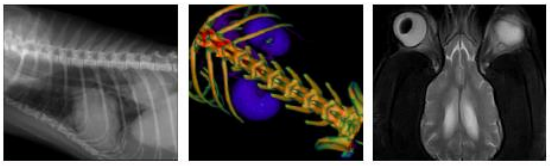

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1-800-838-4268 info@sonopath.com

PATIENT

Sam Farley

SPECIES

Canine

BREED

Husky X

SEX

SF

AGE

5 Years

INTERPRETED BY

Nele Eley, DVM
Dr. med. Vet. DipECVDI

HOSPITAL NAME

Animal Health Partners

REFERRING VET

Dr. Marchal

INVOICE

52147

DATE

5-14-22

PRESENTING CLINICAL SIGNS

About 4-5 days before the presentation, she was slower than usual and a day ago she was reluctant to walk. She has been lethargic with her head low. She has also been having trouble standing and putting weight on her right front and back legs. She also has a history of iliopsoas injury.
Abnormal PE/Chem/CBC/UA Results: Mentation: Bright, alert and responsive. Cranial nerve exam: No deficits noted. Gait/posture: Ambulatory with no ataxia or paresis. Postural reactions: Proprioceptive positioning and hopping were normal in all limbs. Spinal reflexes: Normal patellar. Normal flexors but pain elicited as she attempts to flex pelvic limbs bilaterally.
Sensory/nociception: Mild hyperesthesia elicited with palpation along the caudal lumbar/LS region. CSF analysis: Protein level pending. WBC = 9.6/uL (normal 0-4/uL), RBC = est. 6000/uL; low numbers of normal mononuclear cells; no atypical cells or infectious organisms identified.

MAGNETIC RESONANCE IMAGING STUDY OF THE LUMBAR SPINE

T2, T2-fat saturated, plain and post contrast T1-weighted sequences with and without fat saturation of the lumbar spine and lumbosacral junction available for review. Additional views of the lumbosacral junction in flexed position are available as well.

MAGNETIC RESONANCE IMAGING FINDINGS

Moderate hypertrophy of the ligamentum flavum is seen and causes narrowing from a dorsal aspect at the lumbosacral junction. The lumbosacral intervertebral disc presents only minor degenerative changes and minimal protrusion; however, ventral and lateral smooth new bone formation of the lumbosacral vertebral end plates is seen and there is a moderate bridging spondyloses between L6 and L7. The new bone formation of the lumbosacral end plates causes mild bilaterally symmetric stenosis of the lumbosacral neuroforamina within their exit zones. The ligamentum flavum is stretched is flexed position which decreases the dorsal narrowing of the vertebral canal. The dorsal longitudinal ligament between the lumbosacral vertebral bodies is stretched as well which causes the minimal disc protrusion to reduce back to no visible narrowing of the vertebral canal from the ventral aspect. The neuroforaminal stenosis is similar between the neutral and flexed positions.

There is a type 1 lumbosacral transitional vertebra.

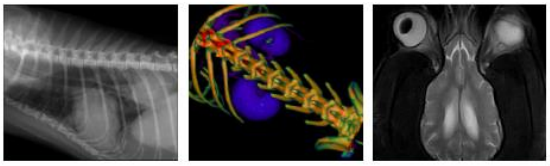
Moderate spondylosis deformans and mild intervertebral disc protrusion are noted at T12/13. There is mild intervertebral disc protrusion T13/L1 as well with no evidence of direct compression of the spinal cord.

No structural abnormality of the psoas major attachments to the lesser trochanter are seen and the signal and volume of the iliopsoas musculature is bilaterally symmetric.

Mild to moderate effusion of both coxofemoral joints is seen.

MAGNETIC RESONANCE IMAGING DIAGNOSIS

- Moderate lumbosacral stenosis with ligamentum flavum hypertrophy, minimal intervertebral disc protrusion, and spondylosis deformans with mild bilaterally symmetric neuroforaminal stenosis.
- L6/7, L7/S1, and T12/13 spondyloses.



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- Mild disc protrusions T12/13 and T13/L1.
- No visible changes of the iliopsoas muscle and psoas major tendon.
- Mild bilateral coxofemoral joint effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The main finding appears to be the lumbosacral stenosis which in this case is mainly caused by the ligamentum flavum hypertrophy and new bone formation narrowing the exit zones of the lumbosacral neuroforamina mildly. The intervertebral disc protrusion is minimal at this point. However, a dynamic component cannot be ruled out.

Structural iliopsoas muscle and psoas major tendon injury are not seen which, however, is not unusual in stage 1 musculotendinopathy which typically entails microarchitectural changes only. Stage 1 musculotendinopathy hence, cannot be ruled out. However, no macroscopic injury is seen and secondary iliopsoas pain due to lumbosacral and/or hip joint pathology appears to be a potential in this patient. The presence of hip dysplasia and coxofemoral joint osteoarthritis should be ruled out.

The significance of the mild effusion appreciated in the MRI images is unclear. A full assessment of the coxofemoral joints was not possible.

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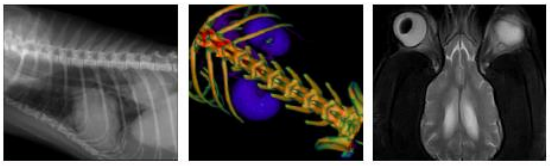

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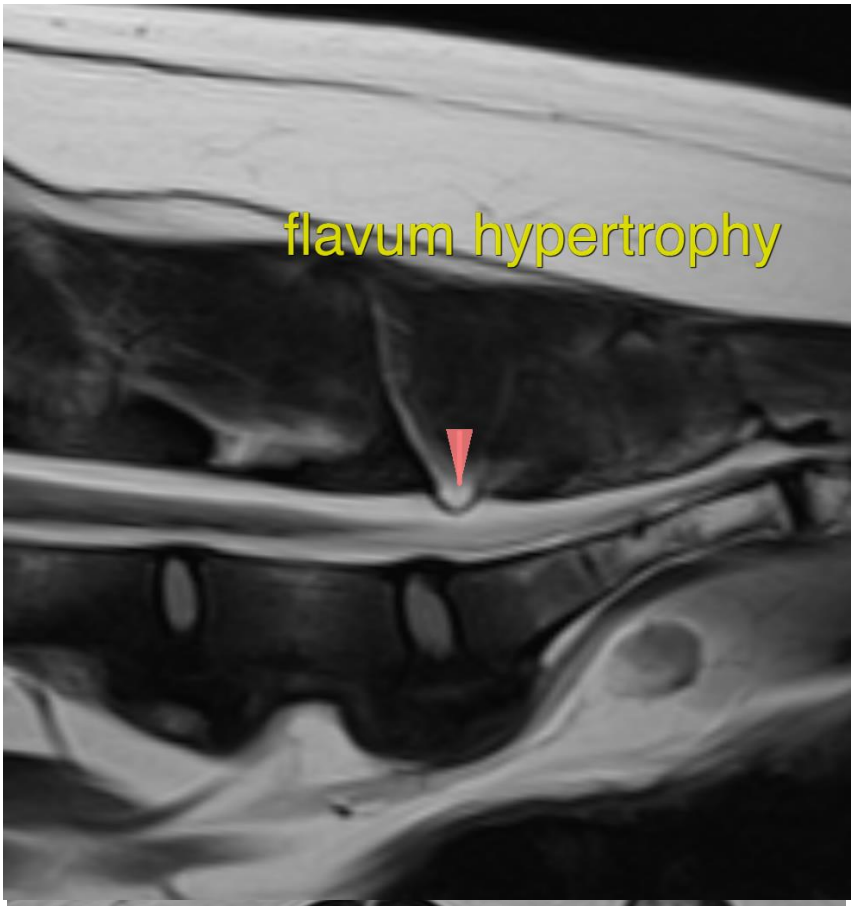

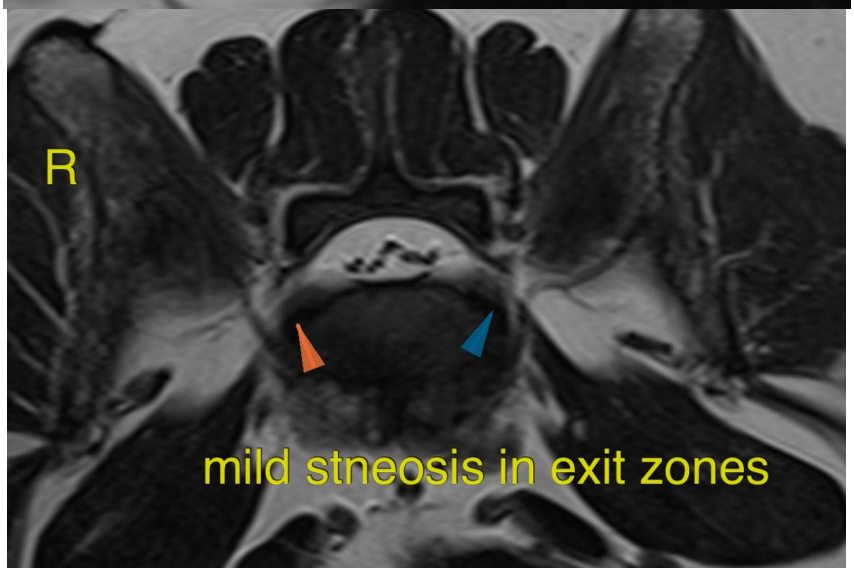

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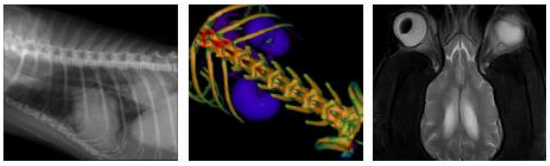

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
European Specialist in Veterinary Diagnostic Imaging, Cert. Radiology,
Senior lecturer University of Giessen, Germany, Veterinary Faculty, Department of Radiology
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