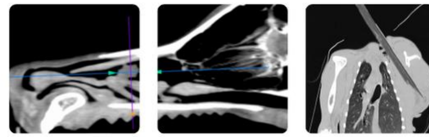


PATIENT

Boss Clarkson

SPECIES

Canine

BREED

Cross Breed

SEX

MN

AGE

6Y, 5M

WEIGHT

n/a

INTERPRETED BY

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

IMAGING PERFORMED BY

Ana

HOSPITAL NAME

Animal Trust - Bolton

REFERRING VET

Ana Valega

INVOICE

73865

DATE

2-19-26

PRESENTING CLINICAL SIGNS

- 05/12/25 Admitted into hospital for investigations of C+/dyspnoea
- Bloods (not transferred to file) - severe neutropenia, BG low (but sample not ran immediately), urea mild elevation.
- TFAST:
- LHS chest - 1 B-line, rest nad
- Heart - basic assessment OK
- RHS chest - cranial lung lobe soft tissue opacity on scan, no fluid.
- Radiographs:
- DV - Right cranial lung lobe radio opaque region, lung lobe looks to be displaced caudally - pleural space lesion?. Cardiac silhouette
- R lateral - severe bronchi-alveolar(?) pattern throughout particularly perihilar region
- L lateral - cranioventral - soft tissue opacity displacing lung dorsally.
- DDx - pneumonia, foreign body, mass lesion, lung worm??
- Not better at home on medications (cefalexine, pardale V+), still dry cough constantly
- Today BAL performed, waiting on results
- Upon examination of throat +++ mucus accumulation - green foamy mucus upon trachea entry region

Abnormal PE/Chem/CBC/UA Results: WNL

COMPUTED TOMOGRAPHIC STUDY OF THE HEAD & THORAX

A pre- and post-contrast CT study of the head and thorax are provided for review totaling 3 series. Transverse, soft tissue and bone algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

HEAD

The nasal cavities and turbinates are within normal limits.

The frontal sinuses are normally aerated.

The cribriform plate is intact.

The nasopharynx and oropharynx are unremarkable.

The tympanic bullae are air-filled with normal wall thickness and contour. No fluid accumulation or osseous abnormalities are identified. The external auditory canals are unremarkable.

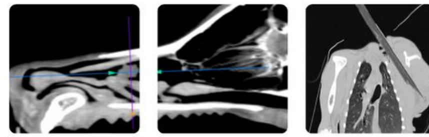
The globes and retrobulbar spaces are normal.

No intracranial mass effect, midline shift, or ventriculomegaly is observed.

The calvarium, facial bones, and skull base are normal in contour and attenuation.

The temporomandibular joints are bilaterally congruent.

Triadan 311 and 411 are absent.



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The medial retropharyngeal and mandibular lymph nodes are unremarkable.

The salivary glands and thyroid glands are within normal limits.

THORAX

The trachea and principal bronchi are patent and within normal limits.

There is diffuse bronchial wall thickening affecting nearly the entire bronchial tree, with variable severity among lung lobes.

Multiple bronchial abnormalities are identified, including a cylindrical bronchiectasis, severe in the left caudal lobar bronchus and its respective tertiary branches. Stenosis of the left cranial lobar bronchus. Marked obstructive mucoid impaction with associated bronchial dilation in the right caudal lobar bronchus. Multifocal mucoid impactions within tertiary and subsegmental bronchi, producing a tree-in-bud pattern.

The cranial subsegment of the left cranial lung lobe is consolidated, with associated volume loss.

The cranial mediastinal lymph node (one identified) and tracheobronchial lymph nodes are mildly enlarged.

The heart and pulmonary vasculature are within normal limits.

The pleural space, ribs, diaphragm, and thoracic wall are unremarkable.

The thoracic esophagus is unremarkable.

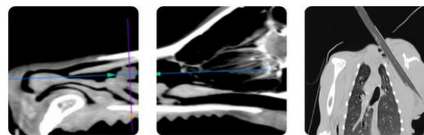
COMPUTED TOMOGRAPHIC DIAGNOSIS

- Severe, diffuse bronchial disease characterized by generalized bronchial wall thickening, multifocal cylindrical bronchiectasis, bronchial stenosis, extensive multifocal mucoid impaction - multifocal tree-in-bud pattern. Differential diagnoses include severe inflammatory/infectious bronchial disease, concurrent bronchiectasis and mucoid impaction. Less likely primary bronchial neoplasia.
- The focal consolidation of the left cranial lung lobe likely represents inflammatory or infectious pneumonia with associated atelectasis, and/or pulmonary fibrosis.
- Mild enlargement of the cranial mediastinal and tracheobronchial lymph nodes, likely reactive.
- Normal nasal cavities and nasopharynx.
- Absent Triadan 311 and 411.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The thoracic tomographic findings are consistent with severe, chronic inflammatory lower airway disease, with secondary bronchiectasis and widespread mucoid impaction.

The presence of cylindrical bronchiectasis, bronchial stenosis, and obstructive mucoid plugging supports a severe, chronic process. Differential diagnoses include chronic inflammatory airway disease and infectious bronchitis (bacterial or parasitic). Parasitic etiologies such as lungworm infection should be considered; dirofilariasis is less likely. Also, primary bronchial neoplasia is considered less likely.



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The focal consolidation of the left cranial lung lobe most likely represents inflammatory or infectious pneumonia with associated atelectasis, and/or pulmonary fibrosis.

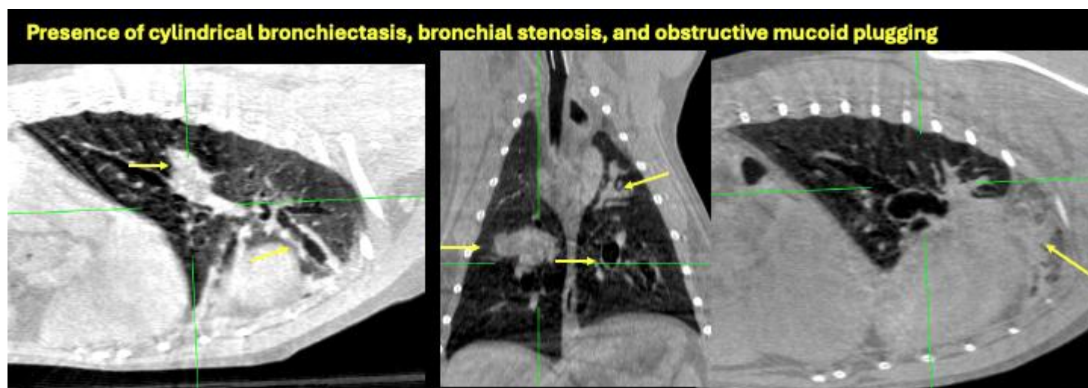
Mild lymphadenomegaly is most consistent with reactive lymphadenitis.

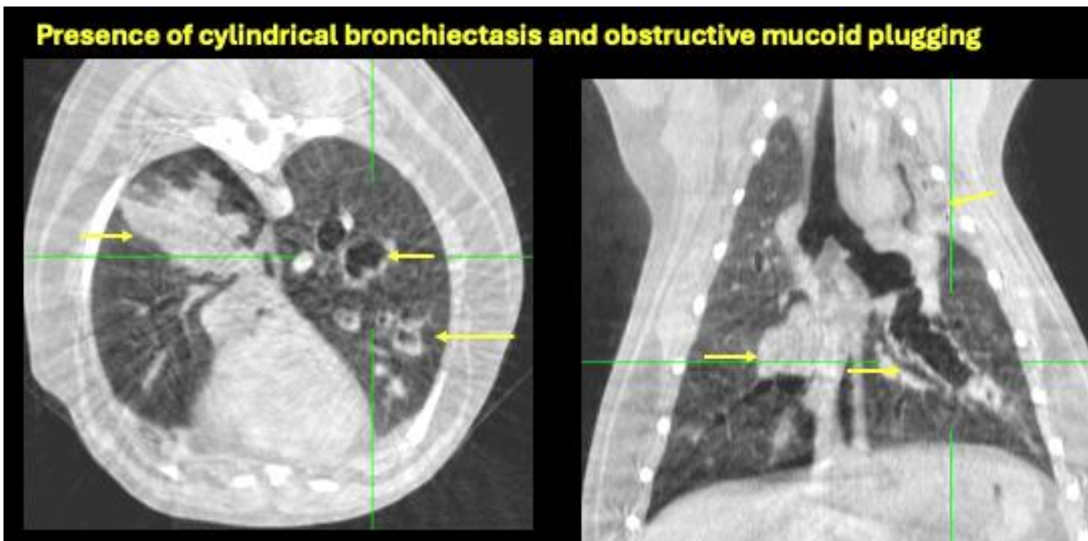
Given the severity and chronicity of the bronchial changes, some of the bronchiectatic alterations are likely irreversible.

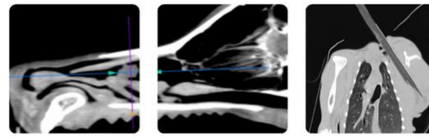
In addition to awaiting bronchoalveolar lavage cytology and culture results for definitive etiologic diagnosis, parasitic testing (including Baermann technique, PCR, and testing for dirofilariasis) is recommended if not already performed.

Long-term airway management may be required. Follow-up thoracic imaging is recommended to assess response to therapy and disease progression.

A specific foreign body is not identified; however, there is partial obstruction of the right caudal lobar bronchus, where the most extensive mucoid impaction is observed.







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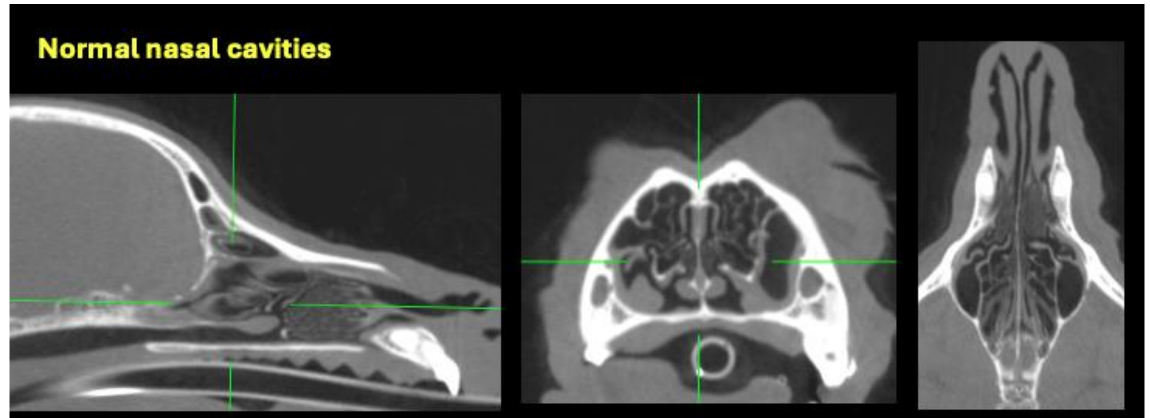

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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