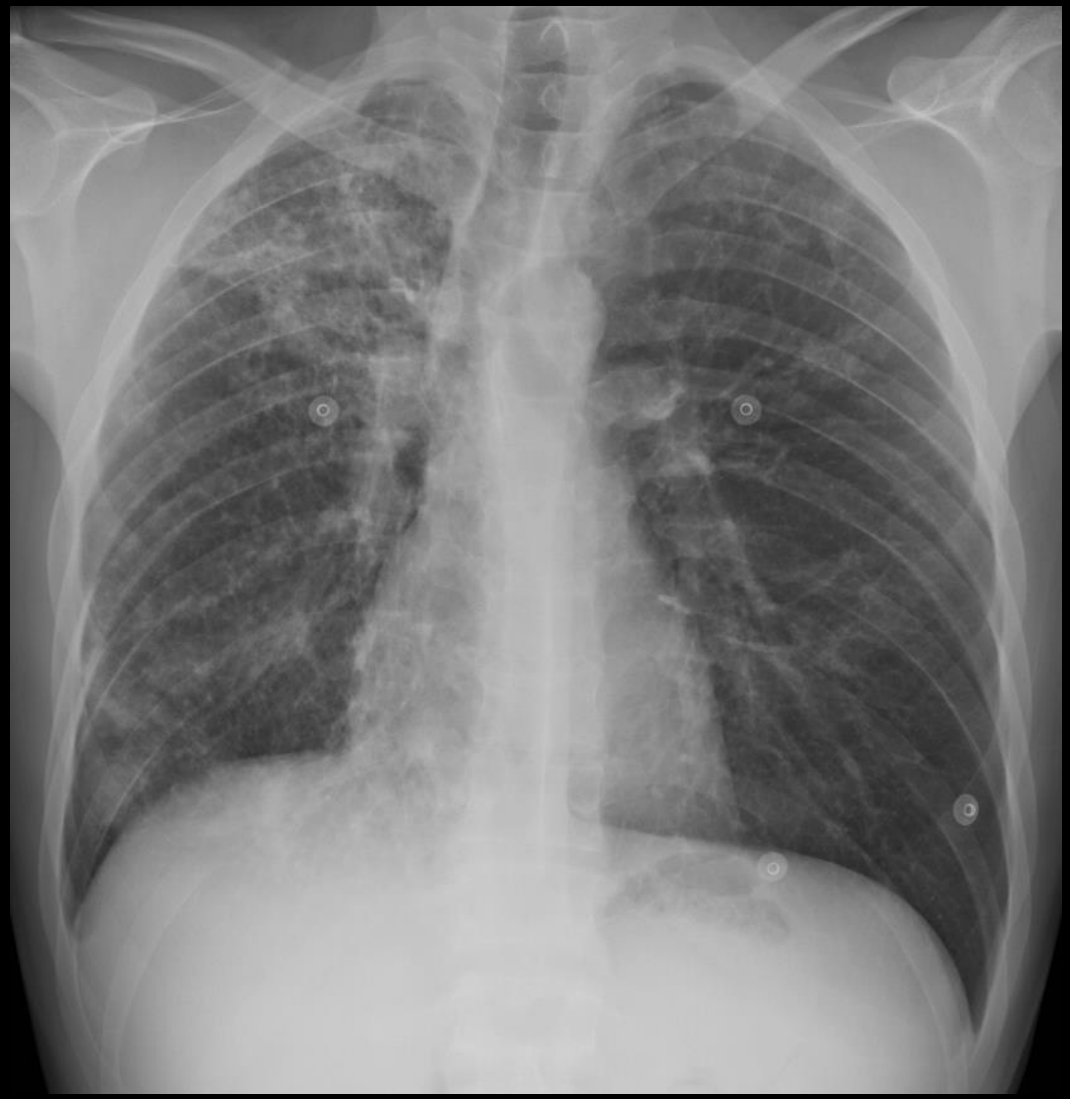
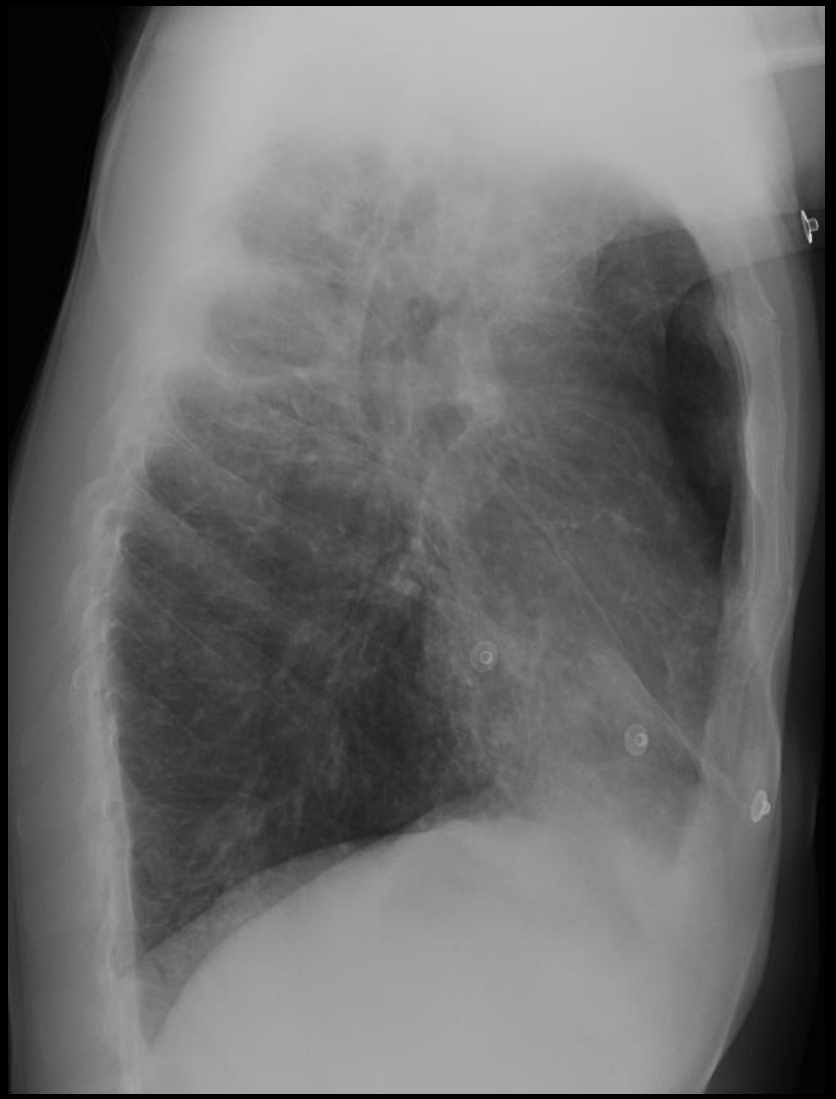
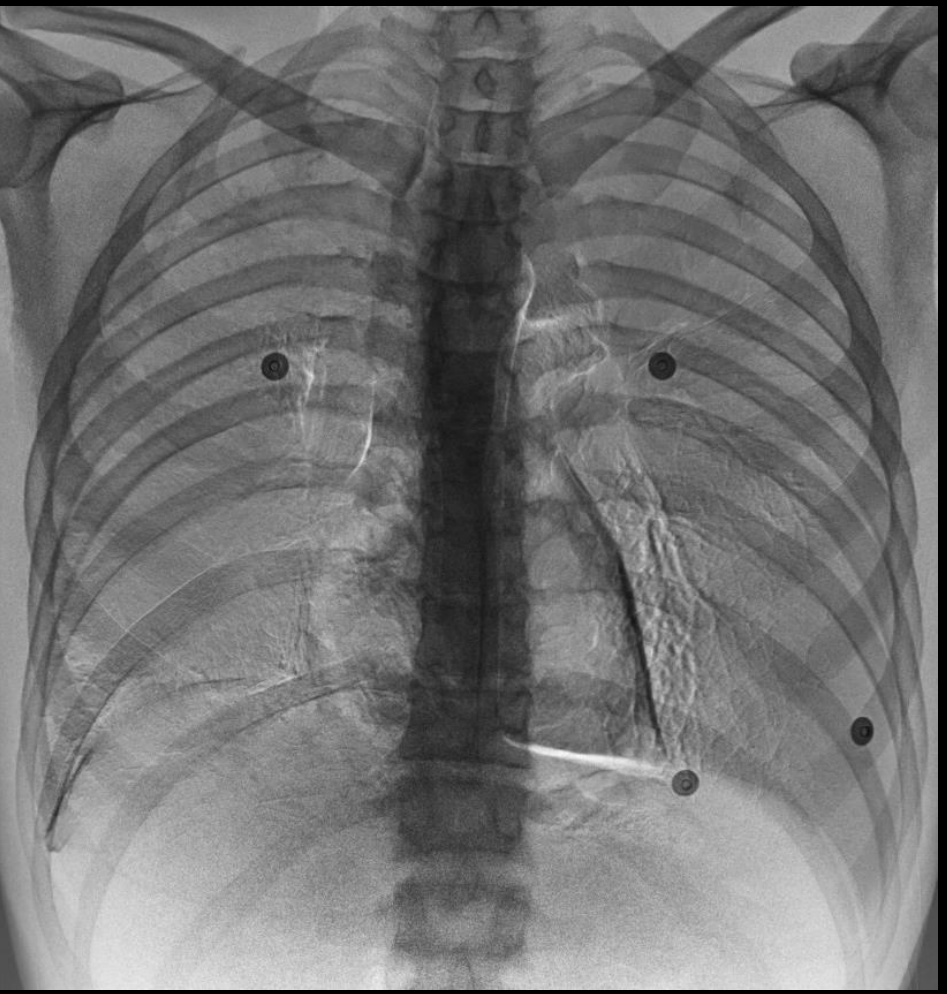
32 ans. Altération de l’état général depuis 3 semaines. Fumeur à 15 PA. Dyspnée, fièvre et toux résistante à la Pyostacine.





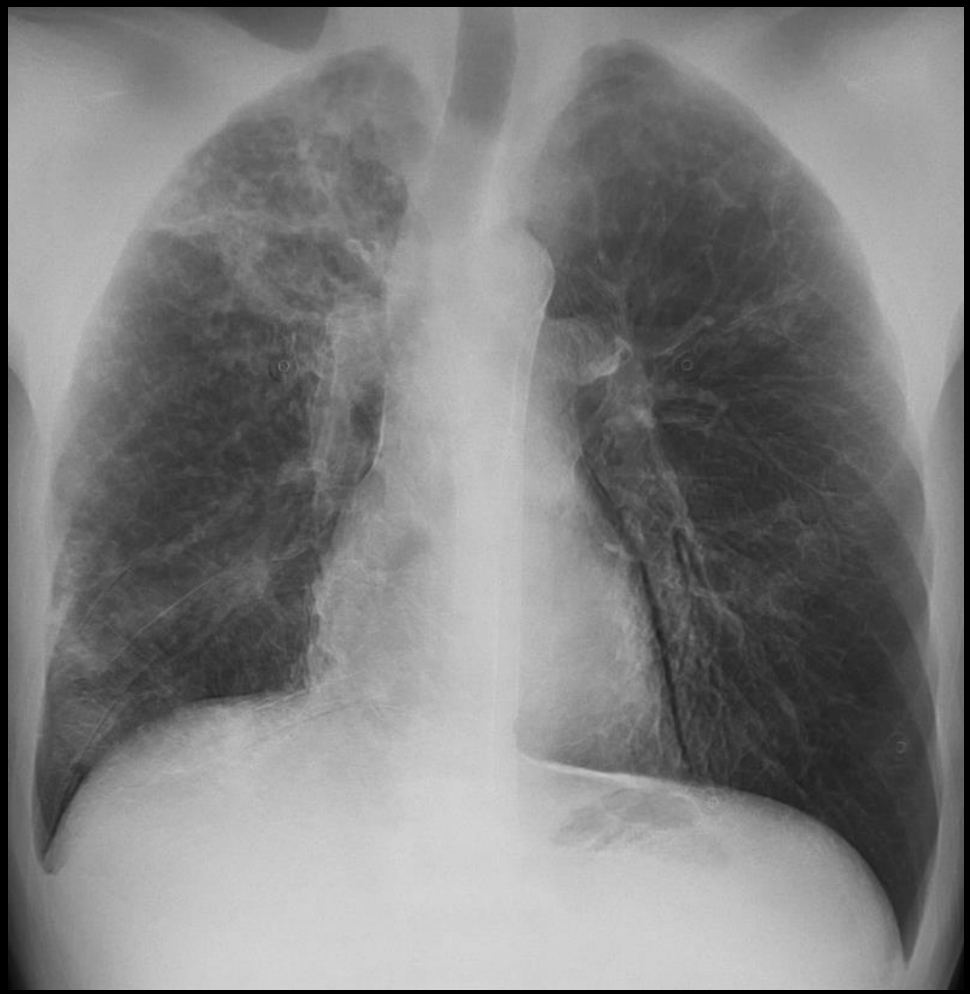
- Anne Chanson IHN

radiographie thoracique en "double énergie"

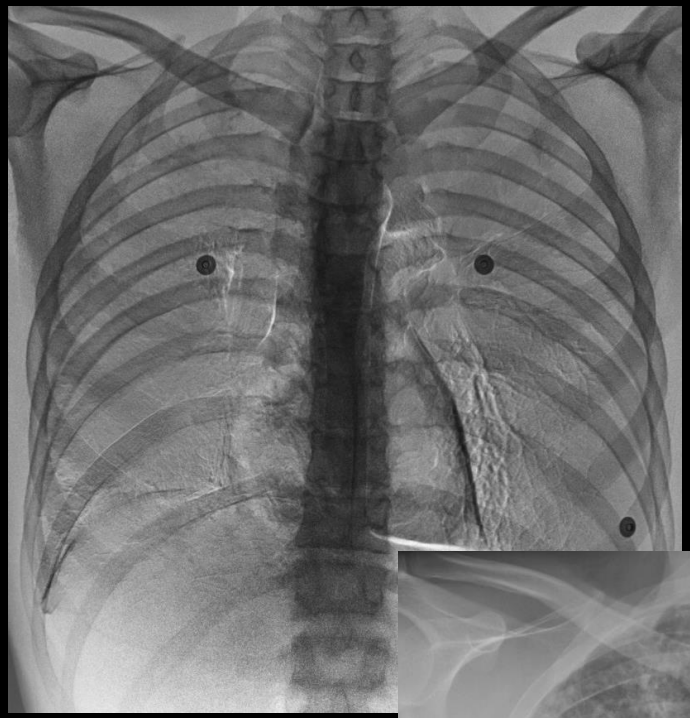


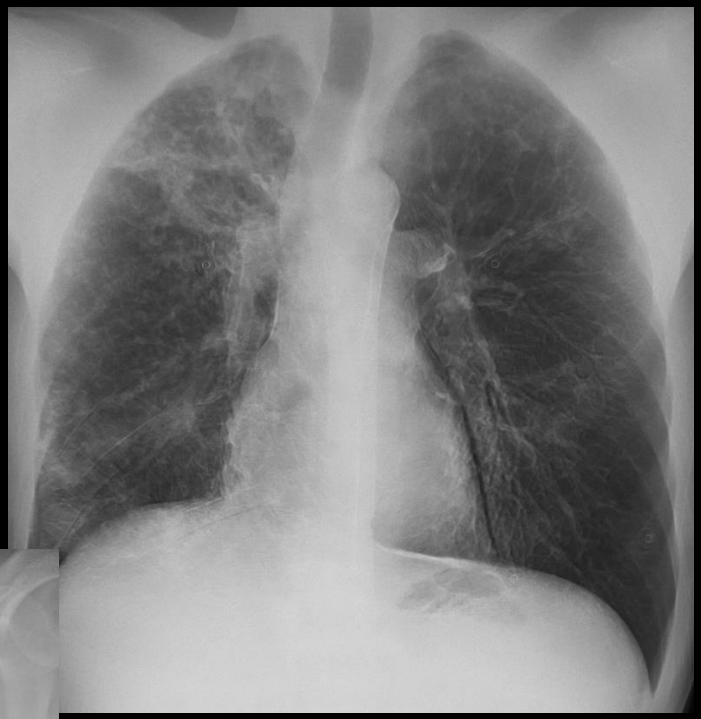
densités élevées structures calcifiées (squelette), métalliques (électrodes)

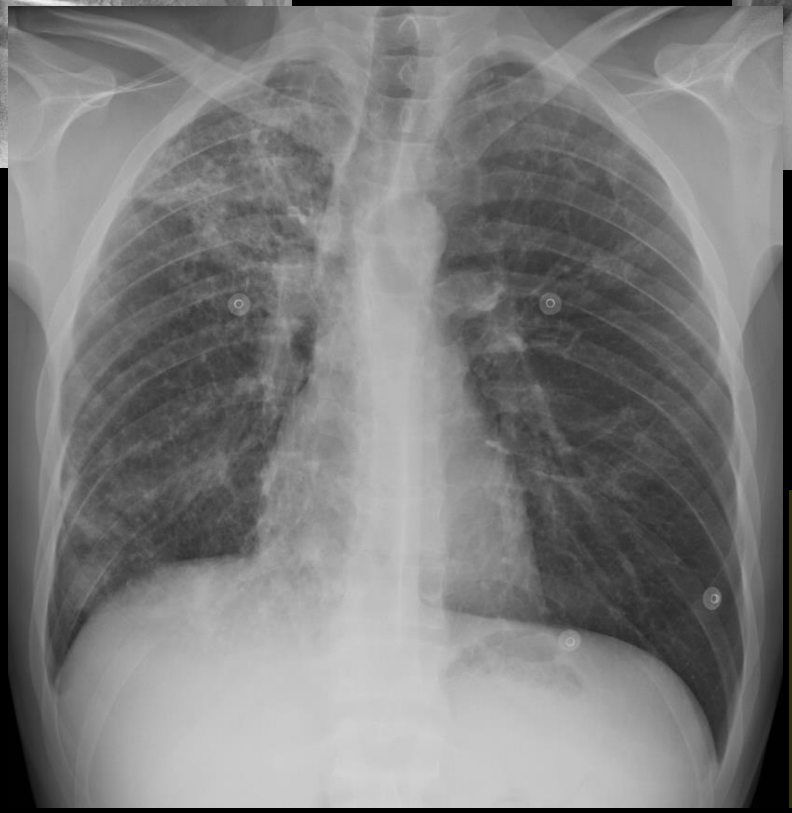
artefacts sur les contours des structures cardio-vasculaires et les coupoles diaphragmatiques , dus au décalage de 200 ms entre les expositions à tension moyenne(80 kV) et à tension élevée (120 kV)



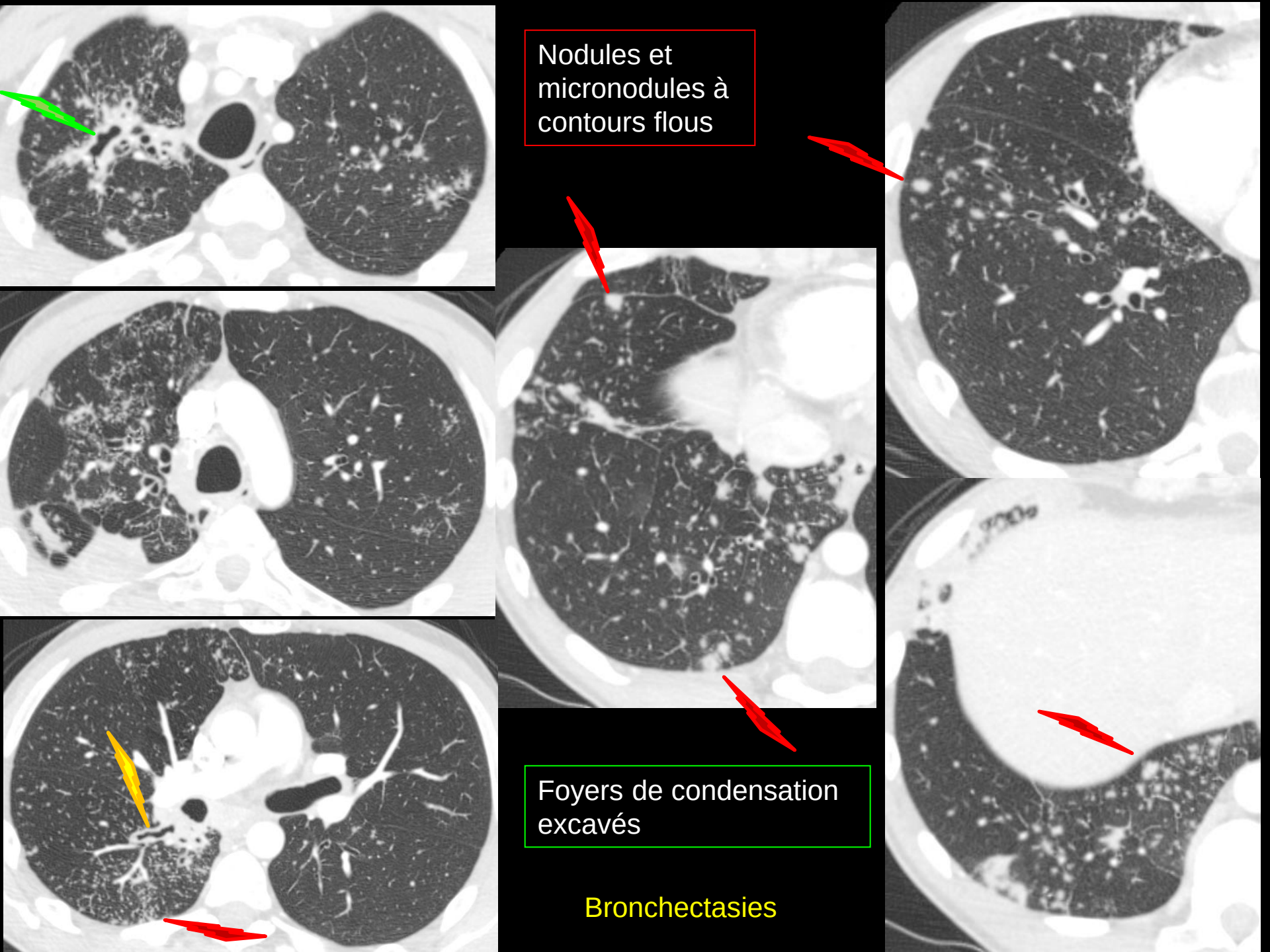
densités faibles : tissus mous (eau) ,graisse et gaz , sans les densités élevées

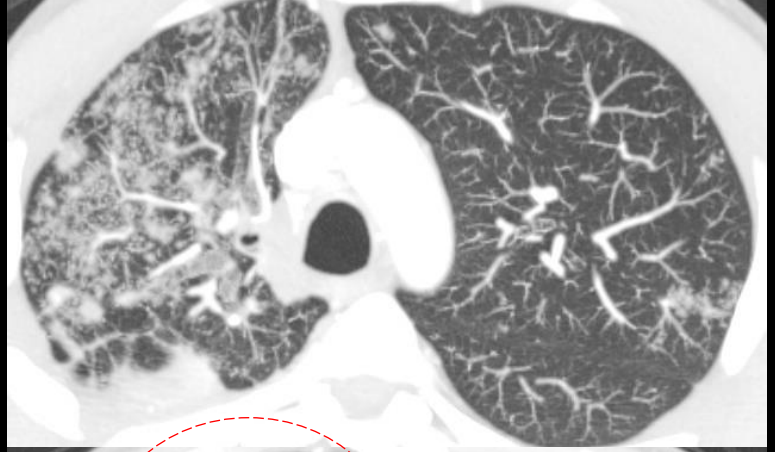


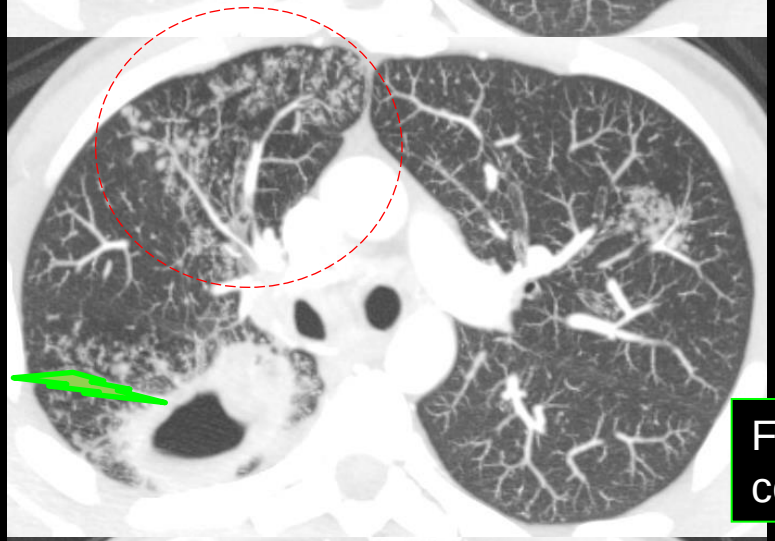


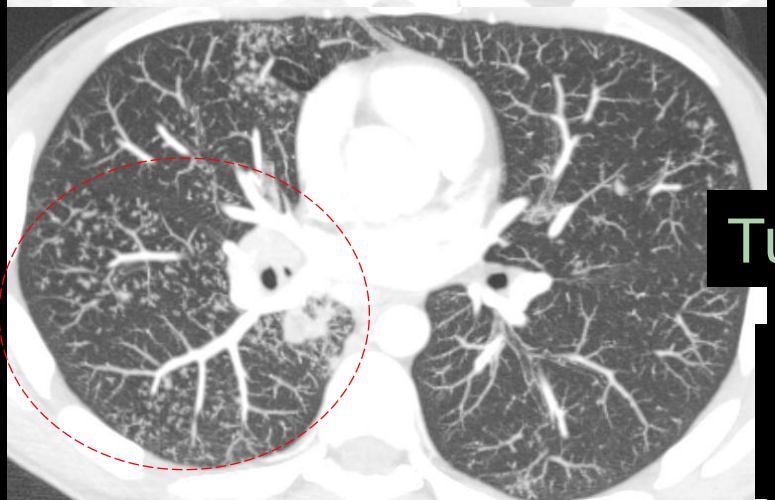


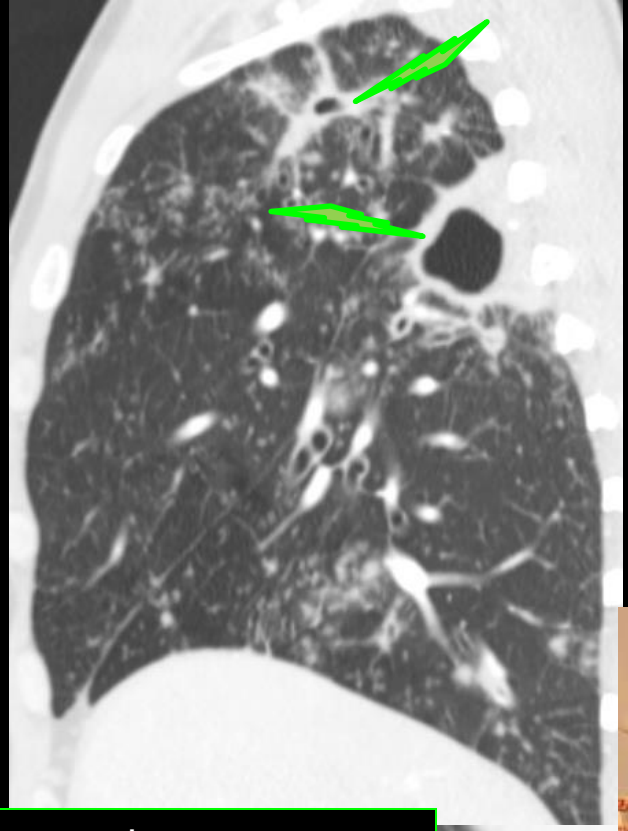
sommation des 2 images précédentes (densités élevées + densités faibles) conduisant à l'aspect classique du thorax en radiographie standard


Nodules et micronodules à contours flous
Foyers de condensation excavés
Bronchectasies



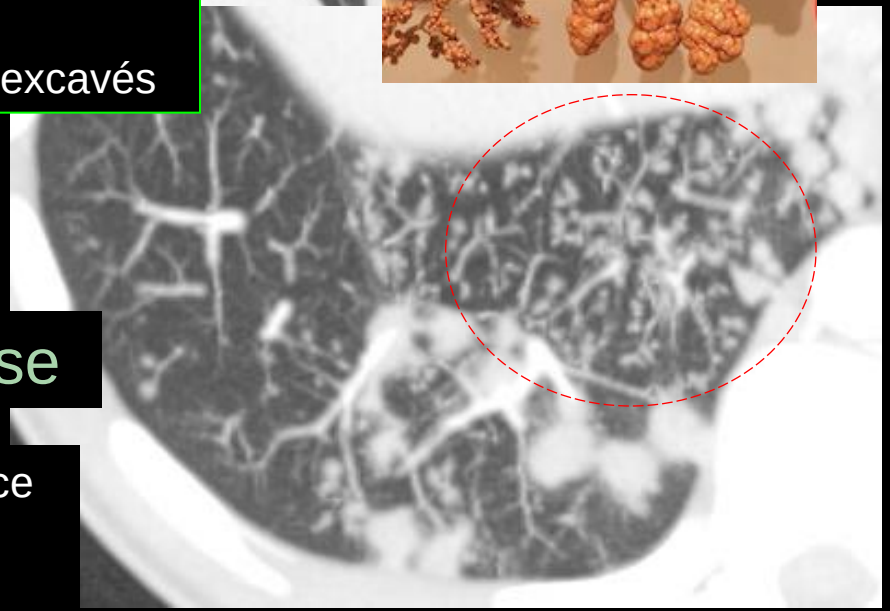






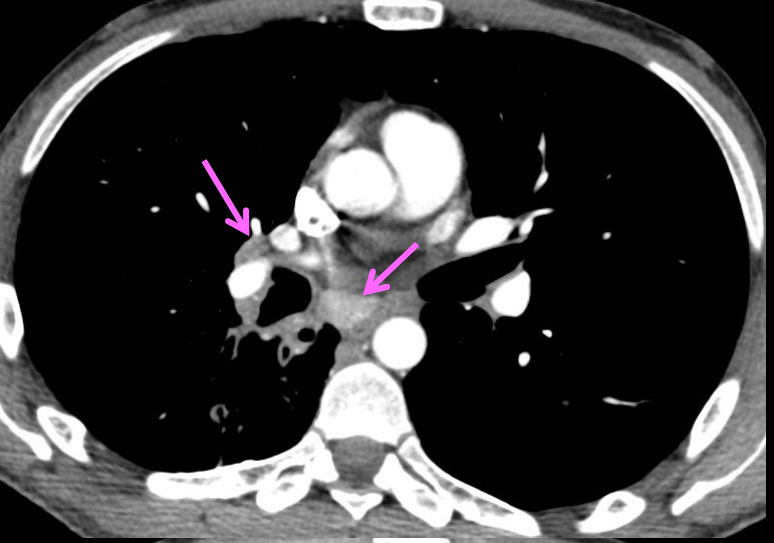
Micronodules branchés "en arbre à bourgeons" (distribution segmentaire bronchogène)

Foyers de condensation excavés

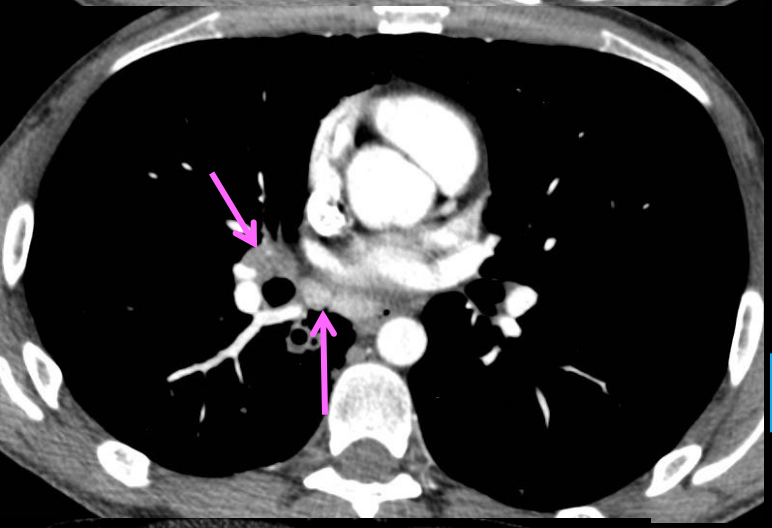


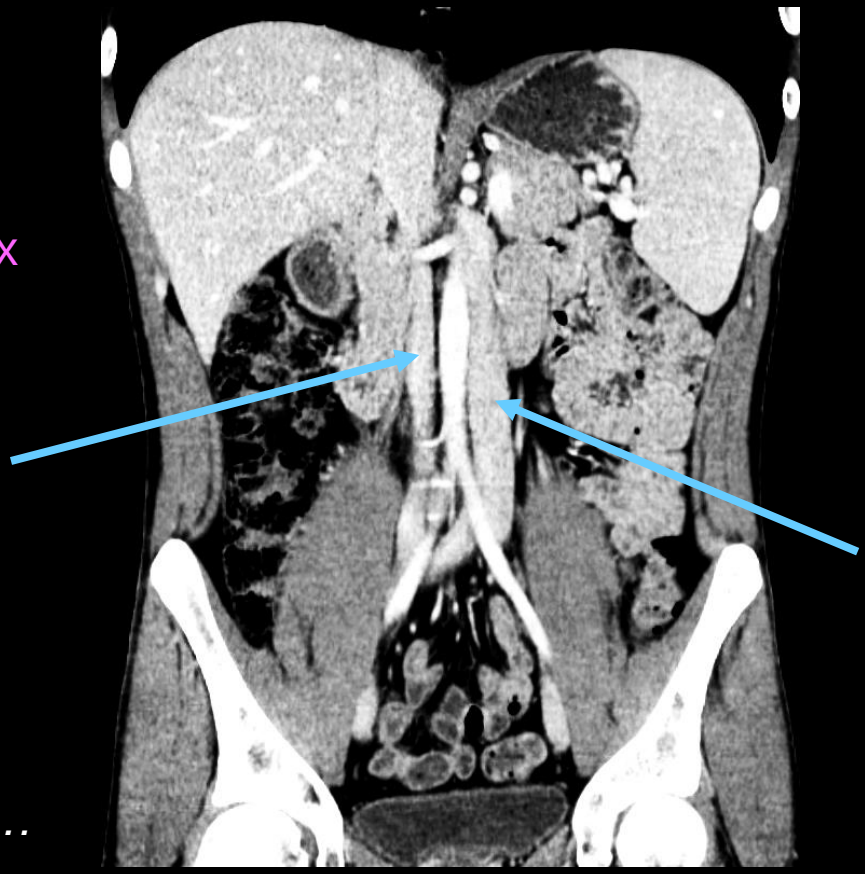
Tuberculose

Prédominance segments supérieurs



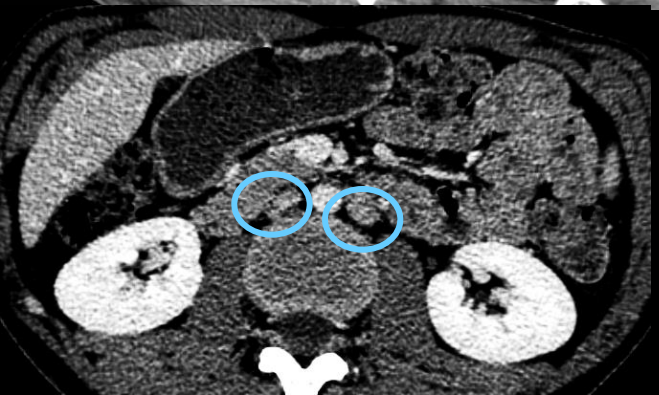
Ganglions
médiastinaux
et hilaires D

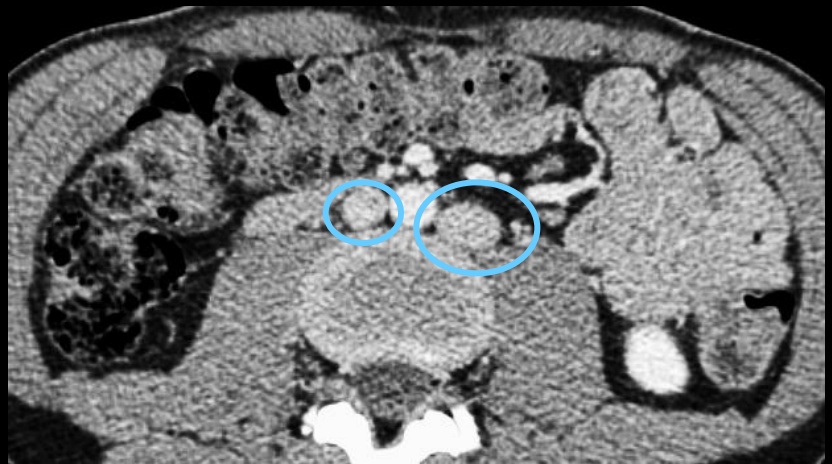




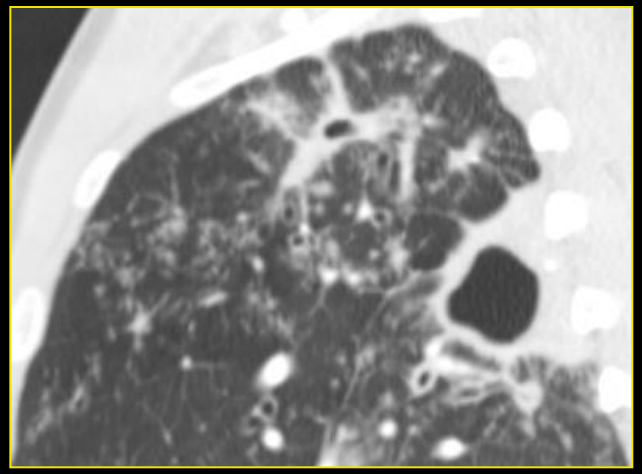
Par ailleurs…

VCI sous rénale double





Tuberculose pulmonaire post-primaire



- Prédilection pour les lobes sup
- Absence d'ADP
- Excavation (50%)

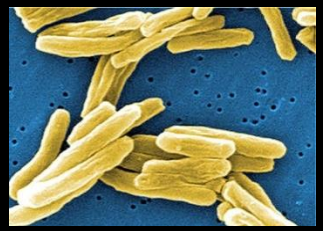
primaire vs post primaire

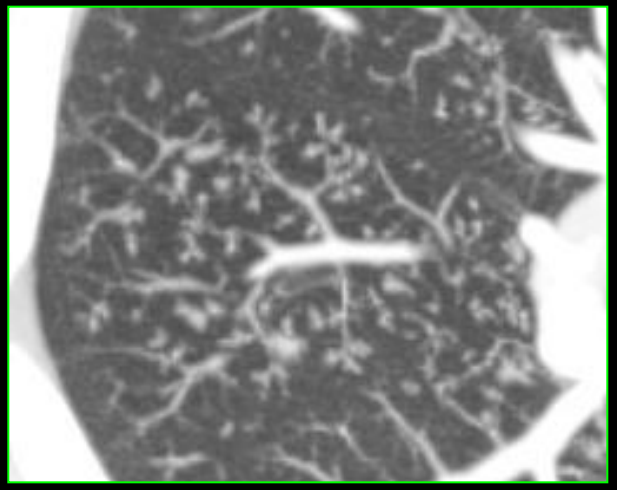
Atteinte parenchymateuse :

- Foyers de condensation mal définis, diffus, prédominant dans les segments apicaux et postérieurs
- Bilatérale 2/3
- Excavation au sein des foyers de condensation, à parois épaisses irrégulières

Atteinte des voies aériennes :

- Bronchiolite segmentaire : TB active
- Sténoses bronchiques, bronchiectasies….



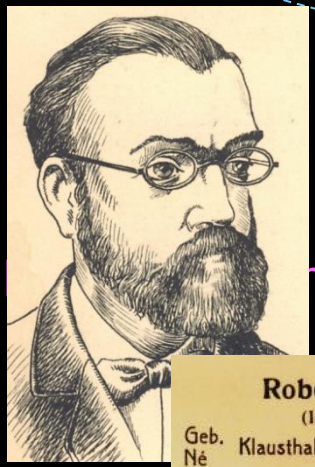


Tuberculose pulmonaire primaire

Atteinte parenchymateuse

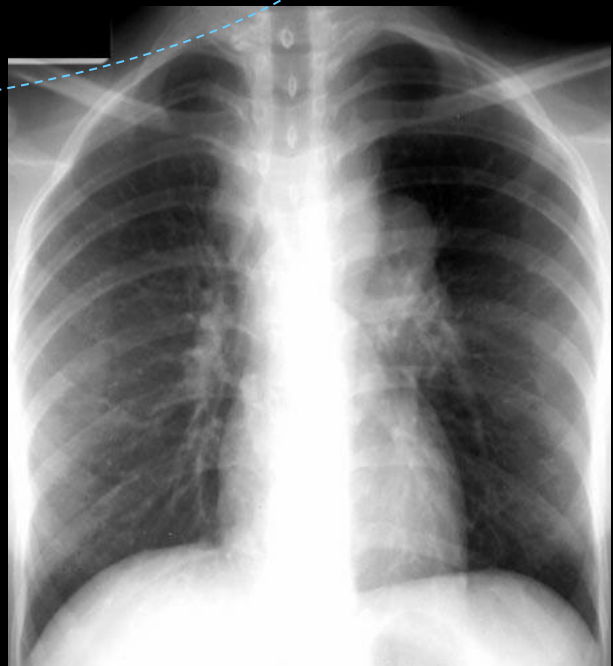
- Condensation dense, homogène
- Prédominance lobes inférieurs / LM

diagnostic différentiel : pneumopathie bactérienne vs TB primaire :
- ADP typiquement unilatérales droites (2/3), hilaires/paratrachéales droites
- Absence de réponse aux antibiotiques
- Si nodule de plus de 2 cm : hypodense (nécrose)



Robert Koch
(1843-1910)
Geb. Né Klausthal — † Baden-Baden
Microbiologist — Microbiologiste.

nmigrée / VIH +



Burrill J et al. Tuberculosis : A Radiologic Review. RG 2007; 27:1255-1273

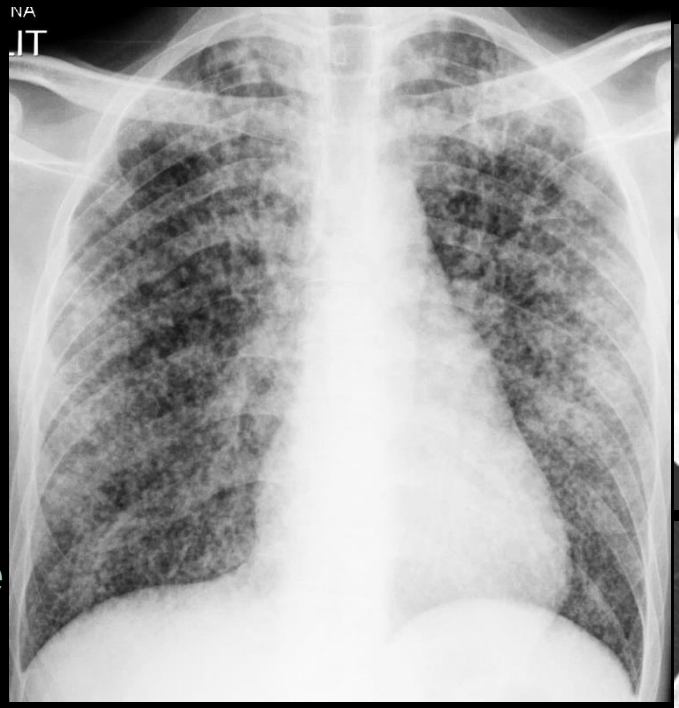
Primo-infection tuberculeuse

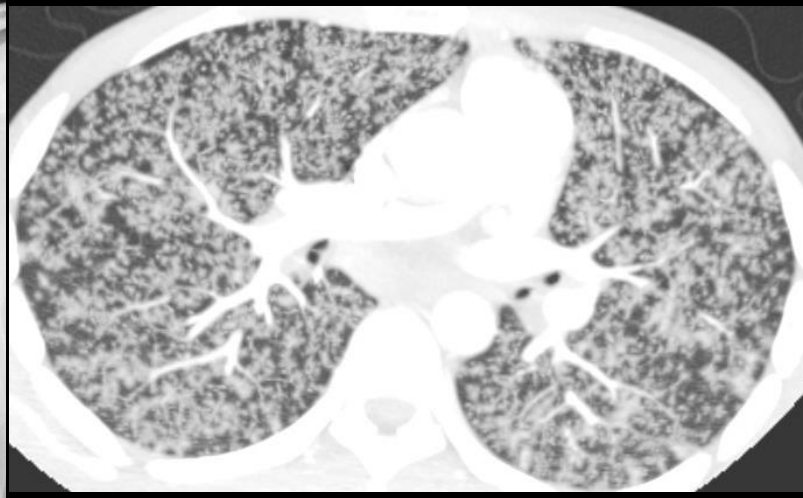
Miliaire tuberculeuse

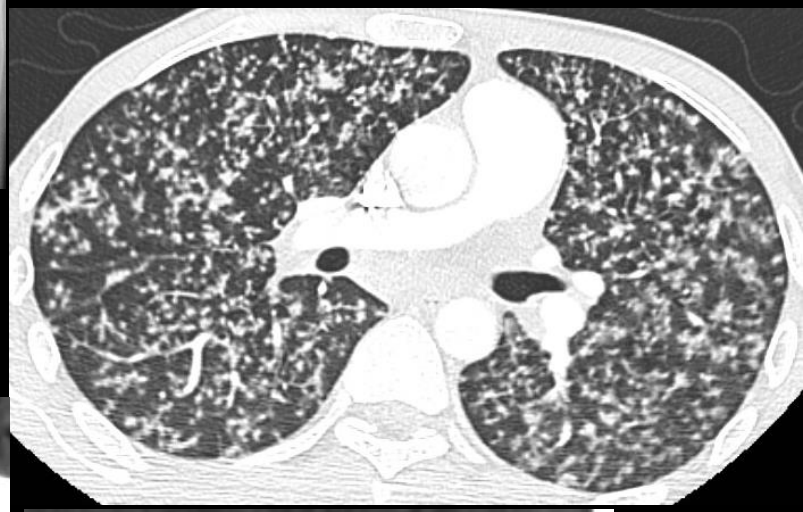
Micronodules diffus

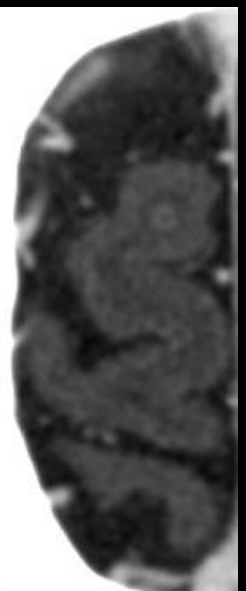
2-3mm

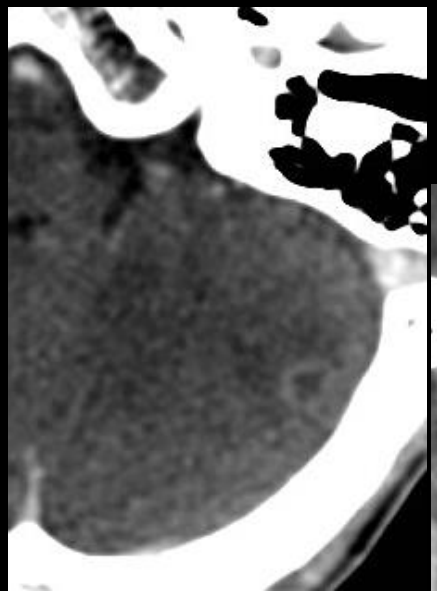
Distribution aléatoire



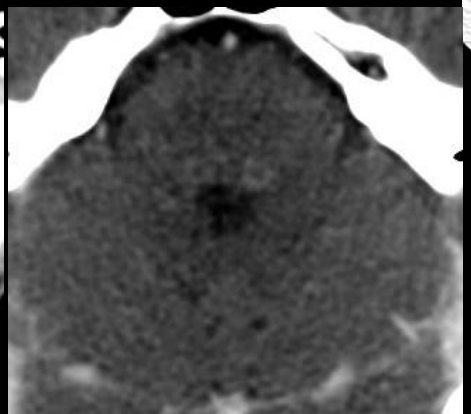


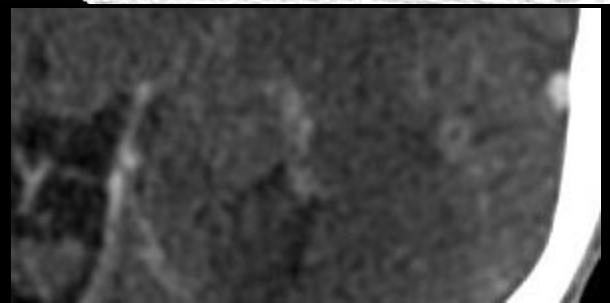




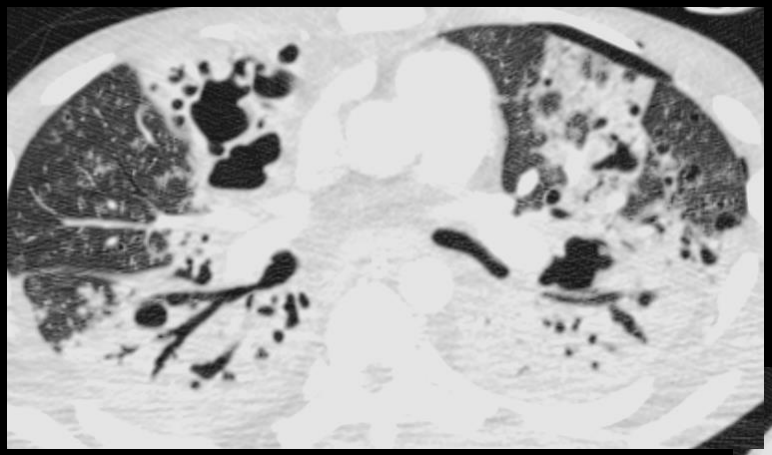


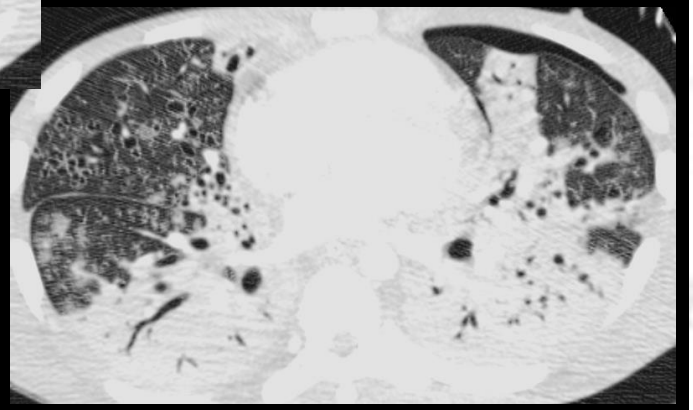
26 ans, malgache

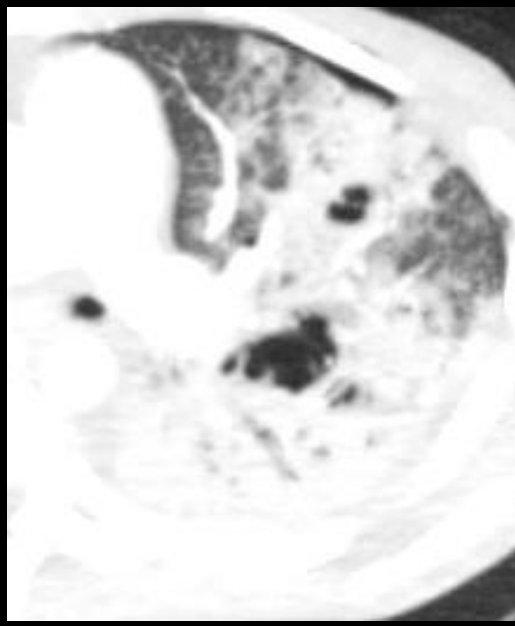


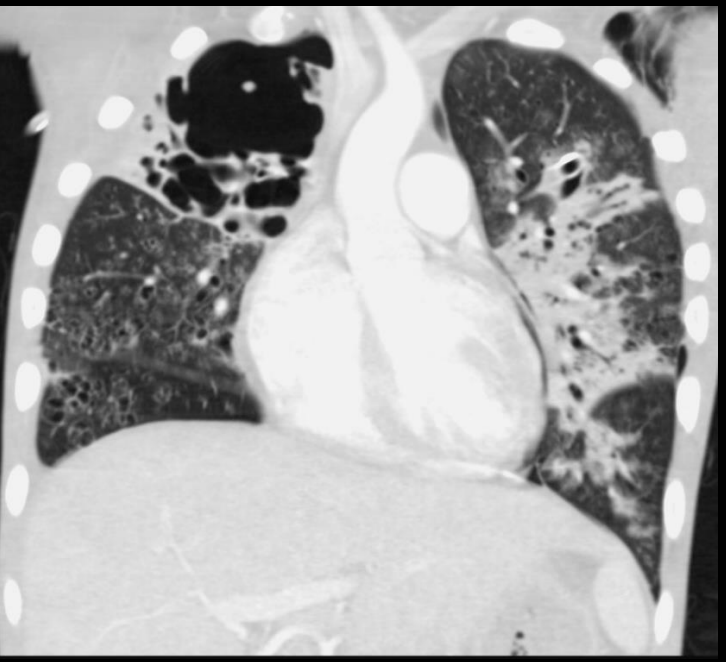


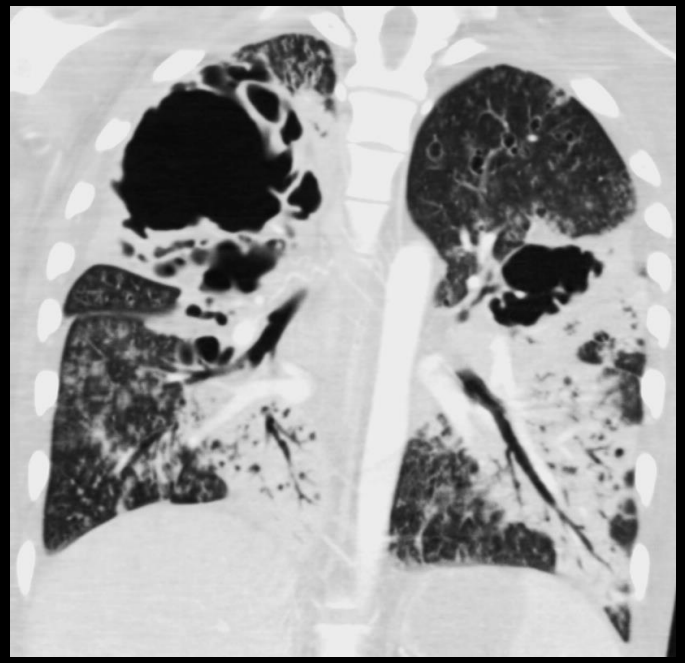
quelques exemples
d'atteintes
tuberculeuses

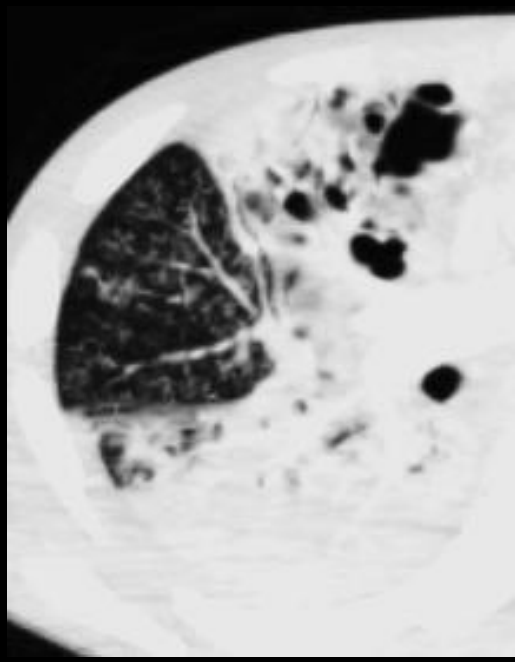




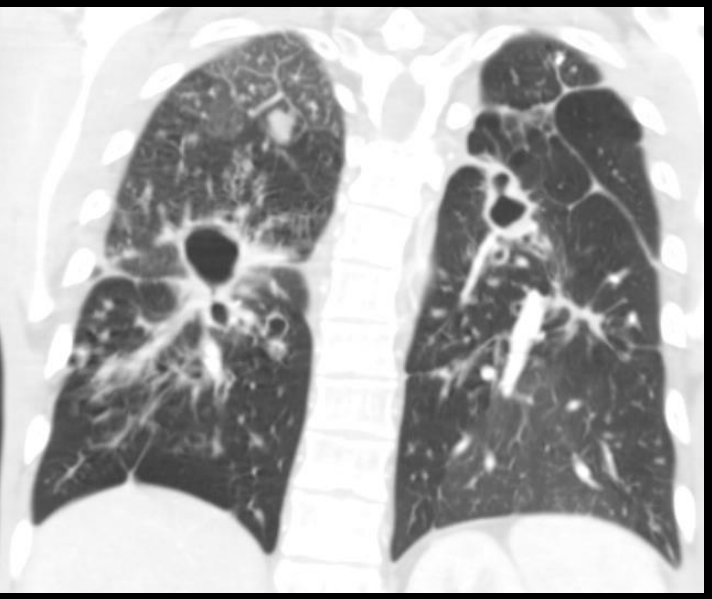


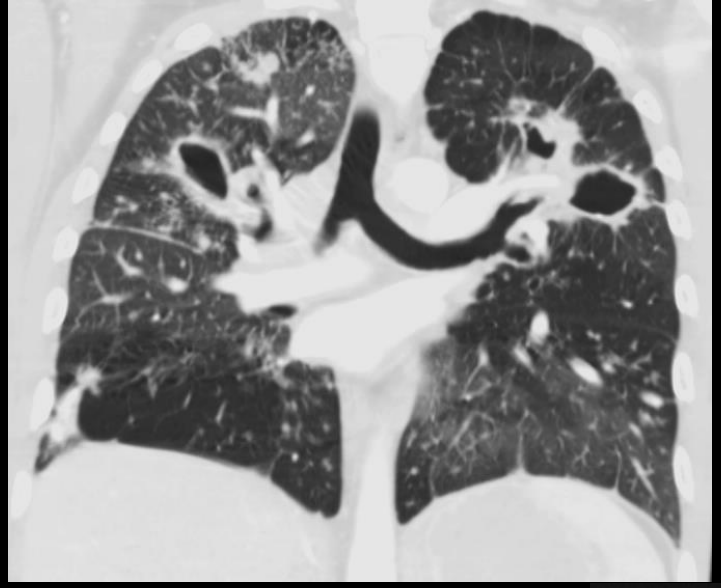


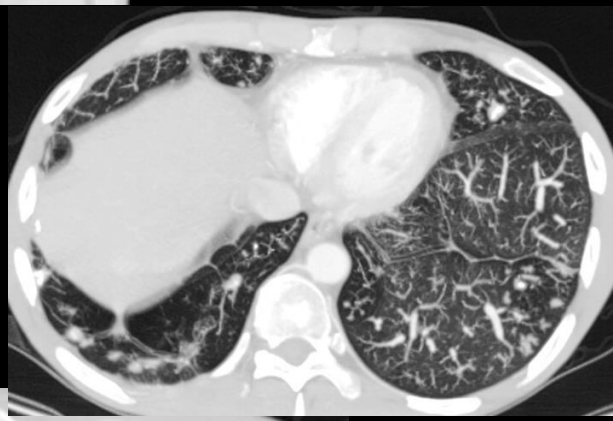


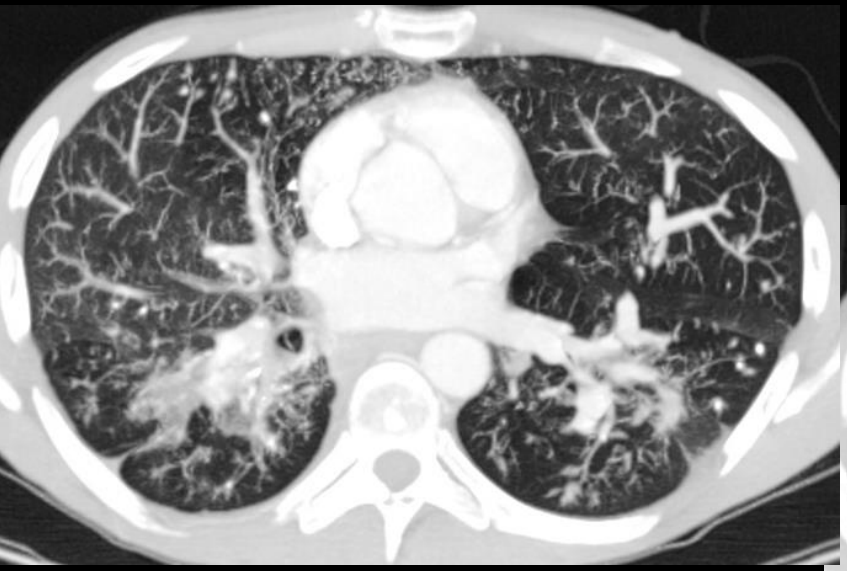


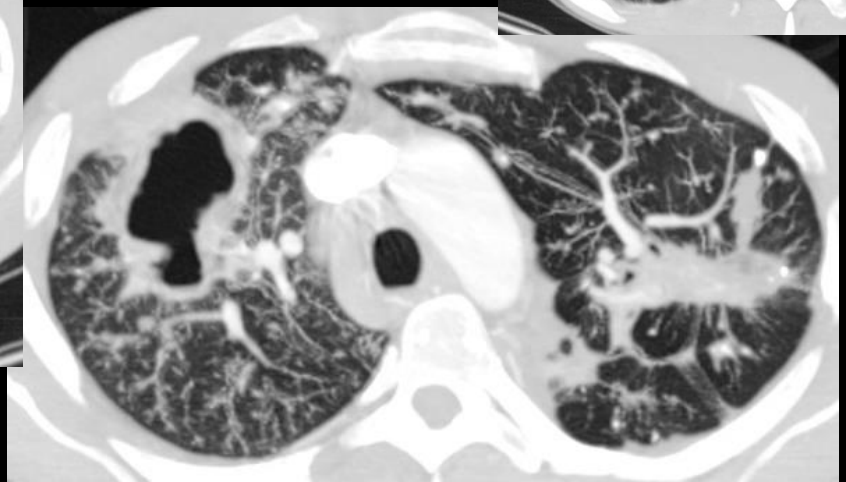
32ans



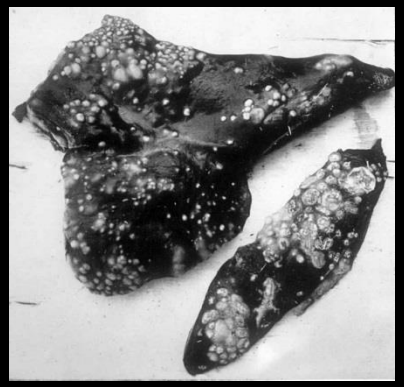


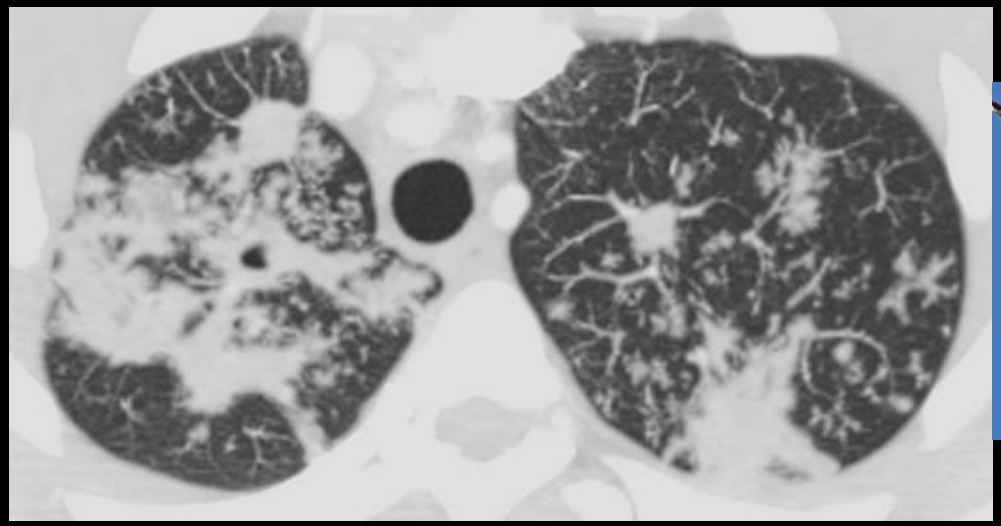


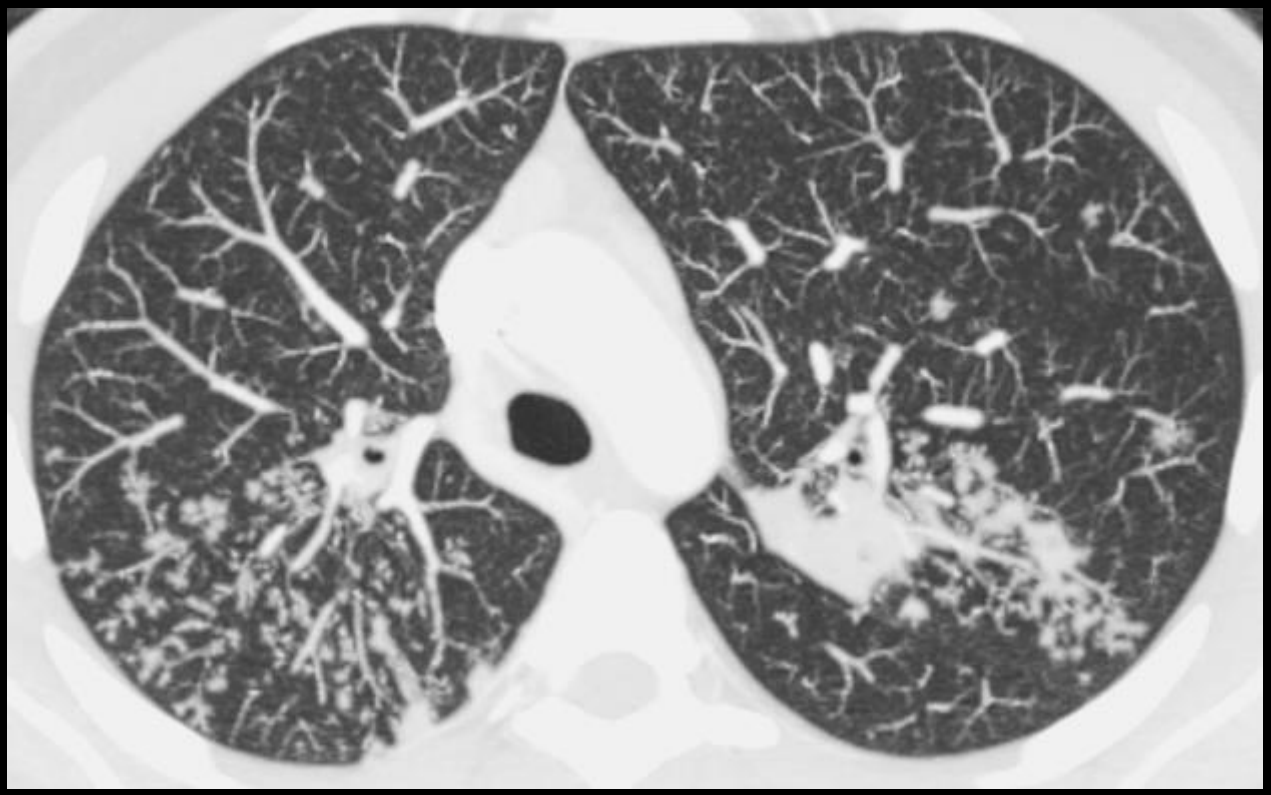


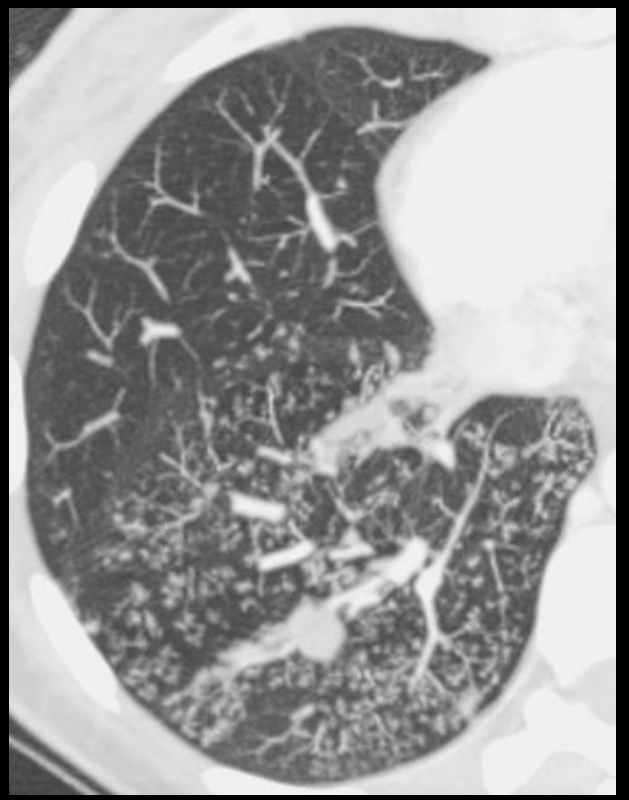


30ans. Toux chronique depuis 3 à 4 mois. Fumeuse (15 paquets/an).

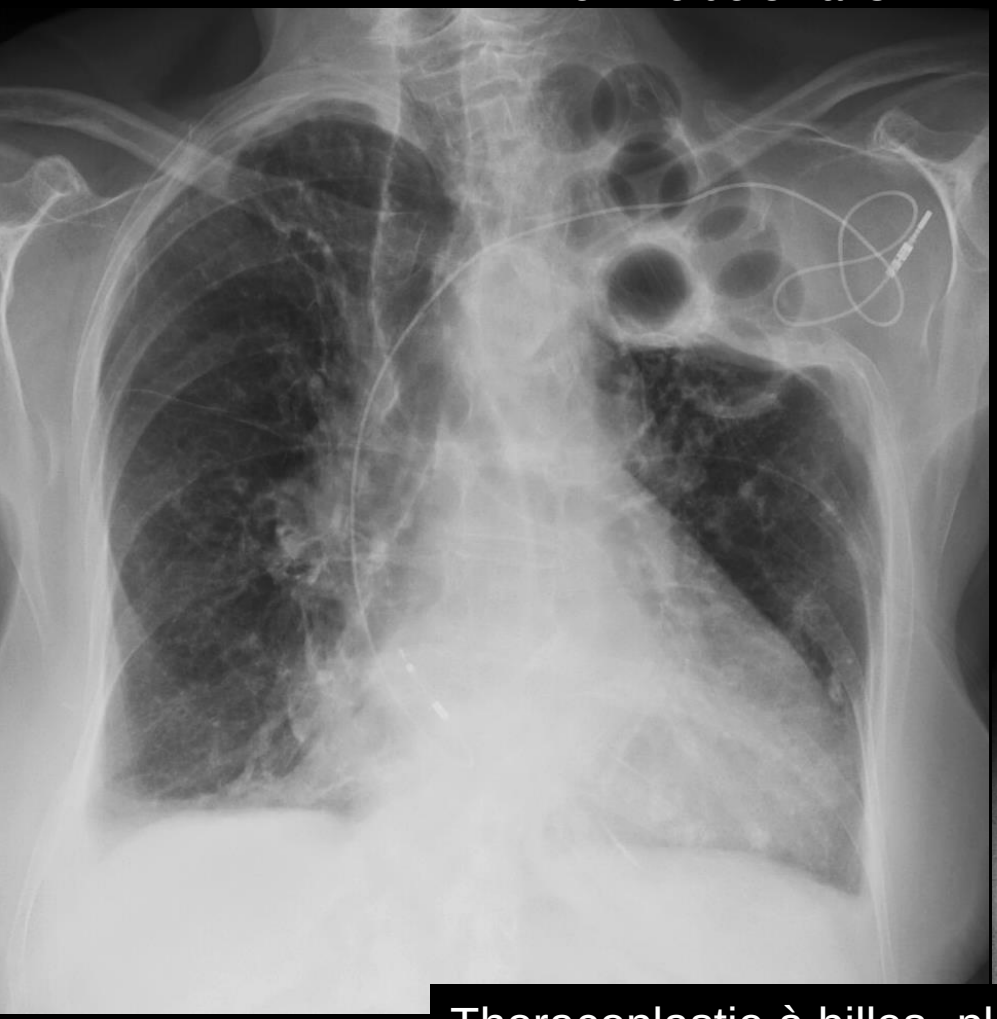


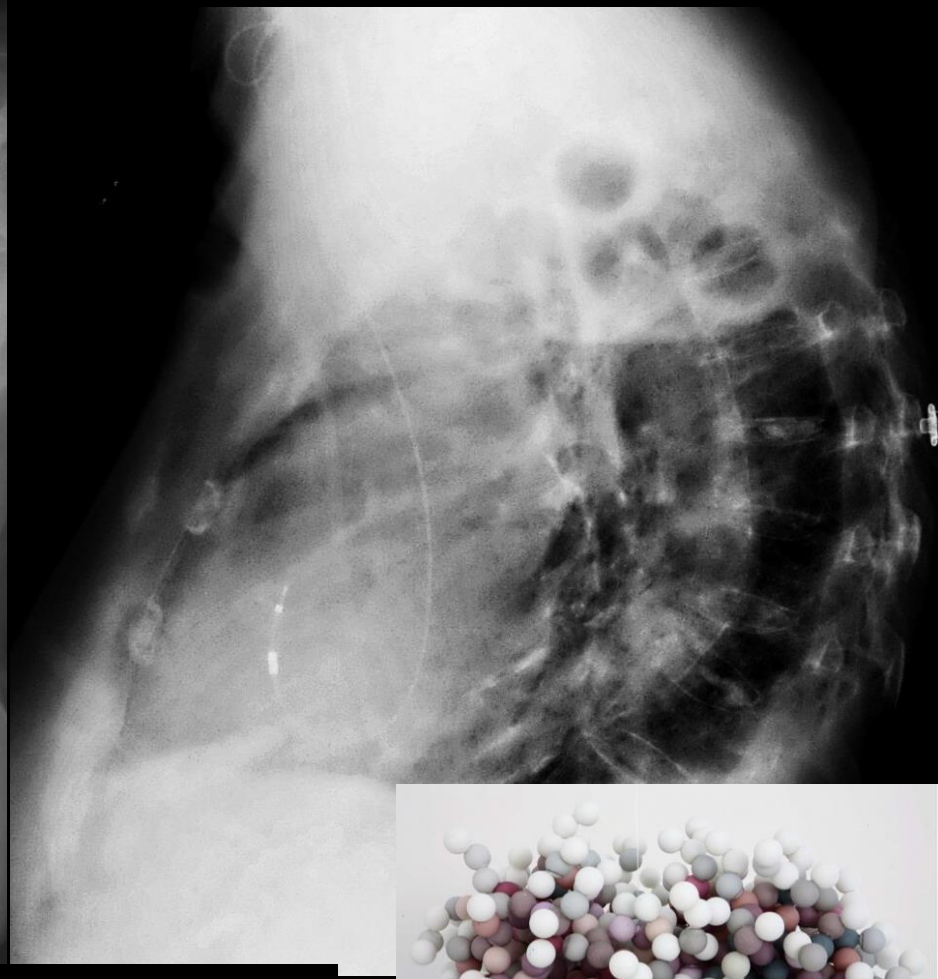






Femme de 87 ans





Thoracoplastie à billes -plombage

Objectif : collapsus parenchymateux ; collapsothérapie

Initialement à l'air (pneumothorax +/- pneumopéritoine "entretenus",collapsothérapie extra-pleurale (intervention de Sebestyen) , puis chirurgie d'exérèse des premières côtes et remplissage à l'aide de graisse, paraffine, sphères de lucite (poly-méthacrylate de méthyle/plexiglas), balles de ping pong….