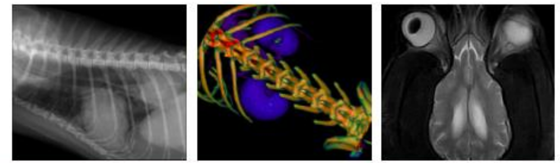


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Lucy Magerman

SPECIES

Canine

BREED

PWD

SEX

FS

AGE

9 years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Animal Health Partners

REFERRING VET

Westgarth

INVOICE

52211

DATE

5-31-22

PRESENTING CLINICAL SIGNS

Hospitalized AHP April 20th for respiratory signs (wheezing, congested, nasal discharge, reverse sneezing) and pelvic limb lameness (L > R). Was oxygen dependent on presentation. Chest rads showed consolidation of R middle lung lobe, with pelvic limb rads unremarkable. Was hospitalized in ICU - received oxygen therapy and broad spectrum abx. Had surgery consultation while in hospital with evidence of early R cranial cruciate ligament insufficiency Assessed by AHP ER for ongoing respiratory signs, also with stertor/stridor and nasal discharge described. Note- patient has chronic history of elevated ALP with US performed in Jan 2020 unremarkable at that time. Recent UCCR elevated. 4-5 days after discharge- started sneezing, congested with nasal discharge- yellow/green/green discharge. Has started coughing up that same mucus membrane sometimes too. Still has a rumbly cough that hear at least daily- but not consistently. When sleeping is OK. Will wake up a few times overnight and have reverse sneezing fits and sometimes that cough too. Seems to be exercise and excitement trigger it and make it worse (but will have these flare ups overnight when nothing triggering it either). Sometimes after eats may happen too. Was just all coughing when first came up in April. Since discharge is when the nasal signs developed. Deep/wet sounding cough- phelgm-y cough. No episodes distress since then. Abnormal PE/Chem/CBC/UA Results: April 13, 2022: -CBC: mild reticulocytosis (144) with normal HCT (0.48), rest WNL -biochemistry: ALP 2,111 H (160), triglycerides 3.85 H (1.71) -T4: WNL -4DX: negative April 19, 2022: -UCCR: 87 (>34) April 20, 2022 -UA: USG 1.038, 18 wbc per high power, 1 rbc, neg protein, suspect presence rods + cocci -thoracic rads: consolidation R middle lung lobe -pelvic limb rads: no obvious orthopaedic abnormalities

COMPUTED TOMOGRAPHY OF THE SKULL, THORAX AND ABDOMEN

A pre- and post-contrast CT study of the skull, thorax and abdomen in a bone and soft tissue reconstruction are provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

Skull

The maxillary incisors present evidence of mild periodontal disease.

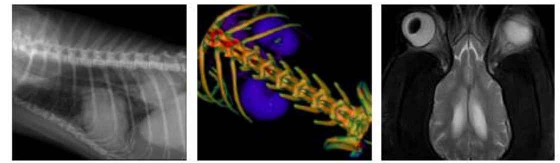
In both nasal cavities, a moderate amount of fluid attenuating material is attached to the nasal mucosal linin, L>R. Post contrast administration, moderate thickening of the nasal mucosal lining is noted.

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.



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Thorax

The bony and surrounding soft tissue structures are within normal limits.

The sternal, cranial mediastinal and tracheobronchial lymph nodes are small elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform and considered within normal limits.

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

The bronchial tree presents with regular branching and tapers uniformly towards the periphery as expected, the bronchial walls are thin and smooth. The bronchus-to-artery ratio is within normal limits.

The lung lobes present a generalized mild decreased volume. The most ventral dependent aspects of the lung parenchyma are consolidated. Level with the heart, the caudal segment of the left cranial lung lobe is completely consolidated and the volume is moderately decreased.

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

Abdomen

The serosal fat presents normal attenuation behavior. There is no evidence of peritoneal effusion or peritonitis.

Both kidneys present within normal limits for size, shape and organ architecture. After contrast administration a bilaterally symmetric and uniform nephro- and pyelogram is noted.

The adrenal glands are within normal limits for size, shape and organ architecture.

The spleen presents with normal shape, even surface, uniformly attenuating parenchyma and homogeneous contrast enhancement, unremarkable.

The hepatic volume is moderately increased the liver is protruding beyond the costal arch; the gastric axis is deviated caudally. The caudoventral hepatic margins are rounded.

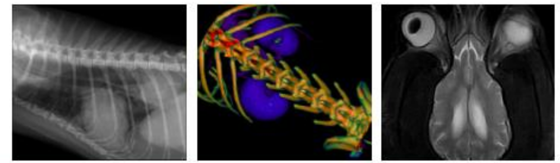
In the body of the pancreas, level with the portal vein, a well-defined, fluid attenuating lesion, measuring 11 mm in diameter is appreciated.

The position, delineation, wall and content of the gastrointestinal tract are considered within normal limits throughout.

The intervertebral disc L6/L7 is moderately protruding into the vertebral canal, occupying approximately 70% of the cross-sectional area of the vertebral canal at the same level. The cauda equina fibers level L6/L7 are deviated dorsally. The lumbosacral intervertebral disc is mildly protruding into the vertebral canal.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Rhinitis
- Ventrally distributed alveolar pattern of the lung with generalized mild decreased volume of the lung parenchyma
- Hepatomegaly
- Pancreatic cyst
- Intervertebral disc protrusion L6/L7 with compressive myelopathy



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- Periodontal disease upper incisor teeth
- Spondylosis deformans

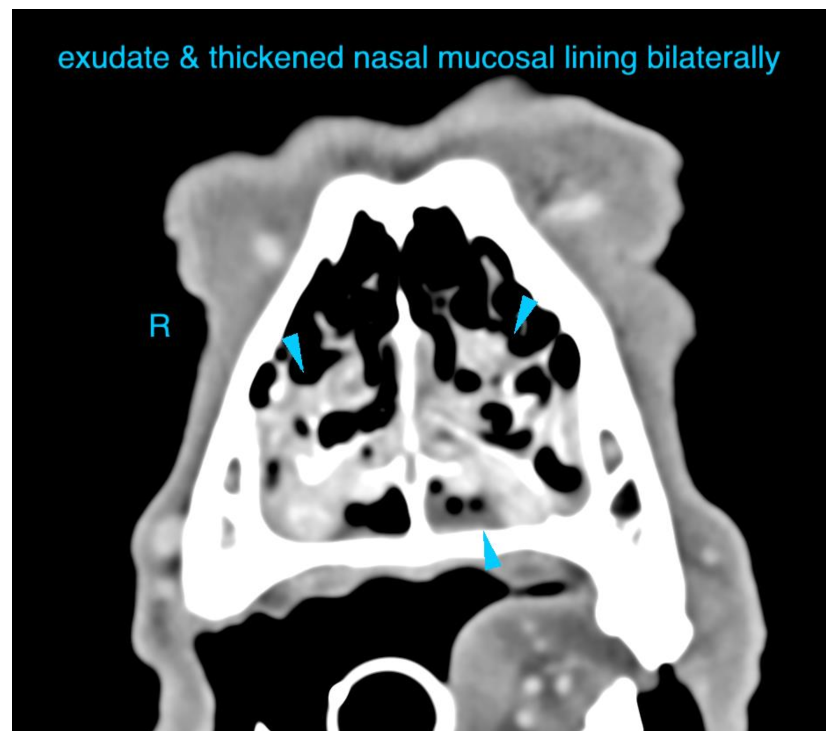
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No underlying cause for the rhinitis is appreciated and the presumptive diagnosis is non-specific rhinitis (e.g. lymphocytic plasmocytic, eosinophilic) which might trigger inflammatory lower airway disease with potential bacterial superinfection, explaining the ventral distribution concerning for pneumonia. Rhinoscopy including biopsy and sampling for microbial culture can be used as advanced diagnostic tests as well as bronchoscopy including BAL.

Potentials for the hepatomegaly include metabolic hepatic disease, hepatitis or diffuse neoplastic infiltration. In case of doubt, ultrasound guided FNA sampling and/or Tru-cut biopsy can be used as minimally invasive methods for further workup.

The pancreatic cyst is most suggestive for retention cyst versus pseudocyst, however, cystic pancreatic carcinoma is a consideration but the odds are considered low.

The intervertebral disc protrusion L6/L7 might cause dynamic compression of the cauda equina fibers and can be a source for pain/lameness.



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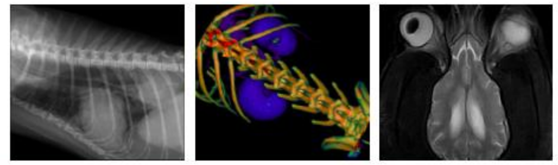

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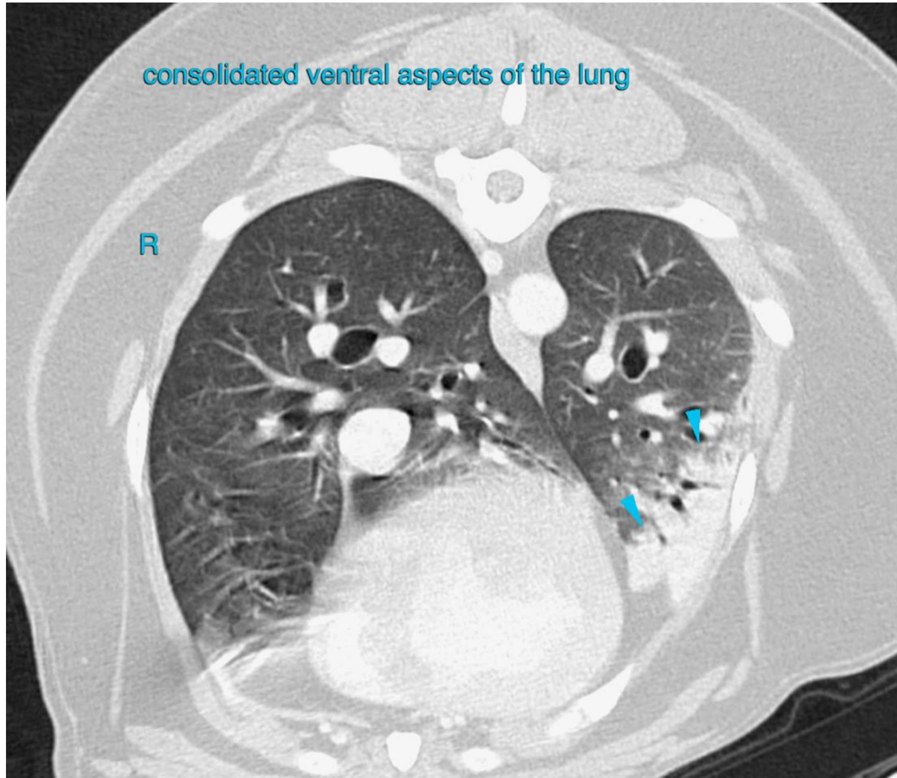

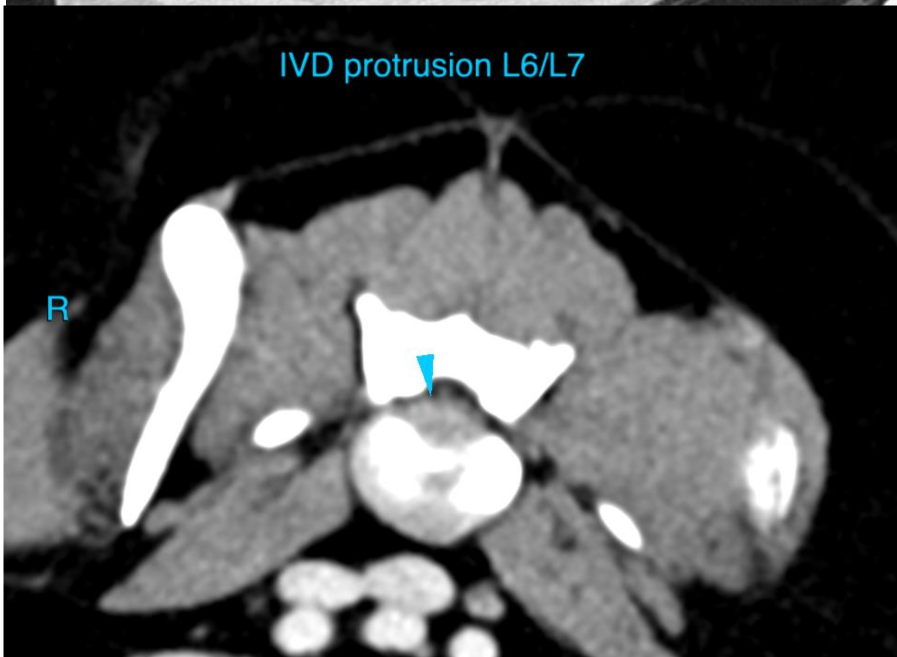

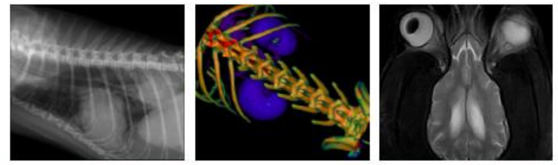

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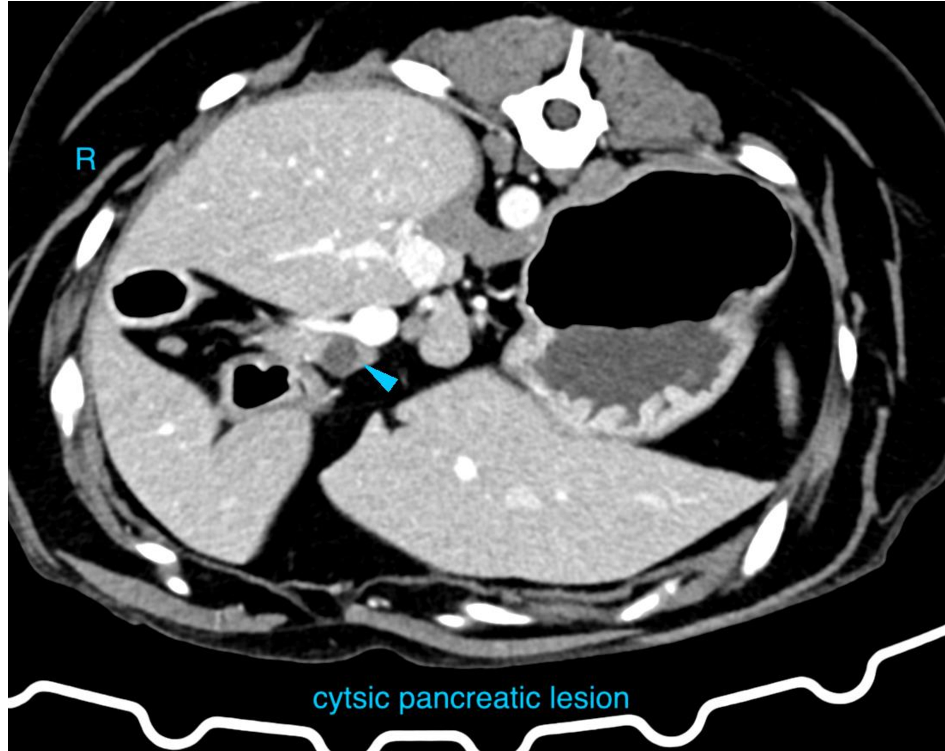

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sebastian Schaub, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI
sebast.schaub@gmail.com