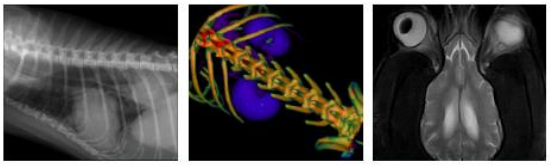

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1-800-838-4268 info@sonopath.com

PATIENT

Louie Hamilton

SPECIES

Canine

BREED

Pug

SEX

Neutered Male

AGE

9 Years

INTERPRETED BY

Sebastian Schaub, DVM Dr. med. vet. DipECVDI

HOSPITAL NAME

Southern Oregon VSC

REFERRING VET

Dr. Ravi Seshadri

INVOICE

16822

DATE

8/12/22

PRESENTING CLINICAL SIGNS

History: Presenting Complaint: ataxia, lethargy, seizures earlier in the week Transfer: Cerenia injection 8/10 at noon, 7.5 mg clorazepate PO BID x 7 days, 30 mg Cerenia PO q24 hours, Skull rads performed Chem17: Glob 4.9, ALP 253 CBC: HCT 39.7, WBC 14.42, Neu 10.97, Monocytosis 1.83 FNA submitted to CSU Significant PE Findings: Quiet mentation, cranial nerve exam appears unremarkable. Delayed CP x 4 and intermittently reactive (brisk vs significantly delayed on same limb) knuckling in right forelimb when standing but left hemiparesis more pronounced with hopping and postural placement exam. Is able to ambulate with significant ataxia, Firm, fixed mass right mid lateral/ventral cervical region, very painful on cervical range of motion - most significant with dorsiflexion DDx: inflammatory, neoplasia, abscess DIAGNOSTICS: Serial neuro exams static Client Discussion: Sunday night, Monday night and Tuesday morning he had seizures. On Tuesday morning he fell off the bed with the last seizure. He was acting normally on Monday. He has had seizures in the past, usually 1 every 6 months. This is his first cluster. Tuesday he was walking very slowly and had his head down. Wednesday morning he went to Bailey AH, he got clorazepate which he received at 2030 Wednesday night. this morning he seemed more clear and was walking better but he declined again throughout the day. He may have been exposed to fertilizer in the garden. Overnight for the last 2 nights he seemed warmer to touch than normal. He ate yesterday during the hour that seemed better when he got home from the veterinarian but then he declined again. He did not eat today but did drink some water. There has been no vomiting. He is not currently on flea and tick preventative. The other dog in the house is acting normally. he seizure is an arched back, rigid extremities and he vocalizes. they last about 60 seconds, when he recovers he has a post-ictal phase. He is dazed for about 30 minutes and he is ataxic. They always happen in the middle of the night except for Tuesday. Discussed differentials and care. CT here vs transfer for neurology. Abnormal PE/Chem/CBC/UA Results:

COMPUTED TOMOGRAPHIC STUDY OF THE SKULL

A high resolution pre- and post-contrast including a myelographic CT study of the skull/neck is provided for review.

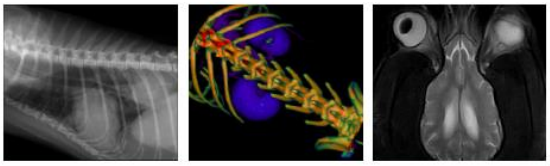
COMPUTED TOMOGRAPHIC FINDINGS

Triadan 106, 206, 305, 311, 406, 410 and 411 are absent. Triadan 101, 102 and 203 present a significant periapical widening of the periodontal space perforating the nasal cavity. Triadan 107, 108, 207, 209 and the mandibular incisor teeth present significant widened periodontal space.

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. The horizontal segment of the external ear canals is moderately narrowed.



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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 right mandibular lymph nodes, the right medial retropharyngeal & deep cervical lymph node are moderately enlarged, uniform soft tissue attenuating and contrast enhancing.

The right superficial cervical lymph node is poorly defined, enlarged and presents with a heterogeneous contrast enhancement pattern, sparing multiple hypoattenuating regions.

The subcutaneous tissue along the right lateroventral aspect of the neck is swollen and presents a significant soft tissue striation.

The myelographic study of the neck presents with moderate motion artefacts. Level with C2/C3, a teardrop shaped moderate widening of the dorsal subarachnoid space is noted, distorting the spinal cord at the same level.

The spinous process of T1 is incompletely fused in the midline, appearing bipartite.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Subarachnoid pseudocyst level C2/C3 with myelocompression
- Lymphadenopathy right superficial cervical lymph node with signs of cavitation
- Steatitis along the right ventrolateral aspect of the neck with accompanying lymphadenopathy of the regional lymph nodes and
- Periodontal abscess formation 101, 102, 203 with oronasal fistula formation
- Advanced periodontal disease 107, 108, 207, 209 and the mandibular incisors
- Multiple absent teeth
- Stenosis external ear canals

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The steatitis in combination with the lymphadenopathy of regional lymph nodes along the right aspect of the neck are supporting the diagnosis of inflammatory origin – possibly with abscessation of the right superficial cervical lymph node. Regarding the history, abscess formation has already been confirmed by aspiration. Complementing workup by FNA sampling of the lymph nodes would be beneficial to rule out neoplastic infiltration – such as mast cell tumor.

In the myelographic CT study a significant widening of the subarachnoid space dorsal to the spinal cord is appreciated, level C2/C3, consistent with subarachnoid diverticulum/pseudocyst formation. Both acquired (e.g. trauma, inflammation) as well as congenital malformations of the subarachnoidal space – considered less likely due to the age of the patient – can be the cause for diverticulum formation. Marsupialization of the subarachnoid diverticulum/pseudocyst can be considered as treatment option.

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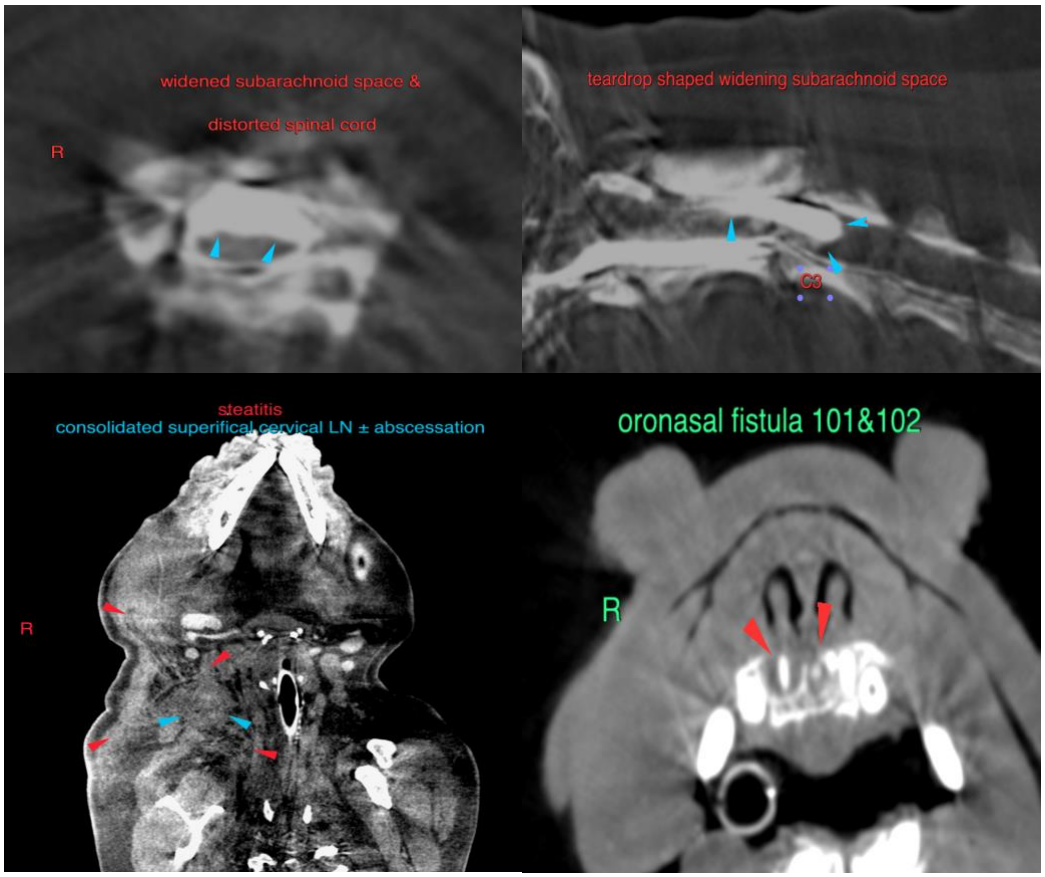
In the present study of the brain there is no evidence of macromorphological disease of the brain, which supports the presumptive diagnosis of idiopathic epilepsy.

In case of the strong clinical suspicion of structural intraparenchymal changes, an MRI may be considered.



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

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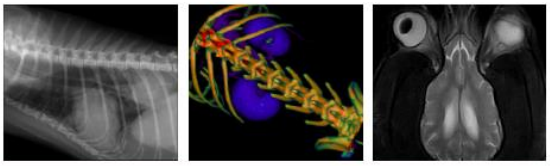

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