

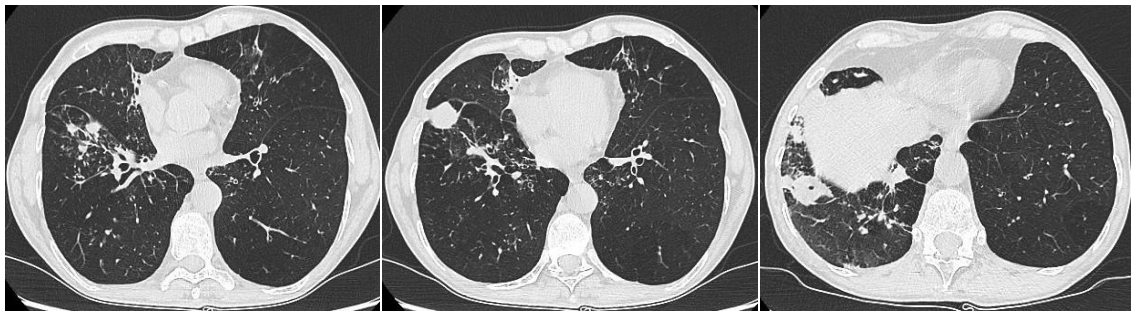
Supplementary material

Korzeniewska-Koseła M, Gątarek J, Bęstry I, et al. Tuberculosis diagnosed by thoracic surgeons. Pol Arch Intern Med. 2021; 131: 633-642. doi:10.20452/pamw.16020

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Supplementary material

Figure S1

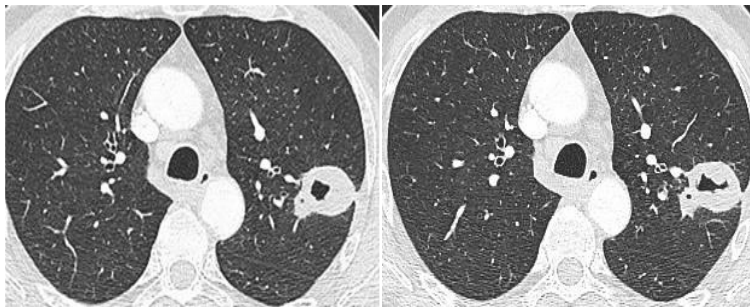


S1A

S1B

S1C

Imaging findings in a 62-year-old, diabetic, cachectic woman who presented with a history of fever and cough persisting for several weeks and a radiological suspicion of tuberculosis from computed tomography features. A–C –computed tomography (lung window, axial plane): A – emphysema and diffuse bronchial wall thickening; B – bronchiectasis – the most numerous in the middle lobe, lingula, and basal segments of the right lower lobe. In the left lung, mainly in the lingula, single small nodules corresponding with the plugs in the bronchioles can be seen. C – multiple massive, disseminated nodules of similar morphology in the right lung, among them consolidations of different shapes and sizes, with slight cavitation

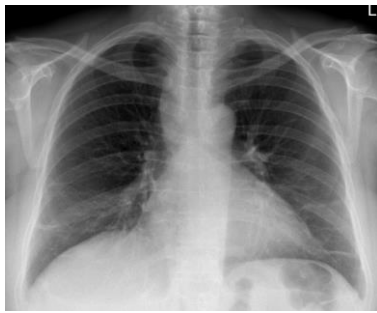


S1D

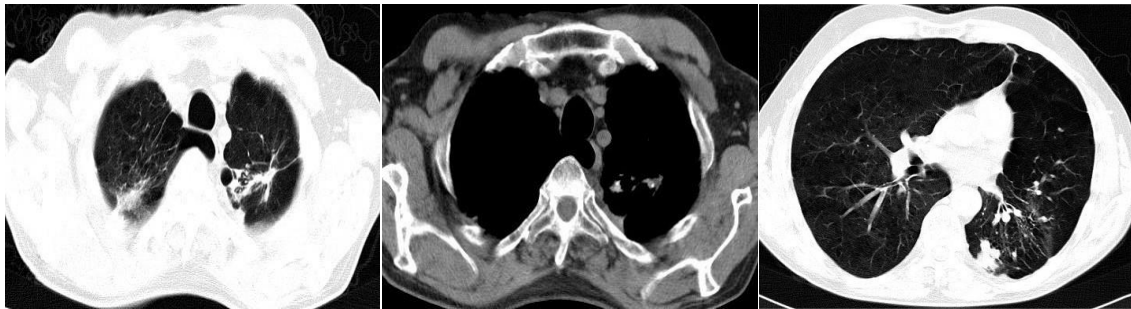
S1E

Imaging findings in a 51-year-old diabetic man with a history of alcohol abuse and cigarette smoking who was referred to our Institute with a radiological suspicion of necrotic lung tumor detected accidentally on chest radiograph a month earlier. D, E –computed tomography (lung window): D – thick, irregular-walled cavity, partially adjacent to the pleura in the apical-posterior segment of the left upper lobe; E – several perihilar nodules of up to 6 mm in diameter, located below the cavity.

Figure S2



Imaging findings in a 54-year-old woman with difficulty swallowing. Endobronchial ultrasound was performed before mediastinoscopy, but no microbiological tests for tuberculosis were carried out. The chest radiograph (posteroanterior view) shows enlarged right paratracheal lymph nodes. Linear opacities with scars in the lingula and the right lower lobe can also be seen.



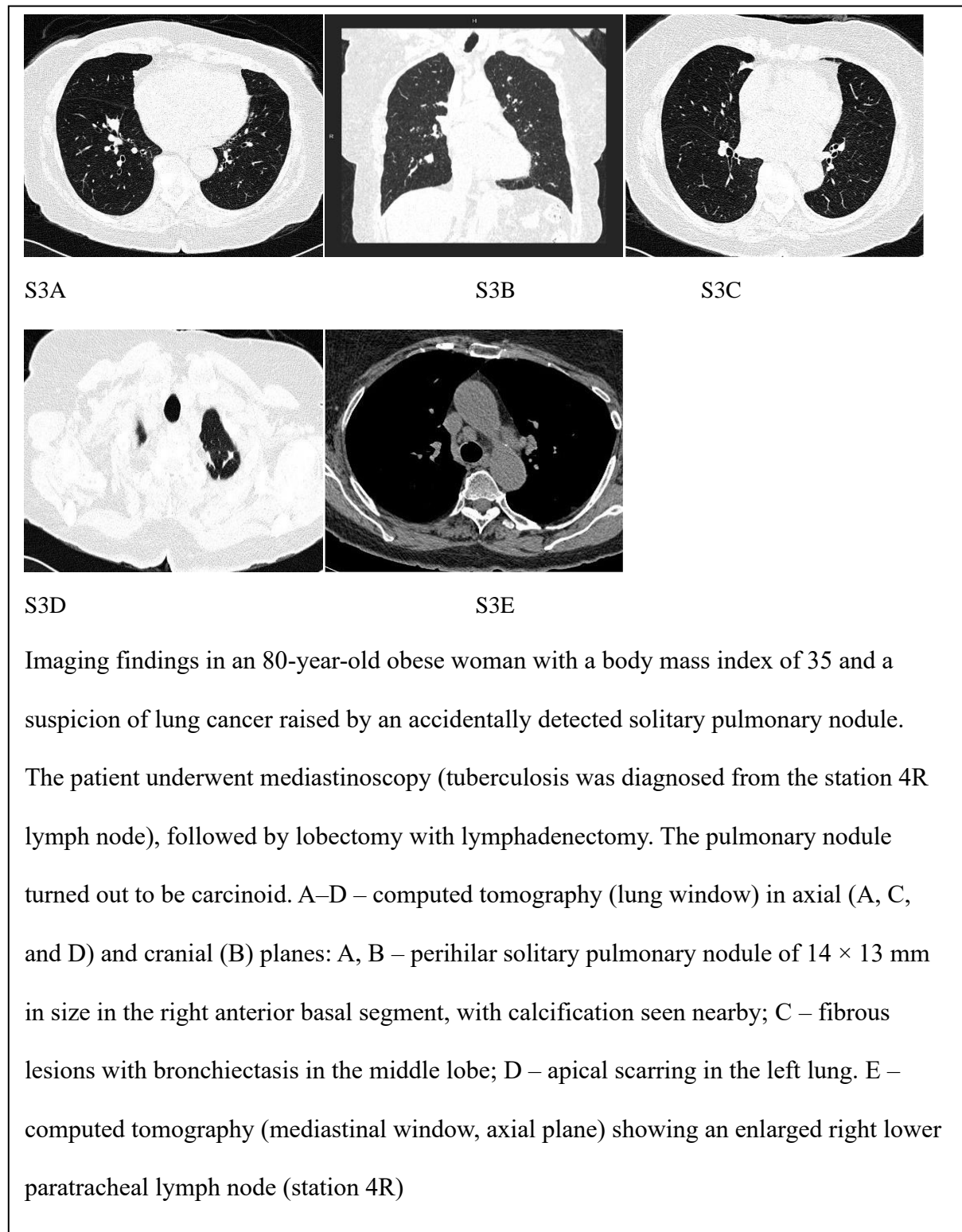
S2A

S2B

S2C

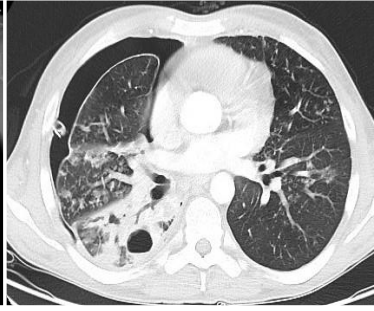
Imaging findings in a 61-year-old man with a history of tuberculosis, admitted with a suspicion of “scar carcinoma.” A–C – computed tomography: A – lung window showing scars and nodular lesions in the upper lobes and the apical segment of the left lower lobe, more prominent on the left side; B – soft-tissue window demonstrating calcification; C – lung window showing advanced emphysema and poorly defined parenchymal consolidations (“scar carcinoma”?) among scars in the apical segment of the left lower lobe.

Figure S3

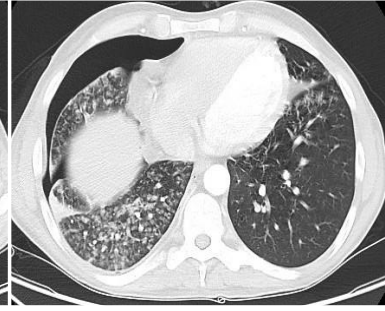




S3F



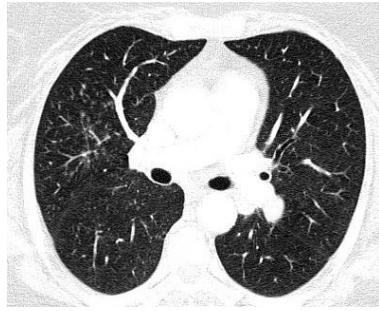
S3G



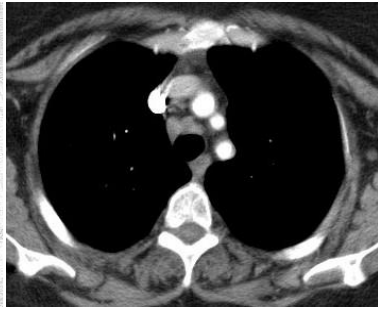
S3H

Imaging findings in a 37-year-old cachectic man with a history of cigarette smoking and fever, admitted due to pneumothorax. A radiologist suggested tuberculosis based on the patient's computed tomography. F – chest radiograph (posteroanterior view) showing right-sided pneumothorax; a drain in the right pleural cavity; bilateral patchy consolidations, predominantly in the right lung; confluent consolidations in the right lower lobe, with signs of cavitation; and an oval, well-defined opacity in the right subclavian area. G, H – computed tomography (lung window) demonstrating right-sided pneumothorax surrounding the lung and a drain in the right pleural cavity (G) and patchy parenchymal consolidations in both lungs, confluent in the right lower lobe, with apparent air bronchogram and cavitation (H)

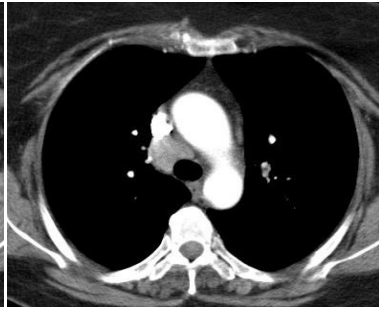
Figure S4



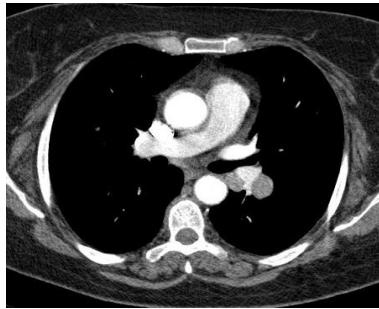
S4A



S4B



S4C



S4D

Imaging findings in a 51-year-old female immigrant from a country with a high incidence of tuberculosis, with a history of cigarette smoking, obesity (body mass index, 35.3), and cough persisting for a month who was referred to our Institute with a suspicion of pulmonary malignancy or sarcoidosis. The diagnosis of tuberculosis was reached based on the analysis of a lymph node specimen obtained during mediastinoscopy. Preprocedural sputum smears and cultures yielded negative results for tuberculosis (molecular tests were not performed). A – computed tomography (lung window, axial plane) showing diffuse small nodules in the right parahilar region; B–D – computed tomography (mediastinal window, axial plane) demonstrating enlarged mediastinal lymph nodes—upper paratracheal, right lower, and left hilar.

Figure S5



S5A

Imaging findings in a 51-year-old man with a history of diabetes, cigarette smoking, and alcohol abuse. Lesions on chest radiography were detected accidentally. A – chest radiograph (posteroanterior view) showing irregular consolidations in the left upper and middle zones and in the upper zone of the right lung.



S5B

Imaging findings in a 67-year-old man admitted with a suspicion of lung cancer (a radiologist also considered tuberculosis). B – chest radiograph (posteroanterior view) demonstrating irregular consolidations with low-density foci that suggested cavitation in the upper zones, mainly in the apical and posterior segments of the right lung and the apical-posterior segment of the left lung; discrete linear opacities in the lingula; left pleural effusion, and a deformed and dilated left hilum.