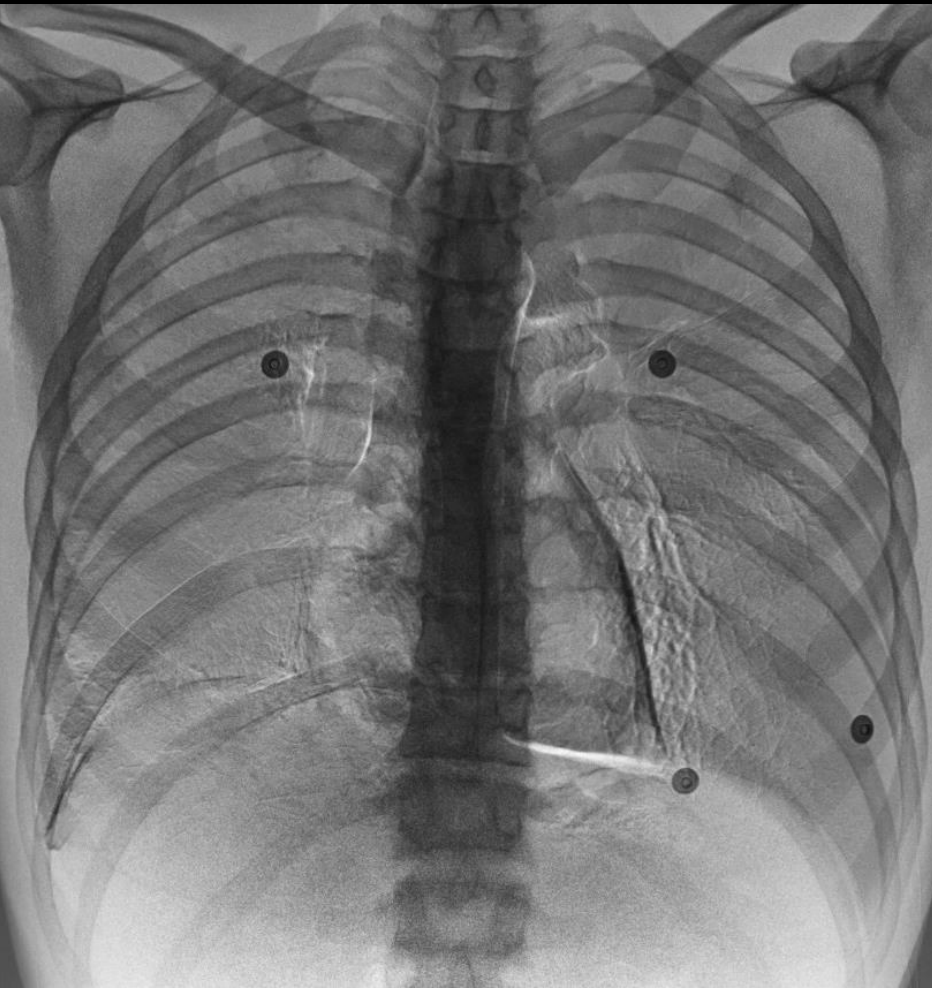


32 ans. Altération de l'état général depuis 3 semaines. Fumeur à 15 PA.
Dyspnée, fièvre et toux résistante à la Pyostacine.



- Anne Chanson IHN

radiographie thoracique en "double énergie"



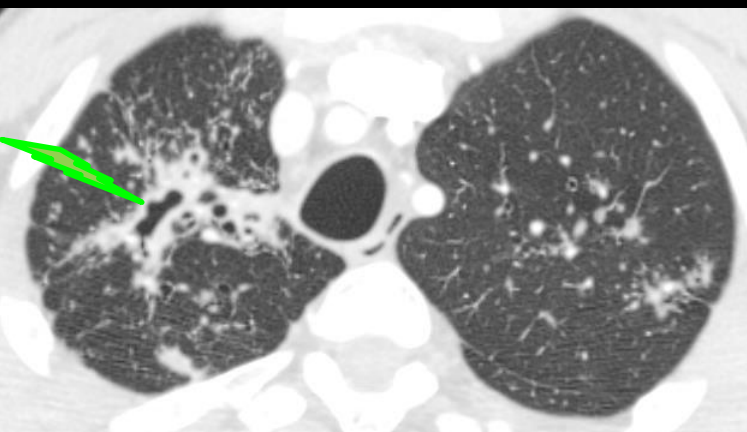
densités élevées structures calcifiées (squelette), métalliques (électrodes)
artefacts sur les contours des structures cardio-vasculaires et les coupes diaphragmatiques, dus au décalage de 200 ms entre les expositions à tension moyenne (80 kV) et à tension élevée (120 kV)



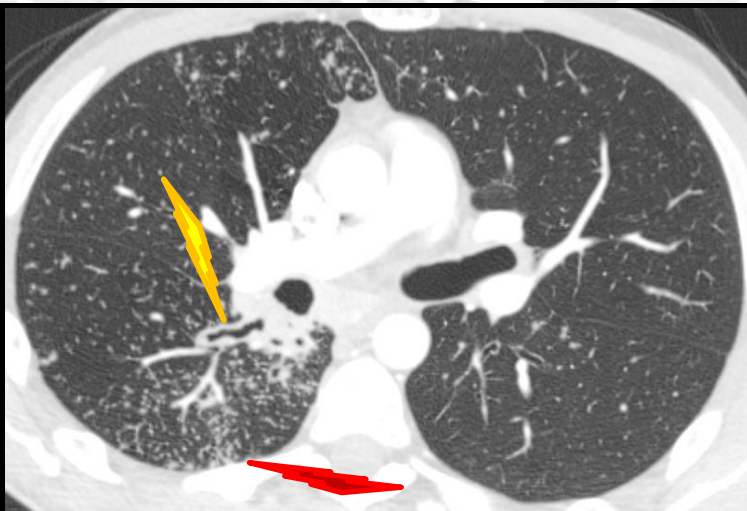
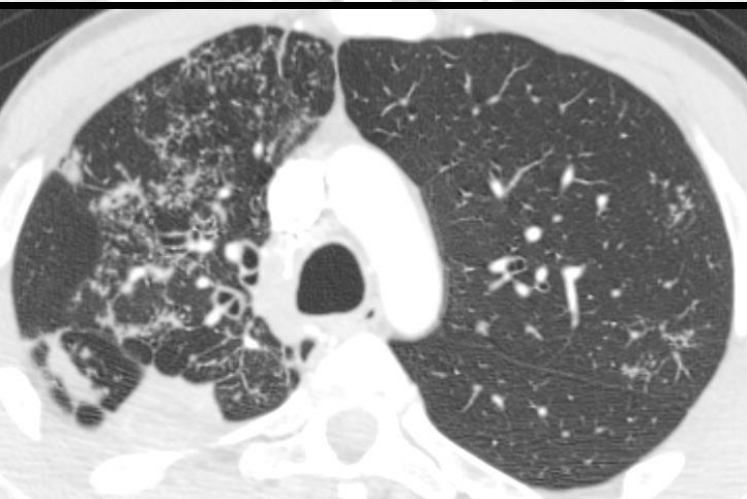
densités faibles : tissus mous (eau), graisse et gaz, sans les densités élevées



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

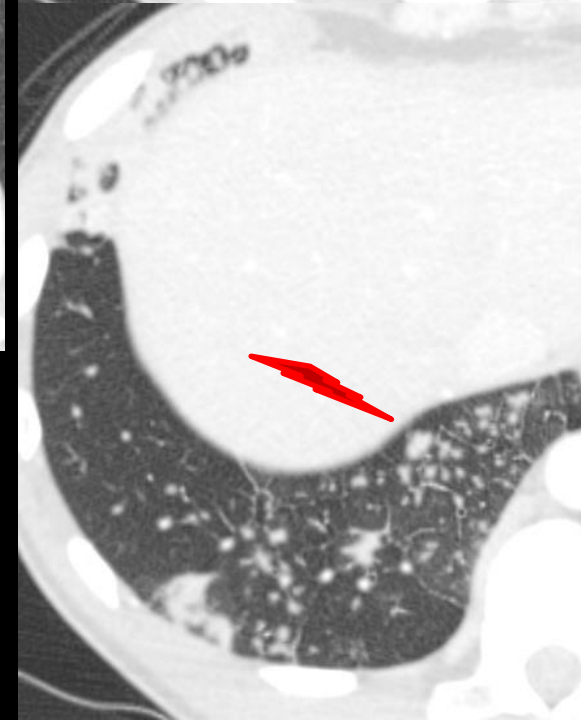
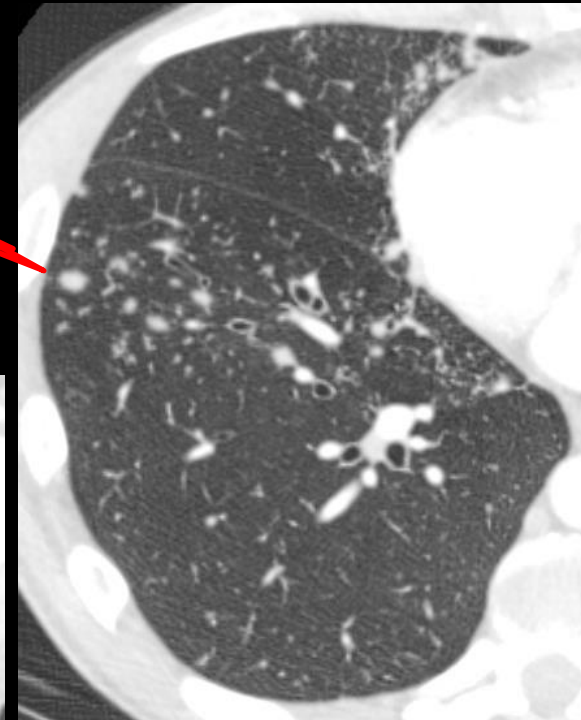
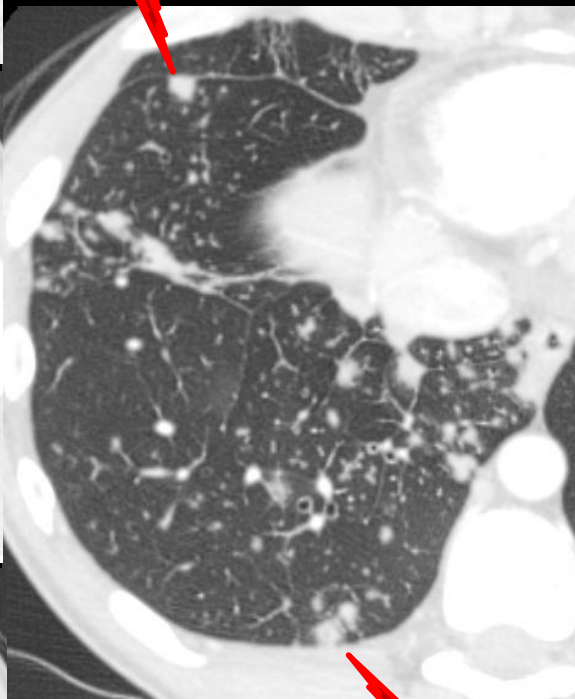


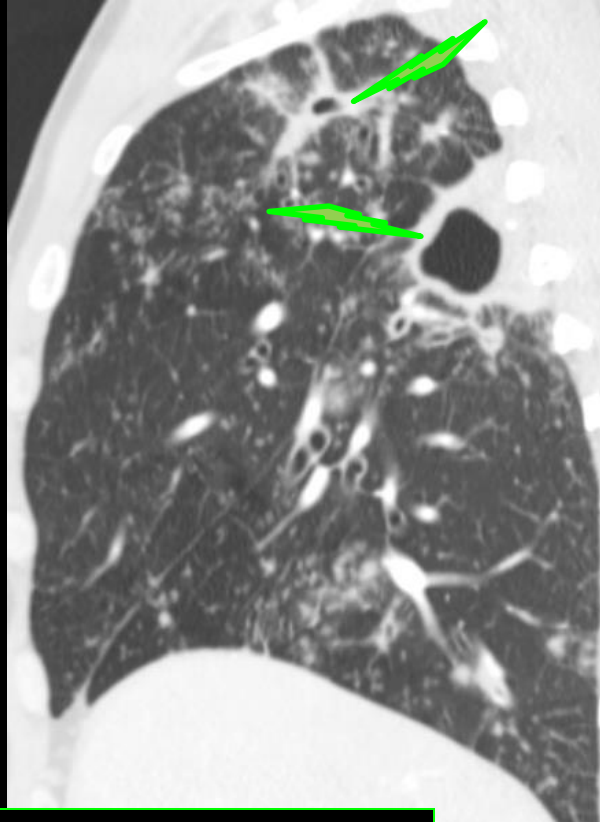
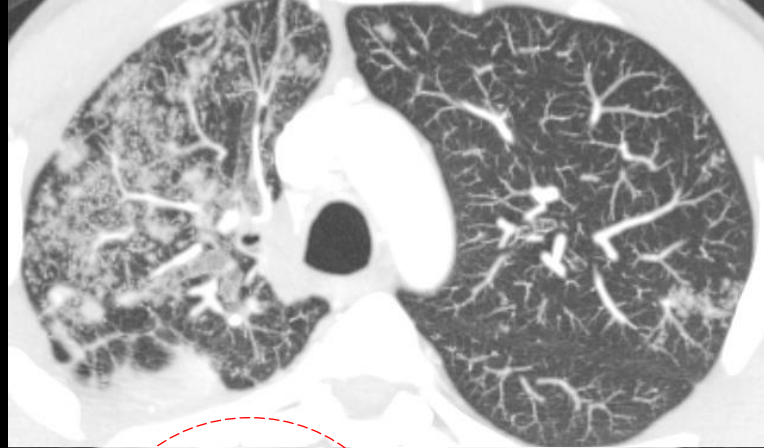
Nodules et
micronodules à
contours flous



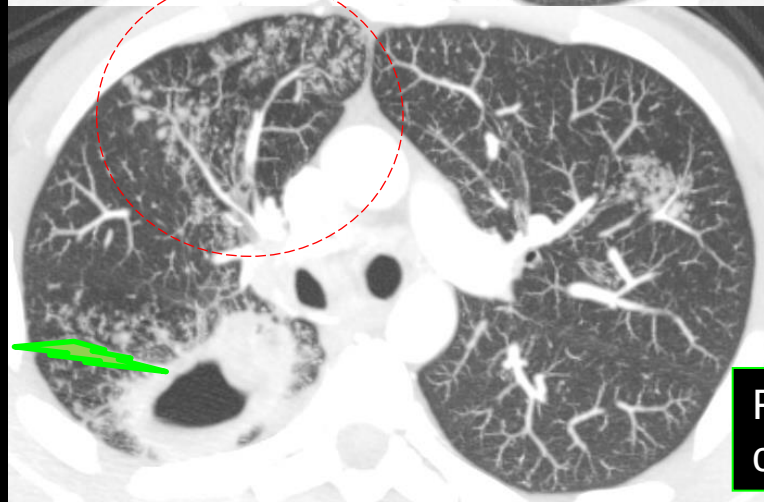
Foyers de condensation
excavés

Bronchectasies

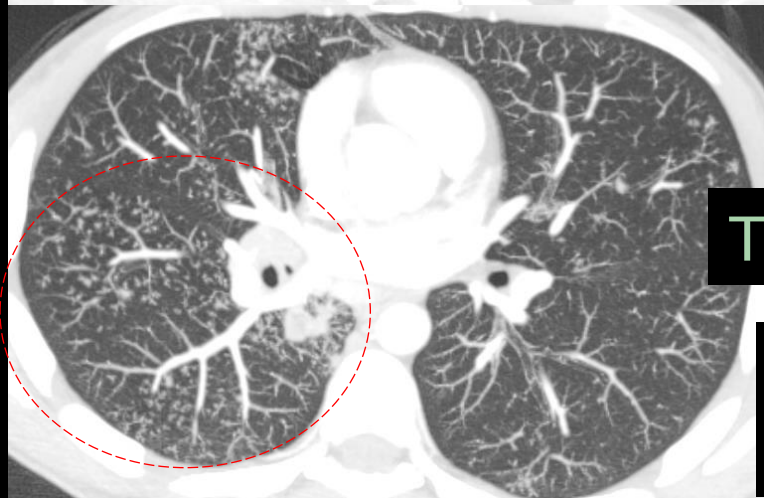




Micronodules
branchés "en arbre à
bourgeons"
(distribution
segmentaire
bronchogène)

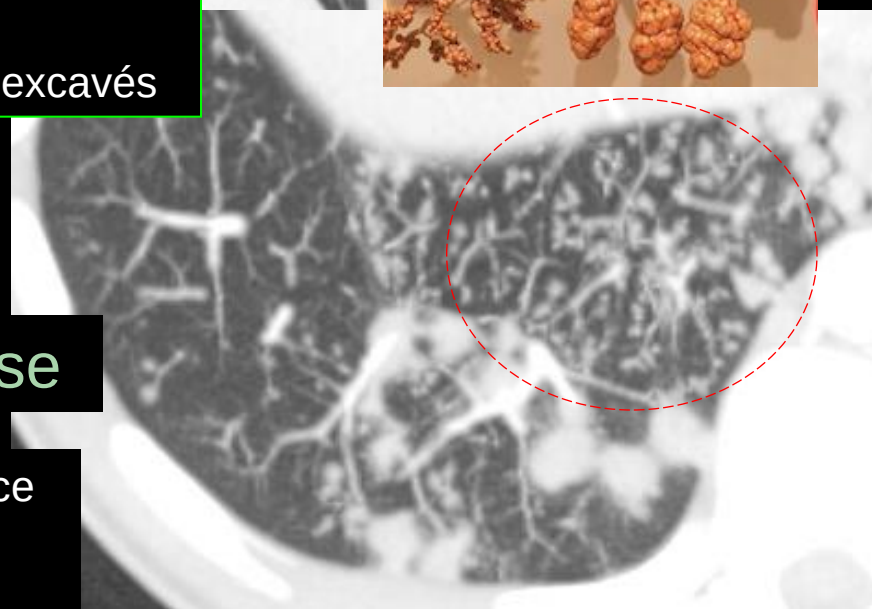


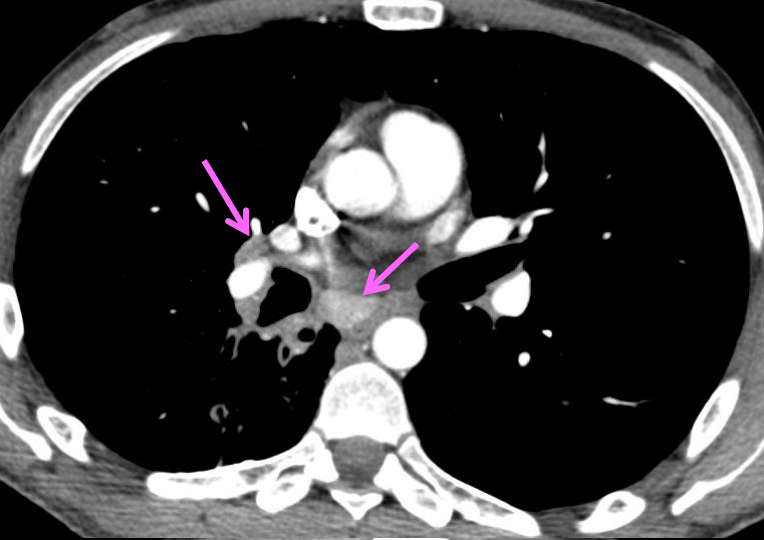
Foyers de
condensation excavés



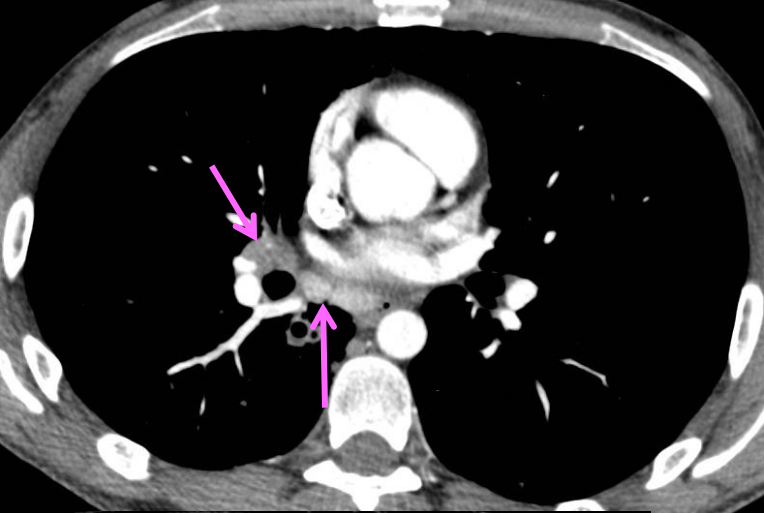
Tuberculose

Prédominance
segments
supérieurs



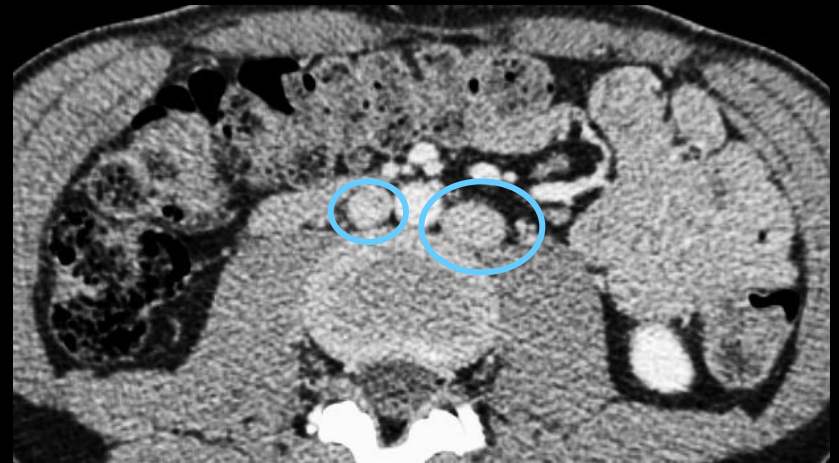
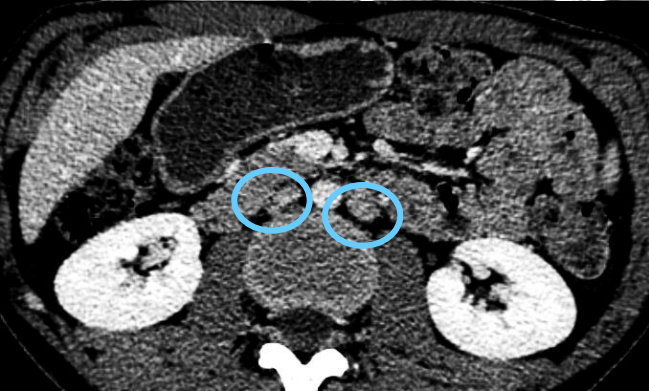
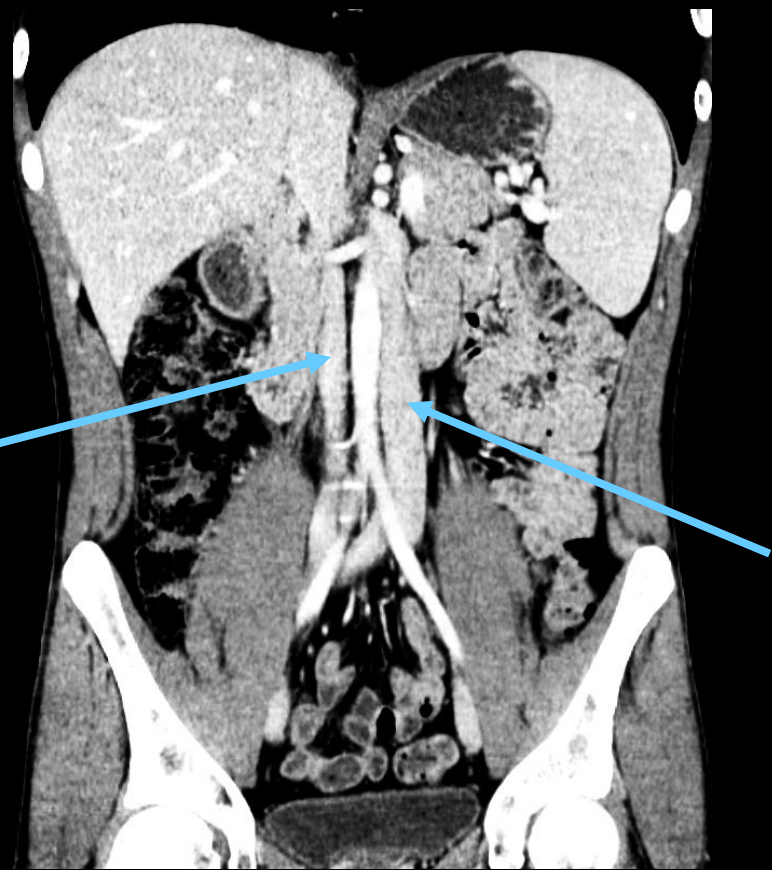


Ganglions
médiastinaux
et hilaires D



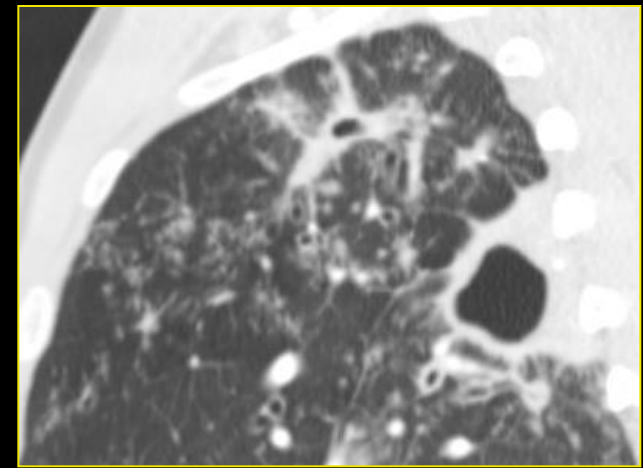
Par ailleurs...

VCI sous rénale double



Tuberculose pulmonaire post-primaire

- Prédilection pour les lobes sup
- ~~absence de PASP~~
- ~~primaire~~
- Excavation (50%)

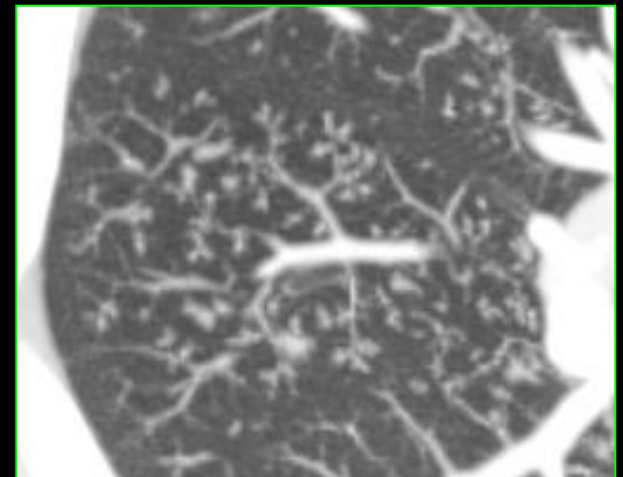


Atteinte *parenchymateuse* :

- 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....



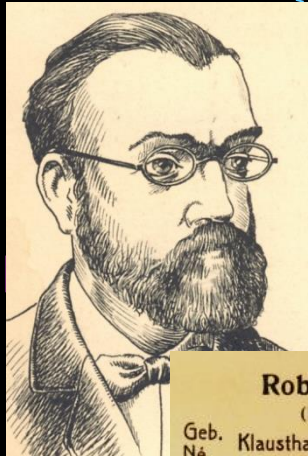
Tuberculose pulmonaire primaire

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)



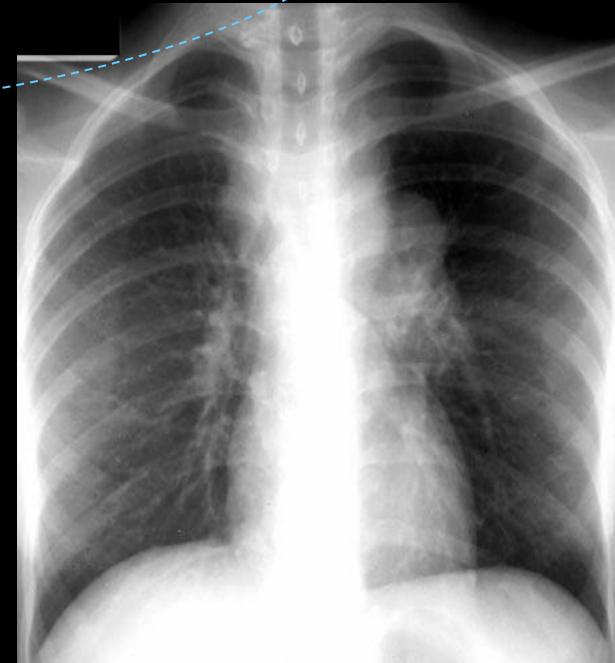
Robert Koch

(1843-1910)

Geb. Klausthal — † Baden-Baden

Microbiologist — Microbiologiste.

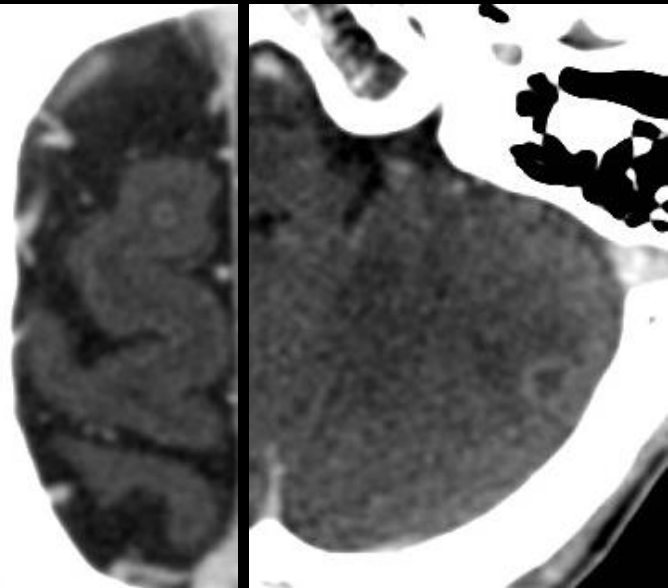
immigrée / VIH +



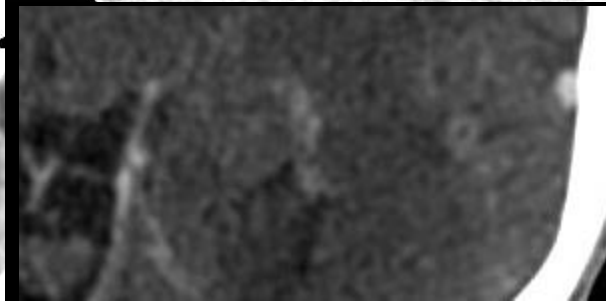
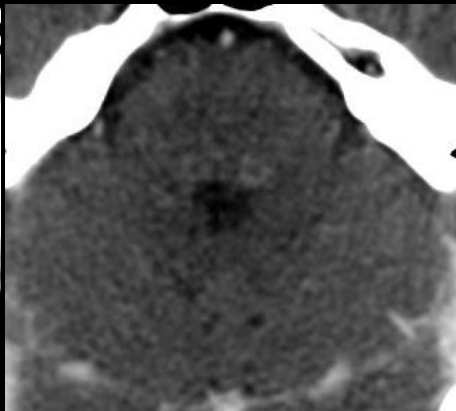
Primo-infection tuberculeuse

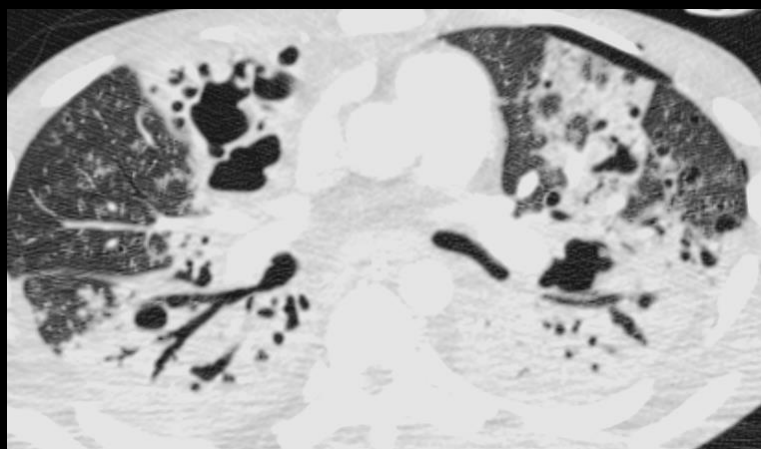
Miliaire tuberculeuse

Micronodules diffus
2-3mm
Distribution aléatoire

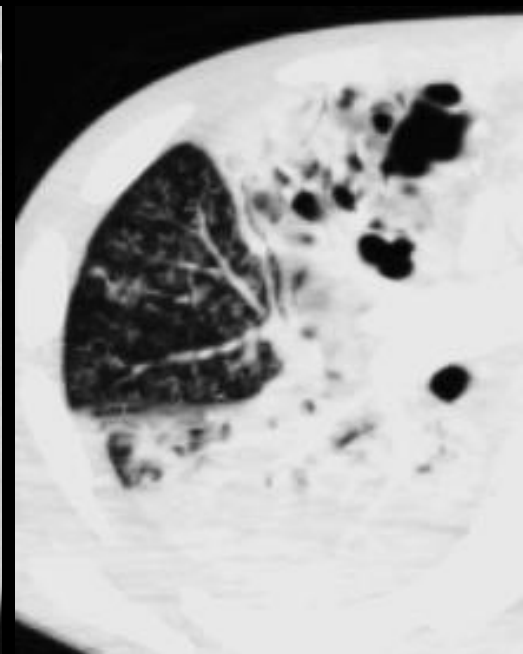
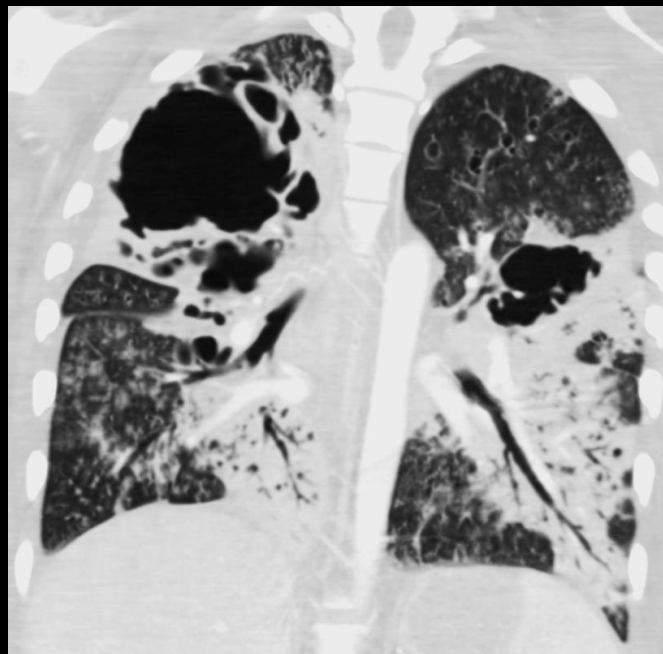
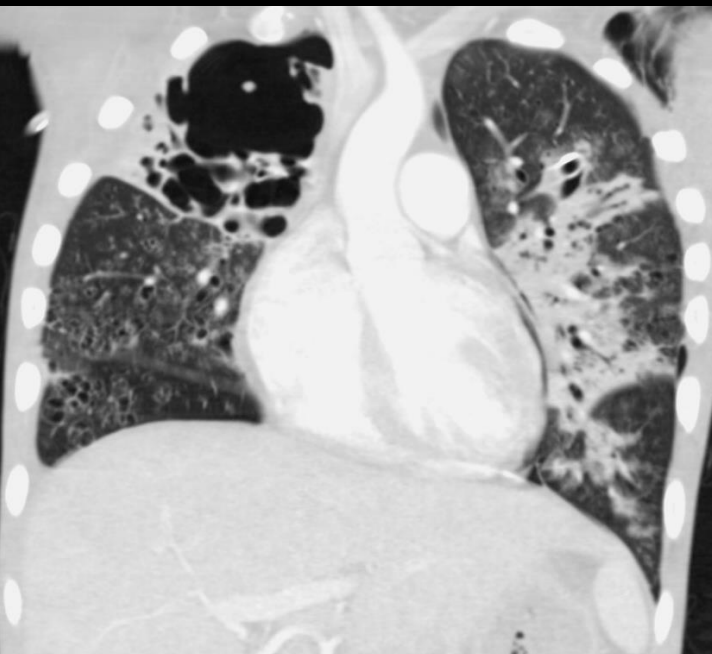
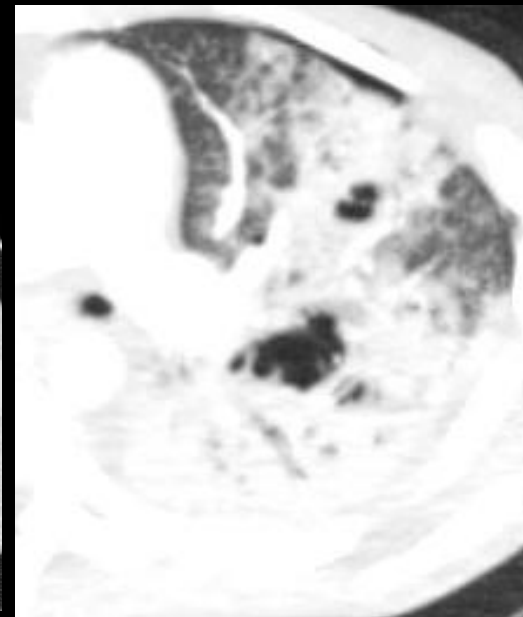
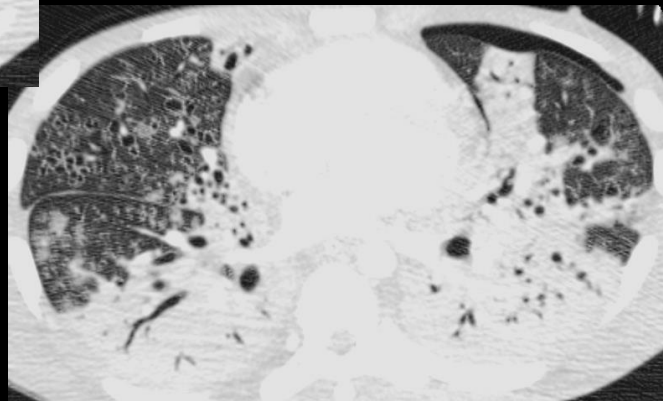


26 ans, malgache

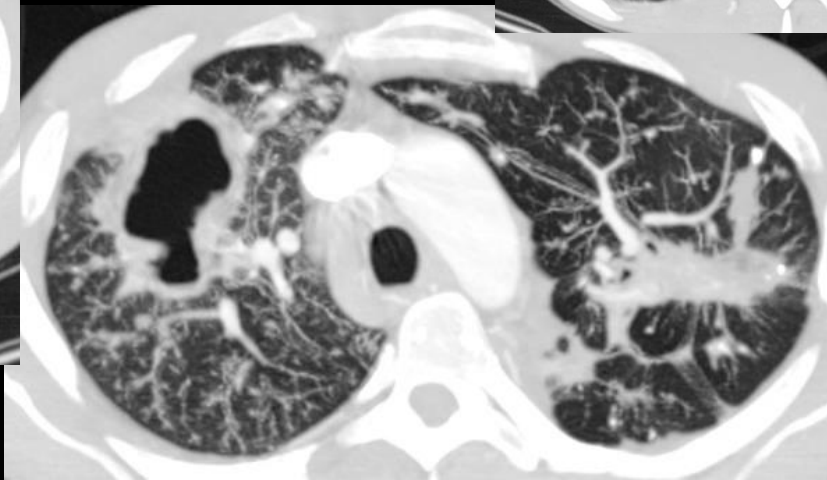
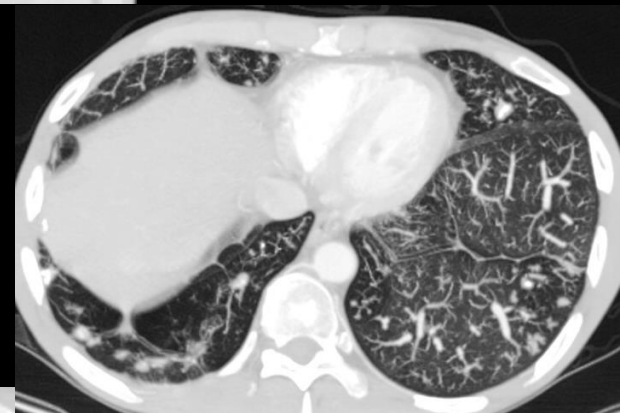
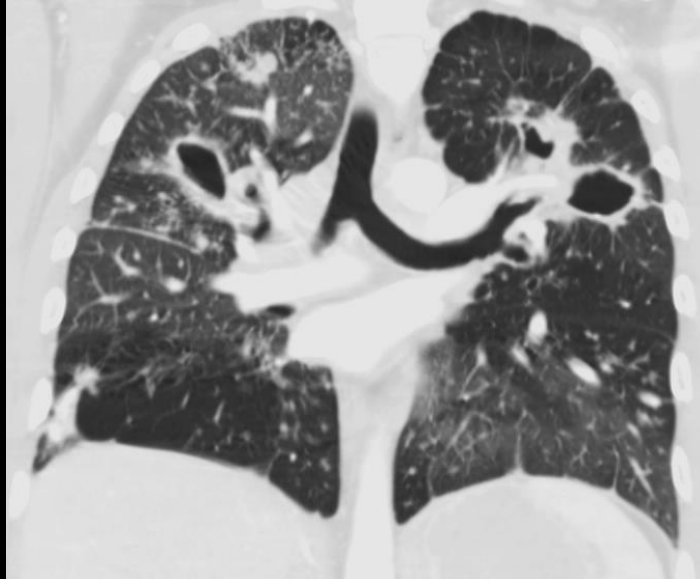




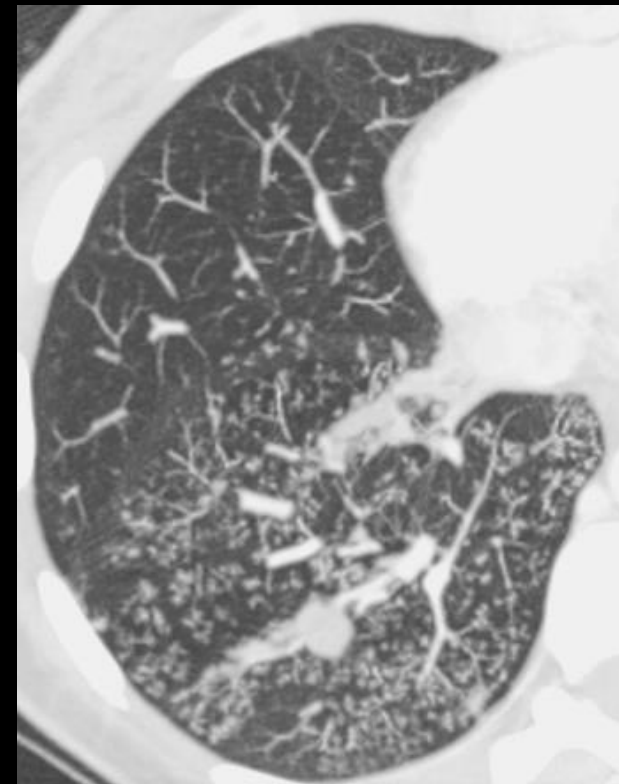
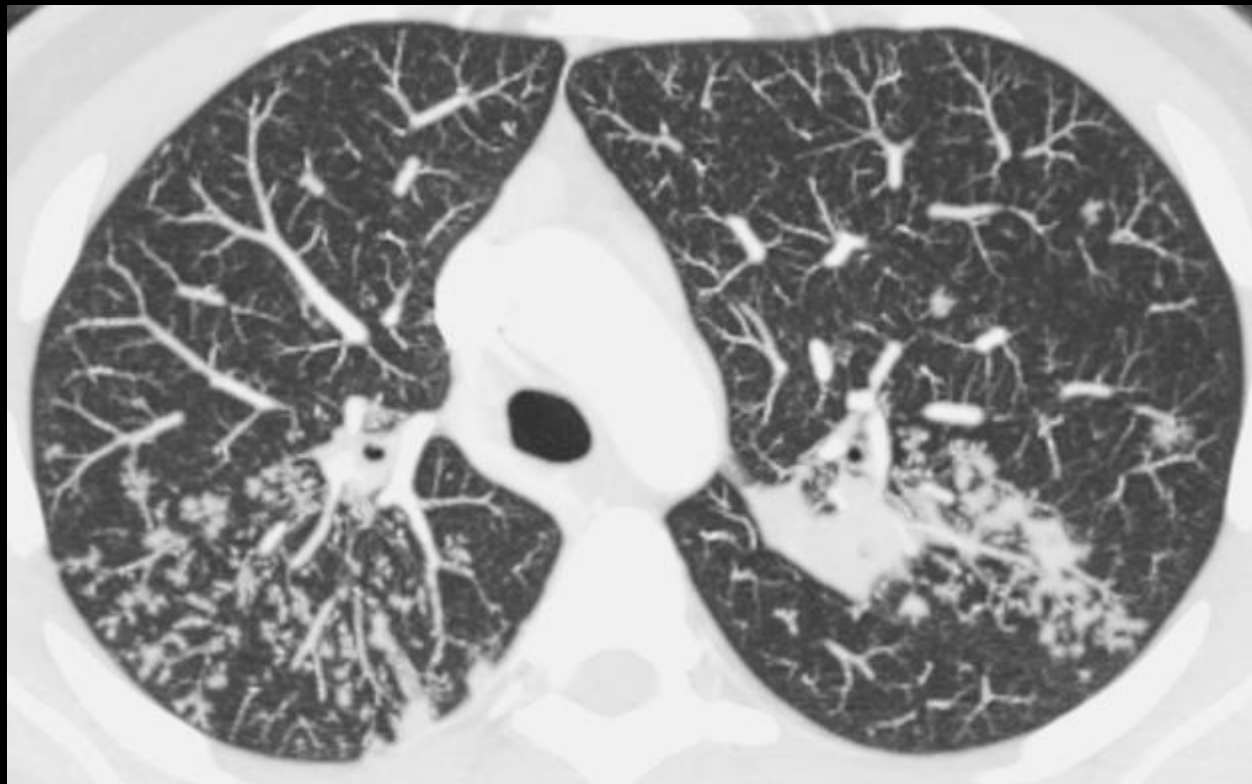
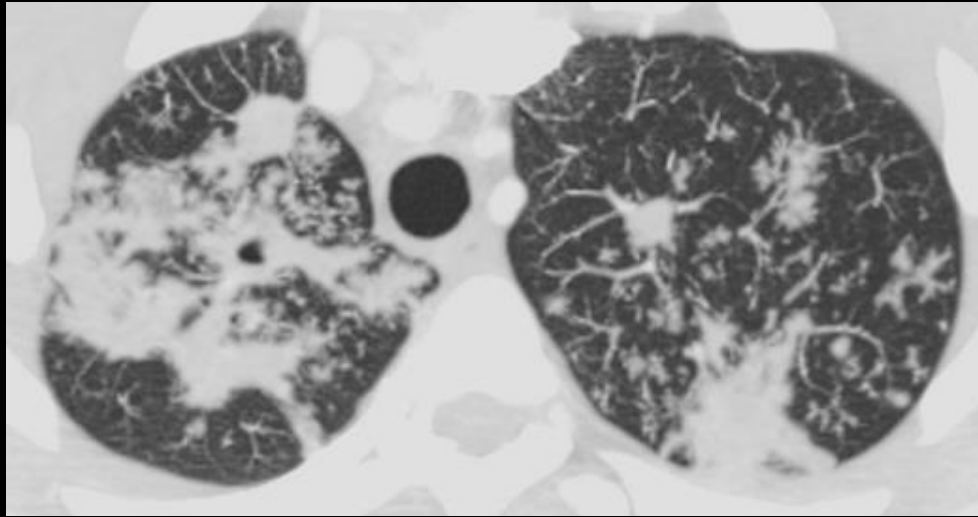
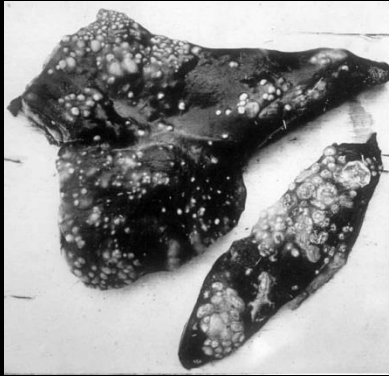
quelques exemples
d'atteintes
tuberculeuses



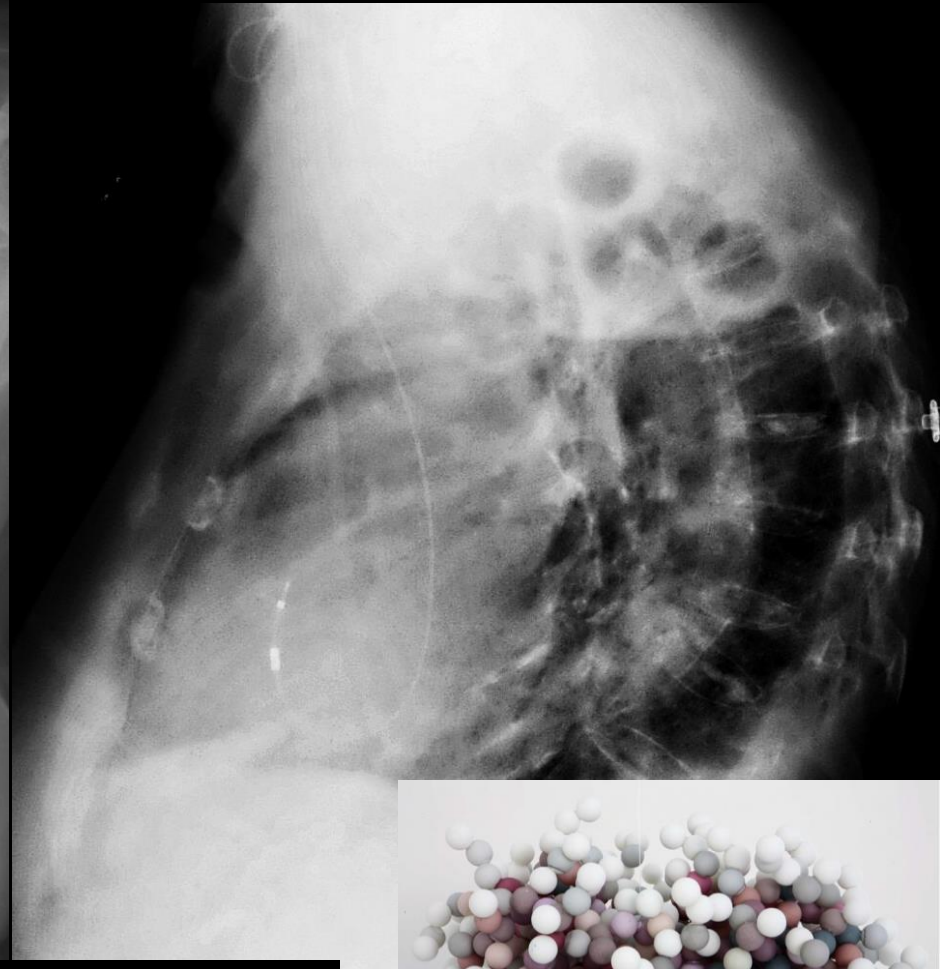
32ans



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....