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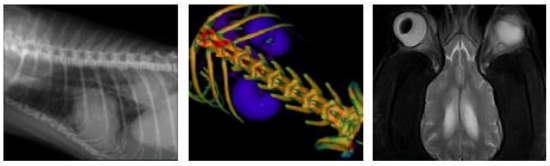


PATIENT

Milo Shifren

SPECIES

Canine

BREED

English Bulldog (Mixed)

SEX

Male Neutered

AGE

9 Years

INTERPRETED BY

Sebastian Schaub, DVM
Dr. med. vet. DipECVDI

HOSPITAL NAME

Animal Surgical Cener

REFERRING VET

N/A

INVOICE

58961

DATE

6-21-23

PRESENTING CLINICAL SIGNS

Presenting Complaint: Left Pelvic Limb lameness, left stifle Last Staging: chest rads and abd ultrasound, fluid cytology was done, possible pulomany nodules, cytology- L popliteal - mildly reactive, L stifle- suspicious for sarcoma, L femur- rare spindle cells Current medications: rimadyl q12h, gabapentin q8h PHYSICAL EXAM FINDINGS: MSI: ambulatory X3 with L rear limb moderate lameness, L distal femur swollen and painful Pain Score: 1 (0-5), BCS 6 (1-9), QOL: 7 (1-10) ASSESSMENT: 9 y/o M/N English Bull Dog with L distal limb neoplasia- R/O HS vs. SCS vs. other
Abnormal PE/Chem/CBC/UA Results: CBC/CHEM 6/21/23 WBC 9.44 10^3/uL NEU# 5.87 10^3/uL LYM# 2.89 10^3/uL MON# 0.43 10^3/uL EOS# 0.23 10^3/uL BAS# 0.02 10^3/uL NEU% 62.2 % LYM% 30.6 % MON% 4.6 % EOS% 2.4 % BAS% 0.2 % RBC 6.88 10^6/uL HGB 17.3 g/dL HCT 44.9 % MCV 65.3 fL MCH 25.2 pg MCHC 38.6 g/dL ABNORMAL RDW-CV 15.1 % PLT 353 10^3/uL MPV 8.8 fL BUN 16.7 mg/dl CRE 0.7 mg/dl IP 3.3 mg/dl Ca 9.7 mg/dl TP 7.1 g/dl ALB 3.2 g/dl GLOB 3.9 g/dl ABNORMAL GLU 128 mg/dl ABNORMAL TCHO 355 mg/dl ABNORMAL ALT 28 U/l ALP 170 U/l ABNORMAL GGT < 10 U/l TBIL 0.1 mg/dl

COMPUTED TOMOGRAPHY OF THE THORAX, ABDOMEN AND HIND LIMBS

A high resolution pre- and post-contrast CT study of the hind limbs and a post-contrast CT study of the thorax & abdomen are provided for review.

COMPUTED TOMOGRAPHIC FINDINGS

Thorax

T8 presents as hemivertebra.

The periarticular bones of both shoulder joints present mild osteophyte new bone formation. The included right elbow joint presents advanced osteophyte new bone formation along the periarticular bones.

The mediastinum is significantly widened by fat – resulting in retraction of the lung lobes from the thoracic wall.

A cranial mediastinal lymph node is prominent and rounded.

At the medial aspect of the aortic arch a roundish, uniform soft tissue attenuating lesion is seen, measuring 2.5 x 3.4 x 9.0 cm.

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.

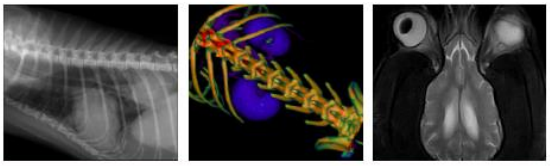
The ventral aspects of the lung parenchyma present zones with dystelectasis. The lung parenchyma presents the expected architecture and attenuation behavior.

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

Abdomen

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 a bilaterally symmetric and uniform nephro- and pyelogram is noted.



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

The spleen presents with normal shape, even surface, uniformly attenuating parenchyma and homogeneous contrast enhancement, unremarkable.

The hepatic volume is increased and the liver is protruding caudally beyond the costal arch; the caudoventral margins are rounded.

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

The vertebral endplates along the lumbosacral junction present moderate spondylosis formation. The lumbosacral intervertebral disc is protruding into the vertebral canal, occupying approximately 80% of the cross-sectional area of the vertebral at the same level.

The left medial iliac lymph node is mildly enlarged.

Hind limbs

The osseous and surrounding soft tissue structures of the pelvis are within normal limits. Both coxofemoral joints present smooth osseous margins and congruent joint spaces.

The left stifle joint presents a marked circumferential soft tissue swelling. The periarticular bones of the left stifle joint present advanced osteophyte new bone formation and multifocal irregular shaped and variable sized geographic osteolytic lesions of the subchondral bone of the femoral and tibial condyles.

The right stifle joint presents advanced osteophyte new bone formation along the periarticular bones and a moderate intracapsular soft tissue swelling is appreciated.

The patella of both stifle joints is located at the cranial aspect of the medial trochlear ridge.

The osseous and surrounding soft tissue structures of the tarsal joints bilaterally are within normal limits.

COMPUTED TOMOGRAPHIC DIAGNOSIS

- Marked articular swelling left stifle joint with polyostotic semiaggressive osteolytic lesions of the periarticular bones of the right stifle joint
- Mild lymphadenopathy left medial retropharyngeal lymph node
- Advanced degenerative osteoarthrosis right stifle joint – suspect underlying pathology of the cranial cruciate ligament ± meniscal disease
- Articular swelling right stifle joint
- Heart base mass versus enlarged cranial mediastinal lymph node
- Hepatomegaly
- Degenerative osteoarthrosis right elbow joint
- Significant widening of the mediastinum by fat
- Zones of dystelectasis ventral aspects of the lung
- No evidence of pulmonary metastatic disease
- Degenerative lumbosacral stenosis with compression of the cauda equina fibers

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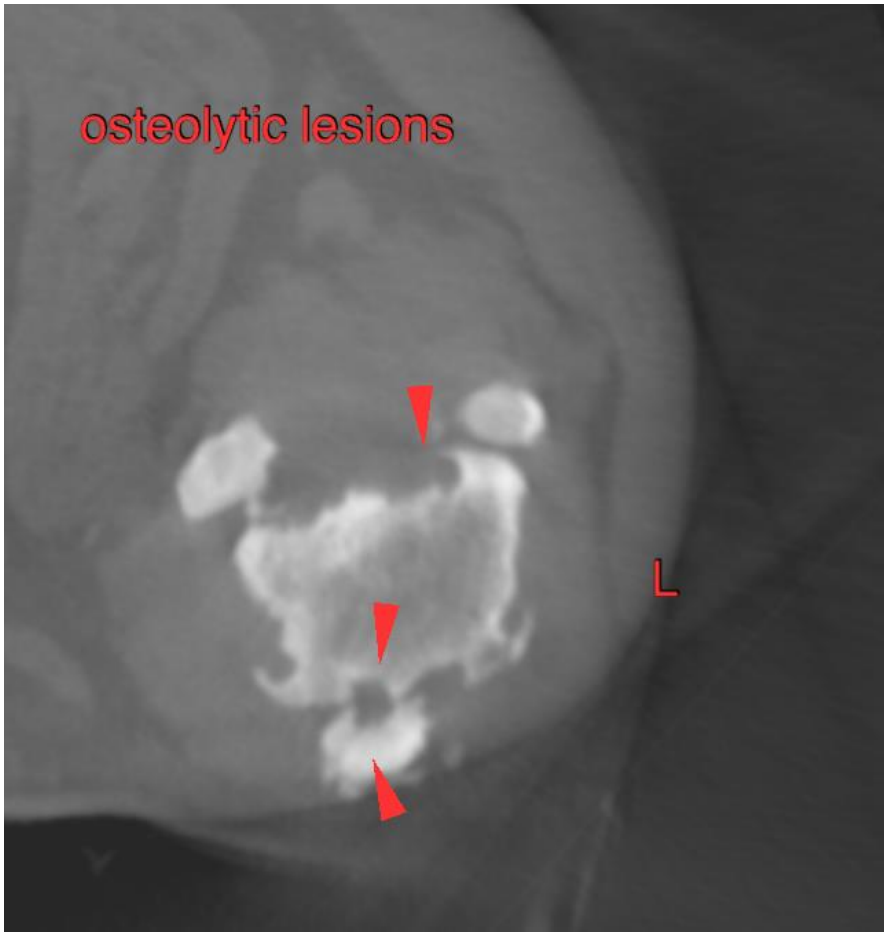
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes of the left stifle joint can support the diagnosis of potential sarcoma – such as synovial cell sarcoma – of the left stifle joint. A differential is advanced degenerative osteoarthrosis and accompanying arthritis. Biopsy of the joint capsule would be ideal for further differentiation.

The prominent left medial iliac lymph node is equivocal for reactive hyperplasia or metastatic disease; ultrasound guided FNA sampling can be used for further differentiation.

The appreciated mass at the medial aspect of the aortic arch can present heart base mass – paraganglioma is most common. An enlarged lymph node is a potential – metastatic disease versus reactive hyperplasia.

Potentials for the hepatomegaly include metabolic hepatic disease, hepatitis or diffuse neoplastic infiltration. In case of doubt, ultrasound guided FNA sampling and/or Tru-cut biopsy can be used as minimally invasive methods for further workup.



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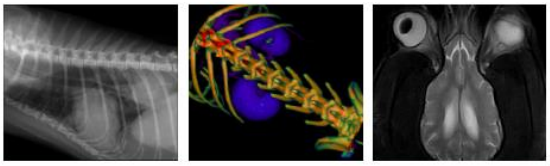

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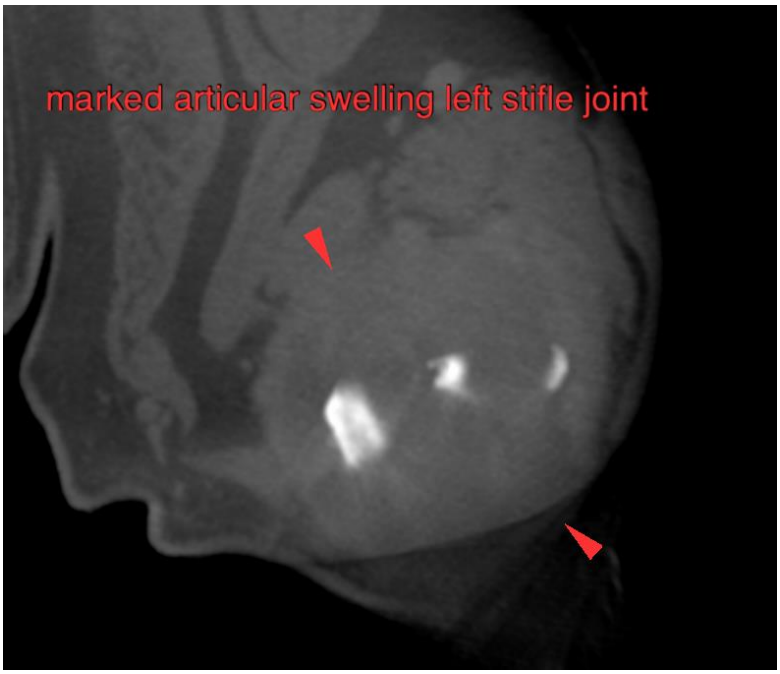

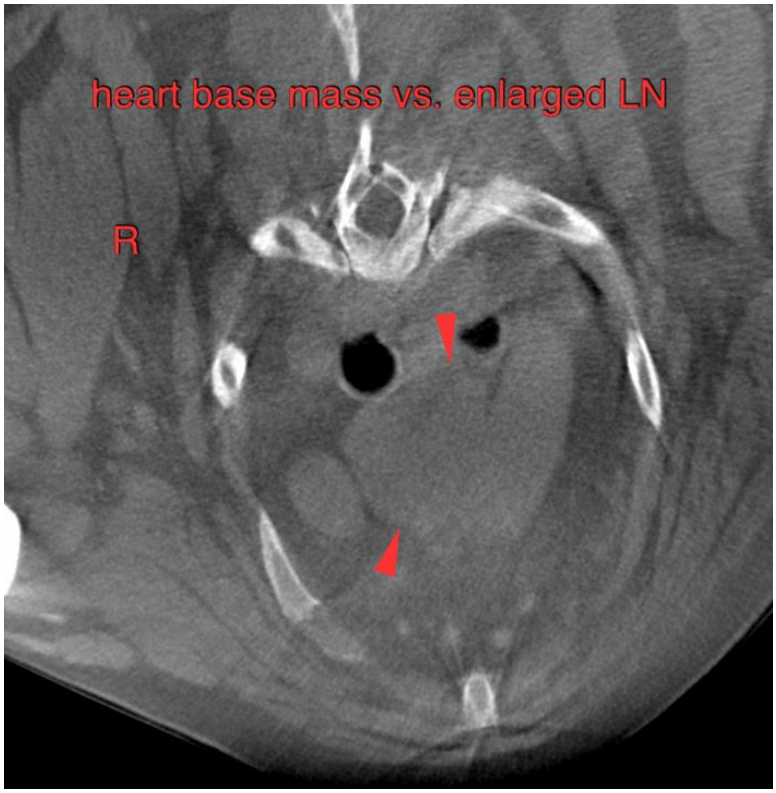

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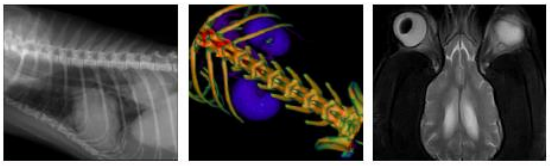

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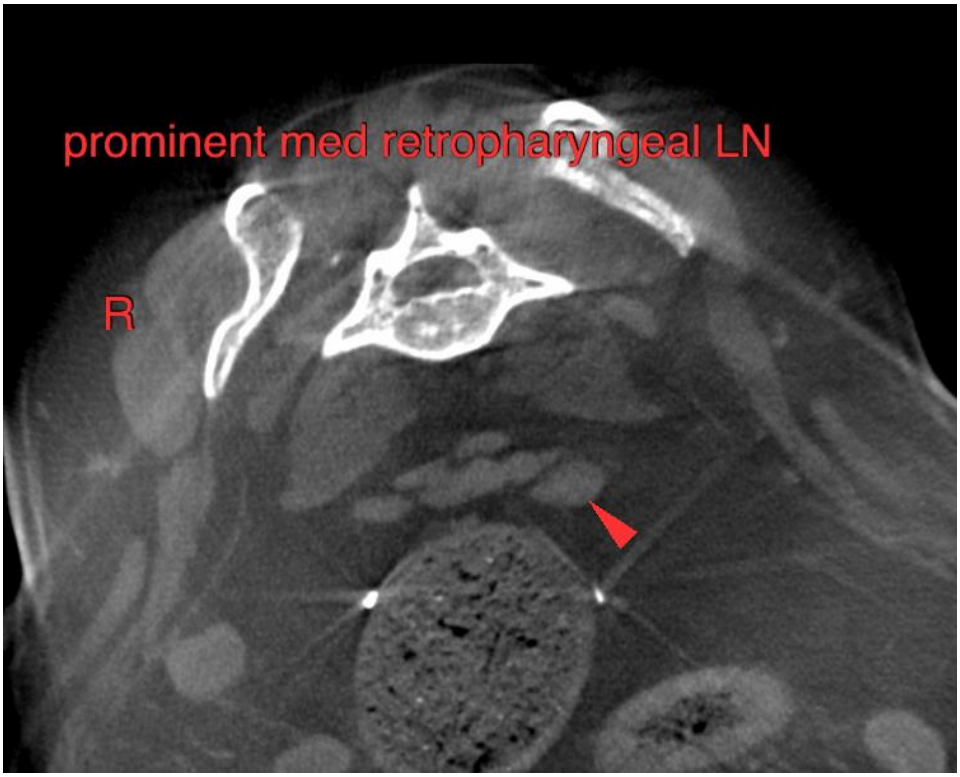

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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