



PATIENT

Teddy Taitz

SPECIES

Canine

BREED

Coton De Tulear

SEX

MN

AGE

6

WEIGHT

6

INTERPRETED BY

Tilde Rodrigues Froes,
DMV, MSc., Dr. Med
Vet., Dipl. CBraRVet

IMAGING PERFORMED BY

David

HOSPITAL NAME

Animal Surgical Center
- Oceanside

REFERRING VET

Infernuso

INVOICE

73686

DATE

2-10-26

PRESENTING CLINICAL SIGNS

- cervical myelopathy
- No cp deficits or segmental reflexes
- fully ambulatory
- cervical myelopathy rule out IVDD vs tumor

COMPUTED TOMOGRAPHIC STUDY OF THE SPINE

Pre- and post-contrast (myelographic) computed tomographic examination of the cervical, thoracic, and lumbar spine was provided for review. Two series were obtained, including one pre-contrast series and one myelographic acquisition. Images were acquired in the transverse plane using bone algorithms.

COMPUTED TOMOGRAPHIC FINDINGS

SPINE

A normal number of vertebral bodies is present, including C1 through C7, T1 through T13, L1 through L7, the sacrum, and caudal vertebrae.

Vertebral alignment is normal throughout the thoracic and lumbar spine.

At the T12–T13 intervertebral level, a small amount of ventrally located hyperattenuating extradural material is present within the vertebral canal, extending into the right neurovascular foramen and resulting in mild spinal cord compression. Concurrent mineralized disc material is present within the respective intervertebral canal.

At the L5–L6 intervertebral level, a discrete amount of ventrally located hyperattenuating extradural material is present within the vertebral canal, resulting in minimal spinal cord compression. Mineralized disc material is also identified within the respective intervertebral canal.

At the L4–L5 level, in-situ mineralized intervertebral disc material is noted.

Vertebral bodies demonstrate homogeneous osseous attenuation, smooth cortical margins, and normal size and shape.

The paraspinal musculature is symmetric, with normal volume and attenuation.

Myelographic Findings

Following contrast administration, contrast medium is appropriately distributed within the subarachnoid space, with normal cranial and caudal flow.

At the T12–T13 level, mild dorsal elevation and minimal ventral interruption of the ventral contrast column are also observed, corresponding to the extradural lesion identified on the pre-contrast series, slightly right-sided and ventral in location.



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Multiple discrete dorsal elevations and minimal ventral interruptions of the ventral contrast column are observed at the C2–C3, C3–C4, and C4–C5 intervertebral levels. The dorsal contrast column is unremarkable.

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COMPUTED TOMOGRAPHIC DIAGNOSIS

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- At the T12–T13 intervertebral level, mild spinal cord compression is present, associated with mineralized intervertebral disc material and right-sided ventral extradural compressive myelopathy.
- At the L5–L6 intervertebral level, minimal spinal cord compression is present, also associated with ventral extradural mineralized disc material.
- Multiple discrete dorsal elevations and minimal ventral interruptions of the ventral contrast column are observed at the C2–C3, C3–C4, and C4–C5 intervertebral levels. Differential diagnoses include intervertebral disc bulging, less likely artifact.
- In-situ intervertebral disc mineralization is noted at the L4–L5 level.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The tomographic and myelographic findings are most consistent with multifocal intervertebral disc disease, predominantly affecting the thoracolumbar junction. Mild spinal cord compression is identified at the T12–T13 intervertebral level, with minimal compression at L5–L6.

The cervical spine demonstrates discrete, multilevel, intervertebral disc bulging.

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Considering the patient's ambulatory status and mild spinal cord compression, conservative management and clinical monitoring are suggested. Neurological reassessment is recommended if clinical signs progress, and MRI may be considered if further evaluation is required.

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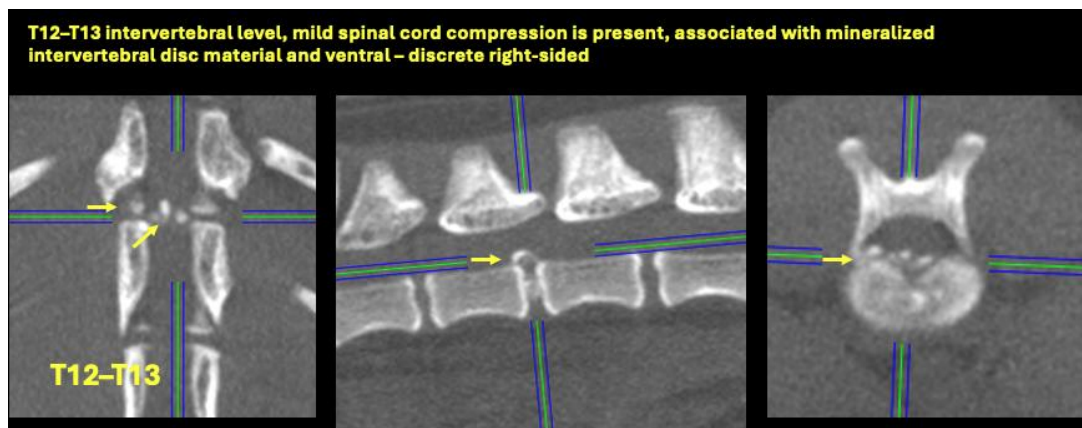
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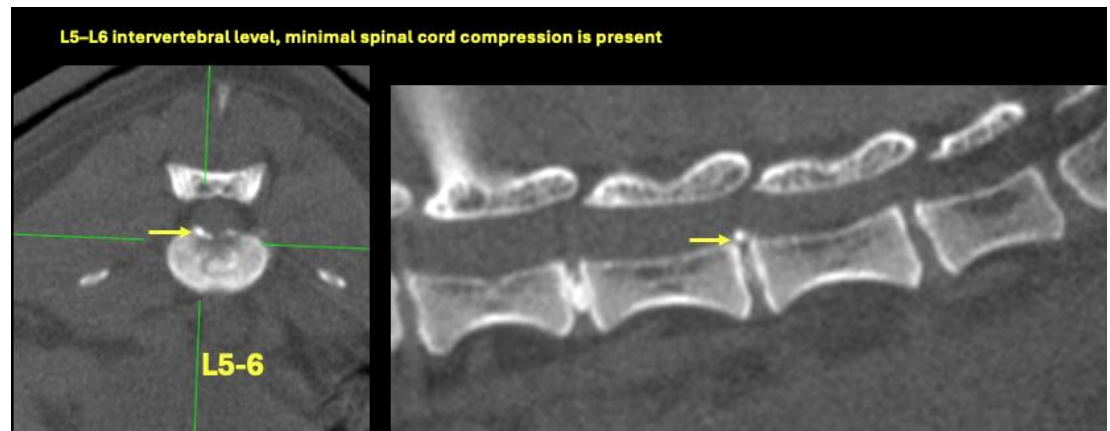
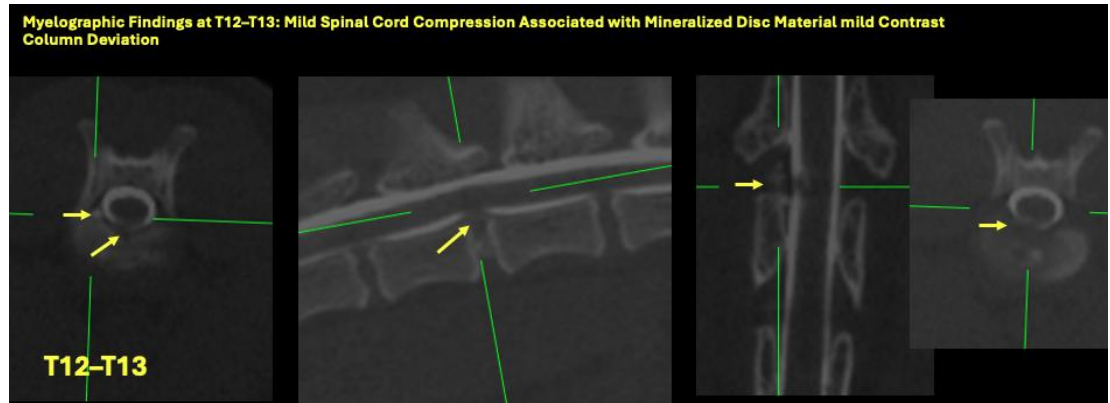
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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