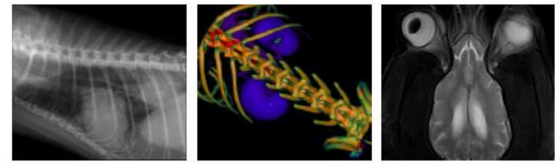


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Jack - O Fernandez

SPECIES

Canine

BREED

Jack Russell Terrier

SEX

Male Neutered

AGE

15 Years

INTERPRETED BY

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

HOSPITAL NAME

Paseos Veterinary Center

REFERRING VET

Dr. Ferrer, DVM

INVOICE

56522

DATE

2-2-23

PRESENTING CLINICAL SIGNS

Presented for evaluation of breathing abnormalities and possible syncope episodes that get exacerbated when getting agitated. A normal activity like going to the potty or standing to drink water cause distress. Pt also has a history of seizures and is currently on Keppra. A previous CT of the head did not reveal abnormalities. Pt has come with respiratory distress and pt has crackles auscultated in the lung field bilateral. A previous echocardiogram has been done and major cardiac abnormalities that will explain cardiac origin of the respiratory distress. An abdominal ultrasound was also done as pt did have unrelated GI clinical signs and no abnormalities with the abdomen that will be explained the respiratory and fainting clinical sign. Pt is currently on Keppra and started recently on prednisone to see if helps with distress. A furosemide injection was also given today. Pt seems oxygen dependent. Future plan includes CT scan of thorax.

RADIOGRAPHIC STUDY OF THE THORAX AND CERVICAL SOFT TISSUE

Orthogonal views of the thorax and cervical soft tissue are provided for review totaling 5 images.

RADIOGRAPHIC FINDINGS

The nasopharynx, pharynx, soft palate, epiglottis, and laryngeal saccules are normal. Between lateral views, the air column height of the cervical and intrathoracic trachea as well as the mainstem bronchi are moderately variably narrowed.

A small amount of gas is seen superimposed on the cervical esophagus.

A moderate chronic bronchial pattern and unstructured interstitial pattern is noted throughout all lung lobes. In addition, a patchy alveolar pattern is seen in the left caudal lung lobe with reduced lung volume expansion. The lung volume is not expanding adequately even in the inspiratory phase.

The cardiovascular structures are normal.

A thin non-divergent pleural fissure line is seen between the right cranial lung lobe and right middle lung lobe.

The mediastinum is normal.

The liver is moderately enlarged with elongated bulbous margins, displacing the gastric axis caudally.

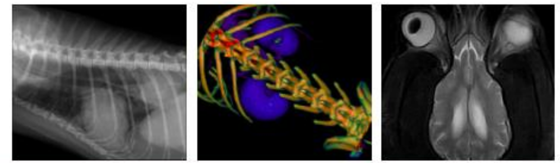
The stomach contains a small amount of gas and heterogeneous ingesta material, which redistributes normally with changes in patient position.

The remainder of the collimated abdomen is normal.

Minor periarticular ossification is seen at the caudal aspect of both shoulders.

Abundant fat stores are seen in the subcutaneous tissues and mediastinum.

No other abnormalities are identified.



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RADIOGRAPHIC DIAGNOSIS

- The identification of the redundant membrane, associated reduced diameter of the cervical trachea, and region of the carina between the inspiratory and expiratory phase is indicative of dynamic tracheal collapse and bronchomalacia.
- Moderate generalized bronchial pattern with tree-in-bud appearance and interstitial pattern with reduced lung volume expansion, differential diagnosis includes allergic lower airway disease, chronic bronchitis (infectious bronchitis), pulmonary fibrosis, interstitial pulmonary lung disease, less likely non cardiogenic pulmonary edema, or ARDS. Concurrent passive pulmonary atelectasis.
- Visible pleural fissure, differential diagnosis includes mild pleural thickening, fibrosis, scant pleural effusion, tangential beam artifact, or fibrosis.
- Normal visible nasopharynx and larynx.
- No radiographic evidence of cardiomegaly or decompensate cardiac disease.
- Hepatomegaly. Differential diagnosis includes metabolic vacuolar change (endocrinopathy), inflammatory, or less likely infiltrative neoplasia.
- Excessive corporeal score.
- Minor shoulder osteoarthritis, incidental

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The possible cause of the clinical signs is likely associated with tracheal collapse, bronchomalacia, and chronic bronchitis/pulmonary fibrosis. The differential diagnosis of non-cardiogenic pulmonary edema and acute respiratory distress syndrome (ARDS) could be considered; however, they usually cause more acute and urgent clinical signs. Medical therapy is suggested. If the patient does not improve, a bronchoalveolar lavage may be useful in obtaining samples for cytology, culture, and sensitivity. A fluoroscopy or bronchoscopy may be used for better dynamic airway exam.

Abdominal ultrasound is suggested for further evaluation of the liver, if the patient has any correlated clinical or laboratory signs.

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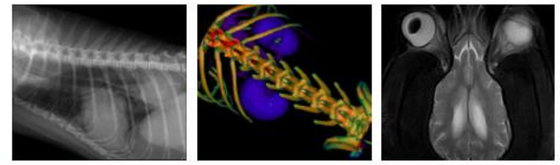

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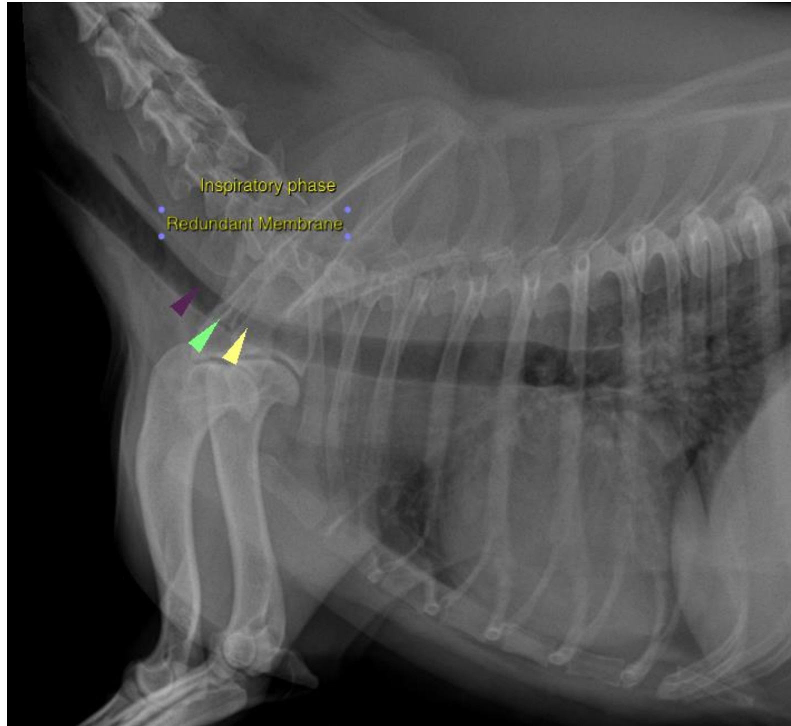

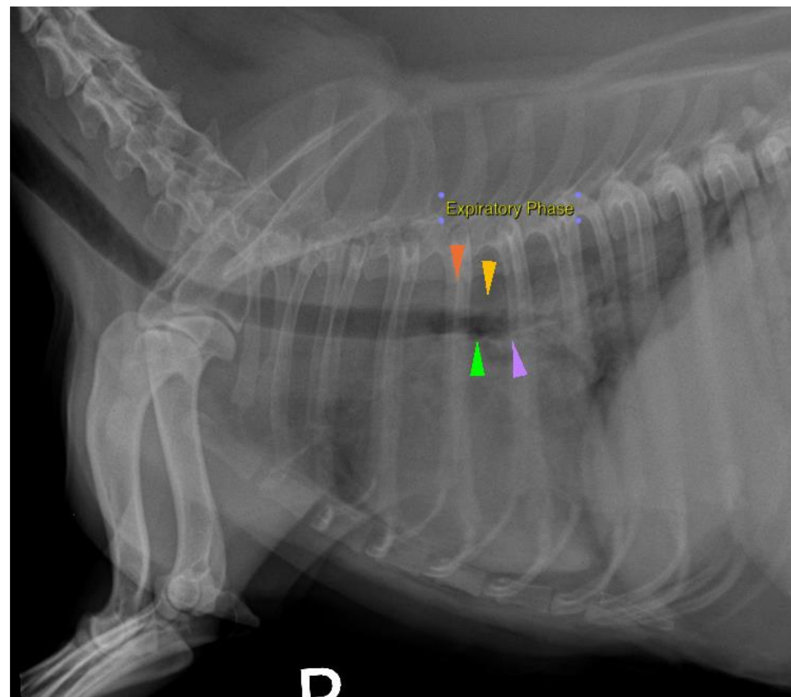

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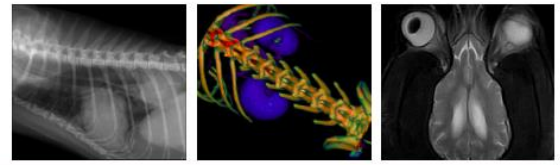

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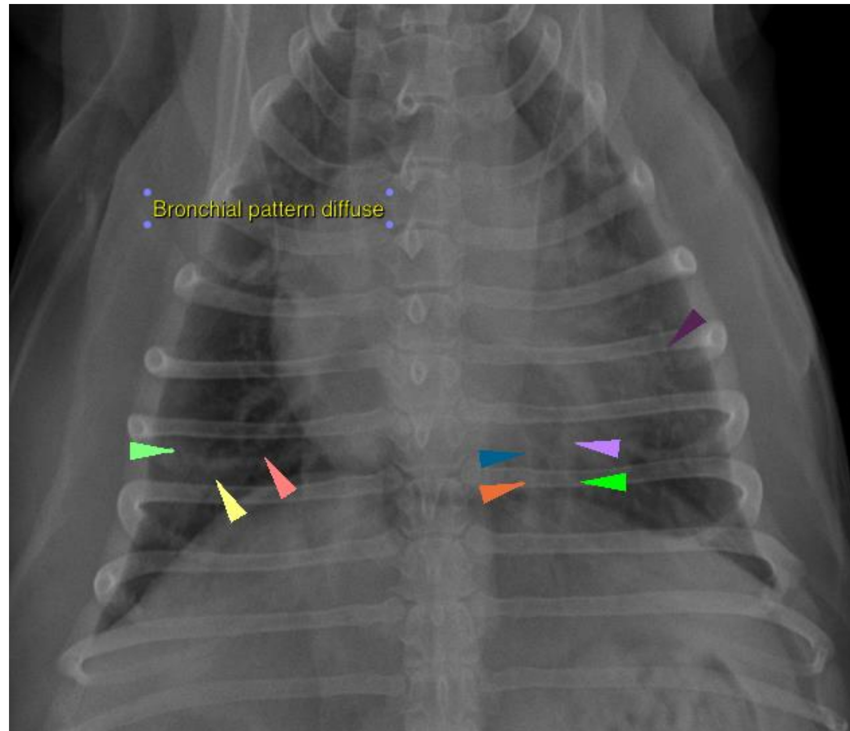

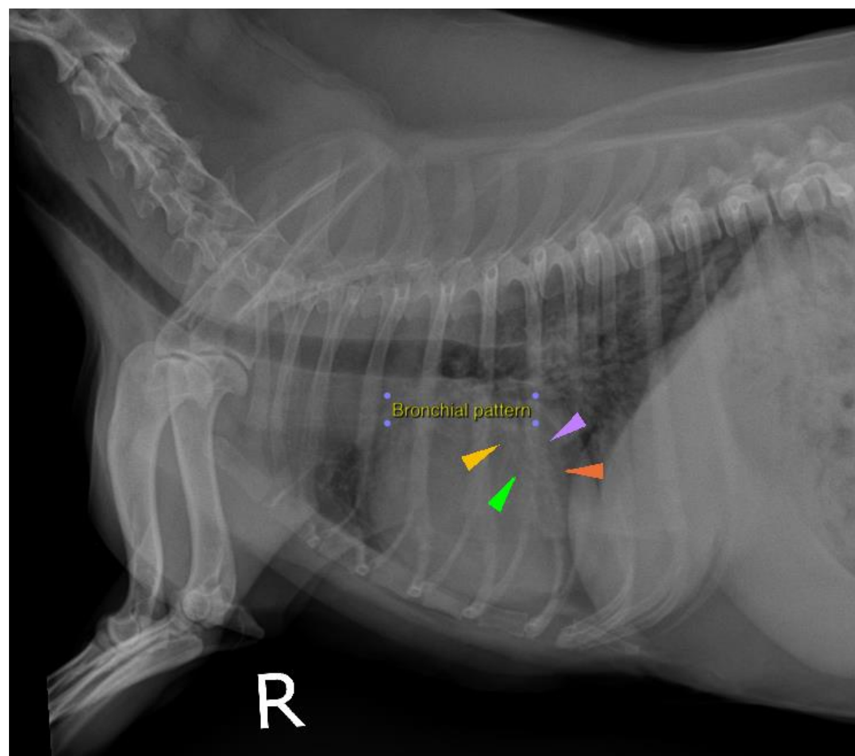

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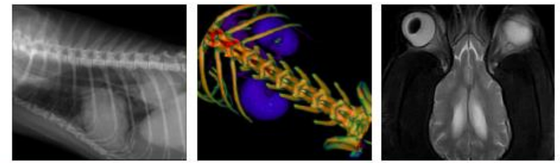

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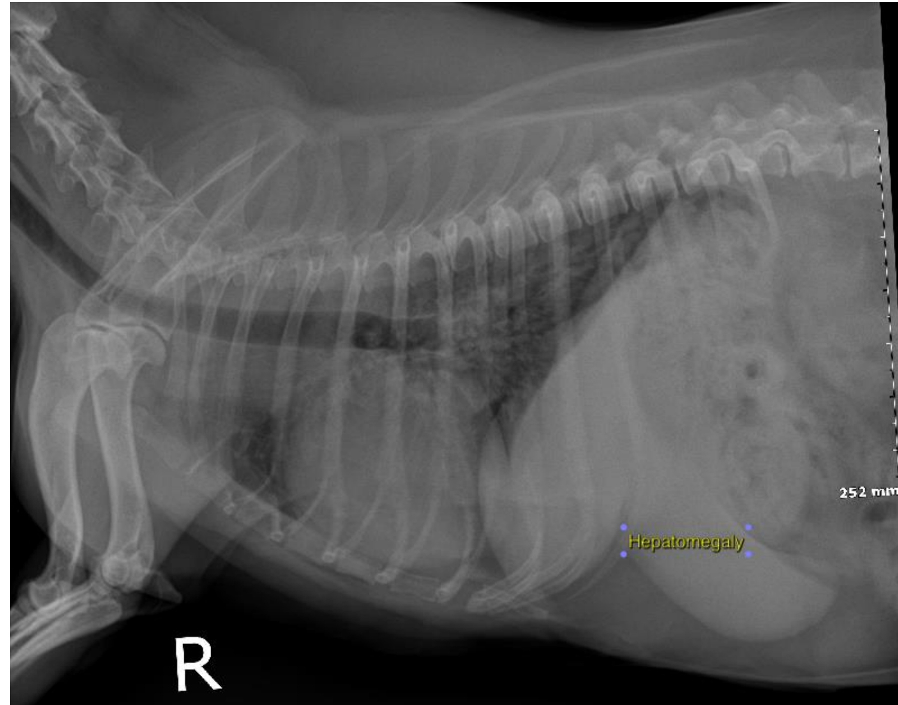

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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