A 59-year-old female patient presented with fever and dry cough. Chest radiography taken at admission to the emergency department showed pulmonary infiltrate. The patient was referred to the hospital to undergo high-resolution computed tomography scan (Figure 1).

Figure 1. High-resolution computed tomography, lower pulmonary regions section.
component of the RHS in 83% of those cases. No patient with COP presented nodular RHS or central nodules.

The importance of identifying imaging patterns that could raise the possibility of active tuberculosis has long been recognized as highly relevant for public health and to ensure that infected patients receive the appropriate therapy. Acid-fast bacilli are found in the sputum in only a limited number of patients with active pulmonary tuberculosis. For this reason, antituberculosis treatment is frequently initiated and preventive measures such as patient isolation are taken on the basis of imaging findings suggestive of active tuberculosis even before bacteriological confirmation\(^{(16)}\).

Well-recognized HRCT findings of postprimary pulmonary tuberculosis include centrilobular or airspace nodules, branching linear and nodular opacities (tree-in-bud pattern), areas of consolidation, cavitations, bronchial wall thickening, miliary nodules, tuberculomas, calcifications, parenchymal bands, interlobular septal thickening, ground-glass opacities, pericarticularly emphysema, and fibrotic changes\(^{(11-15)}\). Usually, the nodular appearance of the RHS corresponds to the presence of active granulomatous disease and frequently represents granulomatous infection, particularly tuberculosis. In conclusion, nodular reversed halo sign should be included in the spectrum of parenchymal abnormalities observed at HRCT in patients with active tuberculosis.

**REFERENCES**