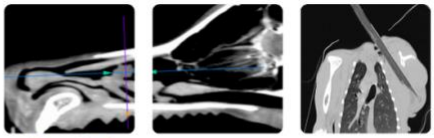


PATIENT

Tina Nicholson

SPECIES

Canine

BREED

Boston Terrier

SEX

Spayed Female

AGE

6 Years

WEIGHT

20 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Brittany Bethel CVT

HOSPITAL NAME

Williamsport West Veterinary Hospital

REFERRING VET

Dr. Stephanie Daverio VMD

INVOICE

14048

DATE

03/04/26

PRESENTING CLINICAL SIGNS

- Pt presented today as referral for CT. This past Friday was playing fetch, she turned and yelped, then started limping on hind right. Saturday back to playing and WNL. Sunday O came home in the afternoon, and P ran out the door to greet her, then fell over door ledge when she was walking back in. She got up and went to the living room, but O notice she was NWB RF. Was able to sit normally after that, but then she was dragging front right and knuckling front right. When Casey opened the treat jar P did jump off the couch and run to the treat, but after that was not able to walk well on own. Within 30 minutes of tripping over the door, she was unable to stand on own and was dragging herself. She was lateral on their ride over. Right pupil small and 3rd eyelid visible upon presenting to Metzger's. Got HWP on Sunday (Milbegard). O also noted that she is unable to hold herself up to E/D and needs assistance. She did seem uncomfortable and painful last night when laid on left side, but not on right (seems to be shoulder/neck origin). P is panting and shaking a lot, presumed to be painful.

COMPUTED TOMOGRAPHIC STUDY OF THE HEAD, NECK AND SPINE

Pre- and post-contrast computed tomography of the head, neck, and spine was provided for review totaling 4 series. Pre-contrast head and neck (bone algorithm). Pre-contrast thoracic and lumbar spine (bone algorithm). Post-contrast head and neck (soft tissue algorithm)

COMPUTED TOMOGRAPHIC FINDINGS

HEAD & NECK

The brain parenchyma is normal in attenuation and symmetric. No intracranial mass effect is identified. No evidence of ventriculomegaly. No evidence of deviation of the falx cerebri is observed.

The calvarium, facial bones, and skull base demonstrate normal contour, attenuation, and structural integrity.

The left temporomandibular joint is subluxated. The right temporomandibular joint is congruent.

The nasal cavities and turbinate architecture are within normal limits.

Aberrant turbinates are present in the right choanal region, considered incidental.

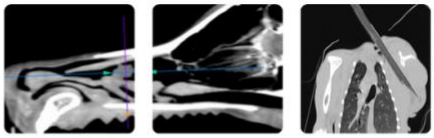
The frontal sinuses are rudimentary, considered an incidental anatomical variant.

The cribriform plate is intact.

The tympanic cavities are air-filled with normal wall thickness and contour. The external auditory canals are unremarkable.

Both globes are normal in size, shape, and attenuation. The retrobulbar spaces are unremarkable.

The nasopharynx and oropharynx are within normal limits. The soft palate is mildly elongated.



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Absence of Triadan 105, 106, 107, 205, 206, 310, 311, 410, and 411.Focal alveolar bone resorption adjacent to the roots of Triadan 108 and 110.

The medial retropharyngeal and mandibular lymph nodes are within normal limits.

The mandibular, parotid, and zygomatic salivary glands are unremarkable.

The thyroid glands are unremarkable.

The trachea and cervical esophagus are within normal limits.

CERVICAL, THORACIC AND LUMBAR SPINE

The vertebral column demonstrates a normal vertebral formula (C1–C7, T1–T13, L1–L7, sacrum).

Overall vertebral alignment is within normal anatomical limits.

A T7 hemivertebra is identified. At the T6–T7 level, a small volume of mineral hyperattenuating material is present along the ventral and right aspect of the vertebral canal, resulting in mild spinal cord compression and mild leftward deviation.

A tiny amount of discrete hyperattenuating extradural material is present along the ventral floor of the vertebral canal at the level of L2–L3. No clear evidence of spinal cord compression.

Multifocal incomplete and complete bridging spondylosis deformans is observed at: L2–L3C2-3, C7-T1, T11-12, T12-13, T13-L1, L1-2, and L2-3.

The remaining vertebral bodies are normal in size, shape, and attenuation.

No aggressive osseous lesions are identified.

The intervertebral disc spaces are preserved.

The adjacent paraspinal musculature is symmetrical and unremarkable.

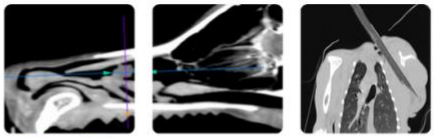
The coxofemoral joints are incongruent (> right), with mild periarticular osteophyte formation at the right side.

Incidental Findings (Collimated Structures). A small incidental cortical renal microcyst is present in the left kidney, measuring approximately 3.6 mm. A urinary catheter is present within the urinary bladder.

COMPUTED TOMOGRAPHIC DIAGNOSIS

The CT examination of the brain and intracranial structures is within normal limits.

Absence of Triadan 105, 106, 107, 205, 206, 310, 311, 410, and 411.Focal periodontal disease adjacent to the roots of Triadan 108 and 110.



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The left temporomandibular joint is subluxated.

Small mineralized extradural focus at T6–T7, located ventrally and to the right within the vertebral canal, resulting in mild spinal cord compression and deviation. Differential diagnoses include mineralized intervertebral disc herniation and/or dorsal proliferative degenerative changes because of adjacent hemivertebra.

Tiny amount of discrete hyperattenuating extradural material is present along the ventral floor of the vertebral canal at the level of L2–L3, without evidence of spinal cord compression.

T7 hemivertebra, likely incidental.

Multifocal spondylosis deformans of the cervical, thoracic, and cranial lumbar spine.

Left temporomandibular joint subluxation.

Bilateral coxofemoral incongruency and right side concurrent mild osteoarthrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The CT examination of the brain and intracranial structures is within normal limits. It should be noted that computed tomography has lower sensitivity than magnetic resonance imaging (MRI) for some specific intracranial diseases, for example, including inflammatory or infectious meningitis, cerebrovascular disease, and certain intracranial neoplasms.

Within the spine, a small, mineralized focus is identified at the T6–T7 level within the ventral right aspect of the vertebral canal, resulting in mild spinal cord compression. This finding may represent a mineralized intervertebral disc herniation and/or dorsal proliferative degenerative changes associated with the adjacent hemivertebra. The clinical significance of this finding is uncertain and may or may not correlate with the patient's neurological signs.

The T7 hemivertebra is considered an incidental congenital malformation.

Additional degenerative changes, including multifocal spondylosis deformans, are noted and are likely incidental or age-related, with low clinical relevance.

Importantly, computed tomography has limited sensitivity for detecting non-mineralized disc extrusion, acute hydrated nucleus pulposus extrusion (HNPE), fibrocartilaginous embolism (FCE), inflammatory myelopathy, ischemic myelopathy, or intramedullary spinal cord disease.

Further diagnostic evaluation may include cerebrospinal fluid (CSF) analysis if inflammatory or infectious myelopathy is suspected, and magnetic resonance imaging (MRI) for more detailed assessment of the spinal cord and soft tissue adjacent structures.

Correlation with the neurological examination findings is recommended.

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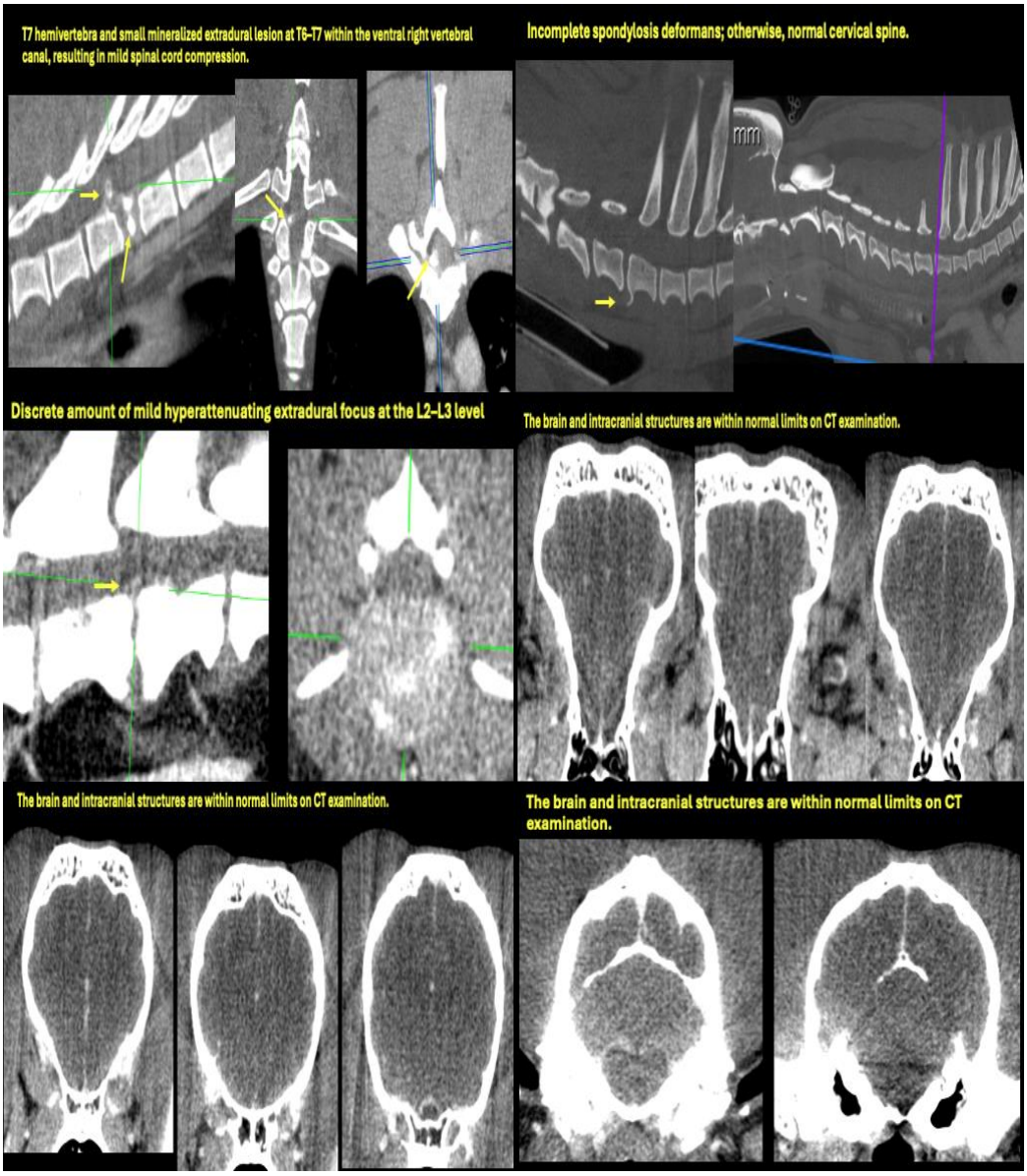

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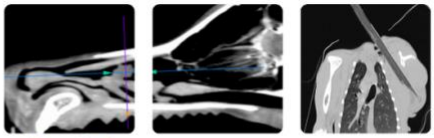

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Educational Teleconsultation Services™

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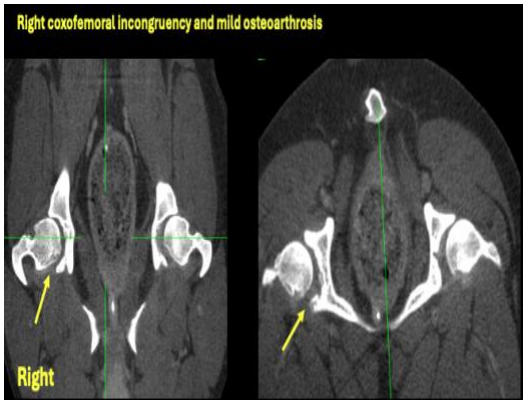

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tilde Rodrigues Froes, DMV, MSc., Dr. Med.Vet., Dipl.CBraRVet
info@sonopath.com