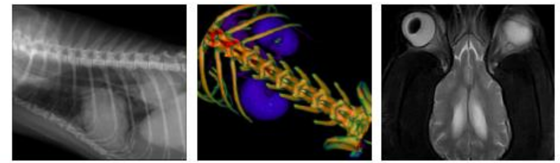

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Bindi Wright, Steven

SPECIES

Canine

BREED

Labrador X

SEX

Female Spayed

AGE

14 Years, 10 Months

INTERPRETED BY

Nele Eley, DVM
Dr. med. Vet. DipECVDI

HOSPITAL NAME

Animal Health Partners

REFERRING VET

Dr. Shannon Westgarth

INVOICE

55065

DATE

11-8-22

PRESENTING CLINICAL SIGNS

Presenting problem: Chronic cough and nasal discharge Energy level: No change, appropriatefor age Appetite/diet: Normal Water consumption: Drinking more since starting prednisone Urination: More since pred V/D/C/S: No vomiting or diarrhoea. Coughing not as bad, seems like a tickle in throat Cough when she's active. Snotty nose more of a concern - thick yellow. Sneezes it out, but also just runs Faeces goes green/orange sometimes and furry like it's moldy. Current medications: Started 1.5 5mg tabs pred a day, half tab day now. Cough was better on high dose of pred but O concerned about QoL - PUPD Stopped pred nose drops Aventi liver Hip/joint vitamins Previous medications: -Cerenia - no improvement of cough -Doxycycline - no improvement of signs -Clavamox -Enrofloxacin -Prednisone - improved signs, however nasal discharge returns when dose is tapered -Denamarin started 2019 -Diphenydramine 30-50mg q8h Background history: -rDVM Notes: Up to date on DHPPR & lepto. History of elevations in liver enzymes. Treated with denamarin since July 2020. Developed a cough in June/22 with no nasal discharge. treated with Cerenia. Cough no better & developed a nasal discharge-yellow-white. Then started sneezing. Treated with doxy. No better. Chest xrays. M1 cardiomegaly. Spondylitis T3-4 & T13-L1. Liver margins rounded. No evidence of pneumonia. Put on amoxiclav. Resp PCRneg. Culture swab of nares & fungal culture (fungus neg) Culture MRSP. Treated with baytril. Improved with prednisone but when decrease the dose, discharge returns

COMPUTED TOMOGRAPHIC STUDY OF THE HEAD, THORAX, & ABDOMEN

Plain and post contrast studies in lung, soft tissue, and bone windows available for review.

COMPUTED TOMOGRAPHIC FINDINGS

Head

The brain presents no deviation from normal anatomy and symmetry. The grey and white matter distinction and the neuroparenchymal attenuation are as expected. The distribution of contrast enhancement is within normal limits throughout the parenchyma and meninges. The ventricular system is non-dilated and within the limits of the expected volume and symmetry.

A moderate amount of fluid attenuating material is present within both nasal cavities accentuating their ventral dependent portions. Diffuse swelling of the mucosal lining of the nasal turbinates is seen. Minor erosive changes are present. The frontal sinuses contain a mild amount of fluid attenuating material, left more than right, as well.

Both temporomandibular joints present congruent joint spaces with even subchondral bone surfaces and are considered within normal limits.

Both tympanic bullae are aerated, the mucosal lining is not seen, the bony wall is smooth and thin. The external auditory meatuses present within normal limits.

The submandibular and medial retropharyngeal lymph nodes are small and elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform.

The salivary glands present within normal limits.

Multifocal dental plaques and mild periodontal space widening are seen.

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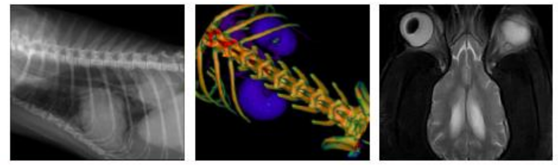

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Thorax

Mild cranial mediastinal lymphadenomegaly is noted.

The cardiovascular structures including the pulmonary vasculature are within normal limits.

The lung presents a mild generalized bronchointerstitial pattern which is evenly distributed throughout the entire lung. No evidence of alveolar infiltrates is seen.

Small incidental gas pockets are seen within the esophageal lumen, there is no evidence of abnormal dilation.

Abdomen

Spondyloses are present between T13 and L3.

A vacuum phenomenon of the left coxofemoral joint is seen.

There is mild degenerative lumbosacral stenosis.

Multiple variably enhancing and partially fat attenuating nodules of up to 2.5 cm diameter are seen throughout the spleen.

The gallbladder is moderately distended. Moderate thickening of the gallbladder wall is seen accentuating the region of the cystic duct. The common bile duct and duodenal papilla present within normal limits.

Mild generalized enlargement of the pancreas is noted with slightly nodular appearance.

The left portal lymph node is mildly enlarged at 1.0 cm diameter.

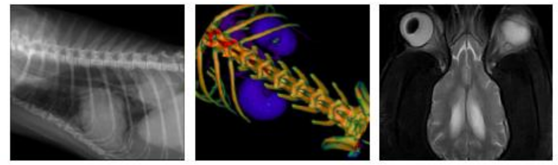
The kidneys reveal small cortical infarcts.

The adrenal glands present within normal limits.

The gastrointestinal tract presents within normal limits.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Moderate chronic bilateral rhinosinusitis.
- Mild generalized bronchointerstitial lung pattern.
- Dental plaques and mild periodontal disease.
- Multiple splenic nodules.
- Suspect cholecystitis.
- Portal lymphadenomegaly
- Suspect pancreatitis versus nodular hyperplasia.
- Cortical renal infarcts
- Spondyloses.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The CT study reveals bilateral chronic rhinosinusitis with minimally erosive changes. Infectious rhinosinusitis such as bacterial and less likely viral is considered by far most likely. Early fungal cannot be ruled out but would be atypical with the pertinent CT findings.

The changes of the lung and bronchial tree indicate potential for concurrent bronchitis. Infectious bronchitis is thought most likely even though eosinophilic / allergic bronchopneumopathy cannot be ruled out as a theoretical differential diagnosis.

The abdominal changes may not be of clinical significance at this point. Nevertheless, there is evidence of cholecystitis.

The portal lymphadenomegaly may represent reactive hyperplasia. A neoplastic infiltrate including metastases of an undetermined primary tumor and round cell infiltrate cannot be ruled out entirely but is thought by far less likely. Ultrasound guided fine needle aspiration could be considered for further definition in case of doubt.

Consider the potential for chronic pancreatitis. Benign age related nodular hyperplasia however is also a possible differential diagnosis.

The splenic nodules are likely to represent myelolipomas and/or extramedullary hematopoiesis/ nodular hyperplasia however primary or secondary neoplasia of the spleen cannot be ruled out. Further ultrasonographic monitoring of the changes should be discussed versus elective splenectomy at some point.

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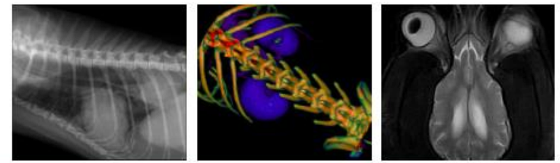

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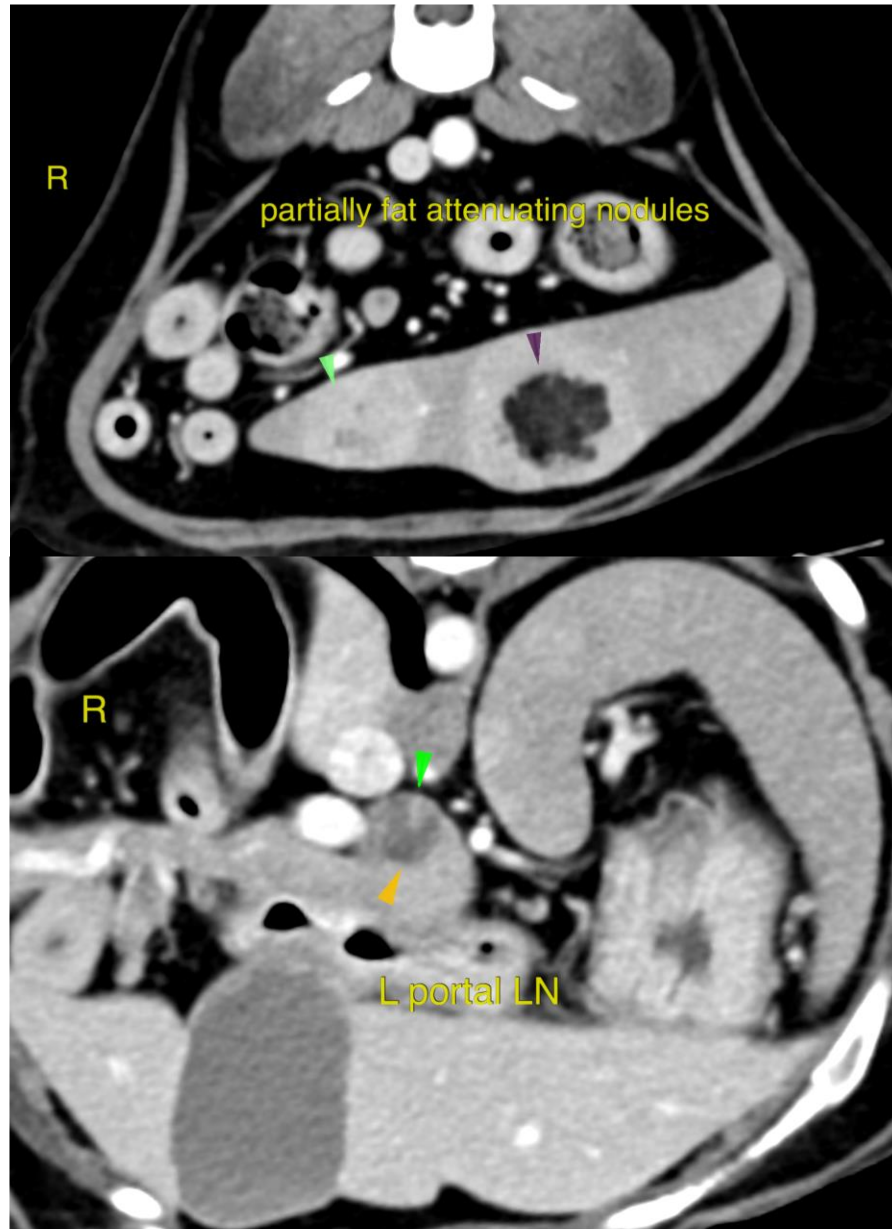

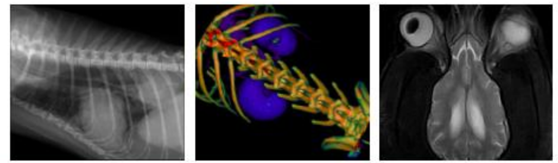

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Nele Eley, DVM, Dr. med. vet., DipECVDI
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Senior lecturer University of Giessen, Germany, Veterinary Faculty, Department of Radiology
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