



PATIENT PRESENTING CLINICAL SIGNS

PATIENT Petey Mantyh
SPECIES Canine
BREED Golden Retriever

History: Presented 8/24/21 for walnut sized mass on left hip that was noted 1 week prior. Still taking walks with o, not acting painful. Cytology suspicious for sarcoma. History of two previous MCT removal surgeries. On exam, large mass left flank - approx 9.6 cm x 14 cm, firm, fixed and uncomfortable on deep palpation. NSOU, small lower left eyelid mass. Static dermal masses on top of head (adenoma like). Approx 1 cm dermal mass at caudoventral base of each pinna. Static dermal mass cranial aspect left elbow at proximal extent of previous surgical scar. Static 0.5 cm raised firm dermal mass left lateral thorax. Mass in Left flank fold increased in size, now approx 1 cm. Previous MCT sites quiet, no palpable mass recurrence appreciated. Approx 5 mm dermal mass left lateral thigh.

Abnormal PE/Chem/CBC/UA Results: Large mass on flank

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX & ABDOMEN

SEX

Neutered Male

Chest:

There is no evidence of pulmonary/mediastinal metastasis. Thoracic trachea and esophagus present as expected. Diaphragm is normal.

AGE

14 Years

The extra-thoracic soft tissues present an increased subcutaneous opacity at the level of the left cranial thoracic wall., thoracic spine as well as ribs and sternum are unremarkable. There is no evidence of bony lysis or abnormal sclerosis.

INTERPRETED BY

Sebastian Jawinski,
 German Board
 Certified Vet Specialist
 in Diagnostic Imaging

Abdomen:

There is a large mass in the area of the left flank noted with maximum diameters of approximately 11 cm. The lesion is rounded and shows capsule like margins with a predominantly hypodense center. The caudal tip and transition to the adjacent soft tissues are mildly fuzzy. Ring enhancement is recognized. The mass mainly is located retroperitoneal deviating the left kidney medially and the protruding the abdominal wall outwards. The tip of the transverse process of L6 reaches the mass, periosteal changes are not recognized. Margins to the kidney and the sub-lumbar musculature are clearly defined. Borders to the muscles of the abdominal wall become indistinct with an indicated "golf tee" sign at the level of the cranial and caudal tip. The peripheral fat tissue shows mildly increased density.

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Meaux

The spleen presents a hypodense nodule of 1.15 cm with mild ring enhancement in the cranio-ventral section. Protrusion of the splenic surface is not recognized.

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The stomach is moderately gas distended and reveals a mass of the gastric wall with diameters of 2.66 x 3.12 cm. Discontinuity of the wall layering is suspected as far as can be assessed.

A small gallbladder stone is detected an incidental finding. Abdominal organs are inconspicuous.

DATE

9/2/21



PATIENT Abdominal lymph nodes and abdominal vessels have no particular findings. Signs of peritoneal/retroperitoneal effusion or free gas are not recognized.

Petey Mantyh

COMPUTED TOMOGRAPHIC DIAGNOSIS

- SPECIES**
- Large retroperitoneal mass left flank
 - Gastric mass
- Canine
- Hypodense nodule spleen
 - Subcutaneous opacity left cranial thorax
 - Calculus gallbladder

BREED

Golden Retriever

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

SEX

Neutered Male

The CT findings of the left flank most likely present malignant neoplasia. The mass is likely originating from the abdominal wall/abdominal musculature involving the retroperitoneum. Fibrosarcoma and rhabdomyosarcoma are common differentials. Borders to the left kidney and the sub-lumbar muscles are respected. The capsule and the ring-enhancing contrast uptake may represent secondary inflammation/abscess formation and central necrosis. With the latter more peripheral reaction or phlegmonous changes should be expected. Foreign material is not recognized.

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The splenic nodule is suspicious for a metastasis or initial fibro-/hemangiosarcoma. Focal splenic hemorrhage may be a differential but is unlikely. The gastric mass is associated with the wall and destruction of the gastric wall layering is suspected. Primary neoplasia including adenocarcinoma, lymphoma or another metastasis is likely.

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I suspect curative resection of the large retroperitoneal mass is not possible since it should include the abdominal wall and the surrounding fat tissue widely as well as the left transverse process of L6. Beside that splenic and gastric neoplasia/metastasis is likely.

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The subcutaneous opacity of the left cranial thorax could represent scar tissue or residual mammary tissue. FNA/Biopsy would be needed for further evaluation.

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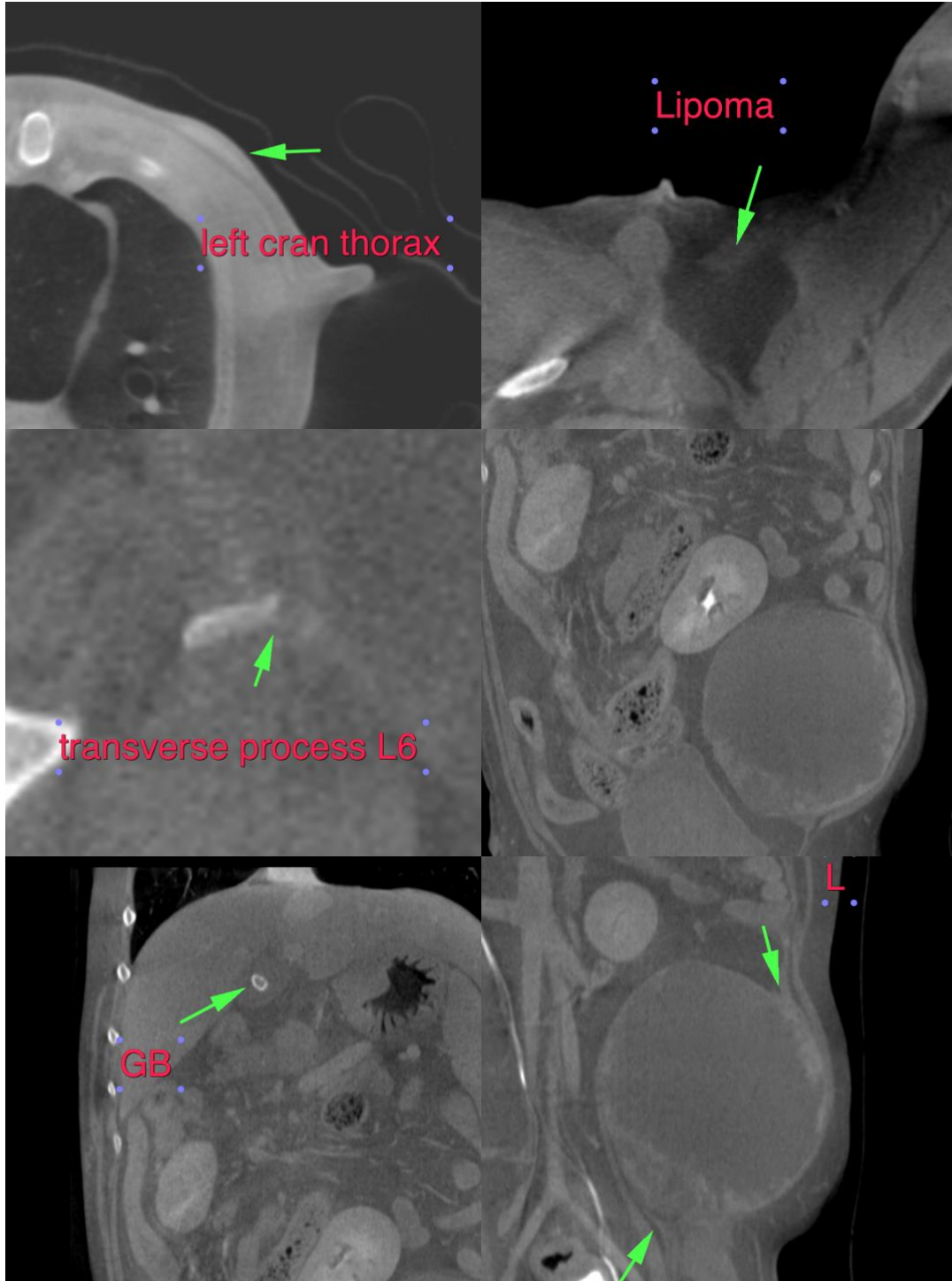
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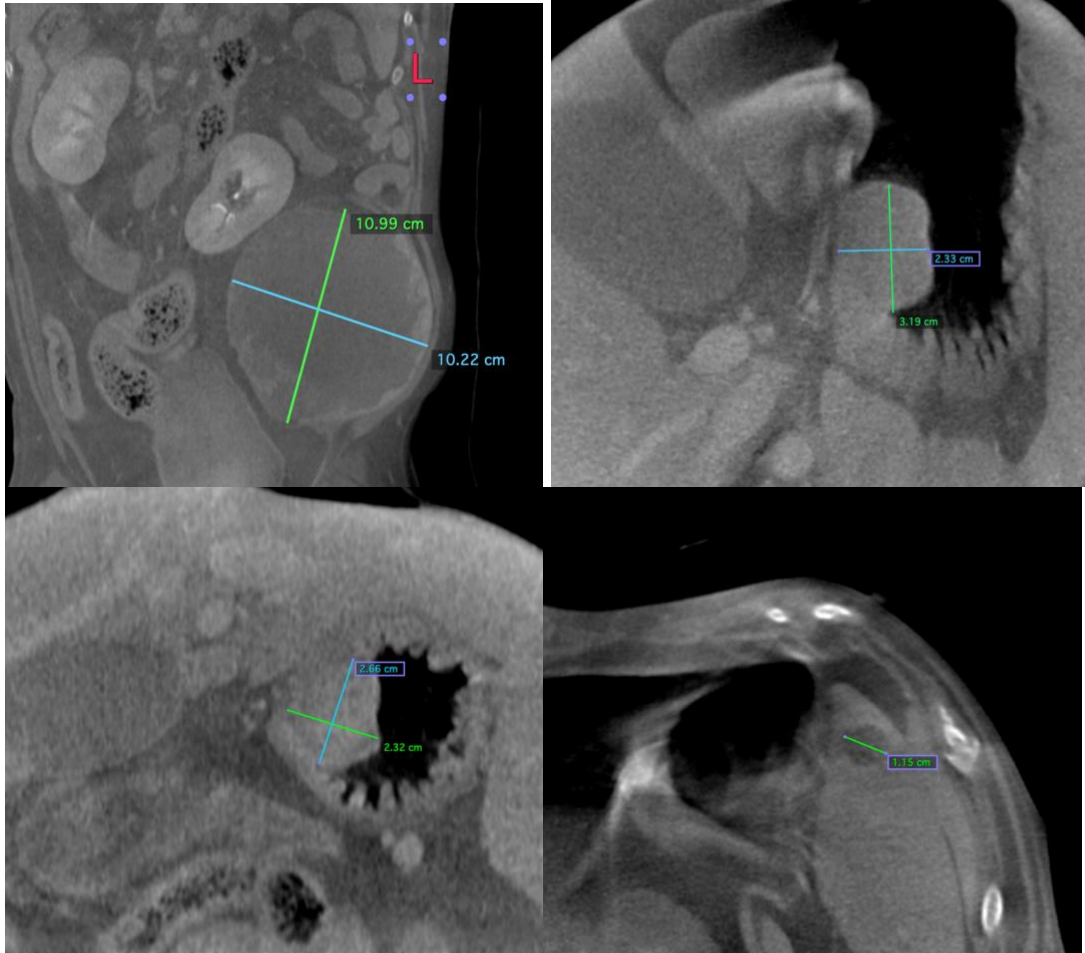
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Sebastian Jawinski, German Board Certified Vet Specialist in Diagnostic Imaging
info@sonopath.com