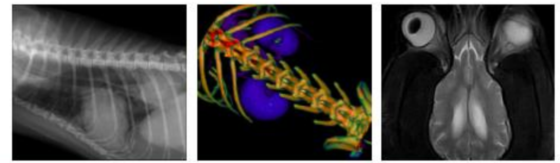


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Kobe Thompson

SPECIES

Canine

BREED

Labrador Retriever

SEX

Intact Male

AGE

3 Years 5 Months

INTERPRETED BY

Heike Rudorf, DVM, Dr. med. Vet., DipECVDI DVR

HOSPITAL NAME

Pocono Peak VC

REFERRING VET

Dr. Christine Coyle

INVOICE

23695

DATE

7/28/23

PRESENTING CLINICAL SIGNS

History: Pt is a field trial dog and intermittently since last year has had times of coughing and gagging, bringing up phlegm. Improved with prior dosing of doxy and Temaril P. Dog also has a hx approx 20 months ago having episode of aspiration pneumonia from swimming during retrieving (responded well to meds). Pt often runs through heavy grass cover during field work and owner concerned because these episodes began after having a large number of seeds in eyes and nose.
Abnormal PE/Chem/CBC/UA Results: Anaplasma positive

RADIOGRAPHIC STUDY OF THORAX AND NECK

Thorax

The body condition score is 5/9 with smooth alternating layers of fat and soft tissue opacity. Spondylosis and bridging spondylosis are present on the ventral thoracic spine. The sternum consists of a normal manubrium sterni and xipisternum. Only four sternebrae are present, one of which appears to be a block sternebra with a concave center.

The degree of pulmonary expansion is fair. The lungs are in contact with the thoracic boundaries and the tips are pointed. The lobar vessels are clearly visible to the tertiary branches and have a physiological size. The bronchial tree is thin walled and tapers uniformly towards the periphery.

The cranial mediastinum is of physiological size and opacity. The trachea diverges from the thoracic vertebrae and the carina is located at T5. A small amount of air is present in the esophagus.

The cardiac silhouette occupies 80% of the chest height and 3.5 intercostal spaces (VHS 11.5). On the VD view the cardiac silhouette occupies ¾ of the chest width and the right side appears slightly prominent. No atrial or outflow tract enlargements are obvious.

Head and Neck

The surrounding muscles and fat layers as well as the retropharyngeal area appear physiological.

On the VD neck view with the slightly oblique head, the inner outline of the zygomatic process of the R temporal bone is undulating and slightly sclerotic; on the straight view this is only just visible rostral to the lateral aspect of the R condylar process of the mandible.

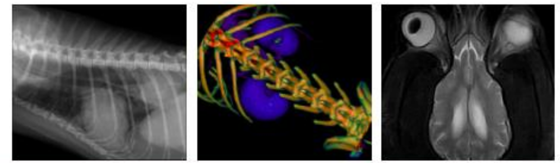
On the lateral view a hook shaped bone structure arises (1.7cm) from the caudal hard palate and extends caudo-ventrally into the lumen of the nasopharynx. A radiolucent line appears just caudal to the bullae at the level of the paracondylar process of the occipital bone. The resulting ventral rhomboid bony structure appears slightly mottled in opacity. Further thin radiolucent lines appear to be located in the body of the occipital bone.

The regions of mandibula lymph nodes, thyroid- and salivary glands appear physiological.

RADIOGRAPHIC DIAGNOSIS

- Surface alteration of R zygomatic process
- Possible alterations of the pterygoid and occipital bones

Incidental finding



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- Spondylosis
- Congenital sternal anomaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes along hard palate and occipital bone most likely represent normal anatomical structures highlighted due to the slight obliquity of the view. The hook shaped structure could represent part of the os pterygoideum (hamulus pterygoideus) and the seemingly separate structure at the occipital bone the condylar process. With a fracture at the occipital bone I expect to see a soft tissue swelling which is absent. However, the bone remodeling on the right zygomatic arch suggests a chronic inflammatory/infectious process.

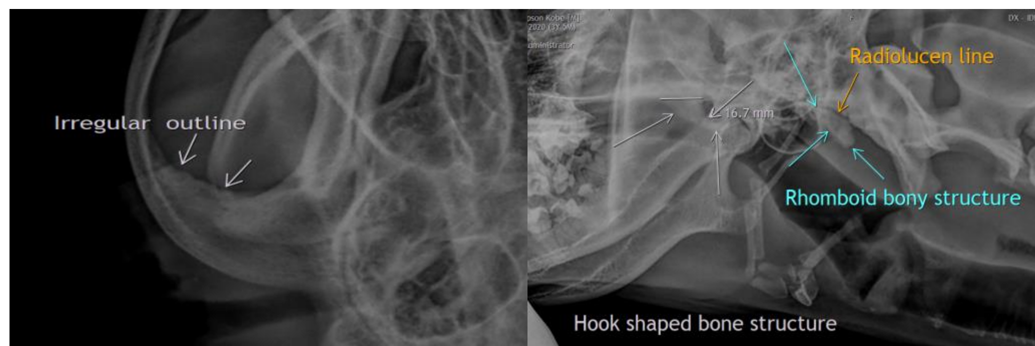
I can see no changes in the lungs (e.g. localized caudo-dorsal or ventral alveolar infiltrate) that would explain the clinical signs. However, bronchitis may be present without radiographic evidence and thus bronchoscopy with broncho-alveolar lavage is necessary to rule out infection and inflammation though hematology shows no leukocytosis or neutrophilia on date 7/28/23.

The right side of the cardiac shadow appears prominent but without an actual enlargement of cardiac chambers or outflow tracts. Unless a murmur is audible echocardiography does not seem indicated.

Gagging and bringing up phlegm suggest an upper respiratory problem and visual examination is recommended to rule out tonsillar pathology, laryngeal paralysis and masses in the pharynx. A CT examination (plain and post i.v. contrast) can help show muscular pathologies such as myositis and post traumatic changes such as muscle atrophy and fibrosis. The bone structure of both zygomatic arches can also be compared more easily. In case the gagging occurs in relation with food intake, fluoroscopy is needed to rule out pharyngeal and esophageal dysfunction.

TECHNICAL COMMENTS

Lead sleeve in primary beam.



The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. 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.

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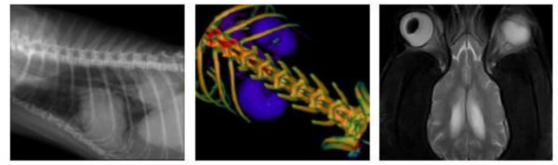

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