



PATIENT PRESENTING CLINICAL SIGNS

Cesar Lynar
Reason for Visit: Coughing, PU/PD History: P presents for second opinion. P has been dx with collapsing trachea and has been pu/pd. O states coughing has gotten progressively worse. P was put on hycodan at 1st vet but O has not been administering meds because they made him very drowsy and did not improve the cough. P has been pu/pd last 8 months and past couple of weeks not very interested in food. A few weeks back P was bleeding from gums, 2 years ago had extensive dental with extractions. O took P to vet and was given abx inj, and P improved, stopped bleeding.
C/S/V/D: coughing/hacking
Abnormal PE/Chem/CBC/UA Results: Hydration: N Mentation: QAR, aggressive esp around face...tries to bite EENT: Cataracts, positive menace OU Oral Cavity: Unable to examine mouth but photos of mouth from owner reveals an approx 1cm mass bleeding adjacent to 208, gingival hyperplasia vs mass that is bleeding adjacent to left lower premolars and a left upper canine with moderate tartar that has some blood adjacent to it but tell if blood coming from there or the mass/hyperplasia. Lymph Nodes: N Skin: N CV/Respiratory: 4/6 left systolic murmur, increased bronchovesicular sounds. Coughing every few seconds in room, non-productive Abd/GI: N Uro/Perineum: N Musculoskeletal: N Neurological: N Senior panel in house: SDMA 52 - r/o CRF BUN/Creat WNL USG 1.030 Eosinophilia 3,120 - r/o GI parasites (recently had parasites, was dewormed and negative fecal in last month at RDVM), allergies, atypical Addison's AMylase >2500 / Lipase 4287 - r/o renal given SDMA 52 vs GI, Pancreatitis (less likely....no abdominal pain, chol/TBili WNL) T4 WNL 4DX - neg

SPECIES

Canine

BREED

Poodle Miniature

SEX

NM

AGE

16 Years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

RADIOGRAPHIC STUDY OF THE THORAX

Radiographs of the thorax in three imaging planes are provided for review.

RADIOGRAPHIC FINDINGS

The intervertebral disc spaces T9/T10 and T11/T12 are collapsed. Multifocal spondylosis formation is seen along the caudal thoracic/cranial lumbar spine.

The extrathoracic soft tissues present homogeneous without abnormalities.

The caudal contour of the cardiac silhouette is steep, and the caudal cardiac waist is lost. The pulmonary vasculature is within normal limits.

The cranial mediastinum presents the expected soft tissue opacity. The mediastinal width is less than twice the width of the vertebral column at the same level.

A soft tissue membrane is bulging moderately ventrally into the tracheal lumen.

Multifocal mild to moderate peribronchial cuffing is appreciated.

The lung parenchyma presents the expected architecture and opacity; the intrapulmonary vascular branching is seen up to the third order lung vessels.

The diaphragm is well delineated with even surface and the expected mild cranial bulging of the diaphragmatic cupola.

RADIOGRAPHIC DIAGNOSIS

- Moderate bronchial lung pattern
- Redundant tracheal membrane
- Mild left sided cardiomegaly without signs of decompensation
- Chronic discopathy T9/T10 and T11/T12

DATE

5-27-22

INVOICE

52151

HOSPITAL NAME

DPC Veterinary Hospital

REFERRING VET

Dr. Feldt



PATIENT

- Spondylosis deformans

Cesar Lynar

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

SPECIES

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The bronchial lung pattern indicates inflammatory lower airway disease and primary inflammatory non-infectious origin (e.g. eosinophilic, lymphocytic plasmocytic, neutrophilic, mixed) is considered more likely than infectious bronchitis (e.g. viral, bacterial, parasitic, protozoal). Bronchoscopy including BAL can be considered as advanced diagnostic test – will also allow ruling in/out bronchial collapse.

BREED

Poodle Miniature

The clinical relevance of the redundant tracheal membrane is unclear but can be a precursor for tracheal collapse.

The left sided cardiomegaly in combination with the heart murmur is likely are sequela to underlying myxomatous mitral valve degeneration with mitral valve insufficiency.

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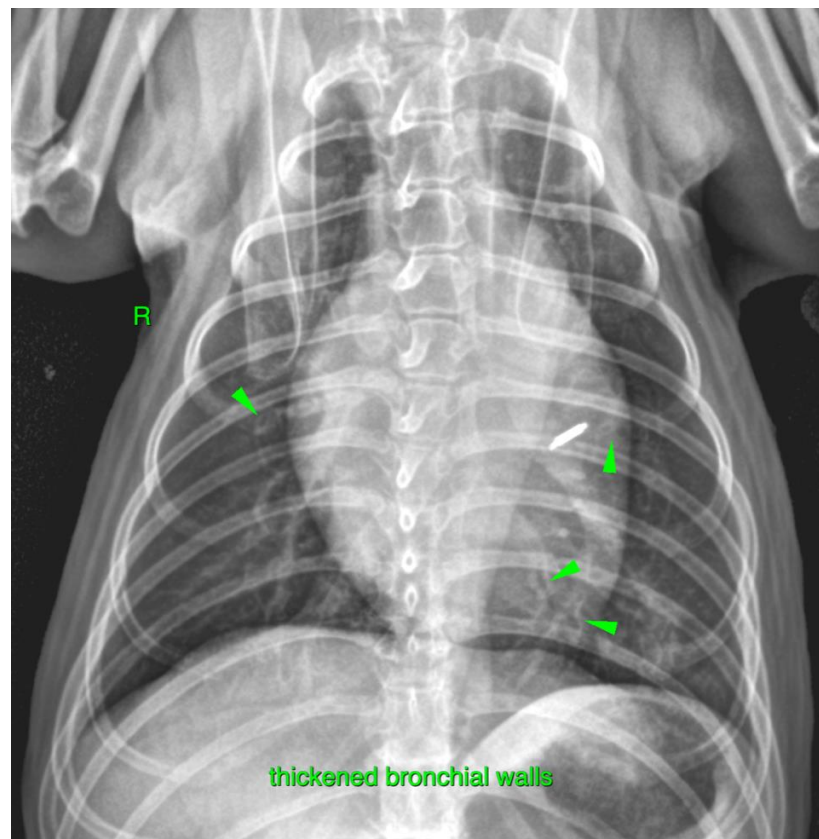
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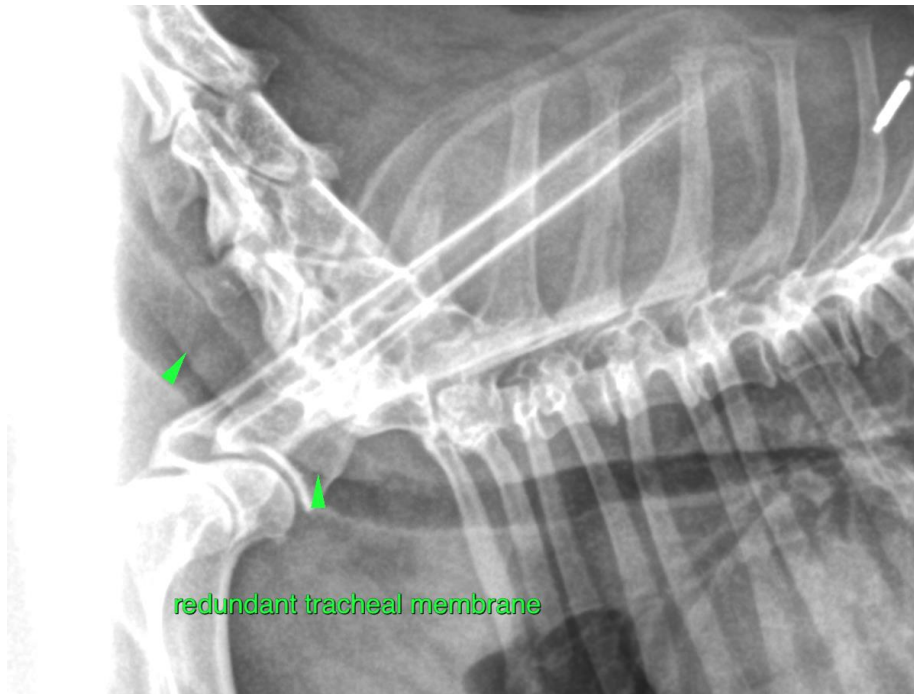
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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