

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



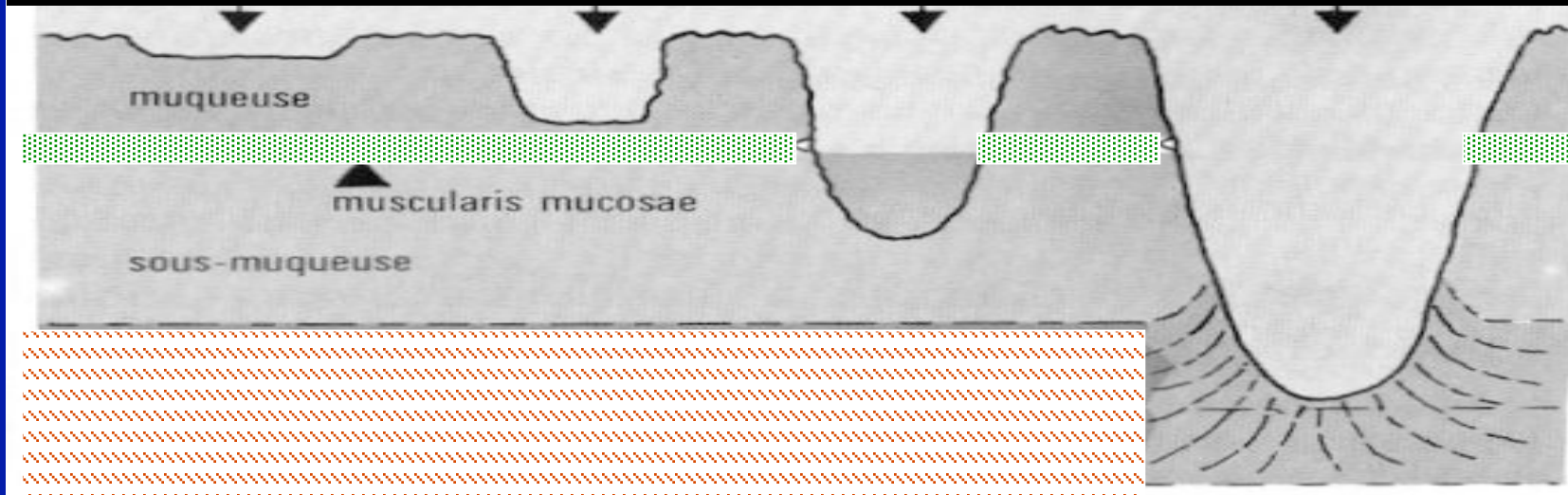
EROSION

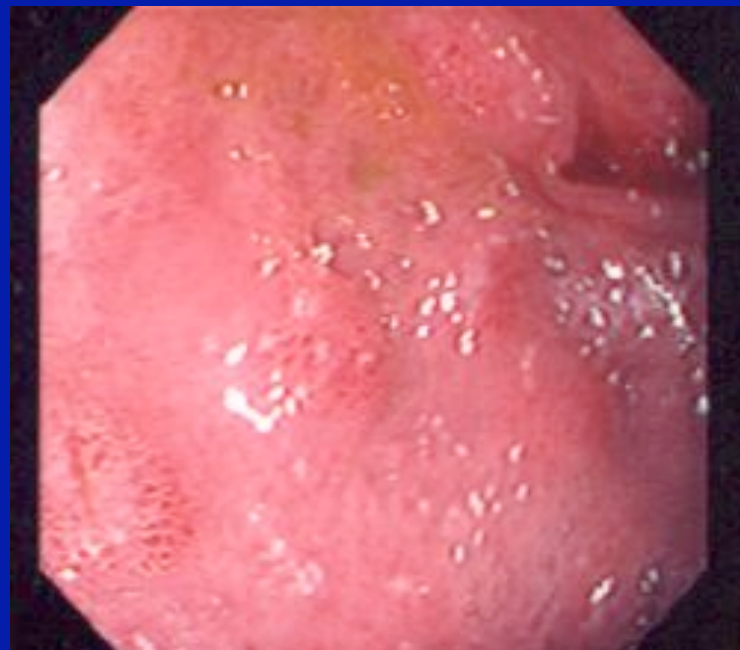


ULCERATION

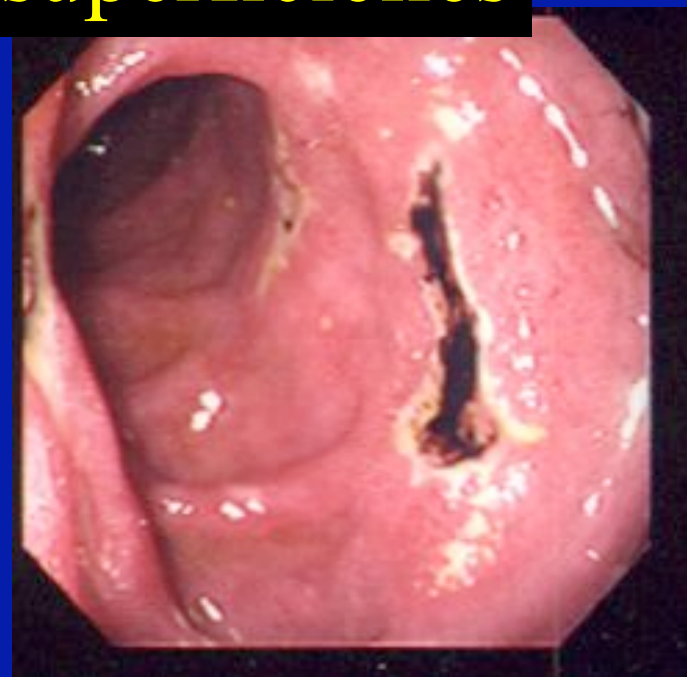
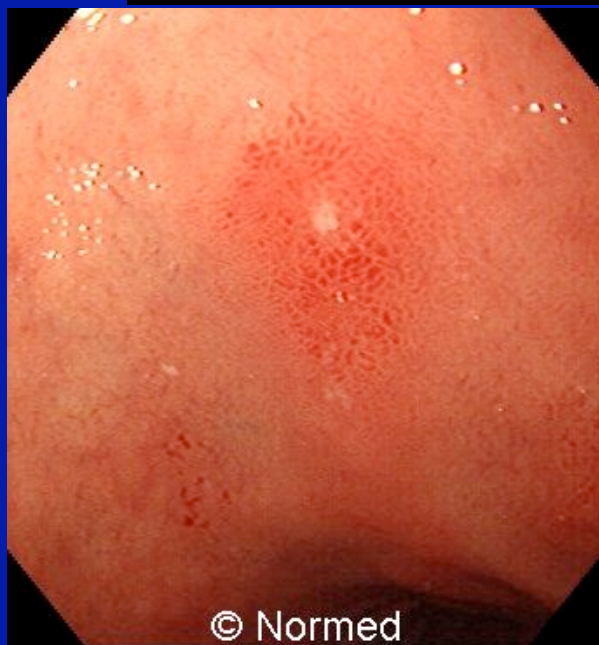


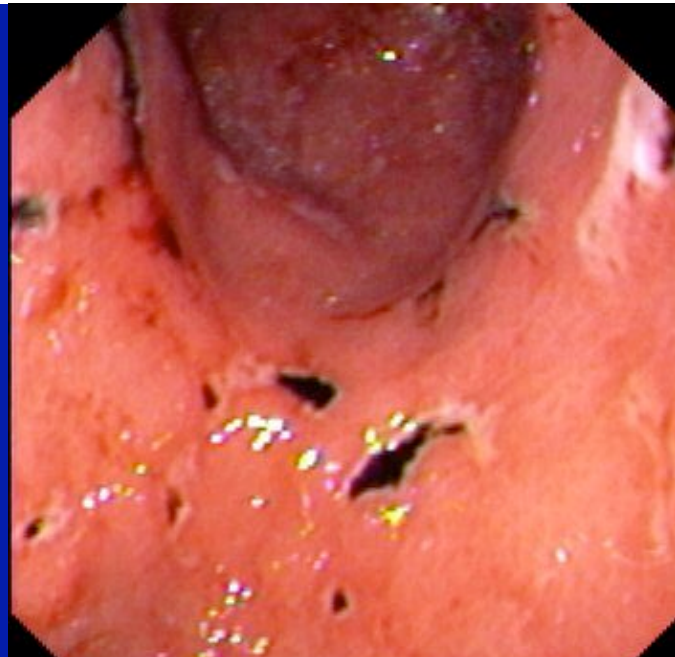
ULCERE





Pertes de substances superficielles





Pertes de substances superficielles



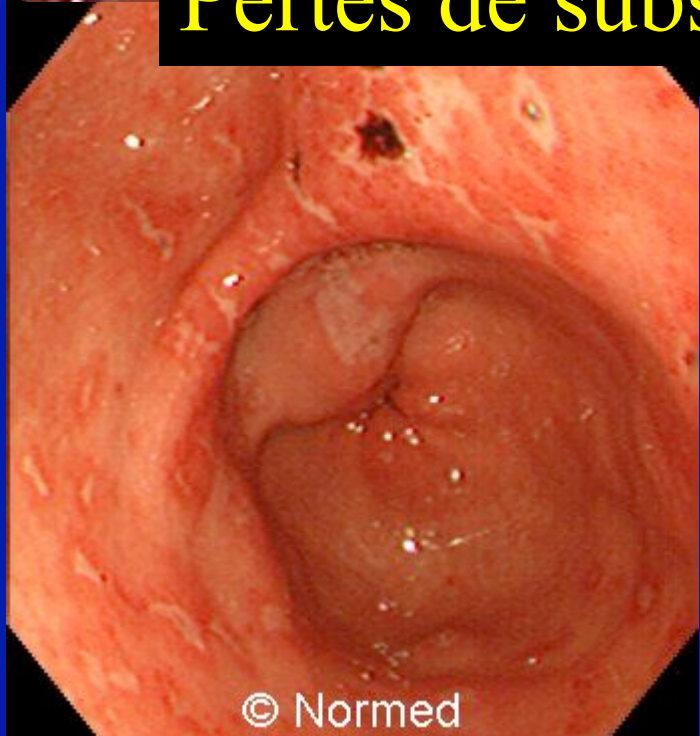
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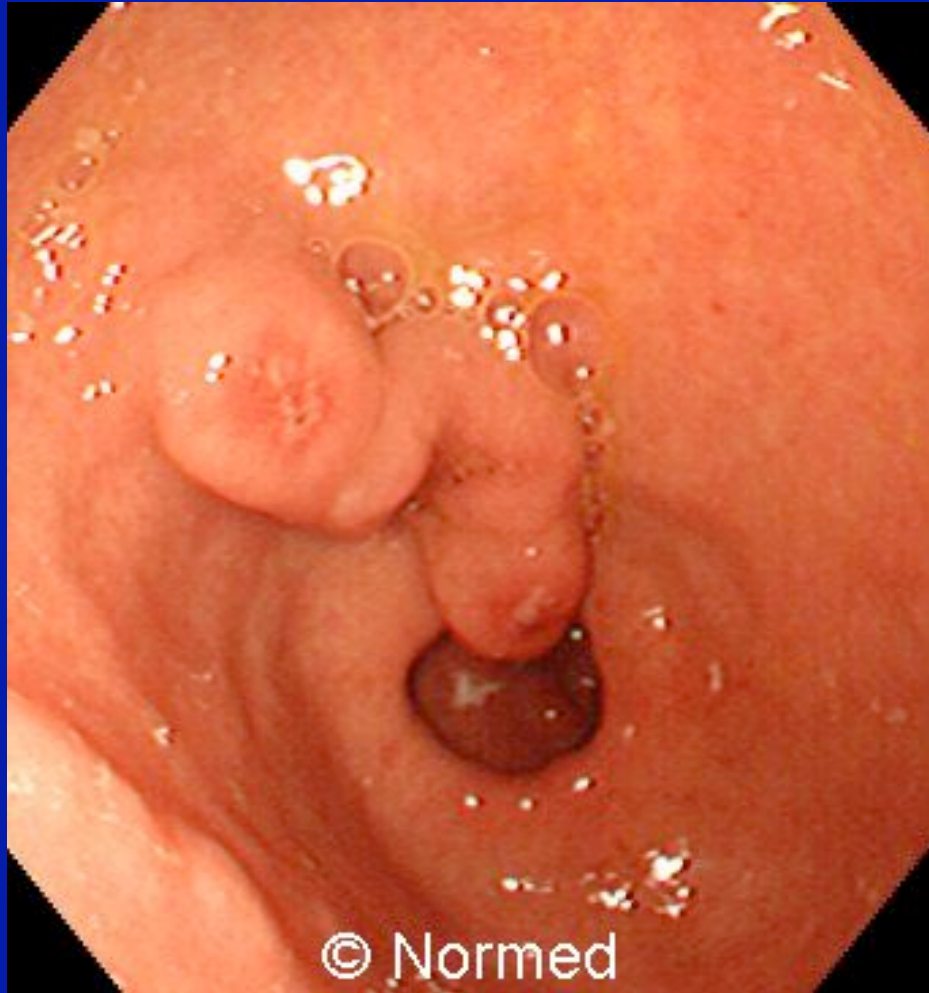
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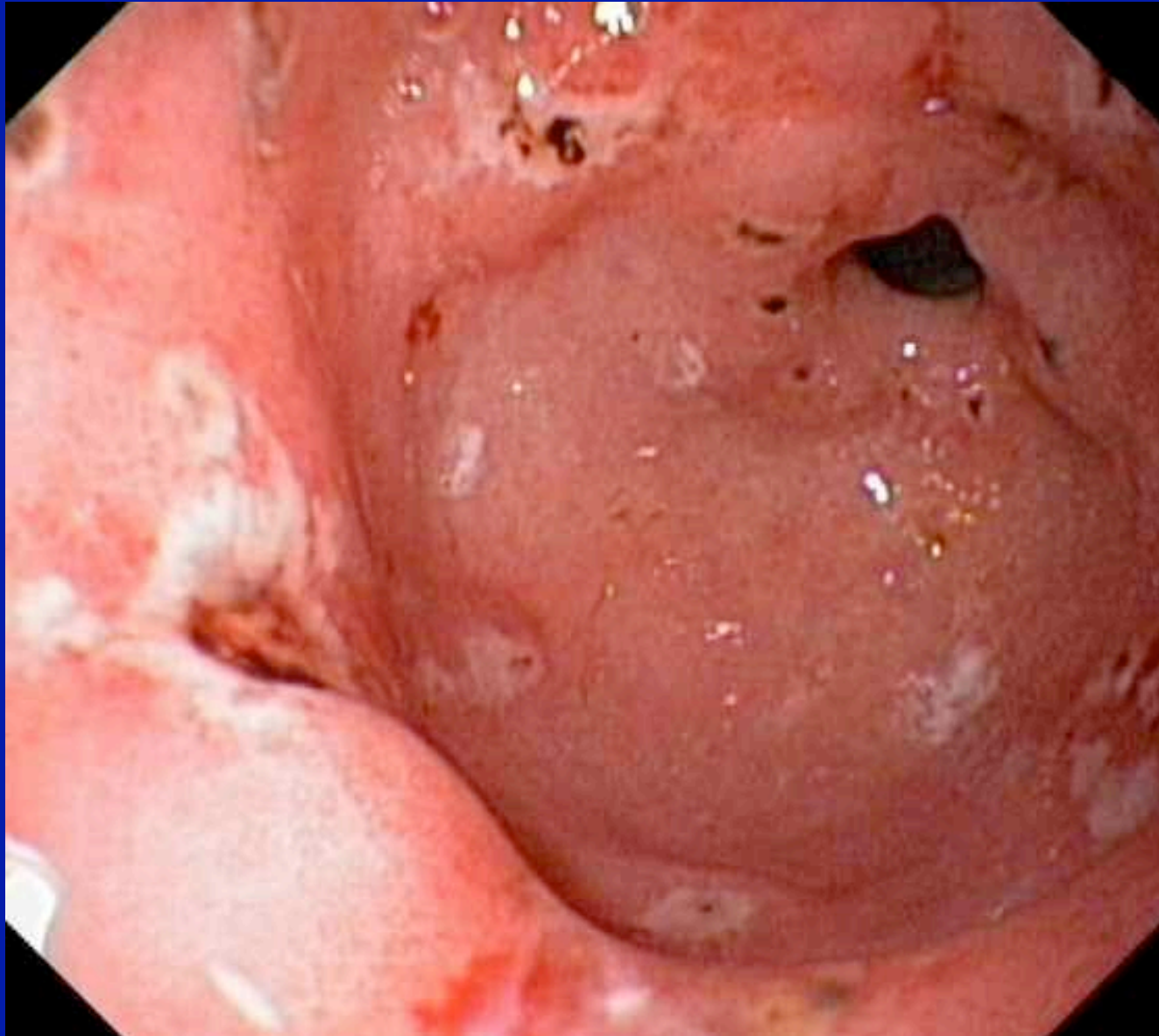
Pertes de substances superficielles

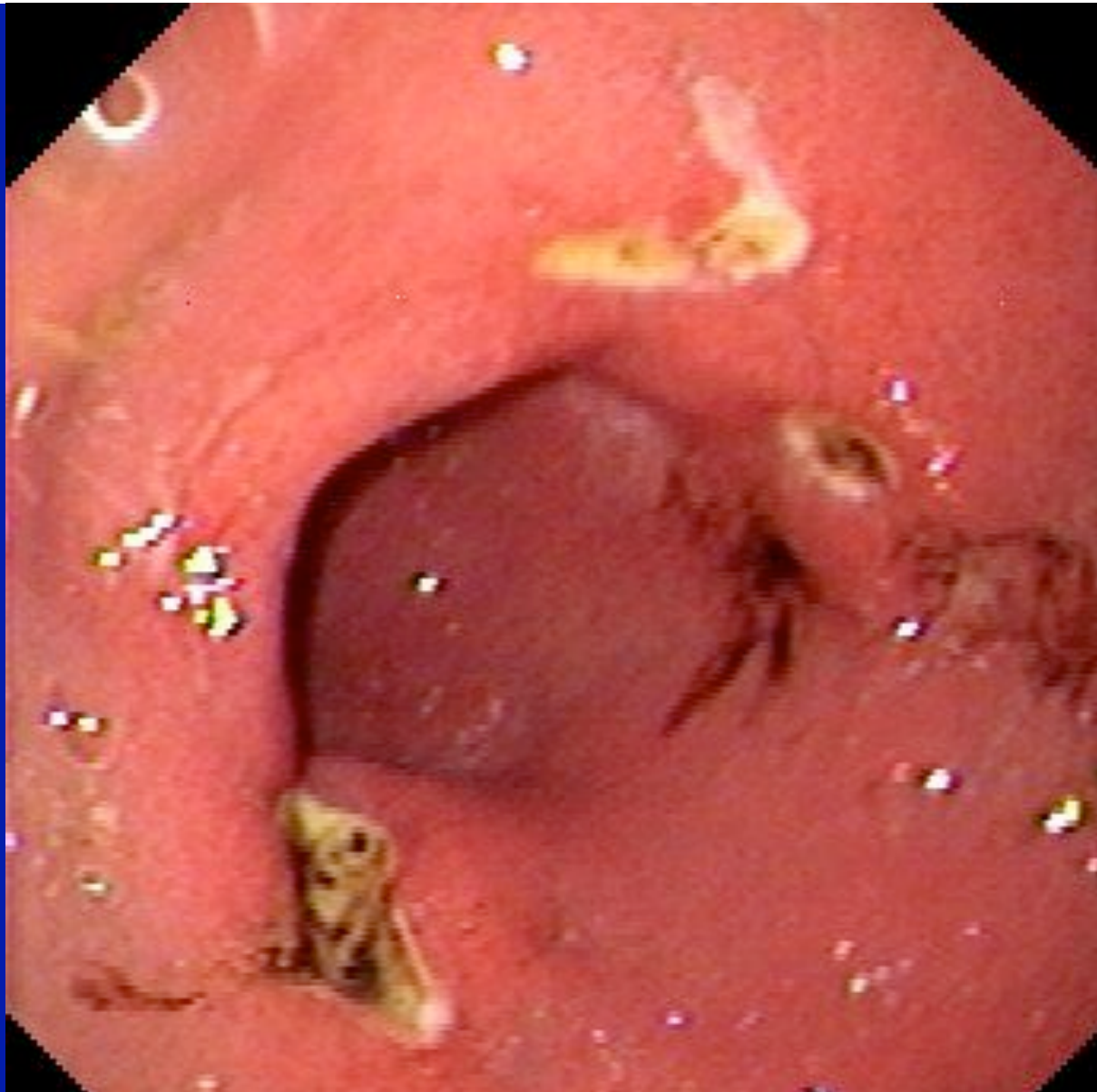


Gros pli pré-pylorique érodé en surface

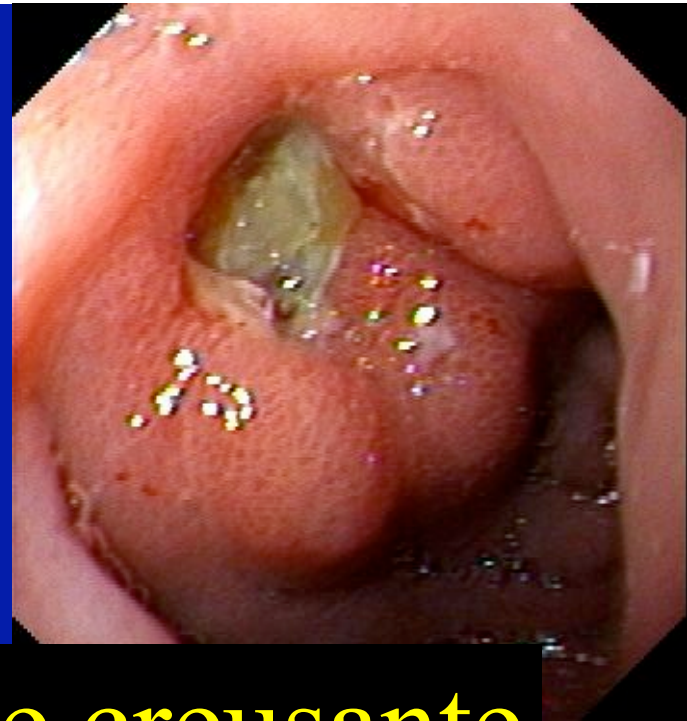


Lésions gastriques liées à la prise d'AINS

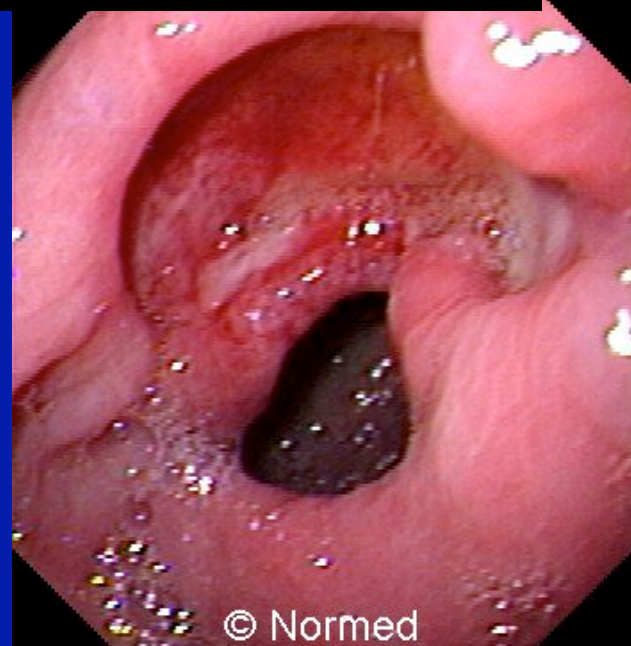
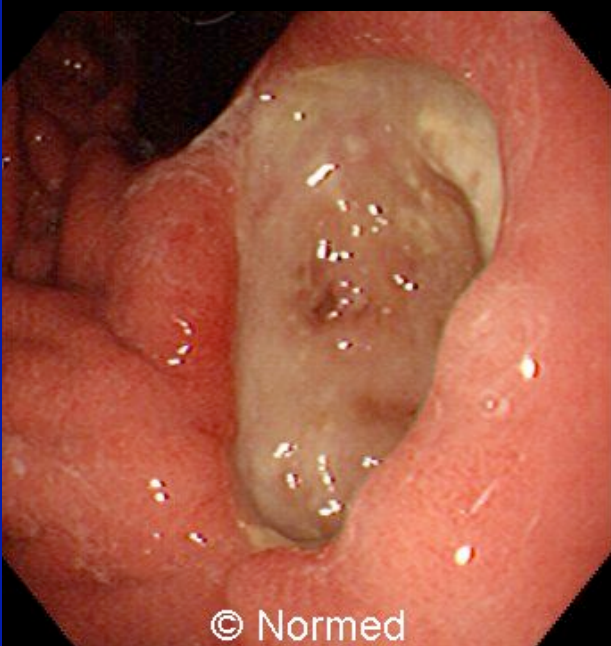




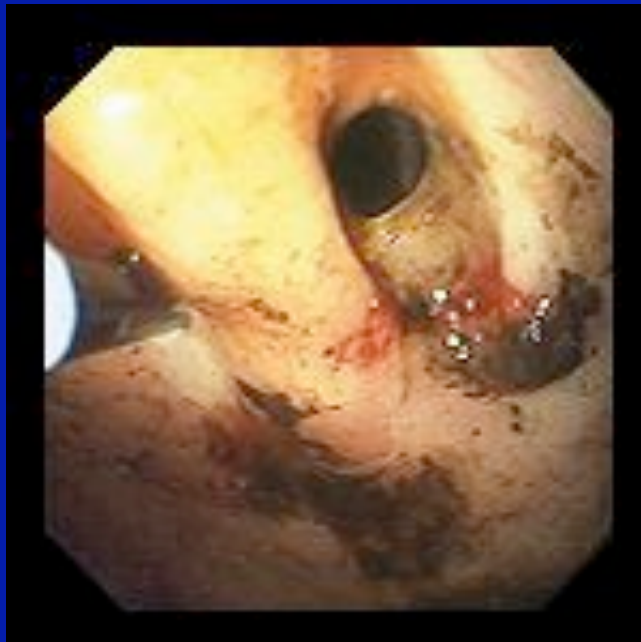
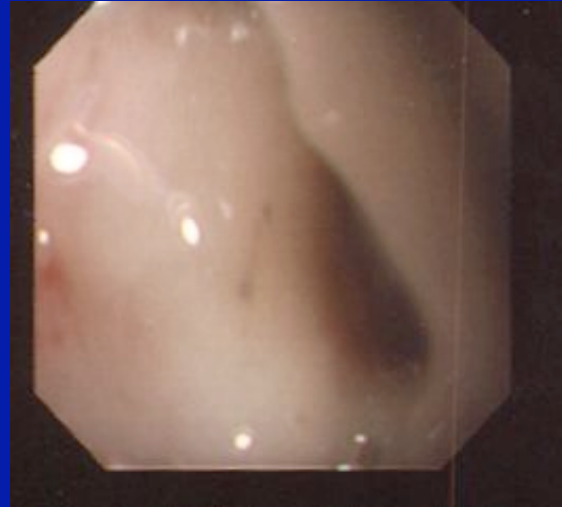
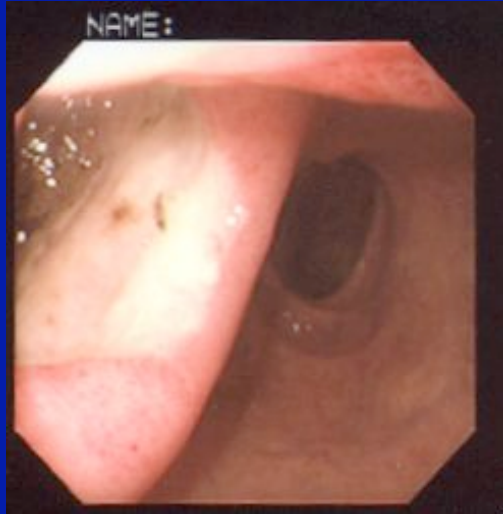
Antrite ulcéro nécrotique



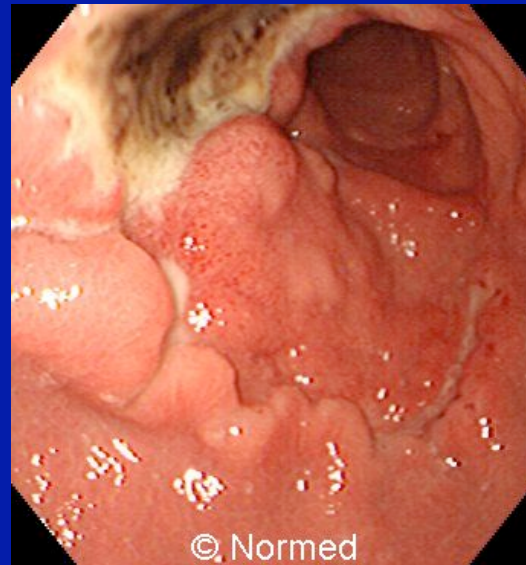
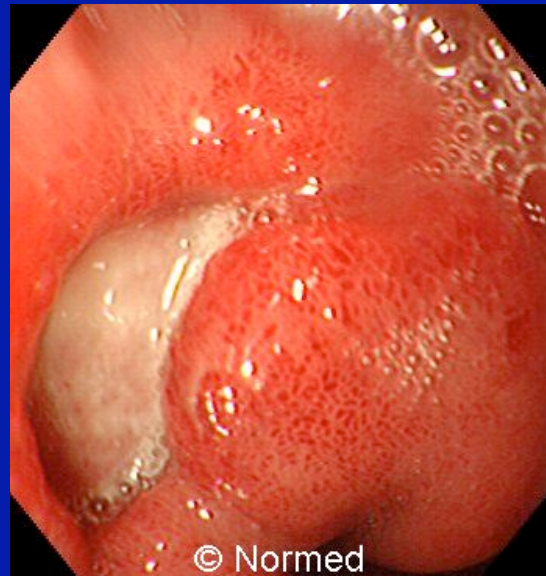
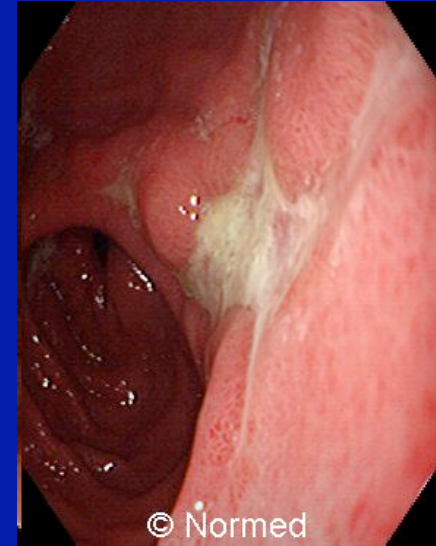
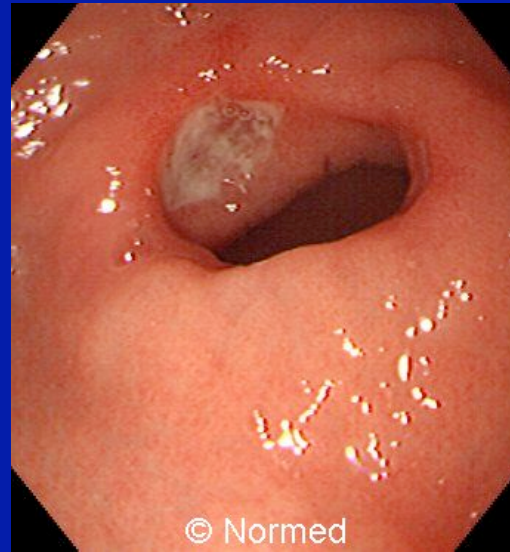
Perte de substance creusante



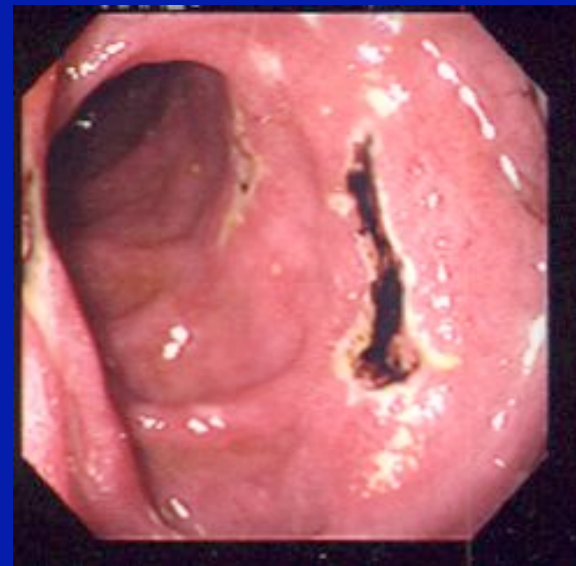
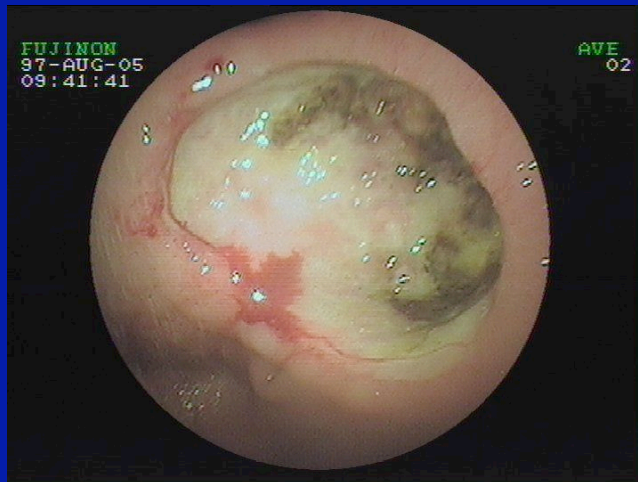
Perte de substance GD : la profondeur



Perte de substance GD : la forme



Perte de substance GD : le fond



Caractère hémorragique



En jet artériel

Active



En nappe



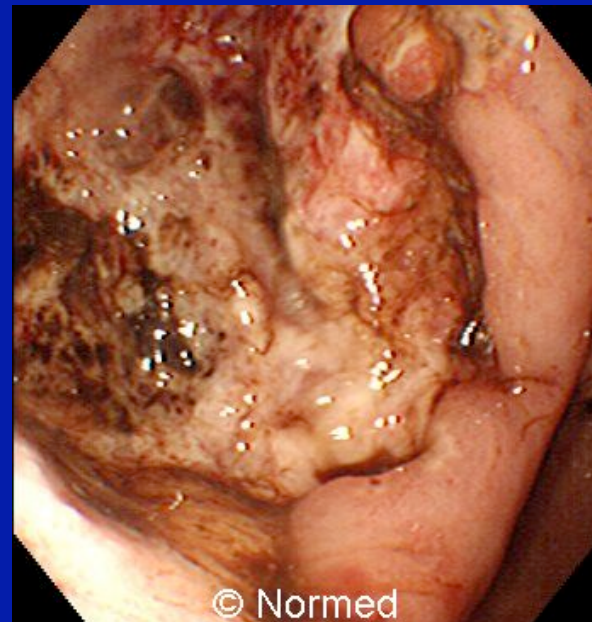
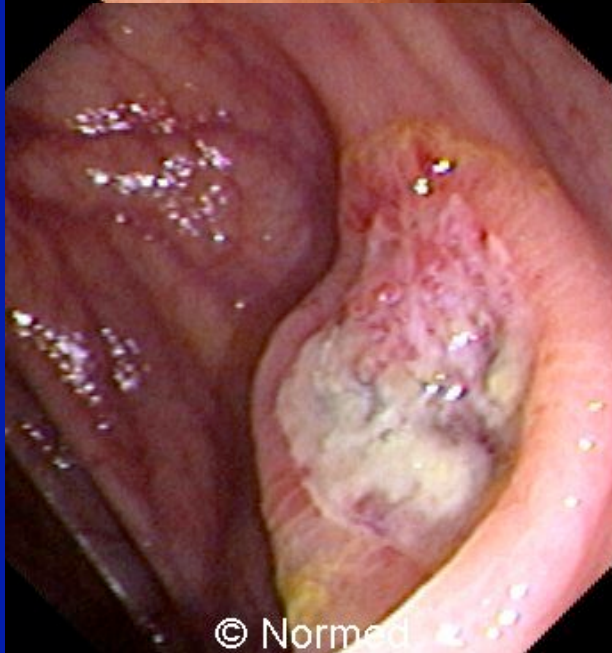
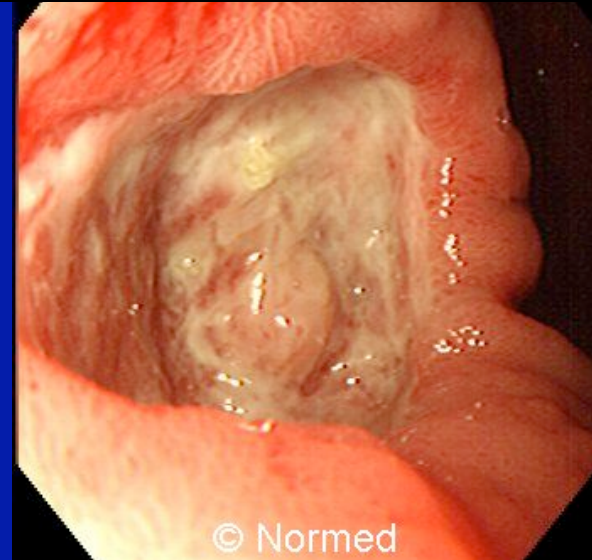
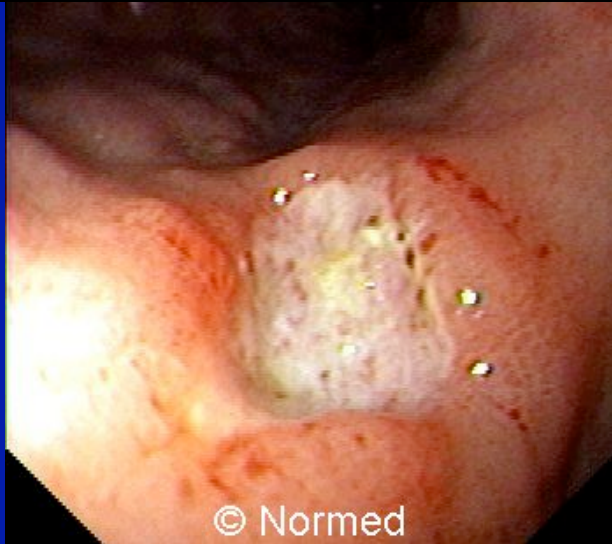
Vaisseau visible

SHR

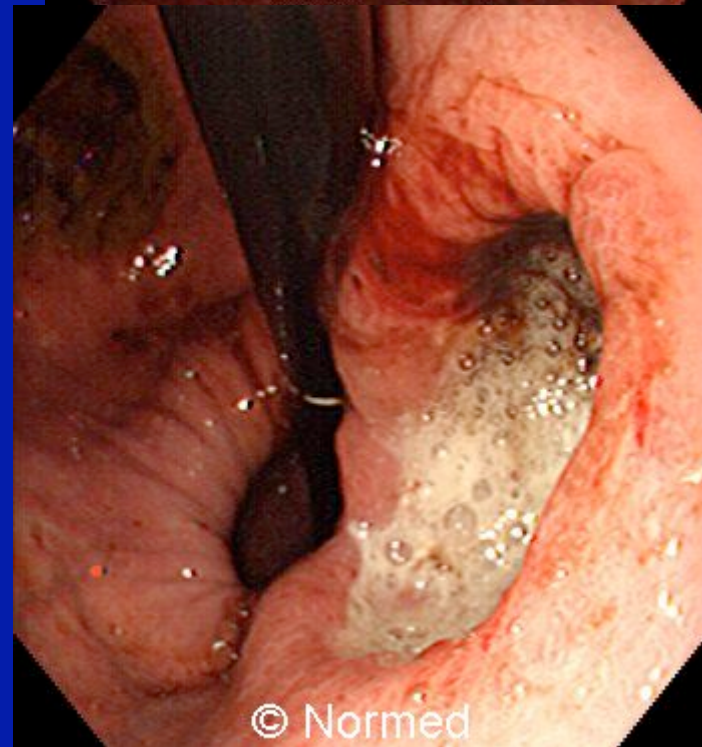
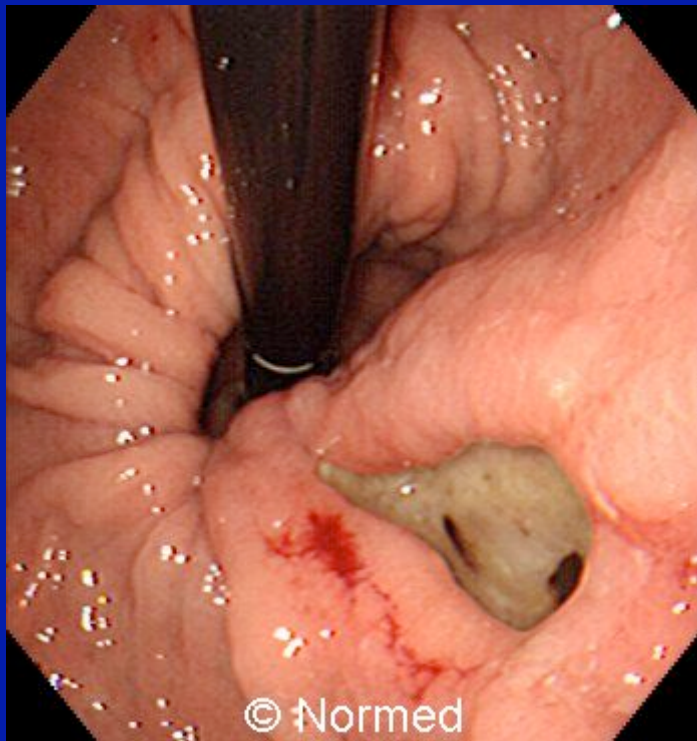
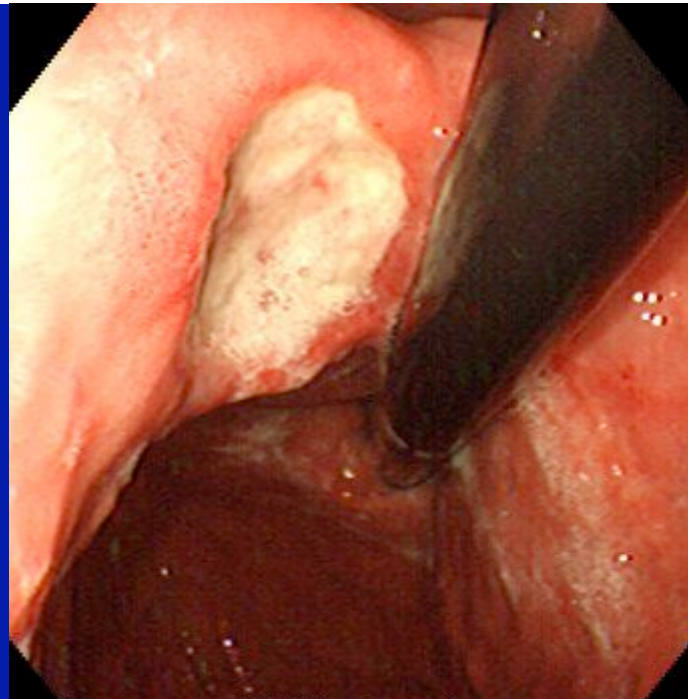


Caillot adhérent

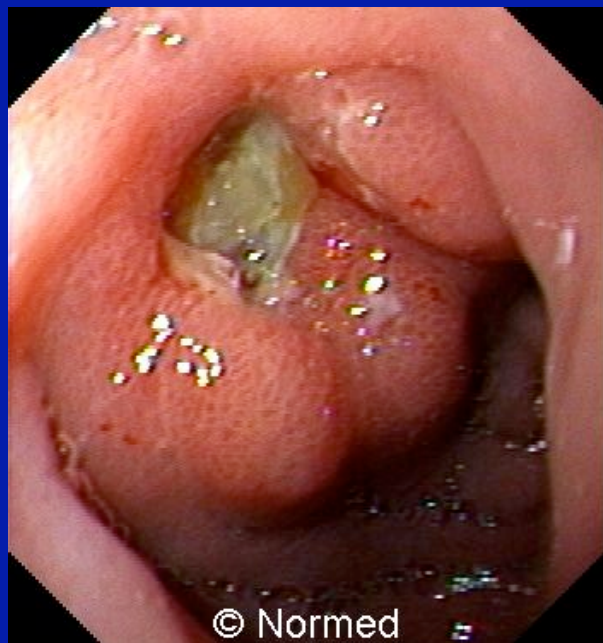
Perte de substance GD : le fond



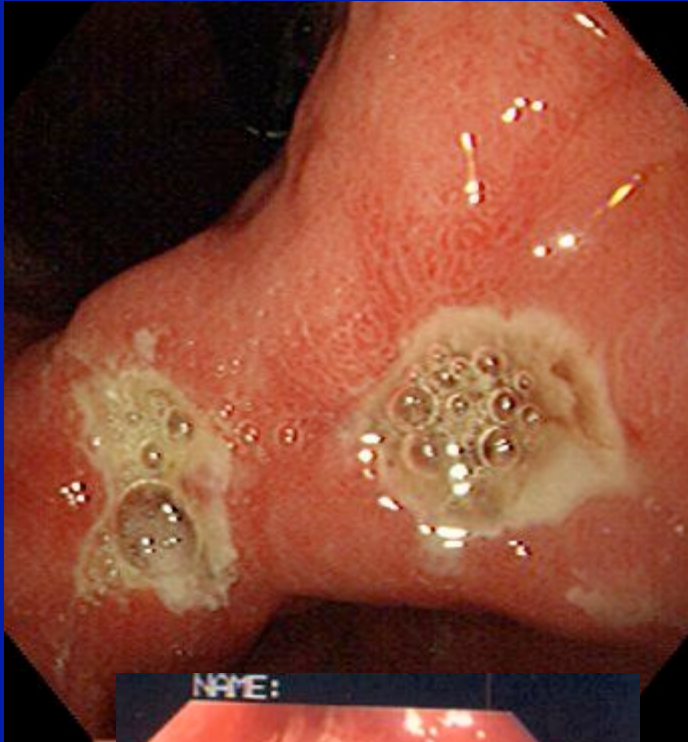
Ulcère gastrique : le siège sous cardial



UD : le siège bulbaire quelle face ?



Ulcère GD : les bords





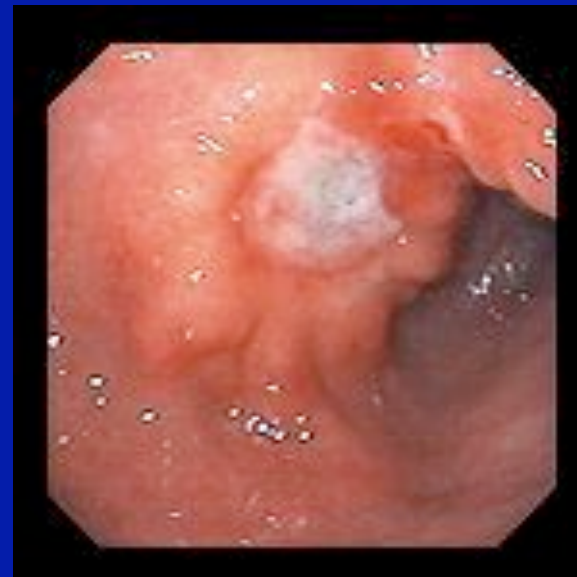
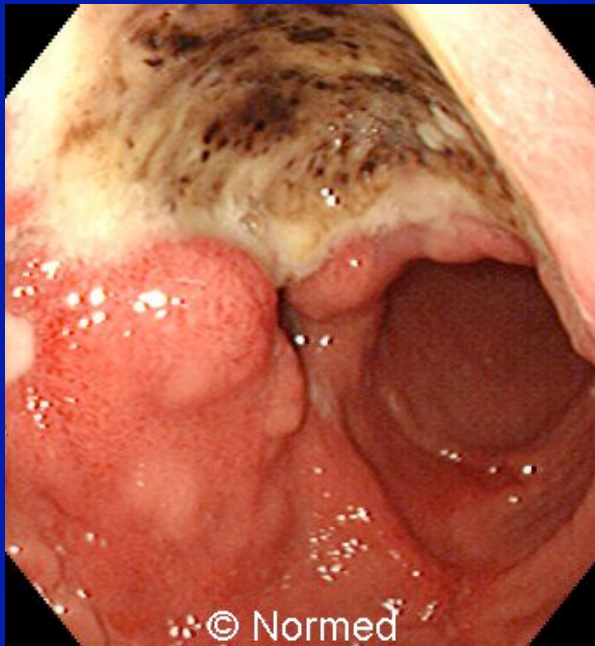
The image is a composite of four endoscopic photographs showing gastric ulcers. The top-left image shows a ulcer with a white, fibrinous center and a slightly irregular, reddish border. The top-right image shows a ulcer with a more defined, slightly raised, and irregular border. The bottom-left image shows a ulcer with a white, fibrinous center and a well-defined, slightly raised border. The bottom-right image shows a ulcer with a white, fibrinous center and a well-defined, slightly raised border. The text "Ulcère GD : les bords" is overlaid in the center of the composite image.

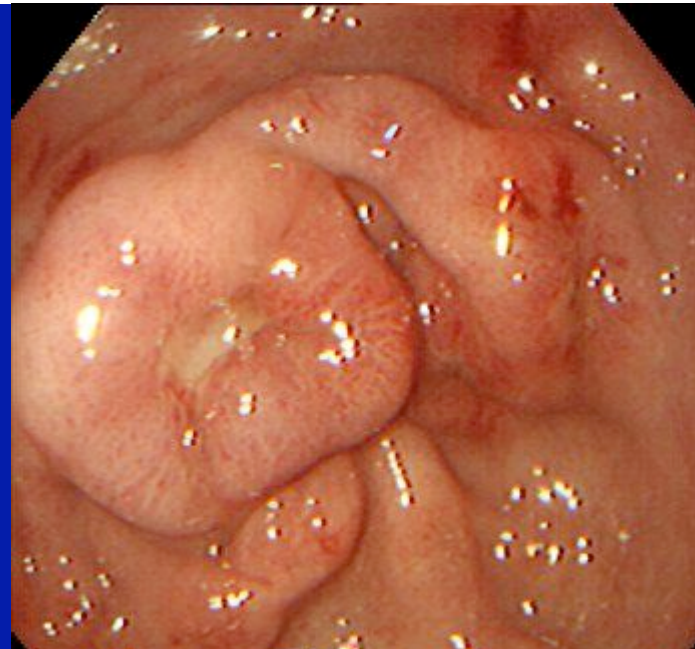
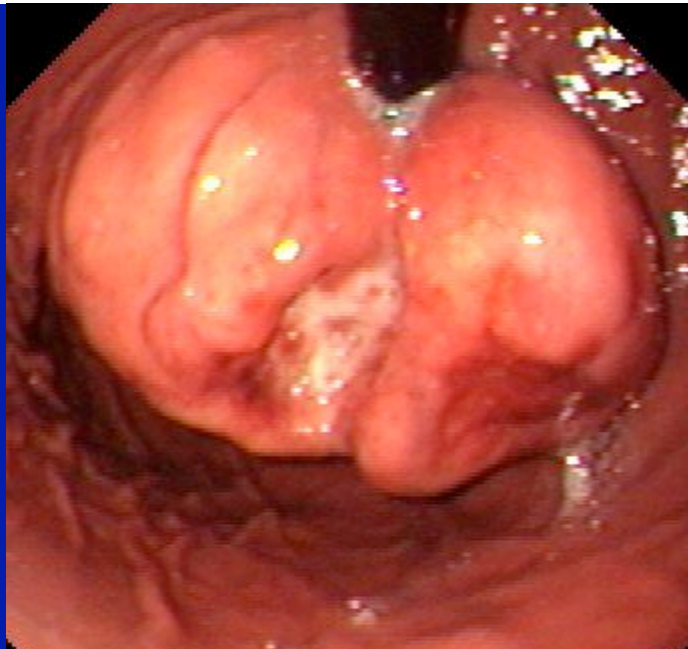
Ulcère GD : les bords

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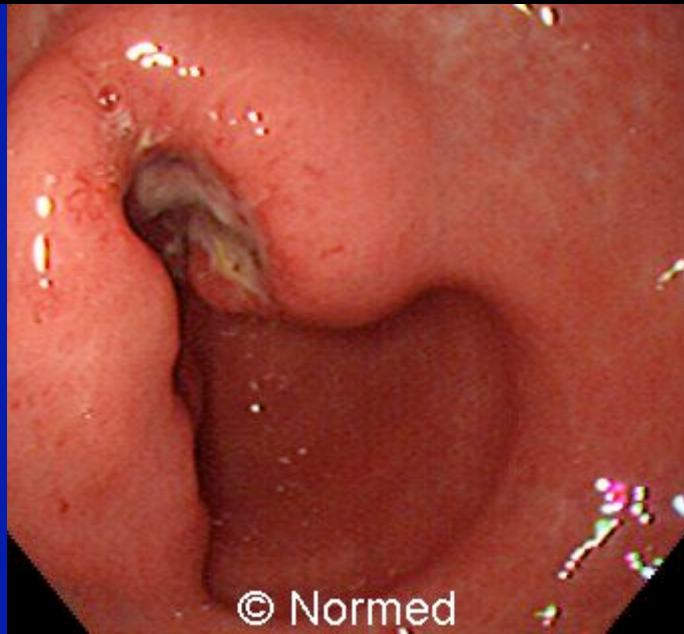
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Ulcère GD : les bords

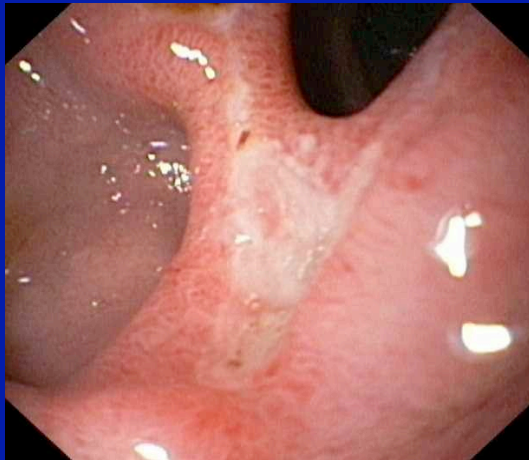




Perte de substance sur lésion surelevée

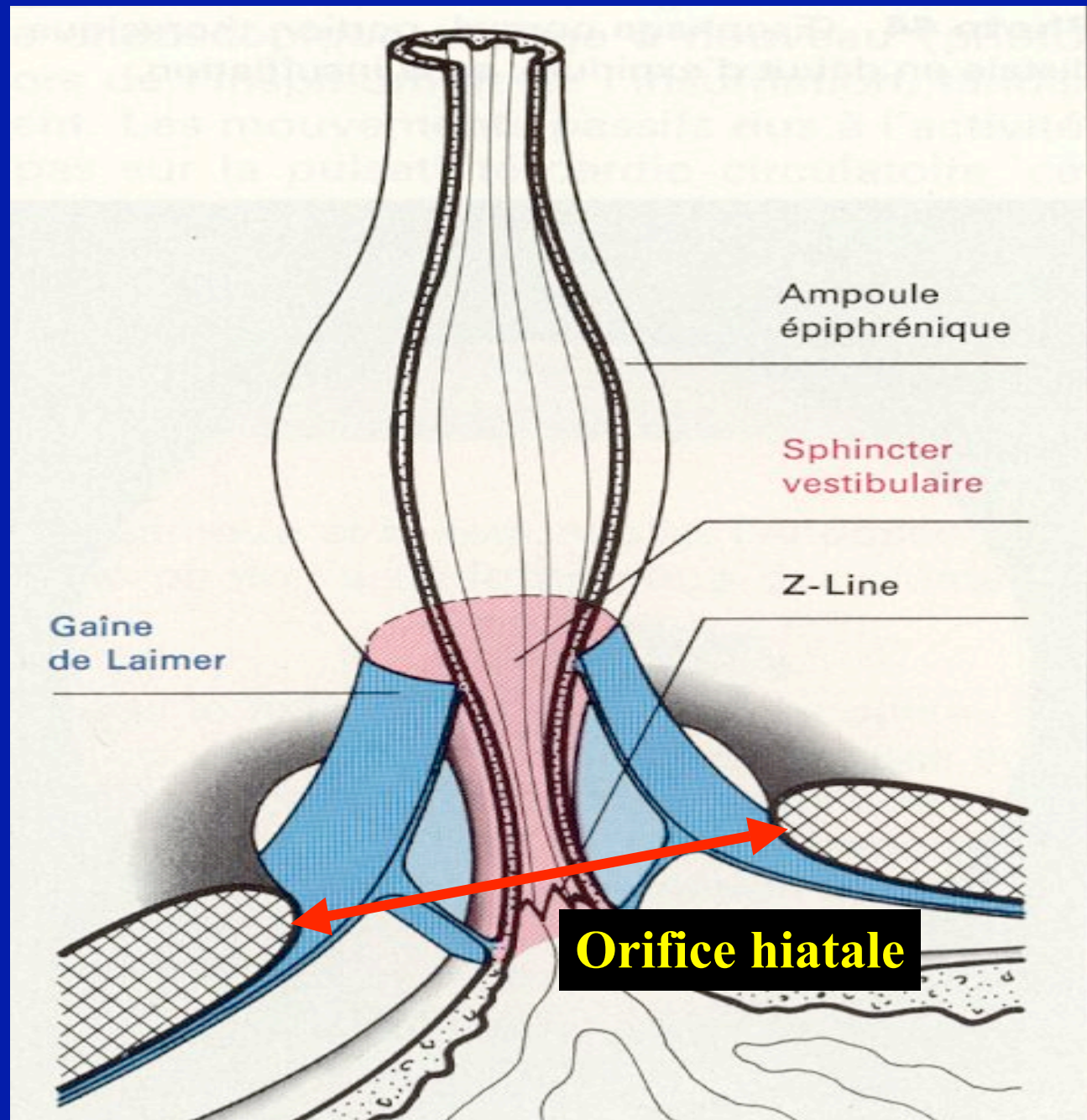


Perte de substance Bulbaire : la zone péri-lésionnelle; déformations associées

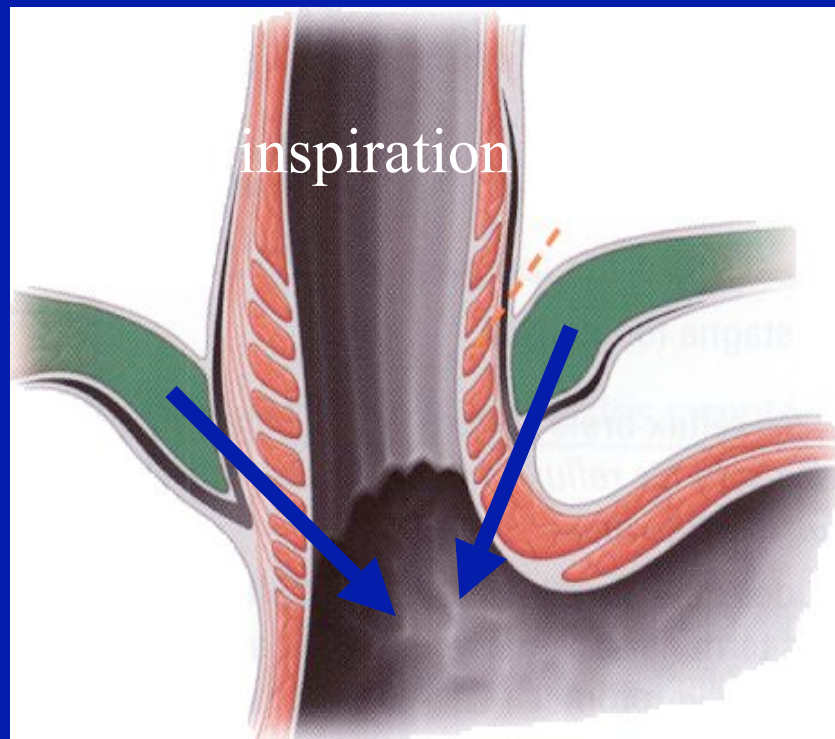


Exploration endoscopique de la région oeso-cardiale

Anatomie de la région oeso-cardiotubérositaire

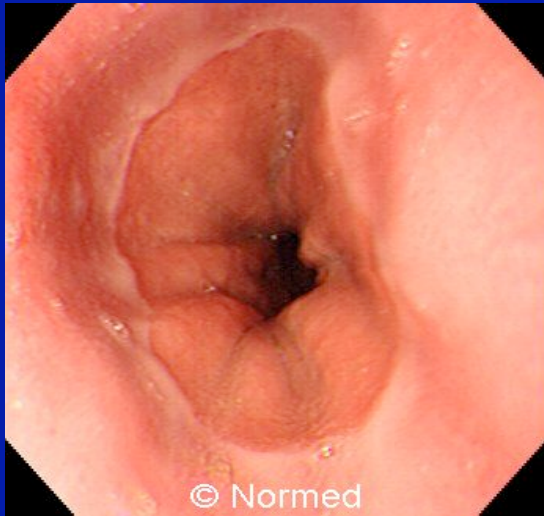


Région oeso-cardio-tubérositaire

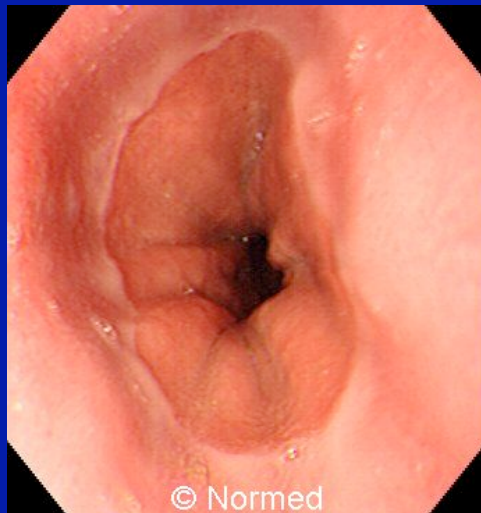


Distance max entre ligne Z et orifice hiatale
en inspiration profonde < 2 cm

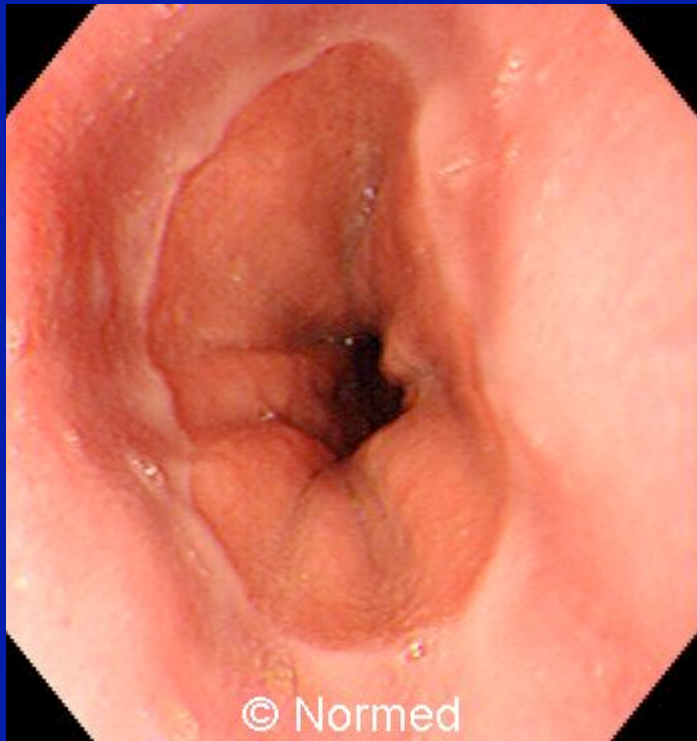
Cardia muqueux- ligne Z



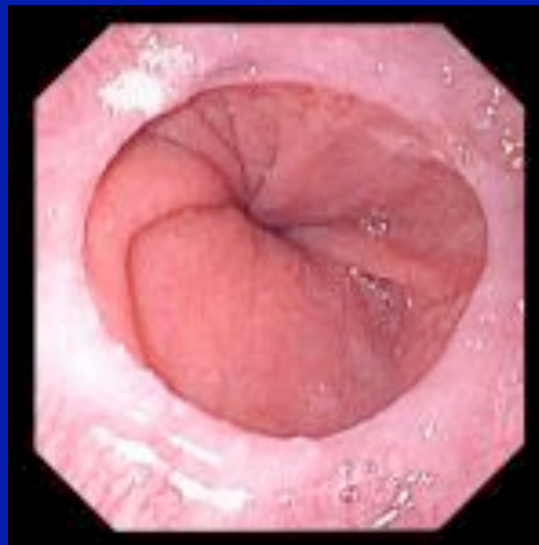
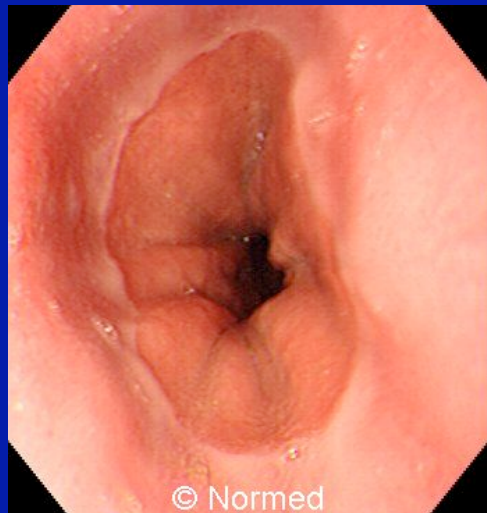
Orifice hiatal



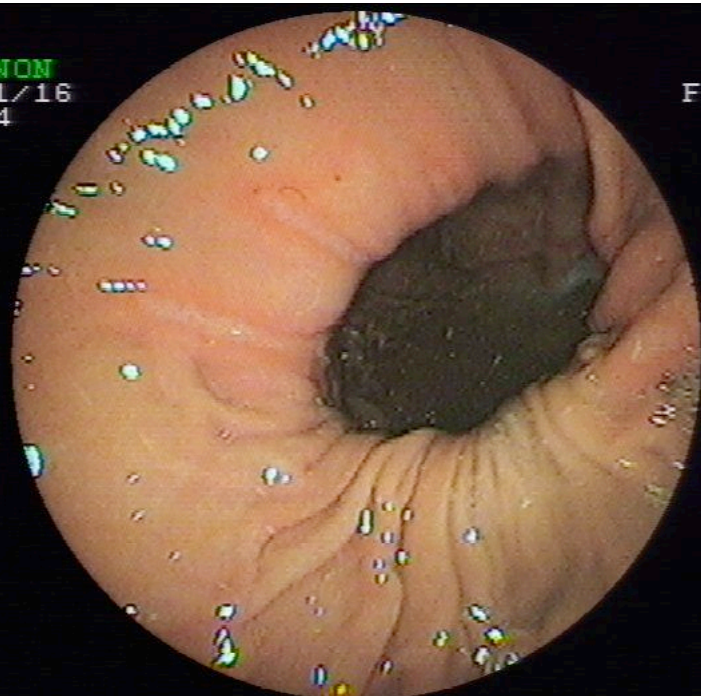
Hernie hiatale



Hernie hiatale par glissement

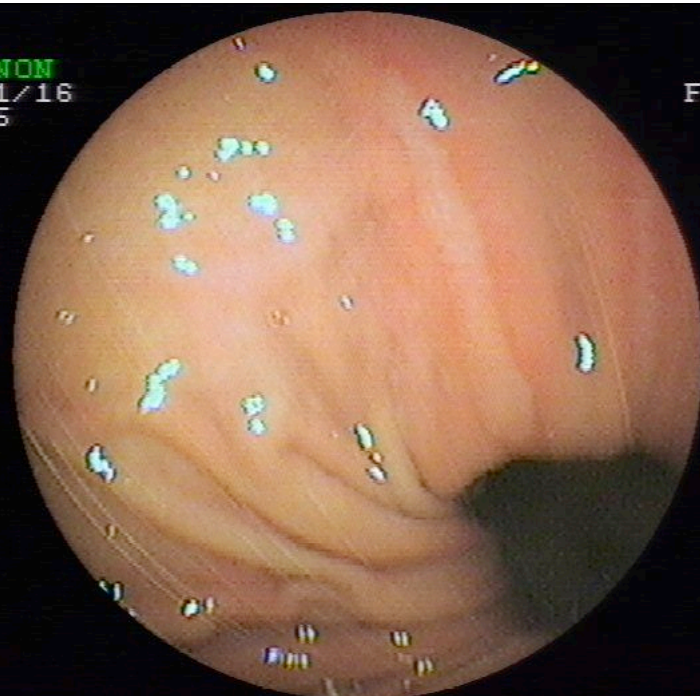


FUJINON
31/01/16
00:04



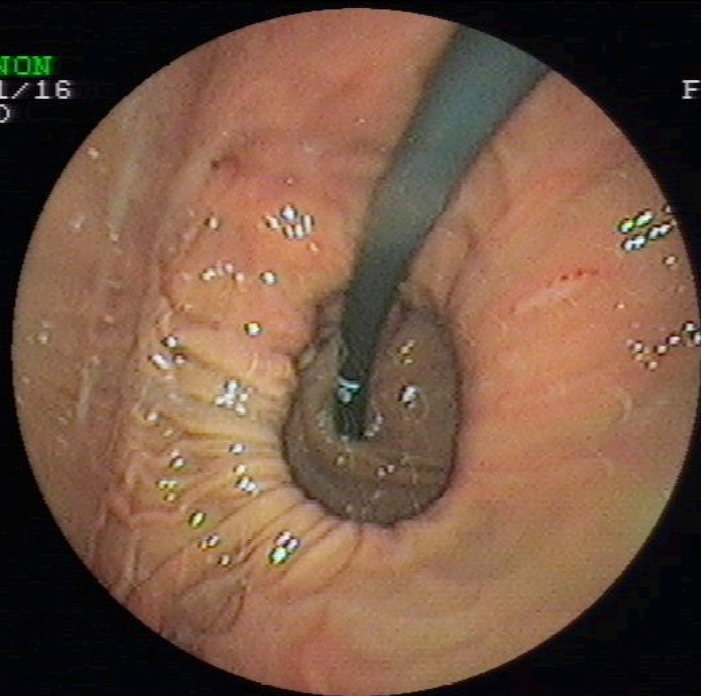
AVE
FILM 00

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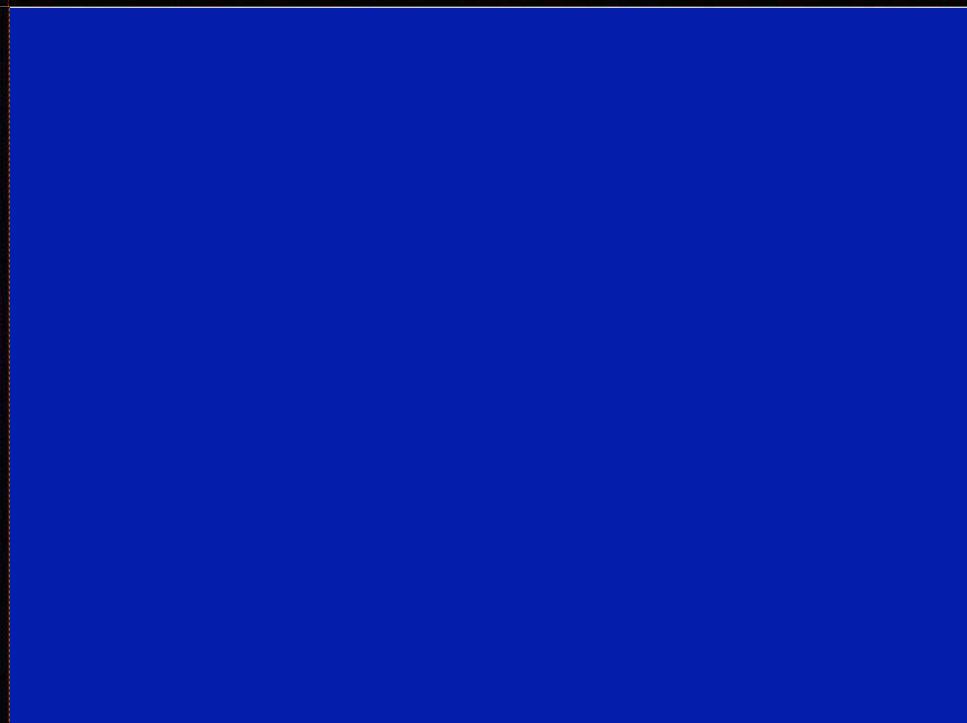


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FILM 00

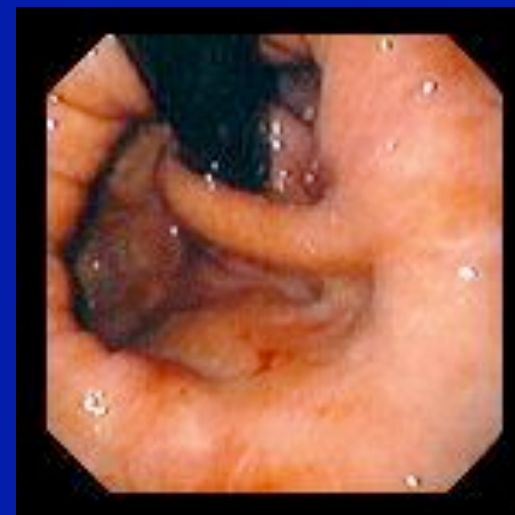
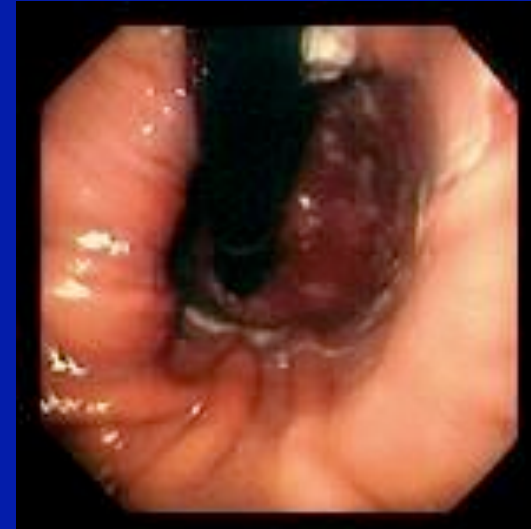
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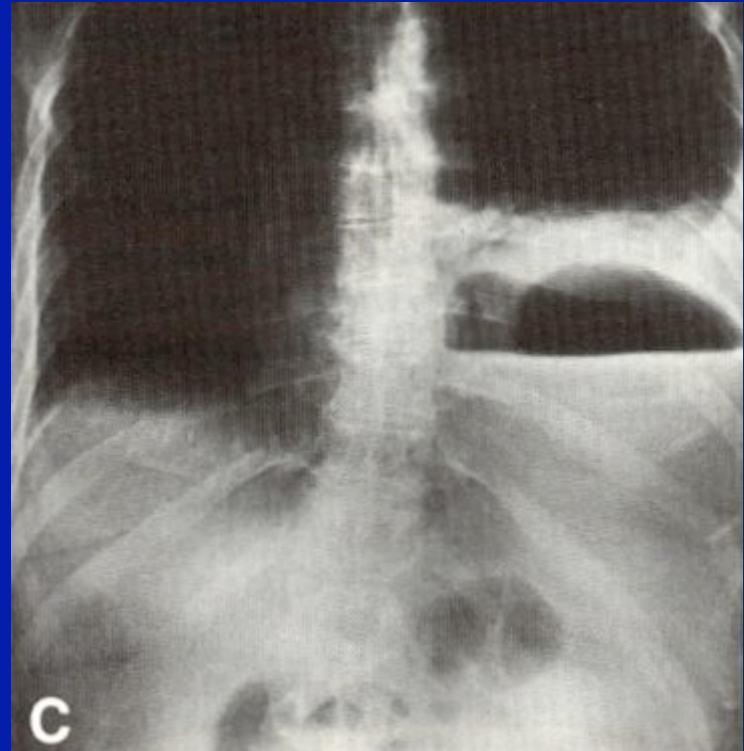
AVE
FILM 00



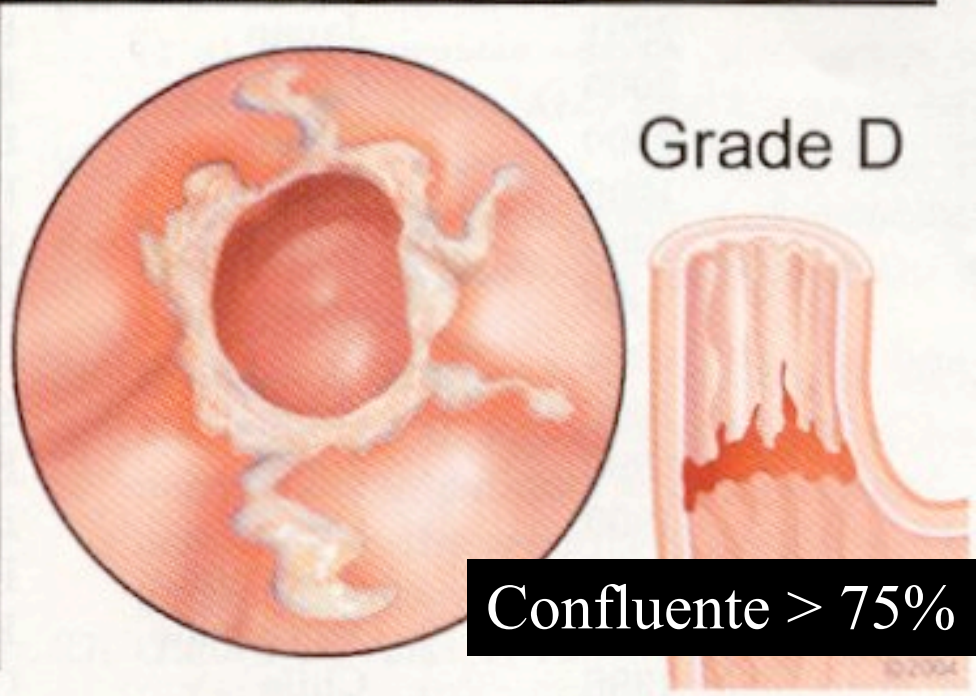
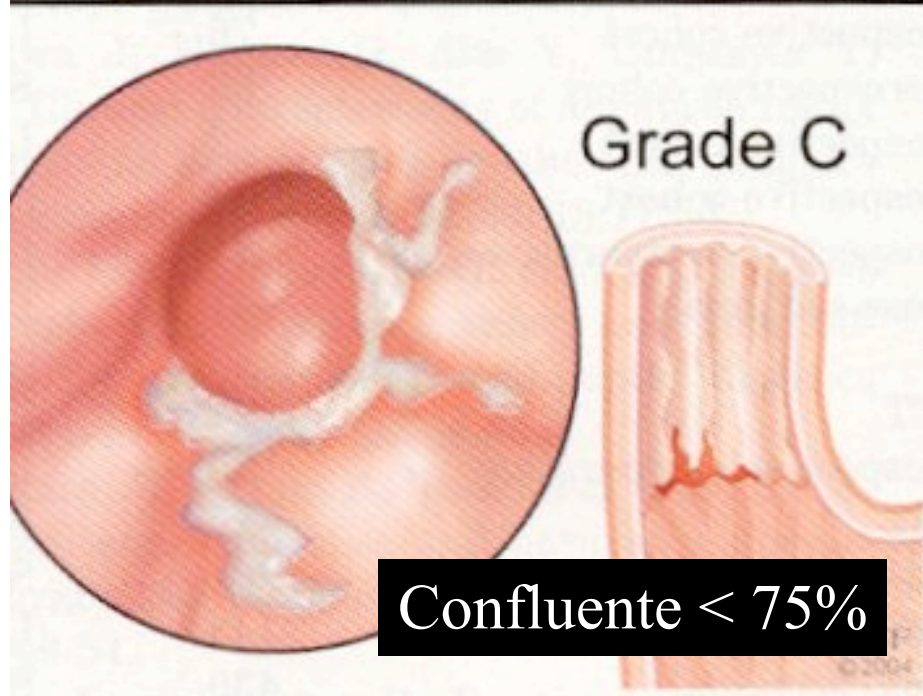
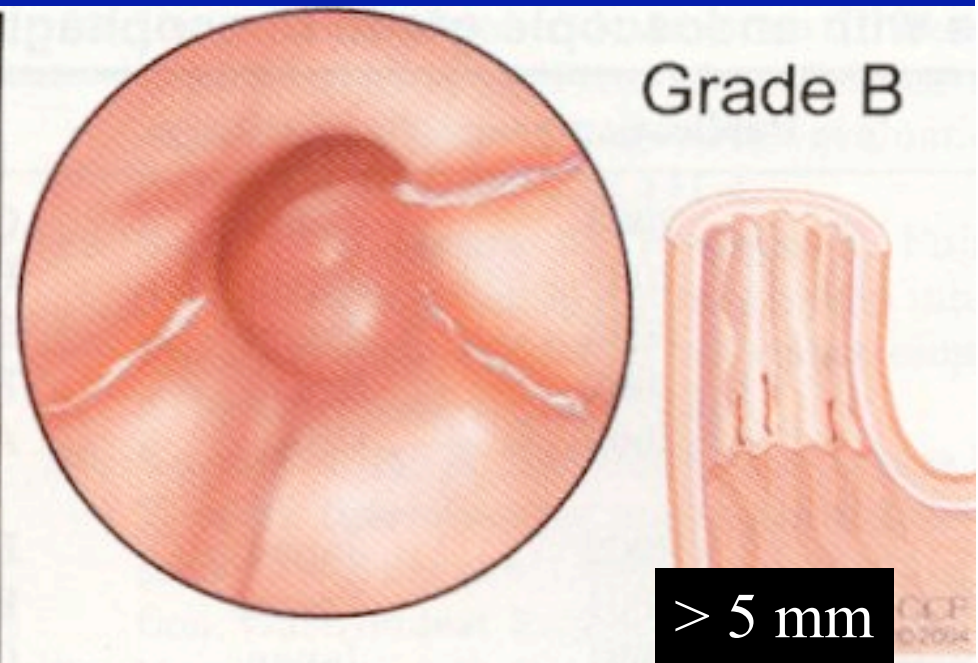
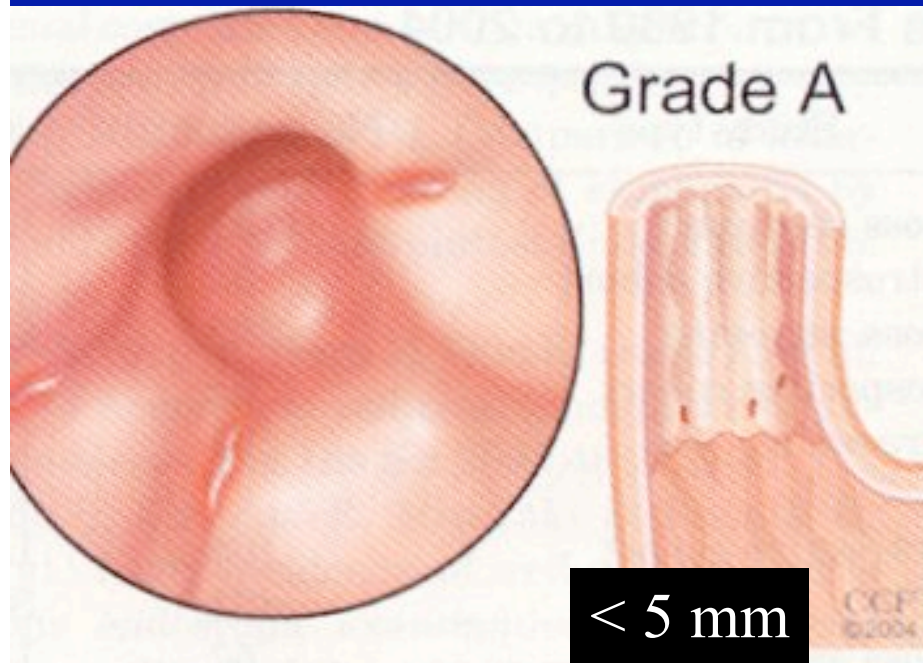
Hernie hiatale en rétrovision



Hernie para oesophagienne



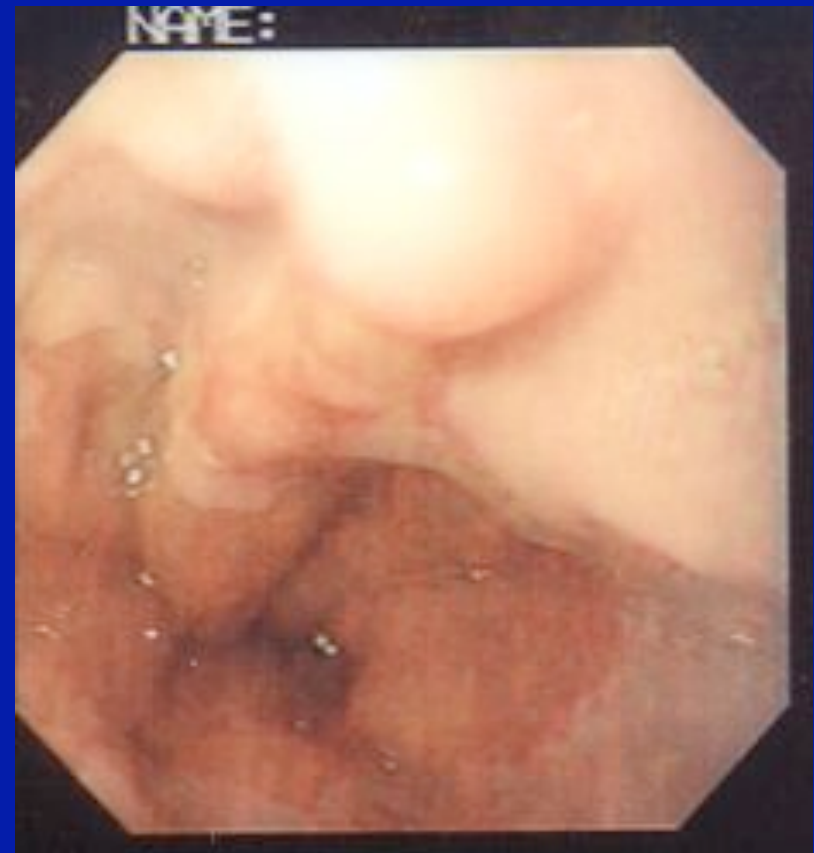
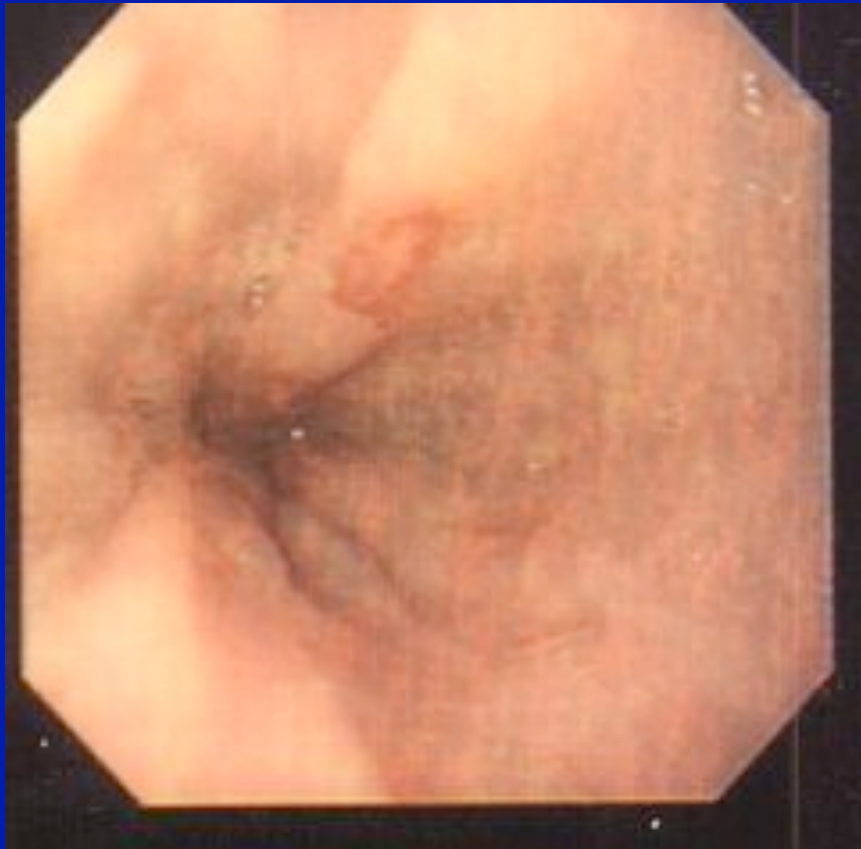
LESIONS OESOPHAGIENNES



Lésion congestive du bas oesophage



OESOPHAGITE < 5 mm



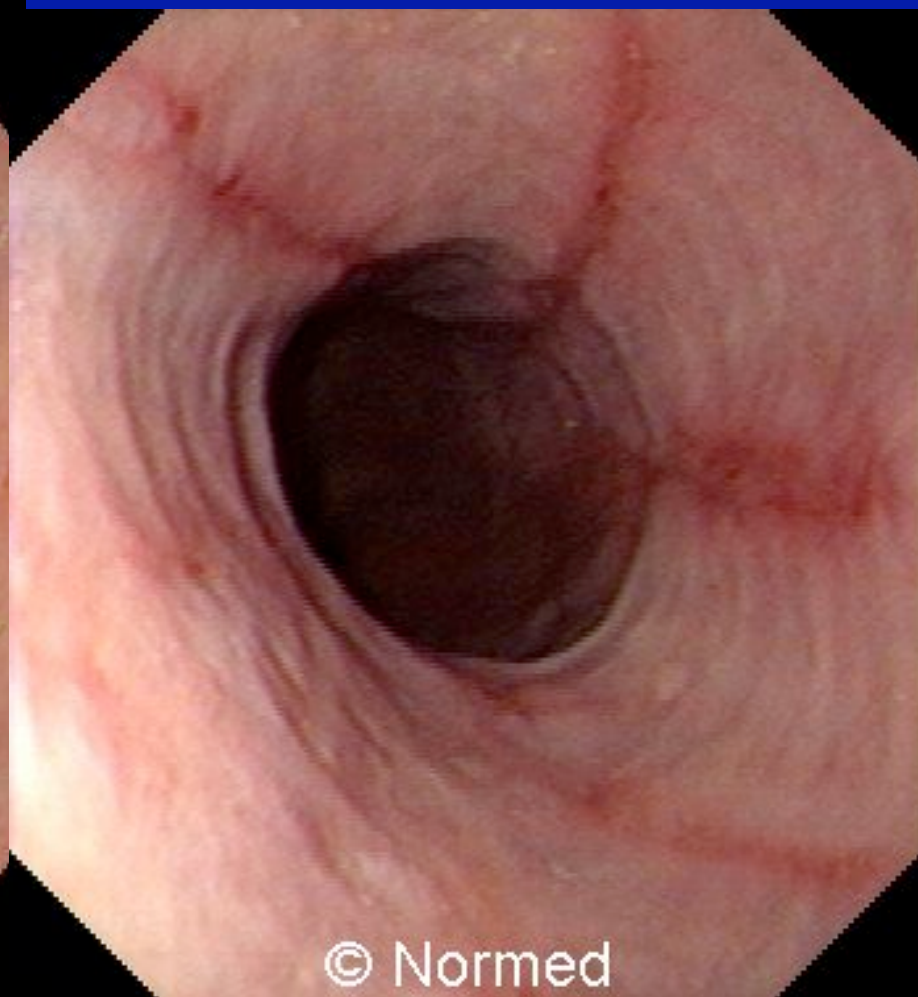
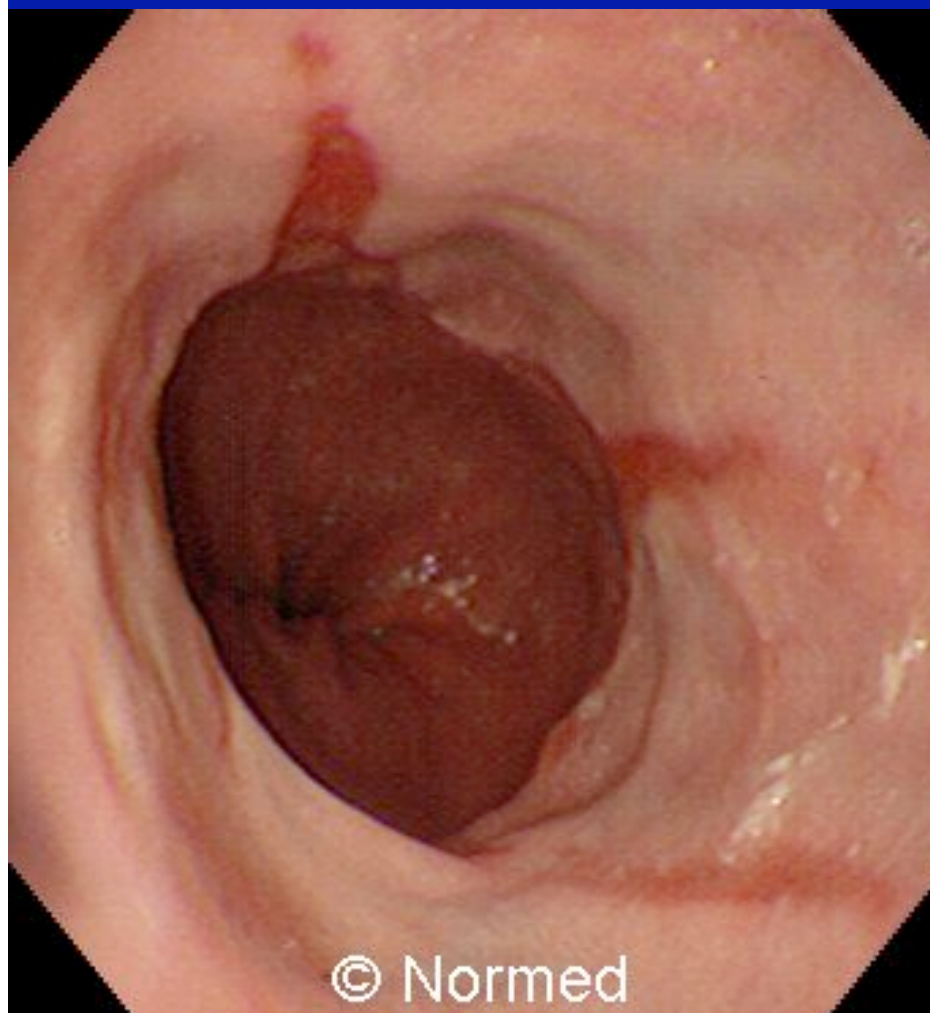


Gastrite jonctionnelle

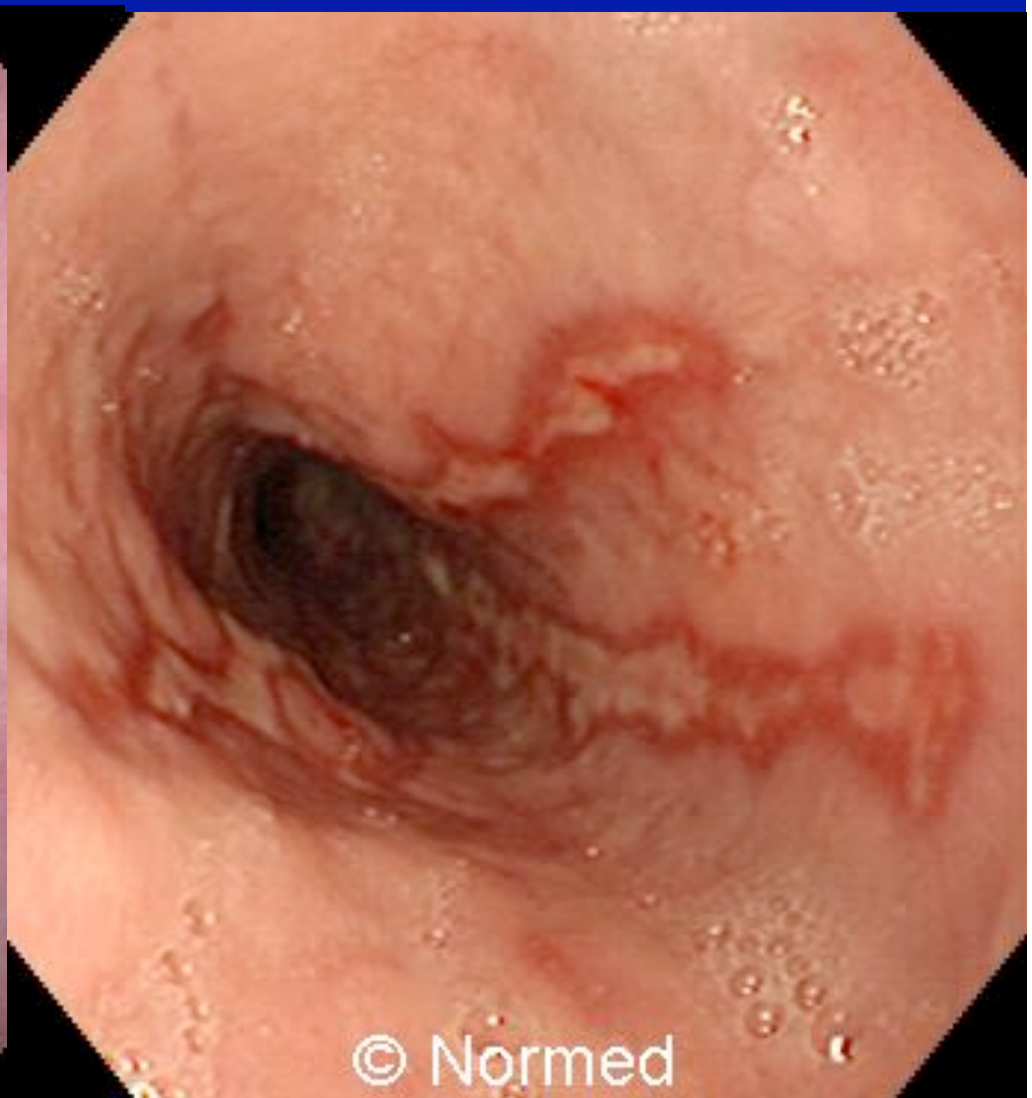
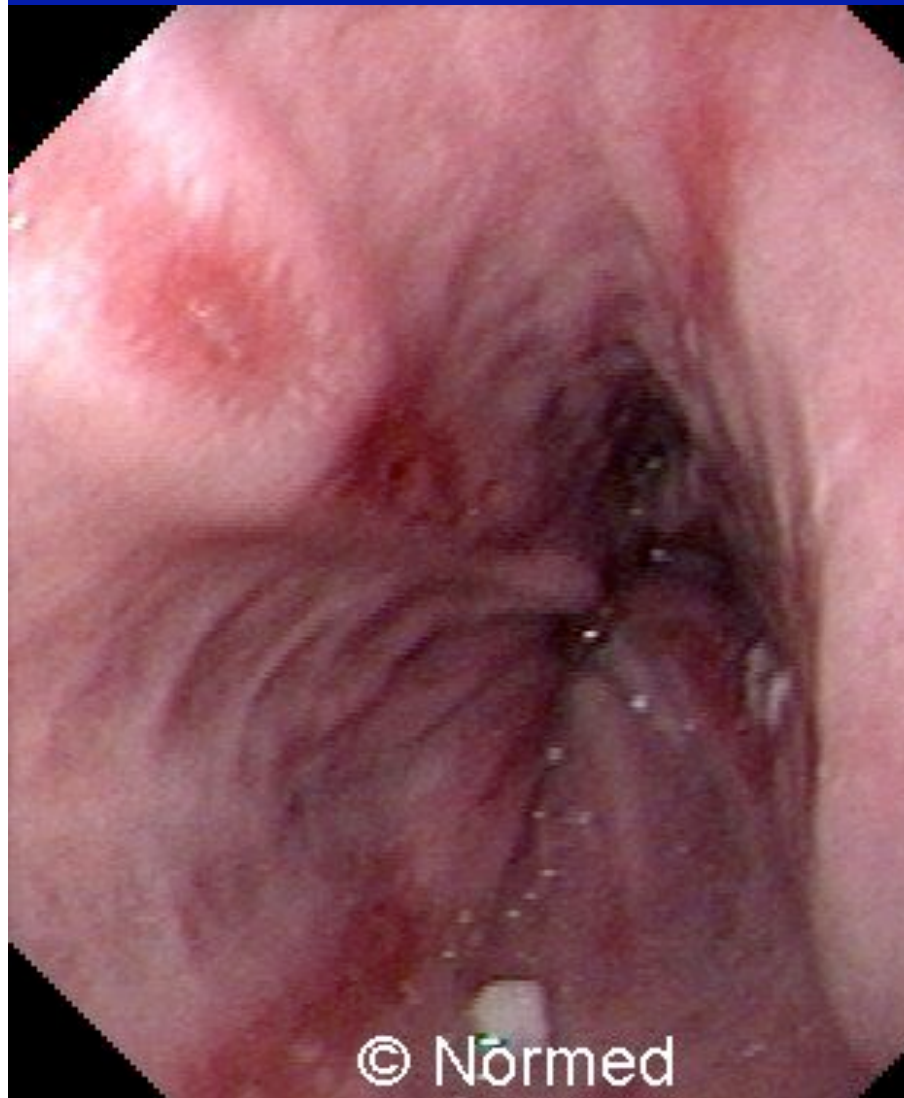
Oesophagite linéaire



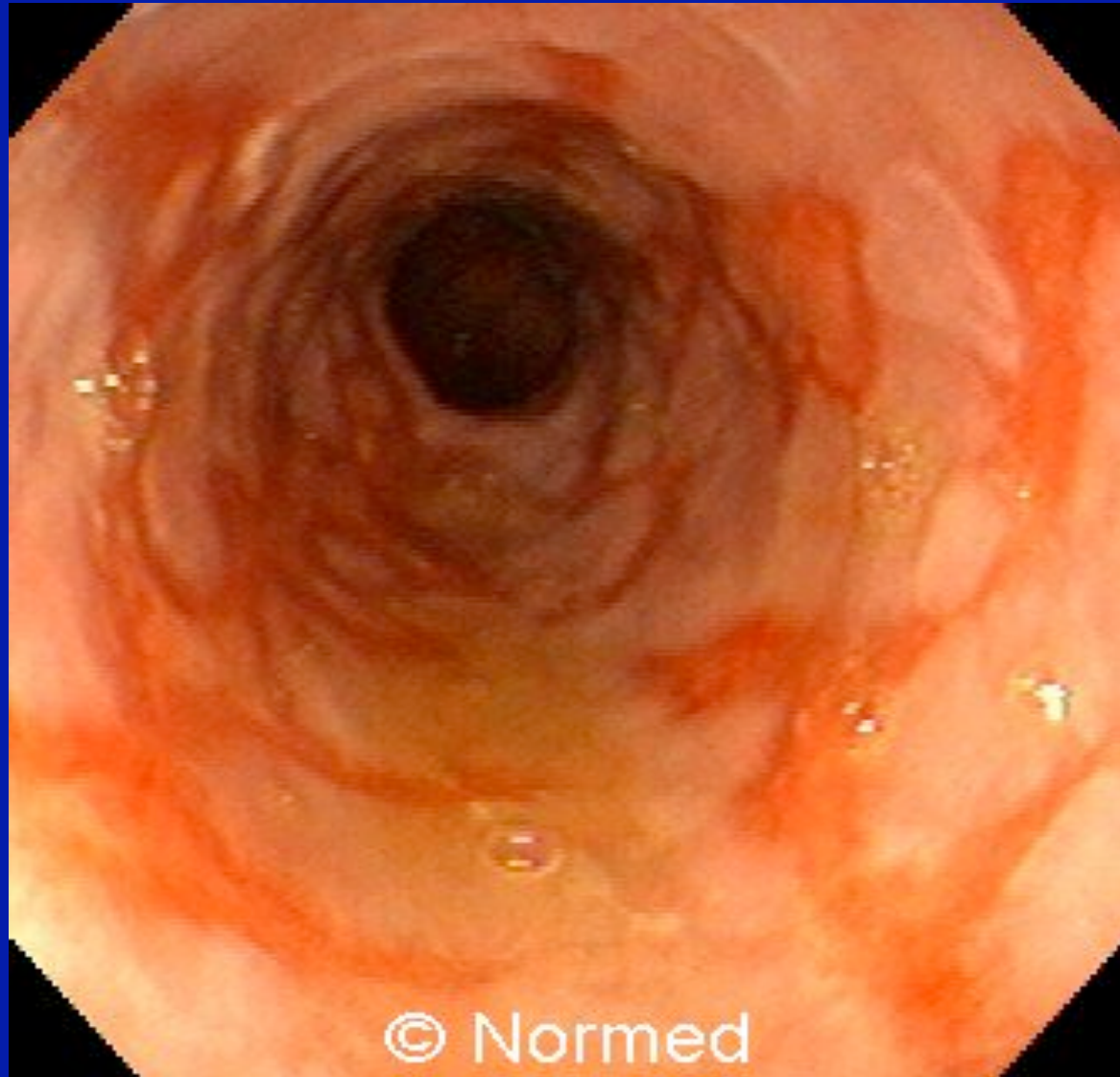
Oesophagite linéaire



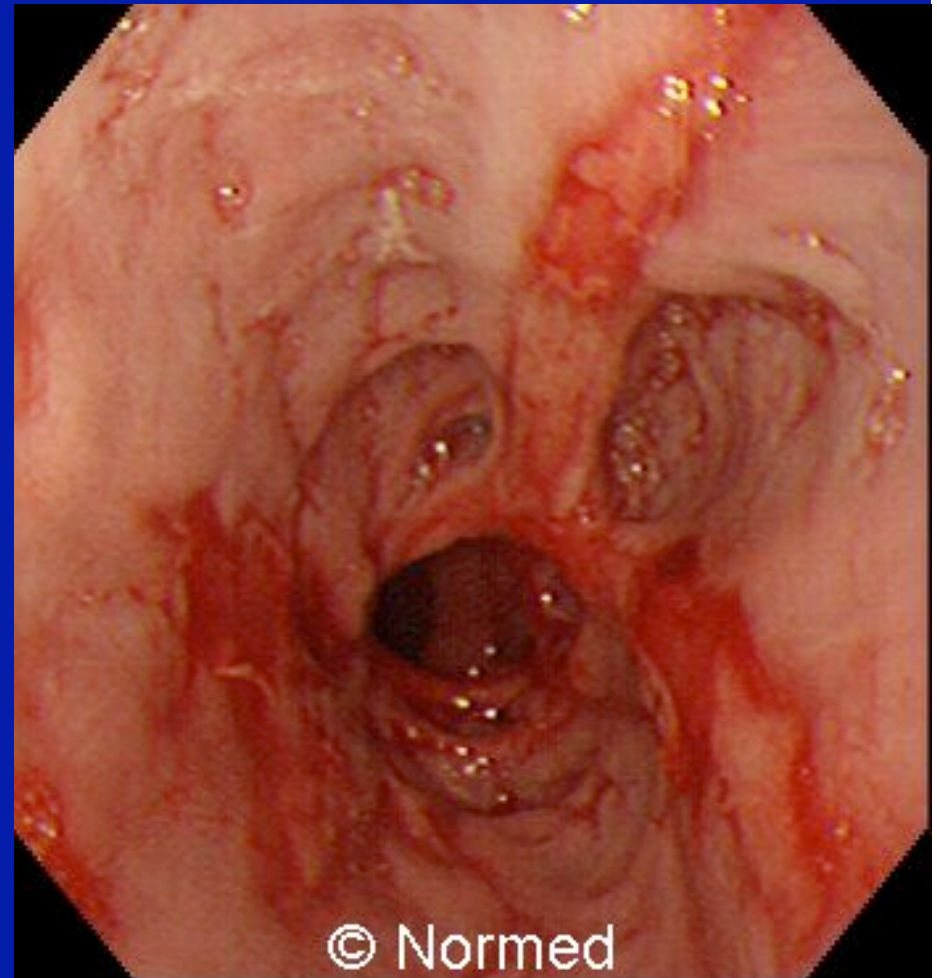
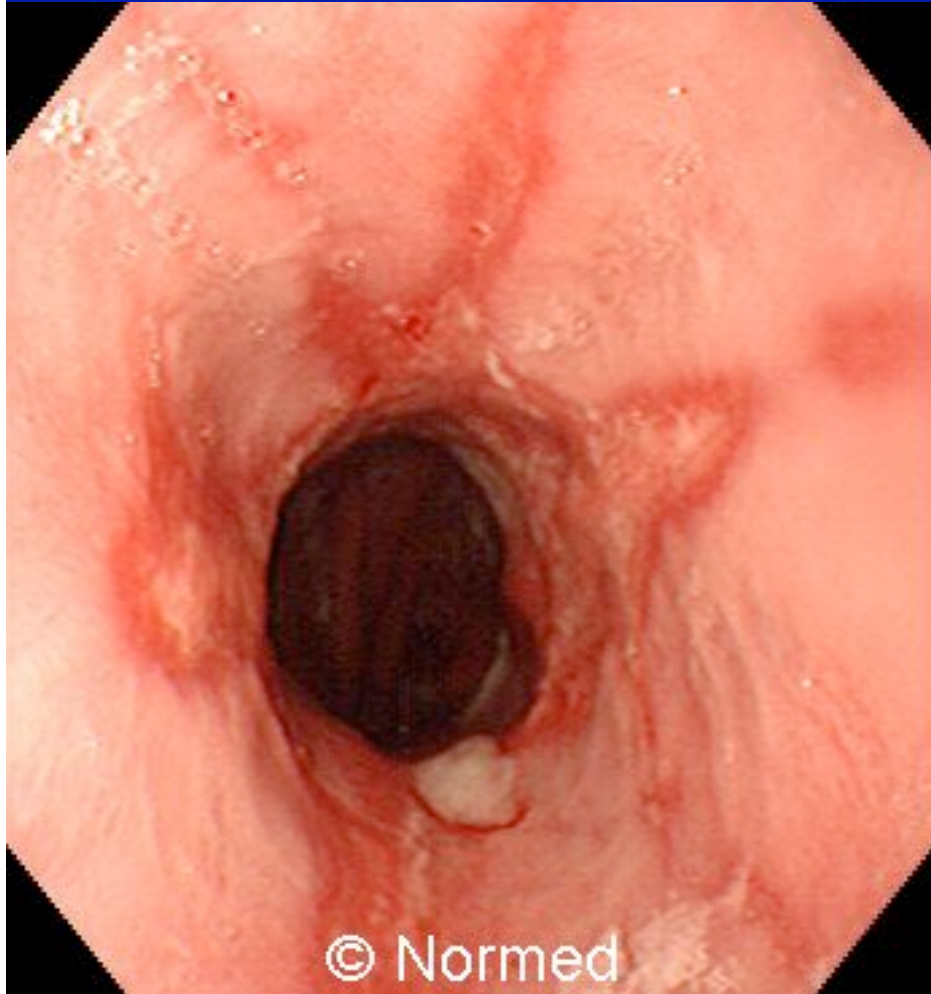
Oesophagite confluyente



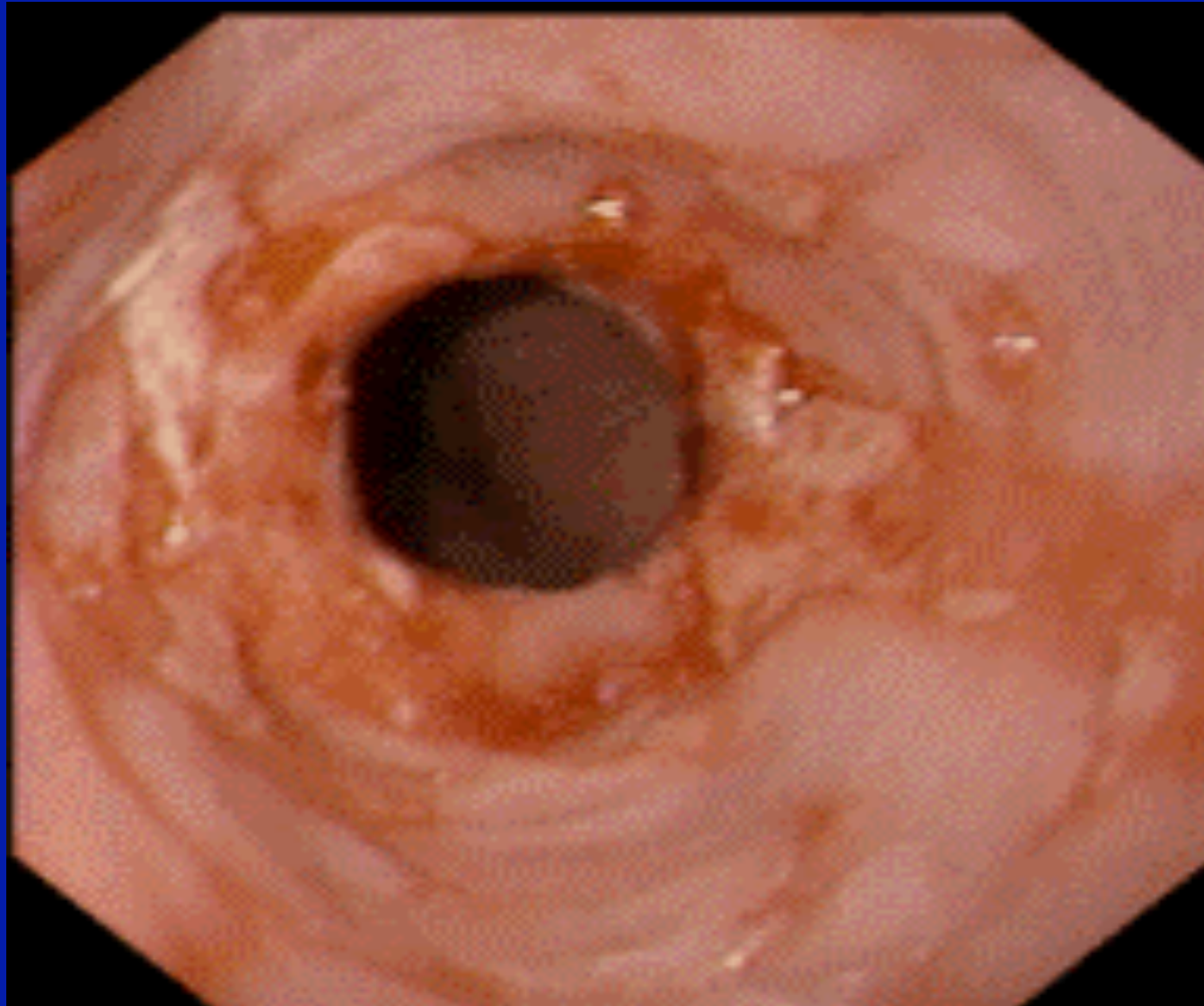
Oesophagite circonférentielle



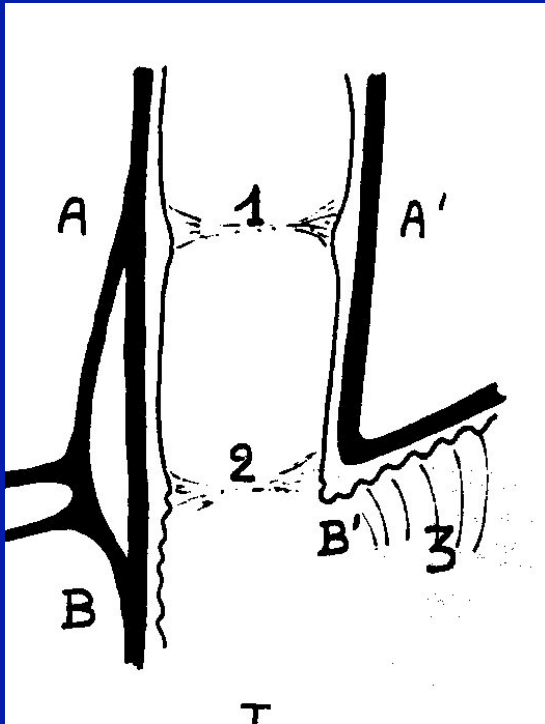
Oesophagite circulaire et sténosante



Oesophagite sténosante



Anneaux du bas oesophage



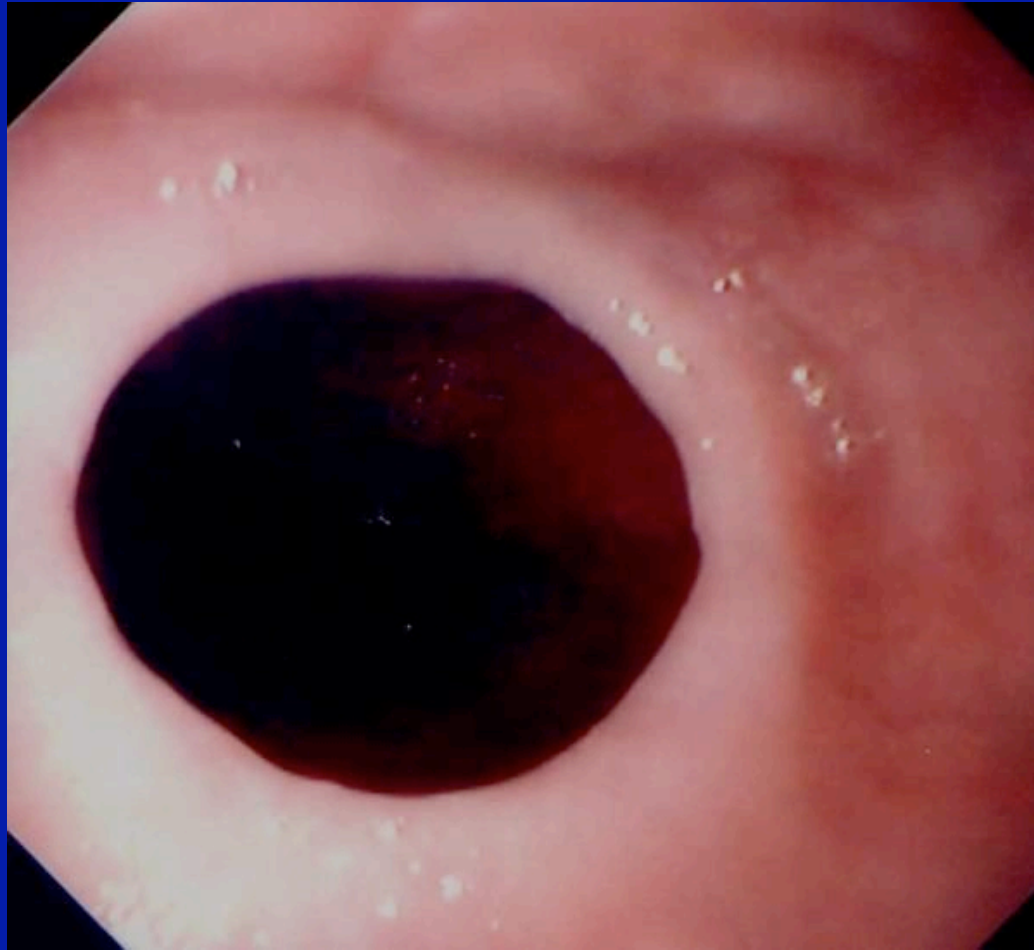
**Anatomie
normale**



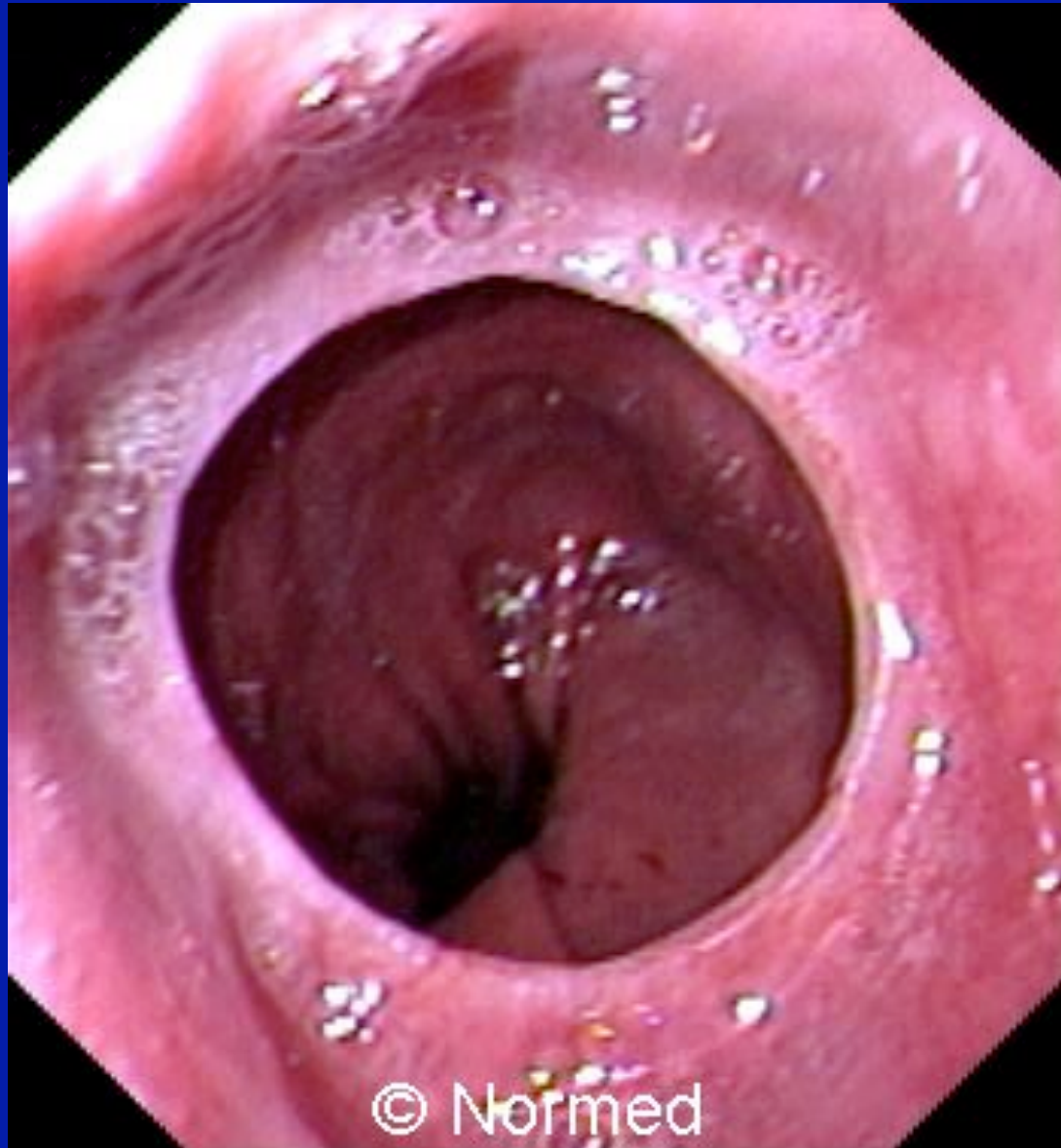
**Anneau
de Schatzki**

Anneau de SCHATZKI

0.2 à 14 % des TOGD



Anneau de Schatzki

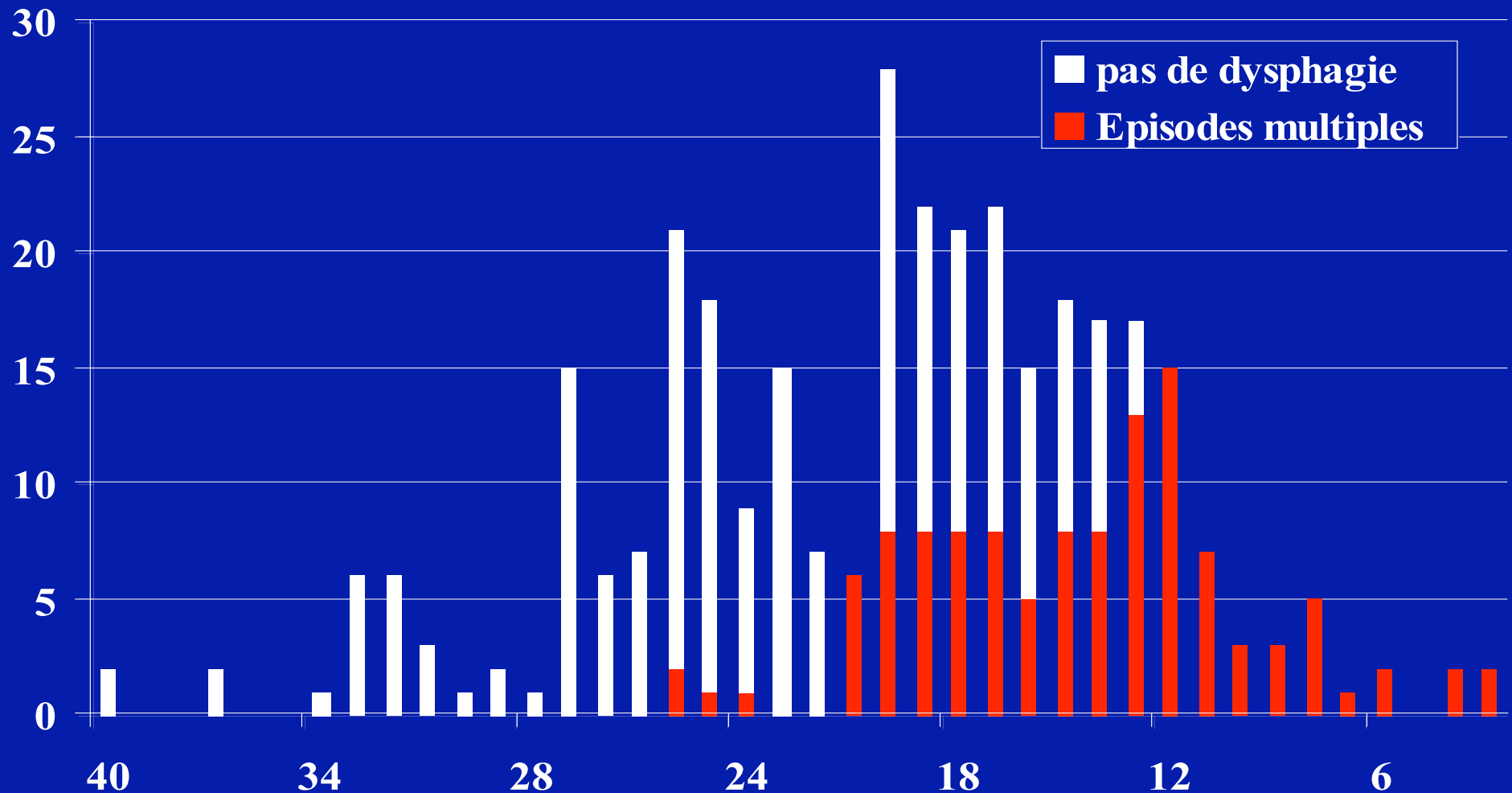


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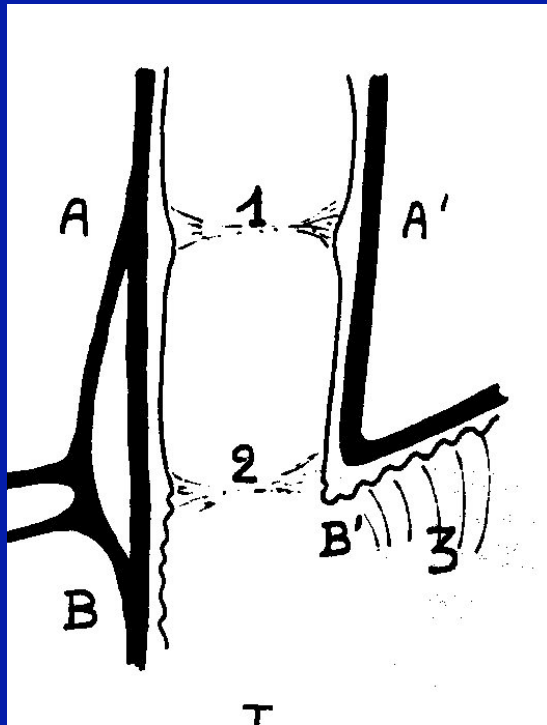
Anneaux de SCHATZKI

relation diamètre et dysphagie

Schatzki R 1963



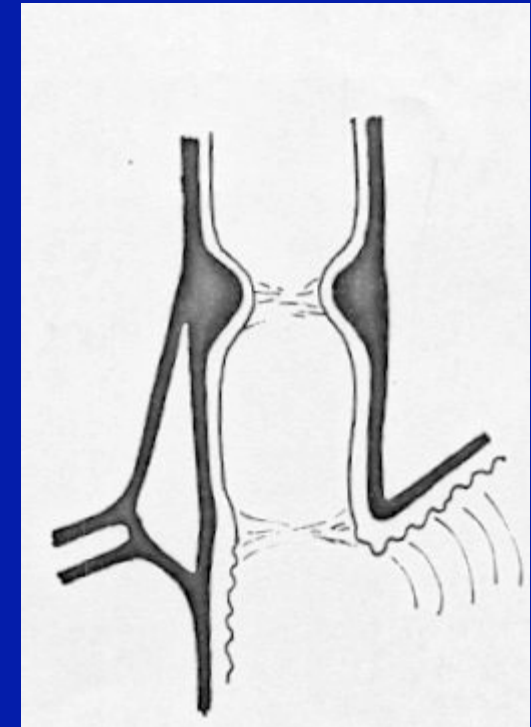
Anneaux du bas oesophage



**Anatomie
normale**

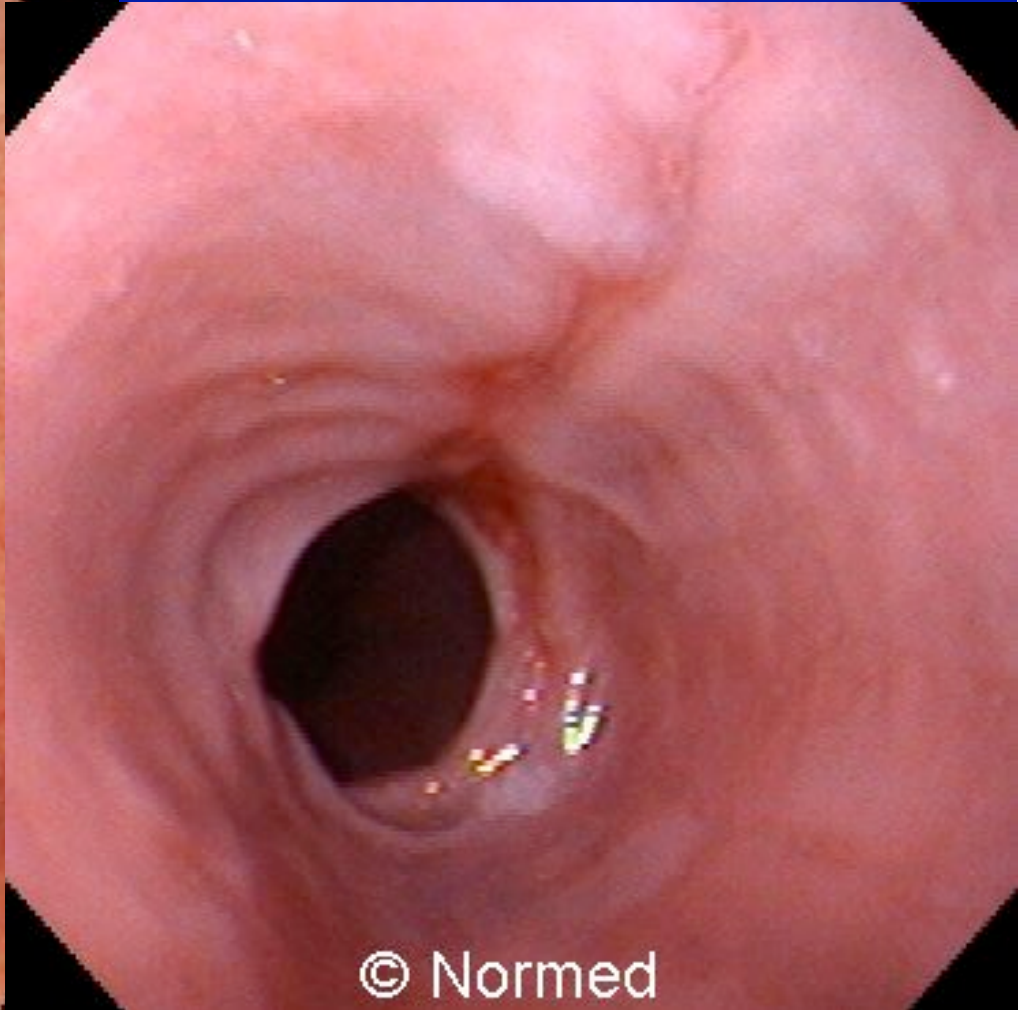
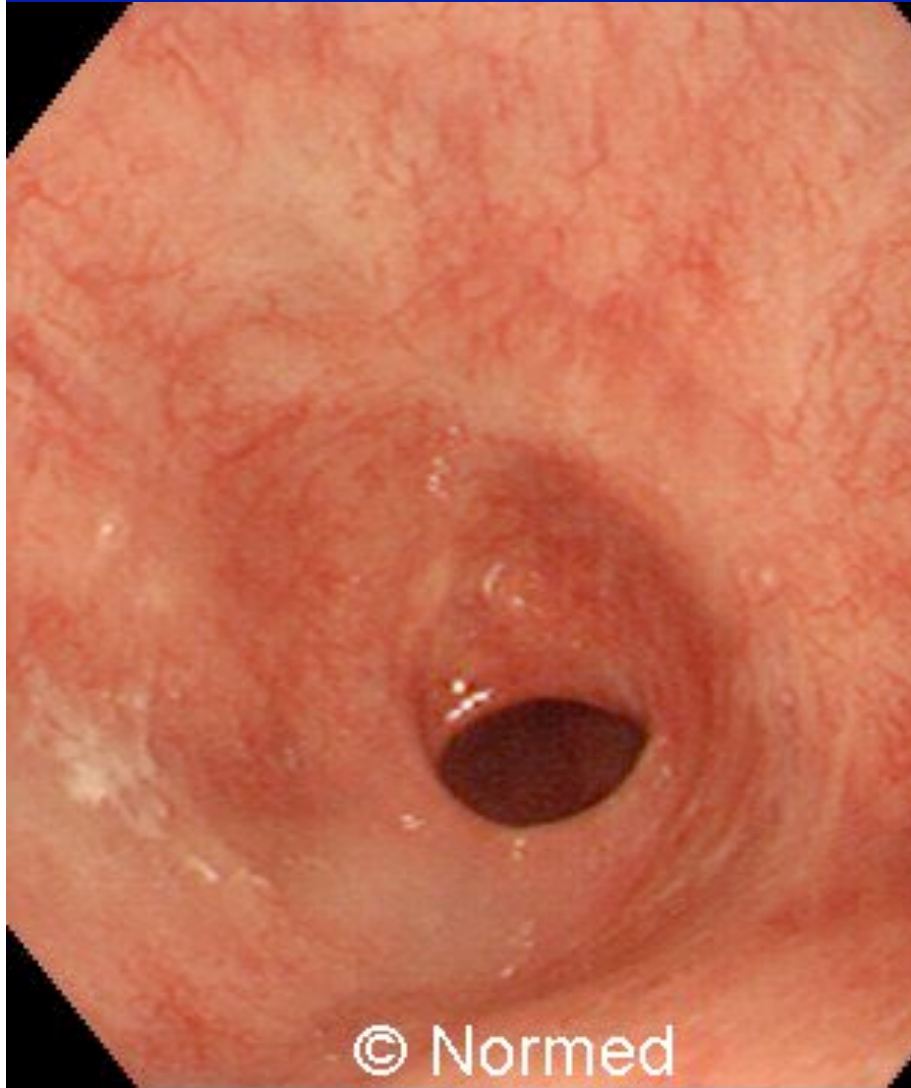


**Anneau
de Schatzki**



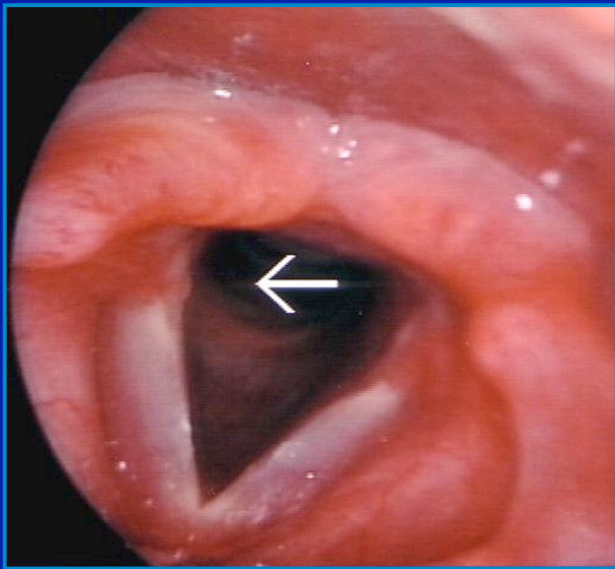
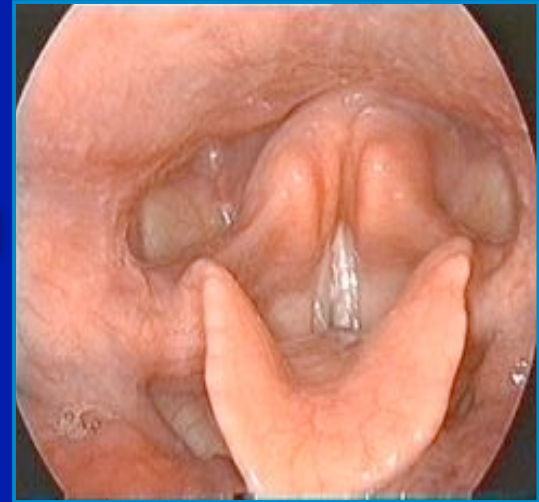
**Anneau
musculaire**

Sténose peptique annulaire

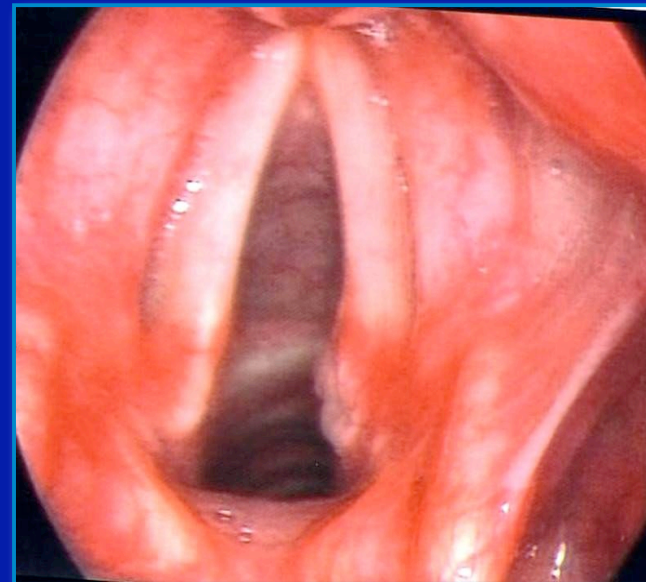


**RGO :
Lésion ORL associée**

•Larynx normal



Laryngite inflammatoire
postérieure



Laryngite inflammatoire postérieure
Granulome postérieur

L'ENDO BRACHYOEESOPHAGE

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
 - cardial
 - **spécialisé intestinal**

Endobrachyœsophage (2) : évolution de la définition

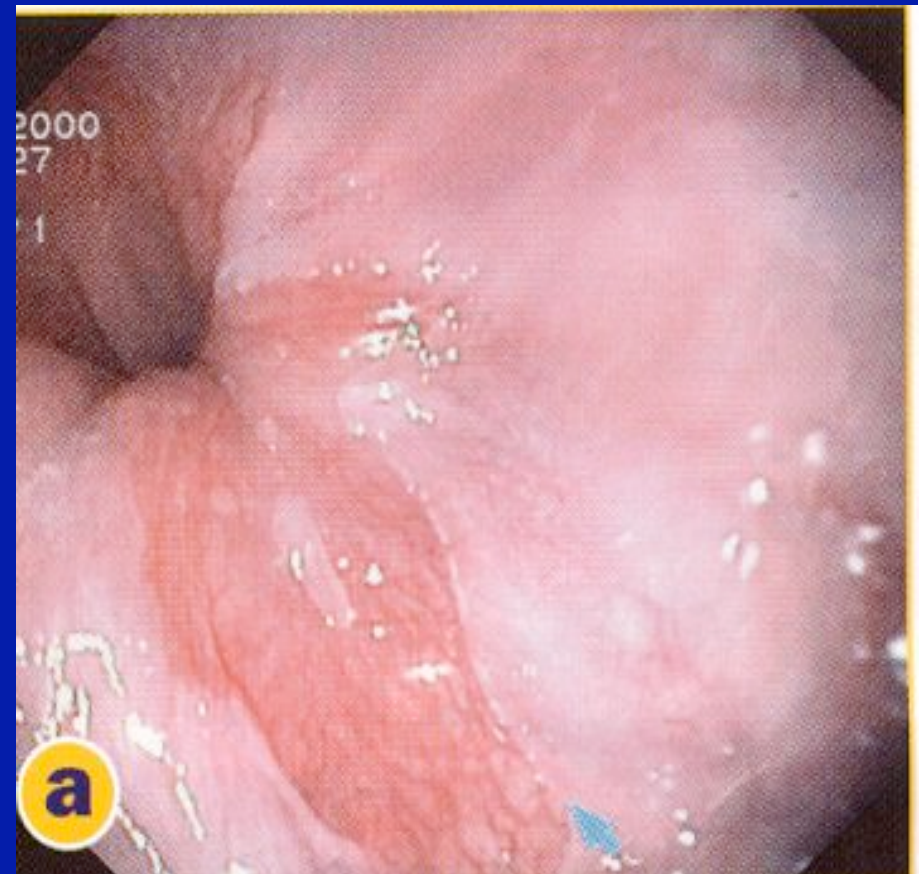
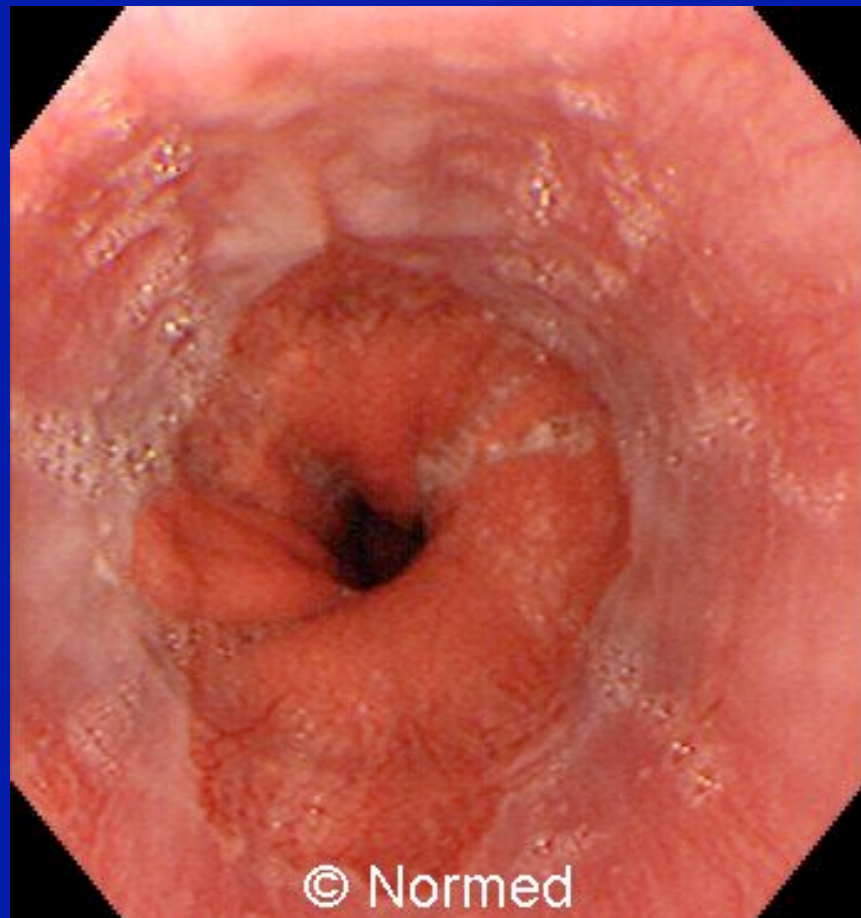
- Longueur circonférentielle ≥ 3 cm (définition classique) :
→ œsophage de Barrett long
- Notion d'œsophage de Barrett court (1994) :
longueur < 3 cm
- Biopsies +++ :
- La métaplasie intestinale très limitée de la jonction œso-gastrique (endobrachyœsophage ultra-court) est très fréquente (30 % des prélèvements)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

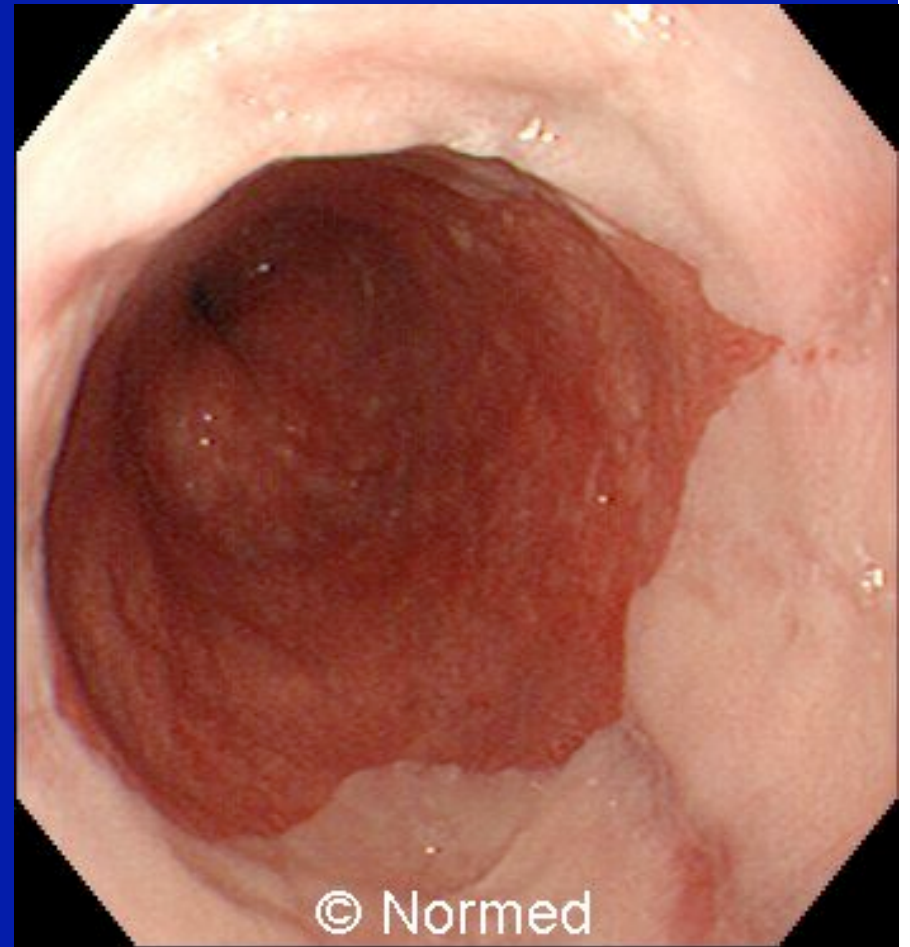
Prévalence de l'EBO

1% de la population générale

10% des malades avec symptômes de RGO

Endobrachyoesophage court





EBO long (> 3 cm)

Endobrachyoesophage court

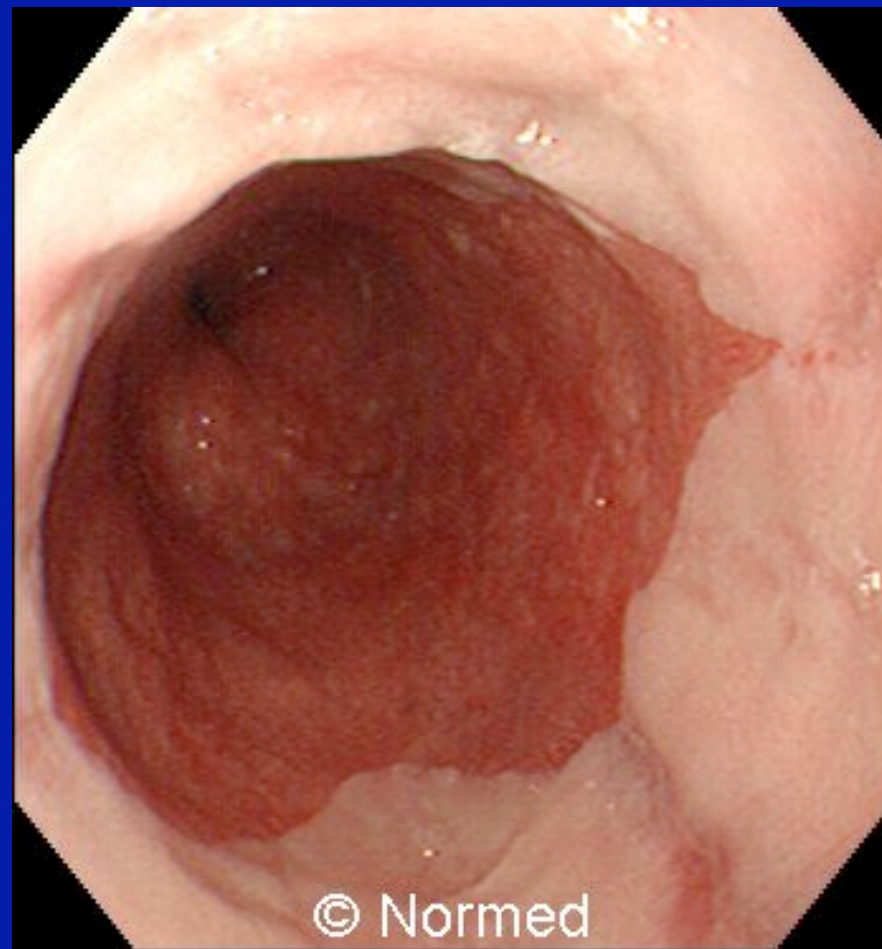


EBO court (< 3 cm)



EBO ultra-court*

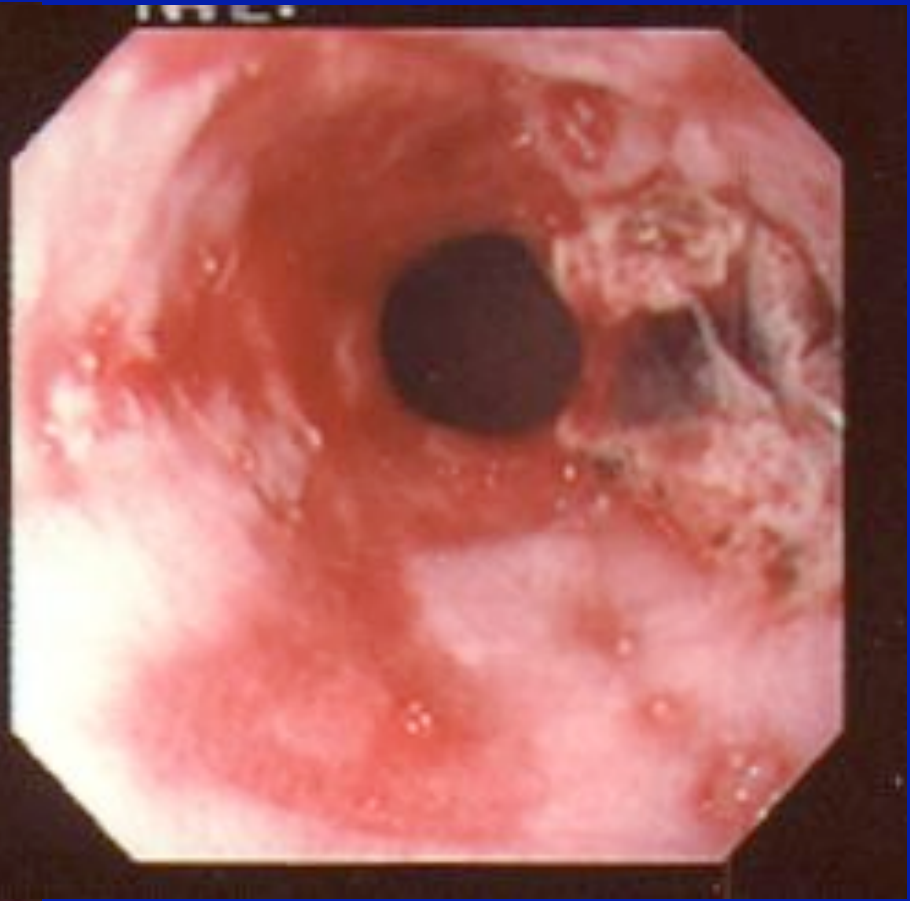
**La détection de l'endobrachyœsophage est
le plus souvent aisée en vidéo-endoscopie**



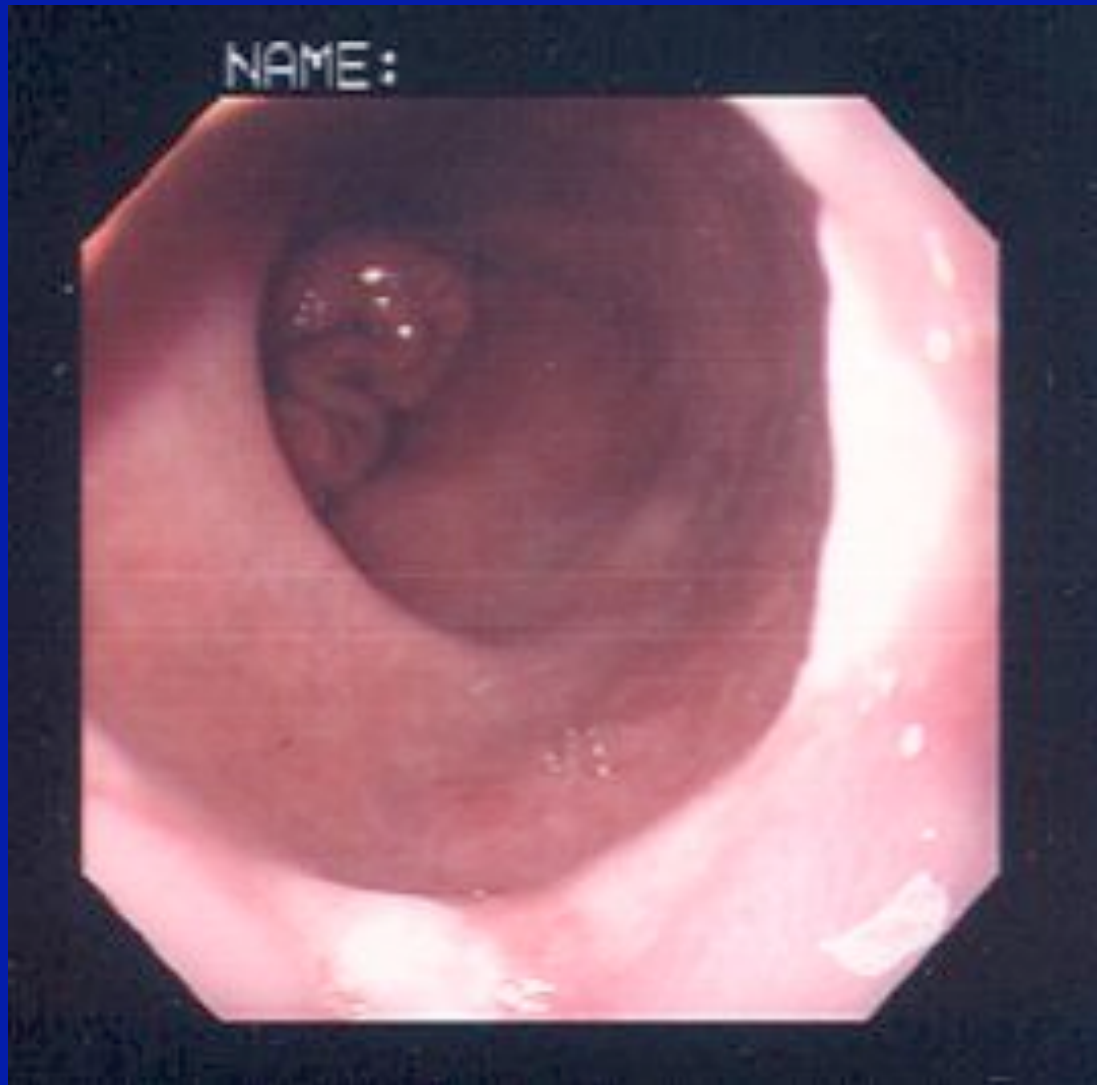
EBO long (> 3 cm)

Œsophage de Barrett long





EVALUER LA HAUTEUR DE L'EBO



ID. NO:
SEX: AGE:
D.O. BIRTH:

05/05/00
10:37:12

NAME:

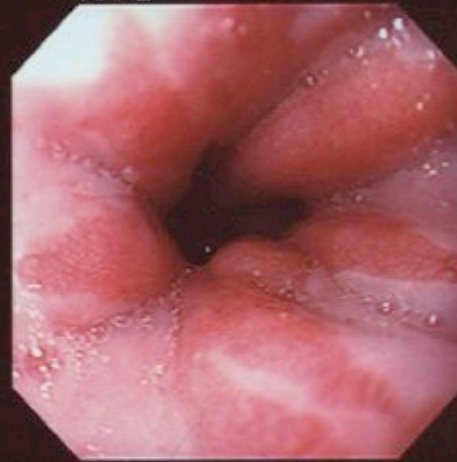


COMMENT:

ID. NO:
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D.O. BIRTH:

05/05/00
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NAME:

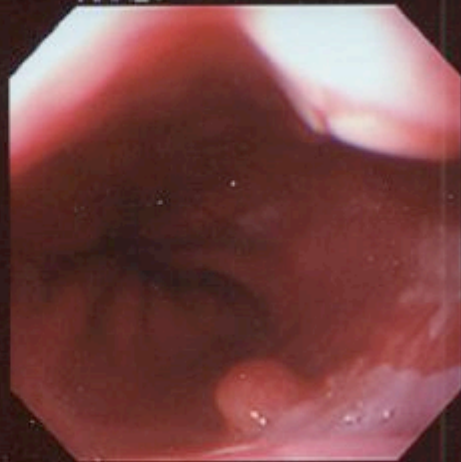


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NAME:



COMMENT:

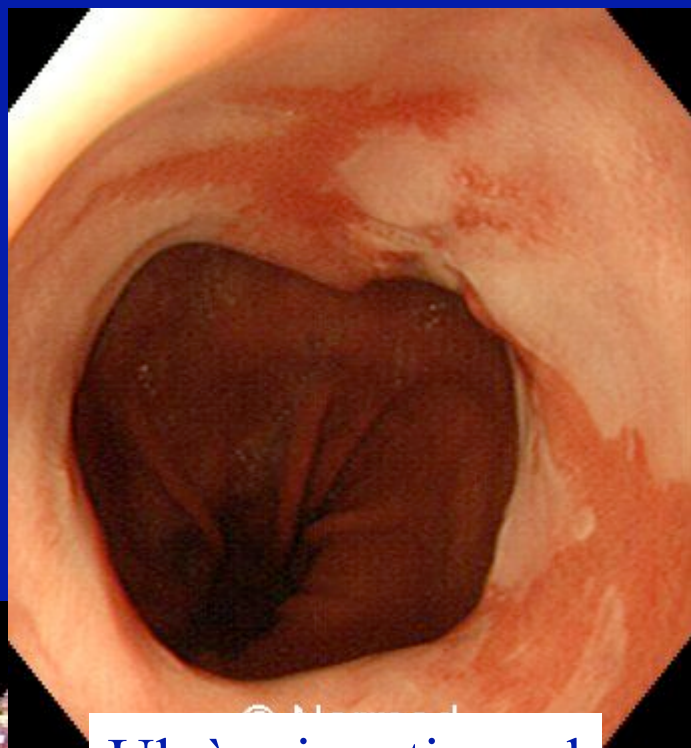
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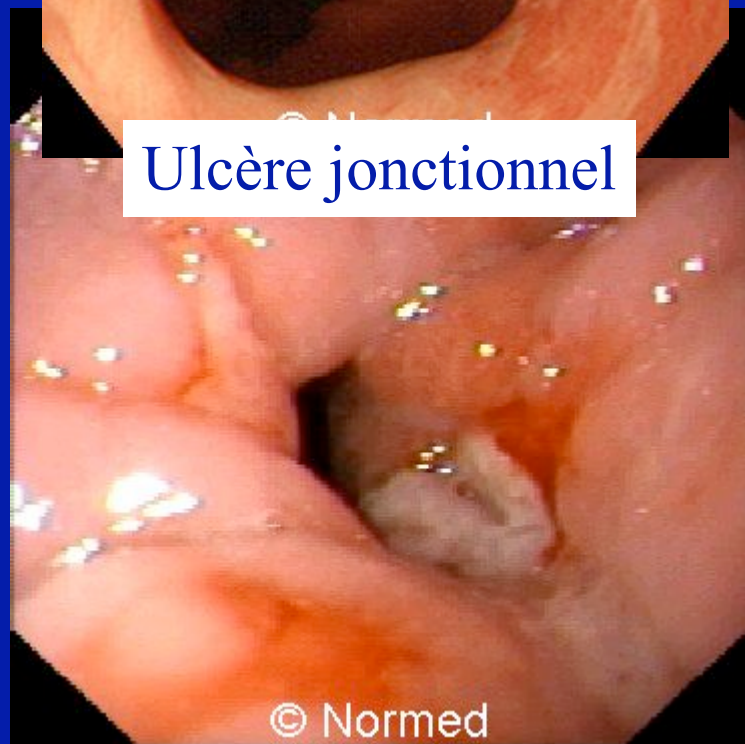
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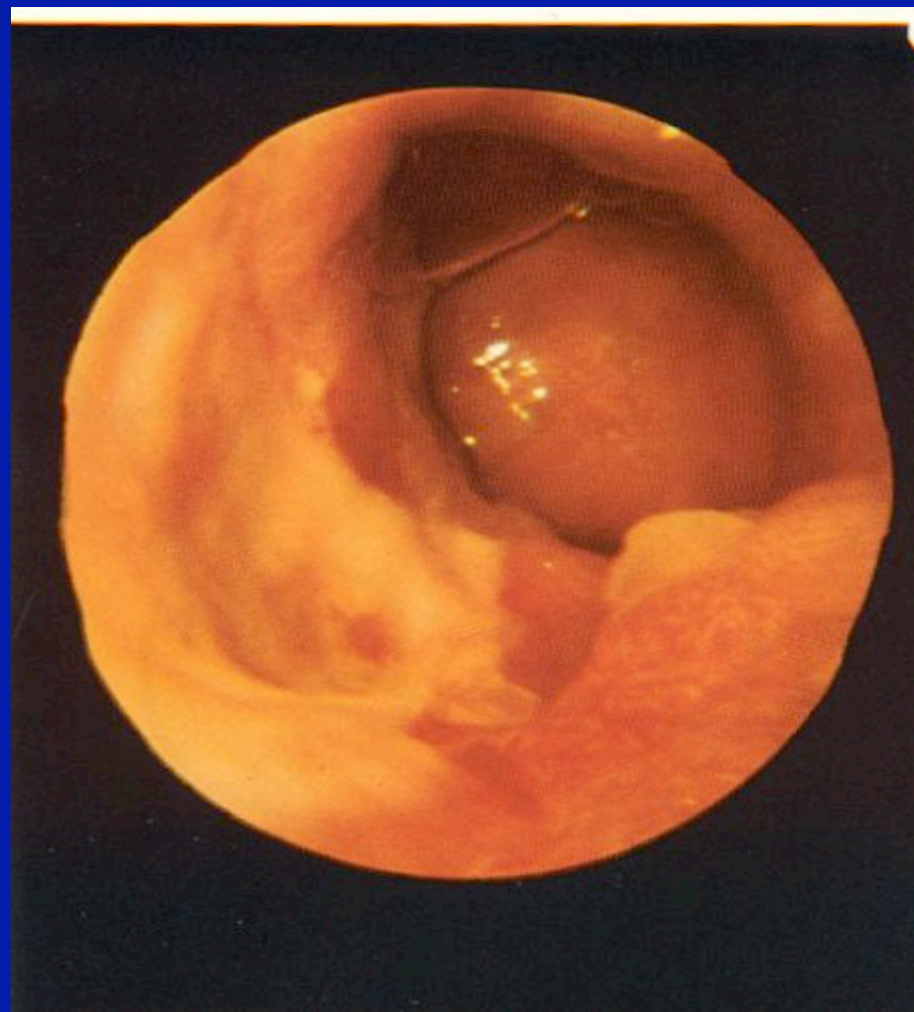
COMMENT:



Ulcère jonctionnel

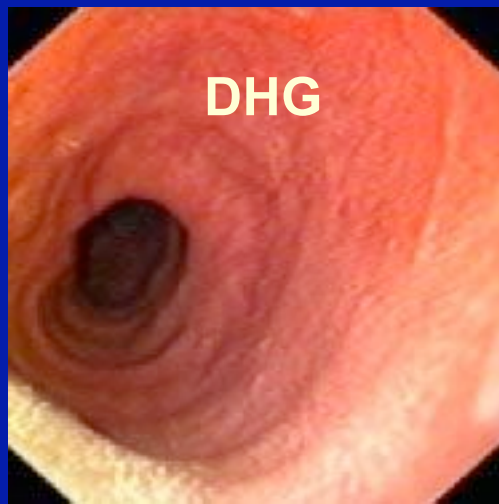


© Normed



Ulcère de Barrett

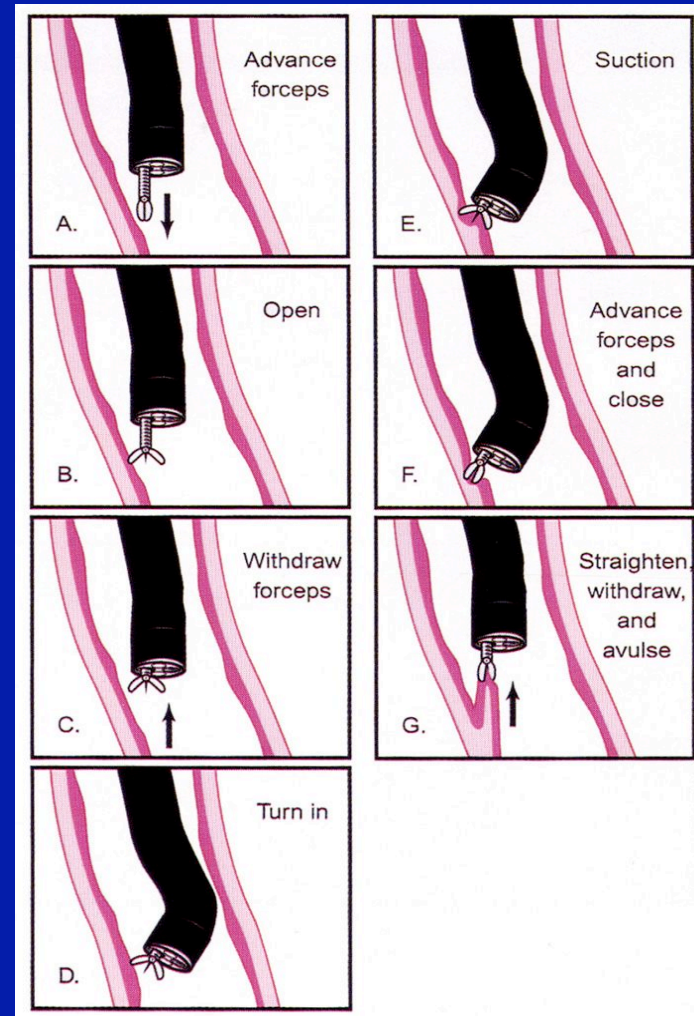
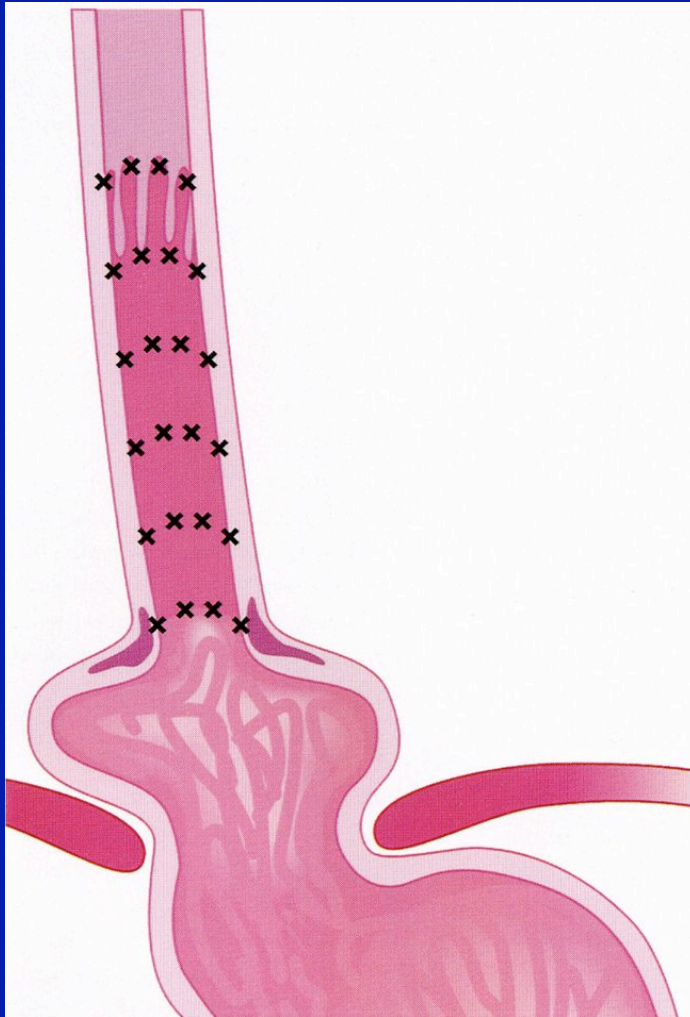
EBO : évolution vers dysplasie et adéno K



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)

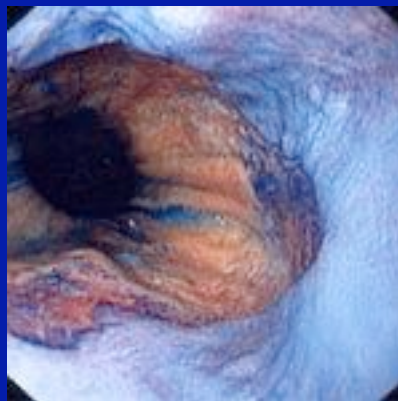
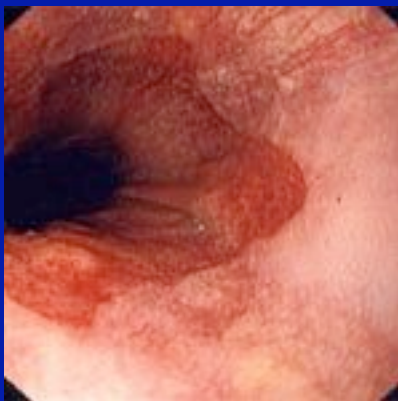
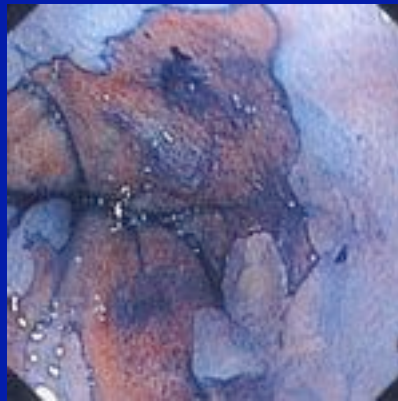
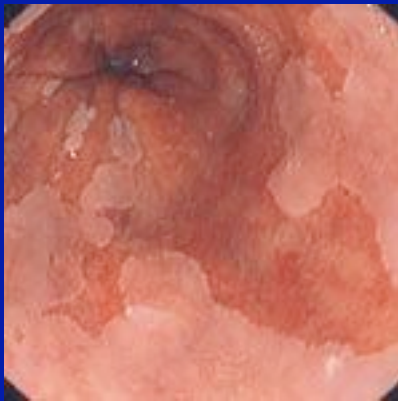
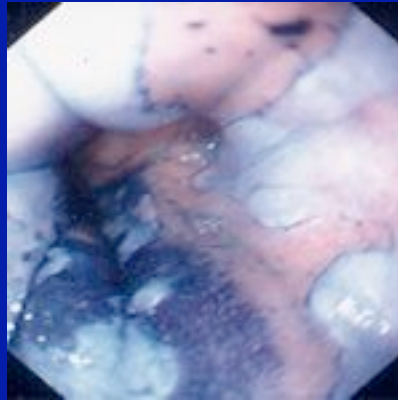
Coloration au bleu de méthylène (1)

- 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)

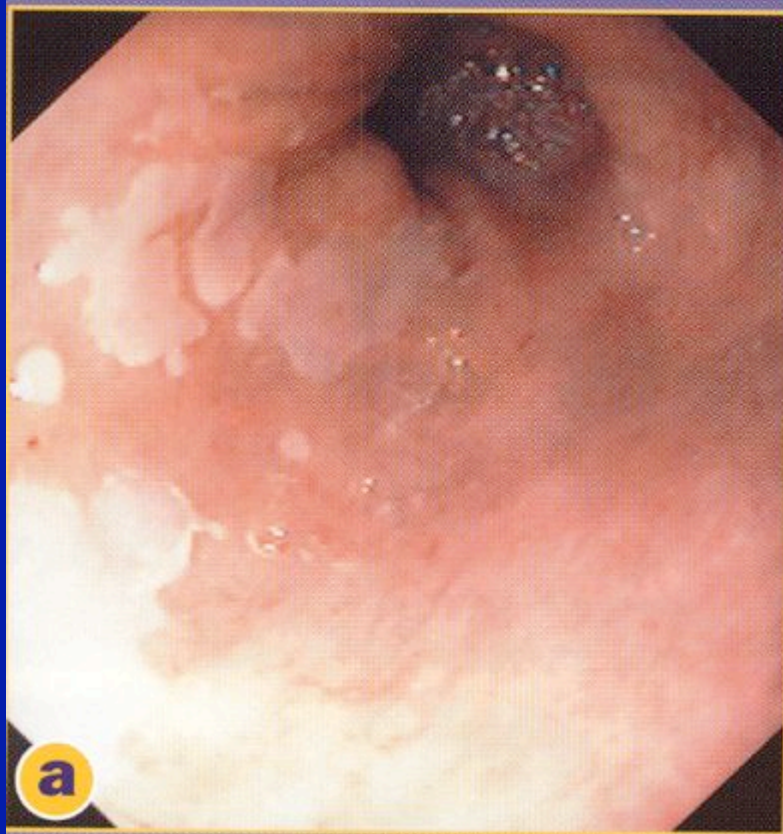
Coloration au bleu de méthylène (2)

- 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 %



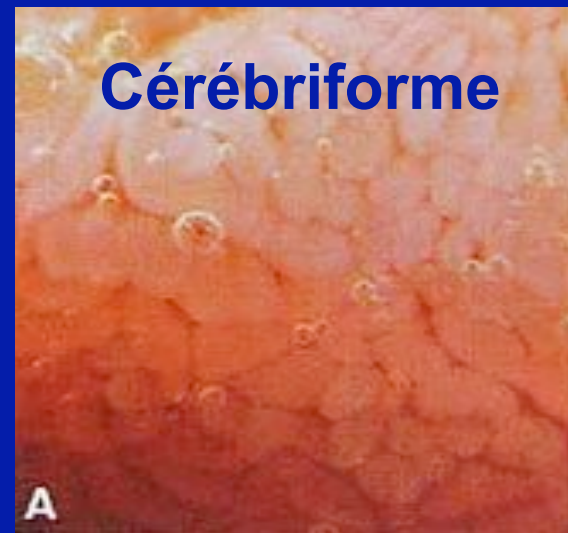
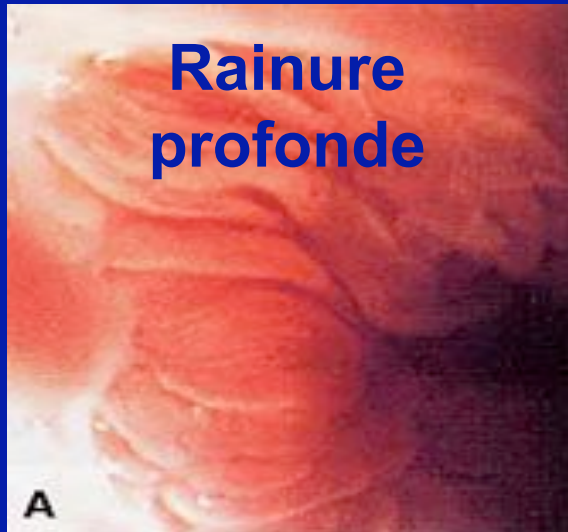
Endobrachyœsophage (6)

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

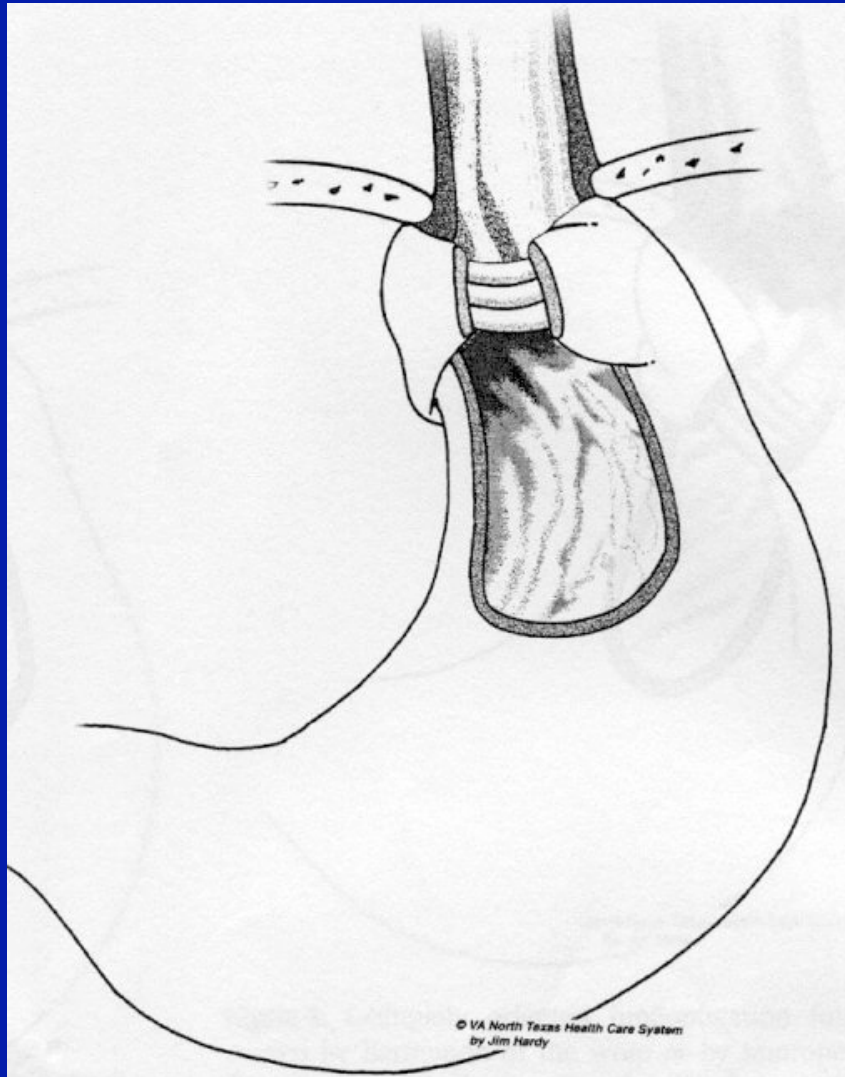
Biopsies multiples aveugles

Biospsies orientées par :

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

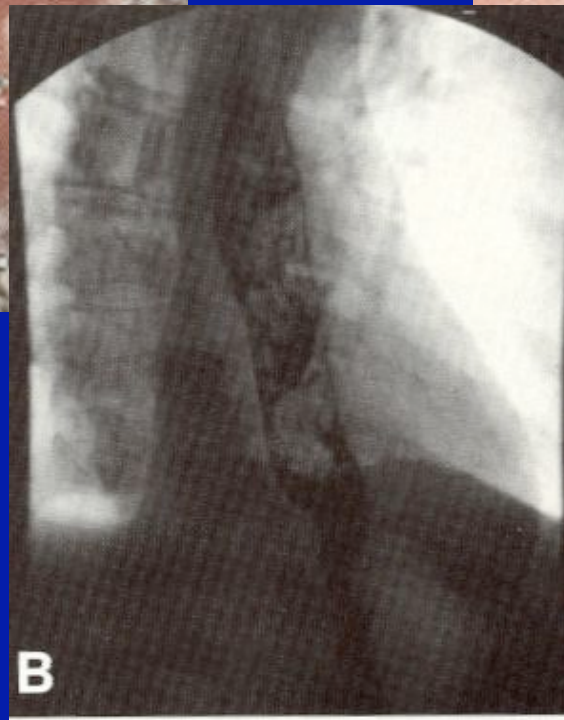
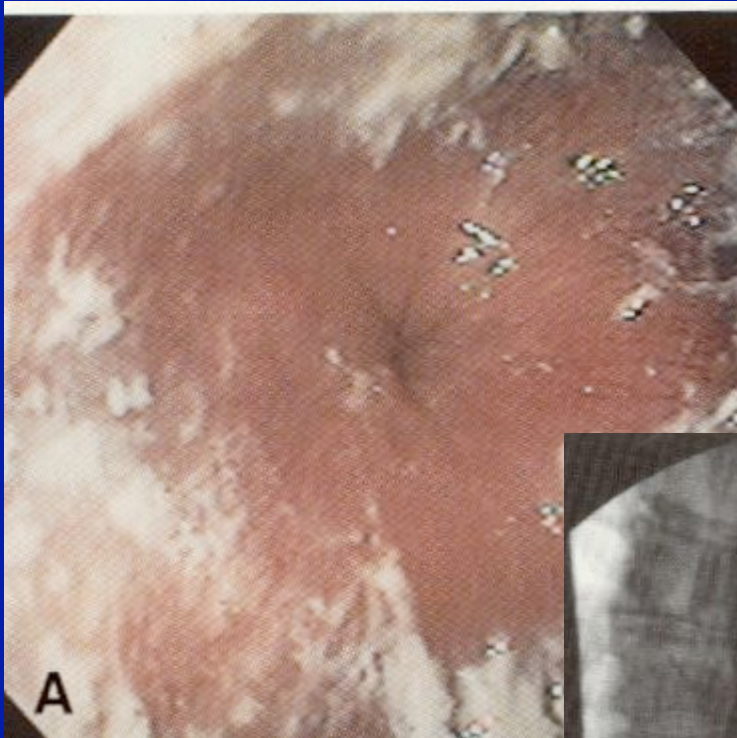
Valve antireflux normale

Aspect endoscopique

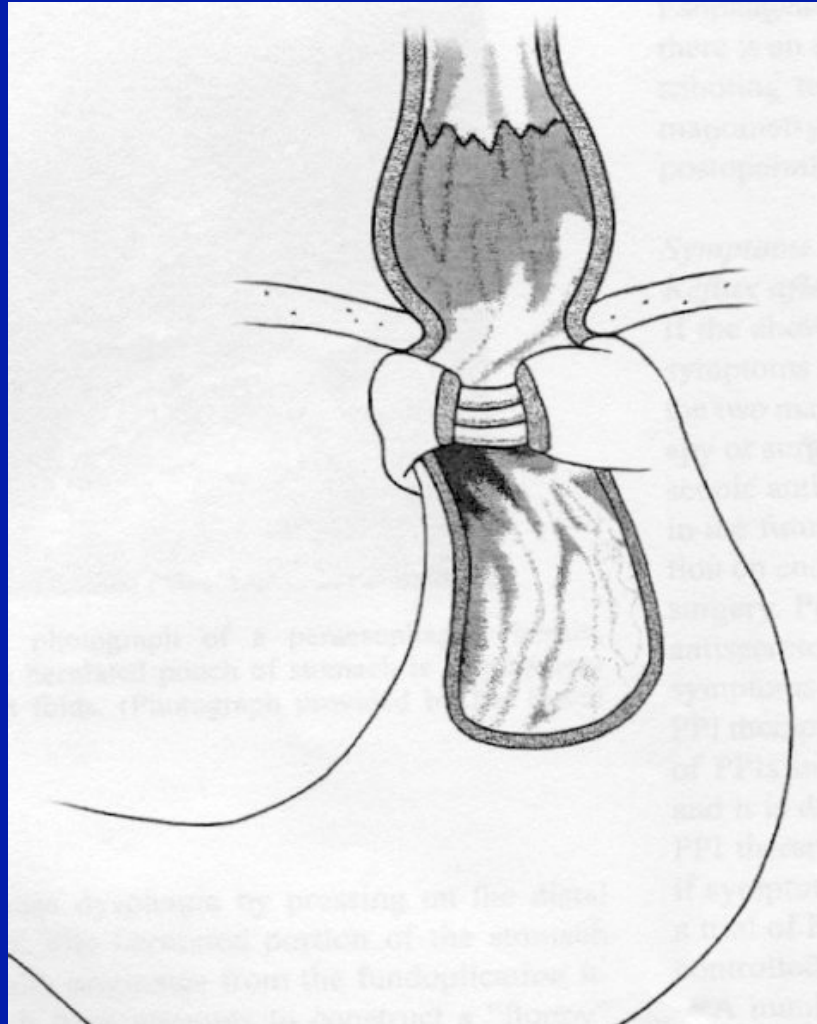


Dysphagie prolongée post-fundoplication

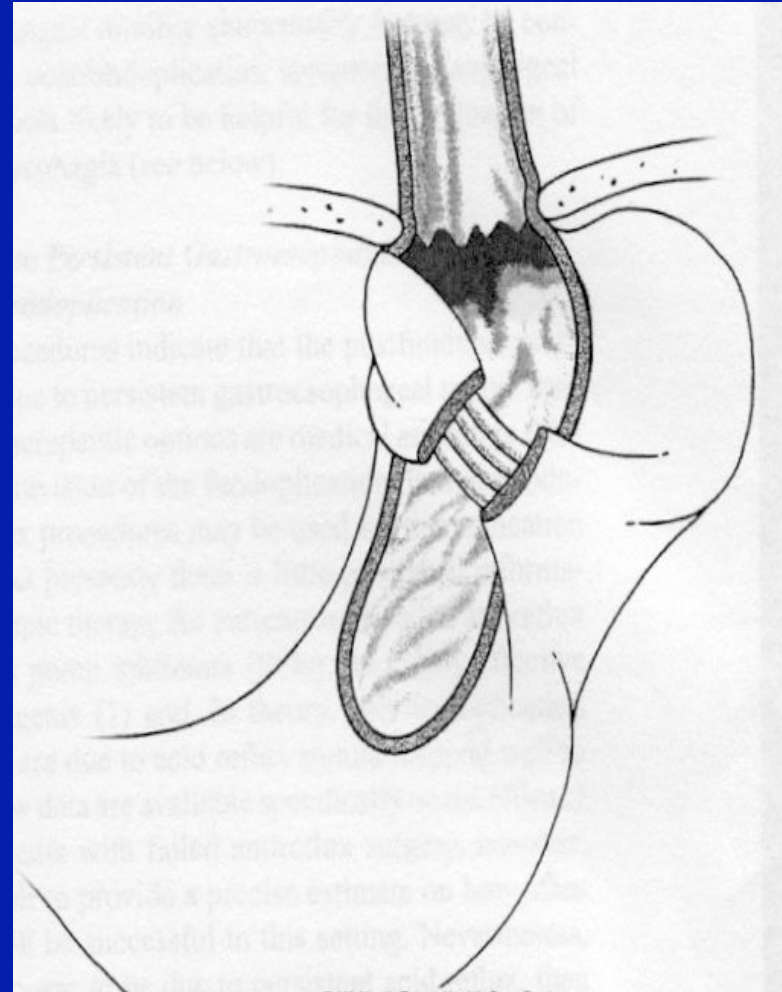
Valve trop serrée-trop longue



Ascension intrathoracique



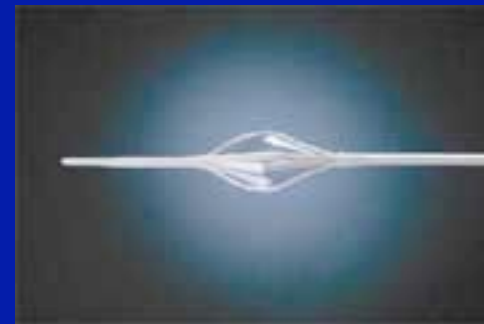
Glissement de la valve



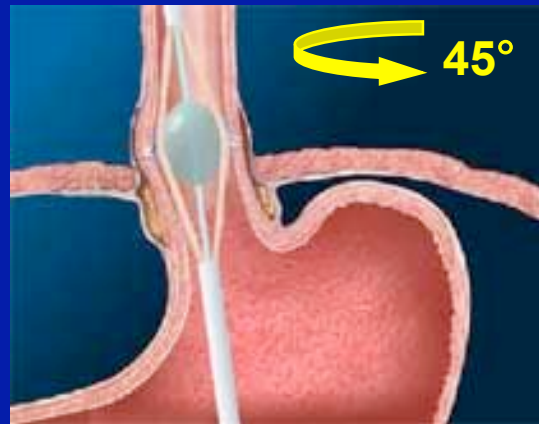
TRAITEMENT ENDOSCOPIQUE DU RGO

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

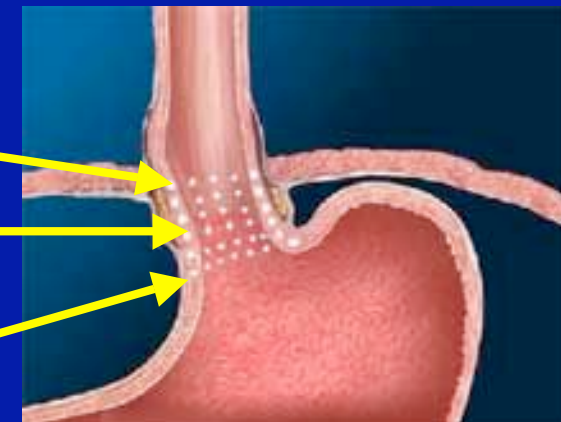


4 niveaux antérogrades

1 cm au-dessus ligne Z

0,5 cm sous ligne Z

2 sites au niveau cardia
(en traction)



Hyperthermie : technique (3)

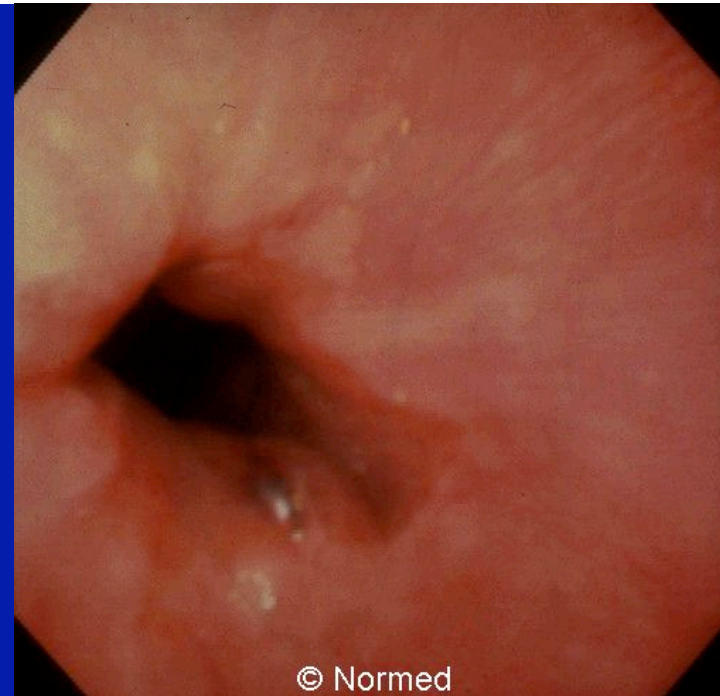
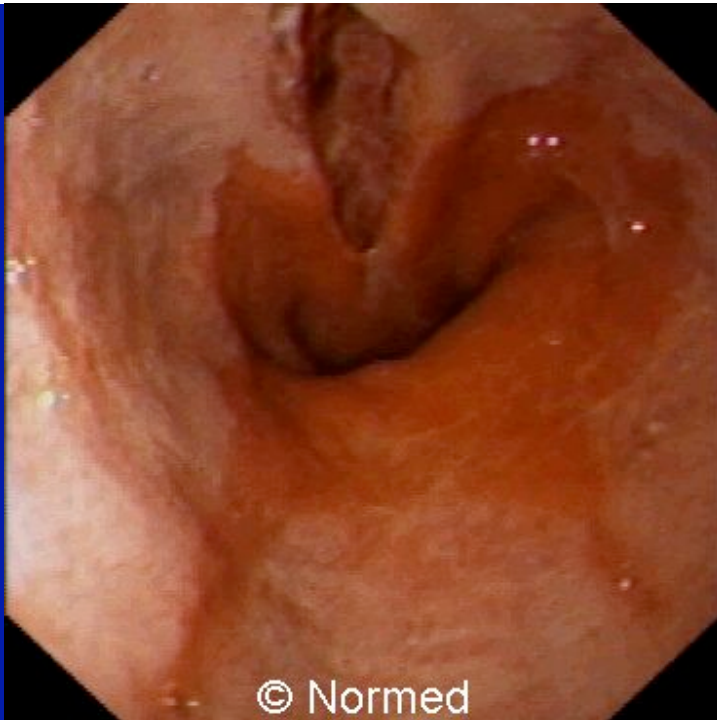
Cardia pré- and post-Stretta



Oesophage distal post-Stretta

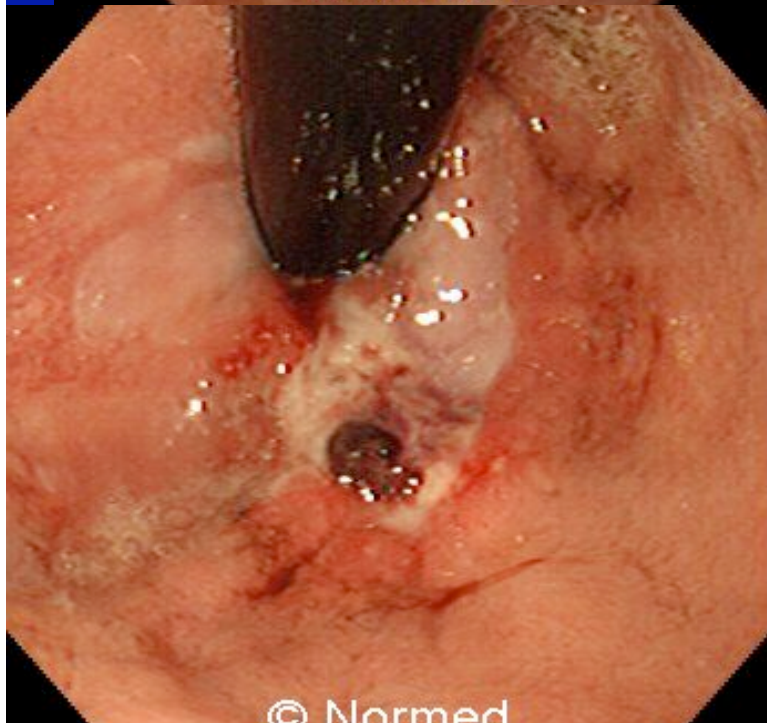


LESIONS OESOCARDIALES NON LIEES AU RGO

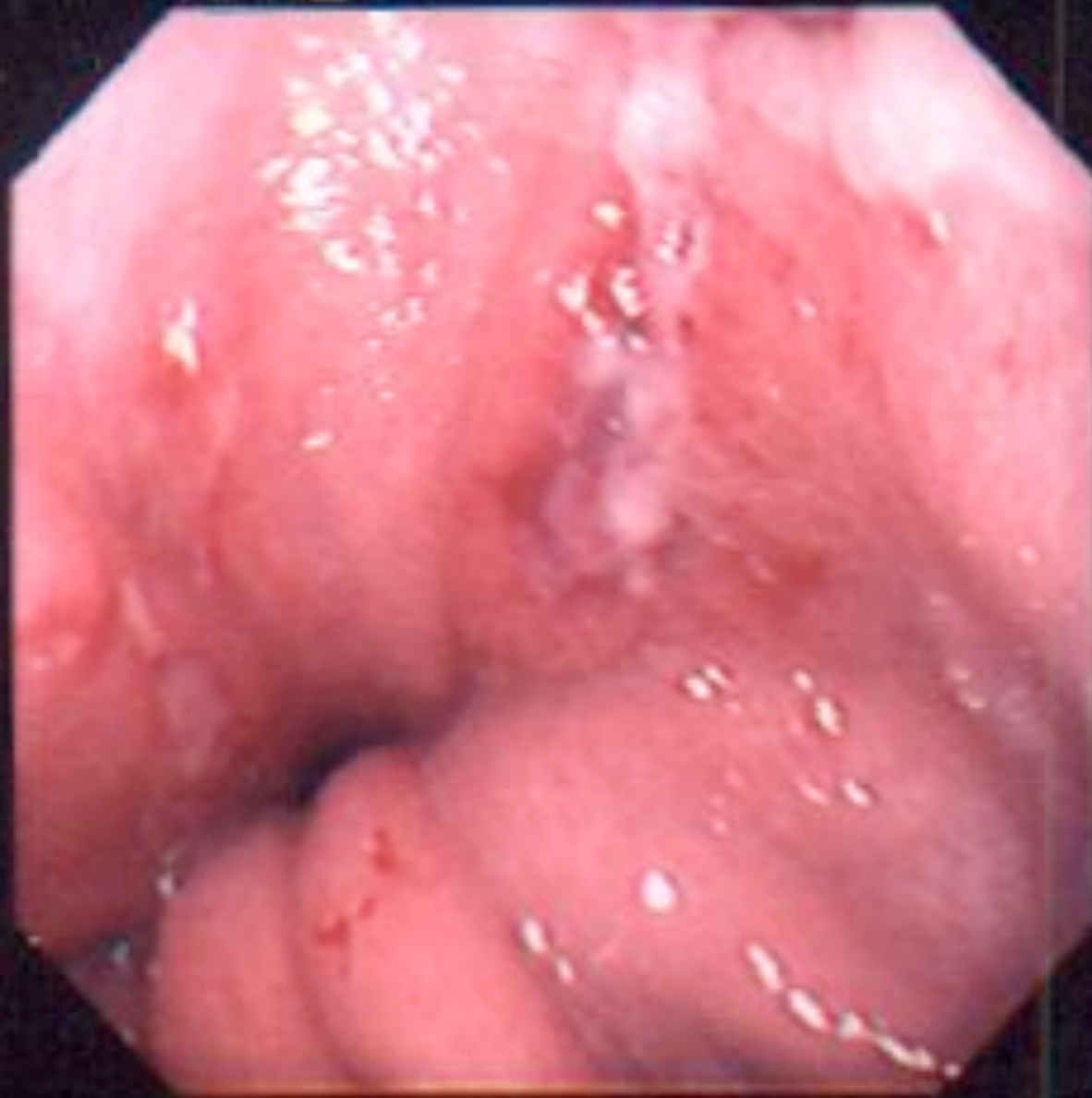


Mallory Weiss

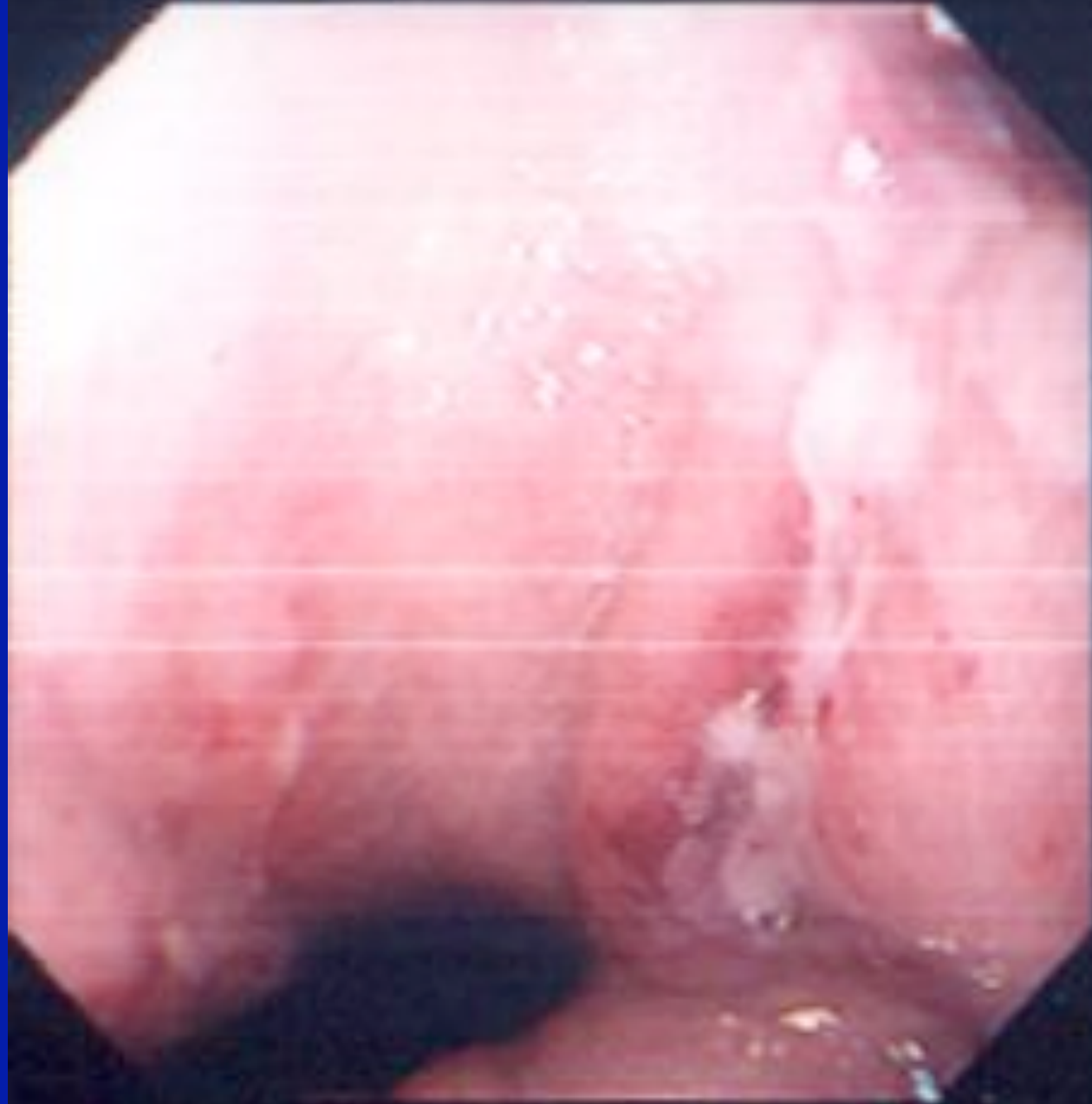
Fissuration longitudinale 5 à 20mm
de long
à cheval sur la jonction muqueuse

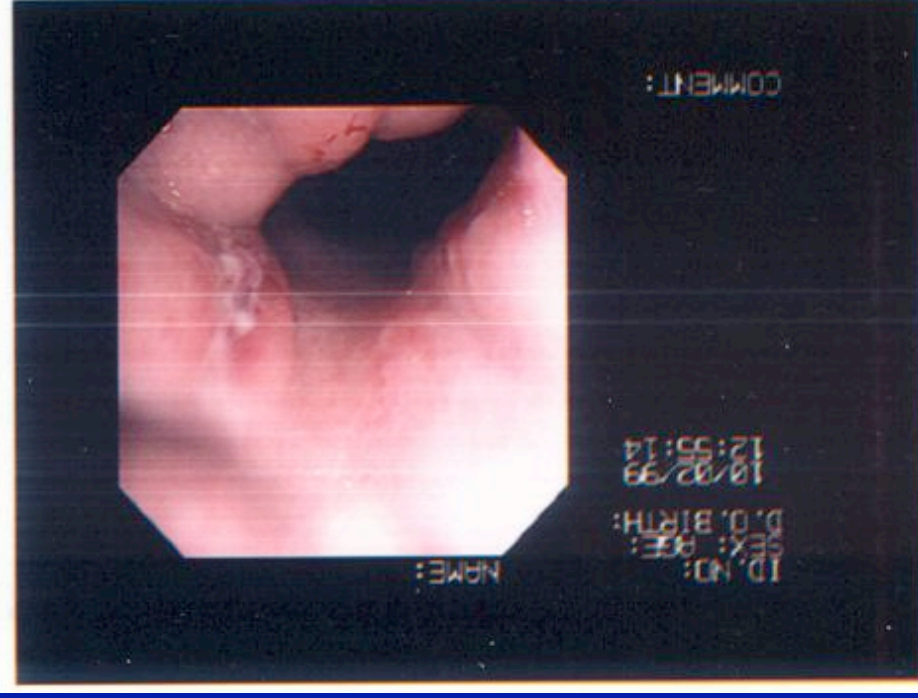
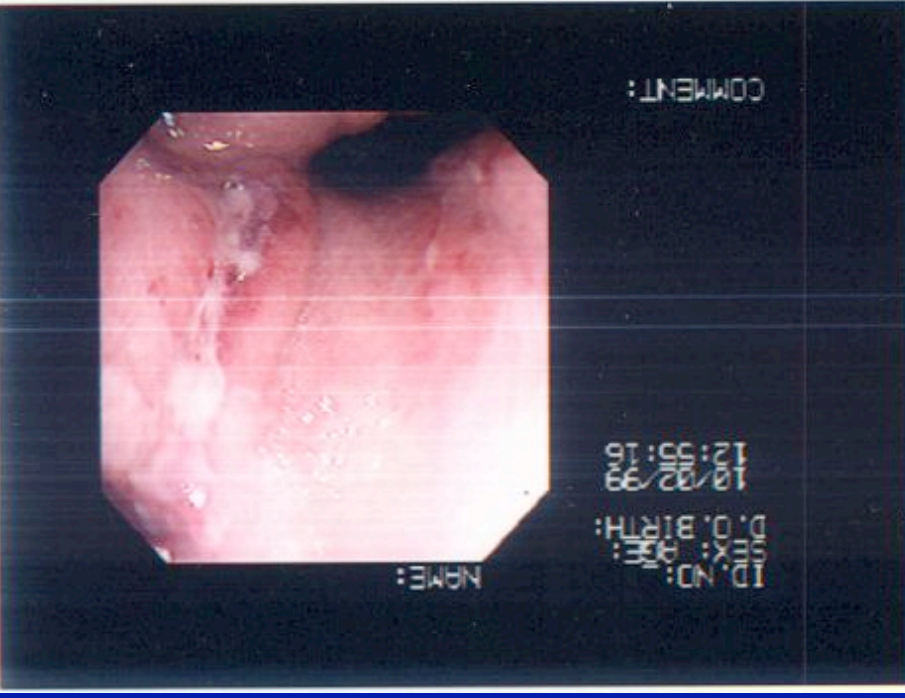
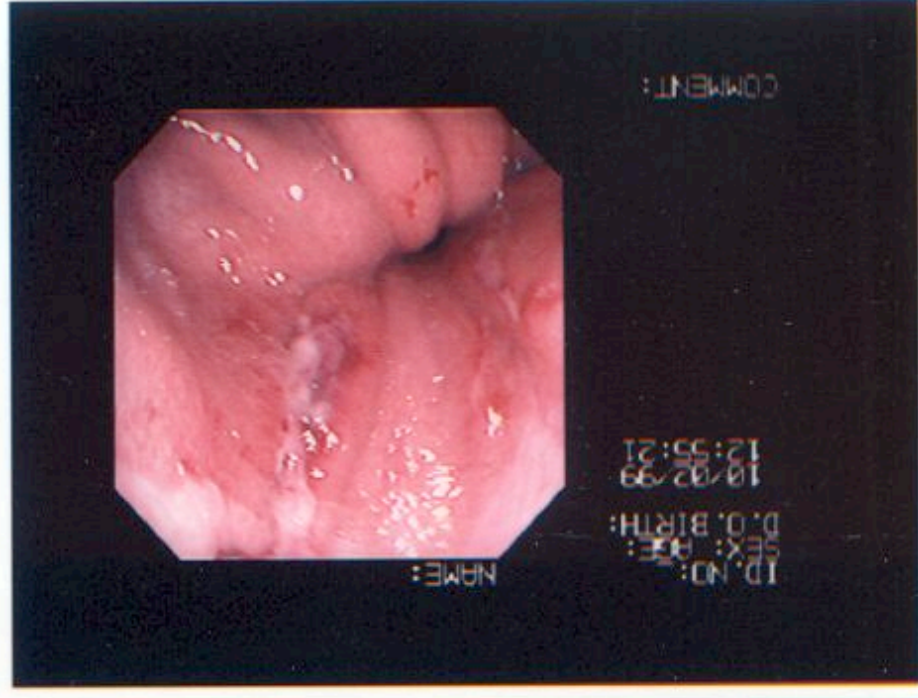
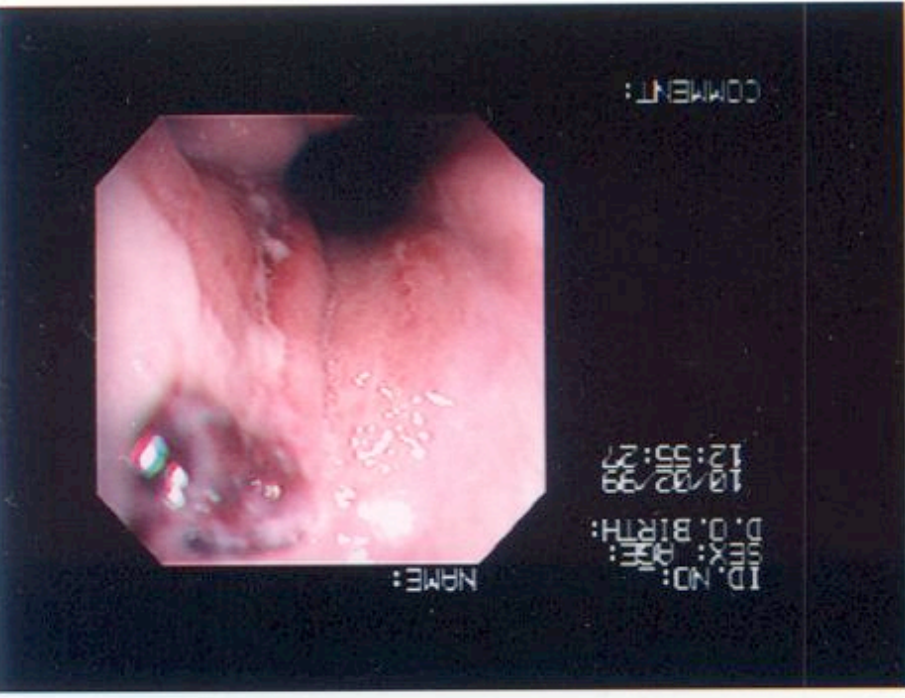


NAME:



NAME:





PROLAPSUS GASTRO-OESOPHAGIEN

