



PATIENT PRESENTING CLINICAL SIGNS

Bono Feldhausen

Bono presented with a 2 month history of labored breathing, coughing and weight loss. Asthma was suspected. There was no response to Prednisolone 5 mg SID. Prednisolone was increased to BID. Fluticasone inhaler and theophylline were added. There was a brief response for about a week. Two weeks ago started to progress again. Theophylline was discontinued last week. Owner thinks he is still losing weight. He has lost 1 lb since November 2021. Radiographs take in both November and December show a marked bronchial pulmonary pattern. Previous diagnosis: Possible asthma Coughing/ hacking: Yes Sneezing/ reverse sneezing: No Difficulty breathing: Labored breathing Breathing when asleep: Yes Exercise intolerance: Not very active Therapies tried and response: Not much of a response to above medications Current medication: Prednisolone, fluticasone inhaler Current symptoms: Coughing fits, labored breathing, lethargy, weight loss General health status: Appetite reduced but still eating. No vomiting or diarrhea. Abnormal PE/Chem/CBC/UA Results: PE: ****Respiratory:**** Abnormal: Tachypneic; mild dyspnea; lung sounds harsh; SPO2 = 80%. Lab: Bloodwork is dated 11/11/21. CBC - PCV = 43.8%, WBC = 8100, neutrophils = 4633, lymphocytes = 2819, monocytes = 130. Platelets = 276,000. Chemistry - ALT = 270, AST = 123, ALP = 175, Lipase = 158, Creatine Kinase = 662, all else normal. Urinalysis - USG = 1.043, pH = 6.0, 1+ protein, WBC = 0-2/hpf, RBC = 6-10/hpf, no bacteria. Bronchoscopy Findings: The lower respiratory tract is imaged using a 5 mm flexible video bronchoscope under light sedation. The bronchoscope is cleanly passed through the larynx into the trachea. Tracheal mucosa is smooth and light pink. Tracheal discharge is not present. The dorsal tracheal membrane is tight and tracheal cartilages are round. There is no evidence of tracheal collapse. The carina and bronchial bifurcations are sharp. Mainstem bronchi are open and clean. There is no evidence of bronchial collapse. Mucoïd discharge is increased. Evidence of a bronchial foreign body is not found. Bronchi appear dilated (able to pass scope further than normal). Bronchoalveolar lavage is performed in the right middle, accessory and left caudal lung lobes using a suction trap and a sterile aspiration catheter. Material is prepared for cytology and culture. The larynx is carefully examined under light sedation. Normal abduction of arytenoid cartilages is observed during inspiration. Laryngopharyngeal structures are normal.

SPECIES

Feline

BREED

DSH

SEX

CM

AGE

12 Years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

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COMPUTED TOMOGRAPHY OF THE THORAX AND ABDOMEN

A high resolution pre- and post-contrast CT study of the thorax and abdomen is provided for review.

REFERRING VET

Megan Witzel

COMPUTED TOMOGRAPHIC FINDINGS

Thorax

The bony and surrounding soft tissue structures are within normal limits.

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The sternal, cranial mediastinal and tracheobronchial lymph nodes are small elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform and considered within normal limits.

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The cardiovascular structures including the pulmonary vasculature are within normal limits.

The lung parenchyma presents with a coarse significant reticular pattern. The lung lobes present scalloping margins with multifocal retraction of the surface. The first and second degree bronchi are multifocal distorted with mild eccentric widening of the lumen. In the cranioventral aspect of



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the left caudal lung lobe, a roundish, irregular marginated, consolidated region with a small gas attenuating center is visible measuring approximately 9 mm in size.

Small incidental gas pockets are seen within the esophageal lumen, there is no evidence of abnormal dilation.

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Abdomen

The serosal fat presents normal attenuation behavior. There is no evidence of peritoneal effusion or peritonitis.

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Both kidneys present within normal limits for size, shape and organ architecture. After contrast administration a well-defined parenchymal filling defect is seen in the lateral aspect of the left kidney, measuring 2 mm in diameter.

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The adrenal glands are within normal limits for size, shape and organ architecture.

Both liver and spleen present with normal shape, even surface, uniformly attenuating parenchyma and homogeneous contrast enhancement, unremarkable.

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The common bile duct is moderately dilated, measuring 2.6 mm in diameter. The first degree branches of the intrahepatic tree are mildly dilated.

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The pancreatic duct is moderately dilated, measuring up to 2.1 mm in diameter. The left lobe of the pancreas presents irregular margins and decreased volume, the pancreatic parenchyma is uniform soft tissue attenuating.

The position, delineation, wall and content of the gastrointestinal tract are considered within normal limits throughout.

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The vertebral endplates of the lumbosacral junction present moderate spondylosis formation. At the lateral aspect of the craniolateral acetabular rim, a triangular shaped isolated mineralized body, measuring 2.3 x 1.8 x 1.8 mm in size is visible.

COMPUTED TOMOGRAPHIC DIAGNOSIS

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- Marked unstructured interstitial lung pattern with multifocal thick interstitial bands
- Retraction of the surface of the lung
- Multifocal traction bronchiectasis
- Thick walled cavitory lesion cranioventral aspect left caudal lung lobe
- Suspect atrophy of the pancreas, possibly secondary to chronic pancreatitis
- Cystic dilation common bile duct and pancreatic duct without evidence of obstruction – considered an age related finding
- Renal cyst

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pulmonary changes are compatible with advanced stage of pulmonary fibrosis with secondary retraction of the surface of the lung and traction bronchiectasis. The thick walled cavitory lesion can present a region of pneumonia with central necrosis or neoplastic transformation – such as bronchogenic carcinoma. In summary the pulmonary changes explain



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the described clinical signs and are irreversible. Treatment options are limited to palliative management. The long term prognosis is very guarded.

The abdominal findings are considered as 'normal' age related changes.

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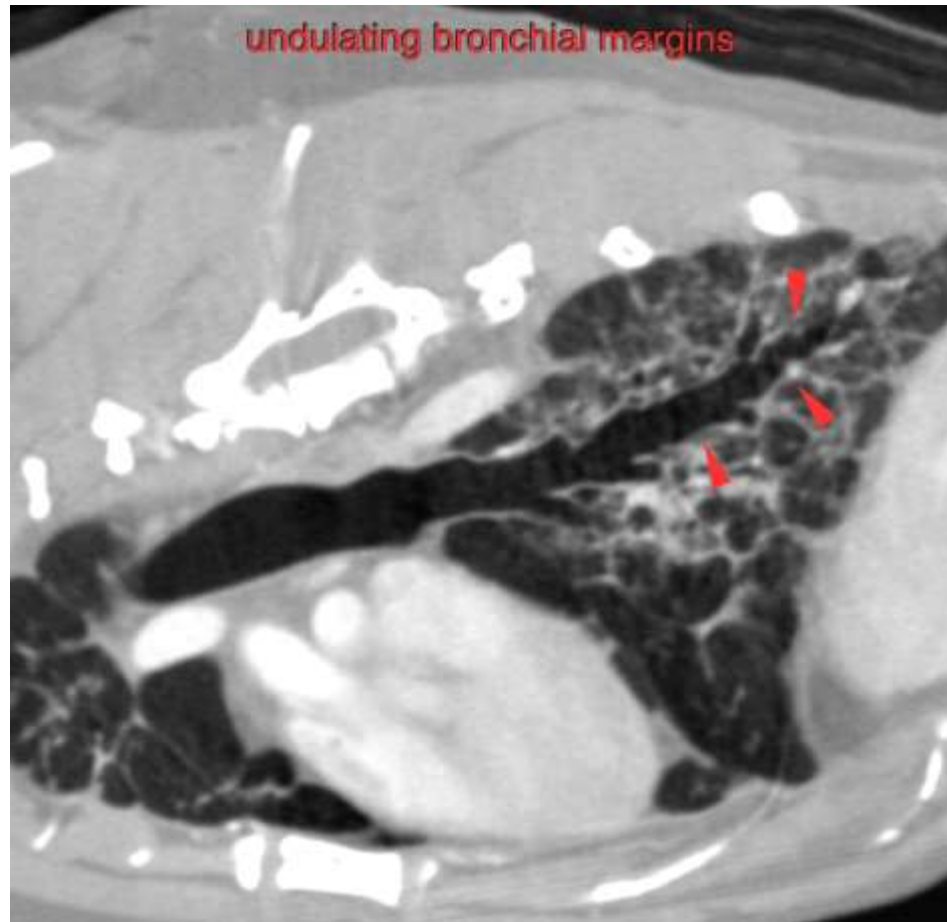
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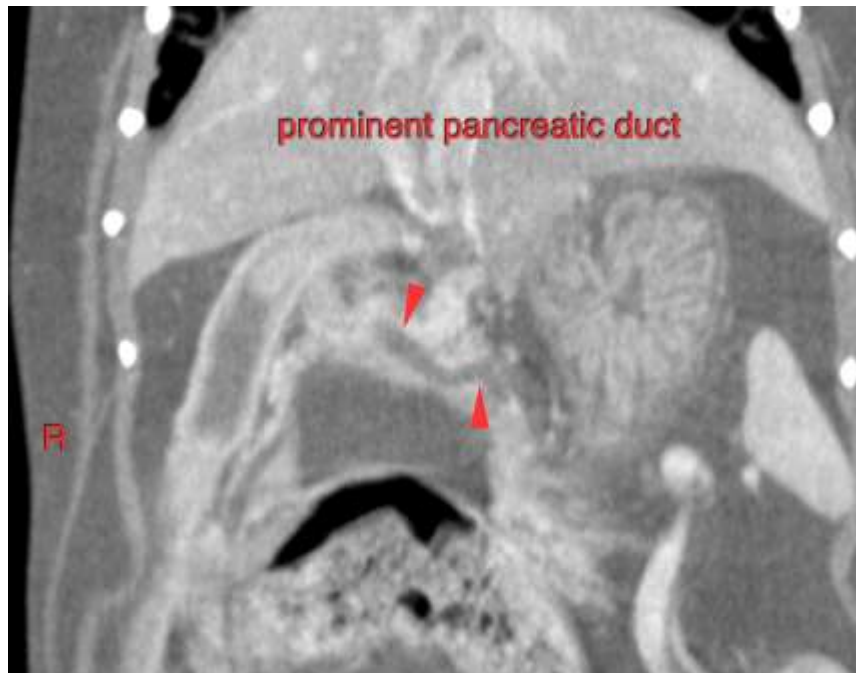
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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