



PATIENT

Buster Pulido

SPECIES

Canine

BREED

Boston Terrier Mix

SEX

Neutered Male

AGE

12 Years

WEIGHT

15.86

INTERPRETED BY

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

IMAGING PERFORMED BY

ERG

HOSPITAL NAME

DTLAVets

REFERRING VET

Dr. Coward

INVOICE

14719

DATE

03/27/26

PRESENTING CLINICAL SIGNS

Buster presents for evaluation of ongoing cough and clear white foamy vomitus for the past couple weeks. Owner reports episodes occur at least every other day and may last up to an hour. No pattern noted and not associated with activity or eating. Cough not elicited on tracheal palpation.

Medical history: hind limb paresis after Librela (resolved) osteoarthritis.

EDUD normal. Sneezing occurs occasionally with clear discharge. No diarrhea. Drinking and energy normal per owner.

Medications: Carprofen 25 mg 1/2 tab BID, Movoflex SID. No refills needed.

No heartworm prevention.

Problem list: mild recurrent cough and sneezing; r/o allergy/post-nasal drip vs soft palate abnormality vs tracheobronchomalacia vs other. Reverse sneezing; r/o soft palate irritation vs laryngeal disorder vs other. Hx adverse reaction to Librela. OA/DJD. Lenticular sclerosis. Grade III dental disease.

Exam: Oral cavity with grade III dental disease, moderate calculus and gingivitis; soft palate difficult to visualize. Cardiovascular normal, synchronous femoral pulses, CRT <2 sec. Respiratory eupneic with clear lung sounds bilaterally, trachea clear, no nasal discharge, cough not elicited. Abdomen normal. Musculoskeletal: mild reduced hind limb ROM, no pain on limb or spinal palpation, mild cervical stiffness and head tilt. BCS 5-9

RADIOGRAPHIC STUDY OF THE THORAX

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

27.03.2026

RADIOGRAPHIC FINDINGS

The body condition score is 5/9 with tucked in abdominal walls.

The disc spaces L1-4 are obliterated or reduced, the endplates are sclerotic and smooth ventral new bone is present. Similar changes appear to affect C3-7.

The cranial mediastinum is of physiologic size and opacity. The trachea diverges slightly from the thoracic vertebrae and the carina is located level with T5.

The degree of pulmonary expansion on the lateral views is fair. On the VD view the lateral tip of the cranial portion of the cranial lung lobe shows a wedge-shaped increase in opacity between ribs 5 and 6. In right lateral recumbency this seems to be supported by an ill-defined region over the cranial heart border. Pulmonary vessels are otherwise well outlined and the bronchial tree is thin walled, tapering towards the periphery.

The cardiac silhouette occupies 75% of the chest height and 3 intercostal spaces. Chamber or outflow tract enlargement is not obvious.

RADIOGRAPHIC DIAGNOSIS

- Focal alveolar opacity L cranial lobe

Incidental findings

- L1-4 and C3-7
- Disc disease



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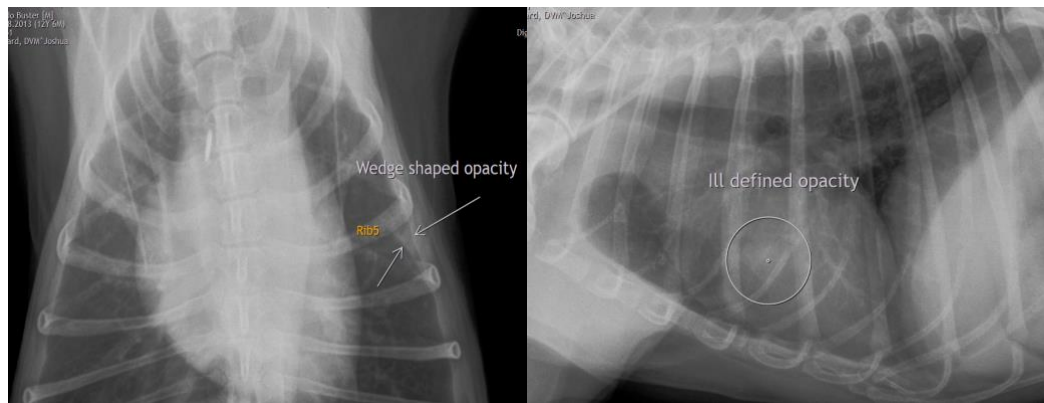
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➤ Spondylosis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small, increased pulmonary opacity could be caused by incomplete re-aeration after a previous left lateral recumbency. However, the rest of the lobes shows a good expansion thus an infiltrate is more likely. Differential diagnoses include infection, tumor and inflammation (e.g., granulomatous). Tracheo-bronchoscopy with BAL is recommended. Alternatively, hematology results can be awaited and antibiotic treatment initiated if an infection is present. Re-radiographing the dog in 2-3 weeks will show if the opacity has increased in size despite antibiotic treatment. Vomitus can be caused by primary gastro-duodenal diseases or secondary to pain e.g., disc disease, pancreatitis.



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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