Anterior thoracic paint with increasing dyspnea for few days. No cough. Decrease of cardiac sounds.
Case N°1

Enlargement of cardiac silhouette. Notice the symmetry of the 2 edges of the heart in their superior part. No sign of alveolar oedema neither left cardiac failure. The most likely diagnosis is pericardial effusion. Diagnosis is easily confirmed with trans thoracic echography.
Woman, 78 years old, dyspnea and anterior thoracic paint.
Nearly symetric cardiac edges. Cardiomegaly (but CXR in supine position Enlarging cardiac silhouette) . No sign of pulmonary oedema. The echography has confirmed a pericardial effusion.
Man 70 years old, chronic chonic exercice dyspnea, and past history of HTA. Acute and severe dyspnea, with non purulent sputum. Auscultation: crepitant bilateral rales.
Case N°3

Chest Xray: cardiomegaly (but in case of CXR in supine position, be careful with false cardiomegaly).

Alveolar and asymmetric alveolar opacities, with perihilar predominance.

**Acute cardiogenic pulmonary oedema.** (Take notice that the alveolar pictures can be assymetric in cardiogenic pulmonary oedema)
Man, 82 years old, no respiratory signs but worsening condition. Systematic chest radiography.
Case N°4

Chest X ray: not good quality because in supine position. Notice the opacity in the left upper lobe. Positive silhouette sign with aortic arch which has disappeared. **Aneuvrysm of aortic arch** is possible…
Case N°4

Scannographic view confirm the diagnosis of aneurvrysm of the aortic arch.

Normal scan view
Dyspnea increasing progressively and anterior thoracic paint.

Courtesy Dr. Van den Homberg-Tanzania
This enlargement is nearly symmetric between the left edge (incompletely seen) and the right one. The heart looks like a « callebasse ». This is highly indicative of a pericardial effusion, associated with left pleural effusion.

In the context of a country with high incidence of TB, the most probable diagnosis is pleural and pericardial tuberculous effusion.
Young child, polypnea and severe dyspnea. Cardiac sounds not audible.
Case N°6

Chest X ray Typical aspect of a very important pericardial effusion. The left and right cardiac edges are nearly symmetric with overlap of the 2 hili. Life threatening situation. Emergency puncture or surgical drainage is required. In country with high incidence of TB infection, TB is the first etiology of pericardial effusion.
Young woman of 18 years old, chronic exercise dyspnea and cough. Abnormalities of cardiac auscultation suggesting *mitral stenosis*. 
Case N°7

Chest X ray: typical « mitral silhouette » with dilatation of the left middle arch of mediastinum silhouette, vascular hilar hypertrophy and perihilar blur, suggesting post capillary HTAP.

Diagnosis must be confirmed by cardiac echography which is the main way for diagnosis and cardiac surgery indication.
Man, dyspnea and anterior thoracic pain.
Case N°8

Chest X ray: enlargement of cardiac silhouette, with symetric cardiac edges. Overlap of the hili, and no signs of pulmonary odema. The most probable diagnosis is pericardial effusion, which can be easily confirmed by standard echography (no need of a specific cardiac ultrasound machine).
Acute dyspnea, non-purulent sputum and no fever. Auscultation: bilateral crepitant rales.
Chest X ray: antero-posterior incidence. Bilateral alveolar pictures (notice the aeric bronchogram on the left side). Clinical and radiological findings strongly suggest pulmonary cardiogenic oedema, even if the alveolar pictures are not symmetric.
Asthenia and exercise dyspnea. No other thoracic symptoms.
Case N°10

CXR: enlargement of middle stage mediastinum with round picture surrounding right hilus. Enlargement of Aortic arch. **Aortic aneurysm?**
Scan view of the previous case: Aneuvrysm or ascending aorta
Case N°11

Man, 65 years old, smoker, exercice dyspnea.
CXR: small round nodule in the inferior lobe, under pleural area. The para aortic line is convex, suggesting possible **descending aorta aneurysm**. On the lateral view the descending aorta is too well visible, which is an argument for aortic aneurysm.
Case N°11

Scan view of the previous case: descending aorta aneurysm with partial thrombus
Case N°12

64 years old. Past history of smoking. Severe exercise dyspnea, and hemoptysis. Left posterior thoracic pain.
Case N°12

CXR: 2 kind of abnormalities: - typical enlargement of the left auricle, with right side or the left auricle visible in the mediastinal silhouette (red arrows), posterior edge of the left auricle well visible on the lateral view (red arrows), and left ventricle enlargement

- round opacity in the left posterior cul de sac, not well visible on the front view, but well visible in the lateral view (yellow arrow): bronchial cancer
Notice on the scanner view the enlargement of the left auricle and of the left ventricle (red arrows).
On the inferior scan view one can see the inferior left opacity: bronchial cancer (yellow arrow).
Man 46 years old, cough and exercise dyspnea, tachycardia, and past history of anterior thoracic pain.

ECG: myocardial ischemic signs. Auscultation: crepitant rales.
CXR: cardiomegaly with left ventricle enlargement. Encysted pleural effusion in the minor fissura (frequent in case of cardiac failure). Enlargment of pulmonary arteries and alveolar diffuse pictures, with perihilar predominance:

**Acute left cardiac failure, with alveolar oedema, in cardiac ischemic context.**
Case N°13

Same patient after treatment: diuretic TNT and CEI
Notice the cardiac and left ventricle enlargement and the 2 right scissura well visible on the lateral view.
Atypical right position of the aortic arch. Asymptomatic patient
Case N°14

Scan view of the previous patient

Normal scan view