



PATIENT PRESENTING CLINICAL SIGNS

PATIENT Autumn Harris
SPECIES Canine
BREED Shih Tzu Mix
SEX FS
AGE 4 Years, 6 Months
INTERPRETED BY Sebastian Schaub, DVM
 Dr. med. vet. DipECVDI

8/13/22- Patient in for down in the back. Has had this issue a few times in the past, was seen by rDVM in march and was given steroids and muscle relaxers. Patient has never had x-rays. Most recent bout of back issues started on Thursday and has progressively gotten worse. owner thinks it is stress related, owner's boyfriend came over with his dog on Thursday and patient hates the dog per owner, and the next day was having walking and back issues. Owner gave a muscle relaxer last night and now today cannot walk at all. Doesn't seem to want to eat. No vomiting, but stools are loose. Having some urinary incontinence. Not up to date on vaccines, no medications, no FTHWP. Diet is Freshpet (wet and dry) and table scraps (such as french fries, chicken, carrots, just whatever. Owner swears they are vigilant that they dont give anything toxic) . Owner approved radiogprahs and exam. Spinal radiographs- severely compressed intervertebral spaces in T10-T11, T11-T12, and T12-T13; spondylosis present along T11, T12 and T13 Discussed best prognostic outcomes for recovery of limb function would be achieved with laminectomy surgery (est 4-5k at OSU). Discussed there is chance of recovery in dogs with deep pain sensation who are strictly confined to crate for minimum 6-8 weeks. Discussed due to the spondylosis forming there is a high chance this could recur in the future; pt should never be allowed to climb stairs/ jump on furniture at home. Advised prophylactic back brace if pt recovers. O elects crate rest at this time; Rx Prednisolone 1 mg/kg PO BID x 7 days, then taper dosage for 3 weeks; Rx Gabapentin 50 mg PO TID for anxiety/ spinal pain; Rx Robaxin 132 mg/kg PO divided into 3 doses daily x 5 days O to bring back if pt loses deep pain sensation (showed how to assess) or ascending spinal necrosis (loses ability to feel forelimbs, panniculus loss); or inability to urinate/defecate on own 4/10/23-Reason for today's visit: pt presented for down in the back. Has been having this issues for a few years. On Robaxin 500mg and Prednisolone 5mg and done laser therapy, O doesn't know if it has been helping at all. This morning pt was very painful, wouldn't let her touch her at all. Pt is still able to eat and drink. Will urinate on herself, hasn't defecated in 2-3 days.

Abnormal PE/Chem/CBC/UA Results: elevated- Glu 171, Neut, PLT, low- EOS, Lymphs UTI

COMPUTED TOMOGRAPHY OF THE CERVICAL, THORACIC AND LUMBAR SPINE

A high resolution pre- and post-contrast CT study of the entire spine is provided for review.

HOSPITAL NAME COMPUTED TOMOGRAPHIC FINDINGS

HOSPITAL NAME Neel Veterinary Hospital
COMPUTED TOMOGRAPHIC FINDINGS THE LAST RIB BEARING VERTEBRA IS COUNTED AS T13.
 Moderate central mineralization of the intervertebral disc C2/C3 is appreciated.

REFERRING VET The intervertebral discs C5/C6 and C6/C7 are mildly protruding into the vertebral canal, distorting the ventral epidural space at the same level.

Deepan Kishore, DVM,MS, DABVP All intervertebral discs along the thoracic spine present central punctuate mineralization.

Level with the intervertebral disc space T8/T9 mineralized material is bulging into the left ventral aspect of the vertebral canal, occupying approximately 5% of the cross-sectional area of the vertebral canal at the same level.

INVOICE

57699 The intervertebral disc space L1/L2 is moderately narrowed. Level with the intervertebral disc space L1/L2, heterogeneous hyperattenuating material is seen in the left lateral and ventral aspect of the vertebral canal, occupying approximately 45% of the cross-sectional area of the vertebral canal at the same level. The hyperattenuating material is extending cranially up to the level of the cranial vertebral endplate L1 and caudally up to the level of the caudal third of the vertebral body of L3. Mild hyperattenuating material surrounding the dural tube can be appreciated cranially up to the level of

DATE

4-10-23 T12 and caudally up to the level of L4/L5.



PATIENT Multiple intervertebral discs of the caudal lumbar spine present mild to moderate central mineralization.
Autumn Harris

COMPUTED TOMOGRAPHIC DIAGNOSIS

SPECIES

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- Left sided intervertebral disc extrusion L1/L2 with pronounced caudal extend up to the level of L3
- Suspect secondary epidural hemorrhage
- Intervertebral disc protrusion C5/C6, C6/C7 and T8/T9 without compressive myelopathy
- Multifocal chondroid disc degeneration

BREED

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left sided intervertebral disc extrusion L1/L2 is a plausible explanation for the presenting clinical signs and surgical decompression is considered as the therapy of choice.

SEX

FS

The hyperattenuating material accentuating the dural tube cranially and caudally is most suggestive for far caudal and cranial migration of accompanying epidural hemorrhage.

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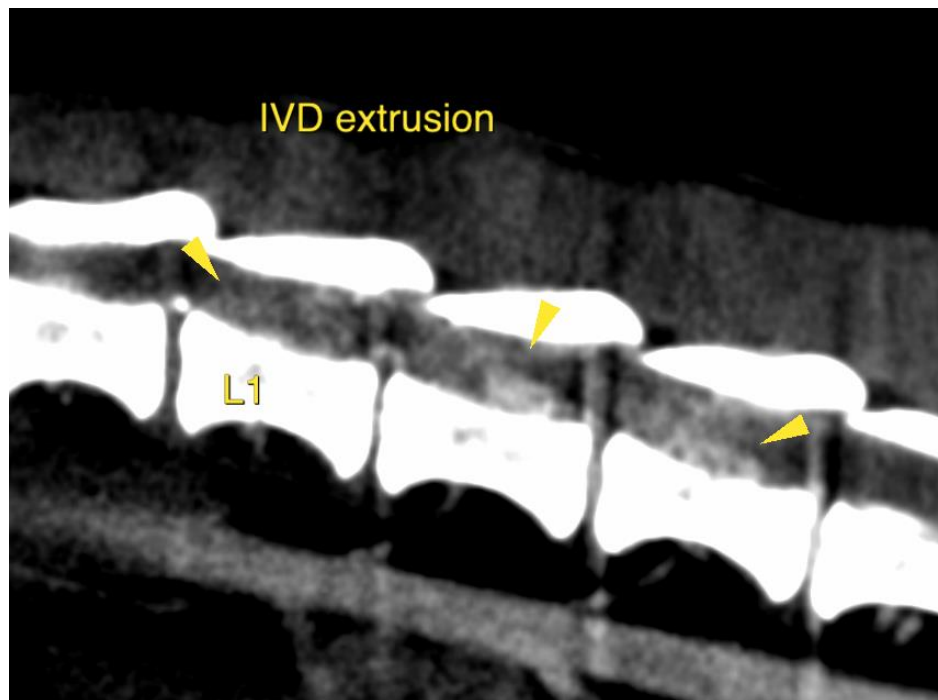
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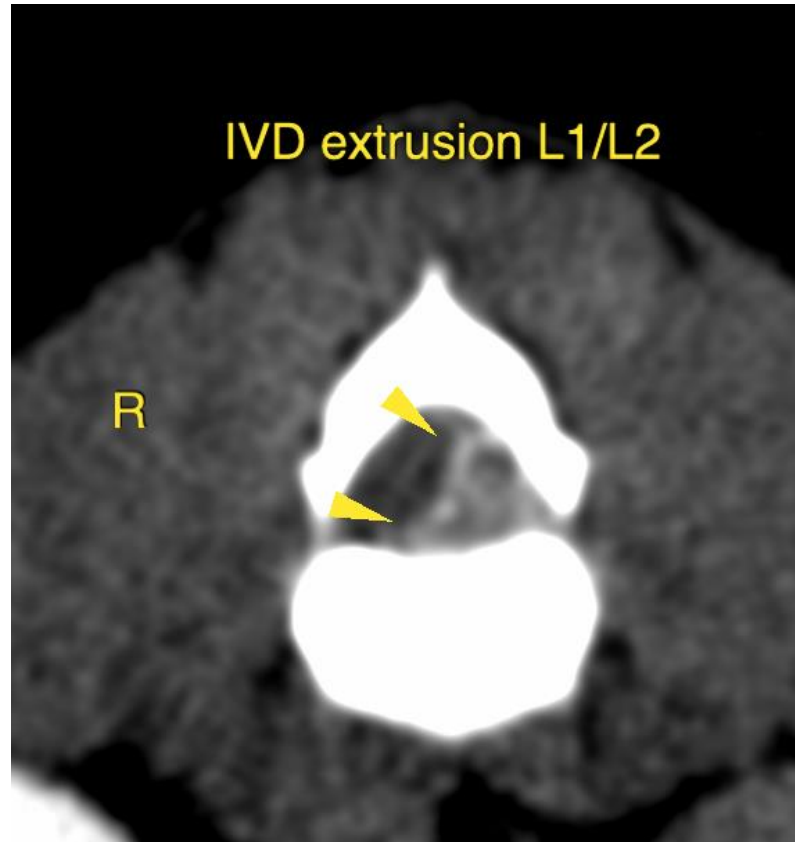
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IVD extrusion L1/L2

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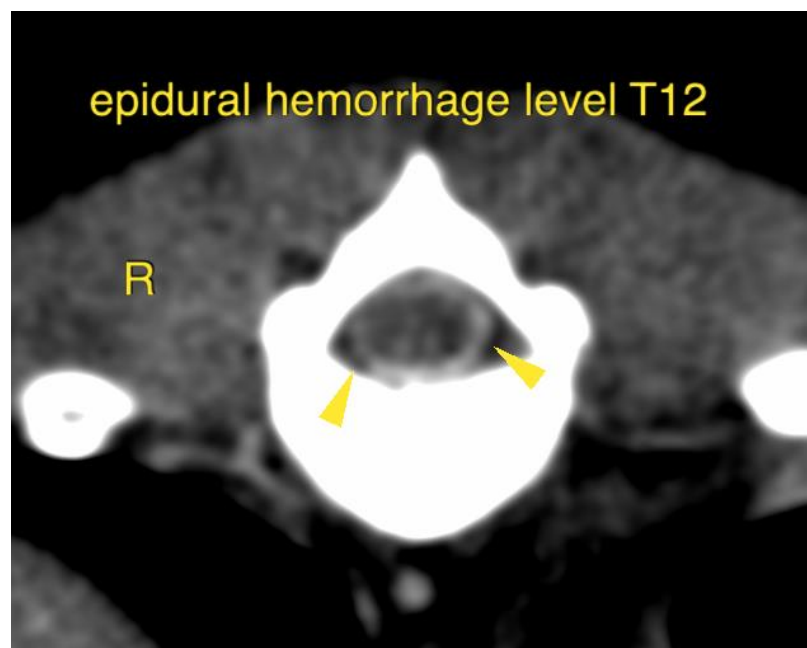
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epidural hemorrhage level T12

R



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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.

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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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