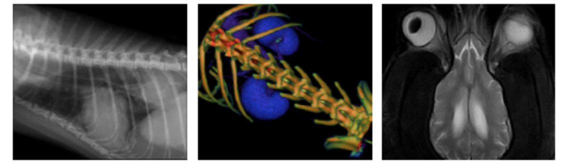


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Calliope Simpson

SPECIES

Feline

BREED

DSH

SEX

Female

AGE

4 Months

INTERPRETED BY

Sebastian Schaub, DVM Dr. med. vet. DipECVDI

HOSPITAL NAME

Animal Health Partners

REFERRING VET

Dr. Marchal

INVOICE

33096

DATE

11/25/21

PRESENTING CLINICAL SIGNS

Calliope was initially presented on November 10th with a history of hyporexia and lethargy. She was pyrexic, had lost weight and dehydrated. She had nystagmus and was circling to the right side. Her gait was very unsteady. Mr and Ms Simpson adopted her at about 8 weeks old through a rescue. They were told that she had cerebellar hypoplasia and was otherwise healthy. There was no documentation of FIV/FeIV testing. Upon presentation bloodwork was done and revealed a mild hypoglycemia and borderline low hematocrit. A parvovirus snap test was performed and was negative. Calliope was given supportive treatments (sq fluids, cerenia, a/d) and clinically improved. She began eating consistently and had more energy. Toxoplasma titres were submitted and came back negative. While waiting she was treated with clindamycin for 2 weeks until clindamycin Nov 22nd. She now has more energy and is eating well but neurological signs are still there. She still has nystagmus, her head wobbles when she is focused on something.

Abnormal PE/Chem/CBC/UA Results: Cranial nerve exam: Resting horizontal nystagmus fast phase to the left. No other deficits noted. Gait/posture: Ambulatory right cerebello-vestibular ataxia characterized by falling to the right, intention tremors, right head tilt and hypermetria in her right thoracic limb. No paresis. Postural reactions: Proprioceptive positioning is normal in all limbs. Hopping is decreased in the right thoracic limb and normal in the other 3 limbs.

MAGNETIC RESONANCE IMAGING OF THE SKULL

T2 weighted, FLAIR, diffusion weighted, SWI, T1 pre- and post-gadolinium sequences in multiple imaging planes are provided for review.

MAGNETIC RESONANCE IMAGING FINDINGS

In the right diencephalon and the region of the left caudate nucleus, a T2 punctuate hypointense lesion is seen respectively, presenting with a prominent susceptibility artefact in the SWI sequences. The parenchyma in the region of the right caudate nucleus presents mild patchy contrast enhancement pattern. The ependymal lining of the mesencephalic aqueduct and mildly of the rostral aspects of the lateral ventricles bilaterally present increased contrast enhancing. The volume of the corpus callosum is significantly decreased.

The CSF is suppressed in the FLAIR sequence.

The folias of the cerebellum present a mild decreased volume with mild widening of the subarachnoidal space. Post contrast administration the cerebellum presents a patchy intraparenchymal contrast enhancement pattern.

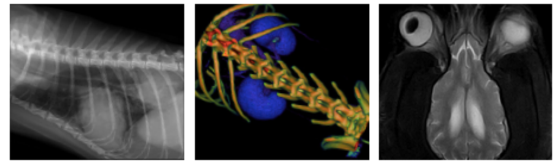
The ventricular system presents the expected dimensions, morphology and the CSF signal is within normal limits in all sequences.

The tympanic bullae are aerated and the bony lining is thin.

Surrounding soft tissue structures in the head region are within normal limits.

MAGNETIC RESONANCE IMAGING DIAGNOSIS

- Multifocal intracranial intraaxial asymmetric distributed contrast patchy contrast enhancing cerebellar lesions and level with the caudate nuclei



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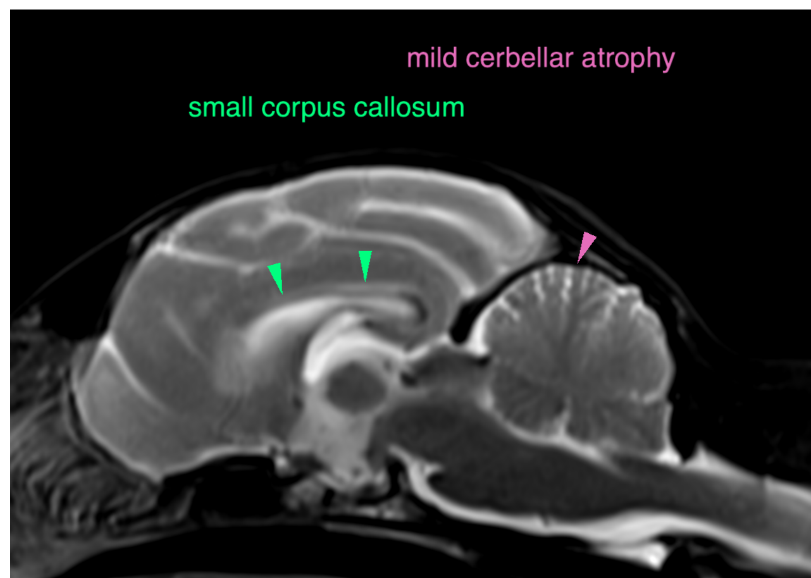
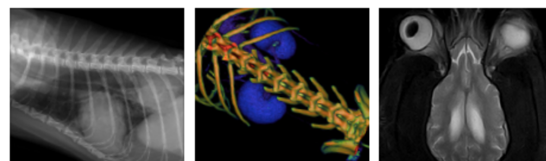
- Two intraparenchymal microbleeds of the brain
- Mild cerebellar atrophy
- Small corpus callosum

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The findings are more likely to be related to underlying lysosomal storage disease – specifically GM2-gangliosidosis or less likely Fucosidosis – than pyogranulomatous inflammatory disease of the brain. The latter would include FIP (but no overt changes of the CSF, ventriculomegaly, fulminant ependymitis), mycotic or protozoal infection of the brain. If not done so yet, a CSF tap is mandatory. Laboratory testing should also be used to rule in/out potential storage disease (e,g, DNA, enzymatic activity). A follow up MRI study in 1-2 month might be considered to check if changes are progressive. The small intraparenchymal hemorrhagic lesions might be unrelated with the above mention findings and can be caused by second entity such as migrating larvae of ascaris.





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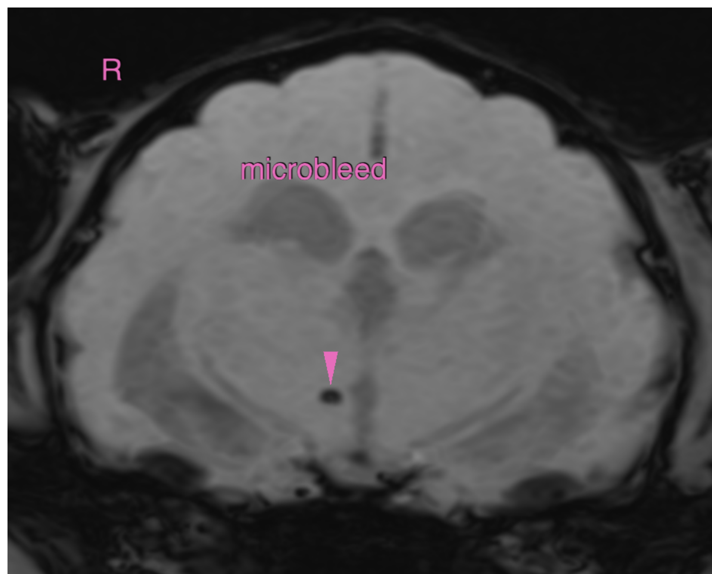

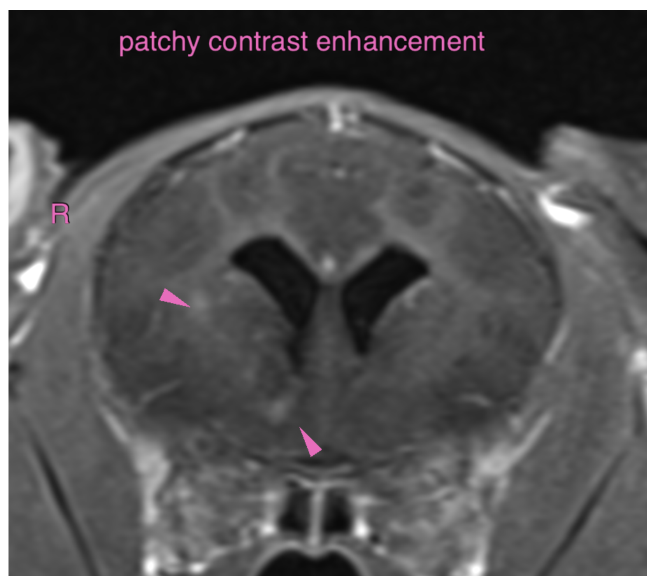

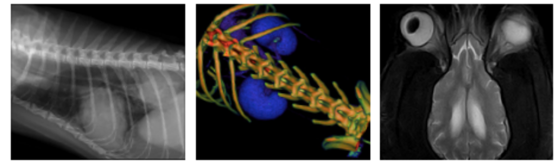

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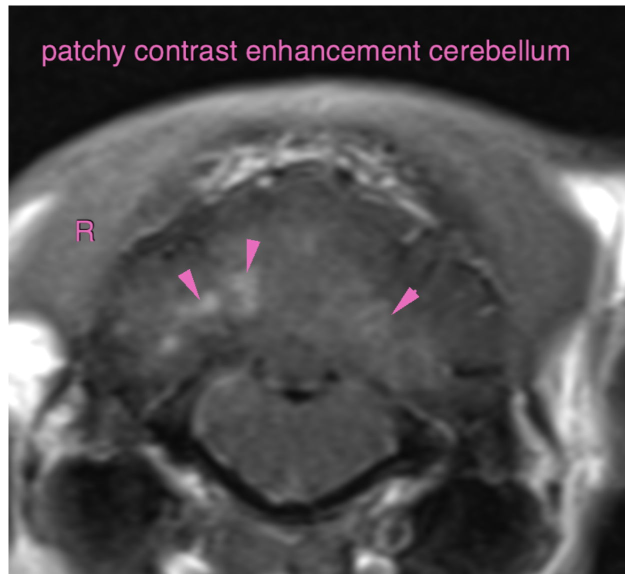

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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