



PATIENT

Buddy The Elf
DeAntonis

SPECIES

Canine

BREED

Golden

SEX

MN

AGE

11Y

WEIGHT

72lbs

INTERPRETED BY

Heike Rudolf, DVM, Dr.
med. Vet., DipECVDI
DVR

IMAGING PERFORMED BY

Amanda Hartman,
DVM

HOSPITAL NAME

White Hall Animal
Clinic

REFERRING VET

Amanda Hartman, DVM

INVOICE

73224

DATE

1-6-26

PRESENTING CLINICAL SIGNS

anorexia x 5 days; gastritis, regenerative anemia; incidentally found lung issues, so suspect chronic as patient has NO dyspnea; no lymphadenopathy; previously had spleen removed 2 years ago, benign mass, found due to regenerative anemia

Abnormal PE/Chem/CBC/UA Results: Referred for AUS due to anorexia; had thickened stomach and duodenum, but noted fluid and hyperechoic material cranial to diaphragm; T FAST- showed pleural effusion, and mixed echogenic pattern through much of the lung field; aspirated the lung tissue/fluid which was serosanguinous and fluid is pending pathologist review. Regenerative anemia; lots of EOS seen on in house cytology from lung aspiration; no bacteria seen, lots of neutrophils, otherwise similar to peripheral blood

RADIOGRAPHS OF THE THORAX

R/L lateral and VD are provided, totaling three radiographs for interpretation.

RADIOGRAPHIC FINDINGS

The body condition score is 6/9 with predominantly dorsal subcutaneous fat.

Small osseous bridges are present dorsal to two intersternal spaces.

The cranial mediastinum is wide and fills approx. 80% of the cranial thoracic width on the VD view; the carina is located level with T6. In right lateral recumbency the ventral thorax is occupied by a soft tissue opacity (STO) which displaces the lung lobes dorsally; this is especially pronounced cranially where only the dorsal 1/3 of the lung lobe is aerated. The lobar edges are rounded. In left lateral recumbency air-bronchograms are visible in intercostal space 4, just distal to the pulmonary vein. The caudo-ventral lobe has an inverted S-shape due to a STO overlying the cardiac silhouette which merges with the STO in the ventral thorax. Thin pleural fissure lines are especially obvious on the left. On the right, a triangular STO extends from the mediastinum towards the periphery level with rib 7 but does not reach the pleural surface. The caudal lobes show a loss of clear vascular outline with bronchial enhancement. In the right caudal lobe air-bronchograms are present in a tubular STO which parallels the caudal vena cava. Caudal displacement of the cranial lung lobes is evident on all three views.

The cardiac silhouette is obscured by the soft tissue opacity

RADIOGRAPHIC DIAGNOSIS

- Mediastinal fluid
- Pleural fluid
- Possible cranial mediastinal mass
- Pulmonary infiltrate (alveolar-interstitial)

Incidental findings:

- Sternal new bone

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The elevation of trachea and carina, in association with the predominantly cranial lobar displacement, is highly suggestive of a cranial mediastinal mass. The mass can represent a granuloma (e.g., eosinophilic), malignant mass (e.g., hemangiosarcoma, lymphoma, thymoma), abscess and cyst. The pleural fissure lines on the VD are thin, and the lung lobes are relatively close to the thoracic wall thus mediastinal seems to be more pronounced than pleural fluid. The interstitial pattern is a non-specific finding and can represent



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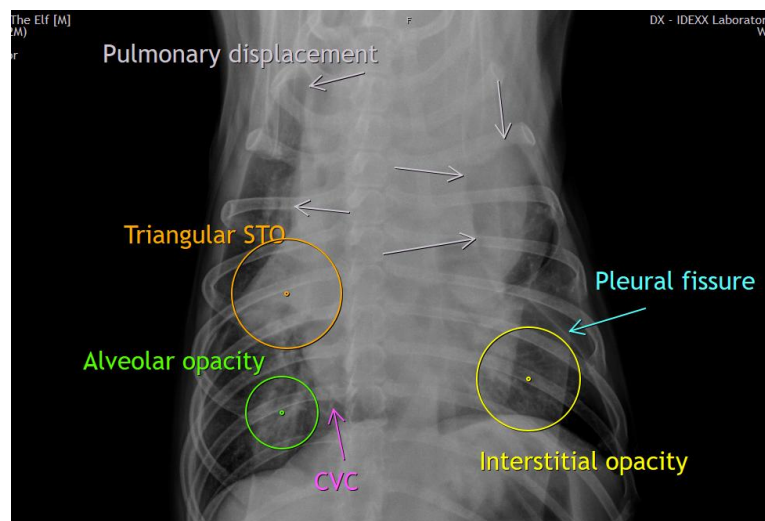
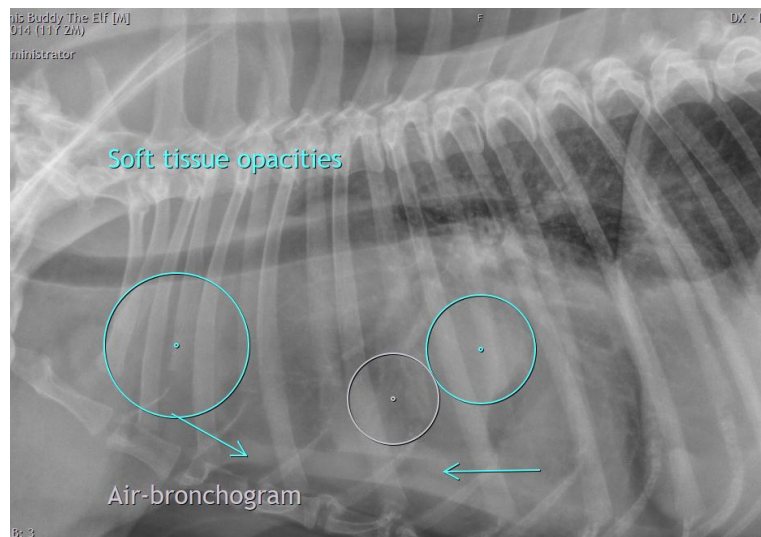
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a combination of superimposed pleural fluid and the only fair expansion of the lung field. Possible differential diagnoses for a true infiltrate include:

- Infection (bacterial, fungal e.g., candida, viral, parasitic)
- Inflammation (allergic pneumonitis, eosinophilic bronchopneumopathy)
- Edema
- Diffuse hemorrhage

The additional alveolar component makes infection and inflammation more likely. The high eosinophile count in the lung aspiration suggests a diagnosis of pulmonary eosinophilic granulomatosis. However, tumour can also cause a high eosinophil count in pleural fluid. A CT examination is recommended to rule out a cranial mediastinal, pulmonary or pleural tumour. The thickened gastric and duodenal walls described in the history should be sampled. As they could be the result of granulomatous or tumour infiltrate.





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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

Heike Rudolf, DVM, Dr. med. vet., DipECVDI, DVR
info@sonopath.com