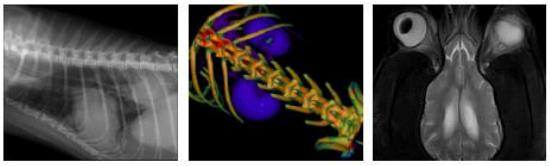
SonoPath Teleradiology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Mya Corbitt

SPECIES

Canine

BREED

Boxer

SEX

Female Spayed

AGE

9 Years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Mobile Pet Imaging
CFL

REFERRING VET

Meaux

INVOICE

50436

DATE

2-18-22

PRESENTING CLINICAL SIGNS

CP deficits on hindlimbs. Deep Pain present. Suspected compressive spinal cord lesion or Brain tumor. Ddx IVDD, discospondylitis, spondylosis
Abnormal PE/Chem/CBC/UA Results: Ambulatory x 4 but with moderate pelvic limb ataxia.

COMPUTED TOMOGRAPHY OF THE SKULL AND THORACIC & LUMBAR SPINE

A high resolution pre- and post-contrast CT study of the skull and thoracic & lumbar spine are provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

Skull

The tooth elements 305, 405 and 411 are absent.

The nasal cavity presents the expected aerated spaces between thin & even conchae and turbinates with smooth mucosal lining.

Both temporomandibular joints present congruent joint spaces with even subchondral bone surfaces and are considered within normal limits.

Both tympanic bullae are aerated, the mucosal lining is not seen, the bony wall is smooth and thin. Both external ear canals present mild to moderate shell like mineralization and are mildly narrowed.

The brain presents no deviation from normal anatomy and symmetry. The brain parenchyma is homogeneous and within normal limits for attenuation and distribution of contrast enhancement. The ventricular system is non-dilated and symmetric.

The submandibular and medial retropharyngeal lymph nodes are small and elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform.

Spine

Multifocal mild spondylosis formation is seen along the thoracic spine. No additional abnormalities of the thoracic spine are appreciated.

The intervertebral disc T11/T12 is mildly protruding into the vertebral canal, distorting the ventral epidural space.

The intervertebral disc L6/L7 is mild to moderately protruding into the vertebral canal, compression the ventral epidural space at the same level. The lumbosacral intervertebral disc is moderately protruding into the spinal canal, mildly displacing the cauda equina fibers at the same level dorsally. The vertebral endplates of the lumbosacral junction present mild spondylosis formation.

In the pictured parts of the abdomen, level with the ileocolic junction, a well-defined, roundish, heterogeneous contrast enhancing nodule, measuring 2.2 cm in diameter is seen.

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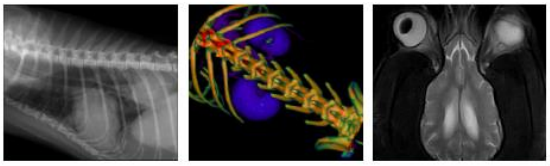

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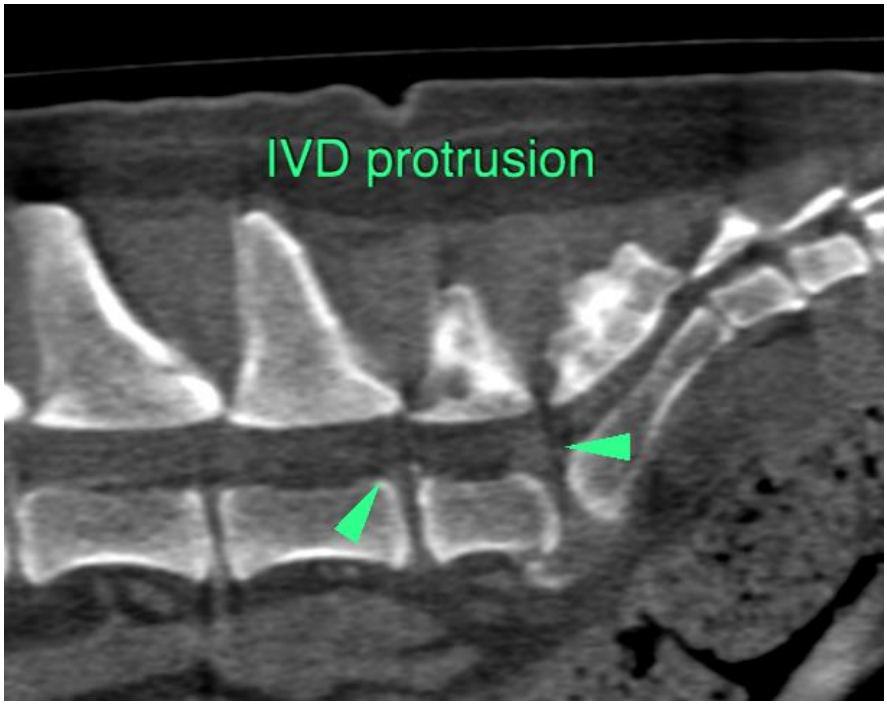
COMPUTED TOMOGRAPHIC DIAGNOSIS

- Suspect intramural eccentric growing mass level with ileocolic junction
- Degenerative lumbosacral stenosis with likely dynamic compression of the cauda equina fibers
- Intervertebral disc protrusion L6/L7 with possible dynamic myelocompression
- Mild intervertebral disc protrusion T11/T12 without compressive myelopathy
- Otitis externa
- Spondylosis deformans
- Absent triadan 305, 405 and 411
- Structural normal brain

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The CT study of the brain, thoracic spine and lumbar spine presents no abnormalities, explaining the presenting clinical signs. The degenerative lumbosacral stenosis is predisposing for intermittent pain but unlikely to be associated with neurological deficits. However, a negative CT study does not rule out extrusion/protrusion of isoattenuating material, acute non-compressive intervertebral disc extrusion, ischemic myelopathy or potential intramedullary lesion. If there is strong clinical suspicion for compressive myelopathy, complementing workup by a myelographic CT study or MRI study is recommended.

There is a potential intramural mass level with the ileocolic junction – such as adenocarcinoma, gastrointestinal stroma cell tumor, sarcoma. An enlarged lymph node ileocolic lymph node is a differential but considered less likely. Ultrasound guided FNA sampling can be used as advanced diagnostic test. If applicable, complete surgical excision appears feasible.



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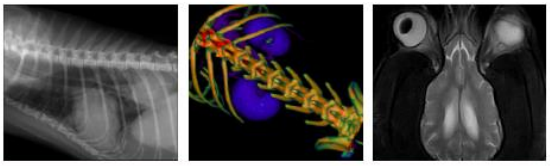

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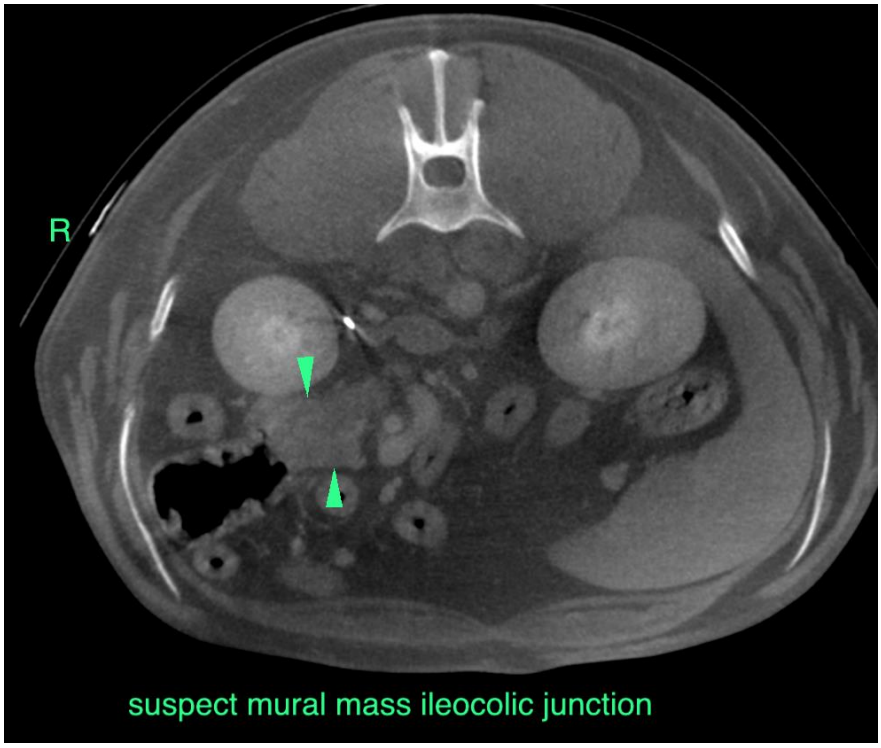

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 Schaub, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI
sebast.schaub@gmail.com