



PATIENT PRESENTING CLINICAL SIGNS

PATIENT
Hank Kutzer

SPECIES
Canine

BREED
Labrador Retriever Mix

SEX
MN

AGE
3 Years

INTERPRETED BY
Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME
Southern Oregon
Veterinary Specialty
Center

REFERRING VET
Ravi Seshadri/Aubrey
Sallee

Ravi Seshadri DVM, DipACVECC Hank is a young male Labrador who previously presented for pneumothorax. On the CT scan an inhaled stick foreign body was noted going through his left caudal lung. He underwent an uneventful lateral thoracotomy, left caudal lung lobectomy and foreign body removal. His recovery was smooth and uneventful and he was discharged in approximately 30 days ago. His recheck radiographs at the time of staple removal from his incision were within normal limits. He presented acutely today with 24 hours of coughing. Repeat radiographs revealed a new pneumothorax. He had a chest tube placed and after drainage of about 700 mL of air had negative pressure in his chest. A repeat CT scan was completed. Images are submitted to Sonopath for evaluation. The previous CT scan has already submitted to Sonopath and can be referenced if needed. Dr Schaub stated (INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS The CT study is highly suggestive for inhaled foreign body and focal foreign body related bronchopneumonia in the caudodorsal aspect of the left caudal lung lobe. There is a linear structure visible in the plain CT study that might represent the foreign body that is extending into the pleural space. The latter would be a plausible explanation for the pneumohydrothorax that is potentially septic. Surgical management by a left lateral approach allowing access to the left caudal lung lobe is recommended.) Radiographs can also be submitted if needed.

COMPUTED TOMOGRAPHY OF THE THORAX

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

COMPUTED TOMOGRAPHIC FINDINGS

The 6th & 7th left rib are converging.

A thoracic tube is entering the left pleural cavity by the 10th left intercostal space.

A small to moderate amount of free gas is seen in the pleural cavity and the lung lobes are retracted from the thoracic wall. In the left pleural cavity, a small amount of gravity dependent, soft tissue attenuating fluid material is seen.

The left caudal lung lobe is absent, a stapler row is seen in the hilar region of the left caudal lung lobe. The volume of the caudal part of the left caudal lung lobe is moderately decreased and the parenchyma presents multiple regions with dystelectasis. The remainder of the lung parenchyma are aerated and present the expected architecture. At the caudomedial aspect of the caudal part of the left cranial lung lobe, a roundish gas attenuating area is seen as well as in the ventral aspect of the right pleural cavity, level with the right middle lung lobe.

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.

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

COMPUTED TOMOGRAPHIC DIAGNOSIS

- History of pneumothorax
- Mild pleural effusion
- History of lobectomy left caudal lung lobe

INVOICE

57100

DATE

3-6-23



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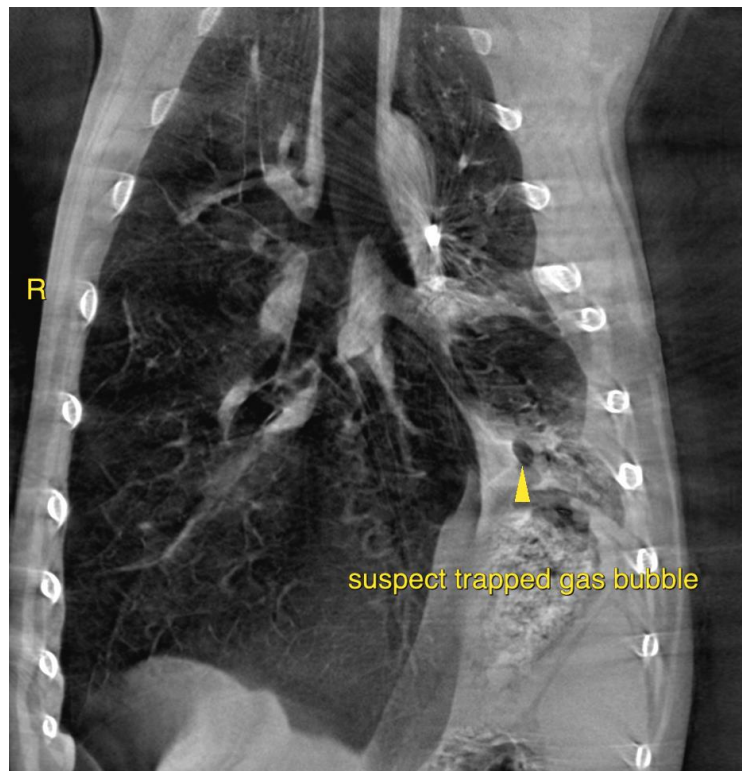
DATE

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Unfortunately, the CT study presents no specific lung lesion explaining the pneumothorax, a ruptured bulla or bleb is likely. The focal roundish gas accumulation adjacent to the caudal part of the left cranial lung lobe can present trapped gas, however a bulla is a differential, but I would consider the odds lower. If the spontaneous pneumothorax does not resolve under conservative therapy and repeated aspirations of the pneumothorax are required either an autologous blood patch or surgery may be used as therapy (surgical intervention is indicated in cases of repeated air accumulation within a 5-day period).

The appreciated mild pleural effusion might be secondary to placement of the thoracic tube with hemorrhage versus transudate/exudate.



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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