



PATIENT

Moxie Allard

SPECIES

Canine

BREED

Viszla

SEX

Intact Female

AGE

8 Years

WEIGHT

21 kg

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

IMAGING PERFORMED BY

Alissa Marsden

HOSPITAL NAME

Westford VERC

REFERRING VET

Dr. Maura Carney

INVOICE

35449

DATE

11/7/25

PRESENTING CLINICAL SIGNS

History: Patient has about a month history of some gagging /hacking, and firm swelling in area of right submandibular node. BW at pDVM overall unremarkable, mild increases ALT/ALP. The swelling can tend to wax and wane. An aspirate of the right sided swelling at pDVM showed reactive node. On Carprofen. Still eating and otherwise acting well. In more recent days, smaller firm swelling in area of left submandibular. On my exam, right sided swelling seems more in area of submandibular or parotid salivary gland, firm, about walnut sized. On left side, smaller (~lima bean sized), feels more like submandibular LN. No obvious oral lesions. Ran endoscope down esophagus-unremarkable. Performed aspirates of both larger right-side swelling (got some fluid material, clear) and smaller left side lesion (not very productive, only one slide with small amount material).

COMPUTED TOMOGRAPHIC STUDY OF THE SKULL, THORAX AND ABDOMEN

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

COMPUTED TOMOGRAPHIC FINDINGS

Skull

A supernumerary triadan 411 is seen.

The nasal cavity presents the expected aerated spaces between thin & even conchae and turbinates with smooth mucosal lining.

Both temporomandibular joints present congruent joint spaces with even subchondral bone surfaces and are considered within normal limits.

Both tympanic bullae are aerated, the mucosal lining is not seen, the bony wall is smooth and thin. The external ear canals are within normal limits.

The brain presents no deviation from normal anatomy and symmetry. The brain parenchyma is homogeneous and within normal limits for attenuation and distribution of contrast enhancement. The ventricular system is non-dilated and symmetric.

Both medial retropharyngeal lymph nodes and the mandibular lymph nodes are moderately enlarged, rounded, uniform soft tissue attenuating and heterogeneous contrast enhancing. The fat surrounding the respective lymph nodes presents moderate soft tissue striation.

Thorax

The vertebral endplates T12/T13 present mild spondylosis formation.

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.



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The lung parenchyma presents the expected architecture and attenuation behavior, but two small ill-defined subpleural zones with nodular pulmonary consolidation in the left cranial lung lobe.

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

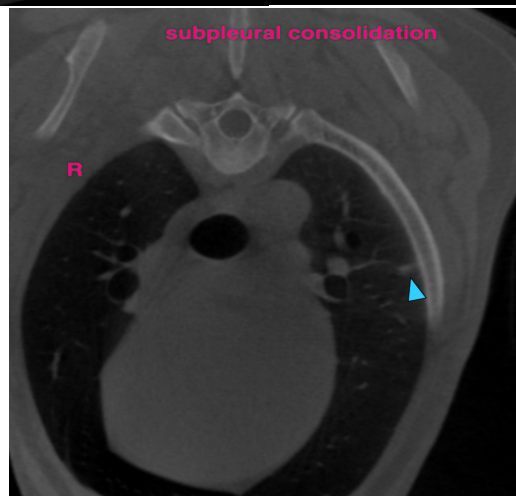
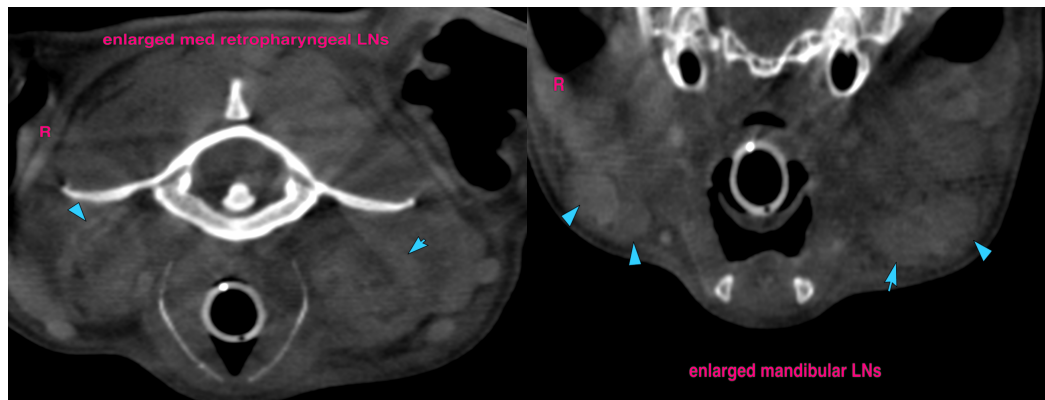
COMPUTED TOMOGRAPHIC DIAGNOSIS

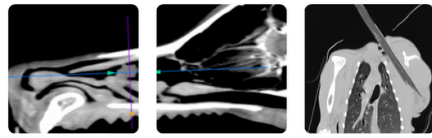
- Lymphadenopathy mandibular lymph nodes and medial retropharyngeal lymph nodes with surrounding cellulitis
- Two small ill-defined subpleural nodules left cranial lung lobe
- Supernumerary triadan 411

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The lymphadenopathy is highly suggestive for lymphadenitis – sterile versus septic – and surrounding cellulitis. Neoplastic infiltration of the affected lymph nodes is a potential, but cytology was negative for neoplastic disease. If underlying infectious cause can be ruled out, the lymphadenopathy may respond to steroid therapy.

The subpleural nodules are most suggestive for fibrosis or small granulomas/round pneumonia – the odds for neoplastic origin are very low.





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