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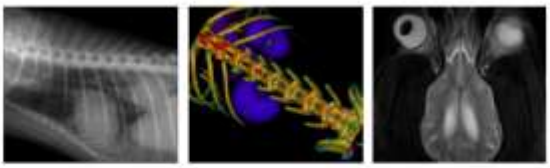

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Dusty Fijalkowski

SPECIES

Canine

BREED

Mixed Breed

SEX

MN

AGE

12 Years

INTERPRETED BY

Sebastian Jawinski, German Board Certified Vet Specialist in Diagnostic Imaging

HOSPITAL NAME

Animal Health Partners

REFERRING VET

Dr. Marchal

INVOICE

49735

DATE

1-21-22

PRESENTING CLINICAL SIGNS

At initial examination on December 29th, he was ambulatory with mild spastic tetra paresis and proprioceptive ataxia mainly seen in the pelvic limbs characterized by knuckling and internal rotation of the hock. Mild weight bearing lameness in the right thoracic limb. Proprioceptive positioning were delayed in the pelvic limbs (worse in the right). Spinal reflexes were decreased withdrawal reflex of the right thoracic limb. Moderate hyperesthesia were elicited with palpation along the cervical vertebral column. Since then, he has been doing well and showing signs of improvement. treadmill underwater, home made physiotherapy step back last week , struggle with right front leg, left paw swollen No signs of pain. Went to rehab, rotary exercises yelped when doing in his right front. Mentation: Bright, alert and responsive. Cranial nerve exam: No deficits noted. Gait/posture: Ambulatory with mild spastic tetraparesis and proprioceptive ataxia mainly seen in the pelvic limbs characterized by knuckling and internal rotation of the hock. Mild weight bearing lameness in the right thoracic limb. Postural reactions: Proprioceptive positioning and hopping were delayed in the pelvic limbs (worse in the right) Spinal reflexes: Decreased withdrawal reflex of the right thoracic limb. Remainder of spinal reflexes within normal limits. Sensory/nociception: Moderate hyperesthesia elicited with palpation along the cervical vertebral column.
Abnormal PE/Chem/CBC/UA Results: mass in the right brachial plexus, mild wobblers at C3-4 and mild chronic disc at C5-6

MAGNETIC RESONANCE IMAGING FINDINGS

Cervical spine

Bony structures of the presented spine show a mild medullary edema of the caudal part of C4 with contact to the caudal endplate. The latter is unremarkable.

The atlantooccipital and -axial transition appears harmonic and inconspicuous.

There are subtle disc protrusions noted at the level of C2/3, C3/4, C4/5 without relevant compression of the spinal cord recognized.

At the level of C5/6 a mild, broad-based, medial to medio-lateral left disc protrusion is detected having ventral contact to the spinal cord which shows a mild impression of the transverse diameter.

Shoulders / Brachial Plexus

There is significant unilateral atrophy of the shoulder musculature on the right recognized with a corresponding soft-tissue mass in the area of the right axillar region of 3.49 x 0.98 cm with an oval to fusiform shape. Mild edema of the atrophic infra- and supraspinatus muscles is detected as well mild peripheral edema and irregular contrast uptake of the axillar mass.

The spinal cord appears homogeneous without pathologic enhancement.

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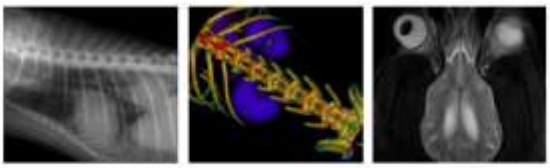

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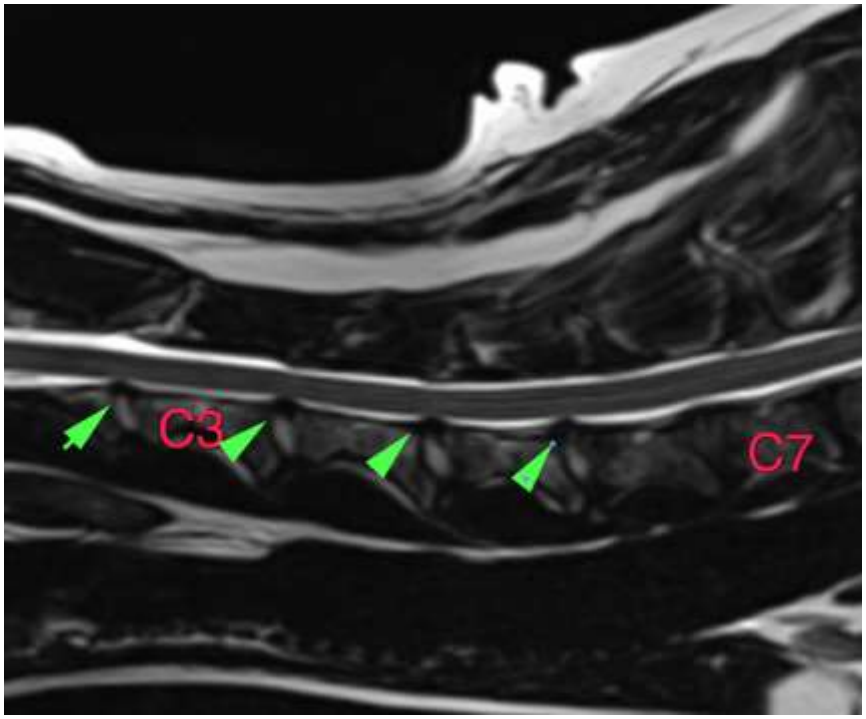
MAGNETIC RESONANCE IMAGING DIAGNOSIS

- Right axillar mass with secondary unilateral muscle atrophy
- Mild disc protrusion C5/6 with subtle signs of spinal cord compression
- Medullary bone edema caudal C4
- Subtle disc protrusions C2/3, C3/4 and C4/5

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

CT findings are highly suspicious for a neoplastic lesion of the right brachial plexus with secondary muscle atrophy. CT cannot differentiate between benign and malignant lesions, but I would rule out an inflammatory process as seen with neuritis. Schwannoma, neurinoma and neurofibrosarcoma are common differentials. This finding however does not completely match with the reported tetraplegia. The protrusion at C5/6 appears mild and more chronic, medullary edema due to a dynamic temporal compression is not detected.

The edema of the caudal vertebral body C4 is an unspecific finding and could represent bone bruise after trauma, active osteochondrosis but also metastatic disease (inflammatory and neoplastic). Final assessment will be a matter of the temporal course or presence of additional nodules/masses.



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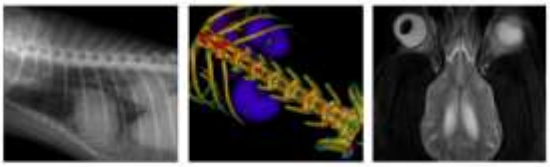

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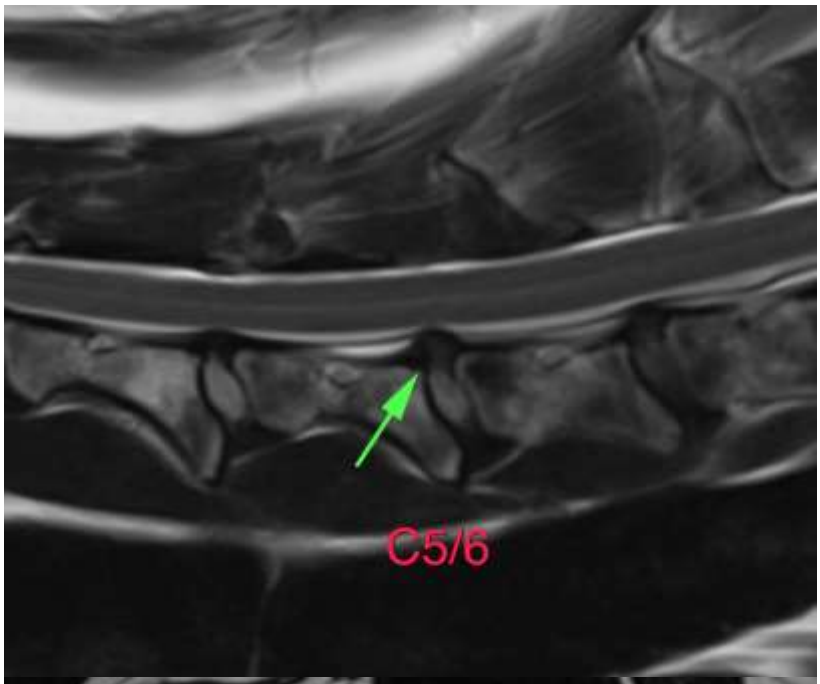

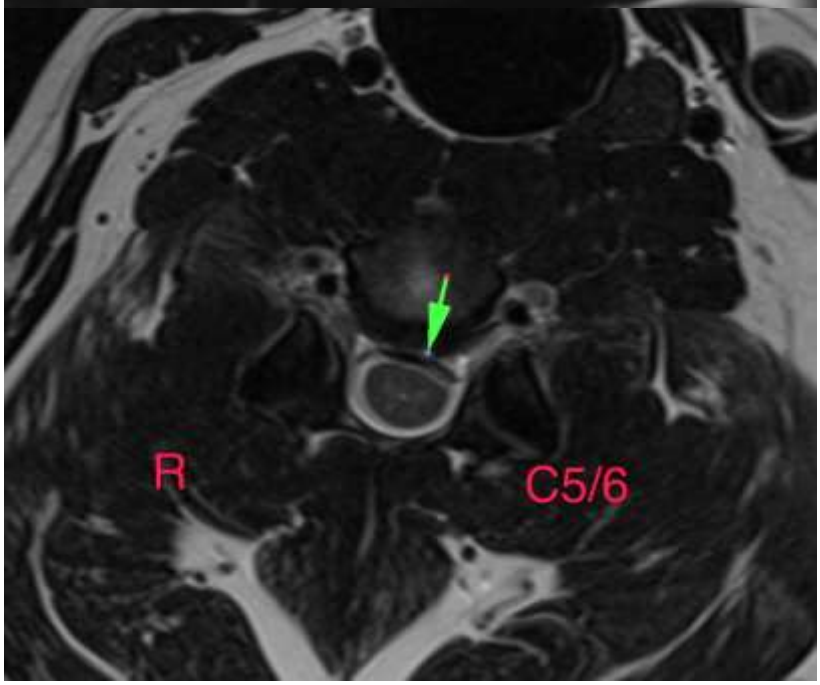

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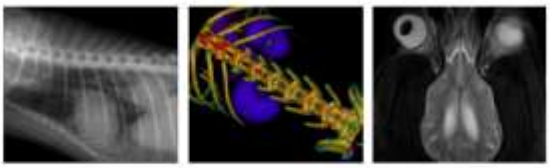

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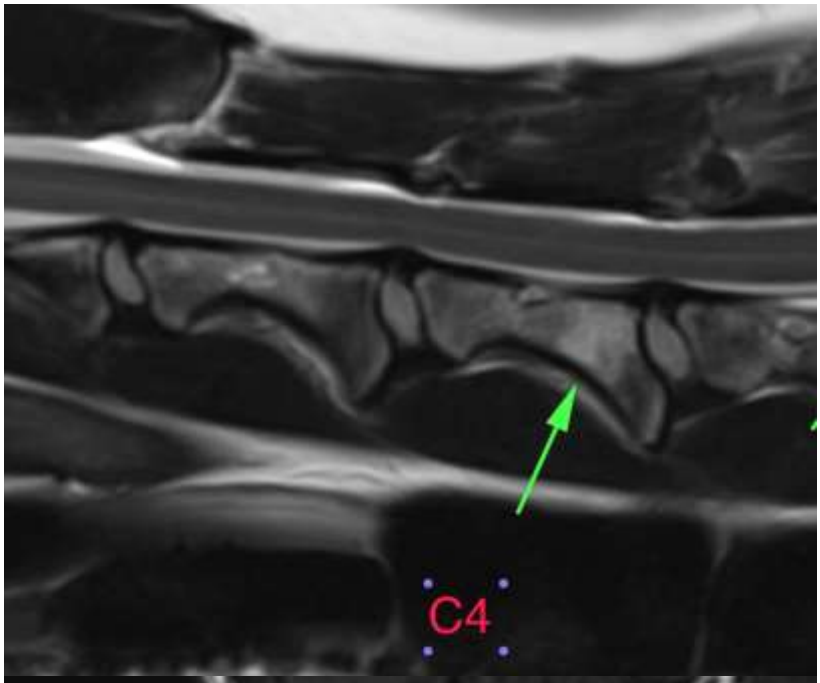

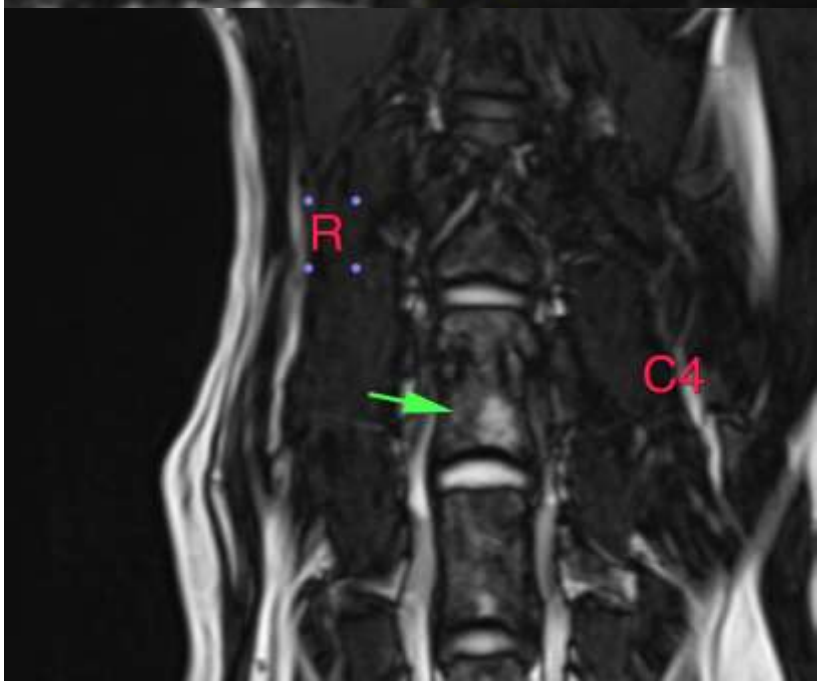

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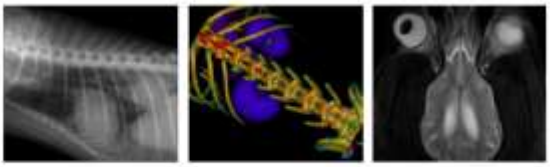

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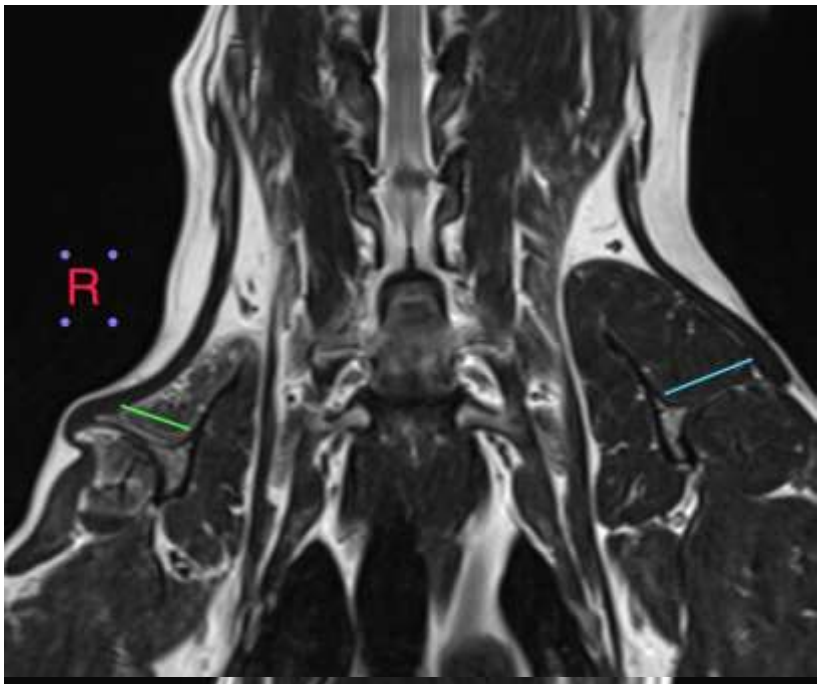

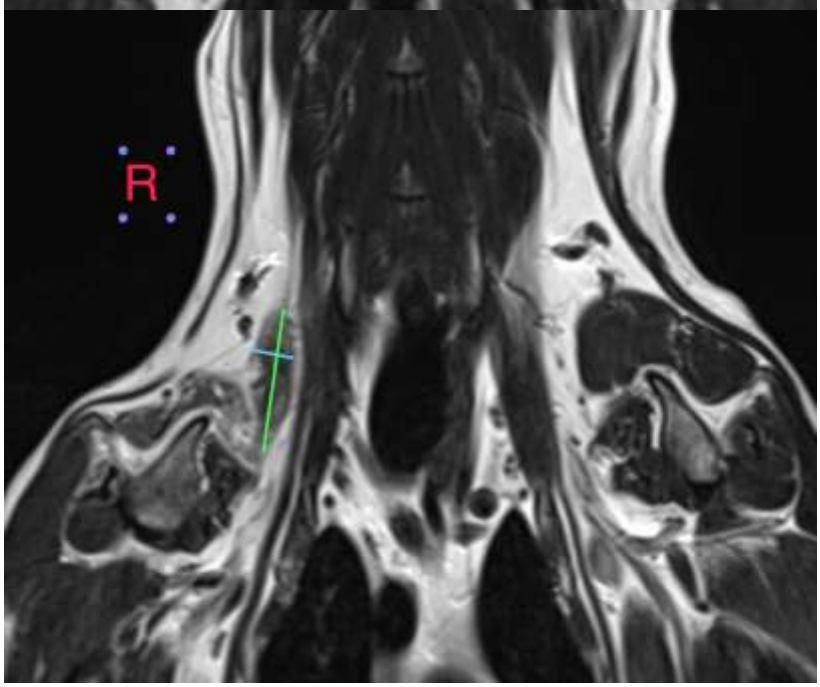

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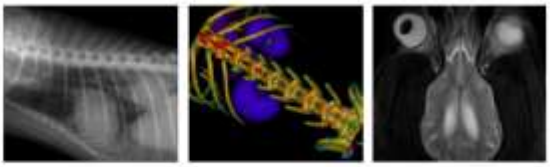

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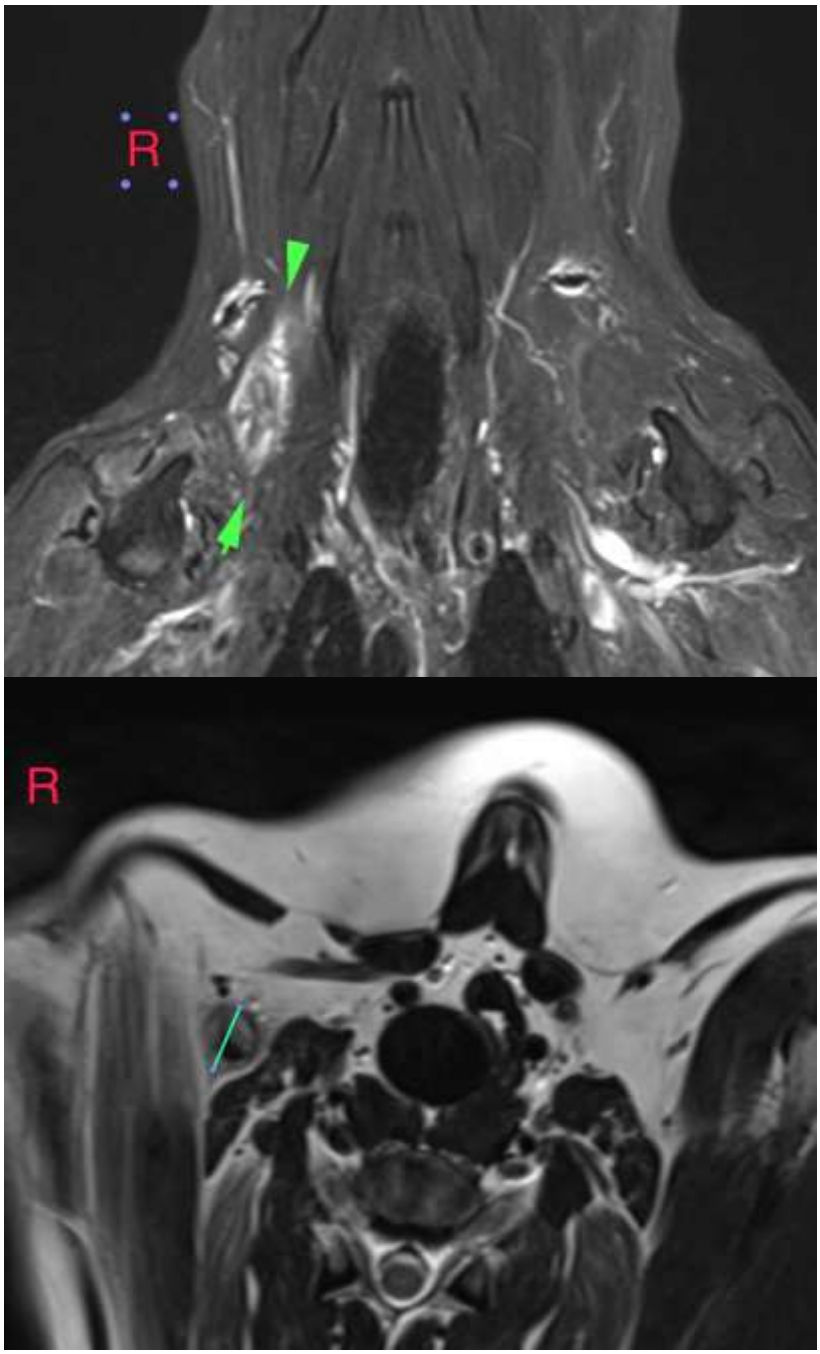

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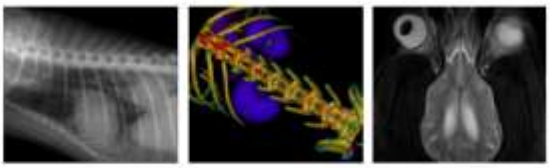

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sebastian Jawinski, German Board Certified Vet Specialist in Diagnostic Imaging
Sebastian.Jawinski@sonopath.com