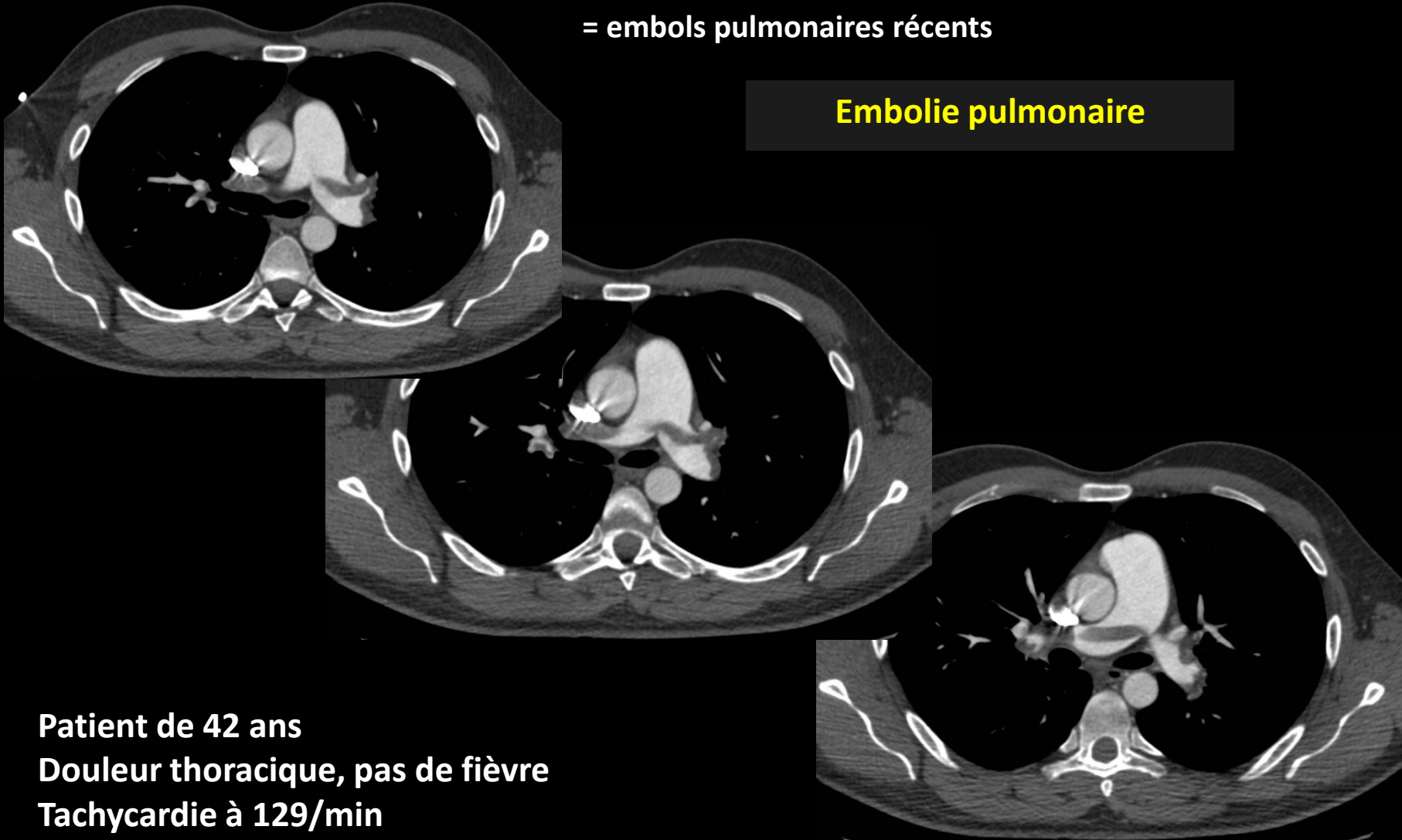


## Cas 1

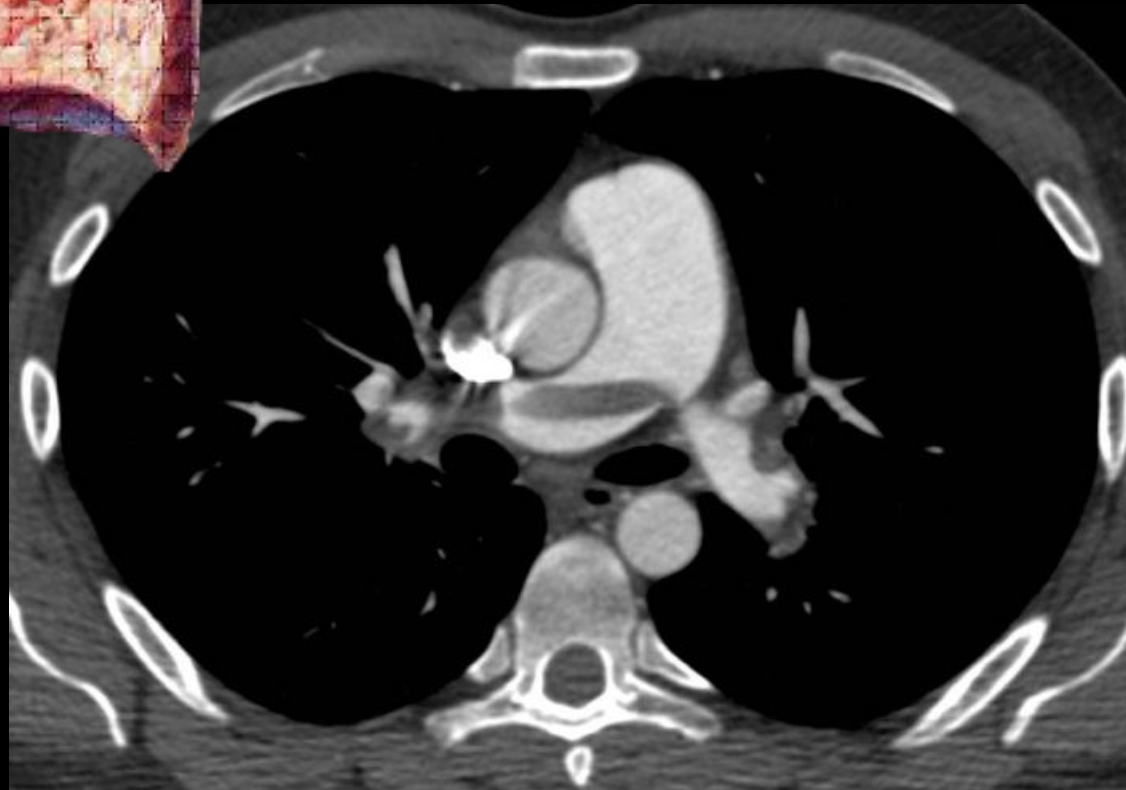
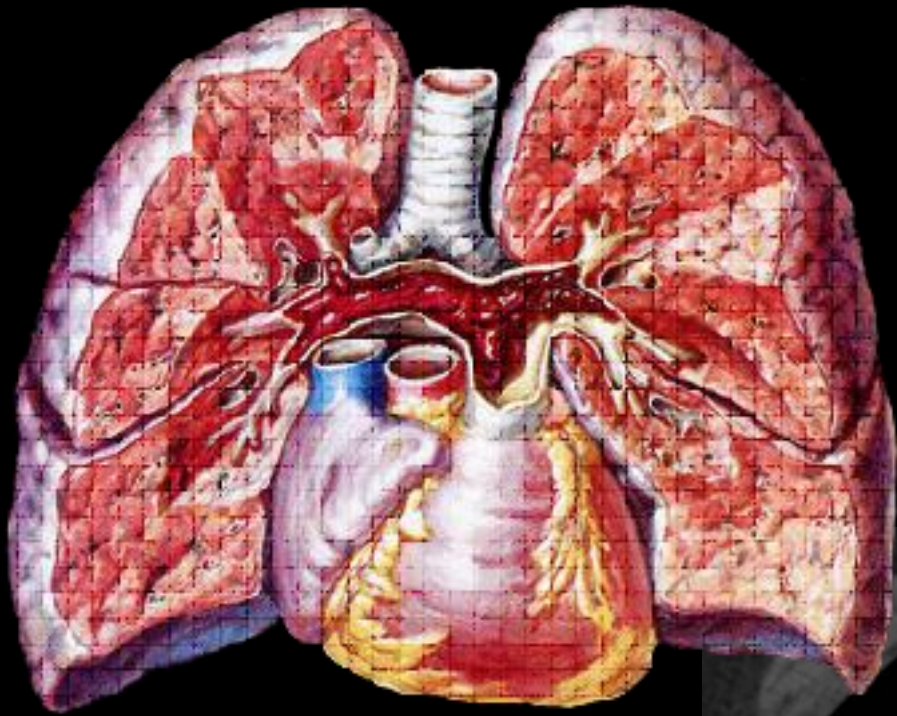
scanner thoracique avec IV ou angioscanner thoracique  
Coupe axiale, fenêtre médiastinale

Défaut endoluminal ou embol au sein des branches de  
l'AP  
= embols pulmonaires récents

**Embolie pulmonaire**

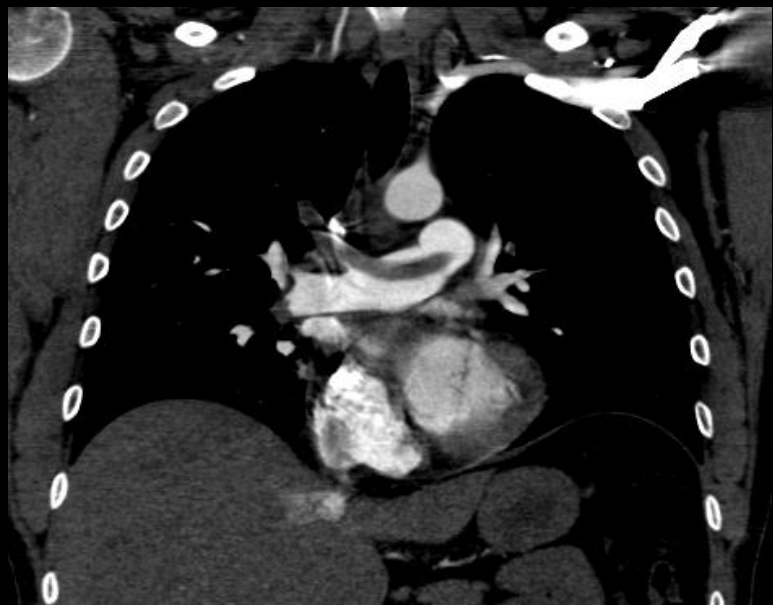


Patient de 42 ans  
Douleur thoracique, pas de fièvre  
Tachycardie à 129/min





**Embole cruorique frais**



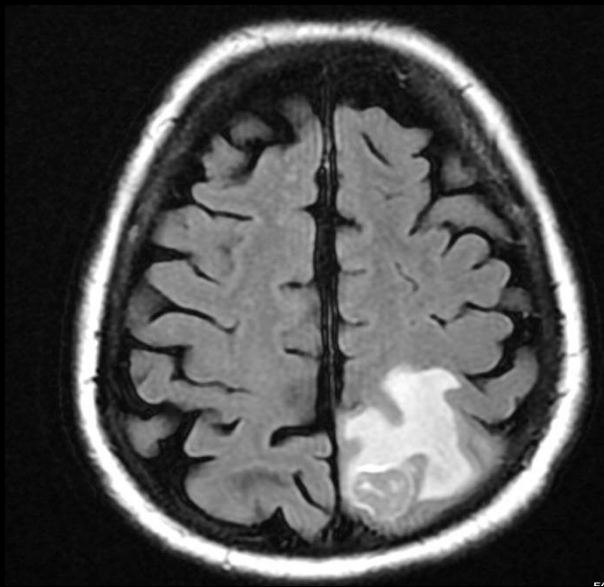
**Dilatation cavitaire du VD: rapport VD/VG>1**

## Cas 2



### Scanner cérébral sans et avec injection

Prise de contraste nodulaire pariétale gauche.  
Hypodensité de la substance blanche péri lésionnelle = œdème dû à l'effet de masse

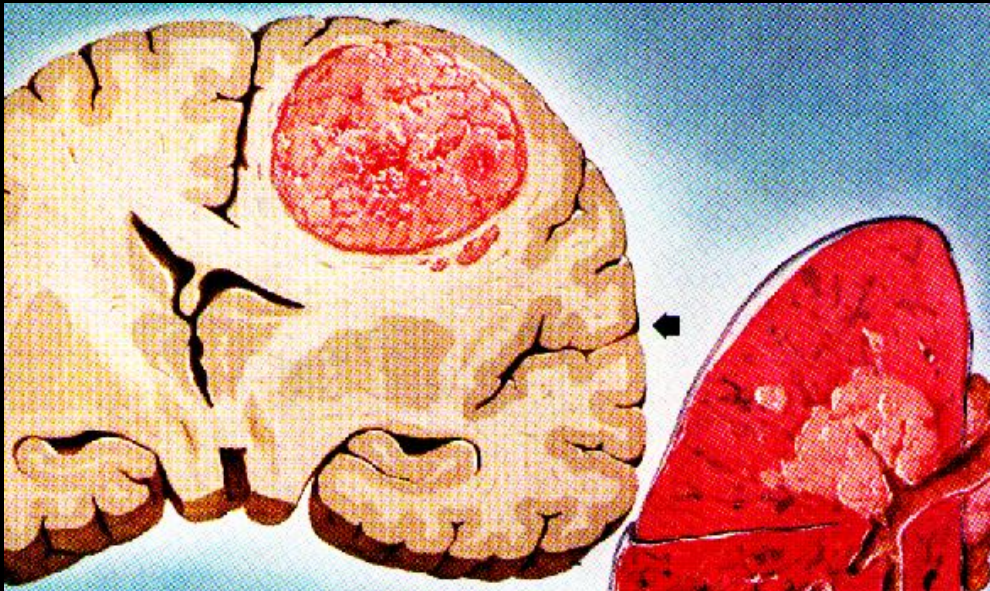


### IRM cérébrale

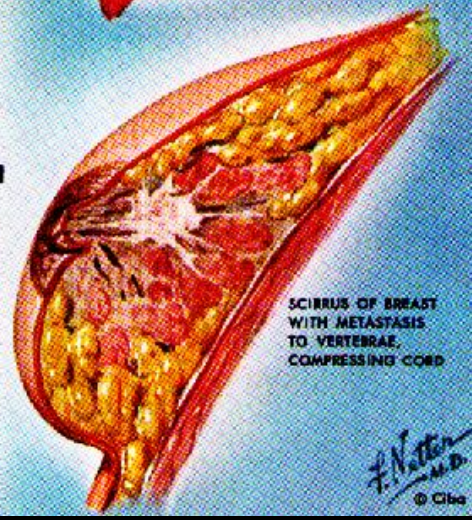
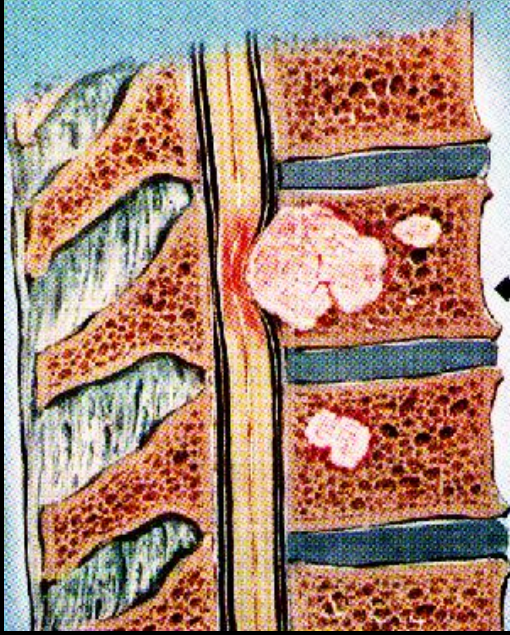
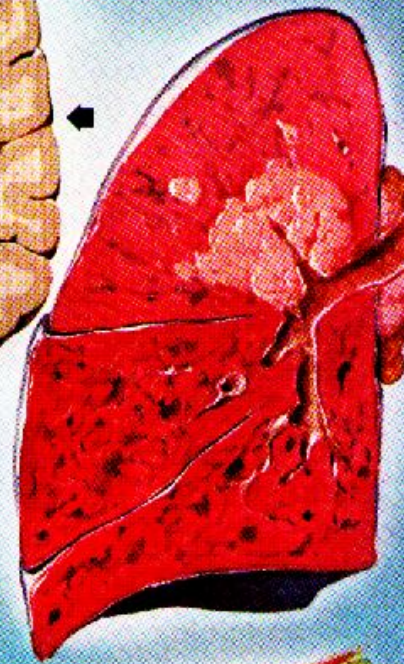
- T1 avec injection de gadolinium, coronal: prise de contraste hétérogène  
- FLAIR axial: œdème péri lésionnel en hypersignal

Patiente de 65 ans  
Antécédent de mélanome

**Métastase cérébrale**

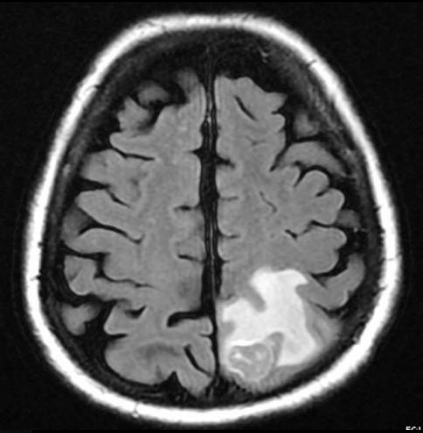


BRONCHOGENIC CARCINOMA METASTASIZING TO BRAIN



SCIRRUS OF BREAST WITH METASTASIS TO VERTEBRAE, COMPRESSING CORD

F. Netter M.D.  
© Ciba



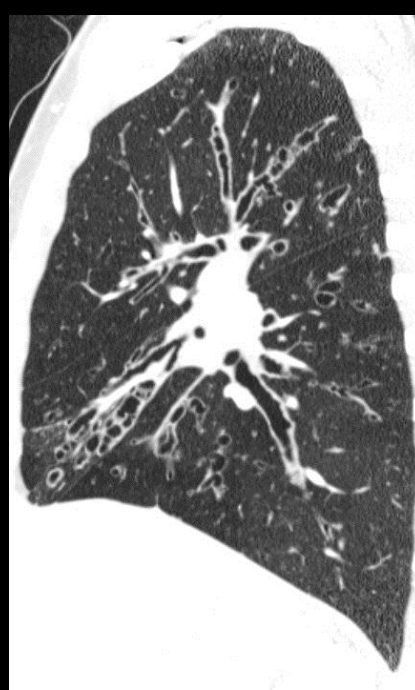
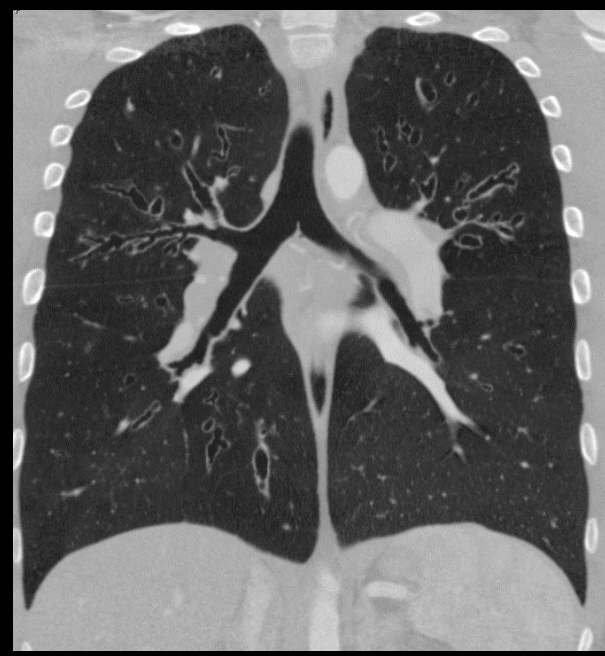
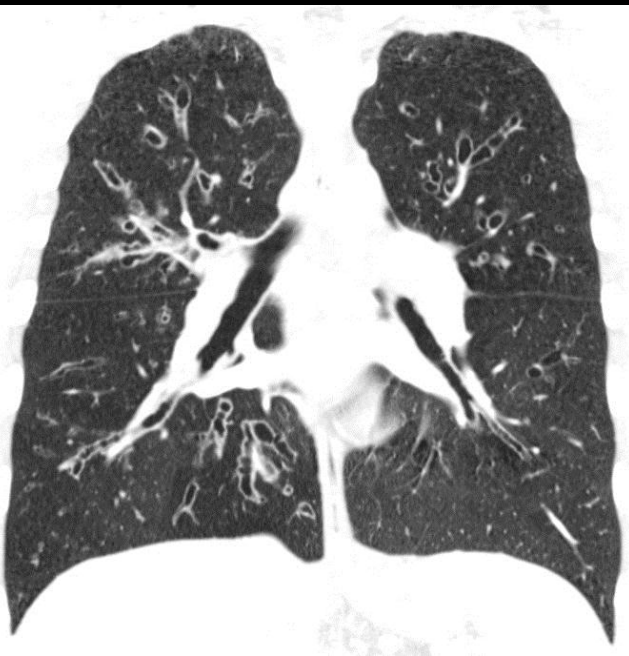
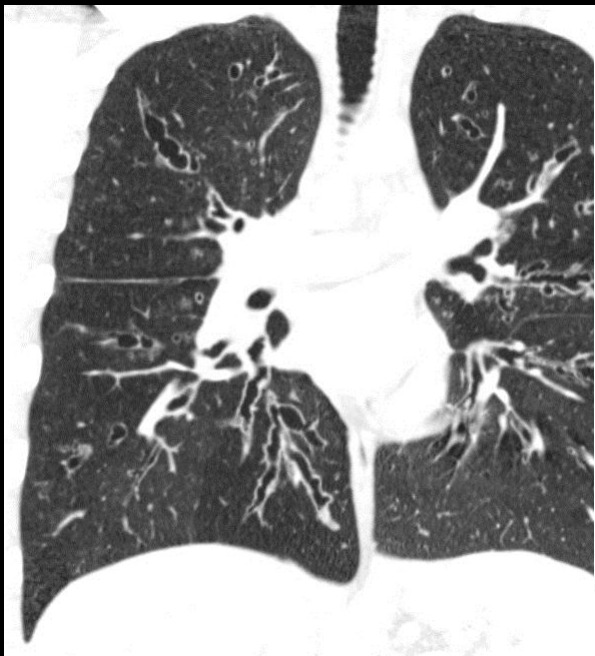
EC1  
DPOV 240  
18mm  
1.5sec

### Cas 3

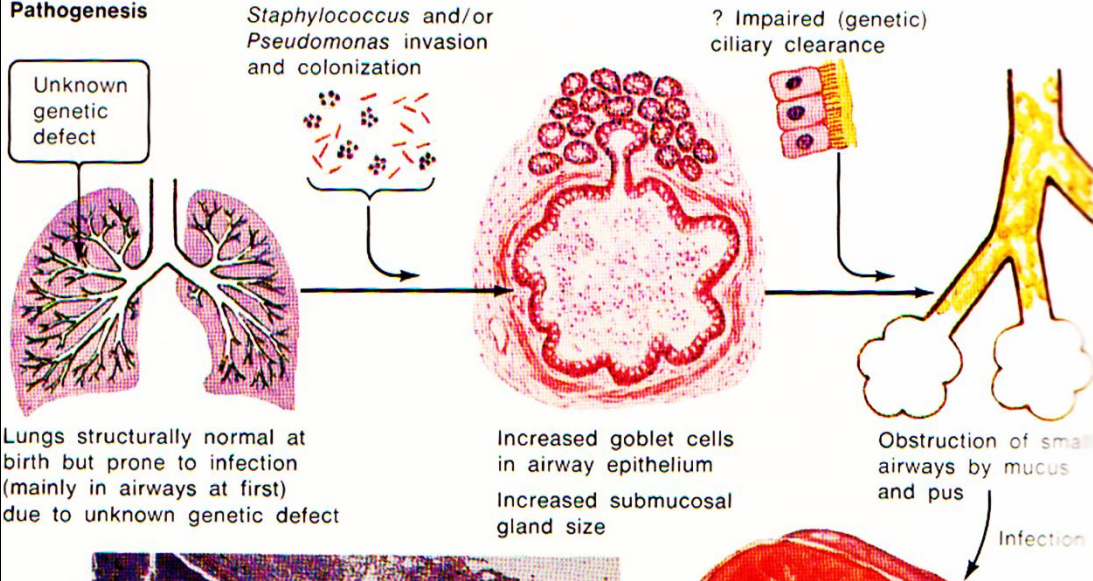


**Patiente de 27 ans  
mucoviscidose**

**Radiographie thoracique de face**  
**- Syndrome bronchique avec  
bronchiectasies bilatérales**  
**- PAC en place**



**Pathogenesis**



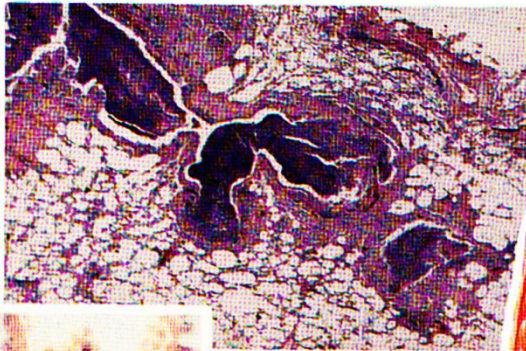
Lungs structurally normal at birth but prone to infection (mainly in airways at first) due to unknown genetic defect

*Staphylococcus* and/or *Pseudomonas* invasion and colonization

? Impaired (genetic) ciliary clearance

Increased goblet cells in airway epithelium  
Increased submucosal gland size

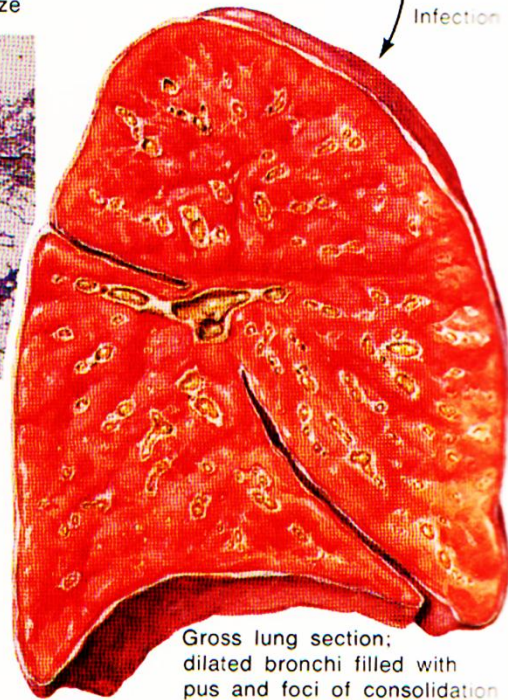
Obstruction of small airways by mucus and pus  
Infection



Group of small airways distended with pus and mucus; peribronchial inflammatory cell infiltration



Section through pleura showing cuboidal rather than normally flat mesothelium



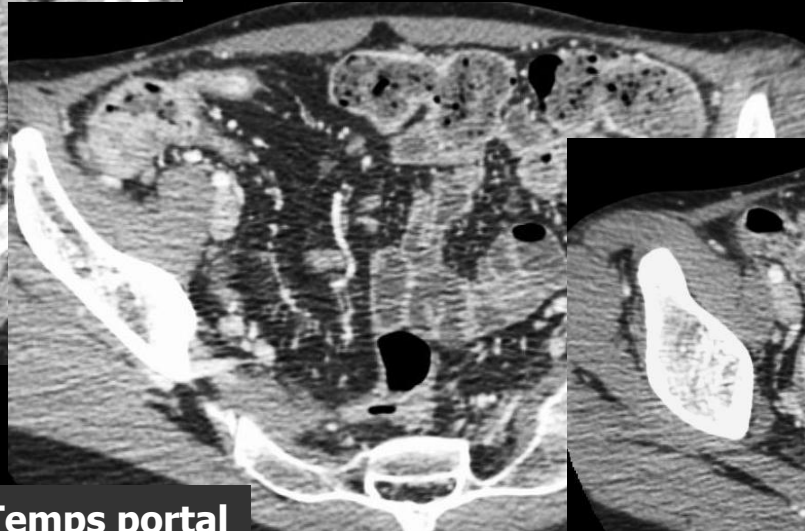
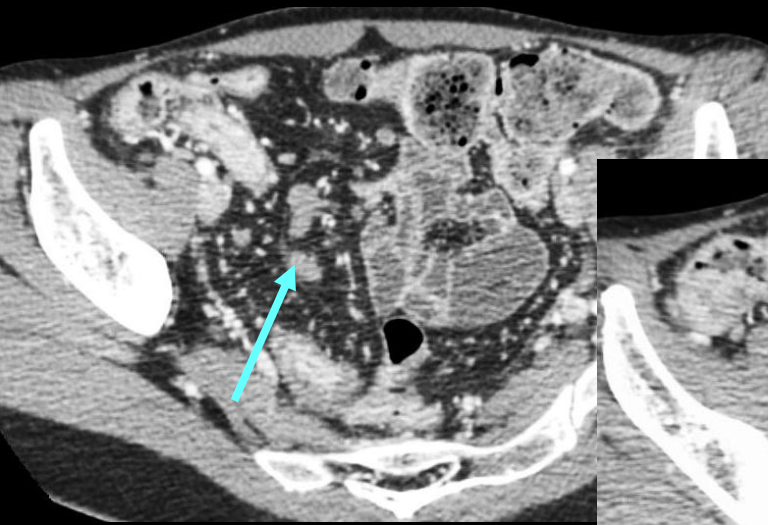
Gross lung section; dilated bronchi filled with pus and foci of consolidation



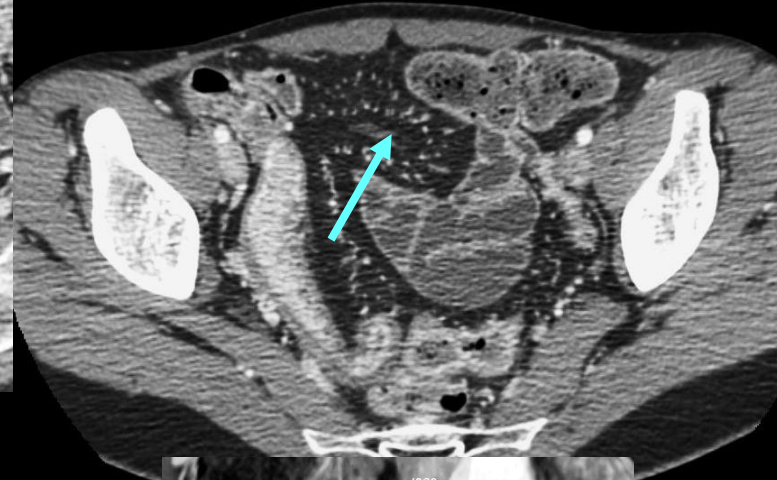
157



Patiente de 32 ans  
Douleurs pelviennes



Temps portal



DIAGNOSTIC  
Poussée inflammatoire de maladie de Crohn

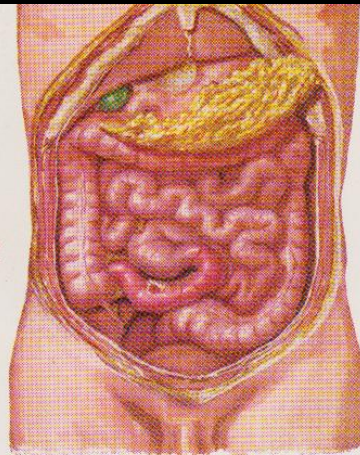




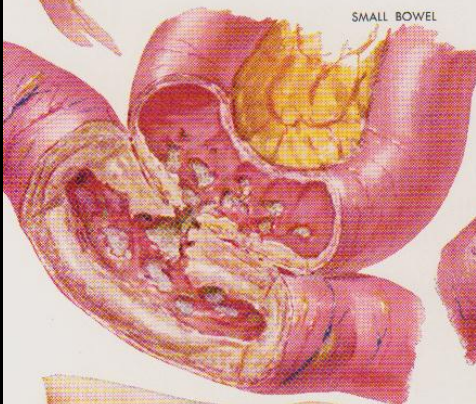
**Poussée inflammatoire de maladie de Crohn**



MESENTERIC ABSCESS

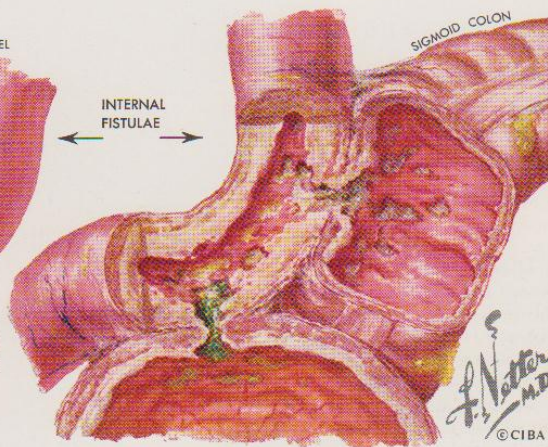


PERITONITIS



SMALL BOWEL

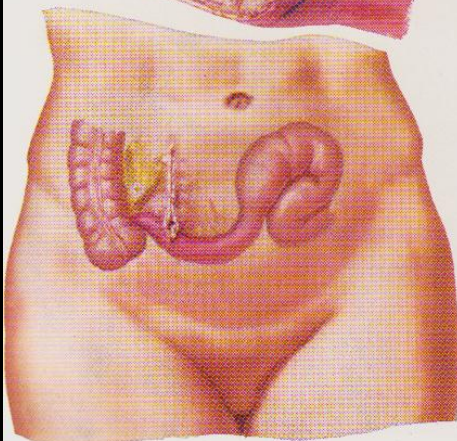
INTERNAL  
FISTULAE



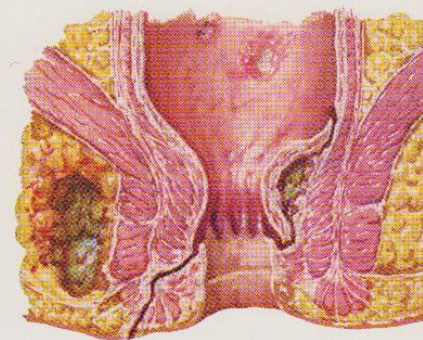
SIGMOID COLON

BLADDER

*F. Netter M.D.*  
© CIBA



EXTERNAL FISTULA (VIA APPENDECTOMY INCISION)



PERI-ANAL FISTULAE AND/OR ABSCESSES

## Cas 5



Scanner abdomino pelvien injecté

Plan axial, reformations sagittale et coronale

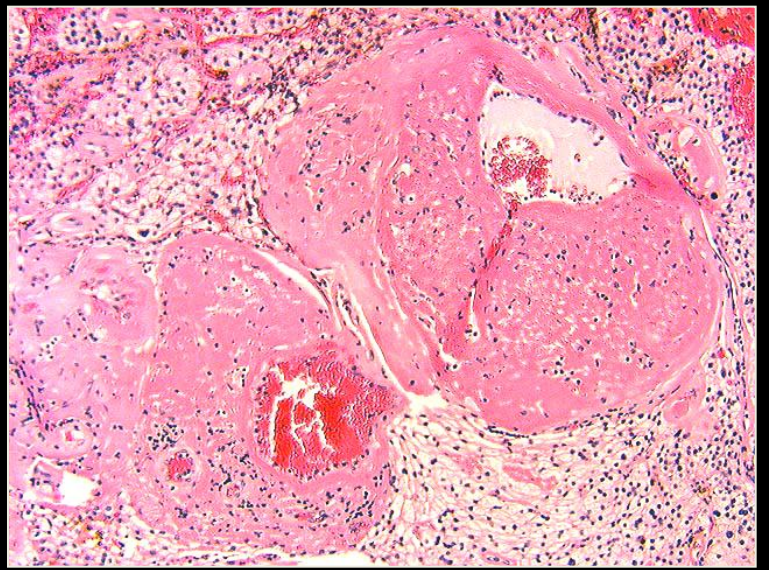
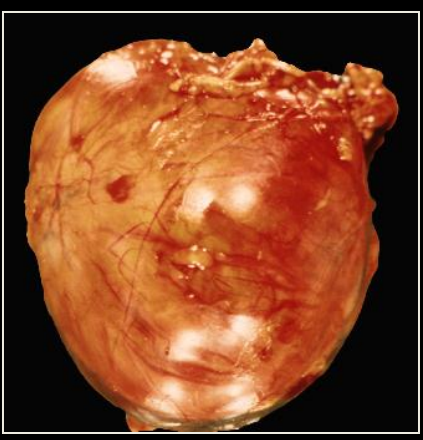
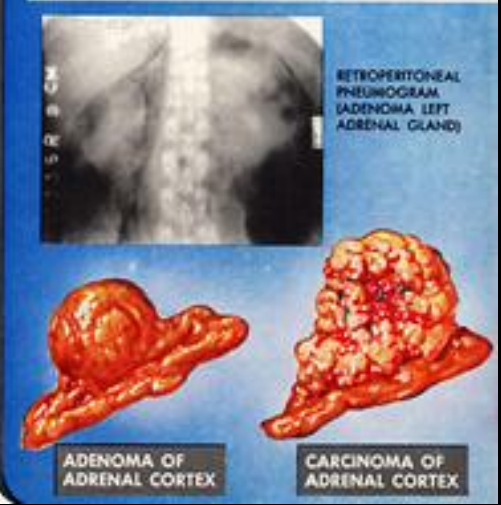
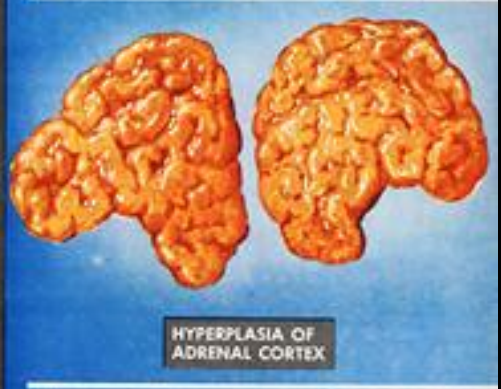
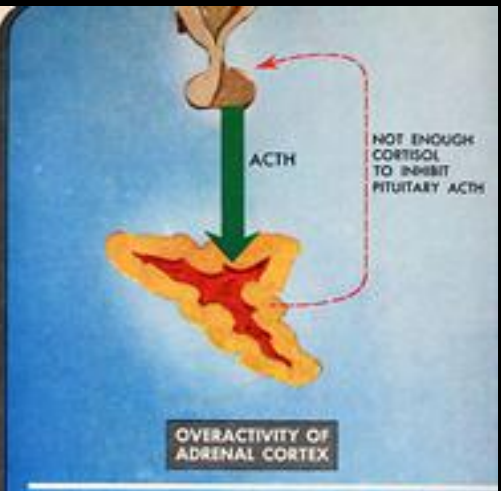
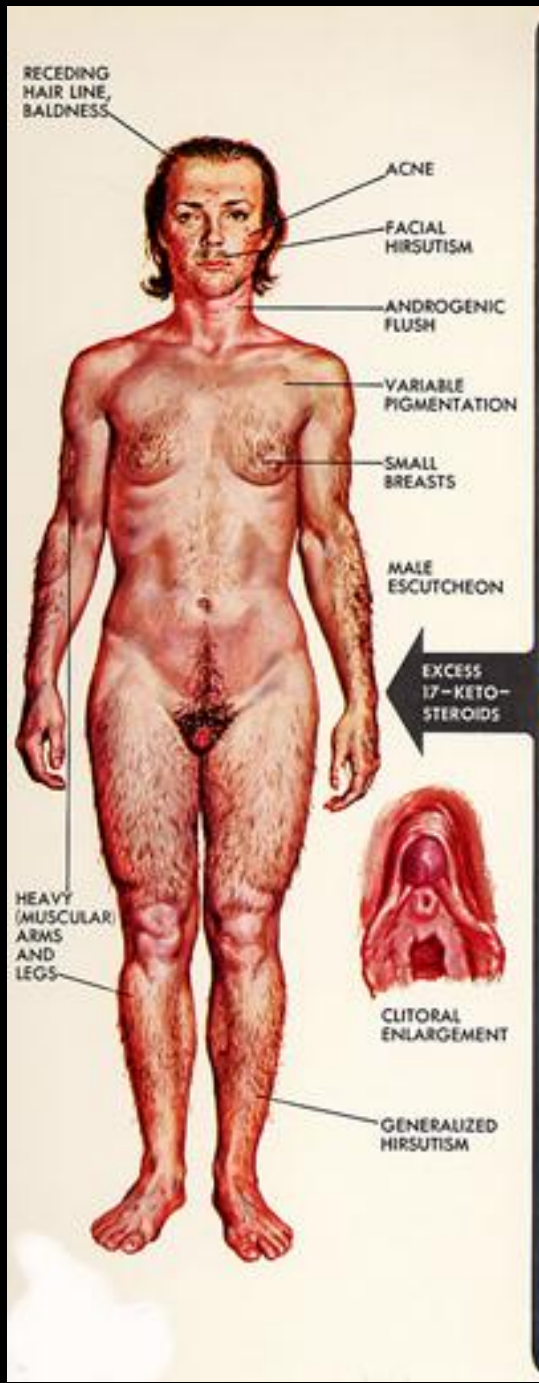
Volumineuse masse surrénalienne droite hétérogène

Refoulant le rein droit et la VCI.

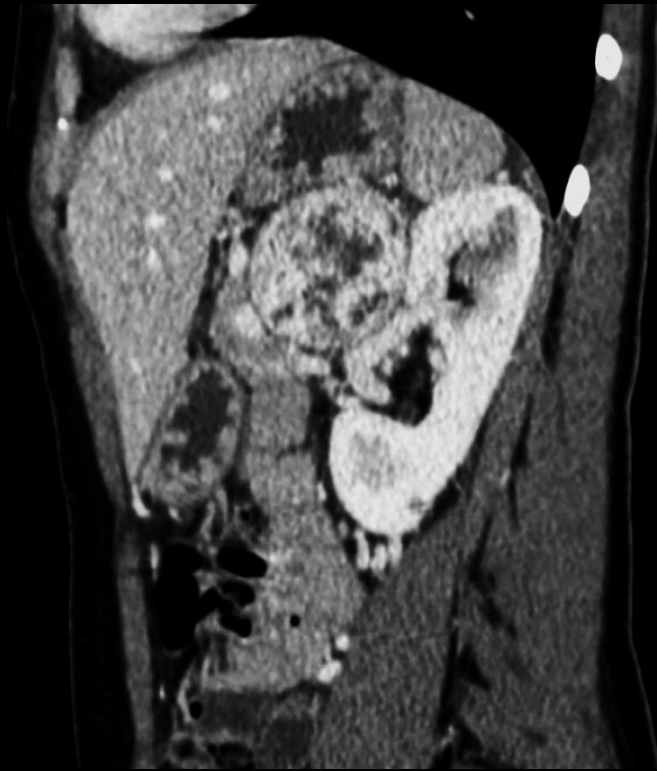
Nécrose et calcifications intra lésionnelles.

Patiente de 58 ans  
Syndrome de Cushing

**Corticosurréalome droit**



## Cas 6

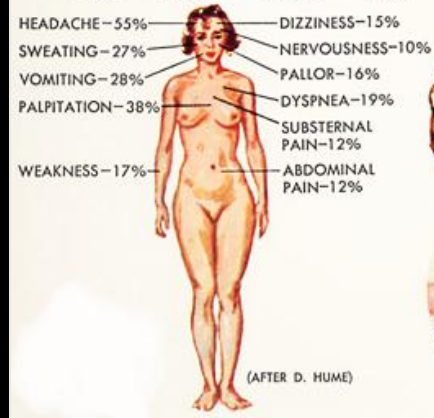
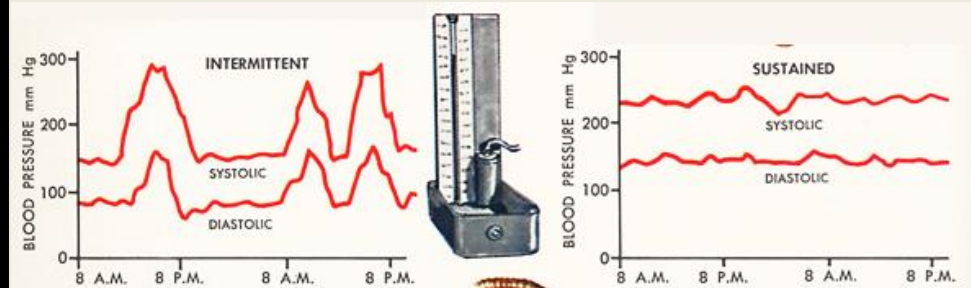
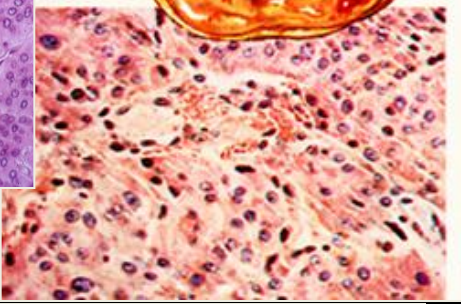
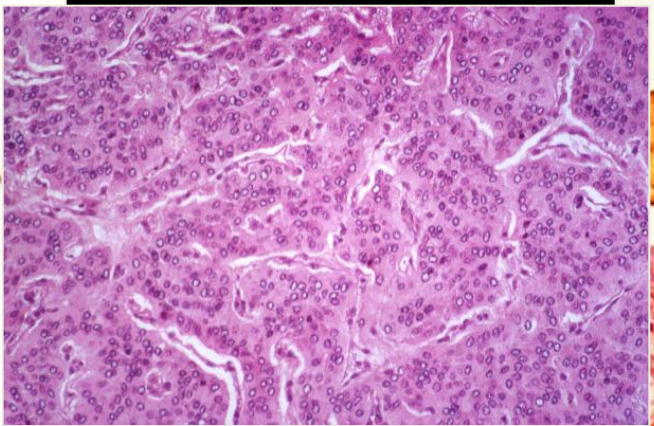
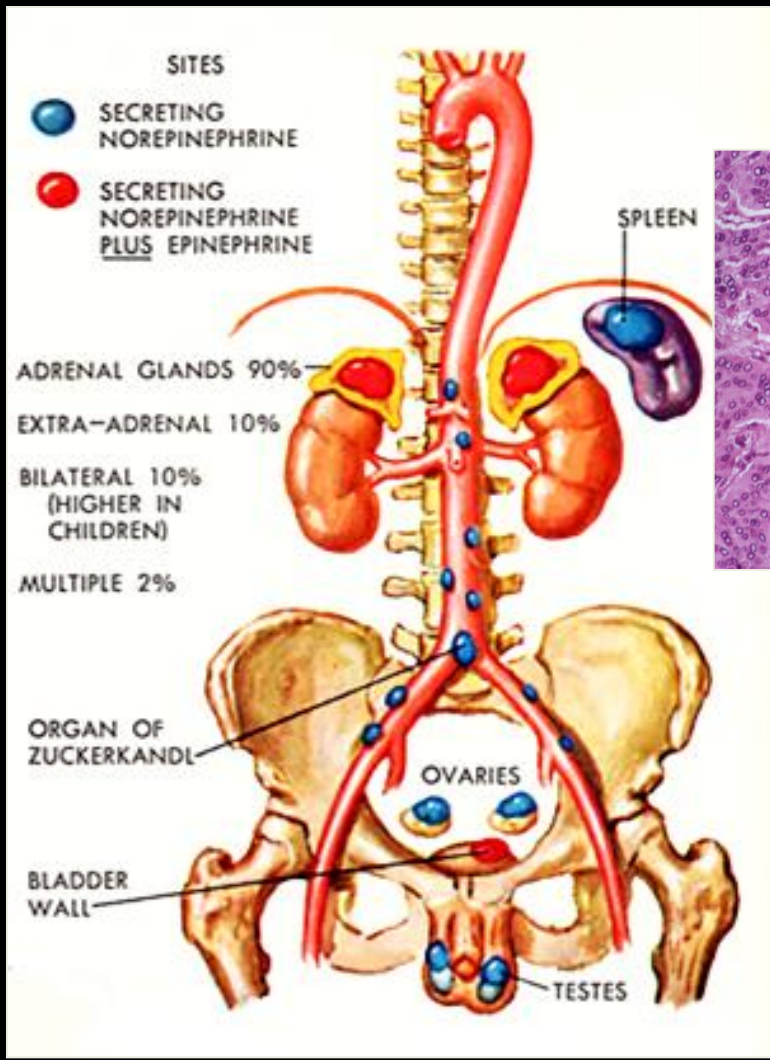


Scanner abdomino pelvien injecté  
Plan axial, reformations sagittale et coronale  
Masse surrénalienne gauche hétérogène  
Refoulant le rein gauche  
Hypervasculaire

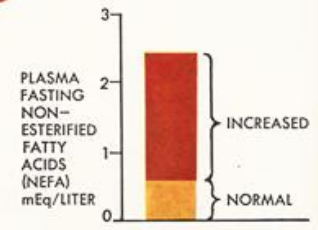
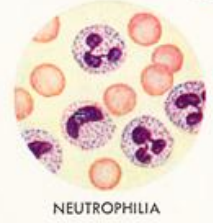
**Phéochromocytome gauche**

Patiente de 26 ans  
HTA, céphalée, sueurs, palpitations

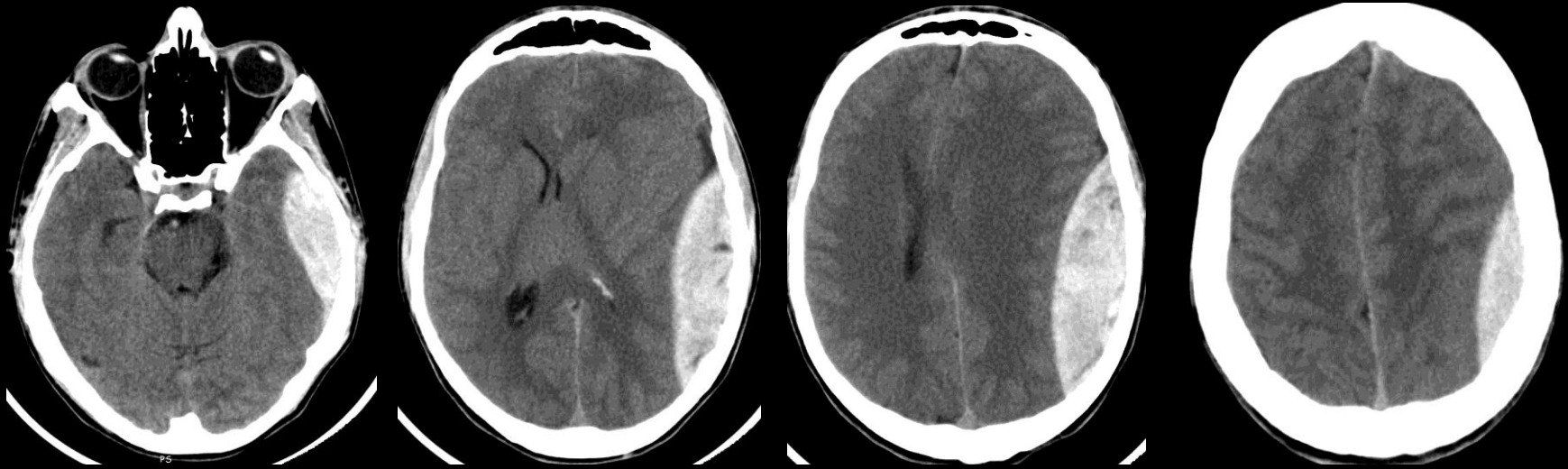




B.M.R. ELEVATED (P.B.I. AND B.E.I. NORMAL)



## Cas 7



Scanner cérébral sans injection

Plan axial

Hyperdensité spontané péri cérébrale

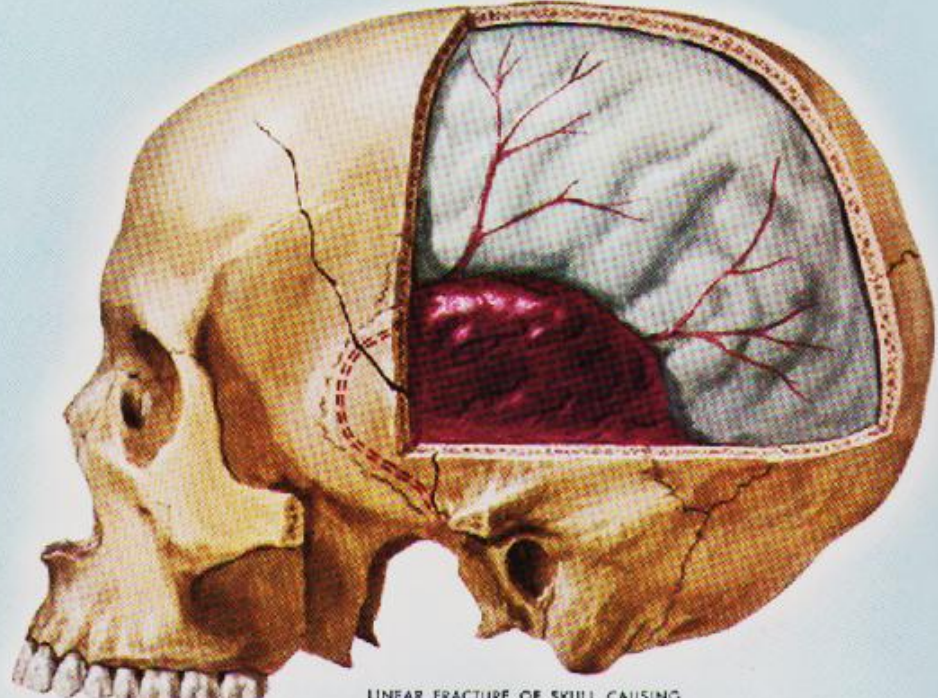
Forme de lentille bi convexe

Effet de masse sur l'hémisphère gauche, début d'engagement sous falcorien

**Hématome extra dural gauche**

Patiente de 65 ans

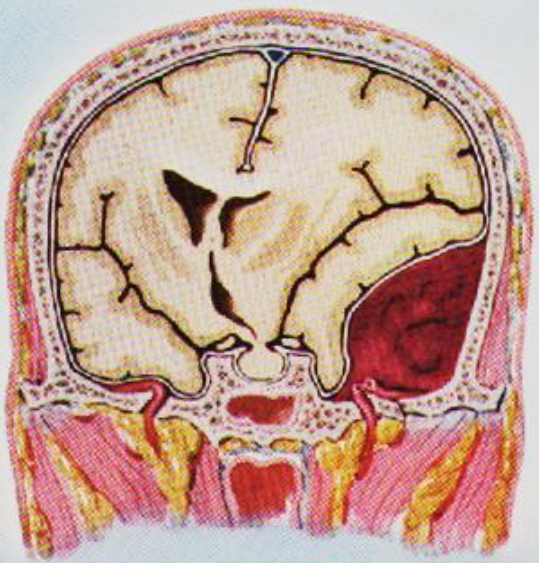
Céphalée et hémiparésie droite 48h après un traumatisme crânien



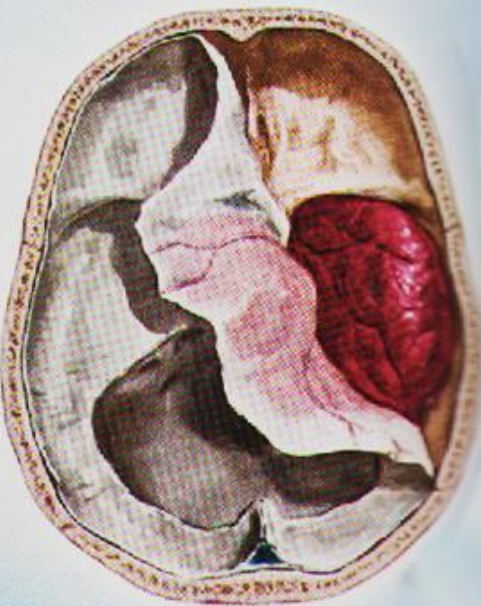
LINEAR FRACTURE OF SKULL CAUSING MIDDLE MENINGEAL HEMORRHAGE



Os pariétal face interne



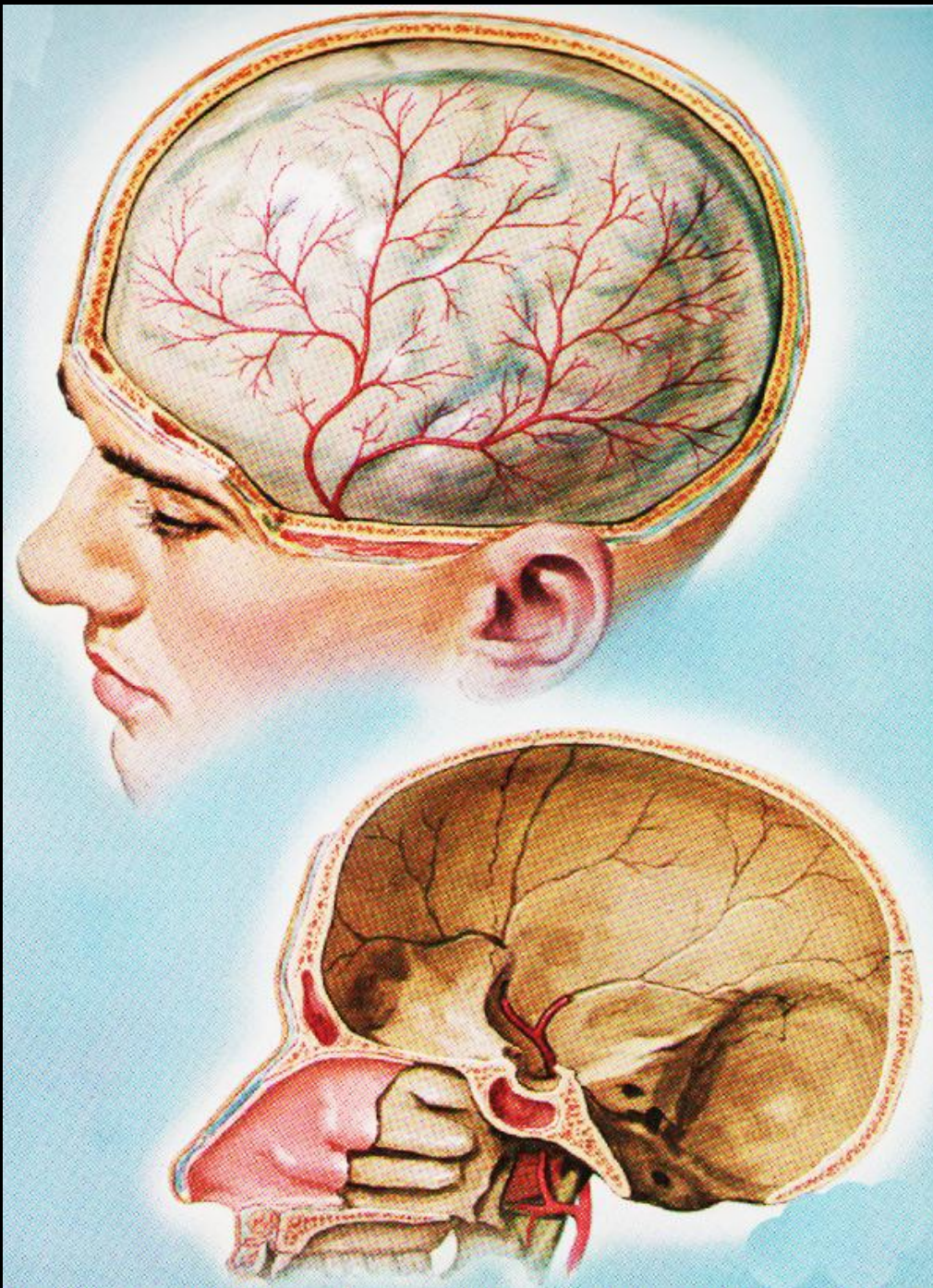
EXTRADURAL HEMATOMA DUE TO TEAR OF MIDDLE MENINGEAL ARTERY AT THE FORAMEN SPINOSUM BY FRACTURE OF THE BASE OF THE SKULL



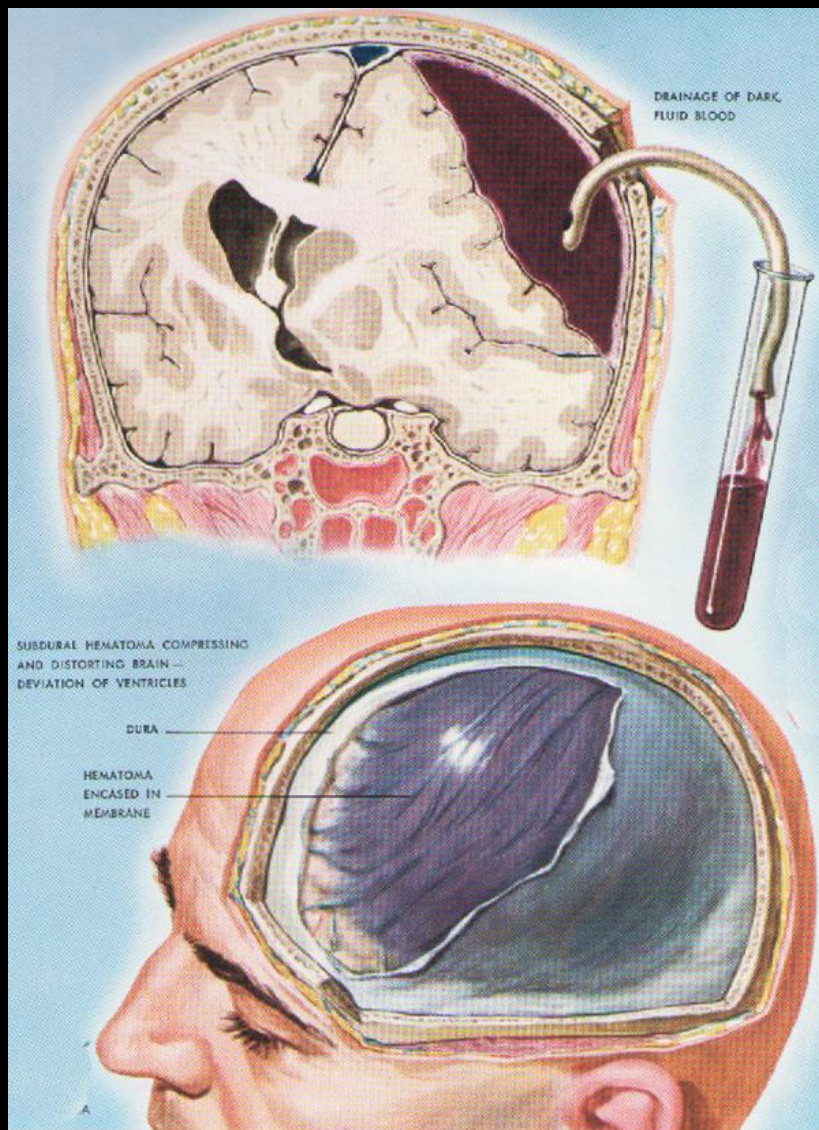
CLOT EXPOSED ON SKULL BASE



Hématome extra dural



**artère méningée  
moyenne**



**Hématome sous dural**

## Cas 8



Angioscanner artériel thoraco abdomino pelvien

Plan axial

Flap intimal aortique avec vrai et faux chenaux

Atteinte de l'aorte ascendante et descendante.

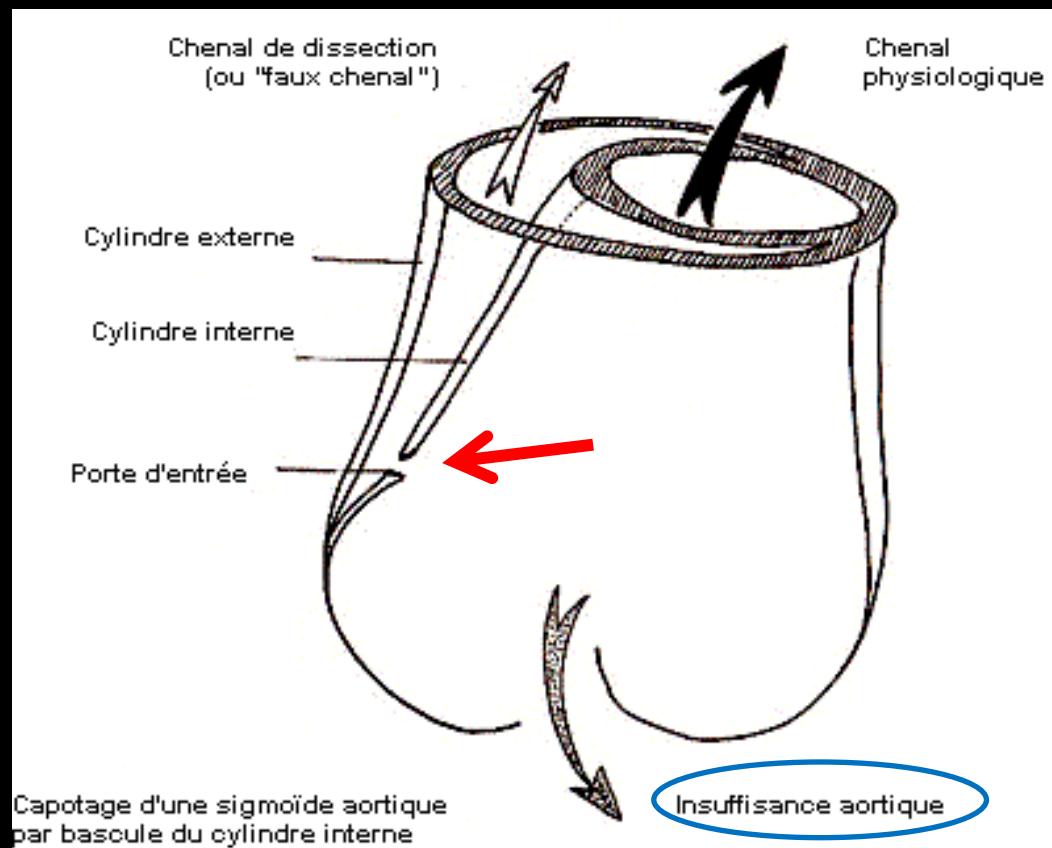
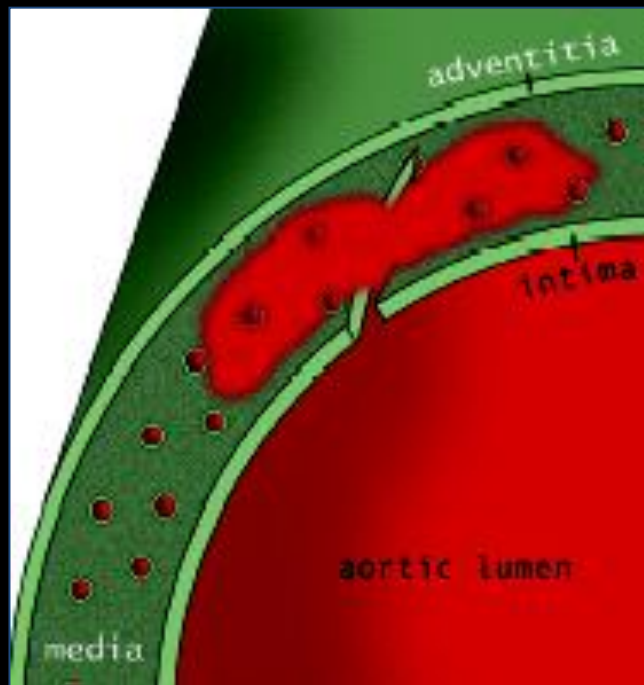
Thrombose du faux chenal à l'étage abdominal

**Dissection aortique de type A**

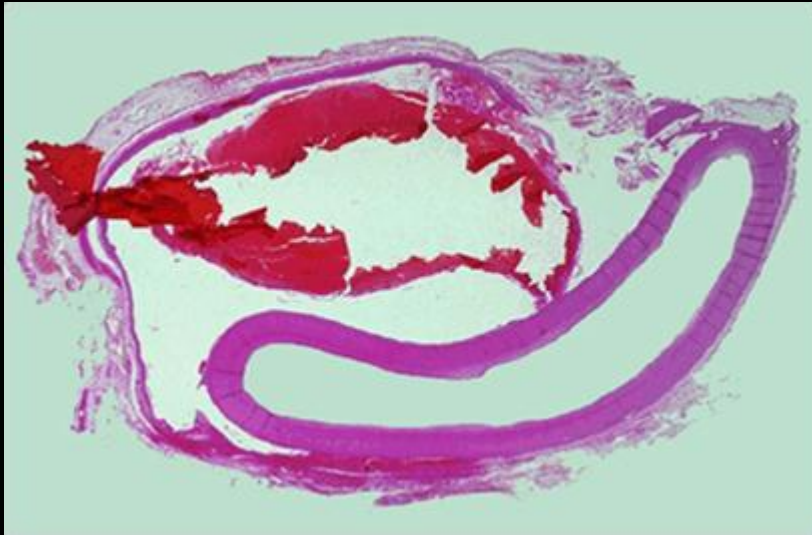
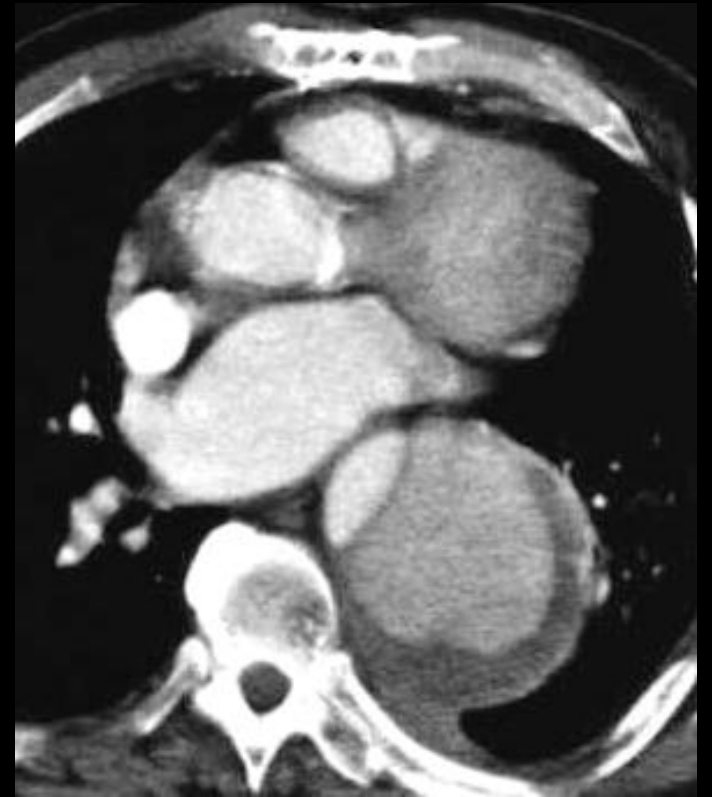
Patiente de 48 ans

Douleur thoracique intense





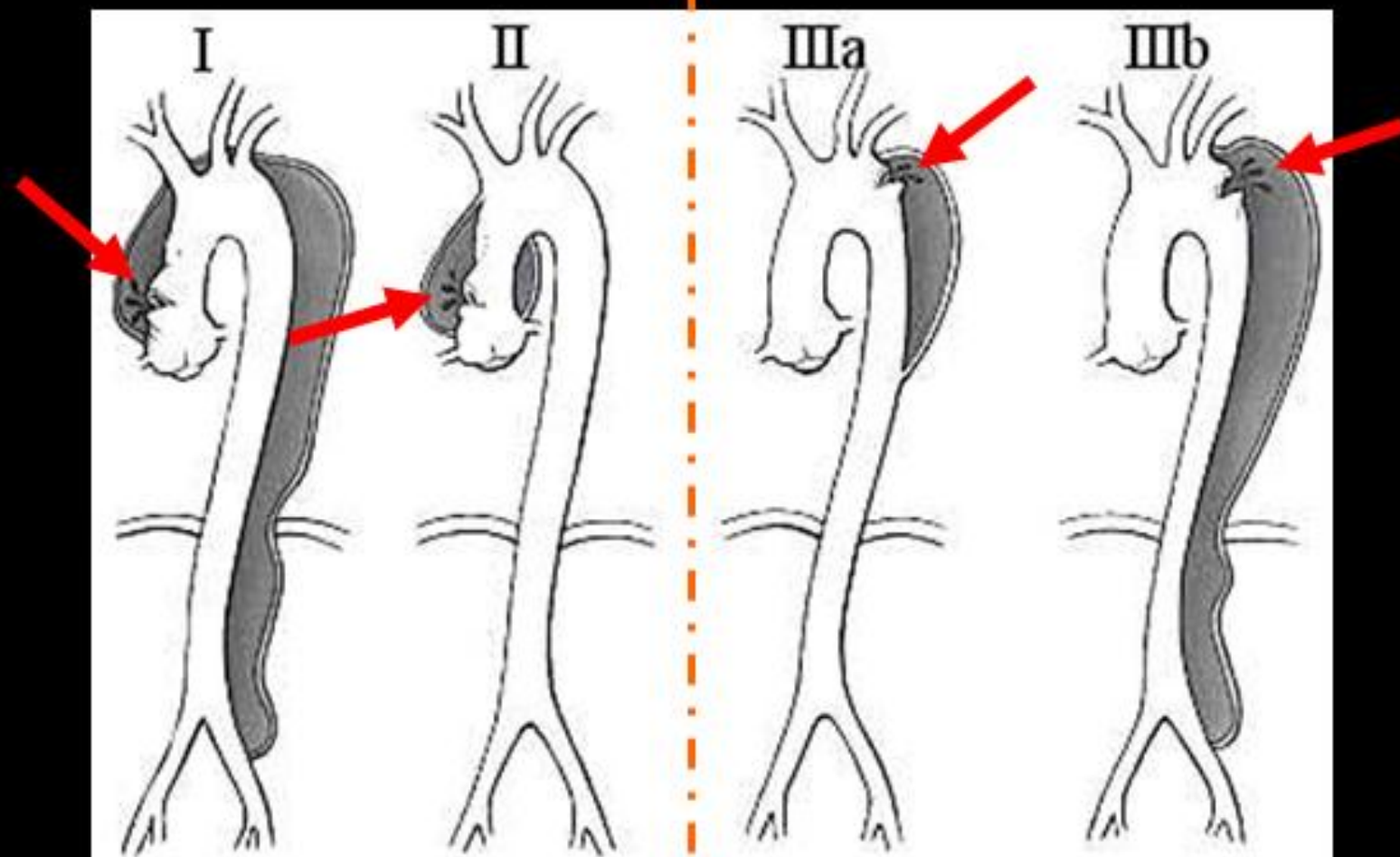
**Fig.1 : Mécanisme de la DAA, et ses conséquences.**



# Imagerie et orientations thérapeutiques des dissections aortiques

**De Bakey type I et II**

**De Bakey type III**



**Stanford type A**

**Stanford type B**

Vrai chenal  
perméable



Faux chenal  
thrombosé



Patiente de 48 ans  
Douleur thoracique intense

# Classification des brèches intimes selon Svensson

## Type I

DA classique avec brèche intinale et double lumière séparée d'un flap

## Type II

HIM sans brèche intinale imagée bien que retrouvée en per-opératoire ou à l'autopsie

## Type III

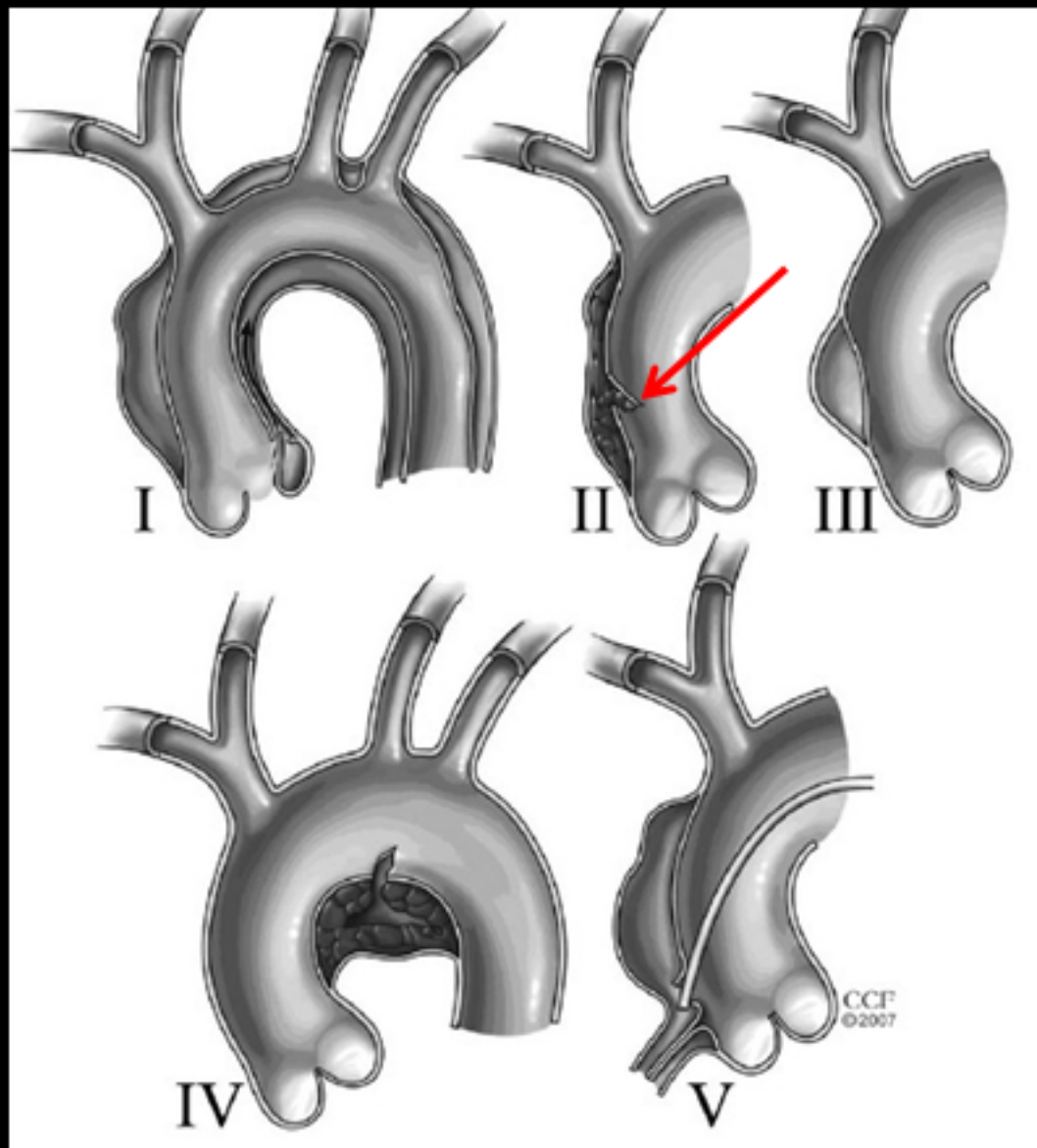
Déchirure intinale limitée sans hématome médial avec renflement excentré au site de dissection suspendue (Marfan +++)  
*diagnostic difficile en CT ou ETT*

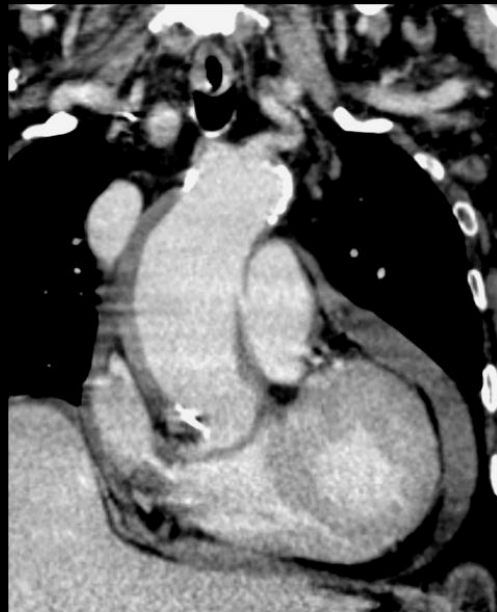
## Type IV

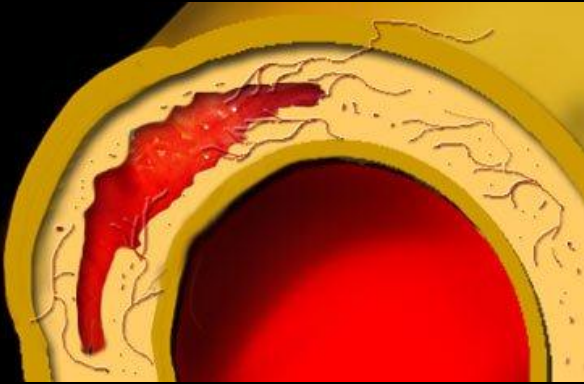
ulcère athéromateux profond jusqu'à l'adventice avec hématome localisé ou anévrisme sacculaire

## Type V

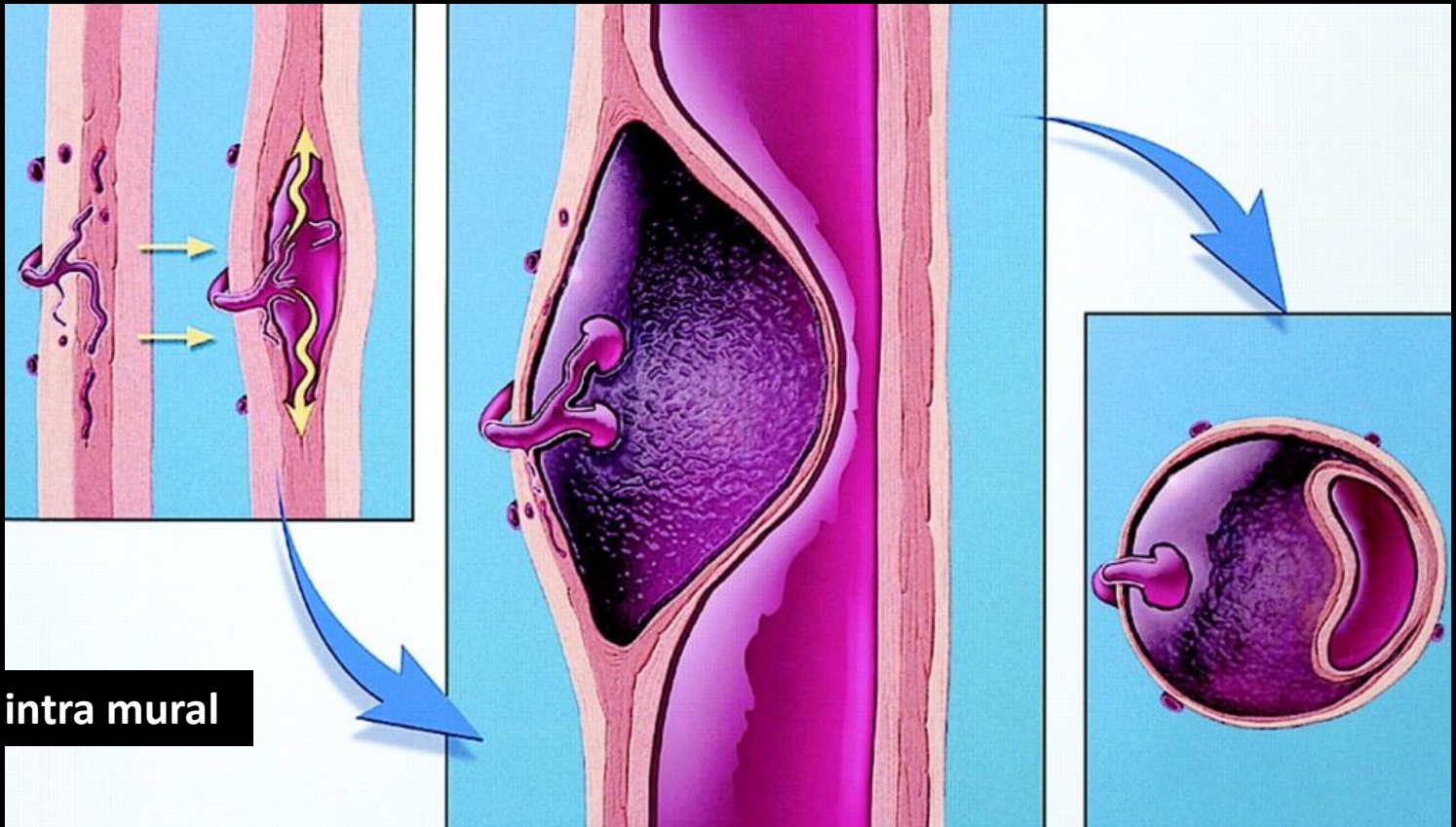
Brèche intinale iatrogène (KT,Chir) ou traumatique (décélération)







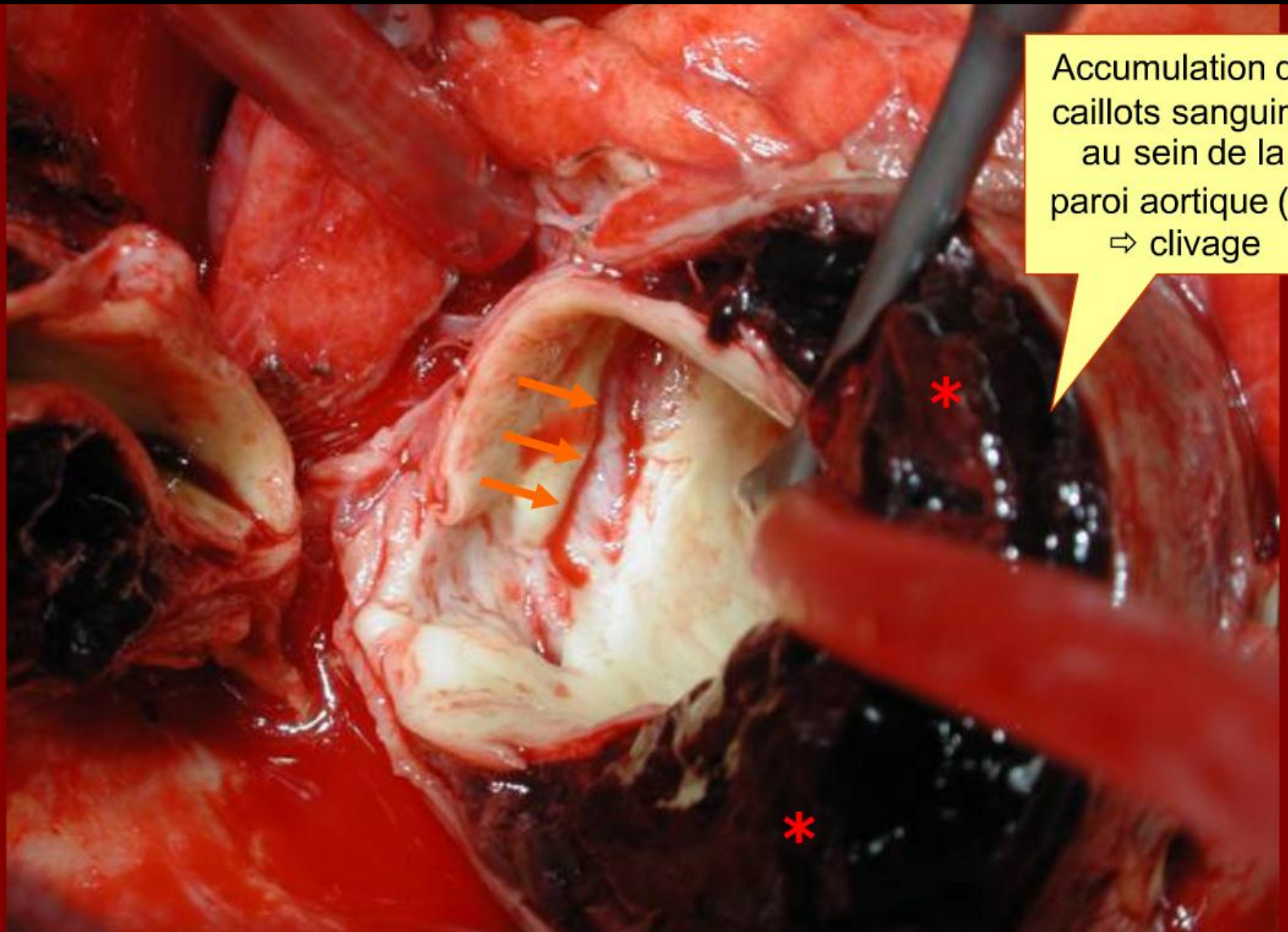
Dissection communicante



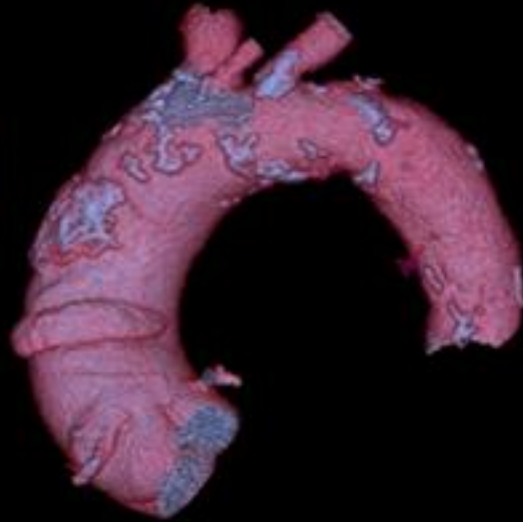
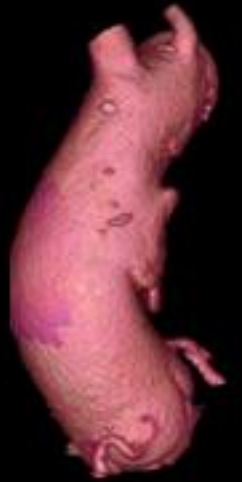
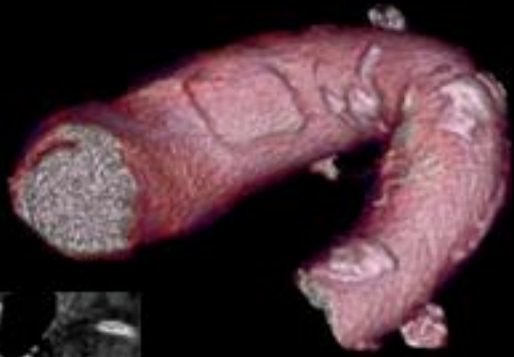
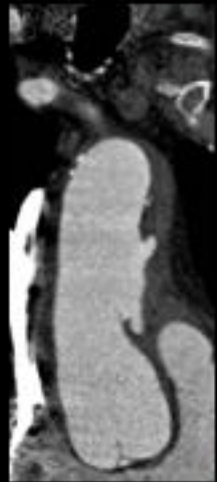


**HD de type A opéré en urgence**

Accumulation de  
caillots sanguins  
au sein de la  
paroi aortique (\*)  
⇒ clivage

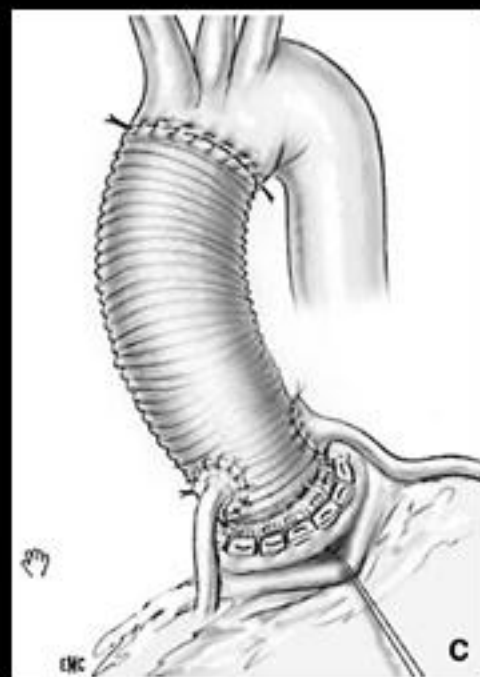
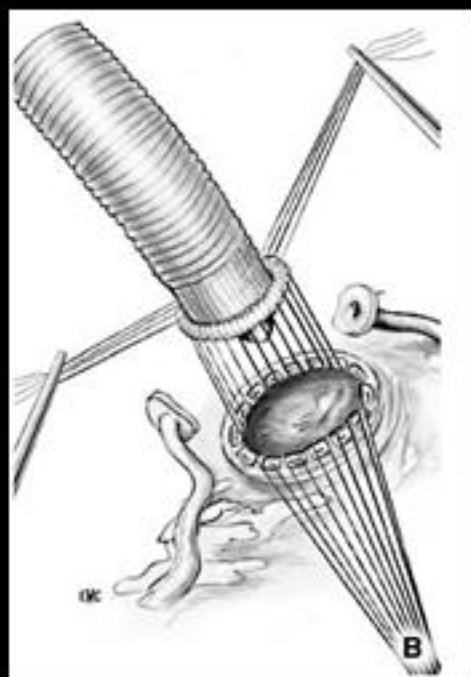
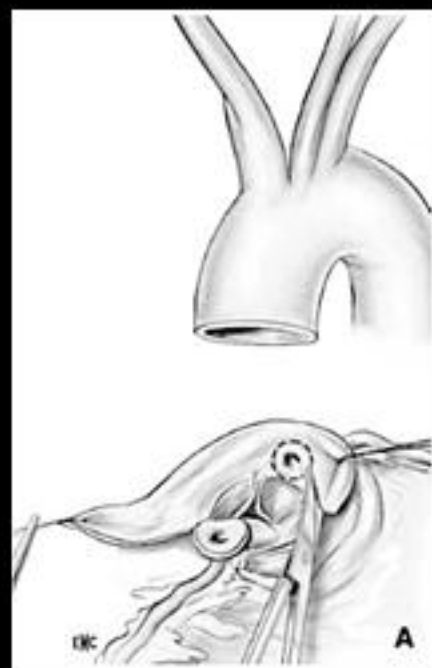


**Signes radiologiques typiques :**



## Anastomose proximale

### Bentall prothèse valvulaire aortique mécanique ou bioprothèse



Resection totale de l'aorte ascendante  
Découpage en bouton et mobilisation des ostia coronaires autr

Mise en place du tube valvé sur l'anneau aortique

Réimplantation directe des ostia coronaires sur la prothèse de Dacron

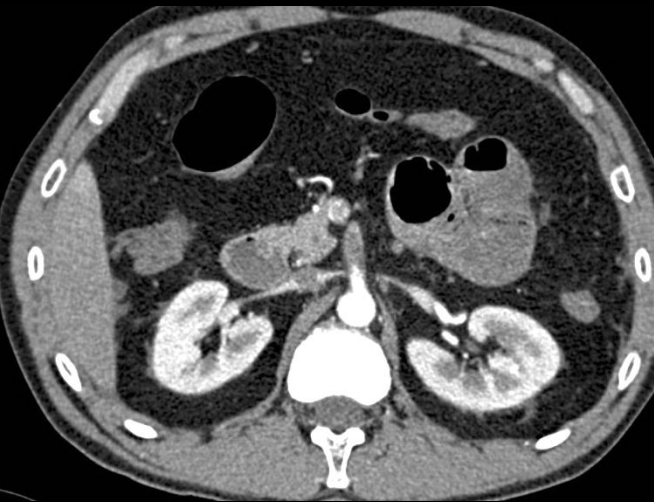


Artériel

Veineux

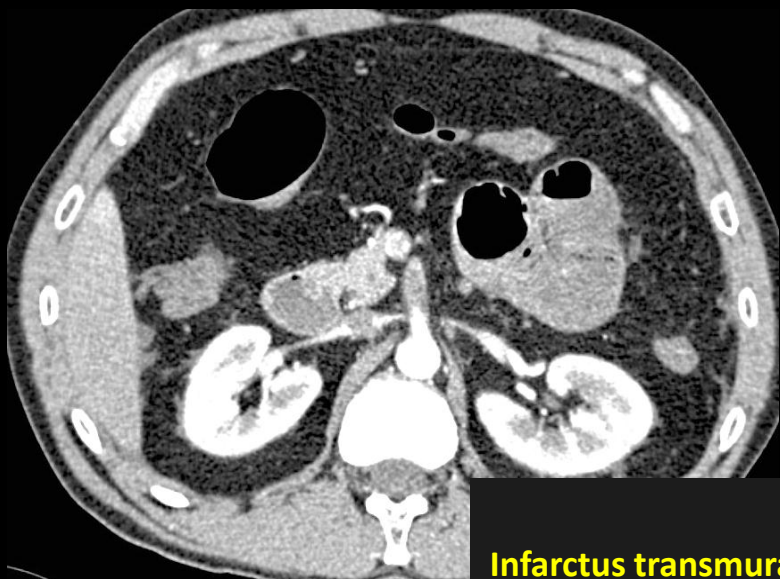
Tardif

Patient de 47 ans  
Douleurs abdominales intenses



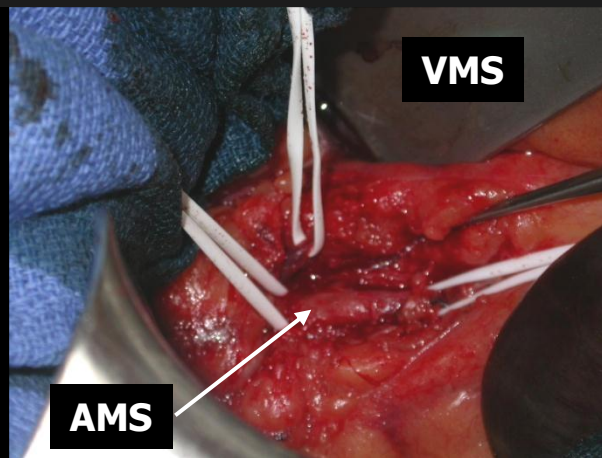
Angioscanner artériel thoraco abdomino pelvien

Plan axial et reformation sagittale  
Défaut de rehaussement d'anses grêles distendues  
Embole dans l'AMS



Diagnostic

**Infarctus transmural étendu du grêle par occlusion de l'AMS**



VMS

AMS



**Thrombectomie / Fogarty**



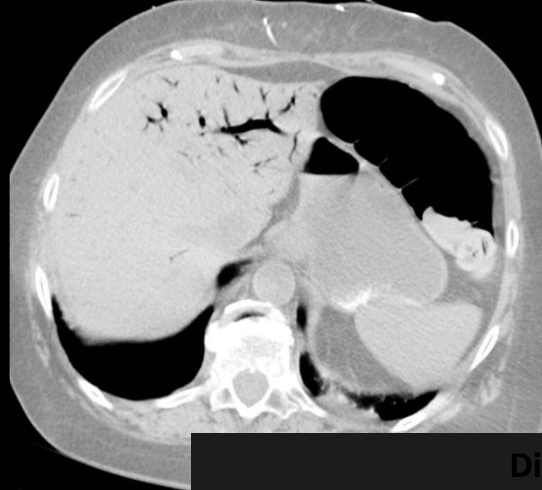
Cas 9 bis : Femme de 75 ans

J12 remplacement valvulaire

Douleurs abdominales diffuses,  
défense

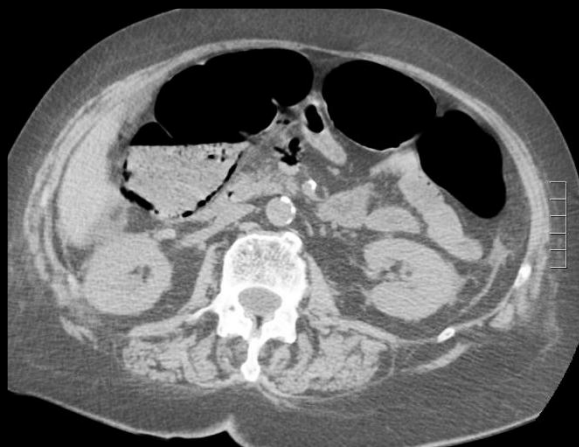
Pas de fièvre

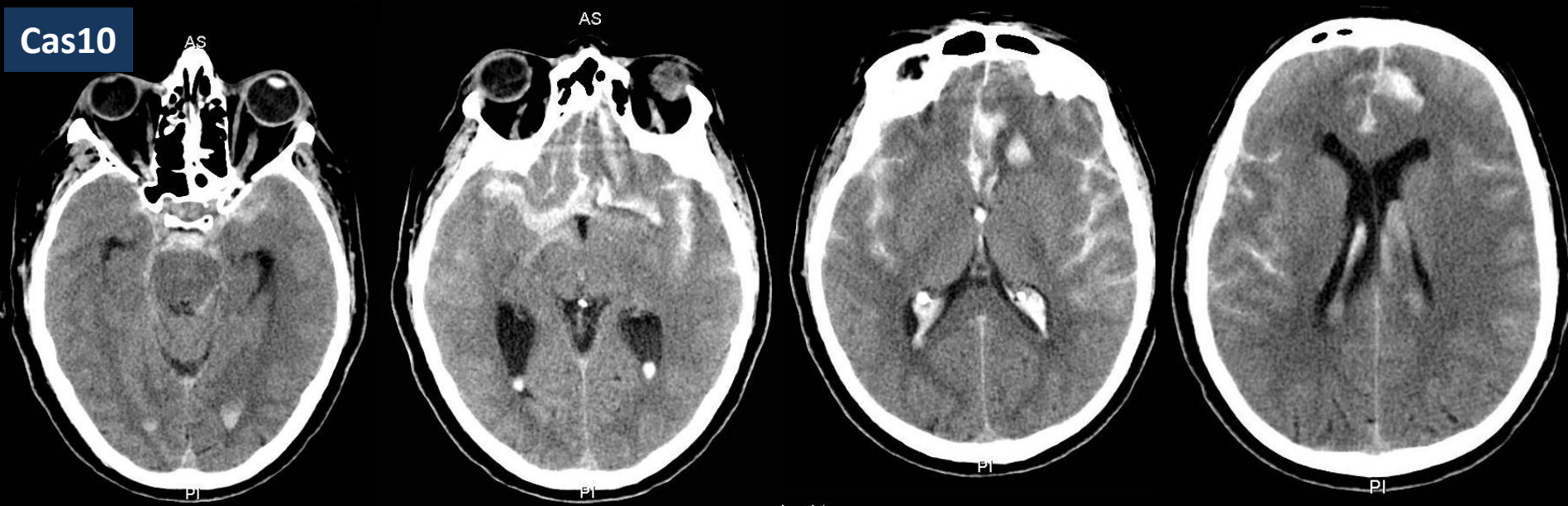
Lactates normaux



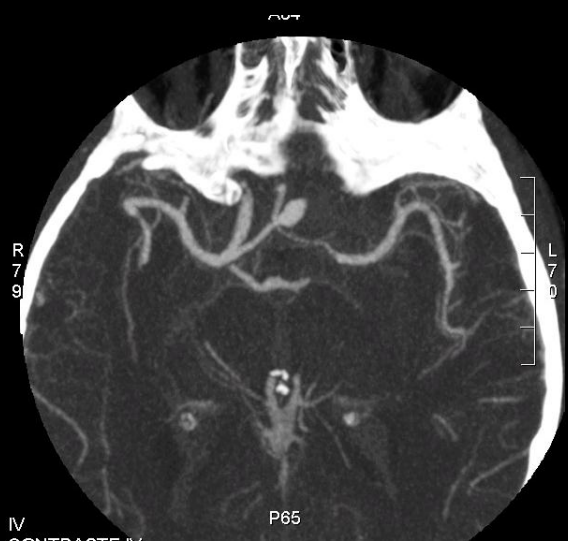
Diagnostic:

**Ischémie artérielle aiguë du territoire de l'AMS**



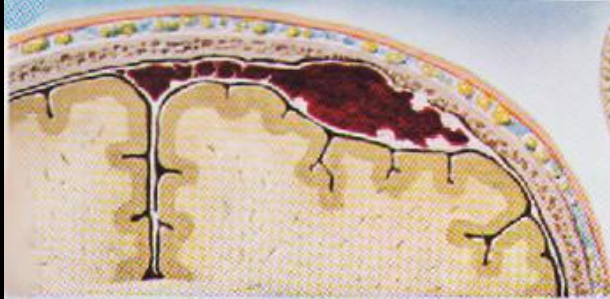


- Homme de 60 ans.
- Coma GCS 4 au réveil.



- Scanner cérébral sans injection et angio-scanner artériel intra crânien.
- Hyperdensité hémattique spontanée diffuse des espace sous arachnoïdiens.
- Hématome intra-parenchymateux fronto-basal gauche
- Inondation ventriculaire

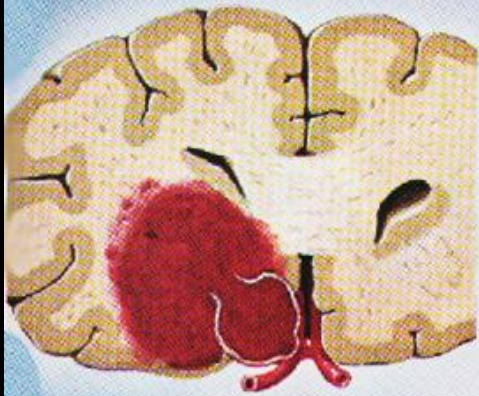
**Hémorragie sous arachnoïdienne (Fischer IV) sur rupture d'anévrysme de la communicante antérieure**



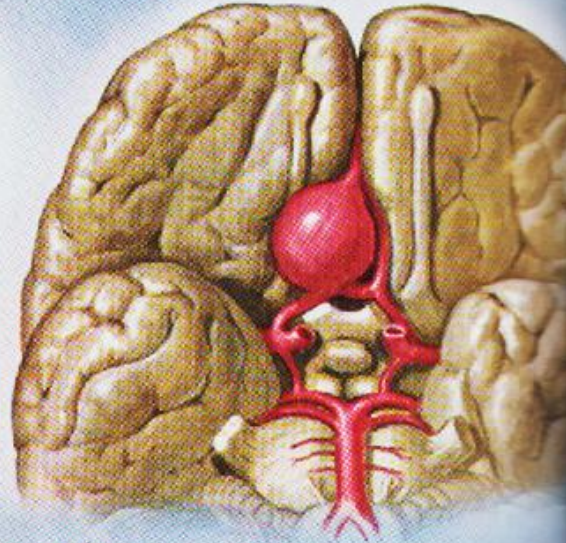
ANEURYSM OF VENOUS SINUS



EROSION OF SKULL BY VENOUS ANEURYSM



ANEURYSM RUPTURED INTRACEREBRALLY



ANEURYSM OF ANTERIOR CEREBRAL ARTERY



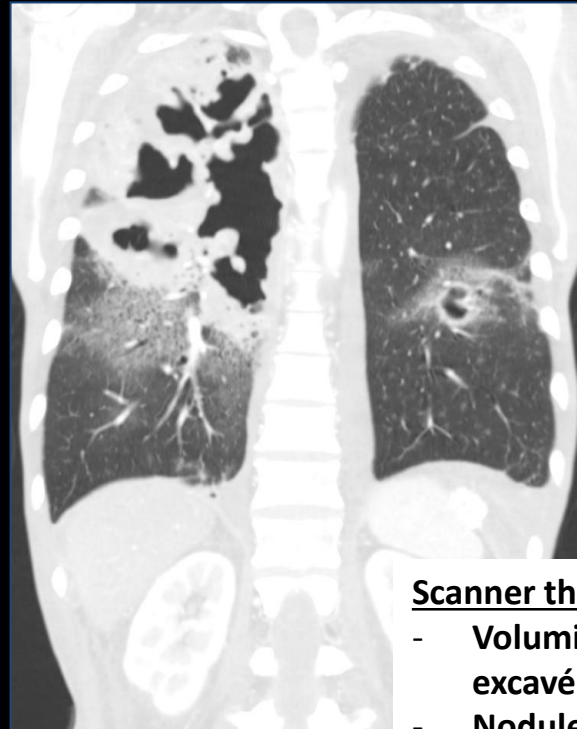
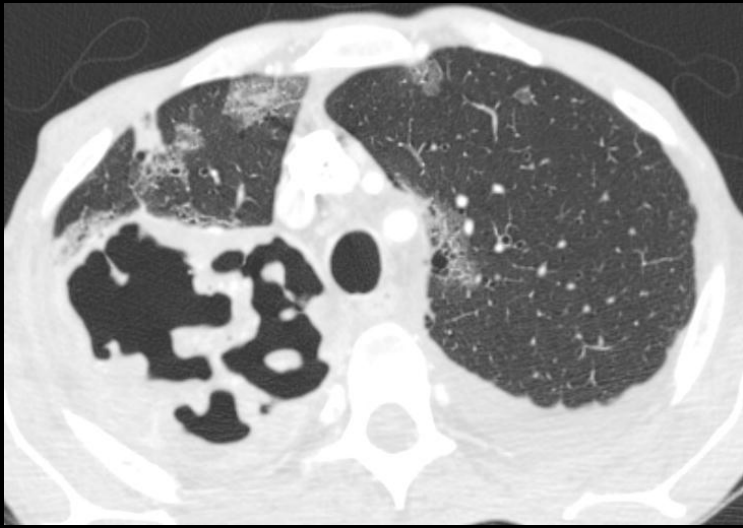
ARTERIOVENOUS ANEURYSM



IV

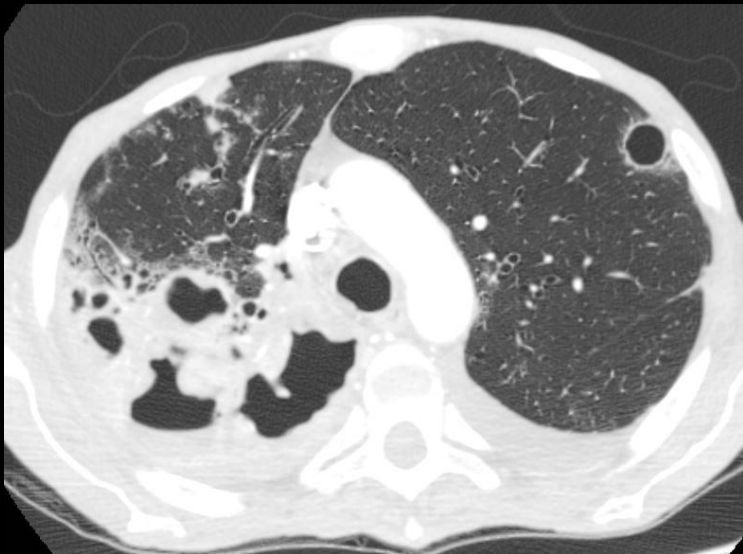
CONTRACTE IV

P65



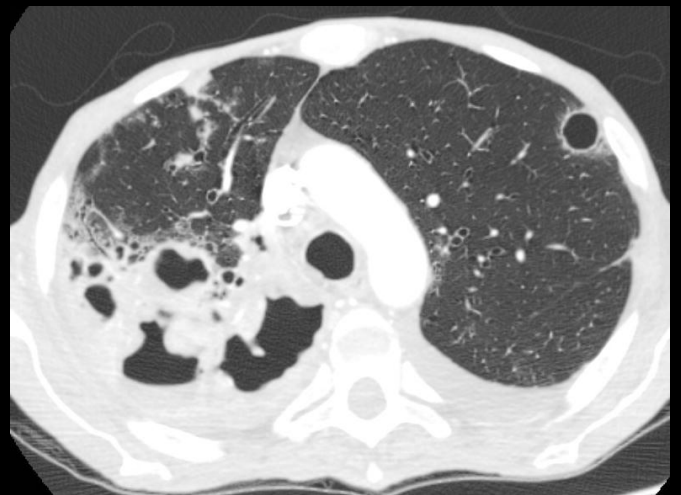
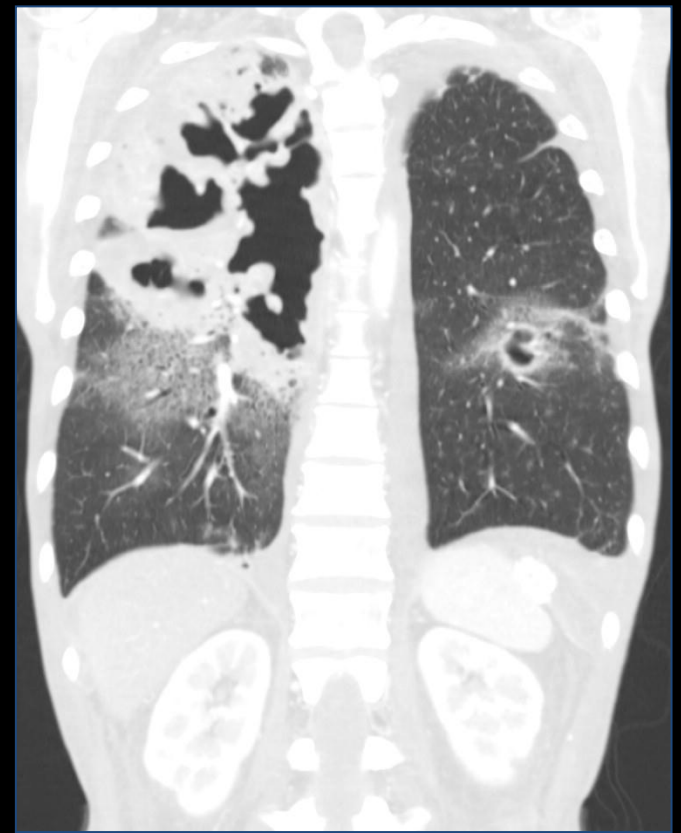
Scanner thoracique sans IV

- Volumineuse masse apicale droite excavée + lésions excavées gauches
- Nodules de répartition bronchiolitique
- Foyers de condensation + plages de verre dépolies
- Epanchement pleural

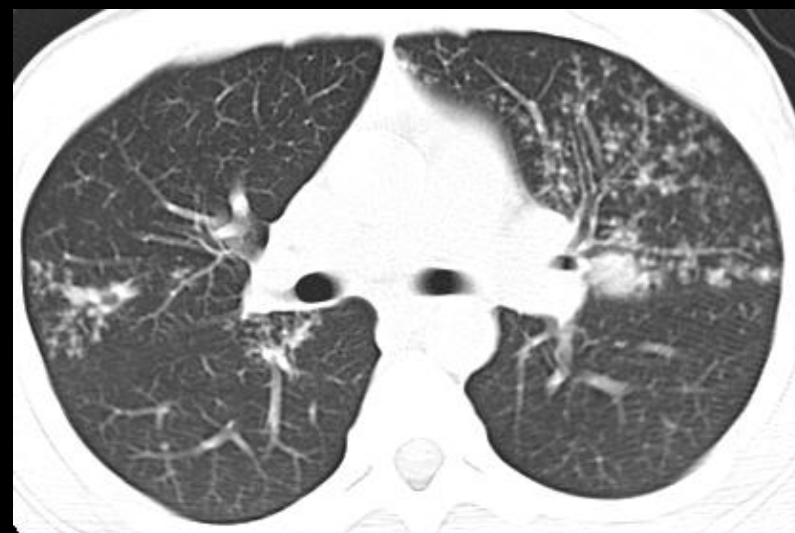
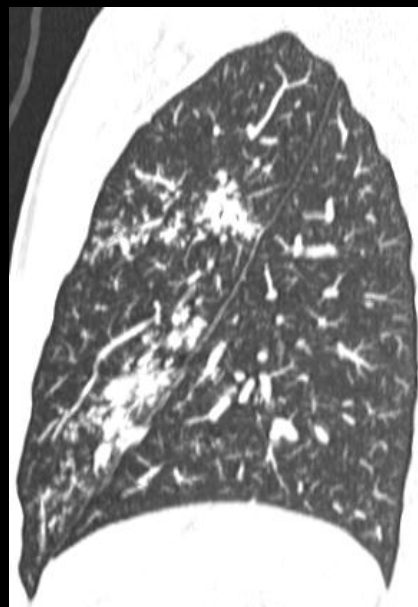
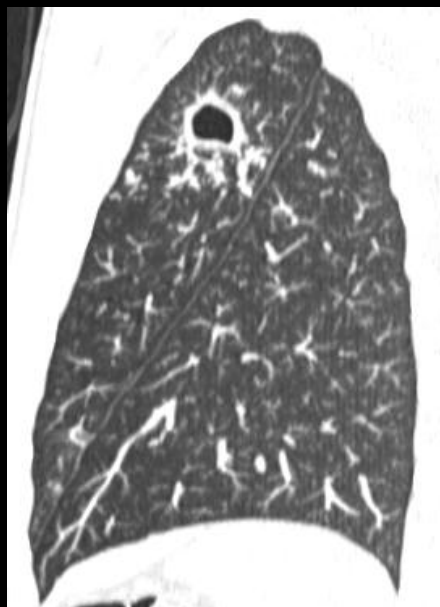


Patient de 52 ans  
Douleur thoracique, fièvre, sueurs nocturnes

**Tuberculose pulmonaire**



**Tuberculose pulmonaire**



**Foyers de bronchiolites : aspect d'arbre en bourgeon**

Femme de 57 ans, chute en arrière avec traumatisme du poignet gauche



- Fracture de l'extrémité inférieure du radius gauche
- Extra-articulaire
- Bascule dorsale du fragment distal, horizontalisation de la ligne bi-styloïdienne.
- Inversion de l'index radio ulnaire distal.
- Fracture de Pouteau-Colles



**Fracture de Gérard Marchand**

## Clinical Manifestations of Osteoporosis

### Axial



Vertebral compression fractures cause continuous (acute) or intermittent (chronic) back pain from midthoracic to midlumbar region, occasionally to lower lumbar region

### Appendicular

Fractures caused by minimal trauma



Proximal femur (intertrochanteric or intracapsular)

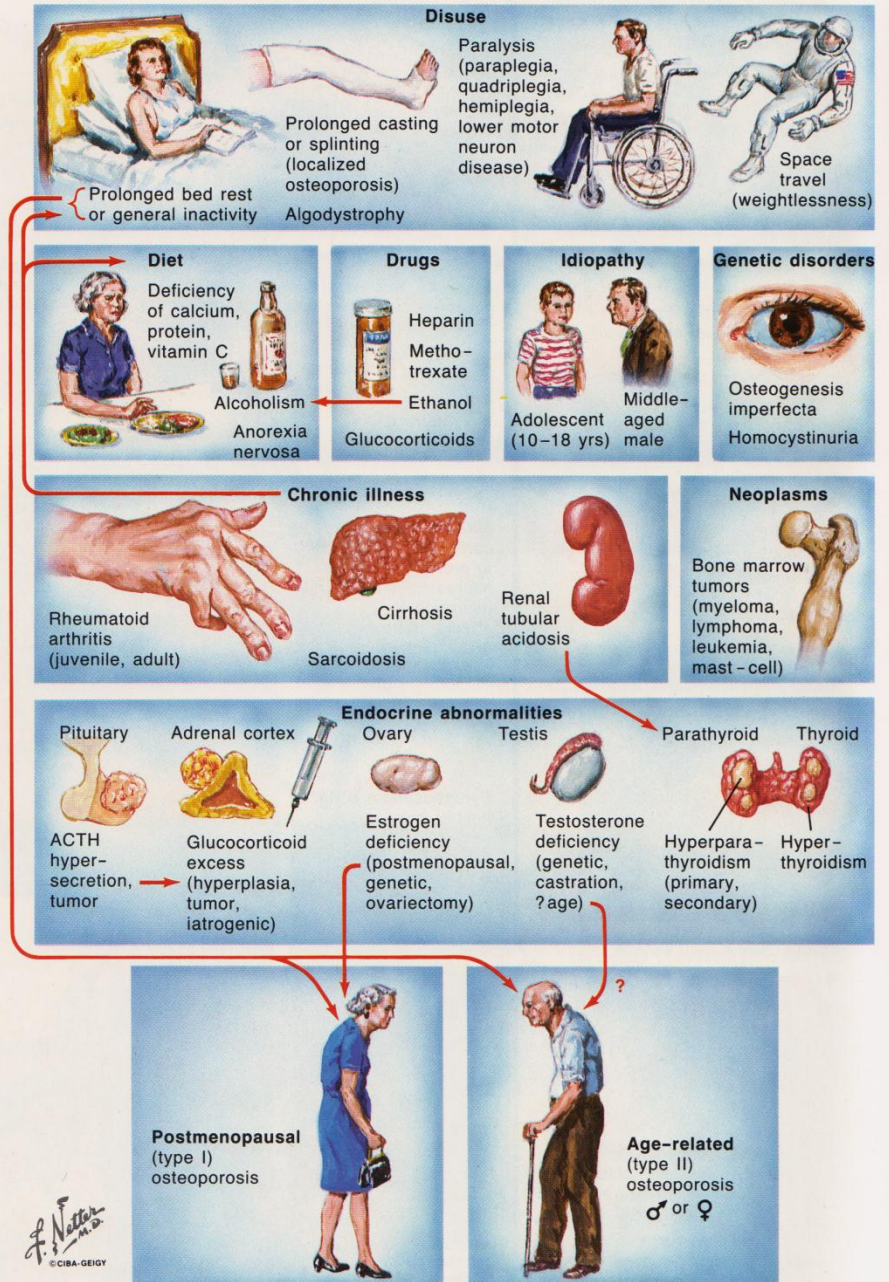
Proximal humerus

Distal radius

Most common types

Progressive thoracic kyphosis, or dowager's hump, with loss of height and abdominal protrusion

## Causes of Osteoporosis



Patiente de 48 ans, surcharge pondérale  
Fièvre et douleur de l'hypocondre droit

**Cholécystite aiguë**



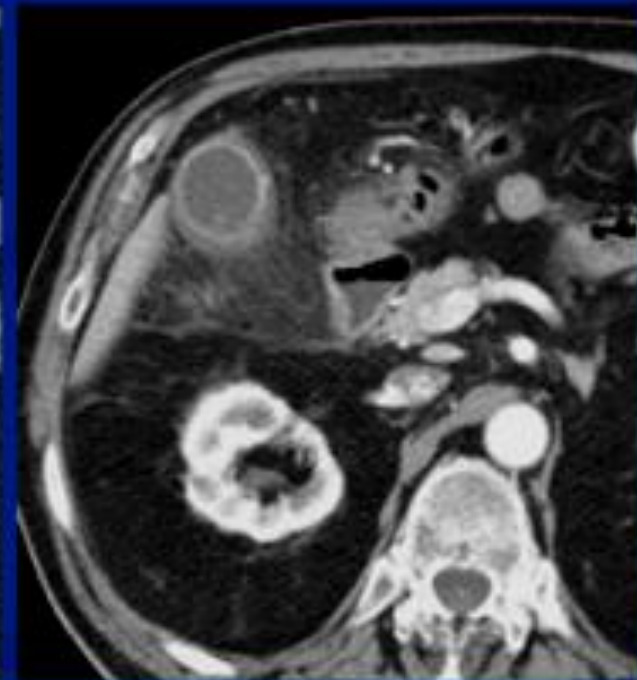
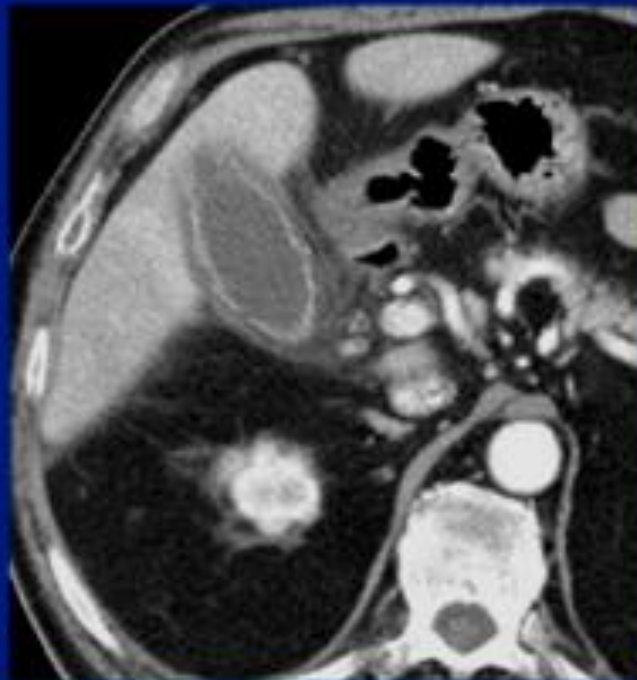
Echographie abdominale

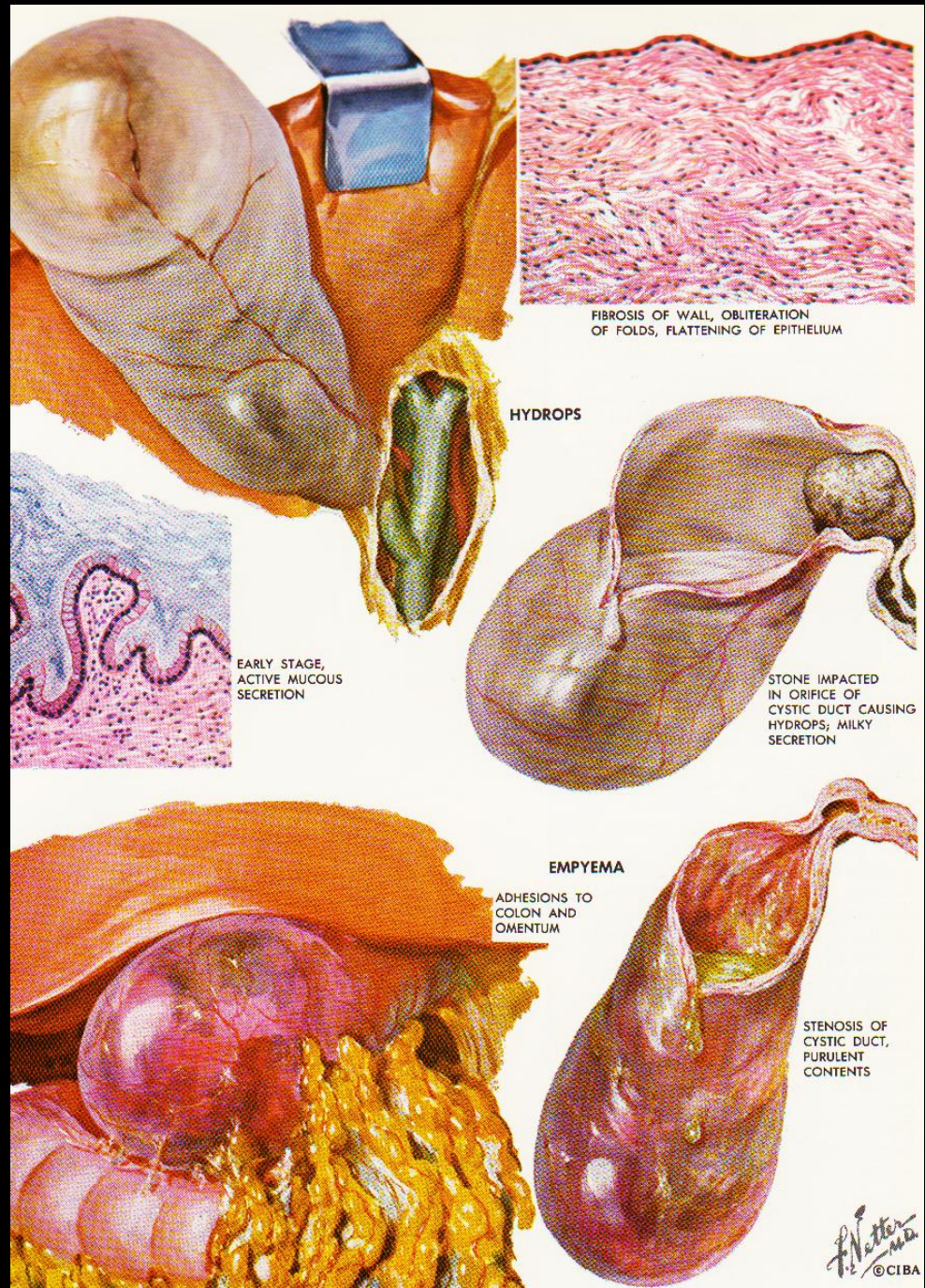
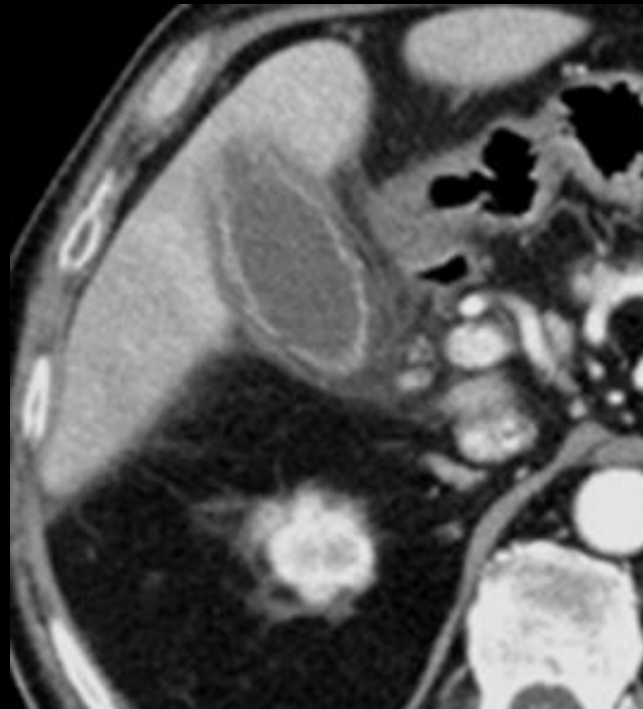
- Distension de la vésicule biliaire
- Épaississement pariétal
- Calcul vésiculaire avec cône d'ombre postérieur
- Murphy +



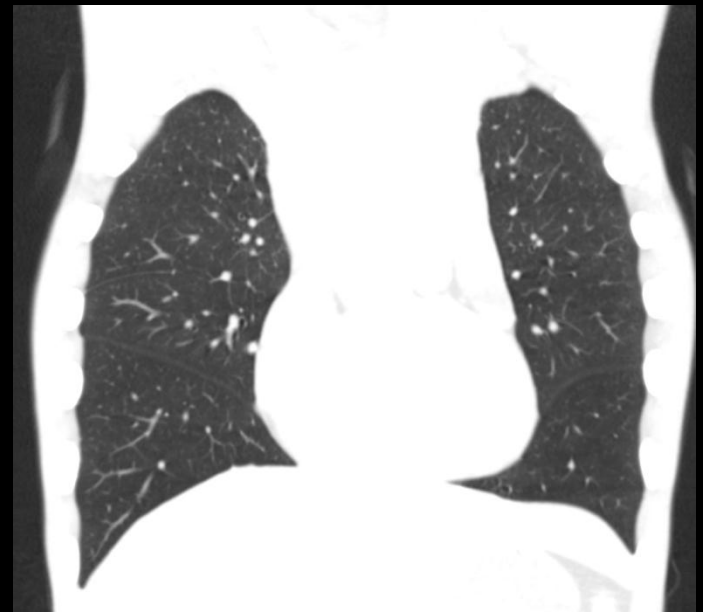
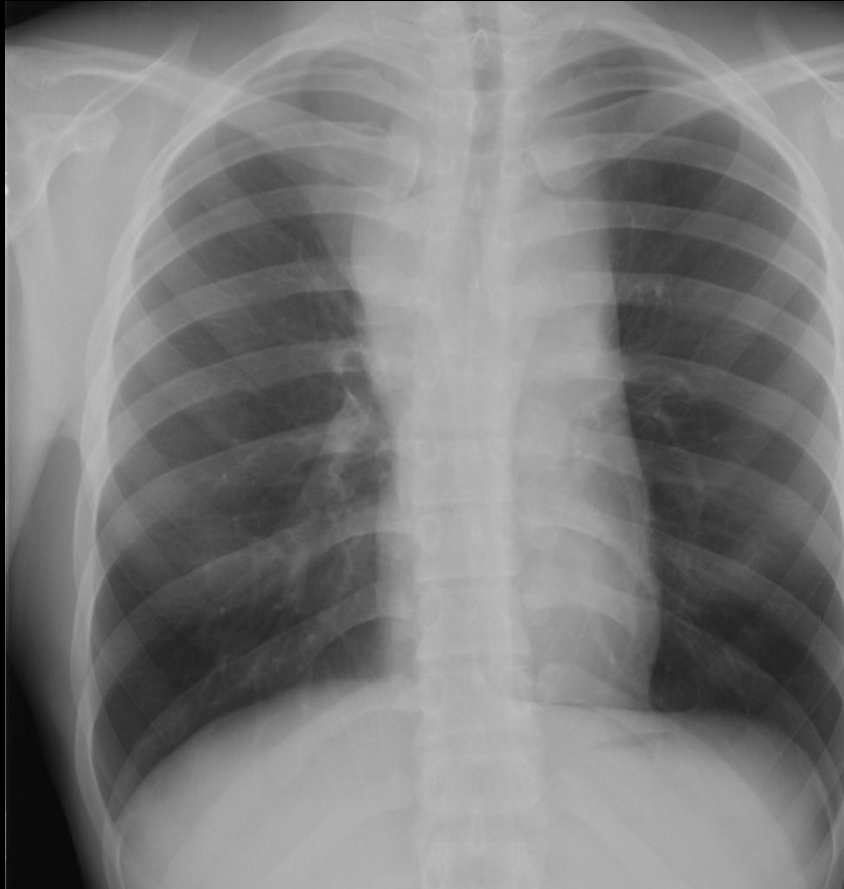
## **TDM :**

- **Infiltration inflammatoire locale de la graisse**
- **Bile hyperdense**
- **Épaississement pariétal**
- **calcul (+/-) => Cholécystite alithiasique**
- **trouble de la perfusion hépatique de contiguïté**
- **diagnostic des complications +++: collections péri vésiculaires**



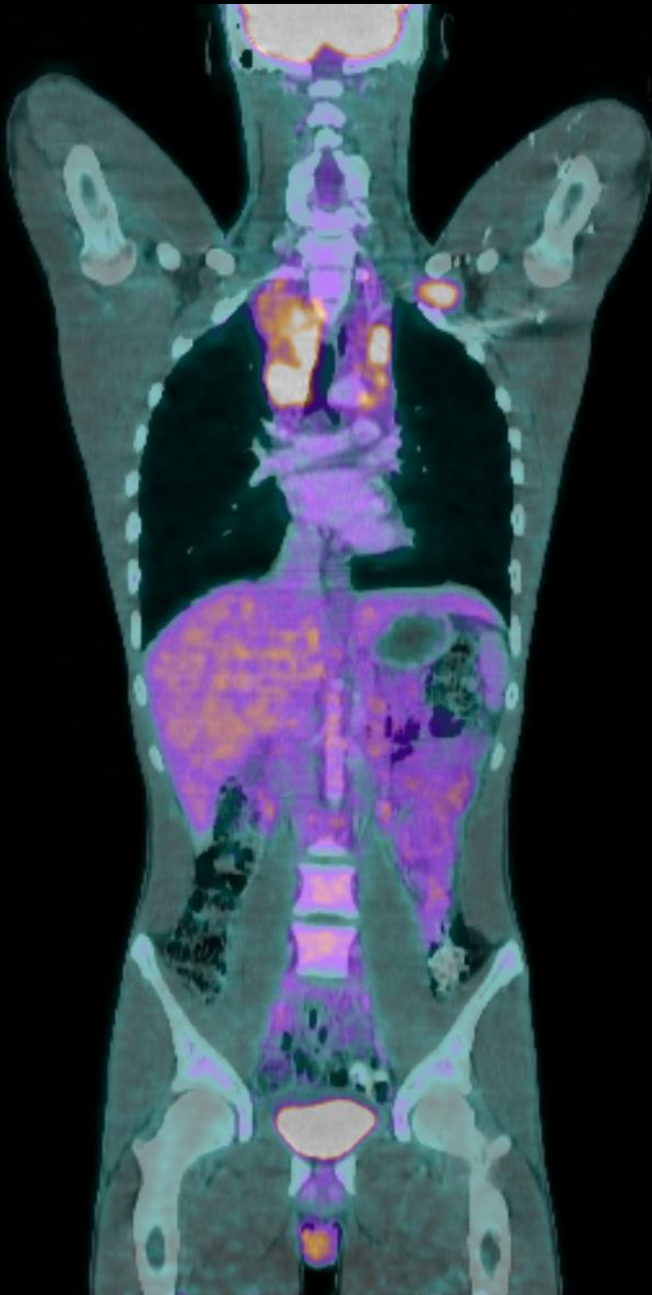


## Cas 14

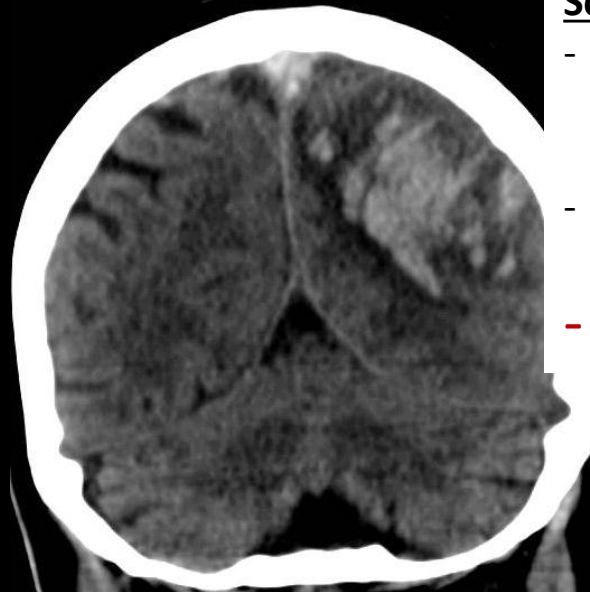
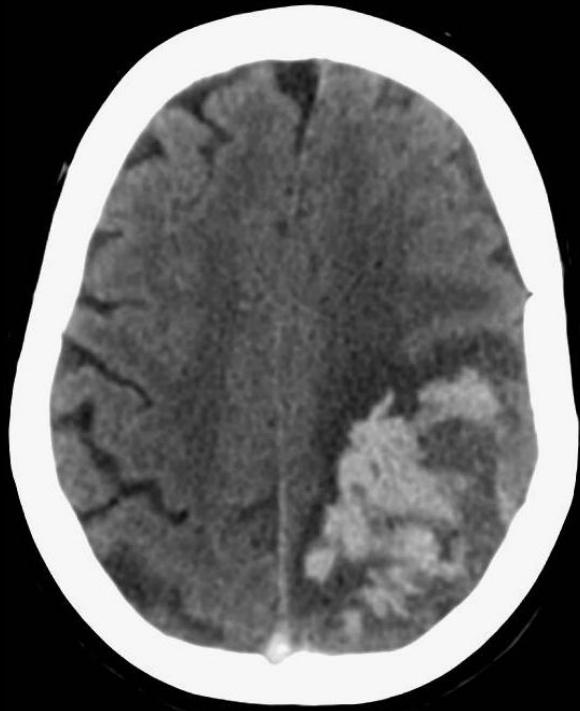


- Elargissement** du médiastin supérieur
- Aspect de **médiastin en cheminée**
- Pas de compression trachéale visible.

Polyadénopathies médiastinales supérieures et sus-claviculaires gauche



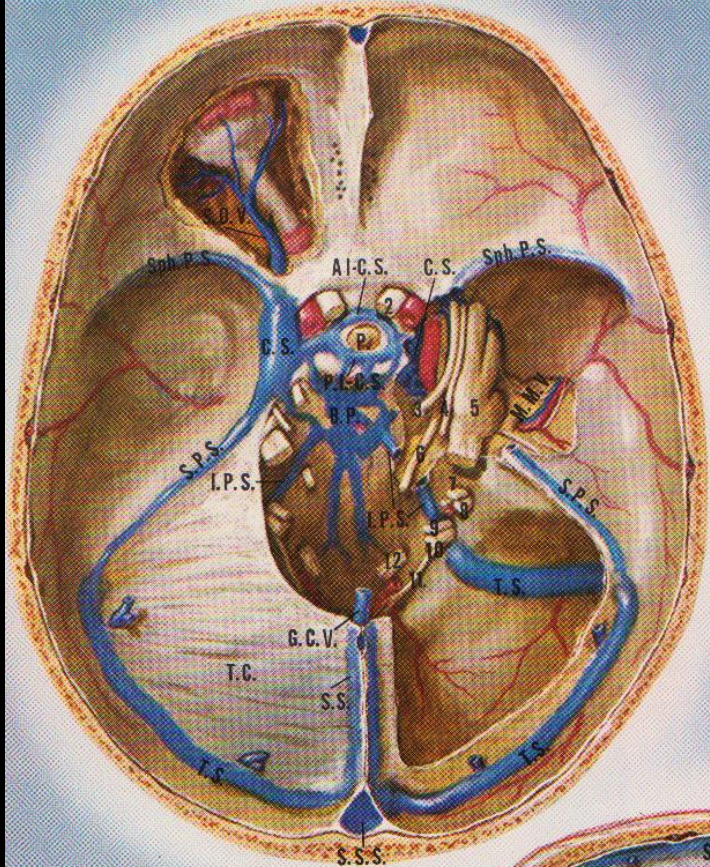
- **Maladie de Hodgkin**
- **Stade II sus-diaphragmatique**



Scanner cérébral sans et avec IV

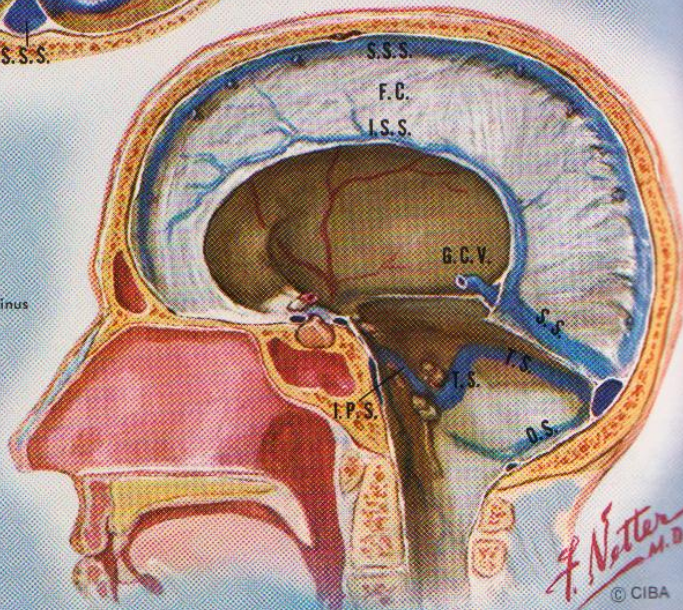
- Hématome intra parenchymateux pariétal gauche
- Hyperdensité spontanée du sinus longitudinal supérieur
- **Signe du Delta**

**Thrombophlébite cérébrale compliqué d'un hématome intra parenchymateux**



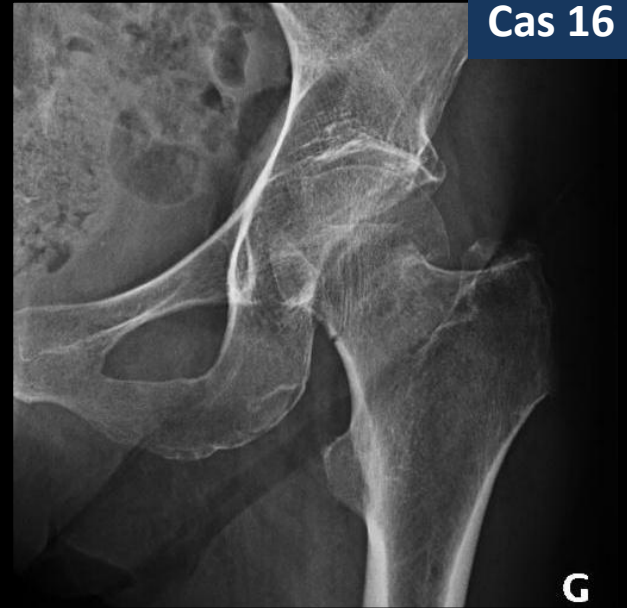
- A.I.C.S. — Anterior Intercavernous Sinus
- B.P. — Basilar Plexus
- C.S. — Cavernous Sinus
- G.C.V. — Great Cerebral Vein
- I.P.S. — Inferior Petrosal Sinus
- M.M.V. — Middle Meningeal Vein
- P. — Pituitary Gland
- P.I.C.S. — Posterior Intercavernous Sinus
- S.O.V. — Superior Ophthalmic Vein
- S.P.S. — Superior Petrosal Sinus
- Sph.P.S. — Spheno-Parietal Sinus
- S.S. — Straight Sinus
- S.S.S. — Superior Sagittal Sinus
- T.C. — Tentorium Cerebelli
- T.S. — Transverse Sinus

- F.C. — Falx Cerebri
- I.S.S. — Inferior Sagittal Sinus
- O.S. — Occipital Sinus



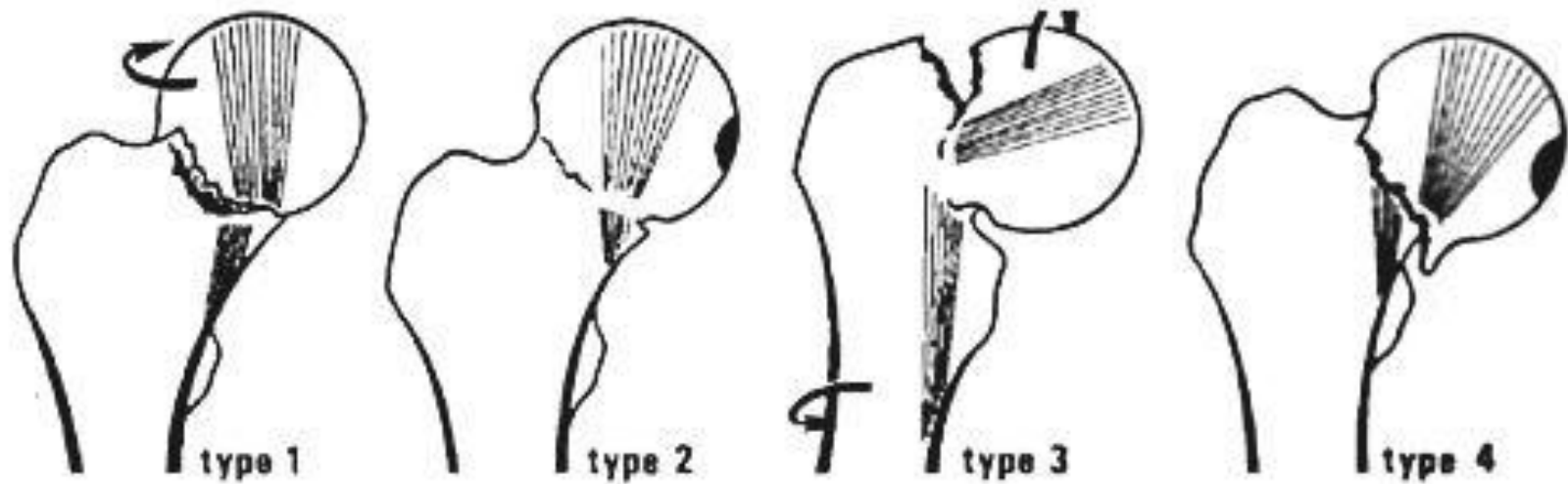
*F. Netter M.D.*  
© CIBA

- Femme de 68 ans, chute sur le côté gauche de sa hauteur.
- Impotence complète à la marche avec douleur de hanche gauche.
  - a



- Fracture du col fémoral gauche (cervicale vraie)
- Engrainée en valgus (verticalisation des travées osseuses)
- Garden I.



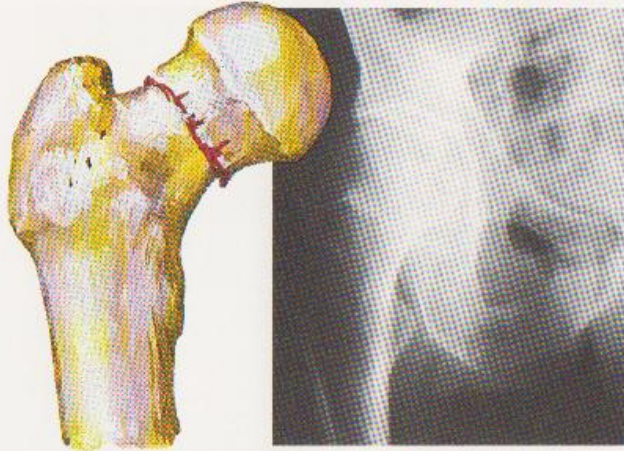


## CLASSIFICATION DE GARDEN

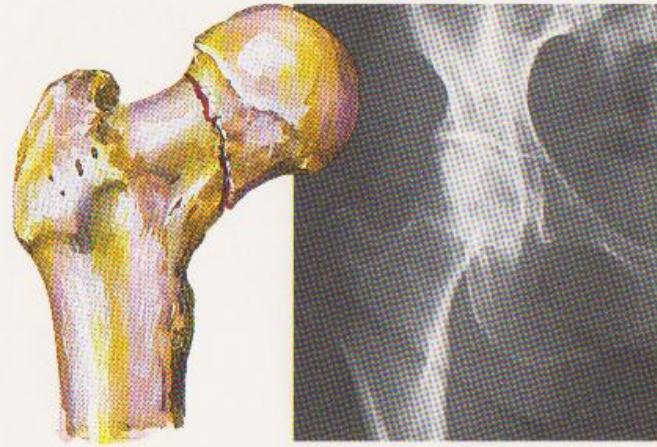
1961



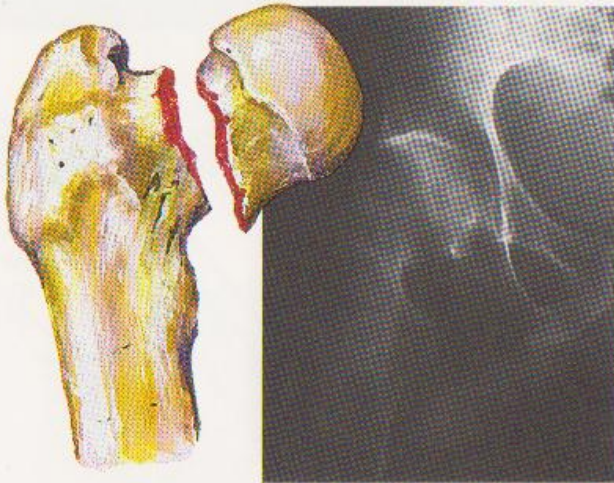
## Intracapsular Fracture of Femoral Neck



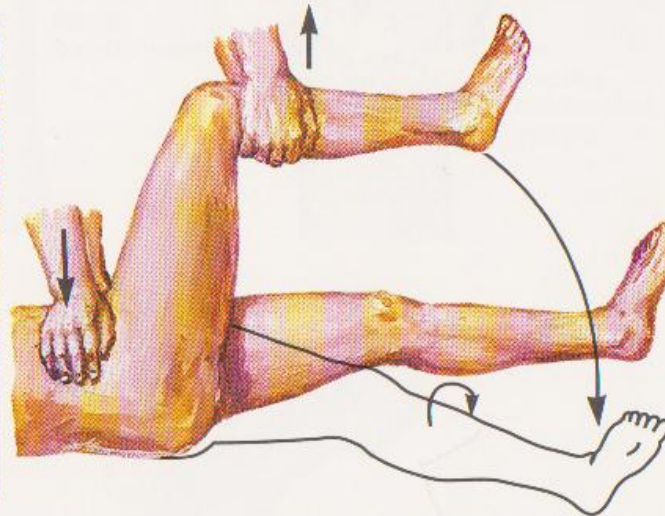
Impacted fracture



Nondisplaced fracture



Displaced fracture. Vertical fracture line generally suggests poorer prognosis



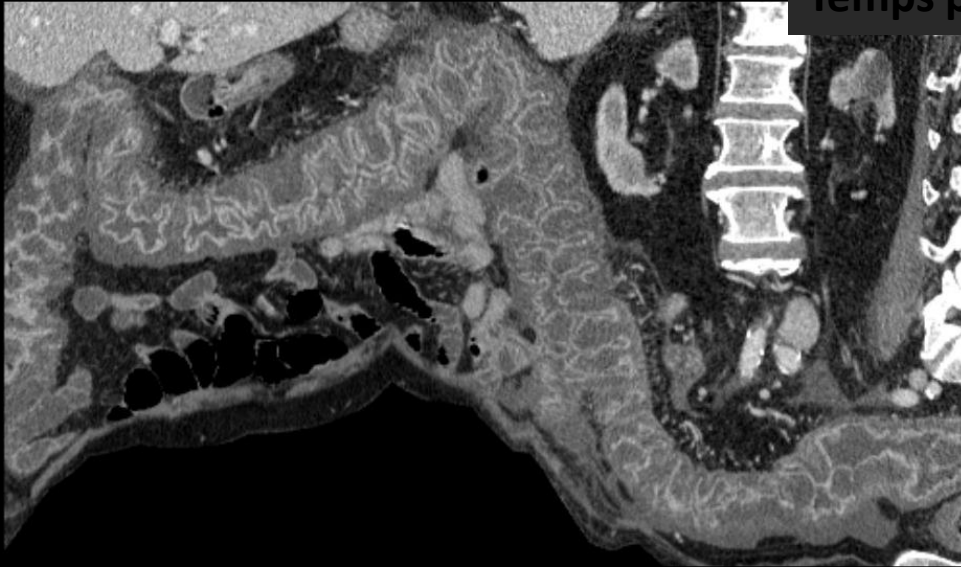
Reduction of displaced fracture with Leadbetter maneuver. With knee flexed, slightly abducted limb slowly flexed to 90°, and upward traction applied as assistant fixes pelvis. Limb then gently extended, adducted, and internally rotated. (Near-perfect reduction essential)

## Cas 17

- Diarrhée fébrile depuis 10 jours
- ATCD : diabète, Polyarthrite rhumatoïde sous Cortancyl

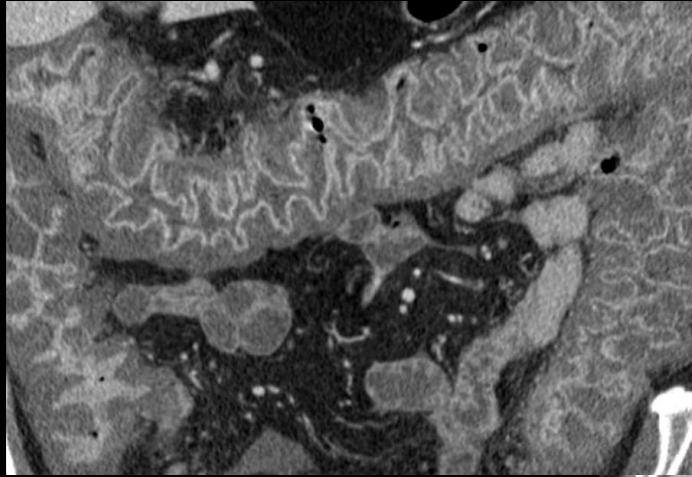


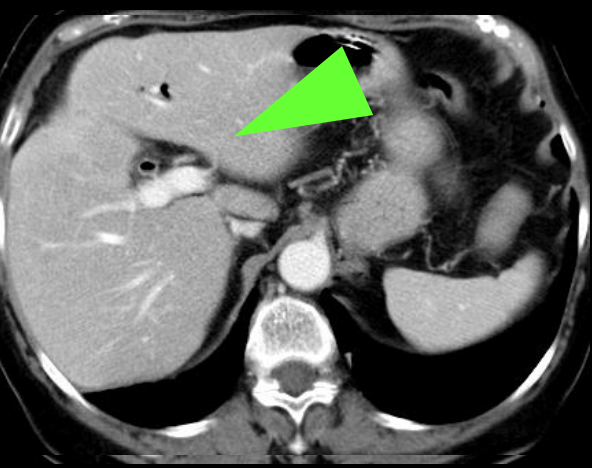
Temps portal



**Colite pseudo-membraneuse**

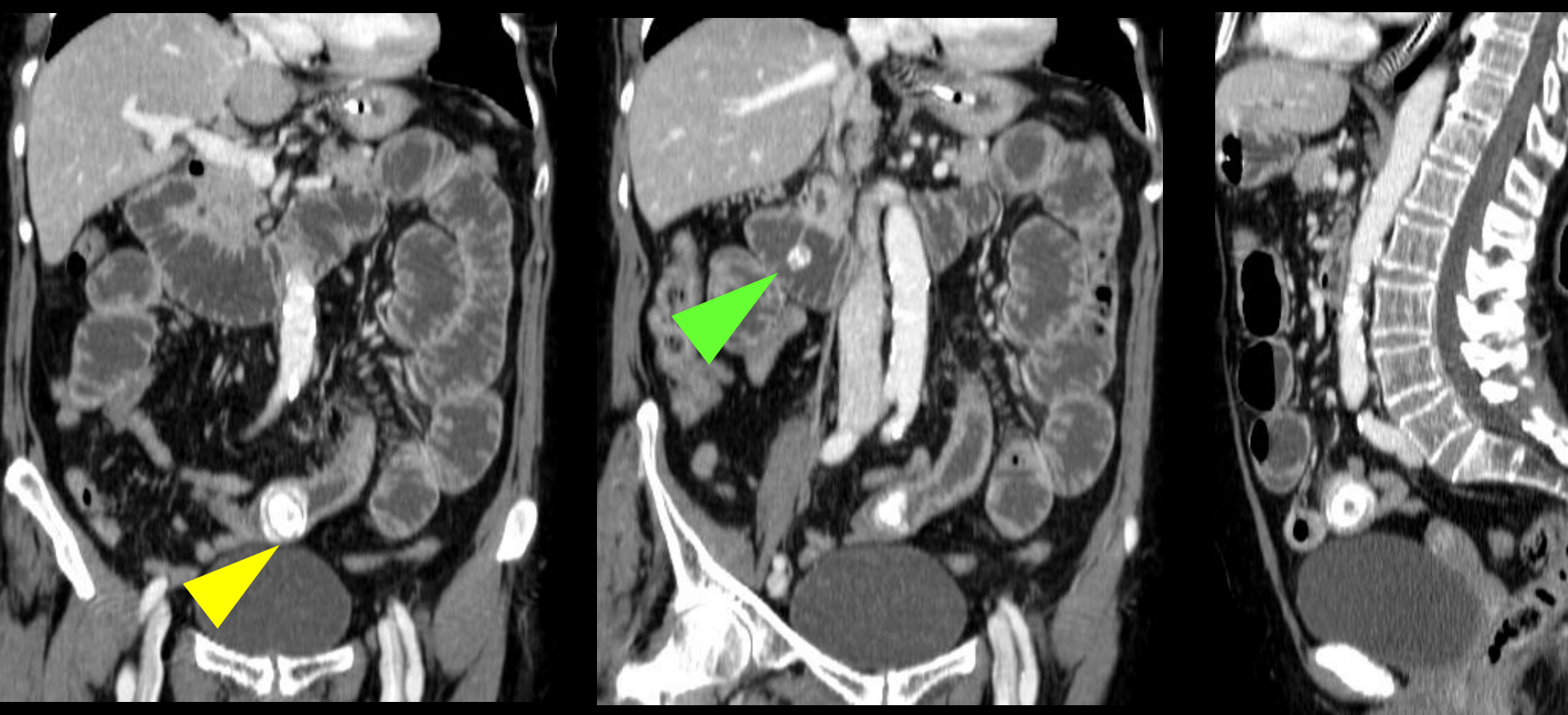






Femme 74 ans. Syndrome occlusif

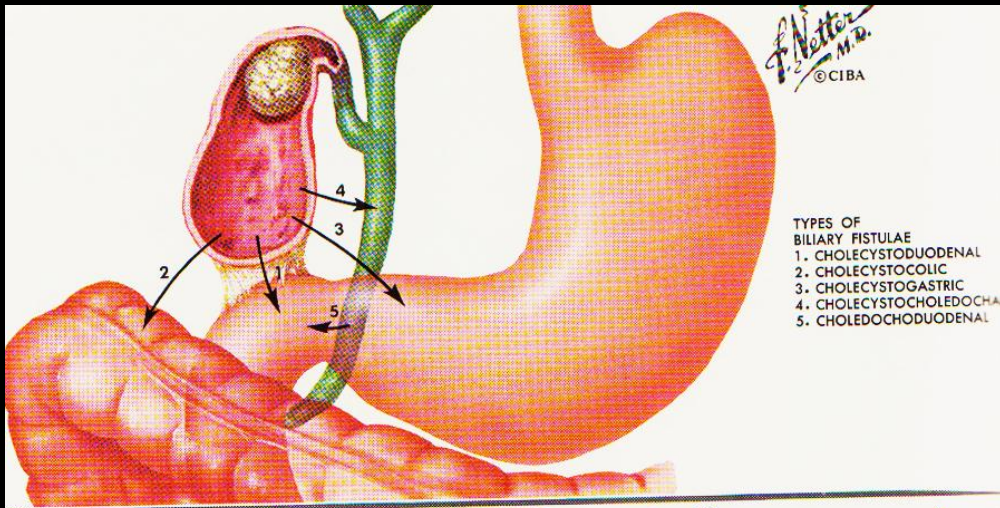
- Syndrome occlusif du grêle
- calcul calcifié au sein du grêle
- aérobilie



## **ILEUS BILIAIRE**

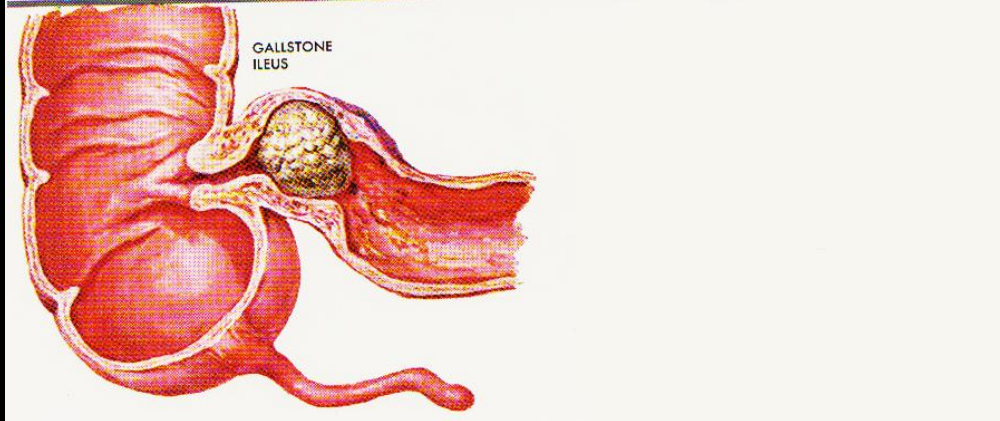
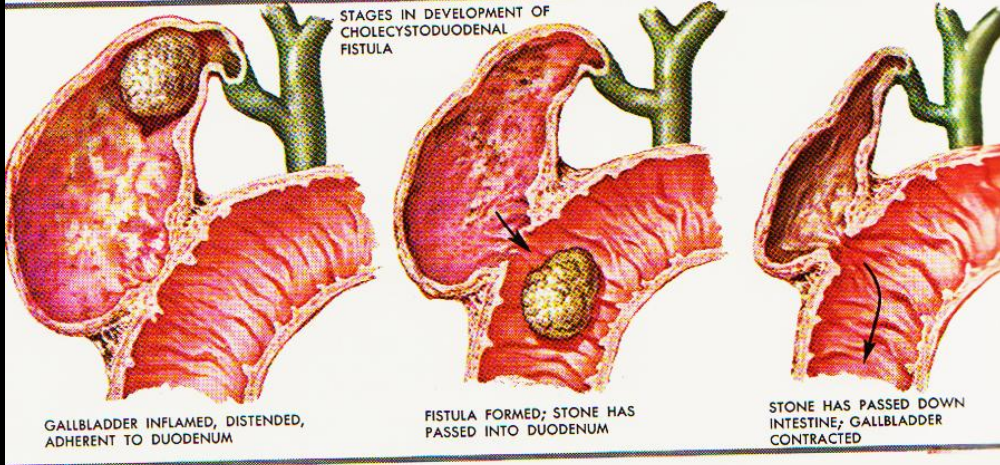
- ⇒ **Calcul d'origine biliaire enclavé au niveau jéjunal**
- ⇒ **Distension du grêle d'amont**
- ⇒ **2<sup>ème</sup> calcul biliaire en D3**





*F. Netter M.D.*  
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- TYPES OF BILIARY FISTULAE
1. CHOLECYSTODUODENAL
  2. CHOLECYSTOGASTRIC
  3. CHOLECYSTOGASTRIC
  4. CHOLECYSTOCHOLEDOCHAL
  5. CHOLEDOCHODUODENAL

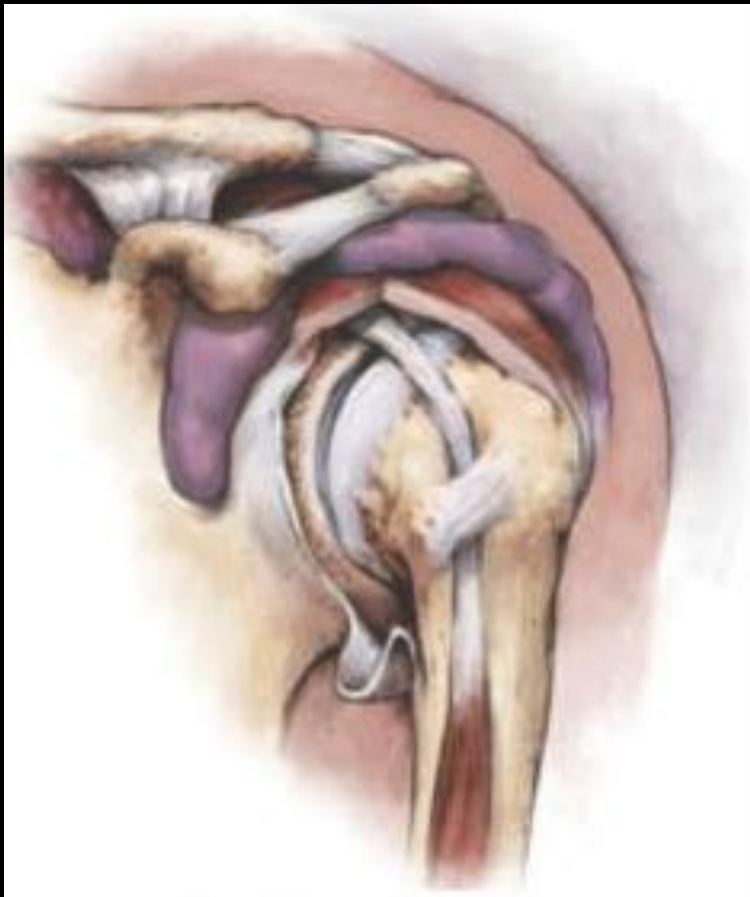


- Homme de 47 ans, maçon
- Douleurs chroniques de l'épaule gauche récemment aggravées avec limitation des amplitudes articulaires.

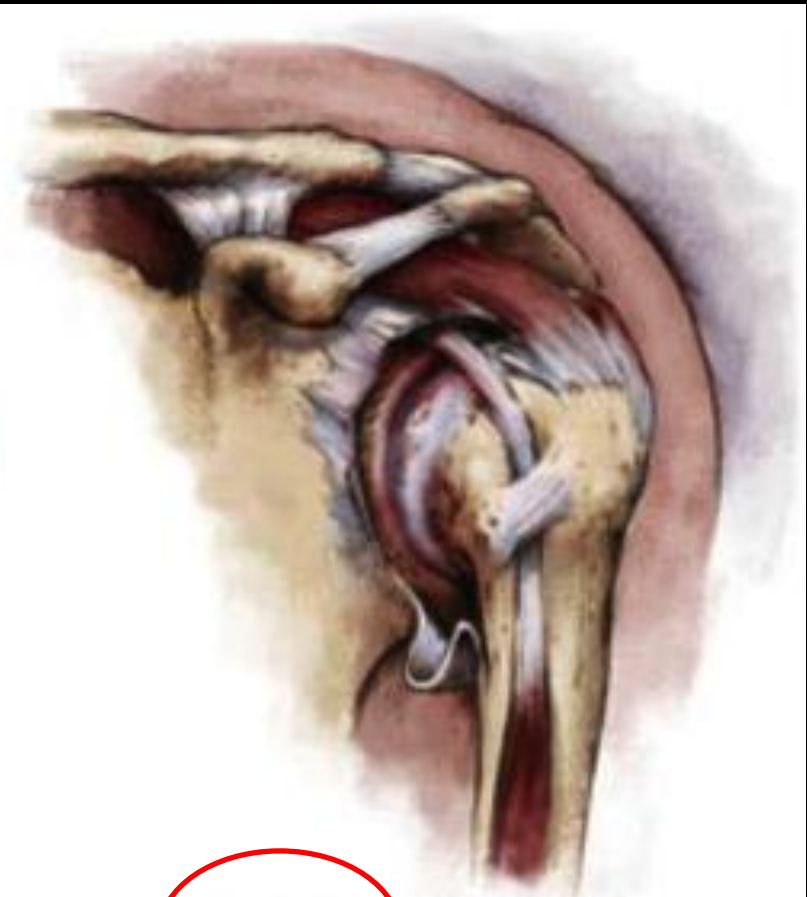


- Déformation céphalique humérale avec aplatissement de la tête.
- Production osseuse de la glène (ostéophytes)
- Respect du cintre gléno-huméral
- Respect de l'interligne huméro-acromial

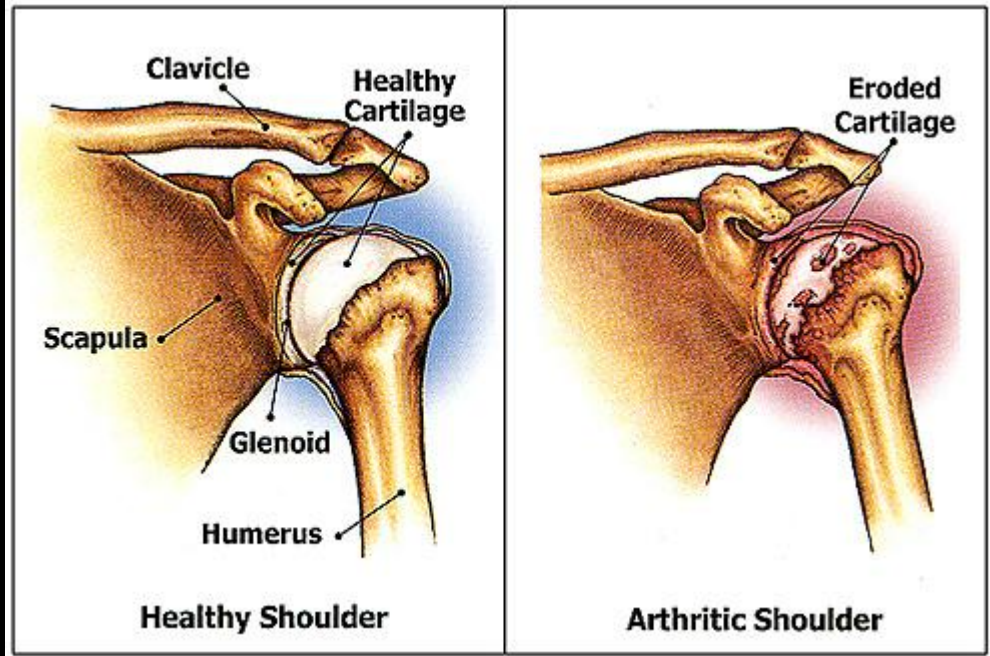
**Omarthrose centrée primitive**



Healthy Shoulder



Arthritic Shoulder

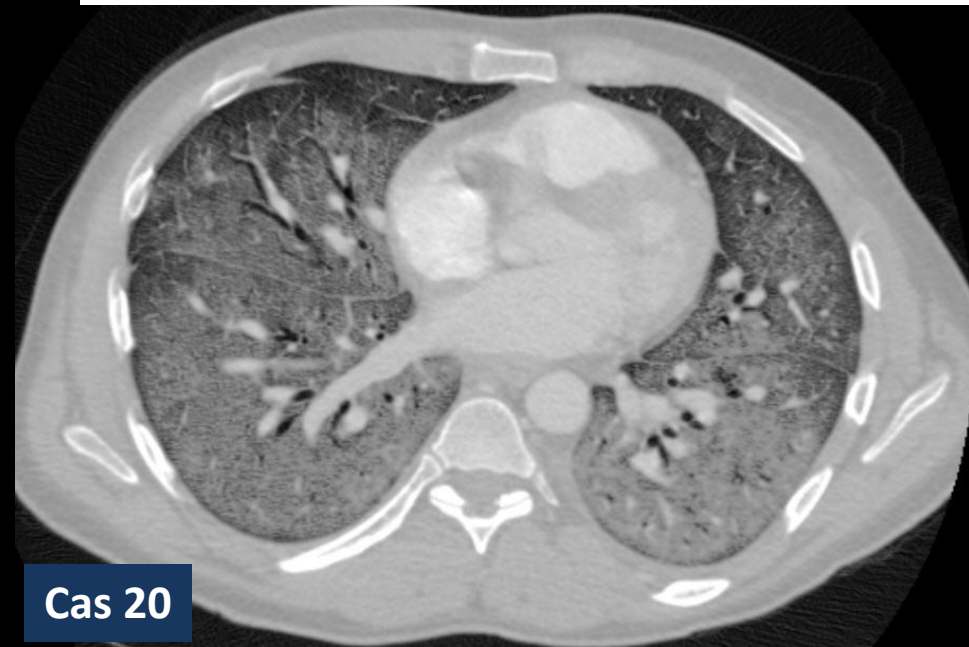


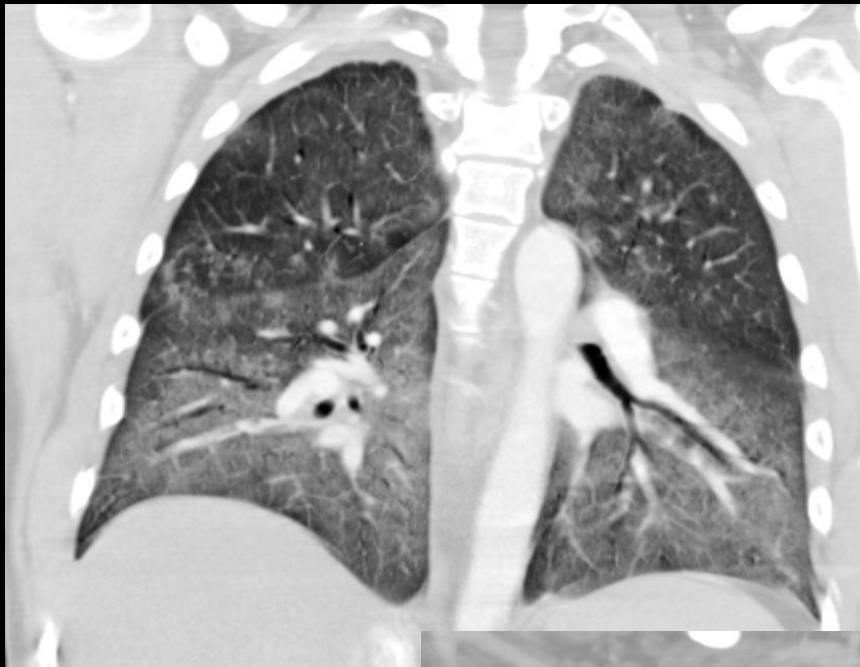


**Homme de 37 ans, pas d'ATCD**

**Tabagisme actif**

**Pneumopathie aiguë hypoxémiante : toux sèche, dyspnée, 38,3° C**

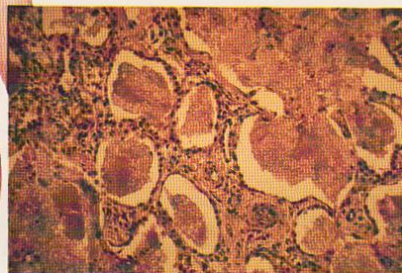
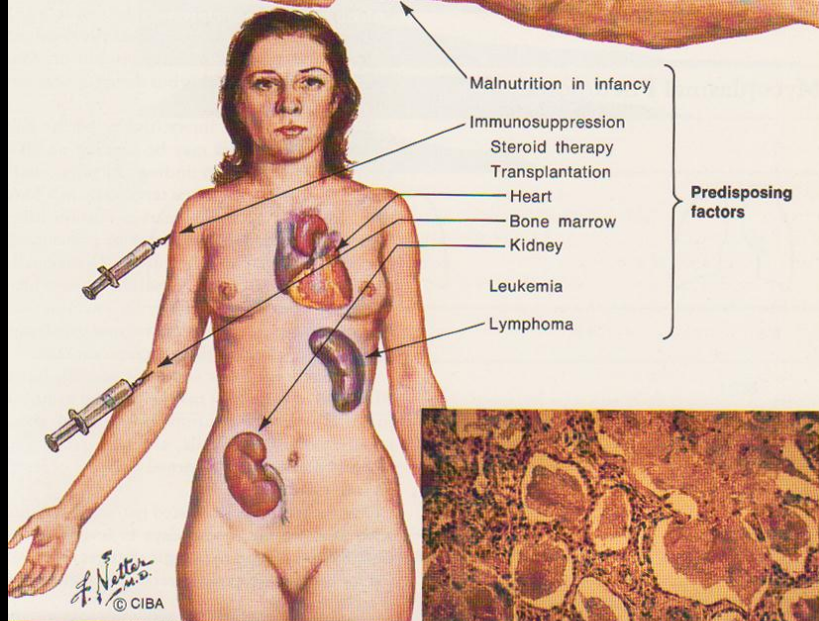
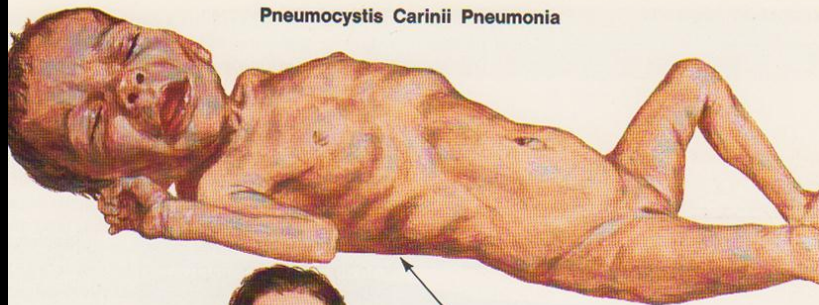




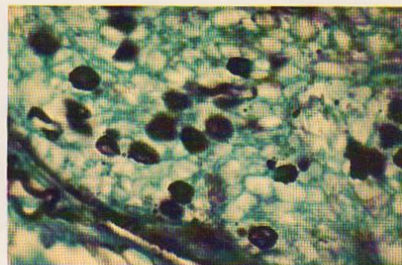
Diagnostic différentiel: CMV , grippe, mycoplasme

**Pneumocystis Jiroveci**

**Pneumocystis Carinii Pneumonia**



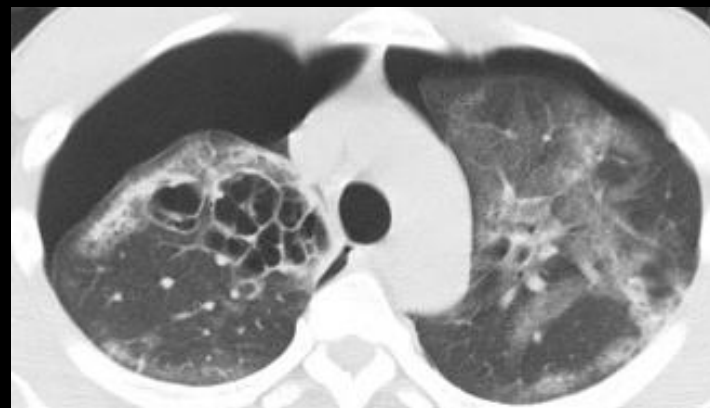
Interstitial lymphocyte and plasma cell infiltration with foamy exudate in alveoli



Methenamine AgNo<sub>3</sub> stain showing *Pneumocystis* organisms in lung (black spots)



Diffuse bilateral pulmonary infiltrates



Cas 21



Homme de 32 ans, pas d'ATCD  
Douleur lombaire gauche  
Pas de fièvre  
BU: hématurie

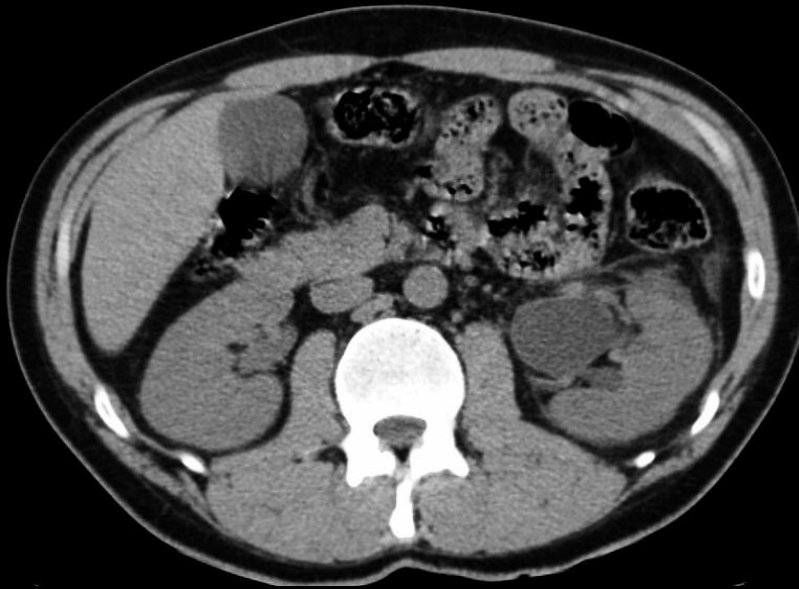
Scanner abdomino pelvien non injecté

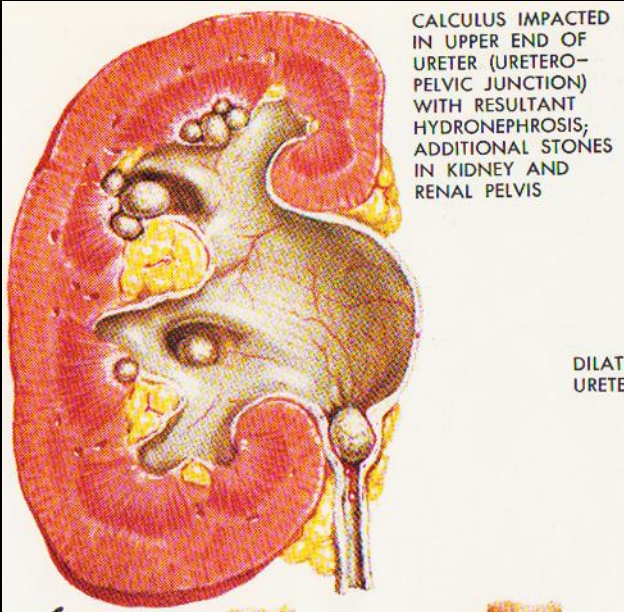
Plan axial

Dilatation des cavités pyélocalicielle du rein gauche

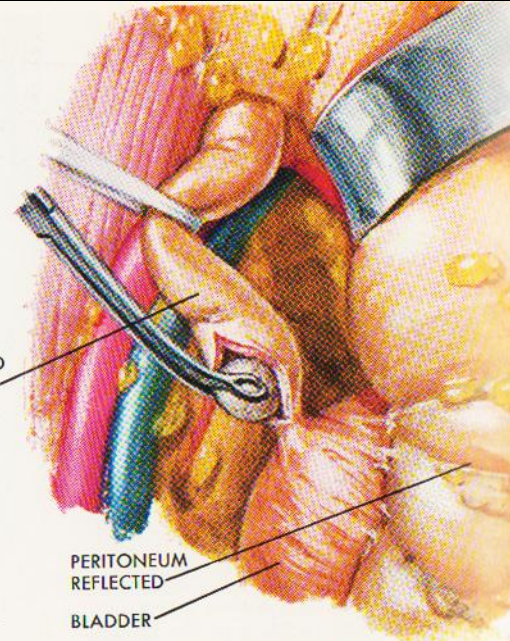
Calcul radioopaque à la jonction pyélo-urétérale

**Colique néphrétique gauche**





CALCULUS IMPACTED IN UPPER END OF URETER (URETERO-PELVIC JUNCTION) WITH RESULTANT HYDRONEPHROSIS; ADDITIONAL STONES IN KIDNEY AND RENAL PELVIS



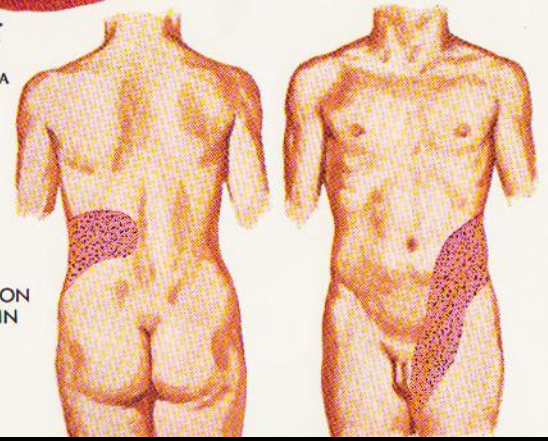
DILATED URETER

PERITONEUM REFLECTED

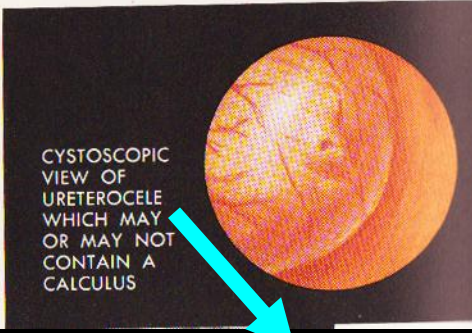
BLADDER

STONE IN LOWER END OF URETER IN PROCESS OF REMOVAL THROUGH URETEROSTOMY

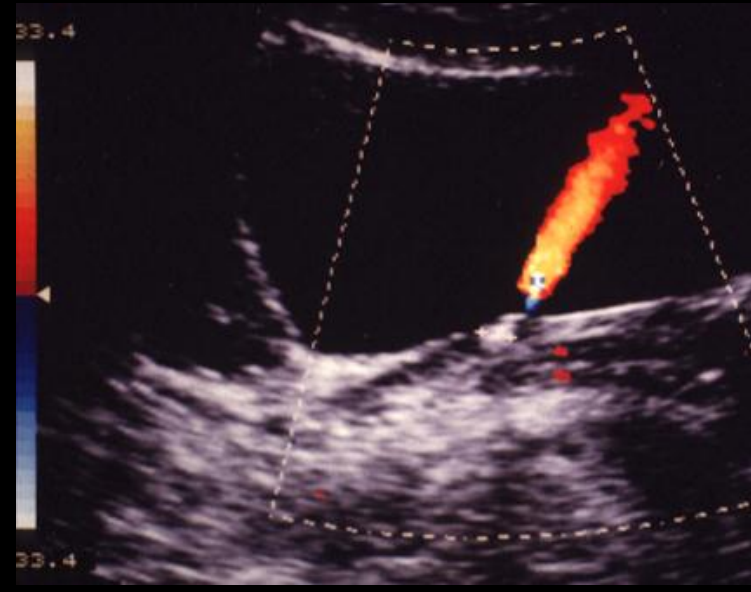
*J. Netter M.D.*  
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DISTRIBUTION OF PAIN IN URETERAL COLIC



CYSTOSCOPIC VIEW OF URETEROCELE WHICH MAY OR MAY NOT CONTAIN A CALCULUS

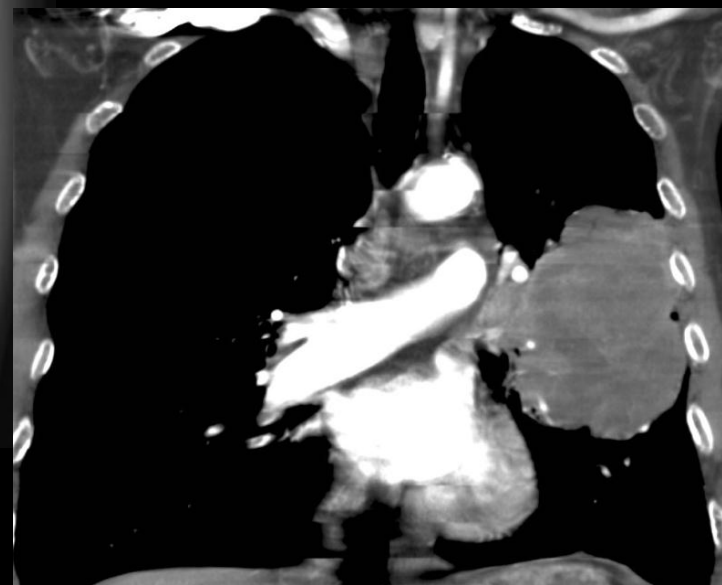


calcul partiellement obstructif du méat urétéral ; jet urinaire accéléré

**Patient de 63 ans**  
**Tabagisme actif à 50 PA**  
**Crachats hémoptoïques**

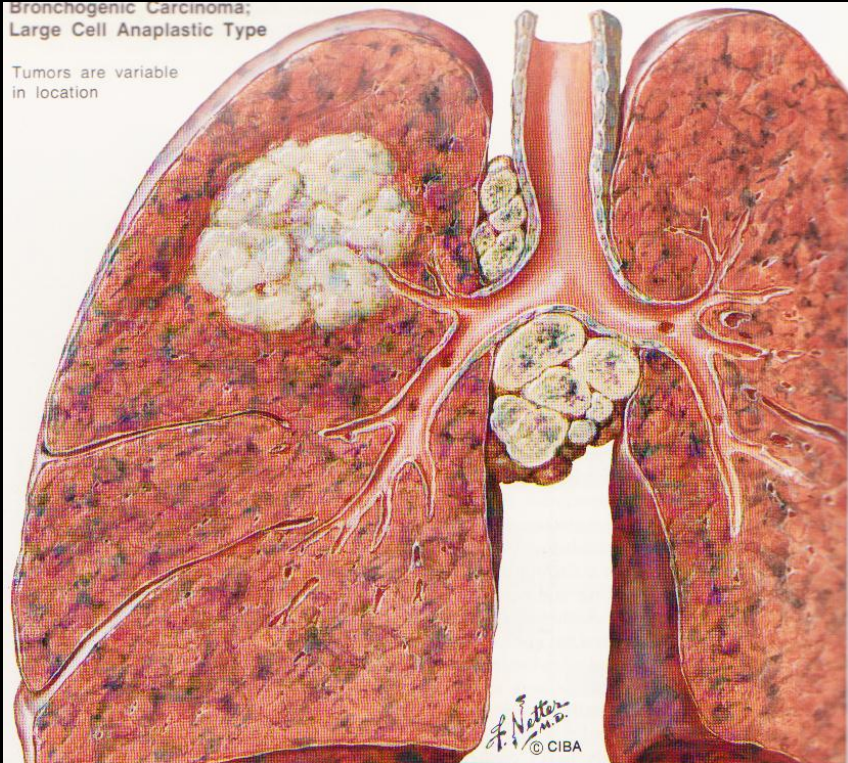
**Radiographie thoracique de face**

- **Emphysème sévère avec volumineuse bulle de l'apex droit**
- **Opacité pulmonaire gauche, hilare, hétérogène**

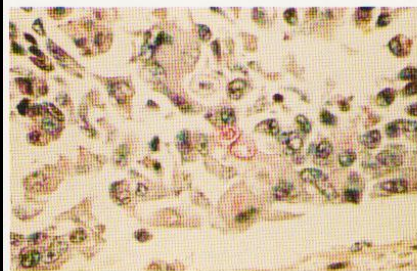


**Bronchogenic Carcinoma;  
Large Cell Anaplastic Type**

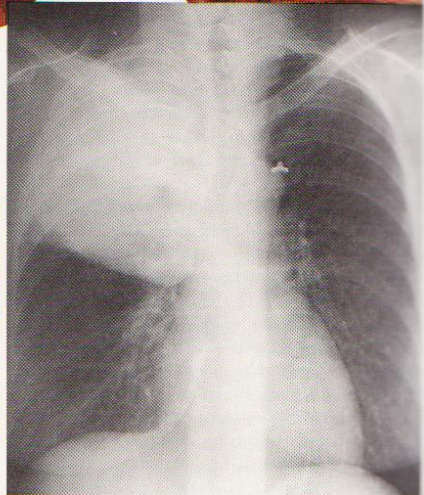
Tumors are variable  
in location



Large cell anaplastic carcinoma  
in middle of r. upper lobe with  
extensive involvement of hilar  
and carinal nodes. Distortion of  
trachea and widening of carina

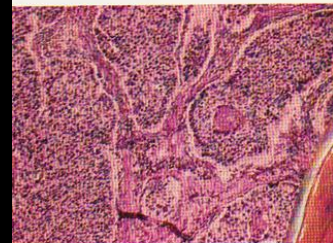


Tumor composed of large multinucleated  
cells without evidence of differentiation  
toward gland formation or squamous  
epithelium. These cells produce mucin  
(stained red). Some tumors may be composed  
of large clear cells containing glycogen

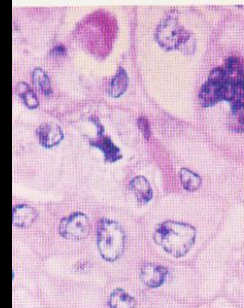


Atelectasis of r. upper lobe obscuring  
carcinoma which has obstructed stem of  
main bronchus

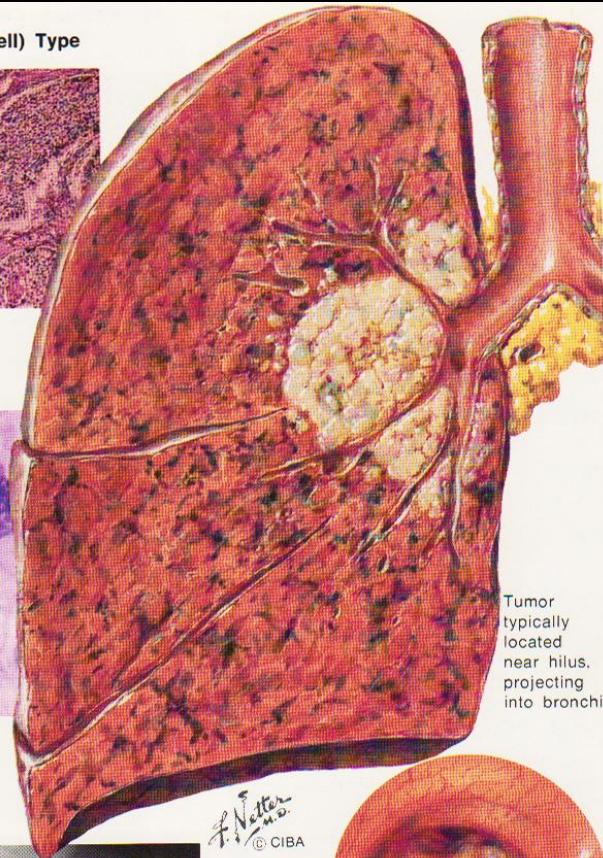
**Bronchogenic Carcinoma:  
Squamous Cell (Squamous Cell) Type**



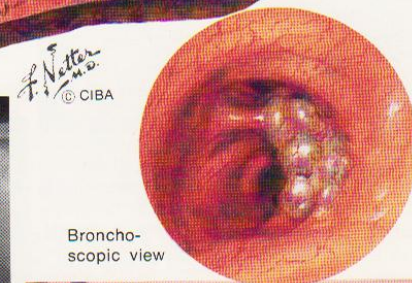
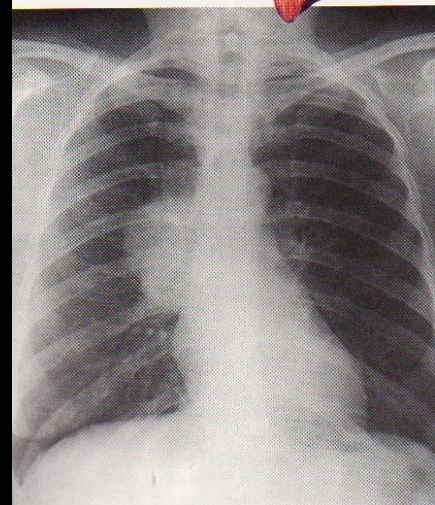
Low power (H and E); nests  
of tumor cells separated by  
fibrous bands. Keratin (horn)  
pearls present



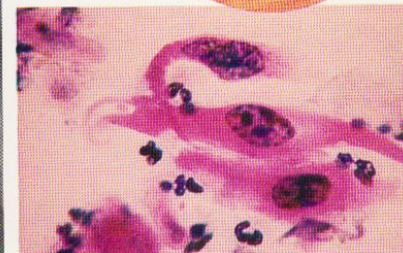
High power; nuclear  
pleomorphism and individual  
cell keratinization (pink)



Tumor  
typically  
located  
near hilus,  
projecting  
into bronchi

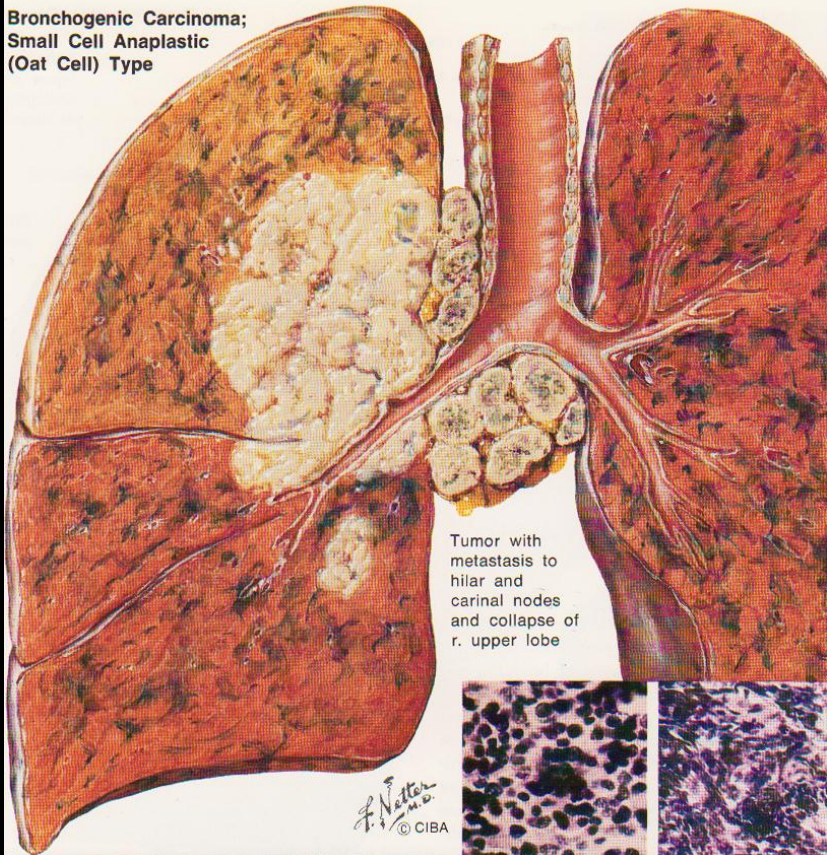


Broncho-  
scopic view

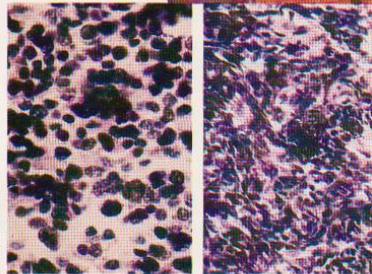


Cytologic smear from sputum or broncho-  
scopic scraping. Cells with dark nuclei and  
cytoplasm strongly pink because of keratin

**Bronchogenic Carcinoma;  
Small Cell Anaplastic  
(Oat Cell) Type**

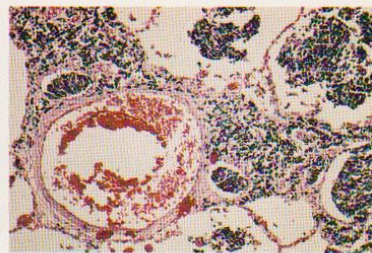


Tumor with metastasis to hilar and carinal nodes and collapse of r. upper lobe



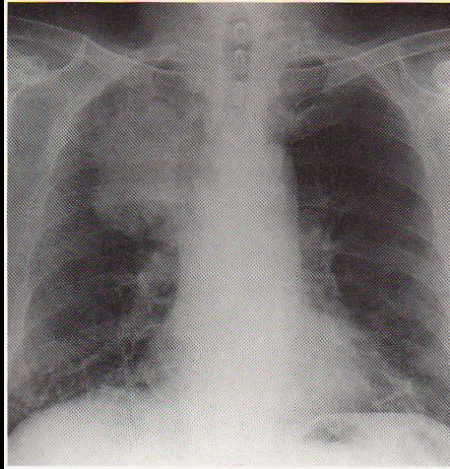
Masses of small cells with hyperchromatic round to oval nuclei and scant cytoplasm

Biopsy specimen. Cells elongated (oatlike)

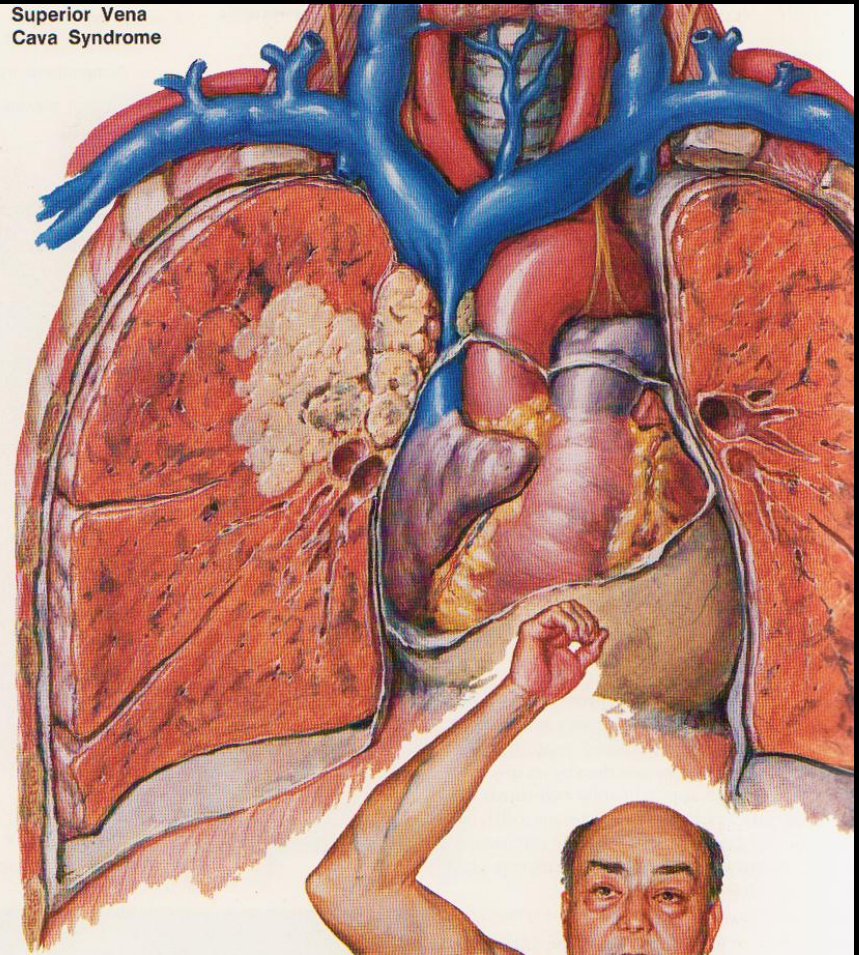


Intrapulmonary lymphatic spread of neoplasm

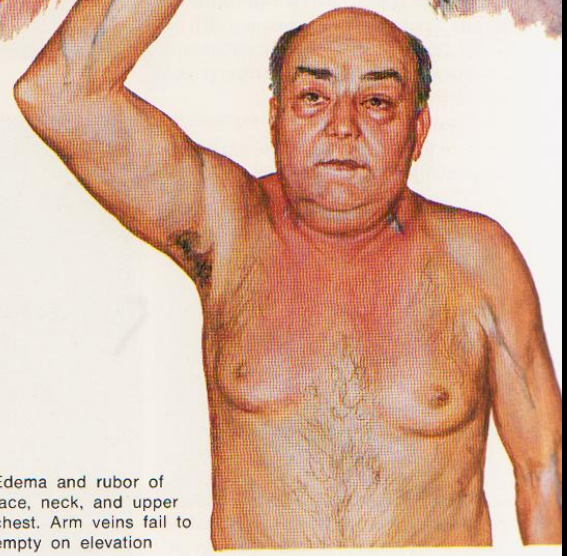
*F. Netter M.D.*  
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**Superior Vena  
Cava Syndrome**



Obstruction of superior vena cava by cancerous invasion of mediastinal lymph nodes, with distention of brachiocephalic (innominate), jugular, and subclavian veins and tributaries

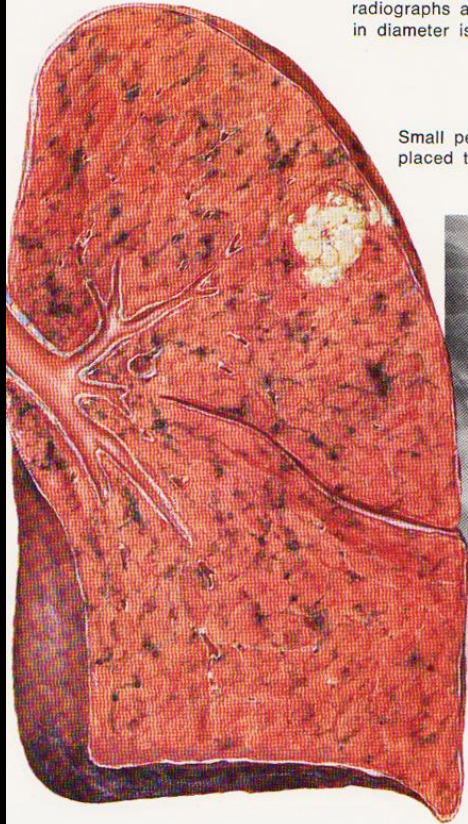


Edema and rubor of face, neck, and upper chest. Arm veins fail to empty on elevation

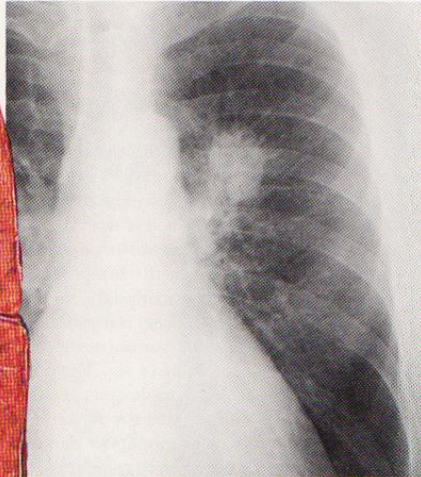
*F. Netter M.D.*  
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### Bronchogenic Carcinoma; Adenocarcinoma

Although it is not possible to distinguish different histologic types of bronchogenic carcinoma from gross specimens or radiographs alone, a peripherally located tumor < 4 cm in diameter is most likely to be adenocarcinoma

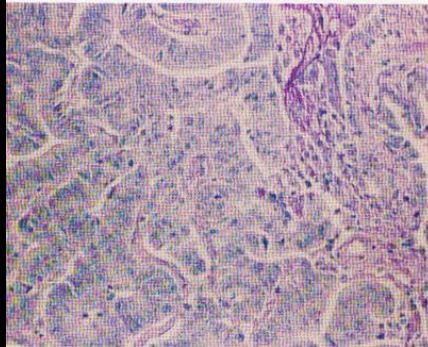


Small peripherally placed tumor, I. upper lobe

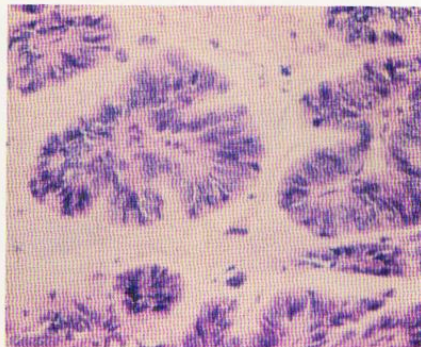


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### Varied histology of adenocarcinoma

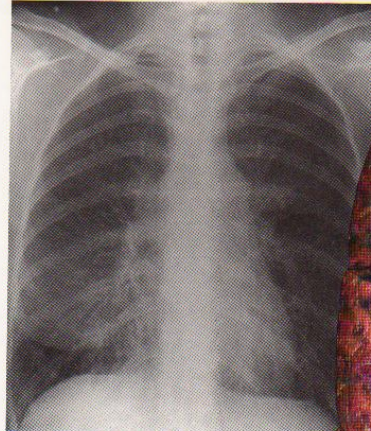


Tumor cells form glandlike structures with or without mucin secretion

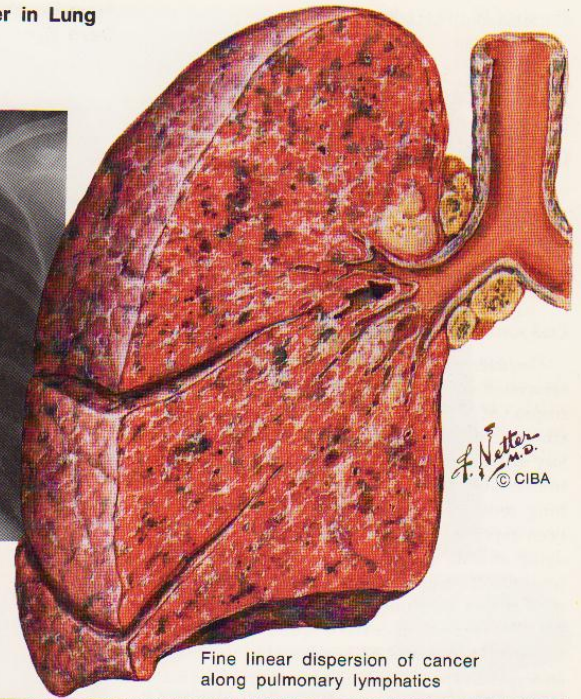


Tumor cells may also form papillary structures

### Lymphangitic Spread of Cancer in Lung



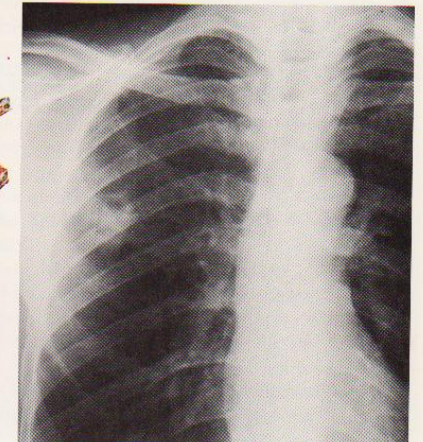
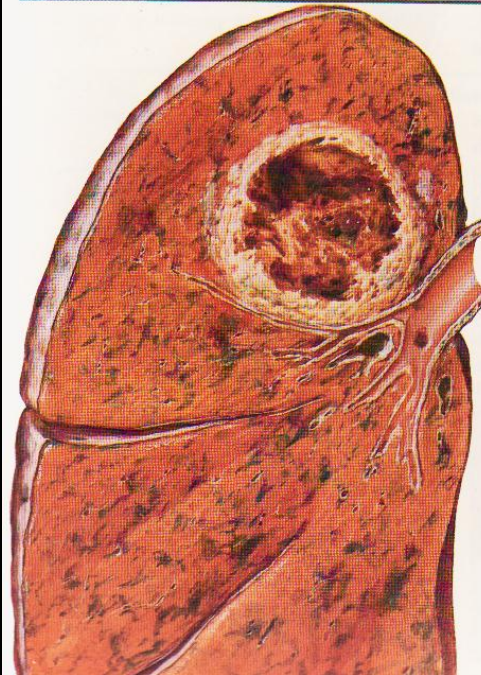
Bilateral lymphangitic cancerous permeation. One or both lungs may be involved, giving a weblike effect. Tumor may be primary or metastatic



Fine linear dispersion of cancer along pulmonary lymphatics

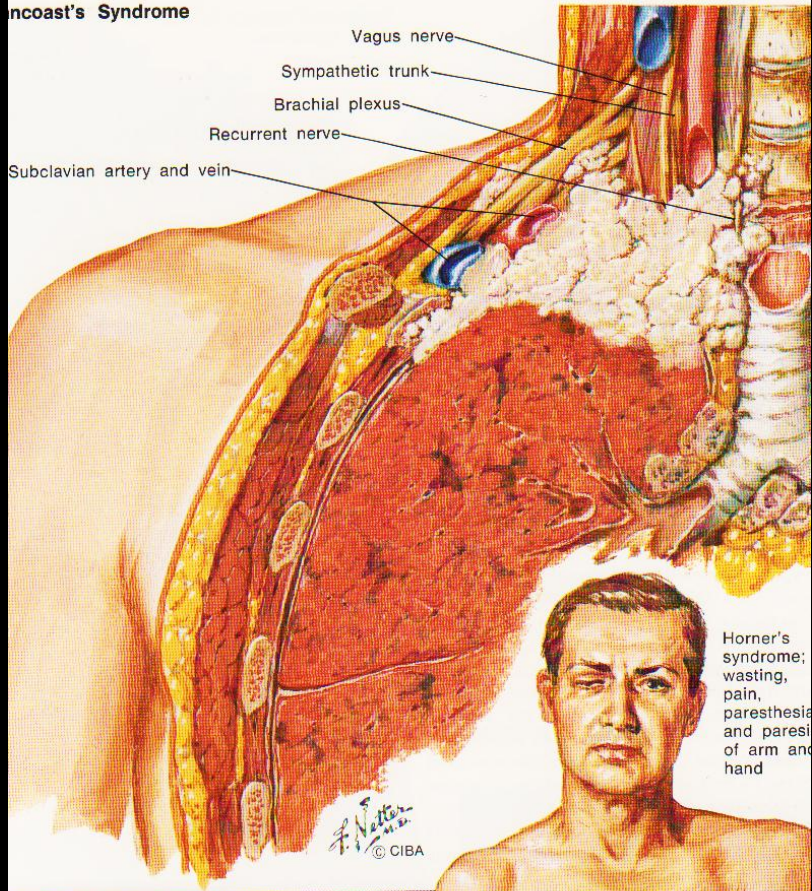
F. Netter M.D. © CIBA

### Cavitation of Lung Cancer



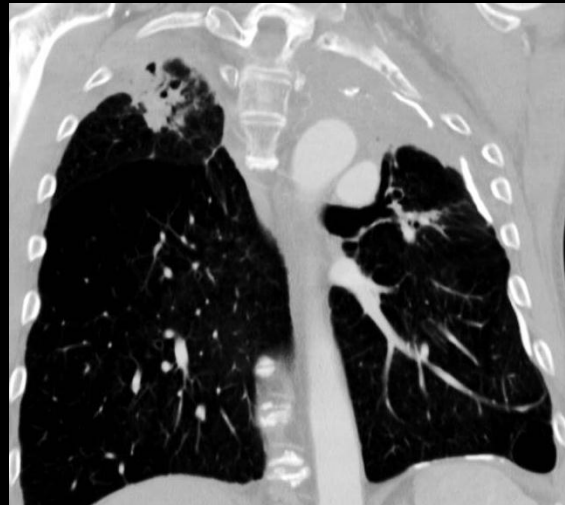
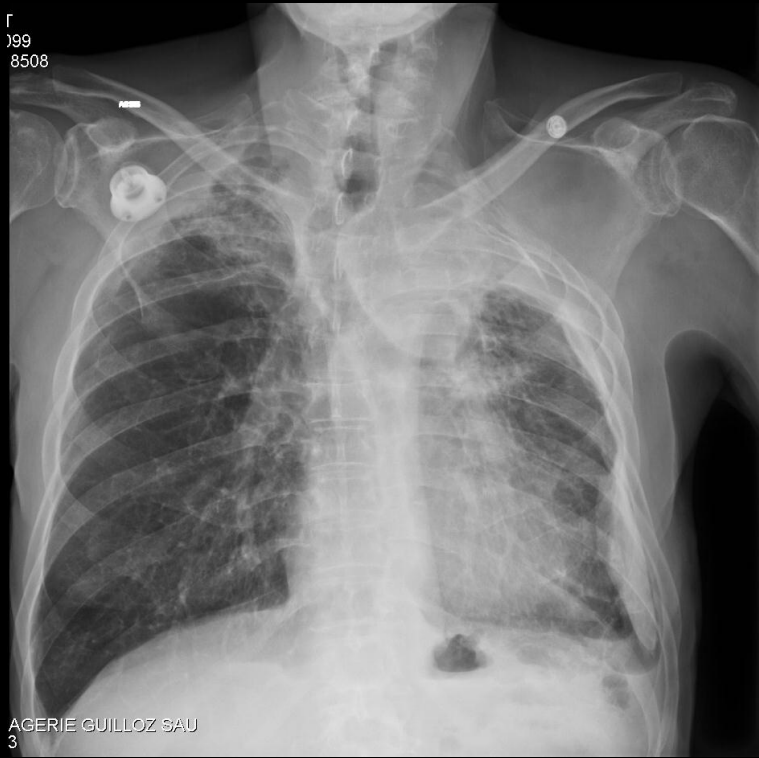
Carcinoma in peripheral zone of r. upper lobe with cavitation

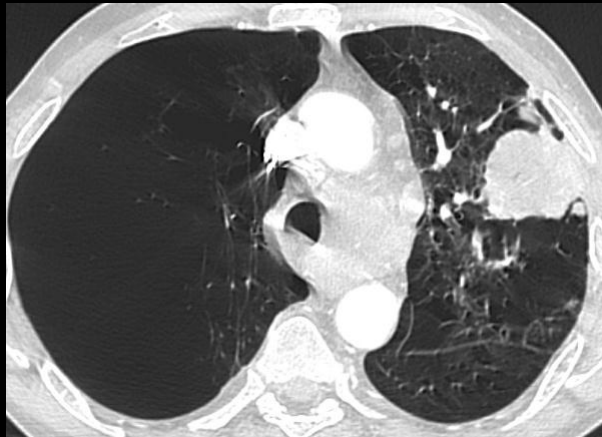
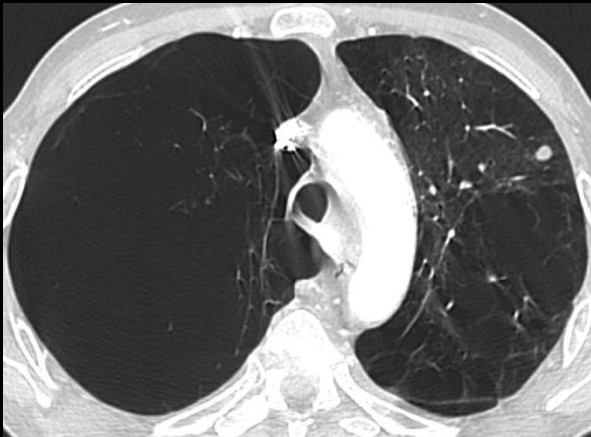
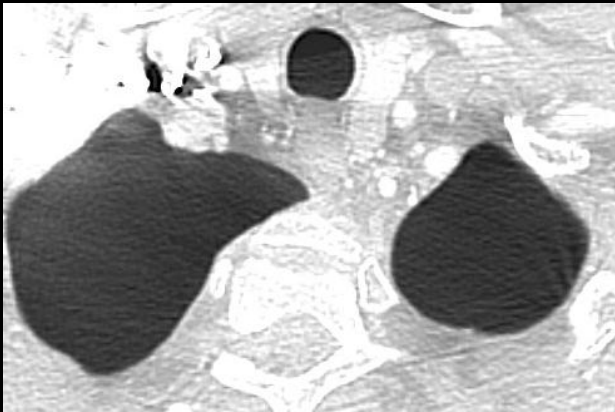
**Traube's Syndrome**



Horner's syndrome; wasting, pain, paresthesia and paresis of arm and hand

199  
8508

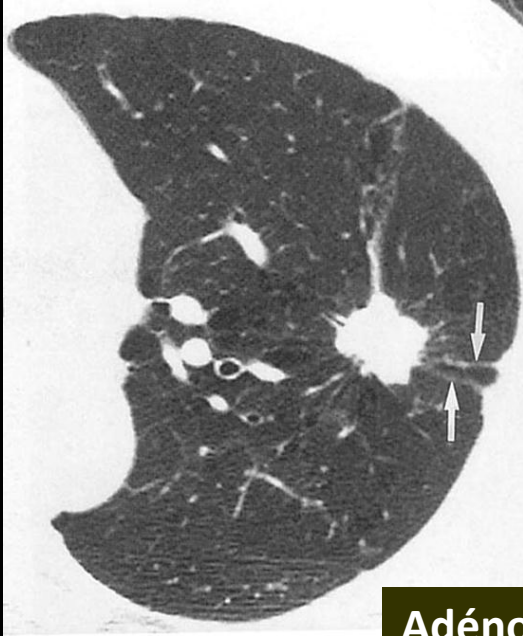




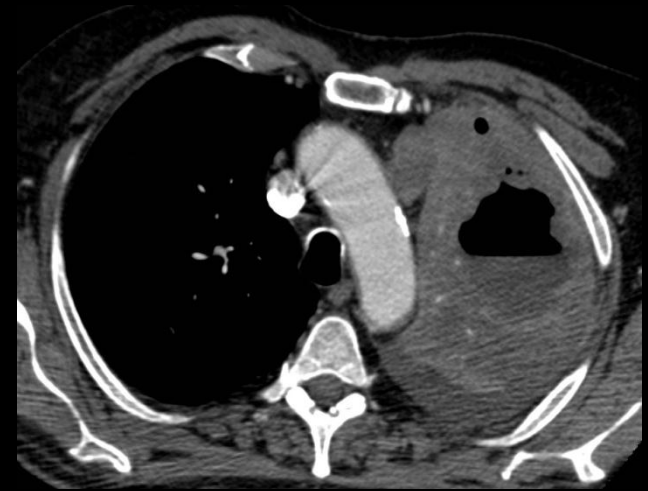
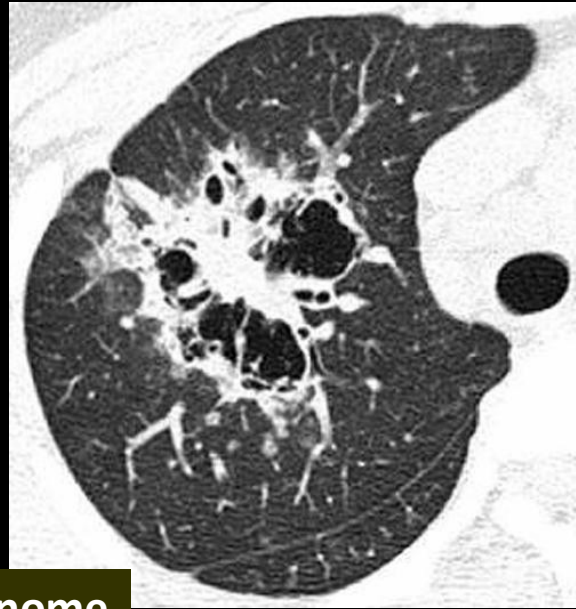
scanner thoracique sans injection

- Emphysème sévère avec volumineuse bulle de l'apex droit
- masse tissulaire hilare gauche: tumeur bronchique

## Formes radiologiques



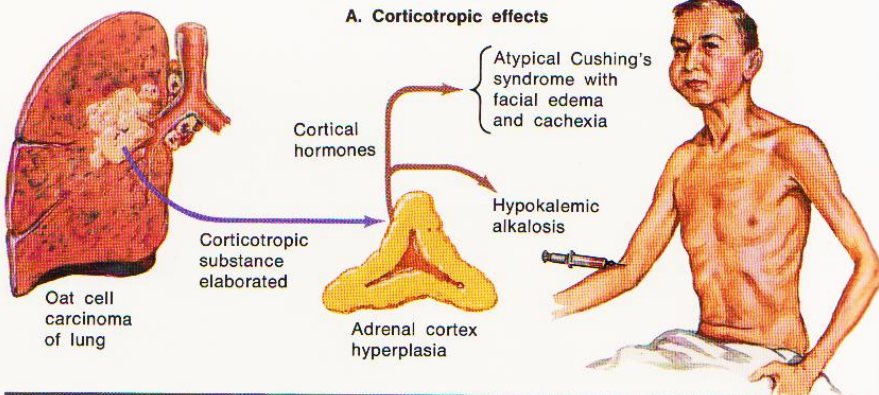
Adénocarcinome



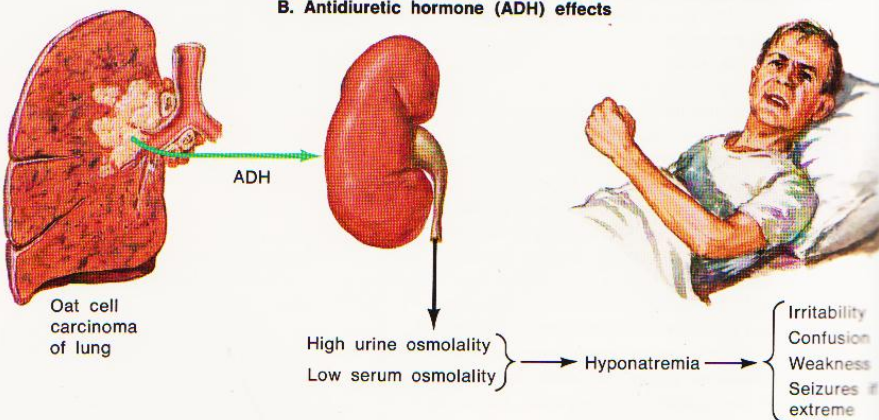
Carcinome épidermoïde

## Endocrine Manifestations of Bronchogenic Carcinoma

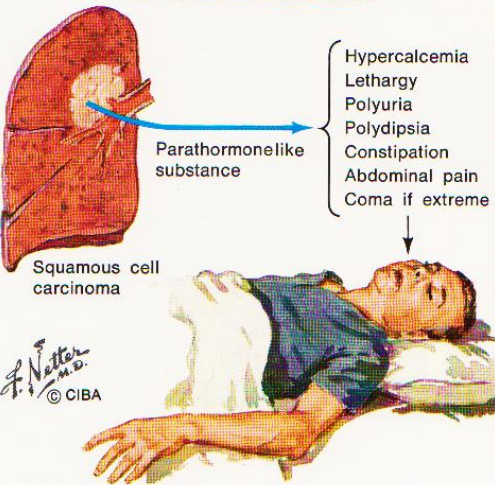
### A. Corticotropic effects



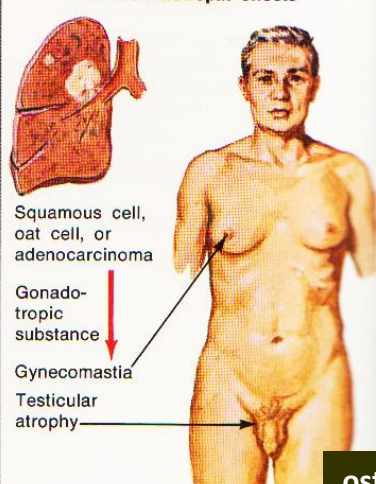
### B. Antidiuretic hormone (ADH) effects



### C. Parathormonelike effects



### D. Gonadotropin effects



## Neuromuscular Manifestations of Bronchogenic Carcinoma

Subacute cerebellar degeneration; vertigo, ataxia

Electromyographic abnormality in Lambert-Eaton syndrome (readings from hypothenar muscles with stimulation of ulnar nerve at wrist). Note low amplitude and initial decline. (Normal = 5 mv or more with no initial decline)

Lambert-Eaton syndrome; weakness of proximal muscle groups (often manifested by difficulty in rising from chair)

Peripheral neuropathy; paresthesias, pain, loss of function

Dementia may occur rarely (may predate onset of pulmonary symptoms)

## Connective Tissue Manifestations of Bronchogenic Carcinoma

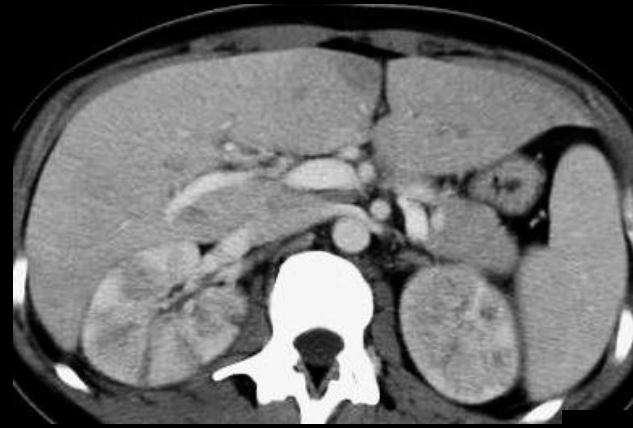
Hypertrophic pulmonary osteoarthropathy

Clubbing of fingers

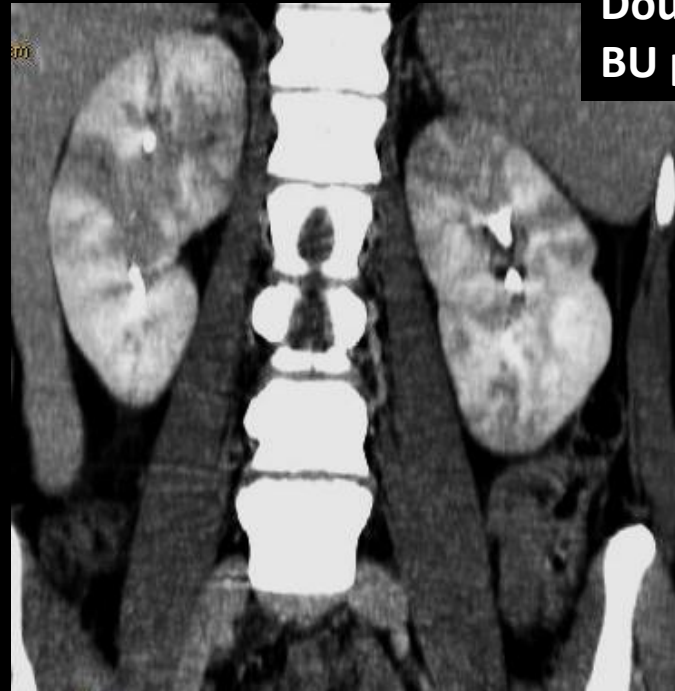
Subperiosteal new bone formation

Swelling of knee joint (synovial effusion may be present)

Edema and/or painful swelling of feet, legs



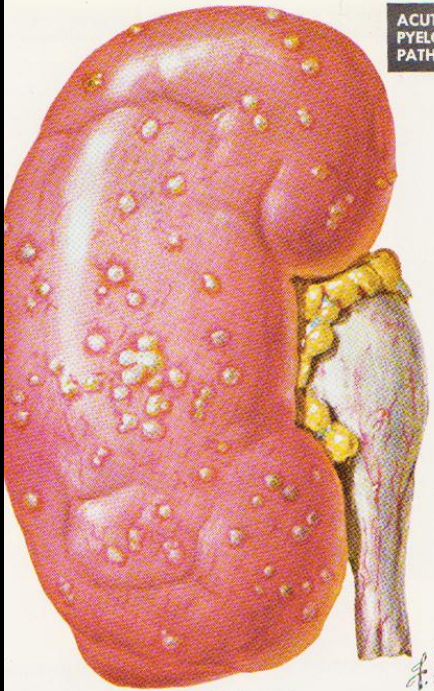
Patiente de 46 ans  
Douleurs lombaires et fièvre  
BU positive



scanner abdominopelvien avec IV

Plages hypodenses parenchymateuses rénales bilatérales: foyers de **néphrite aiguë bactérienne et focale**

**ACUTE  
PYELONEPHRITIS:  
PATHOLOGY**

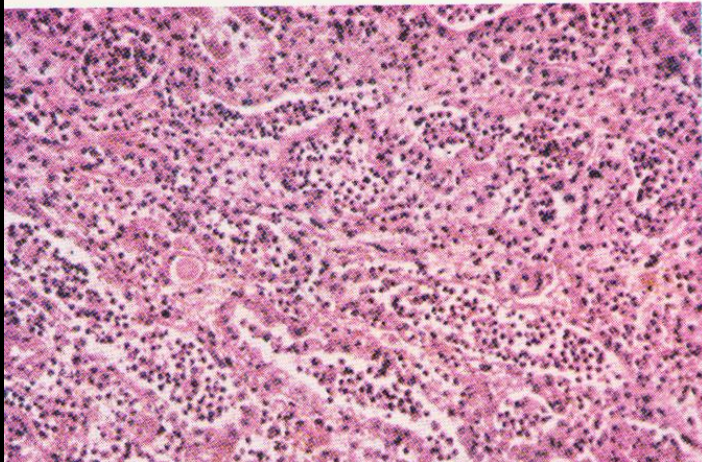
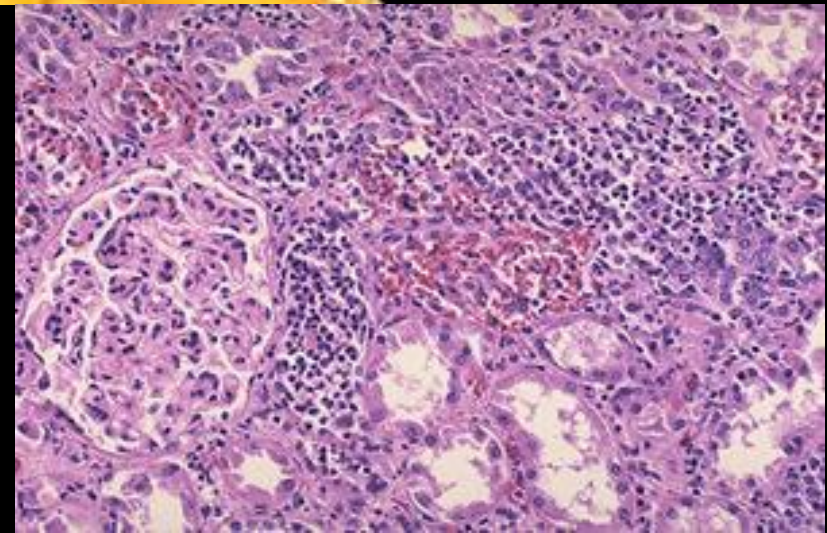


SURFACE ASPECT OF KIDNEY:  
MULTIPLE MINUTE ABSCESSES  
(SURFACE MAY APPEAR RELATIVELY  
NORMAL IN SOME CASES)



CUT SECTION: RADIATING YELLOWISH GRAY  
STREAKS IN PYRAMIDS AND ABSCESSES IN  
CORTEX; MODERATE HYDRONEPHROSIS  
WITH INFECTION; BLUNTING OF CALYCES  
(ASCENDING INFECTION)

*F. Netter M.D.*  
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ACUTE  
PYELONEPHRITIS  
WITH EXUDATE  
CHIEFLY OF  
POLYMORPHONUCLEAR  
LEUKOCYTES IN  
INTERSTITIUM AND  
COLLECTING TUBULES

