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Points-clés de l'intervention de Lewis-Santy

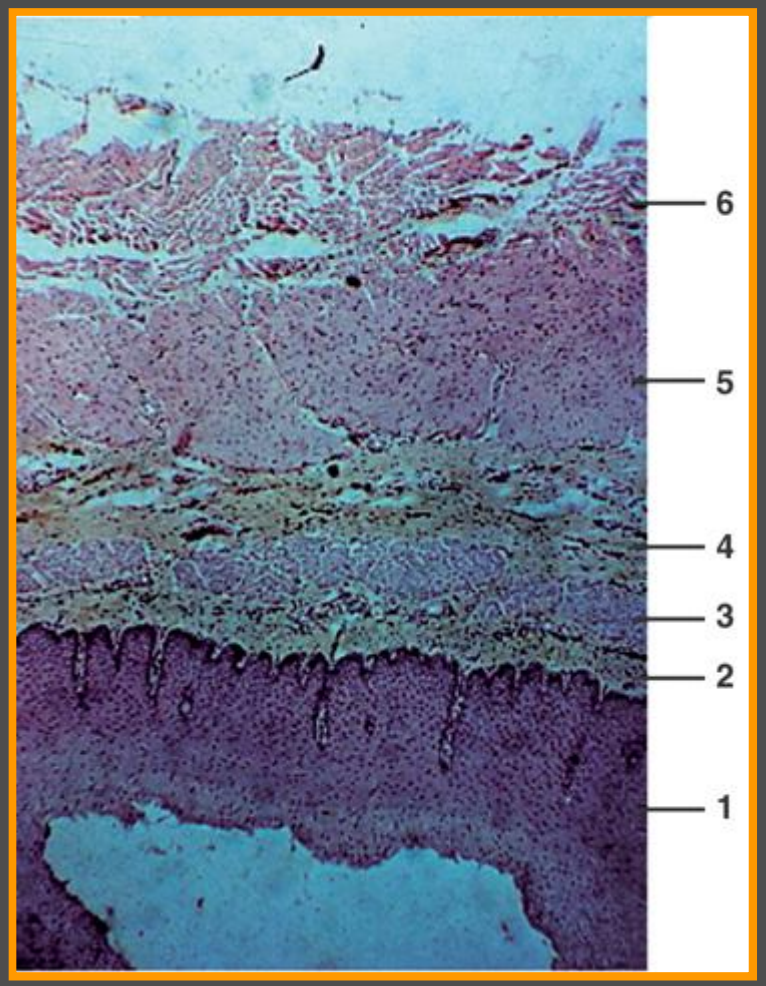
R. Douard

Hôpital Cochin - Chirurgie Digestive et Endocrinienne

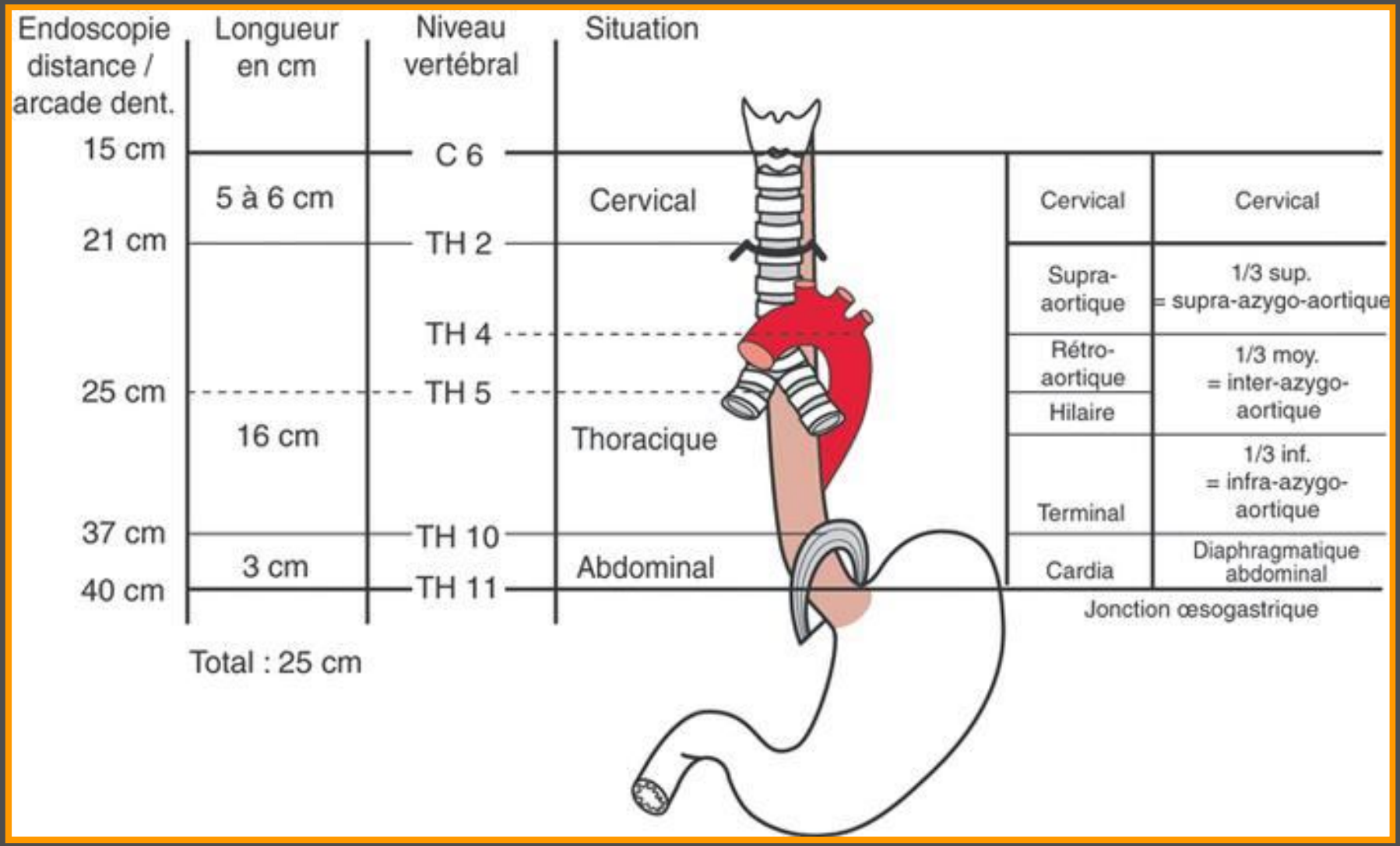
DESC Chirurgie Viscérale et Digestive
Vendredi 13 Mars 2009

Introduction

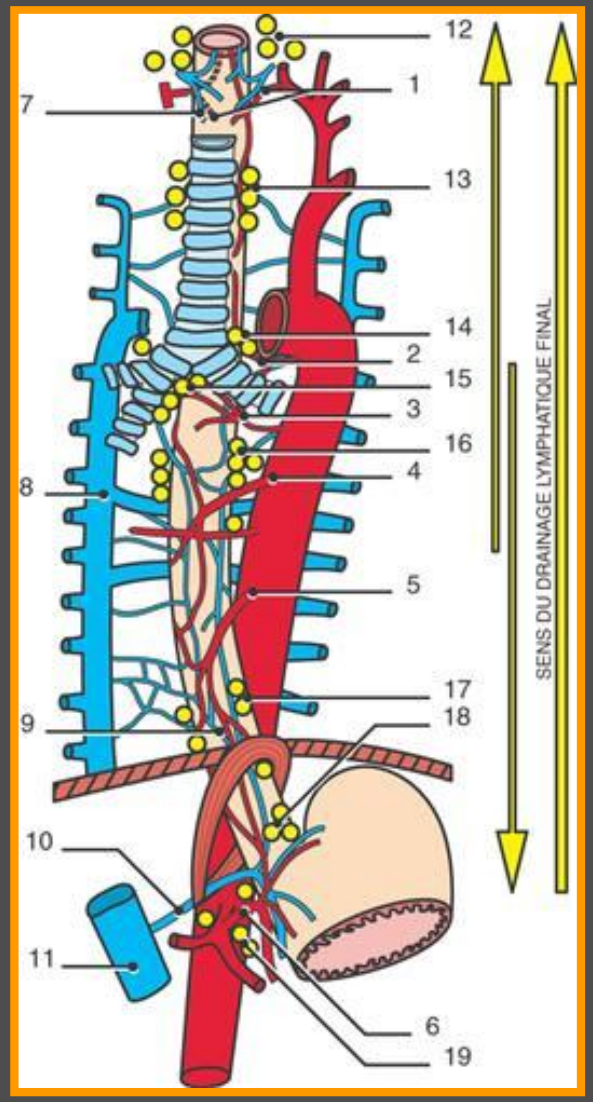
- Pas de séreuse au niveau cervical et thoracique!

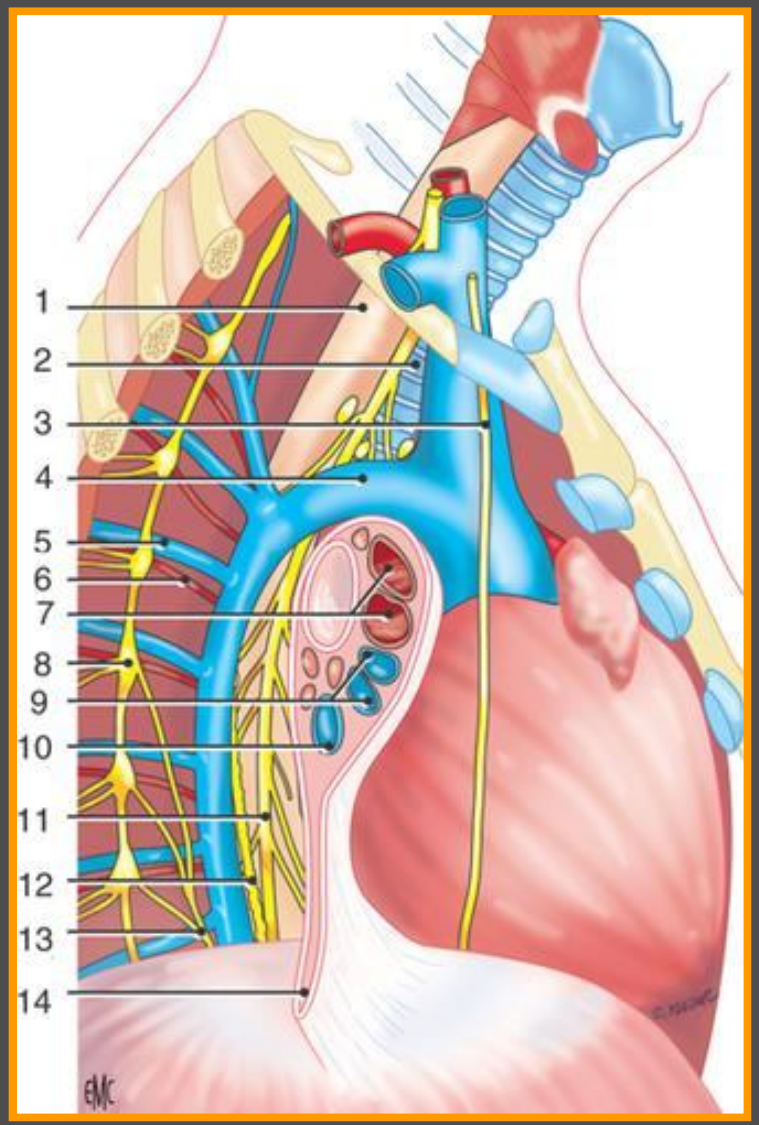


L'œsophage a trois parties

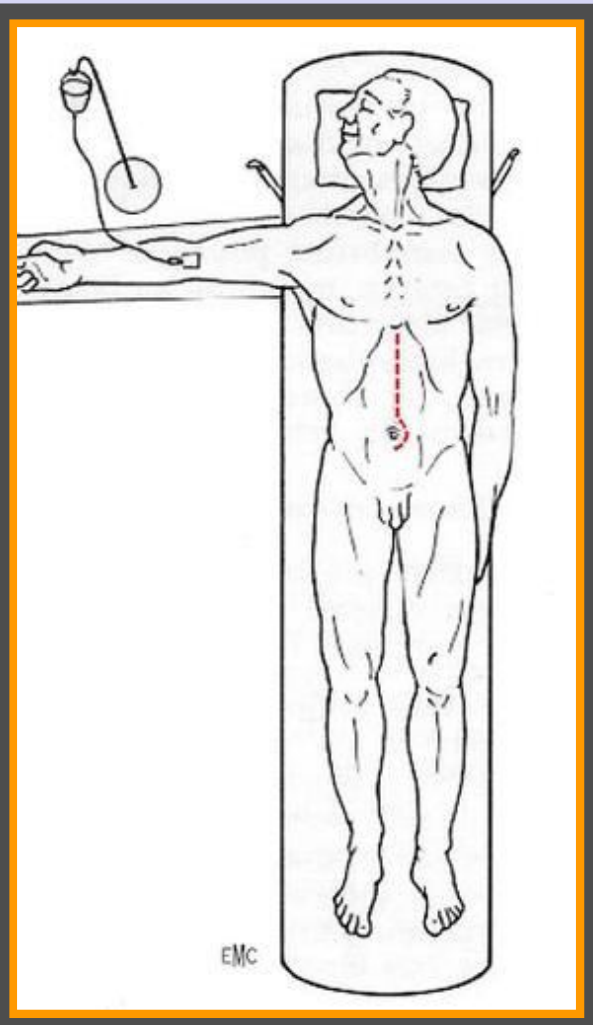


L'œsophage a trois parties



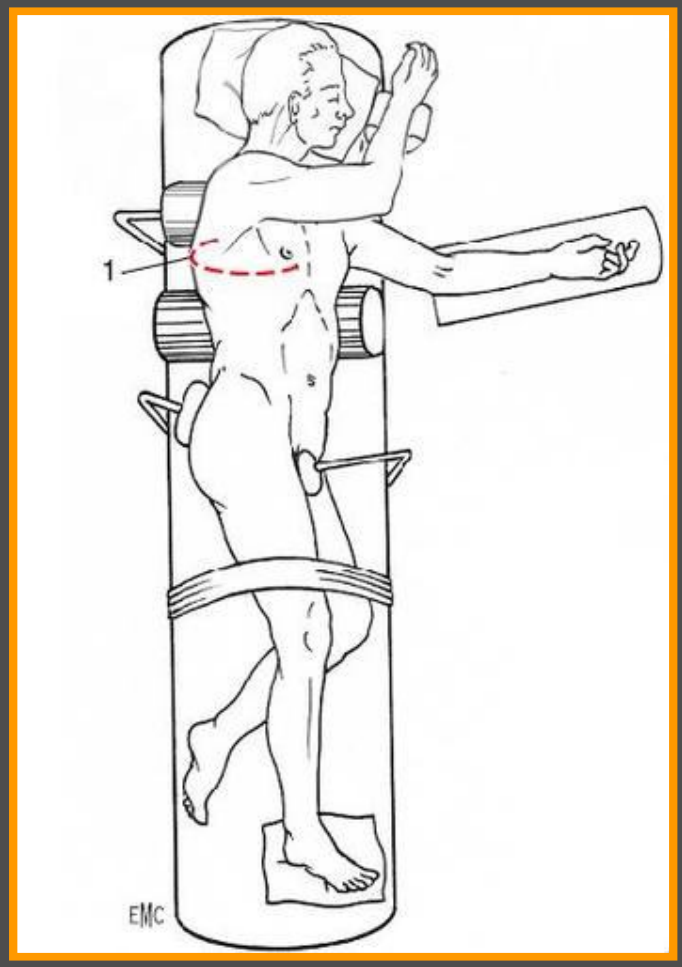


Installation



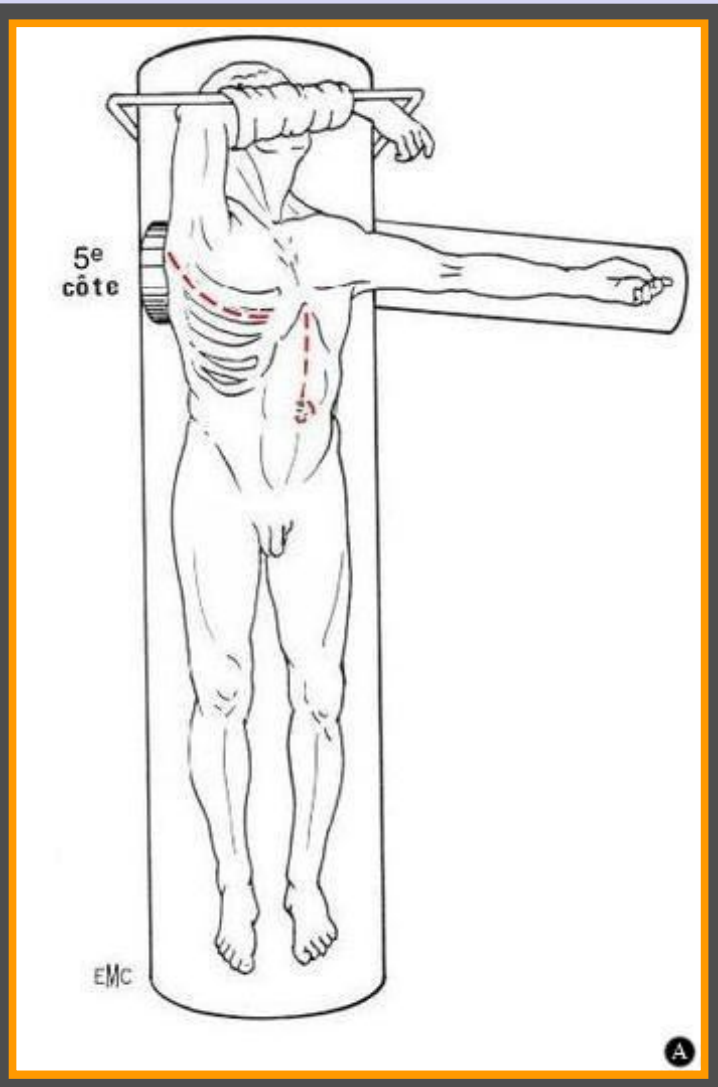
Temps abdominal

Puis

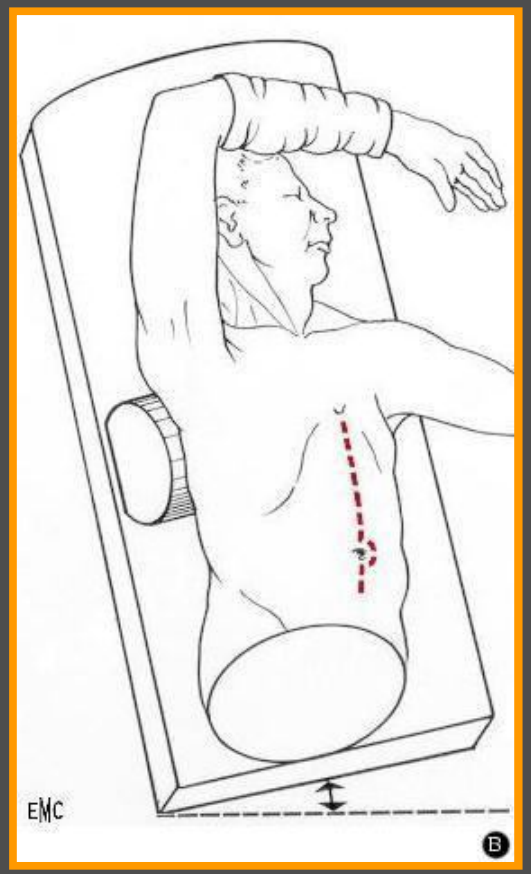


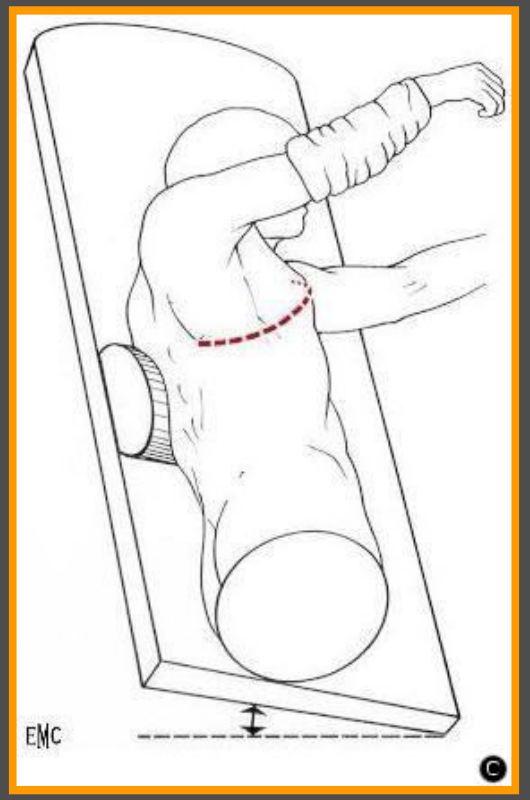
Thoracotomie postérolatérale
5 ou 6ème espace

Installation combinée

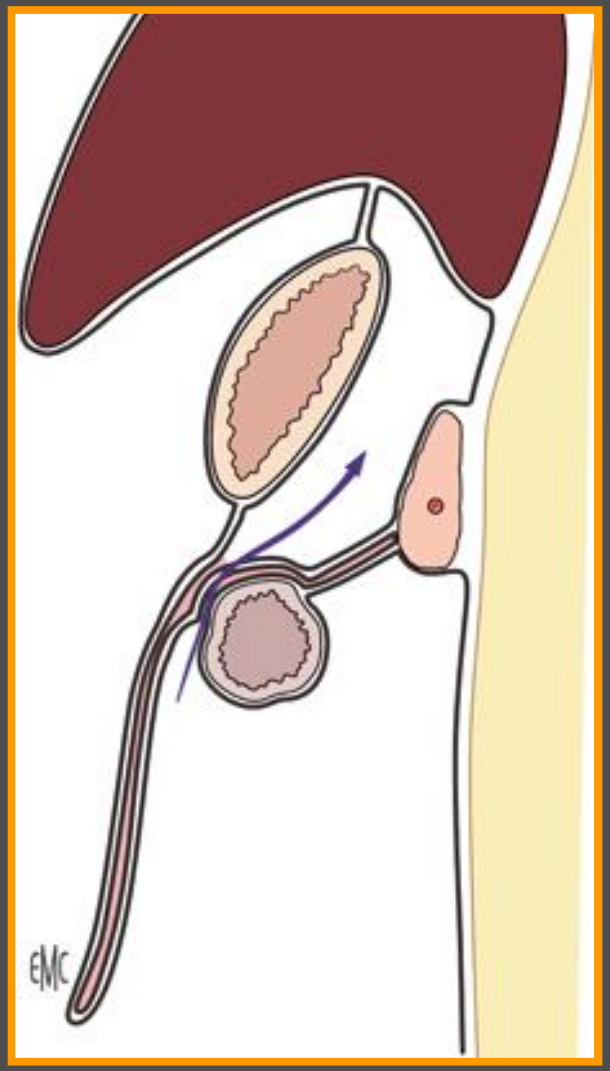


Bof!



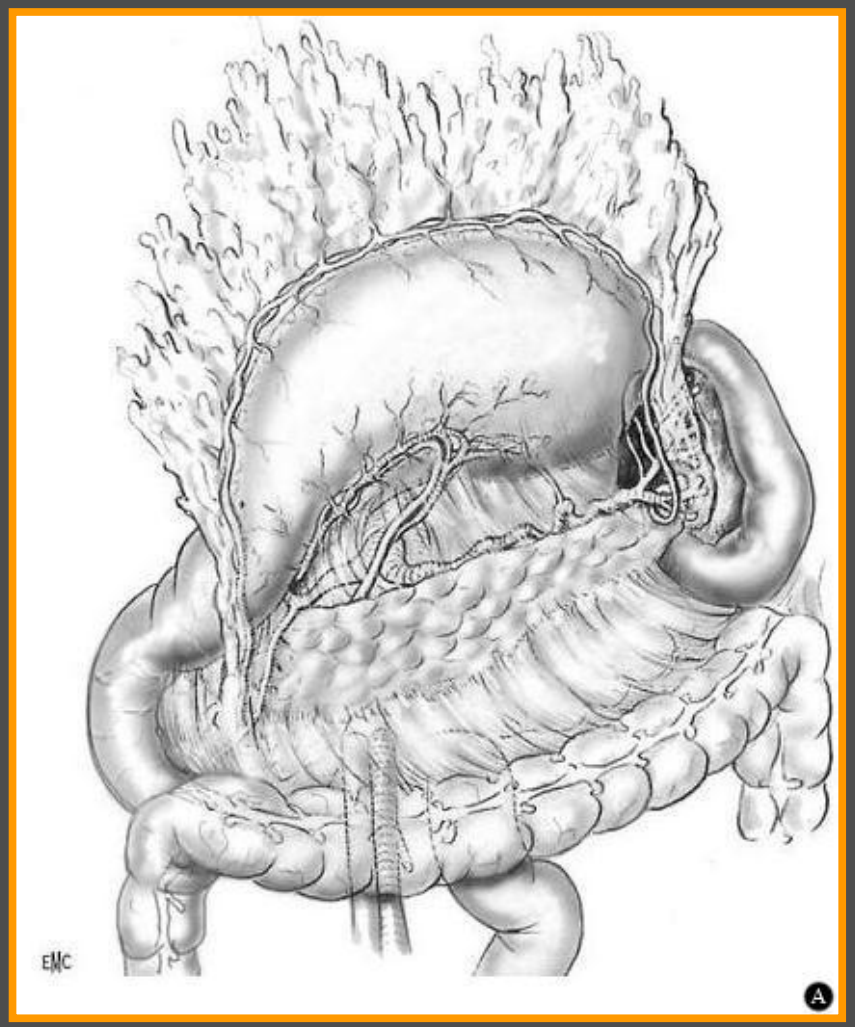


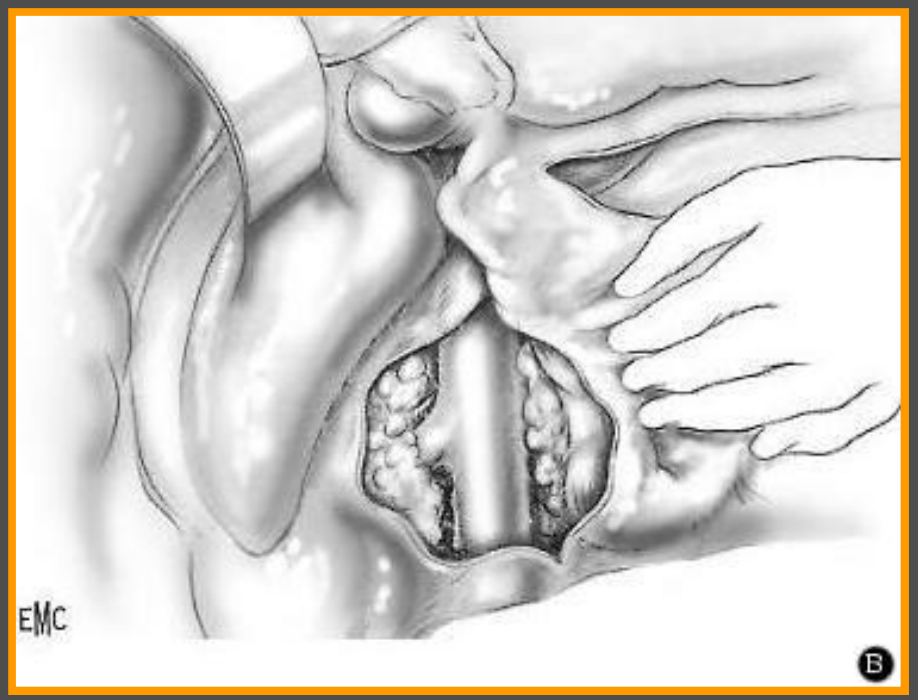
Décollement colo-épiploïque



Décollement coloépiploïque

Décollement duodénopancréatique

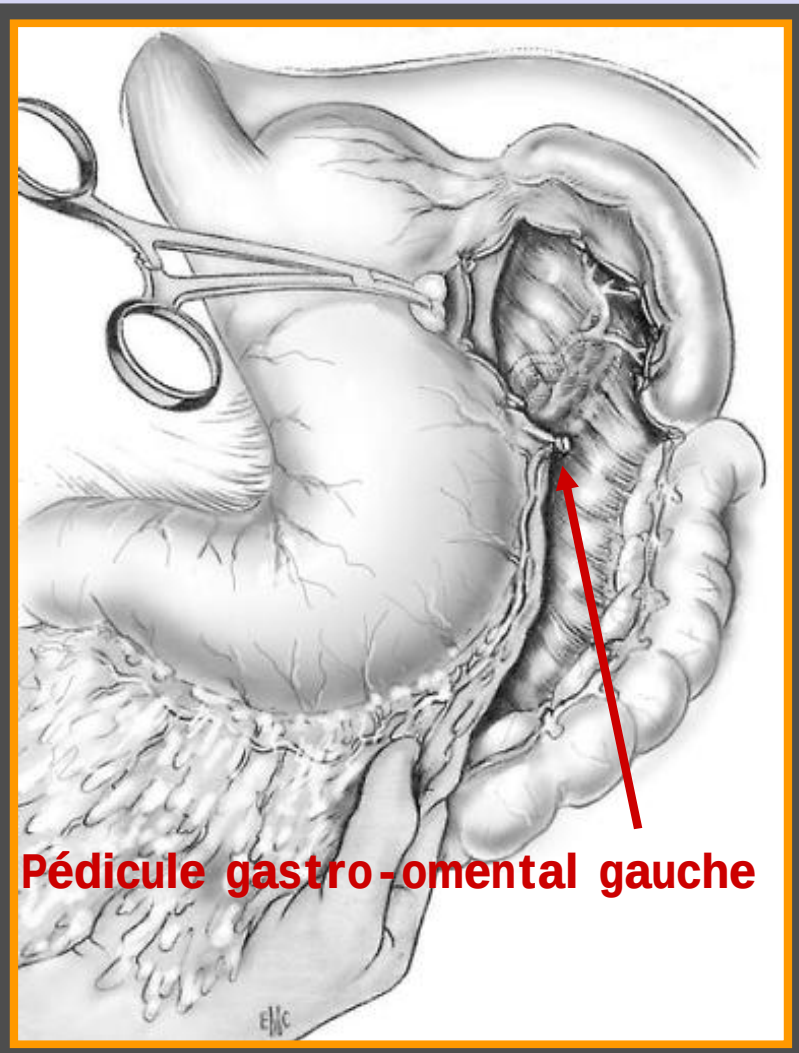


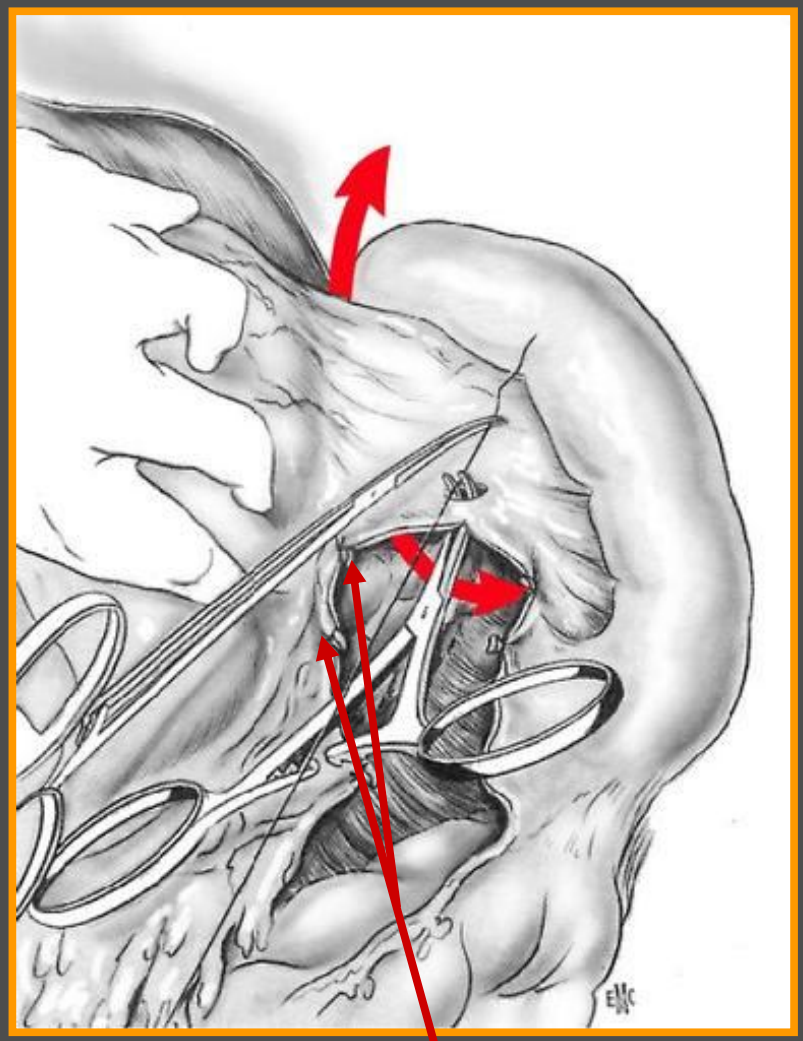


Décollement duodénopancréatique

Attention au pédicule gastro-omental droit!

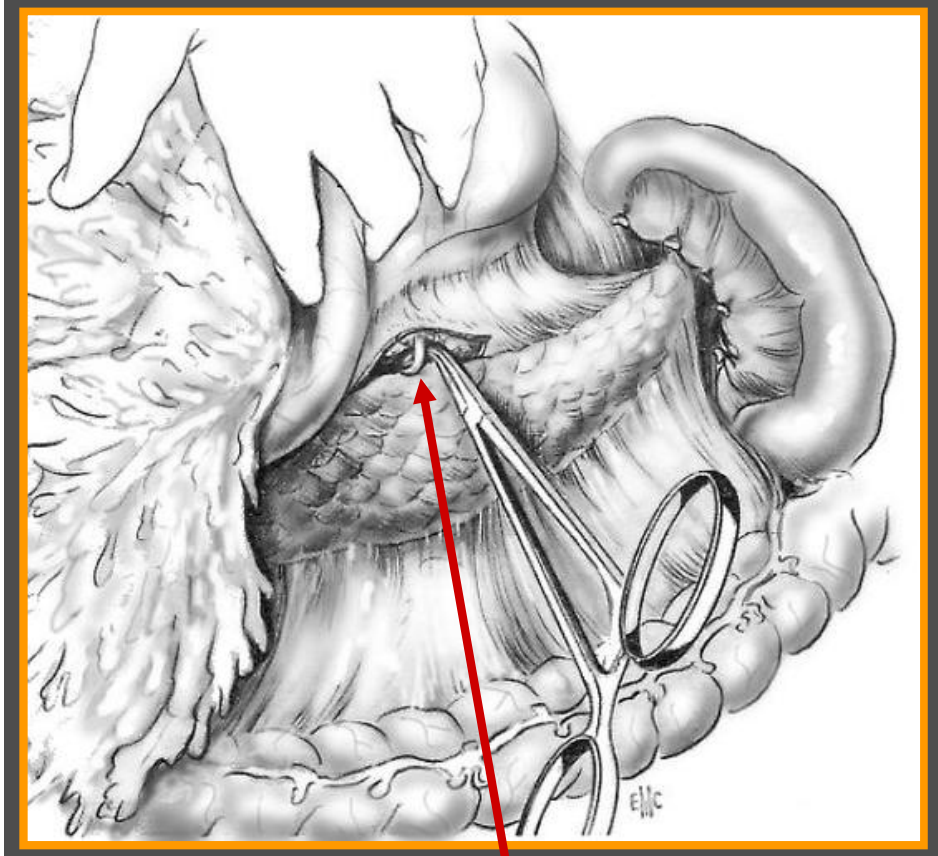
Section du ligament gastrosplénique

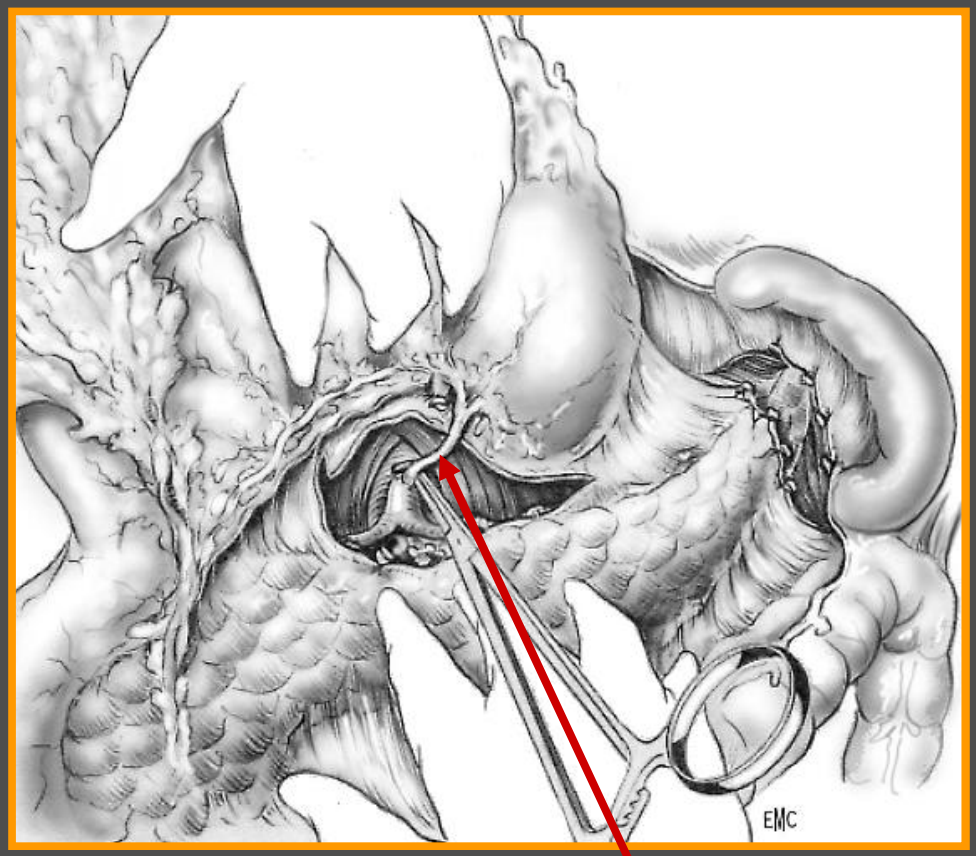




Section du ligament gastrosplénique: les vaisseaux courts

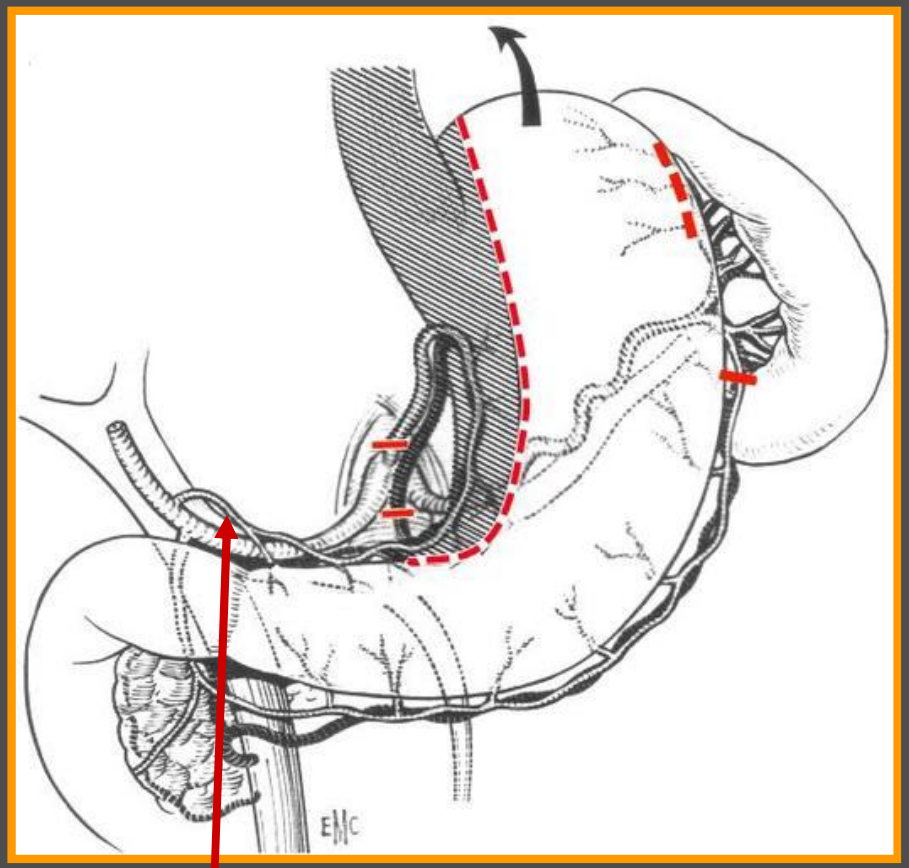
Section des vaisseaux gastriques gauches



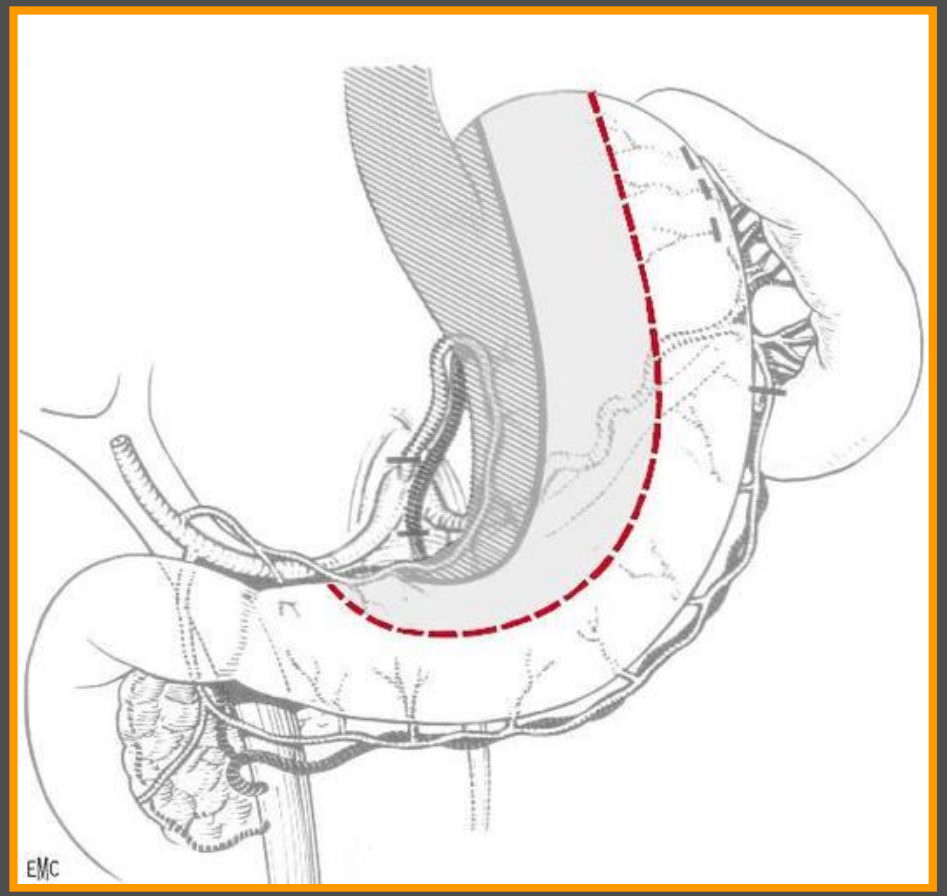


Section de la veine gastrique gauche puis de l'artère

Confection de la plastie gastrique

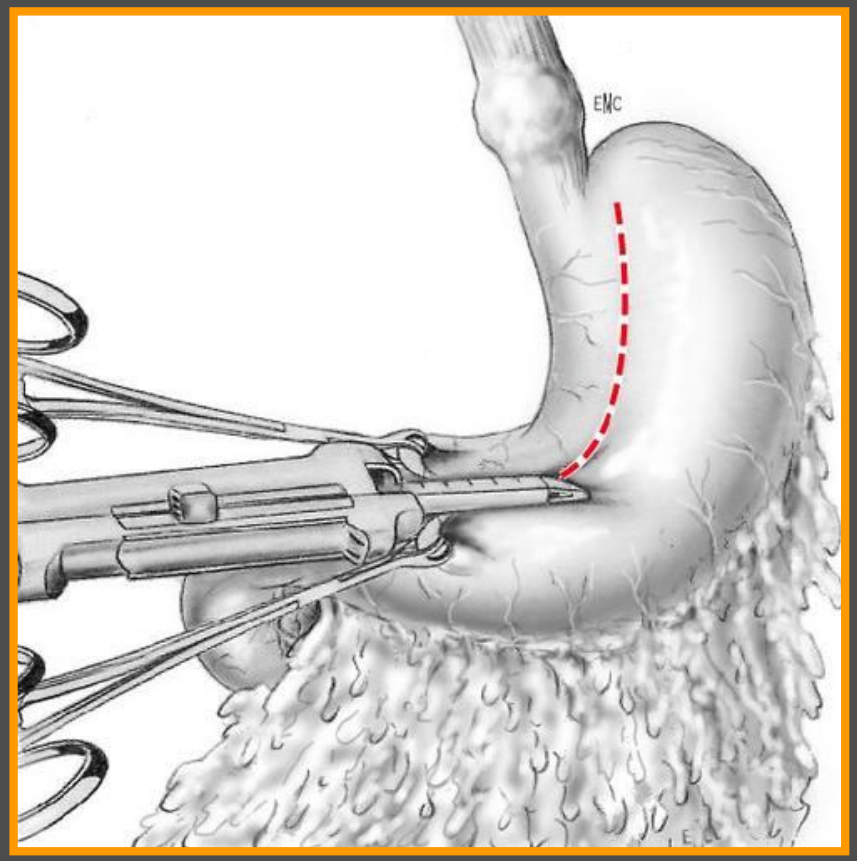


Tube large ou étroit?

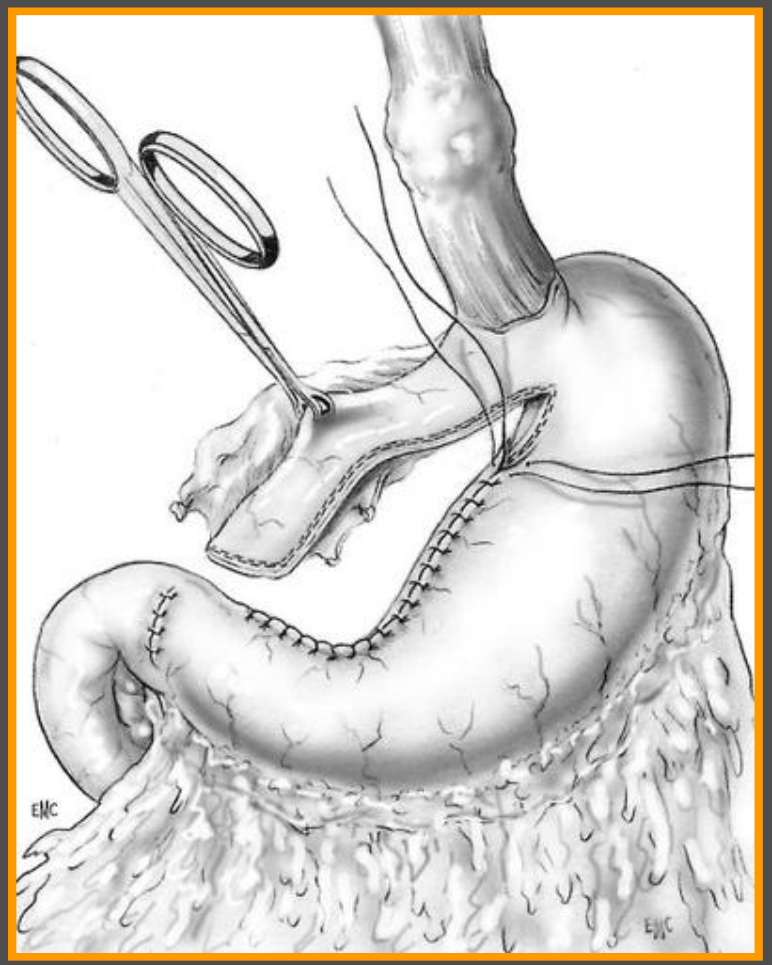


Conservation du pédicule gastrique droit

Confection de la plastie gastrique

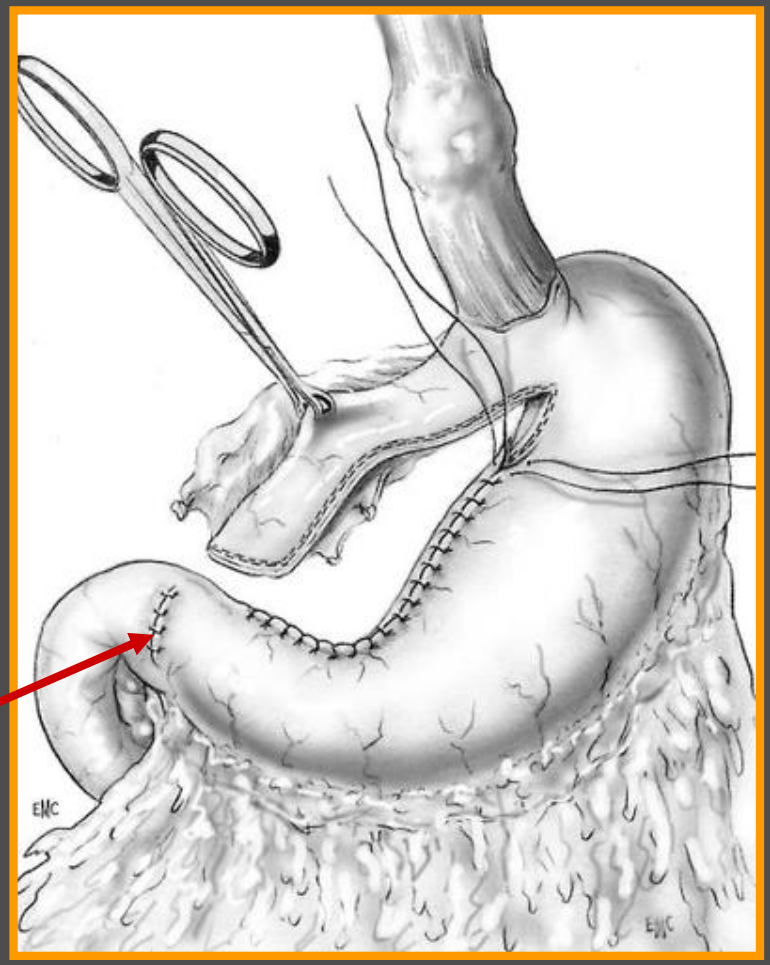


Tubulisation à la GIA courte



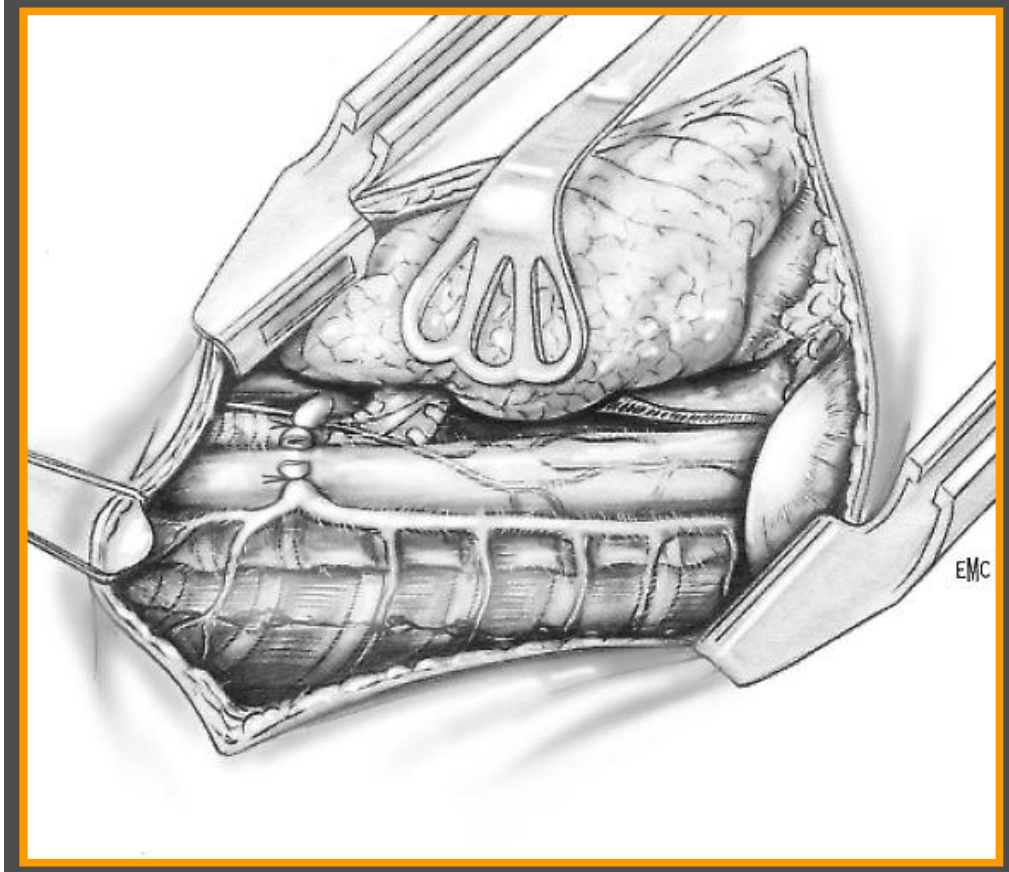
Autres gestes

- Un geste de vidange gastrique est recommandé
  - Pyloroplastie?
  - Pyloroclasie?
- Jéjunostomie d'alimentation?
  - Si elle marche
    - Calibre suffisant
    - Gestion rigoureuse
  - Si elle ne fuit pas …

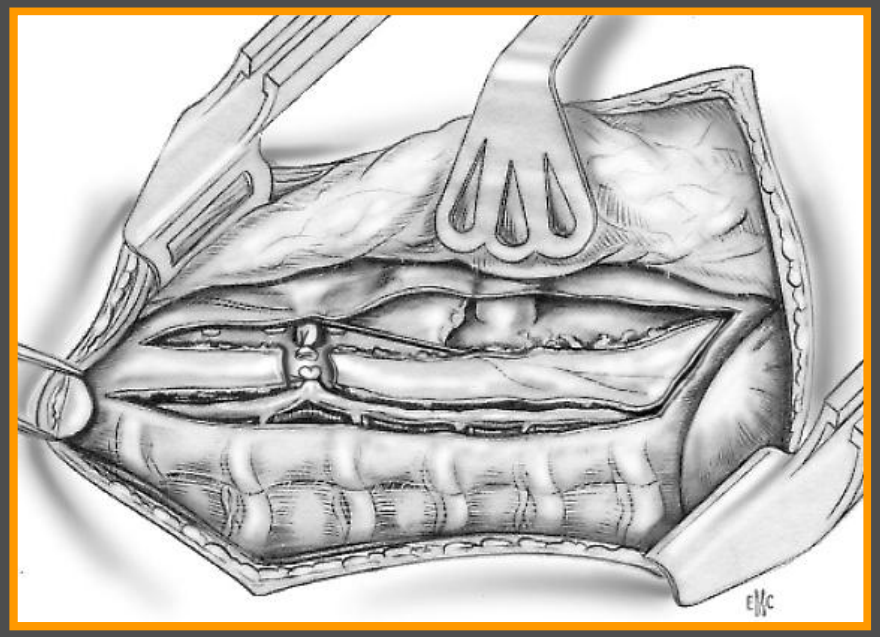


Pyloroplastie selon Heinecke-Mickulicz

Temps thoracique

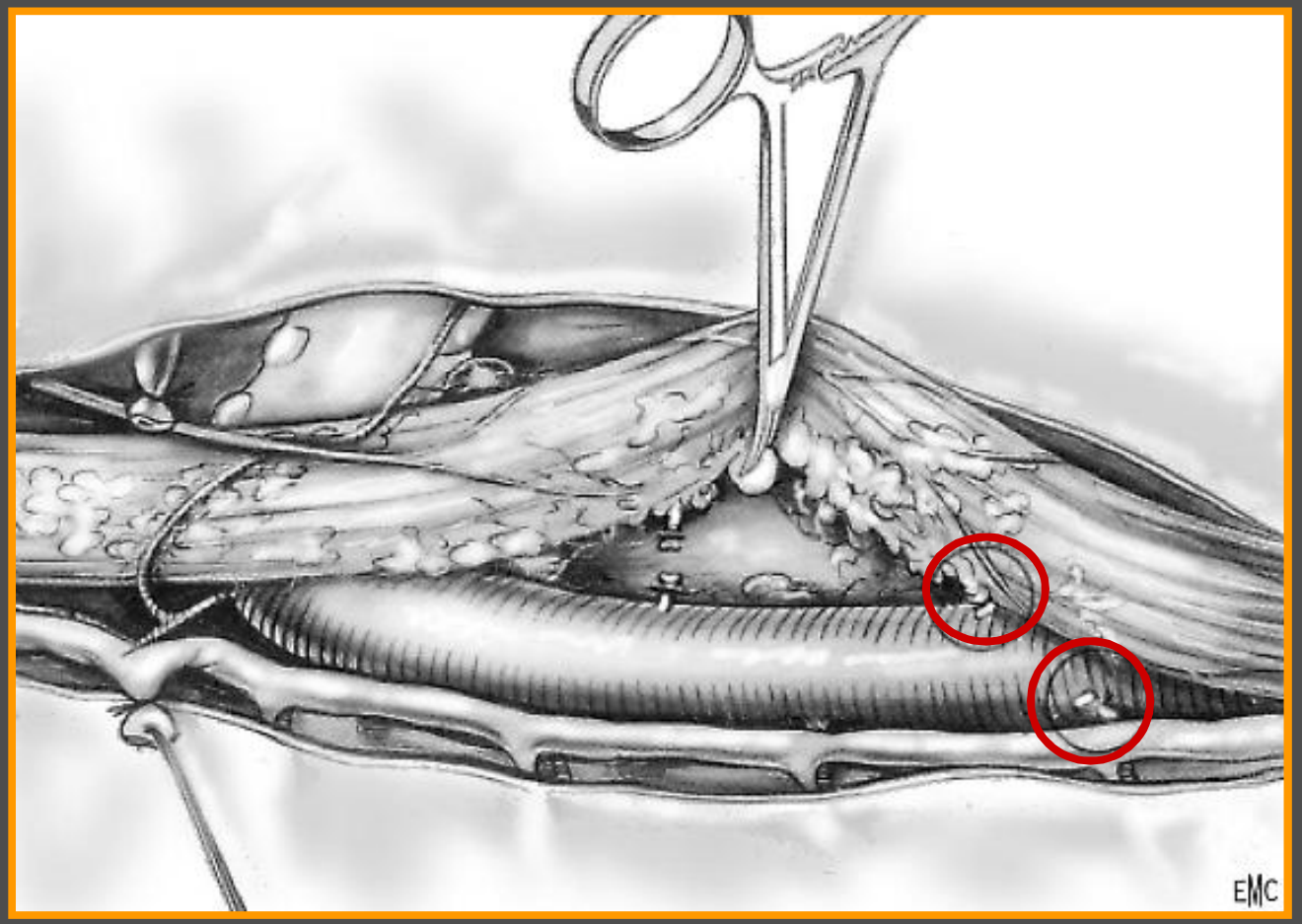


Section du ligament triangulaire droit
Ligature de la veine azygos



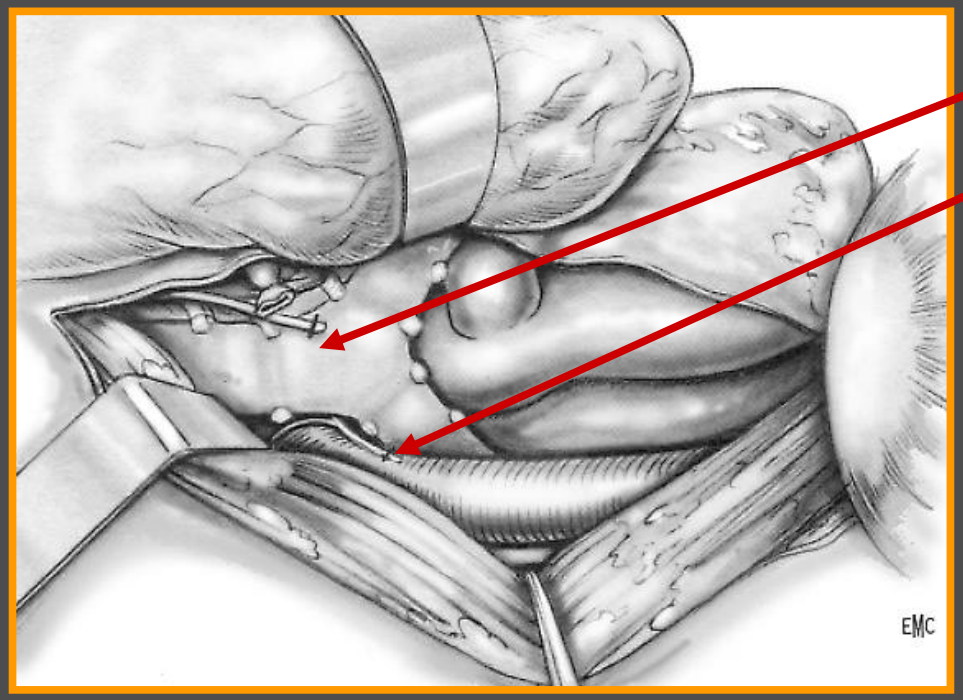
Incision pleurale

Ligature du conduit thoracique



Ligature appuyée au fil non résorbable du conduit thoracique

Temps thoracique

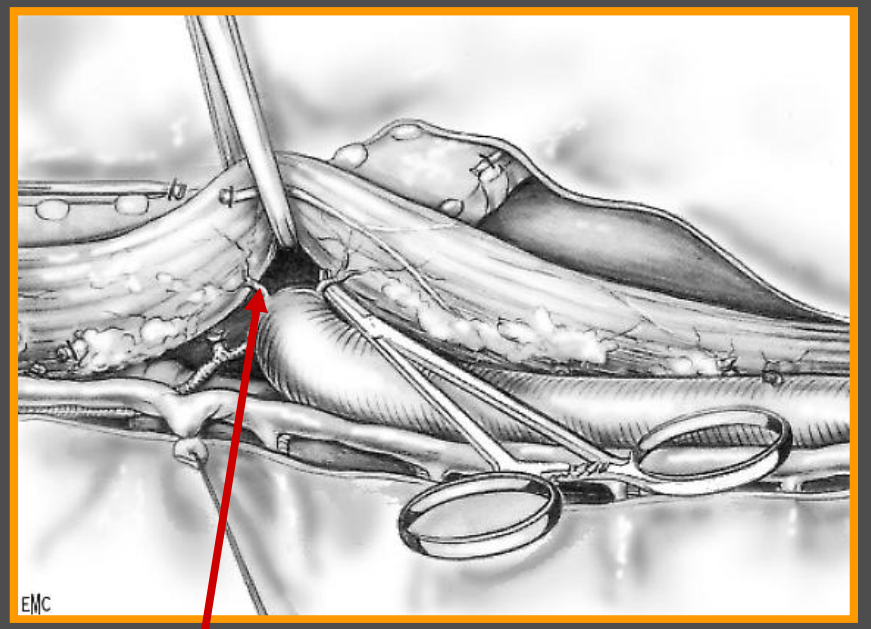


X droit

X gauche en aval du récurrent

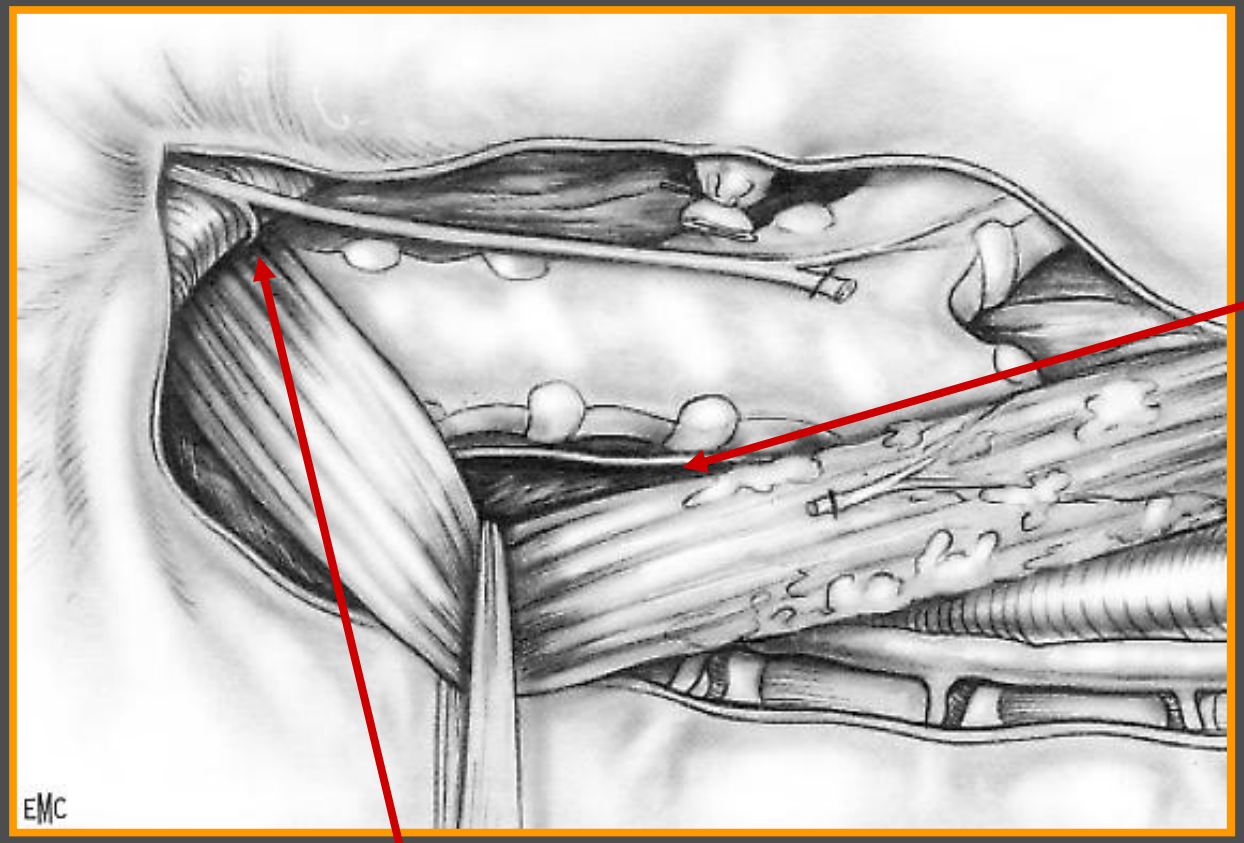
Ligature du vague droit et gauche

Curage intertrachéobronchique



Ligature des artères œsophagiennes

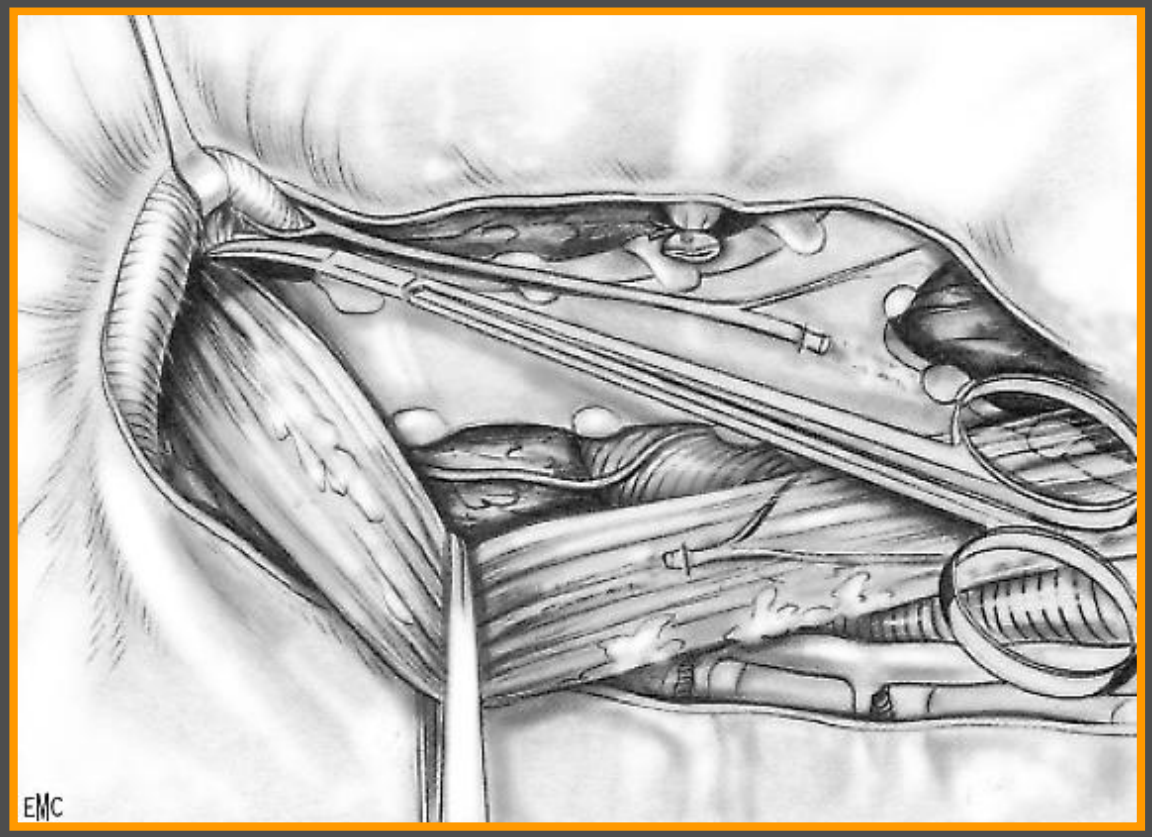
Temps thoracique



Attention au vague gauche donc au récurrent gauche!

Attention au récurrent droit!

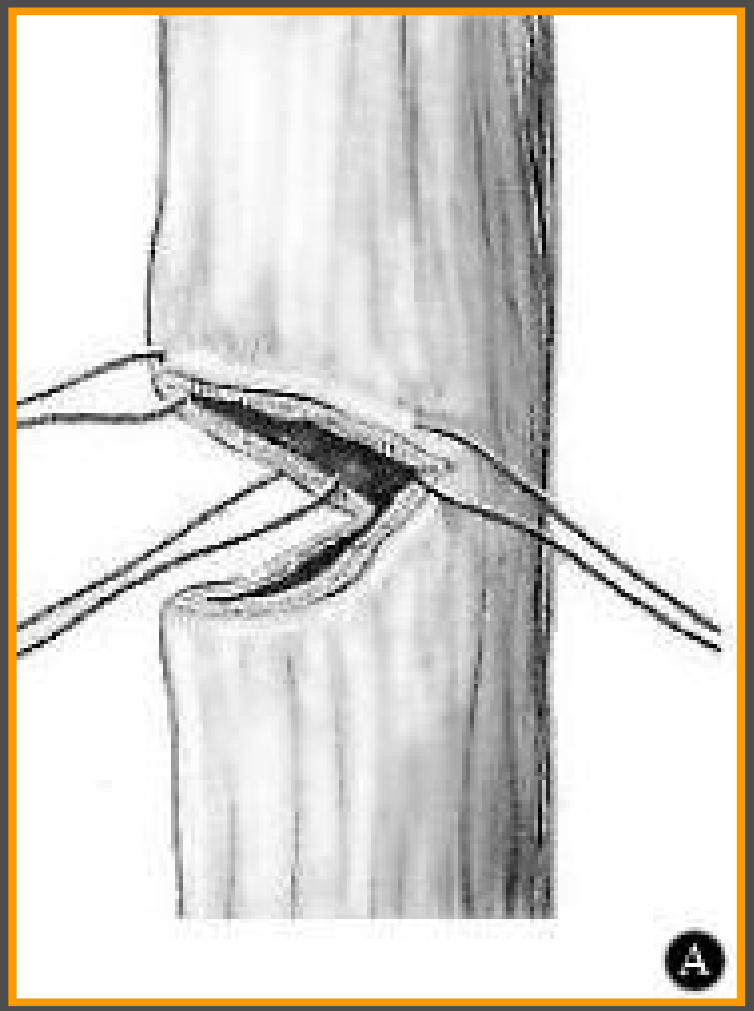
Temps thoracique



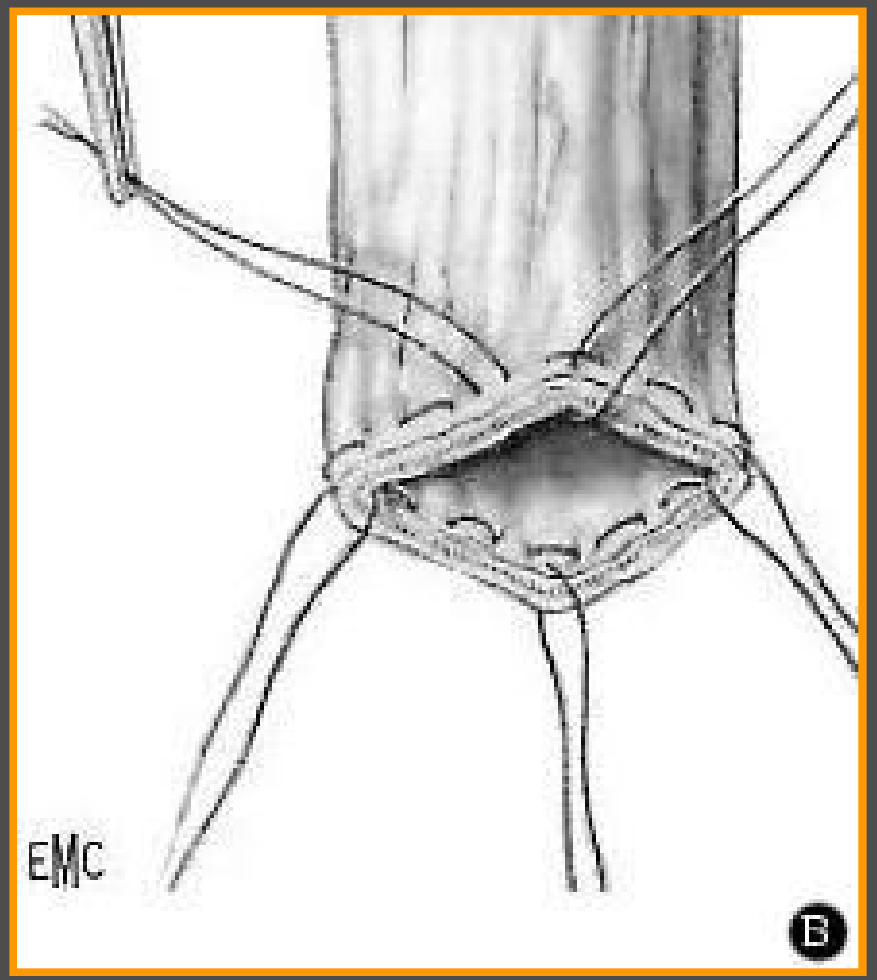
Curages récurrentiels droit et gauche

Ouverture de la loge intertrachéocave de Baréty

Anastomose mécanique ou manuelle ?

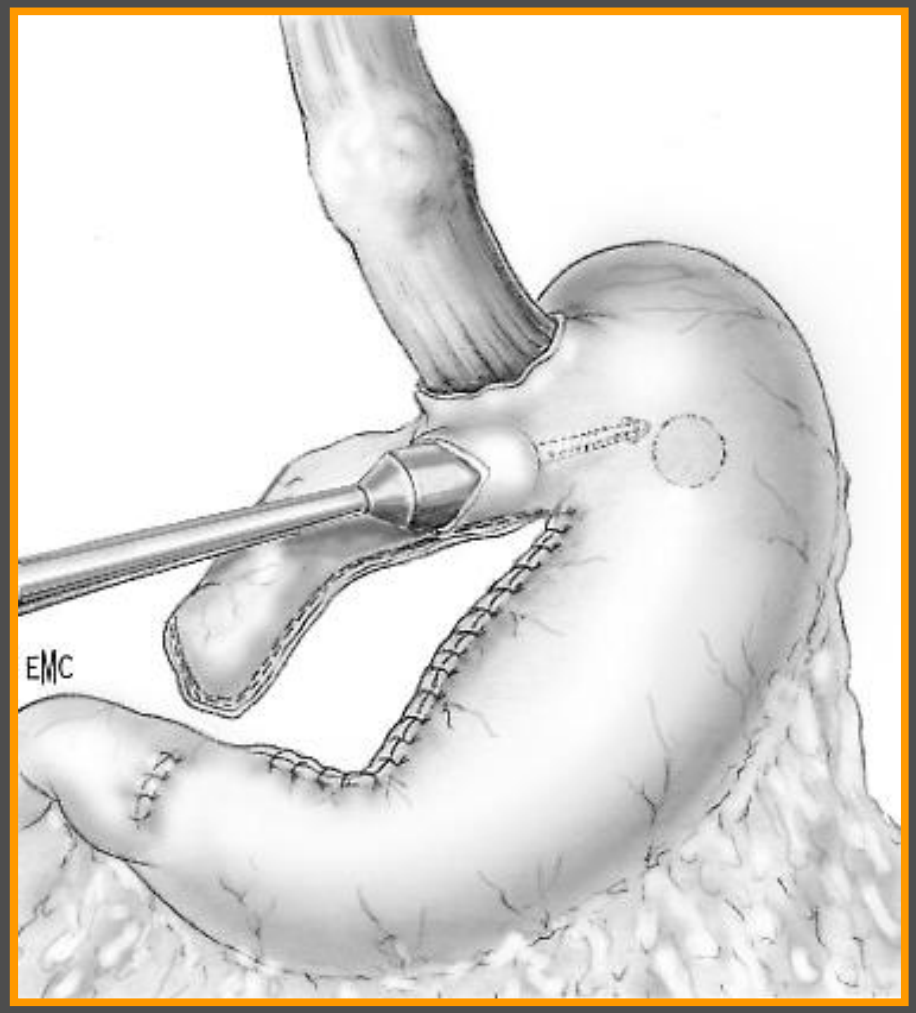


Fils au fur et à mesure de la section!

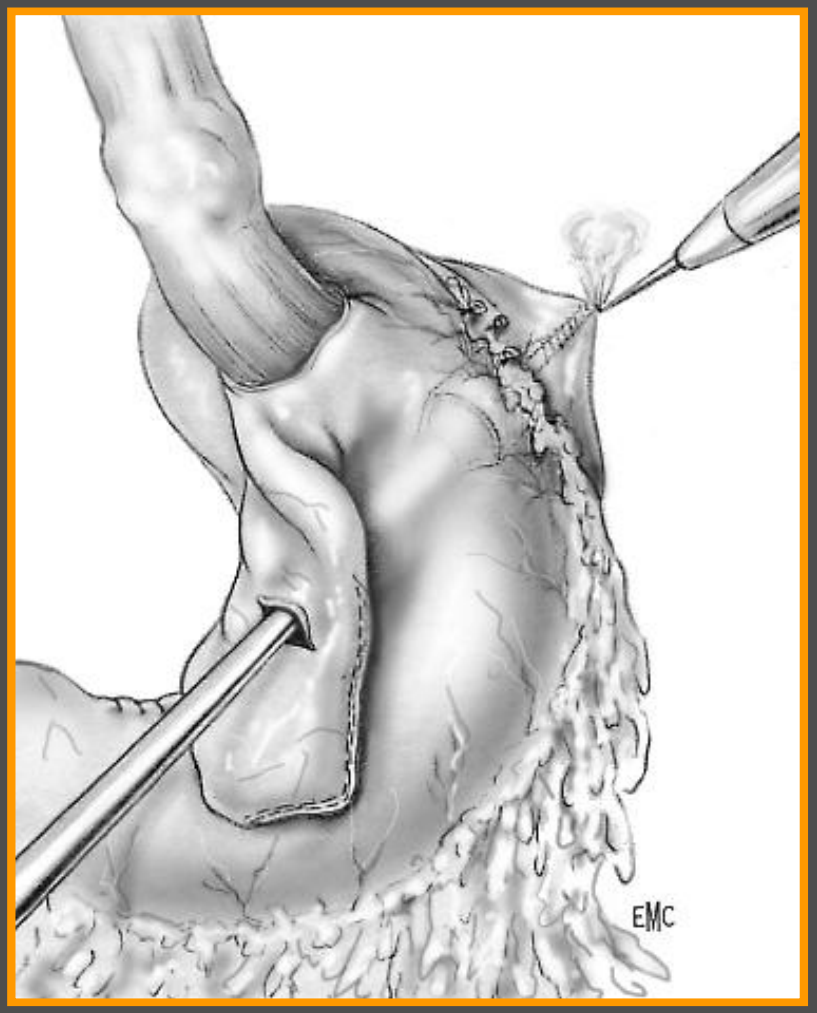


Confection de la bourse

Anastomose mécanique

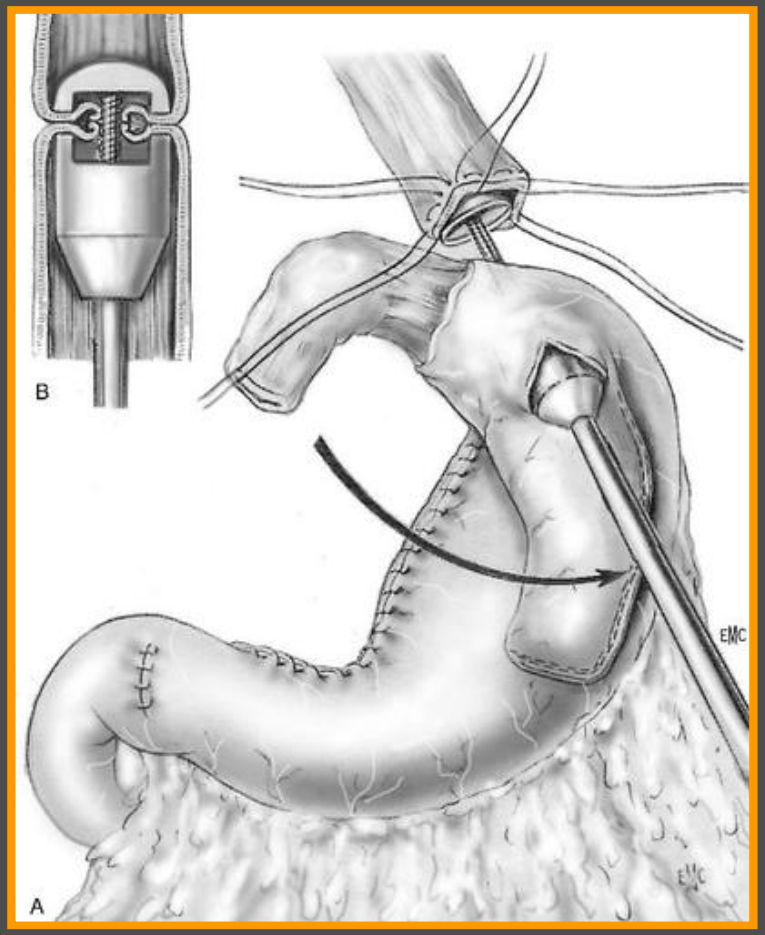


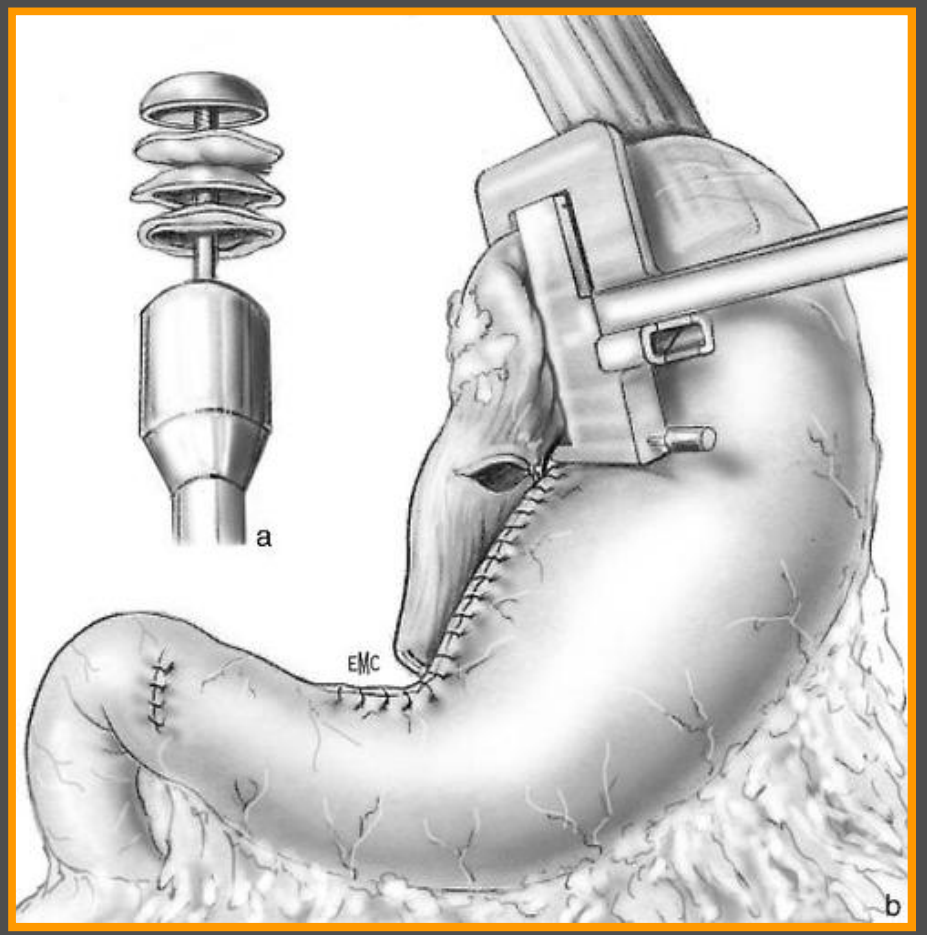
Pince de diamètre > 21 !



Perforation à la face postérieure

Anastomose mécanique





Dans la réalité on est beaucoup plus mal exposé !!!!

Conclusion

- L'intervention de Lewis-Santy
  - Deux installations en début d'expérience
  - Geste de vidange gastrique et jéjunostomie
  - Ligature du conduit thoracique au non résorbable
  - L'anastomose mécanique ne marche pas mieux
    - Plus rapide mais plus chère

Cette intervention donne l'opportunité de léser les deux nerfs récurrents !