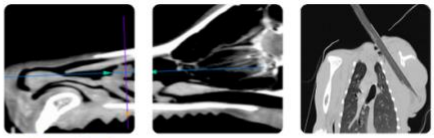

PATIENT

Chloe Routhier

SPECIES

Canine

BREED

Schnoodle

SEX

Spayed Female

AGE

14 Years

WEIGHT

26 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Riley

HOSPITAL NAME

Foxfield Veterinary Services

REFERRING VET

Dr. Riley

INVOICE

13091

DATE

01/10/26

PRESENTING CLINICAL SIGNS

Hx of coughing for 3-4 years. Previous vet had started her on Pimobendan and theophylline and has been well controlled. In the past week P has been having more frequent coughing episodes. Otherwise, P is normal.

Abnormal PE/Chem/CBC/UA Results: Afebrile. MM pink. Heart: murmur 2-3/6, systolic. Loudest L side. Lungs auscultated clear. Skin: multiple SQ masses. Tracheal pinch reaction positive.

RADIOGRAPHIC STUDY OF THE THORAX

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

Undated, non -DICOM images

RADIOGRAPHIC FINDINGS

The body condition score is 7/9 with a larger dorsal s.c. fat accumulation. Ventrally along the sternum extends a crescent shaped fat opacity with localized soft tissue components. A similar fat opacity is located along the right thoracic wall.

Very mild new bone formation is present on some lumbar spinal endplates.

The cranial mediastinum is of physiologic size and opacity. The trachea diverges from the thoracic vertebrae, and the carina is located level with T5/6. A dorsal, crescent shaped, soft tissue band reduces the tracheal air space between C3 and T1 to approx. 30%.

The degree of pulmonary expansion is fair. The lung lobes extend to the thoracic boundaries and their tips are pointed. A bread role shaped lucency is located in the left caudo-dorsal lung field, level with and lateral to the main stem bronchus. It is surrounded by a homogenously thickened and smooth wall. The surrounding lung parenchyma shows an increased opacity with loss of clear vascular outline and mild bronchial enhancement. Medial to the lucent structure a small, round soft tissue opacity (STO) is partially superimposed onto a rib and a second, oval one located slightly cranial to it. This is best visible on the VD view.

The cardiac silhouette occupies 85% of the chest height and 3 intercostal spaces. The caudal heart border appears straight in right lateral recumbency.

RADIOGRAPHIC DIAGNOSIS

Left caudal lobe

- Air filled structure left caudal lobe
- Interstitial pattern

Tracheal collapse

Incidental finding

- Spondylosis, mild
- Thoracic wall lipomata

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differential diagnoses for the air-filled structure/mass in the left caudal lobe include bronchogenic cyst, air filled abscess, and localized bronchiectasis, all of which can be the result of pneumonia, eosinophilic bronchopneumopathy or other inflammatory airway diseases. Further differentials are congenital bronchial abnormality or tumor with the previously necrotic center being replaced by air.

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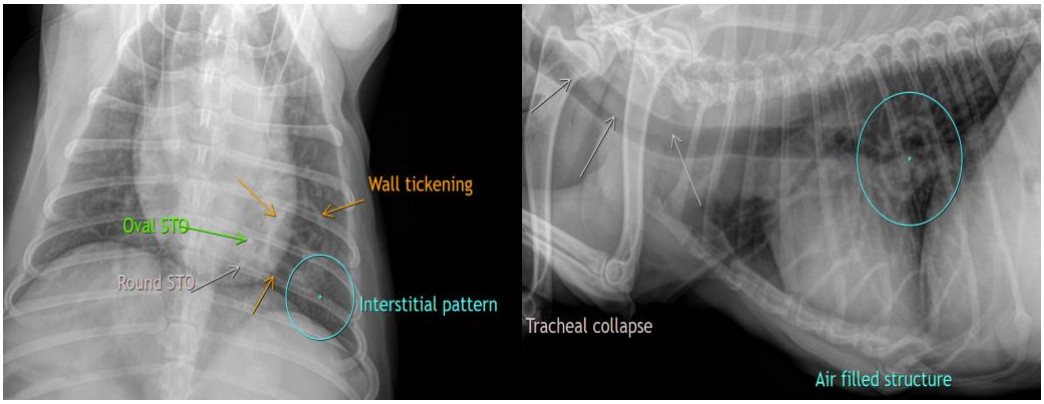
The regularity of the surrounding wall thickening is, however, unusual for abscess and tumor. In case removal is considered, CT is recommended for identification of the relationship between bronchus and air-filled mass. The interstitial pattern lateral to the mass lesion can be due to compression/atelectasis or infectious/inflammatory infiltrate. The two nodular structures identified on the VD view could represent end-on blood vessels, granulomata or metastases.

Tracheal collapse alone can be due to a weakened dorsal tracheal ligament. Tracheal in combination with bronchial collapse is usually due to an altered cartilage development which may go unnoticed until physical circumstances (such as stress, running, excitement) or disease (e.g., mass, pneumonia, bronchitis) reduces the ease of airflow. The gold standard for imaging both pathologies is tracheo-bronchoscopy, and a sample can be obtained for cytology and bacteriology. Due to the presence of a heart murmur, echocardiography to assess cardiac function and valvular appearance is suggested.



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