



PATIENT

Wyatt Kostelecky

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

10 Years 7 Months

WEIGHT

10.4 Pounds

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

IMAGING PERFORMED BY

Dr. Raul Casas

HOSPITAL NAME

State Avenue VC

REFERRING VET

Dr. Raul Casas

INVOICE

36746

DATE

4/23/26

PRESENTING CLINICAL SIGNS

History: presents for complex neurologic and gastrointestinal signs, possible vestibular disease, concern for cerebral neoplasia. Recent onset of repeated gagging/retching without emesis; no vomiting of food, able to keep food down. Abdominal distension, increased bloating, soft yellow stool ("soft serve" consistency) yesterday. Falls during gagging episodes, decreased mobility, struggling to stand/ambulate on smooth floors. Intermittent inappetence (ate half breakfast today), variable water intake. Urinated last at 2:30 am; defecated in house due to urgency. Possible aspiration event; concern for wheezing post-retching. Omeprazole started 2-3 days ago for gastritis; client suspects possible GI upset related to medication. No anti-nausea medication administered prior to visit. Heartworm preventive not given today. Carprofen last given Monday morning, discontinued for steroid washout; no prednisolone started yet.

Current medications: Omeprazole (for gastritis), Heartworm preventive (not given today), Carprofen (last dose Monday morning, discontinued for steroid washout)

Abdominal ultrasound: no masses or free fluid; gas and fluid in stomach.
CT (skull, pre- and post-contrast): performed under general anesthesia.

Abnormal PE/Chem/CBC/UA Results: BCS 6-7/9, Vertical nystagmus OU (more pronounced OS), decreased visual reaction, not blind, Moderate dental disease, 3/6 holosystolic mur PMI L side; 2/6 on R side, Femoral pulses s+s, struggling to stand/ambulate on smooth floors, falls noted, worsened mobility, right-sided head tilt, struggling to stand/ambulate on smooth floors, falls noted, worsened mobility, Abdominal distension 4/20/26 abnormal bw: MCH 25.4, PLT 713, Albumin 4.6, ALP 161, Total Bilirubin 0.7, Calcium 11.9, Glucose 119

COMPUTED TOMOGRAPHIC STUDY OF THE SKULL

A high resolution pre- and post-contrast CT study of the skull is provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

Multiple teeth are absent.

The nasal mucosal lining is prominent, and a small amount of fluid attenuating material is attached to the nasal conchal structures.

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 ear canals are within normal limits.

The brain presents no deviation from normal anatomy and symmetry. The brain parenchyma is homogeneous and within normal limits for attenuation and distribution of contrast enhancement. The ventricular system is non-dilated and symmetric.

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.

COMPUTED TOMOGRAPHIC DIAGNOSIS



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- Mild rhinitis
- Multiple absent teeth
- Normal brain, no evidence of mass effect
- No evidence of otitis media nor interna

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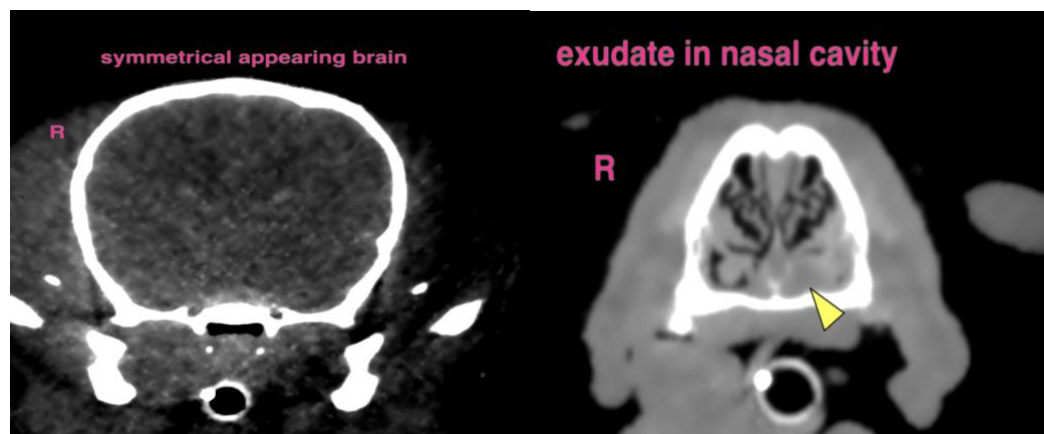
4/23/26

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An underlying macromorphological cause of supposed vestibular clinical signs is not detected. An ischemic insult and/or geriatric vestibular syndrome may be potentials.

If not yet done so the workup should be complemented by examination of CSF and complete bloodwork to screen for brain disease that is not necessarily associated with structural changes of the brain parenchyma and rule out other systemic illness. MR imaging may be indicated in case of the strong suspicion of structural parenchymal changes of the brain.

An underlying cause for the rhinitis cannot be specified, and the presumptive diagnosis is non-specific rhinitis (e.g. allergic, lymphocytic plasmocytic, eosinophilic). There is no evidence of nasal mass, foreign body, mycotic rhinitis or odontogenic rhinitis – I do not see evidence of a tooth root perforating the nasal cavity. Rhinoscopy including biopsy can be used for further workup.



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.

Sebastian Schaub, DVM, Dr. med. vet. DipECVDI
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