



PATIENT

Tessie Green

PRESENTING CLINICAL SIGNS

acute tetraparesis. Mild fever, lethargy and suspected cervical myelopathy Neurological examination: Mentation: Bright, alert and responsive. Cranial nerve exam: Anisocoria (OD smaller). PLR OU mildly responsive (iris atrophy). No other deficits noted. Gait/posture: Non ambulatory moderate to severe spastic tetraparesis associated with mild proprioceptive ataxia in all 4 limbs characterized by paw placement mistakes and scuffing in both pelvic limbs. Once supported, good voluntary movements are seen in all 4 limbs. Seems worse on the thoracic limbs. Postural reactions: Proprioceptive positioning and hopping were normal in all limbs. Spinal reflexes: Normal. Sensory/nociception: No hyperesthesia elicited with palpation along the vertebral column.

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MAGNETIC RESONANCE IMAGING OF THE CERVICAL SPINE AND COMPUTED TOMOGRAPHY OF THE THORAX

SEX

T2&T1 (DIXON) weighted, pre- and post-gadolinium sequences in multiple imaging planes are provided for review.

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MAGNETIC RESONANCE IMAGING FINDINGS

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The intervertebral disc spaces C5/C6 and C6/C7 are moderately narrowed. The intervertebral discs C5/C6 and C6/C7 are mild to moderately protruding into the vertebral canal occupying approximately up to 20% of the cross-sectional area of the vertebral canal at the same level – most accentuated level C6/C7. The spinal cord level C6/C7 is deviated dorsally and mildly distorted by the mass effect. The neuroforamina C6/C7 bilaterally are obliterated by hypointense material, R>L.

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

The epidural fat in the right lateral aspect of the vertebral canal level with T1 is mildly swollen and presents a mild heterogeneous hypointense striation. The fat in the region of the right brachial plexus is heterogeneous with mild contrast enhancement.

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The intervertebral discs along the caudal cervical spine present a loss of the in fluid sensitive sequences hyperintense signal of the nucleus pulposus.

The right hypaxial musculature level C6 to T1/T2 is diffuse moderately hyperintense in the fluid sensitive sequences.

REFERRING VET

Dr. Marchal

COMPUTED TOMOGRAPHIC FINDINGS

In the pleural cavity, a mild to amount of fluid attenuating, gravity dependent material is present. The lung lobes are mildly retracted from the thoracic wall and pleural fissure lines are visible.

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The mediastinal fat is swollen and presents moderate fat-stranding.

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In the periphery of the lung lobes of the lung parenchyma, variable sized, ill-defined, roundish ground glass attenuating lesions are visible. The caudal part of the left cranial lung lobe presents with moderate compression atelectasis. Multifocal punctuate mineralization of the lung parenchyma is present.

The intervertebral disc spaces T5/T6 and T6/T7 are collapsed, and the subchondral bone of the respective vertebral endplates presents moderate sclerosis and mild spondylosis formation.



PATIENT The left shoulder joint presents moderate osteophyte new bone formation.

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IMAGING DIAGNOSIS

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- Suspect mild epidural hemorrhage level T1
- Myopathy right hypaxial musculature level C6 to T2 and steatitis region of right brachial plexus/cranial mediastinum with mild mediastinal effusion
- Mild pleural effusion
- Small regions of unstructured interstitial pattern throughout the lung
- Intervertebral disc protrusion C5/C6 and C6/C7 with mild compressive myelopathy
- Neuroforaminal stenosis C6/C7 with compression of the nerve roots C7 bilaterally
- Regions of dystelectasis of the lung
- Chronic discopathy C5/C6 and C6/C7
- Degenerative osteoarthritis left shoulder joint
- Pulmonary osteomas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The intervertebral disc protrusions along the caudal cervical spine are considered chronic and are more likely to be related with pain rather than neurological deficits. Given the acute onset of clinical signs the odds for ischemic insult or acute on chronic insult with secondary mild epidural hemorrhage are considered high. The muscular edema of the left hypaxial musculature can be secondary to underlying myelopathy.

There is evidence of mild mediastinal and pleural effusion and transudate, or exudate are potentials, a specific underlying cause is not appreciated. Recommend tapping the pleural effusion for further definition. Consider complementing workup by full coagulation panel and testing for lung worm infection such as *Angiostrongylus* sp to rule in/out coagulopathy. Regions of pneumonia due to hematogenous spread, pulmonary interstitial hemorrhage, fibrosis or less likely neoplasia are a considerations for the random distribution of the roundish zones with interstitial pattern as well.



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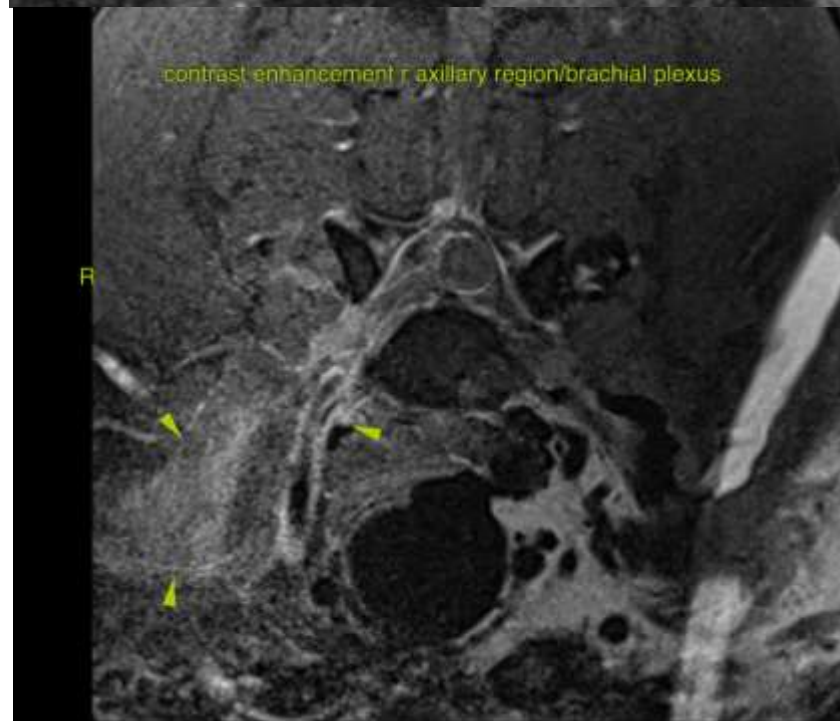
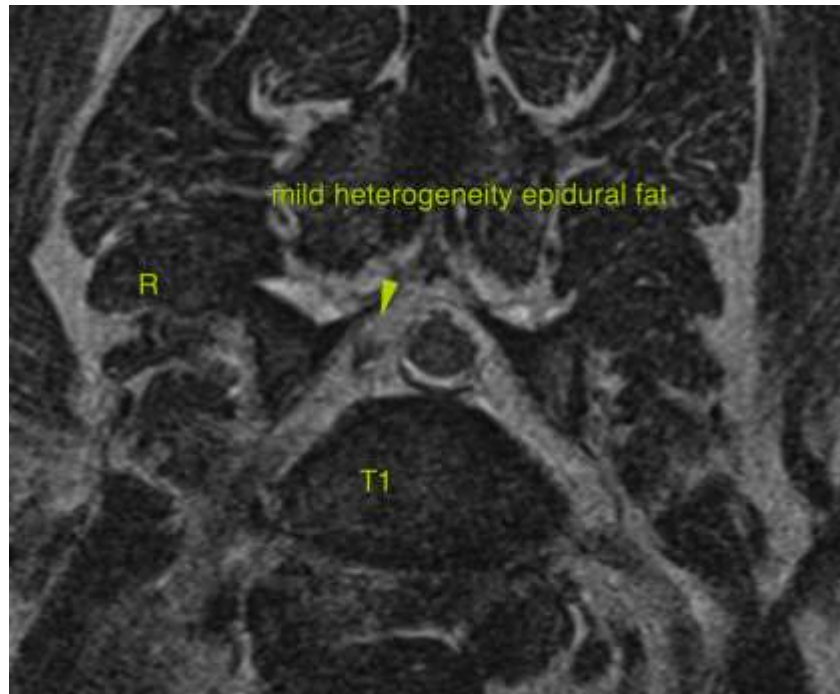
Dr. Marchal

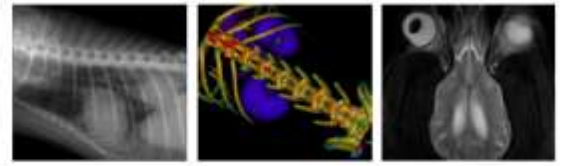
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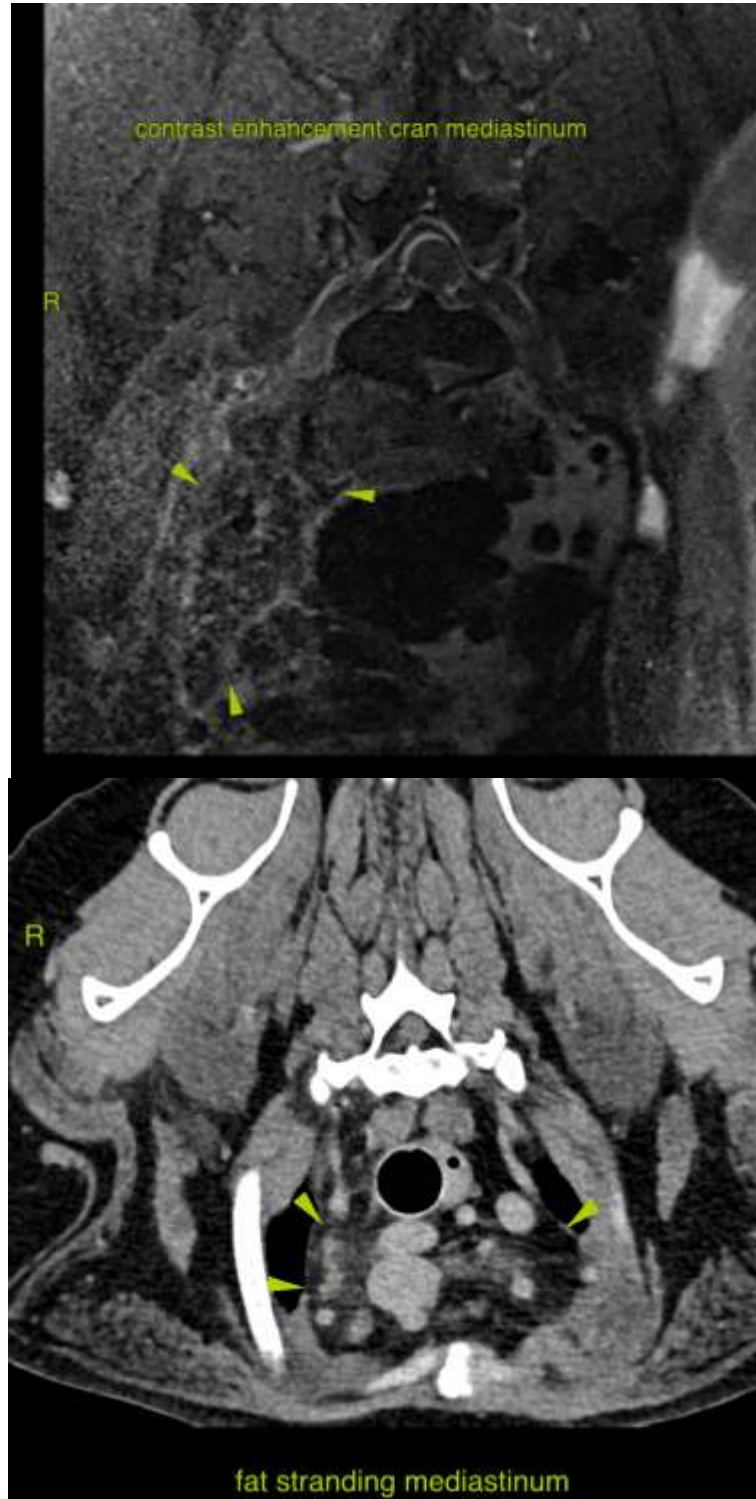
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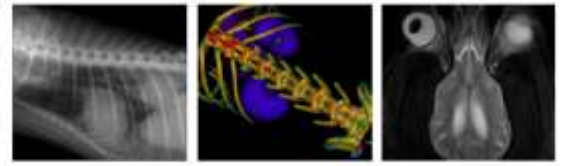
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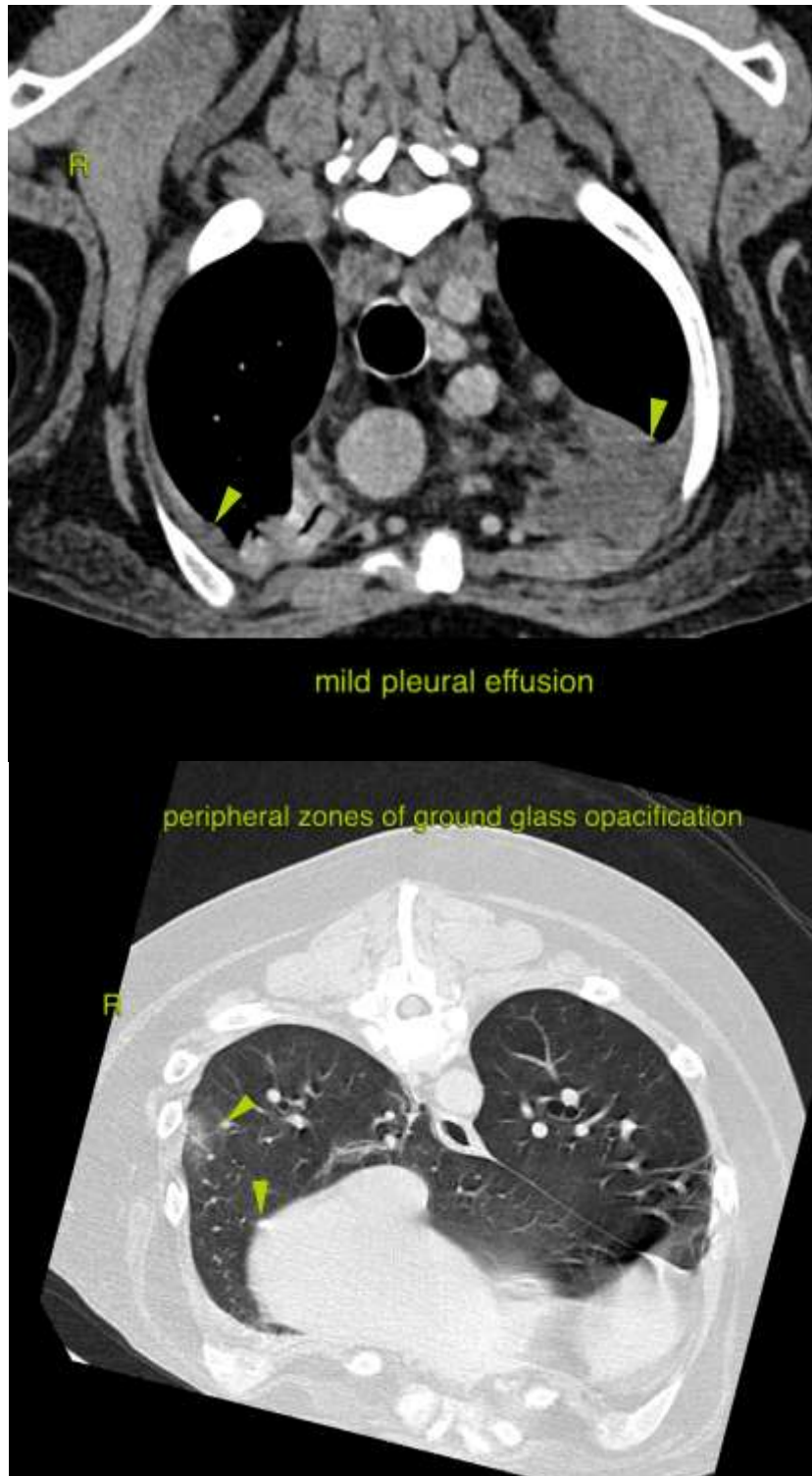
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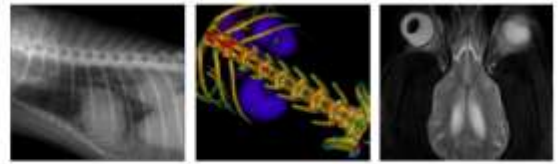
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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