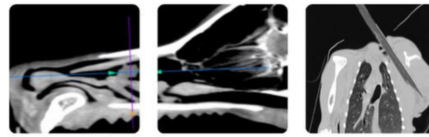


PATIENT

Walter Campbell

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Male Neutered

AGE

3Y, 11M, 19D

WEIGHT

9.10lbs

INTERPRETED BY

Tilde Rodrigues Froes, DMV, MSc., Dr. Med Vet., Dipl. CBraRVet

IMAGING PERFORMED BY

Joseph D'Abbraccio, DVM

HOSPITAL NAME

Catskill Veterinary Services, PLLC

REFERRING VET

Joseph D'Abbraccio, DVM

INVOICE

72658

DATE

11-18-25

PRESENTING CLINICAL SIGNS

11/12/2025: Reason for Visit: Atypical behavior, fever, respiratory distress, pleural effusion Walter presents today with the following concerns: Owner reported that since Friday, the patient has not been acting like himself at home. He has been lethargic, not grooming himself, and his attitude appears dull. The owner also mentioned finding vomit in the house. The patient has been eating and drinking less than normal, and the owner is unsure if he has been urinating or defecating.
Abnormal PE/Chem/CBC/UA Results: PE: Appearance: Missing right forelimb, otherwise no abnormalities in coat or posture described; Fear/Anxiety/Stress Score: 4/5 - Fearful, required mild sedation.; Nose/Throat: Increased respiratory effort Mildly increased bronchovesicular sounds ventrally; Respiratory: Increased respiratory effort, mildly increased bronchovesicular sounds ventrally.; Musculoskeletal: History of traumatic right front limb amputation.; CBC: Lymphocytes 11.96; Platelets 43; Plateletcrit 0.07; Chem: Potassium 3.1; ALP <10; GGT 24;

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A pre- and post-contrast CT study of thorax and abdomen are provided for review totaling 4 series. One pre-contrast series of the thorax, bone algorithm. One pre-contrast series of the abdomen, bone algorithm. One post-contrast series of the thorax, soft tissue algorithm. One post-contrast series of the abdomen, soft tissue algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

THORAX

The trachea and main bronchi are within normal limits.

There are multifocal pulmonary lesions:

A large mixed-attenuation cavitary and soft-tissue mass is present in the right caudal lung lobe (5-7th intercostal space), with heterogeneous post-contrast enhancement. The ventral margin is poorly defined. The lesion measures at least 3.9 cm x 2.1 cm.

A second non cavitary nodular lesion of similar soft tissue attenuation is located in the peripheral caudolateral region of the right cranial lung lobe. The lesion measures at least 0.9 cm x 0.7 cm.

The right middle lung lobe is partially consolidated.

An additional small peripheral consolidation focus is present in the left cranial lung lobe.

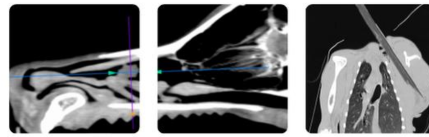
Scattered parenchymal bands are observed throughout the pulmonary parenchyma.

There is mild pleural effusion or pleural thickening, predominantly in the ventral caudal right hemithorax. A small volume of peripheral pneumothorax is present cranially and caudally, gravity dependent.

The sternal, cranial mediastinal, and tracheobronchial lymph nodes are moderately enlarged.

The cardiac silhouette and pulmonary vessels are within normal limits. The contrast medium sufficiently opacifies the cardiac chambers and vessels.

The diaphragm is unremarkable.



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The thoracic wall shows a small superficial lymph node in the right thoracic wall measures 0.6 cm.

The right thoracic limb is absent (previous amputation).

ABDOMEN

The liver is homogenously soft tissue attenuating and uniformly contrast enhancing with normal size and shape. The gallbladder, cystic duct and common bile duct are within normal limits.

The kidneys are normal in size, shape, contour, and attenuation pre- and post-contrast. The renal pelvis and ureters are within normal limits.

The urinary bladder is moderately filled by homogeneously hypoattenuating fluid material admixed with hyperattenuating contrast material. Normal wall thickness.

The spleen is homogenously soft tissue attenuating, and uniformly contrast enhancing, with normal size and shape.

The stomach, small intestine, and colon are of normal distribution and luminal distention, without evidence of mural thickening or mass effect.

The adrenal glands, pancreas, and abdominal lymph nodes are within normal limits.

The serosal fat displays normal attenuation.

The prostate is within normal limits.

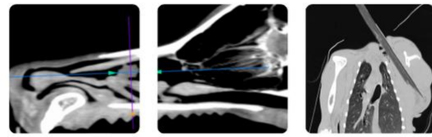
Iatrogenic intraluminal vascular air is noted in the right hindlimb saphenous vein.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Large cavitary and mixed-attenuation pulmonary mass in the right caudal lung lobe, with a second similar lesion in the right cranial lung lobe, and additional focal lobar consolidations. Differential diagnosis includes pulmonary abscess or necrotizing pneumonia considering the patient's age, granulomatous disease (e.g., fungal infection, parasitic infection), less likely primary pulmonary neoplasia (e.g., adenocarcinoma, squamous cell carcinoma).
- Right middle lung lobe partial consolidation and small peripheral consolidation in the left cranial lung lobe, concurrent pneumonia or less likely metastatic disease.
- Mild pleural effusion and/or pleural thickening and small-volume pneumothorax (peripheral, cranial and caudal).
- Scant pneumothorax, possible correlate to large cavitary mass rupture.
- Moderate enlargement of sternal, cranial mediastinal, and tracheobronchial lymph nodes — reactive or less likely metastatic lymphadenopathy.
- Right thoracic wall superficial lymph node enlargement (0.6 cm), reactive lymphadenopathy.
- Post-amputation right forelimb.
- The right thoracic limb is absent (previous amputation).
- Abdominal structures are within normal limits

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The CT study identifies multifocal lesions in the lung parenchyma, with a



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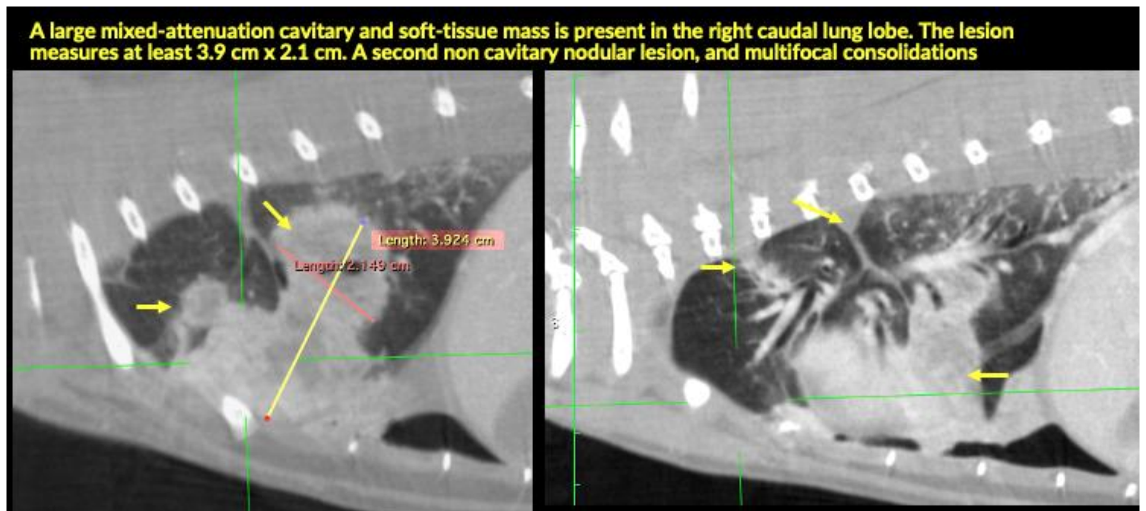
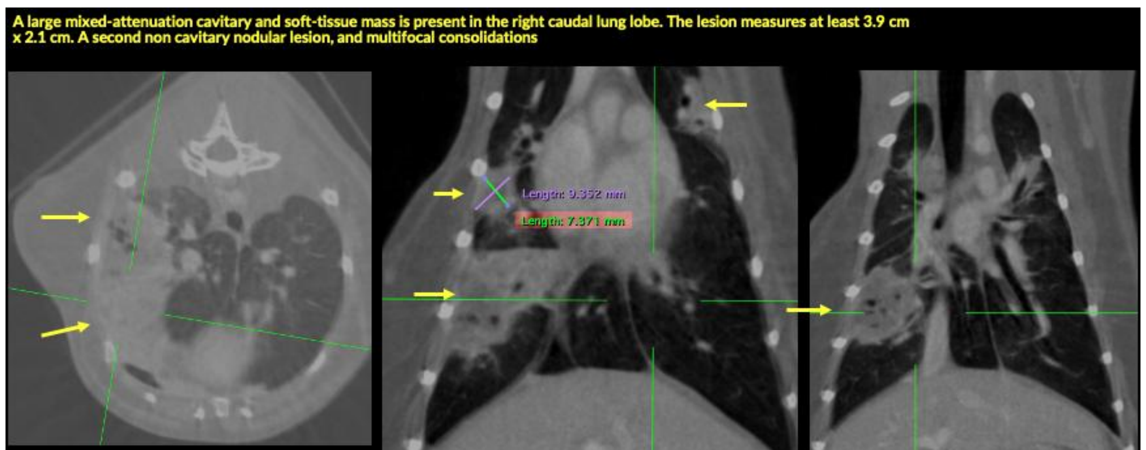
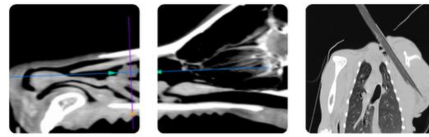
large, irregular, cavitary, mixed-attenuation pulmonary mass in the right caudal lung lobe, along with a second nodular lesion in the right cranial lung lobe, partial consolidation of the right middle lobe, and small consolidation in the left cranial lobe. These findings collectively raise marked concern for severe pulmonary pathology, including pulmonary abscess or necrotizing pneumonia considering the patient's age, granulomatous disease (e.g., fungal infection, parasitic infection), and less likely primary pulmonary neoplasia (e.g., adenocarcinoma, squamous cell carcinoma).

The presence of mild pleural effusion, small peripheral pneumothorax, and regional lymphadenopathy (sternal, cranial mediastinal, tracheobronchial) increases suspicion for a disseminated process.

Given the patient's clinical signs (fever, respiratory distress, lethargy), infectious or inflammatory etiologies remain highly possible, including fungal pneumonia (e.g., Histoplasma, Blastomyces) or parasitic, necrotizing bacterial pneumonia, or pulmonary abscessation. Thoracic ultrasound-guided FNA of the right caudal lung mass and bronchoalveolar lavage (BAL), if the patient's respiratory status permits, are recommended. Fungal antigen and PCR testing (region-appropriate panels) are advised, along with bacterial culture and sensitivity of any sampled material.







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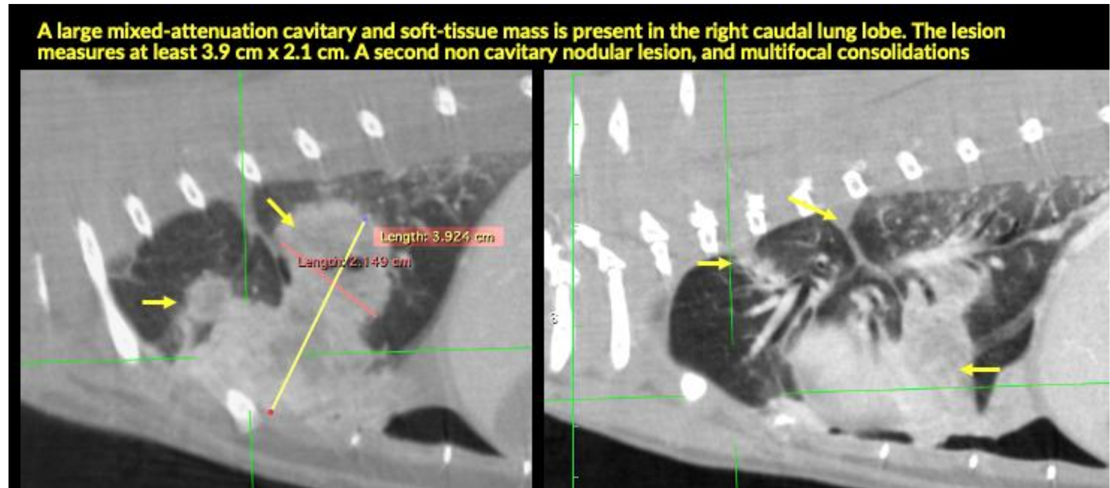

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tilde Rodrigues Froes, DMV, MSc., Dr. Med.Vet., Dipl.CBraRVet
info@sonopath.com