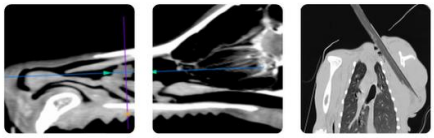

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Jasper Di Bartolo

SPECIES

Canine

BREED

Mareema

SEX

MN

AGE

5

WEIGHT

35

INTERPRETED BY

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

IMAGING PERFORMED BY

Eamon

HOSPITAL NAME

Belconnen Veterinary Centre

REFERRING VET

Eamon

INVOICE

73114

DATE

12-23-25

PRESENTING CLINICAL SIGNS

wheezing for 2 wks pyexic on presentation fluid in chest on tfast
Abnormal PE/Chem/CBC/UA Results: cbc - wbc/neutr mild increase chem normal thoracic fluid purulent, sg 5g/dL, neutrophils+++

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX

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

COMPUTED TOMOGRAPHIC FINDINGS

There is a focal thickening of the left dorsocaudal internal thoracic wall parietal pleura, associated with loss of normal definition of the adjacent intercostal musculature. This area demonstrates increased soft tissue volume and fat stranding, extending into the extrathoracic subcutaneous tissues.

The changes are located subcutaneously internal and external to the latissimus dorsi muscle and adjacent to the iliocostalis thoracis and serratus dorsalis cranialis muscles. The lesion extends for approximately 8 cm, corresponding to the level of the left 10th to 12th ribs.

The adjacent left 11th rib exhibits a mild palisading periosteal reaction. There is no evidence of fracture or radiopaque foreign material.

A mild bilateral pleural effusion is present, with associated multiple pleural “pannus” formation.

In the left dorsocaudal thorax, there is retraction of the left caudal lung lobe adjacent to the thoracic wall lesion.

There is a mild, generalized reduction in pulmonary volume expansion, with dorsal pulmonary retraction and rounded peripheral consolidations consistent with compressive atelectasis secondary to pleural effusion.

Parenchymal bands and faint ground-glass attenuation are observed within the cranial lung lobes. The remaining pulmonary parenchyma exhibits normal attenuation.

The trachea and main bronchi are within normal limits.

The bronchial tree shows normal branching and tapering. Bronchial walls are thin and smooth, and the bronchus-to-artery ratio is within normal limits.

The cardiac silhouette and pulmonary vessels are within normal limits. Post-contrast series demonstrate appropriate opacification of the cardiac chambers and major vessels.

The sternal lymph nodes are enlarged. The cranial mediastinal and tracheobronchial lymph nodes are within normal limits. There is a fat-stranding appearance of the cranial mediastinal fat.

The thoracic esophagus is unremarkable.

The collimated cranial abdominal structures are within normal limits.

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COMPUTED TOMOGRAPHIC DIAGNOSIS

- Focal inflammatory or infiltrative lesion of the left dorsocaudal thoracic wall, involving intercostal and adjacent epaxial musculature, associated with subcutaneous edema and fat stranding.
- Mild palisading periosteal reaction of the left 11th rib, without evidence of fracture, indicating focal reactive osteitis or osteomyelitis.
- Mild bilateral pleural effusion with pleural pannus formation. Differential diagnosis includes pyothorax, less likely neoplastic.
- Reactive enlargement of the sternal lymph nodes and inflammatory changes within the cranial mediastinal fat.
- Mild compressive pulmonary atelectasis and secondary parenchymal changes.
- No evidence of intrathoracic foreign material or pulmonary metastatic disease.

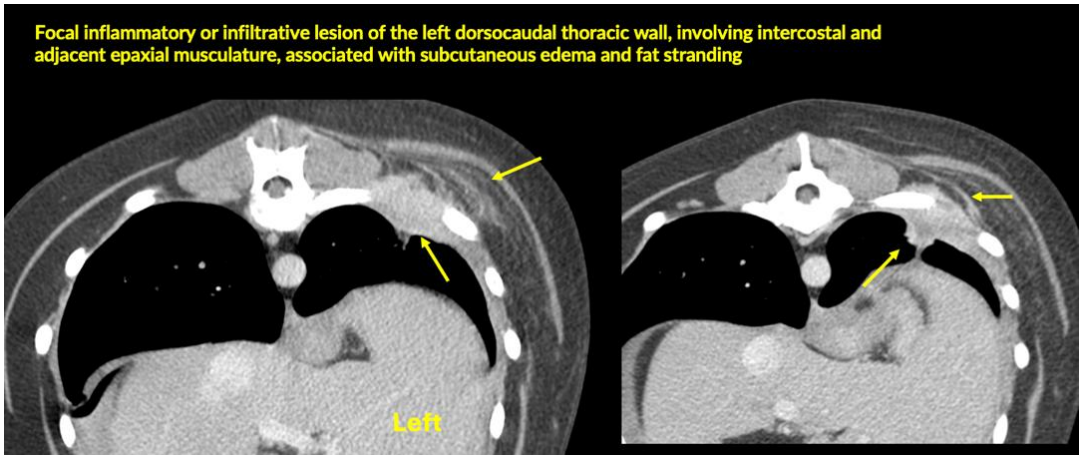
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The tomographic findings are most consistent with a severe inflammatory or infectious process involving the left dorsocaudal thoracic wall, with extension into the adjacent musculature and secondary pleural involvement. The presence of pleural pannus, reactive sternal lymphadenopathy, and mediastinal fat stranding supports an active inflammatory or septic process, correlating with the purulent pleural effusion and neutrophilic inflammatory profile.

The mild periosteal reaction of the adjacent rib is most consistent with reactive osteitis secondary to the adjacent soft tissue inflammation or osteomyelitis. There is no evidence of fracture or radiopaque foreign material.

Ultrasound-guided sampling or biopsy of the thoracic wall lesion should be considered if clinically feasible. Correlation with pleural fluid culture and sensitivity results is recommended.

Ongoing clinical and imaging follow-up is advised to assess response to antimicrobial and supportive therapy. A more invasive exploratory surgical approach may be required if there is inadequate response to medical management.



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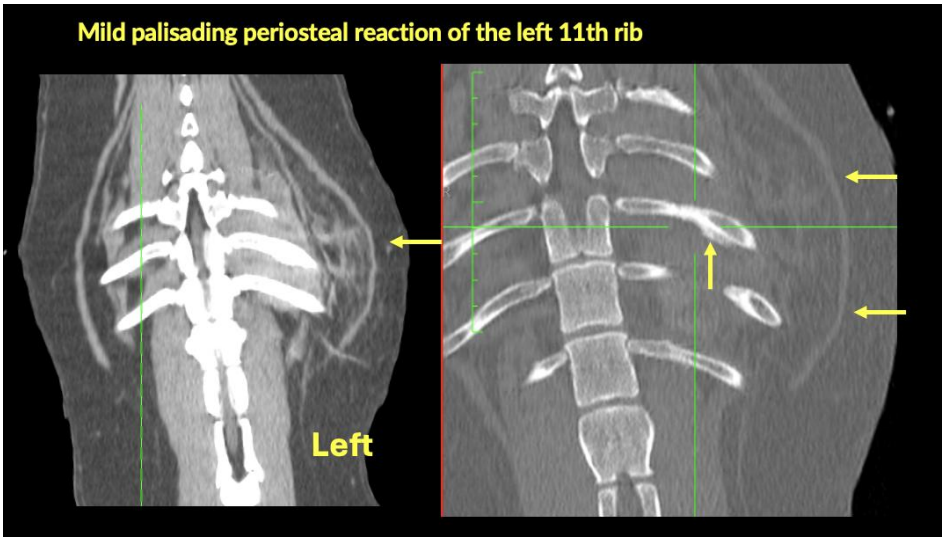

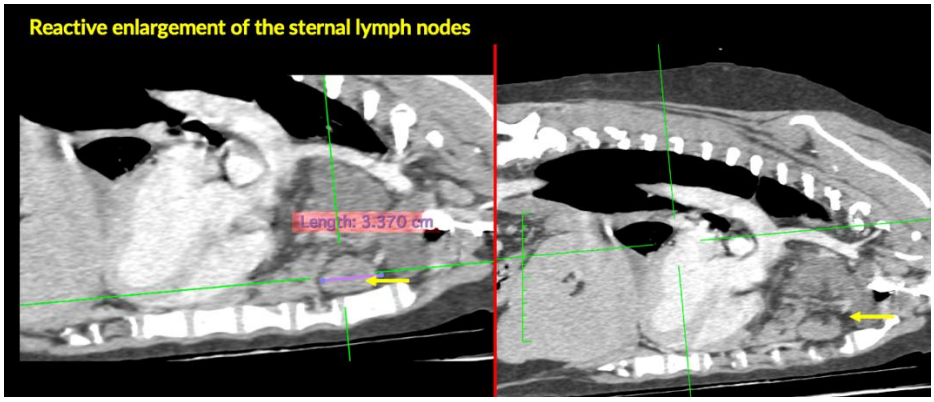

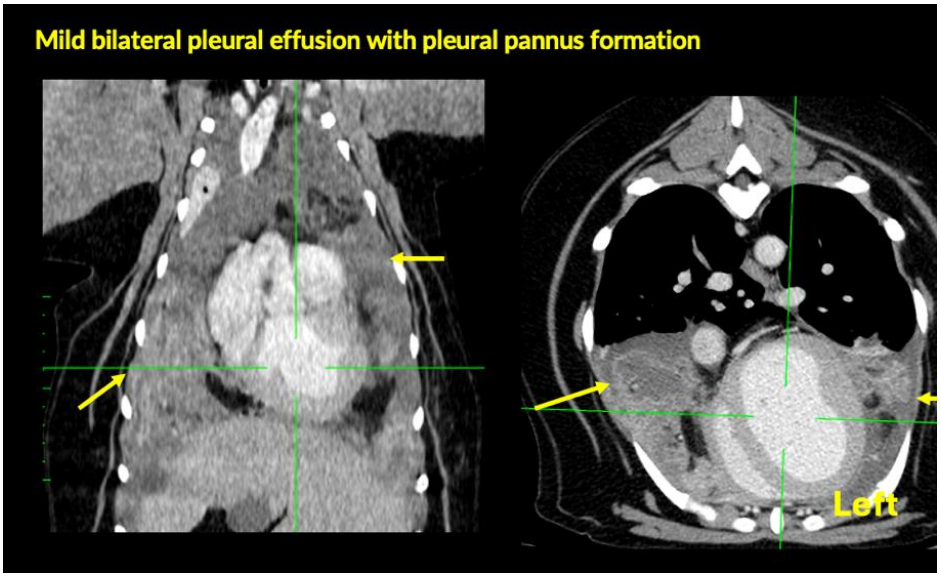

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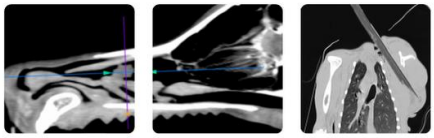

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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