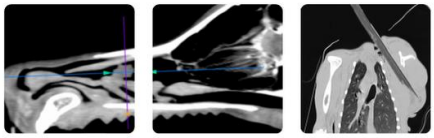

PATIENT

Aries Orvald

SPECIES

Canine

BREED

Pitbull Mix

SEX

MN

AGE

8Y

WEIGHT

47.1kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica

HOSPITAL NAME

Southern Oregon Veterinary Specialty Center

REFERRING VET

Dr. Riddle

INVOICE

75305

DATE

6-3-26

PRESENTING CLINICAL SIGNS

48 hour progressive history from ataxia to paraplegia, deep pain intact, TL hyperesthesia

COMPUTED TOMOGRAPHIC STUDY OF THE THORACIC & LUMBAR SPINE

Pre-contrast CT examination of the thoracic and lumbar spine followed by CT myelography are provided for review (transverse, bone algorithm).

COMPUTED TOMOGRAPHIC FINDINGS

LUMBAR & LUMBOSACRAL SPINE

The vertebral formula is normal (T1–T13, L1–L7, sacrum, and Cd1–Cd6). Vertebral alignment is maintained.

At the L3–L4 intervertebral disc space, there is a moderate volume of mixed-attenuating extradural material located ventrolaterally on the left, occupying approximately 35% of the vertebral canal diameter and resulting in mild to moderate spinal cord compression. The corresponding intervertebral disc is heterogeneous and contains mineralized mixed disc material.

At L6–L7 and L7–S1, there is a moderate volume of mixed-attenuating ventral extradural material occupying approximately 25% of the vertebral canal diameter, causing mild compression of the cauda equina/spinal canal contents and impingement of adjacent nerve roots. The L6–L7 intervertebral disc is heterogeneous with mineralized disc material.

Multifocal in-situ mineralization of intervertebral discs is present throughout the thoracolumbar spine.

Mild irregularity of the L7–S1 vertebral endplates with small subchondral cystic changes is present. Mild subchondral cystic change is also noted within the right sacroiliac joint.

Multifocal incomplete bridging spondylosis deformans is present at T4–T5, T5–T6, T12–T13, L3–L4, L5-6 and L7–S1. At L7-S1 the spondylosis deformans is pronounced, with ventral and lateral osteophyte proliferation resulting in subjective narrowing of the intervertebral foramina at this level.

The paraspinal soft tissues are unremarkable.

Myelographic Findings

Following contrast administration at L6–L7, contrast medium is identified within the subarachnoid and epidural spaces with satisfactory cranial progression to approximately T1 along both dorsal and ventral contrast columns.

At L3–L4, mild focal attenuation of the ventral contrast column is present, consistent with mild-to-moderate ventral extradural spinal cord compression.

At L6–L7, discrete attenuation of the ventral contrast column is present, consistent with discrete extradural compression.

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Mild multifocal irregularities of the ventral contrast column at the injection site are considered artifactual. Mild extravasation of contrast medium into the adjacent subcutaneous tissues is present at the injection site.

Bilateral shoulder periarticular ossifications.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Left ventrolateral extradural disc extrusion/protrusion at L3–L4 resulting in mild to moderate spinal cord compression.
- Additional chronic degenerative disc disease with smaller ventral disc protrusions/extrusions at L6–L7 and L7–S1, causing mild spinal canal and nerve root compression.
- Multifocal in-situ intervertebral disc mineralization consistent with multifocal intervertebral disc degeneration. Differential diagnosis incipient discospondylitis.
- Mild degenerative lumbosacral endplate and sacroiliac joint changes.
- Multifocal mild spondylosis deformans, most severe at L7–S1, where ventral and lateral osteophyte proliferation is noted, resulting in subjective narrowing of the neurovascular foramina at this level.
- Bilateral shoulder osteoarthrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The imaging findings support a diagnosis of thoracolumbar intervertebral disc herniation (protrusion/extrusion) centered at L3–L4, producing mild to moderate spinal cord compression. The presence of concurrent heterogeneous in-situ material may be consistent with acute-on-chronic herniation. This lesion is the most clinically significant abnormality and likely accounts for the patient's acute thoracolumbar myelopathy and paraplegia.

The L6–L7 and L7–S1 lesions also appear chronic and may be of lesser clinical significance based on the degree of compression identified.

Correlation with neurological examination findings is recommended. Given the multiple affected sites and concurrent in-situ disc degenerations, clinical therapy response and disease progression should be accounted for before surgical decompression is considered.

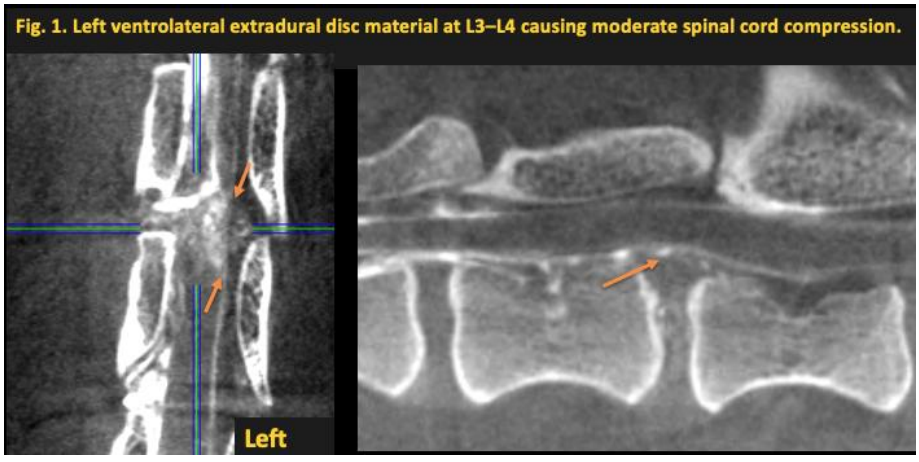

Fig. 1. Left ventrolateral extradural disc material at L3–L4 causing moderate spinal cord compression.

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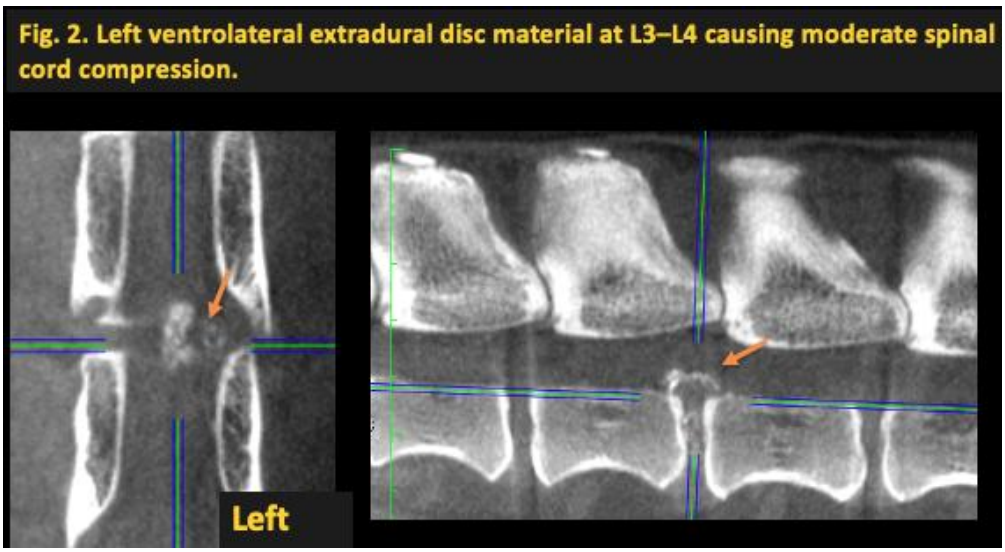

Fig. 2. Left ventrolateral extradural disc material at L3–L4 causing moderate spinal cord compression.

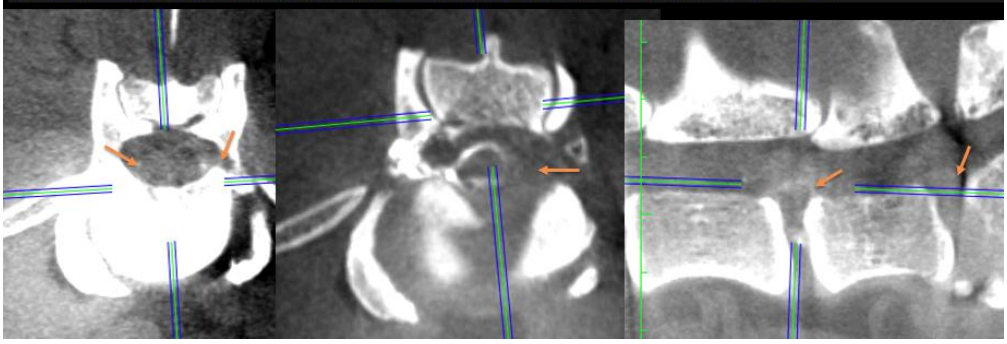

Fig. 3. L6–L7 and L7–S1 degenerative disc disease
Ventral extradural disc material at L6–L7 and L7–S1 causing mild canal narrowing and nerve root impingement.

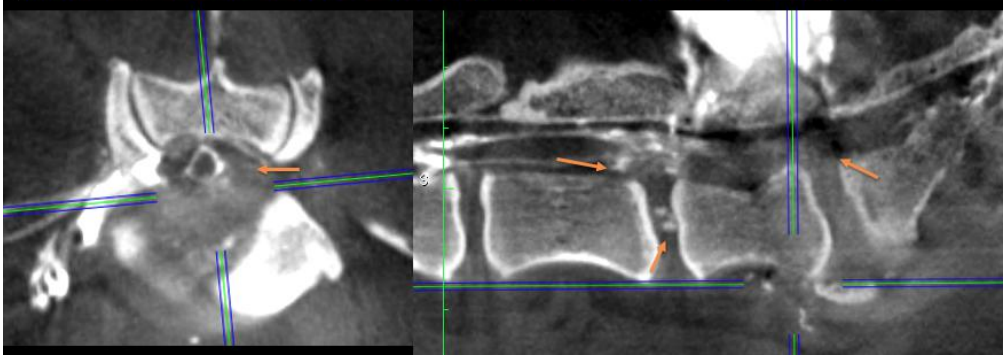

Fig. 4. L6–L7 and L7–S1 degenerative disc disease
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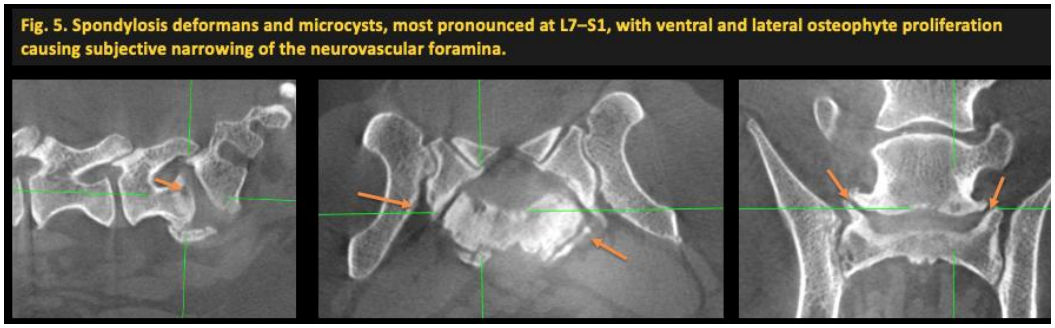

Fig. 5. Spondylosis deformans and microcysts, most pronounced at L7–S1, with ventral and lateral osteophyte proliferation causing subjective narrowing of the neurovascular foramina.

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