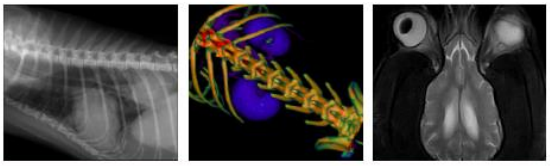
SonoPath Teleradiology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Marlin Polhemus

SPECIES

Canine

BREED

Poodle

SEX

NM

AGE

12 Years, 2 Months

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

DPC Veterinary Hospital

REFERRING VET

Ward

INVOICE

53893

DATE

9-1-22

PRESENTING CLINICAL SIGNS

Reason for Visit: cough/sneezing History: pet is here for ongoing cough and sneeze- was seen else where about march of this year and was told of heart murmer and did chest rads- owner states never really got better and has noted this was week about green yellow d/c from nose and mouth- owner states sound like reverse sneeze. Radiographs from March not available but veterinarian's notes say "enlarged left ventricle" and prescribed benzepril. Also dispensed Clavamox at that time for cough. Still on cough tabs and benazepril. Green mucopurulent nasal discharge (right nostril only vs. both?) started a week or two ago. Long-term history of skin allergies/ear infections. Not currently on medication for skin. HWT end of March at time of onset of cough was negative. C/S/V/D: owner states vomit 1 time flem about 1 week ago in middle of night- owner notes on and off loose stools
Abnormal PE/Chem/CBC/UA Results: Hydration: Adequate Mentation: BAR EENT: Good airflow through both nostrils (glass slide equally fogged when placed in front of nares). Immature cataracts OU. Intermittent right third eyelid gland elevation. Heavy red-brown discharge clumped in hair around otic orifice AU. No cough on tracheal palpation. Oral cavity: Heavy dental calculus--some bridging. Lymph Nodes: Submandibular, prescapular and popliteal lymph nodes normal size, shape and consistency Skin: Generalized multifocal patchy yellow collarettes, miliary dermatitis, multiofcal patches of salivary staining especially x 4 paws. Matted fur overlying apparent lick granulomas anterior metatarsals bilateral pelvic limbs. Nasal planum possibly depigmented but appears moist, symmetrical, no swelling. CV/Respiratory: Normal heart rate and rhythm, grade 3/6 systolic murmur, pulses strong and synchronous, harsh lung sounds left caudodorsal lung fields. Abd/GI: Soft, non-painful, no fluid wave, no palpable masses or organomegaly. Uro/Perineum: No lesions or abnormalities. Musculoskeletal: BCS = 5/9. Ambulatory x 4, stiff gait, thickened stifles and decreased muscle mass bilateral pelvic limbs Neurological: Alert and appropriate. No deficits noted.

RADIOGRAPHIC STUDY OF THE THORAX

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

RADIOGRAPHIC FINDINGS

The vertebral endplates T5/T6 present moderate spondylosis formation.

The extrathoracic soft tissues present homogeneous without abnormalities.

The heart is of normal size and shape, there is no evidence of cardiac chamber or vascular enlargement. 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.

The trachea is normal in diameter and presents the anticipated course. The luminal outline of the trachea is smooth.

The bronchial tree presents with thin walls and tapers uniformly towards the periphery as expected.

The lung parenchyma presents the expected architecture and opacity; the intrapulmonary vascular branching is seen up to the third order lung vessels. In the left lateral view, an irregular roundish central gas opaque lesion is superimposed on the left crus of the diaphragm, level with the 7th intercostal space.

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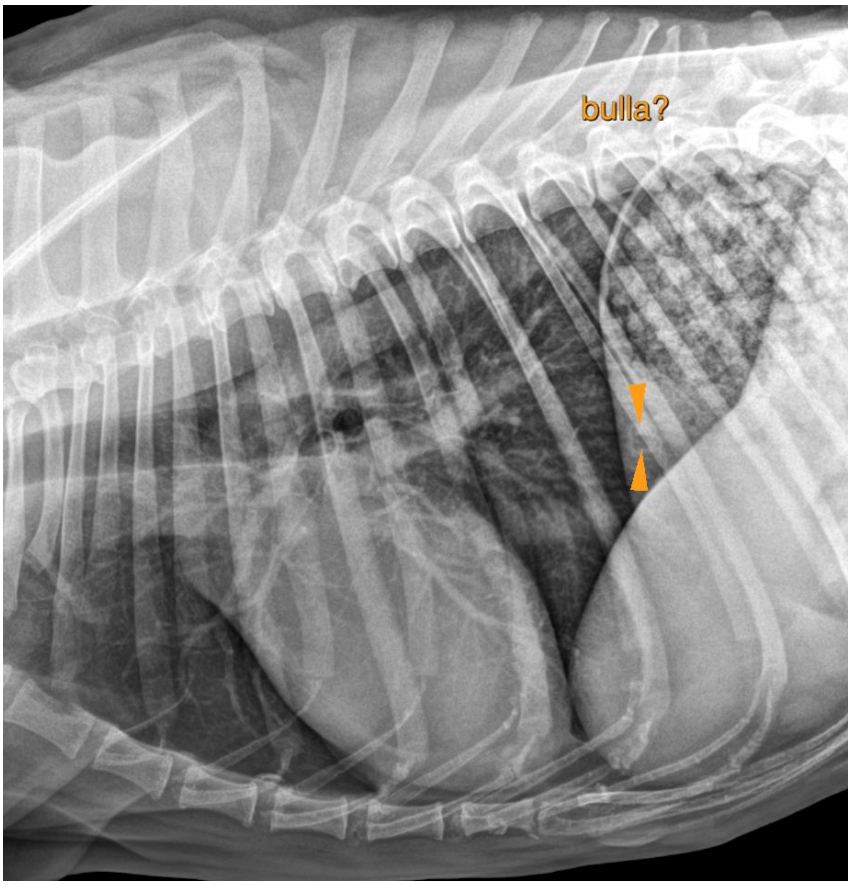
The diaphragm is well delineated with even surface and the expected mild cranial bulging of the diaphragmatic cupola.

RADIOGRAPHIC DIAGNOSIS

- Possible small bulla right caudal lung lobe versus odd summation of the pulmonary vessels
- Spondylosis deformans T5/T6

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The radiographic study of the thorax presents without abnormalities. Given the presenting clinical signs, rule out inflammatory disease of the upper respiratory tract as trigger for the presenting clinical signs.



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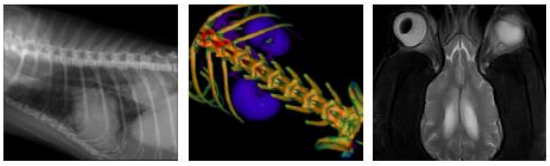

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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