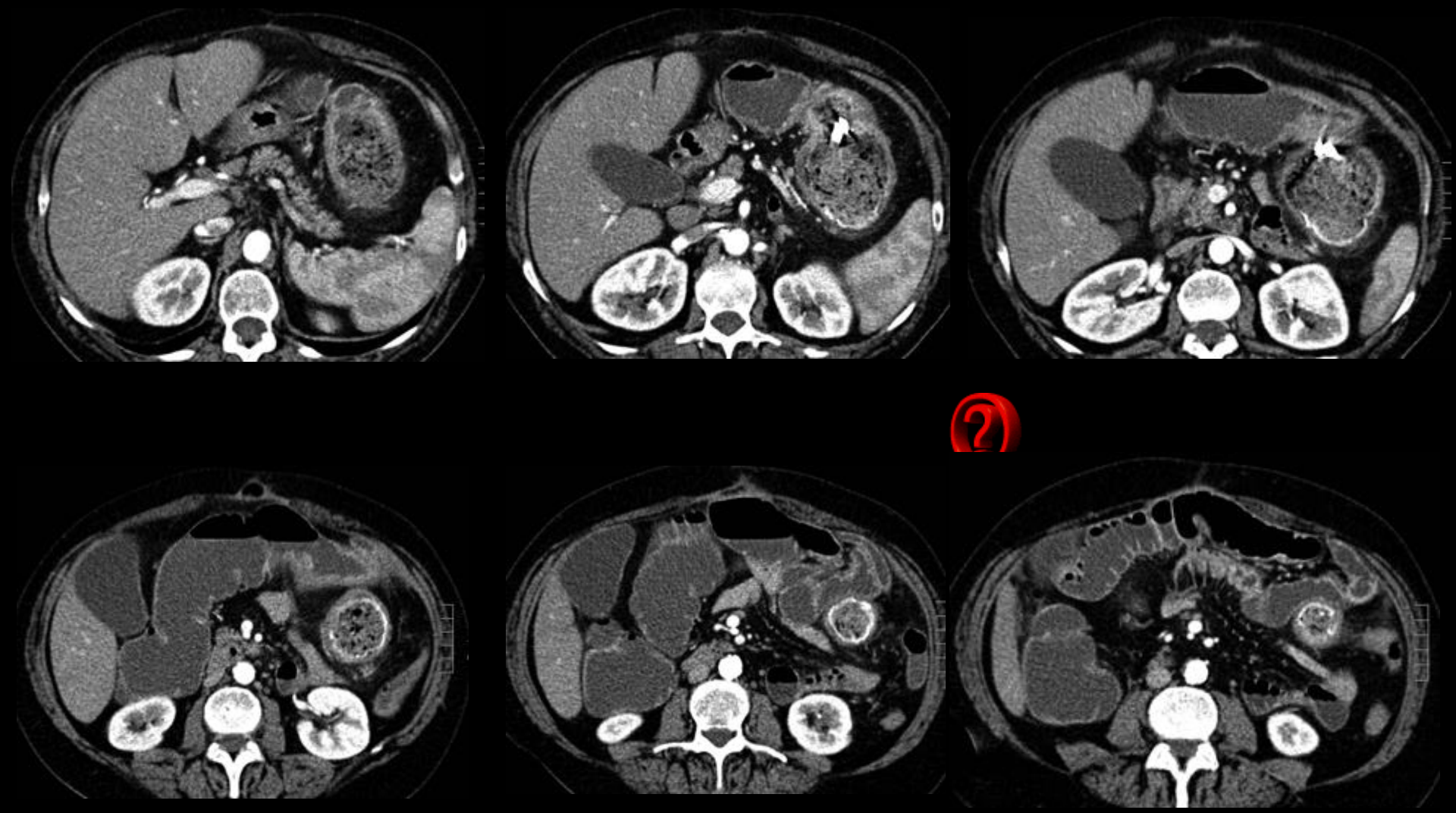
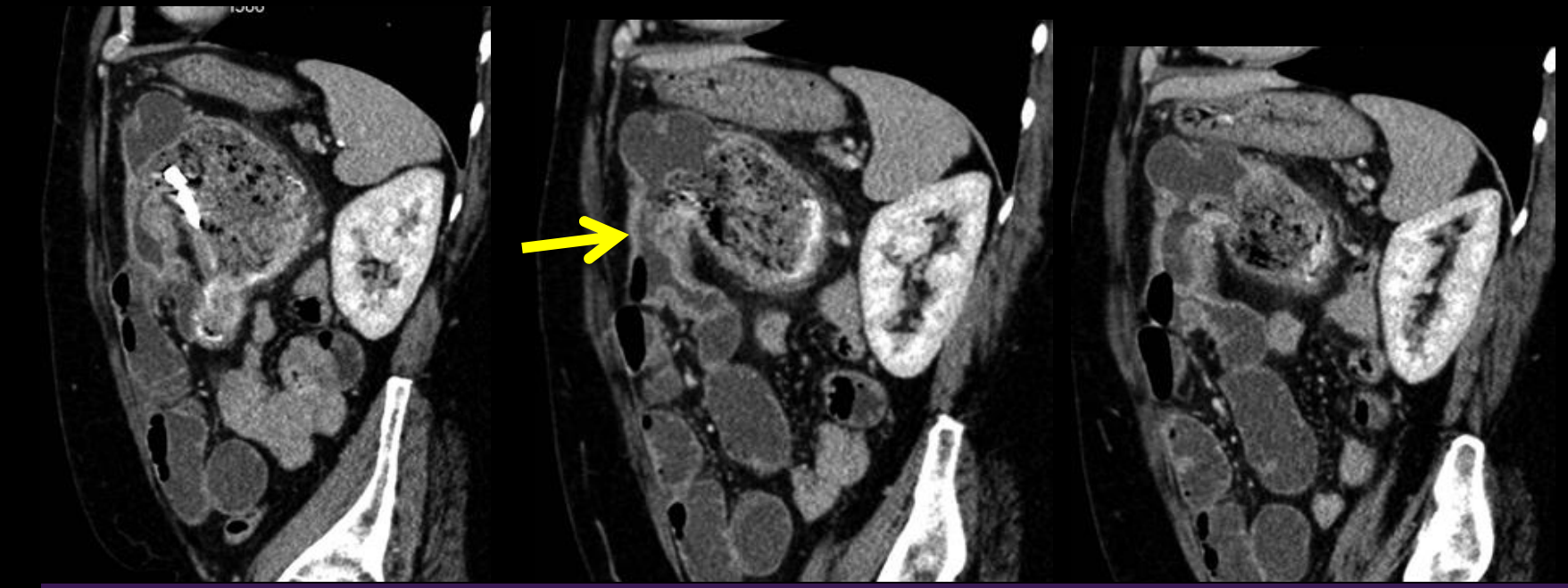
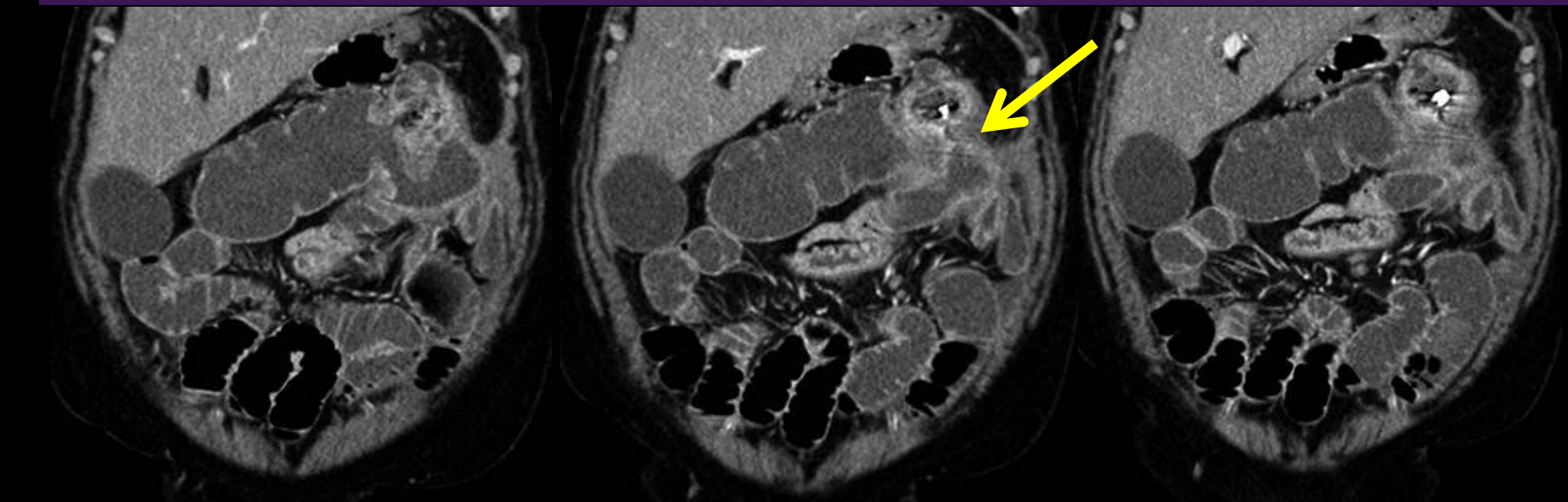
3-1-3 occlusions colo-rectales d'origine endoluminale

3-1-3-1 corps étrangers endoluminaux



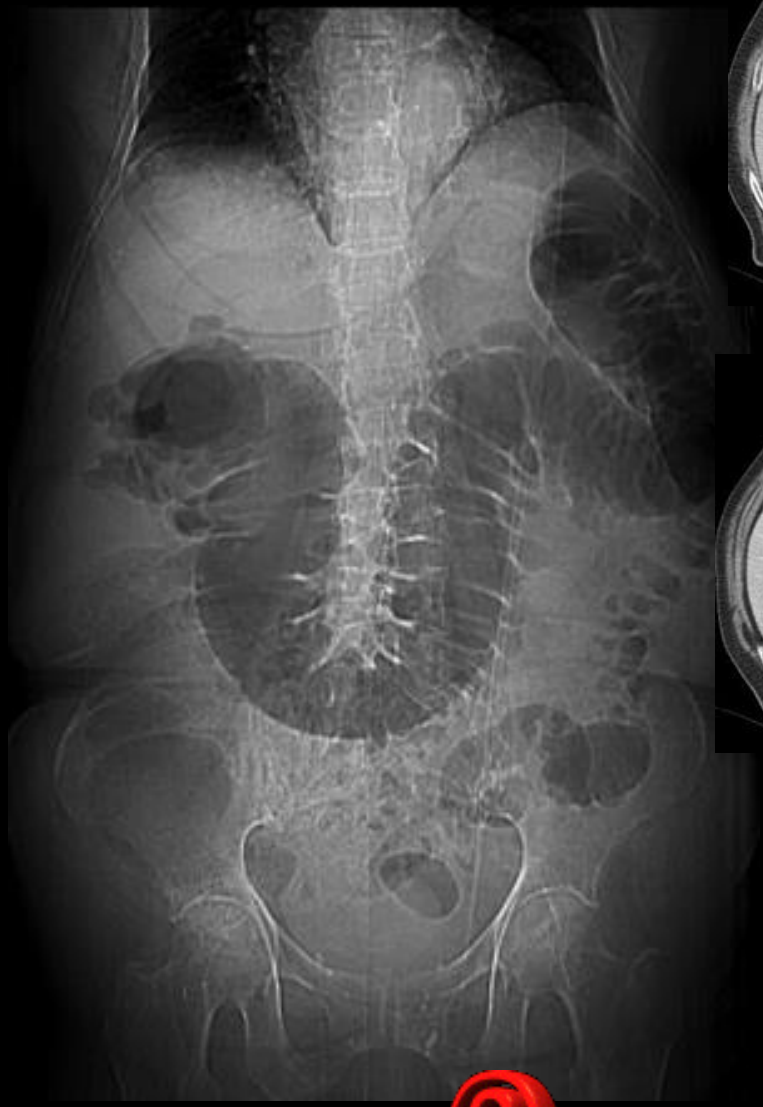


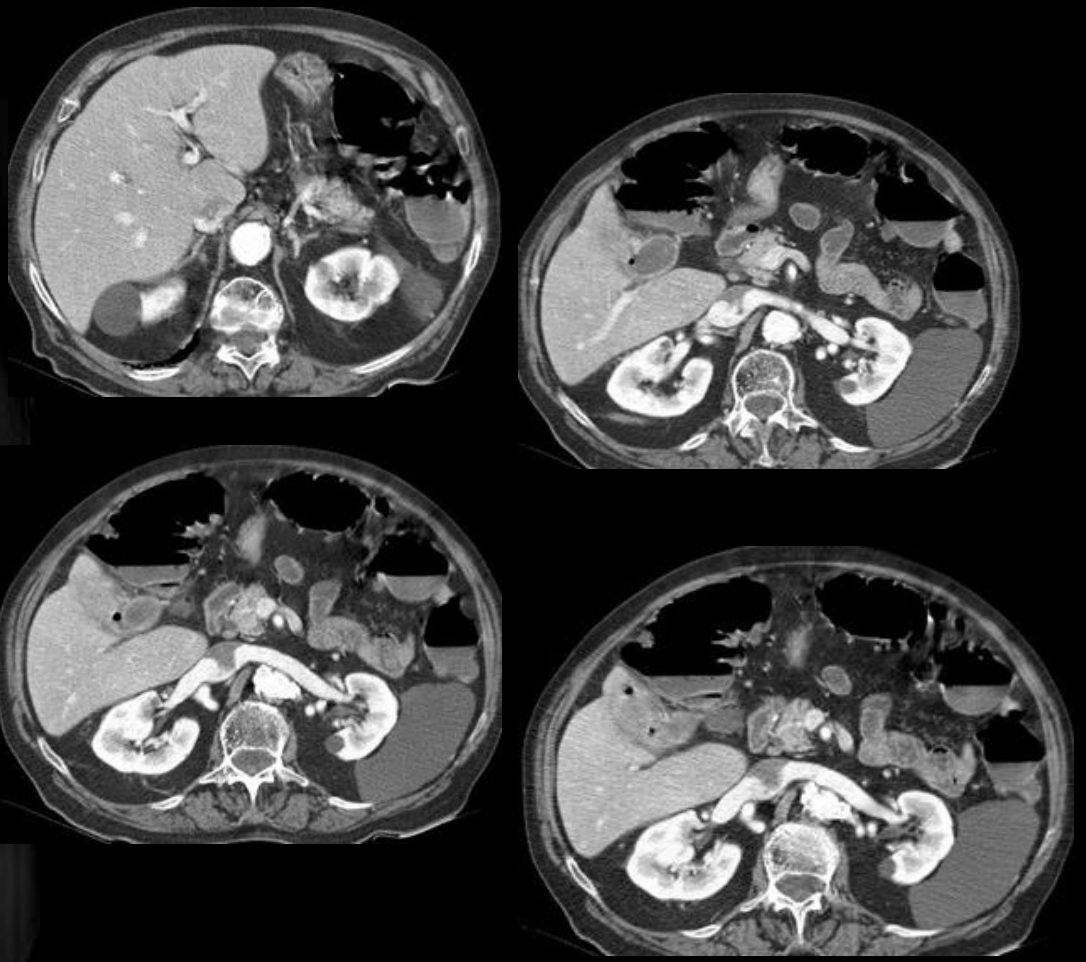
champ opératoire (corpus alienum ou gossypibome) migrant avec fistulisation grêlo-colique et occlusion colique endoluminale de l'angle gauche



patiente de 83 ans , syndrome occlusif de survenue brutale sans signes infectieux;

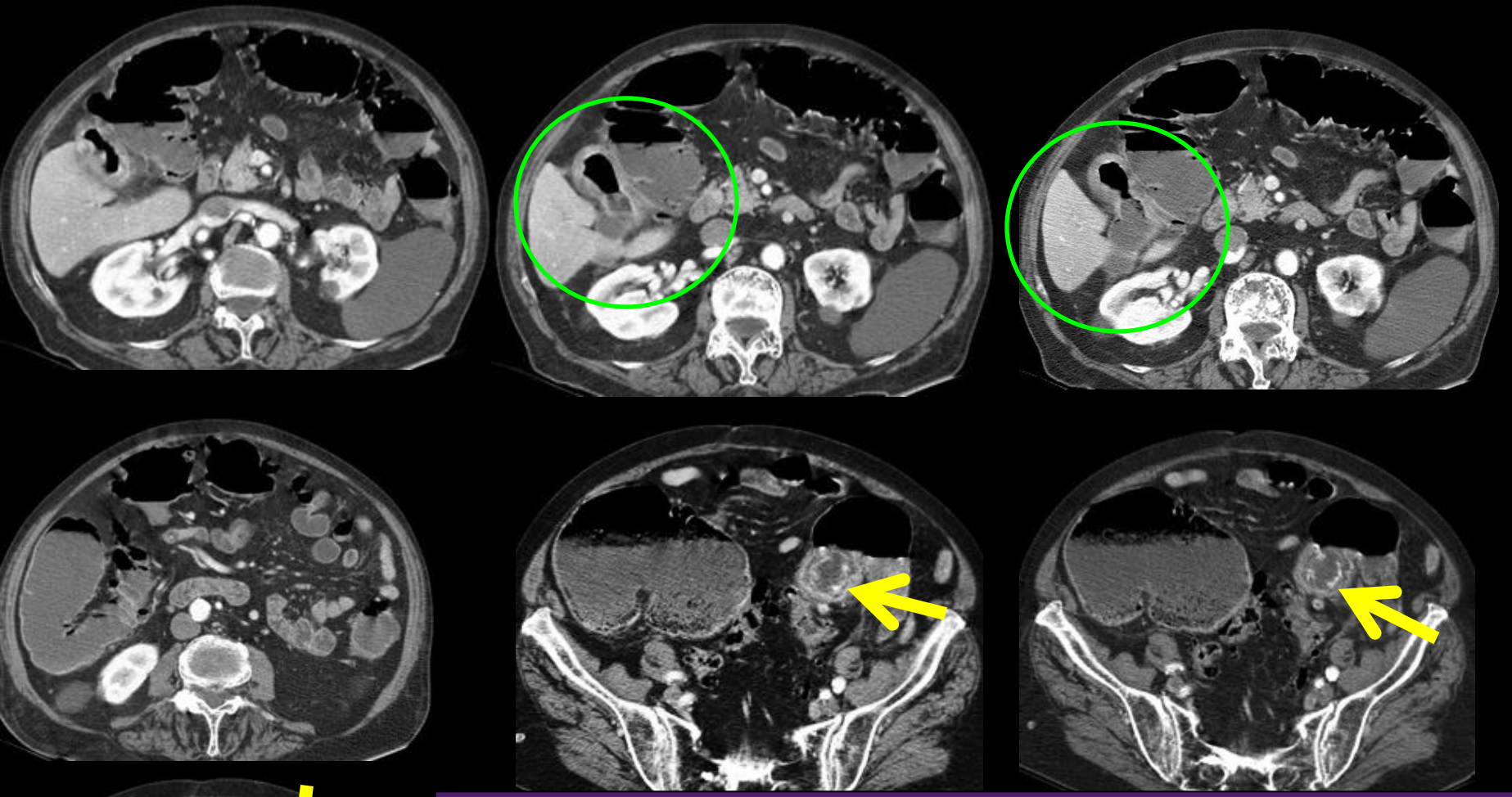
anémie





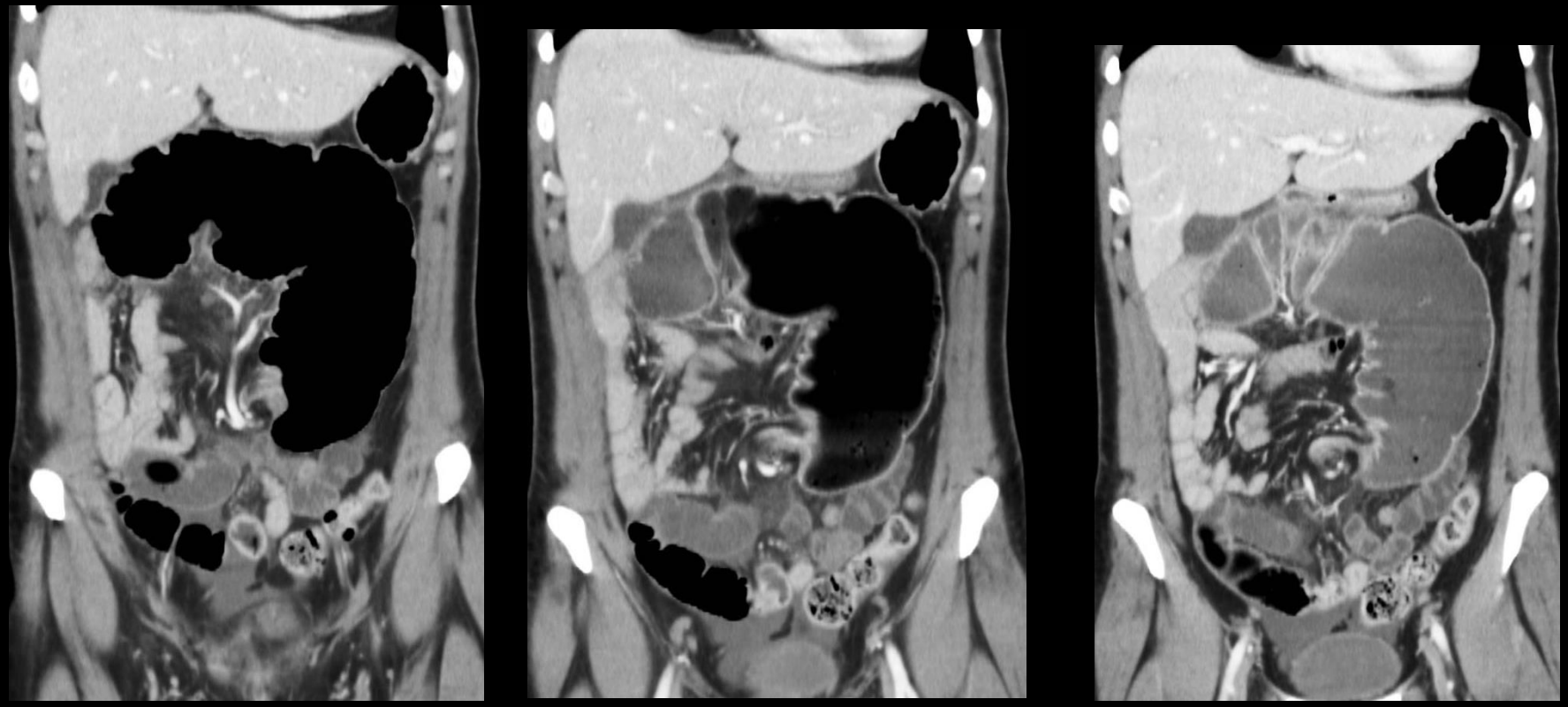
diagnostic

y-a-t-il quelque chose d'inhabituel dans cet iléus biliaire , en dehors de l'absence d'aérobilie intra-hépatique ?



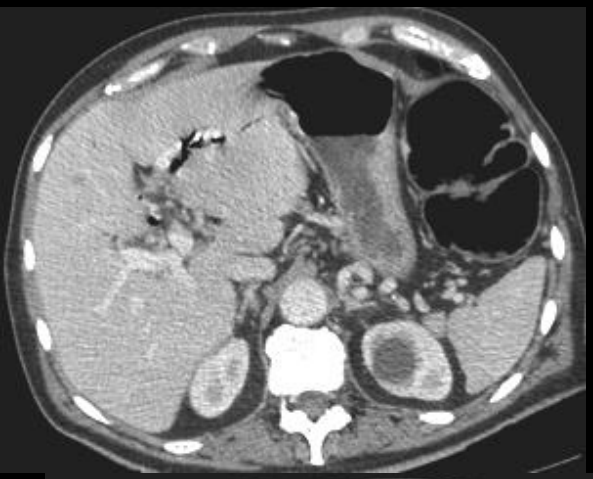
iléus biliaire avec fistule cholecystocolique et calcul bloqué dans un sigmoïde diverticulaire ; distension caecale et risque élevé de perforation diastatique caecale +++++

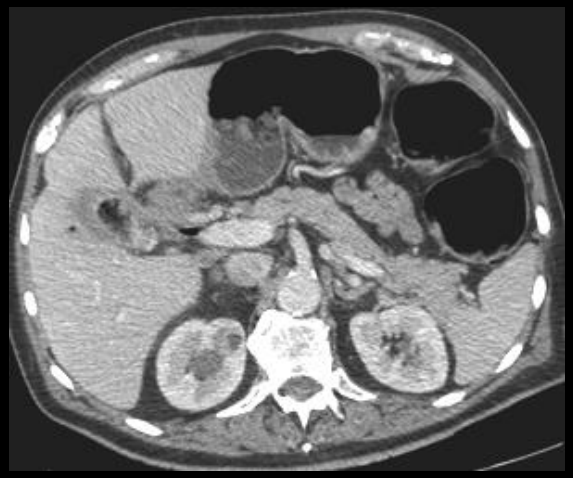
2 à 8 % de l'ensemble des iléus biliaires sont de siège sigmoïdien ; ils correspondent toujours à des fistules directes cholécysto-coliques

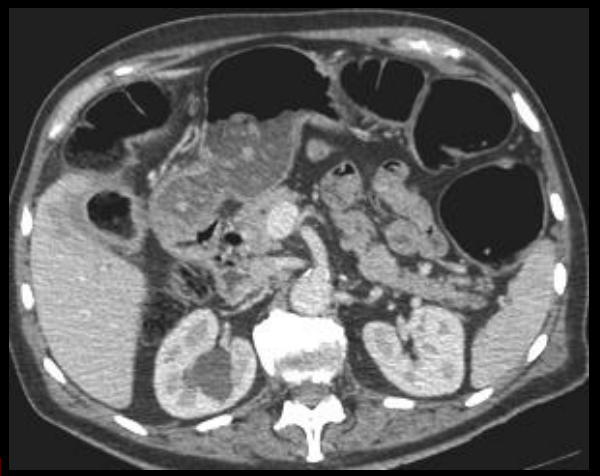


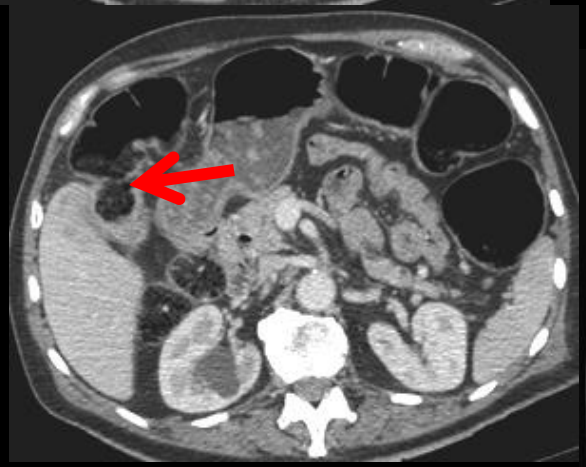
volvulus mésentérico-axial (loop type) d'un mésentère commun complet

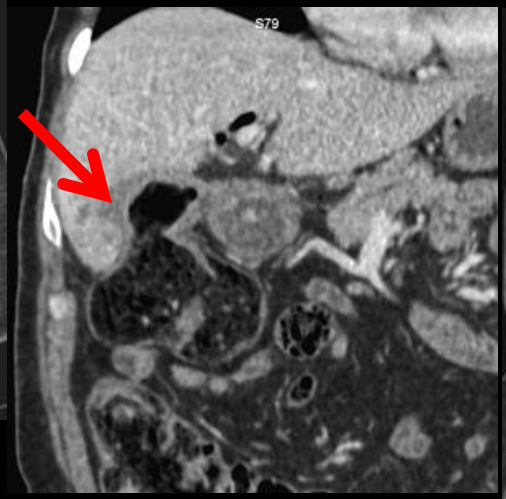
patient de 77 ans , syndrome occlusif fébrile avec douleurs pelviennes

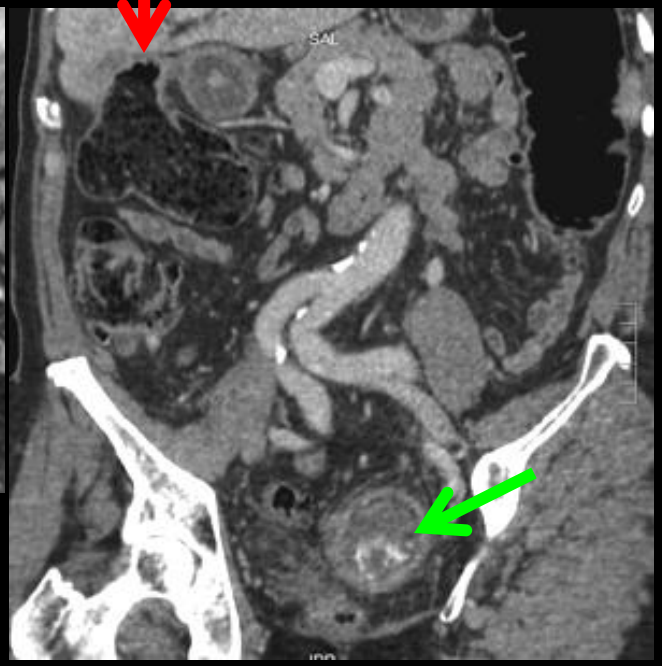






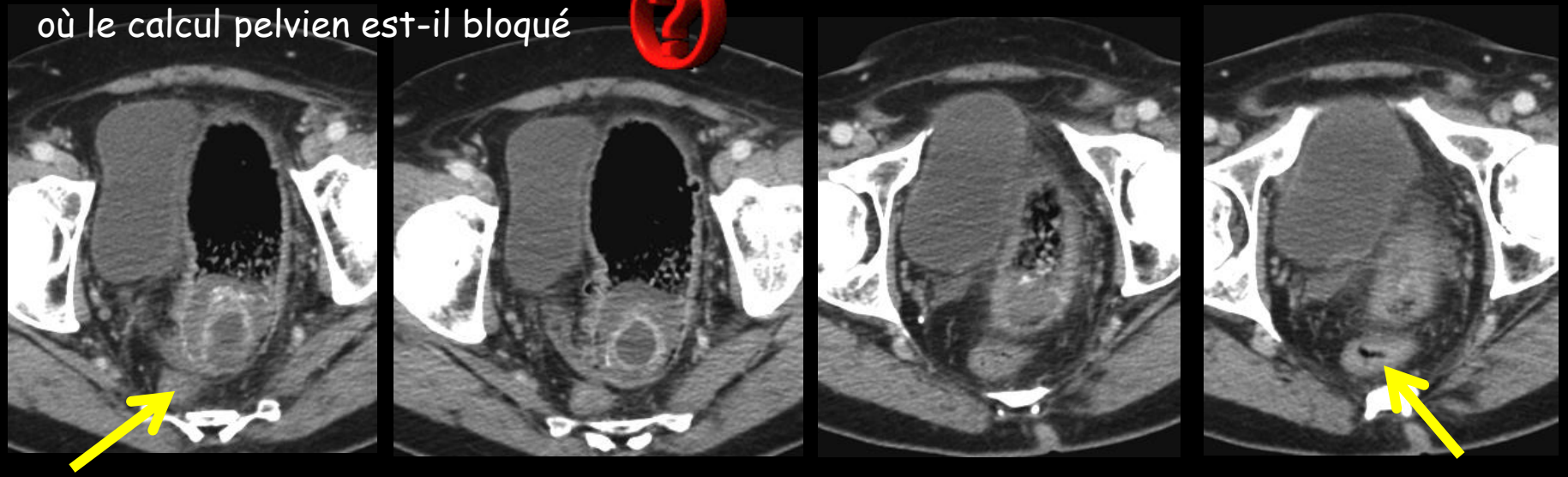


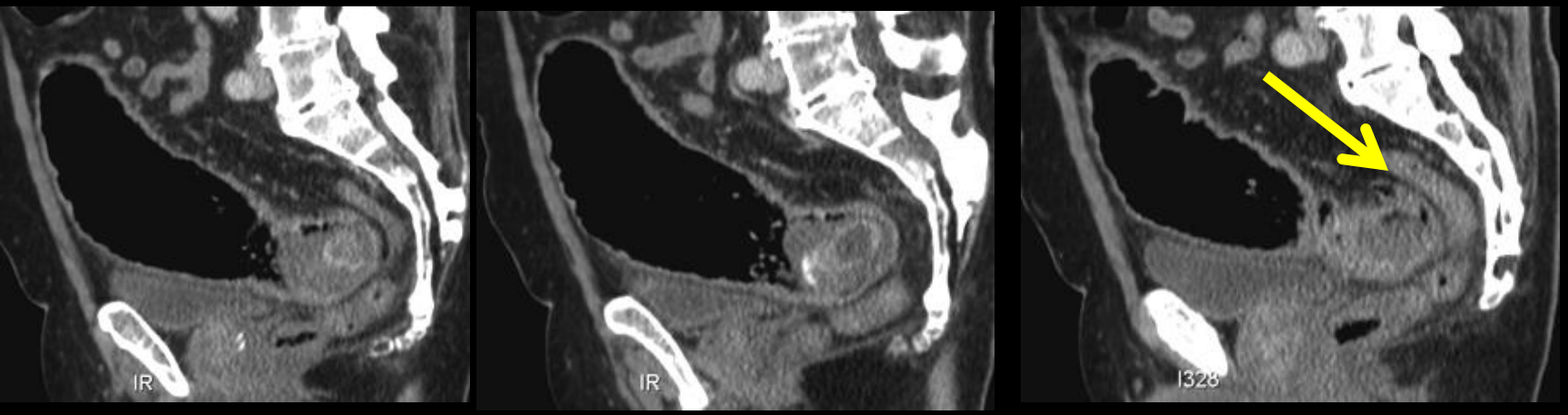




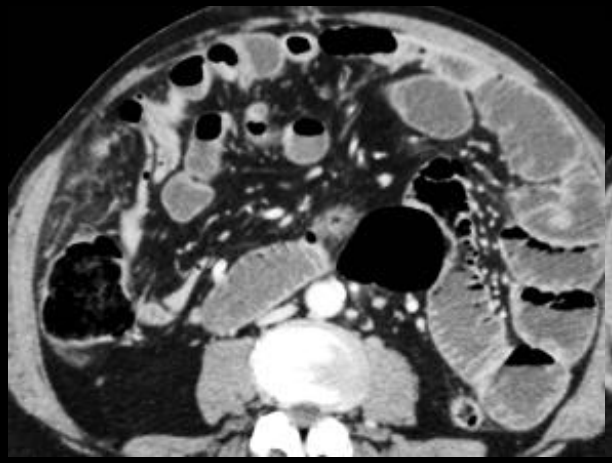
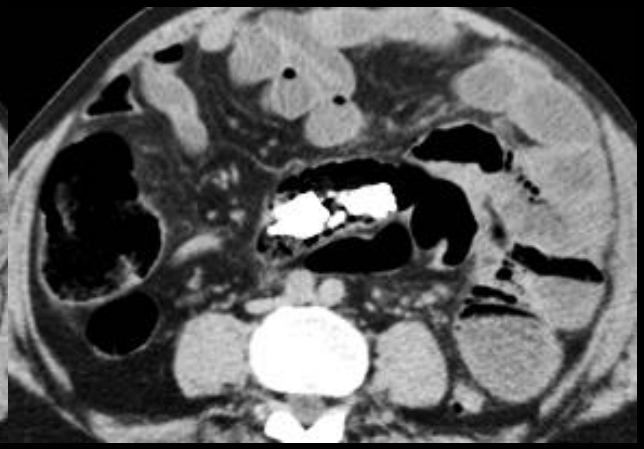
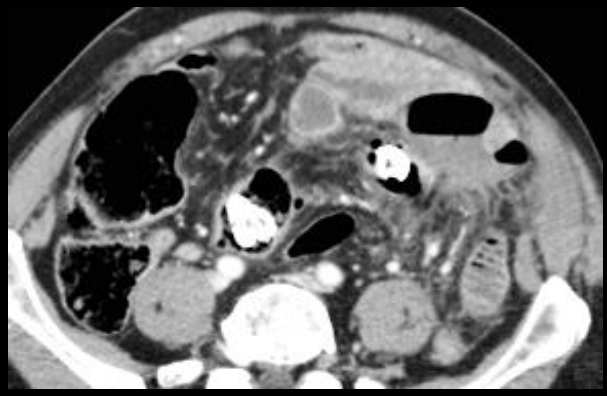
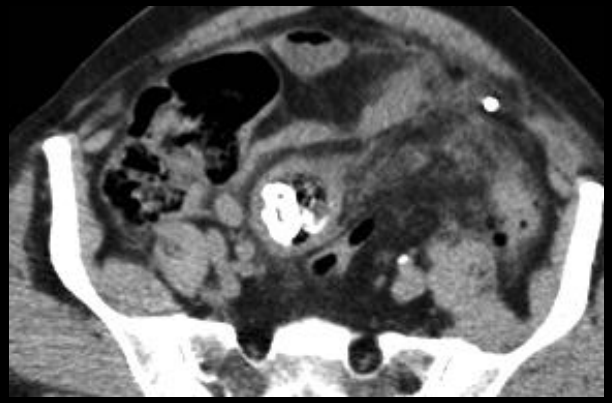
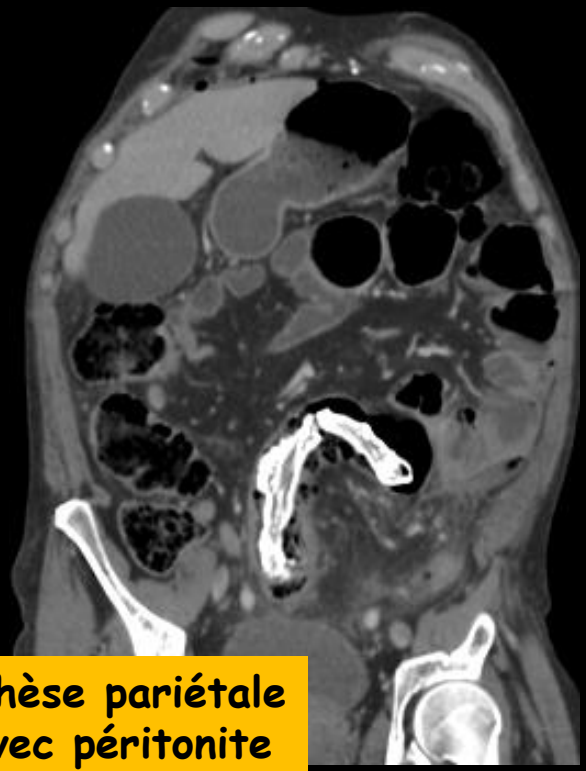
obs. Dr Damien Goudot

où le calcul pelvien est-il bloqué



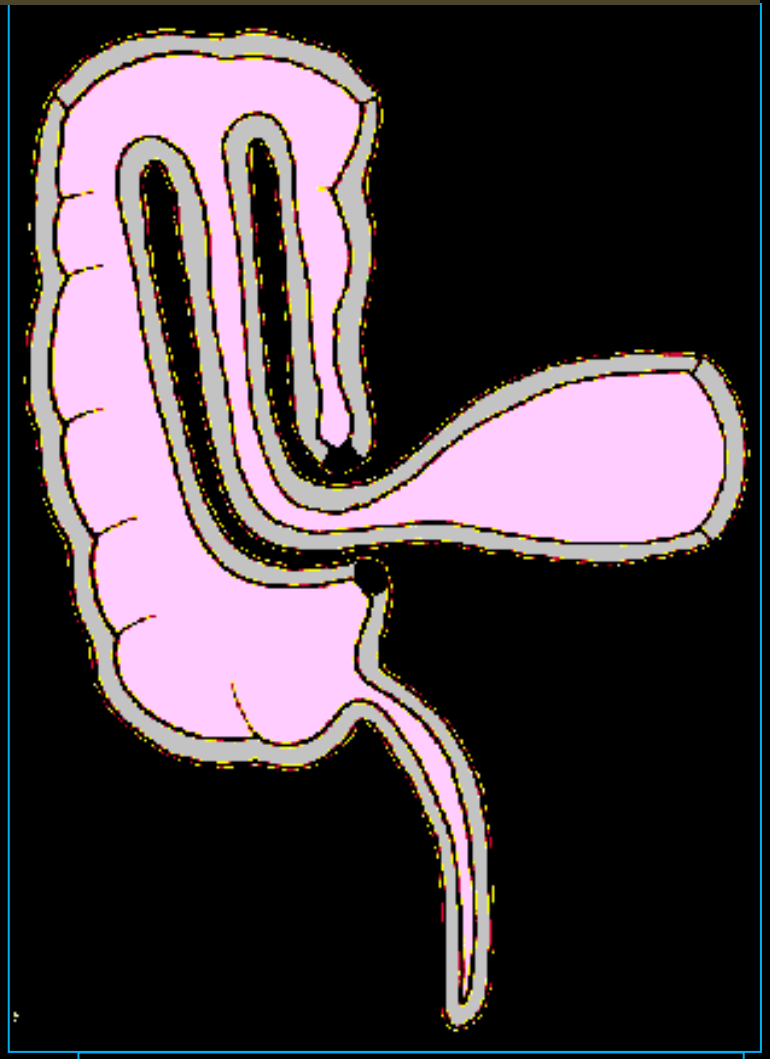


iléus biliaire avec fistule cholecystocolique et calcul bloqué dans le sigmoïde ;
résection sigmoïdienne nécessaire en raison de l'état de la paroi .

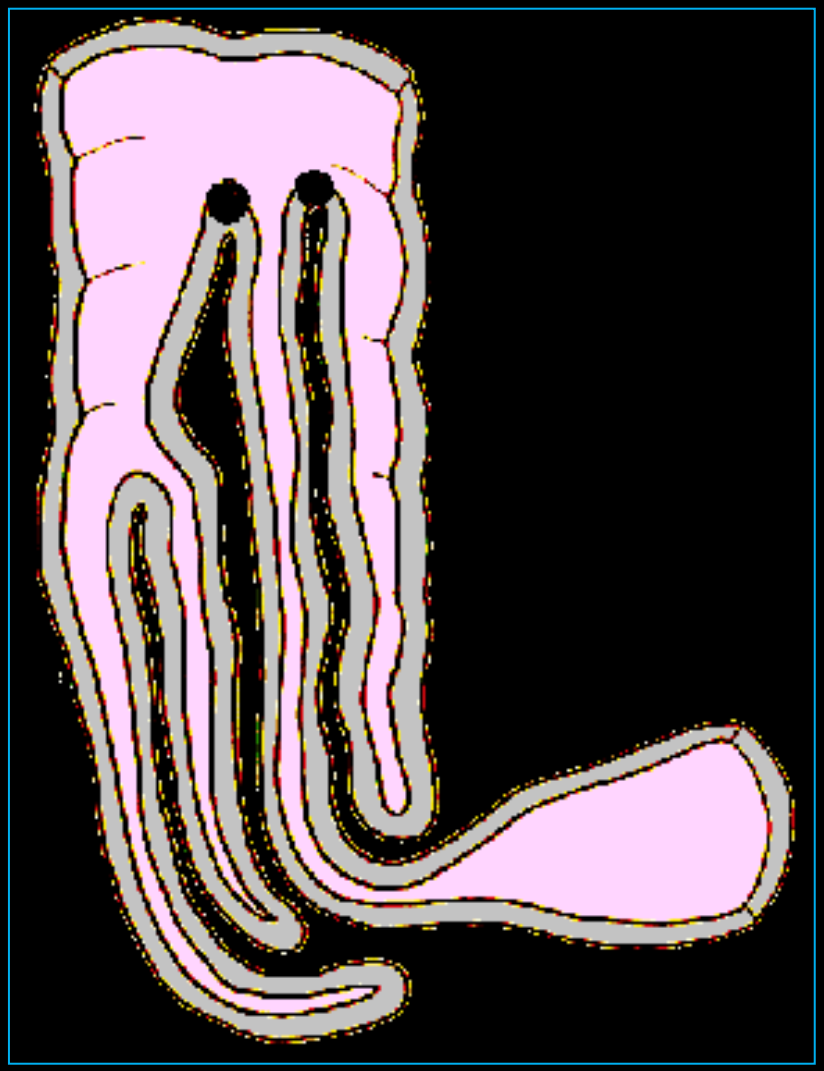






migration sigmoïdienne d'une prothèse pariétale pour cure de hernie inguinale , avec péritonite ;résection sigmoïdienne

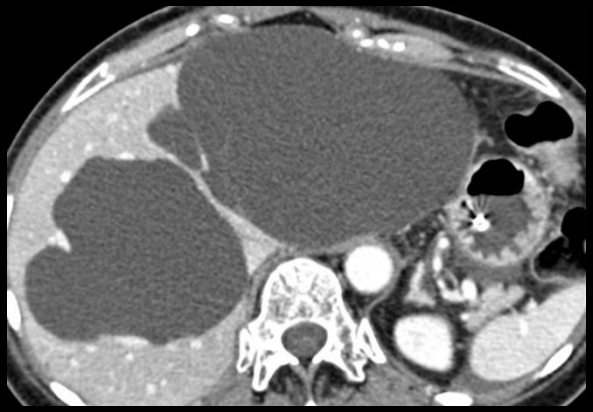
3-1-3-2 invaginations coliques

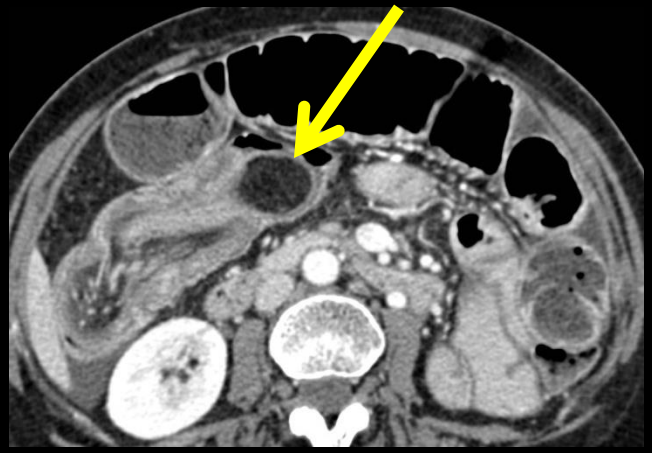


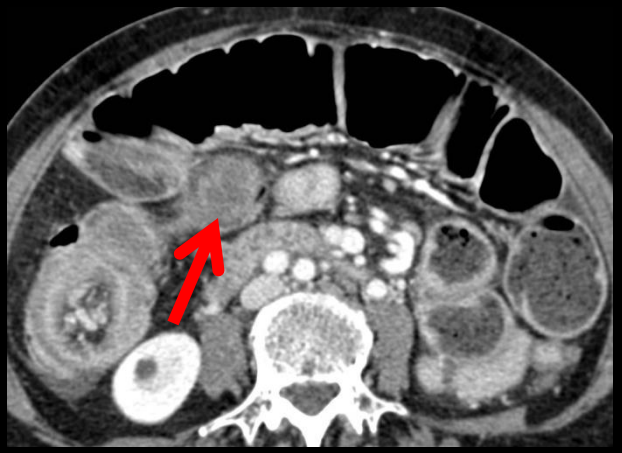
Invagination iléo-colique / transvalvulaire: valvule de Bauhin en place

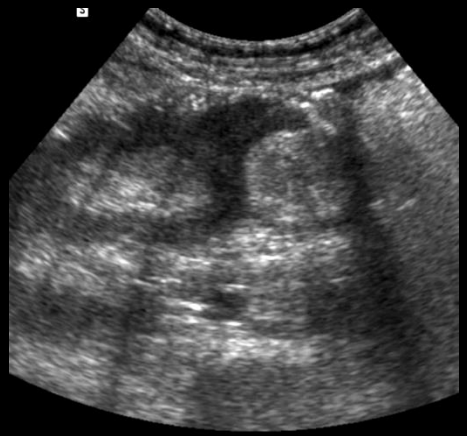


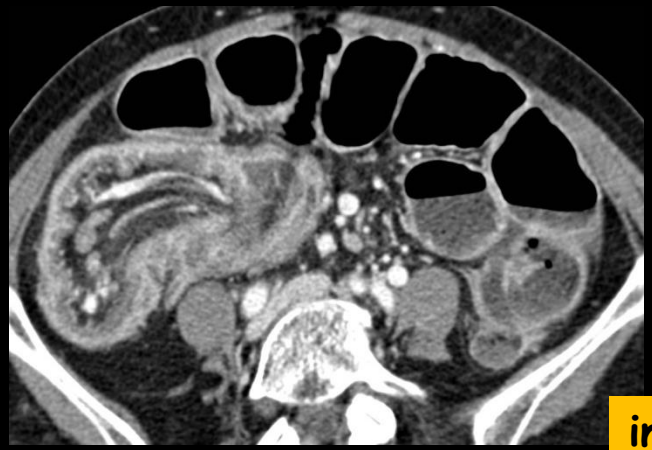
Invagination iléo-caeco-colique : appendice invaginé, valvule au sommet du boudin d'invagination



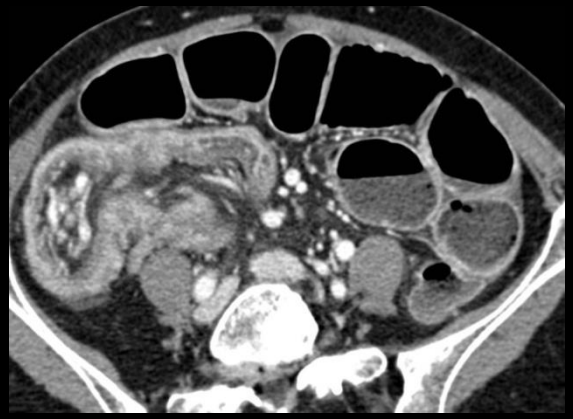


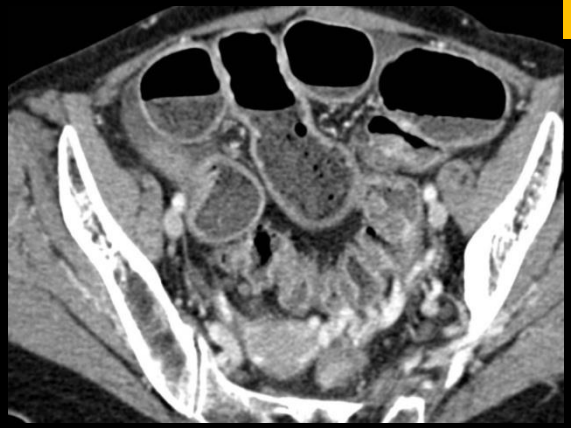




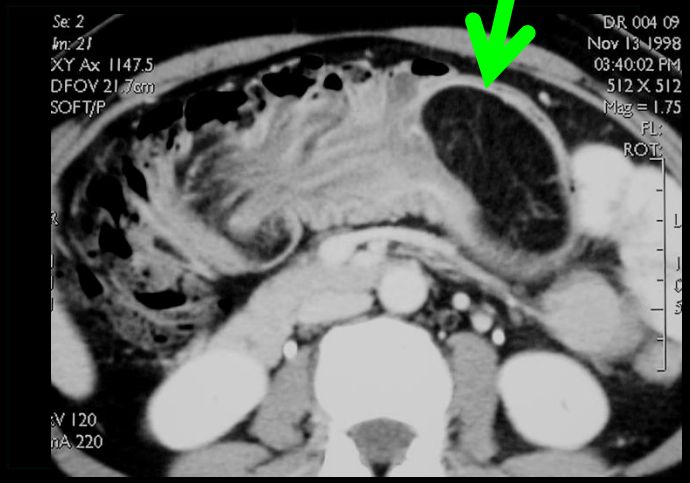


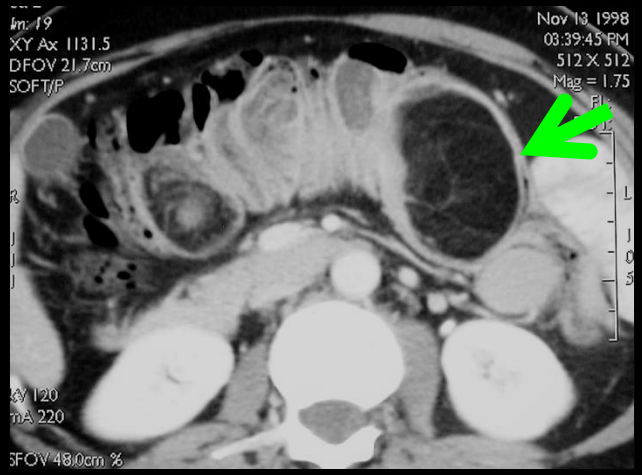
femme, 57 ans
syndrome sub-occlusif
évoluant depuis 15 j
masse palpée en FID

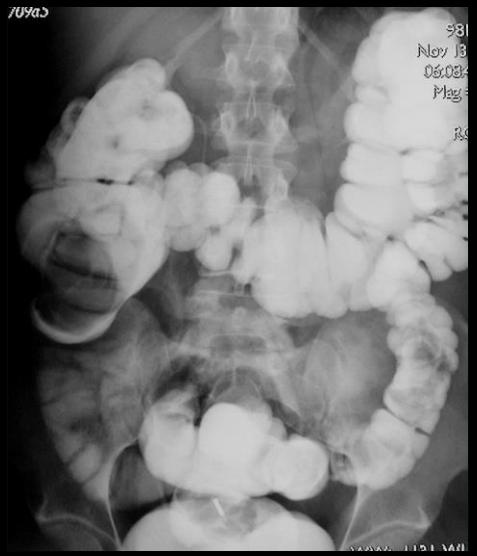


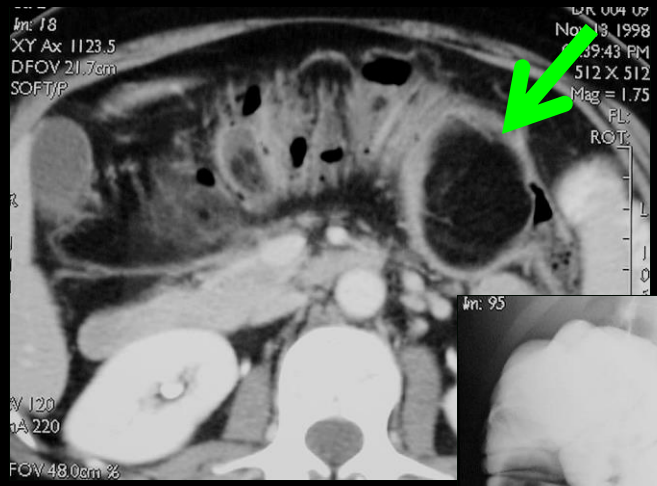


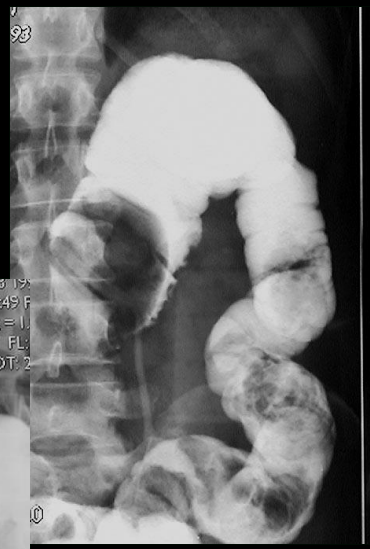
invagination colo-colique
<u>chronique</u> sur <u>lipome</u> caecal

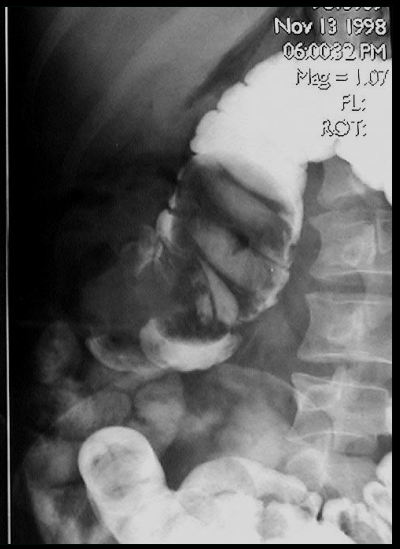


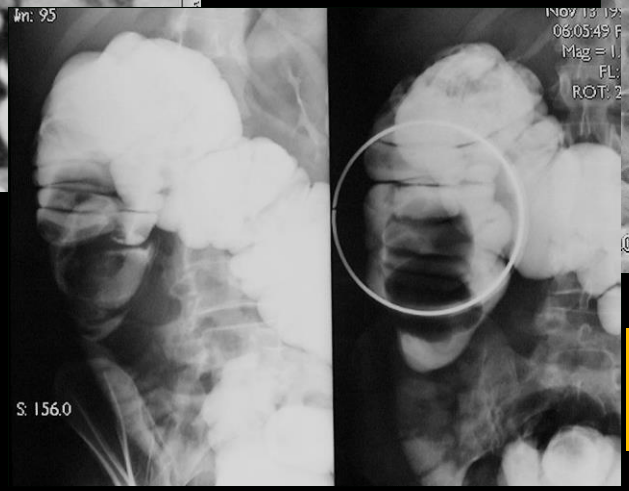




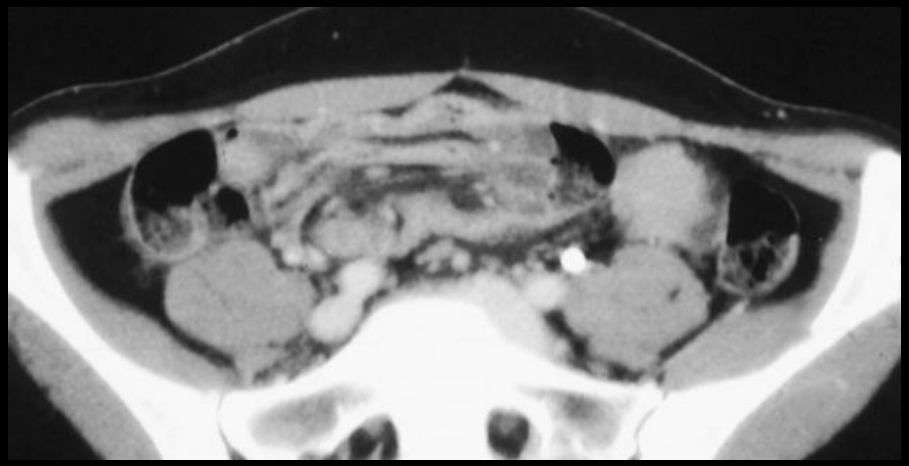


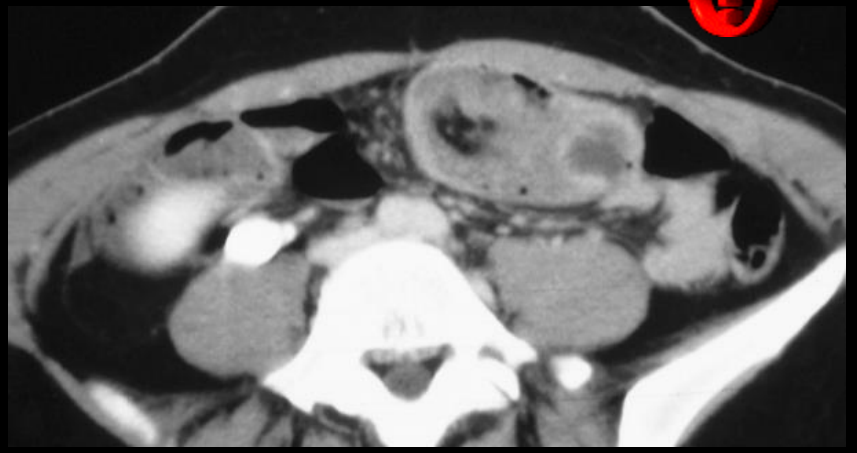


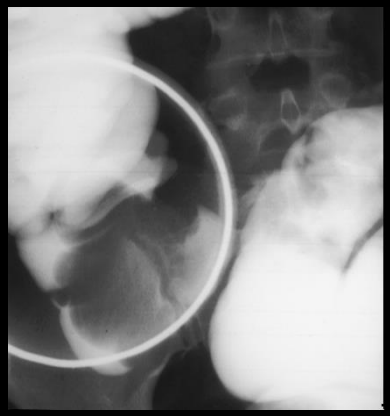


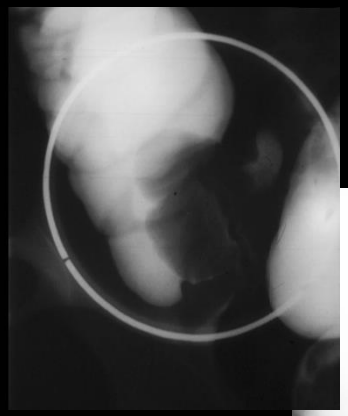


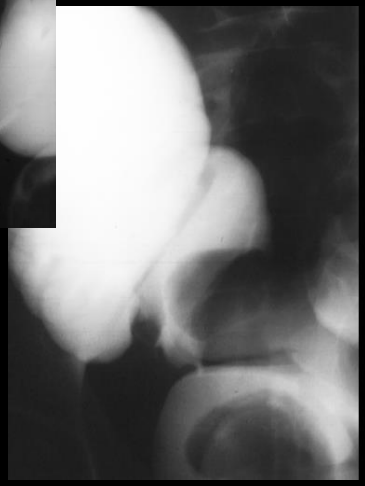
invagination chronique sur lipome du colon ascendant

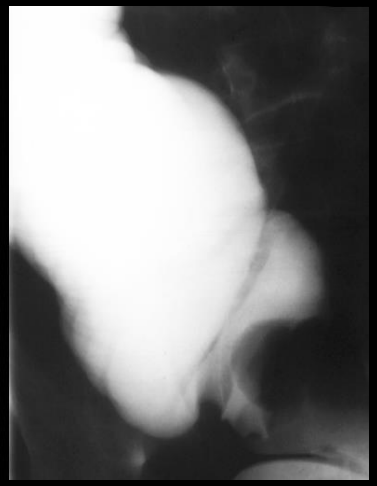


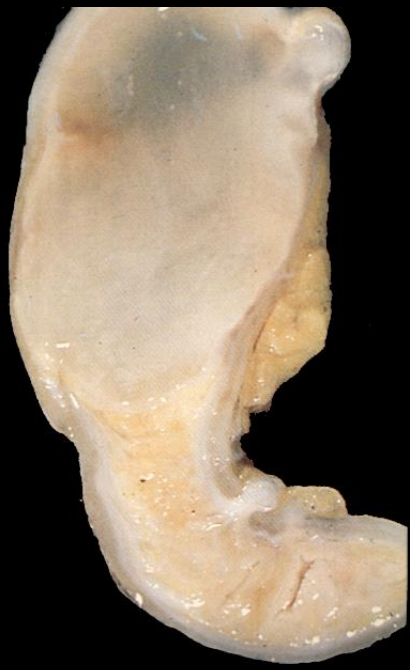




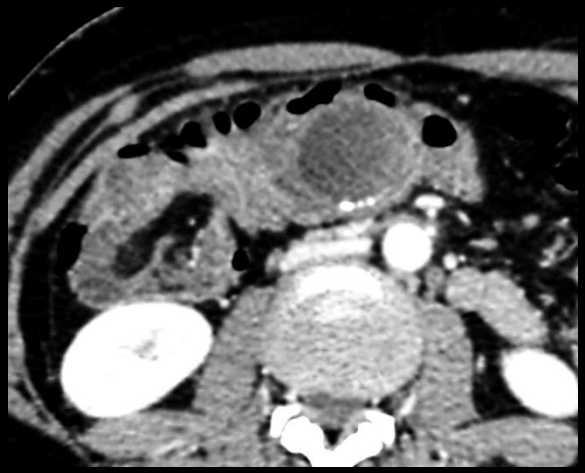
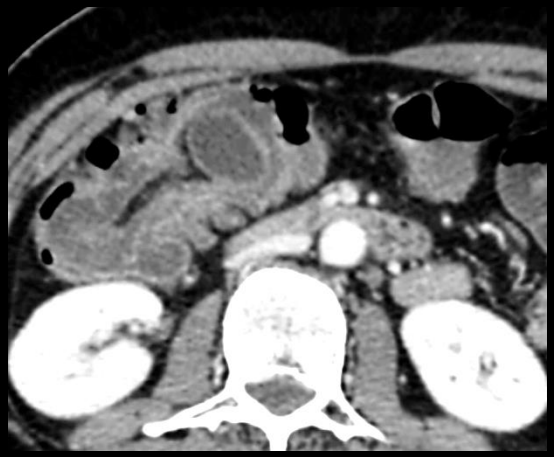
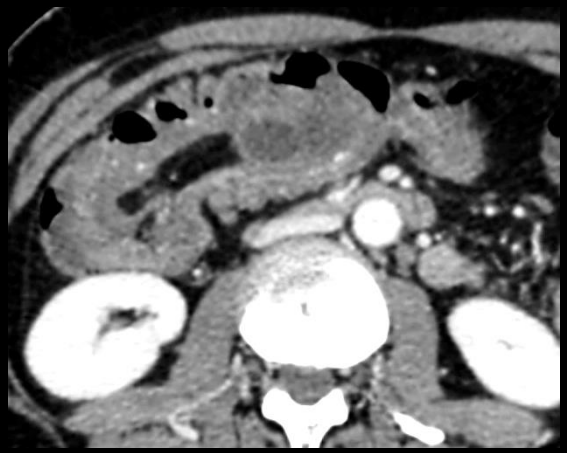
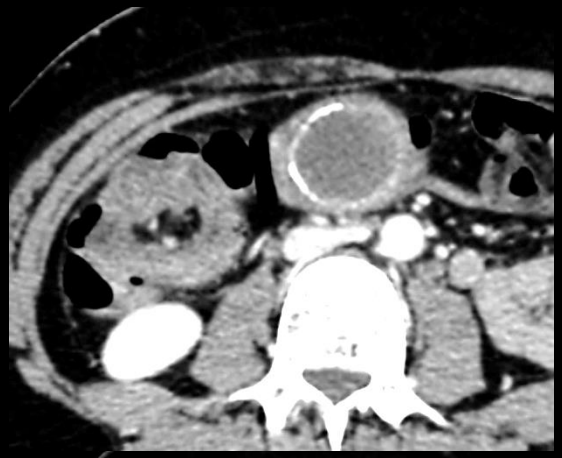
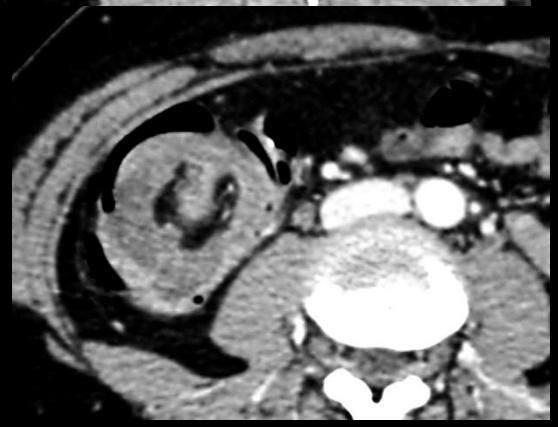
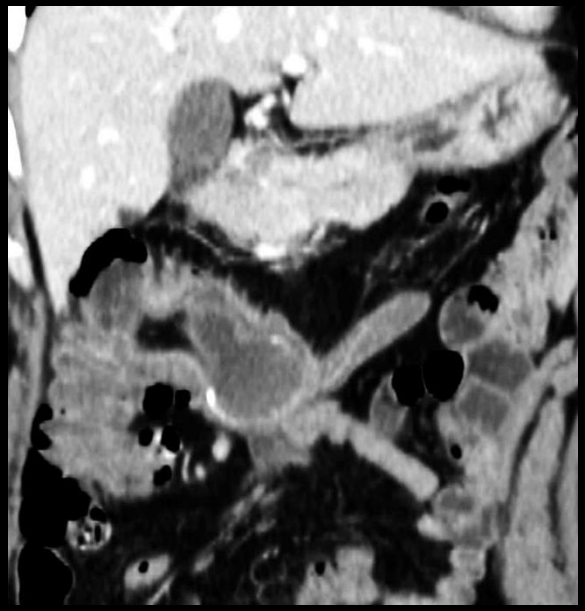
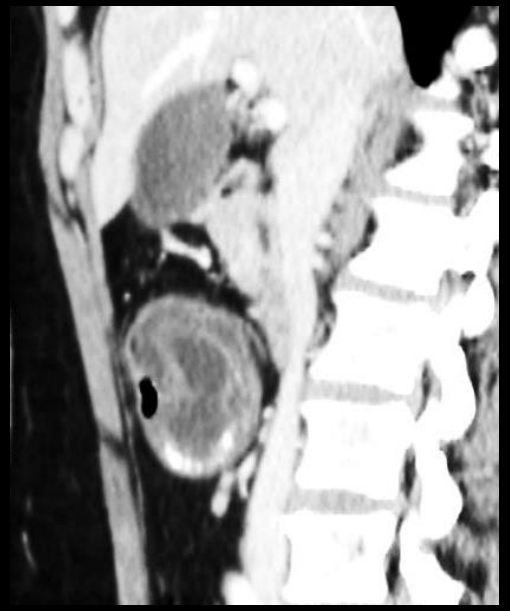






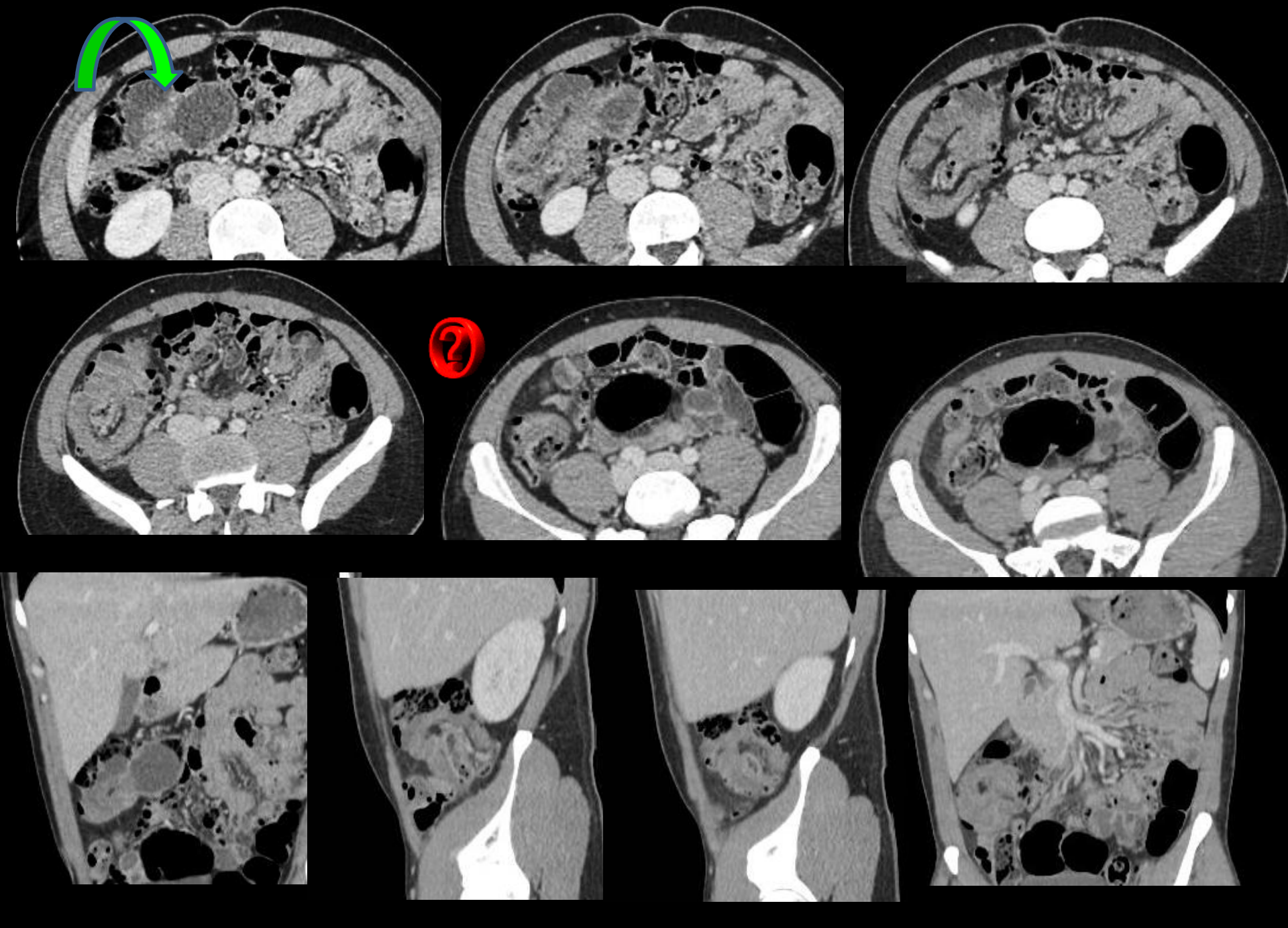


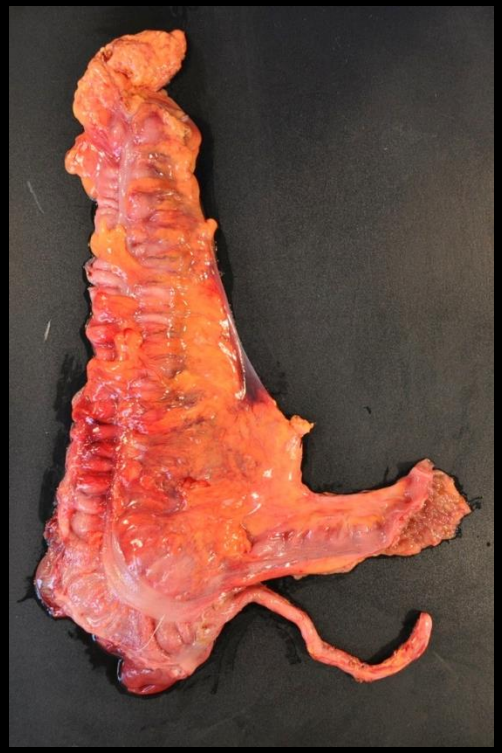
invagination iléo-colique chronique sur mucocèle appendiculaire

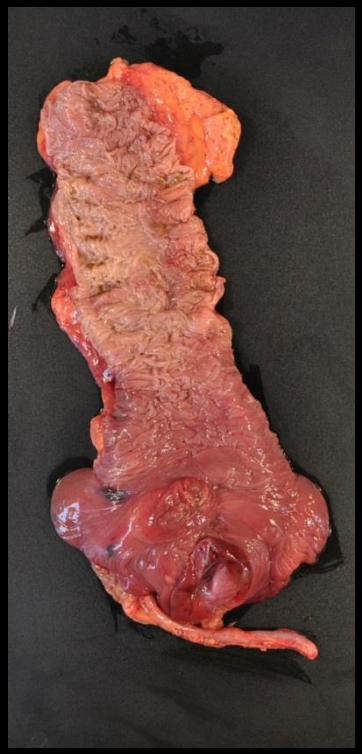








invagination iléo-colique chronique sur mucocèle appendiculaire

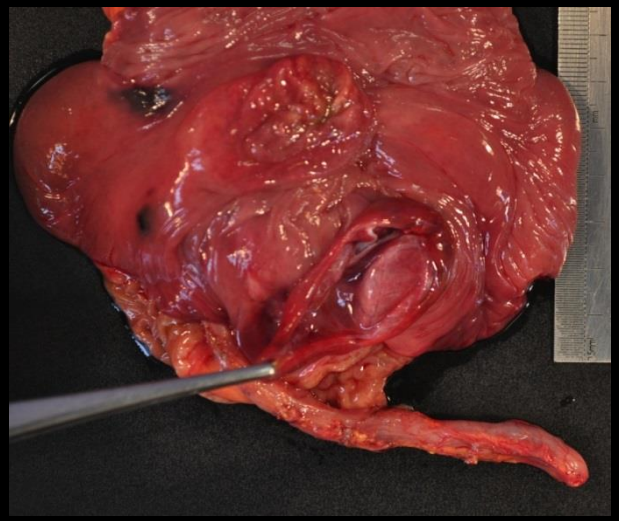
2

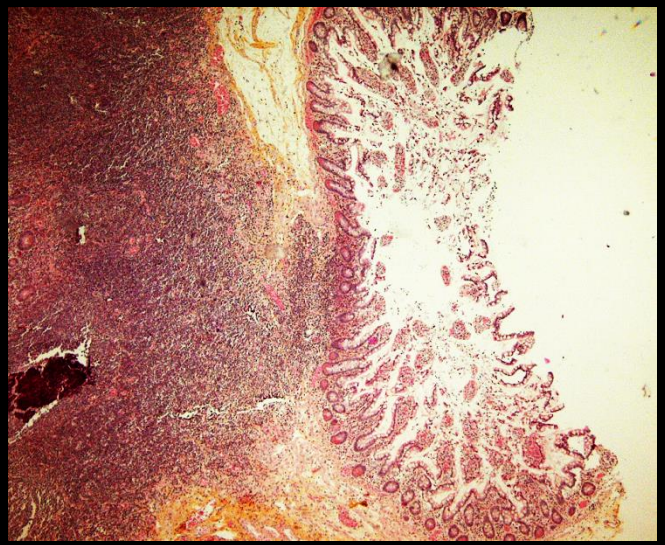


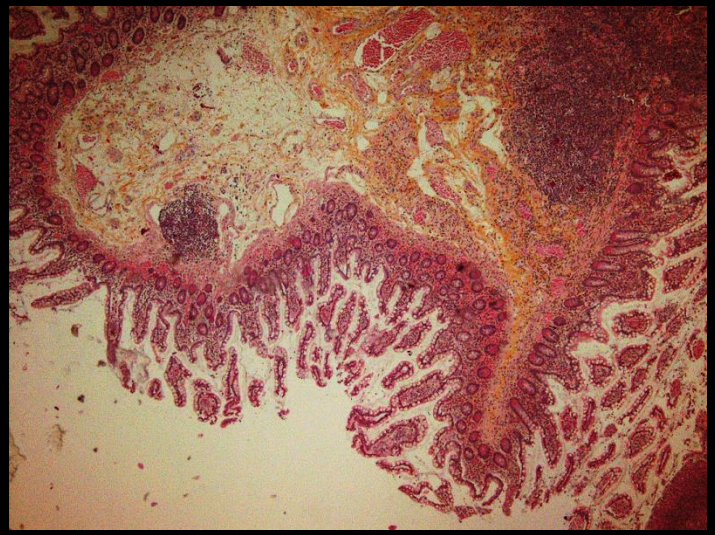




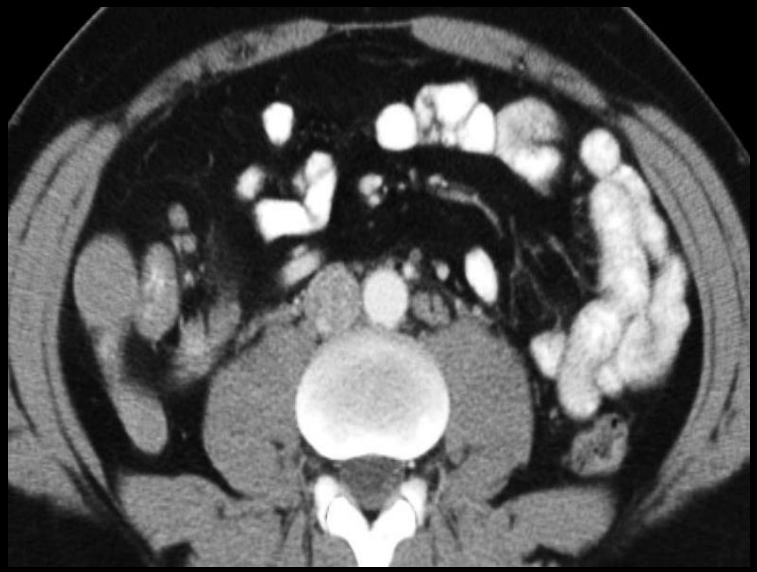
Lésion kystisée correspondant à une lésion bordée d'une muqueuse de type colique remaniée siège de dystrophies architecturales associées à un infiltrat inflammatoire marquée.

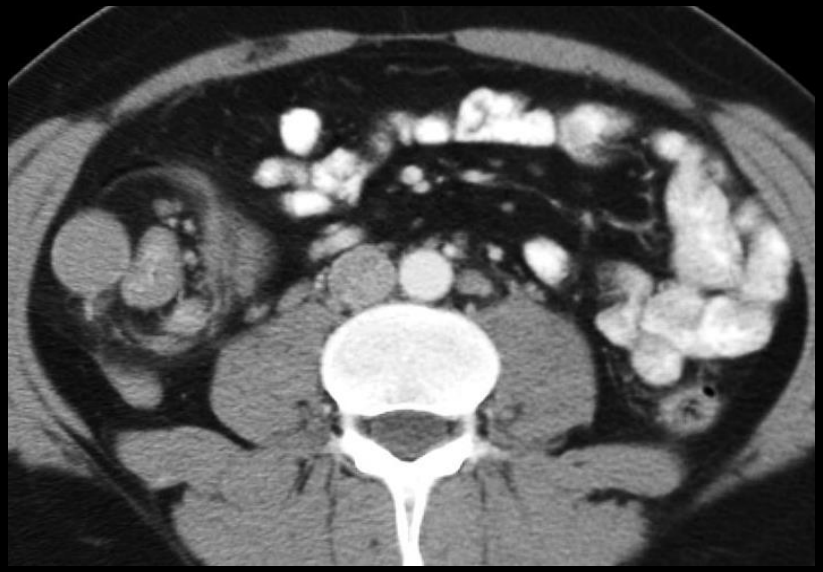


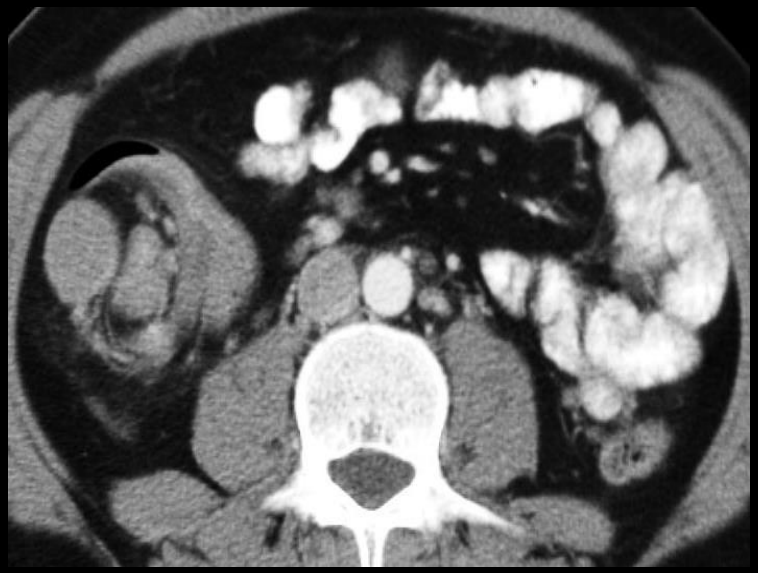


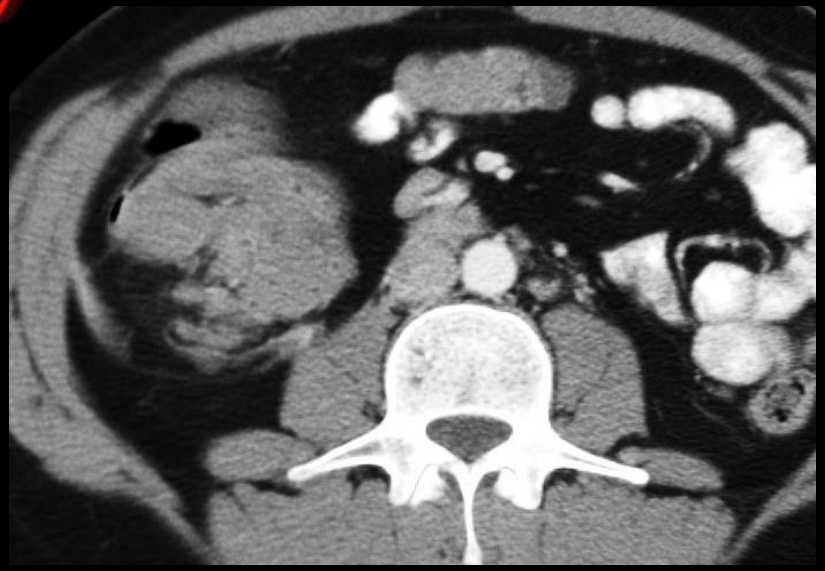


invagination iléo-colique chronique sur duplication kystique colique

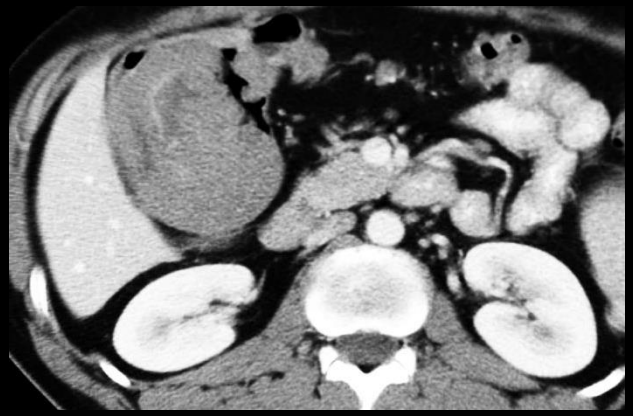
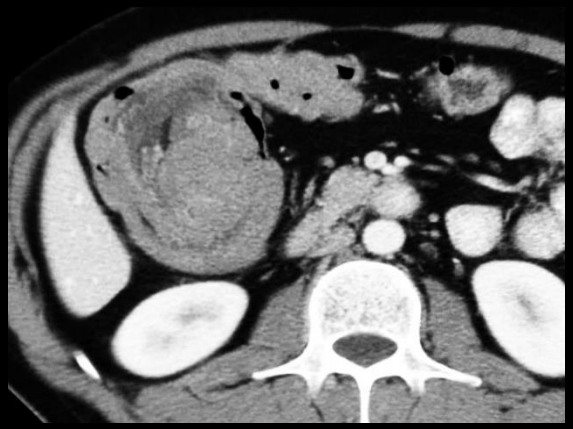
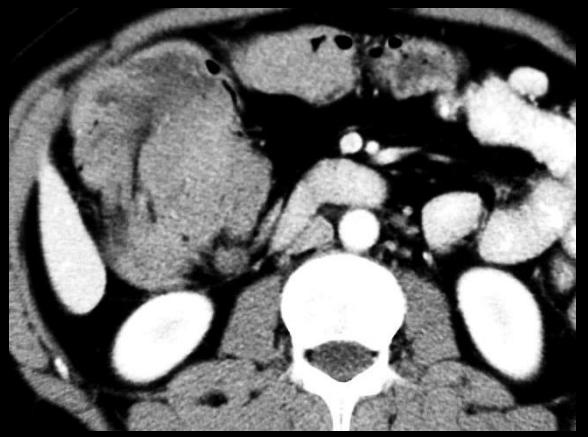
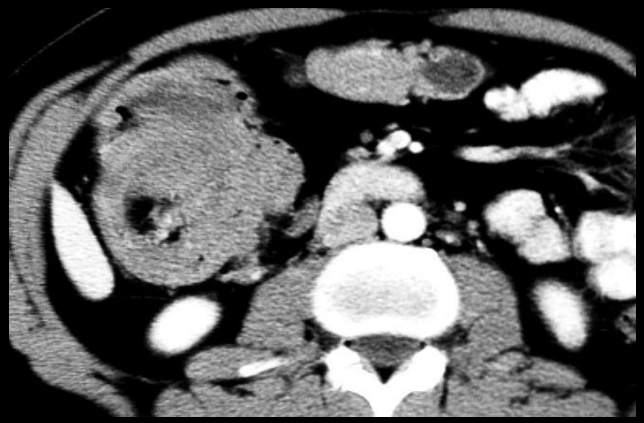
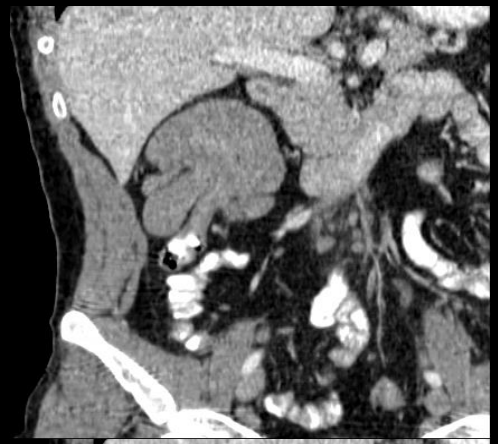
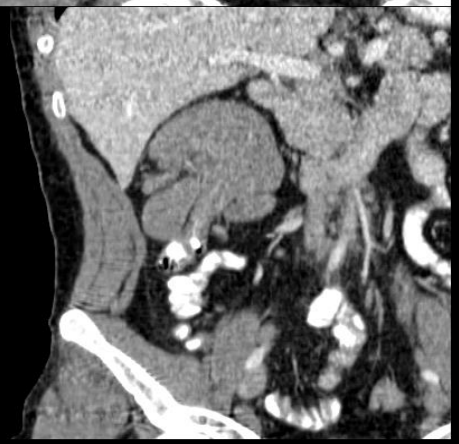
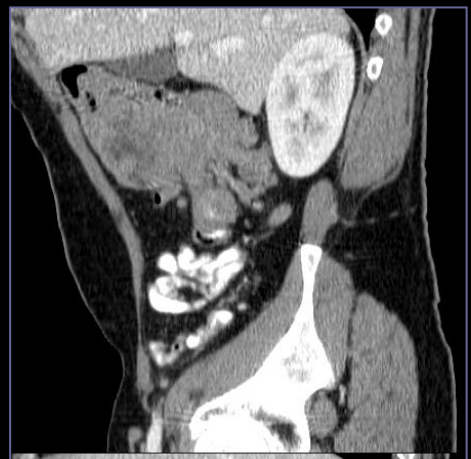
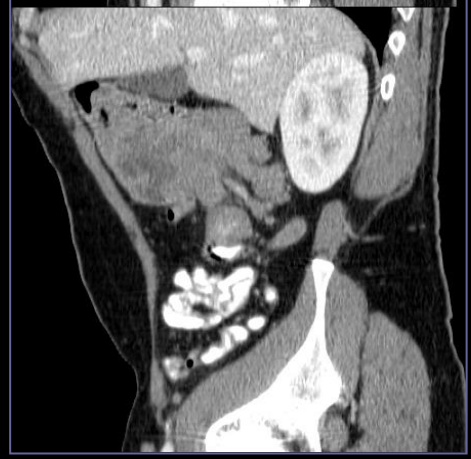




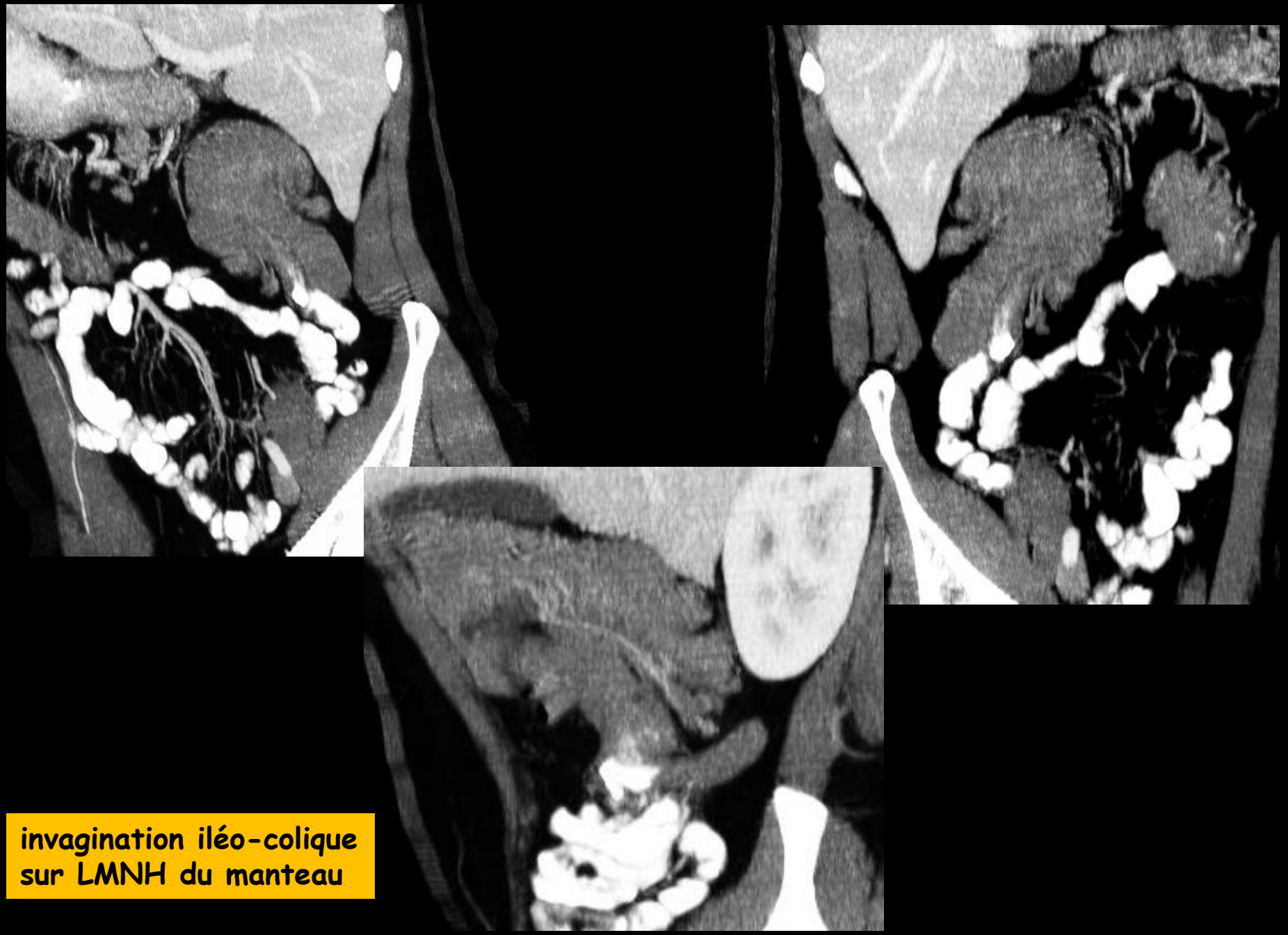




homme 41 ans; rectorragies,
masse du flanc droit

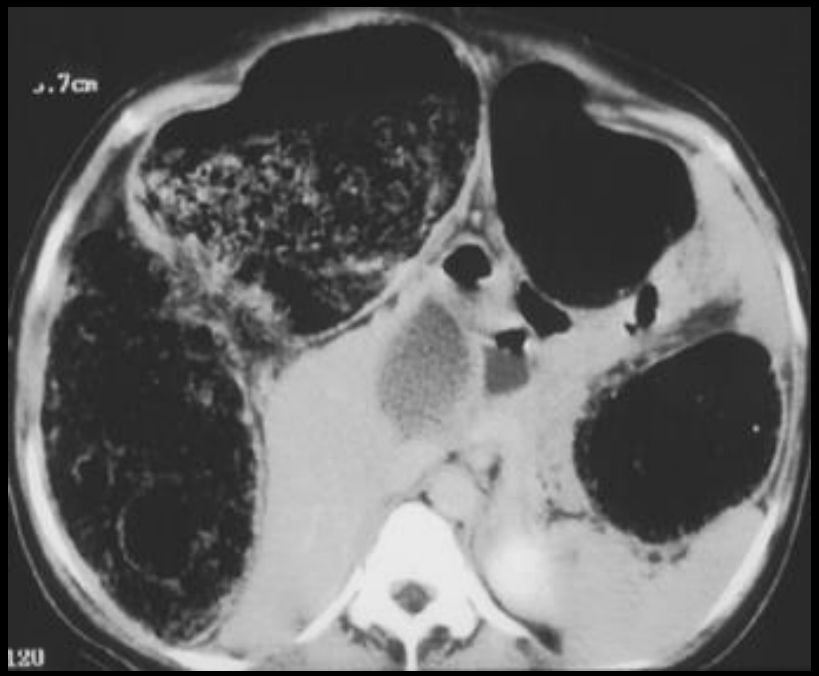









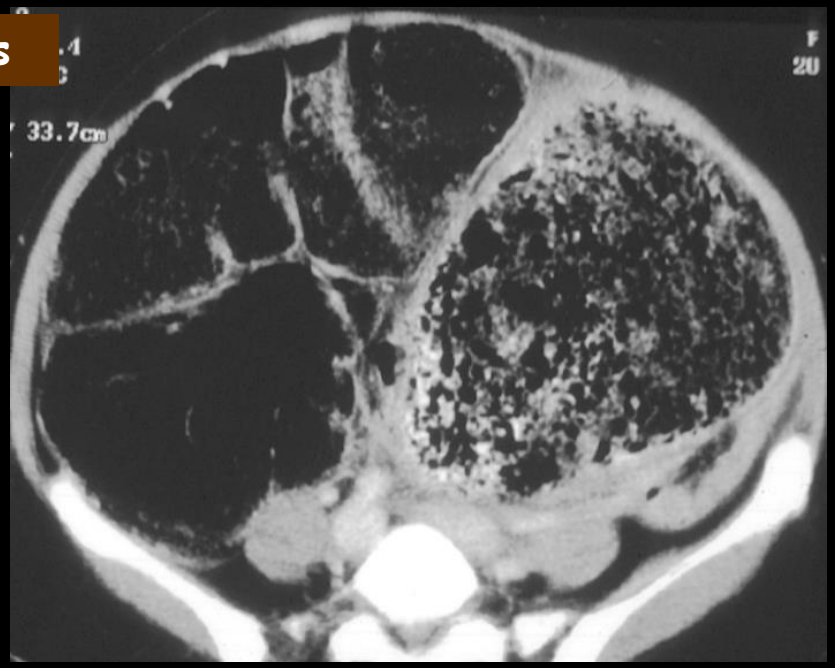
invagination iléo-colique sur LMNH du manteau du carrefour iléo-caecal

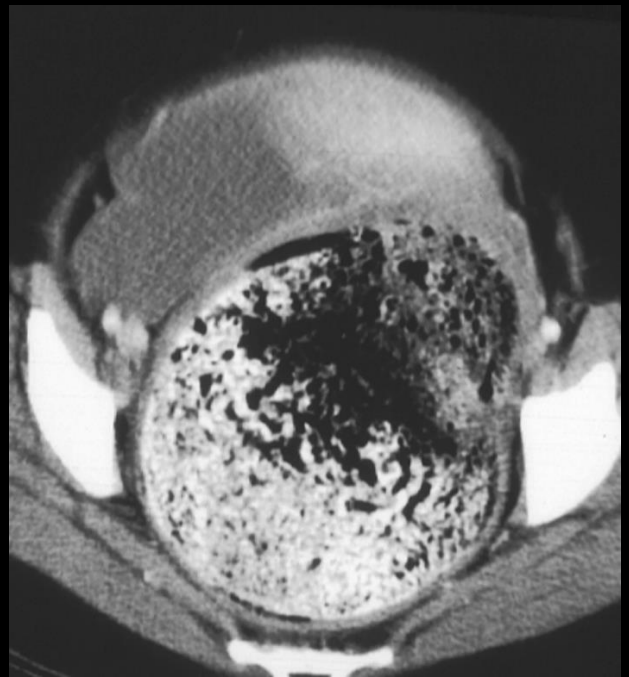


invagination iléo-colique
sur LMNH du manteau

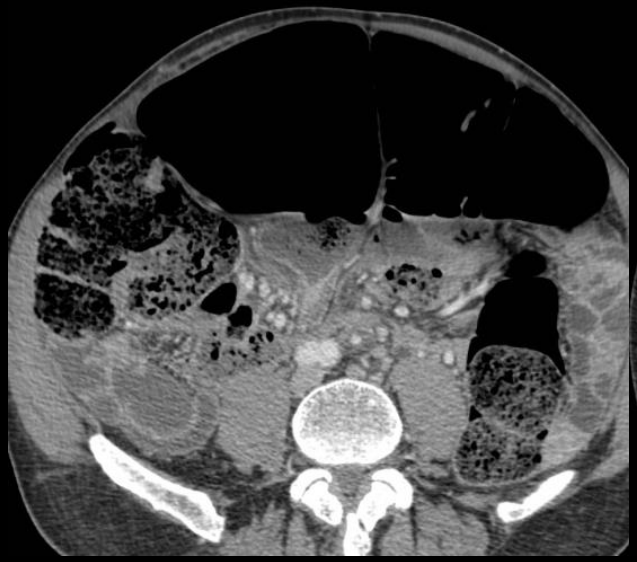
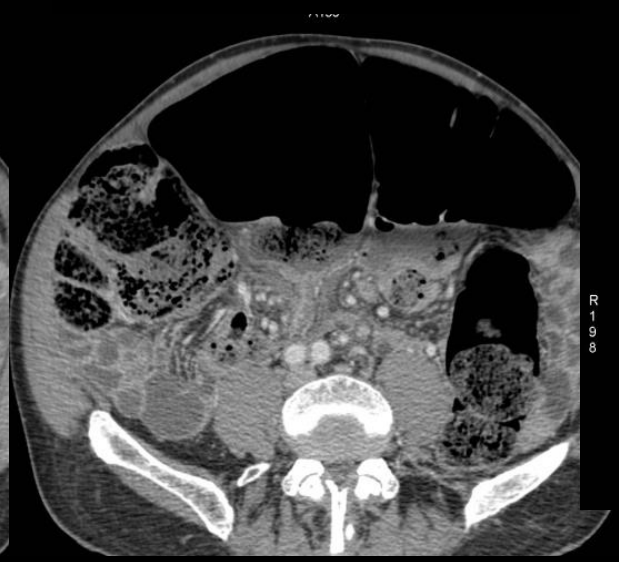
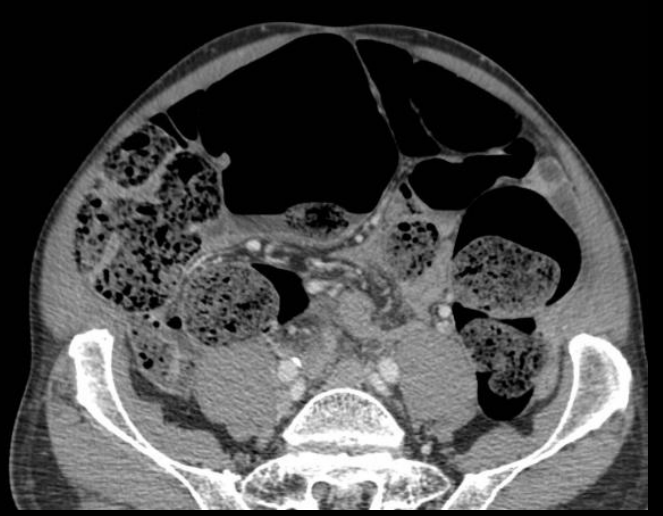
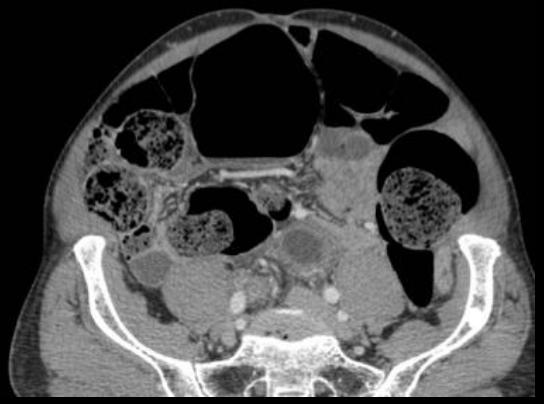
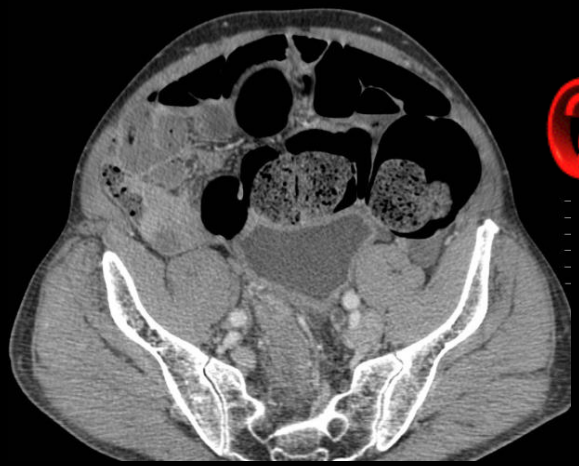
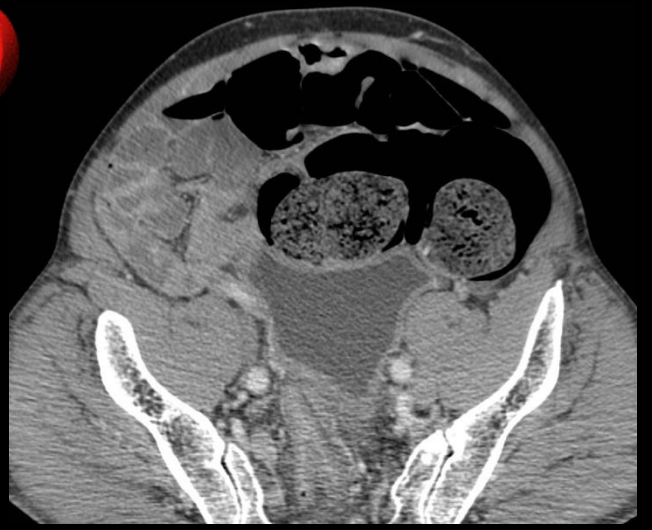
3-1-1 occlusions colo-rectales fonctionnelles

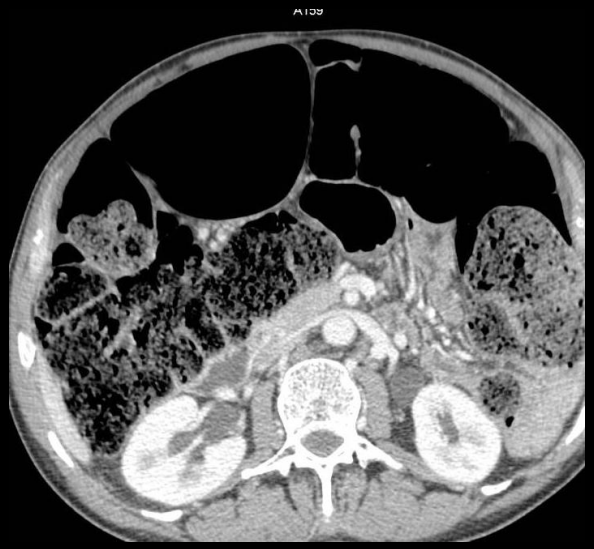


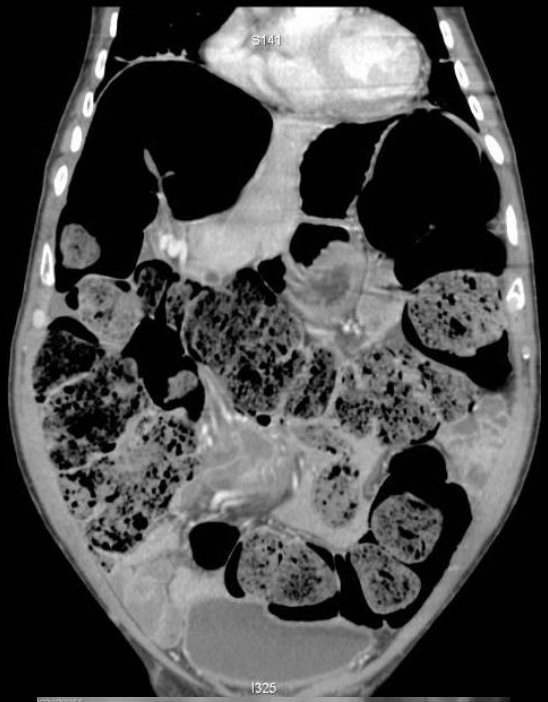


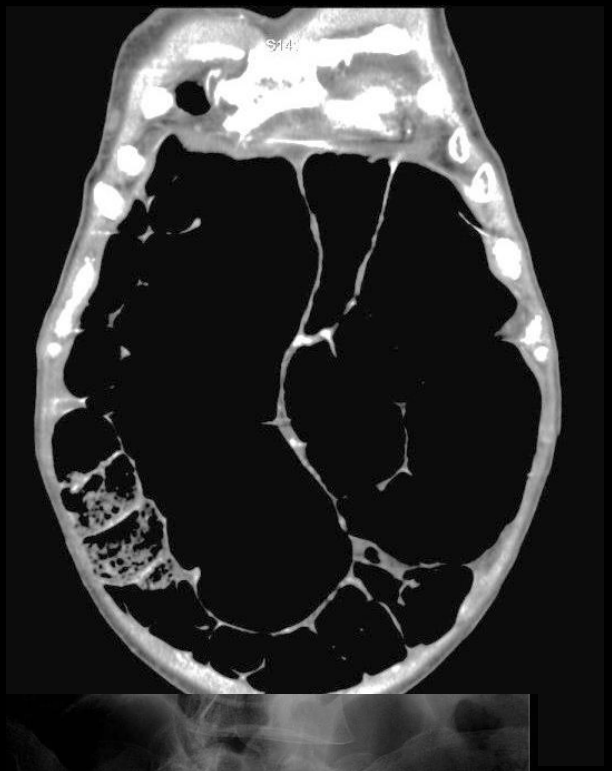


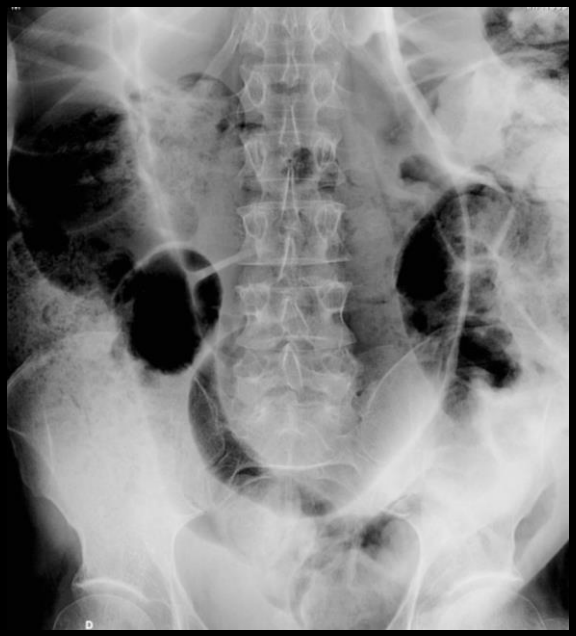
dolichocôlon neuroleptiques

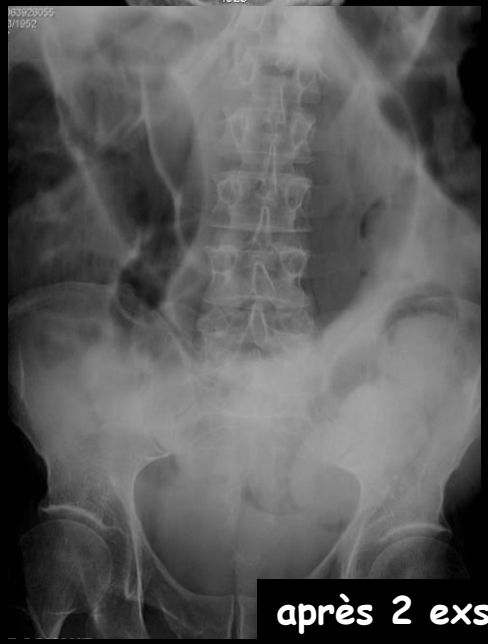







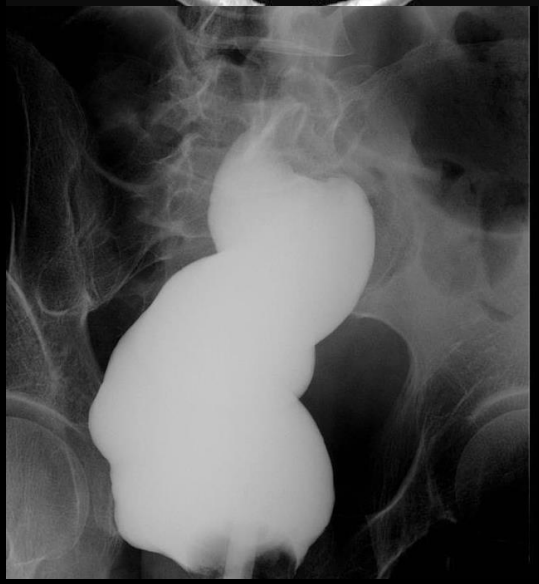




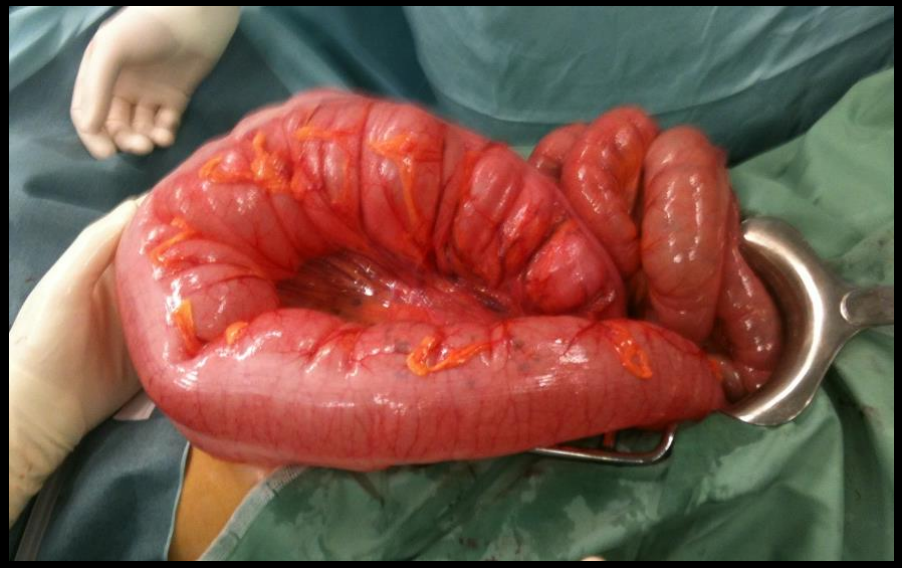


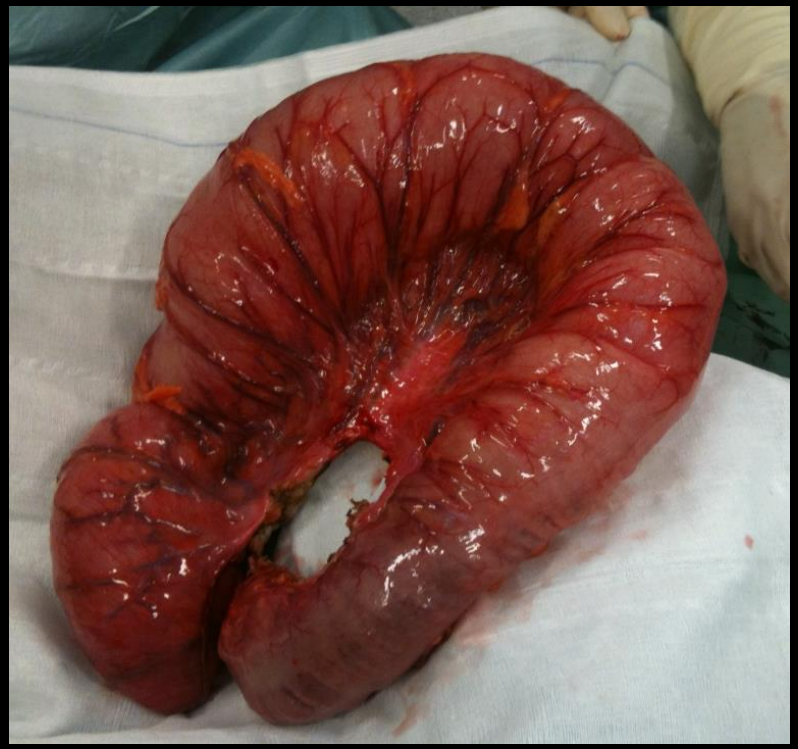




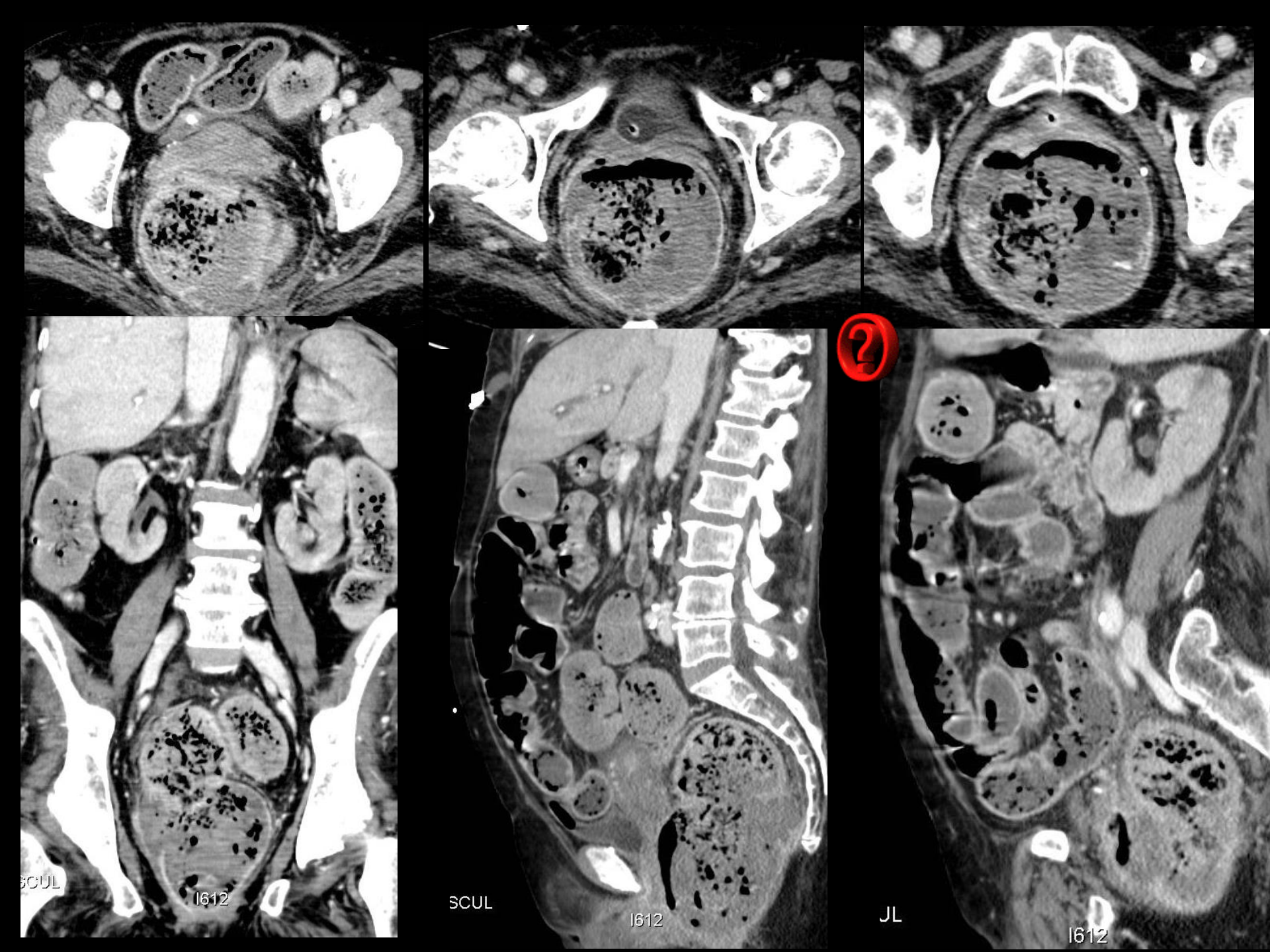


après 2 exsufflations ; patient psychotique





volvulus mésentérico-axial sur syndrome d'Ogilvie chez un psychotique institutionnalisé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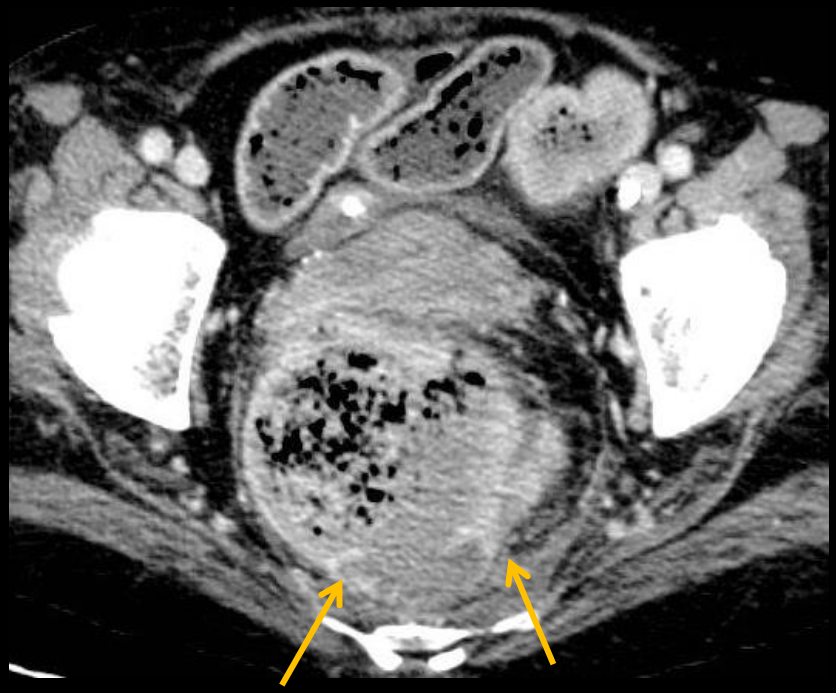
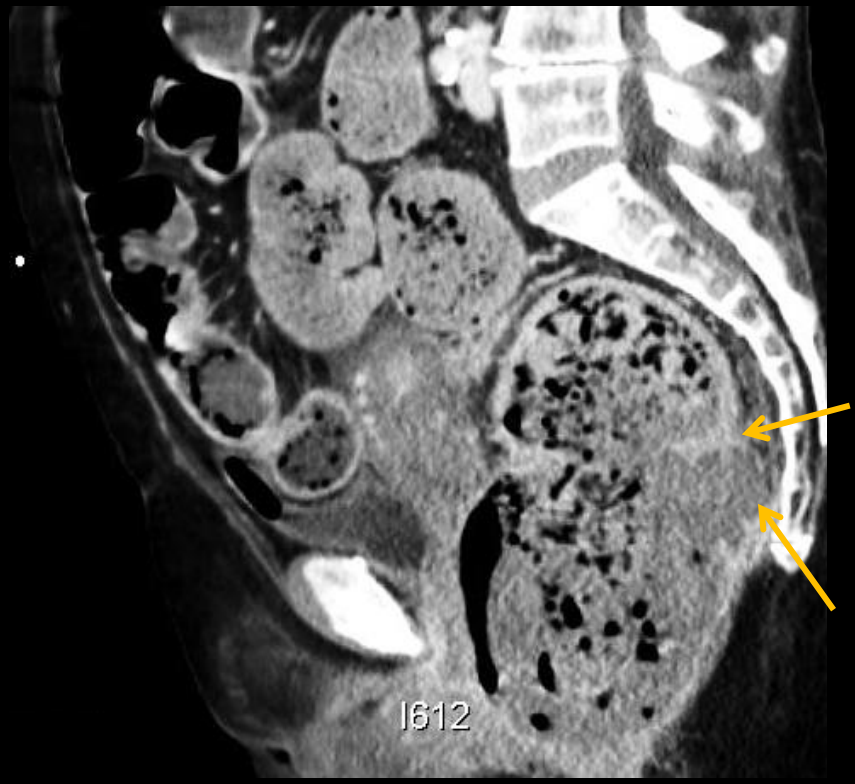
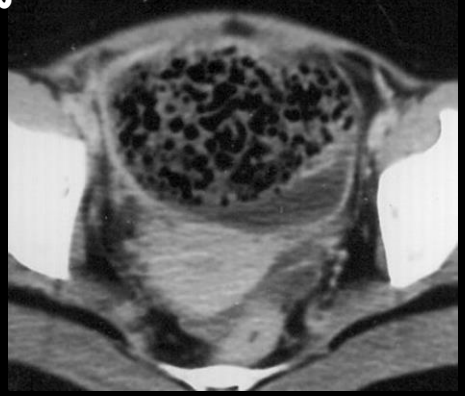
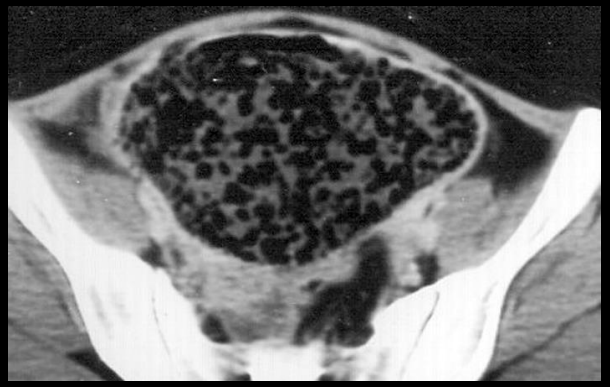


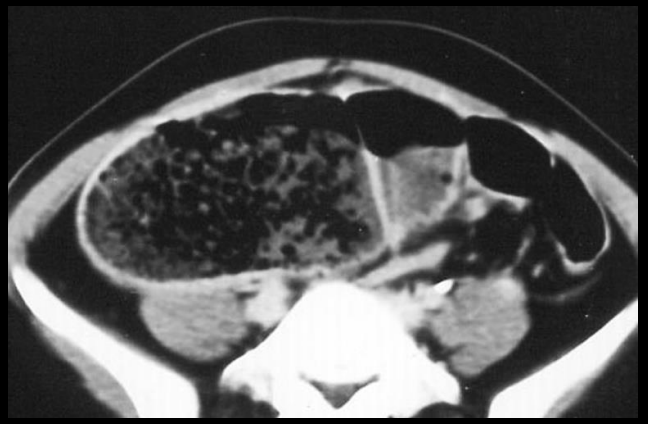


perforation rectale postérieure sur impaction fécale (fécalome)

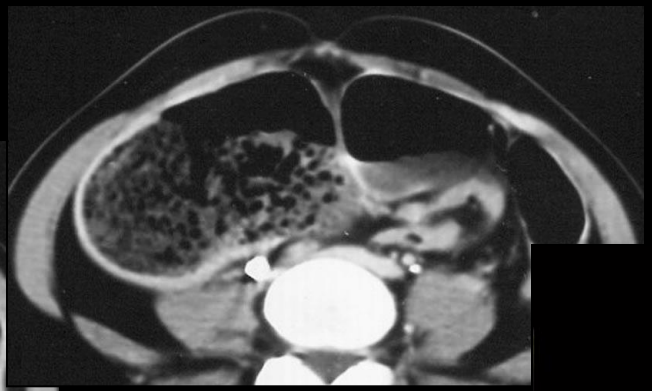
jeune vietnamienne 19 ans ; sd douloureux de la FID

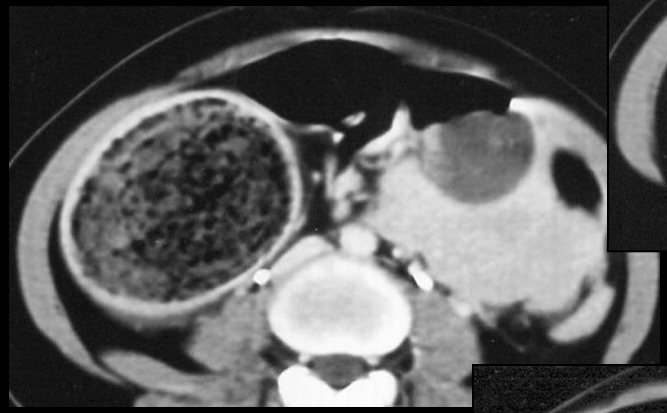




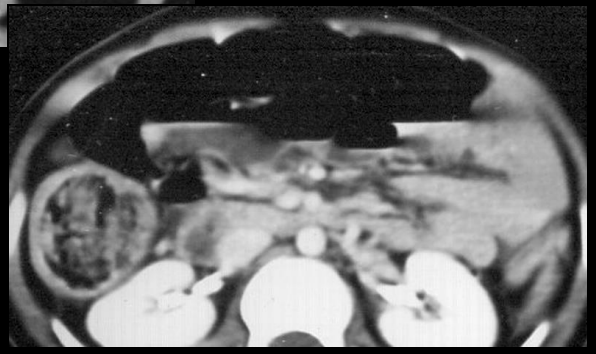


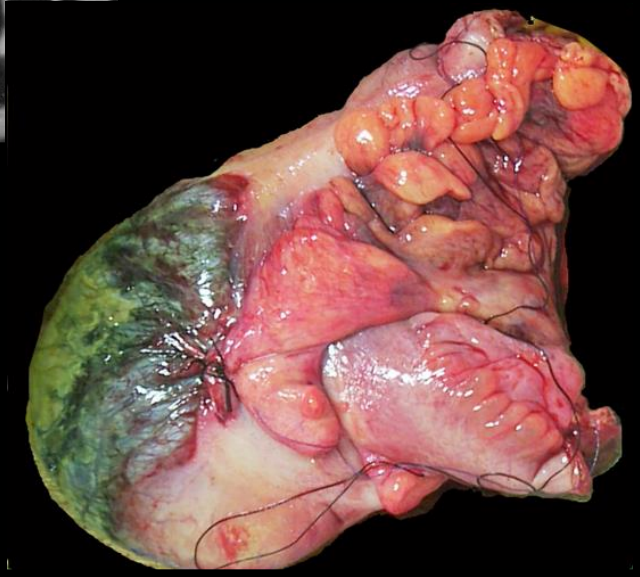
Obs. IN Phi Saïgon

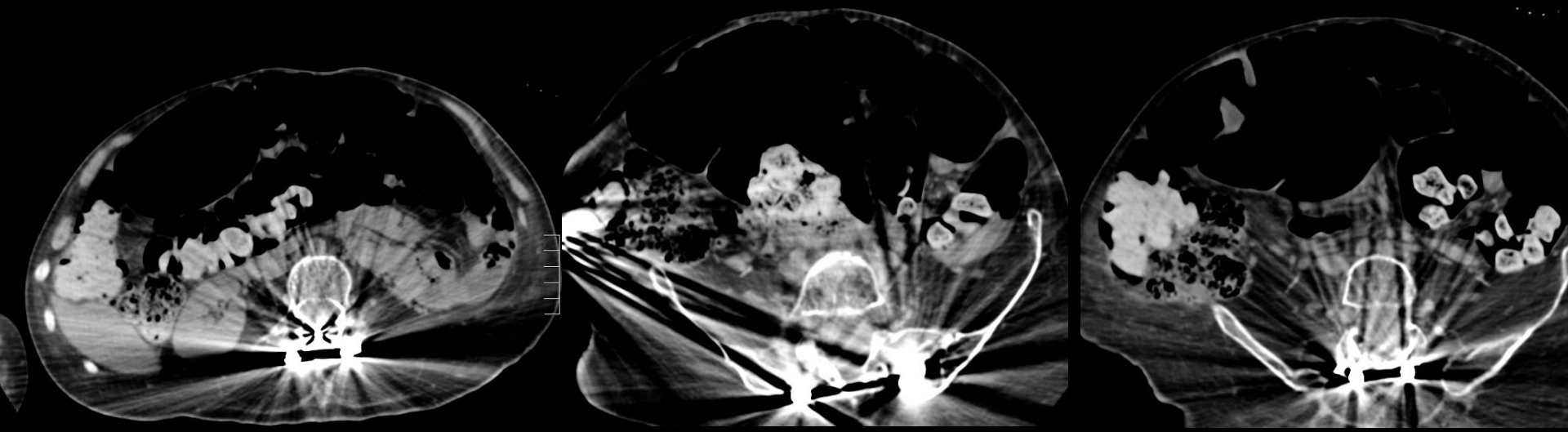


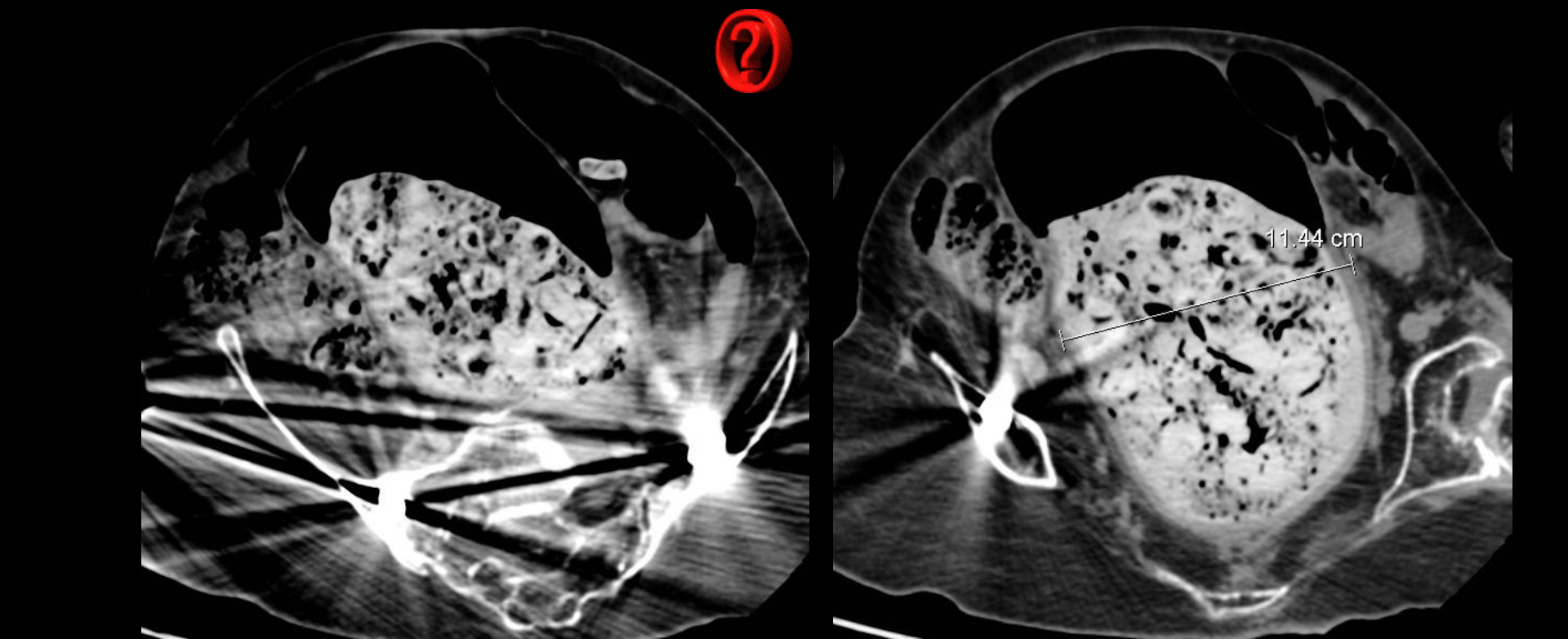


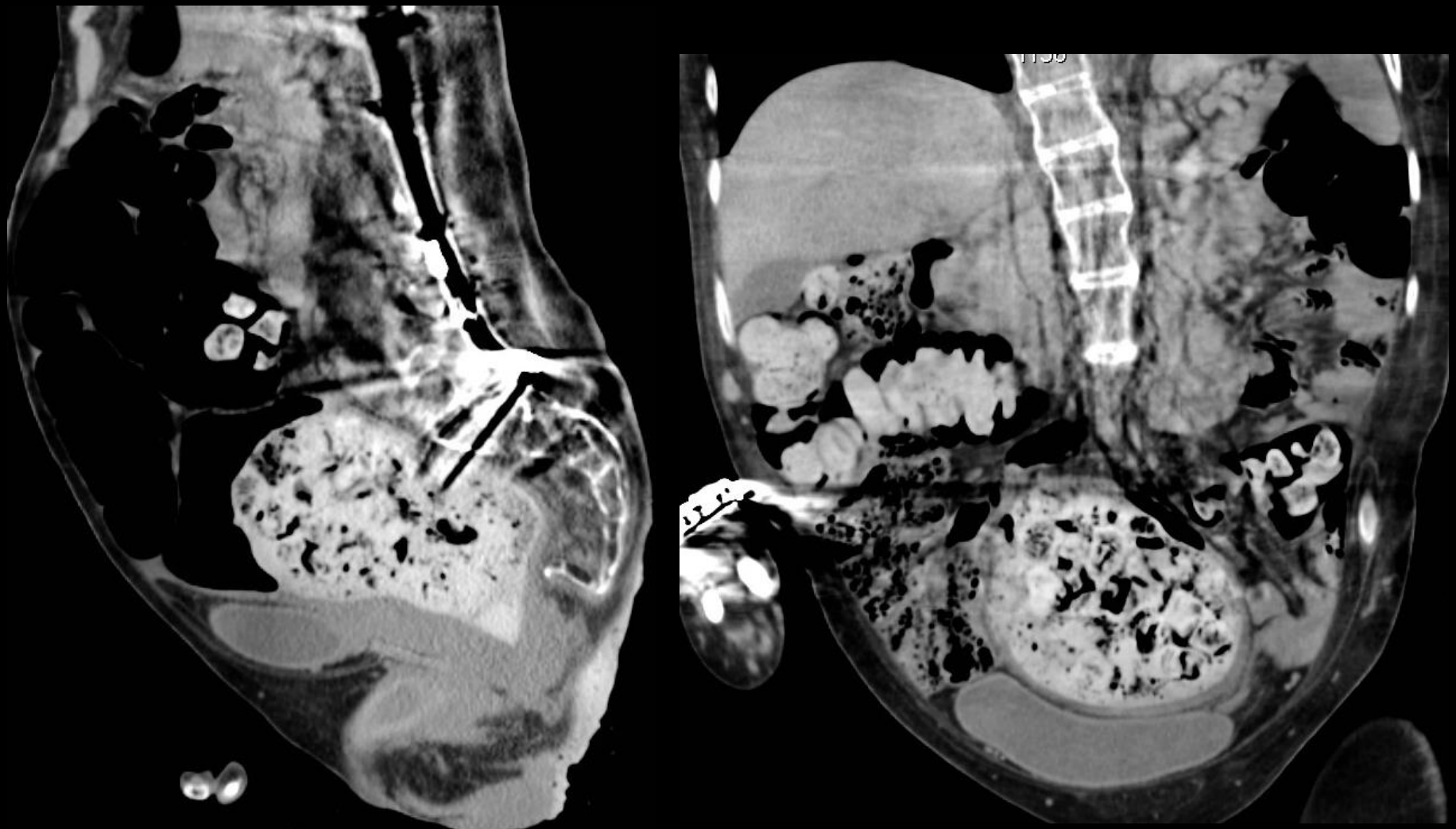
nécrose colique transmurale sur <u>impaction fécale</u>

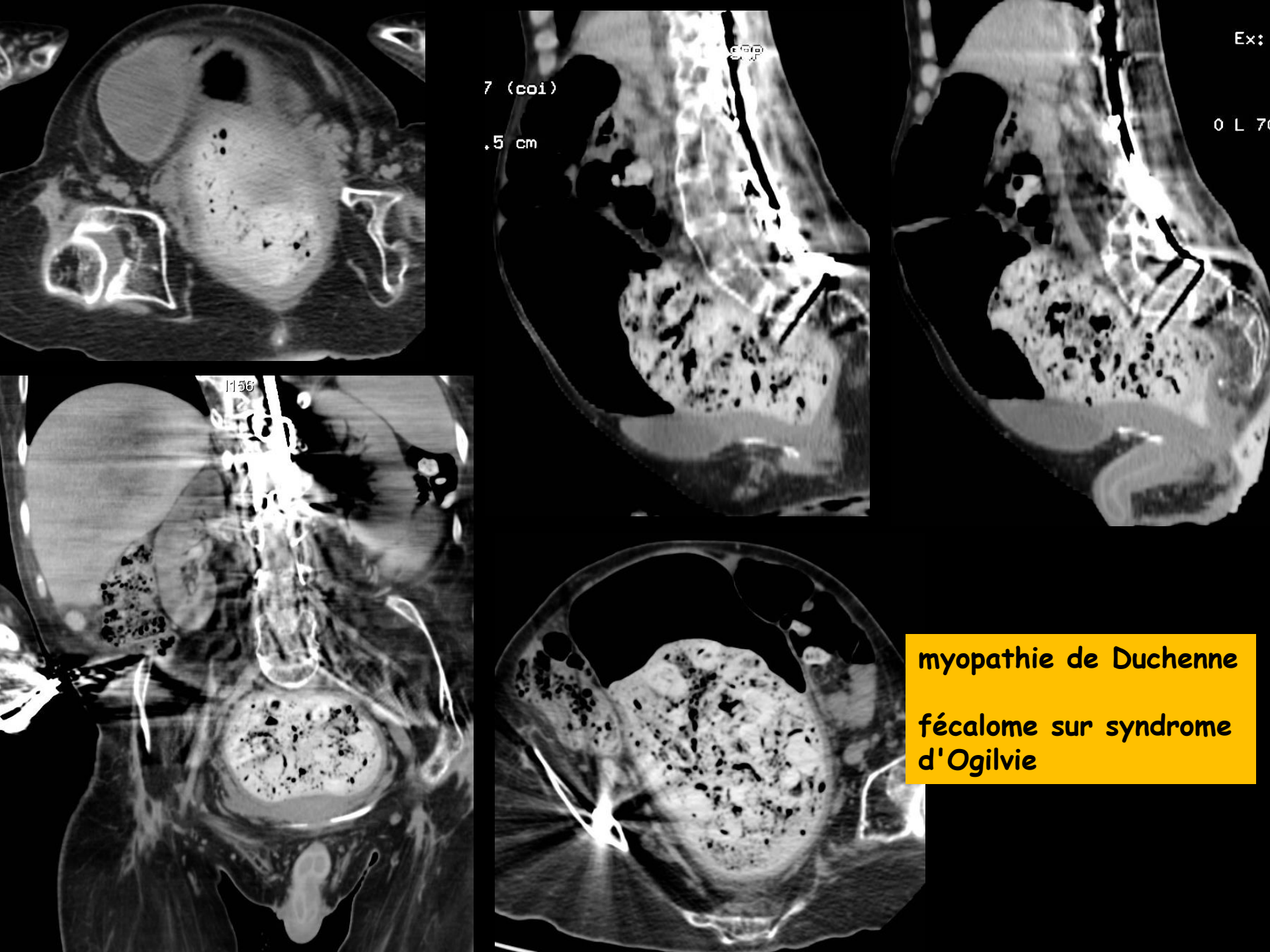







11.44 cm





myopathie de Duchenne

fécalome sur syndrome d'Ogilvie

3-2 bases physiopathologiques des occlusions colo-rectales

3-2-1 les occlusions basses par obstruction

leur tableau clinique reste souvent peu spécifique: ballonnement abdominal, nausées plus que vomissements , modification récente du rythme défécatoire difficile à préciser

leur prise en charge est dominée par le risque de perforation diastatique du caecum la distension caecale , l' encombremant stercoral , l'épaississement de la paroi caecale , l'aspect infiltré du péritoine adjacent…. sont des signes d'alerte qu'il faut impérativement rechercher en imagerie

l'anémie par déperdition, l'aspect rubanné des selles , un syndrome rectal …sont des éléménts cliniques importants que le radiologue doit rechercher dans son dialogue avec le patient <;

3-2-1 les occlusions basses avec strangulation

Les composantes vasculaires des tableaux occlusifs aigus coliques s'observent essentiellement dans les volvulus et dans les invaginations iléo-coliques ou colo-coliques.

Les hernies pariétales et les hernies internes renfermant un segment colique peuvent elles aussi se compliquer d'occlusion avec strangulation vasculaire

3-2 bases sémiologiques de l'imagerie des occlusions basses

3-2-1 les clichès d'abdomen urgent

-images hydro-gazeuses coliques + ou- grêles en fonction de la continence de la valvule de Bauhin

-degré de distension caecale fondamental à apprécier (sur l'ASP en decubitus rayon directeur vertical ou sur le scout view du CT) et à signaler dans le CR

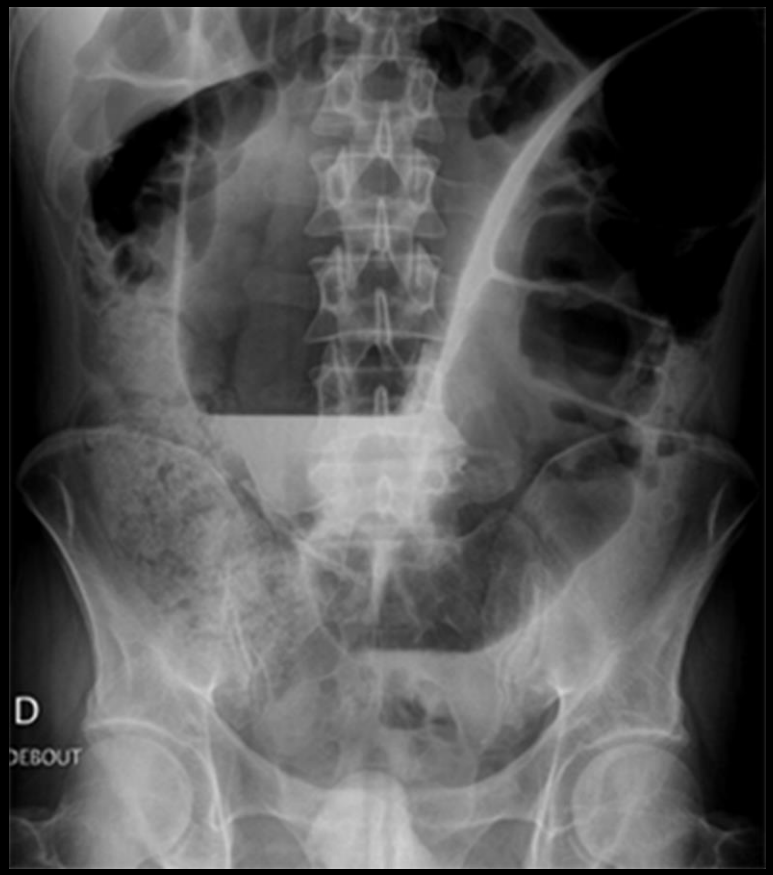
informer en urgence le médecin demandeur de l'examen si le seuil de 90 mm (voir 70 mm) est dépassé

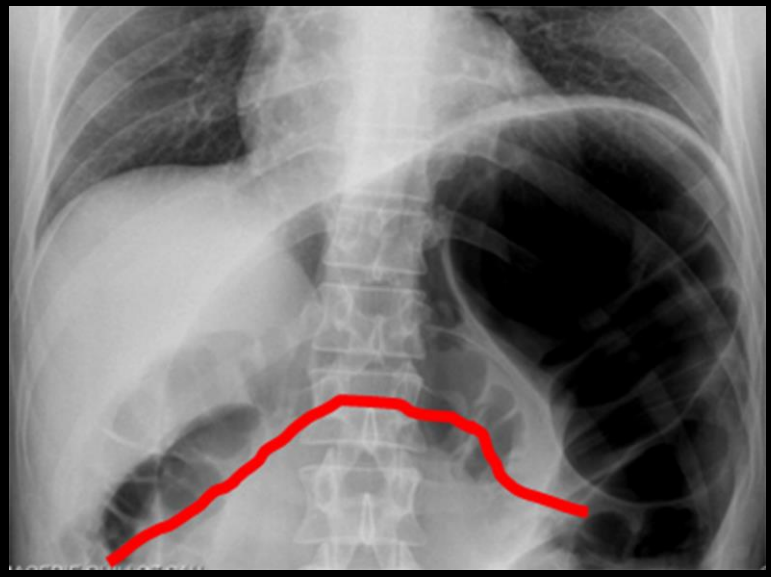
-le pneumopéritoine est le plus souvent massif , ce qui a valeur d'orientation diagnostique mais la perforation caecale peut être "couverte" lorsqu'elle siège sur la face postérieure

-La distension gazeuse est un élément précieux pour reconnaître certaines causes d'occlusion, en particulier le volvulus mésentérico-axial du sigmoïde avec son aspect très typique en " grain de café " pelvi-abdominal. La distension des colons droit et gauche constitue, associée à la précédente, l'image classique de " l'occlusion dans une occlusion".

-Les travaux récents ont insisté sur la valeur diagnostique au scanner, du" signe du pôle nord émergé " (northern exposure sign), expression imagée pour décrire le fait que le sommet du" grain de café" dépasse le niveau du colon transverse et atteint les coupoles diaphragmatiques dans le volvulus mésentérico-axial du sigmoïde. Ce signe est bien évidemment parfaitement visible sur les clichés d'abdomen urgent; c'est d'ailleurs dans cette technique qu'il a été décrit

-une pneumobilie (pneumocholécyste , pneumocholédoque) doit être systématiquement recherchée, n particulier chez la femme âgée chez qui l'ileus biliaire est la 1ère cause d'occlusion

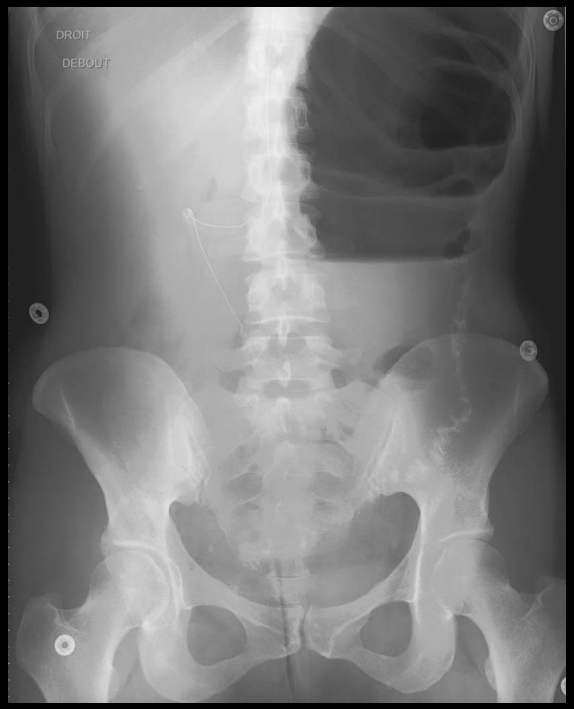


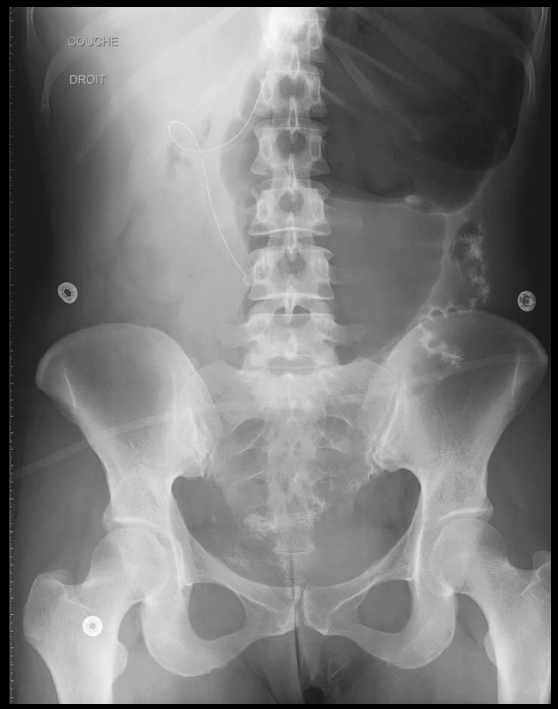


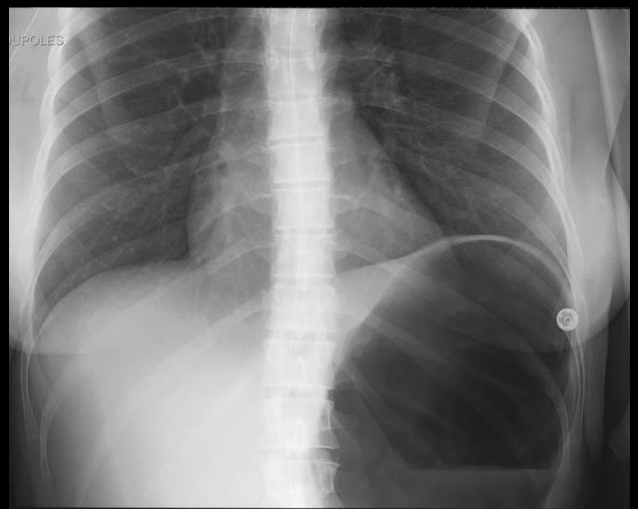
volvulus mésentérico-axial du sigmoïde:

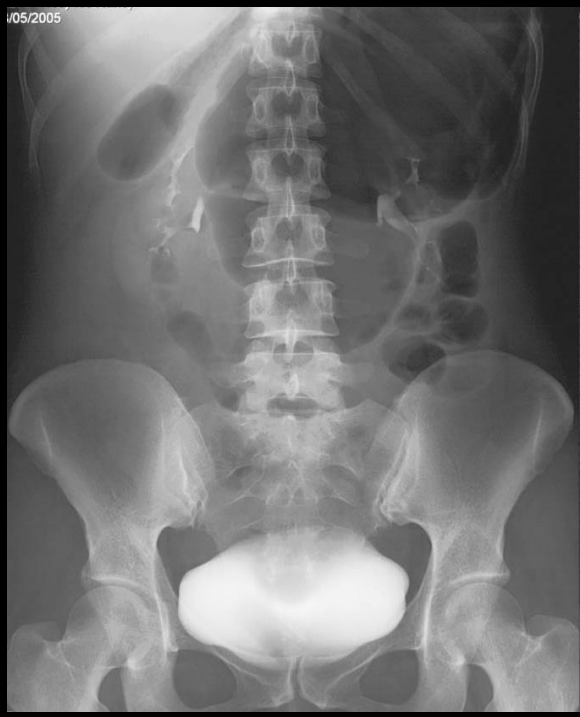
-image "en grain de café" (juxtaposition des parois médiales des 2 jambages) -- croisement des 2 jambages à l'étage pelvien

-"northern exposure sign" le sommet du dolichosigmoïde dépasse le colon transverse

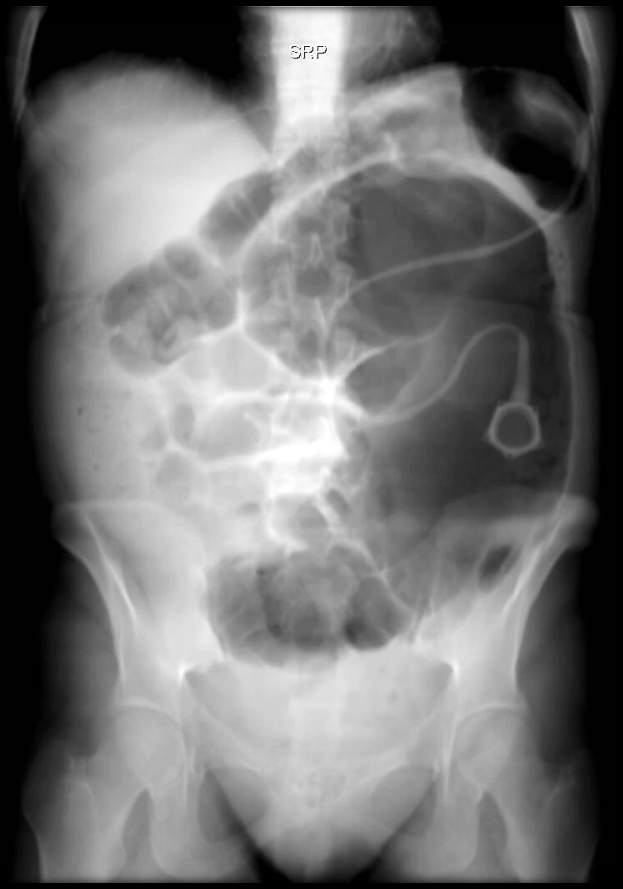


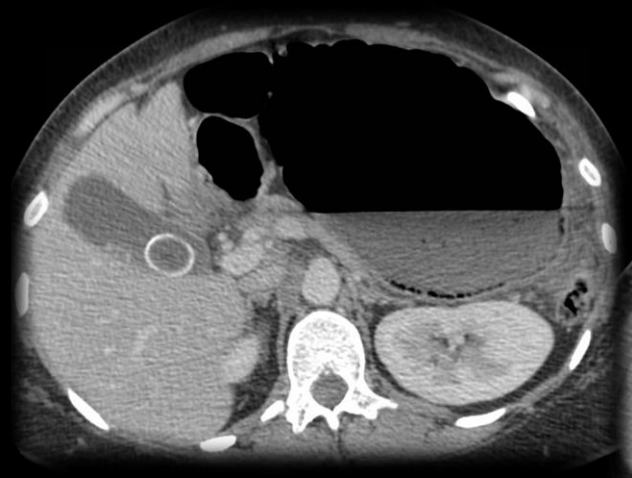


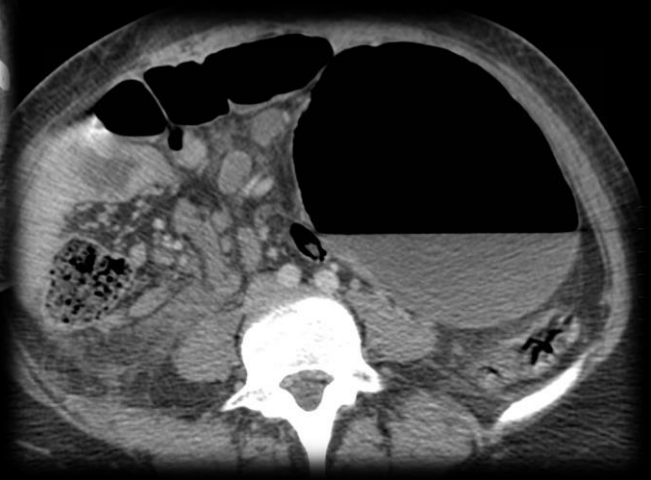


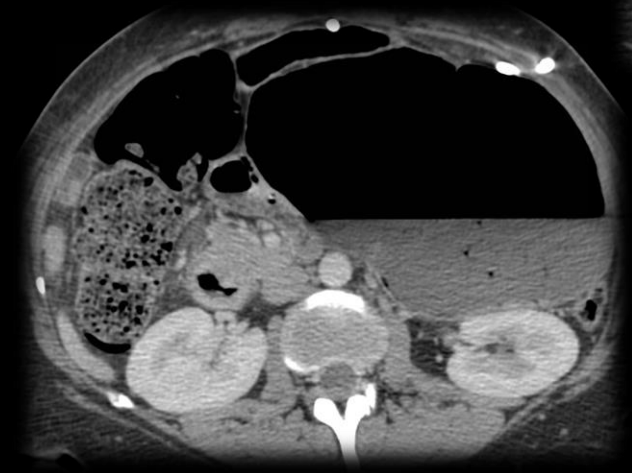


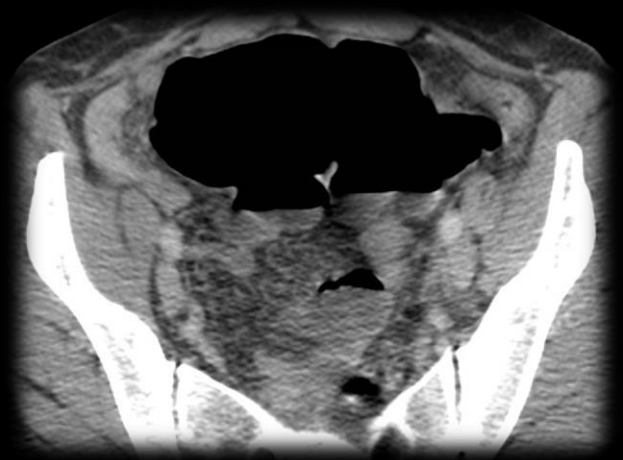
asp. post CT

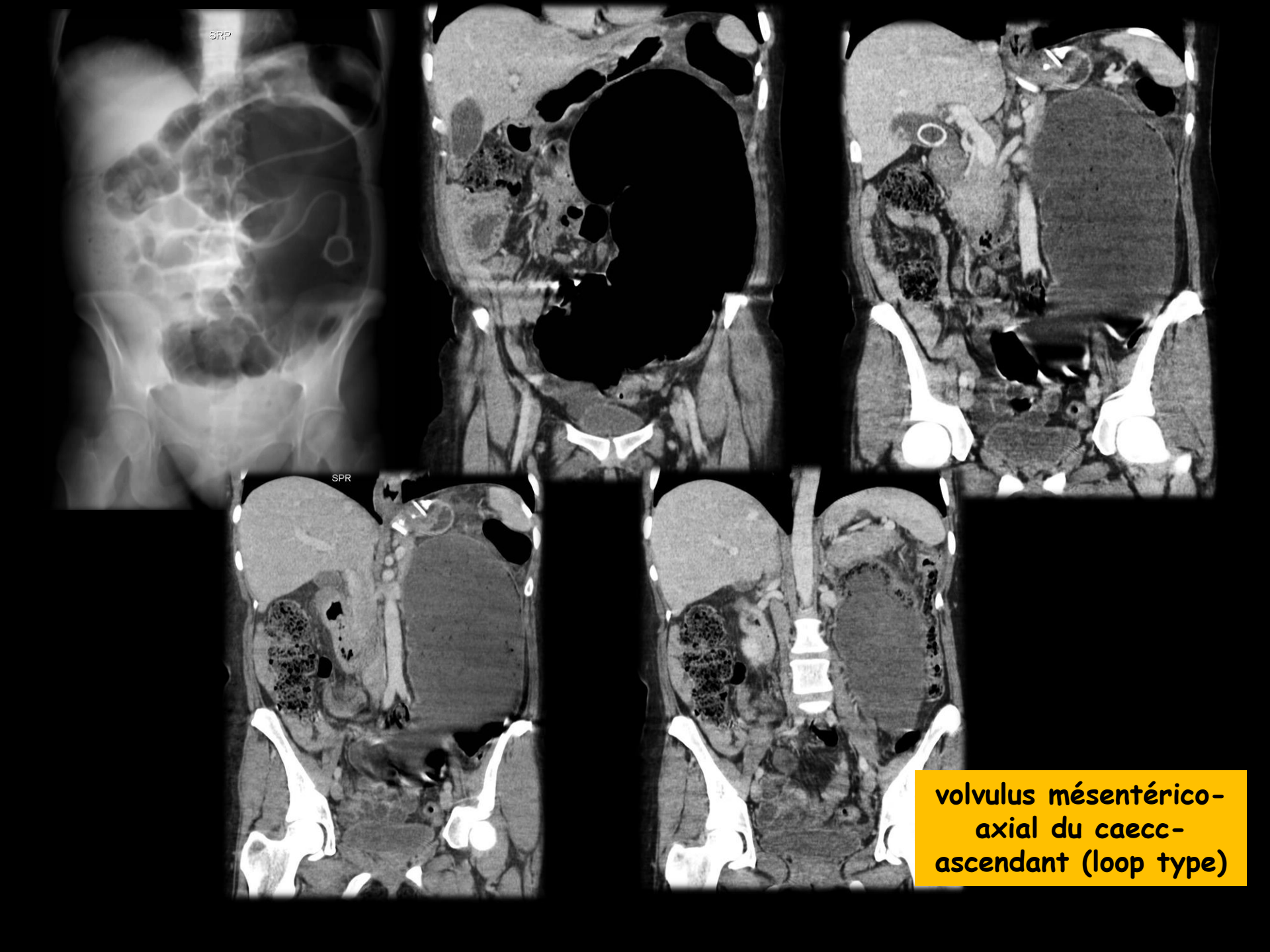

SRP



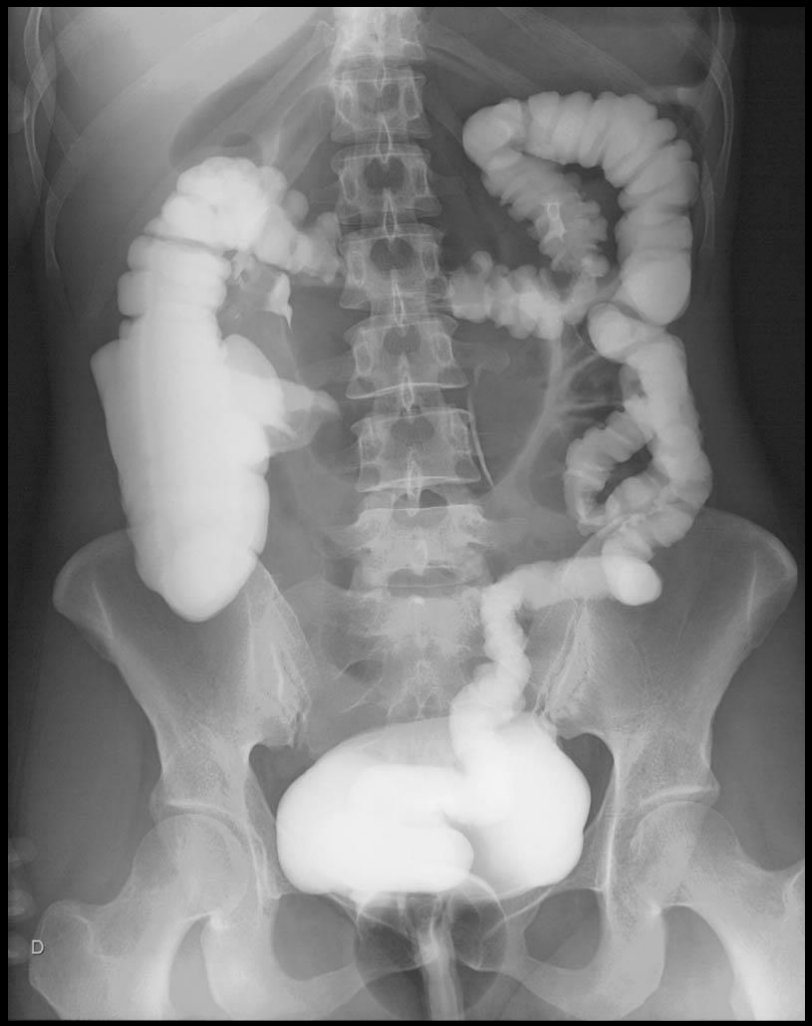








volvulus mésentérico-axial du caecc-ascendant (loop type)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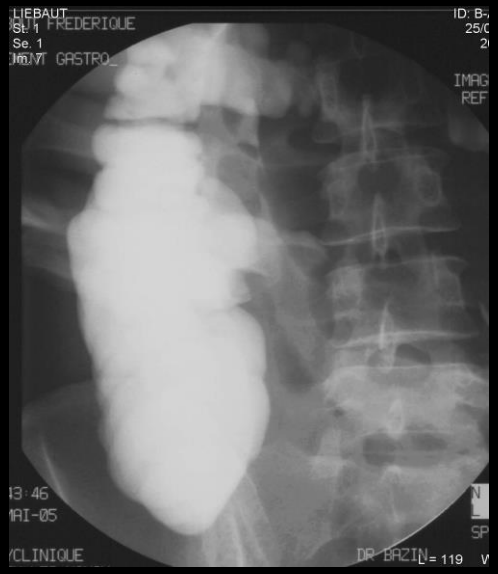
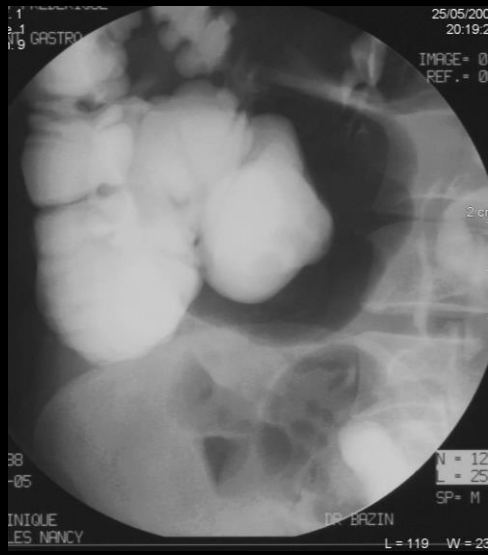
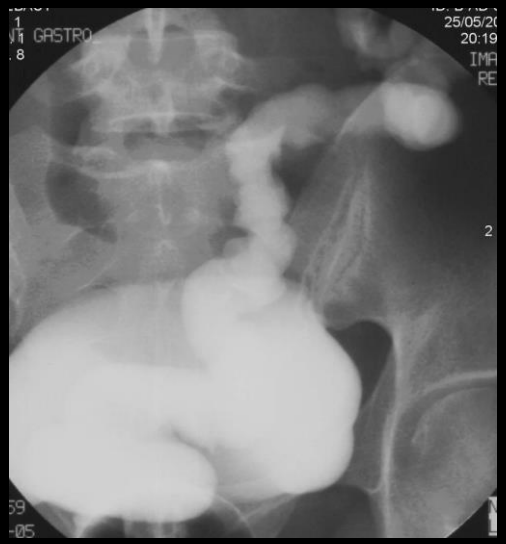
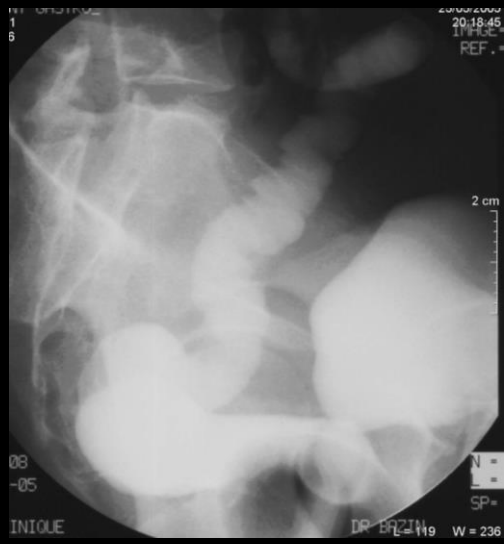
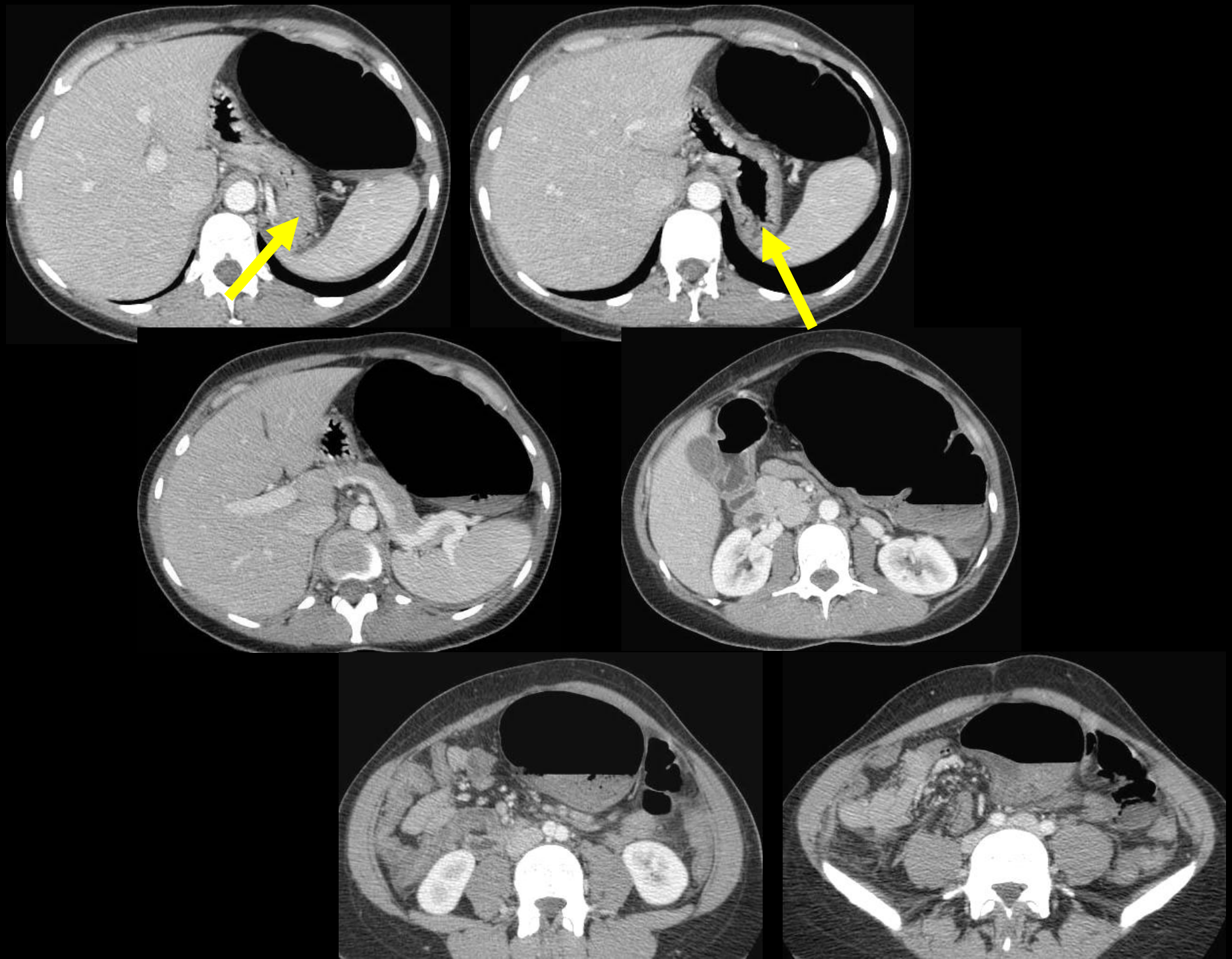
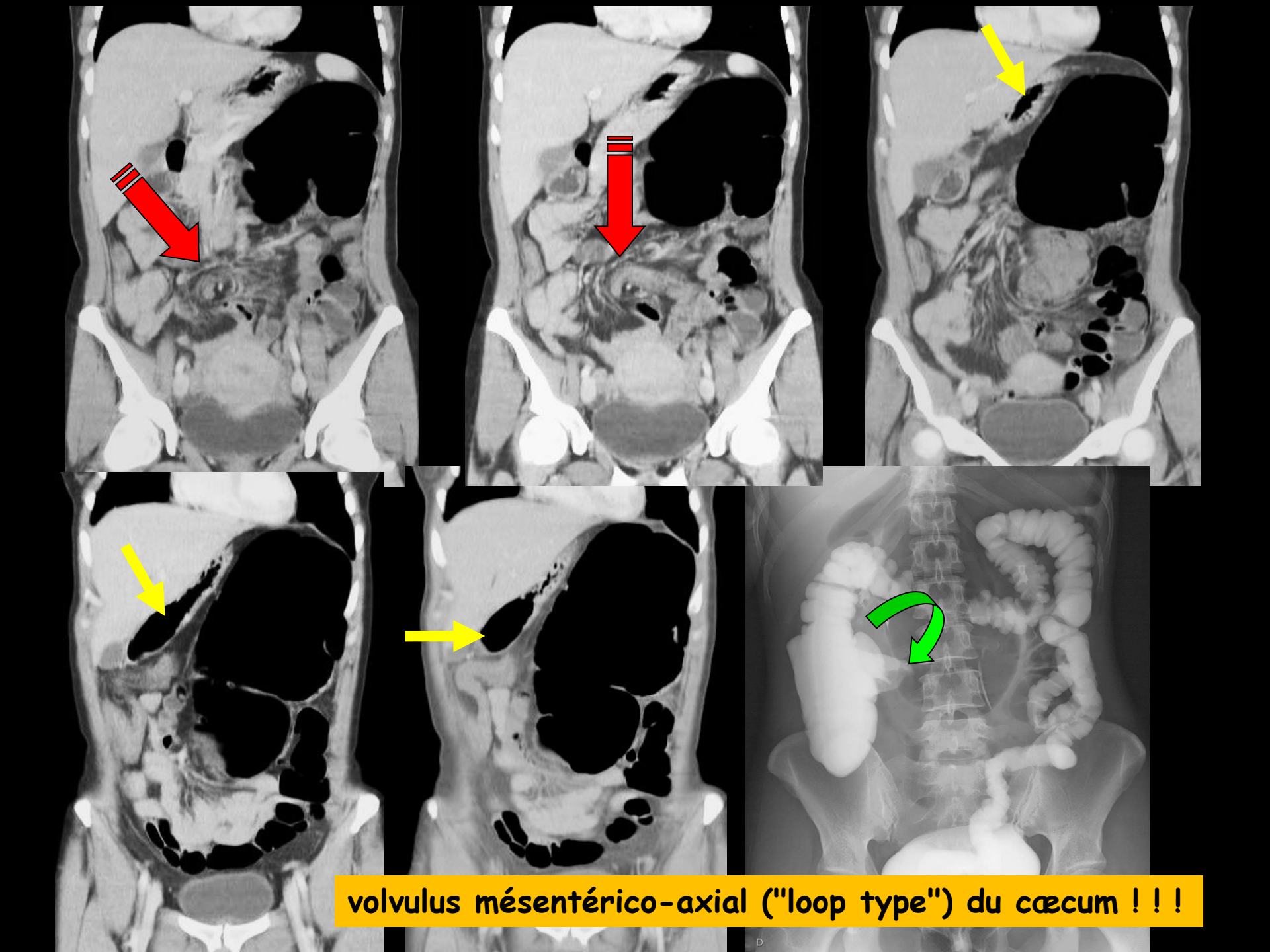

LIEBAUT
FREDERIQUE
GASTRO
DR BAZIN


GASTRO
DR BAZIN
L = 119


GASTRO


2 cm
DR BAZIN
L = 119
W = 236




volvulus mésentérico-axial ("loop type") du cæcum ! ! !

3-3 bases sémiologiques d'exploration des occlusions basses

3-2-2 l'échographie

-pour les segments accessibles en distension liquide : sigmoïde

3-2-3 les opacifications aux hydrosolubles iodés

-en radiographie classique par projection

-de préférence dilués en balisage recto sigmoïdien sur les scanners

3-2-4 exploration scanographique des occlusions basses

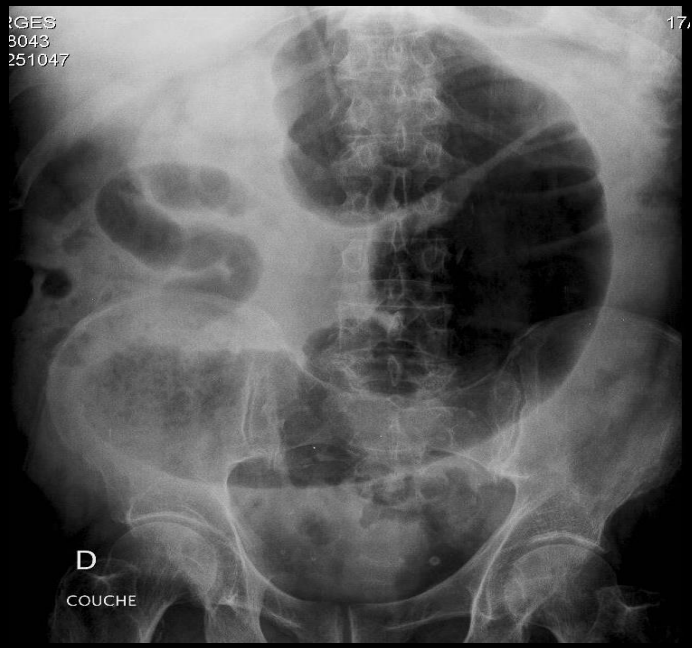
-examen thoraco-abdomino pelvien

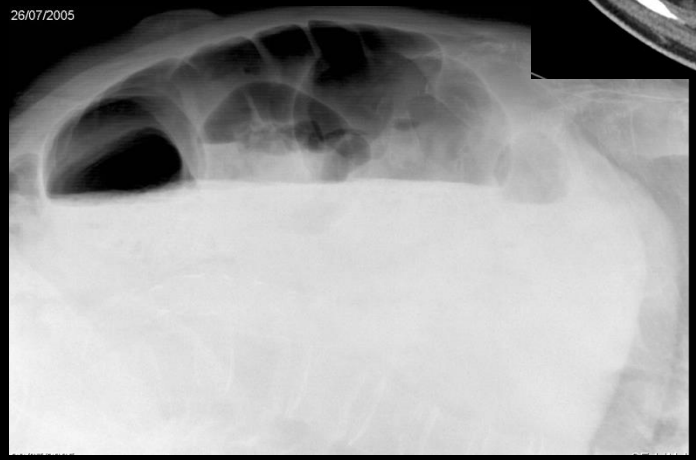
-acquisition avant injection

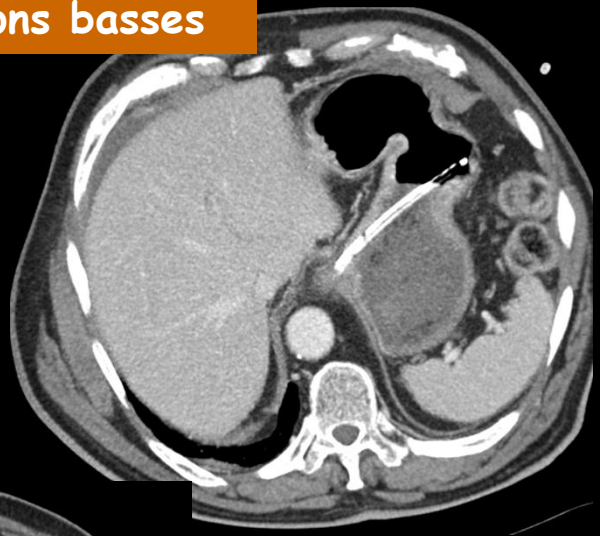
-balisage opaque en fonction de la difficulté d'analyse du contenu pelvien sr les coupes "à blanc "

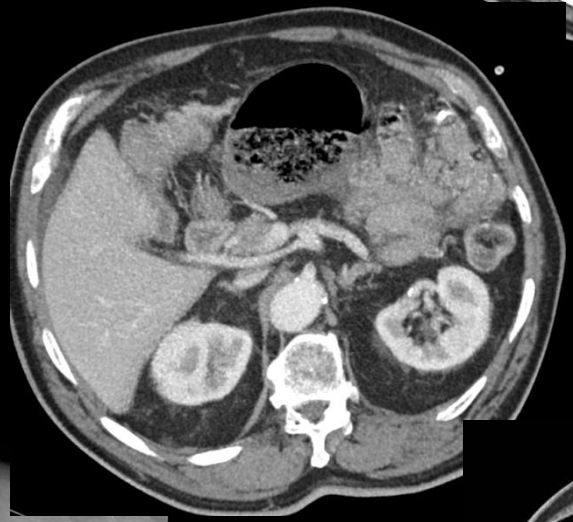
3-2-5 bases sémiologiques scanographiques des occlusions basses

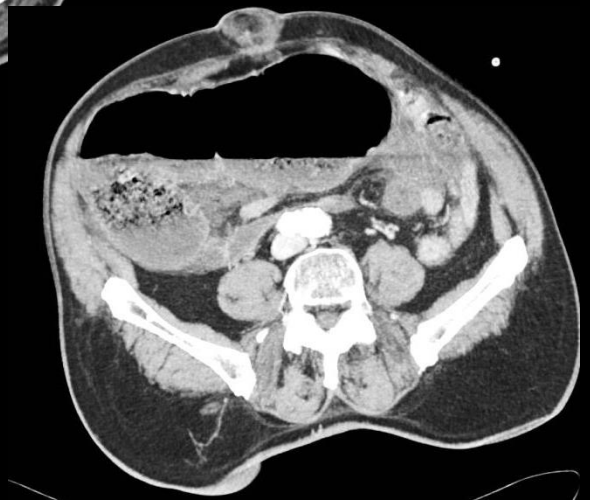
3-2-5 bases sémiologiques scanographiques des occlusions basses d'origine extrinsèque

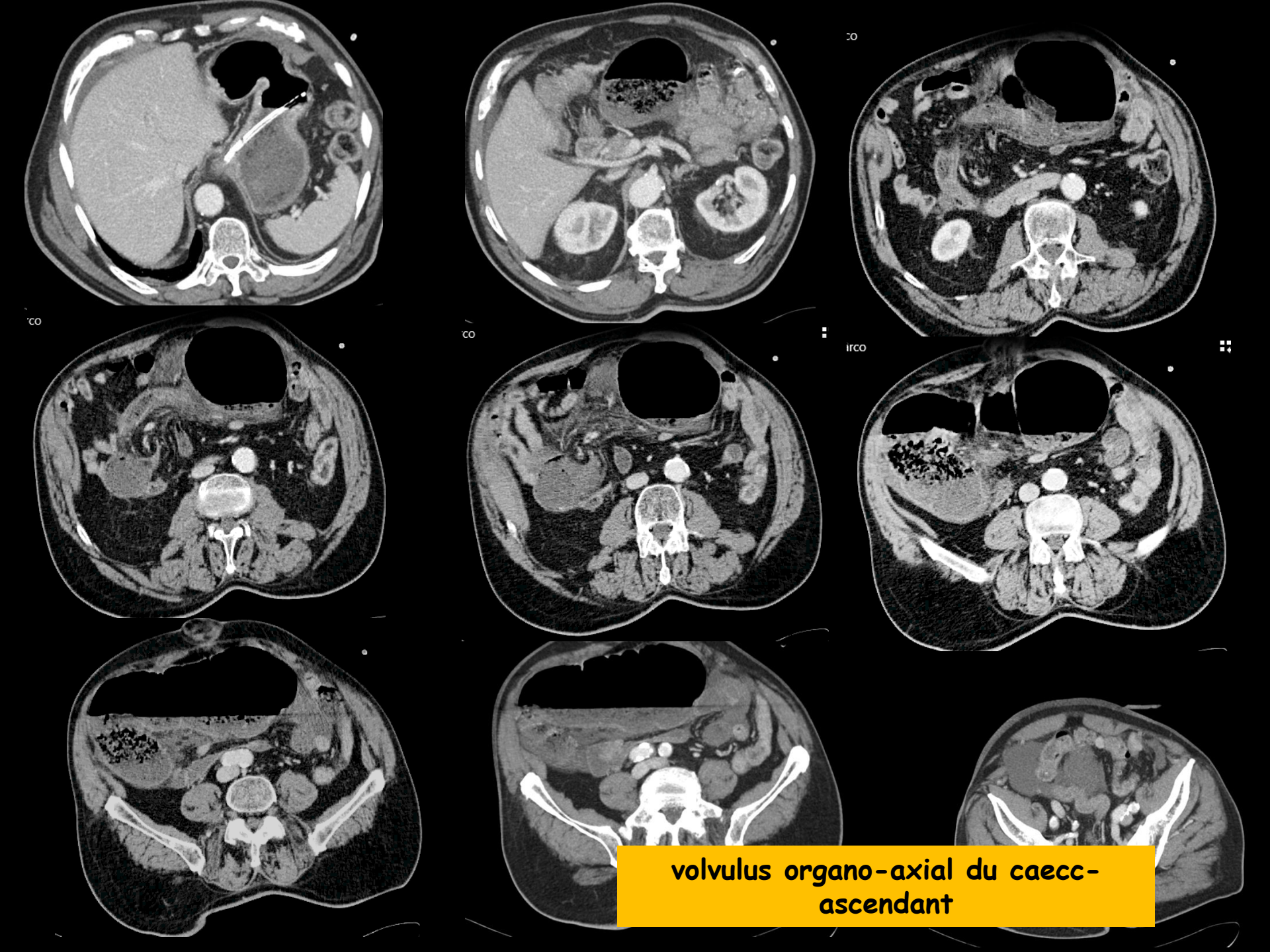




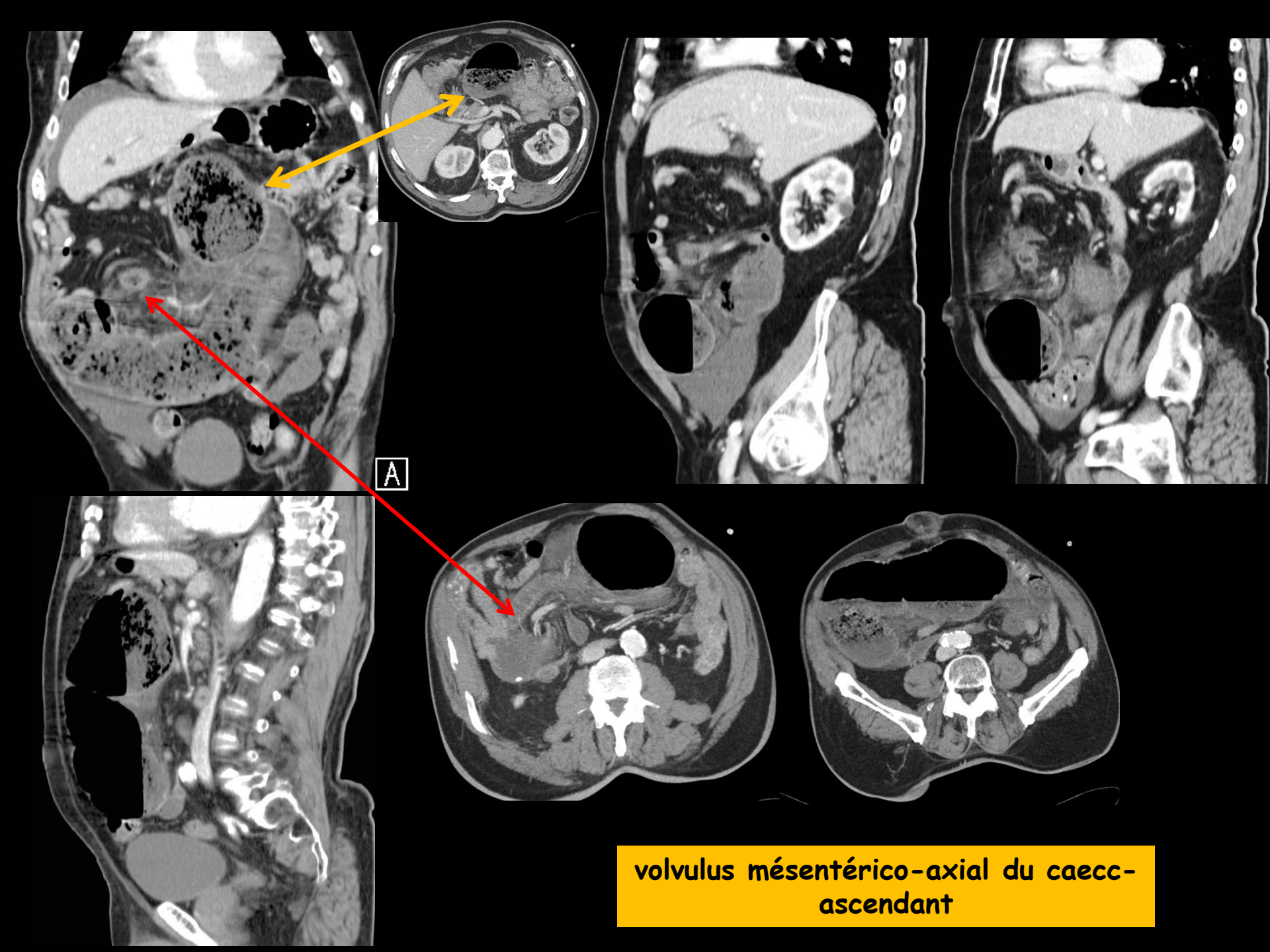




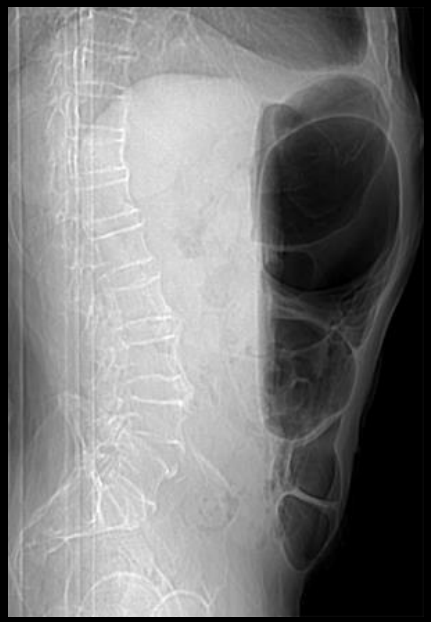


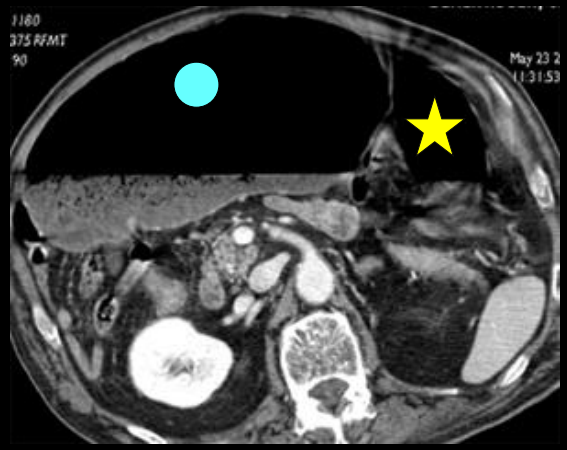


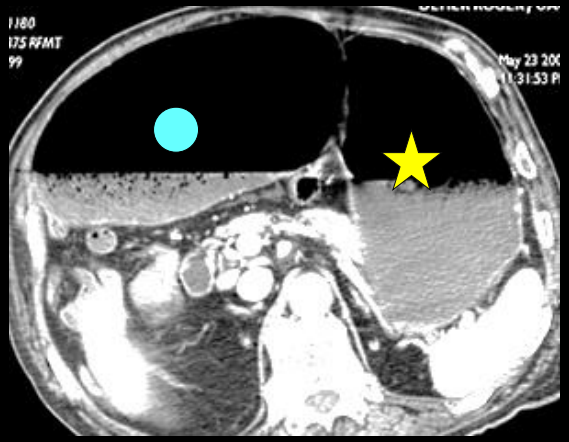
volvulus organo-axial du caecc-ascendant

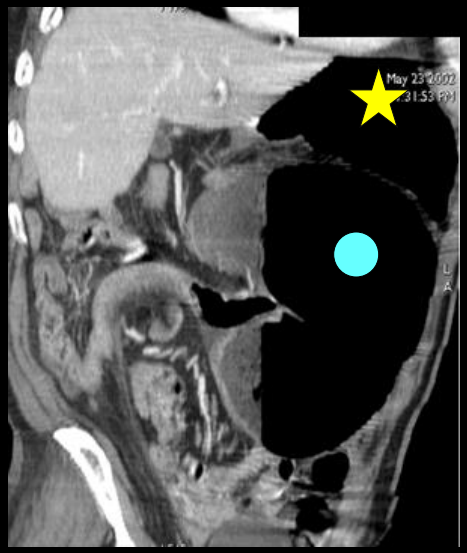


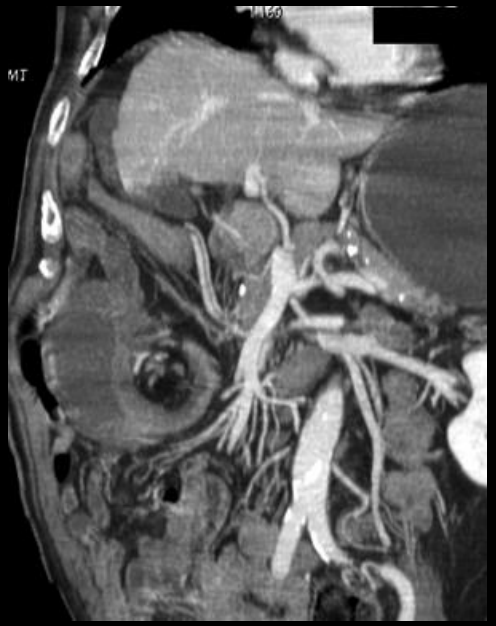
volvulus mésentérico-axial du caecc-ascendant

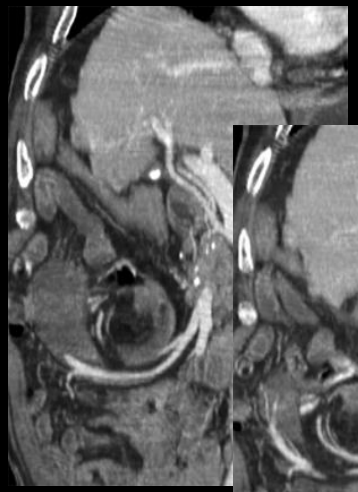


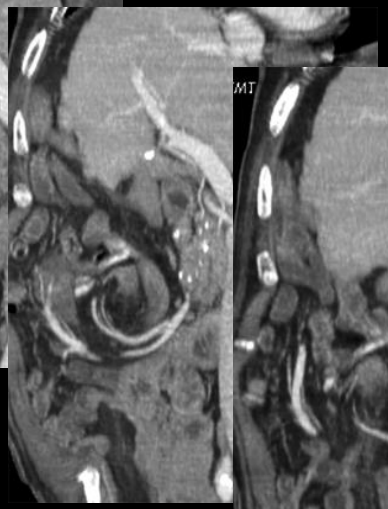


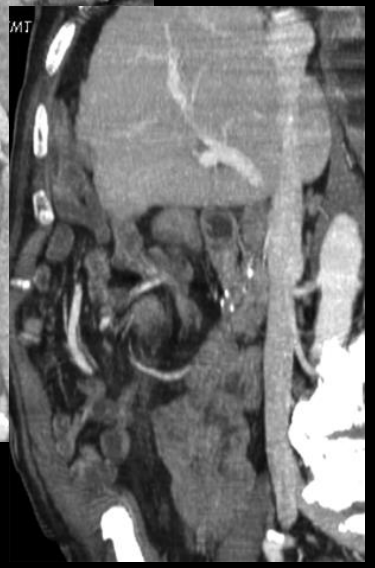




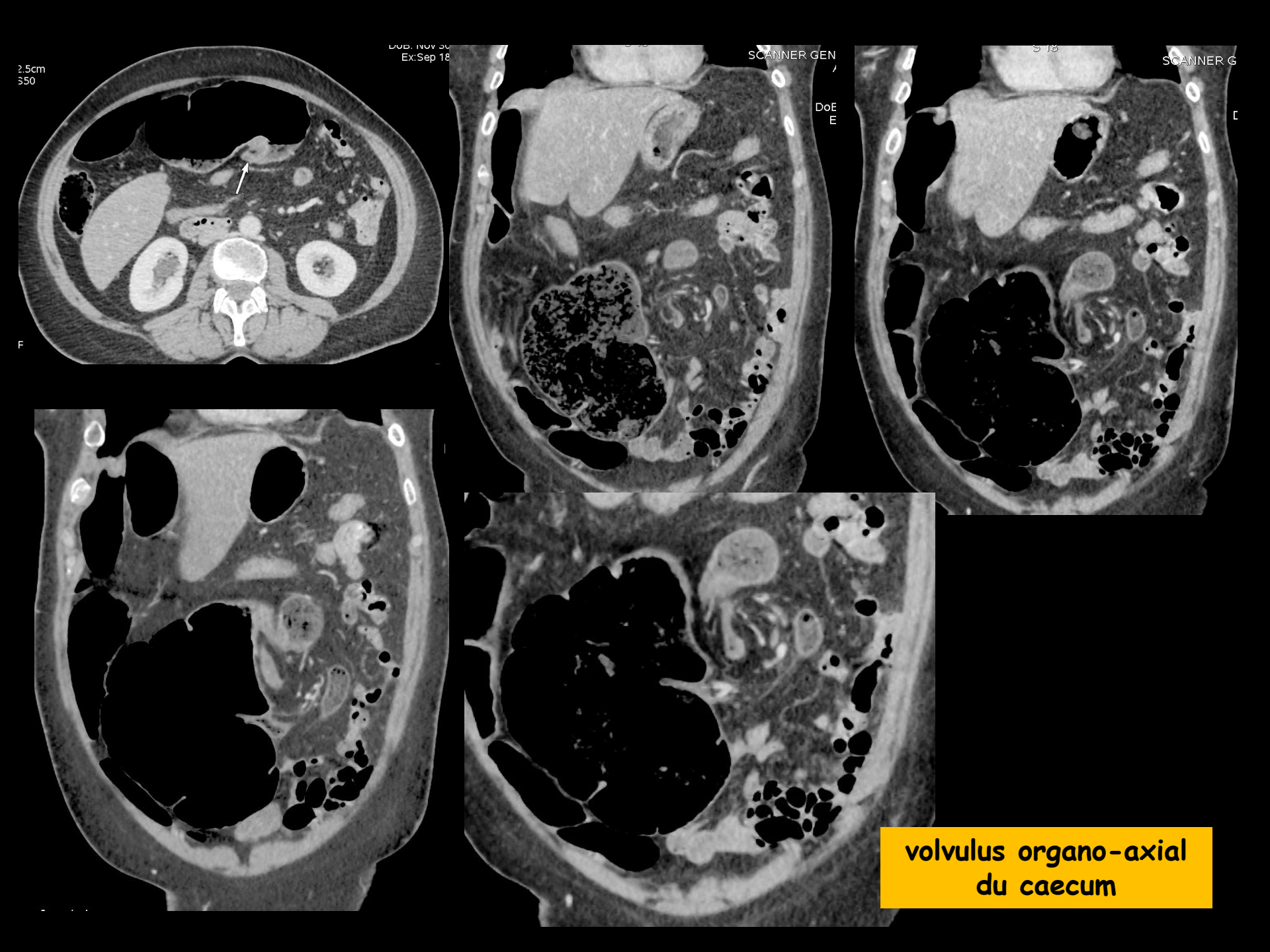




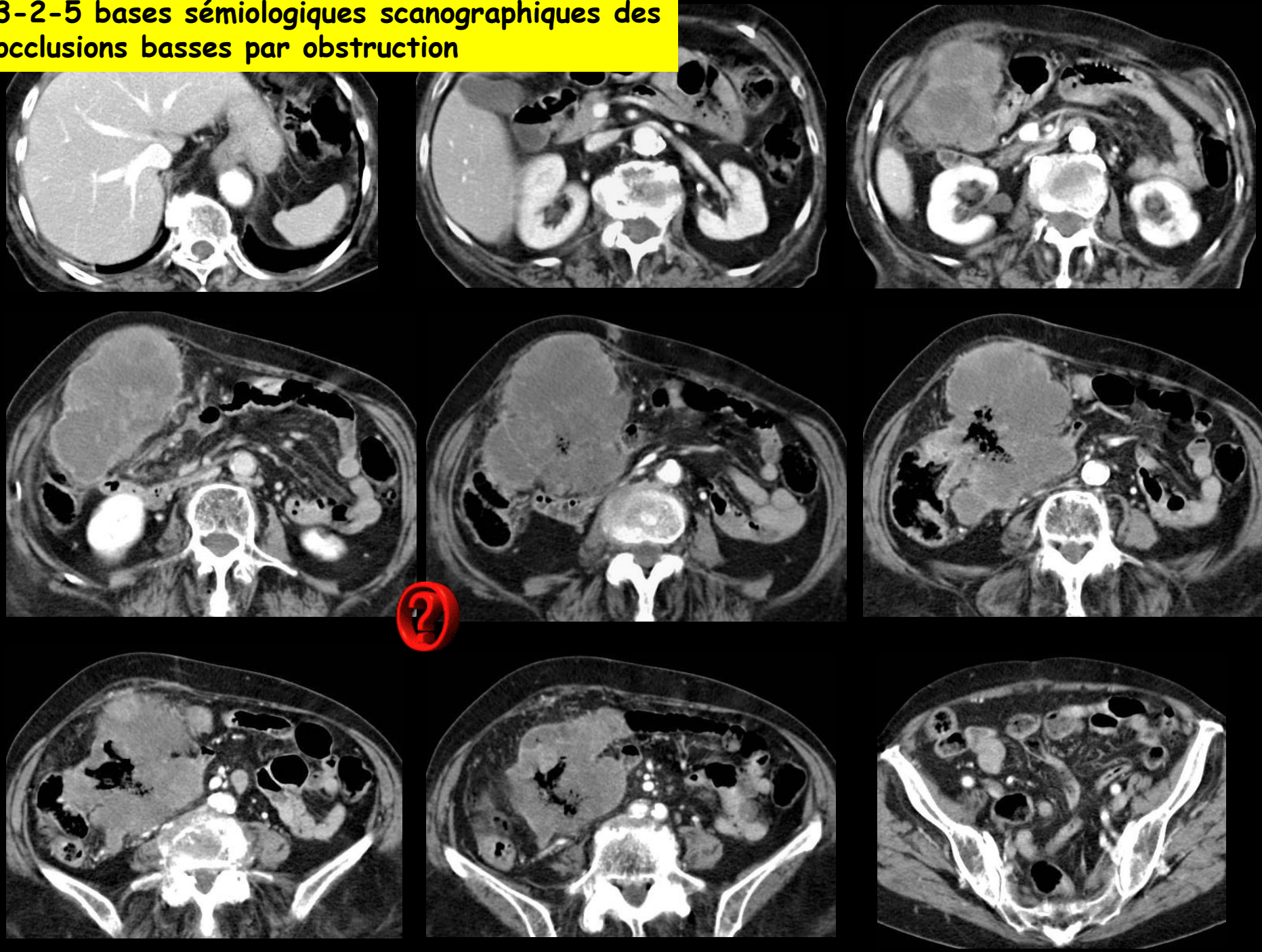


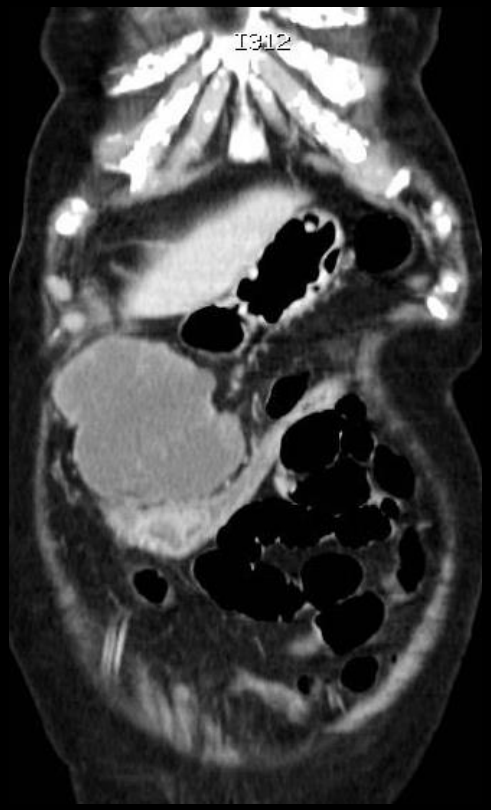


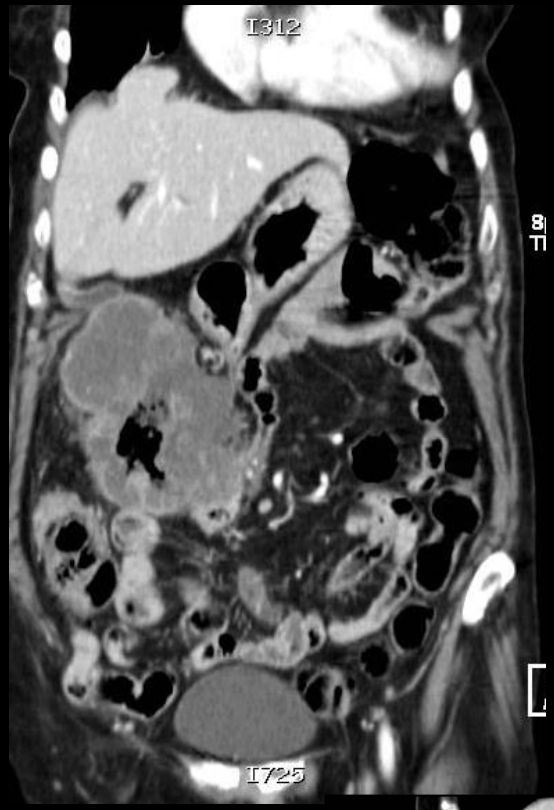
volvulus organo-axial du caecum

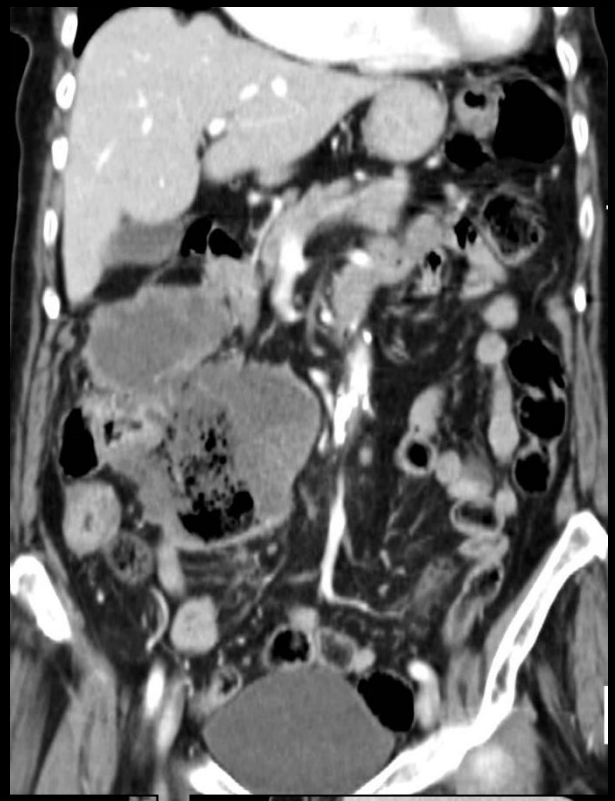

SCANNER GEN
SCANNER G
volvulus organo-axial
du caecum

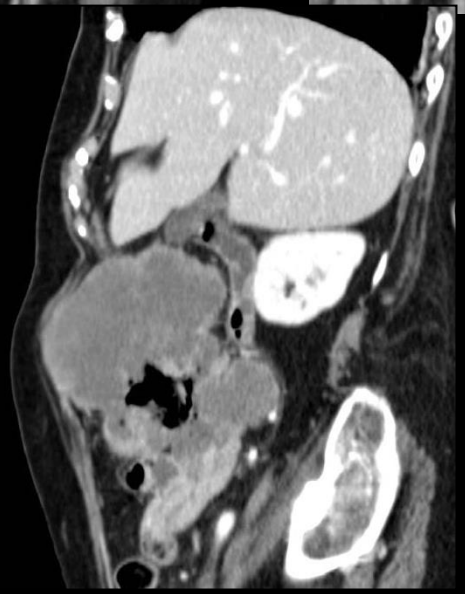
3-2-5 bases sémiologiques scanographiques des occlusions basses par obstruction

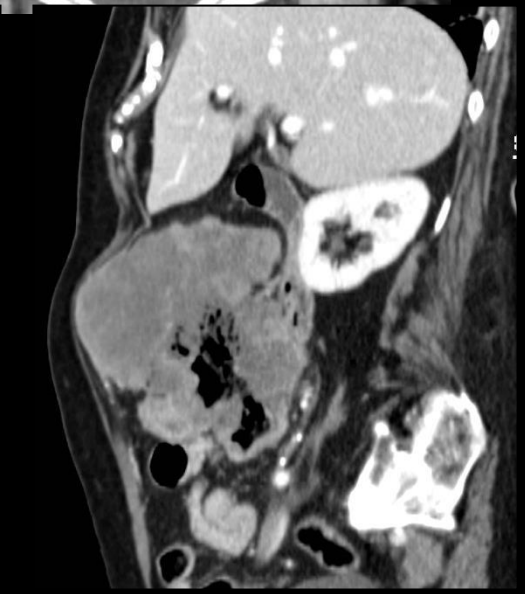




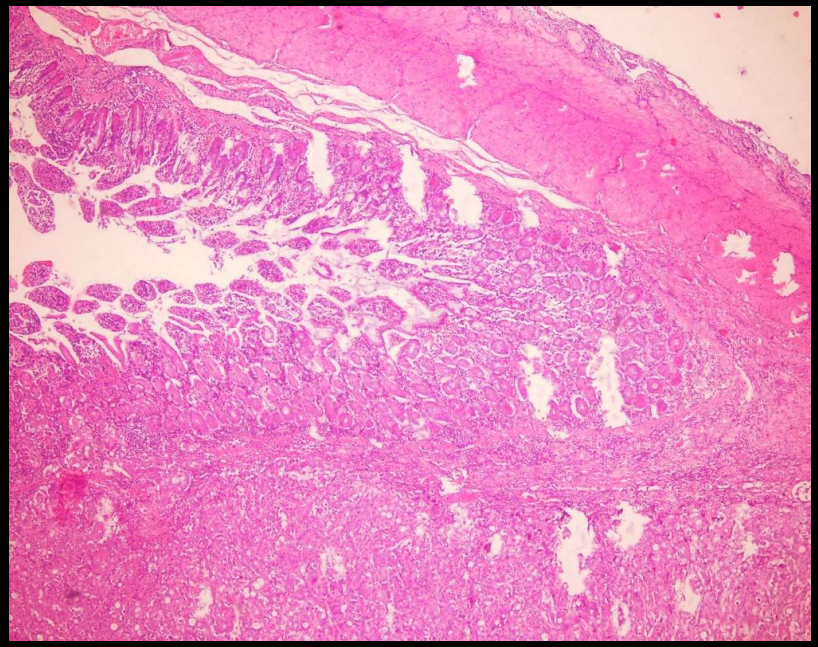


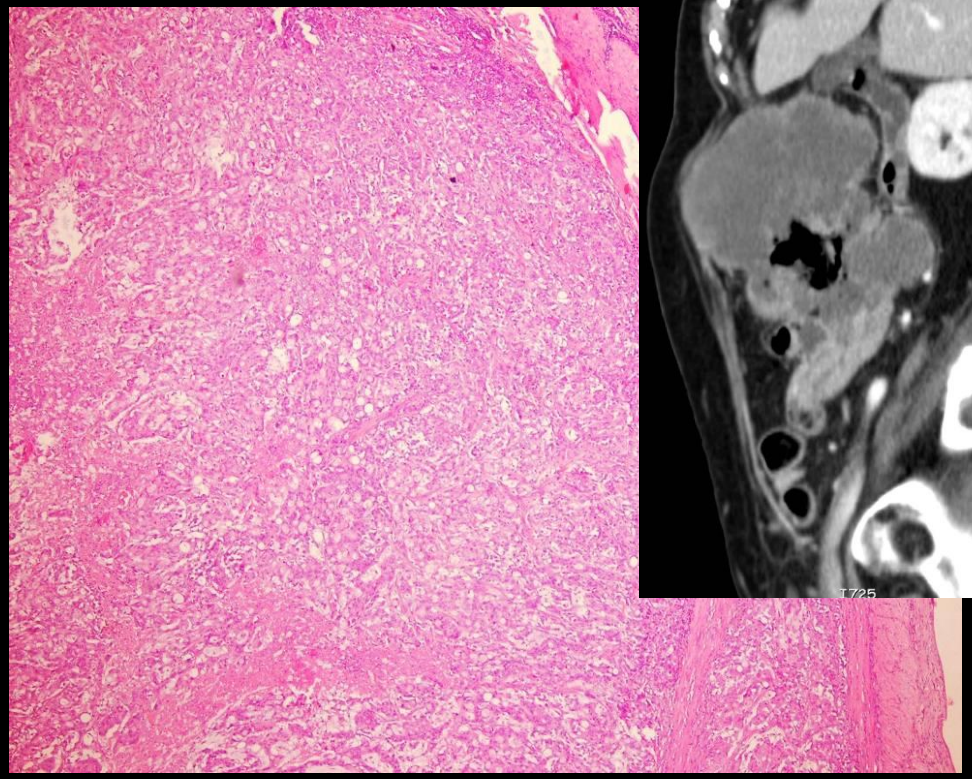




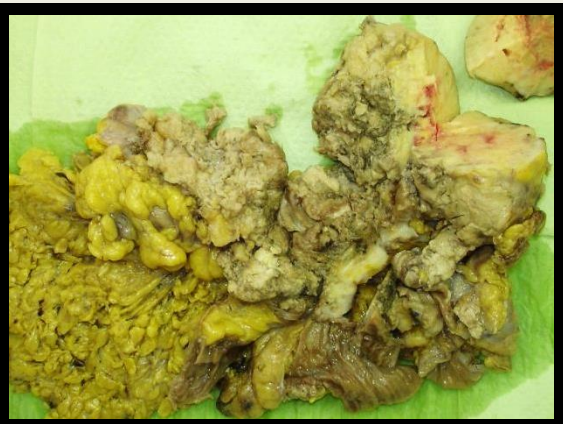


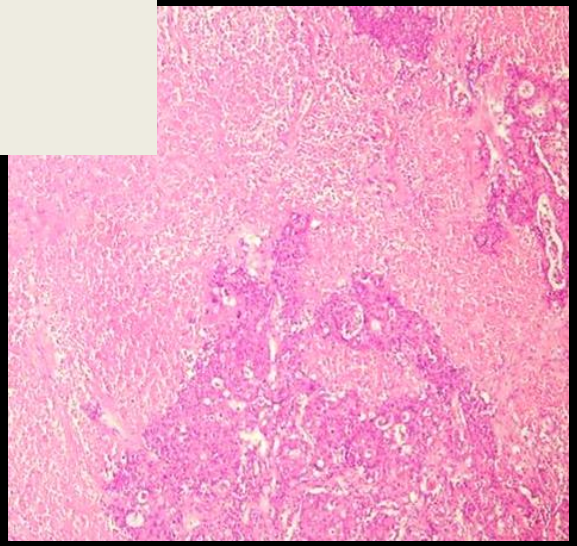
volumineux adénocarcinome de l'angle colique droit , peu obstructif malgré son volume, chez une femme de92 ans, surdosée en AVK

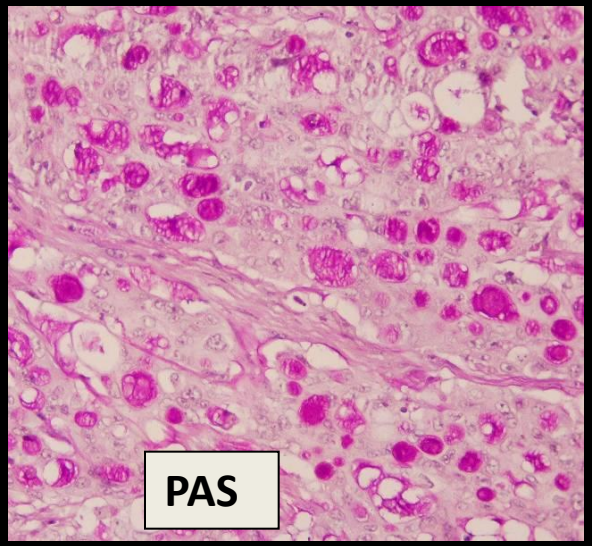


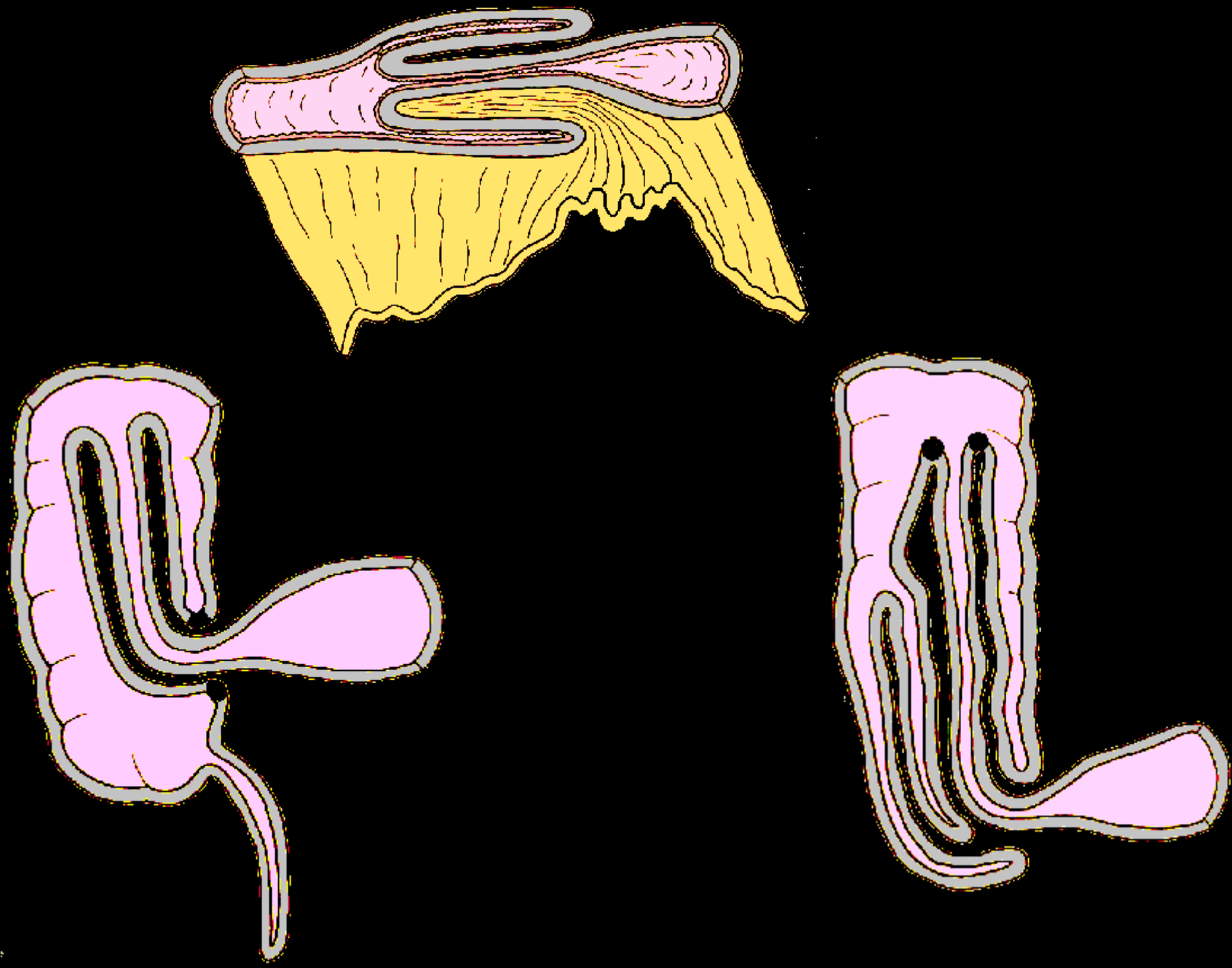


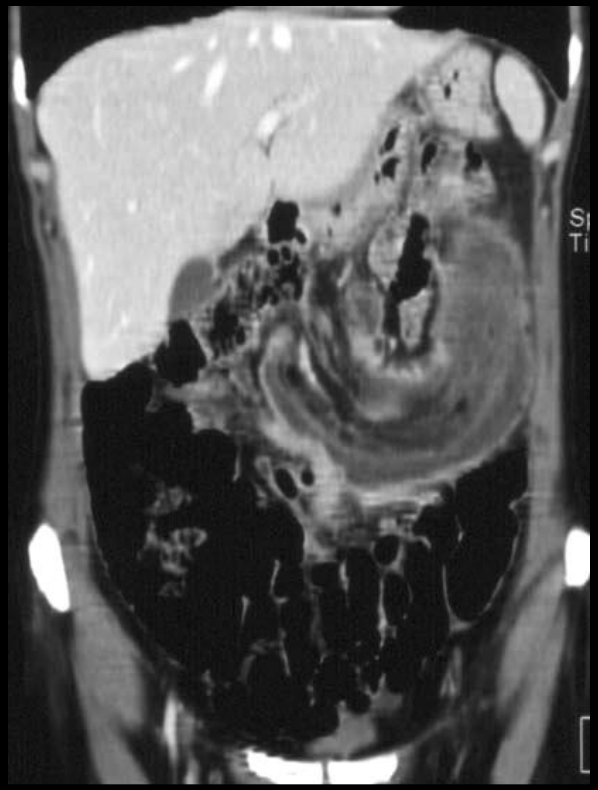
ADENOCARCINOME MOYENNEMENT DIFFERENCIE
Massivement nécrosé
Développement exo-luminal+++
Parois colique et grêles envahies
Emboles vasculaires / Pas de métastases ganglionnaires.
pT4N0

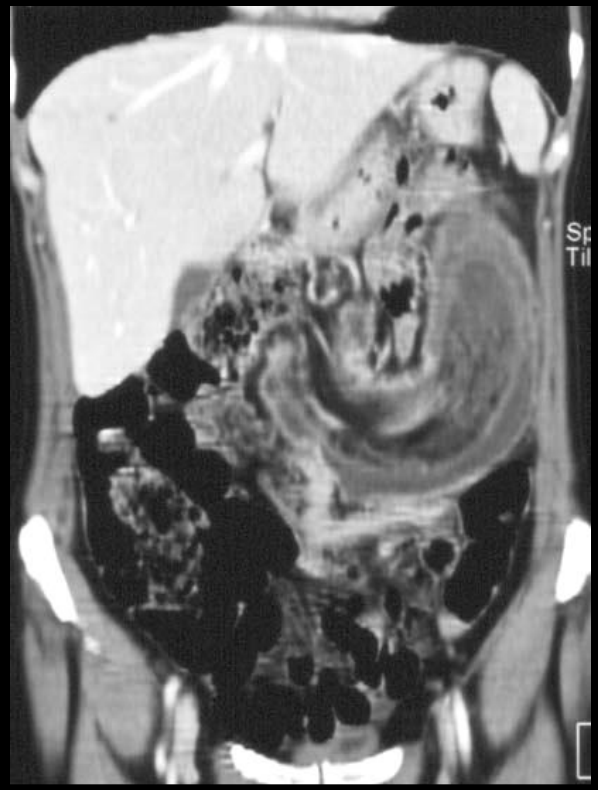












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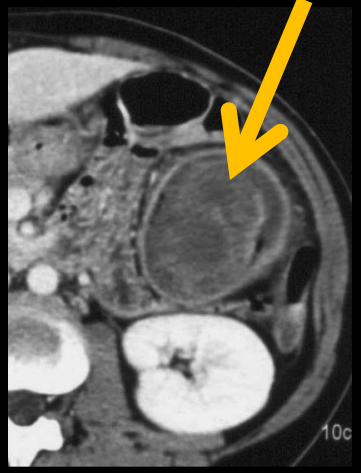
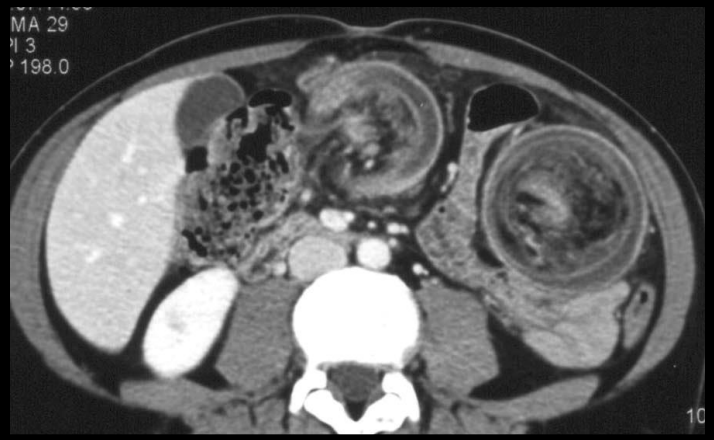
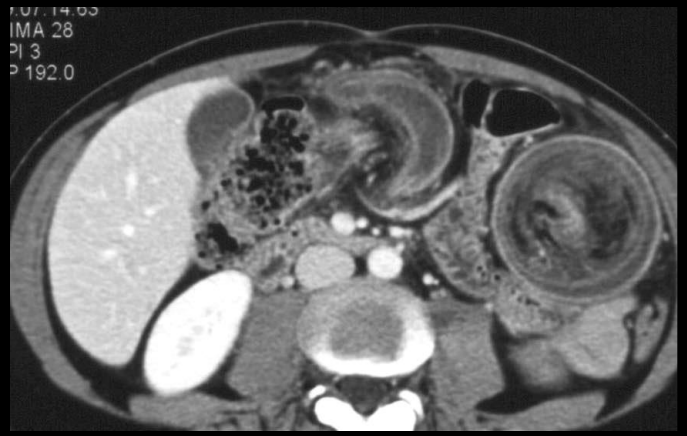
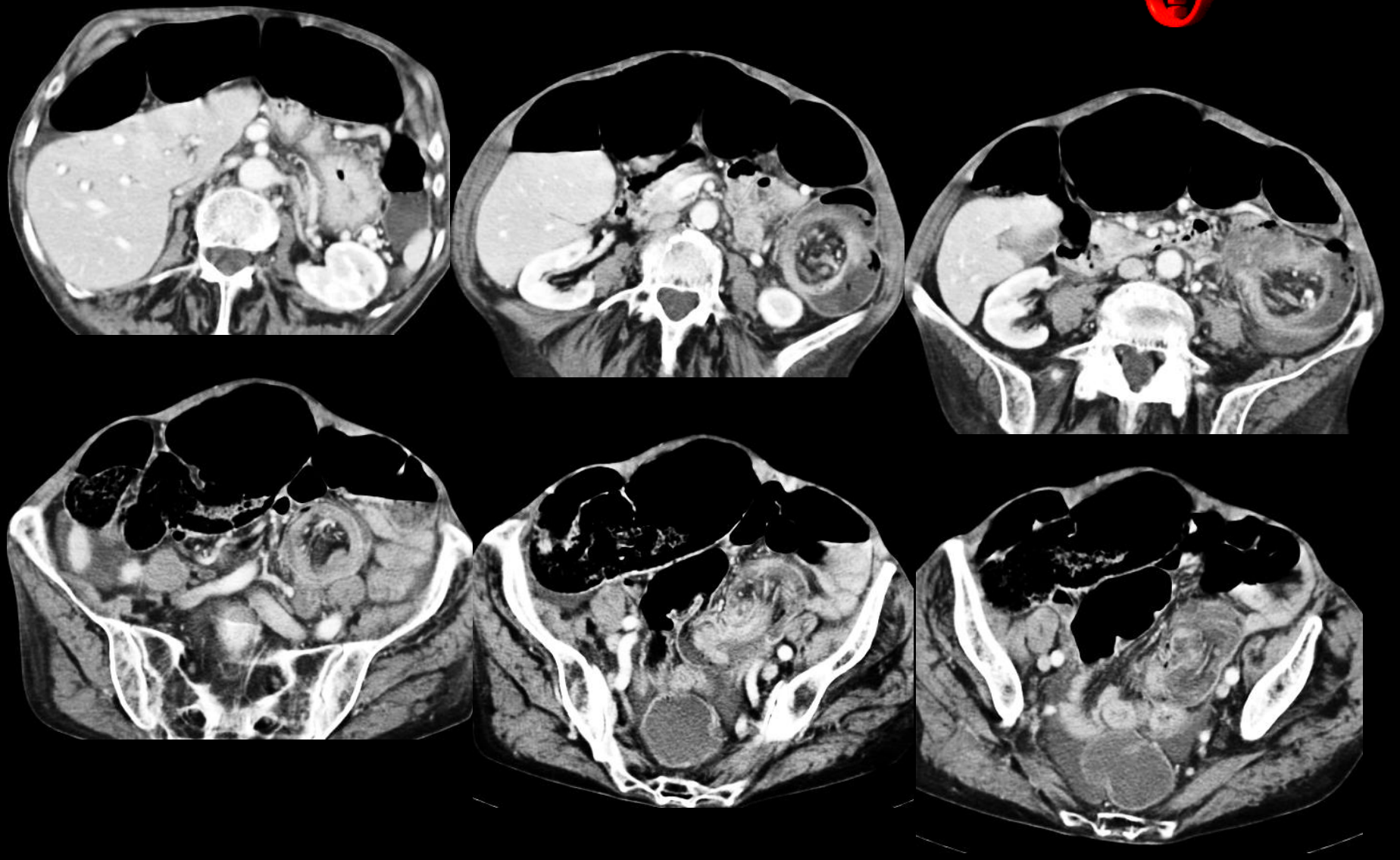


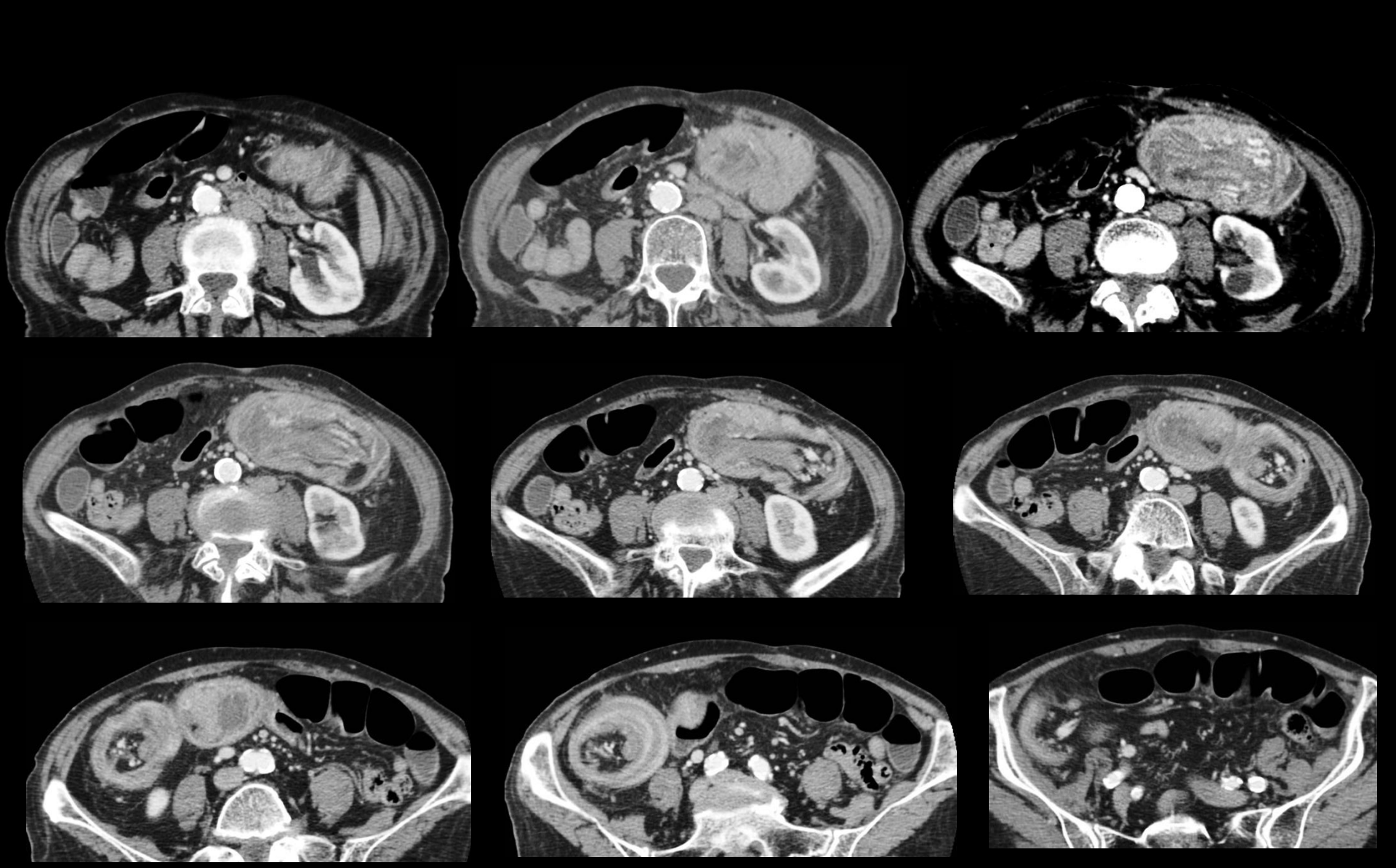




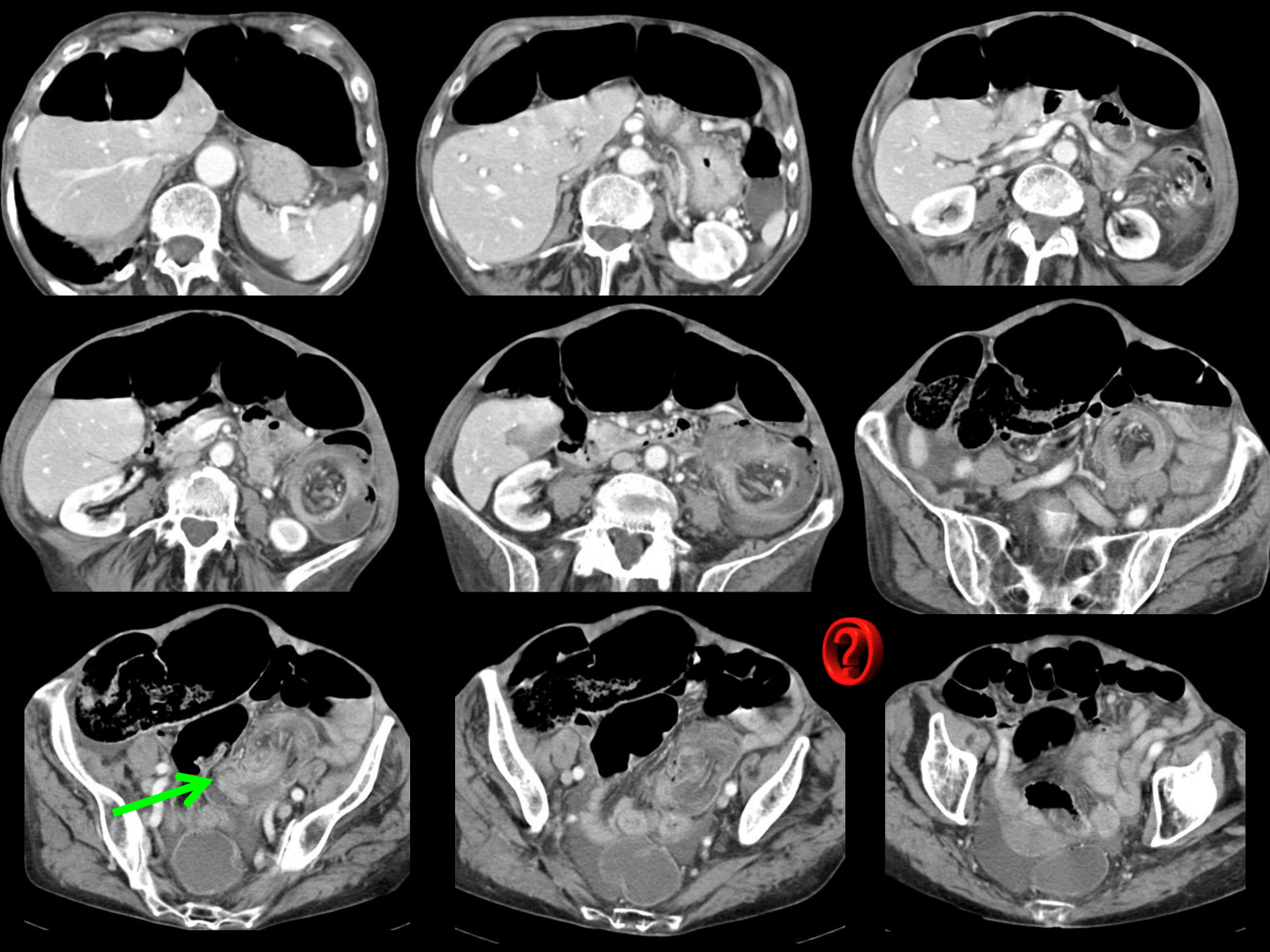
invagination colo-colique sur adénocarcinome sténosant du caecum

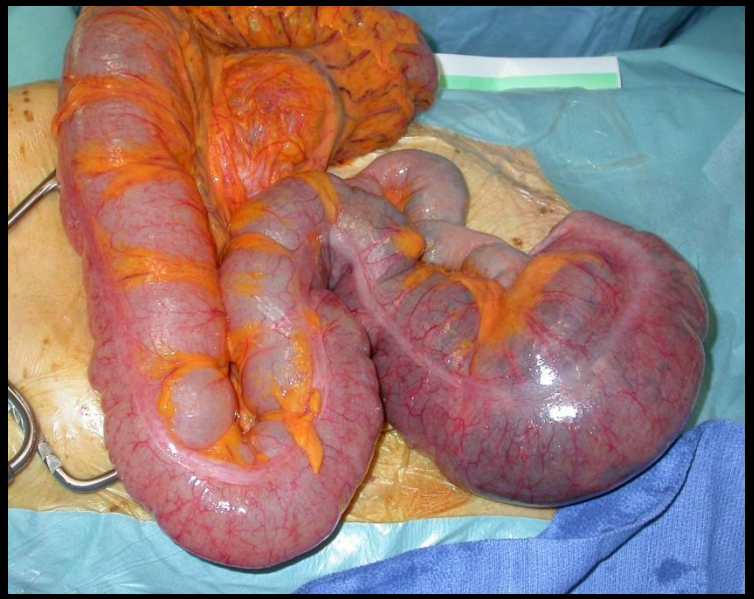


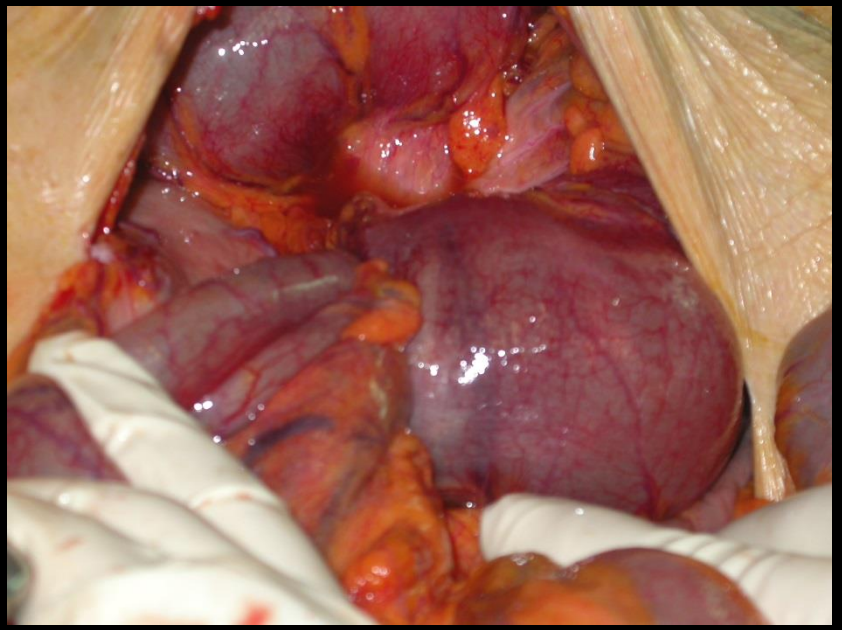
invagination iléo-colique chronique sur adénocarcinome caecal

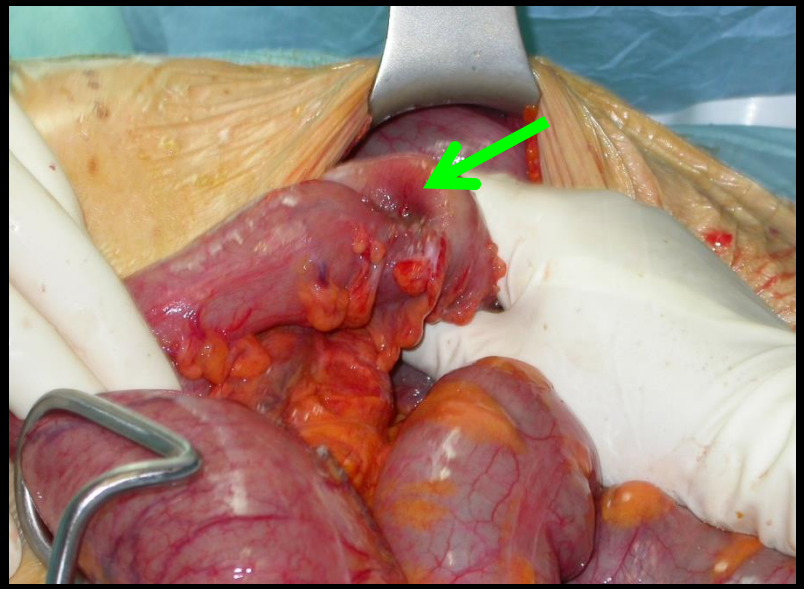


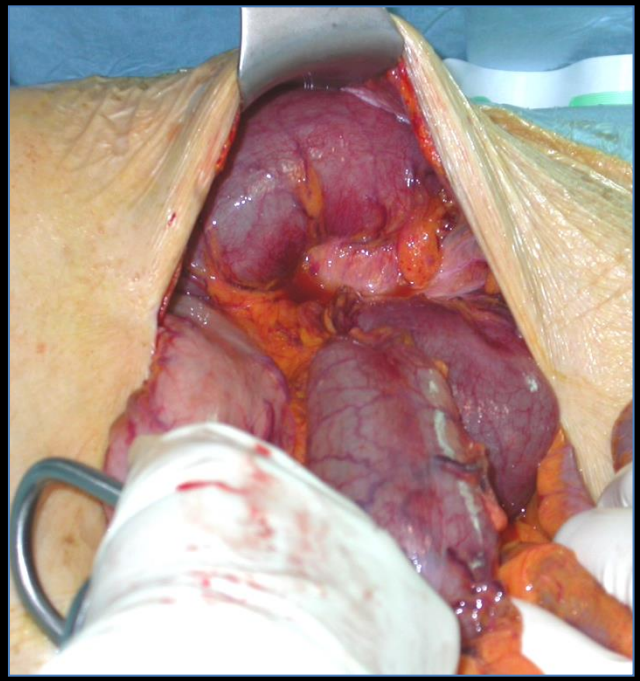
intussusception colo-colique sur adénocarcinome de la valvule de Bauhin

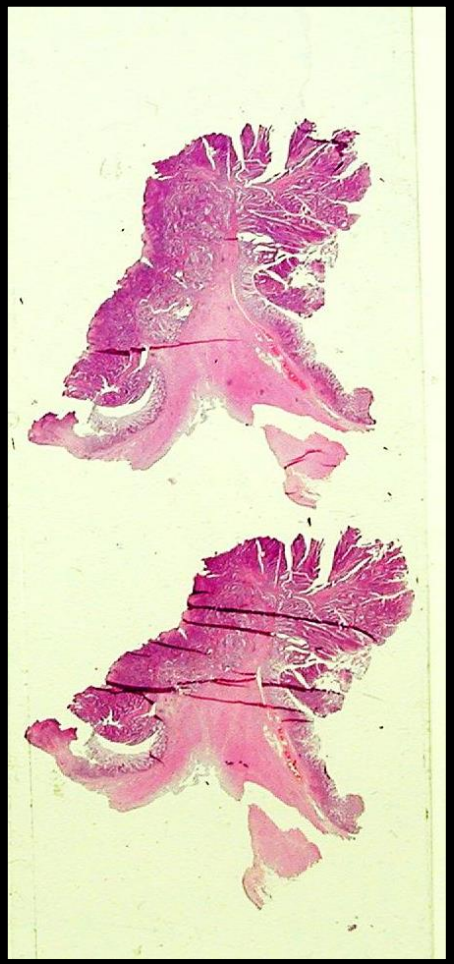


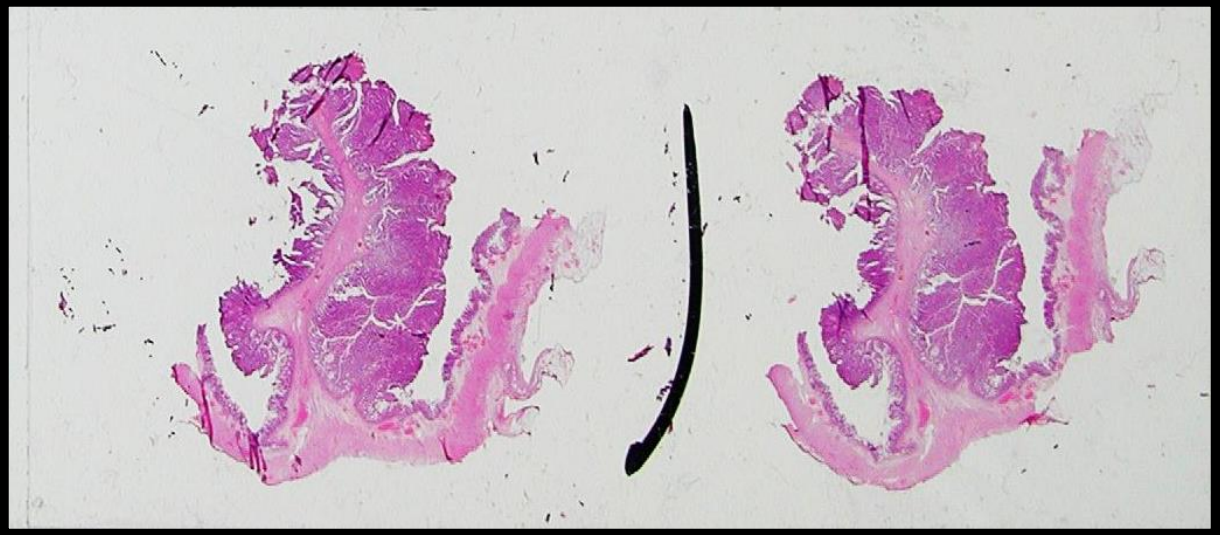


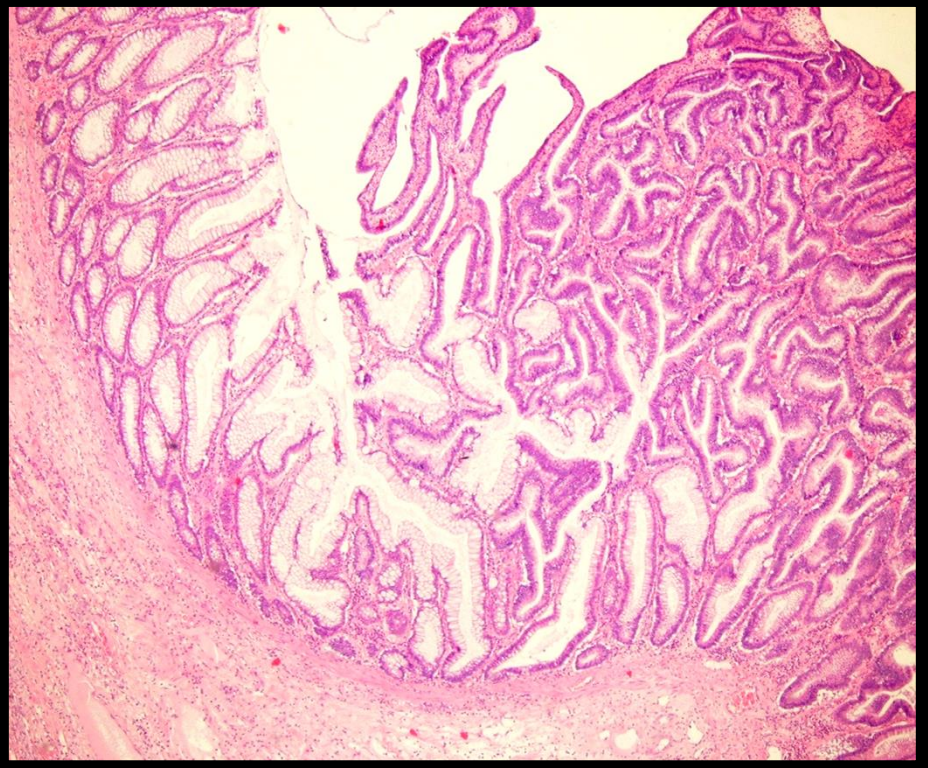




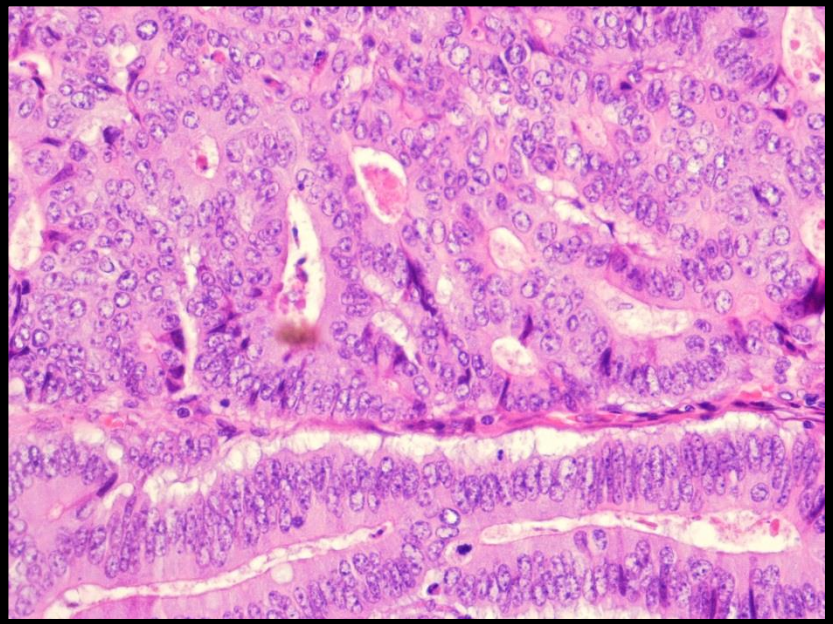


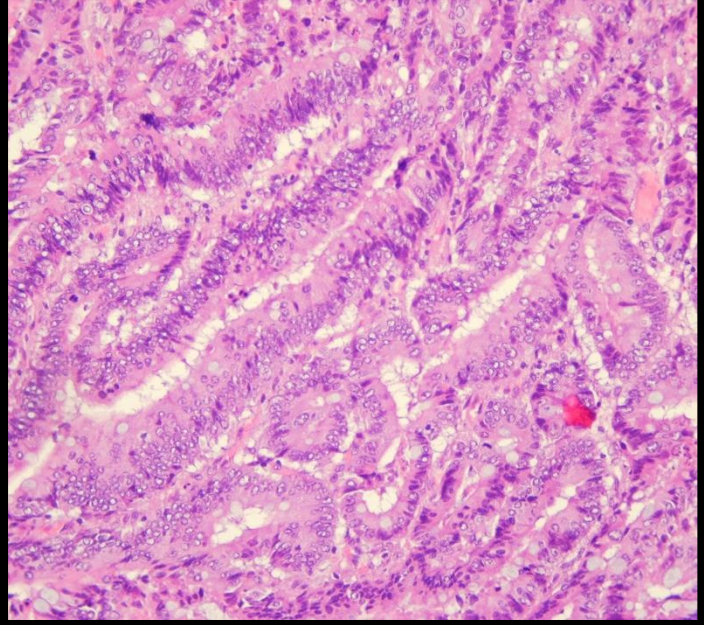


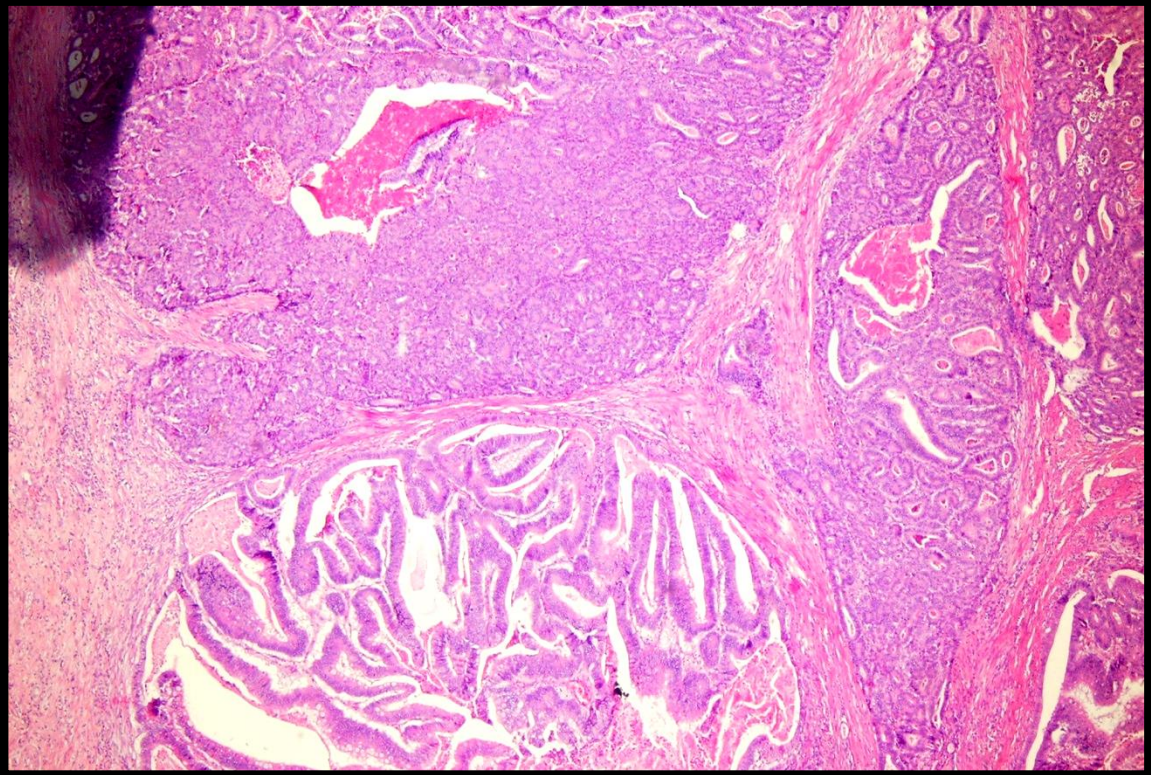


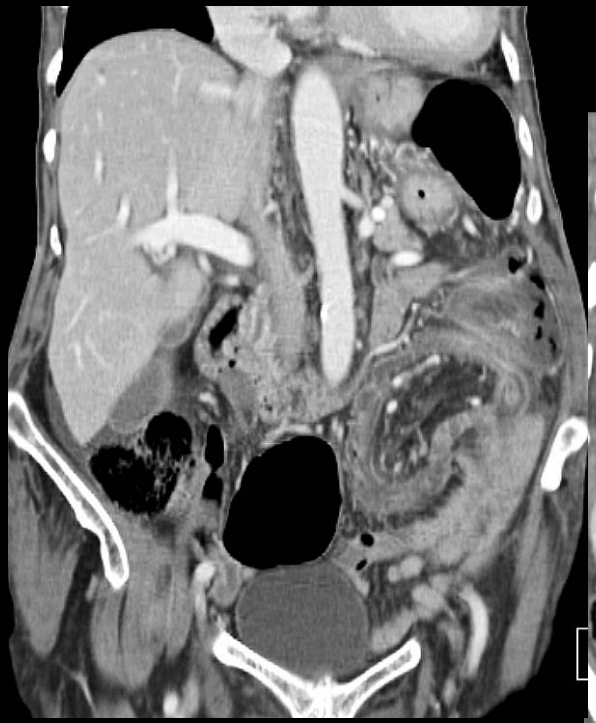


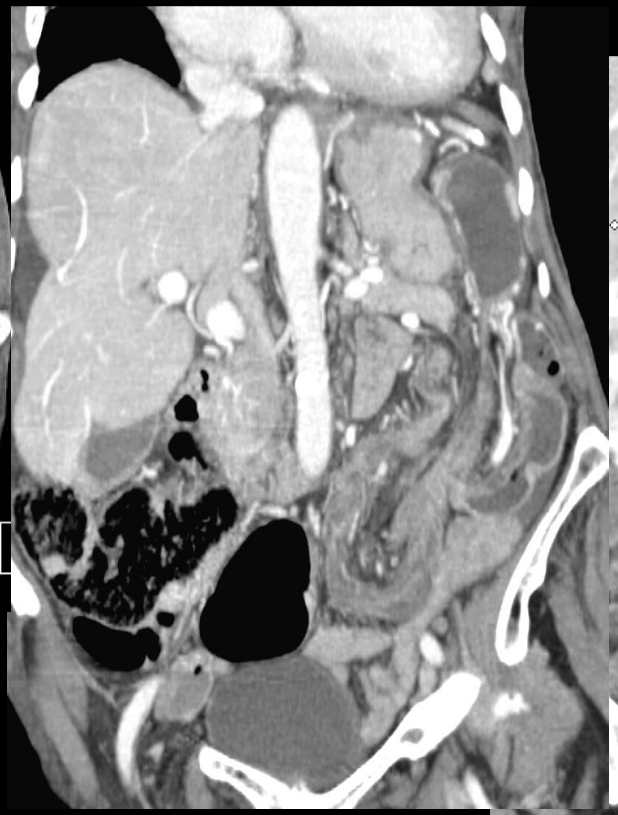
sur la pièce une volumineuse lésion circonférentielle sténosante (adénocarcinome lieberkuhnien bien différencié
 et un polype adénomateux tubulo-villeux avec dysplasie sévère et cancer in-situ

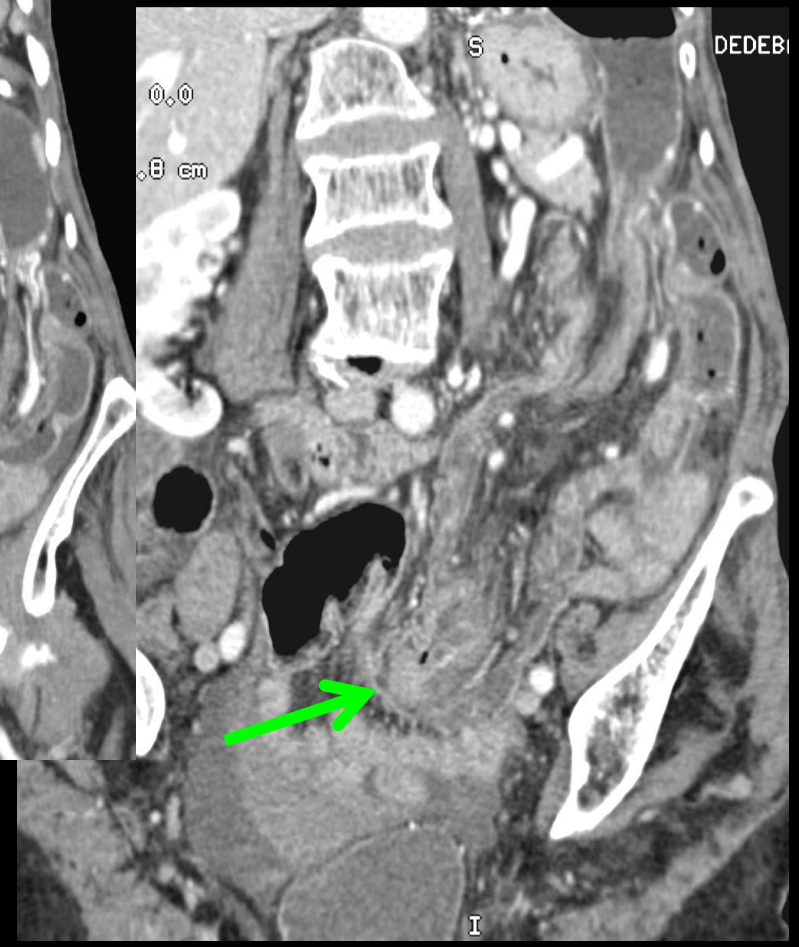


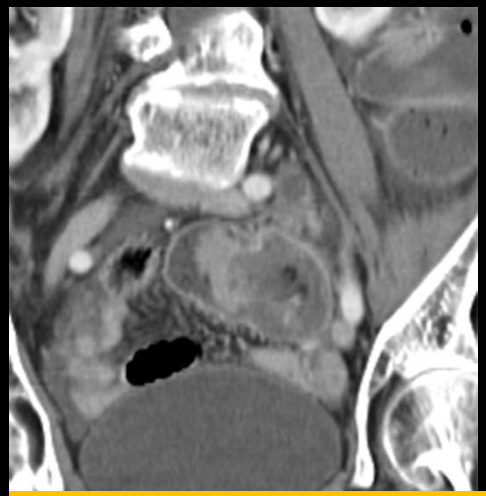




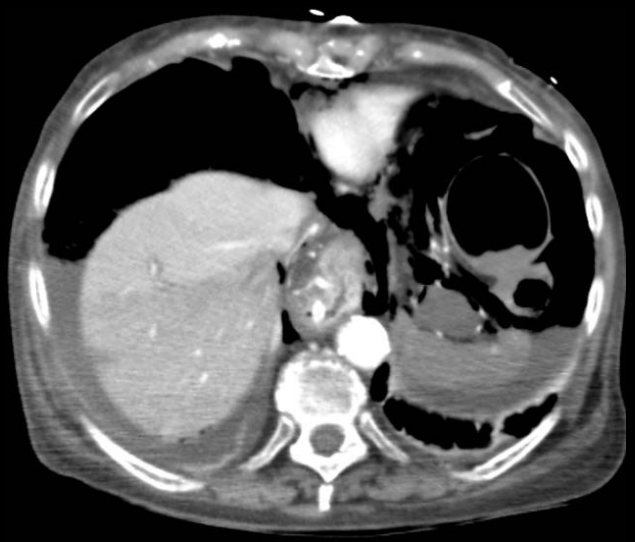
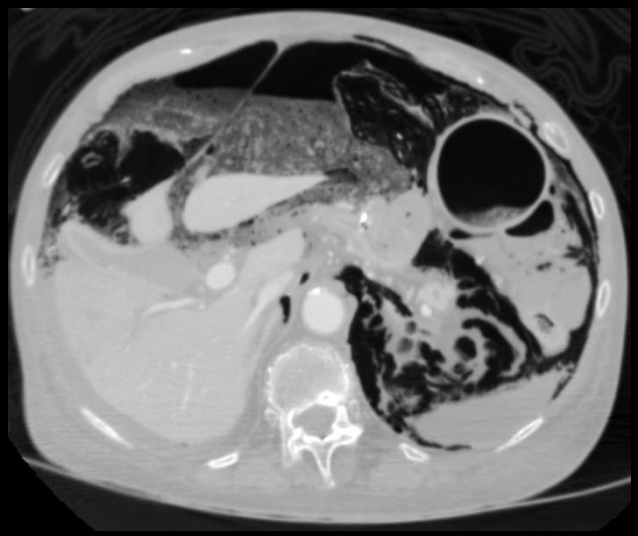
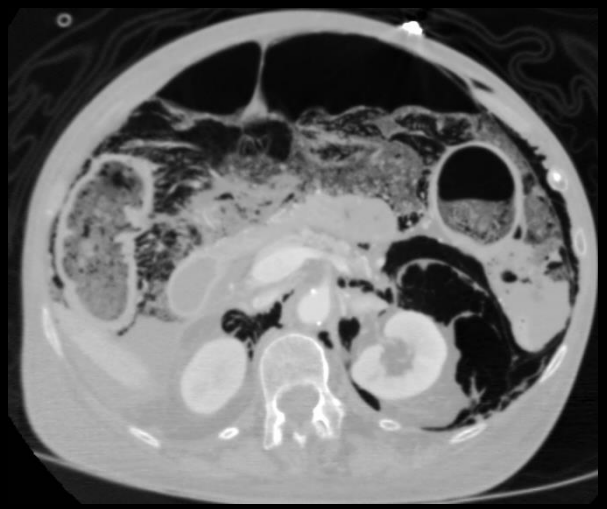
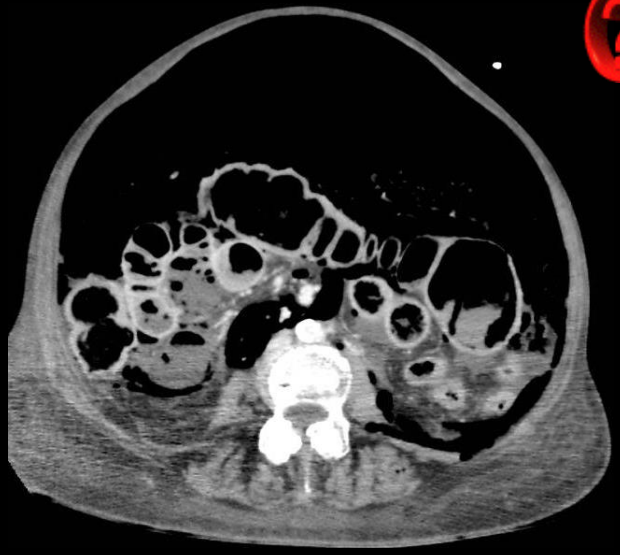
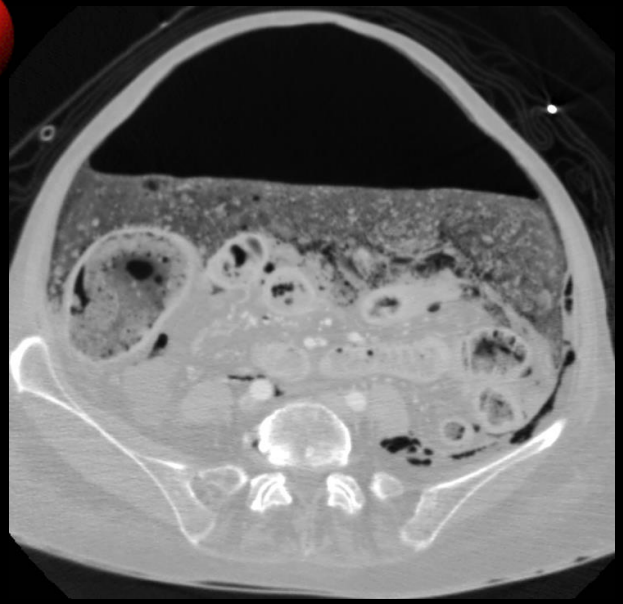


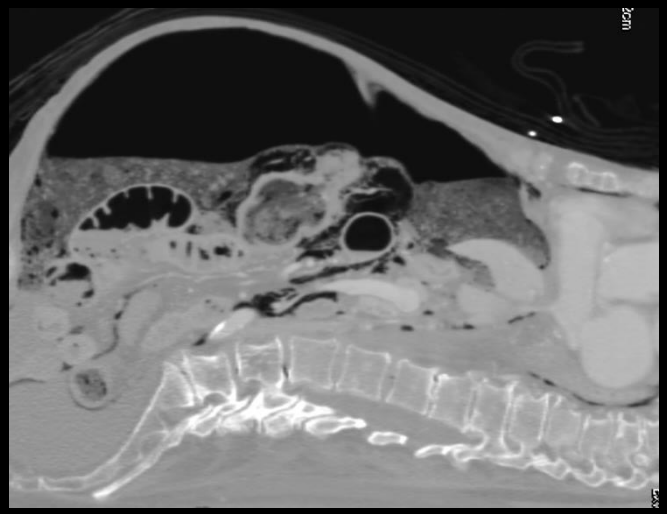


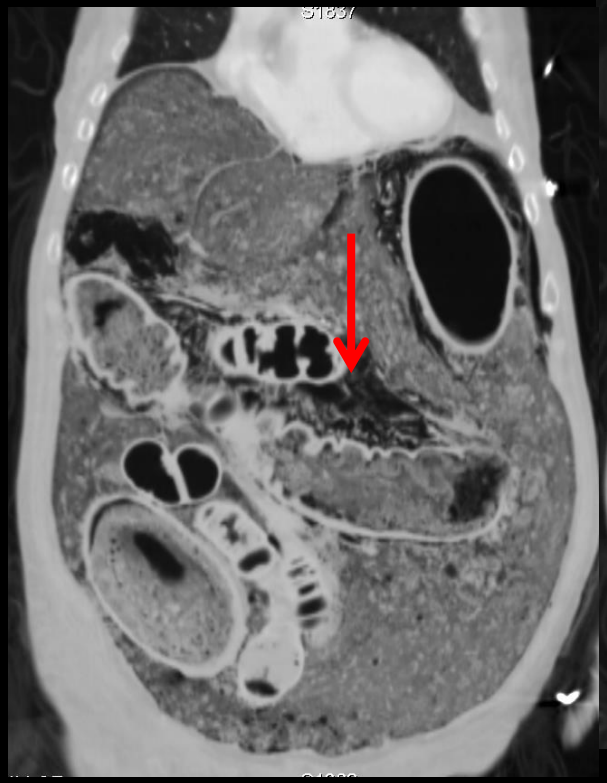




invagination colo-colique sur adénocarcinome sténosant

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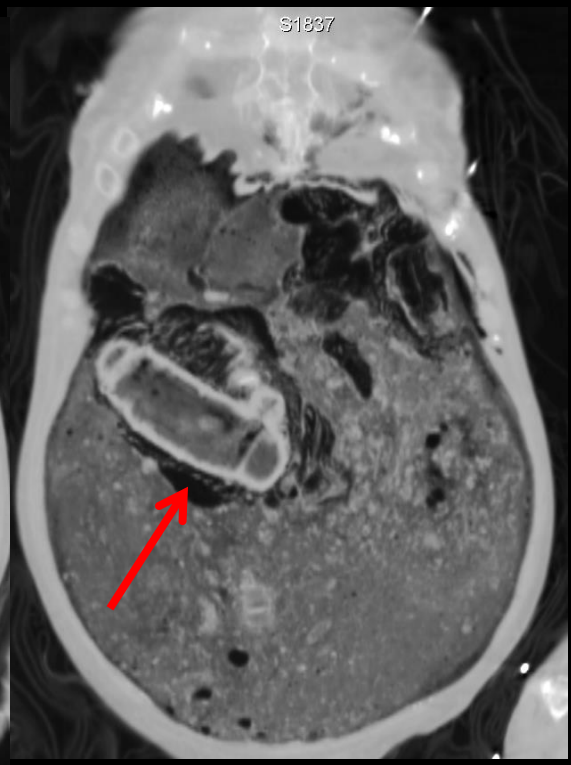
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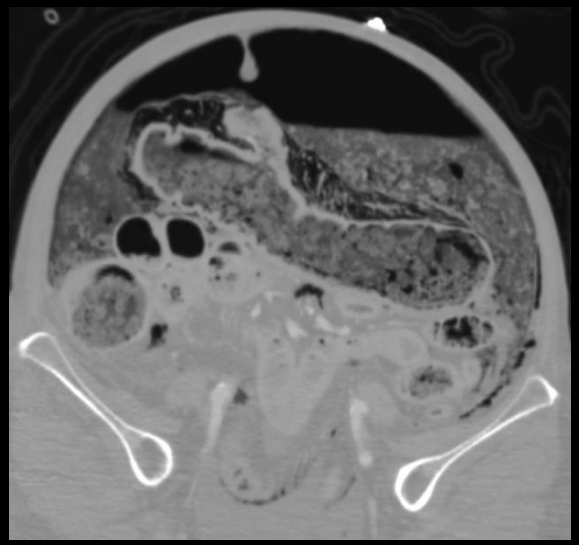

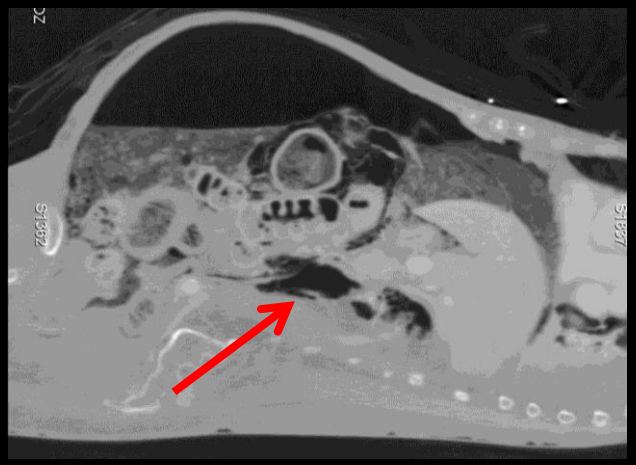

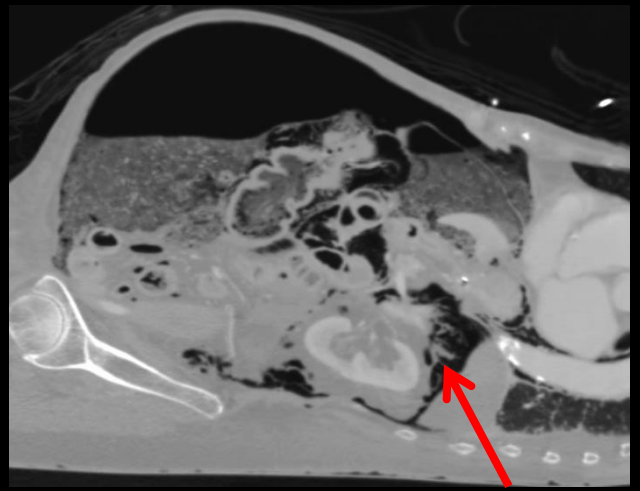

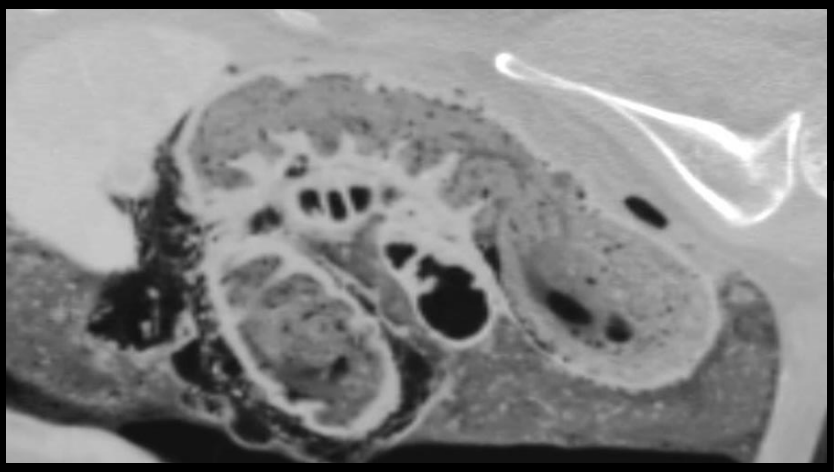

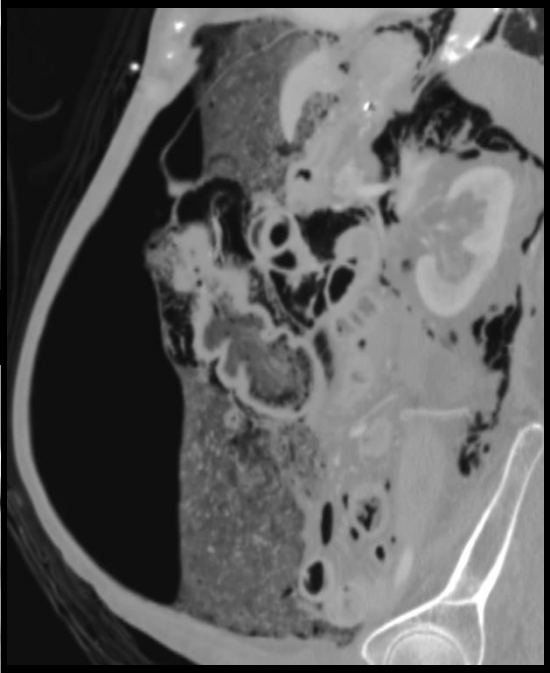

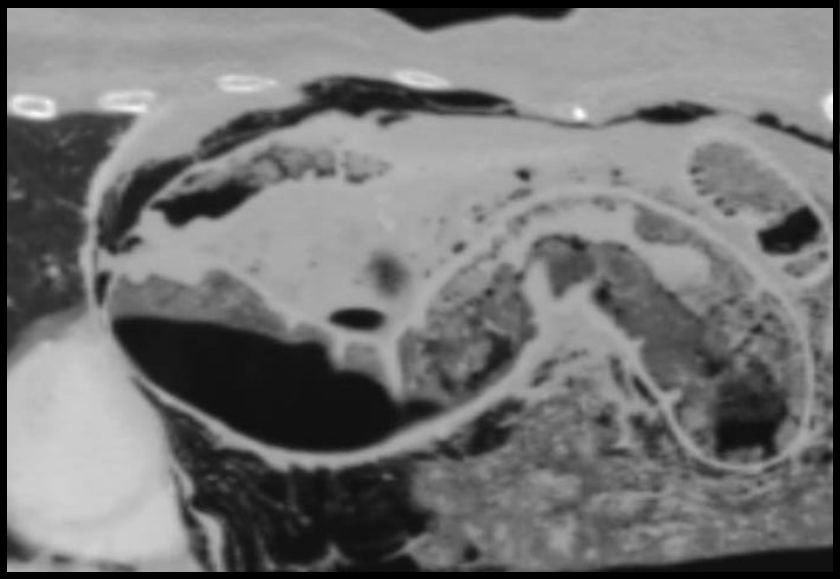

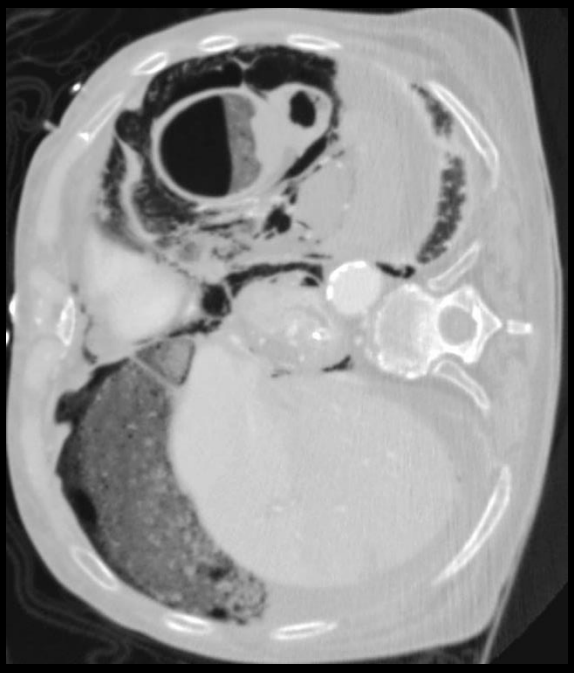

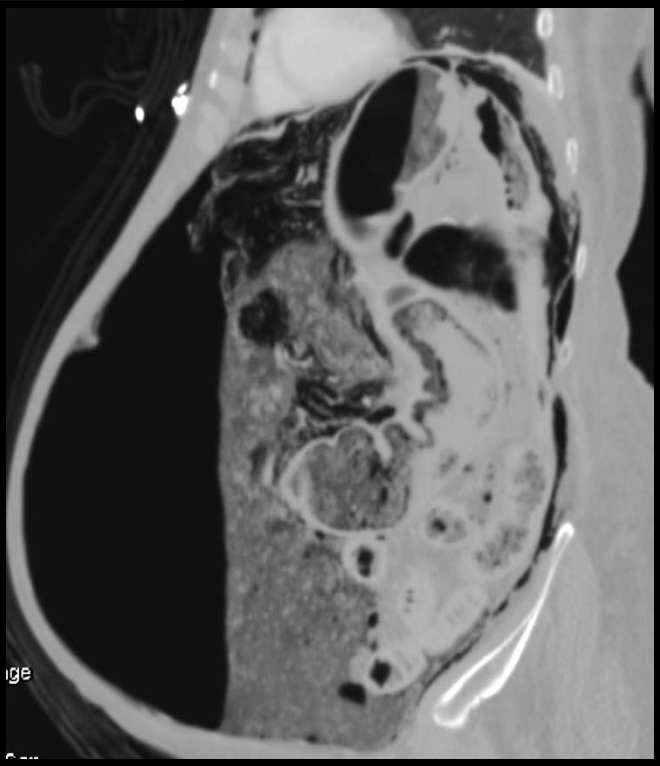

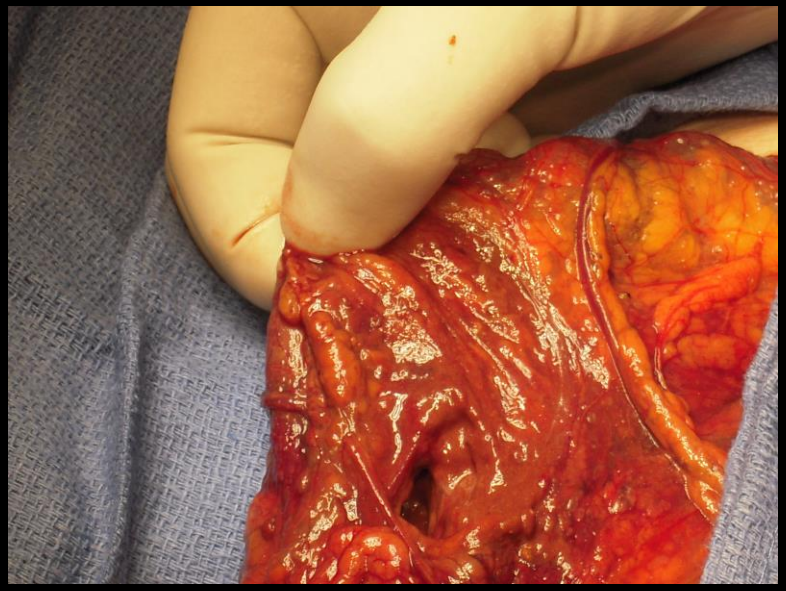

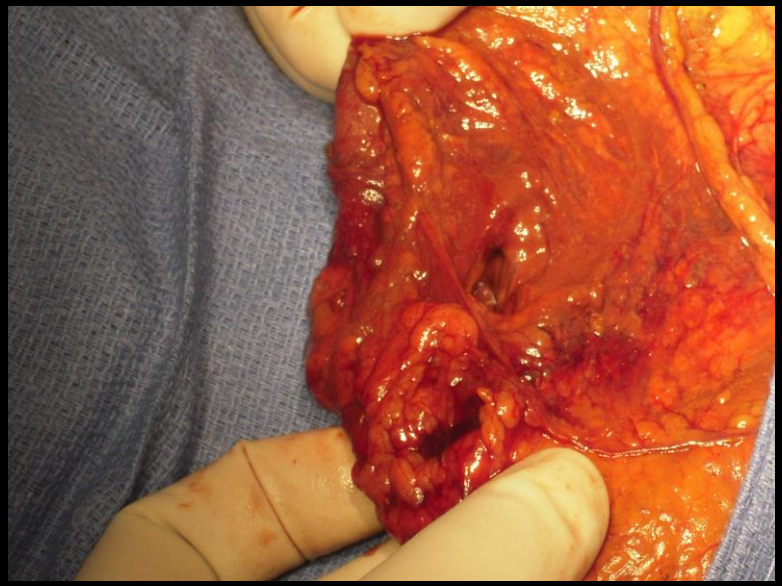

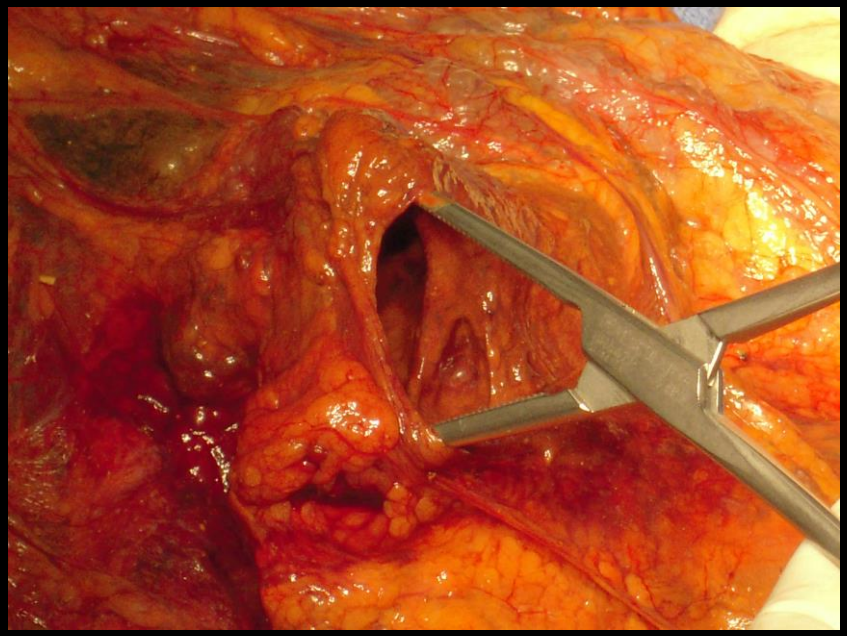

perforation du colon transverse sans cause évidente à l'intervention