

PERTES DE SUBSTANCE GASTRO-DUODENALES

DESCRIPTION ENDOSCOPIQUE

INTERPRETATION

Comment décrire une perte de substance

PROFONDEUR

FORME

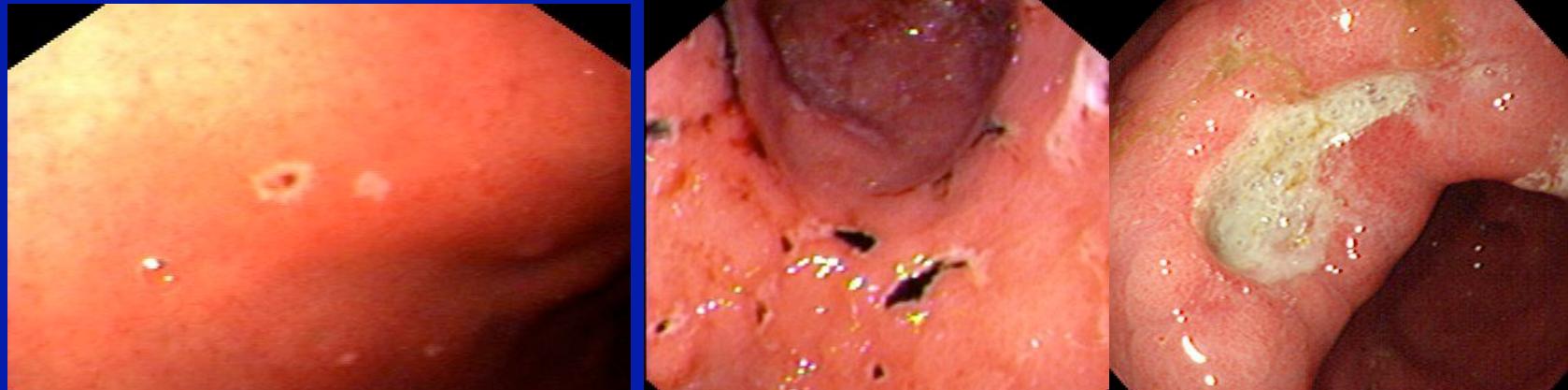
DIMENSIONS

BASE DU CRATERE

BORD

TISSU ENVIRONNANT

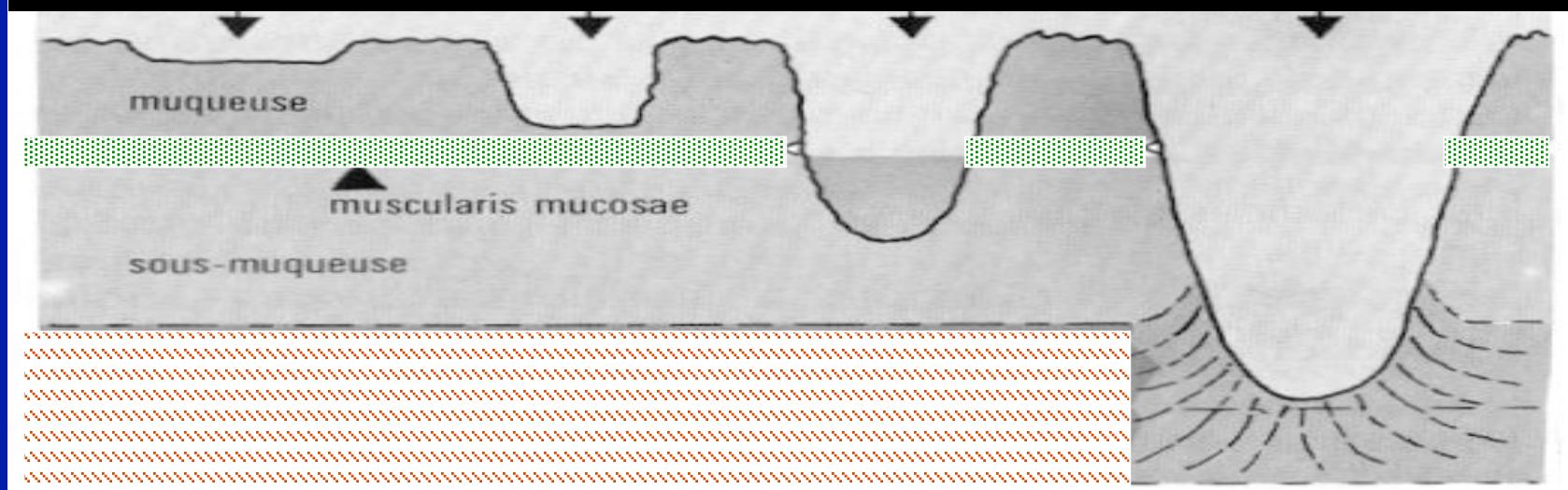
Perte de substance GD : profondeur

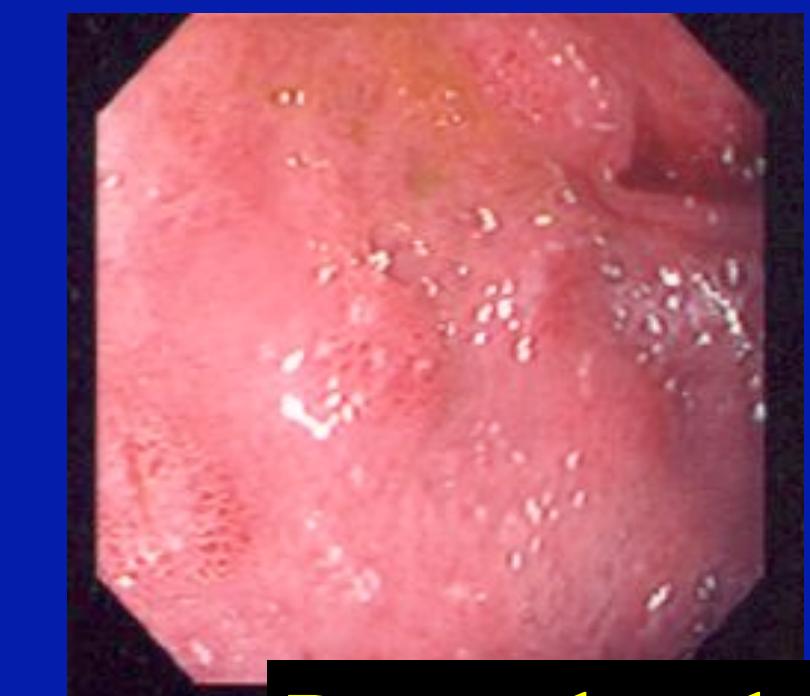


EROSION

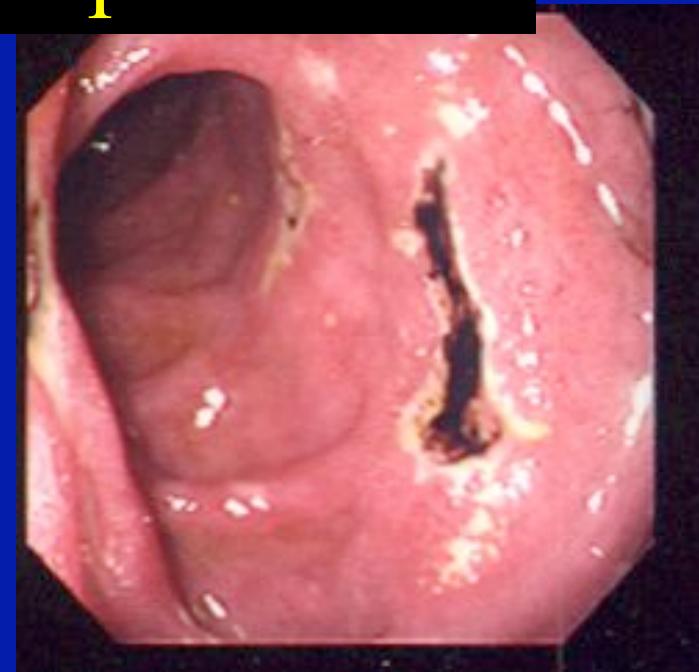
ULCERATION

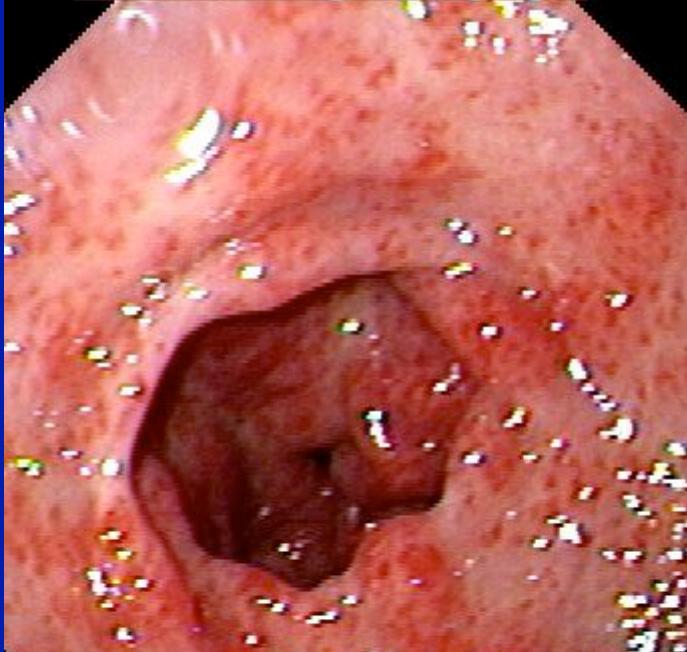
ULCERE





Pertes de substances superficielles



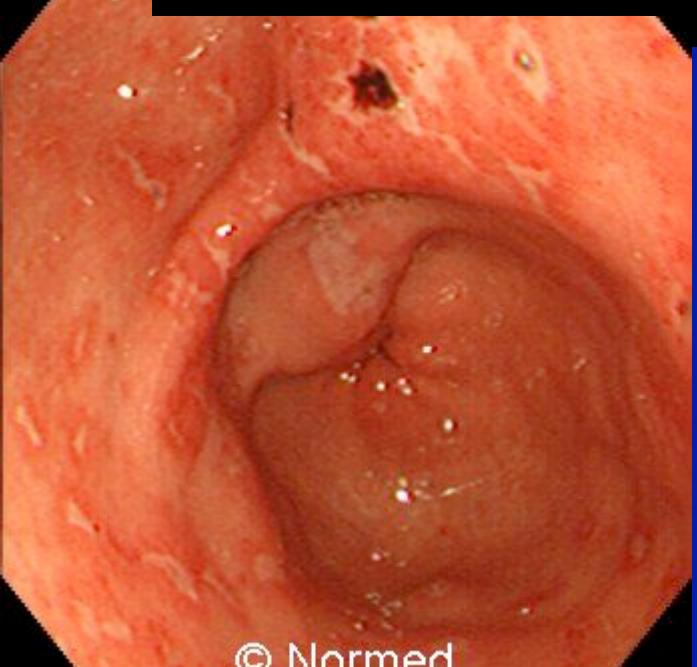
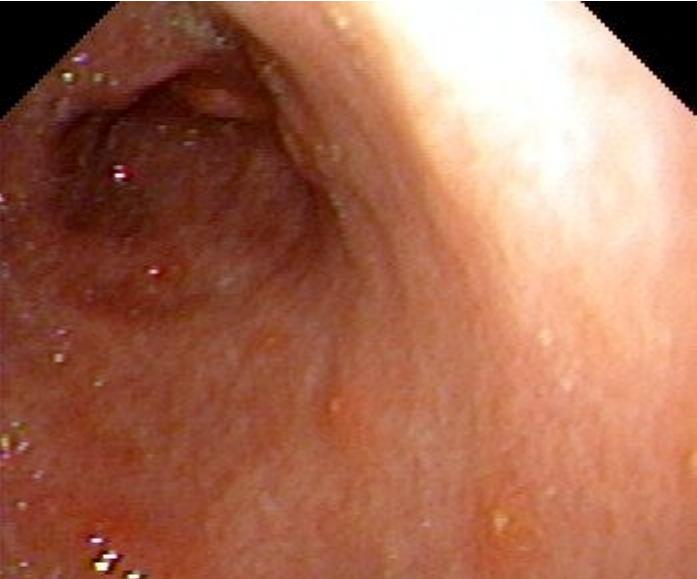


Pertes de substances superficielles



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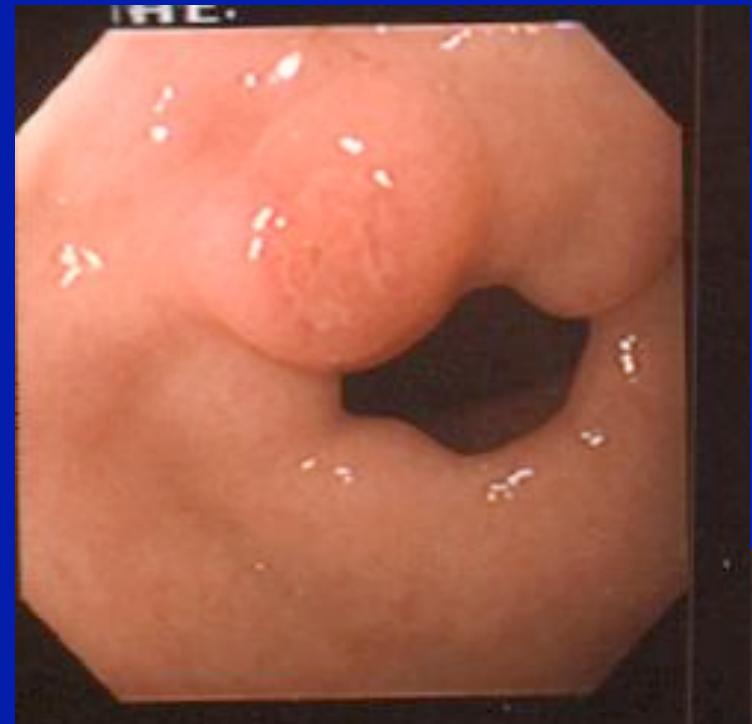
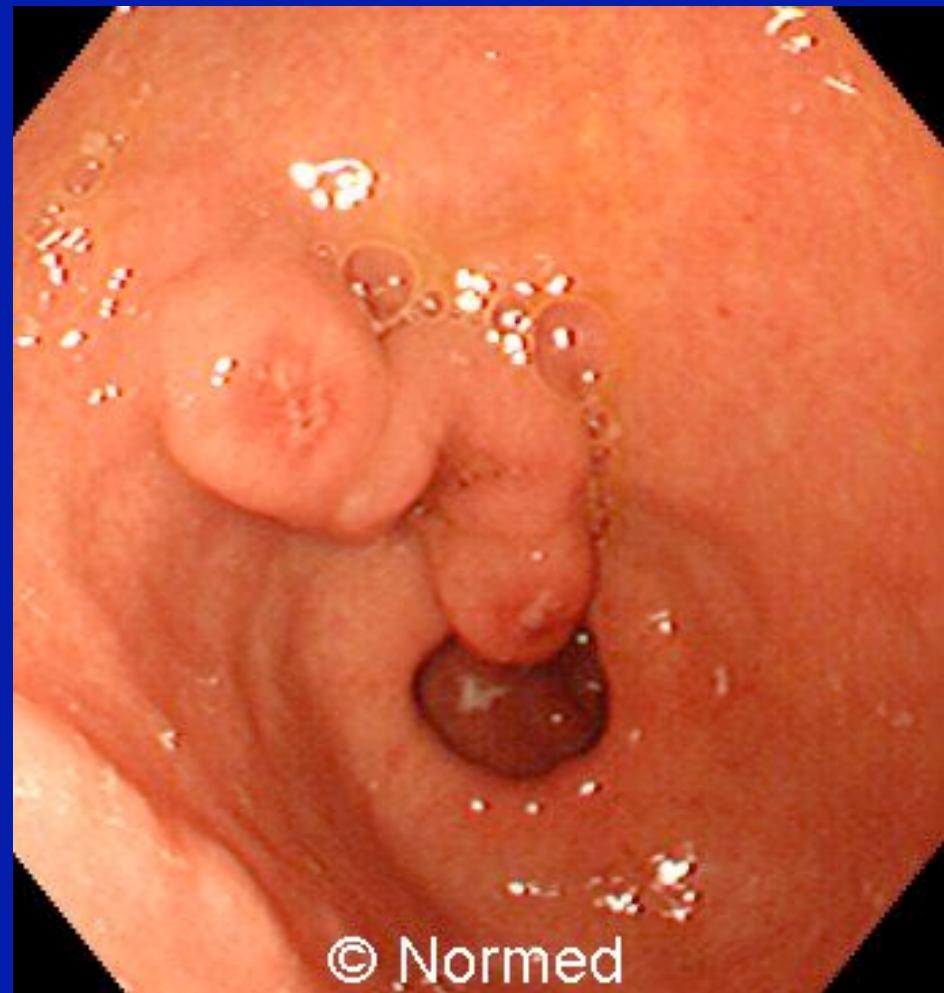


Pertes de substances superficielles

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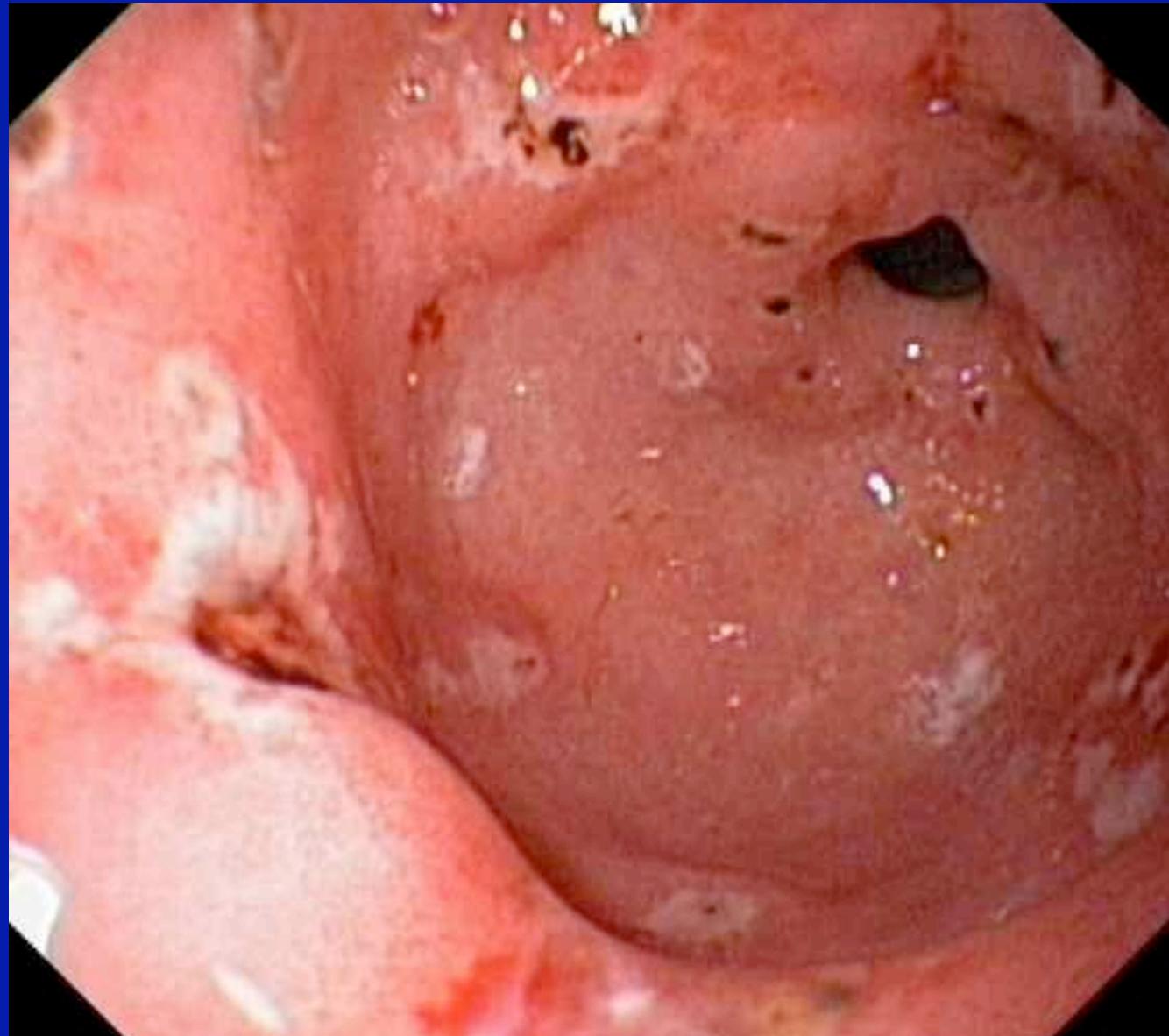
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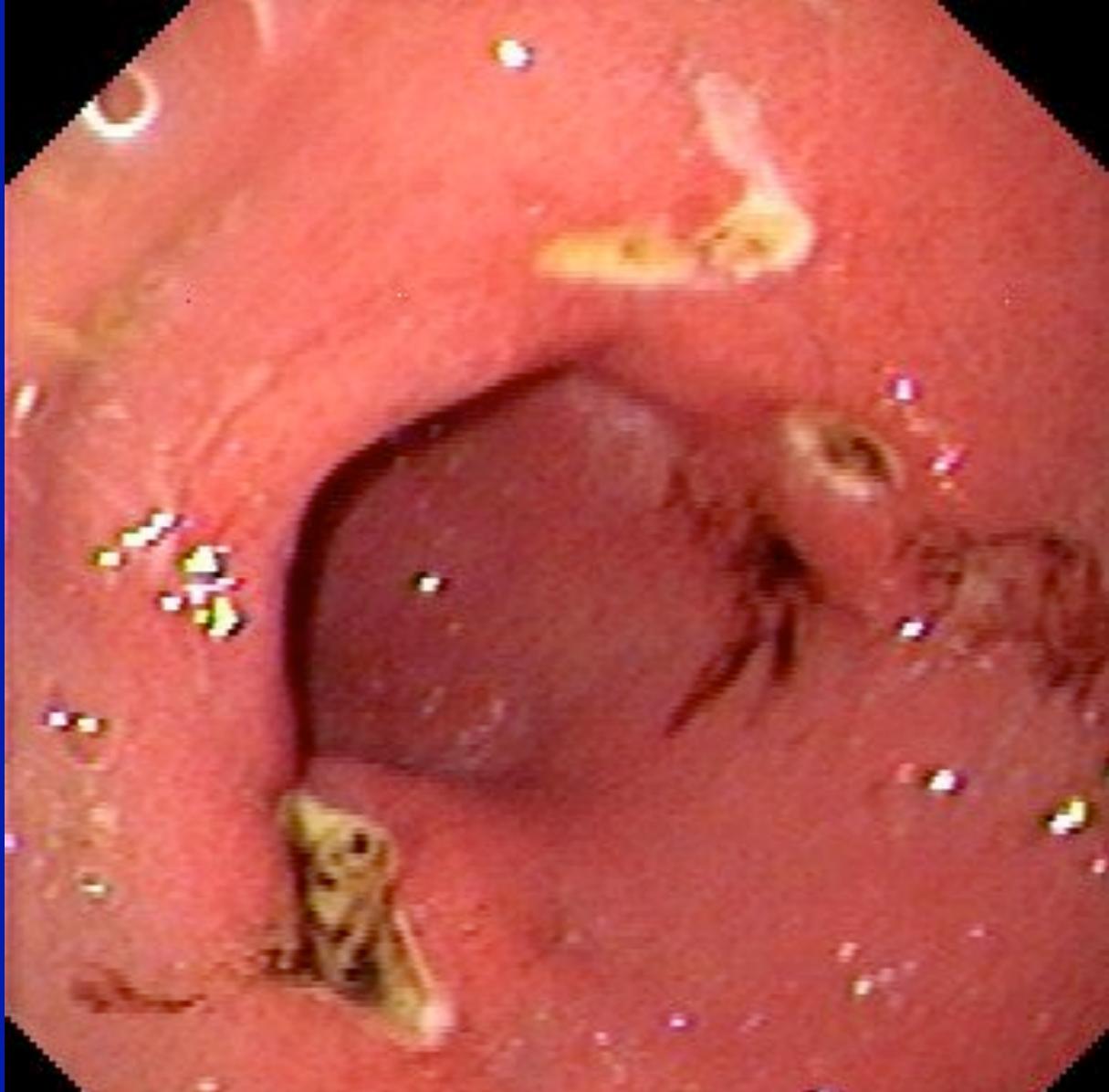
Gros pli pré-pylorique érodé en surface



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Lésions gastriques liées à la prise d'AINS

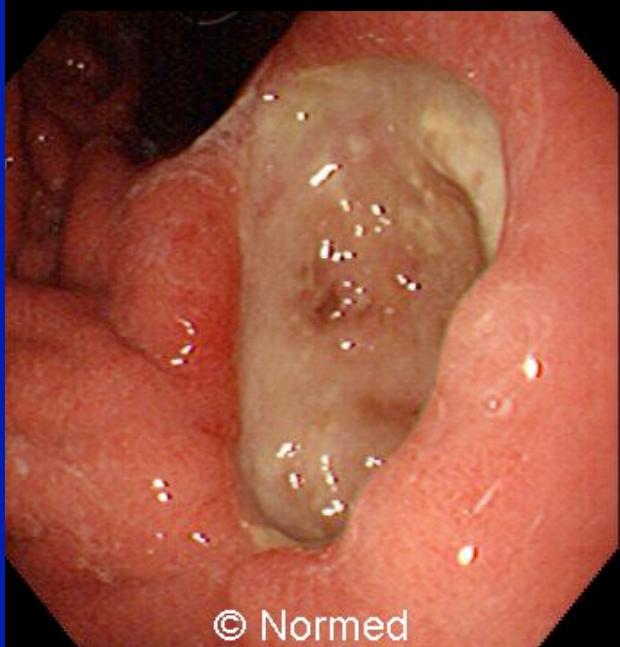




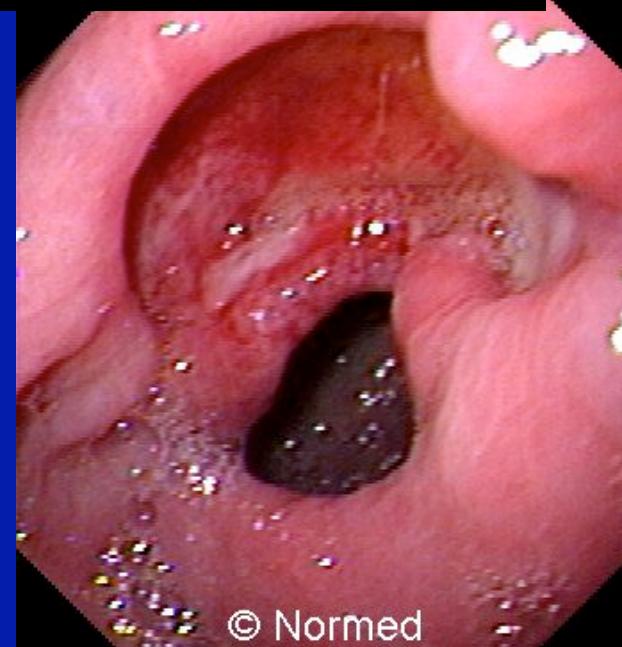
Antrite ulcéro nécrotique



Perte de substance creusante

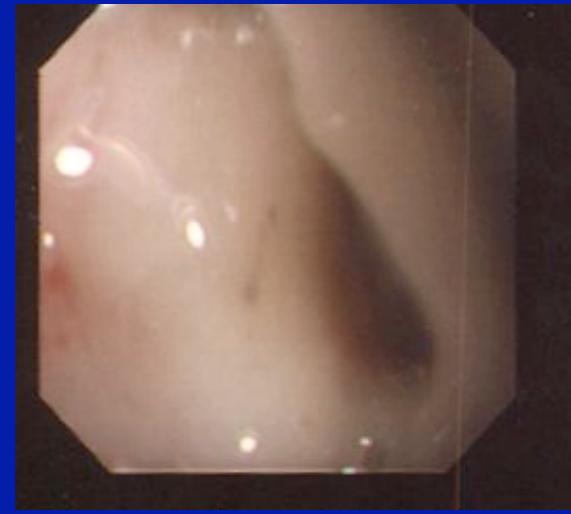
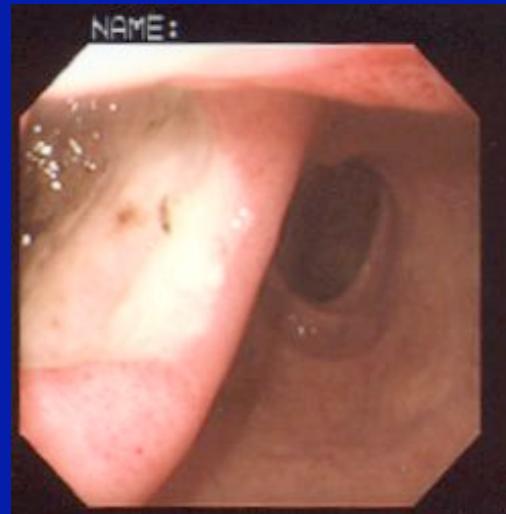


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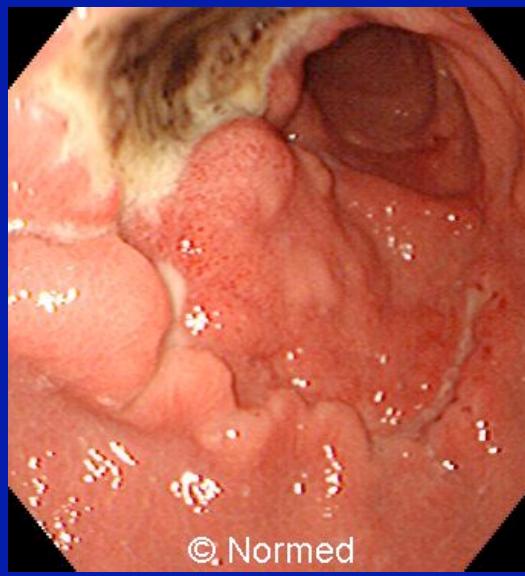
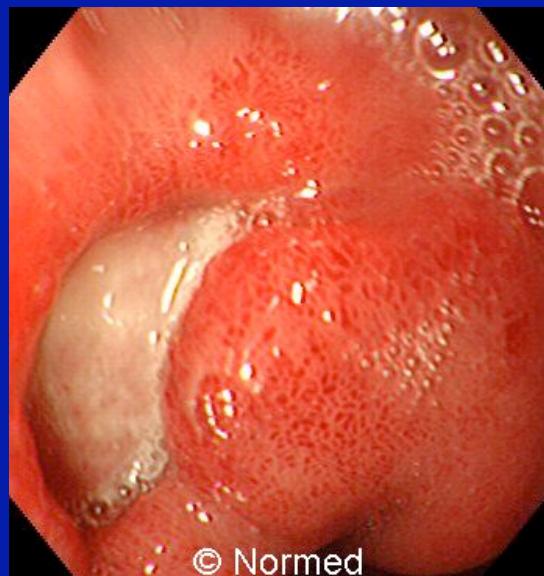
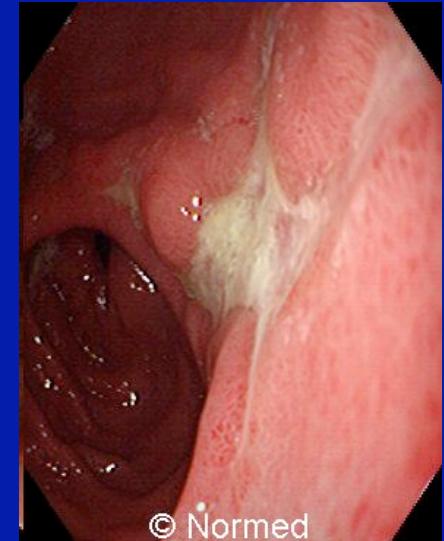
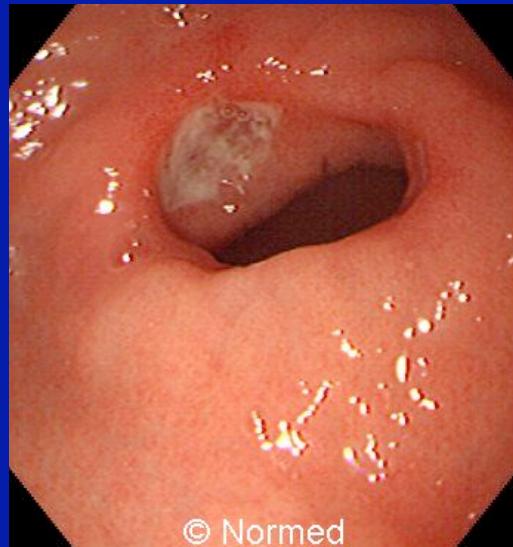


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Perte de substance GD : la profondeur



Perte de substance GD : la forme



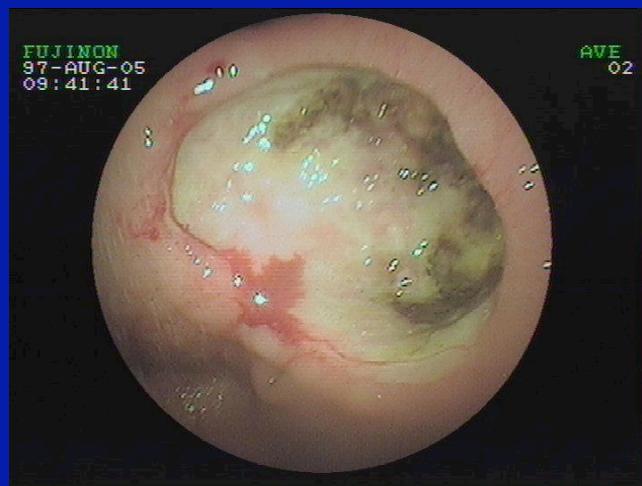
Perte de substance GD : le fond



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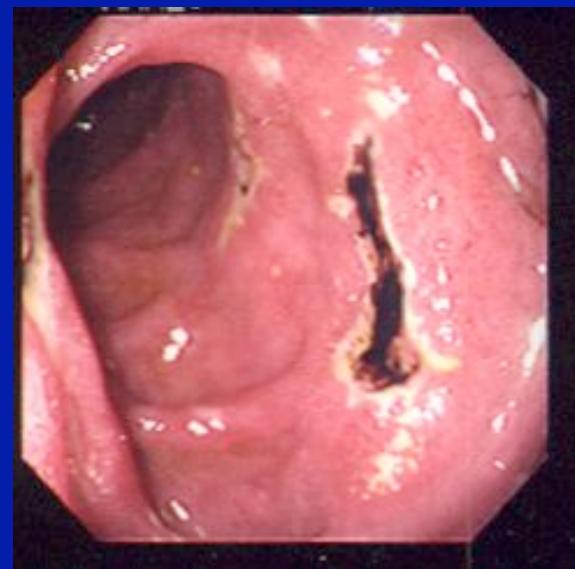


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FUJINON
97-AUG-05
09:41:41

AVE
02



Caractère hémorragique



En jet artériel



En nappe



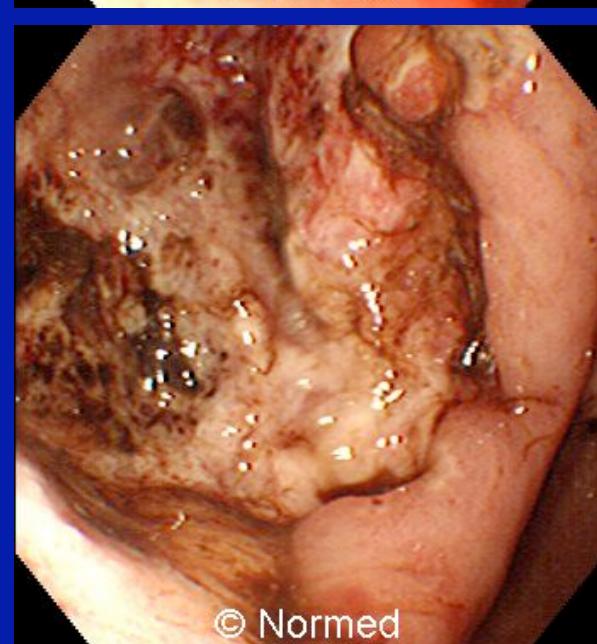
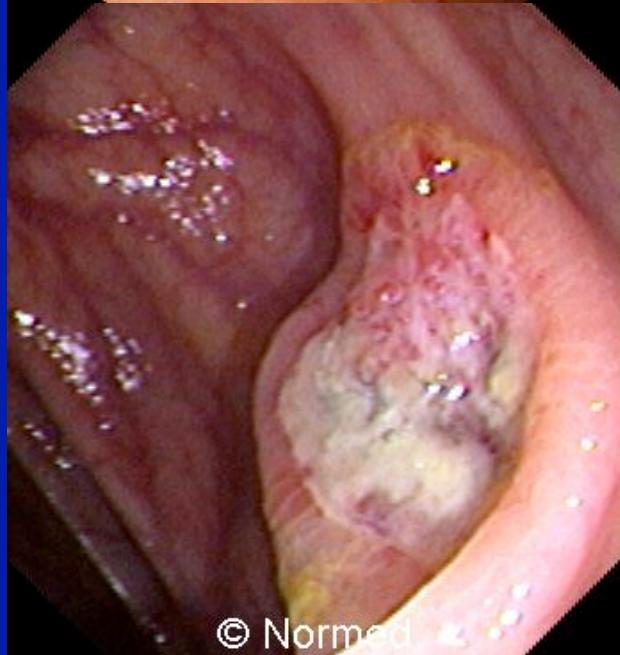
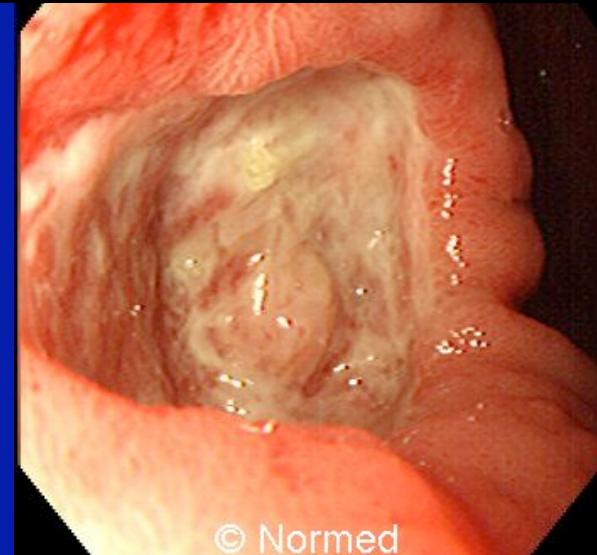
Vaisseau visible



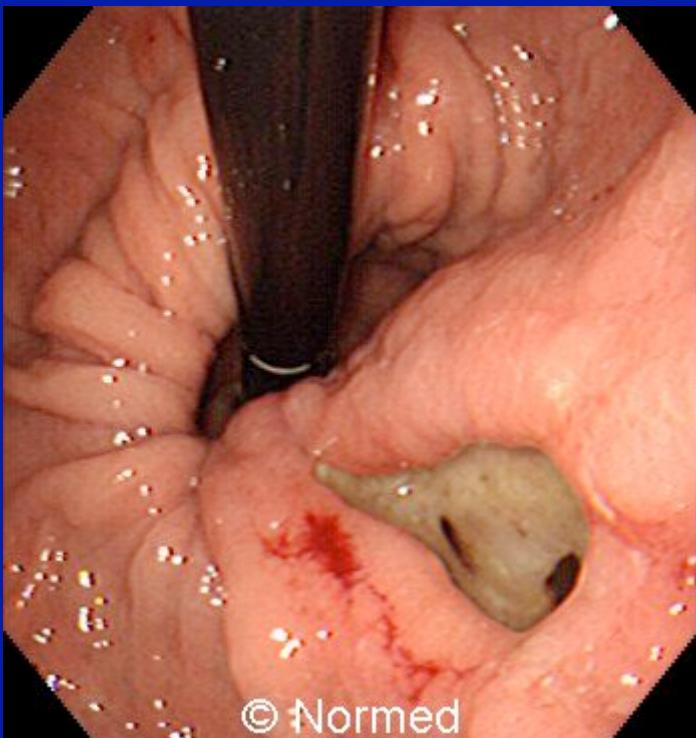
Caillot adhérent

SHR

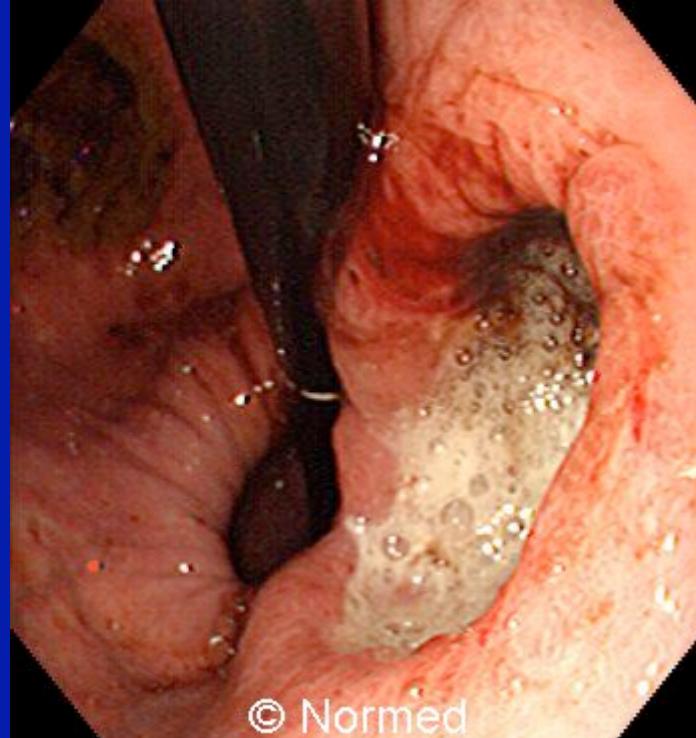
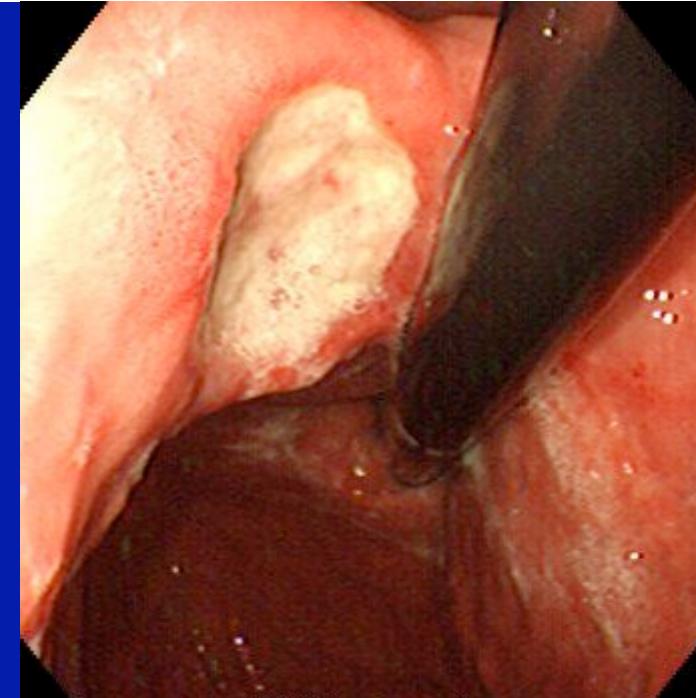
Perte de substance GD : le fond



Ulcère gastrique : le siège sous cardinal



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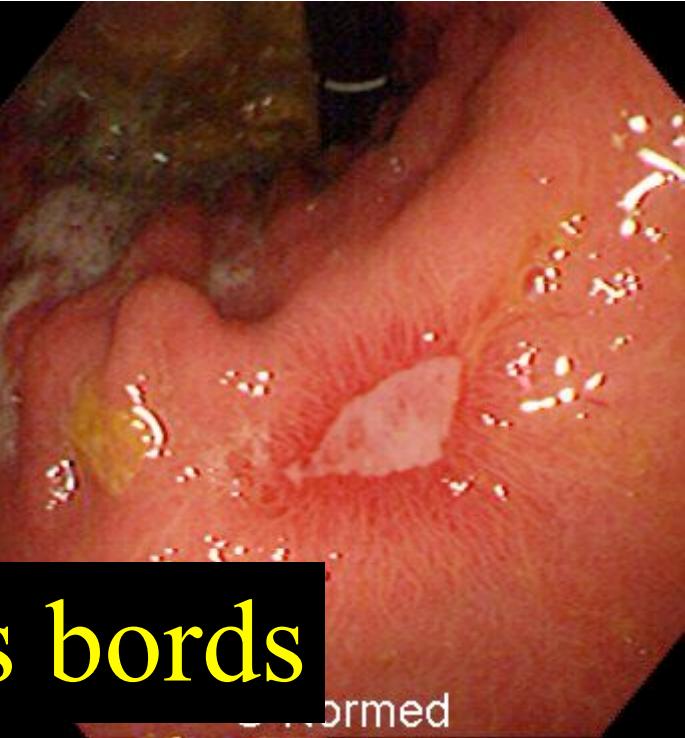
© Normed

UD : le siège bulbaire quelle face ?



Ulcère GD : les bords



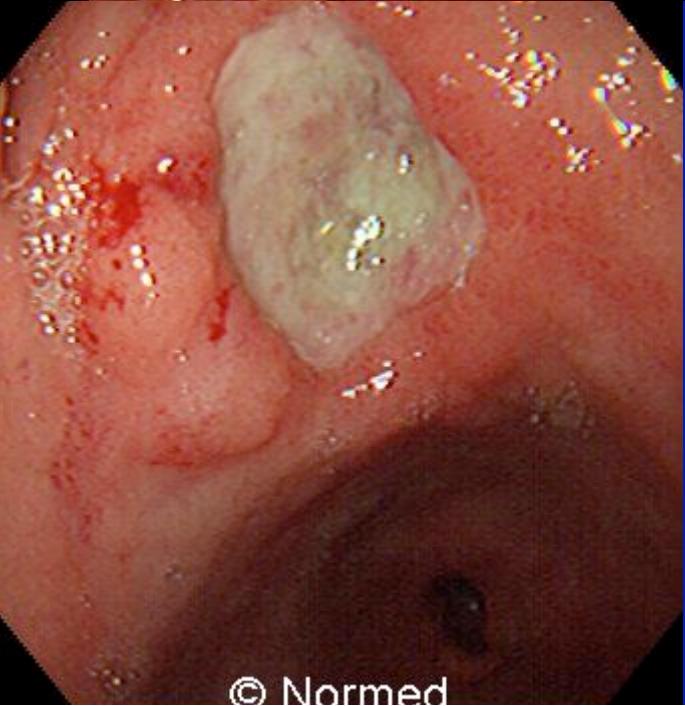


Ulcère GD : les bords

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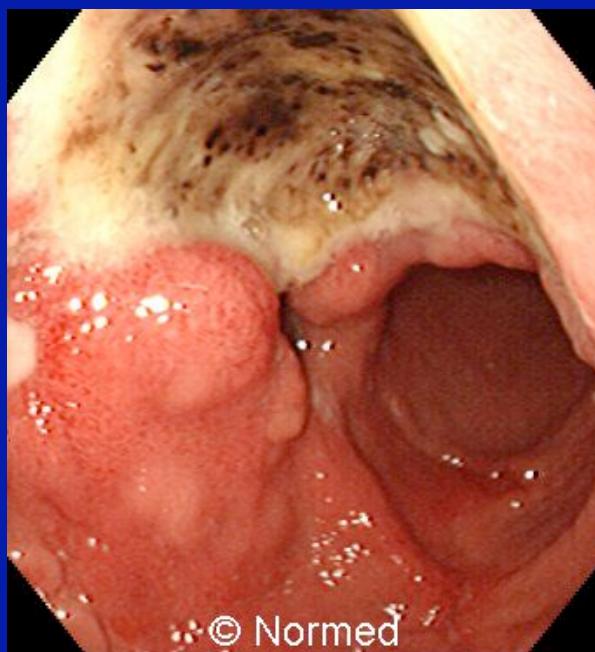


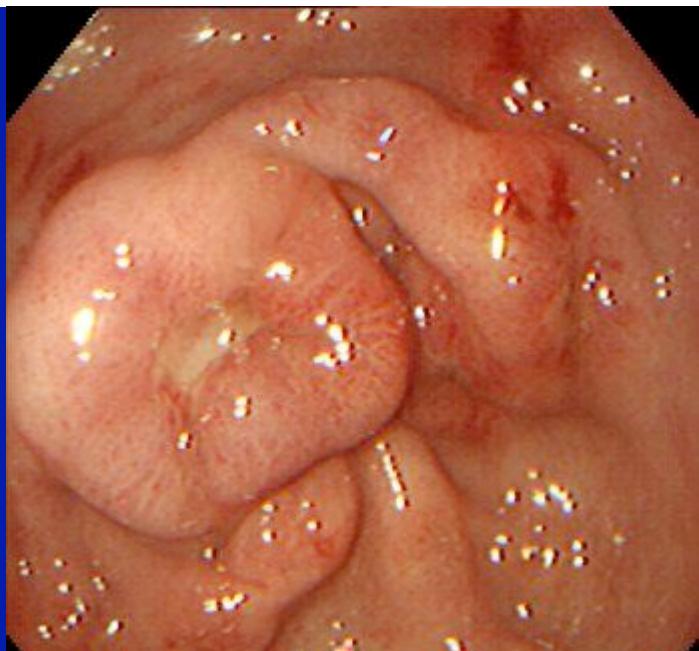
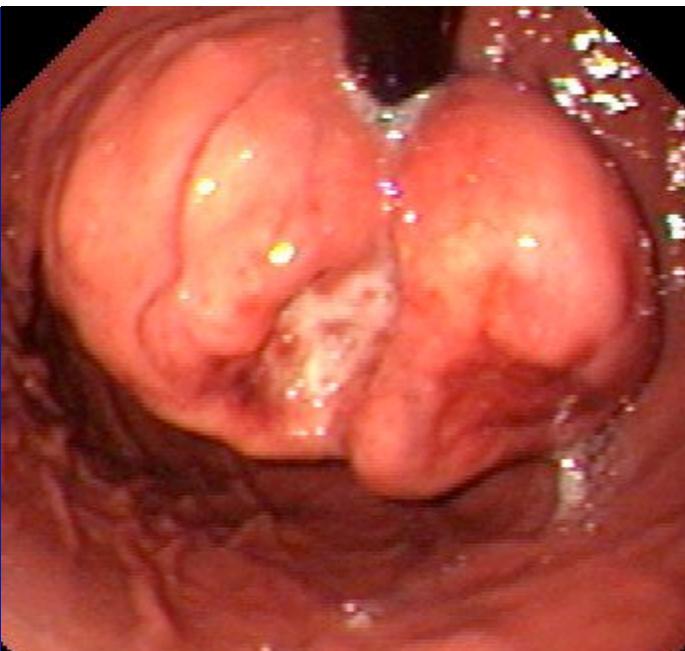
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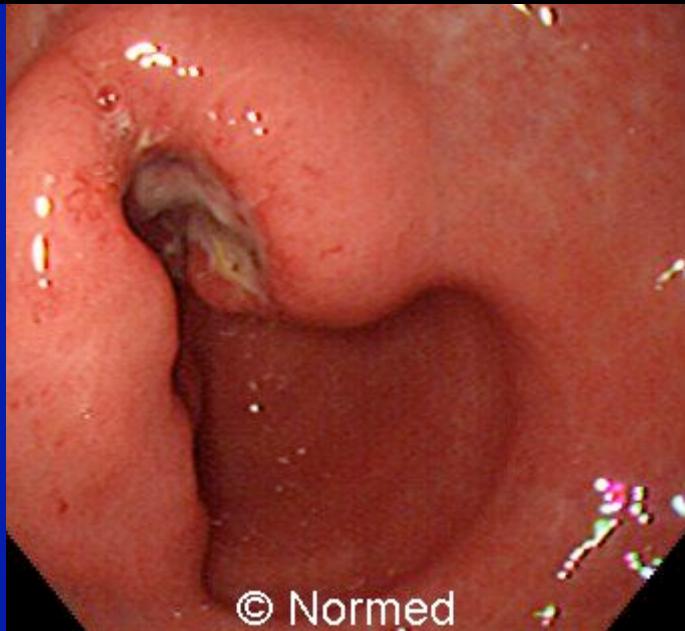
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Ulcère GD : les bords





Perte de substance sur lésion surelevée

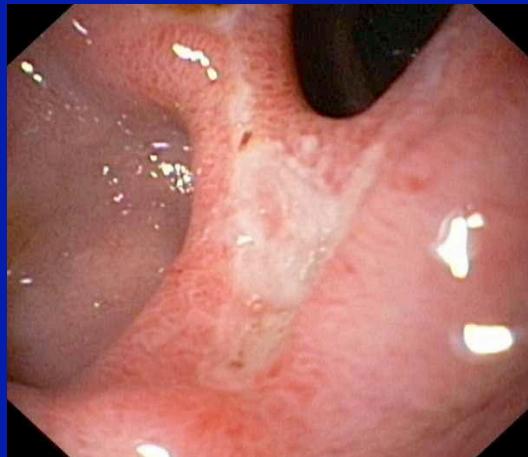


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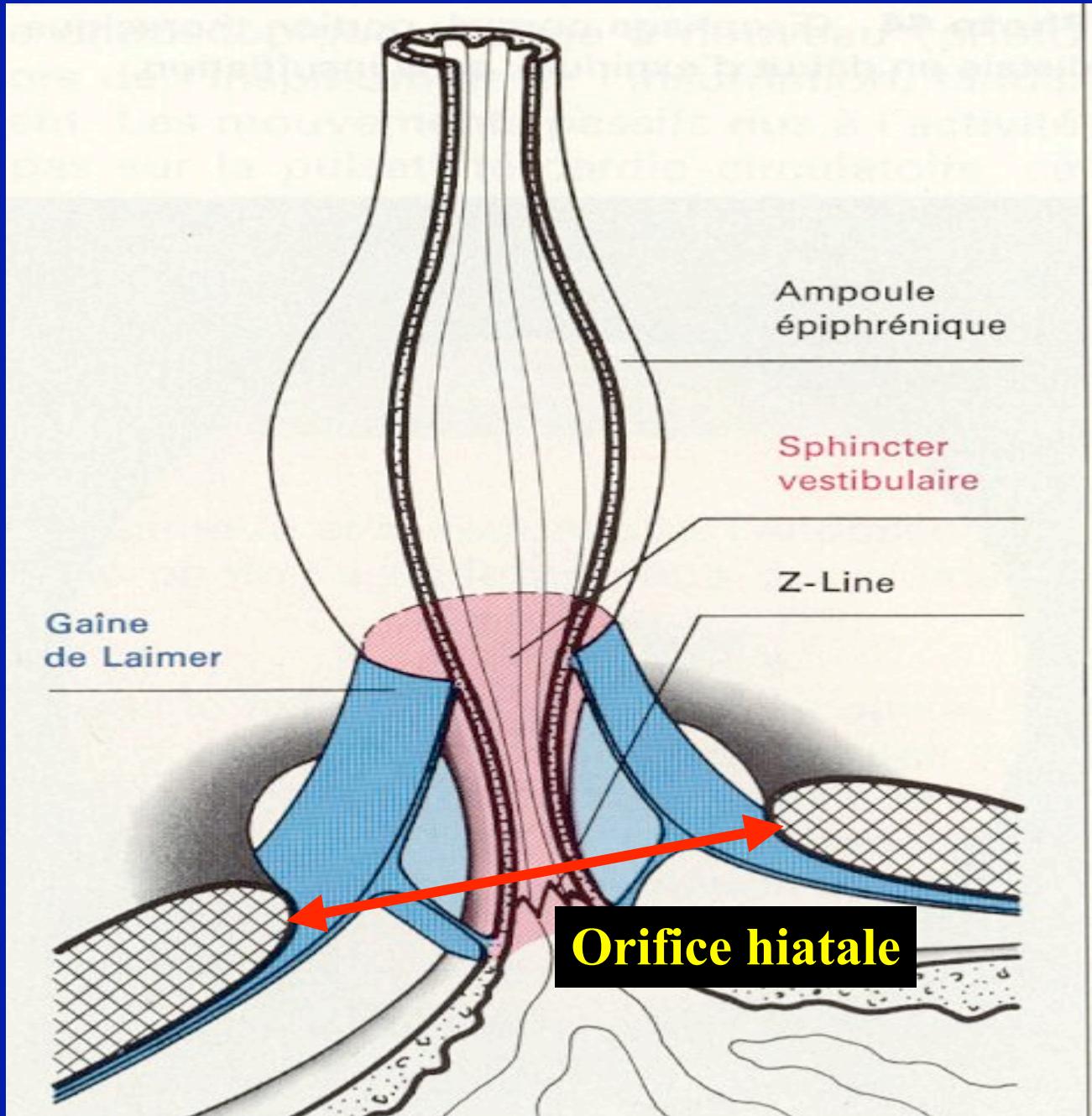
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Perte de substance Bulbaire : la zone péri-lésionnelle; déformations associées

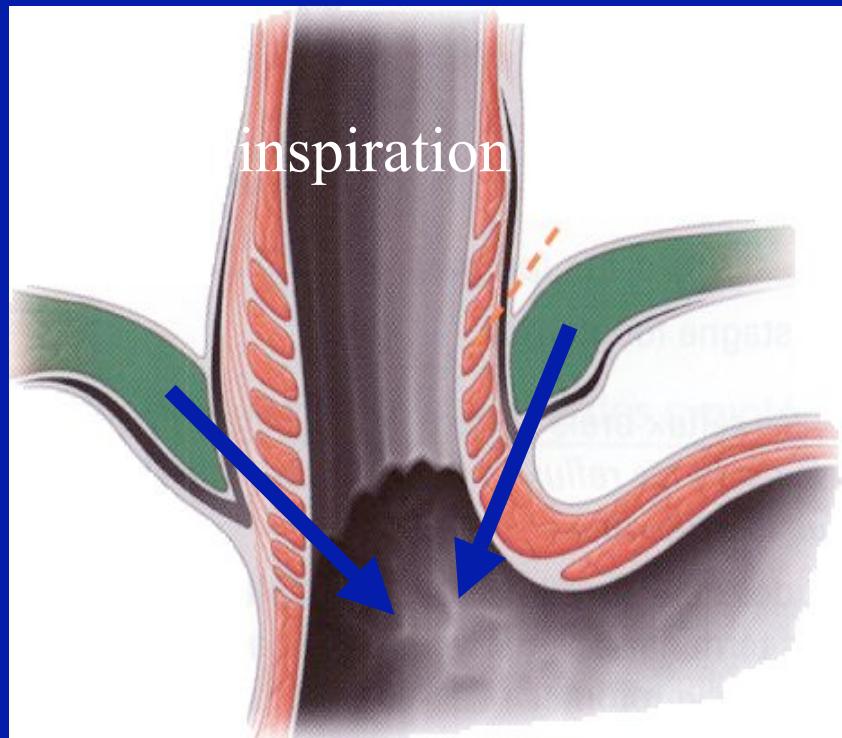


Exploration endoscopique de la région oeso-cardiaile

Anatomie de la région oeso-cardiotubérositaire



Région oeso-cardio-tubérositaire

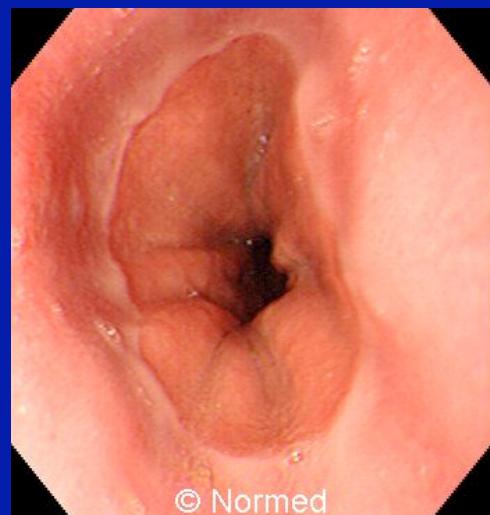


Distance max entre ligne Z et orifice hiatale
en inspiration profonde < 2 cm

Cardia muqueux- ligne Z



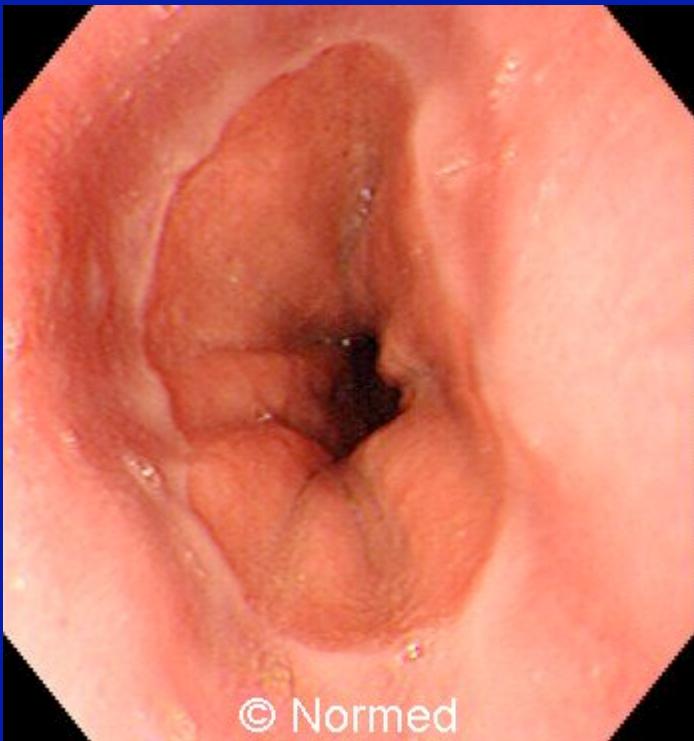
Orifice hiatal



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Hernie hiatale



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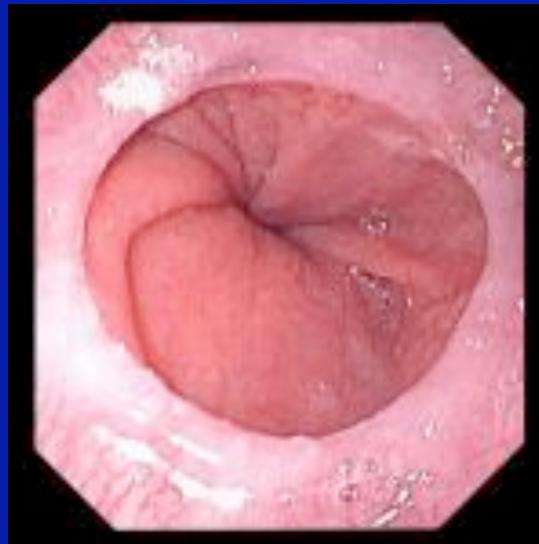


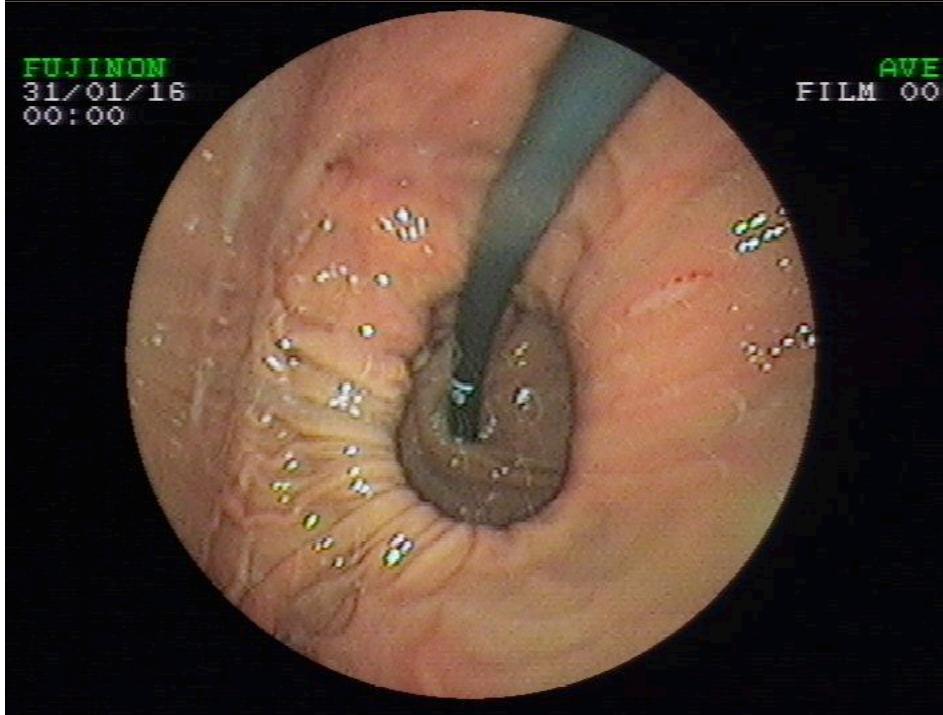
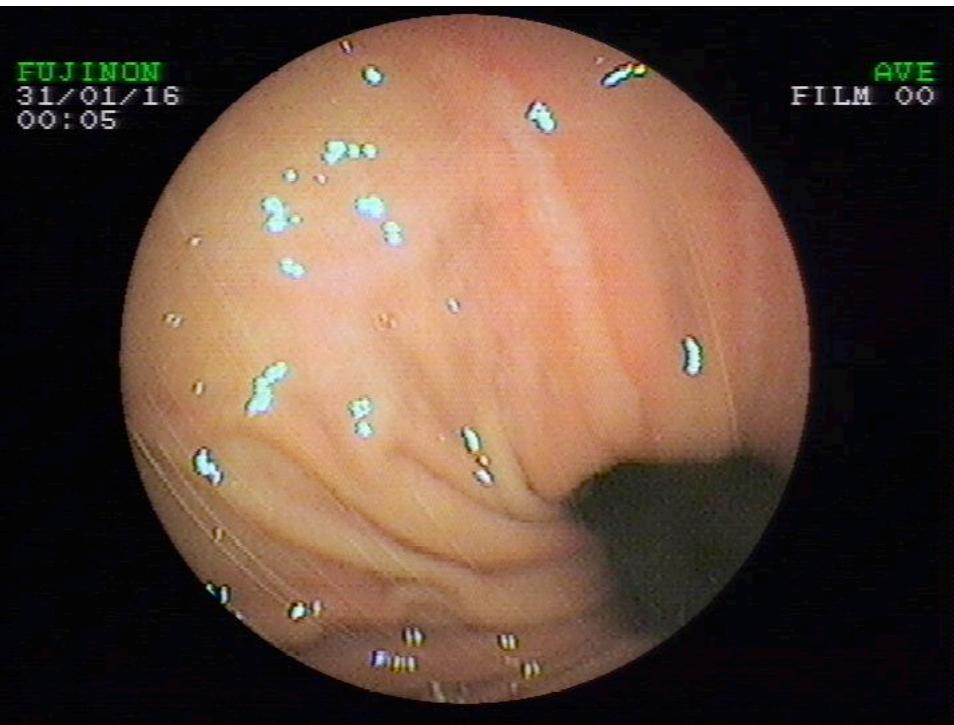
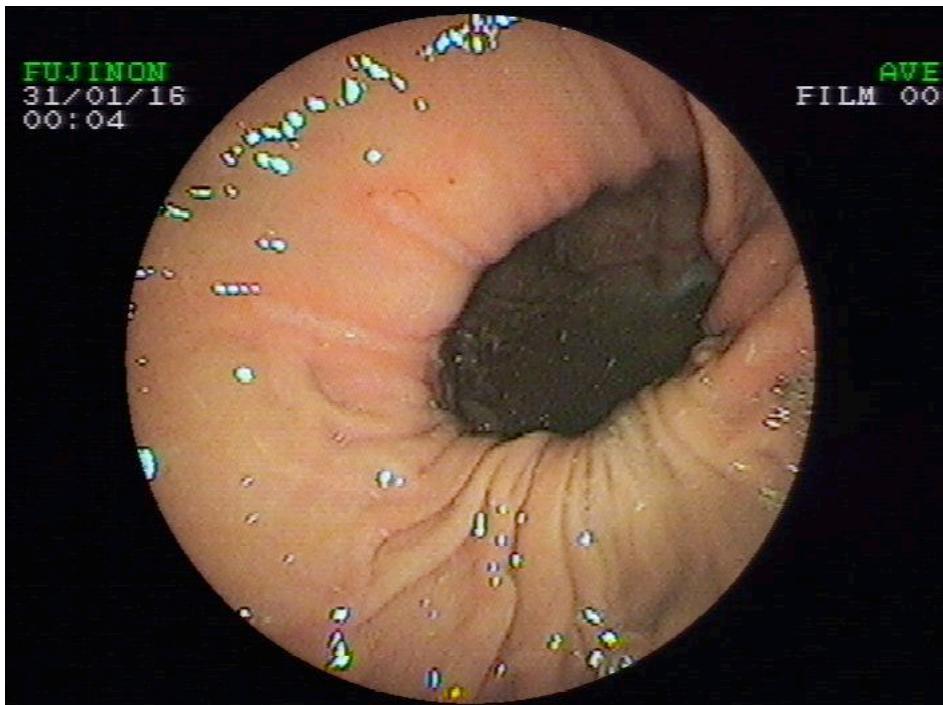
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Hernie hiatale par glissement



Normal





Hernie hiatale en rétrovision



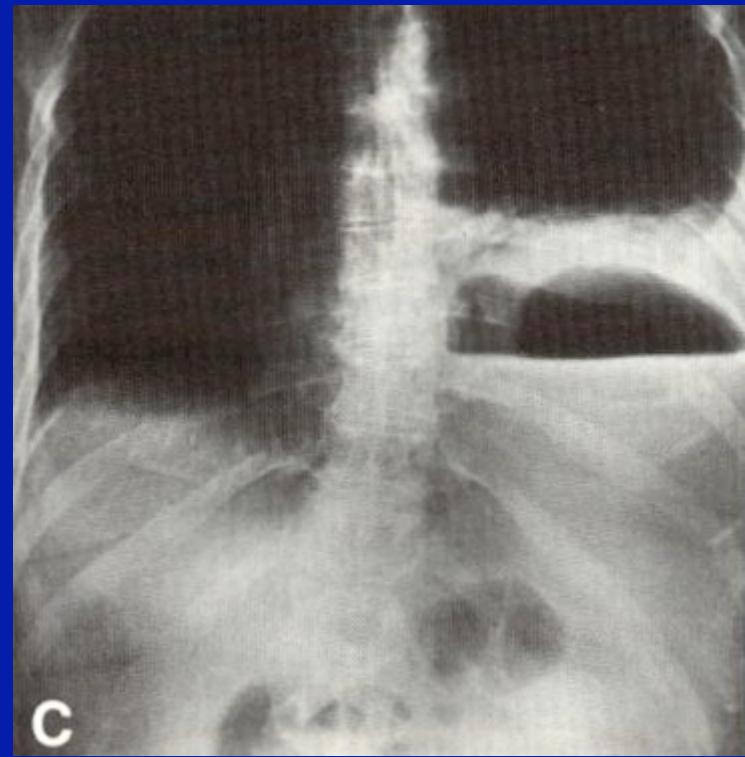
Normal



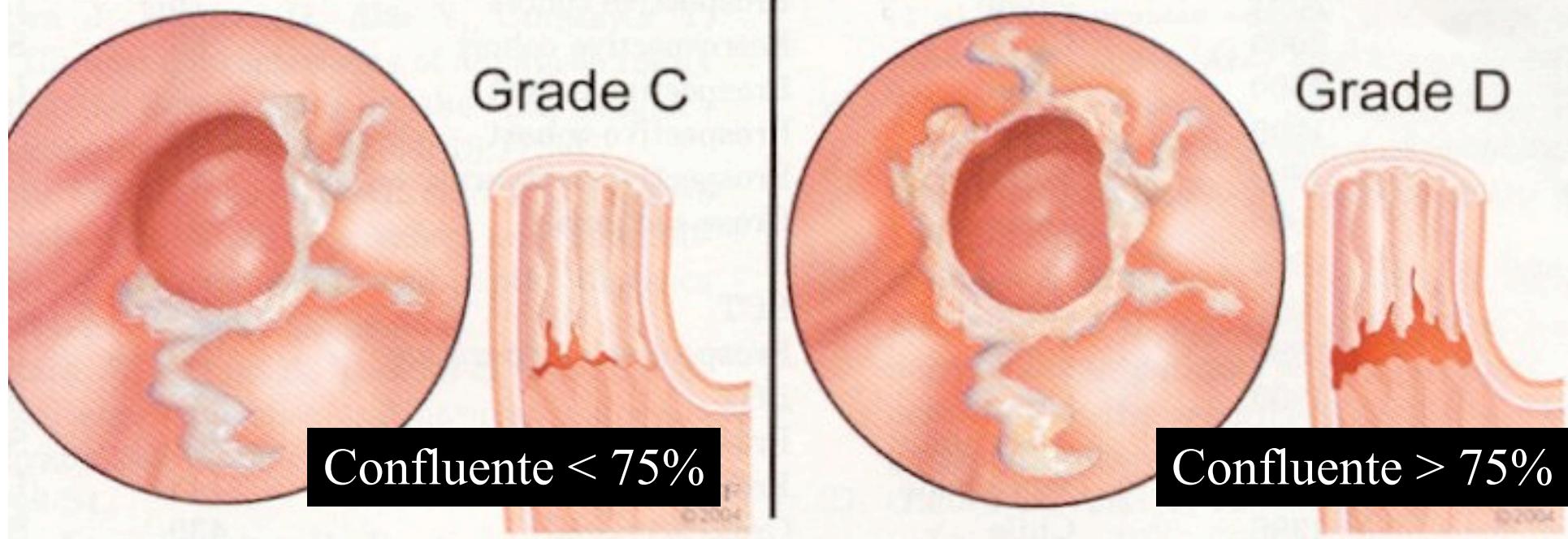
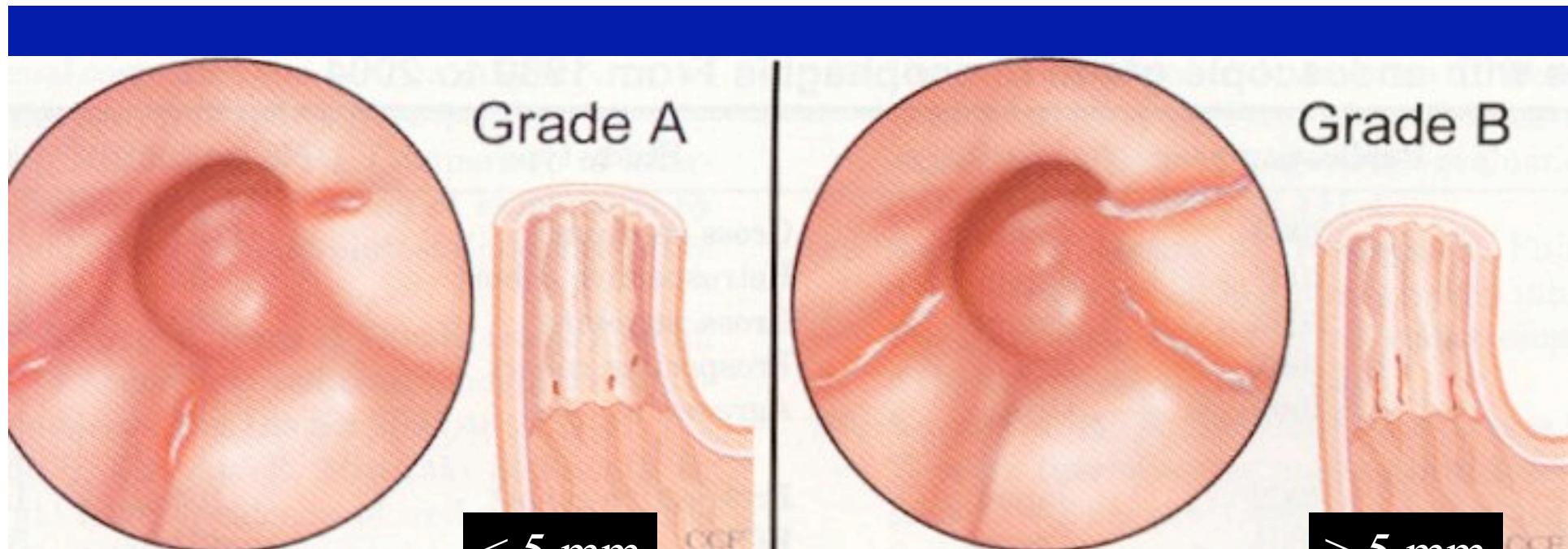
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Hernie para oesophagienne



LESIONS OESOPHAGIENNES

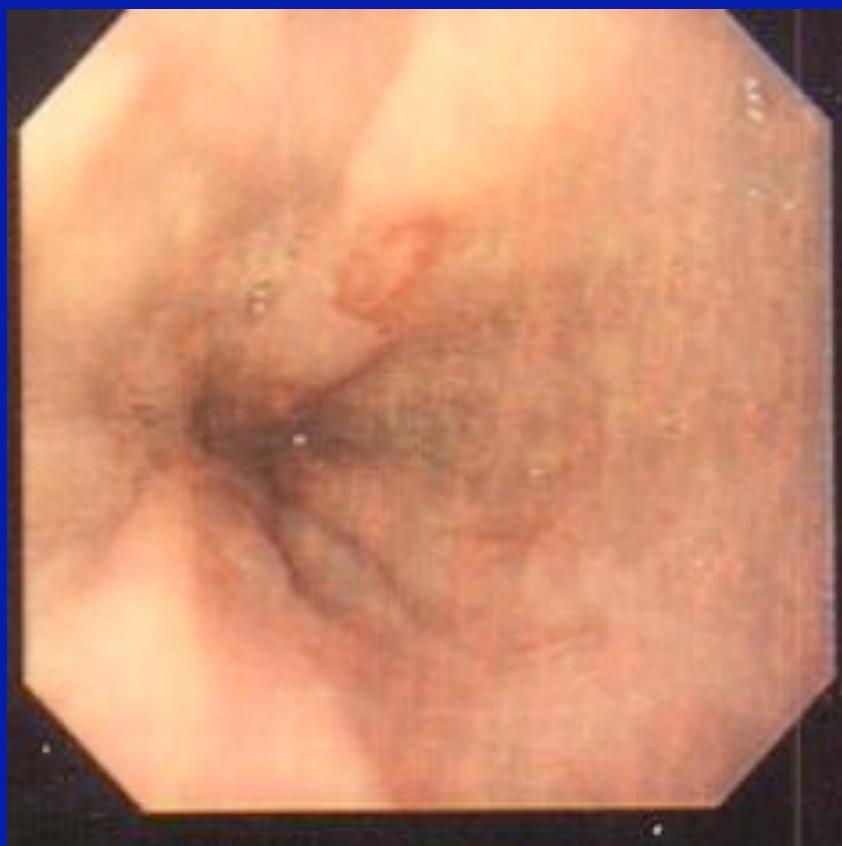


Lésion congestive du bas oesophage



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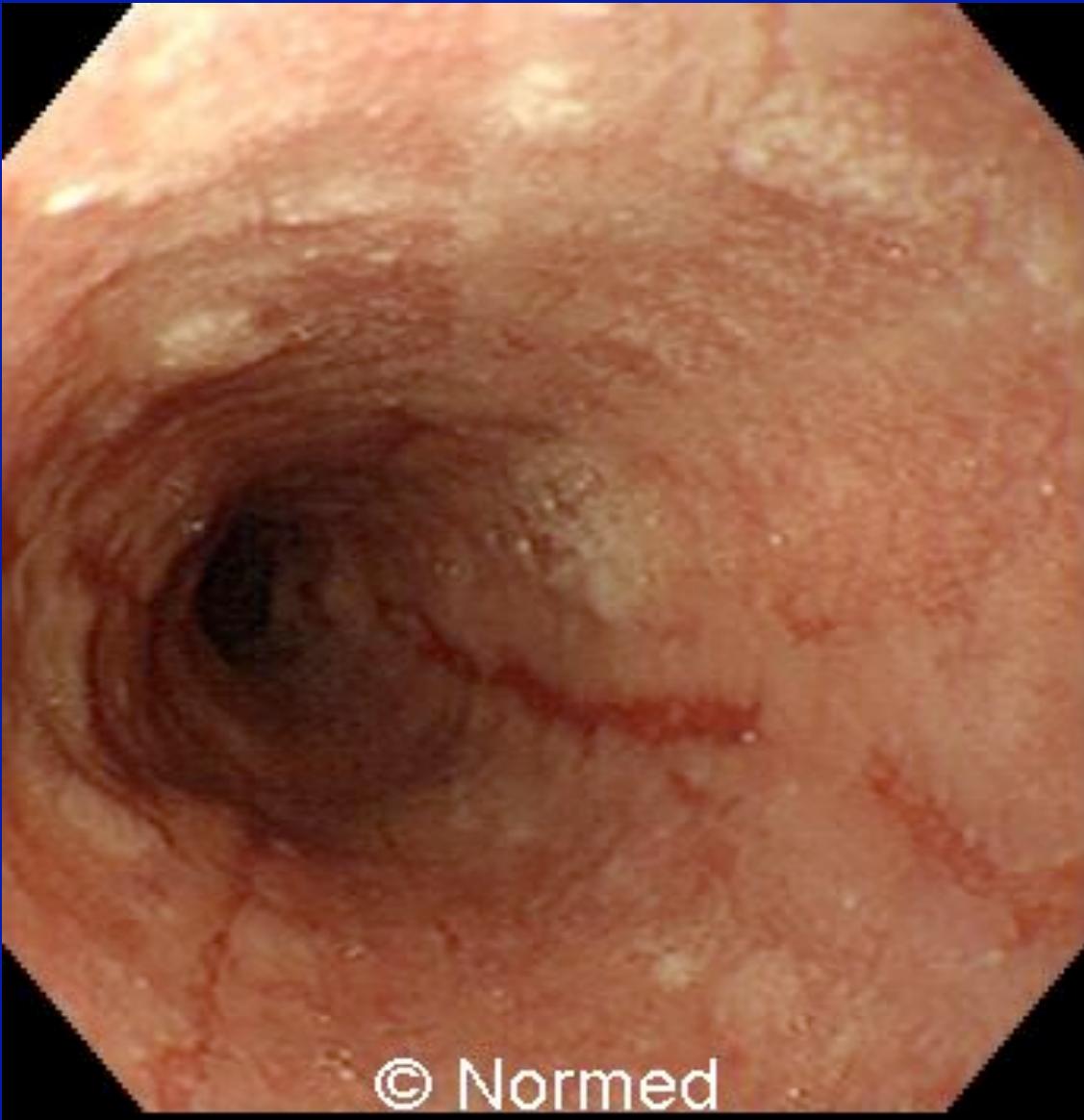
OESOPHAGITE < 5 mm





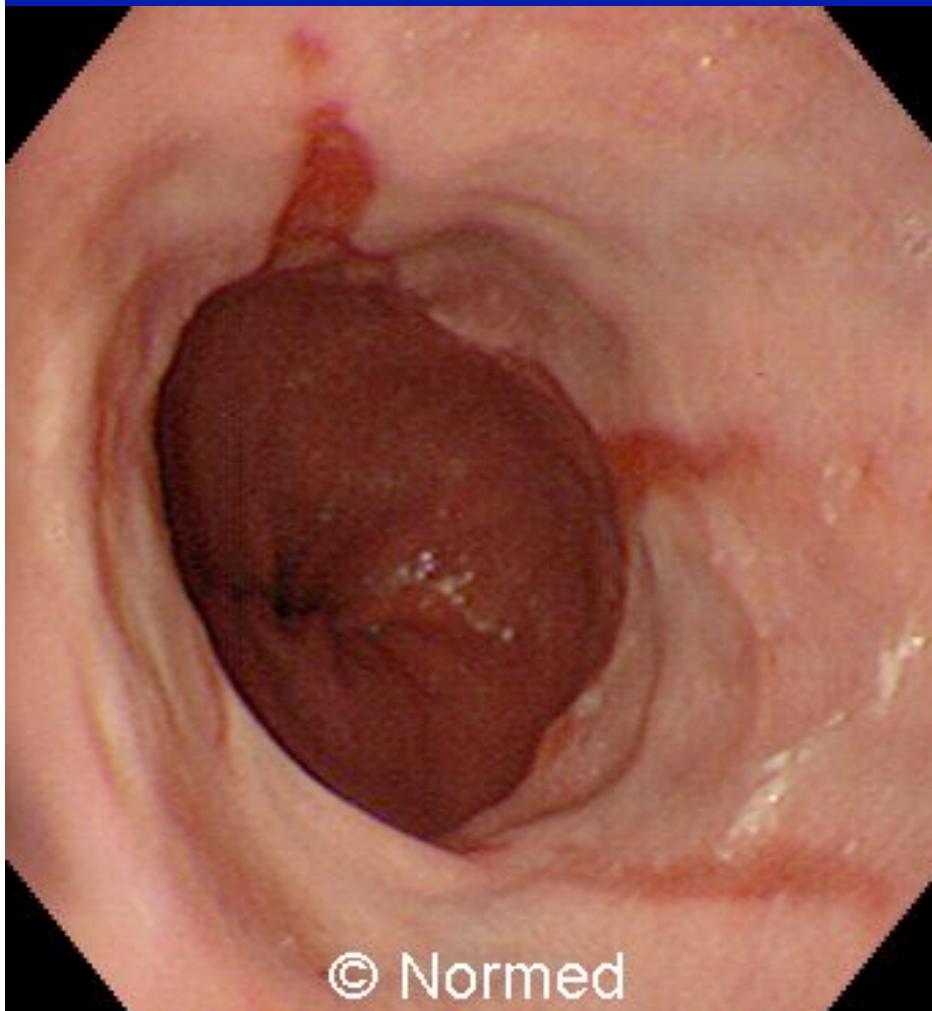
Gastrite jonctionnelle

Oesophagite linéaire

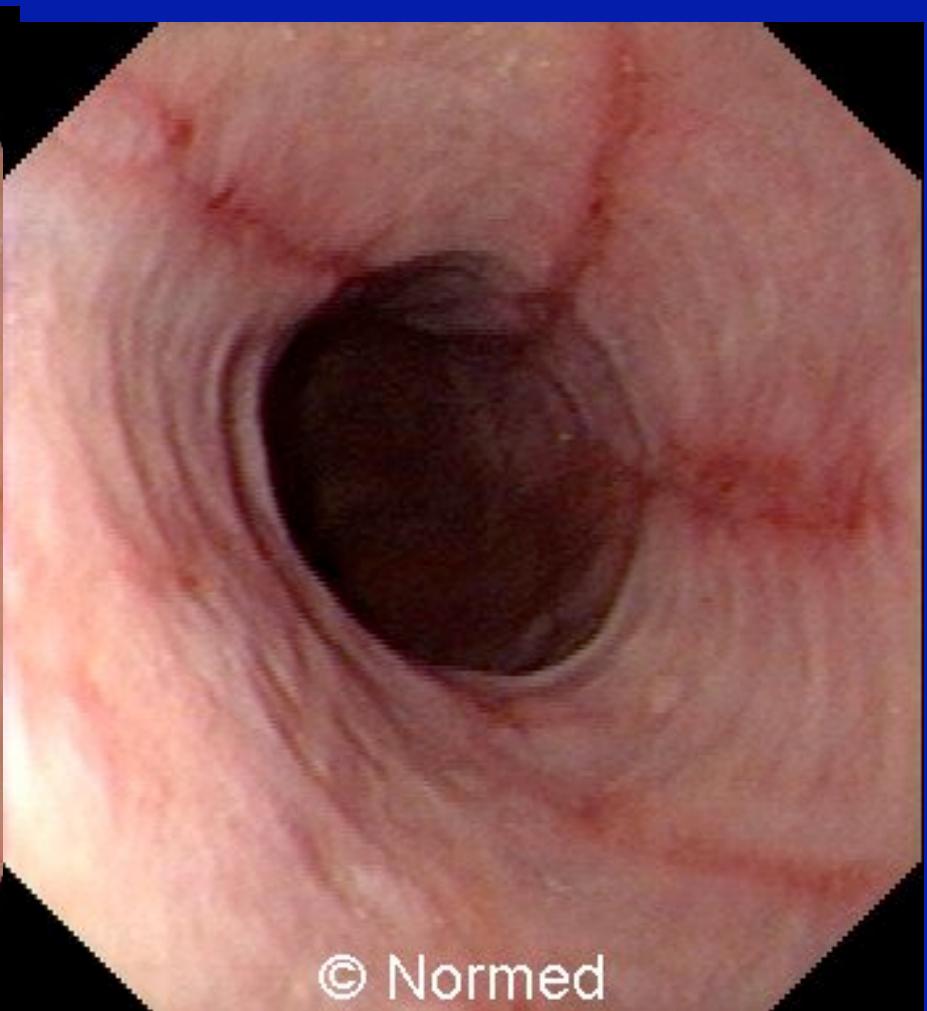


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Oesophagite linéaire

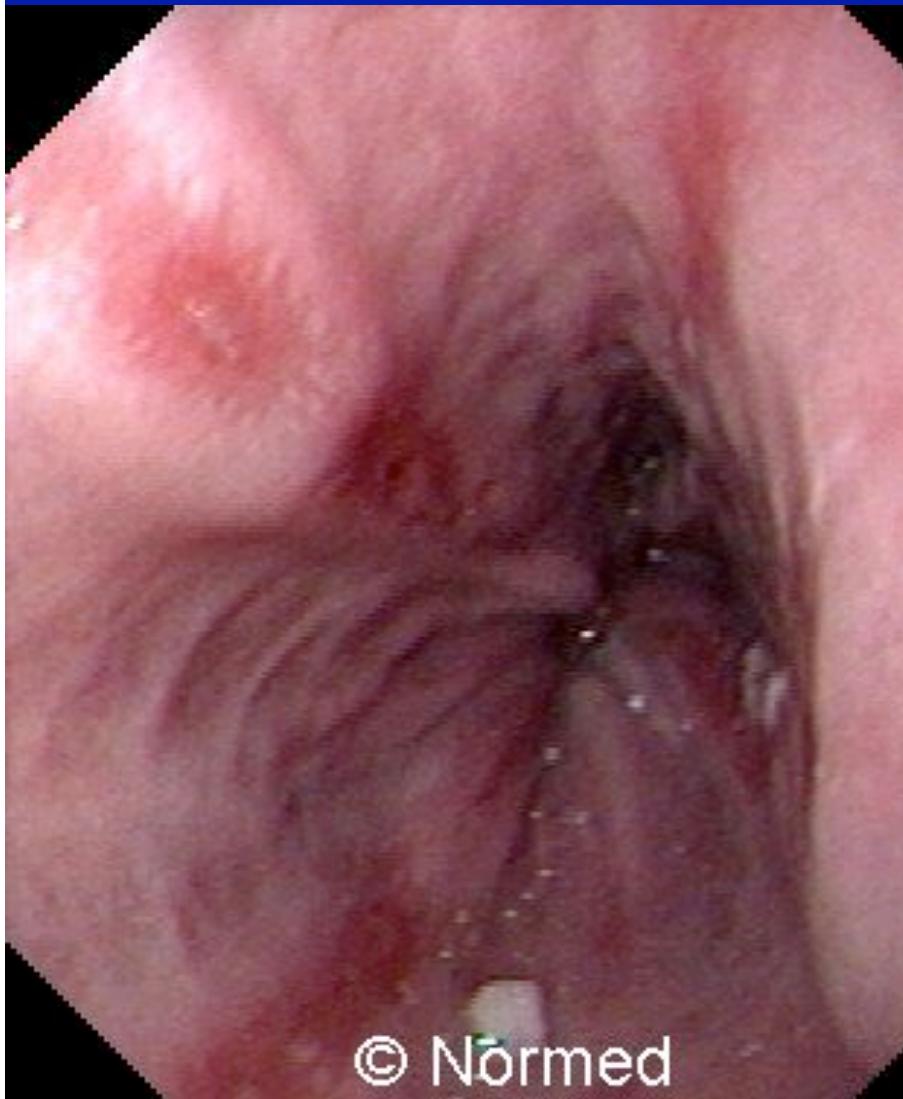


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Oesophagite confluente

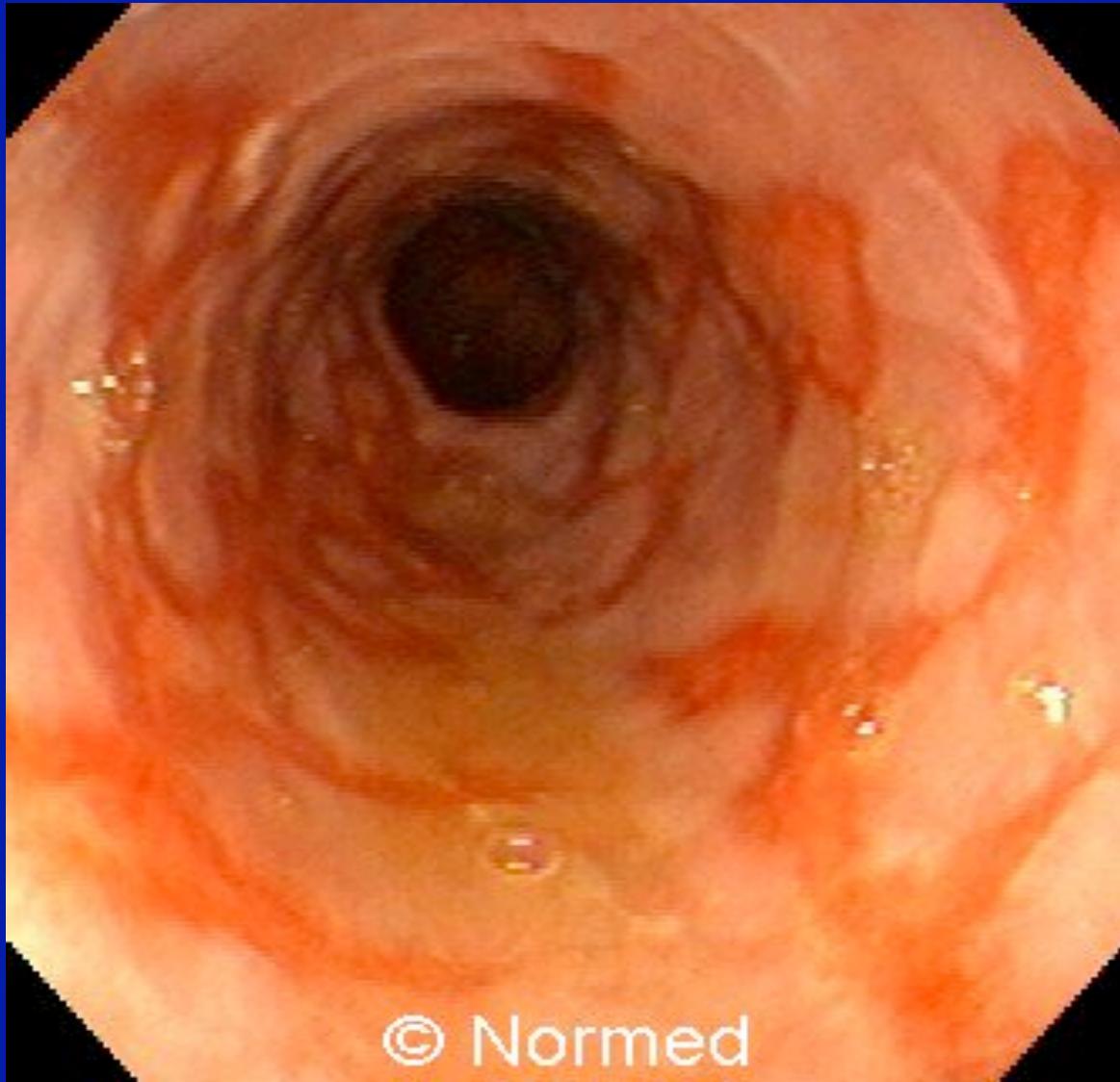


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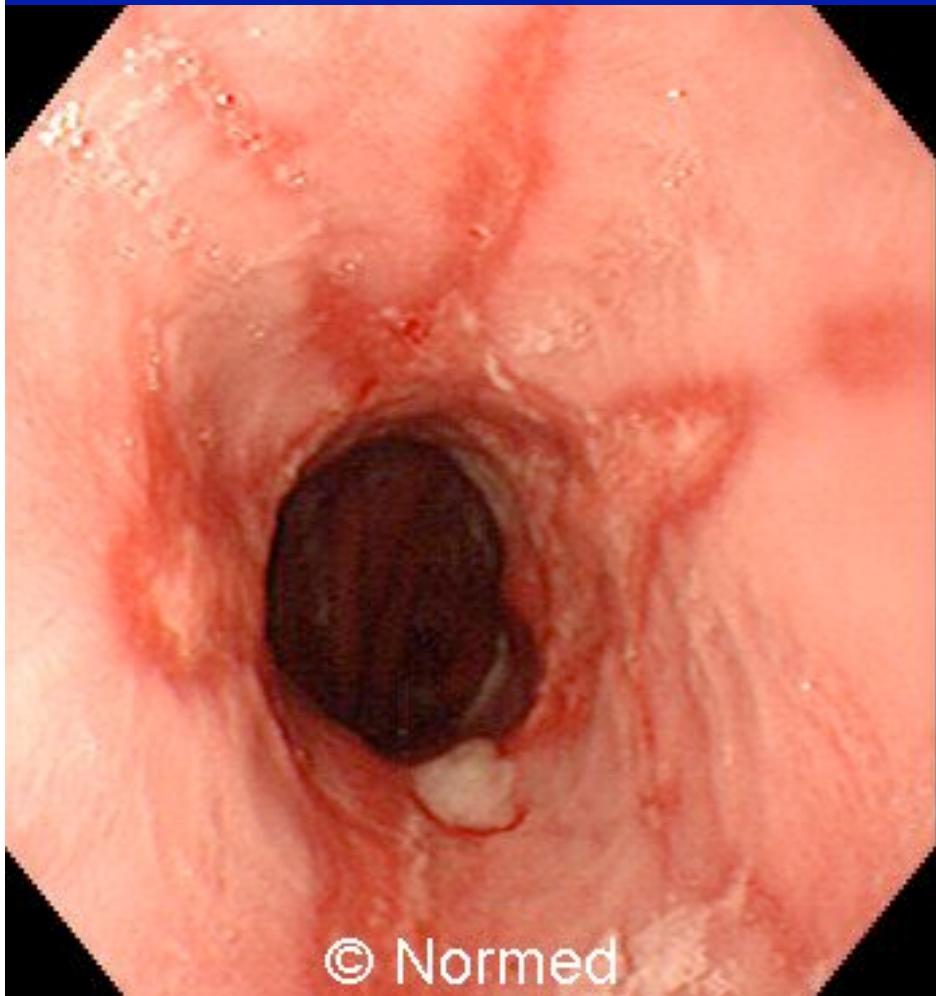
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Oesophagite circonférentielle

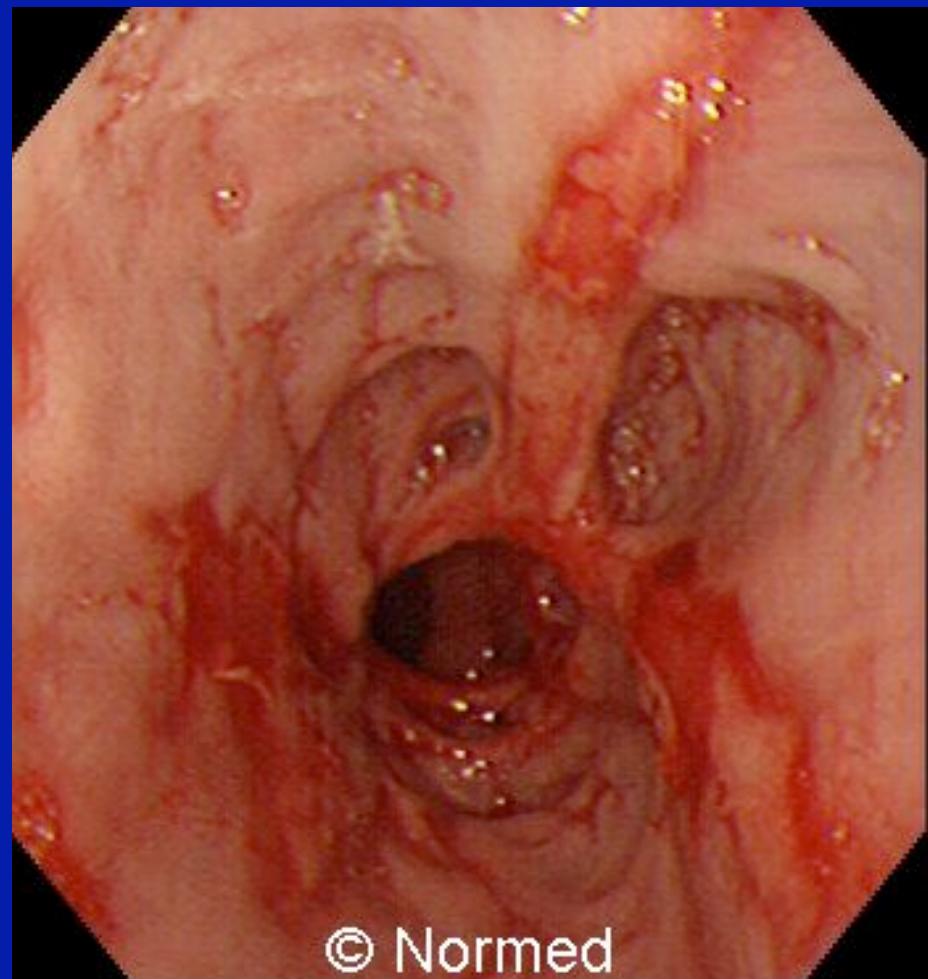


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Oesophagite circulaire et sténosante

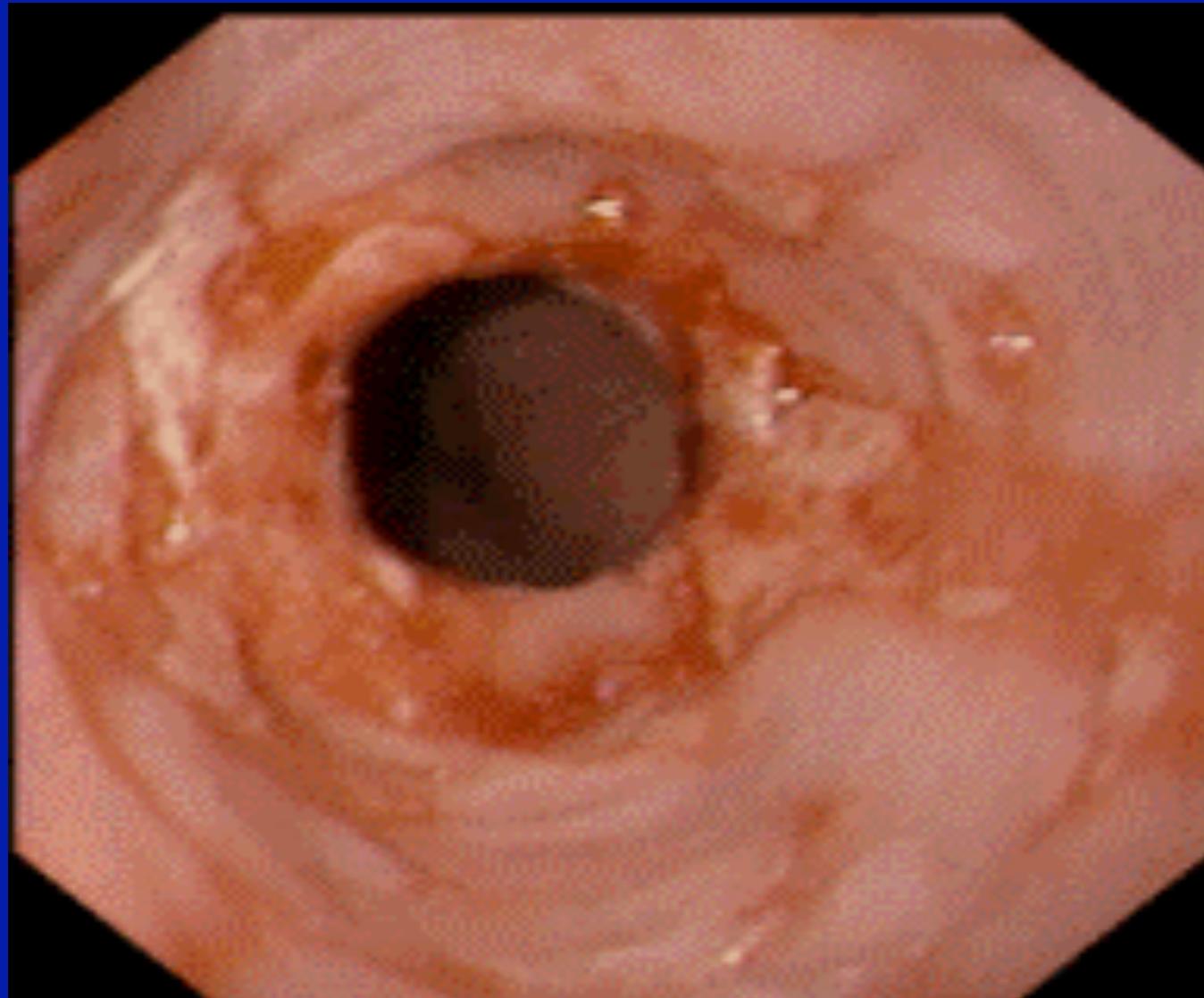


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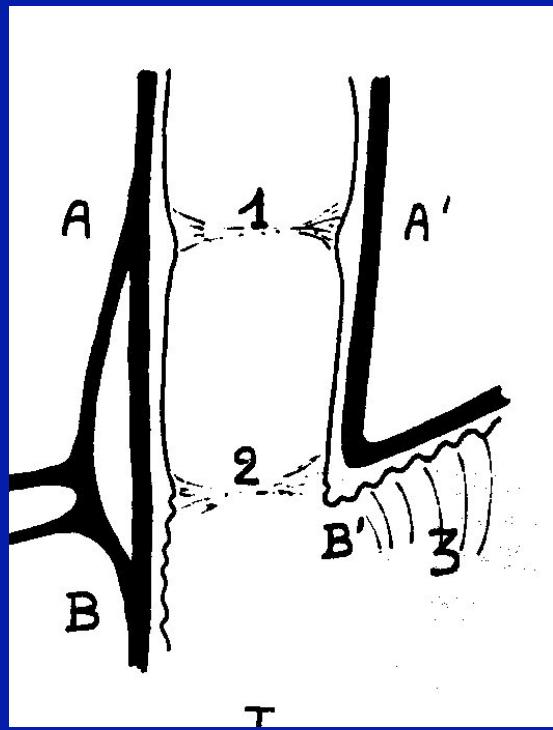


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Oesophagite sténosante



Anneaux du bas oesophage



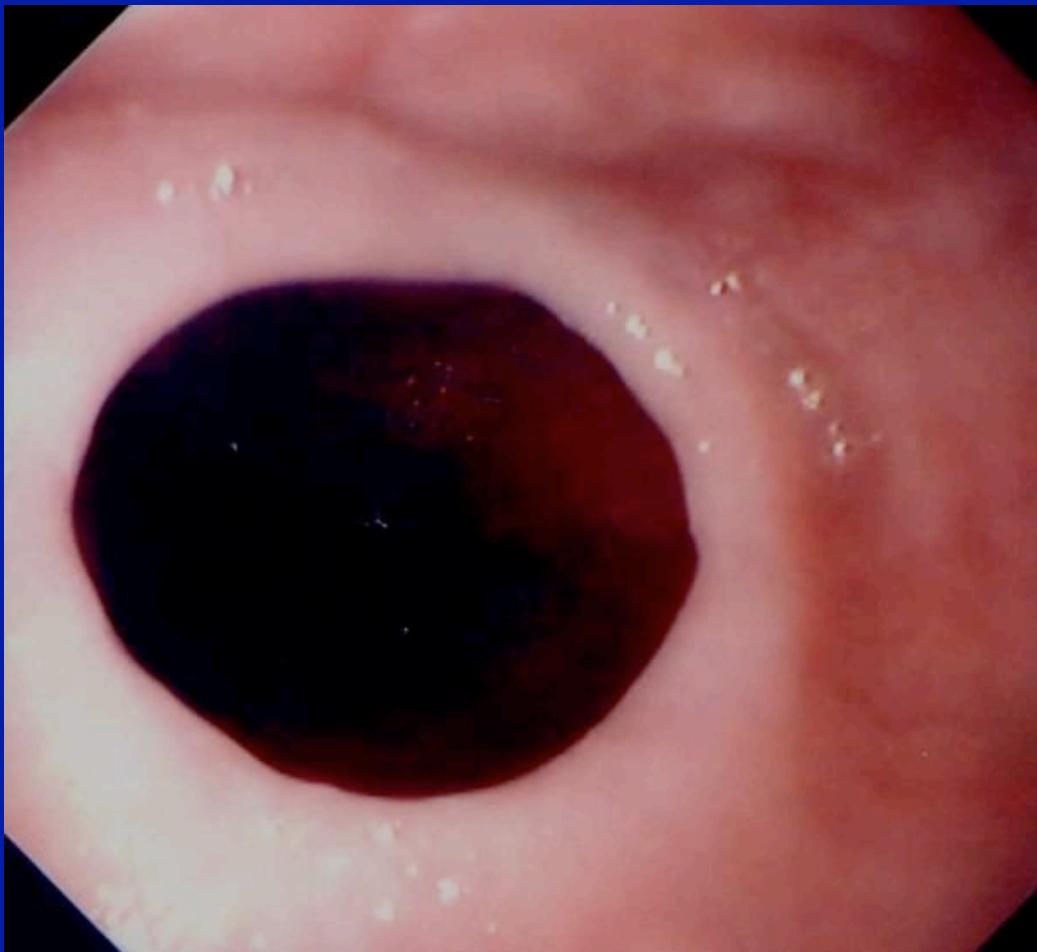
Anatomie
normale



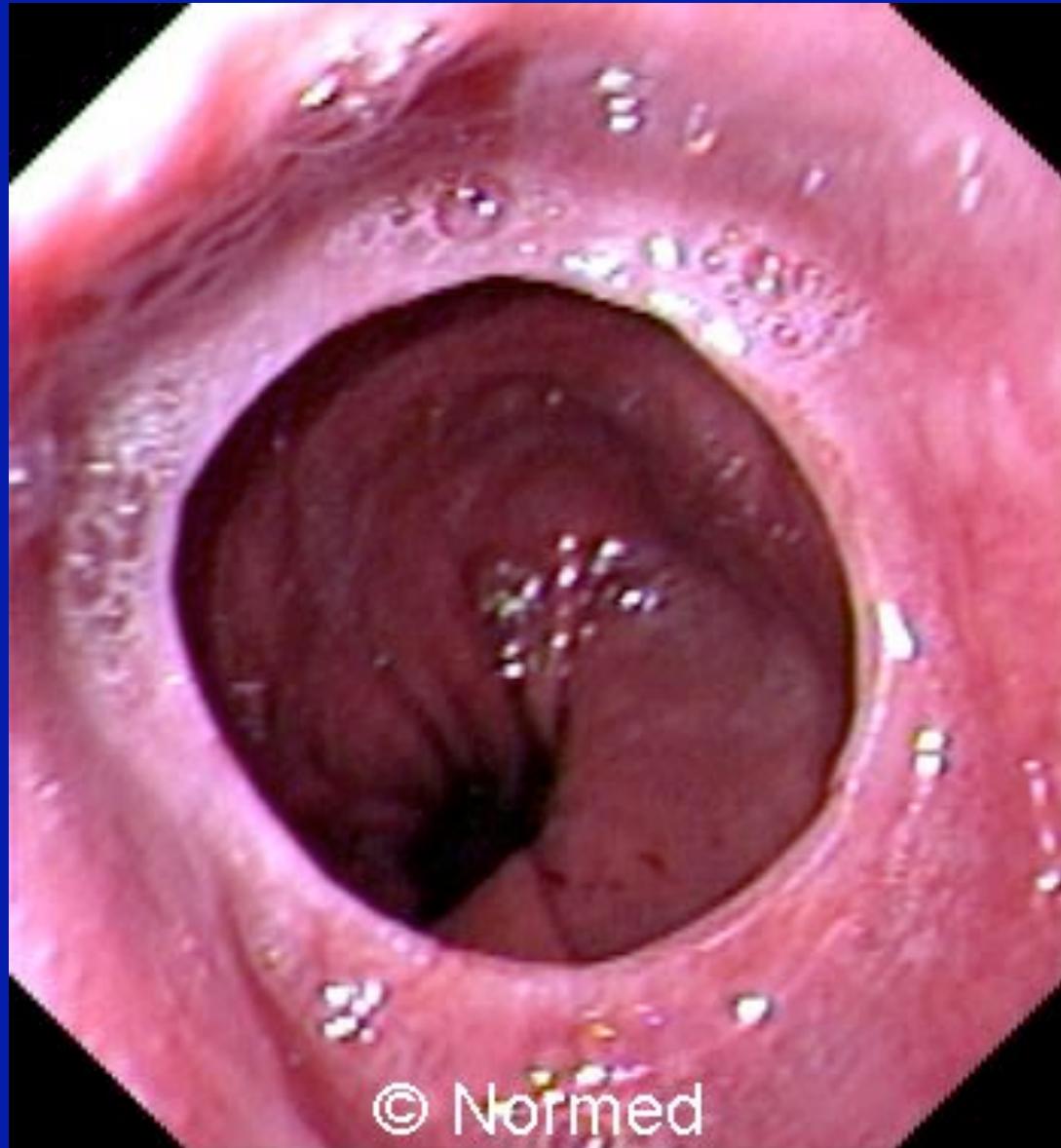
Anneau
de Schatzki

Anneau de SCHATZKI

0.2 à 14 % des TOGD



Anneau de Schatzki

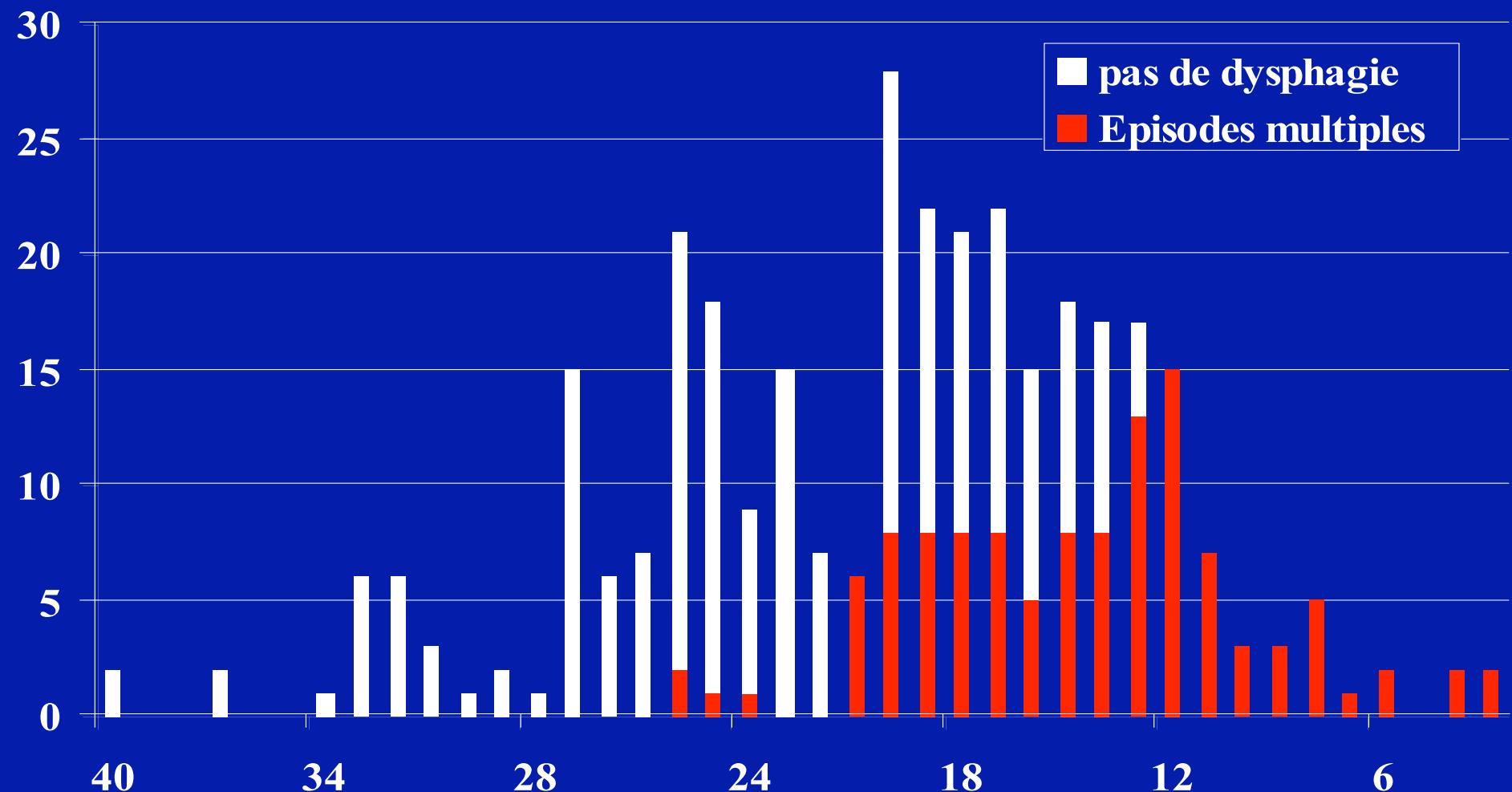


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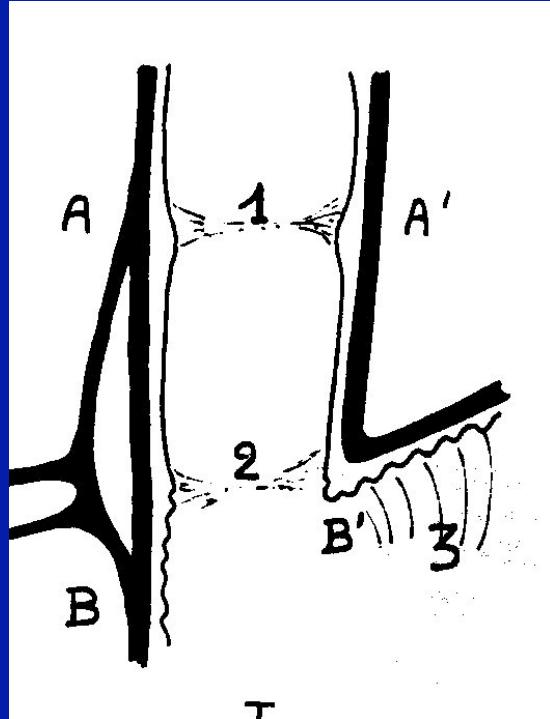
Anneaux de SCHATZKI

relation diamètre et dysphagie

Schatzki R 1963



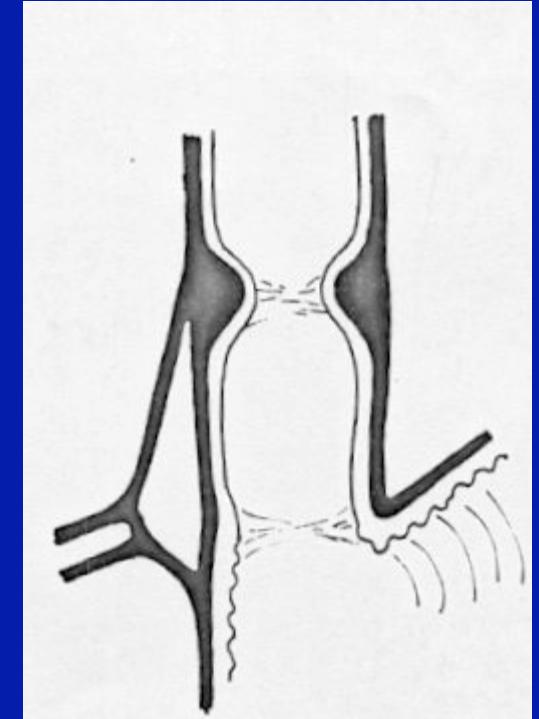
Anneaux du bas oesophage



Anatomie
normale



Anneau
de Schatzki

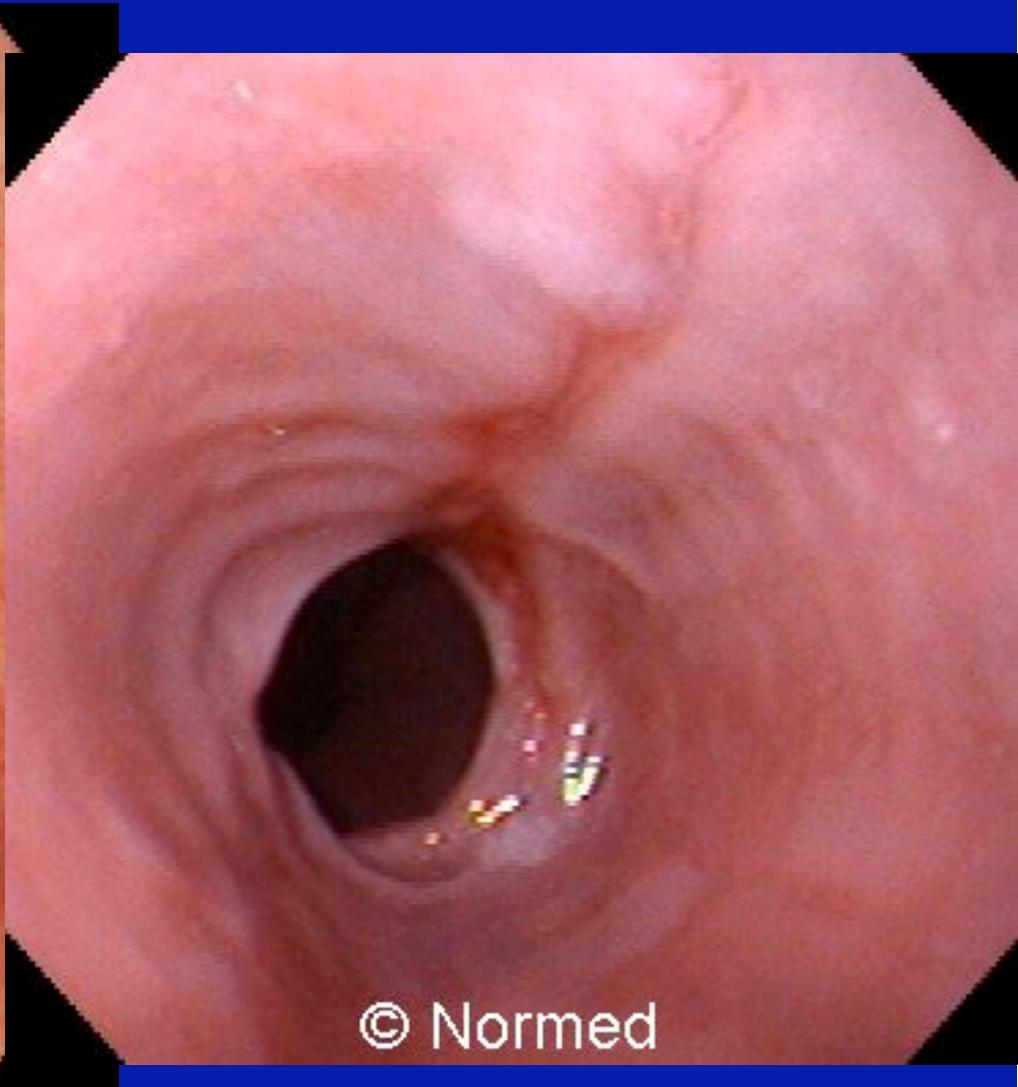


Anneau
musculaire

Sténose peptique annulaire



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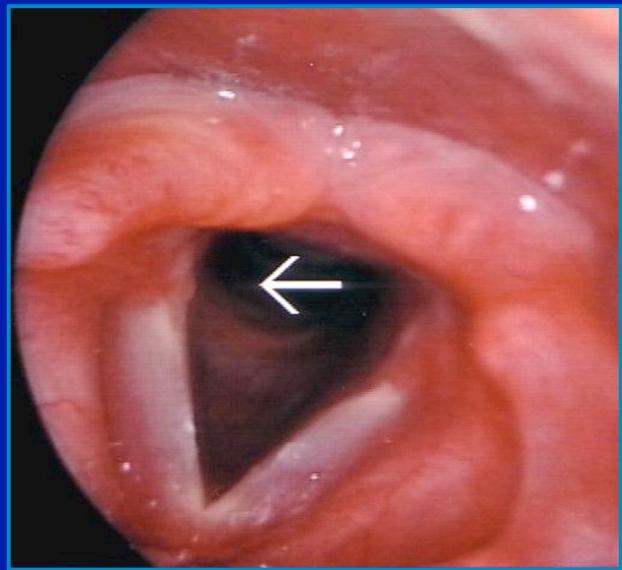


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- Larynx normal



RGO :
Lésion ORL associée



Laryngite inflammatoire
postérieure



Laryngite inflammatoire postérieure
Granulome postérieur

L'ENDO BRACHYOESOPHAGE

ŒSOPHAGE DE BARRETT

Endobrachyœsophage : définition ou œsophage de Barrett (1)

- **Remplacement de l'épithélium malpighien** (au-dessus de la jonction œso-gastrique) par un **épithélium métaplasique cylindrique de type glandulaire** :
 - fundique
 - cardia
 - spécialisé intestinal

Endobrachyœsophage (2) : évolution de la définition

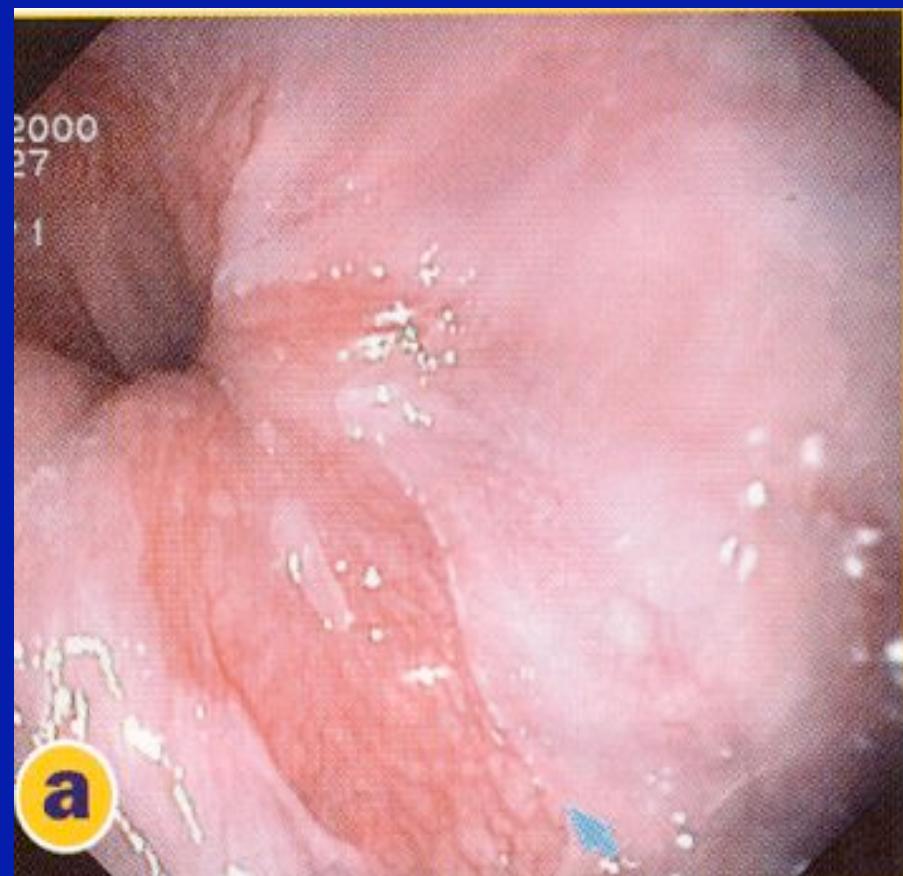
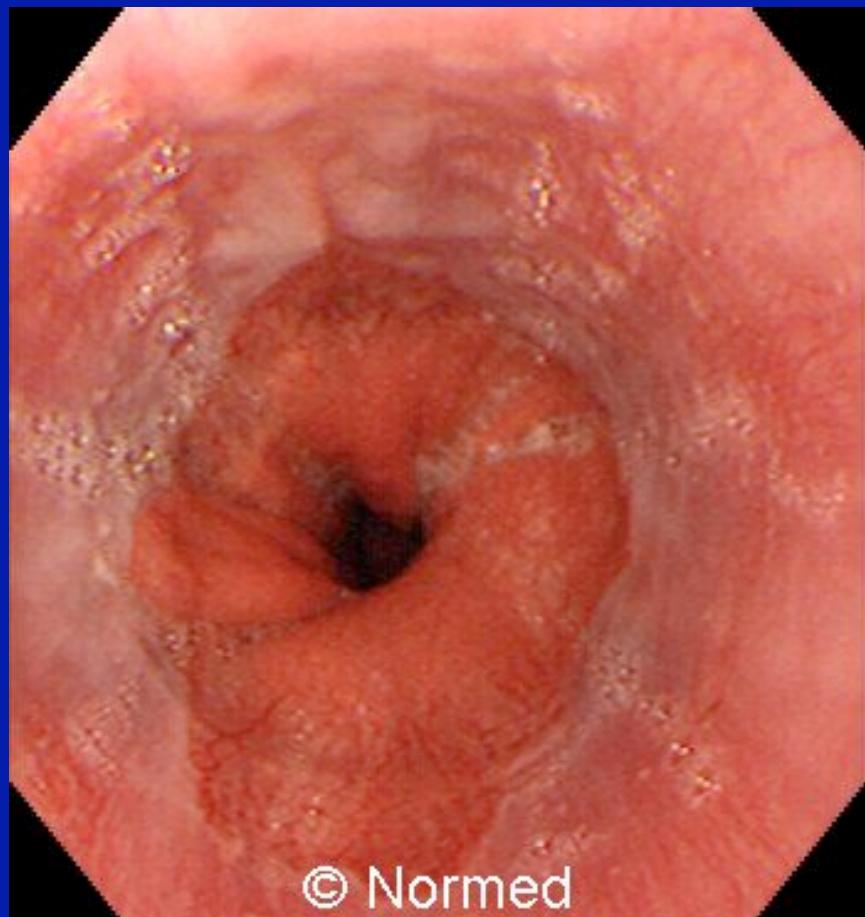
- Longueur circonférentielle ≥ 3 cm (définition classique) :
→ œsophage de Barrett long
- Notion d'œsophage de Barrett court (1994) :
longueur < 3 cm
- Biopsies +++ :
- La métaplasie intestinale très limitée de la jonction œso-gastrique (endobrachyœsophage ultra-court) est très fréquente (30 % des prélèvements) :
→ l'état pré-cancéreux n'est pas démontré

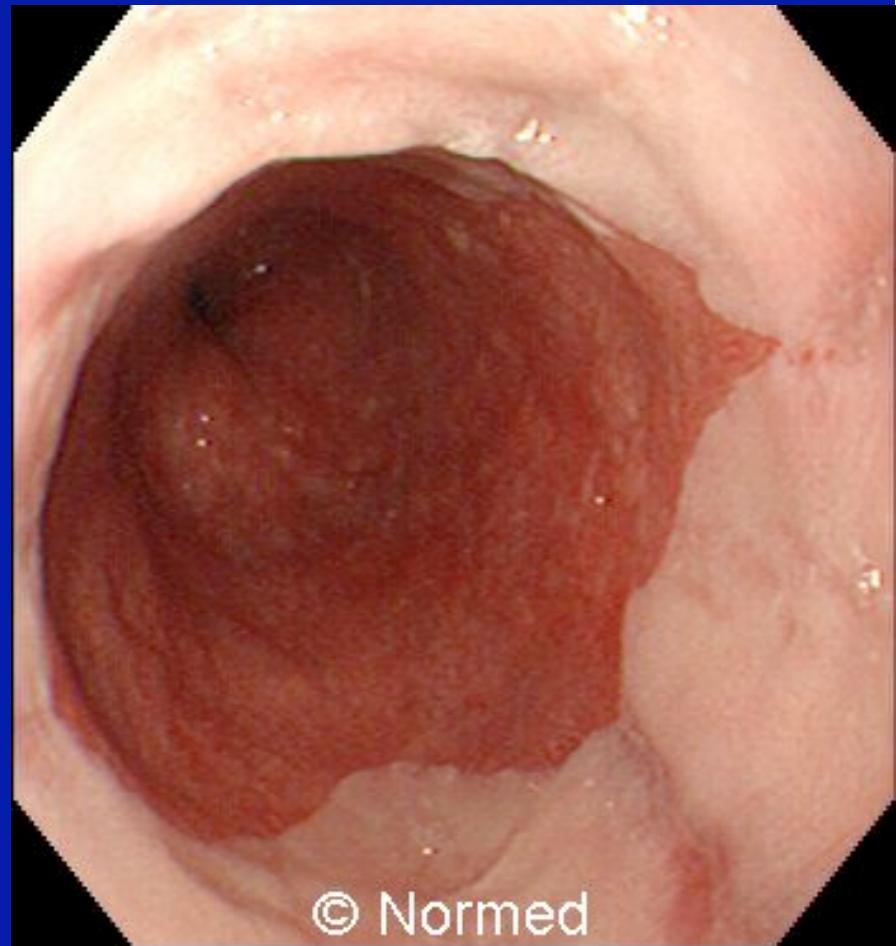
Prévalence de l'EBO

1% de la population générale

10% des malades avec symptômes de RGO

Endobrachyoesophage court





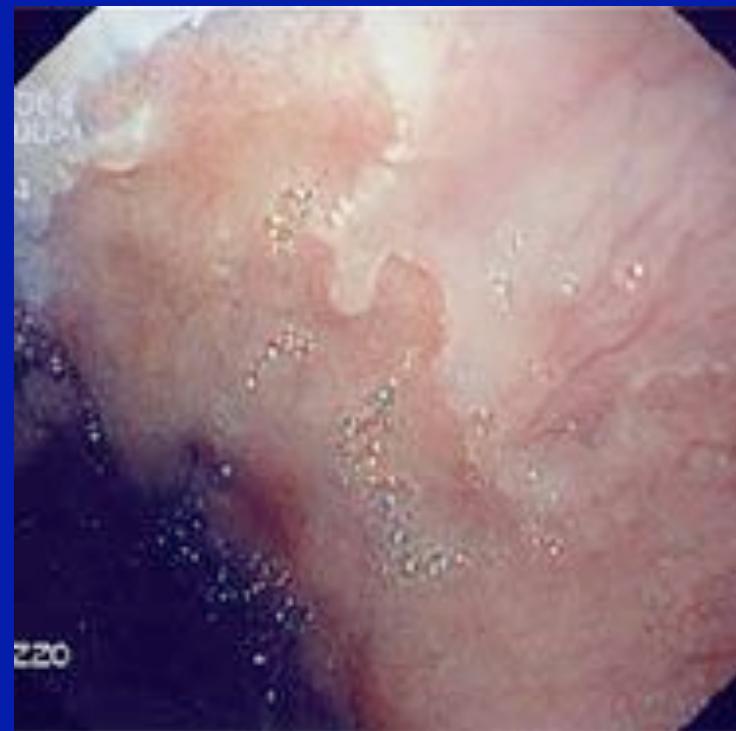
© Normed

EBO long (> 3 cm)

Endobrachyoesophage court

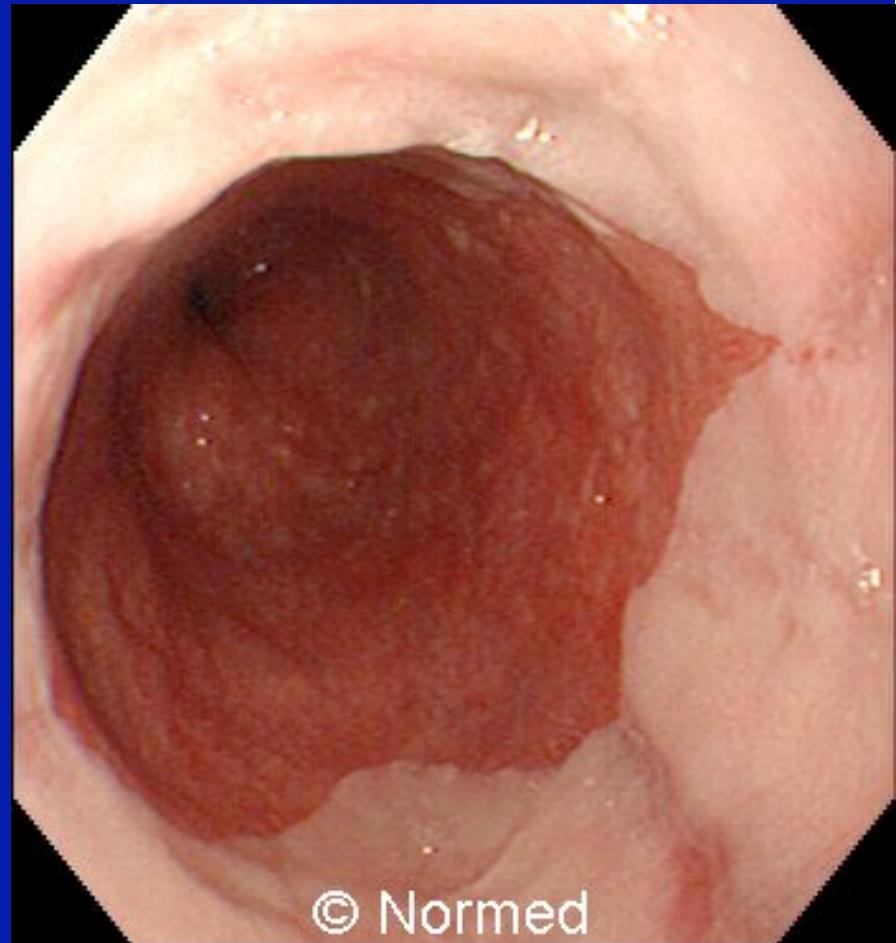


EBO court (< 3 cm)



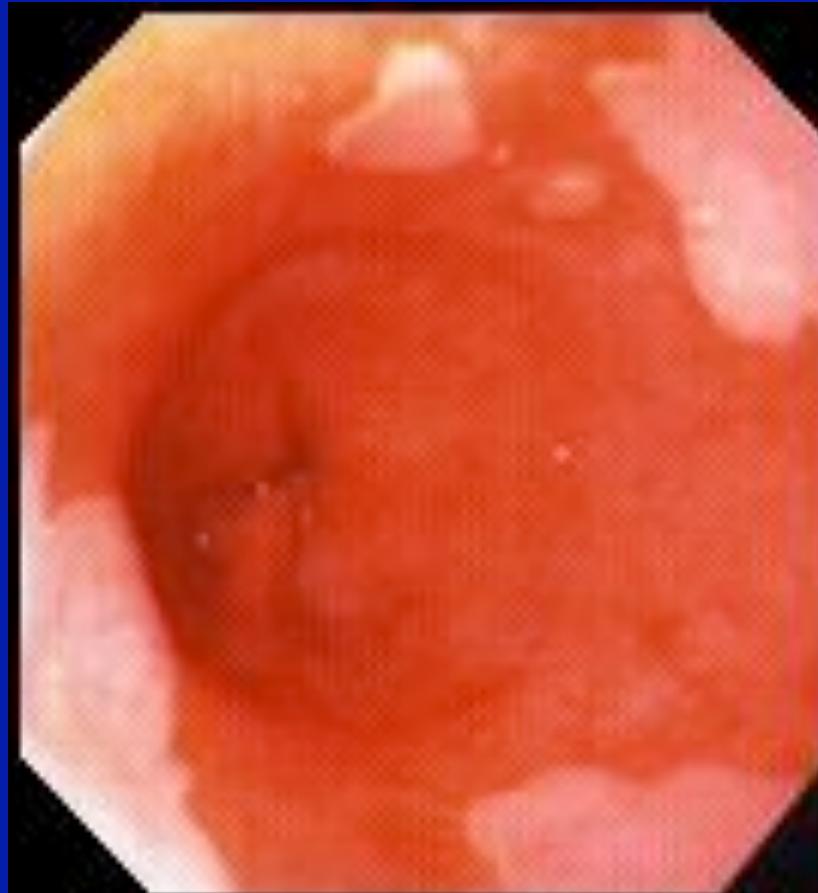
EBO ultra-court*

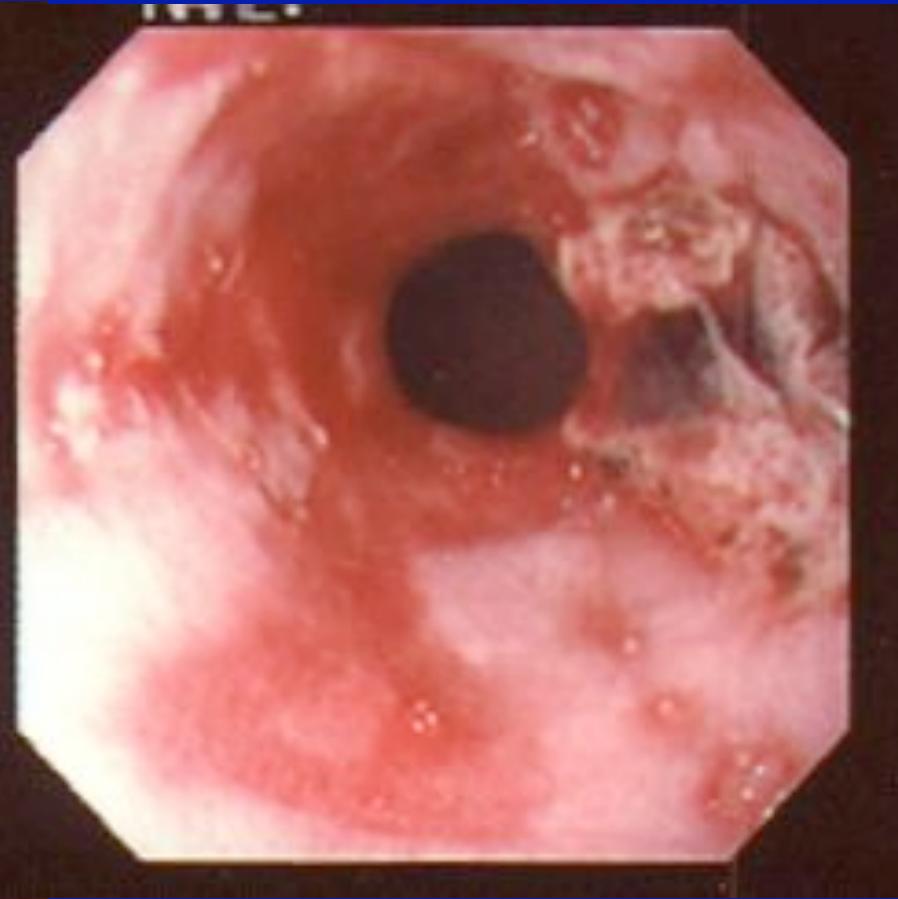
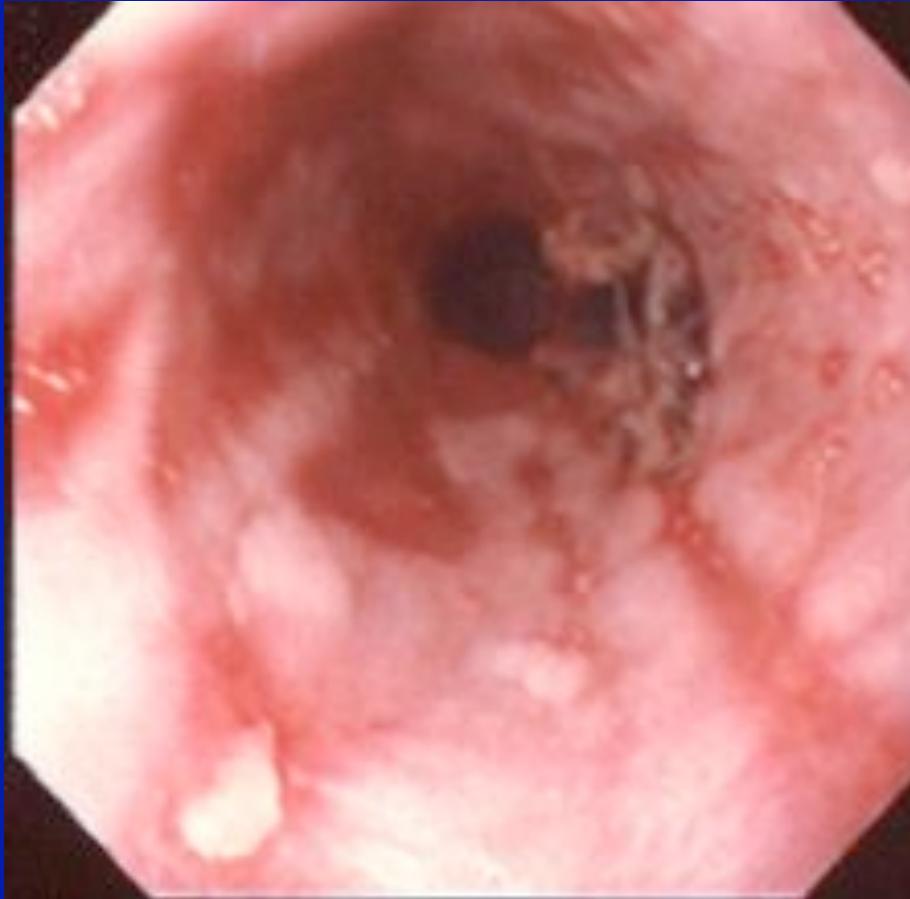
**La détection de l'endobrachyœsophage est
le plus souvent aisée en vidéo-endoscopie**



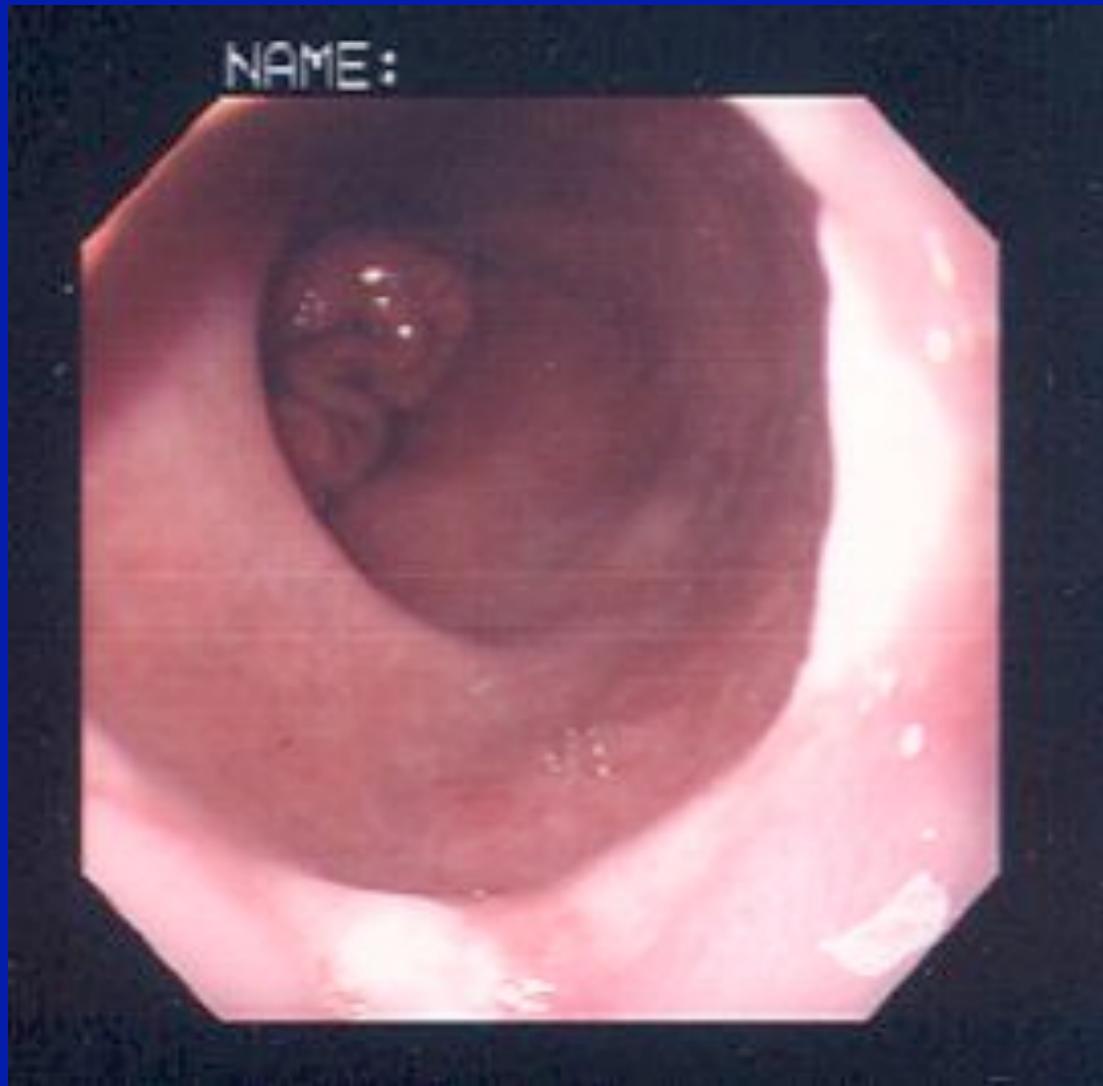
EBO long (> 3 cm)

Œsophage de Barrett long



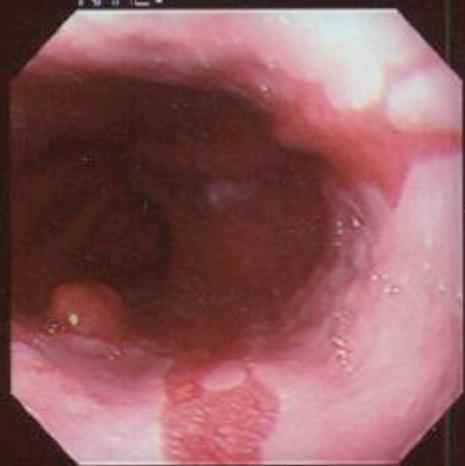


EVALUER LA HAUTEUR DE L'EBO



ID. NO:
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D.O.BIRTH:
26/05/00
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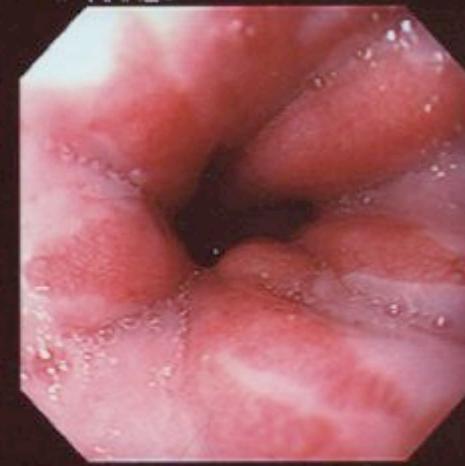
NAME:



COMMENT:

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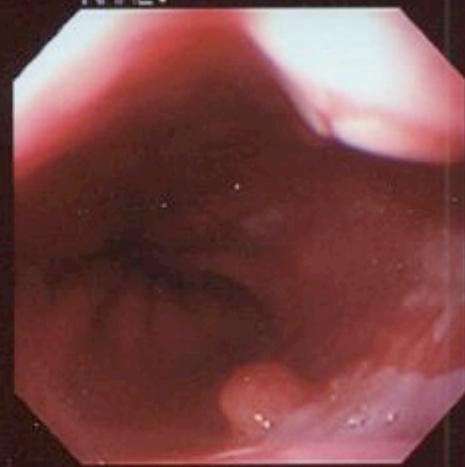
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COMMENT:

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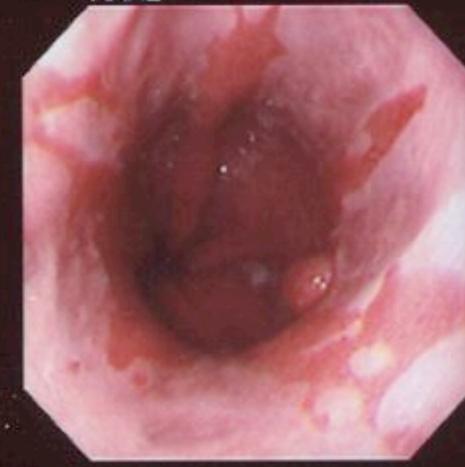
NAME:



COMMENT:

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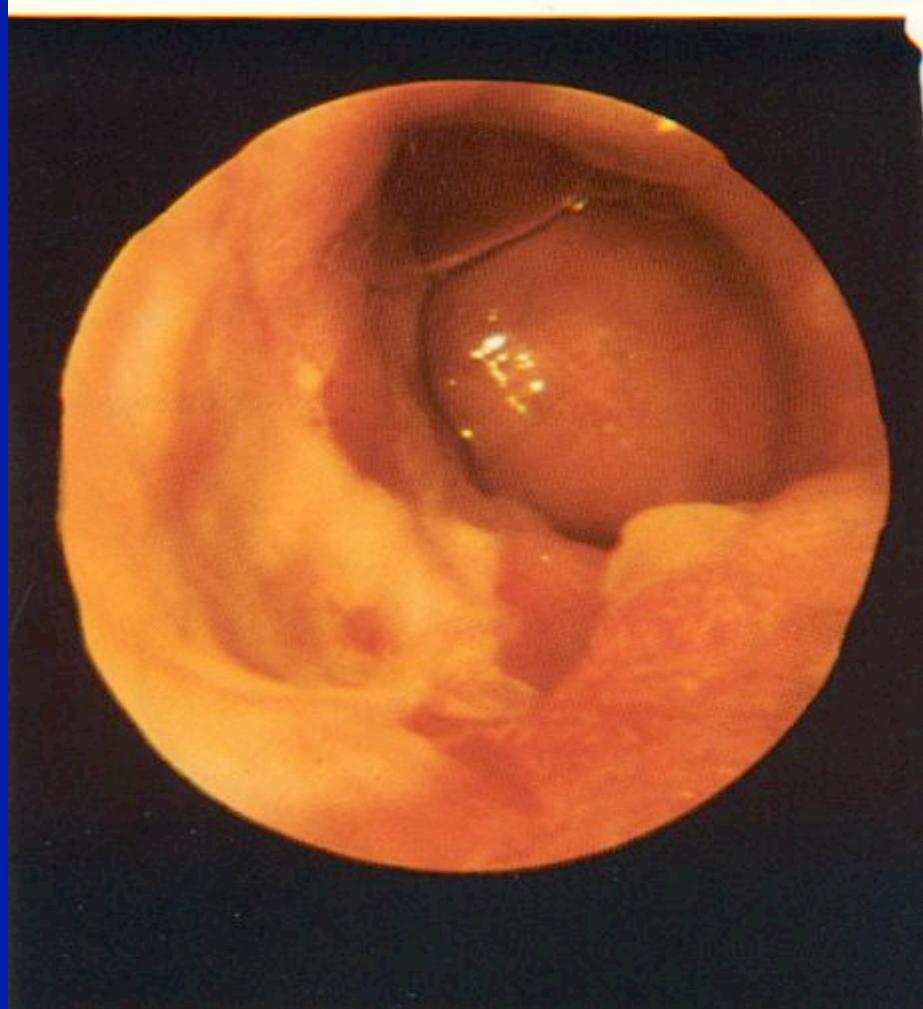
NAME:



COMMENT:

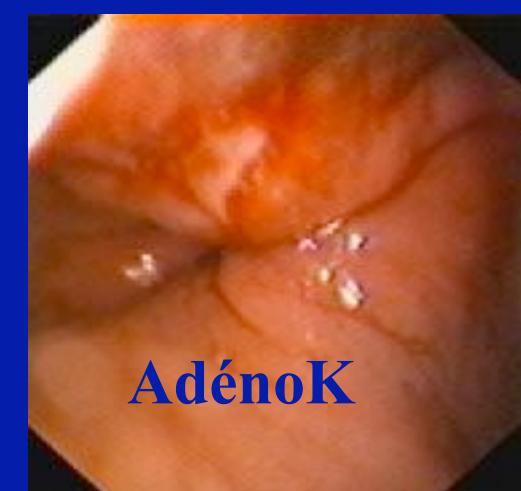
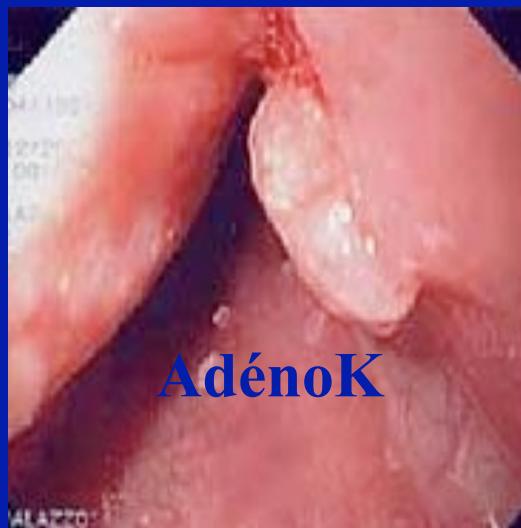


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Ulcère de Barrett

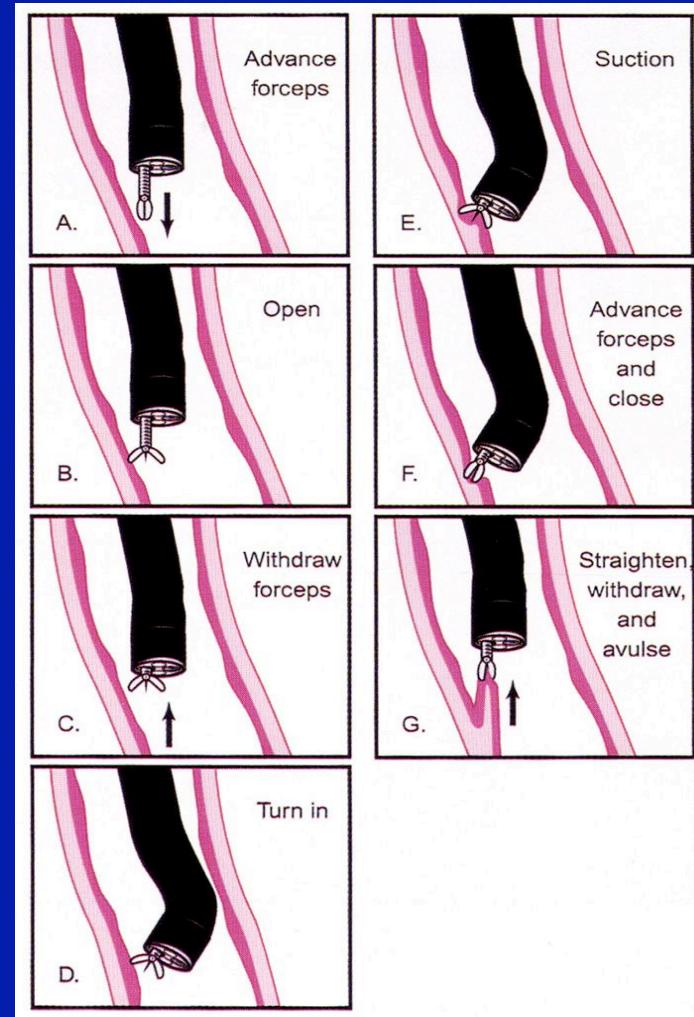
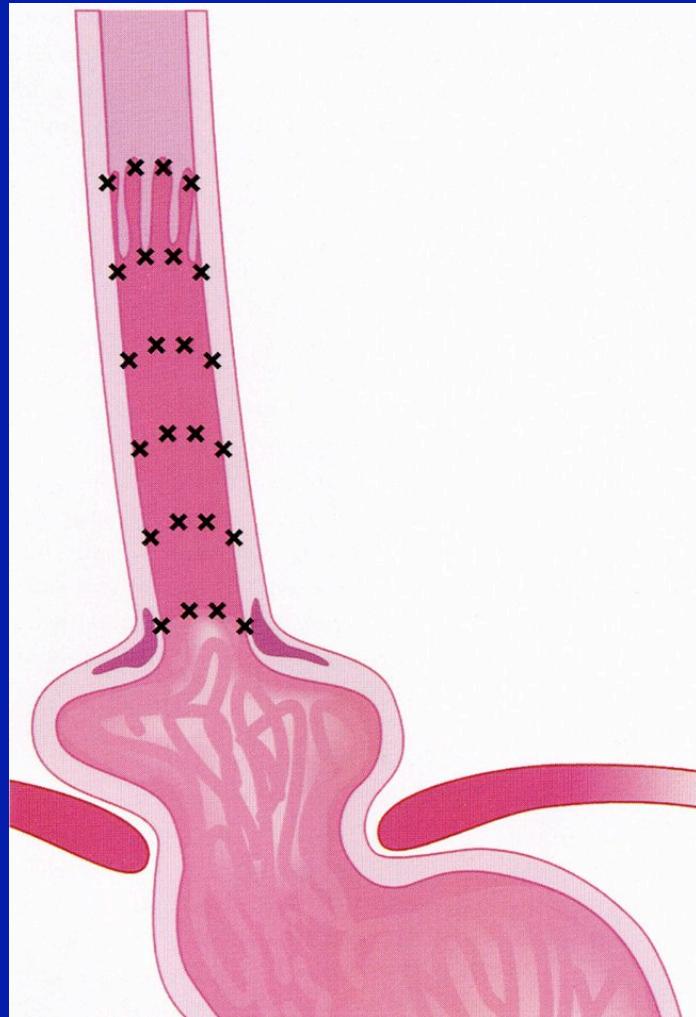
EBO : évolution vers dysplasie et adéno K



l'œsophage de Barrett Protocole de Seattle

- Repérage anatomique
- Biopsies : toutes les irrégularités de la muqueuse, nodules, érosions, dyschromie, ...
- Biopsies systématiques tous les 1 cm en cas de DHG ou tous les 2 cm
- Biopsies des 4 quadrants
- Pince jumbo (?)
- *Levine. Gastroenterology 1993* : 28 patients avec DHG → diagnostic pré-opératoire d'œsophagectomie de 100%

Barrett : la cartographie endoscopique



Endobrachyœsophage (4)

Coloration au bleu de méthylène (1)

- bleu intense homogène = métaplasie intestinale
- bleu peu intense hétérogène : dysplasie

- Serait utile pour le diagnostic d'EBO court ?
- Serait utile pour cibler les biopsies étagées dans l'EBO long ?

Endobrachyœsophage (4)

Coloration au bleu de méthylène (1)

- Technique rigoureuse absolument indispensable :
 - laver avec 10 ml de Mucomyst® ou Mucofluid® à 10 % puis attendre 1 min
 - colorer avec 20 ml (pour l'EBO long) de BM à 0,5 % puis attendre 2 min (aspirer le BM en excès dans l'estomac)
 - rincer abondamment (200 ml d'eau) puis aspirer

Endobrachyœsophage (5)

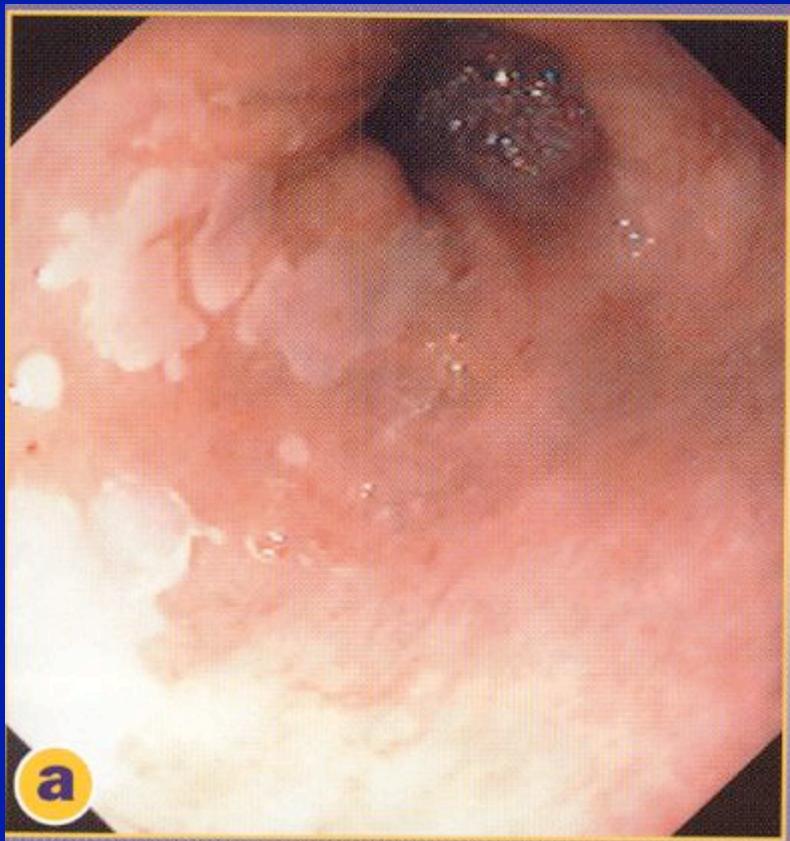
Coloration au bleu de méthylène (2)

- Problème des faux positifs :
 - lavage et rinçage insuffisants
 - érosions
- Problème des faux négatifs :
 - DHG ou carcinome peuvent être bleu négatif
- Technique probablement trop compliquée,



EBO

Bleu de méthylène à 0,5 %

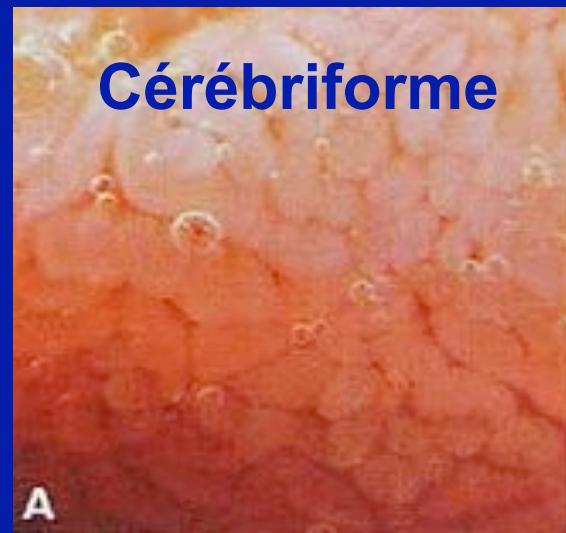
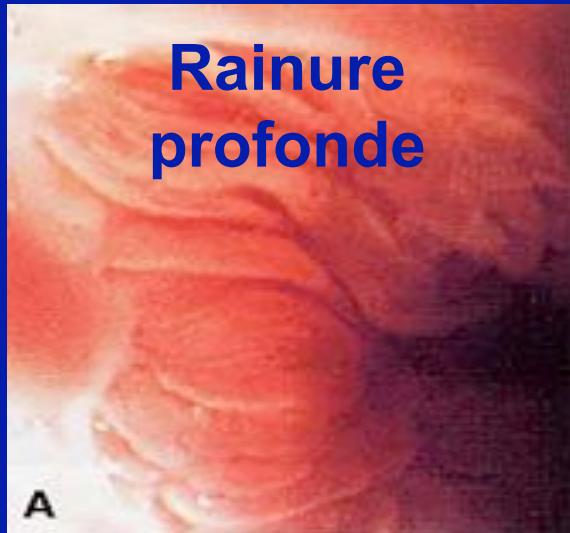


Endobrachyœsophage (6)

Magnification (zoom optique) à l'acide acétique (1,5 %)

- Augmente le grossissement de 1,5 à 150 fois
- Classification en Pit-Pattern, après application d'acide acétique (grossissement de 80 fois)
- Améliore la détection de la métaplasie intestinale
- Pourrait améliorer la détection de la dysplasie

Endobrachyœsophage : Magnification (zoom)



Comment détecter une dysplasie sur EBO en endoscopie

Biopsies multiples aveugles

Biospsies orientées par :

- Chromoendoscopie
- Chromoendoscopie + Endoscope grossissant
- Narrow band Imaging (NBI)
- Fluorescence
- Microscopie endoscopique confocale

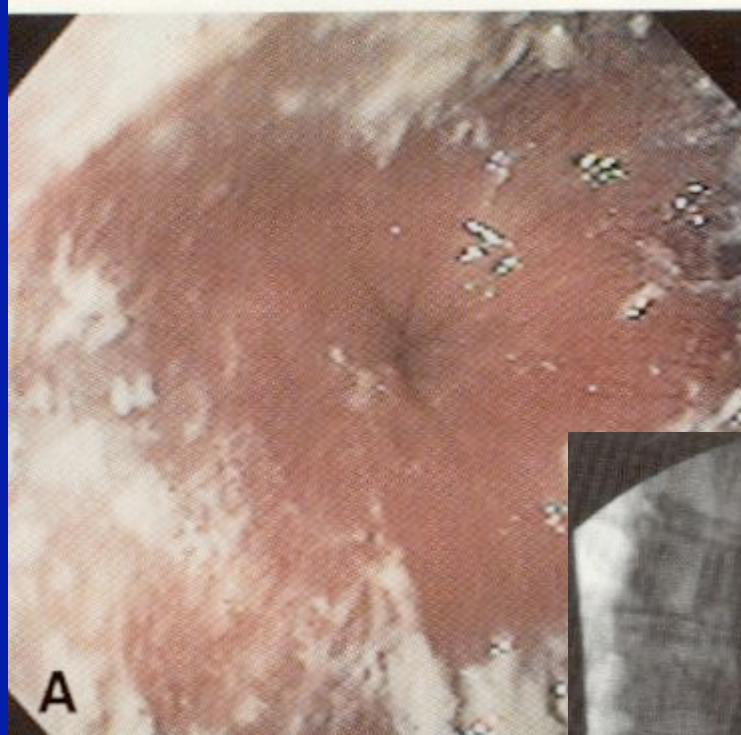
Valve antireflux normale

Aspect endoscopique

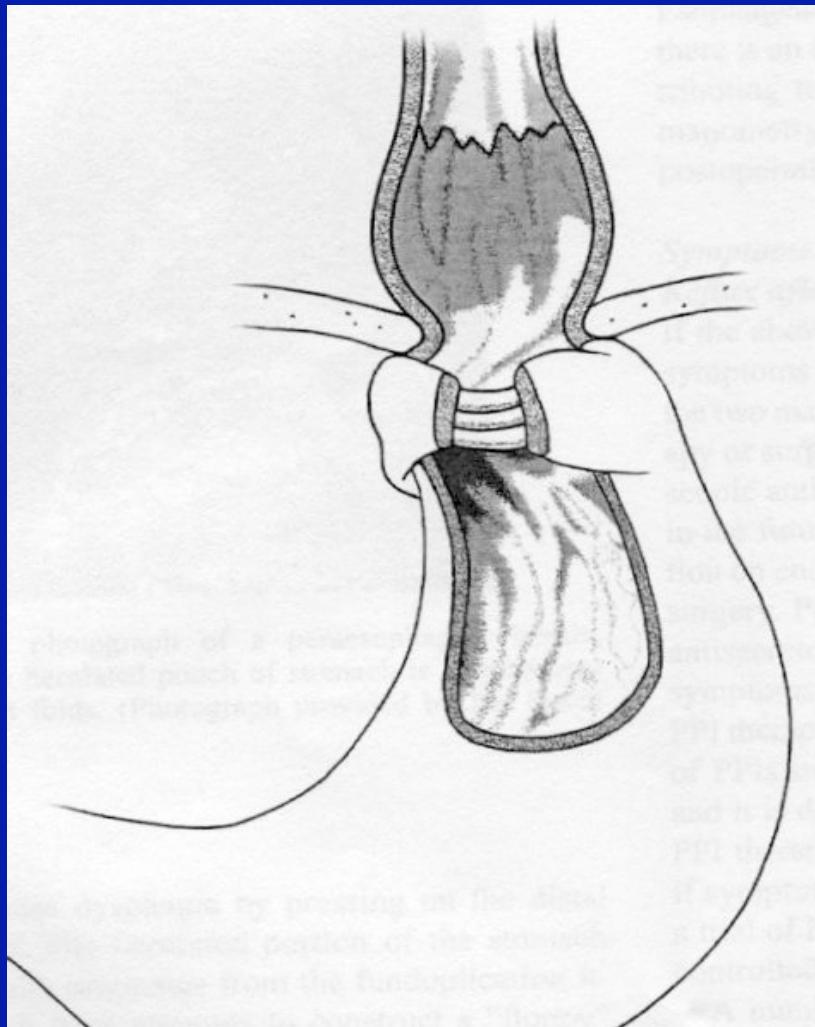


Dysphagie prolongée post-fundoplication

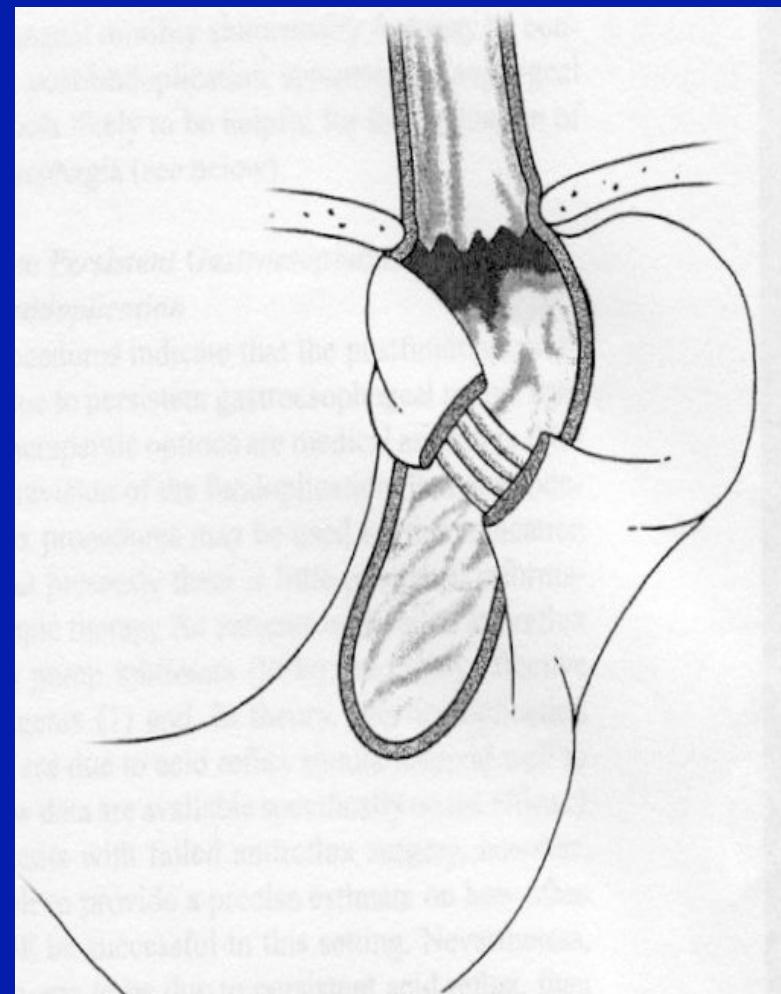
Valve trop serrée-trop longue



Ascencion intrathoracique



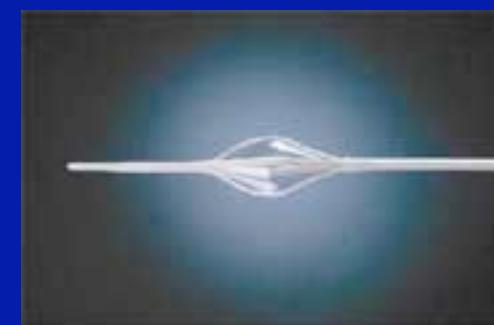
Glissement de la valve



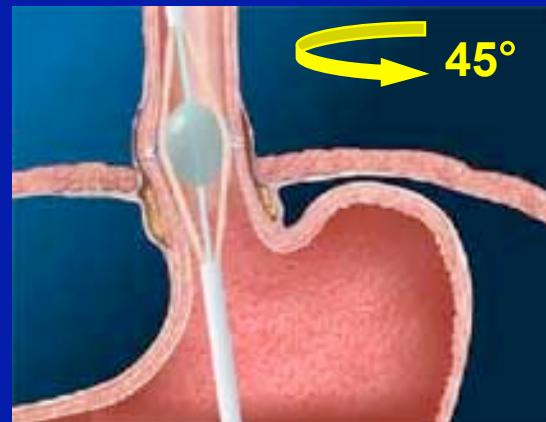
TRAITEMENT ENDOSCOPIQUE DU RGO

Hyperthermie : matériel

Sonde Stretta® : une extrémité de type bougie flexible (20 French),
65 cm de longueur ; 1 ballon (maximum 3 cm) + 1 panier
+ 4 électrodes radiales (5,5 mm) autour du ballon



Hyperthermie : technique (2)



1 cm au-dessus de la ligne Z

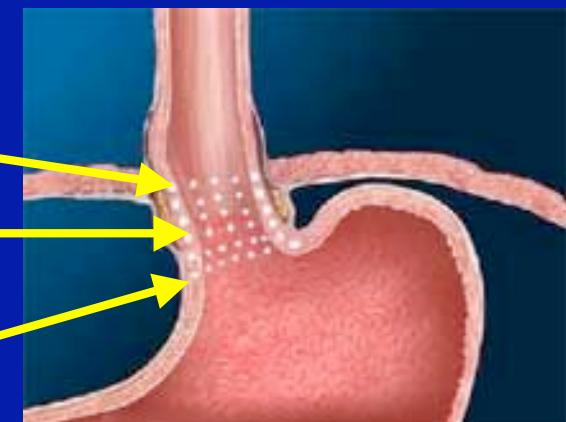


4 niveaux antérogrades

1 cm au-dessus ligne Z

0,5 cm sous ligne Z

2 sites au niveau cardia
(en traction)



Hyperthermie : technique (3)

Cardia pré- and post-Stretta



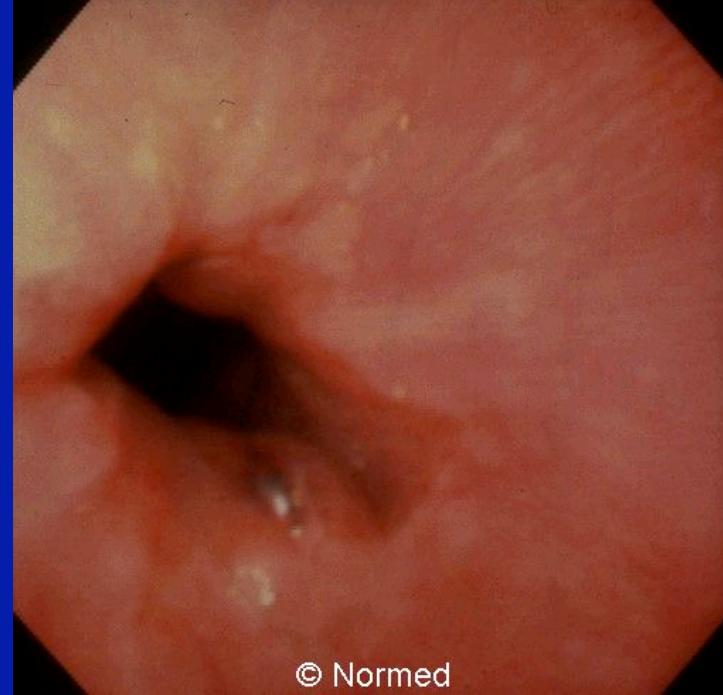
Oesophagus distal post-Stretta



LESIONS OESOCARDIALES NON LIEES AU RGO



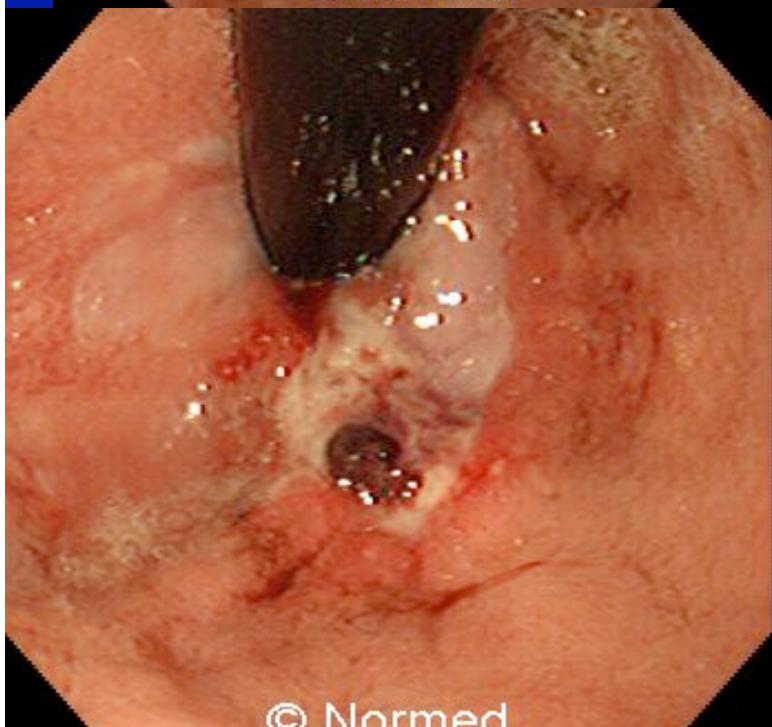
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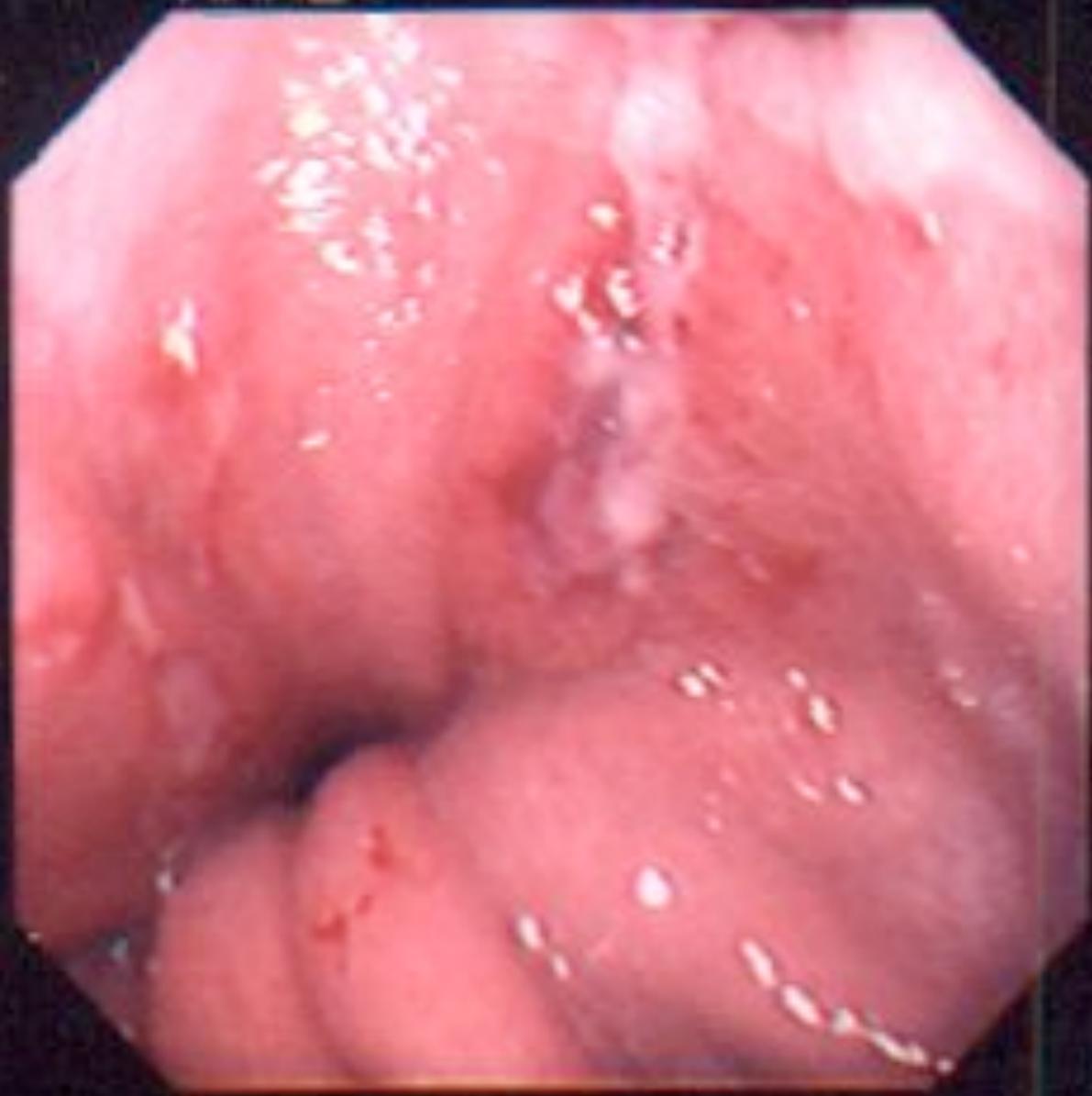
Mallory Weiss

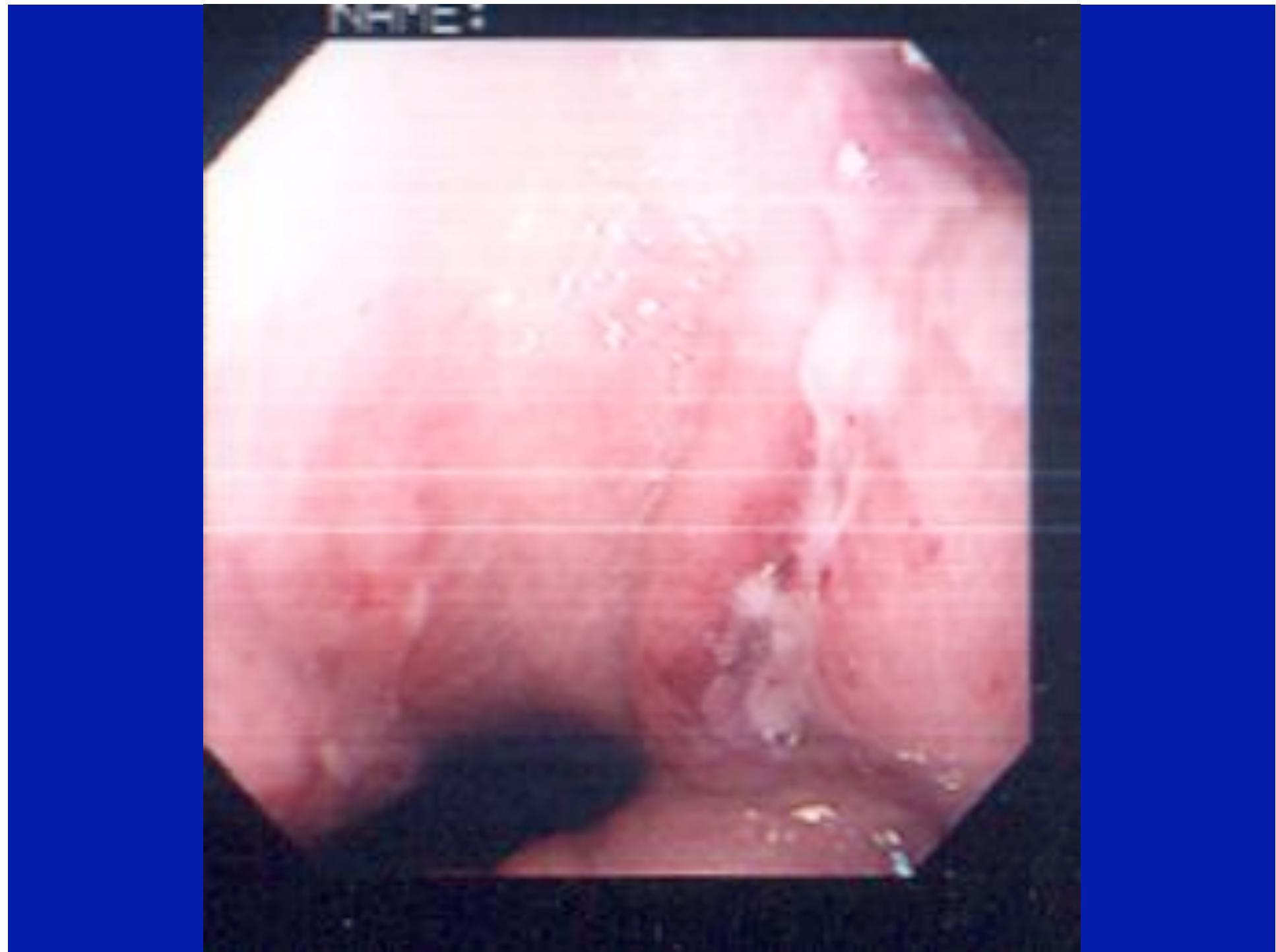
Fissuration longitudinale 5 à 20mm
de long
à cheval sur la jonction muqueuse

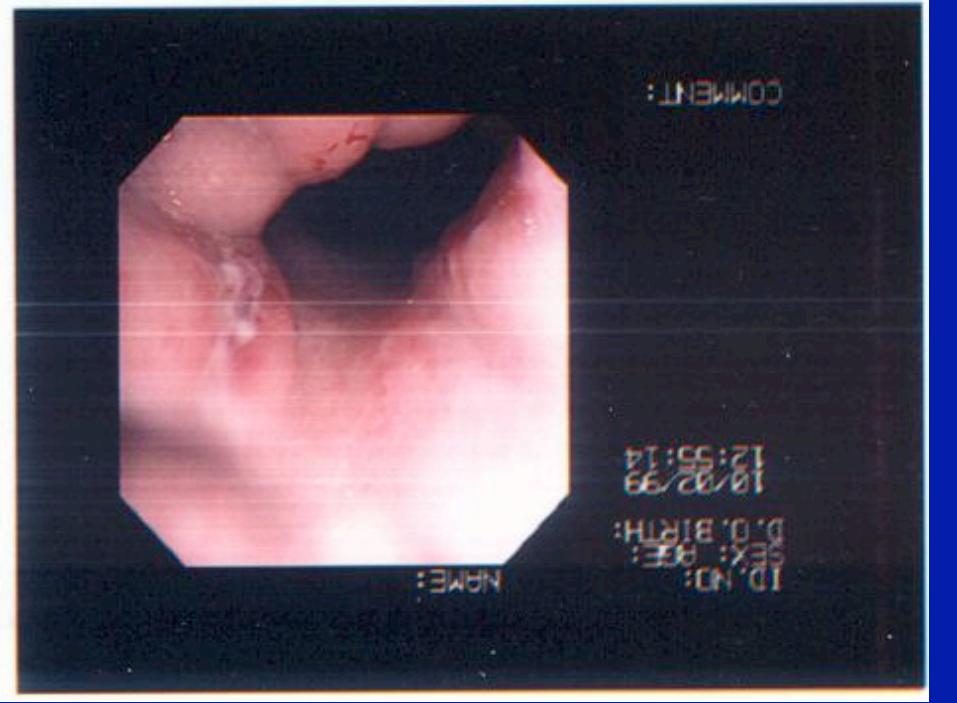
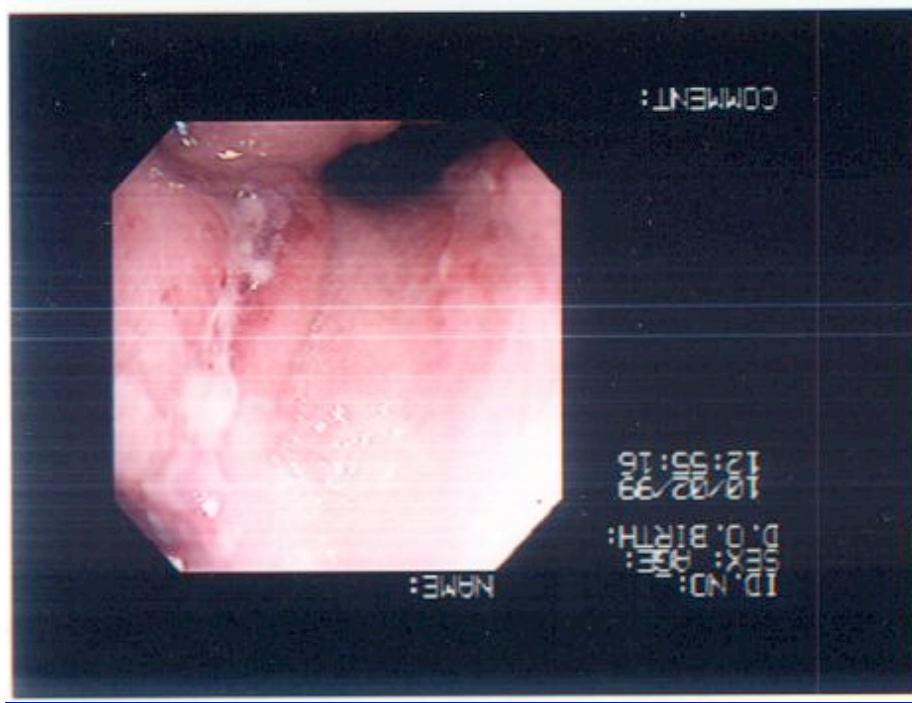
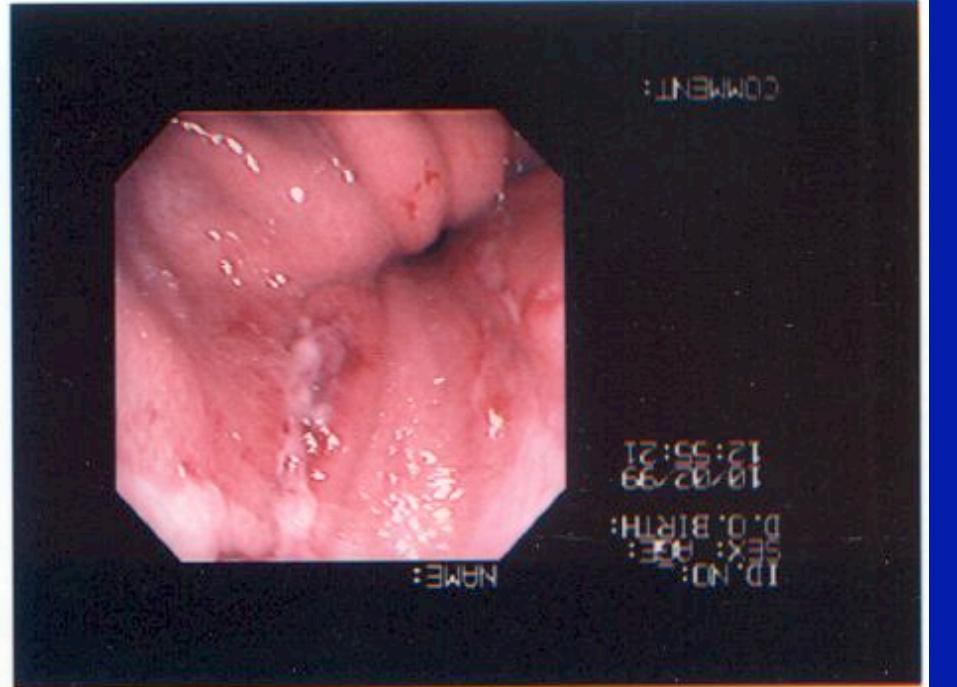
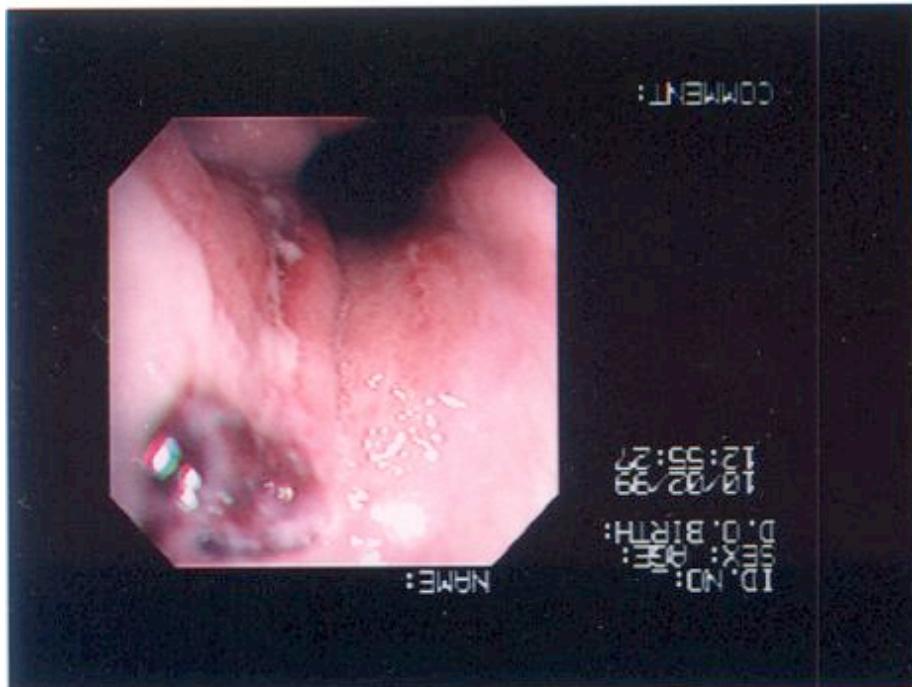


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PROLAPSUS GASTRO-OESOPHAGIEN

