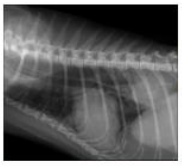
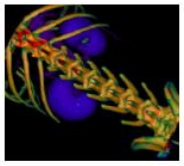
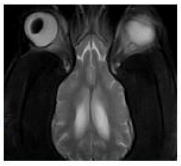

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1-800-838-4268 info@sonopath.com

PATIENT

Dante Walsh

SPECIES

Canine

BREED

Siberian Husky

SEX

Neutered Male

AGE

10 Years

INTERPRETED BY

Sebastian Schaub, DVM Dr. med. vet. DipECVDI

HOSPITAL NAME

Animal Health Partners

REFERRING VET

Dr. Lea Mehrkens

INVOICE

18225

DATE

11/25/22

PRESENTING CLINICAL SIGNS

History: Dante, a 10 year old Male Neutered Siberian Husky, was presented to the Toronto Animal Health Partners Surgery Service for right stifle subcutaneous mass. *Referring Hospital: Campbellville Animal Hospital * **Recent History** - Subcutaneous mass on right stifle region first noted in April 2022 (7-8 months ago), which was initially 2-3 cm in diameter but has progressed significantly in size recently. The mass does not cause discomfort, but possibly affecting mobility. - Presented to referrring veterinarian on Oct 27 - PE: no peripheral lymphadenopathy; auscultation unremarkable - b/w, FNA performed - Current systemic health - Normal appetite, U/D - No V/D/C/S - less energetic - Diagnostics performed - Bloodwork - Oct 27, 22 - CBC: WNL - Chem: WNL - TT4: WNL - FNA of the left stifle mass - Oct 27: non-productive. most RBC but there was a cluster of cells with oval nuclei with increased N/C ratio with tailed cytoplasm **Previous History** - Hx of mildly elevated liver enzyme: ALP (179 U/L, ref 5-160) (June, 2022)
Abnormal PE/Chem/CBC/UA Results:

COMPUTED TOMOGRAPHIC STUDY OF THE THORAX, ABDOMEN AND PELVIC LIMBS

A pre- and post-contrast CT study of the abdomen and hind limbs and a plain CT study of the front limbs in a bone, lung and soft tissue reconstruction are provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

Thorax

Multifocal spondylosis formation is seen along the thoracic spine. Level with the intervertebral disc space T11/T12 and T12/T13, disc material is protruding into the vertebral canal, occupying approximately up to 75% of the cross-sectional area of the vertebral canal at the same level – most accentuated level T11/T12 with right sided deviation and distortion of the dural tube.

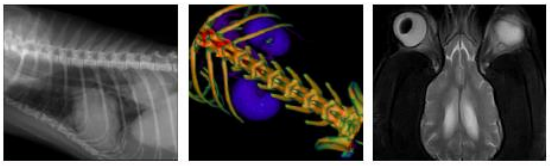
The sternal, cranial mediastinal and tracheobronchial lymph nodes are small elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform and considered within normal limits.

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.
The lung parenchyma presents the expected architecture and attenuation behavior, but zones of dystelectasis of the lung parenchyma of the caudodorsal aspects of the lung field.

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. The right medial iliac lymph node is prominent.

Both kidneys present within normal limits for size, shape and organ architecture. After contrast administration a bilaterally symmetric and uniform nephro- and pyelogram is noted.

The adrenal glands are within normal limits for size, shape and organ architecture.

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

The gallbladder contains a moderate amount of sedimented, hyperattenuating biliary sludge.

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.

The position, delineation, wall and content of the gastrointestinal tract are considered within normal limits throughout.

The intervertebral discs T13/L1 to L4/L5 are mild to moderately protruding into the vertebral canal, occupying up to 30% of the cross-sectional area of the vertebral canal at the same level.

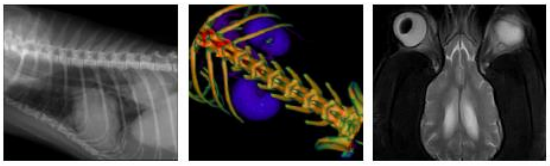
Hind Limbs

The periarticular bones of both coxofemoral joints present very mild osteophyte new bone formation. In the subcutaneous tissue at the craniolateral aspect of the right stifle joint, a well-defined, soft tissue attenuating and mild heterogeneous contrat enhancing mass is seen, measuring 8.1 x 5.0 x 9.0 cm in size. The mass is in close contact with the muscles of the crus and the thigh and the lateral femoral condyle and proximal tibia at the same level. The osseous structures level with the mass present without abnormalities.

The remainder of the osseous and soft tissue structures of both hind limbs are within normal limits.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Subcutaneous soft tissue mass craniolateral aspect right stifle joint
- Mild lymphadenopathy right medial iliac lymph node
- Marked intervertebral disc protrusion T11/T12 with compressive myelopathy
- Intervertebral disc protrusion T12/T13 to L4/L5 with potential dynamic myelocompression
- Dystelectasis of the lung parenchyma
- Mineralized biliary sludge



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- Spondylosis deformans
- No evidence of pulmonary metastatic disease

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The subcutaneous soft tissue mass at the craniolateral aspect of the right thigh is fitting the history of sarcoma or mas-cell tumor are considered as the top differentials. Although complete surgical excision of the mass is considered feasible, due to the close contact with the underlying soft tissues there is an increased risk for reoccurrence of the mass. Recommend discussing adjuvant treatment options with oncologist, based on histopathology results.

The prominent right medial iliac lymph node is equivocal for reactive hyperplasia or metastatic disease; Ultrasound guided FNA sampling can be used as advanced minimally invasive diagnostic tool.

The clinical relevance of the intervertebral disc protrusions is unclear, due to the lack of respective clinical signs – such as ataxia.

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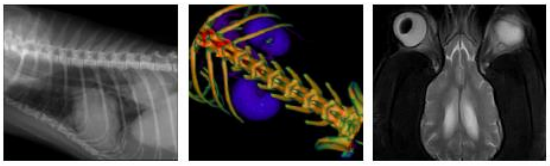

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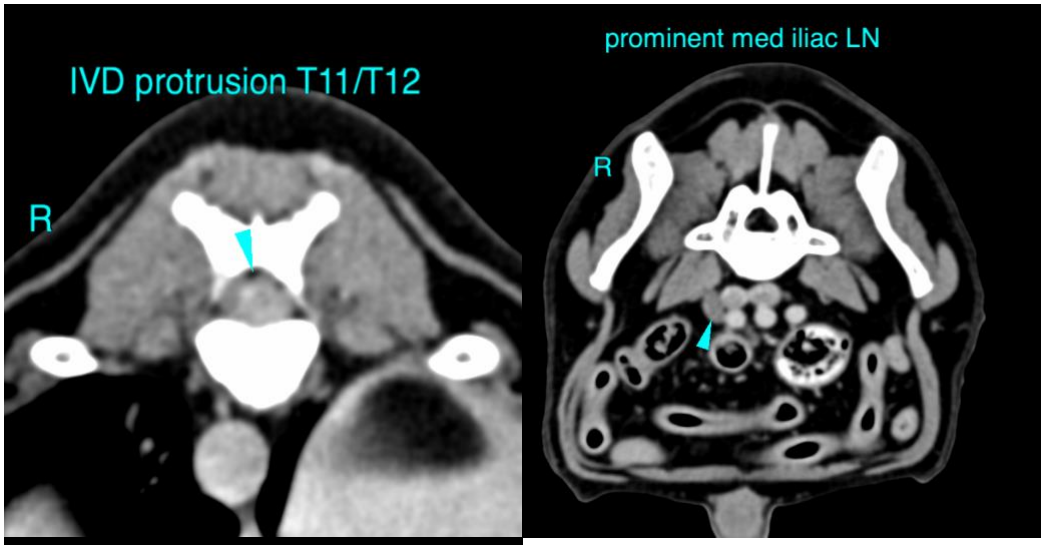

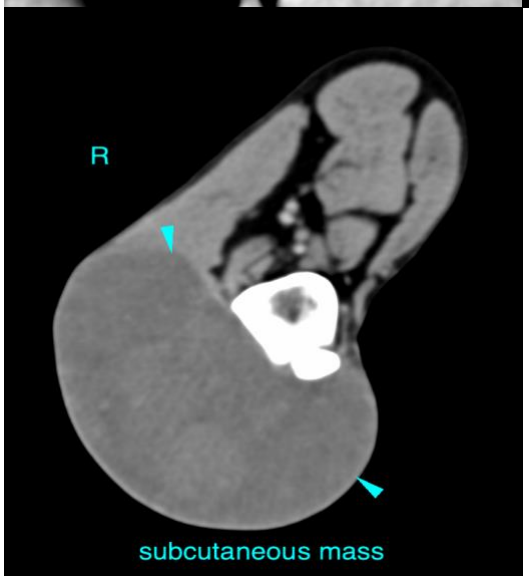

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI
sebast.schaub@gmail.com

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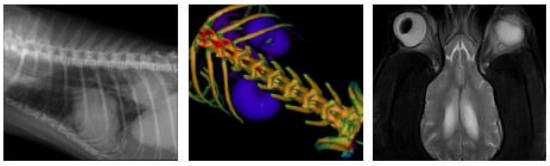

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