



PATIENT

Kuma Brunet

SPECIES

Canine

BREED

German Shepherd

SEX

FS

AGE

3 Years

INTERPRETED BY

Nele Eley, DVM
Dr. med. Vet. DipECVDI

HOSPITAL NAME

Cedarview Animal
Hospital

REFERRING VET

Nigel Gumley

INVOICE

56683

DATE

2-9-23

PRESENTING CLINICAL SIGNS

Had TPLO in LH stifle March 2020, rough recovery for 6 months post-op. In april 2022, developed acute lameness RH leg and suspected to by partial CCL injury. Reinjured RH leg Dec 2022. Left stifle had lateral meniscal damage at time of surgery.

Abnormal PE/Chem/CBC/UA Results: Slight abduction to RH leg at walk, moderate lameness; negative drawer R stifle, no buttress or pain, no obvious effusion. Moderate pain in R iliopsoas, normal hip extension.

ULTRASONOGRAPHIC FINDINGS

Right Stifle

No abnormal effusion is seen within the supra- and infra patellar area. There is no evidence of synovial or capsular thickening or proliferation. The cranial cruciate ligament appears to be continuous and well-delineated, no deviation from normal echoarchitecture is noted. Lateral and medial menisci are within their anticipated positions and align well below the bone surfaces, meniscal surfaces are even and smooth. The echotexture is hypo echoic and uniform. The joint margins are smooth, no osteophytes are seen. The infra patellar fat pad present, the expected echo architecture.

Left Stifle

The patient has a history of TPLO of the left stifle with lateral meniscal injury at the time of the surgery.

Moderate effusion is seen within the supra- and infra-patellar recesses of the left stifle joint. There is mild swelling of the joint's synovium and early periarticular bone remodeling. The cranial and caudal cruciate ligaments present continuous and well delineated. The medial meniscus is in situ, smoothly delineated, and presents uniform internal echoarchitecture.

Ill-defined hypoechoic tissue is seen in the position of the lateral meniscus.

Iliopsoas Tendons

Small isolated ossicles are seen in the psoas major tendon close to their attachment to the lesser trochanter of the femur in both hind limbs.

The tendons are smoothly delineated and present uniform echoarchitecture and echogenicity. The musculotendinous junctions present within normal limits. No abnormalities of the muscular portions are seen.

Both coxofemoral joints present within normal limits.

ULTRASONOGRAPHIC DIAGNOSIS

- Normal ultrasonographic presentation of the right stifle joint.
- Isolated ossicles of the bilateral psoas major tendons with no echoarchitectural changes of the tendon tissue.
- History of TPLO of the left stifle with continuous presentation of the cranial and caudal cruciate ligaments and evidence of lateral meniscal injury as well as synovitis, effusion, and



PATIENT degenerative joint disease.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left stifle joint presents degenerative joint disease, synovitis, and effusion. Interruption of the cranial and caudal cruciate ligaments cannot be seen. Both ligaments appear to be continuous.

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The hypoechoic tissue within the position of the lateral meniscus may represent meniscal tear with prolapse or replacement tissue such as granulation and scar tissue.

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The right stifle joint did not present evidence of cruciate ligament pathology or meniscopathy. The ultrasonographic presentation was within normal limits.

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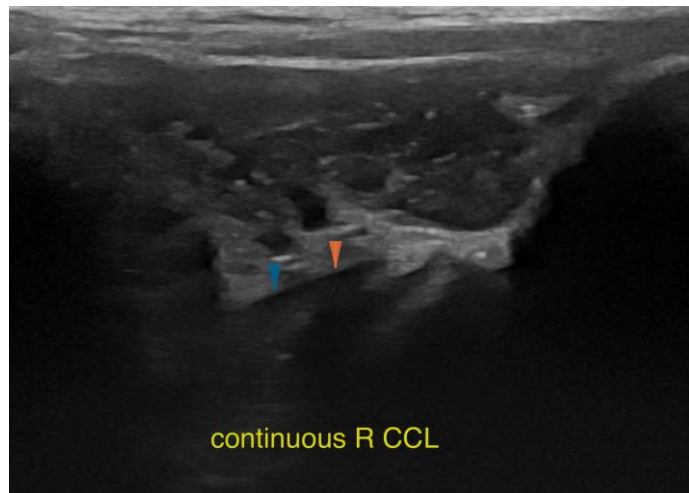
The ossicles within the psoas major tendons are likely to represent separate ossification centers of the lesser trochanter. Avulsion or tendinitis with mineralization cannot be ruled out entirely but is thought less likely owing to the lack of concurrent echoarchitectural changes within the tendon tissue itself.

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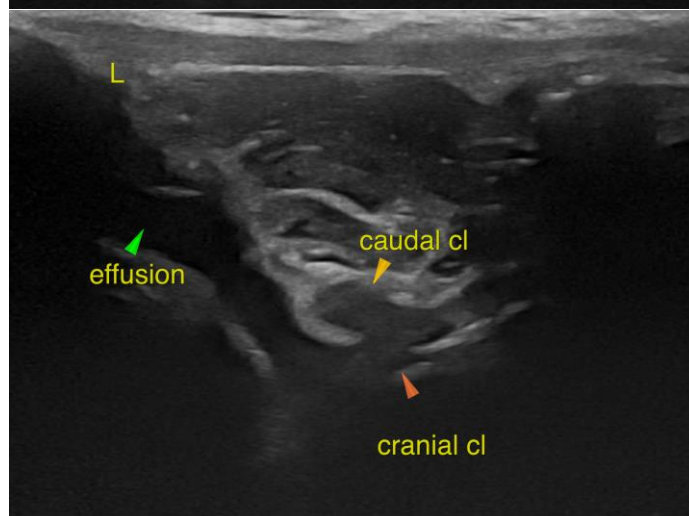
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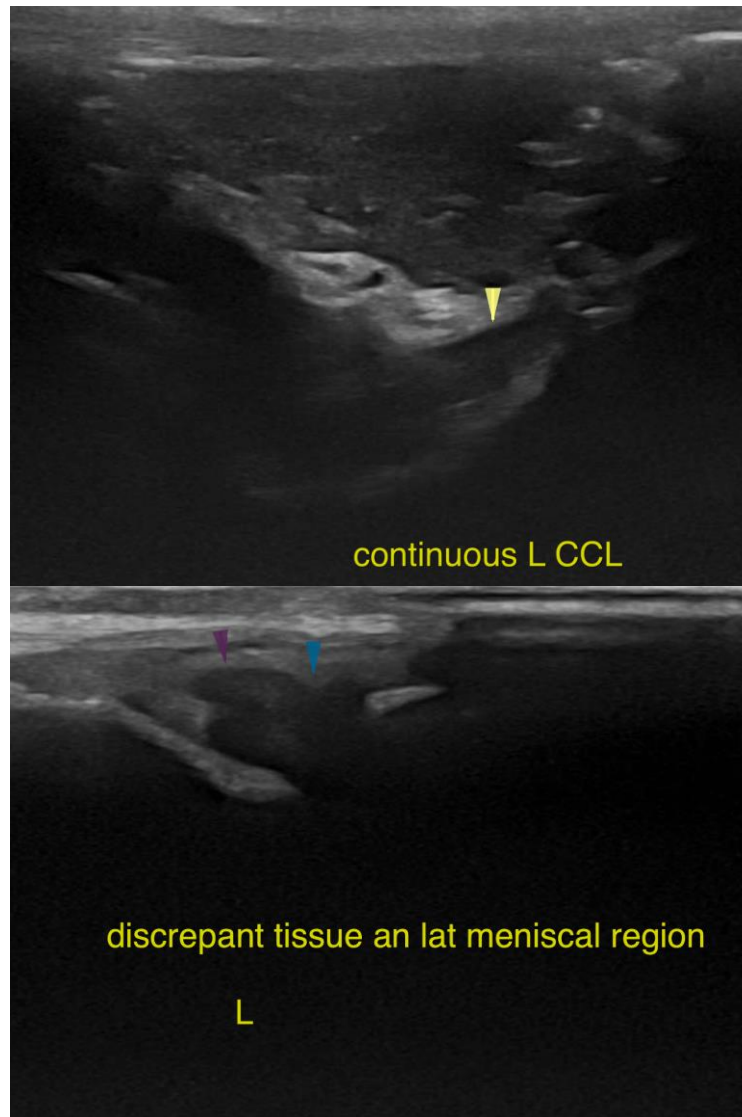
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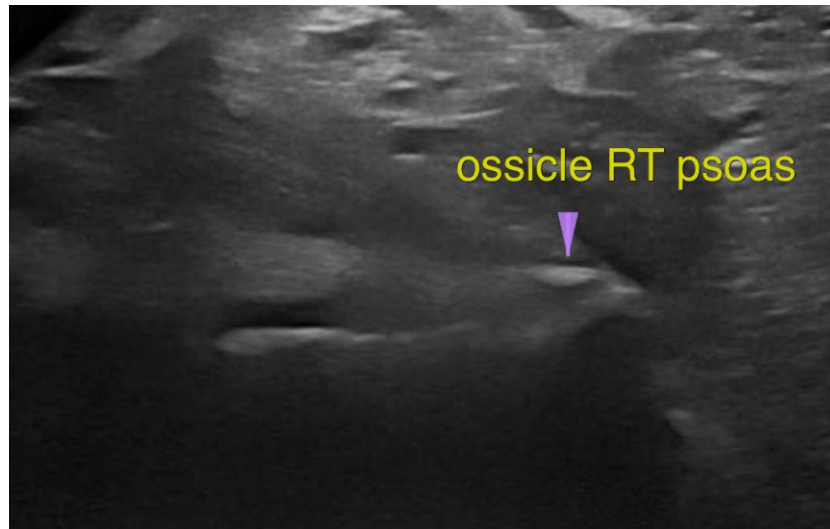
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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