SÉMIOLOGIE DE BASE DES PID: CAS CLINIQUES

L.Cassagnes

Séméiologie des PID

- 1- Détermination des lésions élémentaires
  - Images linéaires septales / non septales
  - Images nodulaires
  - Verre dépoli/ condensations
  - Image kystiques
  - Rayon de miel sous pleural
  - Distorsion architecturale
  - Bronchectasies par traction
- 2- Topographie.

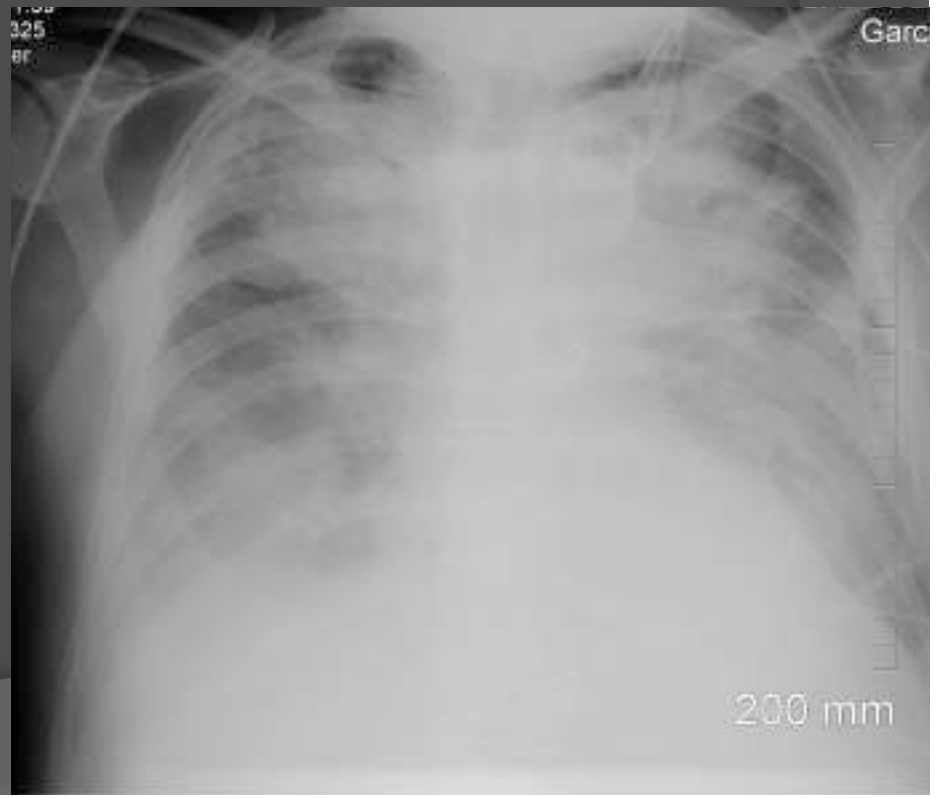
Démarche diagnostique

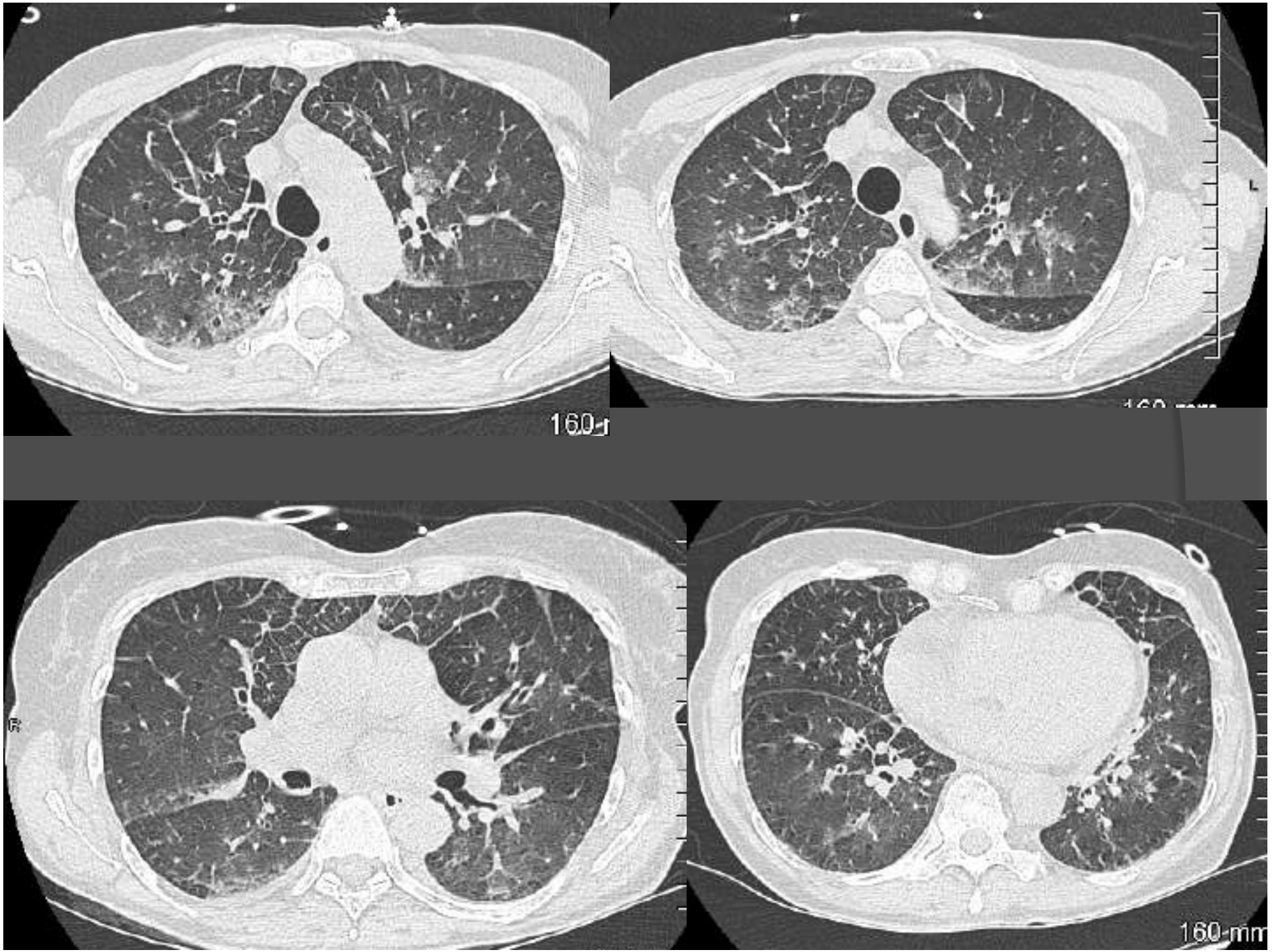
- Identification des **lésions élémentaires**.
- **Distribution** de ces lésions élémentaires, retentissement sur l'architecture pulmonaire éventuelles lésions associées.
- **Evolutivité** temporelle

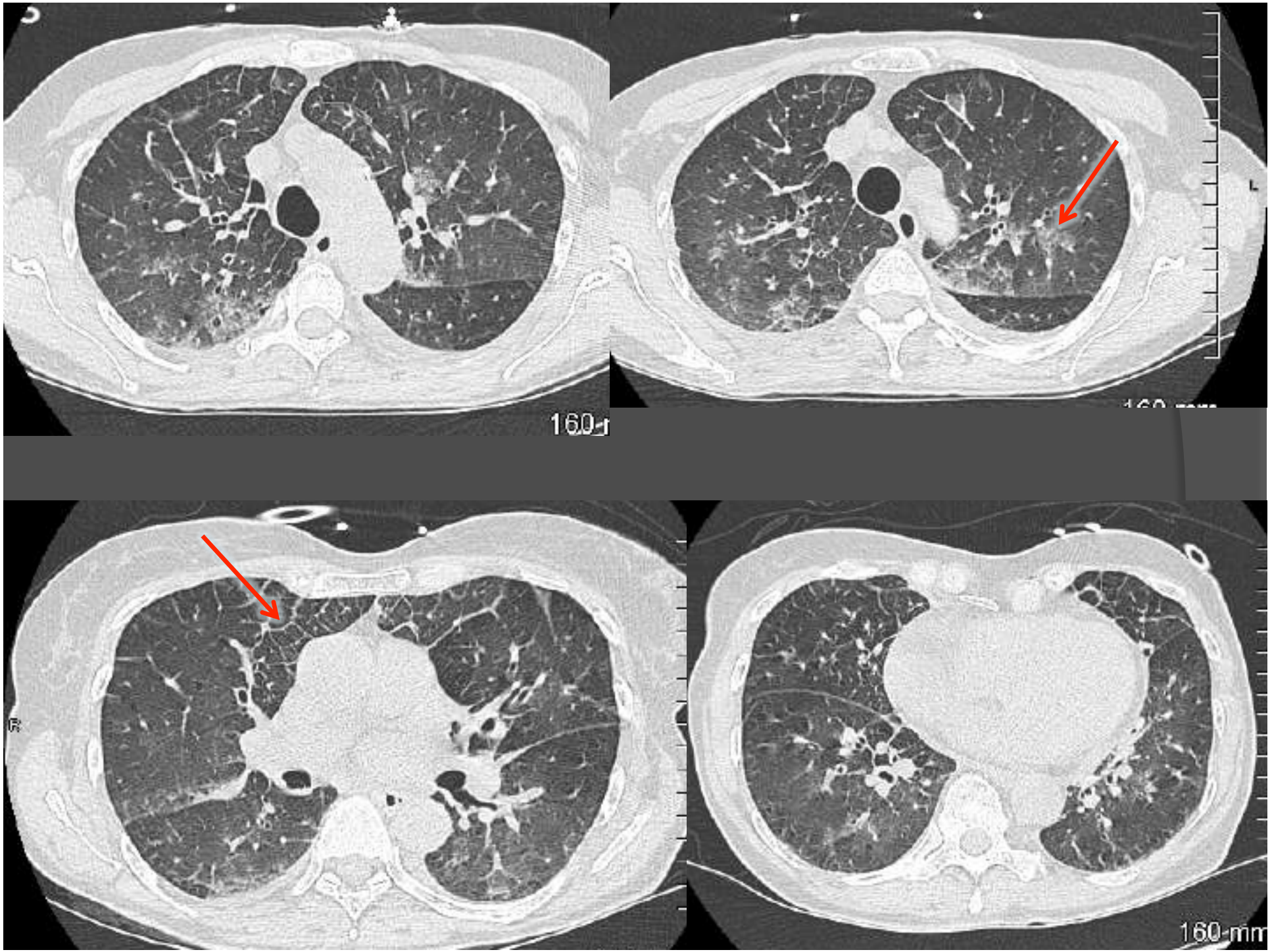
-> permet diagnostic ou gamme diagnostique oriente vers LBA ou biopsie pulmonaire.

CAS N°1

- Patient insuffisant cardiaque connu
- Hospitalisation en urgence pour dyspnée d’aggravation progressive.



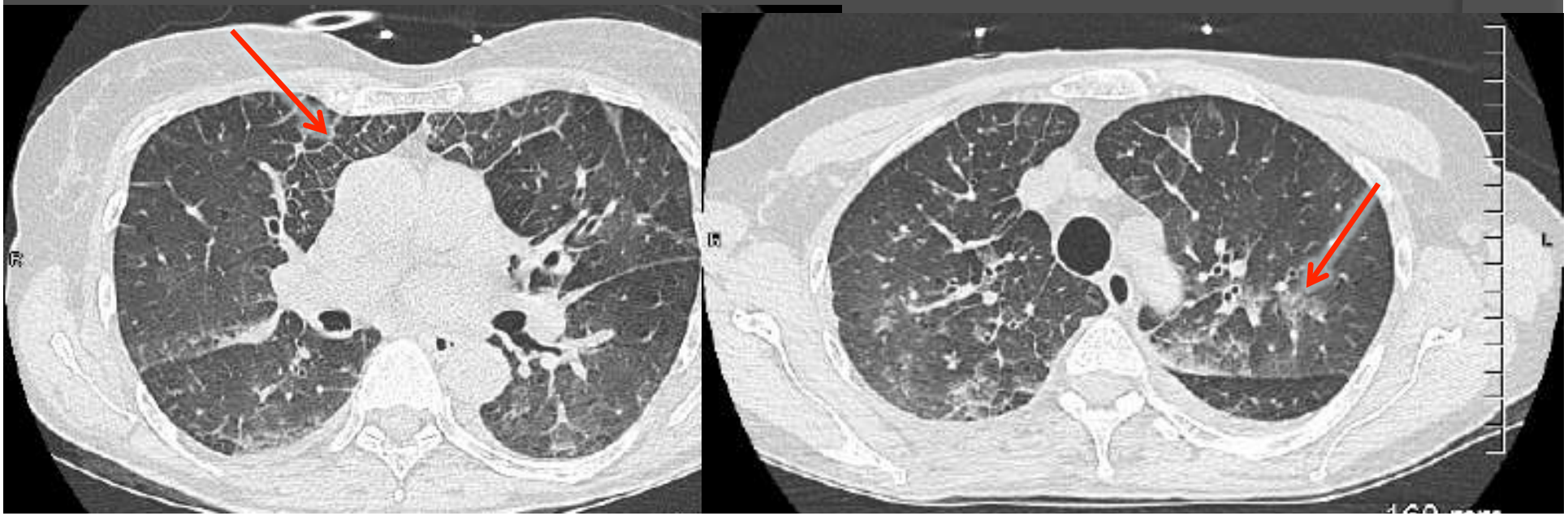




Lésions :
Épaississements septaux
Plages de verre dépoli

Distribution:
Centrale
Atteinte apex et bases

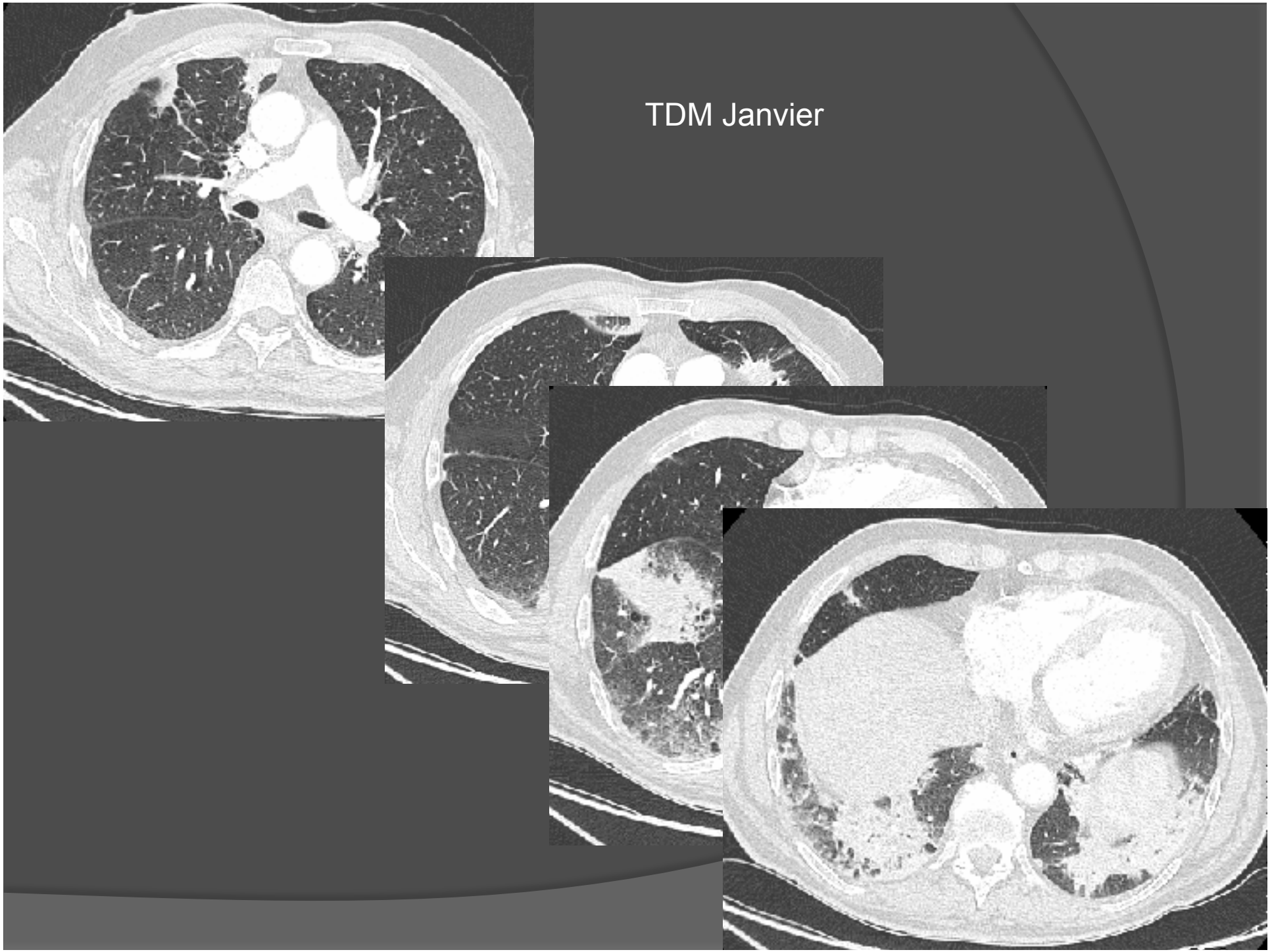
OAP (PID aiguë)



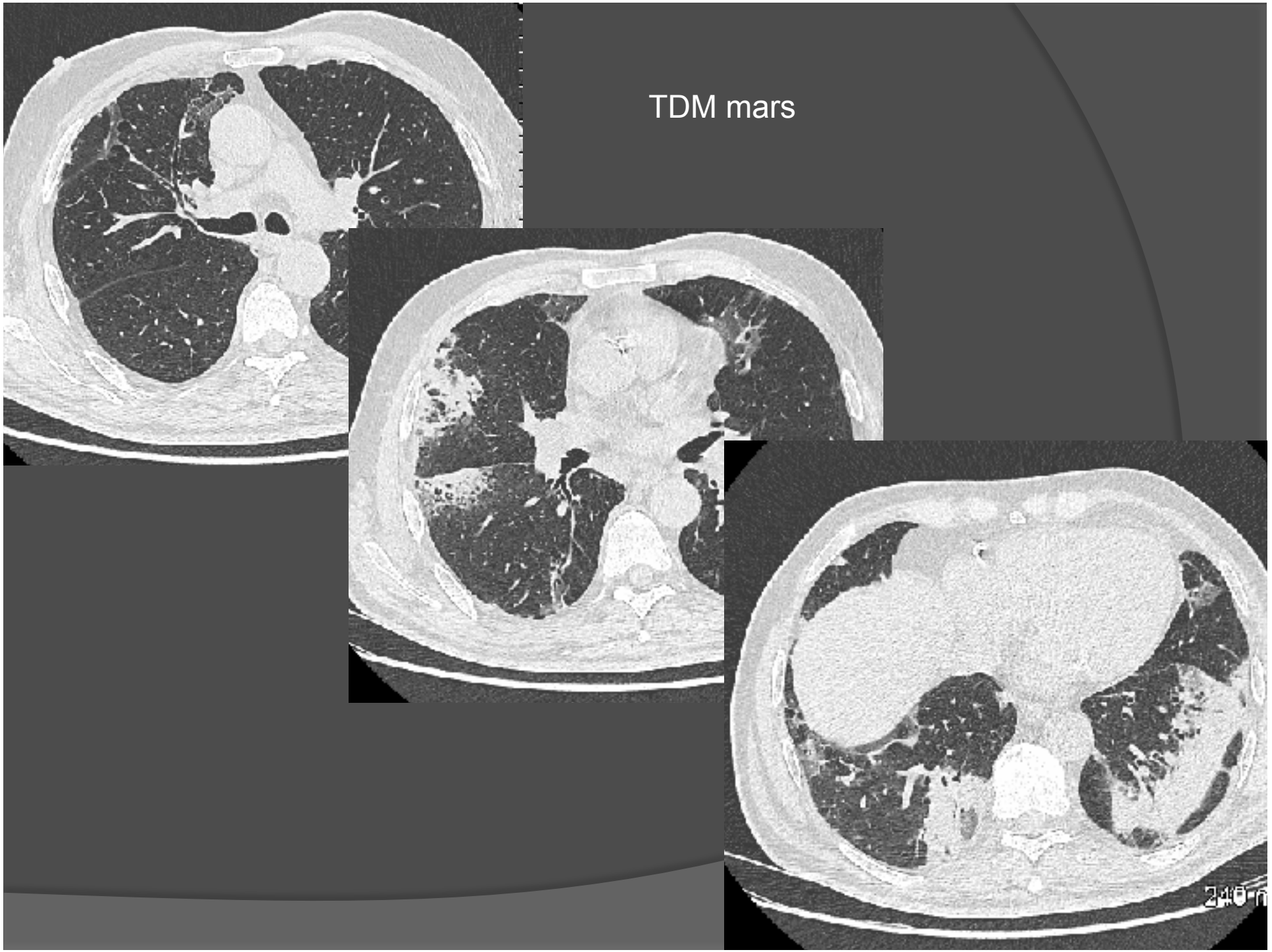
Cas n°2 :

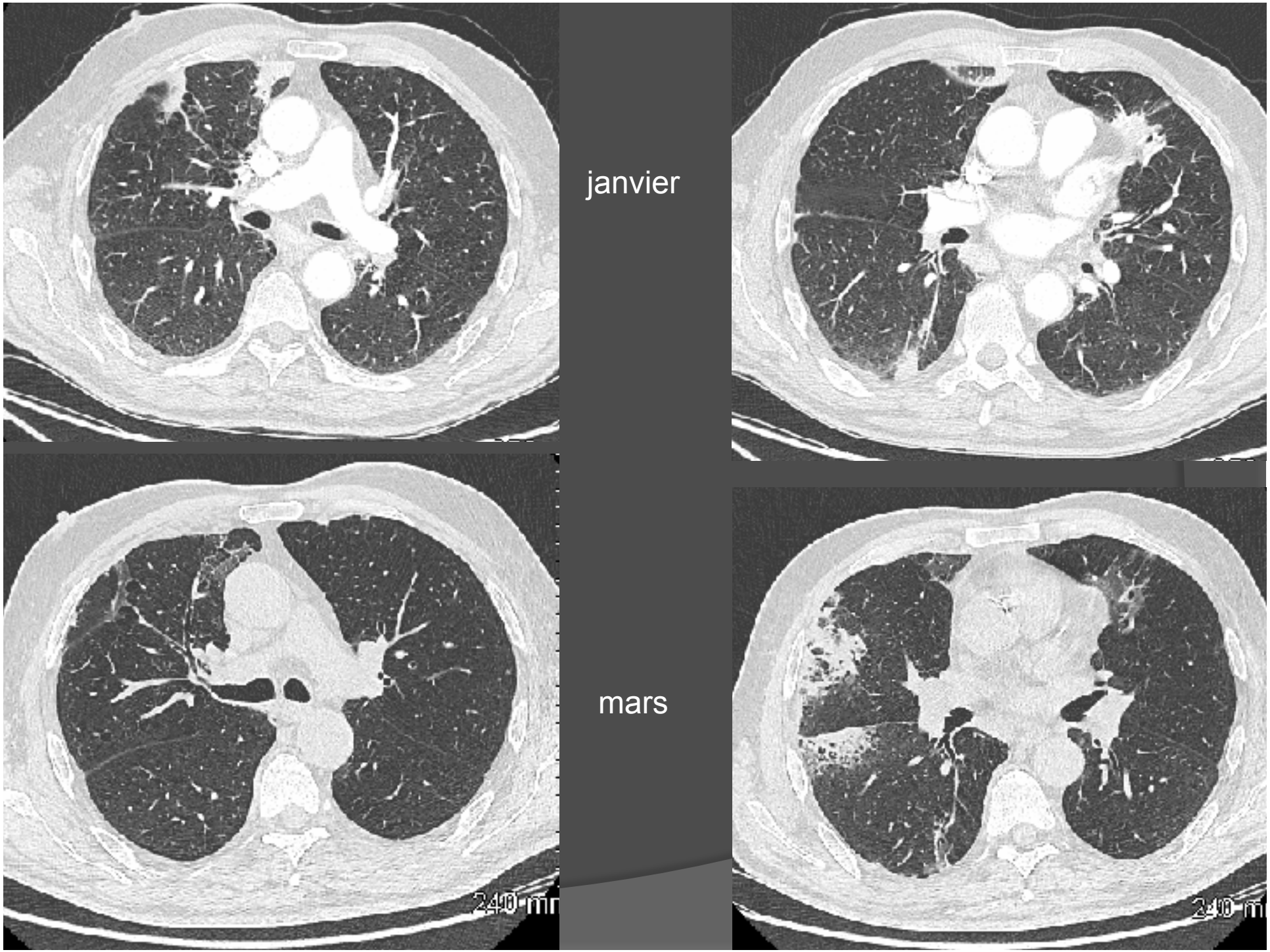
- Patient de 70 ans
- Atcds d'IDM, Rao serré, tabagisme sevré
- Asthénie sans fiévre
- CRP à 100 mg/l
- EFR : trouble ventilatoire restrictif

TDM Janvier



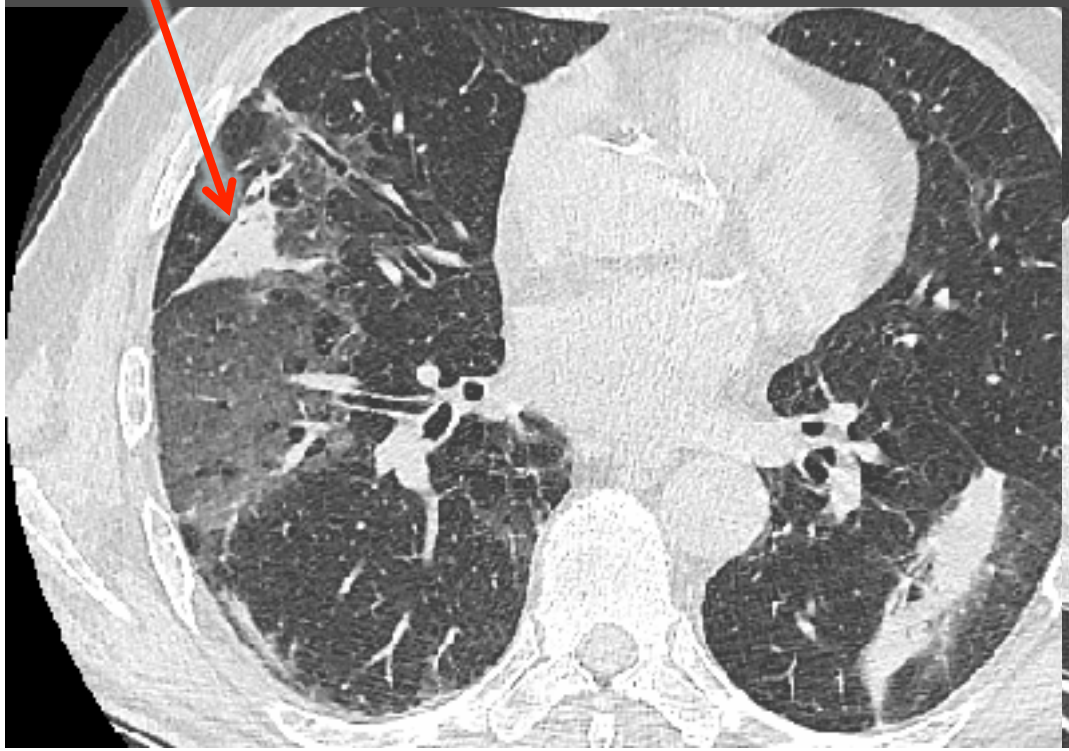
TDM mars

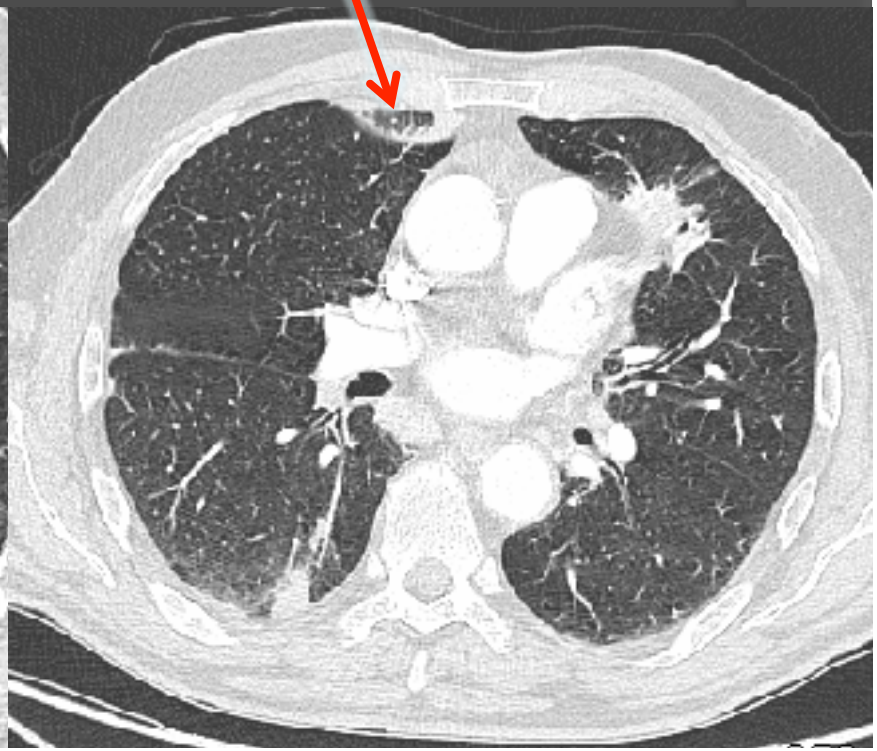


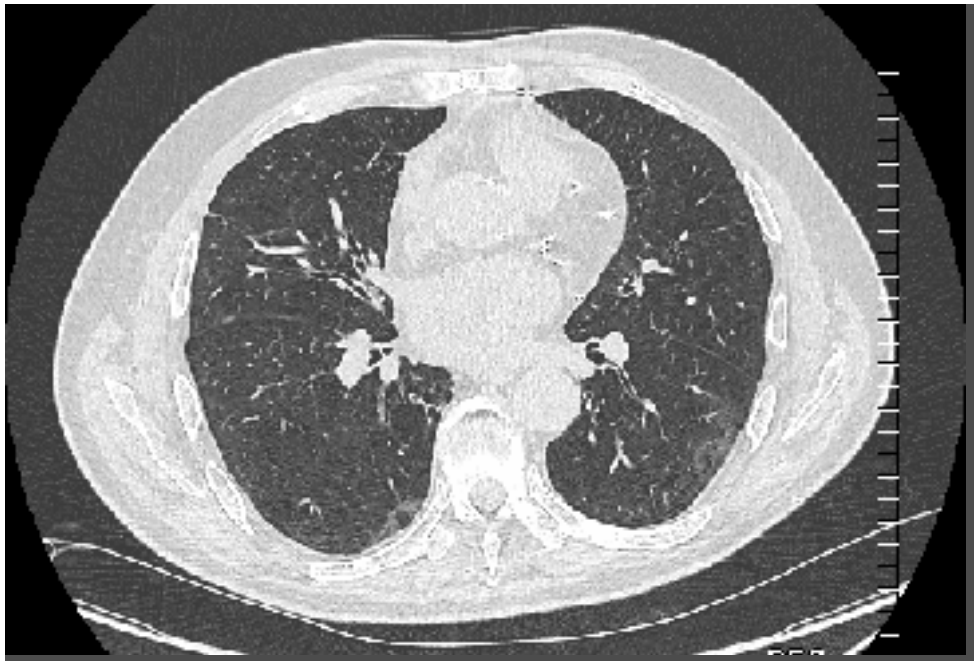

janvier
mars

Lésions:
Condensations alvéolaires avec bronchogramme
Signe du halo inversé

Distribution :
Périphérique
Condensations migratrices

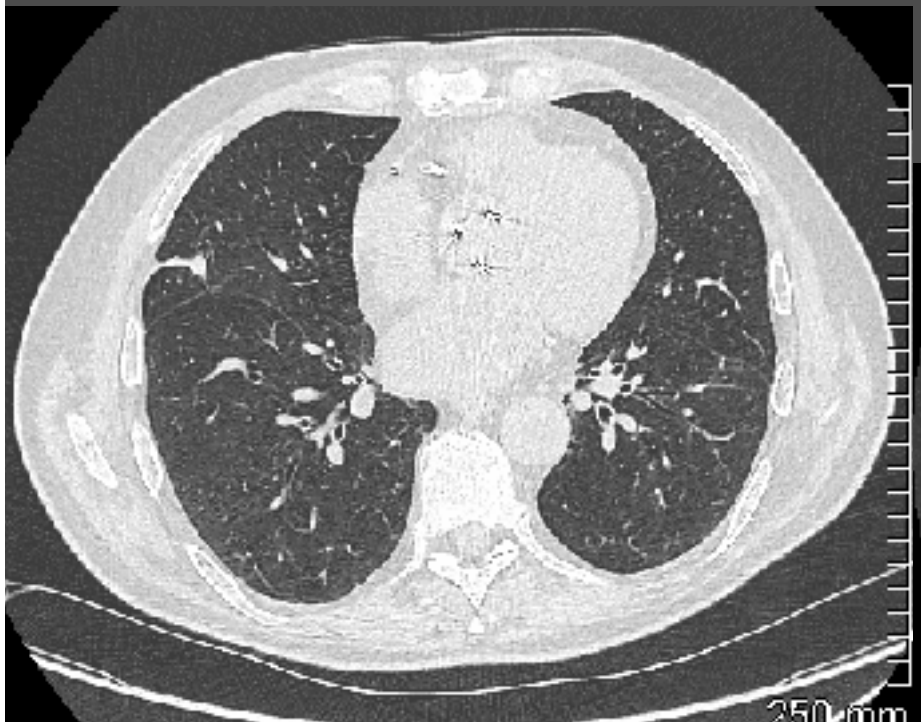


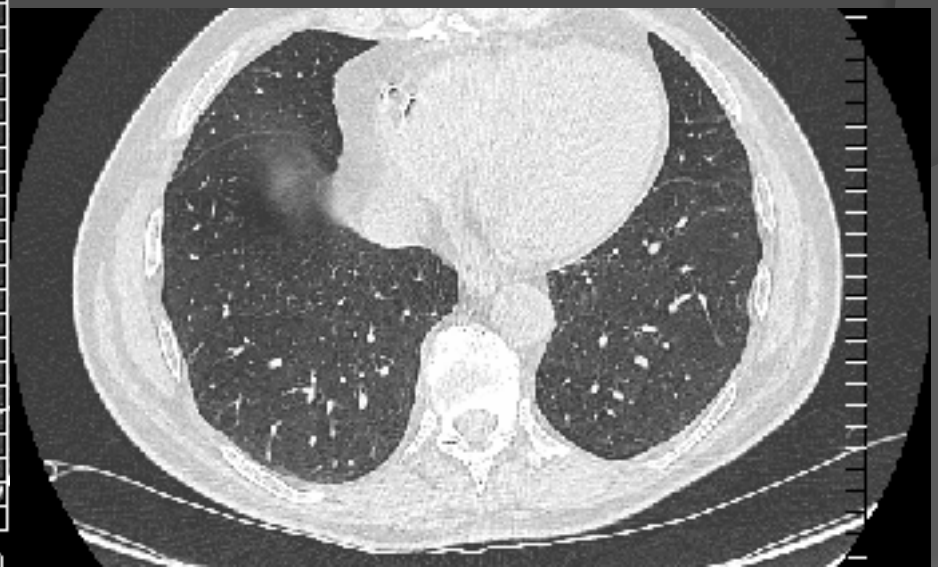




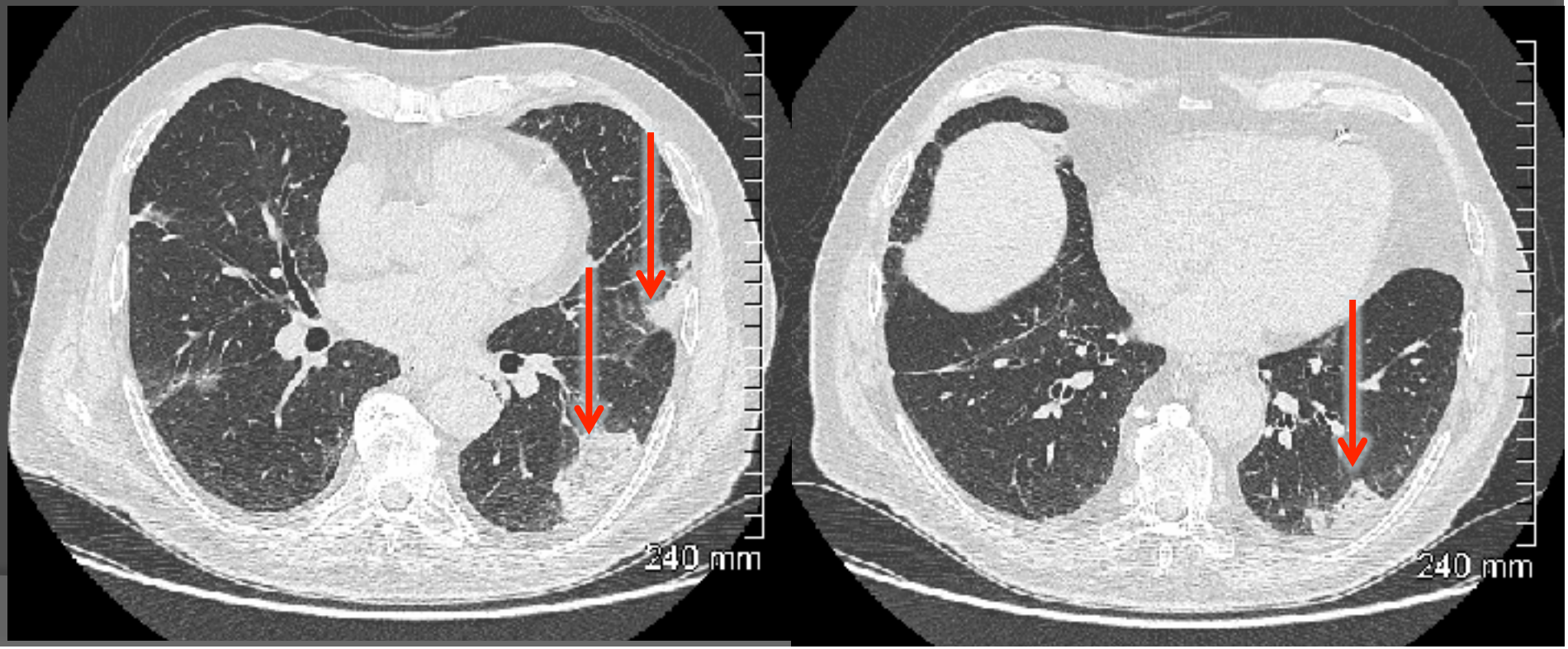
3 mois + tard
(après corticoides)

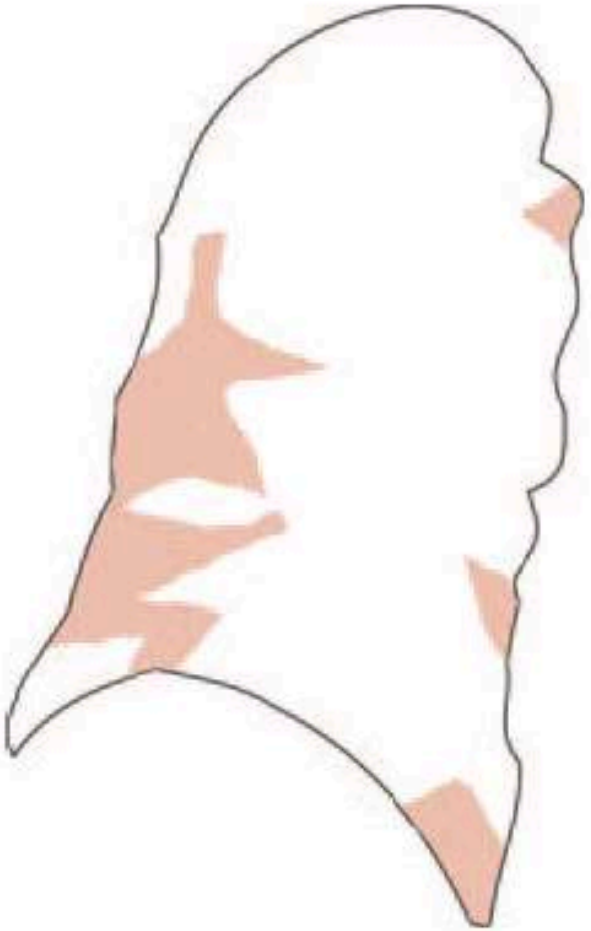
COP (cryptogenic organizing pneumonia) =
PO (pneumopathie organisée) =
ancienne BOOP

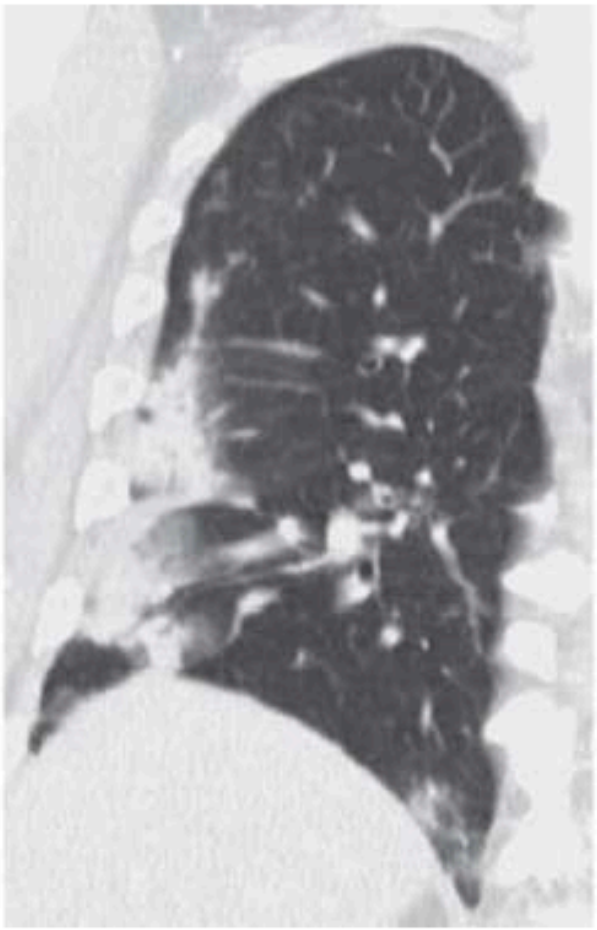


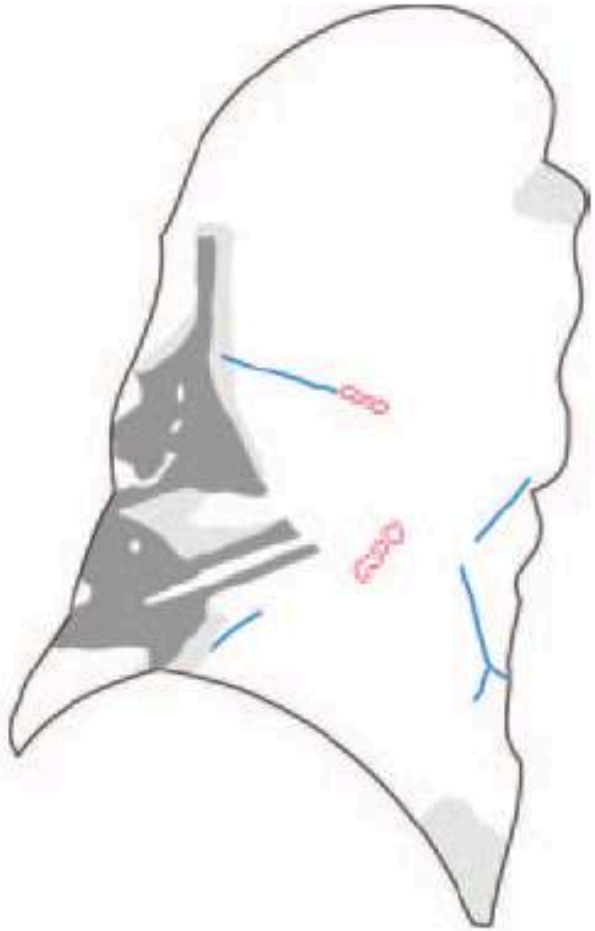


PO :
condensations parenchymateuses avec bronchogramme,
opacités linéaires, gradient apico-basal
Disposition sous pleurale,
Multifocal, bilatéral, migratrices
Signe du halo inversé









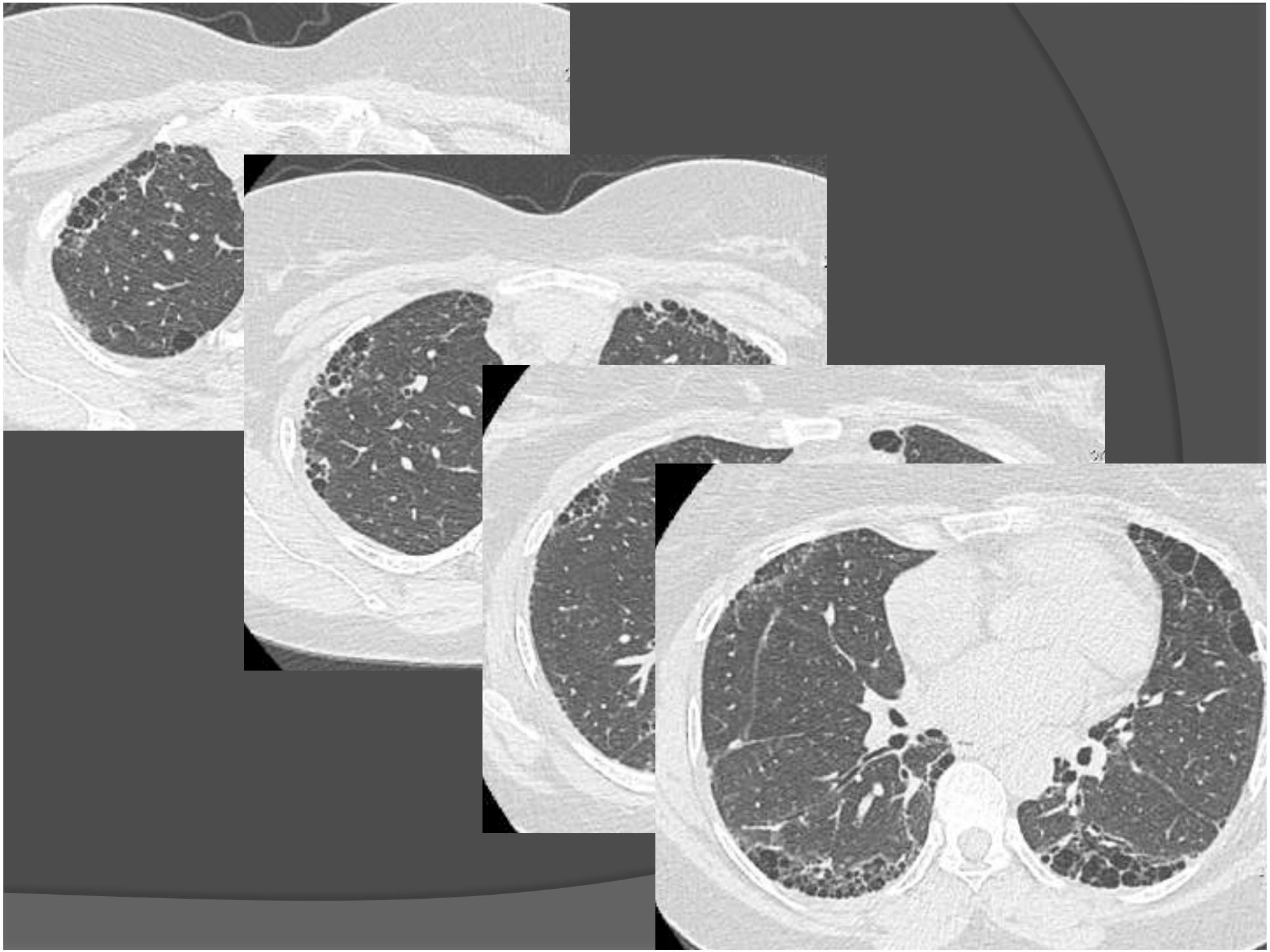
What Every Radiologist Should Know about Idiopathic Interstitial Pneumonias[1]

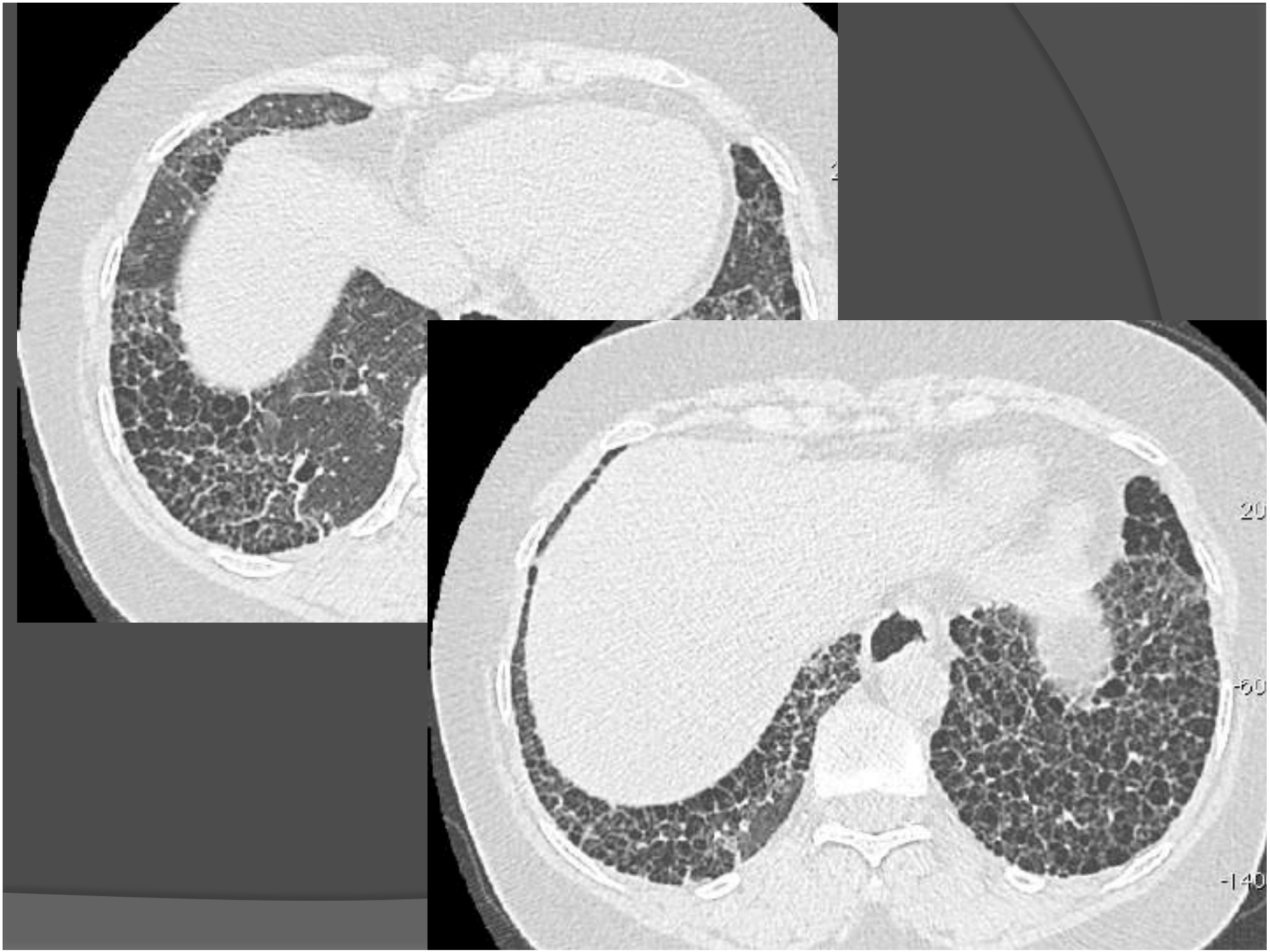
Christina Mueller-Mang, MD • Claudia Grosse, MD • Katharina Schmid, MD • Leopold Stiebellehner, MD • Alexander A. Bankier, MD

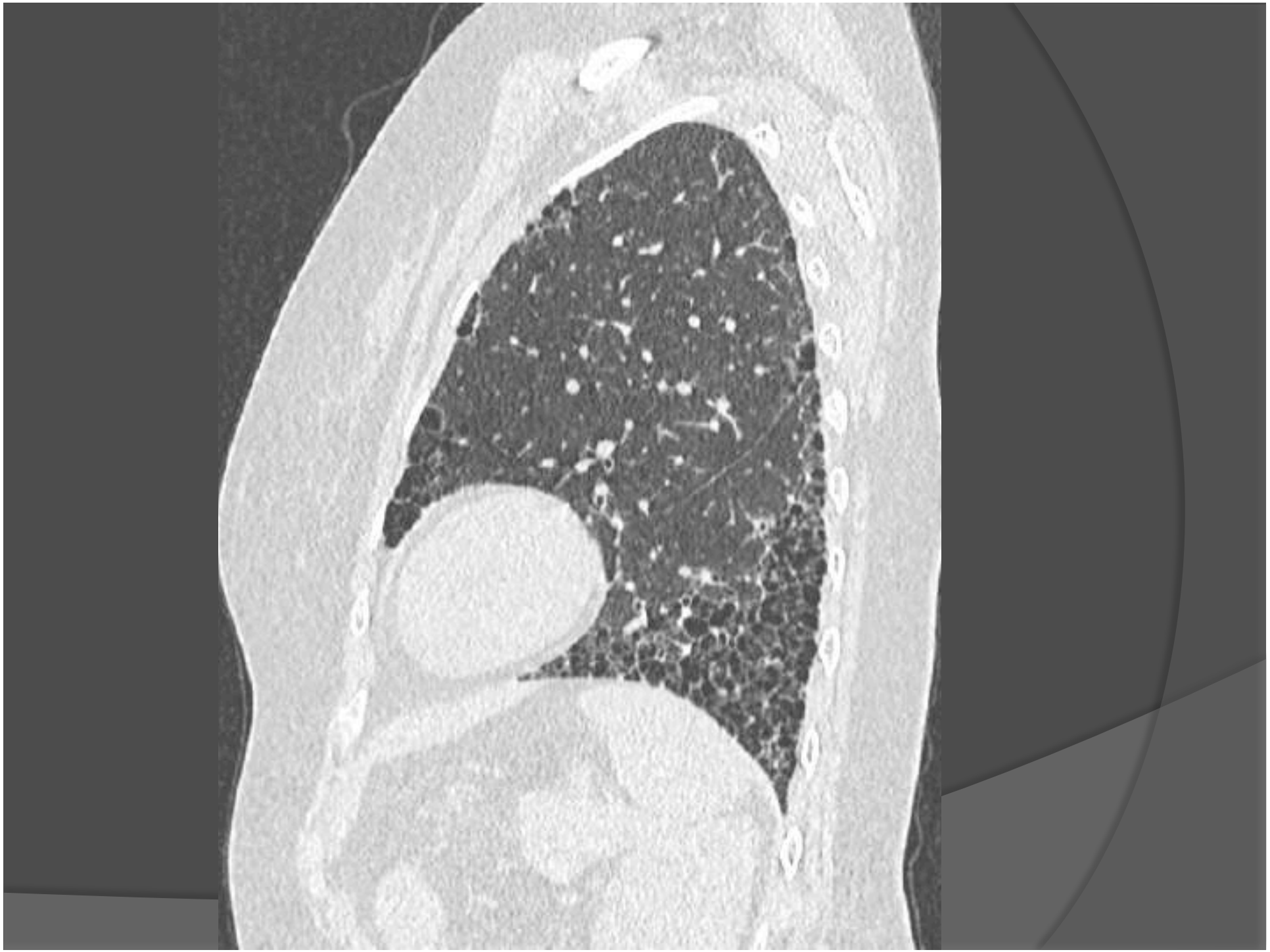
RadioGraphics 2007; 27:595–615

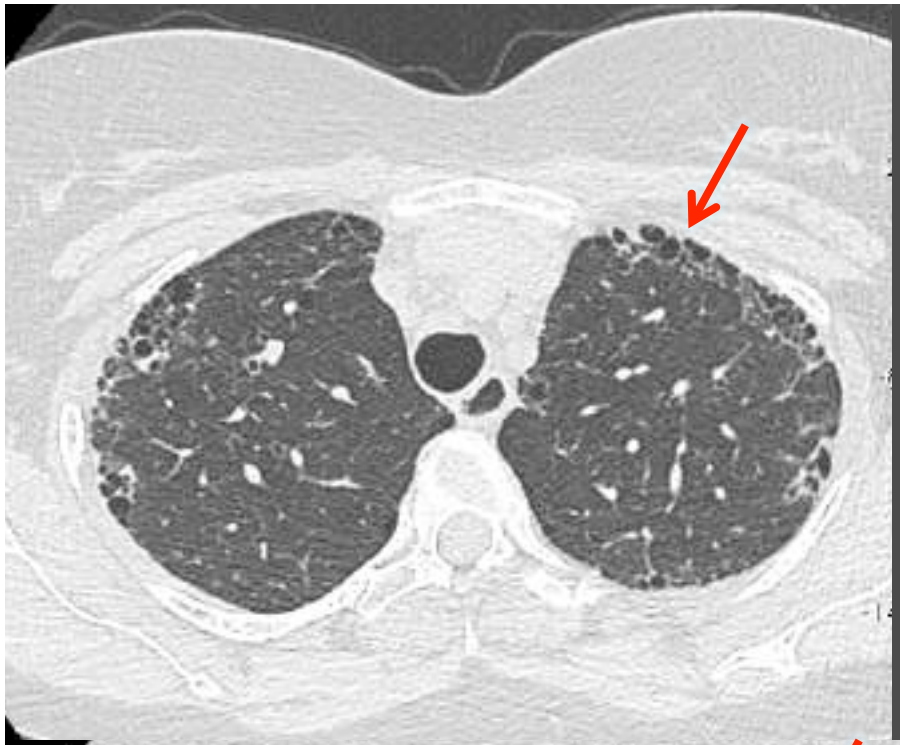
Cas n°3 :

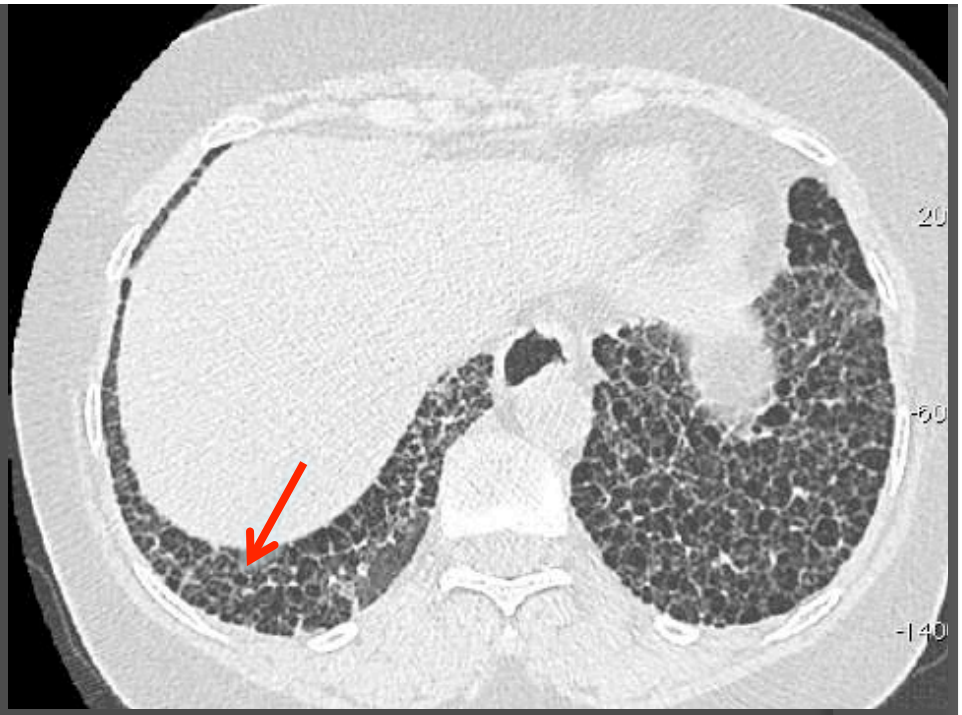
- Patiente de 50 ans
- Dyspnée progressive
- Toux séche
- Crépitants à l'auscultation
- Syndrome restrictif aux EFR

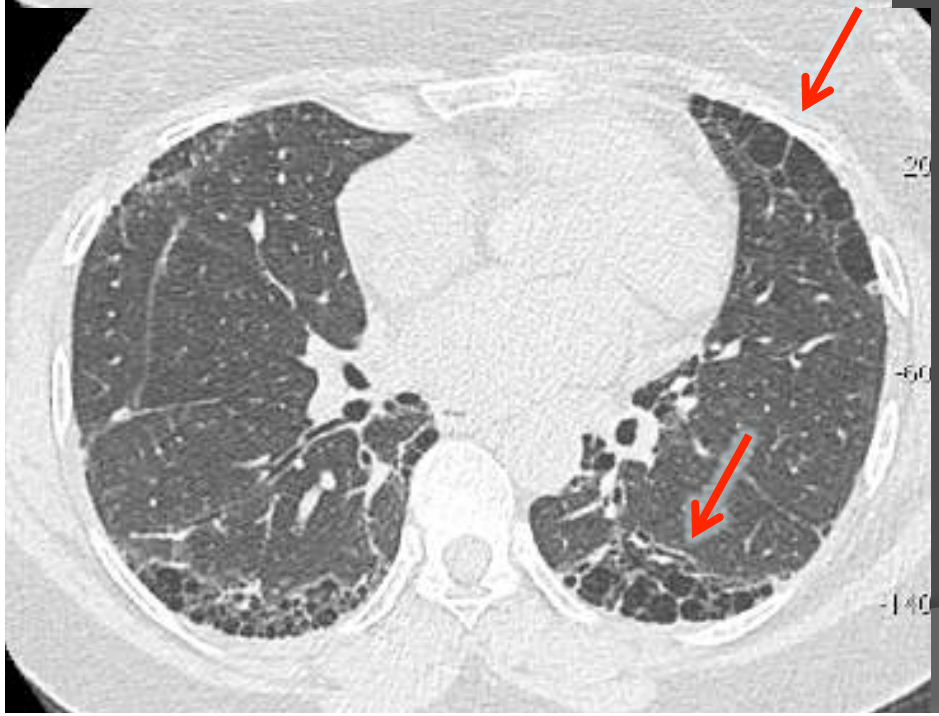



20
-60
-140



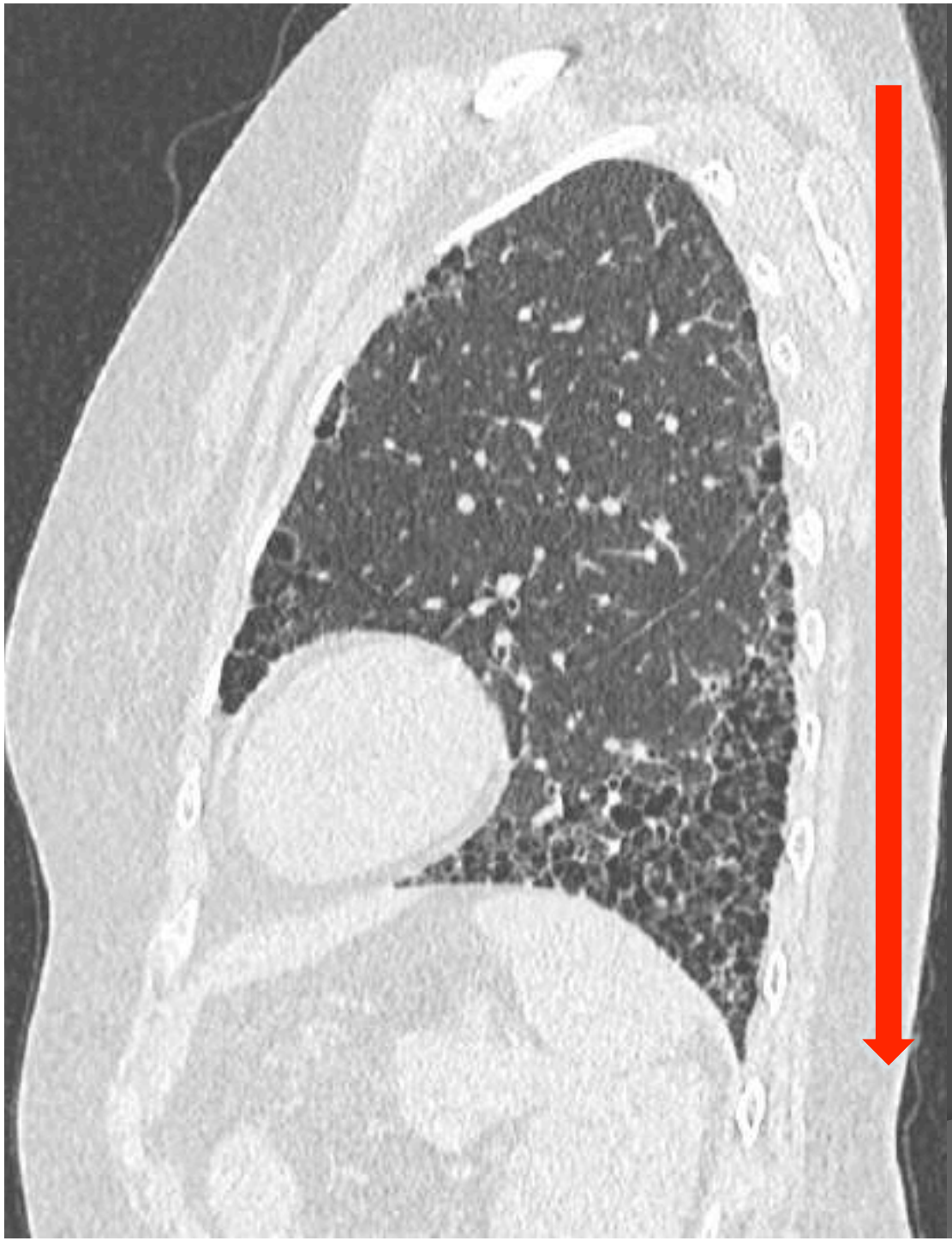






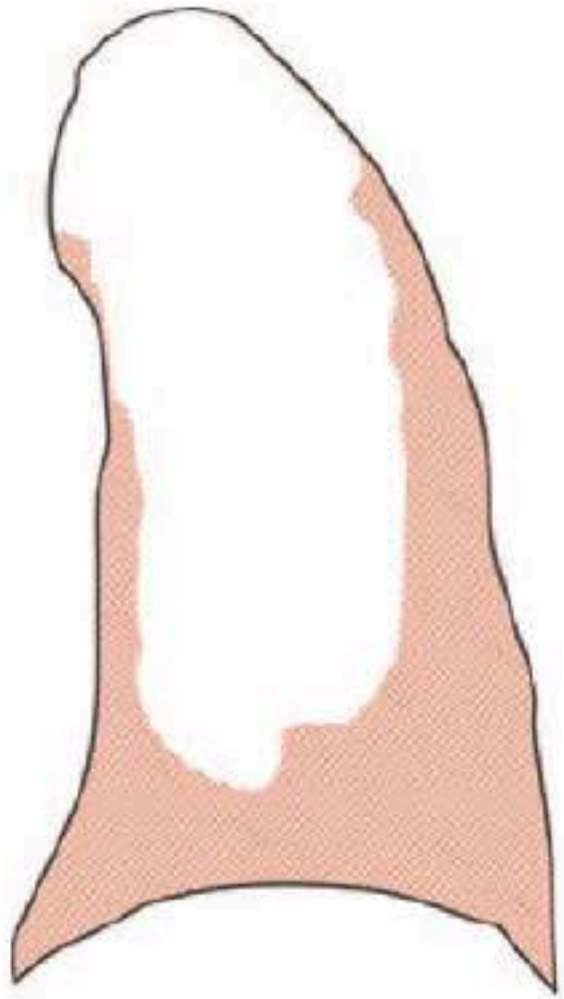
Lésions:
Rayon de miel prédominant
Réticulations
Pas de verre dépoli

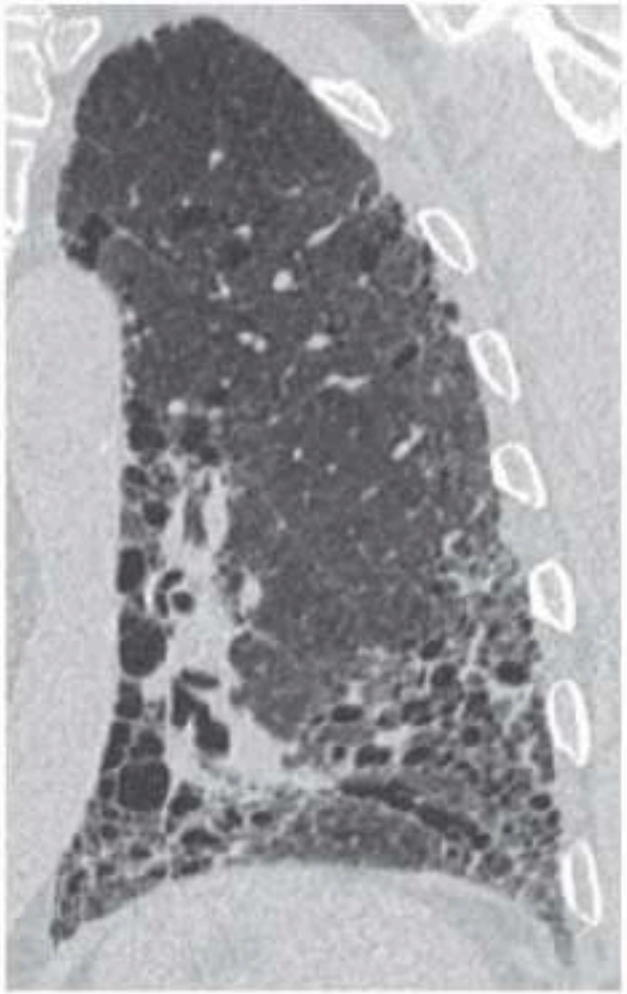
Distribution :
Prédominance sous pleurale

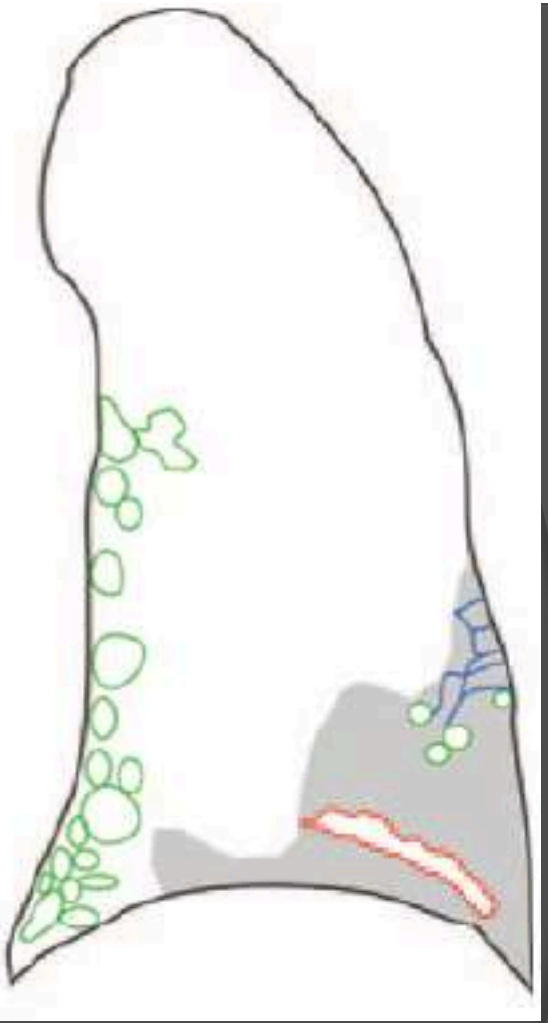


Distribution:
Gradient apico-basal

FPI (fibrose pulmonaire idiopathique) =
UIP (usual interstitial pneumonia) =
PIC (pneumopathie interstitielle commune)







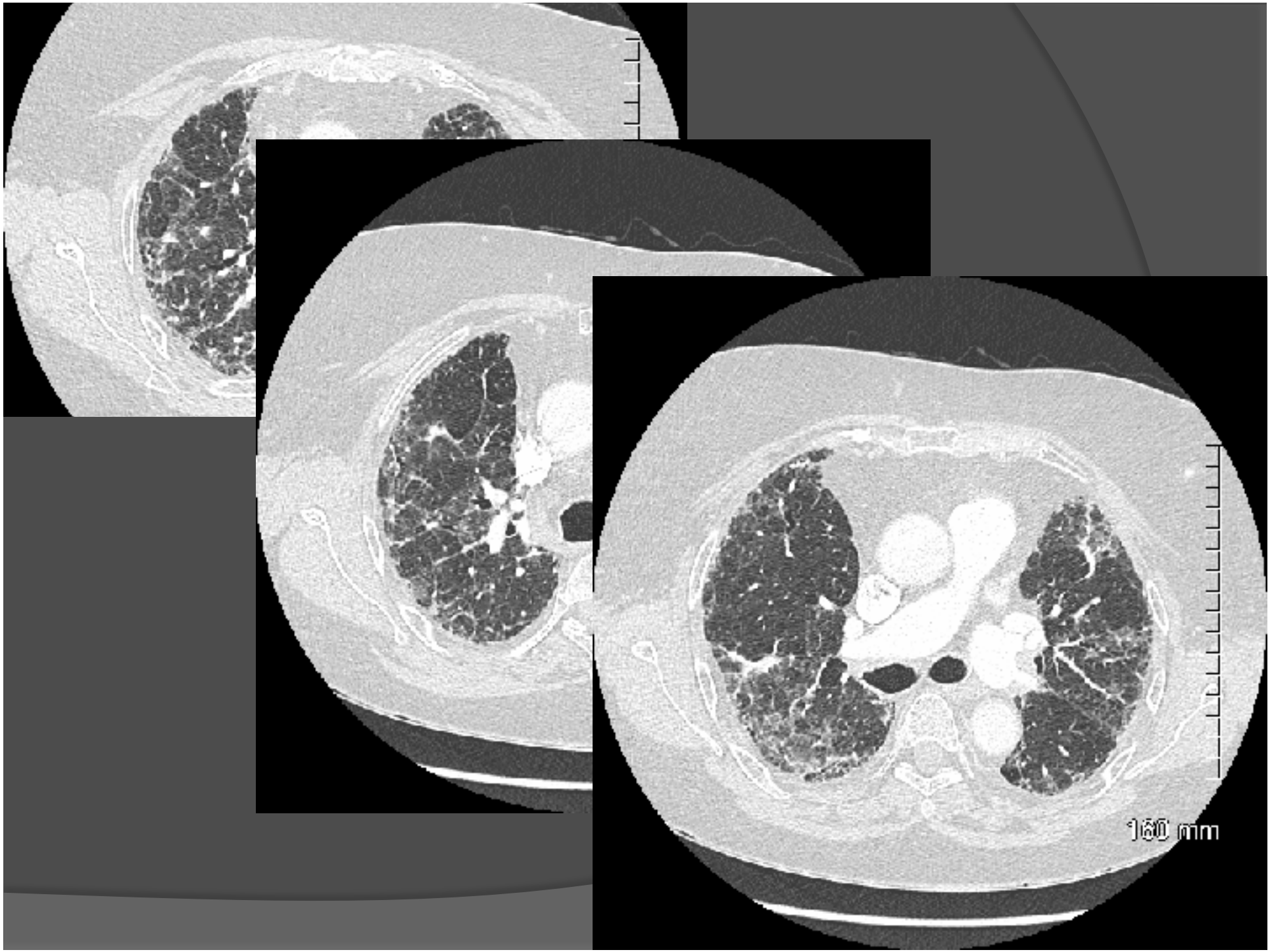
What Every Radiologist Should Know about Idiopathic Interstitial Pneumonias[1]

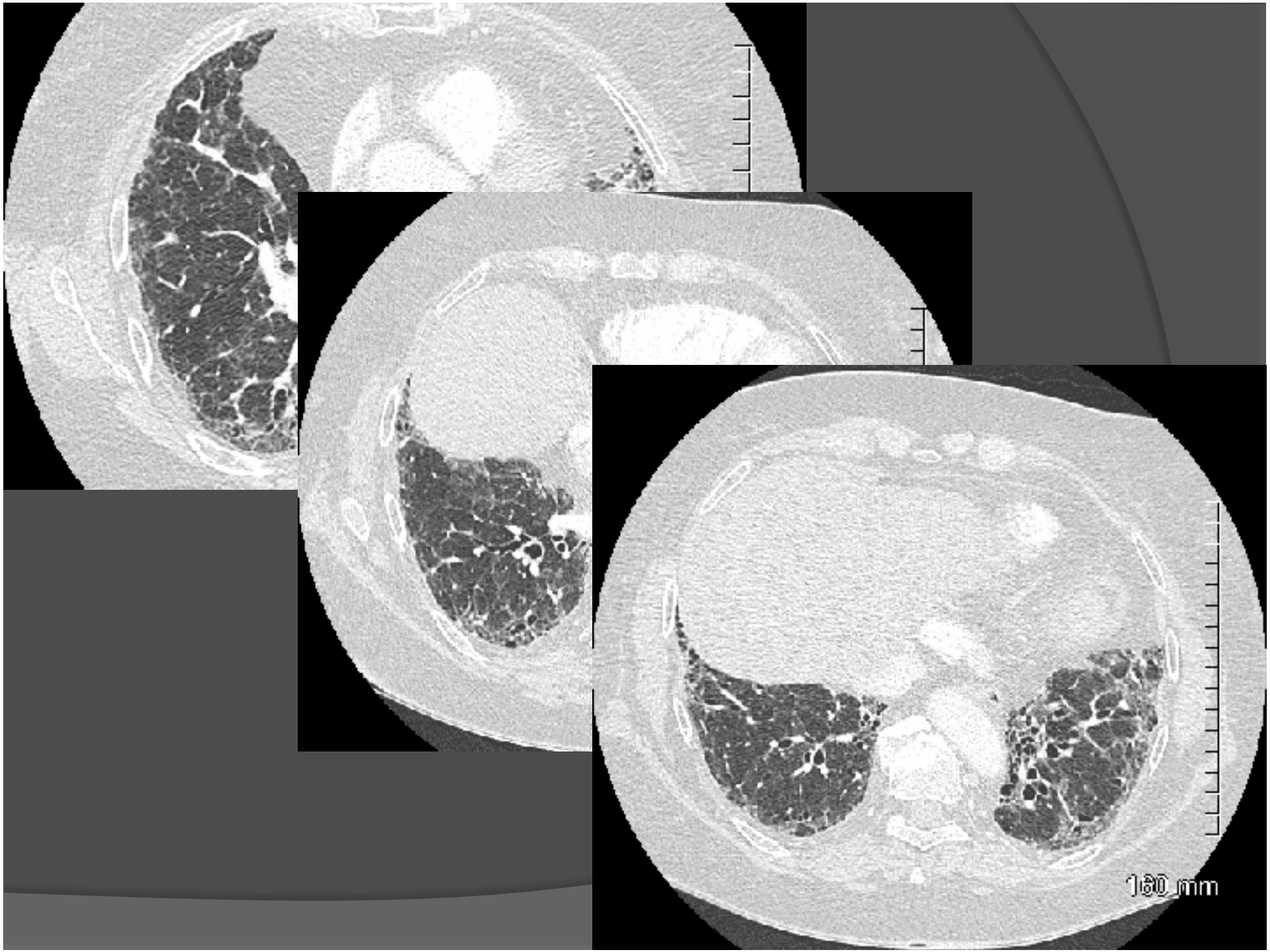
Christina Mueller-Mang, MD • Claudia Grosse, MD • Katharina Schmid, MD • Leopold Stiebellehner, MD • Alexander A. Bankier, MD

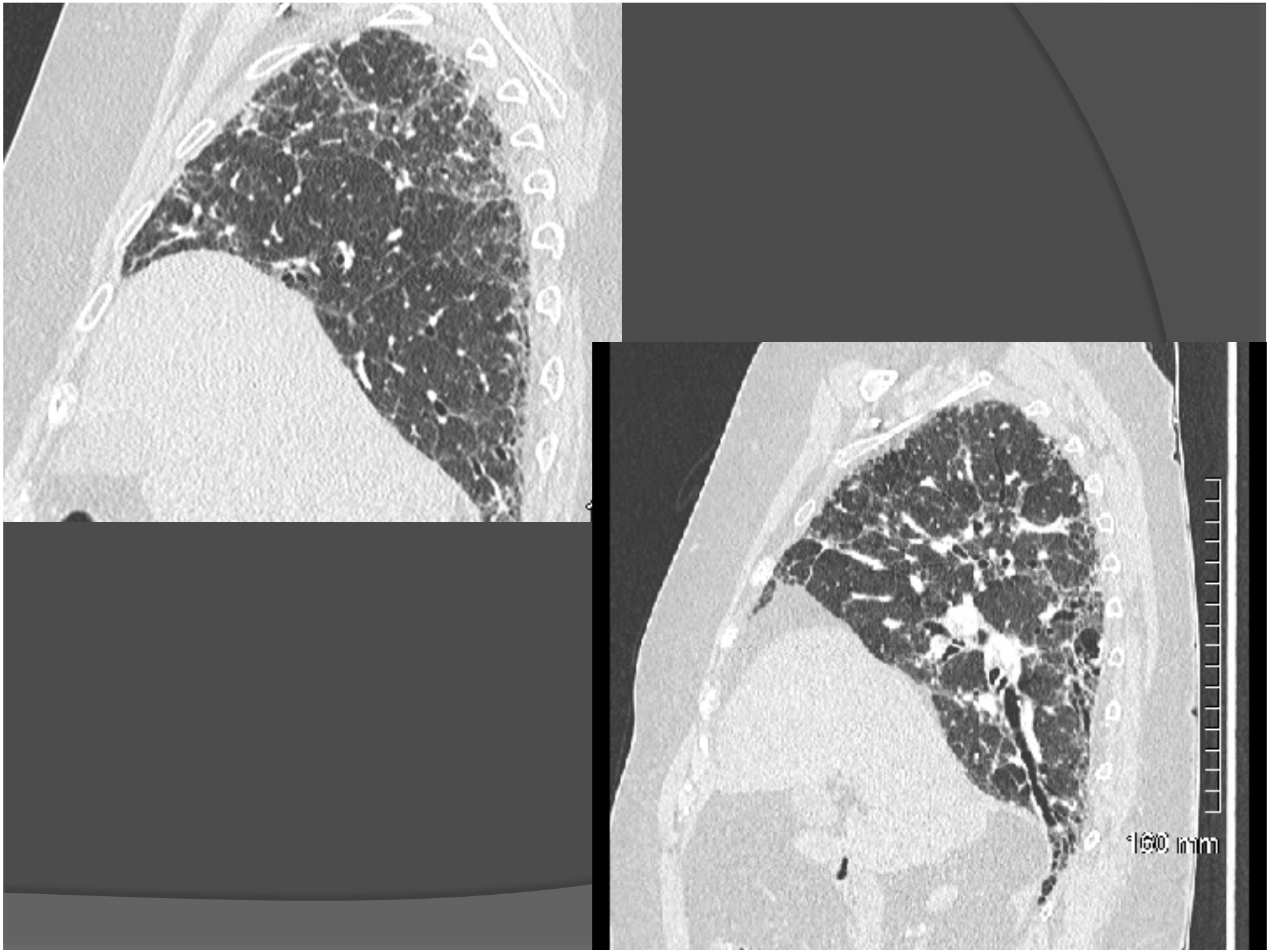
RadioGraphics 2007; 27:595–615

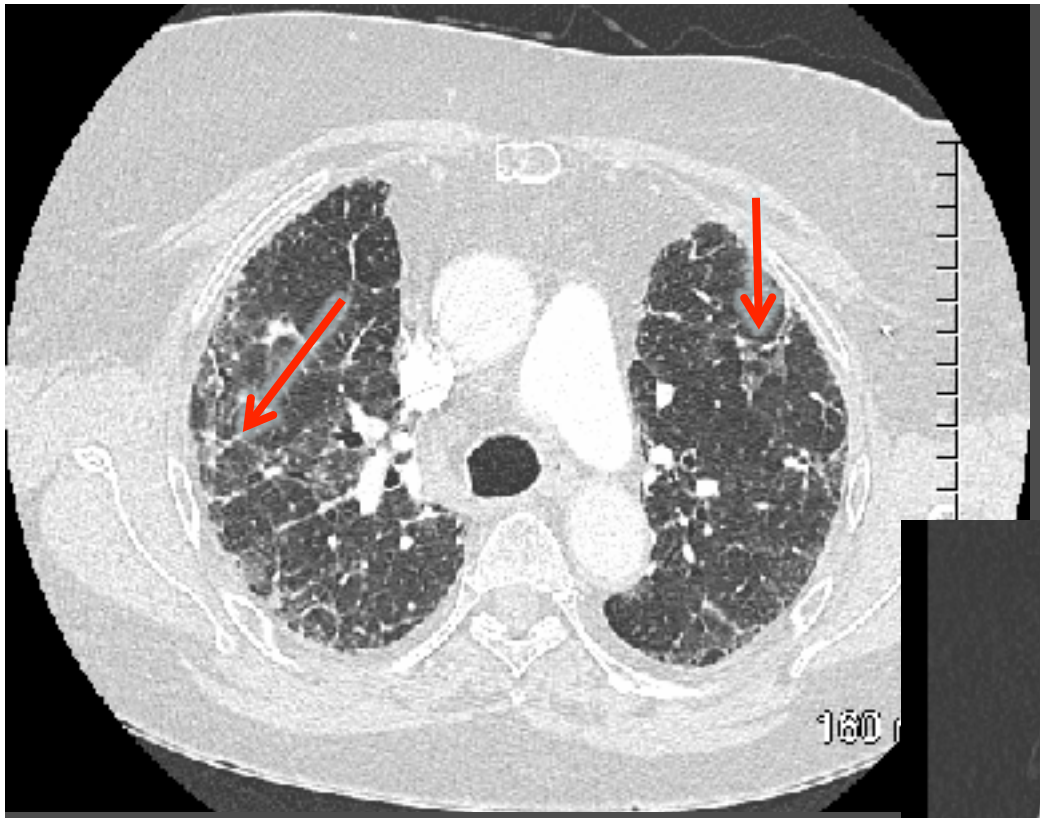
Cas n°4:

- Patiente de 55 ans
- Dyspnée avec toux faiblement productive
- Asthénie et perte de poids
- Râles crépitants à l'auscultation

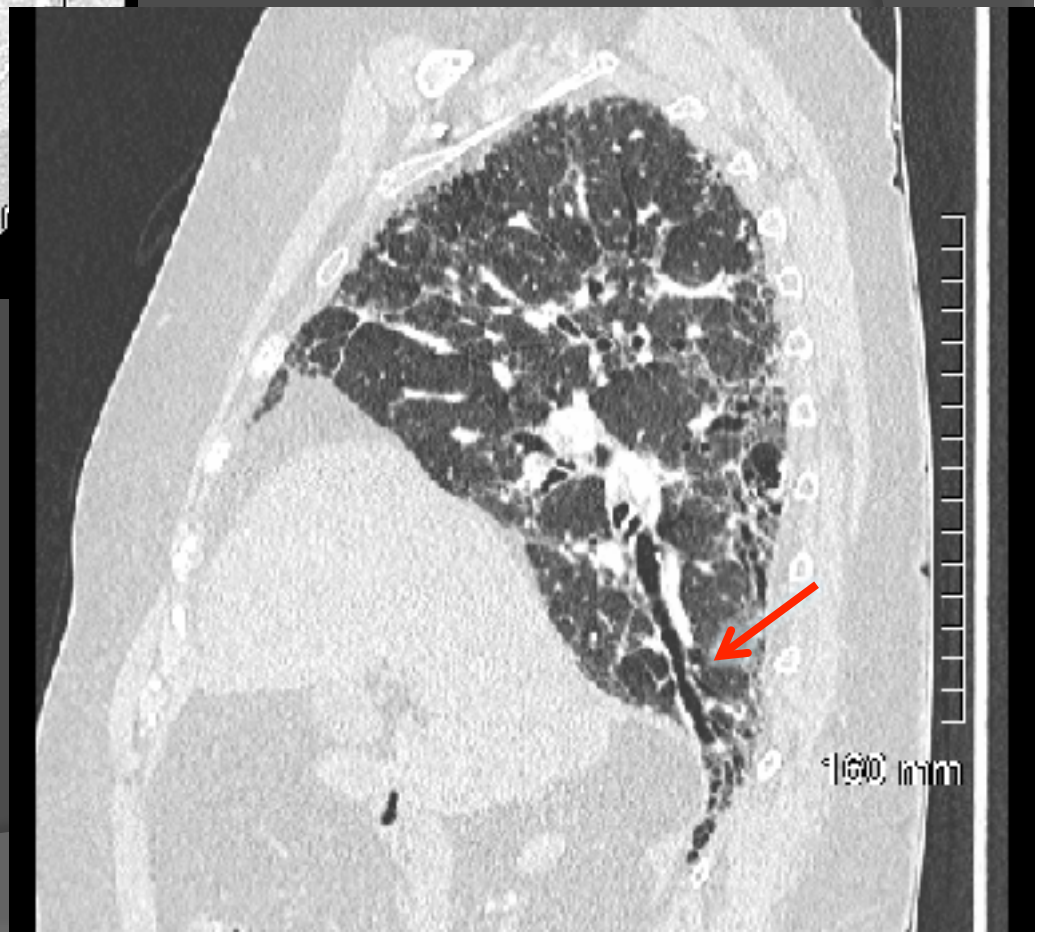

160 mm


180 mm



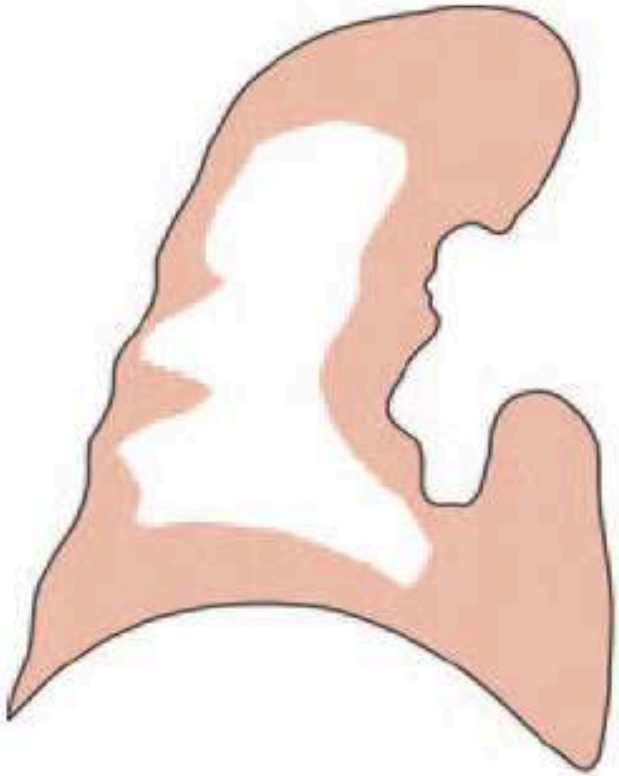


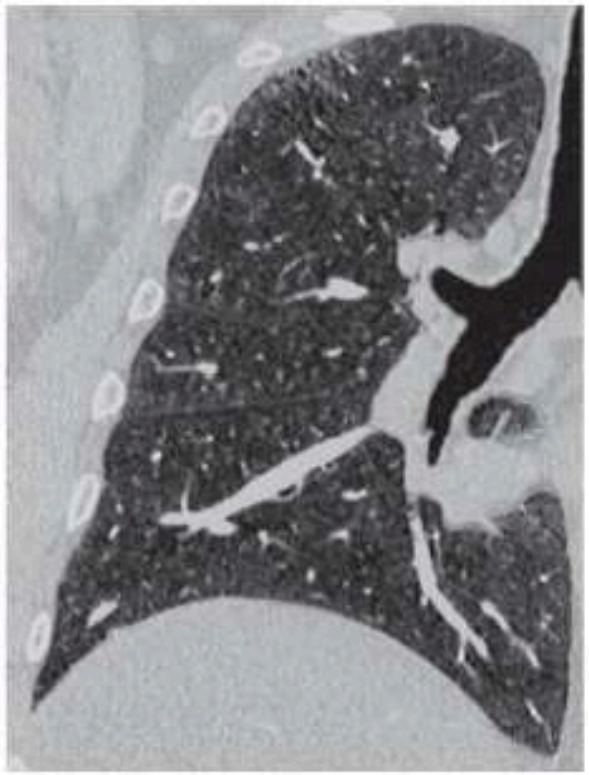
Lésions:
hyperdensités en verre dépoli
Réticulations intra et inter lobulaires
Bronchectasies de traction
Pas de rayon de miel

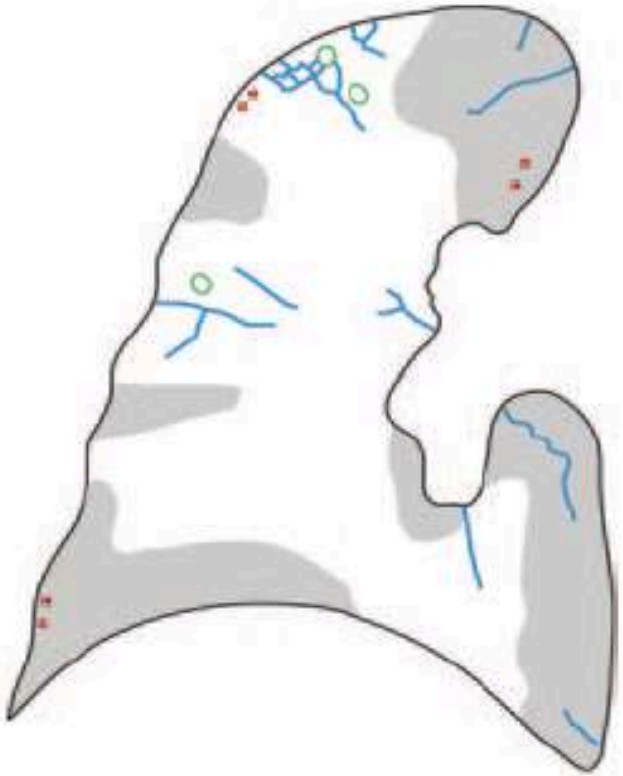


Distribution:
Topographie sous pleurale
Pas de gradient

PINS (pneumopathie interstitielle non spécifique) =
NSIP (non specific interstitial pneumonia)







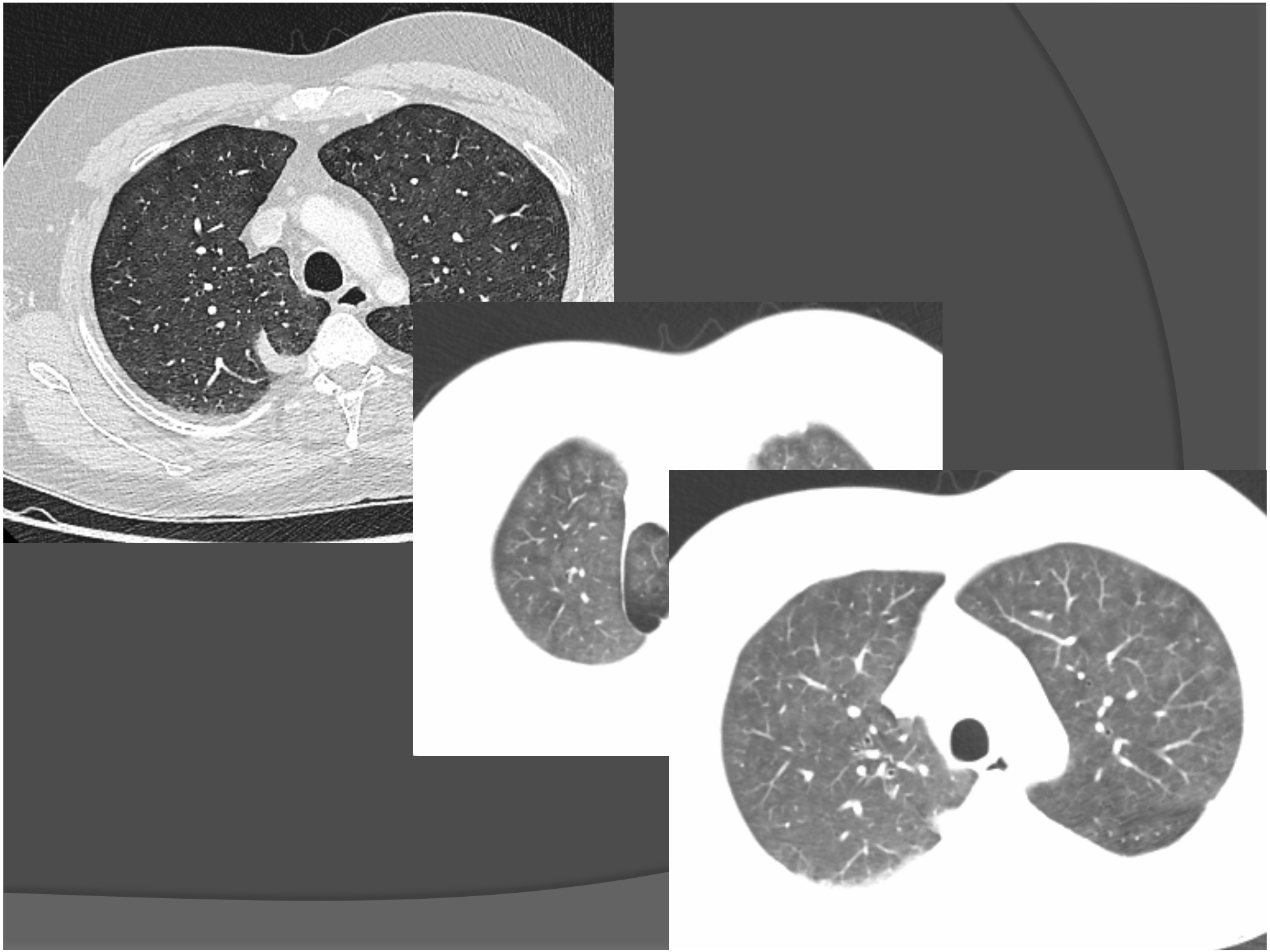
What Every Radiologist Should Know about Idiopathic Interstitial Pneumonias[1]

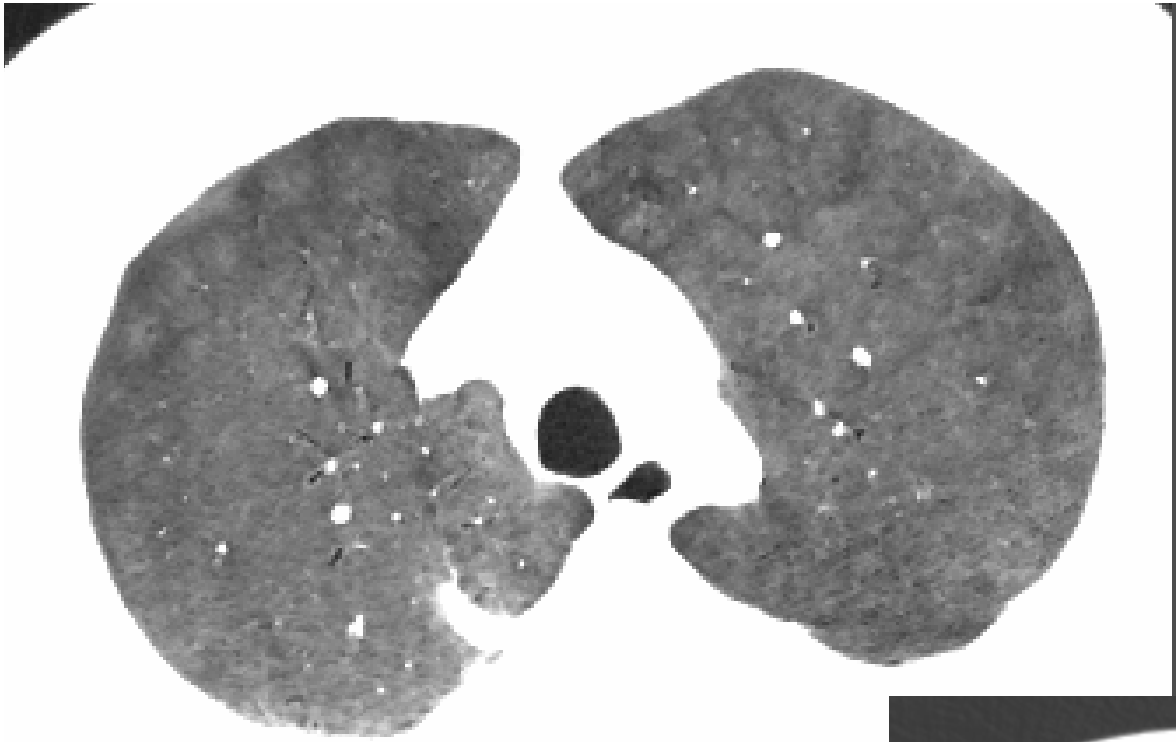
Christina Mueller-Mang, MD • Claudia Grosse, MD • Katharina Schmid, MD • Leopold Stiebellehner, MD • Alexander A. Bankier, MD

RadioGraphics 2007; 27:595–615

Cas N°5 :

- Jeune patient de 32 ans
- Gros fumeur
- TDM pour recherche de lésions pulmonaires
- Discrète asthénie

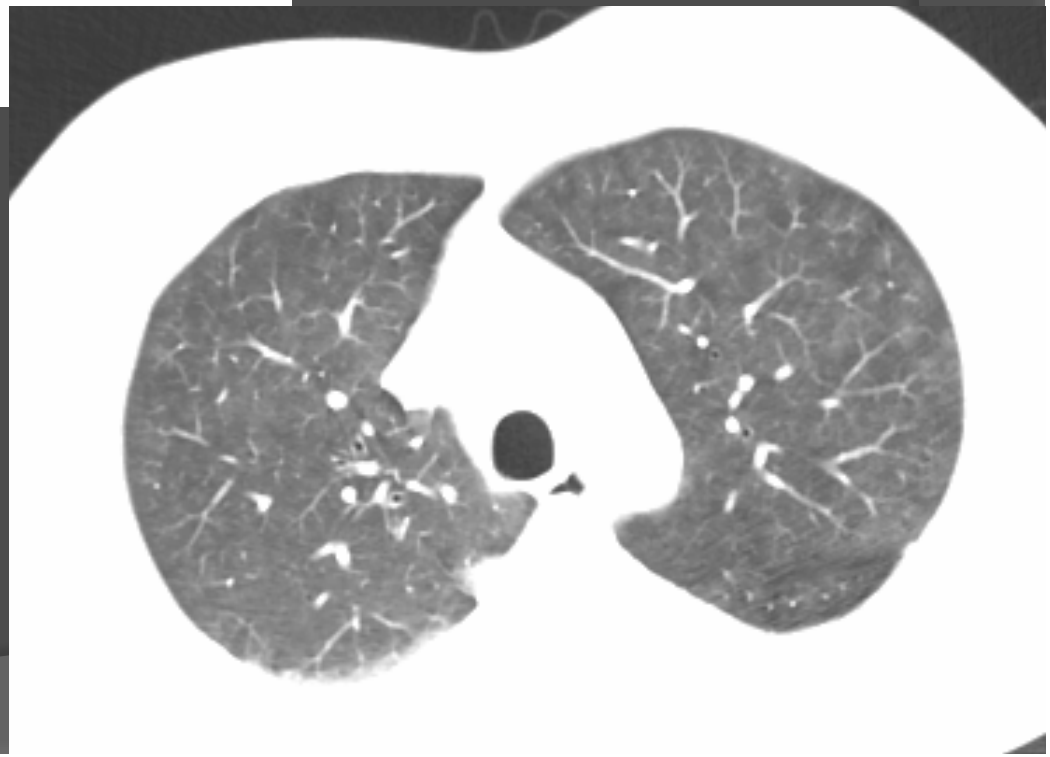


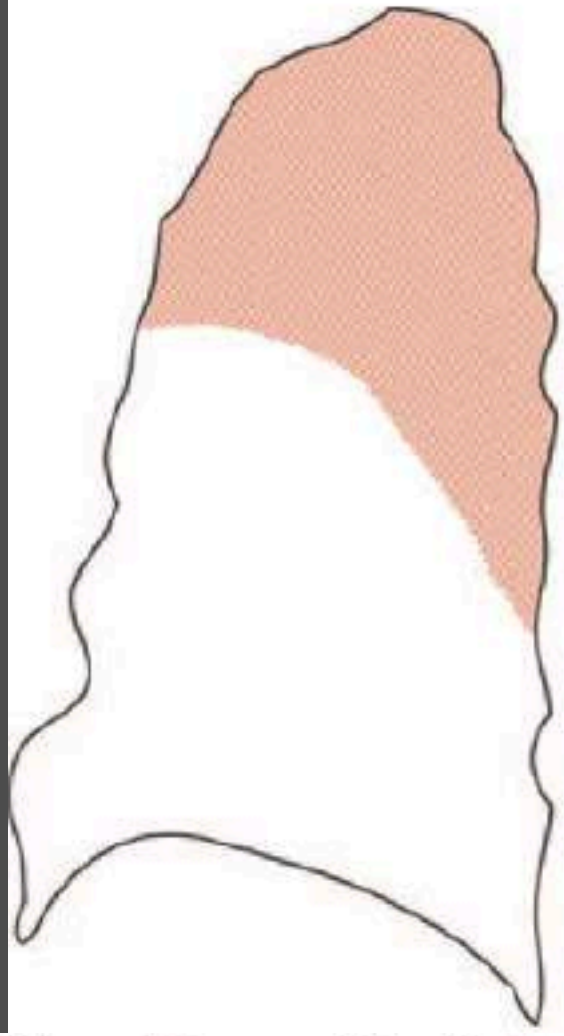


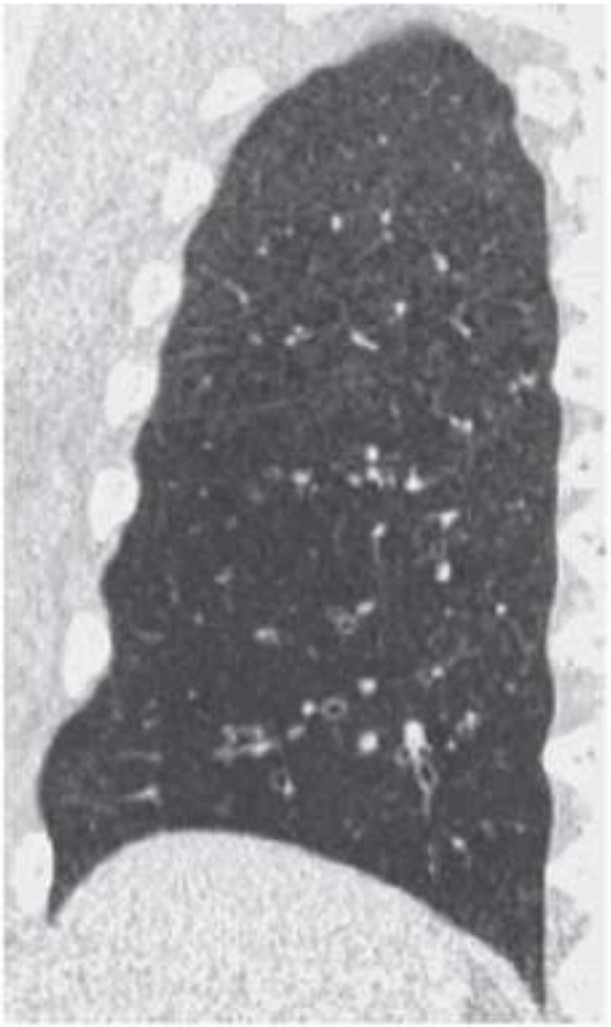
Lésions:
Syndrome micro nodulaire flou
De faible densité
Verre dépoli multifocal

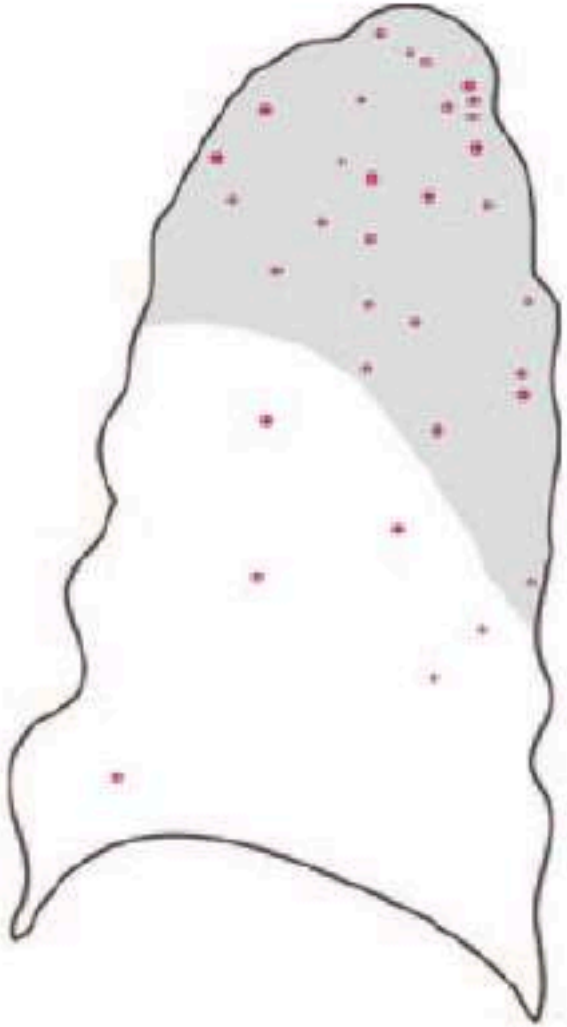
Topographie:
centro-lobulaire
Gradient baso-apical

RB-ILB (respiratory bronchiolitis Interstitial lung disease)









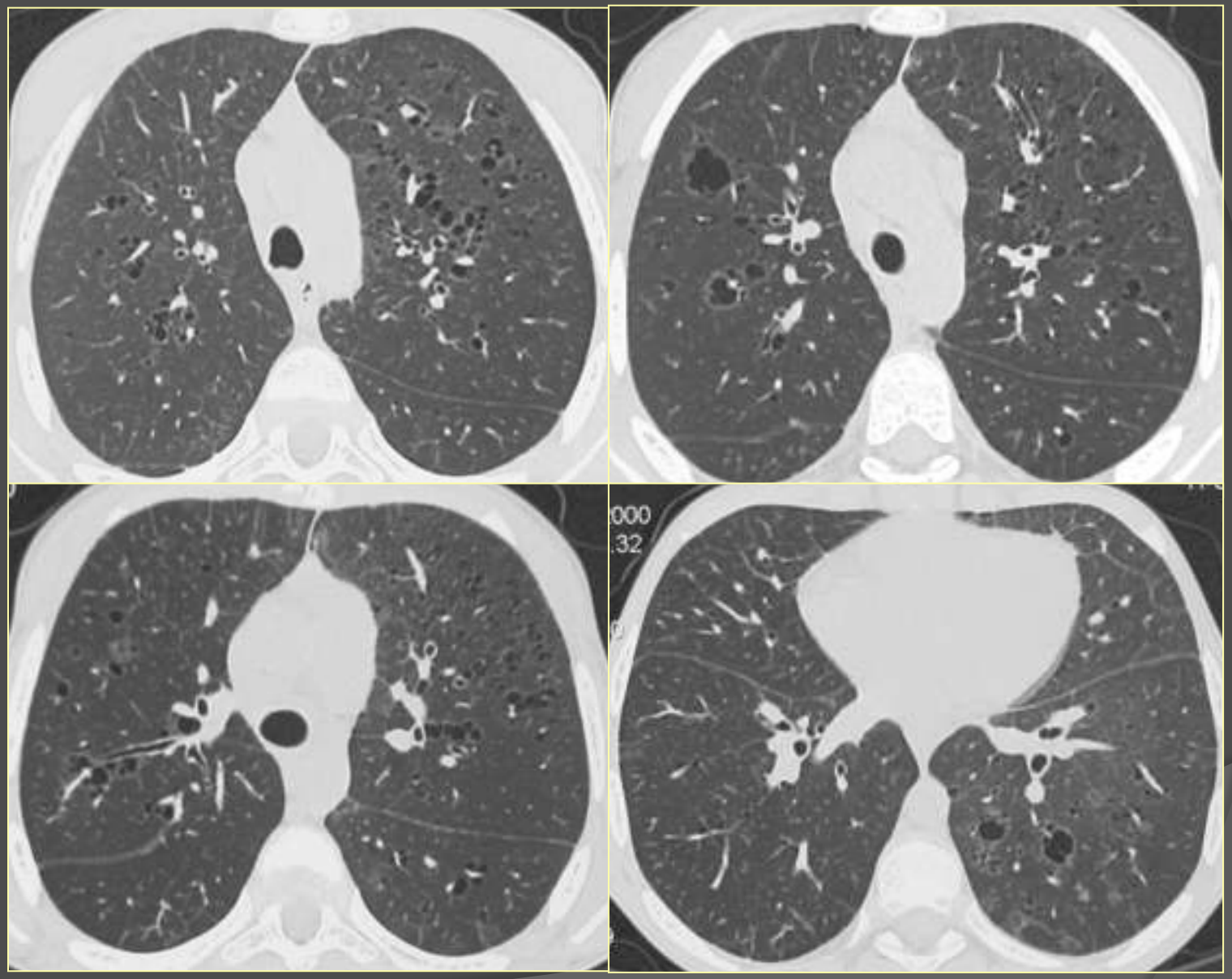
What Every Radiologist Should Know about Idiopathic Interstitial Pneumonias[1]

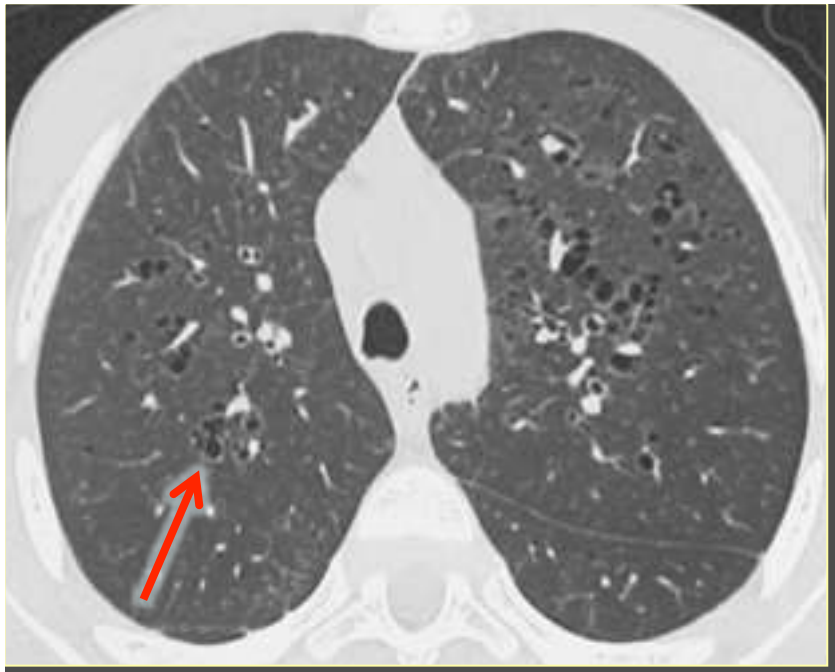
Christina Mueller-Mang, MD • Claudia Grosse, MD • Katharina Schmid, MD • Leopold Stiebellehner, MD • Alexander A. Bankier, MD

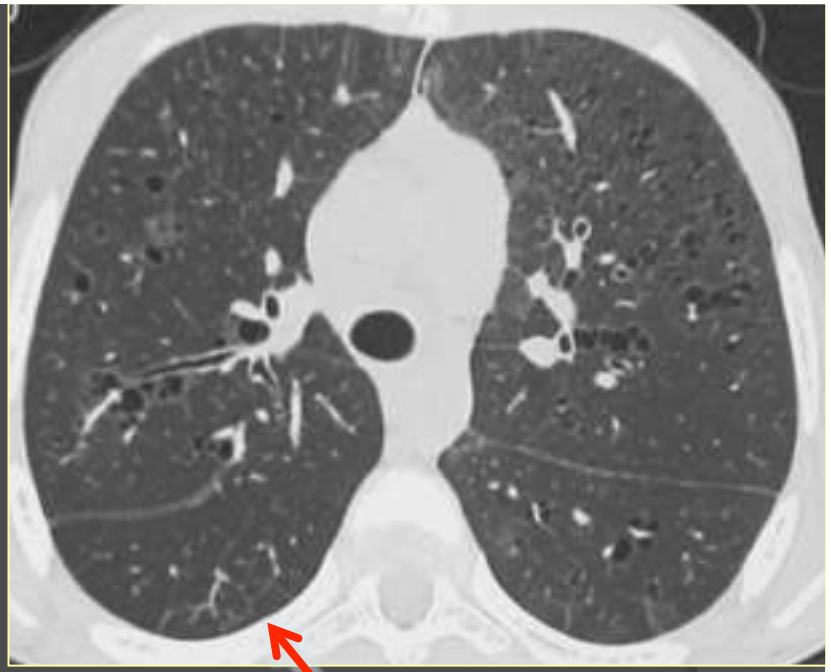
RadioGraphics 2007; 27:595–615

Cas N°6 :

- Patient de 65 ans
- Porteur d'un **syndrome de Sjögren**
- **Dyspnée progressive**


000
.32

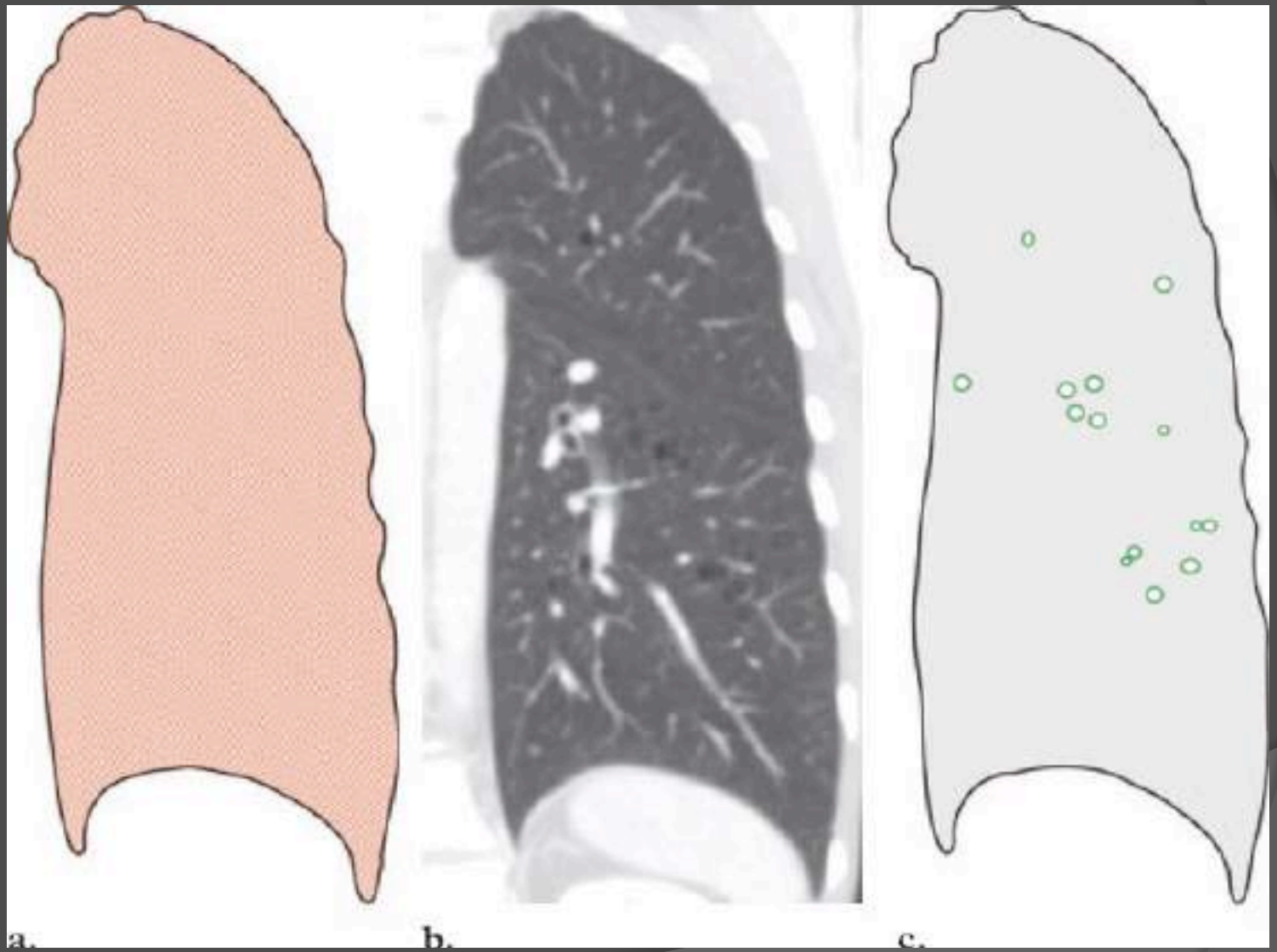




Lésions:
Kystes
Verre dépoli diffus
Nodules centro-lobulaires

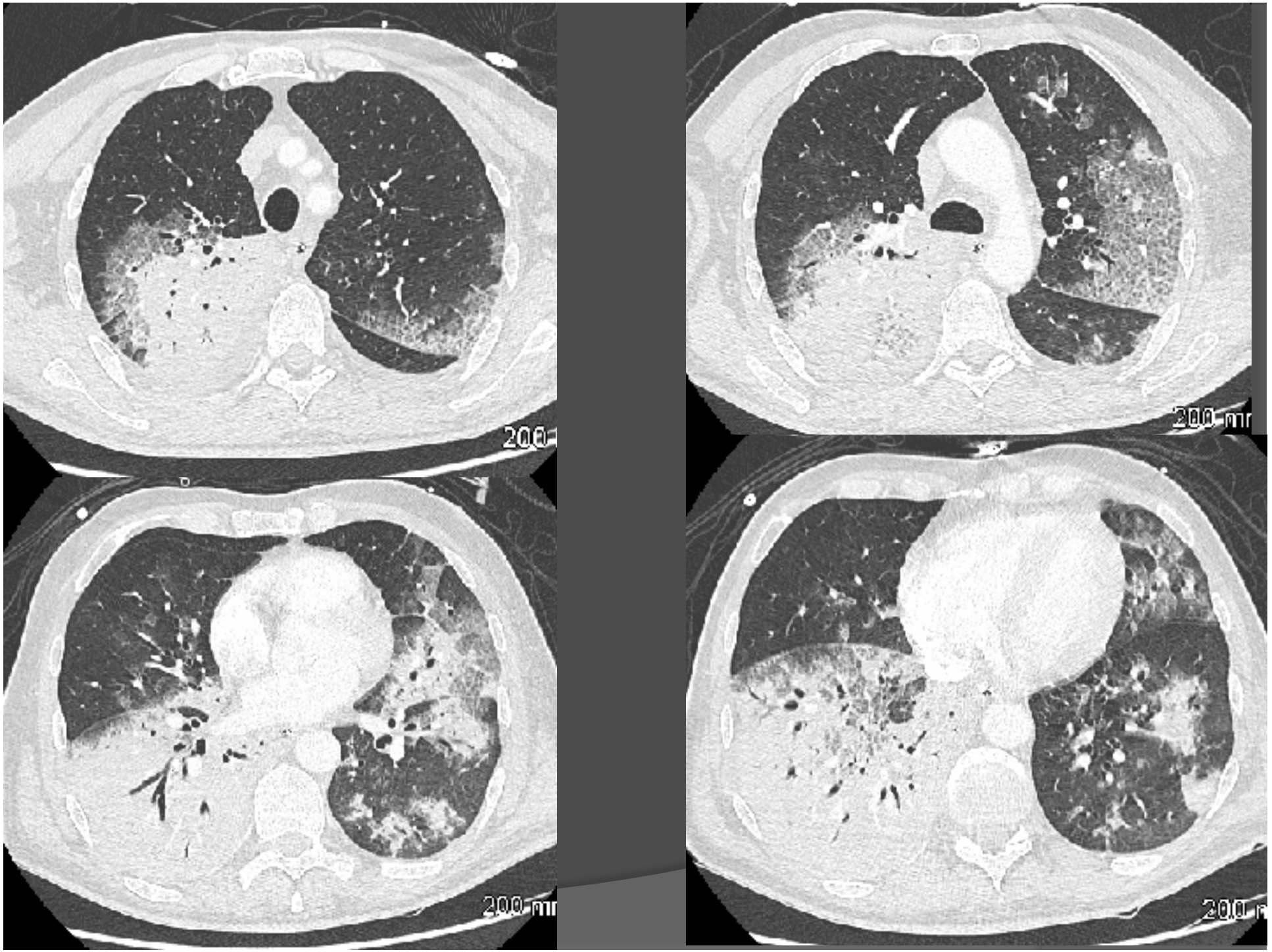
Distribution :
Diffuse

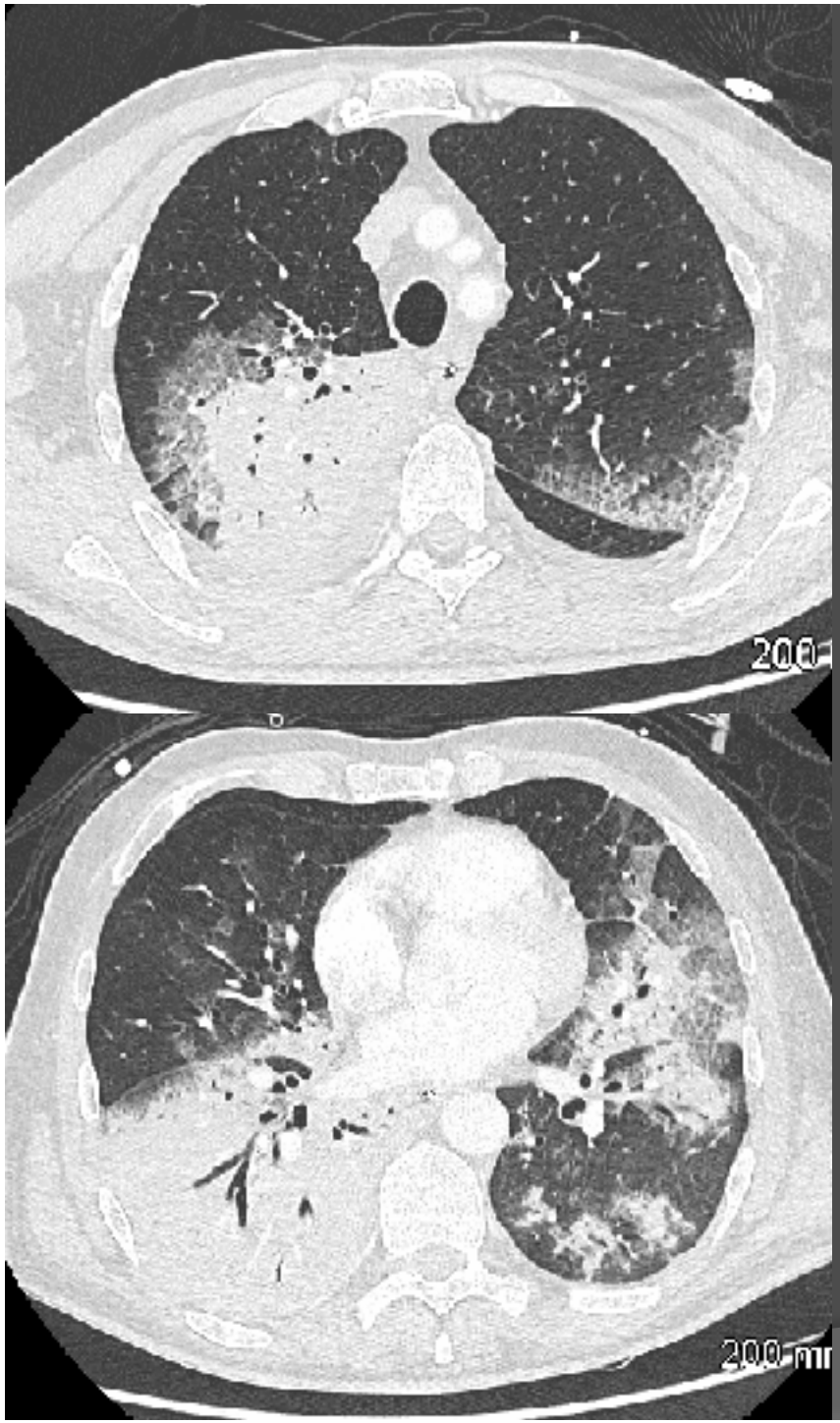
LIP (lymphoïd interstitial pneumonia)


a.
b.
c.

Cas n°7 :

- Patient de 60 ans
- Hospitalisé pour pneumopathie hypoxémiante d'origine infectieuse
- Asthénie +++
- Fièvre à 39°
- CRP à 540 mg/l
- EFR : trouble ventilatoire restrictif





Lésions :
Opacités bilatérales (VD,condensations), homogènes,
bronchogramme
Épanchements pleuraux discrets
Cœur normal

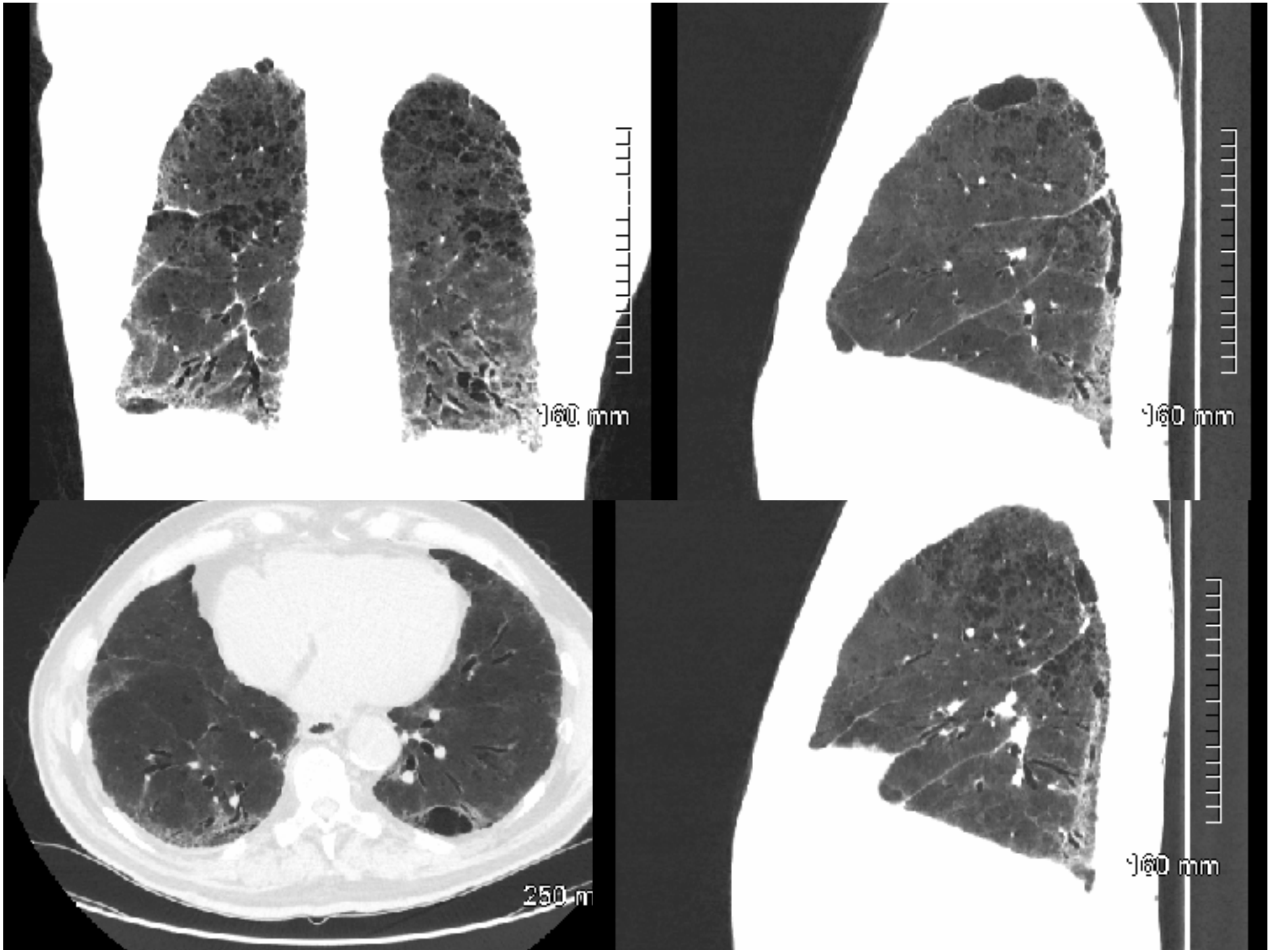
Distribution :
Bilatérales
Gravitationnelles
confluentes

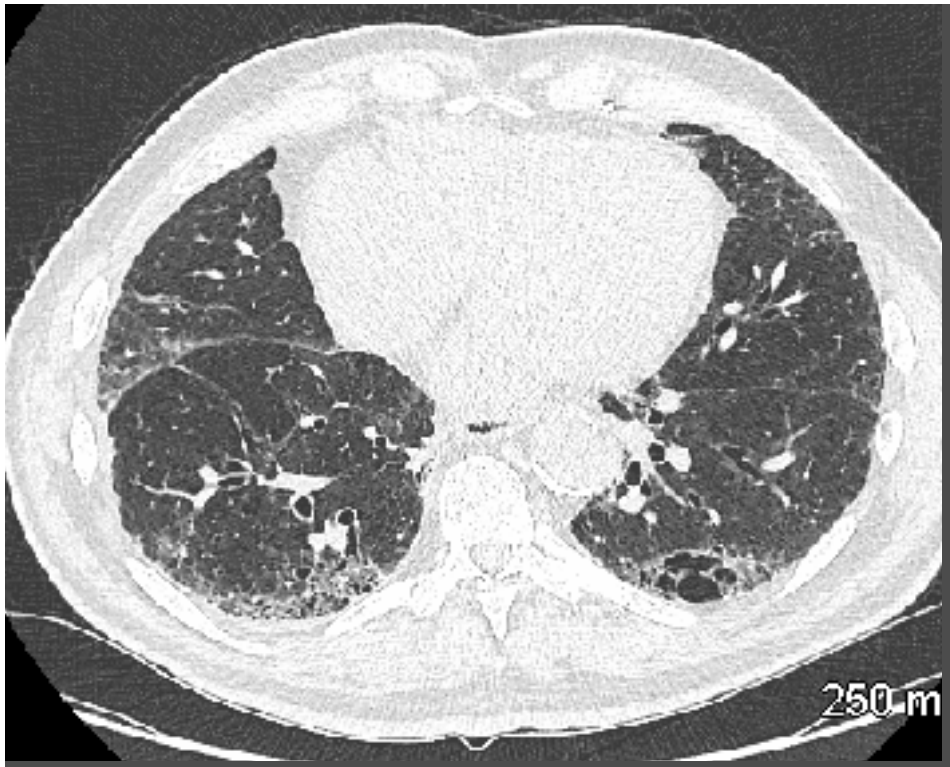
SDRA=
AIP (acute interstitial pneumonia=
DAD (diffuse alveolar damage) histologie

Cas n°8 :

- Patient de 60 ans
- Ancien fumeur
- Dyspnée importante
- CRP à 540 mg/l
- EFR : subnormale


250 mm





Lésions:
Emphysème
Rayon de miel
Bronchectasies de traction

Distribution:
Emphysème aux apex
Fibrose aux bases

Syndrome emphysème/fibrose

conclusion

- Le **compte rendu radiologique :**
  - Description séméiologique des lésions,
  - leur distribution,
  - évolutivité temporelle,
  - site préférentiel de biopsie,
  - dilatation des cavités cardiaques ?
- PIC formelle / possible / exclue ou autre orientation diagnostique
- Importance du contexte clinique +++
- Toujours penser à éliminer une pathologie médicamenteuse +++

www.pneumotox.com