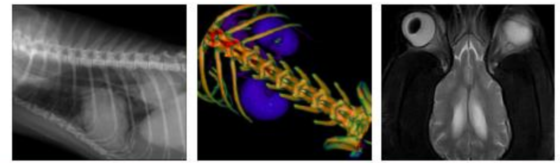


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Michelle Emerson

SPECIES

Feline

BREED

DLH

SEX

SF

AGE

15 Years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

VetMed Consultants

REFERRING VET

Kanda Hazelwood

INVOICE

50219

DATE

2-9-22

PRESENTING CLINICAL SIGNS

Michelle presented 3 weeks ago for stridor, abnormal swallowing, halitosis, unkept coat and weight loss (3 lbs over 2 years). A laryngeal mass was found during a sedated examination. The laryngeal mass was rechecked yesterday under sedation and mass has enlarged. Abdominal ultrasound shows changes in the intestines consistent with enteropathy, intestinal wall thickening, thickened intestinal muscular layer and enlarged jejunal lymph nodes. Chronic renal disease, right sided nephroliths with mild pelvic dilation and dilated common bile duct and pancreatic duct are also reported. Previous diagnosis: Herpes keratitis, renal disease, suspect GI disease Purpose of CT scan: Diagnostic Location of CT scan: Neck and chest Mass (behaviors): Growing in size over a couple weeks Therapies tried and response: Convenia inj improved halitosis due to dental disease. Current medication: famciclovir Current symptoms: Different sound when swallowing General health status: Appetite reduced, drinking okay. Vomited yesterday (when fasting). Stools okay - sometimes soft but formed.
Abnormal PE/Chem/CBC/UA Results: PE: Stridor audible, unkept coat, underweight Lab: Bloodwork is dated 1/21/22. CBC - PCV = 41%, WBC = 17500, neutrophils = 13125, lymphocytes = 1225, monocytes = 175, eosinophils = 2975. Platelets = 188,000. Chemistry - Precision PSL = 45, all else normal. Urinalysis - USG = 1.035, pH = 6.0, 1+ protein, WBC = 0, RBC = 0, no bacteria. Laryngoscopy: The oropharynx and laryngopharynx are imaged using a 2.7 mm 0-degree scope. Raised pink friable mass tissue infiltrates the left side of the larynx and arytenoid cartilage. The left arytenoid cartilage if thickened and stiff. The thickened arytenoid extends medially, occluding the laryngeal orifice. The rostral margin of the mass is biopsied. The mass is then debulked using biopsy instruments, a Coblation wand and an ENT shaver. After debulking, the right arytenoid is still thickened but the laryngeal orifice is more patent. The larynx is evaluated under light sedation and VI Dopram. Normal abduction during inspiration of the left arytenoid is observed. The right arytenoid cartilage does not move. The proximal trachea appears normal. Mass tissue does not extend caudally within the laryngeal lumen.

COMPUTED TOMOGRAPHY OF THE SKULL/NECK & THORAX

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

COMPUTED TOMOGRAPHIC FINDINGS

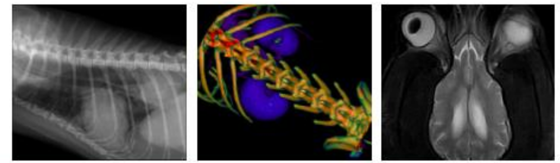
Skull/neck

Triadan 208 presents moderate resorptive lesions and focal geographic osteolytic lesion of the alveolar bone.

The nasal cavity presents the expected aerated spaces between thin & even conchae and turbinates with smooth mucosal lining. Level with the caudal aspect of the soft palate, a mucosal fold causes ring like narrowing of the nasopharynx. Centered on the region of the right arytenoid cartilage, an ill-defined, plaque like, uniform soft tissue attenuating and heterogeneous contrast enhancing mass is visible, crossing the mucosal layer into the submucosal tissues of the larynx. The laryngeal mass is measuring approximately 10 x 6 x 11 mm in size.

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.



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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 mandibular and medial retropharyngeal lymph nodes bilaterally are moderately enlarged, uniform soft tissue attenuating and heterogeneous contrast enhancing .

The esophagus is mildly dilated and contains a small amount of gas and fluid.

Thorax

Multifocal moderate spondylosis formation is seen along the caudal thoracic spine.

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.

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

The pancreatic duct is significantly dilated, measuring up to 8 mm in diameter.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Right sided laryngeal mural mass
- Lymphadenopathy mandibular and medial retropharyngeal lymph nodes
- Periodontal disease 208 with local osteitis
- Marked dilation of pancreatic duct – age related versus obstructive origin (e.g. pancreatitis or mass region of major duodenal papilla)
- Spondylosis deformans
- No evidence of pulmonary metastatic disease

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The laryngeal mass is compatible with neoplasia, presenting a local invasive growth. Differentials include lymphosarcoma, squamous cell carcinoma, melanoma, chondrosarcoma, other. Debulking the laryngeal mass has already been performed and radiation therapy is scheduled.

Recommend FNA sampling of the regional lymph nodes to screen for metastatic spread.

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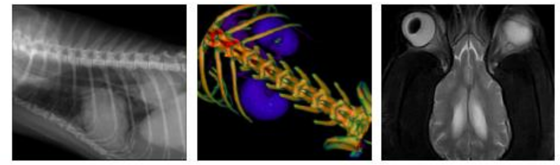

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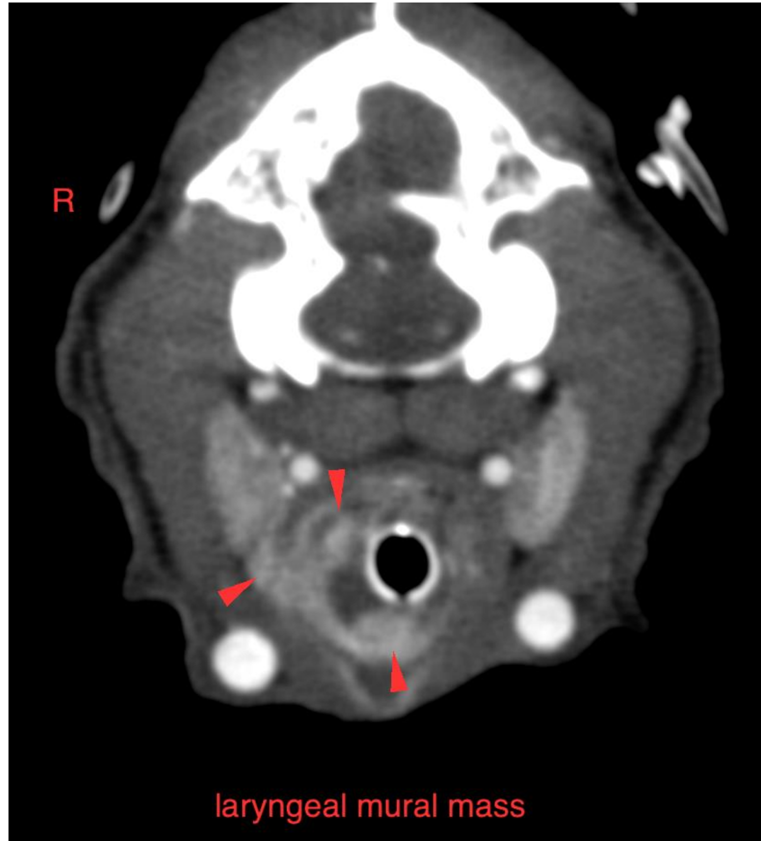

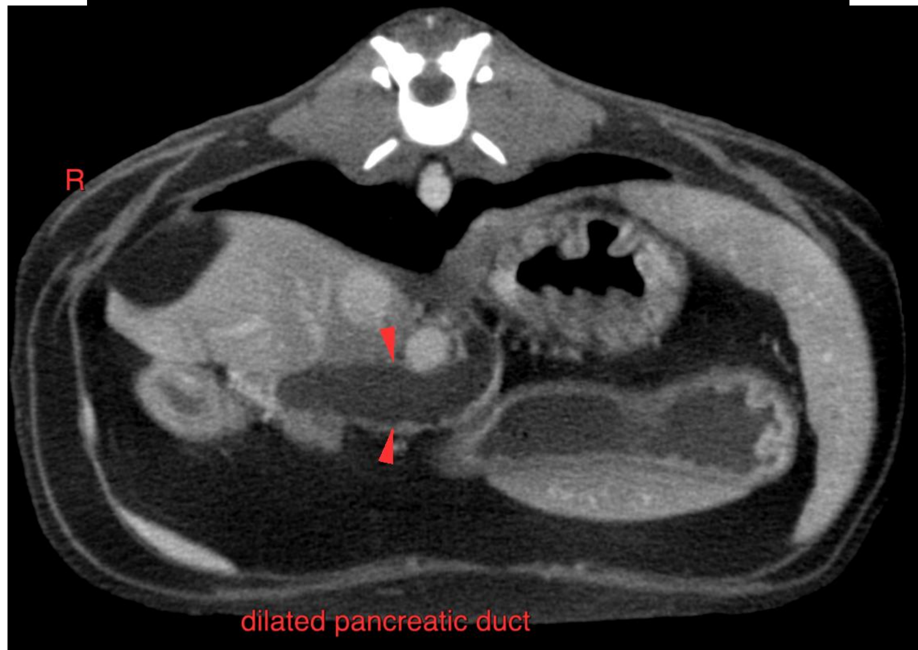

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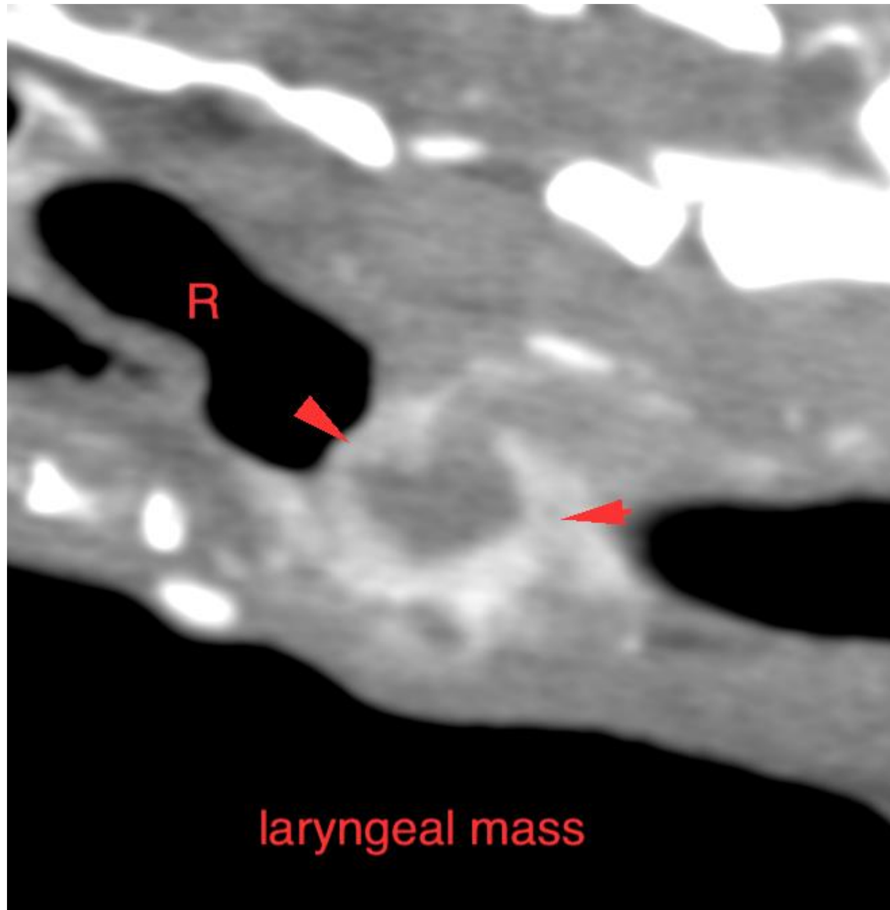

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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