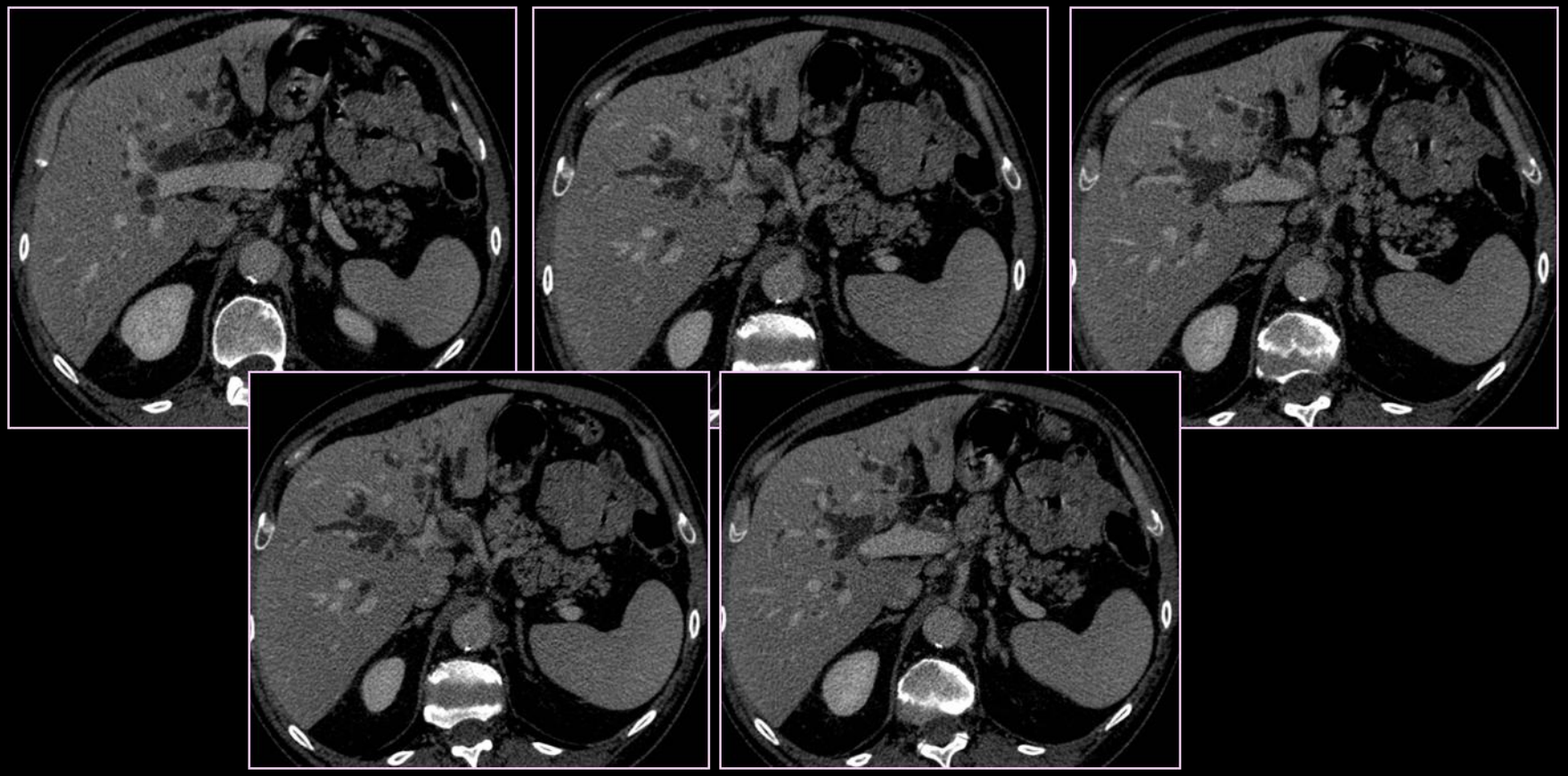




Artère hépatique droite naissant de l'AMS

Evaluation de l'extirpabilité

Extension portale



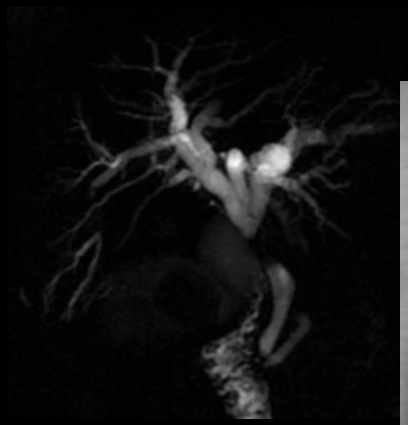
Critères d'irrésécabilité chirurgicale

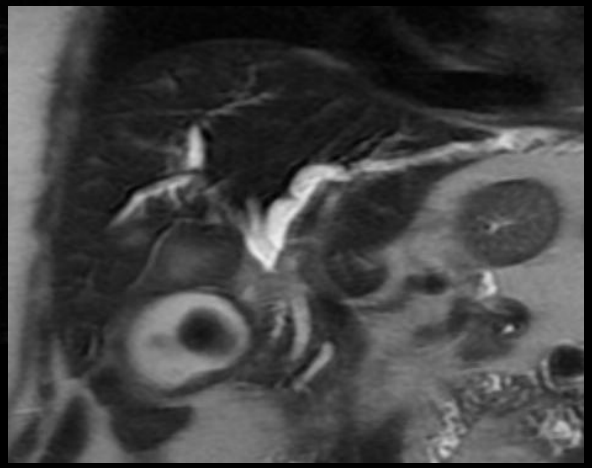
- Soriano et al. Am J Gastroenterol 2004, 99 : 492-501.
  - Comparaison scanner,echoendoscopie, IRM ,angiographie
  - Atteinte vasculaire : **Scanner hélicoidal >> autres techniques**

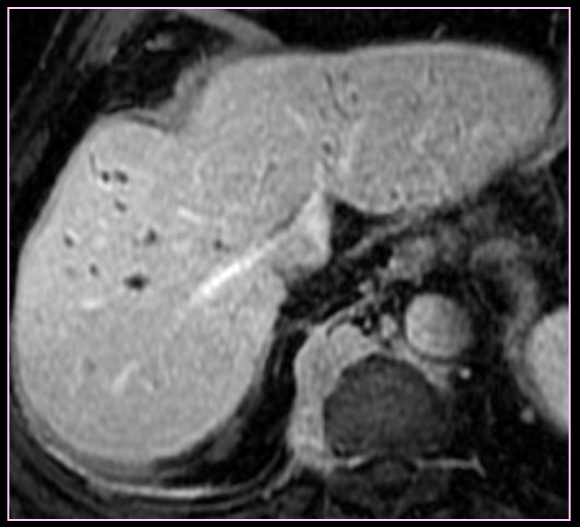
- Comparaisons angio scanner/Chir.
  - Envahissement portal
    - Diag.+ : 85,5 % - 94,4%
  - Envahissement artère hépatique
    - Diag.+ : 88,9% - 92,7%

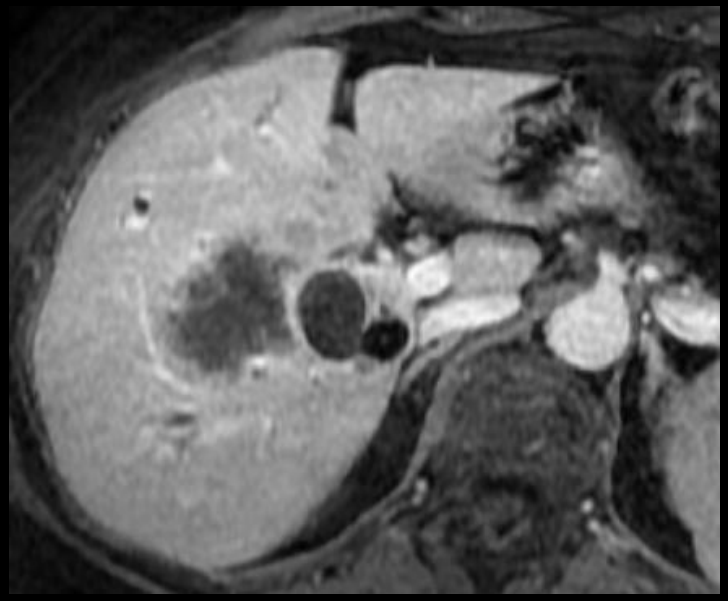
Lee, Radiology 2006

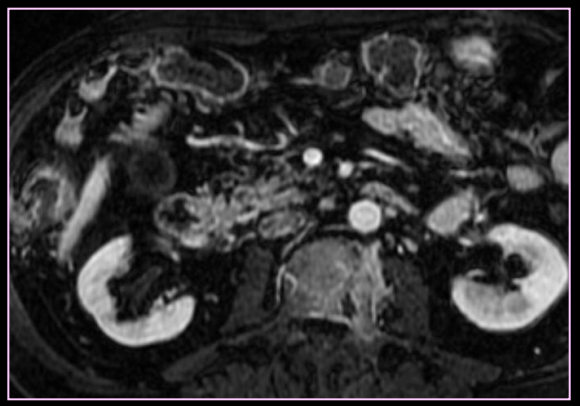
Extension à distance



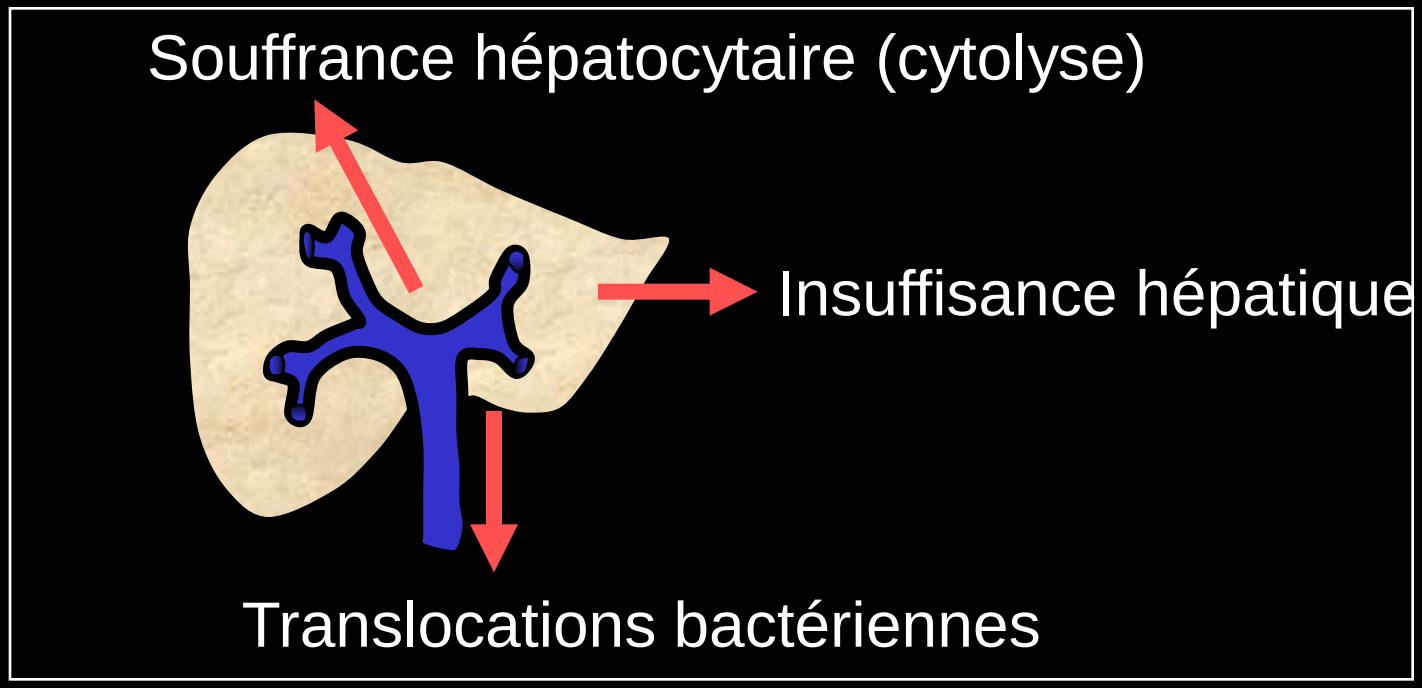








Comment le radiologue peut-il participer à l'« optimisation » hépatique ?

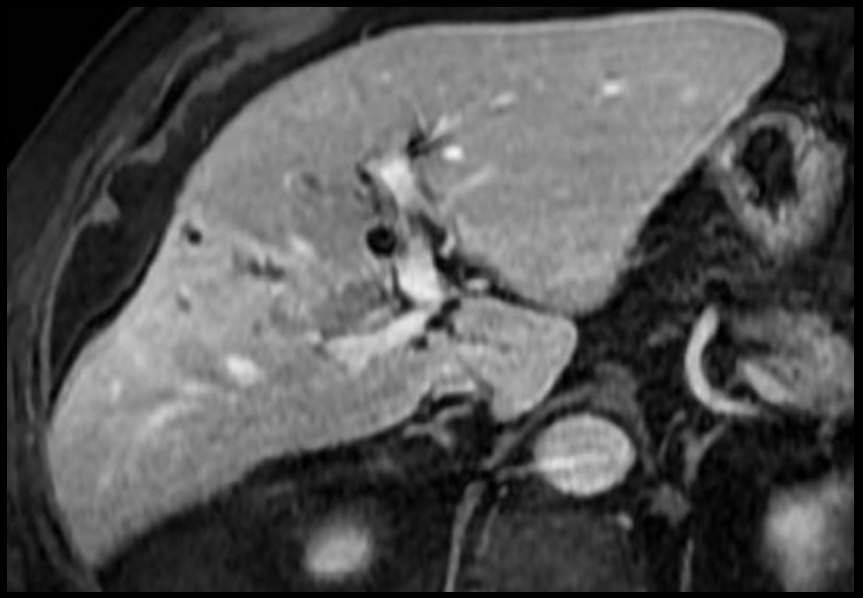


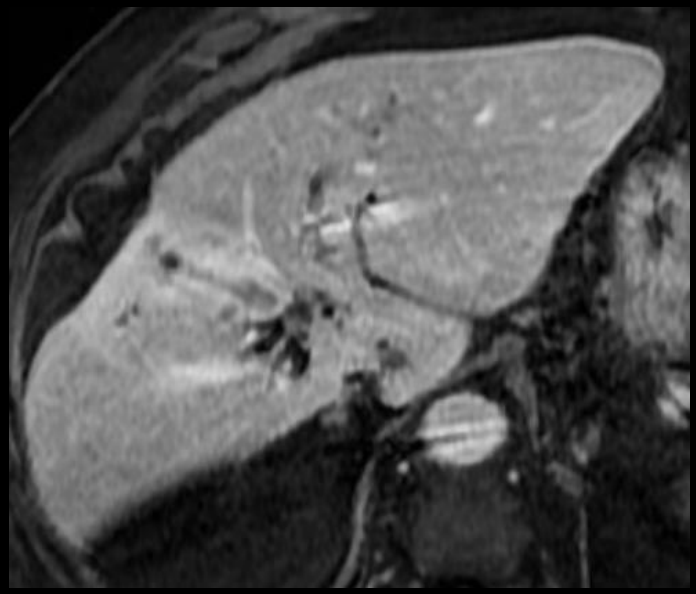
- Drainage biliaire
- Embolisation portale

Etat du parenchyme hépatique sous jacent

Morphologie

Volumétrie du parenchyme hépatique restant

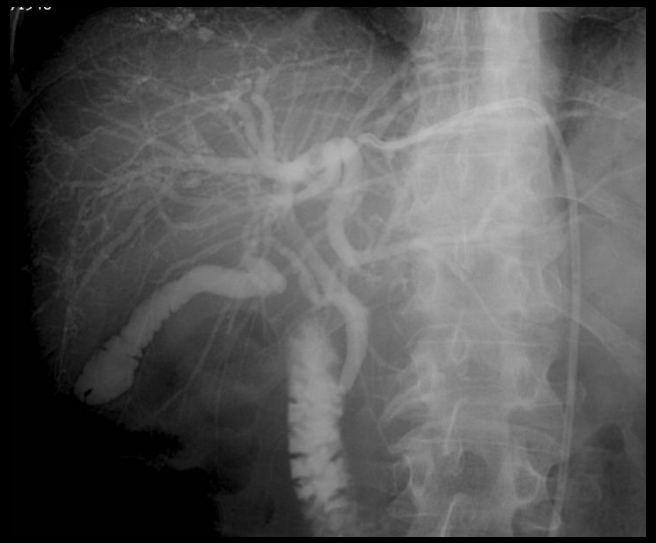


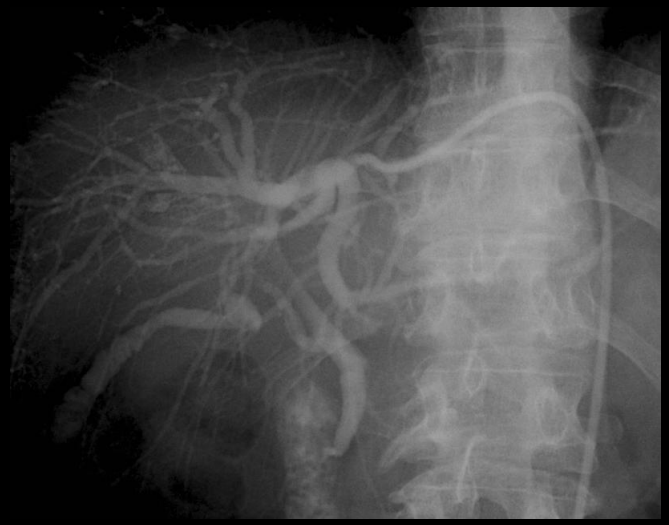


Place de la radiologie interventionnelle

Drainage

Embolisation portale





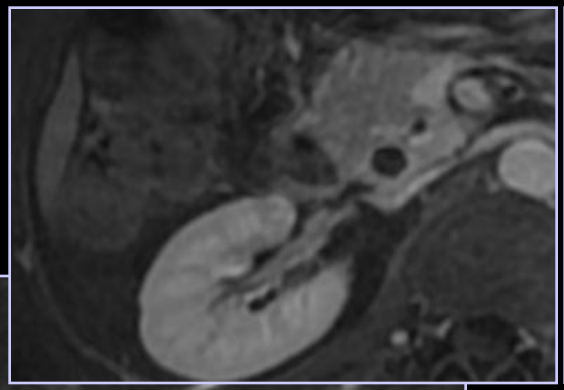
Plan

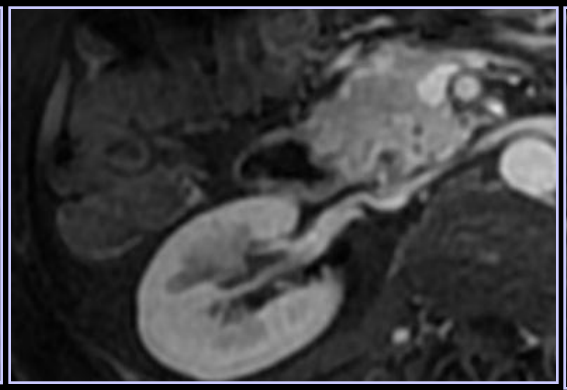
- **Tumeurs de la vésicule biliaire**
- **CCK IH**
- **CCK hilaires**
  - Diagnostic positif
  - Bilan d'extirpabilité
- **Tumeurs du bas cholédoque**

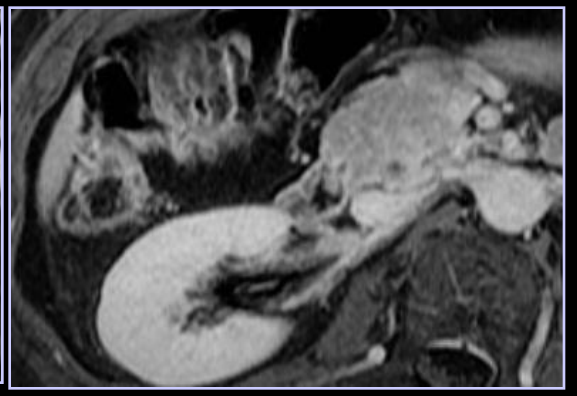
Cholangiocarcinomes du bas cholédoque

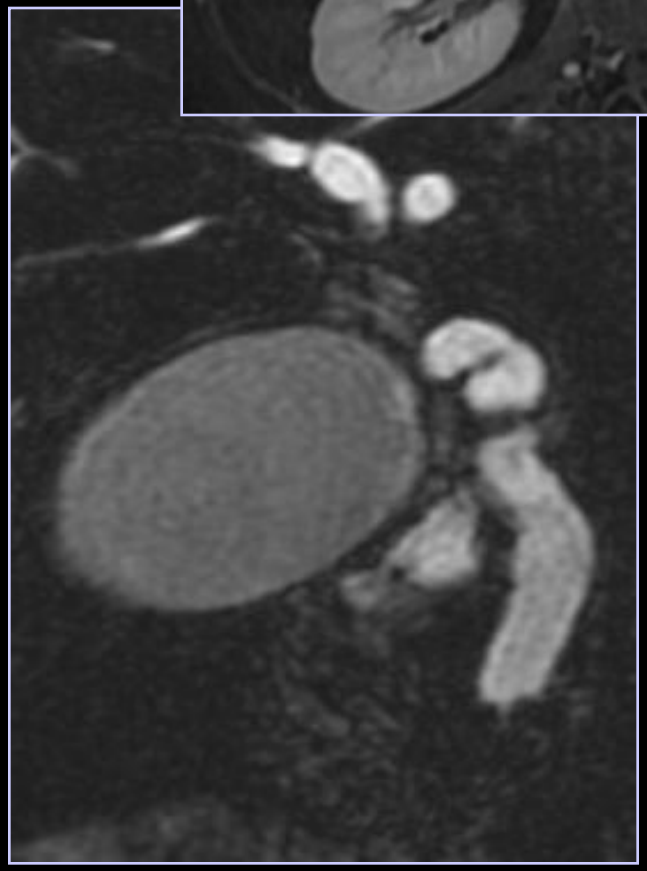
IV.Cholangiocarcinomes du bas cholédoque

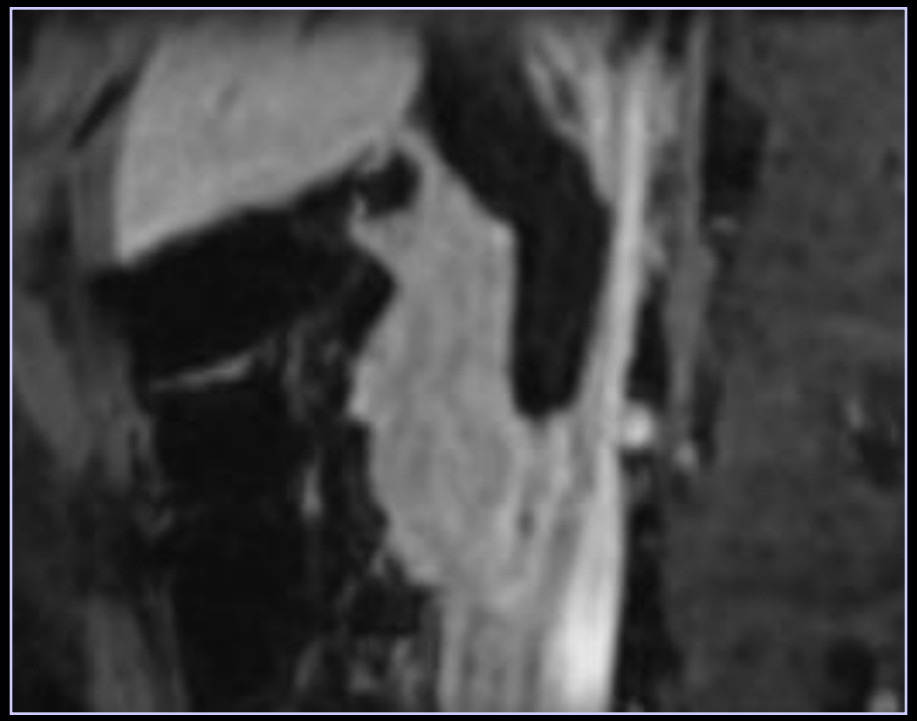
Forme infiltrative



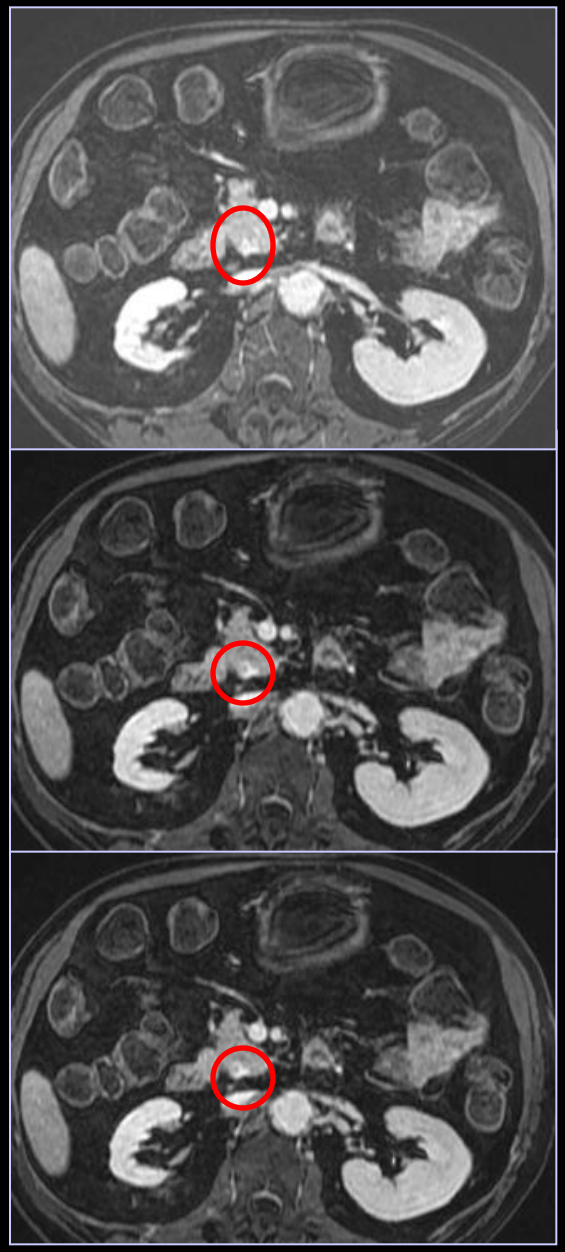




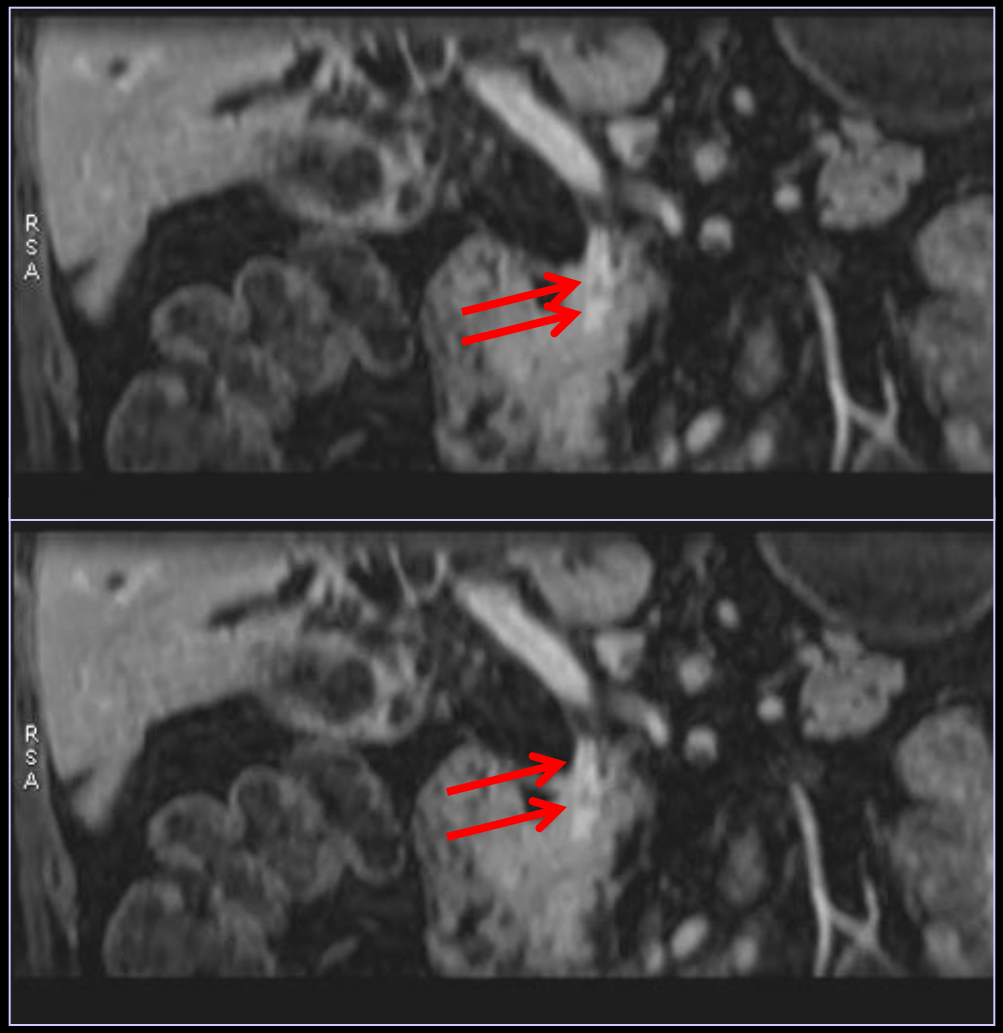




Cholangiocarcinomes du bas cholédoque

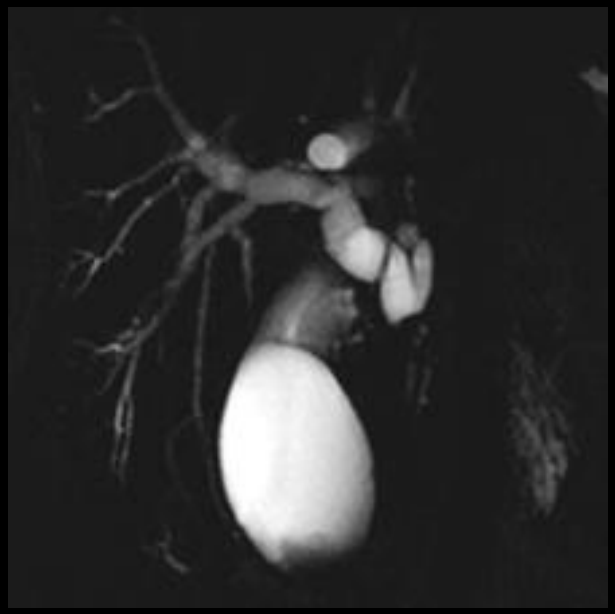


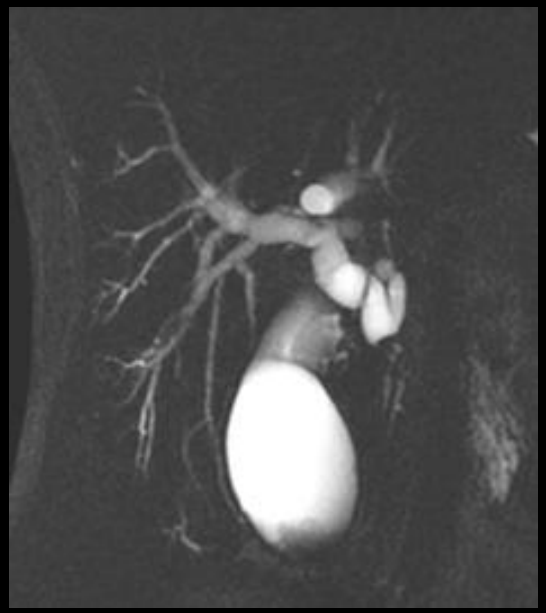
Forme infiltrative

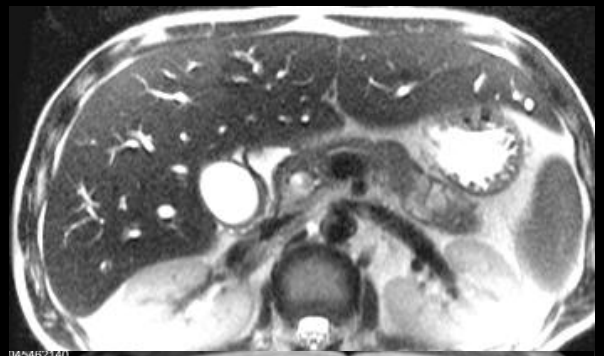


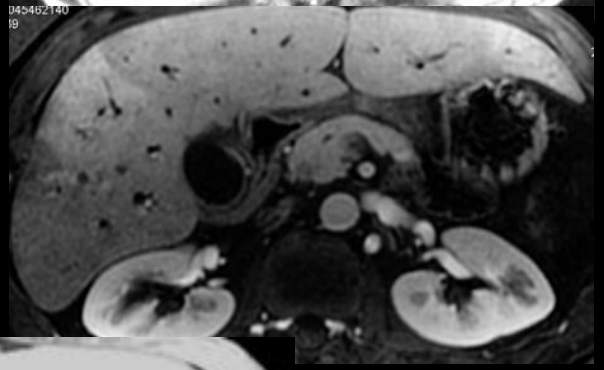
Cholangiocarcinomes du bas cholédoque

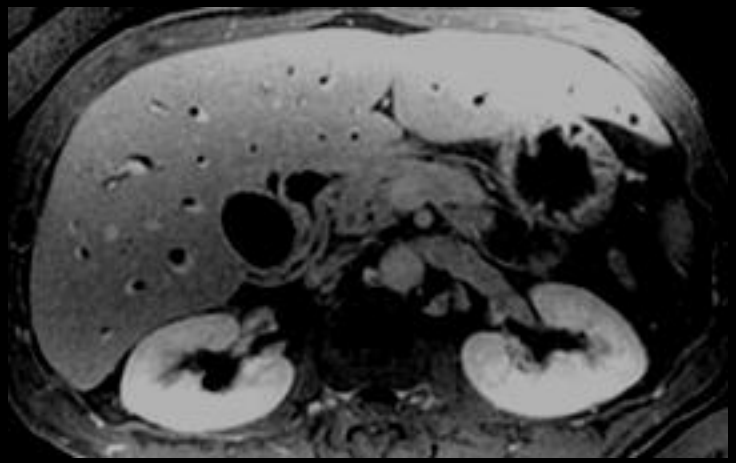
Diagnostic différentiel ADK pancréas

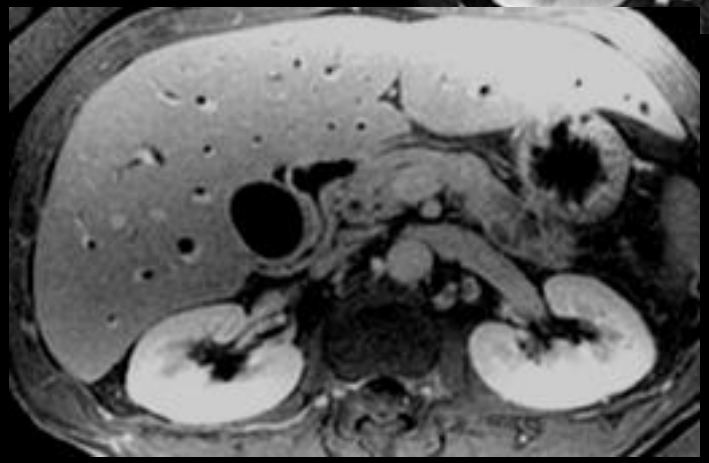




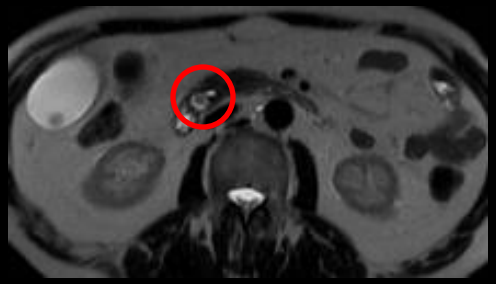


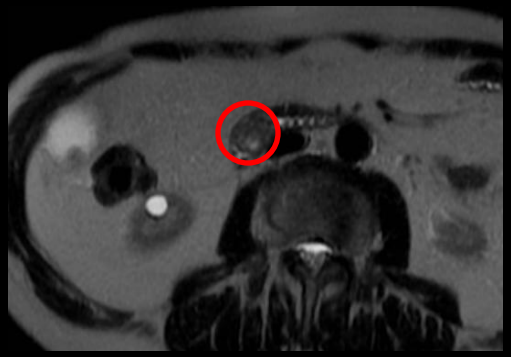


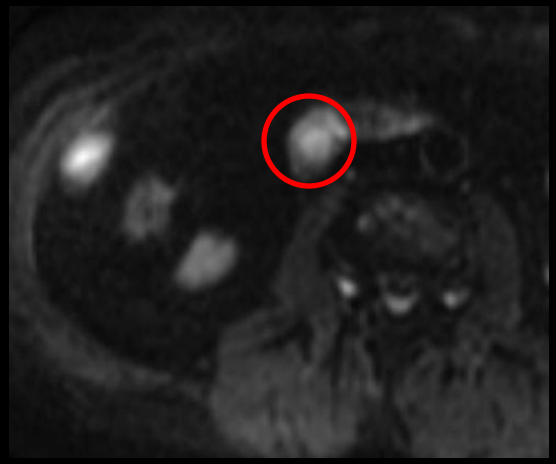


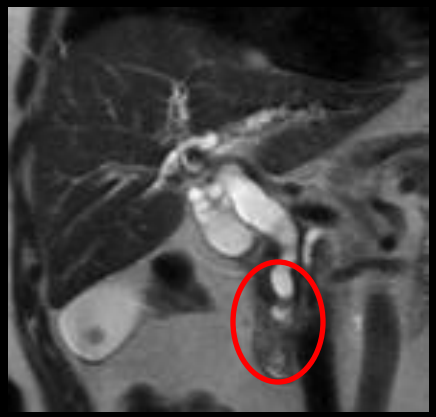


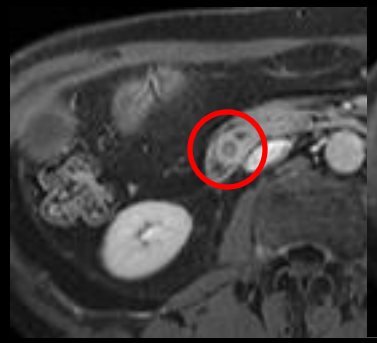
Ampullomes

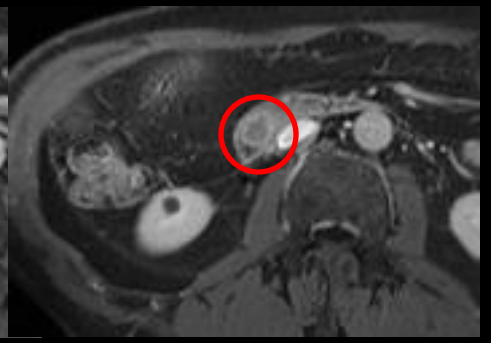


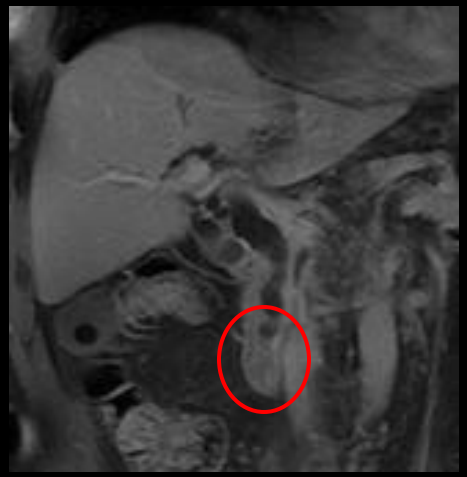


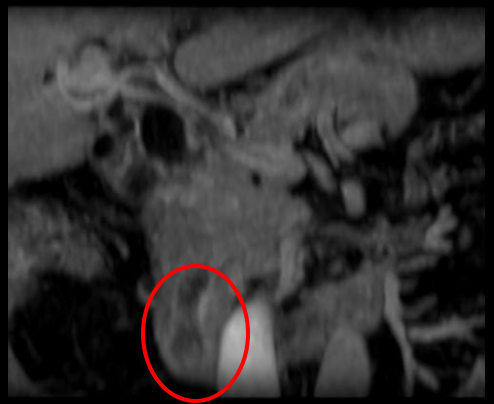




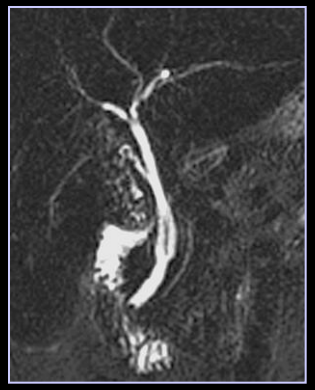




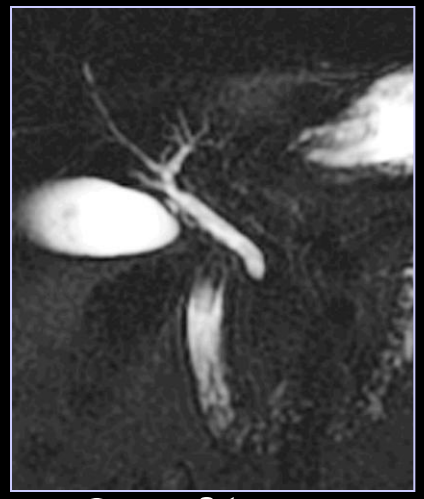




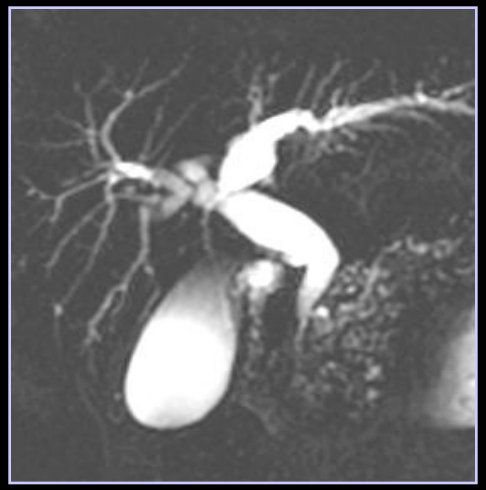
Sténoses bénignes



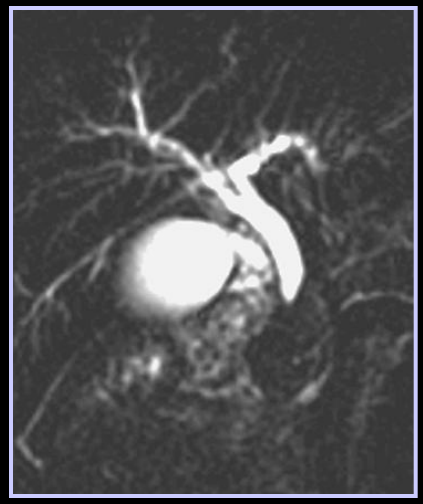
Lithiasique

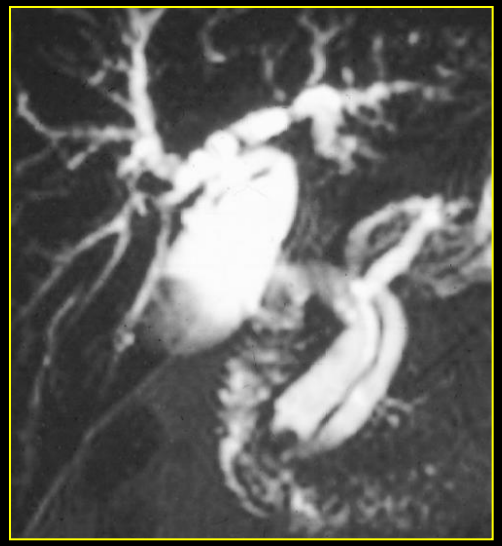


Oddite

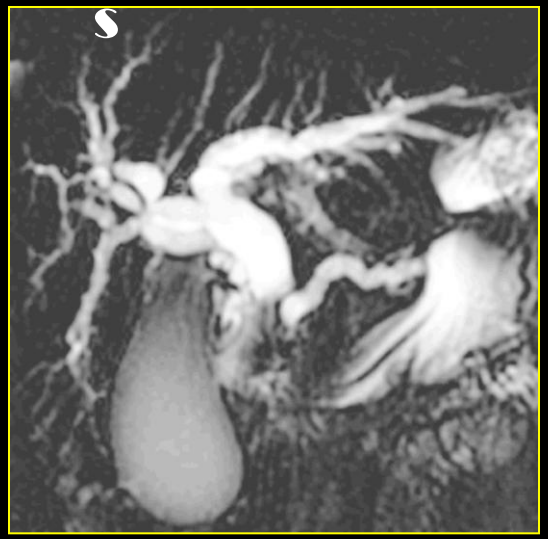


Pancréatites





Ampullome



ADK

Sténoses malignes

Conclusion

- **Masse hép centrée par la vésicule avec extension hilaire**
  - CCK vésiculaire
  - FDR : Long common channel
- **Epaississement irrégulier de la paroi vésiculaire**
  - CCK vésiculaire infiltrant
- **Masse IH : CCK IH**
  - Fibrose : temps tardifs +++
  - FDR : CSP
- **Obstacles de la VBP (hilaires et en dessous)**
  - Eliminer Causes extrinsèques bénignes et malignes
  - Sténose hilaire infiltration pariétale VB : CCK

Tout n'est pas du cancer !!!!! .....

Tumeurs endobiliaires rares

Papillomatose

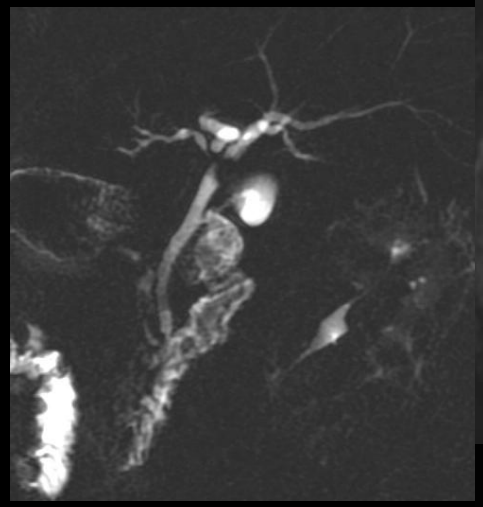
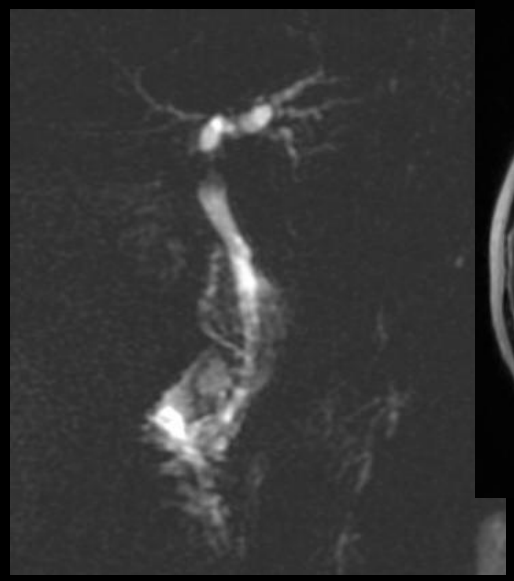
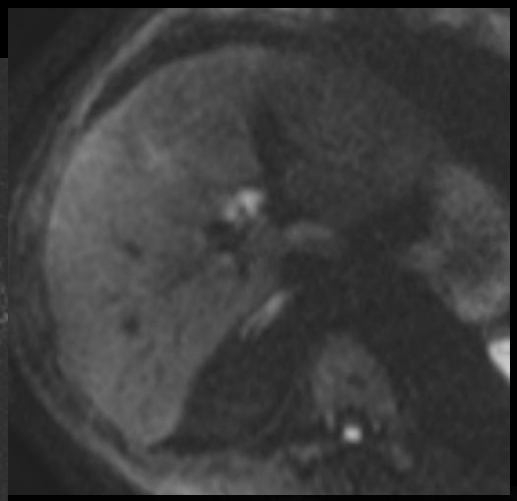
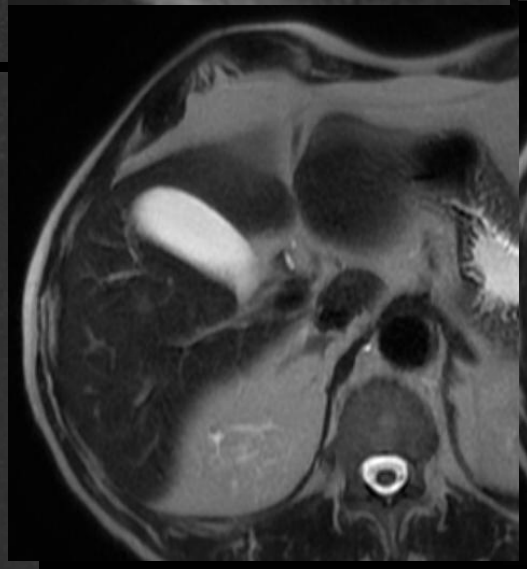
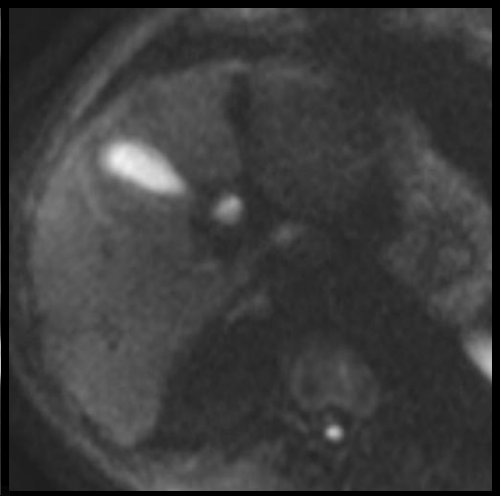
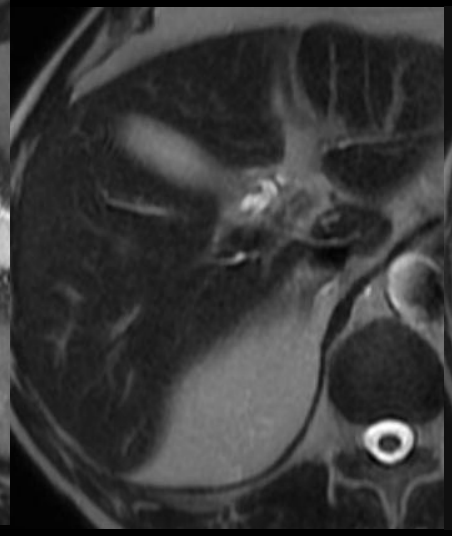
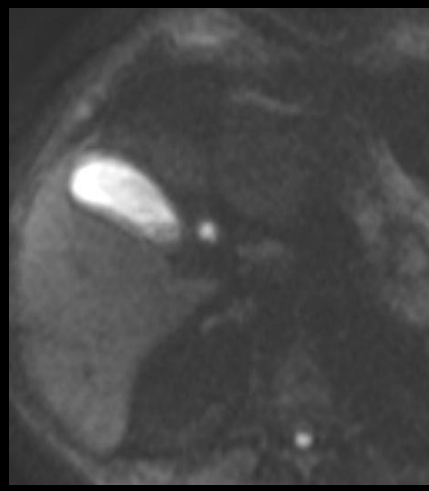
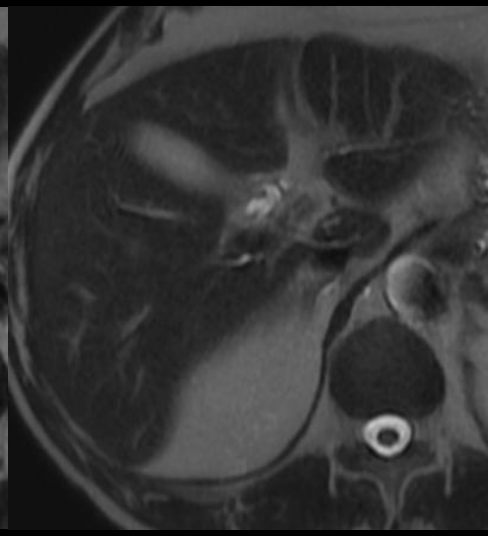
CHC à développement endobiliaire

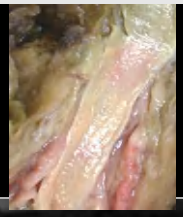
Métastases à développement endobiliaire

Papillomatose

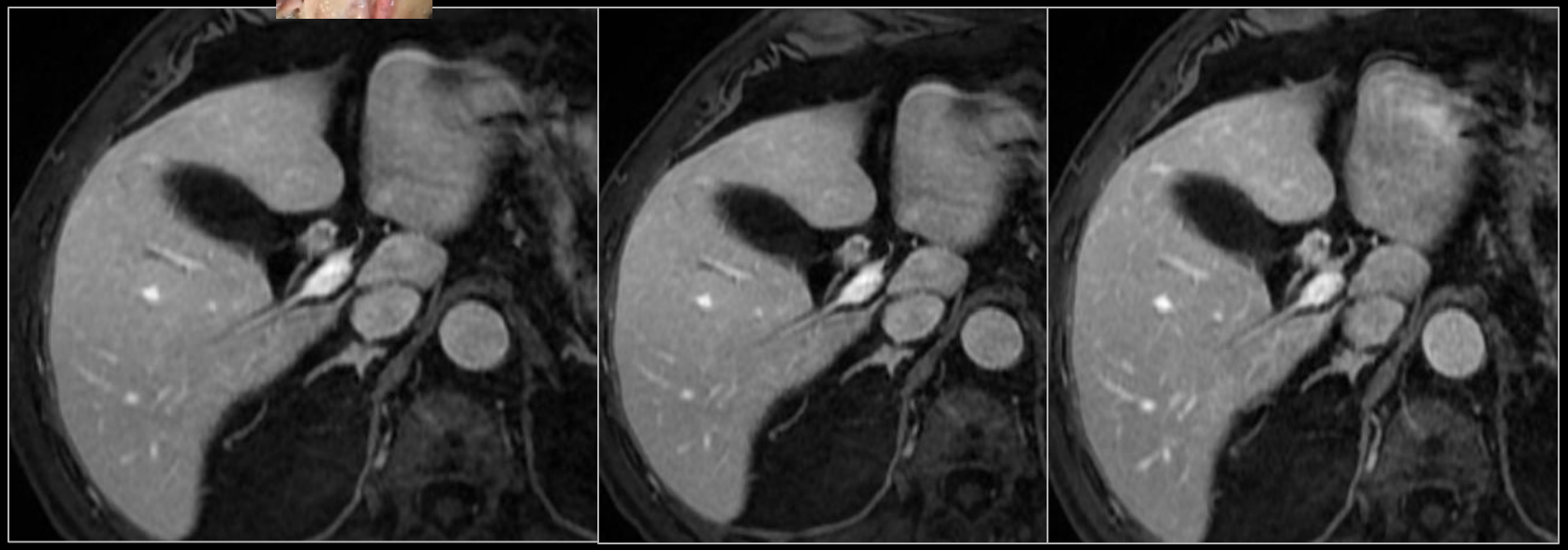
- Papillome biliaire : prolifération papillaire d'un épithélium biliaire atypique autour d'un axe fibro vasculaire
- Papillomatose : > 3 papillomes sur les VBIH ou EH, continue ou discontinue
- Degrés variables de dysplasie : de dysplasiques jusqu'à dégénérées
- 5 classes (différentes classes peuvent coexister)
  - Classes 1 et 2 : dysplasies de bas et de haut grade
  - Classes 3 : carcinome in situ
  - Classes 4 et 5 : invasion micro et macro du parenchyme hépatique et ou des couches fibro musculaires de la paroi biliaire
- Papillomatoses sécrétantes (dialtations en amont et en aval de l'obstacle) et non sécrétantes
- TTT chirurgical , transplantation hépatique envisageable pour les classes 1 et 2 voire 3

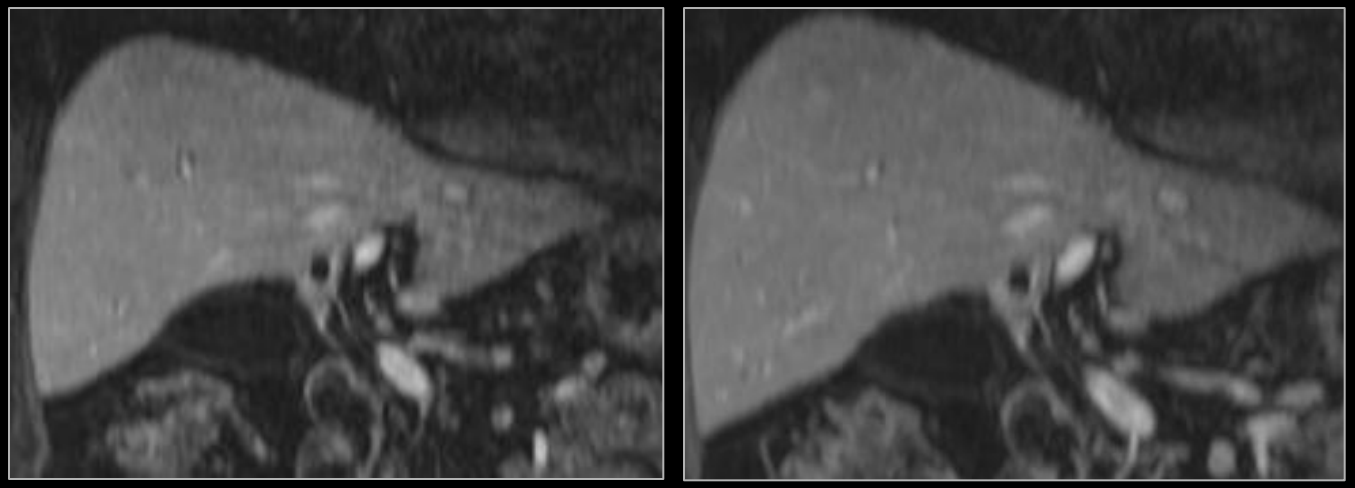
Papillomatose

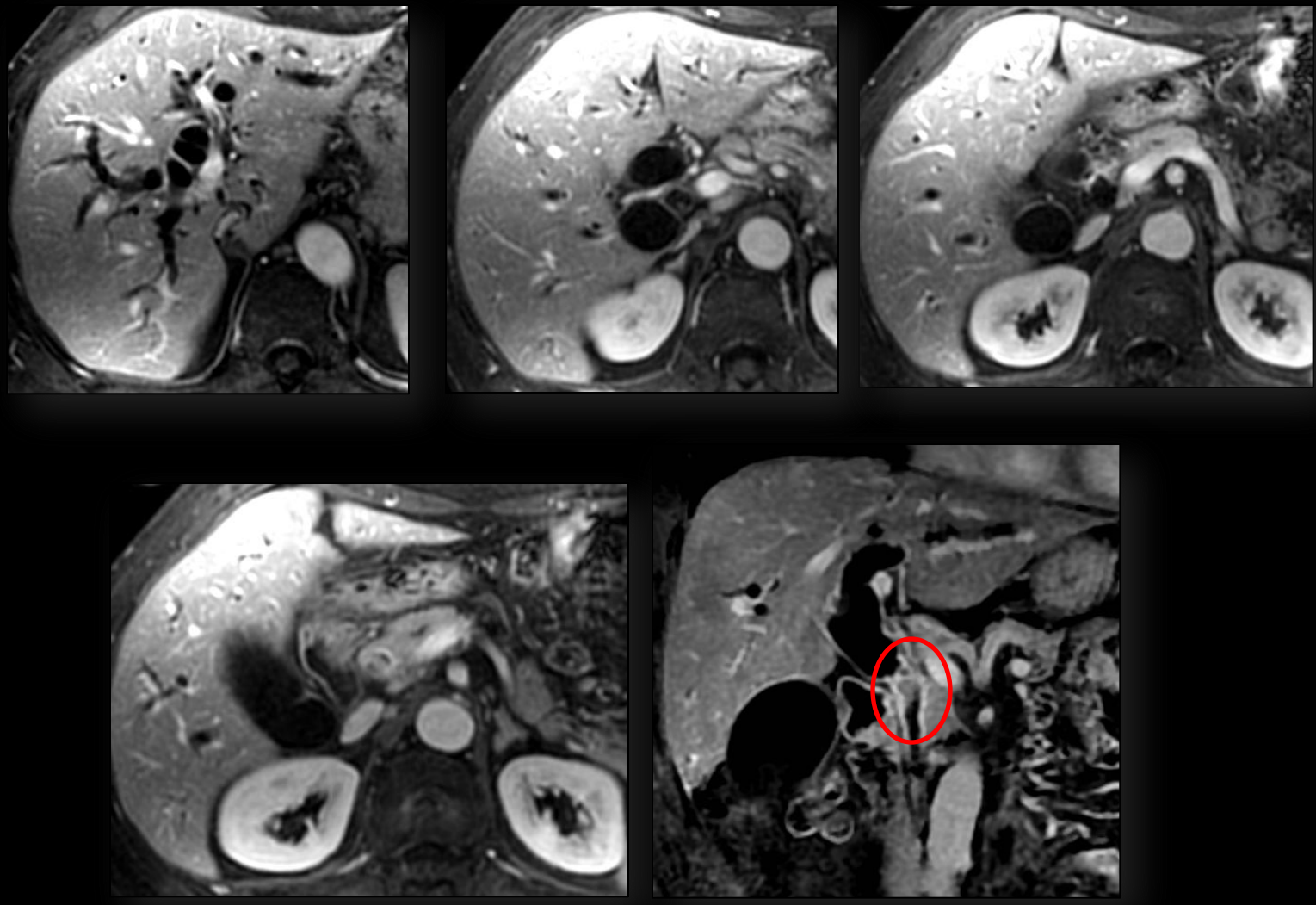


Papillome

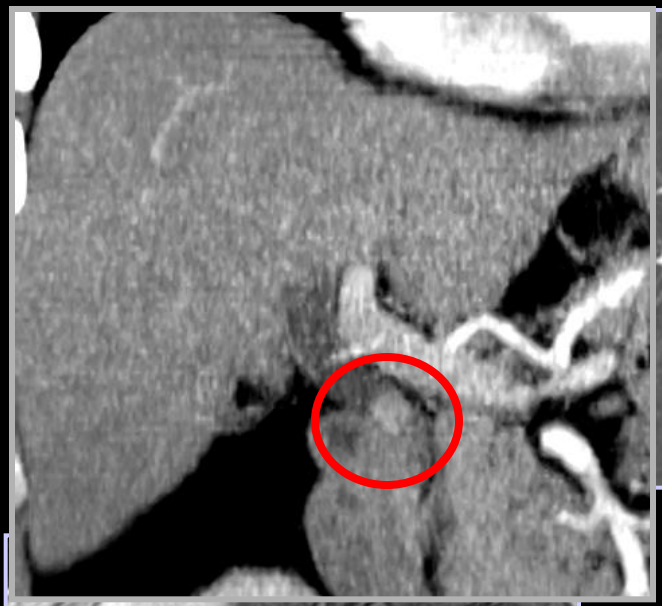


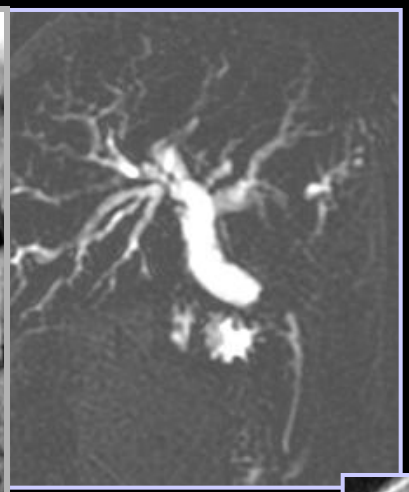


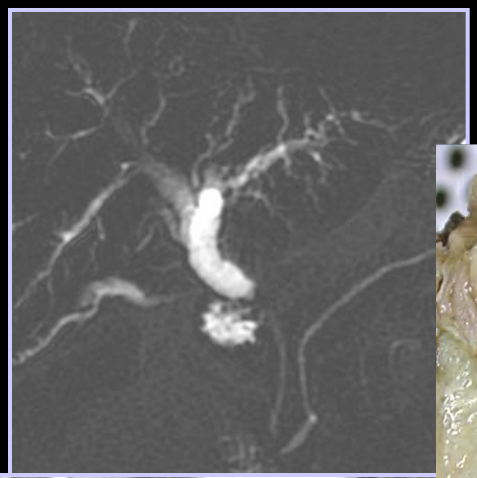
Papillomatose

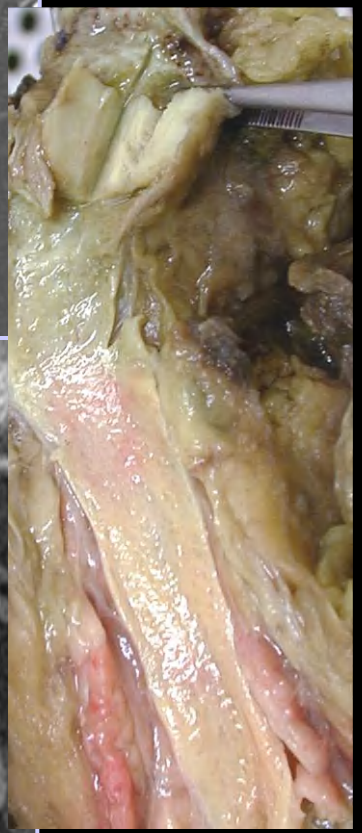


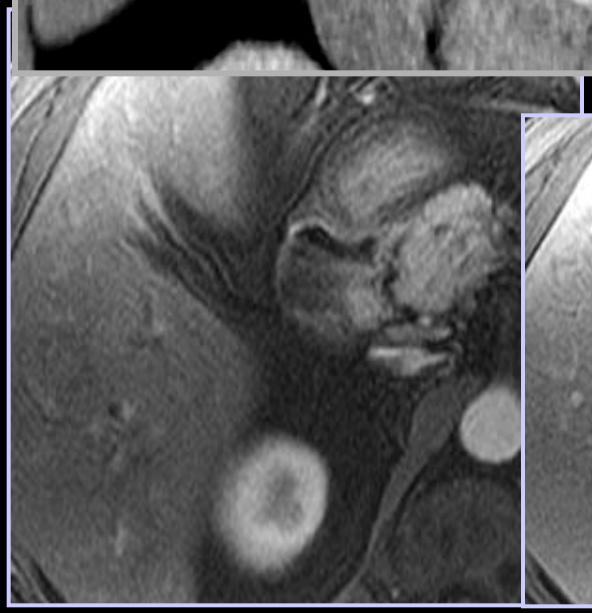
Tumeurs endobiliaires rares

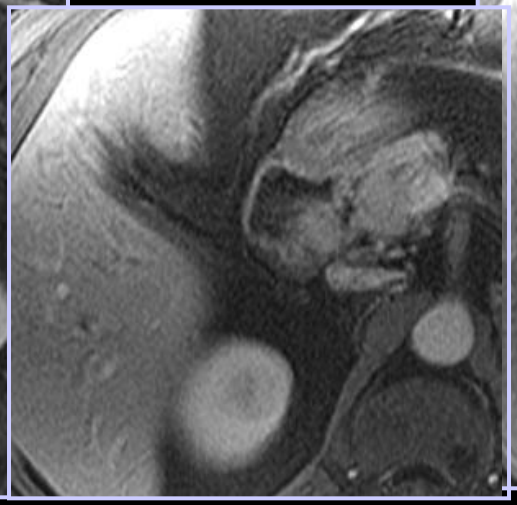


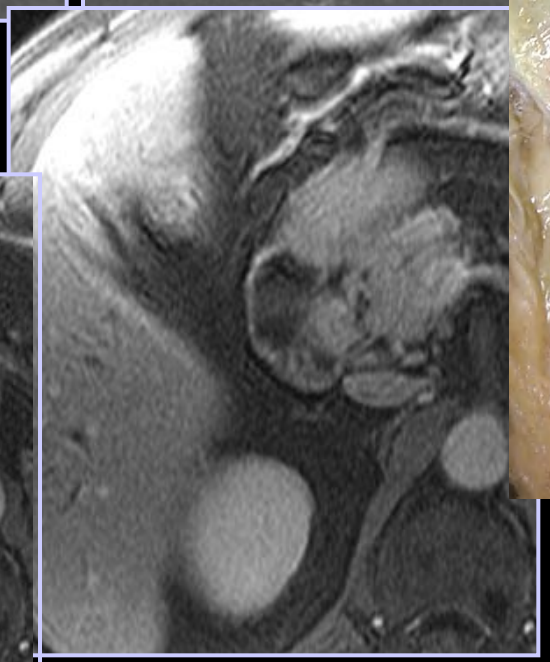


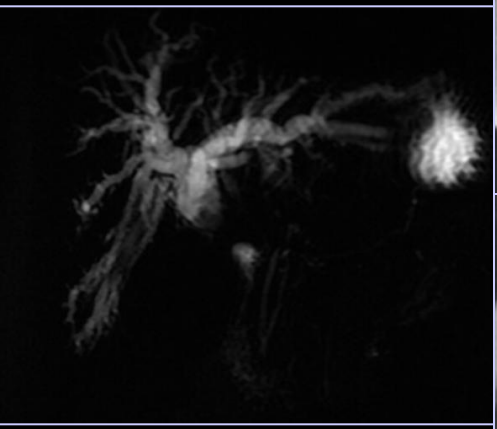


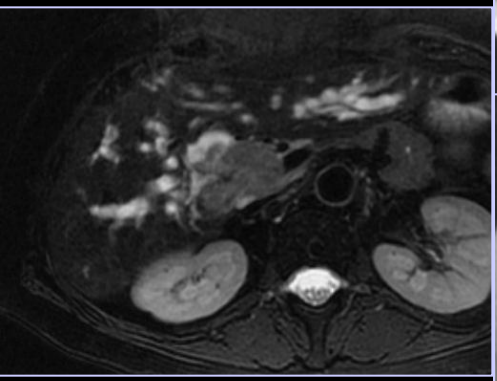


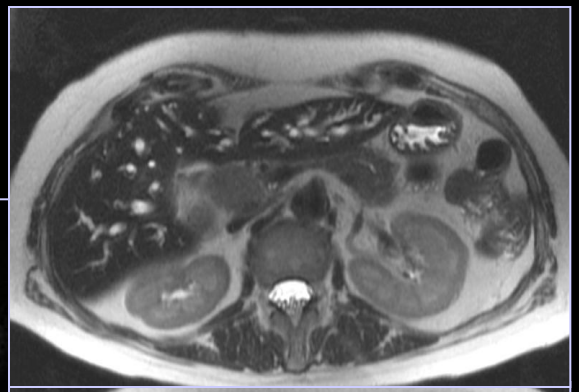


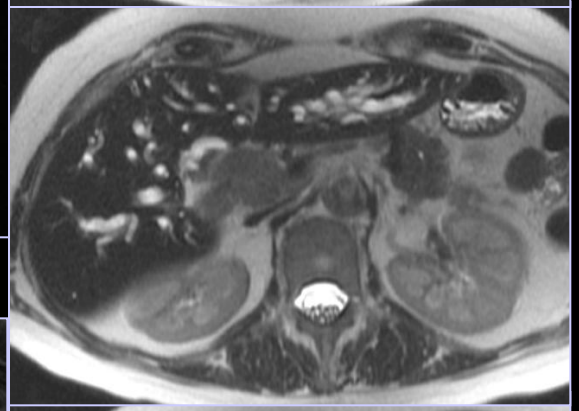


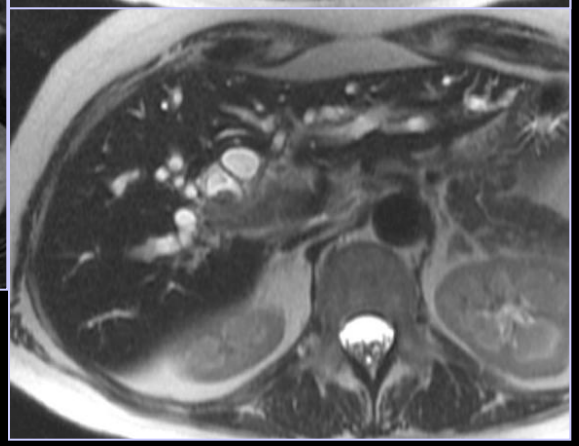




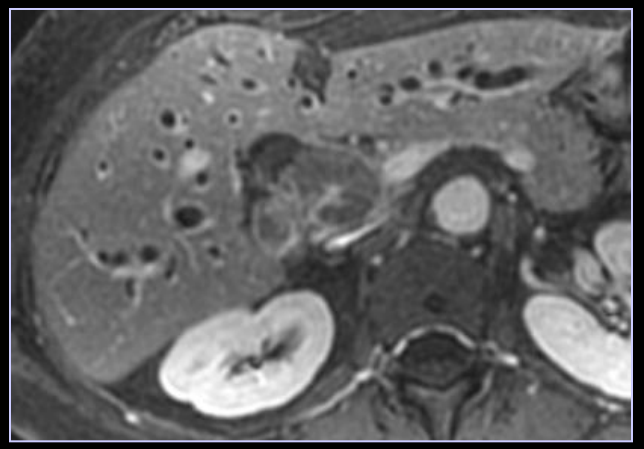


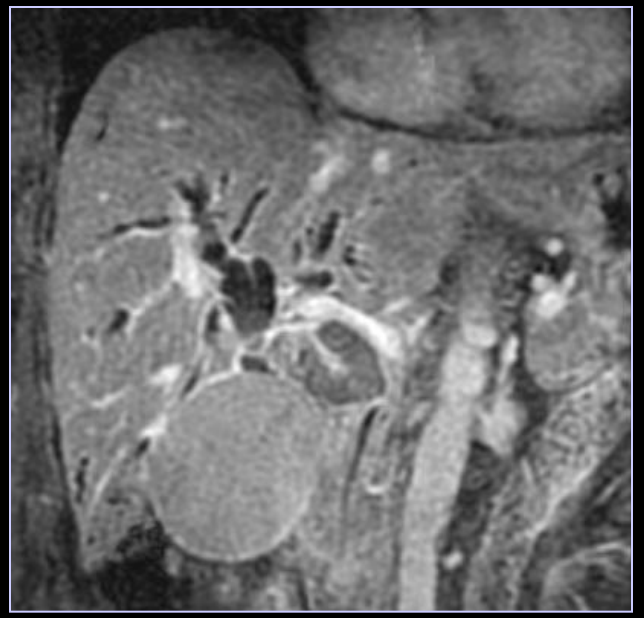






Papillomatose



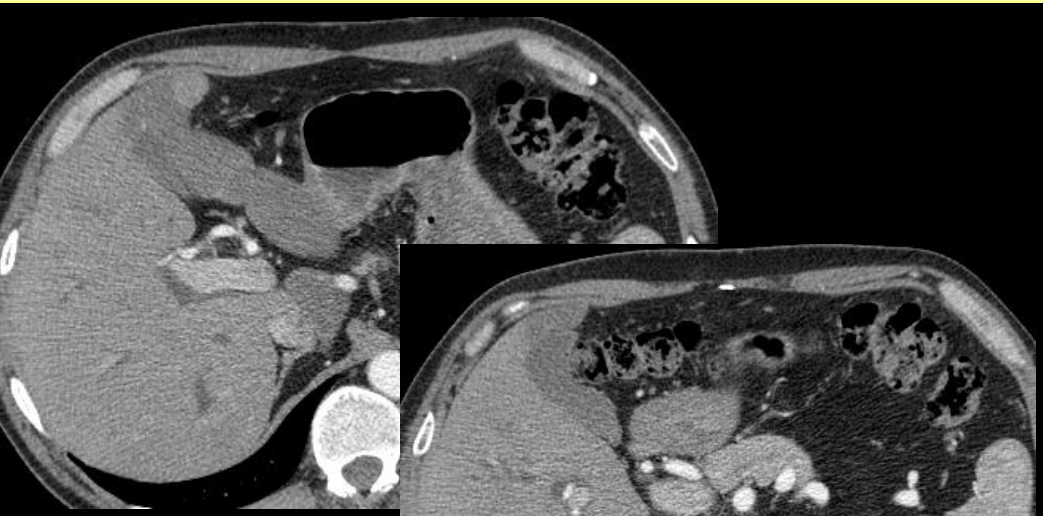


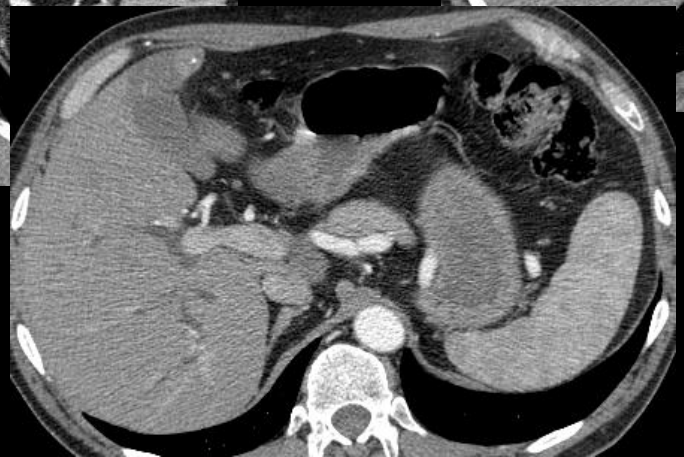
Papillomatose

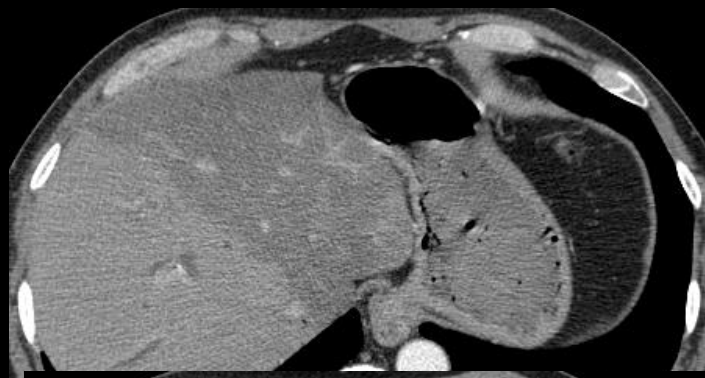
Homme 56 ans

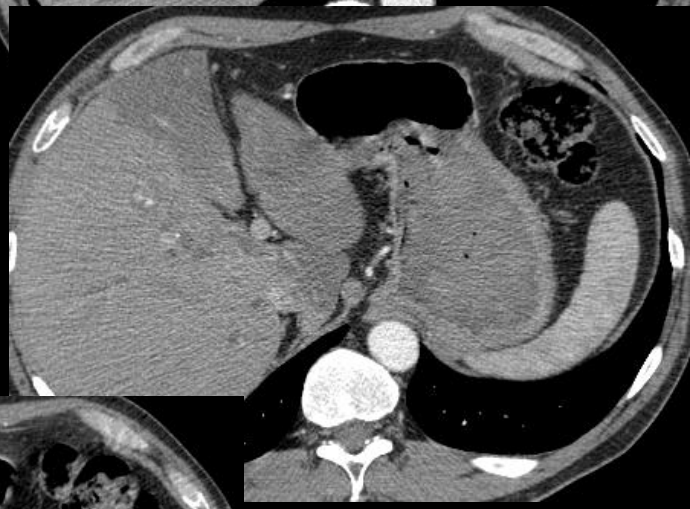
Ictère associé à un prurit majeur

Topographie obstacle ? Nature ?

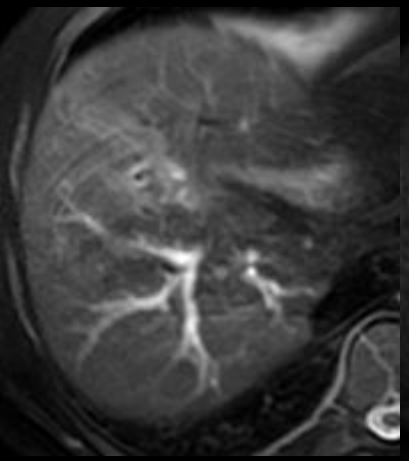
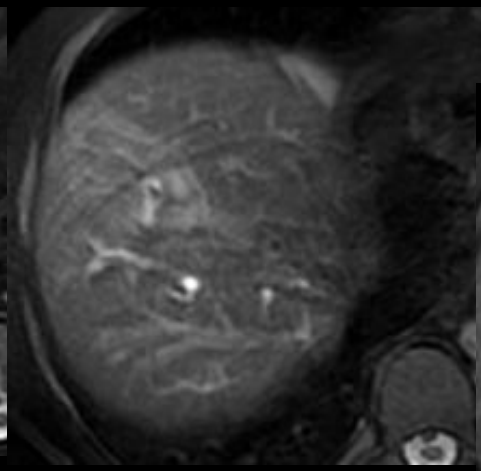
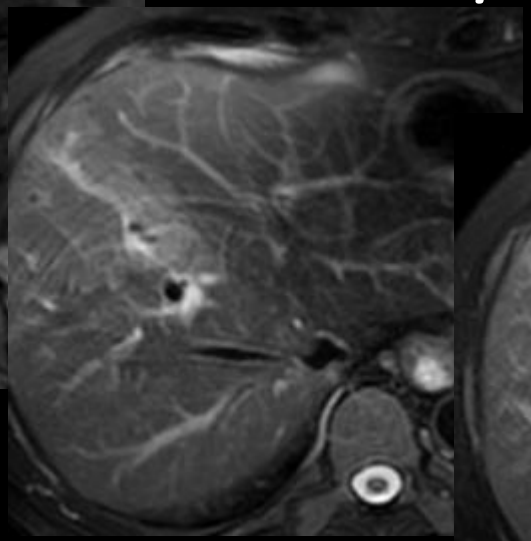
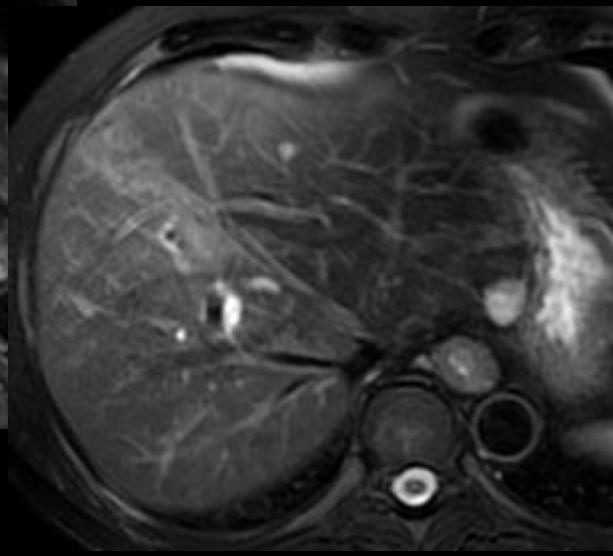
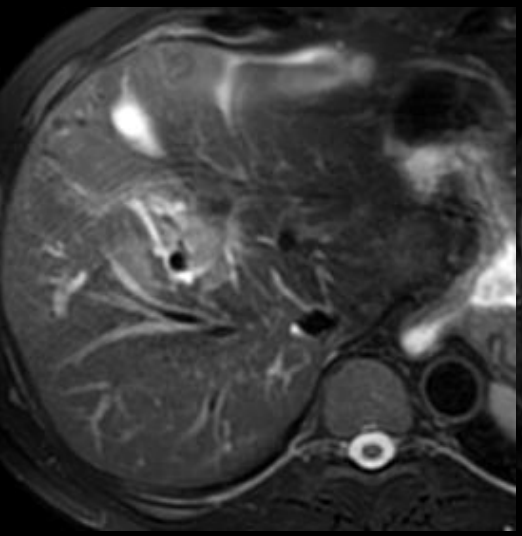
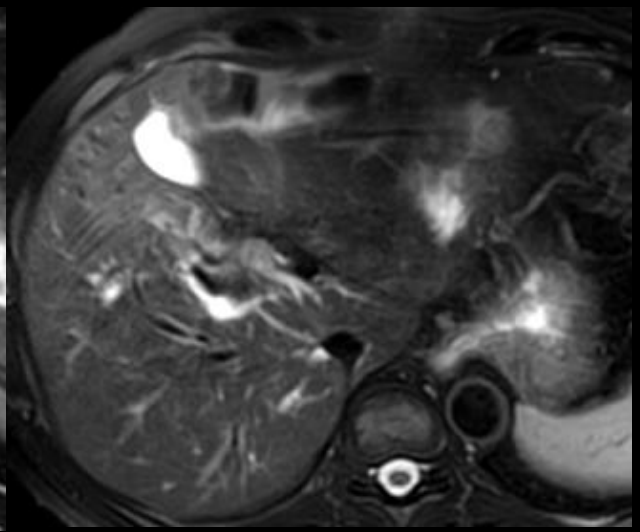
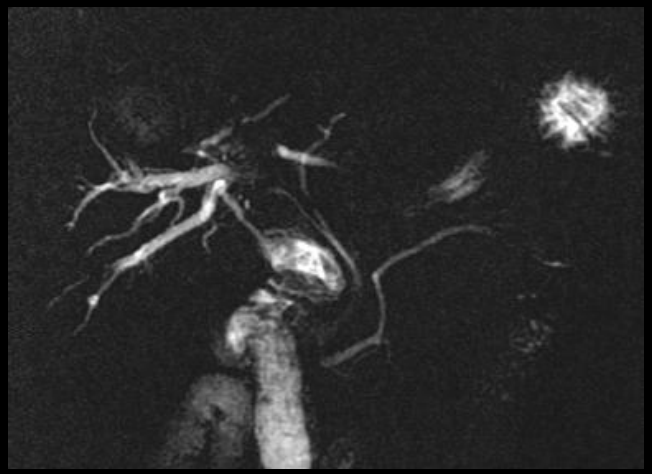




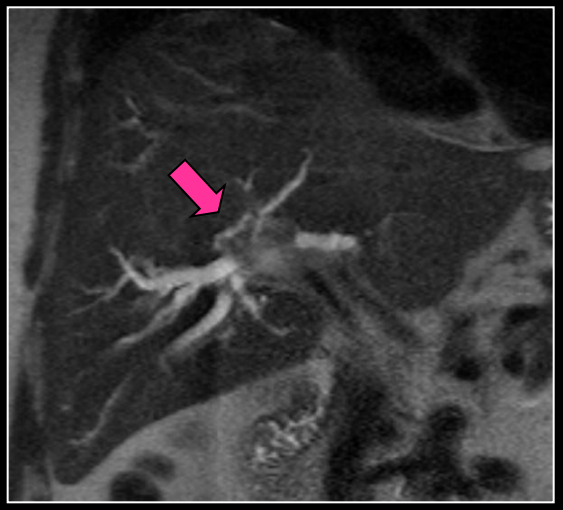


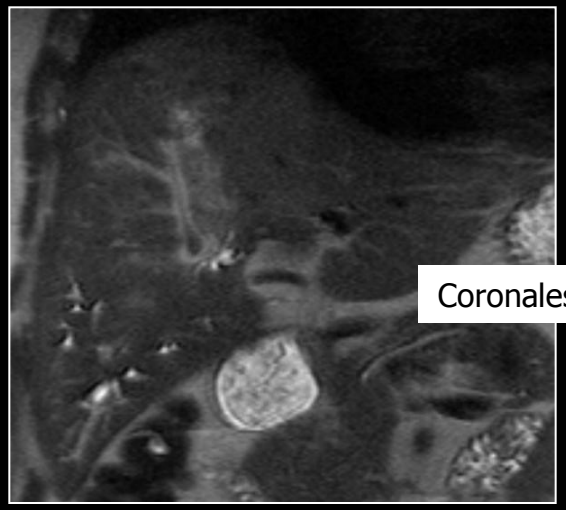


Papillomatose

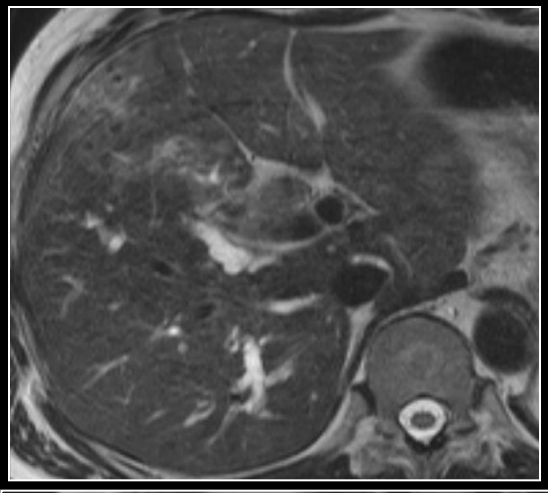








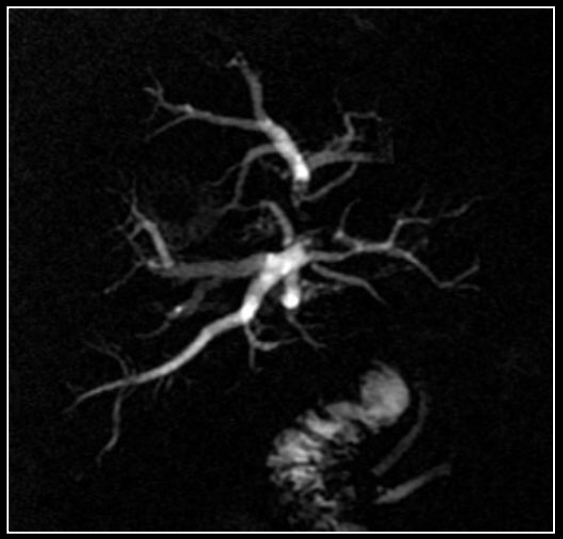
Papillomatose

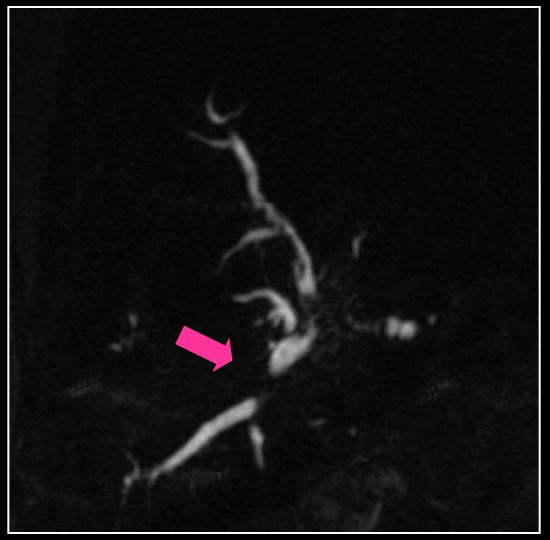


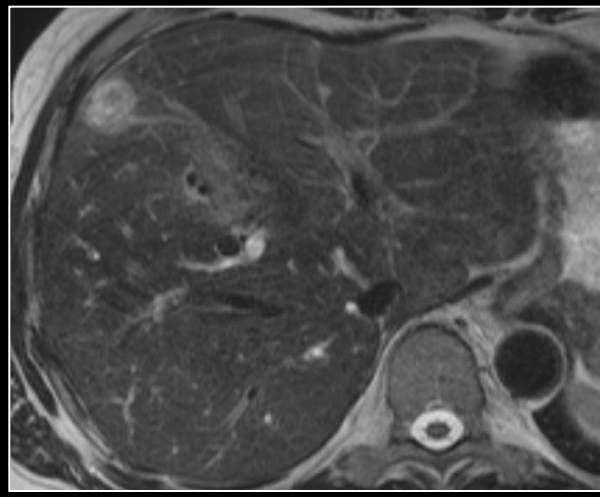


Coronales T2



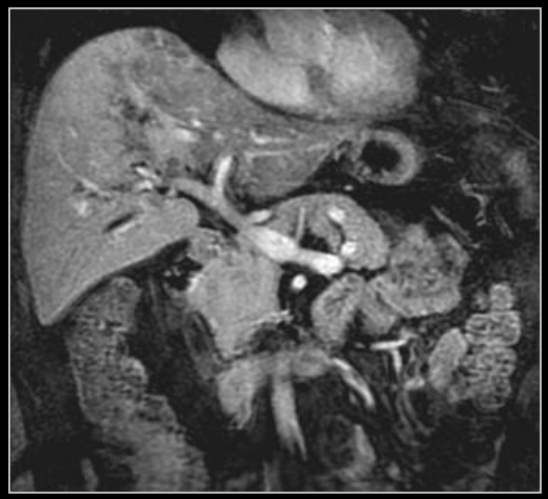
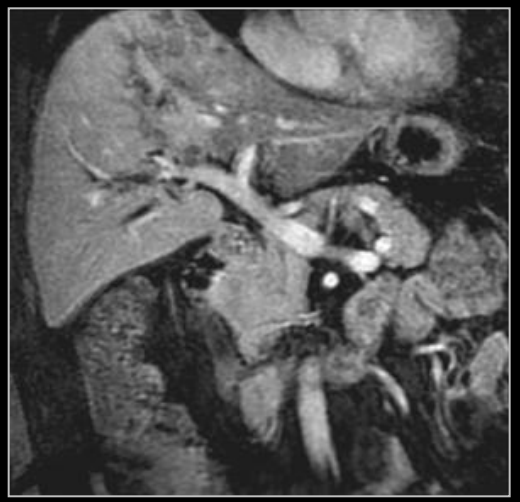
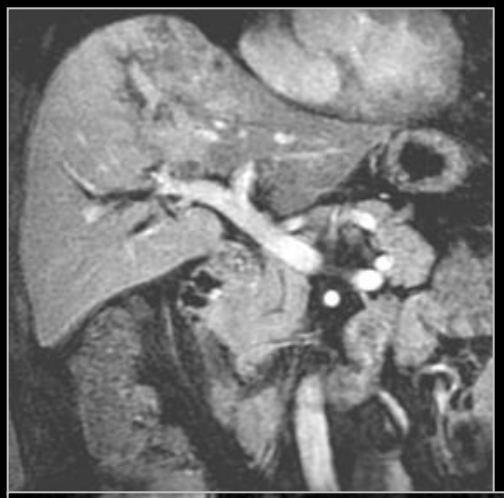
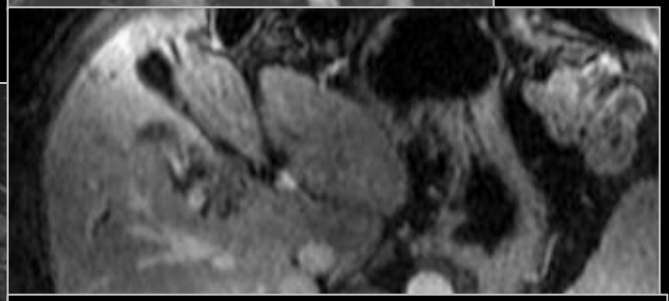
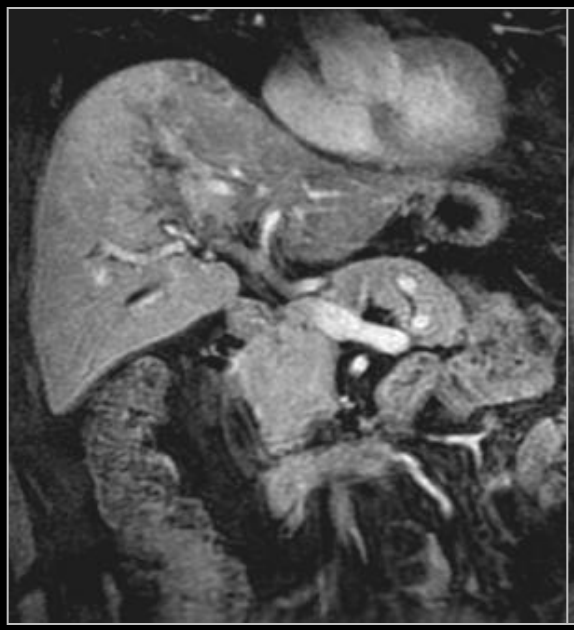
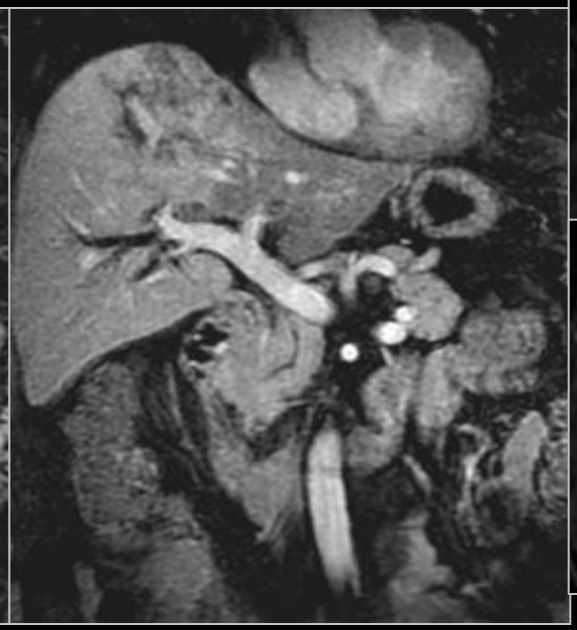
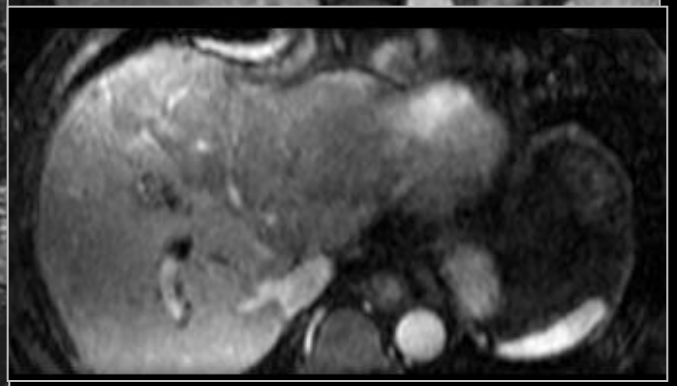


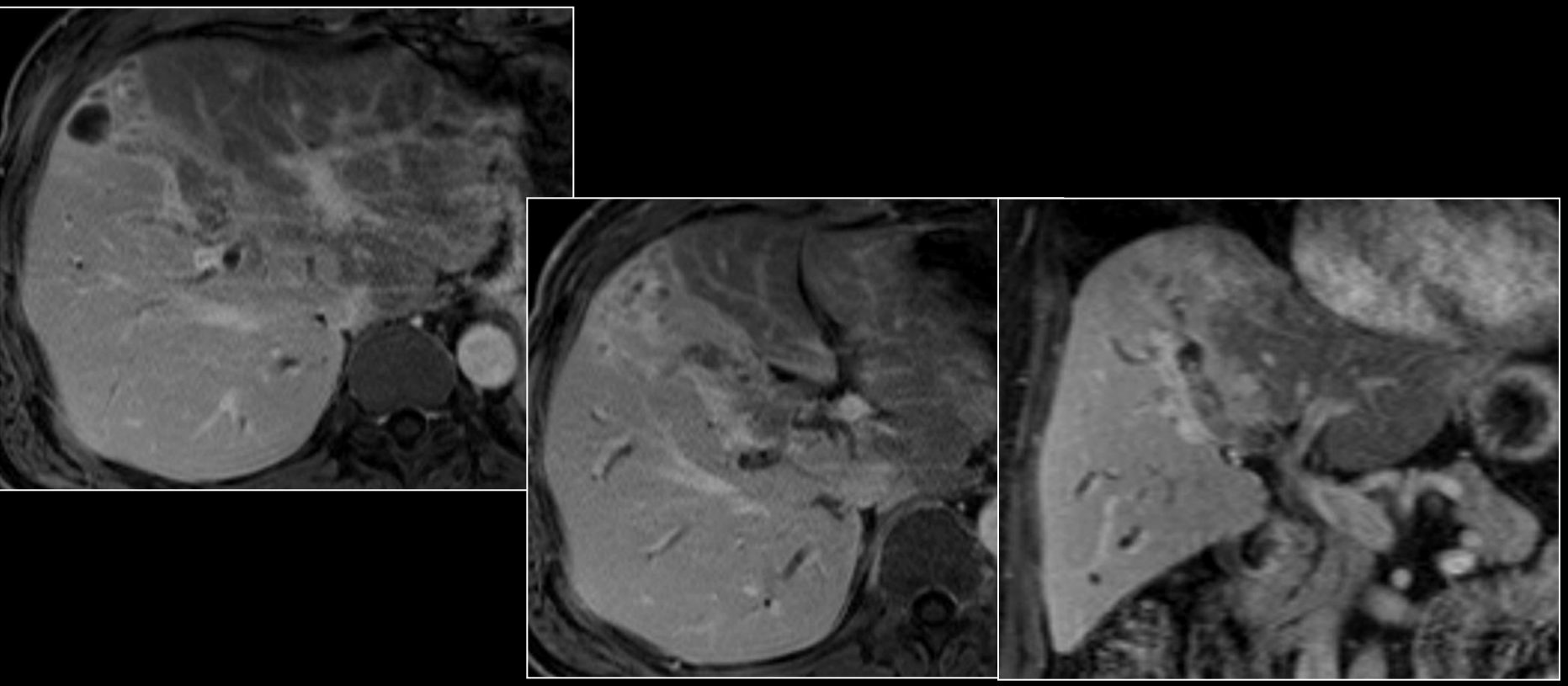




Radiaires SSFSE T2 TE long

Tumeurs endobiliaires rares



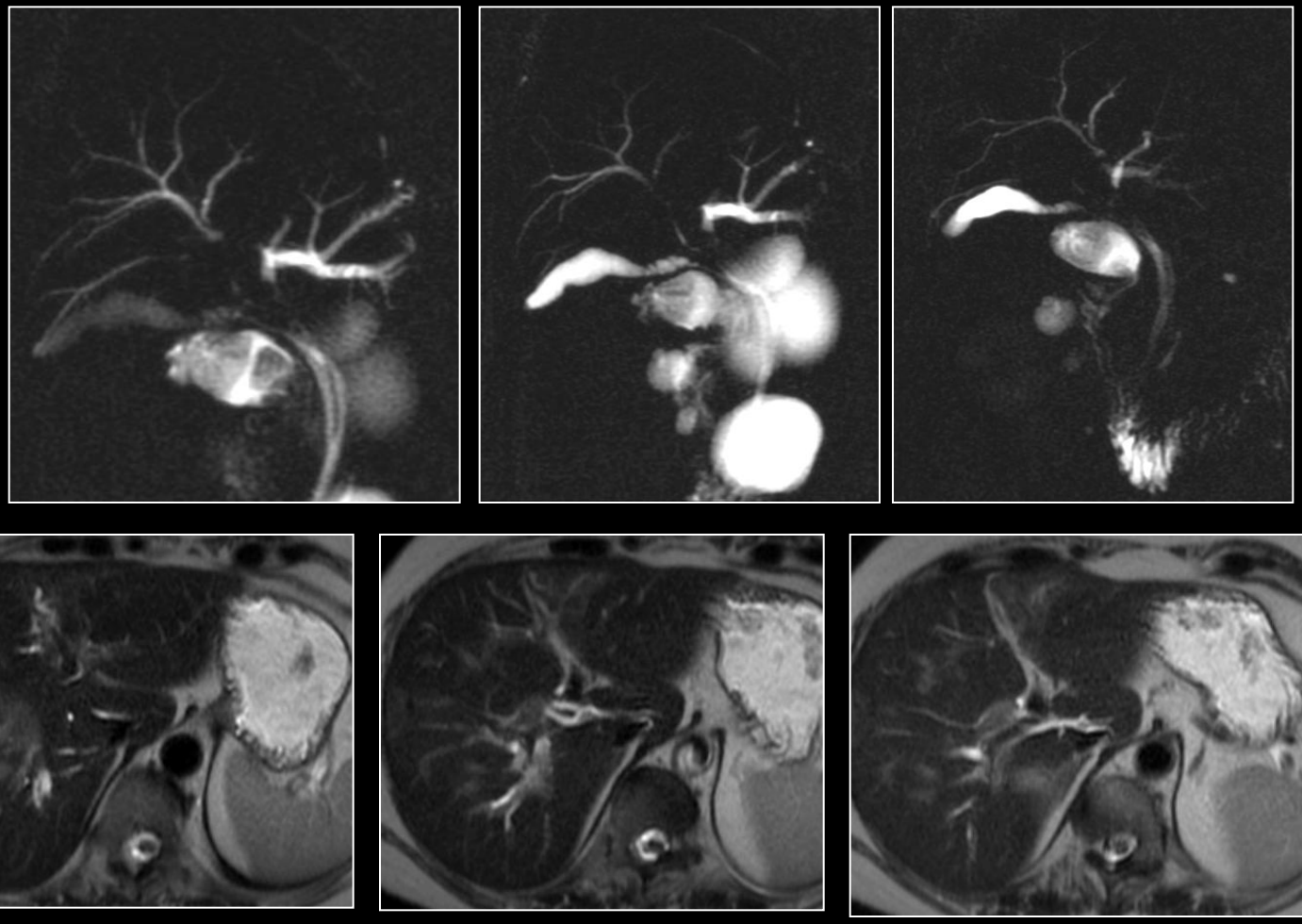
Papillomatose

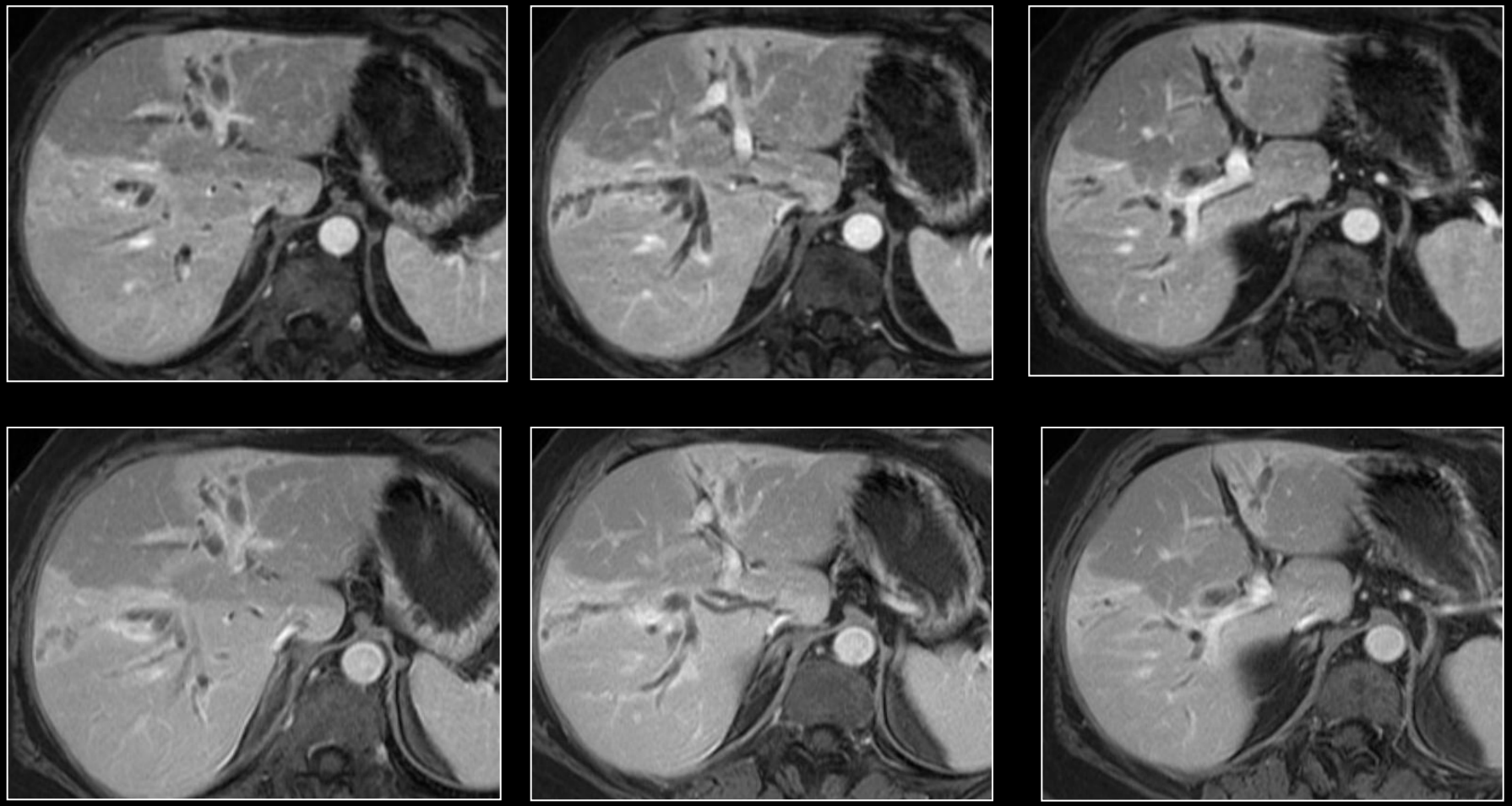
Le patient a bénéficié d'une transplantation hépatique

Tumeurs endobiliaires rares

Altération de l'état général et cholestase biologique chez une patiente opérée 3 ans auparavant d'un adénocarcinome colique.

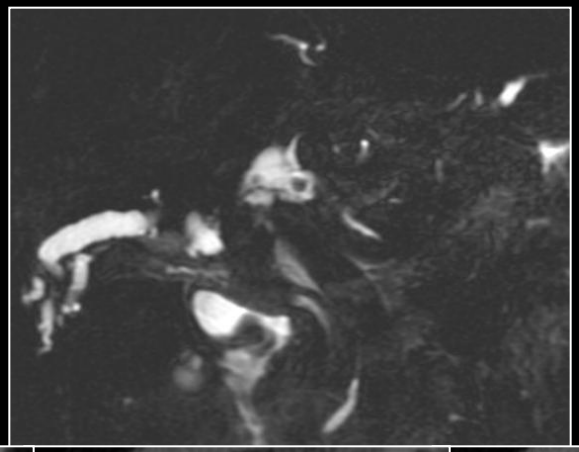
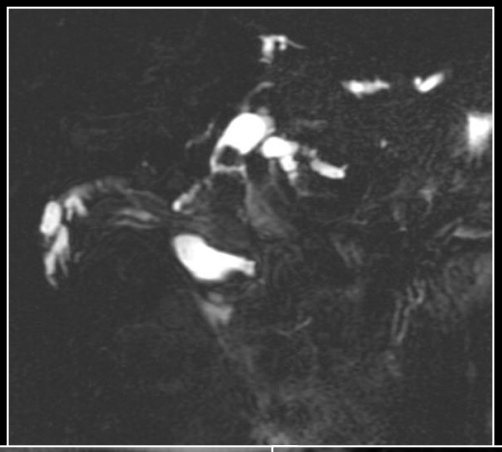
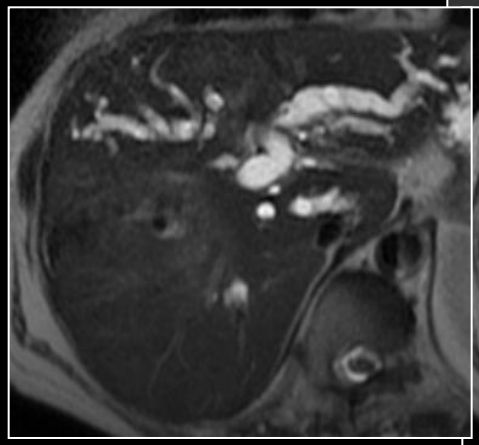
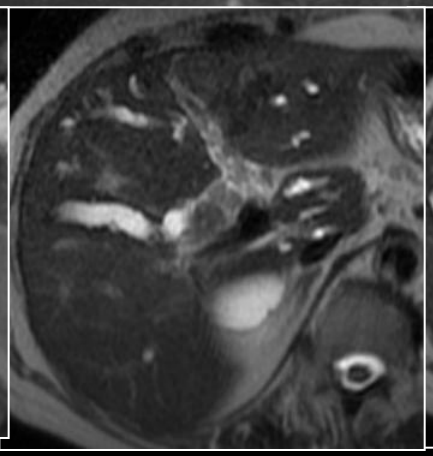
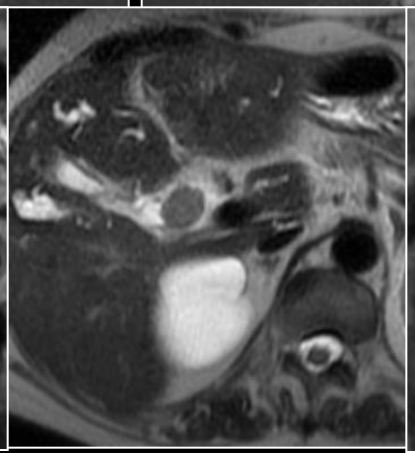
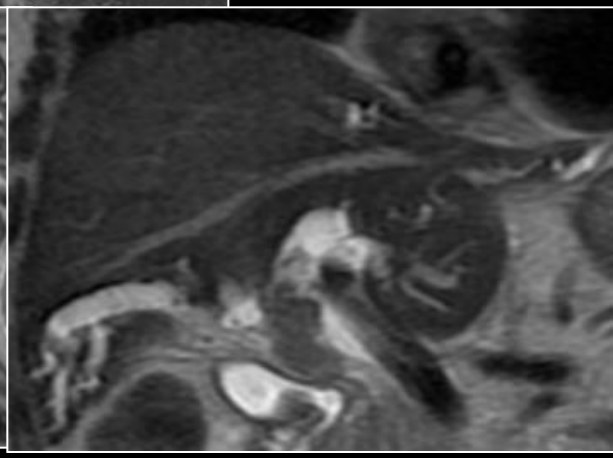
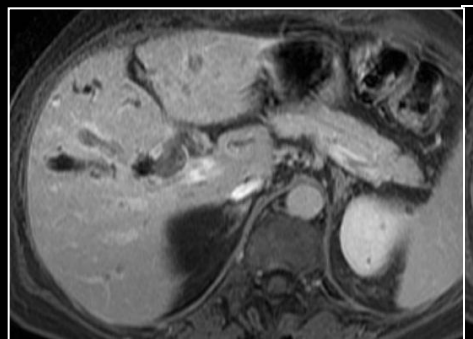
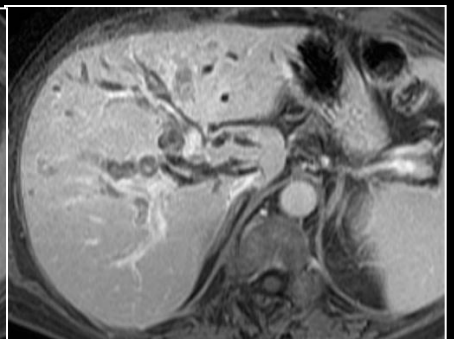
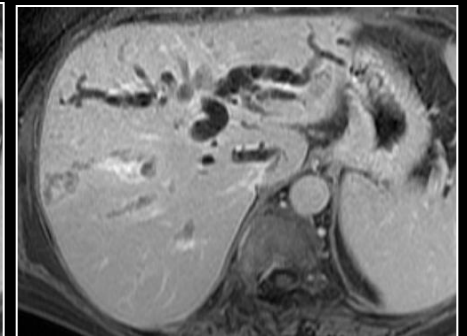
La coloscopie est normale.



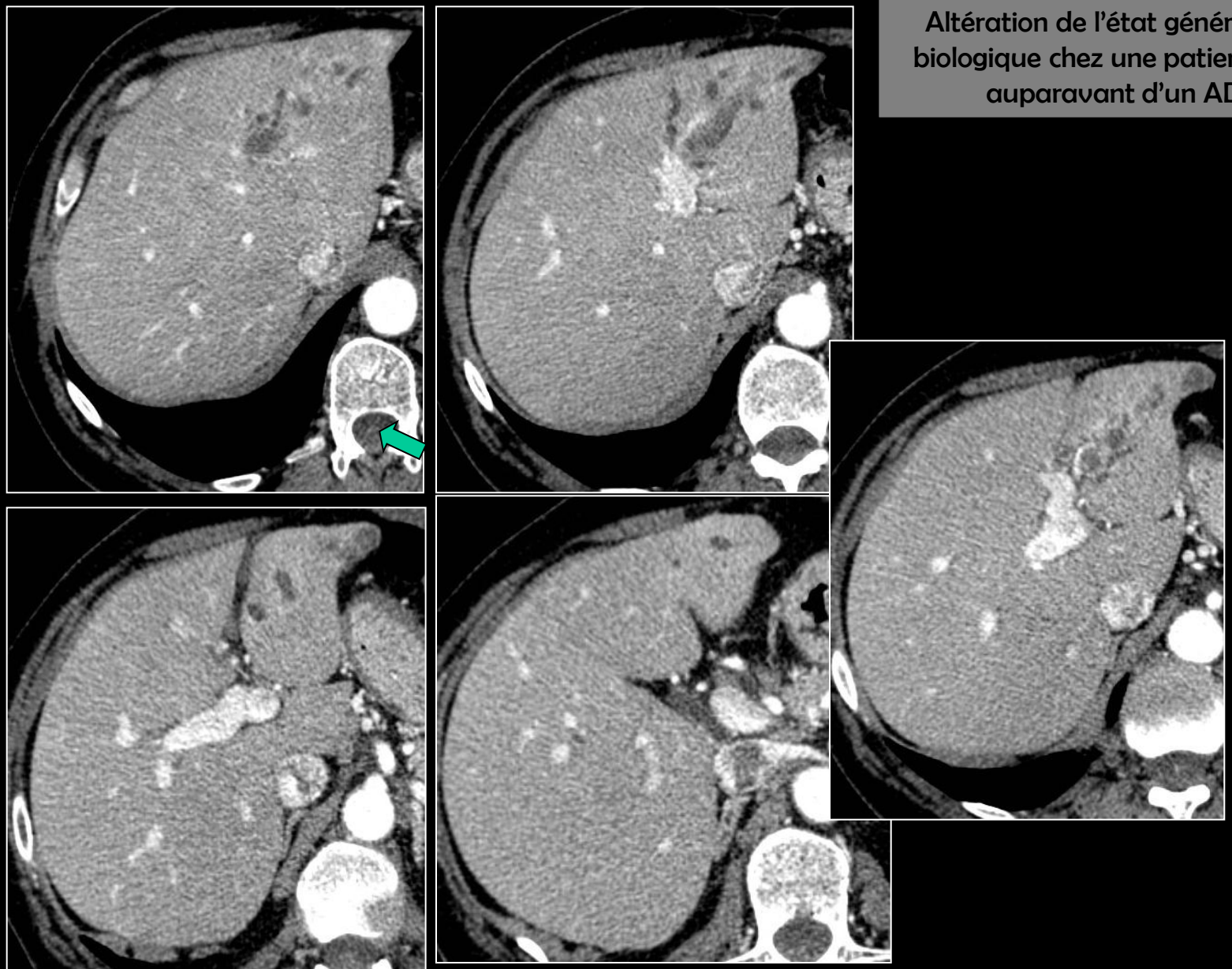


Papillomatose

Métastases endobiliaires

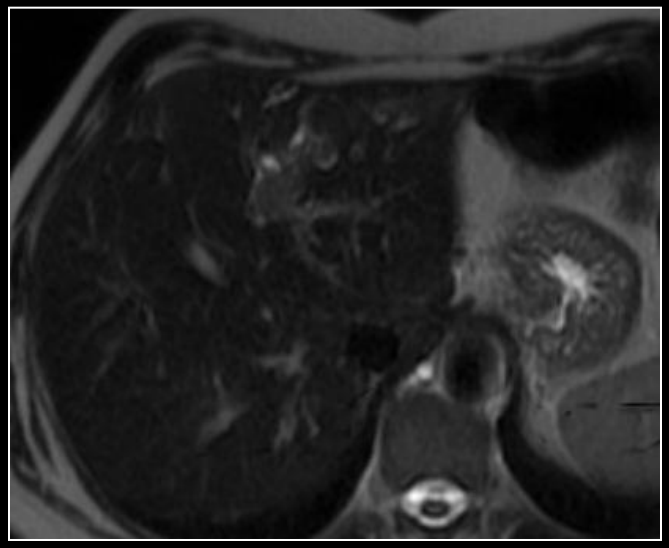











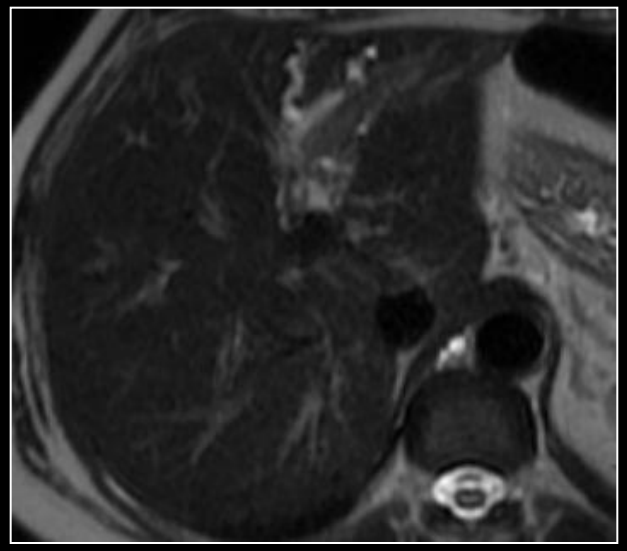
Tumeurs endobiliaires rares

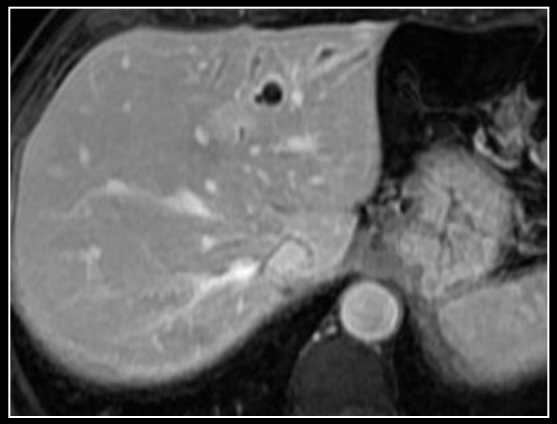


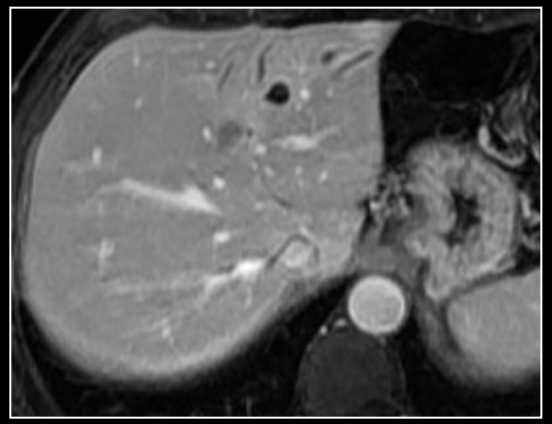
Altération de l'état général et cholestase biologique chez une patiente opérée 5 ans auparavant d'un ADK rectum

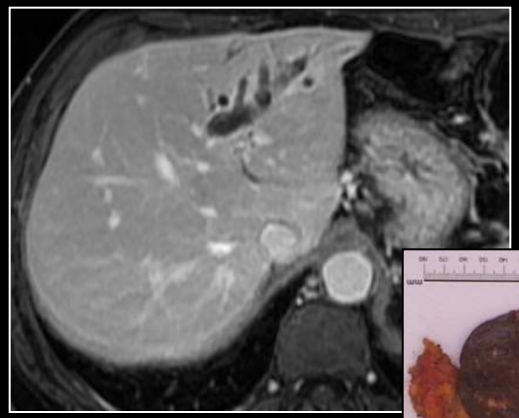
Papillomatose

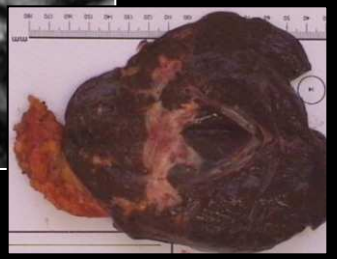




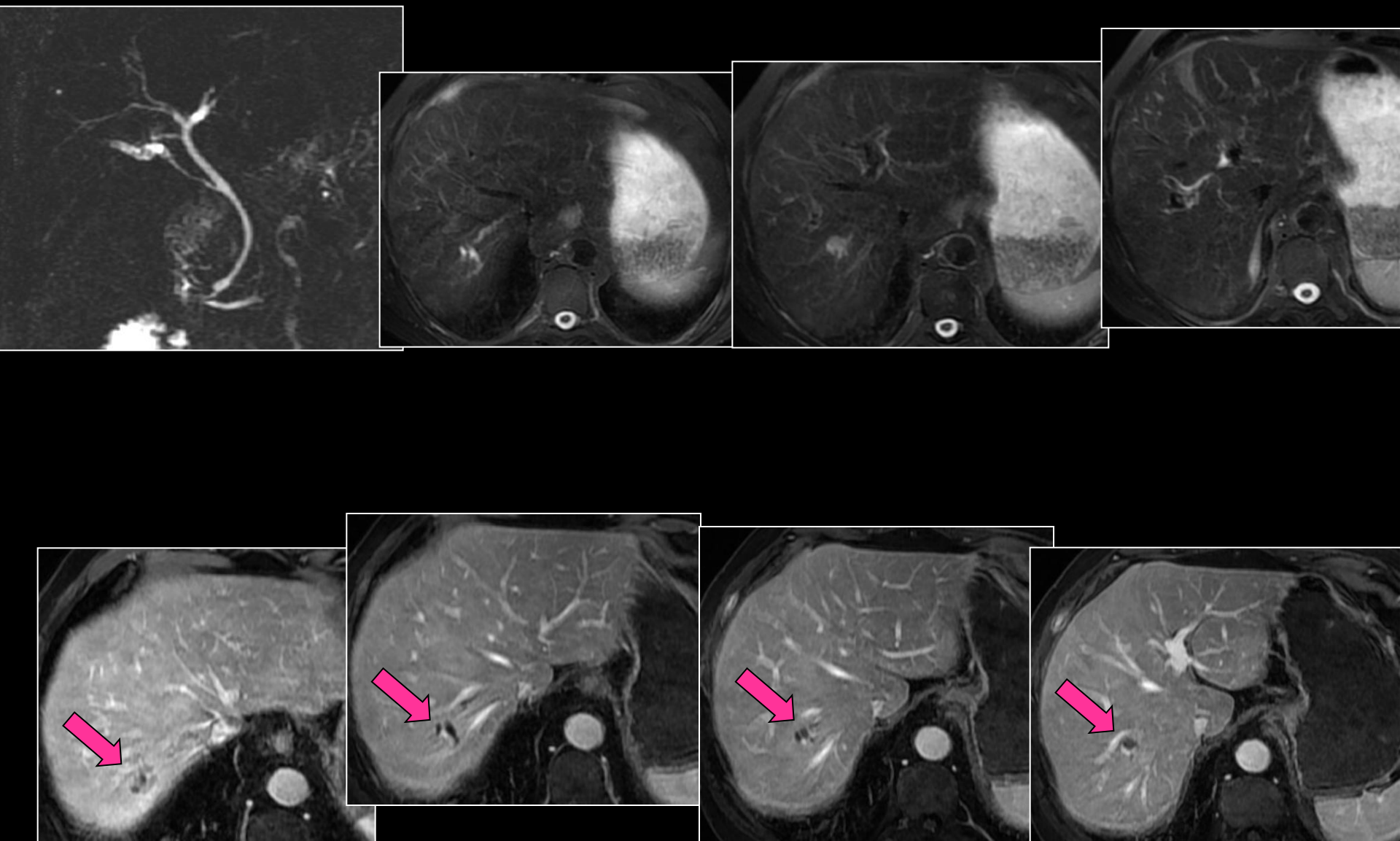




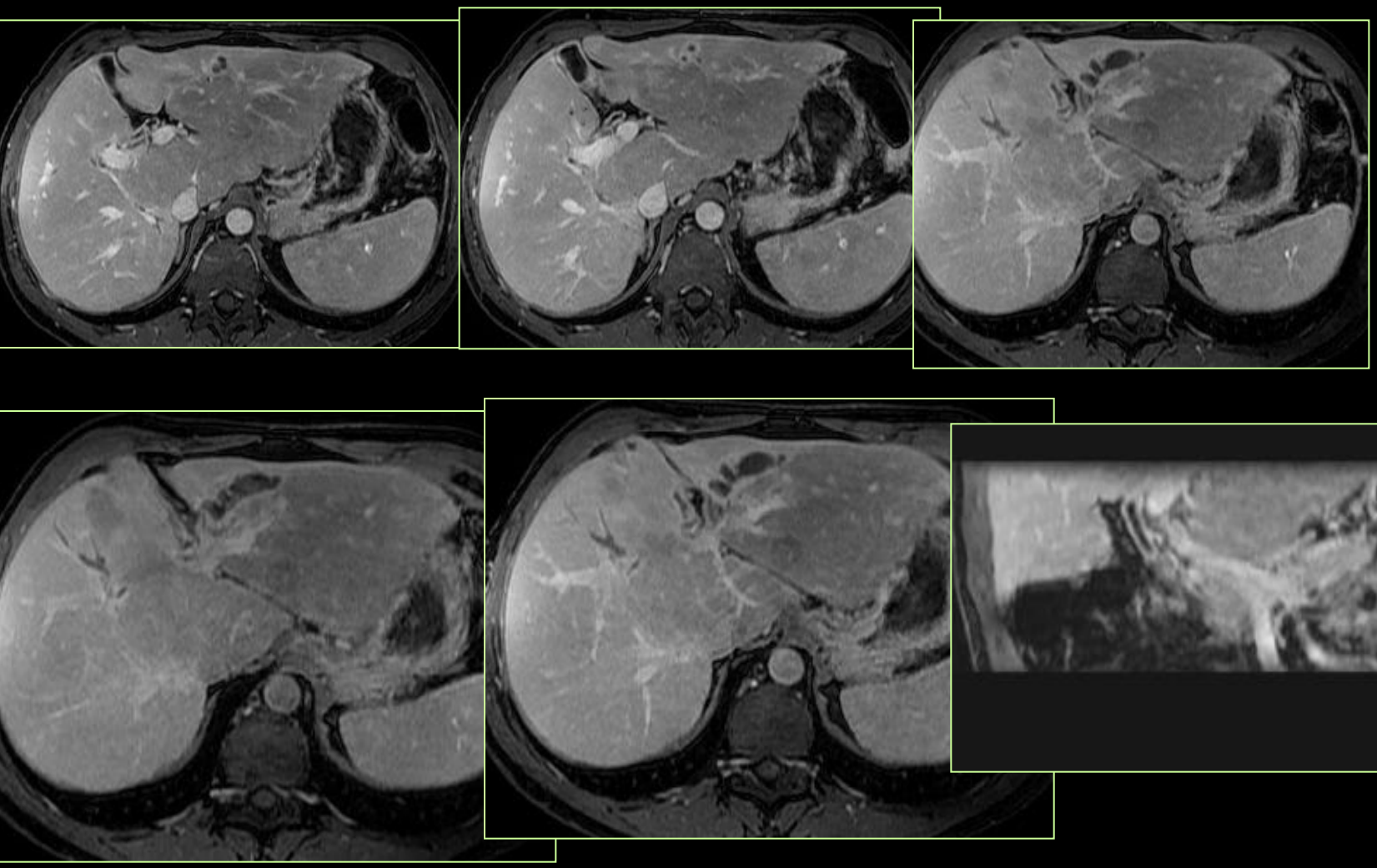




Métastases endobiliaires



Papillomatose



Conclusion

- **Masse hép centrée par la vésicule avec extension hilaire**
  - CCK vésiculaire
  - FDR : Long common channel
- **Epaississement irrégulier de la paroi vésiculaire**
  - CCK vésiculaire infiltrant
- **Masse IH : CCK IH**
  - Fibrose : temps tardifs +++
  - FDR : CSP
- **Obstacles de la VBP (hilaires et en dessous)**
  - Eliminer Causes extrinsèques bénignes et malignes
  - Sténose hilaire infiltration pariétale VB : CCK

Tout n'est pas du cancer !!!!! .....