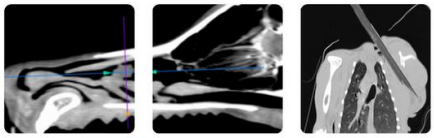


PATIENT

Finley Mergo

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

7

WEIGHT

8.7kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Runde

HOSPITAL NAME

Northeast Veterinary Referral Hospital

REFERRING VET

Dr. Runde

INVOICE

74978

DATE

5-13-26

PRESENTING CLINICAL SIGNS

presented for a history of a heart murmur, increased respiratory rate and bilateral pleural effusion (chylous appearance). Removed approximately 220mls of chylous effusion prior to CT. recent echocardiogram shows mild hypertrophic cardiomyopathy; idiopathic pleural effusion.
Abnormal PE/Chem/CBC/UA Results: glob 5.5, otherwise normal

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A pre- and post-contrast CT study of the thorax and abdomen is provided for review totaling 4 series. One pre-contrast series of the thorax (bone algorithm), Two post-contrast series of the thorax (soft tissue algorithm). One post-contrast series of the abdomen (soft tissue algorithm).

COMPUTED TOMOGRAPHIC FINDINGS

THORAX

A small volume of bilateral pleural effusion is present, characterized by homogeneous hypoattenuating fluid attenuation. No evidence of pleural thickening, pleural nodularity, or pleural pannus formation is identified.

An extensive volume of fat-attenuating tissue is present within the cranial mediastinum, with ill-defined margins surrounding the epicardial surface and causing mild ventral displacement of the cardiac silhouette away from the sternum, widening of the cranial mediastinum, and dorsal displacement of the thoracic trachea.

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

There are multifocal regions (> peripherical) of pulmonary consolidation affecting the right cranial, right middle, right caudal, accessory, and caudal subsegment of the left cranial lung lobes. Except for the right cranial lung lobe, the affected lobes exhibit rounded morphology, compatible with rounded atelectatic change, suggesting chronicity. The consolidated pulmonary regions demonstrate preserved post-contrast enhancement.

The remaining aerated pulmonary parenchyma is unremarkable, with no evidence of pulmonary nodules or masses.

The cardiac silhouette is within normal limits, without evidence of severe atrial enlargement. Cardiac chambers are adequately opacified by contrast medium. The large vessels and pulmonary vasculature are unremarkable.

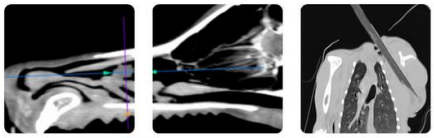
The diaphragm, ribs, and thoracic wall are unremarkable.

The thoracic esophagus is mildly gas distended, likely incidental or anesthesia related.

ABDOMEN

The liver is homogeneous in attenuation and contrast enhancement, with normal size and shape. The gallbladder, cystic duct, and common bile duct are within normal limits.

The kidneys are normal in size, shape, contour, and attenuation pre- and post-contrast. The renal pelvises and ureters are within normal limits.



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The urinary bladder is moderately distended by homogeneous hypoattenuating fluid admixed with contrast material. Normal wall thickness.

The spleen is homogeneous in attenuation and enhancement, with normal size and shape.

The stomach is empty, with normal wall thickness.

The duodenum and small intestines are nondilated and contain small amounts of fluid and gas. Wall thickness and distribution are within normal limits.

The colon contains gas and a moderate amount of heterogeneous fecal material. Normal wall thickness.

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

The serosal fat demonstrates normal attenuation.

A marked amount of intra-abdominal and extra-cavitary subcutaneous adipose tissue is present, consistent with generalized obesity.

There is complete ventral bridging spondylosis deformans at L7–S1.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Small-volume bilateral pleural effusion.
- Extensive cranial mediastinal fat accumulation (mediastinal lipomatosis), causing widening of the cranial mediastinum and mild dorsal displacement of the thoracic trachea.
- Multifocal pulmonary consolidations with rounded morphology affecting multiple lung lobes, most consistent with chronic rounded atelectasis likely secondary to pleural disease and possible mediastinal lipomatosis.
- No evidence of pulmonary nodules, pulmonary masses, pleural thickening, or thoracic lymphadenopathy.
- No significant abdominal visceral abnormalities identified.
- Generalized obesity.
- Complete ventral bridging spondylosis deformans at L7–S1.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The tomographic findings demonstrate a small amount of bilateral pleural effusion associated with multifocal chronic rounded atelectatic changes involving multiple pulmonary lobes. The absence of pleural thickening, pleural nodularity, or thoracic lymphadenopathy reduces the likelihood of pleural neoplasia or granulomatous pleuritis based on CT appearance.

The extensive fat accumulation within the cranial mediastinum is compatible with mediastinal lipomatosis and may contribute to apparent mediastinal widening and mild tracheal displacement. This finding is commonly associated with obesity and is typically incidental.

No pulmonary mass lesions or thoracic metastatic disease are identified.

No underlying cause for the pleural effusion/chylothorax was identified on CT. CT lymphangiography could be considered for further evaluation.

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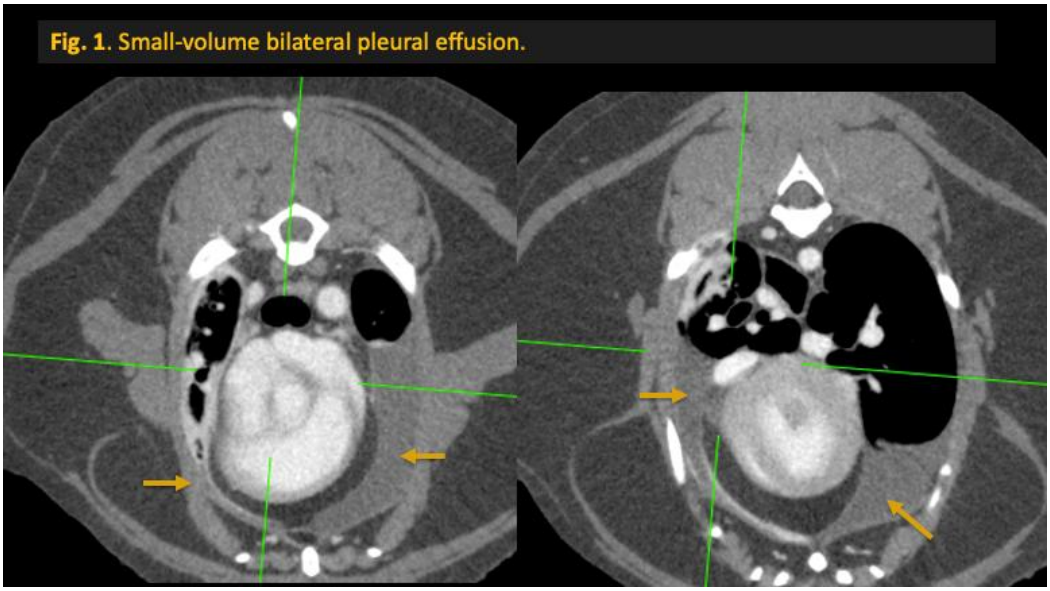

Fig. 1. Small-volume bilateral pleural effusion.

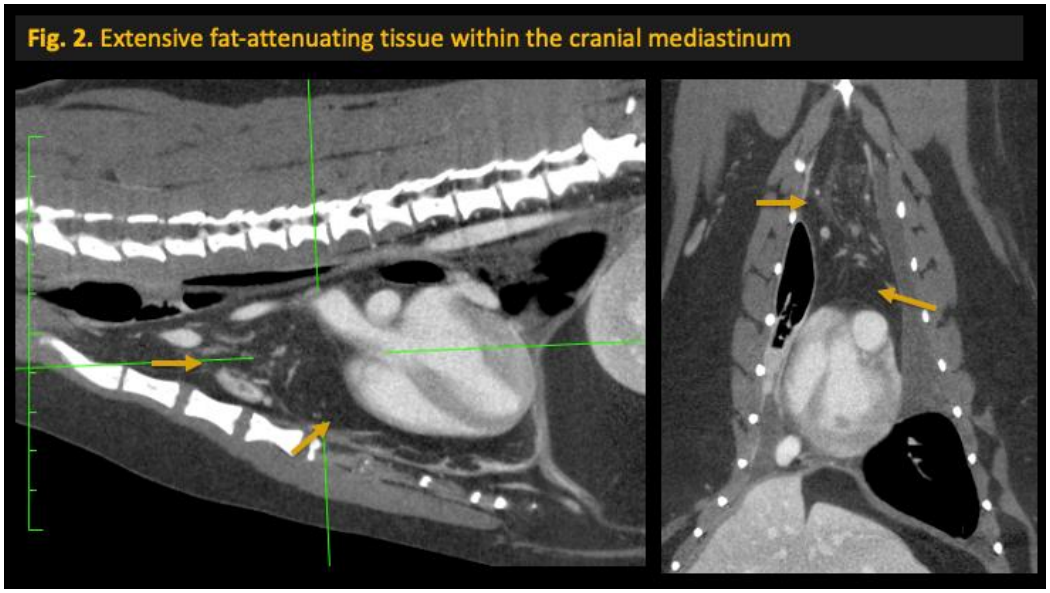

Fig. 2. Extensive fat-attenuating tissue within the cranial mediastinum

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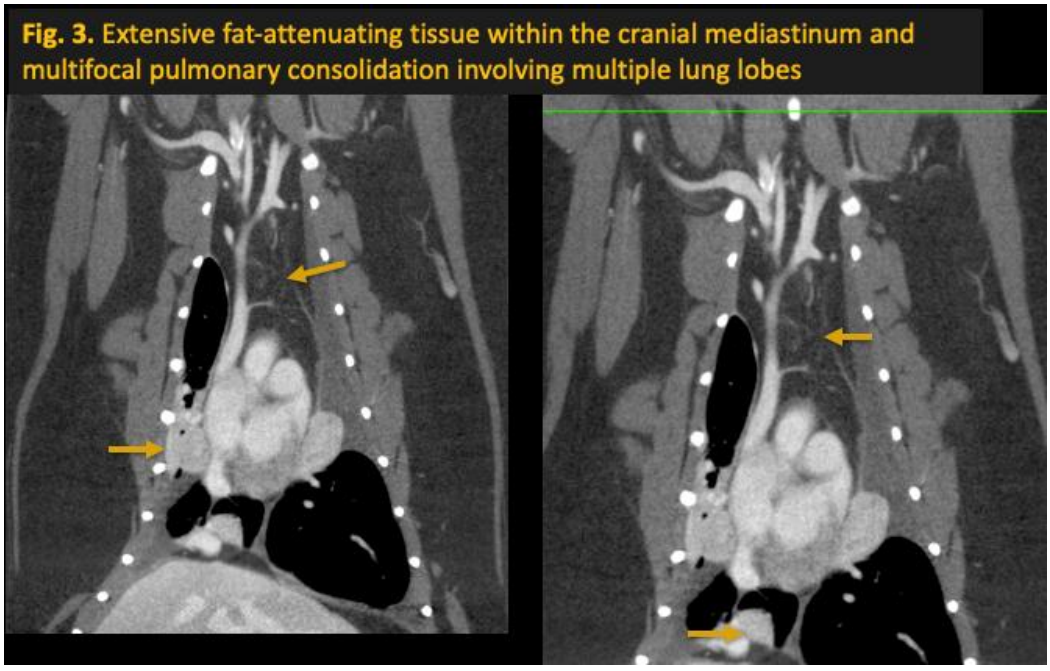

Fig. 3. Extensive fat-attenuating tissue within the cranial mediastinum and multifocal pulmonary consolidation involving multiple lung lobes

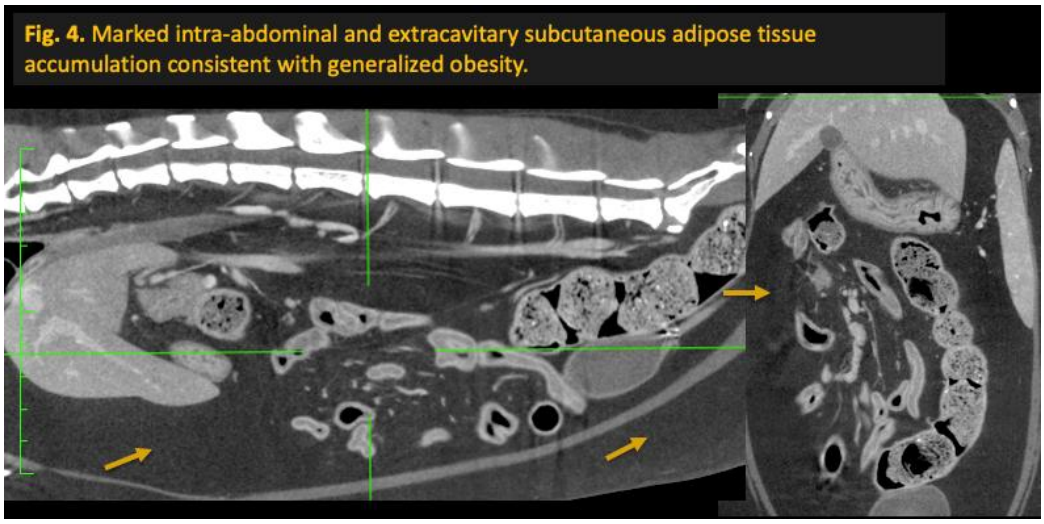

Fig. 4. Marked intra-abdominal and extracavitary subcutaneous adipose tissue accumulation consistent with generalized obesity.

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