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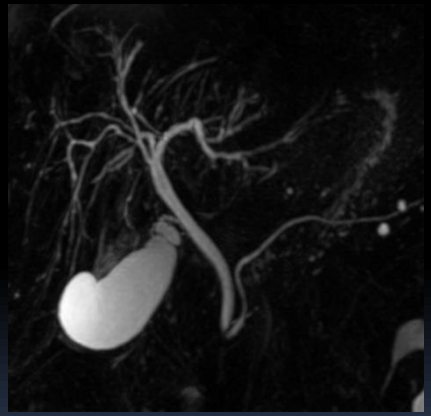
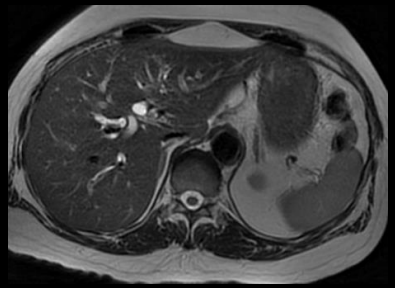
LESIONES SEGMENTARIAS DE LA VÍA BILIAR

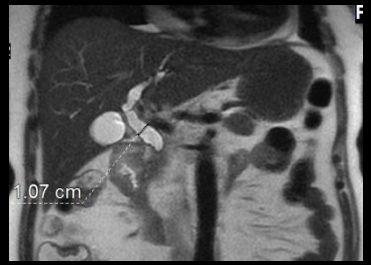
Estudio de la vía biliar

Secuencia principal COLANGIO-RM
Reconstrucción MIP, 3D, VR

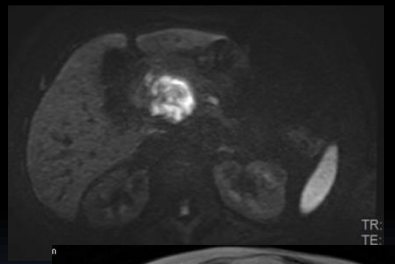


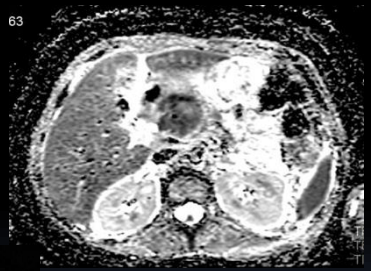
Estudio morfológico secuencia T2

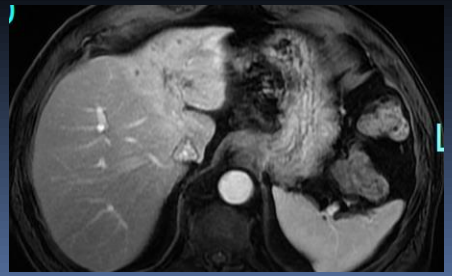


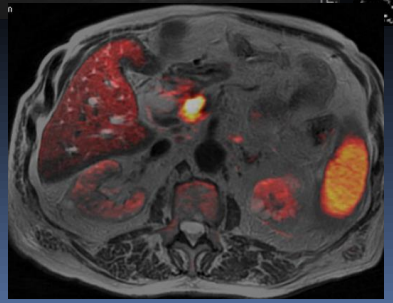


Estudio de difusión/mapa ADC









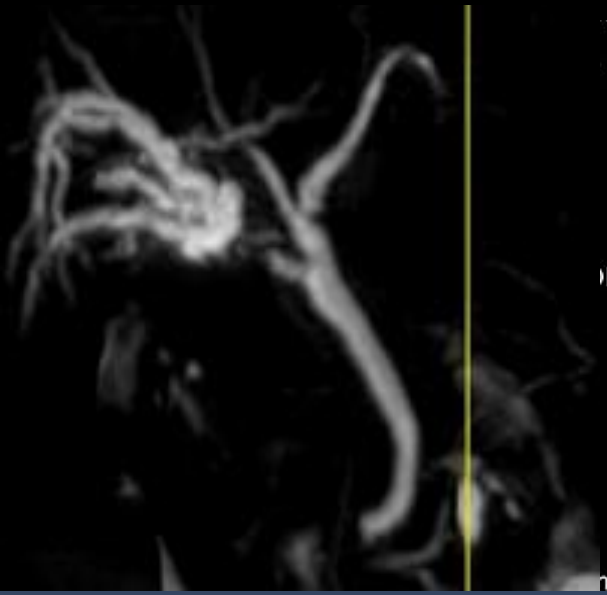
Estudio de perfusión

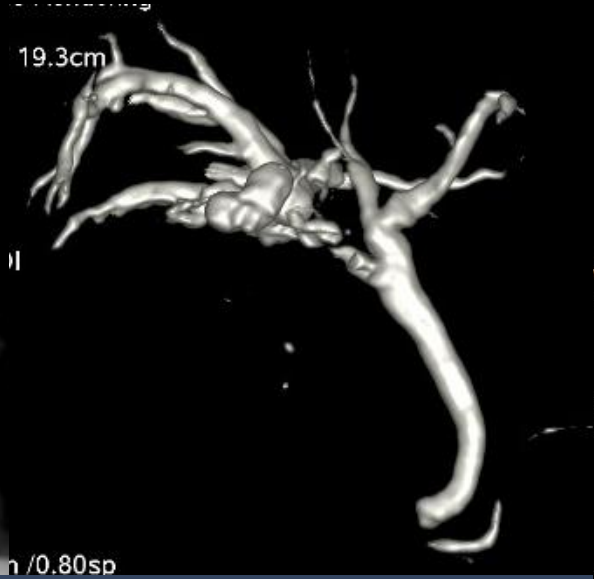
Diagnostico diferencial lesiones segmentarias de la vía biliar.

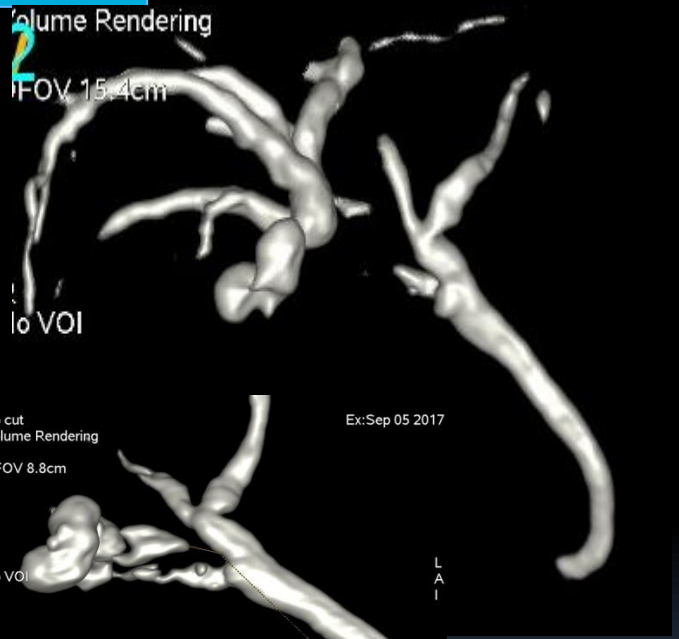
- Tumoral
- Inflamatoria/Infecciosa
- Postquirúrgica

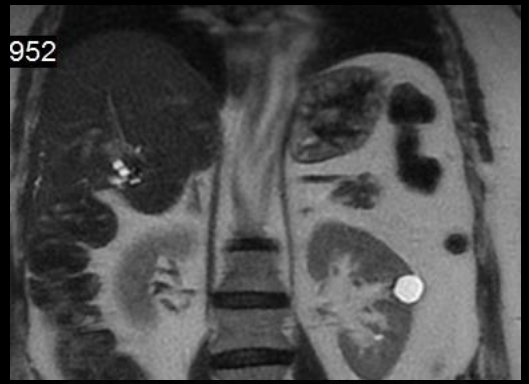
Alteración de Conductos biliares intrahepáticos

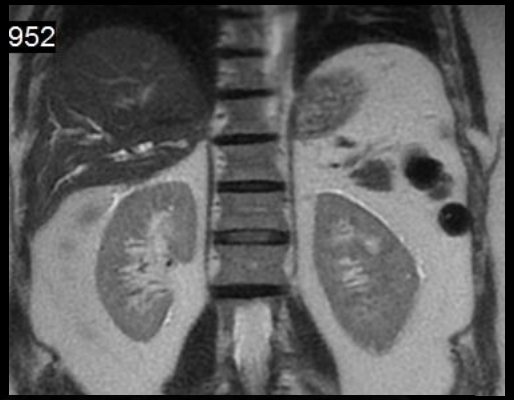
Paciente de 65 años: Colecistectomía por colecistopatía crónica. Presenta una colestasis disociada.

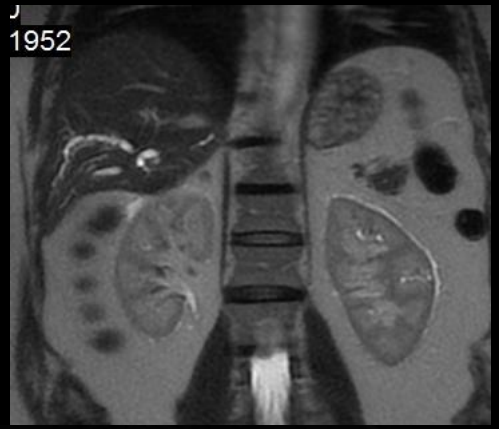


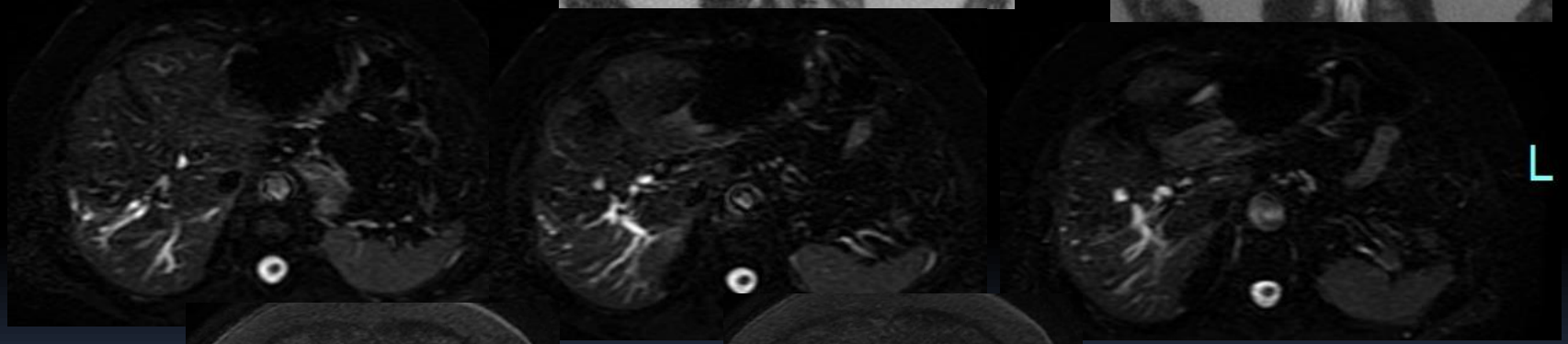


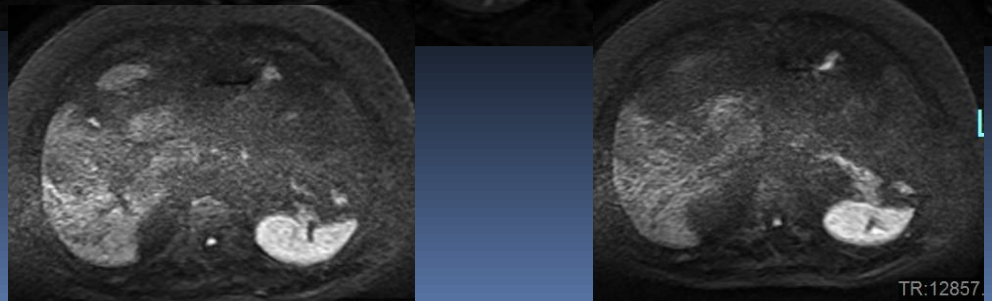






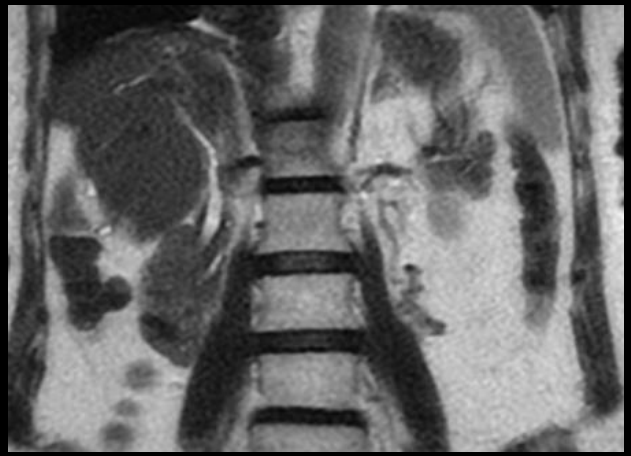
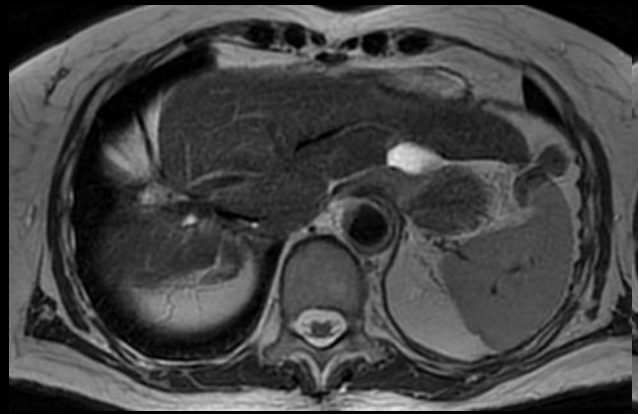
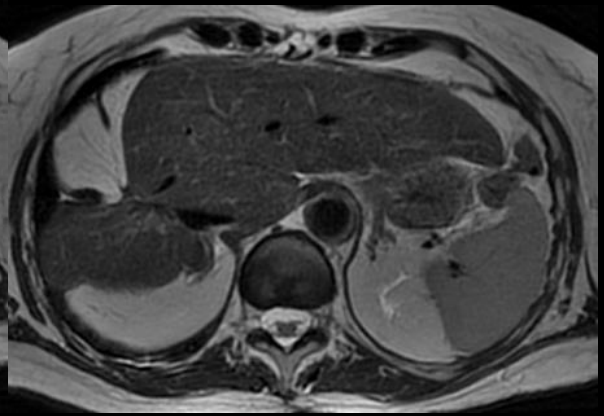
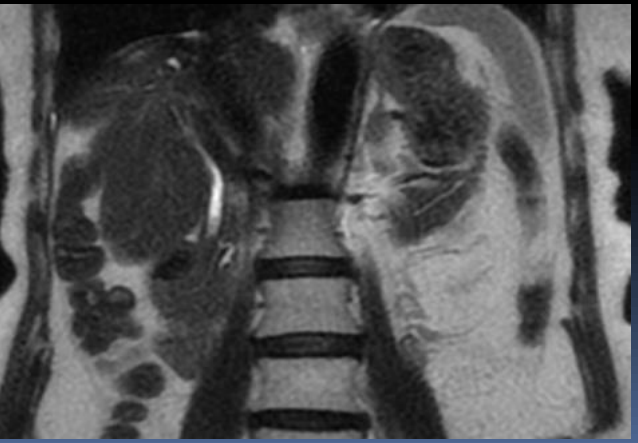
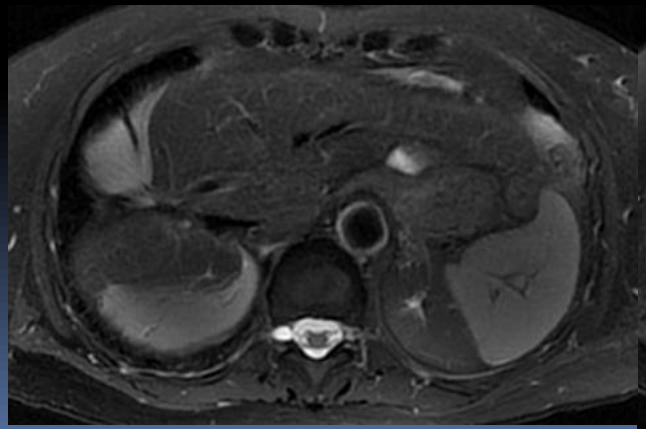
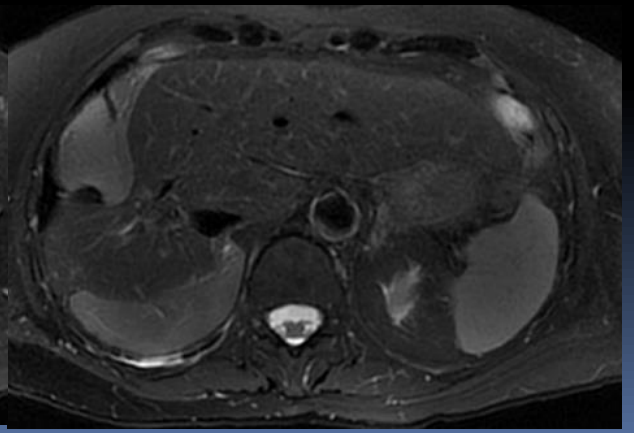


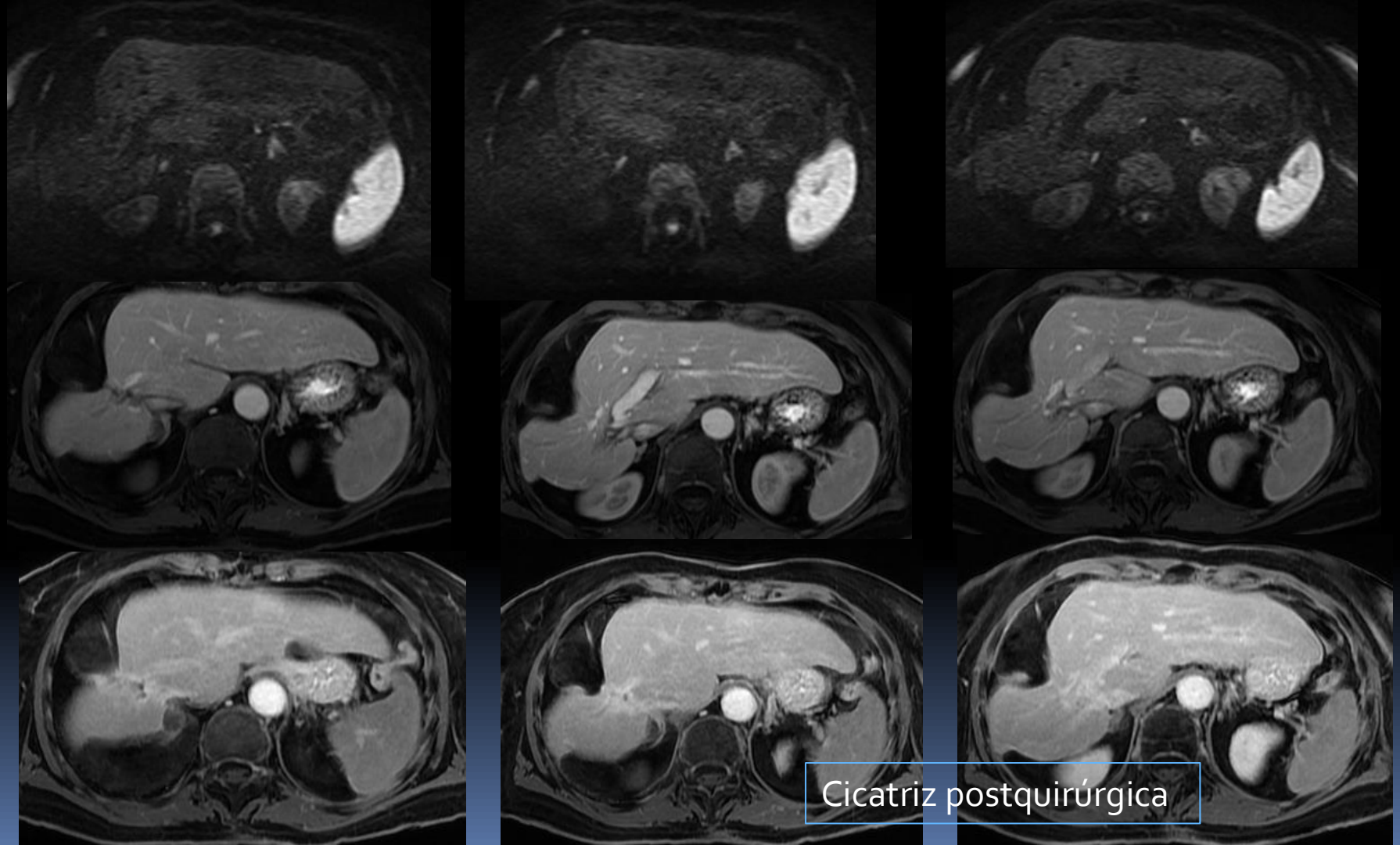




Lesión postquirúrgica de la VB

Paciente de 74 años: Colestasis asintomática.
Antecedente de exéresis de masa quística hepática.

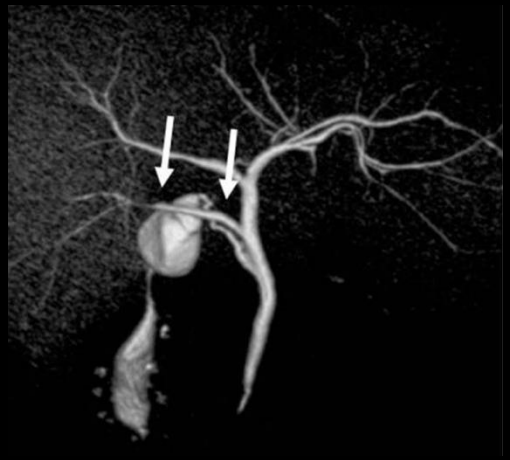







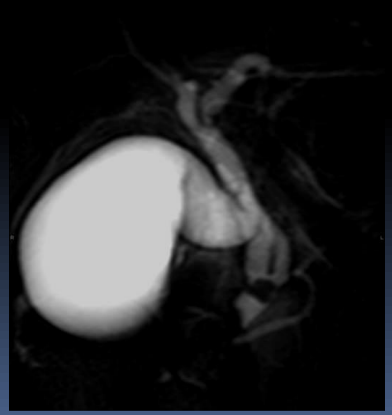

Cicatriz postquirúrgica

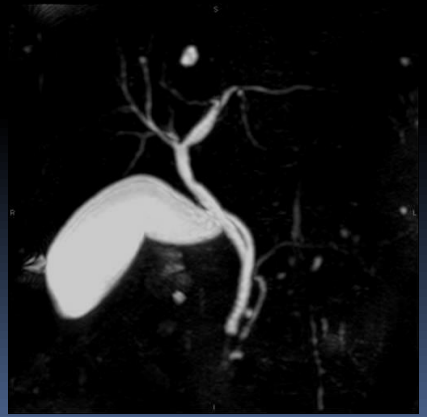
Estenosis quirúrgicas

- Sección parcial o total de la vía biliar principal o de conductos aberrantes que drenan un sector o segmento hepático.
- Incidencia: 0,2-0,7% en colecistectomía abierta. 0,5-0,8% en c. laparoscópicas.
- Mecanismos:
  - Error en la identificación de la anatomía del tracto biliar 70%
  - Daños colaterales: clipado, isquemias de la pared (calor del electrico…)
  - Situaciones de riesgo: colecistitis aguda, gangrenosa, Mirizzi, Vesícula escleroatrófica…

- Las variantes anatómicas de la vía biliar que con más frecuencia pueden crear confusión al cirujano son:
  - **Conducto aberrante** (conducto intrahepático que drena independientemente en la vía biliar extrahépatica (13 a 19%)). El más frecuente es el segmento posterior del lóbulo hepático derecho.
  - **Inserción baja o media del cístico** (El curso paralelo del cístico y el conducto hepático común de al menos 2 cm de longitud)







- Presentación clínica:
  - Durante la cirugía (85%).
  - Postoperatorio inmediato (1 sem)
  - Tardio (3 meses o más)

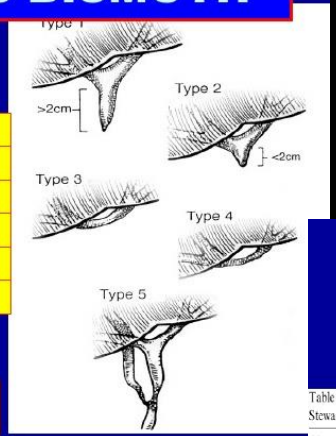
*El clipado de un conducto segmentario produce una atrófia asintomática del segmento.

*Obstrucciones intermitente, colangitis de repeticion, cirrosis biliar, HTP…

- Clasificación:

LESIONES QUIRÚRGICAS DE LA VÍA BILIAR
Clasificación de BISMUTH

TIPO	DESCRIPCIÓN	INCIDENCIA
1	A mas de 2 cm de confluencia de hepáticos	18-36%
2	A menos de 2 cm de confluencia	27-38%
3	Coincide la confluencia, pero preservada	20-33%
4	Destrucción de la confluencia	14-16%
5	Afeccion de aberrante CHD o el colédoco	0-7%

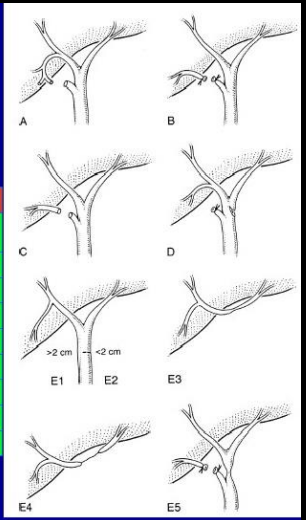


Bismuth H, Majno PE. Biliary strictures: classification based on the principles of surgical treatment. World J Surg 2001;25(10):1241–4.

LESIONES QUIRÚRGICAS DE LA VÍA BILIAR
Clasificación de STRASBERG.

TIPO	DESCRIPCIÓN
A	Fuga biliar en pequeño conducto en continuidad con el hepático común
B	Oclusión parcial de un CHD
C	Transección sin ligación de un CHD aberrante
D	Lesión lateral de conductos extrahepaticos
E1	Transección a mas de 2 cm del hilio
E2	Transección a menos de 2 cm del hilio
E3	Transección a nivel del hilio
E4	Separación de CHD Y CHI
E5	TIPO C mas injuria del hilio

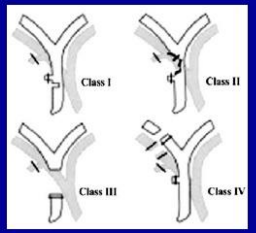
Strasberg. An analysis of the problem of biliary injury during laparoscopic cholecystectomy.
J Am Coll Surg 1995;180:101–25.



LESIONES QUIRÚRGICAS DE LA VÍA BILIAR
Clasificación de Stewart-Way

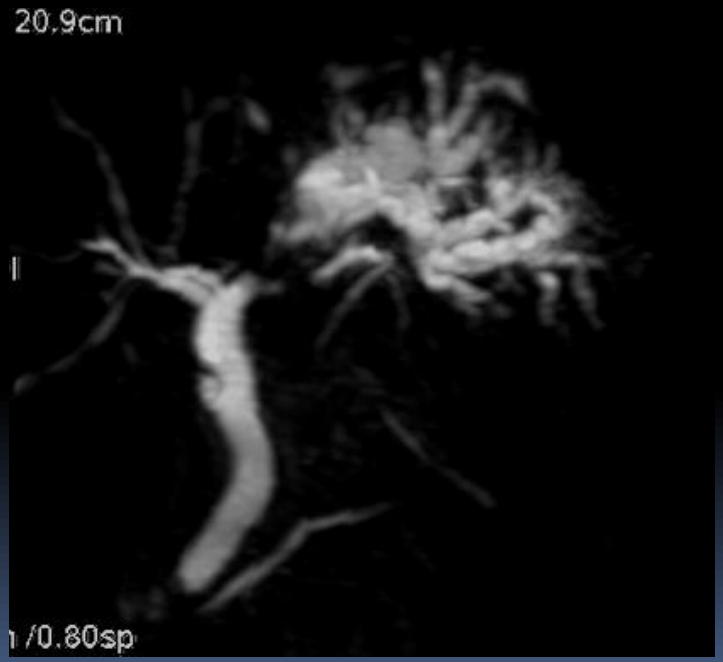
Table 3
Stewart-Way classification of laparoscopic bile duct injury

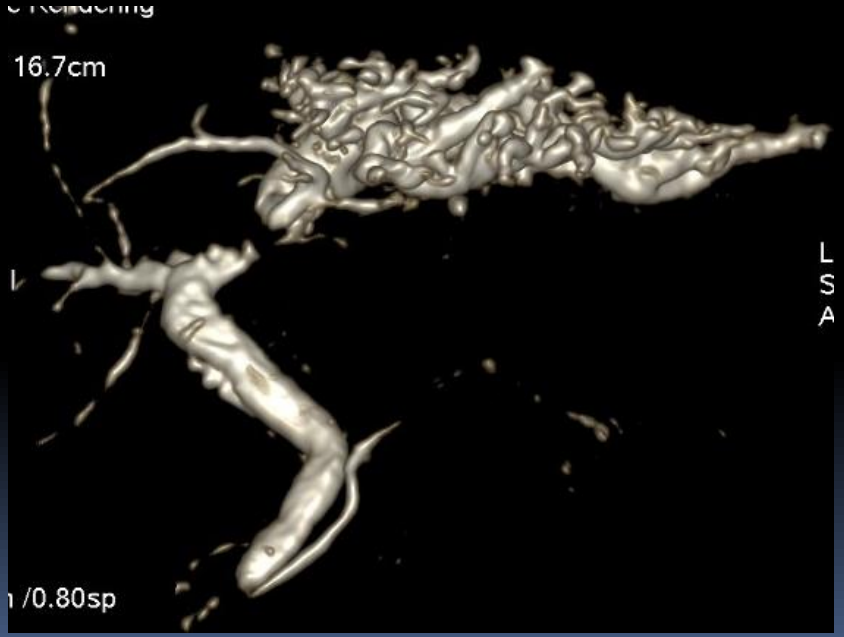
Class	Criteria
I	CBD mistaken for cystic duct but recognized; cholangiogram incision of cystic duct extended into CBD
II	Lateral damage to common hepatic duct from cautery or clips placed on duct; associated bleeding, poor visibility
III	CBD mistaken for cystic duct, not recognized; CBD, CHD, RHD, LHD transected or resected
IV	RHD mistaken for cystic duct, RHA mistaken for cystic artery, RHD and RHA transected; lateral damage to the RHD from cautery or clips placed on ducts

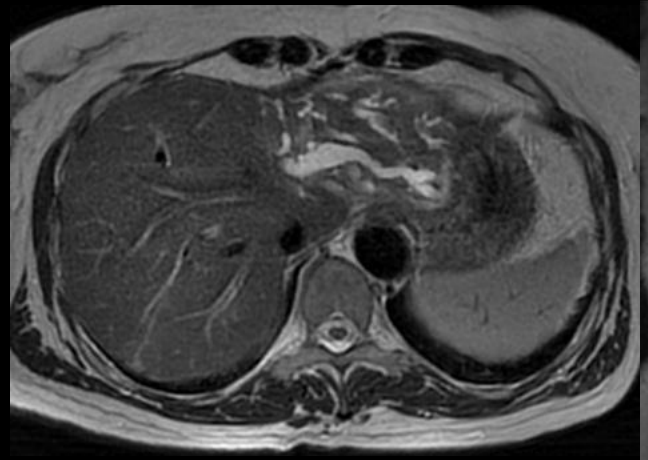


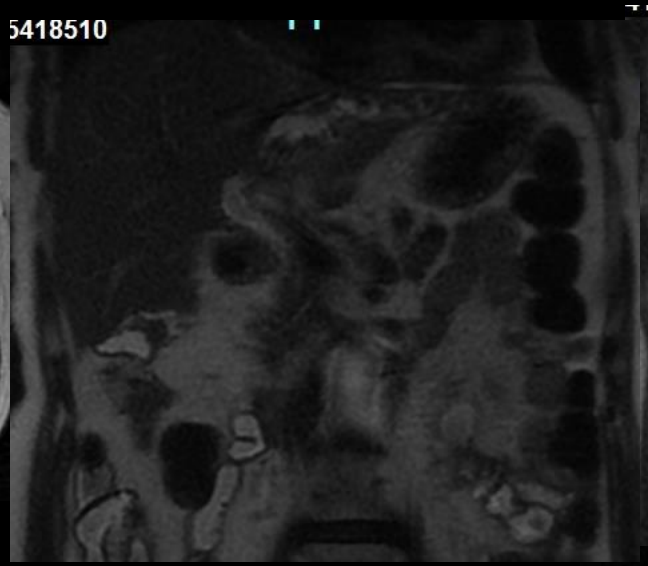
Stewart L, Gantert W, et al. Causes and prevention of laparoscopic bile duct injuries. Ann Surg 2003;237:462;

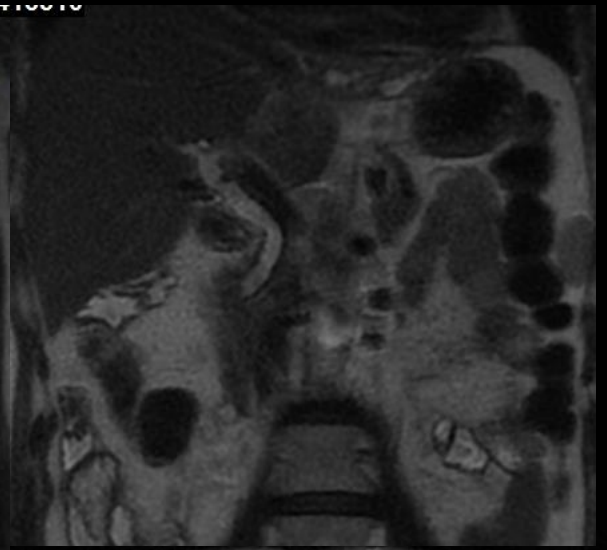
Paciente de 53 años, antecedentes de colecistectomía lap. hace 20 a. Antecedente de varias CPRE por coledocolitiasis de repetición. Clínica de colangitis aguda.

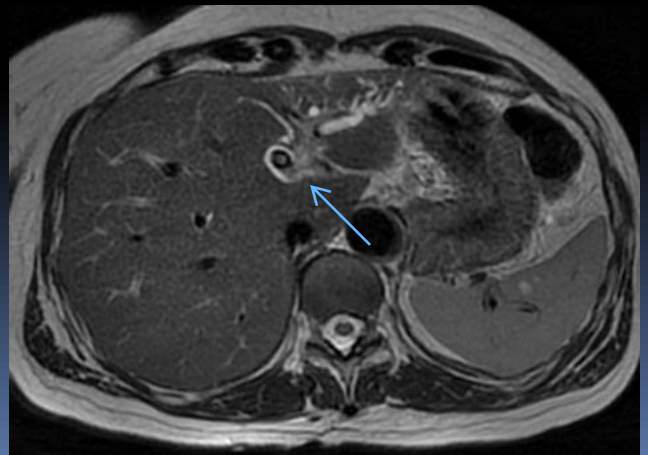


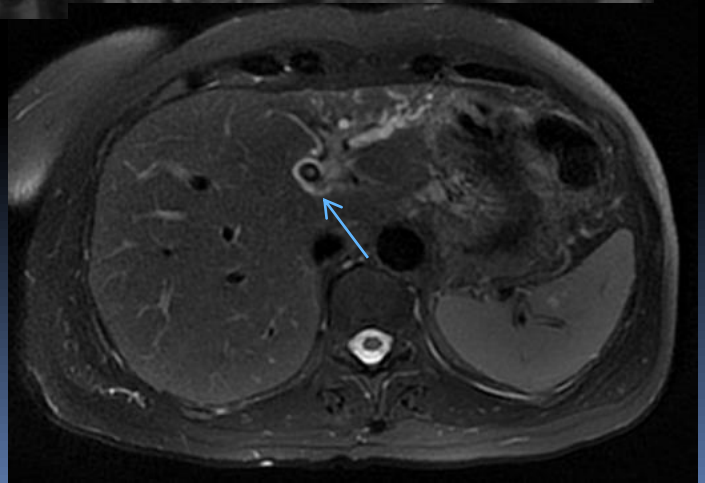






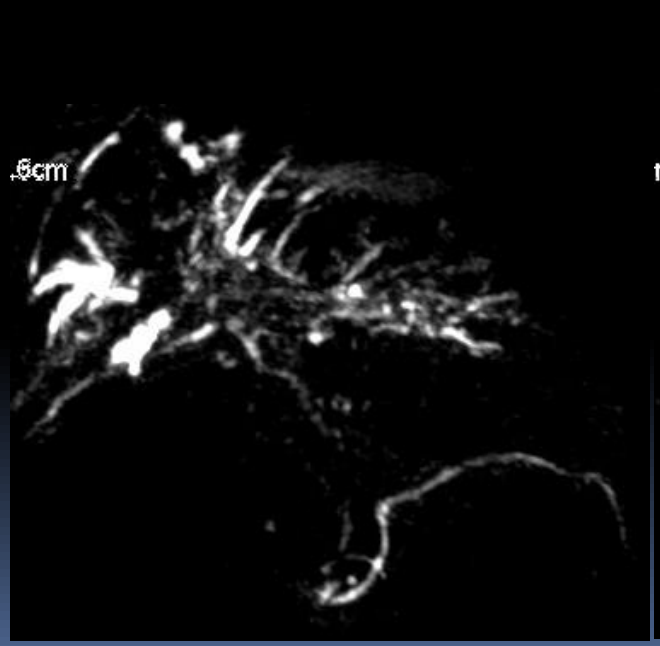


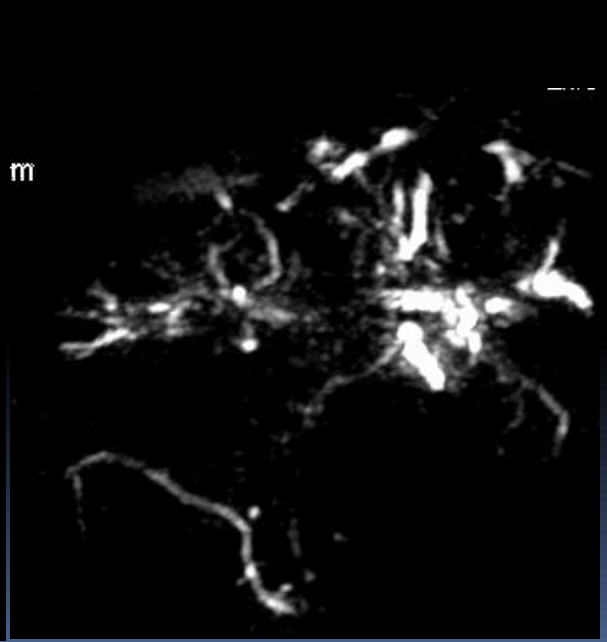


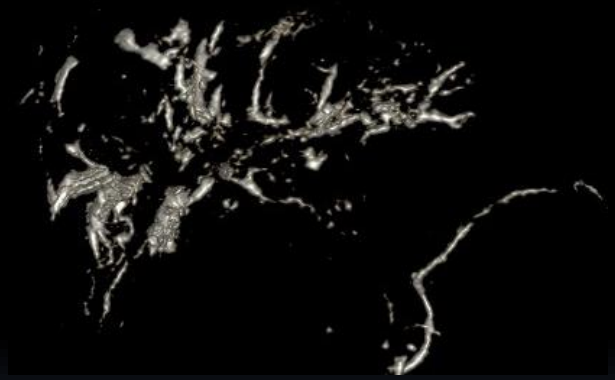


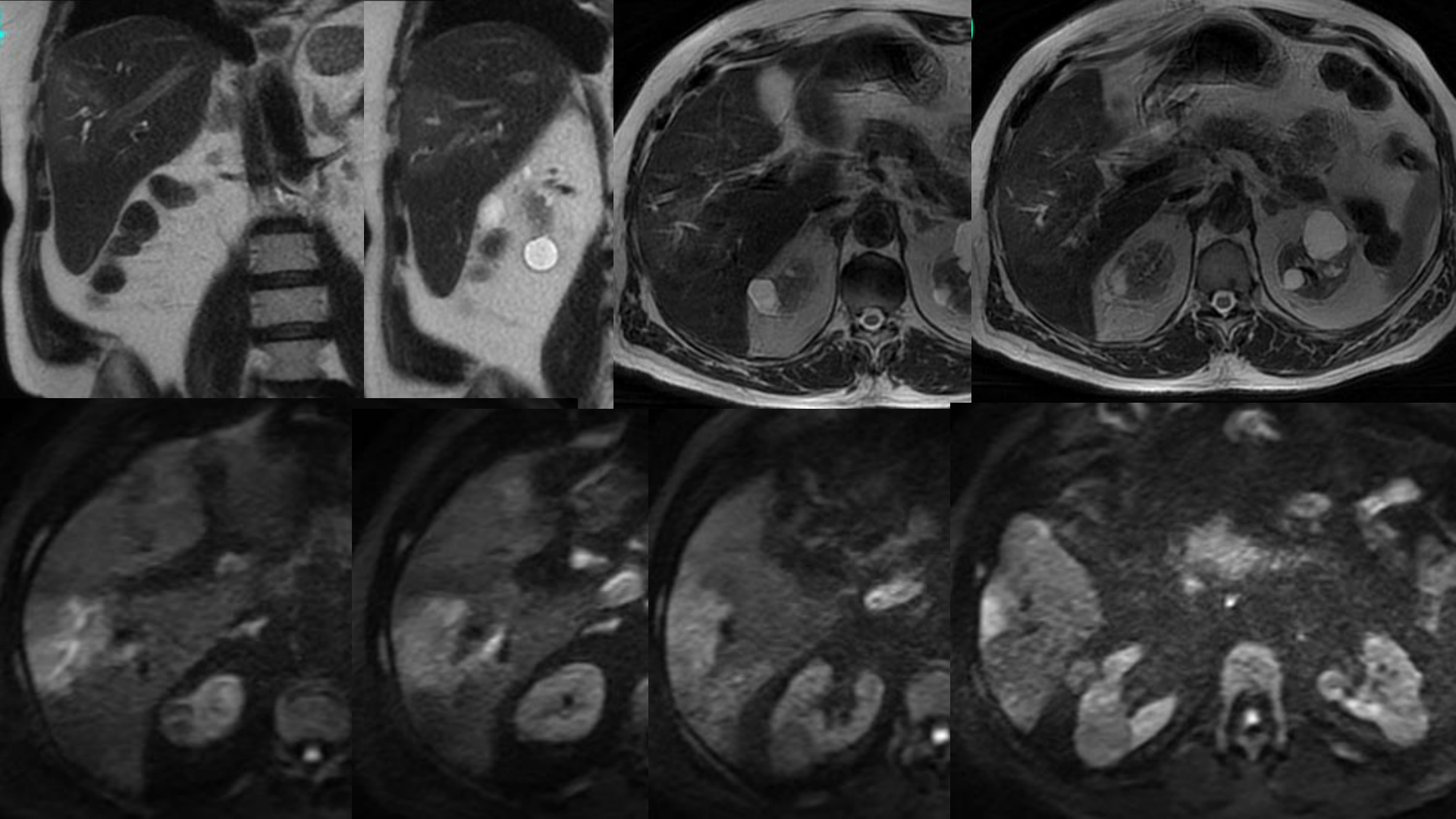
Hepatolitiasis.
TTO: CTPH:
Dilatación de la papila con balón. Impulsión de litiasis a duodeno.

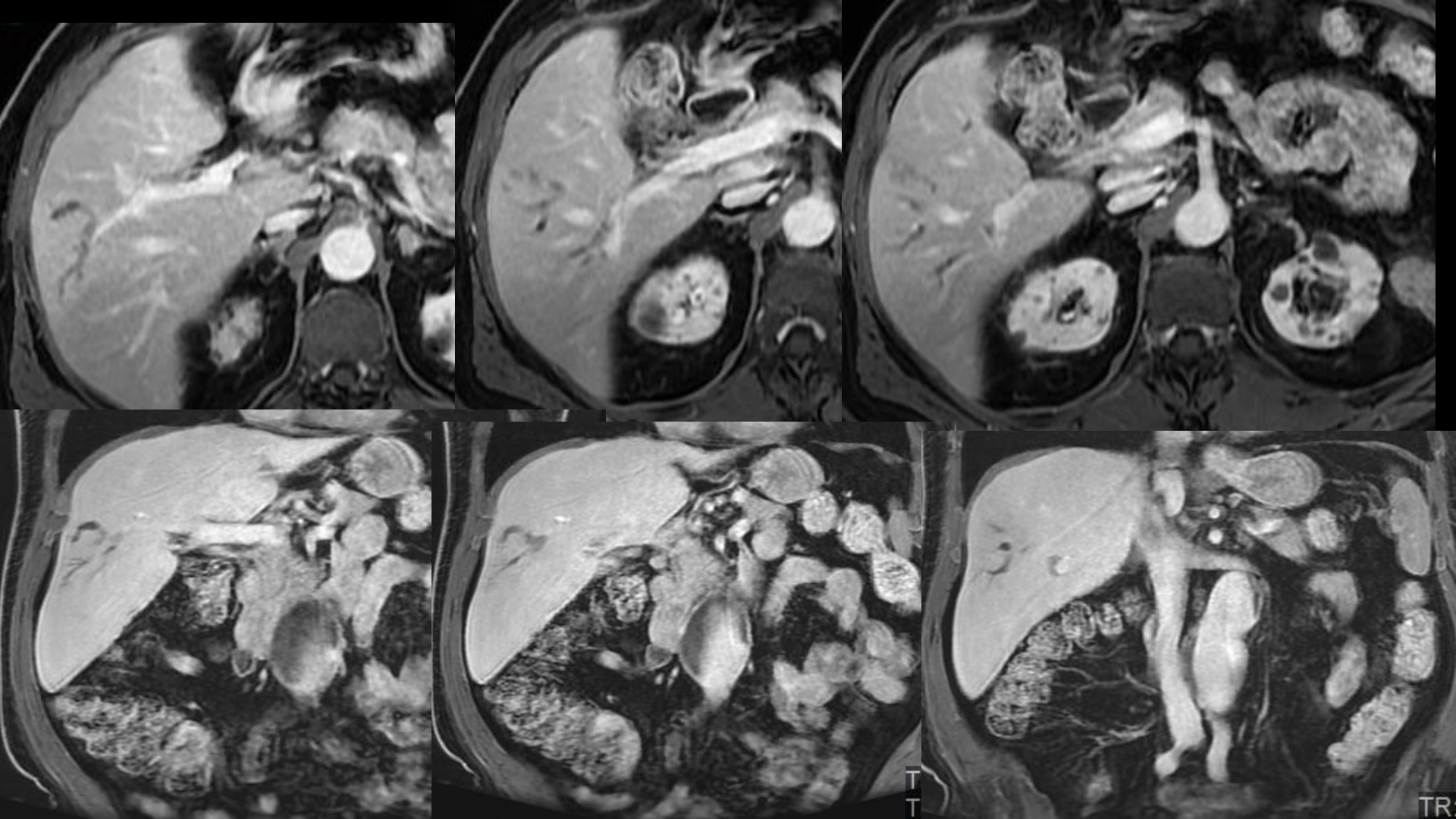
Varón de 66 años. En control se aprecia aumento segmentario de conductos biliares intrahepáticos.
Antecedente de neoplasia de colon intervenida. Colecistectomía y coledocoduodenostomía.





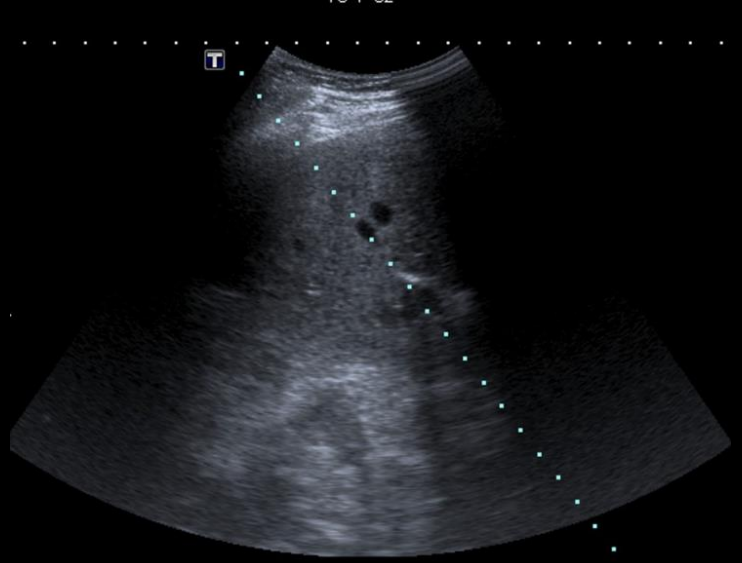




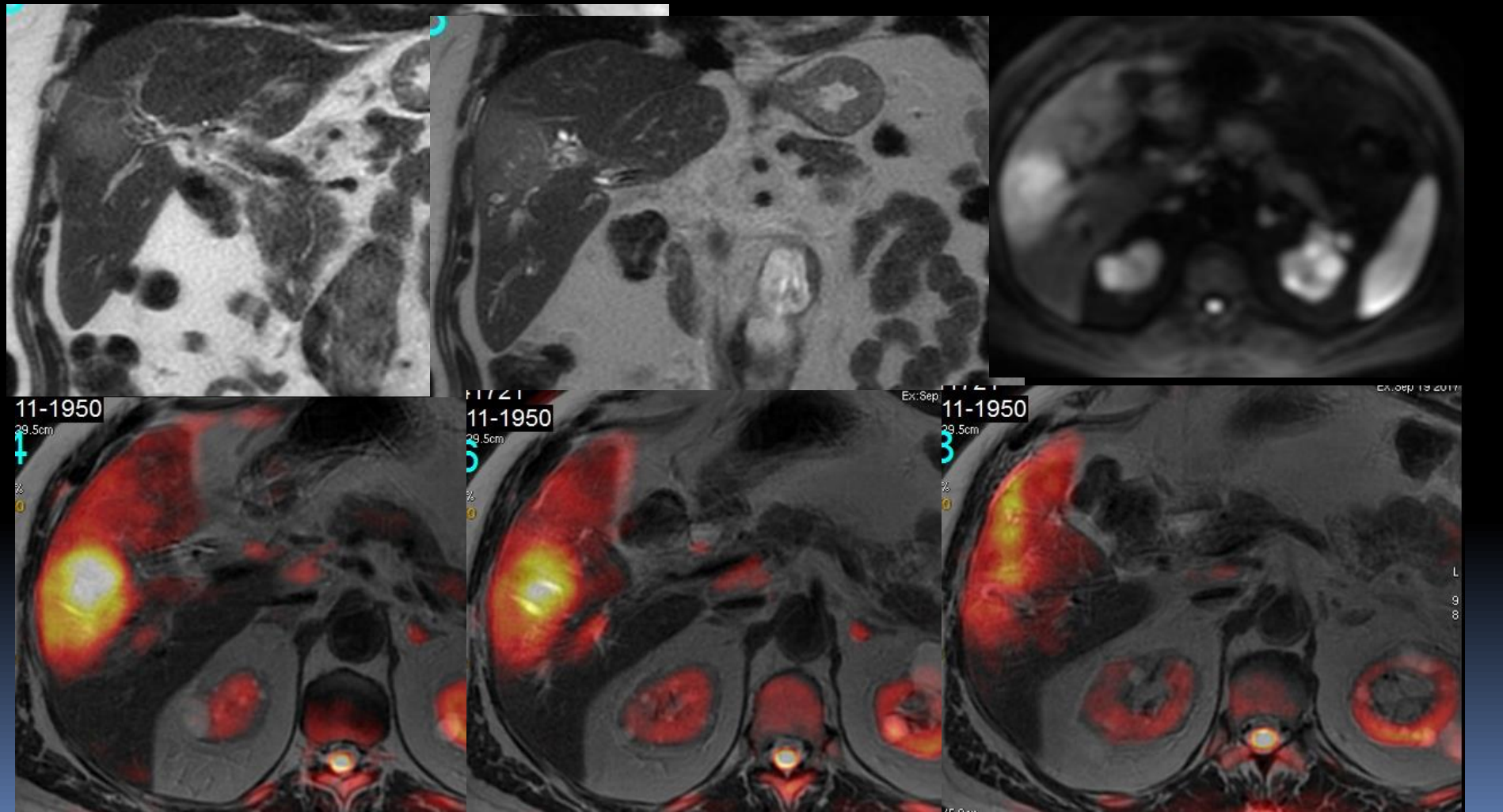


Se intenta biopsia de confirmación.

AP: Granulomas hepáticos con cambios inflamatorios y reparativos focales (fibrosis) a nivel hepático (sugiere posible origen medicamentoso).



Neoplasia de sigma en revisiones. Dilatación de la vía biliar a controlar, biopsia negativa.
RM control.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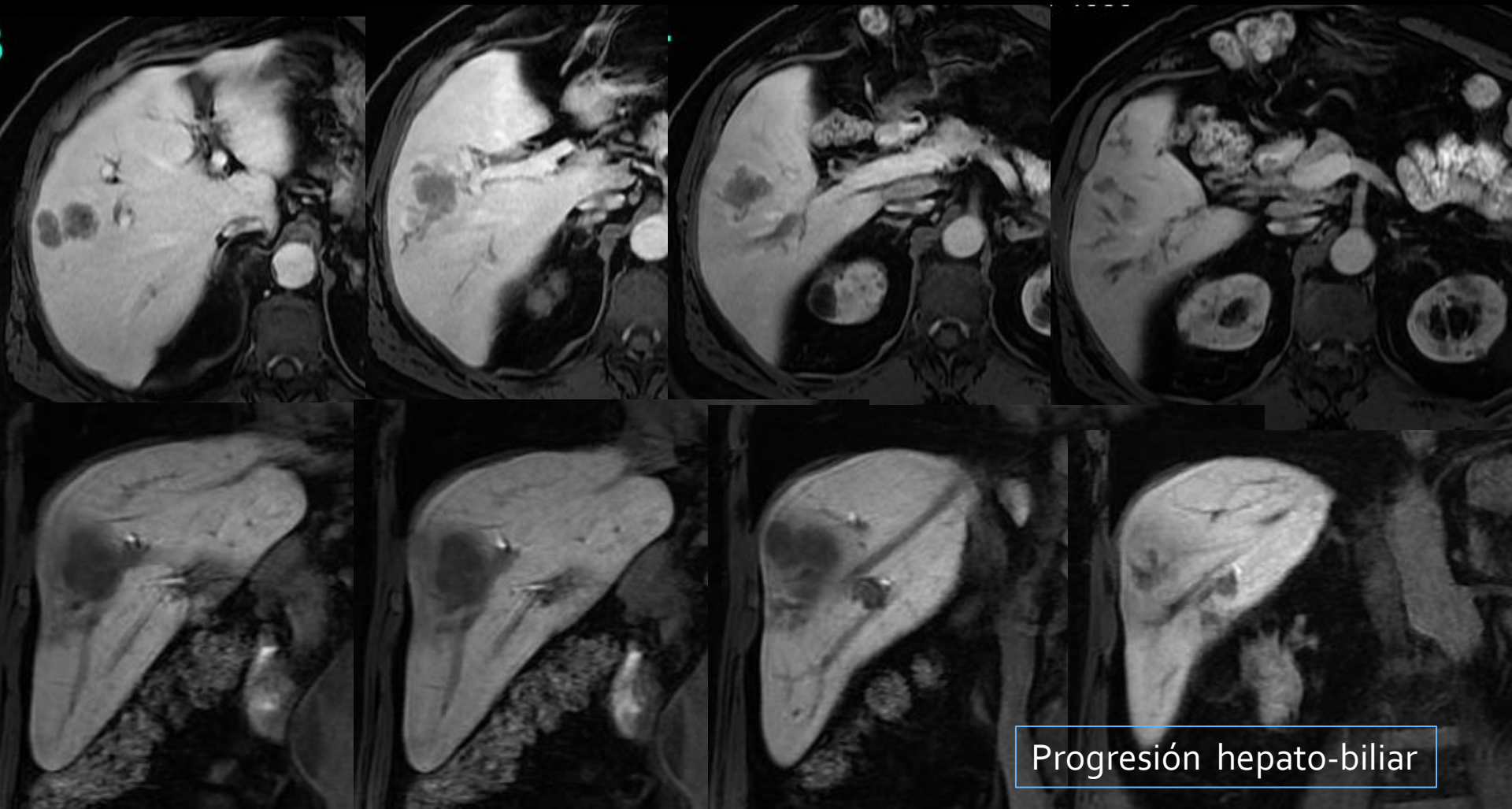
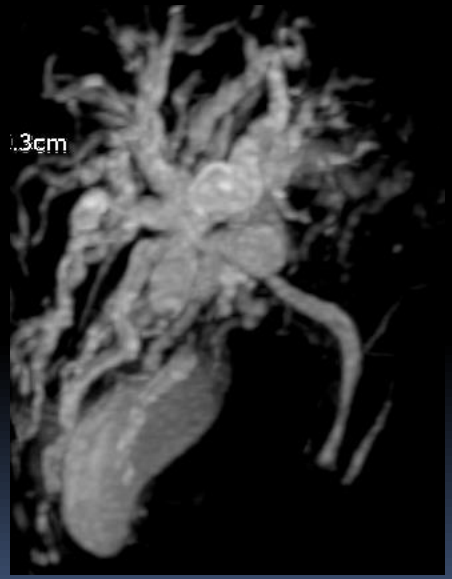
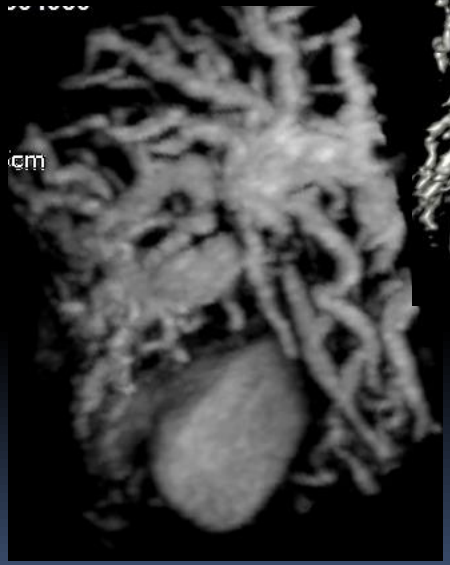
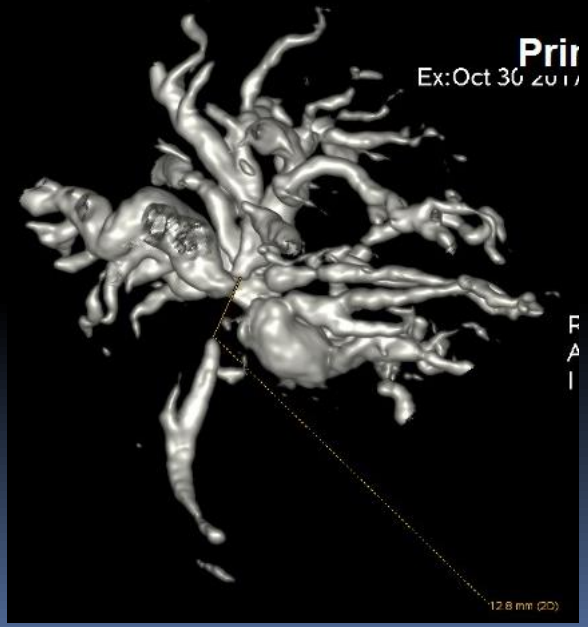

Progresión hepato-biliar

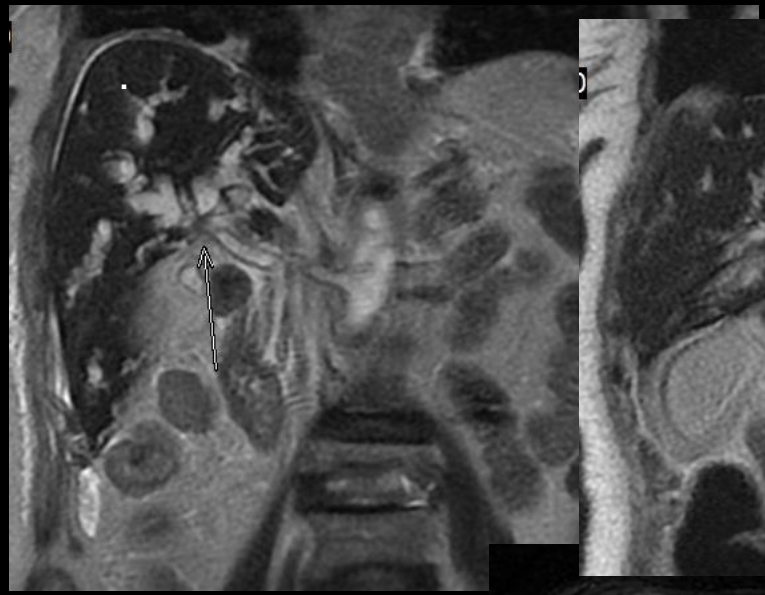
Alteración de vía biliar extrahepática proximal

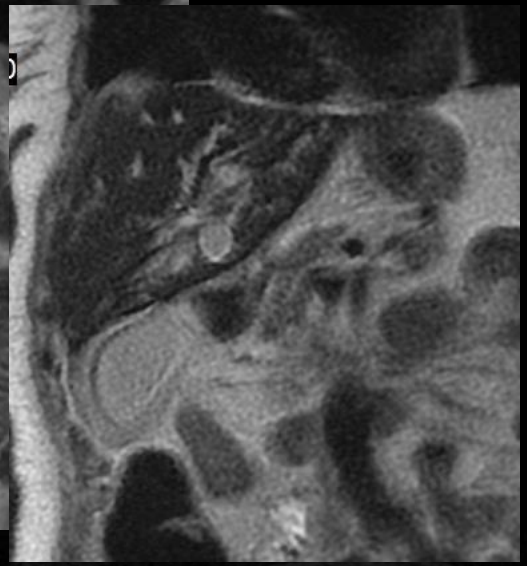
Paciente de 87 años , Ictericia asintomática

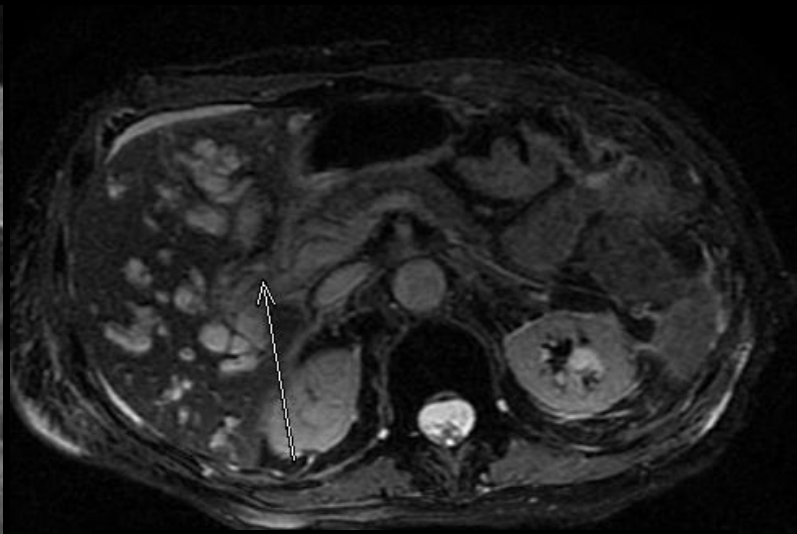


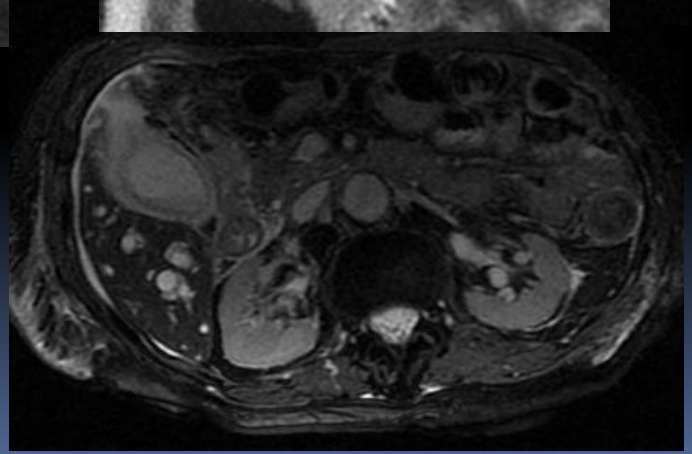


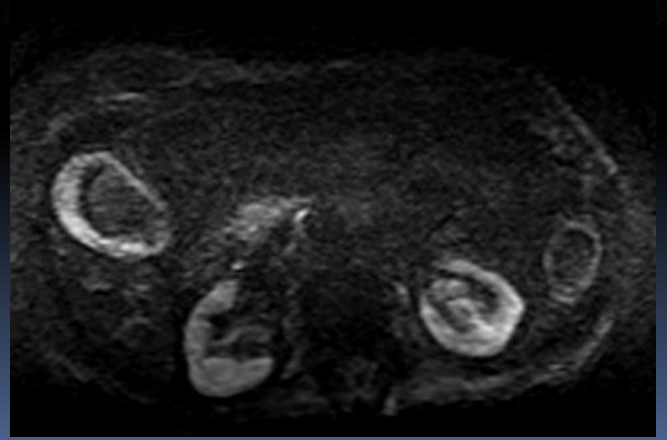






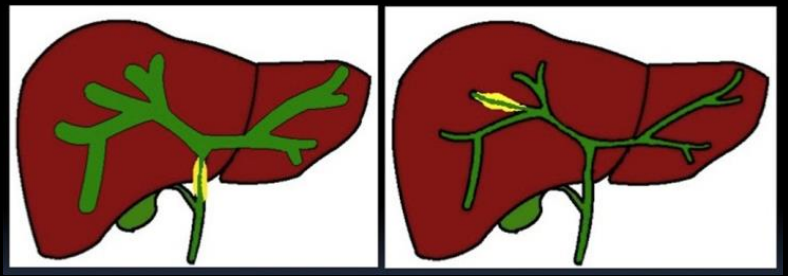






Colangiocarcinoma
Tumor de klatskin

Liver Cancer Study Group of Japan propuso una clasificación basada en el **Patrón de crecimiento tumoral**

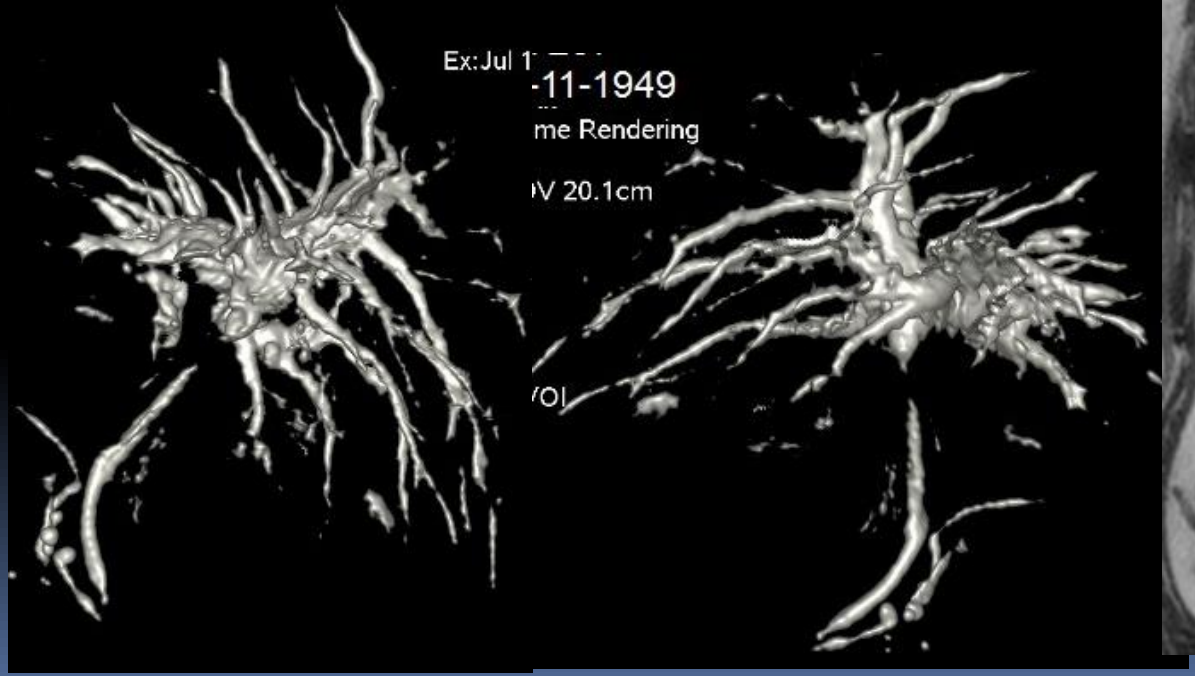


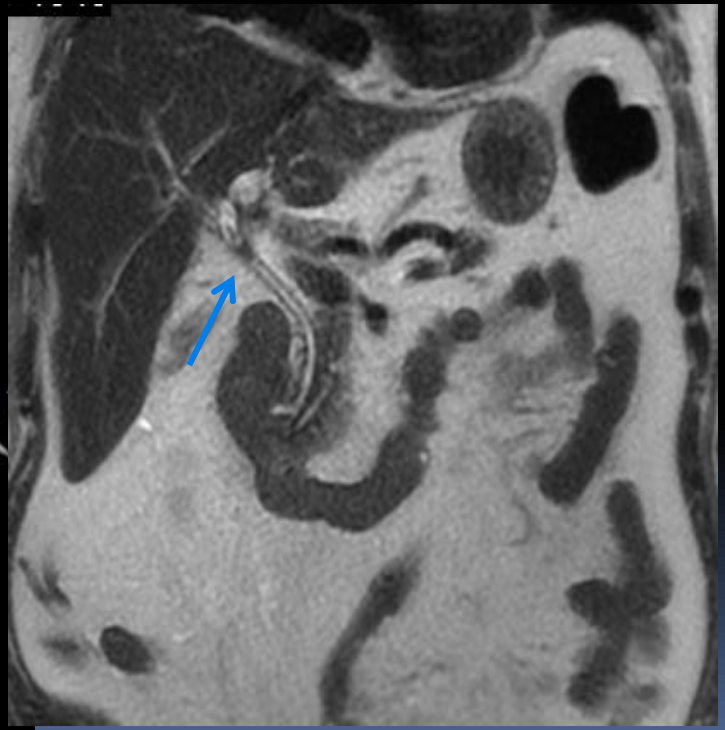
http://dx.doi.org/10.1594/seram2012/S-0952

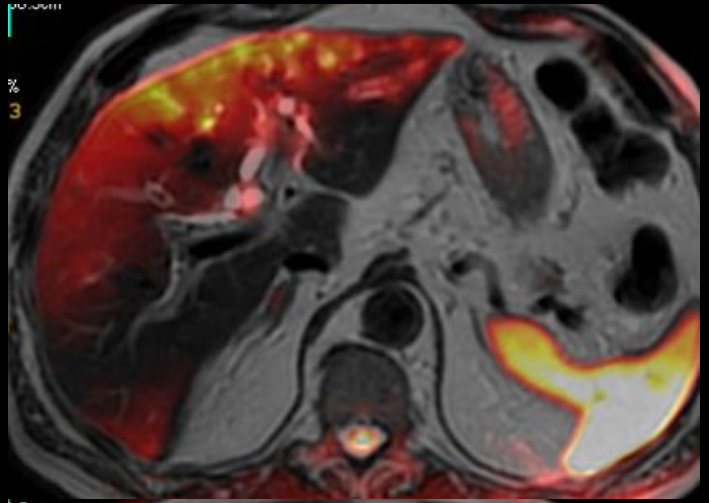
Tipo periductal infiltrante:

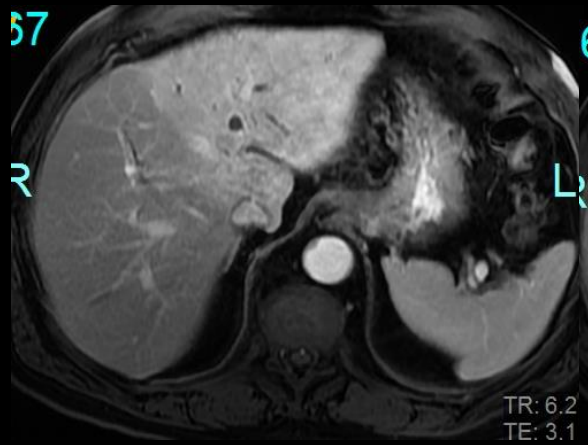
*Crecer a lo largo de un conducto biliar, sin formar masa.
*Engrosamiento periductal difuso.
*La mayoría de los colangiocarcinomas localizados en el hilio son de este tipo (Tumor de Klatskin).

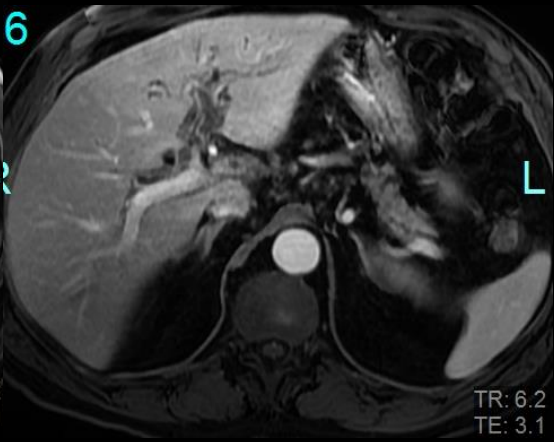
Varón de 67 años. Trombosis portal izquierda y dilatación de la vía biliar izquierda, sin causa aparente , descartar litiasis, neoplasia…

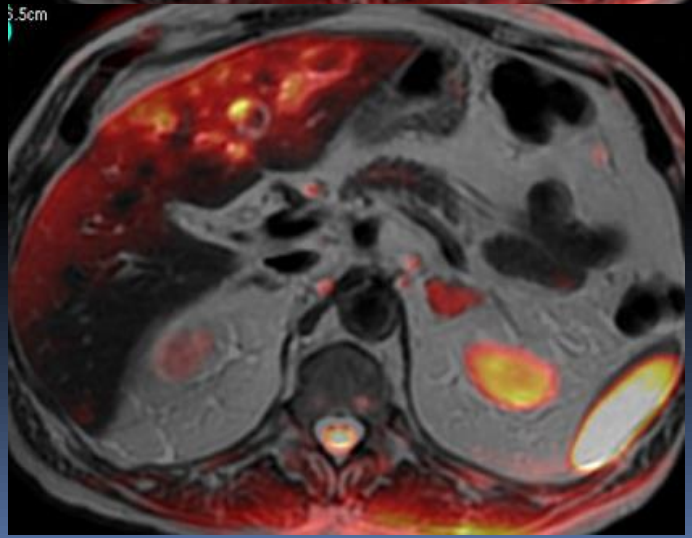


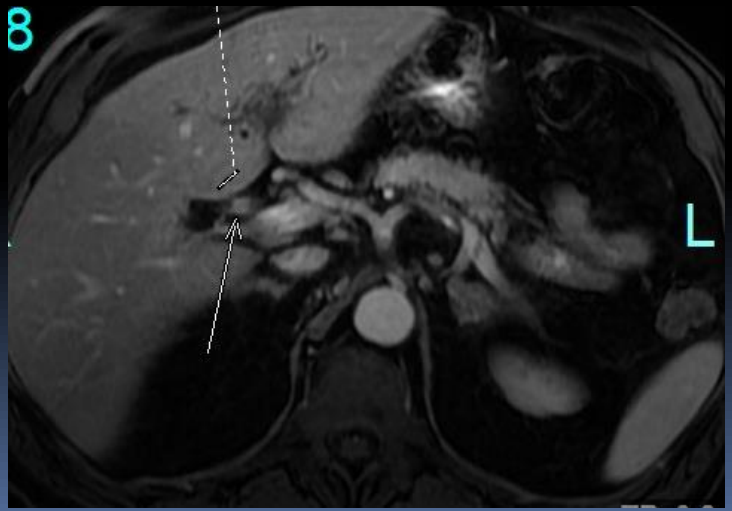





57
R
L
TR: 6.2
TE: 3.1

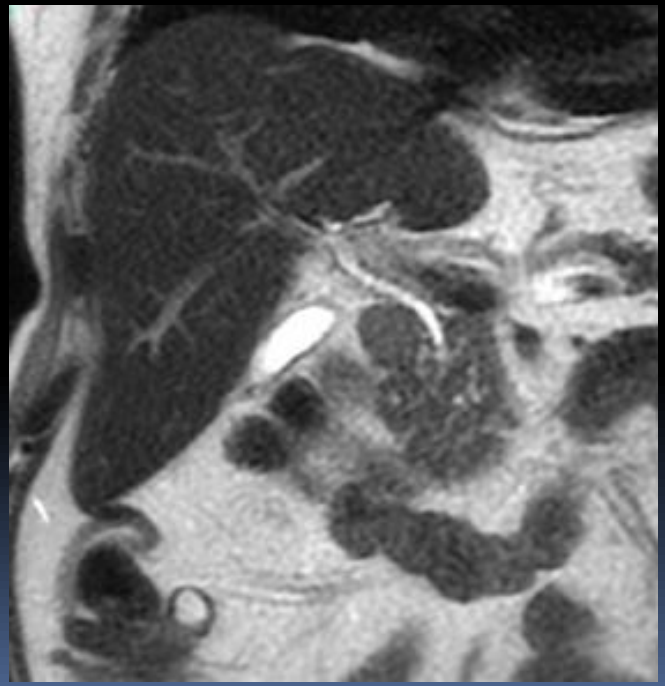

6
L
TR: 6.2
TE: 3.1

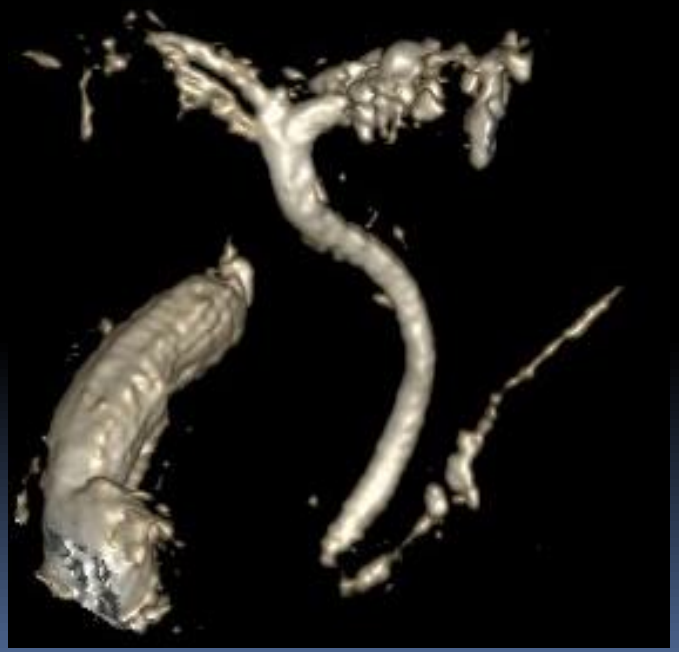

5.5cm

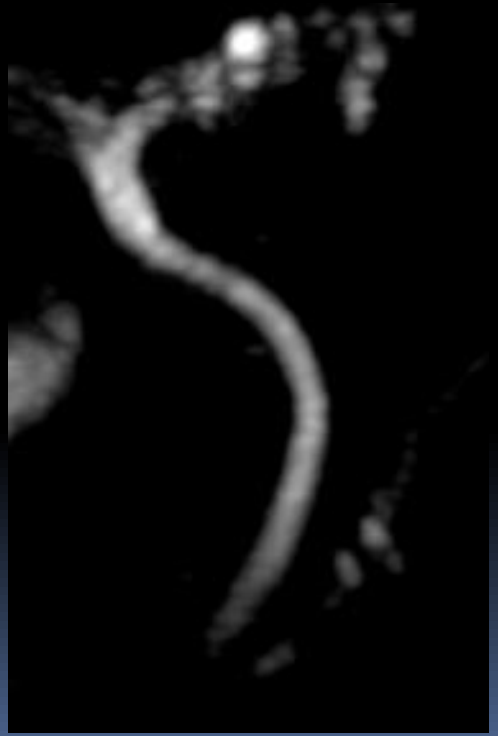

8
L

CPRE: No encuentran estenosis.
No se confirma malignidad.

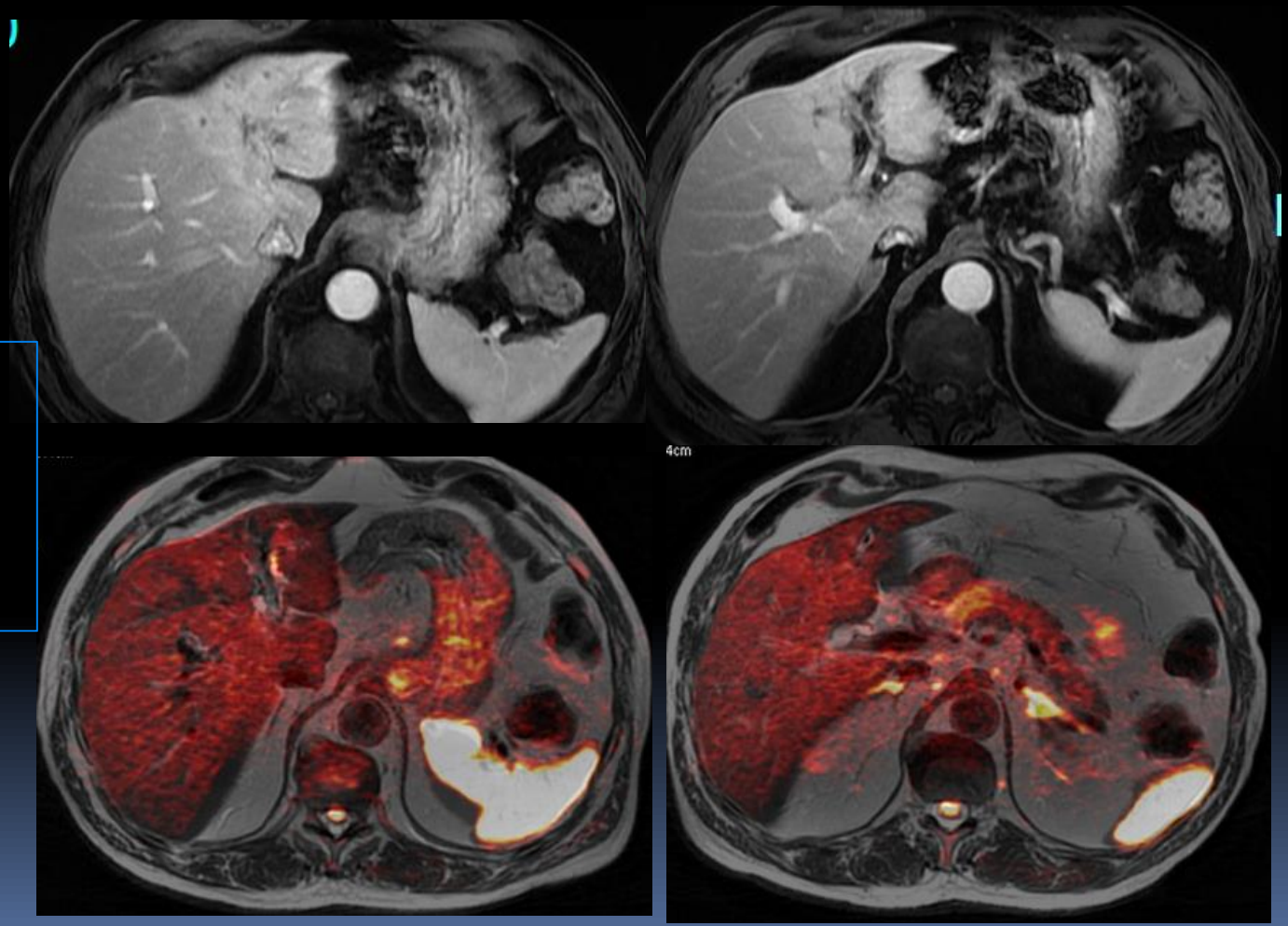
RM control dos meses



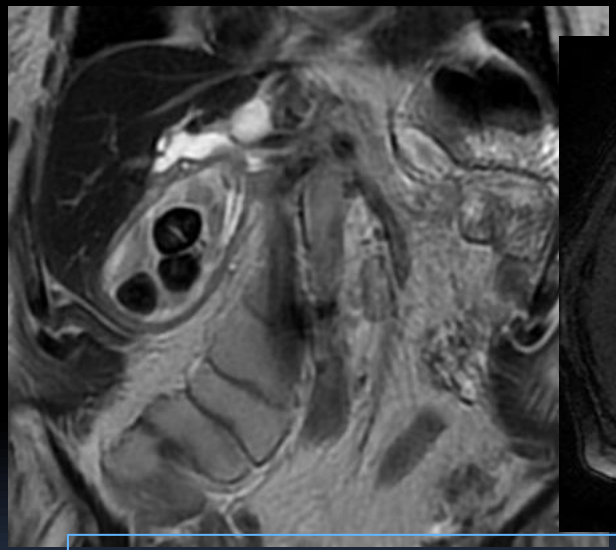


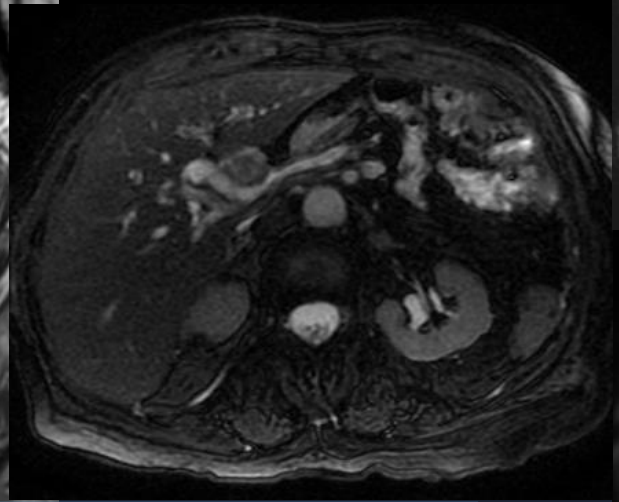


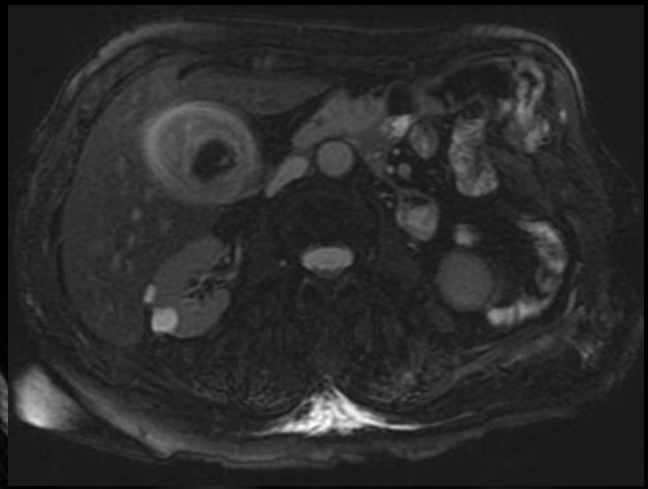
Etiología inflamatoria/infecciosa (colangitis , abscesos hepáticos, trombosis de la porta pileflebitis)

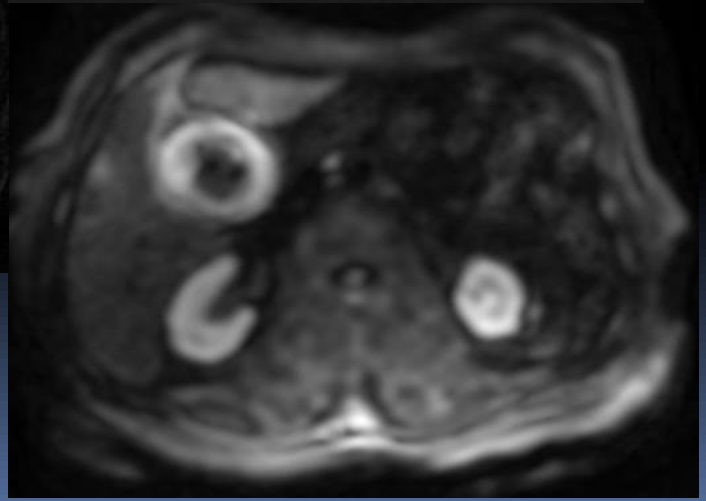


Paciente de 75 años: Clínica de colecistitis aguda. Aumento de la bilirrubina.





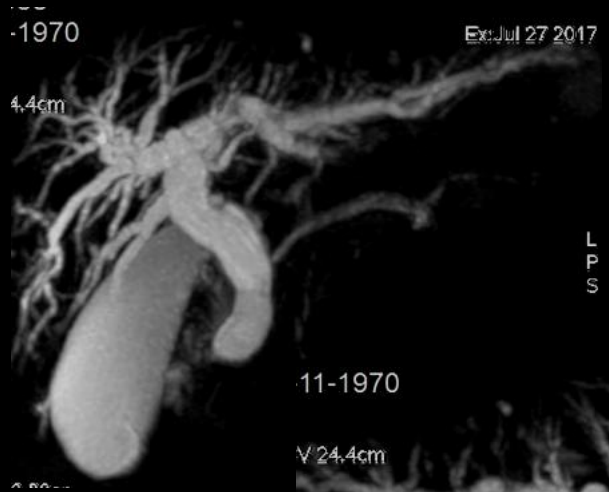


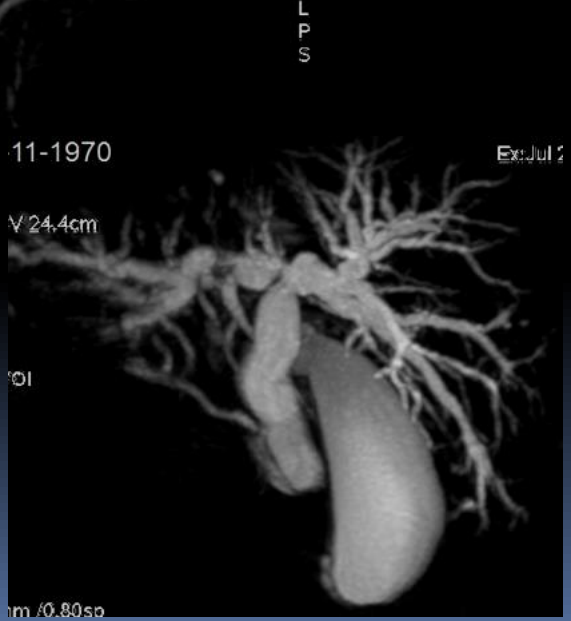


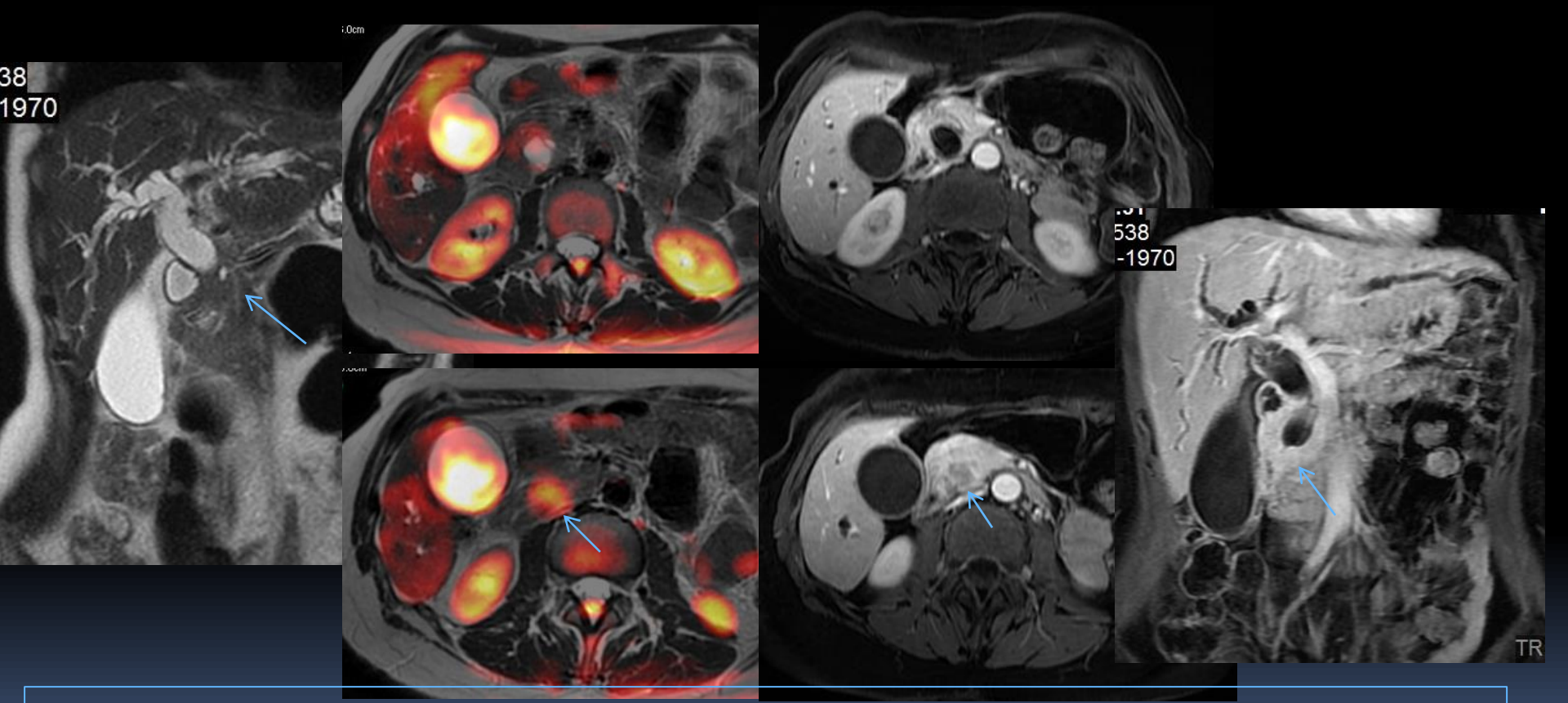
No se identifican coledocolitiasis.
Vesícula hidrópica , inflamada, con contenido, comprime la vía biliar. Síndrome de Mirizzi.
Tto. Drenaje percutáneo.

DD estenosis VB distal con patología pancreática, duodenal…

Paciente de 46 años, con ictericia indolora







Colangiocarcinoma VB extrahepática. Duodenopancreatectomía cefálica: tumor de 2,5 cms. El tumor infiltra pared muscular, submucosa duodenal y páncreas.

Liver Cancer Study Group of Japan propuso una clasificación basada en el **Patrón de crecimiento tumoral**

Colangiocaecinoma
Tipo intraductal:

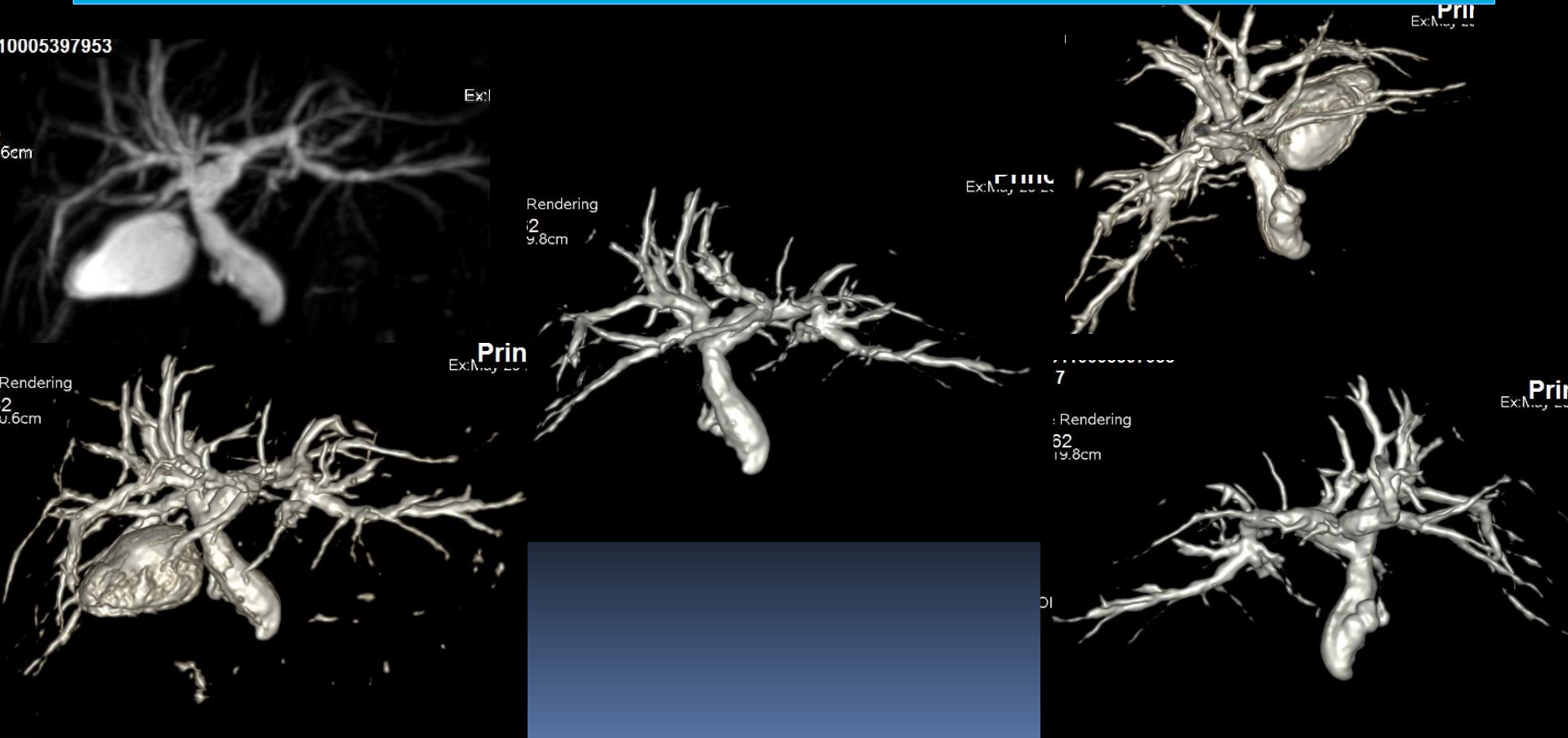
*Tiene un pronóstico relativamente favorable

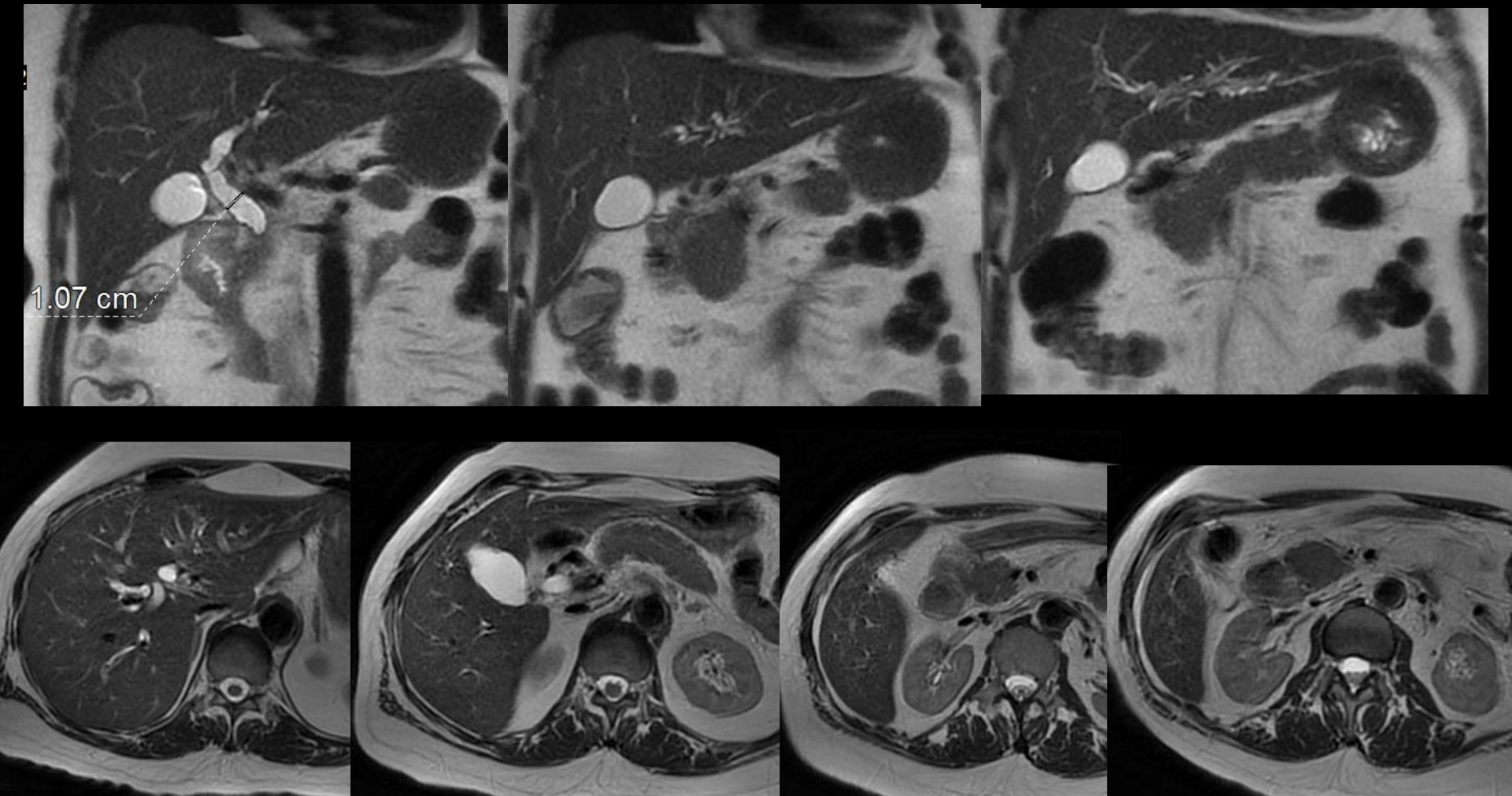
* Patrón de crecimiento es a través de la mucosa superficial, intraluminal.

* Masa intraductal que realza, con dilatación ductal marcada y difusa proximal.

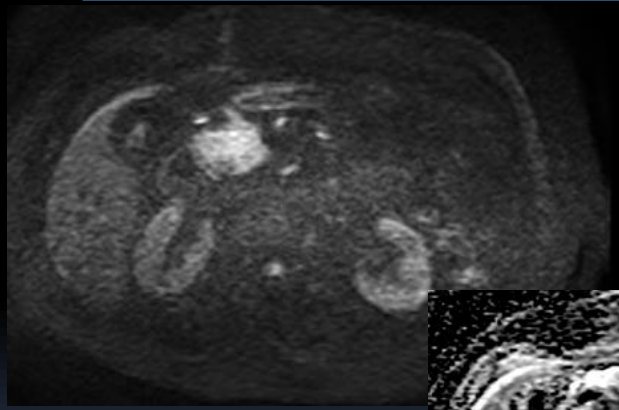
* Extensión transmural tardía (infiltración de estructuras adyacentes)

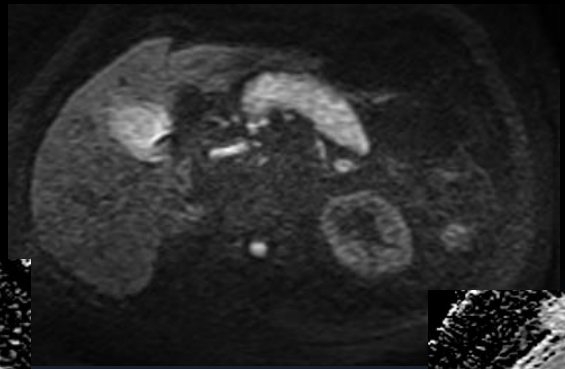
Paciente de 55 años: Intervenida de colecistectomía lap. Nuevo episodio de pancreatitis y colestasis. Descartar complicaciones postquirúrgicas, coledocolitiasis.

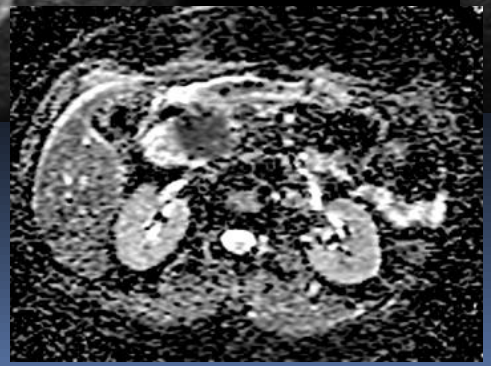


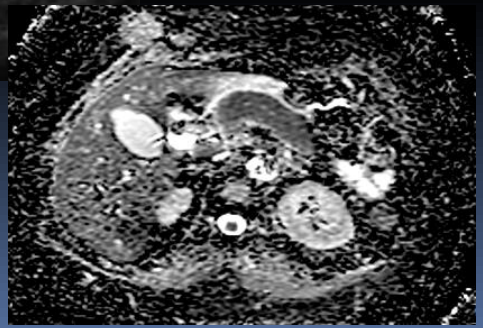

1.07 cm

* Antecedentes: de Gpatía monoclonal sin tto, y enf de Crohn ileocólica corticodependiente.
* 3 episodios de PA: 1º:Barro biliar (colecistectomía), 2º Por el Imurel, 3º PAAF Páncreas: Fibrosis y cambios reparativos, sin malignidad.
* Proceso inflamatorio pancreático (Pancreatitis autoinmune)

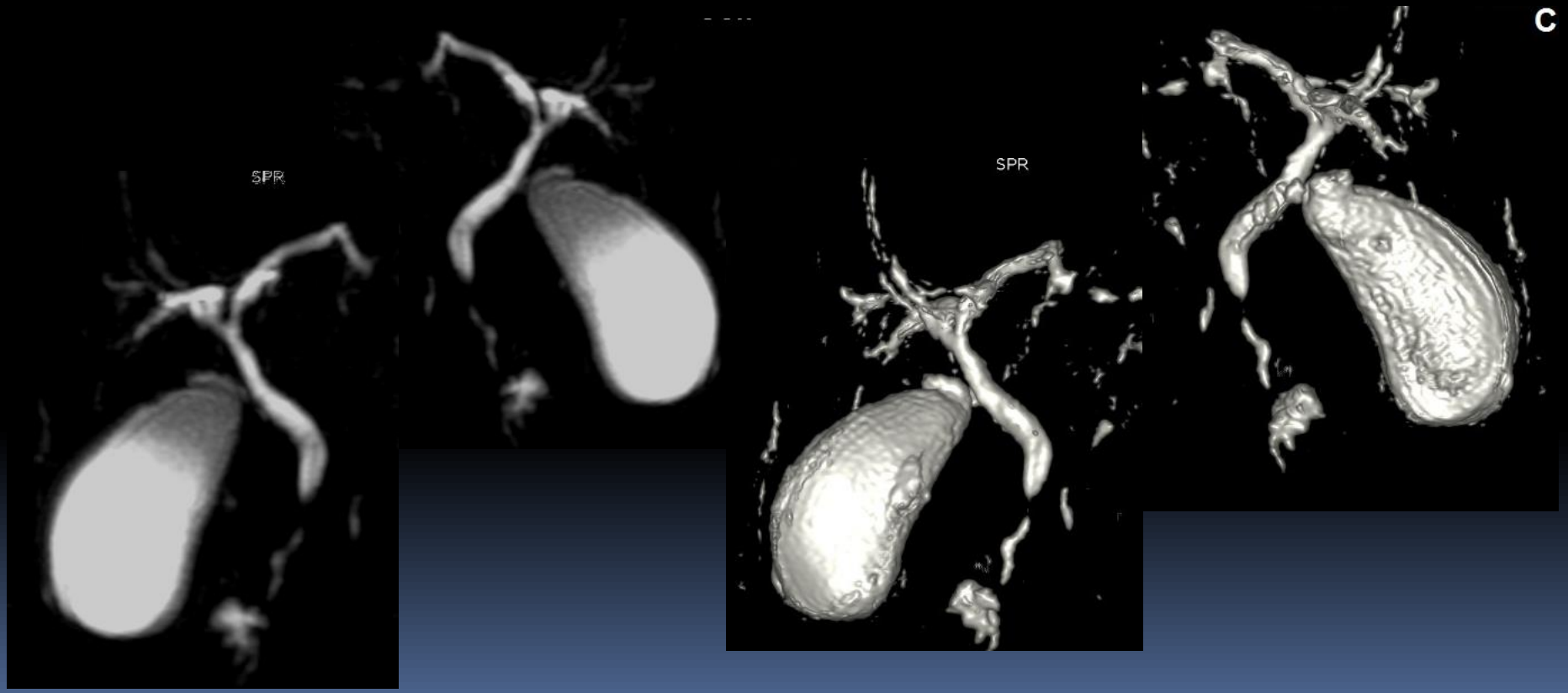




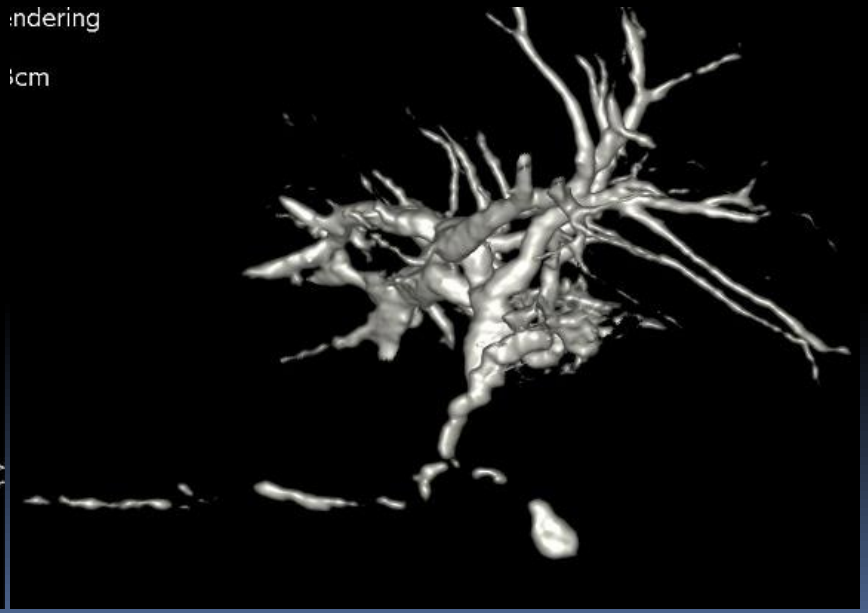


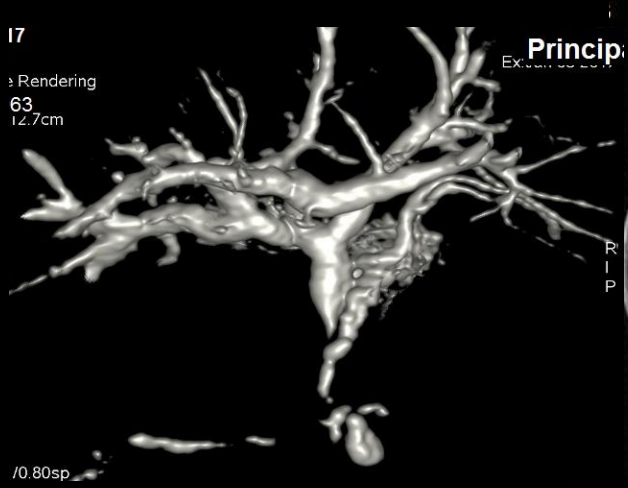


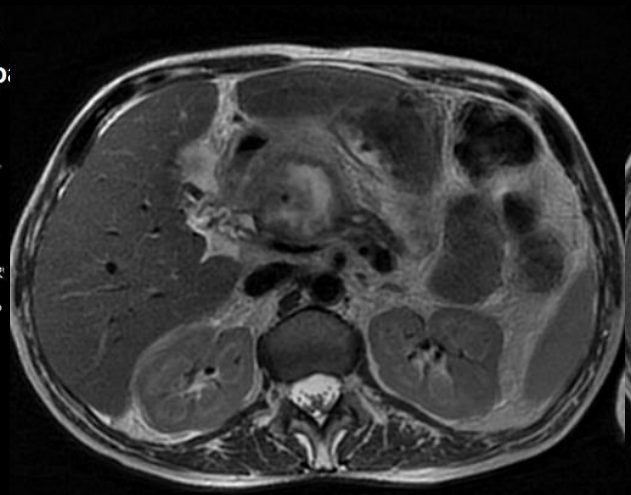
Estudio de colangio-RM previa a la colecistectomía

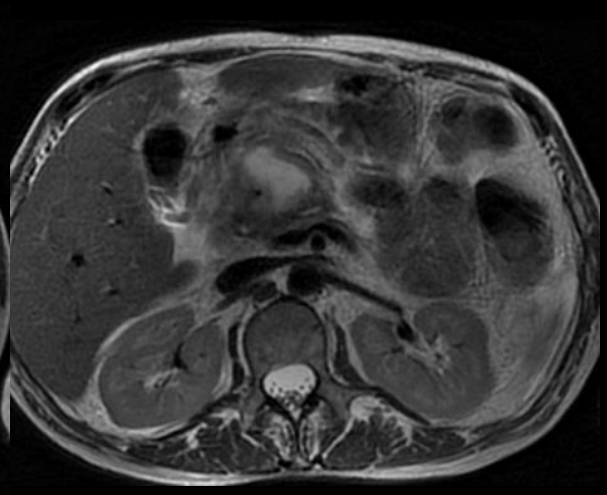


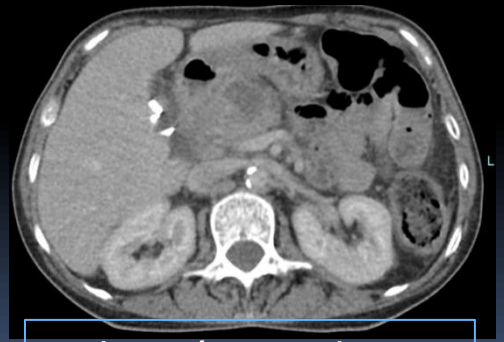
Paciente de 54 años. Epigastralgia irradiada a espalda. Antecedentes de colecistectomía, y de PC (atrofia páncreas en estudios previos). Aumento de la colestasis, descartar coledocolitiasis residual.

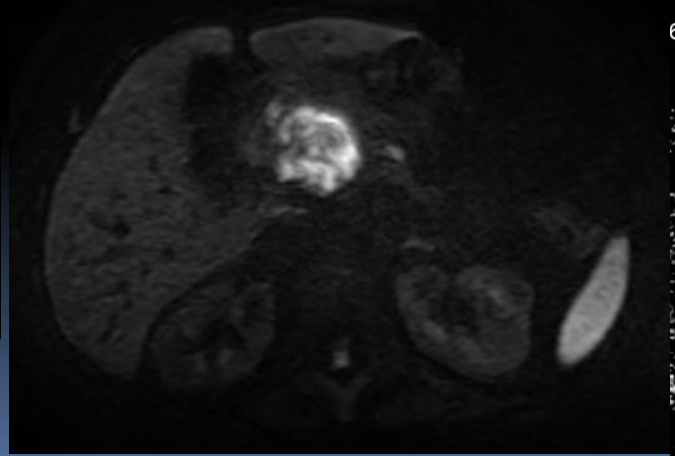


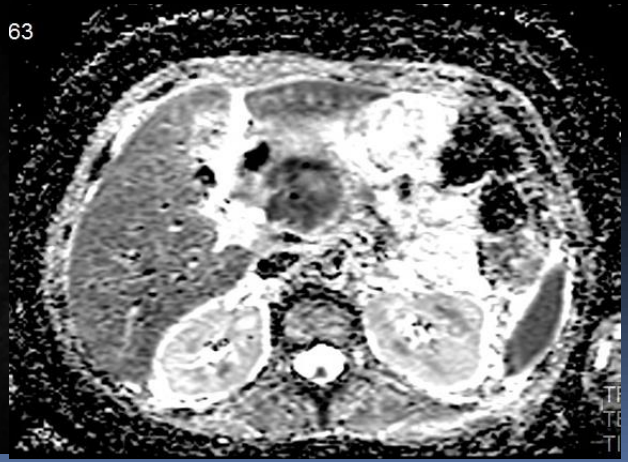






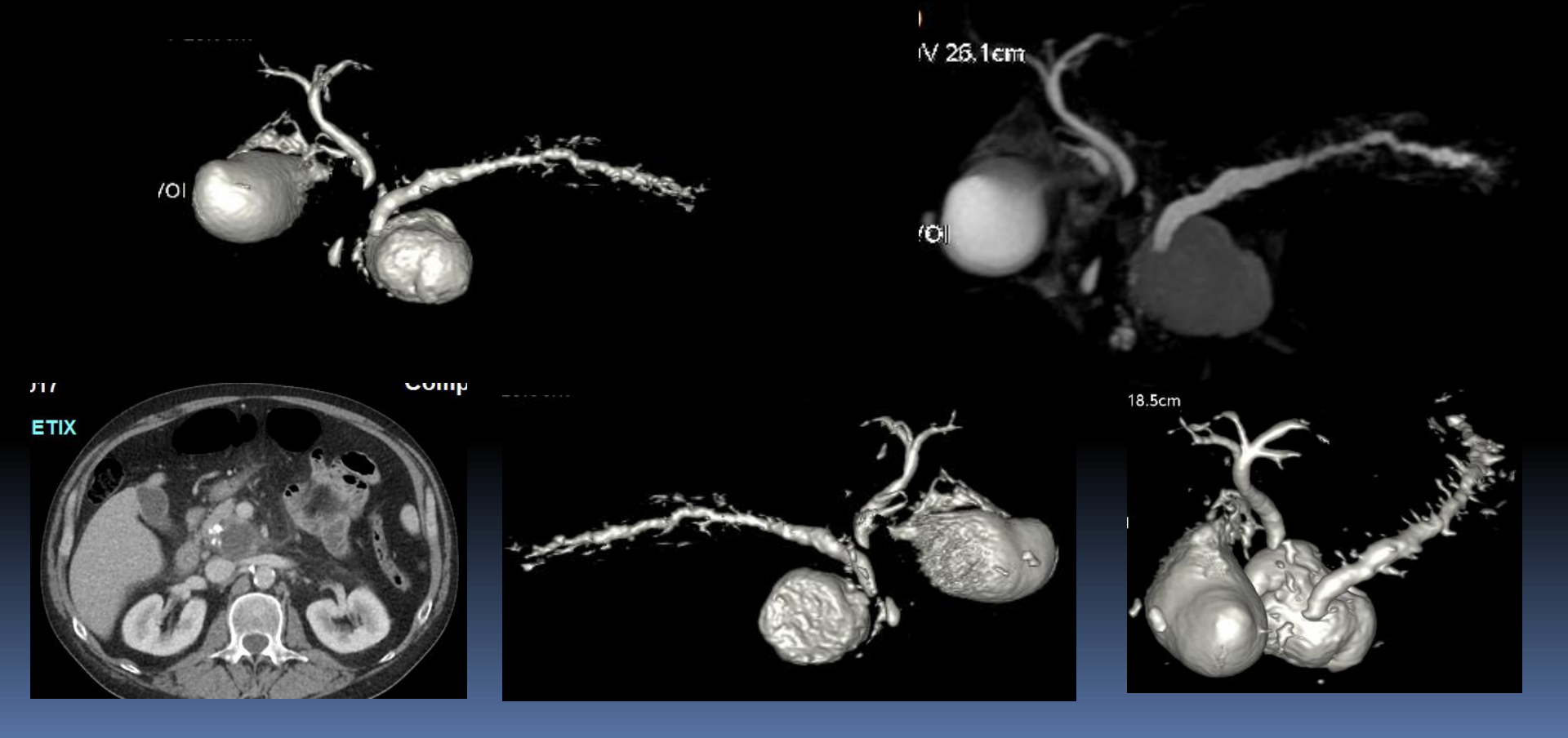


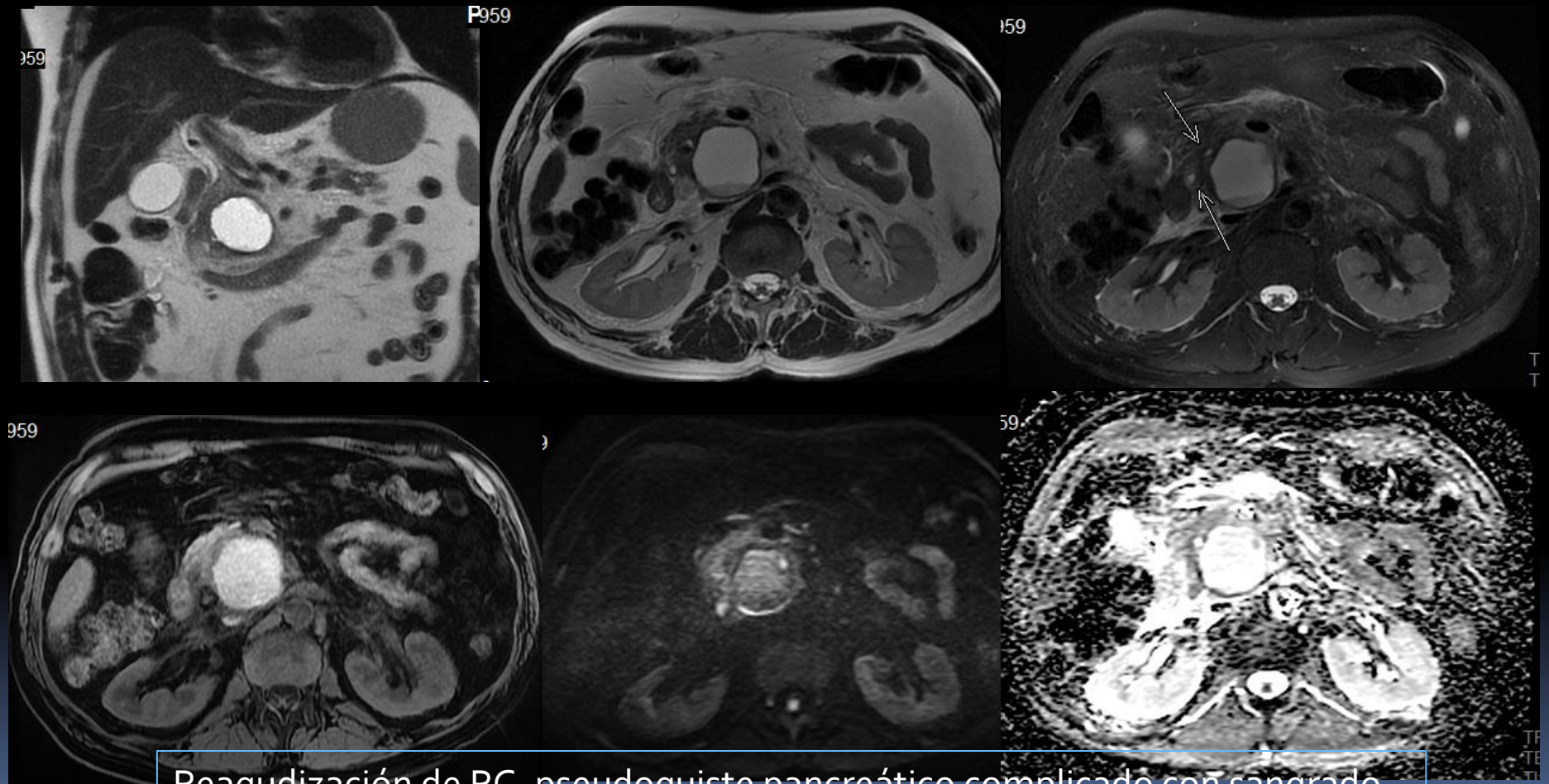




Colección aguda peripancreática.

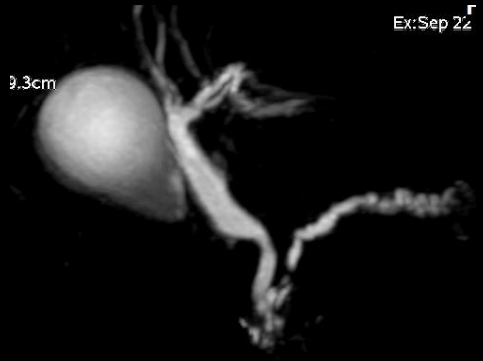
Paciente de 58 años. 3º episodio de reagudización de PC. Valorar complicaciones y vía biliar

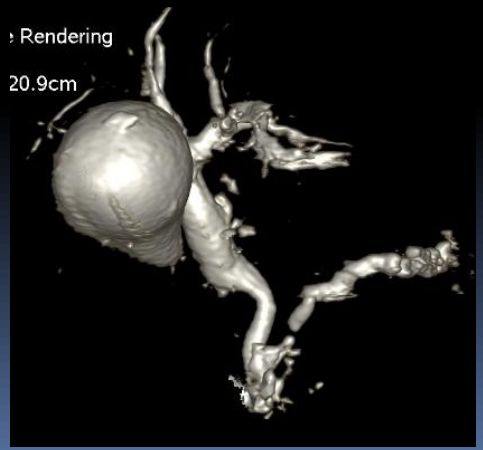


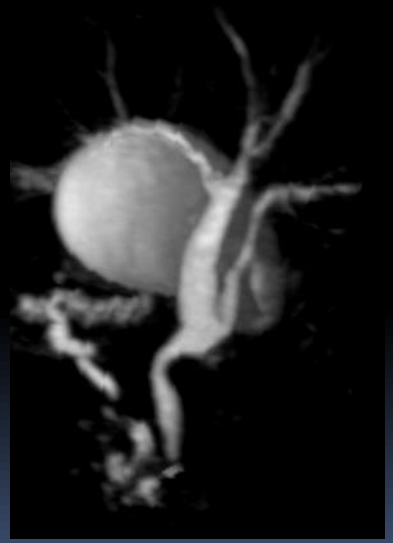


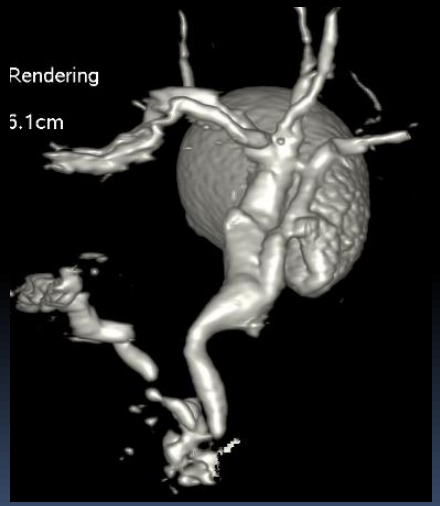
Reagudización de PC, pseudoquiste pancreático complicado con sangrado.

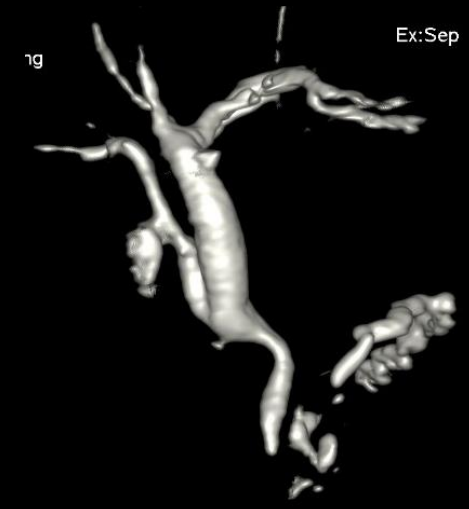
Paciente de 74 años. Epigastralgia e ictericia

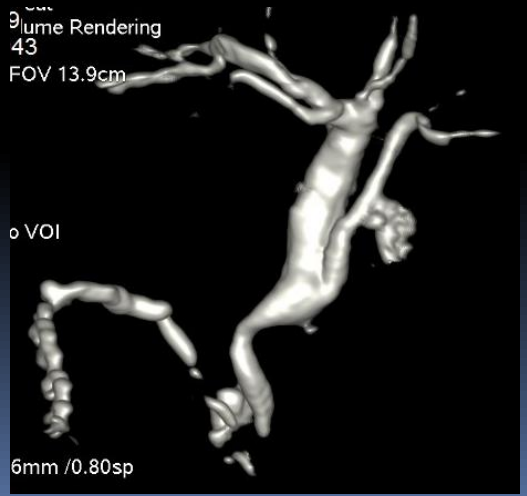




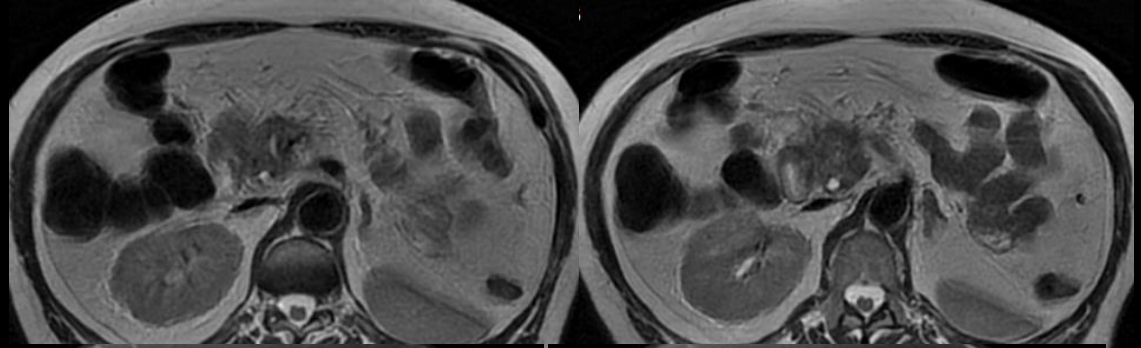


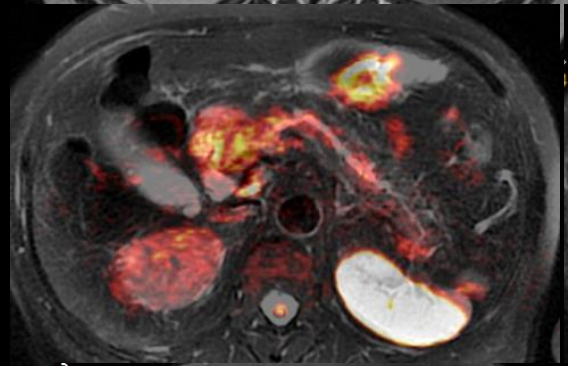


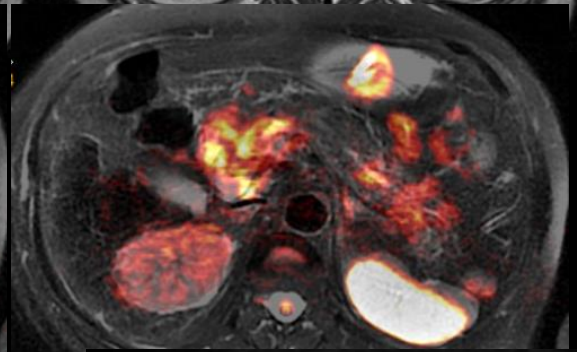


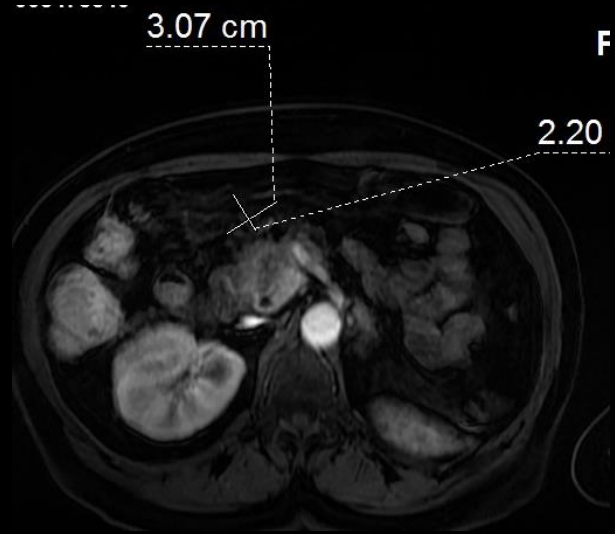


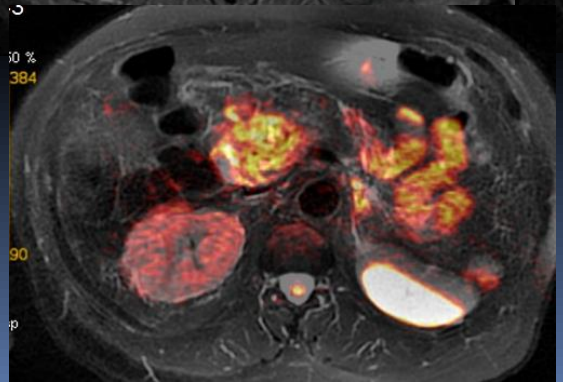
Neoplasia de cabeza de páncreas

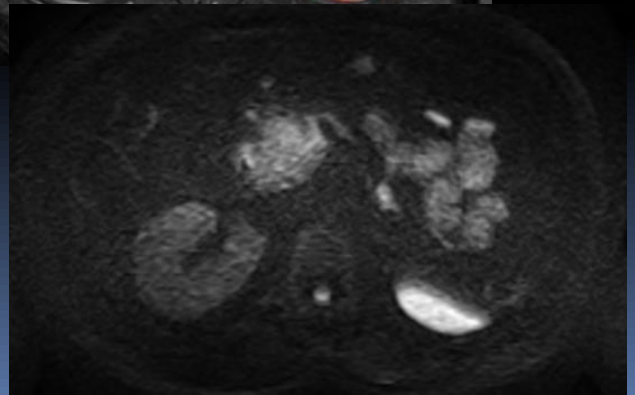


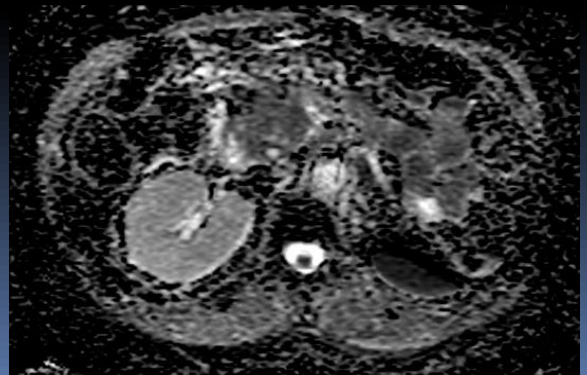




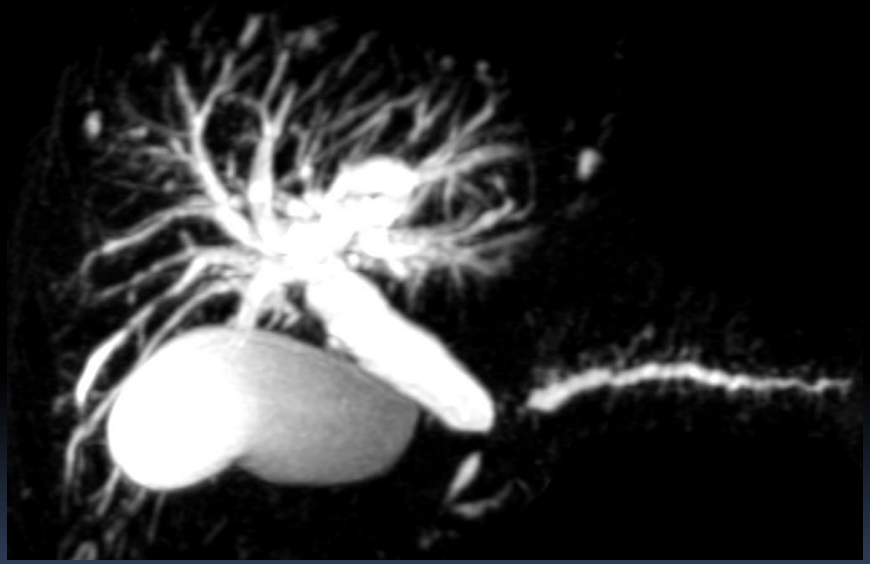


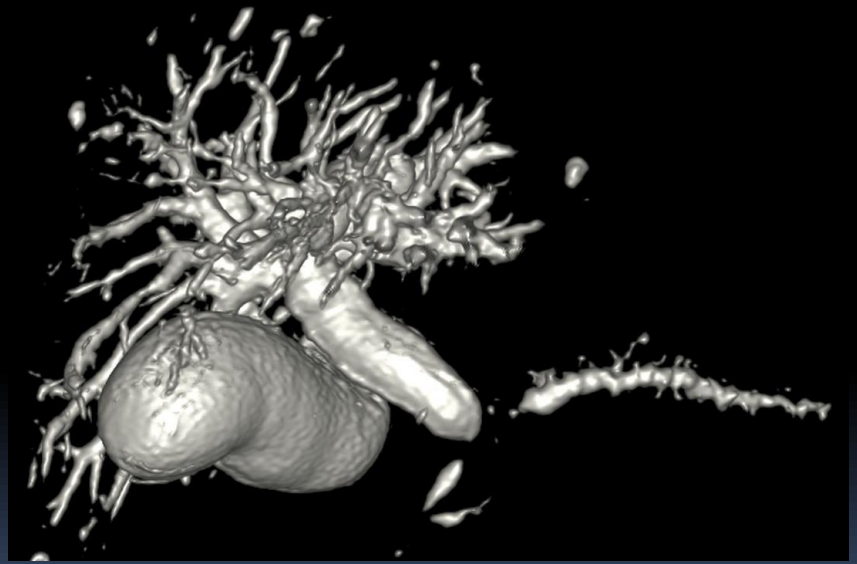


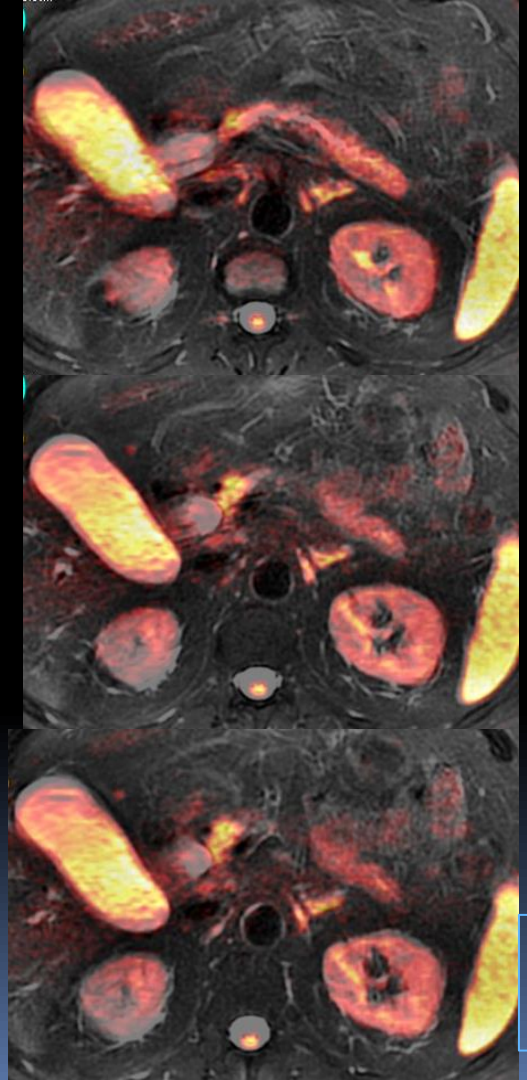


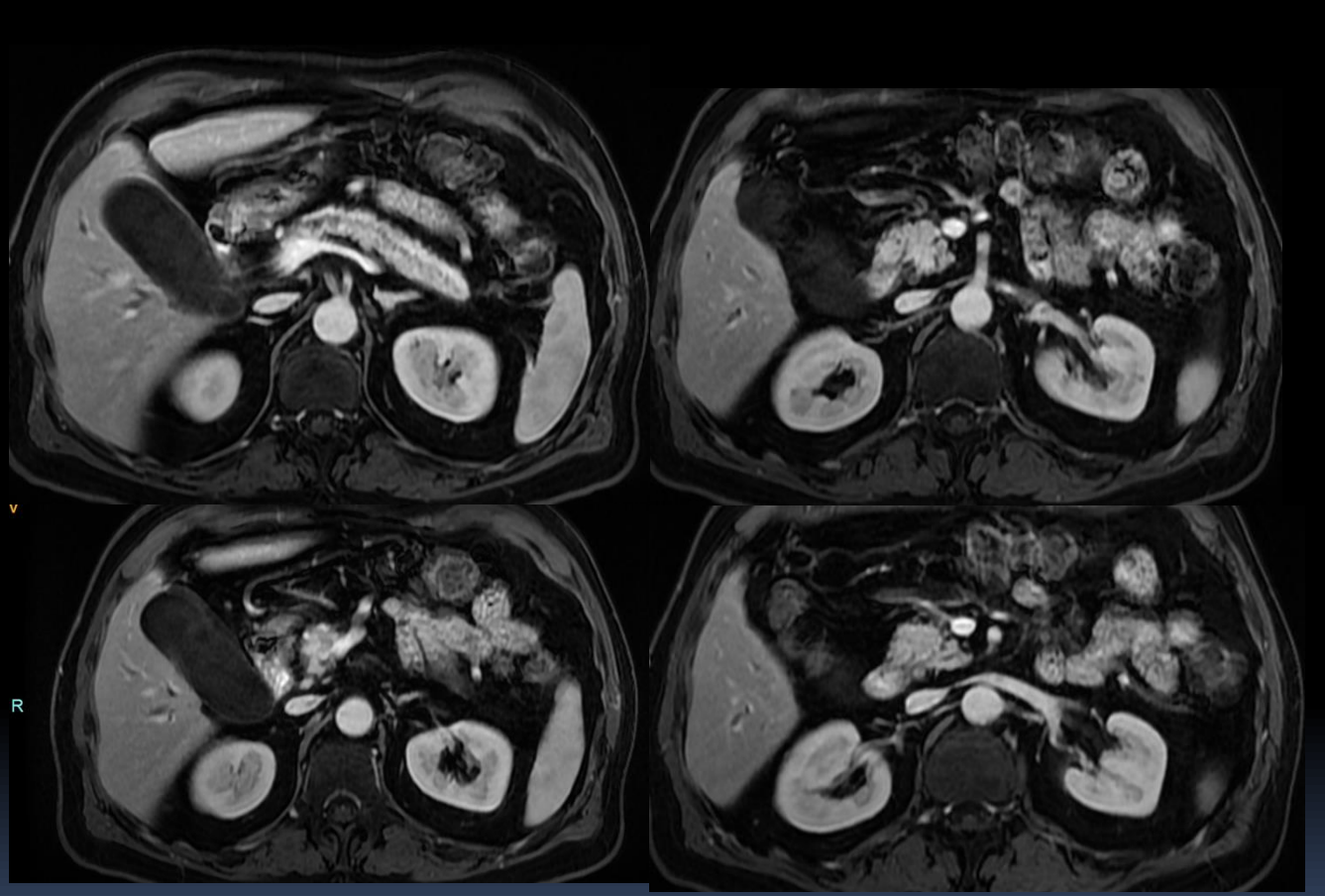


Paciente de 57 a. Ictericia y dolor abdominal



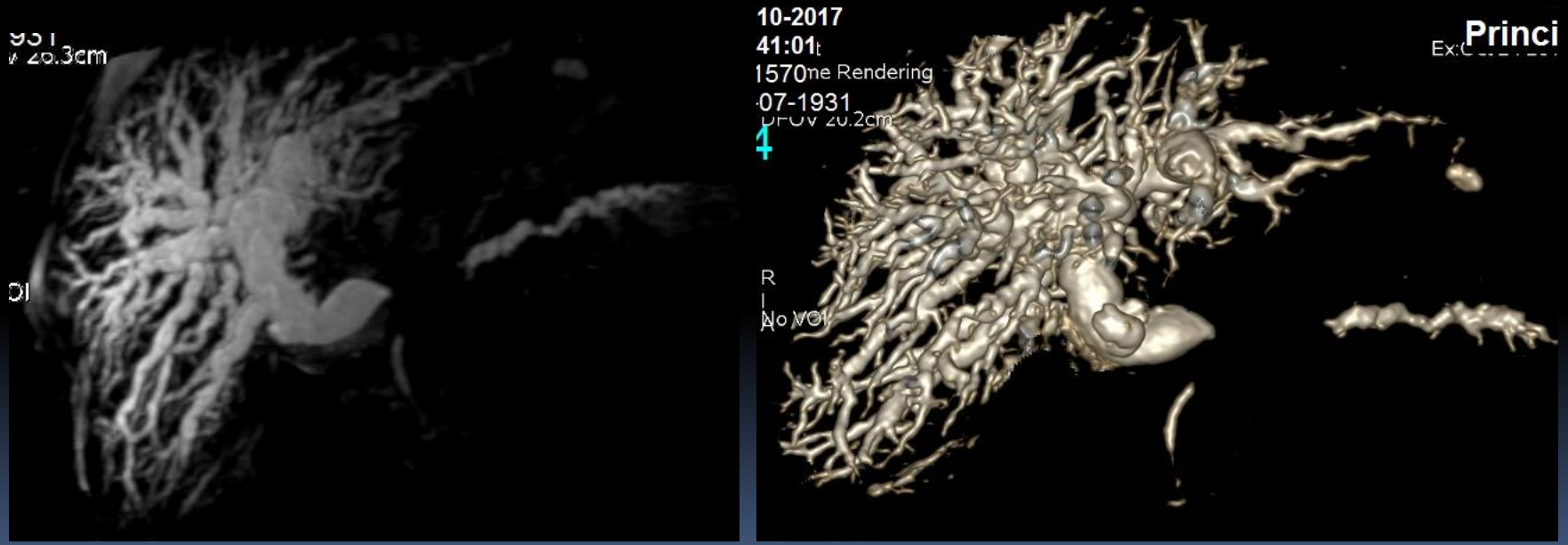


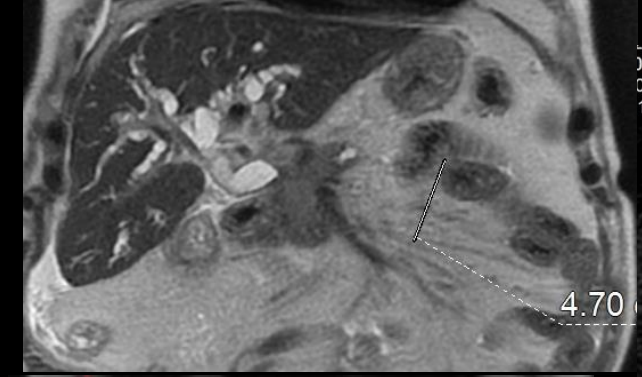


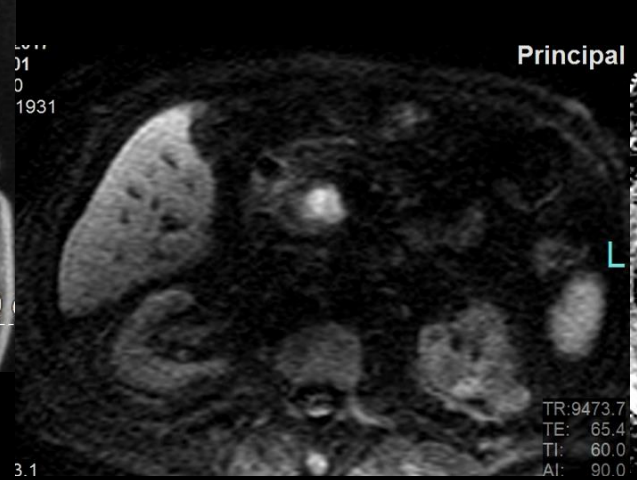


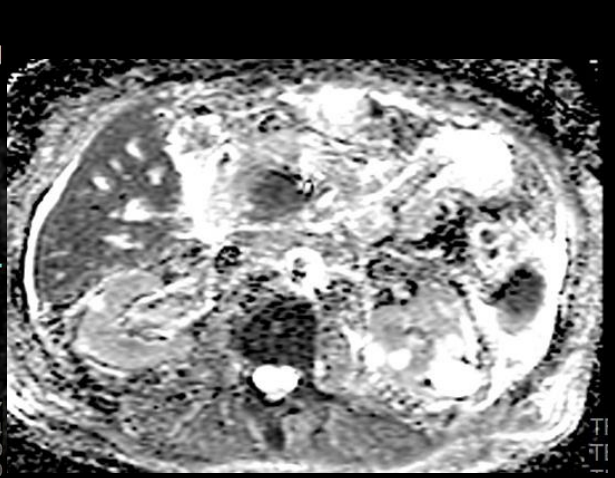
Ecoendoscopia: lesión de 1,8 cms en cabeza-cuello de páncreas, dilatación Wirsung y VB. AP: Neoplasia de páncreas.

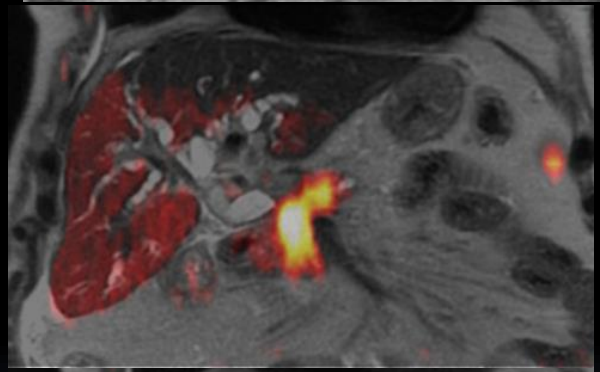
Paciente de 80 años ictericia obstructiva, sospecha de coledocolitisis

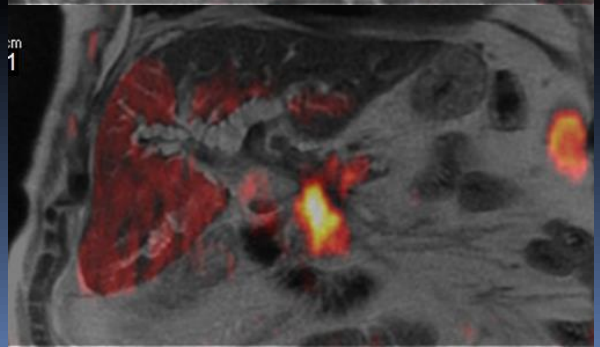


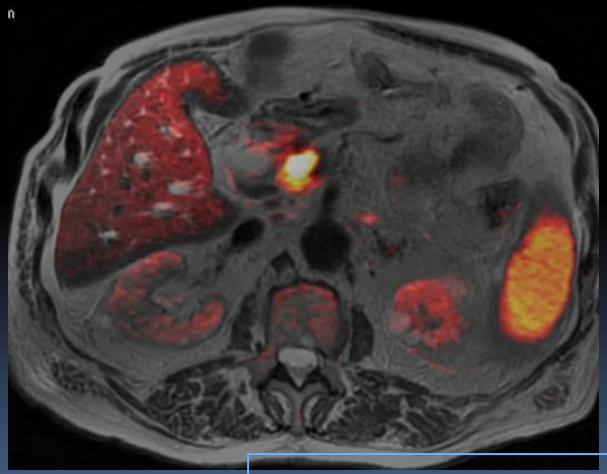


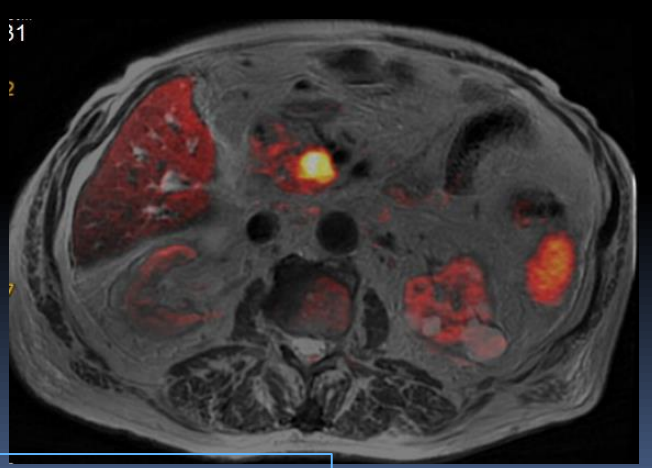






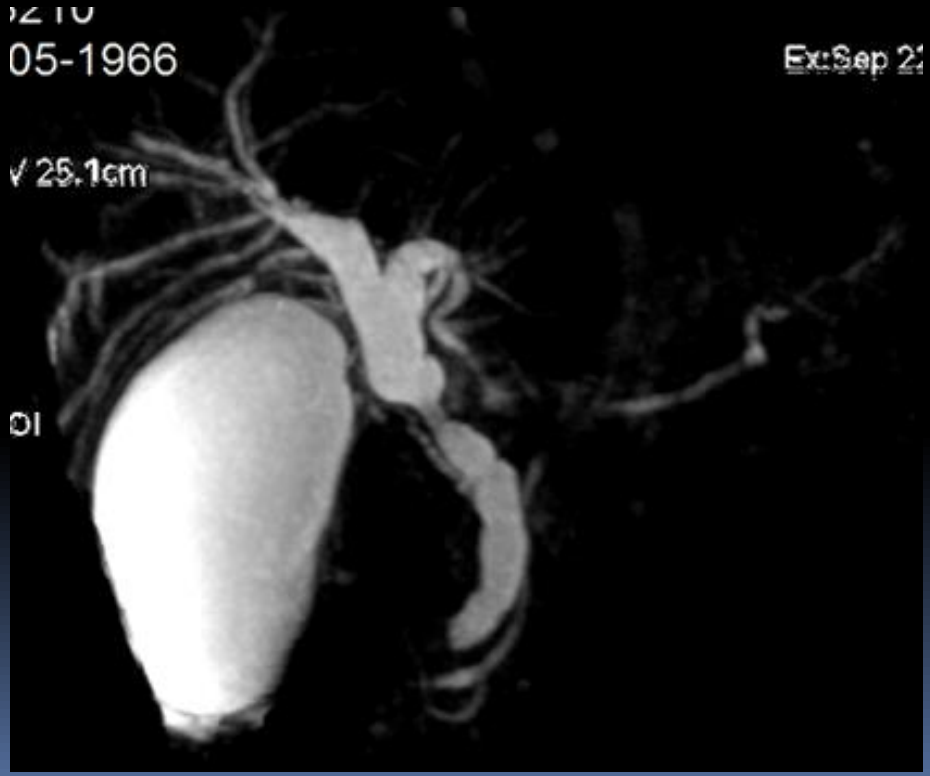


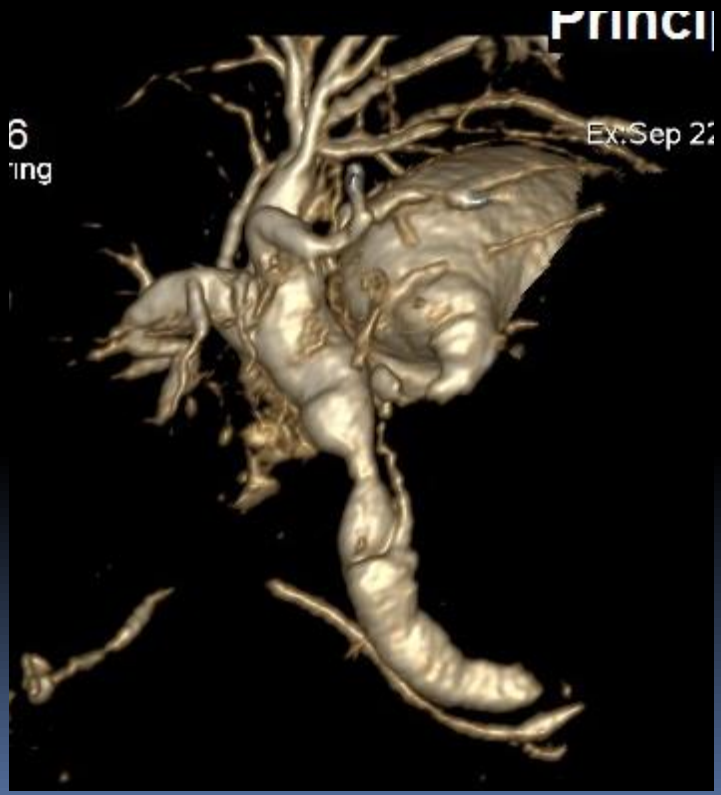


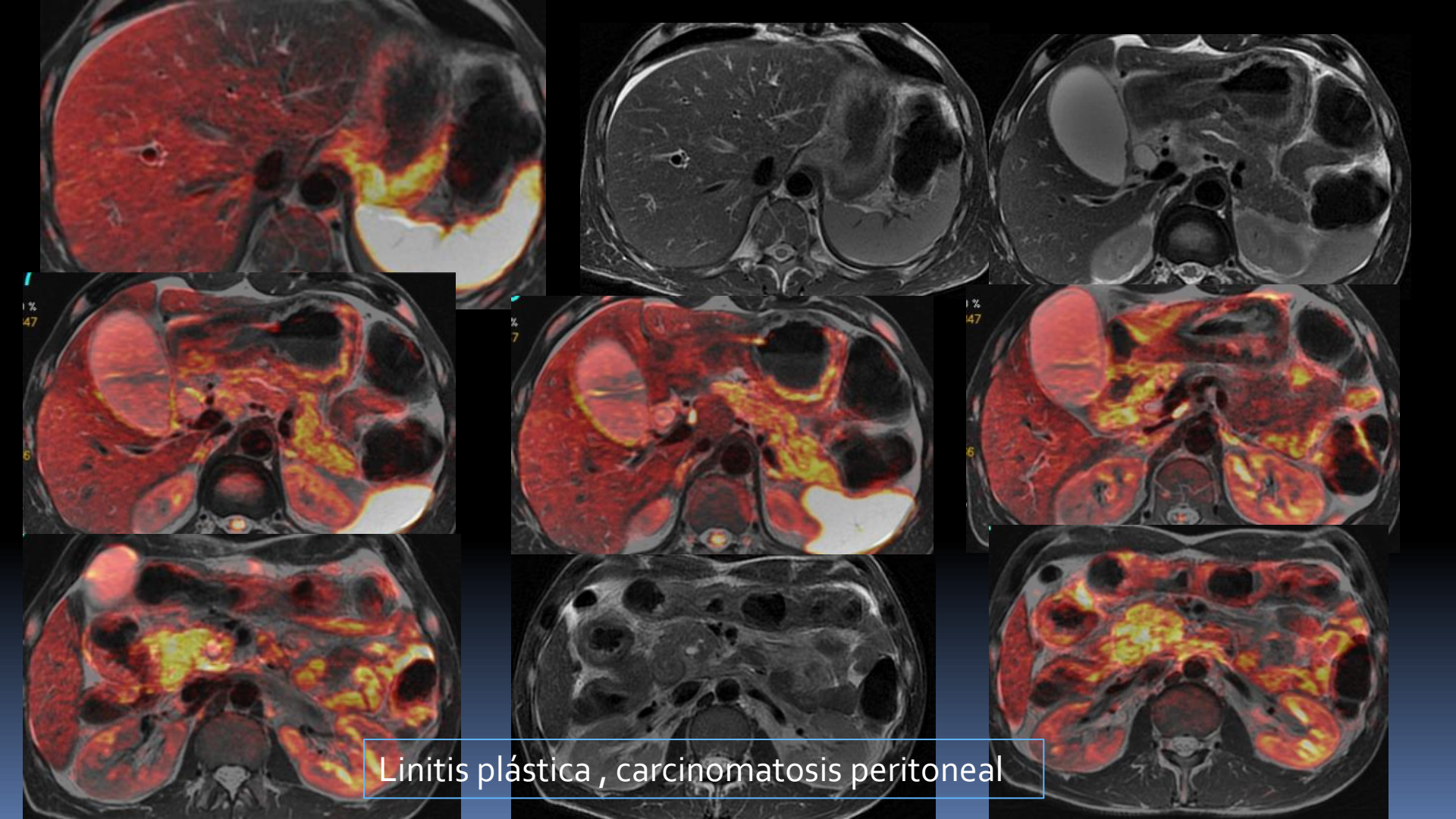


Neoplasia de cabeza de páncreas

Ictericia obstructiva. Antecedente de linitis plástica
Valorar coledocolitiasis o infiltración tumoral.






Linitis plástica , carcinomatosis peritoneal

MUCHAS GRACIAS.