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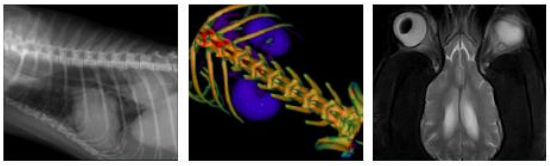

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Jethro Ropel

SPECIES

Canine

BREED

German Shepherd

SEX

FS

AGE

4

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Northeast Veterinary Referral Hospital

REFERRING VET

Dr. Runde

INVOICE

56944

DATE

2-27-23

PRESENTING CLINICAL SIGNS

Presented after being impaled with a stick near the left thoracic inlet. Owner removed stick prior to presentation. Radiographs show a right sided pneumothorax and pneumomediastinum. Removed about 400 mls of via thoracocentesis prior to procedure
Abnormal PE/Chem/CBC/UA Results: Normal

COMPUTED TOMOGRAPHY OF THE THORAX

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

COMPUTED TOMOGRAPHIC FINDINGS

The ventral aspects of the thorax are overexposed, and parts of the lung/intrathoracic structures are burned out.

In the subcutaneous tissue level with the left aspect of the thoracic inlet and along the left thoracic wall, a moderate amount of gas is extending up to the level of the 11th left rib. A cutaneous defect is seen ventrally in the left axillary region.

Free gas is seen in the mediastinum, accentuating the margins of the mediastinal organs. In the caudoventral aspect of the pleural cavity, a moderate amount of free gas is seen, that appears to be walled off by thin serosal membrane. In the cranial aspect of the pleural cavity, no free gas is appreciated.

In the dorsal dependent aspect of the pleural cavity, a small amount of fluid attenuating material is seen.

The left cranial lung lobe presents zones with consolidation of the lung parenchyma, with air-bronchograms and a decreased volume. In the right caudal lung lobe a zone with consolidation of the pulmonary parenchyma and interspersed zones of cavitation (< 4 mm) is seen. The dorsal aspect of the accessory lung lobe presents a ground-glass attenuation pattern.

The costal cartilage of the 4th left rib is separated from the proximal aspect of the rib.

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.

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

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

COMPUTED TOMOGRAPHIC DIAGNOSIS

- History of impalement injury left aspect of the thoracic inlet
- Pneumomediastinum and emphysema along the left thoracic wall
- Pneumothorax, R>L
- Mild pleural effusion – suspect hemorrhage
- Zones of pulmonary consolidation, left cranial and right caudal lung lobe – considered as dystelectasis
- Fractured costal cartilage 4th left rib

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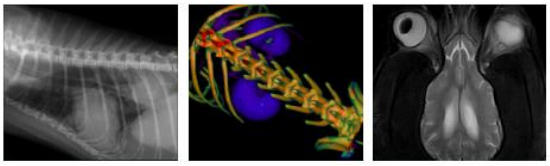

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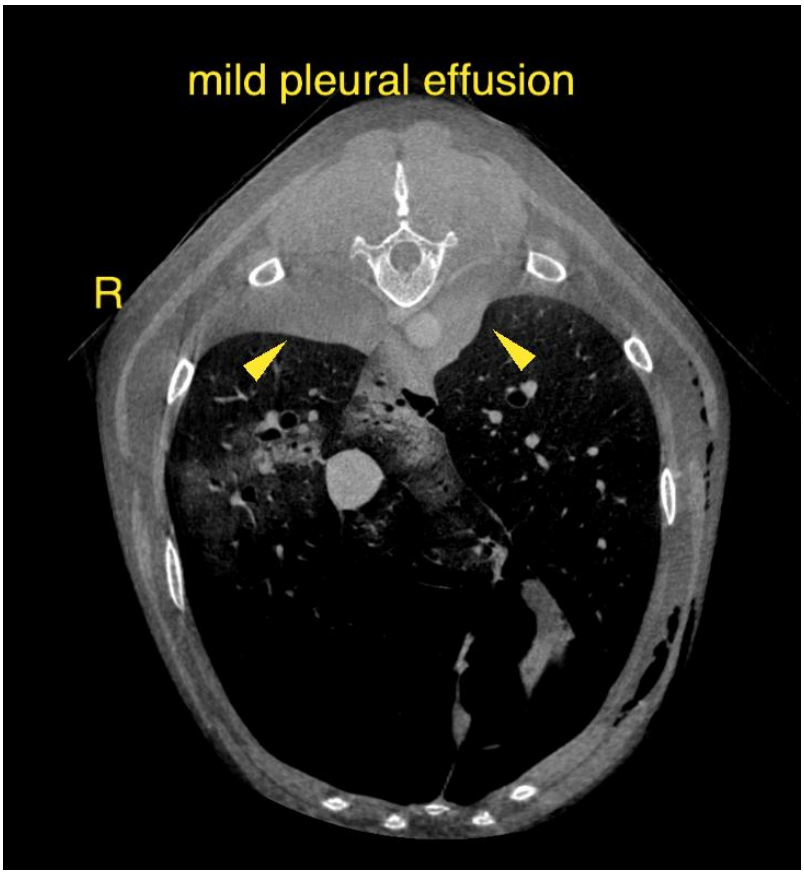
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The findings are fitting the history of impalement injury with the perforation took place in the left axillary region and secondary emphysema along the left thoracic wall. The reported stick likely has lacerated the thoracic wall level with the 4th left rib.

The pneumomediastinum is considered as a sequela of gas dissecting along the fascial planes into the mediastinum. The reported pneumothorax and the appreciated pleural effusion can be a sequela to laceration of the thoracic wall level with the 4th left rib ± laceration of the lung or gas leaking from the mediastinum into the pleural cavity – the latter is considered more likely here. No retained foreign material is appreciated, however small isoattenuating remnants of the stick cannot be ruled out.

If not done so yet, surgical wound management in the left axillary region with intraoperative evaluation of the thoracic wall is recommended.



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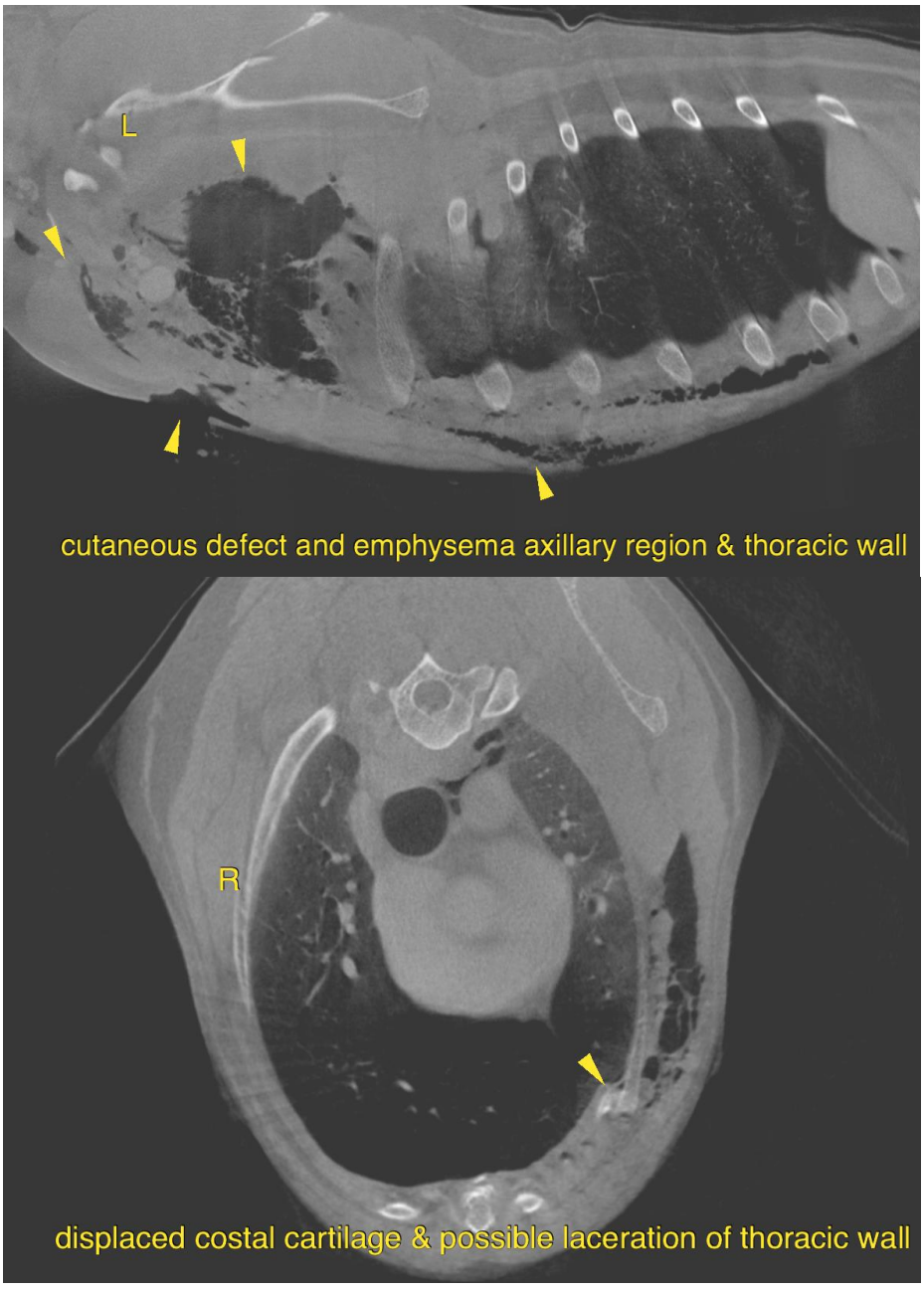

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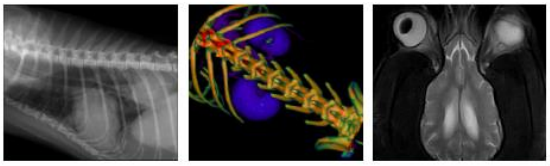

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sebastian Schaub, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI
sebast.schaub@gmail.com