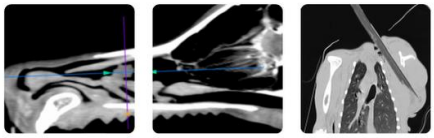




**PATIENT**

Murphy Talbot

**SPECIES**

Canine

**BREED**

Bernese Mountain Dog

**SEX**

Male Neutered

**AGE**

3

**WEIGHT**

44.8

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kari Deryk RVT

**HOSPITAL NAME**

Oxford County Veterinary Clinic

**REFERRING VET**

Amy Lynes

**INVOICE**

74121

**DATE**

3-10-26

## PRESENTING CLINICAL SIGNS

- 2/26/26: presented for inappetence ongoing since February 7th. Owners away on vacation 7-15th and not abnormal to not eat then but did not begin eating since owners returned home. Drinking water, urinating normally. No vomiting. 1 bout of very liquid diarrhea. Sent with low fat canned food, maropitant injection, and metronidazole.
- 3/3/26: still not eating much. No more diarrhea, still no vomiting, still drinking normally. Did eat RC gastro low fat canned at first but since stopped. BAR on exam and ate benny bullies in room. Added in gabapentin and oral maropitant and RC Gastro low fat kibble.
- 3/5/26: called owner for update; hardly eating despite trying broth, rice, chicken, kibble/canned gastro low fat. Owner worried as this has been going on almost a month now. Recommended abdominal ultrasound as next step - reason for elevated ALT? Pancreatitis ongoing issue or something else contributing?
- 3/6/26 had AUS done in clinic and sent via referral to Sonopath - results NORMAL, patient still not eating
- 3/10/26 patient came in for sedated oral exam - no broken teeth, foreign material, masses, etc or other cause for inappetence noted. Chest rads taken and sending today for interpretation. Patient has lost 2.4kg since end of February when this started.

Abnormal PE/Chem/CBC/UA Results: • 2/26/26: Rectal temp 39.5, otherwise BAR on PE. CBC reticulocytes incr (185.8; high end normal 110). Chem ALT incr 436 (high end normal 110). CPL incr 331 (high end normal 200). • 3/3/26: Rectal temp 38.6, otherwise BAR. No further diagnostics performed. • 3/10/26: Rectal temp 39.4-39.5, otherwise BAR. ALT down to 286, 4dx negative. Chest rads taken and submitted for evaluation today. TFAST performed and free fluid was noted in the ventral cranial right side of the chest.

## RADIOGRAPHIC STUDY OF THE THORAX

Orthogonal thoracic radiographs are available for review, totaling four projections: two ventrodorsal (VD) views, one right lateral view, and one left lateral view.

## RADIOGRAPHIC FINDINGS

The thoracic trachea is within normal limits.

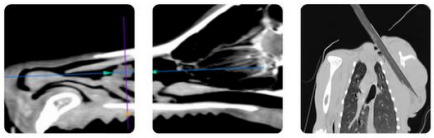
There is mild obscuration of the ventral cardiac border on the lateral views and the caudal cardiac silhouette on the ventrodorsal projection, associated with scant pleural effusion and visible pleural fissure lines.

The pulmonary parenchyma exhibits a diffuse bronchointerstitial pattern. Additionally, there is a lobar alveolar pattern affecting the right cranial lung lobe, with a faint alveolar opacity noted in the right middle lung lobe.

No pulmonary soft tissue nodules or mass lesions are identified. There is no evidence of pulmonary mass effect.

The cardiac silhouette appears within normal limits in size and shape, although partial border effacement.

The pulmonary vessels are within normal limits.





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There is mild soft tissue opacity within the caudal mediastinal/accessory lung lobe region, which may correspond to the small amount of pleural effusion or accessory lung lobe opacification.

The ribs, diaphragm, and thoracic wall are unremarkable.

The esophagus appears normal in the lateral projections.

## RADIOGRAPHIC DIAGNOSIS

- Scant pleural effusion.
- Diffuse bronchointerstitial pulmonary pattern with concurrent focal alveolar pulmonary pattern affecting the right cranial lung lobe and mildly the right middle lung lobe.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The thoracic radiographic findings demonstrate scant pleural effusion and a diffuse bronchointerstitial pulmonary pattern, associated with focal alveolar consolidation in the right cranial lung lobe and faint alveolar opacification in the right middle lung lobe.
Differential diagnoses for the pleural effusion include transudate or modified transudate, while exudate or hemothorax are considered less likely based on the current radiographic appearance.

The pulmonary opacities, particularly the multifocal alveolar pattern and its distribution, are most consistent with bronchopneumonia, inflammatory pulmonary disease, or aspiration pneumonia, which are considered the primary differential diagnoses.

Thoracic ultrasound may be repeat to better characterize its volume and distribution of pleural effusion, and guide fluid sampling if clinically indicated. Thoracocentesis with pleural fluid analysis and cytology is recommended, as this may help determine the underlying etiology. Additionally, pleural fluid analysis may further assist in the characterization of the effusion and help determine whether additional imaging, such as computed tomography, is warranted.

Follow-up thoracic radiographs in approximately 5–7 days, or after initiation of therapy, are advised to monitor progression or resolution of the pulmonary changes. Additionally, if an infectious bronchopneumonia remains a clinical concern, airway sampling, such as a transtracheal wash or bronchoalveolar lavage, may be considered to allow cytologic evaluation and microbiological testing.

Comments: There are no classic radiographic signs of lung lobe torsion, such as marked lobar expansion, vesicular gas pattern, or severe lobar displacement. However, given the nonspecific nature of the findings and the alveolar opacifications with scant pleural effusion, this differential diagnosis cannot be completely excluded.

Radiographs may miss enlarged intrathoracic lymph nodes or occasionally misinterpret normal-sized nodes as enlarged*. When accurate evaluation of intrathoracic lymph nodes is important for clinical decision-making, computed tomography is recommended, as it provides a more reliable assessment.

*Reference: Lye G, Pollard RE, Hartman A, Pemberton S, Kent MS, Zwingenberger AL. Radiographic Detection of Intrathoracic Lymphadenomegaly in Dogs: How Useful Is It? Vet Radiol Ultrasound. 2026 Jan;67(1):e70113. doi: 10.1111/vru.70113. PMID: 41417650.

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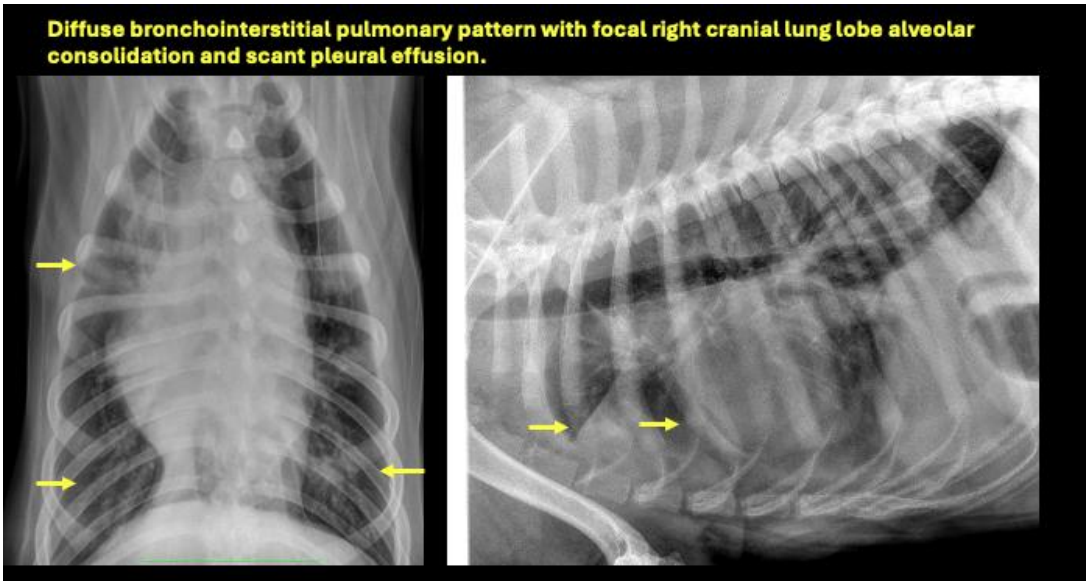


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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