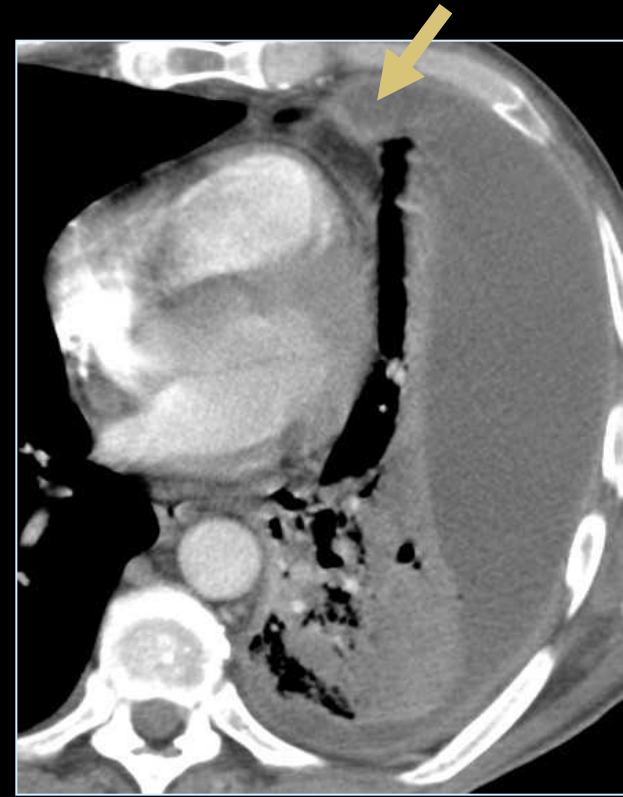
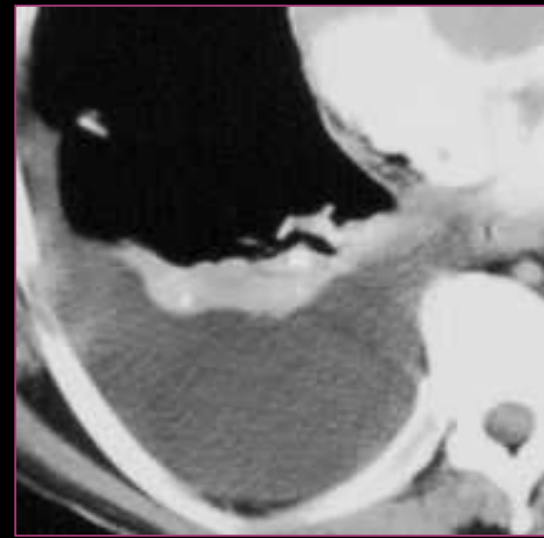
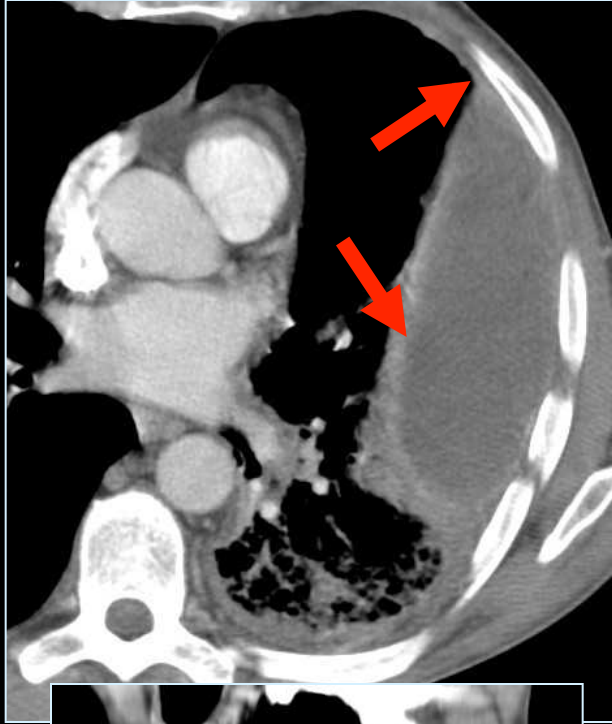


N°1

Empyème pleural

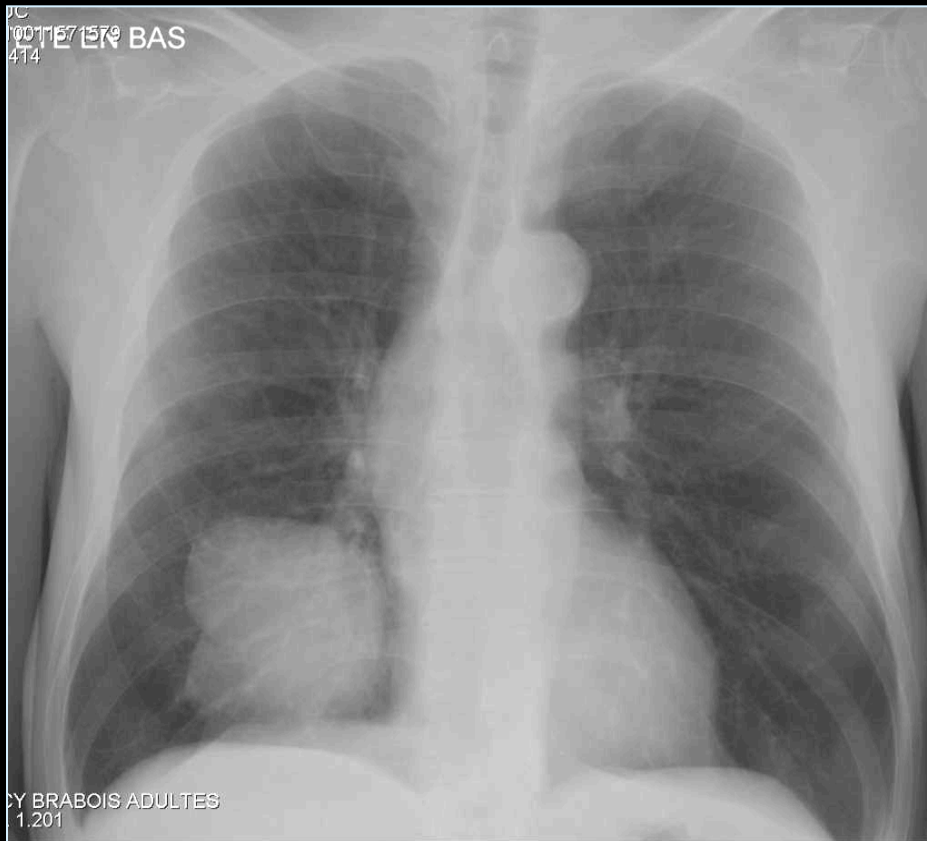


Patient de 47 ans

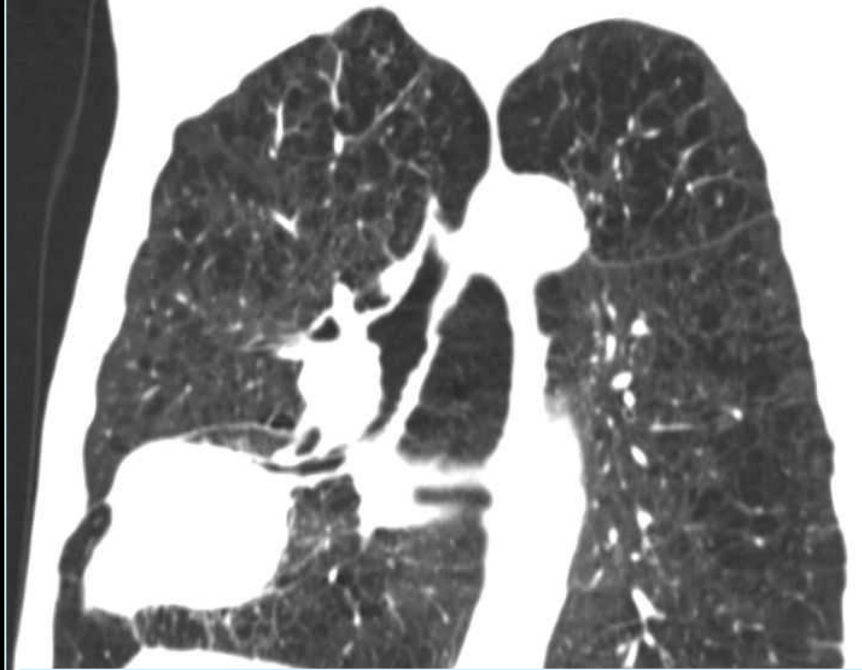
Consulte pour hémoptysies récidivantes

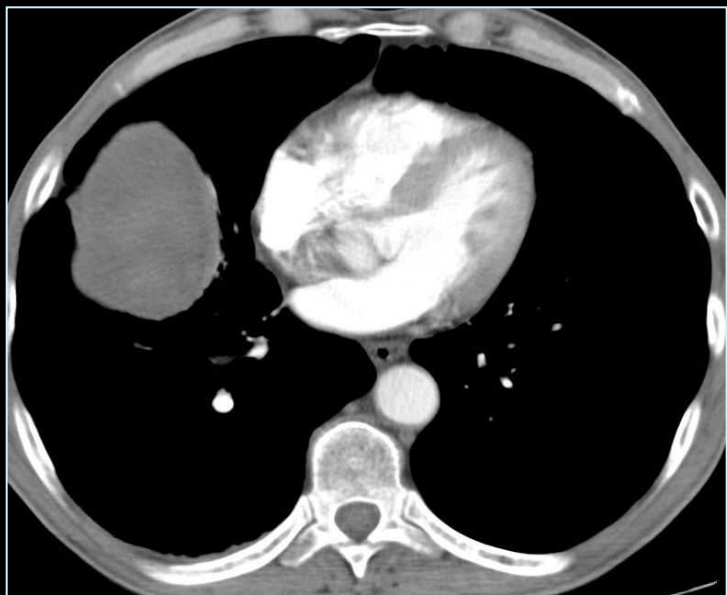
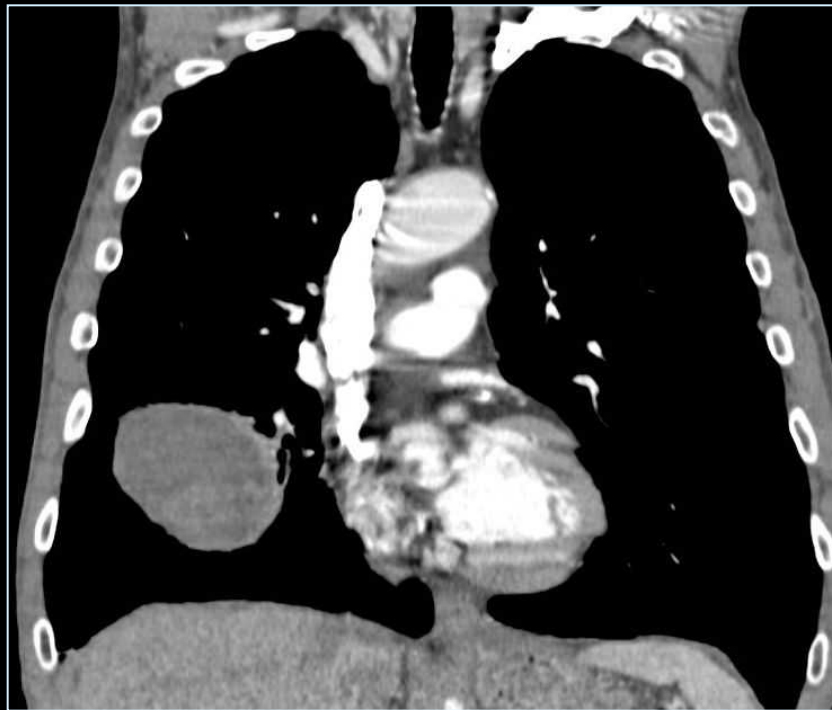
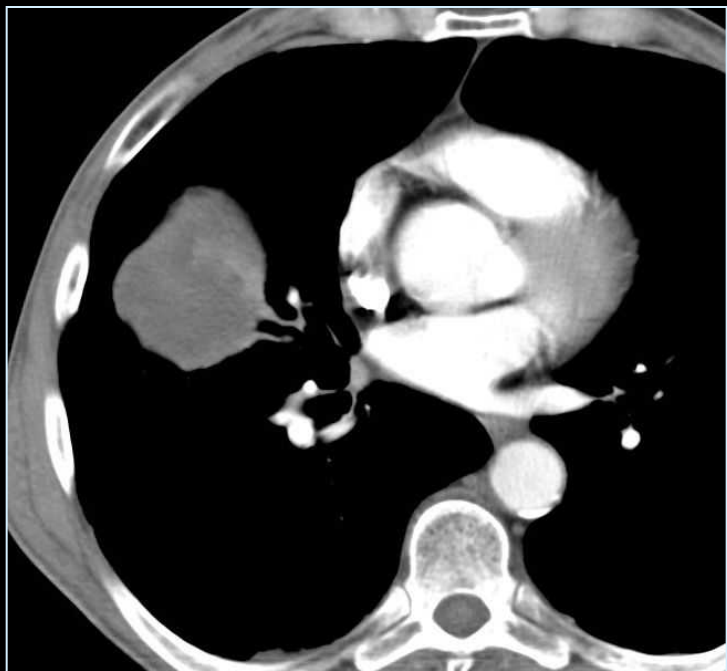
Tabagisme actif environ 25 PA

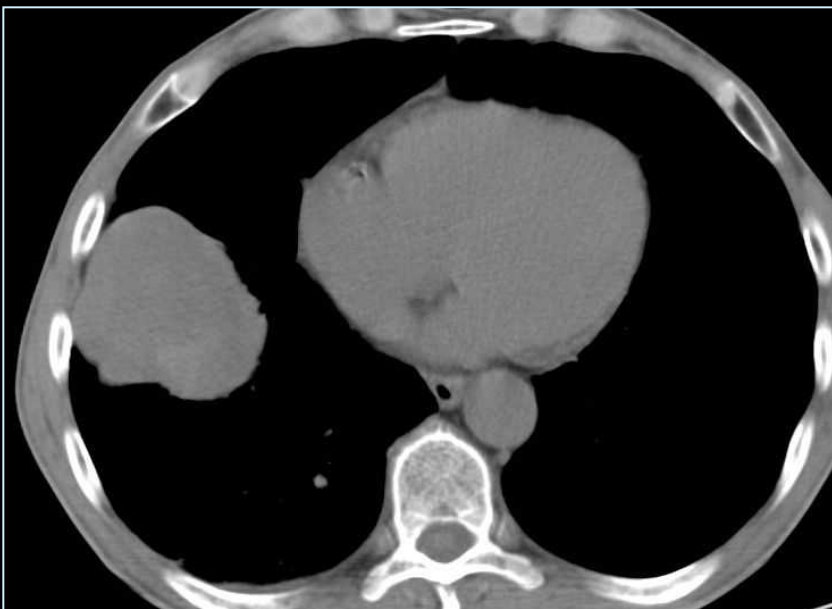
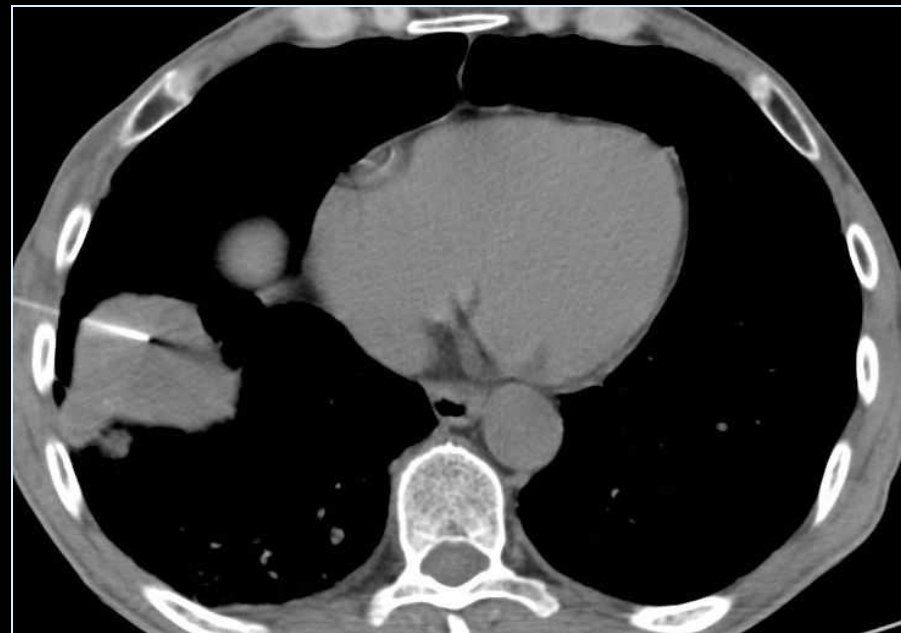
N°2



TDM 1

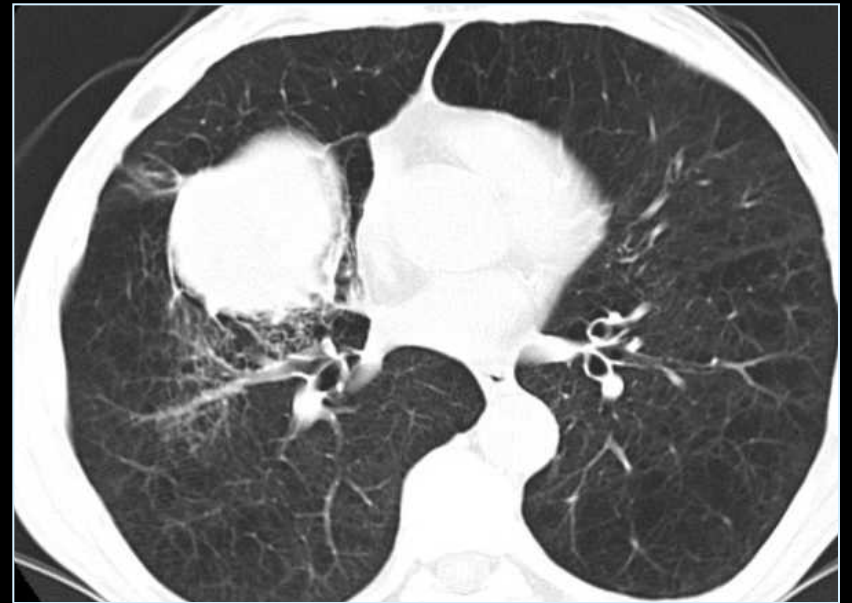
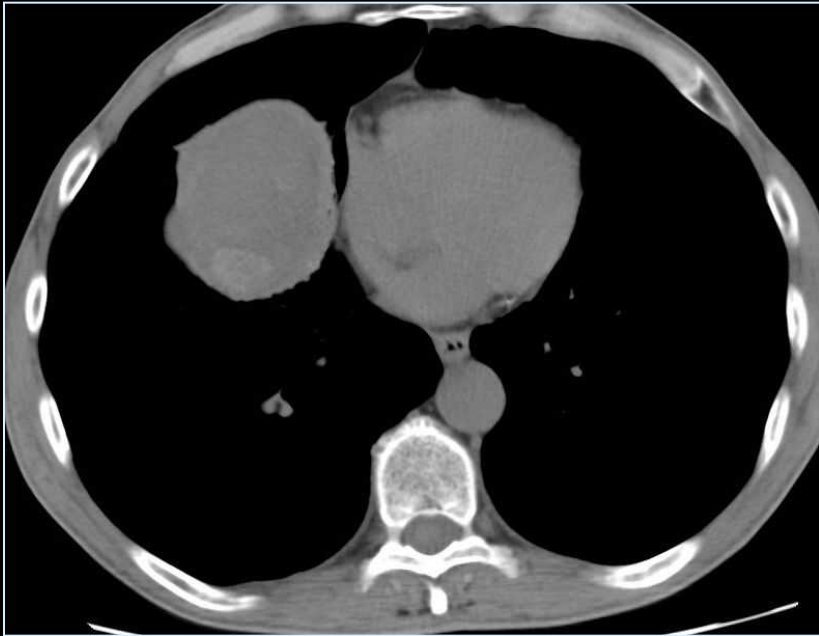






**Biopsie
transpariétale**

TDM 3





1



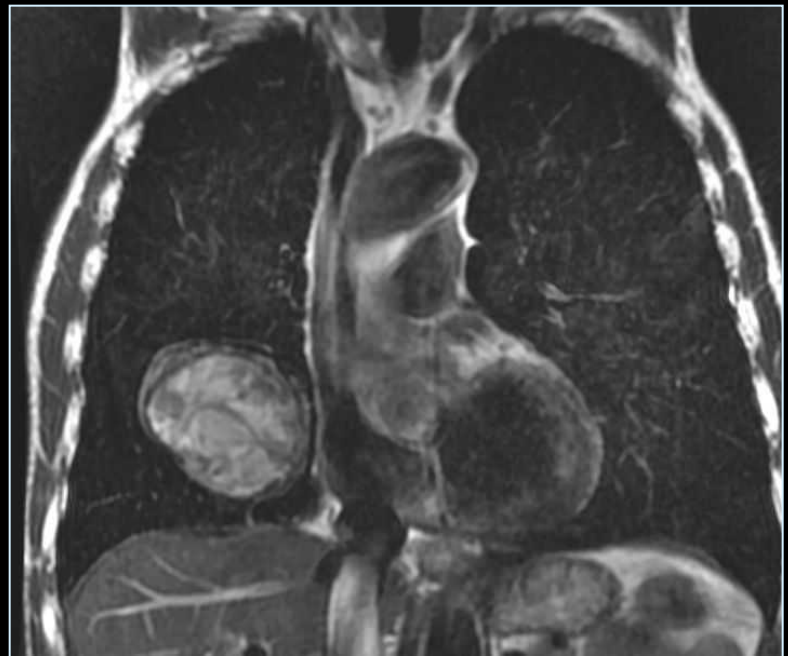
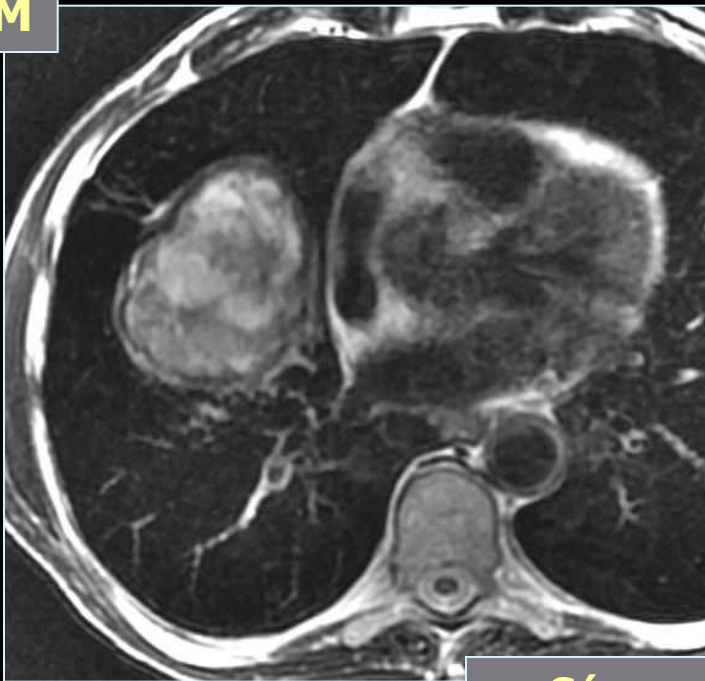
2



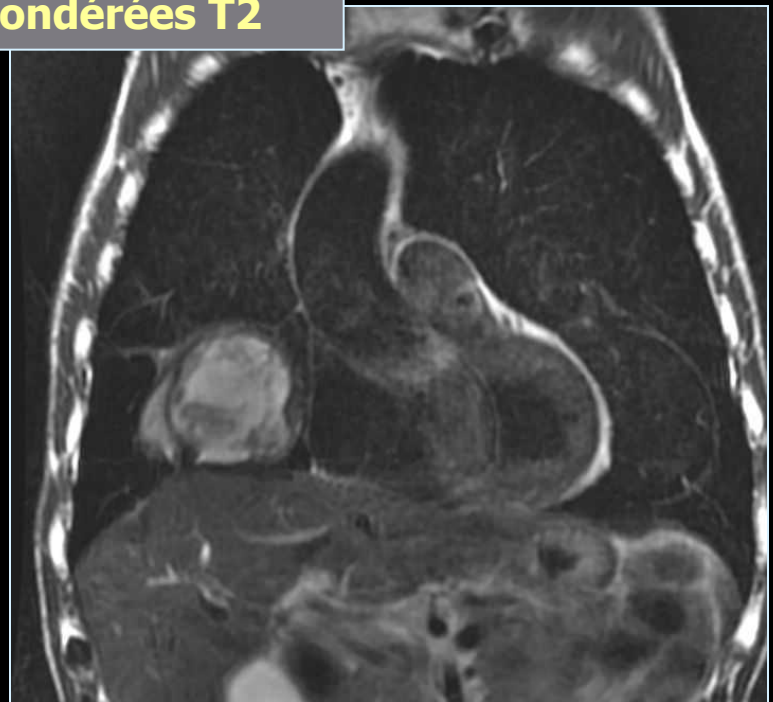
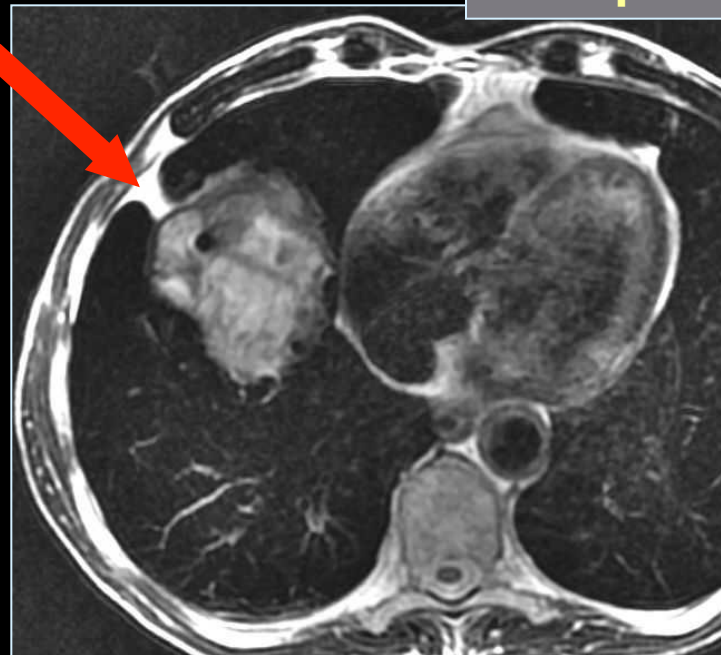
3

TUMEUR MOBILE SUR LES EXAMENS SUCCESSIFS

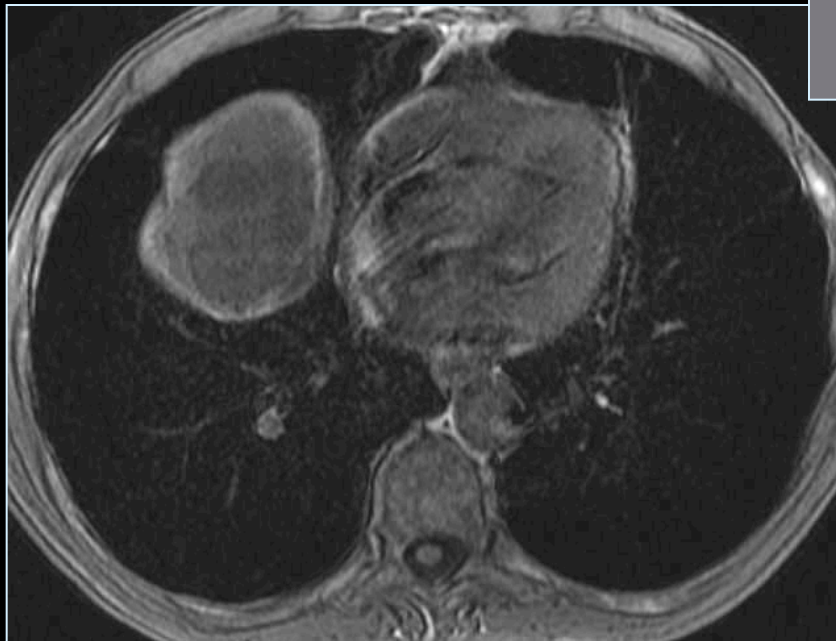
IRM



Séquences pondérées T2



**Séquences pondérées T1 avant et après
injection de gadolinium**

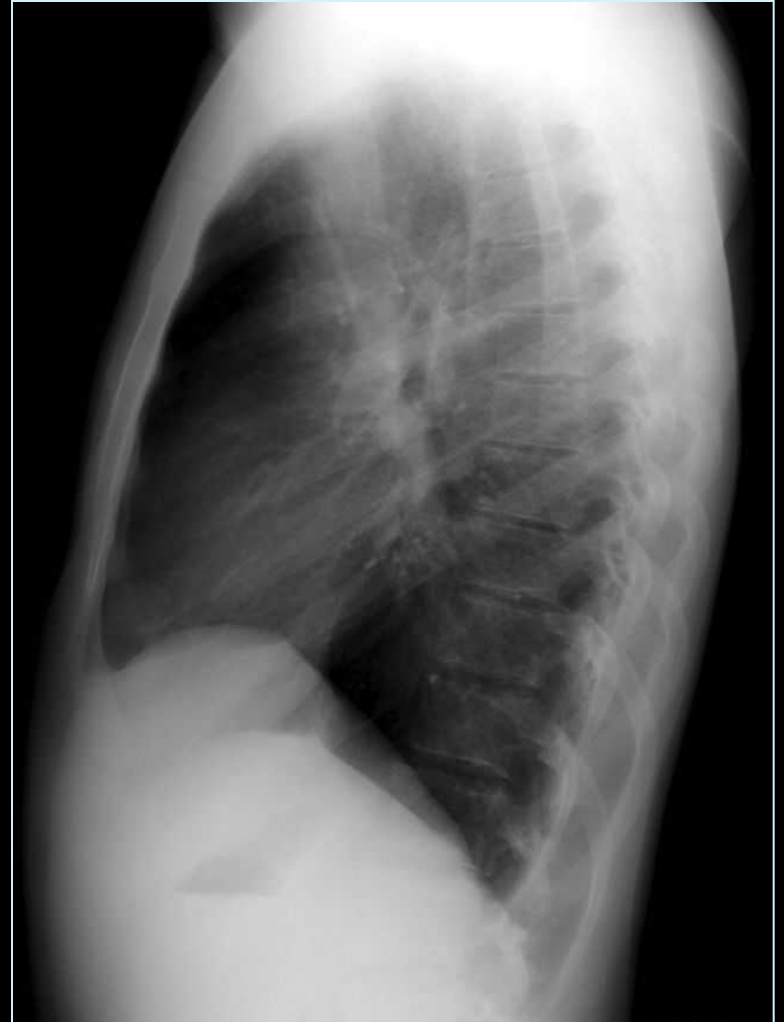
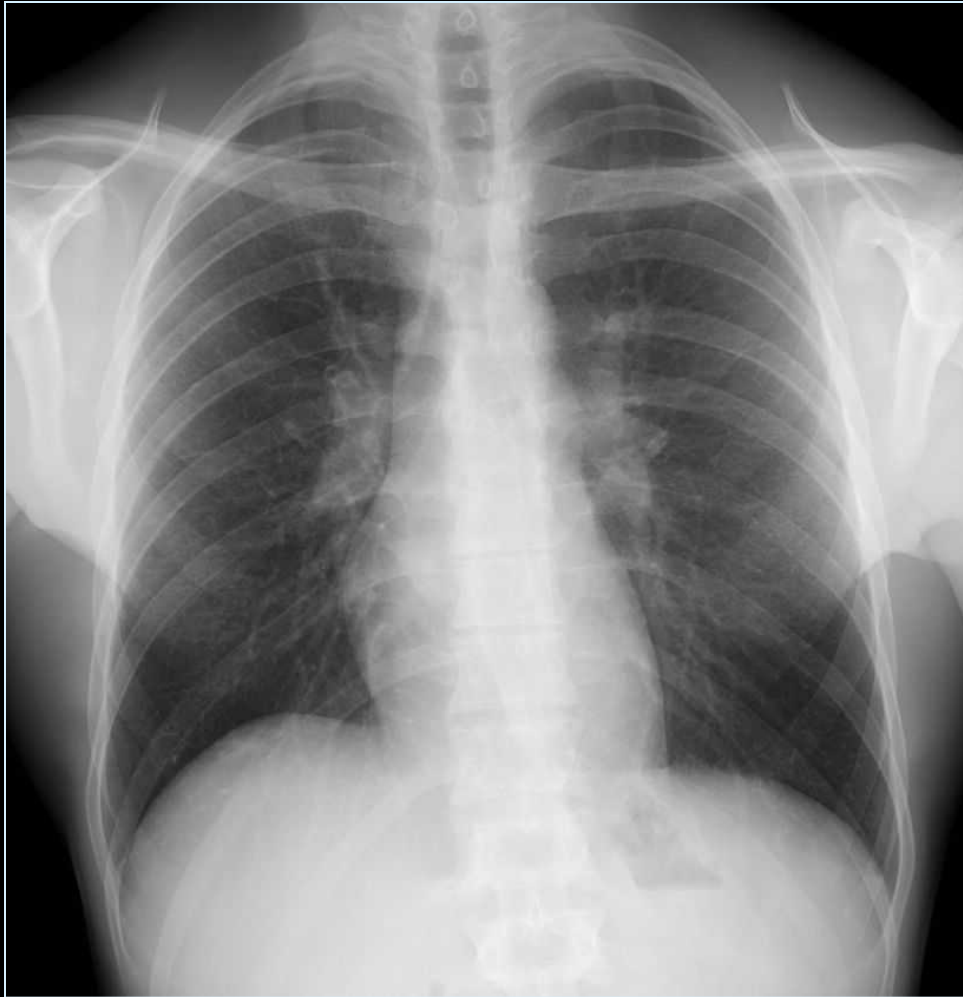


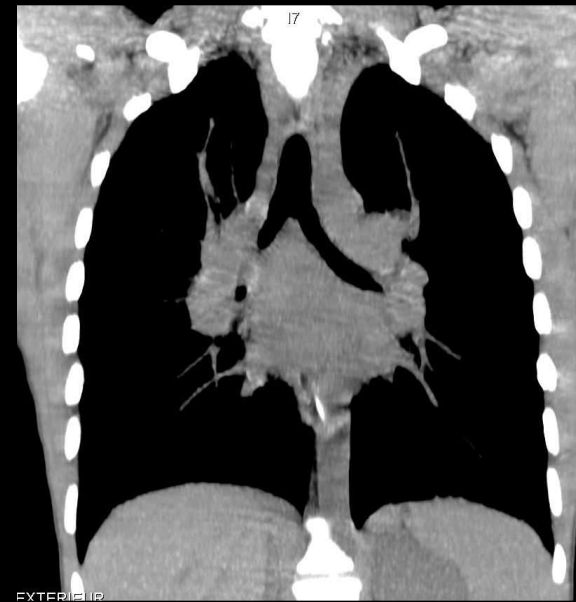
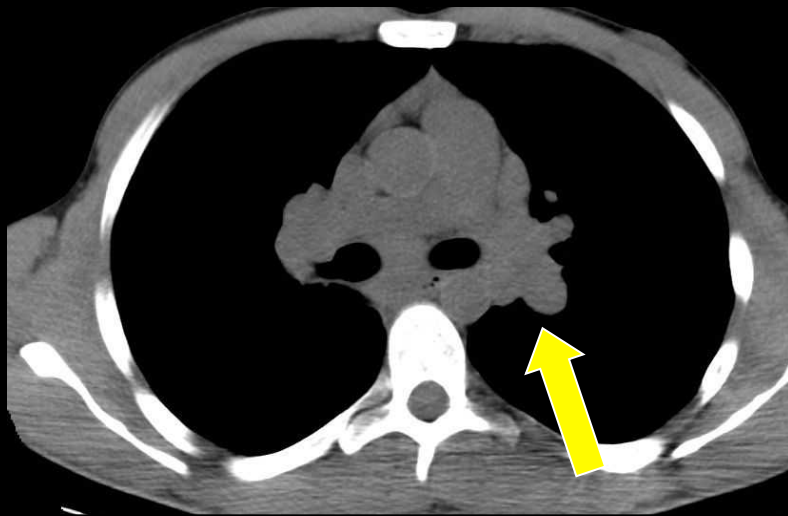
Tumeur fibreuse solitaire pleurale

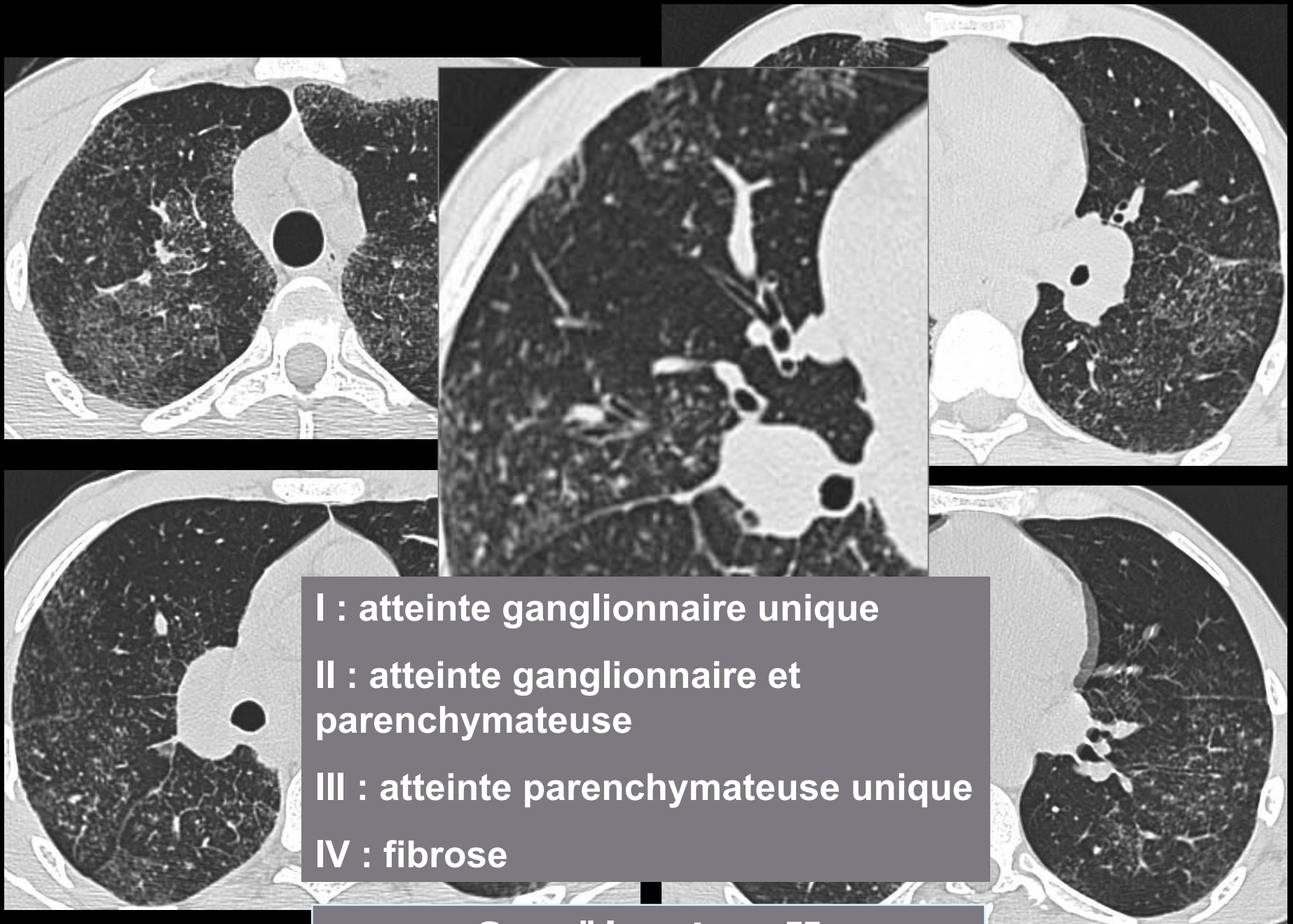
Tumeur fibreuse solitaire pleurale

- Rares 5% des tumeurs pleurales
- Origine cellules mésenchymateuses (c. dendritiques)
- Microscopie c. fibroblastiques et tissu collagène
- 80% développée à partir de plèvre viscérale 50% pédiculée
- Masse avec remaniements nécrotiques ou hémorragiques
- Découverte fortuite
- **RT** masse homogène ronde, angles de raccordements obtus/plèvre
- Localisation scissurale 30% des cas
- **TDM** masse tissulaire bien limitée svt hétérogène selon contingents
- Rehaussement variable, calcifications rares
- **IRM** hypo T1, hétérogène en T2
- **TTT** chirurgical et exérèse complète
- Récidive possible, suivi à long terme

- **Patient 29 ans, sportif**
- **Asthénie et perte de poids importante (8 kg en 1 mois)**
- **Découverte d'une insuffisance rénale avec 60 mg/l de créatinine**



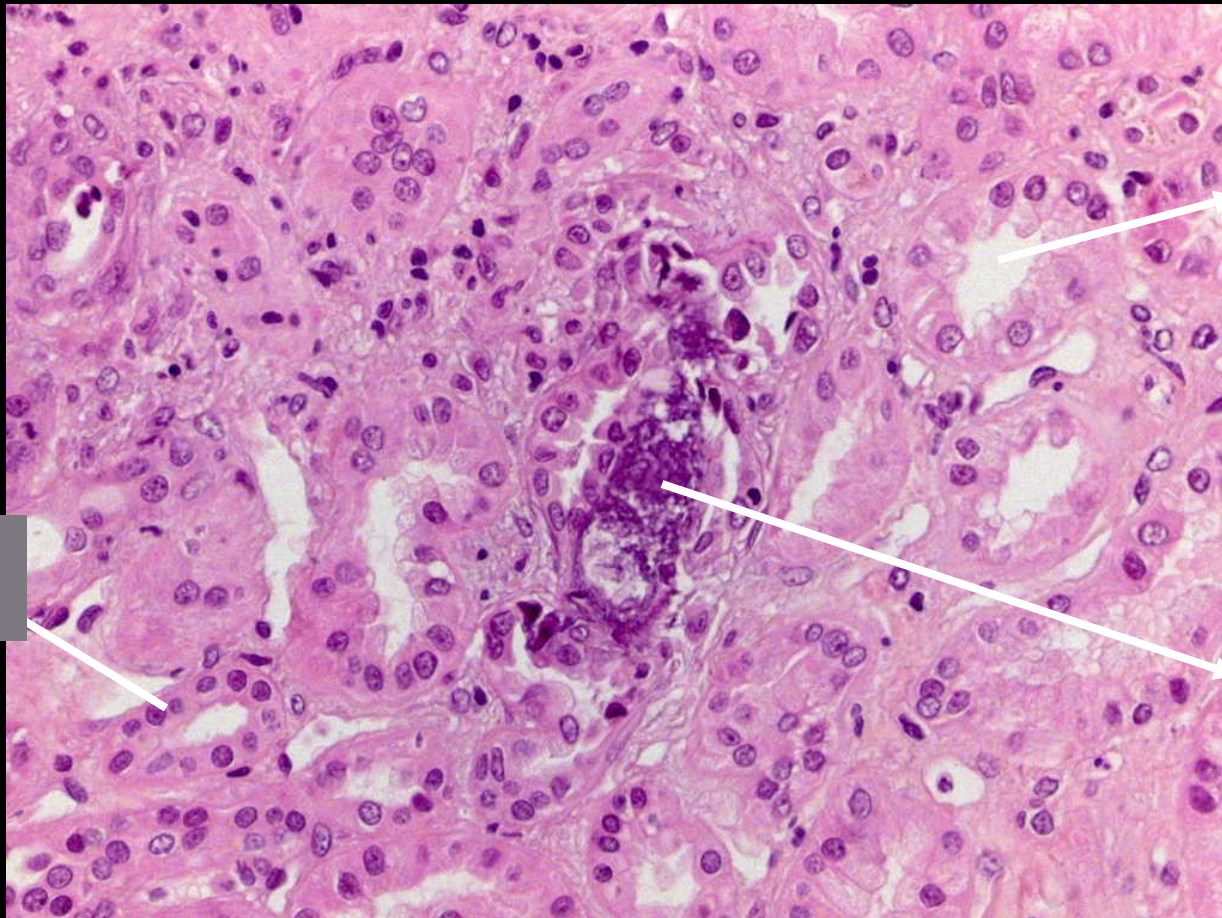




Sarcoïdose type II

Biopsie rénale

Précipitation intra tubulaire de cristaux de Ca avec NTA

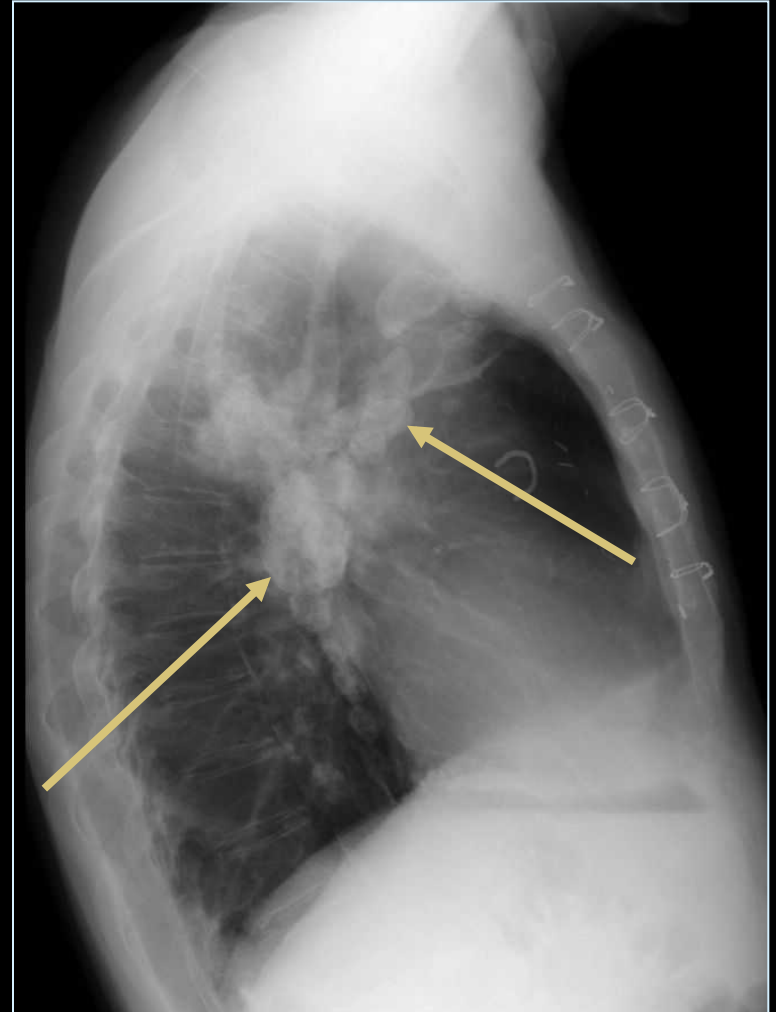
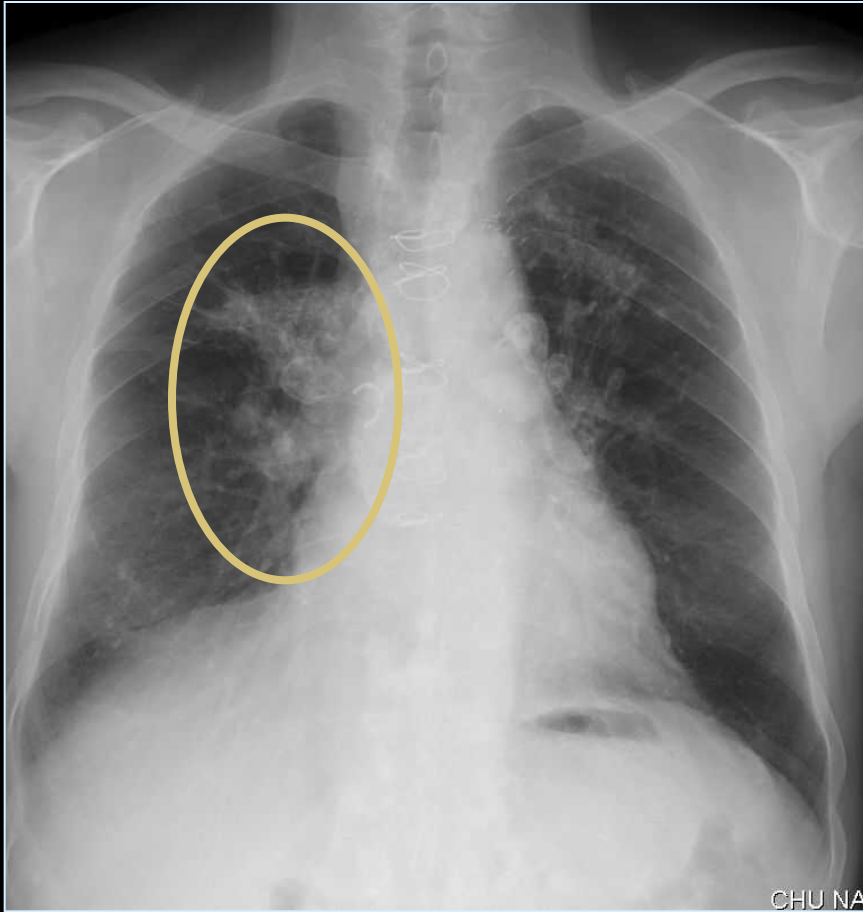


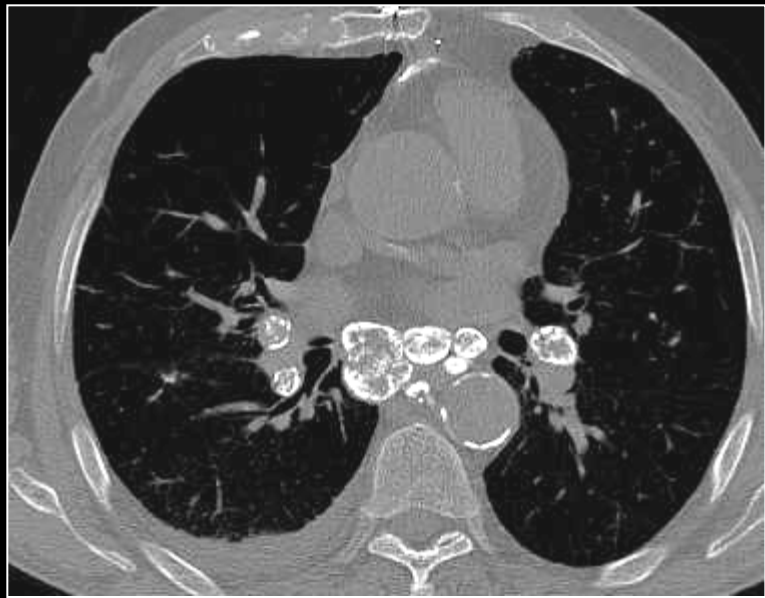
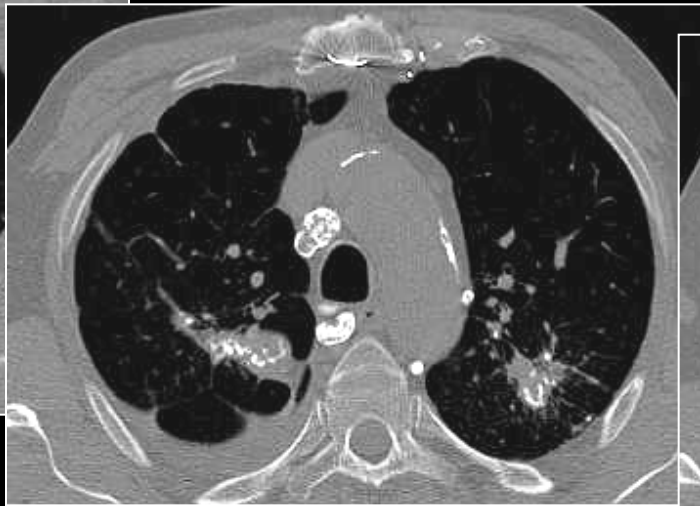
Epithélium
cylindrique

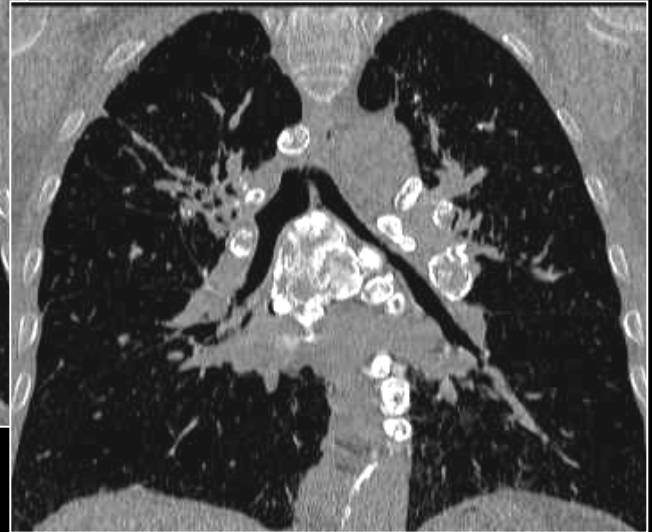
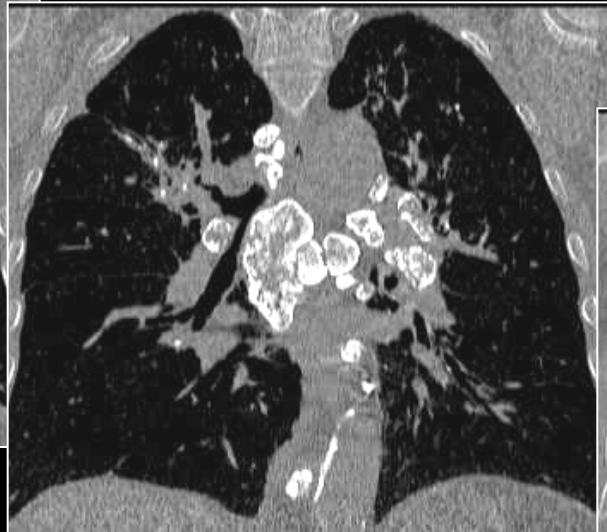
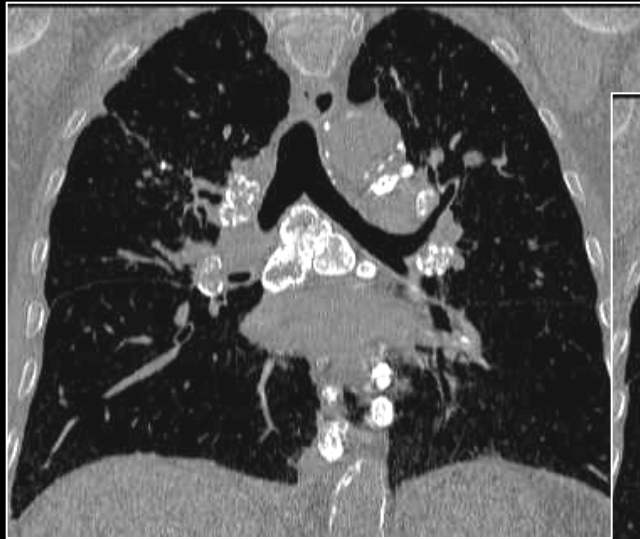
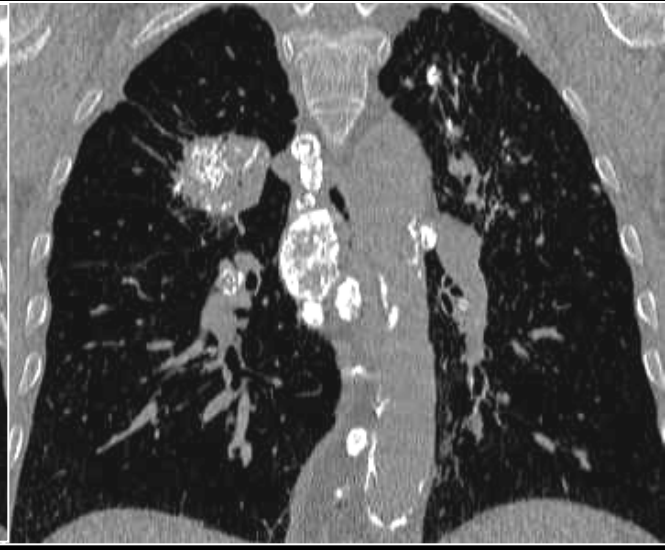
Tubule normal

Cristaux de
Ca $2+$

Aspect en
« coquille
d'huitre »

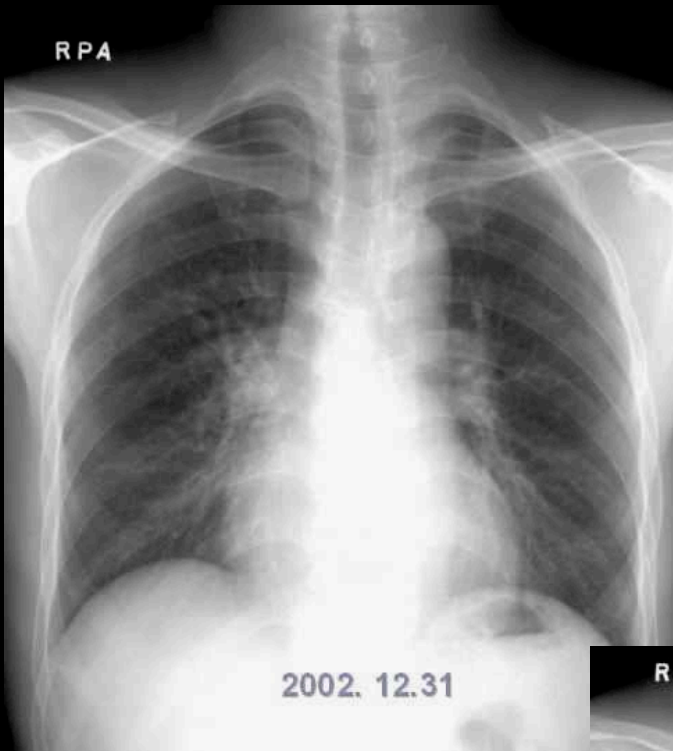






Silicose

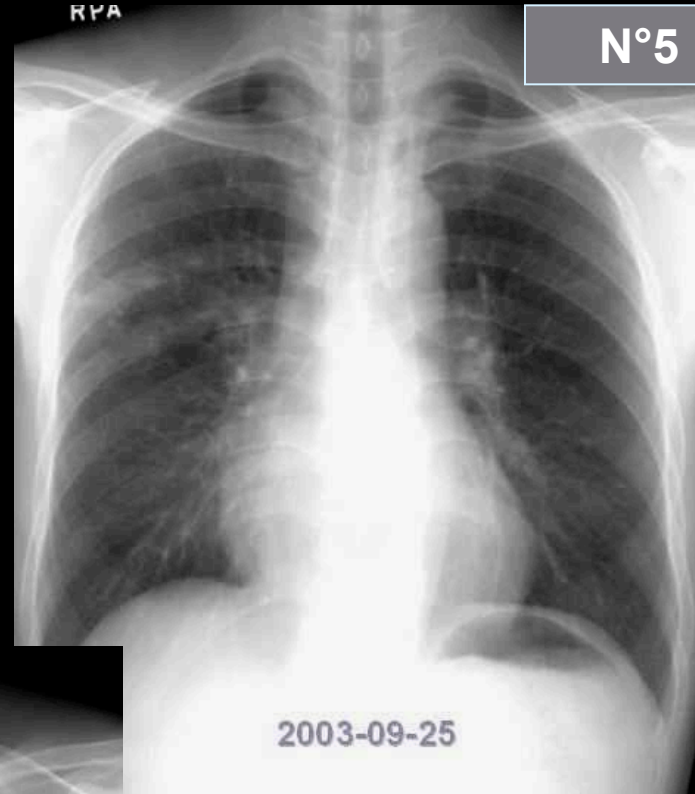
RPA



2002. 12.31

**homme 41 ans,
toux persistante,
crachats et
dyspnée depuis
1 mois**

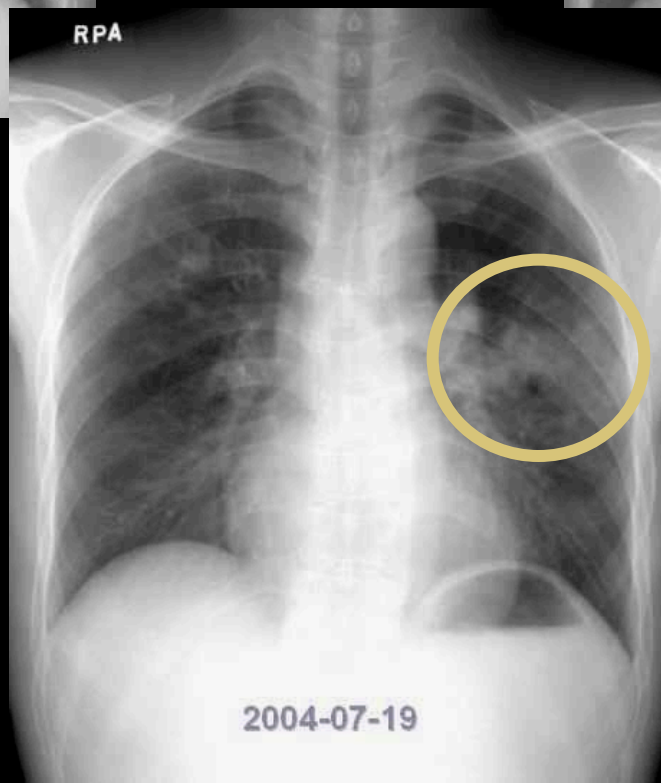
RPA



2003-09-25

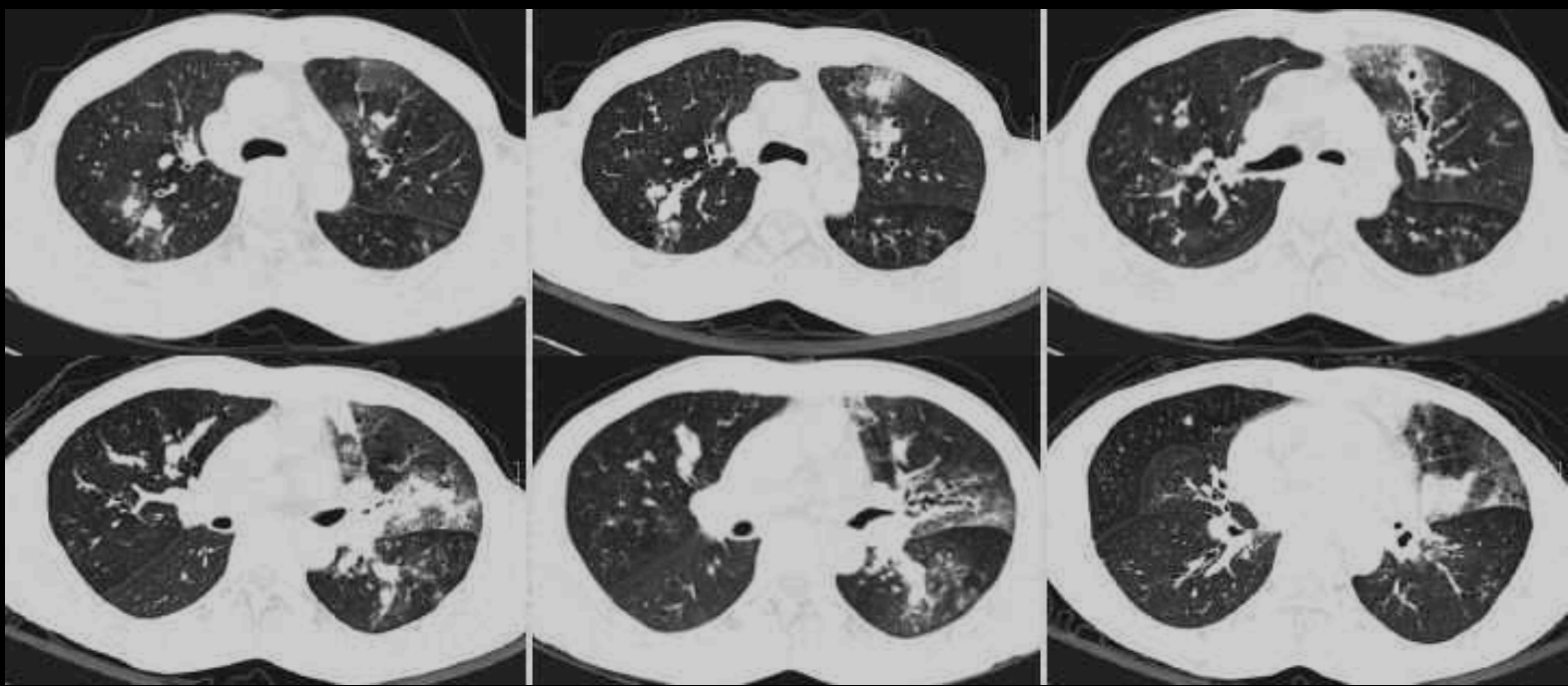
N°5

RPA



2004-07-19





impactions mucoïdes :

- opacités "en doigts de gants" (bronchectasies proximales surtout lobes sup)
- images « en pâte dentifrice »





Aspergillose broncho pulmonaire allergique

Radiographic Findings in ABPA

Acute (transient)

Consolidation (80%)

Mucoid impaction
(bronchocele) (30%)

Atelectasis (20%)

Chronic (permanent)

Overinflation

Tubular shadow

Ring shadows

Vascular deficiency

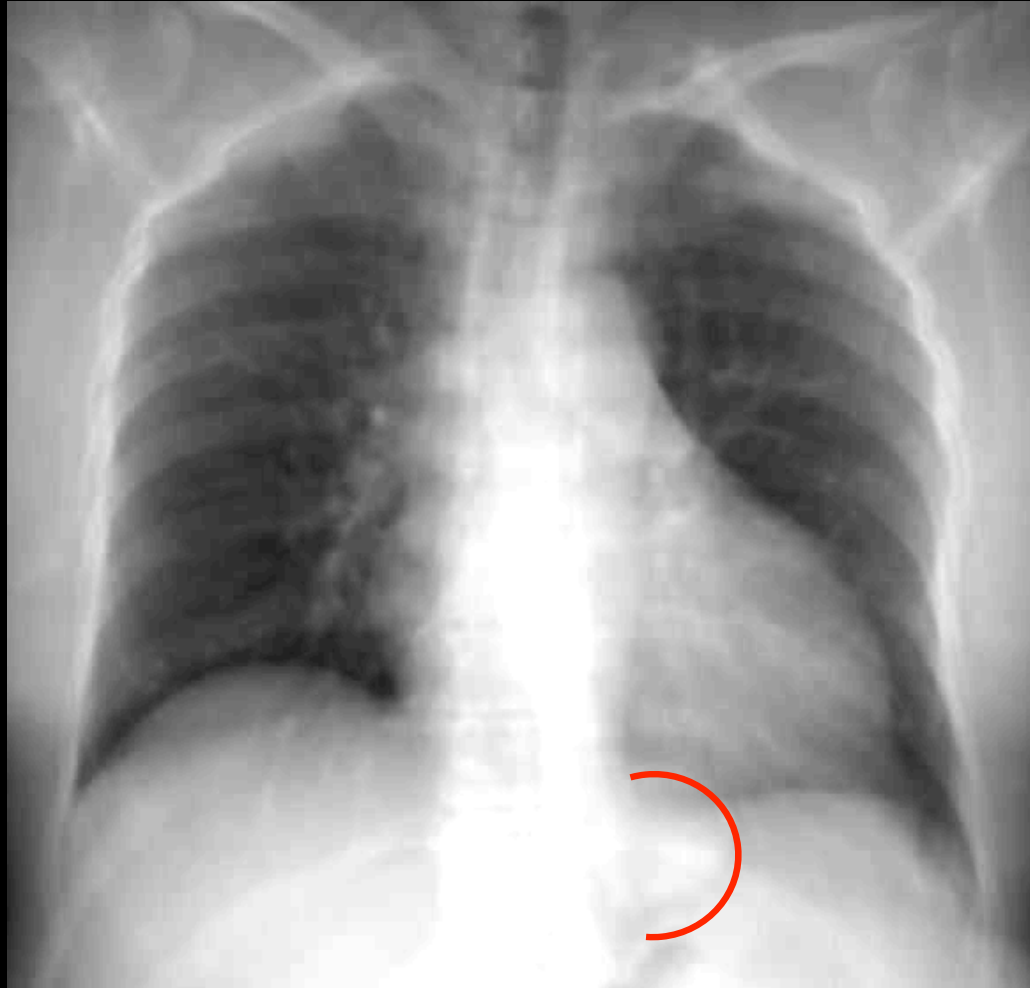
Labor shrinkage

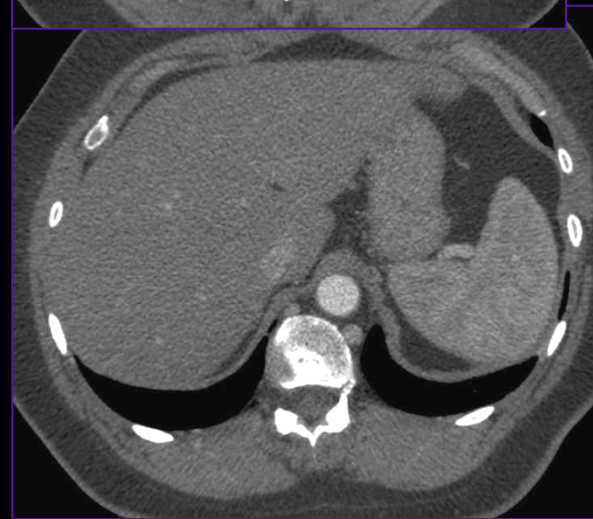
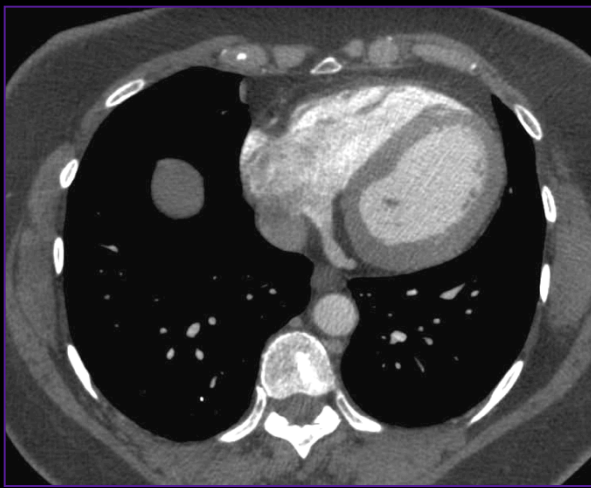
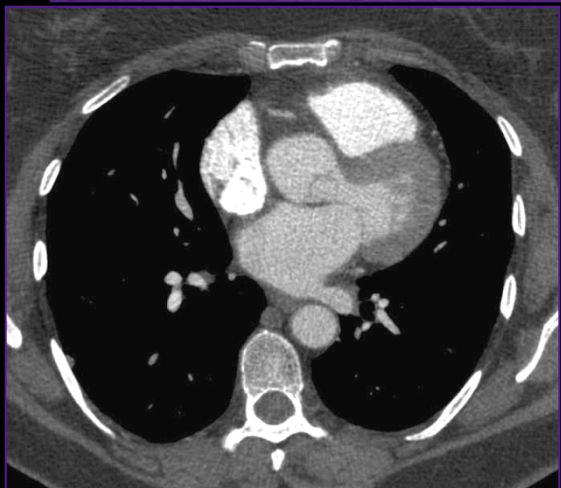
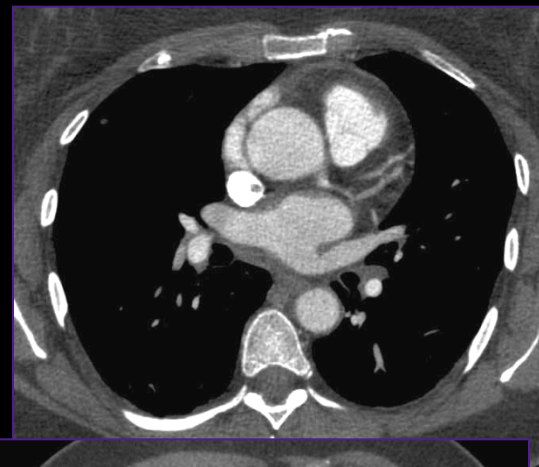
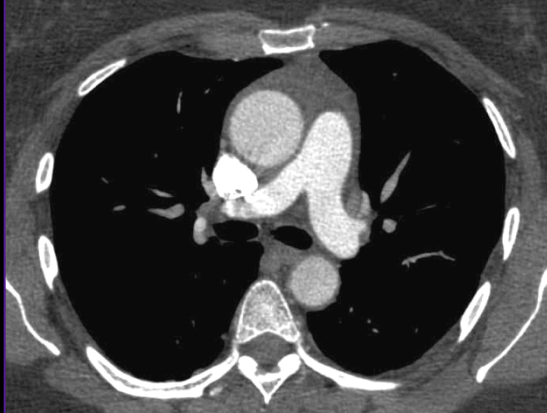
Aspergillose pulmonaire

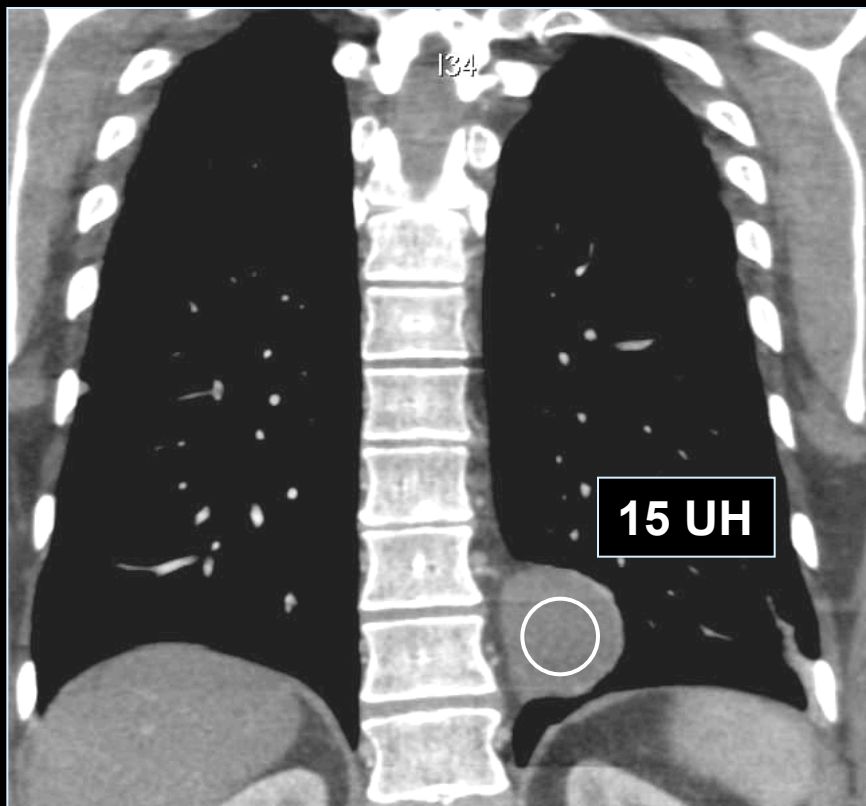
aspergillose broncho-pulmonaire allergique

- ▣ atteinte pulmonaire rare rencontrée uniquement chez des sujets asthmatiques. La pathogénie fait intervenir des réactions allergiques de type I (IgE) et III (complexe AG/AC). les aspergillus inhalés prolifèrent dans les grosses bronches proximales des asthmatiques ,où existent souvent des lésions muqueuses. Les filaments mycéliens induisent une hyperproduction de mucus entraînant ,le cas échéant des bronchectasies proximales.
- ▣ il n'y a pas d'invasion des parois bronchiques par le champignon. les bronchioles distales peuvent être également distendues par le mucus ;leurs parois peuvent être infiltrées par un granulome inflammatoire (granulomatose broncho-centrique).

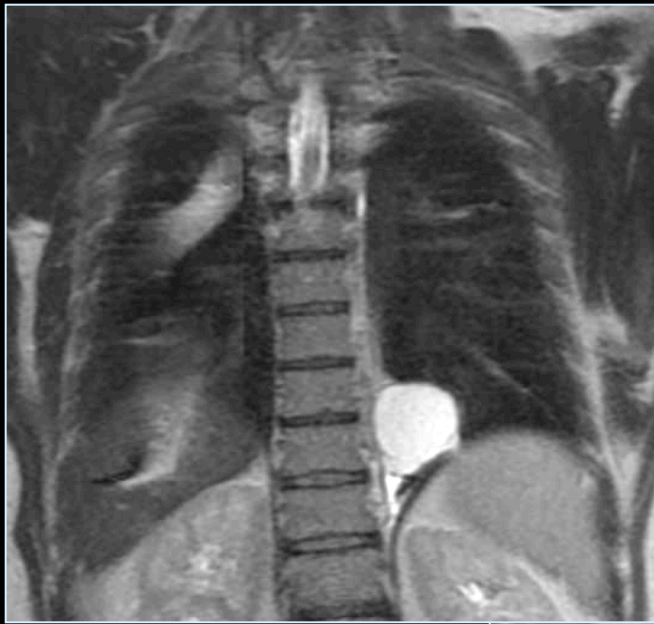
N°6



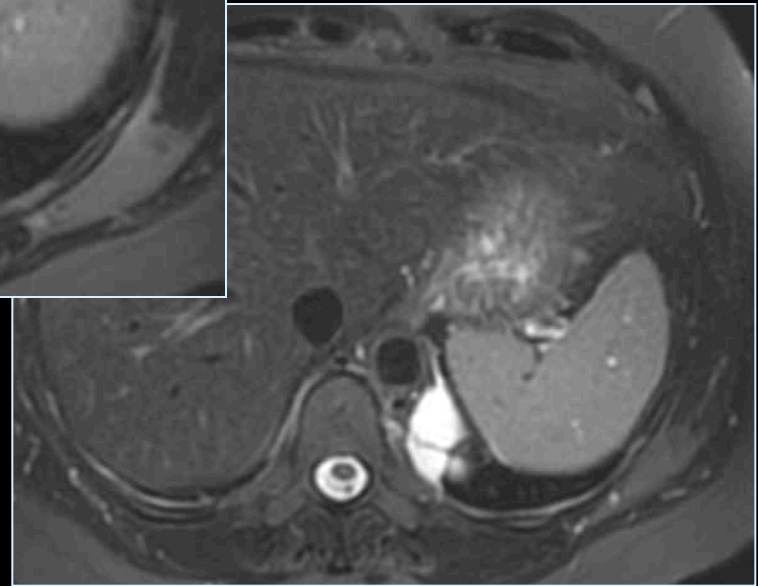
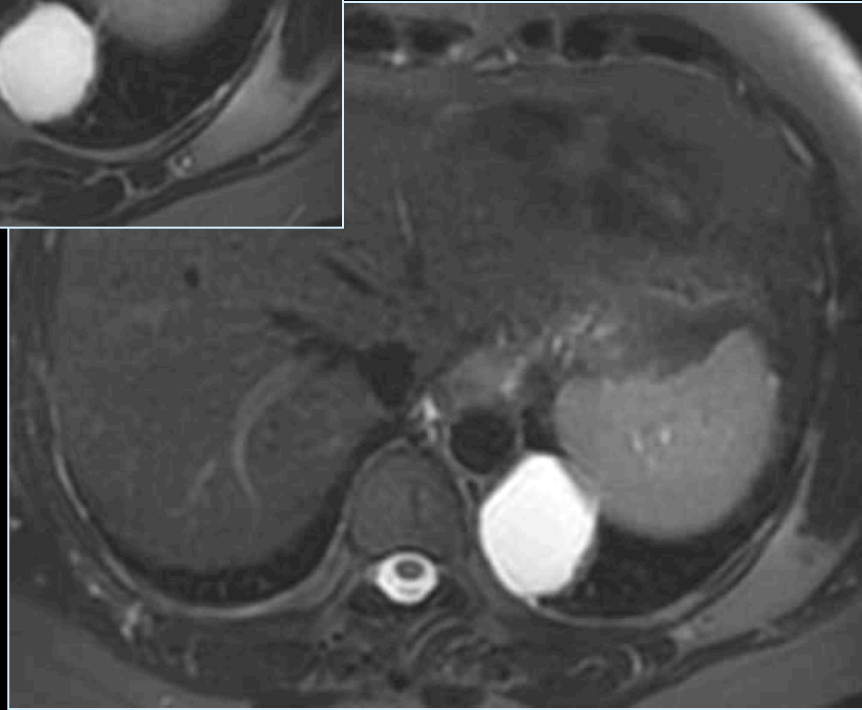
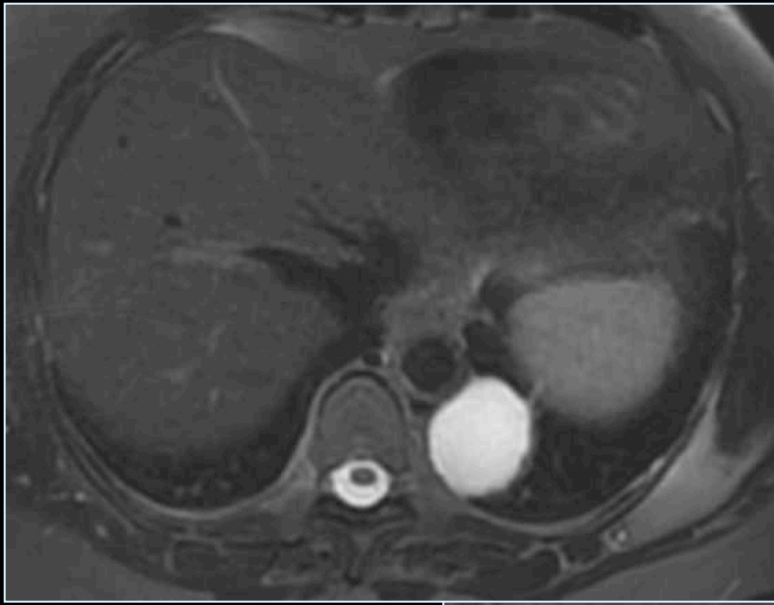




T2 SSFSE



T2 FSE



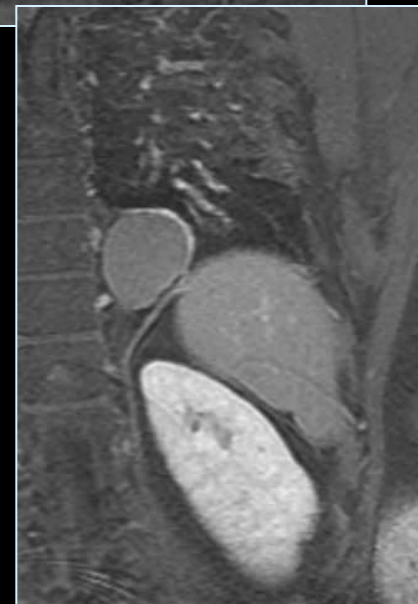


T1

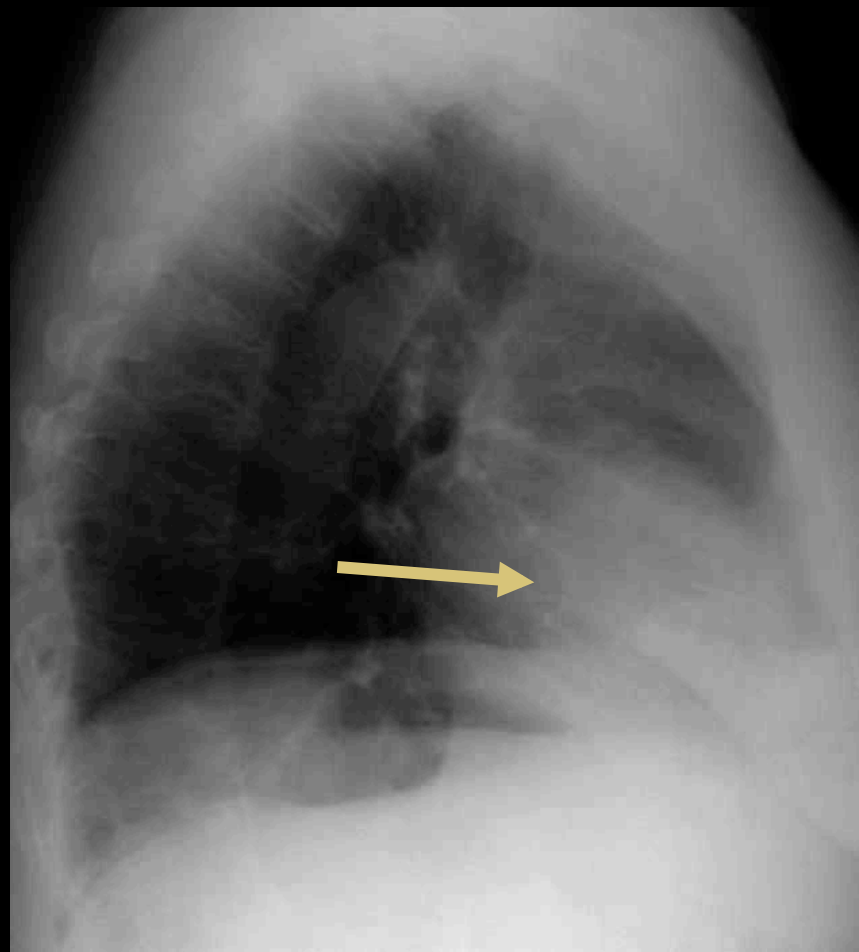
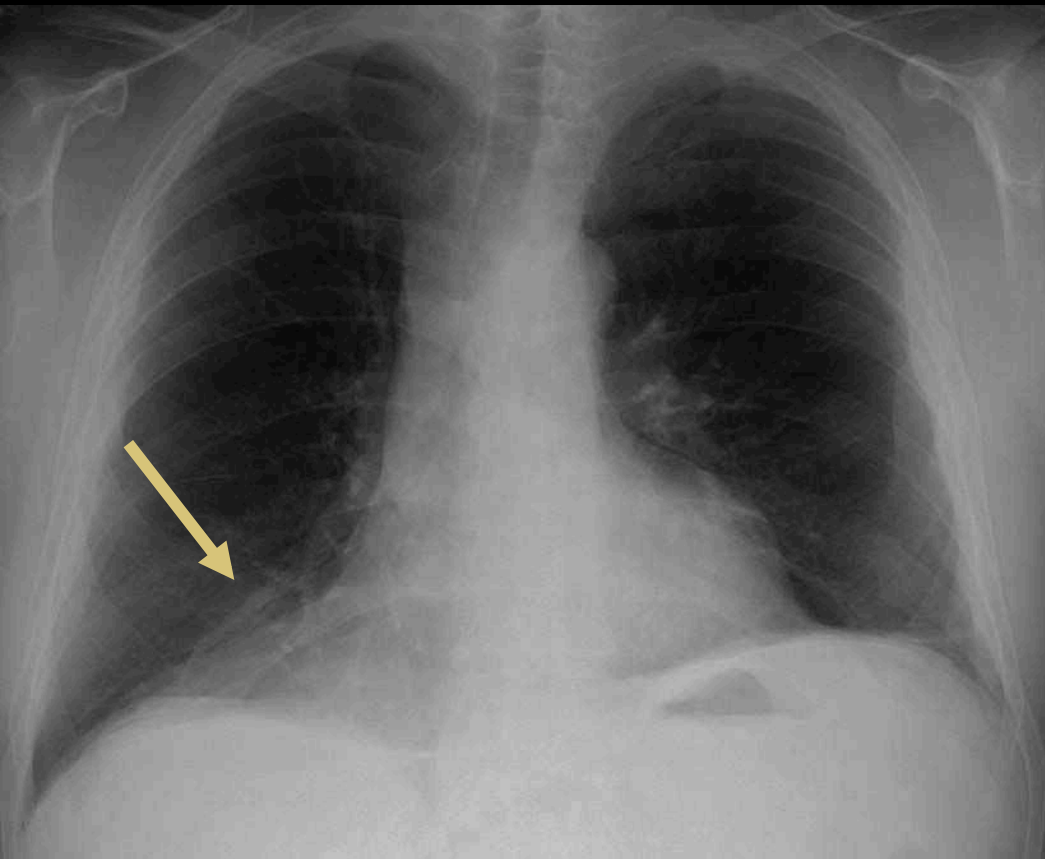
Kyste bronchogénique



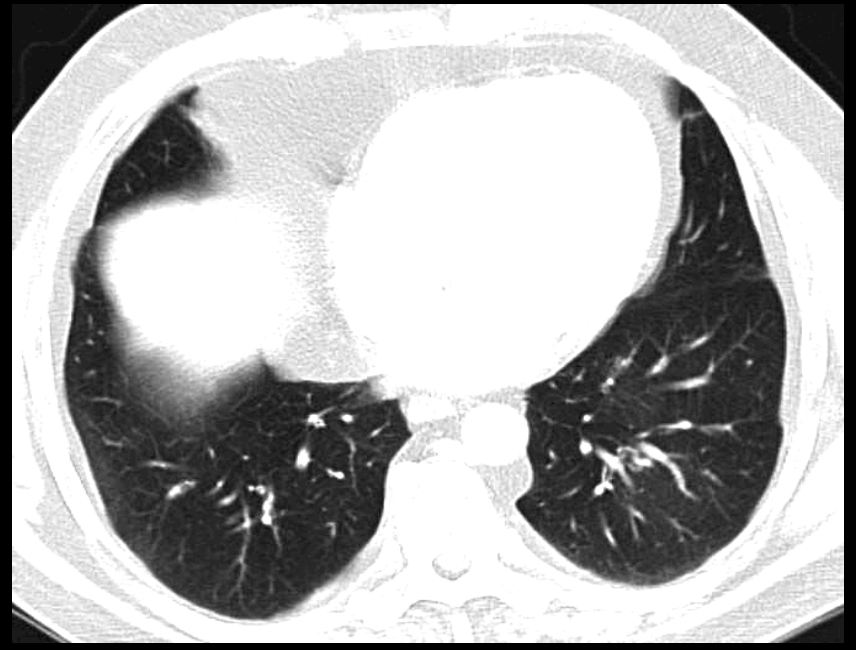
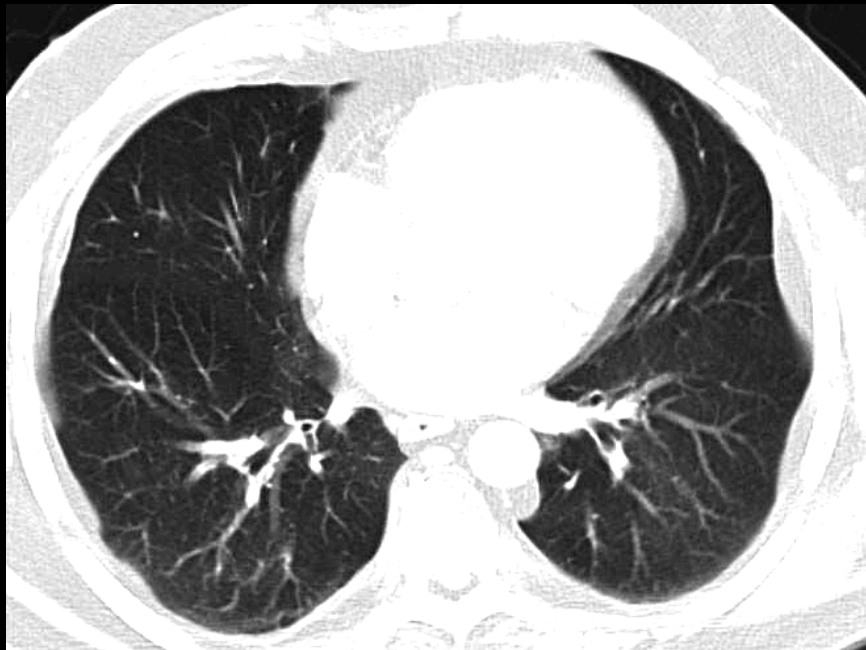
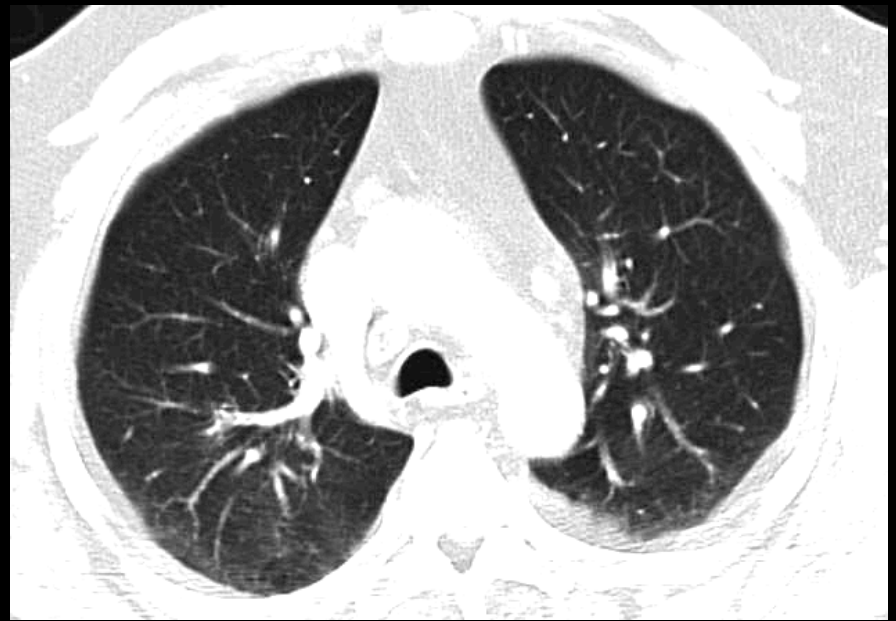
T1 + Gado

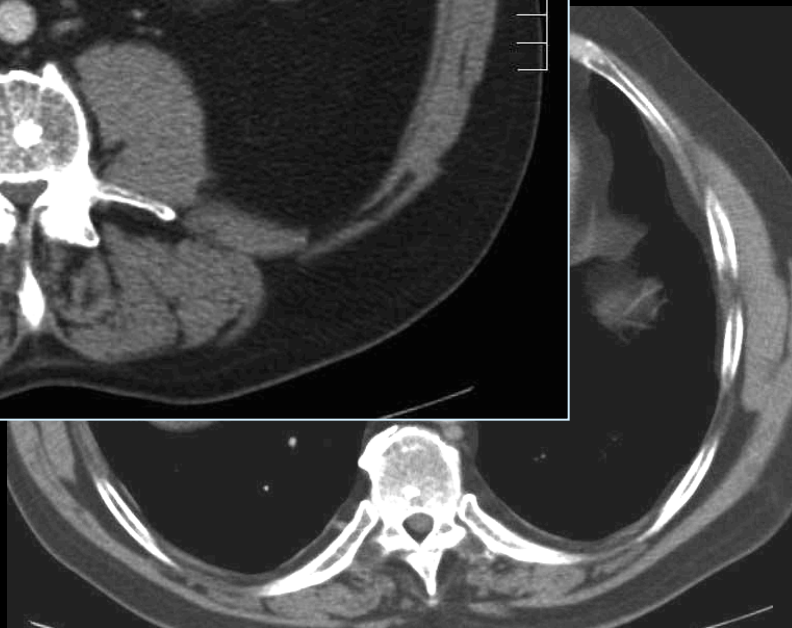
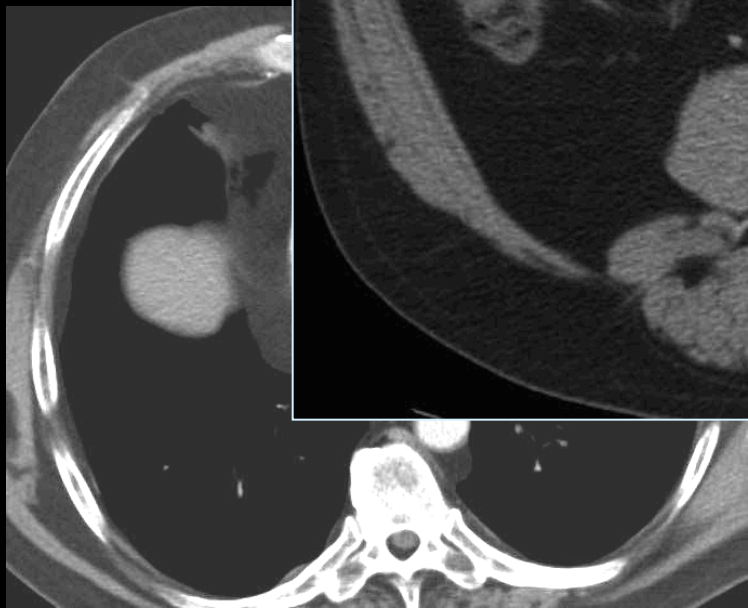
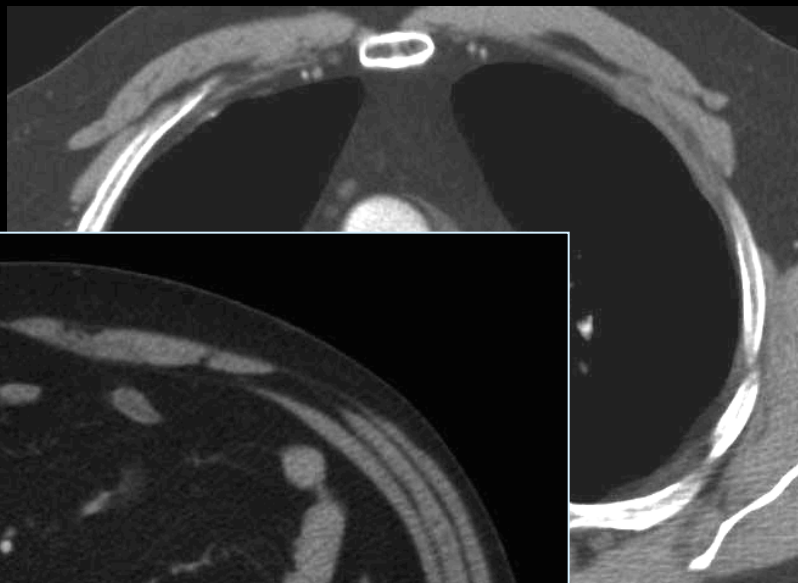
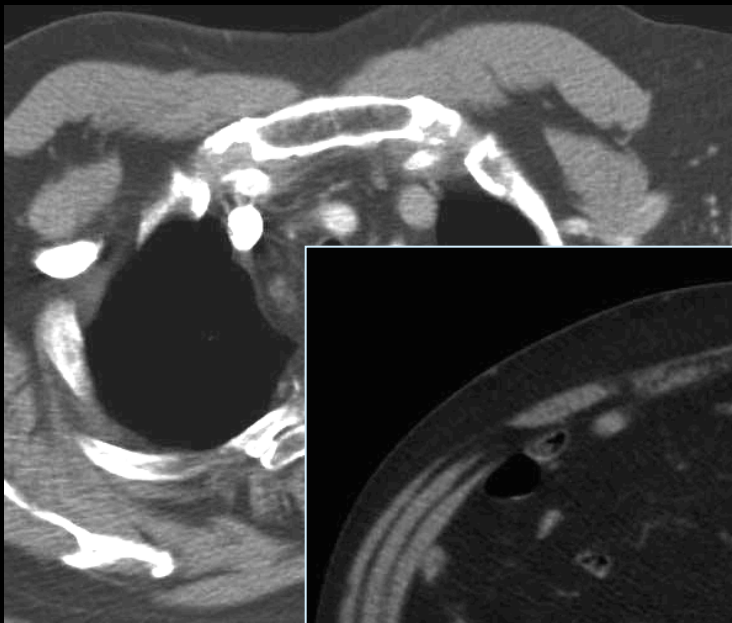


N°7



**PNEUMOPATHIE DU LOBE MOYEN
TRAITEE DEPUIS 1 SEMAINE PAR ATB
TABAGISME A 40 PA SEVRE DEPUIS 2 ANS**





LIPOMATOSE MEDIASTINALE ET EXTRA-PLEURALE

- ▣ CAUSE BENIGNE **D'ELARGISSEMENT MEDIASTINAL ET D'ASPECT D'EPAISSISSEMENT PLEURAL**

- ▣ **OBESITE**

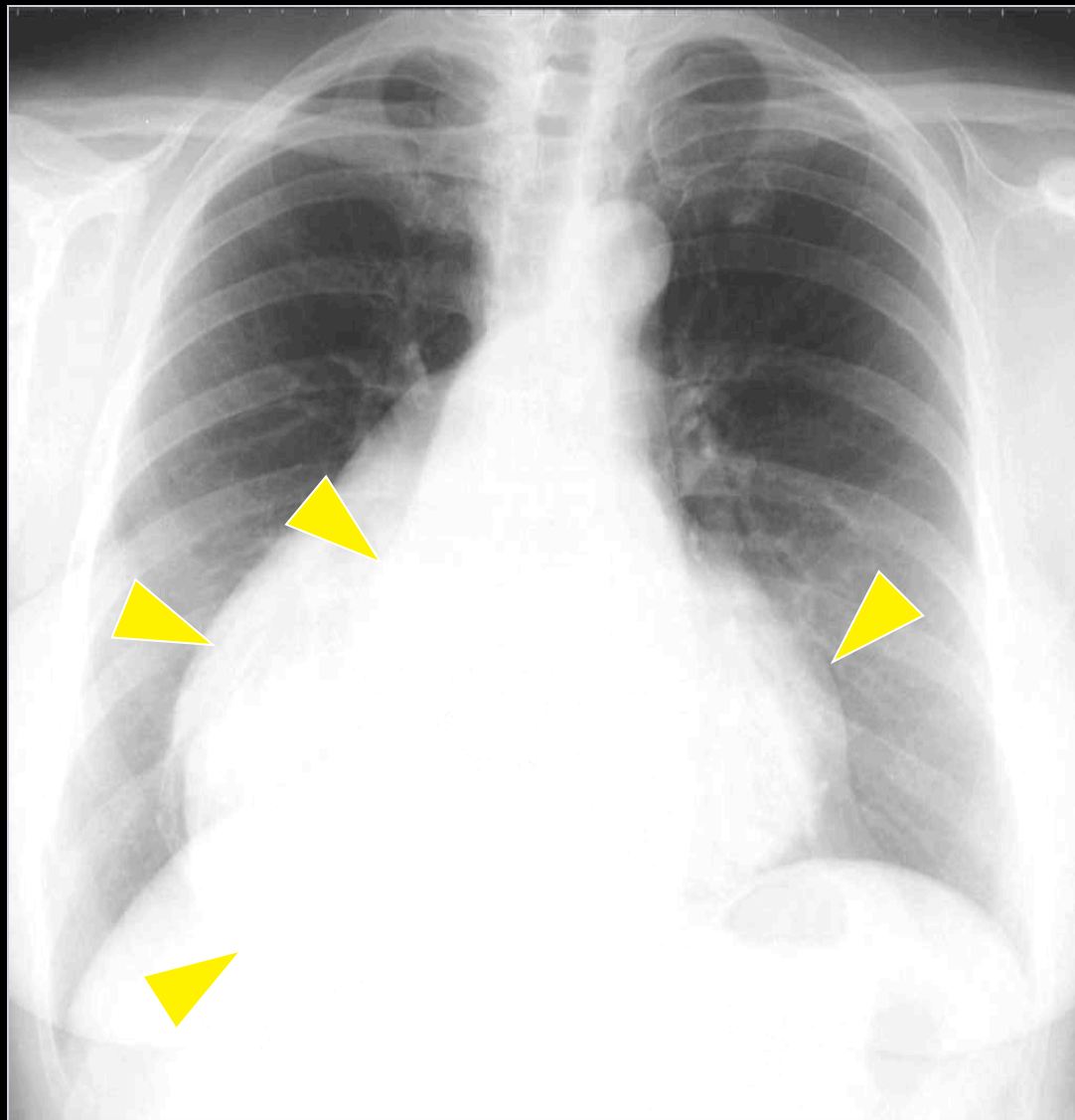
- ▣ **HYPERCORTICISME**

- ▣ *CORTICOIDES*

- ▣ *CUSHING*

- ▣ **EXOGENOSE CHRONIQUE**

- ▣ Patiente de 56 ans
- ▣ Pas de tabagisme
- ▣ Dyspnée mixte crescendo depuis 4 mois
- ▣ Radiographie thoracique.

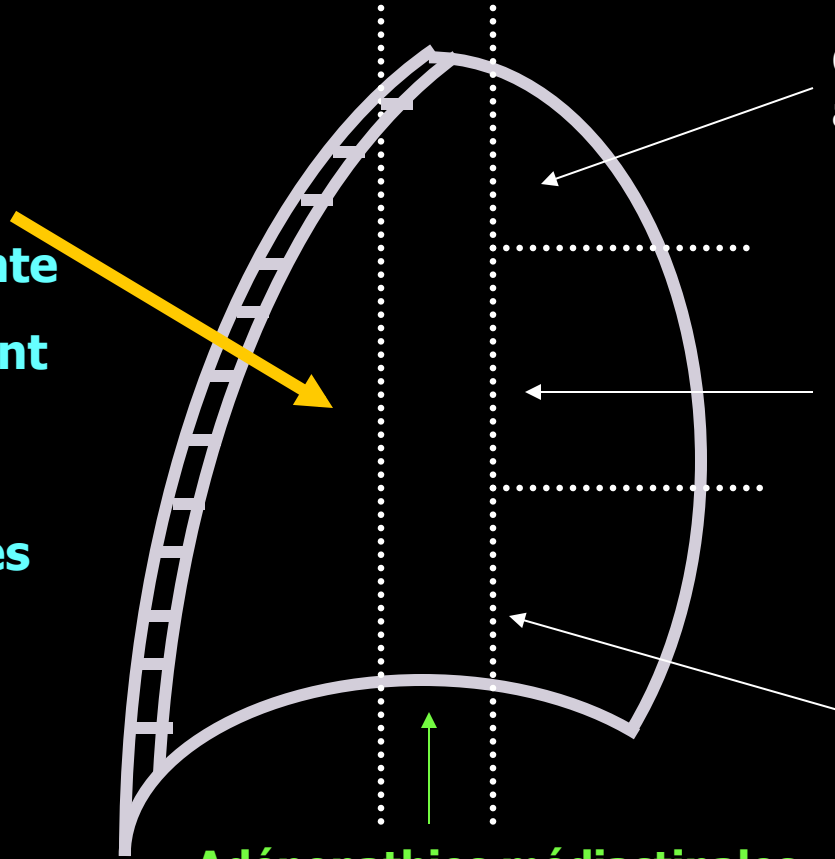


- **Signe de la silhouette négatif** : opacité de siège **postérieur**
- **Signe thoraco-abdominal** : opacité **intra-thoracique**
- **Double contour** du bord gauche du cœur
- **Atélectasie** segmentaire lobaire inférieure droite

—→ opacité **médiastinale postérieure**.

Les loges médiastinales

- Tumeurs neurogènes
- Anévrysme de l'AO descendante
- Goître plongeant postérieur
- Tumeurs oesophagiennes

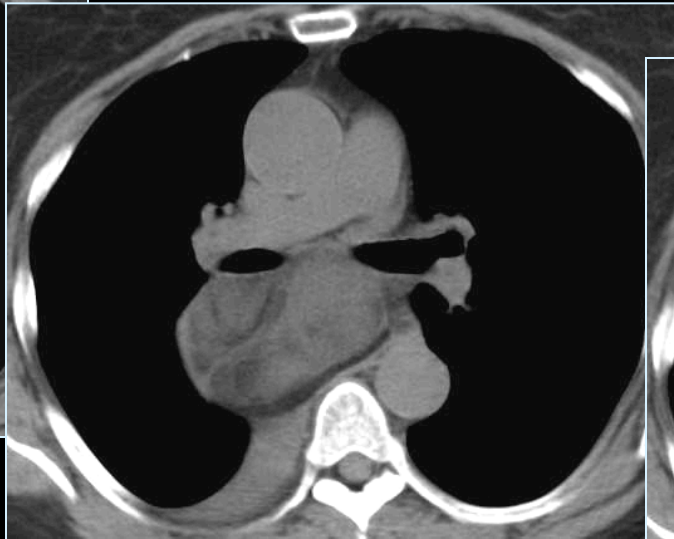
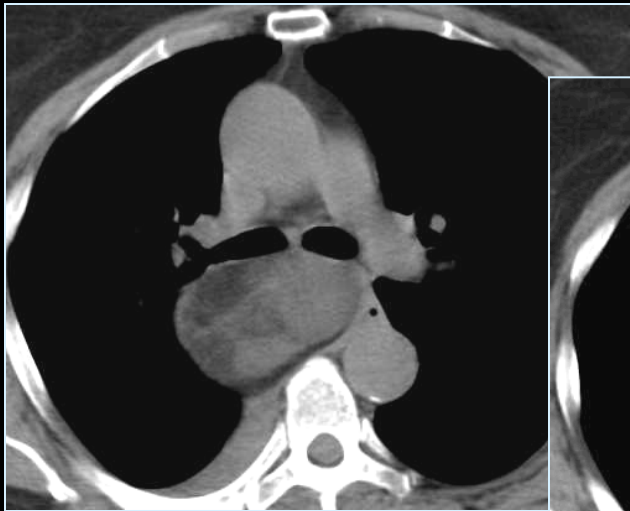
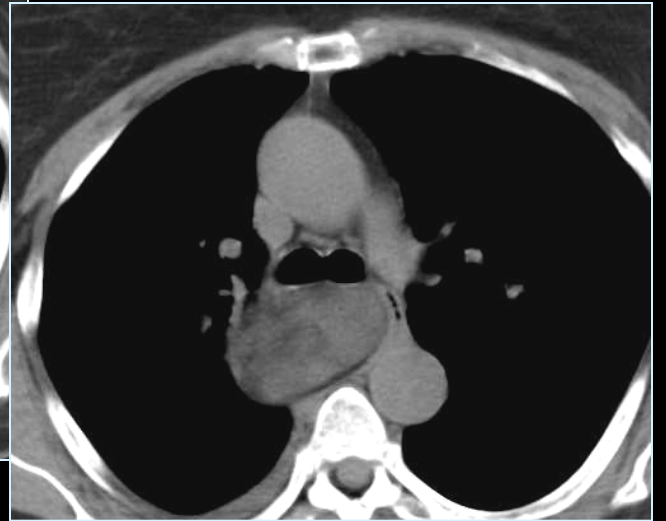
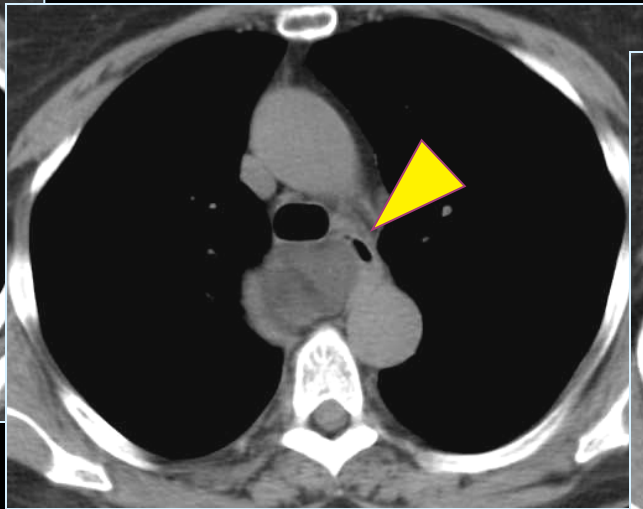
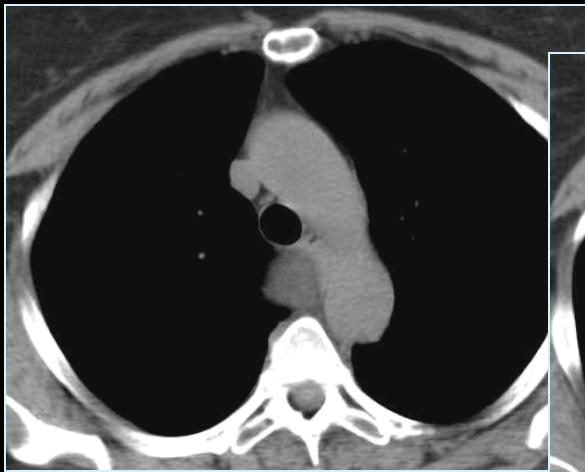


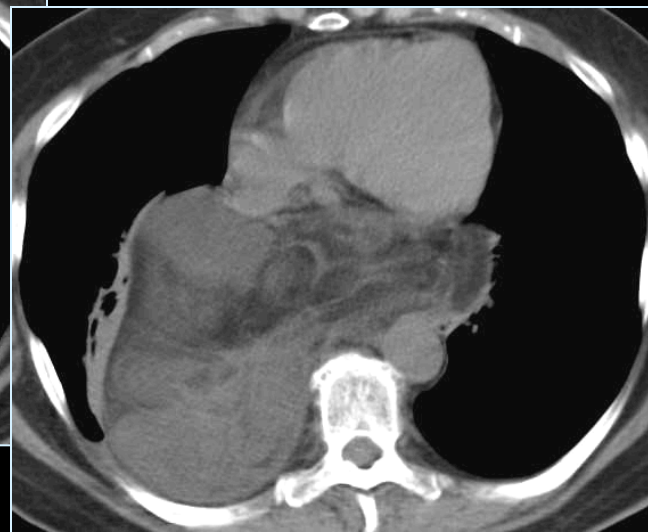
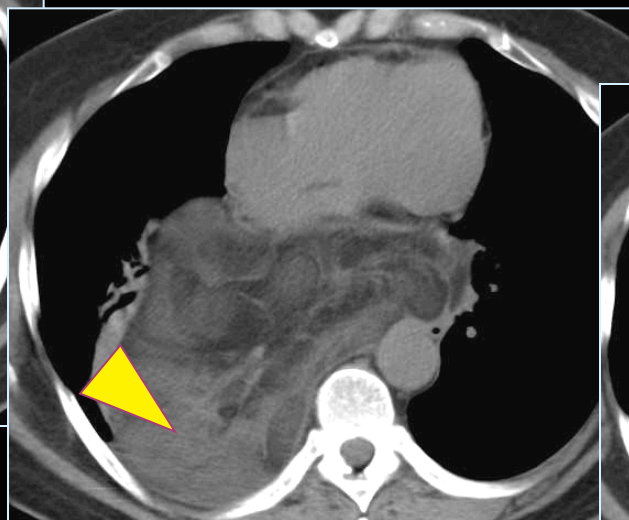
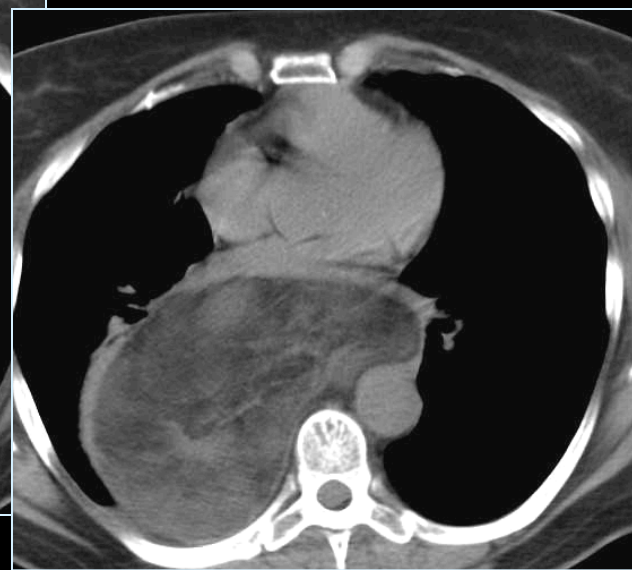
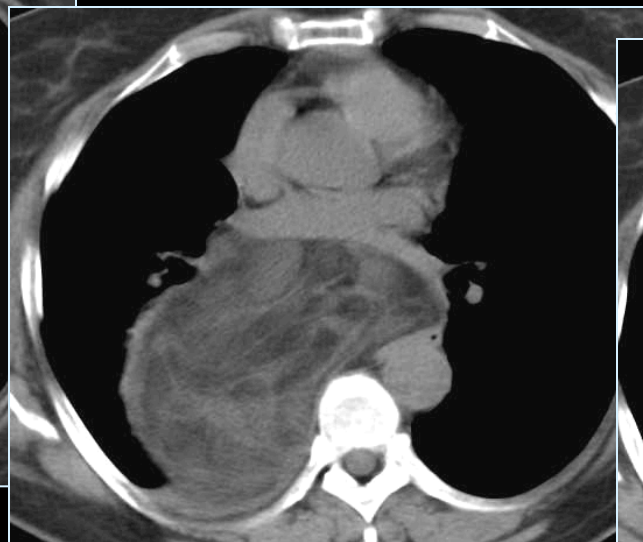
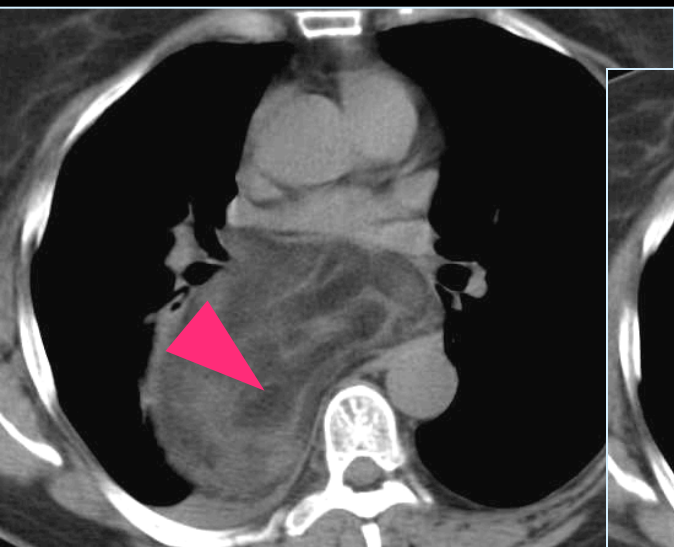
Goître plongeant antérieur

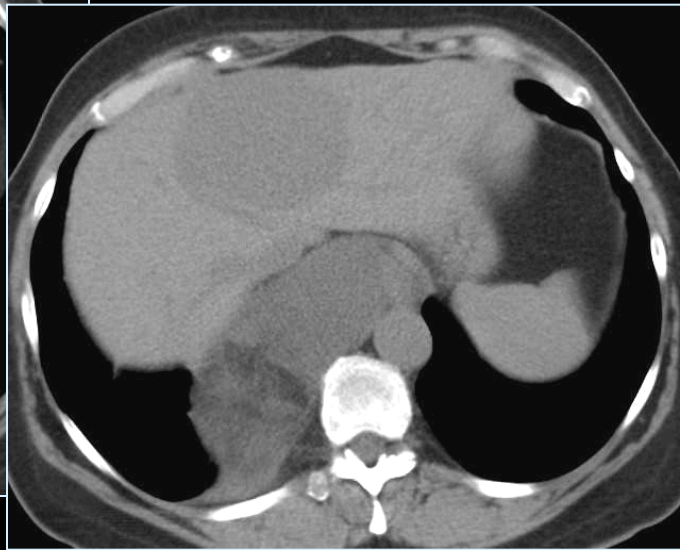
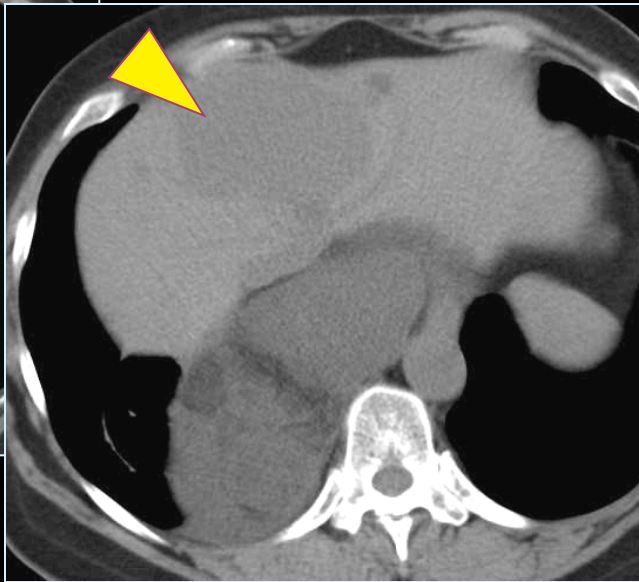
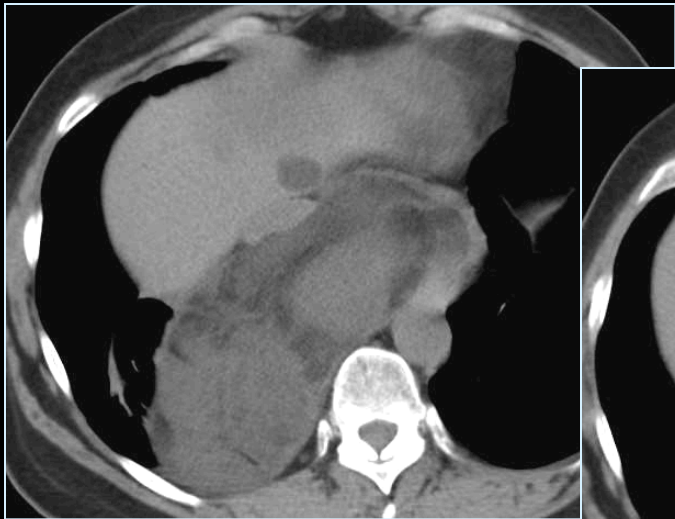
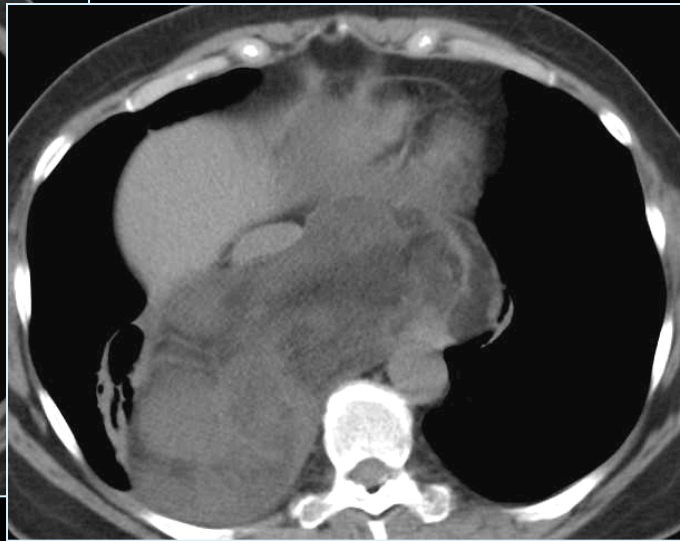
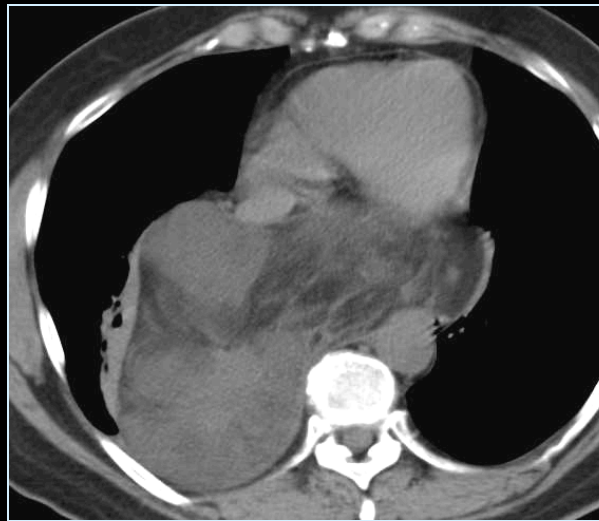
- Tumeurs thymiques
- Anévrysme aortique
- Tumeurs germinales

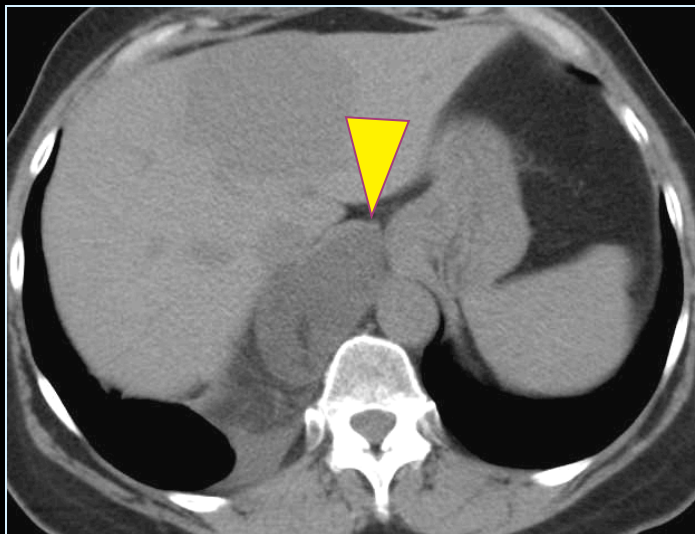
- Kyste pleuro-péricardique
- Hernies épiploïques
- Tumeurs bénignes solides

- Adénopathies médiastinales
- Anévrysme vasculaire
- Kyste bronchogénique

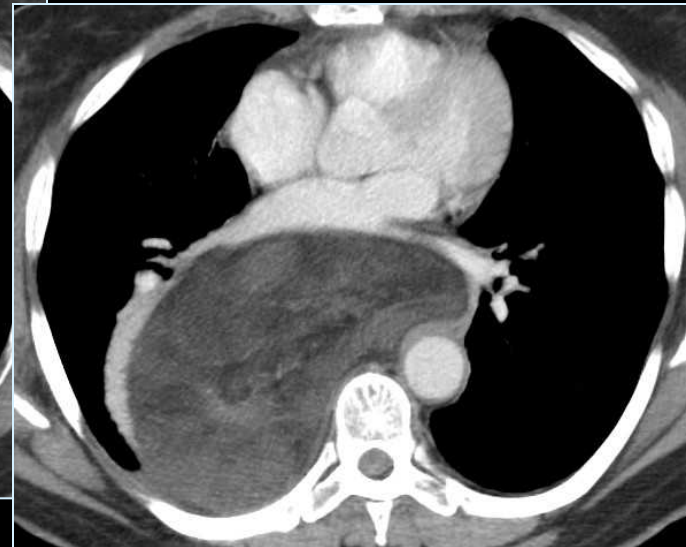
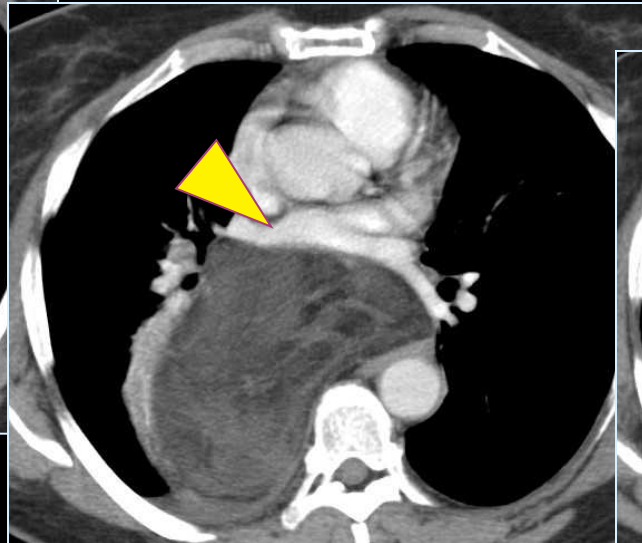
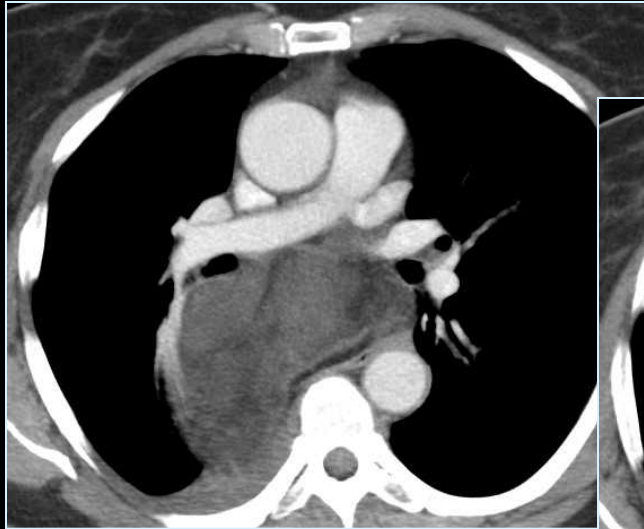
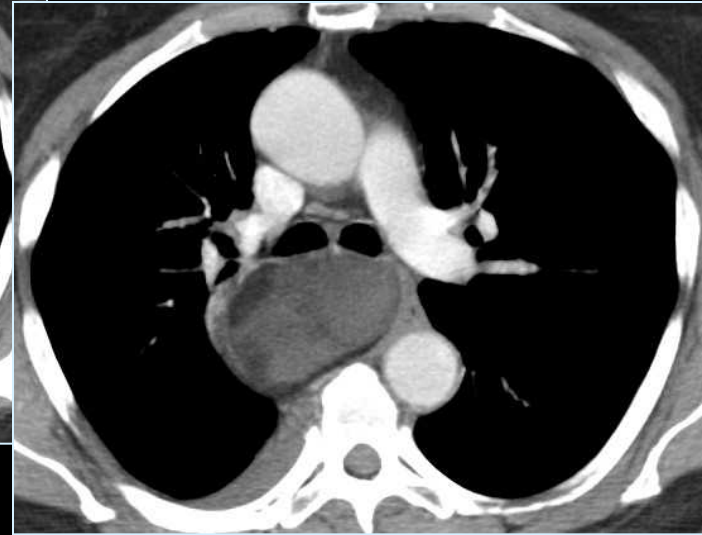
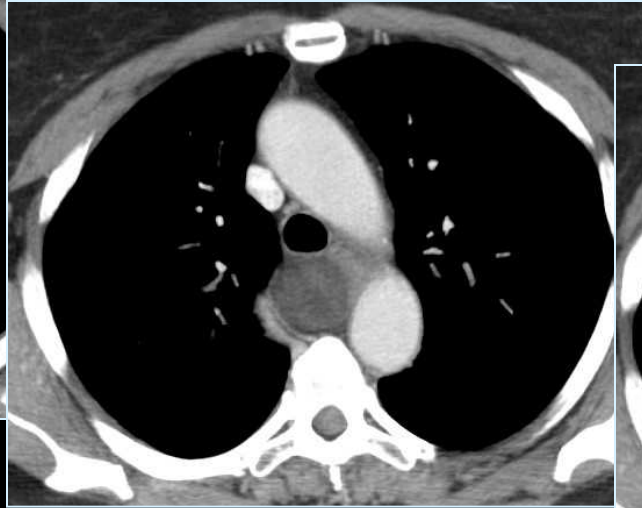
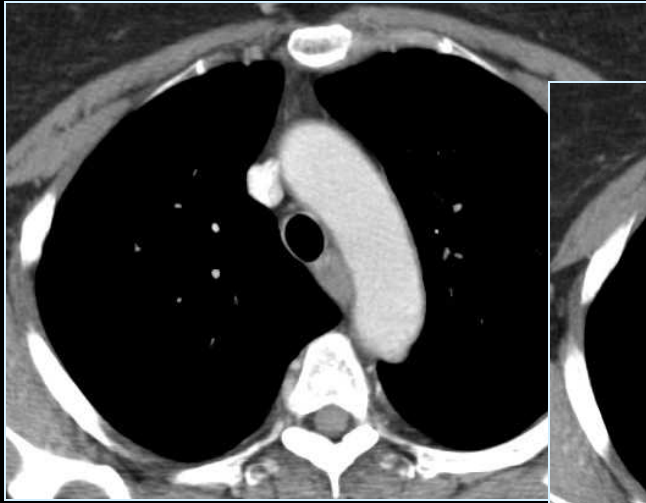


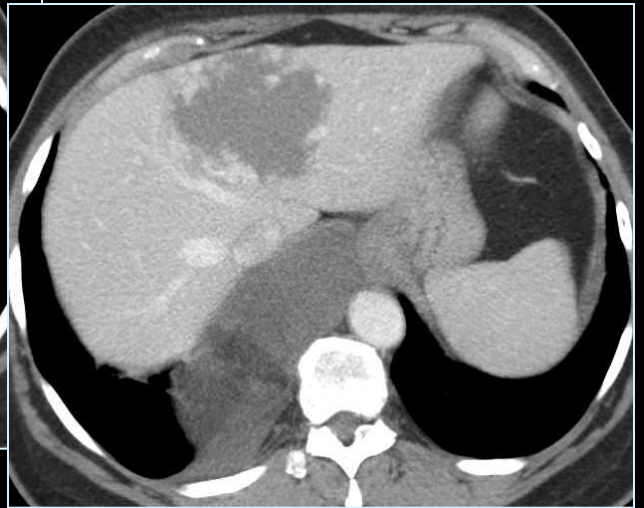
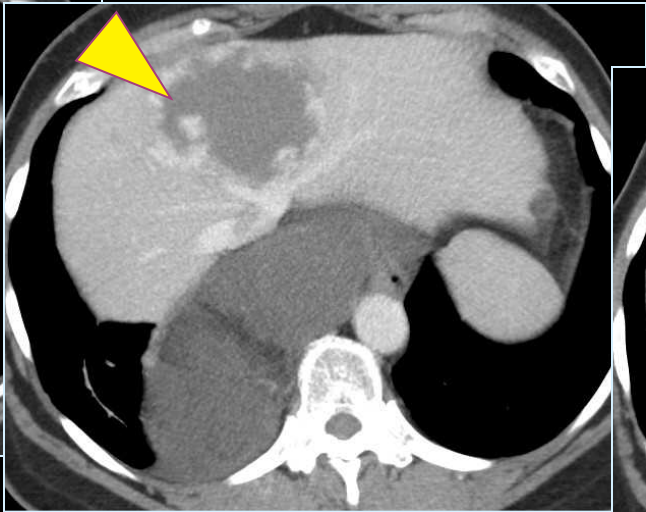
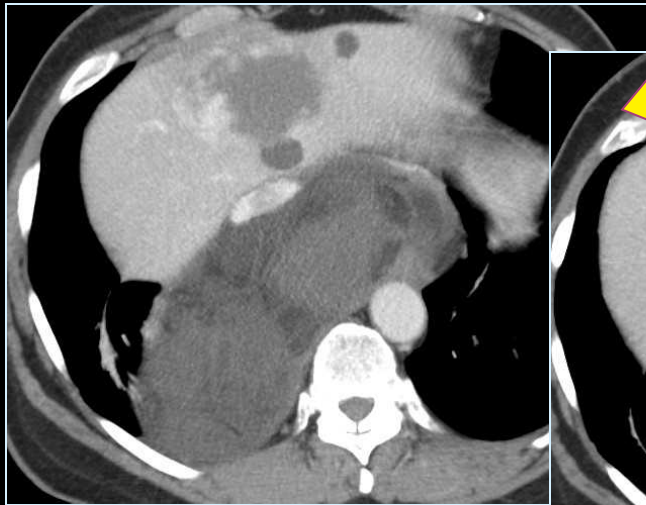
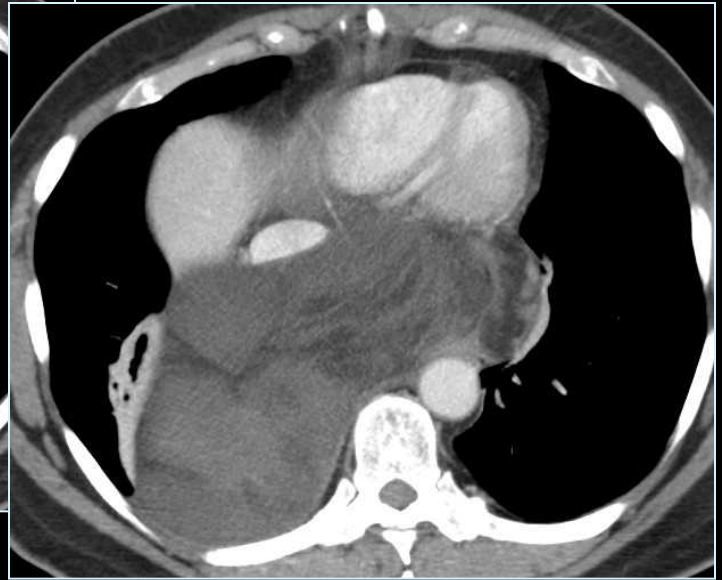
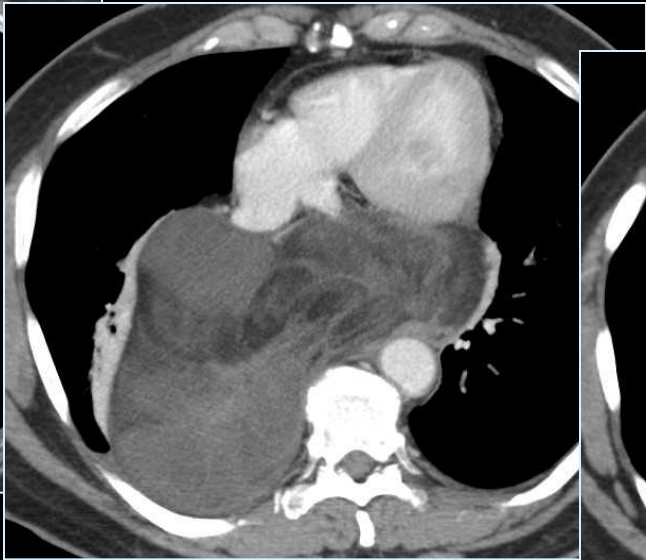
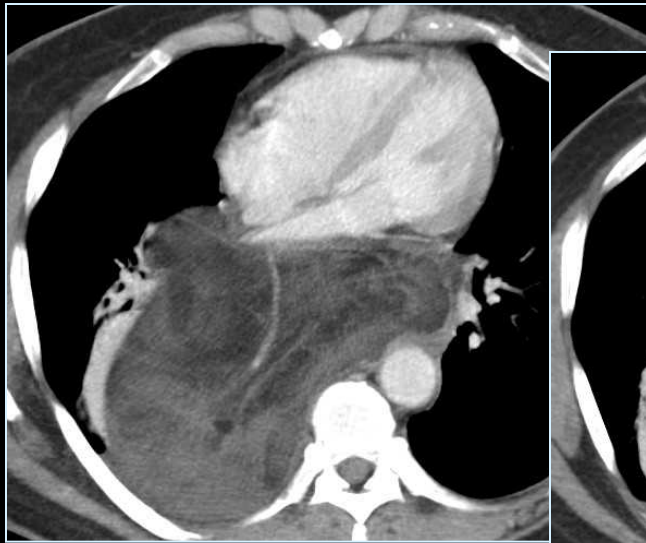




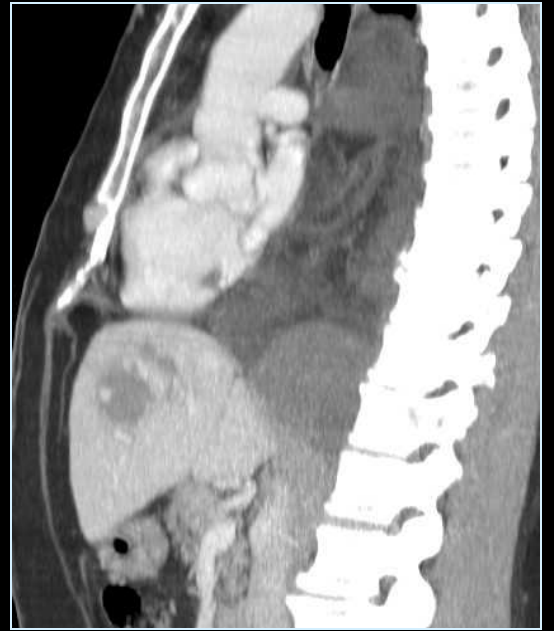


Après injection





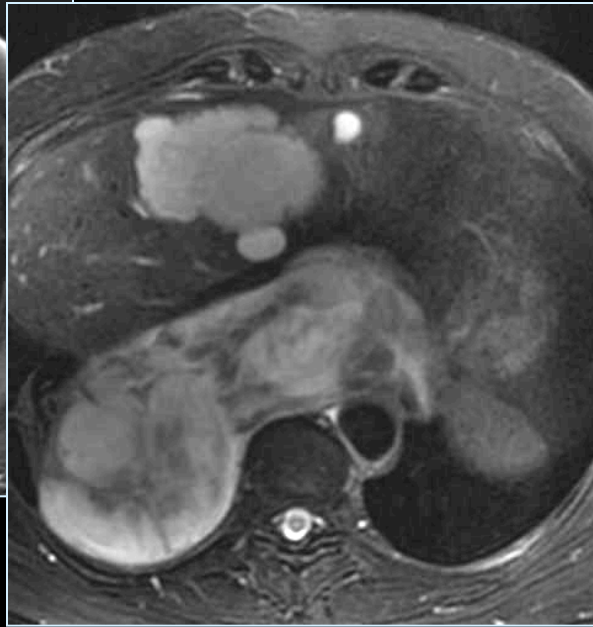
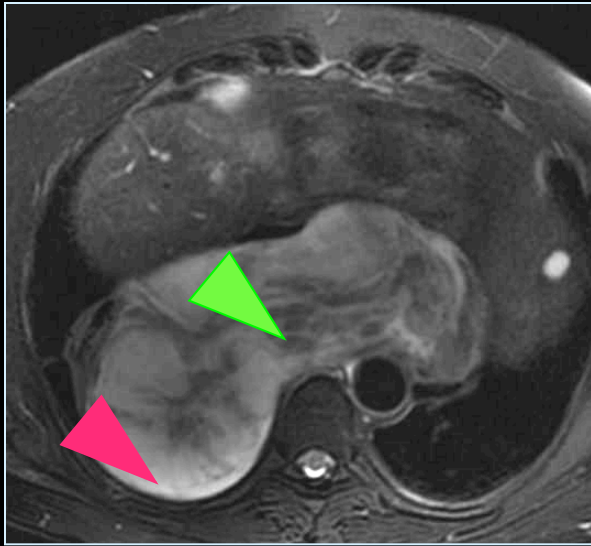




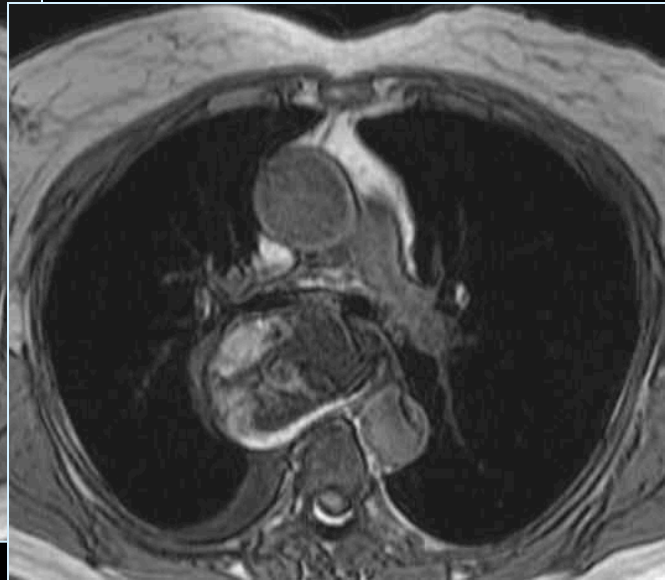
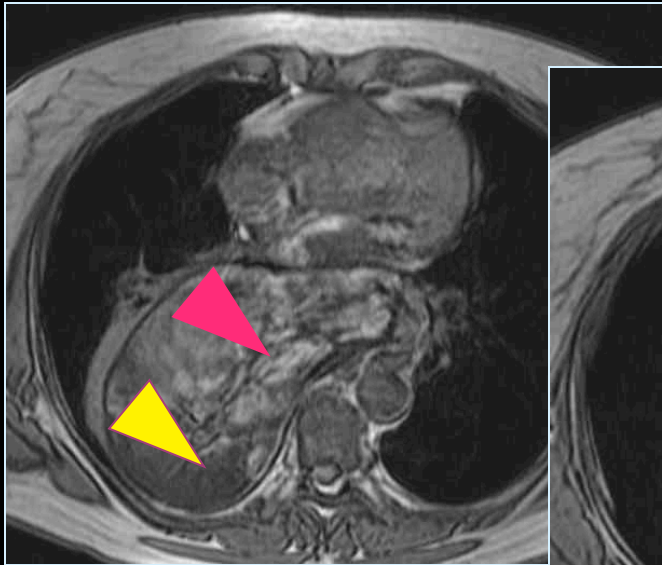
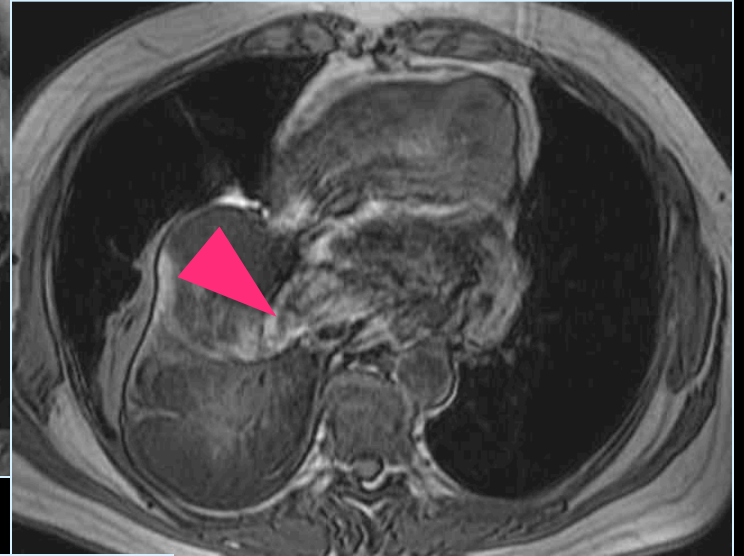
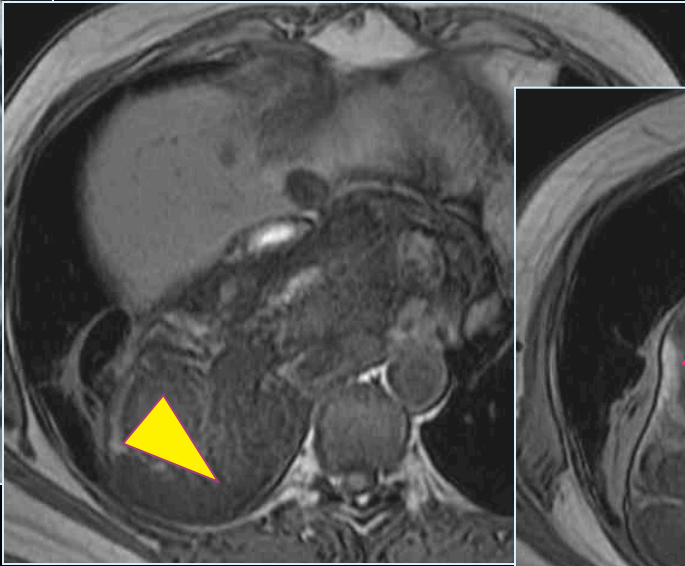
Hypothèses

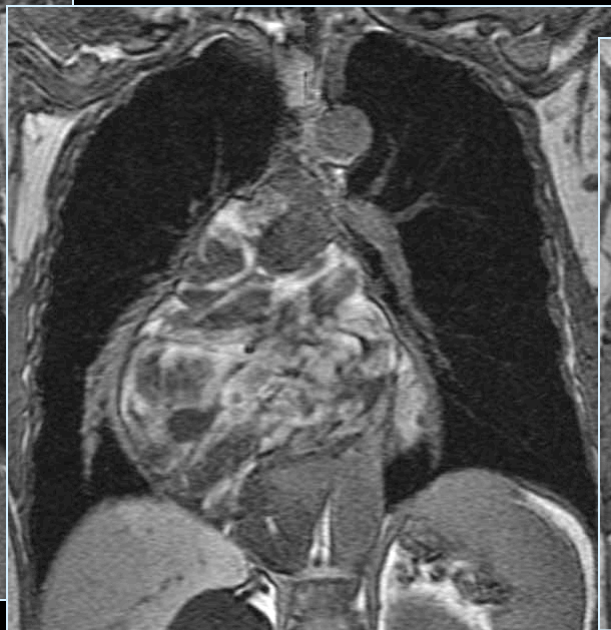
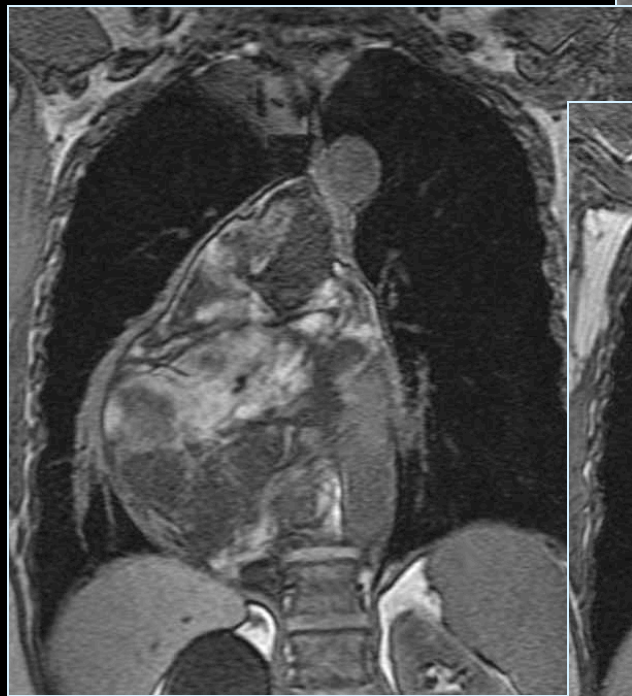
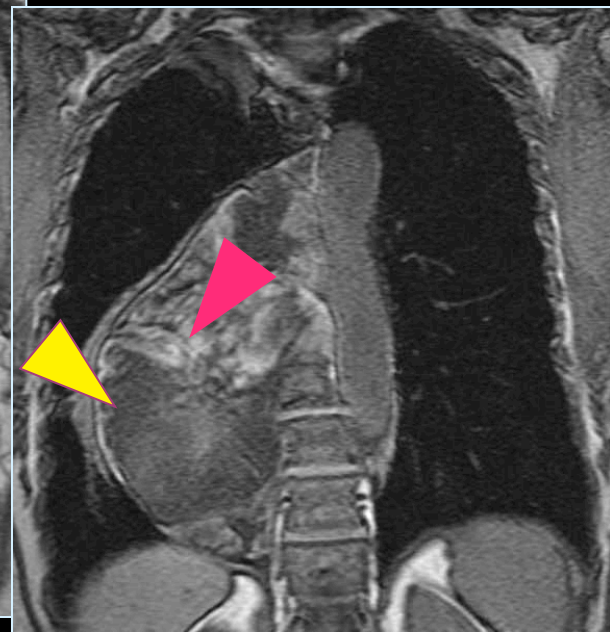
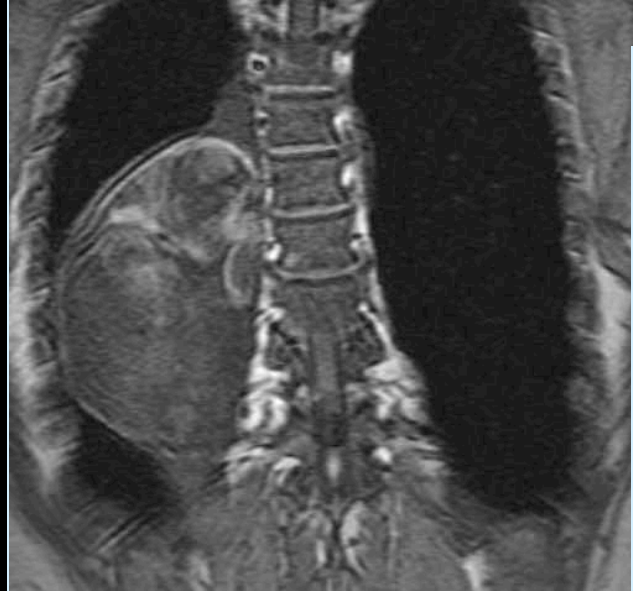
- ▣ Tumeur lipomateuse (lipome, liposarcome)
- ▣ Tumeur germinale

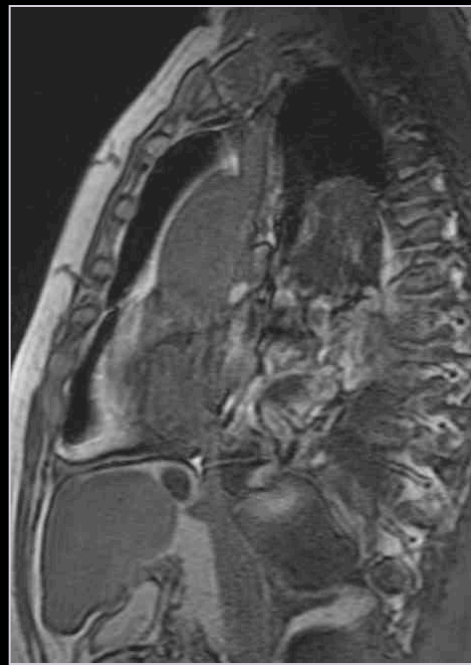
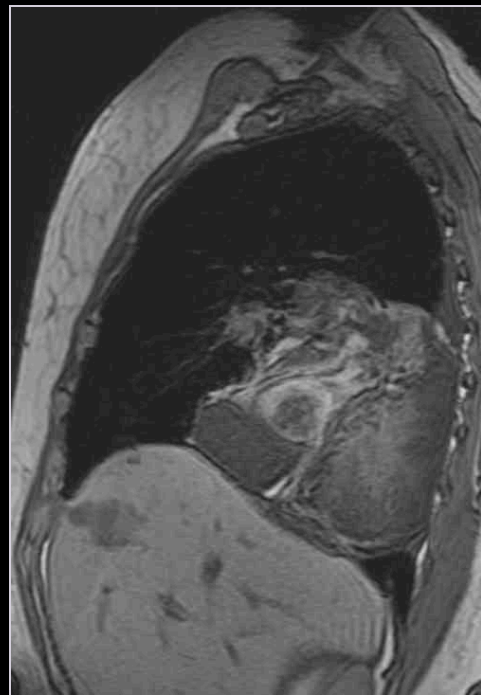
T2 + saturation de graisse



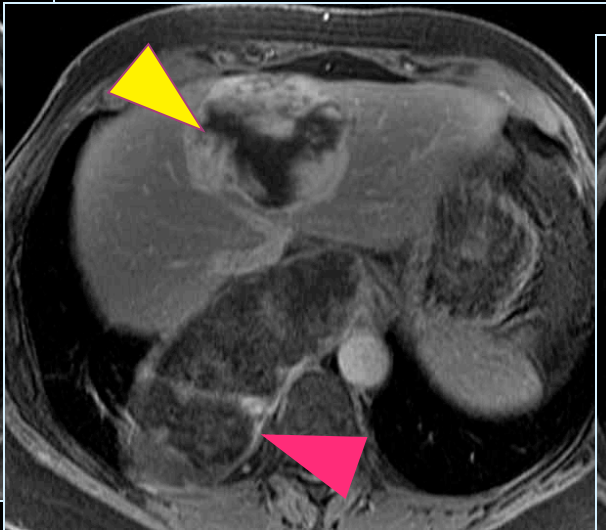
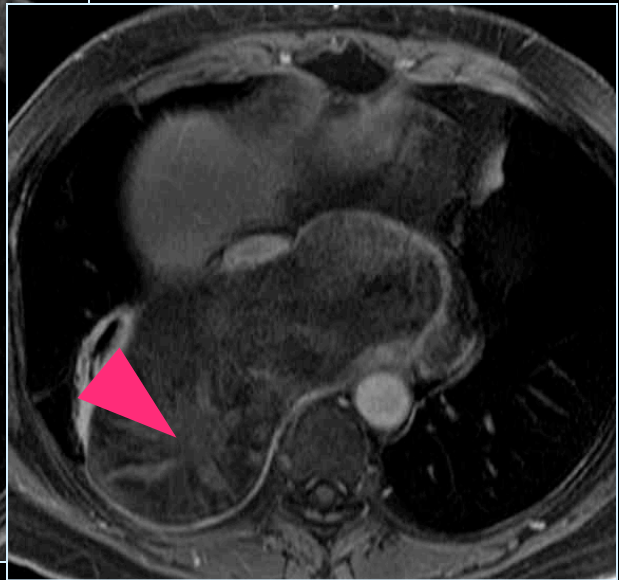
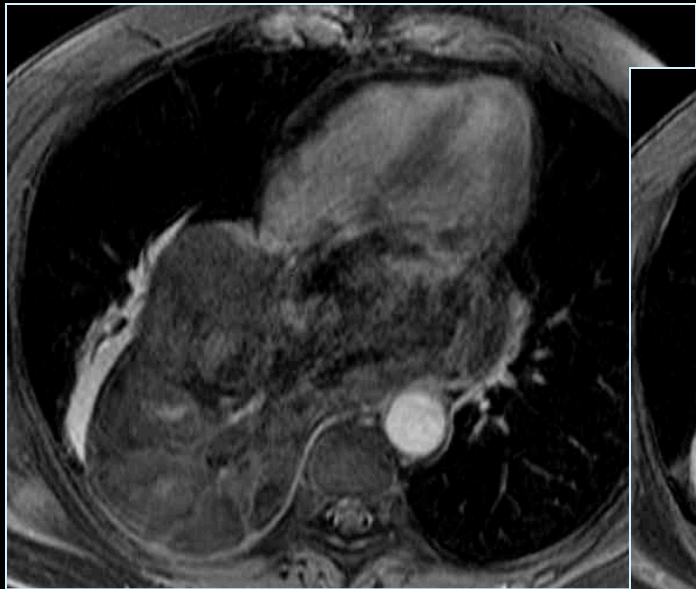
Séquence T1

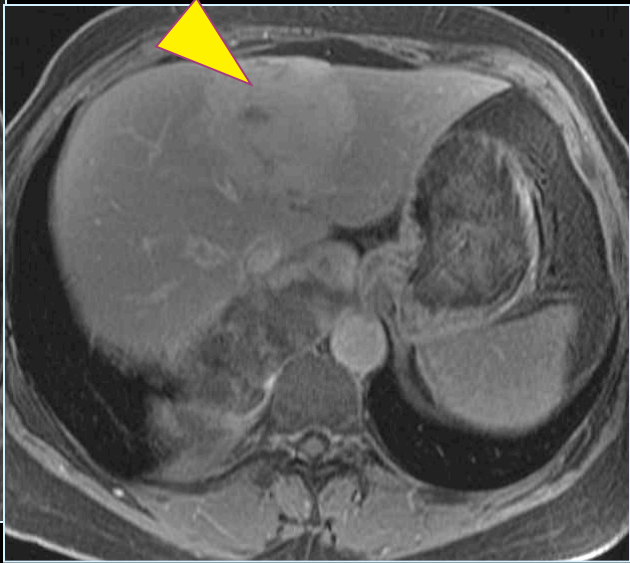
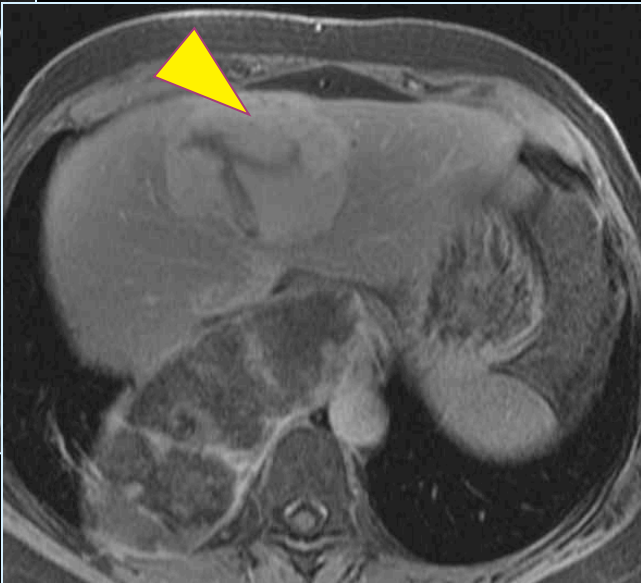
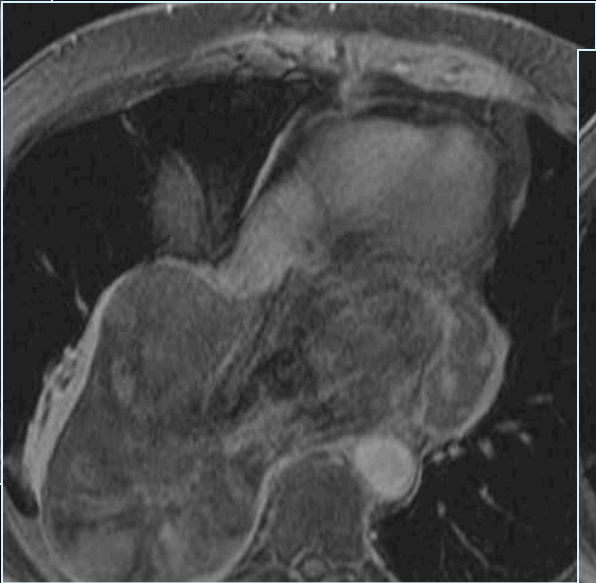
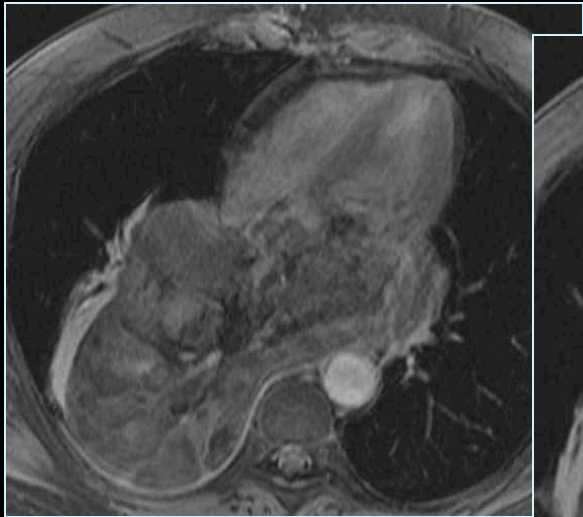


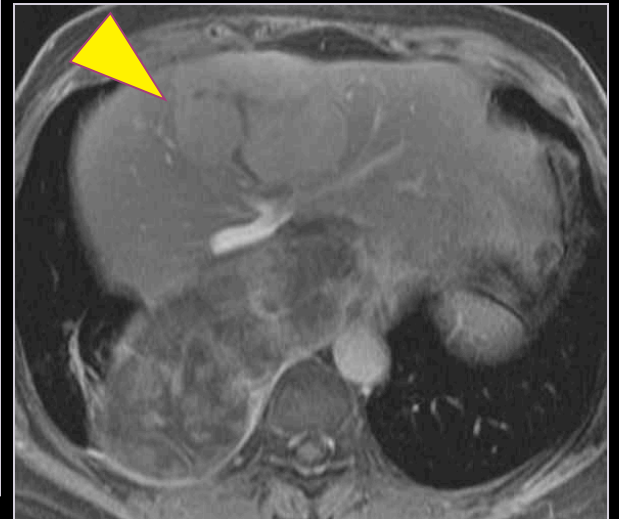
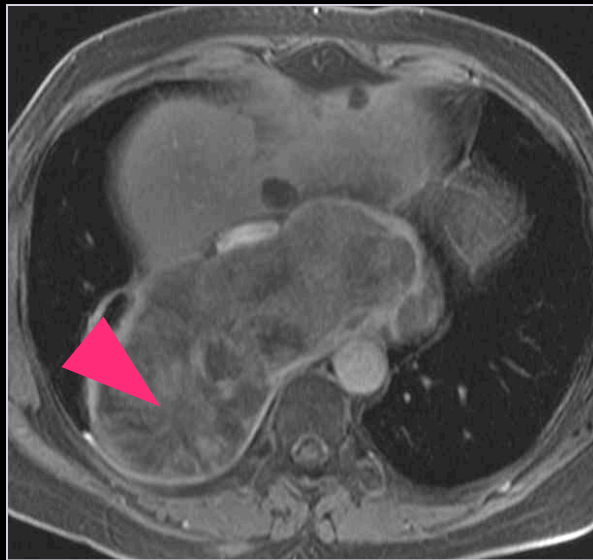
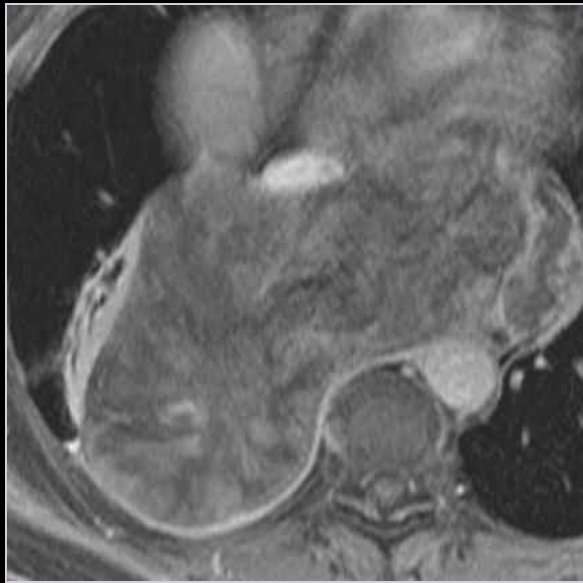
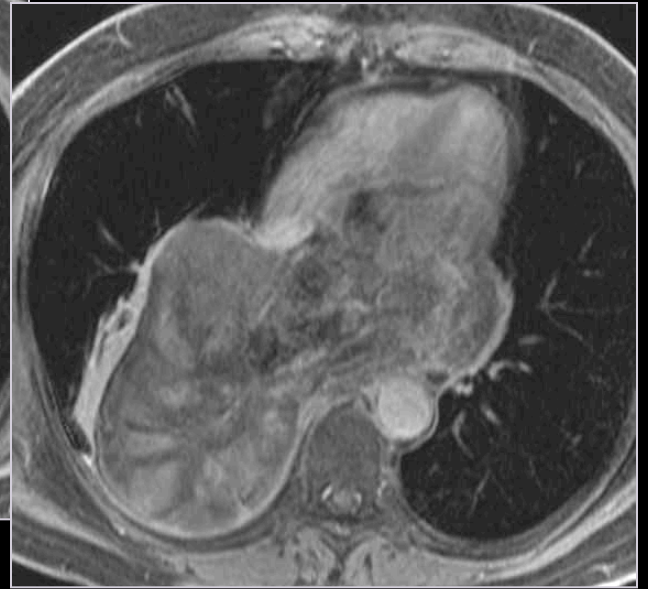
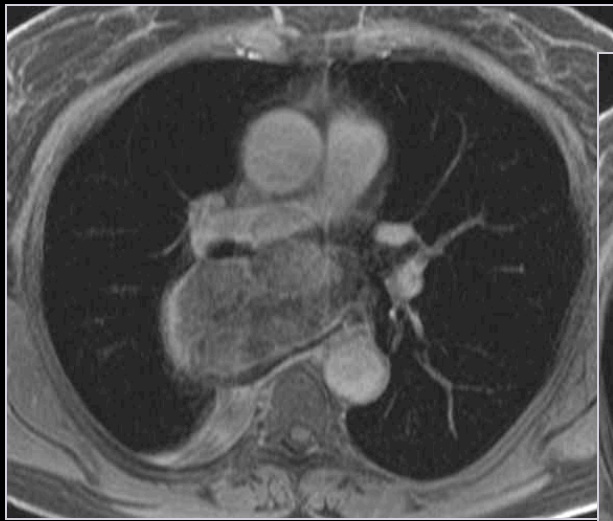




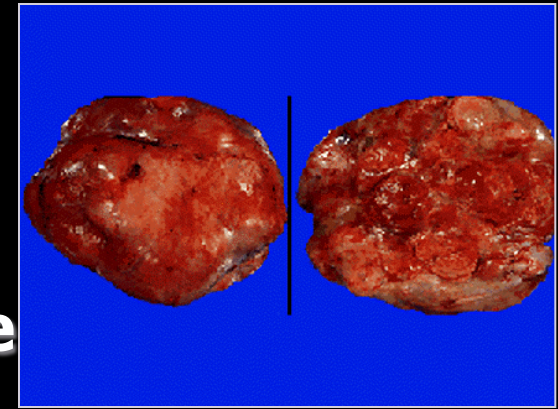
T1 + gadolinium



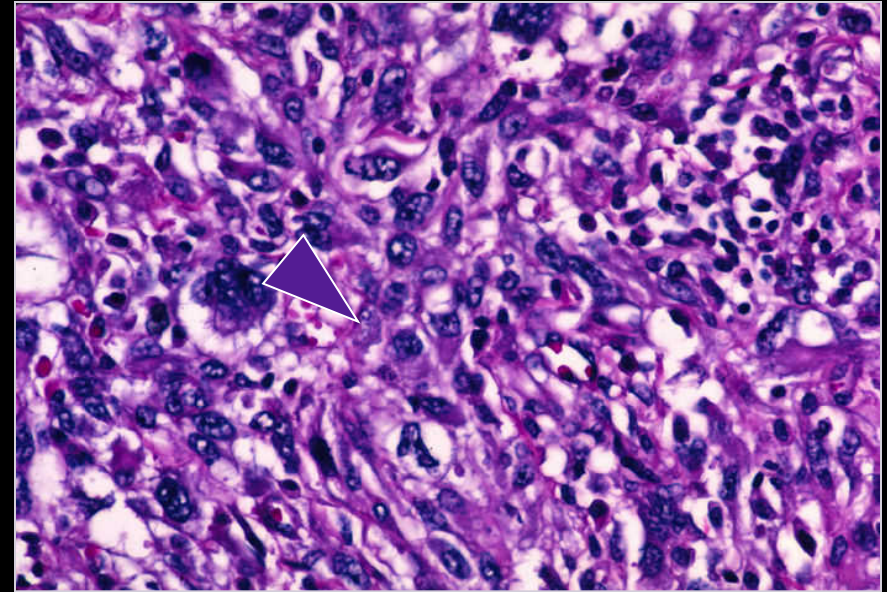
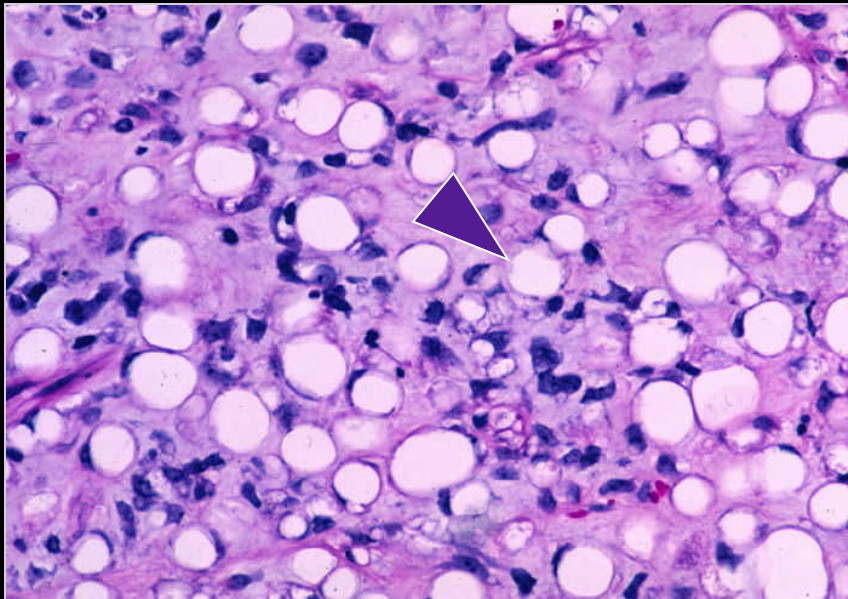




Microscopie optique



▣ Biopsie transcutanée scano-guidée



Adipocytes +- matures, néovaisseaux, stroma fibreux

→ **Liposarcome** bien différencié

Liposarcome

- ▣ **15 %** des tumeurs malignes
mésenchymateuses de l'adulte

→ tumeur la plus fréquente après l'hystiocytofibrome malin

- ▣ **Les tumeurs mésenchymateuses :**

- *T. adipeux*
- Muscles
- Nerfs
- Synoviale
- Mésothélium
- Vaisseaux
- Tissu cutané profond

Liposarcome

- ▣ Apparition *de novo*
- ▣ Pas secondaire à une transformation maligne d'un lipome préexistant.

Liposarcome

- ▣ Sièges les plus fréquents :
 - Sous-cutané
 - Rétropéritonéal

- ▣ Localisation médiastinale RARE :
 - Moins de 1 % des tumeurs médiastinales
 - Moins de 100 cas décrits.

Liposarcome

- ▣ Tumeur de l'adulte
- ▣ Pic de fréquence : entre 40 et 60 ans
- ▣ 60 % des cas : hommes
- ▣ Localisation rétropéritonéale : plutôt femme

Classification des liposarcomes

- **Bien différencié : le plus fréquent : 50 % des cas**
 - Tumeur de **bas grade**
 - **Exceptionnellement métastatique**
- **Myxoïde**
- **Indifférencié : quasi-exclusivement rétropéritonéal**
- **Pléiomorphe : le plus rare, 5 à 10 % des cas**

Clinique

- ▣ Le plus souvent : **asymptomatique**
- ▣ **Compression** des organes voisins, **douleurs**, ...

Imagerie

- ▣ Standard : parfois calcifié
- ▣ CT – MR :
 - contingent graisseux prédominant avec septa fibreux.
 - si aspect semblable à la graisse : évocateur d'une forme différenciée.
 - lipo"sarcome" si septa fibreux épais, irréguliers, hyperintenses en T1+gado.



Traitement

- ▣ Chirurgical +++ : exérèse large
- ▣ Si forme indifférenciée ou exérèse incomplète :
 - Radiothérapie néoadjuvante, peropératoire, adjuvante +- combinées
 - Chimiothérapie en cours d'évaluation, peu efficace

Evolution

- ▣ Récidive loco-régionale possible
- ▣ Survie à 5 ans : 70 % environ