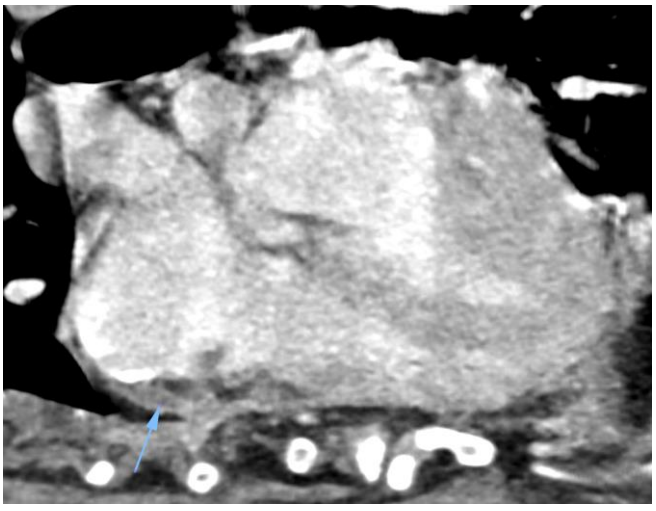
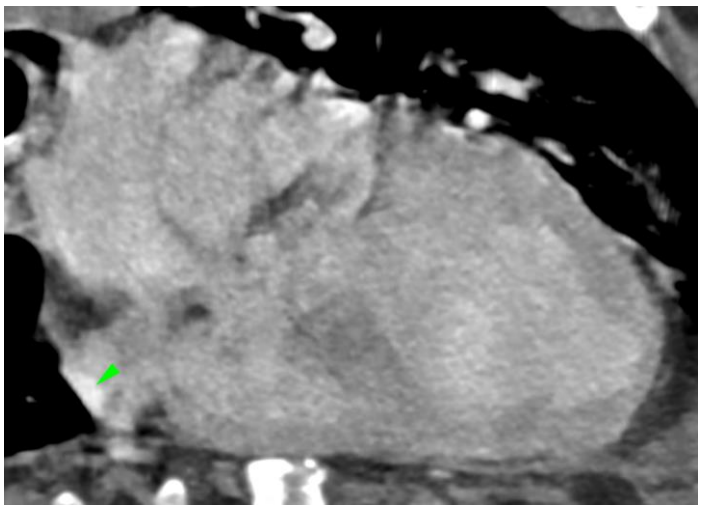
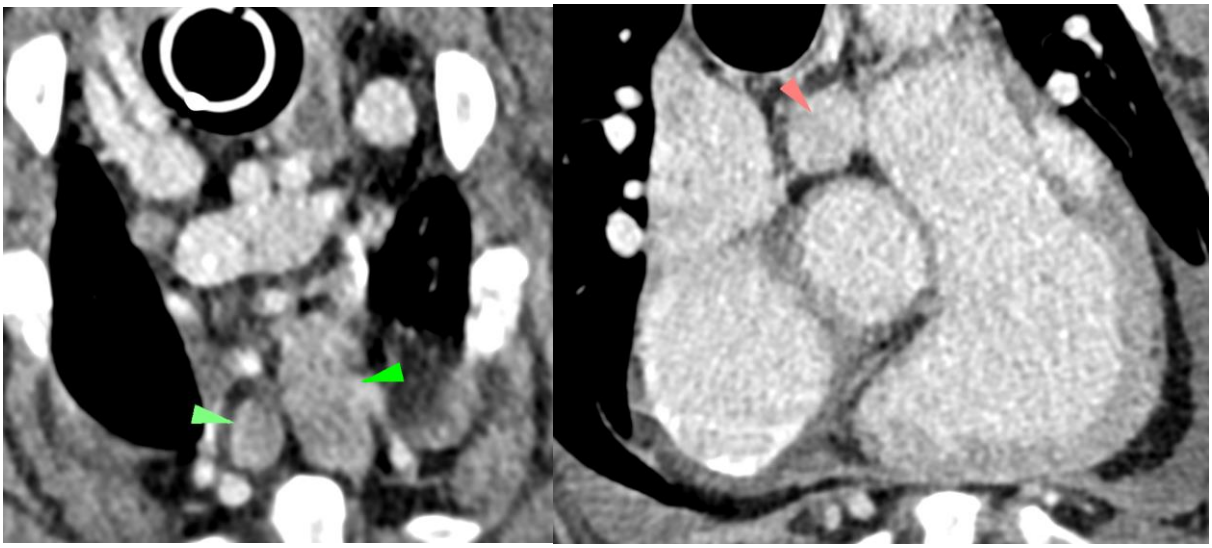
Diagnostic Imaging report

Date: 01/10/2020
Referring veterinary surgeon: XXXX
Hospital: XXXX
Email address: XXXX
Patient name and surname: XXXX
Species (canine/feline): Canine **Breed:** German Shepherd **Age:** 8 year **Sex:** FN
Previous report and date (if applicable): N/A
Body areas scanned and charged:
Thorax and abdomen with contrast
Service required: Priority 24 hrs
Relevant clinical history, clinical findings and diagnostic test results:
Pericardial effusion and RSCHF – 500ml haemorrhagic fluid drained. No discreet cardiac mass – RV wall and AV region appears hyperechoic and possibly thickened. No heart base mass seen. Mildly hyperthermic(39.8oC) but very stressed dog. DDx neoplasia vs idiopathic, unlikely infectious (cyto and culture pending)
Questions to be answered:
Further investigations into cause for pericardial effusion – particularly to exclude neoplastic disease in addition to staging for distant disease
Report
Thorax:
There remains a scant volume of peri-cardial effusion, with a thin crescent of fluid noted ventrally at the heart base, adjacent to the right atrium (see image below, blue arrow). There is accumulation of contrast within the right auricular appendage with an apparent focal thickening of the wall at this level (see image below, green arrow head). There is no evidence of discrete mass associated with the right atrium or auricular appendage. The heart is otherwise unremarkable.

There is mild retraction of the lung lobes ventrally, by a small volume of residual pleural effusion (HU=40), which is mainly left sided in location. There is no evidence of pleural thickening.

The mediastinal and pleural structures are otherwise unremarkable. There is moderate enlargement of the presternal lymph nodes (see image below, green arrow heads), measuring up to 12mm diameter, with further enlargement of the cardiac lymph node (see image below, pink arrow head) There is no evidence of thoracic lymphadenopathy.



There is mild-moderate heterogenous increase in attenuation within the left cranial lung lobe, with associated volume loss and a mild focal consolidation of the ventral tip of the left cranial lung. There are similar but more mild changes noted within the right cranial, accessory and medial aspect of the left caudal lung lobes. There is a reasonably well-defined ground glass infiltrate noted within the caudal most aspect of the right caudal lung lobe. There are occasional mineral dense peripheral foci consistent with osteomata. There is no evidence of pulmonary nodular infiltrate. The lung parenchyma and airways are otherwise unremarkable.

Abdomen:
The liver and biliary tract are unremarkable. The spleen is unremarkable. The urogenital tract and adrenal glands are unremarkable. The gastrointestinal tract and pancreas are unremarkable.

There is no evidence of peritoneal reaction or free fluid. There is no evidence of mesenteric or sublumbar lymphadenopathy.

The visible musculoskeletal structures are unremarkable.

Conclusion

1. Possible thickening of the right auricular appendage wall (craniolateral aspect) – see comments.
2. Scant volume of residual peri-cardial effusion satisfactory drainage noted.
3. Mild ongoing pleural effusion, likely resolving secondary to the reported previous right-sided failure.
4. Diffuse, multi-focal alveolar-interstitial lung infiltrate; most likely represents atelectasis secondary to the resolving pleural effusion. An underlying pneumonia (especially angiostrongylosis) particularly for the right caudal lung changes cannot however be excluded.
5. Moderate presternal and cardiac lymphadenopathy; likely reactive lymphadenopathy secondary to the

effusions. Neoplastic infiltrate is unlikely but sampling would be required for further evaluation.

6. No evidence of pulmonary or abdominal metastatic disease.

Comments

A clear right auricular or heart base mass is not identified on CT examination, however there is a suspicion of a thickening of the right auricular appendage wall cranially. While this thickening is equivocal due to contrast accumulation within the lumen of this structure, I am suspicious of an early auricular appendage mass which would explain the peri-cardial effusion. I would recommend serial scanning of this region with either echocardiography or CT to monitor progression.

Many thanks for referring this case to Vet Oracle Teleradiology. If you have any further questions or comments regarding this case please do not hesitate to contact us at teleradiology@vetoracle.com

Reporting Radiologist

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