



VETCT
CONSULTANTS IN TELEMEDICINE

IT'S YOUR CASE

Species: Canine

Breed: French Bulldog

Sex: Female Neutered

Age: 3 years

Clinical History:

Acute onset respiratory distress. Previous vomiting and now febrile.

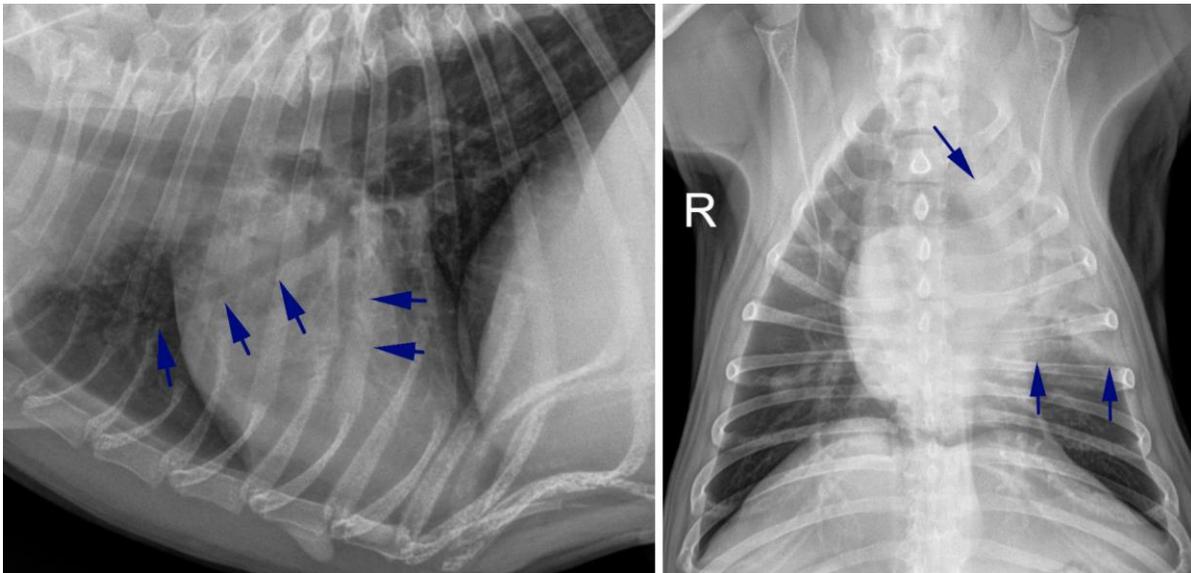
Details of study and technical comments:

A radiographic study of the thorax is available for evaluation. The study consists of right and left lateral views as well as a ventrodorsal view of the thorax.

Diagnostic interpretation:

THORAX:

The left cranial lung lobe has a severe alveolar pattern, evidenced by increased soft tissue opacity, air bronchograms (image below, blue arrows) and positive silhouette sign with adjacent soft tissue opacity structures. On the ventrodorsal view this results in a lobar sign.



Reported by VetCT

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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 cardiac silhouette is normal in size and position. The pulmonary vasculature is well visualised in areas of the lung not affected by the alveolar pattern. The pulmonary vessels are normal in diameter and they taper towards the periphery. The trachea has a normal width. The pleural space and mediastinum are unremarkable.

Multifocal spondylosis deformans is present throughout the thoracic vertebral column and there is intervertebral disc space narrowing from T13 through L4.

A smoothly margined, ovoid soft tissue opacity is superimposed over the right seventh rib in the dorsoventral view. In the lateral views this is seen superimposed on the subcutaneous tissues ventral to the sternum, and it is consistent with a nipple.

Conclusions:

- Alveolar infiltrates of the left cranial lung lobe (cranial and caudal subsegments). Primary consideration is given to bronchopneumonia, likely secondary to aspiration.
- Ventral spondylosis. Incidental.

Additional comments:

The lung changes are severe and explain the clinical signs.

A cause for the vomiting is not identified. If clinically indicated, imaging of the abdominal cavity could be considered to investigate possible causes.

The presence of bronchopneumonia following vomiting is most consistent with aspiration. Radiographic maturity of changes often lag clinical presentation due to the phases of aspiration.

Aspiration pneumonia is a specific subset of bronchopneumonia and is attributed to the inhalation of gastrointestinal material. It manifests in three stages:

1. The chemical phase results from introduction of digestive enzymes into the dependent pulmonary parenchymal fields. This stage is rarely radiographically apparent unless a large volume of fluid has been introduced.
2. The second phase is the inflammatory phase. The chemical insults of the parenchyma results in recruitment of inflammatory cells and oedema.
3. The infectious phase is result from the parenchymal changes producing a conducive environment to bacterial growth.

Frequently, medical management is monitored with serial radiography to determine complete resolution.



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