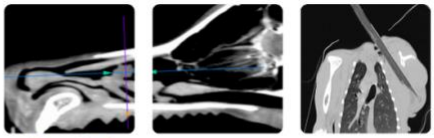

PATIENT

Bolt Crane

SPECIES

Canine

BREED

Staffordshore Bull Terrier

SEX

Neutered Male

AGE

9 Years 10 Months

WEIGHT

32.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Vincent Tavella

HOSPITAL NAME

Williamsburg VC

REFERRING VET

Dr. Vincent Tavella

INVOICE

35973

DATE

12/19/25

PRESENTING CLINICAL SIGNS

History: Patient presents for 24 hour history of vomiting and anorexia. Unable to keep water or food down. Abdomen was distended at home but is normal on presentation. History of Leggs perthes, Hip dysplasia, bladder tumor, Immune-mediated Polyarthritis Chronic pancreatitis, and steroid responsive colitis. Patient is on Cytopoint, Apoquel, Gabapentin, Librela, Dasuquin, Z/d low fat, Budesonide.

Abnormal PE/Chem/CBC/UA Results: PE: Dehydration, Grade 3/6 systolic heart murmur. PMI left parasternal. (New) Chem/CBC/UA - pending Radiographs - Cardiomegaly with suspect pulmonary congestion. Evidence of a gastric foreign body

RADIOGRAPHIC STUDY OF THORAX AND ABDOMEN

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

The disc space between the anticlinal vertebrae T10/11 is reduced. The ribs are straight and run parallel to each another.

Thorax

The terminal trachea diverges from the thoracic vertebrae and dips at the carina.

The degree of pulmonary expansion in left lateral recumbency (LLR) is fair at best. The lung lobes extend to the thoracic boundaries on the VD view; the ventral lobes are slightly displaced dorsally and show rounded edges, especially in LLR. The vascular outline is blurred, and peripheral bronchi are highlighted. The cranial lobar vessels are small (less than 50% of the width of rib 4). A pleural line is present between accessory and left caudal lobe.

The cardiac silhouette occupies 80% of the chest height and 3.25 intercostal spaces (VHS 10.5). The caudal border appears straight, and a large bulge is located at 3 o'clock. The main stem bronchi are slightly displaced.

Abdomen

The abdominal organs are surrounded by fat; diaphragm and abdominal wall are intact.

The liver is located within the costal arch, and the caudo-ventral lobe is rounded.

The spleen appears physiological.

The stomach contains a moderate amount of air, which highlights a triangular soft tissue opacity in the fundus; the pylorus contains soft tissue opaque material with an undulating dorsal surface. On the VD the soft tissue opacity is located in the left lateral fundus, the gastro-duodenal junction is located just to the right of the midline. Distribution and size of the small intestinal loops appear physiological. Colon and rectum contain a small amount of fecal matter.

One renal shadow is evident on each of the lateral recumbent views and appears of physiological size, shape and opacity. On the VD the region of the kidneys is obscured by intestinal loops. The bladder contains a small amount of urine; the neck is located just cranial to the pubic brim.

A prostatic shadow is not obvious.

The sublumbar region appears physiological.

RADIOGRAPHIC DIAGNOSIS

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- Left sided cardiomegaly
- Interstitial pattern
- Hypovolemia
- Possible dyspnea
- Soft tissue structures in the stomach
- Medial displacement of gastro-duodenal junction

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bulge at 3 o'clock and mild displacement of the main bronchi indicates left atrial enlargement due to mitral insufficiency. This can be due to DCM or mitral endocardiosis, though the latter is less likely in larger breeds. The cranio-caudal diameter of the heart in lateral recumbency is borderline large which could be due to DCM or pulmonary hypertension. Echocardiography is recommended. Displacement of the ventral lung lobes is likely due to a combination of expiration and fat, but DCM can cause pleural effusion and a small amount of fluid may be present.

An interstitial lung pattern is a non-specific finding and accentuated by the only fair expansion of the lung fields. In this case possible differential diagnoses for a true infiltrate include:

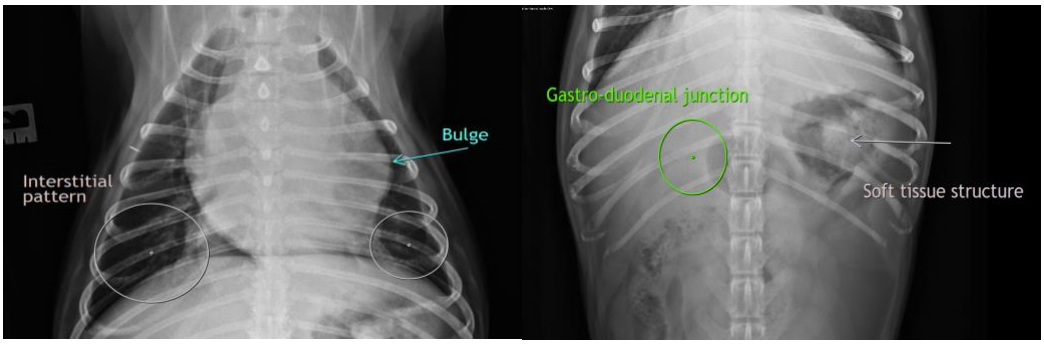
- Cardiogenic edema
- Infection (bacterial, fungal e.g., candida, viral, Rickettsia, Spirochetes, parasitic e.g., angiostrongylus)
- Inflammation (allergic pneumonitis, eosinophilic bronchopneumopathy, smoke inhalation)

Less likely

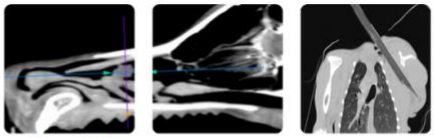
- Early idiopathic fibrosis
- Diffuse hemorrhage
- Tumor (e.g., lymphoma)

Fecal samples are necessary to rule out parasites. Further tests depend on the results of the echocardiography. Hypovolemia can be due to dehydration (e.g., vomiting, diarrhoea, Addison's disease) or overdiuresis.

The movement of the gastric structures along the GIT can be evaluated with follow up radiographs. Ultrasound in different positions of the dog should be able to confirm if the structure in the pylorus is mobile, as suggested by the pyloric air on the VD views. Should they still be in the stomach, gastroscopy may be the best way forward to remove them.



The information and recommendations provided are based on the images presented by the



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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