

PATIENT

Riginald Clow

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

12 Years

WEIGHT

7.91 kg

INTERPRETED BY

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

IMAGING

PERFORMED BY

Dr. Singh

HOSPITAL NAME

Balmy Beach PH

REFERRING VET

Dr. Singh

INVOICE

35842

DATE

2/13/26

PRESENTING CLINICAL SIGNS

History: Coughing episodes, recently recovered from nasal congestion

Abnormal PE/Chem/CBC/UA Results: CBC/chem WNL

RADIOGRAPHIC STUDY OF THE THORAX

The body condition score is 7-8/9 with smooth, alternating layers of fat and soft tissue opacity.

New bone is present on the ventral aspect of some endplates.

The cranial mediastinum is of physiologic opacity; on the VD view it fills the space between ribs 1 and 3 on the left, there while displacing the cranial lobe. The trachea diverges from the thoracic vertebrae, and the carina is located level with T5. A moderate amount of air is present in the esophagus.

The degree of pulmonary expansion is fair at best, and a large amount of fat is located in the cranial abdomen. The left cranial lobe is displaced to rib 3 by mediastinal fat. The increased opacity results in a wedge shaped right middle lobe; the vascular markings over the cardiac silhouette are lost in left lateral recumbency. In right lateral recumbency the cranio-ventral lobe shows an increased opacity which is represented by a loss of clear vascular outline and bronchial enhancement on the VD view. Doughnuts are present in the right caudal lobe.

The cardiac silhouette is slightly elevated from the sternum by fat. It occupies 65% of the chest height and 2 intercostal spaces. In the VD view it is slightly located to the right. Chamber or outflow tract enlargement is not obvious.

RADIOGRAPHIC DIAGNOSIS

- Increased opacity right middle lobe
- Interstitial pattern left cranial lobe
- Peribronchial infiltrate, mild
- Air in esophagus

Incidental finding

- Spondylosis
- Obesity

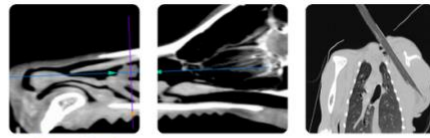
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Airway obstruction is common in the right middle lobe due to mucus occluding the bronchus (e.g., in cats with feline asthma). It can also occur due to an inhaled foreign body, mucus or inflammatory debris secondary to pneumonia, external compression of the bronchus by an extraluminal mass or an intraluminal mass (neoplasm) completely obstructing the bronchus.

Consider bronchoalveolar lavage (BAL) to further differentiate inflammatory (e.g., feline asthma) from infectious etiologies, as well as a respiratory PCR panel (e.g., for Mycoplasma, Chlamydia felis).

Air in the esophagus can be transient due to stress but can also be a sign of esophageal motility disorder which can lead to aspiration pneumonia. Should it be a persistent finding and coincide with regurgitation, further investigations are recommended (e.g., Barium swallow).

Obesity is known to worsen clinical signs of cough and impair lung function; weight control is strongly recommended.



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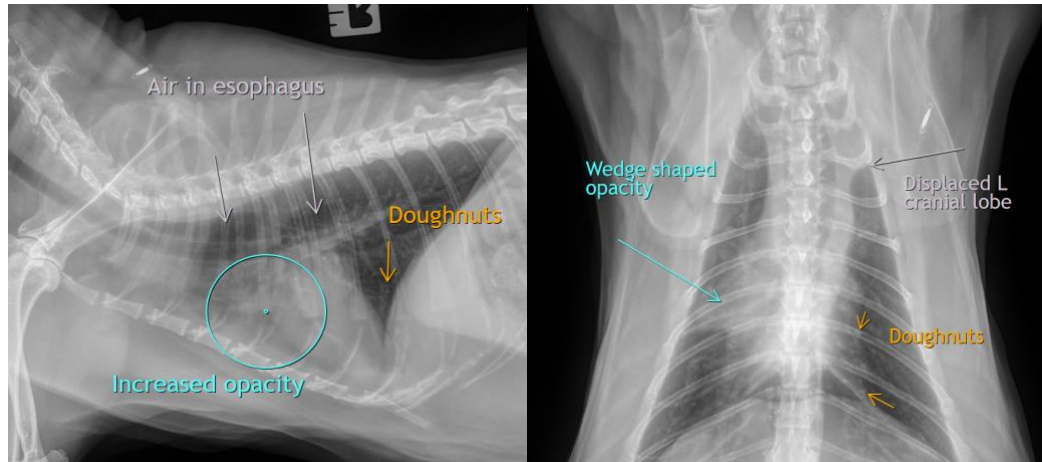
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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