



IT'S YOUR CASE

Species: Feline Breed: Domestic Shorthair (DSH) Sex: Female Neutered Age: 15 years

Clinical History:

She has been having trouble breathing for the past week but began with open mouth breathing last night.

She has been eating, drinking and defecating normally.

Full bloodwork today indicates hyperthyroidism, elevated GGT and monocytosis with decreased eosinophils

Anatomic regions: Thorax, Abdomen

Details of study and technical comments: A radiographic study of the thorax and abdomen is presented for evaluation. The study consists of right and left lateral views as well as a ventrodorsal view of the thorax and of the abdomen.

Diagnostic interpretation:

THORAX:

Asymmetrical soft tissue is in the pleural space (red arrows) but more severe in the right pleural space; this effaces the diaphragm. There is a mass effect from this opacity resulting in leftward displacement of the mediastinum (orange arrows) and dorsal displacement of the trachea (yellow arrow). The margins of the right caudal lung lobe are mildly scalloped (green arrows).

The cardiac silhouette is effaced; pericardial fat does not define the margins. The lung is generally more opaque however this is concomitant with markedly reduced volume.

The right fifth rib is thin, incomplete with smooth margins (light blue arrows). There is widening of the of fifth intercostal space bilaterally.

ABDOMEN:

There is good abdominal serosal contrast.



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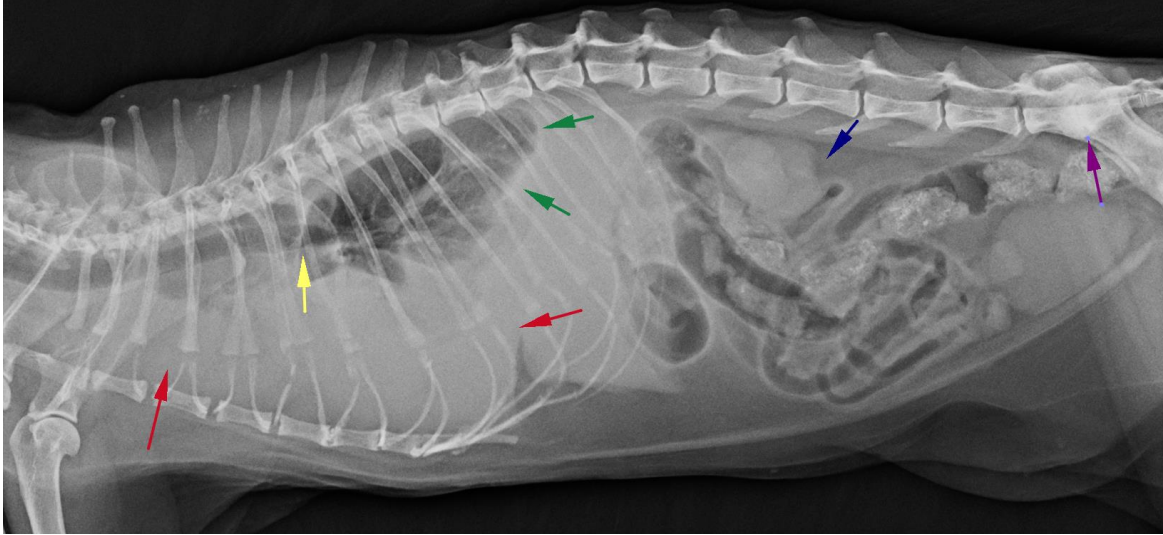
This report is based on the available history and radiographic interpretation only and not on a physical examination of the patient. It has been prepared specifically for interpretation by the currently licensed and registered veterinary surgeon responsible for the care of this patient.

The visible margins of the liver and spleen are radiographically within normal limits.

The gastric silhouette contains gas and is normal in position. The small intestine is generally soft tissue opaque and within normal limits for diameter and margination. Faecal material is in the descending colon and rectum.

The left renal silhouette is flattened on the caudal pole (dark blue arrow). The right renal and urinary bladder silhouettes are smoothly margined and within normal limits. There are no radiopaque calculi.

There is marked narrowing of the lumbosacral junction (purple arrow). The remaining lumbar vertebral column is unremarkable without evidence of fracture, luxation or osteolysis.

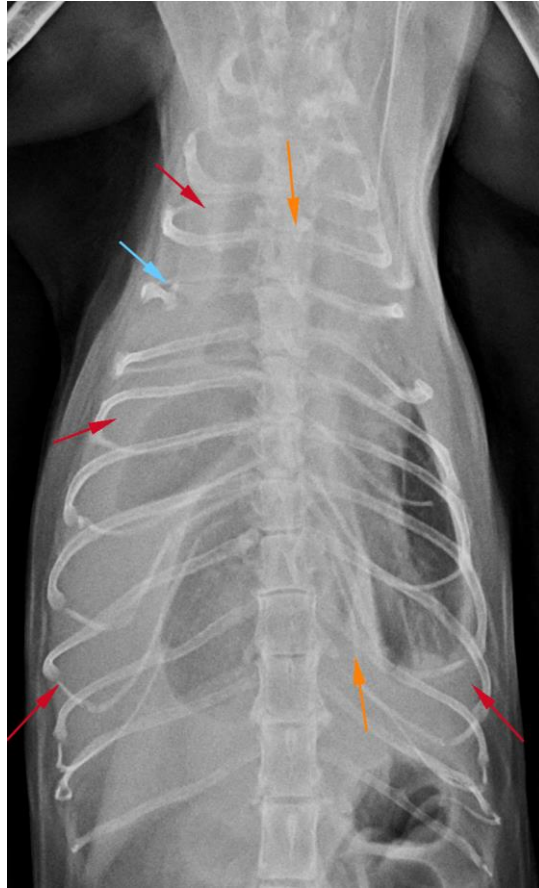


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Conclusions:

- Bilateral and severe pleural effusion.
- Pulmonary pleural scalloping. Consider the potential for fibrosis or pleuritis secondary to chronic effusion.
- Secondary atelectasis.
- Left renal changes. This likely represents chronic renal infarction however concurrent renal insufficiency cannot be excluded.
- Chronic non-union of right fifth rib fracture.

Additional comments:

Asymmetrical pleural effusion is nonspecific and can be associated with pyothorax or other causes of effusion (i.e. neoplasia, inflammation, chyle). The asymmetry suggests that there is a thicker quality of the fluid preventing equilibrium between the pleural spaces. Further evaluation of an underlying cause can be made with thoracocentesis for fluid cytology and therapeutic means. The presence of pleural scalloping can indicate fibrosis and reduced elasticity of the parenchyma; this is relevant to thoracocentesis as complete evacuation of fluid can promote increased shear forces and subsequent pneumothorax.

The presence of pleural effusion impairs characterisation of the cardiac silhouette and obscures confounds ability to determine the presence of cranial mediastinal abnormalities. This can be further explored with thoracic ultrasound or computed tomography.



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