



PATIENT PRESENTING CLINICAL SIGNS

PATIENT Clancy Whittaker
SPECIES Canine
BREED French Bulldog

History: 2 days ago acute onset of lethargy, disorientation, and ataxia following a walk. Did not witness any toxin ingestion. The next day was a bit more alert but still ataxic with head bobbing. Previous hx of chronic right sided head tilt (no cause found on MRI). Occasional head tilt sometimes but no previous hx of ataxia or paresis. Other findings on previous MRI (Apr 2019): Equivocal dorsal funiculus enhancement at C4-5 and over C5. Multifocal thoracic vertebral canal narrowing due to vertebral anomalies (hemi- and butterfly) without clinically significant spinal cord compression/impingement. Severe disc-associated lumbosacral stenosis exacerbated by spondylolisthesis without definitive evidence of cauda equina neuropathy. Diffuse degenerative intervertebral disc disease of the cervical and thoracolumbar spines. Neuro exam: BAR, ambulatory paraparetic, delayed proprioception in pelvic limbs and weak withdrawals in pelvic limbs, pain on low lumbar palpation. Neurolocalization L4-S3 myelopathy.

SEX MAGNETIC RESONANCE IMAGING OF THE THORACIC & LUMBAR SPINE

SEX Neutered Male
 T2 & T1 (DIXON) weighted pre- and post-gadolinium sequence in multiple imaging planes are provided for review.

AGE MAGNETIC RESONANCE IMAGING FINDINGS

AGE 9 Years
 The vertebral canal along the thoracic spine has an irregular shape due to multiple hemivertebra and mild protrusion of multiple intervertebral discs into the vertebral canal – occupying approximately up to 10% of the cross-sectional area of the vertebral canal at the same level.

INTERPRETED BY

Sebastian Schaub,
 DVM Dr. med. vet.
 DipECVDI

The intervertebral discs T13/L1 to L4/L5 are bulging into the vertebral canal, occupying up to 15% of the cross-sectional area of the vertebral canal at the same level. The lumbosacral intervertebral disc is bulging into the vertebral canal, occupying approximately 65% of the cross-sectional area of the vertebral canal at the same level., L>R. The left spinal nerve L7 is thickened and presents increased contrast enhancing. In STIR the vertebral endplates L7/S1 are diffuse hyperintense and post contrast administration, the vertebral endplates L7/S1 and the epidural fat at the same level present moderate diffuse contrast enhancing. S1 is not fused with S2 and has an asymmetric shape.

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All intervertebral discs along the thoracic and lumbar spine present a loss of the in fluid sensitive sequences hyperintense signal of the nucleus pulposus.

REFERRING VET MAGNETIC RESONANCE IMAGING DIAGNOSIS

Dr. Alison Little

- Degenerative lumbosacral stenosis including neuroforaminal stenosis with compression of the caudal equina fibers and active remodeling of the vertebral endplates
- Epidural steatitis level L7/S1
- Neuritis left spinal nerve L7
- Multifocal intervertebral disc protrusions along the thoracic and lumbar spine without or possible dynamic myelocompression
- Multiple hemivertebra along the thoracic spine

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PATIENT

- Generalized degenerative disc disease along the thoracic & lumbar spine
- Asymmetric lumbosacral transitional vertebral (Type III)

Clancy Whittaker

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Level with L7/S1, the contrast enhancement of the epidural fat is suggestive for focal inflammation of the epidural fat – either sterile or due to bacterial hematogenous spread – that can contribute to the clinical suspected L4-S3 myelopathy. The contrast enhancing vertebral endplates L7/S1 can be a sequela to active degenerative osseous remodeling or can be an indicator for early stage of discospondylitis. Consider complementing workup by an abdominal ultrasound examination including complete urinalysis and thoracic radiographs to screen for possible primary infectious nidus.

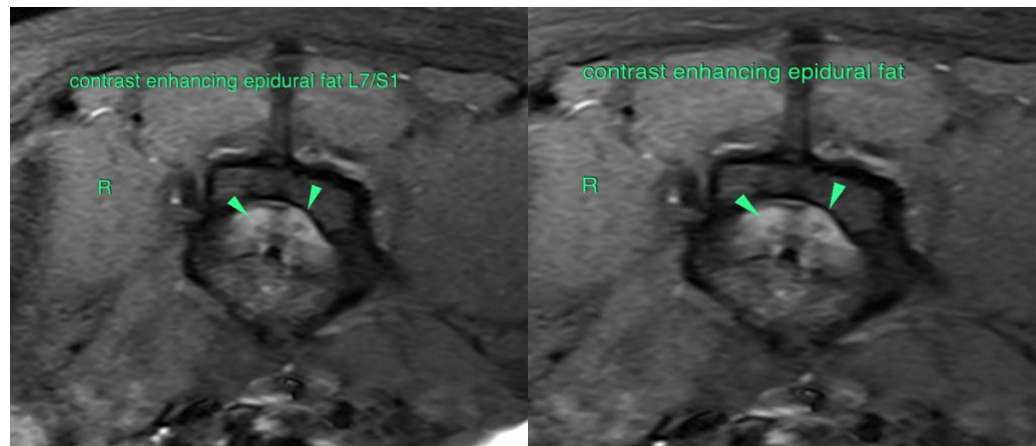
The remaining changes along the thoracic and lumbar spine are considered unlikely to be related with clinical signs, there is no evidence of relevant vertebral canal stenosis/intervertebral disc herniation.

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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.



PATIENT

Sebastian Schaub, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI
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