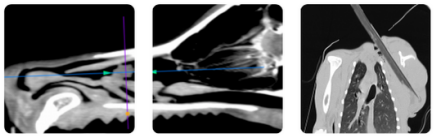

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Candy Villagomez

SPECIES

Feline

BREED

DSH

SEX

Intact Female

AGE

1 Year 4 Months

WEIGHT

6 Pounds 4 Ounces

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Tudor Suciu

HOSPITAL NAME

Animal Clinic of Queens

REFERRING VET

Dr. Tudor Suciu

INVOICE

35678

DATE

11/28/25

PRESENTING CLINICAL SIGNS

History: Coughing for 5 days, productive (from time to time brings up yellow foam after coughing). Today open mouth breathing. Not eating for 3 days. Low energy level. Strictly indoors.

Abnormal PE/Chem/CBC/UA Results: Increased respiratory rate (80), with slightly increased respiratory effort. No heart murmur auscultated. Normal WBC. High globulin 6.6 (2.8-4.8). High bilirubin (1.4), normal liver enzymes.

RADIOGRAPHIC STUDY OF THE THORAX

The body condition score is 6/9 with smooth, alternating layers of fat and soft tissue opacity.

The bony structures are physiological.

The trachea diverges from the thoracic vertebrae and the carina is located level with T5/6. A dorsal tracheal stripe sign is present and a moderate amount of air is visible at different levels in the esophagus.

The cranial crus of the diaphragm is located level with caudal L1, the cupola level with T9. A small gap between cupola and caudal heart border is present. The tips of both caudo-dorsal lobes are slightly retracted from the thoracic vertebrae and appear rounded off on the view labelled R. On both lateral views a generalized loss of clear vascular outline is accompanied by highlighted bronchi. Large patches of alveolar infiltrate with air-bronchograms are located in both caudal and the accessory lobes, in the right caudal lobe this is accompanied by a patch of hyperlucency. Right caudal and middle lobes also show patches of ground glass opacity.

The cardiac silhouette occupies 75% of the chest height and approx. 2 intercostal spaces. Chamber or outflow tract enlargement is not obvious.

The gastro-intestinal tract is distended with gas. Small intestinal loops in the right abdomen are corrugated.

On the VD views the head of the spleen is not obvious between abdominal wall and gastric fundus. A triangular soft tissue opacity is located on the right abdominal wall, level with ribs 12 and 13. A plump structure with an opacity between fat and soft tissue extends along the left abdominal wall. On the lateral recumbent views the head of the spleen is in a physiological position. A lobar opacity between fat and soft tissue is located caudal to the liver and a tubular, branching structure of a more pronounced soft tissue opacity is event in/overlying its proximal 2/3d.

RADIOGRAPHIC DIAGNOSIS

- Generalized interstitial infiltrate
- Multiple, focal alveolar infiltrates
- Small pneumothorax
- Corrugated surface caudal lobes
- Aerophagia

Incidental findings

- Altered splenic shadow

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differential diagnoses for the pulmonary infiltrate are:

- Infection (e.g., bacterial, viral, fungal, parasitic, toxoplasmosis)

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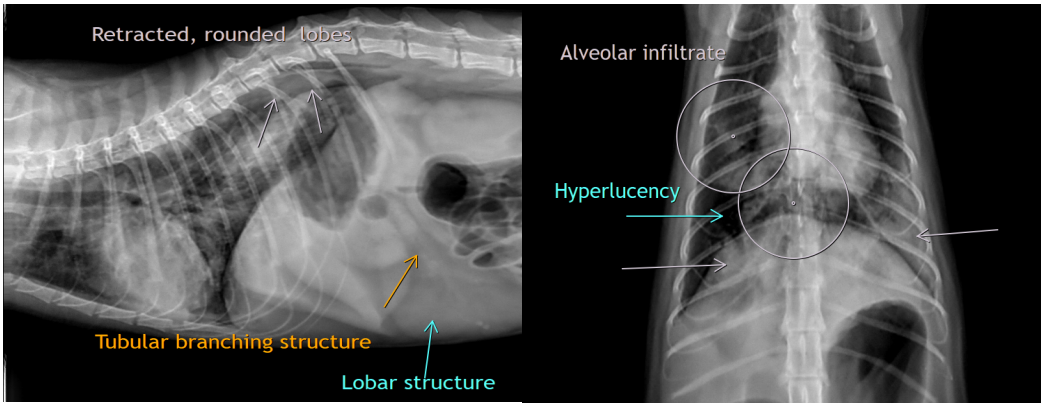
- Inflammation (e.g., granulomatous eosinophilic)
- Bleeding
- Edema, non cardiogenic

Common causes of elevated globulins are infection, immune-mediated diseases and cancers. Samples of the infiltrate should be obtained. Due to the close proximity to the rib cage this can be attempted transthoracic under ultrasound guidance. Hyperglobulinemia in association with hypoalbuminemia are commonly seen with fungal disease.

Pulmonary retraction is mild, suggesting air tracking along bronchi causes the pneumothorax, rather than a ruptured bulla. Rounding of the retracted lobar edges suggests chronicity and a reduced ability for re-expansion.

Hyperbilirubinemia can result from excessive bilirubin production, impaired hepatic uptake or decreased excretion. Excess bilirubin production is most commonly due to hemolysis but may also occur with extensive internal bleeding and breakdown of damaged red blood cells. Severe hyperbilirubinemia (>5.85-11.70 mg/dL) may be due to biliary obstruction that requires surgery. Thus, abdominal ultrasound is recommended.

I also suggest further test: albumin level, FIV, FIP, FeLV if it has not already been done.



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
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