



PATIENT

Jackie Hahm

SPECIES

Canine

BREED

Jack Russell Terrier

SEX

Neutered Male

AGE

14.5

WEIGHT

8.8 kg

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVCI

IMAGING PERFORMED BY

EH

HOSPITAL NAME

Crown VS & A

REFERRING VET

Dr. Ariel Schlag

INVOICE

35369

DATE

10/30/25

PRESENTING CLINICAL SIGNS

History: Dorsal rectal mass found 10/13/25 when pt presented for diarrhea and hematechezia Hx: of B1 AV valve disease, chronic cough, vasovagal/syncopal episodes 15 yo MC JRT presenting for rectal mass and hematochezia. VEG on 10/13/25 for vomiting 2x, hematochezia, tenesmus, soft stool. Last dose of amoxicillin/clavulanate prior to this ER visit with VEG. Dorsal rectal mass palpated at that time. Blood on DRE. Chronic coughing. No treatments attempted for rectal mass yet. Problem started 1 week ago (tenesmus, hematochezia). Leash 2x/day for 20-30 min. Exercise intolerance noted after these walks (20-30 min). Decreased energy, normal appetite, increased water intake compared to other dogs his entire life, normal urination. Defecation - Tenesmus, hematochezia (improving since stopping amoxicillin/clav). Coughing when gets excited (mostly in AM and PM) and occasional syncopal episodes. No seizures. No sneezing or diarrhea. Occasional vomiting. Dorsal to right-sided rectal mass (firm, fixed, located 1.2 cm cranial to the anus. Approximately 4.2 cm (L) x 3.5 cm (W) x 2 cm (H). > 80% of rectal lumen feels compressed. Rectal mass palpates as if originating from within rectal wall rather than mucosal but unable to fully differentiate layer of origin. Scant hematochezia noted. No anal sac masses noted. Normal anal sac material expressed. Ddx - ACA, leiomyoma, leiomyosarcoma, gastrointestinal stromal tumor (GIST), LSA, MCT, carcinoids vs. extra-rectal (prostate, metastatic lymph node).

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX AND ABDOMEN

A high resolution pre- and post-contrast CT study of the thorax and abdomen is provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

Thorax

Level with the 12th right rib, in the subcutaneous tissue, a well-defined, ovoid shaped, uniform soft tissue attenuating nodule is seen.

The sternal, cranial mediastinal and tracheobronchial lymph nodes are small elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform and considered within normal limits.

The cardiovascular structures including the pulmonary vasculature are within normal limits.

The bronchial tree presents with regular branching and tapers uniformly towards the periphery as expected, the bronchial walls are thin and smooth. The bronchus-to-artery ratio is within normal limits.

In the medial aspect of the left caudal lung lobe, a well-defined, uniform soft tissue attenuating nodule is seen, measuring 8 mm in diameter. In the craniodorsal aspect of the left caudal lung lobe, a thick-walled lesion, presenting a small gas attenuating center is visible, measuring 4 mm in diameter. A well-defined, roundish gas attenuating lesion is seen in the lateral aspect of the left caudal lung lobe, demarcated by a thin, soft tissue attenuating wall.

Small incidental gas pockets are seen within the esophageal lumen; there is no evidence of abnormal dilation.

Abdomen



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The serosal fat presents normal attenuation behavior. There is no evidence of peritoneal effusion or peritonitis.

Both kidneys present within normal limits for size, shape and organ architecture. After contrast administration throughout the renal parenchyma bilaterally, well-defined, roundish parenchymal filling defects are visible; measuring <2 mm.

Nodular enlargement of the cranial pole of the left adrenal gland is visible, measuring up to 11 mm in diameter.

Both liver and spleen present with normal shape, even surface, uniformly attenuating parenchyma and homogeneous contrast enhancement, unremarkable.

The portal vein presents a normal order of its tributary veins and intrahepatic branching. No abnormal vessel is noted inside and outside of the liver parenchyma.

The pancreas is evenly contoured; the pancreatic parenchyma is homogeneous and presents uniform contrast enhancement.

Level with the cardia, in the gastric wall, an irregular roundish, soft tissue attenuating nodule with faint granular mineralization is seen, measuring approximately 11 mm in diameter.

In the dorsal aspect of the pelvic canal, an ovoid shaped, well-defined, soft tissue attenuating mass with interspersed irregular mineralization is present, measuring 3.7 cm in diameter and 5.0 cm in length. The rectum level with the mass is deviated ventrally and compressed. The mass in the dorsal aspect of the pelvic canal is occupying approximately 70% of the cross-sectional area of the pelvic canal.

The anal sacs appear unremarkable.

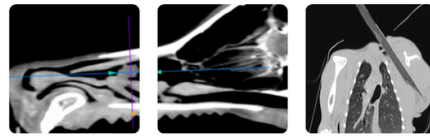
COMPUTED TOMOGRAPHIC DIAGNOSIS

- Soft tissue mass dorsal aspect of the pelvic canal with dystrophic mineralization, blending with the dorsal rectal wall at the same level
- Nodular enlargement left adrenal gland
- Suspect small leiomyoma level with cardia of the stomach – likely incidental
- Solitary pulmonary soft tissue nodule and thick walled cavitory pulmonary lesion
- Non-specific subcutaneous nodule level with the 12th right rib.
- Bulla left caudal lung lobe
- Multiple simple renal cysts

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Due to the size of the mass in the dorsal aspect of the pelvic canal, specification if the mass is intra- or extramural is not possible. Differentials include sarcoma, benign fibroma, rectal adenocarcinoma/leiomyosarcoma/round cell tumor/other or enlarged sacral lymph node (e.g. metastasis of a small mass of the anal sac).

The nodular enlargement of the left adrenal gland can be caused by (non)functional adrenal nodular hyperplasia or neoplastic transformation (e.g. adenoma, adenocarcinoma, pheochromocytoma).



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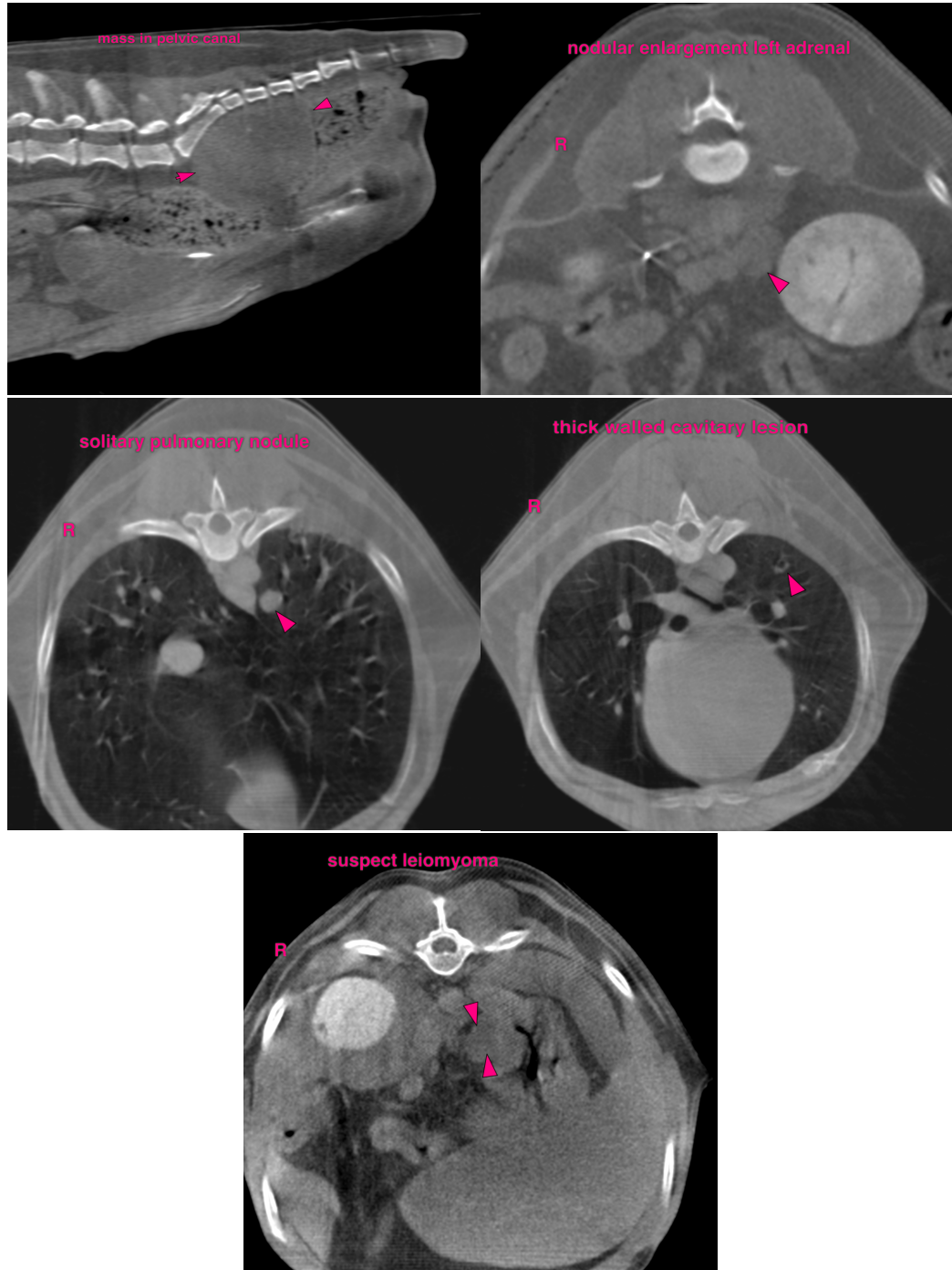
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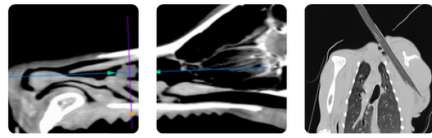
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The solitary pulmonary nodule is not specific and potentials include granuloma, fibrosis, round pneumonia/mucus impaction or metastasis. The small thick walled cavitary lesion can increase the odds for pulmonary metastatic disease.



The information and recommendations provided are based on the images presented by the



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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, DVM, Dr. med. vet. DipECVDI
info@sonopath.com