



**PATIENT PRESENTING CLINICAL SIGNS**

**Louie Savage** Presented 8/26- Acute onset anorexia of 2-3 days duration, increased respirations with labor, fever, indoor only- xrays confirmed free fluid in chest and sample showed purulent material (described below); admitted for hospitalization and stabilization in oxygen, repeat CBCs as indicated below. Chest tube placed today 8/29

**SPECIES**

Feline

Abnormal PE/Chem/CBC/UA Results: CBC on 8/26- WBC 21K (RR 2.8-17), Chemistry on 8/26- WNL Repeat CBC on 8/28- WBC 64K Cytology of thoracic fluid (submitted to cytologist for evaluation)- Marked neutrophilic inflammation (exudate), very likely septic though difficult to confirm, cannot rule out lung lob torsion, FIP, neoplasia, etc FELV/FIV negative

**BREED**

DSH

**COMPUTED TOMOGRAPHY OF THE THORAX**

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

**COMPUTED TOMOGRAPHIC FINDINGS**

**SEX**

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

Male Neutered

A chest tube is entering the left pleural cavity by the ventral aspect of the 5<sup>th</sup> intercostal space.

**AGE**

4 Years

In the pleural cavity, a moderate amount of gravity, dependent, non-contrast enhancing soft tissue attenuating material is present. Pleural fissure lines are appreciated. The lung lobes are retracted from the thoracic wall and present a generalized decreased volume, L>>R. Multiple regions with dystelectasis of the lung parenchyma are visible, L>>R. Post contrast administration, the pleural lining is moderately irregularly thickened with small cauliflower like protrusions emanating multifocal from the pleural lining – most accenatuated along the ventral mediastinum. A small amount of free gas is noted in the ventral aspect of the pleuralcavity.

**INTERPRETED BY**

Sebastian Schaub, DVM  
Dr. med. vet. DipECVDI

The sternal lymph nodes are prominent.

**HOSPITAL NAME**

Petroglyph Animal  
Hospital

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**

**REFERRING VET**

Whitney Jones

- Moderate pleural effusion
- Advanced proliferative pleuritis
- Regions of pulmonary consolidation with decreased pulmonary volume, L>R
- Mild pneumothorax – likely iatrogenic, due to placement of a chest tube

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**DATE**

8-29-22

The findings of the CT study are supporting the diagnosis of pyothorax with significant proliferative pleuritis – might indicate underlying Nocardiosis/Actinomyces infection. Secondary reactive hyperplasia of the sternal lymph nodes. The pulmonary changes are likely a sequela to atelectasis of the lung parenchyma, however accompanying pneumonia is a potential as well. An underlying cause for the pleural pyothorax is not appreciated, it might be a sequela to bacterial translocation of pneumonia, perforating thoracic trauma or migrating foreign body (no foreign material is appreciated).



**PATIENT**

Theoretically carcinomatosis or mesothelioma are potentials for the proliferative pleural lesions.

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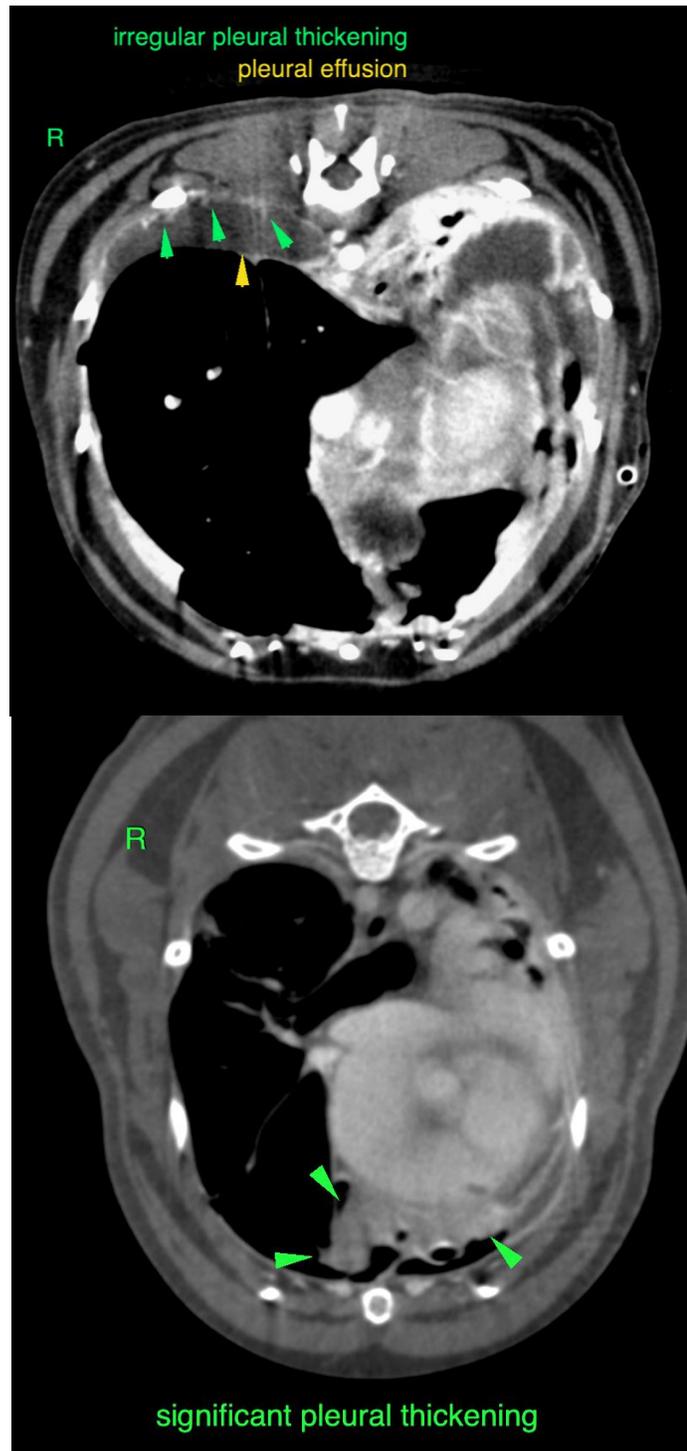
Whitney Jones

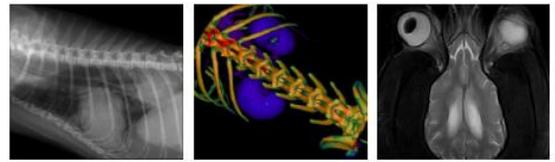
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**PATIENT**

Louie Savage

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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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