SonoPath Teleradiology

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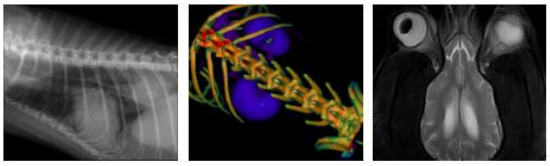


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Ava Handley

SPECIES

Canine

BREED

Golden Retriever

SEX

F

AGE

6 Months

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Colyton Veterinary Hospital

REFERRING VET

Dalton Nguyen

INVOICE

51027

DATE

3-18-22

PRESENTING CLINICAL SIGNS

Diagnosed with pleural effusion at vineyard vet, improved with broad spectrum andtibiotics (clav, enro) and NSAIDs (onsior), thoracic drainage performed as well. Fluid analysis consistent with non septic exudate, pending culture. Presents for thoracic CT scan. Diagnosed on 15th of March, blood work mostly unremarkable Chest ausc - mild increase in respiratory effort, increased lung noise T=38.4. Methadone 0.4ml, ACP 0.1ml IV Alfaxalone 4ml slow IV Intubated Cuff inflated Iso and oxygen Pulse ox monitoring Ventilation under CT 2 VIEW THORACIC RADS - pleural effusion, drained 200mls of serosanguinous fluid before CT Scan CT scan - native and contrast (50mls iohexol IV) Upon extubation patient colour reduced to pale pink/blue, increased respiratory effort (SPO2 60-70%) Lateral thoracic radiograph indicates pneumothorax - localised right side, suspect related to ventilation during CT scan? Alfaxalone 2ml IV given, intubated again. Drained 200mls of air combined on both side and 200mls of serosanguinous fluid on the left side Decision to placed L chest drain at the mid-chest level between ICS 7-9, drained additional 50mls of serosanguinous fluid Placed additional R sided chest drain - removed 600mls of air and 100mls of serosanginuous fluid Marked improvement in SPO2 (95-99%) 4pm Right drain - removed 50mls serosanginuous fluid, no air Left drain - removed 30mls serosanginuous fluid Clavulox 2.5ml SC Onsior 20mg orally Culture results B haemolytic strep - sensitive to clav, resistant to enro CC: Discussed specialist monitoring - declined. Pending CT results decide further plan, will stay here over the weeken, estimated $2000 in total at this stage. Did not recommend transporting back to vineyard at this stage to avoid unwarranted stress Assessment Pleural effusion (non septic exudate) of unknown origin, culture shows B haemolytic - question significance contamination? Pending CT report Pneumothorax - complication associated with GA, ventilation and CT ? Stable now and potentially resolved Stable and eating well Plan Stop enrofloxacin at RV Clavulox 2.5ml SC BID Continue onsior 20mg SID currently Empty chest drains twice daily or pending respiratory status
Abnormal PE/Chem/CBC/UA Results: Blood work wnl Fluid analysis - non septic exudate, light growth, beta haemolytic strep (questionable?)

COMPUTED TOMOGRAPHY OF THE THORAX

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

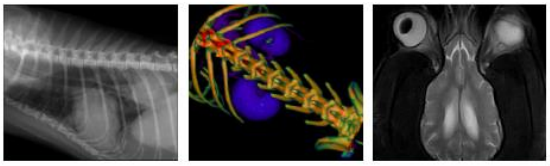
COMPUTED TOMOGRAPHIC FINDINGS

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

There are moderate motion artefacts of the lung lobes.

A significant amount of free gas is visible in the pleural cavity as well as a mild amount of gravity dependent, fluid attenuating material in the ventral aspect of the pleural cavity, presenting a horizontal gas-fluid interface. The lung lobes are retracted from the thoracic wall, presenting a moderately to markedly decreased volume and multifocal consolidation of the lung parenchyma with air-bronchograms is noted. The right crus of the diaphragm is in a caudal position in comparison to the left crus. The right caudal lung lobe is focally attached to the right thoracic wall, level with the 9th right 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.



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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.

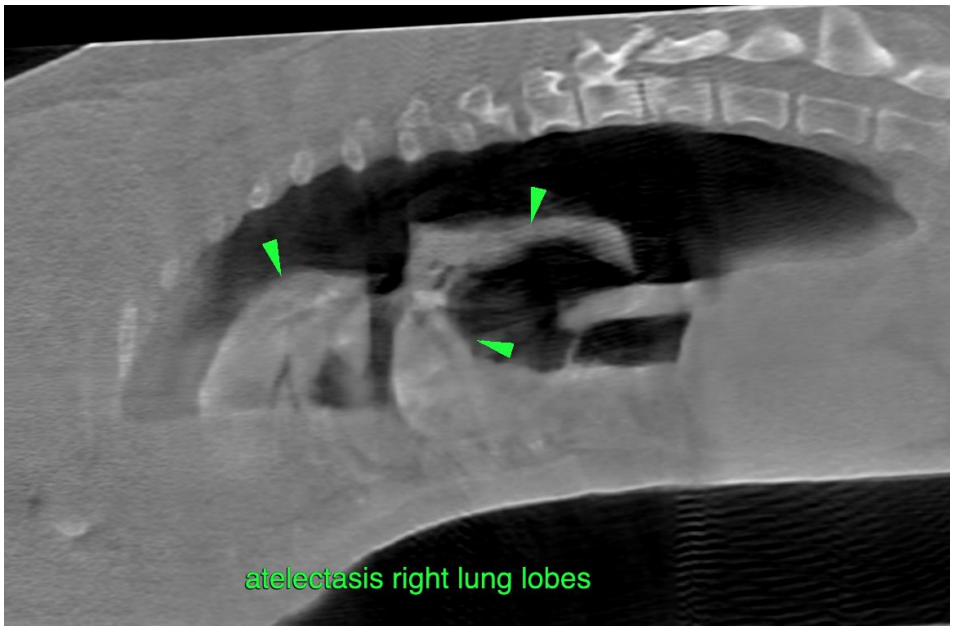
COMPUTED TOMOGRAPHIC DIAGNOSIS

- Pneumohydrothorax with evidence of right sided tension pneumothorax
- Adhesion right cranial lung lobe and right caudal lung lobe with right lateral thoracic wall
- Secondary relaxation atelectasis right lung lobes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The findings are fitting the history of pleural effusion, unfortunately no specific underlying cause for the pleural effusion is appreciated and further therapy options depend on the results of fluid analysis. The pneumothorax might be due to preceding pleurocentesis or secondary to perforated bulla/blep – no underlying cause can be specified, as the pneumothorax appears progressive between the pre- and post- contrast scan a perforated bulla/blep appears more likely. There is evidence of adhesion between the right cranial & caudal lung lobe with the right thoracic wall – this can be due to preceding focal pleuritis, pneumonia, inhaled foreign body (location appears atypical), iatrogenic laceration during pleurocentesis.

Chest drains have already been placed, regarding the history and conservative management of the pneumothorax has been started. If pneumothorax is refractory to therapy, surgical options should be discussed with surgeon.



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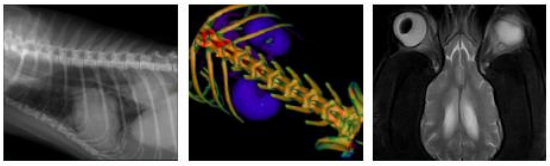

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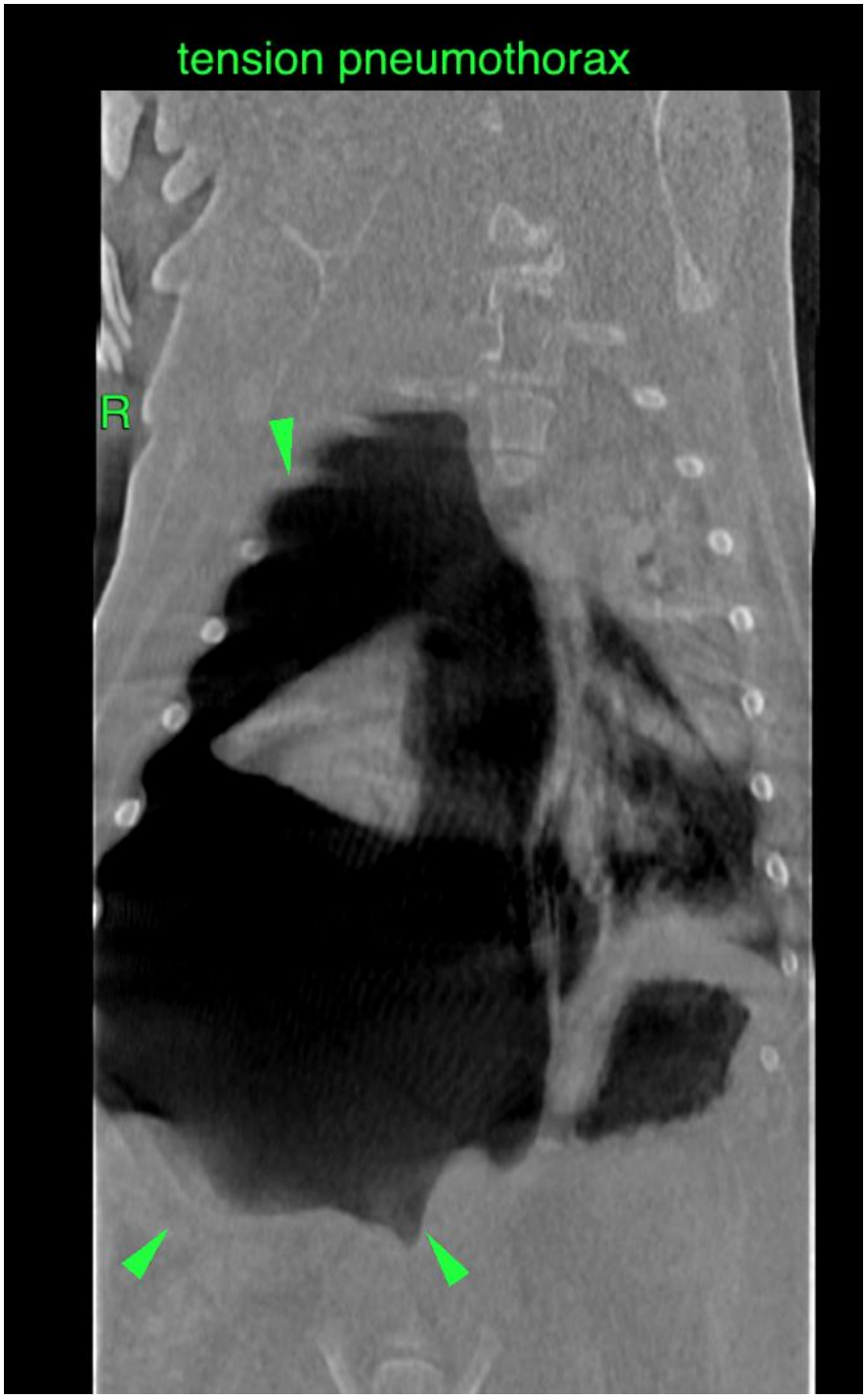

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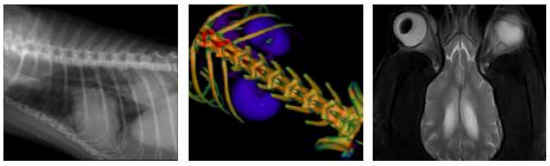

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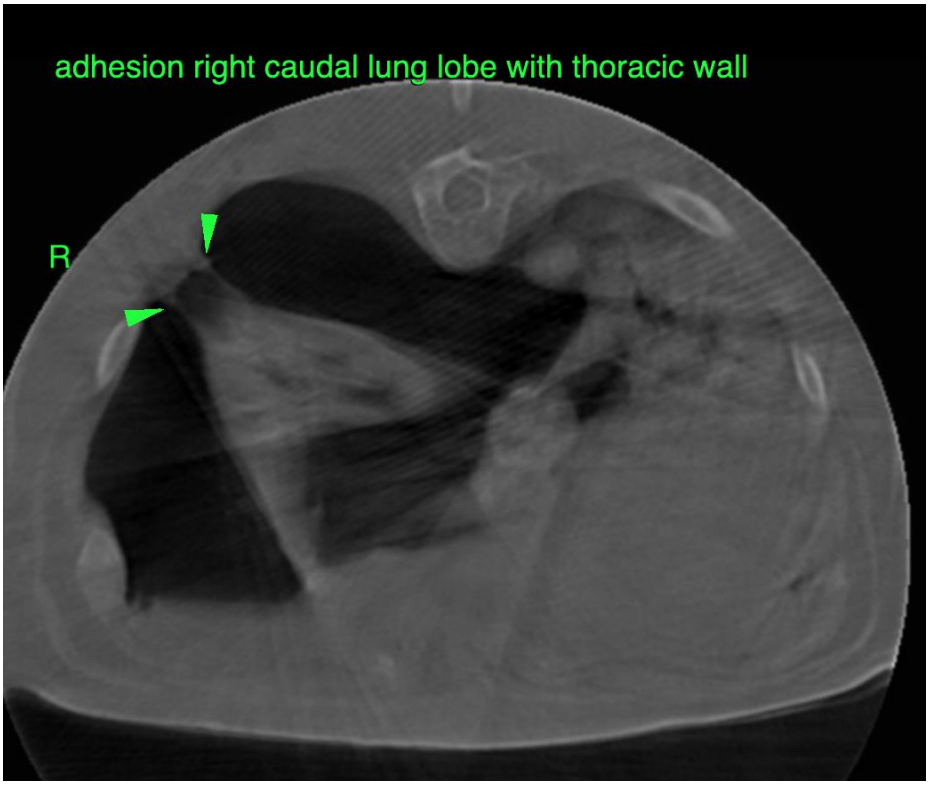

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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