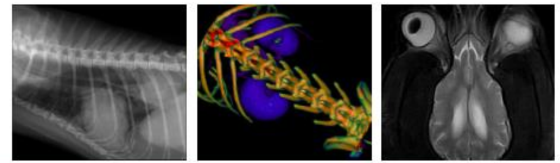


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Max Alvarenga

SPECIES

Canine

BREED

Jack Russell Terrier

SEX

Male Neutered

AGE

16 Years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Animal Surgical Center

REFERRING VET

West Hempstead Animal Hospital

INVOICE

56759

DATE

2-14-23

PRESENTING CLINICAL SIGNS

Unilateral Left sided epistaxis for about 2 weeks Mandibular Lymph Node plump but not overly enlarged generalized weakness History 2 year post left adrenalectomy (adenoma) with liver biopsy

COMPUTED TOMOGRAPHY OF THE SKULL & THORAX

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

COMPUTED TOMOGRAPHIC FINDINGS

Skull

The pictured parts of the dentition are complete and unremarkable in all jaw quadrants.

In the left nasal cavity, advanced destruction of the nasal conchal & turbinate structures is appreciated. A moderate amount of fluid attenuating material is attached to a thickened nasal mucosal lining in the left nasal cavity. The lateral wall of the left frontal sinus presents a zone with osteolysis, perforating the orbit – focal mild contrast enhancement is seen. The perpendicular plate of the left palatine bone presents multifocal moth eaten osteolytic lesions. The cribriform plate is intact.

The left zygomatic gland is mildly prominent and the intraparenchymal ducts are prominent. A focal punctuate mineralization of the parenchyma of the left zygomatic gland is seen.

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.

The submandibular and medial retropharyngeal lymph nodes are small and elongated with a normal short-to-long-axis-ratio is < 0.5, the attenuation and contrast enhancement pattern is uniform.

In the cranial pole of the right thyroid gland, a well-defined, post contrast hypoattenuating nodule is visible, measuring 6.4 mm.

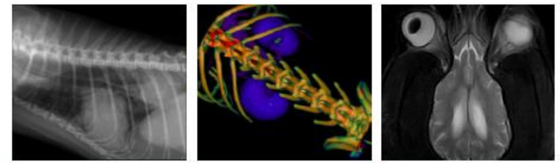
Mineralizations of the intramuscular fascial planes along the axial and shoulder musculature is appreciated.

Thorax

The bony and surrounding soft tissue structures are within normal limits.

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.



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Moderate dorsoventral flattening of the cervical tracheal segment is appreciated. 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.

Dystelectasis of the right lung lobes of the cranioventral aspects of the lung parenchyma are appreciated. The lung parenchyma presents the expected architecture and attenuation behavior.

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

COMPUTED TOMOGRAPHIC DIAGNOSIS

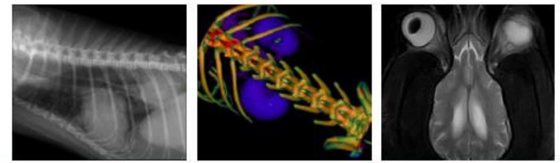
- Left sided advanced destructive rhinitis with polyostotic semiaggressive osteolytic lesions
- Intraparenchymal nodular lesion right thyroid gland
- Mild dystelectasis of the lung
- No evidence of pulmonary metastatic disease
- Mild calcinosis cutis
- Tracheal collapse
- Small sialolith left zygomatic salivary gland

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The advanced left sided destructive rhinitis with polyostotic osteolytic lesions is highly suggestive for underlying mycotic rhinitis (e.g. Aspergillus, Cryptococcus). There is no evidence of a nasal mass, and the findings are unusual for neoplastic disease. Theoretically very severe non-specific rhinitis is a consideration, but I would expect bilateral nasal changes. Recommend rhinoscopy including sampling for microbial culture and histopathology (detection of fungi microscopically is more straightforward than with culture in many cases).

The right thyroid nodule can present (non)functional macronodular thyroid hyperplasia, thyroid neoplasm (e.g. carcinoma) or adenoma of the parathyroid gland. If not done so yet, recommend complete blood work to screen for hypercalcemia and evaluation of T4 levels.

The appreciated calcinosis cutis can be a sequela to hyperadrenocorticism or hyperparathyroidism – correlate with potential laboratory changes.



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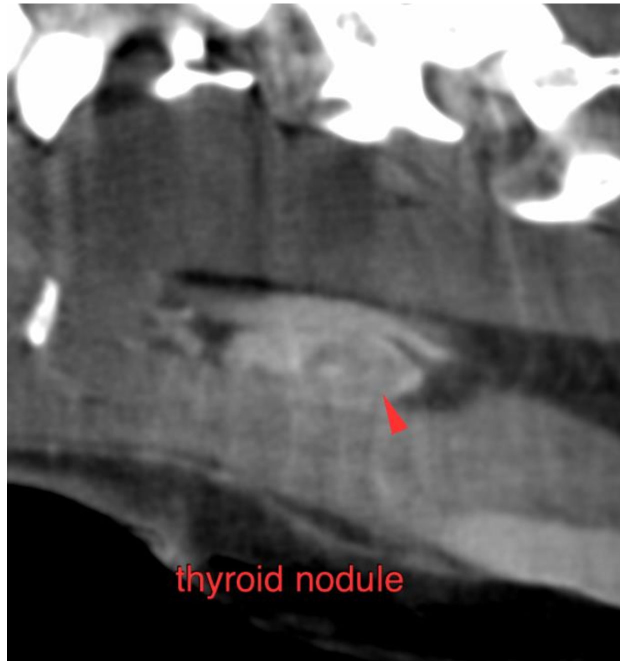

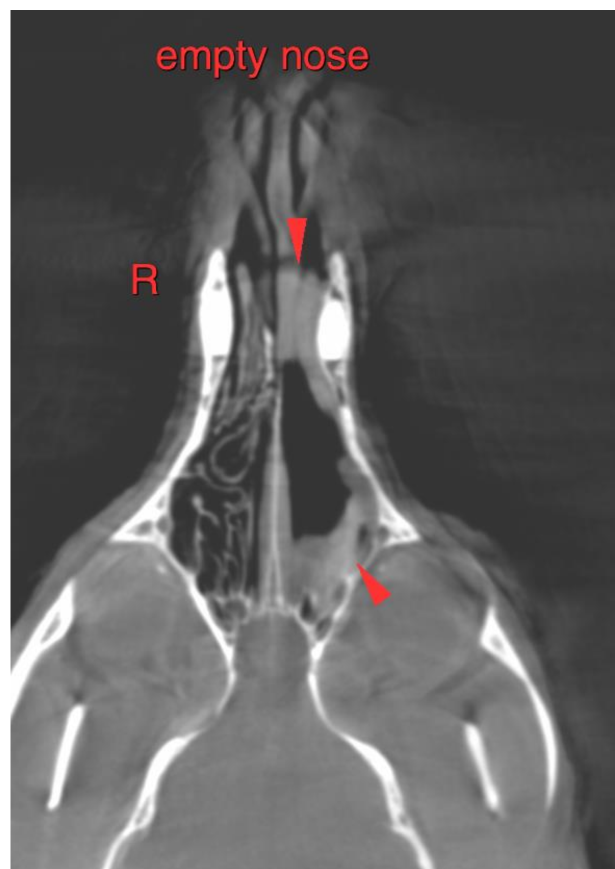

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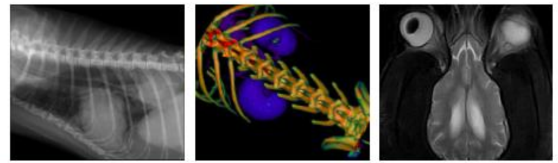

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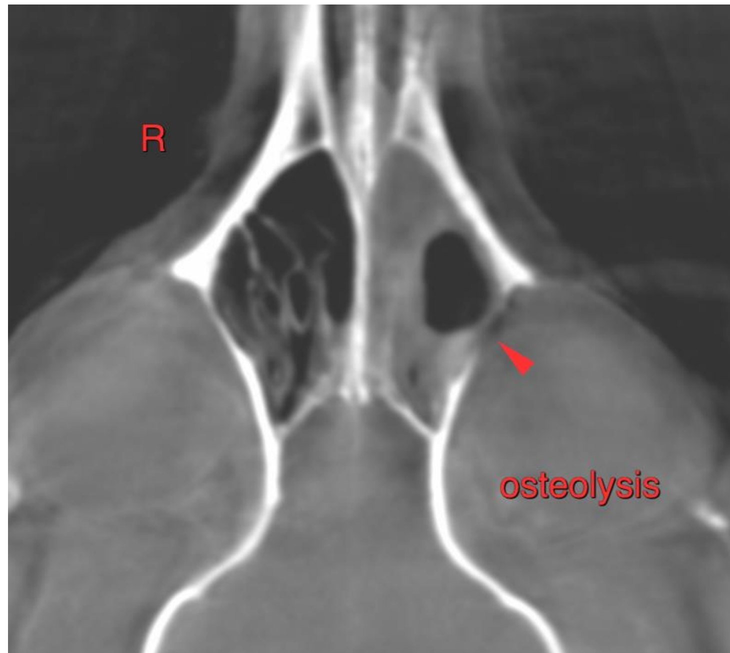

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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