



PATIENT PRESENTING CLINICAL SIGNS

PATIENT
Gertie Wouters

SPECIES
Canine

BREED
French Bulldog

Gertie is currently being hospitalized for marked to severe spinal pain lower spine and constipation. Patient is currently taking anti-inflammatory (metacam), methocarbamol, and gabapentin. Owner said patient did not have any improvement at all after buprenorphine injection at last visit. r/o cauda equina syndrome, IVDD, spinal stenosis, DJD/OA, markedly painful vs infection/inflammation vs neoplasia vs other ruptured LH CCL also

Abnormal PE/Chem/CBC/UA Results: ASSESSMENT Problem List: pain score 4/4 markedly painful hyperesthesia allodynia tachypnea panting painful, sensitive to touch attempting to jump move head tilt to the right decreased CP hindlimbs bilaterally normal forelimbs deep pain noted bilaterally, patient has withdrawal reflex severe muscle tightening/stiffness bilateral hindlimbs Ruptured LH CCL (previous issue) urinating/defecating consciously, but painful to squat

COMPUTED TOMOGRAPHY OF THE ENTIRE SPINE AND HIND LIMBS

A plain CT study of the cervical, thoracic and lumbar spine and the hind limbs in a bone and soft tissue reconstruction are provided for review.

SEX

Female Spayed

COMPUTED TOMOGRAPHIC FINDINGS

AGE

4 Years

THE LAST RIB BEARING VERTEBRA IS COUNTED AS T13.

Level with the intervertebral disc spaces C2/C3 and C4/C5, mineralized disc material is mildly protruding into the vertebral canal, distorting the ventral epidural space at the same level.

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

The thoracic spine presents with multiple hemivertebra and multifocal moderate spondylosis formation.

Mild to moderate mineralization of multiple intervertebral discs along the lumbar spine is seen. L2 presents as hemivertebra with moderate spondylosis formation.

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Level with the intervertebral disc space L3/L4, heterogeneous mild hyperattenuating material is visible in the left ventrolateral aspect of the vertebral canal, occupying approximately 50% of the cross-sectional area of the vertebral canal at the same level. The mild hyperattenuating material is extending caudally up to the level of the caudal third of the vertebral body of L4 and cranially up to the level of the caudal vertebral endplate of L3. A small amount of hyperattenuating material can be appreciated in the epidural space up to the level of L2/L3.

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Mild protrusion of the intervertebral disc L6/L7 into the vertebral canal is seen, compression the ventral epidural space.

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The lumbosacral intervertebral disc is moderately protruding into the vertebral canal, occupying approximately 35% of the cross-sectional area at the same level.

The pelvis and coxofemoral joints present without abnormalities.

DATE

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The femoral trochlear groove bilaterally is shallow. The patella of both stifle joints is located on the medial trochlear ridge. The right stifle joint presents with mild osteophyte new bone formation. Small mineralizations are seen along the caudal aspect of the synovial lining of the right stifle joint.



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A persistent cartilage core is present in the caudoproximal aspect of the tibial tuberosity bilaterally.

The tarsal joints present without abnormalities.

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COMPUTED TOMOGRAPHIC DIAGNOSIS

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- Intervertebral disc extrusion L3/L4 with compressive myelopathy
- Degenerative lumbosacral stenosis with likely dynamic compression of the cauda equina fibers
- Mild intervertebral disc protrusion C2/C3 and C4/C5 without compressive myelopathy
- Suspect bilateral medial patellar luxation
- Mild degenerative osteoarthritis right stifle joint
- Multiple hemivertebra thoracic spine & L2
- Spondylosis deformans

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Female Spayed

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The intervertebral disc extrusion L3/L4 from the left ventrolateral aspect is a plausible explanation for the described clinical signs. Surgical decompression is considered as the therapy of choice – be aware of the predominant caudal extend of the extruded disc material. The material extending cranially likely presents secondary hemorrhage.

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The remaining findings are considered as clinically not relevant at this point.

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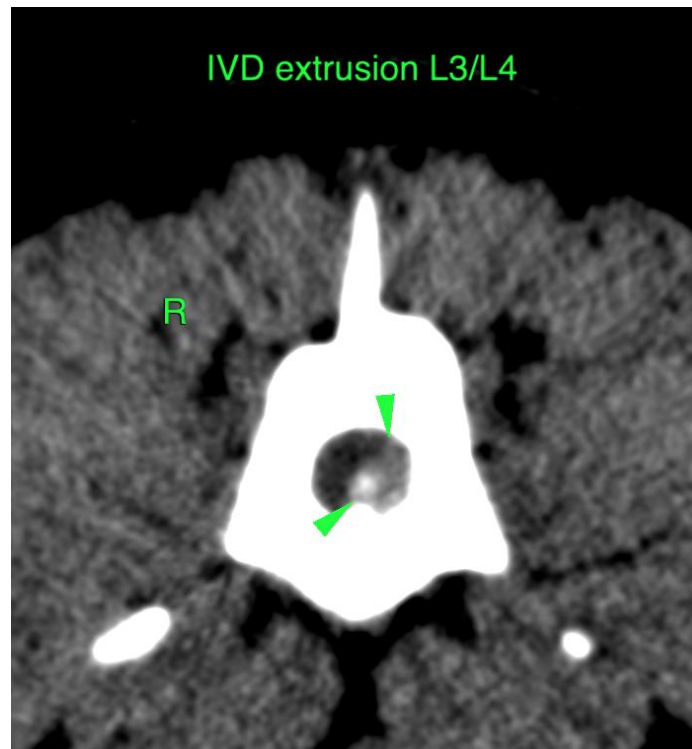
McConnell

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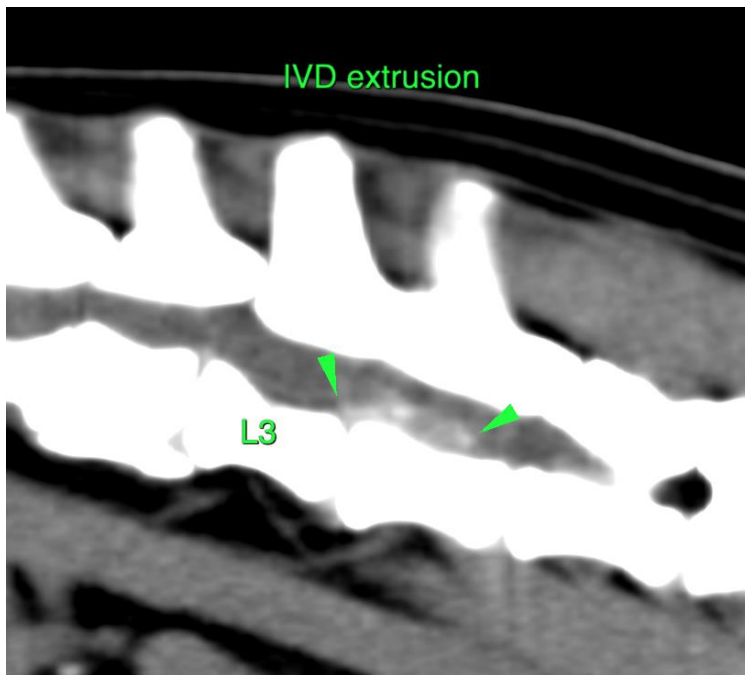
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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