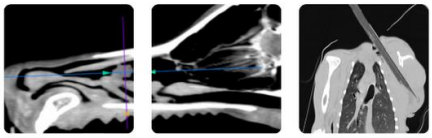


PATIENT

Zorro Karvounis

SPECIES

Feline

BREED

Tabby

SEX

MN

AGE

7Y

WEIGHT

6kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Mobile Pet Imaging

HOSPITAL NAME

Mobile Pet Imaging

REFERRING VET

Armstrong

INVOICE

74130

DATE

3-10-26

PRESENTING CLINICAL SIGNS

- Zorro presented to the ER for acute respiratory distress. (03/10/26)
- Zorro has a history of nonspecific phenotype cardiomyopathy (NCM), ACVIM Stage C, which was diagnosed in June 2025 (Sawgrass Cardiology) after he was diagnosed with congestive heart failure at CSAH. At that time, he was noted to have pulmonary edema and a small amount of pleural effusion. He was managed with furosemide, clopidogrel, Vetmedin, and spironolactone. On a recheck evaluation with his cardiologist in September 2025, his echocardiogram and cardiac
- biomarkers (NT-proBNP and cTnI) had normalized, and the condition was considered resolved or transient. A plan was made to taper and discontinue furosemide and clopidogrel; however, the owner discontinued all cardiac medications at that time, including Vetmedin and spironolactone

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A pre- and post-contrast CT study of thorax and abdomen are provided for review totaling 5 series. Two pre-contrast series of the thorax and abdomen, soft tissue algorithm. One pre-contrast series of the thorax, soft tissue algorithm. Two post-contrast series of the thorax and abdomen, soft tissue algorithm.

COMPUTED TOMOGRAPHIC FINDINGS

THORAX

There is a moderate amount of bilateral pleural effusion, distributed ventrally and symmetrically, slightly more pronounced in the left hemithorax. The fluid is homogeneous with smooth pleural margins. No pleural nodules, masses, severe pleural thickening, or loculated fluid collections are identified.

The sternal lymph nodes are mild to moderately enlarged, maintaining normal shape and margins. The largest measures approximately 1.5 × 0.8 cm.

The cranial mediastinal and tracheobronchial lymph nodes are within normal limits.

The trachea and main bronchi are normal in caliber and course.

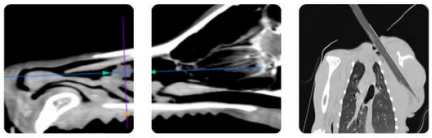
There is reduced expansion of the ventral (gravity-dependent) lung regions, affecting primarily the left cranial, right cranial, right middle, and accessory lung lobes. These lobes demonstrate a slightly rounded contour compatible with passive rounded atelectasis secondary to pleural fluid compression.

The remaining aerated pulmonary parenchyma shows normal attenuation, without evidence of pulmonary nodules, masses, or cavitary lesions.

The bronchial tree demonstrates normal branching and tapering. Bronchial walls are thin and smooth, with a normal bronchus-to-artery ratio.

The cardiac silhouette is within normal size and shape limits. Post-contrast opacification of the cardiac chambers is adequate.

A small amount of pericardial effusion is present without evidence of pericardial thickening.



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There is moderate accumulation of pericardial fat.

The cranial and caudal vena cava, aorta, azygos vein, and pulmonary vessels are normally opacified and show no evidence of filling defects.

The diaphragm, ribs, and thoracic wall are unremarkable.

The thoracic esophagus is within normal limits.

ABDOMEN

The liver is normal in size, contour, and attenuation, with uniform contrast enhancement.

The gallbladder has an incidental bilobed configuration. The cystic duct and common bile duct are normal.

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 distended with hypoattenuating fluid mixed with contrast material. Wall thickness is normal.

The spleen demonstrates a mild mottled enhancement pattern, considered incidental, with otherwise normal size and contour.

The gastrointestinal tract is normally positioned and distended, with normal wall thickness.

The colon and rectum are largely empty and show no abnormalities.

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

The serosal fat shows normal attenuation.

The caudal vena cava, portal vein and its tributaries, and the abdominal aorta are normal and appropriately contrast-enhanced.

The musculoskeletal structures included in the field of view are unremarkable.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Moderate bilateral pleural effusion, homogeneous and symmetrically distributed (slightly greater on the left), with secondary passive rounded atelectasis affecting the ventral lung lobes.
- Mild to moderate enlargement of the sternal lymph nodes, most consistent with reactive lymphadenitis.
- Discrete pericardial effusion without evidence of pericardial thickening.
- No evidence of pleural nodules, pleural masses, severe pleural thickening, or loculated fluid collections to suggest pleural neoplasia or septic pleuritis.
- No pulmonary nodules, pulmonary masses, mediastinal masses, or vascular filling defects identified.
- Normal abdominal structures.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The computed tomography findings confirm the presence of moderate bilateral pleural effusion with associated compressive passive atelectasis of the ventral lung lobes.

There is no CT evidence of pleural neoplasia, mediastinal mass, septic pleuritis, pulmonary thromboembolism, or other thoracic mass lesions.

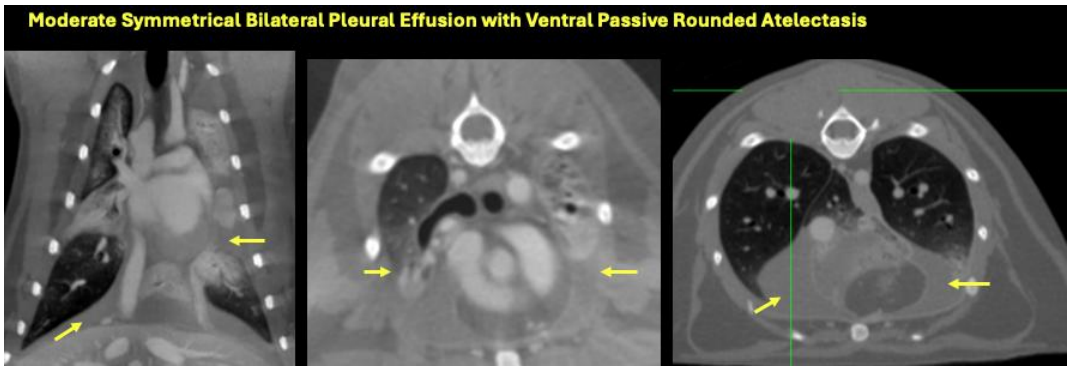
The sternal lymph node enlargement is most consistent with reactive lymphadenitis, although early or incipient neoplastic processes, such as lymphoma, cannot be completely excluded based on imaging findings alone.

Given the patient's clinical history and the results of previous diagnostic examinations, the tomographic findings are compatible with chylous pleural effusion (chylothorax). However, the underlying cause cannot be definitively determined by computed tomography.

Importantly, the present examination does not demonstrate structural abnormalities such as mediastinal masses, cranial vena cava obstruction, vascular thrombosis, or pulmonary disease that could explain the pleural effusion.

In this context, idiopathic chylothorax remains a possible consideration.

Further evaluation with computed tomographic lymphangiography (CT lymphangiography) may be considered to assess the thoracic duct and associated lymphatic structures, particularly to investigate possible lymphatic leakage, ductal rupture or ductal obstruction. This technique may help identify the underlying cause of the chylous pleural effusion when not evident on routine CT imaging.



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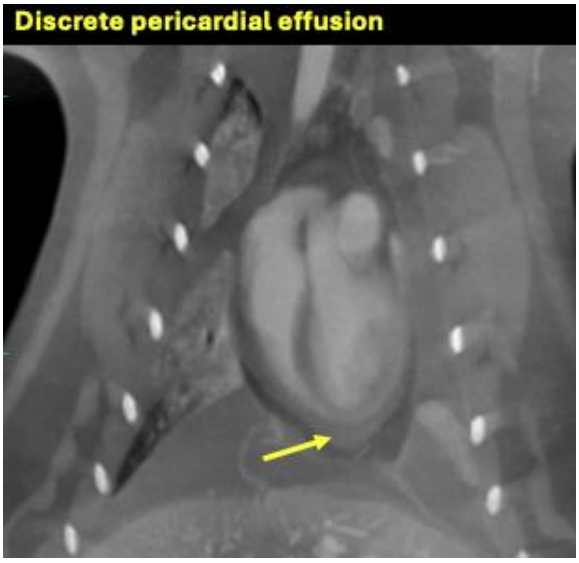

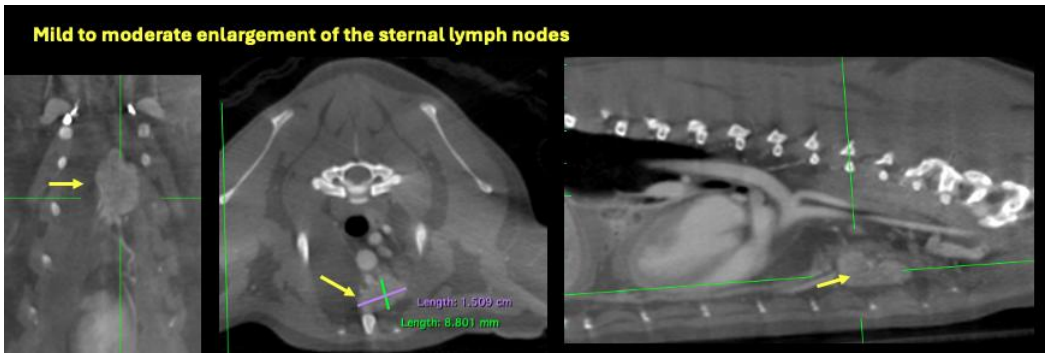

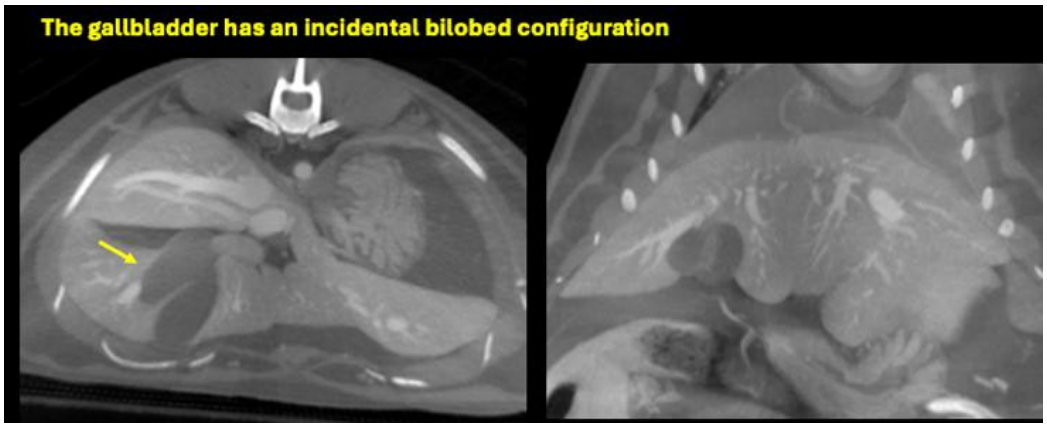

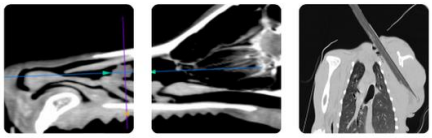

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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