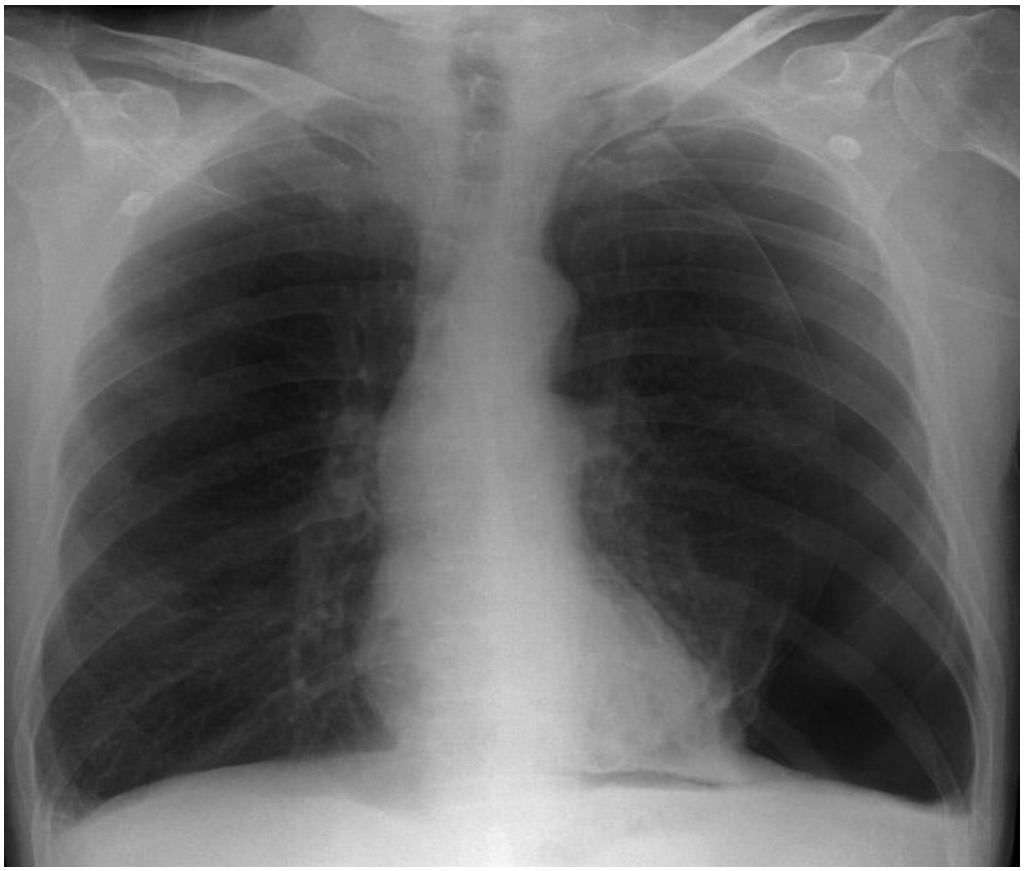
RESPIRATORY
IMAGING



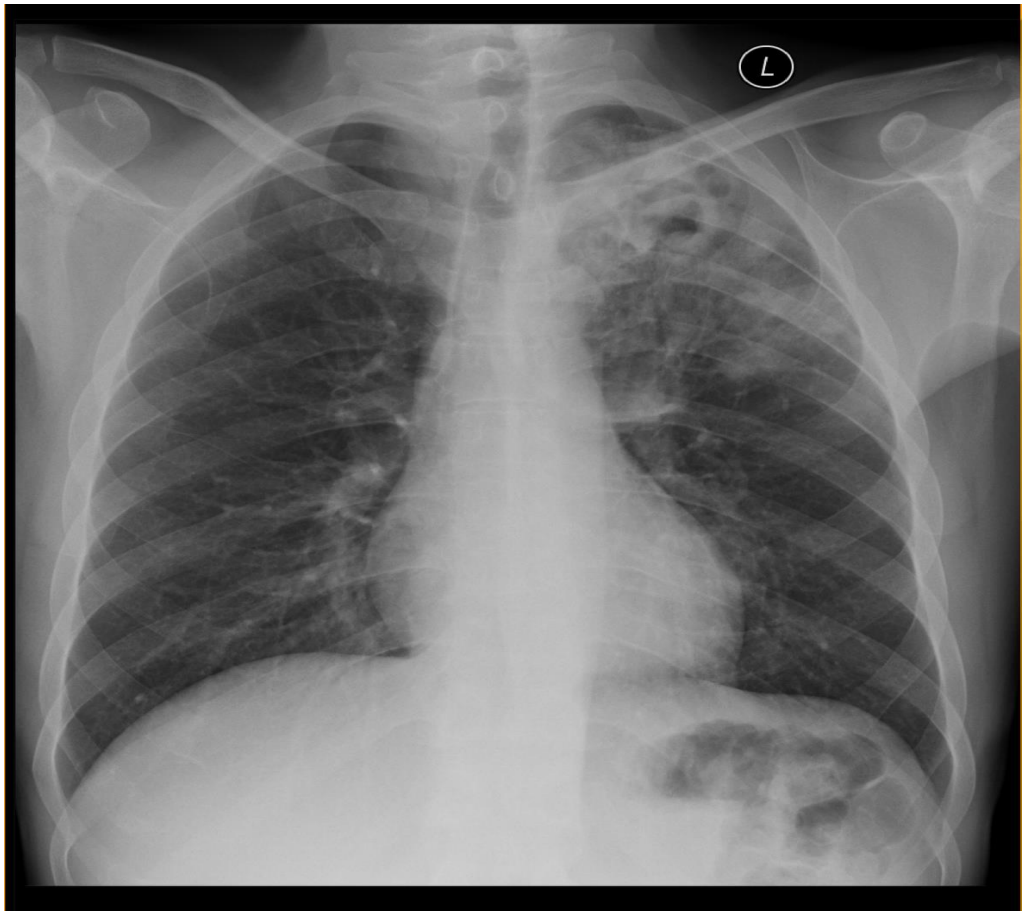
Case 3

24 year old male complaining of pleuritic chest pain and increasing SOB following an RTC in which he was the unrestrained driver.

On arrival his RR is 28, SpO2 is 95%, HR is 130 & BP is 100/50

What is the diagnosis?

What is the IMMEDIATE management?

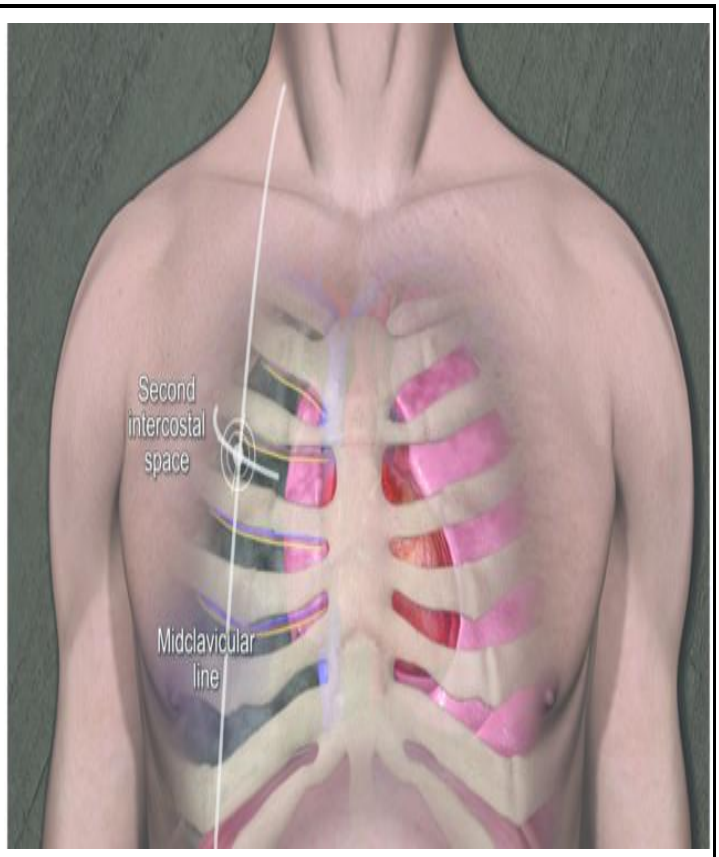


Case 4

A 57 year old man attends ED due to 3-4/52 of cough, malaise, night-sweats and weight loss

What is the diagnosis?

Case 3



Diagnosis: **Tension pneumothorax**
Note carina moving to right of vertebrae but no gross tracheal deviation as yet.

- **Immediate management:**
- **Needle thoracostomy**
  2nd intercostal space, mid- clavicular line

- Caused by progressive build- up of air within the pleural space
- Usually due to lung laceration causing one way valve effect

- Classic signs are:
- Tracheal deviation – usually late sign!!
- Hyper- expanded chest with minimal movement on respiration
- Increased percussion note
- Reduced breath sounds on affected side
- Raised CVP- evidenced by distended neck veins
- Tachycardia
- Tachypnoea +/- hypoxia
- **Tachycardia & tachypnoea may be the only signs present**
- **If not treated will eventually result in PEA arrest due to obstruction of venous return**

Case 3

Diagnosis: **Tuberculosis**

- Caused by Mycobacterium tuberculosis
- Classic symptoms are:
  - Chronic, blood stained purulent cough
  - Fever
  - Night sweats
  - Weight loss- historically known as ‘consumption’
- **CXR** classically shows calcified, cavitating lesion with mediastinal/ hilar lymphadenopathy +/- patchy consolidation. Most common in upper lobes.