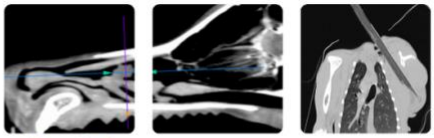

PATIENT

Emma Wubs

SPECIES

Canine

BREED

Pug

SEX

Spayed Female

AGE

5

WEIGHT

15

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Morgan, RVT

HOSPITAL NAME

Oxford County VC

REFERRING VET

Dr. Paisley Canning

INVOICE

36132

DATE

3/6/26

PRESENTING CLINICAL SIGNS

History: Ongoing nasal discharge (constant) and coughing associated with activity. PE is WNL, BW is NAF, PCR for resp infectious disease panel was negative. not improving with benadryl, or antibiotics or metacam or codeine, has been on NG spectra, is a emotional support dog with st.johns ambulance. proBNP is pending

RADIOGRAPHIC STUDY OF THE THORAX

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

The bony structures appear physiological.

The cranial mediastinum contains fat which results in mild slightly caudal displacement of the left cranial lobe. The trachea diverges from the thoracic vertebrae, and the carina is located level with T5. Its diameter is homogeneous.

The degree of pulmonary expansion is fair, and the cupola of the diaphragm is in contact with the caudal heart border. The ventral lobes are elevated from the sternum by fat. On the right lateral thoracic radiograph an airbronchogram is just visible dorsal to sternebra 2 and surrounded by a localized increase in opacity. This is not repeated on the other two views. On the VD view blurring of secondary and tertiary vascular walls is present. Some peripheral bronchi are highlighted. In the tip of the left caudal lobe some small bronchi with mild wall thickening are evident.

The cardiac silhouette is slightly elevated form the sternum by fat. It occupies 75% of the chest height and 2.5 intercostal spaces. Chamber or outflow tract enlargement is not obvious.

RADIOGRAPHIC DIAGNOSIS

- Interstitial pattern
- Localized bronchial component
- Possible focal pulmonary consolidation left cranio-ventral lobe

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pulmonary changes described are equivocal and could represent artefacts due to a combination of inspiratory phase, mild obesity and superimposed foreleg muscle.
Possible differential diagnoses for a true infiltrate include:

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

Less likely

- Edema
- Diffuse hemorrhage
- Tumor (e.g., lymphoma)

Fecal samples should be obtained to rule out parasites.

Rhinoscopy should be carried out to obtain samples for bacteriology and cytology. Serous discharge for instance may be associated with allergies. A CT examination can help assess nasal turbinate integrity which is lost in cases of aspergillosis and tumor but rhinoscopy will have to be carried out for sampling. Tracheo-bronchoscopy will help identify tracheal and/or bronchial collapse and allow

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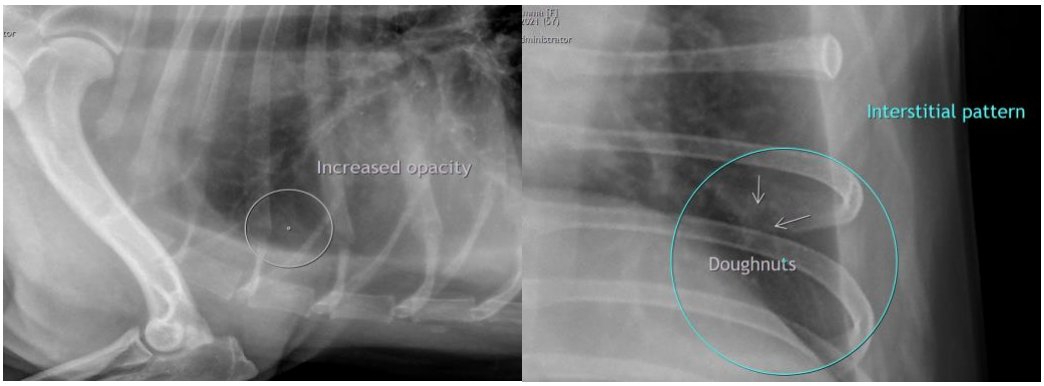
sampling for bacteriology and cytology as bronchitis can be present without radiographic evidence. Obesity is known to worsen clinical signs of cough and impair lung function; weight control is recommended. This is especially true for brachycephalic breeds.

I thus recommend rhinoscopy and bronchoscopy with BAL first. Visual examination of the size of the nares and assessment of larynx as well as soft palate can be carried out during intubation.



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