



PATIENT

Noel Bush

SPECIES

Canine

BREED

Bull Arab X

SEX

Male

AGE

5

INTERPRETED BY

Nele Eley, DVM
Dr. med. Vet. DipECVDI

HOSPITAL NAME

Advanced Veterinary
Imaging

REFERRING VET

Eamon

INVOICE

54506

DATE

10-6-22

PRESENTING CLINICAL SIGNS

multiple hunting wounds - mauled by pigs on several occasions black berry impalement 2020: - perforated lung, spleen and bowel - lung lobe resection performed 3mnt history of persistent cough - now reluctant to leave kennel - lethargic - wont jump onto pickup clinical examination: lethargic, slight pyrexia hacking cough pain over thoracic spine
Abnormal PE/Chem/CBC/UA Results: unremarkable urine; 1040 pH 7 nil sediment

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX, ABDOMEN, HEAD, & NECK

Plain and post contrast studies available for review.

COMPUTED TOMOGRAPHIC FINDINGS

Thorax

Patient has a history of prior lung lobectomy with the lobe being unknown.

It appears that the left cranial lung lobe has been removed. The left caudal lung lobe presents compensatory hyperinflation with multifocal interstitial and subpleural bands. Multifocal pleural thickening is noted. No evidence of an alveolar infiltrate is seen. There is no evidence of pleural effusion. The right cranial and right middle lobe present within normal limits.

Severe regional peribronchial alveolar infiltrate is seen circumferential to the caudal half of the main lobar bronchus of the right caudal lung lobe. There is extensive bronchial wall thickening with complete luminal obstruction with hypoattenuating and partially mineral attenuating material approximately 13 cm caudal to the bronchial bifurcation. The alveolar infiltrate extends up to the visceral pleura which presents regional thickening with increased contrast enhancement.

Thickening and increased contrast enhancement of the right hypaxial musculature of the right thoracic spine are seen. There is extensive sclerosis with unsharp new bone formation of the vertebrae T4-T10. Part of the intervertebral disc spaces present narrowing, vertebral end plate sclerosis, and vacuum phenomenon. The epidural fat and dura matter present linear mineralization as well as increased contrast enhancement.

No evidence of mediastinal lymphadenomegaly is noted.

Abdomen

The abdominal structures present within normal limits.

Note the presence of prostatic hyperplasia in a non-neutered male.

The lumbar spine presents within normal limits except for ventrally bridging L2/3 spondylosis deformans.

The axial musculature of the lumbar spine presents within normal limits as well.

Head & Neck



PATIENT No evidence of structural abnormality of the neck and head is seen.

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COMPUTED TOMOGRAPHIC DIAGNOSIS

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- Foreign material related bronchial obstruction and chronic regional pneumonia of the right caudal main lobar bronchus.
- Myositis of the hypaxial musculature and chronic serial spondylitis T4-T10.
- History of left cranial lung lobectomy with pleural and interstitial scarring of the left lung.
- Spondylosis deformans L2/3.
- Suspect benign prostatic hyperplasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

SEX

Male

The CT findings are highly suggestive for foreign material related obstruction of the right caudal main lobar bronchus. Inhaled foreign material is considered most likely however migrating foreign material due to the reported prior injury cannot be ruled out. Note that the presence of smaller pieces of migrating material remains a potential even though no structural evidence of which is seen at this point.

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The changes circumferential to the right caudal main lobar bronchus are compatible with regional pneumonia and pleuritis.

The spondylitis of the vertebrae T4-T10 is not directly dorsal to the affected area of the bronchus and hematogenous spread of the infection in the lung to the spine is thought likely. There is evidence of extension of the infection into the hypaxial musculature and epidural fat with regional steatitis and potential meningitis.

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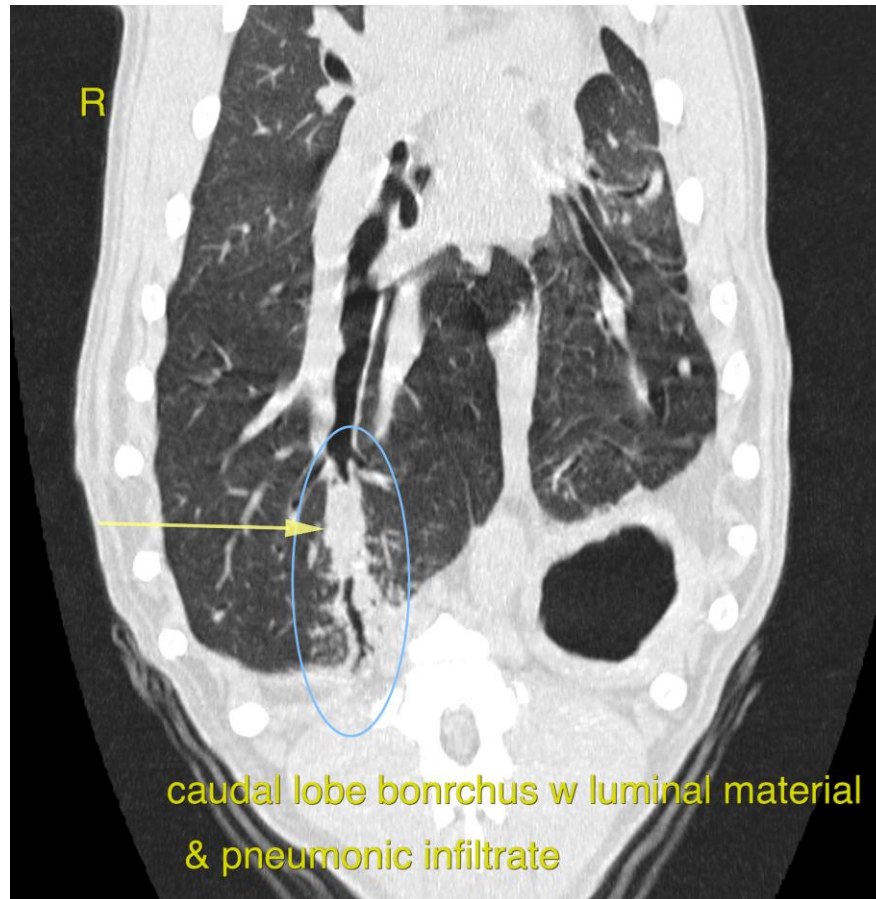
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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